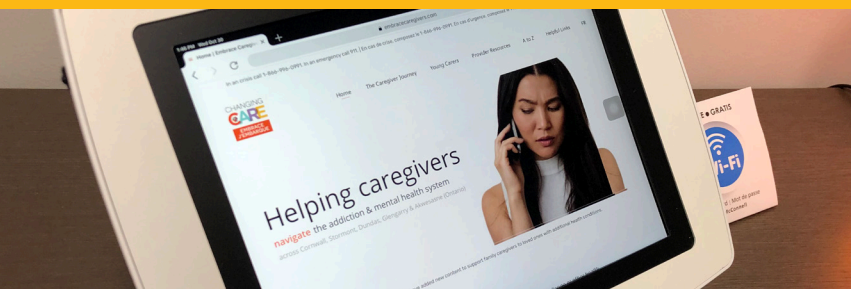




LESSONS FROM **CHANGING CARE**

Testing and Implementation of Change Initiatives



APRIL 2020



ABOUT THE CHANGE FOUNDATION

The Change Foundation is an independent health policy think-tank that works to inform positive change in Ontario's healthcare 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's 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 also like to acknowledge the hard work and creativity offered by the many caregivers and providers who participated in the testing and implementation of change initiatives undertaken by the Changing CARE projects. As a result of those efforts, the experiences of caregivers and providers will be improved in their communities.

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MESSAGE FROM THE PRESIDENT

Family caregivers are the backbone of our healthcare system. Without them, in many ways, the system would crumble. When we talk about system change, the conversation must include the caregiver voice and the caregiver perspective.



But what does it look like to *truly* embed the caregiver voice in the health care system? Not to check a box. But to affect *real* change? While there isn't a one-size-fits-all answer to that question, The Change Foundation is filling in the knowledge gap with some of the lessons our four *Changing CARE* teams have learned on their journeys so far.

In 2015, The Change Foundation launched its strategic plan – *Out of the Shadows and Into the Circle* – which focused on improving the caregiver experience in Ontario. We knew we couldn't do that without listening – and I mean really listening – to caregivers, so that the system could be designed to meet their needs. In 2015-16, we engaged with family caregivers, and health and community care providers, across the province through *The Caring Experience initiative*. In 2017, the Foundation identified four key partnerships from across Ontario to receive funding and support over the next three years to improve the caregiver experience for their individual populations. All four *Changing CARE* partnerships were designed with caregivers in key design and decision-making roles. The partnerships are now leaders in caregiver recognition, support and integration in the Ontario healthcare system and are changing the way healthcare organizations, providers, patients and clients, and caregivers work together.

The *Changing CARE* teams include caregivers every step of the way, making adaptations for the setting, and remaining flexible and open to the spirit of co-design. For these teams, caregiver engagement isn't a checklist exercise, it's core to their being and crucial to their success.

This is the third in a series of reports that focus on learnings from the Changing CARE projects. The first report, *Lessons from Changing CARE: The Discovery Phase of Experience Based Co-Design*, presents practical, how-to tips to help guide organizations in their caregiver and provider engagement efforts. The second report, *Lessons from Changing CARE: Co-Design Events*, focuses on what the Changing CARE projects are learning from their initial co-design events to address priority areas for improvement. The third report focuses on what the Changing CARE projects have learned about testing and implementing co-designed change initiatives.

We hope that you will use and adapt what we've learned about co-designing and implementing change initiatives to improve the way healthcare organizations, providers, patients and families work together. Our intention with Changing CARE was never to limit better caregiver experience solely to those four projects. We want to see improved caregiver and provider experience all across Ontario, and beyond. These learning reports are intended to help on that journey.

Sincerely,

Cathy Fooks
President & CEO

INTRODUCTION

Who are the Changing CARE projects?

The overall goal of the Changing CARE projects is 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 is a fundamental feature of the Changing CARE projects. Co-design can take a variety of forms – they can be large events and involve many participants talking about general themes, they can be small with a limited number of participants focusing on a specific change initiative, they can be time-limited or continuous and embedded in daily project activities. The Changing CARE project teams co-designed change initiatives that are being implemented, sustained and in many cases adapted to spread to additional units, programs or organizations. The following is a brief description of the four Changing CARE projects. Appendix 1 provides a summary and description of key change initiatives undertaken by each of the projects.



Connecting the Dots brings together six local healthcare organizations and family caregivers to create tools and resources that will help caregivers feel more supported, valued and engaged in their essential role. Project partners include the *Huron Perth Healthcare Alliance*, *Alzheimer's 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*. Three streams of work were prioritized: (i) awareness and recognition; (ii) communication and information; and (iii) education, training and supports.



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



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



Improving CARE Together aims 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 Centre. Improving CARE Together is undertaking work in three streams: (i) family caregiver involvement; (ii) family caregiver education and training; and (iii) care transitions.

How is this report organized?

This report focuses on learnings from the Changing CARE projects during the testing and implementation of change initiatives. The fourteen 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 National Health System (NHS) model for sustaining change (staff, process, organization) and are consistent with how the Institute for Healthcare Improvement (IHI) approaches improvement. Each of the learnings are illustrated by stories and examples from the Changing CARE projects.

See Appendix 1 for a description of the Changing CARE resources referenced in this report.



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at
3 things that made
ou smile this w

SUMMARY

3 things that made
you happy this week

SUMMARY LIST OF LEARNINGS:



PART A: PEOPLE

- 1. Include caregivers and providers** as part of the project implementation team and **build their capacity** to effectively participate and fulfill project responsibilities. It is important to include caregivers with lived experience in the area where you are trying to make change.
- 2. Identify champions** in the planning and implementation of the project. **Executive champions** play a critical role in establishing the value of the initiative for the organization. **Managers, physician leaders, and other frontline provider champions** offer valuable insights into the pulse of a unit, department or service and are critical in building support for the initiative through modelling, reinforcing or advocating for change.
- 3. Be strategic in engaging with a variety of frontline providers early** in the testing and implementation process to enable opportunities for them to influence how the initiative is implemented. Frontline providers can promote support for the change initiative, provide valuable insight into considerations for implementation, and identify dissenting points of view about the initiative.
- 4. Engage with experts and key stakeholders** as required to ensure that specific aspects of testing and implementation are appropriately considered and sufficiently addressed.



PART B: PROCESS

5. Establish **structures and tools to guide the planning, testing and implementation** of change initiatives and to support their sustainability.
6. Use **existing diagnostic tools to identify strengths and weaknesses in implementation plans and sustainability prospects.**
7. Look for opportunities to implement **quick wins and basic improvements** (such as new actions to be taken and removal of unnecessary steps) that will demonstrate early progress and have a positive impact on people's experiences. On a large project with a longer timeline, quick wins show immediate value.
8. **Embed the change initiative into the unit or program workflow - test and adjust the initiative through PDSA cycles.** Roll-out the change initiative to other units, programs or organizations, repeating the testing and adjusting cycle to ensure fit with workflows in new areas. Basic improvements could include new actions to be taken, removal of unnecessary steps, or both.
9. **Invest time and resources into communication** - communicate and communicate some more. Provide early and regular updates to frontline providers, partners and stakeholders, and share a roadmap of the change initiatives.
10. Establish a process to **elicit feedback from providers/staff, caregivers and patients after implementation** of the change initiative. The feedback from a range of perspectives can provide valuable insights about the testing and implementation process, support continuous improvement of the change initiative after implementation and inform the testing of new change initiatives.



PART C: PLACE

- 11. Be prepared to adapt change initiatives as they spread throughout different units, departments and programs within an organization or in new organizations** – there is no *one size fits all*. Change initiatives may need to be adapted to align with the culture, processes and structure in a new setting.
- 12. Build a learning culture** that enables change to be tested incrementally and treats failure as a learning opportunity. Failed tests can lead to creative uses of resources, and negative feedback can inform learning. Being open and flexible to the unanticipated can facilitate refining the change initiative so it is practical, adaptable, and sustainable.
- 13. Align change initiatives to organizational priorities.** Alignment of change initiatives to organizational priorities helps to provide clarity of purpose, ensures efficient use of organizational resources, and improves the project's success and sustainability.
- 14. Align with and build on existing systems and resources available in your organization or more broadly in the community.** Look for opportunities to partner with existing community or regional resources, or to adapt existing organizational systems to support change initiatives.

Overall, there were multiple examples from the four Changing CARE projects that success was more likely if the new initiative was linked to an existing process or aligned with an existing initiative or priority. Change initiatives are more likely to stick if they are aligned with existing processes, initiatives or priorities.



PEOPLE

COURTESY OF EMBRACE.

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 and experts in specific areas – can contribute to the testing and effective implementation of change initiatives.

1. Include caregivers and providers as part of the project implementation team and build their capacity to effectively participate and fulfill project responsibilities. It is important to include caregivers with lived experience in the area where you are trying to make change. For example, if the change idea is about improving supports for caregivers in cardiac care, a caregiver to someone receiving cardiac care would have important insights into the care experience.

Think carefully about equity when recruiting for co-design and planning for implementation – “the voice of one is not the voice for all.”

“I didn’t realize a caregiver would be present. This makes the presentation come alive due to shared lived experience.”

