afhto Annual Conference – October 15 & 16, 2014

In Partnership with Patients: True Integration of Care

Westin Harbour Castle, One Harbour Square, Toronto, Ontario M5J 1A6

POSTER DISPLAYS
Listed by theme

1- Accountability and governance for patient-centred care

1 Accountability Management System: Manage Accountabilities, Plan Programs, Organize Indicators and Measure Success- Our Performance Storybook and Song sheet!
2 Leading the Way: Safety Climate as an Indicator of Organizational Culture and Improved Patient Care

2- Engaging the patient in their care

3 Development of a new patient experience questionnaire for lifestyle services in team-based primary care.
4 The Markham FHT "Wellness Poster": A Key Educational Reference Tool For Your Clinic
5 Impact of curriculum design on patient-centred care: Integrating adult learning theory and constructivism into diabetes group education and its effects on patient satisfaction, confidence and learning outcomes
6 Engaging the patient in direct observation for Hand Hygiene in a Primary Care setting
7 Using a Well Baby Video for the Rourke recommended "Education and Advice" counseling during Well Baby Visits for infants two months or younger.
8 Improving Documentation of Our Patients' Decision Makers
9 The iGeneration Goes to Grade 9: Resources to Promote Adolescent Mental Health and Well-Being
10 Improving Self-referral Rates to the Safe Medication Use for Seniors Program: A Pilot Project
11 Who is in the Driver's Seat? -- Creating Sustainable Habit Change Through Interdisciplinary Education and Client Self-Management: A "How-To" in New Program Development
12 The use of technology in TAPESTRY to facilitate data collection and communication between patients, volunteers and interprofessional teams
13 Living Healthy with Chronic Disease
14 Patient Survey for Patients with Low Literacy
15 The iPad Project: an innovative way to engage patients and caregivers in healthcare and literacy.
16 Measuring the patient experience – a novel approach to getting valid, meaningful, comparable results monthly with relative ease
17 Growing a Baby Friendly Ontario with Family Health Teams

3- Responding to community needs

18 The Role of Cognitive Impairment in Causing and Perpetuating Homelessness
19 Speaking Your Language: Improving Language Inquiry and Recording with a Multi-Ethnic Population at Toronto Western Hospital
20 Driving Cessation: Traveling a New Road
21 Improving Care to High Risk Populations through Outreach
22 After Rural Residency: Where do Doctors Choose to Practice? An Evaluation of the Goals of the Rural Ontario Medical Program
23 Healthy Pregnancy Strategy: What to Expect when Rural Wellington Women are Expecting
24 McQuesten Community Nurse Networker Pilot- an Innovative Collaboration in a High Priority Hamilton Neighbourhood
25 Responding to Community Needs: INR Point of Care Testing in Rural Ontario

POSTER DISPLAYS
Listed by theme

4- Team collaboration in patient-centred care

26 It Takes a (Small) Village: How a physician and RPN can ensure best care for patients with HIV
27 Exploring the role of the pharmacist during the referral process between primary and specialty care
28 Planned Diabetes Days: Enhancing Patient Care Through Use Of The EMR
29 Team-Based Approach to Smoking Cessation
30 Group Well Baby Visits: Satisfaction Among Patients, Residents and Providers in a Community Family Health Team
31 Impact of Attachment Disorder in Fetal Alcohol Spectrum Disorder: A signs/Team Approach
32 Using Rounds Centred on Patient Narratives: Building Capacity within a Family Health Team to Improve the Delivery of Care to Vulnerable Seniors
33 Hospital Discharge Med Wrecks: Processes for Pharmacist-Driven Tune-Ups
34 Seamless access to care: Owen Sound Family Health Team and Keystone Child, Youth and Family Services
35 The Primary Care Lung Health Quality Improvement (QI) Guide: Partnerships and Teamwork to Create a QI Guide for Primary Care Lung Health Programs
36 Improving Eye Care for Patients with Diabetes: Collaborating Across Specialties
37 Enhanced Patient Care for Diabetics in Family Health Teams
38 COPD Readmission Avoidance Project
39 Patient Initiated Referral
40 A Multi-Institutional Approach to Improving Maternal and Fetal Health
41 Pathways to Practice™ at Two Rivers Family Health Team
42 Management of Osteoporosis Through an Evidence-Based Pilot Program
43 A new face to a group program: a physician-specialist to help motivate patients
44 Facebook as a Tool for Collaboration and Knowledge Exchange Among Members of an Academic Family Health Team
45 From Disney to Depression: How a Storyboard is being used to Design a Patient-Centred Care Pathway

5- Integrating the community around the patient

46 Impacting Cancer Screening By Employing Different Strategies within Primary Care Settings
47 Beyond Our Front Door: Promoting Community Partnerships to Improve Patient Care
48 Primary care providers' perspectives on using the Champlain BASE eConsult service – a qualitative study
49 A partnership approach to the well child check up

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

50 Collecting and Sharing Colorectal Cancer Screening Data with Primary Care Providers
51 UTOPIAN CPCSSN project: past, present and future
52 Using Visual Analytics to Support Quality Improvement in Primary Care
53 The Step Approach: Standard Treatment and Collaborative Care Lead to Better Hypertension Outcomes
54 Opioid Prescribing Patterns in Family Health Team; The Good, the Bad and the Ugly
55 Patient Encounter Tracking Form – moving into the electronic century!
56 Utilization of Custom Spreadsheets to Support Chronic Disease Management within the London Family Health Team
57 Using the Right Data to provide the Right Care

POSTER DISPLAYS
Listed by theme

58 Creating Registry for Patients with Hypertension: Embarking on a Quality Improvement (QI) Methodology to Improve Care for Patients with Hypertension
59 Documentation tools to assist in the transition and transfer of Spina Bifida patients from a Pediatric Multidisciplinary Clinic to the adult healthcare system.
60 Integrating Hospital Report Manager into a Family Health Team
61 The EMR 'adoption chasm' – looking at EMR current use and how to bridge the 'chasm' between basic and intermediate/advanced use
62 Reduction of Social Work Referral Wait Times Through Effective Triaging and Utilization of Resources

7- Clinical innovations in comprehensive primary care

63 Chronic Pain Management -a Collaborative Primary Care Model to Support Patients living With Non-Cancer Chronic Pain
64 The Transition from Hospital-Based Care for Stable HIV-Positive (HIV+) Patients in Ottawa
65 The Effect of a Structured versus Non-structured Homebound Seniors Program on Resident Attitudes towards House Calls
66 The successful implementation and integration of eConsultation into a Family Health Team to improve access to specialist care
67 Senior's Health Day - Providing an integrated, seamless care to seniors.
68 Cognitive Assessment Clinics: A Model of Shared Care – Nurse Practitioner, Family Physician, & Geriatrician
69 Senior Wellness Program: An innovative collaborative approach to provide comprehensive patient-centred care to promote healthy and independent living at home.
70 Cervical Screening Performance of Family Practice Models in Ontario
71 Individualized versus standard treatment for smoking cessation: Findings from STOP with Family Health Teams.
72 Creating Greater Collaboration by Utilizing Motivational Interviewing as a Common Language within an Inter-Professional Practice Team
73 Getting dermatology consults in less than 5 days by leveraging OTN and technology
74 One Small Step at a Time: A Team Approach to Integrating a COPD Program in the FHT

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.

1 Accountability Management System: Manage Accountabilities, Plan Programs, Organize Indicators and Measure Success- Our Performance Storybook and Song sheet!

1. Accountability and governance for patient-centred care

Heba Sadek, Executive Director, Queen Square Family Health Team
Lindsey Thompson, Health Planner, Queen Square Family Health Team
Abel Gebreyesus, Quality Improvement Decision Support Specialist (QIDSS), Queen Square Family Health Team (Host)

Learning Objectives: Participants will learn about a system structured based on the principles of program planning and demonstrates its applicability to health services planning through building a framework that helps organizations manage the various accountability domains: clinical, administrative, governance. In order to showcase performance in any of those domains, performance indicators should be structured and managed. Participants will explore how to organize the components of their accountability domains in an efficient and meaningful way to facilitate the management, measurement and reporting processes while ensuring stakeholders engagement.

Summary: In the Family Health Teams sector, there are many accountability areas with several reporting requirements and related performance indicators; ministry reports, clinical outcomes, individual providers' performance measurements, administrative requirements, D2D, Prirmary Care Preformance Measurement Framework, STARFIELD model..etc. So, how do we manage all these complexities? How do we build a logical framework to organize and access information? How do we design indicators to measure performance? How do we display results/ prepare reports? And, most importantly, how do we engage staff? The software of the Family Health Team Accountability Management System addresses all these questions and more!

We have developed an innovative solution and tool to manage complexity and are now ready to share our experience and learning in designing a data driven quality improvement initiative. The system enables organizational efficiency through supporting Administrators (manage and monitor performance), IHPs (plan and track services/ programs) , Physicians (keep track of services and outcomes) and QIDSS (manage complexity across multiple teams, link indicators to the different frameworks: D2D/ Primary Care performance Framework, track data, display results and meet the various reporting requirements). The Accountability Management System is designed to enable FHTs organize their services/ programs, structure indicators, store and display results all in an intuitively designed software that is easy to use and comes loaded with guidance for step by step implementation.

2 Leading the Way: Safety Climate as an Indicator of Organizational Culture and Improved Patient Care

1. Accountability and governance for patient-centred care

Sandra Excellent, Regional Consultant, Public Services Health & Safety Association

Learning Objectives:
Learning objective #1- Understand how the analysis of safety climate and insight into organizational culture can influence workplace health and safety and ultimately the quality of patient care

Learning objective #2- Shift the focus from lagging to leading indicators of health and safety performance,

POSTER DISPLAYS

Theme 1- Accountability and governance for patient-centred care

and identify key elements that drive organizational safety climate

Learning objective #3- Become familiar with an innovative and validated tool used to assess health and safety climate in an organization

Summary: It would be difficult to link culture to organizational performance if you do not diagnose the problem in the first place. This poster will showcase an innovate development that takes a closer look at the safety climate as a way to provide organizations with valuable insight into their safety culture to improve their health and safety performance, and advance patient care. Evidence shows that a positive safety culture provides improved bottom-line with better business outcomes. Top performing firms in Canada do not view occupational health and safety as separate functions but as an integral part of productivity, competitiveness, and profitability. A number of elements comprise organizational safety climate and this presentation will explore some key components to focus on when creating healthy and safe workplaces.

This poster will focus on an innovative and validated tool that is used to assess safety climate in an organization. Provide insight into the underlying reasons behind health and safety priorities within the healthcare industry: leadership, vulnerable workers, young workers, etc. Participants will be taken on a journey exploring the benefits of creating a positive safety culture; as well as practical recommendations for improvements that they can apply in their workplace

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.

3 Development of a new patient experience questionnaire for lifestyle services in team-based primary care.

2. Engaging the patient in their care

Anneli Kaethler, RD, MSc (candidate), University of Guelph & Hamilton Family Health Team

Learning Objectives: Learn about the provider and patient input that shaped the development of a new patient experience questionnaire for team-based lifestyle (nutrition and/or physical activity) services in primary care.

Summary:
Purpose: Patient experience is particularly important to assess for lifestyle services (nutrition and/or physical activity) as patients must be active partners to make needed changes. This project aimed to develop and pilot-test a new self-administered questionnaire that would be useful to quality improvement initiatives, based on recent work by the Canadian Institute for Health Information. It is intended that the questionnaire could be stand-alone or part of a larger questionnaire on the primary care experience.

Methods: Provider input was first sought to determine which aspects of the patient experience to include. Providers individually rated and ranked the 17 dimensions/sub-dimensions after group discussions of the Wong & Haggerty dimensions of patient experience. Items from existing patient satisfaction questionnaires were modified and new items generated to address the identified key dimensions. The draft questionnaire was revised based on 2 rounds of cognitive interviewing with 11 patients.

Results: Thirty-eight providers completed the rate and rank survey. The top 10 ranked dimensions/sub-dimensions were: first contact-accessibility, trust, whole-person care, general communication, respectfulness, shared-decision making, economic accessibility, team functioning, and patient activation. The "services provided" sub-dimension was also included based on expert opinion. The draft questionnaire consists of 22 questions that address the key interests of providers and patients. The questionnaire is feasible and demonstrates face validity. Conclusions: Further testing of this new patient experience questionnaire is needed to determine further validity and reliability as well as usefulness to quality improvement initiatives.

POSTER DISPLAYS

Theme 2- Engaging the patient in their care

4 The Markham FHT "Wellness Poster": A Key Educational Reference Tool For Your Clinic

2. Engaging the patient in their care

Lisa Ruddy, RN Clinical Program Manager, Markham FHT

Learning Objectives: In July of 2011, Markham FHT created the "Wellness Visit Poster", and introduced this reference tool into the practice. The poster presentation will outline the Wellness Poster "journey", from the rationale for examining current guidelines through to the conversations the poster has stimulated among providers and patients. • Patients begin asking how the poster applies to them, do they need to see their provider "annually" as they have done in the past • Providers begin to see behavior change in their patients, see improvement in their preventive medicine counselling and their ability to identify when and why patients need to return to the office • Qualitative research study on providers' reaction to and incorporation of the poster into their practices

Summary: Inception – • looking for answers to questions surrounding current guidelines for preventive care, and the evidence behind periodic health exams •Are we servicing our patients appropriately during the periodic health exams? •Does the "language" even support the care that is provided in these visits? Getting the ball rolling – • Deciding on the use of "screening points" to determine a tentative "wellness schedule" for patients to follow along the life continuum •Clarifying the care provided by emphasizing health and wellness as being as important as the management of new or chronic conditions (don't "lump" many problems into one visit) • New language – "Wellness Visits" versus "annuals" or "physicals" to convey to patients the lifelong commitment to their overall health needs, outside of the needs associated with chronic conditions The Poster – •Drafting of a "suggested schedule" for patients to be aware of reasons for screening at different life stages •Not intended to "prevent patients from seeing their provider", but rather to assist the patient to recognize why they are seeing their provider (Is this new problem? Are you following a chronic condition?) • The use of the poster as an educational reference

5 Impact of curriculum design on patient-centred care: Integrating adult learning theory and constructivism into diabetes group education and its effects on patient satisfaction, confidence and learning outcomes

2. Engaging the patient in their care

North York Family Health Team:
Jasmine Montreuil, RD, CDE, MA Ed (c),
Christine Truong, BScPhm, ACPR, RPh

Learning Objectives: From this poster presentation, participants will be able to:

1. Examine Adult Learning Theory and Constructivism.
2. Relate these theories to curriculum development in diabetes.
3. Identify the benefits of incorporating these theories into diabetes group education.

Summary: North York Family Health Team (NYFHT) has taken initiative to further support and enhance our type 2 diabetes education program by incorporating adult learning theory and constructivism. These theories have been documented in education literature to facilitate a deeper understanding of complex concepts, promote opportunities for group learning of practical and relevant knowledge, and foster a stronger sense of agency (Hampton, 2011; Knowles, 1980). Despite these benefits, many programs are designed around content-based instruction, rather than a patient-centred, learning-based educational approach.This poster presentation will review NYFHT's transformative journey toward improved patient-centred care through the integration of adult education theory and constructivism into our diabetes education program. We will present findings around patient satisfaction, patient confidence and learning outcomes.

6 Engaging the patient in direct observation for Hand Hygiene in a Primary Care setting

2. Engaging the patient in their care

Judith Manson, Executive Director, Sunnybrook Academic Family Health Team

Learning Objectives: To understand the components of an innovative approach to engaging patients in their care

Summary: Research has shown that monitoring Hand Hygiene compliance and providing feedback to staff is considered an integral part of a successful program. At the Sunnybrook Academic FHT, we observe 4 moments for hand hygiene as outlined in the Ontario Just clean

your Hands initiative. Currently, auditors observe before and after contact with the patient (moments 1 and 4), and demonstrate a combined compliance of 95%. Effective monitoring of hand hygiene compliance is challenging in this setting and direct observation of moment 2 (before aseptic procedures) and moment 3 (after body fluid exposure risk) is difficult due to: availability of trained auditors, physical layout restrictions, and respecting patient confidentiality.

