



May 23 & 24,
2024

8TH ANNUAL
CANADIAN ASSOCIATION OF
AMBULATORY CARE (CAAC) CONFERENCE

The Future Design of
Ambulatory Care
Is Not in The Hospital:
Leading Change Through Collaboration

Sunnybrook Health Sciences Centre
Toronto, Ontario

CONFERENCE PROGRAM



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WELCOME

The Canadian Association of Ambulatory Care (CAAC) was founded in 2012 to highlight the ground breaking work being performed in ambulatory care settings in Canada and globally.

Our mission is to shape the future delivery of ambulatory care through research, education, practice innovations and leadership in partnership with health system providers.

Welcome to the 8th Annual Canadian Association of Ambulatory Care

Please mute all pagers and cell phones in all sessions.

<i>Registration Includes:</i>	Admittance to all main sessions, concurrent sessions, continental breakfasts, luncheons, and the poster presentation session. Your conference badge will provide you with entrance to these events. Please wear your badge at all times.
<i>Concurrent Sessions:</i>	We have a number of concurrent sessions (=2 concurrent) and will be limited to 50 participants on a first come basis. Please see program for details. We prefer if you remain for the entire session.
<i>Evaluation:</i>	We will be sending out an online conference evaluation which you will receive immediately following the event
<i>Badge Colours</i>	All presenters, delegates and executive members will be wearing badges. To help identify these groups, please look for Board Members.....Maroon Presenters.....White Delegates.....Blue Conference Planning Members.....Rose CAAC Members.....Red

MEET OUR TEAM

CAAC's Board of Executives

Denyse Henry, RN, BHA (Hons), MHM, Founder & CEO

Garry Bassi, MPharm, Vice President Communications

Ashley Hogan, BScN, RN, MScN, Vice President Secretary

Jiao Jiang RN, BScN, Vice President Education

Sameera Khatib, BHA, CRGS, RDMS, Vice President, Special Projects

Ellie Lee, BA, Vice President, Sponsorship & Special Projects

Sherrol Palmer, RN, BScN, CON(C), President

Julia Young, RN, Vice President, Finance

Jing Zhou, RN, BScN, Vice President Membership

Conference Planning Committee Members

Alison Ding

Sameera Khatib

Sarah Lezzaiq

Betty Mannino, Chair, Conference Planning
Committee

Sherrol Palmer

Kareen Williams

Julia Young

Jing Zhou



LAND ACKNOWLEDGMENT

The Canadian Association of Ambulatory Care humbly acknowledge the profound importance of the land on which we gather and meet. We are privileged to traverse and connect with the traditional territories of the many diverse Indigenous Peoples who have stewarded these lands since time immemorial.

We recognize and acknowledge that we are on the traditional territory of many nations including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee and the Wendat peoples and is now the home to many diverse First Nations, Inuit and Métis peoples. We acknowledge their longstanding relationship with this territory, which remains unceded.

As we strive to improve our relationships and play our part in reconciliation, we are committed to nurturing a safe space that uplifts Indigenous voices, helping to ensure they are acknowledged, and free from external constraints.

We are grateful to continue on this personal journey and encourage one another to reflect upon and share the stories of the land, deepen our knowledge of its traditional caretakers, and approach all aspects of cultural customs, identities and creation with respect and reverence.

CONFERENCE AT A GLANCE

Thursday, May 23

Time	Title	Location
6:00 am - 8:00 am	Vendor Set-Up	McLaughlin Auditorium Foyer
7:00 am - 3:00 pm	Registration Open	McLaughlin Auditorium, EG-18a
7:00 am - 8:00 am	Breakfast	McLaughlin Auditorium, EG-18a
8:00 am - 8:20 am	Opening Ceremonies & Greetings: Benedetta Mannino, Conference Chair Sherrol Palmer, President CAAC Denyse Henry, Founder & CEO	McLaughlin Auditorium, EG-18a
8:25 am - 9:10 am	Keynote Address: Dr. Vincent Lin Out of Africa, The Necessity of Transitioning Major Surgical Procedures to Ambulatory Care Setting	McLaughlin Auditorium, EG-18a
	Concurrent Sessions:	
9:15 am - 9:45 am	a) Anita Chin, Tabitha Chiu , Collaborative Change: A Case Study in Endoscopy b) Jamie Kroft , How Advances in Surgical Devices Can Provide Improved Ambulatory Care for Patients with Fibroids	McLaughlin Education Centre Lecture Theatre, EG-61 Harrison Hall, EG-21
9:50 am - 10:20 am	Coffee Break, Vendor Exhibits & Posters	McLaughlin Auditorium, EG-18a
	Concurrent Sessions: Choose Workshop or Presentations	
10:25 am - 12:25 pm	Workshop: Reprocessing Sponsored by SteriPro	McLaughlin Auditorium, EG-18a
10:25 am - 11:00 am	a) Kittie Pang, Dr. Karen Flemming , Advancing Primary Care Coalitions and Cultivating a People-Centred Healthcare System With SCOPE	McLaughlin Education Centre Lecture Theatre, EG-61
11:05 am - 11:40 am	a) Tabitha Chiu, Christopher Colvin , Applying a Human Factors Lens	McLaughlin Education Centre Lecture Theatre, EG-61

Time	Title	Location
11:45 am - 12:20 pm	a) Helen Razmjou, Suzanne Denis, James Falconer, Susan Robarts, Amy Wainwright, Patricia Dickson, and John Murnaghan , Improving Ambulatory Care in Patients with Osteoarthritis of the Knee and Hip joints by Utilizing a Virtual Performance Measure	McLaughlin Education Centre Lecture Theatre, EG-61
12:30 pm - 1:30 pm	Lunch Break, Vendor Exhibits & Posters	McLaughlin Auditorium, EG-18a
1:35 pm - 2:05 pm	Plenary Speaker: Lori Brady , Sunnybrook Outpatient Redesign Journey - The Development of an Outpatient Strategic Roadmap	McLaughlin Auditorium, EG-18a
	Concurrent Sessions:	
2:10 pm - 2:40 pm	a) Susan Joyce, Holly Opara , Using Integrated Care Teams to Improve Access to Primary Care b) Onyinyechukwu Esenwa, Dr. Carolyn Tan , Turning Around Endoscopy Room Turnover: Understanding Drivers of Endoscopy Unit Efficiency and Proposed Solutions	McLaughlin Education Centre Lecture Theatre, EG-61 Harrison Hall, EG-21
2:45 pm - 3:00 pm	Raffle Prizes & Conference Day 1: Closing Remarks	McLaughlin Auditorium, EG-18a
3:05 pm - 4:05 pm	AGM	McLaughlin Auditorium, EG-18a

CONFERENCE AT A GLANCE

Friday, May 24

Time	Title	Location
7:00 am - 8:00 am	Registration & Breakfast	McLaughlin Auditorium, EG-18a
8:00 am - 8:05 am	Announcements & Greetings: Benedetta Mannino, Conference Chair	McLaughlin Auditorium, EG-18a
8:10 am - 8:55 am	Day 2 - Keynote Address: Dr. Shady Ashamalla Chief General Surgery, The Rise of Colorectal Cancer in Young Adults	McLaughlin Auditorium, EG-18a
	Concurrent Sessions:	
9:00 am - 9:30 am	a) Brandon Rawn , The Cost of an Error, There is More at Stake Than Just Financial Implications b) Craig Thompson , Fairness in Complaints Handling - Ontario's Patient Ombudsman	McLaughlin Education Centre Lecture Theatre, EG-61 Harrison Hall, EG-21
09:35 am - 10:05 am	Coffee Break, Vendor Exhibits & Posters	McLaughlin Auditorium, EG-18a
	Concurrent Sessions:	
10:10 am - 10:40 am	a) Monakshi Sawhney , Return to Hospital Post-Ambulatory Surgery, The Shocking Reality and Opportunities for Change: A Population Based Cohort Study b) Adrienne Lee, Cara Macanuel, Jordanne Holland , Behavioural Supports Central Intake and the "One Team" Model: Improving Care Through Systems Level Collaborations	McLaughlin Education Centre Lecture Theatre, EG-61 Harrison Hall, EG-21
10:45 am - 11:15 am	a) Angela Shi, Summer Dong , From ICU to Ambulatory Care - Where the Canadian System Will Begin in the Future b) Amy Ng, Maria Simone , Remote Programming of Cochlear Implants Using Remote Hosted Sites in Distant Communities	McLaughlin Education Centre Lecture Theatre, EG-61 Harrison Hall, EG-21

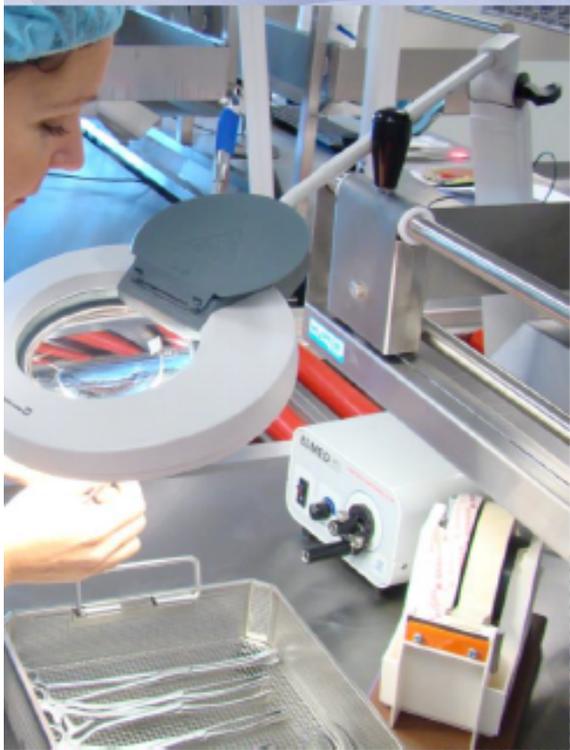
Time	Title	Location
11:20 am - 11:50 pm	a) Jan Flynn, Jaime Barajas, Jiao Jiang , Using Mobile App and Web based Technology to Promote Patient Education in the Pre-admission Clinic	McLaughlin Education Centre Lecture Theatre, EG-61
	b) Julie Sit , Quality Conversation Huddles: Integrating Teams, Facilitating Difficult Conversations About Patient Safety and Promoting Quality Improvement	Harrison Hall, EG-21
11:55 pm - 12:55 pm	Lunch Break, Vendor Exhibits & Posters	McLaughlin Auditorium, EG-18a
	Concurrent Sessions:	
1:00 pm - 1:30 pm	a) Sukhpreet Kainth , Enhancing Sexual Assault/Intimate Partner Violence, Community Partnership and Education	McLaughlin Education Centre Lecture Theatre, EG-61
	b) Grace Liu , Evaluating a New Patient Navigator Role in the Emergency Department to Help Older Adult Patients and Their Families/Caregivers in Discharge Planning and Providing Follow-Up Support (A Pilot Study)	Harrison Hall, EG-21
1:35 pm - 2:05 pm	a) Peggy So, Dione Romero, Sonya Torreiter , Transforming Care: an Evolving Response to Post-COVID Condition	McLaughlin Education Centre Lecture Theatre, EG-61
	b) Premika Premachandiran , Allied Health and Community Engagement in the Emergency Department: Review of the Sunnybrook ED1 Team	Harrison Hall, EG-21
2:10 pm - 2:40 pm	a) Naudea Mair , Opening Doors to Prevent Hospital Admission and Improve Continuity of Care: The Role of the Clinical Nurse Specialist in the Skin and Soft Tissue Infection Clinic	McLaughlin Auditorium, EG-18a
2:45 pm - 3:00 pm	Award Presentations & Closing Remarks	McLaughlin Auditorium, EG-18a

■ CAAC 2024

We would like to take this opportunity to thank our many generous sponsors for their commitment to our Association and dedication to the promotion and advancement of Ambulatory Care throughout Canada.

Platinum Level

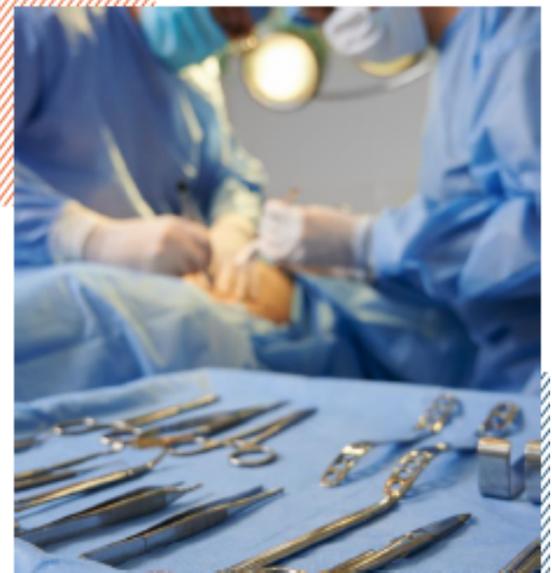




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WELCOME TO SUNNYBROOK HEALTH SCIENCES CENTRE

Sunnybrook Health Sciences Centre

2075 Bayview Ave., Toronto, ON, M4N 3M5
Tel: 416-480-6100 sunnybrook.ca



- Table 1 SteriPro
- Table 2 Endoch Medical
- Table 3 Vantage Endoscopy
- Table 4 Olympus
- Table 5 Steris

GREETINGS FROM THE PREMIER



Premier of Ontario - Premier ministre de l'Ontario

A MESSAGE FROM PREMIER DOUG FORD

Warm greetings to everyone taking part in the 8th Annual Conference of the Canadian Association of Ambulatory Care (CAAC).

