North American Conference on Integrated Care

4th–7th October 2021
Toronto, Canada

1st

Innovation. Inspiration. Integration:
Co-designing for health and wellbeing with individuals and communities
In association with the 6th World Congress on Integrated Care

UNIVERSITY OF TORONTO
DALLA LANA SCHOOL of PUBLIC HEALTH

Institute of Health Policy, Management & Evaluation
UNIVERSITY OF TORONTO

KPMG   HSPN   iCOACH   Patients Included   International Foundation for Integrated Care IFIC Canada   IFIC   IJIC

Oral Presentations

BOOK OF ABSTRACTS
NACIC 2021

Abstract ID: 2

Reducing Avoidable Readmissions in Toronto for Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Community-Acquired Pneumonia (CAP) and Gastrointestinal (GI) Diseases

Presented by: Nicole Nitti

Co-Authors: Jessica Curtis, Marnie Weber, Nicole Nitti, Ian Fraser

_____

Conference Track: People as partners in health and care

Introduction: Reducing avoidable readmissions is an important focus to improve patient care and end unnecessary hospitalization. Toronto had a readmissions rate of 18.3% and CHF, COPD, CAP and GI Diseases were identified to have the highest readmission rates in Toronto Hospitals. This work was established to lead a cross-sectoral, integrated approach to reduce avoidable 30-day readmissions by exploring and understanding readmissions data, drivers and best practices and implement a regional strategy supporting best practices in local environments. The focus was to leverage small investment for big impact. It resulted in a reduction in hospital 30-day readmission rates up to 30%.

Aims and Objectives: Project groups worked in partnership with patients, acute and rehab hospitals, physicians, primary care clinicians and home and community care providers across Toronto. Over 200 people and organizations participated. This work included the following: patient profiles were developed (including social equity factors); patient surveys and interviews were conducted; clinician workshops were facilitated and leading practices identified. Integrated approaches were implemented in hospitals, community and primary care. Clinical champions were identified and physician engagement was measured. A regional, transparent performance scorecard was developed to motivate partners and identify gaps.

Highlights/Results/Key Findings: Project groups developed and implemented strategies:
• Patient oriented discharge summaries (PODS) for Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Community-Acquired Pneumonia and Gastrointestinal Diseases. They were validated and standardized by patients, families/caregivers and physicians.
• Increasing referrals to community services especially for the first 14 days post discharge. The Enhanced Home at Last Program was tailored to patients at high risk for readmission and based on patient feedback. It provides effective transitions through transition coaches and personal support worker supports for patients at home after leaving the hospital.
• Standardized best practices built into existing care pathways. This includes: PODS, completing/sharing discharge summaries with primary care providers within 48 hours, medication reconciliation and referrals to home/community care
• Continuing emphasis on physician and leadership engagement within hospitals and primary care, throughout the project. An important success factor.
• Hospital booking primary care appointments before discharge so patients are seen within 7 days of discharge

Conclusions: Results have been remarkable which has led to a reduction in hospital 30-day readmission rates of up to 30%. This has resulted in better patient outcomes and utilization. Toronto is now one of the lowest in Ontario, with a readmission rate of 12.6%, which demonstrates sustained results.

Implications: This created knowledge that others can follow to reduce avoidable hospital readmissions through:
• Identifying quality gaps. Establishing avoidable readmission targets.
• Tailoring transition supports in the community.
• Enhancing/measuring primary care linkages.
• High provider engagement throughout.
• Integrated approaches with organizational and clinical accountability.
• Patient engagement.
• Ongoing monitoring and feedback.
• Sustaining momentum.

Abstract ID: 15
Facilitating Adaptive Strategy through Design Spurts
Presented by: Christie Newton
Co-Authors: Jacqueline Ashby, Christie Newton

_____

Conference Track: Shared values and vision,People as partners in health and care

Introduction: How do we elicit our community's thoughts and ideas about the design of medical education? How has the pandemic shifted our learning experience for teachers, residents, and patients? Our versatility, adaptation, and ability to fail fast and forward have emerged as important traits in this quickly changing landscape. In this session, we will address these questions and experiment through the design thinking paradigm.

Aims and Objectives: Design thinking, a method of co-evolution of problem and solution, has gained traction in healthcare and medical education as a way to promote a greater understanding of users' experience and to help unpack the challenges and opportunities that we are confronting in our educational journey and delivery of care. Teams are guided through five highly collaborative phases of user empathy, defining the problem, ideation, prototyping, and testing.

Highlights/Results/Key Findings: The ultimate goal is to create a product that can be implemented by team members. We will provide examples of how design thinking has been used within UBC's Department of Family Practice to rethink our curriculum and develop meaningful relationships with our surrounding healthcare community.

Conclusions: Design thinking provided the opportunity for our faculty, administration, and students to voice their concerns and more importantly create solutions that address their environment's contextual and temporal constraints and affordances. Participants of our design thinking sessions described the experience as highly collaborative and thought-provoking. Furthermore, during COVID-19 pandemic, this paradigm

Implications: The design thinking paradigm is one that can be easily transferred to any setting where participants are open to new ideas and thoughts about the challenges and opportunities presented.

Abstract ID: 17

The creation of an adaptive space in a healthcare system: a retrospective organisational analytic autoethnography.

Presented by: Áine Carroll

Co-Authors: *Áine Carroll*

_____

Conference Track: System wide governance and leadership

Introduction: The Health Services Executive (HSE) in Ireland was established in 2005 and is responsible for the provision of public health services in hospitals and communities in Ireland. In 2010, the Clinical Strategy and Programmes Division (CSPD) was created with the aims of transforming the Irish healthcare system by improving quality, access and cost. As healthcare is a complex adaptive system, key to successful transformation is the creation of a dynamic adaptive space to allow interaction, innovation, creativity, testing, knowledge generation and adaptation.

Aims and Objectives: The purpose of this organisational autoethnography is to share my lived experience as a National Director in a National Health service so that it might be used to inform future initiatives.
Retrospective analytic organisational autoethnography is the research method and examines the relationship between the individual and the organisation and allows for insightful and emotionally-rich assessments of organisational life[1].
Using Arena and Uhl-Biens '4Ds' of adaptive space as a scaffolding around which to build the autoethnography, the author describes her experience of leading CSPD and the creation of an adaptive space and reflects on the enablers and challenges [2].

Highlights/Results/Key Findings: Within CSPD, the author created an adaptive space through the development of rich connections across the '4D' connections of adaptive space: discovery, development, diffusion, and disruption. Together, these 4D connections facilitated the human interactions necessary to generate innovative ideas and concepts that were necessary for positive disruption. Although any connections were successful, some were not and the author reflects on possible reasons why. The author found retrospective analytic autoethnography was an effective tool for describing the creation of adaptive space. Using multiple data sources enabled a more analytic and objective analysis without losing the sense of self. Organizational autoethnography has the potential to be a powerful tool for capturing the authentic lived experiences of employees within organisations, yet is a tool seldom utilised in organisational development literature.

Conclusions: This account provides an insight into the author's lived experience as a senior leader within a national public healthcare organisation as she endeavoured to create an adaptive space within the organisation and concludes with some reflections about the gap between innovation and practice in healthcare transformation.

Implications: Organizational autoethnography has the potential to be a powerful tool for capturing the authentic lived experiences of employees within organisations. This account is one person's reflections but using multiple data sources has minimised bias.

Abstract ID: 61

What is the Role of Interprofessional Education in Training Post-Licensure Healthcare Professionals for Integrated Care: A Scoping Review

Presented by: Sue Bookey-Bassett

Co-Authors: Sue Bookey-Bassett, Sherry Espin

_____

Conference Track: Workforce capacity and capability

Introduction: Longer lifespans and living with multiple chronic conditions are driving necessary change in healthcare systems. There is an increasing shift towards team-based integrated care, that is accessible, continuous, and of high quality. Health professional roles are changing rapidly; traditional educational approaches no longer suffice. The World Health Organization and the Institute of Medicine acknowledge that preparation of the healthcare workforce has not kept pace with these changes. Interprofessional education (IPE) and professional development training that includes partnering with patients, providers, and communities are identified as key solutions. However, understanding how IPE supports workforce development for integrated care remains unclear.

Aims and Objectives: We followed the Arksey and O'Malley method for conducting scoping reviews. The CINAHL, MEDLINE, ProQuest Nursing and Allied Health, and Scholars Portal databases were searched using key search terms (interprofessional education, interdisciplinary education, integrated care, integrated health care delivery). Articles included were peer-reviewed, from all sectors, published in English, from the year 2000 to 2020 and comprised post-licensure health care workers. Study selection and data extraction were conducted by two independent reviewers using a standardized data extraction form. Data were collated, summarized, and key themes were identified.

Highlights/Results/Key Findings: A total of 32 papers were included in the review consisting of primary research studies (16), reviews (10), and reports/position papers (6). Integrated care was described as having multiple definitions, various models, key principles, and competencies. Key Themes: The role of IPE in training health care professionals to work in integrated care was elucidated through qualitative thematic analysis. Four key themes were identified: 1) laying the foundation, 2) providing a building block, 3) acting as a catalyst, and 4) generating practice change.

Conclusions: IPE has a critical role in training health and social care providers to work in various models of integrated care and increasingly complex healthcare systems. However, IPE is only one part of a larger program of training that is necessary. Extending IPE beyond traditional roles and settings is crucial.

Implications: IPE should begin in academic programs and continue as workplace learning that is context specific. Evidence and theory-based multi-component interventions are required to reinforce learning in the practice setting. A formal evaluation of the quality of the evidence was not conducted and only papers written in English were included.

Abstract ID: 62

Conceptual models and Canadian case studies to guide collaboratively-based intersectoral integrated health and social care

Presented by: Siu Mee Cheng

Co-Authors: *Siu Mee Cheng, Christina Bisanz*

_____

Conference Track: System wide governance and leadership

Introduction: This highly engaging workshop will seek to provide the audience with an overview of the basic concepts and conceptual models in collaboratively-based integrated health and social care that will be positioned within a Canadian context. This will be accompanied by several Canadian case studies that include care in the community for vulnerable older adults and transitions-in-care from hospital to community to ensure relevance for the audience. This will support participants in applying concepts and components of various models to better support their own integration efforts, and to enable them to critically assess areas of risk and strengths in integrated health and social care efforts, and to avoid common pitfalls associated with integration between health and social services organizations.

Aims and Objectives: The workshop will develop an appreciation of core concepts, conceptual models and external environmental factors that are linked to collaboratively-based IHSC among different organizations. Canadian case study examples will allow for an understanding of IHSC success factors and challenges and how concepts and factors support successful integration. The workshop will ensure engagement from participants using different approaches including polling, break-out room exercises, presentations and group discussions.

The participants will:

1. Have an understanding of some evidence-based IHSC models including key IHSC features.

2. Understand factors that are unique to the Canadian health and social care context that require consideration when engaging in IHSC.

Highlights/Results/Key Findings: Although integrated health and social care (IHSC) is a relatively new phenomenon, the body of knowledge that exists continues to grow globally. This has been accompanied by the development of some conceptual models that can play a critical role in helping to shape and ground planning and services delivery.

Conclusions: 1. At the conclusion of the workshop, the participants will have a basic knowledge of critical components of IHSC conceptual models and their application within a Canadian context.

2. Participants will gain a greater understanding of possible challenges and pitfalls in implementing IHSC that are unique to the Canadian health system

Implications:

Abstract ID: 85
Integrated Care: The Centrepiece of Tomorrow's Healthcare System

Presented by: Erik Sande
Co-Authors: Jacqueline Zonneville, Erik Sande

_____

Conference Track: Resilient communities and new alliances

Introduction: Across Canada, access to healthcare is an ongoing challenge. Pressures within our system – aging population, chronic illness, hallway medicine, climbing demand – have been heightened by COVID-19. The pandemic has further focused our attention on addressing these challenges and more. Through team-based, integrated approaches to care, we can create more sustainable paths to help all patients and communities access support, when and where they need it. Effectively moving care into the community will ensure a stronger future for the health of populations, aligned with "the quadruple aim": better outcomes, better patient satisfaction, improved provider experience and better cost effectiveness.

Aims and Objectives: An Adaptable, Integrated Approach

Integrated care enables choice. It allows patients to have a voice and actively participate in their care decisions. It also allows a variety of practitioners to further leverage their skillsets to bring care directly to patients in their homes and communities; ultimately increasing capacity in our health systems.

Leaders in our sector helped establish these types of adaptive strategies well before the pandemic. Today, these strategies are being pressure-tested, while helping to fill gaps, enhance our ability to deliver healthcare outside the hospital and bring together dynamic partnerships focused on the health and wellbeing of patients.

Highlights/Results/Key Findings: What it Looks Like in Practice

Through mobile integrated health (MIH), a highly relevant adaptive strategy, community care teams, including paramedics, nurses, and other clinicians (in their homes and through other channels such as telehealth and virtual visits), are working to ease emergency department visits, reduce hospital admissions, and expand long-term care options for vulnerable and underserved populations.

In Chatham-Kent, Ontario, there is a proven MIH model, leveraging the skills and mobility of paramedics in the community to provide direct patient care and consultation beyond hospital walls – providing ongoing monitoring of changing or escalating conditions, performing testing procedures and blood analysis, and treating for minor ailments. Evaluations show an 84% reduction in 911 calls and 51% reduction in emergency department visits for targeted populations.

Additional funding is helping expand the community paramedicine program to support patients on long-term care wait lists and other clinically complex patients, locally.

Conclusions: Today's Change, Tomorrow's Future

During COVID-19, paramedics have been mobilized across Canada to conduct swab testing (at LTCs and mobile drive-thru clinics) and are engaged in vaccine roll-out and administration, working with local health system partners.

Paramedics too are providing surge capacity response within remote communities in northern Canada.

Implications: At the Core

Our collective pandemic experiences have reaffirmed what we've known. We must prioritize integration and delivery of healthcare outside the hospital, both in rural and urban settings. We must continue to adapt to ever-changing environments and form new alliances. Otherwise needed change will come to a standstill.

Abstract ID: 96
Campus Model of Care - One Team Approach
Presented by: Dana Khan
Co-Authors: Dana Khan, Elaine Shantz

_____

Conference Track: People as partners in health and care

Introduction: Using a one-team approach to care, the Campus Model of Care has improved continuity of care, consistency in practice (through staff onboarding and ongoing education) and quality of care for the residents within the Fairview Mennonite Community (LTC, RH, villas and apartments). Providing holistic care, personal support services, 24/7 assisted living services for high risk seniors and ease in access to social, recreation and wellness programs. As well as, strengthened health human resource capacity and job satisfaction of the staff. Multi-organization collaboration, resident and staff engagement and a strong communication and change management plan were all keys to success.

Aims and Objectives: A clear vision was established from the beginning and maintained through out. The aim was to fulfil the goals of the quadruple aim, improving quality, efficiency and integrated care to the residents by redesigning patient-centred care. The specific goal was to consolidate PSW services to improve consistency and continuity of care. The resident-centred approach aimed to have residents feel they are part of a community, they are cared for, and they will have the support when they need it. As well, to enhance staff experience through new staffing models and PSWs being part of an integrated care team.

Highlights/Results/Key Findings: eHealth Centre of Excellence conducted a formative evaluation of the campus model, utilizing qualitative and quantitative data (e.g. key informant interviews, staff and patient experience engagement, measurable process improvement changes and cost/value for money). All parties (residents, staff, leadership and partner agencies) reported an improvement in the delivery of personal support services as a result of the campus model of care. Success was attributed to the strong leadership, communication, and excellent execution strategies taken by all parties. Highlights of the model include improved PSW job satisfaction, resident satisfaction with care, improved continuity of care, reduced rates of missed care (virtually no missed care vs. baseline comparison of 0.15% and 1.63% in a comparable neighbourhood model), and servicing more residents at a lower cost for care. The approach to care required contractual changes, adaptive strategies and a strong commitment by leadership of multiple organizations to resident-centred integrated care improvements.

Conclusions: Evaluation of the Campus Model of Care demonstrated significant success in all outcomes measured. The high level of care integration was achieved through strong relationships and through continuous thoughtful communication between Home and Community Care, the leadership and staff at Fairview Community, the residents and the hospitals.

Implications: Since the implementation of the Campus Model of Care at Fairview Mennonite Community in Cambridge, the model has been spread to Parkwood Community in Waterloo. Broader applicability and transferability can apply to other multi-service congregate care sites and neighbourhood based models of care.

Abstract ID: 97

Mindfulness to Combat Healthcare Worker Burnout During Covid-19; an Integrated Care Model

Presented by: Fariha Chowdhury

Co-Authors: *Fariha Chowdhury, Nicole Adams, Soyeon Kim, Sarah Hunter*

_____

Conference Track: Shared values and vision,Population health needs and local context,People as partners in health and care,Resilient communities and new alliances,Workforce capacity and capability,Transparency of progress, results & impact

Introduction: Healthcare workers experience burnout, mindfulness programs have shown to decrease burnout in healthcare workers (1). Early into the COVID-19 pandemic, Waypoint Centre for Mental Health Care (Waypoint) provided a virtual 4-week skills-based Mindfulness Ambassador Program (MAP) to healthcare workers to buffer burnout and contribute to improving patient-care with Waypoint's integrated care system. The current study evaluated MAP's efficacy in mitigating burnout, and strategies to support overall wellbeing.
1. Dreison KC, Luther L, Bonfils KA, Sliter MT, McGrew JH, Salyers MP. Job burnout in mental health providers: A meta-analysis of 35 years of intervention research. Journal of occupational health psychology. 2018;23(1):18.

Aims and Objectives: This study used a mixed methodological approach. Healthcare workers (n= 131; age 31-50 = 53.8%; female = 93%) completed the demographic and Maslach Burnout Inventory questionnaires. A linear regression model was estimated using the generalized least squares via maximum likelihood approach to determine the efficacy of MAP and the factors associated with burnout. Semi-structured interviews were conducted to integrate stakeholders', healthcare workers' and facilitators' perspectives to gain valuable insight towards providing an optimal wellness program in hospitals. The interview questions were co-created with Mindfulness Without Borders and Waypoint Centre. Thirteen participants and facilitators participated, and thematic analysis was used.

Highlights/Results/Key Findings: Quantitative analysis revealed that the 4-week online MAP significantly reduced emotional exhaustion and cynicism in healthcare workers during the pandemic. Increasing the number of mindfulness practices between the sessions significantly increased the chances of reducing burnout.

The semi-structured interviews demonstrated ways the pandemic has taken an immense toll such as work-home separation, emotional exhaustion and isolation combined with the challenge of finding time for self-care. Participants shared how the MAP designed for healthcare workers contributed to their improved personal and professional wellbeing. They shared the ways in which they integrated mindfulness practices into their daily lives. Facilitators experienced increased employee engagement where they felt a sense of connection and compassion within their healthcare team. The data emphasized the importance of supporting continued mindfulness practices and opportunities to bridge into a lengthier, more robust mindfulness program. Providing resources and support for continued practices should be considered.

Conclusions: The 4-week skill-based MAP significantly reduced burnout in healthcare workers and improved wellbeing. MAP success was attributed to the number of daily mindfulness practices and being able to integrate practices into personal and professional life. Integrating participant experiences and stakeholder opinions provided insight into how to enhance the mindfulness program.

Implications: Healthcare systems should consider mindfulness programs to boost the wellbeing of healthcare workers and support patient-care. They should also apply integrated care models when designing, implementing and evaluating mindfulness programs. Longer-term maintenance effects should be explored and condensed mindfulness programs should be compared to non-abbreviated mindfulness programs.

Abstract ID: 104

Compassionate connections, supported communities, planning for future generations: The experience of a cross-sector early childhood summit in Northern BC to inform integration of care

Presented by: Lisa Provencher

Co-Authors: *Erica Koopmans, Caroline Sanders, Lisa Provencher, Lauren Irving*

_____

Conference Track: Shared values and vision,People as partners in health and care,Resilient communities and new alliances

Introduction: The early years (ages 0-8) is a critical stage of childhood development, supporting families during this time requires collective efforts across sectors. Siloed streams limit our ability to meet families' needs thereby missing opportunities to positively influence childhood outcomes. In northern British Columbia a small group of professionals completed training in Compassionate Systems Leadership (CSL). The CSL approach focuses on developing shared knowledge and cultural awareness to strengthen capacity to effectively progress systems change initiatives. Applying CSL with a wider community across northern BC allowed the team to examine how all partners could address silos in early years services.

Aims and Objectives: A first step in applying CSL is to be culturally sensitive and actively relational with professionals working within early years services. In February 2021 we hosted a summit in northern BC, bringing together professionals across child and family serving sectors. The objectives were to find common ground, celebrate local work supporting children, and build on understanding priorities in the early years. Our five day event wove together Indigenous and western pedagogies, highlighting northern First Nation voices and cultural practices. The event used a hybrid model of pre-recorded asynchronous sessions with a concluding full day virtual workshop.

Highlights/Results/Key Findings: Early years services were described as patchy and inconsistent. Critically, the burden of weaving together supports falls to primary caregivers, and across sectors it was acknowledged this created gaps in comprehensive early years services. Many communities worked hard to lessen fragmentation and participants described how relational ways of being helped co-create partnered supports. Participants acknowledged that working compassionately facilitated local initiatives which positively impacted the early years, yet gaps remained including the absence of health's engagement in work across the region. There was consensus that a holistic, culturally respectful, multidisciplinary team, which includes primary health care was needed to support the health and development needs of young children. Discussion focused on expanding hub models of care which exist in select northern communities. A clear message from the summit was a willingness for cross-sector collaboration, and the development of an integrated approach to support families in the early years is required.

Conclusions: In facilitating a safe space that allowed for vulnerability and relational ways of engaging across sectors we discovered commitment, interest, and a willingness for those present to consider new ideas and partnerships that would allow for greater integration of early years services in northern BC's rural contexts.

Implications: Shifting from siloed work to integration across services is complex. Relational ways of being helped providers with this complexity, creating space to learn from each other, begin co-creation, and enhance partnerships. This was evident in early years services but is likely to apply in other service areas seeking integration.

Adaptive Strategies & Change Management
Abstract ID: 107
Adaptive Strategies to Apply a New Model of Integrated Care: The Single Site Order in Seniors Care
Presented by: Francisco Velazquez
Co-Authors: *Francisco Velazquez, Erin Bampton, Ken Casorso, Cathy Nelson, Suzanne Fox*
_____

Conference Track: Population health needs and local context,People as partners in health and care,Resilient communities and new alliances,Workforce capacity and capability,System wide governance and leadership

Introduction: SARS-CoV-2 presented as a complex public health challenge – particularly for spread, morbidity and mortality in seniors' homes. Viewing the need for a rapid and adaptive strategy, the British Columbia Government and Public Health Officer established the Facility Staff Assignment Order (Single Site Order or SSO). The SSO protected society's most vulnerable – the elder population in Long Term Care, Assisted Living, mental health and extended care hospital facilities. To ensure success, system-wide governance was envisioned and established with many stakeholders. Fraser Health implemented and sustained the SSO within the region, which includes 1.8 million people.

Aims and Objectives: The SSO was implemented to lower the risk of COVID-19 transmission by limiting staff movement between facilities. Planning and implementation required system wide collaboration and governance. Competencies for development and application of this new model required mechanisms for timely data collection, changes to Human Resources models, amendments to union agreements, and parameters for accountability.

Through application of change principles such as Prosci's ADKAR Model of Change, a multi-system, multi-stakeholder approach was used in the planning, implementation, communication, sustainment, and evaluation. Stakeholders included the Government, Health Authorities, Unions, Health Employees Association of British Columbia, Care Home Leaders, and others.

Highlights/Results/Key Findings: The SSO undertaking was unprecedented and many components required a rethinking of old processes. A people-as-partners approach facilitated the coordination of the model development and implementation. This system wide governance approach enabled the timing and consistency of communication across all stakeholders and regions. Per change principles, this assisted with adoption, reinforcement and sustainment.

With the newly formed alliances, the following were developed: wage levelling guide, funding template for employers, mechanism to disperse funding to health authorities (and in turn to employers) and processes for monitoring commitments and expenditures.

Through shared relief pools, sites were supported with immediate and urgent staffing needs, specifically with outbreaks. Where needed, Medical Health Officers in each Health Authority assessed and provided exemptions where a health professional required access to more than one site.

Conclusions: The goal of the SSO is to sustain the benefits of the model for the protection of vulnerable populations in higher-risk settings, while recognizing the operational needs of facilities and staff. There are many clear benefits to the single site model that could be considered in a post-pandemic environment.

Implications: Fraser Health and stakeholders have experienced both benefits (reduced spread of SARS-CoV-2) and challenges (reduced casual pools, reduced employee choice for work settings). Implications for sustainability include: Addressing long-range wage leveling and benefits harmonization; Ensuring staffing capacity and maintaining relief pools; health care professionals choosing a workload of multiple sites.

Abstract ID: 115

Does integrated health and care in community deliver its vision? A workforce perspective

Presented by: Linda Wain

Co-Authors: Linda Wain

_____

Conference Track: Shared values and vision,People as partners in health and care,Workforce capacity and capability,Transparency of progress, results & impact

Introduction: There is a change of landscape of health and social care in the community with the movement of Integrated Care Systems which is dependable on the key contribution of the health and care workforce.
The purpose of this paper was to explore and capture workforce perceptions, experiences and insights of the phenomena of Integrated Care (IC) in a community health and care NHS Trust in England; including whether there any associated factors that are enablers, barriers, benefits or challenges; and the level of workforce engagement in the process of integrated health and care. DOI: https://doi.org/10.1108/JICA-10-2020-0061

Aims and Objectives: A qualitative design based on an interpretivist research paradigm was used with a purposive sampling technique. This was a small localised study with five in-depth semi-structured interviews conducted with community nursing, social workers and allied health professionals to explore and elicit from their own words their direct exposure to IC in the community. Colaizzi's (1978) descriptive phenomenological seven-step method was applied to analyse data, with the emergence of 170 significant statements, 170 formulated meanings and 8 thematic clustering of themes to reveal 4 emergent themes and 1 fundamental structure capturing the essential aspects of the structure of the phenomenon IC.

Highlights/Results/Key Findings: The study revealed four interdependent emergent themes: (1) Insight of IC and Collaboration: Affording the opportunity for collaboration, shared goals, vision, dovetailing knowledge, skills and expertise. Professional aspirations of person-centred and strength-based care to improve outcomes. (2) Awareness of Culture and Professionalism: Embracing inter-professional working whilst appreciating the fear of losing professional identity and values. Working relationships based on trust, respect and understanding of professional roles to improve outcomes. (3) Impact of Workforce Engagement: Participants felt strongly about their differing engagement experience in terms of restructuring and redesigning services. (4) Impact of Organisational Structure: Information Technology (IT) highlighted a barrier to IC as differing IT platforms prevent interoperability with one system to one patient. Shared positivity of IC, embracing new ways of working.
Raising the importance for any IC strategies or policy to incorporate the "voice of workforce perceptions and experiences" as key enablers for a fully collaborative approach.

Conclusions: The value and understanding of workforce perspectives through lived experience in practice and the inquisitiveness to seek to listen, understand and learn what matters to people with the "voice of the workforce" a powerful notion and a critical factor to support the scaling up and expansion of the IC agenda.

Implications: Influencing societal change would warrant further insights, understanding and future research both locally, nationally and on a global platform to raise the equal profile of all professionals' unique contribution to IC to reach world health recognition and potential future health care sustainability.

Abstract ID: 158

Post COVID-19 Pandemic Recovery: Towards More Integrated Health and Social Care Systems That Addresses the Complex Needs of Canada's Diverse Populations

Presented by: Karen Davison

Co-Authors: Karen Davison, Vidhi Thakkar, Lorna Stabler, Esme Fuller-Thomson, Maura MacPhee, Simon Carroll, Benjamin Collins, Ron Remick, Brandon Hey, Laura Mullaly, Jake Colautti, Zachary Rezler, Chaoqun (Cherry) Xu, Misha Ishtiaq, Lamson (Shen) Lin, Angela Paric, A

_____

Conference Track: Population health needs and local context,Resilient communities and new alliances,System wide governance and leadership

Introduction: The COVID-19 pandemic has presented many health and social care challenges that have centralized concerns that exist at the intersections of physical and mental health, particularly among equity-seeking populations. Our team of researchers, knowledge users, and patient advisors undertook a scoping review and a rapid realist review to examine interventions to mitigate mental health responses among those with a condition that presents risk of severe COVID-19 infection. This presentation will focus on the findings from the rapid realist review component of our work.

Aims and Objectives: The realist approach identifies contextual factors that trigger underlying, invisible mechanisms associated with intended outcomes, known as context-mechanism-outcomes configurations. Realist literature reviews explain how and why contextual factors act as facilitators or barriers for intended outcomes; they uncover the 'black box' of mechanisms. We constructed a socio-ecological Mental Health Promotion Framework with context-mechanism-outcome configurations to explain why certain mental health interventions work and provide guidance for post-pandemic recovery. The Framework has four systems levels: the health policy level; primary health care/integrated care; the community; individuals, families, and caregivers. The five framework mechanisms are: trust, accountability, power, resilience, and social connectedness.

Highlights/Results/Key Findings: Our rapid realist review was a critical assessment of health and social care systems in the context of the COVID-19 pandemic. The review clearly demonstrated the intersections that occur among health and social inequities, physical health, and mental health. The need for more integrated health and social care was evident across all four systems levels with respect to mental health promotion. Societal recovery from the pandemic presents an opportunity to reverse societal imbalances through a comprehensive, inclusive, and integrated 'reset' of Canada's uncoordinated health and social care systems. Canada has one of the most decentralized governments in the world, comprised of several federal health systems and thirteen provincial/territorial systems that typically operate independently of one another. For example, federal funding mechanisms do not hold the provincial and territorial governments accountable, particularly for social care. A framework that promotes integration within and across systems levels is needed to hold all levels

Conclusions: COVID-19 highlighted health and social inequities in Canada that can no longer be ignored. Better integration of Canadian health and social care systems must be a long-term strategy. Specific contextual factors and underlying mechanisms are associated with improved mental health promotion outcomes for diverse Canadian populations and equity-seeking groups.

Implications: Effective responses to COVID-19's aftermath will necessitate health and social care reforms. Our Mental Health Promotion Framework, constructed through a rapid realist review approach, provides evidence for optimal integration of mental health policy and promotion practices across four systems levels of our Canadian public health care system.

Abstract ID: 167

Designing an approach to evaluation in a complex environment: How the evaluation of Ontario Health Teams adapted to a changing landscape

Presented by: Gayathri Embuldeniya

Co-Authors: *Gayathri Embuldeniya, Ruth Hall, Kaileah McKellar, walter wodchis*

_____

Conference Track: Transparency of progress, results & impact

Introduction: In 2019, Ontario's Ministry of Health launched Ontario Health Teams (OHTs), an ambitious initiative that seeks to ensure that all health care organizations, providers and patients across the province are connected to an integrated team with responsibility for eventually providing all healthcare services for a specific population. Our team was tasked with evaluating OHTs in the context of a landscape transformed by systemic restructuring, shifting healthcare policies and shaped by the COVID19 pandemic. We set out our approach to evaluation in response to this evolving landscape.

Aims and Objectives: We developed a two-phased approach to evaluation. The first formative phase was largely completed in March 2020, just before the pandemic reached Canada, providing contextual and baseline data on how OHTs came together, developed common vision, trusting relationships, governance, and a communication, enagagement and implementation plan. The second phase includes developmental evaluation to provide insight into the heterogeneity of integrated care approaches and the continuous evolution of new models of care. While the first phase provided a snapshot in time (largely January – March 2021), the second will provide ongoing monitoring, from March 2021 – February 2022.

Highlights/Results/Key Findings: The evaluation features five key attributes: longitudinality, ethnography, mixed-methods, incorporation of diverse perspectives, and co-design with OHT participants. The formative phase comprised 1167 surveys distributed across teams that submitted a full application to become an OHT and 125 in-depth interviews with 12 teams. The developmental phase focuses on 6 teams and involves interviews with diverse participants, ethnographic observations of planning meetings and participant journaling over time. Patient and provider experience surveys will also be conducted. The pandemic provided an opportunity to attend virtual meetings, enabling direct insight into team interaction and practice. The overlap of some OHTs across phases also enables insight into how the pandemic impacted OHTs and how OHTs evolved in response. Data collection was informed by key OHT participants who provided guidance and acted as a conduit between OHTs and the evaluation team. Vignettes of insights yielded by different methods will be shared.

Conclusions: Our evaluation approach developed in response to the heterogeneity of integrated care approaches within a landscape shaped by ongoing healthcare reform and a pandemic. It centers a ground-up, participant-informed ethnographic approach that encapsulates a range of methods that yields comparative data across OHTs and insight into individual cases.

Implications: This work demonstrates how intangible outcomes and processes that cannot be measured–from how trust is developed to the experience of integration by differently positioned participants–can be accounted for within evaluations. Other jurisdictions as well as OHTs undertaking internal evaluations may benefit from learning from and adapting this approach.

Abstract ID: 168

Governance and Leadership Challenges and Strategies for Ontario Health Teams

Presented by: G Ross Baker

Co-Authors: G Ross Baker, Paula Blackstien-Hirsch, Michelle Nelson, Heather Graham, Lynne Sinclair, Andrew Pinto, Alana Armas, Rachel Thombs

_____

Conference Track: System wide governance and leadership

Introduction: Ontario has approved 42 integrated care partnerships called Ontario Health Teams (OHTs). These partnerships include community-based organizations, patients/caregivers, hospitals, home care, primary care, and other providers. OHT Leadership Councils, comprised of leaders from these organizations, are accountable for designing new care models for targeted populations. Current provider boards have remained intact; but as collaborative leadership, decision-making and accountability proceed, and care becomes more integrated, new leadership and governance structures and processes will be required to address the scale and scope of care delivery. An adaptive learning strategy, the ADVANCE Leadership Workshop and Coaching Academy, has engaged leaders from 37 OHTs.

Aims and Objectives: Through interactions with leaders and governors, we identified leadership/governance challenges for these emerging partnerships, and strategies to address them. The ADVANCE Program offers a virtual environment for collaborative learning that assists leaders and coaches (recruited from 29 OHTs) to identity key practices and tools for developing authentic collaboration, shared leadership, decision-making, and accountability. The Coaching Academy aims to facilitate more effective governance processes and development of participants' coaching skills. Interview and workshop data from leaders, board members and coaches, and details from "roadmaps" developed by leaders are used to illustrate challenges and approaches to more effective leadership and governance.

Highlights/Results/Key Findings: Ontario's strategy for integrated care focuses on "bottom-up" initiatives within a framework of broader top-down strategies and performance goals. Rather than mandating leadership/governance structures and processes, government has created a "low rules" environment to enable OHT partnerships to develop local arrangements. The ADVANCE Program supports leaders, governors, and coaches in developing effective collaborative governance practices. Evaluation of these activities has been very positive. Key findings to date indicate that many leaders and governors have been challenged by the limited time and resources available to engage with partners to develop trusting relationships, a critical foundation for developing integrated care models. Developing a roadmap targeted at key collaborative tools and practices has helped many OHT leadership councils. Provider boards have had only limited guidance on the new governance arrangements, and greater communication between these boards, and between boards and leaders will be critical in supporting the evolution of effective integrated governance.

Conclusions: Ontario Health Teams are still in early stages of development. ADVANCE supports for leadership development and governance effectiveness have drawn positive reactions, underlining the need for such supports. Developing coaching capability within OHTs linked with interactive leadership dialogue workshops has enabled leaders across partner organizations to engage more effectively.

Implications: Integrated care initiatives have variable trajectories; yet effective leadership and governance, that includes patients/caregivers as leaders, are key components of high performing efforts in any setting. Lessons learned from the Ontario experience suggest that virtual learning and local coaching are an effective approach to improving collaborative governance practices.

Abstract ID: 171

The tenuous beginnings of health system transformation: How Ontario Health Teams enacted change in the context of uncertainty

Presented by: Gayathri Embuldeniya

Co-Authors: Gayathri Embuldeniya, Jennifer Gutberg, Shannon Sibbald, walter wodchis

_____

Conference Track: System wide governance and leadership

Introduction: In 2019, the government of Ontario launched Ontario Health Teams (OHTs), a milestone in the journey towards integrated care and population health management. Yet, early model development was riddled with uncertainty. This research explores what made system transformation possible even in the context of that uncertainty. It explores how uncertainty was manifested at cross-organizational, sectoral, and professional levels across OHTs, and how it could be successfully negotiated.

Aims and Objectives: A stratified random sampling approach was used to select 12 representative OHTs across geography and sector, from 30 OHT applicants. We conducted semi-structured interviews with 125 participants across OHTs who had played key roles in shaping their OHTs, including administrators, clinicians and patient and family advocates. Interviews were conducted one-on-one, using telephone and videoconference, largely between January to March 2019, by experienced qualitative researchers. Interviews were transcribed, anonymized, coded using NVivo 12, and thematically analyzed through a cultural constructivist lens.

Highlights/Results/Key Findings: A sense of uncertainty was identified at three levels: a) at an OHT level, there was uncertainty about certain healthcare policies that were in flux, coupled with the perception of a lack of direction from policymakers; b) at a sectoral level, certain sectors were uncertain about participating due to historic vulnerabilities; and c) at a professional level, physicians were uncertain about the value of the new model and their place within it. These concerns were countered by a recognition of the need for change, the value of the new model, inclusive decision-making, and awareness of and empathy for each other's needs. This helped unsettle traditional hierarchies and facilitated new forms of certainty. We present how uncertainty were experienced across OHTs at different levels, followed by three case studies, one at each level, showing how uncertainty was navigated by participants of a specific OHT and the contexts that facilitated this negotiation.

Conclusions: OHT participants' ability to put in place structures and strategies to navigate uncertainty demonstrates how some forms of uncertainty can be successfully managed and even be productive. Their work was made possible by a deeply felt understanding that traditional power structures needed to be reimagined.

