CONCURRENT SESSIONS
Listed by theme

1- Accountability and governance for patient-centred care

A1 Implementing a Patient Advisory Council in An Academic FHT
B1 How do we as governors ensure we hear and respond to the patient voice?
D1 Creating cultures of quality improvement and patient safety
E1 Rural Wellington Shared Governance Across Health Care Partners

2- Engaging the patient in their care

AB2 Engaging Patients through Portals: Tools and Tales
1. My Cancer IQ®: a new tool for engaging your patients in cancer prevention and screening
2. Patient Portal: Perks and Pitfalls
3. Engaging patients in their care through a secure internet portal
4. Toward the new paradigm of Patient Centred Care

C2-a Using the NHS's Experience Based Design (ebd) methodology to capture and understand your patient's experiences and co-design solutions together.
C2-b Timmins Health Link: Practical Applications of Patient Engagement
D2-b Engaging Rural Adults Living with Chronic Conditions in Exercise
1. Client feedback on a prediabetes lifestyle education program for rural adults
2. HealtheSteps: Engaging Rural Canadian Men in Chronic Disease Prevention and Management Programs
3. Chronic Disease Rehabilitation with Rural Style

E2 Patient Engagement: Progressing from Pamphlets to Partnerships
F2-a Optimizing End-of-Life Planning for Medically Complex Patients
F2-b Telehomecare: Engaging patients with chronic disease in their care using remote monitoring technology and clinical expertise in the home

3- Responding to community needs

A3 Cardiac Rehab in rural Primary Care: it takes a community.
B3 Knowledge to Action: "Health Checks", A Clinical Innovation in Comprehensive Primary Care of Adults with Developmental Disabilities
C3 Development of a Teen Group at a FHT
D3 "It makes you feel more like a person than a patient": Findings from patients receiving integrated home-based primary care (IHBPC) services in Toronto, Ontario
E3 Addressing income security within a primary health care setting: Lessons learned
F3 Primary Care Outreach and Connection in Rural Communities

4- Team collaboration in patient-centred care

A4 Our Best Foot Forward: Setting the Standard for Evidenced Based Multi-Disciplinary Approach for Foot Care Management

CONCURRENT SESSIONS
Listed by theme

B4 The Most Valuable Player (MVP) Clinic - Our Collaborative Journey to Improving Patient Outcomes
C4 Implementation of a Homebound Senior's Program: The Sunnybrook Academic Family Health Team's Story
D4 Renewal of interdisciplinary team processes to enhance linkages to the community and home based health care
E4 The Village Family Health Team's Stepped Care Depression Management Update
F4 Expanding Capacity for Dementia Care: Primary Care-Based Memory Clinics Across the Province

5- Integrating the community around the patient

A5 Collaborative Team focus for Developmental Delayed and Complex Young Man
B5 Hospital at Home: Innovations in Rural Primary Care
C5-a Collaborative Care Model: What does it take to create integration?
C5-b A Person Centered Health and Wellness Ecosystem
DE5 Coordinated Care Planning in the Guelph and East Toronto Health Links
F5 Improving The Road To Recovery

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

A6-a Utilizing EMRs to Support Cancer Screening
A6-b Transitioning between EMR Systems
B6 Using Run Charts to Evaluate Quality Improvement
C6 Mining for data gold: how to recycle imperfect EMR data into useful information
D6 Optimizing Quality of EMR Data to Improve Care: Leading the Human Side of Change
D6-b Primary care performance measurement -- why bother?
E6 Using Hospital Data: Doing Analyses and Building Warehouses
F6 Advancing and Leveraging the Investment Value of EMRs – Project ALIVE

7- Clinical innovations in comprehensive primary care

A7 Closing the primary care loop following hospital discharge – The Markham FHT Medication Reconciliation Program
B7-a The Health Promotion 6Pack (Hp6): Motivating Patients to Change Unhealthy Behaviours in Clinical Practice
B7-b Respiratory Care: From Case Finding to Rehab and Comprehensive Partnerships
1. Case Finding and Managing Chronic Obstructive Pulmonary Disease
2. Exercising the Option to help those with COPD-a Family Health Team approach to Pulmonary Rehab

C7 Treating Insomnia in a Family Health Team
D7 Advances in Mental Health Care: Telepsychiatry Collaborative Care Model/Anxiety Group
1. Integrative Telepsychiatry Collaborative Care: Increasing Patient Access and Provider Confidence for Adult Mental Health
2. Ten Years of Anxiety Group at a FHT-What Have We Learned

E7-a Patients supporting patients: self-management in Chronic Pain
E7-b Identifying and Managing Challenging Complex Chronic Conditions: A FHT/Health Link Initiative to Address Frailty, Complex Geriatric Conditions, and High Health System Resource Use.
F7-a Advanced Care Planning: practical implementation tools and reflections from two Family Health Teams

F7-b Finding a BETTER Way to Chronic Disease Prevention and Screening: The BETTER 2 Program

Each session is identified by a unique code indicating its timeslot (letter) and theme (number). Sessions from the same theme and in the same timeslot are further identified by a letter at the end.

Example: **A6-a** is in Concurrent Session A, Theme 6 and is the second presentation from that theme during that session.

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.

A1 Implementing a Patient Advisory Council in An Academic FHT

Theme 1. Accountability and governance for patient-centred care
Length: 45 minute Concurrent Session

South East Toronto Family Health Team:
Kavita Mehta, Executive Director
Dr. Tia Pham, Lead Physician
TBD, Patient Adivsory Council Member

Learning Objectives: Participants will learn the value of including patients in a meaningful way to give feedback on improving the team as well as what makes a patient centered FHT from their perspective. The session will include the practical aspects of implementing a Patient Advisory Council (PAC) from creating terms of reference to lessons learned from our first year utilizing the PAC.

Summary: The presentation will take the participants through our internal process from conceptualizing a PAC to implementation and next steps for the evolution of the Council. WE will include concrete examples of how other teams can practically incorporate the PAC into their own environments and we hope to give opportunity for participants hear from one of our PAC members.

B1 How do we as governors ensure we hear and respond to the patient voice?

Theme 1. Accountability and governance for patient-centred care
Length: 45 minute Concurrent Session

Debbie MacGregor (Moderator), Executive Director, Bruyere Academic FHT
• Panelists are from 4 different organizations, both FHT and NPLC. Individuals are to be confirmed:
• A patient serving on a board
• A patient serving on a patient panel
• A physician serving on a board
• An executive director: Pauline Gemmell, ED, Essex County NPLC

Learning Objectives: This panel discussion will give participants insight into the approaches currently in use in four different primary care organizations – FHT and NPLC – to hear and respond to the patient voice. Different perspectives on the panel – patient, provider and administrator – will highlight the opportunities, benefits, limitations and challenges of gathering the patient voices. These will include implementation of a formal patient complaint and feedback process, patient surveys, a patient panel, and patient representation on the board of directors..

Summary: Each panelist will present a brief synopsis of the techniques his/her organization employs to hear and respond to the patient voice and will then outline their successes, challenges, outcomes and recommendations.

D1 Creating cultures of quality improvement and patient safety

Theme 1. Accountability and governance for patient-centred care
Length: 45 minute Concurrent Session

Queen's Family Health Team:
Danyal Martin, Clinical Program Coordinator,
Dr. Karen Hall Barber, Physician Lead
Diane Cross, Clinic Manager

Learning Objectives: - Highlight the importance of culture in your quality improvement and patient safety initiatives - Describe the difference between blame and just cultures and how you can tell where your team is now - Describe systems thinking and how it is useful when dealing with issues in a healthcare organization - Review some of the latest theories in quality and safety culture and how you can apply these to your setting.

Summary: Everyone has probably heard the phrase, "Culture eats strategy for breakfast", but no where is this more true than in the case of quality improvement and patient safety. As there is more and more

emphasis on teams working to improve the care they deliver, they are encountering some of the challenges that culture can present. The Queen's FHT started their QI and safety journey in 2008 and a key part of this effort has been to examine and address issues of culture. Through this, we've learned valuable lessons about what approaches work well for building a just culture (i.e. instead of a blame culture) and how your culture can impact your QI and safety projects.

Steps we've taken include: education regarding the importance of incident reporting, clinic-wide incident de-brief sessions, an interdisciplinary committee structure that uses a team-based approach for everything from creating policies to reviewing mental health cases, and "unblinded" and team based reporting. This presentation will focus on defining the aspects of culture that impact QI and safety, how to recognize them in your team, and what steps you can take to improve the culture in your team.

E1 Rural Wellington Shared Governance Across Health Care Partners

Theme 1. Accountability and governance for patient-centred care
Length: 45 minute Concurrent Session

Suzanne Trivers, Executive Director, Mount Forest FHT

Learning Objectives: Learn how health care providers serving rural communities in Wellington County have come together to create a shared vision and mission, governance structures and shared and integrated services that improve service delivery and access for rural residents.

Summary: Presenters will provide a history of the journey the partner agencies have experienced to date, provide details of the steps used to create the vision and mission, challenges and lessons learned, and plans for future endeavors. The focus of the presentation will be on the change management approach that we have found to be successful.

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.

AB2 Engaging Patients through Portals: Tools and Tales

1. **My Cancer IQ®: a new tool for engaging your patients in cancer prevention and screening**
2. **Patient Portal: Perks and Pitfalls**
3. **Engaging patients in their care through a secure internet portal**
4. **Toward the new paradigm of Patient Centred Care**

Theme 2. Engaging the patient in their care
Length: 90 minute Concurrent Session (Four 20 minute presentations with 10 minutes to draw themes and comparisons)

Shawn Chirrey, Senior Manager, Prevention, Cancer Care Ontario
Anil Maheshwari, MD, Lead Physician, Grandview Medical Centre FHT
Jeff Poll, Executive Director, Grandview Medical Centre FHT
David Verrilli, Physician, Village Family Health Team
Patient TBD

1. My Cancer IQ®: a new tool for engaging your patients in cancer prevention and screening

Learning Objectives: Participants will:

• Receive an overview of the evidence concerning the value of health risk assessments in primary care
• Learn about My CancerIQ®, a suite of online cancer risk assessments for patients created by Cancer Care Ontario

• Hear how family health teams can use My CancerIQ® to promote interdisciplinary collaboration and to educate, engage and empower their patients

Summary: Studies have shown that health risk assessments can help to build a culture of health, create or reinforce awareness of chronic disease risk factors, provide personalized health information, and encourage patient to consider lifestyle changes or to access preventative services, particularly if they are part of an ongoing patient/provider relationship or health promotion program. In December, 2014, Cancer Care Ontario (CCO) is launching My CancerIQ®, a suite of evidence-based, interactive online assessments to enable Ontarians to learn their relative risk of colorectal, lung, breast or cervical cancer, with additional cancers to be added in the future. After completing a risk assessment, each user receives a personalized report and tailored action plan for risk reduction, including appropriate screening recommendations and links to existing authoritative online and phone-based behaviour change resources.

Research by CCO suggests family health team practitioners are well-positioned to use My CancerIQ® to open dialogues with their patients about cancer screening and prevention. This presentation will outline the evidence base, objectives, target audience and capacities of My CancerIQ® and describe how it can be leveraged by family health teams to promote patient-centred collaboration (e.g., between dietitians, nurse practitioners, physicians and health promoters) and to educate their patients, engage them in dialogues on cancer screening and prevention, and empower those

with behavioural risk factors to undertake positive change.

