ST. MICHAEL'S HOSPITAL IN COLLABORATION WITH THE PROFESSIONAL PRACTICE NETWORK OF ONTARIO PRESENTS

Interprofessional Transitions in Care Symposium

January 15, 2014

St. Michael's Hospital
Li Ka Shing Knowledge Institute
209 Victoria Street
Toronto, Ontario
Welcome,

Transitions in patient care is a hot topic that has gained a lot of attention recently and improvements in this area have important implications for patient safety and experience. For this reason, we are so excited to have you here to share your knowledge and innovation on transitions across the continuum of care. We hope that you find this session informative with an opportunity to network and learn from experts in this field of work. We also hope that you can take valuable learnings back to your organizations to improve transitions in your local context.

We would like to take this opportunity to thank the Professional Practice Network of Ontario for joining us in supporting this symposium. We would also like to recognize the keynote speakers as well as the oral and poster presenters for sharing their expertise today. Finally, we thank this year’s planning committee for organizing today’s event.

Please relax and have fun!

Conference Leads:

Terri Irwin, RN, MN, Manager, Nursing Practice
Katey Knott, PT, MScPT, Professional Practice Leader, Physiotherapy
Cecilia Santiago, RN, MN, CNCC(C), Clinical Nurse Specialist
Kaleil Mitchell, Project Coordinator, Professional Practice, Nursing Practice and Education
Christine Williams, Administrative Secretary, Professional Practice/Wound Care

Executive Support:

Ella Ferris, Executive Vice President - Programs, Chief Nursing Executive and Chief Health Discipline Executive, St. Michael’s Hospital
Jennifer Istvan, President, Professional Practice Network of Ontario
Heather Campbell, Director, Nursing Professional Practice and Education, St. Michael’s Hospital
Beverly Bulmer, Director, Health Disciplines, Practice and Education, St. Michael’s Hospital

Program Objectives

• To provide a platform to share new/recent quality improvement and research projects on transitions in patient care
• To foster discussion about transitions in health care and provide participants with networking opportunities
• To identify and discuss key issues in transitions across the continuum of care: interfacility, intrafacility and facility to home
• To share innovative approaches and the use of technology in transitions in care
**KEYNOTE SPEAKERS**

**Irfan A. Dhalla, MD, MSc, FRCPC, St. Michael’s Hospital**

Dr. Irfan Dhalla is Health Quality Ontario's Vice President, Health System Performance. He is a general internist at St. Michael’s Hospital, where he cares for inpatients and teaches medical students and residents. He is also an Assistant Professor in the Department of Medicine at the University of Toronto, with a cross-appointment to the Institute of Health Policy, Management and Evaluation. Prior to joining HQO, he served as Medical Director, Quality and Research at St. Michael’s Hospital. Dr. Dhalla continues to hold an Associate Scientist appointment at the Li Ka Shing Knowledge Institute of St. Michael’s Hospital and an Adjunct Scientist appointment at the Institute for Clinical Evaluative Sciences.

Irfan’s research evaluates the way we organize, deliver, finance and regulate health care. He founded and continues to help oversee the Toronto Virtual Ward, a multi-organizational initiative designed to improve post-hospital care. He is also leading a CIHR-funded randomized trial comparing the Virtual Ward with usual care. Irfan's research on opioid-related harm, conducted with the Ontario Drug Policy Research Network, has played a major role in changing the way that opioids are prescribed and regulated in Canada.

His research has been recognized with several awards, including a Rising Star Award and a New Investigator Award from the Canadian Institutes of Health Research, a New Investigator Award from the Canadian Society of Internal Medicine, as well as the 2012 Labelle Lectureship in Health Services Research.

