Conference Program
Day 4: Monday, May 31, 2021

12:00-1:00	**Concurrent Session G: Oral Paper Presentations & Symposium III**	
	G1 – Substance & Cannabis Use (Moderator: Amanda McIntyre)	
	12:00-12:15	**Learning from a Study of Substance Use on an Inpatient Youth Mental Health Unit: A Discussion on Measurement-Based Care** Jillian Halladay, Catharine Munn, Laurie Horricks, James MacKillop, Michael Amlung, Katholiki Georgiades
	12:20-12:35	**Cannabis for Chronic Pain: A Rapid Systematic Review of Randomized Control Trials** Riana Longo, Abe Oudshoorn, Deanna Befus
	G2 – Interprofessional Practice (Moderator: Edmund Walsh)	
	12:00-12:15	**Evaluating Interprofessional Models of Care for Sustainable Healthcare Service Delivery** Alexis Smith, Amanda Thibeault, Carmen Marsh Lansard
	12:20-12:35	**Patient Roles on Primary Care Interprofessional Teams: A Framework** Kateryna Metersky, Carole Orchard, Christina Hurlock-Chorostecki
	12:40-12:55	**Why are Patient Teaching Strategies Not Working Effectively? What Needs to Change? A New Proposed Approach** Carole Orchard
	G3 – Promoting Health Equity: Partnerships & Collaboration (Moderator: Marilyn Ford-Gilboe)	
	12:00-12:15	**The Nature of Place and Disadvantage in Home-Visiting: A Critical Exploration of the Impact of Geography on the Nurse-Family Partnership Program** Karen Campbell
	12:20-12:35	**Realist Evaluation of the Locally Driven Collaborative Project Funded Health Equity Indicators** Shamiram Zendo, Anita Kothari, Marlene Janzen Le Ber
	12:40-12:55	**Evaluating the Incorporation of Community Tenants as Key Stakeholders in a Deliberative Dialogue** Tiffany Scurr, Anita Kothari, Rebecca Ganann, Nancy Murray, Gina Agarwal, Amanda Terry, Ruta Valaitis
	G4 – Symposium III	
	12:00-1:00	**Smart Technologies to Support Mental Health** Cheryl Forchuk & Jonathan Serrato, on behalf of the research team

1:00-1:15	**BREAK**	
1:15-2:15	**Concurrent Session H: Oral Paper Presentations & Symposium IV**	
	H1 – Digital Health: Interventions & Innovations (Moderator: Ryan Chan)	
	1:15-1:30	**Caring Near and Far - A Pragmatic Randomized Control Trial (PRCT) of a Remote Monitoring Home Care Innovation: Family Member/Friend Caregiver and Patient Participant Profiles at Baseline** Lorie Donelle, Sandra Regan, Bradley Hiebert, Merrick Zwarenstein, Michael Kerr, Grace Warner, Michael Bauer, Lori Weeks, Aleksandra Zecevic, Emily Read, Richard Booth, Beverly Leipert, Dorothy Forbes
	1:35-1:50	**"VID-KIDS" Video-Feedback Interaction Guidance for Improving Interactions between Depressed Mothers and Their Infants: A Randomized Control Trial (RCT)** Panagiota "Penny" Tryphonopoulos, Nicole Letourneau
	1:55-2:10	**A Digital Innovation to Screen for Early Cardiac Symptoms with the Prodromal Symptoms Screening Scale (PS-SS)** Sheila O'Keefe-McCarthy, Lisa Keeping-Burke, Karyn Taplay, Ian Chalmers, Lauren Levy
	H2 – Accessing Health & Social Services (Moderator: Karen Campbell)	
	1:15-1:30	**Should I Stay or Should I Go? Influential Factors on Non-Emergent, Emergency Department Use** Amanda Houston, Lisa Shepherd, Mickey Kerr, Richard Booth
	1:35-1:50	**The Experiences of Caregivers of Community-Dwelling Stroke Survivors in Accessing and Using Formal Health and Social Services** Anna Garnett, Jenny Ploeg, Maureen Markle-Reid, Pat Strachan
	1:55-2:10	**Experiences of Arabs in Seeking Health Services: A Scoping Review** Selma Tobah, Lorie Donelle, Sandra Regan, Lloy Wylie
	H3 – Transforming Education & Practice: Culture & Shadeism (Moderator: Victoria Smye)	
	1:15-1:30	**Whose Culture is it Anyway? Disrupting Nursing Education Through Cultural Safety** Kathryn Edmunds
	1:35-1:50	**Towards Understanding of Culturally Sensitive Care for Transgender Blood Donors: A Scoping Review of Health Care Provider Knowledge** Terrie Butler-Foster, I. Chin-Yee, M. Huang, K. Jackson
	1:55-2:10	**Sexual Health and Diasporic Experiences of Shadeism** Gayathri Naganathan, Vasuki Shanmuganathan, Sinthu Srikanthan, Abhirami Balanchandran

	H4 – Symposium IV	
	1:15-2:15	**So you want to use Instruments in your Study? Tips from Experience About Selection, Use of, Either Established or your own Self-Developed Mea**sures Carole Orchard, Dianne Allen, Sibylle Ugirase
2:15-2:30	**BREAK**	
2:30-3:45	**Closing Plenary Address** ***Leading in a Post-Pandemic World: Nursing at a Crossroad*** Lynn M. Nagle, PhD, RN, FAAN Director, Digital Health and Virtual Learning, University of New Brunswick Adjunct Professor, Lawrence S. Bloomberg Faculty of Nursing, University of Toronto and Arthur Labatt Family School of Nursing, Western University *Introduction of speaker*: Lorie Donelle Arthur Labatt Family Chair in Nursing & Associate Professor Arthur Labatt Family School of Nursing, Western University	
3:45-4:00	**Conference Closing Remarks** Victoria Smye, Director, Associate Professor, & Conference Co-Chair, Arthur Labatt Family School of Nursing, Western University	