—PROVIDER,
CONNECTING THE
DOTS

Embrace:

The overall project team is spearheaded by a project manager and a caregiver co-lead. Additionally, each project stream is co-led by a family caregiver and a provider. To ensure caregivers could meaningfully participate in the project stream teams, they were matched to a project stream where they could draw upon and share their lived experience to inform the project. For example, caregivers who recently went through the discharge process on the In-patient Mental Health Unit were invited to be part of the *Caregiver Inclusion in Discharge* project team. To support the capacity of the project team, team members – caregivers and providers – received training on co-design and on the Influencer™ model for behaviour change.

Connecting the Dots:

As a part of changing the culture of how providers engage with caregivers, the team focused at the start of implementation on educating staff about how they could better support, communicate with and empower caregivers by using resources developed through the project. Using training materials co-designed by providers and caregivers, the team conducted in-person education workshops to train staff and providers across the six project partner organizations. In over 100 workshops delivered to 900 providers and staff, family caregivers were part of the planning, co-facilitated and shared their caregiving stories, talked about their experiences with co-design, and shared how they view the value of the *Provider Education*.

Cultivating Change:

Involving caregivers in the *Parent Outreach Program* team helped to uncover common assumptions about caregiver self-care. It was assumed that caregiver self-care was a reasonable and positive aspiration. However, for some caregivers, self-care was associated with selfishness and taking time away from the person they were caring for, and even potentially compromising that person's health and wellness. All team members were caregivers themselves, and through sustained engagement explored the different values associated with self-care for caregivers. This led to a philosophy of *starting where the caregiver is* and building self-care practice incrementally over time.

Improving Care Together:

Caregivers and providers worked in partnership to modify and implement resources in various programs across all sites of St. Joseph's. The team was intentional about engaging caregivers from the specific program or unit to ensure perspectives matched reality. For example, when the team was implementing a *Care Resource Binder* (to facilitate education, communication and transitions) in complex care, caregivers of patients on the unit were engaged in change idea and implementation meetings to provide input and expertise. The caregivers worked directly with providers on the unit to offer important insights that influenced the implementation process.



COURTESY OF EMBRACE.

The Embrace project team launched the embracecaregivers.ca website on national Family Caregiver Day in April 2019. The team celebrated by assembling a display of gloves that tells the story of co-design. Each of the 60 gloves on display acknowledged a local person for their contribution to the website.

2. Identify champions in the planning and implementation of the project. Champions are individuals who are instrumental in leading or promoting change within an organization.¹ They tend to have great credibility with their peers and can be found in multiple levels of an organization – executive, managerial or clinical. Executive champions are corporate leaders who play a critical role in establishing the value of the initiative for the organization. Managers, physician leaders, and other frontline provider champions can offer valuable insights into the pulse of a unit, a department or a service and can be critical in building support for the initiative through modelling, reinforcing or advocating for the change.² In addition to champions, strong project management leadership is critical to successful testing and implementation of change initiatives. Key elements of project management leadership include interpersonal communication skills, negotiation and influencing skills, team building skills, being innovative and thinking long-term, and being motivating and inspiring. The Changing CARE projects benefitted from exemplary project managers who were influential change agents in their organizations and community.

Have leadership visibly champion the changes, including setting time aside in work schedules to engage and participate in the project (e.g., prototyping day; project launches; co-designing days).

Connecting the Dots:

To support implementation and sustainability, frontline providers from across all partner organizations participated in co-design teams to develop caregiver tools and resources. Team members were approached strategically based on their work and life experience. An Emergency Department (ED) nurse who participated in co-design initiatives expressed an interest in further opportunities to support the project. With previous experience as a nurse educator, she began working one day a week with the project team, first as an educator and then providing implementation support for clinical units and departments. Her involvement in the project helped to increase staff buy-in, especially in the ED due to existing relationships.

Embrace:

The project Steering Committee includes members from the hospital's executive leadership team (two vice presidents) as well as a clinical leader. On the In-Patient Mental Health Unit, *Caregiver Inclusion in Discharge initiatives* were championed by the unit manager, and when the initiatives spread to the Emergency Department they were championed by the senior director. The project's executive lead – a vice president – championed the *Embrace* goals and initiatives at the corporate senior leadership table and linked the project goals to corporate priorities and

¹ See: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5720908/#R17>

² See: <https://www.pmi.org/learning/library/essential-leadership-skills-project-managers-6699>

initiatives. The vice presidents participated actively in project events and were viewed as reflecting the corporate commitment to the project.

Improving Care Together:

The project Steering Committee included leaders - vice presidents and directors - from throughout the organization. These leaders embraced the role of champions to drive the importance and alignment of the project with corporate priorities. The leader champions were also helpful in assisting the project team in overcoming barriers. Using platforms such as the Directors' Council, the Leadership Development Institutes and other leadership forums, the directors (who are also co-chairs on the Steering Committee), continued to lead discussions and highlight the project to build ownership and support, and to drive uptake and implementation. The leaders and project team identified clinical champions who have been instrumental in implementing tools and resources at the frontline. These champions have led by example and have provided the project team with valuable feedback throughout the project. Champions at all levels of the organization have contributed to the ongoing success of the work.

- 3. Be strategic in engaging with a variety of frontline providers early in the testing and implementation process to enable opportunities for them to influence how the initiative is implemented. Frontline providers can help promote support for the change initiative and provide valuable insights into important considerations for implementation such as the cultural climate on the unit, readiness for change and whether there are competing priorities. Early involvement of frontline staff can help to identify dissenting points of view, areas of resistance, and myths or rumours about the initiative. The project team can then try to understand and respond to concerns, and address misinformation.**

Improving Care Together:

Engaging with frontline providers in the project working group and listening to the perspectives of unit staff at the start of implementing the *Care Resource Binder* initiative led the team to discover an opportunity to improve the patient follow-up process in the geriatric and rehabilitation units that they otherwise may not have identified. Prior to the implementation, patients were often discharged without a follow-up appointment. Through some quality improvement initiatives, all patients now have a follow-up appointment that is documented in their *Care Resource Binder* before they are discharged from the geriatric and rehabilitation units. This has resulted in improved care transitions.

Roll with Resistance: Lean into dissenting views; on-board naysayers into the co-design team. Rolling with resistance may mean continuing to socialize the idea, instead of operationalizing right away. Giving frontline providers some time to process the change idea and creating space for dialogue without abandoning the idea is a strategy to manage resistance.

Embrace:

At the onset of the *Caregiver Identification* and *Caregiver Inclusion in Discharge* initiatives some staff did not see the need for the proposed changes. By seeking to understand their hesitation, the team used data to demonstrate the need for the change. A plan was created with several strategies to positively influence hesitant staff and leverage relationships in the unit. The unit staff participated in the plan that resulted in assigning the social worker to engage with the patient, caregivers and psychiatrist around planning for discharge. The team also came up with strategies to positively influence staff who were resisting – peers encouraged them to follow the new process, and the new process was reinforced at daily clinical rounds and through the electronic medical record. All staff were asked to participate in the measurement of the new practice using a performance board, and caregiver inclusion in discharge planning became part of the performance management of the department manager. As a result of this open and inclusive approach, staff feel respected and valued and are more willing to adopt the changes.

Connecting the Dots:

The *Time to Talk toolkit* is a recognition and support tool that aims to facilitate awareness of the caregiving role and the value they bring as part of the care team. To drive the adoption of the toolkit among providers in the Huron and Perth counties, physician leadership was crucial. Two physicians have supported knowledge translation efforts, presenting at grand rounds and conferences. Understanding the environment and their peers' perspectives, the physicians shared key messaging for the project to address barriers identified by local healthcare providers. Embedding the toolkit within their own daily practice, and serving as a key point of contact, the physicians leveraged their perceptions and experiences of how the toolkit has impacted their practice and how they work with caregivers. Their messages have been shared broadly with providers and have resonated well with both physicians and frontline staff facilitating the adoption of *Time to Talk* across partner organizations.

Cultivating Change:

The *Care Team Description Wall*, an initiative in the Stroke Care Unit, supports caregivers in identifying the patient's care team and their role. Initially, the wall was designed to include role descriptions and photographs of each team member. However, some frontline staff members expressed concerns about privacy and safety if their photo were to be posted in a public space in the hospital. In response to those concerns, the project working group adapted the project idea: rather than staff photos, the wall included a unique icon designated for each type of provider role on the unit to help caregivers distinguish the roles. Staff were asked to wear buttons with the icon that corresponded to their role/profession. This adaptation to the change idea enhanced the project by reducing efforts to keep the wall up to date with staff photographs while helping caregivers to identify individuals and their corresponding role on the team. Staff expressed that they felt valued and heard during the testing and implementation process and are supportive of wearing the button.

**Physiotherapist/
Physiotherapist Assistant**

I assess what affects your ability to move and develop a treatment plan to improve strength, balance, coordination and mobility. I may suggest specific mobility aids to promote safety and independence. Physiotherapist Assistants carry out treatment plans and support you in reaching your goals.

Social Worker

I provide counseling around community resources, and managing emotions after your stroke. I also provide education about your transition from hospital back to community.

Physician

I provide general day-to-day medical care with a focus on your recovery and preventing future strokes.