Patients were given a survey and asked to 1) observe the HH process for all four moments 2) fill out the survey anonymously and 3) drop it off in a box located in the waiting room. This pilot project was conducted in December 2013 over two and a half weeks with a target of 200 surveys. The aim was to maintain the overall hand hygiene compliance of 95% in all four moments. Process map, root cause analysis and PDSA cycles were used to identify opportunities for improvement for this pilot study. The results of the pilot study suggest that involving the patient as the observer is a feasible and beneficial solution in monitoring HH compliance in a primary care setting.This quality improvement initiative emphasized the importance of patient communication as a novel way to evaluate programs that have direct patient care implications.

7 Using a Well Baby Video for the Rourke recommended "Education and Advice" counseling during Well Baby Visits for infants two months or younger.

2. Engaging the patient in their care

University of Toronto - Toronto Western Hospital Family Health Team:
Andrea Lo, PGY1 Family Medicine Resident
Michael Verbora, PGY1 Family Medicine Resident

Learning Objectives: • Explore an innovative method of presenting counseling information to patients in a clinic, in digital video format (accessible on YouTube) • Assessing the benefits and drawbacks of using digital video to present counseling information for both patients and physicians • To gain insight on challenges we encountered in the process of formation and implementation of digital video within the Family Health Team • To discuss the changes made to overcome challenges with Quality Improvement PDSA cycles. • To discuss our findings: physician time saved and patient satisfaction with digital video education

Summary: A current practices survey in our FHT showed that residents spent an average of 2-3minutes on the counseling part of WBV's, while staff spend 7-10min. The majority of the residents self-reported that they felt that the quality of their counseling was "poor" or "satisfactory", while staff on average felt that they did "very good" counseling. The overwhelming reason cited for a less than "very good" quality of counseling was lack of time during appointments. Based on this, we chose for our quality improvement project to make a Well Baby Video that would review the Rourke recommended "Education and Advice" for Well Baby Visits for infants 2 months or younger in age.

This three minute video aimed to save physicians time during WBV appointments, improve the overall quality of counseling, and finally to increase patient satisfaction and education by making an easy to understand, Rourke guideline-based video that would be available to view before their appointments as well as at home via online access to YouTube when outside the clinic. Our outcome measures included: 1) physician feedback on the quality of the information presented and subjective time saved by using the video in their practices and 2) patient feedback on the understandability/usefulness of the video as well as whether they were likely to use the video again at home for review of information or as a source of reference for family and friends.

8 Improving Documentation of Our Patients' Decision Makers

2. Engaging the patient in their care

Kevin Brophy, PGY-1 Family Medicine, University of Toronto, Toronto Western Hospital
Shayda Ziai, PGY-1 Family Medicine, University of Toronto, Toronto Western Hospital
Benjamin Kaasa, MD, MScCH, CCFP, University of Toronto, Toronto Western Hospital
Ian Waters, MSW, University of Toronto, Toronto Western Hospital
Howard Lau, Administrative Staff, Toronto Western Hospital

Learning Objectives: In order to better serve our patients' best interests, our project sought to improve collection and documentation of our patient's decision makers in our family practice clinic. The objective was to learn more about how information about patient decision-makers was collected and documented in our family practice clinic, and if we could improve this

process to better identify and document who our patients' decision makers are with a simple intervention.

Summary: Chronic illness can lead to acute changes in a patient's state of health and their ability to make decisions about their health care. Advanced Care Planning, including an identified Power of Attorney (POA) and emergency contact person, is essential for efficient care, which is most consistent with the patient's wishes. Our project aims to gather up-to-date information on decision-makers for our patients over age 65 who present for an appointment at the Family Health Team at Toronto Western Hospital. Data-collection and information forms were handed out to patients at reception when they registered for a visit. The data-collection form requested emergency contact information and POA information. The patient's EMR was then updated with the newly-obtained information. Surveys of various staff members helped to gather data on ease of use of the intervention and impact on staff workflow due to the intervention.

During the two-week trial period, a total of 85 patient over 65 presented for an appointment. We received 12 completed patient surveys, of which 11 provided updated decision-maker information, and 9 identified a POA that was otherwise unknown to the clinic. The staff surveys revealed no negative impacts of this process on front line staff or health care providers. This simple and minimally intrusive intervention could allow for the clinic to improve documentation of the contact information for our patients' decision-makers. In addition, we hope that the patient information sheets prompt further discussion and exploration of the importance of Advanced Care Planning for our patients.

9 The iGeneration Goes to Grade 9: Resources to Promote Adolescent Mental Health and Well-Being

2. Engaging the patient in their care

Angela Townend, Social Worker, MSW, RSW, London Family Health Team

Learning Objectives: Participants will acquire knowledge of strategies for health professionals to promote as their adolescent patients transition to post-secondary school. The London Family Health Team has developed evidence-based resources identifying ten key issues teens and their families will encounter as they navigate the social-emotional challenges of Grade 9. Awareness of mental health disorders, school failure and high risk behaviors has led to the development of various in-school student success initiatives. As a constant stakeholder in the lives of these patients, FHT's too can utilize resources to engage these particular students to address and potentially reduce the impact of those identified issues.

Summary: Objective: To provide resources for patients and their families which identify some of the core issues faced by adolescents as they transition into Grade 9 as well as presenting well-defined and sustainable strategies to manage these challenges. Hypothesis and Need: One of the key predictors of student success is an overall positive Grade 9 experience. Research supporting this finding has identified the importance of such variables as regular attendance, level of parental engagement and a student's ability to cope with stress. Our best practice therefore is the provision of resources which may potentially initiate critical discussions between these adolescents and their support systems, ultimately engaging all parties in preparation for some of the inevitable challenges that lie ahead.

This collaboration invites students to take responsibility for acquiring both knowledge and skills necessary for responding more strategically to expected transitional experiences at the post-secondary level. Method: A pamphlet "Are You Ready for Grade 9?" was developed for all patients entering high school as well as two parent handouts, a short and extended version, entitled "Grade 9 Transition – What Parents Need to Know". Using evidenced based research, these resources address ten core themes including mental health, substance abuse, academic stress,and student engagement. These resources were mailed to all rostered families with an adolescent entering Grade 9 while some patients were also provided copies while attending various clinic appointments.

10 Improving Self-referral Rates to the Safe Medication Use for Seniors Program: A Pilot Project

2. Engaging the patient in their care

Mount Sinai Academic Family Health Team:
Suzanne Singh, Registered Pharmacist
Louisa Shan, Family Medicine Resident
Shakti Sivakumar, Family Medicine Resident

Learning Objectives: 1. to discuss a clinic waiting room strategy to promote the Safe Medication Use for Seniors Program to eligible patients 2. to report the impact of a promotional strategy on patient self-referral rates to the Safe Medication Use for Seniors Program 3. to

highlight challenges and opportunities when considering implementing a direct-to-patient marketing strategy designed to facilitate patient engagement in their own care

Summary: The Safe Medication Use for Seniors Program within the Mount Sinai Academic Family Health Team highlights a pharmacist-led model of team-based care designed to systematically screen and address medication-related concerns in an at-risk elderly population. Patients can access this program through self-referrals, however baseline data suggests that most patients who attend the program come from physician referrals. To increase patient awareness and improve self-referral rates to the program, a direct-to-patient advertising campaign involving educational brochures and posters was thus implemented. Results in the following 3 months suggest that this strategy has been effective in increasing patient self-referral rates. Challenges and opportunities when implementing a direct-to-patient marketing strategy designed to facilitate patient engagement in their own care will also be discussed.

11 Who is in the Driver's Seat? -- Creating Sustainable Habit Change Through Interdisciplinary Education and Client Self-Management: A "How-To" in New Program Development

2. Engaging the patient in their care

Humber River Family Health Team:
Amy Bailey, BSW, MSW, RSW-- Registered Social Worker
Rose-Ann M. Bailey, BFA, BEd, MEd(c) -- Health Promoter/Educator

Learning Objectives: This presentation discusses the planning and implementation process of a client-centred, self-management program within a Family Health Team (FHT). Information will focus on the creation of an interdisciplinary client education program to promote healthy lifestyle through habit change and empowerment versus traditional, didactic education. The audience will gain the knowledge necessary to create a stepped approach to care in their FHT that engages clients and their families as key players. Additionally, we will discuss: framework for new program creation, the transition from current culture to group-based self-management, involvement of staff and clients in development, and creating engaging resources and evaluations.

Summary: Family Health Teams (FHTs) continue to evolve to better serve their individualized communities. Many FHTs are utilizing new education methods to provide effective client care that includes self-management principles. The transition away from teacher-student dynamics, to a more interactive environment involving client participation as a sustainable model for behaviour change has increased due to evidence from best practice literature and experience among health providers. The Humber River FHT proposes to implement a multi-tiered strategy, incorporating Craving Change, Chronic Disease Health Management, nutrition education, and individual sessions for clients who require additional support.

The goal of this approach is to provide primary, secondary and tertiary health promotion education to both prevent and manage chronic illness. The tools, resources, and confidence gained in this program will empower clients to play greater roles in their health self-management. To achieve this, we aim to develop a framework that will assess the needs of the targeted population, strengthen collaborative care and services, promote health and community engagement, utilize new techniques and technology in delivery, and develop strategies to guide future self-management program planning and assessment. Once implemented, we hope to collect and analyze data on the program utilization, client and provider satisfaction, and baseline enrolment data to evaluate the efficacy of the program and improve its scope and delivery. The focus of this presentation is to discuss an experiential "how-to" in creating a stepped-approach to client-centered care that not only engages clients and their families as key players, but promotes collaborative care between health professionals.

12 The use of technology in TAPESTRY to facilitate data collection and communication between patients, volunteers and interprofessional teams

2. Engaging the patient in their care

Department of Family Medicine, McMaster University:
Ernie Avilla, Program Manager
Anubha Sant, B. Sc., M. Sc (e-Health), e-Health Strategy Lead, Project Management Consultant
Lisa Dolovich, BSc Phm, PharmD, MSc. Professor, Research Director

Learning Objectives: This discussion will: • Describe how a novel application for the TAPESTRY intervention

called TAP-App (tablet computer) can facilitate communication of health information during home visits between volunteers and patients, and between patients and the interprofessional (IP) team • Demonstrate how the volunteer-patient interaction during home visits can contribute to the design and development of technology for the TAP-App interfaces that address the needs of older adults • Explore volunteer and patients perspectives of the utility of the TAP-App as a data-gathering tool

Summary: One pillar of TAPESTRY (Teams Advancing Patient Experience: Strengthening Quality) is integrating trained community volunteers within patients' healthcare teams to improve patients' experience with primary care through increased knowledge and improved communication. These benefits also extend to the primary healthcare team. This novel approach of engaging volunteers is enabled through the use of technology. TAPESTRY developed an innovative TAPESTRY Application (the TAP-App) to facilitate communication between patient and their healthcare teams improving communication and patient experience while directly addressing the needs of older adults. Data gathering tools include: "Goal setting", "Edmonton Frail Scale"; "Duke Index of Social Support"; "Nutrition Screen II"; and "Activities of Daily Life."

This information generated a report, which was then sent to the EMR system for interpretation by the healthcare team. This novel form of collecting and communicating health information assisted clinicians to have a complete picture of patient's health and informed the delivery of care. The volunteer visits with patients provide an opportunity to understand how older adults interact and react with the technology and how the technology affects the process of information gathering during the volunteer-patient encounter. Volunteers are also able to introduce the benefits of a Personal Health Record (i.e., MyOSCAR), and to demonstrate how to use this system. Findings of the pilot study have allowed a better understanding of TAPESTRY for researchers, clinicians, volunteers and patients and to fine-tune the intervention in preparation for its implementation within the McMaster Family Health team and other jurisdictions across Canada.

13 Living Healthy with Chronic Disease

2. Engaging the patient in their care

Thames Valley Family Health Team:
Clark, Program Administrator,
TBA- in transition between QIDS

Learning Objectives: Participants will gain knowledge of the use of a multidisciplinary approach in educating patients on chronic disease self-management. The poster will encompass patient education on useful techniques for managing their chronic disease in their personal life and in conjunction with the healthcare system. In addition, training healthcare professionals on the most up-to-date and useful techniques for patient directed self-management. For example, all healthcare professionals working with COPD patients would be trained on the most comprehensive breathing techniques.

Summary: The presentation will encompass a brief description of the current COPD education program being run at numerous sites within the Thames Valley Family Health Team. The current program involves services from Registered Nurses, Nurse Practitioners, Respiratory Therapists, Pharmacists, Social Workers, Dietitians and Physicians. The program is currently running at our FHO/MC sites which have a respiratory therapist on staff. Through the use of the COPD Reference Manual (created by a TVFHT Respiratory Therapist), clinicians will provide a streamlined education program to patients on training provided by the FHT Respiratory Therapists. The presentation will educate participants on facilitating patient-centred care for chronic disease management. As well, participants will learn best practices in team collaboration for delivering patient-centred care. manner (including smoking cessation, social work, etc).

14 Patient Survey for Patients with Low Literacy

2. Engaging the patient in their care

Village Family Health Team:
Dr. Manisha Verma, Medical Doctor
Subo Awan, Registered Nurse

Learning Objectives: • Learn about tools available to support the development of a low literacy patient survey • Understand the process Village FHT used to develop its own survey • Hear feedback from patients piloting the low literacy survey and how the team responds • Participants are offered the final survey. Offer to share the survey with other teams.

Summary: Village FHT has over 8,000 registered patients. About 1,000 patients have serious mental

illness and a subset of this group have low literacy. The team has developed a metabolic program for quarterly diabetes management. It has also implemented a number of other adjustments in the delivery of primary care to make it easier for many of our patients.

Examples include:
- offer blood work at clinic instead of asking to go to lab
- High tolerance for no show appointments
- Scheduling patient appointments in collaboration with the care providers at group homes or case managers from CAMH
- Seeking out local optometrist sensitive to the needs of this patient population.

We are eager to receive feedback from a group of patients that often do not freely offer up their opinions and express their own needs.

The presentation will explore:
- The process to develop the survey includes published tools and resources
- The process to pilot the survey with a small group of patients
- The final survey including a comparison to the standard patient satisfaction survey.

15 The iPad Project: an innovative way to engage patients and caregivers in healthcare and literacy.

2. Engaging the patient in their care

Dr. Cathy Faulds, MD, CCFP, FCFP, ABHM, London Family Health Team
Linda Harvey-Rioux, Media Design & Education Consultant

Learning Objectives: This presentation will: • Demonstrate how Family Health Teams can use innovative technologies to foster communication with patients by delivering information on health specific themes and chronic disease programs through slideshows, books, videos and support resources. • Demonstrate an innovative teaching tool for physicians that engages patients in decision making about their own care and promotes health literacy through the use of animated 3D anatomy apps, stats calculators (Frax, Framingham). • Present ways to inform patients about quality improvements of health care delivery by the Team and how the practice is doing within the healthcare system. The iPad showcases information on quality improvement statistics in the practice.

Summary: THE IPAD PROJECT as an innovative tool for engaging both patients and physician was introduced into Dr. Cathy Faulds' examination rooms in August 2013. The preliminary approach was to provide a versatile and interactive tool to offer slideshows on health topics and foster patients' engagement in their own care. In addition, apps on the iPad such as iBooks offer an extension of the learning experience by providing support resources on each topic. Other apps provide health related games for children and adults. The Newsstand app contains current and past issues of 14 digital magazines for patients to browse while waiting. Patients have access to the London Family Health Team website and the Internet.

For the physician, 3D applications for anatomy, shoulder and knee animations, etc, and calculators such as Frax are available on the iPads. The poster will present an example of how adopting new technologies can offer physicians and Family Health Teams ways to be at the leading edge of extending their reach and meeting the needs of their patients. Participants will hear about the development of the innovative use of iPads in the exam room. Presenters will share how the iPad is being used as an interactive tool for engaging patients in their own health literacy through access to health specific slideshows, related books and videos.

