Theme 1 – Population-based primary health care: planning and integration for the community

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15. Working with the Thorncliffe Park Community to Design and Deliver Primary Obstetrics Care

Theme 2 – Optimizing capacity of interprofessional teams

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18. Building Blocks to Better Bones: Bone Health and Fracture Prevention Initiative
19. Building Diagnostic Imaging Appropriateness Pathways for Primary Care from Primary Care
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22. Expanding capacity within Primary Health Care: Development of a Physiotherapy Community of Practice
23. Health Professional Perspectives Regarding the use of Patient-Reported Outcome Measures in an Integrated Primary Care Health Centre – A Pilot Project
24. Healthy At Every Size (HAES) – Collaborating for Best Practice in Weight Management
25. Lend Me Your Ear: Using Auricular Acupuncture to Treat Substance Use and Anxiety/Depression
26. Healthy Living with Pain (HeLP): an Interprofessional Chronic Pain Primary Care Initiative
27. SOARing to New Heights: Exploring Opportunities for NP Leadership in Family Health Teams
28. Turn Key Approach to Quality Improvement for Stroke Prevention: A Practical Team Application
29. Up the Creek without a Paddle: How the Care Navigator at SETFHT Helps Patients Steer through the System
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30 Advanced Care Planning in Primary Care - Lessons Learned
31 Breaking Down the Barriers of Care to Support a Deaf, Developmentally Delayed Patient within the London Family Health Team
32 Comparing two Assessment Approaches in a Primary Care Diabetes Setting to Obtain Descriptive, High-Quality Feedback on the Patient Experience
33 Confused and Lost - Where do I Begin Navigating the Health Care Labyrinth?
34 Evaluation of the Ontario Stroke Network’s Hypertension Management Program: A Model for Stroke Prevention in Primary Care Settings
35 Health Literacy: You were heard but were you understood?
36 Improving Cervical Cancer Screening Rates: Quality Improvement Pilot Initiative
37 Interprofessional Maternity Care in the Mt. Sinai Hospital Academic FHT: Keeping Family Doctors in the Game
38 My Values, My Wishes, My Plan: e-Module for Inter-Professional Teams Toward Effective ACP Conversation with Patients
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45 Data for Quality Improvement: Working with our Hospital Partner on QIP Access and Integration Goals
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51 The Cervical Screening Reminder Calls Pilot: An EMR Optimization Initiative to Support Primary Care
52 Turning Data Lemons into Data Lemonade: Our Journey with 7-day Post Discharge
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59 Destigmatizing mental health shortens wait times
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62 Implementing Health Checks in Primary Care for Adults with Developmental Disabilities in Family Health Teams in Ontario: Engaging Interprofessional Care, Community-based Health Care and Developmental Services
63 Improving the Care and Quality of Life of Patients with Asthma
64 Improving the Effectiveness of Depression Groups in Primary Care: Pilot of Self-Compassion Focused CBT Groups for Depression
65 Leveraging the OCEAN Platform and Tablet Technology to Improve Patient Care
66 Post Hospital Transition of Care: From Inpatient to Family Practice
67 Too Fit To Fracture: Exercise and Physical Activity Recommendations for Fall and Fracture Prevention
Theme 1 – Population-based primary health care: planning and integration for the community

Primary care organizations serve communities with diverse populations facing unique needs and barriers. Identifying needs and planning programs to improve population health and achieve greater equity requires engagement and collaboration with patients and community partners. This stream will focus on population-based approaches to program planning to respond to community needs, developing partnerships, caring for patients in the broader community and Health Links.

Posters:

1. Collaborative Care programs: A Nurse Practitioner Approach to Address the Needs of our Community
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1 Collaborative Care programs: A Nurse Practitioner Approach to Address the Needs of our Community

Theme: 1. Population-based primary health care: planning and integration for the community

Marie-Elaine Delvin, NP-PHC, MSc.N, Prince Edward FHT

Learning Objectives:
- Illustrate the leadership role of the nurse practitioner in the primary health care setting in program development.
- Show how a nurse practitioner can play a key role in the realignment of the primary health care in Ontario.
- Demonstrate how the nurse practitioner can improve patient-centered care and access to care.
- Demonstrate the impact of these NP led programs on the health of the patient and on the health care system.

Summary:
With the health care system requiring restructuring and the aging population requesting the primary health sector to provide more services in the community, and subsequently prevent hospital admissions, the Prince Edward Family Health Team has initiated a new program. This program was developed by a nurse practitioner to support health care services in the home of the patient. Done as a PDSA in line with our Quality Improvement, the Collaborative Care Program (CCP), targets the complex patients who require care planning and coordination of care. One of the goals for these programs is to prevent emergency hospital visits, admission and/or readmission, but also to provide patient-centered care and better access to health care. This program has resulted in strong relationships being built amongst many community partners and was successful in providing integrated health care by the nurse practitioner. This program has shown interesting results with regards to cost on the health care system. Also it demonstrate the value of a nurse practitioner being able to use his/her complete skills set in collaboration with the primary care provider and community resources in order to provide complete health care to the patient in the community.

2 Community-Based Falls Prevention by an Interprofessional Team

Theme: 1. Population-based primary health care: planning and integration for the community

Craig Bauman, Project manager, Doctor of Chiropractic, The Centre for Family Medicine FHT Mobility Clinic

Learning Objectives:
- How to actively screen patients for falls.
- Key history-taking questions and their relevance to fall risk.
• Simple examination, testing methods and clinical pearls.
• Navigation of community resources.

The intent is to convey strategies which can be implemented Monday morning.

Summary:
As Canada’s population ages, there is a growing concern about falls, especially for those already weakened by one of the chronic diseases prevalent in seniors. The effects of a fall can be devastating including fracture, traumatic brain injury, and spinal cord injury. The multidisciplinary team at the Centre for Family Medicine Family Health Team Mobility Clinic in Kitchener, Ontario, has experience in collaboration aimed to reduce the risk of falls for community-based patients; this presentation addresses some of the tools used to help assess patients for falls risk. According to the guidelines on falls prevention published by the American Geriatrics Society (AGS) and British Geriatrics Society (BGS), all patients over age 65, or those with a predisposing condition, should be asked annually if they have fallen in the last year. If two or more falls have occurred, the patient should be referred to their primary care physician for a multifactorial falls risk assessment. If the patient has had one fall in the last year, they should be evaluated for balance and gait, and referred for a multifactorial falls risk assessment if any concerns are discovered. Unfortunately, multifactorial falls risk assessment is not available in all communities. Other professionals may need to help fill this gap. In particular, the Activities-Specific Balance and Confidence Scale, Red and Yellow Flags, the Tied “Up and Go” Test, the Tinetti Balance Assessment Tool, The Otago Exercise Confidence Scale, Red and

3 Development, Implementation and Evaluation of the KidneyWise Clinical Toolkit for Chronic Kidney Disease (CKD) in Primary Care

Theme: 1. Population-based primary health care: planning and integration for the community

Allan Grill, MD, CFP, MPH, Family Physician & Provincial Primary Care Lead, Ontario Renal Network
Karen Tu, MD, MSc, CCFP, FCFP, Family Physician & Senior Scientist, Institute of Clinical Evaluative Sciences (ICES)

Learning Objectives:
1. Review and receive the KidneyWise Clinical Toolkit that outlines the role of the primary care practitioner in managing patients with CKD and the criteria for appropriate referral to nephrology.
2. Learn local, provincial and national dissemination strategies for CKD and other chronic disease clinical tools for the primary care setting.
3. Be introduced to basic principles related to the evaluation of chronic disease clinical tools in the primary care setting.

Summary:
Guidelines for chronic kidney disease (CKD) are available, but FRCP(C) specialists (e.g. nephrology, cardiology) are the main target audience as opposed to primary care practitioners (PCPs - e.g. family physicians, nurse practitioners). Furthermore, their uptake in primary care practice is challenging due to the many medical conditions competing for a practitioner’s time. As a result, CKD is under-recognized amongst PCPs as shown by lack of consistent documentation in cumulative patient profiles, under-utilization of a urine albumin to creatinine ratio (ACR) when screening for and monitoring progression of the disease, and a low rate of statin use in these patients despite evidence-supported international recommendations. In response to this knowledge gap, the Ontario Renal Network developed the KidneyWise Clinical Toolkit to optimize diagnosis, management and, where appropriate, referral of patients with CKD in the primary care setting.

With the purpose of improving the health of patients living with, or at risk of CKD, the KidneyWise Clinical Toolkit will guide patient care in accordance with best practices as documented in national and international guidelines. Participants will also be introduced to ongoing research projects with the goal of evaluating the successful uptake of this toolkit and its effect on validated patient outcomes. This presentation is linked to the theme “Population-based primary health care” as the KidneyWise toolkit helps guide the transition to nephrology care for CKD patients at high risk of progression. In addition, the EMERALD study uses EMR data to highlight the needs of patients with CKD and suggested management.

4 Diamonds in the Rough: Utilizing Positive Deviance to Optimize Care for Complex Patients

Theme: 1. Population-based primary health care: planning and integration for the community

Couchiching Community Health Link:
Rebecca Van Iersel, MD, Lead Physician
Sandy Dupuis, Clinical System Navigator

Learning Objectives:
Participants will learn to apply complexity science to everyday health care conundrums, and discover how positive deviance can be utilized to coordinate and integrate care for complex patients and how it can be useful in optimizing the health care system. Participants will also learn how creating MinSpecs for our Health Link was useful in allowing creative energy to solve known issues. The strategies of positive inquiry and positive deviance align easily with Experience Based Design and keep the patient at the centre of their comprehensive care plan.

Summary:
Health Links are developed on the negative assumption that the system is failing. What it isn’t focusing on are the patients where the system is achieving good outcomes. Positive inquiry provides
a fresh approach to systemic change by reaching out to these "diamonds in the rough" to look for opportunities to optimize the existing system. Identifying what has been helpful and what gaps exist and use the power of the generative relationships to bridge those gaps within the MinSpecs. This process allows for the development of coordinated care plans that improve quality, collaboration and communication. This concept has created a plan for complex, chronic diseases that engages physicians, patients, and caregivers to truly evoke effective, lasting systemic change. This concept is an example of effective patient driven care and is easily adaptable to a variety of patient populations.

5 East Mississauga Health Link: Patient-Driven Care

**Theme:** 1. Population-based primary health care: planning and integration for the community

*Lara De Sousa, Director of Patient Care, Mississauga Halton CCAC*

*Anne McKye, Health Link Coordinator, Trillium Health Partners*

**Learning Objectives:**
- Describe the benefits of East Mississauga Health Link to the patient, the system and the health care partners involved.
- Identify the importance of having a common shared vision and how it will benefit the healthcare system and the patient.
- Define the key principles for a successful Health Link.
- Identify the benefits of the Health Link.

**Summary:**
The East Mississauga Health Link (EMHL) provides high needs’ patients with the care they require, keeping them healthy and safe in their communities of their choice. EMHL is transforming the experience for patients with complex health and social needs through system partnership, integrated care coordination, and a focus on the patient/family voice. EMHL is co-led by the Summerville Family Health Team (FHT) and Trillium Health Partners (THP). Within the Link, MH CCAC plays a lead role in care coordination for patients who are described as high users of the health system.

EMHL partners identified the development of a coordinated care plan as a key foundational step in supporting an integrated and cross-partnership approach to supporting the complex patient. “I am better able to provide attentive, timely, connected care and talk to my patients about what is needed for them. No issue is untouchable. I am building positive, respectful relationships with physicians that benefit my patients.” – Nicole Mohmammed, RN, Mississauga Halton CCAC Care Coordinator

Dr. David Daein, co-lead East Mississauga Health Link said this about how together we are making a difference in the quality of life for patients and their families in the Mississauga Halton region: "There is an opportunity to make a difference, both from a patient perspective and a system perspective on these very, very ill patients."

6 Focusing on Adult Immunizations

**Theme:** 1. Population-based primary health care: planning and integration for the community

*Delhi Family Health Team:*

*Roxanne Piersens-Silva, RPNA, Clinical Coordinator*

*William Thorogood, MD, CCFP, Team Lead*

**Learning Objectives:**
Participants will gain insight into techniques to improve education about and access to adult vaccinations.

1. Describe the importance and impact of adult immunizations for prevention and management of chronic illness.
2. Describe process and outcome indicators that are being used to measure rates of adult immunizations.
3. Identify the key roles that physicians and IHPs play in the process from start to finish.

**Summary:**
The Delhi Family Health Team has a strong initiative focused on educating adults regarding the benefits of immunizations. This grew into a broader vision. The team realized by improving efficiency and more importantly access (weekly nursing clinics) the immunization rates would increase. It is a team effort to educate patients, all IHPs are involved. This presentation will highlight ways of indentifying patients (EMR strategies), successful ways to give recommendations and patient education campaigns regarding adult immunizations.

7 Hungry for Knowledge: Leveraging Community Partnerships and Utilizing an Interdisciplinary Family Health Team to Deliver an Interactive Renal Patient Group Education Program

**Theme:** 1. Population-based primary health care: planning and integration for the community

*Luma Al-Shubbak, MScFN, RD, CQM, CSNM, Registered Dietitian, London FHT*

*Lisa Doerr, MScFN, RD, In Store Dietitian, Loblaw, Inc.*

**Learning Objectives:**
This poster will detail the design and implementation of a skill-building group education model for patients with chronic kidney disease (CKD). Emphasis will be on benefits of practical, proactive nutrition and health education in a group facing significant lifestyle change. Preliminary results suggest this education model strengthened participants’ connection with their primary care dietitian, chronic disease nurse and pharmacist and increased awareness of key nutrition information. Will include discussion of relationship-building and effective division of roles.
and expertise in interdisciplinary intervention, both with community partners and within the Family Health Team model.

**Summary:**
This intervention adapted the successful evidenced-based Diabetes Education Centre (DEC) model to address a renal population by including a disease-specific cooking demonstration in collaboration with Loblaws stores. Developing a CKD process map assisted in constructing a CKD service and resource allocation framework ensuring timely access and appropriate resource use. This identified the need to accommodate more patients through a group approach.

Preliminary program planning steps included case finding of patients with CKD through utilization of standardized EMR codes and developing a roster to assist physicians in CKD management. Twenty-two percent of identified stage II patients were recruited for the sessions, along with 25% of stage III patients. Meals were designed using dietary criteria safe for stage IV patients to challenge the perception of “bland” kidney-friendly food. Intervention purpose was to increase patients’ awareness of CKD and provide knowledge and skills to delay disease progression while improving quality of life. Along with the dietitian, a chronic disease nurse and pharmacist participated in the education components allowing participants to experience the support of the Family Health Team model.

Primary care providers across the province could adopt this model through similar program tools and community partnerships. This model could be modified to address patients with heart disease, diabetes, or other chronic conditions; a common participant request. Partnership benefits include: accessible store locations and free parking; cooking instructors are experienced and can provide culinary expertise; patients build practical skills along with knowledge; and optimizing the capacity of the interdisciplinary team.

**8 Mythbusters: Baby-Friendly Edition**

**Theme:** 1. Population-based primary health care: planning and integration for the community

**Toronto East General Hospital:**

Linda Young, MScN, EdD, CHE, Director of Maternal Newborn Child Mental Health, Interprofessional Practice and Organizational Learning and Lead for the BFI Strategy for Ontario

Kristina Niedra, MA, Project Manager

**Learning Objectives:**

- An understanding of common myths and misconceptions regarding the Baby-Friendly Initiative for Family Health Teams
- Information to make an informed decision regarding pursuing Baby-Friendly as an evidence-based best practice

- Practical examples, strategies and tools to support BFI implementation in a Family Health Team

**Summary:**
The Ministry of Health and Long-Term Care has made a major investment to support Family Health Teams, amongst other organizations in the province, to pursue implementation of the Baby-Friendly Initiative. Baby-Friendly is a WHO & UNICEF global, evidence-based best practice. In the last year, a number of special supports have become available to support implementation, but the uptake of these tools amongst Family Health Teams has been quite low. From feedback at conferences and through dialogue, it has become evident that common myths may be a factor in the reluctance of some organizations to adopt Baby-Friendly.

