Archived Webinar

Listening to the Voices of Children and Families:
Data and Examples of Initiatives at CPRI for Working with Clients
and their Families

Slide 1: Title Slide

SPEAKER 1: Today's webinar is the 2nd in a series of 3 research webinars recorded as part of the 2018-2019 CPRI Education calendar. In today's session, 2 staff from CPRI's Applied Research and Education department will discuss some of the work we have been doing on client and family engagement using the interRAI Child and Youth suite of tools.

Slide 2: Hello & Welcome

SPEAKER 2: I am Naila Meraj. I have been working as a Data Planning Analyst in the department of Applied Research and Education at CPRI for 3 years. I have a Bachelors in Medicine and Bachelors in Surgery (also called MBBS) from Dow University of Health Sciences, Pakistan and an MSc in Health and Rehabilitation Sciences from Western University. My field of research was Health Promotion.

I am leading two projects at CPRI related to client and family engagement that will be discussed in this webinar.

SPEAKER 1: I'm Laura Theall. I have a Masters of Science in Developmental Psychology from McMaster University. I've been a research coordinator at CPRI for almost 10 years, coordinating studies with clinical staff, children, youth and families to promote evidence-informed care. Naila and I both work to create family friendly products that we'll talk about today with the goal of improving mental health service experiences for families.

Slide 3: CPRI

SPEAKER 2: To provide context of where we are, CPRI stands for the Child and Parent Resource Institute and we are located in London, ON. CPRI is a tertiary service provider for children, youth, their families, and community agencies across Ontario.

Our mission is to provide specialized trauma-responsive mental health and developmental services to achieve the best possible outcomes for Ontario's children and youth. We provide assessment, consultation, treatment, research and education. We work to provide accessible and inclusive services that are individualized, culturally sensitive and trauma informed.

Slide 4: Overview

SPEAKER 2: This slide contains our overall objectives for today's webinar.

First we will give a brief overview of the Client Voice and explore why hearing directly from the child/youth receiving mental health care is essential for a client centered approach in mental health care. We will also highlight the benefits of engaging the family as true partners in their child/youth's treatment.

SPEAKER 1: Next we will discuss the interRAI Child and Youth suite of tools and present data showing areas in which families are showing strengths and where they could benefit from additional support for comprehensive care.

SPEAKER 1: Then we will introduce the interRAI Self-Report Quality of Life tool and the Family Quality of Life tool for measuring wellbeing and experience with services by hearing directly from the child, youth, and caregivers themselves.

SPEAKER 2: Finally, we will share some information about two new initiatives that are in progress at CPRI. The first is the Client Health Information Passport also called the CHIP and the Client and Family Engagement or the CaFE Model of care.

Slide 5 : Brief Overview

SPEAKER 2: So, let's start with a brief overview of "Client and Family Engagement". I will share with you what the literature says about the importance of clients' and families' voice in healthcare services and system.

Slide 6: What is Client and Family Engagement?

SPEAKER 2: So, what is Client and Family Engagement? Sharma and colleagues define Client and family engagement, as a partnership between clients, families, caregivers and service providers to improve health care.

Clients are the main stakeholders in healthcare and service delivery. Therefore, it is important to involve them and their families in decision making as they are affected by those decisions at both the individual level such as treatment plans, and organizational level such as research, policy and practice.

There is a popular quote by Valerie Billingham, (1998), that advocates for partnership with clients and the significance of their voice. It says: "Nothing about me without me."

Slide 7: The Client's Voice

SPEAKER 2: After the definition, let's dig into the details of Client and Family Engagement.

Client and Family Engagement is an evidence informed practice that uses evidence from literature, clinical experience and clients and families.

Carman and his fellow researchers share the findings that a growing body of evidence suggests that client engagement may result in better health outcomes, improved quality of care and help control healthcare costs.

These outcomes of engagement can be achieved by adopting the practice as reported by Barry and Edgman-Levitan. They recommend that successfully addressing the values, needs and preferences of clients requires meaningful engagement by enrolling clients and their families as allies to design, implement and evaluate the services and systems of care. In doing so, services can be made more responsive to the needs of clients by viewing problems through their lens and the lens of their families.

Clients are advocates for themselves as well as representatives of their demographic population. Viewing healthcare experiences through clients' eyes can make services more responsive to their needs. Also, knowing the needs and experiences of clients may result in improved services, better health outcomes and reduced rate of readmissions and as indicated by Carman, it can help control healthcare costs.