ABSTRACTS

Concurrent Session G: Oral Paper Presentations & Symposium III

G1 – Substance & Cannabis Use

Learning from a Study of Substance Use on an Inpatient Youth Mental Health Unit: A Discussion on Measurement-Based Care

Jillian Halladay, Department of Health Research Methods, Evidence, and Impact, McMaster University, Hamilton, Ontario
Catharine Munn, McMaster University Department of Psychiatry, Hamilton, Ontario
Laurie Horricks, McMaster Children's Hospital, Hamilton, Ontario
James MacKillop, McMaster University Department of Psychiatry, Hamilton, Ontario
Michael Amlung, McMaster University Department of Psychiatry, Hamilton, Ontario
Katholiki Georgiades, McMaster University Department of Psychiatry, Hamilton, Ontario

The CAMP (Cannabis, Alcohol, Mental health, and Patterns of service use) study was a study on an inpatient youth mental health unit in a tertiary care hospital, which assessed cannabis, alcohol and other substance use among youth, and their influence on severity, impairment and complexity of clinical presentation on admission to the hospital for mental health concerns. The study consisted of four parts including: (1) a self-reported electronic clinical assessment of youth substance use and mental health completed during psychiatric hospitalization; (2) a 6-month follow-up assessment; (3) retrospective (3 years) and prospective (6 months) chart reviews; and (4) frontline Nurse and Child and Youth Workers surveys related to perceptions around assessing and addressing substance use on the unit, including importance, facilitators, barriers. The youth sample included 100 youth (average age 15.4, 78% response rate), who were admitted to a youth inpatient psychiatric unit between September and November 2019. The staff sample included 37 (response rate 86%) frontline staff. Overall, the CAMP study provides preliminary evidence of the feasibility and importance of standardized substance use and mental health assessments during youth psychiatric hospitalizations and identifies considerations for transitioning standardized assessments from being research led to staff led. This presentation will discuss the importance of and next steps for combining research and clinical practice in this clinical area to enable us to bridge current policy and clinical gaps while efficiently addressing and mitigating critical research gaps.

Cannabis for Chronic Pain: A Rapid Systematic Review of Randomized Control Trials

Riana Longo, Arthur Labatt Family School of Nursing, Western University, London, Ontario
Abe Oudshoorn, Arthur Labatt Family School of Nursing, Western University, London, Ontario
Deanna Befus, Arthur Labatt Family School of Nursing, Western University, London, Ontario

Background: The high prevalence of inadequately managed chronic pain indicates the need for alternative and multimodal treatment options. Use of cannabinoids in medicine is becoming a growing area of interest, specifically in the context of chronic pain. The efficacy of cannabinoids for the treatment of chronic pain is not well established.

Aims: The objectives of this rapid systematic literature review are to summarize the efficacy and secondary effects of cannabinoids for chronic pain management.

Design: Rapid systematic review of randomized control trials.

Participants: Individuals with chronic pain (n = 1352).

Methods: Embase, Cochrane, PubMed, and CINAHL databases were searched. Inclusion criteria included cannabis of any formulation used to treat chronic pain of any origin.

Results: Thirteen randomized controlled trials met the inclusion criteria. Five demonstrated moderate analgesic effects of cannabis for chronic pain, and eight concluded there were no significant impacts on pain in the cannabis-treated group versus the control group.

Conclusions: Evidence on the efficacy of cannabinoids for chronic pain shows patient-perceived benefit but inconsistent other treatment effects. These findings indicate cannabinoids may have a modest analgesic effect for chronic neuropathic pain conditions, and that the use of cannabinoids is relatively safe, with few severe adverse events. This review concludes that cannabinoids may have a potential role in chronic pain management. Inconsistent evidence on the efficacy of cannabis to treat chronic pain indicates the need for more studies on a larger scale. Clinicians should draw on available evidence and consider cannabinoids as a potential approach to chronic pain management.

G2 – Interprofessional Practice

Evaluating Interprofessional Models of Care for Sustainable Healthcare Service Delivery

Alexis Smith, St. Joseph's Healthcare London; Western University, London, Ontario
Amanda Thibeault, St. Joseph's Healthcare London; Western University, London, Ontario
Carmen Marsh Lansard, St. Joseph's Healthcare London, Ontario

Purpose
St. Joseph's Healthcare London has endeavored to develop a process by which interprofessional models of care are reviewed across clinical areas on an ongoing basis. This novel review process includes an evaluation of both nursing and allied health models of care, with the goal of identifying models delivery that provide high quality patient care services, while being efficient and sustainable in the current and future healthcare landscape.

Methods
This review is the first known pilot of an established review process that incorporates nursing, alongside allied health, and is collaborative with a finance department. Evaluation of allied health models of care were identified as a gap in the literature such that clear processes and toolkits had not been established or trialed in the clinical setting. Developing this process and the review tools to be used to collect data has engaged a number of stakeholders from the organization, including direct care providers, patients/caregivers, and physicians, and employed modified Delphi techniques for instrument development.

