



Workshop Report

October 5 & 6, 2009
Waterloo

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For participant information/bios, please see www.inforehab.uwaterloo.ca

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How to find what you're looking for

This report is organized by topic areas rather than presented in chronological order. We hope that this helps you:

- Quickly find the information that you're looking for
- Refresh your memory about key points
- Use this document as a valuable resource
- Share certain sections with other people
- Cut and paste sections for presentations or update reports
- Spark new ideas

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Workshop at a Glance

Members of the InfoRehab Transitions group gathered in Waterloo, Ontario (October 5 and 6, 2009) for an interactive workshop designed to meet the following **objectives**:

- Share objectives, plans and work completed to date
- Gather feedback and ideas
- Identify new collaborative opportunities
- Launch team communication and project management tools
- Generate ideas about knowledge translation and exchange strategies
- Start to plan for future InfoRehab initiatives
- Build a cohesive team of investigators and collaborators.

InfoRehab Transitions is the third component of the InfoRehab CIHR funded program of research. The first two components research grants include InfoRehab Development and InfoRehab Home Care.

The primary **aims** of InfoRehab Transitions are to:

- Explore the culture and context of information need, use and transfer before, during, and after health care setting transitions across the continuum of care from the perspective of patients (with a focus on older persons with hip fracture), their families, and health care providers; and
- Address important information gaps relevant to MSK rehabilitation, through application of advanced statistical techniques to large databases with comprehensive health information on clients in home care, complex continuing care, and long-term care.

This ethnographic study will follow 4-8 hip fracture patients/year through their care transitions at each of 3 locations. It is grounded in the reality of each patient's experience. Despite numerous challenges related to ethics and conducting field studies, field-work is underway, coordinated through the University of Waterloo, University of Western Ontario and University of British Columbia. Representatives from each site shared their experiences and progress to date.

On Day 1, the investigators learned from each other about the qualitative and quantitative methods that are planned and/or underway.

Christine Ceci described **ethnography** as a methodology that involves the ethnographer participating, overtly or covertly, in peoples' daily lives, for an extended period of time, *watching* what happens, *listening* to what is said, and *asking* questions. Her presentation generated lively discussion and sharing of experiences, and a number of **ethnography tips** were generated.

Ethnography Tips

- Reflect on and be aware of personal pre-conceptions
- Develop sensitizing concepts at each site
- Read healthcare ethnographies
- Collect data throughout a range of times, environments and situations
- Be present in patient room, staff lunch, nursing station, discharge planning, etc...
- Take only 2 hours of notes at a time
- Try to be unobtrusive
- Watch how things are happening and listen for what is said
- Keep research questions in front of you at all times
- Ask broad questions first
- Use structured observation and interview guides
- Ask broad questions first

A series of presentations by Jeff Poss, Paul Stolee, Mu Zhu, and Josh Armstrong provided insights into the **statistical analysis** completed, planned and being considered.

Here are some the questions that the InfoRehab Stats group is pursuing:

- Can we predict risk factors associated with hip fracture for home care clients?
- Can we predict the potential for functional improvement?
- What are the current profiles of home care clients who are receiving rehabilitation therapies?
- What are the regional characteristics that play a role in the current patterns of rehabilitation therapy provision?
- How does rehabilitation service use relate to client outcomes?
- How are client characteristics and provision of rehabilitation associated to a range of outcomes?
- What risk factors for poor outcomes can we identify for different types of home care clients?
- How can we use computer algorithms to search for items from RAI-HC that best predict service utilization?

On Day 2, an enthusiastic group of collaborators joined the workshop to contribute their experience and expertise in **knowledge translation and exchange**; and their perspectives about **future possibilities** for the InfoRehab team. It became evident that the collaborators wish to be actively involved throughout the program of research, and strategies will be implemented to capture their interest.

Together, the investigators and collaborators identified a plethora of practical KTE strategies and future research questions. Recurring **themes** included:

- Provide information that is succinct, relevant, and not overwhelming for all audiences
- Involve patients and care givers in all aspects of research (questions, ethics, participation, dissemination, and follow-up)
- Provide relevant and consistent information so patients and caregivers can “plan their trip”
- Develop a clear “road map” of what care consumers would need as they transition
- Demonstrate how resources can be better used
- Pay attention to the special needs of isolated community health care providers

Workshop participants completed a form to identify strengths, expertise, skills, and areas of interest. This information will be used to help match **participant profiles** to project needs and keep the busy program of research on track. It will also be a valuable resource to provide capacity building experiences for investigators, collaborators, and students across Canada.

The Waterloo-based team created a series of InfoRehab **communication tools**. Everyone is encouraged to make use of these tools, and to visit the InfoRehab website and Sharepoint site as their “go-to places” for sharing information, resource storage, and project tracking.

Workshop evaluations showed that participants appreciated the interactive exercises, opportunities to meet one another, and the learning experiences. They would have preferred more time to work on specific research initiatives.

Paul would like to extend his sincere appreciation to all the InfoRehab team members for their positive contributions. We are in strong position to make great progress in 2010!

A. PROGRAM OF RESEARCH OVERVIEW



Paul Stolee



- Paul provided a status report on each initiative and listed papers/presentations that came from work completed.

InfoRehab Development

Primary aims:

- Investigate/establish novel techniques for statistical analysis and data mining of relevant clinical and administrative databases.
- Develop innovative strategies to ensure those involved in planning and providing rehabilitation services can use this information effectively to enhance the health and quality of life of persons with musculoskeletal disorders.

InfoRehab Home Care

Primary aims:

- Use available health information to answer important questions regarding the role of rehabilitation in home care. This will be achieved through advanced statistical analyses of available health information, using a large existing database of comprehensive health information on over 300,000 home care clients; and
- Engage home care administrators and clinicians in improving the understanding and use of health information for rehabilitation clients

Methods:

- Knowledge Exchange Panels
- 40 participants (Toronto, Waterloo, London)
- Case managers (15), rehabilitation service providers (physiotherapists/occupational therapists, 15), administrators (10)
- Introduction to RAI–HC
- Level of expertise and comfort with RAI
- Example of data analysis and results
- “World Café” on issues related to use of health information

Barriers and Enablers of the Use of Health Information in Home Care – Themes:

- Accessibility
- Communication/Technology
- Knowledge and Training
- Standardization
- Assessment Tools
- Agency Support and Resources

Key Points

- Major benefits are associated with effective communication of health information
- There is a need to improve communication and feedback
- Users need to understand value and relevance of data
- Interest in greater access to, and use of, RAI data
- Rehabilitation professionals have had limited involvement
- Technology can aid communication, but lack of familiarity
- Ongoing training and support needed
- Standardized, consistent approaches and policies are valued
- Use of health information systems needs to fit within existing processes (e.g., case conferences) and constraints (e.g., high caseload)

InfoRehab Transitions

Primary aims:

- Explore the culture and context of information need, use, and transfer before, during, and after health care setting transitions across the continuum of care from the perspective of patients (with a focus on older persons with hip fracture), their families, and health care providers; and
- Address important information gaps relevant to MSK rehabilitation, through application of advanced statistical techniques to large databases with comprehensive health information on clients in home care, complex continuing care, and long-term care.

