

# 2SLGBTQI+ & Healthcare

**Presenter(s):** Jessica Liem & Harroop Ahuja

2SLGBTQI+ individuals experience increased barriers in healthcare and are at increased risk for unfavorable health outcomes. Through our research at Brock University, it was concluded that the physical environment and interactions with the healthcare professionals can have a large impact on their experiences.

We aim to submit recommendations to Brock Student Wellness and Accessibility Centre (SWAC) based on research with 2SLGBTQI+ students' experiences with SWAC, by April 2021.

To gather the data, a campus-wide survey was created. This survey consisted of questions about the 4 different pillars of SWAC, health services, personal counselling, student accessibility services, and the HUB. This survey was distributed through Brock Pride, Student Justice Centre, Human Rights and Equity, SWAC, and Gay-Straight Alliance. Currently, the results are being analyzed and evidence-based recommendations will be submitted to SWAC in April 2021.

Currently, the results are still being analyzed. However, the recommendations will work to create a more inclusive and equitable environment within Brock SWAC. In turn, more 2SLGBTQI+ students will access these services and increase positive health outcomes.

# ENHANCE YOUR CARE

A **commitment** to providing better care for the 2SLGBTQI+ community

## WHAT WE KNOW

1

**2SLGBTQI+ individuals experience more healthcare disparities than their heterosexual and cisgender counterparts.**



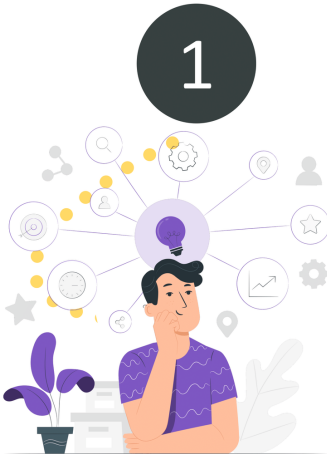
**2X** higher risk for substance use disorder and sexually transmitted infections



**20%** of Ontario 2SLGBTQI+ University students say to provide good care, professionals need more knowledge



**4X** times likely to experience suicidal thoughts



## ALTER YOUR PRACTICE

2

**Strive to create a safe environment where individuals can discuss their health concerns without feeling judged.**

- ✓ Include a diverse range of posters and brochures addressing 2SLGBTQI+ topics
- ✓ Update intake forms to reflect a wide range of gender identities, sexualities and pronouns
- ✓ Strive to hire and maintain a diverse team



3

## BECOME AN ALLY

**Commit yourself to advancing 2SLGBTQI+ voices and topics. Most importantly, commit to personally advocating for equal treatment.**

- ✓ Use correct pronouns and name
- ✓ Participate in educational workshops focused on 2SLGBTQI+ care
- ✓ Advocate for the development of Gay Straight Alliances
- ✓ Create inclusive environments
- ✓ Use gender inclusive language



## GET INFORMED

4

**Build on your pre-existing knowledge to provide better care to the 2SLGBTQI+ community.**

- ✓ Get familiar with Niagara Region and Brock University 2SLGBTQI+ support services
- ✓ Participate in educational workshops focused on 2SLGBTQI+ care



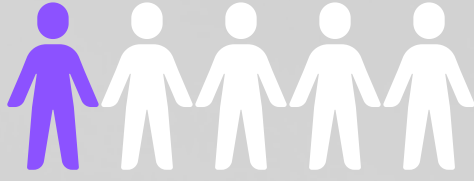
By: Jessica Liem and Harroop Ahuja

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# **A Cup A Day Keeps Dysphagia Away: Increasing Hydration Using a Dose-Restricting Dysphagia Cup**

**Presenter(s): Brent Dryczewycz**

In hospital, patients are often experience swallowing difficulties and are diagnosed with dysphagia as a result of a condition such as a stroke or neurological disease. Diet texture modification is a common management practice used as a means of optimizing patient swallow safety in order to reduce the risk of adverse health events such as aspiration pneumonia. Texture modification often involves the prescription of thickened liquids. However, there are many drawbacks to diet texture modification. However, research suggests that patients on thickened fluids do not consume the recommended amount of fluids and are at major risk of dehydration (Murray, Miller, Doeltgen, & Scholten, 2014; Whelan, 2001; Finestone, Foley, Woodbury, & Greene-Finestone, 2001; Crary, Carnaby, Shabbir, Miller, & Silliman, 2015). The unnatural quality of thickened fluids results in reduced palatability leading to noncompliance and reduced consumption of fluids (Karagiannia & Karagiannia, 2014; Karagiannis, Chivers, & Karagiannis, 2011). This can lead to further complications for dysphagia patients and increase their length of stay in hospital. Assistive drinking tools, such as dose-restricting dysphagia cups, have been recently developed to provide patients with dysphagia with continued access to thin fluids. This could present a safe, effective, and patient-centred alternative to thickened fluids when it comes to managing fluid consumption. However, the use of these cups has not yet been implemented and researched in the rehabilitation setting.