Results
The model of clinical practice review process that has been developed is multi-faceted and includes; an opportunity to explore current state of service delivery, evaluation of financial outcomes, and engagement of peer organizations in benchmarking. This review allows organizational leadership to work collaboratively alongside professional practice, finance, and other clinical areas to develop a model of care delivery that meet patient care needs, optimize scopes of practice, are fiscally responsible, and employ evidence informed decision making.

Conclusions
This model of clinical practice review process has been piloted in two clinical settings, one in mental health care, and the other in a rehabilitation care setting. This presentation will describe the learnings from the pilot process, and will share our progress to date. These tools and processes may be relevant to other healthcare organizations to implement this methodology to review models of care through an interprofessional lens.

Patient Roles on Primary Care Interprofessional Teams: A Framework

Kateryna Metersky, Arthur Labatt Family School of Nursing, Western University, London, Ontario
Carole Orchard, Arthur Labatt Family School of Nursing, Western University, London, Ontario
Christina Hurlock-Chorostecki, Arthur Labatt Family School of Nursing, Western University, London, Ontario

Since the early 2000's, across Canada, a real emphasis was being placed on creation of interprofessional teams in all healthcare settings. These teams, comprised of at least two or more different healthcare providers, often did not and do not include patients as part of team membership. The basis of these teams, however, is the enhancement of patient-centered care delivery and patient healthcare experience. A transformation of these teams is needed if the goals of interprofessional care are to be realized. Currently, there is a paucity of research available on how patients can become members of such teams in terms of what roles they can enact within them. The purpose of this study was to develop a framework, using Charmaz's constructivist grounded theory approach, providing a theoretical explanation into patient roles in primary care interprofessional teams. A total of 10 patients and 10 healthcare providers were recruited from two family health teams in Ontario, Canada to undergo a two-step data collection process: an individual interview and a follow-up focus group. Data were analyzed as being collected. The data underwent a triangulation process to see what was similar, different or missing between the patients and healthcare providers' perceptions of patient roles in teams. This resulted in three patient roles being identified: (1) expert of own health; (2) (co) decision- maker; (3) self- manager. Along with these, the processes, comprised of five parts, and the conditions, comprised of four parts, required for patients to take on such roles in teams will be presented. This study can provide an understanding of what is needed by patients and healthcare providers to transform current practice towards patient inclusion on interprofessional teams in primary care.

Why are Patient Teaching Strategies Not Working Effectively? What Needs to Change? A New Proposed Approach

Carole Orchard, Arthur Labatt Family School of Nursing, Western University, London, Ontario

The current focus on patient teaching for quite some time has been assessing the patient's readiness to learn. However this approach was premised on patients changes in practices to regain their health. Today patients are transitioning across health sectors with shortened times for nurses to integrate patient teaching into their care. Many of these patients are then receiving home care funded by the Ontario Ministry of Health. However, in this funding home care nurses are provided with a one-hour assessment visit that includes teaching patients and or their informal caregivers to carry out the procedures and treatments following a short demonstration by the nurses uses a readiness to learn approach. In this presentation a new approach to patient teaching that used a patient/informal caregiver partnering model will be presented. This model integrates Meleis' Transition Theory and its situational and developmental transitioning, properties, conditions, patterns, and outcomes shaped by collaborative patient/informal caregiver centred care, Kline's Naturalistic Decision-making model (2006), Jarvis' Theory of Learning to Be in Society (, D'Zurilla's Social Decision-making (D'Zurilla, Nezu, & Maydeu-Olivares, (2004) within development of home care nurse's relationship building with patients and their informal caregivers.

G3 – Promoting Health Equity: Partnerships & Collaboration

The Nature of Place and Disadvantage in Home-Visiting: A Critical Exploration of the Impact of Geography on the Nurse-Family Partnership Program

Karen Campbell, Arthur Labatt Family School of Nursing, Western University, London, Ontario

Background: Nurse-Family Partnership (NFP) is a health equity intervention for pregnant and parenting young women and girls experiencing economic and social disadvantage. Public health nurses (PHNs) visit first-time mothers, providing care and support to improve health outcomes. The purpose of this study was to examine how home visiting is influenced by geographical environments.

Methods: Using interpretive description methodology, we explored how PHNs delivered NFP across different geographical contexts. Over 2 years, 10 focus groups were conducted with NFP PHNs. An intersectionality lens was applied to critically explore the influence of geography on NFP delivery.

Results: Health and place are intrinsically linked. Participants indicated that clients' place intersected with circumstances that interfered with their wellbeing. Rural disadvantage is easily discernable, however, geography across all contexts compounded disadvantage for mothers in the NFP program. Clients in rural settings had limited available and accessible health services, whereas urban-dwelling mothers were overburdened by services. The ability to access space in rural communities restricted home-visiting but was a supportive factor in urban areas despite the frequency of homelessness. Travel time was a significant issue for nurses across all contexts and PHNs were more likely to cancel visits to clients living in hard to access areas, particularly when clients did not confirm appointments.

Conclusions: All types of geography has a significant impact on NFP program delivery for clients who were living with multiple forms of marginalization intersects to reinforce disadvantage. Over/under-servicing may lead to negative program outcomes and should be urgently addressed as to utilize resources appropriately.

Realist Evaluation of the Locally Driven Collaborative Project Funded Health Equity Indicators

Shamiram Zendo, Faculty of Information and Media Studies, Western University, London, Ontario
Anita Kothari, School of Health Studies, Western University, London, Ontario
Marlene Janzen Le Ber, Leadership Studies, Brescia College, London, Ontario

Background:
The Locally Driven Collaborative Project (LDCP)-funded health equity indicators are an evidence-based tool designed to be used as an internal assessment tool that guides Local Public Health Agencies (LPHA) in Ontario, Canada, in the delivery of equitable programs and services. In this realist evaluation, which was part of a doctoral thesis project, the aim was to explore if and how these indicators were implemented.