Rationale:

- Patients may be at risk during transitions between health care settings
- Timely and accurate communication of information is critical, however, informational continuity is a major challenge for health care providers
- Appropriate use and transfer of health information is particularly critical in MSK rehabilitation
- This study seeks to understand the circumstances of how health information is used and exchanged, as well as the barriers and facilitators of effective information transfer

Study Overview:

- Follow 4-8 hip fracture patients/ year through their care transitions at each of 3 locations across Canada
- Study grounded in reality of patient experience
- Ethnographic study
 - Semi-structured interviews
 - Hip fracture patients
 - Care giver(s)
 - Health care providers
 - Document review
 - Observation

Paul Stolee (Waterloo Update)

- Grand River Hospital Acute Care in Kitchener Waterloo
- Focus on a small number of patients to gain greater depth of understanding
- Looking at info sharing at the transition points

- Communication of information does not happen as well as we hope (nature of care is complex, multidisciplinary, chronic care)
- Overview: 4-8 patients/year
- 100s of interviews, lots of data
- GRH- AC resource nurses and therapy team will identify potential research participants and achieve consent
- Status: received ethics, a very arduous process, but ready to start recruitment

Bert Chesworth (London Update)

- London methods differ from Waterloo in that people do not physically transition, they stay at the same bed
- Small hospitals that merged
 - Strathroy Hospital
 - Service 12, 500 patients
 - Agricultural area
 - 60 AC beds
 - 2 orthopaedic surgeons
 - 40-50 hips/year
- Four Counties – Smaller (outside Newberry)
 - More traditional home hospital environment
 - Service London/Chatham
 - Volume ½ that of Strathroy
 - Onsite: 2 people to help coordinate
 - Primary recruiting
- Update: Received ethics and currently setting up rollout meetings onsite; ready to start observation phase

Joanie Sims-Gould, Kerry Byrne and Valerie McDonald (Vancouver Update)

- Has ethics for observation/pilot phase with health care workers (not patients)
- Ready to begin pilot work – observations phase, pilot interview questions for development
- Ethnography requires “insider” relationships
- Access to the clinical population

Context:

- 5 authorities, 1 provincial health authority, separate ethics
- Different contexts
- Merging HA's have implications for research
- Different recruitment sites: VCH, FH, CHHM (JSG an affiliate)
- Interview guides: language, right questions
- Full study at Frasier Health
- Interesting program: falls clinic pre-fracture: 75+, significant injury, ER and GP referral, vulnerable and high risk populations

Questions and Issues Raised:

- What happens if someone we are following moves from acute care→rehab→home then has a second event and goes back to hospital – Do we continue to follow them?
- Are we planning to have a periodic follow up schedule?
- When reviewing patient documents, how much of the patient chart should we look at?

Section B: Team Communication Tools

Presentation by: Brandie Steeves

- Would like to make the tools useful and expose members to what we are working on
- **Bulletin:**
 - Quarterly
 - Welcome suggestions and content
- **Website (www.inforehab.uwaterloo.ca)**
 - Process of growing
 - Tools open to input
 - Members only section
 - Link us to your website – we would be happy to add your websites to your bio pages – send to Brandie Steeves
 - House final documents (publications and presentations)
 - Example: ethics certificates in members only site
- **Sharepoint**
 - Project coordination
 - Keeps documents together (i.e. Interview guides)
 - Keeps track of everything (last edited, by whom, etc.)
 - Reminder to answer questionnaire on Sharepoint
- **Refworks**
 - Login & password available on Member Resources section of InfoRehab website
 - Includes:
 - All **references** from grants
 - **Relevant readings**
 - **Ethnography** folder
 - **Content analysis** folder
 - General **qualitative** methods folder
 - Can **customize** additional folders i.e. Adding ``data mining`` folder etc...
- **Knowledge Mobilization**
 - Like to have piece within website (e.g., top 3 articles on machine learning or family care giving training BC)
 - Link TYZE.com
 - Categorized
- **To do list for members**
 - The communications brochure included invitations to submit content for all communication vehicles (brochure, website) and requests to fill in the communications survey – PLEASE do so if you have not had a chance to yet!

SECTION C: QUALITATIVE METHODS

Christine Ceci Presentation Summary

Ethnography

- Refers primarily to a method or set of methods
- In its most characteristic form it involves the ethnographer participating, overtly or covertly, in peoples' daily lives, for an extended period of time, **watching** what happens, **listening** to what is said, **asking** questions....
- Accounting for the organizational contexts of care and/or the extent to which the context itself may be contributing to problems
 - Context not the same as place, it includes people, location, environment, etc – there are norms, standards, procedures that people account for
- Retheorization - The clinical encounter itself is only one part of an assemblage of complex organizational, institutional, and disciplinary resources and practices
- We are interested in observing enactments of:
 - Skill mix
 - Availability and use of resources
 - Routines and guidelines
 - Care protocols
 - Admission and transfer policies
 - Reporting mechanism
 - Rounds, shift reports
- Practical Considerations
 - If information exchange is understood to be ongoing and distributed, and if one of the characteristics of information is that it travels, then how do we 'sample' that?
 - Follow the patient:
 - The 'real' patient and the virtual patient
 - Important at this stage to be open to the field, guided by sensitizing concepts as opposed to firm hypotheses – the pre-fieldwork work, the work already undertaken by part of this group, has provided these sensitizing concepts to the extent that the problem has been defined as a problem of information
 - Decisions to make:
 - Where to observe and when
 - Who to talk to and what to ask
 - What to record and how
 - Concrete descriptions of processes and contexts
 - Brief notes of dialogues and observations of actions
 - Preservation of concreteness and actual words people use are important
- Criteria for sampling/observing should be as explicit and systematic as possible
 - 3 dimensions:
 - Time – identifying time periods when information is moved e.g., in rounds and also less obvious times

- People – may wish to do key informant interviews
- Context – information exchange between co-workers different than between patients and physicians
- Suggested not staying in the field longer than 2 hours at a time
 - Why: because need to write detailed field notes – should give at least 3 hours/session, do as soon as possible after being in the field
- Unobtrusive note-taking – usually short-hand, noting surroundings and actual words

Day 1: Qualitative Group Discussion

Q. How much would we miss if we are primarily sampling for information exchange?

- Keep in mind we are coming at this research with the idea that information exchange is the issue – but it may not be
- Ethnography always feels like you are in the wrong place – so by building in being there at different times/places, particularly at outset, we can focus and not dismiss previous research. How do you know that you are not missing important activities outside of your sampling period? To deal with this issue, data must be collected throughout a range of times and environments and situations.