The aim of this project to develop a system for the provision of a “Dose-restricting cup” to SLP-identified patients with liquid-based dysphagia in HDSHRC by April 2021. The purpose of this system is to improve accessibility and safety for consumption of thin fluid, Optimize thin fluid intake and hydration, while minimizing the risk for secondary health complications and improve dignity, independence and overall quality of life by providing a safe method for consumption of thin fluid.

Our project team is currently testing several dysphagia cups, including the RiJe Cup, Provale Cup and Rose Cup. When investigating these cups, several factors will be considered. This includes its effect on the quantity of fluids consumed, durability, dispensing reliability, versatility and more. These factors will be analyzed to select a cup for use at Hotel Dieu Shaver. Once this cup has been selected, a procedure will be developed for its implementation at Hotel Dieu Shaver.

Preliminary results appear to indicate that the RiJe Cup is the dysphagia cup that best meets the need of Hotel Dieu Shaver. These results have indicated an increase in patient satisfaction, fluid consumption, increased reliability, versatility, durability and more. Other cups, such as the Provale Cup and Rose Cup, have presented with considerable issues, such as poor dispensing reliability or poor durability. A process map has been designed for the implementation of the RiJe Cup at Hotel Dieu Shaver.

Link to KT Tool (Website):

<https://brentdryczewycz.wixsite.com/rijecupproject>

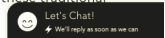
### Why Use a Dysphagia Cup?



**Assistive drinking tools for dysphagia provide patients with access to thin fluids, like water**

Traditionally, patients with dysphagia have received thickened fluids to reduce the risk of complications of dysphagia, such as aspiration-induced pneumonia.

However, these thickened fluids are strongly disliked by patients. This could lead to reduced fluid intake and hydration. Dysphagia cups present a safe, effective and patient-centered alternative to these traditional methods.



### Why the RiJe Cup?

**The RiJe Cup's easy-to-use, adjustable and durable design makes it the best choice for the rehabilitation setting**

The RiJe Cup includes many unique benefits such as the following:

- A sleek design that makes the cup both easy and safe to use
- dose-restricting mechanism to limit the volume of liquid a patient receives with each sip
- adjustable dose restriction ranging from ranging from 3 mL to 15mL per sip

**In this webinar, you will learn how to:**

1

**Safely drink from the RiJe Cup**

2

**Properly assemble, disassemble, refill and clean the RiJe Cup**

3

**Operate the RiJe Cup's dose-restricting mechanism**

**To begin the webinar, please select the option below that best represents you**

**Patients and Family Members**

Click Here

**Speech Language Pathology and Nursing Staff**

Click Here

**Kitchen and Housekeeping Staff**

Click Here

# Babies With Better Care Closer to Home: Leveraging Virtual Care in Neonatal Intensive Care

**Presenter(s):** Jaz Randhawa & Lisa Faulkner

Premature infants are a vulnerable population that often require more specialized care in order to remain healthy during development in the Neonatal Intensive Care Unit (NICU). The NICU at Niagara Health has recently upgraded to an acute level 2C facility, meaning the unit can provide appropriate care for patients as early as 30 weeks of age. The Ontario Telemedicine Network (OTN) is a virtual care technology that allows physicians/nurses to video call specialists. The OTN uses two-way videoconferencing in order to provide access to care for patients within the hospital and other health care locations across the province. Currently, patients within the NICU requiring highly specialized care are often transferred to McMaster Children's Hospital. Through the use of teleconsultations, highly specialized health care teams at McMaster will be able to visualize and assess the symptoms and conditions of the babies accurately. This will allow diagnosis and interventions to be recommended without requiring the relocation of families away from their support systems.

The primary objective is to achieve a higher quality of patient care for these infants within the NICU through increasing the accuracy of diagnosis and interventions, as well as keeping families closer to home. The OTN technology will be continuously monitored and improved as needed to ensure effective use.

