THE CHANGE FOUNDATION

ENGAGE, EXPLORE, EVOLVE

LESSONS FROM
CHANGING CARE

Sustainability and Spread of Change Initiatives

NOVEMBER 2020

CHANGING CARE

ABOUT THE CHANGE FOUNDATION

The Change Foundation is an independent health policy think-tank that works to inform positive change in Ontario's health care system. With a firm commitment to engaging the voices of patients, family caregivers, and health and community care providers, the Foundation explores contemporary healthcare issues through different projects and partnerships to evolve our healthcare system in Ontario and beyond. The Change Foundation was created in 1995 through an endowment from the Ontario Hospital Association and is dedicated to enhancing patient and caregiver experiences and the quality of Ontario's health care.

ACKNOWLEDGEMENTS

The Change Foundation would like to acknowledge the four Changing CARE project teams for their hard work and dedication to improving the experiences of family caregivers in their respective communities:

- **Connecting the Dots for Caregivers** – Huron Perth Healthcare Alliance, Alzheimer Society of Perth County, the North Perth Family Health Team, ONE CARE Home and Community Support Services, the South West Local Health Integration Network and the STAR Family Health Team.
- **Cultivating Change** - Sinai Health System and WoodGreen Community Services.
- **Embrace** - Cornwall and District Family Support Group and the Cornwall Hospital Community Addiction and Mental Health Program.
- **Improving CARE Together** – all sites of St. Joseph's Health Care London.

We thank the project teams for sharing what they have learned when they engaged with caregivers and providers to co-design new processes of care and innovative solutions to long standing challenges.

The Foundation would like to acknowledge the hard work and creativity offered by the many caregivers and providers who participated in the Changing CARE projects. As a result of their efforts to co-design, test, implement and spread change initiatives, the experiences of caregivers and providers will be improved in their communities.

The Change Foundation would also like to acknowledge Sue Bhella, Senior Program Associate, for her leadership in the development, validation and writing of this *Lessons from Changing CARE* report.

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MESSAGE FROM THE VICE CHAIR OF THE BOARD OF DIRECTORS

In 2015, the Change Foundation launched its strategic plan – *Out of the Shadows and Into the Circle* – which focused on improving the experience of family caregivers as they supported patients in their healthcare journey.

Following a competitive selection process, in 2017 the Foundation identified four key partnerships from across Ontario to receive funding and support over three years to improve the caregiver experience within their local communities. All four Changing CARE partnerships were formed with caregivers in key design and decision-making roles – caregivers were included every step of the way, making adaptations for the setting and remaining flexible and open to the spirit of co-design.

As President and CEO of the Cornwall Community Hospital, I was thrilled that, because of our partnership with the Cornwall and District Family Support Group, we were selected as one of the four Changing CARE projects. More recently, I have served on the Board of Directors of the Change Foundation where I have been honoured to help guide its work to improve the experience of family caregivers.

I am delighted to share with you the final Lessons from Changing CARE report, the fourth in a series that focus on learnings from across the Changing CARE projects. The first report presents practical, how-to tips to help guide organizations in their caregiver and provider engagement efforts as they embark on the discovery phase. The second report focuses on what the projects learned from their initial co-design events to address priority areas for improvement. The third report presents recommendations on how to test and implement co-designed change initiatives. This fourth report focuses on what the Changing CARE projects learned about sustainability and spread of change initiatives during the project and beyond the project funding period.

The Change Foundation advised the four projects to think early and often about how we would sustain and spread the many tools and resources that emerged from our Changing CARE partnerships. The four Changing CARE projects were headed into the final stretch of executing plans for sustainability and spread in early 2020. However, with COVID-19 and the rapidly evolving pandemic, many efforts to spread and scale were delayed. This report highlights adaptations made to sustainability and spread plans.

The Changing CARE partner organizations are well positioned to play a leadership role in system transformation that begins with building a culture across healthcare that recognizes, values and supports family caregivers as partners in care. We have also been fortunate to develop expertise in co-design and we have patients, caregivers and providers with co-design experience.

This is the conclusion of a significant piece of work for the Change Foundation of which I was proud to be a part of.

Sincerely,

Jeanette Despatie,
Vice Chair, Board of Directors, The Change Foundation
President and CEO, Cornwall Community Hospital

INTRODUCTION

Who are the Changing CARE projects?

The overall goal of the Changing CARE projects was to improve the experience of family caregivers as they interact with the health system and improve the capacity of the system to support caregivers. Co-design was a fundamental feature of the Changing CARE projects. The Changing CARE project teams co-designed change initiatives that were implemented, sustained and in many cases adapted to spread to other units, programs or organizations. The following is a brief description of the four Changing CARE projects. Appendix 1 provides a summary and description of change initiatives that are referenced in this report.

CHANGING CARE
CONNECTING THE DOTS FOR CAREGIVERS

Connecting the Dots included six local health care organizations and family caregivers to create tools and resources to help caregivers feel more supported, valued and engaged in their role. Project partners included the *Huron Perth Healthcare Alliance, Alzheimer Society of Perth County, the North Perth Family Health Team, ONE CARE Home and Community Support Services, the South West Local Health Integration Network and the STAR Family Health Team*. There were three streams of work: (i) awareness and recognition; (ii) communication and information; (iii) education, training and supports.

CHANGING CARE
CULTIVATING CHANGE

Cultivating Change aimed to co-design a caregiver-friendly hospital and community. The project partners in Toronto—*Sinai Health and WoodGreen Community Services* – focused on building a culture of care in which caregivers were partners, and where caregivers were formally identified, valued for their deep knowledge and actively listened to. The team undertook work in the following four areas: (i) neonatal intensive care; (ii) stroke care; (iii) community; and (iv) caregiver resilience for individuals with serious illness.

CHANGING CARE
EMBRACE J'EMBARQUE

Embrace aimed to improve interactions between family caregivers and providers with a focus on caregivers of those with mental health and addiction challenges. The project partners were the *Cornwall and District Family Support Group* and the *Cornwall Community Hospital*. Embrace's six streams of work were: (i) family inclusion; (ii) caregiver support; (iii) provider education; (iv) young carers; (v) sharing our story; and (vi) a physical and virtual resource hub.

CHANGING CARE

IMPROVING CARE TOGETHER

Sustainability:
How do we hold the improvement gains over time?

Spread:
How do we engage individuals to adopt changes in different contexts?

Improving CARE Together aimed to improve family caregiver engagement and acknowledgement in program planning and direct clinical care at all sites of *St. Joseph's Health Care London* – St. Joseph's Hospital, Parkwood Institute, Mount Hope Centre for Long Term Care and the Southwest Centre for Forensic Mental Health Care. Improving CARE Together undertook work in three streams: (i) family caregiver involvement; (ii) family caregiver education and training; and (iii) care transitions.

The Changing CARE projects collectively co-designed and implemented **over sixty change initiatives**. The projects pursued both similar and unique efforts to support sustainability and spread of their change initiatives to ensure that they continued beyond the funding period.

The Change Foundation played a role in supporting sustainability and spread:

- through the project contracts, we required the teams to plan early for sustainability and spread;
- by establishing and supporting cross-project coordinating groups with additional expertise (in research and caregiving) to develop a measurement plan and evaluation tools; and
- by providing learning and capacity building opportunities for the project teams.[1]

A number of key documents have guided our thinking on sustainability and spread:

- The National Health Service (NHS) model for sustaining change[2];
- The Institute for Healthcare Improvement (IHI) framework to sustain improvement;[3] and
- Health Quality Ontario's guidance on implementing and sustaining change.[4]

How is the report organized?

The report focuses on twelve learnings from the Changing CARE projects on their efforts to sustain and spread project change initiatives. As in previous *Lessons from Changing CARE* reports, the twelve learnings are organized under three categories: people, process and place. Organizing the learnings under these three categories made sense as the categories are similar to those in the NHS model for sustaining change (staff, process, organization) and are consistent with how the IHI approaches improvement. Each of the learnings are illustrated by stories and examples from the Changing CARE projects.

