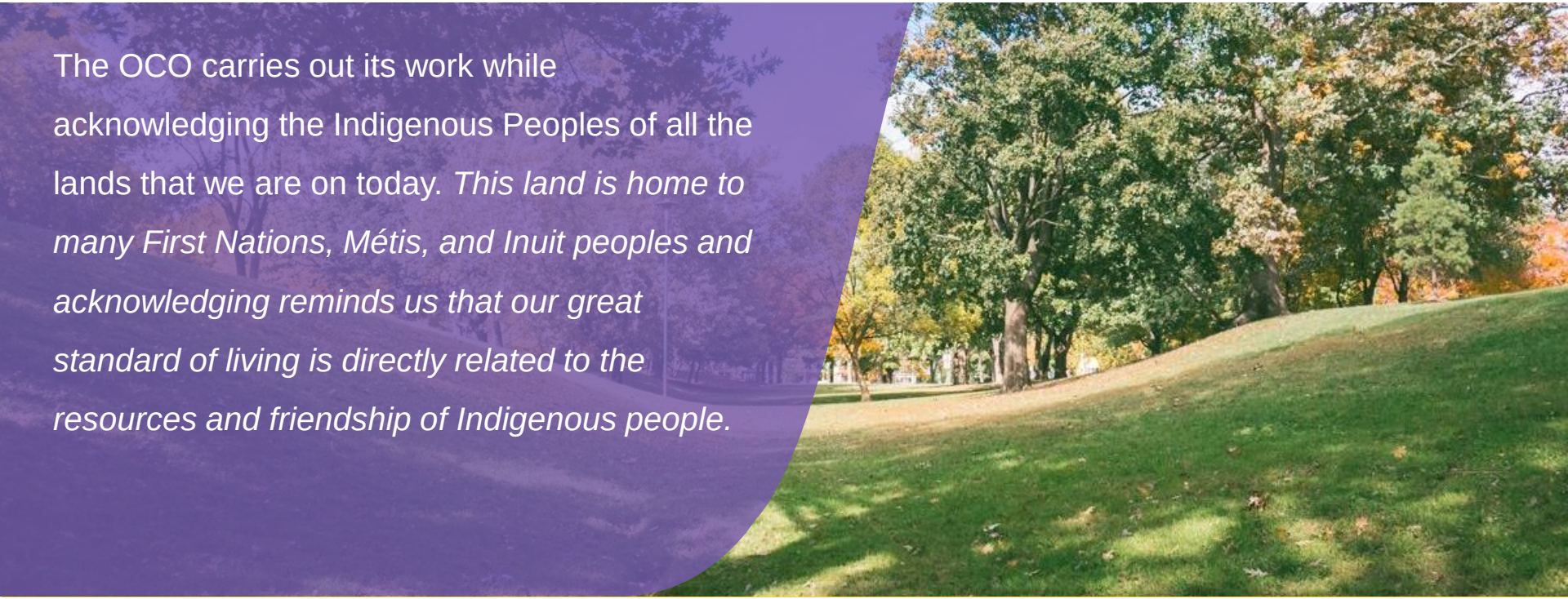
Integrating Caregivers into Ontario Health Team Plans for Improved Transitions

THE ONTARIO caregiver ORGANIZATION

Land Acknowledgement

The OCO carries out its work while acknowledging the Indigenous Peoples of all the lands that we are on today. *This land is home to many First Nations, Métis, and Inuit peoples and acknowledging reminds us that our great standard of living is directly related to the resources and friendship of Indigenous people.*



Overview for Today

1. Why caregiver involvement is critical to improving transitions and how it is important to your Ontario Health Team
2. Practical tips to advance your OHT goals with examples from RNAO and Transitions in Care
3. Actionable examples for your OHT to embed caregiver inclusion and support into your OHT Work
4. Resources and tools for your OHT

Today's Presenters

Adam Wadon
Patient Family Advisory Council
ALC Working Group

Tiffany Budhoo
System Planner

Kristen Campbell
BPSO OHT Coach

Lyndsay Howitt
Senior Manager, Guideline Development and Research

Bianca Feitelberg
Project Lead, Strategic Partnerships and Innovation

OUR PURPOSE

The Ontario Caregiver Organization (OCO) exists to improve the lives of Ontario caregivers; ordinary people who provide physical and emotional support to a family member, partner, friend or neighbour

Improving the Caregiver and Patient Experience in OHTs

Learning Events and education

Tools and resources

Collaboration, Guidance and Support

Connect Caregivers to Support

Caregiving in Ontario

4 MILLION CAREGIVERS

51% sandwich generation

49% of care recipients live with the caregiver

Almost half of care recipients are 75 years or older

Caregiving Experience

49% say it's stressful to find services for their care recipient

76% say they are taking on more responsibilities compared to the past year and are experiencing difficulty getting things done

"Juggling their other responsibilities with new caregiving responsibilities, coordinating care among other healthcare providers and providing physical care to the patient are the most difficult aspects of this transition."