The goal of this presentation will be to clarify misconceptions to promote a better understanding of the goals of the program. In addition, presenters will highlight recently developed supports that will assist Family Health Teams in pursuing implementation of Baby-Friendly best practices.

**9 PATH: Promoting Access to Team-based Primary Healthcare**

**Theme:** 1. Population-based primary health care: planning and integration for the community

**Women’s College Hospital Academic FHT**

Nicole Bourgeois, Dietitian and Health Promoter

Jessie Bawden, Nurse Practitioner

**Learning Objectives:**
Participants will learn about an innovative model of care to efficiently integrate unattached patients into a FHT by leveraging the interprofessional team and working with community partners.

**Summary:**
The PATH project (Promoting Access to Team-based Health Care) is an innovative primary care intake model to enable teams to take on more unattached, complex patients from their communities.

Poor access to primary care experienced by medically and socially vulnerable groups often results in delayed treatment, which leads to patients entering the health system with higher acuity. Family physicians face many barriers accepting complex new patients into their practices including: practices at capacity, blended capitation models of MD compensation (payments are not adjusted for patient complexity), time-and resource-intensive new patient intake, which can take multiple physician visits to complete.
The Women’s College Family Practice Health Centre (FPHC) is an Academic Family Health Team. In recent years, the FPHC has not been formally accepting new patients due to practices being at capacity. In January 2014, the FPHC physician group agreed to accept 120 unattached patients into the practice in order to improve access to our services by our community.

PATH was envisioned to intake patients in a manner that is time-efficient, cost-effective, reduces barriers to taking on complex patients, and utilizes the interprofessional team available at the FPHC. Nurse Practitioner—led group medical visits have been shown to be feasible in other Family Practice settings; we applied this concept to primary care intake.

Change concepts utilized in the project included: developing partnerships, eliminating waste via a group information session for patients, and distributing intake workload through an interprofessional team. The goal of this presentation will be to clarify misconceptions to promote a better understanding of the goals of the program. In addition, presenters will highlight recently developed supports that will assist Family Health Teams in pursuing implementation of Baby-Friendly best practices.

10 Prescribing Literacy for Preschool Infants/Children – a Practical Partnership Model

Theme: 1. Population-based primary health care: planning and integration for the community

St. Michael’s Hospital Academic FHT:
Laurie Green, MD, Staff Physician
Courteney Rudy, Program Co-Ordinator, Reach out and Read Program

Cheryl Skovronek, Regional Manager, Toronto Public Libraries

Kim Beatty, Executive Director, Children’s Book Bank

Learning Objectives:
This poster will describe the benefits/practical aspects of implementing an early literacy intervention, Reach Out and Read, in a family health team setting.

1. Understand the impact of low literacy on health and the importance of early childhood intervention.
2. Learn about the Reach Out and Read model of a health-care based early childhood literacy intervention.
3. Learn how to develop partnerships with local literacy organizations to understand local needs, use resources and connect families.
4. Learn about a practical model to implement a Reach Out and Read program using the EMR.
5. Learn the roles of the inter-professional health team in this model.

Summary:
This poster will focus on the implementation of a health-care based early childhood literacy intervention in an academic family health team in downtown Toronto using community literacy partnerships and an inter-professional, EMR-based implementation model. We will briefly review the incidence of low literacy rates in Ontario and the impact of this on future income/employment and health. The current Canadian Pediatric Society Position Statement, Read, Speak, Sing re: early childhood literacy will be reviewed.

The Reach Out and Read model developed in the United States and currently reaching 1/3 of all children living in poverty will be presented along with the extensive evidence evaluating this intervention. The emphasis of the poster will be on the implementation of this model in a family health team and the role of community partnerships in supporting the program.

Community partners will present their integral role in the program as well as informational material created for distribution to families at well-child visits. A step-wise guide including EMR tools and outline of inter-professional roles will be included.

The potential for province-wide implementation and the creation of a literacy network will be discussed. Visitors will leave with a tool kit to implement, tweak or revise according to their community needs.

11 Public Health and FHT Collaboration: Strategic Processes to Further Desired Outcomes

Theme: 1. Population-based primary health care: planning and integration for the community

Cathy Risdon, MD, DMan, CCFP, FCFP, Physician, Co-Lead, McMaster FHT, Department of Family Medicine, McMaster University

Learning Objectives:
This Poster will offer Attendees:

- Brief and Relevant highlights from current literature regarding public health/primary care collaborations in Canada, including advantages and barriers
- A sample inventory of existing collaborative projects in a mid-large size Ontario city (Hamilton).
- An informal set of “self study” questions to use in your FHT to move forward with collaborations in your own setting.

Summary:
In May 2015, Hamilton Public Health Services and the Department of Family Medicine, McMaster University, including one of two sites of the McMaster Family Health Team (FHT) co-located in the same building. To our knowledge, this is the first organization-level co-location of a public health unit, department of family medicine, and FHT.
The current inventory of collaborations demonstrates that much baseline work between PH and PC-FM is already occurring, independent of deliberate higher level strategic planning. The potential benefits of more intentional collaborations remain to be understood.

Short-term collaborative goals included:
1. developing a committee to build knowledge of and relationships with each other’s organizations
2. planning a shared continuing professional education agenda, and
3. planning to implement increased smoking cessation programming.

A joint process is planned for the fall of 2015 to identify and plan for longer term shared goals.

This poster will discuss known strengths and constraints of PH and FHTs including mandate, methods, and organizational culture. Factors to consider for FHTs to strengthen their collaborations with Public Health will be clearly described.

12 Rapid Recovery Services - Helping Patients Meet their Rehabilitation Needs at Home vs. Hospital

Theme: 1. Population-based primary health care: planning and integration for the community

Learning Objectives:
- Have an understanding of the key principles of successful patient transition from hospital to home
- Identify the targeted impacts of the Rapid Recovery initiative
- Identify the benefits of helping patients meet more intensive rehab needs at home, rather than in hospital
- Define the key principles for successful implementation
- Describe the importance of having a common shared vision and how it benefits the patient and the healthcare system

Summary:
Rapid Recovery services help patients, 18 years of age or older, to recover as much as possible from lost or impaired function, loss of ability to perform the daily functions of life or are recovering from an injury in their preferred place of choice - home. Patients receive service within 24 hours after they leave hospital and intensive rehabilitation service are initiated including daily physiotherapy. Patients who are waiting for rehabilitation can also be discharged home to begin their rehabilitation at home, and then come back to hospital to continue as an in-patient. Regulated health professionals develop personalized care plans for their patients and arrange for the ideal level of rehabilitation services they need to recover at home.

For the health system, because patients receive the care they need to recover at home safely, precious spaces in hospital are available for new patients in need of treatments available only in hospital and patient flow is optimized on a regular basis.

13 Students are Valuable Too: Collaboration with Western's Community Engaged Learning Program

Theme: 1. Population-based primary health care: planning and integration for the community

Learning Objectives:
The poster will provide conference participants the ability to learn how utilizing University students can benefit all parties involved. Thames Valley Family Health Team (TVFHT) will showcase the multiple projects that have involved students within the faculty of Health Sciences at Western University. In addition, participants will gather information regarding the valuable skills students can offer to their own organizations and the ways in which students can be involved in many different aspects of the family health team, and not just as practicum students in a defined placement.

Summary:
TVFHT has partnered with Western University’s Community Engaged Learning (CEL) Program. We have specifically collaborated with two main courses: Global Health Promotions and Gerontology in Practice. Community Engaged Learning at Western, operated out of The Student Success Centre, partners with local and international organizations to mobilize knowledge and exchange resources in order to address critical societal issues. By engaging students, staff, and faculty in meaningful experiential learning opportunities, CEL helps meet community defined needs while promoting students’ sense of civic engagement and social responsibility. The curricular CEL program embeds community projects right into the course curriculum with the intention that community projects will help bring course learning objectives to life while making a meaningful contribution to a community organization.

As an organization, we have been fortunate enough to have eight separate groups of students work along staff members on various projects. For example students have conducted literature reviews for program development, community resource packages, partnerships between community organization and the FHT staff, as well as media development to promote the services the FHT has for patients. In particular, the students have supported the development of a healthy aging program, COPD FHT-wide program, and the expansion of our Mindfulness program. These include but are not limited to research capabilities and accessibility, creative minds, new education knowledge, and the ability to utilize new technological avenues.
14 Transition Navigation for Medically Complex Patients Following Discharge from Hospital – Lessons Learned

**Theme:** 1. Population-based primary health care: planning and integration for the community

*Susan Ward, Social Worker/Transition Navigator, The Ottawa Hospital  
Debbie McGregor, Executive Director, Bruyere Academic FHT*

**Learning Objectives:**
This demonstration project, funded by the OMA and the Ministry, recognizes the struggles that patients have in implementing the care plan following discharge, and the role that navigation can play in assisting with a successful transition.

Participants will learn about:
1. Some of the challenges facing the medically complex patient following discharge from hospital.
2. The role of transition navigation in facilitating the transition to the home environment and community care.
3. The importance of the community/primary care linkages for these patients in preventing readmission.

**Summary:**
This poster describes a demonstration project, funded by OMA and Ministry Partners: The Ottawa Hospital, Champlain CCAC, Bruyère Academic FHT, Champlain LHIN. The poster will describe the goals of the project, tools developed, lessons learned, findings, and suggestions for implementation.

**Background:**
- Poorly executed transitions can have a negative impact on patient health, well-being and safety, caregiver relationships, and unnecessarily increase health care system costs (Rutherford et al., 2012).
- Hospital readmissions can be seen as a signal of system failure: they often occur because of gaps in care and communication, and reflect the complexities of transitions within the health care system (Baker et al., 2011).

This project provides Transition Navigators (TN) to facilitate the transition from hospital to home and primary care follow up. The same TN visits patient both in hospital and at home, and works with patient and caregiver to ensure that the patient’s care plan is carried out successfully:
- Encouraging follow-up appointment with primary care provider
- Linking with PCP or other team member to ensure communication
- Encouraging linkages with community pharmacy to ensure medication success
- Identifying other community linkages to facilitate health and well being

The project’s goals include improving communication and understanding between patients and caregivers, strengthening collaboration between hospitals and primary care, improving the patient experience and lowering the number of preventable readmissions to hospital.

15 Working with the Thorncliffe Park Community to Design and Deliver Primary Obstetrics Care

**Theme:** 1. Population-based primary health care: planning and integration for the community

*Emanuelle Britton, Family Physician, South East Toronto FHT  
Karen Fleming, Family Physician, Women’s College Hospital Academic FHT  
Christie Lockart, Midwife, Midwives’ Clinic of East York  
Madhumita Chaudhary, Administrator, Thorncliffe Park Pregnancy Clinic, and Settlement Counsellor, Thorncliffe Neighbourhood Office  
Michelle Payne, Registered Nurse, South East Toronto FHT and Thorncliffe Park Pregnancy Clinic*

**Learning Objectives:**
Thorncliffe Neighbourhood Office (TNO), several primary care organizations led by the South East Toronto Family Health Team, and the Midwives’ Clinic of East York have worked together since the fall of 2014 to develop and design a primary care pregnancy clinic for the women of Thorncliffe Park.

The poster will outline the work of the steering committee in developing a clinic with and for the community, the road bumps along the way, a description of how the clinic operates and works in partnership with the Midwives’ Clinic and Thorncliffe Neighbourhood Office, and our continued challenges.

**Summary:**
The Toronto Central LHIN commissioned a "current state and gap analysis" to inform a plan to address the health care gaps in the Thorncliffe Park community. The report, which was presented in April 2014, identified significant health care needs within the community. The LHIN provided one-time funding to design and open a pregnancy clinic to provide pre-natal, peri-natal and post-partum care. That funding has since become permanent and the clinic is operating on a budget of $100,000/year.

While several primary care locations close to Thorncliffe Park are accepting new patients and do provide primary obstetrics care, the TNO informed us that most women are not comfortable leaving the community to access care that is 1-3 bus rides away. Many of the neighbourhood women see female obstetricians close to the neighbourhood when they become pregnant, even if their pregnancies are low-risk. The purpose of developing the pregnancy clinic was to offer high-quality primary obstetrics care within the neighbourhood, and to attach women and their newborns to a primary care provider for future ongoing care.
We will describe the process of developing partnerships, designing the service, and our experiences in delivering care to women in Thorncliffe Park. We will also briefly describe the initiatives underway to work with the Thorncliffe Neighbourhood Office to deliver health information and activities to improve health outcomes of mothers and their newborns. These activities are being supported by a Toronto East General Hospital community research grant, as well as funding from the Pregnancy Clinic's budget.
Theme 2 – Optimizing capacity of interprofessional teams

Interprofessional primary care teams are being called upon to provide high-quality, comprehensive, well-integrated care to all patients who need it. This requires high functioning teams able to provide healthy working environments, optimize capacity and allow all team members to work to full scope of practice. This stream focuses on how teams have overcome barriers to engage all team members in providing care, leverage the team to meet community needs, change behavior from solo to group practice, manage conflict within the team, strengthen care coordination internally and in the community, and expand access.

Posters:

16 1-800-Imaging Pilot: Building Partnerships between Primary Care and Medical Imaging
17 A Community of Practice Approach to Building Capacity for Quality Improvement Planning: The DFCM Academic FHT Experience
18 Building Blocks to Better Bones: Bone Health and Fracture Prevention Initiative
19 Building Diagnostic Imaging Appropriateness Pathways for Primary Care from Primary Care
20 Development of an innovative nursing led persistent Non-Cancer Pain Program in Primary Care: Lessons Learned and Initial Outcomes
21 Effects of a Multi-Faceted Mentoring Intervention on Spirometry Knowledge, Quality and Usage in Primary Care
22 Expanding capacity within Primary Health Care: Development of a Physiotherapy Community of Practice
23 Health Professional Perspectives Regarding the use of Patient-Reported Outcome Measures in an Integrated Primary Care Health Centre – A Pilot Project
24 Healthy At Every Size (HAES) – Collaborating for Best Practice in Weight Management
25 Lend Me Your Ear: Using Auricular Acupuncture to Treat Substance Use and Anxiety/Depression
26 Healthy Living with Pain (HeLP): an Interprofessional Chronic Pain Primary Care Initiative
27 SOARing to New Heights: Exploring Opportunities for NP Leadership in Family Health Teams
28 Turn Key Approach to Quality Improvement for Stroke Prevention: A Practical Team Application
29 Up the Creek without a Paddle: How the Care Navigator at SETFHT Helps Patients Steer through the System

16 1-800-Imaging Pilot: Building Partnerships between Primary Care and Medical Imaging

Theme: 2. Optimizing capacity of interprofessional teams

University Health Network:
Karen Weiser, Business Analyst, MBA
Lilly Whitham, Senior Project Manager

Learning Objectives:
- Improve integration between primary care providers in the community and medical imaging within a tertiary sub-specialized environment
- Create clerical Standards of Work to promote excellence in customer service
- Coordinate communication between Primary Care Providers and sub-specialized Radiologist to facilitate urgent imaging when appropriate, and provide navigational and consultative services
- Monitor referring physician experience using provider experience surveys

Summary:
1-800-Imaging is a virtual hub designed to improve integration between primary care providers (PCPs) in the community and the Joint Department of Medical Imaging at the University Health Network. The virtual hub provides PCPs a direct point of contact within a tertiary sub-specialized, academic medical imaging department, to facilitate real-time consultation with a sub-specialized radiologist and to escalate urgent imaging requests.

