



InfoRehab Investigator and Collaborator Workshop Report

March 31 & April 1, 2011
Cambridge, Ontario

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

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Support provided by: University of Waterloo InfoRehab Team and Notetakers

How to Find What You Are Looking For...

This report is organized in **chronological order** according to the agenda.

It is hoped that this workshop report will:

- Refresh your memory about the key points discussed;
- Be a valuable resource in your academic and professional endeavors;
- Enable you to share pertinent information with others;
- Allow you to cut and paste important sections for presentations and reports; and,
- Spark new and exciting ideas.

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Workshop at a Glance

Members of the InfoRehab Transitions team along with collaborators and community partners gathered in Cambridge, Ontario (March 31 and April 1, 2011) for an interactive workshop designed to meet the following **objectives**:

- Share objectives, progress and work completed to date;
- Discuss results and key messages emerging from each site;
- Gather feedback and ideas;
- Identify new collaborative opportunities;
- Actively engage stakeholders in the research;
- Generate ideas about knowledge translation and exchange strategies;
- Start to plan for next steps and future InfoRehab initiatives; and,
- 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 are InfoRehab Development and InfoRehab Home Care.

The primary **aims** of InfoRehab Transitions research initiatives 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 the application of advanced statistical techniques to large databases with comprehensive health information on clients in home care, complex continuing care, and long-term care.

To date, ethics clearance, pre-field work and piloting of the research were successfully conducted at each of the three sites: University of Waterloo, University of Western Ontario and University of British Columbia. At the present time, data analysis is wrapping up and was the highlight of this workshop. Specifically, investigators from each site took time to share their key findings, to gather feedback and to discuss future initiatives for the InfoRehab transitions project. This workshop also provided investigators with an opportunity to place their research within the context of the health care setting by actively sharing their findings with community partners and collaborators, and gathering their feedback.

On Day 1, the investigators went on a 'tour' of our garden-themed Knowledge Transfer and Exchange (KTE) Fair. The fair consisted of seven different stations each with a specific research focus. For example, Station 1 entitled 'In the Garden of Knowledge Translation and Exchange' provided definitions of knowledge translation and exchange (adapted from the CIHR KTE model) and included an illustrated diagram of the stages of the research cycle. Each station included an interactive component to actively engage the participants in the research.

Following the KTE fair, members of our **community panel** gave us the opportunity to ‘take a look inside their world’. Specifically, each of our six panel members gave a brief presentation to provide insights into:

- The environment in which they work;
- What makes their environment special;
- Who their patients/clients and colleagues are and what they care about;
- What is most important to administrators/managers and front line staff in their environment; and,
- The one thing they would like the research team to keep in mind when sharing findings and/or involving people in research in their world.

Key messages shared included:

- Forming strong relationships between the research team and research participants (patients and health care providers) are essential;
- Understanding the roles of HCP and their time constraints are important; and,
- Keeping research practical and quick will help inform practice.

Panel Presentation Highlights

Loretta Bourke, Middlesex Hospital Alliance, Strathroy, ON

- Patients at rural sites want quality care, a small, family-centred environment and quick and friendly service that is close to home.
- Administrators want balanced books, efficiency in a lean environment and centres of excellence.
- She would like researchers to keep in mind that: they are treating therapists, important to keep timelines realistic, and although sites are rural, they still want to be involved in research.

Flora Dell, Canadian Arthritis Network, Moncton, NB

- Fostering relationships is integral to successful KT.
- Users need to be aware of the available knowledge and researchers must strive to close the gap between what we know and do.
- Patients need to play a role in planning their health care.

Marg McAlister, Ontario Home Care Association, Hamilton, ON

- Home care is a currently a ‘hot topic’. However, most home care associations are not well-funded and do not include a budget for research.
- It is often difficult to coordinate the expectation of all key players in care.
- She needs the following from researchers: direct application of research to integrate within practice and policy, information to be transferred to them quickly and efficiently, and for researchers to realize that waiting for the perfect research is not ideal, it just needs to be good enough.

Kathy Sidhu, VHA Rehab Solutions, London, ON

- Her environment is complex as clients experience multiple co-morbidities and come home sicker and quicker.
- Navigating the health care system can be difficult for clients and their therapists often feel disconnected from other health care providers within their circle of care.
- Services need to be available to the ‘right person, at the right time and at the right place’.
- She would like the following from researchers: identification of upstream risk factors for rehabilitation, and sharing of information readily with front line practitioners.

Valerie MacDonald, Fraser Health, Vancouver, BC

- Currently initiatives are underway that focus on musculoskeletal rehabilitation/research in Canada
- Health care providers (HCP) who work closely with patients have the power to improve care. Models for improving morbidity, mortality and functional decline in those patients with hip fracture are needed.
- At current time, leaders in home care would like the following research questions answered:
 - What is the impact? How does this affect us? Why is it a priority (in a long list of priorities)? What are the associated costs for change versus keeping things the same? What are the best ways to do it?

Kathryn Wise, Toronto Central CCAC, Toronto, ON

- There are 18 hospitals in Toronto, each with their own best practices for hip fracture care. Therefore, what works in one hospital may not work in another. They are just now starting to discuss appropriate transitions for hip fracture patients.
- Rehab is 'sexy' and senior leadership is currently investigating innovative health care practice in this area. Need innovative ways to deliver these services - we need a 'rehab revolution'.
- It is important that we have integration across the health care system in terms of partnerships between case managers, health care practitioners and patients.

The afternoon session of Day 1 started with a presentation by Kerry Byrne that described the basic qualitative components of the InfoRehab Transitions project. A series of presentations by Kerry Byrne, Justine Toscan, Selena Santi, Helen Johnson, Jacobi Elliott and Stephanie Hinton then followed and provided insights into the key findings of the **qualitative research** conducted at each of the three InfoRehab sites.

Examples of the questions the InfoRehab qualitative group pursued:

- What is working post-hip fracture from the health provider perspective?
- How does team culture affect transitional care service delivery to medically complex older hip fracture patients?
- How are care transitions for hip fracture patients affected by unclear roles and responsibilities of the patient, their health care providers and family caregivers?
- What are the challenges and facilitators of smooth transitions and hand-offs following a hip fracture in a rural setting?
- How are health information systems currently used in the home care setting?

From the **quantitative research** group perspective, Paul Stolee gave a presentation that described the impact of rehabilitation on outcomes for home care clients with MSK disorders. This research suggests that individuals receiving home-based rehabilitation achieve equivalent or better functional or quality of life outcomes than those receiving inpatient rehabilitation.

The day concluded with a brief presentation by Bert Chesworth regarding investigator observations of the research findings followed by observations from the community panel.

Examples of the panel member observations of the research findings:

- Need for national networks to share information
- Need for information to be translated into application for advocacy purposes
- Need to ensure that the message is delivered to the right recipient
- Important to capture the patient and family voice
- Need to recognize the barriers and gaps in the research
- Need for innovative transitional care models
- Need for common assessments/communication regarding rehabilitation in the community

Day 2, started off with an overview of what was accomplished on Day 1 followed by the objectives for Day 2 of the workshop.

A presentation by Mu Zhu from the **quantitative** perspective of the InfoRehab Transitions project then followed. This presentation examined which home care clients would benefit most from rehabilitation. Specifically, the findings suggest that data mining methods, such as LASSO and random forest, have a potential application in selecting important client characteristics for care planning. This study also confirmed the importance of variables used by the RAI-CA rehab algorithm and identified additional variables that could be considered in rehabilitation planning.

The morning continued with a small group activity that included four 'care planning' teams. Each team consisted of a:

- * Patient
- * Health Care Provider
- * Care Coordinator
- * Administrator
- * Family Member

The task of each team was to travel with the patient to four different care settings. The focus of this task was to learn how to effectively apply research. It was expected that this task would be messy, congested and uncoordinated.

At each care setting, each individual team member had a specific question to answer:

- **Care Providers:** What research findings would we like to share with the care providers and why? What ideas do we have for them about what they should keep doing and what they could do differently?
- **Patients/Families:** What research findings would we like patients and families to know about and why?
- **Administrators:** What research findings would be of interest to administrators?
- **Knowledge Mobilization:** What existing KT (communications, change management, education) strategies could we tap into? What could we do that is innovative? What messages would stick?

Examples of discussion points included:

Care Providers:

- Share existing assessments with all care providers/circle of care.
- Include client/partner in care plans.
- Include rehab professionals for environment adaptation to minimize risk.
- Patient empowerment and family involvement.
- Re-establish trust with patient and family - get rid of Long Term Care (LTC) stigma.
- Start planning early for discharge.

Patients/Families:

- Have an elder-friendly emergency room.
- Provide information on what is going to happen next.
- Have staff ask about types of supports available upon return home.
- Discuss goals for facility and patients/family.
- Explain what a typical transition through rehab looks like.
- Need system navigators.
- Demand timely and accurate/complete transfer of information from acute care.
- Interdisciplinary rounds; rounds at the bedside.

Administrators:

- Family/patient need information.
- Facilitating team culture/in-site workshops.
- System navigation.
- Understand appropriate staffing levels.
- Standardized amendments and guidelines.

Knowledge Mobilization

- Interdisciplinary rounds.
- Patient-centered team culture.
- Develop relationship with LTC facilities and optimize resources available.
- Face-to-face discussions about patient- invite therapists to attend.
- Information needs to be shared more than once and in different forms.
- Follow-up calls in other settings.

After each team had completed their journey, they were asked to find a table and discuss:

What research findings would we like policymakers to pay attention to and why?

Examples of discussion points:

- Helping people with transitions will improve outcomes.
- Older people are vulnerable in care transitions, particularly those without advocates.
- Handoffs are not set up to be timely, they are efficient but information is not being shared.
- Effectiveness of rehab in home care.
- Patients, families, and HCP are feeling lost in transitions, some things need to be done now.
- There are people in the rehab sector that are willing to change models of care.
- Recognizing the support that informal caregivers need.
- Cross-sectoral communication is key to enhancing care.

- Place client/support system in centre of team.
- Important to engage early/often with client/families to build a relationships.

How could we use these findings to make evidence-informed decisions?

Examples of discussion points:

- Using our research to think of better options.
- Making sure all sector policy makers know the research.
- Conversations should happen between LHINs, service providers and government.
- Having a strategy for care transitions (accredibility).
- Using evidence to adopt co-leadership models/cross-sector teams.
- They know how to navigate system- if policy makers have collaboration they can affect policy change- collaboration needs to happen.

When it comes to communication from the research world- what do they want? What messages would stick?

Examples of discussion points:

- Cost, effectiveness and prevention.
- Short, efficient messaging.
- Risks involved, future effects.
- Using real life experience to show that this works.
- Rehab works: enables people to remain in home.
- Rehab and safety.

Paul Stolee wrapped up the morning by discussing the next steps for InfoRehab. A number of important next steps were highlighted including:

- Submission of a midterm progress report;
- Submission of an InfoRehab Home Care grant; and,
- Submission of a Quantitative Secondary Analysis grant.

Future Grant Opportunities were also discussed, these included:

- CIHR Operating Grants;
- CIHR Meeting, Planning and Dissemination Grants;
- CIHR Knowledge Synthesis Grants;
- CIHR Partnerships for Health Systems Improvement Grants;
- CIHR Secondary Data Analysis Grants; and,
- CIHR and NSERC Collaborative Health Project Grants.

To develop future research questions, the participants were placed into groups and asked to answer the following questions:

By combining qualitative and quantitative data, what interesting questions could we pursue?

Examples of discussion points:

- Outcomes of people who are currently getting PT/OT in homecare
- What are the profiles of people not getting rehab?
- Qualitative data could inform future generations of RAI tools; care transitions measure for families
- Change to team culture/measure change to health outcomes
- Compare outpatient rehab with homecare

In the care settings you are most familiar with, what additional questions do you think “grass roots” care providers and administrators are interested in?

Examples of discussion points:

- How do case managers use the RAI tools (which ones) to make resource (referral) decisions?
- What do the RAI tools mean? (training, outputs)
- What are the ethics of predictive tools for access to resources (particularly troublesome for “potential”)
- How do the CCACs make decisions around service priorities?
- System navigation vs. system change?
- How can rehab provision be sustained as time moves forward?
- Is a patient navigator worth the cost: redesign necessary?

What is a “burning question” related to information use and sharing that you would like an answer to? What are you most concerned about for you and your family?

Examples of discussion points:

- How can we ensure that service providers and patients have access to all pertinent information that is translated for lay use?
- How can we make hospitals safe for our loved ones? Particularly with respect to information sharing?
- Who gets access to information?
- If you have questions, who do you ask?
- Can HCP’s provide evidence and reassure patients about the sources of information?
- When are we going to have integrated e-records?
- How do people need to receive the information so they can use it?
- How does HCP’s understanding of privacy and confidentiality influence care?

What is a “burning” question related to information use and sharing that you think policy makers would like an answer to?

Examples of discussion points:

- Is rehab cost-effective?
- Does rehab impact acute care (ALC, ED, LOS) resource utilization?
- Does funding availability influence referrals?
- How can outcomes be improved through system level enhancements (for transitions)?
- How does rehab fit into the whole aging picture?
- How can we tell alternative stories?

Finally, participants were asked to respond to the following question: “what stands out for you, as a result of participating in this workshop?” They then shared their responses with the group.

The afternoon session of Day 2 started with a discussion surrounding the work plan for Phase II of the InfoRehab Transitions Project.

A group brainstorming session was initiated in order to answer the following two questions:

1. How can we maximize the use of existing qualitative and quantitative data?

Examples of discussion points:

- Include trends of quantitative data together with qualitative discourses to produce compelling evidence.
- Have inter-disciplinary teams at various transition points to work on what key information is required for successful transitions.
- Need data beyond discharge planning - not one person’s role.
- What do the patients say they want the HCP to know?
- Examine number needed to treat:
 - How many people need to get one unit of rehab to prevent one re-hospitalization?

2. What new projects/new phase of data collection will we initiate?

Examples of discussion points:

- Action research
- Involve the care providers in determining what the most important outcomes are
- Cost data for cost effectiveness
- Examine the impact of PSW’s on outcomes

Overall, the workshop evaluations showed that participants appreciated the interactive exercises, opportunities to build relationships and collaborate as well as hearing about the research results that emerged from each site. They enjoyed the interactive KT fair and felt that it gave them an opportunity to live the research.

Paul would like to extend his sincere appreciation to all the InfoRehab team members for their positive contributions. We are in a strong position to make great progress in 2011-2012!

Day 1

A. KTE Fair Garden Tour

On Day 1, workshop participants went on a 'tour' of our garden-themed Knowledge Transfer and Exchange (KTE) Fair (see Appendix A). The fair consisted of seven different stations each with a specific research focus and interactive activity, described below.



Station 1: In the Garden of Knowledge Translation and Exchange

This station provided insight into the processes, use, and importance of knowledge translation and exchange in research (see Appendix B). The interactive component of this station included a voting activity where participants voted on which KT strategies they felt were most effective in practice. They were also encouraged to share their ideas for additional strategies not listed. This station also described the cyclical nature of research and the potential areas of involvement for individuals within the scope of research.



The instructions and results of the interactive voting activity are as follows:

Instructions:

- On the table you will see six jars labeled with different Knowledge Translation strategies, and one unlabeled jar.
- In your conference bag you will find 10 stones. Use these stones to “vote” for the KT strategies you think best match the IRT findings. You may place more than one stone in a jar. If you do not see an idea, use the unlabeled jar – write your idea here.

Results:

“Based on what you know about systems of care for older people with hip fracture, when it comes to sharing our research findings, where do you think we should focus our resources?”

| KT Tactic | N |
|---|----|
| Partnering with existing national and provincial government strategies | 24 |
| Working in partnership with seniors groups | 22 |
| Partnering with local media to showcase findings (e.g., newspapers, TV, radio) | 20 |
| Use of social networking sites in connection with health professionals (e.g., TYZE) | 18 |
| Frequently updating knowledge translation skills (e.g., workshops, courses) | 11 |
| Attending professional conferences and writing publications | 10 |
| Other: | |
| <ul style="list-style-type: none">• Work with health care providers and decision-makers in acute/sub-acute care – they have a duty to provide effective evidence-based care to prevent readmissions and keep people safe.• Working with health care system, decision-makers, policy-makers.• Work on less fragmentation of the whole system, not worrying about which funding source each system is.• Make sure that up-to-date education and resources are clear, concise and easy to obtain. | |

Station #2: Blossoming into Solutions for Care Transitions

This station shed light on patient and family needs, as well as, health care provider perspectives surrounding care transitions for hip fracture patients. Participants were able to interactively listen to actual patients describing their options for post hip fracture care. Further, participants were asked to vote on which solutions they felt were most practical to improve information exchange based on results generated by health care providers in a previous ethnographic study.



