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Health Quality Transformation 2015 – Lunch and Learn Presentations

4295

Solo Practitioners in Need

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Background/Context:

Solo Practitioners in Need (SPiN) is a project by the Mid West Toronto Health Link in collaboration with Access Alliance. SPIN addresses the following gaps in care:

1. Solo PCPs lack resources and access community based services for their complex patients.
2. CHCs haveprograms and services that can be better utilized.
3. Health and social service access is difficult for patients with complex psychosocial and medical issues

Objectives:

The goal of SPIN is to improve access to resources for vulnerable populations and better utilize resources in primary care settings. The project aims to enable solo practitioners to connect complex patients to community based resources offered by CHCs by formalizing a referral process to CHC services. Secondly, the project aims to maximize underutilized CHC services by providing access to those in need, and in turn better support for complex patients.

Measures:

Outcome measures: Number of PCPs connected to team based care, percentage increase in resource utilization for CHCs, number of patients referred, number of service referrals, qualitative feedback from patients and providers.

Process measures: Time between referral and connection to CHC, time from CHC receiving referral and patient contact, time between referral and appointment.

Balance measures: Evaluating impact on Central Intake and receiving CHCs, ensuring service timelines are not increasing over time.

Change Concepts:

Health and social service access is difficult for patients with complex psychosocial and medical issues. It was recognized that solo PCPs lack resources and access to community based services for their complex patients, while CHCs have these programs and are underutilized.

The program was designed around the idea of a clinical triage and navigation role at one CHC, which would receive all referrals and disseminate to the appropriate CHCs. The Central Intake role is crucial as it requires a thorough understanding of services provided by the participating CHCs and their appropriateness in each client situation. The following steps were taken to implement this program:

1. Identify test group of solo physicians with complex patients in need of greater support.
2. Define services in demand, community services that can be accessed by external providers and clients, and eligibility criteria.
3. Identify an organization to act as central intake
4. Design a referral and reporting process.
5. Develop referral forms, tracking mechanisms, and targets.
6. Begin the project
7. Meet with a steering committee to inform continuous improvement, address challenges and ensure quality service

delivery.

Please see supporting document attached for an overview of the SPIN referral process.

Outcomes and Results/Lessons Learned :

Results

- Increased access to services for patients with complex medical and psychosocial issues – 388 patients referred through SPIN in the first year.
- Patients attached to most appropriate and supportive community services – 585 service referrals in the first year.
- Assisted physicians to collaboratively manage their complex patients – 32 solo physicians utilized SPiN services and found better connections with community based programs for their patients.
- Increased access and utilization of CHC services – SPIN currently involves the participation of 6 CHCs. Utilization data is being evaluated and will be available for the presentation.
- Qualitatively, SPiN has helped build the CHCs' community profile and forged new relationships with PCPs, strengthened relationships within the Health Link, and provided support to complex patients as evidenced by physician, CHC and patient feedback.

Lessons learned:

- Be practitioner-centred to be patient-centred.
- Be prepared to look at things differently: Innovations are iterative, demand dialogue, flexibility and course correction
- Warm handovers were critical to sustainability. Physicians wanted to be updated, CHCs wanted appropriate referrals. Wherever possible if a service was not available, CHC would attempt to fill in the gaps.
- Communication is essential. Issues and iterative changes were shared in bi-weekly and later monthly phone calls among CHCs. Recaps among stakeholders were held to review progress, tests of change and improvements.

The impact and spread potential

SPIN can be leveraged to reach more patients by partnering with an expanded group of CHCs and PCPs. SPIN provides an opportunity to look at full integration and utilization of CHC scope of services.

The scale and spread of SPIN is already underway with minimal administrative burden as the Central Intake role is already in place allowing CHCs and PCPs to join with ease. More concretely, two CHCs from other Health Links are in the process of joining SPiN with more planned once additional supports are secured.

With the increase in CHC service utilization enabled through SPIN, the project maximizes what the system is already funding. This program improves population health and offers access to services for complex patients by connecting practioners to team based care.

4302

eNotifications: Improving the Coordination of Care for Complex Patients

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Background/Context:

Health Links are improving coordination between hospitals, family physicians, long-term care homes, community organizations and others for complex care patients. The East Toronto Health Link (ETHeL) submitted a business plan to the Ministry of Health and Long-Term Care proposing an enhancement to the distribution of hospital reports to community providers using Hospital Report Manager (HRM), by sending near real-time notifications (eNotifications) via HRM to family physicians when patients are discharged from the emergency department (ED), admitted or discharged as in-patients. Complex care patients make up a significant portion of the 5.9 million visits to Ontario EDs every year.

HRM enables clinicians using an OntarioMD certified EMR to receive hospital reports within the patient chart in their EMR. ETHeL partnered with Toronto East General Hospital (TEGH), South East Toronto Family Health Team (SETFHT) and OntarioMD to pilot eNotifications to approximately 400 physicians connected to HRM. eNotifications are now being expanded in other parts of Ontario by OntarioMD. OntarioMD engaged with the Ontario Association of Community Care Access Centres to connect HRM to its Client Health & Related Information System to augment eNotifications with CCAC and Health Links information (where available) before being sent to primary care providers' EMRs.

Objectives:

OntarioMD achieved its mandate of electronic medical record (EMR) adoption with 85% of community-based physicians using a certified EMR. OntarioMD's goal now is to add further value to certified EMRs by connecting them to patient information collected in other care settings.

OntarioMD is implementing the electronic distribution of reports and notifications from hospital information systems directly to certified EMRs through Hospital Report Manager (HRM), the provincial hospital report solution that has been expanding across Ontario since August 2013. It is anticipated that HRM will dramatically reduce, and eventually eliminate, paper reports for certified EMR users. HRM's objective is to connect all physicians who use a certified EMR and to connect all hospitals in the province to improve communication and transition of care from acute care to the community, particularly for complex patients. To support better coordination of care, HRM also provides timely communication about the patient by sending eNotifications and enable enhanced patient safety and quality care.

Measures:

The outcomes for HRM were to connect as many clinicians and sending facilities as quickly as possible and eliminate paper reports. The interface from hospitals to HRM was considered a quick win by hospitals and this facilitated the almost 100 connections to sending facilities to date.

OntarioMD made the enrolment process for clinicians easy. OntarioMD regional field teams walked through the HRM requirements with them and transmitted their subscriber and end user agreements to start the connection process. About 5,000 enrolments have been processed and over 3,200 clinicians have been connected.

Change Concepts:

HRM is seamlessly integrated into the EMR, with OntarioMD delivering expert change management services to help practices adjust workflow and prepare for implementation, and monitoring the training provided by EMR vendors. eNotifications required no extra training, appearing in the EMR as any other report would.

Outcomes and Results/Lessons Learned :

HRM has connected approximately 100 sending facilities and over 3,200 clinicians. It has sent over 2 million reports to clinicians to date. It has also sent over 25,000 eNotifications from TEGH to over 400 physicians to date. HRM can accommodate many types of reports and is expanding across Ontario.

eNotifications, in particular, have improved communications between hospitals and physician offices. Instead of waiting for the patient to contact the physician's office after being discharged from the hospital, or waiting for a discharge summary which could arrive days or weeks post-discharge, the physician is now aware in a timely manner when a patient was admitted to the hospital and can provide additional information or support to the patient. The physician is able to determine if post-acute follow-up is required within the 7 day guideline and can determine appropriate ongoing treatment.

Results from the distribution of eNotifications have been impressive. The Benefits Evaluation conducted by TEGH in November 2014 reported that 100% of the notifications sent from TEGH to the SETFHT's EMR were reviewed by the family physician within 7 days, and a follow-up action was determined for each patient. Using the ministry definition for follow-up, 54% of these notifications resulted in follow-up appointments compared to an annual rate of 37% in 2013. 57% of the notifications were for patients who were determined to be complex using the ministry definition.

The importance of eNotifications has also resulted in recognition as a Leading Practice by Accreditation Canada.

HRM received a Canadian Health Informatics Award for Innovation in the Adoption of Health Informatics.

4389

Improving Care for Medically Complex Patients Through Innovative Discharge Programs

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Background/Context:

Medically complex patients are at risk of readmission to the hospital during the initial weeks following discharge (McAlister et al, 2015). This is why our organization has focused on ensuring patients have a safe transition home with adequate support. We have created two innovative programs to improve transitions home and reduce readmissions, emergency utilization and avoidable hospitalizations. The CATCH program stands for care after the care in hospital and is offered to medically complex patients that are at risk of readmission. The CATCH program comprehensively addresses patient risk factors and reconditioning needs during the initial week's following discharge. The second innovation is the COPD program offered to those with COPD upon discharge from hospital. This program teaches patients management strategies to prevent readmission and improve their quality of life.

Objectives:

We would like to illustrate how these two innovative discharge programs- the CATCH program and the COPD program-have dramatically reduced readmission rates and improved patient quality of life.

Measures:

Both programs have been developed to support patients at their most vulnerable transition- from hospital to home. Upon discharge patients are appropriately identified and referred to the post discharge program that meets their needs. This is to ensure that reoccurring risk factors are adequately addressed and the patient is provided the support needed to remain safe at home. The cornerstone of the programs is the authentic caring partnership with program staff that truly inspires patients. The CATCH program is staffed by a physiotherapist, nurse and physiotherapy assistant and focuses on addressing both physical deconditioning and risk factors associated with their condition. The COPD program is staffed by a nurse educator who harnesses a therapeutic relationship to motivate and teach patients how to manage their COPD for a better quality of life.

Change Concepts:

Both programs were developed as a result of an environmental scan which illustrated the need to do more to support specific patient populations upon discharge. Specialist, community partners and RVHS's clinical and administrative staff all participated in program design. Program staffs were hired based on the alignment of their passion and expertise. Organizational awareness has spread over time through campaigns, education sessions, and regular rounding to the floors. Both programs now have a steady stream of referrals and have gained significant popularity.

Both programs are held in outpatient clinics, are in small-group based formats and require patients to attend twice a week. Program staffs work with patients individually and as a group to help patients reach their goals and improve physical, emotional and mental well-being. Family members are encouraged to attend as learnings are beneficial for caregivers. The COPD program is eight weeks in length and is module based. Patients are to demonstrate learning before moving to the next module. The CATCH program is generally three to six weeks in length but is based on individual needs and is extended as needed until the patient reaches their reconditioning and self-management goals.

Outcomes and Results/Lessons Learned :

Both programs have had dramatic results. At thirty, sixty and ninety days the CATCH program has had a readmission rate of zero! When we compare this to a similar patient population the length of stay is 15.5%, 20.6% and 25.26% respectfully. The readmission rate for patients attending the COPD program is 1% at thirty days compared to a similar patient population that has a thirty day readmission rate of 12%. In addition, results indicate that patients attending the COPD program feel a 41% improvement in their quality of life as indicated on the COPD Assessment Test (CAT). CAT is a validated tool that grades the impact of an individual's COPD on daily life.

Key lessons have been learned at RVHS through program implementation. The first being that innovative discharge programs can have a dramatic impact on reducing readmission rates and improving the patient's quality of life. Secondly, a key ingredient to a distinguished program is having passionate program staff. Lastly, establishing organizational support of new programs requires a sustained and multi-prong approach to increase awareness and ensure sustainability.

Not only has organizational support been gained but also support from external funders. The Central East LHIN has provided funding to grow the CATCH program. The COPD program has also obtained grant money from contracted vendors to help patients with significant socioeconomic challenges access the program. There is potential for other health care organizations to implement similar programs; this is because the upfront investment can reduce the significant costs associated with readmissions.

4324

Care Conferencing: An Essential Tool to Drive Reductions in Avoidable Emergency Department Utilization for Complex Health Links Patients

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Background/Context:

The MOH LTC Health Link strategy has led to enhanced collaboration and provision of care for patients with complex health needs resulting in improved patient experience and decreased utilization of emergent and acute care services. An important element of this work has been patient self-identified goals and care conferencing to address these complex issues. While care conferencing can take many forms, the East Mississauga Health Link (EMHL) has prioritized care conferencing with patients, Health Link care coordinators (HLCC) and primary care providers. Taking our cue from the vast body of literature showing that patients discharged from hospital have better outcomes if they follow up from their family physician within 7 days of discharge, EMHL has prioritized this communication with primary care.

Objectives:

EMHL's goal is for 80% of HL patients to have a primary care conference, defined as a simultaneous conversation with patient/family, primary care provider and HLCC, and occurring at the primary care provider's office or patient's home in person or via video/teleconference. Ideally, this initial conference occurs within 7 days for hospital referrals and 14 days for community referrals.

Measures:

To enhance on EMHL findings reported one year ago, additional outcome measures have been added to strengthen this work (note the items marked with an asterisks*).

