2007

Celebrating Innovations in Health Care Expo

May 23 & 24, 2007
Direct Energy Centre
Toronto, Ontario

Meeting Community Needs Through Integrated Care

Improving Quality and Patient Safety

Improving Efficiency Through Process Redesign

Innovations in Health Promotion

Innovations in Health Information Management

Innovations in Health Human Resources

Ontario

Celebrating Innovations in Health Care Expo

Thank you

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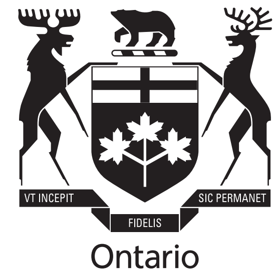

Minister's Greeting

Welcome to the second annual Celebrating Innovations in Health Care Expo. Sponsored by the Ministry of Health and Long-Term Care and Ontario's fourteen Local Health Integration Networks, this special event is a fantastic opportunity to applaud the considerable creativity, intelligence and drive that distinguishes the thousands of health care professionals who are at the heart of Ontario's health care system.

This event showcases how Ontario's health care providers and professionals are embracing the challenge of improving health care in this province, and how they're doing so successfully. It's an opportunity to highlight progress, achievements, partnerships, and innovations across the vast range of organizations that make up our health system, and an appropriate occasion to highlight the health care providers who are generating new ideas and approaches that will save lives and improve health outcomes, both in Ontario and beyond our borders.

I want to thank everyone who has been instrumental in this year's Expo, including all those who made a submission. I would also like to recognize the hard work of the selection committee members, who tackled the considerable challenge of selecting six winners from a field of outstanding excellence.

Thank you all for your ongoing commitment to improving health care for the people of Ontario.

Sincerely,

George Smitherman
Minister

Schedule

Wednesday, May 23

9:00 – Hall C
Expo Open
9:00 am - 11:00 am

11:00 am - 12:30 pm — WORKSHOP

Salon 107	Salon 106	C2	Salon 108
Integrating Service Delivery: New Models of Care	Innovative Knowledge Transfer Techniques to Improve System Performance	Back Office Transformation to Improve Health Care Sustainability	Innovative Community-Based Health Promotion

12:30 – 1:30 BREAK

1:30

Hall C	Hall C
Expo Open 1:30 pm - 3:00 pm	Meet Your LHIN Main Lounge 1:30 pm - 3:00 pm

3:00 pm - 4:30 pm — WORKSHOP

Salon 106	Salon 108	Salon 109
Strengthening Connections Between Long-Term Care and the Rest of the Health Care System	Creating Effective Partnerships with Public Health	Telemedicine: Improving Rural and Remote Access to Health Services

4:30

Schedule

Thursday, May 24

9:00 – Hall C
Expo Open
9:00 am - 10:30 am

10:30 – Hall C
Minister's Award Ceremony
10:30 am - 12:30 pm

12:30 – 1:30 BREAK

1:30 pm - 3:00 pm — WORKSHOP

C2	Salon 109	Salon 108	Salon 107	Salon 106
Enhancing Clinical Integration through e-Health	Diversity, Inclusivity and Wellness: Broadening our Health Care Strategies to Meet the Needs of Complex Communities	Weighing in on Overweight and Childhood Obesity	In, Out, Around and Through: Approaches to Decreasing ER Overcrowding	A New Way of Doing Business: Responding to Mental Health and Addictions Challenges in the 21st Century

3:00 pm - 4:30 pm — WORKSHOP

Salon 107	C1
New Approaches to Managing Surge: The LHIN as Critical Care Network • Champlain Demonstration Project	Shifts in Health Care Education: Evolving Curricula to Meet New Demands

4:30

Workshops

Wednesday, May 23

11:00 – 12:30 WORKSHOPS

Salon 107

Integrating Service Delivery: New Models of Care

• Dr. Hartley Stern	Ottawa Hospital Regional Cancer Centre
• Barry Monaghan	Toronto Central LHIN
• Dr. Hans Kreder	Sunnybrook Hospital
• Dr. Donald Harterre	Peterborough Family Health Team

Salon 106

Innovative Knowledge Transfer Techniques to Improve System Performance

• Dr. Michael Miletin	University of Toronto
• Dr. Bob Bell	University Health Network
• Kelly Campbell	Hamilton Health Sciences
• Rhonda Schwartz	North York General Hospital

C2

Back Office Transformation to Improve Health Care Sustainability

• Paul Faguy	Hamilton Health Sciences

Salon 108

Innovative Community-Based Health Promotion

• Betty Ann Horbul	Porcupine Health Unit
• Alicia Tyson	Ontario Heart Health Network
• Kim Bergeron	Ontario Heart Health Network
• Janet Eagleson	Peel Region

12:30 – 3:00 BREAK

3:00 – 4:30 WORKSHOPS

Salon 106

Strengthening Connections Between Long-Term Care and the Rest of the Health Care System

• Dr. Carole Cohen	Sunnybrook Hospital
• Maria Chu	Yee Hong Centre for Geriatric Care
• Ann Larsen	Alzheimer Society Toronto
• Michelle Clelland	York Central Hospital
• Carol Rose-Kudelka	Parish Nurse Ministry Program

Salon 108

Creating Effective Partnerships with Public Health

• Edwina Gracias	Peterborough County Health Unit
• Neil MacKenzie	Windsor-Essex County Health Unit
• Lyle Hargrove	CAW

Salon 109

Telemedicine: Improving Rural and Remote Access to Health Services

• Dr. Ed Brown	NORTH Network
• Dr. Mark Guttman	Markham Medical Centre
• Dr. Robert Lester	Sunnybrook Hospital
• Dr. Raymond Yee	London Health Sciences Centre
• Gwen Third	Thunder Bay Regional Health Sciences Centre

Workshops

Thursday, May 24

1:30 – WORKSHOPS

C2

Enhancing Clinical Integration through e-Health

- Matthew Anderson — University Health Network
- Lucy Fronzi — Group Health Centre (Sault Ste. Marie)
- Jean-Pierre Soublière — Champlain Regional IM/IT Executive Committee
- Brian Forster — OntarioMD
- Wayne Mills — Trillium Health Centre

Salon 109

Diversity, Inclusivity and Wellness: Broadening our Health Care Strategies to Meet the Needs of Complex Communities

- Anthony Mohamed — St. Michael's Hospital
- Iain DeJong — Streets to Homes Initiative of the Shelter Support, and Housing Administration Division, City of Toronto
- Raymond Chung — Hong Fook Mental Health Association
- Jo-Anne Miller — Ontario Aboriginal Health Advocacy Initiative
- Carol Gordon — Kawartha Participation Projects

Salon 108

Weighing in on Overweight and Childhood Obesity

- Dr. Jill Hamilton — Hospital for Sick Children
- Dr. Glenn Berall — North York General Hospital
- Dr. Meizi He — Middlesex London Health Unit
- Betty Harvey — London Intercommunity Health Centre

Salon 107

In, Out, Around and Through: Approaches to Decreasing ER Overcrowding

- Heather McGillis — Credit Valley Hospital
- Heather Garnett — University Health Network

Salon 106

A New Way of Doing Business: Responding to Mental Health and Addictions Challenges in the 21st Century

- Steve Lurie — Canadian Mental Health Association
- Dr. Nick Kates — Mental Health Program
- Kate Story — Mental Health Centre Penetanguishene
- Dale Butterill — CAMH

3:00 – WORKSHOPS

Salon 107

New Approaches to Managing Surge: The LHIN as Critical Care Network

- Dr. Bernard Lawless — Provincial Lead for Trauma and Critical Care for MOHLTC
- Dr. Redouane Bouali — The Ottawa Hospital
- Dr. Chris Mazza — ORNGE Transport Medicine
- Peter Varga — Humber Regional River Hospital

C1

Shifts in Health Care Education: Evolving Curricula to Meet New Demands

- Dr. Diane Pirner — Ryerson University
- Dr. Joshua Tepper, Assistant Deputy Minister, Health Human Resources — Ministry of Health and Long Term Care

4:30

Celebrating
Innovations in
Health Care Expo

Expo Hall

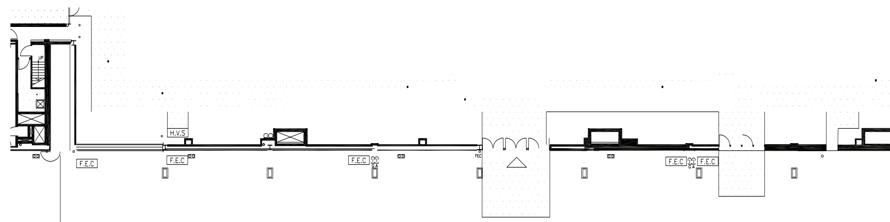

EXHIBIT HALL C

- Meeting Community Needs Through Integrated Care
- Improving Quality and Patient Safety
- Improving Efficiency Through Process Redesign
- Innovations in Health Information Management
- Innovations in Health Human Resources
- Innovations in Health Promotion
- Ministry of Health and Long-Term Care
- Discussion Area

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

Baycrest • 323
MOST Telehealth - Confirmation of Knowledge Transfer

Baycrest developed "Moving on after Stroke" (MOST) program, a self-management program for people with stroke and their care givers, which was shown to be effective in enhancing social participation and social support. A Telehealth element was added to the successful program to determine whether Telehealth could be utilized as a tool for knowledge dissemination and community integration. This allowed for knowledge transfer from an urban academic suite to staff in a regional site and then further to remote communities.

Bridgepoint Health • 325
Bridgepoint@University Health Network Initiative

Bridgepoint @ Primary Care Initiative-Bridgepoint's commitment to partnership has resulted in the formation of a wide range of partnerships over the last several years, including:
- *Multiple partnerships with St. Michael's Hospital*
- *Partnerships with University of Health Network including: the SIMS partnership and partnerships with Toronto Medical Laboratories*
- *The dialysis partnership with The Scarborough Hospital and*
- *Participation in a broad range of provider networks like the GTA Rehab Network, the Ontario Patient Self Management Network and many others.*

Our Bridgepoint @ Primary Care initiative, currently being explored at UHN, is a purposeful next step in our commitment to partnerships. The Bridgepoint @ concept provides an avenue for extending our reach into other settings where complex patients can benefit from the Bridgepoint skills and expertise. In this way, we maximally leverage Bridgepoint's expertise to create capacity in the broader system.

CANES Home Support Services • 418
Home At Last

The goal of the Home at Last-Quick Response initiative is to identify Emergency Department patients who are experiencing adverse episodes due to gaps in the management of chronic illness and who do not require a hospital stay. WOHC will assess for appropriate patients using its Emergency Department Quick Response Teams. A new component in the process will be an assessment to determine if community based assistance by the Home at Last-Quick Response program could enable the patient to return home directly and promptly from the Emergency Department. The patient will be picked up by a pre-arranged, community based transportation service, with a personal support worker (PSW) who will accompany the patient home and make stops for prescriptions if necessary. For patients who live with family/friend, the PSW will stay with the patient until a family member arrives. For those who live alone, the PSW will remain until the patient is settled.

Carefirst Seniors and Community Services Association & York Central Hospital Diabetes Education Centre • 420
Collaborative Community Diabetes Education Program

Collaborative Community Diabetes Education Program is presented jointly by Carefirst and York Central Hospital's Diabetic Education Centre to address ethnic patient's needs. The project demonstrates how the collaboration enhances both programs capacity and accessibility to the Chinese communities. The joint program effort provides a conducive, supportive and interactive environment and

educational activities to raise the patient's awareness and improve the maintenance of their diabetes conditions. The program aims to provide regular monitoring of the patients' diabetes conditions by a health worker and educational activities. The program aims to develop a regular reporting system with the referring family practitioners on the progress of their patients. The interactive reporting system facilitates the physicians monitoring of their patients and positively reinforces their medical intervention for the patients' health improvement. The ultimate goal of the program is to enhance the patients' health status and living quality in the community.

CNIB • 422
Ontario Medical Mobile Eye Care Unit

The Ontario Medical Mobile Eye Care Clinic, known as the CNIB Eye Van, is a fully-equipped medical eye care clinic that provides vital eye care to remote communities across Northern Ontario where services are not available. Each year from March to November, the Eye Van travels over 6,000 km to 30 communities, examining more than 5,000 patients. A group of 20 volunteer ophthalmologists, assisted by two CNIB ophthalmic assistants, carry out vision screening, treat eye conditions and perform minor surgery. The Eye Van is a custom-made transport truck and 48 foot trailer including reception and waiting areas, a vision screening area and a doctor's examination room. Special features include a reinforced floor and hydraulic traveling system that allows for minor surgery to be performed on site. The Eye Van is an integral part of the Prevention of Blindness program for both CNIB and the Ontario Medical Association Section on Ophthalmology.

Facilities Operators Group of Grey Bruce • 424
All on One Page

Moving patients seamlessly from acute care to Long Term Care (LTC) in today's world is hampered on several fronts by the barriers to LTC accommodating the high intensity, acuity and diversity required of them. Having the right mix of staff to care for these residents is becoming difficult in view of the province-wide shortage of nurses. "All on One Page" is a project worked co-jointly with acute, community and long term care to investigate and remedy, where possible, the barriers to the accommodation of higher needs patients in LTC. Areas of investigation included supplies, medications, specific "hard to place" patient populations such as psychogeriatrics, patients colonized with antibiotic resistant organisms and the younger behaviour challenged patient as well as the professional perception that LTC nursing is inferior to acute care. By working together, we have been able to initiate some cross sector changes that are making the transfer process more patient friendly.

Grey Bruce Health Services • 318
A CCAC/Hospital Integrated Navigation Framework

In 2004, the Wait Time Funding agreements between the MOHLTC, hospitals and CCACs opened the door in Grey Bruce to develop a shared framework that would result in positive patient outcomes, enhanced organization efficiencies and meet Wait Time funding requirements. The acute care bed pressures that GBHS was experiencing provided an additional impetus for the development and implementation of a shared navigation framework. It became evident that working separately as two organizations in silos was inefficient and did not assist either organization in meeting ministry mandates and expectations. As a result, the CCAC Executive Director and GBHS CEO set the course and spearheaded the initiation of a Collaborative Projects Steering Committee. The benefits of this shared framework include decreased acute hospital inpatient length of stay, improved patient satisfaction results, standardization of service delivery in the community for specific client populations and follow-up and monitoring of any unanticipated patient outcomes.

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

Grey Bruce Health Network • 324

Planning Surgical Services Across a Health Network

In the summer of 2006, the Grey Bruce Health Network undertook a project to plan surgical services across three hospital corporations in an effort to recruit additional surgeons to the area. The project began with the development of shared principles to guide our decisions. Following this, data was collected on current state of surgical services in the region. An analysis of this data lead to a list of opportunities within the current system and a gap analysis to determine where issues needed to be addressed to make room for expansion in areas. The principles and analysis led to the development of a plan to address an emerging need for increase in Gynecological surgery which was accepted and implemented across the network. This has laid the foundation for using the same principles and data for future surgical services.

Halton Region Health Department • 419

Halton Oral Health Outreach Program

This project is a solution to helping people who have any type of physical, mental or medical problem receive help in getting dental treatment services and help with their daily oral care needs. This project is also a solution for professional caregivers who take care of individuals with physical, mental or medical problems. This project helps them evaluate the oral health needs of patients, refer them for appropriate help and helps them careplan to provide appropriate daily oral care. This project provides seamless oral health services in our community.

Hamilton Health Sciences and St. Joseph's Healthcare Hamilton Niagara Health System, Brant Community • 421

A Comprehensive Model of Integrated Care for Total Joint Replacement

Osteoarthritis is one of the leading causes of severe pain and disability worldwide with treatment aimed at minimizing pain and maximizing function. When conservative management is no longer effective, total joint replacement (TJR) surgery is considered. TJR has been shown to be cost-effective and cost saving and results in dramatic relief of pain and disability. Timely access to TJR is crucial as delayed time to surgery can result in deterioration in function which is associated with inferior outcomes following surgery. Unfortunately, demand for TJR outweighs supply, with predictions that this imbalance will worsen over the next decade, particularly in Hamilton Niagara Haldimand Brant LHIN. Successfully managing increased demand for TJR requires policymakers, service providers and patients to work together to develop standardized, efficient, structured programs of care. This presentation will outline a model of care, designed by partners across Hamilton Niagara Haldimand Brant LHIN that will enable the provision of timely, streamlined access to TJR care.

Hamilton Niagara Haldimand Brant Community Care Access Centre (HNHB CCAC), Niagara Branch • 423

Best Practice Guideline Implementation - Community

The HNHB CCAC is the first CCAC in the province to be selected as a Best Practice Spotlight Organization by the Registered Nurses Association of Ontario (RNAO). Throughout the three year partnership, the CCAC has committed to implement and evaluate a number of RNAO approved Best Practice Guidelines (BPGs). The implementation of this project and the subsequent integration of evidence-based guidelines into case management and community-based health care will have a significant positive impact on client outcomes and the professional development of CCAC staff and service provider staff. This presentation will outline the implementation of three RNAO BPGs (Assessment and Management of Venous Ulcers, Reducing Foot Complications for People with

Diabetes and Client Centred Care) in the community setting. The five phases of implementation and key benefits achieved will be outlined. Increasing the capacity of case managers and service providers to deliver evidence based care will be highlighted.

