



# Primary Health Care Research Day

## 6<sup>th</sup> ANNUAL RESEARCH DAY

A Patients Included Event

#PHCResearchDay

Monday, June 17, 2019

9:00 a.m. to 4:30 p.m.

Collaborative Health Education Building

5793 University Ave.

Dalhousie University Campus

Halifax, NS

Supported by:



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# Primary Health Care Research Day 2019

## Overview

Monday, June 17, 2019 | 9:00 am – 4:30 pm

Collaborative Health Education Building, 5793 University Ave., Dalhousie University Campus, Halifax NS  
#PHCResearchDay

Unless otherwise specified, events are in Room 170

8:00 – 9:00 am	<b>Registration, poster set up and breakfast</b> Please note that posters <i>must</i> be up by 9 am at the latest
8:15 – 9:00 am	<b>Brewing Ideas</b> Rooms 266 and 268
9:10 – 9:20 am	<b>Welcome</b> Dr. Emily Gard Marshall Associate Professor Department of Family Medicine Dalhousie University
9:20 – 9:45 am	<b>Opening Remarks and update on NS Integrated Health Research and Innovation Strategy</b> Dr. Alice Aiken Vice-president, Research and Innovation Dalhousie University
9:45 – 10:00 am	<b>Primary Health Care Directions at the Nova Scotia Health Authority</b> Lynn Edwards Senior Director of Primary Health Care, Family Practice and Chronic Disease Nova Scotia Health Authority  Tara Sampalli Director, Research and Innovation in Primary Health Care and Chronic Disease Management Nova Scotia Health Authority
10:00 – 11:00 am	<b>Keynote Address</b> Researcher, Provider and Policy-maker partnerships to implement evidence informed primary and integrated health care  Presenter: Dr. Walter Wodchis Professor, Institute of Health Policy, Management and Evaluation, University of Toronto Research Chair, Implementation and Evaluation Science, Institute for Better Health, Trillium Health Partners
Available for remote attendance via Zoom: <a href="https://zoom.us/j/686654146">https://zoom.us/j/686654146</a>	

11:00 – 11:30 am	<p><b>Primary and Integrated Health Care Innovations Network Lightning Round</b></p> <p>Presentations from the Primary and Integrated Health Care Innovations Network-supported research</p>
11:30 am – 12:45 pm	<p><b>Poster Session (Coffee Break held during poster session)</b></p> <p>Posters highlighting current primary health care research from health care providers, students, policy makers and researchers.</p> <p>Room 140/150</p>
12:45 – 1:15 pm	<p><b>Lunch</b></p> <p>Room 170</p>
1:25 – 3:00 pm	<p><b>Presentations: Primary Health Care Research (concurrent)</b></p> <p>Presentations highlighting current primary health care research from health care providers, students, policy makers and researchers.</p> <p>Schedule available below</p>
3:00 – 3:10 pm	<p><b>Break</b></p>
3:10 – 4:10 pm	<p><b>Implementing research in the local context – Lessons learned from the SPOR PIHCI Networks</b></p>
4:10 – 4:20 pm	<p><b>Presentation of BRIC NS Student Poster Award</b></p> <p>Beverley Lawson, MSc Director BRIC NS Network</p>
4:20 – 4:30 pm	<p><b>Closing Remarks</b></p> <p>Dr. Emily Gard Marshall</p>

# Building Research for Integrated Primary Healthcare

## BRIC NS

### WHO WE ARE

Building Research for Integrated Primary Healthcare or **BRIC NS** is an interdisciplinary research network of citizens, health professionals, researchers and policy-makers. We support change to improve patient health and experiences, health equity, and the primary and integrated healthcare system. We focus on individuals with and at risk of developing complex health needs.

BRIC NS is one of 11 Canadian Institutes of Health Research (CIHR), Primary and Integrated Health Care Innovations Networks (PIHCIN) which are an initiative of the Strategy for Patient Oriented Research (SPOR) and the Community-Based Primary Health Care Signature Initiative.

### OUR RESEARCH PRIORITIES

- **Integration of care** for those with or at risk of complex needs: health and social needs
- **Innovations** in primary and integrated service delivery (with a focus on multi-complexity)
- Bringing **evidence forward** for the improvement of effective, efficient and timely care
- **Enabling the primary healthcare workforce** to meet the needs of patients with multi-complexity and future demands for a range of services.

BECOME A MEMBER! To learn more about BRIC NS, the support we offer and how to join the network, VISIT [www.bricns.com](http://www.bricns.com) or EMAIL [bricns@dal.ca](mailto:bricns@dal.ca)

BRIC NS is funded by:



## Biographies

**Dr. Emily Gard Marshall, BA, MSc, PhD**, is an Associate Professor in the Dalhousie Department of Family Medicine Primary Care Research Unit, cross-appointed in Psychiatry and Community Health and Epidemiology, a Healthy Populations Institute Associate Research Scholar, Nova Scotia Health Authority Affiliated Scientist, McGill Family Medicine Adjunct Professor, Faculty Mentor for the CIHR TUTOR-Primary Health Care Strategic training program, Board Member of the Canadian Association of Health Services and Policy Research and former CAHSPR Primary Health Care Theme Group Chair. Her mixed methods research examines primary health care access, continuity, and comprehensiveness in community and institutional settings with the goals of improving access equity and optimizing patient and provider outcomes.

She currently leads "MAAP-NS: Models and Access Atlas of Primary Care Providers in Nova Scotia", the first Canadian study linking census provider and practice survey data to equity and comprehensiveness outcomes from billing data; "The UP study: Unattached Patients in primary care - a mixed methods understanding of causes, consequences and solutions"; and the Nova Scotia arm of the CIHR funded ECPC-Study of family physician practice patterns and preferences.

**Professor Alice B. Aiken, CD, PhD, MSc, BScPT, BSc**, is the Vice-President Research & Innovation at Dalhousie University in Halifax, Canada. She is an active researcher focused on health systems transformation and evidence-informed policy-making. Dr. Aiken is currently the Vice-Chair of the Governing Council of the Canadian Institutes of Health Research (CIHR) and chairs the board of Research Nova Scotia. She is elected to the College of New Scholars, Artists and Scientists of the Royal Society of Canada.

She was formerly the Dean of the Faculty of Health at Dalhousie. She is a co-founder and the former Scientific Director of the Canadian Institute for Military and Veteran Health Research, a unique consortium of over 41 Canadian and 7 international universities dedicated to researching the health needs of military personnel, Veterans and their families.

She received her PhD and Masters from Queen's University, Canada, her Physical Therapy degree from Dalhousie University, and a BSc in Kinesiology from the University of Ottawa. She also proudly served in the Canadian Armed Forces for 14 years, first as a ship's navigator in the Royal Canadian Navy, then as a physiotherapist.

She is currently the Honorary Captain (Navy) for Canadian Forces Health Services Atlantic, and a Dame of the Order of St George. For her commitment to the health and well-being of military personnel, Veterans, and their families, she has received the Canadian Minister of Veterans Affairs Commendation, the Queen's Diamond Jubilee Medal, and the Chapel of the Four Chaplains Legion of Honor Bronze Medallion (USA).

**Lynn Edwards** is the Senior Director of Primary Health Care, Family Practice and Chronic Disease with the Nova Scotia Health Authority. Since the inception of the one provincial Health Authority in 2015, she has led the development of a provincial vision and plan for the primary health care system and continues to build a high performing team that works to transform primary health care in NS; while enhancing quality in the system. Lynn completed her Nutrition degree at Mount Saint Vincent University, her internship at St. Michael's hospital and her Masters in Health Administration from Dalhousie University. She has received her EXTRA Fellowship from the Canadian Foundation for Healthcare Improvement and is a Certified Health Executive.

Lynn has worked in both rural and urban Nova Scotia as a clinical dietitian and leader in a variety of inter-professional collaborative teams; as well she has held various leadership roles in the N. S. Department of Health and Wellness in the Health Authority, and within national organizations.

A focus on health system quality, research and integration, understanding health as a complex system, building high performing teams and wellness/ chronic disease continue to be areas of professional focus throughout her career.

**Dr. Tara Sampalli** is Director, Research and Innovation in Primary Health Care and Chronic Disease Management at the Nova Scotia Health Authority, and Assistant Professor of Medical Informatics at Dalhousie University. She obtained her PhD in Interdisciplinary Studies specializing in Health Informatics from Dalhousie University. Dr. Sampalli's research interests include chronic disease management and multimorbidities, integrated models of care, knowledge management, and application of innovative IT solutions in health care.

## Brewing Ideas

8:15 – 9:00 am

#PHCResearchDay

The purpose of these pre-conference sessions is to provide an opportunity for knowledge sharing and capacity building. Moderators will provide a brief overview of the topic and the group will have the opportunity to discuss the issue. Participants come from different backgrounds and are encouraged to learn from each other and be open to the perspectives of others. Groups will be encouraged to think of next steps to continue these conversations and BRIC NS will help these groups set up future meetings and make connections with other people who may be interested in the topic.

Participants must have registered in advance. Participants are encouraged to eat breakfast while attending this session.

### Topic 1: How do we implement patient-centred care in primary care practice?

Room: 266

Providing patient-centred care can include things like involving patients in decisions about treatment and treating patients as individuals, not just as people with a medical condition. Both patients and health care providers agree that patient-centred care is an important part of the health care system. However, defining patient-centred care, and measuring whether it is being done, has been difficult. Finding ways to increase the uptake of patient-centred care in primary health care can help patients have better experiences while receiving care.

#### Facilitators

**Dr. Ruth Martin-Misener** is Professor and Interim Director of the School of Nursing at the Dalhousie University School of Nursing. She is an Affiliate Scientist with the Nova Scotia Health Authority and the Maritime SPOR Support Unit and is Co-Lead for the Collaborative for Research in Primary Health Care at Dalhousie University, and Co-Director of the Canadian Centre for Advanced Practice Nursing Research at McMaster University. The focus of her research is innovative interprofessional team-based models of care in primary health care, the roles of nurse practitioners and other advanced and specialized nurses, and patient engagement in primary health care quality improvements. She teaches nurse practitioner and other graduate students, supervises graduate students and post doctoral fellows, and is actively involved nationally and provincially in developing and evaluating policy for nurse practitioner regulation, education and practice. She has published numerous articles in peer-reviewed journals, presented widely at national and international conferences and is the recipient of several awards.

**Kylie Peacock** is a patient adviser and advocate in the Nova Scotia Health Authority and at the IWK Health Centre in Nova Scotia, Canada. Since her diagnosis of type 1 diabetes at the age of 8, Kylie's personal experiences have shaped her interests and she enjoys interacting with various stakeholders to work towards improving the healthcare system. Kylie has played an integral role at Diabetes Canada through her volunteering efforts. Kylie has provided her perspective on multiple Diabetes Canada committees and working groups, and has played an active role at Diabetes Canada community events and fundraisers. Most recently, Kylie was on Diabetes Canada's new Clinical Practice Guidelines Committee.

She is a BRIC NS Advisory Council community member. Kylie has been involved with multiple BRIC NS and Maritime SPOR SUPPORT Unit initiated health research projects, and this has led Kylie to join multiple national research teams as a patient co-investigator, where she acts as a full team member to create research questions, conduct interviews, analyze data, and disseminate results. This has given Kylie a platform to share her journey and stories of living with multiple chronic conditions and navigating the healthcare system. In addition to Kylie's tireless volunteering efforts, in 2017, she completed her Master of Arts (History) at Dalhousie University. When Kylie is not volunteering or working, she enjoys reading, spending time outside, and being physically active.

## Topic 2: Patient Engagement in Knowledge Translation: Emerging opportunities

Room: 268

In order to use what we know, we need to get the results of research to people who make decisions about health policy and healthcare. This process is called Knowledge Translation (KT). A big part of knowledge translation includes sharing research findings with a variety of audiences. Traditional dissemination activities include presenting at conferences or publishing in peer-reviewed journals. However, these outlets are often inaccessible to patients and the language used in research is often filled with jargon and difficult to understand for people outside of the field. More targeted KT strategies are beginning to be utilized, such as engaging patients through meetings, workshops and social media.

As patient engagement in research increases, roles and opportunities for patients to take part in and inform KT activities also increases. The purpose of this session will be to explore these opportunities.

### Facilitators

**Julia Kontak** is the Knowledge Translation (KT) Coordinator at the Maritime SPOR Support Unit (MSSU), a unit hosted by the Nova Scotia Health Authority (NSHA). The MSSU is administered by Strategy for Patient-Oriented Research (SPOR), a Canadian Institute of Health Research (CIHR) initiative to integrate health research more effectively into practice. Julia is dedicated to the science, education and practice of knowledge translation – the umbrella term used for all activities involved in facilitating the movement of evidence into policy/practice. Prior to working at MSSU, Julia worked at the Nova Scotia Health Research Foundation as a Research Associate for the REAL Knowledge Program and completed her Master of Arts in Health Promotion at Dalhousie University.

**Rebecca Mackay** has been working with Dr. Janet Curran and her team, Strengthening Transitions in Pediatric Care Team at the IWK Health Centre for the past 7 years as a Parent Researcher. Rebecca comes to the table with a parent's voice but also with an understanding of the health care system. Rebecca was employed at the IWK Health Centre from 2000 - 2009 where she was in various administrative roles supporting teams in the OR and in the Executive offices. Rebecca chose to leave work after having her second child as her daughter had a life-threatening event happen shortly after birth. Now that all 3 of her children are all in school full-time, she wants to give time back to the health care system.

Rebecca is involved with various Patient Oriented Research projects within the Strengthening Transitions in Pediatric Care Team and also volunteers at the IWK Health Centre with the Pediatric Emergency Quality Operations Committee (QUOPS) acting as a Parent Advisor.

## Keynote Address

10:00 – 11:00 am | Room 170  
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### Researcher, Provider and Policy-maker partnerships to implement evidence informed primary and integrated health care

In this lecture, Dr. Walter Wodchis will discuss practical considerations when trying to implement evidence into care and policy. Real world examples and the importance of partnerships will be discussed.

This lecture is available for remote viewing: <https://zoom.us/j/686654146>



**Walter Wodchis**, PhD, is Professor at the Institute of Health Policy, Management and Evaluation at the University of Toronto and Research Chair in Implementation and Evaluation Science at the Institute for Better Health, Trillium Health Partners. His main research interests are health economics and financing and health care policy evaluation. Through his research programs which include more than 30 collaborating researchers and as many trainees, Dr. Wodchis has lead several studies examining complex needs of high cost patient groups, the implementation of integrated care programs to address those needs, and evaluations for a number of integrated care programs in Ontario.

## Poster Session

11:30 am – 12:45 pm | Rooms 140 & 150  
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Posters highlighting current primary health care research and quality improvement initiatives from health care providers, students, policy makers and researchers.

**B** Building Research for Integrated Primary Healthcare (BRIC NS) is pleased to offer an award for best student poster given at Primary Health Care Research Day. These posters are eligible for the award and available for viewing in Room 170.

\* These posters feature the work of SPOR PIHCI Networks

	Presenter	Title
1	<b>B</b> Alicia Grant-Singh	Opioid substitution treatment in primary care: Exploring the perspectives of people who use substances and primary care providers
2	<b>B</b> Caroline Straub	Activating Cancer Communities through an Exercise Strategy for Survivors (ACCESS); A Patient Perspective
3	<b>B</b> Isaac Bai	Primary Care Prescribing Patterns for Patients Prescribed Chronic and High Dose Opioid Therapy: An Observational Study Using Electronic Medical Record Data
4	<b>B</b> Keisha Jefferies	Lifting as We Climb: The Community of Black Students in Nursing
5	<b>B</b> Myles O'Brien	Nova Scotia Healthcare Providers' Perspectives on Promoting and Sustaining Physical Activity and Exercise in Healthcare
6	<b>B</b> Nicole Blinn	The experiences of Indigenous students applying to Canadian medical schools: Barriers and facilitators to admission
7	<b>B</b> Arezou Teimouri	Stability of Diltiazem Compounded with White Petrolatum USP for Topical Use
8	<b>B</b> Clare Heggie	Accessing sexualized violence services and supports: Exploring the perspectives of women living in rural places
9	<b>B</b> Jelisa Bradley	Types of Collaboration and provider characteristics associated with improved primary care access: Results from the Nova Scotia MAAP-Study
10	<b>B</b> Martha Jane Paynter	The State of the Science for Women-Centred Perinatal Health Research in Carceral Contexts
11	<b>B</b> Natalie Horne	Primary Care Use and Health Characteristics of Patients with Dementia in Nova Scotia
12	<b>B</b> Ryley Urban	Panel reallocation model for providers in Rural Nova Scotia
13	<b>B</b> Briana Cregan and Duygu Biricik Gulseren	Workplace Bullying, Mental Health and Unhealthy Habits: The Impact of Organizational Identity
14	<b>B</b> Emma Cameron	Perinatal Experiences Among Recently Resettled Syrian Refugees: Barriers and Facilitators to Care
15	<b>B</b> Katie Vaughan	Design, Usability, Accessibility for All: A Case Study of a Rural Recreation Facility
16	<b>B</b> Megan Flynn and Marie-Ève Pomerleau	A qualitative investigation into the barriers, facilitators, and attitudes of clients in an interprofessional student-led clinic

17	<b>B</b> Neda Alizadeh	Barriers and Facilitators for Use of Public Transportation by Older Adults: A Scoping Review
18	<b>B</b> Sophie Sawler	Lets Talk About Sex: Awareness of and access to sexual health primary care resources by Canadian University Students
19	Rekha Dhonde	Health enSuite Insomnia: App-based treatments of chronic insomnia designed for use in primary health care
20	Ellen Stephenson	Health enSuite Caregivers: App-based intervention for distressed caregivers of people with dementia
21	Caitlin Robertson	Physicians perspectives of medical assistance in dying (MAiD): A scoping review
22	Caitlin Robertson	New Brunswick physicians' perspectives toward medical assistance in dying (MAiD)
23	*Fred Burge	Screening for Poverty And Related social determinants and intervening to improve Knowledge of and links to resources (SPARK) Study
24	*Fred Burge	Case management implementation in primary care clinics in Nova Scotia
25	Madeleine McKay	Implementing a fully integrated mixed methods design with a cross-national, multidisciplinary team: the Early Career Primary Care Project
26	Madeleine McKay	Policies affecting primary care practice patterns in British Columbia, Ontario, and Nova Scotia from 1998-2018: An environmental scan
27	Mark Bennett	The Characteristics of Primary Care Providers within Nova Scotia using Administrative Data
28	Beverley Lawson	Follow-up care for patients hospitalized for mental health disorders: Where do adult patients go?
29	Aaron DeRosa	Access is Everyone's Responsibility: Working Together in Managing No Shows and Cancellations
30	Anne Marie Whelan	Formation of a collaborative interprofessional primary health care deprescribing research team in Nova Scotia
31	Diane Theriault	Fracture Liaison Service (FLS): improving osteoporosis care for patients with fragility fractures
32	Jennifer Blok	Parental Perceptions of Water Safety for Children with Autism Spectrum Disorders
33	Kelly Hunter	Building Healthier Communities in Nova Scotia through MicroResearch
34	Larry Baxter	The HIV Stigma Index
35	Melanie Mooney and Isabelle d'Entremont	Taking steps towards supporting Primary Health Care teams in enhancing self-management skills that matter to patients
36	Sarah Bridges	A Neighbourhood Assessment of Opportunities for Physical Activity in Saint John, New Brunswick
37	Alysia Robinson	Can Community Factors be Accounted for in Hospital Performance Measures based on Case-Mix Adjusted Length of Stay?
38	Bonnie Doyle	Optimizing Self-Management of Diabetes and the Role of the Physiotherapist on an Interdisciplinary Chronic Disease Management Team
39	Courtney Heisler	Focusing on the future: Reducing barriers and improving access to IBD specialty care
40	Kaitlin Sibbald	Three ways of "Managing Fatigue": Increasing access by expanding the options for delivery of an effective self-management intervention
41	*Krystal Binns	Patients' Den: Innovation in Empowering Patients to Set Research Priorities
42	Martha Jane Paynter	Protocol for Implementation of Nurse Practitioner Provision of Medical Abortion in Canada