The objectives of the 1-800-Imaging pilot project were to:
- Reduce inappropriate imaging orders
- Reduce emergency department visits
- Improve patient experience of care
- Improve provider experience during transitions to radiology

The pilot project ran from May 2014 to March 2015 and partnered with Seamless Care Optimizing the Patient Experience (SCOPE), an existing program that provides navigational and consultation services through a virtual interprofessional health team to a group of 60 community PCPs.

1-800-Imaging services are the following:
1. Appropriateness Consult: Support for PCPs in selecting the most appropriate imaging when unsure which test is indicated for their patient
2. Radiology Consult: A second opinion on images, reports, or recommendations from subspecialized radiologist
3. Urgent Imaging: Access to urgent imaging for patients with acute symptoms without visiting the emergency department
4. Urgent Reporting: Expedited reports from a radiologist
5. General Informational Requests
The project was designed according to the Institute for Healthcare Improvement principles of the "Triple Aim" to improve patient/provider experience of care, better population health, and lower per-capita costs of care.

17 A Community-of-Practice Approach to Building Capacity for Quality Improvement Planning: The DFCM Academic FHT Experience

Theme: 2. Optimizing capacity of interprofessional teams

University of Toronto DFCM
Patricia O'Brien, RN, BA, CNeph(C)
Philip Ellison, MD, MBA, CCFP, FCFP

Learning Objectives:
The experience of the thirteen University of Toronto (U of T), Department of Family and Community Medicine (DFCM) academic family health teams (FHTs) will be described relative to quality improvement (QI) planning processes, beyond those required by the MOHLTC Quality Improvement Plans (QIP). The specific focus is assessing the impact of a community of practice (C of P) to support interprofessional team effectiveness and capacity building in QI planning, focused on learning processes such as sharing organizational learning.

Summary:
A community of practice is a group of people who share a profession and come together because of a common interest. (Lave & Wenger, 1991). Beginning with the inaugural 2013 MOHLTC QIP submission requirement, the DFCM QI Program has supported faculty, interprofessional team and management learning related to expanding QI planning beyond the minimal required indicators from the MOHLTC. The C of P approach ensures inclusiveness of relevant team members in the QIP planning process and enables capacity building related to QI knowledge and skills.

The C of P has engaged in sessions focused on QIP development, QI measurement, implementation tips, quality-related governance and identification of change ideas using design thinking. In 2014, C of P members were invited to participate in LEAN methodology certification to augment members’ knowledge and skills and this spring members participated in a workshop developing their understanding of patient-centered co-design.

While the achievements related to capacity building are noteworthy, the C of P has met challenges in the QI planning process related to time required to develop and implement QI plans that are relevant, feasible, realistic and aligned with affiliated hospital partners. The challenges related to accessing useful measures for quality dimensions as required by the MOHLTC has resulted in significant changes to the scale and scope of QIP elements and removed the enthusiasm to share site-specific areas of QI focus such as safety, equity and effectiveness that are beyond the MOHLTC directed areas of focus.

18 Building Blocks to Better Bones: Bone Health and Fracture Prevention Initiative

Theme: 2. Optimizing capacity of interprofessional teams

Ontario Osteoporosis Strategy
Judy Porteous, Osteoporosis Canada Regional Integration Lead
Alanna Tucker, Fracture Prevention Coordinator
Owen Sound FHT:
Deb Kean, IT & Communications Support
Barbara Conti, Program Nurse

Learning Objectives:
- To learn how to create a Bone Health Registry within your FHT and identify patients at risk for fracture
- To review standard Fracture Risk Assessment Tools i.e. FRAX and CAROC
- To learn how to incorporate an interprofessional team into patient-centred Bone Health Education
- To evaluate the components of a Group Bone Health Education session
- To learn how to customize Patient Bone Health Report Cards
- To learn how to create strategic partnerships with external organizations

Summary:
The Bone Health and Fracture Prevention Initiative focuses on protecting and improving the bone health of patients within the Grey and Bruce regions. This initiative is unique within the province as we are leveraging existing community resources by collaborating with the Ontario Osteoporosis Strategy. The Bone Health Initiative follows a process of identification, screening, education, and treatment/referral as required. Our presentation will focus on the success of the Bone Health Day and how it can be implemented in other FHTs across Ontario.

Identification:
A Bone Health Registry is created through EMR searches for patients over 65 with a completed BMD. The Ontario Osteoporosis Strategy Fracture Prevention Coordinator (FPC) also receives post fracture data from the hospitals for patients over 50 years.

Screening:
The physician/NP or RN screens patients by completing Fracture Risk Screening Tool scores. The FPC screens patients with previous fragility fractures. Patients at risk for fracture are then invited to the Bone Health Day.
**Education:**
The Bone Health Day Group Medical Visits, supported by strategic external partnerships, provide patients with tools, education and practical strategies to improve their bone health. Patients complete an Osteoporosis Form on a tablet, ensuring efficient input of patient data that populates directly into the patient’s EMR chart and encouraging self-management.

**Treatment/Referrals:**
The physician recommends pharmacological interventions as required and patients receive an individual Report Card with their screening results and any suggested referrals.

**Evaluation:**
Patient Experience surveys are utilized to evaluate the effectiveness of the Bone Health Days and patient satisfaction.

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**19 Building Diagnostic Imaging Appropriateness Pathways for Primary Care from Primary Care**

**Theme:** 2. Optimizing capacity of interprofessional teams

*Jeff Bloom, MD, Family Physician-in-Chief, University Health Network*

*Y. Raja Rampausahaan, MD, Orthopaedic Spine Surgeon, Clinical Champion ISAEC Pilot, Toronto Western Hospital, University Health Network*

*University Health Network Joint Department of Medical Imaging:*
  - Lilly Whitham, Senior Project Manager
  - Jisla Matthews, Senior Business Analyst
  - Karen Weiser, Business Analyst, Office of Strategy Management

**Learning Objectives:**
- Knowledge of best practices related to imaging and management of clinical scenarios commonly presenting in primary care, specifically headache, symptoms suggestive of TIA and stroke, low back pain and knee pain
- Methods for recruitment and assembly of multidisciplinary clinical review panels comprising clinicians (primary care providers, radiologists and specialists) in urban, rural, academic and community practices
- Approaches to establishing primary care leadership of multidisciplinary panels
- Use of a standard consensus-based guideline adaptation methodology to evaluate current best-evidence and front line clinician perspective to develop imaging pathways

**Summary:**

**Purpose:**
Medical imaging is a complex field, with rapidly advancing technology and concerning variability in referral patterns. The Diagnostic Imaging Appropriateness (DI-APP) Project was launched in 2014 to develop robust, Ontario-specific, evidence-based guidelines, framed in the primary care lens to improve the appropriateness of imaging referral practices and help provide the right care, to the right patient, at the right time.

**Goals:**
- Align clinically relevant, evidence-based DI guidelines to develop Imaging Pathways for clinical scenarios that present commonly to primary care, such as headache and low back pain
- Develop recommendations for implementation and sustainability to ensure tools can be adopted into primary care practice and remain current with best evidence

**Methods:**
The Imaging Pathways are developed collaboratively by multidisciplinary panels that are led by primary care providers (PCP) and include radiologists and other specialist physicians. PCPs are strategically positioned as leads to ensure that the pathways are relevant to the end users. The pathway development process adopts elements of the CAN-IMPLEMENT framework, a streamlined version of the ADAPTE methodology for guideline adaptation.

**Conclusion:**
Assembling multidisciplinary clinician groups, led by primary care providers, to develop imaging pathways for their peers fosters sustained engagement to create knowledge products that relevant to end users. Key to achieving widespread adoption will be integrating pathways into primary care providers’ workflow and an implementation strategy that includes training and educational tools.

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**20 Development of an innovative nursing led persistent Non-Cancer Pain Program in Primary Care: Lessons Learned and Initial Outcomes**

**Theme:** 2. Optimizing capacity of interprofessional teams

*Debbie McGregor, Executive Director, Bruyere FHT*

**Learning Objectives:**
Readers will learn about how we developed and implemented an RN led chronic disease self-management for chronic non-cancer pain in an FHT. We will review the lessons learned and the practical steps to building a chronic non-cancer pain program including: development of a valid EMR disease registry, evidence based tools for self-management, lessons learned for implementation in an FHT setting. We will also present our initial outcome data.

Our experience with this program demonstrates that it is possible for RNs to lead a chronic pain self-management program. We feel that our program will be very relevant to other FHTs across the provinces who are working to better serve this population.

**Summary:**
Persistent non-cancer pain is a very common problem in primary care. It carries a high burden of illness to the patient and high
demand on the primary care system. Self-management programs have been found to benefit chronic pain patients and these programs are well suited to be run in an interdisciplinary FHT setting.

Over the last 3 years our FHT has developed expertise in RN-led self-management programs for other diseases including hypertension and congestive heart failure. We have now used this experience to build an RN led program for persistent non-cancer pain.

The program includes:
- development of evidence based tools and interventions to be used by the RN for education in self-management of chronic pain
- creation of a chart audit tool to help identify in advance the needs of patients and triage care
- identification of possible patients through registries and chart audit
- collaboration with the Primary Care provider
- assessment and identification of possible supports available to the patient
- patient self-management education
- a Stanford Self-management on-site peer led group
- CME for our physicians and nurse practitioners to build capacity in chronic pain self-management.

The poster will describe the program and tools and lessons learned.

We will discuss preliminary results:
- Patient participation in RN education
- Group participation
- Satisfaction results
- Pain inventory results
- Participant confidence measure

21 Effects of a Multi-Faceted Mentoring Intervention on Spirometry Knowledge, Quality and Usage in Primary Care

Theme: 2. Optimizing capacity of interprofessional teams

Dishad Moosa, RRT, CRE/ Manager, Provider Education Program, Ontario Lung Association

Learning Objectives:
Asthma is the third most common chronic disease in adults, affecting 8.1% of the Canadian population. Only 35% of patients with asthma report having had spirometry, and 46% of primary care physicians report using spirometry to monitor asthma. Regular use of spirometry in primary care has been shown to decrease over diagnosis and to improve medication adherence.

We sought to design and evaluate a knowledge translation intervention to address the underuse and poor quality of spirometry in primary care. The intervention was designed on the basis of an extensive barriers and facilitators evaluation, and modelled on a peer mentorship program developed by the Ontario College of Family Physicians.

Summary:
This was a pre-and post-analysis, comparing outcomes during a 1-year intervention period to those in the year prior. The program established three mentor-mentee “pods,” each including physician and allied health mentors and corresponding mentees, connected through various methods of communication. We recruited mentees from seven Ontario primary care asthma program sites representing rural, urban, remote and underserviced populations.

Outcomes included:
1. knowledge of spirometry performance and interpretation (self-administered online test);
2. quality of spirometry (spirometry tracings evaluated with ATS/ERS standards); and
3. actual usage of spirometry in patients with established asthma (chart reviews of electronic medical records).

A mentorship-based intervention involving both primary care physicians and allied health practitioners can enhance knowledge, technical competence, and actual use of spirometry in eclectic, real world primary care settings.

22 Expanding capacity within Primary Health Care: Development of a Physiotherapy Community of Practice

Theme: 2. Optimizing capacity of interprofessional teams

Julie Richardson, BSc PT, PhD, School of Rehabilitation Science, McMaster University
Jordan Miller, MSc PT, Woodstock CHC
Dragana Susic, BSc PT MSc, Holland Centre-Sunnybrook Health Sciences Centre

Learning Objectives:
1. To understand how a Community of Practice (CoP) can facilitate collaboration through sharing of resources and consultation of a profession which has recently expanded in primary health care (PHC), including Family Health Teams (FHTs)
2. To understand the need for and subsequent pathway and processes of the development of a CoP.
3. To be familiar with plans for the ongoing development of CoP for physiotherapy.

Summary:
This CoP was formed under the Primary Care Advisory Committee in response to new Ministry funding to support physiotherapists (PTs) who are assuming new roles in PHC,
including FHTs. Several objectives for the initial development of a PT CoP are to:

1. Actively engage PTs working in all primary health care settings, including: FHTs, Community Health Centres, Nurse Practitioner Led Clinics and Aboriginal Health Access Centres
2. Provide a platform for the development of shared objectives and priorities for the members of the CoP
3. Assemble evidence based resources to support multiple methods of service delivery.

We will describe our interactions with the larger CoP network within AFHTO and the benefits of their experience. A challenge for administrators of FHTs is optimizing the hiring of professionals most suited and committed to the development of these new roles. The CoP will provide resources to support the hiring process, and will communicate the vision for, and utility of, the CoP to new hires. These resources will address many challenges that PTs will encounter in this new practice environment, including a large number of rostered clients with needs, ranging from chronic disease to acute injuries.

We will describe our plan to collaboratively develop models of service delivery such as group based care and clinics; building capacity within the interprofessional team; develop evidence-based programs; and share information with members of the interprofessional team regarding scope of practice and contribution of physiotherapy to the care, and quality of life of patients within PHC.

23 Health Professional Perspectives Regarding the use of Patient-Reported Outcome Measures in an Integrated Primary Care Health Centre – A Pilot Project

**Theme:** 2. Optimizing capacity of interprofessional teams

*Deborah Kopansky-Giles, Professor and Chiropractic Program Coordinator, St. Michael's Hospital and Canadian Memorial Chiropractic College*

**Learning Objectives:**
- Understanding the rationale for the use of patient reported outcome measures
- Learning what the perspectives of health providers are with respect to PROM use in primary care settings
- Seeing recommendations made by health providers about use of PROMs in primary care through key informant interview results

**Summary:**

**Objective:**
To assess health professional perspectives surrounding the implementation of a standardized package of patient-reported outcome measures (PROMs) in an inner city, integrative primary health care centre and to identify specific PROMs recommended for package inclusion.

**Methods:**
This qualitative study involved semi-structured key informant interviews with healthcare practitioners working in the primary care health center. All interviews were transcribed verbatim and coded to ensure anonymity. The constant comparison method was used to identify common themes emerging from the data. REB approval was granted to proceed with the project.

**Results:**
Eleven practitioners participated. Responses were divided into major themes: Attitudes around the use of PROMs, PROMs currently in use by the study participant, advantages and disadvantages of implementing a package of PROMs, barriers and facilitators to PROM use in the department, desirable attributes of PROMs to use, and specific PROMs identified for package inclusion. The key informants concurred that the use of PROMs would be useful; however, there were concerns surrounding how the package would be implemented, the relevance to their profession, and how it would be used within and between professions. Participants provided recommendations toward PROMs that should be considered for inclusion as well as suggestions for the department to consider around implementation, specifically a carefully planned and collaborative approach to development to ensure department-wide buy-in.

**Conclusions:**
Participants generally agreed that implementing a standardized approach to the use of PROMs in our primary care setting was desirable. Advantages and disadvantages were identified as well as barriers and solutions to overcome these. Participants felt could be resolved by a careful planning and implementation strategy. The findings from this project will be helpful in the development of a full study inclusive of all health providers and department administrators and staff.

24 Healthy At Every Size (HAES) – Collaborating for Best Practice in Weight Management

**Theme:** 2. Optimizing capacity of interprofessional teams

*Julie Seale, Registered Dietitian, South East Toronto FHT*

**Learning Objectives:**
All FHTs have patients who want to lose weight (for appearance and/or health) or have been told by their health care providers that they need to lose weight. Research actually suggests that increased weight is not the main culprit in poor health; weight cycling, physical activity level, socioeconomic status and eating behaviour all play roles. This poster is intended to increase awareness of HAES and the research behind the approach. More importantly, the poster will outline our challenges to implementing HAES in our FHT and how we have utilized all team members in implementing a HAES approach to weight management.
**Summary:**
Health At Every Size (HAES) is a paradigm shift with regard to the way we view and treat clients. In healthcare, we have been educated and trained that being at a higher weight than "normal" increases health risks and is associated with increased morbidity and mortality, so the current treatment is to prescribe diet and weight loss. The evidence to support this is lacking. This poster will summarize the weight loss research and define HAES.