Slide 8: Engaging Families

SPEAKER 2: We know that Client and family engagement is recognized as central to the health and wellbeing of clients and families.

Family members have a distinct role in the circle of care as they are the main support and advocates for their loved ones. Families are most aware of the needs of the children and youth in their care and they play a key role in promoting the clients' health and wellness, managing chronic and complex conditions and assisting with their transitions and ongoing care.

So, what do we do to practice and implement it? Carman and colleagues suggest that we need to adopt the Transformative Paradigm Shift and view clients and their caregivers as more informed and influential. Similarly Barello and colleagues report that this shift places engagement with clients and their families at the forefront of policy and research practice.

Paradigm shift means working "**with**" rather than **"doing to or for"** the clients. And moving from "professionals as experts" to "families as experts" as they are the most informed about the needs and preferences of clients.

This shift is possible through meaningful engagement and collaboration with clients and their families, which is a crucial element to deliver effective and high quality healthcare. It values clients' experiences and inputs into problem solving and promotes better quality of healthcare, and improved health of clients and families.

Slide 9: Client & Family Centered Care

SPEAKER 2: Meaningful engagement of clients and families and other stakeholders is the foundation of Client and Family Centered Care, which is defined by Parents for Children's Mental Health as an evidence-informed approach to practice that is focused on meeting the needs of both clients and families.

The Center for Addiction and Mental Health informs that the Client and Family Centered Care has three principles, which promote meaningful engagement. The 3 principles are as follows:

1. Family members are experts in needs of their loved ones and can communicate them in the best way possible to other people in the circle of care.

2. Equal partnerships among family members, service providers, and the patient or client, builds trust and promotes collaboration.

3. Providing opportunities to clients and their families for shared-decision making in ongoing care and planning.

A Client and Family Centered Care initiative at CPRI is to promote the quality of life of clients and their families. Its goal is for the child or youth and their family to feel empowered as true partners on the care team so that treatment goals are developed collaboratively. Taking into account self and family quality of life ensures that care plans are individualized according to the strengths and needs of the child and their support system, which in turn helps to sustain treatment gains.

Slide 10: What does the data tell us?

SPEAKER 1: We will talk more about measuring quality of life later. First let's see what the data tells us about family needs. When children and youth have mental health challenges, the entire family is impacted. And the wellbeing of the family in turn can affect the child's treatment outcomes. An important question is how can the needs of the entire family be assessed and addressed?

Slide 11: interRAI slide

SPEAKER 1: When it comes to assessment tools one size does not fit all. For example, tools designed for adults do not take into account the same level of detail regarding caregivers and family functioning. These are key factors to be considered in child and youth mental health.

The adult interRAI tools have been available and in use for many years. CPRI partnered with interRAI to fill in the void for ages 0 to 18, in collaboration with Dr. Shannon Stewart at Western University, who is the interRAI Lead for the Child and Youth Suite.

- Because the tools contain common core data elements individuals can be followed across sectors and systems as they age.

Slide 12: ChYMH

SPEAKER 1: The interRAI ChYMH is the main tool in the Child and Youth Suite of instruments and contains approximately 400 items. It is intended to be used with children and youth 4-18 years old in mental health settings to support comprehensive assessment, care planning, and outcome measurement. The ChYMH assesses psychiatric, social, environmental, and medical issues for children and youth receiving community-based or inpatient/residential services. The basic time frame for assessment is 3 days unless otherwise specified. The ChYMH is scored using a multi-source method, using interviews with the parent, child/youth, case worker, staff and file review, and other sources as needed.

The ChYMH has algorithms to assess areas of risk and need and scales that can be used to support care planning, symptom monitoring, and outcome measurement.

Additional supplements are available as appropriate – including the Adolescent supplement that is completed for all youth 12 years of age and older, and when an assessor feels that a younger child is engaging in adolescent-like behaviours such as substance use.

Slide 13: Map

SPEAKER 1: Our research department contains a dedicated implementation team whose primary focus is supporting sites implementing the interRAI ChYMH, ChYMH-DD, and ChYMH-Screener.

In 2014, CPRI began supporting the implementation at other child and youth mental health agencies. The number has expanded to over 70 agencies using the tools in Ontario as of November 2018.