Methods:
A realist evaluation, of the LDCP-funded health equity indicators was conducted to answer the following questions: For which LPHAs do the indicators work? Why do the indicators work, and under what specific context(s)? And, what mechanism(s) facilitate the intended outcome(s) of the indicators? Data collected to inform the realist evaluation cycle was done in three phases. Phase 1included the following sources: a. Rapid realist review of existing literature, b. Secondary data analysis of data collected through a pilot case study of the indicators; phase 2 included the following sources: c. Two rounds of semi-structured interviews with 22 public health practitioners from 17 LPHAs across Ontario; and phase 3 included the presentation of the theories at The Ontario Public Health Convention (TOPHC 2019) in a 90 minute panel presentation to an audience of approximately 100 public health practitioners, who were given an the opportunity to provide their feedback on the theories presented.

Results:
Creating an organizational context where health equity work is supports requires continuous support from organizational leadership, and allocation of monetary resources and staff time to address health inequities experienced by the local population. It is also critical to develop and maintain working partnerships with other organizations and priority populations. The implementation of the indicators is also dependent on the organization's capacity to integrate health equity as a foundational organizational value.

Conclusion:
The use of realist evaluation adds valuable insight and knowledge about the use of the indicators, and provides evidence generated at a local level which can be used to inform and design policy interventions. This realist evaluation contributes to the emerging and vibrant dialogue around the operationalization of 'equity' as a core value in health, but more specifically in public health.

Evaluating the Incorporation of Community Tenants as Key Stakeholders in a Deliberative Dialogue

Tiffany Scurr, Faculty of Information and Media Studies, Western University, London, Ontario
Anita Kothari, School of Health Studies, Western University, London, Ontario
Rebecca Ganann, School of Nursing, McMaster University, Hamilton, Ontario
Nancy Murray, School of Nursing, McMaster University, Hamilton, Ontario
Gina Agarwal, Department of Family Medicine, McMaster University, Hamilton, Ontario
Amanda Terry, Centre for Studies in Family Medicine and Department of Family Medicine, Epidemiology, and Biostatistics, Western University, London, Ontario
Ruta Valaitis, School of Nursing, McMaster University, Hamilton, Ontario

Background: Deliberative dialogues (DDs) are a collaborative tool used in policy making and healthcare research to enhance knowledge exchange and research implementation strategies. They allow organized dissemination and integration of relevant research, contextual consideration, and input from a variety of stakeholder perspectives on the issue. Despite recent interest in involving consumer, patient, and the public's perspectives in the healthcare research process, DDs typically involve only professional stakeholders and the literature has yet to appropriately explore DDs that include affected community members. This study evaluated a DD that took place in May 2019 involving affected community members in both the planning of and participation in the DD. As part of a larger two-step project to improve neighbourhood health, this community-led DD was developed to improve the social environment and decrease social isolation in a subsidized apartment complex in South Western Ontario. During the DD tenants, public health (PH), primary care (PC), and service providers collaborated to produce actionable solutions to four specific issues: 1) communication between service providers and tenants; 2) engaging tenants in decision-making; 3) social inclusion; and 4) mental health and addiction.

Objective: To determine how the inclusion of community tenants as stakeholders impacts the planning, execution, and feasibility of a deliberative dialogue.

Methods: Collaboration on the development of the DD was assessed using the agendas, meeting minutes, field notes, and researchers' observations collected throughout the planning process leading up to the DD. All stakeholders' contributions to and satisfaction with the DD was assessed using transcripts from the DD, participant observation, and key participant survey and focus group responses.

Results: All stakeholder groups rated the overall DD experience positively and valued the large number of tenants involved. Suggestions to improve the experience for community members were identified through participant feedback and researcher observations. Significant influence of the community tenants on the planning process and decisions about key features of the DD were identified.

Implications: The findings of this study demonstrate the viability of and provide recommendations for DDs involving community members. Participants' ratings of key features can be compared to previous, similarly-assessed DDs to contribute to the overall literature.

G4 – Symposium III

Smart Technologies to Support Mental Health
Cheryl Forchuk & Jonathan Serrato, on behalf of the research team

TELEPROM-Y: Improving Access and Experience of Mental Healthcare for Youth through Virtual Models of Care

Cheryl Forchuk, Lawson Health Research Institute & Western University, London, Ontario
Jeffrey Reiss, Department of Psychiatry, London Health Sciences Center, London, Ontario
Sandra Fisman, Department of Psychiatry, St. Josephs' Healthcare, London, Ontario
Kerry Collins, Department of Psychiatry, London Health Sciences Center, London, Ontario
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Abraham Rudnick, Department of Psychiatry and School of Occupational Therapy, Dalhousie University
Wanrudee Isaranuwatchai, St. Michael's Hospital and Centre for Excellence in Economic Analysis Research, University of Toronto, Toronto, Ontario
Xianbin Wang, Faculty of Engineering, Western University, London, Ontario
Jeffrey Hoch, Department of Economics, University California Davis
Daniel Lizotte, Computer Science & Epidemiology & Biostatistics, Western University, London, Ontario
Richard Booth, Arthur Labatt Family School of Nursing, Western University, London, Ontario

Background: About 1 in 5 youth have a mental illness, with 75 percent of all mental illnesses having their onset in childhood or adolescence (Kim-Cohen et al., 2003). In Ontario, 157,900 youth rated their mental health as fair or poor, a significant increase from 2007 (Boak et al., 2014). Not only do mental health concerns cause difficulties at onset, they can also disrupt important life transitions and developmental milestones, as well as being burdensome throughout the individual's lifespan (Ratnasingham et al., 2012). Consequently, new care approaches are needed. TELEPROM-Y project will evaluate outpatient health care delivery using an electronic Collaborative Health Record (CHR) at three local hospitals and two local community agencies.