[1]Learning event for the Changing CARE teams on "Scale and Spread Across Your Organization" by Dr. Michael Posencheg, Institute for Healthcare Improvement (IHI) Faculty in January 2019.

[2]National Health System. 2010. Sustainability model and guide. National Health System. Retrieved August 24, 2020 from: https://improvement.nhs.uk/resources/Sustainability-model-and-guide/

[3]Hilton K, Anderson A. Psychology of Change Framework to Advance and Sustain Improvement – IHI White Paper. Boston, Massachusetts: Institute for Healthcare Improvement; 2018. Retrieved August 8, 2020 from: http://www.ihi.org/resources/Pages/IHIWhitePapers/IHI-Psychology-of-Change-Framework.aspx

[4]Health Quality Ontario (HQO). 2013. Quality improvement primers: Implementing and sustaining change. Retrieved August 24, 2020 from: http://www.hqontario.ca/Portals/0/documents/qi/qi-implementing-and-sustaining-changes-primer-en.pdf


Think
Says
Does
Feels

SUMMARY LIST OF LEARNINGS:

PART A: PEOPLE

1. Ensure that a **senior leader is accountable** for the sustainability and spread of change initiatives.
2. **Leverage the support of social influencers, advocates, champions and ambassadors** to sustain and spread change initiatives.
3. Ensure your project team has the **human resource capacity** to purposefully participate in efforts to sustain and spread change initiatives.
4. **Enable participants from the earlier phases of the project** – discovery, co-design, implementation – to support sustainability and spread efforts as volunteers.

PART B: PROCESS

5. Build **meaningful and purposeful awareness and educational materials** to influence culture, maintain 'top of mind' status and generate adoption of change initiatives.
6. Develop **tools and resources to build the knowledge and skills** staff will need to sustain and spread the change initiative.
7. **Embed change initiatives in existing corporate planning and measurement structures** as well as in **service level delivery** and workflows to sustain and spread shifts in culture, behavior and practice.
8. Proactively **enable ownership and accountability at the unit/ program level** – transition the change initiative's ownership and accountability from the project team (that co-designed, tested and implemented) to the setting where it has become the new status quo.

PART C: PLACE

9. Ensure change initiatives are **aligned to corporate/organizational priorities**.
10. Be prepared to **adapt change initiatives as you spread** them throughout different units, departments and programs within an organization or in new organizations – **there is no one size fits all**.
11. **Pursue and leverage partnerships, collaboratives, networks and opportunities** to sustain and spread change initiatives.
12. Pursue change initiatives that achieve **alignment of behavior change, practice change and culture change** – once change has become integrated into day-to-day practice as the norm, the change initiative may not be required as is and may need to evolve.

PEOPLE

A. PEOPLE

This section will describe and illustrate key learnings related to how people—patients/clients and caregivers, frontline providers and staff, executive, managerial and clinical leaders, experts in specific areas—can meaningfully contribute to efforts to sustain and spread change initiatives.

1. **Ensure that a senior leader is accountable for the sustainability and spread of change initiatives.** Accountability ensures ownership, strengthens culture, sets expectations and performance measures for achievement of common goals, builds trust and empowers staff.[5] Accountability for change initiatives can identify where progress may be lacking or regressing even after the initiative has been fully implemented. By tying accountability of change initiatives to the portfolio of a senior leader, requirements to regularly track performance and report to a board of directors are established and the change initiative is viewed as a priority.

During changes in leadership, ensure a transfer of accountability to reduce the risk of regression. Be purposeful and explicit in the transfer of accountability and leverage the opportunity to reexamine elements of accountability.

Cultivating Change: Given the natural alignment of the project with the corporate focus on patient and family-centred care, accountability for the project was assigned to two senior leaders – the Vice President of Quality and Clinical Programs and the Senior Director of Quality and Patient Experience at Sinai Health. These senior leaders were able to make organizational decisions, including strategically positioning the project within broader corporate initiatives and including it in the Quality Improvement Plan (QIP)[6] which ensured measurement and overall accountability at a corporate level. The two senior leaders had a responsibility to report progress quarterly to the Board to ensure the strides made towards family-centred care were maintained overtime. Sinai Health hired a Program Lead of Patient and Family Engagement who established a corporate Patient and Family Advisory Council at both the Mount Sinai Hospital and Bridgepoint Active Healthcare campuses. This role supports unit and program councils and acts as a resource to organizational project teams who are looking for patient and family caregiver partners, ensuring all partners are prepared to work together.

Improving Care Together: The project team purposefully leveraged the Corporate Steering Committee and the Leadership Development Institutes[7] to engage with leaders across St. Joseph's Health Care London to sustain and spread the project's change initiatives. With accountability established among two senior portfolios – Vice President of Patient Care and Risk Management and Vice President of Patient Care and Chief Nursing Executive—leaders from across the organization learned how

[5] See: https://www.forbes.com/sites/brentgleeson/2016/12/08/why-accountability-is-critical-for-achieving-winning-results/#1008c91d45e1

[6] See Quality Improvement Plans at https://www.hqontario.ca/quality-improvement/quality-improvement-plans for more information.

[7] Studer Group is an advisory firm that partners with organizations to develop strategies to align leadership teams and improve organizational culture (https://www.studergroup.com/company/about-studer-group).

the change initiatives and project were aligned with the corporate Care Partnership Framework and supported the organization's short and long-term goals. These platforms enabled the sharing of a common understanding and were pivotal in fostering spread of several change initiatives across the organization. As the funded project came to an end, the accountability shifted to one senior leader for continued oversight and sustainability.

Connecting the Dots: With six organizations involved, leaders from each partner organization formed the Steering Committee, along with caregivers and project team members. For most organizations, Executive Directors acted as representatives on the Steering Committee. For the Huron Perth Healthcare Alliance, the Vice President of Partnerships and Chief Nurse Executive served as executive sponsor for the project. The leaders were accountable for raising awareness and driving change during engagement, implementation and through sustainability planning and spread throughout their organization and across Huron Perth. Each organization also identified operational leaders who played a key role in education and implementation of the change ideas and planning for organizational sustainability.

2. **Leverage the support of social influencers, advocates, champions and ambassadors to sustain and spread change initiatives.** Throughout the *Lessons from Changing CARE* reports the importance of identifying and building champions – individuals who are instrumental in leading or promoting change – is highlighted. Champions tend to be well connected to their peers and colleagues; are trusted and have a credible voice; and can be found within multiple levels of an organization – executive, managerial, clinical and supportive (e.g., porters, custodians, dietary staff). Traditionally, influence has been associated with hierarchy (i.e., senior leadership). However, people who are highly connected – "super connector" – can be more influential in change compared to people with hierarchical power.[8] Regroup with champions from the earlier phases of the project as they can garner support and commitment to sustain and spread change initiatives among their colleagues.

Embrace: Recognizing the potential impact of champions, the project team engaged with staff at Cornwall Community Hospital who were known to be "influencers" and had not been part of the Embrace project. Staff were selected to attend a focus group not based on their

[8]Bevan, H. 2018. How to take the power to influence and transform. Chartered Society of Physiotherapy.

The 3% Rule: A mere 3% of the people in an organization, typically influence 85% of the other employees.

Find your "super connectors" Find the 3%! Source

position but based on their informal influence with their peers across the organization. Staff from dietary services, building services, nursing, clinical informatics, communications and leadership were invited. The goal of the focus group was to gain insights into the opportunities to spread the work of the project and to identify staff who were interested in joining initiatives. The insights gathered were also used to create an organizational roadmap to guide the hospital as the spread of caregiver inclusion continues past the end of the project funding.