As of October, 2018 – There were over 95,000 assessments completed for the ChYMH, ChYMH-DD, and the ChYMH-Screener tools, from over 62,000 unique children and youth across Ontario.

Due to partnerships with agencies across Ontario using a common tool and data sharing agreements, we are better able to understand the strengths and needs of clients and families receiving mental health services.

Slide 14: How are families doing?

SPEAKER 1: In the next few slides we will discuss some of the results from recent interRAI ChYMH data from families who have a child or youth with a completed assessment. We will attempt to answer the following questions:

- Do families have supports?
- Are families engaging in activities that promote positive wellbeing?
- How distressed and overwhelmed are caregivers and families?
- Do children and youth generally have supportive relationships with their family?

Slide 15: Sample

SPEAKER 1: To answer these questions we looked at the data from the 2017-2018 fiscal year.

The sample included 4,719 children and youth – the majority were male. Their ages ranged from 4 to 18 years and they were receiving services from the 42 mental health agencies in Ontario that are using the full ChYMH tool.

Slide 16: How Distressed/Overwhelmed are Caregivers and Families?

SPEAKER 1: So how distressed are caregivers of children and youth receiving services from mental health agencies?

Almost half of the caregivers reported being in distress. These families may be experiencing financial difficulties, struggling with mental health issues of their own, having relationship struggles with their partner, and may be having difficulties coping with their child's mental health needs.

In fact, almost half of families are feeling overwhelmed by their child or youth's mental health condition.

Slide 17: Do families have informal supports?

SPEAKER 1: While the majority of families have support from informal sources such as family and friends in case of a crisis, or to help with financial problems, babysitting, respite, and emotional support, it is important to pay attention to the 19% of families who were shown to lack informal support. This information is important because we know that informal support from extended family like aunts, uncles, grandparents and friends reduces the stress caregivers feel, and can promote better outcomes for children and youth. When clinicians are aware that informal supports are lacking, care planning can include supplementing with formal support.

Slide 18: Are families engaging in recreational outings?

SPEAKER 1: On a positive note, 76% of children and youth were reported to have engaged in a family outing within the month that the interRAI ChYMH tool was completed. This data shows that most families are regularly spending time with each other in enjoyable activities.

Slide 19: Are families eating together?

SPEAKER 1: In addition, the data from the ChYMH also indicate that 82% of children and youth in the 2017-2018 dataset reported having had a family meal within the past week. Research shows that regular family meals can have long-term protective benefits including increased wellbeing and healthier eating habits, and reduced risk-taking, depressive symptoms, and substance use. Families who eat together tend to be more connected and communicate more regularly.

Slide 20: Do children/youth have supportive relationships with family?

SPEAKER 1: An overwhelming majority – 84% of children and youth were reported to have strong and supportive relationships with their family. This is great news for the individuals who work with children and youth receiving mental health services. Having a supportive family can play a key role in a child's treatment for mental health needs and ensure that treatment gains are sustained after discharge.

Slide 21: Summing up

SPEAKER 1: To sum up, almost half of the caregivers are feeling are highly stressed, suggesting that clinicians may need to work with them to find services available to support the family's needs. To ensure the best outcomes for the child or youth, it is important to promote a healthy family environment. One way to help families could be to explore informal supports that may be available. Having family and friends to turn to can often be a great help to families who need a break or somewhere to turn when they have a crisis to manage. Although 80% of the families assessed do have these supports, about 20% of the families are shown to be in need of informal supports.

Optimistically, the majority of children and youth are regularly engaging in family activities, having sit-down meals together, and feel supported by their families. This highlights that most children and youth have families who are connected and can be involved during the treatment process – potentially helping to maintain treatment gains in the home. This data represents an opportunity for early intervention to address difficulties before families break down.

Slide 22: How can we hear directly…

SPEAKER 1: As mentioned earlier, it is essential to hear the voices of children, youth, and their caregivers directly. To do this we added two quality of life tools to the interRAI Child and Youth suite to help identify the areas of strengths and needs from the perspective of children, youth and their caregivers, to ask the question "What is happening?", with the goals of maximizing quality of life and ensuring client and family centred care.