16 Measuring the patient experience – a novel approach to getting valid, meaningful, comparable results monthly with relative ease

2. Engaging the patient in their care

St. Michael's Hospital Academic FHT:
Tara Kiran, Family Physician, QI Program Director
Laurie Malone, Executive Director

Learning Objectives: • To reflect on the strengths and weaknesses of your FHT's current approach to measuring patient experience • To understand the logistics of setting up an electronic patient experience survey that is emailed monthly to patients • To become familiar with some patient experience questions from the Commonwealth Fund International Health Policy Survey • To appreciate potential differences in results between a patient experience survey administered in a waiting room and one that is emailed to patients

Summary: In January 2014, the SMHAFHT launched a monthly electronic patient experience survey that is emailed to patients in the month of their birth. Over a one-year period, all FHT patients who have provided us

with their email address will have the opportunity to complete the survey, regardless of whether they have come in for a patient visit during that time. Patients fill out the survey on Fluid Surveys which facilitates data management and analysis. Most survey questions have been taken from the Commonwealth Fund International Health Policy Survey, allowing the FHT to easily compare FHT performance with provincial, national, and international data.

We will be offering patients in the waiting room the opportunity to complete the same electronic patient experience survey on a tablet device in the summer of 2014 to help us understand the generalizability of our email survey results. During our presentation, we will describe the process for our emailed patient experience survey, present data from the first six months, and compare these to data from the same survey disseminated to patients in the waiting room. We will discuss clinicians' reactions to the survey results and also the feasibility of replicating our process at other sites.

17 Growing a Baby Friendly Ontario with Family Health Teams

2. Engaging the patient in their care

Toronto East General Hospital:
Linda Young, MScN, EdD, Director Maternal Newborn Child, Mental Health, Interprofessional Practice and Organizational Learning
Kristina Niedra, MA, Project Manager, BFI Strategy and MCIT

Learning Objectives: The participants will be able to: 1.Describe their understanding of the key goals and objectives for the BFI Strategy for Ontario. 2.Describe the importance and impact of BFI for enhancing maternal and infant health. 3.Describe process and outcome indicators that are being used to measure changes towards BFI implementation for the province. 4.Identify resources available for becoming Baby Friendly and how to access these.

Summary: In the spring of 2013 the Healthy Kids Panel Report recommended that all infants be started on the path to a healthy life through exclusive breastfeeding. Subsequent to the report the MOHLTC announced funding to provide hospitals and community health organizations with training, tools, guidance and resources to help achieve the WHO BFI designation and adopt best practices that meet BFI requirements.

Toronto East General Hospital is leading the BFI Strategy for Ontario in partnership with the Best Start Resource Centre and the Provincial Council for Maternal Child Health. Family Health Teams are one of the seven identified groups for BFI implementation.

This presentation will provide an overview of the BFI Strategy for Ontario including goals, objectives, initiatives to date, lessons learned and results. The key process and outcome indicators identified for the initiative will be discussed along with monitoring and reporting strategies. The presentation will also include a review of the importance of BFI, key research underlying the value of ongoing community support to achieve exclusive breastfeeding until at least six months of age and how to become BFI designated. At the end of the presentation, participants will have a clear understanding of the BFI Strategy and how they might access the resources and supports offered by the strategy to become involved in becoming Baby-Friendly.

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.

18 The Role of Cognitive Impairment in Causing and Perpetuating Homelessness

3. Responding to community needs

Sylvain Roy, Ph.D., Neuropsychologist, Inner City Family Health Team

Learning Objectives: Homeless persons are very high users of healthcare. Data from the neuropsychology clinic from Inner City Family Health Team will be presented and discussed in the context of functional impairments. Due to the complexity of homeless persons' physical and mental health, FHTs must think outside the box when developing intervention approaches for this population. A new model of care that combines aspects of primary care and community rehabilitation will be proposed. Within a interdisciplinary approach, neuropsychologists can play a leadership role in supporting homeless individuals to become better equipped to live independently within the community.

Summary: Cognitive dysfunction was examined in a sample of homeless men exhibiting some functional impairment. Interviews were conducted and neuropsychological batteries administered to thirty-four participants. Seventy-three percent of the sample scored in the impaired range on at least one measure while sixty-four percent scored in the impaired range on three or more measures. Impairments (scores below the 2nd percentile) were most often seen on measures of learning, attention and processing speed and memory. On IQ measures, impaired scores were more frequent in the Non-Verbal than Verbal domain. Half of the sample exhibited at least one instance of TBI, 17.6% exhibited a nontraumatic ABI, 2.9% had a TBI and an ABI, 8.8% had a degenerative disorder, 5.9% had neurodevelopmental difficulties and 14.7% exhibited no sign of a brain disorder.

Rates of mental illness, addiction, and concurrent disorder were much higher than in the general population. MANCOVA analyses were conducted; education was not predictive of neuropsychological functioning, no significant difference was detected between alcohol and other drug users, and no significant difference of performance between income groups was detected. Housed individuals showed superior performance on a D-KEFS test of mental flexibility and alternating attention. Rehabilitation strategies to boost cognition or compensate for impairments, as well as housing and vocational interventions will be discussed.

19 Speaking Your Language: Improving Language Inquiry and Recording with a Multi-Ethnic Population at Toronto Western Hospital

3. Responding to community needs

Toronto Western Hospital Family Health Team:
Anna Chavlovski, MD, Family Medicine Resident
Rachel Wortzman, MD, Family Medicine Resident

Learning Objectives: This project illustrates an example of responding to a multi-ethnic community by inquiring and recording spoken and written language preferences for new patients at the Toronto Western Hospital Family Health Team using validated questions and a standardized approach.

Summary:
Background: Toronto Western Hospital (TWH), which falls within the Toronto Central LHIN, is home to Toronto's most diverse population. Over 160 languages are spoken and 23% of inhabitants have no knowledge

of English or French. Evidence shows that self-reported language is the most accurate predictor of proficiency. Asking about language preference can determine whether a patient is likely to experience barriers that limit ability to navigate the healthcare system and communicate with providers.

Purpose: This quality improvement project aimed to standardize the inquiry and recording of spoken and written language preferences for all new patients at the TWH Family Health Team. Methods: Prior to the initial visit, an intake coordinator asked patients two validated questions about spoken and written language preference: 1) "What language do you want us to speak to you in?"; and 2) "In which language would you feel most comfortable reading medical or healthcare instructions?" Information was recorded in the patient's electronic medical record. The primary care provider recorded the visit length and, if relevant, the form of interpretation used. Balance measures such as time spent inquiring about language were recorded.

Findings: Preliminary results (N=18) suggest that 38% of new patients prefer to speak or write in a language other than English. A subset of patients (17%) comprehend spoken, but not written, English. The silent language needs of these patients may be missed without a systematic approach to linguistic inquiry. This process is estimated to take an additional one to two minutes, indicating its potential sustainability. Conclusions: This project responds to the needs of our linguistically diverse community by identifying and managing communication obstacles between patients and providers. In the future, this may reduce language barriers and achieve greater equity of care.

20 Driving Cessation: Traveling a New Road

3. Responding to community needs

Owen Sound Family Health Team:
Daniella Fry, Occupational Therapist
Paul Faguy, Executive Director

Learning Objectives:
1. Explore the need for a driving cessation program
2. Describe the collaboration between the Owen Sound Family Health Team and the Alzheimer's Society of Grey-Bruce
3. Outline the Traveling a New Road program topics
4. Discuss program outcomes and results

Summary: Traveling a New Road is a psycho-educational driving cessation pilot program for patients with dementia who have lost their driver's license. The program is co-led by the Owen Sound Family Health Team and the Alzheimer's Society of Grey-Bruce and meets monthly over a 4 month period. The program responds to a need in the community to address grief and other emotions that arise due to a loss of driving privileges. The driving cessation program also aims to provide knowledge about community resources and an environment for peer support. According to Fry, Fox, and Donnelly (2013), the goals of the program are to provide patients with "strategies and resources to remain independent and engaged", "an environment where feelings of loss could be discussed and normalized", and "a place where grief related to the loss of a driver's license could be addressed" (p. 25).

The collaboration between the OSFHT and Alzheimer's of Grey-Bruce allows patients to receive expert care from an Alzheimer's Society nurse who specializes in brain health and disease progression and from an OSFHT occupational therapist with knowledge about activities of daily living and the impact of loss of mobility on socialization (Fry, Fox, & Donnelly, 2013). The partnership also ensures that patients receive continuity of care, from early detection of dementia to management strategies and local resources (Fry, Fox, & Donnelly, 2013). Reference: Fry, D., Fox, B., Donnelly, C. (2013). Traveling a new road: A driving cessation group in primary care. Occupational Therapy Now, 15.5, 25-26.

21 Improving Care to High Risk Populations through Outreach

3. Responding to community needs

Sam Tirkos, Physician, South East Toronto Family Health Team
Lauren Cripps, Registered Nurse, South East Toronto Family Health Team
Samantha Brooks, Manager of Health and Seniors Services, Warden Woods

Learning Objectives: The poster will highlight their experience from concept to implementation and outcomes that have been gained through direct outreach efforts to a community with high drug, prostitution and low employment status.

Summary: South East Toronto Family Health Team has committed to a mission of providing outreach to our local community. We have been working with a local community support agency, Warden Woods, to provide on site primary care on a biweekly basis to a very risky population in a high rise apartment building in Toronto. The links with community support and the FHT have greatly impacted the care in the building, including taking advantage of our affiliation with Toronto Public Health to reintroduce a needle exchange on site. Although patients are receiving care on site, the goal, to introduce a marginalized population to the FHT, has impacted a number of patients by rostering them to the team and now providing them with all the associated IHPs on the team.

22 After Rural Residency: Where do Doctors Choose to Practice? An Evaluation of the Goals of the Rural Ontario Medical Program

3. Responding to community needs

Wells, Peter, MD, CCFP, FCFP, FRRMS, ROMP: Executive Director
Allan, Ashleigh, MD, First Year Resident Physician in Mount Forest (McMaster University),
Hunter, Michelle, MSc., ROMP: Program Manager

Learning Objectives:
1. To assess family physicians' learners satisfaction and opinions of ROMP
2. To determine the proportion of family physicians who continue to practice in a rural community upon completion of the program
3. To identify factors influencing family physicians' decisions to practice in rural or urban communities
4. To compare the retention rates of one and two year streams of family physicians who continue to practice in a rural community
5. To develop a demographic profile of respondents

Summary: ROMP's mission is to deliver quality, comprehensive, rural, and regional health professional education to communities in Ontario. ROMP is a voluntary association of physicians who share a commitment to providing quality medical education outside the traditional tertiary care setting. In a partnership with the Georgian College Research Analyst Program and the Rural Ontario Medical Program, the goals of the ROMP were evaluated. Past Ontario rural residency participants were contacted and asked to complete mailed or online surveys evaluating their residency experience and where they are currently practicing, among many other items. The results, conclusions and suggestions derived demonstrate that ROMP has made a great and positive impact on those physicians, with those physicians' 70% likelihood of continuing to practice in a rural locale and being happy to do so.

23 Healthy Pregnancy Strategy: What to Expect when Rural Wellington Women are Expecting

3. Responding to community needs

Sarah Gower, MD CCFP, Family Physician, Upper Grand Family Health Team
Terri Ney, RD. Dietician, Upper Grand Family Health Team
Rebecca Carson, RM, Midwife, Family Midwifery Care of Guelph & Centre Wellington
Lynn Denny, RN, Obsetrics, Groves Community Memorial Hospital

Learning Objectives: -how to get from a small clinical gap to a broad, interdisciplinary strategy -how to champion and organize an multidisciplinary strategy that truly incorporates input from all members -the importance of educating providers, patients and clients around guidelines for healthy pregnancy -ways to reach prenatal women and educate them around nutrition and exercise in a non-shaming, supportive manner -how improving the health and lifestyles of pregnant women can have such a far-reaching effect on the health of your community -how a "Strategy" can be more powerful than "just another program"

Summary: The Rural Wellington Healthy Pregnancy Strategy started as an attempt by physicians to educate pregnant patients around prenatal weight gain and exercise guidelines, with the goal of decreasing BMIs. This grew into a broader vision of a Healthy Pregnancy Strategy for our entire area, with involvement from local midwives, our hospital and other community partners. We realized that there was a general lack of consistency in the education and messaging that prenatal providers & pregnant women were receiving around healthy pregnancies. There were also inconsistencies in how pregnant women were able to access different programs and services in existence, depending on how they navigated our prenatal health care system and which care providers they met.

We believe that targeting these gaps and improving the number of women who achieve healthy lifestyles in pregnancy will improve many of our local pregnancy outcomes, including decreased gestational diabetes and hypertension, lower induction and Csection rates, and fewer health and lifestyle issues in their newborns. Targeting the preconception and postnatal populations has also become a priority.This presentation will review the process of developing our Strategy, and how we got from a group of physicians saying "hey, we should have a handout" to a broad-based, interdisciplinary, community-wide Strategy, and how you could do the same in your area. It will also review the clinical reasoning behind our Healthy Pregnancy Strategy and what we intend to measure and follow as we implement our plans.

24 McQuesten Community Nurse Networker Pilot- an Innovative Collaboration in a High Priority Hamilton Neighbourhood

3. Responding to community needs

Rachael Haalboom, BA BScN McQuesten Community Nurse Networker Pilot, HFHT
Jen Nicholl, BScN Masters of Nursing Candidate, McMaster School of Nursing
Janice Feather, BScN Masters of Nursing Candidate, McMaster School of Nursing

Learning Objectives: To understand how interdisciplinary collaborative partnerships in primary care can improve the health of patients of a Family health team located in a high priority neighbourhood. To understand how a collaborative partnership can design, fund, implement and evaluate an innovative strategy to improve the health and address the social determinants of health of the residents of a high priority neighbourhood.

Summary: the individual, families and the community in both the primary care and community settings in a high priority neighbourhood. A developmental approach was used to evaluate the outcomes of the CNN at the systems level. This data was further enriched with narrative stories from the patients of the primary care practice; located in the community who were connected to the CNN and described their experiences. Further evaluation was completed by using the WHO quality of Life and Hope scales completed by a random sample of practice patients as well as those connected to the CNN. The McQuesten Nurse Networker Pilot will be of interest to primary care practitioners and community health professionals interested in the challenges and opportunities that were identified during the pilot and the strategies that built networks and utilized assets in a high priority neighbourhood.

25 Responding to Community Needs: INR Point of Care Testing in Rural Ontario

3. Responding to community needs

Jeannette Hager, RN, Red Lake Family Health Team

Learning Objectives: Attendees will learn: 1. How we identified issues surrounding access, efficiency and compliance regarding INR testing in our community 2. How we approached community partners and engaged them to improve care for these patients 3. How we revised our INR program to better serve our patients on coumadin therapy 4. The benefits and barriers to point of care (POC) testing 5. Future spread of the program to other community partners

Summary: Traditionally it has been difficult to manage INR populations in small rural communities. The cost of performing this expensive laboratory test limits how often it can be performed. Lack of access leads to poor patient outcomes. By focusing on improving efficiency and access; patients professionals and the community have noticed drastic improvements. Despite seeing all the positive outcomes from this change, funding continues to be an issue. Our spread ideas include at home POC testing by home care nurses, patient self testing and approaching our local nursing home to do POC testing as well.

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 (ie. team development activities, conflict resolution, and flexibility in scope of work for team members).

26 It Takes a (Small) Village: How a physician and RPN can ensure best care for patients with HIV

4. Team collaboration in patient-centred care

McMaster Family Health Team:
Deb Payne, RPN
Lana Bullock, MD

Learning Objectives: Participants will understand how a large group of patients with HIV is monitored and managed to ensure that the guideline standard of care is followed, and that patients have easy access to all of the clinical services that they need.

Summary: A small core team of one RPN and one family physician, both with special focus and training in HIV care, can be highly effective in providing guideline-standard care for about 150 patients with HIV within a family health team of about 12,000 patients. Several elements in this model have ensured our success: an EMR (OSCAR) that will keep track of our population and compliance with recommended guidelines; an RPN who has a deep interest in the people for whom she is providing service, who can be reached easily by phone, and who knows what procedures need to be followed and may be coming due; two family physicians with a long history of providing care for people with HIV; a strong history of collaboration with the local HIV specialty clinic for patients who wish to receive "shared care"; a full scope of allied health professionals within the FHT that can manage the biopsychosocial issues that arise for people with HIV; a strong maternal-child health program within the FHT that can assist with women who are pregnant and their children with HIV.