We have implemented physician surveys at both Niagara Health and McMaster Children's Hospital for physicians who have used the OTN system to report on their experience and their perspective on whether the technology has improved patient outcomes. We are currently in the process of implementing family phone interviews for family members of patients who have used the video-conferencing system to gauge their perspective on the technology as well. Additionally, we have implemented two infographics: one specifically for healthcare providers and another for families in the NICU to make both of these populations more aware of the OTN technology and the potential benefits of using the video-conferencing system on patients. We are also working on a scoping review to examine the existing literature on the use of telemedicine software within neonatal intensive care in relation to safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.

Almost all physicians who have completed the physician surveys have reported that they strongly believe the technology improved patient care and that the teleconsultation was more effective than a phone call. This is important because our main goal is to increase patient care, and this data suggests an enhancement in care. Thus, this project could potentially be spread to other NICUs across Ontario.

# PEDS TECH

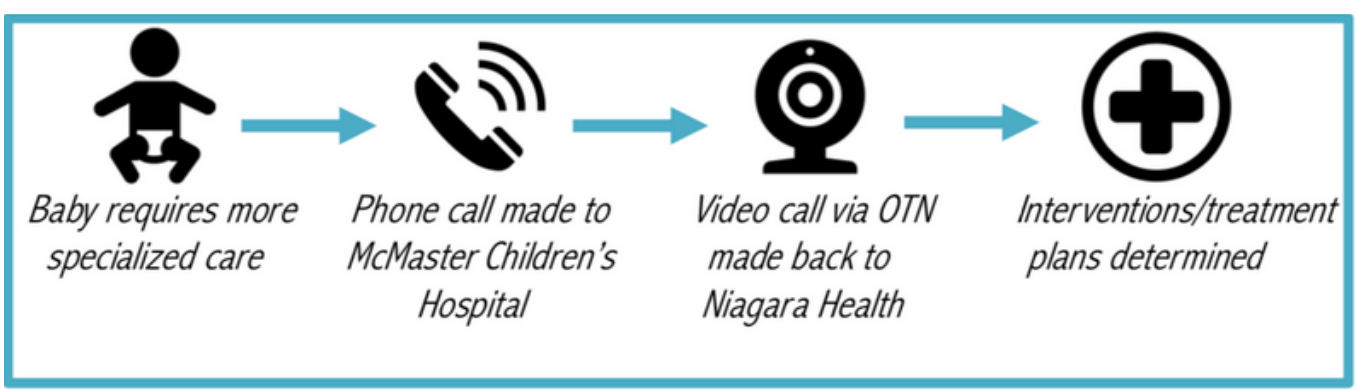
## ONTARIO TELEMEDICINE NETWORK (OTN)



The OTN uses two-way video conferencing to provide access to specialist care for patients across the province. Through teleconsultations, health care teams in the neonatal intensive care unit (NICU) can communicate directly with another hospital site to assist in diagnosis & treatment providing access to neonatal specialist care..

## OTN IMPLEMENTATION IN THE NICU

The OTN provides the newborns at Niagara Health with a specialized team of health care providers including neonatologists. This improves access to specialized care while reducing wait times and travel costs, keeping you and your baby closer to home.



## PROJECT DETAILS

The PEDS-TECH NICU project is an ongoing program that is continuously being monitored and evaluated. To ensure patients are receiving the optimal level of care, dimensions of health care quality will be analyzed (**patient-centred, equity, timely, cost, effective, efficient**). Your opinion is really important to the development and progression of this program!



## FAMILY INTERVIEWS



After the OTN teleconsultation is complete, a member of this research team will reach out to the parent/caregiver to participate in a family satisfaction interview. Once informed patient consent has been received, the caregiver will be contacted via telephone to complete an interview.

## PHYSICIAN SURVEY EARLY RESULTS

1-strongly disagree  
2-disagree,  
3-neither disagree/agree,  
4-agree,  
5-strongly agree,

The following statements were rated by the physicians:



# PEDS TECH

## HOW HAS ONTARIO TELEMEDICINE NETWORK (OTN) VIDEO-CONFERRING INCREASED QUALITY OF CARE?



Increases access to neonatologists at McMaster Children's Hospital



Encourages interprofessional collaboration amongst healthcare professionals



Increases family satisfaction by allowing parents to stay close to patient



Increases accuracy of diagnoses & treatment plans

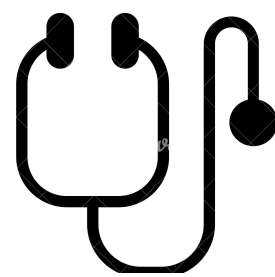
## PROJECT TIMELINE



- **June 2020:** NICU OTN system implemented
- **July 2020:** Physician satisfaction survey created
- **November 2020:** Family satisfaction interview preparation
- **February 2021:** Preliminary data collection for Spring 2021 case report