Slide 23: QoL

SPEAKER 1: We created the Self-report Quality of Life tool for clients ages 7 and up, and the Family Quality of Life for caregivers in order to:

- Provide a basis for **further evaluation** of unrecognized or unmet needs

- Assist mental health service providers with **understanding** the areas of the young person's life where he or she is experiencing strengths and difficulties

- Inform a **care plan tailored** to the unique needs of the child/youth and their family

- And provide the opportunity to improve the quality of life of the child/youth and family to maximize treatment **outcomes**

These interRAI tools are not yet published at this time, and are only in use at CPRI so far.

Slide 24: SqoSPEAKER 1: Concepts

SPEAKER 1: Through a comprehensive literature review we focused on protective factors and indicators of positive mental health.

The Self report QoL is intended to assess:

Basic Needs which includes living conditions, food, safety and privacy

Social connection – feeling respected by others (which for the post-service inpatient pertains to direct care staff), engaging with friends and activities, and family relationships

Services items assess opinions about school and treatment

Items about the self or **the individual** asses feeling healthy (such as being active, getting good sleep), and feelings of autonomy and self-concept

Slide 25: SQoL 1: Design

SPEAKER 1: There are three harmonized versions of the Self-report Quality of Life specific to the time point administered and program status of the client.

The child or youth is asked to rate how true each statement is for him or her based on a three point scale with corresponding emotion icons:

For example, I have choices in how to spend my time.

Slide 26: FamQoL: Concepts

SPEAKER 1: The Family QoL concepts include:

Basic Needs – which for the family has a slightly different focus on life circumstances (such as making ends meet, and coping with stress), and safety within the home and neighborhood

Social –involves informal support from others, and community interaction and enjoying leisure activities

Family Unit – refers to relationships within the home and interpersonal challenges

Services include having access to needed formal supports such as medical and mental health resources, and items to assess service experience.

Slide 27: FamQoL: Design

SPEAKER 1: The Family QoL contains 25 items, 5 of which are reverse scored (such as, we have problems setting arguments).

It's important to note that this is not a proxy report – which means that instead of giving information about their child's quality of life, caregivers are reporting on the family's functioning and wellbeing. In other words, it does not replace the child self-report version, it complements it.

Slide 28: FamQoL: Design

SPEAKER 1: The post service version also contains 16 additional items to assess service experience. The service experience items allow for program evaluation and help to inform where service improvements may be needed at the agency level.

Slide 29: Integrating Perspectives

SPEAKER 1: Using the assessor completed ChYMH and the self report QoL tools together is important to bring all perspectives to light.

At intake the tools can work together to inform a collaborative picture of strengths and needs for treatment planning. Increasing concordance between the child/youth, family, and clinicians has been found to improve treatment adherence and outcomes.

Slide 30: Using the ChYMH and QoL together

SPEAKER 1: It is important to note that to identify **needs**, there is an inverse relationship between the Quality of Life tools and the ChYMH.

For the Quality of life tools low scores indicate areas where life quality may be poor. For the ChYMH, high scores on scales and flagged issues of risk and need identify areas that may benefit from intervention. Using the tools together can help to identify congruency between assessed needs and self reported needs.

Slide 31: Care Planning using tools

SPEAKER 1: Let's go through a fictional example of how the tools can work together to inform care planning:

Max is a 10 year old boy (in grade 5), and has been caught stealing twice in the last 3 months from peers at school.

The ChYMH areas of risk and need flagged were:

- Prevention of criminal activity **for stealing**
- Improve social and peer relationships **for social exclusion by peers**

- And develop personal strengths predictive of clinical resilience such as a notable talent, positive outlook, or adaptability to change, and having difficulty with problem-solving

Scales in the high range show:

- Some issues with Distractibility and Hyperactivity
- And that Peer Relations are strained

Slide 32: Fictional FamQoL

SPEAKER 1: Max's Family's Quality of Life doesn't reveal any problem areas, the caregiver reports that, for the most part, the family handles life circumstances well, and has external support, they are involved with their community, and have good relationships within the family unit.

Slide 33: Fictional SQoL

SPEAKER 1: Looking at Max's Self-report QoL, we see he feels his basic needs are being met and family is a strong source of support (for example, he feels they help him his problems, he gets along with parents and siblings, and enjoys spending time with them).

However, he reports not being socially engaged, he is not feeling respected by others (being treated unfairly), and he lacks a sense of autonomy (feeling he can say what he needs without feeling scared, having choices, and feeling good about himself).