– Spotlight Report 2019

“TRANSITIONS ARE TERRIFYING” –

Brina, Caregiver and Co-Chair of the Essential Care Partner Support Hub Advisory Committee

Why are caregivers so critical to OHT work?

75% of care is provided by family caregivers

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
9:30 - 11:30 AM	PSW	PSW	PSW	PSW	PSW	PSW	PSW
11:30 - 12:30	Family	Family	PSW	Family	Family	Family	Family
12:30 - 3:30 PM	PSW	PSW	PSW	PSW	PSW	PSW	PSW*
3:30 - 4:30 PM	Family	Family	Family	Family	Family	Family	Family
4:30 - 6:30 PM	Family	Family	Family	Family	Family	Family	PSW
7:00 - 9:00 PM	Family	PSW	Family	PSW	PSW	Family	PSW
9:00 - 9:30 PM	Family	Family	Family	Family	Family	Family	Family
9:30 - 11:30 PM	Family	Family	Family	Family	Family	Family	Family
11:30 - 9:30 AM 10 hr Overnight Shift	Family						

*Exception is Sunday when it is 12:30 to 2:30 PM

Terrence Ho, Caregiver Weekly Calendar Schedule for the care of his brother, excerpt from Integrating caregivers as partners in care: Momentum for a whole system approach. Report from the 2024 Caregivers as Partners in Care Roundtable

Caregivers are the Thread

*"**Continuity**. That one person, usually **the caregiver, knows the history, what the patient's been through, what's worked in the past, what hasn't**. And it helps to be realistic about what is the person's baseline…like what is it that we're hoping they can do before we send them home? Just **having that in-depth information and knowledge available to the team is very helpful.**" – Manager, Hospital*

Caregiver Inclusion Improves Patient Care

Health system partners report that **inclusion of caregivers benefits the caregiver, patient/resident, front-line providers and the health system** through:

- Improved communication, and person-centred care **leading** to **better health outcomes, safety, quality of care and experience of care**
- **Improved transitions, prevention of falls** and falls-related injuries, **reduced healthcare utilization and re-admission rates**
- Contribution to pandemic and **healthcare crisis preparedness**
- **Improved working conditions** and workload for front-line providers
- **Reducing stress of caregivers** and making them feel like they can make a meaningful and valued contribution to patient care

Caregivers are Critical to Equitable and Safe Care

"When caregivers are included, the system benefits, especially at transition points where they provide information not just about health issues but about who the care recipient is, what they need in terms of culturally affirming and linguistically appropriate care. This allows providers to provide better care."

- Sam Peck, Executive Director, Family Councils of Ontario

Including Caregivers Improves Transitions

Discharge planning interventions that integrate caregivers into the discharge planning process are associated with 25% fewer hospital readmissions up to 6 months post-discharge.

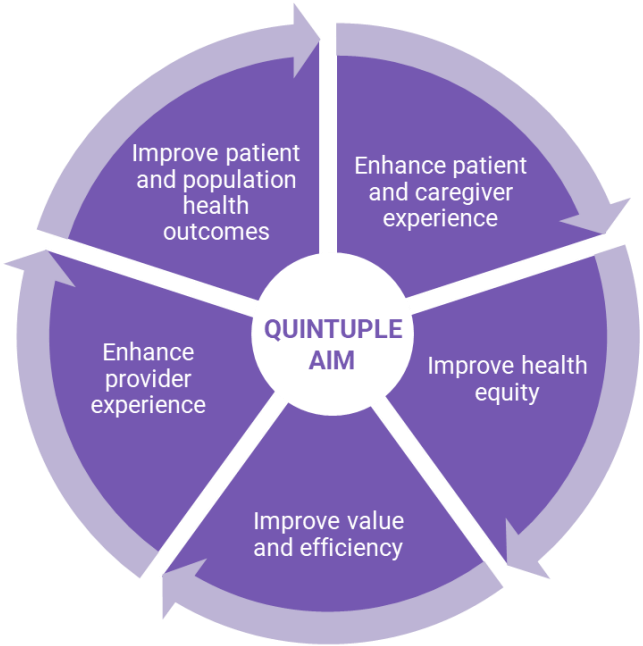
(Rodakowski J. L., 2021).

- Caregivers who receive clear discharge instructions and warnings signs are better able to follow aftercare instructions.

- When caregivers were involved:
  - Patients better understood and could adhere to instructions
  - Providers were able to meet patient's multiple care needs

Caregiver Integration Supports OHT Priorities

- Readiness for Integrated Home Care Delivery
- Integrated Care with a Population Health Management and Equity Approach
- System Navigation



Integrating Caregivers into your OHT Plans for Improved Care

OVERVIEW OF THE BEST PRACTICE SPOTLIGHT ORGANIZATION® PROGRAM FOR ONTARIO HEALTH TEAMS (BPSO® OHT)

OCO WEBINAR: INTEGRATING CAREGIVERS INTO ONTARIO HEALTH TEAM PLANS FOR IMPROVED TRANSITIONS

September 25, 2024

Plan for today

AGENDA ITEM	LEAD
What is a BPSO OHT and why does this program matter?	Kristen Campbell, RN, MN; BPSO OHT coach
How the BPSO OHT program deliverables are designed to support the Quintuple Aim? - Program supports and resources	Kristen Campbell
Overview of RNAO's Transitions in Care and Services Best Practice Guideline • Recommendations focused on caregiver integration	Lyndsay Howitt, RN, MPH; Senior Manager, Guideline Development and Research
Next steps for joining and connecting with our team	Kristen Campbell

WHAT IS A BPSO?