Connecting the Dots: To maintain energy within the project, the team identified staff across partner organizations with a passion for the themes that the change initiatives addressed to create champions and ambassadors. The team utilized existing huddles or staff meetings as a platform to encourage potential champions to act as role models to colleagues. The team purposefully aligned the project with Huron Perth Healthcare Alliance's organizational framework and its existing Patient Experience Office to enable a culture shift that could continue beyond the life cycle of the project. With this alignment, the team tactfully engaged with the Corporate Lead of Patient Experience to create a champion and corporate owner of the change initiatives. At ONE CARE Home and Community Support Services, sustainability of change initiatives was incorporated into the portfolio of two organizational supervisors, ensuring that the caregiver resources and related internal processes were reviewed as standing agenda items during regular meetings at the leader and team level.

3. **Ensure your project team has the human resource capacity to purposefully participate in efforts to sustain and spread change initiatives. Typically, the capacity of a project team begins to dwindle post-implementation of a change initiative. Build up your project team by adding additional members post-implementation – this is especially important for multi-year change efforts. New team members can help bring new energy and a fresh perspective into the project and offer additional hands to do the heavy lifting to root the change initiatives deeply within the organization.**

Embrace: An "Accelerating Family Inclusion" workshop was hosted by the project team as a knowledge transfer and mobilization event to facilitate the spread of learnings and the co-designed resources and tools for providers. To spread change initiatives beyond the Cornwall Community Hospital, the project team offered interested organizations

Consider a "point person" to provide support on the "how to" as change initiatives spread to other care settings within your organization or in external organizations.

their expertise through a "living library" – i.e., project team members offered up to three hours of their time to be used in any way that could be helpful for the participating organization. For example, a team member could present to a board of directors about caregiver inclusion or meet with staff to discuss a specific resource or meet with senior leadership to set the stage for a culture change. This offer was an efficient manner to share project work in a customizable and influential way.

Improving CARE Together: The *Care Resource Binder* was initially implemented in the Specialized Geriatric Services and Spinal Cord Injury Rehab unit at St. Joseph's Health Care London. Several other managers became interested in implementing the binder in their unit/program. The project team worked with patients, caregivers and unit/program staff to co-design the customizations to the binder and coached the unit staff in implementation – requiring a turn-around time of approximately 6-8 weeks. The team experienced capacity-related challenges due to the high intensity work with the new project team through the process (e.g., weekly 1-hour meetings, bi-weekly 1.5-hour meetings). Hiring dedicated staff to support the spread of the binder would have increased the project team's ability to respond and coach multiple units at once. With the surge of interest occurring towards the end of the project, when staff numbers were dwindling down and during the onset of the COVID-19 pandemic, the team developed a "how-to" focused toolkit to enable spread (post-pandemic) and to address the team's capacity challenges. Targeting both sustainability and spread, the toolkit includes key information for new staff training and customizing the binder to new care settings.

4. **Enable participants from the earlier phases of the project—discovery, co-design, implementation—to support sustainability and spread efforts as volunteers.** It's natural for those who have been engaged through the project (i.e., patients and caregivers) to become invested and to ask for other opportunities. The relationships, connections and feeling of contributing to something larger than themselves is something patients and caregivers greatly value. Once the change initiative has been implemented, their participation does not need to end. There may be ways to carve out specific roles and responsibilities to enable continued meaningful contributions – roles on operational level committees and other supportive roles to maintain the change initiative. Enabling participation in the form of volunteerism is not novel – hospitals and other care settings rely upon volunteers to support many patient and family facing roles (e.g., way finding, gift shop operations) so continued supportive roles are not a stretch.

Provide training and orientation to enable your volunteers to feel comfortable and confident in their new roles. Consider co-designing the orientation materials and using a train-the-trainer model to help build capacity of experienced volunteers to support newer volunteers.

Embrace: At Cornwall Community Hospital, some caregivers who were part of the project from the beginning became volunteers in the *Family Caregiver Centre*, which they helped to create as one of the project outcomes. The Embrace Project Family Caregiver Advisor moved into a lead volunteer role in the Centre. Recognizing that the experience of caregivers is best understood by other caregivers, a peer model enabled the Centre to be more than just a place for caregivers to take a few minutes to themselves while in the hospital – rather they can have a cup of coffee, share their story with a peer and learn about resources they may not be aware of. The training content was co-designed with the project team, experienced caregiver volunteers, the hospital volunteer department and an outside organization with experience training for similar roles. Although developing this training was resource-intensive, the material sets the caregiver volunteers up for success and satisfaction in their role.

Cultivating Change: Recognizing that the capacity of healthcare providers to do more can be challenging, the project team worked with Volunteer Services to create and assign a Stroke Volunteer Coordinator role position within the Stroke Care unit. The Stroke Volunteer Coordinator supports the clinical team by welcoming patients and caregivers to the program, distributing the *My Stroke Recovery Binder*, reviewing the knowledge checklist and informing patients and caregivers about the educational supports (in-person at the hospital) available. The team built on the existing volunteer role with the goal of creating more meaningful engagement and having the volunteer feel like a part of the team. Due to COVID-19, volunteers were not allowed in the hospital - once precautions are lifted, this role will be resumed.


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PROCESS

B. PROCESS

This section describes and illustrates key learnings related to how process—the way things are done—contributed to effective sustainability and spread efforts.

5. Build meaningful and purposeful awareness and educational materials to influence culture, maintain 'top of mind' status and generate adoption of change initiatives. Communication is fundamental to sustaining and spreading change. Several sustainability models and frameworks highlight the dependency of adoption on understanding the 'why?', the benefits and alignment with the current environment.[9] Communication that facilitates the sharing of values and knowledge and fosters emotional connections can enable the development of trust and commitment to the change initiative.[10] Elements of change that facilitate buy-in are: responsiveness to need, compatibility with the local context, simplicity, observability and trialability.[11]

Communications that address these elements can aid with: (1) sustaining change initiatives by minimizing the risk of 'out of sight, out of mind' (i.e., seeing the promotions can serve to encourage staff, patients and caregivers to behave in a manner intended by the change initiative – e.g., family inclusion, collaboration); and (2) spreading change initiatives beyond the implementation sites by prompting thought and dialogue. Consider asking staff to develop catchy slogans or project titles to generate interest in the work.

Visual cues (e.g., posters, pamphlets, buttons) can serve as friendly reminders to maintain the new behaviour and these new behaviours can lead to a change in culture where it becomes the new norm.

To help sustain and spread change initiatives, build visual communication materials that tackle one or more of the following considerations:

- Illustrate how the change initiative is responsive to needs and the relative advantage of the change initiative compared to the status quo
- Address how the change initiative is compatible with the current context (i.e., builds within workflows)
- Discuss the impact on staff from a role, capacity, workload and workflow perspective
- Demonstrate the credibility of the change initiative by sharing where it has been implemented
- Share the benefits for staff, patients and/or caregivers and beyond
- Articulate the alignment of the change initiative to the organization's priorities and vision.

[9] National Health System. 2010. Sustainability model and guide. National Health System. Retrieved August 24, 2020 from: https://improvement.nhs.uk/resources/Sustainability-model-and-guide/

[10] Health Quality Ontario (HQO). 2013. Quality improvement primers: Implementing and sustaining change. Retrieved August 24, 2020 from: http://www.hqontario.ca/Portals/0/documents/qi/qi-implementing-and-sustaining-changes-primer-en.pdf

[11] Sahin, I. 2006. Detailed review of Rogers' Diffusion of Innovations Theory. Retrieved from: https://files.eric.ed.gov/fulltext/EJ1102473.pdf

Cultivating Change: WoodGreen Community Services co-designed the *Caregiver Commitment Statement*, a corporate promise that articulates the principles and philosophy of care that caregivers can expect from WoodGreen. Recognizing the need to root the *Caregiver Commitment Statement* and future change initiatives focused on improving the caregiver experience, WoodGreen leveraged the *Caregivers as Partners* eLearning suite to provide staff with a baseline of knowledge and understanding of the need to be patient and family-centred; evidence on the benefits for staff, patients and caregivers; and practical learnings on how to engage, support and empower caregivers. Using the eLearning as a communication tool, WoodGreen was able to raise awareness, share organizational norms and values and build emotional connections to help foster staff buy-in and sustain the new philosophy of care.
To demonstrate alignment of WoodGreen's vision and organizational commitment to becoming caregiver-friendly, the eLearning modules were made mandatory professional development for staff and were included in the orientation process for new hires. Once staff completed the eLearning modules, a badge insert of the *Caregiver Commitment Statement* was provided to commemorate the completion of training and serve as a reminder.