Implications: Understanding the possibilities and challenges of this endeavour will be helpful to program implementers negotiating uncertain environments as well as to policymakers seeking to provide guidance without stymieing local innovation.

Abstract ID: 173

NYG@Home: A Blended Model Supporting Patients at Home During COVID-19

Presented by: Jennifer Roberts

Co-Authors: Jennifer Roberts, Anita Fitches, Karen Fisher, Stacey Grammick, Danielle Holler, Erica Pinto, Zahra Ismail, Marwan Asalya

_____

Conference Track: Workforce capacity and capability

Introduction: In 2019, North York General Hospital (NYG) partnered with two home care providers to implement an innovative and integrated program to support safe and streamlined discharges from hospital to home called NYG@Home. Bayshore HealthCare Integrated Care Solutions, one of the home care providers, recognized early on in the COVID-19 pandemic that patients were fearful to have healthcare workers in their homes. Through the use of decision support tools and education on infection prevention and control protocols and the use of personal protective equipment, our teams successfully managed to alleviate patients' fears and reluctance to have healthcare workers in their homes.

Aims and Objectives: The hospital and home care providers needed to pivot quickly during the COVID-19 pandemic and discover new ways of working to provide safe and effective care to the NYG@Home patients. Teams in the home care setting had to be re-organized and the delivery of many services needed to shift from in-person visits to virtual. Capacity in the system was stretched and directives and orders that were imposed further impacted the pressures on the workforce. Collaboratively, and with the support of the hospital and home care leadership teams, we were able to continue to provide high quality care in the home.

Highlights/Results/Key Findings: In order to change how healthcare was delivered in the home a number of elements needed to be in place including: 1) providing regular and ongoing training to all home care staff on the technology to support the delivery of virtual care, 2) implementing a blended visits model where nurses work to their full scope, including providing personal care, thereby reducing the number of workers that needed to be in the home, and 3) building trust and improved communication channels to ensure that assessments conducted by other healthcare providers were completed and documented in a timely manner and accessible to everyone on the care team. Finally, with a focus on supporting our patients at home and avoiding any unnecessary emergency department (ED) visits, we developed informal partnerships with paramedicine to assist with determining which patients required transfer to ED and which ones could remain at home with enhanced monitoring.

Conclusions: We learned that delivering integrated care during a pandemic requires focused teamwork, trust, collaboration, and an openness to change. Understanding the strengths of each organization to build capacity and test new models provided an opportunity to improve our collective systems while maintaining a focus on quality and positive patient experiences.

Implications: The skills and knowledge acquired to shift models of service delivery quickly during the pandemic can be applied and transferred to future integrated care programs. A shared vision, trusting partnerships, strong infrastructure, and a relentless focus on providing safe and effective patient care have been established and are sustainable.

Abstract ID: 177
Understanding Care Transitions Before, During and Post COVID-19: Patient/Family, Care Provider and System Experiences
Presented by: Katharina Kovacs Burns

Co-Authors: *Katharina Kovacs Burns, Marian George*

_____

Conference Track: People as partners in health and care,Resilient communities and new alliances

Introduction: One of the ongoing challenges in health care is ensuring patients/families and also health care providers have clear direction and implementation guidance around transitions in care across all care and community settings that includes integration, continuity and coordination. Clearly understanding patient and care provider experiences including what works and where improvements are needed with care transitions across acute and community settings has been an ongoing challenge for most health care systems before COVID-19. During COVID-19, efforts to identify and use experience measures were complicated and impacted because of rapidly enforced restrictions and guidelines for patient/client, family and provider safety.

Aims and Objectives: Exploring the experiences of patients/clients, families and care providers with their care transitions between acute and community-based care settings prior to and during COVID-19, along with changes in care outcomes, practices, policies and services became the focus of a two-year pilot study within Alberta Health Services (AHS), Canada. We co-designed relevant experience, process and outcome/impact experience indicators/measures with patients/clients, families and care providers regarding care transitions across acute and community settings; and explored the feasibility for transferring measures and lessons learned for practice, policy and service changes as part of follow-up and post COVID new 'norm' transformation of care transitions.

Highlights/Results/Key Findings: The study involved the Provincial Seniors and Continuing Care Advisory Council, Continuing Care Quality Committee and eight pilot settings involving community and Transitions in Care programs across the five zones of AHS. Each care setting involved care providers and patient/family advisors in co-designing and implementing the initiative, including survey development, and gathering, analyzing and interpreting client/patient experiences. Findings in each of the eight pilots included more detailed patient/family and care providers experience indicators/measures for transitions in care across settings. Clear themes for what makes transitions in care successful are also identified – e.g. clear communication, navigation and information direction for all stakeholders. The aggregated findings have guided the development of a set of core transition in care measures from across acute points of care including Emergency and care units, to various community-based care settings including Home Care, Long-term or other program and care services/settings – e.g. CHOICE programs.

Conclusions: Understanding the experiences of patients/clients, families and care providers regarding care transitions between acute and community-based settings are essential to understanding what works well and where there are 'holes' in the system leading to failed or unsatisfactory transitions across different care settings. Such findings guide quality and safety improvement.

Implications: These core measures are being tested for transferability across all care transition settings. As well, practice, policy and service changes involving care transitions resulting from the impact of COVID-19 are noted for how care settings involving specific transition programs will adapt to "new norms". Further measurement continues.

Abstract ID: 206

Asthma Right Care Global movement: adopting new strategies to get a large scale change in asthma management

Presented by: María Mar Martínez Vázquez
Co-Authors: María Mar Martínez Vázquez

_____

Conference Track: Shared values and vision,Population health needs and local context,People as partners in health and care,Resilient communities and new alliances,System wide governance and leadership

Introduction: According to the Global Initiative for Asthma (GINA) asthma is a serious global health problem affecting all age groups and its prevalence is increasing in many countries.In spite of diverse efforts, and the availability of effective therapies, international surveys provide ongoing evidence for suboptimal asthma control in many countries.Every effort must be made to encourage health care leaders to assure availability of, and access to, medications, and to develop means to implement and evaluate effective asthma management programs. To this end, we should reflect on strategies that would be both clinically relevant and feasible for implementation.

Aims and Objectives: In 2017 the International Primary Care Respiratory Group (IPCRG) initiated Asthma Right Care to get the conversation going about the need at policy and clinical levels to relook at asthma management and move from a state of comfort to discomfort with current state. Then, once people were ready to ask "how can we do better" to offer options. The ARC group focused on finding solutions within the real-life context of health systems to improve asthma care adding value to interventions. They decided to apply the evidence from social movements for health, achieving large scale change and "right care" to asthma.

Highlights/Results/Key Findings: We selected the main message: over-reliance on SABA (short-acting-beta-agonist) to disrupt the status quo and make some noise about the unacceptability of doing nothing. We mapped the asthma pathways and stakeholders to identify where the message starts to go wrong. Then, we kickstarted action with new communication tools, nurtured diverse voices: 12 countries (UK, Spain, Portugal, Canada, Netherlands, France, China, Vietnam, Malaysia, Brazil, Slovenia, Greece), patients, pharmacists GPs, emergency teams, nurses, industry and influenced and interacted with wide array of stakeholders, gaining followers who commit to testing and sharing our tools and messages.

We have already reached over 110,000 frontline health care professionals and global primary care leaders through social media, conference, webinar, journals. We created Asthma SABA slide rule, Novel Reliever Reliance Test, Question and Challenge cards, 6 teaching case studies, Teach the Teacher cascades in Middle East, Australia, Spain and Latin America and E-learning for South African pharmacists.

Conclusions: Asthma Right Care applies the evidence underlying social movements to achieve a large-scale change in asthma management. The movement has the power to both, get asthma patients engaged from the beginning of the process and make professionals reflect on their current practice and request information and support to do better.

Implications: This project can be applied everywhere because it was thought to be adapted to every local context. We created an Implementation Pack "how-to-guide" to enable new local delivery teams to start up.
Sustainability, here, relies on followership; so, as long as you get involve more followers, the movement keeps going

A Multi-Method Case Study of Collective Leadership in System Reform

Presented by: Shannon Sibbald
Co-Authors: Shannon Sibbald, Ruth Hall, Jennifer Gutberg, walter wodchis

_____

Conference Track: System wide governance and leadership

Introduction: In 2019, the Ontario government introduced Ontario Health Teams (OHTs) as a new way of delivering more integrated care. OHTs are mandated to collaborate and integrate care within defined regions by partnering with the array of health organizations within the region. To effectively integrate care across providers requires collaborative leadership to build trust, and to distribute accountability, power, and funding across organizational boundaries. Accordingly, leadership must be peer-driven and inclusive of patients, communities, and frontline workers alongside health administrators. This study describes how OHT leadership was conceptualized and executed and explores collaborative leadership within the formative stage of OHTs.

Aims and Objectives: This multi-method case study design (interview, survey, and document analysis) was conducted on the first cohort of OHTs (n=30) in 2020. In-depth semi-structured interviews were conducted with individuals from a sample of 12 OHTs (n=126). Participants were asked to describe how OHT initiatives were formulated and how different constituents came together to create them. A universal deductive coding scheme was created for analysis. A 42-item survey was administered to 785 individuals across the 30 OHTs to measure capacity and capabilities for integrated care (response rate= 63%). Five items in the survey were specific to leadership.

Highlights/Results/Key Findings: Collaborative leadership facilitated the creation of shared approaches, visions, and goals. OHTs' mandate to collaborate resulted in informal working agreements and consensus-based decision-making models. 67% of participants felt that the leadership created an environment where differences of opinion could be voiced. Despite predominantly positive perception of collaborative leadership in interviews, only 1/3 of OHTs had ≥80% of their respondents indicating they had effective OHT leadership. Participants considered trust an essential component of collaborative leadership, supported through survey results as 71% considered their OHT leadership very good/excellent at fostering respect, trust, and inclusiveness among members. Interview participants described different stages of trust within their OHT. Some participants expressed concern around the 'lead organization' holding too much control over decision-making. This was often mitigated through smaller working groups where participants believed patients and family members were given an equal voice.

Conclusions: Collaborative leadership was a common philosophy across OHTs but approaches to structures varied by context (e.g. history of collaboration, existing infrastructure, etc.). Most participants felt their leadership had established trust and highlighted its importance. As OHTs mature, leadership models must adjust to maintain trust and collaboration between partners.

Implications: When implemented effectively, collaborative leadership structures enable flexibility to adapt as teams progress through stages of development. As OHTs grow and expand, leadership will need to adapt to bridge diverse interests, to find common ground to manage conflict, and to ensure trust is maintained.

Abstract ID: 18

Modifying Essential Coaching for Every Mother, a postpartum text message program, for implementation during COVID-19

Presented by: Justine Dol

Co-Authors: Justine Dol, Gail Tomblin Murphy, Douglas McMillan, Megan Aston, Marsha Campbell-Yeo

_____

Conference Track: Digital solutions

Introduction: Essential Coaching for Every Mother is a six-week postpartum text message program that was previously developing in consultation with postpartum mothers and healthcare providers with the goal of improving women's psychosocial outcomes.1 With the outbreak of COVID-19 in early 2020 and the readiness of the Essential Coaching for Every Mother program to fill the sudden gap in postpartum support, a decision was made to modify the program to be offered immediately. Given that Essential Coaching for Every Mother was developed prior to COVID-19, some modifications were necessary of existing messages and for the inclusion of coronavirus related content.

Aims and Objectives: To ensure that the revised content of Essential Coaching for Every Mother was appropriate and acceptable, the modified messages were piloted with mothers and postpartum healthcare providers simultaneously. Messages were updated using the Government of Canada and World Health Organization guidelines around mother-infant care and coronavirus2,3 and followed the Government of Nova Scotia public health guidelines.4 Ten existing messages were modified and 4 new messages were created. A subset of participants who were involved in the original development were shown the revised messages through screen sharing using video conference software by the first author who conducted all the interviews.

Highlights/Results/Key Findings: Three mothers and seven healthcare providers participated in the modification of the messages. Overall, the mothers and healthcare providers felt the messages were appropriate and relevant related to changes in postpartum care during the coronavirus pandemic. Feedback was related to ensuring that the messages shared information about what mothers could do (e.g., go for walks when safely physically distancing, see their family doctors for vaccinations and follow-ups) and who to contact if they had questions (i.e., call 811). There were also recommendations to provide links to current guidelines in case recommendations changed. Nine messages were modified from the original program to be relevant to COVID-19, of which four messages were collapsed into two, and five new messages were added to the program. During the first two weeks, messages were sent 2-3x/day a day for the remaining four weeks. In total, Essential Coaching for Every Mother-COVID-19 stream has 56 text messages.

Conclusions: The modification of Essential Coaching for Every Mother to be applicable during COVID-19 pandemic was achieved relatively efficiently, with a total of 56 messages. We were able to maintain approximately twice a day messages for the first two weeks, except for three days in which three messages were sent.

Implications: The Essential Coaching for Every Mother postpartum text message program can offer a way to provide evidence-based, people-centered care during a time of challenges associated with COVID-19 pandemic restrictions. By engaging mothers and healthcare providers in the message modification, it helps ensure that the messages are relevant, appropriate, and desirable.

Abstract ID: 22

Co-Designing an eHealth application to facilitate integrated care coordination between healthcare and social care providers: The PopUP! application

Presented by: Jamaica Tan Pei Ying

Co-Authors: Jamaica Tan Pei Ying, Yee Wan Qi, Sow Zheng Kwok, Esther Lim Li Ping, Low Lian Leng

_____

Conference Track: Digital solutions

Introduction: Within healthcare institutional settings, healthcare providers often rely heavily on the hospital's Electronic Medical Record (EMR) system to understand patients' medical history and to determine appropriate interventions. However, due to the lack of an IT system that allows for information integration and secure communication between healthcare and social care providers, fragmentation of patient information is commonplace. This adversely impacts the care coordination between care providers when providing continuity of care to patients in the community. In addition, with the rising numbers of cyberattacks on healthcare institutions, having a secured platform to facilitate integrated care coordination is urgently needed.

Aims and Objectives: This project utilizes co-designing methodology to co-create PopUP!, an eHealth digital application for seamless care coordination and secure sharing of patient records between healthcare and social care providers, to overcome the current system's gaps. Healthcare administrators(n=51), nurse clinicians(n=32), and allied health professionals(n=6) from five health ministries and social care sectors in Singapore were involved in five 2-5hours Design Thinking workshops over two weeks. This served to draft patient Journey Maps, assess needs and pain-points, ideate features, and co-create and co-refine PopUP!. Methods such as affinity clustering, Impact and Difficulty Matrix, and MoSCoW framework were utilized to select the final features.

Highlights/Results/Key Findings: The patient Journey Maps developed provided an overview of patient flow and helped identify key areas for intervention. Seven personas of potential end-users of PopUP! were identified from the needs and pain-points gathered, and guided the How, What, and Who PopUP! will benefit. Of the features shortlisted for the Minimally Viable Product (MVP) of PopUP!, three key features were included (i) an intuitive dashboard with an overview of patients' admission status, number of missed appointments, task lists and key figures of services undertaken, (ii) a medical record tab populated through a secure data integration from existing EMR to PopUP!, and allow seamless sharing of data between authorized healthcare and social care providers, and (iii) One-Care Plan, a collaborative platform for communication and integration of shared plans for patient care across settings. The project is currently in the user-testing phase where potential end-users are involved to assess the usability of PopUP!.

Conclusions: Inter-professional and cross-ministry collaboration should be leveraged upon to co-create an eHealth application that results in quality systems that benefits end-users. The PopUP! was developed to aggregate whole-of-person data for action and to be a viable, and effective solution to integrate patient care between healthcare and social care sectors.

Implications: The use of e-innovations coupled with co-designing and Design Thinking methodology and involving representative stakeholders ensures systemic acceptance and adoption of PopUP!. While the entire Design Thinking process was conducted virtually, the end-product was not compromised. Future improvements include involving patients in the co-creation process to enhance patient-centricity of PopUP!.

Abstract ID: 41
Virtual Mentorship and Consults: Integrating Quality Patient Care in the Home
Presented by: Reena Tabing

Co-Authors: *Reena Tabing, Tammy Rooke, Heather Binkle, Lasha Keith*

_____

Conference Track: People as partners in health and care,Workforce capacity and capability,Digital solutions

Introduction: CarePartners, a home care provider that offers a "full basket" of services cross Ontario, launched a pilot in February 2020 to understand the effectiveness of virtual care tools for home and community care patients. CarePartners Connect is a secure, electronic, communication platform that allows patients and families to communicate remotely with their provider in real-time, allowing for virtual consults, follow-up and monitoring. The COVID-19 pandemic accelerated CarePartners' deployment and broadened the scope to all Registered Health Professionals in the organization. The solution ensures that patients continue to receive high quality and timely clinical care, while minimizing in-person contact.

Aims and Objectives: With a rapid deployment to over 500 front-line home and community care providers in three months, providers were challenged with embedding virtual care within their practice and workflows. To help drive adoption, the program focused on developing a virtual mentorship and consult model that maximizes the benefit of virtual care, through widening the connections with a broader team while a provider is supporting a patient in their home. Through these virtual partnerships and consults, front-line staff working in a dispersed environment would further benefit from coaching and mentorship, ultimately improving quality and better integrating patient care.

Highlights/Results/Key Findings: Results from the last six months shows:
•   Steady levels of adoption and uptake with therapists for direct patient care and for virtual care conferences that integrate the broader care team at the patient bedside
•   Limited adoption with nurses and personal support managers direct with patients
•   Virtual mentorship and consult visits emerged organically through providers using the technology to connect with internal colleagues or external partners to support integrated patient care. With dedicated full-time efforts in supporting change management initiatives and driving adoption at the local level, front-line staff have more readily adopted this virtual model.
•   It is anticipated that continued focus on a virtual mentorship and consult model will help providers gain more experience using the technology with colleagues, which in turn will build confidence in scheduling virtual visits directly with patients.
CarePartners continues to monitor virtual care volumes, including virtual mentorship and consult visits, on a bi-weekly basis.

Conclusions: CarePartners' experience implementing a virtual mentorship and consult model highlights the importance of focused attention on adoption that includes building provider confidence in applying the technology, but also knowing when a virtual visit makes best sense. Continuous engagement with frontline clinicians is key to creating opportunities for virtual integration.

Implications: CarePartners sees continued opportunities to leverage virtual care to integrate care at transition points or to support warm handoffs across sectors; to support equitable access for harder to reach areas; and gain efficiencies to build additional capacity in the system.

Abstract ID: 56

Finding Where Technology Fits: An Integrated Care Program Development Example

Presented by: Meera Vignarajah

Co-Authors: Meera Vignarajah, Kelly Lane, Lindsay Maynard, Marsha Alvares, Samra Mian-Valiante, Christian Veillette

_____

Conference Track: People as partners in health and care,System wide governance and leadership,Digital solutions

Introduction: As digitally-enabled medicine becomes synonymous with mainstream practice, carefully selecting tools that integrate into existing workflows and improve patient and provider experience is needed in order for the impact of digital solutions to be fully realized. In 2019, the Schroeder Arthritis Institute at the University Health Network created an integrated care program for musculoskeletal (MSK) patients to promote integration in health care delivery between hospitals and community providers, drive high-quality efficient care, and improve patient outcomes and experience. Collaborative consensus building was used to identify where digital solutions could enable integrated patient-centered pathways.

Aims and Objectives: The first phase of program development focused on in-depth current and future state analysis of a specific service within the program (Hip & Knee Surgery). Four exploratory in-person sessions were conducted to identify gaps and opportunities where digital solutions could enable integrated patient-centered care. The sessions were hosted with 20 participants across 14 staff unique roles including physicians, allied health clinicians, administrative staff, and a patient partner to understand the care pathway from referral to post-acute rehabilitation. Once the current workflow was understood, the group identified areas for improvement. The patient's lived experience was central to determining these opportunities.

Highlights/Results/Key Findings: Four opportunities identified for improvement could be addressed in part through new digital tools and centralized systems.

1) Patient risk stratification tools to alert the care team of high-risk patients based on clinical and social risk factors prior to surgery could reduce unexpected downstream complications.

2) Patient communication tools to provide direct access to the care team could address patient anxiety when awaiting information about their care plan.

3) Greater system integration of existing booking and care processes to address administrative users' fatigue with patient registration across multiple domains.

4) Central access and visibility of real-time patient information across the care team and with the patient could be strengthened. The main information gaps occurred when patients transitioned from primary care to hospital, hospital to rehab provider or when medically managed.

Access to the right information at the right time emerged as a key tenant for supportive technology integrated care.

Conclusions: By first understanding existing gaps in care, digital systems can be strategically deployed to strengthen relationships between patients and providers. Future work will include identifying key differences for services beyond Hip & Knee surgery to ensure selected solutions are applicable in those contexts and expanding integrated models enabled by technology.

Implications: Funding for procuring digital solutions is often limited so new models for cost recovery should be explored. New integrated funding models for Total Joint Replacement surgery in the province presents an opportunity to invest earnings from efficiencies gained into resources and technology.

Abstract ID: 67

Building the evidence base for integrated care planning: proof-of-concept analysis of a multi-sector integrated dataset in Estonia

Presented by: Adriana Poppe

Co-Authors: Adriana Poppe, Gerli Aavik-Märtmaa, Ene Rebane, Ingo Meyer

_____

Conference Track: System wide governance and leadership,Digital solutions,Transparency of progress, results & impact

Introduction: A major problem in achieving person-centered and integrated care is the fragmentation of individual support into the different service silos. This fragmentation carries through into the world of information, with siloed data systems for different sectors. Therefore, no uniform picture can be formed across different sectors about all the support a person has received. This can result in problems understanding the individuals' needs, their current care situation and how both matches. To tackle those problems and moreover, to improve the quality and efficiency of support systems integrated care models are perceived as an important, innovative and promising way [1].

Aims and Objectives: Data integrated from different sectors is needed for better policy-making, administration of services and people and providing integrated care services at the service delivery level. Therefore, a proof-of-concept version of an integrated dataset to support care integration has been developed in Estonia. It contains data of the social insurance board, the municipalities (responsable for different services), unemployment insurance fund and the health insurance fund and etc.. By using personalized IDs, data sheets from different sectors were linked. The data sets were tested for plausibility in their association, for example, whether people receive pension and unemployment benefit at the same time.

Highlights/Results/Key Findings: Since the dataset is based on registration, social and health data, no population biases are present, which is an advantage in the attempt to display the population of a country/region. Generally, the plausibility checks and proof-of-concept analyses show that the dataset is plausible. Research questions such as the share of persons where trajectory includes hospital services and duplication of service periods can be answered. Nevertheless, it must be said that the data from one sector was of poor quality, which limits the quality of the entire data set. In addition, different coding methods of, for example, dates, lead to error-proneness when linking the data. Some dates contain only a month and/or year, making them difficult to use while, for example, building periods of service provision. Adjustment of the coding strategies among the sectors would be helpful to improve the quality of the dataset.

Conclusions: It is generally suitable for delivering aggregated data for planning and decision-making processes in the context of integrated care. It provides coverage of the different sectors and their services that can be brought together. What assessments, services, benefits etc. was received at a given time can be shown.

Implications: Several limitations such as coding precision have to be considered while carrying out data integration of more regions and/or further analyses.

References

[1]   Council of the European Union. Council conclusion on the Reflection process on modern, responsive and sustainable systems; 2013 [cited 2021 May 31] Available from: http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/140004.pdf.

Abstract ID: 106
Connected Care: Leveraging Virtual Solutions to Build Capacity from Hospital to Paediatric Home and Community Care

Presented by: Krista Keilty

Co-Authors: *Krista Keilty, Stephanie Chu, Jessica Esufali, Kate Langrish, Sophia Lawson, Sandra McKay*

_____

Conference Track: Workforce capacity and capability

Introduction: Accelerated by demands of the pandemic, Connected Care innovates across the paediatric health sector to leverage virtual solutions in addressing the pressing need for capacity building among home and community care (HCC) providers of children with medical complexity. Connected Care services supports a highly specialized and scarce paediatric home care workforce to deliver evidence-based nursing care when children transition from hospital to home. Family caregivers of children who depend on medical technology are integral to informing program development and guiding integration of new technologies and service lines.

Aims and Objectives: Virtual care delivered by Connected Care aims to promote confidence and competence among home care providers of children with medical complexity through uptake of standardized, paediatric best practice. Connected Care engages hospital and home care administrators, interprofessional providers, and family advisors to inform integration of emerging technologies, testing of new virtual solutions, and usability of Connected Care's information technology platforms. Services delivered by Connected Care from hospital to home undergo continuous quality improvement and include: 1) nurse led- 24/7 eConsultative services, 2) virtual simulation-based nursing education, and 3) cross-sector interprofessional virtual visits.

Highlights/Results/Key Findings: Connected Care's virtual community of practice has grown to include >800 homecare providers from >50 homecare organizations. In 2021, Connected Care will deliver >1000 paediatric virtual education sessions, across highly-accessible virtual platforms. The development of virtual simulation-based training modules for paediatric home ventilation have received very positive feedback among partners who describe appreciating the opportunity to practice their skills remotely. This year, Connected Care technologies will support remote access to >400 eConsultations and >1,500 self-directed resources. Consult types from homecare nurses vary with the majority reflecting their questions about medical technology trouble shooting. Real-time feedback indicates homecare nurses are highly satisfied with the eConsultation service giving it 'thumbs up' 99% of the time. Growth has been rapid in conduct of post- discharge virtual visits. In 2021, Connected Care will deliver >600 Virtual Visits bringing together hospital providers, family caregivers and homecare providers.

Conclusions: Demand for Connected Care continues to build, aligned with recovery of paediatric homecare workforce and transition care gaps heightened through and beyond the pandemic. Experience with implementation of technologies linking hospital to home and community signal a high rate of acceptance and usability among diverse end-users across the sector.

Implications: Connected Care is well positioned to innovate in the use of cutting edge technologies to promote system integration. Leveraging partnerships and sharing resources will promote best practice and be scaled to build capacity in delivery of paediatric home care across expanding partnerships and geographies.

Abstract ID: 120

Designing Outside the Lines to Achieve the Quadruple Aim

Presented by: Allison Loh-Kandylis

Co-Authors: *Allison Loh-Kandylis, Kathleen McQueen*

_____

Conference Track: People as partners in health and care,Digital solutions

Introduction: The COVID-19 pandemic impelled healthcare organizations to rapidly innovate and integrate to ensure patients receive the care they need. In 2020/21, several Ontario hospitals and home and community-based partners collaborated to co-design, deliver and evaluate an integrated Restorative Health Approach targeting priority populations such as frail seniors to improve system capacity, while achieving sustainable health and system outcomes.

By involving people as partners and using existing technology in unprecedented ways to enable real-time information sharing, patient activation, and to achieve one integrated interdisciplinary care plan, we were able to better support clinical decision making, team collaboration and person centered care.

Aims and Objectives: The aim of the Restorative Health Approach is to create coordinated and continuous pathways that support safe, timely transitions of care, while focusing on person-centered goal attainment, shared decision making and enabling patients and families to reach their optimal level of functioning and well-being.

To achieve these goals, partners took a flexible and intentional approach to integration; partnering with patients, caregivers, and health and social care partners to create one integrated team with shared goals focused around patient and family needs. To drive integration and enhance team satisfaction, technology was leveraged in innovative ways to collaborate and monitor health.

Highlights/Results/Key Findings: The engagement of clients and families was essential to goal achievement, supported by coordinated and integrated interdisciplinary teams and digital tools that were designed to enhance the care experience. Real-time information sharing at the point of care and one integrated person-centered interdisciplinary care plan was essential to an informed, collaborative and integrated care team focused on coordinating care around the patient's needs. Remote patient monitoring was leveraged to not only monitor vital signs but also support patient self-management and adherence to clinical pathways.

Quadruple Aim Outcomes:
• 70% reduction in ED visits
• 50% decrease in service plans
• 30% decrease in hospitalizations
• 88% patients experienced sustainable functional improvement
• 60% patients discharged to self-care
• 88% patients experienced reversal in clinical frailty
• 80% caregivers report a positive change in loved one
• 92% providers feel empowered in their role
• 88% providers feel the program enables collaborative practice
• 100% patients feel safe and supported at home

Conclusions: Out of the box thinking is required to optimize and redesign technology to achieve the quadruple aim. Technology is a key enabler that not only accelerates integration across the care continuum but also supports a unique restorative health approach that results in superior outcomes.

Implications: Active involvement of people in design, implementation and evaluation of technology ensures digital tools are meaningful and supports integrated care, which is critical to adoption. People need to be a part of the design process and supported along the way to sustain change, enhance scalability and achieve desired outcomes.

Abstract ID: 134

Digitally Integrating Acute and Long-Term Care

Presented by: Jonathan Sachs

Co-Authors: *Jonathan Sachs, Tyler Aird*

_____

Conference Track: Population health needs and local context,System wide governance and leadership,Digital solutions,Transparency of progress, results & impact

Introduction: Transfers between acute facilities and the community (namely long-term care homes) have long suffered from challenges to integrated care, often stemming from the current reliance on paper documentation, follow up phone calls, and discussions with the patient to enable transitions in care. Current processes are inefficient for staff and hinder quality care by increasing the risk of errors and readmissions.

PointClickCare, the leading electronic health record (EHR) provider for senior's care, is working to support this challenge through digital innovation. Their new product, Harmony, creates a two-way, digital integration between a hospital EMR and the EHR in long-term care.

Aims and Objectives: This presentation will provide an overview of Harmony, and its capabilities. It will focus on Harmony's benefits by highlighting the first implementation of Harmony in Canada, at St. Joseph's Healthcare Hamilton (SJHH).

SJHH implemented Harmony beginning in the Spring of 2020. Their focus was on validating the potential of an acute-LTC integration, using the hospital's Epic HIS system, and St. Joseph's Villa, a healthcare system partner LTC home that uses PointClickCare. Key areas of focus for project evaluation included validating the clinician experience, timeliness of information being shared, and ease of access to the information within clinical workflows.

Highlights/Results/Key Findings: Results from the project evaluation will be shared, including positive results from clinician surveys and interviews, as well as efficiency and time savings resulting from data integration incorporated into the admission and discharge processes.

The presentation will also provide insights on the potential for tools like Harmony to enable integrated care coordination and population health management, which are key enablers of successful models of integrated care. Real-time population health dashboards can support the success of innovative approaches to integrated care, such as the Ontario Health Teams (OHTs) and Accountable Care Organizations (ACOs) in the United States.

Conclusions: The ability to digitally integrate acute and long-term care can provide numerous benefits, including workflow efficiencies and improved clinical decision-making across the continuum. It also supports strengthening the relationship between hospitals and community providers, which are foundational to quality care as we begin to apply lessons from the COVID-19 pandemic.

Implications: Compared to other digital innovations, this innovation has a unique opportunity to scale and spread across Ontario, particularly in support of the new OHT integrated care model. Harmony is also EMR 'agnostic' so it can be implemented at both Epic and non-Epic hospitals.

Abstract ID: 196

Cross-sectoral Virtual Meetings. Goals and Plan for the patient's hospitalization

Presented by: Ditte Høgsgaard

Co-Authors: *Ditte Høgsgaard*

_____

Conference Track: Shared values and vision,Population health needs and local context,Digital solutions

Introduction: Cross-sectoral Virtual Meetings (Virtual4M) is videoconference on the patient's hospitalization when an exchange of knowledge and information about the patient's situation is needed. 4 refers to four partners in the virtual meeting (M). The four partners are patient, relative, primary, and secondary sector. The conference will be held at the hospital immediately after the patient's hospitalization. The aim for health care professionals from both sectors to exchanging their expectations for the patient's hospitalization with the patient and relatives at a video conference and to draw up goals and plans

Aims and Objectives: Create better cross-sectoral processes together with patient and relatives
• Increase patient and relative satisfaction with cross-sectoral processes
• Strengthen the cross-sectoral collaboration between the health professionals, which must contribute to knowledge sharing, greater understanding as a basis for common goals, and a plan for the citizens' course
• Reduce the number of readmissions
The study should examine
• how Virtuel4M can strengthen cross-sectoral collaboration on patients' coherent processes
• patients 'and relatives experience of satisfaction and quality in transitions
• whether a Virtual4M at admission can contribute to fewer unintentional admissions and discharges

The patient group is 65+-year-old chronic and multi-sick patients who need home nursing

Highlights/Results/Key Findings: Design
The overall design is action research, where researchers together with health professionals, patients, and relatives have developed Virtuel4M. The study has a qualitatively oriented study design. Data comes from observational studies, single interviews, focus interviews, and registration forms.

Innovation:
1. Cross-sectoral workshops, where staff participating in the project are informed and taught in the implementation of cross-sectoral Virtual4M.
2. Virtual4M is coordinated and planned together with the patient and relatives
3. Health professionals responsible for the patient's situation and course participate in the interview.
4. The conversation is conducted virtually

Content of the conversation at the videoconference is:
• Mutual expectations for admission
• Special attention to "what is most important to you" for patient/relatives
• Coordination and planning
• Agreements for possible follow up

Conclusions: Result: 10 Virtuel4M will be conducted in August/September 2021. Presentation of the 10 Virtual4M conclusion at the conference

Implications: Create better cross-sectoral processes together with patient and relatives
Increase patient and relative satisfaction with cross-sectoral processes
Strengthen the cross-sectoral collaboration between the health professionals
• Reduce the number readmission

Abstract ID: 1
Improving care for patients with depression: A collaborative project with community pharmacy and primary care providers

Presented by: Anastasia Shiamptanis

Co-Authors: *Anastasia Shiamptanis, Jenn Osesky, Joanna deGraaf-Dunlop*

_____

Conference Track: Shared values and vision,Population health needs and local context

Introduction: Re-admission rates for mental health and addictions issues are significantly higher than any other health issue. In northern regions in Ontario, Canada, readmission rates are the highest in the province. In these regions there are reported challenges which serve as barriers to treating patients with mental health disorders. These include: low health care provider-to-population ratios, travel time to reach service providers, higher hospital readmission rates, and local demand for services.
The purpose of this project was to improve quality of care through provider collaboration for patients with depression.

Aims and Objectives: A group of primary care physicians and community pharmacists co-designed and tested a model to implement best practices and improve care for patients with depression. The model was aligned to the Ontario Health Quality Standard for Major Depression. The project was conducted using continuous quality improvements methodologies and was informed by a patient's lived experience receiving care in the community. The project leads provided a training session on CQI to the group members. The model was informed by a patient's lived experience receiving care in the community. Through this model, pharmacists provided regular follow-up to patients prescribed new antidepressant therapy.

Highlights/Results/Key Findings: Through this initiative, pharmacists followed-up with 29 patients every 2 weeks as per the HQO Quality Standard, provided education on adjunct supports and engaged in additional clinical activities such as pharmaceutical opinions. Outcomes were measured through patient survey and emotional mapping. A total of 14 patients completed a survey and 93% of respondents indicated that they felt better supported and would recommend this model to others. The emotional mapping was analyzed to determine any trends in negative and positive responses. Balancing measures were also collected through a provider survey. A total of 5 providers complete a survey and 80% felt that the collaboration was helpful to patents and would recommend this project to colleagues. Community pharmacies were able to sustain this model and embed this into their practice for their patients with primary care.

Conclusions: Through this project, a model was established that integrated care between community pharmacy and primary care to provide support for patients with depression. Patients received follow-up care from pharmacists in collaboration with primary care. Care was provided across the continuum, aligning with best practices to maximize health outcomes.

Implications: The model is this project is applicable to other patient populations and conditions in which collaboration and strengthening primary care can help to improve outcomes by implementing best practices.

Abstract ID: 8
Learnings from the field – An Integrated model of care for Hip and Knee Bundle Patients at UHN
Presented by: Marsha Alvares

Co-Authors: Marsha Alvares, Samra Mian-Valiante, Silvi Groe, Christian Veillette

_____

Conference Track: People as partners in health and care,System wide governance and leadership,Aligned payment systems

Introduction: The Ontario Ministry of Health announced new Integrated Funding Models for Hip and Knee replacement surgery in 2018, providing a single payment covering the spectrum of care required for an individual health issue. Aim was to promote greater integration in health care delivery, drive high-quality efficient care, and improve patient outcomes and experience.

The Schroeder Arthritis Institute at University Health Network (UHN) developed an integrated care pathway that optimized patient transitions home after total joint replacement (TJR) based on best practice guidelines and enabled by large-scale change management, technology and value-based partnerships with a focus on patient engagement and collaboration.

Aims and Objectives: Value-based bundle funding models require innovation in care delivery to provide quality, evidence-based care across the care episode, improving efficiencies while maintaining strong clinical outcomes and patient satisfaction. Our existing pathways were challenged with inconsistent application of evidence-based guidelines and lack of patient representation in co-design and outcome measurement.
Our objective was to develop an integrated model at UHN utilizing existing partnerships to optimize the patient and caregiver experience, coordinate care in collaboration with the patient and their families to empower them and support transition home, identifying opportunities for efficiencies in care delivery that aligned with best practice.

Highlights/Results/Key Findings: Our integrated pathway began in April 2019 with 1287 TJR patients. Updated surgical guides, videos and resources facilitated patient empowerment and preparedness, early acute mobilization and warm handoffs to post-acute rehabilitation partner providers contributed to improved patient experience. Transitions home were supported by a 24/7 access-to-care line and a Clinical Care Coordinator to address complex patients. Key efficiency metrics included reduced acute length of stay (from 2.1 to 1.6 days for hips and 2.4 to 1.7 for knees) and increased percentage of patients discharged home (from 88% combined average in 18/19 to 95% for knees and 96% for hips in 19/20). Most significant was the reduction in inpatient rehabilitation referral, down from 15-17% in 18/19 to 1-3% in 19/20. The pathway achieved a patient reported satisfaction rate of 96% upon discharge. Onboarding of Patient Partners was critical in the evolution of our integrated pathway and continues to inform ongoing changes.