Station #3: Budding Researcher Posters

This station featured a number of student research posters describing the research and key findings from each of the InfoRehab sites. Research findings are intended to be shared and discussed, and this station provided students with the opportunity to showcase their work (see Appendix C).

Station #4: Just Another Fish in the Pond: Reflecting on Care Transitions

The qualitative component of this station provided a pictorial representation of the phases of the InfoRehab Transitions project as it was conducted at the Waterloo site. Additionally, workshop participants were able to 'catch' some quotes from patients, health care providers, and caregivers surrounding their experience with care transitions. Participants also learned the numerous ways that the Waterloo site has shared their research findings with others (see Appendix D).



The quantitative component of this station described the various papers and presentations emerging from the research team at the University of Waterloo (see Appendix E).



Station #5: The Rural Vegetable Garden

This station highlighted key findings from the London site surrounding care transitions following hip fracture. It showcased the key elements necessary for successful transitions between families, patients and their health care providers, and discussed the importance of the family's role in information exchange and decision making. This station also demonstrated how a rural setting can influence care transitions. Specifically, it included a map outlining the numerous kilometers travelled by patients from their home to their care setting. This station concluded with a captivating round of "InfoRehab Jeopardy" where participants could test their knowledge of the London site including: study information, patients, family caregivers, health care providers, and important research themes.



Station #6: The Zen Garden of Knowledge Translation

The focus of this station was to generate ideas on how to make messages "stick", enabling effective knowledge translation. The need for creating innovative ways of engaging providers in person, through interactive e-Learning and using arts-based approaches was emphasized. This station provided participants with the opportunity to browse various resources on creating memorable presentations and how to manage change.



Station #7: Making Connection - Spider-Web Networking Board

This station provided a unique venue for workshop participants to network, through the use of individualized “help-wanted advertisements”. This networking opportunity was intended for those offering their expertise and experience and for those seeking advice or to improve their skill set (see Appendix F).

B. Take an Inside Look at Our World



Members of our community panel gave us the opportunity to ‘take a look inside their world’. Specifically, each of our six panel members gave a brief presentation to provide insights about:

- The environment in which they work;
- What makes their environment special;
- Who their patients/clients and colleagues are and what they care about;
- What is most important to administrators/managers and front line staff in their environment; and,
- The one thing they would like the research team to keep in mind when sharing findings and/or involving people in research in their world.

Loretta Bourke

Middlesex Hospital Alliance, Strathroy, ON

Loretta Bourke has an extensive background as a physiotherapist before becoming Manager of Rehabilitation Services at the Middlesex Hospital Alliance for two rural sites:

- The Strathroy Middlesex General Hospital site - 62 beds and specializes in orthopaedic surgery/general medicine;
- Four Counties Health Services site - 12 beds, and specializes in chronic disease management.

Both of these sites serve a large geriatric population and are primarily utilized by farming communities as well as three nearby First Nations reserves.



Patients at these sites state that quality care, a small, family-centred environment and quick and friendly service that is close to home are the characteristics that are most important to them.

Administrators in this environment state that balanced books, efficiency in a lean environment and centres of excellence are the characteristics that are most important to them.

For Loretta, the information that she would like the research team to keep in mind when sharing findings and/or involving people in research in her world include the need to:

- Understand that they the rehab staff are providing therapists to clients;
- Keep timelines realistic; and,
- Realize that although these sites are rural and small, this does not mean that they do not want to be involved in research.

Flora Dell

Canadian Arthritis Network, Moncton, NB



Flora Dell fostered the development of the Active Living Coalition of Older Adults (ALCOA) and served as vice-chair on the executive. She is the past chair of the CIHR, Institute of Musculoskeletal Health and Arthritis Knowledge Exchange Task Force and sat on the executive of the Canadian Centre of Activity and Aging at the University of Western Ontario. Flora is a founding member of Osteoporosis New Brunswick and is also on the Board of Directors at the Canadian Arthritis Network. She has received numerous honours, including the Order of Canada and the Order of New Brunswick.

In her environment, Flora states that fostering relationships is integral to successful KT. To do this, we need to use our knowledge, skills, and provide support. Users need to be aware of the available knowledge and researchers should strive to close the gap between what we know and do.

Patients need to play a role in planning their health care. At the Seniors Information Centre in Moncton, New Brunswick, their mission is to meet the needs of older adults and families by providing them with access to relevant information which in turn allows them to lead more independent and meaningful lives.

“A goal without a plan is just a wish.”

Marg McAlister

Ontario Home Care Association, Hamilton, ON



Marg McAlister is a registered nurse who provides strategic and operational support to organizations within the health care industry. She is the Director of Policy and Research at the Canadian Home Care Association. She also works closely with the Ontario Home Care Association and the Canadian Caregiver Coalition for whom she provides advocacy support. In her thirty years as a registered nurse, she has held various

management and executive positions in the institutional, home and community care sectors.

Marg emphasized that home care is a currently a 'hot topic', as both the federal and provincial government discussed home care in their recent budgets. Most home care associations at this time are not well-funded and do not include a budget for research. There are a number of issues that need to be addressed within the home care sector including: safety, work-life balance, integration, support of children and geriatric patients, technology, proof of effectiveness and best practices.

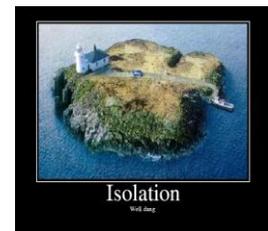
A current challenge within the home care sector includes inconsistencies in terminology used across the different provinces. Specifically, politicians often do not know the difference between family caregivers and home care. This notion highlights the need for greater information sharing between sectors.

Home care is a unique setting as it must accommodate both patient and family wishes. However, it is often difficult to coordinate the expectation of all key players in care. Marg states that within her environment, she needs the following from researchers: direct application of research to practice and policy, information to be transferred to them quickly and efficiently, and for researchers to realize that waiting for the perfect research is not ideal, it just needs to be good enough.

Kathy Sidhu

VHA Rehab Solutions, London, ON

Kathy Sidhu is the Regional Manager at VHA Rehab Solutions, a division of VHA Home HealthCare, which is a non-profit organization that provides in-home services to residents across Ontario. Kathy has participated in numerous regional community health initiatives and has sat on various LHIN and CCAC committees. She is also a course instructor at UWO's School of Physical Therapy and a member of the Canadian College of Health Leaders.



Currently, 6500 unique clients are served by VHA Rehab Solutions. The environment in which Kathy works is complex as clients often experience multiple co-morbidities and thus are more likely to come home sicker and quicker.

Navigating the health care system can be difficult for clients and the therapists of these clients often feel disconnected from other health care providers within their circle of care. It is important to have these services available to the 'right person, at the right time and at the right place' in home care.

Within Kathy's environment, she would like the following from researchers:

- Identification of upstream risk factors for rehabilitation; and,
- Sharing of information readily with front line practitioners.

Valerie MacDonald

Fraser Health, Vancouver, BC



Valerie MacDonald is the Clinical Nurse Specialist for ten Orthopaedic and Surgical sites in the Fraser Health Authority in British Columbia. She is a key figure in the development, implementation, and evaluation of programs of care for orthopaedic and surgical populations. She is a supporting member of the Fraser Health Orthopaedic Standards Team. Valerie is President Elect of the Canadian Orthopaedic Nurses Association and is on the board of the International Journal of Orthopaedic Nursing.

In Canada, 40-57% of those who sustain hip fractures are over the age of 85 years. This indicates that hip fracture is becoming an increasingly relevant issue and will continue to place undue burden on the health care system in terms of bed availability and overcrowding in the ER for example.

There are number of current initiatives underway in Canada that focus on musculoskeletal rehabilitation and research including:

- International Collaboration of Orthopaedic Nursing (ICON) - Hip Fracture Tool Kit
- BC Hip and Knee Arthroplasty Collaborative - 26 teams united by a shared vision: regardless of where you are treated for hip fracture in BC, you will receive the same standard of care
- Bone and Joint Canada - Hip Fracture Tool Kit (linked with InfoRehab)
- Provincial Musculoskeletal Advisory Group
 - Consists of senior leadership and surgeons
 - Proposed a model of orthopaedic care
 - Data working group

Staff who work closely with patients have the power to improve care. We need models for improving morbidity, mortality and functional decline in those patients with hip fracture.

At the current time, leaders in home care would like the following research questions answered:

- What is the impact? How does this affect us?
 - Why is it a priority (in a long list of priorities)?
 - What are the associated costs? If we do it? If we don't do it?

What are the best ways to do it?

Kathryn Wise

Toronto Central CCAC



Kathryn Wise graduated as an occupational therapist from McMaster University and has worked clinically in a variety of settings. Her main area of clinical interest is working with children and the development of best practices and

standardization of practices in settings where there are resource constraints. Kathryn has held leadership positions in both a children's rehabilitation facility and home care sectors. Currently, she is the Manager of Client Services for the Toronto Central CCAC.

In Toronto, there are 18 hospitals each with their own best practices for hip fracture care. Therefore, what works in one hospital may not work in another. In the past, these hospitals have not communicated with each other, and it is just now that they are starting to discuss appropriate transitions for hip fracture patients.

Rehab is 'sexy' and senior leadership is currently investigating innovative health care practice in this area. We need to think about innovative ways to deliver these services - we need a 'rehab revolution'. It is important that we have integration across the health care system in terms of partnerships between case managers, health care practitioners, and patients.

A general discussion followed the panel presentations. The key points emerging from this discussion are highlighted below:

- Kathryn Wise: at McMaster, they discussed a team-based approach to stroke care in the community. Toronto is bringing together therapists from the community and hospital as well as patients and their families. It is important to build trust in these relationships as hospital therapists often do not trust the available community resources, and thus do not want to send their patients home.
- Kathy Sidhu: which venue is ideal in order get this research to the respective disciplines? We need researchers to summarize the findings and provide them to professional groups who can then directly discuss the research results with frontline workers in lay language. It is important to produce something that can be used in practice in the moment or it will get lost.
- Marg McAlister: is it possible to build a collective system for sharing and codifying research?
- Bert Chesworth: what is "good enough" information – can researchers lower the bar?
- Loretta Bourke: therapists are primarily interested in the probability of success. We understand that there will always be a group who won't respond.

C. Overview of Qualitative Research: Kerry Byrne

Kerry provided an overview of the qualitative research associated with the IRT Project. It was explained that by the end of the afternoon presentations, each participant would:

- Have an understanding of the overall InfoRehab qualitative methods used;
- Understand health care provider perspectives about care transitions; and
- Focus on what is working and how can we do more in this research area.

Building on previous research with the InfoRehab team, three needs for future research were identified in order to fully understand care transitions:

1. Need for additional methods besides interviewing techniques;
2. Following patients across various settings – not studying just one transition point, rather multiple transition points; and,
3. Multiple perspectives – HCPs, families and patients.

The research team set out to follow approximately eight hip fracture patients at each site throughout their continuum of care. Patients were recruited in acute care and followed until 6 weeks post discharge into a community setting (assisted living, home with or without home care or long term care). Along the way, where possible, they talked to and observed family caregiver and health care providers. It was important to include all participant groups across different settings, as current literature on hip fracture does not capture all participant views across the care continuum.

The use of qualitative methodology means:

- Patient and family voices about hip fracture care are captured;
- A long lens for each patient’s journey rather than institutional specific findings; and,
- Follow-up with hip fracture patients to learn about the processes which affect their hip fracture recovery outcomes.

D. Presentation Summaries

Kerry Byrne

Finding the bright spots- Strengths based approach to care transitions post hip fractures

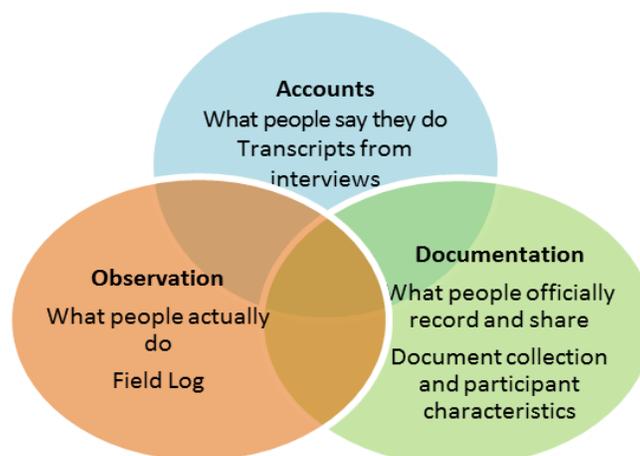
Building on our previous research with the InfoRehab team we recognized 3 needs for our future research program if we were going to fully understand care transitions:

1. Additional methods besides interviewing techniques;
2. Following patients across various settings – not studying just one transition point, rather multiple transition points; and,
3. Multiple perspectives – HCPs, families and patients

Methodology:

Ethnographic Field Study:

- 3 study sites
 - Waterloo, Ontario; London, Ontario; Vancouver, British Columbia
- We set out to follow approximately 8 hip fracture patients at each site throughout their continuum of care. Patients were recruited in acute care and followed until 6 weeks post discharge into a community setting (e.g., assisted living, home with or without home care or long term care)
- Used three specific methods of data collection:



Vancouver Site:

- Phase 1
 - Key Informant Interviews with HCPs
 - Learned about where to go 'next'; made connections; had key concepts to follow-up
 - Sampling: purposive, convenience, and snowballing
 - Coding: topic and analytical
 - Techniques for rigour: memo writing and team analysis
- Phase 2
 - 6 hip fracture patients and families
 - Interviews
 - Observations
 - Document reviews

This presentation is in reference to phase I (17 HC providers):

Strengths and Solutions-Based Approach:

- The central tenet of a strengths-based approach is on the identification of existing strengths to effect positive and sustainable change. For example, the applied action research by Shendell-Falik, Feinson and Mohr, (2007) highlights the effectiveness of a strengths based approach for working with healthcare providers involved in patient transfers. Their outcomes, such as using resources more efficiently, better documentation and user designed communication tools translate into better patient safety and economic efficiency.
- Need to:
 - Identify what is working;
 - Explore insights into possible strategies for change (Sims-Gould et al 2010); and, not only identify problems but rather examine individuals capabilities (Saleeby 2006)

Findings:

"We can trust and bargain that things will happen but once in the community these things are not happening"

- Theme of "Whatever happened to Mrs. Smith".
 - Lack of a feedback loop
 - Need to bring results back to the providers
- Providers don't know what happens in each of the settings since home visits often do not occur
 - Could use Google Maps/Street view to see what is going on at home
 - Use pictures of the home to examine the environment

Implications:

- Shared experiences with patients and families
 - Both providers and families often feel 'lost' and are unsure of what will happen next
- Harness experience of HCPs
- Small incremental change
 - We are looking for solutions that are workable, e.g., workshop between acute and community providers; this will contribute information to 'core content' for a video to be used on website, provided to families.
- Identify, share and work together

Next Steps:

- Structurally ask HCPs what would work
- Provide visuals regarding what is going to come next
- HCPs rotate back and forth
 - Care in hospital → Care in community
 - Better understanding of transitions for providers

Following Kerry's presentation, each table was asked to answer the following questions:

a) What are the strengths of health care providers you have worked with that could help to improve care transitions for hip fracture patients?

Summary of Discussion:

- Experience with population and their environments
- Knowledgeable/understanding of:
 - system
 - patients
 - what works/doesn't work
 - clinical/medical information
 - roles of HCP/different perspectives
- Individual characteristics: imaginative, good listeners, proud, passionate, open to sharing, realistic, practical, caring, resourceful, collaborative, patient, accepting of change
- Credibility with patients and families
- Recognize issues and overcome barriers

Detailed Discussion Points:

- OT and PT clinical strengths/equipment and home safety
- LOA or day pass to assist and transition
- Visit to rehab or LTC facility if transitioning there
- E.g. a health provider who summarized all information step-by-step when the client went home could do (in order of priority/chronological)
- E.g. PT identified a client need for QoL that was out of scope
- Identifying the human element
- Music therapy
- They are good listeners
- They are imaginative
- Very knowledgeable especially about resources
- They are not afraid to refer to others
- They are interested in what others do and how to collaborate with others
- Good intentions
- System knowledge
- Excited to change and improve
- It is a well thought out clinical area
- Medical information/knowledge
- Hunger for knowledge
- Broad range of clinical experience
- Openness to understand other perspectives
- Realistic with time
- Emphasize practicality of solution
- Recognize issues and overcome barriers
- Credibility with patients and families
- Proud of work, passionate, open to sharing
- Resourceful
- Care about the patients and the care they receive
- Clinical expertise
- Know what works on the frontline
- Know the system - what works and what doesn't
- Able to accept change and would be able to implement the change
- Do not make assumptions, listen to patient
- Want to connect with other parts of system

- Understanding of patient experiences
 - Clinical/expert knowledge
 - Knowledge of the roles of difference health care providers
 - Experience with the population
 - They know their home environments (in small rural towns)
 - They know what is likely to work and not work
 - Know surgeons → continuum of care
- but they don't know how
 - Don't know the contributions they are making
 - Work in rehab because want to support people, make progress → turn frustration into energy
 - Know ins and outs
 - Care and want to be better

b) What are the key strengths that you bring to the area of care transitions?