Q: Initial pre-work – started with BC group – start off being with staff rather than patient to see the general process

- Purpose: so you can see how things are supposed to be working and can compare. Byrne – Helps to have an organizing idea – patient and virtual patient – have some parameters on what we are looking at e.g., virtual patient – therefore, we would need some clarity as to what we really mean by that (virtual patient)

Q: How do we find out what the real story is?

What people say they do, they may not actually do. Also, medical record people/clinicians – do not actually get the information they need – virtual patients able to get some kind of general standard information so you know what you are supposed to get. Often things missing from charts, particularly with chronic conditions – do not have a common assessment underneath from which to base.

Case managers have access to RAI data but do not actually access it as it takes too long

- Either they do not have time to do their job effectively...or, the data is not 100% necessary for people to complete their job satisfactorily
- This is why we should be cautious about looking at the research as just being about a problem with information – issue may be more about time constraints or people may not have a sufficient appreciation of the information to make efforts to go and retrieve it or the information may not be relevant.
- Do not have to throw away all previous knowledge, but need to try to come in with open eyes

Q. What are important things that you've learned doing ethnographic research?

- How you conceptualize what you are doing
 - Watching *how* things are happening

- Sensitizing concepts – being aware of our own background and pre-conceived notions – less rigid than hypothesis – helps build in parameters – loose
 - Keep research questions in mind
- Saturation – theoretical impossibility
- What caused you the most trouble? (Ex. Of question...)
 - Do not want to make it gender-based – it should come out in the analysis
 - Let the person lead you
- Always have research questions in front of us
- Observe/be at:
 - Patients room
 - Nursing station
 - Discharge planning
 - Staff lunch
 - Maybe when family is leaving
 - Then just kind of float
 - Maybe this needs to be more structured due to the lack of expertise
 - Need safe guards to ensure the quality of research

Q. What's the difference between real patient and a virtual patient?

- Virtual patient is information about the patient (not the physical patient) – e.g. Chart, how workers speak about the patient
- Possible that in one context that there are many versions of both the real and virtual patient
 - E.g. Nurses and doctors may speak about patients differently resulting in 2 different virtual versions of the patient
- Suggests ongoing analysis
 - Try to avoid collecting piles of data and then trying to make sense of it – interpret as you go along

Q. If the “real patient” is the same as the “virtual patient” which one we are most interested in for this program of research?

- Response: No consensus

Q. Are we planning to do purposive sampling to get patients with different characteristics – because patients with different characteristics may have different trajectories?

Guidance based on experience with ethnography:

- Ask the primary caregiver when personal support worker, etc. comes in; try interviewing patients with and without caregivers present – likely to get different information; suggested developing a **structured field note guide** for making observations
- Goal of our observation is to achieve continuous observation – not just set point in time – continuous picture of entire process

- For an ethnography approach – our interview questions should be big broad questions first – before biasing the respondent by asking more specific questions
- **Read some medical ethnographies** to learn about the research methods/process

Q. How can we go into an interview with a blank slate?

- Reflective work prior to going into the field, what are my own pre-existing notions – once we are aware of them they are less likely to enter into the analysis
- Suggest developing a **bank of pre-existing notions for each site**

Q. How do we do analysis – possibility of using computer software?

- Novel applications to software (Mu Zu's idea)
- Try to develop some kind of automatic analysis tool for qualitative research
- Computer software can be used as organizational tool, not analysis “people do analysis”
- Layer on top of qualitative analysis – **social constellation**
 - Track exchanges between people
 - Look at individual as centre of egocentric web
 - Web included virtual and real patient – not just one of each, may be hundreds of each

Q. What tips do you have for interviewing in the home?

- Timing
 - Interview together all the time
 - Ask patient/care giver if they want to interview together
 - Might want to do both
- Structured guide prompts for after interview (audio-tape may be helpful)
 - Setting
 - Tension
 - Feelings
 - Structure
- Differentiate between hospital and home setting

Q. How do we determine the relevance of observations?

- It is all context. Recognize that observations and descriptions are reality. Conducting an evaluation of everyday life by observing processes and practices. Some people can do member checks. Importance of sensitizing concepts and paradigms.
- What you notice will change you as an interviewer.
- Need to be open to what people say and do. Requires many skills that we already have.

Q. How do we handle when the interviewee says one thing and what we observe is different?

- Important that what people say is not always consistent with what they do; therefore, approach by observing and asking.

Q. How do you know when you have enough?

- Always ongoing
- Saturation
 - Theoretically impossible
 - But have to finish at some point

Q. How many probes are good/problematic?

- Different ways to do this, for better or worse
 - Broad questions first
 - Finalize interview guides
 - Sensitizing concepts at each site
 - Read healthcare ethnographies

Day 2: Summary of Qualitative Group Discussion

Based on Review of Interview Guide

- Patient Description Questions
 - The London site will have RAI-AC data for all patients – do not need to analyse this information
 - How much of this info will be in the patients chart if we are not able to use RAI?
 - Most will be in chart, hip fracture questions may not be.
- Purposive Sampling
 - What characteristics are we going to use to do our purposive sampling?
 - Identify times
 - Start sampling widely (bedside, rounds, staff reports)
 - Be around during informal reactions (lunch, coffee, hallway)
 - Long list of possible characteristics listed and group was reminded about the small sample size so we will have to limit
 - BC site is planning to only interview females, thought about doing purposive sampling based on care giver type, they will investigate what characteristics are important during their pilot/observation phase
 - Important to include patients with cognitive impairment – because this is representative of the population of patients with hip fracture
- Observation Phase
 - BC and London described their observation plans (long self-contained period, include spontaneous interviews)
 - Question raised about ethics of this process at the UW site
 - Talked about consent for informal interviews – may require multiple versions of the consent form
 - Suggestion for Waterloo group speak to **Sherry Dupuis** or someone else that has done observational research at UW on to best approach ethics/example ethics applications