Links2Care, Supporting 4 Program Partnerships • 518

Home at Last!

Finalist

The Home at Last! program is an innovative collaboration between hospitals and the community service sector designed to smooth the transition for patients from hospital to home. This smooth transition is achieved by coordinating an enhanced hospital discharge process, to meet a pre-determined discharge time, with community support services arranging transportation home and a Personal Support Worker or a Home Help Worker to assist the patient to get settled. The worker will prepare a homecoming meal, pick-up prescriptions and basic groceries and remain with the patient until a family caregiver arrives home or 9:00 pm. The next day, the Home at Last! Care Coordinator will follow-up with the patient and family to arrange any needed community services and supports so the patient will get well at home and reduce the possibility of readmissions to the hospital.

Northeastern Ontario Dementia Assessment and Consultation Service • 520

Delivering Diagnostic Services in a New Way

The Northeastern Ontario Dementia Assessment and Consultation Service provides access to specialized Geriatrician services through the use of videoconferencing technology. The primary focus of this service is to provide early identification, diagnosis and service planning for older adults with dementia or memory loss. The service saves the client the time and expense of travelling to see a specialist. Benefits are that this is less stressful and more convenient to the client and their caregivers.

Providence Continuing Care Centre – Geriatric Psychiatry Service • 522

Mobile Interprofessional Coaching Team

The mobile inter-professional coaching team (MICT) is an inter-professional team of specialty geriatric practitioners and seniors advocates who work collaboratively with primary care practitioners located in Family Health Teams and community supports to develop effective inter-professional practice for seniors with concurrent chronic health conditions. The various disciplines involved with the initiative include nursing, family medicine, physiotherapy, pharmacy, psychiatry, social work, dietary and public education coordinators. Coaching is broadly defined as a formal process in which practitioners from multiple professions and sectors engage in collective learning. Collective learning takes place through participation in group-based activities that involve inter-professional mentorship, preceptorship and leadership building for the purpose of assisting participants to enhance a wide variety of professional, leadership and personal performance issues.

Rosedale Medical Group • 524

FHT Collaborative Practice with Chiropractors

Health and illness is defined by many factors including mind, body and environmental circumstances. Successful recognition and application of a multifactor approach has lead to interdisciplinary collaborative health teams. The goal of this study was to introduce strategies that would improve collaboration between chiropractors and physicians in a primary care setting for musculoskeletal

problems. We used various communication strategies, pain and disability scores, focus groups, and patient and provider satisfaction questionnaires to assess effectiveness of this collaboration. We found significant improvement in patients' pain and disability scores within the first four weeks of treatment ($P<0.05$), as well as decreased medication use. The majority of patients (96%) were very satisfied with participation in the study. In conclusion, our experience suggests that successful collaboration between health care professionals can provide comprehensive quality care and that this model may serve as a framework for integrating allied professionals in a primary care health team.

SIMS Partnership • 519
ER Notification

Emergency (ER) Notification between the Toronto Community Care Access Centre (CCAC) and University Health Network is an innovative step towards integrating care across the health sector. When a patient is registered upon admission to the ER, the ER Notification system uses an automated patient profiling tool to identify appropriate patients for CCAC assessments. A notification is sent to a CCAC Care Coordinator's Blackberry via secure e-mail 24 hours a day, seven days a week, ensuring no potential patient misses a chance to access community services. The notification is also sent to the Whiteboards (computerized boards that track patients' status), improving the teamwork and communication among staff. In the event a notification is sent for a patient who is already a CCAC client, the CCAC is notified early enough to hold a previously scheduled in-home visit, providing time to update the service plan to meet the current needs of the patient.

St. Joseph's Health Centre, Toronto • 521
Anything Is Possible With Effective Collaboration!

This project exhibit will afford participants a wonderful story that demonstrates the power of delivering integrated health care services through multiagency contribution. The service example showcased will focus on access to oral health care, which is a major problem in vulnerable communities that are often faced with social and economic disparities. For people who are socially and economically disadvantaged, regular access to primary dental health services is largely unavailable. However, there is valuable research that clearly links oral health care to overall physical, psychological and social well-being by enabling individuals to eat, communicate and socialize without discomfort or distress. The exhibit will outline creative opportunities that were employed to sustain a free oral health clinic.

St. Michael's Hospital, Centre for Research on Inner City Health • 523
CAISI Project

The Client Access to Integrated Services and Information (CAISI) Project aims to end chronic homelessness and enhance the health and well-being of people who are homeless by integrating care between multiple health and shelter service agencies. The project includes the development of an open source software tool and building agencies capacities to integrate. At the individual level, the project supports the rapid assessment of clients, multi-agency case management and appropriate referrals to shelters, support services and housing placements. At the population level, the project enhances the ability of the community to gather current data, which can be used for advocacy, program planning and research that creates positive social change. CAISI is currently used by 11 agencies in three Ontario cities and is strongly supported by agencies, front-line staff and homeless clients all of whom contribute to the development of the project on an ongoing basis.

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

South West Community Care Access Centre • 320
No Pain – Lots of Gain

Many healthy patients undergoing Hip or Knee joint replacement surgery can be discharged home one day after surgery to recover in the comforts of their home with the help of the CCAC providing the care. This has the potential to reduce hospital-based infections and improve patient satisfaction with the therapy. The program involves physical therapy training preoperatively, use of multiple oral medications for pain management combined with infusion of local anesthetic around the joint for 48 hours for pain relief and early ambulation starting on the day of surgery. Once the patient qualifies for discharge, they are discharged home to be looked after in the comforts of their home by the CCAC. Physiotherapy is continued at the patient's home and the wound catheters are removed by the CCAC 48 hours after surgery. This paradigm provides good quality of pain relief with no/minimal weakness of the leg. Nausea is significantly less.

Sunnybrook Health Sciences Centre and St. John's Rehab Hospital • 525
Improving Cancer Care Through Collaborative Alliances

TSRCC at Sunnybrook Health Sciences Centre, a teaching, acute care hospital and St. John's Rehab Hospital, a specialty rehabilitation hospital, recognized an opportunity to serve oncology patients who would benefit from a rehab experience to return them to their optimal functional status. A partnership program was developed to deliver cost effective rehabilitation services for oncology patients.

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thehealthline.ca, South West End-of-Life Care Network and South West Community Care Access Centre • 322
Partnership to Support Choice in End-of-Life Care

When it comes to end-of-life care in the community, knowledge is power. Clients, caregivers and professionals need to know what resources are available and how to access them. The South West End-of-Life Care Network collaborated with thehealthline.ca, an innovative web portal and the South West Community Care Access Centre (formerly the London-Middlesex CCAC) to create a suite of communication vehicles that complement and support one another: a website, video and users guide. By working together the three organizations were able to create a resource that contributes to patient quality of life and satisfaction, facilitates knowledge transfer, fosters collaboration and provides a model for sharing information about dying at home.

The Ottawa Hospital • 319
Improving Regional Access to Cancer Surgery

To improve access to quality cancer surgery and reduce regional wait times, the Champlain Regional Cancer Program created an innovative "hub and spoke" care model. Serving as the cancer services hub, The Ottawa Hospital Cancer Assessment Clinic is the gateway to access to cancer care. To enhance care and provide access for patients closer to home, satellite programs across the LHIN will provide quality care based on their capacity and community's needs. With one triage point, the new model ensures that:

- *Care is better coordinated*
- *Surgery wait times are reduced*
- *Patients get quality care, closer to home*
- *Care is standardized regionally*
- *Access to appropriate care occurs in the appropriate facility*

- *Patients have access to expert consultation*
- *Patients benefit from shared medical expertise*
- *Patient satisfaction and confidence in treatment is improved*
- *Healthcare resources are used efficiently*

The Ottawa Hospital • 321

Outpatient Management of Pleural Effusions

Finalist

A common complication in advanced cancer is the accumulation of fluid in the lung, known as a malignant pleural effusion. This causes shortness of breath and significant discomfort. Usual treatment includes inserting a chest tube to drain the fluid and then instilling medication to prevent the fluid from reoccurring. This entails an inpatient hospital stay of approximately 16 days. The Ottawa Hospital Regional Cancer Centre, working in collaboration with the Ottawa Community Care Access Centre has implemented a pilot program to manage this complication in the outpatient setting. A new type of chest tube, the PleurX catheter, is inserted and the fluid is drained in the outpatient clinic. The patient is visited by trained nurses three times a week to drain the fluid. Once the fluid is drained the tubing is capped and covered with a dressing so the patient can continue with normal activities. No hospital admission is required.

Third Age Outreach (St. Joseph's Health Care, London) • 618

Lean on Me

Lean on Me is a training program for volunteers to enable them to work with frailer seniors in community settings. Volunteers participate in a four-module training session. Topics covered in the training include establishing boundaries and recognizing barriers; safe community mobility (such as how to coach someone up from a chair); overcoming vision & hearing challenges; common diseases among older adults; how to communicate across cultures; dealing with mental illness, dementia, physical and intellectual challenges. This presentation outlines how multiple partners within the health care and community sectors engaged in a successful collaboration to develop, implement and evaluate a pilot trial of Lean on Me. The evaluation results indicate that the development team and the nine participants were satisfied with the program and that the knowledge and confidence to provide safe and adequate support increased among the trained volunteers. Lessons learned and next steps will also be discussed.

Thunder Bay Regional Health Sciences Centre • 620

Multi Site Cardiac Rehabilitation Program

Finalist

Our goal was to establish access to Cardiac Rehabilitation programming to sparsely populated remote communities within the region of Northwestern Ontario which lie outside the city of Thunder Bay. Through utilization of the Ontario Telemedicine Network we have implemented a fiscally responsible program model, with removal of barriers to participation for 50% of the region's population. Along with development of a coordinating site, eight partner sites have now been established within the region. Professional staff development has been undertaken with establishing ongoing linkages and resource sharing between the sites. Regional clients now have access to program elements to assist them in the self management of their risk factors associated with their cardiac disease, while remaining in their home communities.

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

Total Joint Network • 622
Integrated Model of Care for Hip Fracture Patients

A new model of care was designed for patients that are admitted to hospital from their home setting following a hip fracture. This new model was trialled at four organizations in Toronto through the summer of 2006. The model was found to result in significant improvements in care for patients from their admission to the emergency department, through their stay in acute care and inpatient rehabilitation and was found to facilitate a faster return to their home. As such during 2007 the model of care is being implemented in acute care hospitals, inpatient rehabilitation hospitals and Community Care Access Centres across 38 healthcare organizations from Oshawa to Halton.

Trillium Health Centre • 624
"Sweet Success:" An Integrated Chronic Disease Program

The "Sweet Success" community-based group exercise program for people with diabetes began as an innovative, hospital-community collaboration idea to demonstrate the integrated Ontario Chronic Disease Prevention and Management Framework in action. While ostensibly an exercise program, the design and intent of this collaboration is also to address underlying determinants of health for patients (e.g. social isolation, economic, educational, cultural, accessibility) and to address the barriers that exist between clinical and community-based programs (e.g. legal, medical clearances, bridging different organizational cultures and approaches, sharing expertise and knowledge transfer). The anticipated result was to create a proactive, seamless and integrated program with better and more sustainable health outcomes for people living with chronic conditions. The measurable benefits that participants in the "Sweet Success" program have enjoyed are: increased client satisfaction, increased frequency of physical activity and improved metabolic control (markers for diabetes control).

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

Bridgepoint Health • 244

Self-Management Model of Care in the Community: Applying the Principles to a Falls Prevention Program

The model of self-management is a cornerstone for those who want to achieve successful health related outcomes (Mensing 2002). Using this model, Bridgepoint Community Rehab developed a pilot project to apply self-management principles to falls prevention to promote behavioural change in clients and caregivers. Falls in the home represent a source of morbidity for adults in the community. A fall may jeopardize one's ability to live independently and safely. The Falls Prevention curriculum was designed to develop clients and caregivers knowledge and awareness of risks and to assist them to implement safety strategies. The principles that we identified for change included: treatment plans of engagement, the development of problem-solving skills and evaluation of self-efficacy. Outcomes expected are: an increase in self-efficacy and the facilitation of self-directed behaviour. Clients and caregivers will independently identify potential safety risks and take appropriate actions to prevent falls.

Cancer Care Ontario • 241

Provincial Palliative Care Integration Project

The Provincial Palliative Care Integration Project (PPCIP) is a continuous quality improvement project with implementation occurring across all LHINs. The PPCIP aims to improve delivery of palliative care services through the development and implementation of a system of integrated assessment, delivery and communication across care sectors. PPCIP is using the Model for Improvement as the quality improvement framework. The model includes setting improvement aims, measuring achievement and using Plan, Do, Study, Act (PDSA) cycles for testing and implementing changes. A rigorous evaluation component has been implemented including regular feedback to the regions on achievements related to the improvement aims and evaluation of the impact of the quality improvement approach. A central project team, 13 Regional Improvement Coordinators and Regional Steering Committees and over 40 Improvement Teams have provided the necessary structures and processes for sustainable improvement. The PPCIP is jointly funded by Cancer Care Ontario and the Ministry of Health.

Cancer Care Ontario (CCO) • 340

CCO Computerized Physician Order Entry Initiative

Most chemotherapy is managed with paper-based processes that are prone to result in errors. One tool proving its worth to patients and their oncology teams is Canada's most extensively utilized CPOE system for oncology, developed by CCO. This system allows physicians to directly prescribe complex chemotherapy and related drugs by computer, minimizing harmful medical errors such as handwriting interpretation and dose calculations prevalent in paper-based systems. Today, CCO's CPOE system has been adopted in eleven cancer centres across Ontario and over 50% of chemotherapy orders are placed electronically by over 500 physicians. CPOE is a proven Electronic Health Record technology for reducing serious medication errors. Constantly improving patient safety by reducing serious medication errors in the areas of ordering, transcription, dispensing and administration, medical oncologists using CPOE say they would no longer be willing to practice without it.

Canadian Red Cross Community Health Services • 246

Professional Care Boundaries Training DVD

The Canadian Red Cross Community Health Services has developed a training DVD about professional care boundaries called Who is Helping Whom? This 30-minute DVD focusing on community care will help workers identify risks to themselves and clients that

result when workers perform tasks that are outside of the client's care plan. The DVD features dramatizations of situations in which Community Support Workers cross the boundaries of professional care. Scenes include workers accepting money from a client, eavesdropping on a client's private conversation and giving a ride to a client's family members. A narrator identifies the risk to client and worker in each situation and comments on the possible consequences of crossing professional care boundaries. Based on input from CHS Supervisors about actual challenges to professional care boundaries, this DVD is a relevant, efficient tool to reduce the incidence of client and worker risk and leads to better quality care.

Centre for Global eHealth Innovation, University Health Network • 248
Human Factors 101: A Course in Patient Safety

Human factors is the discipline concerned with how people interact physically and psychologically with products, tools procedures and processes to optimize well-being and overall system performance. Studies in adverse events have identified better use of human factors principles as a key strategy in making health care safer. The Human Factors 101 Course presented by the Healthcare Human Factors Group at University Health Network is designed to build knowledge and increase awareness of human factors among healthcare workers by providing a high-level overview of the importance of human factors concepts in a clinical context. The objective is to provide health care practitioners with knowledge to be risk-aware and error-wise in order to reduce adverse events. Since its initial launch in December 2006, the HF101 course has been presented to over 130 healthcare professionals from hospitals including Toronto General, Toronto Western, Princess Margaret, Mount Sinai and The Hospital for Sick Children.

COTA Health • 243
SAFER-HOME v.3: A Home Safety Outcome Measure

Home safety is influenced by a person's health and ability to function within the home setting. When a person's health is poor, carrying out activities safely in the home can be challenging. COTA Health, an organization providing in-home rehabilitation, mental health and community support services, has developed a tool that helps identify safety issues in the home. This tool (the SAFER-HOME Version 3), has been developed for use by occupational therapists with individuals experiencing health problems. The therapists check for safety problems such as getting in and out of the bathtub. Since the tool has been designed as an outcome measure, occupational therapists use it before making recommendations and after improvements have been carried out. If the safety issues have been successfully addressed, the score on the second assessment will be better than on the first, proving the effectiveness of the service in increasing safety in the home.

COTA Health • 245
Improving Community Care in Pediatric Feeding

The move towards community-based care drives the trend towards shorter hospital stays and early discharges from pediatric tertiary care centres. As a result, community organizations have seen a rapid increase in the number of infants and children referred for ongoing management of complex feeding problems. COTA Health recognized the challenges faced by community-based pediatric clinicians and the need for change in current practice. A task force was created to identify and develop common client issues, desired outcomes and best practice guidelines. This process was supported by a literature review and collaboration with rehabilitation representatives from partnering tertiary care centers. A feeding screen and revised assessment tool were developed and a resource manual produced for use by the occupational therapists providing pediatric services. Consultation with tertiary care centers led to an inter-professional feeding network to support the development of disciplines working together to deliver seamless and coordinated, team-based care.

