

■ Meeting Community Needs Through Integrated Care

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Baycrest •

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 •

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 •

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

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

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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 •

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 •

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 •

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.

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Grey Bruce Health Network •

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 led 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 •

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 •

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 •

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

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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.

Lake of the Woods District Hospital's Community Programs •

Medically Enhanced Co-ordinated Care for Addiction

Clients addicted to Opioids who had tried other methods to address their addiction had to leave their family and community to get methadone treatment. This did not work. Lake of the Woods District Hospital's community program Addiction Services Kenora (ASK) is an outpatient treatment centre. Staff were aware of how effective methadone treatment can be for some individuals - it could strengthen families, decrease crime, increase labour markets and change communities. So with the support of the local police, hospital, town council, pharmacies and doctors, a methadone program was launched within current resources. Our program is called M.E.C.C.A. (Medically Enhanced Co-ordinated Care for Addictions). Services we provide are: comprehensive medical assessments, multidisciplinary treatment planning, counselling treatment, withdrawal management, 1-800 number for support, methadone treatment as relevant, drug education, family support for mental health and addiction issues and Addiction Services Kenora's usual programs.

Links2Care, Supporting 4 Program Partnerships •

Home at Last!

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 •

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 •

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

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develop effective inter-professional practice for seniors with concurrent chronic health conditions (see Appendix A for Project Model). The various disciplines involved with the initiative include nursing, family medicine, physiotherapy, pharmacy, psychiatry, social work, and 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 •

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 •

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 •

Anything Is Possible With Effective Collaboration!

This workshop 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 workshop will outline creative opportunities that were employed to sustain a free oral health clinic.

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

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.

South West Community Care Access Centre •

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 •

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.

thehealthline.ca, South West End-of-Life Care Network and South West Community Care Access Centre •

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.

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The Ottawa Hospital •

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 •

Outpatient Management of Pleural Effusions

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) •

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, and 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.

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Thunder Bay Regional Health Sciences Centre •

Multi Site Cardiac Rehabilitation Program

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.

Total Joint Network •

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 •

"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).