- 4. Engage with experts and key stakeholders as required to ensure that specific aspects of testing and implementation are appropriately considered and sufficiently addressed. Your team may not have all the expertise needed to carry out the project. Experts and key stakeholders may have specific expertise and may provide an organization-wide service, a specific service within the workflow, or they may be experts external to your organization.**

Cultivating Change:

To develop *E-Talks* on the Neonatal Intensive Care Unit (NICU), the team engaged the hospital’s clinical ethicist to guide the development of a new consent form to allow for on-going consent from parents. The team also liaised with communications staff about where and how to provide the videos with language options. To implement *E-Rounds*, the team engaged with the IT department to ensure the technology components such as cameras, video and online systems operated efficiently. In the community stream, research expertise was needed to support the design of the process and outcome evaluation for the *Caregiver Self-Care* project. The team reached out to the hospital’s in-house scientific associate at the *Bridgepoint Collaboratory for Research and Innovation* who guided the development of the survey questions and evaluation tools, as well as workflow considerations to help frontline providers collect evaluation data.

Embrace:

The project team wanted to develop a companion resource for *Making Privacy and Consent Rules Work for Family Caregivers* that would focus on interactions between healthcare providers and the caregivers of those with mental health and addiction challenges. Given that privacy and consent rules are determined by two pieces of legislation – the *Personal Health Information Protection Act, 2004* and the *Health Care Consent Act, 1996* – the team contracted legal expertise (a lawyer with extensive expertise related to mental health, capacity, privacy and consent) to advise on the development of the questions and answers, and to approve the final resource: *Questions & Answers on Patient Privacy and Consent in The Addiction and Mental Health System in Ontario*.

Improving Care Together:

Surveys and interviews with residents and their families at the Mount Hope Centre for Long Term Care, a *St. Joseph’s Health Care London* site, indicated there were opportunities to improve the move-in process

for both residents and their families/caregivers. To understand the current state and identify areas for improvement, a small working group was established. Using co-design and lean principles, the group created *Move-In Process Initiatives* to improve current processes. For example, the group concluded that the process for labelling clothes caused undue confusion and lengthy wait times. To fully understand the current process, as well as challenges and potential strategies for improving the labelling process, the seamstress became a key stakeholder in the quality improvement process. With the seamstress' input, the laundry inventory/labeling process was redesigned and demonstrated results immediately, including a reduction in hand-offs from five to three, smoother daily work demand for the seamstress, and improved resident and caregiver experiences.

The Change Foundation:

The Change Foundation played a backbone role³ to support shared opportunities for learning and development across the four Changing CARE projects, engaging both with technical experts and experts with lived experience to support these learning opportunities. The Foundation engaged with *The Point of Care Foundation* and the *Institute for Healthcare Improvement* early in the process to provide foundational training and capacity building for the project teams. The Foundation also contracted with experts to provide guidance and expertise in the development of specific tools and resources.

The Point of Care Foundation

To build capacity around Experience-Based Co-Design among the Changing CARE projects, the Foundation sponsored a learning event from U.K. Point of Care Foundation at the start of the projects.

Institute for Healthcare Improvement

To support the spread and sustainability of the project's quality improvement initiatives, the Foundation sponsored 1:1 coaching with the project teams from a faculty member at the U.S Institute for Healthcare Improvement.

Gavel

To develop *Making Privacy and Consent Rules Work for Family Caregivers*, the Foundation contracted legal expertise to work with the four Changing CARE teams to help understand privacy and consent laws in Ontario.

Stack of Books

To understand adult learning principles and frameworks to guide adult learning, the Foundation contracted work with an adult learning expert to help guide the development of the *Caregivers as Partners* eLearning Suite for Healthcare Providers.

Laptop with Book

To guide the development of the *Caregivers as Partners* eLearning Suite for Healthcare Providers, the Foundation partnered with experts in digital learning and eLearning design and development.

³ See: https://ssir.org/articles/entry/six_proven_practices_for_backbone_organizations#https://www.fsg.org/publications/understanding-value-backbone-organizations-collective-impact



COURTESY OF IMPROVING CARE TOGETHER.



Proposed Agenda

Topic	Notes for book and content development
10:00	Registration (30 min)
10:30	Break and registration energy (15 min)
10:45	Workshop on adult print (20 min)
11:15	Break (15 min)
11:30	Workshop: What are we achieving? (20 min)
11:45	Reflection & Next Steps (15 min)
12:00	Mealtime

Adult Education Principles

- Adult Learning
- Practical
- Relevant
- Self-Directed
- Experience, Collaboration
- Task-Oriented
- Autonomy
- Feedback + Praise

8 Lean Wastes

- T - Transport
- I - Inventory Excess
- M - Motion
- V - Waiting
- O - Overproduction
- O - Overprocessing
- D - Defect
- S - Skills Waste

Health Literacy Strategies

- Look for clues missed opportunities not written down instructions
- Use audio visual aids
- Use demonstration
- High light or circle main points
- Use simple language
- Teach back
- Encourage patient/caregiver partnerships
- Encourage a buddy

PROCESS

COURTESY OF CULTIVATING CHANGE.

B. PROCESS

This section describes and illustrates key learnings related to process, or *the way things are done*. The majority of improvement work is focused on improving a process or solving a problem. There were numerous learnings from the Changing CARE projects that related to the process of how things were done. These learnings contributed to effective testing and implementation of the change initiatives.

5. Establish structures and tools to guide the planning, testing and implementation of change initiatives, and support sustainability of the initiatives. Structures include committees or working groups that meet on an agreed upon timeline to provide guidance and oversight on the operational functions from the project level. Tools include planning or tracking templates to help ensure the project components stay on track and aligned with overall project goals.

Connecting the Dots:

The project's Operational Committee included members from the six partner organizations who implemented the change initiatives. The committee played a pivotal role in guiding the testing and implementation of the project's change ideas at each of the six partner sites. Committee members played an integral role as the project team worked with leaders and champions from each partner organization to develop customized education and implementation plans. This process supported sustainability, ensuring that the implementation strategy took into consideration the individual partner organization's structure, policies and priorities.

Embrace:

The project team established an Implementation and Sustainability Committee early in the project timeline with a purpose to provide support and guidance to all project streams – e.g., oversight to ensure the project streams were focused on the project goals, there was coordinated communication, and attention to measurement and sustainability. This committee developed a two-page template, the *Embrace Implementation Guide*, for the project teams to document goals, decisions, methods and lessons learned, along with links to key resources. The Embrace Caregiver Website project team also developed a tool that caregivers and staff could use to recommend resources to include on the embracecaregivers.ca website.

Embrace Caregivers
A series of guides to improve the experience of family caregivers in the addiction & mental health system.

Caregivers as Partners in Project Planning

We committed to bringing caregivers and providers together to co-design and implement project initiatives. We recognized that we couldn't do this without first developing a shared understanding of our methodology. Bringing caregivers and providers together for training on our selected organizational change model before we got started made the most sense.

Motivation	Approach	Decisions	Progress
Healthcare projects are often planned and implemented by a team of providers with little or no input from the families affected by the change.	We brought the caregivers and providers on our project team together to participate in two days of training on our selected organizational change model: <i>Influencer</i> ³ , by Vital Smarts ¹ .	Is there a true commitment to using the organizational change model consistently? Is there a training cost and funding source? Is the training locally available or is travel required? Travel can be a challenge for caregivers.	Project implementation moved along faster than usual by getting everyone on the same page early on. The project plans were inclusive, comprehensive, and clear.
To ensure that the voice of caregivers was integral to our work, we wanted caregivers and providers to be equal members of the team.		Who are the caregivers and providers that will be working directly on the project? Will each caregiver and provider team member be trained? Is paid compensation required for the training time spent by caregivers and providers?	
We envisioned caregivers and providers making strategic project decisions together.		Can the training be delivered to participants with a wide range of education levels and project management experience? Does the training schedule and pace need to be adjusted?	

Embrace Caregivers
A series of guides to improve the experience of family caregivers in the addiction & mental health system.

Including Caregivers In Patient Discharge

We set out to change the way health providers in our hospital's Inpatient Mental Health Unit include family caregivers in planning and preparing for the discharge of their loved one by co-designing the discharge process with them. We called the project, "Mission Recognition".