Conclusions: An integrated pathway for hip and knee bundle patients achieved our aim of improving patient and caregiver experience. Patient feedback was critical in identifying current gaps and opportunities for enhancing integration with technology and care navigation roles to support recovery at home.

Implications: Integrated care models have proven to be sustainable and patient-centric, ensuring strong clinical outcomes and efficiency in care delivery. In order to sustain these models, it is critical that efficiencies are re-invested to support recovery at home through care navigation role and technology.

Abstract ID: 23
Integrated Health System Response to the First Large COVID-19 Outbreak in Alberta
Presented by: Shelanne Hepp
Co-Authors: Shelanne Hepp, Ana Mladenovic, Stephanie Crichton

_____

Conference Track: Shared values and vision,System wide governance and leadership,Transparency of progress, results & impact

Introduction: In April, 2020 the High River, Alberta area was connected with North America's largest COVID-19 outbreak at the time. The primary care response in Canada with COVID-19 has been documented by others. However, this study describes the health system response in Alberta with the first large rural outbreak in Canada, which was within the geographic catchment of the Calgary Rural Primary Care Network. This study describes the context of the healthcare system that enabled an unprecedented response to the outbreak, factors that contributed to success or challenges with response, and lessons learned or strategies implemented from the experience.

Aims and Objectives: An exploratory study was conducted to gain understanding of the COVID-19 outbreak in High River, Alberta where a pandemic response was new for the Calgary Rural Primary Care Network (CRPCN). A convenience sample of 11 health system leaders were interviewed using a semi-structured interview guide. Verbal consent was obtained and interviews were between 30 to 60 minutes in length. Interviews were recorded and transcribed for ease of analysis. A coding framework was developed based on the interview guide and initial interviews. Atlas.ti was used for the qualitative data analysis and themes were coded to the framework.

Highlights/Results/Key Findings: Organizations involved in the response include Alberta Health Services, Primary Care Networks and Business Unit, Non-Government Organizations, City of High River, and Isolation Hotels. Primary Care Networks played a major role in the outbreak response through testing sites and follow up care. Organizational roles and processes were identified and created, with redundancies and challenges identified. Success was attributed to teamwork, which was described as being eager to help and take on different roles and tasks, and co-operation, which was described as health system leaders and organizations working together towards common goals and strategies to overcome the outbreak and having a coordinated approach to patient care. Documenting developments and changes through the creation of plans, pathways, maps, or checklists to capture ongoing decisions and including social services in the response planning were strategies identified to help with the pandemic response. Daily meetings with key stakeholders allowed all to stay focused.

Conclusions: Health system leaders described a response plan that did not consider a large rural COVID-19 outbreak. Stakeholders worked together, with admitted challenges, to integrate care across the healthcare system in response to the outbreak. Organizations executed a response under high pressure conditions with Primary care mobilizing their first testing site.

Implications: Responding to COVID-19 outbreaks became easier as roles and processes were refined and ongoing changes communicated frequently and effectively. Primary Care responded with clinicians' safely monitoring and treating patients virtually, as COVID-19 infections and mutant strains increased. Further testing sites were deployed upon demand and patient care response sustained.

Abstract ID: 24

Ontario Inter-professional Spine Assessment and Education Clinics (ISAEC): Patient, Provider and System Impact of an Integrated Model of Care for the Management of Low Back Pain (LBP)

Presented by: Raja Rampersaud
Co-Authors: Raja Rampersaud

_____

Conference Track: Population health needs and local context,People as partners in health and care,System wide governance and leadership

Introduction: Low back pain (LBP) is a highly prevalent and poorly managed condition. The Inter-professional Spine Assessment and Education Clinics (ISAEC) uses an interprofessional, multidisciplinary, integrated-care model to provide upstream secondary and tertiary standardized clinical evaluation, individualized education and self-management recommendations for LBP patients in remote to metropolitan geographies. As a pilot, started in Jan 2013, the ISAEC program has seen over 6500 patients and grown from 220 to 540 PCPs (20% of whom are Nurse Practitioners). Additionally, 14 trained Advanced Practice Clinicians (Chiropractors and Physiotherapists) and 3 Clinical Practice Leads are supported by 8 specialist champions.

Aims and Objectives: The objectives of this study were to determine the impact of the ISAEC evidence, patient and provider informed integrated-care pilot on 1) Patient reported satisfaction and outcome; 2) Primary care provider (PCP) satisfaction and knowledge transfer; 3) Surgical referral appropriateness; and 4) Utilization of spinal imaging from the perspective of the healthcare. Methods included 1) Mixed methods study for patient and provider evaluation (patient reported outcomes measures and satisfaction surveys). 2) Institute for Clinical Evaluative Sciences (ICES) administrative data analysis comparing spine imaging test ordering by ISAEC and non-ISAEC physicians and determine the direct cost impact.

Highlights/Results/Key Findings: The mean wait time for ISAEC initial assessment was 12 days. Overall patient satisfaction (n=2482) was 99% and 95% felt they understood their condition better. For 811 patients enrolled in a prospective study, a mean reduction in Oswestry Disability score of 10 was observed at 6 months. Enrolled PCPs (n=134 /220) on average showed a two-fold increase in their confidence managing LBP and 97% reported overall satisfaction with the program. Within the ISAEC network of providers, surgical referral appropriateness was 96% (compared to 20-30% prior to ISAEC).
Compared to non-ISAEC PCPs, the overall annual utilization for all LBP-related diagnostic imaging ordered by ISAEC-PCPs fell 28% in year 1 and an additional 5% in year 2 compared to their non-ISAEC peers. This translated to an annual estimated per physician cost avoidance of $3150 and $4175 in year 1 and 2 respectively based only on imaging.

Conclusions: In single-payer public healthcare delivery system, a shared-care, stratified education and self-management model of care for LBP provides significant positive multidimensional impact on patients, providers and the health care system. Overall, the ISAEC integrated care model was able to improve on the quality and appropriateness of care, while reducing cost.

Implications: The pilot ISAEC integrated care model has been re-named Rapid Access Clinics-Low Back Pain and successfully adopted and implemented as a provincial program in 2019. Current patient and provider experience and satisfaction mirror the aforementioned pilot results. Furthermore, program pilots are now running in two other Canadian provinces.

Abstract ID: 26
An "Asset Based Community Development" approach to delivering integrated care to support older people in Mid & East Antrim, led by Mid & East Antrim Agewell Partnership (MEAAP).

Presented by: Andrea Tierney

Co-Authors: Andrea Tierney, Sarah McLaughlin

_____

Conference Track: Shared values and vision,Population health needs and local context,People as partners in health and care,Resilient communities and new alliances,Workforce capacity and capability,Transparency of progress, results & impact

Introduction: MEAAP, a charitable organisation, used an "Asset Based Community Development" approach to collaborate with local Health Care Practitioners and Commissioners to develop an integrated care model which aimed to improve quality of life for older people in our community by putting wellbeing on a par with medical needs, namely IMPACTAgewell®.

MEAAP secured an investment of £1,000,000 in 2016 to 'prove' the IMPACTAgewell® multidisciplinary model of care, over a 3 year period. This was awarded via The Dunhill Medical Trust's UK-wide call for proposals to deliver a "bottom-up, community asset based approach to delivering social care for Older People.

Aims and Objectives: Six 'Locality Hubs' were established in 2017, meeting monthly in GP Practices with a Community Pharmacist, Social Worker and their IMPACTAgewell® Officer. Together, the members identify Older People, 65 years old and over, who are most at risk and/or vulnerable, to secure initial consent. This allows the IMPACTAgewell® Officer to commence support over a 6 month period.

The Older Person is supported by their Locality Hub to develop a 'Health and Well-being Action Plan' namely their "My IMPACTAgewell Plan", based on the social determinants of health, focusing on their home, wellbeing, health, community and future.

Highlights/Results/Key Findings: By March 2020, IMPACTAgewell® has expanded to 16 Locality Hubs, received 1,300 referrals and published our 'Action Research Evaluation' results:

•   Fiscal Return on Investment (FROI) - for every £1 invested, £1.87 of savings has been generated in terms of unscheduled health and social care.
•   Social Return on Investment (SROI) - for every £1 invested, £2.52 of a social return on investment has been achieved when considering all service users, health care practitioners and carers.
•   Community Pharmacy Ratio - for every £1 spent on community pharmacists within the project they delivered savings of £3.86.
•   Older People Surveys - Increasing satisfaction suggests that older people were accessing support they hadn't previously.
•   Health Care Practitioners – A significant increase in "Stronger partnerships" (15% net) and "improvement in Skills and Knowledge" (11% net), with a marginal increase in "increasing job satisfaction" (3% net). This was despite a small "increase in time pressures" (-3.3% net).

Conclusions: An "Asset Based Community Development" approach and strong partnerships ensured IMPACTAgewell® could adapt to the COVID-19 pandemic. A scoping exercise gained feedback for what support was needed for service users and health care practitioners. This led to offering multiple services of support via telephone, doorstep/home visits and video conferencing.

Implications: MEAAP secured commitment from the Health & Social Care Board to sustain IMPACTAgewell® in partnership with The Dunhill Medical Trust, fund the scale and spread of the model and allow MEAAP to establish a trading subsidiary to potentially cascade the learning to extend IMPACTAgewell® beyond Mid & East Antrim.

Abstract ID: 31
Implementing Large-Scale, Whole-System Integration – Learnings in Alberta

Presented by: Richard Lewanczuk
Co-Authors: Richard Lewanczuk

_____

Conference Track: System wide governance and leadership

Introduction: Having a single health system within a large jurisdiction such as a Canadian province offers advantages of administrative and procurement efficiency, equity, clinical consistency, and the ability to effectively interact with entities which exist at the same geopolitical level. However, large scale integration is exponentially more challenging given the need to take advantage of centralization while still adapting to local circumstances and addressing local needs. Integrated care requires integration internally and externally with many sectors.

Aims and Objectives: The objective of this work is to share considerations when organizing integration within a large health system.

Highlights/Results/Key Findings: We adapted an approach of "Do locally what makes sense to do locally, and centrally what makes sense to do centrally". This involved a concurrent top-down, bottom-up approach allowing people feel a sense of ownership. Secondly, identification of partnerships necessary for integration was important but learning how to interact with these partners was challenging given their numbers/diversity. Critical partnerships included provincial government departments, the volunteer sector, primary care, businesses, municipalities and community organizations. To address the challenge, local health administration interacted with local entities and central administration interacted with government departments, province-wide organizations and with "organizations of organizations". Finally, establishing a coordinating mechanism/body is critical. Logically, a jurisdiction-wide entity is best suited for this. This could be a government department or the formal health system. This was our practice, using the logic of "If we don't do it, nobody else will"

Conclusions: We have learned that neither a fully centralized, nor a totally decentralized model facilitates integration. Rather, a system which optimizes central and local relationships seems to work best.

Implications: Every country or health care system is unique. Our learnings have been based on experience but each system needs to find a comfortable equilibrium which allows for the relationships to exist which support optimal integration.

Abstract ID: 39

Canadian Integrated Health and Social Care Case Studies: success factors that support integration

Presented by: Siu Mee Cheng

Co-Authors: Siu Mee Cheng

_____

Conference Track: Shared values and vision

Introduction: Integrated health and social care (IHSC) is known to support improved health and social care outcomes for vulnerable patient populations, including older adults. With an aging population, there is a sense of urgency to find more holistic approaches to address the needs of vulnerable older adults effectively. This is an emerging phenomenon in Canada and is very much in its nascent stage. Government-driven and grass-roots based community experiences continue to evolve across Canada, and contributes to the body of knowledge that will help inform how IHSC can be leveraged to better support care an aging population.

Aims and Objectives: A multiple case study of three integrated health and social services initiatives in Ontario, Alberta and Nova Scotia was undertaken to examine critical integration factors that support successful services integration among different healthcare, social services and other human services organizations serving older adults. The study also sought to understand the environmental factors that exert an influence on services integration. The three cases studied are all community-based initiatives: geriatric assessment program collaboration situated in Camrose, AB; Healthy-at-Home located in north Toronto, ON and the Middleton Day Program in Annapolis Valley, NS. Data was based on informant interviews and focus groups.

Highlights/Results/Key Findings: The case studies revealed that there were ten common critical inter-organizational factors that support integration among all three cases: shared vision and goals across all services partners, inter-organizational culture of collaboration and reliance, information sharing, strong communications, dedicated resources including finances, accountability agreements among partners, team-based care approaches, leadership, role clarity, and the role of champions. Of these ten integration factors, it was noted that communications and shared vision and goals were considered the most critical across all three cases. There were six contextual factors that were noted to have had an influence, positive, negative or both, on services integration across all three cases, despite the different geographic and governance systems: regional health authorities; government health and non-health policies and agendas at all levels; aging populations; urban, suburban and rural settings; close sense of community; public funding and operating within not-for-profit environments.

Conclusions: IHSC is occurring voluntarily at the community-level in Canada. The critical integration factors that help to support integration are focused on helping to drive trust-building between different sectoral organizations. The case studies show that these factors are fundamental despite significant contextual differences including geography, funding models and governments

Implications: An important implication of the findings of the multiple case study is that IHSC can occur with minimal bureaucracy and technology. Collaboratively-based integration should focus on initially building relationships among the services partners. Energy need not be focused initially on technology and bureaucratic instruments for early success

Abstract ID: 45
Long-term life care at home: a bottom up, community-driven model for long-term care reform in Canada

Presented by: Justine Giosa

Co-Authors: *Justine Giosa, Margaret Saari, Paul Holyoke, John Hirdes, George Heckman*

_____

Conference Track: People as partners in health and care

Introduction: Almost all Canadians want to live, age and receive care at home, yet long-term care (LTC) reform continues to narrowly focus on renovating and expanding residential care facilities that serve a small proportion of the aging population and are not well-integrated with the rest of the health care system. A broader system-wide perspective on long-term care should start with ensuring people at home have access to a wide range of community and home-based care and support services to meet their medical, functional and social 'life care' needs and delay or prevent their admission to a LTC facility.

Aims and Objectives: A bottom-up approach to re-imagining LTC in Canada was applied with people in their homes as the starting point. The objectives were: 1) to understand the long-term 'life care' needs of older adults; 2) to develop a new model of long-term life care at home; and 3) to assess the feasibility of the model. An explanatory, sequential mixed methods design was used. Phase 1 involved historical analysis of 2018-19 Canadian interRAI home care assessments (n=283,601). Phase 2 was a 6-week modified eDelphi process with interdisciplinary home care clinicians (n=42). Phase 3 involved initial comparisons of needs and daily care costs.

Highlights/Results/Key Findings: The home care population was segmented into 6 unique groups based on known risk factors for LTC admission including social frailty, caregiver distress, chronic disease management, cognitive impairment and behaviours, and geriatric syndromes. Almost all groups had 'life care' needs according to the 6 dimensions of the Pillars for Positive Health1. Sixty-five types of community-based services were considered in the development of integrated care packages to meet the life care needs of each group. The emerging model of long-term life care at home includes care packages ranging in daily care hours from 3.1-8.1 hours per day, including both direct home care by interdisciplinary providers and coordination time to integrate with other community services. There is significant overlap in the life care needs of older adults currently receiving home care and LTC in Ontario confirming potential to shift care to the community. Initial cost comparisons suggest possible short and long-term benefits.

Conclusions: Deep engagement of interdisciplinary home care clinicians provided a realistic and experienced lens for developing a new model of long-term life care at home. The 6 care packages represent an integrated continuum of LTC services that will give older Canadians more options to live, age and receive care at home.

Implications: Current steps involve focus groups with older adults, family caregivers, and interdisciplinary community-based clinicians beyond home care to validate and refine the new model and understand additional referral and integration channels. Next steps involve implementation and evaluation of the new model in the Ontario health care environment.

Abstract ID: 47
Overcoming Hidden Barriers to Health System Integration

Presented by: Troy Stooke

Co-Authors: *Troy Stooke, Jo-Louise Huq, Robert Bear, Gail MacKean*

_____

Conference Track: People as partners in health and care

Introduction: Fully-integrated regional and provincial healthcare systems should increase system efficiency and effectiveness. Development of these systems is typically spearheaded by acute care organizations. However, there are hidden barriers that that lie outside of these organizations that must be overcome if we are to realize the benefits of integration. IMAGINE Citizens Collaborating for Health (IMAGINE) is an Alberta-based, citizen-led non-profit organization focused on engaging with Albertans in their communities on important matters related to health and healthcare. IMAGINE's iKNOW Health (Knowledge, Navigation and Ownership) program is a co-designed effort of citizens with health organization leaders to understand and increase health literacy.

Aims and Objectives: IMAGINE's initiatives are surfacing and engaging with critical barriers to health system integration including health literacy, inequitable service design, access, delivery, an inconstant, still weak person-centred care culture and rapidly transforming digital health landscapes. Many barriers limit integration. Integration cannot be achieved absent a citizenry with personal health, digital health, and health systems literacy. IMAGINE's iKNOW Health project aims to surface and address these literacy barriers. Guiding principles of the project include engaging with the public to build relationships, surface and use information in co-design activities, and support empowerment. These activities are undertaken in various in-person (pre-covid)/virtual environments.

Highlights/Results/Key Findings: IMAGINE's projects related to building literacy/reducing barriers to integration include:
• Healthcare Basics for Albertans - a plain-language resource about
 Alberta's health system.
• The first ever Alberta health navigation survey offered in nine first languages – first languages are critical to building literacy.
• A youth-led research project - "What health information do youth need & how do they want to receive it?"
• Best practices for working with ethnocultural communities to improve health literacy via the Sound Mind/Sound Body partnership.
• Co-designing a community health ambassador model to create two-way dialogue between people and Alberta health system partners.
• Community conversations- to develop a Digital Health Literacy Map. People asked for help to understand why and how to navigate publicly available digital health tools in Alberta.
IMAGINE is working on other fronts to promote wide understanding and effective implementation of of health literacy concepts in Alberta communities.

Conclusions: Co-design of health literacy materials enables local people (ambassadors of trusted health information in their communities) to select, share and adapt information tailored to their own unique situations. Together with health system leaders we found some answers to the hidden barriers that obstruct peoples' acquisition of deeper health literacy.

Implications: Integration will only be possible when people are health literate. Digital health literacy requires more than access to a full and complete electronic health - it will require that people can use digital information with system providers. Partnering with people is required to unleash the potential value of health integration.

Abstract ID: 53
Canadian case studies the influence of public policies in driving health and social services integration for older adult populations

Presented by: Siu Mee Cheng
Co-Authors: Siu Mee Cheng

_____

Conference Track: Shared values and vision

Introduction: Literature on integrated health and social care (IHSC) show that this phenomenon can result in enhanced health outcomes for vulnerable and high risk patient populations and help to minimize avoidable acute care utilization within healthcare systems. There are global examples where governments and government policies play a critical role in helping to create a supportive environment to advance IHSC at the national, regional and local levels. This phenomenon is at a nascent stage in Canada, and the role that government policy can play in advancing IHSC is not fully understood within the Canadian context.

Aims and Objectives: A multiple case study was completed of three successful IHSCs situated in Alberta, Ontario and Nova Scotia in order to explore how government policies and agendas at the national, provincial and municipal level influence the three IHSCs. The IHSCs included a community-based partnership of health and social care organizations serving geriatric patients in Camrose, Alberta, a day program with twenty sites in north Toronto, Ontario serving vulnerable clients living in the community, and a day program serving older adults living in rural communities in the Annapolis Valley, Nova Scotia. Data derived from key informant interviews and focus groups.

Highlights/Results/Key Findings: There was commonality in government policies among the three cases, despite differences in urban/rural landscape, government regimes and governance systems. In the three cases, all the publicly funded health and social care organizations identified the challenge of operating in environments of austerity where funding was considered inadequate to meet demand and programming costs. All cases identified privacy legislation as a barrier towards integration; this was significant between healthcare and social care organizations where information sharing was limited. It was noted that the community partnership in Camrose was positively influenced by federal and provincial healthcare policies and government agendas that focused on dementia, mental health, primary care and Alberta Health Services. In contrast, the day programs in Ontario and Nova Scotia were influenced by health and social care policies and government agendas from all three levels of government that addressed poverty reduction, seniors care, and immigration.

Conclusions: The study showed that Canadian public policies and government priorities can exert a strong influence, negative and positive in IHSC at the community level. Some policies, like privacy legislation and austerity agendas are inhibitive, while other policies, such as seniors care and poverty reduction, can create fertile conditions.

Implications: The multiple case study findings reveal that IHSC can arise from the convergence of different healthcare and social care policies that drive inter-sectoral collaboration at the local level, and suggest a whole-of-government approach to policymaking for older adult populations in Canada.

Abstract ID: 57

Hope, bridge, meaning: Implementing peer-support in homelessness during the COVID pandemic

Presented by: Mathieu Isabel

Co-Authors: Mathieu Isabel, Daniel Turgeon, Antoine Boivin, Nadia O'Brien, Gwenvaël Ballu, Genevieve Castonguay, Ghislaine Rouly

_____

Conference Track: Shared values and vision,Population health needs and local context,People as partners in health and care,Resilient communities and new alliances

Introduction: The COVID-19 pandemic disproportionately affects people experiencing homelessness, both in terms of health and psychosocial impacts. Building trust and collaborations with healthcare services and community resources are paramount to mitigate the consequences of the pandemic, especially in heavily affected urban areas across Canada. Peer-support programs have been associated with improved sense of empowerment, quality of life, reduced substance use, and increased access and use of primary care services. However, it is unclear whether the implementation of a peer support intervention in homelessness is feasible in the context of a pandemic that has profound impacts on existing community services.

Aims and Objectives: This project aimed at assessing the benefits, feasibility and acceptability of implementing a peer-support intervention for people experiencing homelessness during the COVID pandemic in Montreal. Working collaboratively and playing a bridging role between primary care professionals and community organizations, a peer-support worker performed on-site visits in shelters, outreach interventions in the street, and participated in clinical discussions. He offered support through shared experiences, role modeling, and linkages to different resources. A focus group was conducted in March 2021 with clinicians, administrators and the peer-support worker himself to reflect on their experience of integrating a peer-support worker within their team.

Highlights/Results/Key Findings: We documented strong support and reciprocal benefits for all those involved in this initiative, including clinical team members, the peer-support worker himself and people living with homelessness. Three key findings emerged from our focus group. 1) Peer-support offers hope for people experiencing homelessness, through the embodied example of a peer who built a new life beyond his experience in the streets. 2) Peer-support acts as a bridge, helping to establish trustful relationships with people experiencing homelessness despite social stigma and suspicion toward public institutions. It practically helps to connect with a number of resources in the community and healthcare system. 3) Peer-support brings a sense of shared meaning among team members, reconnecting them with the purpose of their work during the darkest days of the COVID crisis. Peer-support also prevents compassion fatigue by supporting care providers in addressing their client's psychosocial needs.

Conclusions: Peer-support offered a model of hope for people experiencing homelessness during the COVID pandemic. It served as a bridge between health and community resources, and contributed to a sense of shared meaning and mutual support for care providers. Strong and productive relationships between clinical and community partners were also established.

Implications: It is feasible to implement peer-support in homelessness, even during an acute crisis such as a pandemic. Peer-support can act as a powerful leverage for integration between clinical and community care for people living with complex conditions. Future research should document the long-term impacts and sustainability of such programs.

Abstract ID: 60

Integrated care for children and youth through interRAI: Promoting efficiency across mental health care service sectors in Ontario

Presented by: Valbona Semovski

Co-Authors: *Valbona Semovski, Angela Celebre, Shannon Stewart*

_____

Conference Track: People as partners in health and care

Introduction: In Ontario, the mental health care system is overwhelmed by the volume of individuals requiring services and supports. It is estimated that 1 in 5 children and youth will experience a mental health concern, but the majority will not receive the needed treatment. Over the years, a lack of coordination between service sectors has consistently been endorsed as one of the contributors to the mental health care system's shortcomings. The difficulty in navigating the mental health care system has resulted in a call for the development of a standardized assessment system that will improve efficiency and integration across service sectors.

Aims and Objectives: To address the need for an integrated health information system, interRAI designed psychometrically sound instruments to coordinate the provision of services for infants, toddlers, children and youth. The interRAI mental health suite of instruments supports a life course approach to assessment and care planning.

Highlights/Results/Key Findings: A number of characteristics make the interRAI child and youth suite of instruments an integrated health information system including a shared clinical focus and conceptual basis related to care planning, a common language across instruments, and a standardized data collection method. The various instruments have several applications that are made possible through the embedded scales/algorithms, care planning protocols, outcome measures, and quality indicators. This allows for client profiles to be created in a uniform manner through standardized practices across service sectors. The integrated nature of the interRAI assessment system is illustrated with three examples highlighting the prevalence of self-injurious intent, self-injurious behaviours, and depressive symptoms across the suite of instruments. Data was obtained from children and youth seeking mental health services within the Province of Ontario.

Conclusions: This research depicts the critical utility of interRAI's assessment system, as it allows us to take an integrated look at important trends and patterns across various service sectors, including the experience of self-injurious intent, self-injurious behaviours, and depressive symptoms among children and youth.

Implications: In Ontario, the implementation of the interRAI child and youth suite has been effective in organizing care delivery and is currently being adopted by other provinces. The instruments emphasize a needs-based approach to care, reducing disparity in mental health services.

Abstract ID: 63
Implementation of an integrated care pathway in primary care clinics to improve the health of older adults: a realist evaluation
Presented by: Owolabi Gaudens Pamphile Acakpo

Co-Authors: Owolabi Gaudens Pamphile Acakpo, Émilie Dionne, Laeticia Coudert, Jacobi Elliott, Paul Stolee, Julie Fortin, Susie Gregg, Joanie Sims-Gould, Anik Giguere, Pierre-Hugues Carmichael

_____

Conference Track: Population health needs and local context,People as partners in health and care,System wide governance and leadership

Introduction: Older adults look to their primary care practitioners to assess their needs and coordinate their care, but their health concerns are often missed in too-short office visits and appropriate referrals may not be made for further assessment or community services. We have therefore implemented a novel care pathway in primary care clinics, consisting of three integrated strategies: frailty screening using an interRAI instrument; shared decision-making to choose a treatment plan using decision aids; and facilitated access to specialized assessment and community resources using a novel digital platform.

Aims and Objectives: We aimed to describe how, for whom and under what circumstances the proposed pathway was correctly implemented. We used a realist evaluation, based on mixed-methods. Four family medicine clinics in Quebec agreed to implement it. We asked older adults (aged 70+) rostered in these clinics, healthcare providers (HCPs), and clinic managers, to complete surveys before and after the implementation (CIHI providers and organizational surveys, PACIC,EQ-5D-5L). Interviews were conducted to understand and describe the factors influencing implementation fidelity. We used mixed statistical models, inductive/deductive thematic analyses guided by the Consolidated Framework for Implementation Research. Findings were integrated into Context-Mechanism-Outcome configurations.

Highlights/Results/Key Findings: We recruited 113 HCPs (73%women), 310 older adults (58%women, mean age 79.06 ±5.6SD). We conducted 34 interviews with a sample of older adults and eight focus groups (40participants) with HCPs and managers. Only one of the four participating clinics fully implemented the pathway. We found increased patient activation and pain/comfort after implementation. The clinic with full implementation showed, high fidelity in using screening (91% older adults), low fidelity in using decision aids (35%) and the referral platform (2%). Good collaboration between the implementation and clinical teams and co-designing the pathway (C), generated good perceptions and receptivity towards the pathway (M), leading to a better acceptability and adoption (O).
Conversely, internal challenges (logistical, administrative, human resources) (C) led participants to perceive the pathway as requiring too many resources, as less of a priority and more likely to hinder their objective of accessibility and attendance to the clinic (M), leading to abandonment (O).

Conclusions: Collaboration between the implementation and clinical teams, and promotion and support of the pathway at the organizational level, are key factors to implementation success of strategies to improve primary care of older adults.

Implications: Results of this study highlight the importance of good collaboration and user involvement in implementing similar integrated approaches. Obstacles encountered and lack of completion in study sites highlight the challenges of implementing strategies to enhance integrated care in primary care settings.

Abstract ID: 68

Bridging the Gap between Symptom Onset and Diagnosis in Axial Spondyloarthritis: an integrated and stratified model for early detection

Presented by: Laura Passalent

Co-Authors: Laura Passalent, Kala Sundararajan, Anthony Perruccio , Christopher Hawke, Nigil Haroon, Robert Inman, Raja Rampersaud

_____

Conference Track: Workforce capacity and capability

Introduction: Axial spondyloarthritis (axSpA) is a systemic inflammatory arthropathy affecting the spine and sacroiliac joints and can also affect the peripheral joints and other body systems. Inflammatory back pain (IBP), associated with axSpA, can be difficult to differentiate from mechanical back pain (MBP) amongst primary care providers. This leads to significant delay in diagnosis, chronic pain and potentially irreversible structural damage in people diagnosed with axSpA. In order to mitigate these factors, a rheumatology inter-professional model of care (MOC) to screen for axSpA was established in Toronto, Canada.

Aims and Objectives: Aim: To evaluate a novel inter-professional MOC to screen for axSpA. Objectives: 1) measure diagnostic delay; 2) measure referral wait times from primary care to rheumatology screen; 3) determine the precision and accuracy of the screening process and 4) determine patient satisfaction with the MOC. Methods: Adults with back pain attending a dedicated community back program (www.isaec.org) underwent primary screening for IBP. Patients meeting IBP criteria were referred for a secondary screen by a physiotherapist with advanced rheumatology training. Precision and accuracy of each screen were measured against the clinical judgement of a rheumatologist with axSpA expertise.

Highlights/Results/Key Findings: In total, 410 patients underwent primary and secondary screening over a 3-year study period. Mean age was 36.9 years (±9.8); 55% were female; average back pain duration was 7 years (±7.2). HLA-B27 was present in 14.4% of patients. Average time from back pain onset to diagnosis for patients with medium or high risk of axSpA (as determined by rheumatologist) was 6.0 years (±6.3). Median wait time from primary to secondary screen was 22 days. AxSpA risk assignment by rheumatologist was 63.6% (MBP or low risk axSpA) and 36.4% (medium or high risk axSpA), with 18.0% of all patients receiving a final diagnosis of axSpA. HLA-B27 performed poorly as an independent screen (sensitivity=28%). The best combination of sensitivity (68%), specificity (90%), positive predictive value (80%) and negative predictive value (84%) was evident with the secondary screen. A large proportion of patients were satisfied with the model of care (93%).

Conclusions: The inclusion of a secondary screening process utilizing an interprofessional model can shorten time to diagnosis, with high precision and accuracy in patients with axSpA. This unique MOC demonstrates high patient satisfaction, improved access to care and may contribute to increased quality of life in this patient population.

Implications: The above model of stratified and integrated screening leverages existing human health resources through the optimization of professional scopes of practice. Such integrated models have the potential to improve efficiency and access to appropriate care for patients with a variety of musculoskeletal conditions.

Abstract ID: 75
The effect of network-level payment models on care network performance: a scoping review of the empirical literature
Presented by: Thomas Reindersma

Co-Authors: *Thomas Reindersma, Isabelle Fabbricotti, Sandra Sülz, Kees Ahaus*

_____

Conference Track: Aligned payment systems,Transparency of progress, results & impact

Introduction: Fragmentation of health care services remains widespread, resulting in adverse effects such as inefficient and inequal care. Networks have the potential to address those 'wicked' problems. However, current ways of paying seem to impede coordination and collaboration. Health-care providers are predominantly reimbursed through traditional payments models that reward volume rather than value, such as fee-for-service or diagnosis-related groups. It is believed that moving from separate provider reimbursement to joint reimbursement of networks stimulates coordination between providers and encourages flexible use of resources. Ultimately, jointly reimbursing networks through network-level payment models is assumed to lead to improved performance.

Aims and Objectives: Our aim was to study how network-level payment models affect the performance of health-care networks. Due to the broad nature of this aim, a scoping review was conducted. Six bibliographical databases were searched, combining various terms that reflected 'payment model' and 'interorganizational network'. Articles were eligible for inclusion if they described networks, payment (models), performance indicators and if it was a peer-reviewed, empirical study set in an OECD country. Network performance was defined as the ability of the network to satisfy the payment model's objectives. We distinguish four categories of performance: spending, utilization, quality of care, and other consequences.

Highlights/Results/Key Findings: 63 studies were included with the majority of studies stemming from the USA (N=58). Payment flows to the network were more common than payment flows in the network (N=57 vs. N=6). Global payment with add-ons (N=49) was the most common model, followed by pay-for-performance (N=7), capitation (N=4) and bundled payment (N=3). In general, the results show that payment models have mixed effects on performance. No single payment model proved able to consistently improve on all four categories of performance. However, in the majority of studies performance in terms of quality and utilization remained stable or improved. Spending was not curbed under the disease-based bundled payment model. Our results also show that the relation between payment models and performance is not necessarily stable, with several factors of importance: timing of the performance assessment, cohort entry year, and scope of services offered by the networks explain differences in performance.

Conclusions: Although network-level payment models are still in their infancy, this review shows that these models have the potential to improve performance of networks. Given the increasing omnipresence of health-care networks, it is fruitful to keep experimenting with joint reimbursement of those networks.

Implications: It might prove worthwhile to develop more theory-based understanding on the contexts and mechanisms under which payment models lead to certain performance. As alternative payment models gain momentum, this understanding can enhance transferability of knowledge and subsequently support providers in preparing for future (mandatory) payment reform.

Abstract ID: 79
Lessons learned from co-creating seniors' community hubs for older adults in social housing

Presented by: Christine Sheppard

Co-Authors: Christine Sheppard, Sander Hitzig, Sarah Gould, Andrea Austen

_____

Conference Track: Population health needs and local context,Resilient communities and new alliances

Introduction: An increasing number of older adults are aging in place in social housing. However, low-income older adults in social housing are disproportionately affected by poverty, social isolation, and health challenges that increase their vulnerability. Access to health and community support services are therefore critical for helping older adult tenants age in place, but access to these services within social housing buildings is uneven. Community hubs one strategy to co-locate health, social, cultural, recreational, and other resources for older tenants in one location to facilitate better access to services.

Aims and Objectives: The goal of our project was to co-create a seniors community hub model to be implemented in the seniors' buildings of a large social housing landlord serving 14,000 older adults in Toronto, Canada. To do this, we conducted in-depth qualitative interviews and focus groups with 58 health and community support service providers, as well as with 74 older adults living in the housing complex. Interviews focused on the relevance and need for co-locating community hubs directly in buildings, the types of services and programs that should be offered, and the barriers and facilitators that partners may face during implementation.

Highlights/Results/Key Findings: Participants acknowledged that most recreation spaces in the buildings were not well-utilized, and that the limited programs currently available were misaligned to the interests and needs of older tenants. A co-located community hub model centered on principles of trust, equity, inclusion, and flexibility was thought to be the best way to promote access to services while reducing isolation and fostering a sense of community. Service providers highlighted considerations for selecting a hub location, including accessibility, public transit access, availability of on-site kitchen, and the size of the programming space.
While older tenants wanted access to a variety of recreation, social and health programs through a community hub, some were concerned that the hub would limit their access to communal spaces within the building for their own tenant-led activities. Others were concerned about safety, especially if the community hub were to be open to other older adults living in the community.

Conclusions: Findings highlight the opportunity for seniors' community hubs to increase access to health, social, cultural, and recreational programs for older adults living in social housing. Several recommendations were made to engage tenant leaders and community partners to ensure program offerings with the needs and interests of the local community.

Implications: Our findings point to several design and implementation considerations that may impact the success of a seniors' community hub model in a low-income social housing building, which can serve as a roadmap for other community partners looking to implement a similar initiative. Engaging tenant leaders is key for successful implementation.

Abstract ID: 80
Reflecting on Meaningful Research-Policy-Practice Partnerships: A Case Example Using Implementation Science to Improve Housing Outcomes for Low-Income Seniors
Presented by: Sander Hitzig
Co-Authors: Christine Sheppard, Sander Hitzig, Andrea Austen, Jorge Rios

_____

Conference Track: Population health needs and local context

Introduction: Research, community-based and government organizations are increasingly seeking opportunities to form research-policy-practice partnerships to promote the application of evidence-based decision making to improve health and social outcomes for vulnerable communities. The current project focuses on the development of such a partnership to co-design and evaluate a new housing services model seeking to advance housing outcomes for low-income older adults living in Toronto Community Housing, North America's second largest social housing landlord.

Aims and Objectives: Our team 'embedded' a research staff with the partner organization to foster an effective research-policy-practice collaboration and used the Consolidated Framework for Implementation Research to support the co-design, implementation, and evaluation process of the new housing services model. This included: 1) identifying all relevant stakeholders; 2) co-creating evidence in partnership with key stakeholders; 3) facilitating large-scale planning meetings to co-design an action plan; 4) supporting the development of an evaluation framework; and 5) providing opportunities for knowledge exchange and transfer across each phase of the initiative.

Highlights/Results/Key Findings: In collaboration with our stakeholders, we co-created three guiding research questions and developed a bevy of different data sources that would inform decision making and ensure that the major stakeholders had the opportunity to share their lived experiences. In addition to a scoping review and environmental scan, we were able to conduct in-depth qualitative interviews with 116 older adults and service providers living and working in Toronto Community Housing and host a planning meeting with 72 interdisciplinary stakeholders to understand existing challenges and the types of changes they wanted to see in a new model. Throughout this process, our primary goal was to rapidly process and translate our findings into useable products to support our partners, which included policy-briefs and reports, as well as information sessions and workshops.

Conclusions: Our approach created opportunities for older tenants and community partners to actively participate in the co-creation of the intervention. Our use of an embedded researcher ensured that our policy and practice partners were able to design a new housing strategy that will improve housing and health outcomes vulnerable older adults.