2. Patient Portal: Perks and Pitfalls

Learning Objectives: Participants will learn the following about the use of a patient portal in a FHT: Common physician/staff misconceptions Real world experiences of physicians/staff Best way to deploy Mistakes to avoid Patient usage data AND

Summary: The patient portal is thought to be one of the best ways to engage patients in their care. There are many misconceptions regarding this technology. Learn about one Family Health Team's experience with the portal including the common physician/staff misconceptions that were initially present vs the real world experiences of physicians/staff after deployment. Through our mistakes over the first 1-2 years, learn the best way to deploy this technology and how it helps to engage patients in their care.

3. Engaging patients in their care through a secure internet portal

Learning Objectives: • Understand the technology including compliance with privacy legislation • Describe how the Village FHT and its patients use the technology to engage patients in their own care • Develop ideas about how this tool could be used with your own team and patients

Summary: Since 2012, the doctors and nurse practitioners at Village Family Health Team have used a secure website and mobile app called Wellx to exchange electronic messages with patients. Using Wellx, the team saves time by sharing test results, specialist appointment details and other information with patients, without worrying about the privacy and security concerns associated with email. Village FHT also uses Wellx to instantly broadcast information like flu shot clinic announcements to all of its patients. Wellx is central to Village FHT strategy in terms of patient engagement and access. We continue to refine how we use it to initiate or respond to patient/provider dialogue. November 2013 survey results reflect positive patient experience. This presentation will be delivered by the Lead Physician, Dr David Verrilli and one of his patients. A demonstration will be given.

4. Toward the new paradigm of Patient Centred Care

Learning Objectives: Understand novel tools to collect patient feedback - such as automated surveys, iphone/ipad apps etc Recognize the importance of Patient feedback as data Understand how patient portals can save clinician time and improve patient experience. Understand the importance of patient advisory councils.

Summary: The Wise Elephant Family Health Team along with 4 other FHTs have implemented the miDASH patient portal for their patients. The portal is part of a new paradigm in the way FHTs can engage patients in their own care. Patients can ebook appts, evisit, erefill, and eview their charts. They have also begun video appts with their providers. Patient feedback can be automated through a number of tools including sms, email and webforms. This presentation will discuss these tools and how they have impacted patient engagement in our teams.

C2-a Using the NHS's Experience Based Design (ebd) methodology to capture and understand your patient's experiences and co-design solutions together.

Theme 2. Engaging the patient in their care
Length: 45 minute Concurrent Session

Partnering for Quality- South West CCAC:
Rachel LaBonte, Program Lead
Andrea McInerney, Quality Improvement Coach
TBD

Learning Objectives: Attendees will receive an introduction to the tools and techniques developed in the NHS to capture and understand patient's experiences. Central to this methodology is that solutions are co-designed with patients as equal partners at the table. The power of narratives and stories will be illustrated in specific examples of successes that are described in the presentation. Participants will leave with the foundational knowledge of ebd tools and techniques in hopes they consider application back at their own team/site.

Summary: Patient experience - what's it all about? Differentiating between and understanding our patient's experiences of care from their level of satisfaction are essential in the delivery of high quality patient care. The Partnering for Quality Team will be delivering a session on Experience Based Design (ebd), a methodology developed by the NHS in the United Kingdom. Experience based design follows four phases: Capture, Understand, Improve, and Measure designed to assess and improve patients' experiences. During the presentation attendees will learn the theory of the

methodology and understand the specific tools that can be applied in their practices to achieve successes similar to those that will be described in the presentation. The objective of this presentation is to build capacity in Primary Care Teams to lead and implement patient experience improvement work in their teams.

C2-b Timmins Health Link: Practical Applications of Patient Engagement

Theme 2. Engaging the patient in their care
Length: 45 minute Concurrent Session

Julia Peart RN, BScN, Timmins Health Link Care Coordinator, Timmins Family Health Team
Jennifer McLeod RN, BNSc, MEd, Executive Director, Timmins Family Health Team

Learning Objectives: Participants will gain knowledge regarding: - Techniques to achieve successful patient engagement in decisions about their care in a primary care setting. - Patient care interview that allows practitioner to utilize patient experience as a valued parameter for determining care needs of greatest priority. - Incorporating effective patient goal coaching methods that facilitate the co-creation of a patient's care plan with their team. - Value of completing a patient discovery interview in addition to clinical assessment in the identification of the most relevant patient needs.

Summary: The presentation will begin with a brief, high level overview of the Timmins Health Link initiative. The main presentation will describe the following: - Patient Discovery Interview - interview tool, modifications made by presenter to be appropriate in a primary care setting - Patient Goal Coaching - Timmins Health Link team's use of motivational interviewing techniques and client readiness assessment to effectively engage patient in care plan co-design - Presentation of case studies to demonstrate successes and challenges with technique - Review of project evidence and results - Strategies for continued patient engagement through primary care and sustainability of health system transformation

D2-b Engaging Rural Adults Living with Chronic Conditions in Exercise

1. **Client feedback on a prediabetes lifestyle education program for rural adults**
2. **HealtheSteps: Engaging Rural Canadian Men in Chronic Disease Prevention and Management Programs**
3. **Chronic Disease Rehabilitation with Rural Style**

Theme 2. Engaging the patient in their care
Length: 45 minute Concurrent Session (Three 10 minute presentations followed by 5-10 minutes to draw themes and comparisons)

Adrienne Vermeer, Registered Dietitian,Star FHT
Sean Blaine, Family Physician, Star FHT
Sheila Cook, BSc, HealtheSteps Knowledge Broker, InFacilitation
Katie Mairs, MSc, HealtheSteps Knowledge Broker, Lawson Health Research Institute
Lisa Melburn, RN, Cardiorespiratory Nurse, Upper Grand Family Health Team

Learning Objectives:

- To review feedback assessments and consider their role that they have to play in program buy in and ongoing engagement
- Identify tools and activities resulting in positive behaviour modification based on focus group discussion
- How to approach Community Partners and the importance of ongoing communication
- Provide a list of evidence based assessment for physical and psycho-social assessment
- Learn about barriers and enablers to men participating in Chronic Disease Program Management from 3 sources of evidence (literature, surveys of men and interviews with health care providers)

Summary: Chronic disease is the leading cause of death in Ontario. According to the World Health Organization only 1 out of 7 people get enough physical activity which puts people at risk of developing a chronic disease. In rural areas, healthcare organizations struggle to support their clients with chronic disease to get enough physical activity due to lack of local support. Barriers also include geography, transportation, driving conditions during winter months, affordability, lack of knowledge and confidence. Engaging clients in their care is a key component of all education programs that are developed to respond to the needs of that community.

This presentation will illustrate three approaches to address gaps in physical activity in rural communities.

1) STAR FHT will highlight their pre diabetes education program and impact on behaviour modification as assessed by program feedback forms and focus groups. 2) Upper Grand FHT will emphasize the importance of utilizing the scarce resources in a rural community. Evidence based assessment tools will discussed and tips for their use.
3) The Healthestep program will share findings of a CIHR funded project to help FHTs learn why men typically do not participate in chronic disease prevention and management (CDPM) programs and what we can do about it.

E2 Patient Engagement: Progressing from Pamphlets to Partnerships

Theme 2. Engaging the patient in their care
Length: 45 minute Concurrent Session

Genevieve Obarski, Executive Lead, The Change Foundation

Learning Objectives: • Understand the evidence and necessity for authentic engagement and partnership between providers and health system users.

• Be able to understand and apply the basic principles of authentic patient engagement.
• Learn about successful engagement initiatives in Ontario and elsewhere.
• Understand how to use patients' stories to drive change.

Summary: The Change Foundation, an Ontario based Health Policy think tank, along with 2 of it's engaged patients/family members, will highlight key evidence, strategies, and examples of successful improvement resulting from partnerships between health system providers and those that they serve.

F2-a Optimizing End-of-Life Planning for Medically Complex Patients

Theme 2. Engaging the patient in their care
Length: 45 minute Concurrent Session

Dr. Kimberly Wintemute, MD CCFP FCFP, Medical Director and Lecturer, North York Family Health Team and University of Toronto
Danuta Southgate, MSW, RSW, Project Coordinator, North York Family Health Team

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Learning Objectives: 1)Become familiar with research demonstrating importance of end-of-life planning; 2) Learn an innovative way to support patient decision-making in end-of-life planning, using EMR patient identification; outreach; standardized training for AHPs and physicians; a defined and standardized clinical pathway; available Canadian tools and resources; and EMR data collection..

Summary: In evaluating the North York Central Health Link (NYCHL) "high user" data, we identified a lack of clarity around the timing of transition from active treatment into palliative care for patients with end-stage respiratory conditions. Studies show that most people want to die at home, but over 70% die in hospital (Canadian Hospice Palliative Care Association, 2012). This pilot project optimizes end-of-life planning through standardized provider training and patient-focused, end-of-life care discussions earlier in the course of illness than otherwise would typically occur. The target population is patients aged 70 and over, diagnosed with either CHF or COPD and with a co-morbid condition (based on the Canadian Primary Care Sentinel Surveillance Network). Ultimately, by optimizing end-of-life planning, we hope that a greater portion of Ontarians who wish to die at home may do so, with a more timely transition from active treatment to palliative care, and with well coordinated clinical services. The clearly defined, simple and sustainable clinical pathway can be easily spread among primary care providers.

F2-b Telehomecare: Engaging patients with chronic disease in their care using remote monitoring technology and clinical expertise in the home

Theme 2. Engaging the patient in their care
Length: 45 minute Concurrent Session

Dr. Ed Brown, MD and CEO, Ontario Telemedicine Network

Learning Objectives: - Learn how Telehomecare can empower patients with chronic disease to better manage their disease - Understand the details and benefits of OTN's Telehomecare program and how Telehomecare is a "good fit for a FHT" - Review the evidence for Telehomecare - Deliberate on the future for Telehomecare and virtual health.

Summary: Presentation Style: The presentation will be led by OTN's Dr. Ed Brown and will include a review of the program's evaluation. In addition, up to three primary care physicians that have first- hand

experience with Telehomecare will also participate in a panel-style discussion. Presentation Content: The current Telehomecare Program provides COPD and Heart Failure patients with improved quality of life by motivating patients and teaching them the skills to self-manage their condition with confidence. As a result, patient confidence and self-management skills increase significantly; thereby avoiding unnecessary ER visits and inpatient hospitalizations are reduced.

The program includes: • Monitoring of vital signs with simple-to-use equipment in their own homes from Monday to Friday. • Remote monitoring of BP/P/weight and O2 Saturations for early identification of warning signs of exacerbations and notification to Primary Care Physician if required. • Weekly health coaching from specially-trained clinicians including registered nurses and respiratory therapists. • Progress reports including trend reports to identified circle of care

The presentation will be a combination of hands-on practical information in a panel discussion shared by the primary care physicians as well as a review of the evaluation results and a view of the virtual health care future by Dr. Ed Brown. Target Audience: Although the presentation will be by physicians with the main target being fellow physicians, it will be of interest for anyone that has a mandate to improve chronic disease management and support patient's improved quality of life in their home.

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.

A3 Cardiac Rehab in rural Primary Care: it takes a community.

Theme 3. Responding to community needs
Length: 45 minute Concurrent Session

PEFHT:
Cathy Brose, RN
Wanda Parks, Community Support Planner
Nancy Locke, Physiotherapist, Quinte District Rehab

Learning Objectives: Participants in this session will gain knowledge of what it takes to establish a Cardiac Rehab program in a rural setting. Discussion will outline key ingredients of success: expert external support for program development from established Cardiac Rehab Facilities ; to interdisciplinary collaboration (MD, MD specialist, Physiotherapy, Nursing, Community Support Planner, and other allied health professionals); and finally the community partnerships that made it all possible.