Process Measures:

- Number of care conferences
- Time from enrollment to care conference

Outcome Measures:

- Emergency/acute service utilization 6 months pre and 6 and 12 months* post HL enrollment
- Service utilization by early and late care conference*
- Achievement of patient goals by care conference (with or without conference)*

Qualitative measures:

- Patient/provider experience with care conference*
- Patient and coordinator report on reasons for no care conference*

Change Concepts:

Care conferencing is important for all Health Link patients. If patient situations are truly complex, there is opportunity for enhanced understanding of patient needs and wishes by primary care and coordinators alike. EMHL care coordinators make it a priority to invite a care conference with their primary care provider for all Health Link patients as early as is possible. This includes assisting with the arrangements, such as booking the appointment and transportation if needed, and even setting up videoconferencing in the patient's home if travel is not possible for one or other of the parties. Care conferencing with other health care providers and specialists is also important but access to this larger team is not a reason for delaying early conferencing with primary care.

Outcomes and Results/Lessons Learned :

EMHL has achieved care conferencing in 55% (n=105) of all enrolled patients and 39% (n=41) have occurred within targeted time period. Care conferencing is challenging.

At 6-months post-enrollment, EMHL patients (n=131) have had a 36% reduction in emergency department visits compared to the 6 months prior to enrollment. Patients who participated in a care conference (n=77) had a 18.7% reduction in emergency department visits at 6 months relative to those who did not receive a care conference. This finding was slightly reduced at 12 months of follow up, with a relative reduction of 11.1%. In the early stages, those who did not have a care conference had 93% more emergency visits in the first 30 days post enrollment. In a sub group analysis of patients receiving care conferencing, those that occurred within 7 days of enrollment benefitted from more than a two-fold reduction emergency utilization as compared to those with a later care conference. This is consistent with literature finding regarding early post-acute care following discharge.

While patients did not report a significant difference in their meeting their goals (81% with care conference, 75% with no care conference), information, derived from interviews reveals that care conferencing has improved patients' relationship with their primary care provider and their experience of health care. HLCC and primary care providers also reported an improved understanding of and progress toward patient goals.

Patient experiences along with quantitative data support the value of care conferencing in the Health Links population. As just over half of EMHL patients participated in this innovative care coordination and communication tool, there remains a large opportunity to further drive patient and resource utilization outcomes in this Health Link and beyond. The importance of care conferencing has had significant influence in the Mississauga Halton LHIN such that the Mississauga Halton CCAC is exploring the adoption of care conferencing as a standard of care for all complex patients. Additional research is required to explore enablers and barriers to care conferencing and to improve the generalizability of this Health Link innovation.

4070

Rural Hastings Healthlink : System Navigation in Primary Care

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Background/Context:

The Rural Hastings HealthLink (RHHL) is one of seven primary care led, early adopter HealthLinks within the South East LHIN. RHHL applied the triple aim framework in developing the role of System Navigation in primary care supporting transitions in care and addressing system breakdowns. Incorporating the principles of triple aim, primary care and broader sector partners focused on: the delivery of coordinated care, improving the patient's experience, integrated system planning as the patient transitions from one part of the system to another, improving health outcomes that focus on social and medical complexity and reducing health care costs. To support our vision for change embedded System Navigators and Data Management Coordinators within four primary care sites support a system that enables, promotes ownership and improves health through engagement, leadership, innovation, performance management, and continuous improvement.

Objectives:

To improve the overall patient experience every identified RHHL patient is attached to a primary care System Navigator. All identified complex patients have a care coordination plan. The plan is introduced to the patient/family through the System Navigator who engages the practitioner and patient / family in establishing their plan of care. The patient's care team (primary care & broader sector) is engaged in supporting the patient's plan of care either with the patient present or through engagement by the System Navigator. Regular follow up by the System Navigator on monitoring the patient's goals and progress reinforces one of the goals for establishing relationships that improve patient satisfaction throughout their journey.

Measures:

Core Indicators

1 % reduction of avoidable ED visits
2 % reduction of unnecessary hospital admissions
3 % reduction in LOS
4 % reduction of 30 day re-admits to hospital
5 Primary care follow up within 7 days of discharge
6 # of home assessments completed
7 # of complex patients with access to primary care provider
8 # of complex patients with a Care Coordination Plan
9 # of complex patient identified
10 # of complex patients who refused service
11 # of external referrals given by the System Navigator
12 # of internal referrals given by the System Navigator
13 # of external agencies involved pre-care coordination plan
14 # of external agencies involved post care coordination plan
15 # of complex patients with a self management goal
16 # of medications complex patient is prescribed
17 # patients with 10 or more medications
18 # of complex patients receiving medication reconciliation after hospital discharge
19 # of complex patients enrolled in CDPM initiative
20 # Physicians using system navigator to support caseload
21 #Complex patients with Medication Reconciliation
22 Primary Care follow up within 7 days of hospital discharge

Change Concepts:

The Rural Hastings HealthLink established a structure to support inclusion in integrated system thinking, planning, performance management, evaluation and accountability for continuous improvement. Coalition design included representation from the four primary care organizations in the RHHL, regional sector partners (Hospital, CCAC, CSS, MH&A, LTC) and patients.

The four primary care sites (North Hastings cFHT, Bancroft FHT, Centre Hastings FHT and Gateway CHC) actively engaged in integrating the role of System Navigator within their care teams and garnered physician participation. Lead Physicians; Dr. Brown (BFHT), Dr. Stewart & Dr. Webb (CHFHT), Dr. Quinn (Gateway CHC) and Cheryl Marks (NP- NHFHT) actively participate on the RHHL Steering Committee and support the integration of the role of System Navigator and promote utilization of the role and spread across their teams.

Outcomes and Results/Lessons Learned :

April 1 2014 to March 31, 2015, RHHL System Navigators completed 152 Care Coordination plans with 87% of Physicians using the role of System Navigator, 100% of patients with a Care Coordination Plan had a medication reconciliation completed and 100% of patients had a primary care follow up within 7 days of hospital discharge. RHHL has provided a Return on Investment to the system at $2,667,482.00 at the end of fiscal 14/15 with a demonstrated 87% reduction in ED visits and 83% reduction in hospital admissions and 71% reduction in LOS.

In order to address complex problems boards, providers and patient/families need to shift their mindset to a systematic approach that focuses on the relationships between organizations and the progress towards shared objectives. The RHHL model success and ability to sustain is based on five enablers to support this systematic approach. The approach can be shared with other regions.

These include:

i **Common Agenda**: - shared vision, joint approach through agreed action
ii **Shared Measurement** –performance management consistent across all participants, hold each other accountable.
iii **Mutually Reinforcing Activities** – coordinated plan of action
iv **Continuous Communication** – common motivation and build trust
v **Backbone Support** – dedicated staff , specific skill sets, structure to lead, initiate and coordinate participating organizations

4174

Keeping At-Risk High Needs Clients on the Radar – The Community Agency Notification (CAN) Program

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Background/Context:

A challenge faced by community providers is maintaining connection with at-risk high needs clients, such as frail complex seniors and those with serious mental health and addiction issues, when they experience a medical emergency. Not knowing when, where, or who has transitioned creates a gap between established services and people they support. The Community Agency Notification (CAN) Program is an innovative initiative that partners Toronto Paramedic Services (TPS) with community providers to ensure that gap is bridged by providing electronic notifications to providers when their CAN clients have contact with paramedics. Notifications indicate if the person was helped at home or taken to hospital and provides information on what hospital the person was taken to and when.

The value of the program is notifications are usually sent in 'real time' and allow providers to better respond to clients' changing needs resulting from declines in health, injuries, or changes in their environments. Providers can proactively follow-up with the person, family, or hospital to check on the client's condition and determine next steps. The CAN notification facilitates clients receiving seamless transitions of care, which may result in fewer ER visits, shorter hospital stays, and a more effective continuum of service delivery.

In the summer of 2014, TPS tested the rate of notifications being generated by 911 calls involving paramedics at five buildings with approximately 400 CAN clients. They found notifications were only being triggered in approximately 20% of cases. The system was dependant on TPS's 1000 paramedics knowing to use the CAN ID assigned to the client to generate a notification. TPS and providers felt to be truly effective the program needed to increase the percentage of 911 calls triggering CAN notifications and increase the number of CAN clients.

Objectives:

Improve the care of at-risk high needs clients by

- Improving the percentage of 911 calls involving paramedics that trigger CAN notifications
- Increasing the number of clients registered for CAN

These objectives would improve care for clients by enabling community providers to proactively follow up.

Measures:

Outcome

- Increase the number of providers notified through CAN when their clients are helped at home or taken to the hospital by paramedics from less than 20% to 80%
- Community providers follow-up with their at-risk clients 100% of the time when they receive a CAN notification

Process

- Increase the number of notifications triggered when CAN clients called 911 and are helped byparamedics by 300%
- Increase the number of CAN clients by 30%

Change Concepts:

Several interventions undertaken:

- TPS developed and implemented a system in September 2014 where CAN notifications were automatically triggered when, as a part of their regular work flow, a paramedic entered a patient's Health Card number.At the backend, TPS tied the CAN ID number to the HC number.CAN notifications would be triggered even if the paramedic was unfamiliar with CAN.
- TPS held Paramedic CMEs in February, March, and April 2015 to educate more paramedics about CAN.
- The Don Valley Greenwood Health Link (DVGHL) committed to registering 270 new CAN clients at WoodGreen between July 2014 and June 2015.
- The Community Navigation and Access Program (CNAP) and the TPS's Community Paramedicine Program worked together in 2014 and 2015 to roll out the CAN program to more CNAP agencies and increase the number of clients registered for CAN

Outcomes and Results/Lessons Learned :

The outcomes for the interventions:

- Post implementation of Health Card triggered CAN notifications the percentage of notifications being generated by a call to paramedics rose in the five buildings evaluated from less than 20% to 80%.
- The CME sessions for paramedics corresponded to an approximate 100% increase in the CAN ID triggered notifications that are proactively triggered by paramedics
- Overall the number of notifications per month has increased on average more than 300%
- The DVGHL registered 348 CAN clients at WoodGreen between July 2014 and June 2015
- The number of clients registered to CAN rose from 1796 to 2764, an increase of 968, which is an increase of more than 30%

As a result of the notifications received by WoodGreen staff between April 1 and June 30, 2015 the program facilitated the following results:

- 78 CAN notifications received
- 100% of notifications followed up by at least a phone call or visit
- 39% of situations further follow up was required
- 41% of situations the circle of care within agency were informed
- 28% of situations the external circle of care were informed
- 24% of situations new services put in place
- 17 clients were admitted and in 82% of cases providers had contact with hospital

4377

Establishing a foundation for QBP Performance: Driving Quality in Health Records and Documentation at TSH

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Background/Context:

Due to changes in HSFR, coding and documentation has become increasingly important and has a direct impact on hospital funding. Improving the quality and efficiency of the coding process will ensure hospital maintain a budget that allows for continued provision of an outstanding care experience for our patients.

Objectives:

The Scarborough Hospital's QBP Steering Committee conducted a root cause analysis on the potential administrative gaps in QBP performance. Upon review of the TSH Health Records Balanced scorecard it was determined that a Lean

Rapid Improvement Event should be conducted to: 1) address increasing trend of chart defects that created wasteful rework for the Health Records coding team; 2) improve the timeliness of coding Turn-around to meet the 30 day target 3) Improve the overall productivity of the team

Measures:

The outcomes for the team included *Access* as defined by the metric "Monthly Coded Chart Turnaround time" as well as *Productivity* or "Percentage of non-coding time" as defined by workload summary reports.

Process measures included reducing the number of monthly chart deficiencies, ie charts that were missing key aspects of patient care documentation and thus were driving rework and non-productive time for the Health Records coding team.

Change Concepts:

The Health Records Coding Lean Rapid Improvement Event was the first to be conducted within the Health Information management portfolio. A cross-functional team was commissioned with representatives from Finance, Decision Support, Patient Registration and staff across the Health records department. Clinical leaders and physicians were engaged throughout the 5 day event. Spanning the process flow from when a patient chart is available for coding to when clean data is submitted externally (i.e. CIHI and CCO), process mapping and spaghetti diagrams were used to visualize the multiple handoffs and extra steps required in current state. Numerous gaps and opportunities for improvement were identified by the team including: 'siloed' information and knowledge across the health records team; inconsistent communication across the finance, decision support departments; unclear expectations or service level agreements with physicians; and a lack of focus on internal auditing processes.

Over the course of 3 months a series of improvements were implemented including weekly huddles within the coding area, a Data Management Committee involving Finance, Decision Support and Patient Registration. Implementation of process audits or "Quality Checks"; change management and education with physicians on the importance of timely documentation; refinements on the existing corporate Medical Staff Chart Completion Policy and renewed escalation processes to inform physician leaders of chart deficiencies.

Outcomes and Results/Lessons Learned :

The resulting outcomes include a 47% improvement monthly coding turnaround time (nearing target of 30 days) as well as meeting the productivity target of reducing non-coding workload to less than 5%. Through ongoing engagement of physicians at departmental business meetings and at Medical Advisory Council, chart deficiencies reduced by 36%.

