

Evidence *in* Context

Health research — synthesized and contextualized for use in Newfoundland & Labrador

Health System/Knowledge
User Feedback
CHRSP Studies 2008-2014

Newfoundland & Labrador Centre for

**APPLIED
HEALTH
RESEARCH**

www.nlcahr.mun.ca

About this Report

CHRSP is committed to evaluating and optimizing the relevance, uptake and impact of its research studies for its health system partners.

Once sufficient time has elapsed between publication and the opportunity for our health system to apply the results (this depends on the topic and the complexity of the interventions under consideration but can be anywhere from one to five years after publication and dissemination), CHRSP solicits direct feedback from stakeholders and decision makers to evaluate uptake by asking how the reports were used and to identify areas for potential improvement.

Whom do we ask and how?

We email a very brief, two question survey to all CHRSP Champions, Health System Leaders, Contextual Advisors, Team Consultants, Project Team members, and to anyone who attended the dissemination event for each study. Responses are then gathered/collated from emailed replies and recorded in the evaluation folder for each study.

SAMPLE EVALUATION SURVEY

In _____ (date), you [consulted with us on a project] and/or [attended a knowledge translation presentation] hosted by NLCAHR on the topic of _____.

We are writing to follow-up on the '*Evidence in Context*' report prepared under NLCAHR's Contextualized Health Research Synthesis Program (CHRSP). This report, entitled _____ in Newfoundland and Labrador, synthesized and contextualized existing research about _____.

NLCAHR is committed to improving the quality and relevance of its CHRSP reports; as such, we are seeking your input. Please provide a brief response by return email to the undersigned. If appropriate, these questions can be shared with other stakeholders in your organization and reported back to me.

Was this report useful/relevant to your organization? If so, how?

Please tell us briefly how the report was used or considered in policy decisions: whether it was distributed within your unit, discussed at meetings, referenced in any briefs, incorporated into any decisions, became part of your research library, etc.

If the report was not useful or relevant, please tell us why not and how it might have been improved.

Here, briefly describe why the report was not used or considered in policy decisions: whether it was not applicable to your particular area of responsibility, whether it was instead disseminated to others, and/or suggest ways our research program might improve its reports.

Health research can only have an impact when researchers and healthcare professionals work together to enhance uptake through communication. Your feedback is therefore critical to improving our research practice. Thank you for helping us better understand how CHRSP reports are utilized in healthcare policy decisions.

To learn more about NLCAHR and the CHRSP program, please visit us online:
www.nlcahr.mun.ca/chrsp

Feedback included in this report

All feedback has been anonymized for this report

RHA= Regional Health Authority | Government NL= a government health ministry

Some of the feedback included in this report was not solicited by CHRSP but has been included because it was provided in correspondence/ direct communication with our partners. It is also important to point out that for some completed studies, CHRSP continues to work with partners to follow-up on next steps to implementation/ practice; because some studies remain as “works in progress” the surveys for those have been deferred until an evaluation of uptake would be more appropriate for stakeholders.

- Home Dialysis Snapshot (2018)
- Agitation and Aggression in Residents with Dementia in LTC (2014)
- Fall Prevention for Seniors in Institutional Healthcare Settings (2014)
- Age-Friendly Acute Care (2012)

- Mobile Mental Health Crisis Intervention (2012)
 - Youth Residential Treatment (2010)
 - Reuse of Single-Use Medical Devices (2010)
 - Options for Dialysis Services in Rural and Remote NL (2008)
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2018: Options for Home Dialysis (Snapshot)

Link to report: <https://www.nlcahr.mun.ca/CHRSP/HomeDialysis2018.pdf>

Unsolicited feedback contained in email correspondence from the Department of Health & Community Services

I reviewed the Snapshot yesterday and found it very helpful. In fact, I just discussed several of the HBT 'enabling' strategies (HBT Open House and assisted self-care) with the Eastern Health Dialysis Program Manager and we both agree that they are appropriate for implementation in NL. Thank you again. I am distributing the report to the members of the Provincial Kidney Program Advisory Committee during our meeting next week. We will be discussing the findings.

2014: Managing Agitation & Aggression in LTC Residents with Dementia

Link to report: <http://www.nlcahr.mun.ca/CHRSP/DementiainLTC2014.php>

Unsolicited feedback contained in email correspondence from a Regional Health Authority.

Sent: Thursday, August 28, 2014 5:30 PM

To: Kean, Robert

Subject: RE: full draft of our report on LTC residents with dementia

If it helps- your report gives me some good material to use when trying to convince nursing staff and administrators of the importance of the Music & Memory program that we are implementing. I have shared this report with all VPs in our organization. I quote your report saying that music is the first on the list- so know that your report has helped on a very real and tangible level. I will be using it when I try and expand the Music & Memory program to the provincial level next spring.