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

COTA Health • 247
Innovating Mental Health Practice in the Community

People with anxiety disorders are referred to COTA Health through the Toronto Central CCAC. Some consider suicide and live in risky house situations. In order to help people in a positive and cost effective way, COTA Health has pioneered an innovative, evidenced based protocol for the treatment of anxiety in the community. A 12 visit manual was developed with step-by-step instructions for the OT and client to assist the client in learning new strategies for coping with their anxiety. This approach, based upon cognitive behavioural principles, teaches clients ways to change how they think and how they behave in response to anxious feelings. Implementation of the protocol included an external expert and involved training 30 mental health OT's. Evaluation using a retrospective analysis is underway. Preliminary findings suggest the protocol is being received positively by clients while supporting a shift in service providers practice within a shorter term rehabilitation model.

Dietitians of Canada – Ontario Region • 342
Best Practices for Nutrition/Food Service in Long Term Care (LTC)

Best Practices for Nutrition, Food Service and Dining in Long Term Care Homes is a compendium of guidelines, strategies and tools to provide guidance to Registered Dietitians (RDs). The Best Practices promote a consultative and interdisciplinary team approach to the provision of all components of Nutrition, Hydration and Dining for residents in LTC including Administration, Menu Planning. Food Production, Nutritional Care and Quality Dining. The goal of Best Practices is to provide a program that ensures each resident receives appropriate nutritional care and interventions in the least restrictive and most effective manner and that this care is provided in a supportive and pleasant environment. Best Practices follow a quality cycle of Assess, Plan, Implement, Monitor, Evaluate and Improve to guide the program. Ideas from across Canada were solicited to ensure the Best Practices document will assist RDs working in LTC to provide optimal nutrition care and dining experiences.

Dietitians of Canada • 344
Practice-Based Evidence in Nutrition – PEN

Practice-based Evidence in Nutrition [PEN] is a dynamic web-based service designed by dietitians, for dietitians to improve the quality of nutrition care dietitians provide to their clients/patients. The content of the PEN service is based on actual questions that arise in dietitians everyday practice. Leading experts and practitioners search the scientific literature related to practice questions, review and summarize the research and develop bottom line advice to guide dietitians practice decisions. Links to the relevant literature, as well as to client tools and resources consistent with the scientific evidence, are included, providing an integrated and seamless resource accessible from the computer desk top. Dietitians of Canada has consulted leaders in knowledge translation and transfer as well as technology innovators in developing the innovative PEN service.

Group Health Centre • 249
Health Promotion Initiatives (HPI)
Finalist
The Health Promotion Initiatives (HPI) program is a partnership of the Group Health Centre providers. Under the direction of the GHC Joint Management Committee, the HPI committee, made up of several physicians and managers, meets once a month to administer the program. HPI was created to develop and evaluate evidence-based outcomes management programs and improve the quality of care for 60,000 rostered patients. Disease site registries are enabled through the utilization of an EMR, practice management

applications and web technology. What began as an innovative idea, is now a network of quality management and improvement programs in diabetes, congestive heart failure, anticoagulation, osteoporosis, smoking cessation, immunization and mammography screening. Benefits include:

- *Improved health outcomes*
- *Integrated care*
- *Improved access to care*
- *Timeliness of care*
- *Improved communication between healthcare providers*
- *Consistent, coordinated patient and provider education*
- *Patient self-management tools*
- *Collaboration with other community partners*

Hamilton Health Sciences • 346

Surveillance and Screening of Antibiotic Organisms

A collaborative and cross-departmental process change has Emergency Department nursing staff primarily responsible for the surveillance and screening of patients at risk of having an ARO has fostered a successful and innovative change in professional practice. Hamilton Health Sciences has developed and implemented medical directives for the screening and surveillance of antibiotic resistant organisms (AROs). This approach ensures compliance with the Public Hospital's Act and the Nursing Act while improving the length of time a patient may wait to be tested. The key benefits of early identification include a reduced risk of spreading AROs, reduced length of patient stay in hospital resulting from delays in culture results and improved efficiency in patient flow and bed utilization related to decreasing the need for patient isolation. Implementation of such innovative approaches of care will decrease patient risk for exposure to AROs and ensure compliance with regulatory standards.

Hamilton Health Sciences • 348

Hamilton Health Sciences ICU Antibiotic Strategy

Hamilton Health Sciences committed senior leadership support and quality and process improvement resources available through its Clinical Appropriateness & Efficiency Program to support the Hamilton General Site ICU in adapting a strategy to improve antibiotic utilization. The protocol included objective criteria for risk stratification, best practice guidelines for diagnosis and recommendations for the choice and duration of antibiotic treatment in cases of suspected Ventilator Associated Pneumonia (VAP) and Non-VAP infections. The implementation phase of the protocol was comprised of number Plan-Do-Study-Act (PDSA) cycles as the team responded to stakeholder feedback and initial process and outcome data. The impressive measurable results achieved in improving patient safety (reduced MRSA and fungal infections), clinical outcomes (reduced ICU length of stay) and clinical resource utilization (drug cost savings) earned the project the 2006 Canadian Healthcare Excellence in Quality Award (CHEQA).

Headwaters Health Care Centre • 341

Patient Centred Care Rewired

Headwaters Health Care Centre's vision is patient centred compassionate care in the face of change. Patient Centred Care is a priority and a number of strategies have been implemented over the past few years to enhance knowledge and practice of patient centred principles. Most recently, Headwaters has embarked on the implementation of the Studer Principles to provide a standardized

approach and tools to achieve service excellence. Headwaters is in the process of implementing five of these initiatives. These include the implementation of white boards on medicine and continuing complex care units, use of key words at key times as a framework for improving communication between the interdisciplinary team and the patient, hourly rounding of patients, discharge follow up phone calls and physician/team communication cards. The impact of these initiatives will result in improved patient and staff satisfaction and enhanced patient safety through improved communication and patient centred initiatives.

Humber River Regional Hospital (HRRH) • 343
Rapid Response Tool Kit to Infectious Outbreaks

It is an ultimate goal of every Healthcare Organization to prevent the spread of infections that lead to more serious outbreaks. Efficient operations by Infection Prevention and Control are one of the key factors for Patient Safety. In a time of crisis, such as an outbreak, it becomes pivotal to contain and control the event through simple, comprehensive and effective operational processes. Developing a standard outbreak management procedure at our multi-site hospital was tested and successfully implemented in February 2006. HRRH refined the processes to facilitate rapid response to confirmed or potential outbreaks. As a result, HRRH was able to improve the effectiveness and efficiency of the Infection Prevention and Control strategies initiated for the management of potential outbreaks and prompt containment and resolution of the confirmed outbreak at Humber River Regional Hospital. The project demonstrated an innovative approach to improving efficiency through process redesign.

Holland Orthopaedic & Arthritic Centre – Sunnybrook Health Science Centre • 347
The Coach Program: Innovative Patient Support

In today's healthcare environment, patients and their support persons are encouraged to be active participants in their care. The Coach Program maximizes human resources by formally integrating patients' family and friends into their health care teams. This unique use of an underutilized human resource was designed to decrease patient anxiety, increase patient confidence, enhance coping with shorter lengths of stay and smooth the discharge planning process. The patient is encouraged to identify a friend or family member who will be their coach. The coach acts as a motivator, resource and second set of ears during preoperative planning, the hospital stay and coping at home following discharge. A staff survey in 2006 reported positive feedback in a number of areas and provided suggestions for program improvement. Key areas for future development include a patient survey and improved program visibility.

Jarlette Health Service • 349
Achieving A Least Restraint Culture

The Least Restraint Culture Project focused on reducing the use of physical restraints through providing education and alternative measures. This was a corporate quality improvement initiative, which has directly enhanced resident safety and quality of life. The steps involved included a corporate review, setting a benchmark, standardizing definitions, policies and procedures, providing families and caregivers with education and employing individualized alternative measures for residents who may otherwise have been restrained. We also worked closely with Therapy Supplies to look at how seating options could most effectively be used. Outcomes of this project are monitored monthly through an established Quality Indicator Analysis program as we track the restraint use in all homes and the numbers of falls with injury.

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

Markham Stouffville Hospital • 440

Medication Reconciliation at Hospital Admission

Markham Stouffville Hospital is a progressive community hospital that services a rapidly growing and diverse patient population. Our goal is to Make it Great for all of our patients and medication reconciliation is a top priority at our institution. Medication reconciliation is a process that ensures the patient's best possible medication history is captured and used to re-order medications upon admission. Our process to collect the medication history in the emergency department and reorder patients' medications had many redundancies and thus did not capture the most accurate list to be used by the physician. A medication reconciliation form was created and a process implemented in the emergency department to facilitate the ordering of the patients usual medications by the admitting physician. The use of this form has improved patient safety by reducing unintentional variances and potential adverse events and increased effectiveness of nursing, pharmacy and physician time.

Mount Sinai Hospital • 442

Best Practice in Critical Care Checklist

A collaborative working group consisting of physicians and nurses from five adult academic critical care departments in Toronto identified nine evidence-based best practices to target in quality improvement initiatives. The decision regarding which practices to target was based on the strength of supporting evidence; the potential impact on patient outcomes; the availability of associated quality indicators for measurement and the relevance to stakeholder ICUs. The evidence-based practices identified by the collaborative working group were incorporated into a best practice checklist to be completed by both nurses and physicians during weekday shifts in the Mount Sinai Hospital medical/surgical ICU. The best practice checklist is both a quality improvement intervention and a data collection tool. Quality indicators embedded in the checklist remind nurses and physicians about best practices at the point of care and the data extracted from the best practice checklist provides reliable real-time data regarding the adherence to evidence-based practices.

Ontario Transfusion Coordinators • 444

Algorithm for Preoperative Hemoglobin Optimization

Blood conservation has become an integral part of the continuum of care in surgical services. Current practices for patients with anticipated high surgical blood loss vary widely across the province. A working-group of Ontario Transfusion Coordinators (ONTraC) developed a tool to provide assistance to health care practitioners in their patient centered approach to hemoglobin optimization and anemia management. A literature review identified common risk factors for transfusion and numerous interventions available to reduce the risk of exposure to allogeneic transfusion. Applying the appropriate patient specific intervention is necessary. A flow chart representative of a provincial (ONTraC) approach to enhancing perioperative blood conservation was developed. At regular intervals the medical director and coordinators systematically reviewed the content to ensure efficacy and validity. The algorithm provides a standardized, evidenced based, synergistic approach to transfusion avoidance which supports patients' right to appropriate treatment. Key Words: blood conservation, perioperative, evidence-based tool, algorithm, ONTraC

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

Providence Healthcare • 141
Medication Reconciliation in Rehab/Complex Care

Patients often are admitted to hospitals with complex medication regimen. Discrepancies in medication orders could lead to adverse drug events. A Rehab/Complex Continuing Care setting presents unique opportunities for pharmacists to perform medication reconciliation. On admission, pharmacists obtain the best possible medication history by interviewing the patient, reviewing all medication relation documentation, clarifying any discrepancies and writing medication orders on the doctor's order to be reviewed and co-signed by the physician. This process significantly reduces discrepancies that are undocumented and unintentional. The average medication reconciliation success index was 95%. Pharmacists play a critical role in medication reconciliation, which has a positive impact on patient care and patient safety.

Providence Healthcare • 143
Warfarin Dosing Service for Ortho Rehab Patients

Complex, surgical patients are routinely referred to rehabilitation hospitals for subacute and transition care. The goals of the pharmacy warfarin service were to optimize anticoagulation management and to improve patient outcomes and patient safety. Retrospective evaluations were completed 2003-2006, comparing two control groups to the anticoagulation service patients. The results showed that the pharmacy warfarin service was safer and more effective. The key ingredients were a strong interprofessional team; certified anticoagulation pharmacists; an evidence-based medicine approach to anticoagulation management and continuous quality improvement.

Princess Margaret Hospital • 446
Healing Beyond the Body

The PMH has turned to the volunteer sector to provide new and sustainable support services in order to reduce cancer patients' emotional distress. Offered as a collaboration between the Psychosocial Oncology and Palliative Care (POPC), Survivorship, Patient Education and Volunteer Resources Departments, the Healing Beyond the Body Program was launched in 2006 as a comprehensive, hospital-wide volunteer strategy. Through this initiative volunteer roles have been broadened to include emotional support and promotion of self-management. Now a part of the hospital infrastructure, volunteers have become fully integrated onto the care team which expands the type and amount of volunteer support available to patients. This new service increases the hospital's ability to meet previously unmet needs for support, information and orientation to the complex cancer care system, which have been shown to help reduce distress for patients.

Queen's University Emergency Syndromic Surveillance Team • 448
Occupational Health Syndromic Surveillance System

Syndromic surveillance is the monitoring of initial disease symptoms, which may provide early warning of an unusual health event or disease outbreak. The purpose of our innovation project is to use routinely collected computerized occupational health visit data, in order to develop, implement and evaluate an innovative, real-time, early warning surveillance system, linked with an existing Emergency Department Syndromic Surveillance (EDSS) system. This project is the first in Ontario to conduct real-time surveillance of occupational health reporting with an infectious disease focus. By monitoring respiratory and gastrointestinal illness activity within the community (EDSS) and hospital (occupational health) settings, the integrated system intends to provide enhanced early warning for

communicable disease outbreaks which may help to characterize the occurrence and transmission of infectious diseases and allow for increased infection control measures and implementation of emergency plans. Consequently, this information could be used to reduce health care worker absenteeism.

St. John's Rehab Hospital • 648
IRIDE: An Ethics Decision-Making Model

A common language was needed for us here at St. John's Rehab to discern and discuss ethical care for the betterment of patient care, staff and volunteer work life. The Ethics Committee created the IRIDE model to assist in the decision-making of ethical situations. The model is a basic decision-making model and is applicable to all areas in the hospital.

St. Joseph's Healthcare Hamilton, Schizophrenia Service • 145
A Consumer Evaluation of Mental Health Services

A Program Improvement Council chose to engage consumers in the planning and evaluation of tertiary mental health services through a consumer run research study. The focus was to examine the differences between consumer and conventional administration of a standardized patient satisfaction questionnaire and identify aspects of service provision not conventionally captured. Supported by a Steering Committee and a staff resource researcher, the consumer team completed 129 matched pairs of surveys. Lessons were learned about leadership, role of senior management, commitment, communication and infrastructure to ensure success. In the process, not only did consumers participate in evaluating health services, the project built capacity for consumers to participate in further evaluation/planning projects, while raising the profile and credibility of consumers in such roles. The initiative introduced hope, raised expectations and impacted observing consumers and clinicians concerning what is possible.

St. Joseph's Healthcare Hamilton • 147
Patient and Staff Safety Project: Working Together

Workplace injury and related sick time contribute to the current shortage of nurses available to provide safe care and can influence quality of work life, yet nurses have more work related injuries than other professions. There is also evidence to link adequate staffing and patient outcomes such as falls and pressure ulcers. To address this issue, the MOHLTC funded the education and equipment related to mechanical lift devices. SJHH championed an innovative approach to this project by incorporating the RNAO Best Practice guidelines for the Prevention of Falls and the Prevention of Pressure Ulcers within an interdisciplinary implementation framework: Assess, Plan and Move. Several improvements were realized as a result of this project related to:

- *Identification of patients at risk*
- *Patient handling*
- *Documentation tools*
- *Lift equipment*
- *Participants will benefit from this practical blueprint created for implementation and sustainability*

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St. Joseph's Healthcare Hamilton • 149
Ensuring Safe Transitions: Medication Reconciliation at Discharge

Patient Safety is a critical issue on the agenda of hospitals across the country. The ISMP identified poor communication at transition points is responsible for approximately 50% of medication errors and 20% of adverse drug events. Medication reconciliation is a powerful strategy to reduce these errors. While this process has primarily been initiated on admission, little has been done at the point of discharge and thus SJHH chose to implement at this point. An electronic medication prescription form was developed to replace the current handwritten prescription pads which reduced the risk of transcription error and improved legibility. The form is completed by the physician, copied for the chart, faxed to the family physician and the original is given to the patient to fill at their community pharmacy. Participants will benefit from this overview of the development of this creative solution and practical strategies for implementation of medication reconciliation at discharge.

St. Michael's Hospital • 441
Unique Contributions by Pharmacists in the OR

The Operating Room Pharmacy is staffed by a pharmacist and two technicians. In addition to drug distribution duties, staff aid in the development and implementation of strategies to reduce the risk of medication errors and improve patient safety. Medications stocked in standard anaesthesia drug trays have been standardized hospital wide. Secondary medication trays have been developed based on specific drug requirements for each surgical specialty. Medications that are considered high risks or with similar packaging are affixed with an auxillary label to alert Anaesthetists prior to administration. Finally, pre-printed physician orders for Surgical Antibiotic Prophylaxis have been developed. The implementation of these orders will ensure appropriate antibiotic selection and administration at an optimal time pre-operatively for optimal effectiveness.

