2012 Conference Concurrent Sessions Abstracts

Grouped by Time Period (First digit (A to G) designates the time period and second digit (1 – 11) designates the thematic stream)

Day 1 – Tuesday, October 16, 2012

Concurrent Session A - 10:45 to 11:30 AM

A(1) - 11: Seniors Serving Seniors: Using Focus Groups To Inform Programming

Length of presentation: 45 minutes

Theme: 1 - Improving the patient's experience of care

Abstract: This workshop will describe the process of recruitment, selection and engagement of a patient focus group to help inform patient-centered programming. We will also detail the delivery of three seminars for seniors developed on the basis of patient feedback. Analysis of Taddle Creek Family Health team patient demographics revealed that over 25 % of our population was adults over 55. In order to embark on relevant services for this population, we enlisted the help of a group of volunteers over 60 years of age. To inform our recruitment, we conducted a session with an expert whose book identified those factors associated with successful aging, administered a survey and asked physicians to identify likely candidates. A social worker and physician facilitated the focus groups. The first group of seniors identified two means of responding to their healthcare concerns: a seminar series and a group program. The decision was made to start with the seminar series. The group highlighted 8 topics of interest to them and helped decide on a series of 4 topics in the 2nd meeting of their focus group. These first three topics, Medications and Aging, Memory Preservation and Healthy Eating received highly positive evaluations from those in attendance. The benefits of engaging patients in program execution as well as the challenges in using focus groups will be reviewed. The structure and content of our three seminars will also be detailed.

Presenters:

- Pauline Pariser; Physician Co-lead; Taddle Creek FHT
- Raymond Chong; Social Worker; Taddle Creek FHT

A(2) - 61: Strengthening The Team Beyond The FHT– Integrating CCAC As Part Of Your Healthcare Team

Length of presentation: 45 minutes

Theme: 2 - System integration: building the team beyond the FHT

Abstract:

Background: Collaborative partnerships between FHTs and Case Managers from CCAC yields improved capacity, coordination of care, health outcomes, enhanced client satisfaction and a reduction in system costs.

Description/methodology: Partnering for Quality (PFQ) brings together key health care providers in an integrated approach to the prevention and management of chronic disease. Central to the team is the client who becomes actively engaged in the management of their chronic condition. Each practice builds an interdisciplinary team including physicians, nurse practitioners, nurses, CCAC case managers and other service providers. The teams work collaboratively to measure process and clinical care improvements.

Results: The benefits realized include an increased understanding of CCAC's role in partnership with FHTs:

- improved communication between FHT and CCAC (100% of respondents stated they felt there was improved communication)
- improved care coordination and system navigation

- improved screening and early identification
- increased use of guidelines and tracking of indicators
- reduced visits to ER and hospitalization (5% reduction each year)

Observations/conclusions: Prior to PFQ, a large number of providers functioned within a traditional, episodic health care system. Outcomes of a more collaborative partnership yield improved capacity and, coordination of care, health outcomes, enhances client and partner satisfaction and reduces system costs.

Presenters:

- Anita Cole; Regional Client Services Manager; South West Community Care Access Centre
- Rachel LaBonte; Outreach Manager; South West Community Care Access Centre - Regional Coordination Centre

A(3) – 70+72:

Length of presentation: 20 minutes each

Theme: 3 - Getting data and using it to improve care

1. The Canadian Primary Care Sentinel Surveillance Network (CPCSSN) - Studying Chronic Disease in your Practice

Abstract: PURPOSE: This study examined how to effectively use a clinic based electronic medical record (EMR) to increase cancer screening in a family health team, serving patients in a rural community in Ontario, Canada. The clinic's integrated EMR reminder system was updated to correspond to the current cancer screening guidelines for breast, cervical and colorectal cancer. METHODS: Randomized testing of the updated EMR cancer screening reminder algorithm was conducted, with implantation of the system occurring in January 2012. Queries based on the reminder system were built into the EMR to monitor and track cancer screening at the clinic level, allowing for preventative care resource allocation to be modified. RESULTS: The EMR reminder system initially identified over 2,000 patients requiring routine cervical, breast or colorectal cancer screening. The preliminary results indicate that the EMR reminder system provides an accurate, up-to-date method for physicians and nurses to conduct cancer screening with patients or refer patients, at the appropriate time points. In addition, the updated EMR reminder system and queries allow for the collection of accurate clinic level data on cancer screening. CONCLUSION: An EMR based reminder system used in a primary care practice is a valuable and effective tool to monitor and promote preventative care services. Investment in an effective EMR reminder system for cancer screening programs can maximize benefit for patients, providers and the clinic.

Presenters:

- C. Sarai Racey; PhD Candidate; University of Toronto
- Suzanne Trivers; Executive Director; Mount Forest Family Health Team
- Ken Babey; Medical Director; Mount Forest Family Health Team
- Joan Antal; Project Manager for Provincial Under, University of Toronto; and Never Screened Project, Cancer Care Ontario
- Dionne Gesink; Assistant Professor; University of Toronto

2. Utilization Of An Electronic Medical Record To Increase Cancer Screening In Primary Care

Abstract: The Canadian Primary Care Sentinel Surveillance Network (CPCSSN) was established in 2008 as a national primary care network for the surveillance of chronic disease incidence, prevalence, and management. CPCSSN functions as a 'network of networks' and includes ten university primary care research networks across Canada. The Network collects and maintains a database of de-identified

patient health information from 300 primary health care practices with EMRs and approximately 300,000 patients in seven provinces (British Columbia, Alberta, Manitoba, Ontario, Quebec, Nova Scotia and Newfoundland). We are currently extracting de-identified patient health information every 3 months from 8 different EMR software systems to study 8 chronic diseases: chronic obstructive pulmonary disease, dementia, depression, diabetes, epilepsy, hypertension, osteoarthritis and Parkinson's disease. As part of our reporting on chronic disease in Canada, we have developed a feedback report for participating sentinel practices which includes information on chronic disease and management in the practice compared with the region, province and Canada. This presentation will introduce CPCSSN and the feedback on chronic disease that is available to practices that join the network.This information can be used by clinicians for reflective practice and improvement in care.

Presenters:

- Richard Birtwhistle; MD MSc FCFP; Canadian Primary Care Sentinel Surveillance Network

A(4) - 82: Realizing The Benefits Of An EMR Using A Maturity Model Framework

Length of presentation: 45 minutes

Theme: 4 - Leveraging technology to improve quality and efficiency of care

Abstract: Engaging physicians in adopting EMRs is critical since it is estimated that over 80% of patients' data resides in community physicians' offices. In 2012, adoption of EMRs is expected to increase to 65% in Ontario which represents a critical mass of potential EMR users. The success and sustainability of EMR adoption is dependent on measurement of meaningful use of systems by these physicians. OntarioMD has developed an EMR Maturity Model as part of a Change Management approach to support current users in optimizing their EMR. We created a framework and tools to assess benefits realization, which can provide physicians/groups with a realistic, valid and reliable snapshot of their progress. This can be used in planning initiatives aimed at reaping the benefits of improved capabilities in an EMR enabled office, significantly improving clinical outcomes for patients, practice productivity and efficiency. This model will be demonstrated here.

Presenters:

- Darren Larsen; Senior Physician Peer Leader; OntarioMD

A(7) – 107+108:

Length of presentation: 20 minutes each

Theme: 7 - Improving care for people living with mental health challenges

1. A Journey to 'Peer Led' WRAP (Wellness Recovery Action Plan) Groups

Abstract: Taddle Creek Family Health Team (TC FHT) is acting on the knowledge that we are underutilizing an extremely valuable, untapped resource, the "patient". We are learning how to partner with our "patients" as they create the lives they wish to lead. We want to share our journey in one successful partnership: Peer Led WRAP Groups. TC FHT took a 'leap of faith' in supporting the first ever WRAP Group to be held in a Family Health Team and everyone is now reaping the rewards of our effort. The presentation will begin by ensuring there is common knowledge about WRAP Groups by outlining what a WRAP is, the evidence to support this intervention, and an outline of WRAP goals. We will then provide TC FHT's timeline to achieving 'Peer Led' WRAP Groups, sharing key insights into how we made it happen. These insights include accepting sage external guidance, creating a core group of visionaries, assessing the organization's culture, achieving team 'buy in', identifying champions, logistics, outcomes and do's and don'ts. Throughout the journey, we learned the impact of hearing the "patient" voice and thus you will hear a voice from a WRAP graduate. In closing, we will share our future plans for more

patient involvement and secure time for you to ask questions or to share "patient" partnerships you have built.

Presenters:

- Sherry Kennedy Kennedy; Executive Director; TCFHT
- Lora Judge; Social Worker; TCFHT

2. Developing and Implementing a Stepped Depression Care Management Program in a Community FHT

Abstract: Village Family Health Team is a Wave 5 FHT that opened its doors in August 2011. The FHT currently has 6 FTE physicians, 1 NP, 2 RNs and 1 SW with a current roster of 2550 patients, increasing by 400-500 patients per month. Village FHT has an emphasis on excellence in primary mental health care, both by ensuring that mental health and addictions get addressed by the primary health care team and by providing primary care to patients with serious mental illness and/or addiction disorders. In the annual planning process, Village FHT identified a population of patients with Major Depressive Disorder who may benefit from a Depression Care Management Program. In 2012-13 the FHT is piloting an innovative program that will provide population-based, measurement based, treat-to-target management of depression, using a stepped care model and an interprofessional team. A robust literature supports the clinical and cost effectiveness of the stepped care model for collaborative management of depression in primary care.1,2 Core elements of the stepped care model include evidence-based treatment of depression, systematic monitoring of treatment response using validated scales, weekly review and incremental intensification of treatment for treatment refractory patients, and regular liaison between the Social Worker, Psychiatrist, and Family Physician. Interprofessional education is embedded within case review and liaison. The goal of the pilot program is to identify if the program is feasible and acceptable to patients and staff, and generate preliminary data regarding clinical outcomes. We will identify any program characteristics requiring modification prior to offering the program more widely. The presentation will discuss the development, implementation and early outcomes measures of the program, and will also discuss modifications to the program as it unfolded based on patient and resource requirements. Given the prevalence of depression managed in primary care and the substantial evidence supporting interprofessional collaborative models of stepped care for depression, this program has widespread relevance. By the end of the presentation participants will be equipped to adapt this program to their unique FHT's needs and resources. 1. Gilbody, S. et al. (2006) Collaborative care for depression: A cumulative meta-analysis and review of longer-term outcomes. Archives of Internal Medicine, 166: 2314-2321. 2. Unutzer, J. et al. (2002). Collaborative-care management of late-life depression in the primary care setting, JAMA, 288 (22): 2836-2845.

Presenters:

- Lindsay Williams; MSW; Village Family Health Team
- Tania Tajirian; Family Physician; Village Family Health Team
- Charles King; Family Physician; Village Family Health Team
- Nadiya Sunderji; Sessional Psychiatrist; Village Family Health Team

A(8) – 111+113:

Length of presentation: 45 minutes
Theme: 8 - Access and capacity

1. The effect of panel size on quality of care across primary care models in Ontario, Canada

Abstract: Rational: Existing data suggest that quality of care may be compromised when family physicians are responsible for managing large numbers of patients (panel size).
Objective: Determine the impact of larger panel size on the quality of care delivered.
Approach: Linked health administrative data from Ontario was used. The dataset was limited to physicians with panel sizes >1200 (4,195 physicians, 8.3 million patients). Multivariate regressions were used to assess the independent relationship of panel size and quality of care adjusted for: patient age, sex, income quintile, practice location, case mix, and physician age and sex. We present the results on two dimensions of quality: preventive care and accessibility (non-urgent emergency department visits).
Results: Mean/Median panel size was: Fee-For-Service: 2042/1855, Capitation: 1951/1857, FHT: 1867/1792. The quality of preventive care decreased modestly with increasing panel size across all models. The percentage decrease in the overall preventive score between panel size of 1200 to 2000 and 1200 to 3000 was -3.4% and -9.5% respectively in capitation models, -1.8% and -4.8% in FFS and -0.1% and -5.8% in FHT. Our initial analysis found no consistent drop in non-urgent ED visits with increasing panel size across models; we will further investigate this relationship.
Conclusions: Our analysis of health administrative data suggests that larger panel size may compromise preventive care but not accessibility. Our multivariate models may not fully account for all patient and practice characteristics.

Presenters:

- Elizabeth Muggah; MD, MPH, Clinical Investigator; Bruyere Research Institute
- Simone Dahrouge; PhD, Director; Bruyere Research Institute
- Richard Glazier; Institute for Clinical Evaluative Sciences
- William Hogg; Bruyere Research Institute
- Jaime Younger; Institute for Clinical Evaluative Sciences
- Alexander Kopp; Institute for Clinical Evaluative Sciences
- Steven Hawken; Institute for Clinical Evaluative Sciences

2. How do FHTs compare? Characterizing family health teams and their performance in Ontario

Rational: Since the 2005 implementation of the Family Health Team (FHT) model in Ontario, limited research has compared the performance of FHTs to other primary care models. Objective: Compare the performance of FHTs to two other primary care models in Ontario: fee-for-service and blended-capitation. Approach: We used both health administrative data and chart data to compare the performance of physicians practicing in the three models serving >90% of Ontarians. We assessed: Access (# of non-urgent emergency room (ER) visits/patient/year), Continuity (proportion of visits to own provider), Comprehensiveness (proportion of services provided/20 assessed), and Prevention (proportion of eligible cancer screening tests performed). We also reviewed 4,120 randomly selected medical charts of patients with, or at high risk of developing, cardiovascular disease (CVD) in 71 practices across the Champlain region. Results: Preventive care (57%) and comprehensiveness (66%) were higher in FHTs and blended-capitation models compared to fee-for-service (51% and 57%, respectively). FHTs and fee-for-service had lower continuity (69%) compared to the blended-capitation

model (73%). FHT (0.68) and blended-capitation (0.54) patients had higher non-urgent ER use compared to fee-for-service (0.34). This is potentially due to their greater rural population. Hypertension, dyslipidemia, and chronic kidney disease management was similar across models. FHTs were more likely to provide smoking care and obesity management. Conclusion: Blended-capitation and FHT models compare favourably with the fee-for-service model. There is some indication that FHTs may provide better management of risk factors. A longitudinal evaluation is required to better understand the impact of the FHT model on performance.

Presenters:

- Simone Dahrouge; PhD, Director; Bruyere Research Institute
- Clare Liddy; MD, MSc, Clinical Investigator; Bruyere Research Institute
- William Hogg; Bruyere Research Institute
- Jatinderpreet Singh; Bruyere Research Institute;
- Jenna Wong; Institute for Clinical Evaluative Sciences
- Monica Hernandez; Bruyere Research Institute;
- Monica Taljaard; Ottawa Health Research Institute

A(9) – 134+138:

Length of presentation: 20 minutes each
Theme: 9 - Best practices in health promotion and chronic care

1. Heathy You - Adult Obesity Program

Abstract: According to data from the 2010 Mississauga Halton LHIN Health Profile, 44.8 % of adult residents are classified as overweight or obese. In order to more effectively manage treatment for the large volume of patients in our FHT who are obese, the "Healthy You" Program was implemented in June 2011. The program was adapted from the "Healthy You" Program previously developed at the Hamilton Family Health Team. Rather than considering the degree of weight loss alone, the goal of the program is focused on weight management, achieving the best weight possible in the context of overall health and quality of life. This is an interprofessional program including the dietitian, certified fitness specialist/pharmacist, social worker and chiropodist.Individual follow-up is offered as well as group follow-up at 3 months and 6 months post-program completion The first 4 cycles of this program have been evaluated according to the following criteria: All participants enrolled in program: % of participants complete progom % of participants report satisfaction with program - would recommend program to others - # classes, length of classes - usefulness of materials, interest level Participants who completed the 7 week program and attended at least 1 group or individual follow-up session Anthropometric: - >5 % weight loss or reduction in waist circumference Behavioural: - improved health practices as evidenced by lifestyle assessment - reported answers in “often – 4-5 x week” or “all the time – 6 – 7 x week” increase after program attendance

Presenters:

- Barbra Martin; Social Worker MSW, RSW; Credit Valley Family Health Team
- Claudia Mazariegos; MAN,RD - Dietitian; Credit Valley Family Health Team

2. Self Management Ontario – Providing Chronic Disease Prevention And Management Options

Abstract: The Self-Management Strategy is part of a provincial initiative to address the growing challenges of chronic disease prevention and management. Through the delivery of both self-management training for individuals living with or at risk for chronic conditions including diabetes, and

self management support for healthcare providers, the strategy aims to increase the level of skills, knowledge and confidence needed to live well with ongoing health conditions. Within each Local Health Integration Network (LHIN) there is a Self Management Coordinator overseeing the delivery of services throughout their jurisdiction. For people living with or at risk for chronic conditions the initiative has made evidence-based programs available including: standardized programming for chronic disease self management (licensed Stanford programs); and access to online chronic disease self management. The marketing and outreach strategies in each LHIN have been tailored to address the unique needs of the population to whom they provide service. For healthcare providers the initiative has made professional development opportunities available to enhance clinician's self-management support skills. The Institute for Healthcare Communication's "Choices and Changes" is an example of a workshop that helps clinicians reflect on their practice and increase their skills to work with their patients to make health behaviour changes. Mentorship and follow-up are integral parts of the skills training package that connects clinicians to communities of practice and encourages ongoing dialogue at the team level. Self-Management Ontario exists to connect patients and healthcare providers with evidence-based programming to assist in the prevention and management of chronic conditions.