Motivation	Approach	Decisions	Progress
Family caregivers are often left out of the patient discharge process. This process is often last minute, lacks careful planning and does not address patient recovery.	We envisioned providers including caregivers in conversations about patient discharge, right from the start. We imagined caregivers included regardless of their ability to be present in-person for discharge planning and receiving special consideration, even in the absence of patient consent.	Is there a staff role to assume the lead in discharge planning or is a team approach required? How early in the patient admission will caregivers be included in discharge planning? How will providers communicate with caregivers who are not at the hospital or who visit on evenings or weekends? What role does each member of the health care team have in discharge planning?	As a result of the improved process, caregivers are included in the planning for patient discharge, their concerns are heard, they feel more prepared to receive their loved ones at discharge, and they know the next step in their loved one's care. Providers benefited from the streamlined process, eliminating a last minute rush.
Including caregivers reduces stress and helps them feel confident and prepared to receive their loved one. Caregiver involvement yields better health outcomes for the patient, reduces hospital readmissions and lowers healthcare costs.			
Method			
<ol style="list-style-type: none"> 1. Bring providers and caregivers together to co-design the patient discharge process. We engaged people familiar with the current process. 2. Orient collaborating caregivers to the specialized terminology involved in patient discharge, the discharge process, and the organizational change model used by the project team. 3. Generate provider understanding and appreciation for the initiative early in the process. We held weekly huddles, ran newsletter articles and posted bulletins about the initiative on the unit. 4. Conduct baseline surveys with caregivers and providers to map the current process and identify gaps that need to be addressed. 5. Share the survey findings and ask caregivers and providers for suggestions. 6. Build consensus for a future where providers involve caregivers in patient discharge planning. 7. Use an organizational change model to develop an action plan. Clearly identify who does what, by when and include steps to sustain the change. 8. Communicate pending process changes to providers, at staff meetings and in writing. 9. Implement the changes and continue frequent follow-up to hear what is working and what is not. 10. Repeat the survey with caregivers and providers to collect feedback and measure the organizational change that is achieved. 			

Cultivating Change:

The project team used the *Ministry of Health's Health Equity Impact Assessment*³ in all aspects of its engagement. The assessment guide was used to recruit caregiver advisors who were representative of the diverse communities served. The guide helped to identify and remove barriers to caregiver advisor participation such as remote participation, parking costs and evening meetings. The change ideas supported equity-based improvements in programming and service design. The project team was able to build capacity and raise awareness about health equity among all project stakeholders.

³ See: <http://www.health.gov.on.ca/en/pro/programs/hea>

6. Use existing diagnostic tools to identify strengths and weaknesses in implementation plans. For example, the *National Health Service (NHS) Sustainability Model*⁴ (see visual below) is a diagnostic tool that can be used to identify strengths and weaknesses in an implementation plan and predict the likelihood of sustainability for the change initiative. Ten questions are organized under three domains - staff, process and organization. The tool can support narrowing in on areas with a lower score to help build a practical strategy that would increase the likelihood of sustainability for an improvement initiative.



Connecting the Dots:

The project team used the *NHS Sustainability Model* for the pilots at two project partner sites. They completed the tool with leaders and champions before the co-design sessions, at implementation and mid-way through the pilot. For each of the ten factors, leaders and champions agreed on a level that best described the status of the situation. Completing the scores for the ten factors helped the team to prepare and plan for their pilots at the two sites, identify strengths and weaknesses in their plans, and find opportunities to improve the sustainability of the change idea.

Embrace:

The project team used the *NHS Sustainability Model* on the In-patient Mental Health Unit during the testing of the *Caregiver Inclusion in Discharge*. As expected, the first time they used the tool the resultant

⁴ See: <https://improvement.nhs.uk/resources/Sustainability-model-and-guide>

score was low, but by focusing in on the lowest scores they were able to zone in on areas of improvement. They developed an action plan to tackle each area with a low score, and repeated application of the tool showed improvement, demonstrating the likelihood of sustainability of the changes made.

7. Look for opportunities to implement quick wins and basic improvements that will demonstrate early progress and have a positive impact on people’s experience. A quick win is an improvement that can be delivered shortly after the project begins; quick wins are easy to implement, inexpensive and have a narrow and focused scope. Quick wins provide project momentum by demonstrating value; they help onboard new departments and attract project champions; and they provide confidence to the broader organization that the project is worth supporting. On a large project with a longer timeline, quick wins show immediate value by getting something done. Basic improvements could include new actions to be taken, removal of unnecessary steps, or both.



Improving Care Together:

Through experience surveys and qualitative interviews, the project team knew the admission process to the *Mount Hope Centre for Long Term Care* was difficult for caregivers, new residents and staff. A working group used lean tools to better understand the current situation and identify areas for improvement. A key finding was that caregivers were not receiving enough information before move-in day, which resulted in stress for families. Under the *Move-In Process Initiatives*, staff and caregivers co-designed a simple email with *need to know* information to be sent to families prior to the move-in date. The email included information about what to bring on move-in day, where to park and what the day would look like. A hard copy was offered to those families who did not have an email account. This was a small change, but resulted in high impact for the caregiver experience by decreasing stress and feelings of being overwhelmed.

Who to call in Huron and Perth
Resources for caregivers



<p>Ontario Caregiver Helpline 1-833-416-2273 (24/7)</p> <p>Ask a Nurse Telehealth Ontario 1-866-797-0000 (24/7)</p> <p>Urgent Emotional Support Huron Perth Helpline and Crisis Response 1-888-829-7484 (24/7)</p>	<p>Huron Perth Community Support Services Network 1-844-482-7800 (M-F 8:00am to 6:00pm)</p> <p>Home and Community Care, South West Local Health Integration Network 1-800-811-5146 (7 days/week 8:00am to 8:00pm)</p>
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Connecting the Dots:

The *Who to Call in Huron Perth card* was a quick and easy-to-use resource that included key numbers for caregivers: for assistance in an emergency, for urgent emotional support and for connection to local services. The business card was designed to support volunteers at the project's *Caregiver Connection* groups. The caregiver hosts requested a simple and discreet way to provide key resources to caregivers in attendance. Once created, all six project partners wanted cards for their staff to use during key interactions with caregivers. Nurses in the hospital Emergency Department and physicians within the Family Health Teams embraced the card, which also highlights the *caregivershuronperth.ca* website. Partner organizations started sharing the card with their stakeholders, including Emergency Medical Services and the Canadian Mental Health Association.

Cultivating Change:

At the Community Caregiver Summit, caregivers and providers described their ideal experiences when seeking and using community services for caregivers. When the data was synthesized it was clear that summit participants shared not only what they needed, but also how they wanted to receive services. This early learning led to the co-design of a *Caregiver Commitment statement* that helped caregivers understand both the community service providers' commitment to them, and staff's ongoing mission to be caregiver-friendly. This quick win was easy to co-design and *Our Commitment to Caregivers* has been printed and widely shared in various formats (posters, one-pagers, ID badges).




**OUR COMMITMENT
TO CAREGIVERS**

AT WOODGREEN COMMUNITY SERVICES, WE WILL ALWAYS:

- Recognize you as an individual
- Acknowledge you in your role as a caregiver
- Appreciate your efforts, experience and ideas
- Maintain respectful and empathetic communication
- Value you as a care partner
- Encourage you to also take care of yourself


WOODGREEN
CHANGING LIVES.
MAKING A DIFFERENCE.

8. Embed the change initiative into the unit or program workflow – test and adjust the initiative through PDSA cycles. Roll-out the change initiative to other units, programs or organizations repeating the cycle of testing and adjusting in order to ensure fit with the unique workflow in that unit, program or organization. Plan for and develop education or training opportunities for all staff in the unit or program, so that they are ready for the change.



A PDSA cycle does not need to be a large undertaking - it can be run with just a handful of participants.

Cultivating Change:

To support the implementation and sustainability of *E-Rounds* in the NICU, the process for identifying parents to participate, and for coordinating the secure virtual round, was built into the role of social workers in the NICU. The team of social workers had regular touch-bases with parents of infants in the NICU. Leveraging these regular touch-bases, the social worker could ask if there were any barriers to attending in-person rounds and offer remote participation in the rounds. When a parent wanted to participate in *E-Rounds*, the social worker coordinated a secure teleconference between the providers and the parents. Building off the success of *E-Rounds*, the technology and process is offered to support e-meetings for families and family participation in education sessions. In the community stream, the *Self-Care for Parent Caregivers* modules in the *Parent Outreach Program* required changes to the role of home visitors, their workflows and the tools they used. Staff home visitors now follow the same workflow as the pre-existing parent outreach model with additional steps, tools and prompts focused on supporting self-care for the parent caregiver. Incorporating the change idea into an existing workflow, included staff accountability for the new process. To further embed the change idea, the app used for tracking and case notes was updated to include parent self-care goal-setting. This helped to systematize and standardize the new work flow within the existing system.

Improving Care Together:

The *Care Resource Binder* work started in Specialized Geriatric Services. A working group was established to develop the core components of the binder and tools to support the use of the binder. Once the tools were developed, the binder was implemented on a small scale to test the process (PDSA cycle) - five patients/caregivers were given a binder on admission. Project team members monitored the use of the binder over the inpatient stay, made notes and interviewed staff, patients and caregivers at discharge. Information gathered was used to modify the

binder and workflow process. The binder was re-implemented across the unit with the content and process improvements. Embedding the use of the binder into the workflow was key to the success of this initiative. The project team worked with unit champions to develop the process and a training plan to ensure all staff understood the purpose of the binder and how to use it. *Care Resource Binders* are being rolled out across the organization (i.e., in Complex Care, Stroke, Spinal Cord, Veteran’s Care Geriatric Psychiatry and Breast Care). Small working groups are tailoring the binder to suit the needs of the patient and caregiver population in each program/department.

9. Invest time and resources into communication – communicate and communicate some more. Provide early and regular updates to frontline providers, partners and stakeholders, and share a roadmap of the change initiatives – i.e., the current status and plans to move forward. Communication efforts can explain how the initiative will impact all individuals involved and debunk rumours or myths regarding the change initiatives. Be thoughtful about the communication strategies you use. Sometimes promoting initiatives passively by using posters or pamphlets is less effective than having a champion host a *lunch and learn* or breakfast event or working through inter-professional groups to increase awareness of the initiative. Investing in meaningful communication will build transparency, trust and support for change initiatives.