Ambulatory care professionals are crucial to our health care system. The outpatient services they provide alleviate hallway health care by freeing up hospital beds for those who need them the most. They also allow patients to heal and receive treatment closer to their homes and loved ones.

This event will be a wonderful opportunity to update your knowledge with new and vital medical information, share best practices, and network with your colleagues. I thank CAAC for hosting this event, and I commend its members for their commitment to promoting the highest standards of ambulatory care.

Best wishes for a successful and productive conference.

A handwritten signature in black ink, appearing to read 'Doug Ford'.

Doug Ford
Premier

■ GREETINGS FROM THE MAYOR



Message from the Mayor

A warm welcome to everyone attending the 8th Annual Canadian Ambulatory Care Conference.

This event is a great platform for ambulatory care professionals to gather and share insights into innovations, trends and educational opportunities concerning ambulatory based healthcare and the patient experience. This year's conference theme, "The Future Design of Ambulatory Care is not in the Hospital: Leading Change Through Collaboration", highlights your essential, frontline work as a critical component of our healthcare system. Thanks to your dedicated efforts each and every day, our residents can receive dedicated, on the spot medical care across our city.

The City of Toronto extends gratitude to ambulatory care professionals, for your hard work and tireless efforts in caring for the health and well-being of our residents. Thank you for being a wonderful support that our residents can always rely on in their time of need.

On behalf of Toronto City Council, please accept my best wishes for a great conference and continued success.

Yours truly,



Olivia Chow
Mayor of Toronto

■ CAAC CEO'S MESSAGE

Dear colleagues and guests,

Welcome to Toronto and the CAAC 2024 Conference.

One of the priorities for the CAAC is for patients to have access to the right care, in the right place, at the right time. We know that hospitals are appropriate for some patient care but is often not the best place for many patients whose needs are better met in the comfort of their homes. Delivering this will mean supporting more patient-centred access to care closer to home that is delivered in a much more integrated way. We know that long stays in hospital are not good for patients and can lead to poor health and economic outcomes. Recent studies have shown that discharge delays have increased since the pandemic resulting in patients in a hospital bed longer than they need to be: Discharge planning must be made a healthcare priority and should begin when patients are initially admitted to hospital to ensure that they can go home or are transferred to an appropriate setting as soon as possible. This process requires collaboration with social care partners to ensure the right processes are in place to facilitate prompt discharges.



I am confident that as a result of attending the CAAC conference you will be able to gain a greater insight into what other providers are doing within Canada and globally to move care closer to home for patients.

Care closer to or at home without the need for hospital admission is not only often more convenient for patients, but with timely access can help avoid the reconditioning and prolonged recovery that can accompany a hospital stay. The CAAC is committed to working with our members and stakeholders to strengthen this process for our patients.

This year's conference brings together the very best ambulatory care experts in one forum. I look forward to meeting you all for our innovative and transformational sessions. Take advantage of this knowledge translation event and network to enhance the care being provided to patients.

Sincerely,

Denyse Henry

Denyse Henry
Founder & Chief Executive Officer, CAAC

■ CAAC PRESIDENT'S MESSAGE

Welcome back!

The last 4.5 years have been traumatic for us all on many levels. We have seen a global pandemic, the development, testing and implementation of vaccines in record time and the sacrifices of healthcare workers everywhere. We have also witnessed the vulnerability of our healthcare system, the impact of the pandemic on marginalized communities and raising the cover off the disparities in our cities and country. In many places wearing a mask became a political statement and a reason for confrontation and violence.



As we emerge from the pandemic and look to the future, we are moving toward new models of care and settings to address the backlog of procedures and surgeries. CAAC continues our mission to shape the future delivery of ambulatory care through leadership, research, education and proactive innovation.

At this conference you will find answers to your questions about what you can do in ambulatory settings. We have worked hard to bring you a program that shows innovation and caring dedication by healthcare professionals. I know you will find answers to your questions and ideas to address the issues at your institution. Ask questions, seek out other experts and ask for feedback from your fellow delegates.

The Association is looking forward to a bright future, helping our members and healthcare professionals contribute to the innovation in ambulatory care and recognize how it contributes to the future of healthcare.

Thank you to our Sponsors, Planning Committee, Board members and friends of the CAAC.

Enjoy and I look forward to meeting you.

Sincerely,

Sherrol Palmer Wickham

Sherrol Palmer Wickham
President, CAAC

■ CAAC CONFERENCE CHAIR MESSAGE

Dear Friends,

Welcome to the 8th Annual Canadian Association of Ambulatory Care Conference(CAAC). It is my pleasure to host this year's conference in beautiful Toronto, Ontario. Together with our dedicated group of CAAC board and conference committee members, staff and volunteers, I am honoured to serve as your chair for the 2024 season.



Our focus is [“The Future Design of Ambulatory Care is Not in the Hospital: Leading Change Through Collaboration”](#) From our outstanding itinerary of presenters and sponsors, we strive to provide you with thought provoking and transformational seminars. Our aim is to dispel some myths surrounding mental health, engage you with technology, and heighten your cultural awareness through demonstration of tools and resources that our speakers have found exceptionally helpful.

To accomplish this goal, I encourage your active participation in the various activities we have organized. I sincerely hope you have an enjoyable and rewarding experience. On behalf of the CAAC, please accept our Thanks for making us a part of your journey to transform and reinvent Ambulatory Care outside of the hospital setting.

Warm Regards,

Betty Mannino

OUR CONFERENCE HIGHLIGHTS

The Future Design of Ambulatory Care is Not in the Hospital



Presentations

Concurrent Symposiums — Thematic presentations as part of group/panel



Developing Solutions

Harnessing technology and our work force using new innovative approaches



Keynote Speakers

Inspiring the transformation of our future in healthcare



Networking

Educating, empowering, enabling our leaders of today for the future of tomorrow

DISTINGUISHED GUEST SPEAKERS



Vincent Lin MD, FRCSC

Professor, Associate Scientist

*Department of Otolaryngology - Head & Neck
Surgery, Sunnybrook Research Institute*

*Sunnybrook Cochlear Implant Program, Biological
Sciences, Hurvitz Brain Sciences Research Program
Faculty of Medicine, University of Toronto*



Shady Ashamalla MD, FRCSC

Professor, Associate Scientist

*Department of General Surgery - Surgical Oncology
Sunnybrook Research Institute*

Faculty of Medicine, University of Toronto



Lori Brady, Vice President,

Community Integration,

Partnerships, and

Ambulatory Care,

Sunnybrook Health Sciences

Centre

AGENDA: THURSDAY MAY 23, 2024

Registration & Breakfast

Location: McLaughlin Auditorium, EG-18a

7:00 am - 8:00 am

Opening Ceremonies:

Location: McLaughlin

Auditorium, EG-18a

8:00 am - 8:20 am



The Future Design of Ambulatory Care is Not In the Hospital:
Leading Change Through Collaboration

Denyse Henry, *CAAC Founder & CEO*

Sherrol Palmer-Wickham, *President CAAC*

Benedetta Mannino, *Conference Chair*

Opening Keynote Address

Location: McLaughlin Auditorium EG-18a

8:25 am - 9:10 am

Dr. Vincent Lin, *MD, FRCSC Professor, Associate Scientist*

Dept of Otolaryngology – Head & Neck Surgery,

Sunnybrook Research Institute

Sunnybrook Cochlear Implant Program, Hurvitz Brain



*Sciences Program
Faculty of Medicine, University of Toronto*

Dr. Lin is an Otolaryngologist/Head and Neck Surgeon, a Fellow at the Royal College of Surgeons of Canada and a Professor in the Department of Otolaryngology - Head and Neck Surgery, Temerty Faculty of Medicine at the University of Toronto.

He obtained his medical degree at Queen's University and completed a 5 year residency in Otolaryngology - Head and Neck Surgery. Dr. Lin subsequently completed a clinical fellowship in Otology-Neurotology at Sunnybrook Health Sciences Centre, University of Toronto. Further research fellowship was also performed in hair cell regeneration at the University of Washington, Virginia Merrill Bloedel Hearing Research Centre.

Dr. Lin's clinical and surgical focus is on otologic and neurotologic conditions such as vertigo and hearing loss. He is an accomplished Otologist/Neurotologist at Sunnybrook Health Sciences Centre with a surgical practice consisting of lateral skull base tumors, cochlear implants, auditory implants and mastoid and middle ear surgical diseases.

Dr. Lin's research focus is also on auditory & vestibular hair cell regeneration, cochlear implants and corticosteroid pharmacokinetics and inner ear effects.

He has a clinical appointment as an Associate Scientist at Sunnybrook Research Institute in The Hurvitz Brain Sciences Research Program and also holds an Associate Member appointment in the Institute of Medical Science, University of Toronto.

Dr. Lin is a member of the examination committee on the Royal College of Surgeons & Physicians of Canada for Otolaryngology – Head & Neck Surgery and is the Otolaryngology clinical lead for Cancer Care Ontario and the Chair of the Section of Otolaryngology – Head & Neck Surgery at the Ontario Medical Association.

Concurrent Session 1 (choose A or B)

9:15 am - 9:45 am

Concurrent Session 1A

9:15 am - 9:45 am

Location: McLaughlin Education Centre Lecture Theatre, EG-61

1A) Collaborative Change: A Case Study in Endoscopy

Anita Chin, BSc, BScN, MN, RN, Sinai Health System, **Tabitha Chiu**, BEng, MHSc, Sinai Health System

Learning Objectives and Outcomes: Case study demonstrating a multidisciplinary, collaborative investigative approach to a quality and process improvement initiative

Abstract: Objective. A multi-disciplinary team at Mount Sinai Hospital, Toronto, Canada, was formed between Endoscopy, Medical Device Reprocessing Department (MDRD), Infection Prevention and Control (IPAC), Biomedical Engineering and Human Factors to investigate three instances of unexpected fluid exiting the air port of the scope. Together with the support of our executive leaders and by applying a collaborative approach to our investigations, changes to equipment use and supplies were made to improve clinical practices, optimize processes and mitigate risks to patient safety.

Method/Results. Investigations were implemented to understand the source of fluid. This included process mapping and human-system interaction risk identification of Endoscopy reprocessing, drying equipment, scope equipment and procedure room areas by MDRD with the support of our IPAC and Human Factors team. A review of equipment Instructions For Use (IFU) documentation was conducted by Biomedical Engineering with the support of our vendor product engineers to ensure alignment with vendor label usage. Through testing of the tubing system used for irrigation and lens cleaning by Biomedical Engineering and Human Factors, it was identified that the tubing system design has implications to mitigate risks for inappropriate water infiltration and back flow of fluid. While the investigation was ongoing, interim safety measures were applied operationally with our clinical teams to ensure staff and patient safety. The investigation followed a systematic delineation of potential contributing factors, which allowed interim safety measures to be adjusted accordingly, but required clinical teams to pivot frequently. Ongoing engagement from physician and nursing

teams was a significant factor to successfully continuing smooth operations during the investigation.

Conclusions / Audience Takeaways. This case study demonstrated a multi-faceted investigation approach that was systematic and has potential to be translated into a framework for addressing incidences or implementing quality improvements. The comprehensive nature of the investigation resulted in better understanding the components of the equipment needed to support clinical practice while mitigating potential risks. Moreover, our experiences in collaborating together has led to a more holistic vendor engagement

Contributors (Sinai Health System): Jonathan Ayres, Garry Bassi, Andrew Cheung, Anita Chin, Tabitha Chiu, Nima Esmailzadeh, Myren Mendoza, Andrea Morillo, Kamran Samanian

Concurrent Session 1B

9:15 am - 9:45 am

Location: Harrison Hall, EG-21

1B) How Advances in Surgical Devices Can Provide Improved Ambulatory Care for Patients with Fibroids

Jamie Kroft, MD, FRCSC, LL.D, Sunnybrook Health Sciences Centre, Women's College Hospital

Uterine fibroids are one of the most common types of benign pelvic tumours, estimated to affect up to 70% of biologically female patients, causing heavy menstrual bleeding, "bulk symptoms" such as pelvic pressure, urinary and gastrointestinal symptoms, along with infertility.

Hysteroscopy is one type of surgical treatment for fibroids that can treat small fibroids (<5cm) that extend into the uterine cavity. These procedures have been historically performed in the operating room under general anaesthesia. However, ambulatory hysteroscopy using local anaesthesia and/or sedation has been made possible by using smaller hysteroscopes with different mechanisms for tissue removal. This presentation will review the newer ambulatory options which have equal treatment success and are substantially less expensive than hysteroscopy performed in the OR.

Most fibroids cannot be treated with hysteroscopy and require an inpatient surgical

procedure called myomectomy. Recently, laparoscopic radiofrequency ablation (LPA-RFA) has been introduced as a novel day surgery procedure that uses a special dual electro-surgical probe with an attached ultrasound device that identifies and treats fibroids at the same time. Patients treated with LPA-RFA have a shorter duration of hospital stay, lower intra-operative blood loss, shorter recovery time and low surgical reintervention rate compared to myomectomy. This presentation will also discuss the benefits of this new intervention compared to traditional myomectomy and how this can provide patients with improved access to an outpatient treatment option.