- Suggestion was for all 3 sites to develop a **structured observation guide**
 - This guide should include times to visit – important to observe both formal and informal interactions – find out when these occur during pre-field work
 - Suggested a 3 phase plan 1) pre field work (literature reviews, identifying pre-existing notions, getting to know location contacts), 2) Observation, 3) Interviews, knowledge of how things work
- Difference between observing a person vs. observing a role
 - Discussion about doing multiple interviews with one care provider if they serve multiple patients in our sample – no decision
 - We want to focus on providers with the most interaction with the patient – however, do not want to exclude informal or “less important” interactions
- How do we choose which healthcare provider to interview?
 - Perhaps the healthcare provider who works most closely with the patient, more directly
 - Suggested: “blanket” ethics or perhaps an opt out for healthcare providers?
 - Concerned about the difference in asking “what do you do?” vs. what was done
 - In London, the clinical leader is the discharge planner
 - If we interview key healthcare providers only, we might miss out on other opportunities. In previous work in ethnography, the best interviews were with the maintenance workers.
 - Can we capture this solely with observation?
 - Can we use the data collected from healthcare providers?
 - Conduct interviews in a “public place”
 - Could we use an open consent sign to post?
 - Recommended approaching people and obtaining consent

Process recommendations

- In pre-field work, BC held off on patient ethics so they could get in with the providers in a stepwise fashion because they didn’t understand the process
- Reminded us to keep our research questions at the forefront
- Prioritize data collection; focus on admission and discharge care transition. I.e. attend the rounds discussing the patient’s discharge to find out who makes this decision
- Create a **website** that would provide **structure for observation**
- Could provide interview guides, have a discussion board, not to change the interview guide but to layer in strategy
- Environmental bias exists because the decision must be made when to observe, how much time to allot, where to observe
- Issue of richness of data vs. inclusivity that may arise with the varying trajectories

SECTION D: STATISTICAL ANALYSIS - QUANTITATIVE METHODS

Summary of Presentation – Jeff Poss – Home Care Data Overview

RAI-HC

- 2002: mandated for all adult, non-palliative, home care clients expected to be on service > 60 days
- Required for all applicants to long term care placement (community and hospital)
- Reassessment at 6 months or earlier if clinical change
- Generates about 225,000 assessments per year on about 160,000 individuals

interRAI Contact Assessment (CA)

- Designed as an intake tool to capture standardized information for all adult CCAC clients:
- Immediate care planning
- Help decide if full RAI-HC may be appropriate
- For those clients not receiving RAI-HC, will have consistent information provincially
- Gradual implementation: May 2006, still not complete today
- Sometimes called CIAT (Common Intake Assessment Tool), which incorporates CA and other administrative items
- When completely implemented: 500,000 / year

interRAI holds intellectual property on instruments

- Jurisdictions use instruments, anonymized data flow back to interRAI
- Other Data (through Ontario Association of Community Care Access Centres)
- Admission Discharge Records
- Service Records
- All four data sources (RAI-HC, CA, Admit/DC, Service) linkable through common, non-real world identifier

Summary of Presentation – Paul Stolee - Answering Questions Using RAI-HC

Hip fractures can be prevented

- Falls prevention: e.g., muscle strengthening, environmental modification
- Medication and dietary supplements
- Hip protectors
- New technologies

Identification of the most important risk factors would enable appropriate targeting of prevention strategies

Risk Factors for Home Care Clients

- Measurement of potential risk factors, using RAI-HC data
- Which variables are most highly associated with hip fracture in home care clients?

Methods

- RAI-HC data for long-stay home care clients in Ontario, aged 65+
- N= 40,279; Mean age: 81.5 (SD: 7.1); 65.8% female
- Risk factors were those identified in:
- Osteoporosis Society of Canada clinical practice guidelines (2002)
- More recent literature
- Risk factors selected were those that could be measured using RAI-HC items:

- 33 Variables, as measured in initial assessment

Factors Associated with Higher Risk

- Age 85+
- Gender: female
- Osteoporosis
- Use of ambulation aide
- Falls
- Unsteady gait
- Cognitive impairment
- Severe malnutrition
- Tobacco use

Factors Associated with Lower Risk

- Arthritis
- Morbid obesity

Risk Factors Females

- Age 85+
- Use of ambulation aide
- Falls
- Unsteady gait
- Cognitive impairment
- Severe malnutrition
- Tobacco use

Risk Factors Males

- Age 85+
- Osteoporosis
- Parkinson's Disease
- ADL decline

- Use of ambulation aide
- Tobacco use

With Osteoporosis

- Age 85+
- Gender: female
- Use of ambulation aide
- Falls
- Tobacco use

Without Osteoporosis

- Age 85+
- Gender: female
- Parkinson's Disease
- ADL impairment
- Use of ambulation aide
- Falls
- Cognitive impairment
- Severe malnutrition
- Tobacco use

Potential Risk Factors Not Measured

- Low Bone Mineral Density
- Low Body Weight
- Reduced Muscle Strength
- Prior Fracture
- Maternal History of Hip Fracture
- Early Menopause
- Greater Height at Age 25

Conclusions:

- Some risk factors for hip fracture are those commonly associated with frailty, including cognitive impairment, use of an ambulation aide, and unsteady gait.
- Risk factor profiles may be different for those with/without osteoporosis and for females/males.
- Osteoporosis found not to be a risk factor for females when considered separately or vice versa – probably due to strong association between these variables.

Predicting Potential for Functional Improvement using Machine Learning Algorithms

- Looking for patterns and relationships in large datasets, that provide new knowledge or that may be used to make predictions

Conclusions:

- Potential role for data mining and other alternative algorithms in prediction and clinical decision-making
- Interpretability of results a challenge - Would clinicians accept a "Black Box" approach?

Overview of Presentation - Josh Armstrong - Enhancing home care rehabilitation through better use of health information

Importance:

- A number of studies have produced evidence of the feasibility and effectiveness of rehabilitation for older persons in home-based settings (Gill, 2002; Giusti, 2006; Crotty 2003; Kuisma, 2002; Gitlin, 2006a; Gitlin, 2006b)

Despite knowledge that:

- (a) MSK disorders such as hip fracture are very costly to the system and can result in a cascade of adverse events, and
- (b) That home-based rehabilitation can improve functional outcomes...
 - Older MSK patients do not always receive the needed rehabilitation services:
 - 71.2% of older home care clients assessed as having rehabilitation potential did not receive any type of rehabilitation therapy (Hirdes et al., 2004)
 - In a recent study of resource utilization in eight CCACs, only 26% of home care clients with hip fracture received rehabilitation (Poss et al., 2005)
 - Many fracture patients are not evaluated and do not receive osteoporosis treatment (Jaglal, 2003)
 - 41% of home care clients with osteoporosis did not receive pharmacotherapy (Vik et al., 2005)

Questions:

- What are the current profiles of home care clients who are receiving rehabilitation therapies?
- What are the regional characteristics that play a role in the current patterns of rehabilitation therapy provision in the 14 CCACs/LHINs of Ontario?
- Mixed linear analyses will be used to explore the hierarchical aspects of the data holdings
- Regional characteristics and individual attributes will be modeled to predict rehabilitation service use
- How does rehabilitation service use relate to client outcomes (i.e. functional independence, institutionalization, hospitalization, death)?
- Multivariate logistic regression and survival analysis will be utilized to investigate how client characteristics and provision of rehabilitation are associated to a range of outcomes
- Risk factors for poor outcomes will be investigated for different types of home care clients (hip fractures, other fractures, dementias, etc.)
- Home care clients requiring rehabilitation are at a critical turning point in terms of their:
 - Future functioning
 - Quality of life
 - Potential to live independently
- Use of information systems to ensure appropriate and equitable access to rehab should lead to major benefits for both older home care clients and the health care system.