 <p>Create a summary of the planned changes for program, unit or department staff, including the names of the project team members, long before implementation.</p>	 <p>Work with caregivers to inform social media messaging about the implementation of change ideas.</p>	 <p>Attend unit huddles and business meetings to provide project updates to the rest of the team.</p>	 <p>Use “Lunch and Learns” or breakfast meetings to profile initiatives and distribute printed materials or electronic resources to build momentum and support implementation.</p>
	 <p>Attend nursing unit council meetings to provide project updates.</p>	 <p>Prepare updates from the Steering Committee to all partner organizations on the status and plans.</p>	
		 <p>Find ways for staff on the project team who do shift work to easily communicate with other team members and project leaders.</p>	

Cultivating Change:

During testing of the *E-Rounds* initiative on the NICU, the project team was surprised by the divisiveness in support for the project among nursing staff. Some were supportive of the project while others were opposed. Team members heard that there were rumours circulating that

the implementation of *E-Rounds* would lead to mandatory recording of nursing staff. The team started to provide regular updates during the Nursing Unit Council, which helped to dispel the rumours. The team also increased the level of nursing engagement during the incremental implementation of *E-Rounds*, ultimately leading to growing support for the initiative on the unit.

Improving CARE Together:

To support implementation of the *Care Resource Binder* in Specialized Geriatric Services, workflows of several providers had to be modified. The project team worked with unit champions to develop a training plan to ensure all staff understood the binder change initiative and how to use it. The resulting training plan was multi-pronged: (i) training sessions were held during staff meetings and at team huddles; (ii) emails were sent to staff to explain the *CARE Resource Binders* and how staff could use them; role-specific cue cards were created to support learning and adopting the new workflows; and (iv) posters and communication boards promoted the resource binder and training sessions.



Connecting the Dots:

Implementation support by full-time education implementation specialists was provided across partner organizations. This process involved working with champions and leaders, and actively communicating by: (i) attending staff/team meetings, huddles and patient/client rounds;

(ii) identifying successes, gaps and process improvement areas; (iii) hosting lunch and learns and/or coffee breaks; and (iv) offering one-on-one coaching and mentoring opportunities. This approach developed ongoing communication strategies within organizations to reinforce education on tools, resources and implementation processes. Investing time on the unit, in the clinic and in the community allowed the project team to identify, connect with and empower early influencers for sustainability.

10. Establish a process to elicit feedback from frontline providers and staff, caregivers and patients/clients after implementation of the change initiative. Feedback from a range of perspectives can provide valuable insights about the testing and implementation process, support continuous improvement of the change initiative after implementation, and inform the testing of new change initiatives. Providing an opportunity for patients/clients, caregivers and frontline providers/staff to offer feedback is key to demonstrating the value of their voice in the process of improving care.



Cultivating Change:

In planning for the launch of the *Family Presence Policy*, the team scheduled meetings with the 14 units at the *Bridgepoint* site where team members, leadership and security staff could explain the new policy and respond to questions and concerns. The new policy was communicated widely before the launch (i.e., posters were put up outside patient rooms and in the elevators, breakfast events were hosted to educate providers about the go-live date, etc.) After the shift from visiting hours to the Family Presence Policy, team members returned to all units to ask how it went. They also established a process to monitor the number of caregivers staying overnight and documented concerns and suggestions from providers/staff, patients/clients and families.

The Change Foundation:

The Caregivers as Partners initial 3-part provider education series was tested at each of the Changing CARE project sites. A short survey was developed to help elicit feedback from providers and staff at the sites. Using the feedback gathered, changes were made to the series (e.g., reducing statistic-related content) and the modules were finalized and re-launched. Through asking for provider and staff feedback, the Foundation was able to determine whether the content was perceived as meaningful and useful, and whether it resonated with the target audience.



PLACE

COURTESY OF CONNECTING THE DOTS.

C. PLACE

This section describes and illustrates key learnings 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. There were numerous learnings from the Changing CARE projects that related to the context in which change initiatives took place. These learnings are particularly relevant when considering sustainability and spread of change initiatives.

- 11. Be prepared to adapt change initiatives as you spread throughout different units, departments and programs within an organization or in a new organization. There is no *one size fits all*. A change initiative that was met with success in one area of an organization or in one organization may not necessarily attain the same level of success in another area or in a partner organization. Change initiatives may need to be adapted to align with the culture, processes and structure in a new setting (unit or program) or a new organization. When spreading a change initiative to a new area, set up a working group to co-design the customizations or modifications to the change initiative to increase the likelihood of successful implementation, sustainability and buy-in from frontline providers.**

Improving CARE Together:

The Care Resource Binder, originally co-designed and implemented in Specialized Geriatric Services, was spread to Complex Care, Stroke, Spinal Care, Geriatric Psychiatry, Breast Care and Veteran's Care programs. Recognizing that the patient and caregiver population is different in each of the programs, small 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 of the program areas, and to determine opportunities to embed the binder into existing workflows. For example, patients in the Veteran's Care program expressed that they would like to include small personal items, such as photographs in the binder. Accordingly, one of the customizations to the *Care Resource Binder* in the Veteran's Care program was the addition of a few pages of photograph pockets.



Connecting the Dots:

Phased co-design teams developed caregiver resources in various settings, with team members from partner organizations. The variety of team members and caregivers ensured that the resources created would be adaptable for use within another setting. Three key project streams

included creating a *Time to Talk* toolkit, developing communication tools and resources, and customizing provider and caregiver education content. A family health team took the lead on developing the *Time to Talk* toolkit; a hospital inpatient unit took the lead on the caregiver communication tools and resources; and a community care provider took the lead on developing education content. Through a number of organizational planning meetings, the suite of local resources and tools were further reviewed to consider the unique culture of care and processes, in order to implement and share the resources with caregivers and clients/patients.

Embrace:

Caregiver Inclusion in Discharge was first tested and implemented on the In-patient Mental Health Unit. When Caregiver Inclusion was expanded to the Emergency Department (ED), a new project team of caregivers, ED providers/staff and senior leadership was set up to guide the testing and implementation of *Caregiver Inclusion*. The senior director in the ED played a pivotal role in removing barriers to the project’s success. Given the environment and work processes in the ED, modifications were required to effectively and meaningfully include caregivers in the care process. As part of ensuring staff support and planning for sustainability of caregiver inclusion in both in-patient mental health and the ED, changes were made to human resource processes and forms in the unit and department. For example, to support a culture of caregiver inclusion, new requirements about recognizing and supporting family caregivers were embedded in job interview questions, job descriptions and performance reviews. In addition, the electronic health record was adjusted to include new questions pertaining to caregivers.

		2020/03/03
		13:28
 ED - Caregiver Identification		<input checked="" type="checkbox"/>
4 ED - Caregiver Identification		<input checked="" type="checkbox"/>
ED - Caregiver Identified	-----	
ED - Reason Caregiver Not Identified	-----	
ED - Verbal Consent to Share Information	-----	
ED - Caregiver Contact Name/Phone Number	-----	
ED - Plan of Care Discussed/Shared	-----	

12. Build a learning culture that enables testing of change incrementally and accepts failure of elements of change as a learning opportunity. Failed tests can lead to creative uses of resources and negative feedback can inform learning. If something doesn't work, ask *why*? Then ask *who else* or *what else*? These will reveal other, perhaps previously hidden supports or resources that may work better. Being open and flexible to the unanticipated can facilitate refining the change initiative so it is practical, adaptable to other groups and sustainable.

Cultivating Change:

The *Caregiver Profile* was designed to give staff and caregivers in the Seniors Day Program more opportunities to connect and learn about each other, and for staff to offer timely and relevant support based on the caregivers' responses to a series of questions. During the PDSA cycles it became apparent that despite early commitment to the idea, staff did not view the form favourably. Some were struck by the intrusiveness of the questions and others felt uncomfortable asking the questions. The co-design team re-engaged the staff in small group prototyping sessions to re-design the caregiver profile and address some of their concerns about scope creep and the need for supported conversations with caregivers. This led to clarifying new workflows to support the completion of the profile with caregivers, as well as equipping staff with new tools to help them support caregivers.

Connecting the Dots:

The *My Healthcare Journey Binder* was designed to help caregivers and patients manage healthcare information, appointments and questions they may have through a series of organized templates they could use and adapt as needed. Initially piloted in an inpatient unit in acute care, the early results of the pilot were not as favourable as anticipated by the project team. The project team quickly learned that due to the acute nature of some patients' conditions and challenges of staff leaders to find an appropriate time to connect with caregivers, the setting was not ideal. In subsequent PDSA cycles, the setting was extended to other hospital, primary care and community settings and positive results were witnessed.

13. Align change initiatives to organizational priorities – strategic priorities of the organization, its accreditation goals, or corporate-wide initiatives. Alignment of the change initiatives to organizational priorities helps to provide clarity of purpose, ensures efficient use of organizational resources and improves the project’s success and sustainability. When aligned to corporate priorities, the project becomes complementary and reinforcing rather than an initiative that is competing for time and resources.