Summary of Discussion:

- Knowledge of the health care system
- Can influence change/set priorities
- Provide insight into different settings and HCP's
- Use more universal (common) language
- Provide different stakeholder perspectives
- Communication between settings/sectors
- Experience with care transition measurement
- Publications
- Bridge gap between patient and HCP
- Links with other networks to facilitate care across continuum
- Empathy, understanding, passion, commitment

Detailed Discussion Points:

- Empathy, understanding the broader perspective
- Passion and commitment
- In a position to influence change
- OHCA has written a paper on care transitions (i.e., things to be considered at time of transition with practical solutions) - presented to LHIN CEOs
- OHCA website (www.homecareontario.ca) publications page - the site is full of resources/papers on various aspects of home care (history, providers etc.)
- Knowledge of health care system
- Experience in measuring care transitions
- Links with the networks that facilitate care across continuum (e.g., stroke network)
- Management across continuum of care (e.g., staff relief in hospitals and LTC)
- Capacity to set institutional priorities
- Cross-sector communication
- Tap into care transitions
- Provide insight to the way different settings and health care providers work (not limited)
- Can talk in more universal language (not medical jargon)
- Bridge gap between patient and health care provider
- Continuing care data information
- Different levels of stakeholder (patient, family, HCP) information and perspective
- Objective 3rd party view
- Synergy of multiple networks to disseminate information
- Diversity of skill sets and background
- Challenges and frustrations from the family perspective (no communication)
- Flow of information
- Try to use common language
- Human resources

Question: How does team culture affect transitional care service delivery to medically complex older hip fracture patients?

Definition of Team Culture:

- How the team operates including its selection procedures, power structure, and practice procedures
- Requires attention to 2 central questions:
 1. Who is on the team?
 2. How do team members work together? (Grumbach & Bodenheimer, 2004)

For this study: Considered themes of Team Membership, Roles, Responsibilities

Why is Team Culture Important?

- Integrated Delivery Systems of Care
 - Coordinates care across the entire continuum, and uses information systems to link patients, health care providers, and informal family caregivers (Adair, 2003, Shortell et al., 2010)
 - Functional vs. Clinical integration
 - Key issue: Continuity of Care Across Care Settings
 - Informational, Management, Relational (Haggerty et al., 2003)

Waterloo Site - Data Collection Strategies:

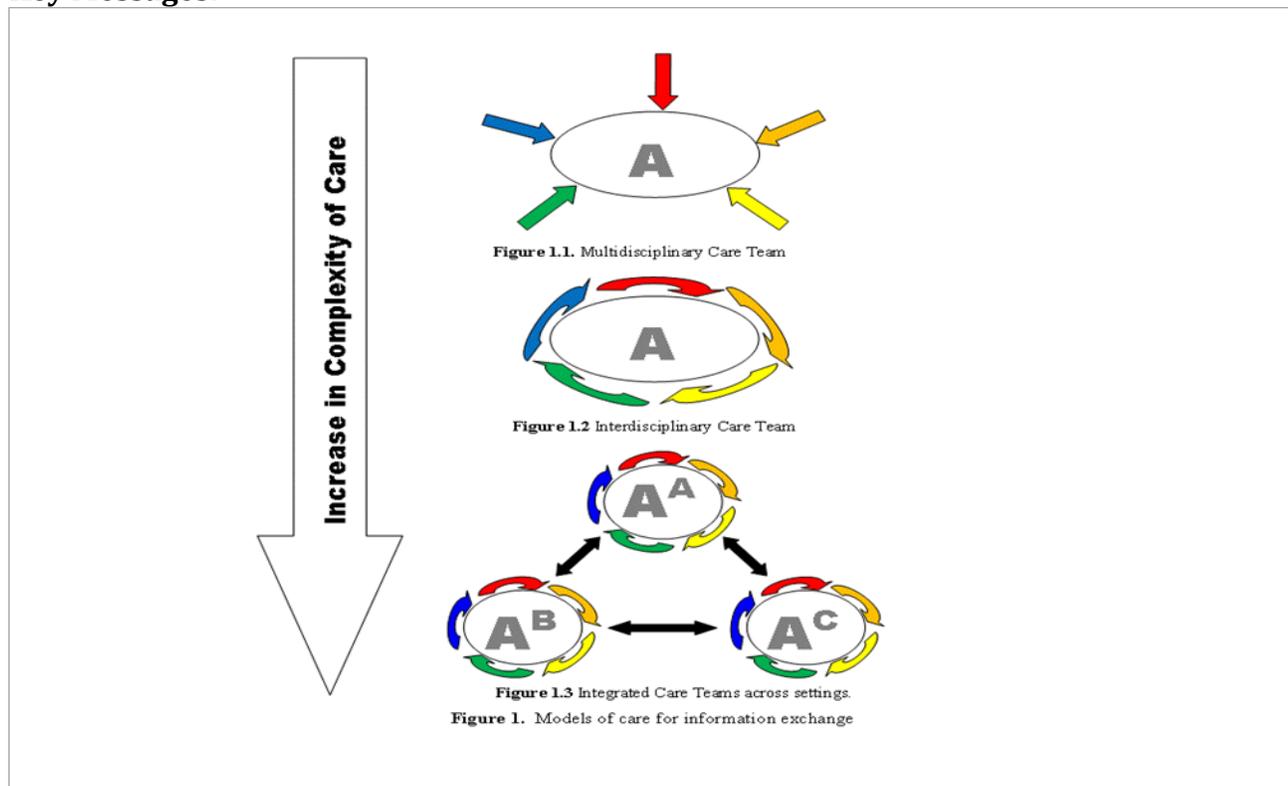
- UW is not a teaching hospital – challenging, as had to build credibility with hospitals and CCAC
- Patient Tetrads: 36 interviews in total
 - Patient
 - Informal Caregiver (ICG)
 - 2 HCPs (at least)
- Expanded to those with mild clinical impairment
- 6 Patients interviewed:
 - 3M, 3F; 71-94 years of age, with mean age of 83; 2-4 transitions
 - Many returned to original care setting
- 6 ICGs - 83% children, 17% spouses; 20-75 years of age
- 350 pages of transcribed text
 - 2 researchers (met with another to avoid bias in analysis)
 - Completed by hand and NVIVO8

Findings:

Team culture issues in transitional care for elderly hip fracture patients - themes that emerged from the data include:

| TEAM ASPECT | OUTCOME |
|---|--|
| MEMBERSHIP "Unclear Who is Involved in the Circle of Care" | <p>➔ Patient excluded from care decisions</p> <p>➔ Caregiver lacks confidence in care ability</p> <p>➔ Healthcare Provider completes redundant tasks</p> |
| RESPONSIBILITIES "Blurred Boundaries in Care Tasks" | <p>➔ Patient disengages from self- management</p> <p>➔ Caregiver shoulders too much responsibility</p> <p>➔ Healthcare Provider lacks ownership in duties</p> |
| ROLES "Discrepancies in Job Descriptions Creates Communication Issues" | <p>➔ Patient not sure who to direct questions to</p> <p>➔ Caregiver left to initiate communication</p> <p>➔ Healthcare Provider does not tailor information shared</p> |

Key Messages:



- Increased complexity with team integration
 - Multi-disciplinary care needed within settings
- Gatekeeper determines who is in the team
- Collaboration and shared communication → team member aspect
 - Increase responsibility and membership within setting → integrated team
- Integrated care often involves blend of traditional and non-traditional care to link people across the settings i.e. role clarity (membership, responsibility and roles)
- "The influencer" – identifying the vital behaviours to influence change
- What are the vital behaviours care teams could bring in to make changes:
 - No program evaluation/funding/management
 - Only communication

Following Justine and Selena's presentation, each table was asked to answer the following questions:

a) Based on these findings, what specific vital behaviours could care team members put into action to improve care transitions? Consider how they work with each other in care settings and between care settings.

Summary of Discussion:

- Use client-friendly language
- Timely and effective communication to patients/families/HCPs and across care settings
- Listen to patient/family needs and goals
- Exchange information with the patient directly
- Use innovative programs (e.g., music therapy)
- Documentation/standardization of forms
- Observational skills
- Liaison between HCPs and patient/family

Detailed Discussion Points:

- Using client-friendly language
- Timely communication
- Effective communication to ensure care transition
- Where forms are in use, fill out all parts of the form (e.g., front and back)
- Find out what info the receiving care provider needs and ensure this info is sent (e.g., need to know basis)
- Spend more time ensuring patients and families know who is who
- Slow down, to allow patients to process information
- Collaboration between HCP and the client to develop overall team goals for the client to achieve
- Make sure clients needs/goals are the centre of the discussion
- Discussion at the bedside, not in an isolated room to update the patient with the care team
- Documentation/standardization of data elements/conversations/conclusions to assess if client needs
- Medicine reconciliation/appropriate prior to the discharge
- Red flags- how to pick up warning signs (common signs)
- Discharge planner made - we start upfront
- Sharing of information between affiliated care settings
- Target information to specific groups using direct language
- Improve communication between groups involved in transition
- Face-to-face meetings
- Innovative programs such as music therapy (flexibility and willingness to change)
- Educating about roles when a team is brought together (e.g., what is each profession's core competency?)
- Appoint main liaison within team to inform patient and family early. Also, this person would coordinate with next setting
- Observational skills
- Clinical rounds to leverage team skills/rapports and lessen quantity of people who interact with patient
- Pathways/protocols should be available to patients and family - empowering clients with clinical information
- Listening to a patient's goals
- Unrealistic expectations
- Ask the patient their care needs
- Provide caregivers with necessary information if they do not have this - provide contact information for others

b) What could be done to include patients as members of the team?

Summary of Discussion:

- Talk to them, listen, ask questions
- Build goals with patients
- Include patients in decision-making process
- Tailor therapy/activities to individual patient backgrounds
- Acknowledge that patient is part of the health care team
- Conduct clinical rounds bedside
- Have patients communicate with other patients in similar setting/experience

Detailed Discussion Points:

- Conducting clinical rounds at patient's bedside
- Important for all HCP to understand that patient is a vital member of team
- Ask if they have questions, ask them what do they need to know
- Ask family caregivers what information they need
- Make sure client needs/goals are the centre of the discussion
- Discussion at the bedside, not in an isolated room to update the patient with the care team
- They should be involved
- Norm vs. Exception
- Talk to/with them not at them
- Listen
- Asking questions, taking notes, and highlighting the important points
- More personal
- Include patients in team meetings
- Patient-centred interactions
- Discuss and build goals with patients
- One-on-one with another patient already in the setting
- Inter-sectoral information sharing – let's not reinvent the wheel
- Inter-RAI helps identify questions not asked by professional lens - holistic person-centred lens
- Look at what inspires an individual and build from that
- Build back time for quality patient engagement
- Tailoring therapy activities to individual backgrounds - one size doesn't fit all
- Training to provide positive role models of 'taking the time' early on with patients has longstanding results and time savings
- Involve them in the decision making process
- Ask them what they want

Question: What are the challenges and facilitators of smooth transitions and hand-offs following a hip fracture in a rural setting?

Study Setting - Rural:

Middlesex Hospital Alliance:

- Strathroy: Four Counties Health Services, Middlesex General Hospital
- Patients travelling greater distances for rehab

Study Participants:

- 11 patient networks:
 - 8 females, 3 males
 - age range: 69 - 92
- 10 family caregivers
- 24 health care providers
- 55 interviews

Transitions Included:

Some example trajectories

Home → Strathroy → Home with home care services

Home → Strathroy → Long Term Care (LTC) - permanent

Retirement Home (RH) → Strathroy → London → Strathroy → RH

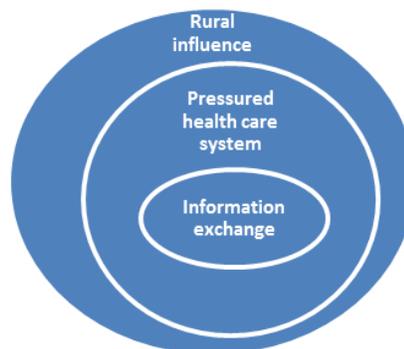
Home → Strathroy → RH/LTC (Short Stay) → Home

RH → other rural Hosp → Strathroy → Respite → Strathroy → LTC

Findings:

This presentation focused on findings surrounding the initial key transition from acute care.

- Discharge destination is a key decision requiring information exchange
- This decision occurs in a pressured health care system
 - Pressure on HCPs, their patients and families
- Rural setting influences this information exchange
 - Positively and negatively



Key messages:

- Transitions get sticky under pressure
- HCP educate but have to hasten the decision making process
- Families and patients are stressed so don't have knowledge/time

Recommendations:

- Patients need increased time to process information, to make decisions and to get better
- HCPs work hard to develop a relationship of trust and respect with patients to facilitate decision making
 - Ease process in future as population ages

Following Helen and Jacobi's presentation, each table was asked to answer the following questions:

What specific strategies could be used to make the most of the time available to:

- **share information**
- **process information**
- **make decisions**
- **develop trust relationships**

Summary of Discussion:

- Have all key players involved from the beginning
- Share information, have team/family meetings, educate family from beginning, build in time for questions
- Early introduction to discharge planning/expectations
- Use lay language/ensure information is easily understandable
- Use multimedia, InfoRehab bulletin etc. to disseminate information
- Share personal stories, show empathy to build trust
- Include patient in goal-setting
- Share RAI data across sectors
- Identify clients with rehab potential
- Avoid information overload to patient/family
- Training around effective, practical communication skills
- Interdisciplinary training in professional education to increase trust and lessen the need to assert professional autonomy (geriatric outreach team)

Detailed Discussion Points:

- Supporting a decision-making process vs. giving them all information
- Overwhelming with info-overload - have information available upon request
- Provide information to them in an easily understandable form - small paper with comments, so they can refer back to them
- Have all key players involved from the beginning
- Don't share information until you are certain
- Share information - continuous communication, come prepared with questions that need to be answered, bring a voice recorder
- Process info - continuous communication,
- Patient has their own ideas
- Learn from what has been done (don't reinvent the wheel) - lets share information (EMR)
- How to develop dialogue - building in the time for this (saying 'I have time' when offering to answer).
- Build in time for facilitation for Q&A between HCP and patient
- Training around effective, practical communication skills
- Interdisciplinary training in professional education to increase trust and lessen the need to assert professional autonomy - existing model - geriatric outreach team

- | | |
|--|--|
| <ul style="list-style-type: none"> organized timelines • Make decisions - creating an agenda/timeline, decide goals with client input • Develop trusting relationships - share personal stories, show empathy • Share info - InfoRehab bulletin • Demographics are online • Hear things more than once • Need to be explained in basic terms • Health care providers • Share RAI data across sectors • Change language from 'discharge planning' to 'care transitions' | <ul style="list-style-type: none"> • Integrated tool - relevant and tailored, patient-friendly, smog, teach back clear • Multimedia - messaging, using preferred media (e.g., Facebook, Tyze, You Tube) • Build trust day 1 - look at interim strategies • Family needs to be educated about all options right away • Early introduction to discharge planning/expectations • Dedicated person to identify information and share with the team • Team/family meeting - family, patient, • Identify those clients that have 'rehab potential' |
|--|--|

Selena Santi and Stephanie Hinton

Bridging the information divide: Strategies for information sharing in home care

Study Overview:

Goal: to improve home care rehabilitation for persons with MSK disorders through enhanced use of available health information.

Purpose: to understand current use of health information systems in home care.