**Lianne Jeffs, RN, BScN, MSc, PhD, St. Michael’s Hospital**

Lianne Jeffs is the inaugural St. Michael's Hospital Volunteer Association Chair in Nursing Research. Her research program focuses on quality care transitions across the health care system and using performance data to drive quality healthcare. Lianne has delivered several presentations and published in academic and professional journals and a co-author on book chapters on patient safety and quality measures and method. Lianne has held several progressive leadership positions and continues to mentor clinicians and students in health services research and knowledge translation methods. She has received several awards for her scholarship and leadership including the Leadership Award, Society of Graduates in Institute of Health Policy, Management & Evaluation, University of Toronto in October 2012; Graduate Teaching Award for Excellence in Precepting from the Lawrence S. Bloomberg, Faculty of Nursing, University of Toronto in September 2011; and Canadian Institutes of Health Research –Institute of Health Services and Policy Research Rising Star Award in May 2010.

Lianne received her PhD from the Department of Health Policy Management and Evaluation, Faculty of Medicine, University of Toronto (U. of T.) in June 2010; and she holds a Master's of Science, Department of Nursing Science, U. of T. and a Bachelor of Science in Nursing, U. of T. She holds an Assistant Professor (status) appointment with the Lawrence S. Bloomberg Faculty of Nursing, University of Toronto and Institute of Health Policy Management and Evaluation, University of Toronto.

**Bob Parke, BA, BSW, MSW, MHSc, Bioethicist, Humber River Hospital**

Bob Parke has a keen interest in the day to day ethical issues related to transitions in care planning, integration and continuity of care across all points of care as well as advance care planning.

Presently Bob Parke is the bioethicist at Humber River Regional Hospital where he provides ethics consultations for patients, families and staff. He is active in the Research Ethics Board. Additionally he is also actively involved in organizational ethics activities such as co-chairing the Humber River Hospital’s Advance Care Planning Steering Committee. He is also a board member of St. Clair West Services to Seniors. This is in keeping with his goal to bring bioethics support and engagement into the community and long term care centres.

Bob Parke has written several publications including “Beyond Hospital Walls: Defining the Role of the Bioethicist in Long Term Care” and “Successful Advance Care Planning Through Quality Disease Management.”
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<td>08:00</td>
<td>Registration and Continental Breakfast</td>
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<td>08:30</td>
<td><strong>Opening Remarks</strong></td>
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<td>Irfan A. Dhalla, MD, MSc, FRCPC, Vice President, Health Quality Ontario, Health System Performance</td>
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<td><em>Why does everyone care about transitions?</em></td>
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<td><strong>Intrafacility Transitions Intershift Transitions</strong></td>
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<td>Toronto Rehab-University Health Network Department of Physical Therapy, University of Toronto</td>
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<td>Transition Care Clinic: An evidence-based and multidisciplinary model for transitioning survivorship patients from acute oncology to primary care</td>
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<td>Keynote Presentation</td>
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<td>12:00-13:00</td>
<td>Lunch/Poster Viewing</td>
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<td>13:45 - 13:55</td>
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<td>13:55 - 14:40</td>
<td>Keynote Presentation</td>
<td>Allan Waters Family Auditorium</td>
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<td>14:40 - 15:30</td>
<td>Refreshments/Poster Viewing</td>
<td>LKSI 2nd Floor Gallery</td>
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A. Intrafacility / Intershift Transitions

Lisa Harper & Suzie Laj, Trillium Health Partners

*Transfer of accountability is everyone’s business*

The presentation will describe an interprofessional, integrated and iterative approach utilizing PDSA methodology to create tools and processes, aligned with guiding principles, to address the interprofessional transfer of accountability (ToA). The tools and processes were developed to identify expected standards for ToA to improve communication of patient information associated with transition of care across three sites. Random chart audits in each program/unit will be utilized to determine compliance with tool and adherence to practice processes. Stakeholders will also be engaged to elicit level of satisfaction towards ToA processes and utility of tools.

Nicole Kirwan, St. Michael's Hospital

*Implementing best practices in bedside transfer of accountability in mental health settings*

The presentation will describe a quality improvement project initiated in a large academic health science center to standardize the technical information communicated between nurses at change of shift and engage mental health consumers in a Psychiatric Emergency Service and Inpatient Mental Health Program in a meaningful way in transfer of accountability at the bedside. Their experience shows that best practices in bedside transfer of accountability can be successfully implemented in acute care mental health settings when careful attention is paid to engaging clinicians and mental health consumers in quality improvement efforts. Lessons learned in this quality improvement project are widely applicable to other specialized health care settings.