Cultivating Change:

From an organizational perspective, all project initiatives must include patient and caregiver involvement in order to meet Accreditation Canada standards. In the *Stroke Caregiver Training and Education* initiative, the co-design team made a deliberate effort to align work with the Stroke Distinction Accreditation. Change ideas from the initiative were chosen for the Excellence in Innovation Project, which was presented to the accreditors by the project team and a caregiver advisor. The presentation included the co-design, implementation and full evaluation of the initiatives. The organization was recognized with Stroke Distinction from Accreditation Canada in September 2019.



The launch of the *Caregiver Identification (ID)* initiative was coordinated with the hospital’s organization-wide launch of its Family Presence policy. With the implementation of the *Family Presence* policy, families and caregivers have 24-hour access to their loved ones. To ensure patients could rest without restricting access to families and caregivers, quiet hours were introduced. Family caregivers who stay during quiet hours are issued a caregiver badge (Caregiver ID) from security staff and the badge provides access to the unit where the person they are supporting is staying.

“We recognize how important family caregiver support is to the health and wellbeing of members of our community; we are proud to provide a space for those caring for others”

—PRESIDENT AND CEO, CORNWALL COMMUNITY HOSPITAL

Embrace:

With family inclusion as an organizational priority and recognition that hospitals do not tend to have dedicated space and support for caregivers, one of the project priorities was to establish a *Family Caregiver Centre* within the *Cornwall Community Hospital*. The centre is conveniently located on the main floor of the hospital – high value space demonstrating the hospital’s commitment to family caregivers. Caregivers can receive printed resources, one-on-one support from trained volunteer caregivers and access to resources on the *embracecaregivers.ca* website. *The Family Caregiver Centre* provides caregivers with access to a lounge,

kitchenette and family meeting room. The opening of the *Family Caregiver Centre* supports the hospital's shift to a family inclusion culture.



Improving Care Together:

In 2017, *St. Joseph's Health Care London* launched *the Care Partnership* framework, a corporate framework to improve engagement and the experiences of patients, residents and caregivers across the organization. *St. Joseph's* also identified patient and family engagement as a priority in the 2018-2021 strategic plan – *Innovating Together* – which highlights the importance of engaging patient and family partners in quality improvement, research, committees and councils. The Changing CARE work is grounded in *the Care Partnership framework* and supports this strategic priority. More recently, *the Care Partnership Office* was established to operationalize the corporate priority of changing how providers, patients and family caregivers work together. *The Care Partnership Office* was a result of the significant inroads made by the *Improving Care Together* project to accelerate patient and caregiver engagement and co-design. The office will help to sustain the project's work, build capacity for engagement and co-design and facilitate culture change across the organization.

Connecting the Dots:

Three partner organizations – *Alzheimer Society of Perth County*, *Huron Perth Healthcare Alliance*, *the North Perth Family Health Team* – joined four other organizations – *Alzheimer Society of Huron*, *Clinton Family Health Team*, *Knollcrest Lodge* and *Ritz Lutheran Villa/Mitchell Nursing Home* – to engage in a unique accreditation prototype survey aimed at improving access and transitions of care across multiple healthcare sectors. This accreditation survey was the first of its kind in Ontario where seven separately governed organizations were collectively surveyed and evaluated as one. On multiple occasions, surveyors highlighted strong existing collaborative partnerships built on trust as a key driver in the success of this collaborative accreditation survey. Many patients/clients, family members, caregivers and community partners shared positive feedback on the importance that commitment to system-focused healthcare has on population health and overall patient outcomes. This collaborative accreditation initiative was aligned with the philosophy of *the Connecting the Dots project*, where collaboration and commitment of various sectors along with patients/clients and caregivers, was an

influential driver towards achieving patient-centred care and meeting Accreditation Canada standards for client and patient experience.

14. Align with and build on existing systems and resources available in your organization or more broadly in the community. Look for opportunities to partner with existing community or regional resources, or to adapt existing organizational systems (e.g., electronic medical records, databases, human resource systems, organizational learning systems).

Connecting the Dots:

A key project initiative was the caregivers' website – *caregivershuronperth.ca* – a centralized directory of services and supports available to caregivers and patients/clients in the Huron and Perth counties. A key feature of the website is the ability to bookmark services into a customized list that can be printed or shared via email. The website was built by leveraging the *SouthWesthealthline.ca* platform, pulling data from the existing infrastructure to populate information on the mini-site. This approach of building on an existing resource greatly reduced the need for maintenance efforts (seamless updates occur on the mini-site as changes are made on *SouthWesthealthline.ca*). All caregiver resources co-designed through *Connecting the Dots* are available on this website for use by caregivers and healthcare providers within Huron and Perth counties.

Cultivating Change:

Through engagement with caregivers and staff/providers, access to respite care options that are flexible and accessible was identified as a priority. *The Caregiver Resilience (CaRe)* pilot offered innovative delivery of hospital and community respite services to caregivers caring for individuals with serious illness. The pilot provided a suite of services for caregivers – adult day programs, in-home respite services, caregiver support groups, one-on-one supports and short-term hospital stays. A new in-patient caregiver resilience bed was created recognizing the need for 24-hour respite support to meet the specific care needs of caregivers that arise from their own health challenges and life events. The pilot introduced a new way of perceiving the client and caregiver as care partners whose needs are entwined with each other. In order to streamline and embed workflow into existing service structures, both organizations engaged with various departments (e.g., admitting, ethics, privacy, research) and service teams. The project team developed a deeper understanding of each other's organizational culture and opportunities to leverage strengths.

Embrace:

The project team heard that there was a community organization – the local chapter of *Bereaved Families of Ontario* (BFO) – that was closing due to lack of funding. This organization had a strong leader and a cadre of well-trained volunteers who were skilled in active listening and providing support to others. This community resource was instrumental in the launch of the *Family Caregiver Centre* (i.e., their training resources informed the development of a training program for volunteer caregivers in the centre and some of the BFO volunteers became volunteers in the *Family Caregiver Centre*). As well, the decision was made to embed responsibility for the volunteers in the Centre with the hospital’s volunteer coordinator in order to merge it with the hospital’s volunteer program. The project’s *Young Carer* initiative provides another example. The community was successful in its application to establish one of the Youth Wellness Hub Ontario sites in Cornwall. The project team linked their *Young Carer* initiative to the youth hub given the common goals and population. This *Eastern Champlain Youth Wellness Hub* is co-led by the young carer who is leading the *Embrace Young Carer* stream – the only Youth Wellness Hub in the province that is co-led by a young person; and who will host a young carers support group.

The Change Foundation: *The Caregivers as Partners* suite of provider education modules has been developed to be available in three formats – LMS (Learning Management System) format, PowerPoint format, and online web format. For organizations with LMS, the modules can be adapted for implementation across the site based on specific LMS requirements. For organizations without LMS, the PowerPoint versions can be used to support group learning (lunch and learns or department meetings) and the online format can be used for individual learning. The four Changing CARE projects have each developed a different implementation plan for rolling out this provider education resource. Some have made all modules mandatory for all staff/providers, while others have taken a department by department approach.

See Appendix 2 for learnings from co-designing the Caregivers as Partners learning suite.

APPENDIX 1 – DESCRIPTION OF THE CHANGING CARE RESOURCES REFERENCED IN THE REPORT

EMBRACE	
Caregiver Inclusion in Discharge Initiatives	<p>A collection of resources to support caregiver inclusion in the inpatient mental health unit at the Cornwall Community Hospital:</p> <ul style="list-style-type: none"> • The Discharge Checklist for the Family Caregiver is a resource that encourages caregiver participation in the discharge process from the inpatient mental health unit at Cornwall Community Hospital. Formatted as a booklet, the resource supports caregivers in proactively thinking about the information they may require to support a smooth transition from the hospital to the community for the person they are caring for. • The Discharge Pamphlet for the Family Caregiver supports caregivers in participating in discharge planning discussions with healthcare providers. The pamphlet offers key questions for caregivers to consider asking providers to facilitate smooth transitions.
Caregiver Identification (ID)	<p>The Caregiver Identification (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.</p>
Embrace Caregivers Website	<p>A bilingual resource hub (https://embracecaregivers.com/en/ or https://embracecaregivers.com/fr/) designed to meet the unique needs of family caregivers in the addiction and mental health system across Cornwall, Stormont, Dundas, Glengarry and Akwesasne, Ontario (Canada). Engaging over 600 caregivers and healthcare providers in a rigorous co-design process, the project team created a Content Decision Matrix (adapted from Dalhousie University’s “6 Criteria for Websites”) to guide the content inclusion process.</p>