Guiding Framework: Promoting Action on Research Implementation in Health Services (PARIHS)

Study was comprised of:

- Literature review
- Initial knowledge exchange panel (KEP) workshops
- Consensus survey
- Follow-up KEP workshop

Methodology and Findings:

1. Initial KEP Workshop:

- Three full-day Knowledge Exchange Panels held in:
 - London
 - Waterloo/Wellington
 - Toronto Central
- Participant recruitment initiated through CCACs
- 40 participants at three workshops (home care administrators, managers and service providers)

Findings:

Facilitators:

- Usability of tools
- Time conscious processes

- Client centered
- Inter-professional practice
- Supportive work environment

Barriers:

- Challenges with models of information sharing
- Limitations of RAI
- Missing information
- Lack of client information
- Inconsistency
- Limitations of organizations

2. Consensus Survey

- 17 Questions; total of 95 Items
- Survey was administered to 40 different health care providers using Survey Monkey over 3 month period

Sample:

- 22 people responded (55% response rate)
- 86% = Female; 14% = Male
- Occupation
 - 5 Physiotherapists
 - 4 Occupational Therapists
 - 2 Registered Nurses
 - 5 Case Managers/Coordinators
 - 6 Administrative Positions (Directors, Managers, Vice Presidents)

Findings:

- Information needs vary by organization/setting

3. Follow-up KEP workshop:

- Purpose: to bring together researchers and decision makers and service providers in home care to look at ways to improve the understanding and use of health information for rehabilitation clients
- Presentations:
 - Using and sharing health information in home care
 - Integrated Assessment Records
 - Predicting functional outcomes for MSK patients receiving home care: does rehabilitation make a difference
 - Recognizing heterogeneity in 150,253 home care clients who used PT/OT services
 - CCAC Rehab Services in Ontario: Findings from RAI and administrative data
 - Integrated Client Care Project
 - Using and Sharing Information in Care Coordination: A population based approach

Recommendations:

- Strengthen relationships between CCAC and Service Providers.
- Knowledge exchange and dissemination opportunities so home care professionals are aware of initiatives, innovations, and research.
- RAI training to CCAC case managers and service providers to improve assessment, care planning and interpretation of outcomes.

- Tackle privacy challenges related to information sharing.
- Broaden the Integrated Client Care Project.
- Further develop and test a “Personal Health Profile” summary of key RAI data.
- KTE/training strategies to allow users of EHIS (i.e., RAI-HC) to understand the usefulness of the tools and data collected.

Next Steps:

- KT grant application: “Building capacity in community care by leveraging the value of information exchange”
 - KT workshops will provide consideration and education about how to use standardized assessments (i.e. RAI –HC) for:
 - Care planning
 - Increased understanding of client populations
 - Improved client outcomes
 - Addressing potential gaps in care
- HC Operating Grant:
 - Pilot use of PHPs to understand the impact on assessment and service provision

Following Selena and Stephanie’s presentation, each table was asked to answer the following question:

What additional questions would you like to ask to learn more about barriers and facilitators to information exchange in health care?

Summary of Discussion:

- | | |
|--|--|
| <ul style="list-style-type: none"> • Assumptions people make about the continuum of care - how does this effect information exchange (assumptions about competence, what providers are doing) • Role of case managers versus role of providers <ul style="list-style-type: none"> ○ Why don’t case managers share InterRAI assessments? ○ Why don’t providers value InterRAI? ○ What can be done to change the model to allow the two to assess together and better use the assessment information? ○ How best to bring case managers and providers together? ○ How to get client-centred information in to the record/plan? ○ How does the system work to keep knowledge from practitioners - e.g., constant change in procedures, disallowing telephone calls ○ Do ‘guidelines’ increase or decrease | <ul style="list-style-type: none"> • What can we do to facilitate the receipt of info? • What would facilitate the use of this info? • What is the base of that information? • How do we know about the quality of info? • What do you need to know to trust the info? (interpersonal trust, standardizing info from multiple users) • How can we create a common language? How to find a common interpretation? • What are the common areas of overlap? • Would it be possible to have access to RAI-HC data (for health care providers) • Would it be possible to have providers submit data to RAI-HC (conflicts of interest) • What are the solutions? • How do you track who has access to health information? • Why is there limited trust between sectors? • Are patients concerned about sharing PHP/privacy? • Can clients have access to their information/EHR? • Can clients have and carry their information on |
|--|--|

communication?

- How 'accountability' has been interpreted by the system (i.e., to be accountable is to write a report) has limited information exchange

them/their custodian?

- What is the cost?
- In each care setting, what info must they get? What is the minimum data that you need?

Detailed Discussion Points:

- Assumptions people make about the continuum of care - how does this effect information exchange (assumptions about competence, what providers are doing)
- Role of case managers versus role of providers:
 - Why don't case managers share InterRAI assessments?
 - Why don't providers value InterRAI?
 - What can be done to change the model to allow the two to assess together and better use the assessment information?
 - How best to bring case managers and providers together?
 - How to get client-centred information in to the record/plan?
 - How does the system work to keep knowledge from practitioners - e.g., constant change in procedures, disallowing telephone calls
 - Do 'guidelines' increase or decrease communication?
 - How 'accountability' has been interpreted by the system (i.e. to be accountable is to write a report) has limited information exchange
- In each care setting, what info must they get?
- What is the minimum data that you need? (ask this at each interface).
- What is the optimal info that you need?
- What can we do to facilitate the receipt of this info?
- What would facilitate the use of this info?
- What are the common areas of overlap?
- Would it be possible to have access to RAI-HC data (for health care providers)
- Would it be possible to have providers submit data to RAI-HC (conflicts of interest)
- Feedback vs. Feed forward
- Systems to support information flow from primary care and involvement of patients history
- What are effective and efficient info flow?
- Use of RAI in CCACs and SPs
- Why can't everyone have access?
- Common language for info exchange in health care
- What are the solutions?
- How do you track who has access to health information?
- Why is there not trust between sectors?
- Are patients concerned about sharing PHP/privacy?
- Can clients have access to their information/EHR?
- Can clients have and carry their information on them/their custodian?
- What is the base of that information?
- How do we know about the quality of info?
- What do you need to know to trust the info? (interpersonal trust, standardizing info from multiple users, how can we create a common language? How to find a common interpretation?)

Paul Stolee

But does it make a difference? The impact of rehabilitation on outcomes for home care clients with MSK disorders

Question: What are the benefits of home-based rehabilitation for older persons with MSK disorders?

Study Methodology

Two Studies:

1. Systematic Literature Review

- Inpatient vs. Home-based Rehabilitation for older adults with musculoskeletal disorders
- Results: 9 RCTs and 3 cohort studies
- Findings: Studies varied greatly by:
 - inclusion/exclusion criteria;
 - frequency and content of home interventions;
 - assessment tools utilized;
 - frequency and duration of follow-up

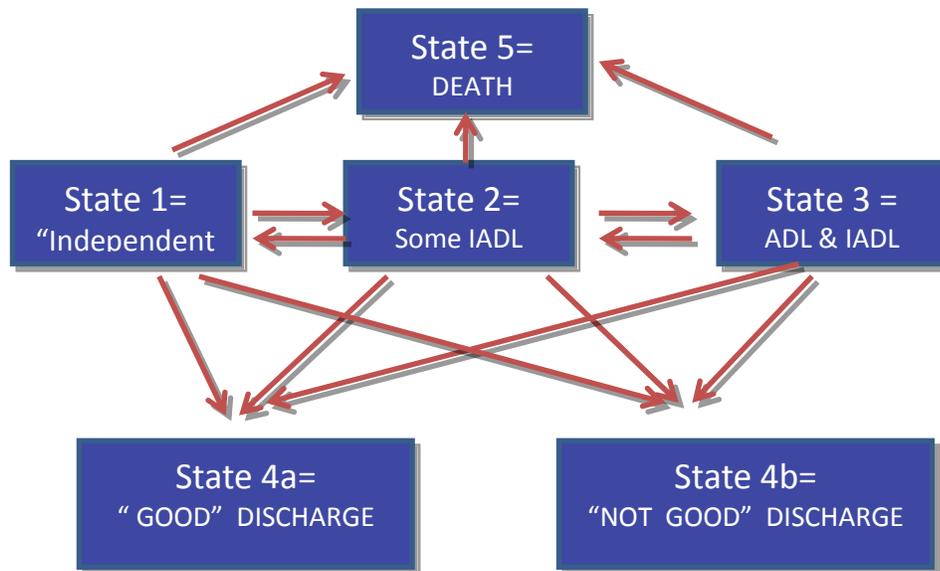
Home-based rehabilitation achieved equivalent or better functional or quality of life outcomes than inpatient rehabilitation

2. Statistical analysis (Multi-State Markov Models)

- RAI-HC data to investigate impact of PT/OT on functional outcomes for home care clients with MSK disorders
- Data: MDS-HC data for home care clients in Ontario with:
 1. MSK disorder (arthritis, osteoporosis, hip fracture or other fractures)
 2. At least one “admission” to home care
 3. Baseline assessment and at least 2 consecutive assessments
 4. A date of death or discharge for each admission
- N = 99,764, 74.9% female
- Age = < 65: 11.6%, 65-74: 16.0%, 75-84: 41.8%, 85+: 30.6%
- Controlled for: Age, Sex, Falls, ADLs, CHESS, CPS, DRS, Multiple Morbidities, Stamina
- “Good” Discharge =
 - Service plan complete
 - Other community services
- “Not Good” Discharge =
 - Admitted to LTC
 - Hospitalized

Multi-State Markov Model:

- A multi-state model which considers the client’s baseline status or ‘state’ at the start of a course of OT/PT treatment at home and their ‘state’ at its completion



Findings:

- Patients who are functionally “independent” (State 1) and who receive rehab are 1.57 times more likely to have a “good discharge”
- Patients with some IADL impairment who receive rehab (State 2) are 1.79 times more likely to be have a “good discharge” and 1.46 times more likely to become more functionally independent
- Patients with both IADL and ADL impairment (State 3) are 1.17 times more likely to improve their functional status, and 1.32 times more likely to have a “good discharge”

Why is this Important?

- RAI data can provide evidence of impact otherwise lacking at a system level
- Rehabilitation (PT/OT) provided through home care programs, can achieve functional benefits for clients with MSK disorders, and system benefits in terms of successful discharges from home care and reduced LTC admissions
- Many older home care clients (and many older persons generally) who could benefit from rehabilitation do not receive it (77% of clients in this study)
- Resources for home care rehabilitation are being reduced in Ontario

Following Paul’s presentation, each table was asked to answer the following question:

What do you think would make politicians take notice of these research results?

Summary of Discussion:

- | | |
|--|--|
| <ul style="list-style-type: none"> • Need to better market our research/create awareness • Show cost-benefit, cost of avoidable hospitalizations, reduce ALC days etc. • Bring in personal experience • Create a body of evidence, new stories, ‘sticky’ message | <ul style="list-style-type: none"> • Hold community forums and invite politicians • Create accountability • Build political will with voters • Use opposition health critics/client and senior service groups (e.g. CARP) to lobby |
|--|--|

Detailed Discussion Points:

- We need to better market our research - do they even know it?
- Create a body of evidence - what do we need to tell them?
- Prevention and show net benefit in terms of dollar - speak to their values
- Build political will within voters
- Personal experiences
- Costing > outpatient
- Long-term model for different models of since delivery
- Has to have a population
- Has to be high pressure
- Cost of avoidable hospitalizations
- Grill this information to senior lobby groups for them to make case
- Human rights issue
- Link to ALC - reduces hospitalizations, reduces ALC days
- Community forum and invite politicians, clients, clinicians, and families. Politicians to give opening remarks
- Provide compelling data and create messages that stick
- Pre-written form to send comments directly to MPPs/create accountability
- News stories
- Create awareness/sound bites of results
- Link to ALC situations and how home based rehab reduces the frequency of ALCs
- Have clients/seniors associations (CARP) lobby politicians
- Commit to closing beds and cost savings
- Use the opposition health critics to lobby
- Rehab is an essential service
- Number needed to treat - for every x patients who get rehab, 1 person avoid re-hospitalization, LTC
- Cost-benefit analysis

E. Investigator Observations on Research Findings: Bert Chesworth

To provide a summary of the Day 1 investigator observations of the research findings, Bert Chesworth asked each participant to rate the importance of the following statements using a scale from 1 to 10:

1. Think applied research not just research
2. Think informing expectations not just informing
3. Think family knowledge not just family
4. Think relationship building not just relationship
5. Thinking time pressures not just time
6. Think community supports not just community
7. Thinking predicting rehab potential not just rehab
8. Think patient clusters not just patients
9. Think team culture not just teams
10. Think patient networks not just patients

The results are not provided in this report as this was an individual exercise and was meant to facilitate reflection of the research findings presented on Day 1.

F. Panel Member Observations

To wrap up Day 1, each panel member was asked to share their responses to the following two questions:

- What did you hear that you think the people who work in your world will be most interested in?
- What do you think they will find challenging to get their heads around?

Audience members were then invited to ask the panel members any questions or provide comments.

Key Discussion Points:

- Outpatient physio “clinics” are alive in the public sector. However, they are expensive, hard to sustain and there are very few left in circulation.
- There is a need for national networks to share information.
- Research needs to be translated into application for advocacy purposes.
- Marketing research:
 - Message needs to be delivered to the right recipient
 - Empower the recipient by creating an understanding
 - Important to include patient/family voice
 - Proactive interventions for preparation
 - “We prepare our children for life, we as adults need to prepare ourselves for aging”
- Teams to bring sectors together:
 - Are there models in place and are they successful?
 - How can sectors influence patient outcomes?
 - This will eliminate barriers of understanding/role clarity exchange.
- Recognition of barriers/gaps:
 - Patient info/guide to give context of pressures at fundamental and system levels
 - Decision support tool (DVD) - Families/patients access around care transitions
- Innovative transitional care models
- Common assessment/communication among rehab and community
 - Need to convince others of importance
 - Think outside the box : change how we do things

Day 2

Day 2 started off with an overview of what was accomplished on Day 1 followed by the objectives for Day 2 of the workshop.

G. Presentation

Mu Zhu

What home care clients are most likely to benefit from rehabilitation?

Purpose: To predict rehabilitation use in home care

Background:

- Many seniors who could benefit from rehabilitation in home care do not receive service.
- RAI-HC standardized assessment conducted with long-stay (>60 days) home care clients in Ontario and elsewhere.
- New RAI Contact Assessment (RAI-CA) being introduced as a screener, including variables used to target rehabilitation.

Question: Which characteristics of home care clients are most important in predicting rehabilitation use?

- This study used data mining methods to determine which variables in the RAI-HC are most predictive of rehabilitation use for home care clients.
- Identified variables from the RAI-HC that can be compared with variables from the RAI-CA to predict rehabilitation use.
- Want to use current state-of-the-art 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). Examine whether the items are included in the RAI-CA?

Study Methodology:

- N = 135,184 newly admitted HC clients (Oct 2005 –Mar 2008).
- D = 239 variables
- RAI-HC population is different from the target population of RAI-CA. Items deemed most predictive of service utilization based on RAI-HC data may not be the best for the general target population of the RAI-CA.
- Frequency Matching
 - Took stratified samples from RAI-HC database in such a way that the joint distribution of five key “demographic” variables reflected similar characteristics of those who are assessed using the RAI-CA
 - Age, gender, ADL, cognitive skills, falls
 - matched in both DB’s
- LASSO used as opposed to binary outcome
 - Penalize the regression coefficient so that some become zero
 - If regression becomes zero then it is not included in the model
 - Lambda controls the amount of shrinkage - choose lambda so if larger then will get smaller number of variables and vice versa

- Novelty 1
- Used a solution path
 - As opposed to choosing one lambda, we looked at the whole path
- If lambda is large you can see where the variables enter the model
 - May be more important for clinicians to see which variables are most important so that they're ranked
- We used an ensemble approach for variable selection/ranking.

Results:

- Confirmed the importance of variables used by the RAI-CA rehab algorithm ... except "cognitive skills for daily decision-making" ... but some variables identified by LASSO *maybe* serving as surrogates (e.g., H7A, O2B –"clients believe ...")
- Identified additional variables which could be considered in rehabilitation planning ...seems to pay more attention to physical rather than cognitive conditions.
- Data mining methods such as LASSO and random forest have a potential application in selecting important client characteristics for care planning.

Questions from Workshop Participants:

- Kathryn Wise
 - How do you predict who needs it more, as these results talk about who actually GETS OT/PT, whereas we need to predict who has the greatest potential to benefit?
- John Hirdes addressed view of Sid Katz (original chair of Institute of Medicine)
 - Thought we needed a more comprehensive instrument
 - Also worked on the nursing home RAP and the home care CAP (more restrictive)
 - Anyone in a nursing home can benefit but only trigger was that anyone in a nursing home with ADL impairment would get therapy
 - RAI CAP
 - Accepted on cognitive impairment, etc.
 - Had to narrow disability potential as denied those with dementia
 - CCACS not using the new ADL CAP
 - 3 parts: those in non-trigger, those who trigger, and those who trigger for functional decline
 - Tried to get those who get therapy and improve
 - PHAC looking at:
 - Neurological conditions - prevalence, risk factors , and applicability of RAI to predicting rehab
 - Currently people with these conditions tend to get more rehab than those with dementia
- Paul Stolee: Emphasized that specific groups of clients might need to be identified

Following Mu's presentation, each table was asked to answer the following question:

How can we use these results to plan rehabilitation services?