Weight stigma is a barrier to health care. It has been shown that a large number of healthcare providers have weight biases and these can affect the care they provide. This may cause patients to have stress and mistrust when it comes to their doctors and other providers, leading to avoidance of primary care. For example, when people feel pressure to lose weight by their primary caregiver, they stay away from primary care. HAES focuses on reducing weight bias.

Implementing HAES at a FHT is challenging because it opposes all that we have been taught about weight. This poster will outline SETFHT’s journey in this process.

**25 Lend Me Your Ear: Using Auricular Acupuncture to Treat Substance Use and Anxiety/Depression**

**Theme:** 2. Optimizing capacity of interprofessional teams

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Jason Hunter, Addictions & Mental Health Counsellor, South East Toronto FHT

**Learning Objectives:**
South East Toronto Family Health Team has several IHPs who offer smoking cessation counselling and free NRT to smokers who are ready to quit. Our Addiction and Mental Health counsellor also sees patients with other substance use/abuse issues and offers treatment and referral. In order to augment the available services for individuals with all forms of substance use/abuse, our AMH counsellor has begun to offer auricular acupuncture. Auricular acupuncture practitioners use 5 fine-gauge needles at designated points in the ear just under the skin. The presentation will offer participants some background information and published evidence, our own evidence, and a demonstration of the technique.

**Summary:**
Auricular acupuncture was developed by the Lincoln Recovery Centre (NYC) in the mid-1970s as a treatment for addictions, mental health, disaster and emotional trauma to be used in addition to traditional Western behavioural approaches to care. The National Acupuncture Detoxification Association (NADA) was established in 1985 and now trains individuals in providing auricular acupuncture. The procedure is used as an adjunct to other interventions such as individual counselling and education. Our new AMH counsellor is trained through NADA and had provided auricular acupuncture services in his previous work at Toronto East General Hospital’s Withdrawal Management Centre.

Upon review of our smoking cessation rates (which have not been impressive), and in discussion with some of the patients referred to him, he suggested that he offer AA to patients with substance use/abuse issues (nicotine as well as other substances). When the MDs at SETFHT heard about this, they were very excited for him to also offer AA for patients with anxiety/depression. SETFHT social workers already offer mindfulness/anaxiety workshops and individual counselling, and the FHT was generally excited about being able to offer another therapeutic intervention for our depressed/anxious patients.

After reviewing the liability implications and the cost (both were minimal), patients with substance use/abuse are now being referred to our AMH counsellor by MDs, NPs, RNs and our mental health team. If it is possible for our AMH counsellor to do more, he will begin accepting patients with anxiety/depression in the summer.

**26 Healthy Living with Pain (HeLP): an Interprofessional Chronic Pain Primary Care Initiative**

**Theme:** 2. Optimizing capacity of interprofessional teams

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Mt. Sinai Academic FHT:
Jessica Munro, BN, PHC, NP
Susanne Singh, BScPhm, PharmD, RPh
Michelle Naimer, MD, MHSc, CCFP

**Learning Objectives:**
In November, 2013, the Healthy Living with Pain (HeLP) Program was established as a quality improvement initiative by the Mount Sinai Academic Family Health Team. The program was designed to better assess, monitor and manage patients with chronic, non-cancer pain on chronic opioid medication. In this session, we will present the inter-professional program, share our victories and challenges in developing and running this program, and review outcomes to date.

**Summary:**
Chronic pain is a growing global health problem and represents considerable economic and social burden. At the same time, opioid prescribing has been controversial. In Ontario, the number of deaths related to prescription opioid overdoses increased five-fold from 1991 to 2004. It is essential that Family Health Teams are able to properly assess, manage and monitor patients on chronic opioid medications. This task becomes increasingly difficult in an Academic Family Health Team, where patients are often exposed to a number of different learners. Residents in our practice have encountered verbal abuse and threats by patients, unsanctioned dose escalations, doses of opioid medication that exceed safe levels, multiple prescribers, multiple pharmacies, poor pain control and patient and resident dissatisfaction.

In November 2013, the Healthy Living with Pain (HeLP) Program was established as a quality improvement initiative to attempt to...
better manage patients on chronic opioid medication for chronic non-cancer pain in the Mount Sinai Academic Family Health Team. This presentation will describe the interprofessional model developed to better assess and monitor patients on chronic opioid medications. The flowsheet developed for use in the electronic record to ensure thorough monitoring and consistent communication amongst providers will be presented, as well as the model used for interprofessional discussions. Finally, overall observations will be presented including challenges and benefits of the program.

27 **SOARing to New Heights: Exploring Opportunities for NP Leadership in Family Health Teams**

**Theme:** 2. Optimizing capacity of interprofessional teams

**Guelph FHT:**
Seraphina McAlister, Nurse Practitioner
Ashley Cressman, Nurse Practitioner

**Learning Objectives:**
This poster will present the process and outcomes of a one-day retreat attended by a team of 12 NPs. The ‘SOAR’ method informed the strategic planning activities of the day whereby the team identified strengths, opportunities, aspirations and results to help guide them toward a “preferred future” (Stavros & Hinrichs, 2010). Findings elicited from a qualitative analysis of textual data collected during the retreat are discussed in relation to a framework for interprofessional interventions in health care practice settings. Readers will walk away with practical and innovative approaches to interprofessional collaboration such as opportunities for team building and knowledge exchange.

**Summary:**
**Background:**
NPs working in family health teams have crafted a “new and different health service” in response to the needs and demands of primary care consumers (Carrery et al., 2007; Contandriopoulous et al., 2015; Daly & Carnwell, 2003). And yet, little is understood about the capacity for NP leadership within these interprofessional practice models.

**Methods:**
Textual data were collected during a one-day NP retreat that was informed by the ‘SOAR’ strategic planning approach. Then, two members of the NP team inductively analyzed notes from the semi-structured group discussions to identify emergent themes. A member checking approach was used to present findings to the NP team to elicit feedback and spark further discussion.

**Results:**
Four themes emerged from this inquiry: building a team identity, optimizing the NP role, facilitating knowledge exchange, and putting ourselves out there. To further explore NP capacity for leadership in family health teams, these themes were considered through an interprofessional lens using a framework for understanding the nature of interprofessional interventions (Reeves, Goldman, & Zwarenstein, 2009). Interventions that were identified during the retreat targeted organizational, team, and individual practice levels, for example: shaping policy, participation in decision making, developing communication tools, creating interprofessional education opportunities, as well as cultivating and utilizing the NP knowledge, skills and attitudes to exercise capacity for leadership in family health teams.

**Conclusion:**
These targeted interventions aim to optimize the NP role, enhance interprofessional collaboration, and ultimately make a positive impact on primary care service delivery and consumer outcomes.

28 **Turn Key Approach to Quality Improvement for Stroke Prevention: A Practical Team Application**

**Theme:** 2. Optimizing capacity of interprofessional teams

**David Makary, MD, CCFP, QI Lead Southlake Academic FHT**

**Thrombosis Canada:**
Nicola Banks, BSc, Executive Director
Alan Bell, MD, CCFP, Executive Member

**Learning Objectives:**
This poster will:

- Highlight a facilitated approach to quality improvement (QI) that addresses some of the challenges primary care teams face with QI implementation.
- Showcase point of care encounter tools for stroke management which are embedded within the Electronic Medical Record.

**Summary:**
Each year approximately 50,000 Canadians suffer a stroke. Strokes are the leading cause of disability, and the third leading cause of death in Canada. They cost the Canadian economy at least $2.7 billion dollars annually. Primary care teams play a pivotal role to ensure that evidence-based strategies to prevent stroke are appropriately implemented, however a significant care gap exists.

Thrombosis Canada has created a supportive and EMR-integrated quality improvement program founded on evidence-based medicine and point of care clinical tools. Facilitated Quality Improvement (FQI) is an innovative approach to practice improvement that builds on the fields of Knowledge Translation, Patient Safety and Quality Improvement. It provides a turn key platform in which participants are offered evidence-based clinical endpoints, practice tools and training to improve clinical processes, point of care decision making, care outcomes, and support more effective team functioning, and provider satisfaction.
The project engages multiple team members including physicians, allied health, administrative staff and even learners and allows for increased collaboration in identifying at risk patients and being part of their treatment plan. This facilitated QIP focuses on the identification and screening of atrial fibrillation, appropriate management including risk stratification and treatment with anticoagulants, and finally on optimizing annual review of management in patients with atrial fibrillation. This Facilitated Quality Improvement Plan (FQIP) has been accredited and approved for 6 MainPro-C credits. We are happy to announce that we have gained the capability to expand the FQIP to 10 sites. We will be requesting expressions of interest shortly and look forward to beginning this new opportunity at your site.

29 Up the Creek without a Paddle: How the Care Navigator at SETFHT Helps Patients Steer through the System

Theme: 2. Optimizing capacity of interprofessional teams

Danielle Del Duca, Care Navigator, South East Toronto FHT

Learning Objectives:
The Care Navigator is not a unique role in the FHT environment. However, our Care Navigator is not an RN who assists the frail elderly; rather, she is a social worker who functions more as a problem-solver, referral agent and general support to our patients and their families who face a multitude of challenges that can be broadly defined as "social determinants of health."

The poster will outline her various roles and how other FHTs might introduce some of these elements to their care navigator position.

Summary:
The SETFHT Care Navigator is a bit different from those in other FHTS in that her background is social work (she is a MSW) and her focus is not primarily on the frail elderly and linking these patients with resources. We have a very involved Health Links team that is responsible for this group of patients through the Virtual Ward, TIP RN program, CCT, etc. Rather, as part of the SETFHT mental health team, our Care Navigator works with patients in a variety of ways, providing assistance with income (general income support as well as financial support for medications), housing (finding housing, keeping housing, bed bugs), legal issues (landlord/tenant disputes), substance use, mental health issues and everything in between.

Our care navigator is also responsible for developing and maintaining relationships with external agencies who can offer care to our patients. For example, she has worked with the Alzheimer's Society around issues of dementia and they are now offering regular sessions to patients/families and the community at large at our SETFHT clinic sites.

In addition, our care navigator is a vital link in our 7-day post discharge visits in that she regularly reviews Hospital Report Manager reports and contacts patients for follow up appointments. She also works with our pharmacist to complete medication reconciliation on patients discharged from hospital.
Theme 3 – Transforming patients and caregivers experience and health

Healthcare in Ontario is moving towards an integrated, population-based health care system; it’s about what’s important to the patient and evolving our health care system to match that. Interprofessional primary care teams work with patients and caregivers to develop services that respond to their expectations and needs. This stream focuses on the programs, initiatives and changes that include the patient and caregiver voice in strategic and program planning, and care delivery.

Posters:

30 Advanced Care Planning in Primary Care - Lessons Learned
31 Breaking Down the Barriers of Care to Support a Deaf, Developmentally Delayed Patient within the London Family Health Team
32 Comparing two Assessment Approaches in a Primary Care Diabetes Setting to Obtain Descriptive, High-Quality Feedback on the Patient Experience
33 Confused and Lost - Where do I Begin Navigating the Health Care Labyrinth?
34 Evaluation of the Ontario Stroke Network’s Hypertension Management Program: A Model for Stroke Prevention in Primary Care Settings
35 Health Literacy: You were heard but were you understood?
36 Improving Cervical Cancer Screening Rates: Quality Improvement Pilot Initiative
37 Interprofessional Maternity Care in the Mt. Sinai Hospital Academic FHT: Keeping Family Doctors in the Game
38 My Values, My Wishes, My Plan: e-Module for Inter-Professional Teams Toward Effective ACP Conversation with Patients
39 R Meditation is Medicine

30 Advanced Care Planning in Primary Care - Lessons Learned

Theme: 3. Transforming patients’ and caregivers’ experience and health

Victoria Stella, RN, Program Manager, Jane Finch FHT

Learning Objectives:
In 2013 the Jane Finch Family Health Team (JFFHT) implemented an Advanced Care Planning (ACP) Program with patients to introduce them to the concept of ACP and discuss with them the importance of a Substitute Decision Maker (SDM) as well as the benefits of discussing their healthcare wishes with their SDM and family. The importance of ACP would be broached by the PCP and, if agreeable, the patient would be given a handout about ACP and then booked for a 45-minute session with our social worker. In January 2015, we began to survey patients immediately prior to and after the ACP intervention to assess the impact of this session of their understanding of basic concepts of ACP.

Summary:
There is clear evidence from Pallium Canada and others that introducing ACP by a PCP has benefits. To date, the JFFHT has conducted over 300 sessions with patients and members of the Jane Finch Community to introduce them to the benefits of ACP. While we had antedotal evidence that these sessions were beneficial, we wanted to survey patients in order to collect data to confirm our hypothesis that the ACP session increases their knowledge of basic important concepts and their satisfaction with our sessions.

The 5 questions asked prior to and after the ACP intervention were:
1. I understand the concept of ACP.
2. I understand the importance of a SDM.
3. In the event that I am not able to make decisions on my own regarding my healthcare, I have/will discussed my wishes with my SDM and my family.
4. I am satisfied this will be/has been a useful discussion about ACP.
5. I would recommend this information session to my family and friends.

The patients ranked each question from 1-5 ranging from very little knowledge or agreement with each question (1) to very good knowledge or agreement (5) wrt to each question.

It is clear from the initial surgery results that there is benefit to these sessions. We will continue to collect data so that the our population size is adequate in order to confirm our hypothesis using meaningful statistical analysis. We believe it is possible for other multi-disciplinary teams to use this approach and begin introducing these important concepts at the primary care level.
31 Breaking Down the Barriers of Care to Support a Deaf, Developmentally Delayed Patient within the London Family Health Team

Theme: 3. Transforming patients’ and caregivers’ experience and health

London FHT:
Heather Rumleskie, RN, BScN
Catherine Walsh, MD, CCFP, FCFP, Board Chair

Learning Objectives:
- Better understand the barriers to providing care affecting patients who are deaf and developmentally delayed.
- Recognize the benefits of better communication with the deaf and developmentally delayed and how it can improve the quality of the patient’s care.
- Understand the importance of the role of community partners in the circle of care with the deaf and developmentally delayed patient.

Summary:
Achieving optimum patient centred care requires effective communication between clinicians and patient. However, this communication can be challenging when it comes to patients who are deaf and developmentally delayed. Despite often establishing strong relationships with their individual primary care providers, it can still result in inadequate comprehension of disease management and poor treatment adherence.

Through a patient example, we will examine how a deaf, developmentally delayed, elderly, diabetic woman with anxiety disorder who lives on her own, navigates the health care system. We will identify barriers of care and show how the London FHT helped support the patient in adherence to treatment.

For 29 years, this patient’s relationship with the health care provider was based on a traditional model of care. A circle of care had been established to include a sign language interpreter (Ontario Interpreting Services) and her social worker (Canadian Hearing Society). There were also specialists and a foot care nurse that saw her as well. Five years ago this physician joined the London Family Health Team, and a chronic disease nurse became an integral part of her circle of care. Although those involved were working in collaboration, there remained a lack of communication amongst care providers. Upon a routine follow-up appointment after the patient’s meeting with a specialist, it became apparent that the patient was limited in her understanding of what was being asked of her which resulted in non-adherence to treatment.

With further discussion, the physician organized a meeting and established the patient’s circle of care, which included the above care providers as well as the CCAC Case Manager which was pivotal to her support. An action plan consisting of regular communication, improved follow-through from physician/specialist appointments, regular homecare visits by nursing to establish adherence to the intended treatment plan including medication, reducing poor outcomes and improving overall care.