Implications: The key strategies for building successful research-policy-practice partnerships include identifying and balancing the needs of various stakeholders and implementing processes for meaningful communication across partners. There is also a need to acknowledge and understand barriers that may hinder or slow down the process (e.g., legal agreements, research ethics, etc.).

Breaking down silos: building collaborative partnerships to increase access to health and support services for older adults in social housing
Presented by: Christine Sheppard
Co-Authors: Christine Sheppard, Sarah Gould, Sara Guilcher, Andrea Austen, Sander Hitzig

_____

Conference Track: Population health needs and local context

Introduction: Housing is an important determinant of health, as poor housing conditions are consistently linked to negative health outcomes. Many older adults across Canada are aging in social housing but are more vulnerable than seniors who rent or own their own home due to higher rates of social isolation, disability, and chronic physical and mental health conditions. Furthermore, the lack of integration between housing and health services makes it difficult for older tenants to access needed supports.

Aims and Objectives: We examined barriers and facilitators that health service agencies experience in providing on-site services to older tenants living in a social housing complex in Toronto, Ontario, Canada. First, we conducted a survey of 33 health and community support service providers that work directly with older adults living in the social housing complex to examine their relationship with key housing staff who support tenants. Next, we conducted semi-structured interviews and focus groups with 58 health and community service providers to examine the barriers and facilities they faced in providing on-site services to older tenants.

Highlights/Results/Key Findings: While most service providers (84%) were aware of housing staff who support rent and leasing matters, only 70% were aware of housing staff that help tenants access services to support their physical, mental, and social health. In the interviews, service providers identified challenges to providing services on-site, including: a lack of coordination between partner agencies offering duplicative services in the building, inconsistent 'red tape' for establishing formal agreements with the landlord, high housing staff turn-over, incompatible policies and practices across sections, and difficulties sharing information across sectors. Many also described that pest control and safety issues impacted their ability to safely provide services on-site. Participants reflected on opportunities to make it easier to provide services on-site to tenants, including having access to 'touch down' space to work in, simplified and consistent partnership process across all buildings, and more opportunities to collaborate directly with housing staff to identify who need support.

Conclusions: Seniors living in social housing face a variety of challenges that negatively impact their ability to age-in-place. While services are available in the community to support older tenants, there are several opportunities to enhance access to these services through a stronger and more collaborative relationship between landlords and service providers.

Implications: Our findings highlight the need for more effective integration of housing and health services. Simplified processes for establishing partnerships with service agencies and more opportunities for communication and collaboration with housing staff would ensure that services are reaching the most vulnerable tenants.

Abstract ID: 84

WSO SSO Global Mapping Project

Presented by: Rachel Thombs

Co-Authors: *Rachel Thombs, Patrice Lindsay, Sharon McGowan, Michelle Nelson, Sarah Belson*

_____

Conference Track: Shared values and vision,Resilient communities and new alliances,Workforce capacity and capability

Introduction: Stroke support organisations (SSOs) are non-governmental organisations focused on advocacy and long-term stroke support, and aim to drive better outcomes in stroke prevention, treatment, and long-term care. A key priority of the World Stroke Organization (WSO) in strengthening global capacity for stroke care is the development of SSOs by establishing, supporting, and strengthening a global network, particularly in low and middle-income countries (LMICs). In May 2019 the SSO Committee of the WSO proposed a mapping project of all SSOs known to WSO globally which was completed in February 2021.

Aims and Objectives: The objectives were to: (a) increase understanding of the organisational background of SSOs globally; (b) obtain a snapshot of SSO service delivery, awareness, and advocacy activities globally, focused on the 2018 calendar year; (c) obtain data for further analysis of the scale and reach of SSOs and their activities; and (d) obtain data for further analysis of SSO capacity to produce evidence of value. A questionnaire focused on organisation profile and activities across the stroke care pathway was sent by email to identified SSOs and any gaps in the data were followed up by email and telephone.

Highlights/Results/Key Findings: 92 SSOs from 58 countries participated. There is considerable potential for SSOs to drive improved stroke outcomes globally as they work along the entire stroke care pathway and at all levels in support of integrated care. From the smallest to the largest, SSOs reach beyond their borders to build collaborative capacity and network with other stroke organisations at the regional, national, and international level. SSOs also support resilient communities by investing in interventions at the community level and mobilising large numbers of people affected by and engaged with stroke. They also utilize predominantly volunteers in the delivery of their stroke awareness and support activities. However, SSOs report that sustainability of human and financial resources, and inadequate national strategies for stroke prevention, treatment and recovery are major challenges to increasing their impact. To address these challenges, they call for increased partnership between their organisations and government, clinicians, and academics.

Conclusions: This project has shown that SSOs are operating globally delivering activities across the stroke care pathway and are working in ways that support integrated care. Findings suggest that for SSOs to maximize their contribution to driving improved stroke outcomes, capacity building, increased partnership and collaboration require considerable investment.

Implications: These insights can guide further analysis and focused research aimed at benchmarking the activities of SSOs along the stroke care pathway with evidenced based guidelines, and to explore capacity building activities for SSOs. Recruitment strategies were limited, likely resulting in several SSOs being left out of this inaugural report.

Abstract ID: 132
Shifting Paradigms: Developmental Milestones for Integrated Care
Presented by: James Shaw

Co-Authors: James Shaw, Jennifer Gutberg, Mudathira Kadu, Paul Wankah-Nji, G Ross Baker, Carolyn Steele Gray, Ann McKillop, Mylaine Breton, walter wodchis

_____

Conference Track: System wide governance and leadership

Introduction: Discussions of integrated care have ranged in focus from large-scale health system transformations, to discrete interventions intended to enhance local continuity of care. Beyond these variations in scale and focus, literature on integrated care has used a variety of conceptual frameworks to explain various activities and elements necessary to achieve integrated care. Existing frameworks have helped to advance research and practice; yet the complexity of changing practice required to achieve integrated care across the policy, organizational, and clinical levels complicates efforts to represent or implement these innovations in straightforward ways.

Aims and Objectives: In this paper, we present a novel strategy for conceptualizing integrated care as developing through a series of milestones observable at the organizational level. Based on analysis of four integrated care organizational case studies in Canada and New Zealand, we outline how this approach to conceptualizing integrated care both resolves the tension of crossing the macro, meso, and micro levels of analysis, and generates new practical insights to guide policy and practice. Methods consist of qualitative interviews, observation, and document analysis across cases, and qualitative data were analyzed temporally to identify milestones as indicated by participants over time.

Highlights/Results/Key Findings: We define a milestone as the occurrence of a salient event that is perceived by respondents to facilitate or disrupt efforts towards the development of integrated care. We synthesize these events at the organizational level, suggesting that the organizational level of analysis is the most appropriate level to represent the significance of these milestones. Our analysis identified six categories of milestone:

(1) Strategic relational milestones, referring to building relationships between stakeholders.
(2) Strategic process change milestones, referring to efforts to improve quality in practice.
(3) Structural (intra-organizational) milestones, referring to changes in organizational structure.
(4) Structural (inter-organizational) milestones, referring to changes in the legal, operational, or leadership structures that facilitate relationships between organizations.
(5) Environmental milestones, referring to changes in the social or natural environment.
(6) Political milestones, referring to changes in the control and allocation of resources.

Conclusions: Our results generate a new conceptual framework for understanding the achievement of integrated care as occurring through a series of milestones. This approach enhances the focus on achieving integrated care "in the wild", in the actual environments in which leaders, clinicians, policymakers, patients, and caregivers work to implement integrated care.

Implications: Our model emphasizes two practical points. First, that there is no single series of sequential steps that must be taken to achieve integrated care. Second, that policy efforts to support integrated care ought to encourage organizations and their collaborators to work toward milestones that facilitate the development of integrated care.

Abstract ID: 133
Increasing Equitable Access to Interprofessional Primary Care Teams in North Toronto
Presented by: Jocelyn Charles
Co-Authors: *Jocelyn Charles, Kaitlin Siou, Monisha Persaud, Emmi Perkins, Ross Kirkconnell, Jagger Smith*
_____

Conference Track: Workforce capacity and capability

Introduction: Achieving better patient experiences and health outcomes, more efficient use of health care resources, and enhancing provider experiences for sustainable care requires high performing primary care. Both patients and their family physicians must have access to an integrated network of allied, nursing and social care services that together are accountable for meeting a wide range of health and social needs in a timely and efficient manner. In Toronto, Ontario, there is a wide discrepancy in the access to interprofessional teams by family physicians and a need to re-align existing resources to more efficiently meet practice needs.

Aims and Objectives: Aim: To improve access to regular interprofessional consults, just-in-time advice and/or co-located inter-professional health provider (IHP) resources in primary care to meet the unique health needs of local practice populations. The North Toronto Ontario Health Team is leveraging work done in Guelph, Ontario, to build integrated and equitable primary care in a diverse, urban community. Analyses of primary care provider roster data allows an understanding of the unique needs of a patient population, and the ability to assign IHP support based on the level of need. This novel approach seeks to create relationship-based interprofessional primary care teams.

Highlights/Results/Key Findings: The highlight of this project is the transferable methodology for assessing individual primary care rosters to determine the need for interprofessional team support to connect to existing resources. Classification of practice population needs is three tiered: high/rising/low/no need for each type of support (e.g. high percentage of complex patients indicates high need for nurse practitioner). The data is from a large administrative database and detailed EMR searches, and is supplemented by qualitative assessment of gaps in care through a functional assessment survey. Using this methodology developed in a small Ontario community (Guelph Ontario), the North Toronto Ontario Health Team is creating relationship-based teams in a diverse urban setting where designated interprofessional staff from other collaborating organizations are either co-located in-office or providing regularly scheduled virtual support once weekly (for high-needs practices), 1-2 times per month (for rising-needs practices), or on an as-needed basis (for low needs).

Conclusions: With increasing complex health and social needs in primary care and growing challenges in managing health care resources, there is a need to better align existing resources to meet practice needs. This methodology uses practice level data and local interprofessional resources to equitably build access to interprofessional care teams.

Implications: This methodological approach to understanding primary care practice roster needs and matching to existing local interprofessional health resources in different contexts could contribute to the development of sustainable high performing primary care in a wide range of geographic , economic, and cultural settings.

Abstract ID: 141

Implementation of clinical guidelines for osteoarthritis together (IMPACT): project protocol for a participatory health research approach to implementing high value care

Presented by: Jacqui Browne

Co-Authors: Jacqui Browne, Stacey Grealis, Clodagh Toomey

_____

Conference Track: Shared values and vision,Population health needs and local context,People as partners in health and care,Resilient communities and new alliances,Digital solutions

Introduction: Despite a wealth of strong evidence on the effectiveness of exercise and education for hip and knee osteoarthritis (OA), implementation of these interventions in healthcare settings is currently sub-optimal. An international physiotherapist-supervised education and exercise programme for hip and knee OA (Good Life with osteoArthritis from Denmark (GLA:D)) was chosen for implementation due to evidence on effectiveness for patient outcomes,[1] the inclusion of a patient registry to collect outcomes and the ability to adapt to other cultural contexts.[2] This paper captures the key methodologies used in the co-design, implementation, and evaluation of the IMPACT project to confront the problem.

Aims and Objectives: Using a type III hybrid implementation-effectiveness design, work packages include: (1) ENGAGE key stakeholders to form a steering committee and survey stakeholders to inform development of the IMPACT implementation strategy based on the Consolidated Framework for Implementation Research (CFIR), (2) IMPLEMENT GLA:D Ireland by training physiotherapists across health settings (primary care, secondary care, private practice) during pilot testing, (3) EVALUATE short and long-term qualitative and quantitative implementation indicators, and patient outcomes related to pain, function, quality of life and healthcare utilisation from the patient registry up to 12-months post-programme, (4) SHARE results with engaged stakeholders and rollout the programme nationally.

Highlights/Results/Key Findings: Key stakeholders including two patient representatives and one advocacy group member, five researchers, four physiotherapists, one GP and one orthopaedic consultant have been engaged to the form the IMPACT steering committee and co-design the implementation strategy. Key sources that informed this strategy include (1) theoretical framework adapted from CFIR constructs (patient, physiotherapist and intervention characteristics, inner and outer setting, process), (2) best evidence from a literature review of barriers, enablers and strategies for implementation of OA programmes, (3) local context from surveys distributed to Irish GPs, physiotherapists and patients with OA, (4) expert consensus from steering committee members. Some of the main strategies identified include development of learning tools for health care professionals and patients to improve referral pathways to exercise and education and dispel myths related to exercise safety for joint disease. To reduce barriers related to patient accessibility, evidence-based programmes should be available across multiple health settings.

Conclusions: GLA:D Ireland delivery will result from comprehensive implementation strategy development using theory, evidence, knowledge of context and stakeholder consensus. Incorporating a participatory approach and including end-users in planning, co-design, implementation and evaluation is a critical approach to overcoming barriers and ensuring appropriate care is delivered to patients who need it.

Implications: This model can act as a template for implementation of clinical practice guidelines for other chronic conditions across healthcare settings. This research has the potential to change practice and promote a policy of exercise and physical activity referral for chronic disease that utilises community engagement effectively and enacts change 'together'.

Abstract ID: 142
Leveraging Volunteers to Develop and Maintain Directory of Health and Social Care Resources During the COVID-19 Pandemic

Presented by: Josee Li

Co-Authors: *Josee Li, Charlotte Thomas, Janet Prvu Bettger, Leah Whitehead, Sahil Sandhu*

_____

Conference Track: Shared values and vision,Population health needs and local context,Workforce capacity and capability,Digital solutions

Introduction: With each month of the COVID-19 pandemic, unmet health and social needs increased. Unfortunately, maintaining up-to-date information on available resources to meet those needs was a challenge. As public health guidance evolved weekly, existing resources, such as food pantries and pharmacies, experienced reduced capacity, shifts to virtual service delivery, and frequent changes in their hours of operations. New resources, such as emergency financial assistance programs, also emerged to mitigate the consequences of the pandemic. In Durham, North Carolina, there was a need for a centralized platform to access accurate resource information.

Aims and Objectives: Our team of university student volunteers partnered with a social services non-profit to create, maintain, and disseminate an online directory of health and social care resources in Durham County between May 2020 and October 2020 during the COVID-19 pandemic. Our goals were to ensure the resource directory was (1) publicly accessible, (2) available in English and Spanish, (3) up-to-date, (4) amenable to community feedback, and (5) tailored to community needs. For included resources, we captured the name, target recipients, purpose, description, website links, contact info, language access, status during COVID-19, and the date resource information was last updated.

Highlights/Results/Key Findings: We sourced and consolidated existing county-level resource directories to centralize information on 370+ resources across 12 health and social care domains (e.g., transportation, housing, medical care). 51+ students across our two organizations worked in small teams by resource domain to update information every few days in spreadsheet format in a Google Sheets platform. The public also contributed updates through a comments feature.

Our directory was hosted online by the county public health department and distributed widely via social media, email, and other trusted websites. Our partner non-profit operated a hotline to provide directory navigation support. Targeted dissemination efforts further included (1) integrating the directory into the local health system's intranet, (2) synthesizing resources for paper handouts for in-person distribution at health centers and food pantries, and (3) curating a population-focused directory serving the needs of older adults. Our directory served as the local foundation for a statewide platform now available.

Conclusions: Promoting integrated health and social care through cross-sector referrals requires providers to access accurate resource information. Student volunteers mobilized quickly and efficiently to support the information needs of the community when needs were high and resources were constrained. Volunteers are a low-cost, high-value resource to support integrated care efforts.

Implications: Our community resource directory model, facilitated by student volunteers, can be replicated to serve emerging health and social care integration efforts. Essential components included strong relationships with community partners, faculty oversight and guidance, and a defined student leadership structure. Students invested in public and population health make this model sustainable.

Abstract ID: 145

The role of paramedics in integrated models of care

Presented by: Amir Allana

Co-Authors: *Amir Allana, Kerry Kuluski, Andrew Pinto, Walter Tavares*

_____

Conference Track: People as partners in health and care,Workforce capacity and capability,System wide governance and leadership

Introduction: For over two decades, grassroots initiatives have driven paramedicine to grow beyond its traditional role of emergency transport to include primary, palliative and preventative care. Paramedics are interacting with more organizations and providers than they did previously. This has contributed to tensions in role definitions, regulatory frameworks and funding models. Health system leaders need to address these tensions to effectively utilize paramedics in achieving the goals of integrated care, and to foster multi-professional collaboration between paramedics and other providers. As governments look to update frameworks for paramedic education and practice, their role within integrated care teams remains understudied.

Aims and Objectives: This scoping study establishes a foundation of knowledge on the role of paramedics in integrated care. Following Arksey and O'Malley's method for scoping reviews, a comprehensive search of the literature was conducted for programs and initiatives where paramedics worked with at least one other health or social care provider. Qualitative content analysis was done to identify the clinical, professional, organizational, system-level, functional and normative aspects of these programs, and the roles of paramedics within them. Findings were organized using Valentijn's Rainbow Model of Integrated Care taxonomy. Common features, challenges and areas of further study were documented.

Highlights/Results/Key Findings: The literature search yielded 10,435 unique citations; 137 documents with 108 unique programs were included in analysis and clustered into two models of care. "Care pathways" models target broad populations experiencing an event: e.g., heart attack, psychological crisis, fall, hypoglycemia. Paramedics' roles in these models involve informal collaboration with other providers, providing standardized assessment, treatment, and triage, and activating follow-up pathways. "Care team" models target populations with complex, ongoing needs. Paramedics' roles in these models involve formal collaboration with care teams, treating symptom exacerbations, implementing individualized care plans, and conducting scheduled home visits. Across both model types, paramedics play an unscheduled response, case-finding and care navigation role, and serve as additional health human resources for public health outreach initiatives. Programs face challenges with unclear role boundaries, interprofessional education and understanding, legislation that mandates transport, medical oversight mechanisms, misaligned payment systems, inadequate data infrastructure and the culture of emergency medicine.

Conclusions: Paramedics can help achieve goals of integrated care by allowing systems to flexibly respond to client needs: providing unscheduled and scheduled services, activating appropriate emergent and preventative care pathways, and supporting public health. Further work is needed on interprofessional, organizational and system-level integration of paramedics to better enable these roles.

Implications: This study can help health system leaders consider how paramedics fit into the skill-mix of care teams. When updating frameworks for education, regulation and funding, the flexible, adaptive function of paramedics within local systems should be retained and enabled. This study was limited to comparable health systems in high-income countries.

Abstract ID: 154

Integrating geriatric medicine and mental health services to better serve older adults in Southwestern Ontario

Presented by: Lyndsey Butler

Co-Authors: Jacobi Elliott, Lyndsey Butler, Jody Glover, Kelly McIntyre Muddle, Cheryl McDonald

_____

Conference Track: Shared values and vision,Population health needs and local context,People as partners in health and care

Introduction: The South West Frail Senior Strategy (SWFSS) is improving care for older adults and caregivers in Southwestern Ontario. Through literature review, clinical expert interviews, and engagement with over 500 providers, older adults, and caregivers, a priority that was identified was to integrate geriatric mental health and medicine providers into local cross-sectoral teams. These teams would have local coordinated intake and access processes and have agreements in place across organizations to support collaboration. Through local co-design, the aim of this work is improve access, outcomes and the experience of the health care system for older adults with frailty and their caregivers.

Aims and Objectives: The South West Frail Senior Strategy (SWFSS) is improving care for older adults and caregivers in Southwestern Ontario. Through literature review, clinical expert interviews, and engagement with over 500 providers, older adults, and caregivers, a priority that was identified was to integrate geriatric mental health and medicine providers into local cross-sectoral teams. These teams would have local coordinated intake and access processes and have agreements in place across organizations to support collaboration. Through local co-design, the aim of this work is improve access, outcomes and the experience of the health care system for older adults with frailty and their caregivers.

Highlights/Results/Key Findings: The local cross-sectoral team make-up across the region were similar with respect that they involved Alzheimer Society, Geriatric Medicine and Geriatric Psychiatry providers, however, varied in size, disciplines, employers, and level of integration. Preliminary data with the onset of these teams were collected.
The membership of the work groups to build these teams varied across the region based on existing partnerships, local priorities, and available resources. However, across all working groups it was critical to establish links with local priorities and the regional Steering Committee to ensure communication and alignment.
Challenges of this work include being adaptable to local priorities and securing commitment to prioritize system-level change alongside daily clinical commitments.
Next steps include complete implementation of collaboration agreements and coordinated intake and access processes.

Conclusions: By locally co-designing these integrated cross-sectoral teams within a regional strategy, the aim is for a more standardized approach to accessing specialty geriatric services. We anticipate improved outcomes and experiences for older adults and their caregivers, decrease in health care utilization costs, as well as increased provider satisfaction.

Implications: Despite variations in resources, it has been found that there is significant value in learning and sharing across the different regions. The approach of local co-design in order to integrate specialized geriatric care in the community across urban and rural geographies has high applicability for others.

Abstract ID: 162
Measurement of Integrated Care (IC) deployment in residential care during COVID pandemics
Presented by: Juan Carlos Contel Segura
Co-Authors: *Juan Carlos Contel Segura, Fèlix Martínez, Anna Vila, Aina Plaza, Sebastia Santaeugenia, Tino Martí*

_____

Conference Track: Transparency of progress, results & impact

Introduction: Integrated health and social care is a policy priority in Catalonia. During COVID pandemics impact in care home has been huge in terms of incidence, hospitalization and death. Mortality in care home related to COVID has been in Catalonia 40% of all deaths related to COVID In global population.
There have been a great effort of all health and social care system to give appropriate response to severe situation in care homes. Integrated Care approach has been an essential key component in the model of care as both Health Care and Care Homes are responsibilities taken by different ministries.

Aims and Objectives: Objectives: 1) Evaluate the current maturity level of and readiness for integrated care in care homes in different territories in Catalonia. 2) Assess the current situation that allows identifying breeding lines for the updating and progress in IC model in care homes.
The SCIROCCO Exchange self-assessment tool (see: https://scirocco-exchange-tool.inf.ed.ac.uk/en_gb/) is a self- assessment tool to assess a region's readiness and maturity for integrated care. It builds on the conceptual Maturity Model for Integrated Care developed by the B3 Action Group on Integrated Care of the European Innovation Partnership on Active and Healthy Ageing.
190 professionals from 18 regions were assessed

Highlights/Results/Key Findings: Relatively low scores in all 12 dimensions in SCIROCCO maturity model. Remarkable increase in 2021 scores compared to the pre-pandemic situation scores. Territorial differences exist even if rurality does not seem to be a determinant factor in IC in care homes maturity.
"Structure and governance" and "Breadth of ambition" among the highest rated SCIROCCO dimensions and "Funding" and "Evaluation methods" among the lowest rated in both individual self-assessments and consensus self-assessments.
"Structure and governance" and "Breadth of ambition" among SCIROCCO dimensions that increase the most their scores in the current situation compared to the pre-pandemic situation.
Some valuable qualitative information is identified as areas to be improved: need of better labour conditions, need of a share and integrated health and social information and interoperable health and care record, need of incorporating a more systemic and comprehensive perspective with demographic segmentation and stratification approach. Theses qualitative information will be incorporated in updated IC model.

Conclusions: Before pandemics, development of Integrated care in residential care has been scarce. During pandemics, Integrated Care approach has been adopted both at ministries level and regional level implementing a range of Integrated Care initiatives to cope with vulnerable situation of people living in care homes in Catalonia.

Implications: Integrated Care policy and action in care homes should be maintained overtime and reinforced in last stage of pandemics to create a scenario of collaborative work and transformation in residential care. IC should be incorporated in other long term care policies (home care,...) in new updated design and implementation.

Abstract ID: 165

Canadian Policy Context – Driving the Design of an Integrated People-Centred Health Systems Standard and Implementation Tools

Presented by: Patricia Sullivan-Taylor

Co-Authors: Patricia Sullivan-Taylor

_____

Conference Track: System wide governance and leadership

Introduction: Despite national and international policy commitment to implement integrated health systems, we lack standards that support evidence-based design, implementation, and evaluation. Some stakeholders perceive existing frameworks as too theoretical. Health Standard Organization's (HSO) Integrated People-Centred Health Systems (IPCHS) standard was developed to bridge this gap between theory and practice. This session will profile the Canadian policy context, population health needs, partnership and lessons from the design and early uptake of this standard and implementation tools. Discussion will include transferability to other countries and learnings across different settings.

Aims and Objectives: The IPCHS standard will facilitate implementation of integrated health systems and monitoring of outcomes. Canada's health and social care system is a federated model with ten provincial and three territorial systems that cover 38 million people. In 2018, health spending in Canada was 10.7% of GDP compared to 8.8% in 36 OECD countries. Early forecasting on COVID-19 health spending suggests that increased costs could vary from 0.3 to 10% of GDP, depending on response measures.
Canada's population health outcomes lag those of eight OECD countries, who spend less and achieve higher life expectancy at birth.

Highlights/Results/Key Findings: Integration of health and social services is a national and jurisdictional priority and exists in most strategic direction documents from governments, health authorities, and healthcare organizations.
System-level policies and programs have been implemented nationally and provincially. The IPCHS standard is for use globally by health and social service ministries, administrators, and health systems/authorities. Complementing existing frameworks, the standard is divided into 10 design principles that address different aspects of health and social service integration with criteria guidance for policymakers and health system partners. The IPCHS standard, released in May 2021, was co-designed with policymakers, administrators, providers, patients, and academics. Additional feedback was received from a diverse audience during two public review periods and consultation with policymakers and system leaders.
Two implementation tools are being co-designed to assist with standard adoption and use globally. Both prototype tools are available for testing in Fall 2021 with final tools released in Fall 2022.

Conclusions: For integration to work, governance models must account for the complex and evolving needs of health and care systems. Governance models must break down barriers and facilitate co-operation over competition. This standard and implementation tools will facilitate implementation and monitoring of progress and outcomes.

Implications: The Integrated Care Assessment Tool helps health systems/networks understand where they are on the integration continuum and what is needed to advance their integration goals. Meanwhile, the Pathways Toolkit ensures integrated care best practices are applied within the local context. These tools and the IPCHS standard are applicable globally.

Abstract ID: 166

Developing a Core Set of Indicators to Assess the Quality and Impact of Integrated Care for Older Persons Living with Complex Health and Social Care Needs and Family/Friend Caregivers: a Delphi consensus study

Presented by: Kelly Kay

Co-Authors: Salinda Horgan, Kelly Kay, Adam Morrison, Jeanette Prorok

_____

Conference Track: Transparency of progress, results & impact

Introduction: Indicators of healthcare quality for older persons typically measure aspects of care that are in keeping with acute care ideals. However, these indicators continue to entrench outmoded approaches to care. If we intend to transform services to better meet the health and care goals of older persons and caregivers, we must establish appropriate performance measures, aligned with the goals and intentions of integrated care. Provincial Geriatrics Leadership Ontario undertook a systematic process to achieve consensus on a core set of indicators of integrated care for older persons living with complex health and social care needs and their family/friend caregivers.

Aims and Objectives: The selection of a core set of indicators was informed by a systematic process that included: i) literature review, ii) stakeholder consultation, iii) scan of existing data sets, iv) ranking pre-selected indicators, and v) achieving consensus on a core indicator set. Throughout the project, we sought to emphasize the voice of older persons (including caregivers) and to reduce the impact of power dynamics. We did this by purposefully over-sampling older persons; holding separate meetings to prepare older persons to participate as equal partners; analyzing the data provided by older persons separately to identify differences in ranking patterns between groups.

Highlights/Results/Key Findings: Consensus was achieved across relevant stakeholder groups on a core set of indicators. This indicator set can be used to holistically measure the quality and impact of integrated care for older persons with complex needs and caregivers, across the continuum of care. The findings represent a departure from traditional indicator sets, in that they are intended to be applied across types and levels of support. Moreover, they enable micro, meso and macro levels of analysis across short, mid and long-term timepoints. Several novel indicators are included in the core set. These are indicators, proposed by older persons, caregivers and health professionals, that they believe ought to be collected. Finally, A number of lessons were learned about the best ways to optimize the participation of older persons and caregivers in a consensus-building exercise to select a set of core indicators.

Conclusions: The proposed set of indicators is informed by the voices of older persons, caregivers and health professionals. We hope to encourage a shift away from the use of more traditional indicators, that overlook the impact of integrated care in domains of importance to older persons and caregivers.

Implications: The proposed indicators can be used by programs, organizations and systems across the continuum of care to evaluate integrated care for older persons with complex needs and caregivers. The indicator set will be validated as part of a future verification study.

Abstract ID: 179
Integrated primary care workforce planning in the City of Toronto: Co-development and operationalization of a fit-for-purpose planning toolkit
Presented by: Sarah Simkin

Co-Authors: *Sarah Simkin, Cynthia Damba, Ting Lim, Nathalie Sava, Ivy Lynn Bourgeault, Caroline Chamberland-Rowe*

_____

Conference Track: Population health needs and local context,Workforce capacity and capability,Transparency of progress, results & impact

Introduction: Regional planning capability is increasingly necessary to ensure that the healthcare needs of defined communities can be met. In the City of Toronto, disparities in access to integrated primary care provided the impetus for the development of a comprehensive Primary Care Strategy. The strategy, which was developed with patient and provider input, aimed to improve patient access to care, service integration, and system efficiency. Ontario Health Toronto recognized that achieving this was contingent upon adequately planning for future health workforce needs and that robust, regional-level workforce planning processes that include the developing Ontario Health Teams, would be necessary.

Aims and Objectives: The project goal was to co-develop and operationalize an evidence-informed toolkit for integrated, multi-professional, needs-based primary care workforce planning. Underpinning the approach is a health workforce systems framework that acknowledges the social, political, geographic, economic and technological contexts within which planning is situated. The toolkit includes qualitative tools that were used to conduct extensive consultations with key stakeholders and point-of-care providers to mobilize their substantial knowledge of the local primary care workforce and of community-level population health needs. The toolkit also includes a quantitative workforce planning model, which is being developed and operationalized in partnership with Ontario Health Toronto.

Highlights/Results/Key Findings: Our team adopted a participatory approach to build internal workforce planning capacity within Ontario Health Toronto, enabling the progressive adaptation and refinement of the toolkit through the first cycle of planning. The co-developed toolkit includes fit-for-purpose qualitative, descriptive processes and quantitative planning approaches that support high-quality health workforce planning activities. The iterative and interactive planning approach includes horizon scanning, scenario generation, workforce modeling, and policy analysis. To identify neighbourhoods in need of additional resources, the quantitative model assesses the alignment of population health needs with workforce service capacity for all 140 neighbourhoods in the city from 2016 to 2026. Interactive dashboards enable local stakeholders to test scenarios relevant to planning in Toronto, including patient mobility, population and provider diversity, and population growth, to understand the impact of changing conditions. A scenario-based allocation step can be added to optimize alignment by shifting service to alternate providers or virtual care.

Conclusions: The co-developed fit-for-purpose approach to integrated primary care workforce planning addresses specific regional and Ontario Health Teams' planning challenges and will provide an essential evidence-base to facilitate equitable distribution of primary care human resources. It will establish open, transparent, ongoing partnerships, building capacity, and enhancing trust and buy-in amongst stakeholders.

Implications: This toolkit was designed to meet the needs of Ontario Health Toronto and would require adaptation for full transferability to other jurisdictions. The principles and processes are applicable across jurisdictions, but the technical assumptions are context-dependent and would require adjustment for unique stocks, flows, and policy levers within different systems.

Abstract ID: 180

The Winding Road from Plan to Action: A Qualitative Study Exploring Operationalization of Person-Centeredness and Engagement in an Integrated Patient Care Context

Presented by: Reham Abdelhalim
Co-Authors: Reham Abdelhalim, Agnes Grudniewicz, Kerry Kuluski, Jennifer Gutberg, Sobia Khan, walter wodchis

_____

Conference Track: Shared values and vision,People as partners in health and care

Introduction: Implementing person-centered initiatives is still a major challenge in most healthcare systems, particularly when the target population are persons living with complex health and social care needs and when those initiatives span many providers and settings. While person-centered care increasingly informs the provision of care, healthcare structures and practices continue to be aligned with a disease-centered siloed model. They often ignoring the significant value and knowledge persons living with complex need and their family caregivers may bring into the conversation when allowed to be engaged better in planning, delivering, and evaluating their care.

Aims and Objectives: This study investigated an Ontario-wide initiative (Health Links) that aimed to provide person-centered coordinated care (integrated patient care) to persons living with complex health and social care needs. We examined how implementation plans were operationalized during the first two years of implementation. Two data sources were used; Health Links' implementation documents were utilized to understand the implementation plan for person-centeredness and engagement, and interviews with leaders and providers were used to understand the extent to which these plans were operationalized. Qualitative content analysis was the analytic approach used to analyze 75 documents and 60 interviews.

Highlights/Results/Key Findings: The implementation documents were clear on the "what" of person-centered coordinated care; they acknowledged person-centeredness as a cornerstone to Health Links and underscored the value of engaging patients and caregivers. This vision was similarly supported by interview participants. However, the "how" was rarely described in the documents, which left conceptualization of these concepts and consequently operationalization open to interpretation. This was reflected in the data as participants had different views on what person-centeredness was and how to engage patients. The implementation plans did not include guidance on factors facilitating implementation or on anticipated obstacles. Documents did not reflect that providers and patient/caregivers were involved in creating these implementation plans. This resulted in participants highlighting several challenges regarding operationalizing person-centeredness and engagement, including lack of readiness and training for patients and providers, difficulty for patients and caregivers to attend committees, paucity of incentives and overall need for implementation support.

Conclusions: Results highlighted important factors to consider when planning new models of person-centered coordinated care delivery including. These factors include stakeholders' engagement in creation of implementation plans, pre-implementation efforts including awareness, training and change management as well as identifying the challenges that might occur and developing mitigation strategies to tackle them.

Implications: The challenges identified in this study on moving from planning to implementation can inform other's efforts in designing and implementing new interventions.

Abstract ID: 184
Mobile Team Vaccine - Standing up an Integrated Health Delivery System in 48 hours
Presented by: Shiran Isaacksz
Co-Authors: *Emily Hay, Shiran Isaacksz*

_____

Conference Track: Population health needs and local context,Resilient communities and new alliances

Introduction: The Toronto region, a culturally diverse and densely populated area in Canada (6.3 M residents, 46.1% immigrants) was faced with a need to rapidly establish and scale up immunization of high-priority COVID-19 vaccine recipients. The Ontario Government and Ministry of Health asked health system partners to respond. University Health Network (UHN) established "Mobile Team Vaccine" together with partners across the continuum of care including primary care, long term care and retirement homes, hospitals, and Toronto Public Health (TPH). This rapidly formed integrated health delivery system created a ground-up community of practice, to protect the most vulnerable populations.

Aims and Objectives: Vaccination efforts initially targeted the most vulnerable populations in Long-Term Care and Retirement homes/ congregate settings. Data and learnings were used to implement a Toronto-wide mobile vaccination strategy aimed at residents in priority postal codes and neighbourhoods facing high incidents of COVID-19 and low vaccine uptake (e.g vaccination rate of 28% vs 40% city average). The goal was to accelerate equitable access to vaccine for vulnerable communities, as fast and safely as possible. Change efforts were focused on multiple clinical and community partners, to quickly align and work together, to achieve a coordinated and sustainable model for mobile vaccination efforts.

Highlights/Results/Key Findings: The aim of mobile vaccination efforts was to provide equitable and low-barrier access to vaccine. Mobile Team Vaccine required a coordinated and community-led approach, to maximize reach in marginalized and vulnerable communities within the Toronto area.
Clinical capacity and operational efficiency were aligned to support rapid scale up of vaccinations, achieved through community engagement, and a backbone support team. The team leveraged expertise, processes, infrastructure, and learnings from flu vaccination and community testing efforts. Efforts were scaled up to facilitate additional coordinated vaccination efforts for more than 200,000 individuals within the Greater Toronto Area. A data-driven approach was used to inform mobile pop-up vaccine clinics locations; clinics were set up in areas at highest risk from COVID-19, by examining factors such as incidents of COVID-19, rates of hospitalization, and vaccine uptake on a weekly basis.

Conclusions: Leveraging previously established relationships in primary care, hospital partners and community partners, supported thorough a backbone support team, and learnings from flu vaccine and community testing, enabled rapid, equitable and low barrier access to vaccinations to vulnerable populations within the GTA.

Implications: The initial mobile vaccination efforts in Long-Term Care and Retirement homes/congregate settings set the foundation for the Toronto-wide mobile vaccination strategy. Lessons learned were shared with community partners and Community Ambassadors in practical, hands-on learning, and shadowing experiences for team members during mobile clinics.

Abstract ID: 198
Exploring key stakeholders' attitudes and perspectives on the integration of medical assistance in dying and palliative care services in Canada

Presented by: Gilla Shapiro
Co-Authors: Gilla Shapiro, Eryn Tong, Rinat Nissim, Gary Rodin

_____

Conference Track: Shared values and vision,System wide governance and leadership

Introduction: Medical assistance in dying (MAiD) was legalized in Canada in 2016 for individuals with a grievous and irremediable medical condition. Upon legalization, MAiD was implemented at the provincial, territorial, and healthcare institution levels and varied across contexts. Substantial overlap exists in individuals requesting MAiD and those who are eligible and seeking palliative care (PC) services, yet policies and recommended practices to ensure optimal delivery and coordination of these services are not well-developed. Multiple models of delivery and coordination of MAiD and PC are possible, but it is unclear which model is most feasible or acceptable across Canadian health settings.

Aims and Objectives: The aim of this qualitative study is to understand the perspectives of key MAiD and PC stakeholders across Canada regarding these services and the optimal relationship between them. Key stakeholders were purposively sampled to seek representation from diverse regions and those with leadership expertise and experience with MAiD and/or PC. Virtual semi-structured interviews were conducted with 22 stakeholders between April and June 2021. Interview transcripts were coded independently by two researchers and reconciled to identify key themes using conventional content analysis.