27 Exploring the role of the pharmacist during the referral process between primary and specialty care

4. Team collaboration in patient-centred care

Bruyère Research Institute:
Corey Tsang, B.Sc Phm Research Assistant
Clare Liddy, MD, C. T. Lamont Primary Health Care Research Centre

Learning Objectives: 1. To identify the completeness of medication information during the transitions between primary and specialty care 2. To propose the new, optimized role a pharmacist may have in the referral process

Summary: A preliminary retrospective chart audit of the outpatient endocrinology clinic at The Ottawa Hospital demonstrated that medication information provided to endocrinologists is often missing or incomplete. Additionally, subsequent consultation notes are often unclear regarding who is to implement medication changes or recommendations. Missing, incomplete or unclear medication information provided to specialists or primary care providers may lead to unintentional medication errors, suboptimal or redundant therapies. Pharmacists have successfully streamlined the transmission of accurate medication information in other interfaces of care, for example, admission and discharge to and from acute care.

This was achieved through medication reconciliation, a recognized accreditation standard for hospitals. In this study, we hypothesize the potential role of pharmacists working with primary care teams to facilitate accurate, comprehensive transfer of medication information between primary and specialty care. A potentially long wait time between referral and consultation may lead to changes in medication, doses and clinical inertia. Proposed integration of the pharmacist in the referral process: Collaborating with the patient and their primary care provider, a pharmacist may conduct a medication history to thoroughly review past treatments, documenting both successes and failures. In preparation for the patient's appointment, final medication reconciliation may be conducted and given to the patient for specialists' use.

After the appointment, the pharmacist may coordinate the communication of medication recommendations made or implemented by a specialist to the patient and their primary care provider. Future research should address the integration of pharmacists into the referral process and aim to identify facilitators, barriers and patient-orientated outcomes.

28 Planned Diabetes Days: Enhancing Patient Care Through Use Of The EMR

4. Team collaboration in patient-centred care

Owen Sound Family Health Team:
Louise Armstrong, RN, BSN, MSc, CD, Diabetes Nurse Educator
Debbie Kean, IT Support and Communications

Learning Objectives: Participants will learn: 1. The importance of standardized coding and data input in the EMR. 2. How the EMR can be used to assist in the identification, recall and management of patients with DM. 3. Use outcome measures to inspire team motivation to develop strategies to improve care . 4. Incorporate optimization of FHT resources through Planned Diabetes Days

Summary:
Population: 35,000 patients serviced by 20 physicians, 5 NPs, nursing, allied Health professionals, clerical staff. Total 2800 DM patients, 2500 followed in scheduled quarterly visits. Improvement journey in the care and treatment of DM patients: 2009 - 1 Physician/NP participated in Partnerships for Health, spread to 3 physicians in group 2009 – Solo physician tested independent program to maximize efficiencies in diabetes care. Diabetes Planned Visit developed through study and collaboration of both approaches. DM visit is physician led, with nursing support; provide all elements of diabetes care with focused quarterly patient education components. 2011 Spread to 10 physicians at time of multiple-site merge to single facility. Building designed to accommodate multi-patient visits in future programs 2014, Participation of all 20 physicians

EMR Standardization: Enhance accuracy of diabetic registry and facilitate data collection through standardization of coding to DM1/DM2. DM Encounter form, reminders, all requisitions accessible within one form in EMR. Standard screening and referral process to appropriate allied health team members and regional diabetes education program. Quarterly data collection shows impact of team effort on achieving clinical goals. Recent data will be highlighted at the AFHTO Conference

Sustainability: OSFHT Diabetes strategy steered by Diabetes Action Team DAT Committee meet monthly to review processes, identify areas for improvement based on clinical measures and discuss strategies to improve patient outcomes. Presentation of quarterly reports to physician group Ensure standardization of care through ongoing education opportunities.

29 Team-Based Approach to Smoking Cessation

4. Team collaboration in patient-centred care

PEFHT:
Janice Hall, Pharmacist
Dee Hazell, RN
Sylta Gyugen, NP

Learning Objectives: We hope to show the evolution of a smoking cessation program from a PCP office visit discussion to a team-based program that uses patient feedback to guide program development. When the Prince Edward Family Health Team was established in 2006, brief smoking cessation interventions were provided by some of the physicians and nurse practitioners in their individual practices. Now, we have adopted the Ottawa Model for Smoking Cessation team-wide and participate in the STOP NRT program through CAMH. A registered nurse and a pharmacist have time designated for smoking cessation appointments, which can be booked directly by anyone within the FHT. In 2012-13, we had 1078 documented patient encounters for smoking cessation.

Summary: A registered nurse began the program by taking the TEACH training through CAMH, while working with COPD patients. In response to an identified gap in service, a goal was set to provide consistent and accessible smoking cessation services in a patient-centered manner. In 2010, the FHT's newly formed QI committee embraced smoking cessation as a project and supported consistent tracking of data. We worked on improving the number of patients with smoking status documented, and followed the interventions towards helping the identified smokers quit. We began a partnership with the OMSC and the CAMH STOP NRT program in 2011. A summer nursing student in 2012 made a series of follow up phone calls to our patients; we continue to make these calls and to focus our efforts in response to this feedback.

We have concentrated on keeping our program simple, flexible and accessible. We have offered individual visits to primary care providers' offices to help them fit the protocol into their practices. With the use of documentation shortcuts and a schedule template in the EMR, we have made it easy to get patients face to face with a trained counselor. Our upper management has endorsed and supported the program by providing sufficient resources. We have learned that it's never just about the smoking, and work closely with other clinics in our team, such as mental health, diabetes and foot care. The smoking cessation team works with the entire family health team, has adapted to the needs of the patients and uses feedback from everyone to continue to evolve. Our next step will be to incorporate more stress management suggestions into the initial counseling sessions, the need having been identified from the phone surveys. As well, the telephone contact appears to have provided patients with encouragement to think about and in some cases, request another smoking cessation counselling appointment

30 Group Well Baby Visits: Satisfaction Among Patients, Residents and Providers in a Community Family Health Team

4. Team collaboration in patient-centred care

Betty Hum, Physician, South East Toronto Family Health Team

Learning Objectives: Several studies have already demonstrated that families are satisfied with the care received and that resident education around well baby care is improved with group visits in a pediatric clinic. In our study, we assessed the satisfaction with group well baby visits among patients, providers and residents in the setting of a community family health team. We also created a start-up guide to map out the process of group well baby visits as well as specific evidence-based educational objectives for each of the cohorts and evaluated its satisfaction among providers.

Summary:
Context: Well baby care is traditionally delivered by individual visits with the family physician, at which time he/she must provide appropriate anticipatory guidance, screening, physical examinations and immunizations. The expanding breadth of evidence-based educational topics deemed standard of care puts a further strain on time-limited appointments and physicians find it difficult to address everything adequately.The group well baby visit provides an alternative model of care to more effectively deliver comprehensive well baby care.

Objective: Several studies have already demonstrated that families are satisfied with the care received and that resident education around well baby care is improved with group visits in a pediatric clinic. In our study, we assessed the satisfaction with group well baby visits among patients, providers and residents in the setting of a community family health team. We also created a start-up guide to map out the process of group well baby

visits as well as specific evidence-based educational objectives for each of the cohorts and evaluated its satisfaction among providers.

Design: Anonymous surveys were administered to patients, residents and providers participating in the group well baby visits held at a community family health team. Participants: All parent participants were English-speaking and literate. All participating nurses, supervising physicians, residents and dietitians must have been provided with the start-up guide prior to the sessions. Parents and providers who did not complete an entire group well baby session were excluded.

Outcome Measures: The 5-point Likert scale questions were grouped into interval values and reported as percentages. The open-ended questions were thematically analyzed.

Findings/Conclusions:This study demonstrates general satisfaction among patients, residents and providers with group well baby visits in a community family health team environment and also identifies some specific challenges to address in order to further improve satisfaction.The start-up guide was regarded by providers as a useful tool and may serve as a guide for future practices considering the adoption of this model of care.

31 Impact of Attachment Disorder in Fetal Alcohol Spectrum Disorder: A signs/Team Approach

4. Team collaboration in patient-centred care

FASD Clinic, St. Michael's Hospital, Toronto, ON:
Dr. William Watson, MD, CFPC, Family Physician - Department of Family Practice, Medical Consultant
Dr. Brenda Stade, NP-Pediatrics, PhD, NP and Lead

Learning Objectives: 1. The conference participants will understand the signs/presentation of Fetal Alcohol Spectrum Disorder (FASD). 2, The conference participants will understand the signs/presentation of Attachment Disorder In children with FASD. 3. The conference participants will increased their skill in idenitfying Attachment Disorder in children with FASD, and identifing appropriate interventions.

Summary: Caused by prenatal exposure to alcohol, Fetal Alcohol Spectrum Disorder (FASD) is the leading cause of preventable developmental disabilities among Canadian children. Clinically it has been noted that many children with FASD also demonstrated Attachment Disorders. There is a paucity of research examining the incidence of Attachment Disorder in children with FASD. In this study a prospective chart review was conducted to determine if children presenting for a diagnosis of FASD in a large urban centre also met criteria for Attachment Disorder.

Four hundred (400) children, aged 3 to 18, from across Ontario participated, and 78 % met criteria for Attachment Disorder. This presentation will describe how signs of Attachment Disorder makes diagnosis of FASD more difficult, how we formally referred children for a diagnosis of Atttachment Disorder to the mental health professionals associated with the team, and how interventions post-diagnosis of FASD focused on both Attachment and FASD with better outcomes in this population of children.

32 Using Rounds Centred on Patient Narratives: Building Capacity within a Family Health Team to Improve the Delivery of Care to Vulnerable Seniors

4. Team collaboration in patient-centred care

Women's College FHT:
Nicole Bourgeois, Dietitian
Susan Hum, Research Associate
Mary Novak, Registered Nurse
Sheila Dunn, Family Physician
Leslie-Anne McDonald, Registered Nurse

Learning Objectives: 1) To understand the development and growth of an interprofessional (IP) team focused on the care of the medically and psychosocially complex elderly over the age of 80 2) To increase understanding of the use of narrative for Family Practice 3) To understand the types of patients discussed and the insights gained from narrative discussions

Summary: In Ontario, geriatric care falls primarily on family physicians. However, many primary care providers (PCPs) feel overwhelmed in managing the complex medical and psychosocial care needs of their patients aged 80+. PCPs are faced with ethical dilemmas, often stemming from the tension between health care goals, families' and society's concern for safety, and the patient's goal of autonomy. Moral residue often results from these challenging dilemmas. In June 2011, Women's College FHT created an IP Elder Care Team to build internal capacity for geriatric

care. The Team used patients' narratives as a basis for practice enhancements for improved elder care, which included Elder Care Rounds. The goals of these monthly Rounds included: providing IP support to family physicians managing care, naming and exploring the discomfort felt by PCPs, bringing some clarity to the nature/complexity of these challenges and identifying key community resources for patients.

These Rounds are designed to elicit the views and value the contributions of all participants. They are solution-focused, grounded in our patients' narratives, and offer a bottom-up approach to understand the challenges, and ultimately improve the care of our older patients. On average 14 participants attend monthly, including: physicians, nurses, social workers, pharmacists, a dietitian, learners, a CCAC coordinator and a psychogeriatric resource consultant.

An analysis of 25 patient stories discussed at Rounds identified recurrent themes and dilemmas. Consequently, training and education sessions were provided to staff on identified topics, resources were created and shared, and several QI and research projects have been initiated.

33 Hospital Discharge Med Wrecks: Processes for Pharmacist-Driven Tune-Ups

4. Team collaboration in patient-centred care

Guelph Family Health Team:
Jen Dunlop, RPh, BScPharm, Clinical Pharmacist
Naomi Dore, MSc, BScPhm, ACPR, Clinical Pharmacist

Learning Objectives: As a result of reviewing the content of the poster, participants will be able to:
- Identify two processes for pharmacist medication reconciliation and assessment for patients post-hospital discharge
- Adapt the process for testing within their own primary care setting

Summary: One of the changes we are testing to improve patient transitions from hospital and decrease hospital readmission is a pharmacist medication reconciliation and assessment visit post-hospital discharge. We are in the early stages of testing two different processes within three clinic sites. Our processes, including identification of individuals eligible for Pharmacist review differs slightly at each clinic. Feedback about the processes from patients and care providers will be highlighted.

Our learning so far highlights the following as keys to success:
- Timely access to information from hospital about the patient's discharge
- Team approach that involves the office admin staff, physician, pharmacist and primary care nurse clinician
- Utilization of the electronic medical record to keep the team informed
- Flexibility to refine the process as we learn from testing within the individual clinic sites to establish a process that works for the patients, provider and site
- Ability to offer back-to-back pharmacist / physician visits so the patient does not need to make two trips to the clinic.
- Ability to offer pharmacist home visits at some clinics if required

Challenges we are still testing changes to address include:
- Following up with patients unable to be reached by the pharmacist or administrative staff
- Working with reception to ensure we are catching all eligible patients
- Working to identify ways the team (including front reception staff) can better message to patients to bring all of their prescription and over the counter (including herbal, creams, ointments, inhalers) products into the visit.

34 Seamless access to care: Owen Sound Family Health Team and Keystone Child, Youth and Family Services

4. Team collaboration in patient-centred care

Owen Sound Family Health Team:
Karla Lang, Clinical Supervisor, Keystone Division
Paul Faguy, Executive Director

Learning Objectives: 1. Describe the OSFHT and Keystone collaboration 2. Provide examples of the seamless integration of programs and services for OSFHT patients 3. Highlight the partnership's added value and increased continuity of care

Summary: The Owen Sound Family Health Team and Keystone Child, Youth and Family Services collaboration is unique within Ontario. The integrated partnership allows OSFHT patients seamless access to

all Keystone programs and services. Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy (MOHLTC, 2011) describes how this partnership fills a gap in child and youth mental health services in the rural Grey and Bruce county regions for children and youth with primary care providers, but who require additional mental health services and supports.

With a shared EMR system and full access to programs, services, and clinical staff; patients receive truly comprehensive care. Some of the services and programs available to OSFHT patients through the collaboration with Keystone include: a co-ed crisis, assessment, and stabilization group home for youth aged 12-18, Telepsychiatry clinical assessments/consultations and monthly psychiatric program consultations, eating disorder program, the specialized birth to six team, therapeutic recreation program, specialized military program, and in-home child and youth support and assessment.

Owen Sound Family Health Team staff also have access to all professional development training offered to Keystone staff, and a wide range of therapeutic assessment/treatment expertise for managing issues such as sexually offending behaviour, children involved with fire, and attachment disorders. Reference: Ontario Ministry of Health and Long-term Care. (2011). Open minds, healthy minds: Ontario's comprehensive mental health and addictions strategy. Toronto, ON: Queen's Printer for Ontario.

35 The Primary Care Lung Health Quality Improvement (QI) Guide: Partnerships and Teamwork to Create a QI Guide for Primary Care Lung Health Programs

4. Team collaboration in patient-centred care

Ontario Lung Association:
Sara Han, Primary Care Asthma Program (PCAP) Provincial Coordinator
Oxana Latycheva, Clinical Health Systems Initiatives, Manager

Learning Objectives: Participants will gain knowledge and have better understanding on the need for and the importance of QI guidance documents in assisting health care providers in carrying out QI within their primary care site to improve practice and, ultimately, lead to better care to the patient. Participants will also gain a better understanding of the teamwork and partnerships that were key in the development of this QI guide and meeting the need to carry out QI within lung health programs in primary care.