Summary: Prince Edward County is a rural (island) community, populated primarily by seniors and with a high prevalence of cardiovascular disease. A Cardiac Rehab program in Kingston required a 200 km round trip by car twice weekly, no public transportation is available and very few patients were attending following their cardiac event. The rural community spirit kicked in and within a year, a fully equipped exercise area was made available through local fund raising events. A comprehensive medically supervised program of exercise and education, followed by supporting community activities and planned events, is now available to our patients requiring cardiac rehabilitation.

Cardiac Rehab is a medically supervised 12 week exercise program. After a screening and assessment process, exercise prescriptions are followed and are adapted and individualized as needs change and progress is made. Personal goals are reviewed periodically and support is provided to assist patients in meeting their goals. Weekly education sessions are provided by PEFHT professional staff and cover such topics as nutrition, stress management, medications, behaviour modification and goal setting. Self management is emphasized and an ongoing healthy life style is strongly encouraged. Ongoing success in lifestyle modifications is achieved at the PEFHT CR program through our "Moving On" segment. The Community Planner maintains contact with graduates for a year (or more if the patient wishes), conducting surveys, planning group activities and social events, and notifying them of relevant community programs and activities.

B3 Knowledge to Action: "Health Checks", A Clinical Innovation in Comprehensive Primary Care of Adults with Developmental Disabilities

Theme 3. Responding to community needs
Length: 45 minute Concurrent Session

Ian Casson, MD, MSc, CCFP; Family Physician, Queen's Family Health Team; Department of Family Medicine, Queen's University
Elizabeth Grier, MD, CCFP; Family Physician, Queen's University Department of Family Medicine
Andrea Perry, OT Reg (Ont.), MHSc; HCARDD Facilitator, Underserved Populations Program, Centre for Addiction and Mental Health
Laurie Green, MD, CCFP; Family Physician, St. Michael's Hospital Academic Family Health Team; Department of Family and Community Medicine, University of Toronto
Meg Gemmill, MD, CCFP; Family Physician, Queen's Family Health Team; Department of Family Medicine, Queen's University

Learning Objectives: From this presentation and interactive discussion, participants will gain knowledge of: • the implementation of the Canadian Consensus Guidelines and Tools for the Primary Care of Adults with Developmental Disabilities (DD), in particular the recommendations for periodic comprehensive health reviews and interdisciplinary care, • recent results describing access to primary care in Ontario from the Health Care Access and Research in Developmental Disabilities (HCARDD) study, • barriers and enablers from the experience of three pilot projects in Ontario: Kingston, Toronto and Thunder Bay. Participants will have the opportunity to explore how implementation in their own Family Health Team might be successfully accomplished..

Summary: The presentation will be introduced by researchers with a brief description of the "knowledge" that comes from a unique database linking the Ontario Ministries of Health and Long-Term Care and Community and Social Services and identifying a cohort of over 65,000 adults with developmental disabilities. This has yielded information about use of primary care services, hospitalizations, rates of annual preventive health exams, cancer screening, and medication use. The research supports the current Canadian Consensus Guidelines for the Primary Care of Adults with Developmental Disabilities.

Front-line workers in FHTs will then present a description of the "action" that has arisen out of this knowledge: the implementation of Health Checks in pilot projects in Family Health Teams in Ontario. Health Checks focus on preventive maneuvers, common conditions, accommodations often necessary for persons with developmental disabilities (for instance, in communication) and coordination with community services. We are learning that implementation of such an innovation should take different forms in different settings and requires the participation of administrative and clerical staff, patients and caregivers and community agencies, as well as health professionals. To conclude the session, we plan to lead a discussion among those attending about their perceptions of barriers and enablers to rolling out this guideline to enhance the access to and quality of care for adults with developmental disabilities in Ontario.

C3 Development of a Teen Group at a FHT

Theme 3. Responding to community needs

Length: 45 minute Concurrent Session

K. Lynn Dykeman, Social Worker MTS, MTh, MSW,RSW, McMaster, University

Learning Objectives: Learning Objectives 1) Explore rationale for development of Teen Group. 2) Consider goals of group. 3) Review methods for selecting group participants. 4) Discuss publicity of program. 5) Examine issues related to scheduling of group. 6) Discuss integration of group into clinic programming. 7) Explore typical group session.

Summary: This presentation will explore the development of the Teen Group at the Stonechurch Family Health Centre, part of the McMaster Family Health Team. The experience of this site may help inform other FHTs about possible use of group methodology when working with teens. Some teens to date have indicated a preference for group therapy over individual therapy. Group therapy appears to provide an effective cost-effective treatment modality that is well received by the teens, and has produced promising results.

In the Summer of 2013, due to an increasing number of anxious teens, particularly in response to school attendance, a Teen Group was started at the Stonechurch Family Health Centre. The initial group was a structured 8-session program that used mindfulness and cognitive behaviour therapy techniques. At the completion of group, the teens requested that the program continue. Based on teen feedback, the group now meets every second Monday and is much less structured in nature. Teens generate topics for discussion, which have included dealing with parents, dealing with peers, procrastination, substance use, and sexual orientation. The group uses a drop-in format, and attendance generally ranges between 6 and 8. About 25 teens have participated in group.

D3 "It makes you feel more like a person than a patient": Findings from patients receiving integrated home-based primary care (IHBPC) services in Toronto, Ontario

Theme 3. Responding to community needs

Length: 45 minute Concurrent Session

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Thuy-Nga (Tia) Pham, MD, South East Toronto Family Health Team Physician Lead, South East Toronto Family Health Team, Toronto East General Hospital
Gayle Seddon, Director, Community Services, Toronto Central Community Care Access Centre
Tracy Smith-Carrier, PhD, Assistant Professor, King's University College at Western University

Learning Objectives: After this session, participants will be able to: • Identify current models adopting the integrated home-based primary care (IHBPC) model in Toronto, Ontario • Describe key partnerships in primary and community care that promote integration at the point of care • Summarize key themes from qualitative data exploring patients' experiences and perspectives receiving IHBPC • Outline the advantages and challenges of using telemedicine with the frail older adult population.

Summary: A successful health care system will be one in which there is seamless integration and collaboration across care sectors. Innovative approaches are also needed to contend with the complex and inter-related health and social problems faced by the frail older adult population. One approach that is gaining momentum is the home-based primary care (HBPC) model. We add the word 'integrated' to describe our HBPC model (renamed IHBPC), recognizing the importance of fully integrating medical, cognitive and social care services at the point of care. This model reflects these key design features: the provision of ongoing, comprehensive medical and social care to frail older adults, interprofessional team service delivery and after hours availability for urgent issues.

Our study documents the findings from seven research sites adopting the interprofessional team model in Toronto, including: five academic family health teams (FHTs), one community-based FHT and a team operating out of a community social support agency; all with an embedded care coordinator from the Community Care Access Centre. We will present research findings from qualitative data exploring patients' experiences receiving IHBPC. Key themes include the necessity of the service for this population; the obstacles associated with office-based care; the benefits of IHBPC; improvements in patient satisfaction and quality of care; the benefits and challenges associated with the coordination of care services; as well as the uncomfortable aspects of IHBPC, including areas for improvement for the model. Preliminary observations will also be discussed on how to incorporate the use of telemedicine to improve patient care.

E3 Addressing income security within a primary health care setting: Lessons learned

Theme 3. Responding to community needs
Length: 45 minute Concurrent Session

Andrew D. Pinto, staff physician & research fellow, Department of Family and Community Medicine, St. Michael's Hospital
Karen Tomlinson, income security health promoter, Department of Family and Community Medicine, St. Michael's Hospital
Danyaal Raza, family physician, MPH candidate, Harvard University

Learning Objectives: At the end of the presentation, participants will have: 1. Gained knowledge of the evidence that supports addressing income security within primary care as a high-impact intervention on a key determinant of health. 2. Gained knowledge of the challenges faced by interventions in this area, applicable to other work on health promotion within Family Health Teams. 3. Gained skills around designing interventions on income security, based on lessons learned within the St. Michael's Hospital Academic Family Health Team (SMHAFHT).

Summary: Social processes and structures that impact our health have been labeled the social determinants of health (SDOH). Income security, a person's actual, perceived and expected income, may be the most influential SDOH. A large body of literature links income security with health, yet interventions to improve income security rare exist in our health care system. First, we will present a conceptual model of how income security health promotion works within primary health care.

Using realist methods, this model was refined with input from experts from across Canada and using findings from a systematic review of the literature. Key mechanisms that support successful interventions include: a) ensuring the health promoter is embedded within the health care team, b) developing a trusting relationship between patient, family physician and health promoter, and c) demonstrating success in improving income security, which builds support among skeptics. Second, we will discuss lessons learned from engaging in income security health promotion at the St. Michael's Hospital Academic Family Health Team over the past six months. We will outline the referral and follow-up process and identify common challenges

faced by patients. We will present our standardized approach to improving income security to support the replication of this model in other FHTs.

Third, we will discuss our plans for a pragmatic randomized controlled trial, the IGNITE (addressInG iNcome securITy in primary carE) Study. The presentation will finish with an analysis of how new evidence could inform policy change to support income security of all Ontarians.

F3 Primary Care Outreach and Connection in Rural Communities

Theme 3. Responding to community needs
Length: 45 minute Concurrent Session

Elsa Mann, Team Leader, Rural Wellington Community Team
Melissa Grenier, CCAC Care Coordinator,
Penny Wilson, Outreach Worker
Shannon Reaume, Outreach Worker
Jesse Sepers, Outreach Worker

Learning Objectives: Learn how the role of an outreach team acts as an extension of primary care in the rural communities of Wellington County. This team of workers have lived experience navigating social and health networks, and engage with complex, at risk and vulnerable residents. Hear the early findings of the program, including gaps and barriers to care, social determinants of health in rural communities, and collaboration between existing services. Keeping the criteria of those served open to all residents in our rural geography, has allowed the team to serve rostered patients, non-rostered patients and those individuals who have no primary care physician.

Summary: The Rural Wellington Community Team (RWCT) was born out of the statement "we don't know what we don't know". This presentation will review the barriers and gaps that patients experience and the resulting effects on their health that are often unidentified. The team was charged with answering the question "What can be done differently to ensure these complex, at risk and vulnerable individuals have their needs met"? The team meets individuals 'where they are at', and works primarily in the community. Individuals referred are asked to identify their own needs and goals vs. those imposed on them by others. The team is comprised of Outreach Workers imbedded in each of the four Rural Family Health Teams in Wellington County, one CCAC Care Coordinator and a Team Leader. Each team member serves as a conduit of information, communicating with primary care and acting as 'the glue' between the needs of the individual and the services they require in the community, being a support similar to a coach or family member.

The Team is still in development but has established a practice of patient centred goal setting, and action planning. Where multiple providers are involved, the Worker will draw everyone together at the individual's request, to create a Coordinated Care Plan. The RWCT has quickly been a welcome addition to the Family Health Teams, and service providers in the community. Presenters will share a number of stories (non-identifying and shared with permission) to illustrate the connections that were created as a direct result of the RWCT.

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).