Presenters:

- Susan Anderson; Self Management Coordinator; Hamilton Health Sciences
- Natasha Beckles; Professional Education Coordinator; Central East CCAC
- Christine McIntosh; Self Management Coordinator; South Georgian Bay CHC

A(9) – 150+151:

Length of presentation: 20 minutes each
Theme: 9 - Best practices in health promotion and chronic care

1. Reaching Out To Provide Diabetes Care In The Community

Abstract: Our FHT based Diabetes team is funded through the Ontario Diabetes Strategy. Therefore our program provides diabetes management to both our rostered and community patients. Through the outreach component of this program, which is 1/2 day per week, we partner with Streetsville Medical FHO. We have been able to transfer Diabetes knowledge to the 5 primary care physicians that we work with at the FHO. This has been done through just in time coaching, weekly presentations and reinforcement of new guidelines, including insulin starts and medication adjustments to meet targets. Physicians are evidencing increased comfort with Diabetes Management at a more sophisticated level. Tools have been implemented including the standardized evidenced based Insulin Prescription Pad and Medical directives. An evaluation of physician satisfaction including clinical practice changes has been completed. A patient satisfaction survey has also been completed from the Outreach participants from the FHO. The survey confirmed that the program is meeting the patients' needs and that the patients are very satisfied with the service. Examples of feedback from the comments section: "The program made a change in my life. I now eat healthier, exercise and my blood level has dropped from 9.0 to 6.0 and is getting better every day."

Presenters:

- Mike Beausoleil; RN, BScN, CDE; Credit Valley FHT
- Sandy Macaulay; RD, CDE; Credit Valley FHT

2. Sustaining The Lung Health Program

Abstract: The Credit Valley Family Health Team (CVFHT) has had previous success piloting a Lung Health Program. In partnership with the GSK PRIISME Program and QIIP, the progam elements included

screening spirometry, COPD and Asthma education, and smoking cesssation. This program has now been spread across the CVFHT. In October 2011a partnership with the Ottawa Model for Smoking Cessation (OMSC) was established. Various components of Lung Health Program have been evaluated. This presentation will describe the integrated program and the following aims and outcomes: Increased documentation of smoking status from 20% to 80% using Smoking Status Screener (SSS) OMSC Guideline Implemented use of the Canada Lung Heath Test (CLHT) to standardize identification of patients at risk for COPD . Target 80% Referral of 100% of patients at risk for COPD to spirometry and follow up COPD education and Smoking Cessation Counselling Referral of 100% of patients who smoke with Asthma Diagnosis, post spirometry and asthma education to Smoking Cessation Counselling Comparison of pre and post COPD patient program evaluation using the Quality of Life St. George's Validated Questionnaire at 1 year

Presenters:

- Heather Hadden; Pharmacist BScPhm; Credit Valley Family Health Team
- Marnie Martin; Family Practice Nurse BScN, RN, CRE; Credit Valley Family Health Team
- James Pencharz; Family Physician; Credit Valley Family Health Team

A(10) - 25: Caring For Patients With Severe Physical Challenges

Length of presentation: 45 minutes

Theme: 10 - Meeting needs of special populations

Abstract: This presentation discusses access issues to primary care for people who have mobility issues due to severe physical challenges. This includes patients in wheelchairs due to spinal cord injuries, neurologic conditions, and musculoskeletal impairments. Research has repeatedly shown that where a problem with access exists in the general population, it is much more severe in disadvantaged populations, such as those with disabilities. For example, disabled people are much less likely to receive routine preventative services such as mammograms, PAP smears, vaccinations and lifestyle counselling. The literature identifies significant access problems related to four factors: physical barriers to access, primary care providers' lack of specific expertise about disability, attitudes of professionals, and systemic barriers. A "Mobility Clinic" was developed by the Centre for Family Medicine FHT with support from the Ontario Neuro-trauma Foundation (ONF) and the Schlegel-UW Research Institute for Aging (RIA) to study and address these issues. The Mobility Clinic provides support and services to patients, their families, and their primary care givers to facilitate access and primary care in keeping with the general population. In short, the Mobility Clinic "levels the field" in primary care for those with mobility challenges using an inter-professional model.

Presenters:

- Joseph Lee; Chair & Lead Physician (MD, CCFP, FCFP, MClSc); The Centre for Family Medicine FHT
- James Milligan; Director, Mobility Clinic (MD, CCFP); The Centre for Family Medicine FHT

A(11) – 41+42:

Length of presentation: 20 minutes each

Theme: 11 - Strengthening the FHT team

1. Integrating Occupational Therapy Into The Family Health Team: Year One Summary

Abstract: Occupational Therapists have now been working for 1 ½ years in the McMaster Family Health Team. The focus of the presentation will be to describe Occupational Therapy involvement to date. This will include the trends in referrals, range of patients seen and the issues that were addressed, types

of assessments and interventions and outcomes to date. Examples of team collaborations that have been useful will be presented. Our role and involvement in education of Primary Health Care physicians, allied health clinicians, residents and students will be provided We will discuss the issues and concerns that have arisen as well. These include boundaries of what is feasible to provide, managing wait lists, ensuring appropriate referrals and skills the FHT Occupational Therapists have needed to develop. Discussion of integration of groups into practice to help provide most efficient care based on the referral trends. Cases will be discussed to illustrate each of these with comments from patients and staff. To date it appears that occupational therapists are a valuable addition to the Family Health Team and are helping to provide Better Care, Better Health And Better Value.

Presenters:

- Martha Bauer; Occupational Therapist; McMaster Family Health Team
- Colleen O'Neill; Occupational Therapist; McMaster Family Health Team

2. The Role Of Physician Assistants In Family Health Teams

Abstract: Physician Assistants (PAs) are academically prepared and highly skilled healthcare professionals. PAs practice medicine in collaboration with a Physician and are able to provide a broad range of medical services in various clinical settings to improve timely access to care. PAs provide quality healthcare services and have the ability and capacity to make a significant impact on how these services can be delivered in Family Health Teams (FHT). This presentation will reveal the unique ways in which Physician Assistants, with their flexible scope of practice, support the Family Health Team in areas of program development, screening and primary care services. The Physician Assistant model is a collaborative approach with Physicians and Allied Health Professionals which strengthens team based care. Learn how PAs are able to become readily involved with FHT programming to promote health and to manage chronic disease. This innovative integration of the profession into Family Health Teams improves patient access to care and supports the team in an economically advantageous manner.

Presenters:

- Catherine Duffin; BSc., MSc., BHSc.PA, Canadian Certified Physician Assistant; Upper Grand Family Health Team

A+B(6) - 159: Leadership And Governance For Quality: Preparing To Implement "Excellent Care For All" In Primary Care

Length of presentation: 1hour 30minutes

Theme: 6 - Strengthening FHT leadership and governance

Abstract: The preamble to the Excellent Care for All Act (ECFAA) recognizes “a high quality health care system is one that is accessible, appropriate, effective, efficient, equitable, integrated, patient centred, population health focussed, and safe.” It calls for a number of measures to be taken by Ontario’s health care organizations to be “responsive and accountable to the public, and focused on creating a positive patient experience and delivering high quality health care.” ECFAA implementation began with hospitals; government is now giving priority to its implementation in primary care.

Learn from the experience of six FHTs that are already well on their way in this journey. In this 90-minute panel presentation they will compare and contrast their experiences in advancing quality improvement in their FHTs – through governance, leadership, planning, implementation, measurement and monitoring. A representative of the Ministry of Health and Long-Term Care’s Quality Improvement Branch will give an update on plans for ECFAA implementation in primary care.

Presenters:

- Bruyere Academic FHT: Debbie McGregor, Executive Director and Jay Mercer, Medical Chief for Family Medicine
- Hamilton Family Health Team: TBD
- North Perth & North Huron Family Health Teams: Mary Atkinson, RN, B.Sc., MBA; Executive Director
- Queen's Family Health Team: Karen Hall Barber, BSc (Hons), MD, CCFP; Physician Lead and Danyal Martin, BAH, BEd, MA; Clinical Program Coordinator
- St. Michael's Hospital Academic FHT: Tara Kiran, Family Physician
- MOHLTC Quality Improvement Branch (to be confirmed)

A+B(9) - 128: Asthma Action Plans: Green Light, Yellow Light, Red Light - Go! Integrating New Canadian Thoracic Society Asthma Knowledge Into Action … Plans For Preschoolers, Children And Adults

Length of presentation: 1hour 30minutes
Theme: 9 - Best practices in health promotion and chronic care

Abstract: Introduction: The Canadian Thoracic Society Asthma Clinical Assembly has recently published an update that includes recommendations on escalation therapy within Asthma Action Plans for children and adults. In response, The Ontario Lung Association's (OLA) Provider Education Program (PEP) has developed an Asthma Action Plan Workshop that has integrated these recommendations and offers a unique evidence based knowledge translation platform for health care providers to facilitate integration of these recommendations into practice. Objectives: After participating in the workshop, participants will develop baseline knowledge of the components of an asthma action plan; state the level of evidence and describe recommended steps for escalation therapy in the yellow zone of action plans; and be able to satisfactorily complete an action plan for children and adults with asthma reflecting these recent CTS recommendations. Methods: Experts in the area of both paediatric and adult asthma will deliver a workshop developed and approved by professional members of The Ontario Thoracic Society and the Provider Education Program, Ontario Lung Association. The workshop will be delivered utilizing both a didactic and interactive case-based approach in order to maximize knowledge translation. Conclusions: After participating in The OLA PEP workshop on Asthma Action Plans, health care providers will demonstrate a better understanding of the most recent evidence- based recommendations on escalation therapy in the yellow zone for both children and adults with asthma.

Presenters:

- Jennifer Olajos-Clow; Acute Care Nurse Practitioner and Certified Asthma Educator; Kingston General Hospital

Concurrent Session B - 11:35 to 12:20 PM

B(1) – 10+12:

Length of presentation: 20 minutes each
Theme: 1 - Improving the patient's experience of care

1. Respecting Our Patients And Each Other ~ A Customer Service Approach

Abstract: Faced with a rapidly growing number of patients and a corresponding growth in staff to meet our patients' needs, Health for All (HFA) Family Health Team (FHT) has developed this policy. A customer service approach that respects patients and each other encourages staff to maintain a

consistent response when there are disruptions caused by concerns or complaints from patients or families and when staff is working through difficult situations that could impact their relations with one another. This policy applies to all staff, including our physicians. The goal of this approach is to ensure that staff not only responds to patients and their families in a timely, consistent and respectful manner but also accepts the responsibility to respond in a timely, consistent and respectful manner to difficult situations involving each other. We may view each of these individuals as 'customers'. There are many ways to define a complaint. The HFAFHT defines a complaint as "communication that involves an interaction between a staff person and a patient, family member or another staff person that may imply adverse outcomes with legal, medico-legal, malpractice, employment standards or other significant socio-cultural consequences. Such complaints challenge the well being of the FHT and the good relations we try to maintain with patients and with each other. There are ways to facilitate a positive outcome when handling a concern or complaint. These affect our conversations, attitudes and behaviour. Our presentation will share principles to use when responding to a concern or complaint, identify the roles each of the staff and physicians can play in the process (both in reactive and proactive situations) and will also touch on the debrief that can take place between staff and physicians once the resolution of a difficult concern or complaint has occurred.

Presenters:

- John Maxted; MD MBA CCFP FCFP; Health for All Family Health Team
- Jodi Heard; Administrative Lead; Health for All Family Health Team

2. Champagne Club: Assessing Excellence In Customer Service At An Academic Family Health Team

Abstract: Patients' health largely depends on the primary health care sector and involves a sustained partnership between patients and providers. There is increasing evidence that the service aspects of health care are closely linked to health care outcomes. Patient satisfaction has emerged as an increasingly important parameter in the assessment of health care quality. In improving the service delivery on primary health care teams, there is a need to place high priority on the patients and their level of satisfaction with the provided services. Partnerships in healthcare are also becoming recognized as one of the primary innovations needed as healthcare evolves. Engaging both patients and staff in the process of quality improvement is an important step in developing working partnerships. Open dialogue and responsiveness to feedback assists in removing barriers in health care delivery and leads to improved patient outcomes. The goal of this initiative was to guide quality improvement initiatives at a two-site Academic Family Health Team by better understanding the patient experience. This was accomplished through staff led one-on-one interviews with clinic patients. Engaging patients and clinic staff in the process of quality improvement facilitates partnerships in healthcare and provides the team with the opportunity to improve how we work with our patients. In this presentation we will share our teams initiative, our outcomes and the next steps in our quality improvement journey.

Presenters:

1. Katharine De Caire; NP; McMaster Family Health Team
2. Lynn Dykeman; MSW; McMaster Family Health Team
3. Kati Ivanyi; MD; McMaster Family Health Team
4. Adriana Kasunic; Business Clerk; McMaster Family Health Team
5. Dale Guenter; MD; McMaster Family Health Team
6. Margaret Moscardini; Education Associate; McMaster Family Health Team

B(2) - 55: Local Health Integration Networks & Family Health Teams: From The Action Plan To Implementation

Length of presentation: 45 minutes

Theme: 2 - System integration: building the team beyond the FHT

Abstract: The Minister's Action Plan for Health Care outlines a vision for an integrated system that puts primary care at the centre of the care continuum as a natural anchor for patients, playing an essential role helping navigate the system, particularly for seniors and those with multiple chronic conditions. To achieve this vision, the Minister proposed the "Local Integration of Family Health Care". This presentation will outline the thinking and work that has been completed to date and considerations for future direction.

Presenters:

- Paul Huras; CEO; South East LHIN
- Bryn Hamilton; Senior Consultant; LHIN Collaborative

B(3) - 71: Transforming Your EMR Data Into Useful And Usable Information: A Practical Guide For The Perplexed

Length of presentation: 45 minutes

Theme: 3 - Getting data and using it to improve care

Abstract: There is no question that EMR data are potentially very valuable. These data are needed in order to measure quality of care and to plan and evaluate FHT programs. As well, there is likely to be funding for reporting performance metrics in the future. However, collecting data from EMRs can be difficult and frustrating. Once these data are obtained, transforming them into useful and usable information such as reports is even more challenging. This workshop will present challenges and solutions from two different FHTs, using three EMRs. We will provide practical steps and tips that you can use to improve your data so that, once extracted, it can become information with less difficulty. This will include: • Data Manuals (Practice Solutions, OSCAR, Nightingale) • Description of different data extraction methods • Use of data clerks (Summer students) to rapidly improve your data • Other potential sources of assistance such as shared data management expertise across several FHTs The seminar will be of interest to FHTs and clinicians looking to improve their data and monitor their performance.

Presenters:

- Michelle Greiver; MD CCFP; North York Family Health Team
- Sanjeev Goel; MD CCFP; Wise Elelphant Family Health Team

B(4) - 81: Have Your Specialist Come To You: Ontario Telemedicine Network Endocrinology Project

Length of presentation: 45 minutes

Theme: 4 - Leveraging technology to improve quality and efficiency of care

Abstract: Objective: Access to specialty services is important when managing complex diabetes; however, access is limited in many areas. Ontario Telemedicine Network (OTN) could provide timely care to those not able to access specialty services due to transportation barriers. The Diabetes Regional Coordination Centre (DRCC) in collaboration with Hamilton Health Sciences (HHS) was able to satellite into Quest Community Health Centre (Quest) to provide care for complex diabetes patients who otherwise would not be adequately managed without referral to a specialist. Method: DRCC developed a protocol with assistance from OTN to develop a process that worked for all parties involved. Protocol

ensured that team was ready to assist in delivery of care, had adequate training on technology and appropriate technical and medical support. This presentation will review one case from the OTN project. Chart review of patient used to look at change in glycated hemoglobin (A1C) and other markers. Interviews were conducted with the patient, Quest HCP and the endocrinologist regarding the experience. Results: Patient A1C dropped from 13.3% to 8.7%. Patient felt experience was exciting opportunity for health management and felt it was not different from other appointments. Patient also enjoyed having a familiar team present. Quest HCP found OTN experience enhanced their knowledge of diabetes. The endocrinologist felt that due to the required organization of the OTN process, visits were very effective. Conclusion: Overall OTN Endocrinology appears to be beneficial not only to patient outcomes, but educating primary care staff on complex diabetes management.