BPSO - Best Practice Spotlight Organizations® (BPSO®)

- 20+ years
- Supports effective implementation of Best Practice Guidelines (BPGs)
- Aims to enhance the use of evidence in decision-making to improve health outcomes and optimize healthcare delivery for persons and their caregivers (support network)
- Achieves the quintuple aim

WHAT IS A BPSO OHT?

- ✓ Offers an evidence-informed approach to scale up and spread best practices within integrated systems of care
- ✓ OHTs enter a formal partnership with RNAO for a four-year “pre-designation” period to work across multiple sectors to collectively implement BPGs
- ✓ Tailored strategies to support OHT objectives and deliverables, ensuring alignment with the quintuple aim
- ✓ Mobilizes teams from across disciplines and sectors including caregivers




BPSO OHT NETWORK

BPSO RNAO BEST PRACTICE SPOTLIGHT ORGANIZATION OHT
For integrated systems of care

archipel.
Équipe Santé Ontario | Ontario Health Team

East Toronto Health Partners

Northern York South Simcoe
ONTARIO HEALTH TEAM

NORTH WESTERN TORONTO
Ontario Health Team

CAMBRIDGE NORTH DUMFRIES OHT

Chatham - Kent OHT
ONTARIO HEALTH TEAM

MAAMWESYING
NORTH SHORE COMMUNITY HEALTH SERVICES INC.

Équipe Santé Ontario Health Team
Ontario Bimaadzwin Niigaanwiwaad

Sarnia-Lambton
ONTARIO HEALTH TEAM

BPSO OHT Program Supports - *free of charge*

- ✓ Dedicated coaching team
- ✓ Best Practice Guidelines that advance OHT goals and align with priority populations
- ✓ Leading Change Toolkit
- ✓ Capacity building
- ✓ Quality indicators
- ✓ Knowledge exchange with local and global network
- ✓ Funded fellowship opportunity for a team

Best Practice Champions Network

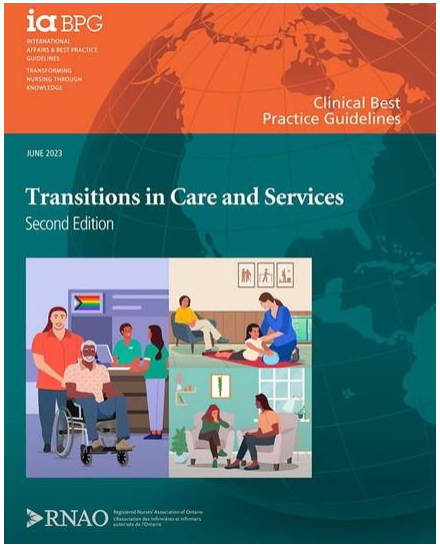
LEADING CHANGE TOOLKIT™

ACPF

NQuIRE®

OVERVIEW OF THE TRANSITIONS IN CARE AND SERVICES BEST PRACTICE GUIDELINE

Recommendations focused on caregiver integration



Download for free:
https://rnao.ca/bpg/guidelines/transitions-in-care

Purpose and scope

Provides evidence-based recommendations for nurses and members of the interprofessional team, organizations and the health system to support safe and effective transitions in care for pediatric and adult persons and their caregivers (support network).

Includes transitions:

- Within organizations
- Between/across organizations and sectors
- Between healthcare and social care settings

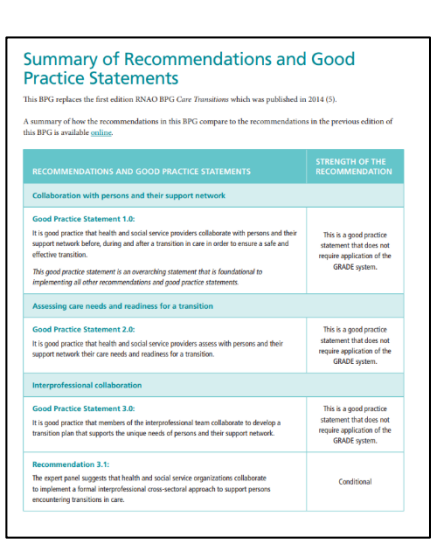
The *Transitions in Care and Services,* Second Edition BPG is a foundational guideline for all health sectors. It is central to the work of BPSO OHTs and was developed in consultation with them.

BPSO RNAO BEST PRACTICE SPOTLIGHT ORGANIZATION OHT
For integrated systems of care

Good practice statements and recommendations

Five broad areas:

- collaboration with persons and their support network
- assessing care needs and readiness for a transition
- interprofessional collaboration
- review of medication history
- navigation support



Summary of Recommendations and Good Practice Statements

This BPG replaces the first edition RNAO BPG *Care Transitions* which was published in 2014 (5).