Summary: PCAP is delivered within a multidisciplinary team of primary care providers with the leadership of a site coordinator and/or a Certified Asthma/Respiratory Educator (CAE/CRE). The program is modeled on evidence-based tools (action plans, care maps, program standards and decision algorithms) and foster engagement of the patient and family in the management of their asthma and/or COPD. A need arose to create a QI guide to assist CREs working within their primary care team, in carrying out QI activities in accordance with HQO and the Ministry of Health and Long-Term Care (MOHLTC) mandate focusing on the nine dimensions of a High-Performing Health-Care System

(1). Health Links, a new MOHLTC initiative, are designed to provide integrated care for the top 5% of users of the health care system. Asthma is a major reason for hospital admissions among the pediatric population (2) and in the adult population, patients with COPD are identified as one of the top 5% of high users of the health care system. The partnerships that were made with various stakeholders (including OLA and HQO) and multidisciplinary professionals from various primary care models and disciplines were essential in ensuring that this QI guide was a useful and relevant tool in primary care. It was imperative that a multidisciplinary approach was taken so that the QI guide would be multi-dimensional and be used for conducting key QI activities to improve patient experience. References: 1. http://www.health.gov.on.ca/en/pro/programs/cdpm/pdf/framework_full.pdf 2. Kovesi T. Achieving Control of Asthma in Preschoolers. CMAJ 2010; 182(4): E172-183

36 Improving Eye Care for Patients with Diabetes: Collaborating Across Specialties

4. Team collaboration in patient-centred care

St. Joseph Health Centre Toronto:
Vanessa Redditt, Family Medicine Resident (PGY2)
Sarah Basma, Family Medicine Resident (PGY2)

Learning Objectives: This project explores the application of quality improvement principles to improve documentation practices within a family health team to

enhance the clinical care provided to patients with diabetes. It also highlights concrete opportunities for collaboration between family health teams and specialists, such as ophthalmologists, to enhance chronic disease management through improved interdisciplinary communication and standardized, integrated documentation tools.

Summary: The Ontario Ministry of Health aims to ensure that 80% of adult Ontarians with diabetes receive timely monitoring of 3 key diabetic markers: measurement of HbA1c in last 6 months, measurement of cholesterol in last 12 months, and retinal eye exam in last 24 months. As of December 2012, only 41% of our diabetic patients had a documented retinal exam within the last 2 years. Using quality improvement principles, we analysed possible contributors to this gap in care. We noted that some of our patients had undocumented retinal exams (i.e. we had not received a consult note from optometrist/ophthalmologist), whereas other patients had not undergone retinal examination.

Using the plan-do-study-act (PDSA) quality improvement methodology, we first introduced a new field in our clinic's electronic medical record (EMR) to capture self-reported retinal exams. We then collaborated with our hospital's ophthalmology team to jointly develop a simple reporting form for both new consults and follow-up diabetes retinal exams that would be faxed back to family doctors. We also provided brief education sessions in our family health team on the importance of timely retinal exams for diabetic patients. These strategies helped to significantly increase the proportion of our diabetic patients receiving recommended eye care; by June 2013, 55.5% of our patients had a documented retinal exam within the last 2 years. This project highlights the practical application of quality improvement strategies and opportunities for interdisciplinary collaboration to improve patient care.

37 Enhanced Patient Care for Diabetics in Family Health Teams

4. Team collaboration in patient-centred care

Linnea Corbett, RN, Program facilitator, Cottage Country Family Health Team

Learning Objectives: Participants will be able to: * Discuss the importance of standardized coding in the EMR and the impact on patient registries when coding is not standardized * Describe how measuring outcomes and setting goals can motivate teams to take action to enhance care of their patients * Describe an example of patient recall system to follow up on patients at high risk * Discuss optimization of FHT resources to take on quality improvement initiatives * Describe how program format improves patient care and increases patient's desire to participate in healthy lifestyle changes

Summary: • In April 2012 the Gravenhurst Cottage Family Health Team formed a diabetes quality improvement team to focus on improving outcomes of their diabetic patients. The team includes 6 doctors 1 NP, 2 RN's , dietician, pharmacist, social worker, IT , and 2 support staff. The team wanted to look at their diabetic population of patients and determine how well they were being managed by the team. They began by setting clinical goals which are reflected in the section above.

• Following this they were able to determine their baseline measures vs. their goals. This helped the team to clearly identify areas where they could make changes in their processes (running of tests) or treatment strategy to close the gap between what they were currently achieving and what their desired goal was. The team realized that standardization of coding was imperative to enhance the accuracy of their diabetic registry , and the team went through the registry to "clean it up" by changing the coding of all diabetics to "type 2 diabetes". • The team meets on a regular basis to discuss different strategies to improve outcomes for their diabetic patients.

Some developments of our program are:
Defined roles and responsibilities of team members to avoid duplication of effort. A comprehensive "Sick Day Protocol" for type 2 Diabetics to follow A Diabetic Program where every Type 2 Diabetic Patient in our practice receives the same standard of care through individualized appointments involving the nurse, allied health care professional, and physician

38 COPD Readmission Avoidance Project

4. Team collaboration in patient-centred care

Owen Sound Family Health Team:
Chris MacDougald, RRT, CRE
Richard Eppel, ,Clinical Pharmacist
Jen McCarl, Program Nurse, RN, BScN

Learning Objectives: 1. Describe the rate of COPD hospital admission and readmission in the Grey Bruce regions 2. Define the strategies employed by the COPD Readmission Avoidance Project 3. Explore the collaboration between health care organizations within the project 4. Discuss the success of the program outcomes

Summary: In Canada, COPD has the highest hospital readmission rate of all chronic diseases (CIHI, 2008). The COPD Readmission Avoidance Project is a collaboration between the Owen Sound Family Health Team, the Community Care Access Centre, and Grey Bruce Health Services. The goal of the project is to reduce hospital readmission rates and emergency department visits related to COPD.

To achieve this goal, the Owen Sound Family Health Team is automatically notified of any FHT patient who is discharged from the hospital after admission for COPD. The OSFHT performs a follow-up phone call within 48 hours to all FHT patients post discharge and schedules an appointment with their primary health care provider or with the respiratory therapist within 7 days of discharge. The OSFHT clinical pharmacist also performs medication reconciliation for COPD patients. The RRT or physician provides home visits within 7 days post discharge for patients who are unable to come into the FHT. CCAC also provides a home visit from a rapid response nurse post discharge.

The project utilizes pathways and order sets to standardize care, and performs discharge medication reconciliation prior to discharge from hospital. COPD project folders containing educational material and care plans are currently being distributed to the medicine and emergency units, with plans to expand distribution to surgery, monitored beds (step-down), and woman and child units. Reference: Canadian Institute for Health Information. (2008). Health indicators 2008. Ottawa, ON: CIHI.

39 Patient Initiated Referral

4. Team collaboration in patient-centred care

Thames Valley Family Health Team:
Clark, Program Administrator
TBA- in transition between QIDS, QIDS

Learning Objectives: This presentation will demonstrate how the use of patient-initiated referral bookings reduces Interdisciplinary Health Professionals (IHP) no show/late cancellation rates dramatically (though the referral is still initiated by the physician to the IHP, the patient is responsible for contacting the site to book the related appointment - rather than the IHP being responsible for contacting the patient to book).

Summary: TVFHT has seen noticeably positive results in efficacy and patient-engagement when switching from an administrative-booked referral appointment to a patient-initiated referral process. By putting the responsibility of booking an IHP appointment in the hands of the patient, it facilitates patient engagement and lends itself towards a more efficient referral process. Giving patients the responsibility to book their own IHP appointment, results in patients exclusively booking the appointment when they in fact see the value of the appointment. This process is more efficient for both the site and it's staff as patients who are interested in the service tend to be less likely to cancel or skip the booked appointment. As such, this presentation will demonstrate the value of team collaboration in patient-centred care.

40 A Multi-Institutional Approach to Improving Maternal and Fetal Health

4. Team collaboration in patient-centred care

J. Christie Webster, BScN, RNEC, PHCNP, Owen Sound Family Health Team

Learning Objectives: 1.To increase awareness of a problem/need (antenatal smokers) in Grey/Bruce by utilizing available resources (BORN, LHIN data). 2.To encourage collaborative partnerships and move away from vertical silos to horizontal flow of service provision between3 institutions: public health, hospital and primary health care. 3.To utilize Electronic Medical Record systems to identify smokers as well as promote provider initiated referrals for smoking cessation counselling within a Family Health Team. 4.To increase uptake of an available resource (smoking cessation counselling) within an organization. 5.To identify lessons learned from this intervention project.

Summary: The main objective was to urge obstetrical care providers to discuss the issue of smoking cessation with their antenatal patients and refer them to a trained pharmacist to assist them with smoking cessation. Using a cooperative model, the improvement project brought together people from a variety of backgrounds and

sectors to create a dynamic multi-institutional model that would help improve maternal and fetal health. Working with the Grey Bruce Health Services, the Grey Bruce Public Health Unit, and the Owen Sound Family Team, the intervention team collaborated to reduce smoking rates using simple tools such as smoking status reminders and electronic medical record messages. The improvement project has placed women at the centre of the care process. As a direct result, there has been an increase in identified pregnant smokers, and an increase in patients who were referred to a pharmacist for smoking cessation counselling.

This initiative produced favourable results, including a 50% increase in provider-initiated referral s and the creation of a basic program template that can be used and implemented by other health organizations. Future issues to address include partnering with other organizations to increase access to transportation, especially for young antenatal patients; diversifying communication platforms such as through twitter or Face book; and ensuring that there is a method for simple and continuous feedback of results to health care providers.

41 Pathways to Practice™ at Two Rivers Family Health Team

4. Team collaboration in patient-centred care

Two Rivers Family Health Team:
Caroline Rafferty, Executive Director, RN,
Jessie Rumble, Health Promoter, RN

Learning Objectives: From this presentation, participants will learn about the development of the "Pathway to Practice™" model. Participants will have the opportunity to review the tool and understand how it supports nursing and allied health practice at Two Rivers Family Health Team.

Summary: In April 2012, Two Rivers Family Health Team was selected by the Registered Nurses' Association of Ontario (RNAO) to engage in the Best Practice Spotlight Organization® (BPSO) candidacy program. We are currently in our third and final year of our candidacy period. As a BPSO candidate, Two Rivers has implemented six best practice guidelines. This initiative, which is funded by The Ontario Ministry of Health and Long-Term Care and matching organizational funds, supports our nursing and allied health staff in providing evidence-based, primary care.

As a part of this innovation, the Two Rivers Family Health Team has developed a clinical best practice adoption model and resource tools referred to as "Pathways to Practice™".

This presentation will focus on the development of the model, and the tools supporting nursing practice in providing enhanced primary care. "Pathways to Practice™" utilizes the Quality Assurance requirements of the College of Nurses and the extensive professional development opportunities we have developed as part of our BPSO candidacy. Our model focuses on the dissemination of knowledge and skills across all of our nursing staff to optimize nursing capacity and capability to provide more comprehensive services to our patients in support of health promotion, illness prevention, and chronic disease management.

42 Management of Osteoporosis Through an Evidence-Based Pilot Program

4. Team collaboration in patient-centred care

London Family Health Team:
Dr. Cathy Faulds, MD, CCFP, FCFP, ABHM
Emily Stoll, BSc, Program Planner

Learning Objectives: Attendees should understand: • how to implement evidence-based guidelines into a program that is applicable in a primary care or FHT setting • how to utilize EMR tools and other resources to develop chronic disease programs and track measures • the importance of a collaborative team approach to successful chronic disease management • the benefit of education sessions in sharing knowledge across specialities • the importance of treating osteoporosis with the same attention as other chronic diseases

Summary: The London Family Health Team (LFHT) has developed a pilot program centered on evidence-based guidelines for management of individuals with osteoporosis through improved patient outcomes. The aim of the LFHT was to improve outcomes for patients with osteoporosis, while ensuring that our care was patient-centered. Five of our team physicians were able to participate in the pilot.

To begin, rosters of patients previously diagnosed with osteoporosis were compiled. Patients were scheduled for a complete osteoporosis assessment, including screening and management. This assessment was prompted by and recorded in a customized EMR

template. This template was then used to extract patient data for each of the process, outcome and balance measures that were deemed appropriate by both the 2010 Osteoporosis Canada Guidelines and the LFHT's Osteoporosis Pilot Group. Standardized recording of diagnositic testing for osteoporosis, such as BMDs and bloodwork, was also implemented and allowed for easy extraction of data. Development of these EMR templates, standardized recording, and other tools was assisted by community partners and specialists.

Physician education sessions were hosted for team physicians to ensure full understanding of the program process, for assistance in diagnosis, management and treatment decisions on a case-by-case basis and to keep up to date on osteoporosis treatments and screening. Additionally, a patient education session was held with Osteoporosis Canada to educate patients about bone health. Although this pilot project is still in its infancy, the LFHT is aiming to have monthly population data for review and to eventually spread this program to the entire LFHT.

43 A new face to a group program: a physician-specialist to help motivate patients.

4. Team collaboration in patient-centred care

Don Mlls Family Health Team:
Adijatukubra Musa MSc, RD, Registered Dietitian/Health Promoter
Dr. Mark A. Kotowycz, MD, MBA, FRCPC - Cardiologist; Peter Munk Cardiac Centre, University Health Network, Toronto
Irene Peralta, MN, NP, Nurse Practitioner
Donna Farrows, RPN, Registered Practical Nurse

Learning Objectives: 1) Participants will see how the addition of a physician specialist to a multidisciplinary educational program for pre-diabetic patients will help with the dissemination of knowledge about Diabetes. 2) Participants will come away with practical tips for implementing a successful group education program.

Summary: Patients in a primary care setting are commonly diagnosed with pre-diabetes (pre-DM) which generally refers to impaired fasting glucose (IFG) or impaired glucose tolerance (IGT). The challenge with these patients is to motivate them to take action against this condition. At the Don Mills Family Health Team, we invited clinic patients diagnosed with pre-DM and their caregivers to attend a 4-week interactive group program called: Diabetes: Are You At Risk? The class format consisted of formal and informal sessions facilitated by a Nurse Practitioner, a Registered Dietitian, and a Fitness Instructor. In the most recent iteration of this program, we added a cardiologist, who could provide a more authoritative perspective on the consequences of diabetes and poor lifestyle choices. Patients were taught to understand their blood-work (fasting glucose, HbA1C), received education on nutrition, had a Zumba demonstration and attended a Q&A with the cardiologist.

At the completion of the 4-week program, participants were given an evaluation form with set questions such as Which class did you find helpful? Were the handouts useful? Did the program meet your expectations? The feedback survey demonstrated that patients valued sessions that involved the cardiologist, exercise and nutrition. In conclusion, we found that 1) involving a physician-specialist is feasible and would be of interest to pre-DM patients attending an educational program; 2) Participants preferred interactive hands-on sessions that provided them with useful take-home tips. These strategies can be used to promote attendance at similar programs in the future.

44 Facebook as a Tool for Collaboration and Knowledge Exchange Among Members of an Academic Family Health Team

4. Team collaboration in patient-centred care

Department of Family and Community Medicine St. Michael's Hospital:
Emily Nicholas, Research Assistant
Aisha Lofters, Family Physician, Assistant Professor, Clinician Scientist - MD PhD CCFP

Learning Objectives: To provide a potential model for using social media (specifically the Facebook platform) as a tool to improve communication and knowledge exchange between the St.Michael's Hospital (SMH) academic family health team (AFHT) members. Referring to findings from team member surveys, recorded group activity as well as reflections from the investigators, we will share successes, failures and lessons learned one year after the implementation of a private Facebook group for our AFHT. Methods to increase enrolment, and subsequent involvement, of AFHT members with the online platform and plans to maintain the, will be highlighted.

Summary:
OBJECTIVE: To assess the feasibility of utilizing social media to improve communication and knowledge exchange between members of the SMH AFHT.

SETTING: St. Michael's Hospital Academic Family Health Team (SMH AFHT), composed of five clinics spread across four distinct sites

PARTICIPANTS: All SMH AFHT members, including physicians, nurses, and allied health professionals (i.e. pharmacists, social workers, etc.) were eligible to be group members of the private Facebook group.

METHODS: A pre-implementation anonymous online survey was administered. Upon launch of group, in-person training sessions related to Facebook use and privacy were conducted. Various measures of Facebook group activity were recorded. Data collection and analysis are ongoing.

RESULTS: Preliminary observations ten months post launch of the on-line group show that 42 members, just under a third of those who were invited (29%). Early analysis of indicates activity in the group was at a maximum shortly after implementation, a decline in activity around the new year with a slow increase to a plateau in the following months. Anecdotal evidence suggests the main barriers to use of the on-line group are too little time, privacy concerns and lack of incentive to use the group.