Lessons Learned include:

The importance of health information to QBP performance: Through this lean event, TSH staff and physicians developed a deeper understanding of the challenges faced by our health records team and the importance to working together

Connection between Finance, Data, and Health Records: Leaders also appreciated the need to develop regular process check points between health records and other information management departments.

Applying improvement tools and concepts in an administrative support department: Staff readily understood and applied lean thinking in their workplace – initiating team huddles, process audits and kanban.

Engaging physicians in administrative change: Helping physicians understand the importance of charting and documentation was a key driver to improvement. The health records team illustrated the impact of chart delays using data that was meaningful to our physicians.

4038

Improving the Care-Experience by Integrating the QBP on Discharge for Patients with COPD

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Background/Context:

Exacerbation of COPD is the leading cause of hospital admission and readmission above all other chronic conditions (Benady, 2010). In January 2013, the Ministry of Health and Long-Term Care, in partnership with Health Quality Ontario, released the Quality Based Procedures (QBP) for COPD which is aligned with the goals of delivering high-quality care and fiscal responsibility. The report addresses how the paradigm shift to quality improvement identified the need for strong clinical engagement, and system capacity building, for change and improvement in provider adoption of best practice for patient outcomes.

There is a need for close collaboration between acute and primary care providers to improve chronic disease management. Within the QBP is the Continuum-of-Care model for COPD management, which provides recommendations for practices in both the acute episode of care and the post acute, community care phase. The *COPD Continuum-of-Care Model* contains recommendations for the discharge of patients from hospital and transition to the community. Cambridge Memorial Hospital is strategically aligned to continue building on the existing foundation of care and *improving the care experience* for patients with COPD and implement the Pre-Discharge Planning component of the Quality Based-Procedures (QBP) for COPD, specifically Care Modules 5 and 6

Objectives:

The purpose of this project is to implement the Pre-Discharge Planning component of the QBP for COPD. As part of the QBP, patients are selected for full review by the project nurse practitioner if they meet the inclusion criteria as described by the QBP such as, admission to hospital for COPD or COPD exacerbation.

Implementation of the pre-discharge component of the QBP, includes a focused review of all available documentation, diagnostic testing, a full clinical assessment of the patient by the nurse practitioner prior to discharge, medication review and reconciliation, inhaler technique review, smoking cessation education and support and the development of a comprehensive, collaborative-based, self-management plan with a full documented report on or before discharge to the family practice care provider, and health care providers as required. Components of the report include, a current medication list to the community pharmacist, report of necessary titration and oxygen prescription to the oxygen provider, referral to the COPD Clinic or suggestion for Respirology consult as reviewed and a list of all scheduled clinical investigations, preparation instructions for diagnostic testing, and all scheduled follow up appointments. This structured Pre-Discharge Planning Project provides fundamental information related to the development of the management plan for the patient with COPD on discharge and builds communication linkages with multiple caregivers within the community.

Measures:

Project goals include:

1. increase the number of patients who have completed diagnostic testing
2. reduce exacerbations and hospitalization rate
3. reduce 30-day readmission rate
4. improve communication with primary care
5. improve communication with health care staff within the hospital setting

Change Concepts:

The COPD Clinic at the Cambridge Memorial Hospital is an outpatient program providing patients with COPD with education, clinical assessment, and ongoing management of their COPD. Redesigning our existing clinical services meant that we expanded our foundational service to include nurse practitioner review of patients during hospitalization and just prior to discharge and improved communication with community providers, including pharmacy, oxygen vendors, physiotherapy, CCAC, and primary care providers as required. This is a demonstration of the ongoing commitment to continue to fulfill our role as a community hospital and meet the needs of our patients. This project created efficient and effective partnerships within our community structure while simultaneously engaging the high-priority patient at every step through ongoing communication and dialogue promoting knowledge transfer and building a culture of quality.

Outcomes and Results/Lessons Learned :

Cambridge residents living with COPD are empowered through this pilot project, by improved contact with the health care team at Cambridge Memorial Hospital, personalized contact by with the nurse practitioner prior to discharge, and engagement with the community as necessary, in the provision of health care services. Improving the care-experience to support patient centered care on discharge for patients with COPD provides a collaborative, focused approach to developing patient-centered goals of care and interventions.

Primary care has been positively impacted as is the broader health care system through the identification of individual care needs for health promotion and illness prevention and the facilitation of scheduled appointments, follow up and clinical investigations. This project promoted a culture of collaboration between the patient, the hospital, community and primary care providers working seamlessly to communicate the needs of each individual patient and their goals of care.

4345

The Ottawa Hospital COPD Outreach Program

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Background/Context:

Patients with Chronic Obstructive Pulmonary Disease (COPD) have a high rate of readmission to The Ottawa Hospital

(TOH) within 30-days of discharge following an acute exacerbation of COPD (AECOPD), and the cost of treating these patients is higher than any other disease. Evidence indicates that by optimizing the efficiency and effectiveness of medical and self-management through improved coordination and communication among all stakeholders the risk of hospital readmissions may be reduced.

Objectives:

To implement a COPD Outreach Program and demonstrate improved care quality, effectiveness and efficiency for patients, families and providers within TOH and the Community.

Measures:

Outcome Measure

Reduce 30-day readmission rate by 25%

Process Measures

- Smoking cessation counseling
- Self-management education
- Follow-up appointment with PCP
- Pulmonary Rehabilitation

Change Concepts:

The Ottawa Hospital is one of 19 teams across Canada to receive seed funding and the opportunity to participate in a 12-month pan-Canadian collaborative through the Canadian Foundation for Healthcare Improvement in partnership with Boehringer Ingelheim (Canada) Ltd. The goal of the collaborative includes the development of innovative approaches to improve COPD care across Canada.

The Ottawa Hospital, in collaboration with community partners, developed a COPD Outreach Program aimed at providing high-quality, seamless care for patients admitted with an acute exacerbation of COPD (AECOPD). Currently, our team enrolls patients admitted to TOH with an AECOPD from Respirology; Medicine and Family Medicine Services across two campuses. Through collaboration and coordination of care by TOH clinicians with specialized training in COPD management, patients are safely transitioned back into their homes with a home visit scheduled and conducted within 2 weeks of discharge, monthly monitoring for 3 months thereafter and at 12 months. All patient encounters, including telephone advice are recorded in the Electronic Health Record and faxed to the appropriate care provider as required. Patients have access to an information line where they can speak with a team member for non-urgent COPD management inquiries or questions on navigating the healthcare system. Additionally, community resources are reviewed with each patient and referrals are made as appropriate. Consequently, every patient is recognized as unique, and their treatment plan is reflected in meeting their specific knowledge, concerns and needs.

Outcomes and Results/Lessons Learned :

Outcomes in the first 6-months (November 2014-May 2015)

The goal of the program is to enroll 100 patients over a 12-month period. In the first six months, 66 patients (29 males & 37 females) are enrolled in the Outreach Program. There is a **75% reduction in COPD-related readmissions** for patients in the program compared to 12-months prior to enrollment.

- Mean age is 73.6 years (SD = 10.4)
- 100% of patients who smoke received smoking cessation information/counseling
- 86% of patients had either made an appointment with or seen their PCP within seven days of discharge
- 4.5% of patients received facilitation of a referral to a new PCP
- Referral to community resources – 41% to Pulmonary Rehabilitation; 4% to Palliative Care and 55% of patients were not interested in a referral to community resources
- 100% of PCPs +/- Specialists received a fax outlining the Outreach Team involvement

22 patients have received Baseline questionnaires:

- 86% of these people have never smoked or do not smoke now
- 86% indicate they have not had a conversation with their doctor about what to expect in the future with COPD
- 68% have high school education or less
- 77% have an annual income < $40,000
- 100% of target population received self-management education (including a COPD Action Plan)

The COPD Outreach Team continues to build capacity through best-practice and knowledge transfer with hospital and community stakeholders. Service gaps are shared, and mitigation strategies are identified which include the development of a COPD pathway in collaboration internal and external stakeholders.

One of the key success factors of the program is recognizing the significance of relationship building between the healthcare provider and patient/family. Once a relationship has been established, the patient/family is motivated to participate in creating a plan of care, and subsequently feels empowered to articulate this plan to other healthcare providers (e.g their Primary Care Provider, Pharmacist).

One of the limitations of the program includes the capacity to see patients admitted from nursing homes. Creative solutions or scaling-up opportunities to address this population could include building capacity among TOH Outreach Nurse Practitioners currently working in nursing homes in the Region. Additional opportunities include receiving referrals from the Emergency Department, and on a larger scale, organizing a committee to look at developing a COPD Toolkit that could be rolled out across the Region.

4136

Implementing a System-Wide Engagement Strategy to Support Collection of Stroke Rehabilitation Intensity Data across Ontario

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Background/Context:

Quality-Based Procedures Clinical Handbook for Stroke (2015) recommends that each person with stroke receive a minimum of 3 hours of individualized intensive therapy per day in inpatient rehabilitation. Currently, as patient time in therapy is not captured, the Ontario Stroke Network (OSN) collaborated with the Ministry of Health and Long-Term Care (MOHLTC) and Canadian Institute for Health Information (CIHI) to have rehabilitation intensity (RI) included in the National Rehabilitation Reporting System (NRS). As of April 1, 2015, the MOHLTC mandated RI collection in the NRS for all stroke patients in Ontario. Given this is a province-wide initiative, an engagement strategy that includes collaborating with multiple stakeholders was necessary to develop a standardized knowledge translation approach for clinical implementation and sustainability of RI measurement.

Objectives:

1) To implement a province-wide strategy to support stroke RI data collection and reporting;
2) To understand the clinicians' experiences in collecting RI data in order to further support clinicians during RI data collection.

Measures:

A province-wide survey was conducted in 2015 to assess uptake and understand the clinicians' experiences in implementing RI. Outcome measures included:

1) Total number of hospitals reporting readiness to collect RI data;
2) Percentage of hospitals that used workload measurement systems (WMS) versus other methods to collect RI;
3) Percentage of clinicians who entered RI data in 10 minutes or less.

Qualitative questions on a one-time electronic survey were used to understand clinicians' experiences in order to identify barriers and enablers for RI data collection. Thematic analysis was used to identify themes related to practice change and unintended consequences from RI data collection.

Change Concepts:

Collecting RI requires a shift from accounting for time **clinicians** spend providing therapy to documenting how much time the **patient** spends in therapy. Capturing patient time in therapy relies on clinicians having the tools to track these data, educational materials and training. Adaptation of WMS to collect RI requires organizational support and resources.

The Approach

In 2014, the OSN struck a task group that collaborated with the MOHLTC and CIHI to develop and implement a province-wide strategy to support RI collection and reporting. For current state analysis, the task group reviewed provincial use of WMS and conducted site interviews with 4 hospitals that were going through the change process in adapting their WMS to accommodate RI data collection. In learning from these hospitals on the steps taken to adapt their WMS, educational resources were then developed to support provincial implementation. To facilitate provincial spread and the transfer of knowledge, the OSN Regional Rehabilitation Coordinators Group (OSN RC Group) was leveraged to disseminate resources/information and gather ongoing feedback to identify emerging issues and inform implementation. A 12-item electronic post-implementation survey was also developed by the group and disseminated by the OSN RC Group to inform ongoing resource development. This survey was designed to capture the clinicians' experiences during RI data collection, and was piloted at one site before dissemination to NRS hospitals 3 weeks post implementation.

Outcomes and Results/Lessons Learned :

Based on information gathered from the OSN RC Group, 46 hospitals reported readiness to collect RI data as of April 1, 2015, with 2 other hospitals reporting a start date 1-3 months later. Three hundred and twenty-one clinicians from 47 hospitals responded to the survey. Common approaches for collecting RI were identified and included adaptation of WMS to accommodate RI data fields (64% of sites, N=47) and manual collection. Clinicians also reported that collection was feasible, with 71 percent of clinicians reporting that it takes 10 minutes or less to enter RI time. Among clinicians, data accuracy had the highest frequency (30%) of all challenges reported (N=358). Ease of access through WMS was the most prevalent enabler reported (50%, N=23). Qualitative themes related to practice changes and unintended consequences. Further analysis is ongoing.

Overall, a provincial structure that leverages regional relationships effectively mobilized 46 hospitals across Ontario to collect stroke RI as of April 1, 2015. Stakeholder engagement at a regional level allows for the development of tailored resources to meet local needs. Opportunities for improvement in RI collection relate to enhancing data quality and consistency of data collection across sites. Future work will focus on the development of resources to address issues related to quality assurance and utilization of the data to support stroke system improvement. Additionally, this data is being used to develop resources for clinical implementation of increased RI. Learnings from this work are being used to inform system planning and can be applied to other provinces and diagnostic groups interested in RI in rehabilitation settings.