32 Comparing two Assessment Approaches in a Primary Care Diabetes Setting to Obtain Descriptive, High-Quality Feedback on the Patient Experience

Theme: 3. Transforming patients’ and caregivers’ experience and health

Jane Finch FHT:
Stephanie Varriano, Registered Dietitian
Suki Kaur, RN

Learning Objectives:
1. Compare delivery methods of a patient experience survey
2. Evaluate strengths, limitations and implications of the focus group versus individual written survey method
3. Utilize patient feedback to modify program planning and care delivery to meet the needs of patients not meeting evidence based targets.

Summary:
Primary care teams are engaging in quality improvement initiatives to provide a better patient experience, improve the health of the population, and increase efficiencies. Patient experience is positively associated with clinical effectiveness, and certain aspects of care are best assessed by asking patients. Evidence shows that focus groups can facilitate increased understanding of perspectives of culturally and linguistically diverse groups, as in the Jane and Finch community.

Using clinical data to track outcome measures, we saw a care gap in a group of younger patients (under the age of 65) who were close to achieving glycemic targets (between 0.07-0.08 Hba1c). In order to better serve these patients, we sought to discover if the delivery method of our patient experience survey would have an impact on the quality of the responses we received. To understand this, the survey would be conducted in two ways: in a focus group setting with peer discussion, or completed individually. Focus group results will be compared with survey results qualitatively, and these will be used to identify which method works best in our selected population. This will guide future initiatives to hear the voice of our target population and thus improve patient-centered care.
Confused and Lost - Where do I Begin Navigating the Health Care Labyrinth??

**Theme:** 3. Transforming patients’ and caregivers’ experience and health

Anne Donaldson, CEP Member (health care client and caregiver), East Toronto Health Link
Maggie Bruneau RN, MHSc, CHE, Vice President, Partnerships & Chief Nurse Executive (CNE), Providence Healthcare

**Learning Objectives:**
1. Empowered and knowledgeable consumers will lead to a more effective and efficient usage of the health care system.
2. Understand where some of the gaps exist for patients to access the right care and at the right place.
3. Explore reasons why primary care might not always be the first stop on a patient’s health care journey.
4. Share a possible system navigation approach that can be delivered and communicated by patients and caregivers to consumers.

**Summary:**
East Toronto Health Link’s Community Engagement Panel, which comprises a membership of current health care consumers and caregivers, has developed a comprehensive health care navigation module which will be delivered across the Health Link geography, including various community spots.
The module has been trialed at Providence Healthcare in Toronto where many recommendations for improvement were received and implemented, with further trials scheduled in the community.
The intent is to have the module available online for every consumer in Ontario.
Along with the navigation module, the CEP will also develop a patient checklist, pamphlets and a personal care plan.

Evaluation of the Ontario Stroke Network’s Hypertension Management Program: A Model for Stroke Prevention in Primary Care Settings

**Theme:** 3. Transforming patients’ and caregivers’ experience and health

Ontario Stroke Network Hypertension Management Program:
Stephan Sundquist, Senior Manager
Pauline Therrien, Clinical Specialist

**Learning Objectives:**
Participants will learn about practical resources provided to primary care teams through the Ontario Stroke Network (OSN) Hypertension Management Program (HMP) that can enable providers’ to deliver best practices in cardiovascular disease prevention. The HMP is modeled on Ontario’s Chronic Disease Prevention and Management framework, and concordant with Canadian Hypertension Education Program (CHEP) guidelines. Access to practice-level and individual patient outcomes provides a means for ongoing, detailed tracking of program effectiveness and clearly illustrates degree of compliance with applicable guidelines and denotes areas of improvement.

**Summary:**
Since 2012, the Ontario Stroke Network (OSN) has delivered the provincial Hypertension Management Program (HMP). The HMP is modeled on Ontario’s Chronic Disease Prevention and Management framework, and reflects best practice care delivery as outlined in the Canadian Hypertension Education Program (CHEP) guidelines. The HMP goal is to improve cardiovascular disease prevention through a focus on hypertension. In 2013, the OSN undertook a comprehensive evaluation of the HMP to inform stakeholders on the effectiveness, ongoing sustainability, and feasibility for program expansion.

**Method:**
A mixed-methods approach was used, including a quantitative HMP data repository analysis to evaluate changes from patient baseline of blood pressure (BP), relevant lab values and risk factor self-management. The qualitative evaluation involved site visits and surveys with participating health care providers (HCPs) and enrolled patients which further addressed experiences with program delivery.

**Results:**
Quantitative results showed statistically significant reductions in systolic and diastolic BP for HMP patients with initial diagnosis of hypertension (HTN), elevated BP as well as for those with diabetes. HCPs expressed increased confidence in HTN diagnosis and treatment, better understanding & compliance with CHEP guidelines, improved inter-professional communication and reported success in providing patients with the knowledge and skills for self-management of HTN. Patients reported greater confidence in abilities to monitor BP and address modifiable risk factors as a result of health information received. Improvement opportunities for program integration, workflow and enhanced health information resources were identified.

**Conclusions:**
Evaluation outcomes of HMP delivery were positive overall, showing benefit for HCPs and patients with hypertension. Opportunities have been identified to explore program evolution including: improving point-of-care access to evidence and outcomes reporting for HCPs, as well as creating capacity for comparing HMP patient outcomes to population data.
35 Health Literacy: You were heard but were you understood?

Theme: 3. Transforming patients’ and caregivers’ experience and health

Sally Boyle, RN, BScN, CDE, Program Lead South West Self-Management Program, South West CCAC

Learning Objectives:
- Define health literacy
- Identify prevalence and effects of low health literacy
- Understand their role and the importance of communicating clearly
- Apply “Universal Precautions” tools and skills in health communication

Summary:
Health Literacy refers to a person’s ability to access, understand and act on health related information. This is affected by an individual’s knowledge, skills, experience and beliefs. Self-Management is central to the Ontario’s Chronic Disease Prevention and Management Framework and is critical for long term impact as it’s the client’s daily decisions and health behaviors that influence how well their chronic diseases are controlled. Unfortunately in Canada, 60% of adults have low health literacy skills and therefore are not able to adequately manage their health and health-care needs. This results in reduced health knowledge, less use of preventative care services, medication errors, increase hospitalizations and decreased quality of life.

It is essential that health care providers be aware of not only the impact of low health literacy but also their responsibility to communicate clearly with clients and most importantly, check for understanding. The complexity of the message and the health professional’s ability to communicate using simple, plain language are important factors. Everyone in the health care system has a responsibility to use effective communication skills in order to affect health outcomes.

This presentation encompasses awareness training, written and verbal communication and design, as well as utilizing Health Literacy “Universal Precautions” which recognize that every encounter is at risk for miscommunication and that a shame free environment needs to be established. Understanding is a two way street and health literacy bridges knowledge and behavior.

36 Improving Cervical Cancer Screening Rates: Quality Improvement Pilot Initiative

Theme: 3. Transforming patients’ and caregivers’ experience and health

Camille Assad, Project Clerk, Bruyere FHT

Learning Objectives:
- How to implement a preventative care quality improvement project.
- How to design a protocol for clerk follow-up for preventative care.
- How to create a process for year round preventative care in an academic family health team.
- Participants will be given a template for a poster to be put in each provider office that gives step by step instructions how to access and use the Preventative Summary Report in the Telus PSS EMR.

Summary:
This study was a quality improvement pilot initiative that was carried out in an academic family health team. A pilot project was initiated where a clerk was responsible for contacting patients that were due for a pap test (according to the electronic medical record). This project was responsible for increasing the number of patients that received pap smear resulting in both better patient health outcomes and benefiting doctors through the preventative care bonus as a corollary.

Methods:
- Lists of patients due for the various screening maneuvers were distributed to the appropriate physicians for review.
- Unscheduled patients were called and offered an appointment to come in for their pap test.
- Patients already scheduled for appointments- reminders were put on the appointment reason.

Recommendations/Next course of action:
- Front desk staff is trained to look at reminders. When patients call for apt, they can remind patients that they are due for cancer screening.
- Using our TV screens to promote cancer awareness months.
- Mailing out reminder letters to patients.
- Sending reminder text messages to patient.
- Providing physicians and nurse practitioners with their preventative care summary lists to review monthly.
- Develop a “preventative care protocol” for all staff including Physicians, nurses and clerks.
Interprofessional Maternity Care in the Mt. Sinai Hospital Academic FHT: Keeping Family Doctors in the Game

**Theme:** 3. Transforming patients’ and caregivers’ experience and health

**Mt. Sinai Academic FHT:**
- Alison Meikle, RN, Maternity Care Nurse
- Lianne Butterfill, MD, Family Medicine Resident
- Anne Biringer, MD, CCFC, FCFP, Ada and Slaight Family Director of Maternity Care

**Learning Objectives:**
Participants will learn about the role and the experience of each member of the Mt. Sinai Hospital Academic FHT (MSHAFHT) maternity care team. A unique aspect of this program is the integration of a family medicine resident into the prenatal, intrapartum and postpartum care of each woman. The benefits of this model as well as the inherent challenges will be discussed.

**Summary:**
**Context:**
The number of family physicians providing full scope (including intrapartum) maternity care continues to decrease in Ontario. Mt. Sinai Hospital Academic FHT is committed to fully integrating the family medicine resident into the interprofessional maternity care team with the hopes that they will see this as a viable component of comprehensive practice when they graduate.

**Program:**
Centred on a maternity care nurse, the team provides care to approximately 160 pregnant women per year. Each woman has a primary staff physician and resident physician who alternate prenatal visits and attend her birth. The role of each member of the team (which also includes dietitian, social worker, pharmacist, team nurse and nurse practitioner) will be described in the workshop. In addition, several maternity care team members (in particular, the family medicine resident, maternity nurse and staff family physician) will share their personal experiences with the program.

**Evaluation:**
MSHAFHT is known for supporting family medicine involvement in full scope maternity care and graduating residents who want to include this in their future practices. Our patient survey confirms that our program meets the needs of the women that we serve while attending to the educational needs of the residents.

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My Values, My Wishes, My Plan: e-Module for Inter-Professional Teams Toward Effective ACP Conversation with Patients

**Theme:** 3. Transforming patients’ and caregivers’ experience and health

**Aasif Khakoo, Director, East Toronto Health Link, South East Toronto FHT**

**Nadia Incardona, MD, BSc, CCFP, Hospitalist and Emergency Physician, Rural Northern Initiative Coordinator; Lecturer, University of Toronto DFCM**

**Learning Objectives:**
1. Define Advance Care Planning and its relationship to an individual’s values and its importance in transforming patients’ & caregivers’ experience and health.
2. How Advance Care Planning discussions can include Goals of Care and End of Life Care discussions.
3. Define a provider’s role as a facilitator in Advance Care Planning and learn a process to guide patients and caregivers through Advance Care Planning.
4. Learn some of the common scenarios where ACP is done, as well as actual words for effective conversations with patients and caregivers.
5. Recognize the 6 steps an individual will go through in Advance Care Planning.

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

The East Toronto Health Link (ETHeL) has developed an interdisciplinary and interprofessional facilitator model of the ACP process. Our model is stratified to respond to the spectrum of health experiences of patients (i.e., the healthy adult age 50, the adult with a progressive chronic disease, and the adult in their last year of life). The facilitated model used a values-based practice model to assist patients with identifying their values and wishes for future care. Training for ACP facilitators therefore focuses on values-based practice, advanced communication skills, and an improved understanding of the ethical and legal issues of ACP.

This poster will provide an overview of the model, approaches to common barriers to ACP in primary care and an approach to
incorporating ACP into routine care of patients within a family health team. In addition, we will provide examples and scenarios from the e-Learning Module and provide access to engage in the module post-conference.

39 Meditation is Medicine

Theme: 3. Transforming patients’ and caregivers’ experience and health

Natalie Clark, Program Administrator, Thames Valley FHT

Learning Objectives:
Participants will learn how to implement a mindfulness program and by gaining knowledge in the following areas:

- The benefits of incorporating group mindfulness practice options for patients within their own FHT.
- An overview of the variety of practice options that have been tried, tested and shown to be effective (open drop in format, evening/day/Saturday, full day workshop, 4-week)
- The key components of the program
- Outcome measurement tools: How mindfulness can assist patients with a variety of health care needs (such as health promotion and chronic disease management).

Summary:
The Thames Valley FHT (TVFHT) Mindfulness Program is a skilled-based workshop focusing on the introduction of mindfulness/meditation techniques through experiential practice. This workshop provides patients with training in relaxation, guided imagery, and techniques to increase daily mindfulness and decrease physical and psychological symptoms of stress. TVFHT began offering the workshop due to high demand and repetition observed within individual appointments.

Due to high attendance rates and demand, the Quality Improvement team established a committee comprised mainly of social workers from the FHT who have a passion (and interest in training in this area) for offering patients the opportunity to learn and practice mindfulness. The group meets on a regular basis to discuss best practices, (identify and address professional development needs), share experiences and improve patient experience based on responses from satisfaction surveys.

TVFHT increased the offering of the Mindfulness program from one site to five sites over the course of a few short months. Patients all over our geographical spread now have access to the positive benefits of incorporating a mindfulness practice into their lives. In addition, participants that have completed the workshop are referred to attend bi-weekly practice sessions, where social workers expand the scope of techniques allowing for the opportunity to gain increased knowledge. Participants of the program highly recommend the program to others and provide very positive responses on satisfaction surveys. Providing patients the ability to attend a group program has decreased lengthy one-on-one appointments with our social workers, therefore improving access to the right care.
Theme 4 – Building the rural health care team: making the most of available resources

*Rural health care teams face unique challenges in providing care across large areas with small teams, isolated patients and limited access to resources. These teams find innovative solutions to reach remote patients and specialist care using technology, creating teams and community partnership across significant distance to provide care in a timely manner. This streams focuses on the lessons and innovations that maximize the use of resources in these environments which can be applied in wider team-based primary care settings.*

**Posters:**

41  One-Week Rural Placements for First-Year Medical Students – Building the Rural HealthCare Teams of Tomorrow

40  **Helping Patients Overcome Barriers to Regular Exercise**

**Theme:** 4. Building the rural health care team: making the most of available resources

**Wawa FHT:**

Anjali Oberai, MD
Jordan Knorz, Summer Student

**Learning Objectives:**
The first learning objective covers assessing the physical activity habits of the patient base, and identifying the most common barriers to exercise.

The second objective covers implementing exercise prescriptions. We describe strategies that allow providers to easily identify, explain, and prescribe the most suitable type of exercise to a given patient, while placing minimal time strain on the visit.

The final objective covers using customized text messages to help patients stay motivated to exercise. We discuss the content and schedule of these messages, as well as how to send these messages over the Internet and automate their delivery.

**Summary:**
We developed a survey to identify barriers to regular exercise facing our patients. It takes under 2 minutes to complete, and we collected 123 responses.

We then developed a streamlined process for prescribing exercise, and an exercise prescription pad design to facilitate this process. First, we work with the patient to choose a type of exercise they could safely enjoy. This is usually walking. Then, we prescribe a program tailored to circumvent the specific barriers facing the patient.

The prescription pad includes templates for workarounds to common barriers. Inactive patients are prescribed shorter exercise sessions, with instructions to increase session length (or add new sessions) as their fitness increases. Patients with many time constraints are prescribed interval routines. These involve alternating paces, and produce similar results in less time than maintaining one pace. Finally, providers may give unique instructions at their discretion. For example, patients with foot injuries are referred to a chair-based exercise group.

The exercise prescriptions address needs identified by the survey. Other health teams across the province could use these tools to help their patients sustain active lifestyles.

Some evidence suggests receiving customized text messages may increase motivation to exercise. We launched a pilot project to test this. Messages include reminders to exercise, and the short- and long-term benefits of physical activity. We work with patients to select the message content and schedule. Messages are then scheduled for automated delivery over the Internet. This project could potentially provide an inexpensive patient outreach method.
One-Week Rural Placements for First-Year Medical Students – Building the Rural HealthCare Teams of Tomorrow

**Theme:** 4. Building the rural health care team: making the most of available resources

**Rural Ontario Medical Program:**

Dr. Peter Wells, MD, CCFP, FCFP, FRRMS, Executive Director
Michelle Hunter, MSc, Program Manager
William Lampe, MSc

**Learning Objectives:**

Student selection, rural clerkship rotations and residency programs, and incentives to practice in rural communities have been targeted, with varying degrees of success, to address the shortage of rural Canadian physicians. An additional opportunity to influence students’ beliefs towards, and interest in, rural healthcare is during pre-clerkship, when exposure to rural medicine can bias them toward rural practice.