CONCLUSION: The presentation will refer to findings from team member surveys, recorded on-line monthly group activity as well as qualitative observations, to illustrate successes, failures and lessons learned after the implementation of a private Facebook group for the SMH AFHT.

45 From Disney to Depression: How a Storyboard is being used to Design a Patient-Centred Care Pathway

4. Team collaboration in patient-centred care

Judith Davidson, Ph.D., C. Psych., Psychologist, Kingston Family Health Team

Learning Objectives:
• Learn what a "storyboard" is, and how one was created as the foundation of a clinical pathway for people with depression.
• Understand how this person-centred method can support a Family Health Team in delivering optimal care at all points of contact with the person.
• Know that this approach must involve input from patients and all parts of the Team including governance, clinicians, reception, and anyone else who influences patient care.

Summary: We set out with the goal of providing optimal, seamless care for any adult patient presenting to the Team with depression. We formed a Depression Initiative working group. "Storyboarding", a method originally used in the design of motion pictures, can be used to design patient-centred health care systems. "It is a demanding, insightful, and comprehensive task to design a care system so that everything is focused on the systems of patient healing. It entails some paradigm shifts. It requires bold leadership and institutional commitment" (Art Frohwerk). This method is allowing us to design processes across the whole Team aimed to support the person with depression, to provide continuity of care, to allow the providers to offer evidence-based treatment options, and to deliver best care. We will share our experience to date with this project.

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.

46 Impacting Cancer Screening By Employing Different Strategies within Primary Care Settings

5. Integrating the community around the patient

Dr. John Day, Erie St. Clair Regional Primary Care Lead, Erie St. Clair Regional Cancer Program
Neelu.Sehgal@wrh.on.ca, Manager, Integrated Cancer Screening Program, Cancer Program, Windsor Regional Hospital
Priyanka Philip, Decision Support, Regional Cancer Program, Cancer Program, Windsor Regional Hospital

Learning Objectives: Participants will be able to describe the implementation of an innovative, cost-effective pilot which includes 4th year Nursing students placed within different Primary Care settings with a highlight on one FHT. The focus of the placement was on integrated cancer screening and prevention. Participants will also be able to compare another initiative within the same FHT that involved a targeted mail out of FOBT kits to identified eligible patients. Participants will be able to identify the challenges, successes and the key outcomes of both initiatives.

Summary: Primary Care based, one-on-one direct interactions have shown to result in a greater uptake in cancer screening. To demonstrate this, the nursing pilot brought together key strengths in the community including the University of Windsor, Regional Cancer Program and Primary Care Physician (PCP) offices. Over the course of the 2013/14 academic year, 10 students completed their placements in 3 primary care offices and 1 Family Health Team with a focus on cancer screening. Due/overdue patients were identified. Eligible patients already scheduled for an office visit were seen by the Nursing students, unscheduled patients were called. The direct interventions involved education on the screening tests and completion/booking of appropriate tests. The patients were followed up with at specified time intervals. The qualitative research component to the pilot involved obtaining informed consent from patients willing to participate in the research study.

Consenting patients were contacted by a member of the Research team to gather qualitative data on factors that may impact screening decisions. University of Windsor REB approval obtained. The FOBT mail out project involved the identification of all eligible patients from 6 Physician rosters. These patients were mailed a package containing the FOBT kit, completion instructions and a screening brochure. Completion results were tracked against the original list of patients to determine completion rate. The presentation will describe all detailed outcomes from both initiatives and include the quantitative and qualitative results from the nursing pilot (the analysis of which is currently ongoing).

47 Beyond Our Front Door: Promoting Community Partnerships to Improve Patient Care

5. Integrating the community around the patient

Tracey Beckett, Social Worker, QFHT, Adjuct Instructor Queen's University, BASc, BSW, MSW, RSW, Queen's Family Health Team

Learning Objectives: Smoking cessation continues to be the most preventable cause of death and disability, and, therefore, has been a focus in primary care. By going beyond the 5As (ask, advise, act, assist, ask again) approach, the Queen's Family Health Team has developed a comprehensive multidisciplinary approach to smoking cessation. An example of the program's effectiveness has been highlighted by outcome measures indicating comparable performance despite having a higher prevalence of patients with mental health and or substance abuse disorders -- a population generally identified as having greater challenges with smoking cessation or reduction.

Summary: According to research, people living with mental illness and or substance abuse disorders are more likely to smoke in general, to smoke more cigarettes per day, to be more addicted to tobacco than others, and less successful in making quit attempts. The Queen's Family Health Team's comprehensive multidisciplinary Smoking Cessation Program in partnership with community healthcare services enabled us to commit to a higher level of monitoring and support to our patients.

Effective smoking cessation requires modifications and more intensive interventions as programs continue to evolve. Collaborating with various community care providers is instrumental not only for the promotion of smoking cessation or reduction, but also for relapse prevention. Engaging patients, patients' family members and community providers in smoking cessation meets the individual needs of patients. The benefits of this approach are not limited to those with mental illness or substance abuse disorders, but can benefit broader patient populations as well.

48 Primary care providers' perspectives on using the Champlain BASE eConsult service – a qualitative study

5. Integrating the community around the patient

C.T. Lamont Primary Health Care Research Centre, Bruyère Research Institute:
Clare Liddy, MD MSc, Clinical Investigator
Justin Joschko, MA, Research Assistant
Paul Drosinis, MPH, Research Assistant

Learning Objectives: This presentation will describe the Champlain BASE (Building Access to Specialists through eConsultation) eConsult service and explore the themes and sub-themes that emerged from our analysis of provider feedback. Participants will gain an understanding of how eConsult is improving access to specialist care for patients in the Ottawa region, and how primary care providers perceive and respond to the eConsult system. Participants will be given a demonstration of the eConsult service and have the opportunity to discuss the implications of this using this service to improve access by patients to specialist care.

Summary: This presentation will introduce participants to this innovative and unique approach to reducing wait times for specialist care, which remains a significant barrier to care in Canada. The Champlain BASE eConsult service is a secure, web-based tool that allows primary care providers quick access to specialist care for their patients. As of April 30, 2014, the eConsult service has processed 2825 eConsults, with over 40% of specialist referrals being avoided. Primary care providers using eConsult (physicians and nurse practitioners) may select from over 40 specialty groups. Our eConsult service is proven effective and easily adopted by clinicians as it requires only a standard computer with internet access, along with setup and training which typically take 30 minutes or less. Following the closure of each case, providers complete a short survey with multiple choice and open text fields.

Our study included all eConsults submitted between April, 15, 2011 and December 31, 2013 in which the provider elected to leave a text response. We will present the results from this qualitative study using thematic analysis with constant comparison to analyze the perspectives of the primary care providers who use the service. Evidence from this study demonstrates the high level of satisfaction by primary care providers when using the Champlain BASE eConsult service. Understanding the results of this study will help primary care providers, health care leaders, policy makers, specialists, administrators and other health care stakeholders appreciate the implications of using eConsult services to reduce the wait times for specialist care.

49 A partnership approach to the well child check up

5. Integrating the community around the patient

Andrea Thompson, Registered Nurse, Lactation Consultant, Stratford Familly Health Team

Learning Objectives: In 2008, Stratford family Health team and Public health teamed up to develop a program for the enhanced well child check up at 18 months. With other partnerships such as University of Guelph they developed a model, procedures and policies around this 18 month visit. Over the past 6 years, this program has grown and changed but a strong partnership remains.

Summary: The presentation will show how a partnership was started and grew through challenges and changes to become a very strong and successful relationship. It will show how this relationship has sprouted new community partnerships and connections. It will explain the model and processes used to create

an integrated approach to the enhanced well child check up at 18 months and how we have added a well child check up at age 3. It will present how this partnership keeps the parenting and child health journey consistent throughout the community.

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.

50 Collecting and Sharing Colorectal Cancer Screening Data with Primary Care Providers

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

Christine Stogios, Project Analyst, Cancer Care Ontario
Shama Umar, Senior Project Analyst, Cancer Care Ontario

Learning Objectives: Participants will learn how CCO shared colorectal cancer screening data electronically in the ColonCancerCheck Screening Activity Report (CCC SAR) with primary care providers in a safe and secure manner via eHealth Ontario's ONE® ID and as a result, postively impacted patient participation in colorectal cancer screening. Providing a comprehensive view of the end to end cancer screening journey ensures the patient is not lost amongst the coordination of care.

Summary: Cancer Care Ontario (CCO) developed the Colorectal Screening Activity Report (CCC SAR) as a supplementary tool for primary care physicians who are part of a patient enrolment model (PEM) in Ontario to support them in better understanding their cancer screening activities and how to efficiently coordinate cancer care for their patients. The CCC SAR is the first online report delivered to primary care providers via eHealth Ontario's ONE® ID which allows physicians to access their patients' colorectal screening data in a safe and secure manner.

By equipping family physicians with patient-level data that is grounded in CCO's evidence-based clinical guidelines, the CCC SAR demonstrates an innovative and dynamic approach to increasing screening rates for colorectal cancer and the appropriate follow-up of abnormal results.The CCC SAR provides primary care physicians with a summary of their rostered patients' colorectal cancer screening-related history and status and was designed with the intent of supporting both population health management and opportunistic screening. The report leverages provincial administrative and clinical datasets to summarize screening activities on a per-patient level and actionable follow up recommendations based on CCO's clinical guidelines. To evaluate the impact of the reports on colorectal screening participation rates and appropriate follow-up of abnormal results, a Generalized Estimating Equation model was used.

Additionally, feedback from frontline clinical providers who have accessed the CCC SAR has been collected along the way, influencing the report's design over time.

51 UTOPIAN CPCSSN project: past, present and future

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

Babak Aliarzadeh, MD, MPH, Canadian Primary Care Sentinel Surveillance Network (CPCSSN)
Michelle Greiver, MD, MSc, CCFP, FCFP, North York Family Health Team
Chris Southgate, Research Associate, Canadian Primary Care Sentinel Surveillance Network (CPCSSN)

Learning Objectives: This poster will provide a brief history and update of the CPCSSN (Canadian Primary Care Sentinel Surveillance Network) project. We will focus on the CPCSSN network in Toronto, which is part of UTOPIAN (the University of Toronto Practice Based Research Network). We will describe methods used for EMR data extraction and processing, number of patients and participating primary care providers, data items, potential uses of CPCSSN data by FHTs, and future direction and plans for the expansion of CPCSSN-UTOPIAN.

Summary: CPCSSN started in 2008. Over the past five years, we have proven that it is possible to extract and process anonymized patient data from multiple EMRs, and use it for chronic illness surveillance and research. Eleven university department of Family Medicine across Canada are participating in CPCSSN; UTOPIAN, representing the University of Toronto, is one of them. UTOPIAN has recruited more than 100 primary care providers in the GTA, including family physicians and nurse practitioners. We have developed productive relationships with EMR vendors; this has made it possible to extract anonymized data from four different EMRS, originating from local and ASP servers, every three months. We clean, code, de-identify, and transform the raw clinical EMR data into a format suitable for analysis and reporting.

The format is EMR independent and is standardized across all of CPCSSN in Canada. Each participating sentinel receives a quarterly confidential feedback report on clinical indicators that compares his/her patient population with patient population at site, network, province and national levels. In addition, we can return their complete set of de-identified, cleaned and coded CPCSSN data to participating organizations; this data can be re-identified locally and has been used for reporting, quality improvement initiatives, and locally relevant research projects. This poster will provide a snapshot of methods used for data extraction and processing and current data holdings and plans for future expansion of CPCSSN-UTOPIAN initiative.

52 Using Visual Analytics to Support Quality Improvement in Primary Care

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

Brice Wong, MSc, Quality Improvement Decision Support Specialist, Windsor Family Health Team

Learning Objectives: In this presentation, the facilitators and barriers of using an EMR and visual analytics to implement a guideline-based pediatric obesity program in a multidisciplinary primary care practice will be discussed. We will show how visual analytics can be used to initiate changes in clinical workflow, improve the quality of data within the EMR, and to analyze patient data to create a registry of patients at risk.

Summary: Ontario's Action Plan for Health Care highlights a focus on quality in primary care. At many Family Health Teams across the province, prevention and early intervention are clinical priorities. The focus of the Child Health initiative, in particular, is on the implementation of routine screening and surveillance of children to prevent adverse health outcomes later in life.

Primary care practices are encouraged to use electronic medical record systems to support their quality improvement (QI) work. Ongoing data collection and monitoring can be used to identify opportunities for improvement by assessing progress against baseline data. Visually displaying and analyzing data in useful and usable formats can promote better understanding of QI initiatives, assist in clinical decision-making, and help sustain improvement gains within the practice. The pediatric obesity program was revitalized when visualization and visual analytic techniques were applied to the data. A web-based data visualization library was used in conjunction with spreadsheet and graphing applications to create more accurate, engaging and interactive representations of the data. Superimposing the data visualizations on existing WHO

growth charts allowed for an interactive method of registry development.

The application of data visualization and visual analytics in primary care enhances the healthcare provider's understanding and use of data used to drive quality improvement programs. Our experimentation with a web-based platform not only offers a mechanism to spread QI programs across multiple practices, but also shows that many of the time-consuming tasks in a traditional spreadsheet application can be automated, reducing the time and skill set needed for thorough analysis demanded by QI. As the demand for reporting in primary care grows, so does the volume of primary care data and the need to manage that data using data visualization and visual analytics techniques.

53 The Step Approach: Standard Treatment and Collaborative Care Lead to Better Hypertension Outcomes

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

London Family Health Team:
Jonathan Williams, BMSc, Program Planner
Dr. Cathy Faulds, MD, CCFP, FCFP, ABHM
Dr. Tracy Ouellet, MD, CCFP, FCFP

Learning Objectives: Attendees will be able to: • Fully understand the importance of data standardization in managing hypertensive patients; primarily how standardization can foster tool development to measure balance, outcome and process measures • Recognize the benefits of creating a Quality Improvement Committee; primarily regarding the benefits to continually monitoring outcome measures and introducing program components to meet patient needs (Example: addition of a Renal component) • Recognize the benefits to continued education; primarily how educational CME sessions can increase the scope of practitioners and introduce prescription algorithms

Summary: Hypertension is a chronic disease of growing concern. The London Family Health Team (LFHT) implemented a standardized chronic disease program designed around evidence-based clinical guidelines to improve measures of high blood pressure in our hypertensive and diabetic populations. The program model includes process maps, logic models, computer templates, spreadsheets and other resources to standardize the care provided. This was done through the formation of a Hypertension Quality Improvement Committee (H-QIC) to evaluate the program monthly and implement necessary interventions.

The H-QIC identified that the spreadsheet was not accurately highlighting the degree of patient deviation from their blood pressure targets. Therefore, the spreadsheet was modified such that blood pressure targets were broken down into increments to better identify how close the patient was to target. The H-QIC also arranged a Continuing Medical Education (CME) session with a specialist. The CME introduced a standardized, step-approach prescription algorithm to treat hypertension. Each physician was provided with a list of patients with diabetes who had a recent blood pressure out of target and identified their current drug treatment plan. The physicians were then able to review the patients individually and overcome their prescribing inertia.

Outcome measures include percent of patient at their blood pressure target and those with a self management goal in the past year for both hypertensive and diabetic patients. The standardized approach, introduction of a prescription algorithm and use of a care team have been pivotal in maintaining and increasing the percent of patients with blood pressure at target.

54 Opioid Prescribing Patterns in Family Health Team; The Good, the Bad and the Ugly

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

Papneja, Purti, MD CCFP/Physician, Department of Community and Family Medicine at UFT

Learning Objectives: 1. Participants will increase awareness of guidelines on Effective and Safe prescribing of Opioids for Chronic Non-Cancer Pain. 2. Participants will learn about using EMR (PSS) to ensure proper documentation before initiating opioids.