80% of physicians strongly agreed that patient care was improved with a NICU teleconsultation



### Main Concerns Addressed

- Neonatal abstinence syndrome
- Central hypotonia
- Hydronephrosis
- Feeding concerns

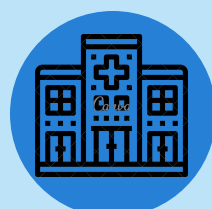
## NEXT STEPS



Physician focus groups via video-conferencing



Scoping Review on how telemedicine in the NICU affects six dimensions of healthcare quality

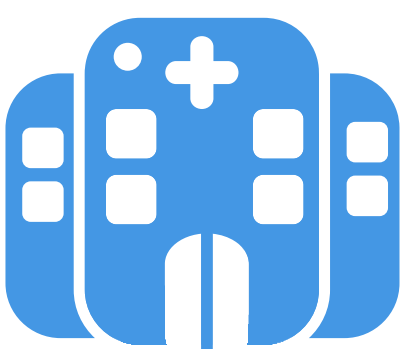


Sustainability & spread to other hospital sites in Southwestern Ontario



Evaluation of patient outcome data every 6 months

## DIMENSIONS OF HEALTHCARE QUALITY



- **Patient-centred:** Specialist care access through telemedicine allows reduced transfers to other facilities & improved family satisfaction keeping patients closer to home (1).
- **Equity:** Telemedicine in neonatal intensive care units allows for a higher level of care closer to home. This reduces geographical disparities in access to specialist care.
- **Cost:** Use of telemedicine in the NICU may avoid unnecessary transfers, saving up to **\$1,220,352 USD each year** (3).



# **Integrating Social Prescribing at Quest Community Health Centre**

**Presenter(s):** Kahlan Woodhouse & Caitlin Muhl

Social prescribing refers to when primary care providers prescribe their patients to non-medical programs. The current pandemic has put an emphasis on the importance of community and connections. Social prescribing approaches health in a holistic way, addressing

How can social prescribing be formally ingrained in the culture at Quest? What can be done to take processes that are already occurring and streamlining them to integrate social prescribing in a way that is logical, patient centred, and efficient?

As of March 2021, we have done a literature review, conducted interviews with community health centres in Ontario that were part of the Alliance pilot, conducted surveys and focus groups with both staff and clients, created KT resources, and created a menu that houses all programs offered at or through Quest.

A large component of social prescribing is a navigator/link worker. Ideally there is a position dedicated to this role, however, funding has not allowed for this to be the case at Quest. As a result, social prescribing has had to be diffused amongst almost everyone at Quest, with many of the duties a navigator-type worker would have had on program coordinators and social workers. The hope is for all clients at Quest to feel a sense of belonging in their community, and to address the social determinants of health in a realistic, long term manner.

# SOCIAL PRESCRIBING

## AT QUEST COMMUNITY HEALTH CENTER



### What is it?

#### WHAT IS SOCIAL PRESCRIBING?

Social prescribing is when primary care providers connect their clients to non-medical community programs. This lets clients connect with their community and gain a sense of belonging, improving their overall health.

### How does it work?

#### WHAT CAN I EXPECT TO SEE?

Common social prescribing programs include yoga, hobby groups or coffee chats! It can also connect you to volunteer opportunities or give you the chance to showcase a skill and share it with others.



### Does it help to me?

#### HOW CAN I BE CONNECTED?

Social prescribing can take many forms. This makes it a great fit for anyone and everyone! There are countless ways for our clients to be connected with programs or services to address their complex needs.

### Talk to one of the staff members at Quest!

#### JOIN OUR SOCIAL PRESCRIBING MOVEMENT

There are dozens of programs offered at or through Quest. Ask your primary care provider for more information or let us know if there is something you would like to see. We hope to see you at one of our programs soon!



CHECK OUT OUR SOCIAL PRESCRIBING MENU FEATURING ALL OF OUR PROGRAMS OFFERED AT QUEST!

# Social Prescription

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Check all that apply:

- Feeling lonely
- Could use a hobby
- Stressed about food/housing
- Want to get involved in the community
- Feeling blue
- Want to get moving
- Getting older
- Other: \_\_\_\_\_

# Optimizing KT with the development of a Mental Health Program Referral Poster

## Presenter(s): Azaan Adnan

At Pathstone Mental Health, a common area of confusion and frustration to involved individuals is that of the meaning behind what different programs are. At Pathstone, there are three main programs offered, being the Family Intervention program, the NHS Brief program, and the High-Risk program. Nothing is quite straightforward regarding what goes on behind referring a youth to their appropriate program and what each program actually entails. Involved parties such as community program workers or health care workers can sometimes be too busy or lack the surface level explanation behind explaining the aspects of these programs that youth may be referred to.