Summary of Discussion:

- Use to get additional funding
- Determine who should receive rehab
- Educate clinicians across team, engage them in discussion of results and potential applicability for decision-making
- Consider variables identified by LASSO in care planning
- Achieve consistency
- Tailor rehab to individual
- Understand and clarify intent of rehab
- Use RAI-CA algorithm
- Use data to inform clinical judgments
- Use data to set priorities for utilization

Detailed Discussion Points:

- Use it to challenge who is/is not getting rehab
- Link to outcomes
- Education of clinicians across team
- Engage clinicians to do a reality check of the list - different subsets of items may mean something different to different providers
- Consider variables identified by LASSO in care planning
- Investigate use of stair climbing as a variable in RAI-CA algorithm or other rehab decision-making - how reliable, valid, useful
- Engage clinicians in discussion of results and potential applicability for decision-making
- Continue to do analyses to assess utility of algorithms, caps, etc.
- Get more funding
- Determine what groups should receive rehab
- Achieve consistency
- Tailor rehab to individual - goal setting
- Understand and clarify intent of rehab (e.g., to improve function, to prevent decline)
- Look at data in more depth
- This research identifies the patterns of referral and not the appropriateness of the referral. Needs to be contrasted with literature and wisdom of providers (i.e. cognitive deficits, cancer)
- Use the RAI-CA algorithm as a decision support for rehab referrals
- Use ranking for priority allocation
- From adv. point of view able to advocate, clarify what cancer data means, implication - different cancer care from palliative care (more pain)
- Use the data to inform clinical judgment, not to make the decision for you (engage the person in conversation)
- Understand results in context (i.e. not who needs rehab but who gets rehab)

H. Current Findings - Mobilization Opportunities



This small group activity included four teams, each with a:

- * Patient
- * Health Care Provider
- * Care Coordinator
- * Administrator
- * Family Member

The task of each team was to travel with the patient to different care settings. The focus of this task was on how to apply research. It was expected that this task would be messy, congested and uncoordinated. Participants had 45 minutes to complete the care journey and respond to a number of questions.

Scenario #1

1) Home

- Anna is an energetic 79 year old. She and her husband, George, live in an apartment building in a small town with a community hospital.
- Their two adult children live in the city about 3 hours away.
- During a surprise storm in March, Anna slips on a patch of ice and fractures her left hip.
- George calls 911 and she is transported to acute care at their community hospital.

In this transition scenario...

Care Providers

What research findings would we like to share with the care providers and why? What ideas do we have for them about what they should keep doing and what they could do differently?

- No relevant research at this stage.
- Find the right people, ask the right question.
- Start communication early.
- Discharge planning at admission.

Patients and Families

What research findings would we like patients and families to know about and why?

- Doesn't mean you can't go home.
- Think about options.
- Get family involved.
- Things happen quickly.
- Expected length of stay 5 days.
- Keep a journal during hospitalization.

Administrators

What research findings would be of interest to administrators?

- No response provided

Knowledge Mobilization

What existing KT (communications, change management, education) strategies could we tap into? What could we do that is innovative? What messages would stick?

- Information package
 - Above details
 - Expectations/what happens/possible options

2) Acute Care Community Hospital

- Anna is keen to “get doing some exercises” so she can get back to her active life.
- After a stay in acute care, she is transferred to the rehabilitation unit after a week of delays.

In this transition scenario...

Care Providers

What research findings would we like to share with the care providers and why? What ideas do we have for them about what they should keep doing and what they could do differently?

- Communication from acute to rehab needs to happen.
 - Easier in a small hospital.
- Assessments info to hospital.

Patients and Families

What research findings would we like patients and families to know about and why?

- Educate George about rehab, possible outcomes.

Administrators

What research findings would be of interest to administrators?

- Patient pays for transfer, think of other options.

Knowledge Mobilization

What existing KT (communications, change management, education) strategies could we tap into? What could we do that is innovative? What messages would stick?

- Visual aids.

3) Rehabilitation

This community hospital has had a hard time recruiting physiotherapists so Anna doesn't get as much therapy as she thought she would.

In this transition scenario...

Care Providers

What research findings would we like to share with the care providers and why? What ideas do we have for them about what they should keep doing and what they could do differently?

- Work in a collaborative fashion.
- Explain limited resources.
- Work with community providers to fill the gap when discharged home.
- Be sure to include staff from in-patient rehab and community.

Patients and Families

What research findings would we like patients and families to know about and why?

- Conversations often and early.
- Consistent messages.
- Chance for advocacy
 - Complain to decision makers.
- Need to know options.

Administrators

What research findings would be of interest to administrators?

- Should have communicated lack of resources.
- CCAC should have assessment.
- Discharge planning should already be well under way.
- Need to know collaborative teams benefit the system.

Knowledge Mobilization

What existing KT (communications, change management, education) strategies could we tap into? What could we do that is innovative? What messages would stick?

- Team meetings.
- Build upon current protocol.

4) Home Care

- Anna recovers well and everyone agrees that with home care supports she can return home.
- Once again, she is surprised by how little therapy she gets. She is committed to doing her exercises but she worries whether she is doing them properly.

In this transition scenario...

Care Providers

What research findings would we like to share with the care providers and why? What ideas do we have for them about what they should keep doing and what they could do differently?

- Rehab should have communicated.
- Communication with programs in community.

- Communication of assessments to client.
- PHP (personal health profile).

Patients and Families

What research findings would we like patients and families to know about and why?

- Need to know private pay options.
- Needs to know why she will only get three.
- Request for more information.
- Better communication is needed.
- What rehab will look like in the home.
- Must know family roles.
- Need to advocate for therapy (research shows most don't get rehab).
- Get a family physician.

Administrators

What research findings would be of interest to administrators?

- Should communicate assessments to service providers, patients.
- Be aware of lazy clinical practice.

Knowledge Mobilization

What existing KT (communications, change management, education) strategies could we tap into?

What could we do that is innovative? What messages would stick?

- Video tape of exercises.

5) Emergency

- Unfortunately, 2 months after she returns home, Anna experiences severe back pain and numbness in her legs. Since she doesn't have a family physician, George calls 911 and she goes to Emergency.
- She is admitted while they do tests.
- George is worried sick not knowing what is going on.

In this transition scenario...

Care Providers

What research findings would we like to share with the care providers and why? What ideas do we have for them about what they should keep doing and what they could do differently?

- Use the IAR.
- Use past assessment information.
- How to use RAI.
- Education on the use of RAI.

Patients and Families

What research findings would we like patients and families to know about and why?

- Call transition coach.
- Plan.

Administrators

What research findings would be of interest to administrators?

- Get the IAR working.
- ED screener.
- Make sure past assessment info is available.

Knowledge Mobilization

What existing KT (communications, change management, education) strategies could we tap into? What could we do that is innovative? What messages would stick?

- No response provided

Scenario #2

1) Home Care

- Wilma and her husband Fred live in a small house in the country. They are both in their late 80s and are determined to live at home for the rest of their lives. They cannot imagine living in an apartment building or one of those “homes”. Two weeks ago they started having some home care support for bathing and house work. Their daughter Pebbles is going through a nasty divorce and is considering moving back home.

In this transition scenario...

Care Providers

What research findings would we like to share with the care providers and why?

What ideas do we have for them about what they should keep doing and what they could do differently?

- Importance of considering the patient system, e.g. including husband's at home, rural setting.
- Importance of cross-sectoral communication

Patients and Families

What research findings would we like patients and families to know about and why?

- Including/notifying full patient system/family.
- Preparing/anticipating.

Administrators

What research findings would be of interest to administrators?

- Sharing records.
- Anticipating/preparing for discharge destination.
- Preparation needed.

Knowledge Mobilization

What existing KT (communications, change management, education) strategies could we tap into?

What could we do that is innovative? What messages would stick?

- Information package to follow patient.
- System navigator.
- Television/video to follow patient for next care setting.

2) Acute Care

- One day Wilma slips while doing down the back steps and breaks her hip. The home care provider calls 911 and Wilma is transported to the hospital 30 minutes away.

In this transition scenario...

Care Providers

What research findings would we like to share with the care providers and why? What ideas do we have for them about what they should keep doing and what they could do differently?

- Sharing the records- hospital records/treatments/recommendations.
- New assessment is needed related to a change in status- e.g. no longer able to do stairs, added caregiver burden to spouse.
- Cross-sectoral communication - team culture, caregiver burden

Patients and Families

What research findings would we like patients and families to know about and why?

- Disengagement in care is a common experience for patients.
- Patient needs to be included.
- Need to be aware of potential for caregiver burden.

Administrators

What research findings would be of interest to administrators?

- Importance of team culture and cross-sectoral communication, e.g. home risk.
- Patient/client/family partner in all care plans- engage early and often.
- Sensitivity to client time needed to register/process/plan/decide.
- Time pressures to discharge from hospital prevent opportunity to pursue alternative plans.

Knowledge Mobilization

What existing KT (communications, change management, education) strategies could we tap into? What could we do that is innovative? What messages would stick?

- Proactive preparation.

3) Home Care

- Wilma cannot stand being held “prisoner” in the hospital and demands to return home as soon as possible.

In this transition scenario...

Care Providers

What research findings would we like to share with the care providers and why? What ideas do we have for them about what they should keep doing and what they could do differently?

- Early engagement with clients- builds a relationship with clients.
- Potential for rehab.
- Including patient/family early and often, including sharing information about relative risks.
- Team culture is important, include patient/family/caregivers as part of the team.

Patients and Families

What research findings would we like patients and families to know about and why?

- No response provided

Administrators

What research findings would be of interest to administrators?

- No response provided

Knowledge Mobilization

What existing KT (communications, change management, education) strategies could we tap into? What could we do that is innovative? What messages would stick?

- No response provided

4) Long Term Care

- With limited physiotherapy, Wilma’s condition deteriorates.
- Unfortunately, they cannot manage at home. Fred’s back is sore from the years working in the stone quarry and he cannot do much around the house. Pebbles is an emotional wreck.
- Everyone reluctantly agrees it is time to sell the house and move to a facility where at least they can be together.

In this transition scenario...

Care Providers

What research findings would we like to share with the care providers and why?

What ideas do we have for them about what they should keep doing and what they could do differently?

- Share existing assessments with all care providers/circle of care.
- Include client/partner in care plans.
- Importance of including rehab professionals for environment adaptation to minimize risk.

Patients and Families

What research findings would we like patients and families to know about and why?

- RAI outputs- CAPs- translated to client-friendly language.
- Mutual goal setting/equal partners in care.

Administrators

What research findings would be of interest to administrators?

- Integrated teams enhance care.

Knowledge Mobilization

What existing KT (communications, change management, education) strategies could we tap into?

What could we do that is innovative? What messages would stick?

- No response provided

Scenario #3

1) Retirement Home

- Lee couldn't stand the thought of spending another winter alone so he moved to a retirement home. At about the same time his family doctor retired and Lee isn't sure what happened to his medical records. He has trouble hearing and has COPD.
- While on an outing to a park with the Recreation Club from his retirement home, Lee trips over a tree branch, falls heavily and breaks his hip.
- Lee has always been independent and he never married. His substitute decision maker is his third cousin, who lives in another province.

In this transition scenario...

Care Providers

What research findings would we like to share with the care providers and why? What ideas do we have for them about what they should keep doing and what they could do differently?

- Information to rehabilitation on fall prevention/falls risk.

- Put together package for next stop (phone and talk to acute prior to him arriving).
- Take ownership that information got there.
- Notify family.

Patients and Families

What research findings would we like patients and families to know about and why?

- Notify family about where the patient is going.
- Let families and patient know they have options.
- Even though family is in another province, they need to be proactive and involved/gain knowledge.
- Give patient/family information about acute care- through brochure, video (not just verbal).

Administrators

What research findings would be of interest to administrators?

- Incidence of falls/fall prevention.
- Planning for rehab when patient returns.
- This person needs to know if patient is coming back, and if so, when.
- "Subletting beds when patient is in the hospital."

Knowledge Mobilization

What existing KT (communications, change management, education) strategies could we tap into?

What could we do that is innovative? What messages would stick?

- Website - Framework- each fell in own work.

2) Acute Care

- The Recreation Club goes with him in the ambulance to the nearest hospital which is just 10 minutes from the park.

In this transition scenario...

Care Providers

What research findings would we like to share with the care providers and why? What ideas do we have for them about what they should keep doing and what they could do differently?

- Start planning early for discharge.
- Active strategies for trust building- plan family meetings early with key people (e.g. case managers).
- Trust within team of care providers and communication strategies.

Patients and Families

What research findings would we like patients and families to know about and why?

- Need to be assured of feelings, understanding it is okay to ask questions.

- Letting HCP know that the ICG and patient may not have the knowledge.
- Want families to know outcome results of patient/what is realistic.

Administrators

What research findings would be of interest to administrators?

- Key fiscal/quality, best staff mix.
- Need to know families/patients information needs.
- Facilitate team culture/in-site workshops.
- Our research results came from HCP/ICG/patients, so it is valid.
- Customer service is important to patients and families.

Knowledge Mobilization

What existing KT (communications, change management, education) strategies could we tap into?

What could we do that is innovative? What messages would stick?

- Information needs to be shared more than once and in different forms.
- Follow-up calls in other settings.

3) Rehabilitation Unit

- There's a rehab unit in this hospital which Lee is moved to. Somehow in the hullabaloo, his hearing aid goes missing and he cannot hear a darn thing.
- From his army days, he likes the routine on the rehab unit and appreciates the straightforward physiotherapist.

In this transition scenario...

Care Providers

What research findings would we like to share with the care providers and why? What ideas do we have for them about what they should keep doing and what they could do differently?

- Having clear expectations of patients in new unit.
- Be sure to address specific issues (both family and patients).
- It is okay if patients want to observe/invite them to learn.
- Make sure patient needs are met (e.g. missing hearing aid- unacceptable).

Patients and Families

What research findings would we like patients and families to know about and why?

- Patient empowerment and family involvement.
- Teach about options.

Administrators

What research findings would be of interest to administrators?

- Rehab scheduling, families want to be involved in care.
- Consider home visits for discharge planning (maybe take pictures).

Knowledge Mobilization

What existing KT (communications, change management, education) strategies could we tap into? What could we do that is innovative? What messages would stick?

- No response provided

4) Long-Term Care

- At first, he's told he is doing very well and he will be able to go back to his retirement home. He misses his buddies.
- Then, he is told they cannot manage him there.
- A better fit will be a new Long-Term Care Home. He gets depressed at the thought of moving someplace where he doesn't know anyone. He gets angry when he learns that there is no therapy at this place. He is told he can hire the service privately, but he's not sure he has enough money for that.
- For the first three days at the LTC home, he refuses to get out of bed.

In this transition scenario...

Care Providers

What research findings would we like to share with the care providers and why? What ideas do we have for them about what they should keep doing and what they could do differently?

- Need to be aware of his 'normal' behaviour and regular routines.
- Active strategies to engage previous site.
- Re-establish trust with patient and family, get rid of LTC stigma.

Patients and Families

What research findings would we like patients and families to know about and why?

- Need to know service options in LTC.
- Big transition! Relocation into LTC is a big change, need to involve family and give options and counseling on this big change.
- Issues of what to do with his rehabilitation: will he ever get to go back? Cost issues involved.

Administrators

What research findings would be of interest to administrators?

- Wants info from all previous destinations.
- Psycho-social component for patients when they are going to LTC.

Knowledge Mobilization

What existing KT (communications, change management, education) strategies could we tap into? What could we do that is innovative? What messages would stick?

- Getting people together from different sectors into long-term care.
 - In this situation, if previous provider comes to see him, maybe motivate him in his new home.

Scenario #4

1) Long-Term Care

- Hans felt very lonely after his wife of 37 years passed away. He says he has the usual aches and pains of someone his age – 83. In fact he has several serious health care challenges including mild dementia.
- He gets frustrated with his special diabetes diet and poor eye sight.
- Two years ago, he decided to move to a Long-Term Care Home where he'd get 3 square meals and have some company.
- His son, Klaus, is on a special assignment in Europe for 6-months.

In this transition scenario...

Care Providers

What research findings would we like to share with the care providers and why?

What ideas do we have for them about what they should keep doing and what they could do differently?

- No response provided

Patients and Families

What research findings would we like patients and families to know about and why?

- No response provided

Administrators

What research findings would be of interest to administrators?

- No response provided

Knowledge Mobilization

What existing KT (communications, change management, education) strategies could we tap into?