This poster will:
- Outline ROMP’s initiative providing 1-week rural clinical experiences to pre-clerk medical students;
- Address how the program has influenced students’ attitudes towards, and interest in, rural healthcare;
- Provide practical recommendations for undergraduate medical programs and healthcare professionals.

**Summary:**

In Canada, a gap exists between the healthcare resources and services available in rural versus in urban communities, to which the relative shortage of rural healthcare professions – including physicians – is a contributing factor. Medical student selection, rural clinical clerkship rotations, rural residency programs, and incentives to practice in rural communities have been targeted to address the physician shortage. However, an opportunity exists to direct students towards rural practice during pre-clerkship, when short experiences in rural communities provide an opportunity for exposure to rural communities, medicine and healthcare teams earlier in their studies than would otherwise be possible.

The Rural Ontario Medical Program (ROMP) places undergraduate and postgraduate medical learners in rural communities for clinical rotations. Since 1999, ROMP has offered first-year medical students 1-week rural experiences during their summer break. The aim of this week is to expose students to rural communities and medicine, provide an opportunity to gain clinical experience early in their studies, and increase their interest in rural medicine. The week also serves to familiarize students with the types of healthcare teams which care for rural communities. The findings from this study – specifically, the extent to which ROMP Week influences learners’ beliefs and interest in rural medicine and communities – could be helpful in the ongoing effort to address the shortage or rural physicians and could have implications for other healthcare professionals, ultimately contributing to the sustainment of rural healthcare teams to meet the communities’ healthcare needs.
**Theme 5 – Advancing manageable meaningful measurement**

*Primary health care is growing its capacity to use data for improvement and give measurable evidence of the value of interprofessional primary care. This stream will share experiences of teams collecting and using data, improving access to patient health records while maintaining privacy, and maximizing use of EMRs.*

### Posters:

42. **A Better Flavour of 7-Day Follow-Up**

43. **A Partnership Approach to Pilot Primary Health Care EMR Content Standard: CIHI and Team-based Primary Health Care Organizations**

44. **An E-Learning Approach to Improving Primary Care Team QI Measurement Knowledge and Skill**

45. **Data for Quality Improvement: Working with our Hospital Partner on QIP Access and Integration Goals**

46. **Health Equity: The Key to Meaningful Evaluation**

47. **Improving Patient Access**

48. **Ontario’s Enhanced 18-month Well-Baby Visit EMR Integration and Repository Project**

49. **Putting Data in the Hands of Primary Care Providers to Support Quality Improvement**

50. **Quality Improvement in Primary Care through an Integrated Vascular Health Care Approach**

51. **The Cervical Screening Reminder Calls Pilot: An EMR Optimization Initiative to Support Primary Care**

52. **Turning Data Lemons into Data Lemonade: Our Journey with 7-day Post Discharge**

53. **What’s a QIDSS... and what can they do for you in particular and primary care in general?**

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**42 A Better Flavour of 7-Day Follow-Up**

**Theme:** 5. Advancing manageable meaningful measurement

_Carol Mulder, MSc, Provincial Lead, Quality Improvement Decision Support (QIDS) Program, AFHTO_

**Learning Objectives:**

Participants will build on the information in d2d 2.0 about 7-day follow-up and collaborate to develop consensus on a better definition of 7-day follow-up that is both possible to measure and connects with what is important in team-based primary care.

**Summary:**

Progress on efforts to improve data quality Hospital Report Manager: While OMD reports progress with HRM, there is no perceptible increase in the number of teams who have implemented HRM. There are a minimum of 44 hospitals that teams work with that are still not prepared to send hospitalization data to teams, regardless of the state of readiness of the teams. In addition, not all teams are fully aware what HRM actually does nor how to proceed to implement it. Finally, data on hospitalization are not received by EMRs in a useful way (ie the information is not incorporated into the EMR as “data” that can be searched etc) in all teams who have implemented HRM.

Local, hospital-specific data extracts: The QIDSS have identified a variety of approaches to access hospitalization data locally. These approaches have been described and shared, with the intent of increasing access of teams to hospitalization data, even in a locally defined and at times manual way. Uptake appears minimal, with persistent perceptions of barriers related to data sharing among teams and hospitals.

Encounter types in EMR: The QIDSS have identified a large number of different encounter types (in the range of 60 different types) recorded in EMRs. To make it easier to track ‘follow-up’ activities, it is necessary to categorize these types down to a smaller, more consistent number across teams. While there is some progress in identifying the different types, movement to narrow down the list appears slow.

**Conclusion**

For whatever reason, none of the recommended strategies to improve access to meaningful data for this indicator have resolved the problems with definition and data quality that first surfaced in preparation for D2D 1.0. It is possible that with another year, these strategies may bear fruit. There is also a chance that they may not. In addition to continuing to support and encourage work on these and any other strategies that might emerge, the Indicators Working Group elected to include “7-day follow-up after hospitalization” as a “developmental” indicator in D2D 2.0.
A Partnership Approach to Pilot Primary Health Care EMR Content Standard: CIHI and Team-based Primary Health Care Organizations

Theme: 5. Advancing manageable meaningful measurement

Canadian Institute for Health Information (CIHI):
Mary Byrnes, Manager, Primary Health Care Information
Charisa Flach, Project Lead, Primary Health Care Information
The Centre for Family Medicine FHT eHealth Centre of Excellence and Family:
Mohamed Alarakhia, Director
Ted Alexander, Research Associate

Learning Objectives:
1. Discuss how CIHI’s EMR content standard and clinician friendly pick-lists are being piloted within a team-based primary health care organization
2. Discuss how the pilot is building on existing EMR mechanisms to collect structured data and taking on small tests of change to add new mechanisms
3. Highlight key enablers for EMR data standardization
4. Discuss how insights and lessons learned from this demonstration project will inform the evolution of the Primary Health Care EMR Content Standard.

Summary:
Primary Health Care EMR Content Standard is being piloted by team-based primary health care organizations in conjunction with the Canadian Institute for Health Information (CIHI) to enable the collection of structured, comparable Electronic Medical Record (EMR) data. CIHI’s 45 EMR data elements and validated clinician-friendly pick-lists (CFPL) support clinicians in entering structured data into EMRs using common terms for high priority data fields, such as health concern and social behavior. The CFPL terms are mapped to code systems behind the scenes.

A multifaceted approach is being taken in the implementation of the pilot projects. Key enablers included targeted priority EMR data fields, clinician education, change management, adequate IT resources, standards expertise and strong partnerships. Results from this demonstration project will showcase the potential use of structured information for the calculation of indicator/performance measures. Insights and lessons learned from this project may inform how other team-based practices can use the PHC EMC Content Standard and inform its evolution.

An E-Learning Approach to Improving Primary Care Team QI Measurement Knowledge and Skill

Theme: 5. Advancing manageable meaningful measurement

Patricia O’Brien, RN, BA CNeph(C), University of Toronto
DFCM
Lorri Zagar, MSc, Zagar Health Planning

Learning Objectives:
The Department of Family and Community Medicine’s (DFCM) Quality Improvement (QI) Program has embraced e-learning via development of an online, multi-module series on measurement in QI. The intent is to include Internet technology augmenting delivery options within current QI curriculum offerings and with the goal of reaching more learners across the DFCM’s fourteen academic sites (thirteen Family Health Teams) and beyond to the broader primary care system. The module topics that focus on primary care application of QI measurement include: Introduction to Measurement; Development of a Measurement Plan; Sampling for QI; Using Run Charts in QI; Survey Application in QI.

Summary:
E-learning can be defined as “the use of Internet technologies to deliver a broad array of solutions that enhance knowledge and performance.” (Rosenberg, 2001) The delivery technology is a critical element in the module development, focusing on learner-interface and learner-content interactivity. (Anderson, 2008)

After exploring a number of options, VideoScribe has been selected as the platform for the online modules and is augmented as the whiteboard feature with audio files. The audio files are referenced to common, QI literature references and contextually oriented to the primary care setting of family medicine. Visuals in the VideoScribe file are simple as per a whiteboard approach and align with the audio portion to highlight key perspectives in the content.

Video footage of faculty and interprofessional care team members describing application of the various concepts included in the content is included as separate modules. The video footage of team members from the DFCM academic sites provides the real-life, application experience and is intended to demonstrate feasibility, relevance and practicality of measuring for improvement in primary care.

References:
Data for Quality Improvement: Working with our Hospital Partner on QIP Access and Integration Goals

Theme: 5. Advancing manageable meaningful measurement

South East Toronto FHT
Kaila MacMillan, Pharmacist
Danielle Del Duca, Care Navigator
Tiffany Kress, Dietitian/QI Coordinator

Learning Objectives:
The poster will describe how Toronto East General Hospital has assisted South East Toronto Family Health Team in achieving its QIP goals of reducing ED visits for conditions best managed elsewhere, and increasing the number of patients who have appointments within 7 days of hospital discharge. We will describe how we have used data from HRM to assist in 7-day post discharge appointment and medication reconciliation and how we have used ED reports (including CTAS scores) to identify patients who could have come to SETFHT for care instead of attending the ED.

Summary:
Data for quality improvement needs to be timely and readily available. In reporting QIP measures for 7-day post discharge appointments and ED visits for conditions BME, HQO expects FHTs to use data from the MOHLTC's Health Data Branch. This data is almost a year old by the time we receive it, which might make it good for accountability purposes, but not for quality improvement.

We have been very fortunate that TEGH agreed to be a test site for Hospital Report Manager (HRM). HRM has made it possible for us to get next-day data about our patients discharged from hospital and enables us to make quick contact with them to discuss the need for an appointment/follow up with any of their care providers at SETFHT. It also gives us useful information about medication changes and this enables our pharmacist to do medication reconciliation in the patient's chart before the patient attends for his/her appointment.

In addition to HRM, TEGH provides us with daily reports of ED visits. Initially, these reports simply contained the patient name and date of ED visit. We recently asked them if they could add the patient's CTAS score to enable us to contact those patients who presented to the ED with conditions that likely could have been managed by the FHT. We will present the results of our surveys of these patients.

Health Equity: The Key to Meaningful Evaluation

Theme: 5. Advancing manageable meaningful measurement

Nick Head-Petersen, MPH, Program Evaluator, Manitoulin Central FHT

Learning Objectives:
1. Describe the structure and objectives of the Health Equity Impact as laid out by the MOHLTC;
2. Demonstrate the implementation of the HEIA at the Manitoulin Central Family Health Team (MCFHT);
3. Examine the projected model of delivery of the MCFHT's HEIA in meeting the objectives laid out by the MOHLTC; and
4. Articulate a simple and efficient approach to the successful integration of the HEIA into family health teams across the province of Ontario.

Summary:
Health equity has a direct effect on health outcomes. Addressing health equity within family health team programing and practice ensures quality programs that provide accessible care to all individuals. The Health Equity Impact Assessment (HEIA) developed by the Ontario Ministry of Health and Long-Term Care provides the framework to assess the health equity of programs, policies, and organizations. The Manitoulin Central Family Health Team (MCFHT) has implemented the HEIA tool at the program evaluation level, and in review will demonstrate the changes made to programs and policies that will foster equitable health care outcomes.

The MCFHT's exploration of the challenges and benefits of using the HEIA tool at the program evaluation level will be reviewed. The demonstrated use of the HEIA tool at the MCFHT supports the MOHLTC's statement that improved health equity decreases health disparities between population groups; thereby improving health care outcomes.

Improving Patient Access

Theme: 5. Advancing manageable meaningful measurement

Tricia Wilkerson, Director, Quality and Evaluation, Guelph FHT

Learning Objectives:
- Describe three changes teams made to improve patient access
- Describe the benefits of access improvements to patient experience and emergency department utilization.

Summary:
The access principles have been utilized within Ontario for a number of years and this poster will describe the experiences of a team within one clinic to incorporate those principles and to measure their data over time to see if their changes resulted in improvements. The approach within the individual clinic will be described (e.g., matching daily supply to demand, using the care
team to increase supply and better support patients with frequent visits and post-vacation scheduling. The story of the impact of these changes on the patient experience will be emphasized. Relevant literature supporting the work of the team will also be highlighted on the poster.

48 Ontario’s Enhanced 18-month Well-Baby Visit EMR Integration and Repository Project

**Theme:** 5. Advancing manageable meaningful measurement

_Nancy Novak, RN, BNSc, MEd, PhD, Program Consultant, Government of Ontario Ministry of Child and Youth Services
Cynthia Emerson, Kid eConnect Project Lead, BORN Ontario

**Learning Objectives:**
- Describe key elements in the implementation of the 18-month EWBV EMR project;
- Identify opportunities for expansion of the project at the person, practice and population level; and
- Appreciate project future work in creating a culture focused on enhancing the developmental health and well-being of children.

**Summary:**
The 18-month visit is the last in a series of regularly scheduled primary care visits before school age and is an ideal opportunity for health promotion, prevention and early intervention. Recognizing the importance of this visit, Ontario has implemented an enhanced 18-month well-baby visit to shift the focus at 18 months from a well-baby check-up to a comprehensive assessment of development. Standardized tools (e.g., Rourke Baby Record (RBR) Ontario and the NDDS - 2011) are recommended for use at the visit to facilitate more in-depth discussions with parents on child development, parenting, literacy, and connecting to local community programs that promote child development.

The implementation of an 18-month EWBV for all Ontario children provides an opportunity to collect valuable information on the developmental health of children in the province. The project, as a collaborative effort between Better Outcomes Registry & Network (BORN) Ontario, Ministry of Children and Youth Services (MCYS) and eHealth Ontario has:
- Integrated paediatric best-practice guidelines into an EMR system to guide delivery of paediatric care in line with current best evidence;
- Collected 18-month data from the EMR;
- Transmitted 18-month data to the BORN registry; and
- Reported 18-month results.

Leveraging work created from this pilot project provides opportunities for expansion of the EMR Integration Project and provincial implementation of RBR and NDDS forms for well-baby visits for children from birth to age 5. The project has opportunity to see data collected from over 3 million child health care visits across approximately 5,000 relevant providers in Ontario.

49 Putting Data in the Hands of Primary Care Providers to Support Quality Improvement

**Theme:** 5. Advancing manageable meaningful measurement

_Health Quality Ontario:
Wissam Haj-Ali, Senior Methodologist
Stacey Johnson, Specialist Quality Improvement

**Learning Objectives:**
The purpose of this poster is to provide an overview of the latest version of the Primary Care Practice (PCP) Report. Providers and administrators will learn how to use the data and change ideas in PCP Report to improve as a team for the planning, management and delivery of healthcare services in their practices.

**Summary:**
This poster will introduce the reader to the PCR Report in its latest version, which was informed by a balance of expert advice, users’ feedback and available evidence. We will equip administrative staff and clinical providers with skills and tactics to leverage the range of information available through the PCP Report.

First, we introduce the concept of dashboard that provides high-level snapshot information on performance at a glance. Subsequently, we provide tips on data interpretation considerations for providers and administrators to keep in mind while reading the report. Then we introduce the quality improvement sections that include suggested change ideas to inform improvements in key areas related to cancer screening, diabetes management and avoidable emergency department visits.

The poster will provide an important opportunity to exchange information on the current and future use of the PCP Report to fuel quality improvement efforts in Ontario’s primary care practices.