43	*Ruth Martin-Misener	A Cross Provincial Application of the PACE in MM Framework to Compare Programs for Patients with Multimorbidity in Interprofessional Collaborative Family Practice Teams in Primary Care
44	Brian Condran	Let's put our lessons to use: Refining a framework for building on successful patient/academic partnerships in health research
45	America (Mel) Keddy	Using the Taxonomy of Everyday Self-Management Strategies (TEDSS) Framework to guide quality improvement in chronic disease management
46	*Carole C. Tranchant	The Children's Health Profile and Birth Cohort Initiative in NB and PEI: Using administrative data to generate evidence on the effectiveness of early years primary intervention strategies
47	Holly Mathias	The Association Between Referral Quality, Wait Time and Patient Outcomes in an IBD Specialty Program
48	Judah Goldstein	The co-creation of an Emergency Department based Discharge to Assess (D2A) model of care: A mixed method evaluation of health care provider, patient and caregiver perspective
49	Christina Holmes	Taking Personalized Medicine into the Clinic: A Preliminary Review
50	Lindsay L. Richter	Solutions for Kids in Pain: Mobilizing Pediatric Pain Research to Patients, Practice and Policy
51	Michael Cardinal-Aucoin	Aligning patient and physician goals and expectations in management of chronic disease: an interactive poster presentation
52	Serena Lewis	The Labour Pains of Pre-Fatal Care: Strengthening Our Palliative Approach to Care
53	Bobbi Morrison	Patient Perspectives of Pharmacists' Expanded Scope of Practice
54	*Mathew Grandy	SPIDER - Structured Process Informed by Data, Evidence and Research

## Concurrent Oral Presentations

1:25 – 3:00 pm | Rooms 170, 264, 266, 268

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	<b>Access to Primary Health Care/Interprofessional Teams [Room 170]</b>	<b>Chronic Disease Management/Interventions for Health [Room 264]</b>	<b>Engaging Patients as Partners in Research and Health Services Delivery [Room 266]</b>	<b>Optimizing Community Resources/Healthy Aging [Room 268]</b>
1:25 1:40	<b>Access to Health Care: Emergency Department or Primary Care Office?</b>  Daniel Marsh and Ken Buchholz	<b>Improved access and comprehensive care for individuals with diabetes: Group medical visits initiative in Western Zone</b>  Lisa deMolitor and Isabelle d'Entremont	<b>The meaning of patient-centered care: Perspectives of patients with multimorbidity and teams in primary health care settings</b>  Ruth Martin-Misener	<b>The Effect of Community of Discharge on Length of Stay for Unplanned Hospitalizations: An Indicator of Community Care Integration?</b>  Alysia Robinson
1:45 2:00	<b>Understanding unattached patients: Consequences of unattachment and patient strategies for primary healthcare access</b>  Emily Gard Marshall	<b>Collaboration between the Health Authority and Community Programs to Improve Physical Activity for Nova Scotians: Community Health Teams (CHT)-Canada Games Centre (CGC) collaborative initiative</b>  Jill Robison	<b>*Partnering with Patients and Families in Program Planning and Service Delivery in Primary Health Care: An implementation science approach to evaluating integration of policy to practice</b>  Tara Sampalli (SPOR PIHCI)	<b>*A Realist Review of how Primary Healthcare can use Case Management to Connect End-of-Life Patients &amp; Family Caregivers with Community-Based Supports</b>  Grace Warner, Lisa Garland Baird and Juanna Ricketts (SPOR PIHCI)
2:05 2:20	<b>Virtual Primary Care: A technology-enabled solution to enhance access to a primary care provider for Nova Scotians living in rural and remote communities</b>  David Lapierre and Katie Heckman	<b>Self-management Support Provided by Chronic Disease Teams in Nova Scotia</b>  America (Mel) Keddy	<b>A Collaborative Intervention for Deprescribing: The Role of Stakeholder and Patient Engagement</b>  Shanna Trenaman	<b>*Increasing days spent in the community through Paramedics Providing Palliative Care at Home</b>  Alix Carter (SPOR PIHCI)
2:25 2:40	<b>Alignment of Primary Care Deprescribing Strategies to Nova Scotia Context Using Components of the Behaviour Change Wheel</b>  Natalie Kennie-Kaulbach	<b>Your Weight Your Way (YWWY): Impact of a group-based weight management program delivered by a multidisciplinary primary health care team on health behaviours and chronic disease risk factors over a 6 month period</b>  Jacklynn Humphrey and Kelsey Kennedy	<b>Improving timely access for trans and gender diverse populations in Central Zone: an Exploratory Study</b>  Kolten MacDonell and Jacqueline Gahagan	<b>Pathways for the Prevention and Management of Falls and Fall Related Injuries in PHC</b>  Susan Savage and Suzanne Baker
2:45 3:00	<b>Informing the development of interprofessional primary care teams: A web-tool to present results of a systematic review</b>  Dominika Wranik	<b>Role of culture in designing activity participation programs for elderly immigrants</b>  Shahriar Parvaneh	<b>*From research to practice: the implementation and evaluation of a patient navigation centre for children and youth with complex care needs</b>  Alison Luke (SPOR PIHCI)	<b>Review and Feasibility Assessment of the Camp Hill Veterans Memorial Dental Services</b>  Shauna Hachey

## Panel Presentation

### Implementing research in the local context – Lessons learned from the SPOR PIHCI Networks

3:10 – 4:10 pm | Room 170  
#PHCResearchDay

#### SPOR PIHCI Networks

The Strategy for Patient-Oriented Research (SPOR) Primary and Integrated Health Care Innovations Network (PIHCI) is a pan-Canadian network of researchers, patients, health care professionals, and policymakers from multiple health disciplines and sectors dedicated to conducting primary health care research. An initiative of the Canadian Institutes of Health Research (CIHR), the SPOR PIHCI Network aims to improve patient experience and health, health equity, and health system outcomes by including the voices and perspectives of citizens in research.

Funded in 2015, the pan-Canadian SPOR Network's overall goal is to support evidence-informed transformation and delivery of more cost-effective primary and integrated health care to improve patient experience and health, health equity, and health system outcomes for individuals with and at risk of developing complex health needs.

#### Projects

Getting research to the point of patient care is an essential component of creating a learning health system. In this panel discussion, two projects at different stages of implementation in Nova Scotia and New Brunswick will be discussed:

**“NaviCare/SoinsNavi: New Brunswick Navigation Centre for Children with Complex Care Needs”** assigns patient navigators to children with complex care needs. The services offered are based on the needs assessment the team conducted through a SPOR PIHCI Quick Strike grant in 2015-16. The aim of NaviCare/SoinsNavi is to help facilitate more **convenient** and **integrated** care to support the physical, mental, emotional, social, cultural and spiritual needs of children/youth and their families using a personalized **family-centred** model of care. As of the beginning of June, 148 families have been helped by a Patient Navigator through NaviCare.

**“Case management in primary care for frequent users of healthcare services with chronic diseases and complex care needs: implementation and realist evaluations”** was funded in 2018 through a SPOR PIHCI Programmatic Grant and is currently being implemented into two primary care practices in Nova Scotia. The goal is to introduce a nurse case manager in primary care settings for patients with complex health needs to improve care integration and reduce uncoordinated use of the system.

#### Panel

Moderator: **Kylie Peacock**

#### **Fred Burge**

Nova Scotia Principal Investigator, Case management in primary care for frequent users of healthcare services

Dr. Fred Burge is a Professor of Family Medicine and Community Health and Epidemiology at Dalhousie University in Halifax and a Family Physician. His research interests lie in health services research in Primary Health Care (PHC). He is one of three co-leads on the CIHR funded PHC Innovation team known as “TRANSFORMATION”, a five

year project focusing on the science of performance measurement in PHC. Of specific interest is improving primary care of those with advanced illness. Recently he led a large provincial mortality follow back study to examine unmet health care needs of the dying and co-leads a study to use EMRs to identify those at risk of dying for better care planning. He is committed to strengthening Primary Health Care research in Canada as a founding co-investigator on the team of "TUTOR-PHC" the first CIHR funded interdisciplinary training centre for Primary Health Care research, as co-lead of the Collaborative on Research in PHC (CoR-PHC), a new interfaculty research initiative at Dalhousie University and as the science lead of BRIC-NS, Building Research for Integrated Primary Healthcare, the NS CIHR SPOR Primary and Integrated Health Care Innovations Network.

### **Bonnie Clark Douglass**

Member, Family Advisory Council, NaviCare/SoinsNavi (New Brunswick)

Dr. Bonnie M. Clark was born in Fredericton, NB. Dr. Clark was a founding member of the New Brunswick Cardiology Technicians Association. Dr. Clark is a Graduate from UNB, in the B.Ed. and M.Ed. programs. She went on to take the Criminology Course at St. Thomas University (STU), and worked at the Centre for Youth at Risk at STU. Following the completion of the program she taught Intro to Criminology at STU. She began her Doctoral Degree while teaching. Her Doctoral thesis focused on creating a safety net for at-risk youth developing and creating a program in partnership with the Fredericton Police Force. She completed her Doctorate in Child and Youth Studies at the Nova Southeastern University in December 2006. Dr. Clark spent over three decades serving her community with her expertise in the areas of cardiology and criminology. Her achievements have resulted in provincial, national and inter-national presentations and recognition. Dr. Clark is a published author. She has been working as a Patient Experienced Advisor with Horizon health for close to five years and joined the team at UNBSaint John - NaviCare/SoinsNavi in that role.

### **Shelley Doucet**

Co-Director of NaviCare/SoinsNavi (New Brunswick)

Dr. Shelley Doucet, PhD Nursing, is the Jarislowsky Chair in Interprofessional Patient Centred Care and an Associate Professor in the Department of Nursing & Health Sciences at the University of New Brunswick in Saint John and the Scientific Co-Director of NaviCare/SoinsNavi. Dr. Doucet is also an Adjunct Professor with Dalhousie Medicine New Brunswick and is recognized as an emerging leader in interprofessional education and practice within Canada. Dr. Doucet's experiences teaching interprofessional student teams in classroom and clinical settings, as well as her clinical experiences as a Registered Nurse in mental health nursing and emergency medicine, have led her to establish interprofessional health education and practice initiatives and to explore their outcomes. Dr. Doucet's current research is based in primary health care settings, with a focus on children with complex health conditions and their families. In partnership with Dr. Rima Azar, she was awarded \$750,000 from the New Brunswick Children's Foundation to identify children with complex health care needs and to develop an innovative integrated service delivery model using a patient navigator to meet the needs of this population across the full continuum of care. She was awarded a CIHR PIHCl Quick Strike Operating Grant to expand the scope of the research that was funded by the New Brunswick Children's Foundation. Shelley is also a mother of two, an active community volunteer, and an avid runner.

### **Melanie Mooney**

Health Services Manager, Nova Scotia Health Authority

Melanie Mooney is a Health Services Manager in Primary Health Care in South West Nova Scotia with the Nova Scotia Health Authority (NSHA). She graduated from Dalhousie University in 2012 with a Master of Health Administration and is a Certified Health Executive (CHE) with the Canadian College of Health Leaders (CCHL). Melanie works as a manager with primary care family practice interprofessional teams in South West Nova Scotia.

She also leads quality improvement work in the NSHA Western Zone in Primary Health Care through an Interdisciplinary Quality Improvement & Safety Team with patient and family advisors as part of this team. Melanie is an active member of BRIC-NS, a member of our BRIC-NS advisory council, a member of Collaborative Research in Primary Health Care, a member of Primary Health Care and Collaborative Research in Primary Health Care working committee, Primary Health Care Research Day working group, and a Co-Investigator on several of our priority research projects in Nova Scotia. Melanie grew up and now lives in Yarmouth, NS with her husband and three young children.

### **Ciara Stevens**

Registered Nurse and Case Manager, Case management in primary care for frequent users of healthcare services with chronic diseases and complex care needs: implementation and realist evaluations

Ciara Stevens is an RN working as a Family Practice Nurse at Birchwood Medical Clinic in New Minas, Nova Scotia. Prior to jumping into the realm of primary care, Ciara worked in Critical Care. It was her time in ICU that allowed her to recognize that her true calling is *upstream*, in Primary Care. Ciara is certified as a Family Practice Nurse, a Critical Care Nurse and as a Yoga Teacher. She has a passion involving all things “diabetes,” and especially loves helping to build a sense of community for people living with chronic illness. Lastly, she is a self-proclaimed health and wellness nerd. Ciara holds a Bachelor of Science in Nursing from Saint Francis Xavier University.

### **Walter Wodchis**

## Poster Abstracts

### **1. Opioid substitution treatment in primary care: Exploring the perspectives of people who use substances and primary care providers.**

**Presenter:** Alicia Grant-Singh

**Co-author:** Dr. Lois Jackson PhD

**Introduction:** Opioid use disorder is a major public health problem across Canada, including in Nova Scotia. Opioid substitution treatment (OST) is an effective treatment that can help to reduce the harmful effects of substance use. However, access to treatment can be challenging in some Nova Scotia communities. Specialized opioid treatment programs (“methadone clinics”) have been the mainstay of treatment delivery but there remain access issues in some Nova Scotia communities (e.g., long wait times). Increasing access to OST is important and provision of OST in primary care may increase access yet we know relatively little about the barriers and potential facilitators to the provision of OST for primary care providers or key factors that might influence access for people who use substances. **Purpose:** The proposed study will explore the barriers and facilitators to OST in primary care, from the perspective of primary care providers and people who use substances. **Methods:** The proposed exploratory study will use a qualitative research design. Participants will be recruited from the Halifax Regional Municipality (Nova Scotia). Data will be collected using semi-structured, one-one interviews with approximately 5-6 primary care providers and 5-6 people who use substances. **Results:** Results are anticipated to be available in the fall of 2020. **Implications for policy and/or practice:** Opioid use disorder is a complex condition with many health and other risks (e.g., social) for people who use substances. OST can improve health and quality of life. This exploratory study will provide an understanding of some key barriers and facilitators to providing/accessing OST in primary care settings and as such will help to inform policy development related to increasing access to OST.

### **2. Activating Cancer Communities through an Exercise Strategy for Survivors (ACCESS); A Patient Perspective**

**Presenter:** Caroline Straub

**Co-authors:** Melanie Keats, Chris Blanchard, Scott A. Grandy

**Introduction:** At present, there is over 25 years of research data that shows that physical activity (PA) provides significant benefit to cancer patients/survivors (CS). Despite this knowledge, PA programming has not been integrated as a standard of care for CS. As a result, the majority of CS do not perform enough PA to receive the associated benefits. To rectify this problem, the Activating Cancer Communities through an Exercise Strategy for Survivors (ACCESS) was launched (Hfx, NS) in September 2019. ACCESS provides a free 12-week hospital or community-based PA program to interested CS. **Purpose:** This study assessed the effectiveness and sustainability of the ACCESS program from the CS perspective. **Methods:** Participant perceptions of the barriers, benefits, and overall experiences of the program were investigated during a post-program semi-structured interview. **Results:** Seven participants completed the post-intervention interview (♂= 5; ♀= 2). Participants experienced a variety of barriers and benefits regarding the ACCESS program. The results revealed that most participants were referred by oncology staff (n=5). The most common barriers included parking, location, and traffic, whereas the primary benefits reported included improved motivation and fitness, in addition to social and emotional benefits. All participants reported that the program was a positive experience and that they planned on continuing with PA. **Implications:** Overall, the ACCESS program is effective as it was shown to improve subjective physical, psychological and social outcomes. The ACCESS program also appears to have led to a lifestyle change as participants intended to continue with PA after they completed the program. Overall, this program demonstrates the benefits of PA that has been integrated into a primary care model.

### **3. Primary care prescribing patterns for patient prescribed chronic and high dose opioid therapy: An observational study using electronic medical record data**

**Presenter:** Isaac Bai

**Co-authors:** Mathew Grandy, Heather Neville, Sarah Sabri, Beverley Lawson, Jessica Nowlan, Ingrid Sketris

Introduction: Chronic opioid therapy (COT) prescribing for non-cancer pain has increased dramatically in Canada, despite limited evidence. Many risks are associated with chronic and high dose opioid therapy, such as misuse, addiction, overdose, and mortality. Purpose: To determine the feasibility of using electronic medical record (EMR) data to describe opioid prescribing patterns among patients prescribed COT in family practices. Methods: A retrospective secondary analysis of adults (age 18 and over) with at least one opioid prescription in 2017 was conducted using EMR data from the Maritime Family Practice Research Network (MaRNet-FP), consisting of 27 rural and urban family practices in Nova Scotia. Opioid prescriptions were identified using World Health Organization Anatomical Therapeutic Chemical codes. Exclusions were cancer patients and palliative patients, identified using ICD-9-CM diagnostic codes. Primary outcomes were prevalence of patients prescribed COT ( $\geq 84$  days of therapy), and prevalence of patients prescribed high dose COT ( $>90$  morphine milligram equivalents (MME) per day on average). The secondary outcome was quantity of prescribed opioids in all patients in 2017, in defined daily doses (DDD). Results: 45937 patients were eligible for the study, and 2031 patients (4.4%) were prescribed opioids with 6667 opioid prescription records in MaRNet-FP in 2017. Approximately one-third of patients prescribed opioids (732, 36%) were prescribed COT, which made up 4621 (69%) of the opioid prescription records. Of the 732 patients prescribed COT, 159 (22%) were prescribed high dose COT. The median MME/day in patients prescribed COT was 40 (range 0.66 - 1448). The six most commonly prescribed opioids were hydromorphone, codeine, morphine, tramadol, oxycodone, and fentanyl. Implications for practice: Patients prescribed COT and high dose COT were identified in the feasibility study. Future research will examine patient and prescriber characteristics, urine drug screening, and concurrent sedative/hypnotic therapy in order to provide feedback to prescribers.

### **4. Lifting as We Climb: The Community of Black Students in Nursing**

**Presenter:** Keisha Jefferies

Introduction: Black nurses are underrepresented in nursing and advanced practice including leadership roles. Black nurses encounter racism from patients, colleagues and superiors in the form of patients refusing care from a Black nurse and the use of racial slurs by colleagues. Everyday experiences of racism in the workplace are harmful to the mental and physical wellbeing of Black nurses. Additionally, Black nurses describe feeling marginalized within the nursing profession. African Nova Scotians (ANSs) are a highly oppressed group within the larger Black population. Multifaceted racism, combined with a legacy of trauma, has resulted in a unique and particular experience of Blackness for ANSs. Gaps exist in understanding the experiences of ANSs in nursing and the implications for addressing ongoing health inequities. Purpose: This research critically examines the leadership experiences of ANS nurses in health care practice. Guiding questions include: 1) How do ANS nurses perceive leadership? 2) How does race, class and gender interact to influence leadership for ANS nurses? Methodology: Black Feminist Theory and Critical Discourse Analysis provide the philosophical and methodological foundation, allowing for an in-depth examination of power and inequities produced through race, class and gender. Methods: One-on-one interviews using a semi-structured interview guide will be conducted with 8-10 ANS nurses. Audiotaped recordings will be transcribed verbatim and transcripts will be analyzed by examining words and language used by participants to identify how social and institutional structures influence their practice. Results: The results will inform policy, practice and programming in organizations, communities and institutions.

## **5. Nova Scotia Healthcare Providers' Perspectives on Promoting and Sustaining Physical Activity and Exercise in Healthcare**

**Presenter:** Myles O'Brien

**Co-authors:** Myles O'Brien, Chris Shields, Sandra Crowell, Jonathon Fowles

Introduction: Healthcare providers (HCPs) are entrusted with providing credible health-related information. Patients who receive HCP-delivered physical activity and exercise (PAE) advice increase their PAE level. The results of our previous work demonstrated that most HCPs infrequently include discussions about PAE as part of regular patient care due to the challenges they face (e.g. time) and their low self-confidence in discussing PAE with their patients. Purpose: To ascertain HCPs' opinions of what could be done to promote and sustain PAE in healthcare. Methods: HCPs (n=392) across Nova Scotia completed an online self-reflection survey regarding their current PAE practices and opinions. The sample consisted of 125 exercise professionals, 115 physicians, 65 dietitians, 50 nurses, and 37 other HCPs. A total of 670 meaning units were generated by the sample (1.7 units per HCP). Quantitative textual analysis (frequency of theme ÷ number of respondents) was performed to identify common themes. Results: The primary theme most cited by HCPs was to increase the availability of community programs (26.7% of respondents), followed by more educational opportunities for providers (25.2%), greater promotion of PAE from HCPs (19.3%), increased availability of a qualified exercise professional (19.1%), and reduced financial barriers experienced by patients (18.8%). Implications for Policy and/or Practice: Altogether, increased PAE education and a greater availability of community-based PAE programs that are affordable and incorporate qualified exercise professionals, will support the promotion of PAE as a primary aspect of healthcare in Nova Scotia. HCPs acknowledge the important role that they play in promoting PAE in healthcare; however, 1-in-4 HCPs identified the need for more educational opportunities to increase their PAE knowledge, self-confidence with providing PAE content, and ability to overcome impactful barriers that prevent regular PAE promotion.