Connecting the Dots: The *Time to Talk Toolkit* facilitates self-recognition among caregivers (who may not identify themselves as 'caregivers') and awareness among providers of the important role caregivers play in the care team. The toolkit was utilized as a foundational precursor to evoking a culture of family inclusion and partnering with caregivers. The project team utilized a visual communication approach that included:

- strategically placing posters in high-traffic areas around the care settings;
- adding pamphlets to existing packages patients receive (i.e., client intake package) and in waiting and exam rooms;
- leveraging existing caregiver education sessions and support groups as a channel to share information about the initiative;
- developing a lanyard 'tip sheet' for staff and providers to have accessible information on how to meaningfully engage with caregivers; and
- incorporating information about the initiative into the training new hires receive.

6. **Develop tools and resources that help build the knowledge and skills staff will need to sustain and spread the change initiative.** It is important to proactively (during the co-design phase) think about how to shape a change initiative to be easily adaptable and customizable. The more complex a change initiative, the less likely it will be adopted.[12]

   Sustaining change requires:

   - tracking to evaluate whether the change initiative continues to impact the identified indicators as intended; and
   - adapting the change initiative, based on evaluation results, so it can continue to be relevant (i.e., impactful as intended, or modified to meet evolving needs).

   To sustain change initiatives, think about what new staff will need to understand, know and do—what will orientation and onboarding look like and who will it be delivered by? To spread a change initiative to a new care setting, think about what the team will need to know if the current project team is not available as a support.

Create resources that will foster:

- an understanding of the importance of the change initiative—"the why" from different perspectives (i.e., patient, provider, caregiver, system); and
- an increase in capacity—"the how" to adapt, implement, evaluate and adjust.

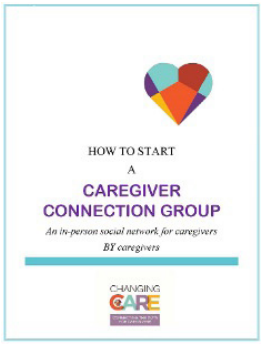
Tools such as step-by-step instructions, key considerations and checklists can facilitate easier sustainability and spread.

Cultivating Change: The *Care Team Description Wall* is a 15' x 4' adhesive vinyl poster that uses plain language to help patients and their caregivers to identify and understand the different roles of providers on the team within the unit/program. At Bridgepoint Active Healthcare, four Care Team Description Walls have been implemented (Ambulatory Care, Palliative Care, and two in In-patient Stroke). Other programs/units expressed an interest in the change initiative. To support spread the team developed an adaptable template and a how-to co-design guide and these resources were shared with programs/units within Bridgepoint Active Healthcare and with other external organizations (e.g., CorHealth Ontario, Ontario Regional Education Group).

[12]Sahin, I. 2006. Detailed review of Rogers' Diffusion of Innovations Theory. Retrieved from: https://files.eric.ed.gov/fulltext/EJ1102473.pdf

Embrace established an Implementation and Sustainability Committee to plan for sustainability and spread and guide the project streams as the project unfolded, rather than at the end. The committee developed purposeful implementation guides that supported the team in standardizing their approach and documentation for developing, piloting, implementing and sustaining the change initiatives. The template can be used as a road map for other units and care settings to use to adapt and implement the change initiative of interest.

Embrace: The Inpatient Mental Health Unit used their electronic medical record (EMR) to reinforce their caregiver identification initiative. Caregiver demographic fields such as name and phone number were built into the patient record. The tasks associated with the caregiver identification program were created in the EMR so nursing and social work could see that the caregiver received their welcome package and were part of discharge planning conversations. Staff feedback was positive as the reminders helped them track tasks to be completed and there was a sense of satisfaction when they saw all tasks completed. An important note when making changes in an EMR is to consider how to build these changes so that they are easily utilized in other departments as the change initiative spreads.



Connecting the Dots: As a partnership of six different health, community and social organizations, the project team developed organization specific reference guides to help each organization sustain and spread the co-designed change initiatives. Recognizing that implementation would differ at each site and occur at a different pace, the reference guides were created by consulting with each organization to ensure alignment between the change initiatives and the organization's priorities, goals, current programs and interactions with caregivers. A "*Consider Using When*" tip sheet was included to support staff in the implementation and use of the change initiatives. An overview of the change initiatives was consistent across the guides to help build a common understanding. Additionally, generic guides were created to support the spread of change initiatives beyond the six project partners. For example, the *How to Start a Caregiver Connection Group Handbook* provides key considerations from the Caregiver Connection Group in the Huron Perth Counties for other communities to set-up and run similar groups.

Improving Care Together: St. Joseph's Health Care London implemented the Caregivers as Partners e-Learning for providers and staff to build a foundation for a shift in culture as articulated in their *Care Partnership Framework*. To enable leaders within the organization to foster the required shifts in thinking and behaviour, a toolkit with examples of

questions to support discussions during huddles and team meetings was developed. Stemming from the understanding that knowledge needs to be coupled with personal reflection to invoke practice change[13], the toolkit is a channel to spread the learnings within the e-Learning across all staff.

7. Embed change initiatives in existing corporate planning and measurement structures as well as in service level delivery and workflows to sustain and spread shifts in culture, behavior and practice. Avoid over-complicating and over-thinking processes – simplicity can be impactful and helpful in spreading and sustaining change initiatives. It is not always necessary to create something new to supplement the existing or overhaul an entire workflow to attain an improvement over the status quo.

Consider adjustments to existing strategic and operating plans that will guide program and service development—simple actions can be impactful in creating meaningful change.

Cultivating Change: At WoodGreen Community Services, a culture shift to proactively recognize, support and empower caregivers was underway. Several programs were re-imagined through the lens of family caregivers. To meet family caregiver needs, rather than develop new programs that would compete for resources with existing programs, WoodGreen took the approach to modify the existing. For example, In-Home Respite Care was altered to include proactive check-ins with caregivers to assess and better support their health and wellbeing. Staff conducted check-in calls every three months to talk about challenges, review the current plan to identify where things could be improved and provide additional support options for caregivers in the program. The check-in script guide, survey and documentation log were co-designed by staff and caregivers. As the "check-in calls" were rolled into an existing program, staff roles were modified to include the new responsibility – this adjustment to role descriptions supported sustainability of the change initiative.

Improving Care Together: Leveraging co-design and lean principles, the project team worked with leaders and staff at Mount Hope Centre for Long Term Care to improve the move-in process by building change initiatives within the current workflows. Over a three-month period, the process of moving-in was extensively reviewed and findings uncovered challenges related to insufficient information, labelling clothing and the parking process. Working with different staff, modifications were made to the move-in process. For example, the admissions support team sends out a pre-arrival email and video link to all caregivers and residents prior to move in day; the seamstress updated the clothing inventory form and

[13]Armstrong, P. (n.d.). Bloom's Taxonomy. Vanderbilt University. Retrieved July 29, 2020 from: https://cft.vanderbilt.edu/guides-sub-pages/blooms-taxonomy/

process that enables clothing to be returned to residents by end of the day. These small changes refreshed and replaced existing processes and have become the new normal.