2014: Falls Prevention for Seniors in Institutional Settings

Link to report: <http://www.nlcahr.mun.ca/CHRSP/FallPrevention.php>

In February 2016, CHRSP sought specific feedback from select healthcare officials about studies on aging to support another funding application. This was not a system-wide survey, but rather directed to senior decision makers only. This feedback was contained in email correspondence from a senior RHA official

Sent: Monday, February 23, 2016 8:21 AM

To: Baker, Rochelle

Subject: RE: Inquiry about CHRSP Studies on Aging

My apologies for the delay in getting back to you. I did share your email with others so hopefully you did get some feedback. Specific to the Falls Prevention for Seniors in Institutional Healthcare Settings (2014) study, we did use the results of this study in collaboration with other best practice documents to support a review of the existing falls prevention program and identification of opportunities to enhance the program. I hope this is helpful.

2012: Age-Friendly Acute Care

Link to report: <http://www.nlcahr.mun.ca/CHRSP/AFAC.php>

REPORT UPTAKE: Health system partners confirmed that the following new policy direction was informed by the findings of the 2012 CHRSP report “Age-Friendly Acute Care” which noted strong evidence for ACE Units to improve the care of seniors in hospitals:



NEWS RELEASE

Eastern Health Implements Acute Care of the Elderly Unit at St. Clare's Mercy Hospital

January 6, 2017 – St. John's, NL: Newfoundland and Labrador's first Acute Care of the Elderly (ACE) unit was introduced at St. Clare's Mercy Hospital this week. This pilot project will see frail patients aged 65 years and over receive tailored, comprehensive interventions to best meet their health care needs.

These patients admitted to 7 West (internal medicine unit) at St. Clare's Mercy Hospital will now meet with one of Eastern Health's specialists in seniors' care to have a comprehensive geriatric assessment and care plan developed. The plan will be implemented in collaboration with the patient's health care team.

SEPTEMBER 2018 CHRSP Feedback Summary Report

"Eastern Health recognizes that one of the greatest challenges we will encounter in the coming years is meeting the needs of an aging population," said Collette Smith, Vice President, Clinical Services, Eastern Health. "By tailoring interventions toward a senior population, Eastern Health is taking steps to ensure their health care needs are met in the most effective way, fostering improved outcomes."

Patients of the ACE unit will be under the supervision of a specialized multidisciplinary team with geriatric expertise. This approach will provide many benefits for patients including a senior-friendly environment, patient-centered care, enhanced discharge planning, frequent medical review and early exercise and rehabilitation.

"Elderly clients often present to hospital with a number of inter-related acute and chronic conditions, their medical needs are often more complex and potentially coexist with functional, psychological, and social needs," said Dr. Susan Mercer, Divisional Chief of Geriatric Medicine, "ACE units offer a comprehensive approach to care and have been shown to reduce lengths of stay, readmissions, long-term care placements and help hospitalized older adults maintain functional independence."

The goals of Eastern Health's ACE unit include:

- To provide optimal care to clients based on best practice guidelines.
- To increase the rate of client and family satisfaction with care.
- To improve the rate of clients returning to their own homes as opposed to another institutional setting.
- To reduce readmissions.
- To reduce total length of stay in hospital.
- To reduce the number of days clients are in hospital while designated an alternative level of care.

Following an evaluation period, Eastern Health will determine whether ACE units will be expanded to other inpatient units in the region.

Stakeholder survey sent May 20, 2015

Government NL: The Age-Friendly Acute Care Report identifies a number of key concepts on the mismatch of seniors being admitted to hospital with an acute episode with the root cause in a chronic condition. The acute care hospital responds to an acute illness with technology and intervention focused on the presenting medical diagnosis, as treatment for the larger chronic condition is not considered appropriate for an acute care hospital admission. Older adults account for one-third of all acute care hospitalizations and almost 50% of all inpatient hospital days. Older adults are admitted in fewer numbers but stay longer; likely because of functional decline and emerging frailty which compounds itself with each passing inpatient day. Outcomes for seniors in acute care are frequently poor and result in a transfer to a long-term care facility. Hospitals can improve outcomes, even outside specialized geriatric units, if staff have enhanced education and training; especially the attending physicians and the use of intraprofessional teams. Geriatric assessments have been found to be key for positive outcomes and enhanced discharge planning contributes to decreased hospital utilization. *The report is very helpful and examines research and the NL context including implications for decision makers in this province. This is a useful document as we consider outcomes for seniors in acute care and how to improve them. It has been circulated to the regional consultants for acute care for their information and consideration when dealing with operational issues and reviewing programs and services.* June 3, 2015