Presenters:

- Gaya Amirthavasar; BKin, MSc -- Health Information Analyst; Hamilton Health Sciences
- Bo Fusek; RN, CDE, BA, BEd, MEd Clinical Nurse Specialist; Hamilton Health Sciences

B(5) - 95: Improving Processes Together: Co-Design With Seniors, Caregivers, And Clinicians

Length of presentation: 45 minutes

Theme: 5 - The Triple Aim in FHTs – better care, better health, better value

Abstract: This session will discuss the healthcare transition experiences and stories that emerged during a recent engagement with Ontario seniors with chronic health conditions and their caregivers – a process that informed an innovative Ontario project called Partners Advancing Transitions in Healthcare (PATH): a first with Ontario patients. PATH is supporting a community coalition of providers, which includes a Family Health Team, and seniors/caregivers who are working together over the course of two years, in an equal partnership, to identify and improve care transition issues in their community. In addition to the focus on patient co-design, the PATH project has a strong focus on tracking indicators that will demonstrate improved quality, patient experience, and health system value. The session will also provide some examples of successful patient-centered care and co-design initiatives.

Presenters:

- Genevieve Obarski; Executive Lead, Program Implementation; The Change Foundation
- Sine MacKinnon; Director, Communications and Public Engagement; The Change Foundation
- TBD ; Physician from the Family Health Team involved in the PATH project
- TBD ; Patient/Caregiver from the PATH Community

B(7) – 89+106:

Length of presentation: 20 minutes each

Theme: 7 - Improving care for people living with mental health challenges

1. FHT Memory Clinics: Building Capacity For Improved Dementia Care Within Family Practice

Abstract: It is estimated that 25% of persons over age 65 have some form of cognitive impairment or dementia. With our aging population and limited specialist resources, primary care clinicians will need to assume greater responsibility for dementia care. This presentation will describe an initiative to build capacity to diagnose and manage dementia through a program of specialized team training, resulting in the development of family physician led interprofessional memory clinics within 25 Family Health Teams in Ontario. Evaluative results will be presented demonstrating reduced wait times to assessment, low rates of referral to specialists, high level of patient and caregiver satisfaction, and provision of high quality of care as assessed by chart audits conducted by geriatricians. The development of FHT memory

clinics represents a significant capacity building initiative that allows the majority of dementia care to be maintained with primary care practice. The model is consistent with current ideal models of chronic disease management and increases efficiency of use of limited health system resources. Further, this innovative model of training and care delivery can be applied to the management of other complex chronic diseases of the elderly.

Presenters:

- Linda Lee; MD, MClSc(FM), CCFP, FCFP. Director, CFFM Memory Clinic; Centre for Family Medicine FHT

2. The "Collaborative Care" Model: Educational Opportunities In Psychiatry For Family Physicians

Abstract: Studies have shown that mental health issues may make up about 25% of a family physician's practice. The bulk of mental health care in a community is currently being done by the family physicians. This has been referred to as the "de facto mental health care network". Thus, it is clearly important for family physicians to continue to develop their skills in this area. In this presentation, we will describe the "Collaborative Care" model for the delivery of mental health services to patients, for the FHT which is based in Hamilton, Ontario. In this model, mental health counsellors are placed directly in the family practice clinic. The amount of time allocated is based on the patient population of the clinic. A consulting psychiatrist visits the clinic for approximately one half day every week or two, again depending on the size of the clinic. We will describe a typical half day for the visiting psychiatrist, which involves direct patient care, both consultations and follow up visits. It also involves indirect patient care, where a number of cases are discussed between the family physician and the psychiatrist, without the patient being seen directly. This longitudinal model of support by a consulting psychiatrist enables the family doctor to increase their skills in this area. Pedagogic principles discuss the fact that the best learning occurs around actual cases, seen in the actual work setting, with ongoing supervision by an "expert". These conditions are explicitly met in this system, with ongoing learning opportunities in the psychiatric sphere. The presenter is also a recent co-editor of a book called "Psychiatry in Primary Care-A Concise Canadian Pocket Guide." The book is seen as a valuable learning tool for family physicians, and will be described.

Presenters:

- Jon Davine; MD, CCFP, FRCP(C); McMaster University

B(8) - 112: Capacity Of Care In The Family Health Team: Learning's From The FHT Physicians Survey

Length of presentation: 45 minutes

Theme: 8 - Access and capacity

Abstract: The Family Health Team (FHT) needs to be positioned to provide the majority of primary care required by their patients. As clinical leaders, the opportunity for family physicians to deliver change within the FHT, and more broadly to the health care system, is before them.

This presentation will build upon the issues identified from the 2011 Ontario Medical Association and the Association of Family Health Team of Ontario's joint survey of FHT physicians. Key issues to be examined will include how FHTs can provide timely access to care, continuity of care and effective transitions of care by establishing a strong, collaborative and integrated Family Health Team that provides value to patients, physicians and the health system.

Presenters:

- Peter Brown; Senior Policy Anayst; Ontario Medical Association

- Chris Cressey; Chair, OMA FHT Issues Committee and Lead MD; Minto-Mapleton FHT

B(9) - 144: "An Ounce Of Prevention": A Primary Care Based Prevention Program For Pre-Diabetic Population

Length of presentation: 45 minutes
Theme: 9 - Best practices in health promotion and chronic care

Abstract: Objective: To address the increasing need for diabetes prevention strategies in those identified as pre-diabetic by piloting and evaluating a newly adapted diabetes prevention program. Target Groups: The program is designed for all individuals who are considered to be pre-diabetic according to the Canadian Diabetes Association guidelines. Participants are recruited within an academic primary care clinic of about 12,000 patients in Ottawa, Ontario. Activities: The program offers a series of four weekly group sessions (two-hour each) to eligible individuals. Each session consists of a 90-minute educational module that includes knowledge and motivation for diabetes prevention, exercise, diet, and self-management techniques and strategies followed by a 30-minute component of active exercise. Following completion of the 4 sessions, participants are emailed or called weekly for 12 weeks to provide motivation and tips. At the 3 month mark patients come back to the clinic for a follow-up group session where all baseline measurements are taken again. Maintenance groups are held every 6 weeks for all "graduates" of the program. Deliverables: "An Ounce of Prevention" was launched in January 2010 and held its first series of group sessions in June 2010. We have now offered the session to 8 groups (64participants). Results of the evaluation surveys show that participants are highly satisfied with the content as well as the format of the program and think that the content is relevant to them. Based on participant's feedback and lessons learned during the implementation of this pilot project, the program undergoes further trimming. Effectiveness and sustainability studies of the program are under development.

Presenters:

- Clare Liddy; MD, MSc, Clinical Investigator; Bruyere Research Institute

B(10) – 24+27:

Length of presentation: 20 minutes each
Theme: 10 - Meeting needs of special populations

1. "Speak Freely": Counselling Drop In Clinic For Teens

Abstract: The reasoning behind the inception of "Speak Freely": Counselling Drop In Clinic for Teens stemmed from Children's Mental Health Ontario, whom stated that the first step in a mental health intervention for youth was to go to their Family Doctor – as is often the case with any health related concerns. However, while several child and adolescent mental health organizations have walk-ins and distress lines, created to be accessed in times of need, we have seen very little of this accessibility in Family Health Teams and GP offices, specifically attending to adolescent mental health. And, if we are directed to be the first point of contact our Family Health Team wanted to be better equipped. This targeted program attempts to reach traditionally unreachable adolescents through a more casual "drop in" approach; meaning that they do not need a referral from, or an appointment with their Family Physician to access service. They need only to be a rostered patient. Further, it is an opportunity for empowerment in our adolescent population. Speak Freely is their chance to feel like they have control and agency in their care, as they do not require their parents to make the appointment, nor will the information go back to their parents if they do not want it to. Speak Freely is just that, an opportunity to

speak freely without reservation, judgment or worry of the consequences as it is a completely confidential and private session.

Presenters:

- Sandy Rao; Registered Social Worker/Mental Health Therapist; OakMed Family Health Team

2. Developing A Patient-Centred Primary Care Model For Vulnerable Older Adults

Abstract: PURPOSE: Women's College Hospital Family Practice Health Centre (WCHFPHC) seeks to develop, implement and evaluate a patient-centred model of care that addresses community-dwelling seniors' complex medical and psycho-social needs; uses existing internal and community-based resources; and reduces health care utilization, while preserving the patient-FHT relationship. METHODS: A multi-pronged approach was adopted by our Elder Care Team (family physicians, nurses, pharmacists, a geriatrician, dietitian, researchers and a CCAC coordinator). In June 2011, we began weekly meetings to review and develop clinical recommendations for complex patients and identify healthcare system delivery gaps. These efforts resulted in an electronic health records (EHR) database clean-up, formation of internal and external partnerships, and development of monthly Elder Care Rounds. Funding was sought to support our information gathering (scoping review of the literature and key informant interviews) and knowledge translation activities. PRELIMINARY RESULTS: To date, 45 team meetings and two Elder Care Rounds have occurred. Over 1300 elderly patients were identified from our preliminary EHR clean-up. Successful attributes of existing care models have been identified from a preliminary review of over 500 Medline citations and team meeting discussions. Funding was awarded, and additional database searches/literature reviews and key informant interviews will commence this summer; culminating in a Stakeholder Summit this Fall. CONCLUSION: During this session, key findings, lessons learned, and implementation issues arising from the development of our collaborative care model for vulnerable seniors will be highlighted. The resultant reports and tools will be shared with other FHTs interested in developing similar models of care for their frail seniors.
ACKNOWLEDGEMENTS: Lisa Fernandes RPh (WCHFPHC) and Katherine McAuliffe RN (Toronto Central CCAC)

Presenters:

- Lisa McCarthy; RPh PharmD MSc; Women's College Hospital Family Practice Health Centre (WCHFPHC)
- Susan Hum; MSc; WCHFPHC
- Nicole Bourgeois; RD; WCHFPHC
- Paula Rochon; MD MPH FRCPC; WCHFPHC
- Sheila Dunn; MD CCFP-EM MSc; WCHFPHC
- Mary Novak; RN; WCHFPHC
- Cynthia Whitehead; MD CCFP PhD; WCHFPHC

B(11) - 40: Evidenced Based Approach To NP Recruitment And Integration

Length of presentation: 45 minutes

Theme: 11 - Strengthening the FHT team

Abstract: A nurse practitioner (NP) is a registered nurse with advanced university education and skills that enable him or her to provide personalized quality primary health care to patients. We work in partnership with family physicians and other healthcare professionals. Nurse Practitioners (NP) are a relatively new to Family Health Teams (FHT) in Ontario. Despite 1500 registered NP's in Canada (CNO May 2012), they are often difficult to recruit and once employed, overlap of scope of practice between RN's and MD's can cause role confusion. Despite an abundance of evidence to support the role as well

as recommended steps for successful integration, at times, knowledge translation eludes us. Practice models described by Dr. Dicenso and at the time Provincial Chief Nursing Officer Sue Matthews in the Report on the Integration of Nurse Practitioners in the Province of Ontario (2005) will be presented and discussed as options to avoid role confusion. The Canadian Nurse Practitioner Initiative (CNPI) Implementation and Evaluation Toolkit will form the discussion with a practical – evidence based steps support successful NP integration.

Presenters:

- Jo-Anne Costello; CDE, MScN, NP / Lead Nurse Practitioner; Guelph Family Health Team

Concurrent Session C - 2:00 – 2:45 PM

C(1) - 7: Evaluating The Impact Of Two Different Forms Of Diabetes Self-Management Education On Knowledge, Attitude And Behaviours Of Patients With Type 2 Diabetes Mellitus

Length of presentation: 45 minutes

Theme: 1 - Improving the patient's experience of care

Abstract: Research was conducted through the University of Western Ontario, in collaboration with Diabetes Care Guelph, examining adult patients with type 2 diabetes mellitus. Patients were randomized and exposed to different delivery methods of teaching diabetes education, conversation maps and traditional patient classes. A pre/posttest design was conducted to assess changes in participants' knowledge, attitude, behaviours. Focus groups were conducted after education was provided to explore patients' perceptions of the different delivery methods. The results and outcomes of the research study will be discussed in this oral presentation.

Presenters:

- Laura Briden; RD, CDE; Diabetes Care Guelph, Guelph Family Health Team

C(2) – 53+54:

Length of presentation: 20 minutes each

Theme: 2 - System integration: building the team beyond the FHT

1. Improving Transitions In Care

Abstract: A newly created position for a RN navigator to liaise between Brockville General Hospital (BGH), Community Care Access Centre (CCAC) and the Upper Canada Family Health Team (UCFHT). The RN navigator will work in the hospital assessing UCFHT patients who are identified by the physician doing hospital rounds as needing education on chronic illness or requiring further bio-psycho-social assessment. The navigator would then connect the patient with the appropriate UCFHT allied health professional to provide education, assist with coping and managing the chronic disease, counselling and further assessment if necessary.

The RN navigator will work collaboratively with BGH and the CCAC in patient discharge planning to also ensure the transition from hospital to community is as smooth as possible.

Presenters:

- Sherri Hudson; Executive Director; Upper Canada Family Health Team

2. Safety In Transitions Of Care: A Focus On Solutions

Abstract: Transition of care among providers has been identified as a major contributor to poor and/or unsafe patient care and may be a source of medical errors. It has been shown that gaps in communication are a serious concern during transitions of care. Timely and effective information transfer not only helps improve patient safety, but also employee safety. To improve quality of patient care and ensure employee and patient safety, the Public Services Health and Safety Association (PSHSA) held two focus groups with key informants on the issues related to transitions of care in the healthcare sector. Focus group participants included researchers, union groups and provincial government representatives, as well as stakeholders from acute care, mental health, community and long-term care sectors. Focus group participants shared a number of challenges related to transition of care, including the lack of current and pertinent medical information available at the time of transfer and legal implications of information transfer. Based on the feedback from the stakeholders, PSHSA developed a list of solution-focused action items to address the identified transition of care challenges and improve the health and safety outcomes for patients and employees. Family Health Teams are a valuable partner in the circle of care and are strategically positioned within the healthcare system to serve as gatekeepers of critical patient information. This session will examine the leading transition of care practices across the healthcare system, challenges and provide possible solutions aimed at advancing both client and employee safety during transfers.

Presenters:

- Henrietta Van Hulle; RN, BN, COHN(c), CRSP, CDMP/ Director of Prevention Services; Public Services Health and Safety Association

C(2) - 59: Primary Care And Public Health Collaboration: Lessons Learned For Interorganizational Teams

Length of presentation: 45 minutes

Theme: 2 - System integration: building the team beyond the FHT

Abstract: Recent evidence demonstrates that primary health care systems can be strengthened by building stronger collaborations between public health (PH) and primary care (PC) sectors, which will lead to more integrated systems, improved access to care, and health outcomes for patients. As the Drummond Report 'Commission on the Reform of Ontario's Public Services' (2012) recommends that improvement in coordination of patient care will be enabled by regional health services integration, future research needs to document what has worked and lessons learned for interorganizational team collaborations. Based on the final study in a four year program of research, we used case study method to explore processes and structures to support PC and PH collaborations. Ten in-depth case studies were conducted in ON, NS, and BC. Data collection strategies included photovoice, focus groups, document analysis, and a partnership self-evaluation survey. Collaborations selected for the case studies ranged in scope, purpose, populations served, locations, and team member roles: They addressed numerous health issues. Preliminary results show that models for delivering primary health care, including Family Health Teams (FHTs), play a significant role in collaborations. The purpose of this presentation is to share key lessons learned from case studies related to factors influencing collaboration. Results will focus on intrapersonal factors (e.g., personal qualities, knowledge, and skills); interpersonal factors (e.g., role clarity); organizational factors (e.g., leadership, organizational culture); and systemic factors (e.g., government policies, and mandates). Case study examples will highlight lessons learned and conclude with implications for policy and practice specific to primary health care.

Presenters:

- Ruta Valaitis; RN, PhD, Associate Professor, Chair PHC Nursing; McMaster University

- Linda O'Mara; RN, PhD, Associate Professor, School of Nursing; McMaster University

C(3) - 67: Data Presentation Tool: An Innovative Software Application To Generate Reports On Quality Of Care

Length of presentation: 45 minutes

Theme: 3 - Getting data and using it to improve care

Abstract: Generating reports on quality of care for a physician's practice or for a FHT can prove to be surprisingly challenging. EMRs have generally been disappointing in terms of their ability to generate useful ongoing reports. Getting clean data out of EMRs requires a lot of work from FHT clinicians and staff, and the results are not always what is expected. The Canadian Primary Care Sentinel Surveillance Network (CPCSSN) is a national project hosted by the College of Family Physicians of Canada. We extract data from ten different EMR applications across the country in order to study some of the most common chronic diseases as they are managed in primary care. CPCSSN's Data Presentation Tool (DPT) is the software used to generate reports on the quality of care, by physician, by practice location and by group. DPT also provides reports on data quality to help Teams manage and improve data in their EMRs. In this workshop, we will demonstrate the DPT, using actual anonymized data. Examples can include data on the spread of the new anti-coagulant (dabigatran) in practice, data on quality of care for different chronic diseases and findings on the wide variability of data entry habits in primary care EMRs.