St. Michael's Hospital • 443
The Voice of Inner City Health Clients

A client satisfaction survey was developed to meet the unique needs and demographics of an inner city population on an in-patient unit in a tertiary care hospital. This survey is reviewed continually and is used to identify strengths and areas for improvement with the goal of improving quality of care. The newly created satisfaction survey identifies the client's satisfaction level in various domains and initiates and drives action plans to improve the client's experience. The development of a new satisfaction survey has been effective in capturing the voice of an in-patient, inner city health population and implementing changes to enhance a positive experience.

St. Michael's Hospital • 445
Standards and Approvals for Patient Education

Patient and family education is an important element of quality health care. Despite this, patient education materials at St. Michael's Hospital have varied widely across the organization and have not always been patient-centred. There has also been a lack of resources to assist staff with the development of patient education materials. The Patient Education Program at St. Michael's Hospital has developed standards and an approval process for patient education materials to ensure that patient education is of high quality and meets patients' needs. To develop these resources, the Program conducted a literature review, including a scan of other hospitals and other health care institutions. Patient focus groups were conducted to gather feedback and consultation was undertaken with stakeholders. The standards and approval process were implemented in February 2007. This presentation will highlight this innovation, its importance for other institutions and key success factors with other healthcare providers, group and institutions.

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

Kamala Persad-Ford, RN, MScN • 449
Pain Management Education After CABG Surgery

The purpose of the study was to find out whether patients who received pain management education had a smoother post-op recovery period than patients who did not. An educational tool, a booklet on pain management was used in the study. The project was implemented in a downtown, teaching hospital. Subjects were randomly selected from a convenience sample and placed into two groups, half were placed in the controlled group and half in the study group. Subjects chosen were pre-booked for CABG surgery. Full approval from the ethics board of the institution was obtained. A survey was used to evaluate the outcomes. A consent was completed by each participant. Subjects were informed that the project was strictly voluntary.

St. Michael's Hospital • 447
Ticket To Home
Finalist
Patients are not always ready for or expecting to be discharged home from the hospital when doctors and other hospital staff tell them they are being discharged. The aim of the "Ticket To Home" project was to improve the information and communication patients and families were given leading up to discharge. A list of discharge goals to be followed and achieved by each patient prior to being discharged home was created. These goals were posted beside each patient's bed for daily review. A larger laminated poster of the "Ticket To Home" was mounted in the hallway by the nursing station.

The Arthritis Society • 541
Getting a Grip on Arthritis®

The Getting a Grip on Arthritis program was developed to help the team of health professionals working at five Community Health Centres in Ontario to identify arthritis and manage it appropriately. The program consisted of a workshop on the assessment and management of two common types of arthritis (rheumatoid arthritis and osteoarthritis) followed by additional activities to reinforce the learning. Arthritis books and videos were also donated to local libraries. At follow-up, clients from the participating Centres reported receiving more information about their type of arthritis, medications, treatment options and community resources compared to a control group (providers from two other Centres). They also reported more referrals to The Arthritis Society therapy program. Providers reported increased confidence in performing a joint examination and fewer barriers to arthritis care. This innovative project was one of the first to show changes in the management of arthritis in a primary care setting.

The Credit Valley Hospital • 543
Low Risk Chest Pain Protocol

A new protocol was developed for the management of low risk chest pain patients. Prior to the protocol, patients presenting to the ER with low risk chest pain were often admitted to hospital. Currently, care is guided by an evidence based order set. Management of the patient is standardized and includes serial ECGs and cardiac enzymes. Eligible patients are then referred to the Cardiopulmonary Department for a timely exercise stress test and cardiology consult. This has resulted in a decrease in admissions of over 50% (16.6% to 7%). Patients surveyed were very satisfied with the new protocol which helped reduce their anxiety over their chest pain event. Furthermore, physicians of 50 consecutive ER low risk chest pain patients were surveyed and reported that the protocol prevented admission for 10% of the patients and reduced ER length of stay for 24% of patients.

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

The Children's Hospital of Eastern Ontario • 545

Paediatric Standardized Concentrations

Finalist

Current guidelines recommend limiting and standardizing the number of drug concentrations available for IV infusions. Within the paediatric setting, fluid volume is important and concern exists regarding the possibility of increased 24-hour fluid volume intake by instituting standardized concentrations (SC). Objectives - To establish that drug infusion volumes administered to Paediatric Intensive Care Unit (PICU) patients using the proposed SC will be no more than 10% greater than using current variable concentration infusions over a 24-hour period. Methods - A retrospective review was performed to calculate the 24-hour fluid volume related to IV drug infusions and compare this with the calculated volume that would be administered if SC were used. Conclusion - The majority of SC volumes were <10% greater than those using variable concentrations, which addressed most concerns regarding potential increased fluid intake. These results provided and evidence based approach to implement SC within the institution in order to opimize patient safety.

The Hospital for Sick Children (SickKids) • 547

Parent Attitudes about Disclosure of Medical Error

Numerous studies report that patients almost universally desire full disclosure when harm occurs from medical error. The object of this study was to assess parent's attitudes about disclosure of medical error involving their child to the parents themselves and thresholds for disclosing of the error to their child. Parents of children on the inpatient units and out-patient clinics at a pediatric hospital were surveyed using a questionnaire. Parents want to be informed if any harm (real or potential) to their child is anticipated as a result of medical error. Although the threshold differs, most parents want their children told as well. Ethnicity, previous experience with error and the age of the child all seem to have an impact on parents requirement for disclosure of adverse events to their children.

The Michener Institute for Applied Health Sciences • 549

CAMERA: Mutidimensional Simulation and Assessment

The Centre for the Advancement of Multidimensional Education, Research and Assessment (CAMERA) at the Michener Institute for Applied Health Sciences is being developed to advance multidimensional learning through interprofessional education, research and assessment. CAMERA is the working title for the reconfiguration of two floors at Michener to serve as a 21,000 square foot assessment and simulation centre. The objectives of the CAMERA initiative are aimed at reducing medical errors in clinical practice through the provision of evidence-informed education, enhanced learner preparedness and a significant contribution to the advancement of multidimensional learning and interprofessional education. The research focus of the CAMERA facility includes investigation of the effectiveness of medical simulation as an assessment tool and the formalized inquiry into the psychometric properties of simulation-based performance assessments, providing valuable information to the knowledge base in the field of medical simulation, directly supporting the evolution of interprofessional education and care.

The Ottawa Hospital • 640

Chemotherapy Home Infusion: Improving Access

This project allows eligible patients with colorectal cancer to receive chemotherapy in their home across the Champlain LHIN. This type of chemotherapy regimen is repeated every two weeks over a period of approximately six months. This program makes life easier for patients including: access chemotherapy closer to home; reduction in traveling; increased quality of life close to family members;

and allowing patients to continue their normal routines including continuation of work. CHIPP is a collaboration of interdisciplinary health professionals at TOHRCC, Community Care Access Centres, nursing agencies providing home care and community pharmacies all working together to provide the best care for patients. Patients start their chemotherapy at a clinic, however, can then return home on an pump that gives the drug for 46 hours. A visiting home nurse monitors patient's symptoms, the infusion and disconnects the pump in the patient's home.

Toronto Central CCAC • 642
Community Ethics Project

Under the leadership of the Toronto CCAC, the five CCACs of Toronto, six service provider organizations and one community health centre participated in the project known as Ethical Decision-Making in the Community Health and Support Sector. The project was launched to address the lack of resources within the community sector to help health and support workers to deal with complex ethical issues by developing a common approach to ethical decision-making. The Ethics Project has resulted in the development of a Code of Ethics and Decision-Making Framework as tools for a common, cross-sectoral approach to dealing with ethical dilemmas in the community. A Community Ethics Network, representing a cross-section of community based service organizations is now up and running and ethics in the community is now being added to the education curriculum of health care professionals at all levels of the health field.

Toronto East General Hospital • 240
Patient Simulation for the Entire Health Care Team

Using high-fidelity mannequins a simulation program curriculum was created. Several scenarios were created to address the needs of individual team members as well as communication bewtween team members during critical events. We survey a particular group of health care professionals (eg nurses, physicians, respiratory therapists) and identify their learning needs. A curriculum is then developed and a survey is performed at the end of the training period. We then compare the team member's knowledge and comfort with a particular scenario before and after the intervention. We also measure the effectiveness of communication between team members during critical events. We hypothesize that the simulation program will improve skill level of the entire health care team, improve patient safety and improve the satisfaction af all team members.

Toronto East General Hospital • 242
Who said it was going to be easy?

Toronto East General Hospital (TEGH) is committed to having a 95% electronic patient record by 2010. Part of TEGH's journey was the implementation of electronic allergy documentation as a back drop for the new pharmacy order entry system, and an essential foundation towards Electronic Medication Administration Record and Computerized Physician Order Entry (CPOE) projects. The allergy information collected remains with the patient's information from admission to admission and is integrated with other applications such as Diagnostic Imaging and Scheduling, therefore, providing an allergy alert across systems, enhancing the organization's ability to provide safe patient care. The overall goal was to improve the quality of allergy information collected by documenting all allergens and their reactions. The implementation of this project meant a change of practice for clinicians, additional computerized documentation and required organizational support. TEGH went live with electronic allergy documentation in November 2006.

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

Trillium Health Centre • 644

Getting the Right Mental Health Care with One Call

To respond to community needs of user friendly easily accessed services, Trillium Health Centre partnership with several other providers implemented a central intake service for Child and Adolescent Mental Health Services across the region. Building on the work of Child and Adolescent Mental Health, all the adult Mental Health programs at Trillium and case management services provided by one of our community partners implemented a central point of access for services. The implementation of these services resulted in streamlined access for clients and their families, reduced duplication of services, better match of client needs to services and increased community collaboration.

Thunder Bay Regional Health Science Centre • 646

Most Appropriate First Placement: Goal on Admission

In 2004, we entered the new Thunder Bay Regional Health Science Centre, an amalgamation of two previous sites. In planning for the delivery of services in the medical care services, we created sub specialty units to provide care for specific groups of patients. Soon after the relocation took place, staff indicated that they felt that they were transferring patients more frequently between the units, creating dissatisfaction for both the staff and the patients. Through a quality of care improvement process we examined this move activity and undertook measures to address the issues. With the introduction of a Nurse Admissionist to the Emergency department, we have been able to facilitate the most appropriate first placement of our patients. This action has supported the delivery of quality of care to our patients, decreased utilization of resources, as well as improving both staff and patient satisfaction.

University Health Network • 540

Creating One Model of Quality Care for GIM Patient

The UHN GIM units have embarked upon building recommendations around a GIM model of care to create sustainable improvements to ED-GIM patient flow. An effective Care Model is one that responds to the specific needs of a patient: the required skill set is available when needed, the appropriate clinicians are available when needed and the right mix of interdisciplinary providers is available and established in a way that facilitates patient-centered care through team cohesion and effectiveness. Developing a recommended model of care for GIM requires a 3-pronged approach:

- *Conducting a current state analysis (literature review, benchmarking, workload analysis, unit profiles and nursing care needs review)*
- *Developing recommendations*
- *Creating a roadmap (recommendation, implementation, timelines and cost)*

The development of an overall care model will contribute not only to improved patient flow, but also to enhanced staff and patient satisfaction, quality of care, patient centred care and communication.

University Health Network • 542

Development of a Medication Reconciliation Tool

Medication discrepancies occur frequently at hospital admission and discharge. Medication reconciliation is recognized as an essential process to reduce discrepancies and improve prescribing practices. The University Health Network has developed an electronic tool that facilitates the medication reconciliation process. The Electronic Medication Information Transfer Tool (EMITT) is populated with

patient demographics, allergies and medications from the patient chart. The tool facilitates the documentation as well as the coding of medication discrepancies. EMITT is integrated with the electronic discharge summary application and is able to generate an e-prescription upon discharge. The tool also generates a medication letter, a patient medication grid and a medication wallet card. The success of this project is attributed to the high degree of clinical leadership and involvement throughout the entire development of the electronic tool. It is anticipated that similar electronic models can be easily adopted at other healthcare institutions.

University Health Network • 544
Applying Human Factors to the Procurement Process

In this project, a process was developed to incorporate human factors methods into a hospital's medical technology procurement process. The method was formalized after human factors methods were used to obtain safety and usability performance data on several medical technologies. The Human Factors Informed Procurement (HFIP) process has 11 steps that are a blend of tasks already inherent in a traditional procurement process and human factors methods. The results of employing this process are a clear understanding of the safety and usability issues associated with various products before a purchasing decision is made.

University Health Network • 546
Creation of the Healthcare Human Factors Group

The objective was to create a team of human factors professionals at the University Health Network (UHN) in Toronto to address issues of device, software and environmental design as they pertain to patient safety. Human factors is the study of how people interact physically and psychologically with tools, technologies, processes and environments and is recognized as being critical to patient safety. The mission of this newly developed non-profit team is to make healthcare work for humans through safe, usable and effective technologies and processes. Our vision is a healthcare system that at every stage in its process is informed by human factors principles. From 2002 to 2007 the program has grown to be the largest human factors program dedicated to healthcare in the country with a growing demand for human factors research and services.

University Health Network • 548
Improving Patient Safety Using Real Time Surveys

Over 7% of all patients admitted to a hospital in Canada experience an adverse event, including hospital acquired (also called nosocomial) infections, of which over one third are deemed preventable. Monitoring the way in which healthcare practitioners deliver care in order to reduce the risk of patient infection is the main goal of this project. Project staff use handheld computers to observe how practitioners carry out specific aspects of patient care which are known to often lead to infections. This data is then used to identify which patient units, staff and patients are most associated with such infections and to better target resources at lowering these risks. This data is also used to provide summary data to external agencies relating to the hospital's performance in reducing such infections.

Improving Efficiency Through Process Redesign

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

Carefor Health & Community Services • 332
A Nurse-led Leg and Foot Ulcer Service

In November 2000, a nurse-led community leg and foot ulcer service was developed to improve the healing rates of chronic ulcers, while reducing the cost of delivering care. The new service had core elements: an evidence-based clinical leg-ulcer protocol, nurses dedicated to and trained in ulcer care, stream-lined linkages to specialist physicians for consultation and referral and led by an advance practice nurse. Nurses' skills are central to the success of the service as the nurse completes a comprehensive client assessment to determine the cause of the ulcer, makes treatment decisions and interdisciplinary referral. Strategies have been implemented for ongoing training and leadership development of the entire team to ensure sustainability of the program. One-year post implementation healing rates had improved dramatically for all types of ulcers. Efficiency of the service was demonstrated by a reduction in the number of nursing visits and in the cost of dressing supplies.

CECCAC, TSH and Projects with MOHTLC • 334
Bridging the Gap: Connecting Healthcare Providers

Clients moving from hospital to home often find themselves repeating personal information several times when dealing with healthcare organizations. This is onerous for the client and the healthcare professional as both want to be concentrating on client health concerns, not collecting demographics. A comprehensive analysis was conducted, concluding that changes should be made to refine existing processes and use approved standards. As well, a need was identified to integrate the independent systems together to enable efficient sharing of client information. CECCAC, Scarborough Branch, TSH and MOHLTC then joined forces in an initiative called the Client Transfer Collaboration Project (CTC-P). The project has addressed:

- *Refining/automating/existing business processes*
- *Connecting various systems*
- *Effectively transmitting client data throughout the healthcare continuum*
- *Healthcare providers in Scarborough enter client data only once and electronically share that information safely and securely with the hospital, CCAC and the service provider community, as required.*

Centre for Global eHealth Innovation, University Health Network and Mt. Sinai Hospital • 329
Facilitating Patient Self-care via Tele-monitoring

The goal of this study was to improve chronic disease management by developing a home tele-monitoring system that uses medical devices (eg. blood pressure monitor, blood sugar meter, weight scale) and a mobile phone. A program running on the mobile phone relays measurements back to a data repository, where rules are applied and alerts are generated. Alerts are sent to the family doctor by fax and to the patient on the mobile phone. The system is designed to not only detect trends in home readings that require attention, it also reminds patients to take their measurements if they fail to adhere to the preset schedule. These adherence messages are sent directly to the patient's home phone. A four month pilot study of the system was conducted with diabetic patients with high blood pressure. Over the four months, overall blood pressure dropped significantly and patient adherence to monitoring exceeded expectation.

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

Dryden Area Family Health Team • 331

"It's Your Health!"

Finalist

The Dryden Area Family Health Team has designed a program branded "It's Your Health!" The program is divided into sections: Healthy Living, Manage your Health and Your Health Toolkit. Each component of the program recognizes the need of the patient by providing group/individual care. "Healthy Living" is a health promotion/prevention group based service providing education on exercise/nutrition, disease screening, immunization, stress/relaxation, safe medication, healthy weights, smoking cessation, alcohol guidelines and healthy new beginnings (pre/post natal). "Manage your Health" is group based focusing on chronic diseases and related issues including COPD, arthritis, hypertension, mental health (anger management and a mental health day program) and a nutrition program to prevent/reduce weight related complications. "Your Health Toolkit" is individual appointments with the appropriate provider based on the needs of the program. Patients flow in and through the program based on the needs and care plan as determined by their FHT healthy assessment.