RHA This one page and four page summary was shared and discussed at the OT council, a group of OTs that represent all RHA programs. It was also posted on a shared information folder. The report was useful in validating the need for OT in acute care. Having evidence to support the role of the OT in particular in discharge planning is excellent. I have used this report in briefing notes. This also provided evidence for the importance of interdisciplinary team intervention. A working group focused Inter-professional

education/collaboration to ensure that healthcare students are learning this important skill has now been established. This working group has representatives from Faculty of Med (MUN), Social Work (MUN), Pharmacy (MUN), Nursing (MUN), Professional Practice (EH), Fieldwork coordinators (Dalhousie OT/PT) Respiratory (CONA) and Therapeutic Recreation (MUN) FYI - Currently there is discussion of an OT/PT school at MUN. MUN Faculty of Med is currently the only School of Med in the country without an associated school of Rehabilitation. In revisiting this report – I feel our RHA has not focused sufficiently on the educational needs that are outlined. Something to work on. June 3, 2015

RHA The report was circulated and discussed within meetings related to improving patient flow and discharge planning. I do not recall it being incorporated into any decisions or becoming part of our research library. The report was applicable to my area of responsibility. I support the researchers doing formal follow up with the RHA to help impact transfer of knowledge into practice. June 11, 2015

Provincial Nursing Association Although our association does not make healthcare policy decisions ourselves, we do advocate with Government and stakeholders for policies that support the provision of quality healthcare and will respond to calls for input into government policies/programs that impact the health of the population. We have used (and will continue to use) CHRSP reports in this context. Regarding the Age-Friendly Acute Care report, we included a bulleted summary in our 2012 Environmental Scan. The scan would have been shared with members of our Council, relevant committees and posted to our website. We continue to share information about CHRSP reports with our committees (including Council) and, where relevant, we use the evidence in our briefs/briefing notes, public policy documents, and responses to calls for input on government strategies. I hope this is helpful. If you have any other questions or would like further clarification, please let me know. June 15, 2015

2012: Mobile Mental Health Crisis Intervention

<http://www.nlcahr.mun.ca/CHRSP/RERMMH.php>

“Using the Memphis Model of mobile crisis intervention, 161 visits to homes were made in April 2018 compared to 84 visits in April 2017.” -CBC News July 2018

“The Memphis model for mental health crisis intervention was recommended to the All-Party Committee on Mental Health.... when we looked into it, the CHRSP study on Mobile Mental Health Crisis Intervention supported its use. So yes! CHRSP certainly supported us in being able to fund and support the implementation of the Memphis Model in the province.” -Government Official

2010: Youth Residential Treatment Report

http://www.nlcabhr.mun.ca/CHRSP/YRT_Full_Report.pdf

Full stakeholder survey sent September 15 2011

RHA: With my CEO's support, I circulated this report through all senior managers to staff of the organization. It was more relevant for a smaller group of organizational staff (than was "The Reprocessing and Reuse of Single-Use Medical Devices in NL" report which was completed at about the same time) and received attention from this smaller group. I anticipated its use was likely at provincial committees of senior managers and directors for community based services and I think that the implications of the recommendations are still being discussed. I hope that this helps. October 7 2011

Government NL: This report was very useful and relevant because we are developing two new youth treatment centers for the province. The document was circulated to the provincial advisory committee (overseeing the youth centers) in its draft versions prior to October 2010 and in its final format after that. The report has been considered in decisions around model of care as well as target populations of youth who would most benefit from residential treatment. It has also been referenced in internal notes and documents to help inform decision making. October 11 2011

RHA: The report has been an integral part of the planning and development phase for the Youth Treatment Centres that are being developed in this province – particularly in leading us to best practice material on programming and raising key questions and considerations. It continues to be referred to and referenced at both our provincial steering committee and local advisory committee levels, but most especially by myself and the manager of the centre being developed by our RHA, as we are the leads in terms of the nuts and bolts of planning and developing staffing, training, treatment modalities / programming and evaluation /outcome measures at the centres. October 27 2011

Provincial Policing Organization: This report was not used in any police policy decisions to the best of my knowledge. However, it increased awareness for officers regarding the youth clientele that we deal with. A number of officers attended the release of the report at the time and this increased knowledge added to their awareness. I do not believe that any policies relevant to this have been changed since that time. I believe that the researchers did a good job and that any information with respect to the clientele that police deal with increases understanding and awareness, which in turn, aids first responders in their approach. October 12 2011