## **6. The experiences of Indigenous students applying to Canadian medical schools: Barriers and facilitators to admission**

**Presenter:** Nicole Blinn

**Co-authors:** Maya Biderman, Leah Carrier, Amy Bombay, Indigenous Health Interest Group

Introduction: Indigenous peoples are underrepresented in the health professions, particularly medicine. Indigenous physicians represent only 0.25% of physicians in Canada. Indigenous students may experience barriers in the medical school admissions process, including limited access to extracurricular opportunities, barriers to and within standardized tests including the MCAT and CASPer, and limited access to role models. Access to Indigenous-specific admissions support programs and financial aid for standardized testing may help to facilitate admission. However, no studies have yet examined the distinct experiences of Indigenous students applying to medical schools in Canada. Purpose: The purpose of this project is to understand barriers and facilitators in the Canadian medical school admissions process, as identified by Indigenous students. Methods: This proposed multiple methods study will be conducted using an online survey and optional follow-up semi-structured telephone interviews. The survey will include both closed and open-ended questions to understand the experiences of Indigenous students applying to Canadian medical schools. The qualitative survey questions will be analyzed using qualitative description, and frequency distributions and descriptive statistics will be used to capture the quantitative survey questions. Thematic analysis will be used to analyze any follow up interviews that occur. Anticipated Results: Findings will provide insight into Indigenous students' experiences applying to Canadian medical schools, highlighting barriers and facilitators in the admissions process. Implications for policy/practice: This study may future policy and/or support program development to enhance facilitators to admission identified in this project while reducing barriers. Improving the recruitment and retention of Indigenous medical students may improve the health outcomes of Indigenous peoples and contribute to more

culturally safe provision of healthcare and medical education. Increasing the representation of Indigenous physicians can create conditions for more accessible, equitable primary health care for Indigenous peoples in Canada.

## **7. Stability of Diltiazem Compounded with White Petrolatum USP for Topical Use**

**Presenter:** Arezou Teimouri

**Co-authors:** Remigius Agu, Pollen Yeung

**Introduction:** Diltiazem is compounded in community pharmacies for chronic anal fissures treatment. Currently, literature information on the beyond-use-dates (BUDs) of compounded diltiazem for topical use is scarce. **Purpose:** To investigate the stability of diltiazem (2%) in White Petrolatum dispensed in white plastic (WP) and glass amber (GA) containers. **Methods:** Diltiazem compounded with petrolatum was dispensed in WP and GA containers. The products were stored at 23°C, 40°C and 4°C, respectively. We determined the potency of the formulations on days 0, 7, 14, 30, 60 and 90. We also assigned BUDs according to storage temperature, the USP and organoleptic properties considerations. Two-way ANOVA and Tukey's post-hoc test were used for data analysis and a p-value of <0.05 was considered statistically significant. **Results:** In both WP and GA jars, diltiazem remained potent for up to 90 days at 23°C and 4°C (p>0.05), excluding day 60 (p<0.05). The potency of the formulations stored at 40°C was inconsistent and outside acceptable USP range of 90-110% as early as on day 7 for GA jars and day 30 for WP jars. Changes in organoleptic properties occurred by day 7 in both jars for formulations stored at 4°C and 40°C. Changes were significant by day 90 at 4°C (increase in apparent viscosity, difficult to mix) and day 14 at 40°C (decrease in apparent viscosity, fluid-like) in both jars. Apparent viscosity decreased to a lesser extent at 40°C in GA jars at days 60 & 90. **Implications for Practice:** We recommend that pharmacists incorporate this research into their clinical practice and assign a BUD of 90 days for diltiazem (2%) ointment stored at 23°C and a BUD of 30 days when stored at 4°C. **Formulations exposed to elevated temperatures (40°C) may be used within 7 days if contained in WP or GA jars.**

## **8. Accessing sexual violence services and supports: Exploring the perspectives of women living in rural places**

**Presenter:** Clare Heggie

**Co-author:** Dr. Lois Jackson, Dalhousie University

**Introduction:** Women face significant barriers accessing formal services and informal supports in response to a sexual violence experience. These barriers include but are not limited to: victim blaming, stigma, and fear of a re-triggering or traumatic experience. Barriers exist at both the societal and community level. Rural sexual violence survivors face greater barriers to access. Rural areas generally lack the services available in urban area. Additionally, rural women tend to face higher additional risks and lower socioeconomic status, which exacerbates the previously identified barriers to access. This proposed study fills a gap in the literature by exploring the experiences of women living in rural areas. **Purpose:** The objective of this study is to explore and understand the experiences of adult women living in rural Nova Scotia who have experienced sexual violence. Specifically, the research questions ask: What are the experiences of women living in rural Nova Scotia who attempt to access/access/don't access formal and informal services and supports after experiencing sexual violence? What influences the use (or not) of services and supports following a sexual violence experience, for women living in a rural place? What services and supports do women who have experienced sexual violence think are needed in rural places? **Methods:** Qualitative, individual interviews will be conducted with women who have accessed or wanted to access formal services and informal supports. Data will be analyzed using a critical feminist phenomenological framework. **Results:** Results will describe the experiences of women living a rural place who have survived sexual violence. Key barriers and facilitators to service access will be identified.

Implications for Policy and/or Practice: An exploratory understanding of the experiences of survivors living in rural places could improve existing under-used services and inform new approaches to integrated care.

### **9. Types of Collaboration and provider characteristics associated with improved primary care access: Results from the Nova Scotia MAAP-Study**

**Presenter:** Jelisa Bradley

**Co-author:** Dr. Emily Gard Marshall

**INTRODUCTION:** Accessible primary health care (PHC) provides better preventative care, reduces hospitalizations, and improves patient satisfaction. Collaborative models of PHC are being adopted as a strategy to improve PHC in Canada. Previous studies have examined how organizational models or payment structures of PHC practices influence healthcare outcomes, however; the processes and methods by which PHC providers collaborate and their individual effectiveness has not been adequately demonstrated. **PURPOSE:** This study defines the elements of collaboration being implemented within PHC practices in Nova Scotia and examines whether these methods of collaboration are associated with better access outcomes for patients. **METHODS:** The Models and Access Atlas of Primary Care in Nova Scotia (MAAP-NS) gathered survey data from all PHC providers and their practices in the province of Nova Scotia. Data were collected through cross-sectional census telephone and fax surveys. PHC provider and practice characteristics were collected. Collaborative elements (e.g. regular meetings, care protocols) and measures of accessibility (e.g. acceptance of new patients, wait-times for routine appointments) were also collected. **RESULTS:** Twenty-one collaborative measures obtained from the surveys were subjected to a Principal Component Analysis and loaded onto three components, named: Formal Protocols, Shared Resources, and Shared Patients. PHC providers who reported collaborative elements involving Formal Protocols and Sharing Patients were more likely to be accepting new patients unconditionally and had shorter wait-times for routine appointments. Providers who reported Sharing Resources were less likely to offer evening/weekend care and had longer wait-times for routine appointments. **IMPLICATIONS:** Our findings suggest that having formal protocols and sharing patients (i.e. collaborating in patient care) is significantly more predictive of improved access than simply sharing resources (i.e. business-related collaboration).

### **10. The State of the Science for Women-Centred Perinatal Health Research in Carceral Contexts**

**Presenter:** Martha Jane Paynter

**Co-authors:** Emily Drake PhD(c), Christine Cassidy RN PhD, and Erna Snelgrove-Clarke RN PhD

**Introduction:** Women are the fastest growing population in prisons worldwide. Most research on incarcerated women in the perinatal period is focused on non-maternal outcomes, such as birthweight; non-health outcomes, such as recidivism; and risk factors that do not emerge from the perinatal experience specifically, such as substance use. Women prisoners experience complex health histories, including disproportionate victimization, poverty, mental illness and substance use disorders, which may complicate perinatal health. Carceral force and isolation may impact health outcomes. **Purpose:** The aim of this scoping review is to centre women in a synthesis of existing research on perinatal health outcomes of incarcerated women. **Methods:** Scoping reviews intend to synthesize the types of research and findings in an area using a systematic approach. Support of an experienced medical research librarian was used to develop and implement our search strategy. Databases included CINAHL, PubMed and PsycInfo. We included empirical studies published in English or French, with no pre-defined date range. The population of interest included women or transgender individuals who were incarcerated at any point during the perinatal period. **Results** Forty-five studies met the pre-set systematic review criteria and were reviewed in full-text and 13 studies met consensus for inclusion. Included studies were published from 1989-2014; 12 were based in the USA and one in Australia. Outcomes of interest included operative deliveries, gestational complications, depression, stress, experiences, bonding and sterilization. Only

one mentioned breastfeeding. Implications: Research needs to examine the prevalence and impact of carceral force, consider intersecting identities such as race and class, and focus on health outcomes of importance to women. Health care providers must be conscious of intersecting layers of discrimination and trauma incarcerated women experience and its impact on maternal health in the perinatal period. Health care providers have a duty to advocacy, compassion, beneficence and preservation of patient dignity and autonomy.

## **11. Primary Care Use and Health Characteristics of Patients with Dementia in Nova Scotia**

**Presenter:** Natalie Horne

**Co-authors:** Dr. Emily Gard Marshall, Dr. Melissa Andrew

**Introduction:** The 2016 Canadian census reports 19.9% of the Nova Scotian population is 65 or older, a larger proportion than any other province. Dementia is a neurodegenerative condition of advancing age affecting cognition, memory and personality. With improvements in longevity and the aging boomer population, national prevalence of dementia is projected to rise 66% from 2016 to 2031. Primary care is the corner stone of dementia care. Previous studies suggest other health characteristics may be associated with primary care use rates. Nova Scotia studies are limited to impacts of the aging population on emergency service use. **Purpose:** The study will use Maritime Family Practice Research Network (MaRNet-FP) data which amalgamates health information from electronic medical records of Nova Scotian patients across the province. The purpose is to analyse the relationship between primary physician visit rates and characteristics of patients with and without dementia. A secondary purpose is to identify if patients with dementia are prescribed different classes and number of medications versus patient without a dementia diagnosis and if there are differences in medication use between women and men. **Methods:** Data from patients ages 65 and older in January 2017 will be gathered based on characteristics: dementia diagnosis, age, gender, rural versus urban residence, chronic condition type and number of chronic conditions, medication type and number of medications. These characteristics will be compared to rates of physician visits in a 2-year period and any significant correlations will be highlighted. **Implications:** Data analysis may reveal relationships between characteristics listed and rates of primary physician visits and/or medication use. This information can be used to inform policy on resource allocation and health care optimization. Data analysis may find differences in medication and/or primary care use between men and women which can be used to inform practice.

## **12. Reallocation Model for Providers in Rural Nova Scotia**

**Presenter:** Ryley Urban

**Co-author:** Dr. Peter VanBerkel

**Introduction/Purpose:** The research relates to primary care in rural Nova Scotian and aims to improve patient access time and avoid provider over utilization. A clinic operating in the New Glasgow area has partnered with Dalhousie for capturing primary data and structures the motivating problem. **Methods:** The partnered clinic is a Collaborative Clinic, and therefore an opportunity exists for patient sharing. There are two specific research questions: 1) Can reassigning patients among providers positively impact access and provider utilization and 2) Can a similar approach be used to assign patients to a newly introduced provider, who were previously assigned to an existing “most responsible” provider. In addressing these questions we consider provider utilization (quantified through availability and overtime), the overall disruption of patients (i.e. the quantity of patients who change providers), and provider patient mix. **Results:** On-going, expected to be conclusive by June 17th. **Implications:** The panel optimization model incorporates existing providers, (Physicians and Nurse Practitioners) and is sufficiently general to adapt to growing patient demand and increases in providers.

### **13. Workplace Bullying, Mental Health and Unhealthy Habits: The Impact of Organizational Identity**

**Presenters:** Brianna Cregan, Duygu Biricik-Gulseren

**Introduction:** The experience of workplace bullying can have chronic stress effects on one's health outcomes (Biricik Gulseren & Kelloway, 2018). Previous research has explored the biopsychosocial consequences of workplace bullying (Cregan and Kelloway, 2018), but little research has been conducted on the role of workplace bullying on healthy habits. The moderating role of organizational factors are also largely missing in the literature. **Purpose:** The current study aims to explore the impact of workplace bullying on mental health and unhealthy habits and how organizational identity may alter this relationship. Specifically, this study tested the effect of being exposed to bullying at work on unhealthy habits (i.e. unhealthy eating, smoking and alcohol consumption) through mental health. The moderating effect of organizational identity on bullying and mental health was also examined. **Methods:** We used a sample of 1357 employees from the General Social Survey (Statistics Canada, 2016) which is a nationally representative sample of Canadians. We used Process Macro Model 7 (Hayes, 2017) on SPSS for the analyses. **Results:** Being exposed to bullying at work was found to be positively related with high levels of drinking and smoking. Similarly, bullying and healthy eating was negatively correlated. Mental health partially mediated the relationship between bullying and unhealthy habits. Finally, identification with the organization was found to be a significant moderator of bullying and mental health relationship. **Implications for policy/practice:** Workplace bullying can impair individuals' mental health and contribute to the development of unhealthy habits. However, positive organizational variables such as identification with the organization can protect individuals' health. Leaders within primary healthcare should be aware of the impact of organizational factors on individuals' health outcomes. Organizational communication and industry-level policy can be informed by this perspective to help shape employee sense of belonging and engagement with certain health behaviors.

### **14. Perinatal Experiences Among Recently Resettled Syrian Refugees: Barriers and Facilitators to Care**

**Presenter:** Emma Cameron

**Co-author:** Dr. Lois Jackson

**Introduction:** For many refugees, resettlement in Canada is a difficult transitional period, fraught with the challenges of adapting to a foreign country. Learning to navigate the Canadian healthcare system is one such challenge. Perinatal care (prenatal care, labour/delivery, and postpartum care) has been highlighted as particularly difficult to access. Pregnancy necessitates frequent, ongoing interactions with the healthcare system, often involving a variety of healthcare providers (e.g., family physicians, obstetricians) across settings (e.g., primary care clinics, hospitals). Studies in other healthcare settings have highlighted language, financial limitations (e.g., no access to transportation), and a limited understanding of how to access health services as barriers to accessing healthcare. Barriers and facilitators to accessing perinatal healthcare for resettled refugee women have never been studied in NS. **Purpose:** The purpose of this study is to identify the barriers and facilitators facing resettled Syrian refugees accessing perinatal care in NS, as reported by (i) postnatal refugee women, and (ii) healthcare providers (e.g., family physicians, doulas). **Methods:** A qualitative methodological approach will be taken. Participants will include 8-10 Syrian refugees who have been pregnant and given birth in NS and 8-10 healthcare providers who have cared for resettled Syrian refugees. Women must have been in NS for six months of their pregnancy, given birth within the last five years, and be at least four months postpartum. A focus group will be conducted with postnatal women, aided by an interpreter. Semi-structured interviews will be conducted with healthcare providers. Focus group interviews will be translated into English, transcribed verbatim, and analysed using thematic analysis. **Anticipated Results:** This study will provide an understanding of key barriers and facilitators to maternal health services for resettled refugees. **Implications:** These findings will

serve as a foundation for creating policy guidelines and interventions aiming to improve access to maternal health services in NS.

### **15. Design, Usability, and Accessibility for All: A Case Study of a Rural Recreation Facility**

**Presenter:** Katie Vaughan

**Co-authors:** Dr. Amanda Casey, Dr. Mikiko Terashima

Physical activity is one of the universal recommendations for maintaining good health for individuals with and without disabilities. However, options for physical activity may be limited for individuals with disabilities, in particular, due to a lack of accessible equipment, facilities, and lack of knowledge. Although recreation facilities are the ideal place for individuals with disabilities to be physically active, they are often unusable due to their inaccessible built environment. Effective changes to the built environment may alter the environmental and societal factors that foster physical inactivity. Therefore, the study followed a collaborative approach to evaluate the design, usability, and accessibility of a rural recreational facility by exploring the perceptions of users with and without disabilities. The case study consisted of five focus group sessions (N=46) and three site evaluations using the AIMFREE instrument: consumer version (N=2) and professional version. The focus groups and site evaluations yielded three commonly identified themes emerging from the principles of universal design: (1) equitable use, (2) size and space for approach and use, and (3) simple and intuitive use. While the recreation facility provides physical activity opportunities to diverse users within the rural community, the facility currently does not meet the needs of all users. To address current barriers, five participant priorities related to universal design have been identified in order to increase access and usability to the rural recreation facility.

### **16. A Qualitative Investigation into the Barriers, Facilitators, and Attitudes of Clients in an Interdisciplinary Student-led Health Clinic**

**Presenter:** Megan Flynn, Marie-Ève Pomerleau

**Co-authors:** Kathleen MacMillan, Carl Kooka, Emily MacMurdo, Gaithre Kalainathan, Angelena Kuhn, Nicole Blinn, Michelle Bérubé, Jubal Stewart, Lauren Moritz (All affiliated with Dalhousie University)

**Introduction:** Student-led clinics are becoming increasingly common in Canada, serving to encourage collaborative practice and education among trainees, and to deliver health care to marginalized populations. Existing evaluations focus on the experience of the student participants, while few evaluate the patient experience. Halifax Outreach Prevention Education Support (HOPES) is an inter-institutional collaboration between healthcare related programs at Dalhousie University, Mount Saint Vincent University, and Medavie HealthEd in Halifax, Nova Scotia. **Purpose:** The objective of this study is to investigate the attitudes, perceptions, and barriers to healthcare access for clients attending a student-led clinic in Halifax, Nova Scotia, for the purpose of quality improvement and better understanding of the patient experience. **Methods:** Participants will be recruited through the HOPES clinic in Halifax. Participants will be invited to be interviewed during their clinic visit, with the purpose of exploring themes that can lead to further improvement of HOPES. **Anticipated Results:** The findings will highlight the experiences of the participants and add to the developing literature, given that relatively little is known about clients' experiences accessing student-run health services.

**Conclusion/Implications:** Little is known about the experiences of participants accessing student-led clinics. It is important to understand their experiences in order to address potential barriers and support initiatives that provide opportunities to access for research participants.

## **17. Access to Community Services by Public Transportation, Barriers and Facilitators for Use of Public Transportation by Older Adults: A Scoping Review**

**Presenter:** Neda Alizadeh

**Co-authors:** Parvaneh, S., Goettl, H.R., Hau, M

Introduction: Older adult population is rising to 1.4 billion by 2030 and 2.1 billion by 2050 worldwide. The communities need to prepare for these impending changes. Access to public transportation is a necessity to achieve this goal. Objectives: The purpose of the study was to examine and summarize the currently available knowledge of the barriers and facilitators for using public transportation by older adults. Methods: A scoping review of the literature was conducted using five databases: MEDLINE, CINAHL, Academic Search Complete, and Urban Planning @ ProQuest. The Arksey and O'Malley (2005) methodological framework was used to carry out the scoping review. Keywords used in database searches included terms synonymous to the concepts of transportation, older adults, and barriers or facilitators. Results: A total of 233 articles were retrieved from the search strategy, only 23 studies met the study criteria. Five primary themes were found to influence the use of public transportation by older adults: physical environment, institutional environment, social environment, geographical location, and person-level factors. The most commonly reported barriers were under the physical environment theme including 'vehicle/in-transit', 'timing and scheduling of services', 'cost or funding for passes and public transportation', 'bus driver behavior', 'availability of services', 'routes and connections', psychosocial factors', and 'physical factors. Among facilitators for using public transportation for older adults, 'cost/funding for passes and public transportation', 'availability of services, routes and connections' were the most important factors. Implications for policy and/or practice: Considering an increasing number of older adults' population highlights considering requirements for considering special policies to facilitate their mobility for community access. The results of this study may be considered by policy transit developers and decision-makers to improve older adults' access to public transport. This can may increase their access to community services, and better health services outcomes.