GTA Rehab Network • 333

Defining Evidence-Based Parameters for Rehab

In response to a changing rehab landscape in which rehabilitation is offered in many different settings with variations in service scope, the GTA Rehab Network is leading the way in defining and standardizing the core components of rehabilitation across the care continuum using evidence-based parameters. The initiative involved the creation of a new conceptual rehab framework to delineate the services, differential criteria and key activities of rehabilitation and the development of standards of practice for specific rehab populations. The goals of this initiative are to increase consistency between rehab programs so that clients and referrers are better equipped to make referral decisions; streamline the referral process; establish evidence-based standards of practice for performance measurement; lay the groundwork for consistency among rehab programs to enable discussions around supply, demand, resourcing of rehab programs and contribute to system planning and support advocacy activities for equitable and timely access to quality services.

Hamilton Health Sciences – Henderson Site • 335

MOH-LTC Critical Care Coaching Site

Hamilton Health Sciences has responded to patient flow and bed capacity pressures at its Henderson Site by launching a Patient Flow Innovation and Learning Site. This HHS Corporate Strategic Initiative is supported by an executive lead and the expert quality and process improvement resources of HHS Clinical Appropriateness and Efficiency (CARE) Program. Particpation by Henderson ICU in the MOH-LTC Critical Care Patient Flow and Inter-unit Coordination Performance Improvement Collaborative (supported by an MOH-LTC Critical Care Coaching Team) was aligned with other sub-initiatives within the Patient Flow Innovation and Learning Site to contribute to the overarching aim of ensuring that the right patients have access to the right care at the right time, in the right place and by the right provider. Within a recognized quality improvement framework, key ICU stakeholders worked together and collaboratively with system-level stakeholders to develop, implement and evaluate, tests of change within rapid cycles of improvement.

Holland Orthopaedic & Arthritic Centre, Sunnybrook Health Sciences Centre • 328

New Assessment Model for Hip & Knee Replacement

Co-Finalist with 330

The Holland Orthopaedic & Arthritic Centre is striving to improve access and reduce wait times for patients referred for hip and knee

replacement surgery. There is now a central point of contact for all patients being referred for surgery. Patients receive prompt appointments where they attend a clinic and are assessed by Advanced Practice Physiotherapists and specially trained Registered Nurses who provide education and confirm that the patient is a surgical candidate and wishes to proceed with surgery. By creating new roles for health care professionals such as the Advanced Practice Physiotherapist, the Holland Centre is maximizing available human resources to offset shortages in other areas (eg. orthopaedic surgeons). Improving access and managing wait times for hip and knee replacement patients is a priority of the Toronto Central LHIN and is aligned with the Ontario Wait Time Strategy and the Ontario Health Human Resource Strategy.

Holland Orthopaedic & Arthritic Centre of Sunnybrook Health Sciences Centre • 330

Innovative Role: Advanced Practice Physiotherapist

Co-Finalist with 328

An innovative strategy was created to improve system efficiencies and assist with addressing the waitlist crisis in hip and knee replacement. An Advanced Practice Physiotherapist (APP) role was created to provide assessment prior to surgical consult and post-operative follow up allowing surgeons to devote more time to the operating room and seeing new patients. A theoretical framework for the development and implementation of an advanced practice nursing role was applied. Buy-in has been achieved and medical directives support the new role. APPs are seeing 15-20 patients per clinic day. A nine item satisfaction survey has been administered to over 120 patients selected from surgeon led clinics and APP led clinics. Satisfaction was high and no significant difference (p=0.782) was observed between the mean satisfaction scores. The arthroplasty APP role is a viable strategy to support the non-surgical care traditionally performed by surgeons and has contributed to wait list reduction.

North York General, Markham Souffville and York Central Hospitals (partnership) • 428

Total Joint Assessment Centre (TJAC)

The TJAC is a partnership between North York General, Markham Stouffville and York Central Hospitals. This innovative project is a strategy to reduce wait time for total joint replacement surgery. A comprehensive assessment is done by a clinician during the first visit. This allows for triaging, so that surgical patients proceed quickly to a second visit (surgical consultation). First visit includes education regarding the disease process, a plan of care and treatment options for non-surgical patients. For surgical candidates, education is provided regarding the procedure, risks, benefits and before and after care. Patients and families involvement is fostered by involving them in the treatment plan. Patients deemed surgical can choose between the surgeon with the shortest wait list, participating hospital and/or surgeon. Project evaluation encompasses quantitative data including volumes and wait time data and qualitative data on patients, GP's and surgeon's satisfaction with the clinic, using evidence based survey tool.

Northeast Mental Health Center, North Bay Campus • 430

Regional Specialized Outreach in Mental Health

The Regional outreach services of the Northeast Mental Health Center, North Bay Campus are an innovative approach to specialized mental health care within a large rural and diverse population of Northeastern Ontario. These include an array of assessment, treatment, education and consultation services designed to meet the needs of individuals with developmental disabilities and mental illness, senior's mental health problems, individuals with concurrent substance abuse and mental illness and individuals with an early episode of psychosis. The services were developed using a "Hub and Spoke" model designed to ensure best practices in specialized mental health care are disseminated and implemented consistently. The results of the services demonstrate better access to care and reduced need for inpatient hospital admissions when the client requires specialized mental health care. This is extremely important in the region due to the distances clients would have to travel to access services at a regional hospital.

Improving Efficiency Through Process Redesign

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

Saint Elizabeth Health Care • 432
Workload Measurement in the Community: Responding with Innovation

The purpose of this project was to conduct an in-depth workload analysis of nurses, including Registered Nurses and Registered Practical Nurses, working in a primary provider model of care delivery in the community setting. A number of nursing workload measurement systems have been reported, but most are descriptive in nature and most do not measure the activities of community nurses. This study obtained high quality and timely data to assist decision-makers to understand the complex components of nursing care delivery. This resulted in the development of a new model of care delivery that improved the overall working environment for nurses, while achieving client outcomes in the community.

South West Community Care Access Centre • 434
No Stone Unturned: Overhauling Work Processes

The London Office of the South West CCAC completed an intensive review and modification of all work flow and communication processes in order to adopt a paperless system of documentation and communication. Consensus decision making and a whole organization approach to gathering input and revising the work processes was very time consuming but certainly time well spent. With a future vision in mind the group agreed to move to a new electronic information exchange tool (portal). In addition, an electronic assessment form was developed and implemented so that all CM, (including off site and hospital based staff) complete assessments electronically. The electronic assessment tool also facilitated integration of the CIAT, RAI and PMI and FORTIS data base. The change not only affected internal staff, but all service providers and LTC changed over to receiving client information electronically through a portal.

St. Joseph's Care Group and Thunder Bay Regional Health Sciences Centre • 529
Thunder Bay Mental Health Programs Common Intake

The three main outpatient mental health psychotherapy and psychiatry service providers in Thunder Bay collaborated to improve access to services for consumers. By developing a common referral form, intake and waiting list, these three providers came together to create Thunder Bay Mental Health Programs. In addition, all three programs clearly defined the services they provided, thus allowing for the development of a continuum of outpatient mental health care. The creation of Thunder Bay Mental Health Programs has allowed for a new common intake system where consumers and referents have easier access to the services they require and seamless movement within the system to address changing client needs.

St. Joseph's Health Care, London • 531
The REACH Home Care Delivery System

REACH is an advanced, new type of medical home care delivery system. It differs from most other home care systems in that it is specifically designed to monitor the health and medication compliance of persons who have severe mental illness and are treated at home on an outpatient basis by Assertive Community Treatment (ACT) teams. REACH can reduce the treatment cost by more than 20%, while significantly increasing the quality of treatment and satisfaction.

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

St.Joseph's Healthcare, Hamilton • 533

Does Competency Based Orientation increase the Clinical Competency of New Orientees in the Mental Health Setting?

Objective: Competency Based Orientation (CBO) is a method to facilitate the acquisition and application of clinical knowledge, skills and attitude. The recent revisions of the Standards of Psychiatric and Mental Health Nursing Practice warranted a thorough evaluation of the CBO with subsequent redesign. This project will describe an evaluation of the current CBO in Mental Health and Addiction Program at St. Joseph's Healthcare, Hamilton. Methods: Before-after experimental design, which involved the administration of subjective and objective measures pre and post orientation. In addition, clinicians were given the opportunity to provide feedback on their orientation experience. Results: Results show significant improvement in the competency level of all orientees. Results also display that orientees with previous experience that undergo CBO report significantly higher pre self-assessment scores. Conclusions: CBO must be looked at as a valuable tool for orientating mental health clinicians and for ensuring safe and competent patient care.

St Joseph's Health Centre • 535

Patient Access and Flow Demonstration Project

The current growth in the volume of emergency room visits coupled with the growth in demand for inpatient medicine beds will outstrip SJHC's present ability to admit, treat and discharge patients. Further to this, patients are waiting longer than necessary for care in the emergency department (ED) (Schwartz, 2006). As such, in November 2006, the hospital embarked on a major demonstration project to significantly improve patient access and flow from the ED through the general medicine continuum. Interdisciplinary working teams gathered input from staff across the hospital to develop solutions for the ED, admissions and discharge processes to improve both the patient and staff experience. Within two months of implementing system wide-improvements, the team achieved reductions in key wait times throughout the ED and medicine unit admission and discharge process.

St. Joseph's Care Group • 628

Right Care, Right Time, Right Place

Concerns with efficiency of admission processes and complex continuing care/rehabilitation bed utilization within the North West Region prompted St. Joseph's Care Group to complete a service review in 2005. From within existing resources, the admission process was redesigned to accommodate new roles and reduce variation. Partnerships with the local acute care facility (Thunder Bay Regional Health Sciences Centre) and the North West Community Care Access Centre were required to operationalize the redesigned process now in place for one year. Implementation has reduced all of mean admission wait time to complex care/rehabilitation services and both alternate level of care days and surgical cancellations for our acute care partner. New referral patterns decrease delays in admission to long term care from acute care and the number of facility transfers for clients destined for long term care. Increased measures include case mix index and utilization of convalescent and interim long term care beds.

St. Michael's Hospital • 429

Technologist Led PICC Line Insertion Program

This program trains a registered technologist to insert PICC lines which tradionally have been inserted by a physician and in doing so decreases the wait time for the patient. The PICC line can be used to give patients treatments such as chemotherapy, antibiotics and intravenous fluids and feeding. It can be used to take samples of blood and the patient can go home with the line in place. Since the PICC line can be left in place for long periods of time, the patient can have treatments without having to endure multiple needle

insertions. This is very advantageous for patients who have small veins that are difficult to access. It means much less pain and inconvenience to the patient. Since implementation, in most cases, a PICC line may be inserted on the same day as the request, enabling faster treatment and decreasing the length of stay in the hospital.

Sunnybrook Health Sciences Centre/University Health Network • 433

Improving Continuity of Care: Electronic Sign-out

Finalist

Continuity of care or the transfer patient care from one provider to the next, referred to as patient sign-out, occurs on a daily basis. Transferring pertinent clinical information such as past histories, medications and other issues of concern is essential to this process but without mechanisms in place to ensure this transfer occurs efficiently, care becomes fragmented and patient safety is compromised. In response to this issue, Sunnybrook Health Sciences Centre designed and developed a web-based electronic sign-out application. The application is simple to use and can be accessed by multiple users from any PC with internet access, essential considering sign-out for most clinical teams occurs at the same time. The electronic sign-out application is now being used by virtually all services across Sunnybrook. The University Health Network (UHN) partnered with Sunnybrook to develop a similar solution and the same trend is being seen in other teaching hospitals across the GTA.

The Credit Valley Hospital • 435

Credit Valley Emergency: Rapid Assessment Zone – C

The approach to managing patient throughput and system factors associated with ED wait times were the primary focus of this Six Sigma initiative to evaluate efficiency of processing CTAS III patients. The project was initiated in January 2005. Process mapping, root cause and statistical analysis of delays resulted in redesign of the process through the collaboration of stakeholders, literature review, site visits and organizational action planning. The outcome was a redesign from sequential to parallel processing with a devoted CTAS III rapid assessment area called RAZ. Dedicated physician coverage in RAZ was necessary to achieve the length of stay (LOS) reduction goal. Results demonstrate a decreased LOS from 315 to 277 minutes, left without being seen from 9.5% to 5.2% and triage to MD assessment from 169 to 137 minutes comparing January to December 2006. This improvement in efficiency through process redesign demonstrates innovation in providing Emergency Department care at CVH.

Toronto ABI Network • 534

Improved Integration Through Regional Coordination

Given the complexity of ABI services in Toronto and the challenges that providers, families and clients faced in negotiating the system, a regional coordinator role was established in 1995. Through the regional coordination office (housed within the Toronto ABI Network), stakeholders were convened to identify and clarify the key issues of access and to develop an appropriate response. Over a 17 month period, the Network achieved consensus on standardized referral and response processes and a centralized wait list. The redesigned referral process was implemented with full buy-in from all parties. The trust that was established through this collaborative process served to strengthen the implementation of the change process. The centralized referral system, with one point of contact, increased referral efficiency and ensured that people get to the right service. Further, it reduced the likelihood that an individual will get lost in the system by ensuring access to follow-up.

Exhibitors

Improving Efficiency Through Process Redesign

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

Toronto East General Hospital • 634
My Story: Colouring the Patients' World

The My Story idea was adapted for TEGH as an interdisciplinary staff project during a leadership development program supported by the hospital. It exemplifies the hospital's vision for patient-focused care and its commitment to patient satisfaction. My Story is a tool used by the patient or family members to highlight the details of the patient's life that are not always captured in clinical documentation, such as hobbies, favourite things and relationships. My Story is posted at the patient's bedside and can be viewed by all caregivers attending to the patient. My Story was initially piloted on palliative care and surgical units. Our own staff created a powerful and moving video to introduce My Story to TEGH. The My Story tool has had a profound effect on staff and patient and family response has also been extremely positive. TEGH is now committed to implementing My Story in all patient areas.

University Health Network • 528
Improving OR Workflow via Process Redesign

The University Health Network (UHN) has identified the need to transform its Operating Rooms (ORs) into higher performing clinical areas by implementing sustainable process redesign strategies aimed at enhancing quality of care, the patient experience and efficient operations. Initiatives within the OR Transformation Project are currently underway to ensure that these goals are realized. The methodologies used to improve and standardize processes and the outcomes for the following initiatives will be reviewed: 1) Redesign of the OR Day, 2) Optimizing Central Processing Department (CPD) processes, 3) OR Patient Coordination and Turnover and 4) Preoperative Patient Assessment Process. Moving forward, the goal is to sustain the changes implemented in the Perioperative departments via standardized reporting practices and accountability framework.

University Health Network • 530
Improving the Clinical Workflow

It was observed that much variability existed in processes. In addition, many bottlenecks in patient flow were identified which eventually lead to wait times throughout the overall process. A need to decrease the lead times of various bottleneck sub-processes was identified. A high-level workflow analysis of patient flow from the ED to GIM units was undertaken through the use of value stream mapping or VSM. Several initiatives were identified from this analysis such as 18/7 Ultrasound. The objective of this intervention was to increase the availability of Ultrasound after regular hours of operation for urgent cases, thereby decreasing turn-around times from the time of order placement to result reported. To accomplish this new processes, roles and schedules needed to be identified. A 46% decrease in turn around time was observed. This resulted in increased and timely access to ultrasound procedures and quicker result turn around time due to better utilization.

University Health Network • 532
Improving the Clinical Work Environment

The Emergency Departments at the University Health Network recognized that a great deal of time, about five hours a day, was being wasted searching for supplies and equipment: time that could otherwise be spent on direct patient care. Their goal was to create and maintain an organized, clean, safe and efficient workplace to build and sustain smooth, efficient patient flow and care. This was accomplished by standardizing workspace, supply areas and equipment practices in key areas of the department using lean 5S+1 methodologies in a weeklong focused Rapid Improvement Event. Solutions were designed, implemented and sustained by an

interdisciplinary clinical team who learned the lean methodologies and applied them to their own Work Environment. They reduced wasted time searching for supplies and equipment by over 50%, created more space in their department (142 square feet), improved staff satisfaction by 14% and improved their 5S+1 audit score by 18%.

Whitby Mental Health Centre • 630

Electronic Conferencing Moving Forward

Whitby Mental Health Center has created an electronic conference (Team Conference and Team Discharge Summary) application that captures professional assessment information from the Resident Assessment Instrument Mental Health v2.0 (RAI-MH v2.0). The Team Conference and Team Discharge Summary provides clinical transformation through technology. It compares the assessments to identify Resolved, Repeated and New items that the health care team should explore in a more in-depth fashion. This format allows for the client and the health care team to assign goals to problems and identify various interventions to assist in meeting those goals. The electronic Team Conference and Team Discharge Summary Report encompasses the PsychoSocial Model of care and is specific to our mental health population. It allows the health care professionals to evaluate the interventions provided and modify the plan accordingly thereby improving patient outcomes.