Professor, Memorial University: I attended the launch of the report and as a result of seeing the report, invited Pablo Navarro to speak to our MPH students in a course titled "Disease and Injury Prevention" for the session on Addictions. I am not involved with policy-making, but I found the report to be comprehensive and a very useful teaching tool. The systematic review also served as a model for the MPH students on how to develop research strategies. This was briefly discussed in class. October 12 2011

2010: The Reprocessing and Reuse of Single-Use Medical Devices in NL

Link to report: <http://www.nlcahr.mun.ca/CHRSP/SUDS.php>

Full stakeholder survey sent October 1, 2011

RHA: As suggested in my response on the use of the Youth Residential Treatment report, this report was very useful to us. The discussion to help prepare the report actually helped us to revise regional policy, in keeping with the best evidence. The report was shared with all senior management but was particularly useful to our infection prevention and control staff. I liked the involvement of the provincial infection prevention and control committee since this group has responsibility for setting provincial policy direction. October 9 2011

RHA At the time of my report, I worked in Quality and Risk Management and was assigned to/working with Infection Control as one of the programs I supported. This document, well-researched and well written, was referenced in the policy on Reuse of Single Use Devices that was written by the Infection Control Department. The document was also referenced at meetings during discussions on this topics, so, from that viewpoint, it was very useful. I believe that given the small amount of research done in this area, synthesizing that information was important. The document will support any programming that Infection Control will endeavour in this area and will provide evidence to support practice decisions in the future. October 15 2011

RHA The report is useful to the organization. I have used in preparing for internal and external discussions. October 17 2011

RHA Prior to submission of this document representatives from hospitals across the province met and discussed SUDs. As the Regional Clinical Nurse Specialist for Instrument Reprocessing/Perioperative, I also attended. The team was given a draft of the report and asked to provide input prior to the report going into circulation. I can forward my concerns/communication around this FYI, if you are interested. Although we were one of the hospitals across the country who did have a policy in place around SUDs and reprocessing, as the report notes below, we did not change our policy or practice based on this report. The CHRSP Report noted: “60% of hospitals across Canada that reprocess have a written policy, and the hospital in NL was one of them.”

“As of 2010, all provincial Regional Health Authorities have issued policies stating that the reprocessing or reuse of medical devices labeled as single use is not permitted. Our RHA approved a policy in 2008 prohibiting the reprocessing of SUDs except under specific circumstances such as the reprocessing of a single-use device that has never been used but has passed the expiration date.(52) Our RHA specifies that written instructions for reprocessing must be provided by the manufacturer, however, this approach should be viewed with caution since reprocessing instructions do not usually accompany devices intended for single use.” In October 2010, the regional infection control nurse, and one of our OR Coordinators and I attended a

Medical Device Reprocessing Forum put together by Accreditation Canada and Canadian Standards Association. There were a couple of agenda items around SUDs. The second day the full afternoon session involved a Panel Discussion consisting of speakers involved with: infection control, CSR Management, Health Canada and Company Reps.

During this time there was a fair bit of discussion around the reuse of SUDs. I highlighted our RHA's policy related to SUDs requesting input from the panel as to whether or not we should continue reprocessing SUDs that expired, if we had clear, written manufacturer instructions and we could meet the listed requirements? Interestingly enough, the company we received the product and manufacturer's instructions from was also present and they proceeded to inform the panel and assembly the reason they were able to provide us with instructions and the go ahead to reprocess. The majority of people who responded from the panel supported our RHA policy. This was further discussed with my manager and the VP for Quality Management and a decision was made to continue with our present practice. I hope this answers their questions below, do not hesitate to call me if you need any further clarification. October 20 2011

RHA This report was used to support our single use device policy and was also brought forth in patient safety. October 20 2011

RHA This is good information for us to keep us in the loop as to what others are doing. It was distributed to all leadership in areas of interest. It is part of my own library of documents relates to SUD's. I would be interested in another scan in a few years to see what has changed etc. CADTH also conducted a national scan last year.

2008 Rural Dialysis

Evaluation of the first CHRSP Project (Methods and Uptake)

<http://www.nlcahr.mun.ca/CHRSP/DIALYSIS.php>

Conference Call | Tuesday, March 4th, 2008 | 1:30 – 2:30 pm

This report pertains to health system feedback received after our very first CHRSP Project in 2008. The questions begin with the specific example of the Dialysis Project and move to consider the overall approach to the Contextualized Health Research Synthesis Program (CHRSP):

The Team

1. When forming the research team on dialysis, were the right people brought to the table?
2. Was anybody missing? Was anybody superfluous or inappropriate?
3. Were team members given adequate guidance about their roles in the project?

