Behavioural Supports Ontario
Projet ontarien de soutien en cas de troubles du comportement

Behavioural Supports Ontario

Event Summary

Supporting People Living in the Community

Event Date: November 15, 2012

Prepared by – The Alzheimer Knowledge Exchange

In partnership with:

Ontario Health Quality Ontario Qualité des services de santé Ontario

Ontario Local Health Integration Network Réseau local d'intégration des services de santé

Société Alzheimer Society Ontario

Alzheimer Knowledge Exchange Réseau Alzheimer pour l'échange des connaissances

table of contents

(Click section title for quick access)

Section 1 Introduction & Purpose……3

Section 2 Primary Care…….....4

Section 3 Managing Transitions……..6

Section 4 Person-Centred Care…… 7

Section 5 Integrated Care / Cross Sector Collaboration…….9

Section 6 Evaluation Findings……11

Section 7 Current Innovations …….....14

Section 8 Conclusion & Next Steps……...15

Section 1 Introduction & Purpose

Many health and social service providers intersect to provide support for persons with responsive behaviours and their families within their home and during their journey through the health care system. The Behavioural Supports Ontario project (BSO) has set out to build a health system that has an integrated service delivery, coordination and management and a knowledgeable care team based on capacity building focused on older persons with challenging behaviours due to cognitive impairments and their families.

Health service providers in the community must be invested in as they are leaders across regions and are vital to the sustainability of behavioural supports. This knowledge exchange event of November 15, 2012 provided an opportunity for many to come together, some for the first time to develop ways we can take action and ensure behavioural support innovations are realized and supported on the community level. This event was a true collaboration between sectors, organizations and LHINs that brought together a total of 67 participants.

Objectives for the day included:

- Learn from each other about existing community initiatives that effectively support the needs of the BSO population and examine enablers of success so that these might be applied in other communities.
- Define how the desired future state of behavioural support for those experiencing responsive behaviours looks within the community services sector.
- Examine service needs, processes and gaps between the current and desired future state for this population.
- Identify methods and resources for improving the system of care within the community services sector.
- Propose a shared course of action and suggest guidelines for next steps within the community services sector.

The event was based on four main themes of Integrated Care/ Cross Sector Collaboration, Primary Care, Managing Transitions and Person-Centred Care. We heard from some of those working within the community who provided examples of what is happening in regards to behavioural supports and how their innovations can be implemented in other communities.

After hearing from our presenters, participants split up into breakout sessions of their choice focused on the themes for the day. The breakout sessions were facilitated by Health Quality Ontario (HQO) and supported by knowledge brokers of the Alzheimer Knowledge Exchange (AKE) and the knowledge translation specialist of the Coordinating and Reporting Office (CRO).

Based on insight from discussions throughout the day it can be said that the overarching themes of priority action are primary care and managing transitions. The themes of person-centred and integrated care/cross sector collaboration are principles that should be present in all areas of our work and the recommendations provided can help inform promising practices in all sectors.

Overall, we are seeing these common threads:

- Everyone is accountable
- Needs for common language across sectors
- Using technology to communicate and share provincially
- Ways to share client/patient information,
- Need for meaningful measures of service
- Building on resources and tools already gathered and have one common BSO brand
- Bringing in the person and family and ensuring we use a bottom up approach
- Find ways to share and create knowledge
- Building in more education
- Challenge of keeping it all affordable
- Provincial leadership needed

The recommendations and suggestions for change in this document can be seen as guideline for LHINs and organizations. We want to work together to put these recommendations into practice across LHINs with provincial support. As you review this document please keep the following in mind:

- How can the recommendations be implemented in your LHIN/organizational practice?
- What recommendations fit into your current action plan or priorities?
- Are there pre-existing innovations related to the recommendations that would support their implementation?
- If so, how could these innovations be shared with the broader BSO community?
- What support do you need to move forward?
- This is a collaborative effort- let's focus on what we can do better together, not separately.