50 Quality Improvement in Primary Care through an Integrated Vascular Health Care Approach

**Theme:** 5. Advancing manageable meaningful measurement

_Ontario Stroke Network:
Stephen Sundquist, Senior Manager, Primary Care
Colleen Murphy, Project Manager, Primary Care Work Group

**Learning Objectives:**
Participants will learn about the provincial Vascular Health Primary Care Work Group’s (PCWG) priority activities under development:

1. A point-of-care Vascular Health Assessment and Support Tool (VHAST) that will maximize EMRs’ integration of consistent vascular health (VH) data elements and provide a
succinct patient data overview of VH status and trends, including comparisons to clinical practice guidelines.

2. A VH Quality Improvement (QI) Toolkit serving to support implementation of QI plans in primary care. Secondly, participants will learn how the PCWG’s collaborative and integrated approach aimed to ensure that the resources included manageable and meaningful elements (e.g., measures).

Summary:
Vascular diseases are the leading cause of preventable death in Ontario. The Ontario Stroke Network (OSN) seized the opportunity to impact vascular disease burden by establishing the Vascular Health Primary Care Work Group (PCWG) in 2012. One PCWG goal was to develop resources to enable implementation of vascular health (VH) best practices and quality improvement (QI).

The PCWG was engaged in the establishment of a shared vision and provincial VH priorities for PC. The top two priorities for development were identified: 1) a comprehensive, point-of-care, decision support Vascular Health Assessment and Support Tool (VHAST) building on effective elements of OSN’s Hypertension Management Program; and 2) a VH QI Toolkit. The PCWG was tasked with overseeing development and implementation including: change management approaches, stakeholder engagement and evaluation plans.

The iterative and broad consultative process for gathering elements for the VHAST and VH QI Toolkit has elicited different perspectives and further refinement. The PCWG has been instrumental in reinforcing the aim to develop resources that incorporate meaningful and manageable QI elements (e.g., measures) and streamline the process for evaluation and reporting.

Although early in development, the VHAST and VH QI Toolkit have been positively received as incorporating “feasible, meaningful, useful, and scalable” elements based on an integrated, patient-centred approach to healthcare delivery. PC stakeholders have demonstrated continued interest and enthusiasm in these priorities that aim to build capacity to implement VH best practices and QI plans. The OSN is strengthening connections (e.g., HQO, CDA, ICES) ensuring alignment and efficiencies.

The Cervical Screening Reminder Calls Pilot: An EMR Optimization Initiative to Support Primary Care

Theme: 5. Advancing manageable meaningful measurement

Cancer Care Ontario:
Zabin Dhanji, BA MBA PMP, Project Manager
Alyssa Cloth, Senior Analyst, BA PMP
Jenna Tuck, IT/Administrative Assistant, Aurora Newmarket FHT

Learning Objectives:
Cancer screening detects pre-cancerous changes, or cancer at an early stage when there is a better chance of treating it successfully. Cancer Care Ontario (CCO) developed the Cervical Screening Reminder Calls (CSRC) pilot to support primary care providers (PCPs) in increasing their cervical screening rates. The pilot consisted of two components. First, practice staff were trained to utilize their electronic medical records (EMRs) to identify eligible patients for screening. Once identified, practice staff invited patients via telephone to get screened. This presentation will describe the pilot and a case study of the Aurora Newmarket Family Health Team’s (ANFHT) pilot implementation.

Summary:
Early detection of cancer leads to better outcomes and more options for treatment, thereby reducing mortality. Primary Care Providers (PCPs) play a key role in cancer screening. The Cervical Screening Reminder Calls (CSRC) Pilot marries two CCO interventions to support PCPs in increasing their cervical cancer screening rates.

The first component was to support PCPs in learning how to utilize their electronic medical records (EMRs) to identify patients within their practices who were eligible for cervical screening. While EMRs have been widely adopted across Canada (Ontario: 80%, Alberta 75%, B.C. 80%), primary care practices are at various stages of maturity in their use. CCO has developed a comprehensive suite of tools and training to help PCPs utilize the current functionality within their EMRs for cancer screening. A demonstration of the tools and training will be provided during the presentation.

The second component was to use call scripts to telephone eligible patients and invite them to schedule Pap test appointments. Several systematic reviews and research conducted by the Ministry of Health and Long Term Care (MOHLTC) have found that patient reminders increase cancer screening participation, especially when encouraged by their healthcare provider. The literature also demonstrates a positive effect of telephone reminders compared to letters, especially when scheduling an appointment with a patient for cervical cancer screening.

Having outlined the evidence behind the pilot design, a case study, including implementation highlights and outcomes, will be
presented on the Aurora Newmarket Family Health Team’s (ANFHTs) pilot implementation.

52 Turning Data Lemons into Data Lemonade: Our Journey with 7-day Post Discharge

Theme: 5. Advancing manageable meaningful measurement

Women’s College Hospital Academic FHT:
   Holly Finn, Program Coordinator
   Susie Kim, MD, QI Lead

Learning Objectives:
Our poster will help participants to learn how to:
1. Engage the broader team to ensure patients aren’t falling through the cracks
2. Develop a system that enables/facilitates meaningful, real-time data capture and feedback for ministry-prioritized indicators.

Summary:
Reporting on 7 day post-discharge follow-up rates has been difficult to interpret in a meaningful way, due to the delay in receiving data feedback from the MOH, and a perception that most system improvements would be out of our control.

Our team at the Women’s College Academic FHT set out to better understand our baseline, and this started with the recognition that our tracking process could only account for discharge reports actually received. The team saw that there was room for improvement and aimed to:
1. Increase the proportion patients who are seen within 7 days of hospital discharge (per MOH criteria).
2. Develop a system that enables meaningful, real-time data capture and feedback for ministry-prioritized indicators.

Our change ideas were to:
1. Create a process to ensure patients are followed upon discharge summary receipt. This required: engaging a broad team (admin, health records, nurse, pharmacist, MD, etc.), creating a process map, and a tracking sheet.
2. Obtain access to more accurate and timely information regarding patients who have been discharged from hospital by:
   a) analyzing patterns for discharges received by hospitals,
   b) proactively contacting health records departments of selected hospitals, and
   c) developing working relationships with selected hospitals.
3. Improve patient education on importance of follow-up

Lessons learned and next steps:
It has become clear that patients and teams are already proactive in arranging follow-up without our intervention. Further improvements for our team involve better integration of pharmacist, and a feedback mechanism for teams on outcomes.

53 What’s a QIDSS… and what can they do for you in particular and primary care in general?

Theme: 5. Advancing manageable meaningful measurement

Carol Mulder, MSc, Provincial Lead, Quality Improvement Decision Support (QIDS) Program, AFHTO

Learning Objectives:
Participants will hear how QIDSS approach their work individually to meet individual team needs and collectively to help teams take advantage of the collective strength of QIDSS.

- Teams with QIDSS may have a better sense of the kinds of things they can do together
- Teams without QIDSS can get a sense of the collective products/process that might be useful to them.

Summary:
This poster expands on the What’s a QIDSS? video to demonstrate in practical terms how QIDSS help teams make progress in QI and performance measurement, whether they are just getting started or are leading the field. QIDSS working in teams across the QI spectrum will share what they do individually and as a collective to make a difference in primary care.
Theme 6 – Leadership and governance for accountable care

Boards hold their organization’s management accountable for performance. In turn, boards are accountable to their “shareholders” – for FHTs and NPLCs, this is the Ministry of Health and Long-Term Care. Accountability in primary care is evolving – it includes patients, the local community, community partners, Health Links, and increasingly, LHINs. Primary care boards and leaders must have the means to track performance, quality of care and value delivered, take action when needed, and meet the expectations of those to whom the organization is accountable. This stream focuses on the practices, tools and tips to support boards and leaders in good governance, strategic population-based planning, performance measurement, making evidence-informed decisions and supporting the development of leadership within the team.

Posters:

54 Explaining Governance and Accountability to All Members of the FHT: Making it Happen and Getting them Involved

55 Implementing an Infection Prevention and Control Program for Primary Care

56 Improving Patient Access and Clinic Efficiency

54 Explaining Governance and Accountability to All Members of the FHT: Making it Happen and Getting them Involved

Theme: 6. Leadership and governance for accountable care

Bruyere Academic FHT:

Jay Mercer, MD, Lead Physician, Board Chair
Debbie McGregor, Executive Director

Learning Objectives:

Visitors to this poster will learn approaches that can be used to explain governance and accountability to various participants in the FHT including clerical staff, nursing, nurse practitioners, allied health and physicians. Attendees will also be presented with opportunities they can use to engage these individuals in the management and accountability functions of the organization.

Summary:

This poster presents a detailed explanation of the approach that our FHT has used to explain governance and accountability to all the members that make up our team. Approaches specific to clerical staff, nursing, nurse practitioners, allied health and physicians will be explained. It will also discuss the approaches that we have used to get all of these team members actively engaged in the management of the FHT as well as how they can help the FHT to be accountable both in terms of providing exemplary care and acting as good stewards of the public.

55 Implementing an Infection Prevention and Control Program for Primary Care

Theme: 6. Leadership and governance for accountable care

South East Toronto FHT:

Maureen Gans, Director, Interprofessional Practice and Quality Improvement
Jason Santos, RN
Sam Tirkos, MD, Family Physician & QI Lead
Jennifer Neumann, Clinical Support Staff
Noreen McMullan, Clinical Support Staff

Learning Objectives:

This poster will outline South East Toronto FHT’s journey in developing and implementing an Infections Prevention & Control program. This project was developed with the support of the 9-day IDEAS training program. The poster will outline our first step in developing the program, which was instrument reprocessing. We will describe our project team and their unique skills and perspectives, what we had done prior to the project with respect to reprocessing, the proposed changes, how we advocated for changes that involved cost and time, and how we established buy-in. We will also outline the steps still to be taken within a broader IPAC program.

Summary:

In the realm of patient safety, Primary Care practices have not traditionally been as vigilant as hospitals in instituting Infection Prevention and Control (IPC) policies and procedures. The South East Toronto Family Health Team (SETFHT) had several individual IPC policies and procedures and many of the staff have worked in hospitals and have integrated IPC procedures that have not specifically been put into policy at SETFHT; however, we had no overarching IPC program.

In the summer of 2014, in preparation for the upcoming influenza season, as well as doing preparedness training for Ebola, we conducted an audit of our IPC practices. The audit tool was adapted from the Community IPAC Audit Tool. 54% of the items
were graded as "red" (i.e., not in compliance) and 20% were "yellow" (i.e., in compliance with minor improvements of additional staff education). It became very clear that we need to develop a comprehensive IPC program, with evaluation/audit tools and an implementation plan. The SETFHT Board supported our application to IDEAS for advanced training to assist us in this important patient safety work. Our IDEAS project team includes a physician, 2 RNs, 2 clinical support staff, our Director of QI and our Manager of HR. Several of these staff are also members of our joint health and safety committee.

The IPAC program will form part of a broader incident management program that will also include incident reporting and vaccine management.

56 Improving Patient Access and Clinic Efficiency

Theme: 6. Leadership and governance for accountable care

South East Toronto FHT:
Stephen Beckwith, IT/Operations Lead
Stephanie Houghton, Manager, Human Resources

Learning Objectives:
We will describe how we piloted and then implemented a new system to improve the efficiency of and patient satisfaction with their contact to make or cancel appointments. We will outline the changes in staffing, training, and policies that we made, the lessons learned in implementing a new system with sometimes reluctant staff, the changes we made after the initial pilot, and how things are working now.

Summary:
As with all FHTs, we want to be able to offer our patients same day/next day appointments for urgent matters. We do have appointment times available each day, but our patients reported they had difficulty getting through to make an appointment. This was distressing to patients and providers. While our patients have had the option to make/cancel appointments using an online portal from our website, many still prefer to call the clinic. We have two clinic sites and the phone systems are separate, as one phone system is linked with Toronto East General Hospital and the other is not. As a result, patients had to call one of two clinics to make/cancel appointments. We had been challenged to respond to these calls in a timely manner. We had also been challenged in managing patient expectations and disappointment with our system.

We began a pilot in November 2014 that included several changes to the way we had responded to patient calls: we consolidated phone staff to one site and asked patients to call just one central number; we re-organized existing staff to ensure adequate phone coverage; we rotated staff through phone and other admin positions to prevent burn-out and increase job satisfaction; we encouraged patients to use the online system to make appointments and ensured staff frequently reviewed those emails; and we gave staff additional training to encourage more efficiency in their phone discussions and to improve customer service. We will describe the results to date.
Theme 7 – Clinical innovations keeping people at home and out of the hospital

A sustainable health system must meet the triple aim of better health, better care and better value. Primary care teams have comprehensive programs focused on everything from health promotion, mental health, illness prevention through chronic disease management to palliative care. These programs engage the whole team in providing care where and when patients need them in order to help them stay home and out of the hospital. This stream focuses on successful examples and lessons learned in program planning and delivery for teams to use in their own community.

Posters:

57  An Interprofessional Approach to Post-Discharge/ER Visit Follow-up: Minding the Gap between Acute and Primary Care
58  Cancer... How to Live Through the Diagnosis
59  Destigmatizing mental health shortens wait times
60  Early Integration of Palliative Care in Primary Care: INTEGRATE Quality Improvement Project
61  Effective implementation of a geriatric home care program in a Toronto based family health team
62  Implementing Health Checks in Primary Care for Adults with Developmental Disabilities in Family Health Teams in Ontario: Engaging Interprofessional Care, Community-based Health Care and Developmental Services
63  Improving the Care and Quality of Life of Patients with Asthma
64  Improving the Effectiveness of Depression Groups in Primary Care: Pilot of Self-Compassion Focused CBT Groups for Depression
65  Leveraging the OCEAN Platform and Tablet Technology to Improve Patient Care
66  Post Hospital Transition of Care: From Inpatient to Family Practice
67  Too Fit To Fracture: Exercise and Physical Activity Recommendations for Fall and Fracture Prevention

57 An Interprofessional Approach to Post-Discharge/ER Visit Follow-up: Minding the Gap between Acute and Primary Care

Theme: 7. Clinical innovations keeping people at home and out of the hospital

Ottawa Hospital Academic FHT:

Doreen O’Sullivan, Clinical Nurse, RN, BScN,
Elizabeth Contestabile, Clinical Nurse, RN, BScN

Learning Objectives:

- Identify the key issues in care transitions from acute care to primary care.
- Highlight findings from recent publications that identify the importance of this issue from a patient safety and quality of care perspective.
- Describe an interprofessional team approach to patient follow-up post inpatient discharge and post emergency department visit. Discuss initial evaluation data related to patient and staff satisfaction, “near misses”, and actions resulting from follow-up. Explore areas for deeper understanding of how transitions from acute to primary care can be strengthened in order to minimize risk to patients and families, and promote efficient utilization of both primary and acute care system resources.

Summary:
Care transitions from acute care to primary care have been identified as a time of vulnerability and risk for patients and families. Harm can arise from medication errors, lack of follow-up of pending inpatient test results, and inadequate communication between inpatient and primary care providers that can result in discontinuity of care. Increasingly this gap in care has become a focus of both patient safety and quality improvement activities. Our Family Health Team set a goal of streamlining the process of post inpatient discharge and post emergency department visit follow-up for patients discharged home. Roles of the interprofessional team were clarified, process maps developed, and a documentation template for our EMR was implemented. Patient and staff evaluation of the new process has been very positive and the actions resulting from follow-up have resulted in improved care for our patients and families. A number of “near misses” have been identified in a timely fashion so that potentially serious consequences were averted. Evaluating the impact of this initiative on the wider health care system is occurring through our LHIN Quality Improvement Plan. Impact on the following related indicators is being tracked: % of Emergency visits “best managed elsewhere”; number of high risk patients with a follow-up appointment with their family doctor within 7 days of discharge; and readmission to hospital within 30 days. By “minding this gap” continuity is strengthened, and patient and family outcomes improved.
Cancer... How to Live Through the Diagnosis

Theme: 7. Clinical innovations keeping people at home and out of the hospital

Thamesview FHT:
Barb Lather, Business/Program Manager
Graeme Millington, MSW, RSW

Learning Objectives:
Participants will learn how patients are able to receive a diagnosis and continue to live their lives with a team surrounding them during the cancer journey. We cannot stop all cancers but we can help by empowering patients through knowledge, accessibility and compassion.