Connecting the Dots: The project team delivered a modified in-person version of the *Caregivers as Partners* eLearning for providers in lunch and learn formats across the project's six partner organizations. Within these sessions, staff learned about caregivers, how to better support, engage and empower them, and tools/resources readily available to providers to support caregivers. The team conducted a training blitz for staff over a series of months. The team also wanted to ensure new staff received the training as they joined the organization. *Caregivers as Partners* is now part of the employee orientation checklist and the *Caregiver Resources Standard Reference Guide* is accessible to all staff through each organization's intranet and Learning Management System (LMS). A slide deck with notes was shared with smaller organizations that do not utilize a formal LMS which can be used during an in-person orientation or reviewed by staff independently. Both learning options featured standardized content and messaging regarding the change initiatives, with an option for each organization to incorporate their own unique processes for implementation.

8. **Proactively enable ownership and accountability at the unit/program level – transition the change initiative's ownership and accountability from the project team (that co-designed, tested and implemented) to the setting where it has become the new status quo.** Through the transition, pause to identify and understand the perceptions and emotions of the new setting – this is a renewed opportunity to address resistance by sharing values and knowledge, establishing the credibility of benefits and developing emotional connections to the benefits of the change. Understanding and finding meaning in change are crucial to adoption.[14] Through sharing responsibility and witnessing results towards a common goal, a commitment to participate in the improvement can be generated.[15]

   Along with embedding the change initiative within existing workflows (Learning #7), tie the change initiative to roles or positions (i.e., not a person) to support sustainability of the initiative overtime. To maintain the relevancy and usefulness, consider developing a working group or committee with the dual purpose of on-going evaluation and adaption to meet evolving needs. Building a mechanism for continued measurement can enable making small adjustments to the change initiative to maintain relevancy over time.

To sustain the change initiative over time, tie the responsibility of task delivery to a role/position. Think about what role it naturally makes sense to add the new process to. Consider role boundaries, resources, training and capacity required to successfully carry out the responsibility.

Cultivating Change: *E-Rounds* is a service delivery model that extends the principles of Family Integrated Care by leveraging technology to enable meaningful parent engagement in the Neonatal Intensive Care Unit (NICU) at Mount Sinai Hospital. Recognizing that there may be barriers that prevent parents from being present on the unit (e.g., work responsibilities, caring for other children), *E-Rounds* enables parents to stay more involved in their baby's care by participating in medical rounds remotely through an encrypted electronic teleconference system. During COVID-19, the opportunity was enhanced by offering *E-Rounds* more frequently (i.e., moving from two times a week to five times). Even though volunteers and intern students were not permitted in the NICU during COVID-19, the team offered the additional *E-Round* times demonstrating the value of this communication between parents and the care team.

[14]National Health System (NHS). (2010). Sustainability model and guide. National Health System. Retrieved August 24, 2020 from: https://improvement.nhs.uk/resources/Sustainability-model-and-guide/

[15]Hilton K, Anderson A. Psychology of Change Framework to Advance and Sustain Improvement – IHI White Paper. Boston, Massachusetts: Institute for Healthcare Improvement; 2018. Retrieved August 8, 2020 from: http://www.ihi.org/resources/Pages/IHIWhitePapers/IHI-Psychology-of-Change-Framework.aspx

Embrace: When the Inpatient Mental Health Unit created a new team lead position, accountability for caregiver inclusion on the unit was built into the position. The new team lead was already a champion of the unit's caregiver initiatives so formalizing her role in holding staff accountable to sustain the changes was seamless. The team lead role includes monitoring and supporting the identification of caregivers, ensuring they receive the welcome package and that the care team includes caregivers in care and discharge planning.

Improving CARE Together: As the *Care Resource Binder* became a change initiative of interest across several units/programs at St. Joseph's Health Care London (i.e., Specialized Geriatric Services, Spinal Cord, Stroke, Veteran's Care, Geriatric Psychiatry, Complex Care), the project team worked with staff to co-design program-specific Care Resource Binders. Continuous Quality Improvement (CQI) working groups on each unit were established as a part of the sustainability of the binders - the working groups are responsible for reviewing and updating the content as needed. To support the on-going spread of the *Care Resource Binders* across the organization, the *Care Partnership Office* is expected to provide a supportive role supported by a how-to guide developed by the project team


Multi Vote
Project
Ide
A. Caregiver Centre in Healthcare Facility
B. Resource Website fo
C. Caregiver Network
D. e-Rounds
E. Caregiver Support Gro (focused on psychotherapeutic
F. Enabling Choice in In-H Care
G. Time to Talk Toolkit
H. Caregiver Communicati
I. My Healthcare Journey B
J. Caregiver Connection Gro Website (with local resources)
K. CARE Binder
L. Education Checklist (to ensu training is transparent & consistent)
M. Discharge Checklist (a forma ensure patients & caregivers are prep discharge)
N. Roles List (provider's name & contact info)
O.
P.

PLACE

C. PLACE

This section describes and illustrates key learnings about effective sustainability and spread related to place. For the Changing CARE projects, place refers to the context of a unit or program, the larger organization or the broader community context with partner organizations or collaboration opportunities.

9. Ensure change initiatives are aligned to corporate/organizational priorities.

Demonstrating a clear association between the change initiative and the organization's vision and strategic goals can support the sustainability and spread across the organization. When aligned to corporate priorities, the change initiative becomes complimentary and reinforcing rather than competing for time and resources. A robust understanding of where the organization stands today and where it is headed will be crucial to facilitate alignment.

Connect with senior leadership to learn how the project can support broad organizational quality improvement priorities and become part of the organization's Quality Improvement Plans (QIPs). QIPs are a blueprint to hold and guide an organization's quality priorities and are guided by the Quadruple Aim framework.[16] Incorporating change initiatives within the organization's QIP ensures accountability to complete on-going evaluations and reporting to the Board of Directors, Ministry of Health and public. When results demonstrate achievements towards the organization's goals (i.e., association between the change initiative and contribution to the goal), it becomes more difficult to revert back or de-prioritize the change initiative. Other opportunities to align change initiatives with corporate priorities include accreditation and organizational efforts to be recognized for leading practice (e.g., Registered Nursing Association of Ontario Best Practice Spotlight Organization).

Use the four domains of Quadruple Aim to help you shape the change initiative in its early days – the more direct of a relationship between the change initiative and impact, the greater likelihood for gaining organizational commitment.

Improving CARE Together:

The project was formally embedded in the hospital's Quality Improvement Plan (QIP) recognizing the synergies and alignment between the project's change initiatives and the organization's priorities and goals. This enabled the project to remain 'top of mind' over its three-year lifecycle with quarterly reporting to senior leadership and the board of directors and profiling at leadership development events. By including the project in the QIP, senior leadership was eager to participate in the Steering Committee and access to leaders became feasible. The project received direct oversight from two directors and the project manager had regular touchpoints with multiple hospital vice presidents and other leaders who helped to shape the change initiatives, mitigate barriers and enable sustainability and spread. For example, the *Care Resource Binder* was

[16] https://www.hqontario.ca/Quality-Improvement/Quality-Improvement-Plans/Quality-Improvement-Plan-Guidance

shaped to be aligned to both improving discharge and enhancing patient and family engagement (two of the organizations strategic priorities) which simplified and accelerated how the concept of the binder could be embedded into care practices across the organization. Furthermore, the project was successfully embedded in one of the principles in St. Joseph's Health Care London's Strategic Plan. A corporate *Care Partnership Office* was established with a role and mandate to promote patient and family engagement across the organization and build capacity of staff to partner with patients and families. The office will:

- offer co-design support to units and programs across the organization;
- oversee the *Family Presence Policy*;
- support leaders to recruit patient and family partners;
- take ownership of the *Caregivers as Partners* elearning modules embedded in the LMS; and
- promote and update any of the other change initiatives developed through the project.