A4 Our Best Foot Forward: Setting the Standard for Evidenced Based Multi-Disciplinary Approach for Foot Care Management

Theme 4. Team collaboration in patient-centred care
Length: 45 minute Concurrent Session

Margie Zimmo, RPN, Guelph Family Health Team
Kari-Anne Mills, RN BscN, Diabetes Educator, Diabetes Care Guelph

Learning Objectives: Participants will learn three important elements of advancing foot care in their primary care setting:

1.The importance of foot care services: Participants will gain an understanding of foot care and how it relates to complications of diabetes and the circulatory system; poor glycemic control, decreased mobility, hypertension and hyperlipidemia. In addition, biomechanical changes can result in ulcers and amputations from shearing, friction, pressure or trauma.

2. Utilizing a multidisciplinary team approach to clinical foot care interventions: The importance of early detection, detailed foot exams, standardized screening, documentation, working with allied health care providers and family physicians to provide comprehensive treatment, and community referrals will be reviewed.

3. Individual and Group Education: Through patient education at the primary care level and the use of best practice guidelines, (CNO, CDA, and CAWC) unnecessary complications and expenses on both patients and to the health care system can be reduced.

Summary: Participants will learn from the Guelph FHT's experience in delivering a standardized foot care program which is comprised of two primary components: a multidisciplinary team approach to clinical foot care interventions and individual and group foot care education. The multidisciplinary team approach to clinical foot care is a vital element of the foot care program to reduce time to referral, positive patient outcomes, and to provide a holistic approach to care. Collaboration with community resources allows us to provide other treatment to our patients as well as education on foot care, footwear, and foot safety. Patient progress is documented through both written and photographic evidence in order to track and share progress with the patient's health care team. This approach allows for proactive and up to date care. Expansion of the current program is planned and will involve the Diabetes Education Centre in order to pilot a standardized approach to provider education with the focus on standardized assessment, charting and referrals to both FHT and non-FHT health care providers.

Patients have two options from which to receive foot care: individual appointments or group education. Individual appointments provide comprehensive hands-on treatment for more complex patients. While patients receive care for their presenting problem, the underlying focus is on health promotion and future illness prevention. Additionally, non-complex patients or those with healthy feet looking to prevent future complications can attend a group education class run by the foot care nurse and registered kinesiologist.

B4 The Most Valuable Player (MVP) Clinic - Our Collaborative Journey to Improving Patient Outcomes

Theme 4. Team collaboration in patient-centred care
Length: 45 minute Concurrent Session

Barrie and Community Family Health Team:
Shelley Cameron, Clinical Manager
Stephanie MacGowan, Registered Nurse
Angela Lamothe, NP
Katherine Whiteside, Social Worker

Learning Objectives: Our Family Health Team has created a clinic for medically complex patients that uses a comprehensive, interdisciplinary approach where we acknowledge that the most valuable contributor to successful healthcare delivery is in fact the patient. Session participants will learn how we : - provide consistent, collaborative healthcare in one environment to medically complex and marginalized patients - use a patient-centered approach to stabilize and improve health status for patients experiencing multiple chronic illnesses - maximize health outcomes and improve access to community resources by assisting patients to navigate the healthcare system - positively impact overall healthcare costs by our approach.

Summary: The MVP Clinic was created to support phase one of the Barrie Community HealthLink's business plan. As the lead organization for our HealthLink, the BCFHT recognized the need to change the way healthcare is delivered in our community therefore committed resources to this project. Using an interprofessional approach to care, our goal was to open a clinic for patients with multiple complex conditions, limited access to a primary care physician, and who are 'high cost' users of the healthcare system.

Our team includes an administrative assistant, NP, RN, Pharmacist, Social Worker(SW), Registered Dietitian, Occupational Therapist, and physician and internal medicine support. The MVP Clinic embraces the philosophy that the patient is in fact the 'most valuable player' in their healthcare and works with each patient to prioritize personal goals and any medical needs identified by the clinicians. This collaboration starts at the initial visit with the patient, RN, SW, and pharmacist completing an in-depth health history, patient goal identification, and medication review.

By using this approach, we can better identify and support ALL aspects of the patients' life and overall health (physical, mental, and socio-economical issues). We also work very closely with community partners to help the patient navigate community resources and to ensure that the patient experiences a seamless journey across the healthcare continuum. Both early hospital data and the patients stories we have heard and witnessed demonstrate that our collaborative practice significantly improves patient experience and therefore overall health and wellness.

C4 Implementation of a Homebound Senior's Program: The Sunnybrook Academic Family Health Team's Story

Theme 4. Team collaboration in patient-centred care
Length: 45 minute Concurrent Session

Sunnybrook Academic Family Health Team:
Dr. Alison Culbert, Family Physician
Jane Smart, RN

Learning Objectives: Attendees of this session will: 1. Understand the implementation of a Homebound Senior's Program which is a model of team collaboration in patient-centered care providing innovative, integrated, multidisciplinary team based care to homebound seniors. 2. Learn about the benefits of this successful interprofessional team approach to providing care to some of our most vulnerable patients. 3. Review some qualitative data on provider and patient/caregiver satisfaction since the implementation of our formal "Homebound Seniors Program" in June of 2012.

Summary: The Sunnybrook Academic Family Health Team's Homebound Seniors Program is an innovative, integrated,interprofessional project that provides team based care to homebound seniors (those who require a home visit due to a physical, social and/or psychological barrier which prevents them from accessing the clinic.) Our Family Health Team has had a long tradition of physicians providing house calls. These were usually done after clinic hours which made it difficult to include learners or involve other health care providers. The formal creation of our Homebound Seniors Program has led to the booking of set half days per month where team members see patients together. One of our nurses has been assigned to manage this roster of patients and this has been a key improvement in the delivery of care to this population. She is the first point of contact for patients and caregivers and is able to arrange additional home visits if required. Monthly rounds with a consultant geriatrician have also

enhanced this program. This session will describe the development and implementation of this program as well as some preliminary outcome data.

D4 Renewal of interdisciplinary team processes to enhance linkages to the community and home based health care

Theme 4. Team collaboration in patient-centred care

Length: 45 minute Concurrent Session

McMaster University:
Doug Oliver, MSc MD CCFP, Associate Professor
Lisa Dolovich, BScPhm PharmD MSc, Professor and Research Director
David Price, MD CFPC PCFP, Professor
Kalpana Nair, MEd MSc PhD, Research Coordinator
Ernie Avilla, Program Manager

Learning Objectives: 1. Understanding of how volunteers, technology, and the primary care team can be engaged to better meet the goals of patients 2. To share processes and tools that have been implemented to facilitate communication between team members 3. To share processes and tools that have been implemented to facilitate connection to community agencies.

Summary: The provision of care for older adults can be challenging due to complex life and health realities for this population. TAPESTRY (Teams Advancing Patient Experience: Strengthening Quality) is a community based primary health care program that aims to foster optimal aging for older adults living at home using an interprofessional primary health care team delivery approach that centres on meeting a person's health goals with the support of trained community volunteers, system navigation, community engagement, and use of technology.

This presentation will share learnings from the initial development and implementation of TAPESTRY within a 2-site Family Health Team (FHT). TAPESTRY generated patient reports for the FHT based on information collected by volunteers that summarized of issues important to the patient, key alerts for follow-up, and scores from tools completed. Within the FHT, a number of processes emerged to better facilitate communication between health care providers. At one site, a weekly team huddle was implemented to discuss TAPESTRY reports; at the other site time was allocated within team meetings for TAPESTRY discussions. This allowed for development and planning of next steps. Regular communication between the interprofessional team and volunteer coordinator helped to facilitate areas of follow-up for the volunteers. One key area of improvement identified was having a TAPESTRY champion within each site. Moving forward the system navigator will take a more active role in engaging the team and connecting the patient to community services. Coordination of care and sharing of information between agencies are areas of further development within TAPESTRY.

E4 The Village Family Health Team's Stepped Care Depression Management Update

Theme 4. Team collaboration in patient-centred care

Length: 45 minute Concurrent Session

Andrew Ross, Social Worker, MSW RSW, Village Family Health Team
D. J. Rodie, MD PGY5, University of Toronto
Manisha Verma, Staff Physician MD, CCFP, Village Family Health Team

Learning Objectives: 1)Analyze the relevance of a Stepped Care Model for depression in primary care

2) Describe the benefits of such an intervention

3) Anticipate the challenges of knowledge translation of research into community settings

4)Understand the steps necessary to implement a Stepped Care Depression Program.

Summary: Evidence supports increasing the capacity in primary care to manage a wider range of mental health issues. Village FHT has about 750 patients with a diagnosis of depression. Village FHT presented the concept of a Stepped Depression Management Program at AFHTO 2012. At AFHTO 2014, we will present the outcome of two years of work. Stepped Depression Management is a treat to target program. The PHQ-9 is used to detect major depression and systematically monitor patient's status. It provides a clear, evidence-based stepped-care approach for the provider to know how to best change or intensify treatment if needed. A consulting psychiatrist reviews the patient case load with the social worker and family physician and offers assistance for patients with depression that is severe or not improving.

Our presentation will consist of a review of literature demonstrating effectiveness of this approach in other settings as well as a review of public policy supporting shift of mental health management to primary care. We

will provide a description of the program including goals and outcomes, what we learned, and how we came together as a team to deliver patient-centred care. We will take questions and also discuss our plans to expand mental health services at the Village FHT in collaboration with a CAMH.

F4 Expanding Capacity for Dementia Care: Primary Care-Based Memory Clinics Across the Province

Theme 4. Team collaboration in patient-centred care
Length: 45 minute Concurrent Session

Linda Lee, MD, MCISc(FM), CCFP, FCFP; Director, Memory Clinic, Centre for Family Medicine Family Health Team

Learning Objectives: Participants will learn about: 1. The interprofessional primary care Memory Clinic model. 2. The training program designed to increase capacity for dementia care. 3. Current memory clinic implementation across the province. 4. Potential for expansion to other complex geriatric conditions. 5. Key lessons learned in the development, implementation, and expansion of memory clinic model (enabling factors, challenges, system barriers)..

Summary: A primary care-based memory clinic model has been developed to address existing challenges of providing dementia care within family practice. To support this model, a training program was developed as a capacity-building initiative to support primary care providers to maintain the majority of dementia care within primary care practice. Over 456 individuals have participated in the Memory Clinic training program, representing family medicine (109), nursing (137), social work (52), pharmacy (39), the Alzheimer Society (60) and other disciplines. There are currently 49 operational memory clinics across the province; this will grow to 64 by the end of 2014. These clinics support over 500 medical practices, with a combined patient base of over 700,000. The majority of clinics have been established in Family Health Teams; several exist in other practice models suggesting the generalizability of the model to practices with varying structures and resources. Partnerships with the Alzheimer Society have contributed to improved care coordination and integration between primary and community care.

Although the focus of the clinic is on cognitive impairment, there is interest in adapting and expanding this model to integrate care for additional complex chronic geriatric conditions (heart failure, falls, COPD, and frailty). This presentation will describe the memory clinic care model, training program, implementation across the province, and potential applicability to other complex geriatric conditions.

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.

A5 Collaborative Team focus for Developmental Delayed and Complex Young Man

Theme 5. Integrating the community around the patient
Length: 45 minute Concurrent Session

Marc Sawyer, MD, CFFM
Tina Woods, Supervisor, DEAFBLIND association
Marg Alfieri, Registered Dietitian, Centre for Family Medicine FHT

Learning Objectives:
1. to learn how teams react the unique needs of a developmentally delayed young man, by rapidly responding to needs
2. How teams need to be flexible and contain members from organizations from outside one's FHT.
3. learn from our lessons on how to overcome challenges when working with team members from within one's FHT,community and with patient's family.