Section 2 Primary Care

The following are aims, action steps, ideas, reflections and resources from participants that surfaced during the breakout sessions and larger group discussions.

Aim: To knit services together at the point of care with a set of principles (prevention, early detection, support, connection) that is led by the primary care sector that will roll up into best practice primary care interface at the provincial level.

This will help to:

- Formally see spread happen, talk about the vision and start to see some change (health links)
- Determine what changes we can make.

Action steps:

- Provide a funded day for primary care providers (family health teams/ community health centres/ nurse practitioners etc.) to present an overview of BSO shared care to all 14 LHIN primary care leads to initiate dialogue for the identification of associated action/deliverable based on needs of primary care
- "Super dream": 14 engagement events (as above) in each LHIN to recognize local context
- Create some urgency at provincial tables to filter LHIN areas to have BSO at the table e.g. advanced healthcare
- At the local/ LHIN specific level:
  - Identify champions/early adopters
  - Identify specific test of change
  - Sit down with the LHIN based primary care leads and have a meeting re: BSO and potential opportunities
  - Creation of local ½ day of BSO population needs and ask primary care: what do you need to best serve person/family through the experience?
  - Consider value stream mapping/process map of community primary care doc.
- Improve Communication and engagement between CCAC/ broader community sector/ acute care/specialty care/primary care/person and family with lived experience
- Begin to identify the BSO liaison (go to) within each family health team, community health centre and solo practice
- Go on site (to them) to build relationship- make them see and feel change, bring stories so they can feel the impact (Work Force Management)
- Build on existing relationships with identified contacts (facilitate communication)
- Identify one or two primary care providers/provider groups and wrap supports with focus on person being served within the networks of the system
- Encourage funders to have SHARED deliverables
- Seek funding to reduce hospital use.

Themes:

- Collaborative nature of working together – shared geriatric services /medicine/Mental Health
- Complexity – need strong leadership – policy, culture & practice
- Motivation
- Not duplicating
- Psychogeriatric Resource Consultants for Primary Care and Long- Term Care (i.e. Waterloo-Wellington model)
- Understand your population
- Importance to knit together specialty, primary and community care
- Coming together at Point Of Care
- Dedicated leadership across system
- Critical importance for building trust
- Building capacity for Primary Care – Honour need to integrate with specialty care
- Support models of care that address capacity → build on one another
- Build continuity → no failed handoffs
- Transitions from Acute care to Long Term Care
- What does client want? We want to better understand
- Broader and more consistent definition of circle of care → privacy issues used

- Community Care Access Centre receives information but doesn't always share
- Physicians need to engage better with providers
- Some bring delegates that trust – if can't get them to the table how else can you communicate?
- Reciprocated energy and engagement with Primary Care and BSO
- Primary care to feel better supported by Geriatric Mental Health Services and other support sectors

Resources/Tools to make this happen:

- Binder on site with information Client – everyone to adopt this communication tool as a best practice
- South West – test notification to physician
- Integrated records
- Lead staff person for client
- How to coordinate information → move from disease specific to individuals – Chronic disease,
- Create your own "Susie" (referring to Psychogeriatric resource Consultant for primary care)
- Who should you leverage? Long –Term Care Home administrators; Primary Care from across LHINs to mobilize other contacts
- Sometimes different people – salaried models – Nurse Practitioners and physicians with Community Health Centres
- Leverage other teams – Ontario Medical Association, First Link, (Alzheimer Society) Ontario College of Family Physicians, Health Force Ontario
- Leverage other information you have and be strategic in communications
- Repatriation agreements – also have sign off by medical directors
- Communication – better way to interface with Community Care Access Centres; one Client Manager with physician
- Enhance communication with client – file in home with client
- Prescription print out
- Reports from specialist translated for client and to physician.

Notes:

- Top down agenda will not work!
- Need multi-pronged approaches and Facilitators for local/regional actions and connections.