<p>Embrace Implementation Guide Template</p>	<p>A project planning template developed by Embrace’s Implementation and Sustainability Committee to guide project working groups and teams in planning for implementation, spread, and sustainability as the project unfolds; rather than at the end. The 2-page template facilitated the Embrace team in standardizing their approach and documentation for developing, piloting, implementing and sustaining the project’s change ideas. The template enables documenting project goals, decisions, methods, lessons learned, and key resources used. Once the template has been completed, it can serve as a road map for others (e.g. units, programs, or organizations) to use to adapt, modify and implement the change idea of interest. The template has been used by the team to publish the following guides: Partnering with Caregivers in Project Planning & Including Caregivers in Patient Discharge.</p>
<p>Family Caregiver Centre</p>	<p>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.</p>
<p>Making Privacy and Consent Work for Family Caregivers</p>	<p>A resource to simplify understanding the requirements of Ontario’s privacy and consent legislation and foster closer collaboration amongst healthcare providers and caregivers in the addiction and mental health system. This is a companion piece to The Change Foundation’s privacy report (Making Privacy and Consent Rules Work for Family Caregivers).</p>

Young Carers Initiatives

A collection of resources to build awareness around the role of young carers, build a culture that recognizes young carers as partners in care, and connect young carers with local supports in the community:

- The Young Carers Zine is created by and for young carers and features text and artwork from the Embrace project's youth advisors. The Zine introduces the concept of young carers, helps to normalize the experience of carers and highlights available support services for youth to connect with. It also invites young carers to get involved in the Embrace project.
- Rights of a Young Carer is a commitment by Cornwall Community Hospital to acknowledge young carers, remove barriers for their participation and recognize them as partners in care.
- Are you a Young Carer? is a decision tree resource to support self-identification of young carers as caregivers ("carers") - and to connect them with services and supports in the community.
- The Young Carer Advisory Commitment Statement of Understanding is a document that explains the purpose of the Young Carer Advisory Committee and outlines confidentiality and consent processes. The Committee enables a platform for young carers to share their perspectives, experiences and stories.
- The Young Carers Awareness Fact Sheet illustrates facts and statistics about young carers, and features advice for healthcare providers to consider when a young carer is involved in caring for someone with an addiction or mental illness.

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.

Care Partnership Office

Aligned with St. Joseph's Healthcare London's corporate Care Partnership framework and strategic priorities, a corporate Care Partnership Office is under development with the aim of facilitating patient/resident and caregiver engagement across the organization. The office will also provide support to sustain the work of the Improving CARE Together project, which has focused on caregiver inclusion and education and on improving the caregiver experience during care transitions.

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.
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CONNECTING THE DOTS

Caregiver Communication Toolkit

The Caregiver Communication Toolkit is a series of documentation and process related change initiatives implemented across the Huron Perth Healthcare Alliance to improve the interactions between caregivers and providers and the healthcare system at large. The key changes to documentation include updates to the organization's Meditech electronic medical record that involves: (1) the addition of a new patient note template that allows healthcare providers to document communication with and information shared by caregivers; and (2) an update to the Interdisciplinary Database's (IDB) existing Social, Home and Community Supports section that enables documentation to be collected about caregivers during admission. When the IDB is completed, 'patient has a caregiver' prints automatically on the daily nursing worksheet. The caregiver information documented in the EMR is transferable to physicians and is a step towards improving provider-to-provider information exchange. Team members continue to work with inpatient units to incorporate conversations about caregiver identification and supports into daily Discharge. Additionally, to encourage caregiver inclusion, at the Huron Perth Healthcare Alliance a sticker has been added to the existing bedside whiteboards, highlighting an existing space for caregivers to write their name and any questions they have for the care team. Staff are encouraging caregivers to use this section and may write the information for them.

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.

<p>Caregivers Huron Perth Website</p>	<p>A virtual resource repository, www.caregivershuronperth.ca is designed to help caregivers and healthcare providers across Huron and Perth counties find local services, programs and resources. Built as a micro-site on the Southwest Healthline platform, the website pulls from the existing infrastructure to populate information about group activities, events, clinics and resources in an organized and easy-to-use manner as informed by caregivers and providers. A key feature of the website is the ability to bookmark services into a list that can be printed or shared via email. This means providers and caregivers can build a personalized repository of supports.</p>
<p>My Healthcare Journey Binder</p>	<p>The My Healthcare Journey Binder supports caregivers and patients in managing their healthcare information, appointments and questions through a series of organized templates that can be used as is or adapted as needed. The co-designed templates have been informed by the needs of family caregivers and include places to capture: personal information; medications and allergies; medical history, vital signs and activities of daily living; consent; healthcare providers, appointments, tests and procedures; hospital visits; community care; and care planning. A calendar and pages to journal are also included. To help caregivers manage their own stress and health the binder includes caregiver tips in each section.</p>
<p>Provider Education Training Materials</p>	<p>In-person education sessions were facilitated throughout Huron and Perth counties by an education specialist and a caregiver (when possible), with the aim of showing healthcare providers how they can better engage with, and support family caregivers in their daily work. Along with featuring content from the Caregivers as Partners eLearning modules, the sessions introduce providers to the suite of tools/resources co-designed through the Connecting the Dots project. Partner organizations are encouraged to use, adapt and implement the tools and resources in their own way. Sessions are typically two hours in length. Customized versions were developed, by request, to accommodate organizational needs, staff availability and content related to staff roles within project partners and Huron Perth.</p>

<p>Time to Talk Toolkit</p>	<p>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 and is available at www.caregivershuronperth.ca.</p>
<p>Who to Call in Huron & Perth</p>	<p>The Who to Call in Huron Perth Card is a quick and easy-to-use resource that includes key phone numbers and websites for caregivers to use in an emergency, to access urgent emotional support and to connect with local community services. The card is being implemented across project partners and is available at www.caregivershuronperth.ca. A number of stakeholders in Huron and Perth counties have also requested the card for use within their organizations.</p>

CULTIVATING CHANGE	
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 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.
Caregiver Identification	The Caregiver Identification (ID) is a visual way to acknowledge and identify family caregivers in healthcare settings and facilitate their role as partners with the healthcare team. The ID, which is a visual icon, can be implemented in many different ways to formally and informally recognize caregivers. To support caregiver inclusion, the ID has been implemented by the patient’s bedside in care settings (with the patient’s consent) for providers to easily be able to identify and include caregivers in care planning. The ID has also been implemented as a physical access card in conjunction with family presence policies to remove barriers caregivers may experience in visiting a patient during quiet hours.
Caregiver Profile	To enhance caregivers’ access to and experiences of onsite respite care, the seniors day program is improving its communications with caregivers by: (1) implementing a new co-designed caregiver profile template to accompany the client profile and support conversations between staff and caregivers; (2) creating resources to help staff actively support caregivers through easy referrals; and (3) co-designing a brand refresh for the ADP to better reflect its values, principles, and strengths to existing and potential clients and caregivers.

<p>Caregiver Resilience (CaRe) Pilot</p>	<p>The Caregiver Resilience Pilot tests a model of care that aims to provide caregivers with temporary relief by offering a suite of services caregivers can choose from as they fit their needs. Services include: (1) In-Hospital bed for up to 13 days, (2) Adult Day Programs, (3) In-Home Personal Support Worker support, and (4) Individual and group-based caregiver support. The pilot is an integrated project delivered by WoodGreen and Sinai Health.</p>
<p>Self-care for Parent Caregivers (within the Parent Outreach Program)</p>	<p>To support self-care for parent caregivers, WoodGreen has integrated a parent self-care module into the existing Parent Outreach Program Curriculum. The module follows a co-designed model that promotes incremental shifts in awareness and practice around self-care. The model is supported by workbooks that share strategies and prompts for each phase, for staff and caregivers. The workbooks for staff focus on strategies to enable conversation and support self-care awareness and practice. Caregiver workbooks provide tools and space to work through the proposed model.</p>
<p>E-Rounds</p>	<p>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.</p>
<p>E-Talks</p>	<p>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.</p>
<p>Family Presence Policy</p>	<p>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. This policy removes the barrier of caregivers having to schedule their support around visiting hours.</p>

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).

APPENDIX 2: LEARNINGS FROM CO-DESIGNING EDUCATIONAL MODULES FOR PROVIDERS WITH PATIENTS/ CLIENTS, CAREGIVERS & HEALTHCARE PROVIDERS

The Change Foundation, in partnership with the Changing CARE teams, collaborated with patients/clients, caregivers and healthcare providers to co-design the *Caregivers as Partners* elearning suite. The suite aims to help providers improve the family caregiver experience and ultimately become partners in care through two series of learning modules. Recognizing the unique opportunity to develop and implement a single set of common educational modules across all four Changing CARE projects, the teams centralized development with the Foundation's support.

Below are 10 key learnings from The Change Foundation's journey of co-designing the learning modules:



1. Develop a coordinating group to co-design and guide the development of the learning modules.

A coordinating group can play a supportive role in each step of the development process. Initially, the group can support co-designing and curating content by brainstorming and prioritizing topics to include and directing the group towards existing resources. Further along in the journey, the group can support validating and reviewing content for alignment with the intended purpose, and help identify language sensitivities and any further refinement opportunities.

In formulating a coordinating group, consider:

- a group size of 10 to 15 individuals
- including experts in the field who can bring a breadth of perspectives and experiences
- including key stakeholders who can help support your dissemination efforts
- developing terms of reference (TOR) with a clear purpose, objectives, timelines, and roles to help guide the group. TOR can be very useful in maintaining scope and managing scope creep.

Remember to keep the coordinating group engaged throughout the development process by regularly communicating, sharing updates and leveraging the group's unique expertise.