The aim of this project is to produce an easily accessible resource to assist in making program pathways clear to the general public. This will alleviate many general questions that people typically have, and hones in on the following three characteristics that are generally most asked about: Focus, Aim and Delivery.

Baseline data collected from family feedback and community partners led us to realize the gap between the general public and understanding what the three programs are and who they are for. This resource, in poster form, makes the use of graphic design and color to engage its intended audience. Text is clear and easy to read, with important words bolded, abbreviations made clear, and emergency contact information available if required by product users. We plan on implementing this both internally and externally, as we believe this could be a good resource for Pathstone staff to quickly refer to. Measures of effectiveness will be collected on the basis of improved feedback and less questioning along the lines of what the three programs are or who they are for.

This product serves to inform interested parties on three relevant program pathways at Pathstone regarding youth (Family Intervention, NHS Brief, and Pathstone High Risk) given that these programs are programs where individuals find the most trouble fully comprehending. The impact that this will have is prospectively of significance, given that a resource like this is currently absent at Pathstone even though many of the questioning that families and youth have stem from questions related directly to the why of these programs, as in why they are being involved in them for those that are referred to specific programs.

# Youth Program Process

for Informative Purposes

## Programs of Interest:

1. Family Intervention
2. NHS Brief
3. Pathstone High Risk

**NEED HELP NOW?**  
Call **CALL CRISIS SERVICES**  
**1-800-263-4944 – 24/7**

**General Contact:**  
Tel: 905-688-6850  
Fax: 905-688-9951

**Abbreviations:**  
McMaster 3G Mental  
Health Unit: **M3GMH**  
Niagara Health  
Psychiatry Emergency  
Reponse Team: **PERT**

**Focus:** Counselling & Therapy

**01**

**Aim:** To alleviate stress, anxiety, depression, ADHD, and/or manageable high-risk behaviour in youth aged 6-18.

**Delivery:** one-on-one and/or in direct collaboration with family. Clinics, group settings, and more are used to facilitate program and individualized program goals.

Therapist, patient and family must work together closely to plan appropriate interventions and identify realistic goals for therapy.

Patient and family must be ready to engage in change. Receptivity is key! Be ready for new ways of thinking about and approaching a variety of challenges.

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### Family Intervention

\*NOT to be used for youth with high risk of self-harm or suicide.

**Focus:** Acute Crises

**02**

**Aim:** To alleviate acute crisis and/or significant mental health concerns in youth aged 6-17.

**Delivery:** one-on-one and in direct collaboration with family.

Requires referral from **M3GMH** or **PERT**. Referrals are made within 3-5 days of discharge on the basis of an acute crisis.

Patient & family must be ready to work closely and produce individualized plans for therapy and support in reducing crisis-related behaviour. Follow up plan for steps after completion of NHS BRIEF will be provided.

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### NHS BRIEF

\*see NHS Brief Crisis Pamphlet for more.

**Focus:** An elevated risk to harm self or others.

**03**

**Aim:** To alleviate significant and **imminent** high-risk behaviour (e.g. severe self-harm and suicidal ideation / attempt) in youth of any age.

**Delivery:** Intensive individualized treatment to reduce risk. Delivered one-on-one and in collaboration with trusted contacts if necessary.

Program requires referral from community partners (e.g. PERT, Police, school, etc.). Follow up plan is discussed upon reduction of risk.

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**Pathstone High Risk**

\*Please contact for more information.

# **PAS-AUTO: ALS Partner Assisted Scanning Mobile Application Project**

**Presenter(s):** Klaudi Lekaj

ALS is a condition that leads to the degradation of the patients motor neurons. Damage to these motor neurons leads to the patient struggling with simple voluntary movements such as walking, talking, and chewing. Currently there is no cure for ALS and it is a progressive condition where the state of the patient gradually gets worse as time goes on. Therefore, since there is no current cure for this condition it is crucial to have tools developed and implemented to increase the quality of life of ALS patients. This is how our project come about, we sought to improve the quality of communications that ALS patients had as many can no longer talk and do not have the motor control of their arms that the previously did to use devices such as computers to type.

The aim of this project is to develop and implement a communication tool that can be used by those who have ALS as a means to improve the quality of their communications.