What could we do that is innovative? What messages would stick?

- No response provided

2) Acute Care

- One night when he got up to go to the bathroom, he forgot to use his walker and fell and broke his hip.
- He was transported to the nearest acute care facility in the city hospital, 90-minutes away.

In this transition scenario...

Care Providers

What research findings would we like to share with the care providers and why? What ideas do we have for them about what they should keep doing and what they could do differently?

- Know our morbid status, e.g. mild dementia.
- Whether using assistive devices.
- Don't label.
- Phone the home, get specific info on them.
- Acute risks, how to detect.

Patients and Families

What research findings would we like patients and families to know about and why?

- Have an elder-friendly emergency contact.
- Is there an advocate for our loved one?
- Hip precautions for patient and family.
- Information on what's going to happen.
- Staff to ask about what support will be available on return to home.

Administrators

What research findings would be of interest to administrators?

- Understand the appropriate staffing levels.
- Need standardized amendments and guidelines.
- Trained care aides to help with lower level, under supervisor of nurse.
- Info exchange about med. complex.
- Match care needs with medical needs, including appropriate info for patients, helping to situate the patients.

Knowledge Mobilization

What existing KT (communications, change management, education) strategies could we tap into? What could we do that is innovative? What messages would stick?

- Policy and culture to contact care facility.
- Information from home- summary of info- include a picture.

3) Rehabilitation

- From the acute care hospital, he was transported across the city to a regional rehabilitation unit.
- At first, he didn't like all the therapy and was more confused. This was a busy place- people didn't just lie around in bed. But after a while, he could feel how it was making a big difference.

In this transition scenario...

Care Providers

What research findings would we like to share with the care providers and why? What ideas do we have for them about what they should keep doing and what they could do differently?

- Detect and monitor delirium for risks.
- Medication- sharing accurate and timely information.
- Behavioural changes should be monitored.
- Evidence-based tools, e.g. questions to ask patient for e.g. falls prevention.
 - Need to use the bathroom.
 - Pan.
 - Anything you need.

Patients and Families

What research findings would we like patients and families to know about and why?

- Goals for facility and patients/family.
- What a typical transition through rehab looks like.
- System navigators for Klaus.
- Demand timely and accurate/complete transfer of info from acute care.
- Interdisciplinary rounds and rounds at the bedside.

Administrators

What research findings would be of interest to administrators?

- Systems navigators.

Knowledge Mobilization

What existing KT (communications, change management, education) strategies could we tap into? What could we do that is innovative? What messages would stick?

- Interdisciplinary rounds.
- Patient centered team culture.
- Develop relationship with the LTC facilities and optimize resources available.
- Face-to-face discussions about patient- invite therapists to attend.

4) Long-Term Care

- Upon discharge, he went back to the familiar surroundings at the Long-Term Care Home. The first morning right after breakfast, he asked where he should go for Physio.

In this transition scenario...

Care Providers

What research findings would we like to share with the care providers and why?

What ideas do we have for them about what they should keep doing and what they could do differently?

- Physio teams have chatted. Physio has arrived an hour earlier to discuss patient and his physio is held that afternoon.
- Later, he will attend an exercise plan.
- Medications were reconciled in advance.
- His assessment for osteo from acute care has been transferred and enacted.

Patients and Families

What research findings would we like patients and families to know about and why?

- Klaus was very happy with his acute and rehab care and was informed in advance of returning home and was there to greet him.
- Klaus is recommending each of the care setting for their fabulous care.

Administrators

What research findings would be of interest to administrators?

- Klaus is no longer lonely. The lady in room 305 is his new “meal buddy”.

Knowledge Mobilization

What existing KT (communications, change management, education) strategies could we tap into? What could we do that is innovative? What messages would stick?

- No response provided

After each team had completed their journey, they were asked to find a table and discuss:

What research findings would we like policymakers to pay attention to and why?

- Rehab in HC is effective. Effectiveness of rehab in home care.
- Save money for system.
- Targeted services is possible (won't break the bank).
- Helping people with transitions will improve outcomes.
- Know the impact on system.
- Older people are vulnerable in care transitions, particularly those without advocates.
- Everyone in the system is missing information.
- Handoffs are not set up to be timely, they are efficient but information is not being shared.
- Patients, families, and HCP are feeling lost in transitions, some things need to be done now.
- We can predict outcomes.
- Ignoring it won't make it go away, fund research to produce solutions.
- There are people in rehab sector that are willing to change models of care.
- Home care is effective, results surrounding this.
- Recognizing support that informal caregivers need and that they do valuable work.
- Proactive, preventive measures, including rehab.
- Cost-effective approaches, detail the “how”.
- Cross-sectoral communication is key to enhancing care.
- Key to place client/support system in centre of team.
- Important to engage early/often with client/families to build a relationship with

clients/caregivers.

- Provide time to make decision/opportunity to recuperate/main gains in health status prior to determining final care setting.

How could we use these findings to make evidence-informed decisions?

- Use our research to think of better options.
- Make sure all sector policy makers know the research.
- Conversations should happen between LHINs service providers and government.
- Shifting of funding.
- Having a strategy for care transitions (accredibility).
- Use evidence to adopt co-leadership models/cross-sector teams.
- They know how to navigate system- if policy makers have collaboration they can affect policy change- collaboration needs to happen.

When it comes to communication from the research world- what do they want? What messages would stick?

- Budget and effectiveness and prevention.
- Cost avoidance.
- What is the \$ value.
- Short, efficient messaging.
- Are there any risks involved? Future effects?
- Showing real life experience, that this works!
- Rehab works: enables people to remain in home.
- Rehab and safety.

I. What's Next for InfoRehab? - Paul Stolee

Midterm Progress Report

Components:

- Overall progress
- Strengthening capacity and adding expertise in priority areas relevant to policy decision makers
 - (focus on publications, presentations, reports, books, theses, media coverage)
- Supporting trainee development
- Strategies for knowledge translation and exchange
 - (focus on planned and delivered KT strategies, target audiences engaged)
- Impact and innovation
 - (focus on influenced policy, program change, new theory, new method, new capacity)



Submitted Grants

- InfoRehab Home Care
 - Applied for CIHR KT grant
 - Purpose: to provide education about use of Electronic Health Information Systems (i.e. RAI-HC) and components to consider when designing and implementing new systems.
 - Also provides education about the ways that RAI data can be used to determine population characteristics, as well as to understand predictors and outcomes of service utilization.
 - Combines translation of qualitative and quantitative research.

Submitted Grants

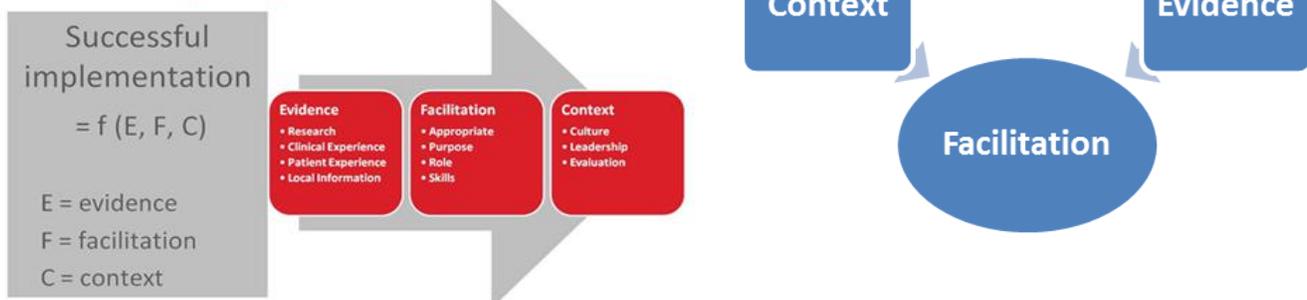
- Quantitative Analysis
 - Applying for a CIHR Institute of Aging Secondary Data Analysis Grant that will be used to define client populations, and will also continue with the clustering work.
 - Guiding question: Are outcomes of rehab different for different subgroups?

Future Grant Opportunities

- CIHR Operating Grants
- CIHR Meeting, Planning and Dissemination Grants
- CIHR Knowledge Synthesis Grants
- CIHR Partnerships for Health Systems Improvement Grants
- CIHR Secondary Data Analysis Grants
- CIHR and NSERC Collaborative Health Project Grants

Research Opportunities

Promoting Action on Research Implementation in
Health Services (PARIHS)



Ideas that have come up so far:

- How are long-stay rehab clients different from short-stay?
 - i.e. those who didn't get the RAI-HC
- Predictors of rehab use and outcomes
 - Individual and geographical predictors

- Impact of integrated health teams on continuity of care
- System navigation
- Online networks
 - To organize services
- Personal health profile
 - For rehab service providers

Other Ideas...

Participants were put into groups and each group was asked to answer a specific question. The results were then shared with the group.

By combining qualitative and quantitative data, what interesting questions could we pursue?

- Outcomes of people who are currently getting PT/OT in homecare
- What are the profiles of people not getting rehab?
- Qualitative data could inform future generations of RAI tools; care transitions measure for families
- Change to team culture/measure change to health outcomes
- Put trends (quant.) together with discourses and produce compelling evidence
- Compare outpatient rehab with homecare
- Use qualitative data to facilitate information translation of quantitative results
- Are we talking to each other?

In the care settings you're most familiar with, what additional questions do you think "grass roots" care providers and administrators are interested in?

- How do case managers use the RAI tools (and which ones) to make resource (referral) decisions?
- What do the RAI tools mean? (training, outputs)
- What are the ethics of predictive tools for access to resources (particularly troublesome for "potential")
- Easy to access rehab from hospital but how do you identify (and serve) those who need a "top-up"?
- How do the CCACs make decisions around service priorities? (Acuity Scale)
- System navigation vs. system change?
- What to do about these issues? We know rehab works but what can we do to get help?
- How can rehab provision be sustained as time moves forward?
- Is a patient navigator worth the cost: redesign necessary?
- Decisions based on funding
- Transitioning to a population-based model

What's a "burning question" related to info use and sharing that you would like an answer to? What are you most concerned about for you and your family?

- Service providers and patients should have access to all pertinent information → translated for lay use (How do we do this?)

- How can we make hospitals safe for our loved ones? Particularly with respect to information sharing?
- Who gets access to information?
- If you have questions, who do you ask?
- Can HCPs provide evidence and reassure patients about the sources of information? (to enhance trust rehabilitation)
- “Not one size fits all” – the setting matters as to what information is relevant/important
- When are we going to have integrated e-records?
- What is actually possible in these units to improve info sharing? (What does it take to prove it?)
- How do people need to receive the information so they can use it? (interpretation, meaningful, etc.)
- How does HCPs understanding of privacy and confidentiality influence care?
- More specifics around prevention (when to start? How?)

What’s a “burning” question related to information use and sharing that you think policy makers would like an answer to?

- Is rehab cost-effective?
- Does rehab impact acute care (ALC, ED, LOS) resource utilization?
- Does funding availability influence referrals?
- How can outcomes be improved through system level enhancements (for transitions)
- What will get me re-elected? (positive)
- How does rehab fit into the whole aging picture?
- How can we tell alternative stories?
- How can I expand the planning horizon (i.e., make the decisions I know should be made about rehab, etc.?) AND still keep my job?
- Contrast life with/without rehab
- Transitions poorly executed = increased costs
- Transitions are a safety issue = adverse effects = negative impact on system sustainability
- Make it a problem (get it in the public eye) – over-emphasize
- Outcomes (long term)
- Sexy-electable
- Statistics
- Money

Participants were invited to reflect on their entire workshop experience and share their responses to this question:

What stands out for you as a result of participating in this workshop?

They were then asked to form a group and share their responses with others. A complete listing of the responses is provided below:

- “There needs to be a better way for translating research information to the front line workers.”
- “We are all striving to reach the same goal: to improve the quality of life for older adults with hip fractures. We are all passionate. Importance of including patients in rehabilitation/care trajectory.”
- “Need new models for transitional care.”
- “Meeting new young researchers.”
- “We have a lot of opportunity and work to do!”
- “Inspired by KTE Research Question: How can we come up with knowledge exchange strategies for older patients with specific limitations, e.g. culture, language?”
- “The need to get data to the consumer.”
- “How nice it is to have activities and diverse formats to: 1) present info; and 2) effectively network.”
- “How do we use our research to inform and engage older adults? How do we make rehab sexy?”
- “Collaboration needed between different transitions (e.g. acute, rehab, outpatient rehab, LTC, patients). How can we get everyone on the same page?”
- “Take away message: A great day, sharing great ideas! Very interesting in bringing care providers together, bringing home care into hospital- planning prior to discharge. Allowing for decrease in communication loss.”
- “Need for acute and community collaboration to develop a care transition program.”
- “Need to engage family members in the discussion of what home care services are needed.”
- “There needs to be a continued effort to build the body of evidence through rigorous research to guide and support decision-making.”
- “Client is the center of the healthcare system. Communication, team work, access to rehab, and transitions need to be improved to improve the client experience.”
- “Research question: A systematic review of health-related QOL measures after hip fracture surgery.”
- “Changing the model of care and providing the patients with a voice in the decision-making (decision support tools). The need to advocate for rehab.”
- “The importance of creating messages that stick and how to accomplish this for creating/affecting policy change.”
- “The importance of framing research results in a friendly ‘positive’ tone.”
- “It’s about relationships, and relationships take time.”
- “We are battling health care delivery problems which are decades old. Are we fighting 21st century issues with 19th century delivery models?”
- “Researchers need to learn to make their messages ‘sticky’.”
- “The importance of looking at team culture for implementing strategies. ‘Care transitions is a team sport and yet all too often, we don’t know who are teammates are, or how they can help.’ –Eric Coleman. Great quote!”
- “The lack of communication and trust between health care providers during transitions from hospital to home causing delays in transfer because HCP may believe clients will not get therapy at home.”
- “How difficult it is to focus on the patient rather than the assessments, team/providers.”
- “The ways in which many of the ‘problems’ discussed today seem to be effects of the way systems are currently organized and/or the unintended consequences of other processes.”
- “How can we implement a process to identify clients that would benefit from rehab in home care (e.g. RAI-CAPs, client population)?”
- “I would support the need for InfoRehab Research III ‘Building National Gardens’.”

J. Work Plan for Phase II

The afternoon of Day 2 started with a discussion about the work plan for Phase II of the InfoRehab Transitions Project.



The following questions were asked:

1. How can we maximize the use of existing qualitative and quantitative data?

- Include trends of quantitative data together with qualitative discourses to produce compelling evidence
- Have inter-disciplinary teams at various transition points to work on what key information is required for successful transitions.
- Need data beyond discharge planning - not one person's role
- What do the patients say they want the HCP to know?
 - May check with the commonly used outcome indicators to see if they are included in them (Bert Chesworth)
- Examine number needed to treat
 - How many people need to get one unit of rehab to prevent one re-hospitalization

| Max Use of Qualitative and Quantitative Data | Students | Cross-site | Other sites (Mary/Christine) | Publications | Future Grants | Interested in |
|---|-------------------------|------------|------------------------------|---|-------------------------|---------------------------|
| 1. Quantitative trends and discourse (stories within context) | YES (use existing data) | YES | YES | report to policy makers, macro/micro analysis | Secondary data analysis | Change foundation, JA, BH |
| 2. Qualitative (case study, theorizing/ conceptual, what happens to people in the system) | | | YES | YES | | KB, CC, BH, ME |
| 3. Interdisciplinary cross sector | | | | | | BC |
| 4. Questions patients + families have, strategies to make system work them (follow-up with research participants) | | | YES | YES | | KB, JT, BH, SS, JE |
| 5. Data beyond d/c planning (care transition, flow through, on-going) | YES | YES | YES | | | ME, SS |

| | | | | | | |
|---|-----|-----|-----|--|--|------------|
| 6. Qual - how to interpret RAI (id duplications), what does it do/not do (how get additional - eg. extra RAI - what's best available info?) | | | | | | ME |
| 7. Qual - what do pts. say they want HCP to know about them (to outcome measures - pt. reported outcomes - varies overtime) | YES | YES | YES | | | SS, JE, BC |

2. What new projects/new phase of data collection will we initiate?

- Action research
- Involve the care providers in determining what the most important outcomes are
 - i.e. quantitative data that can be combined with the qualitative data
- Small pilot projects
 - E.g., one page discharge summary
- Cost-effectiveness data - impact on re-hospitalizations, ALC etc.
- Use of PSWs
 - Examine the impact of PSW's on outcomes

| | Site | Students | Cross-Site | Other Sites | Publications | Future Grants | Interested in |
|---|---------------------------------|----------------|------------|-------------|--------------|---------------|---------------|
| | | | | | | | |
| 1. Re-Hospitalization -Predictions | | | | | YES | | JA |
| 2. Action Research (sustain) -practice, small, pilot (small, interventions/tools) | Waterloo London Vancouver | YES YES | YES YES | YES | YES YES | YES YES | KB, BC, JE |
| 3. Rehabilitation -System Outcomes | ALC - J.H. | | | | | | |
| 4. Cost data ~ Cost effectiveness (need to treat to achieve an outcome) | | | | | | | JA |
| 5. Fiscal year trends for service types/levels | | | | | YES | | BC, JA |
| 6. PSW trends -Different models (evaluation) | | | | | | | KB, JA, MF |

Appendix A: IRT Knowledge Exchange Garden Tour Guide

*Enjoy the IRT
Knowledge
Exchange
Garden Tour*



Welcome!