Presenters:

- Dave Jackson; Data Manager, CPCSSN; South Alberta Primary Care Research Network (U of Calgary)
- Karim Keshavjee; Clinical Data architect; CPCSSN
- Ken Martin; Information and Technology Manager; CPCSSN
- Anita Lambert-Lanning; Project manager, CPCSSN; College of Family Physicians of Canada
- Babak Aliarzadeh; Data Manager, CPCSSN; North Toronto Research Network, U of Toronto
- Michelle Greiver; Chair, IM IT committee; North York Family Health Team

C(4) – 83+84: Chronic pain in primary care: Can new EMR tools make it easier to provide evidence-based care?

Length of presentation: 45 minutes

Theme: 4 - Leveraging technology to improve quality and efficiency of care

Abstract: Caring for people with chronic pain presents many challenges. Family Health Teams are well suited to provide an interdisciplinary approach to pain management. Electronic tools for the EMR have the potential to provide clinicians with evidence-based recommendations, add greater value to the provision of care (both for clinicians and patients) and to systematically collect data for disease monitoring.

This presentation will draw from three projects (across three EMR vendors) that are at different stages of developing and piloting Computerized Clinical Decision Support Systems for Chronic Pain in primary care. We will discuss the common elements to chronic pain care in an EMR environment (in other words integrating evidence into EMR functionality), highlight ways in which each project has tailored the functionality (e.g. introducing a pain management tool for patient access through a Personal Health Record or designing an automatic insurance letter for narcotic prescriptions) and discuss success factors that will contribute to our collective understanding of improving the quality of care provided to Chronic Pain patients and the necessary enablers to support clinicians.

There will be an opportunity for participants to provide input to help maximize the effectiveness of a Chronic Pain EMR tool within the FHT environment, as well as identify ways in which these tools could be implemented beyond the three pilot projects. Participants will leave with a better understanding of how tools for chronic disease management can be developed, as well as a plan for how this tool could be integrated into the work of their own FHT.

Presenters:

- Dale Guenter; Associate Professor in Family Medicine; McMaster FHT
- Martha Bauer; Occupational Therapist; McMaster FHT;
- Inge Schabort; Associate Professor of Family Medicine; McMaster FHT
- Paul Taenzer; Psychologist; Knowledge Transfer team for Top Alberta Doctors
- Kalpana Nair; PhD Research Coordinator; McMaster FHT
- Jess Rogers; Director; Centre for Effective Practice
- Paul Murphy; Pharmacist; Hamilton FHT
- Brenda Copps; Family Physician; Hamilton FHT
- James Rainey; Family Practice RN; Hamilton FHT
- Doug Kavanagh; Family Medicine Resident, Toronto Western Hospital; Founder, Cognisant MD

C(7) - 109: Mental Health Care: Every Team Member Has A Role.

Length of presentation: 45 minutes

Theme: 7 - Improving care for people living with mental health challenges

Abstract: A panel of primary care team members including a pharmacist, dietitian, psychiatrist, family doctor, nurse and a practice manager, from different primary care teams will share innovative ideas of how they are sharing mental health care across their unique teams. The programs, processes and experiments presented by panel members will focus on the Hamilton Family Health Team's current quality improvement aim, "Every practice team will participate in Quality Improvement that will lead to care being more patient-centred, more timely and focused on populations." To whet your appetite here is a sampling of what will be presented – Patient & Family Group Depression and Anxiety Education Sessions with a psychiatrist and mental health counsellor (patient centred); Using motivational interviewing skills and a planned team approach to engage more patients in a range of mental health treatment groups (timely access); Utilizing registries to provide parents experiencing anxiety disorders, who have young children, with educational materials and support as an early intervention/prevention strategy (population focus).

Presenters:

- Trish Murphy; Psychiatrist; Hamilton Family Health Team
- Anne Mallin; Pharmacist; HFHT
- Angie Mazza-Whalen; Family Physician; HFHT
- Michele Macdonald; Registered Dietitian; HFHT
- To Be Determined ; Registered Nurse;
- To Be Determined ; Practice Manager;

C(9) - 131: Improved Weight Management In Primary Care

Length of presentation: 45 minutes

Theme: 9 - Best practices in health promotion and chronic care

Abstract: Purpose: This initiative aimed to develop a flexible population-based planning framework for inter-professional primary care organizations to deal with obesity management. Methodology: A

scoping literature review was completed to identify evidence of improved obesity management in primary care (2003-2012). In the second phase, focus groups were conducted with providers and patients; transcripts were thematically analyzed for ideas on new services. The final phase was review of the planning framework by 18 Family Health Teams in Ontario using a moderated consensus process. A national panel also reviewed the draft, with the help of the Canadian Obesity Network. Results: The scoping review revealed that about 80% of intervention studies were directed to diabetes and/or cardiovascular diseases in adults. The most promising strategies included intensive skills training with patients, case management, provider education and additional provider tools (e.g. treatment algorithms and access to specialist expertise). For program planning purposes, providers identified 5 target groups: pregnancy to 2 yrs, 3-12 yrs, 13-18 yrs, 18+ yrs at risk or with health conditions, and 18+ with complex care needs. Activities for each target group were prioritized under categories: raising awareness, principles of clinical care, service delivery, expanded services, and practice initiatives. Conclusion: The framework represents a significant effort to create a population–based planning tool, suitable for use at the organization or regional level, and informed by both evidence and providers' perspectives on feasible and applicable approaches for the Canadian context. The framework is being used to develop implementation studies and could be useful in program planning.

Presenters:

- Paula Brauer; PhD, RD1; University of Guelph
- Dawna Royall; MSc, RD; Nutrition Research Consulting, Fergus
- John Dwyer; PhD; University of Guelph
- Michelle Edwards; PhD; University of Guelph
- Rick Goy; PhD; University of Guelph
- Tracy Hussey; MSc, RD; Hamilton Family Health Team
- Nick Kates; MBBS, FRCP(C); Hamilton Family Health Team

C(9) - 149: Navigating Care Maps For Chronic Respiratory Disease, Knowledge Translation Tools To Improve Outcomes For Patients With COPD And Asthma

Length of presentation: 45 minutes

Theme: 9 - Best practices in health promotion and chronic care

Abstract: Introduction: The Ontario Lung Association has developed a number of evidence based tools to assist primary care providers with improving outcomes for patients with chronic respiratory disease. The tools used in the Primary Care Asthma Program (PCAP) – an asthma care map, an algorithm and an action plan have improved patient outcomes and reduced expensive healthcare resources. The asthma care map and treatment algorithm have been revised according to the 2012 Canadian Thoracic Society asthma guidelines. The OLA has adapted the successful asthma management model (PCAP) for COPD patients and created similar tools for the management of COPD. Tool Validation: A study completed by To et al, demonstrated, that most HCPs favored using the asthma care map (72%), believed it decreased uncertainties and variations in patient management (91%), and considered it a convenient and reliable source of information (86%). The COPD and Asthma Care Maps are available for adaptation into EMR's. The asthma care map was tested for usability using a 5-phase approach, by the University Health Network Healthcare Human Factors group.

Presenters:

- Carole Madeley; RRT, CRE, MASc / Director, Respiratory Health Programs; Ontario Lung Association
- Ana MacPherson; RRT, CRE, MASc / Provincial Coordinator, PCAP; Ontario Lung Association

C+D(5) - 94: Building a House Calls Practice: The Key Features and Processes of an Integrated Home-Based Primary Care Model

Length of presentation: 1hour 30minutes

Theme: 5 - The Triple Aim in FHTs – better care, better health, better value

Abstract: The health care system in Ontario will be increasingly challenged in the coming decades to meet the needs of an ageing population. Innovative models are required to meet the complex inter-related health and social problems faced by one of the most marginalized populations in society, frail and homebound older adults. We will present an integrated home-based primary, specialty and community care model with the intention of increasing awareness and building capacity for this model of innovative healthcare service delivery built upon existent Family Health Team infrastructures. This interactive workshop integrates a number of the Association of Family Health Teams of Ontario's (AFHTO) conference themes, particularly improving care for special needs populations in light of the Triple Aim of FHTs to promote better care, better health and better value for health care services. The presentation in form of a 1.5 hour workshop provides practical guidance for FHTs interested in launching and sustaining team delivered, home-based primary care services in partnership with local community care service agencies. Data will be presented on different models and composition of teams that have emerged in the provision of home-based care as a platform to discuss effective operationalization of integrated home-based primary care processes within existent FHT structures. Participants will explore the importance of effective partnerships with their local community care service agencies and other professionals in the home-based care field, as well as discover resources (e.g., toolkits, operations manuals, funding guides, etc.) that may be harnessed in the design and implementation of an integrated home-based primary care program.

Presenters:

- Thuy-Nga (Tia) Pham; MD, MSc, CCFP, Lead Physician; South East Toronto FHT
- Sabrina Akhtar; MD, CCFP, Physician Lead; Toronto Western Hospital FHT
- Mark Nowaczynski; MD, PhD, CCFP, FCFP, Clinical Director; House Calls
- Samir Sinha; MD, DPhil, FRCPC, Director of Geriatrics; Mount Sinai and the University Health Network Hospitals
- Dipti Purbhoo; Senior Director, Client Services; Toronto Central Community Care Access Centre
- Stacy Landau; Executive Director; Senior Peoples' Resources in North Toronto (SPRINT)

C+D(8) - 110: Back To The Future: Health Quality Ontario's Programs To Support Quality Improvement In Primary Care

Length of presentation: 1hour 30minutes

Theme: 8 - Access and capacity

Abstract: Health Quality Ontario (HQO) recognizes primary care as the foundation of the health care system who can act as leaders and key informants for quality improvement. Building on the quality improvement work the primary care sector has been leading in access and chronic disease in the past few years, HQO is engaging its primary care partners including family health teams to achieve a coordinated provincial program of action. Through the Advanced Access & Chronic Disease and bestPATH programs, HQO is focused on working with its primary care partners to optimize primary care service delivery through improvements in areas such as accessibility, continuity of care, and chronic disease management. The Advanced Access & Chronic Disease program works with primary care providers (including Family Health Teams) and their teams on a model that removes unnecessary waits and delays for patients, thereby improving access to primary care. As of September 2012, the program also includes chronic disease management which builds a foundation for the bestPATH program. bestPATH will build on the successes of Advanced Access and Chronic Disease and focus the healthcare

system on optimizing the care it delivers to Ontarians with chronic diseases. Individuals with one or more conditions such as diabetes, congestive heart failure, coronary artery disease, stroke, and chronic obstructive pulmonary disease have complex care needs. Ensuring smooth transitions across the continuum of care is critical to managing these conditions and ensuring that people consistently receive the treatments that are scientifically proven to benefit them.

Presenters:

- Trish O'Brien, Health Quality Ontario

C+D(10) - 26: How Can Family Health Teams Promote The Health Of People With Developmental Disabilities?: Practical Steps That Teams Can Implement And Extend To Other Special Populations

Length of presentation: 1hour 30minutes

Theme: 10 - Meeting needs of special populations

Abstract: There are an estimated 65,000 adults (ages 18 to 65 years old) in Ontario with a developmental disabilities (DD) and include people with Down syndrome, Fetal Alcohol Spectrum Disorder and Autism Spectrum Disorder. Their health needs are complex since they experience co-morbidity, have difficulty communicating symptoms and advocating for care, and often lack necessary supports and resources. This workshop focuses on strategies to address these clinical and systemic challenges by Family Health Teams (FHTs). Research has shown that comprehensive health assessments of people with DD improves illness detection and health promotion. In Ontario, however, recent studies indicate that only 20% of adults with DD have received a comprehensive health assessment over a 2 year interval. Increasing this rate is a target that FHTs, with their interdisciplinary approach to disease management and focus on health promotion, can help to achieve. It would be a measurable indicator of the quality of primary care not only for this special population but more generally. Through discussion of cases, workshop participants will explore the point-of-care use of a Preventive Care Checklist adapted to the particular health needs of people with DD, how a FHT can promote its use, and practical ways to make the application of this Checklist, the adapted Cumulative Patient Profile and related tools, efficient and effective, such as their incorporation into electronic medical records.

Presenters:

- William F. Sullivan; MD, CCFP, PhD, Family Physician; Surrey Place Centre, St. Michael's Hospital
- Ian Casson; MD, MSc., FCFP; Program Director, Developmental Disabilities, Department of Family Medicine, Queen's University
- Angela Gonzales; RN, MN, Advanced Practice Nurse, Health Care Facilitator, Toronto Network of Specialize Care; Surrey Place Centre,

C+D(11) - 38: Strengthening Team, Improving Care

Length of presentation: 1hour 30minutes

Theme: 11 - Strengthening the FHT team

Abstract: Well-intentioned quality improvement initiatives are often less effective than expected. This is often because efforts have focused on improving one component part or process in isolation from its intricate connection to others. Family Health Teams can be viewed as complex adaptive systems made up of agents – people (professionals and patients) – that are diverse and interact in non-linear ways. Collaborate with a colleague and/or patient one day and get a specific outcome, repeat the process again without changing anything and get a very different outcome. (Consider in particular patients with diabetes, mental illness, chronic pain for examples in your own experience.) Why? Because the

individual people in the system have the freedom to act in ways that are unpredictable, and their actions change the context for others. Rather than working on taking away that freedom through the traditional "command-and-control" hierarchy, we focus on embracing and working with it, enabling a more resilient system. By using a lens that not only recognizes the importance of understanding the individual parts but focuses on the relationships between the parts, the result is systems that can better deal with, and thrive in times of change and finite resources. This interactive workshop – led by a Mental Health Counsellor and Physician – will focus on practical tools to help build strong relationships within your teams and therefore with your patients to improve individual, team and patient outcomes. Our focus will be on chronic disease management and building productive interactions and relationships.

Presenters:

- Callum Anderson; Mental Health Counsellor; Sherbourne Family Health Team
- Jamie Read; Physician; Sherbourne Family Health Team

Concurrent Session D - 2:50 – 3:35 PM

D(1) – 8+9:

Length of presentation: 20 minutes each
Theme: 1 - Improving the patient's experience of care

1. Holistic Palliative And Wellness Support For The Whole Family

Abstract: This presentation will describe an effective collaboration at the Upper Grand FHT between the palliative nurse, social worker/counselor, and physicians/NPs in providing a unique, holistic continuum of care. We will address the timing of the intervention and how the program optimizes the care and well-being of the both the patient and the family members. From the patient and family viewpoint, key elements of the program include constant and familiar team members for in-home assessment, pain and symptom management, system navigation, end-of-life planning, legacy work, grief counseling, and ongoing support of family members post death. From the FHT viewpoint, key benefits include fast, reliable communication among team members, collaboration with the MD/NP regarding the patient's evolving status, the need for resources and referrals, and preventative interventions with family members. This collaborative program provides an effective model for holistic, palliative and wellness support for the whole family in the rural community

Presenters:

- Shelley Lillie; Palliative RN; Upper Grand FHT
- Andrea Hall; Social Worker/Mental Health Therapist; Upper Grand FHT

2. Gaps & Patient Perspectives On The Organization Of Health Services For Post-Gestational Diabetes

Abstract: Objectives: To gather information on the thoughts and ideas of women with a previous GDM diagnosis on the organization and structure of T2DM prevention services. This qualitative study was undertaken as part of a larger project.
Methods: Women with a previous diagnosis of GDM were identified from medical records. A total of 30 patients met the criteria and were invited to participate by mail, 10 women accepted. A single 60 minute focus group of 10 participants was facilitated with a professional moderator. Five predetermined questions were constructed using the Ottawa Model of Research Use, to identify perceived gaps and

barriers in postpartum care. The session was audio taped, transcribed and opinions thematically analyzed.
Results: Participants' responses revealed themes on the organization of health services: receipt of conflicting messages; the challenge of competing priorities; apprehension about the post partum diabetes test; lack of ongoing moral support; difficulty applying knowledge to sustain behaviour change. Identified needs included: a child-friendly environment and additional skill based resources. They recommended merging community and health services with follow-up testing; and restructuring of services as a group support format. The participants recognized that any format could be effective provided it was more accessible, and felt face-to-face contact was important.
Implications & conclusions: Future development of services should engage community resources in the planning, development and implementation. The format of the services offered is key. Women with young children require care that is child friendly, flexible and optimizes the use of their limited time to support their own behaviour change and long-term health.

Presenters:

- Amy Waugh; RD CDE; Upper Grand FHT
- Trina Fitter; RD CDE; Groves Memorial Community Hospital

D(2) - 57: Breaking Down Barriers - How Two Organizations Joined Forces To Improve The Mental Health Needs Of Rural Youth

Length of presentation: 45 minutes
Theme: 2 - System integration: building the team beyond the FHT

Abstract: It is well known that the area of children's mental health is one that is both challenging and complex. And for youth living in a rural community, it is also an area where resources are limited and funding is scarce. However, for the small community of Listowel, these challenges have been met full force by the joining of two organizations, united to help significantly improve mental health services for children and youth in this rural setting. Since June 2009, the North Perth Family Health Team along with the Huron Perth Centre for Children and Youth have worked together to form a unique relationship that focuses on providing the best mental health services to the most amount of children. Through this collaboration, wait times have been drastically reduced, access and knowledge of mental health services for children have been well established, and the community has witnessed how two organizations, funded by separate ministries, can work together towards a common cause – helping to improve the mental health of our children and youth.