A summary of how the recommendations in this BPG compare to the recommendations in the previous edition of this BPG is available online.

RECOMMENDATIONS AND GOOD PRACTICE STATEMENTS	STRENGTH OF THE RECOMMENDATION
Collaboration with persons and their support network	
Good Practice Statement 1.0: It is good practice that health and social service providers collaborate with persons and their support network before, during and after a transition in care in order to ensure a safe and effective transition. *This good practice statement is an overarching statement that is foundational to implementing all other recommendations and good practice statements.*	This is a good practice statement that does not require application of the GRADE system.
Assessing care needs and readiness for a transition	
Good Practice Statement 2.0: It is good practice that health and social service providers assess with persons and their support network their care needs and readiness for a transition.	This is a good practice statement that does not require application of the GRADE system.
Interprofessional collaboration	
Good Practice Statement 3.0: It is good practice that members of the interprofessional team collaborate to develop a transition plan that supports the unique needs of persons and their support network.	This is a good practice statement that does not require application of the GRADE system.
Recommendation 3.1: The expert panel suggests that health and social service organizations collaborate to implement a formal interprofessional cross-sectoral approach to support persons encountering transitions in care.	Conditional

Pages 12-13

Transitions in Care and Services Recommendations and Good Practice Statements aligned with caregivers

1. Collaboration with persons and their support network

It is good practice that health-and social-service providers collaborate with persons and their support network before, during and after the transition in care in order to ensure a safe and effective transition.

2. Assessing care needs and readiness for a transition

It is good practice that health and social service providers assess with persons and their support network their care needs and readiness for a transition.

Transitions in Care and Services Recommendations and Good Practice Statements aligned with caregivers

5. Navigation support

It is good practice for health-and social-service providers to provide persons with information and support to manage their needs during transitions in care.

KEY POINTS

- The BPSO OHT program is aligned with Quintuple Aim and OHT deliverables.
- Offers structure and supports to help disciplines, across the spectrum of care work together to implement consistent, evidence-based practices.
- The *Transitions in Care and Services* BPG is a foundational guideline for all health sectors and central to the work of BPSO OHTs.
- The *Transitions in Care and Services* BPG provides evidence-based recommendations for nurses and members of the interprofessional team, organizations and the health system to support safe and effective transitions in care for pediatric and adult persons and their caregivers (support network).

RNAO

THANK YOU!

This work is funded by the Government of Ontario.

All work produced by RNAO is editorially independent from its funding source.

How to connect with our team

Submit questions or inquiries, Kristen Campbell at kcampbell@rnao.ca

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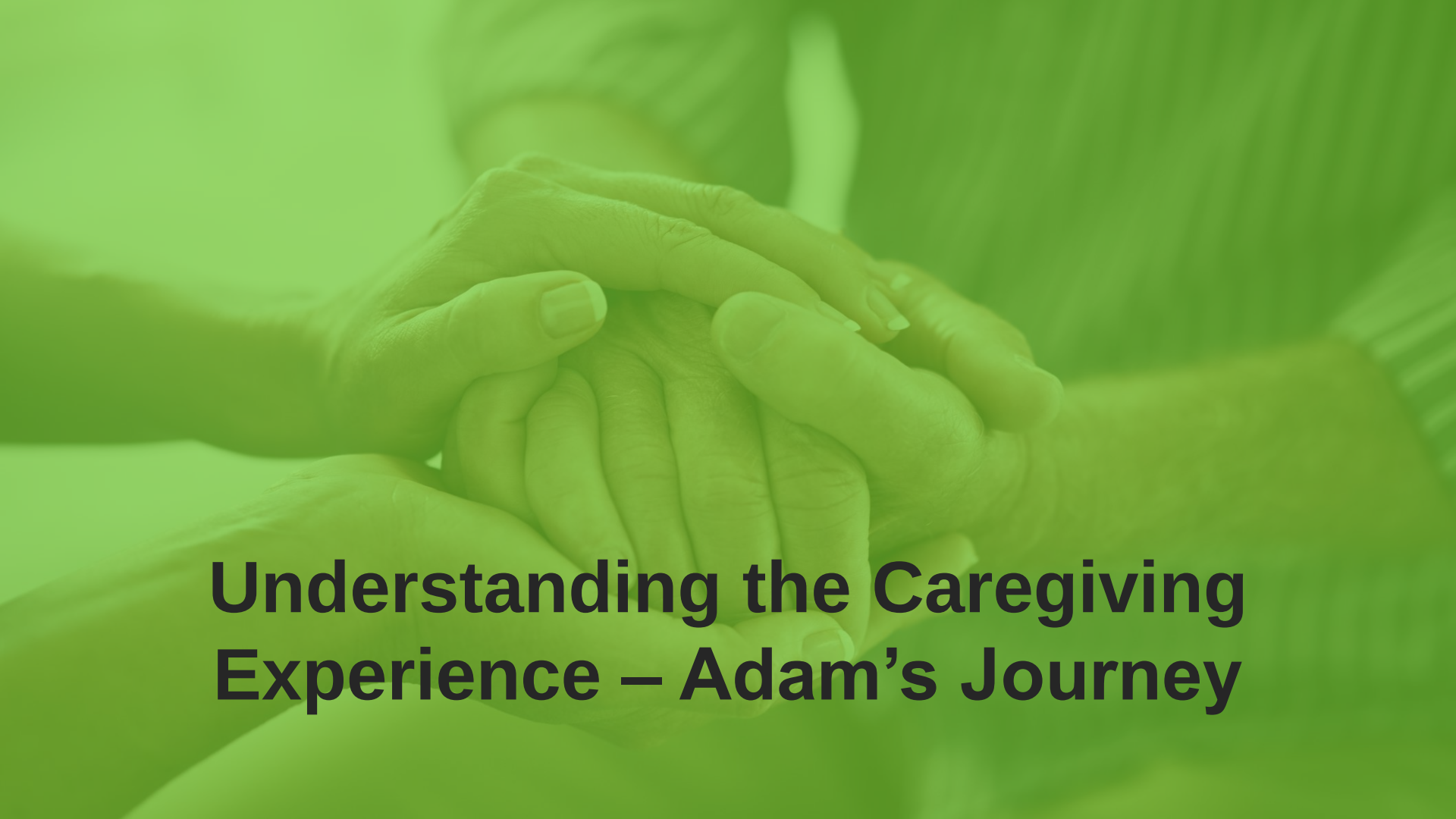