Slide 34: Fictional Summary

SPEAKER 1: The clinical picture from the ChYMH shows the behaviours and observable areas of need: Problem behaviour of stealing, distractibility and hyperactivity likely indicating a need for help regulating emotions, difficulty with peers suggesting the need for social skills development, and the need for opportunities to develop personal strengths.

The Quality of Life tools show positive aspects of Max's life not evident in the clinical presentation: family wellbeing is positive overall and Max views his family as a source of support. The child's perspective also reiterates the need to improve interactions with peers, and highlights a feeling of lack of respect from others. Also the need to develop autonomy (or feeling good about himself) is revealed through self report.

Slide 35: Evaluating Outcomes

SPEAKER 1: As shown in the example, the ChYMH and Quality of Life tools can be used in care planning. These tools can also help to evaluate outcomes:

- Using the ChYMH at different time points can assist with understanding a child's areas of improvement and unmet needs through change in scale scores and flagged areas of risk and needs. We will talk more about measuring outcomes using the ChYMH in the next webinar.

- The Quality of Life tools can also inform on areas of improvement, unmet needs, and importantly provide information on service experience from the perspectives of the child/youth and the family.

Slide 36: Clients report

SPEAKER 1: Looking at actual Self-report QoL data from inpatient and outpatient clients before receiving services at CPRI, we see a dip in the area of friends and activities, suggesting that many of these children and youth with mental health challenges may need support for improving social connections. There is also room for improvement in the areas of autonomy and self concept, health (such as sleeping well at night), school, and understanding what to expect from treatment. In contrast, the domains reflecting their home life are more positive: they have good living conditions and food, as well as strong feelings of privacy and safety at home. The ratings of family relationships are high, which mirrors the ChYMH data presented earlier showing that most families have strong supportive relationships.

Slide 37: Families report

SPEAKER 1: Actual family quality of life data indicates on average that our clients' families show the greatest needs in the areas of life circumstances (for example, making ends meet), being involved in the community and enjoying leisure activities, and experiencing interpersonal challenges (such as stressful bedtimes, and trouble settling arguments).

Knowing the domains in which a client and family report their greatest needs can help to guide clinicians in treatment planning that will have the most impact. Likewise, seeing domains rated highly such as feeling safe and having positive family relationships and interactions can inform clinicians about strengths that can be used in care planning to promote and sustain treatment gains.

Slide 38: Family Service Experience

SPEAKER 1: A sample from the 16 service experience items from the post service Family Quality of Life show room for improvement in wait times to receive services. Satisfaction with staff being responsive and showing respect for clients' diversity is high, along with overall satisfaction with services. In addition, caregivers report having a better understanding of their child's strengths and needs, and increased confidence as a caregiver as a result of services received.

Slide 39: Products to improve…

Speaker 2: As mentioned earlier, CPRI is working on two projects related to Client and Family Engagement: The first is the Client Health Information Passport (CHIP) and the other is the Client and Family Engagement (CaFE) Model of Care with the goal to enhance client and family engagement at individual, organizational and community levels.

I will share the details of these projects in the next few slides.

Slide 40: CHIP

Speaker 2: The literature suggests that there is a need to develop ways to enable effective sharing of children and youth mental health and healthcare information with the clients, their caregivers and healthcare providers. (Nguyen, Lennox & Ware, 2014; Vaz, 1995)

Identifying this need at CPRI, the Applied Research and Education Department has designed the Client Health Information Passport (CHIP). The CHIP is a concise and easy to understand communication tool designed to deliver individualized health and healthcare information to the clients, their families, other caregivers and health care providers such as the emergency service providers, community service providers and teachers.

The CHIP is generated as an outcome report of the interRAI ChYMH assessment tool that Speaker 1 talked about earlier. The CHIP is intended to support children and youth aged 4 to 18 years who are experiencing mental health challenges and require services and supports.

Slide 41: Objectives of CHIP

Speaker 2: The CHIP has 4 objectives:

The first objective is to foster knowledge translation which means to share the client's health information with the people included in the circle of care in an easy to understand and user friendly format.

The second objective is to develop care coordination between the services so the transitions are smooth.

The CHIP is also intended to engage and empower the clients and their families. The simple language and better understanding of health information is envisioned to engage the clients and their families and empower them to use it when they need to.

The CHIP can also be very helpful in emergency situations by providing pertinent health information in a concise manner.

Slide 42: Designing the CHIP

Speaker 2: The CHIP was designed by using the Human – Centered Design Thinking approach.