Embrace: Aligned with Cornwall Community Hospital's strategic focus to build a culture of family caregiver inclusion, the project team developed and submitted a three-year plan to the senior leadership. The plan includes spreading the culture of family inclusion across the organization through the spread of project initiatives. Connecting the work to the corporate strategic plan and departmental operating plans demonstrated the commitment to the culture of family inclusion in the organization. Additionally, senior leadership supported transitioning one of the project working groups to be the group overseeing the spread and sustainability across the organization. This "Caregiver Inclusion Action Group" will report progress to the senior team and to two existing patient and family committees.

10. **Be prepared to adapt change initiatives as you spread them throughout different units, departments and programs within an organization or in new organizations – there is no one size fits all. Observability—"the degree to which the results of a [change initiative] are visible to others"[17]—is a key factor to adoption. However, a change initiative that had success in one care setting may not necessarily attain the same level of success in another area. The Institute for Healthcare Improvement (IHI) highlights there is "no data to suggest that a 'perfect innovation' spreads on its own"—successfully adapting a change initiative entails balancing its core elements with the flexibility to customize to the implementation setting.[18] We often believe that by doing the same thing we will achieve the same results, like following a recipe. Carefully identifying which aspects of the change initiative are essential can mitigate risks of replicating the change as is.**

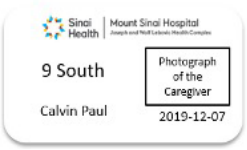
When spreading a change initiative to a new setting, consider forming a working group with representation from staff in the new setting to co-design the customizations and modifications. Enabling staff who will be impacted by the change initiative to shape, influence and co-create the adaption distributes power and releases intrinsic motivation – crucial domains to building commitment and sustaining gains over time (IHI, 2018).

Improving Care Together: *The Care Resource Binder,* originally co-designed and implemented in Specialized Geriatric Services, was spreading to Complex Care, Stroke, Spinal Care, Geriatric Psychiatry, Breast Care and Veteran's Care programs. Recognizing that patient and caregiver populations were different in these programs, working groups in each area were established to guide how the binder would be tailored to optimally suit the needs of patients and caregivers in each area and to determine opportunities to embed the binder into existing workflows. For example, patients in Veteran's Care expressed that they would like to include small personal items such as photographs in the binder—one of the customizations to the binder was the addition of pages of photograph pockets; in the Rehabilitation unit, education was a large focus of recovery and education materials were more comprehensive compared to other programs.

Cultivating Change: Bridgepoint Active Healthcare instituted a *Family Presence Policy* (FPP) in conjunction with a *Caregiver ID* program to welcome families and caregivers with 24-hour access to the person they were caring for. Together *FPP* and *Caregiver ID* are a catalyst for facilitating family inclusion and recognizing family caregivers as partners in care in healthcare settings. As part of the initiative, quiet hours were introduced from 9 p.m. to 7 a.m. so patients can get the rest they needed

[17]Sahin, I. 2006. Detailed review of Rogers' Diffusion of Innovations Theory. Retrieved from: https://files.eric.ed.gov/fulltext/EJ1102473.pdf

[18]Hilton K, Anderson A. 2018. Psychology of Change Framework to Advance and Sustain Improvement – IHI White Paper. Boston, Massachusetts: Institute for Healthcare Improvement. Retrieved August 8, 2020 from: http://www.ihi.org/resources/Pages/IHIWhitePapers/IHI-Psychology-of-Change-Framework.aspx



without restricting access to families and caregivers. Each patient can identify two caregivers, one who may remain during quiet hours (with exceptions made in palliative care). These designated caregivers are issued a *Caregiver ID* badge from security giving them access to the patient's unit. Recognizing the value of coupling *FPP with Caregiver ID*, Mount Sinai Hospital adapted and implemented their own iteration by consulting with the Bridgepoint implementation team to learn what worked, pitfalls to avoid and key elements of the program to maintain. The Mount Sinai team decided not to use an ID card (which is similar to an employee access card and can be costly)—they decided that designated caregivers would receive a sticker with their printed photograph.

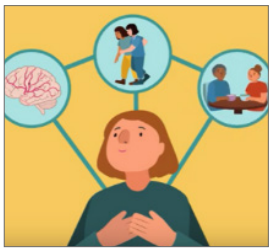
Connecting the Dots: With the goal of improving family inclusion and enhancing interactions between caregivers and providers and the healthcare system at large, the Huron Perth Healthcare Alliance implemented a series of documentation and process related change initiatives. Key updates required to the organization's electronic medical record (EMR) included:

- the addition of a new patient note template that allows healthcare providers to document communication with and information shared by caregivers; and
- changes to the Interdisciplinary Database's (IDB) existing Social, Home and Community Supports section to enable documentation to be collected about family caregivers; when the IDB is completed on admission, 'patient has a caregiver' prints automatically on the daily nursing worksheet to facilitate the recognition of the patient-caregiver dyad and encourage caregiver inclusion in care planning.

Though changes to the EMR are at an organizational level, each unit/program has implemented processes around the documentation differently as per their workflows. For example, within the Inpatient Mental Health unit, this additional information about the caregiver is now collected within their Admissions Assessment documentation area. The documentation of caregiver information was adapted by the North Perth Family Health Team with updates made to their EMR system that includes identifying if a patient has a caregiver and/or is a caregiver themselves. Similarly, the South West Local Health Integration Network adapted the patient/family communication section of their EMR.

11. **Pursue and leverage partnerships, collaboratives, networks and opportunities to sustain and spread change initiatives. Think beyond your organization to the broader community. Take an integrated care approach to facilitate the sustainability and spread of change initiatives by reaching out to existing collaboratives and partners and taking the opportunity to build new partnerships. Remember to consider partnerships that go beyond the walls of health care – i.e., partnerships with organizations where the people you serve frequently go to or engage with (e.g., community centres, places of worship, local library).**

Seek out and be prepared to respond to opportunities to spread the change initiative - some opportunities may appear unexpectedly and creating a new collaborative can be mutually beneficial.



Cultivating Change: *E-Talks* is a series of videos featuring veteran Neonatal Intensive Unit (NICU) parents – whose babies were previously in the NICU - who offer hope and support to parents currently experiencing a NICU journey at Sinai Health. The videos are included as a resource within the peer-to-peer support program and available on the information screen within the Family Lounge at Mount Sinai Hospital. As a part of spread efforts, *E-Talks* was included in a research study, *Family Integrated Care (FICare) Plus* between Mount Sinai Health System, Sunnybrook Health Sciences Centre, St. Joseph's Health Care Toronto, Toronto Public Health and Sick Kids. The videos are also being used in the *FICare Home Training of Nursing Staff* at Mount Sinai Hospital.

The *Caregiver Training and Education Program in Stroke Care* is a program at Bridgepoint Active Healthcare that proactively provides caregivers with equitable access to training and education, empowering them in their roles. Six short animated video modules available in seven languages have been modeled after the in-person sessions. The video series was translated into French, Italian, Portuguese, Mandarin, Cantonese and Arabic to improve access, health equity and health literacy. Through networking and partnering, the videos have been added as a resource and promoted through various avenues (i.e., Toronto Stroke Network, the Aphasia Institute, Heart and Stroke Foundation, strokebestpractices.ca). A plan is under development to reach out to communities who speak one of the languages listed above to further spread the use of this virtual resource.

Embrace: The project team leveraged local, regional and provincial opportunities for mutual benefit to support, spread and sustain caregiver inclusion. When the local chapter of Bereaved Families of Ontario closed, the team recognized that the organization's dedicated, experienced and well-trained volunteers suddenly had no volunteer role. The project was successful in recruiting some of the volunteers to be caregiver volunteers in the *Family Caregiver Centre*. Near the end of the project's funding, the Champlain region finalized a regional caregiver strategy. Seeing the opportunity, the project team approached the leads of the regional strategy and offered to be "early adopters" and to contribute the Embrace experience and material to the strategy. Some members of the project team were also leading the opening of a *Youth Wellness Hub* (YWH) site, a provincial initiative to open "one-stop -shops" for health, wellness and social services for youth ages 12-25. The project team recognized a natural fit with their young carers work and transitioned this group to become the founding members of the local YWH Youth Advisory Council. Efforts to spread awareness of young carers, how staff can identify young carers and staff education on the unique challenges of young carers continued through the local YWH site and spread to the other YWH sites in the province.