Methods: 120 youth (ages 14-25) will be recruited from the caseloads of 46 staff/care providers. Participants will use a smartphone application (app) to connect to the CHR. Semi-structured interviews will be conducted at baseline, 6, and 12 months. This is a participatory action research project utilizing a pre-post, mixed methods design. A standardized evaluation framework will be instituted to facilitate systematic effectiveness, economic, ethics, and policy analyses. The primary outcome measure for effectiveness will be the Community Integration Questionnaire – Revised. Some of the functions of the app include: making/cancelling appointments; text messaging; emailing; and filling out questionnaires. If the youth are unable to attend a scheduled appointment in person, the care-provider and youth can have a virtual visit. Virtual visits should reduce missed appointments.

Results: Focus group feedback found that the youth appreciated having the data plan and app and used it for a variety of purposes including managing potential employment, and securing housing as well as their mental health. Concerns centered on the login process which they wanted simplified. We anticipate that the participant and care-provider experience will be enhanced, leading to: 1) improved healthcare outcomes and patient quality of life; and 2) reduced healthcare costs by preventing hospitalization and reducing the need for outpatient visits. Each of these aspects will help ensure that our program results speak to as many participants, agency staff, health care professionals, and policy- and decision-makers as possible.

Smart Technology for Individuals with Severe Mental Illness in a Variety of Community Homes

Cheryl Forchuk, Lawson Health Research Institute & Western University, London, ON, Canada.
Abraham Rudnick, Dalhousie University, Halifax, NS, Canada.
Deborah Corring, Western University, London, ON, Canada.
Dean Astolfi, Canadian Mental Health Association, London, ON, Canada.
Norman Turner, London-Middlesex Community Housing, London, ON, Canada.
Dan Lizotte, Western University, London, ON, Canada.
Jeffrey Hoch, University California Davis, California, United States of America.
Rupinder Mann, Lawson Health Research Institute, London, ON, Canada.
Barbara Frampton, CONNECT For Mental Health, London, ON, Canada.
Wanrudee Isaranuwatchai, University of Toronto, St. Michael's Hospital, Toronto, ON, Canada.
Jeffrey Reiss, Lawson Health Research Institute & Western University

Introduction: Many people experiencing severe mental illness remain in hospital or are readmitted because appropriate home care in the community is not readily available. However, the implementation of smart technology into community residences is a potential solution in supporting individuals with mental illness and comorbidities.

Objective: The objective of this study is to evaluate the use of smart technologies for individuals with severe mental illness residing in the community.

Methods: The study is currently recruiting 13 participants in community homes (aged 18-85). Participants are offered screen devices such as smartphones and touch-screen monitors. These enabled video-conferencing, prompts/reminders, and transmission of formal and informal questionnaires to their care-providers through the Collaborative Health Record software. Wireless health-monitoring devices such as weigh-scales, smartwatches and automated medication dispensers are provided as needed. The data from these are exported to the Lawson Integrated DataBase for care providers to track participant health. Participants will complete interviews at baseline as well as 6-month and 12-month follow-ups. Focus groups with participants and care providers will be conducted at 6-months and 12-months. The primary outcome measure is community integration. Focus groups will be analysed through an ethnographic qualitative approach.

Results: Participants and care providers have been positive towards the technology so far. It is anticipated that participants will demonstrate greater levels of community integration, housing stability and self-care for mental health and chronic illnesses.

Discussion: This technological innovation could reduce care provider burnout by reducing the number of psychiatric emergency room visits, travel times, and undesirable police and ambulance service interactions. It is envisaged that the implications of this study may lead to a revision of the Assistive Devices Program in Ontario.

Caring Near and Far - A Pragmatic Randomized Control Trial (PRCT) of a Remote Monitoring Home Care Innovation: Family Member/Friend Caregiver and Patient Participant Profiles at Baseline

Lorie Donelle [1], Sandra Regan[1], Bradley Hiebert[1], Merrick Zwarenstein[1], Michael Kerr[1], Grace Warner[2], Michael Bauer[1], Lori Weeks[2], Aleksandra Zecevic[1], Emily Read[3], Richard Booth[1], Beverly Leipert[1], Dorothy Forbes[4],

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[2]Dalhousie University, Halifax, Nova Scotia
[3]University of New Brunswick, Fredericton, New Brunswick
[4]University of Alberta, Edmonton, Alberta

This presentation will provide an overview of a multi-province study examining the use of home-based remote monitoring (RM) technologies intended to support the care of older adults in their home. A RM model of homecare has been implemented in Nova Scotia and Ontario; a composition of passive RM devices (e.g. motion sensors, cameras) are individually tailored to older adult homecare recipients with the goal of linking older adults, family/friend caregivers, and healthcare providers to support older adults' aging in place; to remain safely in their home and avoid or delay higher levels of care. Preliminary (baseline) results will be presented from homecare patients and their family member/friend caregivers related to 1) patient functional status and quality of life, and 2) family/friend caregiver stress and functional health status.