Summary: Our FHT worked seamlessly with other organizations within the community, from the patient's group home, to his parents, CCAC, local hospital and Developmental services agency to provide the care that this patient required. This was a new patient to our FHT, and because of his extremely high risk, this new team did not have time to do the usual forming, storming and norming. We had to function at a high level as this patient was experiencing oropharyngeal dysphagia, aspiration and malnutrition which were potentially life threatening. Our team would like to share our successes, lessons learned and what motivated us. The patient and his mother will be joining us in discussing how effective collaboration was life saving.

B5 Hospital at Home: Innovations in Rural Primary Care

Theme 5. Integrating the community around the patient
Length: 45 minute Concurrent Session

Stephanie MacLaren, Executive Director, Prince Edward Family Health Team
Geri Claxton, RN, H@H Team Lead, Prince Edward Family Health Team
Brad Gunn, NP, Prince Edward Family Health Team
Carol Ravnaas, Senior Director, Strategy Partnerships and Accountability, SE CCAC

Learning Objectives: Participants will learn the results to date (including successes and challenges) of this innovative 2 year multi-organization pilot project aimed at avoiding hospital admissions and reducing hospital stays. The presentation will incorporate learnings with respect to patient/caregiver experience, service delivery and program development, in addition to organizational change management since its launch in September 2013.

Summary: Launched in September 2013, Hospital @ Home [H@H] is a partnership project between Prince Edward Family Health Team, SE CCAC, Quinte Healthcare Corporation, and Queen's University, Saint Elizabeth Healthcare. The aim of the Hospital @ Home is to divert appropriate patients requiring inpatient care to a program that wraps the necessary care around the patient in their own home – the right care at the right time in the right place. It aims to meet the Ministry of Health and Long-Term Care's priorities of better access, better quality and better value.

CONCURRENT SESSIONS
Theme 5- Integrating the community around the patient

Patients are cared for by a Care Team which includes a physician, nurse practitioner, Team Leader, CCAC Care Coordinator, personal support workers, nurses, pharmacist and social worker. Additional Care Team members may include a wound care nurse, diabetes educator, physiotherapist, occupational therapist, dietitian, palliative care nurse, congestive heart failure nurse, COPD nurse, community health service provider, or other appropriate health care professional. All members of the Care Team participate in goal setting and discharge planning with the patient and caregiver. Information is exchanged daily between Team members at a Team conference, in person or by use of "virtual" technology, and through use of the PEFHT electronic medical records. The presentation will feature discussion from multiple partner/provider perspectives on their experience of the program and learnings in addition to an incorporation of patient experience in the form of narrative or video.

C5-a Collaborative Care Model: What does it take to create integration?

Theme 5. Integrating the community around the patient
Length: 45 minute Concurrent Session

Sue Jones, Qualtiy Improvement Coach NSM LHIN, Health Quality Ontario
Marie LaRose, Executive Director, Georgian Bay Family Health Team/Health Link

Learning Objectives:

The participants will: • identify how to choose sector partners to construct integration • how to involve patients in the re-design in creating an integrated model of care • how technology can impact on the integration of care and how this health link has used partnerships to move technology forward • how to create the culture of thinking differently.

Summary: The making of this health link has the elements of a process that has included the historical stages of team formation and through that process has created change in a positive format for patients and their families. We will show the approach used, the process for creating culture change, the ideas tested, evaluated and re-tested and the outcomes in relation to the patient. We will provide information on patient engagement, evaluation of patient engagement, the learning's from the healthcare professional's perspective and how physicians have become involved. The system we currently practice in has gaps and the purpose of redesigning was to create innovation to address the gaps from the patient's perspective and we will demonstrate some of the innovative ideas that will address the gaps in care for the South Georgian Bay population in the creation of the Collaborative Care Model along with some of the tools developed to implement the model.

C5-b A Person Centered Health and Wellness Ecosystem

Theme 5. Integrating the community around the patient
Length: 45 minute Concurrent Session

Department of Family Medicine, McMaster University:
Anubha Sant, Management Consutlant,
Tracey Carr, Executive Director
David Chan, Director of IT

Learning Objectives: This panel will bring together representatives from clinics using transformational technology to enable patient centered care. This panel discussion will:
• Explore the importance of a PHR as a patient engagement tool; • Discuss the importance of providing patients access to evidence based content; • Discuss the importance of reliable curated clinical decision support content, used at the point-of-care; • Explore the workflow of integrating volunteers into primary care delivery, using a tablet app interfaced with the PHR and EMR; • Discuss potential implementation challenges and how to address them; • Discuss opportunities for building provider buy-in and addressing privacy concerns..

Summary: With the emphasis shifting to patient-oriented care and collaborative care models with patients as partners, the electronic personal health record (PHR) has generated considerable interest and investment in recent years. The PHR allows users to assign a team that can advocate for them, by providing members in their formal and informal circle-of-care to access elements of information available within their PHR. On the surface, PHRs offer many opportunities for both patients and providers, including increased patient engagement, better self-management of chronic conditions, greater convenience for patients, and improved office efficiency; however, they are not without their challenges, and many providers have concerns about impact on workflow, privacy legislation, and liability.

Additionally, there is a lot of interest in patients actively searching for health information, including treatment

options and wellness content, on the internet. There are a vast amount of resources available over the internet that provide users access to health content, however there exists a gap in validated and curated content. The Know2Act App, developed at McMaster University, bridges the gap to provide patients users to clinically validated and acknowledged content. Providers now have the ability to receive patient-context-specific, evidence-based and trusted information, directly into their EMR at the point-of-care encounters, while further having the ability to share this content with patients, to ensure patients have access to the most credible information. The purpose of this panel will be to explore a clinics' experience with a large eHealth system consisting of an EMR, PHR and a social CDSS, including benefits to patients and providers, implementation tips, and challenges.

DE5 Coordinated Care Planning in the Guelph and East Toronto Health Links

1. **How Health Links Provide Coordinated Care Planning for Complex Patients – Keeping it Patient Centred and Provider Enhanced**
2. **Integrating the community around the patient**

Theme 5. Integrating the community around the patient
Length: 90 minute Concurrent Session

Thuy-Nga Pham, MD, Physician Lead SETFHT and East Toronto Health Link, South East Toronto Family Health Team
Dr Pauline Pariser, MD, Physician Lead Taddle Creek FHT and Mid West Toronto Health Link, Taddle Creek Family Health Team
Dr Jocelyn Charles, Chief Department of Family Medicine Sunnybrook Hospital, Sunnybrook Hospital
Ross Kirkconnell, Executive Director, Guelph Family Health Team

1. How Health Links Provide Coordinated Care Planning for Complex Patients – Keeping it Patient Centred and Provider Enhanced

Learning Objectives:

1.Recognize what makes patients complex and how to identify them in your Health Link

2. Identify shortcomings in our current system that considers patients only as single organ diseases with contradictory isolated chronic disease management guidelines.

3. Be able to list alternate clinical models and programs to manage the needs of complex patients using interprofessional teams and a more holistic approach.

4. Apply principles of coordinated care planning to complex patients using present frameworks on care plans.

Summary: More than 50% of Canadian adults, and 81% of older adults in the community have a chronic health condition, and patients older than 65 years of age require treatment for 6.5 chronic illnesses on average, thereby often consuming the largest proportion of health care resources. On the other hand, Clinical Practice Guidelines (CPGs) have a single disease focus and often conflict with each other. Complex patients and their primary care providers often struggle with chronic disease guidelines and a health care system that has been designed for single disease entities and that does not take into account challenges with mental health, poverty, cognitive impairment, and substance usage.

In our presentation we will review how Health Links can identify complex patients in their region using a combination of different approaches. The need for better coordinated care for complex patients to promote optimal quality of care and efficient use of health system resources will be highlighted, and key components of coordinated care planning will be discussed. A variety of care models will be introduced to the audience that have been pioneered in Toronto and that illustrate coordinated care planning using interprofessional teams across different settings and organizations.

2. Integrating the community around the patient

Learning Objectives:
• How to build on existing organization and community "health link " approaches

• How to work with pilot coordinated care plans prior to the availability of MOHLTC's on line tool

• How to customize health link approaches by building on the existing community strengths and structure

• How to go beyond the initial phase of identifying health link members, raising provider awareness by deepening work within the provider community and scaling up to support the anticipated 'health link' population.

CONCURRENT SESSIONS
Theme 5- Integrating the community around the patient

Summary: Many community health and social service providers are serving the vulnerable population that health link addresses. Audience members will hear how Guelph has engaged both typical and atypical organizations and processes to support health link members as they would like versus, as the systems have been designed to operate.

F5 Improving The Road To Recovery

Theme 5. Integrating the community around the patient
Length: 45 minute Concurrent Session

Keely Freeburn, B.A. Case Manager, Addiction Counsellor, Addiction Outreach Muskoka Parry Sound
Christine Fitchett, BScN RN(EC) MScN; Primary care nurse pracitioner, Cottage Country Family Health Team

Learning Objectives: 1) Discuss the challenges of treating and helping those with addictions 2) Review evidence based recommendations for harm reduction and sobriety 3) Introduce the integration, innovated strategies and early success findings from the collaboration of Addiction Services and Primary Care 4) Review of a complex patient case.

Summary: Historically addiction programs worked separately and privately from primary care. As a direct result from LHIN funding, service programs such as Addiction Services have allowed for more collaboration with health professionals to come together to meet the needs of the patient. Since our collaboration in February 2013, Addiction Services and primary care have improved communication, and success with patients with addictions. It has kept the patients accountable as more than one service was supporting them as they worked towards harm reduction and sobriety. Our presentation will demonstrate how simple changes and integration of two models of care can come together and effectively improve the harm reduction and sobriety of patients. We will present a complex case that was successful with the integration of our community services around her harm reduction and sobriety.

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.

A6-a Utilizing EMRs to Support Cancer Screening

Theme 6. Using data to improve transitions of care and care coordination
Length: 45 minute Concurrent Session

Zabin Dhanji, Project Manager, Cancer Care Ontario, Project Manager, Cancer Care Ontario

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Learning Objectives: By harnessing the existing functionality of an electronic medical record (EMR), primary care providers can apply evidence based cancer screening guidelines to identify patients who are eligible for screening. Appropriate follow up strategies can then be implemented to ensure that these patients get screened. Cancer Care Ontario (CCO) has developed training guides and tools for PS Suite and Accuro EMR, who collectively have 40% of the Ontario market share. The guides take a population health and opportunistic approach to screening and also include information on data standardization and practice workflows to help practices optimize their EMRs..

Summary: Primary care providers (PCPs) play a crucial role in the journey of a cancer patient, both in ensuring that patients get screened for cancer and navigating them through the healthcare system should they require care. The focus of this presentation will be on providing PCPs with information on tools and resources to support cancer screening through the use of current functionality in their EMRs.

Through the use of electronic medical records (EMRs), PCPs can ensure that patients who are eligible for screening are identified and then implement interventions to follow up and invite them to screen. The EMR Optimization project team has developed guides and supporting resources for the PS Suite EMR and Accuro EMR.

The focus of these tools is to provide practices with guidance on:
1) Cancer Care Ontario screening guidelines and recommendations

2) Developing searches to proactively identify patients who are eligible for screening

3) Understanding the Preventative Care Summary Report and how it differs from the screening searches outlined in section 2

4) Developing EMR based reminders for patients eligible for screening to prompt a conversation between the clinician and patient

5) Providing best practices around data discipline and standardization

6) Illustrating sample practice workflows Examples and preliminary results of the implementation at the CANES POC will be shared including impact, challenges and lessons learned. Examples of dissemination/collaboration opportunities with other organizations/stakeholders will also be discussed.