Coffee Break & Exhibits - Sponsored by Endoch Medical 9:50 am - 10:20 am

Location: McLaughlin Auditorium, EG-18a



Concurrent Session (choose Workshop or Presentation)

10:25 am - 12:25 pm

Workshop Session: 10:25 am - 12:25 pm

SteriPro

Location: McLaughlin Auditorium, EG-18a



Topics and description of workshop:

- a. Detergent study results and how it improves efficiency and quality while reducing costs
- b. Case study AOAO

c. The top issues in an MDRD and what you need to look out for

Ajay Jain, Chief Business Development Officer

Tom GAO, Director of Business Development

Afshin Yousefi, Plant Manager (Speaker)

Anas Aljabo, Chief Scientist (Speaker)

Gino Picciano, former CEO of The Ottawa Hospital (Speaker)

Concurrent Session 2 (choose Workshop or A)

10:25 am - 11:00 am

Concurrent Session 2A:

10:25 am - 11:00 am

Location: McLaughlin Education Centre Lecture Theatre, EG-61

2A) Advancing Primary Care Coalitions and Cultivating a People-Centred Healthcare System with SCOPE

Kittie Pang, MHA(CC), **Karen Fleming**, B.Sc. (Hons), MD, M.Sc. CCFP, FCFP

Primary Care is widely acknowledged as the cornerstone for authentic system integration in healthcare (Ontario Ministry of Health, 2022). Historically, however, collaboration with Primary Care has been hampered by fragmentation due to the absence of a unified Primary Care organization (Misra et al., 2020). Enter the Seamless Care Optimizing Patient Experience (SCOPE), a pioneering virtual interdisciplinary team designed to foster relationships and trust within the broader healthcare system. SCOPE functions as a barometer, alerting stakeholders to the specific needs of Primary Care. This article explores SCOPE's innovative role in connecting solo and small group practice primary care providers (PCPs), hospitals, and communities in Ontario.

The effectiveness of team-based primary care models like SCOPE in enhancing patient outcomes and reducing Emergency Department visits and avoidable hospitalizations is substantiated by robust evidence (Pariser et al., 2019). The grassroots development of SCOPE involves a strategic partnership with Sunnybrook hospital, leveraging its support to address the unique needs and barriers faced by local PCPs. This includes enhancing access to specialists, home care, and system navigation. Detailed tracking of engagement with Sunnybrook SCOPE informs continuous improvement and expansion of SCOPE pathways. Communication channels, such as phone, email, social media, and office visits, facilitate comprehensive insight into PCPs' workflows and administrative

challenges. Continuous feedback mechanisms, including surveys, interviews, and regular meetings with the Physician Advisory Group (PAG), contribute significantly to shaping SCOPE's evolution.

As SCOPE expands across Ontario, gaps in standardized core offerings become apparent, necessitating a nuanced understanding of local contexts and Primary Care needs. This program evaluation employs Quality Improvement (QI) surveys and interviews to glean insights from both Sunnybrook SCOPE users and their patients. These highlight SCOPE's efficacy in addressing care needs while pinpointing areas for further investigation. QI interviews with SCOPE PCPs delve into reasons behind pathway usage, identify care barriers, and propose enhancements for future utilization. Findings emphasize the importance of bi-directional communication and codesign with stakeholders. Recognizing the absence of a universal approach to health system integration with Primary Care.

SCOPE's commitment to adapting to local contexts makes it an adaptable model for international audiences. SCOPE's commitment to building trust through a community of practice, service-oriented approaches, and regular communication positions it as a progressive force in advancing primary care (Pariser et al., 2019). The next phase involves standardizing core elements across SCOPE sites and establishing a platform for PCPs to openly share challenges, fostering an environment of honest collaboration. In conclusion, SCOPE stands as a transformative initiative, navigating the intricate landscape of Primary Care, fostering collaboration, and contributing to the evolution of a people-centred healthcare system.

Reference: Ontario Ministry of Health (2022).

Ontario Health Teams: The Path Forward. Retrieved from the Ontario Ministry of Health Website: https://www.health.gov.on.ca/en/pro/programs/connectedcare/oht/docs/OHT_path_forward.pdf

Misra V, Sedig K, Dixon DR, Sibbald SL. Prioritizing coordination of primary health care. *Can Fam Physician*. 2020 Jun;66(6):399-403. Erratum in: *Can Fam Physician*. 2020 Aug;66(8):554. Erratum in: *Can Fam Physician*. 2020 Aug;66(8):554. PMID: 32532718; PMCID: PMC7292521.

Concurrent Session 3 (choose workshop or A)

11:05 am - 11:40 am

Concurrent Session 3A:

11:05 am - 11:40 am

Location: McLaughlin Education Centre Lecture Theatre, EG-61

3A) Applying a Human Factors Lens

Tabitha Chiu, *BEng, MHSc, Sinai Health System*, **Christopher Colvin**, *Sinai Health System*

Learning Objectives and Outcomes:

What is human factors, human factors engineering, and user-centred design and why are these important to patient safety?

How has human factors principles and methodologies been applied in hospital ambulatory care settings at Sinai Health System?

How can you incorporate human factors principles and methodologies into your work?

Abstract: Human Factors is an essential field in safety critical industries including aviation, nuclear energy, military and transportation. However, the importance of applying human factors in hospital organizations is only more recently being recognized. As such, there are very few guidelines on how human factors should integrate within hospital operational activities, and what, and when human factors methodologies should be applied to fast-paced, complex healthcare operations. Moreover, the highly structured, time and resource-intensive, user-centred methodologies and research applied in other industries often needs to evolve and adapt to address hospital constraints and rapid assessment and recommendation development requirements.

Sinai Health System, a large tertiary hospital in Toronto, Canada, began its journey of integrating human factors into its operations in 2017. As Sinai Health is undergoing a multi-year redevelopment project, where most of its facilities and clinical units will be completely redesigned and rebuilt, human factors principles were first integrated in facility redevelopment activities. The goal was to proactively build safety and quality into system design by bringing human factors perspectives into the collaborative design process. Today, a team of three human factors practitioners are continuing to infuse human factors engineering principles and practices into an every growing number of hospital initiatives focused on new space and process design, technology implementation, and patient safety and quality improvement. With the intent of

enhancing safety and usability in the design of work systems and technologies, human factors is a lens that assesses systems, considering the characteristics, capabilities and limitations of humans.

This talk showcases how human factors principles and methodologies have been incorporated into Sinai Health ambulatory settings' change initiatives to support quality care practices. Specifically, examples are drawn from areas of new unit construction, process design, incident investigation and new technology implementation. Human factors follows a collaborative approach that is system-focused, rather than individual-focused, to develop meaningful, effective system changes. By routinely applying human factors concepts to address issues related to delivering safe care to patients, hospitals will become more resilient as user-centric technologies and workflows are implemented to make patient care more streamlined and efficient.

Concurrent Session 4 (choose workshop or A)

11:45 am - 12:20 pm

Concurrent Session 4A:

11:45 am - 12:20 pm

Location: McLaughlin Education Centre Lecture Theatre, EG-61

4A) Improving Ambulatory Care in Patients with Osteoarthritis of the Knee and Hip joints by Utilizing a Virtual Performance Measure

Helen Razmjou, PT, PhD, Advanced Practice Physiotherapist, **Suzanne Denis**, MSc, PT, **James Falconer**, **Susan Robarts**, BSc, BHSCPT, MSc, **Amy Wainwright**, MSc, PT, **Patricia Dickson**, MSC, OT, **John Murnaghan**, MD, FRCSC

Purpose: The purpose of this study was to examine the reliability and validity of a virtual performance measure (VPM) in patients with osteoarthritis of the hip and knee joints who were referred to the Rapid Access Clinic at the Holland Centre for consideration of arthroplasty surgery.

Methods: The VPM score was based on the results of 10 videos showing increasing difficulty in performing specific functional tasks. Patients watched 40 videos and chose the one that best reflected their own level of function. Self-report measures were the

lower extremity functional score (LEFS) and pain scale. Performance-based measures were the 30-second Chair Stand Test and the 40-meter fast-paced walk test.

Results: Data of 200 patients (100 knee OA and 100 hip OA), 134 (67%) females, mean age: 66 ± 8 were examined. Internal consistency of the VPM total score was 0.88 and 0.90 in hip and knee OA respectively, reflecting good and excellent values. Moderate correlations were observed between the VPM total score self-report scores in both samples. Factor analysis showed different patterns of underlying structure of data, depending on the site of joint involvement. Similarly, performance measures showed different patterns of correlations with the VPM score depending on the site of joint involvement. Both VPM and LEFS outcomes were able to differentiate between candidates and non-candidates for arthroplasty.

Conclusions: The VPM is a reliable and valid virtual outcome measure in patients with osteoarthritis of the hip and knee joints. Digitally based outcome measures facilitate ambulatory care through remote measurement of functional difficulties where in-person assessment may not be possible, or can allow patients to provide relevant performance-based information in advance of in-person visits to optimize the visit.

Lunch & Poster Presentations 12:30 pm - 1:30 pm

Location: McLaughlin Auditorium, EG-18a

Sponsored by: SteriPro



Visit Poster Presentation and Sponsor Booths

Plenary Speaker 1:35 pm - 2:05 pm

Location: McLaughlin Auditorium EG-18a

Sunnybrook Outpatient Redesign Journey - The Development of an Outpatient Strategic Roadmap

Lori Brady, BA, MScPT, MHSc, Vice President Community Integration, Partnerships and Ambulatory Care, Sunnybrook Health Sciences Centre



Concurrent Session 5 (choose A or B)

2:10 pm - 2:40 pm

Concurrent Session 5A:

2:10 pm - 2:40 pm

Location: McLaughlin Education Centre Lecture Theatre, EG-61

5A) Using Integrated Care Teams to Improve Access to Primary Care

Susan Joyce, MD, CFPC, PCN Lead, MDPAC(C), Primary Care Network Co-Lead, North Toronto Health Team

The City of Toronto is facing unprecedented challenges in meeting the health care needs of its residents due to a significant reduction in the number of family physicians providing comprehensive primary care. Many family doctors are reducing their practices or retiring early due to burn-out with a high administrative workload (average of 19 hours per week) or because of significant rent increases in a rapidly growing city. In addition, fewer new graduates are practicing comprehensive family medicine. Over 20% of patients attending our local Emergency Department have no family doctor. The

creation of integrated health hubs with improved access to team based care will be effective in delivering the right care in the right place.

Leveraging data available to the North Toronto Ontario Health Team (NT OHT), an analysis was completed to define the primary care gap in North Toronto. Using a Population Health Management approach, we learned that the unmet primary care gap in North Toronto will increase by 73% by 2026, due to population growth and fewer family doctors. Over 80% of our family doctors do not have access to interprofessional healthcare providers (IHPs), the lowest in the Toronto area.

To ensure access to primary care for our residents, a strategy was developed with the goal of ensuring every NT OHT resident has access to team-based primary care. This will be achieved by attracting and retaining physicians by improving access to IHPs locally. The first phase of the strategy is the creation of two Integrated Health Hubs. These Health Hubs will recruit primary care providers to support 20,000 unattached patients, along with IHPs that are needed to support this population. In the future, the IHPs at the Health Hubs will be expanded to support and retain local primary care providers and their patients, who do not have access to teams. Furthermore, the IHPs will also provide care to seniors living in seniors buildings in our local community, to support earlier intervention for our senior population with rising care needs.

The Integrated Health Hub will be the foundation for this model of care. In addition to team-based supports, other specialties and support services on-site will also be explored to improve access (one-stop shop experience for patients), with the potential to reduce the cost of business for primary care providers. The Hubs will also provide back-office supports for primary care as a way of reducing the administrative burden. It is anticipated that these supports will enable larger rosters per doctor, helping to reduce the access issues currently facing our system.

A robust plan is in place to guide the development of Integrated Health Hubs, including Vision and Advocacy, Care Model and Operations, Space and Capital, Partnerships and Engagement. The NT OHT is working closely with all stakeholders, including primary care providers and local community members, in the development of the Integrated Health Hubs in North Toronto. This is a key foundation that will enable improvement in access to primary care, making practice easier for our providers, and making life easier for the residents of the NT OHT.

Concurrent Session 5B:

2:10 pm - 2:40 pm

Location: Harrison Hall, EG-21

5B) Turning Around Endoscopy Room Turnover: Understanding Drivers of Endoscopy Unit Efficiency and Proposed Solutions

Onyinyechukwu Esenwa, BSc, Medical Student, **Carolyn Tan**, MD Internal Medicine

Background: Endoscopy units are being challenged to provide timely and quality care, despite limited resources and an ever-growing patient population. Decreasing procedure time is unlikely to yield sufficient time savings and may compromise quality. Non-procedural factors, such as room turnover, play a crucial role in efficiency and are prime targets for quality improvement initiatives.

Aims: 1) Understand practices at local hospitals that contribute to room turnover efficiency, 2) Examine the magnitude and sources of variation in room turnover efficiency at Sunnybrook Health Sciences Centre (SHSC), and 3) Streamline and optimize a solution to assist with obtaining informed consent process for colonoscopies.

Methods: Interviews were conducted with team leads at five Toronto hospitals. Routinely collected data from SHSC were analyzed to understand the magnitude and variation in efficiency by provider and reasons for delays. Non-procedure time (NPT) defined as the duration from 'patient 1 scope out' to 'patient 2 scope in' served as the primary measure of efficiency. Direct observation of endoscopy cases was completed to identify contributors to variation in efficiency. To address a key contributor, a brief video was created describing colonoscopy and its potential risks and benefits. Using a critical case sample design with maximum variation, 12 participants were recruited to view the video and complete pre- and post-1:1 semi-structured interviews using learner verification and revision principles. Qualitative analysis is underway.