Whitby Mental Health Centre • 632

An Integrated Hospital Approach

- *Mental Health Centre: An Integrated Hospital Approach*
- *Navigating new waters from a Provincial Psychiatric Hospital to a Public Hospital with a Mental Health Specialty*
- *Navigating new waters - a Central Intake process.*
- *Charting a New Course - Specialized Outreach Services*
- *Managing Patient Flow - Centralized Bed Management*
- *Exploring New Opportunities - Discharge Planning*

Innovations in Health Information Management

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

ConnexOntario Health Services Information • 400

ConnexOntario eServices: A Sector Resource Portal

ConnexOntario eServices allows organizations in the addictions, problem gambling and mental health sectors to provide required program and availability information to ConnexOntario Health Services Information through a user friendly web portal. This method of reporting provides stakeholders timely access to current descriptive program information as well as capacity and wait time data. This electronic portal also provides secure access to important planning information for key stakeholders such as the MOHLTC, the LHINs, researchers and the participating organizations. ConnexOntario eServices offers various useful tools which include a searchable electronic organization contact directory and the ConnexOntario Dashboards. For those with access, the ConnexOntario Dashboards displays valuable real time information by extracting data from the ConnexOntario database as changes are reported within the service sectors.

Continuing Care e-Health Program • 402

One Person One Record: The Road to Seamless Integrated Community-Based Care

The Continuing Care e-Health Program plays a critical role in improving the health care system for care providers, patients and clients. It is supporting community and home-based health care services with standardized tools they need to work more efficiently and provide better quality care to their clients. The CCeH Program is closely aligned with the Ontario's e-Health Program and the LHIN e-Health strategy to reach our goal of One Person One Record. The Programs technology solutions:

- *Make it easier and faster for patients to move through continuum of care*
- *Maintain timely, consistent and accurate information to provide better patient and client care*
- *Equip care providers with tools to collect and share meaningful information securely*
- *Facilitate better resource management achieved through monitoring and reporting of data to ensure health care dollars are spent efficiently*

Department of Family Medicine, McMaster University, Hamilton and Fig.P Software Incorporated • 404

P-PROMPT

Finalist

P-PROMPT is an innovation in information management for primary care physicians, nurse practitioners, nurses and their office staff that greatly helps them to systematically keep all of their patients always up to date with several key and potentially life-saving preventive care services, including pap testing for cervical cancer every two years in women aged 35 to 69, mammography screening for breast cancer every two years in women aged 50 to 69, influenza vaccination every autumn in seniors aged 65 and over and completion of primary childhood vaccinations in children by age two. P-PROMPT clearly displays the patients who are now due for a procedure, so that they can be recalled and scheduled in. P-PROMPT also mails timely reminder letters to overdue patients. P-PROMPT was tested with 249 physicians and their teams and showed large improvements in the percentages of patients who were kept up to date with their preventive care.

Heart and Stroke Foundation of Ontario HSFO • 408

Primary Care Chronic Disease Decision Support

Hypertension is the most common reason for primary care visits. The project aims to equip health care providers with a toolkit to help them work with their patients to better manage and control hypertension. Since health care providers maintain patient information in

paper charts or in electronic records, collecting information about enrolled patient becomes difficult to achieve. The difficulty is even greater when one takes into consideration busy and fast-paced practices. The Heart and Stroke Foundation of Ontario has developed a web-based data set that is capable of accepting information faxed, manually entered and received from electronic medical charting systems. This information is available only to the corresponding provider and will be used to generate practice audit reports to help practitioners enhance their practice.

Information and Privacy Commissioner/Ontario • 410

Short Notices under PHIPA

The IPC and the Ontario Bar Association collaborated to develop short notices for health care professionals in Ontario, who have had to comply with PHIPA since November 2004. This legislation requires that health care providers notify patients how their personal health information can be collected, used, or disclosed. Physicians, hospitals, long-term care facilities can do this by posting short notices, which are a condensed privacy notice written in plain language. They can distribute the accompanying brochure to patients who would like more information. The colourful posters and brochures are intended for three types of health care providers: health care practitioners such as physicians or chiropractors can post and distribute Your Health Information and Your Privacy in Our Office; long-term care homes use Your Health Information and Your Privacy in Our Facility and hospitals rely on Your Health Information and Your Privacy in Our Hospital.

INET International Inc. • 412

Telemedicine: Supporting Diabetes Self-Care

The Dr. Silver-INET collaboration created the INET Wireless Diabetes Program. Its primary objective is to prevent diabetes related complications with better control of glycemic levels, measured by HA1C. The secondary objective is to realize a tremendous cost savings with more efficient use of doctors and nurses time. The core component of the program is the relationship between healthcare professionals and patients supported by a wireless diabetes management protocol. This protocol describes how a patient can enter their glucose readings into their cell phone and transmit the results to their healthcare professional. The protocol further details how the healthcare professional, in turn, is able to monitor any number of patients on his/her PC or PDA device. A healthcare professional, if required, can take immediate action with a message electronically sent to the patient's cell phone.

Leamington District Memorial Hospital, Chatham Kent Health Alliance & Ontario Telemedicine Network • 401

The Virtual Psychiatric Emergency Room

Finalist

The project involved establishing a unique partnership within the LHIN that included a rural community hospital, Leamington District Memorial Hospital (LDMH); a psychiatric health care facility, Chatham Kent Health Alliance (CKHA) and the Ontario Telemedicine Network (OTN). The partnership created a virtual specialized psychiatric/mental health program at LDMH's Emergency Department. When a patient with a mental health/emotional crisis presents in the LDMH Emergency Department, the ED staff contact the on duty mental health crisis nurse at CKHA. The mental health crisis nurse assesses the patient at LDMH by conducting a virtual real time interview using video-conferencing technology. Based on the nurse's assessment, recommendations are made to LDMHs ER nurse/physician regarding proposed patient care. If the crisis nurse assessment suggests the patient requires a psychiatric admission, she liaises with the on-call psychiatrist at CKHA to make arrangements for direct admission there.

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

Ministry of Health and Long-Term Care/Ministry of Health Promotion • 411
Smoke Free: Using Technology to Break the Habit

The Tobacco Inspection Data Collection Tool was deployed in May 2006 in support of the Smoke-Free Ontario Act. It provides the Public Health Units and the Ministry of Health Promotion with the tool to track and monitor activities related to tobacco purchases and consumption. TIDCT is a web-based application, which is easily accessible through www.PublicHealthOntario.ca. The public health inspectors collect data on paper forms and then the information is entered into the province-wide database. A mobile version (Tablet PC) is also being piloted, with the intent that public health inspectors will switch from paper-based forms to electronic forms in the future. This will give inspectors immediate access to historical data while they are in the field.

Princess Margaret Hospital, University Health Network • 405
Provincial Synoptic Operative Reporting Project

Epithelial ovarian cancer (EOC) is the deadliest of all gynecologic cancers. Comprehensive documentation of operative surgical findings as well as the nature of the surgical procedure is crucial in evaluating prognosis of ovarian cancer patients and in assisting in the decision to offer further therapy. Current operative documentation process which involves a surgeon dictating a note does not allow easy access to data and its analysis. Gynecologic Oncology Group of Ontario is conducting a pilot that involves collecting surgical data electronically at the time of surgery utilizing Princess Margaret Hospital's eCANCERovarian electronic note automation tool. This innovative approach to documenting health care is the first time in Ontario that surgeons in separate hospitals and LHINs will be using the same technology to capture relevant surgical data that in turn will be used to evaluate quality of care. If successful, this process will be extended to other surgeons and hospitals.

Public Health Division, Ministry of Health and Long-Term Care • 413
The Power of Portals: Transforming Public Health

The Public Health Portals encourage a new way to communicate. Implemented in April 2005, www.PublicHealthOntario.ca and www.eHealthOntario.ca operate within a secure environment to provide public health and eligible broader health sector organizations with a range of products and services at no cost to the end user. They are innovative because prior to this, there was no central location for public health professionals in Ontario to communicate, share information and work together over the Internet in real time. The Collaboration Tool has allowed 100 groups to establish e-Communities, with 6,000 individuals registered or in the process of registering. The portals provide access to the Ministry's alerting system, which can transmit Important Health Notices to 31,000 health providers within hours in a health emergency. Public health inspectors use web-based applications such as the Tobacco Inspection Data Collection Tool. A Virtual Library provides access to scientific journals and searchable databases.

Shared Information Management Services (SIMS) Partnership • 407
Integrated Diabetes Patient Portal

The SIMS Partnership Diabetes Patient Portal is a major step forward to realizing the vision for building a chronic disease management infrastructure that links the continuum of care across the SIMS Partnership. Diabetes is a complex condition where a patient must navigate the health care system, work with members of his/her health care team and perform daily self-management activities to achieve optimal health outcomes. The Diabetes Patient Portal provides a single point of access to personalized health information, care and treatment plans, education and links to community programs for patients with Type 2 diabetes across nine different healthcare organizations. The Diabetes Patient Portal is intended to empower patients and improve patient-centred health

outcomes by substantially increasing patients direct involvement and engagement as active members of their care team. This project leverages the technical infrastructure developed for the PMH Breast Cancer Survivorship and Tri-LHIN Chronic Kidney Disease Patient Portal.

Sunnybrook Health Sciences Centre • 409

Leveraging Hospital Systems for IM

Since the objective of the Decision Support (DS) department at Sunnybrook Health Sciences Centre is to fulfil the information needs of the organization we have embarked on a series of initiatives that will greatly improve our ability to obtain timely, reliable access to quality data throughout the hospital. These include: 1. Data Warehouse (DW) 2. Case Costing System 3. Budgeting Solution 4. Business Intelligence (BI) Tools 5. Key Performance Indicators (KPI) and Corporate Scorecard. Together these five elements provide great analytic power to DS and the hospital as a whole. This will better manage our valuable and scarce resources while improving patient care.

Thames Valley Family Practice Research Unit • 502

International Classification of Primary Care

Finalist

The workload of family physicians can be described using standard measures. This allows us to more effectively characterize primary health care. Currently, this information is not available through sources such as the Ontario Health Insurance Program billing data. Therefore, we set out to describe the workload of 29 family physicians participating in the Delivering Primary Healthcare Information (DELPHI) project. The DELPHI project established electronic health record (EHR) infrastructure in primary health care practices with the goals of: 1) creating a researchable primary health care database, 2) improving information sharing in an interdisciplinary care setting and 3) to describe, assess and improve the quality and continuity of primary health care delivery. Providers used the International Classification of Primary Care (ICPC-2-R) to code diagnoses, reasons for encounter and episodes of care within their EHR. ICPC-2-R is internationally recognized for its ability to capture symptoms and non-disease conditions specific to primary care.

The Credit Valley Hospital • 504

CVH's Electronic Performance Monitoring

On April 1st, 2006, The Credit Valley Hospital (CVH) launched its first electronic performance measurement tool in the form of a Balanced Scorecard system (BSC) using a unique integrated electronic dashboard. The initial roll-out was at the Corporate and Board levels. The BSC was based on CVH's Quality Framework and organizational strategic goals. It was designed to be used as a performance management system and a measurement tool that enables the organization monitor it's Mission, Vision, Values as well as its strategic goals and translate them into action. The outcome of the scorecard is presented in a user-friendly integrated and electronically accessible dashboard. This format allows leadership and staff to view performance on a quarterly and fiscal year basis and to communicate the results within the organization in an effective and timely manner.

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

The Michener Institute for Applied Health Sciences • 506
Digital Slide Technology (DST): The New Frontier

Traditionally, the microscope has been used in the Medical Laboratory Science (MLS) Program for diagnostic and educational purposes in the area of microanatomy for histology, hematology and cytology. The evolving area of digital slide technology (DST) is now providing other innovative avenues to enhance learning and clinical preparedness in the area of MLS. Its employment could translate into increased student accessibility, increased student and faculty synchrony through viewing the same digital images, flexibility between static (glass) images and dynamic (digital) images and reduced tutorial time. The Michener Institute has embarked on an initiative to be the first post-secondary institution dedicated to allied health to incorporate DST into the MLS Program as a learning enhancement tool. With this new evolving technology Michener aspires to eventually create one of the most comprehensive digital slide databases in Canada and expand its application of DST to all the sub-disciplines of MLS.

University Health Network (UHN) • 508
Empowering Clinician with Information

The Communication of Information portfolio is one of six themes for the ED-GIM project. The overall goal of the project is to improve patient care and patient flow through sustainable interventions in the Emergency Department and General Internal Medicine units. The methodologies used will be packaged and shared with hospitals across Ontario in the form of a toolkit. The portfolio supports providers in their day-to-day activities through visual displays and indicators to help them better manage patient flow. The visual indicators communicate the past, current and future activity on the ED-GIM units as a whole. Moreover, these indicators are used to standardize information and to help manage the daily processes more efficiently. Prime examples of the tools used under this portfolio include an electronic Inpatient Whiteboard, a communication tool that displays real-time patient care plan in a centralized location and a monthly Dashboard that displays key process indicators.

University Health Network • 510
Strategy Focused Org, Balanced Scorecard Method

The Balanced Scorecard (BSC) was designed to address a critical shortcoming in traditional management systems: the inability to link long-term strategy with short-term measures. This inevitably left a gap between the development of strategy and its application. The theory of the BSC signals a shift from a singular focus on the measurement of performance, to the management of strategy. The BSC establishes strategy execution as a core competency within the organization. At UHN, the Balanced Scorecard framework for goal setting ensures that all teams/departments are working towards collective goals. It is framed to be more responsive to the organization's purpose statement. By plotting common directions, the organization's vision- to achieve global impact- can be attained. The Balanced Scorecard at UHN is an evolving framework that is highly responsive to the needs of the organization. Annual revision ensures that the right things are being measured in the right way.

VON Canada • 512
Stay@Home with VON: A TeleHomecare Project

This collaborative project between VON Canada and the Erie St. Clair CCAC, involves intensive monitoring of 25 people with type II diabetes at high risk for hospital or emergency room visits. Eligible participants take part in a six-week, peer-led Chronic Disease Self-Management program based on the Stanford University model. A community-based physical activity component and disease

specific education by health professionals is included. Client self-management is enhanced through technology-enabled daily monitoring of weight, blood pressure and blood sugar. Telehome monitoring equipment installed in the home enables real time transmission of data to a central station for review by a registered nurse. Proactive interventions to address changes in the client's status are initiated to prevent a health care crisis. All data is stored in an electronic client record that can be viewed by the client and the interdisciplinary team via a secure portal.

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

Central Local Health Integration Network (LHIN) Health Human Resources Committee • 200
Central LHIN Human Resources Collaboration

A new Committee has come together to address health human resources issues in the Central Local Health Integration Network (LHIN). Ten priority issues were identified and projects have been established to work on the first two: recruitment and training. The providers in the region are holding a joint Career Fair in March and exploring group purchasing of internet recruitment advertising. Joint training is being planned including the use of the provincial telemedicine network to reduce cost and make it easier for more staff to participate. While these project teams develop regional recruitment and training initiatives, the Committee will work with the service planning committees of the LHIN to help implement the Integrated Health Service Plan. Support will be provided to the service planning committees to help them identify the health human resource implications of their service integration plans and the actions needed to be successful.

Huron Family Health Team • 202
HealthKick Huron
Finalist
HealthKick Huron is putting into action a model for healthcare human resources development, investment and recruitment that is suited to rural communities. The model looks to encourage youth to pursue healthcare careers, develop the skills of the current healthcare workforce to meet demands of skill shortages and to develop resources and capacity of the local communities to participate actively in the recruitment and retention of healthcare professionals. Innovative and flexible, this project model seeks to evolve over time and incorporates diverse partnership strategies to enact its local initiatives.

Med-Emerg Inc. • 204
HHR Planning for an Influenza Pandemic

Many organizations have warned that a flu pandemic could be a major public health catastrophe. In order to effectively deal with such a crisis, it is important to do as much advanced planning as possible. In collaboration with the Ontario Ministry of Health and Long-Term Care, we have developed a health human resources planning framework and planning handbooks for planners, health care providers and volunteers. The framework starts with a catalogue of every competency which will be necessary during a flu crisis (site management, intubation etc). Once a list has been completed, planners then examine which care providers (nurses, physicians, volunteers etc.) can provide the needed competency. This framework and the tools which support it, will allow local planners and other key health decision makers to develop in advance, effective plans for dealing with the increased pressure on the public health system which a flu outbreak will cause.

OMNI Health Care Ltd • 206
Scope of Practice for Non-Registered Staff

Our non-registered staff are usually the first set of eyes in identifying well being among our residents due to giving them their primary care. By enhancing their skills we would be ensuring our residents lead healthier lives with less risk, have registered staff that have more time to focus on clinical needs, increase interaction among the teams in the homes and decreasing the need for copious meeting to meet MOHLTC standards while ultimately empowering our people to be all they can be.