2. Identify the overall purpose and objectives of the learning modules, and clearly define the intended audience to determine the scope of the modules.

Having a clear purpose and defined intended audience is useful in determining what content to include and how to frame it.

Is the purpose of the module to set a baseline understanding? Is the module building from a presumed pre-existing baseline of knowledge, and if so, does this exclude any sub-set of your intended audience? Will content be clinical in nature? What is the key take-away message from the module? Thinking through such questions will help guide you in determining the scope of the modules – i.e., the appropriate content breadth, readability level, and suitable terminology.

In defining your intended target audience, be as detailed as possible. For example, defining your target audience as healthcare providers is too broad. Does your definition mean anyone working in the healthcare space? Does it include only direct service providers (i.e., nurses, physiotherapists) or does it also include supportive staff (i.e., administrative clerks, environmental services)? Is it inclusive of all healthcare sectors?



3. Determine the appropriate medium(s) to deliver and disseminate the educational module to your intended audience.

Education can be delivered in face-to-face group settings (lunch and learns), through web-based individual learning (a website) or through organizational electronic learning management systems (LMSs). Each medium has benefits and disadvantages. For example, while a lunch and learn offers greater engagement opportunities, it can be difficult to schedule.

To determine what format may be ideal or feasible, consider the following:

- What is the size of the intended audience? Is the education for all staff in the organization, or specific units and professions?

- How is education currently delivered in the organization? Is there an existing LMS and/or expertise in-house to build elearning modules?
- Are there financial parameters you are working with? Facilitating a lunch and learn with a presentation will be cheaper than creating web-based training.
- Are there opportunities to spread the modules beyond the unit, program or organization they are currently being developed for? If yes, consider building the modules in a format that allows for easy adaptation.

Try to offer the modules in more than one format to increase uptake, especially when the education may not be mandated.



4. To create learning modules that are effective and resonate with your intended audience, take the time to build your capacity in Adult Learning Principles and Educational Frameworks.

The goal of providing education or training is to go beyond facilitating the learning of material and create engagement to support retention and application of the learning in everyday practice. To develop skills and broaden knowledge to influence attitudes and behaviours, particularly with diverse teams and in diverse environments, understanding the principles of adult learning can be helpful. For example, according to Adult Learning Principles, adults learn best when the learning is: relevant and meaningful to the learner; focused on solving an issue (practical); enables active engagement; and is directed to a goal.

To support the application of Adult Learning Principles, use educational frameworks such as Bloom's Taxonomy that provide instructional strategies and assessments to consider.

As the majority of accreditation requirements are based on adult learning principles, effectively applying them in your learning module will support your accreditation efforts.



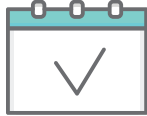
5. Understand the requirements for accreditation by professional healthcare organizations/bodies before developing the modules to facilitate greater reception and uptake among the intended audience.

There are several regulated healthcare professions that must engage in continuing professional development, such as physicians and nurses. These healthcare professionals may be more receptive to education that has been upheld to a rigorous quality assessment process and standard of excellence by an accrediting body such as the Canadian Nurses Association or the Ontario College of Family Physicians.

Although there initially may be no intention of seeking accreditation, understanding the requirements can help you align your processes to be eligible to apply for accreditation if it becomes a priority.

For example, a common requirement to be eligible to apply for accreditation is the formation of a scientific committee with representation of a set number of specific health professionals to guide the development work. Knowing this can support you in including the right number and type of professionals in your coordinating group and review phase.

Accrediting healthcare organizations can also support your knowledge translation and exchange efforts by promoting your learning materials through their communication channels such as their websites and social media channels, and through regular communication updates to members.



6. Use PowerPoint to develop the learning modules to visualize the learner's experience and look for opportunities to enhance their engagement with the material.

When gathering information to use as content, we tend to include more information and resources than we will use in the final product. Everything in the information gathering stage seems important.

PowerPoint is a tool that can support you in organizing content, so it logically flows and is manageable and digestible by learners. It can readily support you in applying Adult Learning Principles to build effective learning materials.

Visually seeing the number of points on an issue can help you to weed out content that may not be as important. It can also illuminate opportunities to include infographics, other visuals, multi-media and interactive activities to enhance the learner's experience.

For example, adults learn best when the learning matches their learning style. Folks may be visual, auditory, and/or kinesthetic learners or learn best by reading/writing. To support different learning styles, Adult Learning Principles stipulate using varied teaching methods to convey the learning. As you build each slide in PowerPoint, you can begin to experience how learners will interact with the content and recognize opportunities to embed different learning methods. If you have three slides of didactic content in a row, you may want to consider introducing a new learning format such as a video or interactive activity.

Building the learning module using PowerPoint enables you to bring the content to life and shape how you want learners to engage with the material.



7. Incorporate content that is tangible, practical and actionable. The *how-to* is key when you want to facilitate behaviour and culture change.

When developing learning modules, you may choose to include statistics and rates to help build the case of the issue(s) the module explores. While numbers can help to convey the importance of the issue, they don't drive behaviour or culture change. Simply knowing x% of patients/clients are not asked about issue A, does not inform the learner on how to change the statistic.

Learners are interested in the *how-to*. Providing tangible and practical information such as steps, instructions and examples can help inform the learner of what they can do to change the norm.

Packing the learning modules with numbers and factoids facilitates a non-engaging environment.

When building content, for each topic, use the following framework to guide you:

- Briefly in plain language explain why the issue is important to the learner (make it relatable, and applicable to day-to-day practice)
- What can the learner do to change the norm?
- What are the steps or actions they can take?

As you build content for the learning modules, try to curate content rather than re-create it. The purpose of the learning module is not to include everything but the kitchen sink. If a resource on a topic already exists, provide some highlights or key messages and reference the resource. If the learner would like to dive deeper into the topic, they know how to navigate to it.



8. Enable diverse perspectives in the content validation process by building multiple review phases with different reviewers in each phase.

When co-designing the learning modules, your coordinating group will offer direction and guidance in brainstorming topics, creating a table of contents and reviewing the first draft of the learning module. To prevent reviewer fatigue with the same group of people, create multiple review phases with a new set of reviewers in each phase. This also enables opportunities for unique perspectives and experiences to shape the content in the learning module.

Each review phase does not need to be a large cumbersome undertaking. Consider building in two to three review phases with five to ten reviewers in each phase to make the process manageable. The initial review phase would be with your coordinating group.

When inviting reviewers to participate, you may want to consider bringing together individuals with:

- diverse professional backgrounds (i.e., nurses, social workers, occupational therapists),
- working in different healthcare sectors (i.e., community care, hospital) and/or settings (i.e., community, urban).

You may also want to consider the eligibility criteria for accreditation to ensure you invite reviewers who support you in meeting the requirements to apply.



9. Book individual meetings with reviewers to enable them to build time in their busy schedules to review and provide feedback.

Often when eliciting feedback from colleagues, an email with the ask, and a due date is sent – but it is unlikely you hear back from everyone. To overcome this challenge, actually scheduling time in your reviewers' calendars prevents them from over-committing themselves.

For example, if you have developed a 20-minute module, schedule a 45-minute meeting with the reviewer. Spend the first 5 minutes going over logistics (e.g., purpose of review, type of feedback anticipated). If the module has been developed on a website, show the reviewer how to enter in their feedback. Use a video-conferencing tool to help facilitate your meeting – this way your reviewer can see your screen and your friendly face too! Remember to connect with potential reviewers at least one month before the review cycle begins as calendars fill up quickly.

Below is an example of an invitation email sent to a reviewer. The email explicitly explains the meeting purpose and process.

We would like to invite you to provide feedback on the electronic version of the ABC modules that are currently in development. For the review, we would set a 45-minute meeting in your calendar based upon what date and time works for you. During the first 5 minutes of the meeting, we will go through some logistics. You will need to sign into the video-conference through the link in the meeting invite. After going over logistics, the video-conference will end and you can use the remaining 40 minutes to review the module and share your feedback using your computer and the module link provided. You will not need to come down to our office. Is there a date and time that works best for you between (Date) and (Date)?



10. Develop a robust review framework to guide you in reviewing, analyzing and prioritizing the feedback received.

You can expect to receive feedback that is conflicting, positive, negative and indecisive. Creating a guiding framework can support you in critically analyzing feedback and refining the learning module. In developing your framework, consider elements that will help you assess: whether the comment made is within scope, if it is an opinion, what the degree of effort is, and what the impact or value of making the change is. Critically thinking about these elements can ensure the changes to be made are of value.

Document the feedback received by the page or slide – include the person's name, and the full comment. Consolidating the feedback in this manner will enable you to efficiently see what reviewers have said about the particular content and allow you to proceed with changes suggested by the majority and find the right balance. Document decisions and the rationale behind them so you can explain why changes were made.

When comments are negative or critical in nature, connect with the reviewer one-on-one to understand where they are coming from. Remember, each of your reviewers are bringing their unique lived experiences and expertise – they may not always agree with the voice of the majority and that is okay. In such situations, use your TOR to help you navigate through challenges such as scope and purpose.



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CONTACT US

The Change Foundation
200 Front Street West
Suite 2501
Toronto, ON M5V 3M1

Phone: 416-205-1579

www.changefoundation.ca