Results: Over a 12-month period, 750 outpatient procedures met inclusion criteria. The median NPT for the unit was 19 min, ranging from 13.5-23 min across endoscopists. Three main contributors to inefficiency were identified: incomplete consent forms, endoscopist availability, and patient-related delays, with incomplete consents representing a significant proportion of delays. Subsequently, a video was created to expedite the consent process. Preliminary findings from the qualitative analysis of participant responses to the video will be presented.

Conclusions: Turnover times at SHSC are similar to those reported by other local centres, with notable variation across endoscopists. Incomplete consent forms and patient-related delays may be addressed by providing information via video to patients scheduled for colonoscopy to supplement current approaches to informed consent.

Raffle & Prizes 2:45 pm - 3:00 pm

Location: McLaughlin Auditorium EG-18a

AGM

Location: McLaughlin Auditorium, EG-18a

3:05 pm - 4:05 pm

■ AGENDA: FRIDAY MAY 24, 2024

Registration & Breakfast 7:00 am - 8:00 am

Location: McLaughlin Auditorium EG-18a

Announcements & Greetings 8:00 am — 8:05 am

Location: McLaughlin Auditorium, EG-18a

Benedetta Mannino, *Conference Chair*

Day 2 Opening Keynote Address

Location: McLaughlin Auditorium EG-18a

8:10 am - 8:55 am

Dr. Shady Ashamalla, MD, FRCSC

Professor, Associate Scientist

Department of General Surgery - Surgical Oncology

Sunnybrook Research Institute

Faculty of Medicine, University of Toronto

Dr. Shady Ashamalla is a surgical oncologist at Sunnybrook's Odette Cancer Centre with special expertise in minimally invasive surgery for cancers of the lower gastrointestinal tract. He also has extensive academic experience in surgical education and surgical simulation.



Dr. Ashamalla's practice is completely devoted to lower gastrointestinal cancer surgery, and he strives to advance minimally invasive approaches in cancer surgery. He has

been appointed to the University of Toronto as an Assistant Professor and surgeon educator, with academic interests in surgical simulation and knowledge translation.

Dr. Shady Ashamalla obtained his undergraduate Honours degree from the University of Guelph in Biomedical Sciences followed by a Master of Science degree at Queen's University. He then completed his medical degree and a residency in General Surgery at the University of Toronto. Dr. Ashamalla then went on to complete advanced fellowship training in both Minimally Invasive Surgery and Surgical Oncology.

Concurrent Session 1 (choose A or B)

9:00 am - 9:30 am

Concurrent Session 1A:

9:00 am - 9:30 am

Location: McLaughlin Education Centre Lecture Theatre, EG-61

1A) The Cost of an Error: There is More at Stake Than Just Financial Implications

Brandon Rawn

When an error occurs, there is more at stake than just financial implications. This presentation reviews the contributing factors to how errors occur in medical device reprocessing, focusing on human factors and how to implement thoughtful correct actions.

Concurrent Session 1B:

9:00 am - 9:30 am

Location: Harrison Hall, EG-21

1B) Fairness in Complaints Handling - Ontario's Patient Ombudsman

Craig Thompson BAsC, MHSc. *Health Administration, Patient Ombudsman*

Patient Ombudsman is an impartial organization whose role is to help resolve complaints from current or former patients, residents and their caregivers about experiences in Ontario's public hospitals, long-term care homes, home and community

care services, and soon integrated community health services centres as well. Patient Ombudsman works with both sides to reach a fair resolution.

In this presentation, Patient Ombudsman will provide an overview of the office's role, mandate, jurisdiction and complaints process. Participants will gain an understanding of how Patient Ombudsman uses fairness principles in its resolution process to address complaints about negative health care experiences; at what point patients and caregivers should contact Patient Ombudsman; and how the office helps patients and caregivers navigate complaint processes across the health care sector.

Participants will gain a better understanding of how Patient Ombudsman works with all sides (patients/caregivers and health sector organizations) to address common complaints.

Understanding the role Patient Ombudsman plays in the health care system, as well as the most common complaint themes, will enable participants to better address patient and caregiver concerns, and to proactively address common complaints. Learning about what to expect when a complaint is made to Patient Ombudsman will allow for improved complaints handling and better outcomes.

Coffee Break & Exhibits - Sponsored by Stryker

Location: McLaughlin Auditorium, EG-18a

9:35 am - 10:05 am



stryker

Concurrent Session 2 (choose A or B)

10:10 am - 10:40 am

Concurrent Session 2A:

10:10 am - 10:40 am

Location: McLaughlin Education Centre Lecture Theatre, EG-61

2A) Return to Hospital Post-Ambulatory Surgery, The Shocking Reality and Opportunities for Change. A Population Based Cohort Study

Monakshi Sawhney, PhD, NP(Adult), Nurse Practitioner & Associate Professor, Queen's University

Introduction: Advances in healthcare delivery have allowed for the increase in the number of ambulatory surgery procedures performed in Canada. Despite these advances, patients return to hospital following discharge. However, the reason for unplanned healthcare use after ambulatory surgery in Canada is not well understood.

Aim: To examine unplanned healthcare use, specifically emergency department visit and hospital admissions, in the 3 days after ambulatory surgery in Ontario, Canada for adults and children.

Method: This population-based retrospective cohort study was conducted using de-identified administrative databases. Participants were residents in the province of Ontario, Canada; and underwent common ambulatory surgical procedures between 2014 and 2018. The outcomes included emergency department (ED) visit and hospital admission. Incidence rates were calculated for the total cohort, for each patient characteristic and for surgical category. The odds ratios and 95% confidence intervals were calculated for each outcome using bivariate and multivariate logistic regression.

Results: 484,670 adults underwent select common surgical procedures during the study period. Patients had healthcare use in the first 3 days after surgery, with 14,950 (3.1%) ED visits and 14,236 (2.9%) admissions. The incidence of ED use was highest after tonsillectomy (8.1%), cholecystectomy (4.2%) and appendectomy (4.0%). Incidence of admissions was highest after appendectomy (21%). Acute pain (19.7%) and haemorrhage (14.2%) were the most frequent reasons for an ED visit and "convalescence following surgery" (49.2%) followed by acute pain (6.2%) and haemorrhage (4.5%) were the main reasons for admission. 83 468 children underwent select ambulatory surgeries. 2588 (3.1%) had an ED visit and 608 (0.7%) had a HA in

the 3 days following surgery. The most common reasons for ED visits included pain (17.2%) and haemorrhage (10.5%). Reasons for HA included haemorrhage (24.8%), dehydration (21.9%), and pain (9.1%).

Conclusions: These findings can assist clinicians in identifying and intervening with patients at risk of healthcare use after ambulatory surgery. Implementing approaches to prevent, identify and manage these symptoms may be helpful in reducing ED visits or hospital admissions.

Pain management strategies that can be tailored to the patient, and earlier follow-up for some patients may be required. In addition, administrative decision-makers could use the results to estimate the impact of specific ambulatory procedures on hospital resources for planning and allocation of resources.

Concurrent Session 2B:

10:10 am - 10:40 am

Location: Harrison Hall, EG-21

2B) Behavioural Supports Central Intake and the "One Team" Model: Improving Care Through Systems Level Collaborations

Adrienne Lee, *MSc OT Reg. (Ont.), MSc(Psych)*, **Cara Macanuel**, *CBSOT Clinician*, **Jordanne Holland**, *Clinical Director CAMH*, **Lauren Masci**

Introduction: Toronto Central (TC) Region's Behavioural Supports Ontario (BSO) programs have expanded in response to a growing need for behavioural supports for clients living with dementia. Formed in 2020, the Behavioural Supports Coordinating Office set out to meet the growing demand by centralizing system level flow and triage, and optimizing continuity of care and transitions between sectors. The Central Intake of all regional Behavioural Supports programs has involved close collaboration and partnership with multiple external partners in all sectors. Additional expansion of the TC Region's Behavioural Supports includes the Behavioural Support Outreach Team (BSOT) "One Team" Care Model, where clinicians now move freely between supporting clients in the community, and clients in the LTC sector, instead of being siloed to one sector. This new model has allowed for greater capacity to support intersectoral transitions, and further opportunities for collaboration with external partners.

Results: Since the implementation of Central Intake and Triage for all Behaviour Support programs in the region, we have increased referrals processed, and referrals redirected and supported. Since the expansion of BSOT services, there has been an increase in the number of transitions that we facilitated across a combination of different sectors (Acute care, Community, LTC, Tertiary care).

Conclusion: Starting as a system navigation Hotline in 2020, the Behaviour Supports Coordinating Office has become a central resource to provide wrap-around behavioural support and triage in the TC Region, as well as supportive resources for behavioural system navigation beyond the TC Region. The “One Team” BSOT expansion has also resulted in more seamless transitions for clients between the Community and LTC sectors. Future directions for the BSO Coordinating Office and BSOT programs include:

- Maintaining and building partnerships across the TC region and provincially.
- Reducing wait times and improving access and flow to BSO services across sectors
- Service coordination and improving transitions between sectors.
- Expanding partnerships with Provincial BSO organizations; creating closer connections between behavioural units in the TC region and those throughout the province.
- Ontario Health funding has been provided to further expand the “One Team” model of behaviour support services into Scarborough (in the legacy Central East region).

Concurrent Session 3 (choose A or B)

10:45 am - 11:15 am

Concurrent Session 3A:

10:45 am - 11:15 am

Location: McLaughlin Education Centre Lecture Theatre, EG-61

3A) From ICU to Ambulatory Care —Where the Canadian System Will Begin in the Future

Angela Shi RN BScN, Clinical Manager *myHealth Medical Centre*, **Summer Dong**

Did you know that shortness of breath is a potential sign of chronic obstructive pulmonary disease (COPD)? Don't ignore these small symptoms! Although it might

sound scary COPD is a chronic respiratory condition that develops slowly over time and causes airflow limitations and lung damage eventually. The Public Health Agency Of Canada reports that over 2 million Canadians are living with COPD. Individuals with COPD may struggle to participate in daily activities, including work and social interactions, furthermore, there is a cumulative effect in terms of healthcare costs and missed productivity. Hospitalization rates for COPD have been increasing over time and the economic burden of the disease is estimated to cost \$1.5 billion annually to the Canadian healthcare system.

However, early intervention with ambulatory care can readily alleviate all of these financial burdens caused by COPD on the healthcare system and individuals. It is true. Patients' clinical outcomes can be significantly enhanced with only a routine visit to the family doctor and early intervention; this also spares patients from suffering in the ICU for an extended period of time with unknown outcomes. Additionally, COPD-related healthcare expenses can be substantially decreased. Studies indicate that the cost of early COPD intervention with ambulatory care will be \$700 million, which is less than half of the original cost of \$1.5 billion. So the future of the Canadian system is not ICU in the hospital site, but instead, it starts with ambulatory care now.

Concurrent Session 3B:

10:45 am - 11:15 am

Location: Harrison Hall, EG-21

3B) Remote Programming of Cochlear Implants Using Remote Hosted Sites In Distant Communities

Amy H.C. Ng, M.Sc., Reg CASLPO, Audiologist, Sunnybrook Health Sciences Centre,
Maria Simone, BSc(Hon), MSc. Sunnybrook Health Sciences Centre

Cochlear implants have helped many people hear when conventional hearing aids can no longer help. After the patient's surgery to receive the implant, the externally worn speech processor must be adjusted and customized to fit the patient's needs to optimize outcomes. There are typically 6 in person follow up sessions for adjusting the speech processor in the first year.

Problem: Approximately 6% of our patients are from North East and North West LHINs. These patients must travel long distances to receive cochlear implant services.

The costs and resources and physical ability required to make this trip can become barriers to services.

Objective: We will assess remote programming of cochlear implants for feasibility, satisfaction of results and ease of use.

Method: A total of 8 clinics located outside of the GTA were recruited as remote host sites. These sites were provided with cochlear implant programming hardware and software so that cochlear implant users (N=19) could attend their facility for a programming appointment that would typically take place in person at Sunnybrook Health Sciences Centre. The Sunnybrook cochlear implant audiologist used teleconferencing software to remotely control the host sites' computer to make adjustments to the subjects' speech processors. This session was facilitated at the remote site by one of their staff members. All participants including the cochlear implant user, cochlear implant audiologist, and remote site staff facilitator were asked to fill out a questionnaire following their initial experience with remote programming of a cochlear implant.

Results: Results indicated that this method of remote cochlear implant programming was feasible as clinical service delivery model and yielded high user satisfaction for all participants.

Conclusion: Remote programming of cochlear implants using remote hosted sites has been implemented as a clinical service offering at Sunnybrook.

Concurrent Session 4 (choose A or B)

11:20 am - 11:50 am

Concurrent Session 4A:

11:20 am - 11:50 am

Location: McLaughlin Education Centre Lecture Theatre, EG-61

4A) Using Mobile App and Web based Technology to Promote Patient Education in the Pre-admission Clinic

Jan Flynn RN BSc (*Nurse in Charge*), **Jaime Barajas**, RN, **Jiao Jiang**, NP

Background:

The Holland Centre performs over 4000 surgeries each year with 2200 of these being hip and knee replacement procedures. The remainder of the cases are upper extremity

and spinal procedures. Our changing health care reality has meant reduced hospital stays with fewer resources and an increasing volume of surgeries being performed. We had to brain storm new strategies to ensure our patients continued to have a successful surgical outcome and a positive patient experience despite the challenges.

Empowering patients and encouraging active participation in their surgical journey was key to accomplishing this.