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

St. Michael’s Hospital/The Hospital for Sick Children • 101
Advanced Clinician Practitioner in Arthritis Care

The ACPAC (Advanced Clinician Practitioner in Arthritis Care) Program is an innovative academic and clinical, interdisciplinary training program in advanced musculoskeletal/arthritis care offered to experienced Physical and Occupational Therapists across Ontario. The program is hosted by St. Michael's Hospital in collaboration with The Hospital for Sick Children, Toronto, Canada. The ACPAC program was developed in response to the well-recognized need for an interdisciplinary approach to better manage patients presenting with osteoarthritis (OA) and in the early detection of rheumatoid arthritis (RA). The ACPAC program has its focus in the orthopaedic and rheumatology fields and consists of material delivered in episodic format over ten one-week/month sessions offered September-June, inclusive. There is rigorous and extensive trainee and program evaluation. The ACPAC program aims to maximize skill sets of physical and occupational therapists with advanced musculoskeletal training in order to offset health care resource shortages of traditional arthritis care specialists in Ontario.

St. Michael's Hospital • 103
The Difference A People Strategy Makes

Serving with compassion. At St. Michael's Hospital, this mandate means more than showing compassion for patients; it includes caring for staff. Through the People Strategy, a compelling three-year human resources initiative, staff from across the organization has been actively engaged in improving workplace culture and mapping out the hospital's future. Since launching in 2005, more than 250 employees have volunteered their time and ideas to developing and implementing 50 People Strategy recommendations in the areas of safety, work-life balance, leadership and recruitment. Innovative in its approach of organizational engagement and unprecedented at SMH for the use of cross-functional teamwork on this scale, the People Strategy has given employees a voice and ownership in enhancing the Hospital's work environment and future. With completion wrapping up in June 2007, the People Strategy's presentation will highlight its objectives, structure, staff engagement methodologies, project achievements and results.

St. Michael's Hospital • 105
A Culture of Discovery at St. Michael's Hospital

Building on its well known culture of caring, St Michael's Hospital (SMH) has begun a process to foster a Culture of Discovery. A Culture of Discovery means that every SMH employee, whether they are a clinician, human resources professional, researcher, engineer or a member of the housekeeping staff, is encouraged to become a discoverer. Discoverers ask questions, promote new ideas, inspire innovation and celebrate achievement. They think about new and different ways to do things so that patient care and the hospital's administration are of the highest possible quality. The Culture of Discovery also encourages diverse perspectives and fosters a collective spirit so that everyone can identify issues and solutions. The Culture of Discovery initiative aims to:

- *Foster innovation/discovery across the whole institution*
- *Advance SMH's mission of innovation, learning, caring and accountability as an academic health sciences centre*
- *Contribute to SMH's vision to be Canada's finest health care provider*

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

The Credit Valley Hospital • 208
Our People Care

The Our People Care (OPC) is a unique program as the people of Credit Valley Hospital (CVH) created it, for the people of CVH. It grew from our organizational values, reinforcing the mission and vision and has become embedded in the organizational structures and processes. OPC focuses on investing in our greatest asset, our people, to enable stronger relationships and partnerships between and amongst caregivers and between caregivers and patients and families, facilitating both a healthy workplace and quality care. Studies show that organizations that develop positive, empowering working environments benefit from increased job satisfaction, enhanced productivity, decreased rates of work-related injury and absenteeism and increased recruitment and retention. As OPC has spread throughout the organization, staff and patient satisfaction has improved and more positive attitudes have resulted. Better relationships have strengthened and enhanced CVH's position as a workplace of choice.

The Hospital for Sick Children • 210
Developing Critical Insight - Fellowship for RNs

The CCU nursing fellowship program is a collaboration between the paediatric medicine and critical care units at The Hospital for Sick Children to provide an opportunity for nurses to increase the confidence and competence in managing complex patient situations and to assist with recruitment efforts in the CCU during a time of impending nursing shortage. Nurses from the medical units are chosen to participate in a three month fellowship which includes:

- *Classroom education and skills training*
- *Guided clinical practice with an experienced preceptor*
- *Mentoring by the education leadership to ensure professional learning needs are met*
- *The opportunity to continue to work in the CCU or return with enhanced skills and knowledge to the nurses' home unit*

The Michener Institute for Applied Health Sciences • 212
Defining Clinical Readiness
Finalist
Education of health care professionals is defined by both the development of theoretical and practical skills comprising the total clinical educational experience. The previously undefined construct of clinical readiness for undergraduate allied health professionals was investigated, facilitating the development of a new model of clinical readiness. To define readiness for clinical education, a proposed clinical readiness model was validated through the thematic analysis of data received through qualitative focus groups. The results of this project validate the original model of clinical readiness, facilitating the development of effective academic programming by the Michener Institute for Applied Health Sciences to prepare students for success transition to the clinical experience, while alleviating many of the pressures felt by clinical education partners. The conclusions drawn from this research indicate that the definition of readiness transcends professions and that there exists an inverse relationship between student centricity and the degree of profession specificity.

The Ottawa Hospital • 109
An Innovative Approach to Workforce Planning

The Nursing shortage will have a huge impact on health care organizations, creating the Perfect Storm, with increasing needs and decreasing workforce. With a projected shortage of 78,000 nurses in Canada, The Ottawa Hospital recognized the need to be

proactive in our workforce planning initiatives. Workforce planning is the methodical process of analyzing current workforce, determining future needs, identifying the gap and implementing solutions. There are no workforce planning models in the literature that address the unique requirements of nursing. Nurses play a key role in patient outcomes with the higher number of RN hours being associated with shorter lengths of stay, lower infection rates, shock, cardiac arrest and decreased falls. It is therefore crucial that we know how many new nurses we will need each year in order to ensure the safety of our patients. The model developed has been used over the last 3 years, with >1% variance.

The Ottawa Hospital • 111

Hiring New Graduate Nurses in the ICU

Finalist

To address TOH's Quality Plan goal of ensuring access to care, we needed to add beds to the Intensive Care Unit. The construction of a new Critical Care Wing means that by 2008, we will require an additional 90 new critical care nurses. Traditionally, experienced nurses with existing critical care certification have been hired but the pool of such candidates is dry. Our team, in partnership with two community colleges, developed an innovative learning program that prepared 25 new graduate nurses with the knowledge and skill needed to work in the ICU. Within seven months these 25 nurses were all employed within our two ICU's. This hiring and training strategy has resulted in important benefits for TOH and its patients: a 100% retention of the 25 newly trained critical care nurses; a trend towards fewer vacancies and reduced overtime utilization and experienced nurses who are engaged with the learning team.

The Ottawa Hospital • 113

Innovative Late Career Retention Strategy

The Ottawa Hospital had concerns over the large number of nurses who would be of retirement age by 2011 when we would have a Canadian shortage of 78,000. The MoHLTC Nursing Strategy funded our Late Career Strategy. All participants were nurses 55 and older who were relieved from bedside duty for 7.5 hours per week. The program was based on a literature review on the challenges senior nurses face: providing direct care, carrying a full patient assignment, managing the unit activities and serving as mentors/preceptors to students and new to practice nurses in their units. The nurses who participated in the program were supported with individual and group training on the skills they would need for their project. The key benefits were a decreased turnover with 76.5% indicating delaying their retirement plans. The projects supported novice nurses, patients/families and the nursing units.

The Wellness Group - Toronto East General Hospital • 211

Employee Engagement: Together for Wellness

The Wellness Group was created by a group of staff members of Toronto East General Hospital with the goal of defining wellness in a health care setting and finding ways to promote the personal well-being of each staff member, physician and volunteer. The simple definition of wellness being a balance of mind, body and spirit was adopted with our mission statement being Together for Wellness.

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

University Health Network • 213

Team Renewal: Exceptional Patient Care & Staff Engagement in General Internal Medicine Flourish Through Team Renewal

A foundation of quality patient care and interprofessional team communication in General Internal Medicine (GIM) is critical to the effectiveness and efficiency of ED-GIM patient flow initiatives. Team Renewal is a program of interventions that aims to create and support the delivery of exceptional patient care and interprofessional team engagement. The program includes the development of a learning curriculum, which is directly shaped by GIM front-line staff and leaders. This can be done through the following stages:

- *Identifying needs and creating interest*
- *Plan for renewal*
- *Practice and interprofessional team renewal*
- *Curriculum development and implementation valuation*
- *Through the implementation of this intervention, GIM units will become high-quality practice environments that are patient and family-centered, safe, efficient and healthy, thus increasing staff engagement through a focus on the value of their work, career development and improving interprofessional collaboration.*

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

Baycrest • 201
Living With Arthritis: A Health Promotion Model

Baycrest's Program for Arthritis Control through Education and Exercise (PACEEx) is an evidence-based self-management program for community dwelling individuals with arthritis. This nine-week program (17 sessions) includes non-didactic education, exercise in warm water and a comprehensive educational resource package. Participants engage in interactive, experiential discussions, problem solving and personal goal setting. Formal program evaluation indicated statistically significant improvements in: self rated health status, reduction in pain, confidence in performing activities of daily living, pain management and goal setting ability. The findings provided evidence that PACEEx successfully supports participants in acquiring self-management skills and positively influences health status and future health behaviours. A community hydrotherapy follow-up program is available to PACEEx graduates to maintain healthy behaviours and sustain gains. This approach meets current health care users need for self-directed information and skill acquisition and is supported in the literature as contributing to cost effective health care delivery (Lorig 2001).

Baycrest • 203
Capacity Building: A Falls Prevention Best Practice

The Falls Intervention Team (FIT) is an evidence-based best practice falls prevention model which includes an inter-professional home based assessment and short term intervention utilizing a standardized service pathway. Program evaluation revealed that this model resulted in statistically significant reduction in the number of falls, reduction in modifiable falls risk factors and improved social participation, balance and balance confidence for the participants of this program. Sustainability strategies for the FIT program involve demonstration projects across a number of sectors. While maintaining the integrity of the core falls prevention model, this model is currently being implemented in seven community projects with a number of community partners. The objectives are to integrate this model into existing service delivery systems and to test the delivery of this best practice model to different service delivery sites and from different access points (through self referral, from Elder's Clinic, post emergency room visit after a fall).

Bayshore Home Health • 205
Community Partnerships Promoting Health

Bayshore Home Health and the CCAC of Wellington-Dufferin participated in the Cardiovascular Health Awareness Program in order to bring an evidence based health promotion and risk prevention program into the community. The program resulted in developing community collaboration among health care stakeholders, including hospitals, local physicians, pharmacists, community service providers and volunteers. The project enabled the demonstration of investment in community relationships, health awareness and resulted in a healthier population.

Centre for Addiction and Mental Health • 207
Partnerships for Prevention

Strengthening Families for the Future is a skills based prevention program for families with children between the ages of seven and eleven who may be at risk for substance use problems, depression, violence, delinquency and school failure. The program is unique because it involves the whole family in building the child's resiliency by reducing family risk factors and enhancing family protective factors. Successful implementation in Ontario communities has been possible through building partnerships between various sectors such as community health centres, public health, children's mental health, addictions, adult mental health and child protection agencies. This interactive session will provide an overview of Strengthening Families for the Future, demonstrations of selected skills

development activities from the program and a discussion of implementation issues for providing family based prevention programs within a partnership delivery model.

Dietitians of Canada • 306
EATracker

EATracker lets you track your daily food and activity choices and compares them to national guidelines for activity, food and nutrient. EATracker assesses your food choices and provides personalized feedback on your total intake of energy (calories) and essential nutrients and compares this to what is recommended for your age, gender and activity level. It also determines your body mass index (BMI) and provides information to help you achieve and maintain a healthy weight. Visit EATracker on the Dietitians of Canada web site at www.dietitians.ca/eatracker or www.dietitians.ca/profilan

Heart Health Resource Centre & Ontario Public Health Association • 308
Towards Evidence-Informed Practice

The Towards Evidence-Informed Practice project has connected two Ontario strategies, the Ontario Stroke System (OSS) and the Ontario Heart Health Program (OHHP) through local community partnerships which focus on incorporating best practice concepts and tools to increase the effectiveness of community-based health promotion programs. At the provincial level, the TEIP project supports the local partnerships through the development, evaluation and implementation of program planning and assessment tools to ensure that locally developed programs are based on the best available scientific evidence and that their outcomes can be tracked and evaluated. Through collaboration and integration of program planning, assessment and evaluation activities, the OSS and OHHP have leveraged their strengths and resources resulting in stronger and more effective local health promotion programs.

Humber River Regional Hospital, Griffin Centre and Toronto District School Board • 310
Working Together Across Systems Child & Adolescent Mental Health Seminar Series

"Working Together Across Systems" Child and Adolescent Mental Health Seminar Series is a community-based mental health promotion project developed by parents, the Toronto District School Board, the Griffin Centre and Humber River Regional Hospital to educate the community and professionals about childhood mental illnesses. After participating in focus groups, parents and staff from across the systems worked together to provide education that addressed important issues that they faced on a regular basis. The education was implemented with the unique involvement of youth actors from Etobicoke School of the Arts. The excellent evaluation results spoke to the project's success in meeting the key education needs of stakeholders supporting children with mental illnesses/behavioural issues across community and hospital settings. Relationships across stakeholders were strengthened as a result of their leadership and participation in planning, presenting, implementing, evaluating and attending the Seminar Series. Being involved at every level enhanced their understanding for parents and multidisciplinary staff across systems.

National Network for Mental Health • 312
Improving Mental Health Services Through Informed Choice: A Bottom Up Approach to Changing Provider Behavior

Have you heard of YouTube, a popular free video sharing website? New internet media, like YouTube, have not only enabled consumers to become more entertainment-savvy, they have also created a shift in mental health consumers from passive recipients to

active consumers of health information. Mental health and mental illness are often misunderstood and stigmatized in the general public due to misinformation. Our vision is to facilitate information sharing among educators, consumers and providers of mental health services using a variety of resources such as podcasts (audio) and vodcasts (video). People should have access to credible and easy to understand resources about mental health, mental illness and treatment options, so they can make informed choices about the care they receive. We present information as edutainment in an engaging way to reach people in their day-to-day activities before they may even know there may be a health concern or problem.

Regional Municipality of York, York Region Health Services • 301

Back to School: Absenteeism and Outbreak Detection

Sentinel surveillance uses a well-defined population, such as schools, for the routine collection of data that may be useful in the early detection and monitoring of communicable diseases. In 2005, York Region Health Services (YRHS) collaborated with the York Region District School Board (YRDSB) to implement the York Region Sentinel School Health Monitoring Program. The purpose of this program is to monitor and collect data on student absenteeism due to illness to identify trends or clusters of illness within school communities and York Region. Prior to and during an outbreak, information on student absenteeism is beneficial in targeting prevention strategies and/or deploying treatment resources. Ideally, school absenteeism data can aid in the early detection of outbreaks before they reach their peak level of infection. York Region is currently the only jurisdiction in Ontario, and perhaps in Canada, that collects syndromic school absenteeism data related either to respiratory or enteric symptomology.

St. Joseph's Healthcare • 303

Somatic Health Intervention Program (SHIP)

As a consequence of treating patients with mood disorders at St. Joseph's Hospital, we were concerned about the rates of obesity, diabetes and cardiovascular disease in our patients. These issues, which have been identified as epidemics in society in general, affect patients with mental illness at even higher rates and lead to an increase in premature death. The reasons for this are still unclear, but despite lack of knowledge of the mechanisms causing the problem, we felt it was essential to try to attempt to create programs that offered solutions. We created a structured wellness program for both patients and their families composed of a 16-week group educational component focused on nutrition, activity and behavioural activation. This program is designed to help patients deal with physical illnesses, as well as to implement behaviours such as exercise that have been shown to help treat mental illness.

St. Michael's Hospital • 300

Eat Well, Live Well: Inpatient Information Session

The Eat Well, Live Well healthy eating information session was implemented in July 2006 by registered dietitians in the Heart and Vascular Program at St. Michael's Hospital. This group session, which is offered biweekly to inpatients and their families, includes information on portion control, limiting saturated and trans fats, sodium and sugar, increasing unsaturated fats, fibre and omega-3 fatty acids, drinking caffeine and alcohol in moderation. To encourage participants to actively process the information, trivia are interspersed throughout the session and participants are taught to read nutrition facts labels. Several tools are used including a PowerPoint presentation, Canada's Food Guide, food models and food packages. Participants are given Canada's Food Guide and handouts on how to read nutrition facts labels and healthy eating principles. Based on satisfaction questionnaires, patients and their families are very satisfied with this method of delivering healthy eating information in an acute care setting.

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

St. Michael's Hospital • 302

Using Interventionist Media with Young Parents NFA

Finalist

This is an interventionist participatory action research project which puts digital cameras and photoblogging websites into the hands of pregnant/parenting youth, with the support of media experts and healthcare professionals. Objectives: To learn how young pregnant/parenting women who have experienced homelessness view their lives through the use of photography and blogging (text) and to learn how partnering media with medicine can stimulate social and political action in workshop participants, health care providers, policy makers and the general public. Results: Workshop participants:

- *Shared personal stories with Mayor David Miller*
- *Had a five week gallery tour of their exhibit*
- *Were hired to conduct qualitative interviews and take portraits of participants in another research study*
- *Hosted a youth speak-out event to discuss solutions to current challenges*
- *Presented a declaration to Mayor David Miller*
- *Educated thousands of people about their lives, their strengths and their struggles.*

St. Michael's Hospital and the Fetal Alcohol Spectrum Disorder (FASD) Parent Association of Toronto • 304

FASD: Supporting Families through Education

Background: Families of children and youth living in inner city Toronto identified a lack of knowledge on how to assist their children with behavioral, social and cognitive problems. Prior to the initiation of this program there were no ongoing educational programs for families of children with FASD in inner city Toronto. Objective: To promote support through education for families of children and youth with FASD. Methods: An assessment of the families learning needs was conducted. Parents and professionals worked together to develop a series of ongoing educational workshops for families living with FASD. Results: The workshops have lead to families feelings more supported and more confident on how to assist their children and themselves. The families have also developed more community links. Implications: The initiative may assist other FASD clinics and Parent Associations to support families of children with FASD.