Myra Kreick, College of Nurses of Ontario; Beth Ann Kenny, Federation of Health Regulatory Colleges of Ontario & Serena Shastri-Estrada, College of Occupational Therapists of Ontario

*Federation of Health Regulatory Colleges of Ontario Interprofessional e-Toolkit*

The presentation will describe the development of an interprofessional e-Toolkit to assist teams, clinicians at the point of care, and administrators, in determining roles, responsibilities and services when practice expectations are perceived to be unclear or discrepant, or when there are overlaps in expertise and authority. This tool is meant to support the provision of seamless, safe, high quality patient/client care through an interprofessional model of service provision. As a result of the e-Toolkit, interprofessional care teams will function more effectively in determining roles, responsibilities and services. The e-Toolkit will facilitate team communication to ensure all aspects of the patient’s/client’s healthcare journey are considered. Further research and application of the e-Toolkit will determine ways in which teams are functioning more effectively within their legislated scope of practice for the best interest of client care.
B. Interfacility Transitions

Frances Wright, Sunnybrook Health Sciences Centre & Amber Hunter, Cancer Care Ontario
Improving multidisciplinary cancer conferences: A population-based intervention

Multidisciplinary cancer conferences (MCCs) provide regularly scheduled forums to discuss appropriate diagnostic and treatment options for complex cancer patients and address the need for coordination between providers. MCCs are considered a critical element to cancer systems for complex patients requiring multiple forms of treatment. The MCC program is a model for the implementation of bringing together multiple providers to discuss complex cases locally, regionally and provincially. The presentation will describe the results of a study on a province-wide multi-pronged approach to implementing MCCs and increasing the number of hospitals with MCCs.

Simron Singh, Raman Deol, Angela Boudreau, Debbie Miller, Matthew Cheung, Sunnybrook Odette & Cancer Centre
Lisa Del Guidice, Sunnybrook Health Sciences Centre
Transition Care Clinic: An evidence-based and multidisciplinary model for transitioning survivorship patients from acute oncology to primary care

The Odette Cancer Centre (OCC) is the sixth largest comprehensive cancer centre in North America. The Transition Care Clinic (TCC) was developed for colorectal cancer and lymphoma patients transitioning from acute ambulatory care at the OCC back to their primary care provider (PCP) for follow-up care, assessment, and surveillance after completion of active treatment. The presentation will describe the need for inter-disciplinary development of survivorship and transition programs with buy-in from disease sites, multimodality consensus, revision of eligibility criteria for lymphoma, and implementation of efficient processes to complete comprehensive treatment summaries. The Odette Cancer Centre Transition Care Clinic appears to facilitate safe transition of survivorship patients back to their PCP with excellent acceptance and compliance with guidelines.

Darlene Hubley, Dolly Menna-Dack, Joanne Maxwell, Holland Bloorview Kids Rehab Tracy Paulenko, Toronto Rehabilitation Institute - University Health Network
LIFEspan - Living Independently Fully Engaged - an interfacility transition service providing high quality health care and a unique opportunity for interprofessional education

The presentation will describe an interfacility service that addresses the transition from pediatric to adult rehabilitation services for youth with childhood-onset disabilities. It will also illustrate the value of educating the next generation of health care providers by providing interprofessional education experiences on an interorganizational, interprofessional transition service. This model of care has been highly successful in supporting youth in transitioning from paediatric to adult rehabilitation services and has expanded to other community partners.
C. Facility to Home Transitions

Jo-Anne Howe, Karen Brunton, Toronto Rehab-UHN; Department of Physical Therapy, University of Toronto & Nancy Salbach, Department of Physical Therapy, University of Toronto

*Together in Movement & Exercise (TIME): Building partnerships to increase access to community-based exercise post-discharge*

With a growing trend of shorter length of stay in a facility, facility-to-home transitions are often difficult as patients face the new reality of managing residual impairments at home. This is particularly challenging for those living with the effects of aging or disabilities from neurological or musculoskeletal conditions. The presentation will describe the development of partnerships between health care and community recreation providers in order to increase access to community-based exercise following discharge. The pilot program showed that vulnerable populations had increased access to safe and beneficial exercise.