A6-b Transitioning between EMR Systems

Theme 6. Using data to improve transitions of care and care coordination
Length: 45 minute Concurrent Session

North York Family Health Team:
Michelle Greiver, M.D., CCFP, FCFP, Family Physician
Sue Griffis, RN,MA,DBA,CHE, Executive Director,
Danuta Southgate, MSW, RSW, Project Coordinator

Learning Objectives: a) Forming an EMR Task Force with representation from physicians, providers, support staff and administration
b) Discovering current and future practice goals and priorities through a comprehensive EMR needs assessment
c) Assessing practice readiness to adopt a new EMR system/move to a new server
d) Ensuring FHT physician and allied health provider engagement
e) Identifying FHT physician and allied health provider champions
f) Communicating the findings of the EMR needs assessment in a meaningful way
g) Supporting physician work in the vendor procurement process
h) Proceeding with the vendor selection process.

Summary: The North York Family Health Team (NYFHT) currently uses 2 EMR software applications across 5 servers for its 18 clinical locations. The result is fragmented data, multiple log-ons for chart access or data input, and difficulties messaging across practices. The NYFHT Information Management/Information Technology (IM/IT) Committee formed an EMR Task Force to review the FHT's goals in moving toward a 'one EMR and one server' system. The EMR Task Force began by creating a comprehensive needs/readiness survey to understand current and future EMR requirements, which included readiness to change. This assessment allowed all physicians, providers and staff an opportunity to provide input about their EMR needs as well as their willingness to change.

After review by the Task Force, the assessment was piloted to ensure the format and content was accessible for respondents prior to distribution. The EMR Task Force identified champions to engage physicians/providers/staff through providing information and education about the importance of the assessment. Results were collated, analysed and summarized by the EMR Task Force prior to reporting back to the IM/IT Committee. Based on findings of the comprehensive needs assessment, the EMR taskforce developed recommendations to support physicians in their vendor procurement process. This process is still ongoing at this time.

B6 Using Run Charts to Evaluate Quality Improvement

Theme 6. Using data to improve transitions of care and care coordination
Length: 45 minute Concurrent Session

Lisa Barnett, Quality Improvement Decision Support Specialist, Elliot Lake Family Health Team

Learning Objectives: Participants will learn how to:
1. Start with the data they already have.
2. Use Microsoft Excel to create run charts.
3. Help make the interpretation of the run charts fast and easy for their audience.
4. Annotate the chart allowing for the identification of when improvements were initiated. The workshop will also help participants to understand that data requirements for each of the following differ:

a) Improvement b) Accountability c) Research It is recommended that participants bring a laptop with Microsoft Excel installed. The presenter will be using Microsoft Excel 2013.

Summary: Using run charts to analyze data over time simplifies the analysis of improvements made to processes or systems. They allow teams to easily identify if the quality improvement initiatives are obtaining the desired results. Once improvement has been achieved, run charts allow teams to monitor f the improvement is being sustained. This presentation will provide attendees with an example of how a Family Health Team has modified the reporting format of their indicators by replacing a colour-coded data table with run charts. The presentation will use Microsoft Excel to demonstrate that sophisticated data analysis software is not required for this work. Furthermore, it will show how to use existing data enabling participants the ability to quickly apply this learning upon returning to the office. In order to reinforce the material presented, participants will be provided with a hands-on opportunity to create their own run charts and to present them to the group.

C6 Mining for data gold: how to recycle imperfect EMR data into useful information

Theme 6. Using data to improve transitions of care and care coordination
Length: 45 minute Concurrent Session

Danyal Martin, Clinical Program Coordinator, Queen's FHT
Michelle Greiver, Chair, Information management - Information technology committee, North York FHT
Dave Barber, Assistant Professor, Department of Family Medicine, Queen's University, Queen's FHT
Marjan Moeinedin, QIDSS, North York FHT
Laura Cassidy, QIDSS, Maple FHT

Learning Objectives: FHTs vary in their ability to access and use EMR data. However, much can be done and planned with what is currently available. This presentation addresses: • Learning to work with imperfect data: what are the limitations, how to start and maximize the use of what is currently available, and how to prepare for the future • What additional tools and resources are available and how to access them • What can be done today to improve your EMR data and to plan for data discipline in the future • What are potential issues and problems to avoid.

Summary: EMR data are problematic. Quality can be poor and free text/unstandardized data are often difficult to query. However, many FHTs have already been able to derive significant value from currently existing data. This can involve activities such as querying data in EMRs ("front end data"), supplementing EMR data with external information (for example, the provincial Screening Activity Report or SAR) or participating in projects such as CPCSSN where cleaned/standardized data are returned to FHTs or clusters of FHTs ("back end data" for FHT data warehousing). CPCSSN has now built a significant and growing library of algorithms to clean EMR data, tested across multiple EMRs in Canada. Far from being "garbage", our EMR data is full of golden nuggets that can be mined today. For this presentation, we will discuss the experiences and approaches of different FHTs to using what is currently available, and the structures, processes and outcomes for data use.

A data governance group overlooks data standardization and management activities. Data standardization is implemented by a Data and Analytics team with a QIDSS, data manager and data clerks (summer students). As an example, we are using data on breast cancer received from the provincial SAR to update and standardize both personal and family history of breast cancer. This will allow us to more accurately categorize patients and refer them for high risk breast cancer screening in the future.

D6 Optimizing Quality of EMR Data to Improve Care: Leading the Human Side of Change

Theme 6. Using data to improve transitions of care and care coordination
Length: 45 minute Concurrent Session

North York Family Health Team:
Marjan Moeinedin, Quality Improvement Desicion Support Specialis
Dr. Michelle Greiver MD, MSc, CCFP, FCFP, Chair, Information management - Information technology committee

Learning Objectives: The learning objective is to describe successful change management strategies based on Kotter's 8 steps of change model, which is a comprehensive series of steps that focuses on people and their feelings toward change. The strategies will support your organization to improve patient care through ensuring quality EMR data is collected and coded properly. Our cluster of four (4) Family Health Teams will share the lessons learned from implementation of change management approaches used within our unique sites..

Summary: Data is the cornerstone of quality improvement (QI) in patient care. Standardized clinical data play an important role in measuring and monitoring the quality of healthcare delivery. Data in Electronic Medical Records (EMRs) are often not standardized. As result, the reports generated from EMR systems to support QI efforts are not reliable. Quality improvement efforts depend on accurate data to indicate the presence of conditions. Inconsistency and lack of proper coding can interfere with identification of patients with chronic conditions. Therefore, it is important to ensure that key stakeholders, particularly clinicians, support efforts to optimize EMR data. To best manage the introduction of change in a health organization, a focus on the people side of change is necessary. The difficult task of persuading individuals and groups to change their behaviour has been addressed by many existing change management strategies in the literature. It has been estimated that 70% of change initiatives fail mainly because change plans do not consider human behaviours. The aim of this presentation is to describe change management strategies widely used in healthcare industry that will improve EMR data quality in your healthcare facility.

D6-b Primary care performance measurement -- why bother?

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

Length: 45 minute Concurrent Session

Monique Hancock, ED STAR FHT
George Southey, MD, CCFP, FCFP, Dorval Medical FHT
Carol Mulder, DVM MSc CUTL DBA (cand,), AFHTO

Learning Objectives: Participants in the session will gain a better understanding of exactly how local teams can get involved in D2D and Starfield and what they and their patients can expect to get out of that.

Summary: Primary care providers are facing an ever-increasing number of options and obligations related to performance reporting. This session outlines a measurement approach that can help focus attention on what really matters to primary care providers: the relationship with our patients and our ability to deliver the care that they value. It will show how D2D and the Starfield model consider disease-specific outcomes (e.g. "What's your A1C?") in the context of the relationship between the patient and provider, as distinct from other measurement models.

E6 Using Hospital Data: Doing Analyses and Building Warehouses

1. **Using Hospital Emergency Department Data for Quality Improvement in Family Health Teams**
2. **Analyzing health data across care systems: The NYFHT – NYGH Joint Data Warehouse**

Theme 6. Using data to improve transitions of care and care coordination
Length: 45 minute Concurrent Session (Two 15 minute presentations followed by 5-10 minutes to draw themes and comparisons)

Michelle Greiver, Physician, North York Family Health Team
Karim Keshavjee, CEO, Infoclin
Chelsea Good, Quality Improvement Decision Support Specialist, Upper Canada FHT, Athens District FHT, CPHC-Community FHT, Prescott FHT

1. Using Hospital Emergency Department Data for Quality Improvement in Family Health Teams

Learning Objectives: Emergency department (ED) data provides valuable information for primary care providers and family health teams (FHTs) on their patient's health. While some FHTs receive a copy of their patient's ED visit report from hospitals, trends such as multiple visits in a month, multiple visits for mental health issues, or visits during office hours/afterhours clinics for conditions best managed elsewhere are not evident. This presentation will cover how to request in-depth ED data, the different analyses that can be performed on the data, and how this will encourage quality improvement for both the patient, the primary care provider, and the FHT.

Summary: The Quality Improvement Decision Support Specialist (QIDSS) for Upper Canada FHT, Athens District FHT, Community & Primary Health Care – Community FHT, and Prescott FHT receives hospital data on a monthly basis from Brockville General Hospital (BGH) and Perth & Smiths Falls District Hospital (PSFDH). This data includes the patient's name, medical record number (MRN), visit number, sex, family physician, date of birth, postal code, admittance date, admittance time, CTAS score, and admittance diagnosis. During the presentation, the QIDSS will outline how data is received from hospitals, the difference analyses that can be performed on the above data, and how this is used to promote quality improvement in FHTs.

The QIDSS can determine the CTAS/Triage Level usage per provider per month, the number of patients visiting the ED more than once per month, which patients are visiting for addictions and mental health concerns, and which patients are accessing the ED for CTAS 4 and 5 issues during regular office hours and after hour clinics. Other observations that have been made are patients whose geographic location is closer to the hospital than the FHT, which can be a barrier to accessing primary care. This analysis is in its early stages, but a report is generated and is provided to each primary care provider in the FHT. The provider can use the analysis to identify patients who require more care in office, and educate on appropriate ED usage if necessary. As the reporting progresses more quality improvement opportunities will be identified.

2. Analyzing health data across care systems: The NYFHT – NYGH Joint Data Warehouse

Learning Objectives: Information Technology (IT) projects involving different organizations, multiple stakeholders and sensitive health data are complex. Designers of analytic systems should carefully consider the needs of their stakeholders prior to IT implementation. We describe the processes involved

in designing a health data warehouse containing merged clinical (EMR, EHR) data from a large community-academic hospital (North York General Hospital) and a large FHT (North York FHT).

We also discuss the resulting demonstration database and deployment planning.This feasibility and design project is funded by the NYGH Exploration Fund.

Summary: Patients access care in multiple settings, including hospital and primary care; this is especially common for complex patients. Despite this, data about care are usually contained in electronic silos. Joining and combining health data across systems in order to more fully analyze care is challenging. Following a literature review, we interviewed key stakeholders from primary care, hospital and regional oversight organizations, including clinicians (MD, RN, pharmacist, etc), managers, data managers/analysts, hospital leadership (CEO, COO, CFO), lead physicians, patients, privacy experts and information services and decision support personnel. An initial 'seed' slide presentation was generated to describe key elements underlying a data warehousing system, followed by iterative changes based on feedback from the interviews.