Our team consisted of two groups of mobile application developers who developed the apps based off of our requirements of features that are mandatory for ALS patients to utilize. Once we had the initial app developed we conducted our first field test with clients of Hotel Dieu Shaver who had ALS. Each patient alternated which application they used weekly for two weeks. We used the Mobile Application Rating Scale (MARS) to evaluate both applications and determine areas that required further refinement. We used the ASHA Quality of Communication life scale to determine the initial quality of communication that participants had prior to implementation of the mobile application and once again post-implementation. This would allow us to determine if the application did in fact improve participants communication. After the first field test was done we conducted informal feedback sessions/interviews with our participants to see what further changes they would like to see on the applications. We analyzed the results from the MARS surveys and the feedback sessions to improve and refine our applications. Once refinements were complete we began our second field test of the apps. For the second field test we used the same measures as the first field test: MARS and ASHA quality of communication life scale. This time the participants were given two weeks to utilize the applications. A final comparison between the ASHA scales will be done to see the true effect that the applications had on the participants quality of communication.

Currently our study is in the second phase of field test trials. Based on the results of the first field test we have already noticed that patients quality of communication has already slightly improved and we are awaiting the results of our second field test to have more definitive/conclusive results. The qualitative feedback sessions we had with patients demonstrated that the participants did enjoy the implementation of the tools and their feedback for improvements were taken to create application refinements that met all their requirements/needs to the best of our abilities.

# PAS-AUTO MOBILE APPLICATION

## ALS PARTNER ASSISTED SCANNING APP

### What is ALS?

Amyotrophic Lateral Sclerosis (ALS) is a neurological motor disease. This condition targets and destroys motor neurons. Loss of these motor neurons causes loss of control of voluntary muscle movement, making tasks such as talking and walking difficult.

### Goals:

The goal of this project is to improve the quality of communication in ALS patients

### Methods:

We field-tested the application with diagnosed ALS participants allowing them to experience the app and implement it into their daily life with friends, family, caregivers. We used the MARS survey to evaluate the app performance and the ASHA quality to evaluate quality of communication.

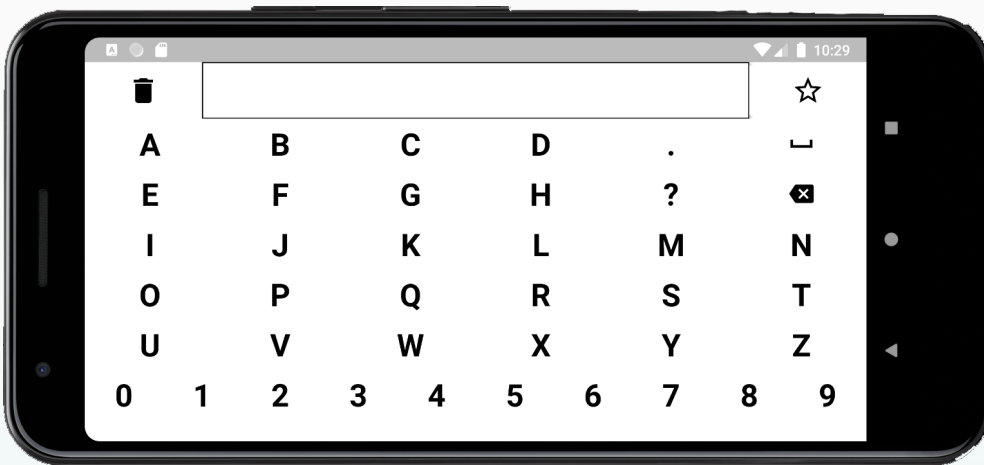
### What is the issue?

ALS is a degenerative disease that progressively worsens over time. Currently, there is no cure for ALS. Therefore, they need tools to improve their lives and manage their condition.

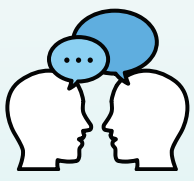
# 30,000

AMERICANS HAVE ALS

### VIEW OF APPLICATION



### Potential Benefits:



#### Improved Quality of Communications

The application allows for more effective and meaningful communication between individuals with ALS and friends, family and caregivers.



#### Less burden on health providers

The application tool lessens the strain on caregivers by allowing the caregiver to focus solely on the patient while the app functions. The app makes the caregivers work less tedious and tiresome.



#### Greater Accessibility

The application allows for greater accessibility as it can be downloaded by anyone and can be carried around anywhere. The app is easy to use and comes with built-in tutorials that quickly teach users how to use it.