Presenters:

- Gabrielle Hershey; Social Worker MSW, RSW; North Perth Family Health Team
- Brenda Dumond-Novotny; BA(Hons.), BSW, MSW, RSW; Huron Perth Centre for Children and Youth

D(3) – 73+74+75: Improving Primary Health Care Data and Information

Length of presentation: 45 minutes
Theme: 3 - Getting data and using it to improve care

Abstract: The Canadian Institute for Health Information (CIHI) is leading several initiatives to improve primary health care (PHC) data and information across Canada. We are working with multiple stakeholders to strengthen and improve the PHC data available to clinicians and health system decision-makers. Our focus is on helping our stakeholders in their efforts to measure, manage and improve PHC by delivering standards, data, insight and knowledge. This program of work includes both data and information solutions. We are guided by four strategic directions: • To be a PHC data and

information standards leader; • To be a source of comprehensive, high-quality pan-Canadian PHC data; • To make high-quality PHC data accessible to health system stakeholders, including clinicians; and • To deliver insight and knowledge that drives quality and health system improvements in collaboration with our stakeholders. In this session, delegates will learn about: • the pan-Canadian PHC indicator update project; • the standard PHC survey development underway; • Ontario adoption of the PHC EMR content standard; • Family Health Team recruitment and progress made in the national PHC Voluntary Reporting System – a voluntary EMR reporting system that is emerging as an important EMR data source; • and the Ontario Primary Care Performance Measurement Summit – an invitational leadership meeting with key primary care data partners and information users in Ontario. The goal of which is to reach agreement on priority measures of primary care performance at the practice, organization, community, regional and provincial levels.

Presenters:

- Patricia Sullivan-Taylor; Program Manager; Canadian Institute for Health Information
- Brenda Tipper; Senior Program Consultant; Canadian Institute for Health Information

D(4) - 51: E Bridging The Gaps In Patient Care

Length of presentation: 45 minutes

Theme: 4 - Leveraging technology to improve quality and efficiency of care

Abstract: The Wise Elephant Family Health Team has developed an innovative solution to addressing the gaps in the health care system as our patients navigate through it. Using a secure IT platform, a e referral system has been developed with workflows bringing accountability to all members of the health care team. The patient is also brought into the circle of care thereby empowering them and enriching their self management skills

Presenters:

- Sanjeev Goel; Lead Physician; Wise Elephant FHT
- Jaipaul Massey-Singh; ED; Wise Elephant FHT

D(6) - 157: The Barrie Situation – Accelerating The Evolution Of A Primary Care Hub By Engaging Clinical Providers, Support Staff, System And Community Partners

Length of presentation: 45 minutes

Theme: 6 - Strengthening FHT leadership and governance

Abstract: The Barrie and Community Family Health Team continues to evolve on many levels to create a primary care hub. “Drivers” of the Evolution;

1) Change has been clinically driven
2) Inclusive – maximum inclusion in all processes of elements or sectors involved
3) Communication / Communication / Communication

Outcomes of the Evolution;

1) The FHT is now perfectly situated to be the hub for health care in our Community
2) Quality Improvement Opportunities
3) Breaking down the walls of healthcare silos
4) Leveraging the strengths of Primary Health Care to deliver “Excellent Centre for All”

To demonstrate the steps of this evolution as well as the challenges and obstacles the presentation will highlight the Barrie IT Project and some clinical programs.

Presenters:

- Brent Elsey; MD; Barrie and Community Family Health Team
- Michael Feraday; Executive Director; Barrie and Community Family Health Team

D(9) - 132: The Ottawa Model For Smoking Cessation In Action At Kingston FHT

Length of presentation: 45 minutes

Theme: 9 - Best practices in health promotion and chronic care

Abstract: Background: Kingston Family Health Team (KFHT) was the first primary care organization in the South East Local Health Integration Network to adopt the Ottawa Model for Smoking Cessation (OMSC). The presentation will highlight the successes as well as the challenges faced in supporting patients to quit smoking. Methods: One of the key concepts of the OMSC is engaging all staff from front-line receptionists to physicians by providing them with individual roles and responsibilities. To be able to provide this level of system wide support to patients in a familiar, trusted and accessible environment is invaluable. Results: At the end of 60 days, 22% of the patients were smoke free compared to the national average of 4-7%. Conclusion: The Ottawa Model has been successfully integrated into a moderately sized team practice spread over multiple sites and has resulted in an enhanced, consistent, non-judgmental approach to identifying smokers to become non-smokers. The next step is to engage the 78% that did not make it. The KFHT is collaborating with colleagues from the Ottawa Model to develop Phase 2 which would address the psychological and lifestyle components of nicotine addiction.

Presenters:

- Colleen Webster; Physician Champion OMSC; Kingston Family Health Team
- Vince Martin; MSW Clinical Lead OMSC; Kingston Family Health Team
- Chris Harris; RN; Kingston Family Health Team

D(9) - 147: Implementing The Healthesteps Program For Healthy Living In Family Health Teams

Length of presentation: 45 minutes

Theme: 9 - Best practices in health promotion and chronic care

Abstract: Chronic diseases are the major cause of death and disability worldwide. Physical activity and other healthy lifestyle changes are important components to primary and secondary prevention of many chronic diseases. Primary care represents the ideal venue to initiate patient behaviour change, but there are many challenges, including physician comfort prescribing exercise and time constraints. Following a brief review of the literature indicating the importance of behaviour change counselling in primary care, this session will discuss findings from knowledge translation activities implementing group behaviour counselling sessions run by allied health professionals in a family health team setting. The overall aim of the Healthesteps program is to facilitate the modification and sustainment of health behaviours to promote a healthy and active lifestyle for the long term. Patients participate in the program, which utilizes the Step Test and Exercise Prescription (STEP™) tool to evaluate fitness and prescribe exercise. Allied health professionals are trained as coaches to facilitate small group discussions aimed to set lifestyle-related goals. As a part of the program, patients monitor their weight, body mass index and blood pressure. To date, Healthesteps has been successfully implemented in two family health teams and is in the planning stages at a number of others. This workshop will provide practical information and discuss facilitators and barriers to implementation in practice.

Presenters:

- Melanie Stuckey; MSc; Western University
- Sheila Cook; Knowledge Broker; InFacilitation
- Katie Mairs; Knowledge Broker; Lawson Health Research Institute

- Robert Petrella; MD, PhD, FCFP, FACSM; Lawson Health Research Institute

D+E(7) - 103: Mindfulness Cognitive Therapy In Primary Care: Adapting A Group Based Model To Address The Diverse Mental Health Needs Of An Inner City Population

Length of presentation: 1hour 30minutes

Theme: 7 - Improving care for people living with mental health challenges

Abstract: Mindfulness and Cognitive Behavioral group therapies are recognized as interventions that help patients relieve distress related to both physical and mental health problems. The original Mindfulness Based Stress Reduction (MBSR) group model that was developed at the Massachusetts Medical Centre was designed for a diverse primary care population with no focus on a particular disorder and was based on a health promotion model that teaches patients skills of managing their own health care needs. This presentation will address the rationale for adapting an 8 week Mindfulness-Based Cognitive Therapy (MBCT) group for an inner city, community family medicine program. As well, the presentation will focus on the results of a study that measured the group's effectiveness, to reduce psychological distress, and strengthen self-esteem, resilience and general well being for individuals diagnosed with a chronic illness and/or other health challenges. Results of the study indicate that most of the study participants were female and were living with a range of illness experiences, such as diabetes and arthritis. Approximately, 25% were born outside of Canada and were also coping with stressful life circumstances, such as unemployment, financial strain and grief. At post-intervention, the intervention group (n = 28) demonstrated a significant improvement on standardized measures of well-being, depression, stress and anxiety which were sustained at four-week post treatment. This presentation will include an introduction to some of the mindfulness interventions that are included in the group and an interactive discussion on considerations for implementing MBCT groups in Family Health Teams, including adaptations for different populations and training of facilitators.

Presenters:

- Rachael Frankford; MSW, RSW; St. Michael's Hospital
- Elizabeth McCay; RN, Ph.D., Associate Profession, Research Chair in Urban Health; Daphne Cockwell School of Nursing, Ryerson University

Concurrent Session E - 3:45 – 4:30 PM

E(2) - 56: An Examination Of Specialists Within Fhts In The Greater Toronto Area

Length of presentation: 45 minutes

Theme: 2 - System integration: building the team beyond the FHT

Abstract: As the primary care system in Ontario continues its movement towards increasing the delivery of highly integrated interprofessional care, some Family Health Teams (FHTs) have incorporated specialists as team members. The purpose of this workshop is to describe what is currently happening across the Greater Toronto Area (GTA) with respect to specialist-within-Family-Health-Team (FHT) models of care. The presenters will review the results of a survey that explores the extent of specialist-within-FHT models existing in the GTA, how current models are set up, the perceived benefits and drawbacks of these models, remuneration aspects and lessons learned that could be informative for the development of prospective partnerships. Time will be left for participants to discuss their own experiences with specialist involvement and learn from one another to explore the benefits and challenges of specialist-FHT collaborations.

Presenters:

- Karen Ng; MD, FRCPC; Mount Sinai Hospital
- Michelle Naimer; MD, CCFP, MHSc; Mount Sinai Academic Family Health Team
- Samir Sinha; MD, DPhil, FRCPC; Mount Sinai Hospital

E(3) - 68: Making It Work: Strategies For Improving Data Discipline In Your FHT

Length of presentation: 45 minutes

Theme: 3 - Getting data and using it to improve care

Abstract: Electronic data, when it is done well, can be incredibly beneficial to your practice – at the administrative level, it can assist with program development or compiling required reports, and at the clinical level, it can help to identify patients who are missing preventative screening tests, behind on their diabetes care, or those who are at risk of certain conditions. The challenge, however, is doing it well – getting a large and busy team to put data in the right spot, every time, is not easy. At the Queen's Family Health Team, we developed several strategies to help improve our data discipline, including re-designed office processes, novel EMR tools, improved communication methods, integration of various external reports (e.g. the Baseline Diabetes Data Initiative and the Canadian Primary Care Sentinel Surveillance Network), and staff engagement and training. Our approach was guided by two principles: "share the load" (i.e. train and empower all appropriate providers/staff members to help with improving the quality of our data) and "keep it simple" (i.e. if it adds work or if it's complicated, they won't do it!). Over the past year and a half, this approach has allowed us to extract reliable data from our EMR that has had a real and tangible impact on patient care - for example, we have increased our flu shots, paps, and mammograms by approximately 16% each and our childhood vaccines by 40%. This session will look at how you can use data to improve your practice, how you can get started with improving your data discipline, and how to engage your team.

Presenters:

- Karen Hall Barber; BSc (Hons), MD, CCFP; Queen's Family Health Team
- Danyal Martin; BAH, BEd, MA; Queen's Family Health Team
- David Barber; BSc, MD, CCFP; Queen's Family Health Team

E(4) - 78: Benefits Of EMR: Using Your System To Optimize The Management Of Chronic Disease

Length of presentation: 45 minutes

Theme: 4 - Leveraging technology to improve quality and efficiency of care

Abstract: Objectives: • develop a process to better manage chronic diseases in an EMR environment • understand the concept of continuous quality improvement/PDSA cycles using an EMR • ensuring your EMR system is set up to remind and alert you of outliers on your patient panel

Synopsis: Your EMR is a tool to vastly improve outcomes in Chronic Disease Management and care. EMR has all the tools to efficiently, record patient data, search for desired parameters easily, sort patients found, perform measurements, target specific outcomes, recheck and monitor performance over time and maximize revenue streams. This session will show you how your EMR can help work with a patient panel and create an office PDSA philosophy using your system so that CQI becomes habit!

Presenters:

- Darren Larsen; Senior Physician Peer Leader; OntarioMD

E(5) - 90: Implementation Of The Asthma Action Plan To Improve Asthma Control, Quality Of Life And Reduce Hospital Visits

Length of presentation: 45 minutes

Theme: 5 - The Triple Aim in FHTs – better care, better health, better value

Abstract: Guelph FHT and Primary Care Nurse Clinician (PCNC) are implementing Asthma Action Plans for asthmatic patients within the FHT. Purpose: To address a substantial knowledge deficit surrounding patients understanding of the disease and their ability to effectively control symptoms and prevent hospital visits. Method: The Asthma Action Plan is used to group all relevant information into one location for easy access. The action plan includes criteria in a color coded chart format; green (controlled), yellow (uncontrolled) or red (out of control) to help guide assessment and establishing patient status at each visit. The chart also allows for a predetermined adjustment in medication to ensure adequate control at all times. Goals are listed in the plan to encourage patient self-management. Possible triggers are identified to increase awareness of confounding factors affecting individual control such as known triggers. Spirometry testing is used to establish baseline function and to ensure adequate control with least amount of medication. In addition to the Action Plan, the PCNC provides individualized patient education on topics that include physiology of asthma; pharmacological treatments and mechanisms of actions. Key topical areas covered include Medication use and adherence, proper inhalation technique and preventing lung infections. Results: The goal is to improve asthma related doctor and hospital visits as well as patient quality of life. The PCNC is able to follow up with the patient and provide a contact within their doctor's office to ensure adequate control throughout the calendar year, regardless of trigger exposure. In addition, the established criteria are used to help clarify and guide the patient to seek prompt medical attention.

Presenters:

- Erin Sevigny; BScN, BSc Kin; Guelph Family Health Team

E(6) - 158: Clarity And Conflict In Governance Roles: Strengthening Leadership And Accountability

Length of presentation: 45 minutes

Theme: 6 - Strengthening FHT leadership and governance

Abstract: Markham FHT provides a real-life case study of an organization that has successfully grappled with development of its governance, leadership and organization culture. Building on their experience, experts in law and governance, will draw key points for governance and leadership in all three types of FHTs – physician-led, community-led and mixed governance models. The session's purpose is to:

- create greater clarity among the different roles – board, board chair, board committees, executive director, lead physician
- identify core competencies required in each of these roles
- identify areas where conflict of interest may arise and ways to manage that conflict

Presenters:

- Dr. Allan Grill is a physician and Vice-Chair of the Board of the Markham FHT
- Ms. Karima Kanani is a lawyer in the Health Industry Group at Miller Thomson LLP
- Ms. Melodie Zarzeczny is a specialist in not-for-profit governance with the Osborne Group

E(9) - 130: Get FHT – A Healthy Lifestyles Program

Length of presentation: 45 minutes

Theme: 9 - Best practices in health promotion and chronic care

Abstract: Get FHT is a healthy lifestyles program developed by the Guelph Family Health Team for those with metabolic syndrome. The aim of the program is to decrease the risk of diabetes and heart disease by improving blood pressure, glycemic control, cholesterol levels and decreasing waist circumference values through lifestyle modification. The program is based on a collaborative approach between the patient and the family health team, which consists of the family doctor or nurse practitioner, registered nurse, dietitian and exercise specialist. Counselling and pharmacy support are also available if needed. This oral presentation will highlight our program structure, format and outcome results.

Presenters:

- Carolyn Fritzley; RD, CDE / Registered Dietitian; Diabetes Care Guelph, Guelph Family Health Team
- Sarah Micks; BScN RN CDE / Registered Nurse; Diabetes Care Guelph, Guelph Family Health Team
- Hilary Davidson; BSc CKin; Diabetes Care Guelph, Guelph Family Health Team

E(9) – 136+141:

Length of presentation: 20 minutes

Theme: 9 - Best practices in health promotion and chronic care

1. Interprofessional Clinical Program Development For A Network Of FHTs

Abstract: To promote evidence-based interprofessional care among FHTs, this project aimed to develop and test a series of protocols to enhance and support the provision of team based care across 6 topic areas. Topics were selected to represent a range of conditions and included: depression, diabetes, end of life, 18-month visit, complex diabetes and childhood obesity. For each topic area, interprofessional practice approaches, tools and information resources were developed and pilot tested to support teams in the delivery of optimal care. The project was directed by the fourteen organizations which comprise the Academic Family Health Team (AFHT) Forum at the Department of Family and Community Medicine, University of Toronto, and was managed by the Centre for Effective Practice (CEP). Materials developed to support teams are freely available to support FHTs across Ontario. Strategies for protocol and tool development and implementation will be discussed across all topic areas with a focus on diabetes and childhood obesity.