There was agreement and strong support to move forward with design and implementation from clinicians (primary care and hospital) and from senior management process. We undertook a trial match of COPD and CHF patients in the primary care EMR database with the hospital database to demonstrate feasibility. 1650 patients with COPD (3% of population) or heart failure (1% of population) were identified in the primary care EMR database. Data were linked and we determined that 78% of those patients had been seen in the hospital at least once and 24% had had at least one in-patient admission in the past 3 years. Following the successful linkage, we wrote a report and generated a data dictionary containing key elements. We generated the first database containing joint data, which will enable quality improvement and research activities to be undertaken.

F6 Advancing and Leveraging the Investment Value of EMRs – Project ALIVE

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

Length: 45 minute Concurrent Session

eHealth Center of Excellence:
Dr. Mohamed Alarakhia, Executive Lead, Project ALIVE; Director, CFFM FHT eHealth Centre of Excellence; Enabling Technologies Physician Lead WWLHIN
Ms. Neha T. Singh, PMP, Project Manager, Project ALIVE, CFFM FHT

Learning Objectives: Good quality EMR data can be a major enabler to supporting transitions of care and improving patient care coordination. Within primary care the level of maturity relative to information management and support tends not to be well developed. With a focus on adoption and innovation, this presentation will share a hands on practical guide of enhancing the quality of data in EMRs by focusing on the following knowledge areas:
1. EMR Clinical Data Prioritization and Standardization
2. Clinician Engagement, Change Management and Training
3. Benefits Realization
4. A SWOT analysis developed from a broad engagement of over 300 primary care practitioners as it relates to the data quality within their EMRs.

Summary: This presentation will specifically demonstrate how to implement a practical model for the standardization and meaningful use of EMR data in order to:
1. Help practices better understand the current quality of the data within their EMRs
2. Focus on codifying EMR data in order to make it "extractable" and allow for integration of this data to support care transitions
3. Enable clinicians to better assess the quality of care and change the way they practice.
4. Demonstrate how high quality EMR data can support transitions of care and care coordination.
5. Share the knowledge from an assessment of the current state of electronic medical record (EMR) use within practice settings in the province of Ontario.
6. Share the results of a broad engagement of primary care practitioners including their views on:
  a. The resources required to help primary care practitioners enhance their current level of EMR maturity
  b. The knowledge and ability gaps that need to be filled in order to help with future integration with other electronic health record systems and support transitions of care
  c. The enablers and barriers to using their current EMR systems more efficiently.

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.

A7 Closing the primary care loop following hospital discharge – The Markham FHT Medication Reconciliation Program

Theme 7. Clinical innovations in comprehensive primary care
Length: 45 minute Concurrent Session

Markham Family Health Team:
Sheetal Desai, Clinical Pharmacist
Lisa Ruddy, Clinical Program Manager
Rebecca Robinson, Program Administrator

Learning Objectives: The presentation will demonstrate the practical implementation of the Markham FHT Medication Reconciliation Program, highlighting the benefits of working within an interdisciplinary team and optimizing the use of the Electronic Medical Record (EMR). The program supports the Primary Care Quality Improvement Plan mandated for FHT's by addressing the objective of integration, specifically "Timely patient access to primary care appointments post-discharge through coordination with hospital(s)". Participants will learn what is necessary to set up a similar program in their own organizations to help close the primary care loop following hospital discharge..

Summary: The Markham FHT Medication Reconciliation Program serves to prevent medication related issues post hospital discharge and the potential for readmission through a standardized documentation process whereby patients and physicians will be able to know with 100% certainty what medications the patient is currently taking. The goal of the program is to obtain the "best possible medication list" when patients are discharged from the hospital and facilitate seamless transition from the tertiary care setting back to primary care.

The program focuses on the most at risk patients recently discharged from hospital and admitted or diagnosed with: pneumonia, asthma, COPD, CHF, diabetes, CAD (stroke, MI, angina) and GI disorders. Patients with several medication changes are also included in the program on a case per case basis. The presentation will include how the EMR was used to obtain relevant clinical data, identify gaps in care, and facilitate better quality data tracking methods to ensure better patient outcomes. The lead of the Medication Reconciliation Program, Markham FHT's clinical pharmacist, will outline findings during typical medication reconciliation visits, as well as share feedback from providers and patients of the program.

B7-a The Health Promotion 6Pack (Hp6): Motivating Patients to Change Unhealthy Behaviours in Clinical Practice

Theme 7. Clinical innovations in comprehensive primary care
Length: 45 minute Concurrent Session

Peter Selby, MBBS, CCFP, FCFP, dip ABAM, Chief, Addictions Division; Professor, Departments of Family and Community Medicine, Psychiatry, Faculty of Medicine and the Dalla Lana School of Public Health, Center for Addiction and Mental Health, University of Toronto

Learning Objectives: 1. Develop an implementation plan of a 5 step model to enhance readiness to change during an office visit.

Summary: How can healthcare practitioners effectively address chronic disease prevention with their clients? This dynamic workshop is designed to help practitioners improve their skills in screening, assessing and intervening with even the most complex or "resistant" clients. The workshop will engage participants using motivational interventions for health behaviour change. The "6Pack" approach (smoking, alcohol, diet, physical activity, stress tolerance and sleep) will be introduced as a novel method of addressing chronic disease prevention in an integrated way. This workshop emphasizes learner engagement, interaction and practice though large and small group discussions, live and video clinical demonstrations, case-based learning with role plays, and individual reflective exercises. Workshop participants will receive a resource handout to facilitate sharing with colleagues and community stakeholders.

B7-b Respiratory Care: From Case Finding to Rehab and Comprehensive Partnerships

3. **Case Finding and Managing Chronic Obstructive Pulmonary Disease**
4. **Exercising the Option to help those with COPD- a Family Health Team approach to Pulmonary Rehab**
5. **Comprehensive Regional Respiratory Care Program**

Theme 7. Clinical innovations in comprehensive primary care
Length: 45 minute Concurrent Session (Three 10 minute presentations followed by 5-10 minutes to draw themes and comparisons)

Dr. Cathy Faulds, MD, CCFP, FCFP, ABHM, London Family Health Team
Emily Stoll, BSc, Program Planner, London Family Health Team
Miranda Ross, Respiratory Therapist, London Family Health Team
Maria Savelle, RN, Certified Respiratory Educator, London Family Health Team
TEACH Trained Smoking Cessation Counsellor, Stratford Family Health Team
Dr. Tim O'Callahan, Family Physician Lead, Amherstburg FHT

Learning Objectives: At the conclusion of this session, participants should understand:

• how to implement evidence-based guidelines into a program that is applicable in a primary care or FHT setting using EMR tools and other resources to develop chronic disease programs and track measures

• the importance of case-finding, regular screening and management of individuals with COPD

• the lack of accessibility to Pulmonary Rehab programs for patients with chronic lung conditions, and learn how the Stratford Family Health Team has created and maintains a nurse-led pulmonary rehab program in collaboration with community partners

• the successes as well as challenges of the program will be reviewed, and one year stats reflecting patient progress will be presented

• how to identify and develop successful sustainable collaboration across health system partners creating integration opportunities leading to improved patient care

• the components of a successful sustainable Respiratory Care program

• the importance of a Clinical Information System to report on clinical outcomes and using strong performance measures to improve health, system and quality of care outcomes

• how to identify the components of a successful multidisciplinary team with a Certified Respiratory Educator as the case manager for patient centred care

• the Integration of best practice across the continuum of 6 FHT's

• the commitment of a regional collaboration creating a primary care network

• the success of robust program outcomes for COPD, asthma and Breathe Application.

Summary: The aim of the London Family Health Team (LFHT) was to improve outcomes for patients with COPD, while ensuring our care is patient-centered. To achieve this, the LFHT developed a program centered on evidence-based guidelines for case-finding and management of individuals with COPD. Customized EMR templates, alerts, and flowsheets were used in patients' charts, while a spreadsheet displayed all outcome, process and balance measures for each patient. The data was reviewed monthly to ensure completeness of care and Quality Improvement and our measures were reported monthly to share best practices and statistics at the provincial level. This program allows for improved patient outcomes through the utilization of physicians, allied health professionals and community resources.

The Stratford Family Health Team Respiratory Clinic, is a nurse-led program, providing four basic work streams: spirometry testing (to confirm diagnosis of a lung condition and assist in management), patient education regarding self-management of a lung condition (COPD, Asthma), Smoking Cessation counselling, and Pulmonary Rehab – to provide a monitored, community supported exercise and education program in an area where access to pulmonary rehab is very limited. The specific benefits in this area will be the focus of the presentation. It is well known that individuals with chronic lung conditions with shortness of breath tend to avoid exercise – the fear that exertion will lead to increased shortness of breath causes them to avoid activity, leading to decreased fitness (muscle strength and endurance), which in turn leads to an increase in shortness of breath when the individual is active. This downward cycle leads to poor management of their condition, and decreased health status. Many patients have been optimized as far as pharmacological treatment is concerned ("maxed out" on their breathing medications), and feels there is no other option to help improve their symptoms. Pulmonary rehab is designed to help reduce symptoms, optimize their functional status, and ultimately help to reduce health care costs through stabilizing their physical condition, and teaching self-management skills. This presentation will describe how an individual nurse-led program is helping to make a difference with COPD patients in the Stratford Family Health Team, in collaboration with a partnership with the Stratford YMCA.

This presentation will showcase the creation of a successful collaboration with 6 FHTs (Windsor, Amherstburg, Harrow, Leamington, Tilbury, Chatham-Hent) and Asthma Research Group (ARGI) within Erie St. Clair LHIN with community based physician leaders, utilization of the CIHR knowledge-translation (KT) framework to contribute to multi-level health system innovation, facilitate guideline implementation, and improve health outcomes, with modest program expenditures in community primary care practices. The Program which focuses on asthma, COPD, and smoking addiction aligns with the foundational elements of Ontario's health system transformation agenda: patient focus, interdisciplinary primary care, right care at the right time along the continuum, is aligned with LHIN1's strategic priorities - chronic disease and reducing acute care healthcare utilization. Sharing of comprehensive e-tool for chronic disease and Breathe APP (The breathe application is a first in Canada).

C7 Treating Insomnia in a Family Health Team

Theme 7. Clinical innovations in comprehensive primary care
Length: 45 minute Concurrent Session

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

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Learning Objectives: Learning Objectives • To know why it is important to recognize and treat insomnia when it is reported. • To see how a program for reversing insomnia works in one Family Health Team • To know that the evidence based, recommended first-line intervention for chronic insomnia is "cognitive behavioural therapy for insomnia" or CBT-I. • To consider how the principles of CBT-I can be used in your own setting.

Summary: Chronic insomnia does not disappear on its own. Left untreated, it continues for years, contributing to poor quality of life, increasing the risk of major depression, compromising glucose metabolism and increasing the risk of type 2 diabetes. The Family Health Team is the ideal place to treat insomnia shortly after it is reported to the family physician. There are very effective treatments; the first-line recommended one in medical guidelines in North America and the UK is Cognitive Behavioural Therapy for Insomnia, or CBT-I.