Method: A pragmatic randomized control trial (PRCT) with four participant groups: 1) older adults receiving current standard of home care; 2) older adults receiving current standard of homecare and RM; 3) family member/friend caregivers of older adults receiving current standard of homecare; and 4) family member/friend caregivers of older adults receiving current standard of homecare and RM. Independent t-test and chi-square analyses were conducted on baseline data to determine the similarity of participants in the two patient conditions, and in the two caregiver conditions.

Results: Analyses revealed no statistically significant differences between older adult groups, and minimal statistically significant differences between caregiver groups. There were no significant differences between groups for caregivers' mean scores on the Zarit Caregiver Burden Scale, Positive Aspects of Caring Scale, Stanford Presenteeism Scale, Todtman Financial Impact Scale, or HARP Activities of Daily Living Scale to assess patient risk of hospitalization. Caregivers' assessment of patient risk of hospitalization was significantly greater ($p < .001$) than patients' self-assessment of risk of hospitalization based on the HARP Scale.

Conclusion: At baseline, caregiver participants experience similar levels of caregiver burden, and patient participants experience similar quality of life levels. How the difference in patient and caregiver assessments of risk of hospitalization may be associated with measures of caregiver burden warrants further attention as the study progresses.

“VID-KIDS” Video-Feedback Interaction Guidance for Improving Interactions between Depressed Mothers and Their Infants: A Randomized Control Trial (RCT)

Panagiota ("Penny") Tryphonopoulos, Arthur Labatt Family School of Nursing, Western University, London, Ontario
Nicole Letourneau**,** Faculty of Nursing, University of Calgary, Calgary, Alberta

Background: Postpartum depression (PPD) is 'toxic' to infant development since depressive symptoms impair maternal-infant interaction quality by diminishing mothers' sensitivity and responsiveness toward infant cues. Infants perceive these behaviours as stressful, triggering cortisol release, which, at persistently elevated levels, constrains a critical period of brain development. Interventions focusing exclusively on maternal PPD often improve depressive symptoms but have not consistently improved interaction quality nor children's developmental outcomes. Given the urgent need for interventions that ameliorate the harmful impact of PPD on the developing child, we designed VID-KIDS, a strengths-based parent-training program comprised of 3 nurse-guided video feedback sessions. VID-KIDS maximizes benefits to infants of depressed mothers by targeting maternal sensitivity and responsiveness and promoting "serve and return" interactions (e.g. baby smiles, mom smiles back), which are foundational to healthy brain development. VID-KIDS Phase 1 (n = 12) piloting demonstrated positive, large effects on maternal-infant interaction quality (d =1.43) and infant cortisol patterns (d=.5), suggesting that nurse-guided video-feedback may effectively promote infant development.

Approach: For Phase 2, we are presently conducting a parallel-group RCT evaluating whether the VID-KIDS program can improve: 1) maternal-infant interaction quality, and 2) infant cortisol patterns, infant development, maternal PPD and parenting stress. Mothers randomized to the intervention receive 3 video-feedback sessions during home visits conducted at 3-week intervals, followed by post-test and delayed post-test (2-month) assessments. Recruitment is underway via partnership with Alberta Health Services (Calgary, Canada). To date, 100 mother-infant dyads have enrolled.

Results: Preliminary findings (n=37) for VID-KIDS Phase 2 show a significant improvement in maternal-infant interaction quality favouring the intervention group. Group differences have been observed with respect to maternal sensitivity $t(35) = -2.50$, $p = .017$, $r = .34$, and cognitive growth fostering opportunities in maternal-infant interactions $t(35) = -2.78$, $p = .008$, $r = .42$. Large positive effects were also observed in the intervention group's pre- to post-test scores for maternal sensitivity to infant cues $t(24) = -4.69$, $p = .000$, $r = .71$. Thus, there is growing evidence that VID-KIDS can improve interaction quality in the context of PPD. This presentation will describe the video-feedback protocol and progress to date.

A Digital Innovation to Screen for Early Cardiac Symptoms with the Prodromal Symptoms Screening Scale (PS-SS)

Sheila O'Keefe-McCarthy, Brock University, St. Catharines, Ontario
Lisa Keeping-Burke, University of New Brunswick, Saint John, New Brunswick
Karyn Taplay, Brock University, St. Catharines, Ontario
Ian Chalmers, Pivot Design Group, Toronto, Ontario
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Background: WOMEN are not equipped to recognize lethal warning symptoms of obstructive cardiac disease because they expect their symptoms to mimic what men experience before a cardiac event. Fifty percent of the time MEN do not experience classic symptoms of chest pain, arm or jaw ache as symptoms of angina prior to a myocardial infarction or diagnosis of coronary artery disease (CAD). Most individuals have described unusual fatigue, nausea and vomiting, bouts of dizziness or shortness of breath as symptoms that have led up to a heart attack. Cardiac disease is the number one killer of men and women. Consistently people delay in getting emergent medical advice and timely treatment for CAD because they do not recognize their early prodromal warning signs. The ability to screen and educate people of the differences and similarities and about sex-specific symptoms of CAD is long over due.

Purpose: The earlier health care providers are able to recognize and screen individuals with serious signs and symptoms indicative of obstructive cardiac disease, the faster they can mitigate and stave off development CAD. That is the premise behind the development of this digital innovation -The Prodromal Symptoms Screening Scale [PS-SS]. The goal is to proactively identify problematic symptoms that people experience months, weeks and days before an acute myocardial event. The PS-SS is a 13-item scale designed for individuals and health care providers to proactively evaluate early warning signs of CAD. The tool accommodates taking a risk factor profile as well and encompasses survey questions based on current evidence-based science of gender specific risk factor differences (i.e. gestational diabetes and hypertension) for targeted screening. This cutting edge-screening tool will help patients, clinicians and the public to identify symptoms of encroaching heart disease, explore problematic symptoms, and assess individuals at risk. Come and find out how you use this digital innovation through this interactive, hands on, orientation to an adjuvant screening tool for women and men at risk for developing heart disease.