Overview of Presentation - Mu Zhu - Predicting Rehabilitation at Home Care Intake Evaluation of the Contact Assessment

Objective

- Use computer algorithms to search for items from RAI-HC that best predict service utilization (e.g., whether or not a patient gets OT/PT service within 6 months of initial assessment).

- Are those items included in the CA?
- Are there unnecessary items in the CA?

Difficulty

- RAI-HC population very different from the target population of the CA!
- Items deemed most predictive of service utilization based on RAI-HC data may not be the best for the target population of the CA.

Strategy under consideration

- Start from the CA database; isolate those that ...
- (a) Were discharged < 60; n=29,951
- (b) But still got a RAI-HC assessment nonetheless; n=3,539
(of these 3539, discharge reasons: 50.6% service plan complete; 17.7% died; 13.1% hospitalized; 6.8% to LTC home; 6.3% 'client preference' (decided home care wasn't for them))
- And merge with a carefully selected subset (c) of RAI-HC data such that the overall sample characteristics "match" the target population of the CA.

Day 1: Quantitative Questions and Discussion:

Q. What patients you will be looking at for your LHIN question – short stay vs. long stay vs. both?

- It should be possible to look at both

Q. Will you take availability of resources into account? I.e. Are people getting referred or not due to lack of resources, e.g., because clinicians do not believe in OT/PT. Colleges will have this info.

Rehab Outcomes

- What is a rehab outcome – how do you measure rehab outcomes?
 - It may be difficult to conceptualize – therefore prove rehab is beneficial
 - Is there a critical amount of resources needed to make a difference (e.g. are 2 visits as beneficial as 5 visits)?
 - Interested if this number is different based on patient characteristics
- When do we measure rehab outcomes – right after rehab has occurs, 6 months later?
 - Suggested if you could look at rehab outcomes for groups receiving rehab over different periods of time – spread out vs. all appointments close together
 - Are rehab outcome different based latent period between event to rehab or transition to rehab
- Should we consider a multiple time series model?
 - Too many chance things that make falls an injurious one

Day 2: Quantitative Informal Small Group Discussion

Discussion of outcome

- How to define outcome
- OT/PT within a time period (aka observational window)
 - 6 weeks/90 days
- Need clinical insight in variable selection
- We have no sense of temporal patterns of rehab in home care
- No evidence of what happens for long stay clients over time in terms of rehab provision
- Fall or ER visit or combinations of events/characteristics (of some sort) should be able to trigger a “need for rehab”
- Falls aren’t in the rehab algorithm
- Can we make an algorithm that can be used in the other data systems as well
- What do clinicians suggest is driving rehab use?

SECTION E: KNOWLEDGE TRANSLATION & EXCHANGE STRATEGY

Consumer Perspective

Question: With respect to this initiative, what do you think will be most meaningful to patients, families, and care givers?

Resource Availability and Access	<ul style="list-style-type: none">• Inform patients/families/caregivers that there are resources.• “Did you know you can get services “.... (for instance – in home)?• “Top 10 things you should know” e.g., services – although maybe not as narrow as just services, maybe just help in general. Should have contact information – have a central repository• Carol Levine’s website regarding transitions: http://www.nextstepincare.org/ - great example of what you can do to make a website relevant to consumers – drop down menu to pick where you are transitioning to and from and provides information pertinent to that particular transition• BC – give patient/caregiver information – like a care map – do it together with them – collaborative plan that also serves as information and includes factors like appointments, what to do if in trouble etc.
Education & Awareness	<ul style="list-style-type: none">• Consumers would like to know about managing the difficult behaviours, the stigma, factors that affect whether people are able return home• Ensure that consumers are taught safe techniques, safe environment• Educate about falls (prevention) – falls, or potential for falls, are very frightening for caregivers – falls can be a trigger point – but also need consumers to know that just because you have fallen does not mean it is going to lead to long term care• Speaking to caregivers regarding falls prevention – have programs• Public Service Announcements – all people should be talking about it – every front line person, media – “I survived a fall”<ul style="list-style-type: none">○ Chumbawamba song – “I get knocked down, but I get up again, you’re never going to keep me down!”• Educate health care providers about the resources available for patients/families so that care consumers get the same information from each provider – system level• We need to have information that is succinct, relevant,

	<p>and not overwhelming</p> <ul style="list-style-type: none"> • Need to be more systematic and formal in terms of delivering core content • Teach to a point of understanding, and if the understanding isn't there, we need to ensure follow up • Develop client-focused tools – these tools would be multi-functional – good to teach with, have a conversation about, then leave with the patient/caregiver for their own referral later on • Can frame qualitative data for patients – barriers and facilitators we have found and corresponding interventions • Need empowerment and better understanding of what rights are, what services are available/covered by insurance vs. free, how region is doing as compared to others
Health Information	<ul style="list-style-type: none"> • We should be developing a structure for a personal health record for hip fracture <ul style="list-style-type: none"> ○ BC – Fraser Health-in process of developing this • Is information flowing in a way that meets the consumer's need? We put a lot on the consumer. • Develop some way of patient being the keeper of their information – give them more control – need to be able to advocate for their own needs • Without all of their information, caregivers and patients can't "plan their trip"
Health Services	<ul style="list-style-type: none"> • We need more steps toward family-centered care • Develop a clear road map of what care consumers would need as they transition
Patient & Caregiver Perspectives	<ul style="list-style-type: none"> • Patients and caregivers need to have a voice in this initiative – as part of the program of research • We need to stop assuming that what people need is greater than reality • Need to look at factors such as caregiver strain – address their needs and their support system <ul style="list-style-type: none"> ○ Would be useful to have a red flag on the RAI assessment regarding caregiver strain etc for when constructing care plan • Families need help with burden • Patients and caregivers want to be heard – feeling squeezed • Care consumers want information right away • There is a need for someone to come in and talk to caregivers/families/patients about "normal" changes that may occur as a results of health condition etc. as compared to what is normal in your relationships

Consumer Perspective

Question: What innovative ways can we use to exchange information with consumers?