Connecting the Dots: In addition to spreading the change initiatives developed through the project within each of the six partner organizations, the project team considered existing community partnerships - including the Community Support Services Network, the Family Health Team Network and Emergency Services in Huron and Perth County - in an effort to achieve community-wide spread. Existing partnerships were leveraged between the Family Health Teams and the Family Health Organizations in the Huron and Perth regions, and local organizations in the Community Support Services Network to provide the *Caregivers as Partners*[19] in-person training to 203 staff and providers in 33 education sessions. The purpose of spreading the training was to facilitate awareness and understanding of the need for a culture change across Huron and Perth to better support, engage and empower caregivers. As well, new opportunities to share co-designed caregiver resources were explored with the South West Respite Network and the Nursing Leadership Network of Ontario.

[19]Connecting the Dots customized the Caregivers as Partners refresher module to be able to conduct 1 hour in-person sessions that highlight resources/tools available within the community to better support caregivers.

The Change Foundation: To support the spread of the resources and tools developed through Changing CARE, the Foundation developed an online *Toolkit* in 2019. The *Toolkit* categorized the resources to align with where organizations, departments or units may be in their journey to improve the caregiver experience. Resources included both finished products and templates for interested organizations and units/programs to build from. The Foundation also conducted webinars and partnered with the Ontario Hospital Association (OHA) to disseminate some of the resources (i.e., *Caregiver ID*) to their wider audience. With the establishment of the Ontario Caregiver Organization (OCO) and its focus on amplifying and spreading existing caregiver support programs, the Foundation transitioned priority resources developed through Changing CARE to the OCO to elevate and spread at a provincial level. With a website refresh completed in 2020, the Toolkit transformed into a user-friendly searchable resource library bridging the connection of the original resources to their evolved format on the OCO's website.

A spotlight was put on the essential role of caregivers when the COVID-19 pandemic hit. After the initial restriction of most caregivers from healthcare organizations, it became evident that the *Caregiver Identification* (ID) program could be adapted to become a proactive tool for organizations to welcome family members back. To support early adopters and other organizations considering new approaches during the pandemic, the OCO and the Change Foundation partnered to create a *Caregiver ID Learning Collaborative* to support organizations with implementation. The learning collaborative has a goal to share knowledge and experience on the implementation of *Caregiver ID*. The OCO and the Foundation supported the collaborative by sharing resources, collating knowledge, showcasing the experience of leading organizations and co-developing additional supports determined by the collaborative. By September 2020, more than 50 organizations had joined a collaborative virtual meeting representing a cross-section of healthcare organizations – e.g., hospitals, long-term care, mental health organizations, palliative and hospice care.

12. Pursue change initiatives that achieve alignment of behavior change, practice change and culture change—once change has become integrated into day-to-day practice as the norm, the change initiative may not be required as is and may need to evolve. Sustainability means "holding the gains and evolving as required, without reverting to the old ways of doing things".[20]

Sustainability can be thought of as a "continuum and not as a final steady state".[21]

Embrace: *The Caregiver Identification (ID)* badge was implemented in the hospital's In-patient Mental Health Unit with the goal of visually differentiating caregivers from social visitors. The unit was also in the middle of other family inclusion initiatives such as improving orientation of the caregiver to the unit and including the caregiver in discharge planning. Giving the *ID badge* to the caregiver quickly became the catalyst or trigger for the rest of the caregiver related activities - orient the caregiver to the unit, give them the welcome package, input the caregivers contact information in the electronic medical record (EMR) and assign related tasks in the EMR. As staff got in the habit of giving the badge, they noticed that even when the badge wasn't given the rest of the caregiver inclusion activities occurred. Staff and caregiver surveys on experience with the badge produced mixed results and evaluations overtime indicated that caregivers felt mostly neutral about the impact of the badge. This led staff on the unit to question whether the badge was necessary given that they continued to converse and engage with caregivers regardless of whether they had an *ID badge*. These results indicated that the culture on the unit shifted to one of caregiver inclusion with the badge serving as a catalyst for that shift in culture. In the early days of the *Caregiver ID* change initiative the badge acted as a means to start conversing in a caregiver-centric approach with caregivers but as these check-in/engagements with caregivers became part of practice, the badge was no longer needed to elicit the prompt.

Connecting the Dots: The *Caregiver ID* initiative, implemented broadly across project partner organizations serves as an overall awareness building and empowering tool for caregivers. Staff in a variety of roles are encouraged to distribute the card to help providers recognize caregivers and prompt meaningful conversations about the caregiving role and available supports. In response to the COVID-19 pandemic, the *Caregiver ID* initiative was adapted to directly support the Huron Perth Healthcare Alliance in maintaining their commitment to the deeply embedded culture

[20] http://www.hqontario.ca/Portals/0/documents/qi/qi-implementing-and-sustaining-changes-primer-en.pdf

[21] Martin, G.P., et al., Innovation sustainability in challenging health-care contexts: embedding clinically led change in routine practice. Health Services Management Research, 2012. 25(4): p. 190-199.

of family and caregiver inclusion and partnership. The organization modified their family and caregiver presence policy to reflect the reality of the pandemic, defined essential family caregivers and leveraged *Caregiver ID* to enable essential family caregivers into the hospital. *Caregiver ID* was used to recognize essential caregivers and for staff to validate that the essential caregiver had passed screening. Furthermore, through the process of providing the *ID* an opportunity to converse about personal protective equipment (PPE) was created. Approximately 80 essential caregivers were provided with a *Caregiver ID* between April and August 2020. The highly visual tool made the process of welcoming essential family caregivers much smoother at a time of such confusion and uncertainty.

APPENDIX

IMPROVING CARE TOGETHER	
Care Resource Binder	An individualized tool that facilitates caregiver involvement in the circle of care by providing opportunities for caregivers to seek the information and education they need to support the patient they are caring for. Co-designed by caregivers, patients and healthcare providers at St. Joseph's Health Care London, the binder includes content such as: • Understanding Your Care Team, a list of defined healthcare provider and staff roles in plain language that was co-developed with caregivers to help caregivers and patients understand the various types of providers that may be on their care team. This resource helps improve health literacy related to members of the care team and their respective roles. • A Communication Log that enables caregivers to document any questions they may have during the patient's hospital stay. In the event the caregiver is not present when a healthcare provider visits the patient, the provider can respond to the question in the binder. The St. Joseph's team has noted that patients are now asking providers to ensure they have addressed the questions in the binder, more actively sharing accountability for care. Binders are provided during admission and updated throughout a patient's stay. Upon discharge, the binder functions as a record of the patient's journey during their stay and a portable resource for on-going care needs

Caregivers as Partners	The Caregivers as Partners learning suite was co-designed by providers, patients/clients and caregivers in recognition of the need for practical and tangible education for providers and staff on how to partner with caregivers. The suite aims to support providers and staff to improve the caregiver experience by highlighting how small changes in behaviour, communication and practice can improve patient and system outcomes and the experience of the entire care team. Developed using Bloom's Taxonomy, adult learning principles and e-learning best practices, the modules are rooted in open learning, are accessibility compliant and available in an online format for individual learning, learning management system (LMS) formats for organization integration and PowerPoint (PPT) for group learning. Two series – Caregivers as Partners and Caregivers as Partners Mental Health & Addiction are available. The initial series is applicable to anyone working in health and community care; and provides healthcare providers with practical learnings on how to engage, support and empower caregivers. The series has been certified by the College of Family Physicians of Canada and the Ontario Chapter for up to 1.5 Mainpro+ credits; and the Canadian Nursing Association for 1.5 CE credits/hours. A summary or "refresher" module is also available can be used as an introduction to the concept of family inclusion and can also be used as refresher course. The second series equips healthcare providers with practical skills and resources to improve the caregiver experience by highlighting what makes the caregiving journey different for caregivers caring for someone with mental health and/or addiction challenges. The series has been accredited by the Canadian Nursing Association for 1.5 CE credits/hours

Move In Process Initiative	In response to learning that the process of transitioning from the community to Mount Hope Centre for Long Term Care is overwhelming, new supports were created to better inform and educate new residents and their families/caregivers so they felt prepared for the move-in day. An email or hard copy outlining detailed information about what the day involves, what to bring on move-in day (e.g., clothing, forms, furniture), where to park, and information about community support groups for families is sent to families/caregivers prior to the move-in day. A "Move In" video has also been created to demystify the move-in process as a way to help decrease anxiety and fears about the transition. A link to the video is included in the email.