Stonegate Community Health Centre • 305

Seniors Wellness Program (SWELL)

The Seniors Wellness Program (also known as SWELL) is a once a week two hour session for 12 weeks for pre-registered participants. There are pre and post assessments with fitness challenges to measure stamina, upper and lower body strength. Each of the other sessions consists of an hour presentation on a topic of education followed by an hour of fitness led by appropriately qualified instructors. Pre-registration data includes a fitness risk screen and consent to contact the family doctor if necessary. There is no fee and the participation is limited to 20.

Thunder Bay Regional Health Sciences Centre (Northwestern Ontario (NWO) Regional Stroke Network) • 307

HEARTBEAT of the Anishnawbe Nation

A DVD education tool was proposed that would be culturally consistent with Aboriginal traditions. The Chiefs of the Nations (NWO) were notified. The focus group had representatives from Nishnabwe-Aski, Grand Council Treaty #3, Union of Ontario Indians, Independent First Nation and health care providers. The focus group directed the working group on how to deliver the key messages (blood pressure & stroke) in a culturally sensitive manner. This included: Elder teachings, Medicine Wheel, mother earth, story telling, community environment, non-intrusive, use of drums and water, visual aids, humour and holistic. The language text would be Ojibwe.

Oji-Cree and English would be dubbed. A sub-working group oversaw the script and the poster/jacket cover in accordance with the direction provided from the focus group. Filming took place in an Aboriginal health clinic, a historic fort site and various rivers. Actors included an Elder, Aboriginal health nurse, Aboriginal patient and Aboriginal youth.

Wellington County Learning Center • 309
The Smiling Project

This project is a dental health literacy project that promotes an innovative participatory approach to developing knowledge in dental health, applying that knowledge to the context of nurturing healthy family life-styles and developing leadership skills in the community to share that learning. The project utilizes an activity-based approach to develop health promotion material in the form of workbooks while examining and analyzing personal health behavior within the community cultural context. The project then offers the participants the opportunity to become co-facilitators of the workbooks with in their communities.

Whitby Mental Health Centre • 311
Stomp Out Stigma Summits for Students in Durham
Finalist
In Durham Region, Summits on Stigma, involve a day-long gathering of student ambassadors who are taught about mental illness through a series of presentations by consumer/survivors and professionals alike with a focus on giving the ambassadors the tools necessary to build anti-stigma teams within their schools. Anecdotal feedback to date has been most positive, but, as part of the overall process, every student is given a pre and post test in order to measure learning and to support further development of the model. This information is currently being analyzed by the coalition with the support of the University of Ontario Institute of Technology. It is felt that by supporting the development of the student ambassadors and their action teams a more profound and concerted impact can be had on the negative imagery and stereotypes associated with people who have a mental illness.

Yee Hong Centre for Geriatric Care • 313
Chronic Disease Self-Management in Chinese Community
Finalist
The Chronic Disease Self-Management in Chinese Community project aims at promoting public awareness in the Chinese community on the need and importance of self-management in coping with chronic health conditions and to deliver the Chronic Disease Self-management Program (CDSMP) developed by the Stanford Patient Education Centre of Stanford University. CDSMP is
- *Community-based*
- *Generic in nature, non disease specific*
- *Led by two trained leaders (professional or lay)*
- *Highly structured (six sessions of two hours meeting once per week) and interactive*

The project includes three major components:
- *To train and build capacity of staff and lay leaders to organize culturally adapted CDSMP in Toronto*
- *To roll out community based CDSMP in Chinese community through licensing with Stanford University and partnering with local organizations*
- *To organize a Chronic Disease Self-Management Promotion Week to enhance public awareness of the self-management concept*

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

Emergency Medical Assistance Team (EMAT)

Health emergencies can sometimes overwhelm the health care system of an affected community or region. If any jurisdiction in Ontario finds that it does not have the capacity to respond effectively to a health emergency, the EMAT may be requested to help through the Ministry of Health and Long-Term Care's Emergency Management Unit. The EMAT is a mobile medical field unit that can be deployed anywhere in Ontario with road access and within 24 hours. The EMAT can set-up a 56 bed unit that provides a staging and triage base and has the capability to treat 20 acute care patients and 36 intermediate care patients. In addition, the EMAT can provide:

- *Patient isolation in the case of an infectious diseases outbreak;*
- *Medical support and decontamination in the case of a chemical, biological or radiological incident; and*
- *Case management and triage of patients in a mass casualties situation*

The EMAT is operated by Ornge and is funded by the Ministry of Health and Long-Term Care.

Hamilton Family Health Team • 625

The Hamilton Family Health Team sees the treatment of chronic health conditions as a priority and is developing specific chronic disease management programs to address these. These programs will have many common features. Each will aim to:

- *Identify, monitor and track individuals in the practice suffering from a specific condition*
- *Provide optimal care according to current evidence based treatment guidelines*
- *Provide information, education and support for clinicians, staff and patients*
- *A program planning grid developed at the Hamilton Family Health Team neatly provides the structure from which all components integral to each of the programs can be drawn.*

Health Council of Canada • 611

Canadians have invested a great deal of trust and money in their universally accessible, publicly funded health care system. That's why the Prime Minister and Premiers created the Health Council of Canada in 2003 as part of the First Ministers' Accord on Health Care Renewal. The Health Council's job is to provide a country-wide perspective on the progress of health care renewal and its impact on the health of Canadians. In the 2004 Ten-Year Plan to Strengthen Health Care, the Council was given additional responsibilities to report on health outcomes. The Council focuses on six key areas – the health of Canadians, primary health care, home care, prescription drugs, the health care workforce and wait times. The Council's many initiatives inform and engage health care providers, research organizations, educators and decision-makers and the ultimate health care stakeholder – the people of Canada.

Kensington Eye Institute • 623

Kensington Eye Institute (KEI) is an Independent Health Facility licensed through the Ministry of Health and Long term care (MOHLTC). KEI is a not for profit corporation established by the Kensington Health Centre and the Kensington Foundation. KEI's objectives are:

- *Improved access to cataract surgery services*
- *Decreased patient wait time for cataract surgery*
- *To ensure Ontarians receive the highest quality health services*
- *To provide opportunities for the involvement of the University of Toronto's Department of Ophthalmology and Vision Sciences at KEI*

• To ensure Ontarians receive good value for insured health services dollars
KEI is an innovative model for a new standard in the delivery of outpatient eye care. It provides patient focused services in an efficient and cost effective manner. This paradigm of providing ophthalmic surgery at the Kensington Eye Institute enables resources in the hospital environment to be properly utilized while out-patient procedures are safely and efficiently performed at KEI.

NYGH Cataract Centre • 619

Ontario Health Quality Council • 643

The Ontario Health Quality Council reports directly to Ontarians on access to services, health human resources, consumer and population health status and system outcomes within the publicly funded health system. By talking to Ontarians, the OHQC has found they want a health system that is accessible, effective, safe, patient-centred, equitable, efficient, appropriately resourced, integrated and focused on population health. These nine attributes of a high-performing health system form the framework for OHQC's research and reporting. In March, the OHQC released Q Monitor, our 2007 report on the quality of the health system. The report analyzes the overall performance of the health system and this year, it also examines the chronic disease challenge and provides examples of best practices from across the province. The report also looks at strengthening quality assurance at the local service delivery level and the Wait Times Strategy as a model for improving the quality of the health system.

Ontario Prevention Clearing House • 608

Peterborough Networked Family Health Team • 627

Primary Health Care Services of Peterborough (PHCSP) consists of 71 family physicians working in five distinct Family Health Teams. We have successfully integrated 17 Registered Nurses, 14 Nurse Practitioners, six Registered Practical Nurses, four Dieticians, five Social Workers and three Mental Health Workers within physician practices throughout Peterborough County. In addition we have attracted three family physicians to the community to establish community based practices. As a result of the investment in Family Health Teams in our community by the Ministry of Health and Long-Term Care we are providing more accessible, more comprehensive and higher quality primary care to an even broader patient roster. We have significantly reduced the volume of patients accessing primary care through the Emergency Department. Currently we are seeing over 800 patients each month in after hours clinics. Today, we are partnering with specialists to develop community-based chronic disease prevention and management strategies and programs.

Peterborough Networked Family Health Teams and Vascular Health Network

The Peterborough Regional Vascular Health Network (VHN) is a unique collaboration amongst family physicians, specialists and other health care providers aimed at improving vascular health throughout the Peterborough region. In 2005, the VHN "hit the road" with the Vascular Health Trailer enabling our dedicated group of nurses to reach more patients in more locations. It succeeded far beyond our expectations, resulting in thousands of visitors to the trailer getting blood pressure checks, cholesterol screening, and vascular

teaching. In partnership with the Vascular Health Network and other community specialists, Peterborough's Family Health Teams are developing a collaborative, patient-centered approach to chronic disease prevention and management.

Ministry of Health Promotion • 606

Ministry of Health and Long-Term Care • 629
Coaching Teams

Performance coaching has recently become a popular method of performance improvement in several corporate arenas; however, it has yet to be fully explored in healthcare. 'Coaching' has several definitions but generally can be described as a sophisticated form of sharing and interaction, which expands the client's awareness of the internal and external barriers in the way of reaching the goal. The professional coaching process involves the coaching team helping to define the goals, supporting the client in executing them by mapping out an action plan and helping them to stay on track. By developing Coaching Team programs in specific areas and making these teams available at no cost to hospitals, the Ministry of Health and Long-Term Care has for the first time, enabled expert knowledge to be transferred throughout the system in a collaborative and coordinated manner. For more information about the Coaching Team model, see our website at: http://www.health.gov.on.ca/coaching

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Ministry of Health and Long-Term Care • 505
Critical Care Information System (CCIS)

The CCIS allows for the electronic collection of adult medical/surgical ICU hospital and patient-specific, critical care data. This data will be made available in the form of aggregated reports, providing a consistent and reliable platform for all hospitals and health planners, to use to inform and improve both the planning for and operation of critical care services. The CCIS will provide information to hospitals, LHINs, LHIN Critical Care Leaders and the province to support "systems-thinking" about how we use our critical care resources and how we think about, plan for and deliver critical care as an "1,800 bed provincial resource."

Ministry of Health and Long-Term Care • 645
Critical Care Response Teams (CCRTs)

CCRTs provide early intervention when health care providers identify patients on hospital wards who show physiologic signs of clinical deterioration. CCRTs can often spare the patient and family the stress of an ICU admission, or, facilitate admission to the ICU, potentially reducing the length of an ICU stay and ultimately improve the patients' outcome. The Government of Ontario has funded the development and implementation of 27 adult CCRTs. Twenty-three are currently providing 24/7 service, while four are developing teams. In addition, four pediatric sites are completing a CCRT demonstration project and six smaller hospitals will soon begin a demonstration project of alternative model CCRTs.

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

Ministry of Health and Long-Term Care • 503/602
Critical Care Strategy

The Critical Care Strategy has its origins in Ontario's battle with SARS and the province's efforts to reduce wait times and increase access to health services. This highlighted the Ministry's limited ability to effectively manage the aggregate of adult critical care services across the province and the fact that the need for critical care services will be steadily increasing over the next two decades. In response to these pressures, the Ministry of Health and Long-Term Care committed $90 million to a provincial strategy, designed to deliver a maximum return on investment in improved access, quality and system integration. The Strategy is comprised of seven components based on recommendations provided by the Ontario Critical Care Expert Advisory Panel. The seven components of the strategy include:

- *Critical Care Response Teams*
- *Critical Care System-Level Training Initiatives*
- *Critical Care Information System*
- *Performance Improvement & Leadership Structures*
- *Ethical Issues of Access*
- *Health Human Resource Investments*
- *Surge Management and Capacity Investments*

More information regarding the strategy can be found online: www.health.gov.on.ca/criticalcare.

Ministry of Health and Long-Term Care • 610
Family Health Teams

Family Health Teams are a key component of the government's plan to build a health care system that delivers on three priorities - keeping Ontarians healthy, reducing wait times and providing better access to doctors and nurses. Family Health Teams are designed around the needs of each community. They are made up of doctors, nurse practitioners, nurses, dietitians, pharmacists, physician specialists, mental health workers and many others – depending on the need. These teams provide comprehensive care, extended hours during evenings and weekends, as well as access to a registered nurse through the Telephone Health Advisory Service (THAS) after hours and on holidays.

Ministry of Health and Long-Term Care • 641
Health Care Improvement Practices Registry

The Health Care Improvement Practices Registry is a source of improvement practices from organizations across multiple health care sectors in Ontario. Since the launch of the Registry in October 2006 we have received an average of 25,067 hits per month, and the Registry currently houses 83 diverse practices from across all 14 LHINs. The Registry is aimed at supporting and fostering a culture of continuous quality improvement across Ontario's health care system. By adopting and adapting applicable improvement practices from the Registry to their own settings, providers can improve the quality of health care services they deliver.

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

Ministry of Health and Long-Term Care • 647
ICU Clinical Best Practices Project

The ICU Clinical Best Practices project is a 16-site demonstration initiative designed to encourage the uptake of evidence-based critical care best practices such as DVT Prophylaxis, prevention of VAP and many others. A variety of innovative approaches are used to support and measure the uptake of these best practices across the network of hospitals. Through daily web-based data collection, regular network videoconferencing, dissemination of guidelines and literature and by providing a variety of targeted knowledge transfer strategies this initiative is proving to be an effective way to support clinical performance improvement at a local level across diverse critical care units.

Ministry of Health and Long-Term Care • 511
Ontario CritiCall Program

The Ontario CritiCall Program, based at the Henderson site of Hamilton Health Sciences, assists physicians caring for critically ill patients by facilitating telephone consultations with on-call specialists who can provide immediate patient management. If necessary, CritiCall can secure a bed for the patient at the nearest facility with the appropriate level of care. Between April 1, 2006 and March 31, 2007, CritiCall call takers facilitated close to 13,000 calls from hospitals across the province. Sometimes a consultation with a specialist is all a physician requires. If a consultation alleviates the need for an air or land ambulance transfer, then CritiCall has fulfilled its mandate by assisting in bed management and the appropriate and timely use of regional services and resources. In order to operate efficiently and effectively, CritiCall relies on its internet-based Ontario Central Bed and Resource Registry. The on line Registry is updated regularly by more than 140 Ontario hospitals and provides immediate access to bed and resource availability for each hospital and contact information for on-call physicians in 50 different medical specialties. In January 2008, continued implementation, management and operations of the Critical Care Information System (CCIS) will be transitioned to the Ontario CritiCall Program.

Ministry of Health and Long-Term Care • 509
Surgical Efficiency Targets Program

Better efficiency and productivity will result in maintaining reduced wait times and more procedures being performed within the same time period, with the same resources. By supporting improvements in surgical management, the Surgical Efficiency Targets (SET) Program will decrease these delays and enhance the quality of patient care. The SET Program focuses on the peri-operative portion of the care continuum and is currently being implemented in all hospitals providing Wait Time Strategy volumes over the next year. Hospitals use a web-based tool to collect a number of peri-operative indicators to identify what is running smoothly and where performance challenges exist. The biggest improvements (and savings) will come from establishing best practices in the province and sharing information on how to make these improvements.

Ministry of Health and Long-Term Care • 507
Wait Time Information Systems

The Wait Time Information System-Enterprise Master Patient Index (WTIS-EMPI) Project is critical to improving access to care in Ontario. The WTIS is a provincial, patient-centered system that standardizes the collection and reporting of wait time data. The WTIS currently captures surgical data for cancer, selected cardiac procedures, cataract, total hip and knee joint replacement, as well as

ORGANIZATION • BOOTH • PROJECT • ABSTRACT

MRI/CT scans. The system will expand to All Surgery beginning in 2007/08. The WTIS is implemented concurrently with the provincial EMPI, the foundation for delivering an electronic health record, to provide patients, practitioners and administrators with better information to manage access to care.

Ministry of Health and Long-Term Care • 604

Wait Time Strategy

Reducing wait times for key health services is one of the Ontario government's top priorities, since wait times are a symptom of a broader problem: managing how patients get access to care. The Wait Time Strategy was formed in November 2004, with the mandate to transform the health care system through a three-pronged approach: capacity building through additional surgical cases; wait time measurement and reporting; and system and process redesign. The Wait Time Strategy is designed to reduce wait times by improving access to health care services for Ontarians in six key services: cancer surgery, selected cardiac procedures, MRI and CT scans, cataract surgery, hip and knee total joint replacements and - as of this year - selected paediatric surgeries.