Presenters:

- Jess Rogers; BA; Centre for Effective Practice
- David Kaplan; MSc, MD, CCFP; North York Family Health Team

2. Building On Existing Tools To Improve Chronic Disease Prevention And Screening: Results Of The BETTER Trial

Abstract: The BETTER Project was a pragmatic cluster randomized controlled trial of a multifaceted and integrated approach to delivering chronic disease prevention and screening (CDPS) maneuvers across numerous conditions within primary care. It was conducted in 8 primary care teams (PCT): 4 Family Health Teams (FHTs) in Toronto 4 Family Practices affiliated with Primary Care Networks (PCNs) in Edmonton. Four family physicians (FPs) from each PCT were involved resulting in a total of 32 FPs. There were 2 interventions: 1) practice-level involving a Practice Facilitator (PF) and 2) patient-level involving a Prevention Practitioner (PP). FPs were randomly assigned to receive: 1) PF only, 2) PP only, 3) PP and PF, or 4) control. The primary outcome measure was a composite score defined as the proportion of CDPS maneuvers for which a participant was eligible at baseline that had been met at follow-up. In total, 789 participants were enrolled, 12 discontinued and 777 analyzed. The primary outcome showed that

control participants accomplished 21% of eligible maneuvers, compared to 28% in the PF arm (p=0.09), 54% in the PP arm and 58% in the PP and PF arm (p<0.0001). The uniqueness of the BETTER Project and its implications will be discussed as they relate to FHTs planning CDPS programs within their practices. A PP from a FHT will review the integrated approach to CDPS used in BETTER and the tools developed to optimize CDPS. A Physician Lead from a participating FHT will review the impact of a PP and its potential resource implications.

Presenters:

- James Pencharz; MD, MSc, CCFP; Credit Valley Family Health Team
- Eva Grunfeld; MD; University of Toronto
- Donna Manca; MD; University of Alberta
- Rebekah Barrett; RD; Taddle Creek Family Health Team
- Rahim Moineddin; PhD; University of Toronto
- Denise Campbell-Scherer; MD; University of Edmonton
- Lisa Patterson; BETTER Trial Investigators

E(9) – 139: Taking Steps Forward: A Pilot Using Small Group Visits for Foot Care Education

Length of presentation: 45 minutes

Theme: 9 - Best practices in health promotion and chronic care

Abstract: Background: Based on the work of a LHIN-wide foot care working group, gaps in programming for individuals with Diabetes to learn more about self-care related to feet were identified. A collaboration between two FHTs, Diabetes Regional Coordination Center and the Southern Ontario Aboriginal Diabetes Initiative resulted in a pilot project for foot care education using a group visit model. Literature Review: A review of the literature identified only two studies that evaluated the value of this type of initiative. The results were positive demonstrating significant impact on smaller group knowledge scores for foot care. The was also an upcoming curriculum using the conversation maps for footcare education, so the decision was made to utilize this tool. Methods: Three pilot sites were used to roll-out the program. Evaluation involved participant responses at three time periods. T1 was a pre-questionnaire , T2 was a post questionnaire and T3 was administered at a site-convenient time three to six months after the education at a routine follow-up. Measures included knowledge, confidence and conviction scales. Results: Preliminary results show positive impacts at T2 on all measures, confidence being the greatest change from an average of 7.7(T1) to that of 9.1(T2). In addition, providers have identified client-specific clinical needs that were dealt with to the satisfaction of the careprovider and the patient. Conclusions: Delivering foot care education using small groups and conversation maps is an effective way to empower patients and enhance their knowledge . Plans are under way to roll this initiative across our LHIN.

Presenters:

- Elenore Wormald; Chronic Disease Management Program Clinical Coordinator; Niagara Medical Group Family Health Team
- Lindsey Cosh; Foot Care Coordinator; Southern Ontario Aboriginal Diabetes Initiative
- April Vanyo; Diabetes Nurse Educator; Garden City Family Health Team
- Bo Fusek; Diabetes Clinical Nurse Specialist; Diabetes Regional Coordination Center, HNHB LHIN

E(9) - 143: Using A QI Model To Develop A Diabetes Program

Length of presentation: 45 minutes

Theme: 9 - Best practices in health promotion and chronic care

Abstract: The Health for All FHT implemented an inter-professional team to develop their Diabetes program using a QI model . Over the past year, the team has worked through the PDSA cycles of improvement to establish a patient centred approach to Diabetes care within the FHT and to meet the needs of their growing population of patients. The team looked at ways to organize and structure clinical management to improve the quality of care, assess patients' diabetes and improve their ability to reach defined targets and also to support better care through improved self-management and patient education. Using the PDSA cycles to build the program, the team focused on the creation and maintenance of a valid database of diabetic patients that uses standardized language within the EMR, the management of their diabetes patients, including their process and outcome measures, by creating, testing and promoting their own EMR Diabetes Management Flow Sheet, and the promotion of self management by offering diabetes information resources and patient group education within their unit. The project team members were provided with education in basic quality improvement language and concepts to assist them through the stages of program development. The presentation will share the implementation stages to build a program using a QI model, including strategies for change, measurement of improvement, effects of change and lessons learned. It will also include all of the interprofessional team members (Physician Lead, Administrative Lead, Dietitian, Family Practice Nurse, and Program Administrator) as presenters and each will have an opportunity to share their roles within the program team.

Presenters:

- John Maxted; MD MBA CCFP FCFP Assistant Professor DFCM, Markham Family Medicine Teaching Unit; Health for All Family Health Team
- Jodi Heard; Administrative Lead; Health for All Family Health Team
- Sergio Rotondi; Program Administrator; Health for All Family Health Team
- Brenda Wilson; Family Practice Nurse; Health for All Family Health Team
- Alison Cox; Registered Dietitian, Certified Diabetes Educator; Health for All Family Health Team

E(9) – 145+146:

Length of presentation: 20 minutes each
Theme: 9 - Best practices in health promotion and chronic care

1. How Often In Your Day Are You Talking With Your Patients About Managing Hypertension Or Dyslipidemia?

Abstract: Many clinicians in family practice spend a large amount of their day educating patients on the strategies to improve hypertension and dyslipidemia, two of the most frequent reported reasons for a primary care visit. If you often hear yourself saying the same thing over and over again throughout your day and wish there was a way to manage this population more efficiently, a group medical visit approach may be your answer. Group or shared medical visits are turning out to be an efficient and effective strategy to provide education, social support, and medical management within a short period of time to patients with similar health issues. Our team including a physician, nurse and dietitian decided to redesign how we manage care for patients with dyslipidemia and hypertension in the office with the use of disease registries and planned office visits focusing on reducing cardiovascular risk. Our Cardiovascular Risk Reduction Group was born! This two hour co-facilitated session offered once a month focuses on improving self care and provides an opportunity for patients to connect with their team, share concerns and questions, obtain their latest lab and blood pressure results while updating their knowledge of nutrition and medications in a group setting. We'll share benefits and challenges of a planned group initiative, tips to get started and lessons learned.

Presenters:

- Michele MacDonald Werstuck; RD MSC CDE Dietitian and Diabetes Educator; Hamilton Family Health Team
- Tara Currie; RN CDE Nurse and Diabetes Educator; Hamilton Family Health Team
- Bruno DiPaolo; Family Physician; Hamilton Family Health Team

2. Humour And FOBT: Taking The Fear Out Of Cancer Screening For The Under And Never Screened

Abstract: Purpose: Colon cancer screening rates are lower than targeted in Ontario. Further investigation indicated that a large proportion of the under and never screened population is illiterate and that the written fecal occult blood test (FOBT) instructions are too complex and wordy for illiterate, low literacy, and English as a second language populations. Our purpose was to develop a humourous FOBT instructional video to overcome this barrier. Methods: The Ontario FOBT written instructions were used as the basis for the instructional video script. Artist sketches and group consensus was used to develop an appropriate character. An iterative process with focus group feedback was used to work towards a final video. Results: Various versions of the video were tested on the regional under/never screened project teams (physicians, nurses, outreach workers), rural community members (n=7 groups), small town (n=4), and suburban community members (n=2 groups). Men had a strong and uniformly positive reaction to the video, requesting that it be on TV and stating that it was “superbowl brilliant”. Women’s reactions ranged from reserved positive to strongly positive. All felt confident and optimistic about performing the test after watching the video. Family health team clinicians indicated they wanted the animation on loop in their clinic waiting areas. Conclusions: Providing an uncomplicated, humourous instructional video can increase awareness of cancer screening, alleviate test fear, increase confidence in performing test, and change attitudes towards screening.

Presenters:

- Dionne Gesink; Assistant Professor; University of Toronto

E(10) – 22+23:

Length of presentation: 20 minutes
Theme: 10 - Meeting needs of special populations

1. Introduction To Traditional Healing Practitioners/Knowledge And Methods: Working With The Aboriginal Patient

Abstract: Traditional Healing Practitioners possess a holistic view of illness and how to treat it. Physical, spiritual, emotional and mental conditions are equally important in the healing process. Wellness means being in a state of balance with oneself, family, community, and the larger environment. Culture and spirituality are the frameworks of treatment developed by Aboriginal communities and both community and family have a key role in helping individuals regain their sense of balance. Traditional Healing Practitioners have formally become a part of this relationship; use of natural medicines/herbs, song and dance, prayer and sacred healing ceremonies (sweats, fasting, healing circles, etc) are used to help address the physical, spiritual, emotional and mental health issues in individuals. We would like to share an introduction of information with Health Care Professionals who are new to working with Aboriginal Patients that access Traditional Healing Practitioners along side Western Medicine.

Presenters:

- Annelind Wakegijig; Lead Physician; Baawaating Family Health Team

- Elizabeth Edgar-Webkamigad; Manager; Baawaating Family Health Team

2. The Rural Geriatric Glue

Abstract: Our health care system exists in "silos" of functions and services carefully marking out turfs. Patient safety, quality of experience, and consistent positive clinical outcomes will remain challenged in this fragmented system. Communication between the various system segments is often poor and creates confusion leading to mistakes and threatens consistency of care, especially for the most complex and vulnerable – our seniors. The North Perth Family Health Team, Listowel, Ontario serving a population of approximately 17,000 has created a model to support seniors and families with navigation and transition from sector to sector. A Nurse Practitioner, with specialized geriatric education, works closely with primary care physicians, consulting geriatrician, hospital, community agencies, and retirement homes by providing assessments where the senior is located. Regular visits are made to the local retirement homes every two weeks, the hospital weekly, a geriatric clinic with the consulting geriatrician monthly, and office and home visits as needed. Education is provided concurrently with these services, as part of chronic disease management. The patients' electronic health record can be accessed in all of these settings to ensure that information is not duplicated and that documentation and communication can occur efficiently. This model of providing Complex Geriatric Care can be easily replicated in small Rural communities for enhanced efficiencies and concerted patient care.

Presenters:

- Wendy Dunn; NP - Adult (Geriatrics); North Perth Family Health Team

Day 2 – Wednesday, October 17, 2012

Concurrent Session F - 8:45 – 9:30 AM

F(2) - 62: Supporting the Patient with Complex Needs - Working Collaboratively with our Partners to Improve the Patient Experience

Length of presentation: 45 minutes
Theme: 2 - System integration: building the team beyond the FHT

Abstract: Many older adults with complex health needs in the East York area of Toronto are regularly re-admitted to the Toronto East General Hospital (TEGH) at a higher rate than average for Toronto. To better serve the needs of this complex patient population, a virtual ward (VW) was embedded in the South East Toronto Family Health Team (SETFHT), an academic FHT located across the road from the community hospital. The goal is to improve continuity of care and reduce rates of emergency department visits and hospital readmissions for patients over 65 who, at the time of discharge, are deemed high risk for readmission. SETFHT includes physicians who can accept new patients, so the VW service is available for unattached/orphan patients as well as for our own patients and is supported through an interprofessional team and Telehomecare equipment. With a focus on a team-based approach to care for patients with complex needs, the VW is managed by a physician assistant and supported by an interprofessional team that includes physicians, nurse practitioner, nurses, care navigator, pharmacist and internal medicine specialist, along with other care providers as needed. With a focus on increasing capacity in primary care and ensuring seamless communication, a case management approach has been taken and the team also includes bi-weekly case conferences with a CCAC case coordinator. For these very complex clients, the care coordinator engages more intensely with the primary care physician with a goal to develop an integrated, shared care plan for support. This has included joint home visits through our new Integrated Care for the Homebound Senior program - a member of SETFHT may do a home visit of a homebound, complex patient that includes CCAC as well as our new partners, community paramedics from EMS. Our partnership has also informed the TC CCAC in its ongoing learnings from the Integrated Client Care Model for Older Adults with Complex Needs that has helped to inform the organization's strategy for primary care integration. Our work is focused on wrap around care in the community to prevent all unnecessary admissions to acute care. However, when admissions are necessary, we have focused on planned admissions and supportive transition – supporting the reduction of ed/alc through a integration lens. This is done by building the team beyond the FHT and improving the patient experience.

Presenters:

- Thuy-Nga (Tia) Pham; Lead Physician; South East Toronto Family Health Team
- Jodeme Goldhar; Lead, Health System Integration for Complex Populations and Primary Care; Toronto Central CCAC
- Stephanie Saunders, Care Coordinator, Toronto Central CCAC
- John Klitch, Superintendent, Toronto Emergency Medical Services

F(3) - 69: The "Dragon Boat Approach": How We Standardized Our Data And Processes Across The FHT To Improve Care

Length of presentation: 45 minutes
Theme: 3 - Getting data and using it to improve care

Abstract: "Teamwork is everything in Dragon Boat Racing. Synchronicity is more important than strength. A perfectly synchronized team will almost always beat a stronger, but less coordinated team." NYFHT has faced significant challenges to promoting a common, coordinated approach to care: we have 17 different office locations, 65 physicians, 32 AHPs and two different EMRs with data in 6 different servers. In order to address the informational aspects of this challenge, we formed the Information Management – Information Technology committee, "IM – IT". The tasks of the committee are to:

- Review FHT policies and procedures regarding IM – IT
- Assess IM – IT needs and gaps
- Recommend, support and implement Standardization of IM – IT process across all groups in the FHT.
- Recommend and support the development of Information Management Systems for the FHT.
- Liaise, when and where appropriate, with vendors

Successes have included standardized and agreed upon patients statuses (active, inactive, deceased, hospital, nursing home etc); standardized designations for smoking; use of coding for chronic diseases; standardized diabetes stamp/templates and flowsheets for both EMRs. The workshop will describe the steps taken to implement our "Dragon Boat Approach", including ongoing interdisciplinary EMR education, production and promotion of data manuals, use of data entry clerks, spread through opinion leaders across the organization and effective support from our Leadership. This workshop will be of interest to both small and large FHTs interested in promoting better care through improved Teamwork.

Presenters:

- Paloranta Jennifer; Diabetes Nurse Educator and Program Coordinator; North York Family Health Team
- Kimberly Wintemute; Medical Director, NYFHT; North York Family Health Team
- Jon Hunchuck; Clinical Pharmacist; North York Family Health Team
- Val Rachlis; Past Chair of the Board, NYFHT; North York Family Health Team
- Karen Rothschild; Administrator; North York Family Health Team
- Taras Rohatyn; Executive Director, NYFHT; North York Family Health Team
- Michelle Greiver; Chair, IM IT committee, NYFHT; North York Family Health Team

F(4) – 85+86: Dropbox And MI OWL: Two Computer Informatics Tools For Enhanced Practice

Length of presentation: 45 minutes

Theme: 4 - Leveraging technology to improve quality and efficiency of care

Abstract: Traditional medical practice has relied on the filing cabinet to store and retrieve paper documents that organize and enhance our practice. Important documents can run the gamut from policies, clinical program descriptions, standing orders and educational handouts. These paper documents are not always easily accessible in the patient exam rooms and not well shared among the Family Health Team (FHT) members. It is also challenging to support other FHTs with these documents. To address these challenges we present two computer informatics tools; Dropbox and MI OWL (Medical Interprofessional Open source Web-based Library), that provide two options for the electronic organizing, storing, searching, retrieving and sharing of information with patients and providers both within a FHT and beyond. These electronic solutions can be used for free and are relatively easy to employ, though both offer different strengths and functionality. Integrating such a tool within a FHT can improve quality and efficiency of care as well as strengthen the FHT team. Beyond the local impact they can improve collaboration and sharing within the larger health care system. Learning Objectives: 1. Understanding Dropbox and its use 2. Potentiating Dropbox use in the FHT, 3. Understanding MI OWL and its use 4. Potentiating MI OWL in the FHT 5. Compare and contrast Dropbox and MI OWL.

Presenters:

- Margaret Tromp; MD, CCFP, FCFP, FRRMS; Prince Edward Family Health Team
- Karen Brooks; RN, BScN, CRE, Chronic Disease Educator; Prince Edward Family Health Team
- Eliseo Orrantia; Lead Physician; Marathon Family Health Team
- Jason Newing; IT Specialist, Marathon Family Health Team

F(5) - 97: Medical Directives & Policies – How To Get Started And How They Can Support Your Quality And Patient Safety

Length of presentation: 45 minutes

Theme: 5 - The Triple Aim in FHTs – better care, better health, better value

Abstract: In January 2010, the Queen's Family Health Team found ourselves without any policies or medical directives of our own. There was a great desire amongst our staff to create them, but we weren't sure where to get started – we knew that for these to be safe, effective, and useful, we needed to have a solid structure in place that would ensure that medical directives in particular were thoroughly reviewed, researched, and vetted before they were implemented; we also knew that we needed processes to ensure that these policies and medical directives were well communicated to new and existing staff, that there was appropriate follow-up post-implementation, and that staff were appropriately trained. Our medical directives and policies have proven to be a key component of our quality and patient safety plan and an excellent way to engage our allied health professionals – they've been instrumental in terms of immunizations, diabetes care, anti-coagulation management, and asthma care. This session will provide participants with practical tips on how policies and medical directives can support your quality plan, how to get started, how to integrate this into your risk management strategy, and how to develop a solid communication and accountability structure.