This self-guided tour is designed to:

- showcase the InfoRehab team's accomplishments to date; and,
- gather your perspectives, ideas and advice.

Stroll throughout the garden in whatever way suits your fancy. Along the way you will experience a number of exciting stops, including:

1. The Garden of Knowledge Translation and Exchange
2. Blossoming into Solutions for Care Transitions (Vancouver Site)
3. Budding Researcher Posters
4. Just Another Fish in the Pond: Reflecting on Care Transitions (Waterloo Site)
5. The Rural Vegetable Garden (London Site)
6. The Zen Garden of Knowledge Translation
7. Making Connections - Spider-Web Networking Board

- ❖ Make sure the time you spend in the garden is not all work and no play. Be sure to take part in our fishing expedition and flower pot toss game for a chance to win exciting prizes.
- ❖ Enjoy tantalizing garden party snacks at each stop along your journey.
- ❖ Also, make sure to 'get caught' in our spider-web networking board at Station #7.

There is space for you to write any notes, questions or comments that may arise throughout your tour. Please keep these notes handy as you will be referring to them throughout the workshop.

Station #1: The Garden of Knowledge Translation And Exchange



Let these thoughts take wing and fly:

- ❖ Research is a cyclical process, a metamorphosis from idea, to action, to sharing, to assessment, and back to new ideas. Think about where you might participate in the cycle of research.

Activity:

- ❖ On the table you will see 6 jars labeled with different Knowledge Translation tactics, and one unlabeled jar.
- ❖ In your conference bag you will find 20 stones. On Day 1 use the 10 **blue** stones to “vote” for the KT tactics you think best match the IRT findings. You may place more than one stone in a jar. If you don’t see an idea, use the unlabeled jar – write your idea beside a number on the sheet provided, then write the number on your stone before placing it in the jar.
- ❖ On Day 2, return to our garden, and “vote” again with your white stones...did your ideas change, take wing and fly?

Notes:

Station #2: Blossoming into Solutions for Care Transitions



Come celebrate a Vancouver spring in the cherry blossom garden!

Sample some cherry jam and get a taste of our data including patient and family information needs and health care provider perspectives about care transitions for hip fracture patients. Take a moment to 'listen' to a patient from our study weigh her options for post hip fracture care. Finally, make sure to vote on the top five creative, yet practical, solutions to improve information exchange generated by healthcare providers in our ethnographic study. And don't forget to enter our door prize competition!

Notes:



Station #3: Budding Researcher Posters

London Site:

- Jacobi B. Elliott, Dorothy Forbes, Bert M. Chesworth, Helen A. Johnson, Paul Stolee. *Family caregivers' contribution to knowledge exchange during transitions following a patient's hip fracture*. Presented at Canadian Association on Gerontology, Montreal, QC.
- Helen. A Johnson, Bert M. Chesworth, Dorothy Forbes, Jacobi B. Elliott, Jenny L. Wells, Paul Stolee and the InfoRehab Team. *Journey through a rural health care system after hip fracture: A qualitative study of handoff to handoff*. Presented at Canadian Association on Gerontology, Montreal, QC.

Waterloo Site:

- **Brooke Manderson, Josephine McMurray, Emily Piraino, Paul Stolee.** *System navigation roles to support chronically ill older adults through health transitions: A review of the literature*. Presented at Canadian Association on Gerontology, Montreal, QC.
- **Jordi McLeod, Paul Stolee, Christine Glenny, Brandi Steeves and the InfoRehab Team.** *Care transitions for older patients who have had a hip fracture: The role of information sharing*. Presented at Annual Knowledge Exchange Conference, National Initiative for Care of the Elderly, Toronto, ON.
- **Josh Armstrong, Mu Zhu, Paul Stolee.** *Heterogeneity among home care clients: A cluster analysis of rehabilitation service users in the Ontario home care system*. Presented at Canadian Association on Gerontology, Montreal, QC.
- **Justine Toscan, Paul Stolee, Sherry Dupuis, Steven Mock.** *Silent partners in care: Examining care transitions on caregivers of hip fractures and stroke patients*. Presented at Canadian Association on Gerontology, Montreal, QC.
- Justine Toscan, Brooke Manderson, Paul Stolee and the InfoRehab team. *Care transitions: The lived experiences of hip fracture patients, health care providers and informal caregivers*. Presented at Annual Knowledge Exchange Conference, National Initiative for Care of the Elderly, Toronto, ON.

Notes:

Station #4: Just Another Fish in the Pond: Reflecting on Care Transitions



All activities in the pond are connected:

- ❖ Health care research brings academics, policy makers, providers, caregivers & patients together to solve “wicked” problems in the pond.

Activity:

- ❖ Follow the frogs – jump along the path of the major events in our research.
- ❖ Catch a quote – listen to the voices of the patients, providers and caregivers we met on our journey.
- ❖ Flip the lily pads - discover the many ways we are helping to build a more sustainable pond by sharing our research with others.

Notes:



Station #5: The Rural Vegetable Garden

Be sure to tour the healthy vegetable garden hosted by the London site team. At the InfoRehab - Rural garden, we map out the travels of our patients for you. How far do you think they travelled? Come see how patients and their family caregivers feel about transitional care after a hip fracture. Decide for yourself if health care providers agree. Test your knowledge by playing an exciting game of InfoRehab Jeopardy and glean some tidbits from our study of care transitions in a rural setting – let's see if your team can win!

Key Messages:

- ❖ Rural setting can influence transitions positively and negatively
- ❖ Families need to have key information exchange to make decisions
- ❖ Transitions are smoother when patients and families experience a relationship of trust and respect with their health care providers

Activity:

- ❖ Test your knowledge of the London Rural InfoRehab site you have gained from our station by playing **InfoRehab Jeopardy**. This interactive game contains 5 categories related to our site: Study Site, Patients, Family Caregivers, Health Care Providers and Themes. Workshop participants will be divided into 3 teams – the team with the highest score wins a prize! Good luck!

Notes:

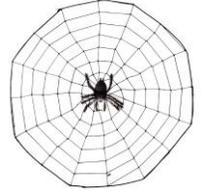
Station #6: The Zen Garden of Knowledge Translation



Uncover the secret of creating messages that “stick”. Simplicity is just one of the principles – can you unearth the others? Turn over your knowledge translation thinking by seeing some innovative ways to engage care providers in person, through interactive e-Learning and using arts-based approaches. Spend a few moments sipping tea and browsing through our favourite books about creating memorable presentations and managing change.

Notes:

Station #7: Making Connections – Spider-Web Networking Board



Do you have specific expertise or experience that you could offer to fellow workshop participants? Are you seeking any particular skills, advice or to just network with others? If so, then get caught up in our spider-web networking board! Complete the 'help wanted advertisement' in your workshop folder and place it on our spider-web networking wall.

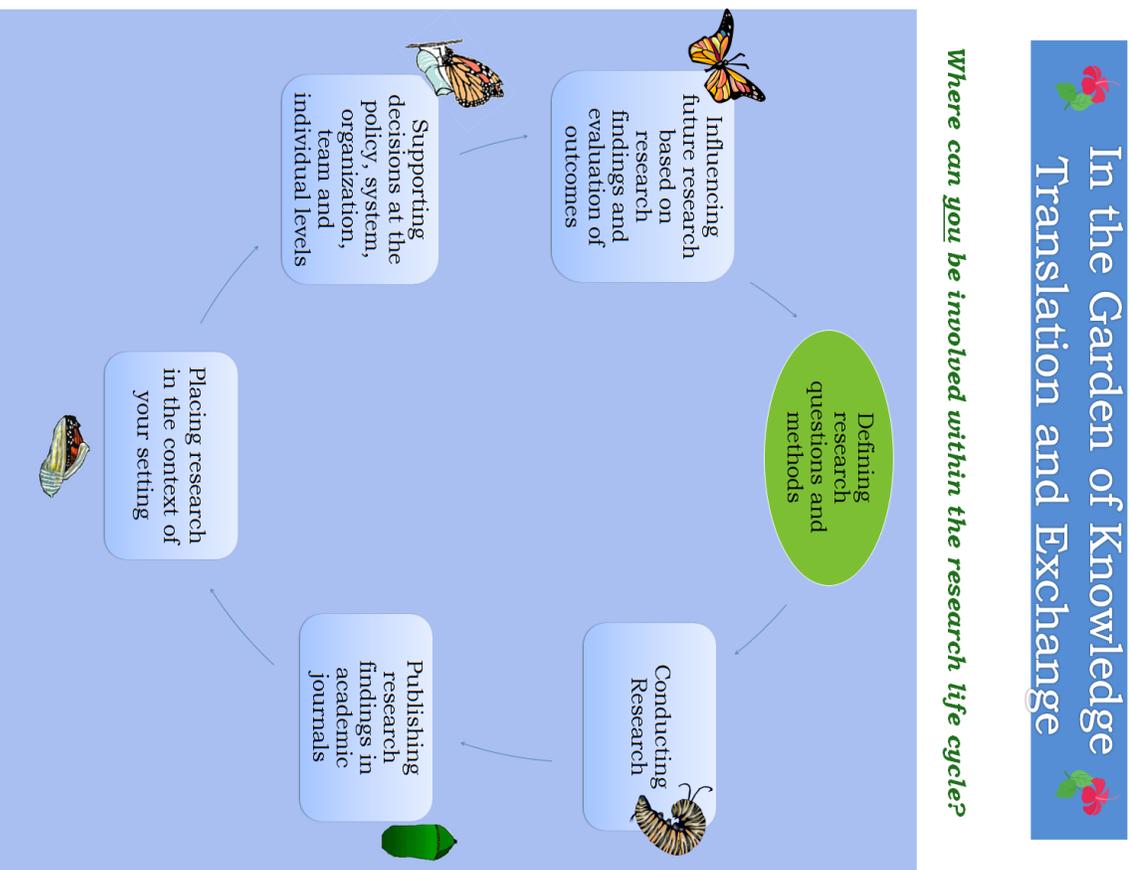
You never know whose web you could get tangled in!

Notes:

Appendix B: Station 1 - The Garden of Knowledge Translation and Exchange Poster

Knowledge Translation

*"The exchange, synthesis, and ethically-sound application of knowledge – within a complex system of interactions among researchers and users – to accelerate the capture of the benefits of research for Canadians through improved health, more effective services and products, and strengthened health care system."***



Knowledge Exchange

*"Collaborative problem-solving between researchers and decision makers that happens through linkage and exchange. Effective knowledge exchange involves interaction between knowledge users and researchers and results in mutual learning through the process of planning, producing, disseminating, and applying existing or new research in decision-making."***

* Canadian Institutes of Health Research (2004). Knowledge Translation Strategy 2004-2009. Innovation in Action. Canadian Institutes of Health Research [On-line]. Available: www.cihr-irsc.gc.ca/e/26574.html

** Canadian Institutes of Health Research (2010). More About Knowledge Translation at CIHR. Available: <http://www.cihr-irsc.gc.ca/e/39033.html>

Appendix C: Station 3 - Student Posters



Family Caregivers' Contribution to Knowledge Exchange During Transitions Following a Patient's Hip Fracture

JB Elliott¹, D Forbes², BM Chesworth¹, HA Johnson¹, P Stolee³ & the Inforehab Team
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Introduction

- Family caregivers are frequently involved in the health care of their loved ones.
- Knowledge translation is defined as “a dynamic and iterative process that includes the synthesis, dissemination, exchanged and ethically sound application of knowledge to improve health, provide more effective health services and products and strengthen the health care system”¹.
- The PARIHS (Promoting Action on Research Implementation in Health Services) framework² combines evidence, facilitation and context to transfer knowledge into practice successfully.
- Despite this understanding, the contribution to knowledge exchange by family caregivers during transitions is still lacking.

Purpose: To determine contributions that family caregivers make to knowledge exchange during transitions between and within health care settings.

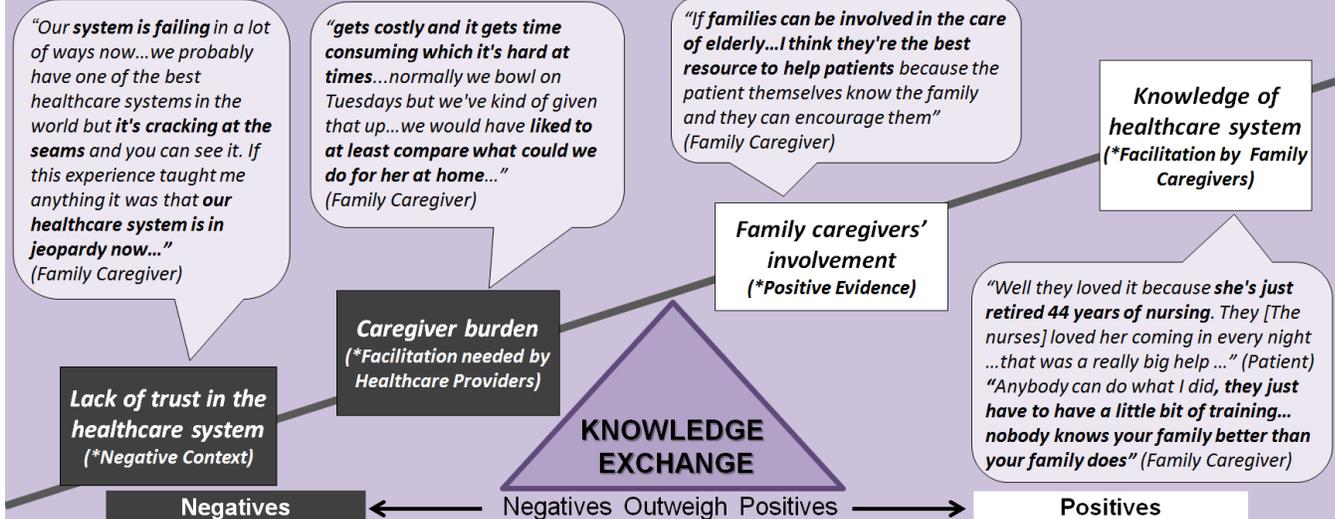
Methodology

- Purposive sample: 11 networks (patients, family caregivers and healthcare providers)
- Interviews, observations, document reviews were done at each transition
- A total of 55 interviews were completed
- Thematic data analysis

Using the PARIHS Framework*

- **Evidence** – Source of Knowledge (Family Caregiver)
- **Facilitation** – Support (information and options, exchanged between caregivers and providers)
- **Context** – Environment (Health care system)

Findings



Key Messages

- Family caregiver involvement in knowledge exchange facilitates transitional care.
- Family caregiver's prior knowledge of the healthcare system contributes to a more healthy transition.
- Knowledge exchange in care transitions is threatened by family caregiver burden, and family caregiver's negative perception of the healthcare system

Recommendations

- An ideal model of transitional care should leverage the contribution to knowledge exchange by family caregivers.
- For families who are unfamiliar with the healthcare system, it is important that health care provides facilitate their involvement.



Acknowledgements:
 Funding provided by Canadian Institutes of Health Research (CIHR), emerging team grant
 Study site collaborators: Loretta Bourke, Laurie McGill & Laura Marshall (Middlesex Hospital Alliance)

References:
¹CIHR (2009). Retrieved from <http://www.cihr-irsc.gc.ca/e/29418.html>
²Kitson, A., Rycroft-Malone, J., Harvey, G., McCormack, B., Seers, K., & Titchen, A. (2008). Evaluating the successful implementation of evidence into practice using the PARIHS framework: theoretical and practical challenges. *Implementation Science*, 3, 1-12.



Introduction

Hip fracture patients represent a population of vulnerable, frail elderly in the health care system, who are increasing in number at the same time as mounting economic pressures are affecting health care system capacity. These patients are cast into an unexpected journey through this system, as they transition through multiple care environments. Each transition requires health care providers to exchange important information as they hand off care to the next care provider, striving to ensure continuity of care for the patient. With a greater percentage of elderly, the rural setting provides a unique context to study care handoffs as this patient population undergoes health care transitions.