Andrea Hoffman & Stephanie Willison, Holland Bloorview Kids Rehabilitation Hospital

*A complex transition: The story of how three clients with complex care needs transitioned from a pediatric hospital to adult independent community living*

The presentation will identify the challenges related to transitioning clients with complex respiratory needs, inclusive of tracheostomy and mechanical ventilation, from a paediatric hospital setting to adult independent community living. It will also describe the processes of building collaboration between the interprofessional team of the hospital and community partners in order to facilitate successful transition, and developing a transition planning pathway for young adults. The presenters will showcase the story of how three young adults successfully transitioned to independent living in the community through strong collaboration between the hospital and their community partners.

Donna Johnson, St. Joseph's Healthcare Hamilton; Kim Ciavarella, St. Joseph’s Home Care & Lee-Ann Murray, St. Mary's General Hospital / Waterloo Wellington CCAC

*Integrated comprehensive care project*

Participants in this session will be introduced to an innovative model of care, the Integrated Comprehensive Care Project (ICCP). This model directly integrates case management across hospital and community care services to support patient-focused care for specific populations with complex needs, seamless transitions between hospitals and community, reduced length of stay in hospital and prevention of readmission to hospital and reduction in emergency room visits. The ICCP project has shown potential for a faster, better, cheaper model of care with seamless transitions for patients.
# POSTER PRESENTATIONS

## A. Intrafacility / Intershift Transitions

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<th>Abstract ID</th>
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<tr>
<td>5274</td>
<td>The benefits of interprofessional education (IPE) to enhance acute stroke care</td>
<td>Melissa Alves, Sandeep Gill, Michelle Ellis, Judith Kelly, Ashley Leone, Jodi Skinner, Krystyna Skrabka &amp; Jacqueline Willems</td>
<td>St. Michael's Hospital</td>
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<td>5295</td>
<td>Improving heart failure education through an electronic documentation tool</td>
<td>Ada Andrade</td>
<td>St. Michael's Hospital</td>
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<td>5293</td>
<td>Implementing transfer of accountability at the bedside (TOAB) in General Internal Medicine</td>
<td>Carol Banez, April Mick, Grace Ojo, Janet Pilgrim, Marta Tamburr, Adassa Wilson &amp; Melissa Guiyab</td>
<td>Toronto Western Hospital</td>
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<td>5290</td>
<td>Go slow to go fast: Moving towards bedside reporting</td>
<td>Jocelyne De Romana &amp; Joseph Gajasan</td>
<td>Toronto General Hospital</td>
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<td>5311</td>
<td>The Discharge Preparedness Protocol: How it improved readiness for discharge in Medical Surgical ICU patients</td>
<td>Jacqueline Devenyi</td>
<td>St. Michael's Hospital</td>
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<td>5282</td>
<td>Improving transition to hospital through the development of a new patient admission history</td>
<td>Lisa Freeman, Barbara d'Entremont &amp; Evelyn Kerr</td>
<td>The Ottawa Hospital</td>
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<td>5304</td>
<td>Piloting the corporate approach to shift-to-shift RN-to-RN bedside transfer of accountability in the cardiology units</td>
<td>Grace Fryfogel, Ayelit Gabler, Norine Meleca, Kaleil Mitchell, Terri Irwin &amp; Cecilia Santiago</td>
<td>St. Michael's Hospital</td>
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<td>5279</td>
<td>Medication reconciliation: An interprofessional approach</td>
<td>Catherine Goacher</td>
<td>Halton Healthcare Services</td>
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<td>5280</td>
<td>Use of integrated care pathways to enhance client transitions in mental health care</td>
<td>Gabriella Golea &amp; Saima Awan</td>
<td>Centre for Addiction and Mental Health</td>
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<td>5319</td>
<td>Patient handover: Developing interdisciplinary procedures for the transfer of accountability from CVICU to the ward</td>
<td>Alana Harrington, Angelo Cruz, Brenda Bjerkseth, Janice Glen, Alison Carre, Mary Mustard, Ellen Lewis &amp; Mark Kataoka</td>
<td>St. Michael's Hospital</td>
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Enabling child & family involvement in nursing shift handover: Development of a standardized communication tool and related practice
Abstract ID: 5303