Understanding the Caregiving Experience – Adam’s Journey

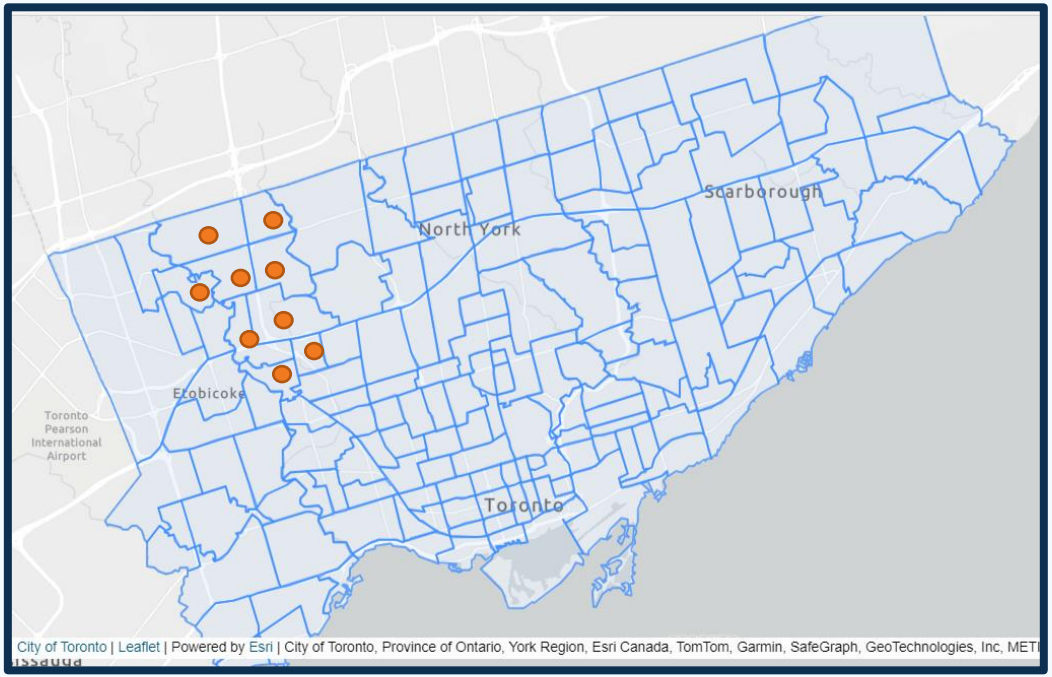
NORTH WESTERN TORONTO

Ontario Health Team

Supporting Caregivers through Collaboration

Wednesday September 25th 2024

Context Setting – About the NWT OHT



Current Signatory Partners

Across Boundaries
Addiction Services
Black Creek Community Health Centre
Canadian Mental Health Association Toronto
Cota
Humber River Family Health Team
Humber River Health
Loft Community Services
lumacare
Runnymede Healthcare Centre
Health
Unison Health & Community Services
villa colombo
West Park