4172

An INSPIRED Approach to Chronic Obstructive Pulmonary Disease: Improving Care and Creating Value

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Background/Context:

Chronic obstructive pulmonary disease (COPD) is a primary cause of Emergency Department (ED) and hospital visits across Canada. The INSPIRED COPD Outreach Program™ based out of Halifax, Nova Scotia, is setting new standards for community-based care of people living with advanced COPD. With over 250 patients enrolled in the program, with sustained 60% reduction in facility use, INSPIRED is ripe for spread beyond the Maritimes. The program targets hospitalized patients with an acute exacerbation of COPD who are most at risk of repeated admissions. A pan-Canadian quality improvement collaborative launched by the Canadian Foundation for Healthcare Improvement (CFHI) with support from Boehringer Ingelheim Canada Limited (BICL), as well as in-kind support from VitalAire Canada, extended the Halifax experience by supporting 19 multidisciplinary healthcare improvement teams across all provinces.

Objectives:

The goal of the INSPIRED collaborative was to help the 19 participating teams:

- Improve patient and family caregiver education, self-management and self-efficacy, particularly for patients with advanced COPD;
- Improve continuity of care across the hospital-to-home transition;
- Enhance home-based care;
- Facilitate effective advance care planning, and;
- Reduce reliance on costly hospital-based care including emergency room (ER) visits, hospital admissions and lengths of stay.

Measures:

Each of the 19 improvement teams have incorporated core metrics in four quality domains as part of their initiatives: patient -and family-centred care, coordination of care, efficiency of the healthcare system and appropriateness of care.

Efficiency measures included: 1) ED visits/visit rate for COPD per year; 2) COPD admission rate; 3) Average length of stay for COPD patients per year; and 4) Unplanned COPD readmission rate (within 30 days, 90 days, six months and one year).

As for coordination of care, teams were asked to track the quality of care transition over the hospital-to-home transition assessing patient/family (individual change Care Transitions Measure-3 or 15 score).

To assess the quality of patient -and family-centred care, teams tracked patient and family reported experience with the program (Using an adapted INSPIRED COPD Outreach Program™ Hopes and Expectations interview guide for patients and families).

Each team selected appropriateness of care measures specific to their interventions (e.g., Percent of patients who received appropriate Medication prescription: bronchodilators (BD) (short- and/or long-acting) for all; combination of long-acting beta-agonists (LABA) + inhaled corticosteroids (ICS) for prevention of exacerbations; Percent of patients who had a Self-management action plan (AP) for exacerbations: teaching/education, written AP, prescription; Percent of patients who were referred to pulmonary rehabilitation, etc.)

With seven of the 19 teams from Ontario, the collaborative provided a great platform for incorporating COPD QBP measures in their overall measurement plan, while going beyond these in order to track data related to other key aspects of their INSPIRED-like interventions.

Change Concepts:

Teams adapted the following INSPIRED COPD Outreach Program™ change concepts and interventions to their local context:

1 Optimization of medications and Action Plan prescription (as per Canadian Thoracic Society Guidelines)
2 Care that addresses continuity across hospital-to-home transitions
3 Individualized, coordinated, and proactive care that includes:
  a In-home COPD-related self-management education
  b In-home psychosocial/spiritual support
  c In-home opportunity for advance care planning (ACP)
  d Phone access to team support during working hours
  e Monthly phone follow-up for 3 months after scheduled home visits
4 Liaison and partnership building with community and allied healthcare support services
5 Monitoring/evaluation for quality assurance purposes

In order to support teams in implementing their INSPIRED-like interventions, the collaborative provided them with funding, coaching, educational materials and tools. The curriculum was designed to provide education in both quality improvement (e.g., content on PDSA cycles, change management, measurement) and in chronic disease (best practices in the management of COPD including self-management support, end-of-life care, effective team-based care, etc.).

Outcomes and Results/Lessons Learned :

Early evaluative results from the collaborative show that two Ontario teams were able to demonstrate outcomes in some of the QBP measures. For example, the Ottawa Hospital achieved an 80% reduction in 30-day readmissions for the 60 patients enrolled so far. The Joseph Brant Hospital achieved a 100% reduction in 30-day readmissions for the 17 patients enrolled to date. Additional evaluative results from the seven Ontario teams will be available by October 2015.

The collaborative can yield valuable lessons from the application of the QBP metrics, while also informing the feasibility of tracking measures in other key quality domains to better assess the quality of care delivered to patients and families living with advanced COPD.

4130

Implementation of a Quality Based Procedure Congestive Heart Failure Care Pathway

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Background/Context:

Quality Based Procedures (QBPs) have been introduced by the Ministry of Health and Long Term Care to minimize practice variations and to enhance quality of care by promoting consistency through implementing evidence based best guidelines. A Congestive Heart Failure (CHF) care pathway was developed in March 2014 and was implemented on a 36-bed cardiac inpatient unit in July 2014. Six months following the implementation of the CHF care pathway, it was recognized that utilization and compliance was poor.

Objectives:

The objective of this initiative is to identify barriers to implementation of the QBP CHF Care Pathway.

Measures:

An evaluation of the project included staff surveys. The main outcome measure is the initiative's impact of the implementation of the QBP CHF Care Pathway

Change Concepts:

In June 2014 the concept of QBPs and the CHF care pathway was introduced to the interprofessional team on a 36 bed cardiac unit. In July 2014, a care pathway was implemented. Six months following implementation, a staff survey was conducted and a quality improvement working group session was held to identify barriers to implementation and utilization of the care pathway.

Based on the working group feedback, efforts were made to improve interprofessional involvement and communication by relocating where the pathway was housed and involving the Team Leader/Charge Nurse as liaison between all members of the team.

The changes to the initial care pathway and process were incorporated and implemented on the unit in April 2015. Two months following implementation, staff was surveyed again to identify effectiveness of changes.

Outcomes and Results/Lessons Learned :

Survey results showed an increase in awareness of the CHF QBP care pathway within the interprofessional team. In particular, 67% of MD and NP respondents were knowledgeable about the care pathway post-implementation, as compared to 0% of MD and NP respondents pre-implementation. The majority (78%) of RNs that responded to the post-implementation survey identified that changes made to the CHF QBP pathway improved their ability to complete it.

Further improvements in the visibility of the QBP CHF care pathway need to be made to promote use/completion and interprofessional involvement. This change initiative emphasizes the importance in ensuring a mechanism is in place to track current practice against recommended practices on a unit level such as auditing compliance and usage of the QBP CHF tools. Chart audits are being conducted to look for variation in practices in CHF management and utilization of CHF care pathways in the Schulich Program as well as the General Medicine Program to reduce variation in CHF management. Through chart audits and staff engagement, the pathway can be refined over time to ensure the utilization of evidence based best practices. The successes and challenges from implementing the CHF care pathway in the cardiac unit will help guide future QBP implementation.

4264

Embracing Technology to Enhance Healthcare Quality

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Background/Context:

The Couchiching Family Health Team COPD Tablet-Based Screening Program is designed to engage patients and optimize COPD population management for better prevention, education, and treatment.

The program, which involves a multi-disciplinary, cross-funtional team and a patient-centric technology platform, has rapidly increased the CFHT COPD population registry, improving access to care for patients at risk. At the same time, it is engaging patients in a positive and meaningful way while providing a new and cost-effective means to screen and educate patients.

Through the use of a cloud-based clinical platform, the CFHT is now enabled to use rule-based technology to collect smoking status information, promote smoking cessation programs, inquire about the patient's desire to quit smoking, complete the Canadian Lung Health Test screening tool and the MRC dyspnea scale. Additionally, email consent and address collection occurs. All of this data is self-reported by the patient, can occur in just a few minutes and is immediately integrated directly into the patients EMR. This standardized data entry can be used to identify patient's needs, direct internal resources (ie. program referral, spirometry required, bill for smoking cessation...) and communicate cross functionally through customized clinical notes.

Objectives:

Responding to the fact that Orillia and area has a large amount of individuals living with COPD, and recognizing the strain this is putting on the community hospital, the CFHT sought a strategy to enhance screening of its COPD population to achieve prevention and management goals. It required an innovative way to engage patients and efficiently collect key COPD clinical insights that could be leveraged in the EMR. CFHT also recognized the need for an internally aligned team, to leverage strategic partnerships and to adopt new technology to ensure success.

Measures:

Although early, milestones have been quickly achieved resulting in the ability to screen 16,000+ patients for smoking status and COPD. The following are key processes/observations:

- Develop a multi-disciplinary, cross-functional team including front office staff for alignment
    - GP's champion efforts to drive QI initiative
    - FHT wide communication
    - Integrate FHT program leads and IT managers to optimize processes
- Strategic partnerships created to drive QI initiative forward
    - Mapping evidence-based, rule-based COPD screening process
    - Implement cloud-based, clinical tablet platform for data collection with direct EMR integration

Change Concepts:

By accessing the data generated by the patient responses in the EMR, clinic staff can clearly identify a patient's needs, coordinate care, direct resources (ie. program referral, spirometry, billing) and communicate across health system partners with customized clinical notes.

4,836 forms have been completed as part of this COPD screening initiative in just 8 weeks, 1274 smoking status questions were completed by patients, and the results automatically added to the patient's chart. For those patients that indicated a history of smoking, Canadian Lung Health Tests (CLHT) was presented; 697 were completed by patients during the same period. For patients with a positive CLHT test result, the MRC Dyspnea screen was also presented (completed 240 times), and spirometry was recommended.

Outcomes and Results/Lessons Learned :

Using this method, over 5% of the total patient population completed COPD and smoking screening in just 30 days.

This is a significant improvement over the previous, paper-based COPD screening process in which only 200 patients were screened at baseline.

On average, the screening process took just 4.5 minutes. Instead of spending this time unproductively in the waiting room, the patient was able to actively contribute to their patient visit and patient record.

Patient feedback has been overwhelmingly positive, many stating they never would have brought up smoking cessation with their provider, however felt comfortable to input it into the tablet and then speak with their provider. Patients have stated they were blown away by the fact that they input this information and their provider not only reviewed it with them but discussed next steps and program they may be interested in as a result of this information.

4080

Developing Primary Care Measures that Matter: Creating a CHC Primary Care Dashboard

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Background/Context:

Recently, there has been a great deal of primary care indicator development and prioritization that has lead to a wealth of primary care indicators.

Community Health Centres (CHCs) have initiated a clinical advisoroy group that consists of physicians, nurse practitioners, nurses, dietitians and clinical managers. This group has attempted to prioritize indicators using a modified Delphi process to create a subset of measures that reflect practice/CHC level priorities that are meaninful to them. A primary care dashboard is being developed to measure, monitor and benchmark CHC progress (compared with other CHCs and their peers) with the ultimate objective of ensuring and maintaining high quality care.

Objectives:

To demonstrate how CHC providers have selected and prioritized a subset of indicators from the Primary Care Performance Measurement Framework and are creating a dashboard to improve care and increase evidence-informed decision making. We are applying a set of peer groups to these reports so that CHCs can compare themselves to their neighbouring CHCs as well as to CHCs that are similar to encourage shared learning and improvement.

Measures:

Data will be gathered from patient surveys, the electronic medical record and administrative data to inform the CHC primary care dashboard.

Change Concepts:

CHC providers have been using performance measures for many years however this initiative allowed the providers to select the measures that were most meaningful to them. This will encourage easy access to actionable data and will strengthen knowledge exchange and quality improvement.

Outcomes and Results/Lessons Learned :

Providers and administration had differing requirements and both are important - we have created different snapshots of data depending on the audience.

4366

Identifying Patient Delirium: Relying upon Screening is Not Enough

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Background/Context:

Delirium is a serious event associated with significant morbidity and mortality with incidence rates up to 50-80%. The development of delirium often initiates a cascade of events culminating in the loss of independence, functional decline, increased risk for falls, prolonged hospital stay and institutionalization. As part of a hospital priority Quality Improvement Plan, the objective over the course of three years is to increase the detection of delirium, focusing on interventions to mitigate & reduce incidence rates.

To achieve this objective, a large and complex initiative has been underway at Sunnybrook Health Sciences Centre (SHSC) since the summer of 2014 to support the screening, prevention and management of delirium. The Confusion Assessment Method (CAM) & complementary cognitive assessment have been implemented in 6 patient care areas, with plans for implementation in another 5 units and 2 sites. While excellent uptake for twice daily CAM screening has been achieved, the identification of CAM positive in patients has been challenging across patient care units. A validated chart abstraction method has been in place since the summer of 2014, providing significant data and context for this work.

Objectives:

Funding from the Regional Geriatric Program of Toronto Senior Friendly (SF) ACTION Program created the opportunity to focus on this priority on one unit at SHSC. The aim of this work is to improve the accuracy of CAM screening of patients to 75% within a 6 month period by using an interprofessional team-based approach embedded in quality improvement methodology.