Purpose:

Feedback from patients indicated that although they supported our existing patient education (patient guides and classes) they were interested in newer technology to access information. The Holland Centre team partnered with patients and a technology company to create a mobile app. The objective was to deliver person-centered-care across the surgical continuum, improve patient education, encourage self-management and utilize interactive modules accessible on mobile devices. Apps were created for patients having a hip replacement, knee replacement, shoulder surgery and spinal surgery. A web version was created in response to patient request and has successfully broadened access to this information.

Findings:

Overall, 98% of patients found the App useful and 66% of patients reported that it prevented at least one phone call to the surgeon's office during their recovery at home. The App includes an evaluation survey which allows patients to provide feedback. As one patient said, "It was a nice motivation to keep on track with preparation ahead of surgery. I found the photos and articles in the library most helpful and reassuring as questions arose during recovery". The modules in each app supports patient learning needs and allows them to actively engage by completing daily health checks. This assists patients in managing the following:

- Preparing for surgery to ensure a successful surgical outcome
- What to expect during the hospital stay
- Transitioning from hospital to discharge home
- Managing postoperative recovery

Conclusion:

Results indicate that the mobile and web based apps improve patient experience. Patient and healthcare provider feedback was obtained at all stages of development and continues with any updates. We would like to share our journey as we created these apps, assessed outcomes and continue to evaluate feedback and data to enhance patient care.

Concurrent Session 4B:

11:20 am - 11:50 am

Location: Harrison Hall, EG-18

4B) Quality Conversation Huddles: Integrating Teams, Facilitating Difficult Conversations About Patient Safety and Promoting Quality Improvement

Julie Sit, *Medical Radiation Technologist, Sunnybrook Precision Diagnostics & Therapeutics Program (Medical Imaging)*

What are quality conversations?

A Spotlight on some quality conversations within medical imaging

What are some benefits to quality conversations?

What are some drawbacks to quality conversations?

Benefits:

Staff engagement

Promote teamwork

Devoted time for quality improvement efforts

Accountability

A visual of our progress

Safe space to discuss safety reports

Drawbacks

Dwindling interest and participation

Used for alternative reasons

Updates, memos, complaining, etc. -

You need a good facilitator/champion

Creative ways to engage team

How do we make it fun?

Lunch & Poster Presentations 11:55 pm - 12:55 pm

Sponsored by: SteriPro

*Location: McLaughlin Auditorium,
EG-18a*



Concurrent Session 5 (choose A or B)

1:00 pm - 1:30 pm

Concurrent Session 5A:

1:00 pm - 1:30 pm

Location: McLaughlin Education Centre Lecture Theatre, EG-61

5A) Enhancing Sexual Assault/Intimate Partner Violence, Community Partnership and Education

Sukhpreet Kainth, *BScN, MScN, Interim Clinical Manager for the Women's College Hospital - Sexual Assault/Domestic Violence Care Centre*

Abstract:

The future design for ambulatory care includes a community approach through collaboration and building capacity. The Women's College

Hospital (WCH), Sexual Assault/Domestic Violence Care Centre (SA/DVCC) is one of the largest Sexual Assault/Domestic Violence programs across Ontario.

The SA/DVCC program is in an ambulatory setting with a strong community partnership, engagement, and presence across Toronto. The SA/DVCC is a 24/7 response program that provides medical/forensic care services to patients over the age of 16 who have recently experienced a Sexual Assault and/or experiencing Intimate Partner Violence (IPV).

The program offers mobile service to seven emergency departments within Downtown Toronto. The program also has strong informal partnerships with community partners such as Victim Services Toronto and Toronto Police Services.

The program sees approximately 800 new patients, with over 2500 visits annually. The work of the program is rooted in collaborative partnerships that are centred around community outreach and education regarding Sexual Assault/Domestic Violence care services, and best practices that are grounded in trauma informed care. Examples of outreach include providing presentations to emergency department leadership and clinicians, family practice health teams, mental health units, Community Health Centres (CHCs), university colleges and Toronto Police Services. Evaluation of these education initiatives through surveys/questionnaires showed a positive impact on trauma informed approach to care, enhancement of providers' knowledge and satisfaction levels and strengthening partnership relationships.

To bolster our healthcare system, we must look beyond our own organization and work collaboratively with community partners.

Concurrent Session 5B:

1:00 pm - 1:30 pm

Location: Harrison Hall, EG-18

5B) Evaluating a new patient navigator role in the emergency department to help older adult patients and their families/caregivers in discharge planning and providing follow-up support (A pilot study)

Grace Liu (PhD), *St. John's Rehab Research Program, Sunnybrook Research Institute, Sunnybrook Health Sciences Centre, Toronto, Ontario, Canada*

Background: Since the transition from the emergency department (ED) to the community can be stressful for older adults and their families/caregivers, a Patient Navigator role was introduced in the ED in a large metropolitan hospital in Toronto, Ontario (Canada) to facilitate the discharge process and provide follow-up care.

Objectives: To evaluate a new PN model of care within the hospital's ED to support the older adult population. Given this new initiative, we aim to summarize the types of case management and/or consults provided, including the response rate, service length and related outcomes.

Relevance: The PN is a social worker who works collaboratively with the hospital's ED and in-home or community providers to help patients navigate needed health and social care services. By evaluating the impact of this novel PN model of care may improve the discharge process and ED-community care transitions for older adults and their families/caregivers.

Methodology: In this observational cohort study, we used the patient tracking list provided by the PN to describe the model of care by analyzing the PN's clinical notes to determine the services provided and patient outcomes between November/2020 to October/2021.

Research Findings: The PN contacted 95% of the patients (n=125) referred to the service in which the average age was 80 consisting of mostly females (74%). The PN provided consultations to 79 patients (≤ 7 days) and admitted 46 patients for case management support. For the 46 admitted patients, the navigator connected with 52% on the same day, provided follow-up care for 92 days (average) and facilitated 83% patients in returning back home or to a supportive housing setting.

Conclusion: In this pilot study, the PN is a key player in supporting the discharge process and ED-community care transitions for older adults by facilitating access to health and social care services and providing follow-up care. As this PN role is emerging in the ED, this study provides preliminary evidence to support this new model of care for older adult patients which can be implemented in EDs in other hospitals. Further research is recommended to understand the impact of PN role in preventing readmission rates.

Concurrent Session 6 (choose A or B)

1:35 pm - 2:05 pm

Concurrent Session 6A:

1:35 pm - 2:05 pm

Location: McLaughlin Education Centre Lecture Theatre, EG-61

6A) Transforming Care: an evolving response to Post-COVID Condition

Peggy So, *OT Reg.(Ont.), Unity Health Toronto*, **Dione Romero**, *SW, Unity Health Toronto*, **Sonya Torreiter**, *SLP, Unity Health Toronto*,

In June 2021, Unity Health Toronto launched an Outpatient Post-COVID Condition (PCC) Rehabilitation Program to serve the growing population of people living with persistent COVID-19 symptoms. To date, the program has served over 800 individuals, where 88% of those referred and participating in the program are 18 – 65 years of age, with multiple accountabilities with respect to work, caregiving, and volunteering. As our team and the medical community came to understand PCC as a chronic, episodic condition, the model of service evolved to include self-management strategies, specialized rehab services available in both in-person and virtual platforms and access to appropriate physical medicine & rehabilitation assessments. Drawing on approaches for similar conditions such as multiple sclerosis and chronic fatigue syndrome, the team developed an 8-week virtual group therapeutic education series. Sessions were facilitated by the interdisciplinary team, focused on self-management and supporting patients with problem-solving strategies related to physical activity, cognition, communication, nutrition and mental health. Based on patient-reported symptoms, fatigue was one of the most common and debilitating symptoms, with energy conservation strategies a focus of education across domains. Alongside the virtual education series, patients were able to access multiple resources via a patient portal to further support self-advocacy and management of their condition. Many of the patients served reported social isolation and lack of connection to others with PCC. As a result, peer support became a central component of the program design, providing a network of validation, social connection and shared strategies. Virtual care model delivery ensured accessibility to the program for those across the province, as well as allowing patients with more severe fatigue and other symptoms to participate.

There is opportunity for further refinement of targeted clinical pathways offering individual assessment and consultation for patients experiencing more debilitating disease or at risk for mental health crises. System navigation and integration with

primary care for PCC is paramount in achieving a high-functioning care pathway. A broader education and awareness approach is required for healthcare professionals, caregivers, employers, policy makers and the insurance industry.

Concurrent Session 6B:

1:35 pm - 2:05 pm

Location: Harrison Hall, EG-18

6B) Allied health and community engagement in the emergency department: Review of the Sunnybrook ED1 Team

Premika Premachandiran, *OT, GPA, MoCA, Sunnybrook Health Sciences Centre*

Hospital care has been shown to account for almost 25% of healthcare costs in Canada (CIHI, 2022). Healthcare expenditure is expected to increase with changing demographic factors including population aging and growth. Sunnybrook has a higher admission rate from ED, compared to similar hospitals. An environmental scan in July 2019 found that Sunnybrook had less allied health presence to other comparator hospitals with lower admission rates. The need for a team-based approach with community partners was identified to provide transitional support back into the community. The Emergency Department One Team (ED1T) is a dedicated inter-professional team based in the Sunnybrook Emergency Department that was formed in October 2019. The goals of the team are to: reduce admissions to hospital of patients who do not require acute level of care, decrease length of stay in hospital, and reduce the risk of return visits to the ED. What makes ED1T unique is it is a team of Sunnybrook health professionals and community-based team members (Senior Peoples' Resources in North Toronto (SPRINT), Leap of Faith Together (LOFT), Community Occupational Therapist (OT), Home and Community Care Support Services (HCCSS)). The inclusion of community health professionals allows for optimizing care in the ED with continued engagement for weeks to months to ensure they are well connected and supported to minimize the need for acute care hospital services. The aim of this presentation is to showcase the work of this innovative team and engage in discussions that support the growth of this and similar teams in other EDs allowing for enhanced care for patients and reduced acute care pressures.

Session 7

2:10 pm - 2:40 pm

Location: McLaughlin Auditorium, EG-18a

Opening Doors to Prevent Hospital Admission and Improve Continuity of Care: The Role of the Clinical Nurse Specialist in the Skin and Soft Tissue Infection Clinic

Naudea Mair, RN., CNS, MSN, IIWCC, CDE; Sherele McGhie, RN., CNS., MA.Ed., WOCC (C)

Aim

Patients with complex wounds are at increased risk of hospitalization. With coordinated care, patients can be safely managed in the community (Fitzpatrick, 2022). In May 2020, Toronto Western Hospital (TWH) University Health Network (UHN) established an inter-professional Skin and Soft Tissue Infection clinic (SSTIc) to reduce hospital admission and improve continuity-of-care for patients. The SSTI clinic was launched during the surge of the COVID-19 pandemic when access to care for most patients was limited. Patients with complex wounds should have access to comprehensive management from clinicians who possess the knowledge, skill and judgement (CNO, 2002; Mackavey, 2016). The Clinical Nurse Specialists (CNSs) practicing on the GIM units collaborated with the General Internist and inter-professional team to provide such care.

Method/Action

Patients presenting to the Emergency Department (ED) were referred to the SSTI clinic for management. Assessment was completed in the SSTI clinic within 72 hours of their initial presentation to the ED. Stable inpatients with complex wounds were discharged from hospital with support and reassessed within two weeks in the clinic. Visits were scheduled until the wounds healed, or care transferred to a long-term community clinic. The CNSs practiced between the clinic and inpatient units to promote continuity of care. Data was collected via clinical reporting tools.

Results and Conclusion

Over 750 patients were managed in the SSTI clinic from May 2020 to December 2022. Most common consults included venous leg ulcers, trauma

wounds, diabetic foot ulcer and diabetes education. Patients were also referred to consult services and home and community care service for specialized and ongoing care.

The SSTI clinic demonstrates the urgent need for management of complex wounds in the outpatient setting. The establishment of the clinic facilitated safe management of patient in the outpatient setting. The CNSs worked closely with the interprofessional team to improve access and promote excellence in care (Patry, 2021). Early access and prompt treatment is key to improved patient outcomes (CNA, 2014).

Next steps

- Expansion of the GIM Skin and Soft Tissue Infection clinic to provide capacity for more patients with complex wounds to access care.
- Utilization of a patient satisfaction survey to capture patient's subjective perspective on their experience in the SSTI clinic.
- Trial of different evidence-based wound care cleansers to increase wound healing time.
- Conduct study on the role of the clinical nurse specialist practice in a rapid referral wound clinic and impact on patient outcomes.

Award Presentations and Closing

*Location: McLaughlin Auditorium,
EG-18a*



Sherrol Palmer, President CAAC

2:45 pm - 3:00 pm

Poster Presentations

Poster Presentation #1: The Union of Ambulatory Care and Data: A Match Made in Heaven

Madeline Logan-Johnbaptiste RN, BN, MN Manager Ambulatory Care, McKenzie Health, Mary Kay Tse, Airo Santos, Agnes Wong

Problem:

The COVID 19 crisis has stretched the healthcare system beyond capacity (CIHI, Nov 2022). To address the demands in ambulatory care services, outpatient clinics (OC) are a key service that can directly affect the operational efficiency of a whole hospital (hua, 2023[SG1]). At Mackenzie[SG2] Health Hospital (MHH), COVID 19 challenges combined with increased patient volumes has led to greater need in OC services at a time when specialist resources are scarce.