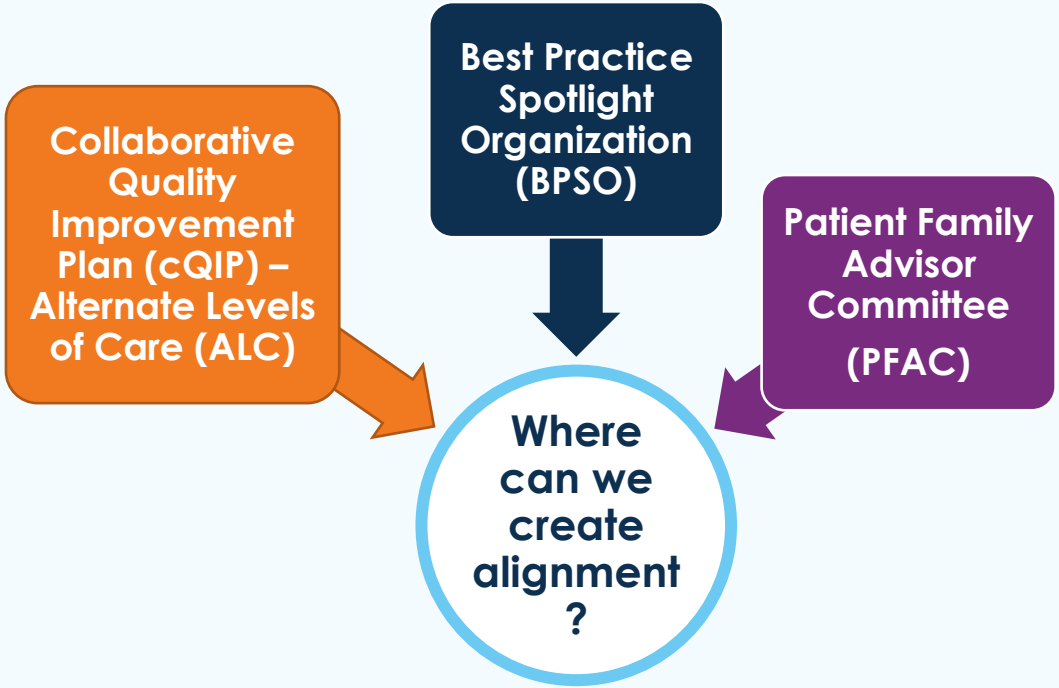
Snapshot - Senior Profile (65+)

Seniors accessing Ontario Health atHome services (homecare services):

- Majority with lower risk of unplanned ER visits within 6 months
- **At least half are at greater risk** of Long-Term Care Home placement and **caregiver burden within 1 year.**
- Higher rates of physical inactivity & overweight/obesity status compared to rest of Toronto*
- Lower rates of tobacco use compared to the rest of Toronto*
- Increasing risk of falls
- **At risk for caregiver burnout**

*Source: PHSI Dashboard-Adult Chronic Disease (ontariohealthprofiles.ca)

Enablers – Looking at our OHT Assets



Enablers – Looking at our OHT Assets

cQIP – ALC

- **Target population for cQIP:** Caregivers of frail seniors
- **Problem statements identified:**
  1. System Navigation
  2. Assessment of Needs
  3. Inclusion in Care Team

Enablers – Looking at our OHT Assets

BPSO

-

Transitions in Care and Services

Best Practice Guideline

- **Goal of BPSO OHTs:** collective implementation of best practices and policies across the OHT

- **Best Practice Statements identified:**
  1. **Navigation support**
  2. **Assessing care needs and readiness for a transition**
  3. **Collaboration with persons and their support network**

Enablers – Looking at our OHT Assets

Patient Family Advisor Committee (PFAC)

- **Goal of PFAC:** Embed patient and family perspectives into OHT initiatives.
- Opportunity to **incorporate co-design principles**

Exploring the Gaps – Local Needs Assessment

What is the caregiving journey and what may be contributing to burnout?

Local Assessment

Completed a series of caregiver focus groups to better understand the local caregiver experience

Summary of Findings (what we heard) **&**

Summary of Recommendations (what caregivers need)

Exploring the Gaps – Local Needs Assessment

Summary of Findings: Participants were asked to share about their experiences during the pre-transition, transition, and post-transition in care periods.

Participants experienced the **most challenges** during the **pre-transition** and **transition periods**:

- Challenges managing the care coordination
- Lack of appropriate resources/information
- Family strain/stress; guilt/emotional burden; financial challenges
- Mixed experiences regarding communication with the care team
- Limited homecare supports

Participants felt **more comfortable** during the **post-transition in care** as they felt **better equipped** with information.

Exploring the Gaps – Local Needs Assessment

Summary of Recommendations:

- Provide information on financial support/guidance
- Access to mental health supports and counselling
- Develop more accessible, relevant and timely information
- Provide advance care plans as a tool for more person-centred care
- Comprehensive and earlier orientation to options to support aging in the right place
- Invest in culturally appropriate supports

Looking Ahead – Change Ideas

Using findings from our **local needs assessment** & the three pillars of the OCO's Essential Care Partner Program: **identify, include and support**, we **developed change ideas.**

Caregiver Initiatives

Supports for Service Providers	Supports for Caregivers	System-Wide
• Senior Services Provider Fair • Education Session	• Caregiver Resource Hub • Caregiver Support Group	• Essential Care Partner Program