Section 3 Managing Transitions

The following are aims, action steps, ideas, reflections and resources from participants that surfaced during the breakout sessions and larger group discussions.

Aim: By 31-Mar-2013, identify the components of a successful transition and define how well we are integrating the transition.

This will help to:
- Identify the barriers to a successful transition
- Break down barriers that arise by defined criteria by addressing gaps in funding policies
- Establish a general understanding and appreciation for the importance of transitions
- Find number of individuals touched by the Mobile Support Team
- Identify the number of successful transfers and where not successful, looping back to bring the Integrated Community Lead (ICL) to try a different direction.

Action steps:
- Create and complete a qualitative survey to understand the qualities that will improve the transitions
- Study the quantitative results of our data.

Themes:
- Warm handoff
- Explicitly take control
- Point of entry and collaboration
- Sharing back successes (need to do better job) – helps people to have effective practice
- Feedback on crisis
- Taking risks
- Some measures don't show impact to client [Alternative Level of Care (ACL)]
- Trialing ICL model
- Interconnectedness between agencies
- Sharing information
- Who is taking on ICL role? Who decides? How to assess value of role?
- Underlying principles needed – clinical expertise
- Organizational culture
- Intergenerational cultures
- Changing statistics and outcomes with more time in case conferencing and less with client
- Knowledge and skills of coordinator (social, larger health system, other systems beyond health – e.g. justice – determinants
- What about unattached clients?
- Stigma – cognitive, mental health, age
- Transitions across health care and associated with the progression of the disease – helping caregivers
- Stigma – mental health and social
- Sustainability as transition in the project.

Resources/Tools to make this happen:
- Kaizen event to simplify language
- Electronic
- Process of transitions – navigator, PSW
- How do you know when transition has occurred and who to notify
- Advanced care planning at other stage to understand process of dementia (progressive)
- Good practice catalogue of transitions – independence to care in home, home to Assistive Devices Program (ADP)
- Partners – families, friends, etc
- Self-management approaches
- Experience Based Design
- Looking to other systems – children's – wraparound; engineers – system design
- System Navigation – it's not new! We need to recognize it is a specialty – not clinicians → people who collaborate, coach, mentor
- Bring on-the-ground teams together to share experiences
- Find ways to capture and share a person's social and medical history.

Section 4 Person-Centred Care

The following are aims, action steps, ideas, reflections and resources from participants that surfaced during the breakout sessions and larger group discussions.

Aim: Common definition and approach to person-centered care across all providers.

This will help to:
- Make the culture change real- method follows intention
- Bring compassion back to decision making
- Move from staff focused to patient focused.

Action steps:
- Create qualitative assessment tool (how we determine the needs and provide what they need)
- Create and standardize meaningful qualitative measures
- Operationalize a value currently based on subjectivity with the objective of transcending across the spectrum of care as a standard objective set of expectations/understanding
- Once operationally defined- link to 3 pillars to define associated actions
- Apply to various sectors: person/family/ provider/organization and systems/broader community.

Themes
- Develop Common language to be informed by those we are serving
- Have an education process using case-based learning- everyone touched by BSO
- Provide opportunity for knowledge exchange at transition points (Person and Family- Community-Primary Care-Hospital)
- Assessing each other's roles, role modeling, knowledge transfer
- Take this to constituents, educate donors
- Engage governors (CEOs, directors, etc.) listening to staff
- Health service providers need to support one another better- no working in silos
- Common sense around care- knowing what the person needs: Person- centered VS specialty- centered
- Measurement of the services we provide not just the numbers
- Importance of relationships- handshakes- informal-assurances to work together
- Flexibility around service "swapping" less regulations
- Impact of stories and qualitative outcomes
- Person- centered includes the caregiver
- Need 24/7 services vs. 9-5
- Priority to needs and wishes of patients before policy/rules
- Warm transfers
- Everyone in the system is equal
- Equitable service for all patients/clients
- Common sense prevails
- Subjective quality- tapping into the felt experience
- Many definitions for person –centered
- Take time to reflect, share learnings, articulate
- Leadership: management buy in, knitting of creative approaches to person- centered
- Bottom- up, informed value of experience
- Competing agendas
- Knowledge capacity built in acute care
- Provincial collaboration and communication needed
- Positive stories are important
- Collaborate with funders
- Do more for less
- Long-Term Care/Mental Health/Community Support Services: poorest funder
- Requires collaborative skill building/knowledge exchange/shifting of cultural competencies and expectations
- Remain inclusive/grounded in the lived experience through all aspects of system transformation.