Highlights/Results/Key Findings: Preliminary results indicated a range of participant perspectives regarding the need for integration of MAiD and PC services. Key stakeholders emphasized the centrality of patient-centered care and patient autonomy to both services. Elements perceived to improve the relationship between MAiD and PC across settings included the use of multidisciplinary teams, clear system-wide governance and leadership, enhanced training, a collegial culture of respect, and shared values and vision focused on patient-centred care. Challenges to coordinating MAiD and PC included the "competition" for mutual resources and differential access of PC and MAiD services.

Conclusions: This qualitative study examined the attitudes and perspectives of key stakeholders regarding the optimal relationship between MAiD and PC services. Irrespective of the level of service integration, an emphasis on the need for education and relationship-building was highlighted for improved coordination of services.

Implications: This is the first national study of the perspectives of key stakeholders of government, health system leaders, and academia regarding the delivery and integration of MAiD and PC services in Canada. Our findings will improve MAiD policy in Canada and inform MAiD policy in other jurisdictions.

Abstract ID: 200
Connected COVID Care: Comprehensive and equitable access to the care and support patients want

Presented by: Melissa Chang

Co-Authors: Tania Carlyle, Melissa Chang

_____

Conference Track: Population health needs and local context,People as partners in health and care,System wide governance and leadership

Introduction: Connected COVID Care is an integrated care initiative co-developed by partners from public health, government, acute, primary, home and community care. Led by University Health Network (UHN) the initiative leverages virtual and home-based care to support equitable access to care and social supports.

Seamless care and support is delivered including to those living with complex/chronic conditions and those facing structural disadvantages. Approximately 20,000 patients have benefited in being cared for at home while maintaining timely access to acute care when needed.

Aims and Objectives: A gap in care was identified early in the pandemic as patients were presenting in emergency departments (EDs) unnecessarily or were without access to needed care. This presented an opportunity to create an innovative virtual and home-based model linking acute care specialties, home and community care, rehabilitation and psychosocial supports. The provision of secondary assessment tools to remotely monitor patients' oxygen saturation allows for remote monitoring in the home.

Highlights/Results/Key Findings: Multi-disciplinary collaboration has been the hallmark of Connected COVID Care from the outset, providing care to UHN patients as well as the broader regional community, including high-risk populations. Building capability and capacity quickly was possible by using the full scope and skillset of a diverse group of practitioners as well as patients and their caregivers.

Connected COVID Care is filling a gap for COVID patients, reducing anxiety and decreasing ED visits and readmissions. Approximately 20,000 patients have benefited while also saving more than 1,180 unnecessary ED visits and preventing a minimum of 542 inpatient bed days in one year. Other highlights:
•   Compliments public health efforts with timely follow-up on results, self-isolation protocols, education for self-management
•   Patient anxiety and self-care are improved with timely access and continuity of care
•   Robust supports for social determinant needs (e.g. housing, food programs, financial assistance)
•   Better patient outcomes from more comprehensive care and timely follow-up

Conclusions: Connected COVID Care is filling a gap for COVID patients, reducing anxiety and decreasing ED visits and readmissions. Having a diversity of opinions, expertise, and lived experience around the table led to greater creativity, innovation, critical analysis, and strength of solutions where they are most needed.

Implications: Lessons learned will inform other innovations in virtual patient care. COVID has pushed a lot of healthcare into the modern era and digitized it while also bringing communities together in shared purpose. Future plans include maintaining processes and infrastructure established to support other surges in care, such as flu season.

Implementing Integrating Care: Top-down Policies and Local Bottom-up Innovations
Abstract ID: 202
Improving Access to Primary Care in Toronto's Community Housing Buildings for Seniors during the COVID 19 Pandemic
Presented by: Jocelyn Charles
Co-Authors: *Jocelyn Charles, Jagger Smith, Jane Smart, Alison Culbert, Traian Rusu*

_____

Conference Track: Workforce capacity and capability

Introduction: Toronto Community Housing (City of Toronto owned), provides housing for 60,000 low-income households in over 100 neighbourhoods. There are more than 14,000 senior tenants in 83 seniors-designated buildings. A process to build an integrated service model to support seniors in these buildings is underway, however the COVID 19 pandemic exposed their increased vulnerability, isolation and limited access to primary care. Recognizing the need to respond quickly, the North Toronto Ontario Health Team (organizations including primary care, hospital, community and home-care) partnered with the Seniors Housing Unit in North Toronto to provide onsite primary care services to 1800 tenants.

Aims and Objectives: Aim: To improve access to primary care in Toronto Community Housing through an on-site clinic, outreach and virtual connections to primary care.
Methods: Participating primary care providers were assigned 1-4 buildings. An onsite clinic was established in each building. A registered health care professional worked with onsite community agencies to identify those at risk or in need of primary care services, provide advice/counselling, and connect seniors virtually to their family physician. A family physician dedicated to the building completed home-visits in the building for those unattached to primary care. All residents were offered both influenza and covid vaccinations on site.

Highlights/Results/Key Findings: A diverse group of health and social service providers joined together in March 2020 to develop a process for connecting with nine seniors' buildings to identify and provide needed supplies and services. Key support and leadership was provided by Baycrest Health Sciences Centre. On-site clinics were established, a communication strategy and manual and toolkit were created. Building huddles and cross-building huddles occurred weekly to share and problem solve. Both influenza and COVID 19 vaccines were administered to the residents at their doorstep, addressing vaccine hesitancy.
COVID-19 case incidence curve was significantly less than the overall City of Toronto. Rate of hospitalization from COVID-19 decreased by 30% in the 9 buildings by April 30, 2020 compared to the overall City of Toronto. Two of the nine buildings have continued to provide on-site and in-home primary care post COVID 19 vaccination. Key success factors will be discussed.

Conclusions: Cross sector collaboration is an efficient and effective way to address urgent needs in low-income seniors housing. Strong leadership as well as co-developed processes, frequent building meetings and cross-building huddles were effective ways of sharing innovative ways of meeting needs with limited resources.

Implications: While building an integrated service model to support seniors in Toronto's low-income housing buildings is underway, the COVID 19 pandemic response in North Toronto allowed for quick collaboration and strategy testing to ensure vulnerable seniors have timely access to primary care. Lessons learned are transferrable to other communities of seniors.

Abstract ID: 11

Integrating primary care and community social services through Social Prescribing

Presented by: Grace Park

Co-Authors: *Grace Park*

_____

Conference Track: Population health needs and local context

Introduction: through partnership with community primary care providers and their older adult patients, Fraser Health is working to promote healthy aging and prevent frailty. A holistic geriatric assessment tool is provided to the PCPs and during care planning, social services referral is created through socialo prescribing. Unite Way has provided grants to fund local Seniors' Community Connectors who receive these referrals from PCP and connect with seniors to identify appropriate community programs to increase exercise and social engagement. The social prescription provides a vehicle to ensure social factors that contribute to frailty development are addressed.

Aims and Objectives: Primary Care providers identify vulnerable seniors during their yearly complex care planning session. Their frailty index is measured using an electronic Comprehensive Geriatric Assessment tool in their EMR. The careplan includes a wellness plan to address goals of care and social factors based on what is important to the senior. The local Seniors' Community Connector located at a chosen Non Profit Agency helps to set goals for the senior to increase their activity and social engagement. Local community resources including volunteer drivers and friendly visitors are deployed to help overcome any barriers for seniors to attend activities.

Highlights/Results/Key Findings: Integration of health and social services through the social prescribing scheme has led to better awareness of activities in the community. As the desire to age in place and promotion of independence in the community for seniors, the holistic approach including social factors that contribute to healthy aging has been highlighted. Primary Care providers have a point of contact for the critically valuable community services for their seniors while the added resource of a seniors' community connector helps to overcome barriers for seniors and increase social interactions. The Canadian Frailty Network AVOID strategy is deployed by the physicians and the seniors community connectors to help motivate the seniors to engage in the health protective behaviors. Working with the Divisions of Family Practice in the FH region helps the project team to reach all primary care practitioners to bring the education on frailty prevention and social prescribing.

Conclusions: While the work has been somewhat curtailed by the Covid 19 pandemic, the primary care prevention of frailty through social prescription is based on evidence and leverages the primary care providers' unique position to intervene as their patients start becoming vulnerable to implement services and programs that will prevent frailty.

Implications: Throughout its development the primary care frailty prevention work called CARES has developed a toolkit that is available for any other health service delivery providers. Webinars have been provided and are available through Doctors of BC Shared Care Services for other jurisdictions who wish to learn more about CARES.

Meaningful Partnership with Patients, Families and Citizens
Abstract ID: 30
Using virtual workshops to bring together young people, parents and professionals to better understand local experiences of health and care services
Presented by: Samuel Miller
Co-Authors: Samuel Miller, Phoebe Rutherford, Gabrielle Mathews, Arpana Soni, Mando Watson, Rianne Steele

_____

Conference Track: Shared values and vision,People as partners in health and care,Resilient communities and new alliances,Digital solutions

Introduction: The NHS (UK) is reorganising health and care services to work in integrated care systems (ICS)(1). This presents an opportunity for children, young people (YP) and parents to be directly involved in the redesign of their local health and care services. The challenge is ensuring the patient voice is heard from across the ICS. Working with researchers from the National Institute of Health Research's School for Public Health Research team, North West London ICS and Imperial Patient Experience Research Centre, our local integrated care collaborative (Connecting Care for Children) developed a virtual workshop to help shape local health priorities.

Aims and Objectives: Key organisations involved in children's health and wellbeing across the ICS were approached to provide 'ambassadors' to recruit YP, parents, volunteers and healthcare professionals. The workshop activities were designed using insights from a local youth health champion.
The video conferencing software Zoom (2) enabled participants to join remotely from laptops and smartphones without having to download software. Zoom's white board and polling facilities created an interactive environment for participants to express themselves and build on each other's opinion. Smaller group "breakout sessions" followed, allowing participants to discuss shared health concerns without the pressure of a large audience.

Highlights/Results/Key Findings: 22 participants attended the workshop from a wide range of backgrounds including young people, parents, grandparents, community volunteers, and professionals from health, social care and the voluntary sector.
Qualitative data was recorded and transcribed during the workshop. A thematic analysis was performed using the software Nvivo. 1st and 2nd authors independently coded the data to identify significant statements and extract relevant meanings. Six core themes emerged as key issues:

- Access to mental health support
- Mental health support in schools
- Navigating the system
- Young people's ownership of their care
- Pressures on parents
- Maintaining a healthy weight

As an output from the event, a workshop report describing these six themes was shared with workshop participants and with local stakeholders in child health service and redesign (3).

Conclusions: Engaging YP in conversations using a virtual platform may be more accessible to YP and is also effective with adults and professionals. Building relationships with citizens, especially YP and their parents through community organisations and youth groups helps to build trust and future engagement in health and wellbeing conversations.

Implications: Our virtual workshop approach is replicable and adaptable to local population needs and is an effective tool to hear and share the voices of citizens. We acknowledge that such workshops exclude the voice of citizens without access to technology.
References
(1)   NHS Long term plan
(2)   Zoom https://zoom.us
(3)   https://www.cc4c.imperial.nhs.uk/our-experience/blog/have-your-say

Abstract ID: 32
Co-Design and Evaluation of Education for the Healthcare Workforce to Provide Person-Centered Care for Family Caregivers

Presented by: Sharon Anderson

Co-Authors: *Sharon Anderson, Cecelia Marion, Wendy Duggleby, Arlene Huhn, Bonnie Dobbs, Lyn Sonnenberg, Glenda Tarnowski, David Howatt, Colleen Turkington, Sandy Sereda, Jasneet Parmar*

_____

Conference Track: Population health needs and local context,People as partners in health and care,Resilient communities and new alliances,Workforce capacity and capability,Digital solutions

Introduction: Changes are needed in the way we support family caregivers (FCGs). FCG distress has risen from 16% (2010) and 33% (2016) to over 50% during the COVID-19 pandemic. FCGs do not have a defined role in current healthcare systems. Specifically, FCGs and healthcare providers need to work as a team yet typically education has targeted increasing FCG's care skills to sustain care rather than educating healthcare providers to support FCG as partners-in-care and to maintain their own health. Caregiving scholars now recommend the healthcare workforce receive competency-based education to identify, assess, support, and partner with FCGs across the care trajectory.

Aims and Objectives: Aims: To describe the co-design of the competency-based foundational Caregiver-Centered Care Education for the health workforce and report on the mixed methods evaluation. To ensure education focused on person-centered care for FCGS, we created the term "Caregiver-Centered Care" defined as a collaborative working relationship between families and healthcare providers in supporting FCGS in their caregiving role, decisions about services, care management, and advocacy. Multilevel interdisciplinary stakeholders including FCGs (n=102) co-designed the education. The teaching and learning resources include six competency-aligned educational modules with videos and interactive exercises that encourage reflection. Kirkpatrick's framework guided our evaluation.

Highlights/Results/Key Findings: Results: Since November 21, 2020, 1203 people have completed the online education (caregivercare.ca). Attendees were satisfied with the overall quality of education (Mean 4.69 (SD=.6) Median 5) (Kirkpatrick, Level 1). Student's paired samples T-test indicated that there were significant pre-post education changes in knowledge and confidence to work with FCGs (Kirkpatrick Level 2): Pre (M=38.6, Sd=6.5) to post (M=47.2, SD=3.4) t (150) = -13.0, p<.0005 (two-tailed). Qualitative results mirror the quantitative results. "This was a wonderful course that provided "real life" examples of what kinds of roles the family caregivers take on and how we can recognize and support their journey as much as the care recipient's journey. Excellent content and I look forward to taking the next course." Interviews with learners three months post education suggests that the education had a positive effect on caregiver interactions in practice (Kirkpatrick Level 3).

Conclusions: Conclusions: Educating healthcare providers to provide Caregiver-Centered Care is a step towards addressing the inconsistent system of supports for diverse FCGs throughout variable care trajectories. Involving multilevel stakeholders in the educational co-design process can help ensure the education is relevant and useful for the healthcare providers who interact with FCGs.

Implications: Although co-design with healthcare providers and caregivers takes more time and facilitation, the efforts are worthwhile through the usefulness of the education to healthcare providers. The participatory approach assists with knowledge mobilization. We are currently co-designing advanced Caregiver-Centered Care education for health providers with significant interactions with FCGs.

Fostering reflexivity in medical learners: development of an educational intervention based on the active involvement of patient-teachers

Presented by: Julie Massé

Co-Authors: Julie Massé, Maryline Côté, Nathalie Belley, Monique Toutant, Eric Lapointe, Geneviève Olivier-D'Avignon, Jean-Jonathan Cocou Gozo, Sarah Numainville, Marie-Claude Tremblay

_____

Conference Track: Shared values and vision,People as partners in health and care

Introduction: Reflexivity allows to develop alternative ways of thinking and new perspectives on action. Fostering reflexivity in medical students is crucial to developing professional practices that are consistent with the needs and expectations of patients and communities. Medical schools are looking for innovative ways to stimulate the development of reflexivity in their students. This project aimed to co-design an innovative educational intervention based on the active and meaningful involvement of patient-teachers to promote the development of reflexivity in undergraduate medical students at Université Laval.

Aims and Objectives: The context in which the intervention will be deployed is small group discussion workshops, where students of a undergraduate medicine course deliberate on fictitious clinical cases. The co-design process aims to define: (1) Who to involve? (2) How to prepare and support these patients? (3) What form will their active involvement take?

The co-design process involved conducting a rapid review of the literature to identify best practices for patient engagement in medical education. Then, a multi-stakeholder steering committee (involving patients, students, course leaders, and research team members) defined the specific elements of the intervention, based on the review results.

Highlights/Results/Key Findings: The review identified 16 relevant studies, which highlighted educational outcomes related to (1) changes in perceptions and attitudes, as well as (2) acquisition of new non-clinical knowledge, skills and understandings. Those outcomes were related to different attributes of educational interventions that shape the learner-patient encounter. Based on these results, the committee defined the critical elements of the intervention, which were:
(1) To recruit patients with diverse experiences of the disease and the health care system and to insure the implementation of appropriate communication strategies to reach them;
(2) To provide fair and appropriate financial compensation to limit financial barriers to participation, especially for people from groups experiencing social vulnerability;
(3) To implement measures for ongoing support to patient involvement;
(4) To plan the modalities of patients' workshop participation to foster a sense of security and meet the preferences of each patient.

Conclusions: The intervention was first implemented from March to April, 2021 and will be evaluated using a mixed design. The educational innovation aims to enrich the training of a new generation of clinicians, towards greater clinical efficiency and better consideration of the moral, ethical, social and political issues of their practice.

Implications: Our review findings are relevant and have the potential to support decision-making within many comparable interventional contexts. Our co-design process could also be adapted to other interventional realities. Our intervention's critical elements should however be reproduced with caution, as they are highly dependent on stakeholders' concerns and local educational context.

Care transitions across the lifespan for Canadians with sex variations

Presented by: Caroline Sanders

Co-Authors: Caroline Sanders, Emma Amyot, Megan Usipuik, Nina Callens, Leigh Crawford, Tiffany Jones, Nicole Todd

_____

Conference Track: Shared values and vision,People as partners in health and care,Resilient communities and new alliances,Transparency of progress, results & impact

Introduction: Sex variations comprise a heterogeneous group of medical conditions. These include congenital adrenal hyperplasia (CAH), androgen insensitivity syndrome, Turner syndrome, and more, reportedly affecting approximately two percent of the population. These conditions can involve lifelong management. However, no research has examined the experiences nor the healthcare practices used with these individuals in their transitions through healthcare in Canada. Further, the majority of research on healthcare transitions from other countries focuses on the pediatric to adult care transfer, despite transitions taking place across the lifespan.

Aims and Objectives: Firstly, we aimed to investigate the current context of care for individuals with sex variations through an environmental scan of the current care pathways and guidelines for transition used by health providers. This included a search of 13 Canadian Children's Hospital websites, a survey sent to providers, and freedom of information requests submitted to these hospitals. Secondly, we sought to learn from the experiences of individuals with sex variations and their families in transitioning through care, along with their providers' understandings of transition for this group. Thus, we conducted engagement sessions in BC and Ontario applying a community-participatory learning approach.

Highlights/Results/Key Findings: Through the environmental scan, we found no hospital-specific resources used by healthcare providers for guiding care transitions for individuals with sex variations. Our engagement sessions consisted of in-person focus groups and virtual interviews with individuals from Ontario and British Columbia. We also included secondary data from a small BC study with women with CAH. Altogether, data from 17 individuals (15 with sex variations and two caregivers) was included. Interviews highlighted three important themes: (1) transition is a lifespan activity – individuals faced different healthcare challenges that required transition as they aged, (2) the building of personal agency, and (3) wellness promotion and healing in this population. An additional output from the study included the co-development of a small advisory group of adults identifying with sex variations, involved in work around health education and consultation.

Conclusions: Canadian care guidelines for managing transition with sex variations are lacking. For individuals with sex variations there is little information to support individual health literacy and self-management. There exists an opportunity for these individuals and their providers to begin building a visible network that can inform care delivery and policy.

Implications: A limitation of this study was failure to adopt inclusive terminology at study conception (e.g., our website domain, dsdtransition.ca). We learnt that intersex or sex variation is preferred by the community. We encourage use of inclusive terminology in healthcare and the co-development of transition guidelines with Canadians with sex variations.

Co-designing a Child and Family Hub for family adversity in Australia: lessons learned
Presented by: Teresa Hall
Co-Authors: *Teresa Hall, Sandie Pullen, Sarah Loveday, Hayley Loftus, Harriet Hiscock*

_____

Conference Track: People as partners in health and care

Introduction: Co-design methods are increasingly employed to solve complex problems in health care in Australia and globally (1, 2 , 3). Despite the proliferation of services developed through co-design methods, the term 'co-design' is used to describe a wide range of processes and practices with varying degrees of stakeholder engagement. In addition, studies often fail to explicate how existing research evidence, practice knowledge and lived experience come together in the co-design process. In this paper, we present our lessons from co-designing a Child and Family Hub in Wyndham Vale, a low socio-demographic and culturally diverse area of Western Melbourne, Australia.

Aims and Objectives: The Child and Family Hub model was co-designed through a 10-week series of workshops and consultations with intersectoral practitioners and families. The process focused on the client journey through the Hub and the workforce infrastructure required for its implementation. A core team of seven stakeholders worked through the British Design Council's Double Diamond human-centred design process (4). The findings of evidence reviews, individual interviews and group discussions were incorporated into the 'Discover' and 'Define' stages. Prototypes were 'Developed' and iteratively tested with over 100 families and 30 practitioners. The workshops were evaluated using the Public and Patient Engagement Evaluation Tool.

Highlights/Results/Key Findings: Strategies to create a common language and understanding of 'adversity', 'child mental health' and 'co-design' served as a crucial foundation for the process. Stakeholder engagement preceding, during and following the co-design process was important for generating trust in and local ownership of the Hub model. These engagement activities included mechanisms to tap into a diverse range of community and practitioner voices and experiences. Client personas were effective for incorporating research findings into the process and generating empathy for clients who will use the Hub. The evaluation outcomes and team reflections on the process highlighted the transformative potential of bringing community and practitioners together to generate mutual learning. Balancing the time commitment of core team members with the need to undertake user testing was a key challenge. Clearly articulating the parameters and fixed inputs to the co-design process based on the research evidence was also required to effectively manage stakeholder expectations.

Conclusions: The Child and Family Hub model was successfully co-designed in partnership with families, intersectoral practitioners and community members with a key focus on the client journey and workforce infrastructure necessary to support families with children 0-8 years experiencing adversity as they navigate the health and social care systems.

Implications: While this study was conducted in one metropolitan area of Australia, the key lessons related to language, stakeholder engagement, team composition and feasibility are useful for informing future research and service design with families experiencing adversity. The next phase of the project tests and evaluates the impact of the Hub.

Abstract ID: 42
The Value and Applicability of Designing Peer Collaboration into Patient Engagement and Partnership
Presented by: Alies Maybee
Co-Authors: *Alies Maybee, Kathy Borthwick*

_____

Conference Track: Shared values and vision,People as partners in health and care,Resilient communities and new alliances,Workforce capacity and capability

Introduction: Learn from patient partners how we developed our roles and contributed recommendations by incorporating a peer-led patient partner working group. We will demonstrate scalability and sustainability of this joint ownership model co-developed and fostered by a healthcare organization and a community of patient partners.
Key to success is the creation of a continuous learning environment (the working group) where patient partners share experiences and gain diverse perspectives from one another, thereby strengthening their role and project contributions, while improving overall engagement satisfaction. The projects benefit from the increased depth of contribution and subsequent decisions made.

Aims and Objectives: We will demonstrate how experienced patient partners worked with the Centre for Digital Health Evaluation (CDHE) to co-design a partnership structure that supports the CDHE and creates a learning environment within the patient partner community.
The structure is based on the principles of integrated leadership, defined accountabilities and mutually supportive relationships. The patient partner community includes a peer-based working group that supports patient partner capacity and expertise development.
Overall, while this approach was developed to nurture trust and support more substantive contributions in increasingly complex projects, it has also increased the meaningfulness of the engagements for the patient partners.

Highlights/Results/Key Findings: The Patient Partner Community (PPC) began with two experienced patient partners working with the CDHE as leads for the engagement co-design.   Additional patient partners were selected based on project needs.
As the PPC grew, a peer-led working group evolved into a collaborative learning community and created deeper connections among members.
In this model, the PPC also supports the development of project plans and budgets. This integrated approach moves a traditional Patient Family Advisory Council to a more active engagement model.   The PPC gives patient partners the opportunity to develop their knowledge, skills and confidence resulting in a greater depth of contribution within their projects.
This model has been in place for over 2 years, covering a range of projects from initial planning and research through to published reports. Patient Partners are experiencing more meaningful engagement because they see their views

Conclusions: We have experienced the success of the patient partner-led working group model and believe it can be applied to most patient engagement frameworks. This peer-led collaboration creates a continuous learning community that supports ongoing patient partner needs and increases the value they bring to the organization.

Implications: Most organizations with patient engagement staff and patient partners could support the introduction of a peer-led working group and the joint ownership model. For sustainability, adjustments to an existing patient engagement framework would need to be made. Trusted relationships are the basis for success.

Abstract ID: 43

Aging and mental health in Canada: top 10 unanswered questions according to older adults, caregivers and health and social care providers

Presented by: Justine Giosa

Co-Authors: *Justine Giosa, Elizabeth Kalles, Paul Holyoke, Heather McNeil*

_____

Conference Track: People as partners in health and care

Introduction: There is growing recognition that mental health is an essential part of overall health, yet mental and physical health care delivery and research remain heavily siloed in Canada. Age-related changes such as loss of social roles, retirement, bereavement, physical and cognitive health issues can have a negative impact on mental health, yet greater emphasis is placed on understanding and responding to physical and cognitive care needs of aging Canadians. There is a dearth of information on aging-focused mental health support, care and treatment and a need to form a meaningful aging and mental health research agenda for improved care integration.

Aims and Objectives: This project aimed to meaningfully partner with older adults, family caregivers and health and social care providers to identify the top 10 unanswered research questions on aging and mental health in Canada. A modified James Lind Alliance priority-setting partnership approach was applied, guided by a steering group representing diverse lived experiences. Consultation methods included two national surveys and four online workshops. Consensus-building was guided by qualitative and quantitative data analysis, a rapid literature scan and a nominal group technique.

Highlights/Results/Key Findings: Survey 1 (n=295) was opened-ended and led to the identification of 42 unique questions that Canadians' have about aging and mental health. A rapid literature scan revealed answers to some questions, but 25 were determined to be unanswered by existing evidence. Survey 2 (n=705) asked participants to choose which of the unanswered questions they felt were most important for future research and led to the prioritization of 18 unanswered questions, as selected by participants overall and those in key under-represented groups (age 76+ years, men, non-Caucasian individuals and those living outside of Ontario). Workshop participants (n=52) identified the top 10 unanswered questions through individual reflection and ranking, sharing of stories, small and large group discussion and voting. The top 10 unanswered questions include topics of skill-building, social isolation and loneliness, access to services (awareness, financial, geographical), technology, person-centred care, provider burnout, care transitions, support for caregivers and shared decision-making.

Conclusions: Partnership with older adults, family caregivers and health and social care providers across Canada led to wide and deep engagement on the topic of aging and mental health. The top 10 unanswered research questions will support an aging-focused mental health research agenda on topics that matter most to Canadians.

Implications: Most older adults, caregivers and health and social care providers involved in this project are interested in continued partnership to: share the top 10 list widely for increased awareness, funding and collaboration; develop research projects to answer the top 10 questions; and promote action on evidence-based answers to Canadians' questions.

Improved partnerships between caregivers and care providers of persons living with dementia

Presented by: Paul Holyoke
Co-Authors: *Paul Holyoke, Justine Giosa, Heather McNeil, Doris Warner, Anna Neely*

_____

Conference Track: People as partners in health and care

Introduction: Persons living with dementia (PLWD), caregivers and care providers know the dementia journey is full of changes – in mental and physical function, care settings, care providers, and roles of caregivers and care providers in providing the "clinical" versus the more "emotional, relational" care. While "person-centred care" tools, practices and approaches are available for providers and PLWD to work together better, there are fewer tools to help caregivers and providers communicate and share their knowledge, progress and activities better so they are working better together at all times, and particular during these changes.

Aims and Objectives: This study evolved over time using our Participatory Research to Action framework. After a specific need was identified by PLWD and caregivers in a focus group, we held six sessions with different caregivers and providers to co-design a prototype tool to help caregivers and care providers work together better. Next, multiple co-design workshops with different communities identified prototype elements that were not relevant and how they should be changed. Each workshop was tailored in collaboration with community representatives.

Highlights/Results/Key Findings: Guided by caregivers and providers from long-term care homes and home care, a prototype tool, Our Dementia Journey Journal, was produced on paper and in an online app to respond to the identified need. We then engaged with PLWD and their caregivers in diverse communities across Canada, including First Nations communities, to see how the prototype would need to be adapted to be culturally, linguistically and geographically relevant and useful. Overall, we heard that the essential components of the prototype Journal, adapted to local needs, will be helpful to improve the care of persons living with dementia by improving caregiver-care provider relationships and shared knowledge through various changes over time. The Journal includes basic information about dementia and links to online resources, tools for encouraging exchange of questions and answers, opportunities to record changes in wellbeing of caregivers and the emotional journey of the potential Journal users surrounding a PLWD.

Conclusions: Through iterations in serial co-design sessions with caregivers and providers, we identified core elements of a tool they believe will improve their partnerships over the dementia journey with its multifaceted changes, and the necessary adaptations to make it culturally, linguistically and geographical relevant.

Implications: We have information about the different versions of Our Dementia Journey Journal to meet the needs of caregivers and providers in rural, remote, suburban, urban, francophone and First Nations communities. These various versions will now be distributed for use and evaluation of their impact on caregiver-provider relationships.

Meaningful Partnership with Patients, Families and Citizens
Abstract ID: 46
The Reflection Room®: promoting discussions on dying and death … and pandemic-related grief
Presented by: Paul Holyoke
Co-Authors: Paul Holyoke, Barry Stephenson, Justine Giosa, Elizabeth Kalles, Anna Neely

_____

Conference Track: People as partners in health and care

Introduction: Thinking about dying and death is something we tend not to do, and those who promote advance care planning for our last days, hours and minutes would like us to do more. We wondered whether providing appropriate places for a form of ritualized, shared storytelling might provide a setting and a time in which people could encounter their own and others' grief and thoughts, feelings and beliefs about dying and death.

Aims and Objectives: We hypothesized that a welcoming physical space where people could encounter short narrative accounts of experiences of dying, death and grief would encourage the expression of thoughts and emotions. The Reflection Room®, conceived as transitional or liminal space, is an immersive experience informed by generative design research and participatory art installations. Design included invitations to enter, nature images, candles, comfortable seating, quiet music and a 'Reflection Wall' for posting stories. The actual use of the Room is iteratively "co-created" through visitors' actions and reactions. Non-participant observation through thematic analysis of stories was conducted to detect what people disclosed and read.

Highlights/Results/Key Findings: Over five years, we installed the Reflection Room® in 57 public and private spaces across Canada and collected over 1,000 reflections (stories). Stories reflected the emotional and conceptual experiences accompanying an encounter with dying and death. The stories also revealed a need or desire to interact with the stories of anonymous others. The stories shared had the quality of an offering to others, rather than straightforward expressions of personal grieving. Themes from the reflections included near and distant memories; continuing relationships past death through dialogue and remembrance; expressions of grief, regret and gratitude; learnings that had emerged through bereavement and grieving; advice to others about living; and observations that unfinished grieving was helped by the opportunity to reflect.

Conclusions: The Reflection Room® used storytelling to prompt expression, and visitors used the Room as they wanted and needed to. The variety and depth of stories shows the Reflection Room® opened appropriate space and time for many visitors--family, friends and caregivers--to publicly share and integrate private conversations and experiences.

Implications: The research team has been asked to deploy the Reflection Room® to address pandemic-related grief and loss in long-term care homes in central Ontario. This is a new opportunity to investigate whether the Reflection Room® can provide space and time for residents, caregivers and healthcare providers to process their grief.

Abstract ID: 48
The Frailty Matters Project: Coproducing a coaching and educational intervention for integrated community teams alongside older people with lived experience of frailty.

Presented by: F. J. Raymond Duffy

Co-Authors: *F. J. Raymond Duffy, Anne Hendry, Mandy Andrew, Constantina Papadopoulou, Janette Barrie, Janetta Martin, Birt Audrey*

_____

Conference Track: Population health needs and local context,People as partners in health and care

Introduction: The number of older people living with frailty is increasing. Awareness of frailty is essential for health and care professionals, as are the skills required to identify and manage frailty. Using participatory action research a coaching and online teaching programme was developed aimed at enhancing the skillset of integrated community teams to manage frailty in primary care. For integrated teams to understand the impact of frailty on someone's life, we recruited older people with lived experience as co-coaches to co-design and help deliver the programme.

Aims and Objectives: The principle aim of the project was to enhance the skillset of community staff to manage frailty in a primary care setting. To this end, a co-designed, developed and delivered, person-centred coaching programme for key integrated community care staff was created. The programme aimed to strengthen their leadership role in managing frailty. The coaching programme was supported by an online educational resource delivered via a blogging platform. This looked at effective and personalized care and support for people living with frailty in the community. The online resource which was also co-created responded to the key staff's needs.

Highlights/Results/Key Findings: The experience shared by the co-coaches added a unique and innovative dimension to the interactive learning for participants. During this process a model was created to illustrate the key requirements of frailty
management education within integrated community teams. The co-produced model, called 'The Frailty House', is an educational framework that can be used to support integrated Teams in the care of people living with frailty in their communities. This has been accomplished even although the delivery and evaluation of the project were seriously disrupted by the COVID-19 pandemic. The model, currently called the 'House of Frailty' has been well received. Steps are being undertaken to both publicize the model and digitize it for use by other interested parties.

Conclusions: The programme offers a way to improve the skill set of community staff dealing with anyone living with frailty they encounter. The resulting 'House of Frailty' model provides an intuitive framework, relevant to current practice that can be easily adapted to suit the needs of other communities.

Implications: Involving people with lived experience from the beginning ensured their concerns were addressed and resulted in a truly co-produced model that could prove invaluable to many integrated community teams. The research was undertaken within one Health Board area in Scotland therefore the model needs tested more widely.

Abstract ID: 51
A National Resources and Resilience Center designed with psychotraumatic peoples working in partnership
Presented by: Luigi Luigi Flora

Co-Authors: *Luigi Luigi Flora, Guillaume Vaiva, Thierry Baubet, Sylvie Molenda, Fabien D'Hondt*

_____

Conference Track: Shared values and vision,People as partners in health and care,Resilient communities and new alliances,System wide governance and leadership

Introduction: Context: From the will of six ministries in France (health, education, interior, defense, justice, higher education and research) was created in 2019 a National Resource and Resilience Center for Psychotrauma (CN2R) with the particularity of wishing to work in partnership with people experiencing psychotrauma.

Aims and Objectives: The CN2R was created with the aim of deepening the knowledge on the psychotrauma and the resiliency processes according to an approach of course in its globality; it has for that four strong axes that are the research, the training and the identification of good practice, the diffusion of the knowledge and the animation of the places of care that are the regional centers of the psychotraumatisms created simultaneously to the CN2R. From its creation, the functioning of this center has been created a transversal axis to the presented axes, the partnership with the people leave... with and a coordinator

Highlights/Results/Key Findings: this coordinator, who has experience in the partnership between scientific and professional knowledge on the one hand and experiential knowledge on the other hand, has created, according to a methodology that will be presented, a community of people with psychotrauma. A community that today actively participates in the partnership with each of the CN2R's axes, whose teams are learning to co-construct in partnership with members of the community in ways that will also be presented. Articles and audiovisual clips have been co-written, juries for research grants have been set up with their presence, and processes for the development of good practices in partnership with the High Health Autority(HAS) and a skills reference framework are underway. A last process for which a partnership is being organized with Montreal on autism and psychotrauma at the initiative of a think tank of the community of people who are experiencing

Conclusions: : That an entity created at the crossroads of 6 ministries and therefore according to a systemic and societal vision to accompany the citizens and society of an entire country towards resilience in partnership with the first concerned demonstrates a progress in the very perception of health.

Implications: In the perspective of transferring to other European states already interested, the partnerships initiated are methodologically constructed, they are thought to be transferable, the limits lie in the youth of this large-scale project.

Meaningful Partnership with Patients, Families and Citizens
Abstract ID: 54

"Project Wire Up" – A Digital Access and Literacy Program for Effective Psychosocial Engagement of Older Adults in Singapore

Presented by: Wan Qi Yee
Co-Authors: Wan Qi Yee, Jamaica Tan Pei Ying, Si Yinn Lu, Ka Shing Yow, Gloria Yao Chi Leung, Nerice Heng Wen Ngiam

_____

Conference Track: Population health needs and local context

Introduction: Social distancing measures were implemented to manage the COVID-19 pandemic. However, these measures have exacerbated social isolation and loneliness in older adults, thus adversely affecting their psychological, social, and physical health. While digital solutions like teleconferencing and tele-befriending can be effective in mitigating the pandemic's impact, uptake of new technology by older adults in Singapore is limited. "Project Wire Up" arose as a ground-up initiative by volunteers from TriGen(nonprofit organization) during the pandemic, in collaboration with Singapore General Hospital(Academic Medical Centre). It aims to address loneliness and social isolation in older adults through digital access and literacy.

Aims and Objectives: The program adopts a three-pronged approach: equip, train, connect. Older adults are Equipped with smartphones, Trained by volunteers for six sessions over three months, and digitally Connected to social networks. Digital skills training is guided by a tiered curriculum of increasing difficulty and contextualized to the needs of older adults. A sequential mixed-method, quasi-experimental pre-post study was conducted to evaluate the program's impact. Primary outcomes include perceived loneliness(University of California, Los Angeles' three-item Loneliness Scale[UCLA-3]), social connectedness(Lubben Social Network Scale-6[LSNS-6]) and self-reported smartphone usage(phone usage scale). Paired t-tests and Wilcoxon sign-rank tests were used at a significance level of 0.05.

Highlights/Results/Key Findings: The study is ongoing. To date, 150 older adults(Range: 57-88yrs) have participated in the study, with 115(M=73.7, SD=9.40) in the Intervention group and 35(M=71.2, SD=7.20) in the Control group. Majority were females(Intervention=52.2%,Control=65.7%), staying alone (Intervention=61.1%,Control=45.7%), and had primary school education or less(Intervention=73.7%, Control=71.4%). Prior to the study, approximately one-third did not own smartphones/mobile phones(Intervention=39.1%, Control=32.4%). For smartphone use, older adults reported significantly higher smartphone usage(Z=-2.44, p=0.02) post-program(Median=11) than pre-program(Median=6). No significant change was observed in the Control group on smartphone usage. There was no significant difference in perceived loneliness and social connectedness between pre- and post-test across the groups yet.