H2 – Accessing Health & Social Services

Should I Stay or Should I Go? Influential Factors on Non-Emergent, Emergency Department Use

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Overcrowding in the emergency department presents a serious and growing problem to the health care system. High volumes of individuals entering the emergency department, with few individuals leaving, results in a build-up of people waiting for care. An impressive published literature base exists on the internal, systematic mechanisms of overcrowding; however, less is known about external factors, specifically the ways in which patients decide to enter the emergency department system. Decision-making as it relates to attending the emergency department has not been fully explored in the literature. The proposed study will explore factors involved in decision-making, as it relates to attending the emergency department, and triage acuity. The study will test a model that was informed by two theoretical frameworks, Rational Choice Theory and the Health Belief Model. In addition to two constructs from these frameworks, Health Literacy and Health-Related Personal Beliefs, two others not included in the frameworks, coping and stress, will be assessed. A proposed sample of 150 subjects will be recruited from emergency departments in London, Ontario. Individuals will complete the Health Literacy Questionnaire, Illness Perception Questionnaire Revised, Brief COPE-28 item, and the Perceived Stress Scale. Additional information on sociodemographic (e.g., age, gender) and clinical variables (e.g., reason for visit, presence of family physician) will be extracted from the medical record. A binary regression analysis will be conducted to examine how patient triage acuity can be predicted by the specified decision-making constructs. Finally, to understand reasons for attending the emergency department from both health provider (approximately 30 Registered Nurses and physicians) and patient perspectives, brief interviews will be conducted. Open-ended questions related to factors involved in decision-making will be asked and discussed. Preliminary findings will be discussed.

The Experiences of Caregivers of Community-Dwelling Stroke Survivors in Accessing and Using Formal Health and Social Services

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Background. Stroke caregivers are significantly and negatively impacted by caregiving, particularly from a psychosocial perspective. The negative effects of caregiving may persist despite stable stroke survivor health suggesting the need for focused caregiver supports. However, little is known about caregivers' access to and use of publicly funded health and social support services.

Purpose. To increase understanding of: (a) stroke caregivers' experience accessing and using publicly funded health and social support services; and (b) the gaps in health and social support services from the perspectives of stroke caregivers and health professionals.

Methods. A qualitative study guided by interpretive description. In-depth interviews were conducted with caregivers of community dwelling adults who have experienced a stroke in the past five years, and health professionals who provide support to caregivers and stroke survivors in Ontario.

Outcomes. Interviews were conducted with 22 stroke caregivers and 18 health professionals. Key themes include: (a) caregivers encounter substantial costs when accessing supports (b) the existing formal health and social services are not meeting the needs of caregivers, (c) trust in the quality and suitability of supports strongly impacts caregivers' decision to use services, (d) and the impact of stroke on caregivers' social functioning is underestimated hindering their access to services.

Take Home Messages. Caregivers of stroke survivors experience ongoing challenges accessing and using formal health and social support services. These challenges could be addressed by increasing access and availability of subsidized community-based supports including respite, psychosocial counselling and peer-based mentoring tailored to meet the needs of stroke caregivers.

Experiences of Arabs in Seeking Health Services: A Scoping Review

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Background:
Considering the political climate, the popularized depiction of Arab Orientalist stereotypes, and the impact of racial biases in the provision of health services, the purpose of this scoping review was to understand the experiences of Arabs upon their receipt of health services, as well as the perspectives of service providers of Arab patients, post-September 11, 2001.

Methods:
The databases of PubMed, CINAHL, Scopus, and Embase, Social Work Abstracts, and Social Services Abstracts, were searched for articles conducted in English in Canada, the UK, USA, and Australia, using search terms of: Arabs; healthcare services; access; cultural humility; cultural competence; healthcare; social services; discrimination. These terms were searched using keyword and database specific terms, searching anywhere in the article (ie title, abstract, body of the article). Citation chaining as also conducted using Google Scholar in order to conduct a hand search of any possible relevant scholarly articles

Findings:
After the initial removal of duplicates, title screening, and abstract reviewal, a total of eight articles were found to be relevant with another four articles found from the citation chaining process. This led to a total of 12 sources addressing the research question. Seven articles were from the perspective of Arab patients and 5 from that of service providers. Three major themes emerged: 1) linguistic/cultural differences as a barrier to giving/receiving proficient care, along with the benefits and detriments of using interpreters or service providers of the same linguistic/cultural background; 2) the experience of perceived discrimination and racism; 3) cultural humility and the training of service providers in administering culturally competent care.

Conclusion:
The findings present important considerations for health equity in service provision. The review furthers the conversation on understandings of cultural competency, the risk of stereotyping in using this approach, and the benefits of shifting to 'cultural humility'. Gaps still exist in exploring the impact of perceived discrimination on this population in seeking care.