It is a creative approach to problem solving that starts with consulting the people you're designing for and provides new solutions that are made to suit their needs and preferences.

We started with the literature review and identified the need to develop a product that could serve as a communication tool for the children and youth with mental health and developmental challenges and also support their caregivers.

We then consulted the stakeholders i.e., the clients' families, caregivers and service providers including the clinicians, social workers, and front line workers.

The next step was to identify and define the contents of the CHIP. We selected the items from the ChYMH that aligned with the needs and preferences expressed by the stakeholders. We then brainstormed the design of the CHIP and through an iterative process, the CHIP prototype was ready for pilot.

Currently we are testing the CHIP by piloting it at CPRI.

Slide 43: What does the CHIP contain?

Speaker 2: The feedback received from the stakeholders guided us towards the selection of items from the ChYMH and addition of other information in the CHIP. The CHIP is divided into sections which presents information in a tabular format. The simple language, colours and graphics make it visually appealing for all age groups.

The CHIP prototype contains information regarding:

- Demographics of clients and their caregivers
- School life
- Their needs and preferences
- Individual Crisis Management Plan
- Services received
- Diagnoses
- Treatment and medications
- interRAI assessment results
- List of additional documents provided to the clients
- And Appointment record

In each section, there is a comment box that was added based on the feedback received from the caregivers. The rationale was to add spaces in the CHIP where the clients and caregivers may have the opportunity to add information or note any changes that may happen after discharge.

Slide 44: Current Status of CHIP

Speaker 2: As shown in the previous slide, we are currently at the step of conducting the CHIP pilot. The goal is to test the CHIP with the main stakeholders i.e., the clients, caregivers, and service providers and to refine the CHIP based on the results of pilot. Pre and post surveys have been designed to evaluate the CHIP.

During this process, clients and caregivers will complete the pre and post surveys before and after using the CHIP.

The feedback from the participants will be used to determine if the CHIP supports ease of communication, improved care coordination and improved quality of life.

The service providers will complete the post survey after reviewing the CHIP with their clients. Their input will inform us if the CHIP can help improve care coordination, reduce evaluation time and cost of care.

Slide 45: Possible future implications

Speaker 2: The CHIP has been created with a vision to have the following implications:

- The CHIP can relieve the burden on clients and families from repeating information when seeking help or other services.
- It can ease care transitions, such as in cases of respite care, wraparound and new service providers. The CHIP may serve as a resourceful information tool for caregivers and service providers to clearly communicate the needs of the clients by providing pertinent health information in a concise and user friendly manner.
- It is designed to improve clients' and caregivers' quality of life through informed care across all services.
- It can provide health care providers with cost effective and fast access to clients' personal and past history, support shorter evaluation time and decreased length of stay in the ER.
- Lastly, the CHIP can help enhance clients and caregivers' engagement and highlight how to support the clients' needs and preferences. It can help reduce hospital admissions and readmissions, and support shorter evaluation time, which may in turn reduce the cost of care.

Slide 46: Next steps

The CHIP pilot began in June 2018 and is expected to be complete by December 2019. We are currently recruiting the study participants and collecting data. The next step will be analysis of data collected through the pre and post surveys. The analysis report will be shared with the stakeholders and it will be used to revise and refine the CHIP as needed. The next step will be to launch the CHIP at CPRI and other agencies.

Slide 47: CaFE

Speaker 2: The second initiative of CPRI related to client and family engagement is the Client and Family Engagement (CaFE) model of care.

In order to embed the practice of Client and Family Engagement and weave the patients' experiences, values and perspectives into the fabric of organizational service delivery at CPRI, the Applied Research and Education Department has partnered with the Family Advisory Committee and Client and Family Centered Care Working Group to develop the Client and Family Engagement (CaFE) model of care.

The Family Advisory Committee (FAC) was formed at CPRI in 2015. FAC provided a space for families to voice their needs, preferences, concerns and priorities. Its members include parents/ foster

parents/ guardians of CPRI clients (both current and past) and CPRI representatives/staff. The FAC advises and makes recommendations to CPRI's Senior Management Team and staff to help make sure that the services are client and family-centred.

The Client and Family Centered Care Working Group includes members from various disciplines at CPRI such as management, social work and research. The group works on a range of activities and initiatives to promote client and family centered care at CPRI.