This focused work is bringing a team of individuals together to use rapid cycle improvement methodology to identify the way forward in accurately detecting delirium. This work will inform future implementations on units across SHSC and ultimately our 2nd year Quality Improvement Plan indicator.

Measures:

The primary outcome measure is % agreement of CAM results with chart abstraction (see Figure 1, 2 & 3). The goal by December 31, 2015 is to achieve 75% congruence between delirium identifiers in the chart and a CAM positive detection by staff, with data signaling a sustainable improvement.

Process measures include delirium screening with CAM twice daily & implementation of interventions to prevent / mitigate delirium (see Figure 4), interprofessional care planning and delirium case reviews and consistent documentation in the patient care record.

Balancing measures include the rate of observer use, rate and type of restraint use and patients admitted with delirium.

Change Concepts:

Using a cause and effect approach to root cause analysis indicates that lack of knowledge of patient baseline status, challenged communication among interprofessional team members, tendency to perceive CAM screening as a moment in time determination and complexities with language barriers and primary neurological deficits all have the potential to impact accuracy. Staff reported that clinical features of dementia and depression can also mimic delirium, further challenging the accuracy of determination. This is complementary to findings in the literature which identify under-recognition of the following risk factors: hypoactive delirium, age 80+, vision impairment, presence of dementia.

Change concepts have included ways to augment awareness of baseline functional status, enhance opportunities for Interprofessional dialogue, integrate delirium dialogue in care planning venues and include delirium in documentation. The involvement of front line staff in roles as Senior Friendly Champions and of other content experts and local leaders have, and will continue to support this work. Weekly audit / feedback to staff is beginning in August. Patients and families will become more explicitly involved beginning in September.

Outcomes and Results/Lessons Learned :

In data collected through chart abstraction over 10 months on 3 patient care units, the median of CAM positive capture is 36% (see Figure 2).

On our focus unit the new median for months May & June (1st two months of the SF Action Program) is 55.56% (see Figure 3). While the unit had a run of higher numbers the latter part of May and 1st 3 weeks of June, accuracy has declined in July. This data provides a platform to work with staff to achieve a solid shift in the data, which will demonstrate process improvement by late fall, 2015.

The learning and the strategies we will put in place on our focus unit will spread to other implementation areas and sites. In addition SHSC has a Care Strategy (see Figure 5) and an engaged group of Senior Friendly stakeholders who are very focused, who will enable further spread of good care. A significant learning with respect to delirium is of the need to validate beyond assessment complex clinical determinations such as deciphering a patient's delirium status. Relying upon assessment indicators is not enough.

4294

Paper-Based to Electronic: Creating Patient-Centred Healthcare for Seniors by Placing Health Data at the Fingertips of Providers and Patients

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Background/Context:

Health data has the power to transform healthcare at the level of individual healthcare encounters to the system as a whole. However, in Canada and nations alike, the approach to health data has been to limit access to patients in fear of being entangled in privacy, security, ownership and ethical concerns. With advances in technology; a shift from paternalistic care to patient-centered care and supportive legislation (i.e. the Personal Health Information Privacy Act), the way we share data is changing.

Making health data accessible to providers and patients can have substantial impacts on enhancing quality of care including improving the patient-provider relationship, improving patient education, engagement and empowerment, delivering patient-centered care, and improving health system efficiencies through reduction in visits, admissions and ultimately healthcare costs.

Objectives:

This presentation will describe the impact on quality of care by bringing health data to the fingertips of senior patients living with chronic conditions and multiple provider groups though the Northumberland *Partners Advancing Transitions in Healthcare (PATH)* project in Ontario.

Measures:

We aim to illustrate through qualitative and quantitative results how sharing health data amongst patients and providers can enhance the quality of care through:

1. Improving the patient-provider relationship
2. Advancing the delivery of patient-centered care
3. Fostering patient engagement and empowerment
4. Increasingly meeting the needs of patients
5. Enhancing the management of conditions
6. Improving accuracy during information sharing
7. Realizing health system efficiencies

Change Concepts:

The ground-breaking PATH project is a community partnership of seniors (patients), caregivers and cross-sector healthcare providers working together to make system-wide changes that will meet the needs and improve the experience of seniors living with chronic conditions as they transition through the healthcare system. Leveraging an Experience-based co-design (EBCD) approach, and putting patients at the forefront of designing innovative solutions, PATH has developed the *PATHway to Aging Well Portal* for patients and providers (https://pathwaytoagingwell.com) coupled with a patient mobile application in both Android and iOS. These intuitive e-solutions allow seniors, caregivers and providers to connect via a computer, tablet or mobile device to share personal health data and information. Perhaps even more remarkably, the PATH e-solutions provide the opportunity to integrate data from primary care (Family Health Team EMR), acute care (Meditech), and patient reported outcomes from the home. These integrations allow patients to 'own' and have access to their health data and share the information as they transition through the healthcare system.

Outcomes and Results/Lessons Learned :

Within three years, PATH has created positive community partnerships that drove the design, development and integration of health solutions needed to drive transformation across the community. To date, over 125 providers and 100 patients have been enrolled in the PATH program. PATH enables patients and providers to send and receive health data in a way that can revolutionize the practice of medicine in Ontario.

The evaluation approach utilized by PATH has been mixed methods (quantitative and qualitative), with a focus on experience. The patient voice is central to the selection of the evaluation measures; reporting and feedback are conducted in real-time and measures are dynamic (i.e. questions and response options changed based on patient feedback). While evaluations are currently underway, preliminary feedback from seniors involved in the pilot has been positive, and the solutions implemented have been well received. Seniors have reported feeling more engaged in their care; better supported to self-manage their conditions; more in control of their health information and empowered to advocate for their care. Further, with the PATH technology tools, many seniors have witnessed a reduction in physician office visits and hospital readmissions. Providers, similarly have praised the PATH e-solutions in allowing them to connect information between each other, review patient reported information and monitor patients effectively across the continuum of care.

In our presentation we will be describing results in measures of patient and provider experience, patient engagement in care, and healthcare efficiency indicators.

4096

Access to Care Surgeon Dashbaord: Solution to Provider- Level Reporting

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Background/Context:

CCO's Access to Care (ATC) program uses provincial, regional and facility level surgical and DI wait time performance data to improve access to care for patients in Ontario. The data is used by various healthcare stakeholders to create reports, tools and services to improve quality of care through increased accessibility. The right information in the right hands at the right time helps drive better patient care. Ontario's 3,000-plus surgeons play a critical role in transforming wait time data into measurable improvements for to access to care. However, detailed wait time data is not uniformly accessible to surgeons in Ontario.

Objectives:

Hospitals and clinicians identified a gap in reporting wait time data directly to surgeons. However, given complexities related to delivery mechanisms and privacy considerations, provider-level wait time reporting had never been attempted at the provincial level. In 2013, ATC piloted a surgeon dashboard with a small group of Ontario surgeons to initiate and inform a provincial solution. The aim of the pilot was to deliver wait time data directly to surgeons providing them a better understanding of their surgical wait times, validated data quality at the surgeon level, and empowered them to review their priority assessment practice. In 2014, a second pilot was launched to a larger group to determine if the previous results could be duplicated.

Measures:

Wait time data for participating surgeons was monitored throughout the pilot, as was their confidence in data quality and the frequency at which they reviewed their wait time data. The median, 90th percentile and % of cases completed within priority access targets for specialist consultation and surgical treatment were measured prior to the pilot and then at the pilot mid-point to assess impact. As well, waitlist size for the collective group of surgeons was monitored as a decrease in waitlist size is often correlated with a future wait time decrease.

Change Concepts:

ATC determined a number of data and logistical solutions were required prior to provincial implementation. New technology was needed to scale reports and distribution from a small pilot to over 3,200 surgeons. Privacy legislation expertise was required to ensure the solution was viable in light of FIPPA and PHIPA.

Outcomes and Results/Lessons Learned :

The results were remarkable based on data submitted by hospitals to the Wait Time Information System (WTIS). Participating surgeons achieved a combined 13% decrease in waitlist size and a 20% decrease in wait times. The second pilot led to the current provincial deployment to 3,000+ surgeons. The simple act of providing surgeons with their own data in a meaningful clinically relevant manner can drive further wait time improvements in Ontario. Providing the data in this manner made surgeons more aware of the data they and their peers were submitting, helping them to align with provincial access targets and validate data quality at the practice level.

4247

Supporting Quality Care in the Home Care Setting

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Background/Context:

Application of evidence-based practice in the community is challenging as community nurses are faced with heavy workloads, often work in isolation and do not consistently have timely access to current and relevant information to guide practice. As Ontario shifts healthcare out of hospitals and long-term care facilities into people's homes there is a need to ensure that nurses and other home care providers have access to resources to support quality patient care.

Objectives:

The goal of this research was to evaluate the implementation of an automated clinical information system (CIS) within a community home setting; to assess nurses' satisfaction and experience with the Clinical Information System (CIS), to assess the effect of the CIS on evidence based practice and client perceptions of use of technology by nurses. Nurses documented patient outcomes using standardized outcome measures developed by the Health Outcomes for Better Information and Care (HOBIC) program.

Measures:

A longitudinal mixed methods design was used. Qualitative descriptive methodology involving semi-structured interviews and focus groups was used to build a contextual understanding of barriers and facilitators of automated CIS adoption, and to determine how assessment tools and best practice evidence influence clinical decisions. Quantitative data collection through surveys was used to gather data on nurses' satisfaction with features of the automated CIS, change in evidence-based practice, and change in organizational context over time. Clients were interviewed regarding their perceptions of the use of technology by nurses in their home.

Change Concepts:

The CIS enables nurses in the home to document using a blackberry, admission assessments, discharge assessments and client re-assessments when there is a clinical change. Standardized assessments of patients' functional health, symptoms (pain, dyspnea, fatigue, nausea), pressure ulcers, falls, and therapeutic self-care (patients' knowledge of their health situation, resources available to them and their ability to manage their medications and treatments), are collected electronically at the point-of-care. Real time reports are used by nurses to monitor the impact of care and ensure, for example, that symptoms are being managed.

Nurses are able to access evidence based resources such as the Registered Nurses Association of Ontario Best Practice Guidelines and the McMaster University Nursing Plus library which provides nurses with access to a searchable database of the best evidence from the medical literature, an e-mail alerting system, and links to selected evidence-based resources.

Nurses are hands on learners therefore multiple strategies for learning were required to support the CIS as well as the use of evidence to support practice. This was achieved through multiple methods such as teleconference, One on One coaching, Clinical eTIPS, provision of an eHandbook, integration into orientation for new staff and nursing team meetings that focused on how to utilize data to shape practice. Staff were provided with ongoing support locally and corporately

Outcomes and Results/Lessons Learned :

Nurses who anticipated the importance of planning time in the clinical setting for introducing the device to clients and troubleshooting potential issues expressed more positive feelings associated with device use. Job satisfaction and nurses positive regard for both the employer and the vocation of community nursing emerged as an important theme for willingness to adapt clinical practice for device implementation. Leadership, a supportive culture and the opportunity for feedback were key to facilitating the CIS implementation (Table 1).

The organization reported an improvement in quality indicators (Table 2). Clients stated that they felt that use of the mobile devices allowed the nurse to better manager their health condition and have a better view of their overall health (Table 3).

Implementation of an electronic health record (CIS) system is generally believed to improve the quality of client care by increasing the availability of client healthcare information and by assuring consistent implementation of evidence-based standards. While the findings of this work indicated a significant improvement in nurses' access to structural and electronic resources to support evidence based practice, there was lower access from time 1 to time 2. It may be that expectations had been raised when the CIS was implemented and by the follow-up the implementation was still in a formative phase and expectations had not yet been fully met.

Development and implementation of a CIS in any setting is a complex and involved process. Nursing leadership is key to any change initiative as well as the commitment of management to engage and support staff. As the shift to community care continues it is vital that nurses and other clinicians in this sector have access to information and evidence to support practice. The findings of this study provide key lessons for the health care system.

4344

Reducing Neonatal Abstinence Syndrome: Integrating Opioid Substitution and Tapering in Prenatal Care

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Background/Context:

The Integrated Pregnancy Program (IPP) at SLMHC provides service to individuals from Sioux Lookout and thirty-two First Nations communities in Northwestern Ontario. SLMHC provides a robust obstetrical program with approximately 500 births annually. With a population dispersed over a vast and remote geographical area, the First Nations people in Northwestern Ontario experience an inequity in the social determinants of health including limited access to support services and health care. Among this population, including expectant women, there is the high incidence of narcotic abuse. Faced with the realities of the addictions crisis, the physicians and staff of the IPP embraced an innovative solution to improve neonatal outcomes and provide supportive resources to both the mother and her partner.

Objectives:

The opioid substitution and tapering component of the IPP aims to manage the abuse of narcotics in pregnancy and reduce the incidence of neonatal abstinence syndrome among infants born to opioid dependant mothers.