## **18. Let's Talk About Sex: Awareness of and access to sexual health primary care resources by Canadian University Students**

**Presenter:** Sophie Sawler

**Co-authors:** Madison Pendleton, Carolyn Arbanas, Stefania Moro, Michael Cardinal-Aucoin

Introduction: In recent years there has been a clear increase in STI rates across Canada, including in Nova Scotia. This trend is particularly strong in the young adult population, especially those attending college/university. Purpose: To assess awareness of and access to sexual health primary care resources by students at a residential university in Canada. Methods: A mixed-methods approach incorporating a structured interview and a survey incorporating semantic differential, Likert scale, dichotomous, and open-ended questions. All participants were students attending St. Francis Xavier University, a residential university in rural Nova Scotia, Canada. Results: A summary of interview responses is provided. Survey data were analyzed by t-test, Mann-Whitney U test, and ANOVA as appropriate. Participants reported general dissatisfaction with their prior-knowledge of sexual health, which they rated as minimal to moderate. Knowledge about STI risk, transmission, safe sex practices, and treatment options varied with gender and degree program. Most female, but only half of male, respondents were aware of at least one option for access to available sexual health primary care resources, including STI screening, on or around campus. Female participants reported this information usually had been acquired by word of mouth. Implications: University students demonstrated a lack of basic knowledge of types of STIs, their transmission, and symptoms. Students were also generally poorly informed regarding availability of and access to sexual health primary healthcare resources. This deficit in knowledge about sexual health and resources combined with certain high-risk sexual practices prevalent in today's culture, involving casual sex with multiple partners, is likely responsible for the increased rates of STIs in this population. Based on these findings, it is

recommended that an increase in availability and visibility of education about safe sexual health practices and sexual resources available to university students be provided prior to and upon arrival at university.

### **19. Health enSuite Insomnia: App-based treatments of chronic insomnia designed for use in primary health care**

**Presenter:** Dr. Rekha Dhonde

**Co-authors:** Ellen Stephenson, Lori Wozney, Jonathan Pierce, David Gardner, Cathy MacLean, Patrick McGrath

**Introduction:** Sleep problems are a common complaint in primary health care. Research suggests that cognitive behavioral treatments for insomnia (CBT-I) are effective, but accessing these programs in a face-to-face setting can be difficult. App-based CBT-I has the potential to address this problem. **Purpose:** To develop and test an app for adult chronic insomnia. **Methods:** Health enSuite apps are being developed in partnership with a local app development company. Health enSuite Insomnia was developed in consultation with sleep experts and incorporates key elements of effective CBT-I programs including: sleep tracking and self-monitoring, sleep restriction, sleep hygiene, relaxation therapy, and changing dysfunctional thoughts and beliefs. This content is being adapted for delivery on a web-based app that can be accessed using a computer or smartphone. This app includes novel features specifically for use within primary health care. These include tools for gradual dose reduction and deprescribing of sleeping pills and, generating and sharing reports based on daily sleep diaries. Two pragmatic effectiveness trials testing the Health enSuite Insomnia app are planned for 2019. The first will test CBT-I program delivered without medication deprescribing and will recruit 400 adults with chronic insomnia not taking prescription sleeping pills. The second will test the delivery of the CBT-I program in combination with deprescribing and recruit 400 adults with chronic insomnia who are ready to begin tapering up to 2 benzodiazepines or Z-drugs. Recruitment for these trials will involve referrals from primary health care providers from across Canada. **Results:** Findings from preliminary testing of the apps and consultation with stakeholders will be presented. **Implications:** Health enSuite Insomnia app will offer an accessible behavioral treatment for chronic insomnia that supports tapering benzodiazepines and Z-drugs. This can be a valuable tool for primary health care providers and has been designed and tested specifically for use in this context.

### **20. Health enSuite Caregivers: App-based intervention for distressed caregivers of people with dementia**

**Presenter:** Ellen Stephenson

**Co-authors:** Lori Wozney, Rekha Dhonde, Janice Keefe, Pamela Fancey, Rowen McKenzie, Jonathan Pierce, Patrick McGrath

**Introduction:** Caregivers of people with dementia are at risk of high levels of stress. An app-based program can provide education and advice that is tailored to their needs. Our goal is to develop an app that will bolster the wellbeing of caregivers of people with dementia. **Purpose:** To develop and test an app-based intervention program for caregivers of people with moderate dementia. **Methods:** Health enSuite apps are being developed in partnership with a local app development company. Health enSuite Caregivers app is designed to provide education and advice in key topic areas (e.g., communication, support, and self-care) tailored to each caregiver's needs. It includes tools for personalized recommendations, goal setting, and reminders. This content is being adapted for delivery on a web-based app that can be accessed using a computer or smartphone. Usability testing followed by a pragmatic effectiveness trial within the primary health care setting is planned for 2019. This trial will recruit 400 caregivers of people with moderate dementia. Recruitment for these trials will involve referrals from primary health care providers from across Canada. **Results:** Findings from preliminary testing of the apps and consultation with stakeholders will be presented. **Implications:** Health enSuite Caregivers app will offer an accessible psycho-educational treatment to bolster the wellbeing of distressed caregivers of people

with dementia. This app will offer primary health care providers a valuable online tool for managing the health of distressed caregivers of people with dementia.

## **21. Physicians perspectives of medical assistance in dying (MAiD): A scoping review**

**Presenter:** Caitlin Robertson

**Co-author:** Dr. Emily A. Read

Medical assistance in dying was legalized in Canada in 2016. Despite this, access to MAiD is largely dependent upon physician willingness to provide this service. For this reason, we performed a scoping review on physicians' opinions toward this topic worldwide. Our objective was to examine the literature in peer-reviewed journals on this topic globally. The scoping review of the literature was conducted by first assessing the titles, abstracts, and then full articles using our exclusion criteria. Papers published from May 2012 to April 2018 were included. Papers that focused on other healthcare providers, and any acts that would be considered illegal in Canada were excluded. This was meant to identify perspectives that would be relevant specifically to physicians in Canada. A total of 174 papers were identified, of which 70 were included in the final analysis. Of the 70 papers included, 23 originated from Canada, with most of those being opinion pieces. Thematic analysis pointed to eight distinct themes: patient autonomy and suffering, the Hippocratic oath, religion, the doctor-patient relationship, physician autonomy, distance from palliative care, protection of vulnerable patients, and the different emotions surrounding MAiD. Legalization of MAiD is an important first step towards providing terminally ill Canadians with control over the conditions of their death. There is a potential that physician perspectives on MAiD can influence access for patients, but with a lack of empirical research, it is clear further research is needed in the Canadian context.

## **22. New Brunswick physicians' perspectives toward medical assistance in dying (MAiD)**

**Presenter:** Caitlin Robertson

**Co-authors:** Dr. Emily A. Read, Dr. Chris Watling

With the addition of medical assistance in dying (MAiD) to Canadian law in 2016, came many challenges to patients and providers. Since physicians and NPs are the professions able to provide MAiD, it is imperative to understand their perspective. In New Brunswick, only physicians are currently providing MAiD within the two regional health authorities. The purpose of this research is to understand what is shaping the perspectives of New Brunswick physicians toward MAiD. We will be conducting semi-structured one-on-one interviews with New Brunswick physicians, following a Straussian Grounded Theory approach to data collection and analysis to understand the social structures in place shaping their opinions on this topic. A snowball sampling approach will be used to recruit participants; we intend to have a purposive sample with half of the sample in support of MAiD, and half in opposition. We will continue data collection until a sufficiency of information is observed. Although data collection is not complete, it is anticipated that we will gain a rich understanding of what is shaping the views of New Brunswick physicians towards this important topic. This research has the potential to inform future studies on this topic. With the new law on medical assistance in dying, it is essential to understand the views of the practitioners legally allowed to provide this service; in New Brunswick, this is primarily physicians. Understanding these perspectives would be important in shaping further policies and regulations in the province.

### **23. Screening for Poverty And Related social determinants and intervening to improve Knowledge of and links to resources (SPARK) Study**

**Presenters:** Fred Burge, Alannah Delahunty-Pike

**Co-authors:** Lois Jackson, Emily Gard Marshall, Rick Gibson, Lynn Edwards, Tara Sampalli, Eunice Abaga, Kris Aubrey-Bassler, Alan Katz, Nazeem Muhajarine, Cordell Neudorf, Andrew Pinto

Context: The social determinants of health (SDOH) contribute greatly to health inequities in Canada. Although there is support to address SDOH in primary care, evidence-based interventions focusing on social needs, particularly poverty, are lacking. Routine sociodemographic data collected in primary care could be used to modify care to a patient's social context, improve diagnostic accuracy by using social determinant risk factors, and identify inequities in health services and outcomes. Objectives: 1) develop and validate a standard tool for sociodemographic data collection and social need identification, for use in a randomized controlled trial (RCT) to routinize poverty screening and related SDOH; 2) conduct a cluster RCT, after pilot work in Ontario, comparing a "modest" approach (tool identifying financial benefits and community resources, used in clinic with brief follow-up) to an "intensive" intervention (dedicated visit and follow-up visits), on change in income and secondary outcomes (community resources connection, psychological stress, quality of life); and 3) evaluate acceptability and feasibility of sociodemographic data collection and use, and patient experience of the intervention. Research team includes patient partners who have been engaged since funding commenced. Setting: 4-5 primary care clinics in Nova Scotia. Part of a larger patient-centred study including Saskatchewan, Manitoba, Ontario, and Newfoundland. Design: cluster RCT evaluating a "modest" (control) vs "intensive" intervention. Quantitative methods include data on patients' accessing benefits and/or increased income post-intervention. Qualitative methods include patient and healthcare provider intervention experience. Participants: 28 clinics in SK, MB, ON, NS, and NL; estimated 1,540 participants. Results: 1) multi-lingual standard for sociodemographic data collection in primary care; 2) implementation guidelines for data collection, extraction, analysis, and use across EMRs; 3) guidelines for engaging patients and communities; and 4) strong evidence from a national, cluster RCT on the most effective way to address poverty in primary care.

### **24. Case management implementation in primary care clinics in Nova Scotia**

**Presenters:** Fred Burge, Alannah Delahunty-Pike

**Co-authors:** Marilyn Macdonald, Mardi Burton, Melanie Mooney, Ciara Stevens, Kyra Taylor, Isabelle d'Entremont, Kris Aubrey-Bassler, Maud-Christine Chouinard, Shelley Doucet, Vivian Ramsden, Catherine Hudon

Context: Patients with complex needs, including multiple chronic conditions, frequently require a variety of health and social services, which can lead to integration of care difficulties. Providers at the primary care level are well positioned to identify needs through collaborative case management (CM). Despite strong evidence supporting CM as an approach to care, there is a lack of evidence about implementation barriers and facilitators. Objectives: 1) generate findings on implementation of CM in primary care for individuals with chronic conditions and complex healthcare needs frequently using healthcare services; and 2) implement evidence-based CM to improve care experiences and outcomes, while reducing the use of healthcare services by these individuals and related costs. Setting: 2 primary care clinics in Nova Scotia. This is part of a larger study including Saskatchewan, Quebec, New Brunswick, and Newfoundland (2 primary care clinics per province). Design: Mixed methods multiple-case embedded study and realist evaluation, implementing CM in primary care clinics, administered by a nurse case manager or social worker, with three different units of analysis: health system (macro); case management in clinics (meso); patient, family and community (micro). Quantitative methods – self-administered questionnaires, service use clinical data, fidelity (accuracy) evaluation. Qualitative methods – semi-structured interviews, focus groups, non-participant observation. Includes 2 cohorts, 12 months each. Participants: Patients with one or more chronic condition who frequently use health services, relatives of patients, and healthcare

professionals at primary care clinics. Results: This study will provide a better understanding of barriers and facilitators to CM implementation in different primary care contexts. It will inform patients, families, healthcare professionals, policy makers, and researchers about how and why CM is effective, under what conditions and for which groups of patients.

## **25. Implementing a fully integrated mixed methods design with a cross-national, multidisciplinary team: the Early Career Primary Care Project**

**Presenter:** Madeleine McKay

**Co-authors:** Goldsmith, Laurie J., Lavergne, M. Ruth, Grudniewicz, Agnes, Rudoler, David, Marshall, Emily, Ahuja, Megan, McKay, Madeleine, on behalf of the ECPC project team

Introduction: Mixed methods scholars emphasize the importance of integration, with key methodologists suggesting studies without integration of qualitative and quantitative phases do not earn the mixed methods label. While mixed methods research designs are now common in Canadian health services research, few examples demonstrate qualitative and quantitative integration. Purpose: This presentation describes our mixed methods study of early career primary care physicians' practice intentions, practice choices, and practice patterns and our attention to integration throughout the study. Methods: We employ a fully integrated mixed methods design to understand early career primary care physicians' practice intentions, practice choices, and practice patterns within the physician workforce in BC, ON, and NS. Our mixed methods study treats qualitative and quantitative methods with equal status, which is operationalized through two dominant arms (one qualitative, one quantitative) and a third arm (quantitative) playing a supporting role. The three arms operate in a parallel manner and inform each other in multiple ways through integration during study planning, data collection and analysis, and interpretation phases. Integration is further supported through regular communication across study sub-teams. Results: We are one year into the implementation of our mixed methods study. We have spent significant time refining our data construction plans within and across the study arms. Early attention to integration at the study preparation phase resulted in the identification of new concepts to use across the study arms. Regular discussion of integration also allowed for expansion of integration plans. This complex study design has been further supported by our commitment to transdisciplinarity and collaboration effectiveness. Implications for policy and practice: Employing integration in mixed methods research requires sustained attention to mixing throughout the study and an openness to creating new concepts and approaches during the study. Attention to integration, transdisciplinarity, and collaboration effectiveness is especially key in cross-national, multidisciplinary teams where different team members have expertise in different components.

## **26. Policies affecting primary care practice patterns in British Columbia, Ontario, and Nova Scotia from 1998-2018: An environmental scan**

**Presenter:** Madeleine McKay

**Co-authors:** Dr. David Rudoler, Amanda Pollicino, Michael Le, Margaret Jamieson, Dr. Ruth Lavergne

Introduction: Despite high ratios of primary care providers (PCP) to population, some Canadians face barriers when accessing primary care. Changes in PCP practice patterns (i.e. volume and mix of services provided) may explain some of the gap between supply and demand. The Early-Career Primary Patterns (ECPC) study aims to understand how PCP practice patterns change over time, what factors contribute to these changes, and the implications this has for the supply of primary care. One potential factor that may contribute to changing practice patterns is an evolving policy and regulatory context. Purpose: To understand this evolving context, we conducted an environmental scan of relevant federal and provincial (Nova Scotia, Ontario, and British Columbia) policies and programs over a 20 year period (1998 to 2018). Methods: We searched key websites related to primary care and health workforce policy using Google's advanced search function. A researcher from each

province, and one assigned to the federal government, reviewed the results of the searches. Each document was assessed for relevance against inclusion criteria (i.e., the document included a description of health human resources policy, models of care, scope of practice, physician payment, training, recruitment, and/or retention). Ongoing work will extract data from the relevant documents to construct a timeline and description of key policy/program interventions. We will validate the credibility of the results of our scan using key informant interviews. Results: Results from the extracted policy documents will be reported, describing key policies enacted by provincial (NS, ON, BC) and federal governments over 20 years. Implications for policy and practice: The results of this scan will inform the quantitative (administrative health data analysis) and qualitative (individual semi-structured interviews with PCPs) arms of the ECPC study. These results will also highlight the policy mix governments have employed to influence the supply of primary care.

## **27. The Characteristics of Primary Care Providers within Nova Scotia using Administrative Data**

**Presenter:** Mark Bennett

**Co-authors:** Beverley Lawson, Fred Burge

**Introduction:** The pan-Canadian TRANSFORMATION study seeks to transform community-based primary health care through comprehensive performance measurement and reporting to support innovative delivery and organization of the Canadian primary health care system. A component of the study seeks to understand and compare provincially funded health care services being provided by Primary Care General Practitioners (GP) across three Canadian provinces. **Purpose:** The objective for this presentation is to describe the composition and characteristics of GPs and the services they provide across Nova Scotia and within each health zone. **Methods:** Secondary data analysis using provincial MSI Physician Billings information and the Licensed Provider Registry. GPs were defined as being listed as a GP in the Physician Registry and billing most frequent for items under general practice. Upon identifying GPs within the province, all billings associated with patients aged 18+ years from fiscal year 2015 were analyzed to understand the services provided by GPs. To quantify the demographics and characteristics of GPs, the Physician Registry was used, in addition to locating a GPs listed address. **Results:** Within the province 1134 GPs were identified through Physician Claims and the Provider Registry. The average age was 50.37 years or age, with 45.86% of GPs being listed as female, and a mean of 21.38 years since graduating. Preliminary results suggest significant differences between provider characteristics such as age, sex and years since graduation, across health zones. Moreover, differences were also evident in services provided such as maternity care, calculated practice panel size and shadow billing. **Implications for policy and/or practice:** Understanding the characteristics of our providers are crucial component to planning the allocation of services throughout Nova Scotia. As we begin to identify gaps in different zones as to services, we will be better equipped to meet demands on the aging population.

## **28. Follow-up care for patients hospitalized for mental health disorders: Where do adult patients go?**

**Presenter:** Beverley Lawson

**Co-authors:** Mark Bennett, Fred Burge

**Background:** Follow-up care provided within a short period following hospital discharge is an important factor in reducing readmission or recurrence of health issues. As part of the TRANSFORMATION study, a multi-province Canadian study of Primary Care (PC) aiming to improve PC performance measurement reporting, readmission rates and provider follow-up for adult patients hospitalized for mental health disorders was examined. **Purpose:** To examine readmission and physician follow-up for adults who had been hospitalized for a mental health disorder (MHD) across Nova Scotia and by health zone. **Methods:** Secondary data analysis using Nova Scotia administrative health data spanning 01April2013 to 31March2016. Records included all adult Nova Scotians (18+ years) eligible for provincial health services. MHD was defined from ICD9/10 codes associated with 2+ MSI physician billings or 1 CIHI hospitalization record over 1 year. **Outcomes:** MHD hospitalization, provider follow-

up (general practitioner [GP] or psychiatry within 7 or 30 days), hospital readmission within 30 days of discharge. Covariates: Health zone, patient age, sex. Analysis: Descriptive, chi-square analysis. Results: Over the 3-year time span, 22.3% of adult Nova Scotians were diagnosed with a MHD; 6,755 (0.9%) were hospitalized. Of those hospitalized, 22% received provider follow-up care within 7 days of discharge; 52% within 30 days. GPs accounted for 95% and 96%, respectively of this follow-up care; psychiatry 5 to 4%. 11.8% were readmitted within 30 days of discharge. Preliminary results indicate significant differences across health zones with respect to a MHD diagnosis, hospitalization for MHD and provider follow-up care within 7 days. Implications for policy and/or practice: There is a large gap in timely follow-up care for adults discharged from hospital for MHDs. Of the minority who did receive follow-up care, almost all was from a GP. Given their generalist lens, practice supports to aid GPs in this role should be readily available.

## **29. Access is Everyone's Responsibility: Working Together in Managing No Shows and Cancellations**

**Presenter:** Aaron DeRosa

**Co-authors:** Mindy Leblanc, Karen Pyra, Cheryl Sharpe, Valerie Nicholson, Megan Renouf, Lissa Lynch, Katy MacDonald, Maryanne Jackson

Introduction: No shows and cancellations of medical appointments affect patients, providers, and pose a barrier to access to care. Access is a priority for Primary Health Care and the NSHA. Purpose: A subgroup of the Northern Zone Quality Improvement and Safety Council (QI&S Council) is working with two collaborative family practice teams (CFPTs) to decrease the number of no show and cancelled appointments through patient-focused strategies. Methods: We are using a participatory process involving members of the QI&S Council, clinic staff, and Patient Family Advisors. Creation of a project charter, expression of interest (EOI) process and form, and literature review were the first steps. Once two CFPTs self-identified through the EOI process, representatives from each team joined the project team and work proceeded to improve capacity to work as a single project team, to develop patient engagement strategies and co-create a standardized data collection methodology and tools. Baseline data is being collected. Baseline Results: During the first 30 days, 92 patients cancelled appointments, providers cancelled 67 appointments. There were 79 no shows, of these 26 confirmed appointment time, 25 were left a message, 11 were unable to reach. Patient engagement phase began with clinic conducting brief telephone interviews with recent no show appointments. Early results identify forgetting & transportation as primary reasons. Limitations: Early data was collected while developing a standardized collection template through a PDSA process making data quality an early limitation. Implications: Using a QI process, QI&S teams can work with CFPTs to co-create standard data collection tools that meet the needs of multiple practices and engage patients in QI projects. Co-designing improvement strategies with patients and providers is considered a key enabler to changing behaviours, meaningful improvements and sustaining practice & process changes.