Presenters:

- Karen Hall Barber; BSc (Hons), MD, CCFP; Physician Lead; Queen's Family Health Team
- Francine Janiuk; BScN RN; Clinic Coordinator Nurse; Queen's Family Health Team
- Danyal Martin; BAH, BEd, MA; Clinical Program Coordinator; Queen's Family Health Team

F(7) – 102+104:

Length of presentation: 20 minutes

Theme: 7 - Improving care for people living with mental health challenges

1. Interdisciplinary Approach To Mental Health Care

Abstract: Mental Health care in Primary Health encompasses a broad range of factors including: age, diagnoses, cultural issues, and educational and income levels. Addressing mental health issues range from management of an acute crisis to support for those living with new diagnoses or chronic conditions to function at their best. Evidence shows that patients are most satisfied with the treatment of psychosocial issues when their needs are met in the primary care setting. Traditionally, this care has been provided by the Family Physician or Nurse Practitioners with referrals to Social Work or Mental Health Therapists. Addressing the issues of this diverse population can place excessive demands on the skill level of the primary care providers, as well as use vast time resources. Referrals to community agencies can be very helpful for some patients but are not always efficient in meeting the needs of all patients, as these resources are often stretched in their capacity to provide on-going support. With the inclusion of a broader range of Allied Health Practitioners into the Primary Health Care teams, the opportunity to expand the team of care-givers to enhance provision of mental health services to

patients was identified. This presentation will focus on the issues encountered and strategies used in development of the expanded mental health team and present preliminary descriptive data to demonstrate initial outcomes for the Mental Health team. Discussion about the use of the Program Logic Model to support potential for further development of the team will be included.

Presenters:

- Irene Glavac Petric; Mental Health Therapist; McMaster Family Health Team
- Anne Childs; FHT Team Co-ordinator; McMaster Family Health Teams
- Sandy Lusk; Nurse Practitioner; McMaster Family Health Team
- Miriam Wolfson; Mental Health Therapist; McMaster Family Health Team
- Martha Bauer; Occupational Therapist; McMaster Family Health Teams
- Susan Carr; Chaplain; McMaster Family Health Teams

2. Shifting People, Practice And Perceptions: Mental Health At EMCFHT

Abstract: How to best respond to the mental health needs of a served population of 30,000 people is a challenge faced by the Etobicoke Medical Centre Family Health Team. The solution was to shift from a more traditional mental health program where a limited number of patients received ongoing 1:1 counselling, to a system navigation approach to facilitate connections and linkages not only within the FHT, but within the larger health care community and beyond. People from 10 to 90 years of age are referred to the service for reasons impacting their health and well-being; from lack of income and housing, to relationship crises, grief and loss, anxiety and depression and the management of distressing and persistent mental illness. The intention of the service is to promote health and wellness rather than perpetuate sickness, and at the outset, referred individuals are oriented to their roles as service participants rather than service recipients. Their readiness for change is explored and their strengths and resources are identified. Relationships with informal supports are fostered and connections with community programs are established. In addition to system navigation, the role of psychological services in FHT mental health has emerged with a broad scope, from detailed cognitive and diagnostic assessment to the direct in-house provision of evidence-based individual and group psychological therapies and the implementation of psychological health and wellness education initiatives. Wait time for initial consultation and service has essentially been eliminated, external community linkages and patient satisfaction have increased and turnover time has been reduced.

Presenters:

- Christine McMulkin; System Navigator; Etobicoke Medical Centre FHT

F(9) - 127: A Business Model For Integrating Community Diabetes Resources In Your Primary Care Practice

Length of presentation: 45 minutes

Theme: 9 - Best practices in health promotion and chronic care

Abstract: This presentation will provide a practical and efficient model for optimizing the Diabetes patient education and improving care management. The Shared Care Model developed by the Halton Hills FHT (HHFHT) in partnership with the Halton Diabetes Program(HDP) will demonstrate how HHFHT: - Reduced patient and provider confusion by maintaining clear linkages and improving the sharing of information; - Improved communication between diabetes educators and primary care clinicians - Provided effective support for complex cases; - Increased patient care capacity within the Family Health Team; - Enhanced knowledge and skills in diabetes management Participants will discuss - The Critical Success Factors for introducing the model; - Unanticipated concerns and benefits that emerged during the development and introduction of the model; - Considerations to be examined to determine

if this model will work in your practice Halton Hills FHT is eager to share how this program has improved the patient's experience of care and promoted the implementation of best practices by leveraging shared resources across the region. "Paperwork and scheduling processes are much smoother. Complex patients are managed more effectively!" reports Executive Director Heather McAlpine. "We hope to expand this program to include other FHT's and primary care settings as soon as we can, this is a good news story" says Nicole Fowler King, Primary Care Engagement Coordinator, Mississauga Halton Regional Coordination Centre.

Presenters:

- Nicole Fowler-King; Primary Care Engagement Coordinator; Mississauga Halton Diabetes Regional Coordination Centre
- Heather McAlpine; Executive Director; Halton Hills Family Health Team

F(9) - 148: Moving Beyond Pediatric Obesity: Putting The Focus On "Healthy Futures" To Optimize Children's Nutrition, Health And Growth

Length of presentation: 45 minutes

Theme: 9 - Best practices in health promotion and chronic care

Abstract: Two Rivers Family Health Team has developed a new and innovative program called Healthy Futures. The goal of this program is to provide education to families to help children and young people enjoy the best possible health now and into their adult lives. When we first examined how we could incorporate a program that targets pediatric obesity and children's eating habits, we identified a gap in services between the 18 month well baby visit with the physician and when children come back for immunizations when beginning school (typically at 4 or 5 years of age). This led to the development of a standardized Healthy Futures visit at 3 years of age, which focuses on growth assessment, blood pressure screening, and nutrition screening. Through use of our EMR capabilities, we search all 3 year olds in the practice on a monthly basis and book a 30 minute appointment with a nurse. We chose to use the Nutri-step screening tool during this visit, as it is a validated tool to screen for nutrition risk in 3 and 4 year-olds. In addition to administering the Nutri-step screening questionnaire, the nurses also measure height, weight, BMI-for-age, and blood pressure. Based on the results, children are classified as low, moderate or high risk and are referred to the appropriate provider. In our first year in operation, we have seen very promising results. Our short-term indicators are the Nutri-step score and physical activity level. We have seen positive changes in these indicators within 3 months of the initial visit in our moderate and high risk population. Our longer-term outcomes include BMI-for-age and blood pressure-for-height. We have been in contact with other FHTs who are struggling to develop a pediatric obesity program. We believe that a program of this nature should target all children with risk factors for chronic disease, which include screening for poor diet, and sedentary behaviour, regardless of BMI-for-age (although this can also be used as one screening tool and/or outcome measurement). Because we screen all 3 year olds, even low risk children get information and education in their initial visit. Screening all children also provides us with baseline measurements for our population, which helps us better understand our patient population. We are developing a 'Healthy Futures' toolkit with all the tools, program algorithms and logic model, custom forms, and outcome measurements, so that other FHTs will be able to start this program in their own centres. We hope that by presenting at AFHTO, we will be able to share our successes and challenges and inspire other FHTs to use our tool kit to create their own Healthy Futures program.

Presenters:

- Cara Kasdorf; RD, Nutrition Program Lead; Two Rivers Family Health Team
- Amber Anderson Lunn; RN, Health Promoter; Two Rivers Family Health Team

F(9) - 155: Opportunities and Challenges in Team-Based Chronic Pain Management

Length of presentation: 45 minutes
Theme: 9 - Best practices in health promotion and chronic care

Abstract: Patients with chronic pain have a right to be treated. Opioids can be an effective treatment for chronic non-cancer pain (CNCP) and should be considered. However, opioids are not indicated in all CNCP conditions, and medication alone is often insufficient to manage CNCP; other effective treatments should also be considered. In team-based care, there is a chance to optimize the management of chronic pain by including other members of the team to provide medication counselling, psychological counselling, cognitive behavioural therapy, support regarding treatment strategies and sources of referral to appropriate outside specialists. This session will talk about current programs and new roles/ services for this complex population.

Presenters:

- Paul Gagnon; Pharmacist; Hamilton Family Health Team
- Anne Mallin; Pharmacist; Hamilton Family Health Team
- Peet DeVilliers; Pharmacist; Maple Family Health Team
- Jennifer Lake; Pharmacist; South East Toronto Family Health Team

F(10) - 21: How The Enhanced 18-Month Well-Baby Visit Has Led To Primary Care-Public Health Partnerships

Length of presentation: 45 minutes
Theme: 10 - Meeting needs of special populations

Abstract: Ontario has introduced an enhanced visit at 18-months of age, recommending a shift in focus from a well-baby check-up to a pivotal assessment of developmental health. Implementation of the enhanced 18-month visit has led to the creation of partnerships between primary care and Public Health (PH) across the province. In many communities, PH is providing education and support to primary care practitioners about the visit. Strategies include academic detailing and secondment of a Public Health Nurse to provide 'just-in-time' learning, support, and resource creation. Data from the new OHIP fee code for the enhanced visit is also driving partnerships between PH and primary care. OHIP billing data identifies potential areas for education and initial data has suggested that children in the lowest income quintile are less likely to receive the enhanced visit. Based on this data, PH and a number of FHTs are collaborating in one community to determine the proportion of children receiving an 18-month visit using OHIP fee codes. Material and social deprivation and geographic location are being examined in relation to the provision of the 18-month visit, which can lead to targeted strategies for the visit.

Presenters:

- Kieran Moore; Associate Medical Officer of Health, Associate Professor; KFL&A Public Health, Queen's University
- Julie Gross; RN, MSc; Offord Centre for Child Studies, McMaster University

F(11) – 36+37:

Length of presentation: 20 minutes each
Theme: 11 - Strengthening the FHT team

1. Compassion Fatigue - The Cost of Caring

Abstract: Excellence in providing compassionate whole person family centered care by a team is the goal of a Family Health Team. However, there is a physical, emotional and spiritual cost to caring! This workshop will look at the key concepts of Compassion Fatigue and how it affects people involved in Family Health Teams. Participants of this workshop will learn how to assess their own Compassion Fatigue and how to use the Compassion Fatigue Test with themselves and their co-workers. Participants of this workshop will learn effective ways to deal with Compassion Fatigue and will leave with a tool kit of practical exercises to help cope with Compassion Fatigue. Participants will also learn about the concept of Compassion Satisfaction and how to identify this in their work. This workshop will help both front line staff and those in a leadership role. Learning Outcomes: 1. Participants will learn the key concepts of Compassion Fatigue. 2. Participants will learn how to assess their own Compassion Fatigue and with their fellow workers. 3. Participants will leave the workshop with a toolkit on how to assess and eliminate the effects of Compassion Fatigue plus see the benefits of Compassion Satisfaction.
Presenters:

- Eugene Dufour; Family Therapist; STAR Family Health Team

2. Remembering What Matters Most: Celebrating Life In A Family Health Team

Abstract: As primary care teams become busier each year, opportunities to reflect on the important work that we do become harder to find. How can we challenge ourselves to take something positive out of the shared clinical experiences that affect us the most? Perhaps no part of our work affects us more than the death of a patient. While it is a fundamental part of the work we do as clinicians, there is rarely an opportunity to slow down to reflect on the ways in which each patient's lives have affected our own. At McMaster Family Practice (part of the McMaster FHT) we have a rich tradition of planning and joining together for a memorial service that both celebrates the lives of patients lost, and fosters an environment for emotional and spiritual healing within the family health team. The purpose of this presentation is to show how one FHT has carved out time to honour both the lives of patients lost and the ways in which their lives have affected their care team. Participants will be challenged to consider ways in which their own FHT can enter into conversations about the clinical outcome that affects all of us the most: the death of a patient who has been under our care.
Presenters:

- Doug Oliver; Family Physician; McMaster FHT
- Dale Guenter; Family Physician/Medical Director; McMaster FHT
- Joyce Zazulak; Family Physician; McMaster FHT

F+G(1) - 6: The Role Of Elder Mediation In The Interdisciplinary Care Of Elderly Patients-What Have We Learned?

Length of presentation: 1hour 30minutes
Theme: 1 - Improving the patient's experience of care

Abstract: This workshop will begin with a discussion of elder mediation, a process used when there is conflict between family members or family members and health care providers. As the baby boomers age challenges are placed upon the resources of primary health care. We must find innovative methods of creating partnerships between formal and informal health care providers. We also need to find creative methods for developing a consensus when creating treatment plans. Elder Mediation has been used to deal with issues such as housing, finances, long term care, holidays, care of a home, introduction of additional support and end of life issues. A role play involving workshop participants will be conducted to develop a sense of the process of elder mediation. This workshop will then explore the

results of a survey of Elder Mediators at the World Summit in Glasgow Scotland in June 2012 exploring the perceived benefits and the process of implementing elder mediation. The implication of these international findings for health care in Ontario will be discussed; what can we learn from the international experience of elder mediators. The benefits of elder mediation as part of the health care offered by the geriatric team at Stonechurch Family Health Centre, a site of McMaster Family Health Team, will then be explored. Improvements to patients and families experiences of the health care system and the improvement in the care of those with chronic diseases will receive particular attention. Partnerships that extend beyond the FHT will also be considered.

Presenters:

- Lynn Dykeman; Social worker, MSW,RSW; McMaster Family Health Team
- Joy White; nurse practitioner; McMaster Family Health Team
- Colleen O'Neill; occupational therapist; McMaster Family Health Team
- Ainsley Moore; Family phyisican; McMaster Family Health Team

F+G(9) - 142: Essential Health Coaching Skills To Improve Treatment Adherence And Health Outcomes

Length of presentation: 1 hour 30 minutes
Theme: 9 - Best practices in health promotion and chronic care

Abstract: About two-thirds of patients with chronic conditions do not take medications as prescribed and do not make health behaviour changes. Healthcare professionals can significantly improve patient adherence by adopting a health coaching approach along with education and counselling. This workshop introduces the 5-Step Health Coaching Model for healthcare professionals to motivate and support patient self-management, including medication adherence and health behaviour changes.

Presenters:

- Durhane Wong Rieger; President; Institute for Optimizing Health Outcomes

Concurrent Session G - 9:35 - 10:20 AM

G(2) – 58+60:

Length of presentation: 20 minutes
Theme: 2 - System integration: building the team beyond the FHT

1. Community Collaboration In Chronic Disease Management

Abstract: The Couchiching FHT and Osteoporosis Canada (the Ontario Osteoporosis Strategy) are empowering patients diagnosed with osteoporosis in managing their disease and reducing the risk of fracture through a program which includes education, self-management and fall prevention strategies. This multi-disciplinary program has been offered four times each year over the past 2 years and has included 130 patients participating in the comprehensive 3 hour session. The results of the program have demonstrated the need for comprehensive management strategies that focus on understanding the diagnosis, targeted physical activity, calcium and vitamin D, fall prevention, pharmacological therapies and the importance of patient self-management. Following the program, 91% of the participants said they would make changes in managing their osteoporosis. Patient readiness is demonstrated by the fact that 83% said they have been diagnosed longer than 5 years and this speaks to learning about chronic disease at the right time and right place.

Presenters:

- Monica Menecola; Simcoe County and Muskoka Area Manager; Osteoporosis Canada (The Ontario Osteoporosis Strategy)
- Deb McKinley; Dietitian; Couchiching FHT

2. Shared Care Collaborative Practice - Palliative Care Model

Abstract: Our team was approached by Cancer Care Ontario (CCO) to pilot and evaluate a shared care palliative care mentorship model. This initiative links with our strategic plan regarding developing an expertise in palliative care and providing outreach into the community through linkages with CCAC and home visits. This program was initiated with a 2 day workshop offered on site by a palliative care MD to our team of 6 physicians, 2 social workers, an RN, pharmacist and nurse practitioner, along with community based RNs from CCAC and Public Health and a a Palliative Care Nurse Practitioner. The workshop to introduce the necessary components of care was called LEAP – Learning Essential Approaches to Palliative and End-of-Life Care. At that point we were enrolled in a research study wtih Cancer Care Ontario. Since that time we have reviewed our patient rosters and identified potential palliative care patients. Several patients have been enrolled into this program. Program elements include: Case findings, direct consultation and ongoing mentorship of clinicians, collaboration between primary care and palliative care experts to build capacity and knowledge transfer, devlopment of pathways identifying care elements in the clinic vs in the home, handoffs between various community, primary care and palliative care providers and implementation of predictors for end of life.