Measures:

A study conducted in collaboration with the SLMHC research department measured the management of narcotic use, the incidence of neonatal abstinence syndrome, and maternal and neonatal outcomes. This study is included in the supporting document section.

Change Concepts:

The approach of the program is based on harm reduction philosophy, with the goal to reduce the incidence of neonatal abstinence syndrome (NAS) and support women with addictions within the context of their family unit. Since the inception of the program in 2012, while maternal narcotic use continues to rise, the incidence of neonatal abstinence syndrome has decreased significantly. Design of the overall program has been enhanced by an interprofessional model that embraces a holistic approach to prenatal care including resources to support expectant families such as addictions and nutrition counseling, parenting skills, education credits and access to traditional healing and ceremonies on-site.

Outcomes and Results/Lessons Learned :

The incidence of neonatal abstinence syndrome has been reduced significantly at SLMHC since the inception of the opioid substitution and tapering program. Given the limited resources in the First Nations communities for addictions support, the IPP model is working well in our opioid dependent maternal population. The effects of this program would be further enhanced with the creation of community programs to support these families post-delivery.

4368

Seasonal Agricultural Worker Health Services: Improving Health Equity for a Marginalized Population

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Background/Context:

The HNHB LHIN has the highest concentration of seasonal agricultural workers among Ontario's LHINs. Haldimand & Norfolk Counties alone have 4800 workers (2014). Seasonal agricultural workers (SAWs) work in Ontario under government sanctioned programs, pay taxes and are entitled to health care services. SAWs face many barriers in accessing health care, including: language, culture, transportation, long work hours, temporary residence, and real/perceived duress from employers. The majority of SAWs in Haldimand & Norfolk did not have access to primary care, leaving limited options (Emergency Department) prior to Spring 2014.

Objectives:

The aim of the SAW Health Services project was to address barriers to access of primary health care services through the implementation of a culturally sensitive, primary care clinic in May of 2014 with a goal of serving a minimum of 120 unique individuals over 250 visits. The initiative targeted client centredness, efficiency, effectiveness and equity dimensions of quality in its construct.

Measures:

Outcome measures selected included:

- Clinical presentations
- Client feedback
- ED Utilization

Process measures selected included:

- # unique individuals seen, visits,
- # visits
- # clients presenting but not seen
- Consultations between providers (internal and external)
- # Health promotion initiatives

Change Concepts:

The initiative provided a service accessible to Seasonal Agricultural Workers where previously there was none. The only possible alternative was an emergency room presentation or going without care.

The development of the primary care service model was completed through the engagement of the population to be served and other community partners. Based on an understanding of the population and needs, clinics were launched two evening a week (one in Simcoe and one in Delhi) along with translation services. Workers typically have three hours of down time during the week where they are bused into town. The Simcoe location was sited at a primary care space within a Loblaws grocery store which allowed workers to seek health care, pick up a prescription, complete shopping, and banking. On-site pharmacy also allowed for translators to accompany workers to convey instructions for how to take medications properly.

The nature of the work completed by SAWs speaks to the need for occupational health support and resources. Occupational health clinics were also provided monthly in collaboration with the Occupational Health Clinics for Ontario Workers. Consultations with occupational health physicians and nurses were available, along with illness and injury prevention resource materials.

Health promotion initiatives were also undertaken to both promote the clinic to workers and additional health strategies. Health promotion initiatives included Spanish and English resource materials, participation at a SAW health fair, and partnership with Frontier College on improving health literacy.

Outcomes and Results/Lessons Learned :

The 2014 season was the launch of this service with 350 unique clients being seen in a primary care drop-in model, through 500 visits in addition to a range of health promotion activities.

100% of the clients were male (age range 21-60) with 51% of workers coming from a Spanish speaking country (typically Mexico). The top five reasons for visit were musculoskeletal concerns (23%), GI issues (11%), skin rashes (10%), blood pressure check/med refill (8%), STI inquiries (6%).

25 workers presented to the Emergency Department (either CTAS 4 or 5) throughout the 2014 season during the clinic times. It was hypothesized that these 25 visits would have been more appropriate for the clinic rather than the ED. However, more extensive chart review would have been required to confirm this.

Clients presenting to the clinic were asked where they would have sought care if the clinic was unavailable:

- 58% said they would have gone to the emergency room

- 22% would have gone to a walk-in clinic (note, there are none in Simcoe)
- 10% would have gone without care
- 10% would have found alternatives (e.g. asked the farm owner to take them somewhere)

Using this data, it could be hypothesized that without the SAW clinic in the 2014 season there would have been 400 more visits to the ED that were not ED appropriate.

Resources for understanding the best model of care to meet SAW need are scarce, creating room for pilot efforts identifying and applying leading practice, evaluation and dissemination of knowledge to other health service providers. The 2015 clinic is open and we continue to review and evaluate the service delivery model. We are hopeful that our work will further this understanding within the province.

4126

Treating the "Difficult to Treat": an Innovative, Community-Based, Collaborative Care Model of Hepatitis C Treatment and Support

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Background/Context:

Hepatitis C (HCV) is the most burdensome infectious disease in Ontario (OAHPP, 2010). In Canada, estimated seroprevalence rates are 0.8%, with 4000 - 6000 new cases occurring each year (Remis, Hogg, Krhan, Preiksaitis, & Sherman, 1998; Zou, Tepper, & El Saadany, 2000). Although the majority of new cases of HCV occur among people who inject drugs, studies in both the United States and Canada have demonstrated that less than 1% of injection drug users initiate treatment (Grebely et al., 2009; Mehta et al., 2008). Barriers to HCV treatment for people who use drugs have been documented at a systems, provider and patient level. Systems barriers include exclusions for public funding of treatment medications and lack of access to specialists willing to treat drug users (Myles, Mugford, Zhao, Krahn, & Wang, 2011). At a provider level, concerns exist about adherence to treatment and mental health side effects, in particular where co-morbid psychiatric issues are present (McGowan & Fried, 2012). At a patient level, barriers to HCV treatment include: lack of knowledge about HCV; past negative experiences with health care providers/systems; as well as other competing health and social issues, such as unstable housing, poverty, incarceration and social isolation (Doab, Treloar & Dore, 2005).

The Toronto Community Hep C Program (TCHCP) is an innovative and effective response to the challenges of providing HCV treatment to marginalized drug users. The program is a partnership between three community-based health centres (South Riverdale Community Health Centre, Regent Park Community Health Centre and Sherbourne Health Centre) with integrated specialist support from nearby hospitals (Toronto East General and the University Health Network). Since 2007, the TCHCP has provided access to HCV treatment and support to individuals who are active substance users and/or have serious mental health issues and who are living in poverty.

Objectives:

The aim of the TCHCP is to address and to minimize some of the barriers to HCV care that are present in most health care settings for people who use drugs and/or have other complex social and health issues, such as unstable housing, poverty, and social isolation.

Measures:

The TCHCP has conducted numerous research studies to explore a variety of quantifiable outcomes including: treatment initiation and virus clearance rates; therapeutic alliance; income and housing stability; and quality of life. Study methods have included chart review, standardized questionnaires, focus groups and one-on-one semi-structured interviews.

Change Concepts:

The program provides multi-disciplinary, collaborative and client-centred clinical care, as well as group support and case management. The program is anchored by a weekly psycho-educational support group at each health centre site. The group is an important space for peer support and knowledge sharing, as well as acting as a bridge to health care. Clients can receive both HCV-specific and general primary health care while in the program. Primary care clinicians (physician, nurse, nurse practitioner) are available during the weekly group sessions with monthly on-site support from the infectious disease specialist and psychiatrist, who also provide ongoing consultation between on-site visits. Primary care physicians have been mentored to be independently able to prescribe and manage HCV treatment medications. In addition to clinical care, clients can also access one-on-one supports including case management, peer support and mental health counselling on-site.

A retrospective chart review of the TCHCP has demonstrated HCV treatment initiation and success rates that are comparable to tertiary care settings. Longitudinal analysis of program data also reveals that housing stability and income level improve significantly for program clients. A study of the program's group component demonstrated high levels of group cohesion and therapeutic alliance, both of which have been shown to have a linear and positive relationship with clinical improvement.

Outcomes and Results/Lessons Learned :

The TCHCP successfully improves access and provides HCV care and support to highly marginalized individuals who would be unlikely to receive treatment elsewhere. Our research and experience have demonstrated that community-based, multidisciplinary, harm reduction models of HCV care driven by client engagement and group support, can lead to improved access to HCV treatment with benefits that extend beyond HCV to key social determinants of health. The TCHCP is now one of 16 community-based Hep C Treatment Teams across the province. Even as treatment regimens for HCV become shorter and easier to tolerate, many individuals with HCV will continue to require multi-disciplinary, supportive models in order to address the significant pre-treatment health and social issues before antivirals can be safely provided. In the context of new treatments, which are costly and require strict adherence, these types of collaborative models may become even more critical for people who are socially and economically marginalized.

4170

Regional Critical Care Response (RCCR) Program: An e-Health Initiative Providing Equity as a Dimension of Quality of Care

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Background/Context:

The Northwest Local Health Integration Network (NW LHIN) Regional Critical Care Response (RCCR) program is an e-Health pilot project that provides 24/7 access to an Intensivist led critical care videoconference consultation from Thunder Bay Regional Health Science Centre to support eleven Northwestern Ontario community emergency rooms and one Level 2 Intensive Care Unit.

This outreach critical care service utilizes the Northwest integrated electronic medical record (EMR) and the picture archiving and communication system (PACS) to facilitate real time viewing of patient data. This coupled with the Ontario Telemedicine Networks (OTN) five point personal computer video conferencing (PCVC) system allows the RCCR team to provide real time patient assessment from a distance.

TBRHSC is the only Level 3 Critical Care unit for the northwest and as such, has an obligation to ensure timely access and quality service to residents in northern communities outside of Thunder Bay. By leveraging existing OTN networks, Regional hospitals can now utilize mobile videoconferencing equipment for critical care consultation when required. The RCCR team consists of an Intensivist, a critical care nurse, a respiratory therapist and when required a critical care pharmacist, nurse practitioner and dietician.

Objectives:

RCCR program has two main objectives; first to improve access to real time critical care expertise, providing best practice in critical care using an interprofessional team approach, secondly provide resuscitative support, early stabilization and whenever possible prevent unnecessary transfers.

Measures:

RCCR program outcomes include numbers of regional transfers, transfer times, as well as staff, patient and family satisfaction. Data will be compared to pre RCCR program implementation and compared to provincial benchmarks. To date, the RCCR program has demonstrated a reduction in regional patient transfers as well as improved access to quality critical care services.

Since implementation of RCCR on March 31, 2015 the team has provided over 170 hours of consultation time for 60 patients from 8 regional hospitals using e-Health technology. In addition, 28 patient follow up consultations have been completed via video and/or telephone and 12 air transfers have been avoided resulting in approximately $204,000 in savings to the Ontario healthcare system.

Change Concepts:

RCCR program delivery model is available 24/7 supported by an Intensivist, registered nurse and a registered respiratory therapist. Additional interprofessional consults can be provided as required including a critical care pharmacist, critical care dietician, trauma nurse practitioner, neurosurgical outreach nurse plus other medical specialties including cardiology, neurosurgery, general surgery and trauma. Patients that require critical care services are referred to the RCCR program by a regional physician through CritiCall. Real time video access allows for initial consultation and ongoing support to healthcare providers working in geographically remote regional hospitals. If a patient requires transfer to a facility for a higher level of care, the ORNGE air ambulance physician may participate on the RCCR videoconference call prior to transfer. The facilitated three-way videoconference between the sending, transporting and receiving physician provides real time collaboration in order to develop the safest and most efficient plan of care for the critically ill patient. Care options and discussion with the patient and or family are also offered whenever possible.

Outcomes and Results/Lessons Learned :

With clinical expertise and e-Health technology, our RCCR program can successfully provide; (1) improved access to specialized critical care services, (2) enhanced quality of care by supporting regional healthcare providers, patients and their families prior to transport (3) increased opportunity for more patients to be cared for within their communities with real time critical care support and (4) improved transportation times within Northwestern Ontario as patient care is optimized prior to transfer.

4111

Improving Access to Emergency Care in Rural Communities - Our Journey

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Background/Context:

Roughly 20% of Canadians live in rural areas. In general, rural citizens are older, have poorer health, and are at greater risk for trauma and fatal trauma than their nonrural counterparts. Despite the greater health care requirements of rural residents, they typically have fewer available resources and face more challenges accessing health care. Emergency departments (EDs) are safety nets for rural citizens as reflected by the significantly large proportion of all ED visits. There are important challenges in providing safe emergency care in rural Canada, including fewer hospitals, greater travel distances, and reduced access to specialized care and health human resources. In spite of these challenges our efforts through the creation of rural health hub at Dryden Regional Health Centre has demonstrated how we have been able to work together to meet and tailor local community's needs in a way that enhances seamless, sustainable service integration and the effective delivery of person-centred, equitable, high-quality, timely health care, whether it is delivered locally or referred to a regional partner.