Looking Ahead – Change Ideas

Supports for Service Providers

Senior Services Provider Fair

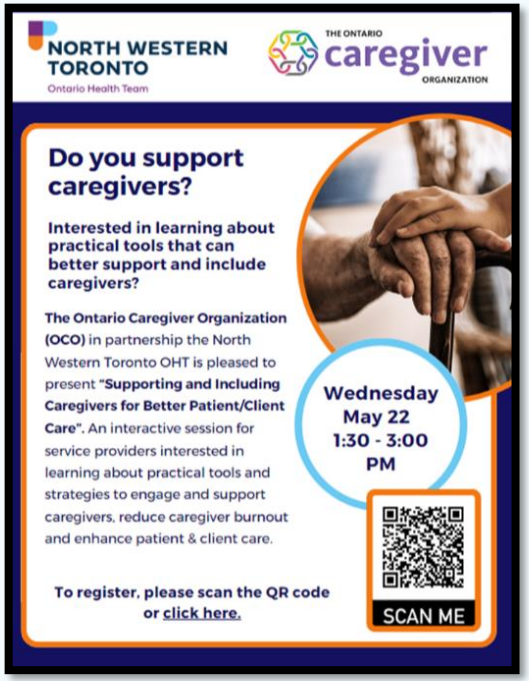
- **Goals and Objectives:**
  - Improve patient transitions/discharges and service navigation
  - Increase service providers' awareness of local services (including referral process, eligibility criteria, etc.)
  - Improve collaboration/partnerships amongst local organizations across sectors/continuum of care

Looking Ahead – Change Ideas

Supports for Service Providers

Education Sessions

- Hosted a webinar in partnership with the OCO to highlight the essential role of caregivers and share practical tools frontline service providers
- Planning an additional webinar on Cultural Competency in collaboration with our Health Equity committee.



Looking Ahead – Change Ideas

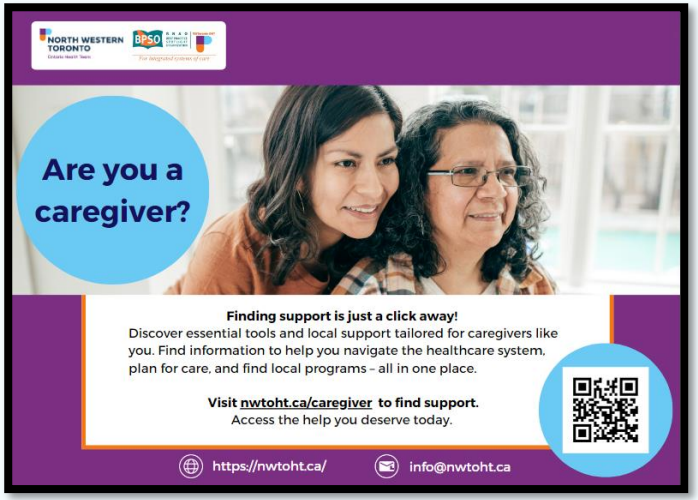
Supports for Caregivers

Caregiver Resource Hub

Online resource that provides information to support caregivers:

- Resources for Advance Care Planning and Goals of Care
- Tips for managing transitions in care
- Information on accessing key supports including financial aid, respite care, support groups, etc.
- Links to navigation tools including Health811, The Toronto Service Directory, etc.

Access the resource at **www.nwtoht.ca/caregiver**

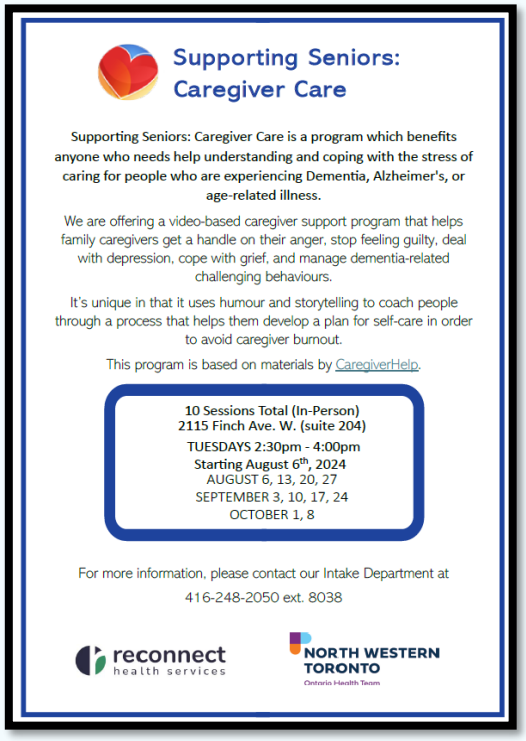


Looking Ahead – Change Ideas

Supports for Caregivers

Supporting Seniors: Caregiver Care Workshops

- 10 in-person workshops **focused on supporting caregivers** who need help understanding and coping with the stress of **caring for people experiencing Dementia, Alzhiemer's or age-related illness.**



Supporting Seniors: Caregiver Care

Supporting Seniors: Caregiver Care is a program which benefits anyone who needs help understanding and coping with the stress of caring for people who are experiencing Dementia, Alzheimer's, or age-related illness.

We are offering a video-based caregiver support program that helps family caregivers get a handle on their anger, stop feeling guilty, deal with depression, cope with grief, and manage dementia-related challenging behaviours.