Population and Methodology:

The Medical Urgent Care Clinics (MUCC) consisting of both General Internal Medicine (GIM), and non-GIM specialty services have[SG3] undergone a quality improvement event in September 2022 with the goals of improving access to integrated ambulatory care and promote ED avoidance. During the event, all operational aspects were reviewed from the lens of Value Based Health Care (North Toronto OHT). The question: "What type of data do we need to operate the clinics more efficiently?" resulted in the creation of MUCC dashboards[SG4] that visually capture patient activity and clinician level data which allow for dynamic scheduling, adding clinics if required to enhance capacity and optimize operations.

Results/Findings:

In collaboration with the informatics team, OC dashboards were created to capture data related to visit types, status and distribution, capacity, and utilization.

Retrospective data[WA5] identify[SG6] trends informing the need to optimize or adjust resources. Specifically, the Strategic Operational Dashboard was built to aid in predicting clinic needs by assessing future available capacity versus anticipated ED demand and trigger staff to open clinic spots in response. These dashboards are integrated via the hospital's Electronic Medical Record, EPIC.

Conclusions:

Visual reporting systems are vital tools necessary to predict future capacity and to make sound operational decisions. Dashboards in MUCC at MHH provide an accurate picture of supply versus demand, clinic distribution and bottlenecks that are addressed via dynamic scheduling. The hospital is planning dissemination of the outpatient dashboards to other ambulatory areas and recommendations include dashboard integration with all MUCC referring sources. Outpatient dashboards afford hospitals the data required for prompt decisions making, culminating in timely access to ambulatory care and ultimately improving operational efficiency throughout the entire hospital.

References:

hua, L., Dongmei, M., Xinyu, Y. et al. Research on outpatient capacity planning combining lean thinking and integer linear programming. BMC Med Inform Decis Mak **23**, 32 (2023). <https://doi.org/10.1186/s12911-023-02106-6>

<https://northtorontoht.ca/wp-content/uploads/2019/09/Overview-Value-Integrated-Care-Population-Health-V2-16-08-2019.pdf>

<https://www.cihi.ca/en/news/ongoing-pandemic-driven-pressures-impact-activities-and-workload-of-health-care-workers-across>

Poster Presentation #2: For Everyone with a Brain: Designing a Barzakay Clinic that Exemplifies the Outpatient Strategic Vision

Carol Robinson, Patient Care Manager, GHBSC, Barzakay Clinic, Sunnybrook Health Sciences Centre

Background:

Sunnybrook's new Garry Hurvitz Brain Sciences Centre ("GHBSC") is the first of its kind in Canada to unify the treatments for brain illness in a state-of-the-art collaborative space. Within that space, the Yuval and Lori Barzakay Brain Sciences Clinic ("Barzakay Clinic") will provide a single point of assessment and care planning for outpatients with neurological disorders. This new venture provided an opportunity for the Barzakay planning team to assemble a working group with the aim to exemplify the new

strategic vision for outpatient care at Sunnybrook through the implementation of outpatient planning principles.

Methods:

The Barzakay working group developed and utilized the following Outpatient Planning Principles to design the new clinic:

1. Space designed for outpatient care
2. Consolidating patient care services and specialist teams currently dispersed across the organization
3. Consistent clinical volume/data capture
4. Integrated models of care
5. Strong patient and family engagement
6. Dedicated clerical, management and health professional staff
7. Referral Management
8. "Hoteling" Model of service for Clinics- monitored for efficiency to maximize use
9. Transition of private clinics into hospital clinics
10. Centralized Scheduling and Registration
11. Common, integrated EHR

The working group also implemented a variety of quality improvement (QI) approaches including: process mapping, data analysis, and the review of internal and external programs best practices. Extensive stakeholder engagement through focus groups, surveys and interviews was also conducted incorporating a variety of perspectives to ultimately co-design a set of standard operating procedures that met the above principles and aligned with the outpatient strategic vision.

Results:

The Barzakay Clinic successfully utilized the planning principles and several QI approaches to achieve a set of standard operating procedures within a clinic designed to exemplify the vision of the new outpatient care strategy.

Next Steps:

The first seven planning principles will be fully implemented to all outpatient Sunnybrook services over time.

Poster Presentation #3: Interdisciplinary Operating Room Ergonomics Needs And Priorities: A Survey of Operating Room Staff

Alexis Mah ^{1 2 3}, *BHS, MD(c)*; **Fahad Alam**, ^{1 3 4 5 6}, *MD MSc*; **Julie Hallet** ^{2 3}, *MD MSc*; **Jeremie Larouche**, *MD MSc*; **Marie-Antonette Dandal**, *BSCN, CPN (C) APN*; **Tara Cohen**, *PhD*; **M. Susan Hallbeck**, *PhD*; **Emmanuel Tetteh**, *PhD*; **Hamid Norasi**, *PhD*; **Csilla Kallocsai**, *PhD*; **Sapna Siriam**, *DC MBA*; **James D. Helman**, *MD*; **Pablo Perez d'Empaire**, *MD*

1 Department of Anesthesia, Sunnybrook Health Sciences Centre, Toronto, ON

2 Department of Surgery, Sunnybrook Health Sciences Centre, Toronto, ON

3 Evaluative Clinical Sciences, Sunnybrook Research Institute, Toronto, Ontario, Canada

4 Department of Anesthesia and Pain Medicine, University of Toronto, Toronto, ON

5 Sunnybrook Canadian Simulation Centre, Sunnybrook Health Sciences Centre, Toronto, ON

6 Collaborative Human ImmerSive Interaction Lab (CHISIL)

Background: Despite existing guidelines for optimal ergonomics in the operating room (OR), poor ergonomics continue to cause musculoskeletal (MSK) injuries among OR staff, worsening patient care, outcomes, and OR sustainability. Lack of ergonomic awareness and education are risk factors. Hence, understanding the status of OR ergonomic interventions is needed to improve their uptake. We examined perceived OR interdisciplinary team ergonomics successes and barriers.

Methods: We conducted a self-administered web-based survey of OR nurses, surgeons, and anesthesiologists at Sunnybrook Health Sciences Centre (n=238) (REB ID 5471). The questionnaire was developed through item generation and reduction, followed by reliability and validity testing. The questionnaire was administered via email over 6 weeks with 3 reminders. The study was registered with ClinicaTrials.gov (Identifier: NCT05541354).

Results: The response rate was 53.8% (nurses 45.2%, physicians 59.3%). On average, respondents perceived that 80% of nurses, 70% of surgeons, and 40% of anesthesiologists experienced MSK injuries, with no differences across groups' perceptions. Recommended ergonomics interventions were rarely used (<25% using) besides specialized clothing (33%), equipment repositioning (59%), and sitting (37%); 80-90% perceived these interventions as beneficial. Reported barriers to optimal

ergonomics were organizational (time, space, equipment, funding), whereas solutions were individual. Fear of unfavourable perception from others was a concern for 62%. Individual ergonomic adaptations were perceived as convenience. Routine team discussion, prioritization, and monitoring of ergonomics was reported by <50%. Anesthesiologists can help team ergonomics through adjusting equipment set-up and patient positioning, nurses via removing unnecessary equipment, and surgeons by adjusting the table and patient positioning, and allowing breaks.

Conclusions: While most reported ergonomic barriers were structural and organizational issues, solutions appeared as individual responsibilities. Team dynamics were not prioritizing nor supporting ergonomics. Education tools leveraging the interdisciplinary team are warranted. Interviews and live observations will supplement this work to build tailored educational tools for OR teams.

Poster Presentation #4: Code Blue Simulation in the Operating Room: An Inter-professional Collaboration

Marie Antonette Dandal, RN, BSCN, CPN (C) - Sunnybrook Health Sciences Centre, **Denyse Henry**, RN, BHA, MHM - Sunnybrook Health Sciences Centre

Abstract: Cardiac Arrest in the Operating Room is a stressful high risk event that involves immediate response from the perioperative team. Sunnybrook hospital is one of the biggest trauma hospitals in Canada and staff must be prepared to manage any critical and emergent situation effectively. The higher turnover rate caused by pandemic affected the operating room with lesser expert nurses than novice nurses. A coordinated response to cardiac arrest is crucial among interprofessional team. Continuous education and training is needed to be able to respond effectively and efficiently during the code blue event. To prepare the team for education and training, a simulation education has been done in the operating room. Simulation education provides opportunities to improve clinical practice and teamwork among interprofessional team. An interprofessional collaboration with the Sim Lab including the anesthesia, anesthesia assistants and OR nurses has been started to run a code blue simulation in the operating room every Friday for an hour starting February until April. Our facility has 80 nurses and everyone was able to participate and observe on

how to attend and function effectively during the code blue. The OR staff including the novice nurses have been oriented to the location, equipment, supplies and medications in the cardiac arrest cart. Everyone has been taught and got the chance to review again how to use the defibrillator machine. The usability of the cardiac arrest cart has been streamlined for code blue in the operating room. An e learning module about Code Blue in the OR has been developed by the sim lab team and became a mandatory learning for all OR nurses. The practice of checking the cardiac arrest carts have been changed to a daily schedule and safety issues had been identified and significantly improved.

Poster Presentation #5: Identifying Risk Factors for Postoperative Delirium Among Geriatric Patients During and After the COVID-19 Peak in a Tertiary Center

Marie-Antonette Dandal, MscN, Project Manager/APN, Sunnybrook Health Sciences Centre, **Payam Tarighi**, **Mehranoosh Dolatshahi**
Denyse Henry, MHM BHA (Hons) RN, Director of Operations ORRS,
Ashlie Nadler, MD, Department of Surgery, Sunnybrook Health Sciences Centre, **Frances Wright**, MD, Department of Surgery, Sunnybrook Health Sciences Centre, **Brigette Hales**, Quality, Patient Safety & Enterprise Risk, Sunnybrook Health Sciences Centre

Introduction: Postoperative delirium (POD) among individuals aged 75 and older has a notable impact on surgical results, leading to higher mortality rates, increased healthcare expenses, and long-term functional decline. This research aims to pinpoint the risk factors associated with POD in the geriatric population during and following the COVID-19 peak at a tertiary medical facility.

Methods: We examined cases of postoperative delirium (POD) in elderly patients using NSQIP data collected from July 1, 2020, to December 31, 2023. Our analysis involved the application of nonparametric tests and a logistic regression model for statistical evaluation.

Results: Among 2,219 elderly patients undergoing surgery over a period of 42 months, the median age was 80.2 years, with males accounting for 45% of the cohort.

Postoperative delirium (POD) was documented in 170 cases, representing a 7.7% occurrence rate. Noteworthy distinctions in patient characteristics were noted among those with a POD diagnosis, including older age and pre-existing conditions such as dementia, functional dependency, and heart failure. Additionally, surgical factors such as prolonged operation duration, higher acuity levels, and anesthesia classification (ASA) were significantly associated with POD. Furthermore, delirious patients exhibited a higher prevalence of serious complications such as COVID-19 diagnosis during hospitalization, wound complications, pneumonia, and elevated rates of readmission and re-operation, as outlined in Table 1. Through logistic regression analysis, pivotal risk factors were identified, including a history of dementia, postoperative COVID-19 infection, ASA \geq 3, wound complications, prolonged ventilation exceeding 48 hours, sepsis, and myocardial infarction. Our regression model demonstrated an area under the ROC curve of 0.75, as illustrated in Figure 1.

Conclusion: Identifying and addressing risk factors associated with postoperative delirium (POD) is essential for designing and implementing quality improvement strategies in geriatric surgical care. Several of these identified risk factors are avoidable, highlighting the significance of enhancing surgical practices to reduce complications and the occurrence of POD.

Table 1 Patient Characteristics and surgical factors

Postoperative Delirium	No	Yes	P*
Number of patients, n (%)	2049 (92)	170 (7.7)	
Age, years	79.9 (77.1, 84.1)	83.0 (79.1 88.5)	<0.01
Sex: Male	906 (44)	0.5 84/170	0.19
Dementia History: Yes	24 (1.2)	22 (13)	<0.01
Functional health status (Partially/totally dependent): Yes	55 (2.7)	21 (12)	<0.01
Heart Failure: Yes	38 (1.9)	11 (6.5)	P<0.01
Preoperative Sepsis: Yes	12 (0.6)	4 (2.4)	0.01
Bleeding Disorder: Yes	35 (1.7)	12 (7.1)	<0.01
Case acuity (Urgent): Yes	415 (20)	79 (46)	<0.01
Postoperative COVID: Yes	20 (1.0)	11 (6.5)	<0.01
ASA Class (ASA \geq 3): Yes	1840 (90)	169 (99)	<0.01
Wound Complications: Yes	89 (4.3)	18 (11)	<0.01

Pneumonia: Yes		25 (1.2)	16 (9.4)	<0.01
Unplanned Intubation: Yes		21 (1.0)	11 (6.5)	<0.01
On Ventilator >48hrs: Yes		12 (0.6)	9 (5.3)	<0.01
Pulmonary Embolism: Yes		9 (0.4)	5 (2.9)	<0.01
Renal Insufficiency: Yes		39 (1.9)	12 (7.1)	<0.01
Stroke: Yes		8 (0.4)	3 (1.8)	0.01
Cardiac arrest requiring CPR: Yes		14 (0.7)	4 (2.4)	0.02
Myocardial Infarction: Yes		21 (1.0)	8 (4.7)	<0.01
Postop Transfusions: Yes		121 (5.9)	27 (16)	<0.01
Postoperative Sepsis: Yes		31 (1.5)	15 (8.8)	<0.01
Readmissions: Yes		137 (6.7)	23 (14)	<0.01
Return to OR: Yes		51 (2.5)	9 (5.3)	0.03
LOS, days		3.0 (1.0 7.0)	10.0 (6.0, 17.0)	<0.01

Note: Binary values (Yes/No) are indicated for all variables except continuous ones, which are represented by median (interquartile range). * Mann-Whitney test.