# **The new normal: utilizing stakeholder experience to guide virtual mental health care for youth**

**Presenter(s):** Holly Bihun & Alison Smoke

As Pathstone initiated a new virtual service delivery model in response to the COVID-19 pandemic, it started to realize the benefits and challenges to this approach for their clients. At present there is limited research with respect to virtual services and their impacts and efficacy in relation to children and youth. This project will lead to the expansion of the knowledge base of virtual care for children and youth mental health services, and identify who might benefit the most from this innovative service model.

The purpose of this research is to explore the use of this virtual care model from the perspectives of the clients, families and providers to support the evidence-based development of a decision aid which will support the decision of virtual or in clinic option for clients.

First, qualitative and quantitative measures of satisfaction, perceived effectiveness, accessibility and opinions of the current virtual component will be collected through three versions of the questionnaire. The three questionnaires (one per stakeholder group) have been designed to collect data from one of the following stakeholder groups: youths aged 12-18 years using Pathstone Mental Health's services, family members and/or guardians of youths using the services, and practitioners providing services virtually. After the completion of the questionnaires, we will engage in separate focus group sessions with each of the three identified stakeholder groups to discuss and identify elements of the virtual services at Pathstone that have contributed to their experience.

The information collected will help guide evidence-based decision making as it relates to virtual health programming for youth. The outcomes include the evaluation of the Pathstone virtual mental health clinic, the creation of an organization-based decision tool for virtual care admittance and the implementation of an educational pamphlet to present to clients with research-based information prior to beginning virtual care.



# The New Normal: Utilizing the stakeholder experience to guide virtual mental health care for youth

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## Provider Partnership

- Staff interviews and observations play an important role in organizational quality improvement
- Provide insight into the processes, concerns and interests of Pathstone



## Family Partnership



- Frequently more costly for the service provider and the public health benefits are significantly lessened when participation low
- Family engagement typically lower among youth and families of colour
- Using the Quality Standard for Family Engagement designed by the Ontario Centre of Excellence for Child and Youth Mental Health

## Questionnaires

- Technological Experiences
- Satisfaction
- Comfortability
- Connection
- Understanding and Empathy
- Non-verbal cues
- Privacy



## Group Interviews



- Discuss and identify elements of the virtual services at Pathstone that have contributed to their experience
- Provide more in-depth understanding of themes highlighted in survey

## Data Report

- Academic-oriented synthesis of results and themes
- Collection of statistics, quotes and data presentations
- Will inform following tools



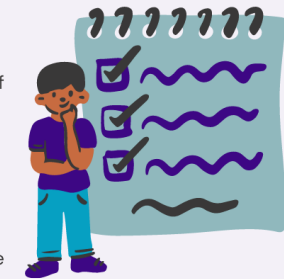
## Educational Pamphlet



- Educational public-oriented KT Tool
- "What you should know before starting virtual care"
- Will present research to larger Pathstone community and prospective clients

## Decision Aid

- Practitioner-oriented KT Tool
- Determine appropriateness of virtual mental health services for client
- Evidence based decision making using relevant, community research and voice



Principle Investigator: Dr. Madelyn Law  
Principle Student Investigators: Alison Smoke & Holly Bihun

# Transition from Hospital Care to Primary Care

**Presenter(s):** Madelyn Cryer & Stefan Radovic

As mental health becomes a growing concern, Niagara Health is experiencing a high volume of patients in the LAI medication clinics. Due to capacity concerns, the medication clinic had to limit the number of new patients it could accept. Patients on LAIs often experience other health and social needs that can be more holistically addressed in primary care. While some patients require hospital care for several reasons, some may be more suitable to receive this care in the community. Currently, there is no standardized transition process for LAI users from specialist/hospital care to primary care and/or other community support services. As a result, patients who may benefit from LAI and broader health and social services in the community, must rely on NH clinics for their medication.

Develop a primary care transition process in order to increase the proportion of long-acting injectable (LAI) medication users receiving LAI services from primary care providers in Niagara.

To develop the transition plan, we attended an observational visit of the LAI clinic to gather first-person insight, created a process map with a QI specialist, had several meetings involving primary care community health partners to determine client inclusion criteria and were able to develop knowledge translation products for both the clients being transitioned and the primary healthcare providers taking on the clients.

One lesson learned is that the client inclusion criteria must be very specific for this population to try to ensure that no adverse health events are experienced as a result of transition. Successful implementation of this transition process will ensure that clients are receiving more holistic health care and access to a wider range of health services. We are hoping that with ongoing transition to primary care providers, Niagara Health will be able to see and deliver LAI medications to more individuals. We are also hoping that this constant flow of clients will help to alleviate any strain that the LAI Medication Clinic is currently facing.