Preliminary findings from in-depth interviews with participants(n=21) suggest that while older adult valued the personalized training curriculum and social exchanges with volunteers, age-related cognitive and physical limitations, design of smartphones, literacy and language barriers, and internalized ageism may hinder their perceived self-efficacy and motivation to learn.

Conclusions: Preliminary findings suggest a digital literacy program that addresses the diverse needs, capabilities and concerns of older adults can effectively increase older adults' smartphone use and digital skills. Further analysis upon completion of the study is required to ascertain the program's impact on perceived loneliness and social connectedness.

Implications: Strengths of the study include the multiethnicity of participants, a replicable three-prong approach adopted in program implementation and use of a mixed-method design. Limitations include a non-randomized design, small number of participants, especially in the control group. Findings from the study can inform interventions adopted in population health.

Abstract ID: 66
The EMBOLDEN study: Using intervention co-design to enhance physical and community mobility in older adults
Presented by: Rebecca Ganann
Co-Authors: *Rebecca Ganann, Sarah Neil-Sztramko, Alvarez Elizabeth, Ayse Kuspinar, Courtney Kennedy, Caroline Moore, Maggie MacNeil, Kylie Teggart, Stuart Phillips, Bruce Newbold*

_____

Conference Track: Population health needs and local context,People as partners in health and care

Introduction: Physical mobility and social participation are key to maintaining independence and quality of life as one ages. Barriers to mobility and engagement lead to social isolation, and poor physical and mental health, which are precursors to frailty. To date, most mobility-enhancing interventions in older persons have been designed by researchers without older adults' input and delivered in controlled settings; translation to real-world contexts is often impractical and rarely occurs. A model to improve mobility in a manner that aligns with older adults' needs/preferences, addresses health inequities, and builds on existing community health and social services, is necessary for real-world impact.

Aims and Objectives: The EMBOLDEN study aims to enhance physical and community mobility of community-dwelling older adults through a novel co-designed intervention. Foundational projects included an environmental scan of local assets/gaps (including COVID-19 impacts) and three systematic reviews for interventions involving: i) group-based physical activity; ii) group-based healthy eating; and iii) system navigation. Utilizing experience-based co-design methodology we explored the experiences of older adults and service providers engaging with community-based health promotion programming. Findings informed priority intervention features and design specifications. A Strategic Guiding Council (SGC) comprised of diverse local health/social service providers and older adults partnered with researchers to co-design the intervention.

Highlights/Results/Key Findings: The environmental scan examined community features to explore neighbourhood-level inequities, identify priority neighbourhoods based on key features, and explore assets and gaps in available health and social programs for older adults. Evidence reviews identified a wide range of group-based physical activity, nutrition, and system navigation interventions to promote mobility in older adults. The intervention co-design process integrated this evidence together with lived experiences to identify strategies to address unmet needs and barriers faced by older adults in neighbourhoods with health inequities and to design the pragmatic trial to test the intervention. For example, the co-design process illustrated recruitment strategies, operational logistics, intervention delivery strategies, and outcomes important to older adults. SGC members were engaged monthly to provide valuable input into study decision-making and understanding of the shifting local context due to COVID-19. SGC engagement is essential for ongoing collaboration, real-world implementation success, and enhanced health and mobility of older adults.

Conclusions: Partnering with diverse stakeholders including older adults and using multiple sources of evidence is critical to identifying optimal design features of a community-based intervention to promote mobility. Ultimately, we aim to implement and evaluate a feasible, acceptable intervention to address health inequities and effectively improve the lives of older adults.

Implications: Central to EMBOLDEN is the collaborative approach to co-designing a program to promote mobility that leverages existing assets, addresses gaps, and can be adapted and implemented in other urban settings. Collaborative program development builds on best practices and existing community assets to support real-world potential for impact, sustainability, and scalability.

Abstract ID: 70

Embracing Client Engagement: A Strategy to Improve Services for Young Onset Dementia (YOD) at the Alzheimer Society of Brant, Haldimand Norfolk, Hamilton, Halton (ASBHNHH)

Presented by: Michelle Lewis

Co-Authors: *Michelle Lewis*

_____

Conference Track: Shared values and vision,People as partners in health and care,Resilient communities and new alliances

Introduction: Receiving client feedback is crucial for providers to identify gaps and improve services. Surveys are typically used to collect client input for quality improvement (QI) consideration - but was this enough? We did not think so. The ASBHNHH conducted client surveys in 2019 and 2020 revealing that clients with YOD and their care partners have unique needs. Embracing client engagement as a framework allows clients to be empowered decision makers who direct what services they need. This paper will focus on our recent shift to empowerment through a co-design investigative project and outcomes for persons with YOD and care partners.

Aims and Objectives: With improved client engagement as a QI Plan indicator, the objectives of this project were to engage persons living with YOD and their care partners to identify gaps in service using co-designed, investigative strategies that promote people as partners in care. Qualitative research methods, including focus group discussions and semi-structured interviews, were used to examine the potential use of the co-design method in designing and delivering improved services. A YOD Advisory Group was assembled and meetings then took place through Zoom with the use of guiding questions, open dialogue, and Google Jam Board.

Highlights/Results/Key Findings: The YOD Advisory Group identified two service gaps to improve and increase: support needs for YOD in general, and resources at the time of receiving a diagnosis. The findings informed the subsequent development of a resource guide outlining "everything to know" when one is diagnosed; and a peer support group for persons with YOD and another for their care partners. Evaluation was also co-designed to better inform the success of these projects. The co-design process was reported to have been significantly empowering for the YOD Advisory Group and staff involved. All reported having benefited from the experience and contributing to the solutions from their own perspectives. Our client engagement efforts through co-design resulted in the development of new programs and resources that now fill the identified service gaps.

Conclusions: This work demonstrates the importance and value of establishing meaningful partnerships with YOD clients through engagement to ensure quality and relevance of services. Lived experience is viewed as a form of expertise and client engagement that is reflected in performance indicators related to the QI Plan for the ASBHNHH.

Implications: It was evident that client engagement contributed to enhanced quality improvement. Lessons learned from the experience of the ASBHNHH can inspire other service providers to engage their clients through co-design and QI projects. Anecdotal accounts of QI planning can be references to inform many other community service contexts.

Meaningful Partnership with Patients, Families and Citizens
Abstract ID: 71
Families as partners in care: A novel model of family engagement in children's rehabilitation and developmental services
Presented by: Andrea Belanger
Co-Authors: Taryn Eickmeier, Andrea Belanger, Brad Sexton, Clare Alexander-Arias, Fadia Omer, Natasha Mills, Jacki Nemisz, Lorraine Sunstrum-Mann, Leslie Suite, Carolyn Hunt, Harry Deeg, Avori Cheyne, Alfred Ng

_____

Conference Track: Shared values and vision,People as partners in health and care

Introduction: In paediatric rehabilitation at Grandview Kids, integrated care begins at intake, with direct input from parents/caregivers, children and youth, to form the goals that will drive service provision. As practitioners continued to embed emerging best practices and policies to support seamless transfer between disciplines, families require additional support throughout their journeys. In 2012, Grandview Kids began the formation of a novel approach of a Family Engagement Team (FET) that is embedded into the development, implementation, and evaluation of daily practice.

Aims and Objectives: Through a series of lived experience interviews, this presentation will showcase the evolution of the Grandview FET to answer the question: "What are the actionable strategies for meaningful partnerships with patients and families?" The FET was founded on the principles that clients and families/caregivers are key partners in care and their voices must be embedded into programs, services, and decision-making processes. Strategies included: senior leadership support; investing in family leaders as employees or volunteers; shifting the focus from top-down to bottom-up engagement co-design with families; and embedding peer support referral process into models of care.

Highlights/Results/Key Findings: The senior leaders with support from the Board of Directors recognized parents/caregivers were more than "service users" but partners in the development, implementation, and evaluation of programs and services. A Family Facilitator Role was established as a full-time employee who led the development of a Family Advisory Council, an Online Parent Support program, and a Youth Advisory Committee. In 2021, the FET has seven paid employees that are current or past parents of clients or were clients, themselves. This expanded FET serve the function of capacity building (e.g., staff training, caregiver workshops, peer support), advocacy and citizenship (e.g., partnering across organizations to voice the needs of families of children and youth with disabilities), and client and caregiver engagement (e.g., co-design of programs, contribution to accreditation). The FET has been successfully embedded into daily practice, with a formal referral process at any point of a client's journey (e.g., intake, assessment, transitions).

Conclusions: Parents/caregivers become true partners in care when they are embedded into the primary functions of the healthcare organization. At Grandview Kids, the FET has built trust among families and clinicians, bolstering a model of integrated care by establishing clear parameters to engage families as active participants in their child/youth's journey.

Implications: The Grandview Kids' FET will share their lived experiences developing meaningful partnerships with families. To begin, the FET must have support from the senior leadership, be willing to reach out to families to collect feedback, and be willing to act on the outcomes; the positive and the challenging.

Abstract ID: 78

Partnering with health, social and community service organizations to build and implement a population health needs framework

Presented by: Mary Modayil

Co-Authors: Staci Hastings, Judy Seidel, Mary Modayil, Jacqueline Krysa

_____

Conference Track: Population health needs and local context

Introduction: In recent years, healthcare service planners and decisions makers in Alberta have received directives to utilize a population health approach when planning health services; however, a common understanding and a consistent approach to address population health needs did not exist. Healthcare service planning has traditionally been based on utilization of health services rather than looking broadly at the health needs of Albertans and their communities. This approach resulted in a narrow focus when planning: medical needs are prioritized at the expense of other health needs. This approach also led to challenges in working with other service organizations.

Aims and Objectives: To address these gaps, it was important to consider perspectives across health, social and community service organizations. A convergent mixed methods approach was used to co-develop an acceptable definition of population health needs and appropriate framework components to support service planning. A broad range of stakeholders were engaged through the following activities: an informal scoping review of grey and peer reviewed literature, key informant interviews across the continuum of healthcare and social service organizations, priority setting through Delphi techniques, and two online stakeholder engagement sessions with broad representation from across healthcare, academia, and community.

Highlights/Results/Key Findings: This multidisciplinary stakeholder engagement resulted in a common definition of population health needs, a Population Health Needs Framework for service planning and a User's Guide. The Framework and User's Guide are comprised of actionable strategies healthcare organizations can apply when planning in collaboration with community partners to better meet the needs of the populations they serve. The Framework is currently being implemented in several primary healthcare settings. One Primary Care Network is using the Framework in conjunction with community data and provider experiences to better understand the health needs of the Edmonton North community and ensure they are providing appropriate health services to the people who live there. Similarly, Alberta's northern communities have been utilizing the population health approach to bring together partners for service planning within 'health neighborhoods'. This work has highlighted how taking a population health approach has become acceptable in the context of healthcare.

Conclusions: Collaborating across health and community sectors during service planning is not easy. The strategies and considerations provided in the Population Health Needs Framework guides joint service planning across the continuum of care, while shifting away from a medical focus towards wellness, to improve population health outcomes and support health equity.

Implications: There has been much interest across sectors and the organization of Alberta Health Services to apply this new Framework during service planning. Applicable across jurisdictions and scales of planning, this Framework presents the opportunity to address population health needs and improve the human health experience in a sustainable way.

Abstract ID: 82
Co-Designing Relational Continuity Interventions for Urban Underserved Patients Experiencing Hospital-Primary Care Transitions
Presented by: Ginetta Salvalaggio

Co-Authors: Ginetta Salvalaggio, Cara Brown, Teresa Cavett, Lee Green, Gayle Halas, Stephen Hwang, Elaine Hyshka, Jesse Jenkinson, Aisha Lofters, Stephanie Montesanti, Francesco Mosaico, Danielle Peebles, Andrew Pinto, Shanell Twan

_____

Conference Track: Shared values and vision,Population health needs and local context,People as partners in health and care

Introduction: Urban underserved populations — communities with lived experience of poverty, unstable housing, and a high burden of physical and mental illness and addiction — historically experience fragmented care, especially in transition between acute and primary care. Relational continuity, i.e., forming lasting and trusting relationships with healthcare providers, is an aspect of care that urban underserved people have identified as critical to treatment adherence and self-care. However, limited research has investigated how to create and sustain relational continuity for this population. A participatory approach is critical to developing contextually-flexible and -relevant interventions that address the transition needs of urban underserved populations.

Aims and Objectives: The study's objectives are to: 1) explore urban underserved patient and clinician experiences of relational continuity during the hospital-primary care transition; 2) co-design relational continuity interventions to improve transitions in care; and 3) elicit the core structure and process adjustments needed to prepare emerging co-designed interventions for implementation. Patients, clinicians, and researchers in Alberta, Manitoba, and Ontario urban underserved settings will undertake three study phases: 1) eliciting experiences via qualitative patient interviews and clinician cognitive task analysis; 2) co-designing interventions via communities of practice (CoPs); and 3) assessing adjustments needed for implementation using human factors and ergonomics engineering principles.

Highlights/Results/Key Findings: Our work to date has been preparatory to ensure successful and meaningful participatory processes. It encompasses three main activities: 1) an environmental scan of key system stakeholders and recent policies addressing care transitions and continuity of care; 2) virtual site visits to orient sites to the study, determine how to support each site's participation, and document each site's organizational structure and any existing team care transition activities; 3) development of the CoPs. In this study, COPs are a group of people with a shared commitment to improving relational continuity and transitions in care using the community's collective expertise. Participating clinical teams have identified a multidisciplinary group of clinician representatives and patient partners for their CoP. Findings from these preparatory activities confirm study alignment with active multi-sectoral initiatives underway in each participating province to address continuity of care and care transitions.

Conclusions: Interventions designed to improve relational continuity gaps during urban underserved hospital-primary care transitions can fail if context is not taken into account. As a necessary precursor to implementation, research is needed to foster engagement, co-design promising interventions for improving transitions, and elicit factors critical for ensuring their successful real-world implementation.

Implications: Anticipated outcomes of the proposed study include: 1) the identification of mechanisms for relationship-enhanced care transitions; 2) capacity-building of transition teams working with urban underserved populations in three Canadian healthcare settings; and 3) contextually-specific, implementation-ready interventions that directly address patient and clinician views/needs.

Abstract ID: 90

Person-centered Parkinson's care Portrayed

Presented by: Thieme Stap

Co-Authors: Thieme Stap, Jan-jurjen Koksma, Richard Grol, Roland Laan, Bastiaan Bloem, Marten Munneke

_____

Conference Track: Shared values and vision,Population health needs and local context,People as partners in health and care,Transparency of progress, results & impact

Introduction: Person-centered care (PCC) is at the center of integrated care. Research into this complex concept often leans towards reductionism, out of scientific convention, which encapsulates PCC in care figures ("I give my care-process a 7/10"), questionnaires, or overly structured interviews. As an alternative, we have developed a more open approach to scrutinizing PCC: a participatory, arts-based research design using photography.

Aims and Objectives: Together with people with Parkinson's (PwP) and their care professionals (from all kinds of disciplines), we have an in-depth conversation on PCC, while a photographer makes photographs of them and their (healthcare related) interactions. Both the photographic and interview materials are analyzed (using arts-based techniques and grounded research methodology), and then used to create an interview template for a second, individual interview with each participant at their home. There, we talk about the photographic material.

Highlights/Results/Key Findings: Together, these thick descriptions offer a 'richer' view of PCC and focus on how chronically ill people learn and co-create PCC together with their care professionals. We have obtained paradigmatic narratives of transformative moments. For instance, there is the story of Bob and Bas. Bas, a neurologist and a renowned care innovator, realized that this new environment and the time spent together there, offered insights that he could use to help Bob carry out his hobby better. And Bob realized that his Parkinson's seems to have made him even more creative, although he already had a creative occupation as an interior designer. Next to these narratives, our research has yielded an abundance of themes, such as "touch in a care relation", "how I want to be seen", "seeing the other", and so on.

Conclusions: We developed an uncommon, participatory arts-based approach to work together with PwP and their care professionals to obtain rich data. This approach yields a myriad of insights in PCC that cannot be summarized in a single sentence. From those insights, we deduce design-principles for improving care practices as learning environments.

Implications: The design principles are directly used in care innovations (i.e. the PRIME-PD study). Adjoining that, the research is used in educational settings, for students and vocational training alike. The applicability and limitations of using photography as a research method have been written about in a bookchapter, coming out early 2022.

Abstract ID: 99

Examining The Association Between Domains Of Frailty And 6-Month Changes In Health-Related Quality Of Life, Living Status, And Treatment Decisional Regret Among Older Patients Referred For Cardiac Surgery

Presented by: Ryan Gainer

Co-Authors: Ryan Gainer, Greg Hirsch

_____

Conference Track: Shared values and vision,People as partners in health and care,Transparency of progress, results & impact

Introduction: Both age and frailty function as key preoperative risk factors for cardiac surgery. Age (chronological measurement) alone is usually a poor marker for predicting older patients' health status, most likely due to failure to reflect functional status in the measurement. Frailty status, which takes function into account, may be a better measure for older patients' health status, although multiple operational definitions of this construct exist. A small number of studies have demonstrated that frailty is a risk factor for various adverse outcomes after cardiac surgery, in older patients.

Aims and Objectives: The overall goal of this research was to determine the impact of varying degrees of frailty on the functional recovery of patients who undergo cardiac surgery. Specific objectives were as follows: (1) Determine the association between domains of frailty and change in HRQoL at baseline and 6 months post-surgery, (2) dependent living status at 6 months post-surgery (3) and treatment decisional regret at 6 months post-surgery. A prospective cohort pre-post design was used to evaluate the exposure (frailty) and resulting outcomes (change in HRQoL; dependent living status; treatment decisional regret).

Highlights/Results/Key Findings: Worse ADL function was positively associated with higher levels of impairment in mobility and usual function HRQoL from baseline to 6 months. As well, worse ADL function was negatively associated with greater HRQoL improvement in men as measured by index scores and across all procedure types as measured by EQ-VAS. Worse mobility function was negatively associated with higher levels of improvement in HRQoL in isolated AVR patients. Lastly, those with worse ADL function had higher odds of experiencing a dependent living status 6 months after surgery (aOR = 2.06 (1.42, 3.00)), and worse ADL (aOR = 1.89 (1.35, 2.65) and cognitive (aOR = 1.77 (1.26, 2.47) function had higher odds of regretting their decision to have surgery.

Conclusions: The current study showed domain-specific frailty, particularly poor pre-operative ADL function, is negatively associated with an individual's capacity to return to optimal HRQoL post-operatively, independent living status and positively associated with experience of decisional regret.

Implications: The evidence-based data has the potential to better inform patients who are at risk for loss of HRQoL and independence with cardiac surgery, allowing them to make decisions in line with values and preferences. Educating patients on the risks of frailty is an important aspect of patient-centered care and individualized

Abstract ID: 110

Co-creating a shared language using a Wiki Page: Findings from the Patient-Oriented Predictive Modelling of Healthcare Utilization Project

Presented by: Shannon Freeman

Co-Authors: *Shannon Freeman, PIper Jackson, Alanna Koopmans, S. Karl Zanon, Grace Kramer, Brent Baker, Susan Prior*

_____

Conference Track: People as partners in health and care

Introduction: Speaking the same language is foundational to support authentic engagement of older adults as research partners. Building and fostering a diverse range of partners on a research team can be a strength but it may also present challenges. This may be especially in areas of research were technical language and jargon are commonly used and in areas where language is developing and adjusting at a rapid pace. To ensure engagement is meaningful and fosters ability for all team members to participant and contribute, effective communication between all participants is paramount. For the Patient-Oriented Predictive Modelling of Healthcare Utilization (POPMHU)

Aims and Objectives: As a geographically distanced research team engaged in patient-oriented research driven work involving machine learning, big data, and predictive modally, actively engaged in research collaborations during times of COVID-19, we developed our shared language by co-creating a team project Wiki page.

Highlights/Results/Key Findings: Our wiki page, developed to be a resource to support collaborative use, uses the MediaWiki software framework. In our presentation, our team members will describe the process of co-development from how our team including older adults set up accounts, navigated and edited the Wiki. While some older adults grasped quickly how to add and edit directly to the Wiki, others were supported by a research assistant to input the information together. Any of our team members may identify and enter into our Wiki the terms and abbreviations that may be new, challenging to understand, or have multiple interpretations. Over time the wiki continues to evolve and now also includes a wider range of functions and serves as a knowledge repository.

Conclusions: We will highlight the value of engaging in co-creation of a shared language using a team Wiki. It has been an excellent source of active dialogue around the importance of language and serves as an important aspect for shared contribution in research.

Implications: We will showcase our POPMHU Wiki as a simple, practical and feasible way and encourage other research teams to consider this means as way to co-create a shared language in their own research.

Patient Involvement in a Scoping Review of Patient-Oriented Machine Learning Research
Presented by: PIper Jackson
Co-Authors: *Shannon Freeman, PIper Jackson, Alanna Koopmans, Michael Fayemiwo, Grace Kramer, S. Karl Zanon, Brent Baker, Susan Prior, Ivy Muturi*

_____

Conference Track: People as partners in health and care

Introduction: The Patient Oriented Predictive Modelling of Healthcare Utilization (POPMHU) project is an exploration of how data science methods can be used to understand and predict transitions in health in a regional context: the northern and central interior regions of British Columbia. These regions include a mixture of urban, rural, and remote communities and a distinctly diverse and changing population. Innovative data science methods such as machine learning and information visualization hold great promise for providing insight and decision support when dealing with the challenges of aging care, particularly due to their ability to recognize idiosyncratic and special features.

Aims and Objectives: One goal of our project has been establishing the current level of patient involvement in data science and machine learning research in healthcare. To this end, our group has performed a scoping review of the academic literature on this topic. It is important to us that this process also be patient oriented. To that end, our patient partners have been involved in vetting challenging inclusions, discussing key findings (particularly regarding our own work), and developing conclusions.

Highlights/Results/Key Findings: The Arksey and O'Malley's (2005) scoping meview methodology was used to identify and describe the current landscape of relevant literature. In our presentation we will highlight the process we took to authentically involve and engage all members of our research team including older adult patient partners, researchers, and trainees. We took a unique step-by-step approach to introduce this scoping review framework and process through example of our previous team activities to develop a shared understanding of the methodology, and what the process and outputs have looked like on past projects. We then engaged in dialogue to refine and guide the current review incorporating feedback from all team members. We will highlight the strengths and challenges to co-producing a scoping review on machine learning and artificial intelligence data science with older adult and caregiver patient partners.

Conclusions: Our team has sought to uphold the values of patient-oriented research in all aspects of our research collaborations, from identification of the research question and literature review through to analysis and knowledge dissemination, are co-designed to include and engage all team members including older adult and caregiver members.

Implications: We provide insight for other teams considering undertaking a scoping review which authentically engages non-academic research team partners.

Abstract ID: 112
Care as empowering people to care themselves, others, and community: Case of Seoul Health-ecosystem Initiative
Presented by: Do-Yeon Lee
Co-Authors: Do-Yeon Lee

_____

Conference Track: Shared values and vision,People as partners in health and care

Introduction: Citizen participation in caring is important not only they can be service provider, but also they are citizen of community that they care about and try to solve matter of health and care in their community. Citizens' role as caregiver is widely discussed, but their role as democratic citizen in care perspective has not been considered much. Moreover, activists' role to empower and support participants to be democratic citizen has not been much known.

Aims and Objectives: The aim of this paper is to reveal activists' role to empower people to be democratic citizen and to support their caring activities. This will be discussed in view of care. From philosophers' perspective who dealt with caring ethics, such as Eva Kittay and Virginia Held, caring is matter of interdependency and relations. I'm going to focus on relationship among activists, participants, and other actors of community. Interviews with 9 activists and 9 citizens from 9 communities in Seoul, South Korea, were conducted.

Highlights/Results/Key Findings: The main subjects of this initiative to promote people's engagement was activists, community based organizations(CBOs), and health committee which was composed of participants. In relations with participants, activists were recruiting participants by meeting people in the communities, supporting to empower recruited people in diverse ways, and they had people-centered attitude all over the initiative. In relations with community, activists were helping participants' activities with linking community resources and other activities in the community. The CBOs were being the base of all these citizens and activists works. Health committees were being the field that participants can discuss health and care issues of their communities and can raise holistic view of those issues. All these process were relational process. It can be also said that activists' works to support participants are caring work.

Conclusions: All these process were relational process. It can be also said that activists' works to support participants are caring work.

Implications: This paper contributes in that it revealed that the facilitator is needed to promote citizen engagement. The more focus on activists role as facilitator, the more citizen engagement could be activated. Limitation is that during covid-19, I couldn't interview diverse stakeholders of communities.

Abstract ID: 117

Addressing Health Equity for COVID-19 Through a Neighbourhood Approach

Presented by: Sarah Downey

Co-Authors: *Sarah Downey, Catherine Yu, Jeff Powis*

_____

Conference Track: Population health needs and local context,People as partners in health and care,Resilient communities and new alliances

Introduction: In December 2020, East Toronto Health Partners (ETHP), the Ontario Health Team (OHT) serving East Toronto, launched a collective COVID-19 immunization strategy for the communities it serves. Comprised of 50-plus community, primary care, home care, hospital and social services organizations working together to create an integrated system of care, the partnership has worked together to deliver COVID-19 vaccines using a nimble, adaptive neighbourhood approach rooted in health equity. This approach has helped protect local communities disproportionally impacted by COVID-19, offering a model that other OHTs and health system partners may follow to equitably and effectively deliver vaccines to priority populations.

Aims and Objectives: This presentation will showcase ETHP's neighbourhood- and health equity-based approach to vaccine distribution, which includes mass clinics and mobile and pop-up efforts. It uses Thorncliffe Park as a case study, a rapidly growing, multicultural neighbourhood in Toronto that is home to many newcomers and essential workers who live in high-density apartment buildings and multigenerational households. These factors have put residents at increased risk of COVID-19 during the pandemic, necessitating a hyperlocal, neighbourhood-based approach to vaccine distribution that engages multiple community partners to help ensure vaccines reach the arms of individuals who need them most.

Highlights/Results/Key Findings: On March 29, 2021, less than 10 per cent of eligible individuals in Thorncliffe Park had received one dose of the COVID-19 vaccine. By May 10, nearly 40 per cent of eligible residents in this community had been vaccinated with one dose. This was due largely to ETHP's neighbourhood approach to vaccine distribution in Thorncliffe Park, which is rooted in healthy equity, trusted partnerships, distributed leadership, embedded primary care and the ability to be nimble and adaptive. Furthermore, the success of ETHP's immunization strategy in Thorncliffe Park did not happen overnight. It was built on the OHT's existing COVID-19 response efforts in the neighbourhood, which, since March 2020, has involved pop-up testing sites, outreach to local schools, wraparound supports and building vaccine confidence with trusted voices. These efforts have strengthened ETHP's relationships with community agencies and residents in Thorncliffe Park, providing a strong foundation for the partnership's local vaccination efforts.

Conclusions: A neighbourhood approach to vaccine distribution rooted in healthy equity, trusted partnerships, distributed leadership and embedded primary care has positive, tangible effects on communities that have been disproportionately impacted by COVID-19. By working together across sectors, ETHP has helped increase vaccination rates for some of Toronto's most vulnerable populations.

Implications: As COVID-19 transitions from a global pandemic to an ongoing health equity issue, this neighbourhood approach may be helpful for ongoing COVID-19 testing, case management and seasonal vaccinations. Furthermore, this community-based model may be leveraged to manage and navigate other illnesses.

Abstract ID: 118
Through the Lens of Patients and Caregivers: Perspectives on Developing a Model for Integrated Care in East Toronto
Presented by: Jill Robinson
Co-Authors: Anne Wojtak

_____

Conference Track: People as partners in health and care,Resilient communities and new alliances

Introduction: The East Toronto Health Partners were one of the first Ontario Health Teams (a new model for integrated care in local communities) to launch in 2019. Our work builds on 25 years of collaboration among different organizations to improve local health care. The relationships and trust we have built across our organizational partners have enabled us to accelerate integrated care. Patients, caregivers and community members have been increasingly engaged in our efforts, but there is more work we can do to engage our whole community in helping improve the health of our population and redesign how care is delivered.

Aims and Objectives: The aim of this presentation is to share the story of the development of the East Toronto Health Partners Ontario Health Team through the lens of patients and caregivers who have been involved in the work. They will share their perspectives on what has worked well in advancing our integration work and where we have opportunities to improve. We will discuss what we have learned about best practices in engagement and co-design and how this applies in our local experience, as well as what is next in our plans to partner with our community to build a local integrated system.

Highlights/Results/Key Findings: In addition to being named as one of the first Ontario Health Teams, the East Toronto Health Partners have taken a number of important steps to advance our integrated care work with patient and caregiver partners, including having patient and caregiver representatives at every committee or table, establishing a community advisory council with diverse representation from our different communities, co-designing new approaches to care delivery with patients and caregivers, and mobilizing a grassroots community response to support our high needs neighbourhoods and at risk populations throughout the COVID-19 pandemic. We will share how patients, caregivers and community members contributed to these key milestones, what we learned, and next steps in our plans to broaden engagement of patients, caregivers and our community.

Conclusions: Engaging patients, caregivers and communities in co-designing integrated care is essential to develop a system that works better for all of us. It is important to share and learn about how to do this well and understand other ways to deepen the connection between care recipients and care providers.

Implications: The East Toronto Health Partners' efforts to create a local integrated system of care provides a model for other regions of Ontario as well as other jurisdictions. We look forward to sharing and learning with others about best practices in advancing integrated systems of care.

Meaningful Partnership with Patients, Families and Citizens
Abstract ID: 119
Design to Action: Community Capacity Building for Opioid Response
Presented by: Maryam Mallakin
Co-Authors: *Maryam Mallakin, Kate Sellen, Christina Dery, Triti Khorasheh, Caroline Bennett Abuayyash, Emily Taylor, Robert Schwartz, Pamela Leece*

_____

Conference Track: Shared values and vision,Resilient communities and new alliances

Introduction: In response to the opioid crisis, communities across Ontario have developed individual opioid action plans to address issues at the local level. Public Health Ontario (PHO) has led the Community Opioid / Overdose Capacity Building (COM-CAP) project, which aims to reduce opioid-related harms at the community level by working with communities to identify, develop, and evaluate supports for local needs around opioid /overdose planning. A co-design approach was used to engage stakeholders in identifying capacity building supports to meet specific communities' needs for improving opioid/overdose knowledge and services at the local level.

Aims and Objectives: A co-design workshop was used to identify community-level challenges, gaps in opioid/overdose plans, and planning. The workshop included 4 activities with 52 participants (representing 7 sectors or groups involved in plans, including 10 people with lived/living expertise of drug use). These four activities were: identifying priority challenges (scenarios & personas); identifying potential support areas & delivery methods (using a capacity building matrix); prioritizing top challenges, priority supports, delivery methods (dot voting); and discussion on project evaluation (evaluation matrix). The activities were tailored to identify capacity building needs with data from prior work (Situational Assessment (SA)).

Highlights/Results/Key Findings: The co-design workshop provided an opportunity to gain a deeper understanding of challenges, gaps, and needs around capacity for opioid/ overdose action and planning experienced at the local level. The results achieved from the co-design workshop enabled the project team to identify and prioritize the main support areas to be considered in the development of COM-CAP project tool(s). The key findings of the workshop were summarized and categorized under five major groupings, each consisting of 5 to 11 specific support requests. The five groupings were 1) Stigma & equity as a cross cutting theme, 2) Trust-based relationships, consensus building & on-going communication, 3) Knowledge development & on-going access to information & data, 4) Tailored strategies & plan adaptation to changing structures & local context, and 5) Structural enablers & responsive governance.

Conclusions: The co-design approach provided a space for sharing and generating knowledge to identify areas for capacity building supports, provide an opportunity to achieve shared understanding, and identify specific information on possible supports. Additionally, employing highly tailored co-design techniques enhanced the effectiveness of large-scale workshop activities on this public health issue.

Implications: Findings from the workshop have applicability for initiatives aimed at capacity building to address the opioid crisis at the community level. This work identified specific areas for implementation and sustainability supports for local opioid planning including plan adaptation (structural & contextual) and ongoing evaluation.

Abstract ID: 125
Long COVID - The Hidden Health Crisis
Presented by: Helena Ferris

Co-Authors: *Helena Ferris, Audrey Devaney*

_____

Conference Track: Shared values and vision,Population health needs and local context,People as partners in health and care

Introduction: Long COVID is a poorly understood complex illness.

Aims and Objectives: There is a growing body of evidence showing multi-organ impairment in individuals at low risk of mortality from COVID. Young females and healthcare professionals are disproportionally affected, with many unable to live independently, care for dependents or work. This has considerable implications for public health and our healthcare systems.

Highlights/Results/Key Findings: With little support or treatment available, long COVID patients are suffering with no certainty as to when or if they will recover. It is imperative that each country has accurate surveillance systems to capture national level data on long COVID. Establishing the burden of disease, identifying care pathways and ultimately effective treatment is central to tackling this hidden health crisis.

Conclusions: In the absence of definitive treatment, it is essential that we raise awareness of long COVID so that patients are acknowledged, listened to and supported.

Implications: Those living with long COVID are experts by experience and have a key role to play in research and the co-design of long COVID related public health policy.

Meaningful Partnership with Patients, Families and Citizens
Abstract ID: 131
Patient and Caregiver Handbook in the Oxford and Area Ontario Health Team
Presented by: Mark Weir
Co-Authors: Mark Weir, Heather Wilson-Boast, Maureen Ross, Valerie Joyce, Ted Hilton, Sheri Louie, Karen Devolin

_____

Conference Track: Population health needs and local context,People as partners in health and care

Introduction: Tasked with improving system navigation for Oxford County and area residents, as per the Ontario Health Team model, the Oxford and Area OHT initiated, co-designed, and distributed a Patient and Caregiver Handbook with Oxford residents.
The inspiration for this work is based in evidence that patients, families, and caregivers who are active and involved in their own care not only have better experiences, but also better outcomes. Further, this can lead to health system efficiencies when individuals are historians of their own health information as they ensue health professionals have access to information upon which to base informed decisions.

Aims and Objectives: The Patient and Caregiver Handbook was developed with the aim of improving system navigation and health literacy. Co-designed by patient and family advisors on the Patient Engagement Action Team, we built a short plain-language document intended to provide helpful practical suggestions – by patients, for patients – to encourage active participation in their care.
To develop the Handbook, a five question survey was completed by committee members around what makes for a positive health experience, how to manage health conditions, and how to support loved ones.

Highlights/Results/Key Findings: Results of the engagement informed nine brief sections with practical advice, including how to approach Appointments, Tests, Procedures, Ongoing Care and Care Transitions, Caregiving, Taking Care of Yourself, Sharing Your Experience, Troubleshooting, and Supports/Resources. Information includes suggestions and questions to spur a conversation between patients, families, and caregivers with their health care professionals and equip individuals with tools they need to keep track of their information and successfully navigate their care between sectors.
The Handbook now resides on our OHT website in the five most used languages in this region. We promoted awareness through our OHT newsletter, Twitter account, and printed flyer in the Oxford Review.
We are in the midst of seeking feedback on usefulness to adapt the guide over time. A link to a survey exists and people are encouraged to share feelings about the Handbook.

Conclusions: Through OHT guidance, patient navigation and health literacy are key domains of an integrated health system. This handbook aimed to tackle these important areas and encourage local patients, families, and caregivers participation in their care.
Supporting navigation and enabling participation improves health system efficiencies and improves experiences and outcomes.

Implications: At the time of writing, to our knowledge, no other OHT has developed a handbook to support patients, families, or caregivers in their direct care. This document is aimed at a general audience, and is not specific to age, demographics, or Year 1 populations. It is written in plain language.

Abstract ID: 136
Caregiver ID: A Valuable Tool to Engage Caregivers as Partners in Care during Covid-19 and Beyond
Presented by: Amy Coupal
Co-Authors: Lisa Salapatek, Amy Coupal

_____

Conference Track: People as partners in health and care

Introduction: Caregivers are essential partners in patient care and play a critical role in providing physical and emotional support to family and friends across many care settings. This became even more evident during Covid-19 as visitor restrictions resulted in unintended consequences for patients and families. The Ontario Caregiver Organization introduced the Partners in Care Pandemic Toolkit to provide practical resources for organizations to welcome caregivers in a safe and meaningful way. At the heart of the toolkit is Caregiver ID – a visual way to demonstrate an organization's commitment to recognizing caregivers as partners in care.

Aims and Objectives: A caregiver identification card is a simple concept that can have a big impact on caregivers. The Change Foundation led the development of Caregiver ID along with its Changing CARE teams and caregivers through a co-design process. Launched in some Ontario hospitals before the pandemic, it became pivotal in the integration of caregivers as essential healthcare partners.
New benefits have emerged during Covid-19. Caregiver ID has been recognized as a key part of enabling caregiver presence. More importantly, it helps build a culture that engages caregivers as partners in care during the pandemic – and beyond.

Highlights/Results/Key Findings: Identifying the caregiver is an important step in establishing a relationship that can yield better care outcomes, better understanding of a patient, and better care experiences for patients, caregivers and staff.
Caregiver ID has also proven to be a valuable tool for safely welcoming the presence of caregivers during Covid-19. It helps to differentiate caregivers from general visitors and assures staff and patients that people have been screened and are permitted to be there. It can also help caregivers to feel more confident to ask questions and be active partners in care.

The Partners in Care Learning Collaborative, led by the Ontario Caregiver Organization enabled cross-sector learning that led to faster, higher quality implementation. Over the past year, Caregiver ID has launched in more than 24 hospital and long term care sites across Ontario. Active engagement of caregivers has been instrumental in roll-out of these programs.