We will:
• Show the importance of treating chronic insomnia at the Family Health Team • Describe the recommended first-line treatment for chronic insomnia, CBT-I •Briefly discuss the role of sleep medication • Describe the

Kingston Family Health Team Sleep Program • Share our experience with this program including outcome data • Highlight the principles of CBT-I • Provide participants with opportunities to consider how they can use these principles in their own teams to help patients with insomnia

D7 Advances in Mental Health Care: Telepsychiatry Collaborative Care Model/Anxiety Group

5. **Integrative Telepsychiatry Collaborative Care: Increasing Patient Access and Provider Confidence for Adult Mental Health**
6. **Ten Years of Anxiety Group at a FHT-What Have We Learned**

Theme 7. Clinical innovations in comprehensive primary care
Length: 45 minute Concurrent Session (Two 15-20 minute presentations followed by 5-10 minutes questions and/or discussion)

Jodi Colwill, BScN, PHC-Nurse Practitioner, Minto Mapleton Family Health Team
Dr. Nikola Grujich, MD, FRCP(C), Staff Psychiatrist. Director, Collaborative Care & Telepsychiatry Program. Mood & Anxiety Program, Sunnybrook Health Sciences Centre. Frederick W. Thompson Anxiety Disorders Centre. Department of Psychiatry, University of Toronto. Sunnybrook Health Scien
Tracy Livingston, RPN - Telemedicine Coordinator, Minto Mapleton Family Health Team and Mount Forest Family Health Team
K. Lynn Dykeman, Social Worker, McMaster Family Health Team
Colleen O'Neill, Occupational Therapist

Learning Objectives: 1. Acknowledge how the innovation of telemedicine has increased patient access to high quality comprehensive psychiatry care 2. Examine how this has be achieved through telemedicine psychiatric collaborative care. 3. Recognize the increased confidence and practice of our primary care providers.

Summary: People are more likely to consult their family physician about mental health than any other provider". Mental health commission of Canada advised that one of their priority recommendations is to therefore "expand the role of primary health care in meeting the mental health needs". With a needs assessments proving a lack of mental health consultants we qualified for increased sessional funds. it was evident that an innovative approach would be needed to address this gap in care. Our presentation will establish how telemedicine effectively and efficiently enhances the comprehensive care for patients with mental health concerns. Telemedicine allows the patient's medical needs to be addressed while decreasing their costs ie: transportation, parking, time off work for another appointment etc. Additionally, by building provider capacity the knowledge is transferable to future patient care. This increases early intervention for patients, decreases provider uncertainty while increasing confidence. Ultimately this allows for continuity of care as the primary care provider has gained the skills to address the patient's needs while reserving 1:1 psychiatry consult for the more complex and urgent cases.

E7-a Patients supporting patients: self-management in Chronic Pain

Theme 7. Clinical innovations in comprehensive primary care
Length: 45 minute Concurrent Session

Kate Nash, MSc, Training Facilitator, Living Healthy Champlain, Bruyère Continuing Care
Julie Ménard, Bilingual Master Trainer for CDSMP,CDSMP and DSMP. Peer Leader for On-Line CDSMP and Better Choices, Better Health, Bruyère Continuing Care
Rachel Davidson, BSc.HK,CK,CSEP-CEP, Regional Coordinator Chronic Disease Self-Management Program, Bruyère Continuing Care
Deborah Sarre-McGregor, MHA, Executive Director,, Bruyère Academic Health Team

Learning Objectives: Participants will: 1.Gain knowledge of the role the Chronic Pain self-management program can play in supporting patients living with chronic pain. 2.Have an opportunity to hear from a patient and peer group leader, the impact of engaging the patient in the self-management of chronic pain, and the role patients can have in supporting each other. 3.Experience one of the components of the Chronic Pain self-management program by participating in a "Moving Easy" session, led by a volunteer leader of the program 4.Learn how to refer their patients to the program in their region..

Summary: Approximately one in five Ontarians suffers with chronic non-malignant pain. Current wait times to see a pain specialist can range from six months to two years. The evidence suggests that patients experience poor quality of life and deterioration in their condition during this waiting period. The Chronic Pain self-management program, a six week group workshop facilitated by 2 leaders 1 or both of whom are volunteers living with chronic pain themselves, provides

participants with support, self-management and coping skills to help manage their pain. The positive reaction to the program across Ontario suggests that it can make a valuable contribution to the management of chronic pain.

This practical presentation will: 1) describe the development of the program in the Champlain LHIN from the initial identification of the need for the program to the current situation, where workshops run continuously both in Family Health Teams and other community settings (5 minutes) 2) explain the important role volunteer leaders play in leading the workshops (5 minutes) 3) provide an opportunity for participants to learn from a volunteer leader the impact the program has had on her ability to cope with chronic pain (10 minutes) 4) give a brief overview of the program and the evidence for its' effectiveness (5 minutes) 5) provide participants with the opportunity to experience one aspect of the program, namely the Moving Easy exercises (15 minutes) 6) Questions and discussion (5 minutes) Total: 45 minutes

E7-b Identifying and Managing Challenging Complex Chronic Conditions: A FHT/Health Link Initiative to Address Frailty, Complex Geriatric Conditions, and High Health System Resource Use.

Theme 7. Clinical innovations in comprehensive primary care
Length: 45 minute Concurrent Session

Linda Lee, MD, MCISc(FM), CCFP, FCFP; Director, Memory Clinic, Centre for Family Medicine Family Health Team

Learning Objectives:

1. Discuss frailty, its manifestation and implications for care 2. Describe "C5-75", a unique program at the Centre for Family Medicine FHT/KW4 Health Link to screen for frailty and other complex chronic geriatric conditions 3. Describe "Community Ward", a unique program at the Centre for Family Medicine FHT/KW4 Health Link to address high users of health system resources 4. Review preliminary outcomes of these programs 5. Discuss lessons learned in the development and implementation of these programs.

Summary: Frailty has been defined as a state of increased vulnerability resulting from age-associated decline in reserve and function. Frail persons are at higher risk of adverse health outcomes and mortality. The "C5-75" (Case-finding for Complex Chronic Conditions in seniors 75+) program has been developed by the Centre for Family Medicine (CFFM) FHT to address frailty in primary care by systematically screening for frailty amongst all persons 75 years of age and older and addressing potential underlying causes using pro-active, evidence-based interventions. Similarly, the "Community Ward" project has been developed to address the unmet needs of community-based patients who are high users of health system resources.

The Community Ward project is a program of home visit outreach involving holistic multidisciplinary team-based case management, integrated within primary care practice. The aim of both of these programs is to develop a systematic primary care approach to screening and managing the challenging conditions most associated with high users of health care system resources, using targeted evidence-based interventions. In addition to addressing medical conditions, these programs attempt to address factors such as nutrition, exercise, and social factors. This presentation will describe these care models and their evaluative assessments, and provide preliminary evidence demonstrating their use in primary care. Key lessons learned in developing these models will be discussed.

F7-a Advanced Care Planning: practical implementation tools and reflections from two Family Health Teams

1. **Advance Care Planning: A Quality Improvement Plan Toolkit for Primary Care Teams**
2. **Advance Care Planning: What we can learn from the experiences of primary care providers in the East Toronto Health Link.**

Theme 7. Clinical innovations in comprehensive primary care
Length: 45 minute Concurrent Session (Two 15 minute presentations followed by 5-10 minutes to draw themes and comparisons)

Dr. Nadia Incardona, MD, BSc CCFP, Hospitalist and Emergency Physician, Toronto East General Hospital; Rural Northern Initiative Coordinator, DFCM Lecturer, University of Toronto
Suzanne Strasberg, MD, Provincial Primary Care Lead, Cancer Care Ontario
Shayna Singer, M.ED., M.S.W., R.S.W., Social Worker, Jane & Finch Family Health Team

Learning Objectives: 1. Discuss the benefits of ACP and common definitions;

2. Showcase the East Toronto Health Link's "Facilitator Model of ACP", including improved

understanding of the definitions of ACP, advance directive, goals of care and treatment plan; an overview of the interdisciplinary model; approaches to common barriers to ACP in primary care and development of practical solutions to address these issues; engage in how to integrate ACP in organizations' policies and overall planning; and appreciate the importance of system leadership in embracing ACP;

3. Showcase Cancer Care Ontario's "ACP Quality Improvement Plan Toolkit", including practical guidance on planning, implementing, monitoring and reporting on improvements in ACP with patients;

4. Highlight the experiences of two Family Health Teams who have engaged in ACP with their patients.

Summary: Advance care planning (ACP) is a process of discussing patient values and wishes with regards to future health care needs including but not limited to end of life care. Ideally ACP occurs prior to acute deterioration, however as highlighted by the national Speak Up campaign many Canadians have not had advance care planning discussions. In the absence of ACP, patients may receive unwanted and inappropriately invasive care. However, when people have discussed their wishes prior to deterioration there is reported improved satisfaction of care from patients and their support network, and decrease in caregiver burnout and depression. When carried out well, ACP aligns treatment with a patient's wishes and increases patient autonomy.

The East Toronto Health Link has developed an interdisciplinary facilitator model of the ACP process. Our model is stratified to respond to the spectrum of health experiences of patients (i.e. the healthy adult at age 50, the adult with a progressive chronic disease, and the adult in their last year of life). The facilitated model used a values-based practice model to assist patients with identifying their values and wishes for future care. Training for ACP facilitators therefore focuses on values-based practice, advanced communication skills, and an improved understanding of the ethical and legal issues of advanced care planning. The session would provide an overview of the interdisciplinary model, approaches to common barriers to ACP in primary care and an approach to incorporating ACP into routine care of patients within a family health team. AND

This presentation will showcase the Advance Care Planning (ACP) quality improvement (QI) toolkit developed by Cancer Care Ontario to support Primary Care Teams who wish to include ACP as part of their QIP. The session will include a brief introduction to Advance Care Planning and provide practical guidance on planning, implementing, monitoring and reporting on improvements in ACP with patients. The presentation will give primary care teams step-by-step instructions on how to use the toolkit and prepare practices for the quality improvement initiative. Particiants will learn tips for developing objectives, establishing targets, identifying measures and baselines for performance, and they will walk away with practical, hands-on examples that can be readily adopted in their primary care practice. Dr. Strasberg will share her teams experience with implementing this initiative in their family health team and her personal reflections on how the work has impacted her practice. The session will allow for ample opportunity for questions and discussion.

F7-b Finding a BETTER Way to Chronic Disease Prevention and Screening: The BETTER 2 Program

Theme 7. Clinical innovations in comprehensive primary care
Length: 45 minute Concurrent Session

Kris Aubrey-Bassler, MD,CCFP(EM), MSc; Assistant Professor, Discipline of Family Medicine, Memorial University of Newfoundland
Carolina Aguilar, , MA, MSc; Coordinator, The BETTER Program, Department of Family Medicine, University of Alberta

Learning Objectives: 1. Develop an understanding of the BETTER approach to chronic disease prevention and screening and how it can be adapted.

2. Decide how to approach and improve prevention and screening in your practice, including how you will target at-risk patients..

Summary: The BETTER Program aims to transform practice and brings together primary care providers, policy/decision makers and researchers to work towards improving CDPS in primary care. Using the BETTER toolkit, the PP determines which CDPS maneuvers the patient is eligible to receive and through shared decision-making and motivational interviewing, develops a unique, individualized "Prevention Prescription" with the patient.

The BETTER approach: 1) is personalized to the patient and the practice, 2) addresses multiple conditions (cervical, colorectal, and breast cancer, diabetes, cardiovascular disease and their associated lifestyle factors - physical activity, diet, smoking, and

CONCURRENT SESSIONS

Theme 7- Clinical innovations in comprehensive primary care

alcohol), 3) is integrated with local, regional and national resources, and 4) is longitudinal assessing patients over time. During the workshop participants will identify and develop a “Practice Prescription” – that is, they will identify how they plan to implement chronic disease prevention and screening in their practice settings. Participants will explore how they can adapt this new and effective approach, identify at-risk patients, and encourage patients to become active participants in their health. The resources and tools that have been developed to support this approach, including tools to evaluate prevention and screening efforts, will be shared.