Presenters:

- Kim Kent; Family Physician; Credit Valley Family Health Team
- Gord Canning; RN(EC) NP-PHN, BScN; CVFHT

G(3) – 66+79:

Length of presentation: 20 minutes each
Theme: 3 - Getting data and using it to improve care

1. Measurement For Learning: Developing Common Quality Measures For Family Health Teams At The University Of Toronto

Abstract: The Department of Family and Community Medicine at the University of Toronto is the largest family medicine training program in North America and includes fourteen core academic teaching practices which are all part of Family Health Teams. Its newly created Quality Improvement (QI) Program envisions family physicians leading improvement in primary health care. In June 2012, the QI Program Committee recommended a small number of quality measures that departmental teaching practices should commonly collect and report. A single preferred measure was selected for each of the six quality domains identified by the U.S. Institute of Medicine: safety, effectiveness, accessibility, patient-centredness, efficiency, and equity. Feasibility of data collection, relevance to clinical practice, and actionability for improvement were all key criteria for measure selection. We will present the chosen measures as well as the rationale and process for selection. We will also discuss next steps and anticipated challenges related to implementation and spread. Common quality measures represent an opportunity to more uniformly improve care and outcomes for patients through collaboration and healthy competition between practices.

Presenters:

- Tara Kiran; MD, MSc, CCFP, family physician; St. Michael's Hospital Academic Family Health Team
- John Maxted; MD MBA CCFP FCFP, family physician; Health For All Family Health Team

- Michelle Naimer; MD, MHSc, CCFP; Mount Sinai Academic Family Health Team

2. The Electronic Child Health Network (eCHN) – Improving Children's Health One FHT At A Time

Abstract: The electronic Child Health Network (eCHN) is a not-for-profit, fully MOHLTC funded organization that is dedicated to improve the care-delivery and outcomes of Ontario's children. A sole functioning Electronic Health Record (EHR) for the pediatric population, it enables healthcare providers with access to a secure private electronic network that allows access to the latest medical information about patients instantly from over 65 hospitals across the province, integrated into a single, coherent medical WebChart. As a supporting tool to any Family Health Team (FHT) caring for children, eCHN enables access to information as soon as it is required, eliminating the need for information gathering from various sources using various means. The portal enhances each FHT's ability to increase its efficiency by providing access to medical information as related to patient treatment and/or care-planning. It improves the ability to obtain real-time clinical data from multitudes of domains, enhances communication with the families, patients as well as with collaborative healthcare providers and in addition, substantially improves the coordination of patient care across the entire spectrum of health care delivery sites. Recently, preliminary partnerships have commenced with over ten FHTs across the province, ensuring eCHN's commitment to further such partnerships, enhance its capabilities based on FHTs needs and ensure the continuous availability of a seamless EHR for each child.

Presenters:

- Via Hascalovici; The electronic Child Health Network (eCHN)

G(4) - 80: The New Frontier: Using Home-Based Technology To Coach Patients On Self-Management Skills

Length of presentation: 45 minutes

Theme: 4 - Leveraging technology to improve quality and efficiency of care

Abstract: Ontario's aging population is growing – almost 80% over the age of 45 have a chronic condition. In 2007, OTN began Canada's largest Telehomecare program to date, enrolling over 800 patients with HF and/or COPD from 8 Family Health Teams across the province. The program helped patients manage their conditions, using technology to deliver daily monitoring information to nurses trained in health coaching. The pilot was evaluated by an external party and demonstrated significant benefits to patients' health while dramatically reducing their utilization of health system resources. Telehomecare improves patient self-management, clinical outcomes, patient and provider satisfaction, best practice and data integration. The family physicians who participated in the pilot study noted a drop in unscheduled urgent visits and were able to have more control over their work days as a result. OTN is preparing to launch a MOHTLC/CHI funded service provincially starting with three LHINs and then expanding to include the remaining LHINs. Through a LHIN based model, LHINs will fund a core group of THC nurses. OTN's role is to provide a scalable technology solution, clinical process leadership as well as change management and adoption support. Family physicians and nurse practitioners will be able to refer patients for this telehomecare service and will be kept informed about their patients' progress. OTN's goal is to foster collaboration among health care providers by integrating with existing care plans. By engaging the patient, the Telehomecare nurse and the primary care provider, optimal chronic disease management can be achieved.

Presenters:

- Janice Owen; BA, MSc, MD, CCFP, FCFP, Medical Advisor, Telehomecare, OTN; Ontario Telemedicine Network

- Jane Brownrigg; RN, BScN, BA, Clinical Lead; Ontario Telemedicine Network

G(5) - 91: In-Home Primary Care Program For Frail Seniors: A Guelph Family Health Team Aging At Home Initiative

Length of presentation: 45 minutes

Theme: 5 - The Triple Aim in FHTs – better care, better health, better value

Abstract: Purpose: To provide a model of care that focuses on a proactive identification of seniors at risk for frailty, understanding of individual and or caregiver stressor(s) and systems navigation to facilitate timely access to services and resources. Method: Guelph Family Health Team (GFHT) established an In-Home Primary Care Program for seniors to support early identification and management of frailty. Three distinct features of this model of care include: An inter-professional team approach to care; In-home care and clinical assessment by dedicated Aging at Home Registered Nurses (AAHRN) with expanded knowledge, expertise and passion for geriatric nursing and remote access to electronic health record (EHR) through wireless technology to facilitate real time communication with the patients' physician to support implementing and reviewing an ongoing plan of care. Results: Our goal is to demonstrate that improving access to primary care by frail elderly can effectively and efficiently address their health outcomes and reduce health care costs (Heckman, 2011 Vol. 11 No.1); (Leff, Reider, & Frick, 2009 Vol 15 No 8); (McCusker, Roberge, & Vandenboncoeur, 1009).

Presenters:

- Kate Nichols; RN; Guelph Family Health TEam
- Heather Kuemmling; RN; Guelph Family Health Team

G(7) - 105: Somatization In Primary Care

Length of presentation: 45 minutes

Theme: 7 - Improving care for people living with mental health challenges

Abstract: Somatization, which has been defined as the association of unexplained physical symptoms with psychological distress and health seeking behavior, is very common in primary care settings. In fact, it has been estimated that it may be present in at least10-15% of patients seen in primary care. Dealing with patients with somatization can often be a frustrating experience for all concerned and can be very costly to the system as a result of unnecessary investigations, treatments, referrals and emergency visits. This presentation will first clarify how somatization is currently classified as well as briefly discuss the possible etiologies of this process.. The remainder of the presentation will focus on learning how to diagnose and manage patients with somatizing conditions. A rating tool-the PHQ-SADS-will be introduced to assist in the diagnosis of somatization as well as in the diagnoses of the anxiety and depressive disorders that frequently accompanies this condition. Cases will be used to illustrate the concepts, the use of the diagnostic tool, as well as the management of somatization.

Presenters:

- Douglas Green; Psychiatrist; The Ottawa Hospital and Bruyere Shared Care Mental Health Team

G(9) – 129+140:

Length of presentation: 20 minutes

Theme: 9 - Best practices in health promotion and chronic care

1. Diabetes Prevention Education In A Rural Primary Care Setting

Abstract: According to The Canadian Diabetes Association, in 2020 one in three people are expected to have diabetes. Action is needed to help individuals prevent or delay Type 2 diabetes (T2DM). An aging population, increased obesity rates and sedentary lifestyle are factors contributing to this rise in T2DM. Studies show that lifestyle interventions that target physical activity and diet reduce the risk of developing T2DM. However, there is limited programming available for prevention of diabetes specifically targeted to rural adults. This pilot study delivers a community-based lifestyle intervention program in a primary care setting, targeting rural adults and will test if the program prevents or delays the onset of T2DM. Rural adults are identified due to the unique environmental challenges and social factors that impact on healthy lifestyle decisions. Rural adults identified to have impaired fasting glucose and/or impaired glucose tolerance, and meet other eligibility criteria, are referred to the program by their physician. Dietitians provide education, and hands-on activities in the area of nutrition and physical activity, to increase participant awareness of their risk factors for T2DM, to promote skill building, and encourage self-management. To evaluate overall effectiveness of the lifestyle and behavior change intervention program, each participant will have an assessment of their blood pressure, anthropometry and biochemical data at baseline and after the program biochemical, anthropometric, and hemodynamic assessments. Feedback using questionnaires and focus groups will be used to make improvements in future program delivery and evaluate the feasibility of this program in a rural primary care setting.

Presenters:

- Adrienne Vermeer; RD; STAR Family Health Team
- Isabelle Giroux; PhD, RD, PHEc; University of Western Ontario
- Bridget Whebby; RD; STAR Family Health Team

2. Village Family Health Team Metabolic Monitoring

Abstract: Village Family Health Team is pleased to announce the start of our Metabolic Monitoring Program for our patients. We started this initiative 2 months ago, first catering to our patients living with serious mental health disorders who have been battling diabetes, have pre-diabetes, or metabolic syndrome. One of the great aspects of our program is that not only are we monitoring our patients' physical wellbeing, we are also introducing peer support for our patients. We encourage our patients to participate in group discussion and sharing of life experiences in relation to diabetes. We also include a variety of learning materials, such as educational videos, handouts, and healthy food options. Each participant in our program will have their blood work monitored at least every 3 months by our team and in addition to group educational sessions, we also offer them individual consultations for lifestyle management. Some of the topics we cover include the importance of daily foot inspections, yearly eye exams, and the importance of healthy eating and regular exercise. Our goal is to ensure that patients living with diabetes or at a risk for developing diabetes have the resources to live a healthy life. Our presentation at the AFHTO conference will cover the purpose of our metabolic monitoring program, why it has become a need in our community, our methodology of raising awareness of the resources available including our own program, case by case patient analysis for group formation, and a synopsis of a typical session. We will also include the feedback we have received thus far from our participants and our future goals for improving our service. We hope to further expand our program and offer participation to all of our patients in our practice in the near future. We look forward to promoting wellness both physically and mentally for our patient population.

Presenters:

- Oksana Konko; Nurse Practioner; Village Family Health Team
- Subo Shivakumar; Registered Nurse; Village Family Health Team

G(9) - 152: Using Collaboration And Competition To Improve Prevention Targets

Length of presentation: 45 minutes
Theme: 9 - Best practices in health promotion and chronic care

Abstract: The Ottawa Hospital Academic Family Health Team (TOHAFHT) is a two site academic FHT composed of health care professionals, with a tripartite mandate, dedicated to clinical service, teaching and research with the advancement of family practice medicine regionally and nationally. The purpose of this initiative was to coordinate the prevention requirements of our patients in cancer-screening and immunizations. Our model of care is a patient- centered and holistic approach with a strong focus on illness prevention and health promotion delivered through an interdisciplinary collaborative team. Preventative health care is one of the building blocks of primary care and an area where we excel. In 2010, the team organized a collegial yet competitive prevention initiative that was based on audit and feedback of individual physician data related to key prevention activities including immunization and cancer screening. A team based approach was then implemented to increase prevention activities. As a result of our interdisciplinary team approach, our physician practices have exceeded our goals and improved ministry targets. In addition to this success we have made other improvements to our prevention strategies that encourage integrated service delivery and empower our patients to take greater responsibility for their health. Feed back from our staff and patients indicate that our strategies are effective, appropriate and meeting the needs of our patients.

Presenters:

- Erica Battram; Clinical Manager; The Ottawa Hospital Academic Family Health Team
- Nadia Tarasco; System Coordinator; The Ottawa Hospital Academic Family Health Team

G(9) – 153+154:

Length of presentation: 20 minutes
Theme: 9 - Best practices in health promotion and chronic care

1. Etobicoke Medical Centre Family Health Team Anticoagulation Clinic

Abstract: How to best respond to the needs of over 420 patients on Warfarin is a challenge faced by the Etobicoke Medical Centre Family Health Team. The solution was to shift from physician managed anticoagulation to a team based model including a pharmacist, RN's, RPN, NP's, and support staff. Our program includes an algorithm based medical directive that allows our Allied Health Professionals to manage Warfarin dosing and education more consistently.

The intention of the program is to ensure optimal monitoring, safety, and education for our anticoagulation patients. Our team has made an impact on adherence to medication and routine monitoring. As part of the program, patients are offered one-on-one counselling and medication review with a nurse or pharmacist as well as given resource materials (such as calendars, information booklets, and a newsletter). We also have a direct voice mail line to make our team more accessible, point-of-care-testing for patients with special needs, and we utilize our EMR for communication and documentation.

This program not only freed up valuable physician time; it has also fostered a sense of teamwork and collaboration within the family health team and has served as a model for which to develop other programs. Our patient feedback has been very positive.

We are extremely proud of this program and would like the opportunity to share what we've learned with others.

Presenters:

- Clinical Pharmacist; Etobicoke Medical Centre Family Health Team

2. Asthma Program

Abstract: Asthma is a common condition that's anything but simple. More than 50% of asthma patients in Canada have uncontrolled asthma. Within a family health team, there are advances in both technology and inclusion of new staff which can improve asthma control in your family health team. Today's session will review a current program and talk about their journey of:

1) Establishing your population ("denominator")
2) Diagnosis of asthma (clinical judgement and objective testing)
3) Coding in EMR
4) Process mapping

Presenters:

- Jonothan Hunchuck; Pharmacist; North York Family Health Team

G(9) - 156: Depression In Elderly

Length of presentation: 45 minutes
Theme: 9 - Best practices in health promotion and chronic care

Abstract: Late-life depression is common in older people. Its incidence increases significantly after age 70 to 85, as well as among those living in long-term care facilities. Depression contributes to excess morbidity and complicates management of comorbid conditions in older people. Diagnosis and management of depression often present clinicians with a challenge. Optimizing management of depression and providing sound advice to older patients with depression requires knowledge and understanding of many clinical factors. The purpose of this review is to highlight salient issues in late-life depression, with a focus on the pharmacotherapy of depression.

Presenters:

- Carlos Rojas-Fernandez; BSc(Pharm), PharmD; Schlegel-UW Research Institute on Ageing; School of Pharmacy, University of Waterloo & Centre for Family Medicine

G(11) – 39+43:

Length of presentation: 20 minutes each
Theme: 11 - Strengthening the FHT team

1. Clinical Collaboration - Family Practice Nurses Working To Full Scope Of Practice

Abstract: The role of the RN has always been very important to the patiient care in our FHT. Each RN is responsible for leading one Prevention or Chronic Disease Management Program. In addition the Float RN is responsible to triage clinical calls, manage INRs and provide just in time teaching and support to the 18 family practice residents that we train. In May 2011 we began to trial a new clinical collaboration role which includes joint care of patients for physicals, well baby visits, PAPs, prenatal visits and pre-op assessments. During the trial and at the end of the first month the following were evaluated:

(a) Clinic flow and handoffs between Clinical RN and MD
(b) Booking Template adjustments
(c) MD/RN feedback re: new role
(d) Need for increased RN education/experience
(e) Role of subjective assessment
(f) Increased accessibility to primary care provider regarding opening up new spots

Following the trial all RN staff were trained and the new role was implemented across the FHT. In March 2012 a full evaluation was done including all of the RNs and MDs. Several improvements have been made to the clinical collaboration.

Presenters:

- Marnie Martin; RN, BScN, CRE; Credit Valley Family Health Team
- Melissa Graham; Family Physician; Credit Valley Family Health Team

2. Transforming Primary Care Through RN And RPN Utilization: Findings From Ontario's Primary Care Nurse Task Force

Abstract: Registered Nurses (RNs) and Registered Practical Nurses (RPNs) in primary care (PC) have knowledge, skill and expertise that can substantively improve timely access to quality services for Ontarians. Yet, a survey of Canadian PC nurses found that only 61% of respondents said they practice at full scope. Implications of an under-utilization of the nursing workforce are dramatic, including: decreased access to PC and increased emergency department/walk-in clinic utilization; public dissatisfaction with health services, health professionals and decision-makers; job dissatisfaction among nurses; system inefficiencies and increased cost to tax payers. Responding to this reality, the Registered Nurses' Association of Ontario (RNAO) launched the Primary Care Nurse Task Force in February 2012, to examine the role of RN and RPNs in primary care and propose solutions for their full utilization. A report issued by RNAO contains a two phased implementation. The first entails an upward role harmonization within the current scope of practice of RNs and RPNs across primary care, to align with a role description proposed by the task force. The second phase deals with expanding the scope of practice of RNs and RPNs to include: RN prescribing, RN care coordination; and the execution of RPN primary care programming. This presentation will provide an overview of the process and outcomes of the task force and highlights of the report, including an overview of its key recommendations. The presentation will also provide an opportunity to share the implications for transforming primary care delivery and nursing practice in Ontario.

Presenters:

- Tim Lenartowych; RN, BScN - Nursing Policy Analyst; Registered Nurses' Association of Ontario
- Doris Grinspun; RN, MSN, PhD, LLD(hon), O.ONT. - Chief Executive Officer; Registered Nurses' Association of Ontario
- Judie Surridge; RN BA - President; Ontario Family Practice Nurses