A12. Katey Knott, Kerri Porretta, Lori Whelan, Spring Crabbe & Beverly Bulmer, St. Michael's Hospital
Health disciplines transfer of accountability
Abstract ID: 5291

A13. Joanne Maxwell, Andrea Macdonald, Sally Lindsay & Connie Castillo
Holland Bloorview Kids Rehabilitation Hospital; Anne Johnston Health Station
Ensuring successful transition to adult care: Development of a partnership transition model for young adults with spina bifida
Abstract ID: 5320

A14. Madhumathi Rao, Humber River Hospital
Novel application of formal transfer of accountability process in an ambulatory surgical milieu
Abstract ID: 5318

A15. Cecilia Santiago, Angelina Berlin, Charles Collantes & Karen Wannamaker
St. Michael's Hospital
Nurse-to-nurse intershift transfer of accountability in an intensive care unit
Abstract ID: 5232

A16. Cecilia Santiago, Terri Irwin, Spring Crabbe, Victoria Buczek, Kevin Berger, Natalee Elvie, Alexis Vieira & Amanda Alberga, St. Michael's Hospital
Ticket to Ride: Keeping patients safe during transport from inpatient area to procedure area
Abstract ID: 5330

A17. Lily Spanjevic, Joseph Brant Hospital
Measuring APN influence in COPD patient outcomes
Abstract ID: 5331

A18. Heather Thomson, University of Toronto
Factors that influence nurse-to-nurse shift handover in the emergency department
Abstract ID: 5278

A19. Kate van den Broek, Jocelyn Bennett, Carolyn Farquharson, Fred Koeman, Howard Hovens & Anita Low, Mount Sinai Hospital
Enhancing the emergency department experience: Expediting patient flow
Abstract ID: 5236

A20. Tina Fernandes Chopra, Darlene Barldaro & Danielle Ferriera, North York General Hospital
Long term mechanical ventilation: Transitioning patients from a critical care unit to an enhanced care unit to improve patient flow
Abstract ID: 5306

A21. Sarah Wallace, Kerry Doherty, Shari Vanderhoek, Elyse Braganza, Linda Lo, St. Michael's Hospital
Call Bell Training: “Call Me...Maybe?” Minimizing Constant Care
Abstract ID: 5277
B. Interfacility Transitions

B01. Paula Cripps-McMartin, Craig Norman, Sandra Walsh, University Health Network & Margaret Oddi, St. Michael's Hospital; Vivian Lee, Bridgepoint Health
Interfacility and Interprofessional collaboration: Facilitating access to the appropriate level of care for patients who require Bi-level Non-Invasive Ventilation (NIV) for sleep disordered breathing
Abstract ID: 5269

B02. Leah Drazek, Cheryl Harris-Taylor, Carolyn Christo & Ana Cavacas
Women's College Hospital
Specialized program for young adults with type 1 diabetes
Abstract ID: 5281

B03. Christine Gordon, Heather McPherson, Cristina Barrett & Lynn Carter
Women's College Hospital
Transition of clinically appropriate patients back to primary care as a strategy to reduce wait times for specialist care in an ambulatory setting
Abstract ID: 5285

B04. Kathryn Hay & Jodeme Goldhar, Toronto Central Community Care Access Centre
Advancing an integrated system of care in the Toronto Central LHIN: Disruptive innovation for system wide integration across complex populations and for supporting the advancement of health links
Abstract ID: 5300

B05. Kathryn Hay, Enrique Saenz & Catherine Prestwich
Toronto Central Community Care Access Centre
Huddle up! Integrated client care project for complex palliative clients
Abstract ID: 5307

B06. Catherine Petch & Judy Smith, Mackenzie Health
Synergistic communication: Facilitating care transitions for older adults with multiple complex conditions
Abstract ID: 5284