### **30. Formation of a collaborative interprofessional primary health care deprescribing research team in Nova Scotia**

**Presenter:** Anne Marie Whelan

**Co-authors:** Jennifer Isenor, Natalie Kennie-Kaulbach, Ruth Martin-Misener, Fred Burge, Sarah Burgess, Olga Kits, Emily Reeve, Lauren Salisbury, Rachel Cormier, Isaac Bai, Heather MacLean, Melissa Helwig

Introduction: Polypharmacy is common in older populations with data suggesting that one in five medications may be inappropriate. This has been associated with negative consequences such as side effects, hospitalizations and death. Deprescribing is the process of tapering, stopping, discontinuing or withdrawing drugs. Research teams in other parts of Canada have led deprescribing initiatives in their areas, but there was no formal research group in Nova Scotia. Purpose: To describe the development of a collaborative interprofessional primary health care deprescribing research team in Nova Scotia. Methods: A core group of 6 health care researchers interested in forming an interprofessional primary health care deprescribing research team met in 2016 and proceeded with building a team using the following methods: 1) creating the team (needed expertise; roles and responsibilities); 2) establishing goals/objectives; 3) determining team functioning (leadership, communication and decision-making approaches); and 4) monitoring team outputs (e.g. presentations, publications, grants); and team functioning (e.g. discussions, surveys, social network analysis. Results: The first team meeting was in April 2017, and as of January 2019 the team had expanded to 9 core members with research assistants/students added as necessary. Two members assumed a co-leadership role, and together with the team, established the overarching goal, set specific objectives and reached a consensus on various aspects of team functioning. The team has received five grants, presented eight posters/oral presentations and has two manuscripts in preparation. A team assessment survey completed in 2018 resulted in changes to communication strategies. A social network analysis is underway. Implications for practice: Having a well built and functioning research team with a common goal of initiating deprescribing strategies in Nova Scotia may help to decrease polypharmacy and associated negative effects in this province.

### **31. Let's put our lessons to use: Refining a framework for building on successful patient / academic partnerships in health research**

**Presenter:** Brian Condran

**Co-authors:** Larry Baxter, Grace Warner, Elizabeth Michael, Tara Sampalli, Ruth Martin-Misener

Introduction: Patients and academics in Nova Scotia have formed partnerships to plan and conduct health research, and many of these teams have been successful in doing so. These partnerships often include other partners such as NSHA staff and decision-makers. It can be challenging to build these diverse teams, so it is important to learn 'what works' and how to apply these lessons elsewhere. Purpose: This poster presentation has 2 purposes. First, to share our team's experience in developing a framework to help us learn from others who have built partnerships between academics and patients. Second, to continue this work and gather feedback from conference participants. Methods / results: Team members held an interactive workshop during the Healthy Living, Healthy Life conference in Fall of 2018. During this event, 4 team members and 10 participants shared their experiences building partnerships between patients, academics, and other partners. A graphic facilitator captured discussion as a poster which the research team will share at Primary Health Care Research Day. Conference participants are invited to discuss the poster with team members and share their thoughts and experiences building research partnerships. Implications / relevance to PHC: This project builds on lessons learned across three research projects related to primary health care. This framework is being refined through consultation with patients and staff from NSHA Primary Health Care to ensure it is relevant to the work of Quality and Safety teams as well as research teams. Presenting this poster at Primary Health Care Research Day will help in this process.

### **32. Fracture Liaison Service (FLS): improving osteoporosis care for patients with fragility fractures**

**Presenter:** Diane Theriault

**Co-authors:** Carla Purcell, Geraldine Griffin, Beverly Pimentel

**INTRODUCTION:** 2010 Nova Scotia (NS) data revealed that only 23% of patients with hip fracture were prescribed an osteoporosis medication post-fracture. FLS is a model of care proven to reduce the post-fracture care gap, repeat fractures and mortality. Nova Scotia Health Authority (NSHA) Primary Health Care (PHC) operates 3 FLSs (Dartmouth, Kentville, Sydney) helping family physicians provide osteoporosis care for their patients with fractures. **PURPOSE:** To review strengths and weaknesses of NSHA PHC FLSs as part of our on-going quality improvement process. **METHODS:** NSHA FLSs participated in Osteoporosis Canada's (OC) national FLS audit for the 6-month cohort of patients enrolled April 1-September 30, 2017. We present the aggregate results for the 3 NSHA FLSs on OC's Key Performance Indicators for the 3i's (identification, investigation and initiation of treatment) and compare to national results. **RESULTS:** In the 6-month cohort period, 347 NS patients were enrolled in the FLSs. In NSHA FLSs, 42.7% of the patients with fragility fracture were identified compared to national average of 57% (range 36-87%). One NSHA FLS exclusion criterium, patients without family physician (FP), was our main barrier (fracture patients without FP were 15.1%, 11.4% and 6.8% respectively in Dartmouth, Kentville and Sydney). Fracture risk was determined in 92.5% (national average 89%, range 63-100%). Treatment initiation in high risk patients was 52.4% (national average 49%, range 24-86%). **IMPLICATIONS FOR POLICY AND/OR PRACTICE:** As a result of this audit, NSHA's FLS Medical Directive has been updated to include patients without FP. For the third i, all Canadian FLSs face common barriers (prevalent myths about osteoporosis and osteoporosis medications). We are working with OC and other Canadian FLSs to develop knowledge translation tools to help dispel these myths. We will be participating in OC's upcoming national FLS audit and hoping for improved results.

### **33. Parental Perceptions of Water Safety for Children with Autism Spectrum Disorders**

**Presenter:** Jennifer Blok

**Co-authors:** Dr. Amanda Casey, Dr. Kevin Moran

**INTRODUCTION.** Unintentional drowning remains the leading cause of death for children with Autism Spectrum Disorders (ASD). Parental overestimation's and overconfidence in water safety has been found to decrease supervision for young children. Despite the prevalence of drowning amongst children with ASD, there is no research available on parental perceptions of supervision and water safety for this population. **PURPOSE.** The objective of the present study is to investigate parental perceptions of water safety amongst children with ASD. **METHODS.** A self-reported questionnaire was distributed to parents (n=59) of children with ASD under 14 years of age through community networks across Nova Scotia, and Ontario. The survey identified parental perceptions of swimming lessons and swimming ability, as well asked questions related to adult supervision, and parental knowledge of water safety. Participants were grouped based on their reports of their child's swimming ability (Group A; average/good swimmers, Group B; poor/non-swimmers). Descriptive statistics were reported and summarized for each question, and a Mann-Whitney U test was used to determine differences between groups. **RESULTS.** Limited differences were found between groups in their responses to statements. Most parents agreed that swimming lessons prevented drowning (68%), and swimming ability was more important than adult supervision (70%). **IMPLICATIONS.** Many parents of children with ASD overestimate the capacity of swimming lessons, and underestimate the importance of supervision to ensure water safety for their children. Given that swimming lessons may contribute to a false sense of security for parents, more education should seek to address these misconceptions and promote increased water safety.

### **34. Building Healthier Communities in Nova Scotia through MicroResearch**

**Presenter:** Kelly Hunter

**Co-authors:** Dr. Noni MacDonald, Dr. Bob Bortolussi

Introduction: Imagine a paramedic, a community health nurse, a cop, and a shelter worker are introduced for the first time and told to dream up a community health problem that they all feel interested in. This is what happens with MicroResearch NS – health problems are identified and tackled by people within the community. The creation of Drs. Noni MacDonald and Bob Bortolussi, MicroResearch originated in Africa and was later brought to Nova Scotia to teach community members how to find solutions to local health problems. These solutions must fit the community, culture, context and local resources to improve health, well-being, and primary health care in Nova Scotian communities. Methods: Attending workshops spanning the course of two weeks, participants are taught practical research skills by trained volunteers and local researchers. Participants are broken into small teams who work together to think up a research project tackling issues relevant to them and their communities. Teams are paired with coaches, who offer advice and help them develop their research proposal. After the workshop, participants receive access to a web-based clinical research curriculum to help them further their knowledge. Teams are encouraged to conduct their projects, with MicroResearch NS offering support through peer reviews, funding opportunities, and advice on knowledge translation. Results: MicroResearch NS has held eight workshops across the province, training almost 100 individuals from a range of disciplines, including medicine, community development, policing, etc. As of April 2019, there have been five projects funded and launched by MR-NS participants. These projects are exploring issues such as pop consumption in the Paqtnkek First Nations reserve and what resources alcohol-addicted homeless men need to improve their lives. Implications for policy and/or practice: The MicroResearch NS program emphasizes the importance of knowledge translation to its participants, encouraging projects that address determinants of health and have a direct impact on their communities, health systems, and primary health care. By informing policy and implementing change, participants are able to address issues that they identify as being relevant to the health and well-being of their communities.

### **35. The HIV Stigma Index**

**Presenter:** Larry Baxter

**Co-authors:** S. Kirkland, M. Liddell, T. Parsons, J. Connors, A. Miller, C. Ploem

Introduction: HIV infection and AIDS have been on the primary health care agenda since the early 1980s and their associated stigma has been a major consideration for public health and prevention messaging. Stigma remains one of the biggest barriers preventing access to HIV prevention, treatment and care. The HIV Stigma Index is a global survey tool developed by and implemented for persons living with HIV (PLHIV). Since 2008, it has been implemented in over 100 countries and in over 55 languages, with Canada being one of the latest. Purpose To explain how the Stigma Index— a tool designed to collect quantitative and qualitative information on stigma, discrimination and the rights of PLHIV— is being introduced into Atlantic Canada in a two-step process; community engagement and as a research project. Methods The project is composed of four main steps: (1) Community mobilization and training; (2) Data collection and analysis; (3) Knowledge translation and exchange; and (4) Community re-engagement. We are currently at the initial step and are planning to begin data collection in the summer of 2019, with the aim of conducting interviews with 100 PLHIV across the four Atlantic provinces. Results This poster will explain the process whereby PLHIV (the “patients”) are in total control of the research process, ranging from building connections, conducting interviews with other PLHIV, sharing their own stories of stigma, analyzing data, presentation of findings, and developing evidence-based anti-stigma strategies.

Implications for policy and/or practice At the core of the research process as both interviewers and interviewees, PLHIV drive how the information is collected, analysed and used. As patient engaged research becomes more widespread in Nova Scotia, this project will serve as a great example of empowerment of patients in the research process; i.e. the far end of the public participation spectrum.

### **36. Taking steps towards supporting Primary Health Care teams in enhancing self-management skills that matter to patients**

**Presenters:** Melanie Mooney, Isabelle d'Entremont

**Co-authors:** Shannon Ryan Carson, Crystal Todd, Tara Sampalli, Tanya Packer, America Cristina Keddy, Jo-Anne Wentzell, Michele, LeBlanc, Mardi Burton, Margo Walsh-Leaman, Natalie Connell, Lisa deMolitor, Jacintha Harvey, Heather Burton, Kim d'Entremont, Rose Rousseau, Brenda Townsend, Virginia MacIntyre, Georgann MacDonald

**INTRODUCTION:** Self-management and self-management support was identified as a priority area for improvement, during a recent accreditation review conducted by the Interdisciplinary Primary Health Care/Chronic Disease Quality Improvement and Safety Team (WZ PHC IQIS). This initiative applied the evidence-based TEDDS Framework and a quality improvement approach to enhance self-management support across the Western Zone. **PURPOSE:** An interdisciplinary collaborative exploration of opportunities to enhance self-management supports for patients across teams and practices in Western Zone. **METHODS:** A mixed methods approach was used to review evidenced-based methods to enhance self-management support for providers and patients. Accreditation Patient Experience Survey results, consultations with collaborative teams, patient and family advisors, researchers and decision makers were used in the review process. A questionnaire, developed based on the TEDDS domains, was used to gather collaborative team perspectives to understand and prioritize self-management support strategies to improve patient outcomes. **RESULTS:** In total, 41 health care professionals (HCPs) and six Patient/Family Advisors (PFAs) completed the survey. Most notably, 90.2% of HCPs and 83.3% of PFAs considered resources strategies as important; 51.2% of HCPs and 50% of the PFAs requested more information on this domain. In addition, 80.5% of HCPs and 100% of PFAs consider internal strategies as important; 48.8% of HCPs and 50% of PFAs requested more information on this domain. The WZ PHC IQIS identified that further investigation was needed and is planning to meet with three teams within the zone to discuss their approach to specific self-management strategy domains. **IMPLICATION FOR POLICY/PRACTICE:** This initiative will help us identify what our collaborative family practice teams need in order to improve their self-management support skills and strategies. Collaboratively identifying gaps and co-designing solutions with teams and patients is expected to yield feasible, effective and sustainable strategies in Primary Health Care.

### **37. A Neighbourhood Assessment of Opportunities for Physical Activity in Saint John, New Brunswick**

**Presenter:** Sarah Bridges

**Co-authors:** Dr. Mary McKenna, Dr. Anil Adisesh

**INTRODUCTION:** Community physical activity (PA) programs have been associated with positive outcomes in the rehabilitation of non-communicable disease and injury, along with reductions in return to work times. Prescriptions for PA are often administered to patients during return to work processes, but availability and location of PA opportunities is not always known within communities. **PURPOSE:** Existing PA opportunities targeted to adult populations in Saint John, including those that focus on rehabilitation, were assessed on physical distribution and accessibility. **METHODS:** All PA opportunities available to adults aged 19-65 were included. Characteristics of opportunities were gathered using a standardized template from program resources and contact with program coordinators by email or telephone. For programs targeting rehabilitation, a second questionnaire was administered. Spatial data analysis was conducted using ArcGIS to determine the distribution of PA opportunities. **RESULTS:** 98 PA opportunities in Saint John were found. Programs were more abundant in the centre of the city, in areas of low population (Figure 1). 98% of these were accessible by public

transportation, and 89% were physically accessible. 87% of programs required fees (membership or pay-per-use) (Table 1). Programs evenly targeted age, gender, fitness level, and skill level (Table 2). Two organizations offered three rehabilitation specific programs to those who have arthritis, survived cancer, or suffered cardiac events (Figure 2). These programs focused on minimizing decline, were accessible through referral from a physician, and were led by physicians, nurses, and physiotherapists. IMPLICATIONS: When creating new PA opportunities and rehabilitation focused PA programs, this distribution should be taken into account as it may have an effect on PA and rehabilitation of residents. Policy should be developed to encourage creating new PA programs in these neglected areas, and encouraging the implementation of more rehabilitation focused PA programs. Future PA prescriptions should take location into account to encourage adherence.

### **38. Can Community Factors be Accounted for in Hospital Performance Measures based on Case-Mix Adjusted Length of Stay?**

**Presenter:** Alysia Robinson

**Co-authors:** Dr. George Kephart, Dr. Leslie Anne Campbell, Dr. Grace Warner, Dr. Pantelis Andreou, Dr. David Stock, Mike Reid

Introduction: Average case-mix adjusted length of stay (LOS) is a widely used measure of hospital efficiency. Community of residence affects discharge decisions; however, it is not included in adjustment models. Purpose: Including community in adjustment models requires the differentiation of community and hospital effects on adjusted LOS; we aim to determine whether this is feasible. Methods: We conducted a secondary data analysis of hospital discharge abstract data for 2010-2014 to examine the effects of community (n=77) and hospital (n=32) of discharge on LOS, adjusted for age-sex groups, end-of-life, disease types and multimorbidity. The community to which someone was discharged, as well as the hospital of discharge were attributed to each hospitalization. Using random intercept models, we tested for interaction between community and hospital, and estimated random effects for each community-hospital combination. Examining patterns in our data through plots and maps allowed us to describe how community effects differ by hospital (and vice-versa). Results: In testing for interaction, a statistically significant likelihood ratio test ( $p < 0.000$ ) demonstrated that communities and hospitals interact in affecting adjusted LOS. When this interaction was further explored using plots and maps, we saw that community effects were not consistent across hospitals, and vice-versa. Furthermore, within hospitals we noted that the communities with longer adjusted LOS were clustered around the location of the hospital. In all, due to the significant and complex interaction between community and hospital, we were unable to differentiate their effects on adjusted LOS. Implications for policy: This research demonstrates the complexity in differentiating the effects of community and hospital on case-mix adjusted LOS. The community to which patients are discharged cannot feasibly be incorporated into hospital performance measures. However, from a policy perspective understanding how hospitals and communities interact to affect LOS may provide important insights.

### **39. Optimizing Self-Management of Diabetes and the Role of the Physiotherapist on an Interdisciplinary Chronic Disease Management Team**

**Presenter:** Bonnie Doyle

**Co-authors:** Tara Jones, Cynthia Keith, Laura Burchell, Jennifer Moore, Lindsay Sutherland

A new innovative model of care called the Hants Health and Wellness Team (HHWT) opened its doors in March 2015. The team was built around the former Hants Diabetes and Nutrition Centre and interdisciplinary team members were recruited including a 0.6 FTE Wellness Facilitator (Physiotherapist). Access to free monitored physical activity (PA) programs for people with chronic conditions were not available in the community. Knowing the significant benefits of PA on chronic disease management, in particular Diabetes, the HHWT Physiotherapist was inspired to develop and implement a PA program called "The Diabetes & Exercise Program". Objective: The purpose of this initiative was to evaluate the outcomes and sustainability of a low cost, small scale physical activity program in a rural setting. Methods: In all 13 patients from the HHWT participated in a 6 week exercise program. Each patient had baseline outcome measures assessed pre and post program and 9 patients completed a 6 month follow up. Blood glucose levels were measured before and after each exercise session. Results: Participants who completed "The Diabetes and Exercise Program" demonstrated improvements with the following outcome measures at the 6 month follow up visit: 30 second sit to stand (mean change of 4 sit to stands), 6 minute walk test (mean change of 60 meters) and exercise vital sign (mean change of 65 minutes/week) by comparing mean scores pre-program and at 6 month follow up. Blood glucose was measured pre and post each exercise session with a mean change of 2.2mmol/L noted. Implications: Recruiting Physiotherapists to Chronic Disease Management Teams can optimize physical activity counseling and prescription to patients ready and willing to adopt a more physically active lifestyle in the pursuit of self managing their chronic conditions, including Diabetes.

### **40. Focusing on the future: Reducing barriers and improving access to IBD specialty care**

**Presenter:** Courtney Heisler

**Co-authors:** Raza Mirza, Sandra Zelinsky, Olga Kits, Sander Veldhuyzen Van Zanten, Jennifer Jones

**INTRODUCTION:** Canada has the highest age-adjusted incidence and prevalence rates of Inflammatory Bowel Disease (IBD) globally. Given its cumulative prevalence, the IBD clinical burden continues to grow. Limitations in accessing specialty healthcare services is not a new issue facing patients and healthcare providers. Despite this persistent problem, no research elucidating the patient perspective using qualitative approaches to compare and contrast the patient experience across Canada has been conducted. **PURPOSE:** Identify and understand barriers to IBD care access through quantitative and qualitative systems mapping. **METHODS:** IBD patients ( $\geq 18$  years of age) were recruited from gastroenterology clinics and communities from both urban and rural locales to ensure adequate representation from geographically diverse regions. Co-facilitated by a researcher and a patient research partner, the focus groups were held in Nova Scotia, New Brunswick, Quebec, Ontario, Manitoba, Saskatchewan, Alberta, and British Columbia. Patient demographics were collected to contextualize observed themes. Themes were distilled through qualitative thematic analysis using Atlas.ti software to ascertain congruence or discordance of patient experiences. **RESULTS:** A total of 63 patients have participated to date across eight provinces, with the majority being females (41/63, 65.08%) from urban regions (34/63, 53.97%). The mean age of participants was 48.34 years (SD=16.16years, range: 16-77 years). Preliminary analyses show that the main patient-identified themes to accessing IBD care fall into the following categories: structural/system issues, processes, experiences, and patients as partners. **IMPLICATIONS:** Healthcare access for IBD patients is complex. It is important to not only have a robust understanding of the healthcare system structure and processes but also the significant impact these factors have on patients in Canada. Access improvement can be best tackled through patient-oriented research and patient-centered exploration of themes related to access to care.