ROC Curve

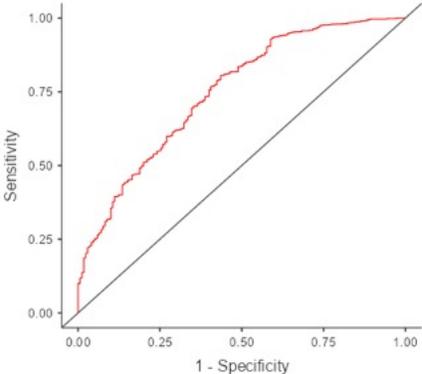


Figure 1 ROC curve illustrating the performance of the logistic regression model of this study.

Poster Presentation #6: Role of Telephone Triage in the Ambulatory Care of Low Back Patients

Maria Rachevits, MD, BScPT, Advanced Practiced Physiotherapist
Helen Razmjou, Susan Robarts, Albert Yee, MD, Joel Finkelstein, MD,
Amy Wainwright, Patricia Dickson

Purpose: The restrictions following COVID pandemic led to increasing recognition of virtual care. This study examined the role of telephone triage in improving ambulatory care in patients with low back pain and its efficacy in triaging patients appropriate for spine surgical consult.

Methods: This was an observational study of patients with low back and/ or leg pain referred to a spine clinic. The telephone interview was conducted by an experienced Advanced Practice Physiotherapist (APP). Patients with red flags (cauda equina syndrome, metastatic lesions, infection, fractures) were excluded. Questionnaires emailed to patients: Back-versus leg pain (Wei et al, 2009), SSHQ 4 questions (Konno et al, 2007), Oswestry disability Index (ODI) and STarT Back. Instructions on performing 5-Repetition Sit-to-Stand test included. The MRI report was reviewed by the APP and the presence of any relative pathology was recorded for analysis. Descriptive analysis and general linear modeling were conducted.

Results: A sample of 100 consecutive patients (50 females, 50%), average age (58, SD: 16, range 20-87 years). The most prominent reason for in person consult with the surgeon was a leg dominant pain (radiculopathy) with concordant imaging findings (27, 77%). There were 5 (14%) cases with signs of unstable spondylolisthesis, and 2 (6%) cases of end stage hip OA requiring hip replacement. Of 100 participants, 40 required an in-person assessment: 35 by a surgeon (33 by a spine surgeon and 2 by a hip surgeon) and 5 by the APP. 27 needed a second phone follow-up by the APP. Therefore 60% did not require in-person visit to the clinic. The isolated scores of ODI, STarT Back and Sit-to-Stand test did not correlate with surgical candidacy ($P>0.05$).

Conclusion: Important components of clinical assessment could be obtained via a structured virtual telephone encounter. Use of virtual triage can improve ambulatory care in patients with low back pain by reducing wait time for surgical consultation and the need for in-person visits to the spine clinic.

Poster Presentation #7: Improving Gynaecological Operating Room Wait Times: Moving Hysteroscopies to an Ambulatory Clinic

Alison Pepler RN, BSN, Grand River Hospital, Andrea Sabourin, RN

Lengthy Operating Room (OR) wait times negatively impact patients requiring gynecological procedures. Safely relocating minor gynecological procedures for women over the age of 16, out of the OR to a Gynecological ambulatory clinic will decrease wait times. This will allow for more OR time and improve patient satisfaction to align with Grand River Hospitals (GRH's) Mission of Quality, Efficiency and World Class care. This quality improvement project set out to determine if moving hysteroscopies out of the OR, and performed in an ambulatory clinic setting would reduce the backlog of OR cases waiting for minor gynecological procedures. A site visit to Niagara Hospital was completed with 2 physician leads, clinic manager, clinic nurse and educator. Criteria was set to include women requiring diagnostic hysteroscopy where the procedure could safely be performed under conscious sedation, with an ASA less than or equal to 2 with fibroids less than 3 cm. An evening of education was provided by the equipment rep, surgeon leads, clinical informatics and manager/educator. The equipment rep provided elbow to elbow support for patients getting hysteroscopies in the Gynecological clinic for 6 months. Patient information pamphlets were created and standardized across all OB providers, including patient preparation and discharge instructions. Pre procedure telephone calls were completed by a clinic nurse to ensure the patient was appropriate and prepared for the procedure. Post procedure phone calls were also completed as follow-up and satisfaction surveys were collected. This was key to reducing confusion or unnecessary cancellations. This project proved to be an excellent opportunity for patients waiting for minor gynecological procedures by avoiding general anesthetic and minimizing recovery time. Data collected for the satisfaction phone calls rated the patient's satisfaction at 5/5. Future considerations include broadening the scope of procedures that can safely be done in an outpatient setting to include D & C's and some Bartholin cysts.

Poster Presentation #8: Check Your Hearing, Change Your Life!

Sylvia Ciechanowski *M.Sc. Audiology, AuD (candidate), Baycrest Hospital*

Abstract

Background: Hearing loss has been identified by the Lancet Commission as the leading potentially modifiable risk factor for dementia. Hearing loss is highly prevalent among older adults, and despite strong evidence of the benefits of improved hearing, hearing loss is typically untreated, increasing risk of social isolation, dementia, and health decline. However, hearing screening is not typically included in the standard recommended battery of tests recommended by physicians for older adults. Evidence supporting screening in identifying hearing loss and improving access to care for older adults and caregivers is needed to support its adoption as a routine component of clinical care through collaboration. A small proof-of-concept pilot study successfully demonstrated in 5 months, almost 900 older adults have self-screened, with 60 providing their contact information and requesting a consultation with an audiologist to discuss their results, readiness to take action, and management options.

Objective: To demonstrate benefit through participant's reduction in perceived hearing handicap as a result of integrating the online hearing screening into partner programs. Secondly, to demonstrate knowledge of hearing status is helpful to caregivers and staff providing care and management.

Methods: Clients being admitted to partner programs (Memory clinic, Terrace, Possibilities, Baycrest@Home) complete online hearing screenings as part of intake process. Participants who consented to participate in the study were contacted in person or over the phone to complete a complimentary phone consult with an audiologist. Participants, SDM's, and caregivers then completed a brief hearing handicap questionnaire (RHHIE-S or SO) upon completion of online hearing screening, and again 3 months post screening to determine if knowledge of hearing status was helpful for participant or caregiver in providing care.

Results: Since March 1, 2023, over 700 participants completed the online hearing screening, of which 75 participants left contact information through their partner program. We are in the final stages of data collection with a total of 45 participants. Survey responses have been positive and at least 37 participants have visited Baycrest

Hearing Services as a result of the online hearing screening. Surveys indicate participants strongly agreed or agreed that hearing screening was beneficial upon admission into partner programs.

Poster Presentation #9: Efficiency Unveiled: Maximizing Hysteroscopic Procedures with Conscious Sedation

Lisa Lin *BSCN, M.Ed, APN, Women's College Hospital,*
Jade Tranter, *RPN, Women's College Hospital*

Abstract

In an already strained healthcare system with increasing surgical wait time, we are continually striving to develop innovations to effectively use our available resources and provide quicker access to services for our patients. The current average surgical wait time for elective hysteroscopic procedures is 182 days. In collaboration between multiple departments, including anesthesia, surgery and perioperative staff, a fast track hysteroscopic procedure program was created to allow for; a high volume of procedures to be completed, while decreasing the demand on staff resources and maintaining patient safety. Our program allows for hysteroscopic procedures (polypectomies, myomectomies and fibroid removals) that would be considered too complex for an office setting, yet not requiring a complete operating theatre, to be completed in a procedural room with minimal staff and conscious sedation to enhance post-operative recovery while maintaining a high standard of care and decreasing postoperative complications. All patients receive a paracervical nerve block to decrease the amount of pain felt during, and post-procedure. Patients receive conscious sedation to allow for quick recovery and decrease in post op nausea and vomiting. Through initial implementation of this pilot project, we were able to perform 10 procedures daily with a recovery time between 30-45 minutes with minimal to no post-operative complications, thereby allowing surgeons to maximize their operating time while safely expediting patients through the surgical program. Another advantage of this program is the decrease in human resources within the perioperative services to allow for overall more cost-effective utilization of personnel and creating a more cohesive interdisciplinary team through close collaboration with one perioperative nurse, anesthetist, surgeon, and registered practical recovery room nurse.

Poster Presentation #10: Healthcare Providers' Perspectives on a Hybrid Outpatient Telestroke Program: A Qualitative Implementation Study

Karl Wong, M.Cl, Patient Care Manager, St. John's Rehab, Sunnybrook Research Institute, Sunnybrook Health Sciences Centre,

Marina Wasilewski, PhD (Doctorate) degree, St. John's Rehab Research Program, Sunnybrook Research Institute, Sunnybrook Health Sciences Centre

Introduction/Background: Although patient outcomes are enhanced by stroke rehabilitation, the recommended amount of therapy is rarely preserved. The COVID pandemic provoked this situation because of disruptions in healthcare. One solution was the rapid and vast transition to virtual care. A hybrid outpatient telestroke program (HOSTP) integrating in-person and virtual care was introduced at St. John's Rehab. The HOSTP can mitigate long-standing barriers that challenge stroke care.

Objectives: This study examined healthcare providers' (HCPs) experiences with the HOSTP and their viewpoints on its implementation, quality, and impact to discover the alterations needed to maximize its delivery and practicability.

Methods: A qualitative implementation study was conducted using the Consolidated Framework for Implementation Research (CFIR). In total, 14 HCPs, primarily occupational (n=4) or physical therapists (n=4), were recruited and interviewed from St. John's Rehab's outpatient program. Interview transcripts were analyzed utilizing a deductive thematic analysis approach.

Results: Regardless of some obstacles (e.g. limited technology, space and equipment, and requiring hands-on care), the benefits the HOSTP offered over in-person care (e.g. scheduling flexibility, fulfilling patient needs, more accessible intake assessments, and discharge planning at home). Overall, the degree to which the program satisfied each patient's specific needs represented the foundation for HCP discussion of the advantages and disadvantages of the HOSTP.

Conclusion: Our results illustrate that enhancing the quality and efficacy of the HOSTP can be accomplished by optimizing virtual care procedures and obtaining better equipment. Expanding on the pandemic-driven momentum with virtual care is crucial

to improving care quality and access for stroke survivors. Acquiring awareness of the advantages and disadvantages of hybrid care can help with the future integration of virtual care into stroke rehabilitation alongside program optimization.

Poster Presentation #11: Improving Brain Health & Memory through Group Education for Older Adults

Serena Lee-Segal, OT Reg. (Ont.), Sunnybrook Health Sciences Centre, Geriatric Day Hospital, **Farah Badar Habib**, OT Reg. (Ont.), Occupational Therapist, **Sonia Nobleza**, RN, BScN, MN, GNC(c), Patient Care Manager for Specialized Geriatric Services

Background and Clinical Problem:

According to projection scenarios, the proportion of the population aged 65 and over will continue at an accelerated pace over the next decade in Canada. With aging, comes normal age-related cognitive changes, but also risk of developing Mild Cognitive Impairment (MCI), which can progress to dementia. MCI refers to cognitive decline, commonly involving memory that is greater than expected for age, but does not markedly compromise independence in carrying out Instrumental Activities of Daily Living.

Research suggests there are modifiable risk factors to reduce the risk of dementia including physical inactivity, unhealthy diet, social isolation, and lack of cognitively stimulating activities. Ambulatory-based memory programs can offer low-cost solutions to help individuals with memory complaints, may also help to reduce the risk of dementia, and promote sustained functional independence in the community.

In November 2023, the GDH conducted a quality improvement project to implement the evidenced based group program called "Learning the ROPES for Living with MCI©" created by Baycrest Centre. The aim of this project is to share early results of this initiative.

Sample Population and Methods:

Twenty patients participated in a 7-week program. Key features include education about MCI and lifestyle factors for promoting cognitive health and reducing risk of dementia, memory training involving practical strategies, and psychosocial support for living effectively with MCI. Participants completed pre- and post- surveys to measure knowledge and satisfaction.

Results:

Pre- and post-test change scores using patient surveys showed improvement on measures of knowledge (i.e., general facts about memory, memory strategies) and satisfaction with self-rated memory ability. 100% of feedback surveys indicated that because of this program, participants made changes to their lifestyle to promote brain health and enjoyed the benefits of being with peers.

Conclusion:

Through the implementation of this quality initiative project, this program offered increased healthcare access to interventions that help address cognitive health and memory improvement. Positive results obtained demonstrate the powerful impact it has on healthy lifestyle modification. In addition, offering group-based programming increases the number of patient throughput and can lead to more efficient use of human resources. In future, the team will be obtaining more detailed feedback on patient and family experience to improve delivery of this initiative.

Poster Presentation #12: Innovative Integrated Care: Piloting an Emergency Department-based Community Occupational Therapist Role

Nadine Narain, *Hons. BSc, MSc OT, MSc HSLI, Sunnybrook Health Sciences Centre*, **Nadia Abdel-Hafez**, **Isabella Cheng**, **Justin Hall, MD**, **Sander Hitzig, MD**, **Miranda Lamb**, **Kitty Liu**, **Sara Morassaei, MD**, **Premika Premachandiran**

Objectives:

1. Design a community occupational therapist (OT) role positioned in an Emergency Department (ED) to complete urgent OT follow-up in the community.