It's unique in that it uses humour and storytelling to coach people through a process that helps them develop a plan for self-care in order to avoid caregiver burnout.

This program is based on materials by CaregiverHelp.

10 Sessions Total (In-Person)
2115 Finch Ave. W. (suite 204)
TUESDAYS 2:30pm - 4:00pm
Starting August 6th, 2024
AUGUST 6, 13, 20, 27
SEPTEMBER 3, 10, 17, 24
OCTOBER 1, 8

For more information, please contact our Intake Department at
416-248-2050 ext. 8038

reconnect health services

NORTH WESTERN TORONTO

Looking Ahead – Change Ideas

System-Wide

Implementation of the Essential Care Partner Program

- Humber River Health is currently implementing the ECP program at two their units (Reactivation Care Centre – Finch Site and their Geriatric Outpatient Clinic)
- Planning to expand to community Spring 2025

Lessons Learned - Collaborating with OHT Groups

Successes

- PFAC:
  - Opportunity for PFAC to bring diverse thoughts/ideas
  - Breaks down silos between service providers and community members
  - PFAC's "voice" is heard throughout the process of the project (from initial idea to final product) – "not just consultants"
- Alignment between multiple OHT priorities

Opportunities

- PFAC: Have clear roles and responsibilities for PFAC to ensure understanding
- Embed caregivers into OHT strategic plan as a key priority population
- Consider long-term sustainability

What's next?

1. Monitor and evaluate usage and efficacy of Caregiver Resource Hub
2. Host education session on cultural competency
3. Design co-design model for other OHT initiatives
4. Spread and scale ECP program to community partners

NORTH WESTERN TORONTO

Ontario Health Team

Want to know more? Connect with **Tiffany at tbudhoo@hrh.ca.**

Thank you!

nwtoht.ca

@NWTorontoOHT

Actions for your OHT

Demonstrate leadership: a commitment to caregivers as a priority is a key first step.

Engage Caregivers at your planning tables for their valuable insights and experience

Acknowledge and Include Caregivers: build caregivers into integrated care pathways and working groups, and OHT priorities

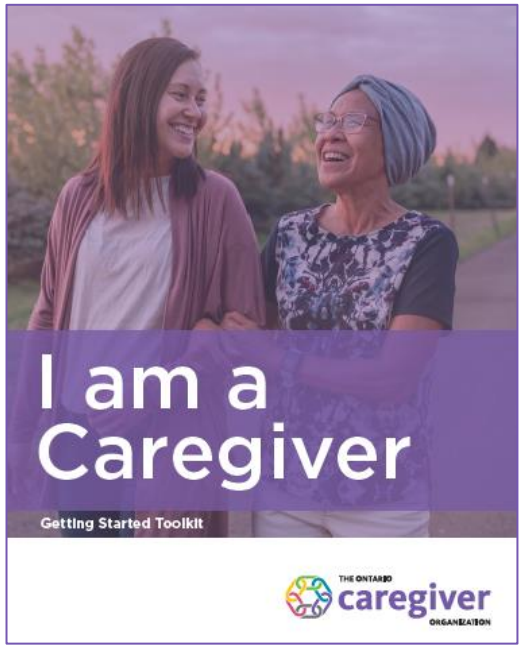
Connect Caregivers to Support: provide caregivers with information, tools and support

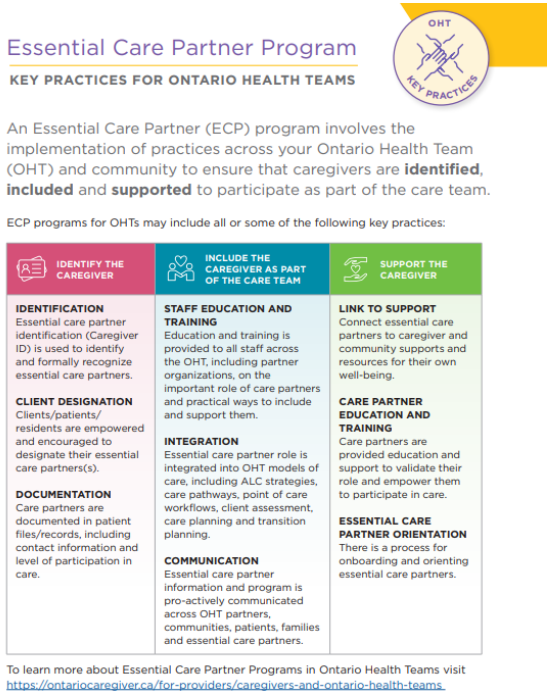
Contact OCO to help you integrate caregivers in your OHT Plans

"Within our Ontario Health Team, we started by defining caregivers in our strategy as a priority population."

– Laura Tenhagen, Project Management Consultant, Sault Area Hospital

Resources for OHTs





[Visit Caregivers and Ontario Health Teams to Learn More]

THE ONTARIO caregiver ORGANIZATION

CONTACT US

Bianca Feitelberg
Project Lead Strategic Partnerships and Innovation
biancaf@ontariocaregiver.ca

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www.ontariocaregiver.ca

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