Summary: Introduction: There has been a steady increase in the use of opioids for treatment of Chronic Non-Cancer Pain (CNCP) over the last few decades. This has led to increased cost of health care due to opioid related side effects and increased risk of addiction and misuse. Objective: To describe prescription pattern of opioids and to assess prescribing compliance with Canadian guidelines for use of opioids in CNCP in an Academic Family Health

Team. Methods: A retrospective chart review
Results: as noted above

Conclusion: In this study, guideline concordance for Grade A recommendations (dosage of opioids and documenting the indication for opioid use) was high. However, at initiation of opioids, there was poor documentation detailing the discussion of risk/benefits of opioids, screening for addiction risk and caution regarding driving. Factors affecting compliance with these guidelines need to be determined and addressed.

55 Patient Encounter Tracking Form – moving into the electronic century!

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

Hope Latam, Quality Improvement Decision Support Specialist, East Wellington Family Health Team (QIDSS Program)
Shirley Borges, Executive Director, Minto-Mapleton Family Health Team
Sandy Turner, Health Promoter, Minto-Mapleton Family Health Team

Learning Objectives: Introduce FHTs to an electronic means of tracking IHP patient encounters within the EMR. Reportable data submitted to the Ministry of Health on a quarterly basis can be entered in a patient chart efficiently during point of care with every patient. This data can then be seamlessly extracted by the FHT for submission. This form can be used to track patient flow, IHP direct/indirect time, cancellations and no shows. Main patient health concerns can be tracked to help guide future and on-going program development.

Summary: This poster will demonstrate the ease of entering patient encounter data within the EMR. It will include screenshots of the custom form that has been developed for our EMR (Telus PS Suite) which allows for quick and easy entry of patient encounter information. The poster will demonstrate how the data is extracted from the EMR, then imported and analyzed in a standalone database. The database has a user-friendly interface that allows for a wide range of reports to be generated and has also been programmed to export the results directly into the MOH Programs and Services Quarterly Report Summary spreadsheets. The tracking system can easily be spread to other FHTs without cost, and minimal staff training. This has been a collaborative effort across local FHTs (East Wellington, Mount Forest, Minto-Mapleton, Upper Grand, Centre for Family Medicine, Grandview, and Two Rivers FHTs), along with the QIDSS program. This poster will work to identify the key steps in successful implementation from gaining management support, to the pilot phase, and finally to a complete launch date. A feedback section will highlight the process from a clinical perspective.

56 Utilization of Custom Spreadsheets to Support Chronic Disease Management within the London Family Health Team

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

Heather Stables, Chronic Disease Nurse, Registered Nurse, London Family Health Team

Learning Objectives: Participants will: •Fully understand how to customize evidence-based spreadsheets for chronic disease management; •Recognize benefits of process measure such as a retinopathy exam with diabetes, outcome measures such as blood pressure (BP), and balance measures such as hospital visits; •Be able to adjust treatment and improve outcomes for patients and chronic disease populations in accordance with Quality Improvement (QI) principles.

Summary: The LFHT has developed custom spreadsheets to complement our chronic disease programs including diabetes, COPD and hypertension/cholesterol. This is done to determine how well the chronic disease population is being managed and to ensure that outcomes are being met in accordance to QI standards. The LFHT collected rosters of patients for each chronic disease of interest and tracked a variety of outcomes for each patient. Information is collected into summary spreadsheets, for each physician's patient roster and for the team as a whole. Patients are categorized based on whether they are controlled or uncontrolled. Then categorizes are colour coded. Colour-flags within the summary spreadsheets are as follows: green to represent the achievement of the target by the total population, yellow is for population within ten percent of the target, and red is for population still striving to reach target. The spreadsheets allow the team to organize the data in a clear manner, see the improvements visually and note outcome, process and balance measures.

Results demonstrate that outcome metrics have improved. For example, in non-diabetic patients there was a 24% increase in the number of patients with BP to target over three years. Furthermore, 26% more patients are getting a retinopathy exam yearly. Finally, COPD patients have had 34% fewer exacerbations over the past 3 years. The LFHT continues to develop these spreadsheets to better support our chronic disease programs. We plan to add in further metrics in the future with the goal of better management of a variety of chronic diseases.

57 Using the Right Data to provide the Right Care

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

North Perth Family Health Team:
Sarah Givens, Oncology Nurse Navigator
Lindsay McGee, Quality Manager

Learning Objectives: This poster presentation will demonstrate the value in dedicating time and resources to reviewing, correcting, and validating data as an important first step in any Quality Improvement initiative. Having correct and reliable baseline data is a key component to guide decision making, resource allocation and processes when it comes to Quality Improvement and if this data is not accurate can lead to inefficiencies, confusion and disengagement by staff and patients. The poster will share a process undertaken at the North Perth Family Health Team, where time and resources were dedicated to reviewing and updating integrated cancer screening reports, and will show the benefits achieved by completing this review

Summary: By providing accurate and reliable data to front line clincians to actively use in their practice the results are three fold: First inefficiencies are reduced in that the data is reliable, and does not need to be double checked allowing front line staff to spend more time with patients. Second, clinician engagement is enhanced by the knowledge that the data is correct, and by being able to clearly identify obtainable targets and make the decision to allocate staff to the project. Third, care coordination as it relates to preventative cancer screeening is more efficient, seamless, and more patients recieve the preventative screening for which they are eligible. The poster will also include important lessons learned about integrated cancer screening.

58 Creating Registry for Patients with Hypertension: Embarking on a Quality Improvement (QI) Methodology to Improve Care for Patients with Hypertension

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

Marjan Moeinedin, Quality Improvement Decision Support Specialist, North York Family Health Team

Learning Objectives: Demonstrating use of quality improvement methodologies to create patient registry for patients with hypertension to proactively improve their care.

Summary: The role of hypertension in increasing risk of cardiovascular disease (e.g. stroke, coronary heart failure) and kidney disease is well documented in the literature. Therefore, it is important to identify patients with hypertension using EMR generated reports. This is to ensure that all the patients with a given condition are identified accurately and they are proactively followed up for appropriate care. In general, standardized clinical data plays an important role in measuring and monitoring the quality of care delivery. Data in Electronic Medical Records (EMRs) are often not standardized. EMRs have limitations in their reporting capabilities. The coding for chronic diseases including hypertension in EMRs is often inconsistent.

Quality improvement efforts rely on accurate data to indicate the presence of conditions and accurately identify the patient population. Inconsistency and lack of proper coding can interfere with identification of patients with chronic conditions. The aim is to create a registry for patients with hypertension by standardizing EMR data entry using diagnostic ICD9 coding in Don Mills Family Health Team as a pilot project .

59 Documentation tools to assist in the transition and transfer of Spina Bifida patients from a Pediatric Multidisciplinary Clinic to the adult healthcare system.

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

Connie Castillo, NP-PHC, Nurse Practitioner, Holland Bloorview Kids Rehabilitation Hospital & The Anne Johnston Health Station

Learning Objectives: The attendee will be able to:

1. Identify key pieces of information which are essential when developing a transfer of care summary.
2. Verbalize the importance of sharing patient information to assist in the safe and efficient transfer of care of a young adult with a chronic illness and/or developmental or cognitive delays.
3. Verbalize the importance of sharing information within the circle of care to assist the patient in navigating the healthcare system.

Summary: The transition from pediatric to adult healthcare services can be very difficult for young adults. The number of young adults with chronic illnesses is increasing dramatically due to advances in medicine. A well thought out and comprehensive transition and transfer of care can dramatically decrease morbidity in these young adults. The primary care provider (PCP) is challenged with helping these individuals navigate the health care system. This is also true with regard to managing the amount of information generated from the multiple providers these patients have to be followed by.

Summarizing the care and vital patient information by the pediatric provider and then relaying this information to the PCP can certainly assist the PCP in managing the information and in turn the patient's medical condition. Other tools in the form of well-constructed updates and referral letters can also assist in the management of patient information. A more streamlined method within the exchange of information among practitioners can certainly decrease patient and family anxiety in regards to transitioning. This process may also assist PCP's who may feel as if they have to start from scratch when taking over the care of these young adults in their practices.

60 Integrating Hospital Report Manager into a Family Health Team

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

Stephen Beckwith, IT/Operations Lead, South East Toronto Family Health Team
Rob Lee, Director IT, Toronto East General Hospital
Sarah Miller, Ontario MD

Learning Objectives: Toronto East General Hospital, Ontario MD and South East Toronto Family Health Team will demonstrate how the report manager has improved patient care with direct notification into the SETFHT EMR.

Summary: The poster will have representation from the hospital (TEGH), Ontario MD and Primary Care (SETFHT) to relay the overall experience from concept to implementation and initial outcomes. The poster will discuss their experience working with Privacy; how to talk to the EMR vendors to improve interface and what specifics were involved to bring all the MDs in the FHT on board and their experiences to create the systems internally and linking to each other.

61 The EMR 'adoption chasm' – looking at EMR current use and how to bridge the 'chasm' between basic and intermediate/advanced use

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

Partnering for Quality Program - South West CCAC:
Rachel LaBonté, Program Lead
Gina Palmese, eHealth Coach

Learning Objectives: Participants will: • gain an increased understanding of challenges that exist in optimizing the use of EMRs; • gain an understanding that improving the use of basic/intermediate functionality is often a prerequisite for using intermediate/advanced features (e.g. queries and reports depend on structured, searchable data) and; • learn a few tips/tricks to help them optimize the current use of their EMR

Summary: With 80% of health care encounters occurring in primary care settings the vast majority of patient data is collected and managed at the primary care level and the transformative change to be undertaken will be reliant on information management supports and tools. Not all users are using their EMR to its fullest potential. Through the results of the Primary Care EMR Needs Assessment, primary care physicians, nurse practitioners and physician assistants have demonstrated that they are comfortable using EMRs for episodic care, however challenged to shift EMR use for practice level management. Through the optimization of EMR use for practice level management, primary care practices will be positioned to achieve positive health outcomes at both individual and population levels, leveraging the full benefits of EMR adoption.

This further provides a significant opportunity to optimize the use of EMRs in the South West LHIN for chronic disease prevention and management and delivery of quality patient care. This presentation will

outline the results of the EMR needs assessment in relation to aspects that impact primary care's ability to use practice level data to improve overall care, transitions in care as well as improve care coordination. The presentation will also include a few 'tips' for primary care that they can take back to their teams and begin implementing right after the conference.

62 Reduction of Social Work Referral Wait Times Through Effective Triaging and Utilization of Resources

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

Garden City FHT :
Yvonne Van Lankveld, RN, BHSc, - Mental Health Program
Debbie Good, MSW, RSW, Social Worker

Learning Objectives: The learner will: • Gain an understanding of challenges in providing Mental Health Services in a FHT • Learn about implementation of a triage and group process to decrease referral wait times

Summary: Patients who are referred to social work must contact the IHP support desk to confirm their intention to seek counseling within 3 weeks. Those who confirmed were triaged by the Mental Health RN, which included referral to external EAP service providers if they had coverage, streamlining access/referral to community mental health programs. The remaining patients were offered a four week CBT skills group, where appropriate, which was facilitated by a contracted social worker. Patients attended 4 sessions, 1½ hours in duration, and had the option of attending day or evening groups. PHQ-9 test scales were administered at week 1 and 3 and the results showed an improvement in mood for many patients. GAD -7 scales were added in the third rotation of sessions. (we will provide update data once all sessions are complete).

Patients were given a certificate of completion, encouragement to continue to use the skills they learned, and a written prompt to confirm their interest in remaining on the wait list for Social Work. Poster presentation display will include a flow chart of the referral process, audit results of referrals, test scale outcomes, handouts patients receive outlining Mental Health Services Process, and the completion certificate.

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.

63 Chronic Pain Management -a Collaborative Primary Care Model to Support Patients living With Non-Cancer Chronic Pain

7. Clinical innovations in comprehensive primary care

Christine Martin, RN., B.S.c.N., Primary Care Nurse Clinician
Lisa Heard RN, BScN, Primary Care Nurse Clinician, Guelph Family Health Team

Learning Objectives: As a result of reviewing the content of the poster, participants will be able to:
- Identify the critical components of a guideline based program to support patients living with non cancer chronic pain
- Identify an evidence based inter professional team process for pain management in primary care
- Adapt the process for testing within their own primary care settings
- Adapt the patient educational materials for use in our practice settings - Adapt the care team educational materials for use in their own primary care setting

Summary: Applying the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain, an inter disciplinary primary care model was created involving collaborative care by the physician, primary care nurse clinician, pharmacist, mental health worker and patient.

We have tested and refined this process to meet our objectives for increased:
- Support to patients in achieving optimal pain control - Monitoring of safe narcotic use and adherence by patients
- Patient knowledge and ability to manage their pain on a daily basis.

The target population for the program is:
- Patients living with non cancer chronic pain
- Patients with chronic pain who are high risk for narcotic abuse
- Patients with uncontrolled pain.

The process we use, team tools (e.g., opioid therapy custom form, brief pain inventory), patient educational materials (e.g., opioid therapy agreement, safe narcotic use) and patient and inter professional team feedback will be shared. Our learning within two clinic locations with eight physicians highlights the following as keys to success:

- Engaged patients who understand and are committed to following the opioid therapy agreement with the care team
- All members of the care team jointly providing shared care
- Continuity of care by all members of the team
- Decision support tools embedded within the electronic medical record
- Care team members who are educated about the guidelines.

Challenges we are still testing changes to address include:
- Optimizing and appropriately utilizing all disciplines involved in the collaborative care model
- Mental health support to address the psychology component of living with chronic pain (i.e. mental health support groups/classes for patients)

64 The Transition from Hospital-Based Care for Stable HIV-Positive (HIV+) Patients in Ottawa

7. Clinical innovations in comprehensive primary care

Nicholas Valela, MPA, BHSc; Program Coordinator, Division of Infectious Diseases, Ottawa Hospital Research Institute
Clare Liddy, B.Sc., MD, MSc. CCFP, FCFP, C.T. Lamont Primary Health Care Research Centre of the Bruyère Research Institute

Learning Objectives: This presentation will highlight a prospective demonstration project attempting to promote the evolution of a comprehensive primary HIV care model in Ottawa to meet the successes of current HIV treatment. Stable HIV+ patients followed at The Ottawa Hospital (TOH) will be transitioned to Primary Care Providers (PCPs) across Ottawa who are best positioned to deliver comprehensive primary care. This presentation will further demonstrate: the transition process via the innovative electronic consultation service (eConsult) promoting interprofessional collaboration; and the means through which TOH will support PCPs in becoming and maintaining competence in providing HIV primary care.

Summary: As a result of combination Antiretroviral Therapy (cART), HIV care has shifted to a chronic disease requiring comprehensive care from both PCPs and specialists. This project will transition the care of stable HIV+ patients in Ottawa from hospital-based specialist care to PCPs using electronic consultation support. Issues: Hospitalist-based specialists have traditionally managed HIV care in Ottawa. This approach may be less relevant for many who are virally suppressed on effective cART and may result in gaps in patients' primary health care. This is only exacerbated by insufficient communication between specialists and PCPs.

Project description: The HIV clinic at TOH currently follows ~1200 patients. Of these, roughly 90% are on stable therapy and could be transitioned to a PCP for routine care. This demonstration project aims to transition stable HIV+ patients to the care of PCPs (MD or NP) across Ottawa. If the patient is uncomfortable receiving care from their PCP and/or their PCP does not wish to provide HIV primary care, the patient will be transitioned to the care of PCPs prepared to do so. These providers will be identified based on their knowledge of HIV primary care. The transition will be supported: (A) through the implementation of eConsult, an established web-based consultation system that will enhance communication to consultative expertise (HIV specialists, HIV pharmacist, and the HIV social worker); (B) through focused provider educational training in HIV care; and (C) through the dissemination of support materials, including primary care and immunization guidelines for HIV+ patients.

65 The Effect of a Structured versus Non-structured Homebound Seniors Program on Resident Attitudes towards House Calls

7. Clinical innovations in comprehensive primary care

Sunnybrook Health Sciences Centre, University of Toronto:
Dr. Rahul Jain, MD, MScCH (c), CCFP,
Dr. Debbie Elman, MD, CCFP, FCFP

Learning Objectives: This poster presentation will allow participants to compare structured versus non-structured homebound seniors programs on resident trainee attitudes towards house calls. Structured homebound seniors programs refer to academic family health team teaching sites which mandate residents to participate in home visits, often in interdisciplinary teams, as part of residency training. The data collected from various sites in Toronto will allow curriculum

planners and leaders in medical education to appreciate the value of implementing structured homebound seniors programs in postgraduate medical education to promote positive attitudes and a culture of providing comprehensive care for complex elderly patients in their homes.