In collaboration with the FAC and CFCC Working group, we designed the CaFE Model, which will complement the lived experiences of clients and families with the clinical expertise of service providers and help improve CPRI's service delivery and quality of care.

Slide 48: CaFE Vision and Goals

Speaker 2: CPRI's vision is to attain a high level of Client and Family Engagement by making the CaFE model of care a cultural constituent of CPRI that will converge the perspectives and support the needs of various service areas.

 The goals of this project are to:

- Foster stakeholder-informed quality improvement that brings real-world relevance and promote a strong culture of client, caregiver and staff engagement. This engagement may help empower clients and families to make their voice heard regarding their needs, strengths and preferences and motivate clients and families to participate in making productive changes in the system for better outcomes.

- The other goal is to align organizational culture and a client and family-centered model of service provision through education, training, policy and practice. The cultural competence will help enhance trust among stakeholders. It will help support an organizational culture and structure and client-centered model of service provision through congruency between policy and practice.

Slide 49: Project Timeline

Speaker 2: We created a 5 year Timeline which has been divided into 5 Phases to achieve the goals of the project. The main actions include development of CaFE training curriculum/guide, capacity building and training the stakeholders, conducting participatory evaluation, refining the model, implementing it and sustaining the practice of CaFE at CPRI.

The goals of year 1 have been achieved successfully.

- We conducted Literature Review to enrich our understanding of client and family engagement and explore the different models in practice.

- We then performed an Environmental Scan to identify CPRI's strengths, gaps and needs in this area. We gathered information through conferences, workshop and organizational process assets such as the past organizational surveys.

- Next, we conducted Needs' Assessment through survey of Family Advisory Committee or FAC members. The results demonstrated barriers such as distance, and the need to improve inclusivity and engagement of families in organizational activities along with their roles and responsibilities related to FAC.

- We shared the Survey Results with FAC and various disciplines across CPRI such as the management, clinicians, social workers, front line workers and other staff.

- Based on the information gathered, we constructed a Need-based Client and Family Engagement (CaFE) Framework for CPRI.

- Another main product of this project is the CaFE poster for internal communication, which you will see in the next slide.

Slide 50: Enhancing the Organizational Culture

Speaker 2: This poster has been designed to support knowledge mobilization and capacity building of clients, families, FAC members and staff at CPRI.

The theme of plant growth with colorful graphics are used to make the poster engaging and easily understood by all age groups. The poster contains the project goal, timeline, activities, enablers and outcomes in a visually appealing manner.

This poster will be placed in different locations within CPRI such as the waiting areas for clients and caregivers, inpatient units, and programs. It will serve as a continuous reminder and tracker of the project. If there is any major changes in the timeline, it will be updated on the poster accordingly.

Another main deliverable of the current phase is the CaFE Curriculum/guide. It is intended to enhance the organizational culture through knowledge sharing, training and implementation of best practice.

Slide 51: Envisioned Outcomes

Speaker 2: This project is envisioned to have a number of positive implications for clients, families, service providers, organizations and community.

Improved stakeholders' knowledge and skills regarding client and family engagement through literacy and training, using the CaFE Training Curriculum/Guide will result in enhanced organizational culture and capacity to support and promote high level of engagement. This will also help build trust and collaboration among stakeholders.

Improved insight and relationships will help remove barriers faced by clients and families, which in turn will result in meaningful engagement and empowerment.

Empowered clients, families and other stakeholders may act as knowledge brokers and facilitate knowledge mobilization to community.

Finally, improved engagement at individual and collective levels may support enhanced quality of care by service providers and better health outcomes for clients and families.

Slide 52: Next steps

Speaker 2: This project is in the second year or phase 2. The CaFE curriculum/guide is being developed and after its completion, it will be sent to the CPRI's Senior Management for approval and implementation. We will then begin to train the stakeholders such as the front line workers, members of FAC, researchers and clinicians.

After successful implementation of CaFE Model at CPRI, we will share the CaFE Training curriculum/guide with other agencies.

Slide 53: Thank you

SPEAKER 1: We hope you enjoyed this webinar! If you have any questions related to the topics presented here please feel free to contact us at the email addresses listed in the slide [laura.theall@ontario.ca; naila.meraj@ontario.ca]

Please also watch our third and final webinar to be posted in the near future. It will be entitled: **Are Children and Youth Getting Better? Outcome Research from the interRAI Child and Youth Tools**

Stay tuned for the release date coming soon!