Objectives:

Enhance the patient experience by providing well-coordinated care, taking into consideration the needs of patients including the delivery of care as close to home as possible, while supporting effective access to care outside the hub when needed.

Identify and action quality improvement initiatives with the goal of meeting person-centred, equitable, high-quality, timely health care in rural community.

Measures:

Process:

- Number of patients
- Response Rates
- Trend Over Time: Emergency Department Wait Time for Physician Initial Assessment (Hours, 90th Percentile)

Outcome:

- Top 2 Box scores for Access and Coordination Dimension in the ED
- Significance testing of Dimension Comparisons to Benchmarks
- Priority Matrix
- Emergency Department Wait time for Physician Initial Assessment (Hours, 90th Percentile)
- Total Time Spent in the Emergency Department for Admitted Patients (Hours, 90th Percentile)

Balance:

- Top 2 Box on emotional support

Change Concepts:

An identified shared need for local health and social system providers to work together to provide high quality health care for the community.

Need to define a local community health plan and QI based on patient experience that includes patients, shared goals and capacity and service mapping that builds on local demographics and assets.

Outcomes and Results/Lessons Learned :

Dryden Regional Health Centre is a part of rural health hub located 320 km from a major centre (Thunder Bay) with a catchment area of 15,000. It caters to the needs of 3 communities and also three First Nations communities. A review of patient experience data in the Emergency department for fiscal years 2011-2014 showed a total number of 2,400 patients sampled with a cumulative response rate of 23.2%. A sub factor analysis and priority matrix helped identify areas for quality improvement initiatives in relation to overall quality of care in the ED. The ED then engaged in a multidisciplinary process improvement project. Representatives from physicians, nurses, and ward clerks, and management met for this months-long project. The first step was to document the process flow of a patient checking in to our department through to discharge. Once all of the process steps were established we looked at the many factors that were involved at each step. The factors were then scored as possible process improvements against cost, ease of change, and patient's safety (a counterbalance). The scores were used to prioritize changes that could be made to our department to improve patient flow. The LEAN process mapping exercise focussed QI initiatives and change ideas in six key areas namely, registration, triage, lobby, treatment orders, charts and disposition. Our initiatives were multi-pronged and ranged from re-educating physicians on acuity and triage levels, developing an algorithm for second physician on call, planning early for admission, use of fast track rooms, information handouts to patients based on diagnosis, nurse connecting with each patient prior to discharge, just to name a few.

Access and Coordination scores FY 2014 showed high scores compared to other dimension scores (correlation coefficient 0.115) indicating QI at the rural hub had helped address access and coordination with respect to its population. Wait times for physician initial assessment (hours, 90th percentile) were also lower as compared to NW LHIN average and when compared to Community Small Hospitals average (2.1 hours vs 2.4 vs 2.3 respectively). Total Time spent in the ED for admitted patients (hours, 90th percentile) also was lower. Our experience can be replicated in other rural settings to improve patient outcomes. In conclusion, through the eyes of patient experience strengthening coordination and QI in health care will support the delivery of effective and high quality health care to patients as demonstrated in our rural setting.

4259

New Approaches to Achieving Health Equity: Design and Development of the Toronto Urban Telemedicine Initiative

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Background/Context:

The Toronto Central Local Health Integration Network (TC LHIN) created the *Toronto Urban Telemedicine Initiative* with funding the Ministry of Health and Long Term Care allocated to them for 11 FTE telemedicine nurses. TC LHIN gave nine distinct projects funding for a nurse (RN or NP) or technician, and technology matched to their purposes – typically video-conferencing or Store Forward. Each project serves individuals with a very complex set of needs, which have been unmet or neglected within existing health care systems and services, while also introducing new and innovative approaches to health care delivery. The Ontario Telemedicine Network (OTN) supports the Initiative with planning, data tracking and reporting, and training.

Objectives:

This evaluation assessed the capacity of the Initiative to achieve benefits for clients related to three aspects of equity in healthcare: quality, access, and productivity.

Measures:

This study used multiple explanatory case analysis. The research team triangulated and converged multiple sources of evidence, including program documents and data, and in-depth interviews with program staff, clinicians, and clients, to rate projects on adherence to hypotheses and rival hypotheses associated with health quality, access, and productivity. (See supporting documents.)

Change Concepts:

These telemedicine projects serve clients with complex sets of needs which are under- or unmet within the current healthcare system; their needs typically include those associated with mental health and/or addictions, chronic medical conditions, and social determinants of health, such as poverty and racism. Examples of target populations included: persons undergoing non-medical detox, substance abuse treatment participants, medically complex children, diabetic clients who had not had their eyes screened in the past year, long term care residents, women with high risk perinatal mental health needs, homebound older adults, and individuals with unhealed chronic wounds. Settings for these projects varied accordingly, with nurses working in hospitals and clinics, long-term care facilities, community care access centres, individuals' homes, and addictions treatment facilities. The breadth and depth of access issues these telemedicine projects are tackling sets them apart from more traditional telemedicine approaches.

Outcomes and Results/Lessons Learned :

This evaluation identified several "lessons learned" associated with the design, start-up phase, and implementation of all of these telemedicine projects. We have produced specific recommendations based on these findings to aid in their ongoing development, facilitate their potential expansion, and to inform creation of new telemedicine models.

- *Design and Start-Up Challenges*: These TM projects faced a variety of challenges in design and start-up, making this phase more complicated and time-intensive than anticipated. Challenges included finding an RN/NP well-suited to the project, determining and acquiring appropriate technology, marketing the project, clarifying the target population criteria and referral processes, and finalizing partner agreements.
- *Established vs. New*: TM projects which supported and enhanced established models of care faced fewer start-up barriers than TM projects which represented an entirely new model of care, while the latter struggled with nurse isolation.
- *Organizational Leadership and Support:* Comprehensive organizational support enabled TM projects to be more responsive to challenges and better able to leverage resources than those with less support.
- *TM Project Impacts on Quality*: The primary factors enabling TM projects to substantially improve the quality of care their target populations received were certain characteristics of the nurse, and technology which worked efficiently and was well-matched to the projects' objective.
- *TM Project Impacts on Access:* These TM projects expanded the understanding of access issues faced by their target populations, and raised concerns about becoming merely another "bridge" in addressing those service gaps.
- *TM Project Impacts on Productivity:* All of these TM projects struggled to achieve their anticipated targets for volume of TM events and clients served by each TM project; tracking and achieving productivity has been complicated by data reporting issues, differences in the intended focus of the project, and technology barriers and facilitators.

Impact/Scalability: These urban telemedicine projects have used modestly funded models of care – a nurse and some technology – to creatively care for clients whose complex sets of needs have been persistently under- or unmet within the current healthcare system. These unique projects have demonstrated their value to health equity in terms of quality of care, access, and productivity, and made substantial and meaningful contributions to the lives of these clients, their families, and the healthcare system. With continued monitoring, flexibility and responsiveness to lessons learned, and aptly placed resources, these benefits will grow, and their potential realized.

4228

Creating a Culture of Patient and Family Centred Care in Ontario Hospitals

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Background/Context:

Patient-centred care (PCC) is not a new concept; however in recent years it has garnered increasing attention in the research literature and practice environment. This extensive focus on has helped to foster health care environments where patients act as partners in their care and are provided with relevant information to make their own decisions. The Ontario government created the Excellent Care for All Act (ECFAA) in 2010 for a number of reasons including, but not limited to: improved PCC, transparency, accountability and motivation for quality in health care. The ECFAA was created with the mandatory requirement that Ontario hospitals create a Patient Declaration of Values (PDoV). In theory the PDoV is conceptualized as a way to improve PCC; however, it is not clear how patient value statements are operationalized in hospital policies and practices to truly influence PCC.

Objectives:

The purpose of this research project was to explore how a leading patient-centred Ontario hospital operationalized their PDoV statement in policy and practice. The objectives of this research were to: (a) understand what role the PDoV plays in policy and practice within a leading Ontario hospital and (b) to examine how a leading Ontario hospital has incorporated these values into their overarching organizational structures.

Measures:

This was a qualitative research project and not a quality improvement project. For this reason, data was collected qualitatively (i.e., individual interviews and document analysis).

Change Concepts:

This was a single case study, which took place in a leading patient-centred Ontario hospital. The hospital was selected through a rigorous purposive sampling process where five PCC experts in Ontario were asked to provide a list of three organizations they viewed as leaders in PCC and in the administration of the PDoV. They then ranked the organizations from one to three, with one being the most successful organization at the operationalization of PCC and the PDoV in policy and practice. The highest ranked organization nominated by the experts was invited to participate in this study. Data was collected through individual interviews with employees (i.e., CEO, patient and family centred care lead, directors, managers, physicians, nurses, PT/OT, allied health, maintenance worker, porter) and patient experience advisors (n=18). Further document analysis (n=10) was conducted (i.e., strategic planning documents such as the PDoV, the 2015 Action Plan, patient experience advisor materials, the quality improvement plan). The document and interview data were uploaded into NVivo, where it was analyzed inductively, using a constant comparative method. The key themes were then compared to reveal relationships that existed among the themes.

Outcomes and Results/Lessons Learned :

The results of the current study provide a frame of reference for patient and family centred care (PFCC) that could be considered by other healthcare organizations. This study provides five steps: 1) setting the stage, 2) inspiring the people, 3) organizational structures, 4) organizational and environmental barriers and 5) reflection and improvement, to create a culture of PFCC in an acute care environment. These five steps translate into 16 core strategies: 1) engaging the community, 2) examining potential organizational/environmental barriers, 3) developing a strategic plan with guiding principles, 4) translating the guiding principles into expected behaviours, 5) creating a patient experience advisor role, 6) defining PFCC, 7) motivating the people, 8) empowering patients and families, 9) fostering a supportive environment, 10) continuous improvement, 11) lack of time and barriers, 12) PFCC from a system perspective, 13) recognizing staff expertise, 14) environmental challenges, 15) culture shift and 16) moving forward. These can be used by leaders and managers to foster PFCC behaviours within their acute care environment. This study is the first of its kind to examine how the PDoV, a component of the ECFAA, was used in policy and practice. The findings of the current study demonstrate how the PDoV was utilized to inform policies and practices, leading to the development of processes and core strategies to foster PFCC within an acute care organization.

4135

Patient Oriented Discharge Summaries (PODS): Early Adopters of the Initiative Share Their Learnings on Improving the Patient Experience of Discharge

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Background/Context:

Poor communication of information with patients and caregivers before hospital discharge can lead to a negative experience, confusion at home and potential for adverse events and avoidable readmissions. Patient experience at discharge has been an issue in TC LHIN hospitals, spurring the LHIN to fund the PODS project.

In 2014, OpenLab worked with patients, caregivers and providers to co-design a simple tool, PODS (see attached PODS template), with the vision that all patients leaving hospital would consistently receive key information, communicated in an easy-to-understand manner.

In 2015, PODS was adopted in selected programs across 8 TC LHIN hospitals representing a cross-section of patient populations and hospitals in the LHIN including acute care, academic, community, surgery, rehabilitation, and pediatrics (see attached hospital list).

Objectives:

Our key objective was to get PODS to patients at all sites by April 2015. Through the PODS initiative, we hoped to see improvement in the patient-centred elements of the discharge process, patient experience, and provider experience.

Measures:

Rapid PDSA cycles were used to implement and refine PODS at each site. Measures of process, patient experience, and provider experience were collected pre- and post-implementation of PODS at each site using structured surveys. Before each monthly meeting of the early adopters, a survey was also sent to project leads to collect data on barriers and strategies to share with the group.

Change Concepts:

With a modest investment by the TC LHIN, PODS and related resources are now freely available under Creative Commons for anyone to use, modify and improve upon.

PODS has been shown to work in different environments: acute care, rehab, surgery, and pediatrics. PODS was customized to fit into each programs' current discharge process resulting in improved patient and provider experience. The early adopter organizations expressed that each population of patients is unique and that through this process, PODS will be more sustainable because it was adapted to meet patient needs. Some organizations have included PODS in their strategic plan for the upcoming year. We have also seen interest in PODS from other organizations.

We created a website with tools to support and sustain PODS implementation including pamphlets, posters, a slide deck for staff training, and a dynamic PODS form with headings available in 15 languages. The site is open for anyone to use. Lessons learned from the early adopters are being package into guidelines and will be posted on the site. For more information, visit the site: http://pods-toolkit.uhnopenlab.ca/

Outcomes and Results/Lessons Learned :

PODS went live at 7/8 sites by April 1, 2015. In the first month post-implementation, over 200 patients across the TC LHIN received PODS. Results from early adopters show marked improvements in patient experience, with minimal burden on providers. Allowing sites to customize PODS also led to improvements in patient and caregiver engagement through their involvement in design, content and delivery of the tool. Provider experience was improved at some sites through the use of standardized discharge instructions for specific diseases.