<p>Make Connections</p>	<ul style="list-style-type: none"> • Plain language summaries • Study – gave case managers brochures to provide if triggered by RAI-HC <ul style="list-style-type: none"> ○ 20% lower falls rate at virtually no cost ○ Acting on the information provided • Connect seniors – Could have peers who calls seniors • Connect to resources/see how things are going • Include different family members/friends etc. and actively involve them in care • Make resources available in more public settings, for instance the mall, areas that may actually help prevent rather than only in hospitals or other medical settings • Workshops for patients and families – e.g., every Thursday there would be a workshop – people can sign up, can come at any time
<p>Technology</p>	<ul style="list-style-type: none"> • Social networking sites – TYZE <ul style="list-style-type: none"> ○ Connects health professionals • Resources should be specifically available with care consumers in mind – good example of this is StrokEngine: http://www.medicine.mcgill.ca/Strokengine/ • There are already too many different websites/resources out there • Use the telephone! Caregivers want people on the phone <ul style="list-style-type: none"> ○ BC-Nurseline – support person for caregivers • http://www.dementiajourney.ca/ - Example of good health knowledge translation • We need to consider what is already out there, and build on existing websites/resources • Add to things like 310-CCAC – phone number and website <ul style="list-style-type: none"> ○ Ministry is going to do an advertising blitz for this resource • Build on existing datasets
<p>Involve in program of Research</p>	<ul style="list-style-type: none"> • Open InfoRehab portal to patients/families/caregivers • How knowledgeable are consumers about research? How many consumers involved in research program? • Need the education of consumers • Get consumers actively involved in program of research, involve patient organizations, media (include

	<p>newspapers, news etc), focus groups – importance of health literacy</p> <ul style="list-style-type: none"> • Change public perception of researchers • Consumers know what questions to ask <ul style="list-style-type: none"> ◦ What innovative ways can we use to get the questions? • Consumers need to be a part of research from the onset – researchers don't involve consumers in the process as they slow them down, however maybe we should be slowing down • Chinese proverb: “Being ill for a long time makes you a good doctor” • There are so many levels of consumers – need to think from the very beginning about what the end use of the research will be and who should be the benefactor
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Policy-Makers' Perspective

Question: What do policy makers care about?

Information Needs	<ul style="list-style-type: none"> • Information – conclusive evidence • Hot points e.g., ER • Deadlines are critical, want to see results quickly • Bite-size information • Timely decision making • Personal messages, story is important
Cost-effectiveness	<ul style="list-style-type: none"> • Money (saving) • Cost-effectiveness – would be nice – right things/ patient outcomes
Strategy	<ul style="list-style-type: none"> • Power – they have influence to say what's done, regional vs. provincial • Looking at bigger picture with disadvantaged populations <ul style="list-style-type: none"> ◦ Complex problems population impact ◦ Delayed impact of results – reality for rehab • Political agenda • Strategic priorities • System responsiveness
Perceptions	<ul style="list-style-type: none"> • Public perception – Avoiding negative publicity • Re-election • Being able to say they have made a difference in what matters most to public • Media attention • Getting credit for success • Issue of the day • Decisions driven by public interest groups, small focus, very vocal

Policy-Makers' Perspective

Question: "What provincial and national strategies can we link our findings and recommendations to?"

Provincial	<ul style="list-style-type: none">• Provincial Aging at Home (ON) strategy• Alberta – Long-term care Quality Improvement• Extramural – New Brunswick• Quality Indicators• Accountability agreements with government• Addressing chronic disease management<ul style="list-style-type: none">◦ Rehab absent in most discussions• Wait time strategies – investing in Rehab to move through system, care paths• ED/ALC – wait times and ALC beds (number of beds)• Funding reduced if person spends + 24 hrs in ER
National	<ul style="list-style-type: none">• National Home Care Strategies e.g., Family caregiver alliance, through homecare associations• Senate report on aging• Public Health Agency of Canada – setting priorities• Importance of recognizing financial commitments<ul style="list-style-type: none">◦ E.g. Canada Health Infoway, E-health Ontario, piggy-backing onto opportunities• Provincial and national knowledge exchange networks<ul style="list-style-type: none">◦ E.g. Canadian Dementia Knowledge Translation Network
International	<ul style="list-style-type: none">• International work on care transitions• Also look at international groups to link findings to

Care Providers – Hospital

Question: How can we capture the attention of care providers who work in fast paced-settings?

Engagement Strategies	<ul style="list-style-type: none">• Through Rounds• Food• Opinion leaders• Prove effectiveness• Feedback about what happened to people who left their care – follow up – system status updates• Engagement – what's in it for me?• Relevant link between cause and effect relationships is important
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	<ul style="list-style-type: none"> • Justification for their work – career advancement • Quality of human contact – interpersonal skills of research team • Physical presence – research office on site • Don't slow them down • Smart tools – information summarization
Communications	<ul style="list-style-type: none"> • Key newsletters • Internal web-based sites • Emergency Department Utilization – Hot Topic • Alternate Level of Care (ALC) – Hot Topics • Lunch room posters • Speciality packaged information – tailored • Less is more – keep it simple - "sticky" messages • Regular updates to care providers about the status of research – after the research is completed • Conditional-targeted-different audiences (doctors, nurses, etc) • Updates on homepage = quick and easy
Education	<ul style="list-style-type: none"> • Continuing Medical Education (CME) credits • Early morning breakfast and learning • Best Practices information = college level endorsement in context of their work day

Researcher – Care Givers

Question: How can we cross the researcher to care provider chasm?

Involvement & Teamwork	<ul style="list-style-type: none"> • From internal planning and development stage – involvement • Involving care providers as decision makers • No time wasting • Understand incentives for BOTH groups - mental benefits and opinion leaders • Teamwork – try to develop relationships/build trust • Advanced practice nurses - good resource • Role of professional colleges – professional associations • Involvement in operational impact – formal assessment • More upfront work with care providers that would inform the ethics process • Research project is meeting care providers needs
Communication	<ul style="list-style-type: none"> • Researcher and collaborator communication • Language used – summarize and simplify • Communicate information within the context of the

	<p>workday – mindful of schedules</p> <ul style="list-style-type: none"> • Present research at front line sites • Give HCPs research and clinical skills: give credit to HCPs/acknowledge their contributions to research initiatives
Education	<ul style="list-style-type: none"> • Educate researchers about front line concerns • Education about the project • Continuing medical education (CME) events - common forums
Publications and Conferences	<ul style="list-style-type: none"> • Professional conferences • CHSE (Canadian Health Service Executives) – Conference / Journal • Publications with professional interest

Care Providers – Community

Question: What unique challenges do they face when providing care in community settings?