EMBRACE	
Family Caregiver Centre	The first support service of its kind in the Eastern Champlain region of Ontario, the Family Caregiver Centre is dedicated to supporting caregivers in their caregiving journey. Located in the Cornwall Community Hospital, the Centre enables caregivers access to a physical space where they can take a break, find information, or talk to someone who understands their experience. The Centre features a lounge, kitchenette and a family meeting room. Additionally, caregivers can pick up printed information, request an educational book on loan, and access www.embracecaregivers.com. The centre is open daily with trained volunteers who have lived experience as family caregivers available to provide one-on one support to visitors.
Caregiver ID	Caregiver ID is any form of official identification (i.e., card, badge, button) issued by a healthcare organization to a patient's caregiver (i.e., family member, friend). It is a strong demonstration of an organization's commitment to family caregivers. At the Cornwall Community Hospital, the caregiver ID is a badge given to family caregivers in the in-patient mental health unit to acknowledge them and promote dialogue with healthcare providers. The ID is a visual reminder of the role of caregivers and is being used to facilitate a culture change in the unit.

CULTIVATING CHANGE	
Caregiver Commitment Statement	The Caregiver Commitment Statement articulates the principles and philosophy of care that caregivers can expect from WoodGreen Community Care teams. The statement was co-designed following a Caregiver Summit in 2018. It is now displayed across all WoodGreen Community Care sites. The commitment statements are also distributed in the form of badge inserts to recognize staff that complete the 'Caregivers as Partners' training.
Care Team Description Wall	An initiative to support caregivers and patients in identifying who is a part of the patient's care team and what their role is. Often, a patient may see several different providers and be unaware of what role the provider has in their care or have trouble recalling the provider's role. Accompanying each description, is an icon to represent the profession. To help caregivers and patients identify them, providers wear a button with the icon that represents their profession. The Wall has been implemented in both the Stroke and outpatient units at the Bridgepoint site and will likely be implemented in other units.
Caregiver Check-ins	WoodGreen's In-Home Respite Care, has implemented proactive check-ins with caregivers to assess and better support their health and wellbeing. For caregivers in the program, staff will conduct a check-in call every 3 months to talk about challenges, ensure the current plan remains flexible, and provide additional support options. Staff and caregivers have co-designed a short check-in script/ survey, and an orientation package. The team has developed a logging and follow-up process.
E-Rounds	An initiative that enables participating in medical rounds more accessible for parents of infants in the NICU. Often, parents are unable to participate in person in medical rounds due to a host of barriers. Using Ontario Telemedicine Network's (OTN) existing infrastructure and technology, parent-caregivers can now participate remotely during morning medical round through a secure video-conferencing system. The new service delivery model is now available across all three zones in the NICU at Mount Sinai Hospital.

Family Presence Policy with a Caregiver ID program	On June 5, 2018, Bridgepoint Active Health introduced a Family Presence Policy. The new policy welcomes families and caregivers with 24-hour access to the person they support. Caregivers who wish to stay during quiet hours (9 p.m. to 7 a.m.) are issued a Caregiver ID badge from security giving them access to the patient's unit. Caregiver ID promotes a healthcare culture that embraces caregivers as partners in care - by recognizing caregivers and facilitating their role as key members of the patient's circle of care.
E-Talks	A series of videos to support NICU parents. The series features advice from veteran NICU parents including words of encouragement and hope. Two videos in the series have been published: (1) Self-Care Tips from Parents and (2) Stories of Encouragement. Serving a diverse community at the Mount Sinai NICU, the videos will be available in the top five spoken languages of parent caregivers in the NICU.
Stroke Caregiver Training and Education	A program that proactively provides caregivers with equitable access to training and education, empowering them in their roles. The project includes: (1) aligning the 6 existing stroke education modules with the stroke networks binder, and includes practical caregiver tips and a co-designed knowledge checklist for patients & caregivers, (2) creating a process to ensure patients and caregivers get the binder, (3) providing an additional education session on Saturday as requested by caregivers and (4) creating 6 co-designed animated videos based on the stroke education sessions and caregiver feedback (translated into Portuguese, Italian, Cantonese, Mandarin, Arabic, French).

CONNECTING THE DOTS	
Time to Talk Toolkit	The Time to Talk Toolkit is a self-recognition and support tool for caregivers. For providers, it facilitates an awareness of caregivers and the important role they play in the care team. The toolkit includes a poster, pamphlet and educational video that have resonated well with both caregivers and healthcare providers during implementation. To help providers engage with caregivers, a tip-sheet and lanyard card with seven tips on how to meaningfully support caregivers has been created. The toolkit is being implemented across project partners.
Caregiver Connection Group	A peer-to-peer social group for caregivers to connect with each other and resources in Huron and Perth Counties. The group is hosted by caregivers for caregivers. The group meets in two communities, one in each county, and is open to all caregivers regardless of age. The aim of the group is for caregivers to develop improved coping strategies and experience reduced stress, anxiety, loneliness and isolation. The initiative is a partnership with ONE CARE Home & Community Support Services and the Stratford Public Library. The pilot began in February 2019 and is currently underway.
Caregiver Inclusion Documentation Changes	Through a series of documentation and process related change initiatives, the Huron Perth Healthcare Alliance is aiming to improve interactions between caregivers and providers and the healthcare system at large. Key changes to documentation related to updating the organization's Meditech electronic medical record (EMR) include: 1. The addition of a new patient note template that allows healthcare providers to document communication with and information shared by caregivers; 2. Changes to the Interdisciplinary Database's (IDB) existing Social, Home and Community Supports section that enables documentation to be collected about family caregivers during the admission process of patients. When the IDB is completed, 'patient has a caregiver' prints automatically on the daily nursing worksheet to facilitate the recognition of the patient-caregiver dyad and encourage caregiver inclusion in care planning.

	The caregiver information documented in the EMR is transferrable to physicians and is a step towards improving provider-to-provider information exchange. Additionally, to empower caregivers and recognize them in the circle of care, a sticker symbolizing caregivers has been added to the existing bedside whiteboards for caregivers to write their name and document any questions they may have for the care team. As a part of fostering a culture of caregiver inclusion, staff encourage caregivers to regularly use the whiteboard and be active participants in the circle of care.
Caregiver ID program	Caregiver ID was initially implemented at the Huron Perth Healthcare Alliance (HPHA) in the Fall of 2019. As soon as the COVID-19 visitor restrictions were put into place, Huron Perth Healthcare Alliance (HPHA) adapted the Caregiver ID program to support the safety of staff, patients and caregivers while enabling a continued care partnership during the pandemic. HPHA modified their Family and Caregiver Presence Guidelines, defined essential caregivers and leveraged Caregiver ID to enable essential caregivers into the hospital. The Caregiver ID was used to recognize essential caregivers and for staff to validate that the essential caregiver has passed screening. Furthermore, through the process of providing the ID an opportunity to converse about personal protective equipment (PPE) was created.

THE CHANGE FOUNDATION

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