Conclusions: Caregiver ID, along with other resources in the toolkit, supports the culture of partnering with caregivers and empowers caregivers to participate as a part of the care team. Measurement of the program's impact has shown improvement in the patient, caregiver and provider experience.

Implications: Over the past year, Caregiver ID has evolved from its launch in hospital settings to long term care homes. Learning Collaborative participants have demonstrated a strong commitment to these tools as part of sustainable culture change, and there is growing interest in application across other care settings.

COVID19 as the Impetus for a Social Movement for Healthcare Transformation: Caregivers as Advocates

Presented by: Maggie Keresteci
Co-Authors: Maggie Keresteci, Donna Thomson, Pamela Libralesso, Julie Drury

_____

Conference Track: People as partners in health and care

Introduction: COVID19 has resulted in meaningful insights gained by many caregiver advocates about gaps in the current systems and the potential to close those gaps across the continuum of care. The pandemic has highlighted that, like many sectors in healthcare, caregiver advocacy is also siloed. Caregiver partners are usually associated with a specific organization, sector, disease or geography. Caregivers are not represented in an integrated way across the continuum of care. For community caregiver advocates, not affiliated with an organization or sector, this affiliation dependency has hindered the ability to influence care and to promote integrated care at the policy level.

Aims and Objectives: As active caregiver advocates, we decided early in the pandemic to combine our networks, knowledge and experience to help bridge those gaps between siloed experiences in healthcare that were exacerbated by the pandemic. We examined our own lived experience, determining that the largest gap in care provision was integrated care. It stands to reason then that during a time of crisis such as a pandemic, attention paid to integrated care would be lacking. By proactively connecting with caregiver advocates, not affiliated with any specific organization, we created a network of support for individuals and a body of shared lived experience.

Highlights/Results/Key Findings: Early in the pandemic, it became clear that the role of caregivers in supporting families and patients, was misunderstood and often undervalued. Individual caregivers began to identify others in similar circumstances and began to bridge various sectors of care and various ministries responsible for delivering care. This organic network of caregiver advocates grew consistently throughout the pandemic to the point where previously isolated voices were brought together, providing a collective of voices. This collective has led to the provision of individual support, reduced isolation, a robust system of knowledge exchange and opportunities to influence healthcare and social policy. It has led to grassroots efforts to organize across sectors; a specific example is in the case of caregivers and parents of those living in congregate settings other than long term care. A collective, Ontario Families Of Group Home Residents, @ONfghr has been formed by caregivers who came together during the pandemic.

Conclusions: While the pandemic has been a challenge for everyone, caregivers in various sectors felt isolated and unable to influence policy relating to those they cared for. Caregivers are isolated at the best of times; COVID19 heightened that isolation. A social movement grew as individual caregivers sought information and needed support.

Implications: The collective voice that has been brought to the forefront by caregivers during COVID19 has been a life-line to many. We have started a social movement that is shared by many, and that will provide much needed peer support now and in the future. This movement is not going away.

Abstract ID: 149
Nurturing Resilient and Compassionate Communities in Scotland
Presented by: Mandy Andrew

Co-Authors: *Mandy Andrew, Anne Hendry, Alison Bunce*

_____

Conference Track: Resilient communities and new alliances

Introduction: COVID-19 has highlighted the importance of solidarity and community resilience based on values of compassion and kindness. Compassionate Communities are citizen led social movements that aim to transform attitudes and behaviours around loneliness, isolation and loss. Informed by our evaluation of Compassionate Inverclyde, IFIC Scotland partners established an innovative Active Learning Programme (CCALP) to support adoption of the approach in other communities. Volunteers, community leaders, and health and care practitioners and managers co-designed a collaborative online programme based on Active Learning principles. An end of programme evaluation was undertaken by academic partners and by an independent consultant.

Aims and Objectives: Ten themed sessions were supported by a facilitator, peer coaches and subject experts. Learning Outcomes were to
- explore the personal attributes and conditions to re-imagine place and create compassionate communities
- understand the key elements required to work with different communities and their assets
- explore and adapt tools that can be used to support engaging and influencing people and communities
- enhance skills to value, empower, support and sustain volunteering, place making and compassionate communities.

Appreciative inquiry methods were used to prompt feedback and ideas for improvement through an online questionnaire for all participants and facilitators, and in-depth interviews with five participants.

Highlights/Results/Key Findings: 78 participants represented 39 rural and urban communities, including some with high levels of socio-economic deprivation. Their background experiences, contexts and expectations differed. A median of 12 people attended the monthly online sessions designed as small group discussions to build relationships, offer safe space for reflection and enable authentic sharing of experiences. Monthly Flash Reports enabled additional self-directed learning and sharing of useful tools and resources.

Connecting virtually was not perceived as a barrier. Feedback was universally positive. Participants particularly valued the appreciative facilitation style; inspiring and honest guest speakers; meeting others with a shared perspective; sense of purpose in group discussions; and wholehearted caring for self and others. Sessions on leadership and community development helped participants understand concepts of social capital and public value. Most participants reported perceived personal growth, greater local influence and several people shared stories of impactful local changes.

Conclusions: The CCALP is already making a tangible contribution to our collective endeavour to build a fairer and more equal Scotland where people and communities live our values of kindness. Participants suggested ideas for improving the CCALP and several have offered to support and mentor a second cohort.

Implications: To recover from the health and economic shocks of COVID-19, we need to sustain more community led support for wellbeing. The CCALP is a promising way to build more resilient communities in Scotland. We are keen to co-design an international CCALP in partnership with IFICs Special Interest Groups and communities.

Abstract ID: 152
One of the Team - Person-Centred Integrated Care
Presented by: Helen Tucker
Co-Authors: Helen Tucker

_____

Conference Track: People as partners in health and care

Introduction: Integrated care has been a theme throughout my career, involving designing, supporting, managing and researching integrated care systems in community hospitals and community services. My PhD in integrated care demonstrated the need to promote person centred care in an inclusive way.

I wanted to share my positive experience of the breast cancer care pathway in NHS healthcare system in the East of England from screening, diagnosis, treatment and recovery. This gives an opportunity to recognise and share good practice, and consider transferable learning from a patient perspective.

Aims and Objectives: My aim was to reflect on my experiences of receiving breast cancer care against key integration frameworks such as the nine pillars of integrated care and to identify what mattered to me. I wanted to celebrate good practice and share transferable learning.

I conducted an autoethnography of my personal experience with observations and reflections. I have then analysed this account incorporating my background, knowledge, expertise and experience of integrated care theory and practice. Learning points have been drawn from key highlights of how my care was conducted.

Highlights/Results/Key Findings: I experienced multiple types of integration including horizontal, vertical and multi-agency as well as person-centred integrated care. I found 8 features that enhanced my positive experience of person centred integrated care. (1) Certainty as I knew what was happening at every stage.
(2) Communication systems worked well including providing me with portal access to my records and texting appointments.
(3) Contact names were given to me of the whole team, including practitioners and support staff.
(4) Compassion was shown by everyone involved in my care.
(5) A Cohesive service and team.
(6) Continuity of care across disciplines, sectors and agencies.
(7) Collaboration between team members who clearly respected each other. (8) Care that I could trust and that was inclusive. I was made to feel part of the team.

Conclusions: My personal experience of breast cancer care in the NHS suggests the concept of the "resourceful patient" is becoming a reality. This experience has given me confidence that person-centred integrated care is becoming embedded in our NHS cancer services and leading to improved experiences and quality of care.

Implications: Patient stories are an invaluable way of learning about health care services and systems, and in particular identifying quality improvements in experience and outcomes. My reflections suggest that the systems worked well, and that there was a culture of person-centred integrated care that was inclusive.

Abstract ID: 161

The role of health literacy and family support continuity prior to and during acute hospitalization for preparedness to discharge

Presented by: Nosaiba Rayan-Gharra

Co-Authors: *Nosaiba Rayan-Gharra, Orly Tonkikh, Nurit Gur-Yaish*

_____

Conference Track: People as partners in health and care

Introduction: Family support provided during hospitalization is essential for communicating with the healthcare team and explaining medical care. Informal caregivers help patients understand information, facilitate information exchange during clinical encounters, and help patients adhere to discharge recommendations and perform self-care tasks. Less is known about the trajectory of family caregivers' ensuring and explaining medical care prior to and during acute hospitalization and its impact on discharge preparedness of patients in terms of their understanding of the explanations and instructions for continued care.

Aims and Objectives: This study examined whether ensuring and explaining medical-care during the current hospitalization mediates the association between involvement of the caregiver in ensuring and explaining medical-care prior the current hospitalization and patients' preparedness to discharge. A prospective cohort study includes 456 internal-medicine-patients at a tertiary medical center in Israel, who were accompanied by an informal caregiver. Involvement in ensuring and explaining medical-care prior and during the hospitalization, covariates such as health literacy levels, demographic, health, and functional status were reported by the patients during the hospitalization; and care-transition-preparedness was reported by the patients in a week after discharge.

Highlights/Results/Key Findings: After controlling for covariates, only high health literacy levels of patients and their caregivers were positively associated with ensuring and explaining medical care during hospitalization and preparedness to discharge ($P < 0.05$). Moreover, mediation analysis indicated significant direct (B(unstandardized) = 1.69; $p = 0.003$) and indirect effect (Mediated effect = 1.28; CI = 0.81 to 1.87) of prior to hospitalization involvement in ensuring and explaining medical care on preparedness to discharge through high ensuring and explaining medical care during the current hospitalization, controlling for functional, mental physical and clinical health status, number of prior admissions, as well as patient's family caregiver's health literacy, religiosity, age and sex (total effect: B = 2.95; $p < 0.001$).

Conclusions: The association between caregivers' experience and involvement prior the hospitalization and preparedness to discharge is mediated by ensuring and explaining medical care during the current hospitalization. Better health literacy of both patient and family caregiver is associated with more family support during patient's hospitalization and preparedness to discharge.

Implications: Our findings suggest that identifying informal caregivers at the time of admission to the hospital and encouraging their involvement also during patients' hospital stay might be a useful strategy to improve discharge processes. Generalizability may be limited due to the characteristics of the Israeli society.

Abstract ID: 163

Volunteering for All – Scotland's national framework

Presented by: Alan Stevenson
Co-Authors: Mandy Andrew, Alan Stevenson, Natalie Masterson

_____

Conference Track: Resilient communities and new alliances

Introduction: Volunteering for All: national framework was developed by the Scottish Government jointly with partners from the volunteer and community sector, local government, NHS, and with volunteers.

The objective of the Framework is to:
•   provide a coherent and compelling narrative for volunteering;
•   Define the key outcomes desired for volunteering over the next ten years;
•   Identify the key data and evidence to inform, indicate and drive performance; and
•   to inform the optimal combination of programmes, investments and interventions.

Scottish Government convened a group, November 2020, of stakeholders to discuss the creation of the Volunteering Action Plan based on this high level 'framework'.

Aims and Objectives: The overall vision is Scotland where everyone can volunteer, more often, and throughout their lives.

The Volunteering Action Plan provides practical 'actions on the ground' achieved through co-production, learning and a spirit of reciprocity involving volunteers, communities and public and private sectors at all development stages.

The Plan's development is modelled on the Human Learning Systems (HLS) which is a response to complexity developed by Dr Toby Lowe and Collaborate CIC and involves utilising various methods and tools.

Highlights/Results/Key Findings: The aim is to co-produce 'The Plan' through a group and individual 'HLS' learning journey:
•   Explore the HLS methodology and reflect upon its implications (be part of a learning community)
•   Enquire through considering evidence and introducing 'lived experience'
•   Understand the system, the existing state and the 'ideal'; what a purpose and vision should be.
•   Change the system. In this action planning context this is about scoping activity but it's also about experimentation.

Within the timeframe of one year we'll translate five outcome areas into specific actions. The Plan will be a 'living document' which will continue to be reviewed, updated and enhanced over the next decade.

As important, participants will learn about their role within a complex system and a very different approach to enacting change (i.e. learning, building relationships and experimentation). This is a competing approach to the dominant paradigm; new public management (Shalock & Bonham, 2003).

Conclusions: This Plan process is transformational, recognising outcomes are achieved by systems rather than organisations. This process is innovative and inclusive, involving volunteers, communities and organisations. Important outputs are a 'living document' for the next decade and a more resilient sector, able to adapt and change, relevant in 2021 and beyond.

Implications: A range of materials will be generated: an online toolkit and process evaluation. This Plan process can be repeated by other cohorts; a 'live' plan is a national 'test and learn' programme.
This provides important learning for HLS applied to other contexts as part of an international HLS learning community.

Meaningful Partnership with Patients, Families and Citizens
Abstract ID: 164
Optimizing Entry into Canadian Cancer Care Systems
Presented by: Leah Stephenson
Co-Authors: *Leah Stephenson, Kathleen Barnard, Louise Binder, Martine Elias, Alexandra Chambers, Fred Horne, Rachael Manion, Jennifer Rayner, Josee Pelletier, Antonella Scali, Michael Smylie, Eva Villalba, Suzanne Wait, Amy Rosvold, Tina Sahay, Sophie Wertheimer, Reb*

_____

Conference Track: Shared values and vision,Population health needs and local context,People as partners in health and care,Resilient communities and new alliances,Workforce capacity and capability,System wide governance and leadership,Digital solutions,Aligned payment syst

Introduction: To address the challenges and leverage opportunities in obtaining a swift, accurate, and appropriately communicated cancer diagnosis, All.Can Canada embarked on a comprehensive assessment of how well Canada is doing in optimizing entry into cancer care. The purpose was to understand the current state of cancer diagnosis in Canada, including identifying outcomes that matter most to cancer patients, nominated practices in cancer diagnosis to adapt, spread, and scale, and areas of inefficiency that represent opportunities for improvement towards identified outcomes, in order to identify priority areas and concrete actions to inform the work of policymakers and other stakeholders.

Aims and Objectives: From June 2020 to March 2021, a consultant with oversight by All.Can Canada's patient-led, multi-stakeholder Steering Committee conducted research. First was a literature review identifying current Canadian practices which aim to reduce diagnosis inefficiencies; summarize what is known about the impacts of the determinants of health on diagnosis; and identify currently used metrics. Qualitative interviews with cancer survivors across Canada investigated diagnosis from their perspectives, including what matters most as they traverse the diagnosis process. A survey of providers across Canada investigated what they perceive to be inefficiencies in diagnosis and factors essential for a quality diagnosis process.

Highlights/Results/Key Findings: Irrespective of cancer type, disease stage, or determinants of health, patients described the diagnosis process as taking place in three phases:

Early – when people first try to interact with a provider over a suspicion of cancer until the first referral;

Middle – when people undergo diagnostic testing to investigate; and

Final – when people arrive at a dedicated cancer facility until they receive their diagnosis.

Across all phases, seven outcomes were identified as being critical to the quality of the diagnosis experience:

- Swiftness of the process;
- Concerns validated by primary care providers;
- Excellent patient-provider communication;
- Effective provider-provider communication;
- Better information;
- Integrated psychosocial support; and
- Integrated care.

Attainment of these outcomes resulted in a more satisfactory diagnosis experience, while failing to attain any of these outcomes had a negative, and oftentimes detrimental, impact.

The research resulted in the start of a quality framework for Canadian cancer diagnosis.

Conclusions: Findings demonstrate cancer diagnoses' fragmented current state and integrated future state. Workforce capabilities, multi-sectoral collaboration, aligned payments and accountability, a national quality framework, and increased care coordination are required. Digital solutions are vital for rural residents and during pandemics. Anti-fragility means transforming cancer diagnosis systems to absorb shock and improve.

Implications: Findings are not necessarily generalizable to newcomers, racialized people, residents of the Territories, and Indigenous populations. Sample sizes preclude conclusions about jurisdictional disparities. Provider survey results are not necessarily representative of all provider groups across Canada. Provider responses to questions about inefficiencies could have been influenced by the COVID-19 pandemic.

People at the Centre: Designing and Delivering National Engagement on Health and Social Care in Scotland
Presented by: Georgina Charlton
Co-Authors: *Georgina Charlton, Louise Coupland*

_____

Conference Track: People as partners in health and care

Introduction: The ALLIANCE designed the People at the Centre programme, to design and deliver two parallel programs of national engagement in response to the Independent Review of Adult Care and remobilisation of healthcare services during/post COVID-19 recovery.
We listened to the voices of people and organisations across Scotland on needs, rights, experiences and preferences of people who use services, their families and carers.
We heard:
- People's experiences of accessing health and social care services, before and during the pandemic
- How the pandemic has impacted on people's health, care support and wellbeing
- People's aspiration and priorities for future service delivery in Scotland

Aims and Objectives: Aims:
- To ensure people were supported to participate and their voices heard, the engagement was accessible through multiple routes and this engagement informed wider policy changes and recommendations.
- To enhance the voice of lived experience, embedding human rights into service improvement.
Utilising the ALLIANCE's membership, partners and key stakeholders, between September- December 2020, the PATC programme engaged with over 1300 individual and 120 organisations from across Scotland's 32 local authority areas.
People participated digitally via online events, online survey, group and individual submissions as well as taking part in organisational, group and one to one interviews, telephone conversations and postal contributions.

Highlights/Results/Key Findings: People spoke about risk balancing during the pandemic, as service prioritised the response to COVID-19 over non COVID-19 needs, resulting in people losing access to services crucial to their health and wellbeing. People shared feeling disempowered and uncertain, unsure which services were available or how to gain access to the health supports they need.
We repeatedly heard the current system of social care supports are inadequate: with disparities across local authority areas in available support and eligibility criteria, despite existing Scottish legislation.
The ALLIANCE submitted the Health Wellbeing and the COVID-19 Pandemic: Scottish Experiences and Priorities for the Future to inform the Mobilisation Recovery Group's (MRG) work and the Independent Review of Adult Social Care in Scotland - Engagement Activity report to inform the Review Advisory Panel which distils over 400 views and learning from individuals and organisations across Scotland- both putting people at the centre of policy and reform.

Conclusions: To effectively remobilise healthcare systems and improve social care support, Scotland must involve its people and communities as active, equal partners; informing and shaping services which meet their needs, supporting them to live well. A human rights based approach can be powerful in catalysing commitment to making meaningful change.

Implications: People are at the centre, their voices, expertise, and rights drive policy and sit at the heart of design, delivery and improvement of support and services. The ALLIANCE People at the Centre Programme (despite time limitations and pandemic restrictions) principles and learning are applicable and transferrable across all sectors.

Empowering Patients as Partners to Develop Person-Centric Tools for Post Hospital Discharge: The Patients Transitions Resources Team

Presented by: Ceara Cunningham
Co-Authors: *Ceara Cunningham, John Hanlon, Helen Neufeld*

_____

Conference Track: People as partners in health and care

Introduction: Many patients experience fundamental breakdowns in the healthcare system as they transition between hospital and home and do not get follow-up care they need. These patients lack confidence in the delivery of healthcare and feel completely alone with little support after discharge. This issue has been amplified with the arrival of COVID-19. To improve health system integration and health outcomes, empowering patients to identify their own care needs and preferences is critical. In Alberta, Canada, a patient led group called the Patient Transitions Resources Team (PTR) has been collaborating with healthcare teams to develop person-centric resources for patients and families.

Aims and Objectives: As part of the COVID-19 response, Alberta Health Services (health services delivery arm; AHS) called upon the PTR team to develop a person-centric discharge planning tool for hospitalized COVID-19 patients to reference as they transition back to their communities. Over an 8-week period, the team created the prototype, reviewed related literature, drew upon their own lived experiences, and conducted intensive interviews with patients and families. Patients and PTR team members engaged in a true partnership, building a foundation of trust, shared accountability, respect, and collaborative purpose, resulting in a united team with common vision and passion for the work.

Highlights/Results/Key Findings: The discharge planning tool, My Next Steps, has been distributed to all acute care hospitals in Alberta and is available on a provincial patient portal called MyHEALTH Alberta. The checklist was designed by patients for patients, written in plain and readily understandable language. It serves as a guide to empower patients to clearly understand what they can do and expect during their transition (e.g., points for conversations with your doctor/health team). Empathy for patients during transitions is key; while providing guidance to empower them to be fully involved in their return to health. The checklist content is acknowledged by AHS as vital to safer transitions from hospital. Key success factors of this work included AHS team members engaging with patients in a true partnership to empower patient leads as equal decision-makers to develop resources and tools which fit their needs and better support patients and families on their healthcare journey.

Conclusions: This patient-led collaborative work provided valuable lessons about co-design processes that can be shared with other teams looking to empower patients and families in their own care, and integrate the patient voice to advance person and family-centered care to support high quality transitions.

Implications: My Next Steps is now being used by the PTR team to create a generic discharge tool (i.e., not COVID specific) for patients and families transitioning from hospital to home. This new version will be adopted across all Alberta's acute care hospitals, embedded within a new provincial electronic health system.

Meaningful Partnership with Patients, Families and Citizens
Abstract ID: 197
Public Experiences and Perspectives of Virtual Primary Care Visits: Outcomes and Future Options
Presented by: Gayle Halas
Co-Authors: Gayle Halas, Alanna Baldwin, Alexander Singer, Alan Katz, Linda Abraham, Vivianne Fogarty, Lisa LaBine, Sarah Kirby, Sabrina Wong, Siddhesh Talpade, Elissa Abrams, Eric Bohm, Jose Francois, Kerri MacKay

_____

Conference Track: People as partners in health and care,Digital solutions

Introduction: Virtual care has been part of part of the first line response to COVID-19 in Canada, which prior to March 2020 had low utilization of technology for patients to communicate with providers. Virtual primary care became the dominant option for addressing individuals' health concerns while maintaining physical distancing measures. With the urgency and rapid introduction of virtual visits in response to COVID-19, patient and public stakeholder input has been bypassed. This research gleaned the perspectives and insights from patients and caregivers around virtual care with respect to accessibility, acceptability and perceptions of quality of care.

Aims and Objectives: The primary objective was to explore public perspectives of the usability, acceptability and sustainability of virtual primary care visits and how virtual healthcare delivery can be improved. A multi-disciplinary and multi-sectoral team designed the study. Data was collected using a self-administered online survey, co-created with a public advisory committee. The survey consisted of 18 questions regarding perceptions of the virtual care visit experience, the outcomes of the visit, and feedback on how virtual visits might be sustained in future. A link to the survey was provided through primary care office visits and advertisements in local Manitoba news media.

Highlights/Results/Key Findings: Responses were received from 325 individuals, between 19-80 years old, with 76% identifying as female. Majority (77%) were from urban communities with 30 minutes or less travel time to their primary care clinics (69%). The virtual visits were primarily telephone (98%), used for a range of needs including follow-up test results (36%), chronic conditions (32%) and advice for a new health condition (32%). The virtual visit was reported as helpful (90%), saved time (78%) and more convenient for access to care (66%). Most virtual visits (92%) were considered completed, with no follow up or follow up if needed. For future, 67% reported they would like the option of phone or computer consultations; 27% were open to considering virtual visits for receiving test results, prescription renewal and follow up for a health problem. Future preferences are for in-person (85%) or phone calls (78%) with one's provider in their usual clinic.

Conclusions: During pandemic restrictions, virtual care, although primarily telephone consultations, bridged care for patients and were well received. A number of considerations were identified for integrating into longer term use. This survey was an effective means of obtaining public feedback, which is essential for those most impacted by system changes.

Implications: The sample was limited to one province in Canada (Manitoba) with limited rural and remote respondents. However several important points are conveyed by patients and caregivers, and need to be considered in policy and operational decision making for the future of virtual health interactions.

Engaging Patients and Family Members in System Reform: The Ontario Health Team Experience

Presented by: Shannon Sibbald
Co-Authors: Shannon Sibbald, Gayathri Embuldeniya, Kristina Kokorelias, walter wodchis

_____

Conference Track: People as partners in health and care

Introduction: Patient and family engagement in healthcare service delivery and design is increasingly recognized as a means of providing more patient-centered care. However, few studies explore methods of building patients' and families' capacities to engage in decision-making or detail how they are involved throughout the design process. Ontario Health Teams (OHTs) are integrated care teams that deliver healthcare within a specified region. OHTs are mandated to engage patients, families, and caregivers in a co-design process, but have the freedom to choose how and when to do so.

Aims and Objectives: The objective of this study was to understand how patient and family advisors (PFAs) were involved in the early stages of planning for health system reform in Ontario, Canada. 127 participants, including 16 PFAs from 12 OHTs participated in semi-structured interviews about their experience in the development of OHTs. Participants were sampled to be representative of the size, geography, and type of lead organization (e.g. primary care vs. hospital). Interview transcripts were coded using deductive thematic analysis.

Highlights/Results/Key Findings: Throughout the planning process PFAs were engaged in one of two key roles a consultative role (through focus groups, town halls, and social media), or a more permanent partnership and leadership roles (e.g. positions on working groups, councils, and voting representation). Most were engaged early in the OHT process and had previous PFA role experience. Capacity-building of PFA occurred through training and education (on jargon, models of care, and funding) and helped PFAs effectively participate. PFAs felt empowered through engagement in important decisions such as participating in hiring decisions. Equal opportunities to participate made PFAs feel like equal partners. Non-PFAs saw PFAs as essential in providing unfiltered and rich perspectives through personal narratives and experience. There was a lack of consistency amongst PFAs and non-PFAs about the time commitments expected of PFAs, how and whether PFAs should be compensated, and the ideal amount of training they should have.

Conclusions: This research provides insights into PFA engagement during system reform. Working through the challenges around compensation, and the amount of training expected of PFAs will be instrumental in building trust and collaborative leadership as OHTs move from planning to implementation.

Implications: The implementation of OHTs reflects a broader shift in healthcare to more integrated care delivery focusing on patient-centredness. It is important to understand and prioritize continued and sustained PFA engagement from co-design processes into implementation and through to evaluation.

Meaningful Partnership with Patients, Families and Citizens
Abstract ID: 210
Discover Digital Scotland: A guide to support citizens on their digital health literacy journey
Presented by: Redmond Sara
Co-Authors: Carmen Paputa-Dutu, Mandy Andrew, Sara Redmond

_____

Conference Track: People as partners in health and care,Workforce capacity and capability

Introduction: Discover Digital aims to raise awareness of digital health and care solutions amongst Scottish citizens. The Discover Digital Guide is a resource to support people to understand how digital tools might benefit their health and wellbeing.
The resource provides an introduction to the topic. It is aimed at individuals who want to use technology in their self management, as well as carers or support workers who can help others build up their skills and confidence. The resource will be developed iteratively in response to feedback and further engagement with stakeholders and citizens, with a particular focus on seldom heard groups.

Aims and Objectives: The Guide's development evolved from conversations and insights from the ALLIANCE's Discover Digital events, 2018-2019. We found simply signposting people to digital tools, however helpful they might be, is not enough. People identified they also need support to develop the skills, knowledge and confidence to be able to use these digital tools and maximise applicability.
The Guide's development focuses on three main areas: digital self management, technology enabled care and digital National Health System (NHS) services. Information was gathered and reviewed through research and multi-stakeholder collaborations, drawing on early citizen feedback. The published Guide is an evolving working document.

Highlights/Results/Key Findings: Early feedback on the guide was constructive: "good information, resources, links and tips." However, there was acknowledgement that the wealth of information could be overwhelming for citizens and overall Guide accessibility could be improved.

Suggested amendments include creating video and audio summaries of the information and testing the content with groups with various levels of digital and health literacy.
The ALLIANCE continues to invite feedback, aiming to further develop the resource in partnership with stakeholders and citizens to understand:
•   How can people be best supported to use digital tools for their health, care and wellbeing?
•   Does our guide provide valuable information that can support people gain skills, knowledge and confidence in using digital tools for health and wellbeing?
•   How can people be best supported to take in this information?

This third sector citizen led initiative is contributing to Scotland's national digital priorities and technology enable care and supporting self management.

Conclusions: Despite the existence of platforms which suggest digital health and care tools, there is currently no first-stop shop for understanding what digital health and care is.
The Discover Digital Guide aims to bridge this gap and support citizens and community workers across Scotland develop their digital health and care literacy.

Implications: Digital health and care literacy are issues that go beyond geographical boundaries, which presents opportunities for collaboration and knowledge sharing. Similarly, most digital tools and online resources can be accessed globally. This presents the possibility for collaborative global solutions and international person-centred learning. The ALLIANCE welcomes collaborative and coproduction opportunities.

Meaningful Partnership with Patients, Families and Citizens
Abstract ID: 212
Support through sunflowers: Growing a community's awareness of hidden disabilities
Presented by: Wendy Smith
Co-Authors: Lonan Challis, Wendy Smith, Rob Kelly, Paul White, Anne Mills

_____

Conference Track: Shared values and vision,Population health needs and local context,Resilient communities and new alliances

Introduction: Some disabilities, which are not always obvious or visible, can make it difficult for people follow regulations such as social distancing. Enabling employers, employees and the public to understand these needs can avoid miscommunication and adverse incidents.
The nationally-recognised Hidden Disabilities Sunflower aims to support those with invisible needs. The Sunflower lanyards are a discrete sign for those who come into contact with the wearer, who can then choose to offer support people who may not ask for help [1]. In 2020, some organisations on the Isle of Man (IOM) began supplying Sunflower Lanyards but there were disparities in access.

Aims and Objectives: In partnership with Hidden Disabilities Sunflower Scheme Limited, Compassionate IOM (CIOM) aimed to give all persons on the IOM with invisible needs access to Sunflower Lanyards. Hidden Disabilities Sunflower and CIOM held three, free, online training events for IOM organisations. Attendees learned about hidden disabilities, the purpose of the lanyard and how to offer support to wearers. To promote the training, the communication strategy included social media, newspapers and Government media for its employees; a large proportion of the population. Businesses who were unable to train all employees could train a few to educate the wider workforce through cascade training.

Highlights/Results/Key Findings: Compared to most work undertaken by Hidden Disabilities Sunflower, which usually involves educating individual corporations or departments, the partnership with CIOM enabled the geographical location of the IOM to become the first Sunflower-friendly Island. Over the sessions, 220 people attended from corporate, third sector, education, retail, Government and public sector. Of those who completed the end of training survey (n=≈50, approximately 23% of attendees), 100% were satisfied with the training (score of 7+ on a scale of 1-10) and none were dissatisfied. All were happy with the timing and structure of sessions. Overall, 84% were 'very likely to recommend' the Sunflower to other businesses and associates and none said they would not recommend.
One participating business had a branch on the Island of Jersey, where staff were also invited to attend the online training. The training inspired wider networks on the Island, leading to Jersey becoming a second Sunflower-friendly Island.

Conclusions: Knowing how to identify the Sunflower lanyards, and what they represent, is crucial for success. A whole community effort is needed to support those with hidden disabilities to live independently and feel connected. Through the free training programme, we enhanced the community's capacity to support one another in daily life.

Implications: The training of 220 public-facing employees created an inclusive culture for people with additional needs. Cascading from this, and with community action, we hope the awareness of hidden disabilities and the Sunflower symbol will become more widespread. However, this requires the community to adopt and share the knowledge.

Reference list
1.   Hidden Disabilities Sunflower Scheme Limited. About the Sunflower [webpage on the internet]. [cited 2021 June 25]. Available from: https://hiddendisabilitiesstore.com/about-hidden-disabilities-sunflower

Abstract ID: 20
Key informants' perspectives on Implementing Patient Navigator Programs within Hospital Settings

Presented by: Kristina Kokorelias
Co-Authors: Kristina Kokorelias, Sarah Gould, Naomi Ziegler, Stacy Landau, Tracey Das Gupta, Amanda Knoepfli, Dan Cass, Sander Hitzig
_____

Conference Track: Population health needs and local context,System wide governance and leadership

Introduction: Older adults with complex care needs and their family caregivers require varied healthcare services, as well as a high degree of coordinated care. Patient navigation Programs (PNP) can serve as an approach to improve the integration of care by addressing the challenging nature of navigating health, community, and social services. Currently, there are pilot patient navigation programs (PNPs) being implemented for senior and/or medically complex patients whereby a health professional from a community agency or provincial government is connected to a patient identified with complex needs, for up to 90 days post-hospital discharge

Aims and Objectives: The objective of this study is to gain insight from key informants to identify organization and system level facilitators and barriers that influence the implementation of PNPs. This study employs a qualitative descriptive study design informed by the Consolidated Framework for Implementation Research. Data was collected through field observation and in-depth interviews with hospital staff (any profession) and community agency staff (any profession) who have interacted with a patient navigator. Data collection explored perceptions of the need for PNPs, the ideal navigator role, and factors that may affect their implementation. Transcripts are being coded and analyzed using inductive thematic analysis.

Highlights/Results/Key Findings: Thirty-eight key informants participated in interviews (17 from the community setting, 21 from an acute care hospital), including 24 front-line clinicians, 13 program directors, healthcare leaders and managers, and 1 physician. Preliminary results suggest that the implementation of PNPs are dependent on: (1) a clear consensus on the need for Patient Navigators as part of the healthcare system and what the role entails; (2) a collaborative process to engage stakeholders, such as clinicians, and to identify champions to promote patient navigation (3) the need for certainty regarding responsibility for implementation (4) the need for integration with current practice and existing workflow processes. Patient navigation models of care are believed to increase patient and caregiver satisfaction and decrease barriers to care for seniors.

Conclusions: To our knowledge, this is the first Canadian study to explore the implementation of PNPs for seniors with complex needs using health care providers working across care settings. This study provides initial insight into the organizational and system-level facilitators and barriers associated with the development and implementation of PNPs.

Implications: Future implementation strategies to adopt PNPs should incorporate evidence on the value of the program and consider collaborative communication and workflow processes. Our sample is limited. Future research with diverse knowledge user groups is required to gain a more in-depth understanding of the factors that influence implementing PNPs.

Abstract ID: 69

Integration of community and primary care based palliative specialty services to support the homeless and vulnerably housed

Presented by: Barbara Blocki
Co-Authors: Barbara Blocki

_____

Conference Track: Shared values and vision,Population health needs and local context,Resilient communities and new alliances,Workforce capacity and capability

Introduction: According to the 2019 HQO Palliative Care at End of Life Report, people prefer to die at home, however 65% of Ontarians are dying in hospital. Our homeless and vulnerably housed are particularly at risk for hospitalization at end of life due to fragile support systems and limited access to health care. As such, there is a need to bring palliative care to our vulnerably housed patients in their preferred and most comfortable settings. Patients' care should reflect their values and wishes so they can live with the highest quality of life possible and ultimately, die comfortably where they choose.

Aims and Objectives: The goal of this initiative is to ensure equitable access to comprehensive palliative care for vulnerably housed individuals and to help them receive care in a manner and space that optimizes their quality of life, comfort, dignity and security in a manner that is supportive of their life circumstances. We set out to achieve these goals through integration of a community-based Palliative Nurse Practitioner and Outreach worker in primary care. Benefits of this model include, strengthened team safety and communication, multidisciplinary team based coordinated approach to care, reduced duplication, expanded reach, and whole person patient centered care.

Highlights/Results/Key Findings: Of the patients served in 2019 by the integrated Palliative team, only 2.6% required intervention in the hospital. Less than 1% of patients serviced by this initiative were readmitted to hospital within 30 days of service. The primary contributing factor to hospital readmissions was patient acuity, housing and inability to support the patient's medical requirements in their current setting. Qualitative data provided by patients, primary care and other external stakeholders validate the benefits of this initiative in improving access to timely person-centered care and services through building supportive and trusting relationships between the patient and care team. The team promoted meaningful attachment to primary care resulting in 33.5 % of homeless and vulnerably housed patients having a primary care clinician. Reports from the team confirmed improved communication, increased safety and expanded reach.

Conclusions: The integration of the palliative NP and outreach worker into existing community teams supporting the homeless and vulnerably housed has resulted in reduced hospital visits, increased number of patients achieving preferred place of care, increased primary care attachment, expanded patient reach, increased safety, improved team communication and improved patient experience.

Implications: Evaluation outcomes resulted in approval for base funding for the NP and recognition of the outreach worker role as a mandatory enabler of success and safety. This fiscal, we are working towards replicating this model in other regions including integration with the Guelph and Area OHT.

Abstract ID: 73
The more we come together, the better care will be – UHN's Integrated Care Experience

Presented by: Shiran Isaacksz

Co-Authors: *Claire Seymour, Melissa Chang, Courtney Bean, Hemjot Mal, Shiran Isaacksz*

_____

Conference Track: System wide governance and leadership

Introduction: University Health Network (UHN), a health system in Canada's largest urban centre, launched a new model of care to improve the care experience with a focus on integrating all aspects of care whether in or outside of a hospital. This Program is developed and delivered in partnership with VHA Home Healthcare as lead agency, home care provider, and collaborative partner to improve patient experience and outcomes. The Program launched rapidly with great results serving +13,000 patients. This presentation will share how trust, effective governance and leadership helped navigate challenges and partner with organizations, to transform how patient care is delivered.

Aims and Objectives: Co-designed by patients and providers, the integrated care experience is seamless, including health and social supports. The Program addressed common patient and caregiver complaints with one:
•   Care team and primary contact
•   24/7 support line
•   Digital health record
•   Integrated fund
The success of this Program is rooted in the philosophy of "One Team" across all sectors from a care delivery and leadership standpoint. This provided the ability to break down barriers and improve communication and collaboration. Key objectives: improve the care experience, clinician satisfaction, quality outcomes and population health, including decreasing length of stay, readmissions and ED visits.

Highlights/Results/Key Findings: The integrated delivery team includes patient/caregiver partners, acute, home & community and primary care, finance and data, and regional government bodies. Patients undergoing surgery and living with chronic complex conditions are in scope.
The Program was live within four-months in Thoracic Surgery (June 2019). Established infrastructure and system-wide partnerships accelerated implementation to Chronic Heart Failure (spring 2020), COVID Care (spring 2020), and Vascular Surgery (fall 2020).
The program has benefited +13,000 patients and early evaluation results indicate improvements in care experience and health system outcomes: 28% shorter length of stay, 48% lower 90-day ED risk, and 33% lower 90-day readmission risk (for the low needs care paths).
The trust built among the "One Team", and strong governance allowed us to adapt to a rapidly changing landscape and expedite expansion to support vulnerable populations. During the pandemic, care paths were adjusted to ensure care continuity, while delivering improved outcomes and experiences.