#### **41. Three ways of “Managing Fatigue”: Increasing access by expanding the options for delivery of an effective self-management intervention**

**Presenter:** Kaitlin Sibbald

**Co-authors:** Packer, T., Ghahari, S., Bukhanova, N., Plow, M.

Introduction: Fatigue is one of the most common and disabling symptoms associated with chronic conditions including multiple sclerosis (MS), brain injury, and cancer. It impacts employment, family and mental health. The widely used ‘Managing Fatigue’ intervention, delivered by occupational therapists, effectively reduces fatigue impact using one-to-one, online, and teleconference formats. However, the comparative effectiveness and non-inferiority of formats is unknown, limiting adoption of multiple options that would increase access to the intervention. Purpose: This study seeks to determine whether delivery using teleconference, online, and one-to-one formats are equally effective in improving physical, mental, and social function, and whether demographic characteristics can or should be used to further tailor the intervention. Methods: The three-arm, non-inferiority randomized control trial (n~610), will compare three methods of delivery for adults with MS fatigue. The online delivery arm of the trial is being led by researchers in Nova Scotia. This presentation will describe the study protocol, focusing on development of the online self-management intervention. Results: Adaptation for online delivery of a therapist facilitated group intervention poses technical, security, and therapeutic challenges. Mimicking a therapeutic environment online requires ingenuity; strategies to build self-efficacy, such as competence mastery and peer modeling, must be deliberately and carefully planned. Therapist training is needed to translate face-to-face group facilitation competencies to the online environment. Lessons learned will be relevant to practitioners and policy makers considering ways to increase access to chronic disease management interventions for people who cannot access them due to employment demands, mobility, transportation, or geographic barriers. Implications: This study will provide evidence for patients and healthcare providers on how to choose from the alternative delivery methods available for people with fatigue secondary to MS and other chronic conditions. Knowledge of implementation strategies to successfully provide online chronic disease management will be learned.

#### **42. Patients’ Den: Innovation in Empowering Patients to Set Research Priorities**

**Presenter:** Krystal Binns

**Co-authors:** Doucet, Shelley; Cook, Lauren; Stoddard, Roger; Standing, Kevin; and Robinson; Bryn

Introduction: Patient engagement has emerged as the next evolution of health research. Although patients are increasingly engaged as meaningful research partners, one area of engagement that has received little attention is patients’ involvement in setting research priorities. Purpose: The purpose of this presentation is to present an innovative model of patient engagement in which patients took the lead in setting research priorities at a public event called the Patients’ Den. Methods: The Patients’ Den was styled after the popular television series Shark Tank and Dragons’ Den. Three months before the event, a call was advertised for three \$5,000 grants for patient-oriented research projects focused on primary and integrated health care innovations. Submissions were screened for eligibility, scientific merit, and feasibility by a panel of four methodology experts and one patient advisor. A shortlist of ten finalists was created. Finalists were then invited to present their proposal to a 7-member patient panel at a public forum. The patient panel were tasked with selecting the three winning research teams. Results: The inaugural Patients’ Den event was held May 10th, 2018. Approximately 80 stakeholders from a variety of backgrounds attended the event, including members of the public, patients, caregivers, clinicians, trainees, researchers, and decision-makers. The event was the first of its kind in Canada and was livestreamed across the country. The Patients’ Den event provided patient advisors with an opportunity to prioritize health research funding; exposed stakeholders to a model of meaningful patient engagement; and created a positive, collaborative environment for patient partners, researchers, and the public to engage in open dialogue without any barriers. The second Patients’ Den is scheduled for October 3rd, 2019. Implications:

Lessons learned will guide those interested in hosting a similar event and help build capacity and best practices for meaningful patient engagement.

#### **43. Protocol for Implementation of Nurse Practitioner Provision of Medical Abortion in Canada**

**Presenter:** Martha Jane Paynter

**Co-authors:** Norman, W., Bryant-Lukosius, D., Munro, S., Dunn, S., Guilbert, E., Roussel, J., Martin-Misener, R.

**Introduction:** From the time of its legal availability in 1969 until 2017, only physicians were permitted to perform abortion in Canada. Almost all abortion procedures were surgical in nature and took place in a small number of clinics mostly in large urban settings, resulting in transportation and economic barriers to access. Mifepristone (medical abortion) was approved for use in Canada in 2016. In 2017, provincial regulators began to authorize nurse practitioners (NPs) to prescribe mifepristone. The Canadian Abortion Providers Support (CAPS) online community of practice has served as a platform for translation of evidence-based information about mifepristone medical abortion, an ask-an-expert section for problem-solving among practitioners, and as a setting for research about emerging barriers and facilitators to providing medical abortion. With approximately 1000 members, this platform provides complementary support for clinical practice, policy change, and advances in research. **Purpose:** The aim of this study is to identify barriers and facilitators to provision of medical abortion by nurse practitioners in Canada. **Methods:** This mixed-method study includes longitudinal online surveys of nurse practitioners, implemented at baseline, six months and 1 year, regarding their practices and provision of medical abortion. It includes telephone interviews with nurse practitioner providers of abortion, non-providers, and other key stakeholders such as nursing regulators and policy makers. Participants will be recruited through the Society of Obstetricians and Gynecologists of Canada online medical abortion training program, nursing regulatory bodies, and educational events. **Results:** This study is currently under ethics review. **Implications:** Primary care NPs may be early and strong adopters of mifepristone, with significant impact for populations traditionally at risk of poor access. CAPS has supported CIHR-funded research projects to examine mifepristone implementation for physicians and pharmacists. This study will inform policy and practice for nurse practitioner prescribing of medical abortion in Canada.

#### **44. A Cross Provincial Application of the PACE in MM Framework to Compare Programs for Patients with Multimorbidity in Interprofessional Collaborative Family Practice Teams in Primary Care**

**Presenter:** Ruth Martin-Misener

**Co-authors:** T. Sampalli, F. Burge, E. Moody, G. Warner, E. Marshall, J. Curran, T. Packer, G. Kephart, S. Wuite, E. Michael, A. Ryer, G. Kohler, L. Edwards, A. Fracini, K. Anderson, R. Urban, S. Ryan Carson, E. Christian, D. Lapierre, A. MacKenzie, M. Mooney, K. Peacock, L. Baxter, K. Aubrey-Bassler, C. Campbell, C. Chisholm, M. Fortin, T. Bouhali, G. Landry, M. Stewart, F. Bahnacy, P. Huras, L. Meredith

**Introduction:** Strong evidence for the essentials of care for patients with complex needs has been synthesized into five features: shared philosophy; internal relations of the care team; external linkages of the care; professional training; and relations with patients. These features are synergistic with the evolution of patient-centred interprofessional team-based care in Nova Scotia (NS) and Newfoundland (NL). **Purpose:** To explore whether the care provided by selected primary care (PC) teams in NS and NL is in keeping with the five features of the Patient-Centered Innovations for Persons with Multimorbidity (PACE in MM) Framework described above. **Methods:** Comparative case study with embedded units. Provincial environmental scans and primary data (value stream mapping, interviews, and patient experience survey) from 6-8 PC practices will be collected in NS and NL. Secondary data from the PACE in MM study will be used in Ontario and Quebec. Data will be analyzed using content analysis and descriptive statistics. **Results:** Features of the PACE in MM framework that are present or missing will be revealed and the reasons for this better understood. Features not found but deemed to be necessary will be considered. The patient voice in PC team processes will be strengthened and promising MM

programs identified. Implications: Knowledge about what and how programs for patients with MM are being offered by PC teams will be advanced and opportunities for patient-centred improvements identified. Ongoing refinements to the PACE in MM framework will be enabled.

#### **45. Using the Taxonomy of Everyday Self-Management Strategies (TEDSS) Framework to guide quality improvement in chronic disease management in Nova Scotia**

**Presenter:** America (Mel) Keddy

**Co-authors:** Packer TL, Sampali T, Kephart G, Audulv A, Ryan-Carson S, Sutherland L, Burton M, Mooney M, Bartholomew-Pushie K, MacLean K, d'Entremont I

Introduction: Collaborative and Chronic Disease Management teams in Nova Scotia are increasing access to care and support for patient self-management. Self-management support is an established component of quality chronic disease management. Despite this, assessing and planning for self-management needs is fragmented and often ad hoc. Purpose: To demonstrate how a patient-oriented framework is influencing program /practice and system-level changes to meet self-management support needs. Methods: The TEDSS framework, derived from the literature and validated qualitatively, categorizes self-management strategies used by clients into seven domains and 25 subdomains. Teams in Nova Scotia have begun using the TEDSS as a framework for quality improvement and planning. The depth and breadth of services being delivered are measured against TEDSS, identifying gaps in service and pinpointing professional development needs of the teams. Development of a patient-reported outcome measure to assist teams deliver care is also underway. Results: To date, 4 chronic disease, 3 primary collaborative practices and 4 primary care networks are participating. The TEDSS framework enables teams to measure and reflect on the current self-management support provided to clients. Teams report that the framework identifies areas of strength and gaps in care delivery, enhances communication within the team, identifies interdisciplinary professional development needs, and illustrates how members of the team contribute to overall care. Use of a common framework across teams helps to plan team composition and resources needed to meet the needs of specific patient populations, especially those with multiple chronic conditions and complex needs. Implications: Used for planning, the TEDSS framework helps transcend the profession-specific lens of team members by focusing quality improvement on the collaboration of team to meet patient needs. It provides information to improve team communication and function, and data to guide planning for team member roles, scope of practice, and composition.

#### **46. The Children's Health Profile and birth cohort initiative in NB and PEI: Using administrative data to produce evidence on the effectiveness of early years primary intervention strategies**

**Presenter:** Carole C. Tranchant

**Co-authors:** Sparks S, Malinski P, Montelpare WJ, Bélanger M, Miedema B, Sénéchal M, Bouchard DR, Barre DE, Jose C, Dalpé L, Rossiter M, Bryanton J, Holland M, Rogers K, McDonald JT

Introduction. Health systems collect vast amounts of administrative data, but these data are generally not analyzed to produce evidence on the effectiveness of primary prevention programs and strategies. Purpose. To identify and advise on the challenges and facilitating factors of accessing and analyzing select administrative health data (AHD) in New Brunswick (NB) and Prince Edward Island (PEI) for the purpose of creating an intra-provincial Child Health Profile (CHP) and population-based birth cohort database, using existing AHD not been previously linked. Methods. A cross-jurisdictional collaboration between NB and PEI with an integrated knowledge translation approach that adheres to each province's unique data policies, data procedures and data governance. This collaboration involves people in various roles: provincial government managers, policy-makers, data custodians, health practitioners, parents/patients, community organizations, in addition to academic researchers. Results. Access to select AHD required considerable time, preparation, cross-province coordination and ongoing discussions. Key facilitators were the NB Institute for Research, Data and Training, a newly

established data repository that holds provincial AHD in NB, and the provincial health authority in PEI. In NB, the existence of well-documented protocols and support from designated personnel were assets facilitating data access and linkage through the data repository. In PEI, REB approval was obtained more rapidly but challenges occurred in subsequent stages of data access directly through the health authority. A CHP focusing on data at birth and 18 months will be developed using the data currently accessible. Implications. This research supports the empowerment of stakeholders such as Public Health and researchers who are trying to leverage ‘big data’ resources to address research and practice questions regarding children’s health in their jurisdiction. The CHP and birth cohort databases will enable stakeholders to monitor and report on child health over the long term, and to evaluate current practices and future health interventions.

#### **47. The Association Between Referral Quality, Wait Time and Patient Outcomes in an IBD Specialty Program**

**Presenter:** Holly Mathias

**Co-authors:** Courtney Heisler (MSc), Julia Morrison (BSc), Barbara Currie (NP), Kelly Phalen-Kelly (NP), Jennifer L. Jones (MD, MSc, FRCPC)

**Introduction:** Canada, and particularly Nova Scotia, has one of the highest prevalence rates of Inflammatory Bowel Disease (IBD) - a chronic disease comprising of Crohn’s Disease and Ulcerative Colitis – in the world. Access to IBD specialty care is required in order to manage and treat disease-related outcomes; however, most specialty care in Canada can only be accessed through a referral. To date, no research has explored the association between referral quality and IBD patient outcomes. **Purpose:** The purpose of the study was to determine whether the quality of referral to a collaborative IBD program influenced wait times and patient outcomes (e.g. disease flares). **Methods:** The quality of 200 referrals to a collaborative IBD program in Nova Scotia was evaluated using an evidence-based metric. The association between referral quality, wait time and patient outcomes (e.g. hospitalizations, disease flares and additional referrals) was assessed using multivariate analysis. **Results:** The majority of referrals received by the program were low quality. Referral quality was not significantly associated with wait time or patient outcomes; however, a univariate analysis did show a significant association between referral quality and wait time; highlighting potential for further exploration. Longer wait times significantly increased the occurrence of disease flares, hospitalizations and additional referrals received while patients were waiting for an IBD specialist appointment. **Implications for policy and/or practice:** Prolonged wait times for patients with IBD are significantly associated with poor patient outcomes (e.g. increased hospitalization) and increased costs for the health care system (e.g. increased amount referrals and administrative work). Although there is literature that suggests that referral quality may be associated with wait time, it is still unclear how it relates to wait time and patient outcomes. Moving forward, the current referral process needs to be critically addressed in order to improve wait times and patient outcomes

#### **48. The co-creation of an Emergency Department based Discharge to Assess (D2A) model of care: A mixed method evaluation of health care provider, patient and caregiver perspective**

**Presenter:** Judah Goldstein

**Co-authors:** McVeigh W, Quinn A, Theou O, Buckler M, Travers A, Campbell S, Moorhouse P, Redgrave J, Shetty N, Aly A, Butts F, Dobson T, Carter A, Jensen J, Clarke B, Aubrecht K, Hajizadeh M, Rockwood K

**Introduction:** An inter-organizational Discharge to Assess (D2A) geriatric evaluation and management service to address the needs of older community-dwelling adults living with frailty may be a suitable alternative to hospital admission. Providing acute care in place can ensure maintenance of mobility and function while preventing independence loss. D2A services implemented elsewhere demonstrate improved collaboration and care transitions between acute, continuing, and primary care. **Purpose:** Our objective is to prepare a protocol and D2A service process map to inform consultations with stakeholders on the barriers, solutions, and processes

required to implement a D2A service locally. Methods: A mixed method sequential model design will be used. Focus groups will be held with healthcare providers, managers, and caregiver support organizations. Heterogeneous groups of key stakeholders will be recruited to foster collaboration, integration, and to develop a shared understanding of the setting's unique features and constraints. We will then conduct semi-structured face-to-face interviews with 60 patients and family/friend caregivers to determine D2A service acceptability. Results: The intervention to be developed will be an integrated D2A service for older adults living with frailty, delivered in their own home following an Emergency Department visit by maximizing the capacity (clinical skills and resources) of Emergency Health Services (EHS) Extended Care Paramedics and NSHA Central Zone Continuing Care resources (functional home care support and nursing services), and developing linkages with primary care. Our research design and D2A service process map will be presented. Implications for Policy/ Practice: Novel non-traditional models of care are required that integrate services to improve care transitions for older adults living with frailty. The outcome of this work will include a protocol to obtain feedback from key stakeholders and draft D2A process map.

#### **49. Taking Personalized Medicine into the Clinic: A Preliminary Review**

**Presenter:** Christina Holmes

**Co-authors:** Kendra Barry, Brianna Gottschall

Introduction: Personalized medicine is the use of a patient's specific information to create a treatment plan that best suits their needs. Personalized medicine draws on recent advances in the omics sciences; including the study of genomics (genes in the human body), proteomics (proteins in the human body), etc., in order to create new diagnostic or predictive tests. Purpose: We present pilot research, including an initial literature scan, which aims to understand the opportunities and barriers to the successful integration of personalized medicine into patient care.

Results: Key issues for the future use of personalized medicine exist that impact the patient, the physician, and policy. Privacy and genetic discrimination issues may arise for patients. Both physicians and patients may have trouble understanding this new category of tests, in addition to coping with incidental (i.e. unexpected) findings and false-positives. Crucial issues for policy makers wishing to guide this process include: the need for standards for new diagnostic tests, anti-discrimination policies and legislation, and analysis of cost-effectiveness for new tests, in addition to concerns about equity for their availability. Implications: Our preliminary research and the literature indicates that there are several issues impacting the patient, the physician, and policy that need to be addressed or weighed in the introduction of new methods of personalized medicine. In addition, while there is substantial literature on personalized medicine related to genomics and some areas of care, such as oncology, other areas, such as proteomics, which are newer, are less well represented in the literature and may have different needs than genomics-based tests. This suggests that emerging areas, in particular, of personalized medicine may require careful input from clinicians and patients.

#### **50. Solutions for Kids in Pain: Mobilizing Pediatric Pain Research to Patients, Practice and Policy**

**Presenter:** Lindsay L. Richter

**Co-authors:** Lindsay L. Richter, Christine T. Chambers, Lisa Lachance, Jennifer A. Parker

Introduction: Canada is a world leader in children's pain research, but this research evidence is not consistently mobilized into practice. In primary health care, undertreated pain can lead to negative health outcomes for children and families and detrimental impacts on the healthcare system. Solutions for Kids in Pain (SKIP) is a new knowledge mobilization network, based at Dalhousie University and co-led by Children's Healthcare Canada, that seeks to bridge the gap between current treatment practices and available evidence-based solutions for children's pain. Purpose: To improve children's pain management in Canadian health institutions by mobilizing evidence-based solutions through coordination and collaboration. Methods: SKIP brings together Canada's

world-renowned pediatric pain research community, primary health care professionals, administrators and policy makers, over 100 partners, and patients and caregivers to collaborate and co-produce interconnected knowledge mobilization activities. Using a “Patients Included” approach, patients and caregivers are integrated at all levels of our activities - in the development of the network, on the Board of Directors and management team, and in the co-creation of tools. Expected results: SKIP will deliver: 1) a user-informed approach to knowledge mobilization that meets the needs of diverse knowledge users; 2) best evidence in children's pain management applied in practice; 3) improved institutional commitment to pain management; and 4) increased public support and expectation for evidence-based pain management. Progress will be evaluated using a performance measurement system supervised by the Board. Implications for policy and/or practice: SKIP will produce and promote knowledge mobilization tools to address diverse knowledge user needs and facilitate institutional change by assisting knowledge users to access, adapt, and implement evidence in practice and policy. With the support of Canadian and International partners, SKIP will significantly impact pain management practices and position Canada as a global leader in knowledge mobilization for children’s pain.

### **51. Aligning patient and physician goals and expectations in management of chronic disease: an interactive poster presentation**

**Presenter:** Michael Cardinal-Aucoin

**Co-authors:** Natalie Cardinal-Aucoin, Carolyn Arbanas

**Introduction:** The CFPC promotes using a patient-centered approach that includes the patient as an active participant in a patient-physician partnership but provides little to no practical tools to help the physician do so. Physicians are trained to use a ‘history-taking’ procedure to collect information from the patient in a primarily unilateral exchange which can be an effective approach to acute care but falls short for more complex cases and the higher demands involved in chronic care. The increased complexity of chronic care management often leads to discrepancies between the goals and expectations of the patient and the provider, and the current model does little to bridge this gap. As illness and disease in Canada have shifted from predominantly acute, communicable illnesses, to a prevalence of chronic disease, there is a pressing need to address these issues. **Purpose:** This project seeks to help better align the goals and expectations of physicians and chronic care patients both during and between visits. **Methods:** We are developing a simple form that will provide 1) a strategic guide to a more efficient, cooperative, and reciprocal patient-physician interaction, with clear and predictable direction for both parties during the health care visit and 2) a summary of the visit and any modifications or additions to the current care plan to improve collaborative goal-setting, compliance, and continuity of care. This form will be tested at a suburban family medicine practice in Canada. **Implications:** We expect implementation to reduce redundancy, save time and money, increase efficiency, improve outcomes, and increase patient and provider satisfaction. **Participation:** We would like to gather input from patients and physicians about this project and encourage you to write your thoughts and comments directly on the poster in the appropriate area.