Definitions

Handoff: "a process in which information about patient/client/resident care is communicated in a consistent manner" from one health care provider to another.¹

Continuity: "the degree to which a series of discrete health care events is experienced as coherent and connected, and consistent with the patient's medical needs and personal context"²

Purpose

This study examined the process by which health care providers exchange information as they hand off care of hip fracture patients within a rural health care system environment.

Methodology

Purposive sample: 11 networks (patients, family caregivers, health care providers)

Ethnographic approach:

- interviews, observation, document review
- at each stage of recovery journey
- total of 55 interviews
- thematic data analysis

Findings

A variety of care trajectories were travelled by patients. Handoffs and information exchange differed by type of care setting involved in the handoff.

Mismatch of "medical needs" vs. "care needs" info

"... the co-morbidities haven't been addressed ... then they get back here ... it's been a transfer in, you have surgery and transfer back, that's all they've been doing, and then we can get into some nightmares..."

"Once they're discharged, they're technically no longer in our circle of care, so you can't actually do a follow up."

Info needs vary by stage of recovery

"I would like to see precautions. ... what is their weight bearing status; or other precautions that I need to know as a physio."

"Sometimes we get it, not usually, no. Sometimes we miss it, because it comes up to two weeks after they've already come here ... so it's past when we've been looking for it"

Loss of accountability across settings

Info doesn't always reach target

Key messages

- Health care providers in one rural setting may not have an adequate understanding of the full scope of information needed by the care provider in the next setting.
- Continuity of care is challenged if information is not received in a timely manner, if wrong information is received, or if no information is received.
- Challenges of information exchange at handoffs reveal that silos of care persist in rural health care.

Recommendations

- Appropriate methods to facilitate the understanding of the information needed by care providers in various rural settings need to be identified.
- Integrated models which expand the circle of care need to be developed to strengthen accountability across settings and improve continuity of care in order for frail elderly patients to realize optimal outcomes.



Acknowledgements: Funding – provided by Canadian Institutes of Health Research, Emerging Team Grant
 Study site collaborators – Loretta Bourke, Laurie McGill, Laura Marshall – Middlesex Hospital Alliance

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System navigation roles to support chronically ill older adults through health transitions:

A review of the literature

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Background

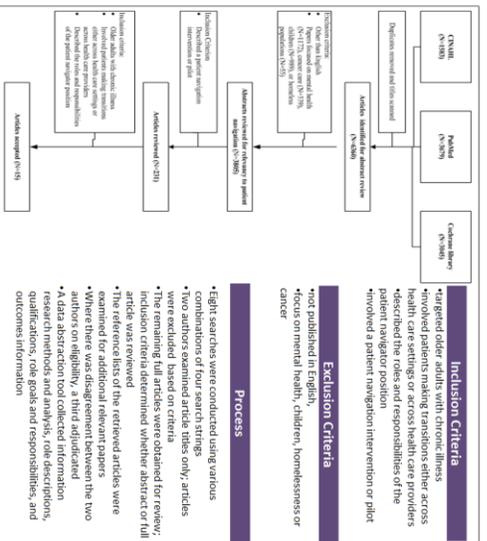
Transitions between various health care services are potential points for fragmented care, and can be confusing and complex for patients and formal and informal caregivers (Ma, Coleman, Fih, Lin, & Kramer, 2004; Boyd et al., 2007). These challenges are compounded for older adults with chronic disease, as they receive care from multiple health care providers in multiple care settings (Golden, Tawary, Dang, 2010). With fragmentation come threats associated with the incomplete transfer of information between health care providers (Kripalani et al., 2007), and greater challenges in managing and coordinating care delivery to ensure optimal outcomes (Golden Tawary, Dang, Roos, 2010; Gratchek, 2000). One innovation in the use of health care workers whose role is to facilitate safe and effective transitions across health care settings, roles commonly referred to as patient or system navigators.

While a number of system navigation models have been developed, there is a lack of consensus regarding the desired characteristics and effectiveness of this role. One-to-one navigation-type roles for high risk patients have been documented in many health care sectors. Generally, target populations include those for which medical complexity and circumstances require additional support in accessing appropriate care.

Objectives

We conducted a systematic review to describe existing patient navigator models which detail the use of a health care worker to assist chronically ill, elderly patients one-on-one as they navigate the transition across a healthcare setting, and to investigate the potential impact of each model.

Methods



Results

15 Papers from 10 System Navigation Models

Types of Studies:

- 13 Randomized controlled trials
- 1 Qualitative
- 1 Descriptive

Outcomes Measured:

- Hospital readmissions
- Time until next admission
- Cost to hospital, community services
- Satisfaction
- Psychological well-being
- Mental quality of life
- Adherence to self-care regimens
- AID and IADL improvements
- Quality of care

Common Elements of System Navigation Roles

Qualifications:

- Post-secondary healthcare training (RN or MSW)
- Advanced gerontological training

Responsibilities:

- Skilled home visits and/or phone support/availability
- Medication management
- Care or treatment planning
- Service or care provider access and coordination
- Patient advocacy
- Patient and family education
- Assessment and management of health status
- Collaboration with health care providers

System Navigation models demonstrating positive outcomes include: Transitional Care (Naylor, 2004), Care Coordination (Clarhorne, 2006), Post-Acute Care Coordinator (Lim et al., 2006), Care Transitions (Parry et al.), Partners in Care (Blaha, 2000), Post-Acute Care Coordinator (Krichbaum, 2007), and Guided Care Nurse (Bout et al., 2008)

Discussion and Conclusions

- Balancing the medical and non-medical approaches to system navigation may help achieve positive outcomes for both the patient, caregivers and the system
- Weighing the individual patient's needs and therefore the time commitment provided by the navigator and the duration of the intervention will ensure optimal resources allocation is matched with appropriate levels of service as patients transition from one care setting to another, it's not "one-size-fits-all" (Blaha, 2000)
- Transition from hospital to home, evidence suggests the intervention should start prior to discharge, have necessary clinical skills to recognize "red flags"
- Degree of patient advocacy is often determined by the funding model for the navigation role; gate-keeping expectations may therefore limit their advocacy and facilitating capabilities to what is affordable rather than what is necessary (Egan, Anderson & McTeggart, 2010)
- Navigation roles could enhance the use of technologies to facilitate information exchanged to improve provider, patient and caregiver interactions, but also separately accomplish information exchange to allow patients to become more engaged in their care and understanding options available to them
- Mixed records of success for this role in its infancy, warrants further development and testing on quality of care and cost of care

Acknowledgements

We gratefully acknowledge the support of the Inforehab staff at the University of Waterloo who contributed to this study. This research was supported by an Emerging Team Grant from the Canadian Institutes of Health Research.

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The manuscript for this systematic literature review has been submitted for peer-review publication.

Heterogeneity Among Home Care Clients: A Cluster Analysis of Rehabilitation Service Users in the Ontario Home Care System

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Introduction

The home health care system in Ontario provides a variety of services to a large number of individuals throughout the province. Included in this array of home health services are rehabilitation therapies (physical therapy (PT) and occupational therapy (OT)), which have been demonstrated to be both feasible and effective for older persons in home-based settings.

Researchers and policy makers have long recognized that home care populations are heterogeneous yet little research has focused on this phenomenon. Population health research studies tend to focus on predictors of outcomes and place less emphasis on exploring the individual differences within their populations under study. Only recently have researchers begun to specifically analyze the heterogeneity that exists within patient populations.

As the large number of older home care clients receiving PT and OT services increases with our aging population, it is important that we develop an improved understanding of these elderly patients in order to better plan and deliver health care services to them. Little is known about whether distinct types of rehabilitation users exist as the heterogeneity within this client population is drastically understudied. The development of this knowledge is possible through the use of data mining in available health data.

Objective

As part of a CIHR sponsored study on rehabilitation services for home care clients (InfoRehab), this study's aim is to develop client profiles by examining how clients that utilize rehabilitation services cluster together based upon their initial assessment data.

Methodology

For this exploratory cluster analysis, we utilized the RAI-HC data of 150,253 clients who received rehabilitation services (OT or PT) within the first 3 months of their initial home care assessment. Due to the large number of variables available within this assessment data, variables that were used in the clustering analysis were selected due to their relevance to rehabilitation service use. In total, 37 variables were used for the clustering analysis and these included ADLs, IADLs, disease diagnoses, demographic characteristics, gender, outcome scores, and age. To search for patterns in these clinical features we used a K-means methodology (nearest centroid sorting). K-means clustering is a popular partitive clustering algorithm that was chosen due to its ability to reach convergence on a solution in large data sets in a short amount of time.

Results

The K-means cluster analysis identified seven client subgroups that had distinct baseline clinical characteristics. Age, cognitive status, health instability, and functional abilities were among the attributes that differentiated the subgroups.

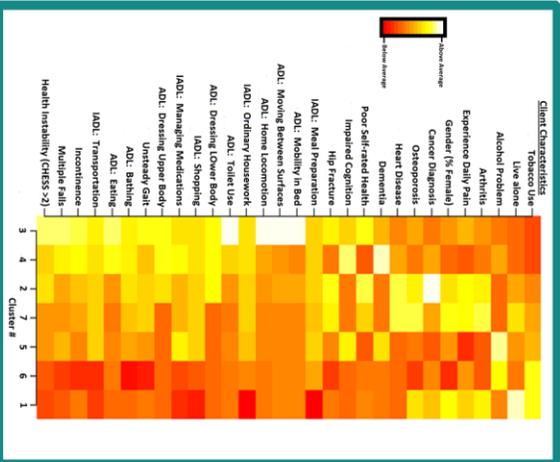
The heat map (typically used in genetic research) graphically illustrates the diversity found in this population. Clusters 3 and 4 are more impaired than the "average" client while clusters 1 and 6 require much less assistance. Clusters 2, 5, and 7 are somewhere in between. Variation still exists within each cluster; however, this segmentation task created 7 relatively homogeneous groupings based on a range of items.

Below, along with some details on the overall sample, are brief descriptions of the 7 rehabilitation client clusters. These descriptions can be considered as profiles. Each cluster varied significantly on the various characteristics available in the RAI-HC data system.

Rehabilitation Service User Profiles

| Entire Sample | Cluster 1 (10%) | Cluster 2 (14%) | Cluster 3 (9%) | Cluster 4 (23%) | Cluster 5 (19%) | Cluster 6 (10%) | Cluster 7 (15%) |
|---|---|--|--|--|---|---|--|
| Female 63% Average Age: 76.9 Average ADL: 18.9 Average IADL: 14.6 Average Health Instability: 1.7 | Older Females who live alone and need assistance with household and bathing | Older Females who need assistance with IADLs and some ADLs | Frail elderly with cognitive problems who are extremely dependent and immobile | Cognitively impaired, dependent but mobile elderly | Elderly needing assistance with IADLs and bathing | Relatively younger impaired males who need assistance with meals, household, and shopping | Functioning elderly females who need assistance with IADLs |

K Means Cluster Analysis: Heat Map



Discussion

Our findings support the view that rehabilitation home care clients are a heterogeneous group that can be broken down into homogeneous subgroups based upon baseline assessment data. These findings are exploratory and require further validation. Through gaining knowledge of this diversity, researchers, policy makers, and home care planners are better able to understand the utilization of rehabilitation services in the home care sector. In view of these findings, as well as the ever increasing amount of health data available, cluster analysis can play a role as a starting point in order to elucidate the naturally forming subgroups or clusters within patient populations. Future research directions include using clustering techniques prior to predictive analyses in order to understand how predictor variables differ between subgroups when modeling various outcomes and resource uses.

TAKE HOME POINTS

- Heterogeneity exists within the population of older home care rehab clients. By applying K-means clustering to clinical assessment data, we profiled seven client clusters ranging from those who needed light assistance to those who were entirely dependent.
- These results demonstrate that cluster analysis can be used as a tool to organize and identify patterns within the rich arrays of clinical information.
- Due to limited resources and an increasing need, we need to improve our understanding of the diversity within client populations. Such an understanding will lead to more effective and more efficient delivery of services.

Appendix D: Station 4 - Just Another Fish in the Pond Poster (Qualitative)

Planning: 2005-2009

- Inforehab Home Care grant funded (HCT and HCT)
- Inforehab Transitions (RT) grant funded
- RT face-to-face workshop

Ethics

- ORE: September '09
- GRH: September '09
- THREB: October '09
- CCAC: May '10

Pre-Field Work: September – December 2009

- Development of interview guides, observation and chart review guidelines
- Weekly review of Grand River Hospital (GRH) patient characteristics to determine eligibility
- Conducted healthcare provider key informant interviews
- Collected relevant documents from each site
- Held information sessions about the study
- Conducted initial site observations
- Developed sensitizing concepts document
- EHR Training
- Distributed "inpatient recruitment packages"
- Summary handouts
- Observation guide

Piloting: January – March 2010

- Nvivo training session for investigators
- Held patient information sessions
- Conducted total of 8 interviews (with patients, informal caregivers, health care providers)
- Transcription and analysis of interview data
- Completion of participant characteristics document

Fieldwork: April – December 2010

- Held Waterloo Nvivo training session
- Ongoing recruitment of health care providers and patients
- Conducted interview and site observations
- Conducted interviews with healthcare providers and patients
- Transcription of interview data
- Modified recruitment strategy

"There's more to health than just physical health. I guess that's how I'm feeling here. You're just another fish in the pond. And when they come along with the hook they'll pull you up and if you're trout they'll put you one place, and if you're bass they'll put you another place, and if you're pike, they'll put you another place."

- Mrs. Arthurs, hip fracture patient on inpatient rehabilitation unit.

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Appendix D Continued:

Quotes:

“There’s more to health than just physical health. I guess that’s how I’m feeling here. You’re just another fish in the pond. And when they come along with the hook they’ll pull you up and if you’re trout they’ll put you one place, and if you’re bass they’ll put you another place, and if you’re pike, they’ll put you another place.” - Patient

“It’s not that I don’t remember, I wouldn’t know [who to ask] anyway because you don’t know whether they’re nurse, health provider or whether they’re just one of the people that serve the meals. You don’t know...” – Patient

“I just think it was pretty unsettling for my mom. To just sort of be yanked out of the hospital and taken to Freeport.” –Caregiver

“I don’t communicate with the case managers there verbally or by voicemail or anything. They have access to all our charting. So they see what we’ve done, and um... then they send over transfer package with the patient, so the staff nurses there know what’s going on. And the PT notes are accessible at both sites.” - Health care provider about CCAC

“I mean there are always areas to improve and I think one of the biggest problems right now that we’re facing is that there is pressure to have people discharged quickly, and there may not be always services available for them when they go home. And a lot of time we would like to keep people here longer than we do.” - Occupational Therapist

“I just feel that you leave acute care and boom, you got something else. There’s no preparation for the patient. There’s no communication between those. So you come from one when you’ve gotten this, you go to another the next day where you don’t get that, but you do have to do this, you don’t have to do that. It’s just overwhelming”—Patient

Appendix D Continued:

KT Strategies at Waterloo

Past Initiatives:

- ❖ Poster presentation at NICE (2010)
- ❖ Oral presentation at UW Graduate Research Symposium (2010)
- ❖ InfoRehab Sharepoint group (2009)
- ❖ InfoRehab website (2009)
- ❖ InfoRehab Bulletin (2009)
- ❖ IRT workshop (2009)

Upcoming Initiatives:

- ❖ Manuscript in process- “Examining culture in transitional care- A multi-perspective analysis”
(tentative title)
- ❖ Freeport Coffee Day

WATERLOO'S QUANTITATIVE AQUARIUM OF KNOWLEDGE TRANSLATION

Predicting rehabilitation potential using machine learning
Journal of Clinical Epidemiology, 2007
BMC Medical Informatics and Decision Making, 2007

Predicting rehabilitation use in home care
Presented at 2010 CAG

Risk factors for hip fracture in older home care clients.
Journal of Gerontology, Biology and Medical Science, 2009

Predicting functional outcomes for MSK patients receiving home care: Does rehabilitation make a difference.
Presented InfoRehab KEP Workshop, 2010

Frailty measures to predict outcomes for home care clients
Presented at 2010 CGS

Heterogeneity among home care clients: A cluster analysis of rehabilitation service users in the Ontario home care system.
Poster at 2010 CAG

“Creating evidence for rehabilitation for older persons with MSK disorders through advanced statistical analyses of health information databases”

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Appendix F: Station 7 - Spider-Web Networking Board Advertisement

Name
Affiliation



Experience & Expertise to Offer

Help Wanted

(Seeking Experience, Skills, Networks, Advice from others)

| | |
|------|---------------------|
| Name | Contact Information |
| Name | Contact Information |