Summary: BACKGROUND: As Canadians aged 65 years and older continues to rise, more attention has been given to home-based healthcare. Homebound seniors have higher rates of diseases, chronic medication use, emergency department visits, hospitalizations, and challenges in accessing care. Despite this growing concern, the number of physicians participating in house calls is declining. Family Medicine residents have generally perceived lack of training as a barrier to pursuing house calls in the future. Few academic centres have looked into instituting a structured homebound seniors program in residency training to improve resident knowledge, skills, attitudes, and confidence in performing house calls.

METHODS: A survey was distributed to Family Medicine residents from all 15 teaching sites at the University of Toronto. Sites having either a structured or non-structured homebound seniors program implemented in the residency curriculum were compared to assess if there is a difference in resident perception of house calls. A needs assessment of resident perspective on improving the house call curriculum was also performed.

RESULTS: The study demonstrated with strong statistical significance that structured programs compared to non-structured programs increase resident exposure, positive attitudes, confidence and plans of pursuing house calls in their future practice. A needs assessment revealed training on billing, procedures, and greater supervision and exposure to house calls would improve training experience. CONCLUSIONS: There are positive implications of this study for the healthcare system, medical education system, practitioners, patients and families in improving and sustaining care for homebound seniors which can be implemented at a national level.

66 The successful implementation and integration of eConsultation into a Family Health Team to improve access to specialist care

7. Clinical innovations in comprehensive primary care

Jay Mercer, MD, Bruyère Academic Family Health Team

Learning Objectives: This research will present fundamental underpinnings of the Bruyère Family Health Team's (FHT) approach in the successful integration of the eConsult service in this complex practice. The audience will learn how to adapt and integrate internal processes to obtain improved access to multiple specialty services and effective organization of the clerical team when using the eConsult service.

Summary: The Champlain BASE eConsultation program is a web-based service that allows a PCP to submit a patient specific clinical question to a specialist. Primary care providers with a specific inquiry simply log on to the system, fill out an electronic form outlining their patients' complaint, and then send the eConsult to a specialists who will respond within a week. Many individual primary care providers and family health teams in the Champlain LHIN are already using the eConsult service as a part of their daily practice including the Bruyère FHT.

The Bruyère FHT (Ottawa, Ontario) is comprised of 29 primary care providers who are providing care for 15,000 patients. The eConsult service was implemented within the team in June 2013. While the service provided to this group was the same as that provided to all of the other enrollees, the fundamental difference was the manner in which the service was implemented into this large complex practice environment.

Integration of eConsultation into existing workflow processes at the Bruyère FHT enabled rapid uptake of a new, innovative service. Active engagement of not only the physicians but the clerical team enabled the FHT to implement eConsultation in a locally adapted manner. The Bruyère FHT has implemented a highly sophisticated electronic consultation service in a manner which is dramatically improving the quality and speed of care delivery within the organization.

67 Senior's Health Day - Providing an integrated, seamless care to seniors.

7. Clinical innovations in comprehensive primary care

Carolyne Kostynuk, Social Worker, MSW, RSW, Red Lake Family Health Team

Learning Objectives: We will share: Program Outline; Policy Document; Scheduling Chart; Rounds

Document; Statistical Gathering Chart; Challenges and Successes; Next Steps

Summary: The idea of a Senior's Health Day is to provide comprehensive and seamless care to seniors by integrating the Family Health Team, the Hospital, and the Physician Group in one program, at one location, at one time reducing the number of appointments for the senior and improving communication between these services. The goal of the program to keep senior's safely in their homes longer and to reduce the number of emergency room visits and hospitalizations through education, assessment, prevention services and improved communication.

Family physicians identify seniors with chronic diseases, and/or those who are isolated, and/or at high risk for repeat visits to the emergency room or hospital and refer them to the program. Participants are assessed, screened, and provided education from a nurse, physiotherapist, social worker, pharmacist, and their physician. The disciplines round on each patient to develop a comprehensive plan for the individual. At the end of the program each participant receives an assessment report, recommendations for referrals to appropriate community services, further follow up with their doctor, or family health team member. For our FHT in which patient's are managed by a team of physicians this provides an opportunity for consistent care.

This program provides the opportunity for the Family Health Team, Hospital, and Physician group to work together with the patient to develop a care plan that includes both the medical and the psycho-social models of care to keep senior's in their home longer, and reduce ER and Hospital visits.

68 Cognitive Assessment Clinics: A Model of Shared Care – Nurse Practitioner, Family Physician, & Geriatrician

7. Clinical innovations in comprehensive primary care

London Family Health Team:
Dr. Cathy Faulds, MD, CCFP, FCFP, ABHM
Samantha Deslippe, Nurse Practitioner

Learning Objectives: Attendees will be able to: 1. Understand the scope of the Nurse Practitioner role in primary care. 2. Recognize the benefits of utilizing a Nurse Practitioner model of shared care within a Family Health Team. 3. Recognize the benefits of utilizing this model of shared care on the health care system in a cost effective and system reduction manner.

Summary: "Dementia is the chronic disease that is most difficult to diagnose and manage," says Dr. Michael Borrie, Director of the Aging Brain and Memory Clinic in London, Ontario. "It also has the most serious future cost implications for our health care system". This collaborative model of a shared care Family Health Team (FHT)-based memory clinic – led by a nurse practitioner in a shared care alliance with family physicians and supporting community specialists – is delivering timely patient-centered care for patients with dementia. It builds the necessary capacity for dementia diagnosis and management within FHTs as they become increasingly prevalent in Ontario.

At the same time, this model utilizes limited specialist resources wisely and in a complementary manner. A previous model has been developed and published as a shared care alliance involving a family physician lead within a FHT, with the support of specialists within the community. This study validates an innovative concept for providing comprehensive quality dementia diagnosis and care within primary care. We are not looking to mimic this model, but rather to introduce a variant using allied health in their fullest scope to support a further cost effective method of integration in our Ontario Health Care system.

69 Senior Wellness Program: An innovative collaborative approach to provide comprehensive patient-centred care to promote healthy and independent living at home.

7. Clinical innovations in comprehensive primary care

Sammu Dhaliwall, RPh, ACPR, Pharm D, Northwest Telepharmacy Solutions
Gisele Barlow, RN, Chapleau and District Family Health Team
Krista Frederikson, RN, Chapleau and District Family Health Team

Learning Objectives: Participants will be able to identify opportunities to incorporate a pharmacist utilizing remote technology to provide improved comprehensive care for Family Health Team patients. Participants will also be able to evaluate the impact of a Senior Wellness program for an aging community.

Summary: In 2012, the Chapleau Family Health Team (FHT) hired a consultant Pharmacist to provide clinical pharmacist services, remotely. The Pharmacist was conducting patient medication reviews via teleconference or using OTN Videoconference for patients taking more than 10 medications. Despite an initial surge in these voluntary interviews, the number of referrals of patients taking more than 10 medications to the Pharmacist quickly diminished. In 2013 the Chapleau FHT identified a growing aging population in Chapleau, Ontario.

In order to serve the population more effectively, the Senior Wellness Program was established in early 2014 and invitation letters, on behalf of the FHT Physicians, were sent to all patients over the age of 65 to participate in the Senior Wellness Program. Interested patients are first interviewed by a FHT Nurse who completes a lengthy Senior Wellness documentation tool. Following the FHT Nurse interview, the patient is interviewed remotely by the consultant Pharmacist who reviews the patient's medication regimen and answers any medication-related concerns. The Pharmacist ensures a Medication Falls Risk Assessment is conducted along with a medication risk assessment for osteoporosis during the interview. Both the Nurse and Pharmacist document recommendations based on their findings. The FHT Physician reviews all assessments and recommendations and discusses end of life plans with the patients.

The Chapleau FHT has noticed a substantial increase in the number of patients wanting to be included in the Senior Wellness Program, the number of medication reviews conducted by the remote Pharmacist, as well as the number of recommendations made.

70 Cervical Screening Performance of Family Practice Models in Ontario

7. Clinical innovations in comprehensive primary care

Jessica Moffatt, Cancer Care Ontario

Learning Objectives: To understand the current performance of Patient enrollment model physicians in providing cervical cancer screening in Ontario. To understand some of the recently implemented tools for improving cervical cancer screening participation.

Summary: A population-based retrospective cohort study of cervical screening in women 20-66 years old enrolled in Ontario Patient Enrolment Model (PEM) intervention: Outcome: For women enrolled in PEMs to assess the cervical screening rates. Covariates include the woman's age, neighbourhood income quintile, and region in which they resided. Variations in cervical cytology coverage by PEM practices are described. Results: Only 72.5% of women enrolled in a PEM had cervical screening. Only 74% of those screened, had their screening completed by their PEM physician. Women at the extremes of the age spectrum had lower rates of screening. There was clear regional variation as to whether the enrolled woman had her cervical screening by her PEM or another non-PEM physician. Cervical screening was more likely to occur as the income quintile increased. The median number of cervical cytology tests in a 3 year period was 100-199 per physician; with 11% doing less than 10 tests in 3 years.

The characteristics of the PEM physicians included 62% males and 28% females. Cervical screening was more likely to occur if the physician was female (58.2% of women screened). Regional variation and woman's income quintile was related to screening occurrence. Conclusions: Although a stipend for preventive cancer care is a part of the PEM, a significant number of women do not receive cervical cancer screening. Physician gender, regional variation and income quintile appear to explain some of the variation. Multipronged strategies focusing on physician (SAR) and women (correspondence) are being implemented to optimize screening.

71 Individualized versus standard treatment for smoking cessation: Findings from STOP with Family Health Teams.

7. Clinical innovations in comprehensive primary care

Dmytro Pavlov, MSc; Research Coordinator, Centre for Addiction and Mental Health (CAMH)

Learning Objectives: This poster will provide an overview of the different models of the Smoking Treatment for Ontario Patients (STOP) program, which began in January of 2006, comparing different methods of smoking cessation intervention delivery. In particular, participants will learn how the STOP with Family Health Teams (FHTs) model, which began in 2011 and is currently provided by 134 FHTs, compares to the STOP mass distribution model, and STOP on the Road (SOR),

with respect to patient outcomes. This poster will provide compelling evidence for a need to incorporate smoking cessation interventions into family practice.

Summary: The STOP program funded by the Ministry of Health and Long-Term Care, and delivered via a collaboration between the Centre of Addiction and Mental Health and Ontario Family Health Teams, is aimed at improving access to NRT for clients of participating organizations who wish to quit smoking, and increasing the capacity of health practitioners to provide comprehensive smoking cessation counseling to their clients.

Through STOP, eligible clients can receive up to 26 weeks of NRT, along with the counseling which is provided by the trained allied health professionals at participating FHTs. Compared to other STOP models, as well as a control group from the Ontario Tobacco Survey, STOP with FHTs participants report a significantly higher quit rate at 6-month follow-up. Compared to other models, unique features of the STOP with FHTs program, which might make it more successful, include the ability to offer a more extensive NRT treatment protocol, dispense combination therapy, and provide a more comprehensive counseling regiment.

Flexible implementation options provided by STOP allow for the integration of effective smoking cessation interventions into organizations with varying degrees of capacity. A comparison of different methods of delivery of the smoking cessation interventions within the STOP Program supports the comprehensive approach offered by the STOP with FHTs model.

72 Creating Greater Collaboration by Utilizing Motivational Interviewing as a Common Language within an Inter-Professional Practice Team

7. Clinical innovations in comprehensive primary care

Brad LaForme MSW RSW, Co-ordinator Substance Use Initiative, Co-ordinator Motivational Interviewing Initiative, Hamilton Family Health Team

Learning Objectives: 1) Understanding the role of Motivational Interview in the change process 2) Understanding how Motivational Interview fits well within the primary care setting. 3) Learn greater inter-professional collaboration via common understanding of M.I. principles.

Summary: "MI is not a technique for tricking people into doing what they do not want to do. Rather, it is a skillful clinical style for eliciting from patients their own good motivations for making behavior changes in the interest of their health." Rollnick, S., Miller, W., Butler, C. (2008). Motivational interviewing in health care: Helping patients change behavior. New York: The Guilford Press.

The Hamilton Family Health Team has initiated the training of inter-professional health care teams in Motivational Interviewing. The purpose of this initiative is to further develop cross professional collaboration within the family practice by creating an understanding of the motivational interviewing style of engaging patients who are struggling with their health care. Such a common language would serve to inform patient interaction, regardless of the level of individual M.I. competence, and create a common structure of health care across the practice team.

By initiating a train-the-trainer model, a core group of allied health professionals has engaged in the training of professional staff across the Hamilton Family Health Team This experiential presentation will examine the experiences of participating in the multidisciplinary Motivational Interviewing training, and the impact of utilizing M.I. in practice as part of a team. The key learning will be that the use of Motivational Interviewing principles can be effectively translated across health care professions and help engage in greater collaboration and consistency of patient care within a family practice.

73 Getting dermatology consults in less than 5 days by leveraging OTN and technology

7. Clinical innovations in comprehensive primary care

Stewart Stein, Manager eConsult/Store Forward, OTN

Learning Objectives: Participants will:

- Learn how to get a dermatology consultation for their patients in less than 5 days
- Learn how to apply for a (no-cost) Telederm account Learn about the efficiencies of asynchronous communication
- Learn about OTN and other services offered by the not-for-profit organization

Summary: In discussion with Primary Care Providers, it is not uncommon to hear of wait times that range from 6-

12+ months to obtain a face-to-face appointment with a dermatologist. OTN's Store Forward Dermatology program has brought wait times to receive a diagnosis and suggested treatment plan from a dermatologist to less than five days. This presentation will review how Primary Care Providers and their staff can access this no-cost program, how it was developed, how it is supported and results to date.

OTN's Teledermatology program is providing faster access to care from two perspectives; directly through electronic consults and as a triage mechanism for alerting dermatologists to serious cases that need an urgent face-to-face appointment. Additionally, OTN's planned expansion of eConsult/store forward technology to other therapeutic areas such as woundcare and psychiatry will be briefly covered. OTN is a not-for-profit organization funded by the Government of Ontario.

74 One Small Step at a Time: A Team Approach to Integrating a COPD Program in the FHT

7. Clinical innovations in comprehensive primary care

Central Hastings Family Health Team:
Dr. Melissa Holowaty, PhD MD CCFP - FHT Physician
Alternate - Monica Deshane, RN (EC) MScN - Nurse Practitioner
Alternate with above- Julie Page, RN MSc MHS PMP - Program Coordinator/System Navigator

Learning Objectives: Attendees will be able to: 1. Value the integrated Team approach to a Lung Health Program. 2. Apply the "one small step at a time" methodology to developing a Lung Health Program. 3. Identify "quick win" strategies.

Summary: Based upon our demographic patient population, it was felt that our patients were underdiagnosed for COPD. We also recognized the need to improve education/management for COPD patients. In March 2011 we began developing a Lung Health program based on best practice guidelines. Being a small FHT, resources were scarce and the impact of a sustainable program was large. A one small step at a time approach was initiated involving care providers and clinical support staff. Level 1 screening was identified as low impact and could be administered by the clinical support staff.

We have expanded to include in house spirometry Level 2 screen using a 3rd party RT and also an NP trained to administer and read spirometry. Our lung health program has expanded to include STOP for FHT and we are moving towards an integrated teaching/management program including the use of action plans (including prescriptions). Long term goals are identification, education and management of COPD patients. Local hospitals are sending discharge action plans for patients who have been admitted and discharged with exacerbations of COPD. Early post discharge visit to the primary care provider or Lung Health NP helps keep care coordinated.

Our interdisciplinary team of physicians, Lung Health NP, dietitian and social worker provide a more comprehensive program to provide care to these patients and assist them in self-management. High users of the ER with COPD can be identified and through our Health Links partnership may receive care coordination with the aim of decreasing ER visits/ hospital admissions