Communications & Access to Information/ Resources	<ul style="list-style-type: none"> • Access to information – no single record • Lack of feedback of outcomes to care providers • Both individuals and population • Communication (between caregivers and professionals) • E-health – use of standardized assessments, triggers, outcomes • Triggering risk assessments • Red flag screening • Using available info • Communication channels are atrocious • Lack of coordination – people get missed • Communication – isolated workers <ul style="list-style-type: none"> ○ 2 agencies: CCAC and provider agencies ○ They do redundant assessments and don't share information • General lack of resources • Re-entry into the system (Leave hospital or district) • People get orphaned • Lack of knowledge of available resources • No home care phone line • No one place to go for info • Language issues
Roles	<ul style="list-style-type: none"> • Harder to get inter-professional collaboration within the home • Potential for isolation • Role clarity –overlap between roles • Untapped potential of non-regulated care providers

	<ul style="list-style-type: none"> • Do front line workers have appropriate skills • Care in the home has a greater skills mix • Skilled pros struggle with how to communicate/monitor • Work is poorly valued and poorly paid • Underutilization of PT/OT assistants in home care
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Knowledge Translation and Exchange

Question: What successful KTE strategies have worked with other research initiatives that you are aware of?

Tailor messages & strategies	<ul style="list-style-type: none"> • Communication and coordination • You need a different KE strategy for non-professional community based care providers <ul style="list-style-type: none"> ◦ Audience specific knowledge translation • Engagement • A better understanding of the gaps • A better understanding of the experience
Specific programs	<ul style="list-style-type: none"> • MAREP – play and film, great example • Careportal at York University and Toronto CCAC • Breakfast sessions <ul style="list-style-type: none"> ◦ Using RAI data ◦ Education sessions ◦ Series, ongoing ◦ Community practice network • SHRTN – communities of practice, fireside chats, knowledge broker • SAIL – falls prevention initiative • Connection to CONA – ICON • Linkage to GSN
Delivery mechanisms	<ul style="list-style-type: none"> • The use of volunteers • Using Seniors to help in providing Seniors with information or care • Seniors are underutilized • Seniors round table discussion • Surveys • Newspaper • Engage international collaborators in comparative exchanges
Challenges	<ul style="list-style-type: none"> • We don't know what works • No standard curriculum • Increasing the acuity of clients • Over emphasis on web based tools • Funding • Transportation and accessible buildings for community programs

Decision Makers/ Administrators

Question: What "pressure points" do they experience that we can link our findings and recommendations to?

Resource utilization	<ul style="list-style-type: none"> • ER visits • ALC numbers in the hospital • Length of stay – shorter • Budgets- finding savings • Human resources – especially in home care • Better resource utilization through improved targeting of patients – e.g. rehab beds • Finding better/creative ways to utilize scarce human resources • Risk management and cost attainment
Information	<ul style="list-style-type: none"> • Using information (from the RAI) to help with navigating the health care continuum • Information flow into LTC – often inadequate leads to challenges in caring for the patient • Not having a good outcome info to make decisions with • Are the right things being measured?
System	<ul style="list-style-type: none"> • Balance of care study - could patients be d/c home instead of LTC appropriate supports were available • Streamlining the assessment process for patients • We are still in "silo" structure • Conflicting vested interests • There is a lack of education on the benefits of rehab • They are being called upon for accountability of use of resources, but do they have the correct mix of resources/staff • Each agency having agency-specific accountability agreements with the LHINs • What the LHINs/ministry have dictated the framework/reporting requirements to be
Public Perceptions	<ul style="list-style-type: none"> • Pressures from different community groups • Public reporting of quality indicators at each agency level by the Ontario quality council - agencies being compared to one another • Public reporting of wait times and infection control • Rehab potential with no OT/PT provided will be reported publicly

Decision Makers/ Administrators

Question: With respect to this initiative, what would pique their interest?

Risk Management	<ul style="list-style-type: none">• What is an acceptable level of "risk" for a patient to live at home• What is the individual's role/responsibility in mitigating risk?• Accountability for continuity care - dependent on transfer of information patient safety influenced by transfer of information
Operational and System Impacts	<ul style="list-style-type: none">• What can the RAI info contribute to informed decision making?• Operational impacts - e.g. Budget, time, resources on participating in the study• Potential cost efficiencies - demonstration of evidence to inform and support resource allocation• If our work would actually develop true quality indicators of patient care/flow efficiencies• If our project could potentially improve flow of patient information relevant to hand-off of care• May improve cost effectiveness of home care/hospital care• Can this contribute to the aging at home strategy?• Inadequate training of front line providers d/t limited budgets is an issue• Accreditation standards now include a follow-up component - our info may provide assistance WRT information flow
Information Flow	<ul style="list-style-type: none">• Potential improvement of communication between agencies• Could this contribute to ongoing development of the E-health record?• Improving use of clinical information to make evidence based/informal decisions at individual/ patient level• If our work will contribute to the decreased Los by improved flow of information to all areas

SECTION F – POSSIBLE FUTURE DIRECTIONS FOR INFOREHAB

Presentations:

Background information and context was provided by:

Valerie MacDonald – Fraser Health Hip Fracture Program

Program Principles:

- Preventative and proactive
- Collaborate and plan with families
- Systematic education/coaching
- Competence and confidence
- Partnering/communicating across the continuum
- Capacity building

Corinne Schalm – Shepherd’s Care Foundation

- Received 4.7 million grant
- Increased capacity at provider level for using information
- Investing in RAI quality consultants
 - 4-5 facilities
 - Engage in using info
 - Program evaluation
 - 2 year project
 - “Make a difference at the bedside”

John Hirdes – Aging at Home Program

- The aim is for our findings and recommendations to lead to better communication and improve flow of information between agencies
- There is a new accountability for continuity of care/ patient safety and accreditation standards
- Information from RAI on other quality indicators will contribute to informed/evidence based decision making
 - For resource allocation human and financial/ cost efficiencies
 - Accountability measures (LHINs).
- There will be opportunities for the InfoRehab group to respond to RFPs that come out of the Aging at Home Evaluation initiative.

Kerry Byrne and Joanie Sims-Gould – University of British Columbia

- What we’ve learned about the challenges care givers have with RAI-HC and sharing information:
 - RAI-HC (>60 days)
 - CA has not rolled out for all patients
 - Lack of knowledge of RAI-HC use
 - Problems with communication
 - Interested in CA, summary PHP
 - Need time and access to data
 - Build it into RFP contracts
 - Lack of familiarity with RAI tools
 - How to harness

- Use in conjunction with clinical data
- Education is needed
- Communication with the case manager and health care provider is needed. Disconnect exists between case manager and provider; most have never met face to face
- There are sceptics but the interest is there

Bert Chesworth – University of Western Ontario

- What we've learned so far:
 - Rural setting with greater co-morbidities and greater information needs
 - More providers serve multiple care settings:
 - Facilitates understanding multi-site transition

Question: Given what we expect to find, how we can expand the current program of research?