B07. Marlene Taube-Schiff, Jill Hamilton, Andrea Regina, The Hospital for Sick Children
Patti Kastanias, Mary Weiland, Sanjeev Sockalingam, University Health Network
Implementation of a young adult support group for bariatric patients: Examining the evidence
Abstract ID: 5259
C. Facility to Home Transitions

C01. Marjorie Hammond, Lee Ringer, Janet Wu, Lisa Luu, Susan Shin, Nancy Rebello, Harsha Babani, St. Michael's Hospital; Danielle DelDuca, Community Outreach Services for Seniors; Khadra Mohamed, Toronto Central CCAC
   *A frail elder’s journey across the continuum of care*
   Abstract ID: 5310

C02. Shelley Kay, Deb Mora, Lou Anne Melburn, Quinte Health Care
   *PRISM: Pathways Resulting in Interprofessional Standard Work and Metrics*
   Abstract ID: 5309

C03. Marnie MacKinnon, Jenna Evans & Esti Heale
   Cancer Care Ontario & IHPME University of Toronto
   *Continuity of care and patient choice in the delivery of chemotherapy: A best practices model for hospital - community transitions*
   Abstract ID: 5317

C04. Lakshmi Matmari, Jennifer Uyeno, University Health Network; Carol S.Heck, University of Toronto
   *Physiotherapists’ perceptions and experiences of the discharge planning process on acute-care general internal medicine units in Ontario*
   Abstract ID: 5261

C05. Joan Park, St. Michael’s Hospital
   *Tools for transitions of care*
   Abstract ID: 5294

C06. Katherine Popovski, Elizabeth Logan & Lorraine Ciccarelli, St. Michael's Hospital
   *Senior friendly strategies for postoperative pain management: A multidimensional approach for safe and effective analgesia from hospital to home*
   Abstract ID: 5313

C07. Catherine Renwick, Theresa Kay & Jane Mosley, Women’s College Hospital
   *‘We have so little time together!’ - Therapeutic relationships between patients and interprofessional care teams in an ambulatory care setting*
   Abstract ID: 5286

C08. Samuel Silver, Ziv Harel, Andrea Harvey, Rania Sobhan, Sanja Neskovic, Jonathan Fetros, Jill Campbell, Ron Wald, St. Michael's Hospital; Chaim Bell, Mount Sinai Hospital
   *An acute kidney injury (AKI) follow-up clinic to improve outcomes in AKI survivors*
   Abstract ID: 5266

C09. Nadiya Sunderji, Mara Goldstein, Joanne Walsh & Danijela Ninkovic, St. Michael's Hospital
   *An urgent psychiatric service to promote care continuity*
   Abstract ID: 5316

C10. Liandi Zhang, Anita Low & Jocelyn Bennett, Mount Sinai Hospital
   *Implementation of post-discharge follow up phone calls for high risk patients on general internal medicine units*
   Abstract ID: 5296
These directions will bring you to St. Michael's Hospital Li Ka Shing Knowledge Institute, 209 Victoria Street, Northeast corner of Shuter and Victoria Street.

**TTC DIRECTIONS**
1. Exit the subway at the Queen Subway station.
2. The Queen Subway station is on the Yonge-University-Spadina subway line.
3. Walk one block north on Queen Street to Shuter Street.
4. Turn right onto Shuter Street and walk east one block to Victoria Street. The Li Ka Shing Knowledge Institute is on the northeast corner of Shuter and Victoria Street.

**DRIVING DIRECTIONS**
FROM THE DON VALLEY PARKWAY
1. Exit at Richmond Street
2. Go west to Victoria Street
3. Go north to Shuter Street

FROM THE GARDINER EXPRESSWAY
1. Exit at Jarvis Street
2. Go north to Shuter Street
3. Go west to Victoria Street

**PARKING**
St. Michael's Hospital offers public parking in a convenient location across from the hospital. The lot is open 24 hours, seven days a week. The entrance is located on Victoria Street just north of Shuter Street on the west side of the Li Ka Shing Knowledge Institute. Parking inquiries should go to the lot manager James Parr at 416-369-1801 ext. 263.