4. Was adequate time given to team members to fulfill their roles?
 - RHA reps were not at the initial meeting for the Dialysis project. They were not clear about their role at first – but became clear as they moved forward. The process took more time than anticipated at first. We need to be clear about the expectations of all parties.
 - The research team should have communicated with other key stakeholders in the RHA (e.g., the medical community for dialysis, site director for PAB, the Mayor and other politicians). A key stakeholder list should have been produced up front. The DHCS was advised of the project at the start.
 - Recommended that the process of ‘contextualized synthesis’ be better explained to those who are new to the idea. A brochure is not enough. Need a thorough explanation of the idea of ‘contextualization.’ The use of an illustrative example (i.e. PAB) was helpful in understanding the importance of contextual factors.

Follow-up: This feedback informed a more fulsome explanation of CHRSP methods and approaches to inform health system stakeholders at future Project Team Meetings and helped develop a set of guidelines for these meetings. A roster of key stakeholders is now developed for every CHRSP project.

The Question

5. Was the question concerning the provision of dialysis services an appropriate one for contextualized research synthesis?
 - a. Was the question of high priority to your RHA and to the overall provincial health system?
 - b. Given that there was no literature specifically on the provision of dialysis services in rural and remote locations, was the study question really susceptible to synthesis?
 - c. What should we do in the future when it turns out that the evidence is lacking? Is a commissioned research project a possibility?
- The research question was very appropriate and the results continue to help them to make decision on dialysis. Combining the evidence with the contextualization made the results more useful to the system.
- In particular, they valued the recommendations made at the end of the report. This was a suggestion made by the external reviewer.
- The recommendations could be used by researchers to identify areas for future research on dialysis services.

Reading and Appraising the Literature

6. Could we/should we have involved the dialysis team more fully in reading and appraising the literature?
7. How can we involve teams in future projects in reading and appraising the literature?
8. Should we disqualify HTAs of poor quality (according to Cochrane Collaboration standards), or include them with a critical appraisal written into the report?

- They did not want to be involved in reading and appraising the literature, but found the synthesis of the evidence in the report to be very easy to follow – even for a novice researcher.
- They valued knowing the limitations of the research evidence that comprised the report, and the explanations of areas where the research was non-existent or very limited.

Synthesizing the Evidence

9. Should the contextualization be written into the synthesis of evidence, or addressed in a separate section of the report?
 10. Should we provide a list of cost drivers, where appropriate?
 11. Should the assumptions used in the economic analyses be made explicit and listed in an appendix?
- Building the contextualization piece into the synthesis of the evidence made the report easier to read.
 - The cost drivers listed in the Appendix were useful.
 - Recommended that the list of ‘assumptions’ made in the studies that comprised the report be listed separately in an Appendix (e.g., the assumption that patients on PD will receive home support – which is not always the case here in NL).

Follow-up: This feedback informed a revised layout for CHRSP reports.

Contextual Factors

12. Did we correctly identify the contextual factors of relevance in this report?
 13. Was the Port aux Basque illustrative example a useful exercise?
 14. Are the categories of contextual factors used in this study transferrable as a template to other topics/issues?
- The contextual factors identified for the Dialysis report are likely to be transferrable to other topics of a similar nature.

Reporting

15. Are the formats appropriate? Too long? Too short?
 16. Is the language level in the reports appropriate?
- The report was not too long or too short.
 - The Executive Summary as 4 pages was fine.
 - The language level was acceptable.
 - It may not be necessary to produce a 1 page summary.

Overall

17. How should we disseminate the finding for this report and for future reports?

18. How can we better engage decision makers in the process?
 - a. for the selection of topics?
 - b. for the synthesis and reporting?
19. How can we improve the timeliness of the report?
20. How else can we improve the process?
21. Was the report useful? How could it be made more useful?
 - ♦ Training in HTA was very helpful and provided the necessary background to understand the process.
 - ♦ Very helpful to use an illustrative example (such as PAB), but it may have created the expectation that the team was going to answer all of the questions on the decision to provide dialysis services in PAB.
 - ♦ The process for the selection of topics was good and everyone felt involved and valued. The filtering process was a fair way to achieve consensus on the topic.
 - ♦ Timeliness of the report would have been improved if it had followed the budget cycle and provided information that would be useful in budget submissions (which are done in October). The report would need to be in their hands by Sept 1st at the latest!
 - ♦ The report was very useful overall and will help them to avoid making decisions without examining the scientific evidence. It is useful for planning purposes, and will likely have utility outside of our single RHA and right across the entire province.