H3 – Transforming Education & Practice: Culture & Shadeism

Whose Culture is it Anyway? Disrupting Nursing Education Through Cultural Safety

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The Canadian Association of Schools of Nursing and the Canadian Nurses Association now recommend that undergraduate nursing students receive cultural safety education. Yet, despite our attention to culture and good intentions, how "working with culture" is taught, learned, and experienced by students, and ultimately practiced by nurses remains problematic, and there is limited evidence that a cultural safety approach has been implemented in education or practice. The purpose of this presentation is to discuss the opportunities and challenges associated with experiencing and teaching cultural safety for nursing students and faculty. The concept of cultural safety arose in New Zealand, developed by Maori nurses in response to the negative health effects of institutionalized and ongoing discrimination within historical and political contexts. Unlike cultural competence, where the focus has become assessing the skills and knowledge of nurses, culturally safe care is experienced and defined by clients. Cultural safety makes explicit issues of power and systemic inequities. The power to declare what is respectful and appropriate care, or education, and who is the expert in that declaration, is highly disruptive as it no longer resides with care providers, or educators. This means that education that is culturally safe is experienced and defined by our students, not faculty. Cultural safety education is not comfortable. It involves hard conversations about assumptions, privilege, stigma and discrimination in both our academic and everyday lives. We will explore the need for safe spaces, the willingness and processes to be deeply reflective, and the changes required in the structures of our institutions. Students who experience their nursing education as culturally safe will be much better prepared to practice cultural safety with their clients in a variety of settings across levels and sectors. A cultural safety approach provides the means for more honest, authentic and socially just relationships and partnerships with our students, colleagues and clients.

Towards Understanding of Culturally Sensitive Care for Transgender Blood Donors: A Scoping Review of Health Care Provider Knowledge

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Background: Transgender blood donors report distressing donation experiences which may indicate difficulties in culturally sensitive care provision. Negative donation experiences can harm donors and the reputation of blood agencies. Discourse regarding best practices in culturally sensitive care provision for transgender donors is absent in transfusion medicine literature.

Methods: To address this knowledge gap, a systematic scoping review applying Arksey and O'Malley's methodological framework was undertaken to explore and understand the extent and range of research related to culturally sensitive care provision for transgender individuals as investigated in other health care disciplines.

Results: Thematic analysis revealed systemic and practice gaps.
Systemic gaps included rigid binary intake processes, uncertainty regarding how transgender individuals are identified in the practice setting, and difficulties knowing when to ask and use pronouns.

Evidence-based recommendations in this review included a two-step intake process asking all individuals their sex assigned at birth and their gender identity and asking all individuals their pronouns at the outset of the therapeutic relationship.

Practice gaps identified a lack of education to assist in caring for transgender individuals. Frequent confusion and conflating of key terms and pathologizing transgender patients were identified. As well as confusion regarding prevalence of gender affirming surgeries and when discourse with patients was required about such interventions. Moreover, there was a lack of understanding of stigma generated by the health care system for transgender individuals and how stigma can elevate health risks.

Recommendations included institutional and purpose built or job specific training on transgender sensitivity, however, there was no consensus on the optimal medium to deliver this education and further research is required regarding the best way to implement these interventions.

Summary / Conclusions: In the absence of transfusion medicine specific research this scoping review identified key knowledge gaps and highlighted evidence-based recommendations in the literature across several health care disciplines. Systemic and practice gaps were identified that if investigated by blood agencies could improve provision of culturally sensitive care for transgender donors. This review provides a call to action for transfusion medicine research on this topic to improve donor experience and the overall efficacy of the blood program.

Sexual Health and Diasporic Experiences of Shadeism

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Shadeism is the process by which lighter skin is equated with perceived health and social benefits. Studies suggest that racialized women have an additional burden to adhere to Eurocentric beauty standards in order to be seen as employable, attractive, and socially and culturally desirable (Charles & McLean 2017; Veenstra, 2011). However, what remains to be studied are how shadeism mediates: 1) priorities (gender, self-image, lifestyle, social relationships, familial networks, employment, social mobility, class, caste) leading to lightening practices; 2) the narrative of 'looking healthy' to be connected to lighter skin beauty; and 3) the cumulative impacts on women's sexual health and wellbeing. How racialized women treat their skin reveals much about the pressures of societal expectations (Rozen et al., 2012). Through a combination of informant interviews, focus groups with arts-based activities, and one-on-one interviews, this qualitative pilot project led by the Alliance for South Asian AIDS Prevention first aims to examine how racialized women (including transwomen) ages 16-35 from the Caribbean, South Asian, Middle Eastern, and North African (MENA) regions are affected by shadeism and how it impacts their sexual health. Second, this project aims to raise public awareness (using community and academic forums, digital venues, and a toolkit) leading towards informed and actionable transformations of sexual health. Through an anti-oppressive, Intersectional Feminist analysis, we will call attention to the complex ways in which shadeism, gender, sex, caste, race, class, location, religion, and age inequities create societal pressure for women.

H4 – Symposium IV

So you want to use Instruments in your Study? Tips from Experience About Selection, Use of, Either Established or your own Self-Developed Measures

Facilitators:
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Dianne Allen, Arthur Labatt Family School of Nursing, Western University, London, Ontario; Conestoga College, Waterloo, Ontario
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Goal: To provide a forum for discussion on the tips in quantitative studies using measures

Workshop Plan:

2.1 Explore what to look for in selecting instruments for use in studies: focus on validity and reliability
2.2 Determine when, how and when not to modify an existing instrument or choosing to use only selected dimensions in the instrument
2.3 What to do when no instrument is found to measure a concept in your study?
2.4 Development and testing of your own instrument
2.5 Normalizing data sets
2.6 EFAs and CFAs; when and when not to use in your study
2.7 Carrying out a CFA for model fit
2.8 Interpreting findings

Each topic will have a short introduction to key points, followed by small group discussion as related to planned studies.