### **52. The Labour Pains of Pre-Fatal Care: Strengthening Our Palliative Approach to Care**

**Presenter:** Serena Lewis, MSW, RSW

**Introduction:** At the heart of integration for a palliative approach to cares is the need for shared power amongst people, families and service providers. The laborious work of dying needs to be complemented with a skilled team, well versed in the needs of a bio-psycho-social-spiritual approach. Striving to identify labour challenges of integrating rural community support for end of life care is essential. **Purpose:** This study explored current evidenced based research, practice strategies, community engaged participation and evaluation to engage in shifting the approach of service delivery, addressing dominant discourses and strengthening a more holistic practice of care. **Methods:** By utilizing an in-depth literature review, as well as community engagement

strategies with 273 diverse healthcare professionals over the course of three years, strengthening a palliative approach to care was developed and piloted with overwhelmingly positive results. Community engagement models that support stronger discourse and death literacy are proving to stimulate changes in society. Building upon existing concepts and theories, a new curriculum that supports staff in critically assessing what a palliative approach to care means today. By actualizing the concepts of a person (family) integrated palliative approach to care, the End of Life Communications course supports provincial and national front-line workers with diverse roles in stimulating discourse and demonstrating an evolving continuum of care. Results: A 40-hour End of Life Communications course was developed and delivered in community and care settings to 273 participants representing over 20 professions, over a three year period. Outcomes: Addressing death literacy, the ability to initiate and embrace conversations along the trajectory of end of life caring, has enhanced the capacity of individuals, families, and organizations to respond to dying, death, and grief in their communities and beyond.

### **53. Patient Perspectives of Pharmacists' Expanded Scope of Practice**

**Presenter:** Bobbi Morrison

**Co-authors:** Bobbi Morrison, Tom Mahaffey, Todd Boyle, Molly Mullin, Paytan Ruiz

**Introduction:** Timely access to primary health care is a challenge for patients. Nationally, Canada has been underperforming in providing patients access to a regular doctor, after-hours primary care options, and timely appointments. Amid increased demands on primary health care in Nova Scotia, a growing number of Nova Scotians have expressed concern about their ability access to primary care. Research has shown that pharmacists' expanded scope of practice (ESOP) could offer a solution. ESOP can improve patient access to primary care, redistribute demands on overburdened health services, and improve patient outcomes, while also being cost effective. Despite Nova Scotians' confidence in pharmacists' ability to administer ESOP services, uptake of ESOP was low when first introduced, but examination of trends over time has been limited. Additionally, the requirement for NS patients to pay for ESOP services is one potential barrier to widespread uptake that needs to be better understood from the patient perspective. **Purpose:** The purpose of this study was to understand the extent to which patient payment poses a barrier to accessing ESOP services by exploring changes over time in the Nova Scotian public's awareness and use of pharmacist ESOP services along with attitudes toward payment. **Methods:** Data was collected via four cross-sectional online surveys of the Nova Scotia public from 2013-2016 and analyzed using SPSS v 25. **Results:** Modest increases in public awareness and use of ESOP services were observed over time, but usage rates remained low. Only a minority of patients expressed a willingness to pay for pharmacist ESOP services. Differences among those willing and unwilling to pay are noted. **Implications:** Pharmacists' ESOP could reduce some burden on a strained healthcare system, and findings show that the public trusts pharmacists to provide these services, but in order to improve patient access to primary care through pharmacy, the barrier of patient payment must be addressed.

### **54. SPIDER - Structured Process Informed by Data, Evidence and Research**

**Presenter:** Mathew Grandy

**Co-authors:** Anders Lenskjold, Sarah Sabri, Rick Gibson, Tara Sampalli, Juanna Ricketts, Fred Burge

**Introduction:** Elderly patients are, in general, frailer and more prone to adverse events and side effects of medication, especially in combination with polypharmacy (many prescriptions). The Canadian Choosing Wisely and Canadian Deprescribing Network are both focusing on four groups of medication that have higher risks of adverse events in the elderly population: PPIs (proton pump inhibitors) for lowering stomach acid production, benzodiazepines for anxiety, antipsychotics for agitation, and long-acting sulfonylureas in diabetes type 2 treatment. These four groups of drugs are potentially inappropriate prescriptions (PIP) for elderly patients. Polypharmacy and PIP can negatively affect patients' health and quality of life while increasing medical expenses. **Purpose:** The aim of SPIDER (Structured Process Informed by Data, Evidence and Research) is to improve care for elderly patients in the family practice with polypharmacy and PIP. The SPIDER process will be

thoroughly evaluated, including satisfaction among primary healthcare providers and patients. Healthcare expenses and patient engagement will also be part of the evaluation. Methods: The study is taking place in Toronto, Edmonton, Montreal, Ottawa, Calgary, Winnipeg, and Halifax. In Nova Scotia, the study is a cluster Randomized Controlled Trial (RCT). Family practices are randomized into two arms, with patients aged 65 and older on ten or more medications being sampled. The intervention arm has Quality Improvement (QI) with deprescription guidelines and workshops. The control arm is given usual care. The data are being extracted from the CPCSSN (Canadian Primary Care Sentinel Surveillance Network) dataset. Results: The local study is in the process of being accepted by the Research Ethics Board at Nova Scotia Health Authority. No results are yet available. Implications for policy and/or practice: Lowering the adverse events and side effects of polypharmacy and potentially inappropriate prescriptions in the primary care setting.

## Oral Presentation Abstracts

### Group 1: Access to Primary Health Care/Interprofessional Teams

#### **Access to Health Care: Emergency Department or primary care office?**

**Presenters:** Dr. Daniel Marsh, Dr. Ken Buchholz

**Introduction:** General practice physicians in a rural community often have multiple demands on their professional time including coverage of Emergency Department, hospital inpatients, home visits and office appointments. The impact of these activities on health care access for patients rostered to a family physician is not easily measured. The Collaborative Emergency Centre (CEC) in Annapolis Royal relies on a local group of family physicians to provide urgent and non-urgent care. Typically, each physician allocates their time 60% office appointments: 40% CEC coverage. Recently, due to health issues, a physician withdrew from the CEC rotation and instead, added an extra day and appointment times for office visits. **Purpose:** To compare access of patients to health care services between emergency department and primary health care office when capacity of primary health care appointments is increased. **Methods:** A retrospective comparison of 2016 and 2018 was performed. The following information was collected from the EMR regarding the patients rostered to the physician: number of patients, average number of visits per month to the Emergency Department, available office appointment times per month, and average number of patients seen in primary care per month. **Results:** From 2016 to 2018 available office appointments increased by 50%. Over the same period of time, ED visits decreased from 155 to 39 per month, a decrease of 75%. Given the increased availability of office appointments, the physician was able to increase his patient roster by 25% from 1423 to 1768. **Implications:** This retrospective comparison illustrates and reinforces the critical importance of providing access to primary health care. Patients, when provided the choice, prefer to be seen by their primary care provider in the appropriate setting. Future policy implementation considerations are to ensure primary care access by limiting the variety of demands on rural physicians and concentrating time toward office-based appointments.

#### **Understanding unattached patients: Consequences of unattachment and patient strategies for primary healthcare access**

**Presenter:** Emily Gard Marshall

**Co-Authors:** Sara Wuite, Frederick Burge, Beverley Lawson, Melissa Andrew, Lynn Edwards, Richard J Gibson, Tara Sampalli, Adrian MacKenzie, Ana Correa Woodrow, Sarah Peddle

**Introduction:** Patient access to primary healthcare (PHC) is paramount, and attachment to a continuous PHC provider is associated with improved population health outcomes. Little is known about the consequences of unattachment from a patient perspective or the strategies that unattached patients use to meet their health needs and access care. **Purpose:** This study informs health system strategies for mitigating consequences of unattachment and for increasing attachment by understanding patient-defined impacts of unattachment and the strategies they use to access PHC. **Methods:** We recruited unattached patients using invitational letters to people on a provincial unattached patient registry, as well as posts on social media and online marketplaces. Qualitative interviews were conducted with nine participants who were purposively sampled based on key demographic characteristics. All analysis was conducted in NVivo 11. **Results:** Four main findings emerged: 1) Unattached patients experience a range of consequences from not having a regular PHC provider. Unattached patients also use creative strategies to 2) attempt to gain attachment to a PHC provider and to 3) address their health needs without a regular PHC provider. 4) Unanimously, participants experienced negative feelings and stress related to their unattachment. **Implications for Policy and/or Practice:** While unattached, the “process” of healthcare, including medical record management and system navigation, is downloaded from PHC providers onto patients, which may contribute to poorer health. Similarly, patients are responsible for seeking new attachment and care while unattached, which has the potential to result in inequitable care and re-attachment

along socio-demographic axes. Unattached patients may benefit from interventions at the “structure” level, such as human resource interventions to ensure an adequate PHC workforce and patient registries/waitlists to facilitate attachment to PHC. Our study suggests that patient registries/waitlists may best support unattached patients by taking a triaged approach to prioritize attachment for patients with greater needs.

### **Virtual Primary Care: A technology-enabled solution to enhance access to a primary care provider for Nova Scotians living in rural and remote communities**

**Presenter:** David LaPierre, Family Physician Western Zone; Katie Heckman, Virtual Care Team Lead NSHA

**Co-authors:** David LaPierre, Chantelle Hazelton, Katie Heckman, Isabelle d’Entremont, Cathy Cruz, Melanie Mooney, Michele LeBlanc, Tara Sampalli, Jo-Anne Wentzell

**INTRODUCTION:** Despite access to a primary care provider being considered a fundamental need for all Nova Scotians, approximately 5% of the population is still waiting on the Need a Family Practice (NFP) registry to be matched to a primary care provider (March 2019 data). Rural parts of Nova Scotia are in particular facing challenges related to primary care access due to many contextual factors including physician retirements, and recruitment and retention issues. One innovative initiative in partnership with IM/IT Virtual Care (VC) in the province is the use of video conferencing technology to enable access to a provider for primary medical care in a collaborative family practice in Digby, Nova Scotia.

**PURPOSE:** To increase access to primary care for people without a family doctor or nurse practitioner living in the Digby Area. **METHODS:** The many challenges faced by the Digby Collaborative Family Practice Team led them to innovate in order to help meet the needs of the community. The VC Clinic pilot began on November 27, 2018. A mixed methods approach is being used to understand the value of VC in enabling access to a primary care provider. In addition to process measures and relevant health outcomes, patient and provider satisfaction are being measured. The number and type of VC appointments are captured in the EMR. **RESULTS:** Total number of attended patient VC appointments was 75 (April 9, 2019). As of now, 100% of patients (18) and providers (2) surveyed were satisfied with their VC experience. Notably, 88.9% of patients said VC enhanced their ability to access care. Further data will be shared during our presentation. **IMPLICATION FOR POLICY/PRACTICE:** Virtual Primary Health Care is a sustainable, patient-centered and cost-effective solution specifically in rural areas of Nova Scotia where recruitment and retention of providers has been a challenge.

### **Alignment of Primary Care Deprescribing Strategies to Nova Scotia Context Using Components of the Behaviour Change Wheel**

**Presenter:** Natalie Kennie-Kaulbach

**Co-authors:** Jennifer E. Isenor, Ruth Martin-Misener, Fred Burge, Sarah Burgess, Olga Kits, Melissa Helwig, Isaac Bai, Emily Reeve, Anne Marie Whelan

**Introduction:** Polypharmacy and inappropriate medication use are an increasing concern with the aging population. Deprescribing may reduce medication-related harm and improve quality of life. The Theoretical Domains Framework (TDF) and Behaviour Change Wheel (BCW) are frameworks for practice change that may assist in the development of deprescribing strategies. The objective was to identify published primary care deprescribing strategies that link to local qualitative data to inform development of deprescribing initiatives in Nova Scotia. **Methods:** Two background studies were completed. A scoping review identified studies that evaluated primary care deprescribing strategies. Strategies were mapped to the BCW Intervention Functions and Behaviour Change Techniques (BCTs). A qualitative study of interviews and focus groups evaluated knowledge, attitudes, beliefs and behaviours toward deprescribing of local primary care physicians, nurse practitioners and pharmacists. Transcripts were coded using the TDF. The key TDF domains and specific subdomains were mapped to BCW intervention functions. BCTs and specific examples from the scoping review relevant to the intervention functions were identified for each TDF domain. **Results:** Most TDF domains and sub-domains described in the qualitative study were linked to specific BCTs and examples from the scoping review. Specific BCT examples

related to the Social Influences TDF domain were patient targeted materials to have them discuss deprescribing with their provider and support from health care providers such as pharmacists to provide medications reviews and recommendations. BCTs related to Memory Attention and Decision Processes included academic detailing and training for existing deprescribing tools. Environmental Context and Resources, although being prominently featured in the qualitative study, was not well mapped to BCTs identified in the scoping review. Implications for Practice: By aligning the views of local healthcare providers with published literature, results of this study highlight areas for future deprescribing initiatives and research in primary care in Nova Scotia.

### **Informing the development of interprofessional primary care teams: A web-tool to present results of a systematic review**

**Presenter:** W. Dominika Wranik

**Co-authors:** Mike Smit, Susah Haydt, Rick Gibson

To develop evidence informed health policies, decision makers rely on the academic community to package information. For example, when developing interprofessional primary care teams (IPPC), questions about funding, remuneration, governance and organization arise. We conducted a systematic review of IPPC structures, the results of which are published: 10.1016/j.healthpol.2019.03.015. In addition, we designed a web-tool with the purpose of sharing the results with decision makers, or any other interested groups. The web-tool prototype is completed and we will be testing its usability in the upcoming months with an online questionnaire and three stakeholder group discussions. We will present the results of the systematic review, and focus on a demonstration of the web-tool as a knowledge sharing approach. Feedback from the PHC Research Day audience will be gathered.

## **Group 2: Chronic Disease Management/Interventions for Health**

### **Improved access and comprehensive care for individuals with diabetes: Group medical visits initiative in Western Zone**

**Presenters:** Lisa deMolitor, PDt CDE Western Zone, Isabelle d'Entremont Primary Health Care Coordinator Western Zone

**Co-authors:** Kim Seeley, Cathy Deveau, Crystal MacNeil, Lisa deMolitor, Heather Angell, Shawna Boudreau, Janice Knapp, Dr. Michael Mindrum, Dr. Amanda Smith, Dr. Kevin McGuire, Debbie Hill, Isabelle d'Entremont, Michele LeBlanc, Mardi Burton, Tara Sampalli, Jo-Anne Wentzell

**INTRODUCTION:** Group medical visits (GMVs) are well supported in the literature as a patient-centric, feasible, cost-effective option. It is also a solution to some expensive problems in health care such as chronic disease management. GMVs are being explored or implemented in three diabetes centres in Western Zone. All have Diabetes Centre staff including a registered nurse and dietitian collaborating with a family physicians, nurse practitioner, and internal medicine specialist. They are implementing GMVs with a common objective of enhancing access and quality of care for individuals with diabetes. **PURPOSE:** To examine the effectiveness of GMVs, as well as to enhance access and quality of care for individuals with diabetes. **METHODS:** A mixed method approach is being used including measuring relevant clinical outcomes, patient and provider satisfaction feedback and a range of process changes. Perceived impact of GMVs on diabetes management and self-management skills is an integral part of this exploration. The Diabetes Care Program of Nova Scotia Registry will be used in order to track potential changes in the patients' A1Cs. **RESULTS:** Preliminary results are promising with high levels of satisfaction being expressed by patients and providers. Other measures such as access, clinical and process outcomes will be shared as part of our presentation. **IMPLICATION FOR POLICY/PRACTICE:** GMVs are a cost-effective and efficient collaborative approach. Not only do they foster collaboration between healthcare professionals, but also follow principles of adult education by encouraging peer support and

education. The discussions generated during GMVs are so rich and can help stimulate critical thinking in patients and promote self-management skills.

### **Collaboration between the Health Authority and Community Programs to Improve Physical Activity for Nova Scotians: Community Health Teams (CHT)-Canada Games Centre (CGC) collaborative initiative**

**Presenter:** Jill Robison

**Co-authors:** Caroline Carr, Jill Robison, Christina MacDonald, Carah Davis, Jennifer Manuel, Julia Jennings, Stephanie McCarville, Sarah Manley, Tina McPhee, Lisa Sutherland, Tara Sampalli, Carla Alderson, Deirdre Smith, Logan Harris, Amber Allan, Melissa Quirk

**Introduction:** There is research-based evidence to support the concept that people are more likely to engage in health and wellness programs offered in their own community. Recognizing the importance of promoting physical activity programs in community-based settings, Primary Health Care (PHC) and the CHT at the Nova Scotia Health Authority have partnered with the CGC to offer a free exercise program to individuals living with chronic conditions in their community. **Purpose:** This quality improvement initiative will examine if improving accessibility by providing a free evidenced based exercise program in the community to people with chronic health conditions will have an impact on physical health. **Methods:** A ten week exercise program was co-designed by staff of CHTs and the CGC. Participants were screened by CHT physiotherapists for exercise safety and appropriateness, and the intervention included a 10 week physical activity program delivered by trainers at the CGC. CHT physiotherapist provided consultation and behavior change education. A mixed-method approach was used to evaluate program outcomes included pre and post measures of 6 minute walk test, sit to stand test, self-reported physical activity, SF-12 Quality of Life, blood pressure, weight, body mass index and %body fat. **Process measures** included number of participants enrolled, completion rate and % attendance. Additionally a partnership evaluation was conducted to evaluate this unique relationship. **Results and Implications:** Upon completion of the program, 60% of participants had a significant improvement in 30-Second Sit-to-Stand test ( $p=0.007$ ) and 76% of participants had a significant improvement in 6-Minute Walk Test results ( $p<0.001$ ). In addition, 47% of participants were meeting aerobic physical activity guidelines by program completion, compared with 6% initially. Post program partnership evaluation revealed a >70% chance that the CHT staff and CGC staff would refer to each other for knowledge and expertise. This study will help establish an approach for PHC to partner with community programs to improve physical activity for Nova Scotians.

### **Self-management Support Provided by Chronic Disease Teams in Nova Scotia**

**Presenter:** America (Mel) Keddy

**Co-authors:** Kephart G, Sampalli T, Dickson R, Keith C, Sutherland L, Packer T.

**Introduction:** Nova Scotia has prioritized a proactive, patient driven approach to chronic disease management through investments in Chronic Disease Management (CDM) teams, supporting clients` self-management and self-management support programs and initiatives. However, teams and policy makers are challenged to determine what areas of self-management are supported and by whom. **Purpose:** To understand how teams in Nova Scotia are supporting self-management areas important to clients living with multi-morbidity using provincial data and case studies of two CDM teams. **Methods:** As part of Nova Scotia Health Authority quality improvement initiatives, types of support and time spent supporting self-management provided by CDM teams were gathered. The Taxonomy of Everyday Self-management Strategies (TEDSS) framework, was used to categorize the time each provider spent supporting the seven TEDSS domains. Providers then assessed their support for and perceived areas of improvement on 26 self-management support subdomains. **Results:** Team 1 sees approximately 3.500 and team 2 2.632 clients/year. Both are multidisciplinary teams, serve adult clients living with multi-morbidity and use the Chronic Care Model to underpin care. All seven areas of self-management are supported by both teams, but in different proportions. Health and Lifestyle Behaviours were prominently supported by Team 1 while the Internal domain was most prominently supported by Team 2.

Within the teams, multiple providers supported a single area. Areas for improvement were substantially different in the two teams. Implications: The seven TEDSS domains allowed teams/providers to visualize and examine their self-management support services. Differences between teams raise important questions; are differences explained by the client population served, differences in team composition and provider scope of practice or perhaps to overlap and lack of clarity in provider roles? Used as a planning tool, NSHA can now ensure appropriate support for patients, plan team composition of CDM teams and identify and plan self-management training for providers.