Collaboration	<ul style="list-style-type: none"> • Linking – meetings like this, reacting to feedback
Methodology	<ul style="list-style-type: none"> • Quantitative and qualitative could inform each other; they run parallel • Acute care instrument – align text data with baseline data • Interview/observation – data fields in assessment • Quantitative Methods to better target rehab services
KTE (inc. experience informed)	<ul style="list-style-type: none"> • Who are the key movers across the system • Understand patients and families • Broader picture rather than a silo'd approach • Excited for evidence to advocate for services because no data exists
Clinical decision making	<ul style="list-style-type: none"> • Clinical decision making changes • Does decision support hold up over time? • Driven by needs – client service for years pushing for personal support services • Adding this temporal dimension • At intake, the algorithm predict rehab over time • Increased clinician understanding so that some data are used in multiple ways • Clinicians understand the data “closes the circle”

Question: What research questions do we believe will be of interest to different stakeholder groups?

Consumers

- For patients transitioning from hospital rehab to home and get lost in the system (confused, lack proper information, stuck), how often does this occur? What are their characteristics? What are the opportunities to intervene?
- How can social network utilities inform care needs at home?
- Does an electronic personal health record combined with electronic social support networks facilitate effective sharing of information at points of transition between health care settings
- What intervention(s) has/have the greatest success rate in reducing hip fractures?

Caregivers – Hospitals

- What does “not enough time” really mean?
 - Time to do the job or time to develop the relationship?
- What are “outcomes” of interest to various people (e.g. Hospital, patients, decision makers) at each of the care transitions?*
- Does a transitional care intervention, based on our findings, work?*
- Can a collaborative transition planning define and meet the needs of patients, families and providers?*
- What is the experience of patients and families and providers in using a collaborative transition tool?*

**Rests on border between community and hospital*

Caregivers – Community

- Does a transitional care intervention based on our findings work?*
- Does the training that informal and formal caregivers receive prepare them for the roles they are required to do and actually do in patients’ homes?
- Can collaborative transition planning define and meet the needs of patients, families and providers?*
- What is the experience of patients and families and providers in the using a collaborative transitions tool?*

**Rests on border between community and hospital*

Policy-Makers

- Does rehab prevent Emergency Room (ER) visits?
- Does rehab reduce hospital length of stay?
- Have any home-based rehabilitation or falls prevention programs reduced ER wait times/ACC days (through decreased number of falls presenting to ER)?

Decision-Makers/Administrators

- Two studies proving additional benefit of rehab
 - Look at Osteoporosis in subgroup e.g., total knee, hip fractures for those *closed complexity with prior “lower” functioning with low morbidity – targeted out-patient therapy
 - Compare regions – Toronto, Hamilton vs. * existing OPD or add OPD
 - Consider home care for stroke, older frail – add *enhanced rehab – examine benefits of additional PT/OT
 - Functional, HSR (*CR, re-hospitalizations, NH), cost benefit
- What is the most effective means of KT to personal care aides regarding rehab management so that key becomes part of supporting individual treatment goals?

Question: What will the InfoRehab team need for current and future success?

<p>Marketing & Communications</p>	<ul style="list-style-type: none"> • Political connections and high level awareness • Marketing strategy • Clarity about key messages <ul style="list-style-type: none"> ○ Elevator speech (1 to 2) minute summary – standard script • Media pres releases about new findings • Simplicity of messaging/ coherent and clear communication plan
<p>Team Dynamics & Process</p>	<ul style="list-style-type: none"> • A lot of energy! To sustain momentum • Ways to facilitate contributions from all the sites • Sustained partnerships with collaborators/ clinical partners • Collaborator involvement from front end of qualitative team via online postings <ul style="list-style-type: none"> ○ specific questions • Regular communication between meetings • Within group of researchers, need to designate people to communicate with collaborators • Continue face to face meetings
<p>Results</p>	<ul style="list-style-type: none"> • Tangible products / credibility • Solutions for the field • Useful for end-users
<p>Engage people from across Canada + Within team</p>	<ul style="list-style-type: none"> • Communication between 3 qualitative sites <ul style="list-style-type: none"> ○ Method templates ○ RA training ○ Debriefing • Workshops like today • Tele-conferences • Web-based communication
<p>+ External</p>	<ul style="list-style-type: none"> • National organizations to tie to other provinces <ul style="list-style-type: none"> ○ E.g. CIHR • Professional associations • National conference • Better understanding KTE as a process <ul style="list-style-type: none"> ○ Consider all consumers
<p>Aware of trends and hot topics</p>	<ul style="list-style-type: none"> • InfoRehab Canada Health InfoWay of E-health records <ul style="list-style-type: none"> • How does rehab map into EHR <ul style="list-style-type: none"> ▪ Currently targeted more standardized care i.e.: medications • Keep eye open for InfoRehab to get involved with this • Utilize CIHI database to describe who is being seen – so map out who is doing what – who is delivering care <p>Releasing data/cost from CIHI (Ian Joiner)</p> <ul style="list-style-type: none"> • Parkwood Hospital – acute transition to inpatient

<p>Aware of trends and hot topics</p>	<ul style="list-style-type: none"> • InfoRehab Canada Health InfoWay of E-health records <ul style="list-style-type: none"> • How does rehab map into EHR <ul style="list-style-type: none"> ▪ Currently targeted more standardized care i.e.: medications • Keep eye open for InfoRehab to get involved with this • Utilize CIHI database to describe who is being seen – so map out who is doing what – who is delivering care <p>Releasing data/cost from CIHI (Ian Joiner)</p> <ul style="list-style-type: none"> • Parkwood Hospital – acute transition to inpatient rehab • Regional Community Stoke Team – London, ON <ul style="list-style-type: none"> • In home assessment, increased rehab potential • Applied to other patient populations • Alberta <ul style="list-style-type: none"> • Wait time reduction • Reallocate money to 20% in LTC, big shift • Following MSK disorders from hospital (Parkwood) to home • Important to consider time of year • Corinne’s project supporting clinical and quality initiatives • E-health technology • VCH had posting for Aboriginal health navigator <ul style="list-style-type: none"> • Potential for hip fracture patient navigator/case manager to follow the patient through the care continuum • The balance of care program <ul style="list-style-type: none"> • Receipt of services decide trajectory • Develop a framework whereby an electronic algorithm might make the decision (based on patient profile, supports in home, living situation, resources) <ul style="list-style-type: none"> ○ Personal Health Record following the patient <ul style="list-style-type: none"> ▪ Align this with TYZE ▪ Health care providers can use it
<p>Funding Opportunities</p>	<ul style="list-style-type: none"> • Public Health Agency of Canada – release new funding stream in 2010 • Being aware of funding for intervention studies <ul style="list-style-type: none"> ○ What do we need for this success ○ Who in InfoRehab has background?