## All About My Transition

*Congratulations on being selected to graduate from the Niagara Health Medication Clinic to \_\_\_\_\_ Community Health Centre! This is a big step towards improving your health and well-being!*

### What Does This Transition Mean?

- You will be receiving your injections from \*PCP name\* at \*CHC Name\* Community Health Centre who you can see more regularly
- You can have longer and more personal interactions with your care provider

### Why Should I Transition? What are the Benefits?

- **Broader variety of health and social services available to you**
  -  Primary care services
  -  Chronic disease prevention and management
  -  Nutritional services
  -  Individual/group mental health counselling
  -  Dental services
  - ...and more!
- **Expand your health care team**
  -  Family physicians
  -  Nurse practitioners/ RNs
  -  Counsellors
  -  Dieticians
  -  Social workers
  - ...and more!

### Ways we will support your transition:

- Someone from your care team at Niagara Health can be available to attend your first appointment with you at \_\_\_\_\_ Community Health Centre
- You can openly communicate with members of your care team from both Niagara Health and \_\_\_\_\_ Community Health Centre



## LAI Transition Patient Care Plan

### Background:

- Individuals receiving long acting injectable antipsychotics at the Medication Clinics at Niagara Health may be more appropriately cared for within a community or primary care setting
- The goal of the Niagara Health Community (NHCOM) transition process is to increase the likelihood for these individuals to have improved health and reduce overall negative outcomes

### Client Information

<b>Name</b>	
<b>Address</b>	
<b>Contact Information</b>	
<b>Pharmacy Information</b>	

### Client Medication Information

<b>Medication Name and Dosage:</b>	<i>*insert medication name and dosage**</i>	
<b>Visit 1:</b>	<i>*Insert appointment information*</i>	<b>Notes:</b>
<b>Visit 2:</b>	<i>*Insert appointment information*</i>	<b>Notes:</b>
<b>Visit 3:</b>	<i>*Insert appointment information*</i>	<b>Notes:</b>

### Contacts at Niagara Health

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### Additional Information/Instructions

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# Pathstone High Risk Youth Program - VTRA

## Presenter(s): Marissa Raso

Currently, there is a protocol known as the Violence Threat Risk Assessment (VTRA), which is how community partners collaborate to assess and develop appropriate interventions to address immediate threats associated with a youth's actions, and provide services and supports through Pathstone. The current challenge is that there is no formal methodology to measure the appropriateness of the referrals being made to this program.

The aim of this project is to review and evaluate the current protocol for referrals to the VTRA program, measure the effectiveness of interventions, and create a feedback loop to optimize the care pathway.

Data has been reviewed through past case files in order to determine baseline demographics and statistical averages regarding characteristics of past participants in the VTRA program. This will allow for an operational definition of "appropriate referrals" to be determined, which can then be used to evaluate future referrals.

Although still in the preliminary stages, current data has revealed that family involvement is crucial to the success of youth within this program. However, many families lack understanding and information regarding this VTRA program, and thus, a KT tool has been developed to help families understand this program and hopefully get them more involved.

# WHAT IS THE VIOLENCE THREAT RISK ASSESSMENT (VTRA)?

A protocol that allows for community partners, such as families, schools, doctors and therapists to collaborate in assessing and developing an intervention to assess immediate risk factors associated with a youth's actions.

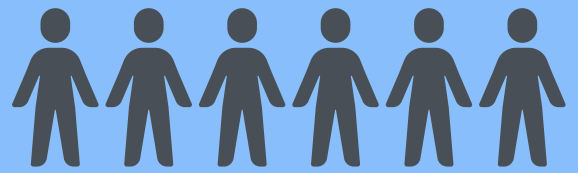
If youth are deemed a risk to the safety of themselves or others, they will be eligible to receive services within the Pathstone High Risk Youth Program.



Within this program, youth will receive intensive, individualized service with a Pathstone therapist specifically tailored to reduce the imminent risk.



Parents and guardians are encouraged to attend caregiver or family sessions with the therapist, and their youth, as this involvement is vital to the success of the youth.



Engagement in the Pathstone High Risk Youth Program may allow for the youth to then be referred to other internal or external programs and services.



Engagement in this program is voluntary in nature, and youth may decide to spend varying amounts of time in the program, depending on their individual needs.

**Number of Therapy Sessions Attended By Youth in the Program**