Conclusions: In less than two years +13,000 patients have benefited and new pathways continue to rollout. The Program continues to identify opportunities to develop partnerships and support shared decision-making across the health system. Ongoing efforts to evolve include expanding connections with community and social supports continue to be critical to success.

Implications: The Program has expanded while navigating challenges posed by a restructuring of health care delivery and the pandemic. Through effective governance, leadership and strong partnerships, the program established a sustainable foundation for rapid growth. This includes breaking new ground in looking at opportunities where regional collaborative efforts may be supported.

Transferable Lessons in Spread and Scale of Integrated Care
Abstract ID: 87
Collaboration in Interprofessional Primary Care Teams during the COVID-19 Pandemic
Presented by: Sandeep Gill

Co-Authors: *Sandeep Gill, Rachelle Ashcroft, Catherine Donnelly, Simon Lam, Kavita Mehta, Toula Kourgiantakis, Keith Adamson, David Verrilli, Lisa Dolovich, Anne Kirvan, Deepy Sur, Maya Dancey, Judy Belle Brown*

_____

Conference Track: Resilient communities and new alliances,Workforce capacity and capability

Introduction: Primary care is the first point of access for health services and primary care teams play a central role in the coordination and integration of mental health services. The pandemic has seen a rising demand for mental health services and primary care teams are well positioned to address these needs. With the pandemic, primary care teams have made a transition to virtual care, however the impact on how teams collaborate to provide mental health care is unclear. The aim of the study is to understand primary care teams' experiences with collaboration related to mental health care during the COVID-19 pandemic.

Aims and Objectives: A descriptive qualitative research design was employed. Family Health Teams (FHTs) are an interprofessional primary care model in Ontario. Using purposeful sampling, we sent invitational letters to executive directors of FHTs across all five Ontario Health regions. Focus groups were conducted with interprofessional healthcare providers providing mental health services in FHTs. Virtual focus groups, led by trained facilitators examined the delivery of collaborative mental health services and its impact on patients during the COVID-19 pandemic. The focus groups were audio-recorded and transcribed verbatim. Thematic analysis was used for data analysis and occurred in parallel with data collection.

Highlights/Results/Key Findings: Eleven focus groups with 10 FHTs were conducted, with a total of 48 participants. Focus groups were conducted with two FHTs in each of the five Ontario Health regions. Three themes were identified in the data: i) pre-pandemic team functioning, ii) new communication processes, iii) collaboration. Teams were able to maximize collaboration from this rapid transition with the advantage of well-established team-based models prior to the pandemic. Teams created new processes for collaboration to adapt to the virtual changes via new channels of communication such as texting, video meetings and phone calls. Collaboration expanded beyond the FHT and into the communities as teams virtually collaborated with community partners. Nevertheless, some participants found virtual collaboration to be isolating due to the lack of in person communications and unscheduled hallway conversations that could only emerge in a co-located in-person setting.

Conclusions: While teams found new ways of communicating, the overall experience of shifting to a virtual team was isolation with less overall collaboration. Virtual team-based communication will likely be a mode of collaboration moving forward, and its advantages and disadvantages will need to be considered.

Implications: As virtual care becomes an integral way of delivering primary care, it will be crucial to understand and learn its impact on collaboration within teams. This will influence how health care providers support each other and in communities as many regions work to strengthen collaborations within Ontario Health Teams.

Abstract ID: 92

Rapid Recovery Therapy Program - Integrated Intensive Rehabilitative Care in the Community

Presented by: Dana Khan

Co-Authors: Dana Khan, Bonnie Camm, Jennifer Rowe

_____

Conference Track: Workforce capacity and capability

Introduction: The Rapid Recovery Therapy Program (RRTP) is a well-established program in Waterloo-Wellington, which has been proven to reduce in-patient length of stay by up to 2 weeks.

The COVID-19 pandemic created an increased need to further expand this program to address health system pressures and support patients in attaining timely access to rehabilitative care services. The RRTP expansion focused on the creation of a virtual integrated care team consisting of hospital and home and community care staff. The strengthened relationships between the community and hospital staff improved transitions for patients and earlier/increased identification of patients who would benefit from program.

Aims and Objectives: Based on feedback from patients and staff regarding transitions of care from hospital to community, and to increase patient flow in hospital, health system partners identified a desire to increase the utilization of the Rapid Recovery Therapy Program (RRTP). The RRTP expansion focused on increased interdisciplinary and inter-organizational collaboration to reduce the demand for in-patient rehabilitative care and associated ALC days; while maximizing functional independence of patients.

The program expansion was designed to support transfer of knowledge/experience and build relationships between hospital and community staff - identifying more patients for the program and creating a more streamline transition for patients.

Highlights/Results/Key Findings: A formal evaluation of the Rapid Recovery Therapy Program (RRTP) was conducted in 2016 by Optimus-SBR. The evaluation demonstrated improved patient and system flow (reduced in-patient length of stay up to 2 weeks), rehabilitative care outcomes in alignment with patients goals and demonstrated through improvements in patient's self-performance status using the ADL-Long Form scale, positive patient experience through patient survey feedback and more cost-effective care compared to in-patient rehabilitative care.

During the COVID-19 pandemic, WWLHIN Home and Community Care, Grand River Hospital and CBI Health were able to collectively increase the number of referrals to RRTP by 67% (65 referrals from December 2020 - May 2021 vs. 37 referrals from June - November 2020) and a 83% increase in referrals from January - May 2021 compared to same time last year.

Patient experience evaluation is being planned and results will be ready to share prior to the conference in October.

Conclusions: The Rapid Recovery Therapy program has demonstrated significant success across the quadruple aim. The increased utilization of the program during the COVID-19 pandemic has been critical in helping to address health system pressures and ensure patients receive the rehabilitative care they need.

Implications: Lessons learned from the RRTP expansion are currently being applied to other Waterloo Wellington hospitals. Broader applicability and transferability can also be applied to improved team integration and communication across organizations for other patient populations.

Abstract ID: 93

Using logic models to support integrated care implementation - lessons from implementation in 9 European integrated care regions

Presented by: Sophie Wang

Co-Authors: Sophie Wang, Oliver Groene

_____

Conference Track: System wide governance and leadership

Introduction: Implementing integrated care is inherently challenging due to the number of actors to engage, the long-term realization of benefits, and assessing intervention effectiveness. Thus, policymakers often rely on transferring best-practices from existing integrated care systems to inform the design of regional initiatives. However, the implementation challenges of simply transferring best practices from other contexts is increasingly acknowledged. SCIROCCO Exchange is an EU-funded consortium that aims to scale-up integrated care initiatives within respective health system contexts through facilitating knowledge transfers and providing personalized improvement support.

Aims and Objectives: Here we demonstrate how logic models can serve integrated care implementation by identifying gaps in causal links between desired outcomes and planned activities, and as a communication tool for stakeholder engagement. We collaborate with 9 regions across Europe at varying stages of integrated care journey to cocreate logic models. Participating regions utilize a validated self-assessment tool that includes twelve dimensions found to be integral in successfully implementing integrated care to identify goals of improvement with patient involvement. We then work with regional leadership and staff to create a high-level model, then proceed to validate the model with wider stakeholders.

Highlights/Results/Key Findings: -   Early engagement with regional actors was key to building the trust required for cocreation of a representative logic model
-         While regional leaders were initially unfamiliar with the use and purpose of logic models, adoption and acceptability increased after its demonstrated value in clarifying goals, and thinking through the causal chain of events that link planned/implemented activities and anticipated outcomes
-         Regions at earlier stages of their integrated care journey focused more on activities and direct outputs while those at later stages focused more on outcomes. Across participating regions, thoughtful work was required to iteratively define the causal links between activities and outcomes
-         The process of logic model development adds value to the process of implementing integrated care systems by challenging stakeholders to think through the causal mechanisms that links activities that are invested and the desired outcomes within the regional context.

Conclusions: One of the reasons that integrated care systems are not scaled up is due to the lack of transparent communication and shared understanding between different actors regarding the causal linkages between invested activities and the desired outcome. Logic models can be a useful tool to close this gap among stakeholders.

Implications: Logic model is a highly adaptable and sustainable tool to support integrated care system at different stages of implementation. We are limited to our initial experiences engaging regional leadership in this work. The next step will be to validate and further refine the logic model with stakeholders on the ground.

Abstract ID: 95

Exploring how focus on physicians impacts pharmacists' role negotiation: Case study of primary care teams.

Presented by: Jennifer Lake

Co-Authors: Jennifer Lake, Aisha Lofters, Jan Barnsley, Zubin Austin

_____

Conference Track: Workforce capacity and capability

Introduction: Primary Care Teams deliver healthcare services and the way that professionals work together is the result of multiple daily interactions. Using Goffman's theories of self and impression management, negotiation of the pharmacist's role was explored. Goffman's theory outlines how individuals (e.g., actors) interact for the people they value (e.g., audience) to achieve outcomes. The aim of this research was to explore how the role of a pharmacist was negotiated in a primary care team. This presentation discusses how the audience of the pharmacist's role influenced role negotiation.

Aims and Objectives: Using a multiple case study design as per Yin's approach, five cases were recruited. Both interview data and documents were collected. Recruitment for each team was four or more participants including Executive Director, pharmacist, physician, and at least one other team member. Data was analysed both deductively and inductively using the Qualitative Analysis of Leuven to create themes. Themes related to the negotiation of the pharmacists' role, the enablers, the actors' relationships, and the influence of the context.

Highlights/Results/Key Findings: Three cases completed participant recruitment and were analysed fully. One of the important factors that influenced role negotiation was the audience for the pharmacists and their role. The audience is a powerful concept in Goffmanian theory because it influenced all interactions including what outcomes are valued during role negotiation. Participants discussed that the pharmacists' role should support physicians and do whatever the physicians valued within the team. Data suggested that participants conferred the power onto physicians versus it being demanded. This likely led pharmacists to negotiate less often; consider how to obtain validation from physicians; maximize behaviours that maintained harmony within the organization; and minimize behaviours that may have embarrassed physicians. Few participants discussed how this focus may negatively impact the patient experience or equity. Additionally, it likely reinforced medical hierarchy in the team which influenced future role negotiation.

Conclusions: Participants envisioned the physicians as leaders and the manager of the relationship with pharmacists. This contributed to a lack of active negotiation by the pharmacist. This may put additional burden on the physicians to "keep the pharmacist busy" and unintentionally reinforced medical hierarchy.

Implications: Although the results and conclusions presented are specific to the cases, interprofessional teams may focus on physicians instead of patients or larger healthcare needs. This may unintentionally influence delivery of services or oppose efforts to maximize scope within teams.

Abstract ID: 122

Impact of Integrated Home care in Catalonia

Presented by: Juan Carlos Contel Segura

Co-Authors: Juan Carlos Contel Segura, Anna Vila, Jordi Amblas, Sebastia Santaeugenia, Pilar Hilarion, Emili Vela, Aina Plaza

_____

Conference Track: Transparency of progress, results & impact

Introduction: There is small knowledge in the literature related to people with Home Healthcare (HHC) and Social Home Care (SHC) in the community. Both HHC and SHC are responsibilities and activities performed by different Ministries and Local Government. Very few tools facilitate collaborative practice between different professionals teams and services working in the home care area.

Aims and Objectives: Objectives:
-Analyse and describe population with both Home healthcare and Social home care services
-Analyse impact of Integrated Home Care services in population living at home requiring home care services
Methods:
→   PHASE 1: Analysis of the level of deployment and degree of achievement of key contents related to a model of integrated care for the different regions of Catalonia: unique shared assessment instruments, individual single care plan, shared protocols.
→   PHASE 2: Evaluate the impact of healthcare on adequacy of use and demand, efficiency and capacity; with indicators of use of services, such as hospitalizations, institutionalization and primary care use

Highlights/Results/Key Findings: Aggregate average score of each of the indicators used in the analysis of the baseline situation of the Integrated Care in home care services was 1.4 out of 5, representing 27.5% of the maximum score.
Integrated Home Care decreases the probability of being institutionalized in a nursing home by 20% and decreases the number of cumulative days of hospitalization in health centres by 2.3%. Primary care visits increases by 2.1%, 6.4% in the case of home healthcare visits and 3,2% virtual visits. No significant impact on hospital admissions was observed.
Integrated Home Care implies that overall increase in social and health spending decreases by 2.2%. There is no significant variation in health expenditure, as the increase in community and outpatient health expenditure by 3.8%, compared to the decrease in inpatient health expenditure (hospitals and social health). There is a significant impact on the increase in social spending by 16.8%.

Conclusions: Among the most valued elements: lack of protocols, culture of little coordination between health and social care, high demanding situation, perception of deficit of political mandate, lack of shared information systems and scarcity of professionals. Among most mentioned facilitating factors: good attitude and recognition of need of Integrated Care.

Implications: This experience of evaluating the impact of integrated home care is the first time carried out in Catalonia. There is a great challenge of overcoming the barrier in terms of data protection, in terms of work with aggregated health and social data, with highly explanatory potential use.

Abstract ID: 124

From transactional client relations to transformational integrated partnerships to deliver maximum value to the patient: A discussion on key success factors and outcomes

Presented by: Shelby Fisch

Co-Authors: Shelby Fisch, Amir Soheili

_____

Conference Track: Shared values and vision,People as partners in health and care,Transparency of progress, results & impact

Introduction: The shift towards Ontario Health Teams and the changing healthcare landscape has created a necessity for organizations across the continuum of the patient journey to work together for optimal patient outcomes. Since January 2013, SE Health rehab services have been contracted out to Mackenzie Health for all its hospital programs. Success of this partnership is leading the way to expanding fully integrated care for patients undergoing total hip and knee replacements, ALC management and transitions across the system.

Aims and Objectives: Changing the mindset from a transactional relationship to a strategic partnership requires organizations to focus on joint outcomes with a solutions-oriented approach. This collaboration leads to innovation in the health space and creates value for healthcare through enhancements for patients and staff, financial gains and improved outcomes. Together we created a partnership agreement utilizing a robust engagement process inclusive of senior leadership, management, front line clinicians and patient and family advisors. The result was a shared accountability model with a joint focus on partnership goals, involving shared risk and performance incentives.

Highlights/Results/Key Findings: This outstanding partnership model has led to optimized clinical, financial and organizational outcomes. Results include: 38% increase in patient rehab minutes; 26% increase in FIM efficiency; 16% increase Case Mix Index CCC program; 19% decrease LOS in Total Joint Replacements; 94% patient satisfaction; and, enhanced communication across team members and management.   Through this innovative partnership, we learned that key success factors include: Alignment of vision and values: Experiences and Innovation; Engagement with leadership, clinicians and patients; Communication and Collaboration; Transparency and trust; Joint accountability on performance. Successful partnerships must be created with a fundamental alignment towards a shared, long-term vision focused on clinical and system outcomes.

Conclusions: In the evolving health care landscape, it's vital that organizations continue to push boundaries and break down silos to innovate and achieve desirable results. We have been at the forefront of creating partnership solutions; removing system barriers; and, working with a shared vision to enhance care and organizational outcomes.

Implications: Our goal is to help leaders and organizations to focus on transforming partnerships towards outcomes. We will share tools and methods to help build collaborative and amenable care relationships that result in a long-term, shared investment in innovation and the attainment of clinical and system outcomes.

Abstract ID: 172

The Medical Psychiatry Collaborative Care Certificate (MP3C) Program: Efficacy and Success of Transition to Online eLearning

Presented by: Alison Freeland

Co-Authors: *Gurpreet Grewal, David Wiljer, Sanjeev Sockalingam, Alison Freeland, Alicia Lozon*

_____

Conference Track: Population health needs and local context,Workforce capacity and capability

Introduction: The Medical Psychiatry Collaborative Care Certificate (MP3C) program was created to build capacity in health care teams and individual providers for delivery of integrated collaborative medical psychiatry care across the continuum of a patient's health journey. The MP3C curriculum was developed using an iterative design process before bundling it into a continuing professional development certificate program accredited through the University of Toronto. In 2020, the MP3C curriculum was transitioned to an online platform that utilizes multimedia asynchronous eLearning activities as well as synchronous interactive webinars to optimize the learner experience for interprofessional collaborative learning.

Aims and Objectives: The MP3C curriculum was transitioned to an online platform to increase the geographic reach of the program and provide participants flexible scheduling for activity completion. Similar to its curriculum development, the online delivery design is also using an iterative process to make adjustments based on input of all stakeholders – learners, lived experience experts, facilitators, online discussion moderator, and the program steering group. The methods for collecting feedback include formal end of course evaluations and post-delivery debrief discussions with facilitators, online discussion moderator, and lived experience experts as well as informal feedback about learner experience shared through email or telephone

Highlights/Results/Key Findings: Since September 2020, 33 participant responses have been collected through the online deliveries of the four Foundational MP3C courses. 91% participants stated these courses were a valuable use of their time and majority reported an increase in knowledge. 88% strongly agreed/agreed that the courses enabled them to describe and use evidence based assessment tools for identification of mental health issues and 97% strongly agreed/ agreed that they have increased understanding and knowledge of integrated collaborative care. Majority of the participants felt that the courses were relevant to their personal learning needs (91%) as well their clinical practice (82%), and that they would recommend these courses to their colleagues (88%).
91% of the learners shared that they intend to use the knowledge gained through these courses in their daily clinical practice and shared comments like "the importance of this material/perspective is paramount to help patients navigate through a challenging healthcare system…"

Conclusions: MP3C program is using an online, longitudinal approach to enhance the knowledge, skills and attitudes of interprofessional teams. The program has been successful in transitioning to a sustainable, scalable online model through utilizing evidence based online learning strategies as well as ongoing engagement of all stakeholders into design improvement.

Implications: MP3C's curriculum is designed to accelerate the adoption of integrated collaborative care to support patients with co-morbid physical and mental health issues. The interactive online platform provides equitable access for a large number of diverse health care professionals to acquire new knowledge and skills to impact system change.

Abstract ID: 175
Using a Learning Health System Approach to Evaluating an Integrated Model of Care in East Toronto

Presented by: Sara Shearkhani
Co-Authors: Sara Shearkhani, Anne Wojtak, Mark Fam, walter wodchis

_____

Conference Track: Transparency of progress, results & impact

Introduction: East Toronto Health Partners (ETHP) is implementing a new integrated care model (ICM). ETHP is comprised of 50+ health and social organizations in East Toronto, with a leadership council consisting of patient/caregivers and six anchor organizations representing the continuum of care. ETHP is co-creating an IC model in which hospital, primary care, community providers and patients and families work together as one coordinated team in order to improve population health, patient and provider experience, and value for money (Quadruple Aim).

Aims and Objectives: The aim is to create a learning health system within ETHP by embedding rapid cycles of evaluation to support learning, knowledge transfer, and decision making for scale and spread of ICM. A developmental evaluation (DE) approach is employed to achieve this goal. The priority population includes seniors with chronic care needs and their caregivers, and individuals with mental health challenges and substance use issues. ETHP's mandate is to expand the model's scope and coverage to cover the entire population of East Toronto. DE started in the fall of 2020 and is set up for 2 years.

Highlights/Results/Key Findings: In our year 1 of DE, an evaluation steering committee including two patient partners was created to provide advice on the ongoing evaluations. To build capacity, evaluation workshops are being held focusing on evaluation types, developing logic models, and measurement. An early implemented ETHP's intervention, winter Surge initiative, was chosen to be evaluated at the project level (total of 15 projects). An evaluation template was developed for use across projects. The embed researcher worked closely with the project leads to develop logic models and choose appropriate measures. Projects used quantitative and qualitative methods to analyze their data. Main findings are: a) significant investment in knowledge-building around choosing appropriate metrics at the project-level is needed; b) system-level identified through the evaluation (e.g. primary care attachment) needs to be collaboratively addressed at the ETHP-level; c) evaluation processes need to be refined to meet the needs of the teams.

Conclusions: ETHP is using DE to create a more integrated system of care for residents and providers across East Toronto. In its early stages, DE has focused on building internal evaluation capacity for internal teams to engage in ongoing evaluation activities creating a community of practice.

Implications: By embedding rapid cycles of evaluation, ETHP aims to support strategic expansion of integrated models of care across its entire population. The focus on building internal evaluation capacity and an evaluation community of practice ensures sustainability.

Transferable Lessons in Spread and Scale of Integrated Care
Abstract ID: 178
A Performance Measurement Framework for Integrated Care Networks
Presented by: Reham Abdelhalim
Co-Authors: Reham Abdelhalim, Suman Budhwani, Patrick Feng, G Ross Baker

_____

Conference Track: Workforce capacity and capability,System wide governance and leadership,Transparency of progress, results & impact

Introduction: Despite the widespread adoption of integrated care initiatives, achieving integrated care goals remains elusive. One continuing challenge is the frequent mismatch between measurement frameworks and goals. Existing literature describes conceptual frameworks or measurement domains without identifying specific measures, or, alternatively, reviews existing measures and measuring tools without explicating how these measures could be used or how they fit together in a performance measurement framework. We sought to develop a performance measurement framework for integrated care initiatives with linked measures that can be adapted to different initiatives and settings and which informs strategy and guides decision-making.

Aims and Objectives: We conducted a scoping a review of peer-reviewed studies and grey literature articles to identify performance measurement frameworks, measurement domains and measures for integrated care. Measures were abstracted and categorized based on structure, process and outcomes; outcomes were further classified based on quadruple aim domains. Thematic analysis was conducted based on recommended measurement domains and subdomains in the literature. This was summarized in an overarching performance measurement framework using a logic model format. Further mapping and analysis of measures was conducted onto the proposed measurement framework based on discussion between study authors and feedback from local policy-makers

Highlights/Results/Key Findings: The initial scoping review search found over 2600 articles; of these, 278 were deemed potentially relevant and screened, resulting in the inclusion of 70 articles. A total of 340 measures of integrated care were found in these 70 articles. Most of these measures were existing outcome measures; and these measures were not directly linked to integrated care initiatives.
A performance measurement framework was constructed including process and outcome measurement domains and subdomains. Process measures were divided into 1) measures of key integrated care activities including personalized care, coordinated care, and interprofessional collaboration, and 2) critical outputs including patient empowerment, communication, continuity of care, planned care, and access. Outcomes domains were mapped to the quadruple aim and included user experience (patient, caregiver), provider experience, health outcomes (system-level, person-level), and cost/utilization. Few measures were found that tapped policy environment, context and initiative structure components.

Conclusions: Despite the substantial literature on integrated care measurement, many current measures are poorly suited to the task of measuring integrated care. We propose a performance measurement framework for integrated care initiatives that provides a conceptually grounded and useful approach for evaluating integrated care.

Implications: Performance measurement of integrated care initiatives is a complex task. We propose a performance measurement framework and linked performance measures that can be utilized to guide implementation and development, informing practitioners, policy makers, funders and evaluators who seek to assess the performance of integrated care efforts.

Transferable Lessons in Spread and Scale of Integrated Care
Abstract ID: 181
Persons Living with Complex Needs' Experience with Integrated Patient Care in Ontario, Canada
Presented by: Reham Abdelhalim
Co-Authors: *Reham Abdelhalim, Agnes Grudniewicz, Kerry Kuluski, walter wodchis*

_____

Conference Track: Population health needs and local context,People as partners in health and care,Transparency of progress, results & impact

Introduction: Many healthcare systems are integrating care for persons living with complex health and social care needs. Successful Integrated Patient Care (IPC) is expected to improve the quality of care, decrease unnecessary healthcare utilization, and enhance patient experience. Patients/persons are the only ones to experience all the care they receive across providers and provider organizations and over time. They are uniquely qualified to say whether their care is integrated in ways that meet their needs and preferences. However, care experience is still one of the least reported outcomes in integrated care evaluation literature.

Aims and Objectives: We assessed the patient experience with a wide-scale IPC initiative in Ontario, Canada. A cross-sectional survey was mailed in July 2019 to 683 patients who were enrolled in the IPC initiative in one local health authority for at least six months. The survey covered constructs of communication, patient empowerment, information flow, relationship with providers, shared decision-making, continuity of care, access, and knowing what to expect. Exploratory factor analysis (EFA) was conducted to reveal the latent structure of the survey. The impact of awareness of having a care plan and satisfaction with the care coordinator on the survey results were examined.

Highlights/Results/Key Findings: The response rate was 26.71%; The constructs that were associated with positive experience were patient empowerment, knowing what to expect, and shared decision making. Communication, information flow, care continuity, and access were not perceived to be enhanced by the IPC approach. Although all respondents had a care plan developed, only 66.6 % of respondents were aware of having a care plan, and less than half reported having a copy of the care plan. The EFA revealed a three-factor solution. The three factors were care planning, person-centredness and Perceived support for coordination and self-management support. Awareness of having a care plan and satisfaction with the care coordinator were both significantly associated with better experience per survey item on most of the survey questions as well as higher average summary scores for the three survey factors. However, regression analysis showed that satisfaction with the care coordinator would better predict the factor scores.

Conclusions: The results indicated that the intended components of the IPC initiative (personalized care plan and care coordinator) were strongly positively related to better patient experience. However, issues with implementing these two components affected the care experience negatively. This was reflected in the low scores on communication, coordination, and information

Implications: Our results can inform researchers on how to better assess the patient experience with IPC initiatives. Additionally, it can guide policy makers, funders, and implementers on what is most important to persons living with complex needs, which can facilitate designing interventions that better align with their needs and expectations.

Abstract ID: 188
Evaluation of an Integrated Care Program for Thoracic Surgery at a Hospital in Ontario, Canada
Presented by: Melissa Chang
Co-Authors: *Emily Hay, Melissa Chang*

_____

Conference Track: Transparency of progress, results & impact

Introduction: Transitions in care from hospital to community can be challenging for post-operative patients. In June 2019, the University Health Network in Toronto, Canada implemented a Thoracic Surgery Integrated Care Program (ICP) to support comprehensive care in the hospital-to home continuum. We conducted a process evaluation to understand patient, caregiver and provider experiences to identify areas for improvement, which was complemented by an outcome evaluation to assess Program benefits relative to quality outcomes and hospital costs. A stakeholder group including patient representatives, providers, and researchers provided critical input on the evaluation plan, interpretation of results and recommendations.

Aims and Objectives: We conducted a mixed methods evaluation to assess the first nine months of the program, which included: 18 interviews with patients and caregivers to understand experiences with dimensions of care; focus group with thoracic surgeons and interviews with IC leads and lead surgeons to understand experiences with care delivery; and analysis of hospital administrative databases to quantitatively evaluate quality outcomes and costs between IC patients and historical patients discharged a year prior to program implementation. The retrospective cohort analysis assessed readmission risk, emergency department (ED) visit risk, length of stay (LOS), and hospital costs, adjusting for age, sex, and residence.

Highlights/Results/Key Findings: The ICP was successful in providing effective coordination and continuity of care, especially during the post-discharge period. Providers reported the ICP supported them in delivering a comprehensive and person-centered care experience. Patients/caregivers expressed confidence in transitioning home with 24/7 access to an IC Lead familiar with their surgery; however, they also identified gaps in educational and caregiver supports. Providers identified a need to strengthen links with primary care physicians and other providers in the patient's circle of care to improve informational continuity and team integration. In low care pathways, the 90-day ED risk of IC patients was 48% lower (95% CI: 0.31-0.87) and LOS was 28% lower (95% CI: 0.60-0.86) than those of the historical cohort. Readmissions were 33% lower (95% CI 0.38-1.18) and hospital costs were 4% lower (95% CI: 0.79-1.16); however, small sample sizes did not permit conclusive findings.

Conclusions: The ICP achieved notable successes in providing effective healthcare experiences for patients and caregivers, positive experiences among providers, and early evidence of program benefits on reduced ED visits and LOS. The results were used to guide ICP improvements and inform expansion to other IC pathways in the hospital.

Implications: Qualitative findings may not reflect the experience of all program patients, caregivers, and providers. Data on quality indicators and costs were limited to the specific hospital, thus omits visits and costs to external institutions. Further analyses with an increased sample size will be important to demonstrate the robustness of findings.

Key Learnings from a Decade of Advancing Integrated Care in Ontario – The Centre for Integrated Care

Presented by: Carrie Anne Beltzner
Co-Authors: Sophie Hogeveen, Carrie Anne Beltzner, Carolyn Gosse, Andrew Costa, Chi-Ling Joanna Sinn, Lindsay Klea
_____

Conference Track: Shared values and vision,Population health needs and local context,People as partners in health and care,Resilient communities and new alliances,Workforce capacity and capability,System wide governance and leadership,Digital solutions,Aligned payment syst

Introduction: The Centre for Integrated Care (CIC), situated within St. Joseph's Health System in Ontario, is an innovation centre committed to research, education and evaluation to support advancement of integrated care across Canada. The CIC supports internal and external organizations across the province to inform the design and implementation of innovative integrated care programs. Learnings from this work began in 2010 and have informed the development of a maturity model for integrated care. As a practical hands-on resource for organizations of any size, at any point in their journey, the maturity model helps self-assess and determine next steps towards maturity.

Aims and Objectives: This presentation aims to introduce the CIC, our recently developed integrated care maturity model, and share key learnings from a decade long journey of working with different stakeholders to advance integrated care. We will highlight how these lessons were applied in the context of the pandemic in the design and implementation of the COVID Care @ Home (CC@H) program, led by St. Joseph's Home Care.

Highlights/Results/Key Findings: Based on our extensive experience, we have developed a maturity model for integrated care. As a practical hands-on resource for organizations, we provide an engaging way to self-assess and determine next steps towards maturity. Key learnings will be shared from innovations in integrated care for surgical patient populations, chronic patient populations and for population health, with a particular focus on application to the development of the CC@H program.
CC@H is a new model of care co-designed with patients, families, and three local Ontario Health Teams (OHTs) that linked up providers and connected COVID patients at home and in the community with 24/7 access to one integrated team. This program integrated with existing regional resources to support hospital partners, manage acute care capacity and primary care in Niagara, Hamilton, and Kitchener and Waterloo.

Conclusions: The lessons learned through the CIC's work with various stakeholders to advance integrated care may be applied by other organizations as they were applied in the design and implementation of the CC@H program, as led by St. Joseph's Home Care.

Implications: Organizations of any size, at any point in their implementation journey will benefit from the lessons that have been learned and shared by the CIC through our work with diverse partners at different stages themselves, including OHTs, regional health authorities, large hospital systems, and smaller local hospitals.

Abstract ID: 192
Implementing Integrated Care: Moving away from Project Management to Adaptive Learning
Presented by: Samantha Laxton
Co-Authors: *Samantha Laxton, Kasia Bruski, Jennifer Wilkie, Emily Alexander*

_____

Conference Track: Transparency of progress, results & impact

Introduction: Transformation in health systems is often approached with the assumption that the solution is known, and the complex issue can be solved with an available process or expertise. However, we have seen technical solutions to complex adaptive problems never work. Integrated care initiatives have highlighted the need for an adaptive approach, however this practice rarely extends to on the ground. Health Standards Organization (HSO) identified the need not only to teach adaptive change, but live it through the implementation of their integrated care initiative bringing a culture of learning and the ability to adapt the project based on real-time feedback.

Aims and Objectives: HSO's Improving Integrated for Youth Initiative (IICY) aims to drive sustainable improvements and better outcomes in the integration of community-based services for youth through the co-design, testing and adoption of evidence-based HSO standards and implementation tools that promote integrated care best practices. Participating in this work are six integrated youth service networks across Canada. The networks began to share feedback that the approach needed to be adapted to better enable their work on the ground. The project shifted priorities and embraced an adaptive approach, learning from the feedback in real-time and adjusting the initiative to better meet the networks needs.

Highlights/Results/Key Findings: Leading by example, knowing the risk to deliverables and timelines, HSO took an intentional pause early into the implementation to ensure feedback could be actioned meaningfully. From there, HSO developed an adaptive approach to incorporate real-time feedback from the networks into the implementation and the products. This included:
- Creating more opportunities for collaboration and knowledge exchange through online platforms and shared meetings
- Development of a framework to evaluate and adjust implementation approaches and materials moving forward
- Building "What We've Heard" into group meetings and information sessions

The outcome of the pause and feedback approach included:
- Increased engagement and participation by networks
- Increased trust and meaningful participation from all stakeholders including youth, community providers, etc
- Higher quality feedback on HSO standards and tools

Conclusions: It is not enough to teach adaptability and learning to those leading on the ground. For initiatives to be successful, an adaptive approach must be taken at every level. This top-down, bottom-up approach has supported HSO in developing higher quality standards and tools for sustainable transformation towards more integrated care.

Implications: The outcome of the IICY initiative will be a series of tools and learnings informed by evidence and lived experience that will be shared through HSO with the rest of Canada and Internationally.

Abstract ID: 194
How Persons Living with Complex Health and Social Care Needs and Their Caregivers Perceived Integrated Patient Care

Presented by: Reham Abdelhalim
Co-Authors: *Reham Abdelhalim, Kerry Kuluski, Agnes Grudniewicz, walter wodchis*
_____

Conference Track: Population health needs and local context,People as partners in health and care,Transparency of progress, results & impact

Introduction: Persons living with complex health and social care needs (PLCN) and their caregivers frequently report poor care experiences. In previous research, PLCN and caregivers described their care as fragmented and not aligned with their needs and goals. In 2011, Singer et al proposed the concept of integrated patient care as one that has the potential of improving the experience of care for PLCN via person-centred care coordination. They proposed a framework to assess patient experience with integrated patient care. A knowledge gap exists on how integrated patient care materializes in practice from the perspective of PLCN and their caregivers.

Aims and Objectives: In order to understand how PLCN who were enrolled in an integrated patient care initiative in Ontario, Canada perceived integrated patient care, we conducted a qualitative study utilizing interviews. Qualitative directed content analysis was used to explore the experiences of participants. Singer et al.'s framework was the theory guiding the directed content analysis. The seven dimensions of the framework were used to code and analyze the interviews helping the team to see what worked well and what needed to improve based on the views of PLCN and their caregivers. Member checking was conducted with three participants to validate our findings.

Highlights/Results/Key Findings: We interviewed 16 participants (six PLCN and ten caregivers). The findings showed that PLCN and their caregivers perceived that the responsibility of care coordination was still largely shouldered by them despite being part of an initiative that aimed to coordinate their care in a person-centered manner. This was mainly because most of the components of the initiative such as care plans and interprofessional collaboration that were supposed to help in care coordination had gaps. Participants wanted to be regarded as co-coordinators and to be provided the needed support to carry such role. Relational aspects of care coordination were shown to be the most valuable to persons living with complex needs and their caregivers. Having a care planning session was more valued than having a care plan. Having a relationship with the care coordinator that was based on partnership was the most valued aspect of having a care coordinator.

Conclusions: Integrated patient care initiatives operate within a healthcare system that is still fragmented and siloed. As a result, the absence of interprofessional and interorganizational coordination reduced the overall impact of such initiatives and raised the importance of relational coordination as a potential solution to facilitate delivering integrated patient care.

Implications: Future interventions that aim at providing integrated patient care might benefit from investing into: a) supporting PLCN and their caregivers continue carrying on their care coordination role and b) focusing more on relational aspects of care coordination until our healthcare system is more ready to enact interprofessional and interorganizational coordination.

Abstract ID: 204
Seniors Campuses – Integrating Mechanisms for Health, Housing and Social Care
Presented by: Frances Morton-Chang

Co-Authors: Frances Morton-Chang, Shilpi Majumder, Whitney Berta

_____

Conference Track: Shared values and vision,Population health needs and local context,Resilient communities and new alliances,System wide governance and leadership

Introduction: Seniors' campuses – physical settings that provide a broad range of inter-related seniors' health and social services and supports through closely coordinated service delivery, collaborative partnerships and shared infrastructure – are innovative care models that seek to address the health and well-being of individuals and the broader healthcare system. Campuses have been evolving over time to overcome the fractured and siloed nature of healthcare in Ontario, Canada and elsewhere with implications for addressing the complex health, social and housing needs of growing populations of seniors desiring to age-in-place. Campuses also provide rich employment, training, research and volunteer opportunities.

Aims and Objectives: Using a comparative case study approach, six seniors' campus case studies each with mixed-housing options , onsite community supports, external-facing community supports to the broader community, and a long-term care home were examined for influencing factors on their evolution, sustainability and potential for optimizing/scaling their integrative properties. Using a diversity lens, case studies were selected from various contexts (e.g., size, maturity, provider-type, geography, special populations). While specific contexts, configurations and key partners varied according to local context, each campus was found to offer benefits at the individual, organizational, and system levels and multiple workarounds to overcome policy and program rigidities.

Highlights/Results/Key Findings: Seniors' Campuses have evolved largely through municipalities, local organizations and/or faith-based communities seeking to address local unmet need for seniors wishing to age-in-place. They leverage existing infrastructure and funding opportunities to build-in additional mixed-housing options, services and amenities. By geographically co-locating the many components, campuses optimize linkages and build sustainable local partnerships to integrate a diverse range of preventive and progressive supports for residents and care partners of the campus (independent living, housing with supports, long-term care) and neighbouring community and further provide opportunities for resident engagement (resident committees, volunteerism, planning social and structural activities) and person-centred/directed care.

Conclusions: Campuses are local innovative "ground –up" solutions that support seniors' desires to age-in-place. They address individual need (progressive person-centred care options), organizational efficiency (increased coordination, economies of scale) and system capacity issues (e.g., addressing need for seniors housing with supports; mitigating unnecessary hospital visits/stays or premature placement to long-term care).

Implications: The pandemic has given pause to evaluate what tools are in the toolbox to address the progressive needs of an aging population desiring to age-in-place. Campuses are proven models that have existed in various forms for decades and can be readily scaled and spread in place of other standalone components.