Among patients given PODS (during the first month of implementation), patient experience was overwhelmingly positive across multiple dimensions (see attached Figure 1). The average percent of patients who responded agree or strongly agree to statements regarding understanding their discharge instructions was 92 percent.

The average improvement for the 5 areas pre- and post-implementation across sites ranged from 9.3 to 19.4 percent (see attached Figure 2). Note that, relative to LHIN-wide scores, these early adopters were already good performers. We believe results could be higher in hospitals with lower baseline performance.

One of the early concerns with PODS was potential pushback from clinicians for fear of additional workload. Provider experience surveys indicate that these concerns did not materialize. Results showed that over 90 percent of providers found PODS easy to use and valuable for patients. Over 80 percent felt it did not add to their workload, but rather improved discharge teaching by ensuring consistency and supporting communication with the patient.

Patients who receive PODS have an improved understanding of their medications, dangers signs to watch out for, when to resume normal activities, appointments to go to and who to call. Although we expect some of this will translate into improved adherence to care instructions, and reduced risk of adverse events and costly readmissions and ED visits, we need to study cost-effectiveness. At several sites we saw the number of phone calls from patients asking about their care instructions decline, freeing up staff. Understanding these effects is part of our future research plan.

4108

Engaging Patients to Improve an Academic Health Sciences Centre - How Sunnybrook is Engaging Patients in Research, Teaching, and Patient Care

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Background/Context:

At Sunnybrook, patient engagement is more than committee work. It is becoming an essential part of the hospital's culture. We will show how the hospital is creating a new reality of patients as participants in research, teaching and patient care.

Our aim is to offer the audience easy to use blueprints and tools to enhance their patient engagement activities.

Objectives:

Overall goal: create meaningful opportunities for engaging patients and families in the unique activities of an Academic Health Sciences Centre.

Research

Create and implement a template to engage patients and families in research study development.

Education

Develop and implement a process to involve patients in the training and assessment of learners.

Patient Care

Develop a quality improvement process to engage patients, families and front line staff in improving the patient experience.

Corporate Support

Develop and implement a framework to include patients in the assessment and evaluation of proposals for the provision of services or business at Sunnybrook.

Policies and Procedures Development

Creation and implementation of an online engagement method to consult patients, families and members of the community on proposed policy changes or initiatives at Sunnybrook.

Measures:

The primary process measure for each area was the creation of template. See below for secondary process measures.

Research

- Determine level of satisfaction in participating in the research process through feedback from patients and clinical investigators.

Education

- Assess level of comfort of patients in educating students about the patient experience

Patient Care

- Assess staff and patient willingness to participate in improvement sessions
- Gauging patient satisfaction as a result of the improvement initiative

Corporate Support

- Assess level of participation and satisfaction amount patients with engagement in the request for proposals process

Policies and Procedures Development

- Indicators for this include the development of the online engagement tool and the number of topics posted for consultation.

Change Concepts:

Research

The devised engagement template has been implemented with patients awaiting a brain aneurysm procedure. The purpose was to gain their feedback on the information they would need to consent to an experimental procedure.

Education

An evaluation template was implemented in the Emergency Department to allow patients to assess the experience of their interaction with a resident. A Patient Experience Advisor administers the questionnaire and shares the feedback with the resident's supervisor.

Patient Care

Sunnybrook created the **P**eople **I**mproving **E**xperience (PIE) initiative. The program works with front-line staff and patients to create focused improvement projects by soliciting input from patients and staff.

Corporate Support

A patient assessment framework has been developed to evaluate requests for proposals (RFPs). A pilot of this involved Patient Experience staff administering a questionnaire to patients to gauge preferences for new furniture. Data were gathered and provided to administration to inform the decision.

Policies and Procedures Development

To overcome the distance barrier of many of our patients, a website has been developed to encourage patient engagement. The site has provided an opportunity for patients to provide feedback on topics such as should Sunnybrook build shelters for smokers. This feedback is presented to the Senior Leadership Team.

Outcomes and Results/Lessons Learned :

We found that staff are interested in patient engagement and appreciate its importance. Our road map has provided staff the tools they need to participate.

Research

Patient engagement is becoming a requirement for researchers to conduct their work. Sunnybrook's approach has offers them an easy to follow solution to achieve this and help inform their studies.

Education

This was so well received, the instructors plan to submit the experience as a research study on using patient feedback to measure student performance. Our intention is to move this across the organization into other settings and professions.

Patient Care

We learned that staff and patients are more likely to be engaged in an improvement initiative if they are involved right from the beginning. Having a concrete, time-limited outcome, and food, sustains this interest.

Corporate Support

Patients and families offer insight that staff may overlook or take for granted. No engagement initiative is too small. If you offer an opportunity and commit to closing the loop, people are happy to participate.

Policies and Procedures Development

An interactive website, where the information is accessible and entertaining, can yield great results from patients. This initiative is portable to other organizations and can be implemented with minimal cost.

4081

Smart Technologies for Mental Health Management

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Background/Context:

Developing innovative smart technologies has been cited by many, including the Mental Health Commission of Canada, as being vital to enhancing the efficiency and quality of mental healthcare systems and services. The present research has been conducted using a Participatory Action approach to ensure that patients and other stakeholders are engaged from the conception of an idea, to implementation of smart technologies, and to interpretation of research findings. The Lawson Integrated DataBase (LIDB) securely integrates data from multiple community care agencies to reduce redundancies in record keeping and help streamline care. This database has been leveraged to support a text message-based mental health intervention (the Mental Health Smart Technologies; MHST) and a personal health record accessible using mobile technologies (the Mental Health Engagement Network; MHEN). The LIDB also has the potential to support additional person-centered interventions.

Objectives:

We have developed, implemented, and evaluated several mental health smart technologies with the purpose of improving outcomes for mental health clients, connecting clients with their health teams, and facilitating the integration of data between service providers.

Measures:

These technologies have been studied using mixed methods (i.e., qualitatively and quantitatively) to help understand client perceptions, as well as effectiveness and potential cost-savings. Quantitative data has been collected using semi-structured interviews with instruments probing issues such as comfort with technology, heath, social and justice system service use, quality of life, and community integration. Qualitative data has been collected using open ended questions and focus groups with mental health clients and care providers.

Change Concepts:

Different technologies have the capacity to bring about change in a variety of ways. The MHEN project, for instance, which provided mental health clients with a smartphone and an electronic personal health record, aimed to improve communication between care providers and clients and empower individuals to manage their own mental health. Through this improved communication and empowerment, it was expected that individuals would experience decreased symptoms of mental illness and enhanced community integration, thereby decreasing reliance on outpatient or emergency mental health services.

Outcomes and Results/Lessons Learned :

The MHEN project demonstrated significant reductions in psychiatric hospitalizations, outpatient visits, and arrests, as well as improved community integration in a group of 400 participants diagnosed with a mood or psychotic disorder. Future projects will study a simpler and more cost-effect text message-based intervention, implement alternative identification strategies such as iris scanners in community agencies, and enhance the capacity for data integration across agencies through the LIDB. These initiatives have the capacity to revolutionize the mental healthcare system.

4343

Learning with and From One Another; Patients and Providers on the Same Improvement Path

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Background/Context:

St. Joseph's Healthcare Hamilton (SJHH) is a 691 bed, multi-site (acute, mental health, and ambulatory), and academic health science centre in Ontario. Staffing is comprised of 4,000 staff and 550 physicians committed to providing exceptional care. SJHH has been on a journey to partner with patients and families for a number of years, but in the last five years has begun formalizing and accelerating this work.

An evidence based approach was used to improve the discharge process for patients on the Rehabilitation unit at St. Joseph's Healthcare Hamilton. Staff and patients partnered to design, educate and implement the teach-back methodology. Both staff and patients identified the discharge process as an area of improvement. Interviews with patients from the unit highlighted two themes: feeling overwhelmed on discharge day and a willingness to be more engaged in their discharge process. The project started in July 2014 and it is part of a collaborative with the Canadian Foundation of Healthcare Improvement (CFHI).

Objectives:

This improvement project aims to enhance patient, family, and staff experience in the discharge process and was inspired from information collected during a series of patient shadowing activities, discharge surveys, and staff feedback. Staff partnered with patients to create an education package on patient-identified priorities. Using an evidence-based teach-back methodology, staff from all disciplines changed their approach to discharge planning and teaching.

The communication and documentation of education has improved along with an increase percentage of patients that are satisfied with their hospital experience. Preliminary results show significant improvement on family involvement in the care and decisions and on information provided around medication and medication management.

Measures:

Process measurements: Weekly we review all patients' charts for evidence of patient education and use of teach back methodology. The audit captures the number of patients that received education using the teach back, the discipline that provided the education, and the topics of education. Up-to date results are presented in a run chart (see attachments).

Outcomes measurements: Patients are surveyed on the discharge day to capture their experience and satisfaction while in hospital. They also receive a call back within 7 days post discharge to identify how the information helped with the transition home. The preliminary results, definitions and comments are provided as part of this abstract (see attachments). Monthly debriefing are part of the engagement and improvement cycles and provide us with information about staff and patients experience.

Balancing measures: Workload was the primary concern expressed by the team and leadership when we initiated this project. A survey was distributed to all practitioners before implementation of teach back and the same survey will be distributed 6 months and 9 months post implementation. The results will provide information on timely consumed to provide education using teach back methodology compared with previous education methods.

Change Concepts:

Education is now provided on the unit every day when required and learning needs are assessed at each interaction. Staff and patient advisors meet on a monthly basis to debrief on the process and discuss how to improve. Patient Advisors also assisted in staff training by observing staff role play the teach-back methodology and provide feedback.

The partnership between staff and patients has evolved since the beginning of the project. We continue to evaluate by shadowing the discharge process, surveying and interviewing patients on their experience. This improvement project engaged patients and families directly in the design, implementation, and evaluation of the discharge process. The Plan-Do-Study-Act (PDSA) improvement model guided us through developing, testing, and implementing changes leading to improvement. This model moderated the impulse to take immediate actions with the wisdom of careful study. Each PDSA cycle build upon the success of the previous cycle.

Outcomes and Results/Lessons Learned :

Together we created a comprehensive education package for rehabilitation unit patient and families that supports with their transition home. Leadership support is essential; debriefings are a catalyst for better process and relationships between staff and patients; high quality process and supplementary materials were a result of true collaboration - this takes time and multiple interactions. This method provides a great opportunity to keep what adds value and eliminates waste**.**

4253

Creating High Quality Initiatives by Meaningfully Including People Living with Dementia

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Background/Context:

Consumer or patient engagement is promoted as best practice however is often done without authenticity leading to "tokenism". This is particularly true for people living with dementia, often viewed as less capable of contributing meaningfully.

The Alzheimer Society of Ontario has been engaged in several initiatives to meaningfully include people living with dementia and their care partners in its work. With several projects underway to better understand how to involve people living with dementia and develop best practices for their inclusion, we will share the work to-date on developing an inventory of initiatives that aim to meaningfully include people in 3 specific initiatives (CIHR funded development of a self-management of dementia education program, mapping the dementia journey through stakeholder consultations, and developing person centred best practices in care for older adult with complex needs). We will demonstrate success factors and lessons learned from each of these.

Objectives:

Develop an understanding of current practices related to including people living with dementia

Create a set of critical elements/best practices for inclusion of people living with dementia

Increase quality of programs/services/products because they are informed by the real needs of end-users

Measures:

How do people living with dementia perceive their roles in initiatives?

How do other stakeholders involved in initiatives view the participation and contribution of people living with dementia?

What do planners/initiative leads and people living with dementia believe are the critical elements and best practices contributing to successful inclusion of people living with dementia?

What do planners/initiative leads and people living with dementia believe are the impacts on initiative outcomes of including people living with dementia?

(Data gathered through process reflections, participant interviews-including people living with dementia and other stakeholders and reflection on/analysis of project outcomes).

Change Concepts:

Include people living with dementia in meaningful ways from planning through implementation of initiatives of the Alzheimer Society

Foster a culture for and enhance capacity of the health and community to meaningfully include people living with dementia

Empower and increase self-confidence of people living with dementia through meaningful opportunities to contribute to society

Outcomes and Results/Lessons Learned :

Meaningful inclusion of people living with dementia requires attention to 4 critical components – People (enthusiasm, commitment, openness, humility), Purpose (clear, meaningful, relevant), Relationships (respect, safety, listening, relationships beyond, facilitation, connections, humour) and Process (honour process, expectations, consistency, information flow, reflecting)

Attention to process and including cycles of planning, testing out, reflecting, and adapting accordingly are critical to respond to the needs of people living with dementia and others involved in the process

Outcomes are significantly improved when people living with dementia are included in proportionately appropriate numbers (e.g. 25-50% of the group depending on goals of the project) and play meaningful roles that contribute considerably to initiative processes and outcomes from the outset and throughout.