**Your Weight Your Way (YWYW): Impact of a group-based weight management program delivered by a multidisciplinary primary health care team on health behaviours and chronic disease risk factors over a 6 month period**

**Presenters:** Jacklynn Humphrey, PDt and Kelsey Kennedy, PDt

**Co-authors:** Jacklynn Humphrey, Kelsey Kennedy, Ashley South, Tina McPhee, Lisa Sutherland, Valerie MacPherson, Andrea Booth, Deirdre Smith, Lindsay Sutherland, Tara Sampalli, Mary Akbari

Introduction: Community Health Teams (CHTs) offer health and wellness programs and services to people in their communities. Empowering people with the knowledge and skills to self-manage health risks is at the premise of the CHTs work. Your Weight Your Way is a group based weight management program that focuses on lifestyle changes to help participants understand the many things that affect weight such as readiness to change, nutrition, physical activity, self-esteem, the environment and goal setting. Purpose: To examine if YWYW can help individuals with health risk factors to be better engaged and achieve better outcomes with weight management. Methods: A mixed methods approach was used in the quality improvement initiative to evaluate the outcomes and the potential to scale up the YWYW program. Outcomes measured included weight, anthropometrics, improvement in medical conditions such as high blood sugar, high blood pressure and blood cholesterol. Results and implications: A total of 28 participants have completed the pilot initiative. Preliminary results are promising with fifty percent of participants having maintained or reduced their weight at the post-program compared to the baseline, with a quarter of the participants maintaining or reducing their weight at the 6-month follow up compared to the post-program. Participants also showed significant improvements in clinical outcomes. A statistically significant difference was seen among the distribution of the participants' fasting glucose at the three time points. This initiative is important to understand how Nova Scotians engage in healthy behaviours such as weight loss and behavior change strategies. YWYW will help inform a provincial strategy for community-based care. It will help establish an approach for PHC to help Nova Scotians engage in healthy behaviours and risk factor management.

**Role of culture in designing activity participation programs for elderly immigrants**

**Presenter:** Dr. Shahriar Parvaneh

**Co-authors:** Holly Weighill, Cassandra Bell, Kripa Sara Thomas, Neda Alizadeh

Introduction. The number of older adults in foreign countries has continued to increase in recent years. This increase in aging immigrants has prompted the development and implementation of culturally sensitive programs globally. There are limited published studies that focused on elements of culture while designing activity participation programs for elderly immigrants. Purpose: This scoping review aims to review and summarise the current literature focused on the role of culture in designing activity participation programs for elderly immigrants. Methods: A scoping review was conducted using five databases: MEDLINE, CINAHL, PsychINFO, and EMBASE. A group of three researchers independently selected and reviewed the articles based on the Arksey and O'Malley (2005) methodological framework. Results: A total of 1851 abstracts were reviewed, out of which only 10 articles met the study criteria. This scoping review revealed six dominant themes regarding cultural sensitivity within programs developed for senior immigrants. Themes included 'communication',

'cultural competence of the professionals', 'cultural beliefs', 'values and traditions of participants', 'access to the programs', 'family influence' and the 'recruitment of participants'. Most of the 10 studies also discussed strategies to eliminate communication barriers and health promotion for senior immigrants. All the studies identified through this scoping review were focused on programs tailored towards a specific cultural group, instead of being inclusive towards various cultures. Implications for policy and/or practice: The results of this study highlighted the inclusion of cultural components in programs for elderly immigrants could significantly improve their health, participation, and welfare. This could guide policy makers/practitioners to consider the importance of developing more culturally diverse programs for improving the physical and emotional well-being of elderly immigrants.

### Group 3: Engaging Patients as Partners in Research and Health Services Delivery

#### **The meaning of patient-centered care: Perspectives of patients with multimorbidity and teams in primary health care settings**

**Presenter:** Ruth Martin-Misener, NP, PhD

**Co-authors:** Tara Sampalli, Larry Baxter, Brian Condran Kylie Peacock, Frederick Burge, Elizabeth Michael, Grace Warner, Lindsay Sutherland, Ryan Macneil, Elaine Moody, A. Francini, Joel Arsenault, Ryley Urban

**Introduction:** Primary health care teams in Nova Scotia help patients navigate the health care system and access services. Chronic disease management teams help patients manage their own health. Many of these teams take a patient-centered approach to providing this care. The NSHA defines patient-centered care as care that focuses on multiple chronic health conditions and involves the patient as a member of the health care team. Less is known about what patients with multiple chronic health conditions think about person-centered care. **Purpose:** This study had two objectives. First, to learn about patients' perspectives of patient-centered care. Second, to learn what primary health care providers need to do for the services they provide to meet patients' definitions of patient-centered care. **Methods:** The research team collected data in three ways. First, by looking at research published on this topic. Second, by interviewing patients from primary health and chronic disease management clinics across Nova Scotia. Third, by working with health care teams at these clinics to map the steps they take with patients. **Results:** 6 clinics participated in this study and 20 patients were interviewed. Patients and care team members likely perceive patient-centered care as meaning different things. Patients from primary health care clinics likely perceive patient-centered care differently than patients from chronic disease management clinics. There are similarities, however. For example, all groups agreed good relationships between patients and care providers was an important part of patient-centered care. What makes for a good relationship, however, can differ based on who you ask. **Implications:** There are similarities and differences in how care providers and different groups of patients see patient-centered care. Understanding these perceptions will help the Nova Scotia Health Authority provide care services that reflect the needs, preferences, and values of Nova Scotians with multiple chronic health conditions.

#### **Partnering with Patients and Families in Program Planning and Service Delivery in Primary Health Care: An implementation science approach to evaluating integration of policy to practice**

**Presenter:** Tara Sampalli, PhD

**Introduction:** The Nova Scotia Health Authority (NSHA) is increasingly partnering with patients and family members. Patients and family members act as advisors on different teams and committees. In NSHA Primary Health Care, patient advisors and staff work together in quality and safety committees to make decisions about the policies and programs that shape health care. **Purpose:** The purpose of this study was to learn about what makes it easier to build successful partnerships between patient advisors and NSHA staff in quality and safety committees. **Methods:** This study used an implementation science approach. An implementation science

approach means looking at what made something work well in one setting and learning how this could be repeated in other settings. The research team interviewed over 30 participants (patient advisors, NSHA staff, and health care providers) to learn about their experiences working together. These interviews allowed the research team to better understand the key ingredients for successful partnerships. Results: These ingredients include:

- Common focused goals: Teams work well when they want to accomplish the same things.
- Productive partnerships: Visible successes help a team build momentum.
- Clear expectations: Team members can contribute best when they know what is expected of them, and when other members know what they each need to participate.

Challenges were also identified. For example, team members have a hard time contributing when they don't know what is expected of them, or how much say they will have in decisions being made by their committee. Implications: Many quality and safety teams are only beginning to build partnerships between staff and patient advisors. The findings of this study will help them come together faster and more effectively.

### **A Collaborative Intervention for Deprescribing: The Role of Stakeholder and Patient Engagement**

**Presenter:** Shanna Trenaman

**Co-authors:** Marjorie Willison, Bryn Robinson, Melissa Andrew

**Introduction:** At a recent World Café Workshop on future deprescribing priorities, Canadian researchers identified that, in addition to implementation evaluation and economic analyses, high quality clinical trials require meaningful patient engagement. **Purpose:** We aimed to develop a deprescribing framework and toolbox of resources for collaborative primary healthcare clinics and long-term care facilities that have pharmacists integrated in these settings with meaningful patient engagement. **Methods:** Sixteen members of our research team met with six patient representatives (identified by the Maritime SPOR SUPPORT Unit) in a “live day” stakeholder engagement meeting. The event provided a welcoming environment for all participants; discussion groups ensured a mix of clinical, research and patient voice; and facilitators focused on engaging all voices equally. Day One discussions were structured around four topics: 1) identifying and prioritizing potentially inappropriate medications to reduce or stop; 2) identifying patients appropriate for deprescribing; 3) effectively communicating deprescribing with both patients and prescribers; and 4) measuring satisfaction with the framework. Day Two used the previous day's input to have groups draft possible frameworks. After the event, participants continued to engage via e-mail, as they refined the proposed framework. **Results:** The “live day” provided helpful insight into patients' interests and changed the shape of the project. For example, patient representatives felt that the original age restriction of 65 years of age or older on potential participants was unfair, as deprescribing may help people younger than 65 years of age. Patient representatives also felt it was crucial to have resources to offer with non-pharmacologic information to increase success of deprescribing. **Implications for policy and practice:** Pharmacists were accepted by our patient representatives as acceptable supports for deprescribing. Successful and meaningful patient engagement improves research projects so they align well with priorities for deprescribing clinical trials.

### **Improving timely care and access for Trans\* and Gender Diverse Population in Central Zone: an exploratory study**

**Presenters:** Kolten MacDonell, Jacqueline Gahagan

This purpose of this TRIC 1 project was to examine criteria-based processes and experiences of transgender patients and clinicians navigating the health systems to access primary care and gender affirming health services, with the goal of developing recommendations to reduce delays in medical care for transgender

individuals in Nova Scotia, including gender affirming hormone therapies and surgeries. To achieve this, in-depth interviews and focus groups were undertaken with transgender individuals and healthcare providers to better understand from their lived experiences and perceptions about timely care for transgender patients and how best to address them. The key study objectives were: i) the formation of an advisory committee to review, advise and assist in the development and implementation of recommendations to address barriers to primary health care and gender affirming health services among trans\* populations, and ii) the development and validation of recommendations in consultation with key stakeholders to reduce delays in care and related health outcomes for trans\* patients. Qualitative data (in-depth interviews/focus groups) were collected from trans\* patients who have been, or currently are, on wait lists for gender transition readiness assessment and from mental health clinicians, family physicians, psychiatrists, and primary health care providers to identify priorities, challenges and opportunities to improve care. Data collected through this project offers a comprehensive overview of the ways in which primary health care can better understand and respond to the needs of trans\* populations, including addressing gaps and opportunities to improve care from the perspectives of patients, providers and health system leaders with a broad objective of enhancing appropriate and timely care for this patient population. Additionally, an objective of our team's work on this TRIC level 1 project was to develop of a TRIC level 2 or level 3 grant submission to undertake the online survey process and develop recommended triage criteria and protocols aimed at improving wait times and related experiences across Nova Scotia.

### **From research to practice: the implementation and evaluation of a patient navigation centre for children and youth with complex care needs**

**Presenter:** Alison Luke

**Co-authors:** Dr. Shelley Doucet, Dr. Rima Azar, Dr. Kerrie Luck

**Introduction:** Patient navigation programs are increasingly being implemented across Canada as a solution to help coordinate patient care; improve transitions in care; help families better understand health, education, and social services; and to serve as a resource for the care team. NaviCare/SoinsNavi is a patient navigation centre in New Brunswick for children/youth with complex care needs. The centre was launched January 2017 and is the focus of this presentation. **Purpose:** The objectives of this presentation are to: 1) present an overview of patient navigation as an effective way to facilitate more convenient and integrated care, and 2) present preliminary findings from the implementation of NaviCare/SoinsNavi. **Methods:** A mixed methods approach was used to explore parents' experiences with NaviCare/SoinsNavi. Fourteen participants who received services from NaviCare/SoinsNavi participated in interviews. Thirteen participants also responded to a satisfaction survey following discharge. Additional demographic information was collected to provide context. Interviews were analyzed using inductive thematic analysis, which allows for identifying, analyzing, and reporting themes within the data. Survey data was analyzed using descriptive statistics. **Results:** Although children served by the centre vary by condition, the majority have a diagnosis of autism spectrum disorder. The most common reasons for calling the centre include respite care, camps, and service referrals. Findings demonstrate that families have substantial needs reflecting gaps and barriers in care delivery across NB. Overall, families were extremely satisfied with the centre. Emerging themes include relief to find someone who would listen, reduced feelings of stress, improved care coordination, and increased knowledge of programs/services. **Implications for policy and/or practice:** This study demonstrates that patient navigation programs are an innovative approach to improve the integration of care for individuals with complex conditions. These findings can inform policy on how to best improve care coordination, improve patient experience, and identify gaps and barriers to care.

## Group 4: Optimizing Community Resources/Healthy Aging

### **The Effect of Community of Discharge on Length of Stay for Unplanned Hospitalizations: An Indicator of Community Care Integration?**

**Presenter:** Alysia Robinson

**Co-authors:** Dr. George Kephart, Dr. Leslie Anne Campbell, Dr. Grace Warner, Dr. Pantelis Andreou, Mike Reid

Introduction: Longer than necessary hospital stays, arising in part from community variation in barriers to discharge, are costly and harmful to patients. Case-mix adjusted length of stay (LOS) is used to benchmark hospital efficiency, however, this measure does not account for community-driven variation. Purpose: Our aim is to estimate the extent to which community affects case-mix adjusted LOS for unplanned hospitalizations, whether this differs by high or low medical complexity, and identify communities that have significantly different LOS from the provincial average. Methods: This descriptive study employs administrative hospital discharge abstract data. The study population includes Nova Scotian residents residing in 77 communities (defined by Forward Sortation Area), aged 30 years and older, with at least one unplanned inpatient hospitalization between fiscal years 2010-2014. The outcome is LOS, adjusted for patient case-mix using age-sex groups, end-of-life, and information on chronic conditions and multi-morbidity. We estimate the extent of additional variation in LOS explained by community of residence using a random intercept regression model. Complex needs are defined using the Elixhauser Index and Resource Intensity Weights. Small-area empirical Bayes estimates are calculated and mapped to facilitate planning. Results: Overall, community of residence is significantly associated with case-mix adjusted LOS; communities one standard deviation away from the provincial mean have 4.6% (95% CI 3.6% - 5.6%) longer or shorter adjusted LOS. Of 77 communities, 17 had an adjusted LOS differing from the provincial average. Across all definitions of complex health needs, we found that community variation in case-mix adjusted LOS varies significantly between persons with lower and higher complex needs. Implications for policy: Assessing LOS-related hospital efficiency by community allows identification of policy-targetable regions within which community-specific determinants of hospital and discharge efficiency can be further explored.

### **A Realist Review of how Primary Healthcare can use Case Management to Connect End-of-Life Patients & Family Caregivers with Community-Based Supports**

**Presenters:** Grace Warner, Juanna Ricketts, Lisa Garland-Baird

**Co-authors:** Akbari, Mary; Tschupruk, Cheryl; Sampalli Tara; Lawson Beverley; Pesut, Barb; Urquhart, Robin; Martin-Misener Ruth; Burge, Fred; Weeks, Lori; Kephart, George; Packer, Tanya

Introduction: Palliative care can be enhanced when Primary Healthcare practitioners use case management functions to connect patients nearing end of life and their family/friend caregivers to critical community supports. This community-based approach to palliative care necessitates the development of partnerships with patients and family/friend caregivers to ensure needs are assessed and planning begins early in the trajectory toward end of life (EOL). Purpose: To partner with family/friend caregivers and health-system partners to conduct a realist review. The review explores how Primary Healthcare settings can implement case management functions to identify patients and their families/friends dealing with EOL to facilitate planning to improve quality and continuity of care. Methods: A realist review using the RAMSES method was used to identify and synthesize the literature. Three reviewers screened 2389 articles identified in an initial systematic search; data was extracted on 39 relevant articles. An additional purposive search on advanced care planning and shared decision making supplemented the original search. Iterative phases of our review process included, consulting with family caregivers and health-system partners, identifying and screening research literature, reflecting on the realist review methodology, extracting and synthesizing data, and developing key program theories. Results: Program theories related to case management functions, and patient/family caregiver centric care were hypothesized per the realist review approach. Two theories explored the evidence related to EOL conversations and planning. Evidence suggests Primary Healthcare practitioners' attitudes toward the palliative approach impact having EOL

conversations, and using assessment tools facilitate conversations that lead to patient/family-centric plans to improve outcomes. EOL-shared-decision-making has inherent challenges that impact conversations and planning. Implications for policy and/or practice: Engagement of family/friend caregivers and health-system partners in the research process is beneficial in identifying valued critical community supports and desired EOL outcomes. However, Primary Healthcare practices face contextual challenges that make implementation difficult.

### **Increasing days spent in the community through Paramedics Providing Palliative Care at Home**

**Presenter:** Alix Carter

**Co-authors:** Jennifer Kryworuchko, Michelle Harrison, Tjingaita Kekwaletswe, Sabrina T. Wong, Judah Goldstein, Marianne Arab, Grace Warner

**Background:** Providing comfort care and support at home without transport to hospital have not traditionally been part of paramedic practice. The novel Paramedics Providing Palliative Care at Home Program includes a new clinical practice guideline, medications, a database to manage and share goals of care, and palliative care training. The objective of this study was to determine essential elements of this new model of care through the application of the Consolidated Framework for Implementation Research (CFIR). **Methods:** Qualitative deliberative dialogue sessions facilitated expert feedback (from Emergency Health Service and palliative care providers and administrators) in a province with (Nova Scotia) and without (British Columbia) the Program. The CFIR framework informed the discussion and coding of the data. Sessions were audio recorded and transcribed. Four team members analyzed the data independently; themes were derived by consensus with the broader research team. **Results:** Themes aligned with CFIR constructs at multiple levels. Inter-sectoral communication between paramedics and other health care providers is challenging due to privacy concerns and the way palliative care is organized and delivered. Relationships with healthcare teams/providers are critical to promoting the new model of care to patients and managing expectations, as well as providing ongoing care. Training was an essential characteristic of the intervention that can be adapted to local needs; though cost is a factor. There were challenges due to the diversity of the paramedic workforce; and culture and implementation climate as a shift in the mindset of paramedics away from traditional roles is required to implement the model. Finally, individual knowledge and belief in the benefits of the Program may be outweighed by fear of increased responsibility and/or decision-making. **Implication:** Applying the CFIR framework allowed for the identification of essential elements, facilitators, and barriers, to the successful implementation of a paramedic palliative model of care.

### **Pathways for the Prevention and Management of Falls and Fall Related Injuries in Primary Health Care**

**Presenters:** Susan Savage, Suzanne Baker

**Introduction:** According to Statistics Canada, falls are the most common cause of injury among older Canadians. The Nova Scotian Frailty, Dementia and Continuing Care Strategies aid to identify and implement interventions that mitigate the impact of falls in seniors. A standardized evidence-based framework for reducing falls and falls related injuries has been developed and evaluated in PHC setting. **Purpose:** To evaluate a standardized framework that supports seniors in falls prevention in PHC settings. **Methods:** A mixed methods approach was used to evaluate the standardized framework developed in this project which is based on the falls prevention algorithm outlined for primary care providers by the Nova Scotia Frailty Strategy. Based on the criteria of a fall within the last 3 months, individuals were accepted into the intervention stream which included further assessment using standardized tools and tailored interventions for minimizing fall and fall related injuries. The outcomes for the project include clinical, functional and process measures, and patient satisfaction surveys. Implementation of this evidence and prevention-based model will support healthy aging and economic impact on the system. **Results:** Study was conducted in a collaborative family practice team (CFPT) in Western Zone,

Nova Scotia. Fifty-three patients from a CFPT in Lunenburg participated. The results show the higher the frailty level, higher the fall risk. Implications for policy and practice: This project will inform/aid adoption of NSHA Fall Prevention policy in PHC settings.

### **Review and Feasibility Assessment of the Camp Hill Veterans Memorial Dental Services**

**Presenter:** Shauna Hachey

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Introduction: For over twenty years, Veterans residing at the Camp Hill Veterans Memorial Building (VMB) have benefited from on-site dental services. Older adults are increasingly maintaining their teeth, however, accompanying chronic oral diseases are associated with poor general health (e.g. aspiration pneumonia and poor glycemic control) and diminished quality of life (e.g. pain, esthetics, mastication). Purpose: To provide an independent assessment of the VMB Dental Services and evidence-based recommendations to support the future delivery of sustainable high-quality dental services. The need for this comprehensive External Review was identified due to feasibility concerns with the current model. Methods: An oversight team consisting of VMB stakeholders and External Reviewers clarified the scope and purpose of the Review through the creation of the Terms of Reference that served to guide the work. During Phase I of the Review, initial insights were gathered through key informant interviews. Phase I clarified the information needs, strategies and processes required for Phase II. Phase II consisted of a detailed secondary data review and analysis to explore and quantify workflow, clinic operations, service utilization, billing and record-keeping (2010-2018). Findings were then synthesized, and recommendations developed. Results: Recommendations were guided by the six dimensions of quality outlined by WHO: effective; efficient; accessible; acceptable/patient centered; equitable; and safe; and, are consistent with NSHA Healthier Together 2016-19 Strategic Direction that commits to person-centred, high-quality, safe and sustainable healthcare. The establishment of a VMB Oral Health Strategic Plan has potential to ensure high-quality oral care for residents and program sustainability. Implications for policy and practice: Ensuring the sustainability and quality of this highly valued program is essential for the health and quality of life of Veterans, particularly those experiencing frailty and mobility issues, and has potential to reduce associated costs with treating oral diseases and related chronic conditions within primary healthcare.