We have initiated a new program at the Thamesview Family Health Team that is a true collaboration of partnership between the Chatham Kent Health Alliance and the Thamesview Family Health Team. This is a pilot project that started in September of 2014. A local surgeon, Dr. Elizabeth Haddad, who performs 90% of our breast cancer surgeries, was approached regarding this project and saw a huge need in the community. The diagnostic imaging department at CKHA has also partnered with Thamesview Family Health Team on this project. Cancer patients were involved in the development of the pilot.

A lunch-and-learn with Dr. Haddad /Social Work presenting had the greatest attendance to date with more than 50 people in attendance. Our physicians were thrilled with this initiative.

Summary:
The pilot program is focusing on cancer patients and their journey through the diagnosis. This is a new initiative that is at the beginning stage, focusing on breast cancer patients with the goal to open it to all cancer patients. As the Business Program Manager for Thamesview, cancer patient, Co-Chair for the Chatham-Kent Cancer Program Planning and Priorities Committee, Partner for Peer Support with the Canadian Cancer Society and a Community Partner for the Cancer Renew Program, I have heard on many occasions from all community partners and patients that this is a much needed resource in the community. Unfortunately, even with preventative care, cancer is still happening and we need to have pilots/programs in place such as these for those going through cancer. This pilot program could be easily duplicated throughout the province in other Family Health Teams.

Currently, when a patient of ours receives a diagnosis of breast cancer, they are immediately given a brochure that has been created in collaboration with the Chatham Kent Health Alliance. On the brochure, the patient is given a resource to connect with when they are ready to initiate contact. For many cancer patients, this is at the time of diagnosis; for others, it is not until they have finished treatment and feel disconnected from the world.

I would love the opportunity to present this new initiative to other Family Health Teams in the Province.

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Destigmatizing mental health shortens wait times

Theme: 7. Clinical innovations keeping people at home and out of the hospital

Thamesview FHT:
Graeme Millington, MSW, RSW, former Mental Health Team Lead
Sue Munro, MD, Family Physician, Family Health Team Lead
Barb Lather, Business/Program Manager

Learning Objectives:
• To educate on the impact of mental health stigma on service provision and how reducing stigma shortens wait times.
• To support health teams to market group therapies and Single Session to stakeholders.
• To introduce a Stepped Care Recovery model, and how this changes mental health service provision in primary care.

We will discuss the use of internet resources, videos, Single Session, Intake, and CBT group in serial [four times/year] supports self-management. We will share our Single Session model, and how its application improves access. Participants will also learn our evaluation process for this program.

Summary:
Redirecting mental health patients from emergency departments requires help-seeking and help-receiving to start before crisis is realized. Shame and loss of status common to stigma suppress help-seeking. The easiest way to reduce stigma seems to be through the universalizing power of group therapies and less formal and more accessible mental health services. The status quo seems to be a mental health program which is resource poor, with one doorway into service resulting in a bottleneck wait list [often 3-5 months].

Presented via OTN, and at the Garden City FHT mental health Conference, this presentation discusses how Thamesview Family Health Team weakened stigma through the provision of mental health care. We discuss how stigma biases treatment provision away from group therapies. In universalizing and humanizing clinically significant worry, fear, shame, anger, grief, loss, and sadness, we can erode associated shame and social anxiety. We posit that groups are especially powerful to this end.

We introduce a Stepped-Care Model and show how multiple levels of an intervention capitalize on patient motivation. We share how technology, Single Session, open access groups, and CBT group therapy in serial reduced our waitlist while still being able to offer eight-to-twelve session individual, couple, and family therapies. Using Stepped Care, resources remain for health promotion and illness prevention; marginalized populations can be sought-out, and trend specific programming encouraged. The battle for more resources can be retired in favour of leveraging current ones. Primary care mental health delivery can be more equitable and resource-responsible to improve access and reduce stigma.
Sometimes we seem to become immobilized by the hope for additional resources to provide service in a way that is most familiar. In promoting one-on-one therapy, we may unintentionally reinforce stigma. As stigma loses power, more will seek support for decreases in social, activity, and work/school functioning. With more frequent groups, the presentation of mental health issues can universalize. Prevalence and incidents rates related to mental health can become more convincing, and through this it is likely more funding may be sought.

60 Early Integration of Palliative Care in Primary Care: INTEGRATE Quality Improvement Project

**Theme:** 7. Clinical innovations keeping people at home and out of the hospital

**Cancer Care Ontario:**
- Dr. Sandy Buchman, BA, MD, CCFP, FCFP / Primary Care Engagement Lead, Palliative Care
- Tara Walton, MPH, BSc / Specialist, Palliative Care

**Learning Objectives:**
1. Participants will understand the current state of palliative care in the primary care setting in Ontario
2. Participants will learn how to implement a quality improvement approach to address palliative care needs in the primary care setting

**Summary:**
The INTEGRATE Project is a 3-year initiative aimed at earlier identification and management of patients who would benefit from a palliative approach across care settings. The project focuses on adapting and implementing educational resources for primary care providers, and implementing integrated care models in primary care and cancer centre settings.

As a crucial first step in developing an approach tailored to the primary care setting, a current state assessment was conducted. Various care providers, researchers, administrators and patients worked collaboratively in future state mapping to design an integrated care model. Implemented as a quality initiative, four primary care practices will identify patients by using the Surprise Question, “Would you be surprised if this person died in the next 6-12 months?” For all patients identified, these practices will complete Advance Care Plans (ACP), engage in goals of care discussions, manage symptoms and work with community providers to provide interdisciplinary care. Implementation of the model will be evaluated.

Participants will learn the methods employed by CCO to identify practice and provider needs and to educate and implement models to identify, assess and manage patients who would benefit from a palliative approach to care early and across settings. Results from the project will translate into provincial recommendations for implementing an integrated palliative approach to care in primary care settings in Ontario.

61 Effective implementation of a geriatric home care program in a Toronto based family health team

**Theme:** 7. Clinical innovations keeping people at home and out of the hospital

**Mount Sinai Hospital:**
- Sakina Walji, MD, CCFP
- Mayura Loganathan, MD, CCFP
- Sheena Luck, NP-PHC, MScN

**Learning Objectives:**
- Demonstrate how the implementation of a home care program significantly increases the number of patients who are able to access care at home and would otherwise have limited access to primary care
- Demonstrate increased availability to primary care for home-bound patients in the acute and chronic setting with a structured home care program
- Reduce poly-pharmacy and potential adverse effects with the implementation of a home care program
- Utilize an inter-disciplinary team within a primary care model to improve access

**Summary:**
Home visits allow home-bound individuals to access timely care. Previous studies have demonstrated that patient groups receiving home care reported greater satisfaction and were less likely to be admitted to hospital or visit the emergency department. A model of interdisciplinary home care may improve the number of individuals able to access care within our family practice unit in a timely fashion.

**Methods:**
The interdisciplinary team consists of a primary physician, nurse practitioner, and a community care access coordinator. We tracked billing codes within our EMR to identify home visiting patients. We conducted a retrospective chart review to compare the number of home visits before and after the implementation of a home visit program. To determine the impact of the program on polypharmacy, we analyzed the number of medications used by patients before and after the commencement of the program.

**Results:**
Prior to the home visit program there were twenty-four patients seen at home; this number increased to thirty-eight after implementing the home care program over five months. The average number of visits per month increased from seven to thirty-three.

**Discussion:**
A home visit program has not only allowed for increased capacity but also increased visits per patient. There was no change regarding the number of medications, however a few patients were seen with no prior primary care and therefore were started on medications. We were unable to gather data to demonstrate whether this program impacts ED and hospital visits.
62 Implementing Health Checks in Primary Care for Adults with Developmental Disabilities in Family Health Teams in Ontario: Engaging Interprofessional Care, Community-based Health Care and Developmental Services

Theme: 7. Clinical innovations keeping people at home and out of the hospital

Learning Objectives:
Participants will be able to find ways to improve access to primary health care services for adults with developmental disabilities in their own community, using health care providers and quality improvement programs in Family Health Teams, Health Care Facilitators from the Community Networks of Specialized Care, Health Links, hospital-based care and developmental (social) services.

Summary:
The evidence for Health Checks in primary care (annual comprehensive preventive health reviews, including physical exam and using Canadian Consensus Guidelines and Tools) will be presented. The evaluation of Health Check implementation projects in three Family Health Teams in Ontario in 2014/15 will be reviewed. Issues identified include identification of the population, building medical professional awareness/knowledge, the logistics of getting patients and caregivers to attend, the use of EMR tools and focusing on local practice priorities such as resident education or patient income optimization.

Presenters include staff of Ontario’s Health Links program, Community Networks of Specialized Care, Health Care Facilitator, Toronto Network of Specialized Care, Surrey Place Centre

• Use of Spirometry for diagnosis and appropriate management of Asthma
• Educating patients regarding the pathophysiology of Asthma, environmental control, asthma triggers
• Respiratory medication and puffer technique,
• The use of a asthma diary and asthma action plan for patient self-management of Asthma
• Uncontrolled asthma vs controlled asthma.

63 Improving the Care and Quality of Life of Patients with Asthma

Theme: 7. Clinical innovations keeping people at home and out of the hospital

Learning Objectives:
To understand:
• The role of a Respiratory Educator in a Family health

64 Improving the Effectiveness of Depression Groups in Primary Care: Pilot of Self-Compassion Focused CBT Groups for Depression

Theme: 7. Clinical innovations keeping people at home and out of the hospital

Learning Objectives:
• Participants will learn skills and knowledge about how to adapt CBT approaches to Depression so that they more fully encompass Self-Compassionate and Mindfulness, in order to
more deeply address maladaptive thoughts, cognitive distortions and self-sabotaging behaviours that maintain depression.

- Participants will learn how to increase patient motivation using self-awareness, self-encouragement and kindness, rather than harsh criticism and automaticity.
- Participants will learn about assessment tools to evaluate aspects of a patient’s self-compassion and be able to integrate these tools with assessments for Depression and Anxiety.

Summary:
Traditional CBT groups are touted as the best practice for Depression. However, Taddle Creek FHT’s experience is that they have been successful for the most part for those with mild depression, but not so effective for those with moderate to severe and/or chronic depression.

Our clinical experience with patients in depression groups showed us that most patients were chronically self-judgmental, had no practices of self-kindness, felt different or felt worse off than most others, blamed themselves, were isolated, felt their depression and their judgements were truthful realities, and often lacked mindfulness skills. Patients in our previous traditional CBT groups had great difficulty with conducting behavioural activation, completing thought records, conducting experiments, and questioning core beliefs. We had also facilitated MBCT groups that are rising in popularity as a good approach to addressing depression (Teasdale, Williams, Segal, 2014). However, the MBCT groups that we facilitated did not specifically target patients with depression, so we were unable to evaluate its effectiveness in treating depression with our patients. Our anecdotal experience of facilitating MBCT groups was that it was too difficult and therefore less effective for the more moderate to severely depressed patients.

Therefore, we redesigned our CBT Depression group based on the works of Elisha Goldstein, Kristen Neff, and Christopher Germer. Our Self-Compassion Focused CBT group for depression actively implements brief mindfulness and self-compassion approaches and exercises in order to integrate the painful effects of depression into healing, reduce self-identification with depressive thoughts and feelings, and use “urge surfing,” “choice points,” and “trigger work” to alter identification with internal states and processes.

In this presentation, we will review the group’s weekly topics and approaches and demonstrate active self-compassion exercises used in our group. We will present the results of our pre- and post-test evaluations of the group using the SADS-15 depression and anxiety scales and Self-Compassion test scores. We will compare this with our past scores for our more traditional CBT groups for Depression.

65 Leveraging the OCEAN Platform and Tablet Technology to Improve Patient Care

Theme: 7. Clinical innovations keeping people at home and out of the hospital

Guelph FHT:
Kirk Miller, Director, Performance and Accountability
Tricia Wilkerson, Director Quality and Evaluation
Jeff Kavanagh, President, CognisantMD

Learning Objectives:
Participants will be learn to:
- Describe the benefits to patient care with using the tablet technology and the OCEAN platform
- Identify ways to incorporate the tablet into the current patient workflow
- Describe improvements from the patient, provider and staff.

Summary:
The presentation will describe the early stages of assessing readiness for tablet utilization within the primary care practice, the support provided to the clinics to incorporate the tablet into their workflows and the early results that we are seeing from patient and team member perspectives. The top 5 ways the OCEAN technology with the tablets are being utilized within the clinics will also be described.

66 Post Hospital Transition of Care: From Inpatient to Family Practice

Theme: 7. Clinical innovations keeping people at home and out of the hospital

Karuna Gupta, MD, Lead Physician, Health for All FHT

Learning Objectives:
Participants will learn how an interdisciplinary team from Markham Stouffville Hospital – including two medical directors, an internist and an academic FHT family physician – was able to engage stakeholders – including physicians, IT, pharmacy, unit staff and health records – to create a comprehensive electronic discharge summary, which is sent to the primary care physician immediately upon completion at the time of patient discharge from the internal medicine unit. This provides timely available discharge information to the primary care provider to enable appropriate follow up after hospital admission. Participants will be exposed to QI techniques demonstrating how effective use of data and adaptive leadership skills can be used to promote change which can effect more successful transitions in care.

Summary:
Our project is a foundational project. Timely follow up after discharge and appropriate management after discharge to reduce the risk of re-admission cannot occur successfully without access to
appropriate information. While primary care access to a timely discharge summary is not likely to be the only determinant of a successful comprehensive discharge, it is likely to be an important component.

This project was enabled through the IDEAS learning program. The team applied multiple QI strategies to achieve its goals. I will show through the poster presentation how QI tools were used to achieve stakeholder engagement, change processes, provide balancing measures, provide a meaningful change in outcome and measure outcome over time.

This strategy could be used throughout the province to enable improved communication from hospital inpatient units to primary care providers and enable a better transition from the hospital to outpatient environment.

67 Too Fit To Fracture: Exercise and Physical Activity Recommendations for Fall and Fracture Prevention

Theme: 7. Clinical innovations keeping people at home and out of the hospital

Too Fit To Fracture (2F2F) initiative created exercise recommendations for people with osteoporosis by generating recommendations using the Grading of Recommendations, Assessment, Development and Evaluation process, and then a Delphi consensus process was used to address physical activity questions frequently asked by patients where evidence was sparse. Cases will be presented to demonstrate how recommendations may need to vary based on clinical presentation e.g., presence of vertebral fracture, pain, gait/balance difficulties. Practice tips, demonstrations and example tools and resources for physicians and patients will be discussed.

Results:
Individuals with osteoporosis should engage in a multicomponent exercise program that includes twice weekly strength training, daily balance training, and daily exercises for spine extensor muscle endurance. Aerobic physical activity is recommended but not to the exclusion of balance and strength training; moderate to vigorous intensity for individuals with no history of fracture, and moderate only for individuals with vertebral fractures. Physical activities of leisure and daily living should be performed using spine sparing strategies (hip hinge, step-to-turn). Restrictions are a disincentive to physical activity participation and should be discouraged. Not all bending and twisting should be avoided, but rapid, repetitive, weighted or end-range flexion or twisting of the spine are movements that should be modified. Patients with vertebral fractures, especially in the presence of pain or hyperkyphosis, should receive instruction from a physical/occupational therapist on safe movement.

Conclusion:
By combining evidence-based recommendations with expert consensus in areas where there is little research to guide recommendations, we can create more comprehensive recommendations that are centred on questions important to patients.