2. Create a patient-centred criteria to identify geriatric patients discharged from the ED and efficient approach for effective transitional care to home Background: Occupational Therapy optimizes a patient's safety and functioning and provides strategies including fall prevention to help older adults maintain their independence in the community. Some patients presenting to Sunnybrook Health Sciences Centre's ED are discharged with community follow-up, including OT home safety assessments. Seamless, connected care across the healthcare system is a challenge, with long waits for home care OT, which increases the risk of ED re-visits and hospitalization.

Aim Statement: This project aims to complete OT home visits within 24-48 hours by 50% for eligible patients age 65 years+ who are discharged from the ED within six months of study initiation.

Methods: A needs assessment identified gaps in care post-discharge from the ED. In partnership with key stakeholder, community partnerships and collaboration for transitions of care were established, which included ensuring sustainable supports are in place to maintain patients' safety and function in their homes. Plan-Do-Study-Act cycles were implemented between July and December 2023 to establish and improve the processes involved in piloting the ED community OT role.

Results: By December 2023, 72 eligible referrals were received. Forty percent of initial visits were made within 24-48 hours. Common concerns by patients and caregivers included falls, weakness, pain and cognitive challenges. The ED community OT provided the following: home safety, mobility and functional assessments, education and equipment prescription for falls prevention, management of activities and instrumental activities of daily living, cognitive challenges, and service coordination to support home-care needs.

Conclusion: An urgent community OT intervention may help to optimize safety and function of older adults in their homes post-discharge from the ED. This project provides an opportunity to examine the perceived experiences of older adults who receive early OT intervention post-discharge from the ED, identify factors that contribute to the success of the ED community OT role, and opportunities to improve integrated care.

Poster Presentation #13: Removing Barriers: Improving Same Day Surgery (SDS) Flow and Process

Ingrid Daley, RN, BA, BScN, MScN, CNCC(C), Denyse Henry, MHM BHA (Hons) RN, Director of Operations ORRS , Anne Van Deursen, RN, MN Sunnybrook Health Sciences Centre, Toronto, ON, Canada

Background/Development: SDS provides care to patients from multiple specialty services and with varying needs for recovery including post-procedural care. Inefficiencies in flow, processes and practice recovery phase of care can result in disrupted services to patient's discharge, stakeholder dissatisfaction and system challenges.

Methods: A quality Improvement (QI) evaluation was performed utilizing direct observation of inflow and outflow activities, interviews with frontline providers, operational leadership and program performance metrics. The metrics tracked included (time to transfer, reasons for transfer delay after recovery interval was completed, and resource availability as factors).

Results: To better understand factors that inhibit and facilitate SDS efficiency a process mapping was completed to address gaps and opportunities to improve SDS workflow. After careful review, factors impacting SDS workflow and delays could be attributed to three specific categories related to people, process, and resources identified as contributing to system inefficiencies.

Conclusion: The quality improvement evaluation and comprehensive process review of SDS services is on-going. The team continues to monitor these selected markers of efficiency and support sustainment of the new processes. System-based process improvement strategies have been identified. Post implementation data collection is being completed.

Poster Presentation #14: Using Culturally Tailored Initiatives to Increase Breast and Cervical Cancer-Related Knowledge and Health Behaviours Among Black Women

Camille Williams, PhD, Elaine Goulbourne, RN BScN MHS CHE, Elijah Gyansa, Ayan Hashi, MPH, Ielaf Khalil, BKin, Rumaisa Khan, MPH 1, Patricia Rabel-Jeudy, BSc CSM, Ruth Heisey, MD, Aisha Lofters, MD PhD

Background

In Canada, racialized and immigrant women are typically underscreened for breast and cervical cancer. Underscreening is linked to numerous barriers including lack of awareness of screening, fear of pain, the stigma of cancer, as well as socio-cultural and socio-economic factors like language barriers and challenges with getting transportation to screening sites. In partnership with community organizations, we co-created two culturally tailored events to address barriers to screening for Black women: an educational event and an on-site cancer screening event.

Methods

Both events were delivered annually in 2022 and 2023. The virtual, free educational events (2022: Breast Health for Black Women; 2023: Best Health for Black Women) empowered Black women with information about risk factors, prevention, and screening. The 2022 and 2023 Breast & Cervical Cancer Screening for Black Women events created inclusive, accessible, and culturally affirming opportunities for screening. Evaluation of whether objectives were met included review of program data and post-event surveys which also solicited feedback from attendees.

Results

Each educational event attracted 450+ attendees. In both years, more than 87% of post-event survey respondents agreed that an event specifically for Black women helped them feel supported. At the screening events, 46 and 48 women were screened in 2022 and 2023, respectively. 81% of respondents noted that they were (extremely) likely to go for mammogram when next due; 87% said they were (extremely) likely to go for a Pap test when next due.

Conclusions

Co-created, culturally tailored educational and on-site screening events provided opportunities for Black women to learn about prevention, risk factors and resources, as well as receive screening for women's cancers. It is possible that, over time, such events may reduce or remove the stigmas associated with cancer and increase cancer-related knowledge and recommended health behaviours among racialized groups.

Poster Presentation #15: A Disconnected Clinical System, Why and How Can it be Fixed

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Introduction

The Canadian clinical system is a dynamic one. In response to shifts within medicine and society, advancements have been implemented throughout the past four decades and will continue to be made in the future [1]. Despite the constant involvement, there were still some issues that came along with it. This paper will discuss and analyze some major problems from the perspective of a clinician and propose a potential solution for these issues.

Methodology

In order to comprehensively identify and propose solutions to the current clinical problem, a combination of methodologies, including a literature review and in-person interviews, was conducted. The following is a detailed explanation of the approaches that were utilized.

Literature Review

The search engines PubMed and Google Scholar were used to conduct the literature review, and the terms "Canadian healthcare system," and "Canadian clinical problem" were used as the key terms. After reviewing the research articles that were pertinent to the intended population, the findings from those publications were analyzed, and then those findings were compiled.

Personal Interviews

Several interviews were conducted with different clinicians. The information that was obtained from these interviews is analyzed, and as a result, insight was provided into the analysis of the issue, and the proposed solution.

Description of the Issue

In most cases, clinicians are responsible for a greater quantity of documentation. One of the responsibilities they have on a daily basis is to transmit and retrieve information about patients from a variety of sources^[2]. The main issue in these processes is the lack of interoperability.

Prior to the first eReferral being launched in 2015, when a patient requested or was required to consult with a specialist, clinicians were required to send the patient information through the traditional fax method. However, the introduction of eReferral in 2015 prompted an increasing number of facilities to begin transitioning to a more modern and effective approach^[3]. The electronic request can be sent by clinicians with just a few clicks of the mouse on the computer. In spite of the fact that the new eReferral system operates in a more efficient manner, it did bring some new issues to the system. As a result of the fact that not all medical facilities in Ontario have adopted the eReferral system, clinicians need to be aware of whether or not the facilities accept eReferral. If not, they will need to manually fax the referral form.

During the course of the interview, the clinician provided a scenario. A patient is advised to have an ultrasound as well as a blood test and prefers to do the test in a particular lab in the area which only accepts requests by fax. Following the completion of the test, the laboratory faxes the results back to the clinician. Based on the results, the patient needs to visit a gynecologist, which only accepts eReferral. In this particular case, the clinician has to scan the report and upload it into the system, then send the eReferral form. Not only these processes disrupted the workflow, but the whole process is also considered to be inefficient by the clinician. And the fact is, it happens on a daily basis in the clinic across the whole industry. The lack of interoperability is time-wasting, but it also creates a documentation burden and furthermore potentially results in clinician burnout^[4].

The disconnected system and lack of interoperability also result in information delays and incomplete patient information. During the course of the interview, the clinician also expressed her concerns. If a patient goes to a medical facility that is located outside of the province or an Ontario medical facility that is not part of the electronic medical record (EMR) network, then there is no way for the clinician to gain access to that specific information about the patient's medical history.

Analysis of Issue

There are various factors contributing to the disconnected system. A lack of data and information sharing between healthcare providers has always been a persistent contributor. There is a lack of uniformity in the way data are handled in the healthcare

system; for example, they could be kept in a different format, on a different platform or database, or even in different mediums like paper or digital. These variations in the patient data create obstacles to the system's interoperability.

In order to get a better understanding of the underlying causes of the problem, it is necessary to conduct a comprehensive review of the structure of the healthcare system in Canada. The Constitution of Canada establishes the three levels of government in Canada—federal, provincial, and territorial—each has specific obligations and responsibilities that they must fulfill. The federal government does not have the responsibility to enforce standardized healthcare administration and delivery across different provinces and territories. The fact that several various stakeholders are involved in each province's healthcare system also contributed to the development of variances, which ultimately resulted in the fragmentation of the system across the country and provinces.

Solution

Proposed Solution

The implementation of standardized guidelines for the clinical system in Ontario, or possibly the whole country, has been suggested as a potential solution to this issue. As a result of the establishment of a standardized guideline, healthcare providers in Ontario are compelled to adhere to it, which may lead to the development of a unified method for the management of healthcare data. This method will effectively promote system uniformity while also addressing the issue of the lack of interoperability that was generated by the existing disconnected system.

It is recommended that the government begin the implementation on a lower level within the system rather than a higher level. For instance, this paper discussed the several different referral methods utilized in Ontario's clinical system, which causes barriers to data interoperability. By providing assistance and requesting all healthcare facilities adopt the EHR system and eReferral procedure, the issue mentioned earlier in this paper could be potentially eliminated.

Critique of Solution

The proposed solution is thought to be approachable; in fact, standardized programs of this type have already been established in other countries. In Denmark, the Danish national healthcare system is a successful example of the national wide digital project. It is distinguished by substantial digitalization, electronic contact among healthcare practitioners, and the methodical utilization of data and digitized work routines. Their 2012 National Telemedicine Action Plan established standards and relevant reference architectures encompassing Denmark's whole healthcare system, including data

measurement, video, surveys, and images [7]. The Danish approach to consistency can be a great reference for Canada to learn from Denmark. Standardized data measurement was provided as part of their national telemedicine plan, which made the data more adaptable, and the system well-connected. Through a Canadian lens, due to the wide variety of platforms and apps that are utilized for telemedicine in Canada, there are often difficulties with data transfer and interoperability. The success in Denmark illustrates that it is possible for the Canadian public healthcare system to enforce some kind of national-level standard throughout the country. However, the solution may also include some possible problems that need to be taken into account. The very first and most obvious factor to take into consideration is the possibility that the current stakeholder would reject the proposal because of financial and revenue concerns. The transition to a standardized system or platform can be expensive to implement, thus the government will need to ensure a certain amount of funding to cover the costs associated with the shift. Unfortunately, due to the nature of the government, it is anticipated that adjustments would occur slowly throughout the healthcare system. It could take years for the solution project to be fully implemented, and an even longer length of period will be required to evaluate the results and outcomes of the solution. In addition to this, it is crucial to take into account the long-term sustainability of the solution project. In order to maintain interoperability between systems in the long term, the government needs to devise a method to assure the system will retain its uniformity after it is established.

Conclusion

In conclusion, the disconnected clinical system in Canada caused so many issues in the industry such as lack of interoperability, information delay, and documentation burden. The rise of such issues can be rooted in a not standardized system without a unified guideline. By learning from the successful example of Denmark, it is possible to solve these issues by implementing standardized guidelines for the healthcare system across Ontario or the whole Country. Cautions need to be made to ensure the solution's adaptability and sustainability. When all of these factors are taken into account, it is likely that Canada will one day be able to design and implement a solution to create a well-connected clinical system that is both efficient and interoperable.

Reference

1. *Martin, D., Miller, A. P., Quesnel-Vallée, A., Caron, N. R., Vissandjée, B., & Marchildon, G. P. (2018). Canada's universal health-care system: achieving its potential. Lancet (London, England), 391(10131), 1718–1735. [https://doi.org/10.1016/S0140-6736\(18\)30181-8](https://doi.org/10.1016/S0140-6736(18)30181-8)*
2. *Snyder, C. F., Wu, A. W., Miller, R. S., Jensen, R. E., Bantug, E. T., & Wolff, A. C. (2011). The role of informatics in promoting patient-centered care. Cancer*

journal (Sudbury, Mass.), 17(4), 211–218. <https://doi.org/10.1097/PPO.0b013e318225ff89>

3. *Bashar, M. A., Bhattacharya, S., Tripathi, S., Sharma, N., & Singh, A. (2019). Strengthening primary health care through e-referral system. *Journal of family medicine and primary care, 8(4), 1511–1513. https://doi.org/10.4103/jfmprc.jfmprc_184_19**
4. *Wu, D. T. Y., Xu, C., Kim, A., Bindhu, S., Mah, K. E., & Eckman, M. H. (2021). A Scoping Review of Health Information Technology in Clinician Burnout. *Applied clinical informatics, 12(3), 597–620. <https://doi.org/10.1055/s-0041-1731399>**

Poster Presentation #16: Infection Prevention and Control in Outpatient Care Settings

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Summary: The objectives of this poster are to outline the routine practices and additional precautions that are to be used in outpatient care settings in order to reduce the risk of transmission of infectious diseases for both patients and staff. Highlighted in the poster is a table which outlines how to manage patients on additional precautions in outpatient areas, key elements of routine practices, as well as how to conduct a point-of-care risk assessment for each patient encounter. Details around how to get in touch with the IPAC team at Sunnybrook are also included



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