Resources/Tools to make this happen:

- AKE and Canadian Dementia Resource and Knowledge Exchange (CDRAKE)
- Concerned Friends
- Other existing networks
- Communities of Practice and Collaboratives
- Family councils
- Accreditation Canada
- Integrated Assessment Records
- Flash emails
- Family guide
- Personhood assessment tools
- Person-centred learning base tool
- Client satisfaction mechanisms
- Lived experience networks.

Section 5 Integrated Care / Cross Sector Collaboration

The following are aims, action steps, ideas, reflections and resources from participants that surfaced during the breakout sessions and larger group discussions.

Aim: Evaluate the collaborative/integrated system to ensure all appropriate links are in place

This will help to:
- Determine the current state of the collaborative care system
- Identify gaps
- Help to create a vision
- Support the persons we serve.

Action steps:
- Work with community sector to develop a report card system for all LHINs to complete
- Questions built around:
  - Is there a supportive/collaborative person- centered system?
  - Where is BSO making a difference
  - Need meaningful quantitative and qualitative measures.

Themes:
- Accountability for system navigation- everyone owns it
- Change Management
- Cultural sensitivity (between workers and with population being served)
- Education/Enhanced Capacity
- Communication across providers
- Complex care of elderly- prioritize staff to work with high risk
- Collaboration across all providers- know your partners
- ONE stop access- make a catalogue/inventory
- Rapid response
- Go after new programs and invite them to be a part of the care team
- Framework needed for integrated care/primary care/CCAC and others
- Embed care coordinator model/clinical geriatric consultant model/psychogeriatric resource consultant model for primary care
- Linkages across LHINs for one body of:/transitions/ ALC /Long-Term Care/Mental Health /BSO/Emergency Medical Services /Community Support Services /Pharmacy
- Collaborate on: tools/testing/sharing across all LHINs
- Shared documentation needed: portable records and electronic referrals
- COMMON language
- Enhanced support for those with early diagnosis (building on innovations such as First Link)
- Need secure way to share information across province (leadership on technology) , (capacity for OTN?)
- Social determinants of health
- BSO strategies for Acquired Brain Injuries (ABI) and developmental disabilities for Long Term Care
- Compensation for teams (different pay rates).

Resources and Tools to make this happen:
- Evaluation/building knowledge
- Core system ingredients
- Algorithms
- System models
- Shared documentation
- Policy (bottom up)
- Governance structures
- Virtual Huddles at point of care/leverage technology
- Knowledge Exchange Portal
- Education in acute care etc.

- Catalog/ inventory of tools/evidence of practice (Need marketing of tools- one hub where all tools/resources are listed and evaluations of these are available)
- ONE brand for BSO (everyone shares their innovations)
- Links to EMS
- Supports for before 65
- Core OTN capacity
- Flash emails
- Housing/CAP missing level 4 housing
- E Health record and references
- Model for linking with pharmacy
- Use “GERI-ACTT” concept
- Clearer definition of roles (ex: Intensive Geriatric Service Workers-needed more).

Notes:

- Instead of integrated system” use “collaborative care system
- CCAC does not service all clients- work with CSS agencies who are seeing the clients? Work inexpensively!
- Challenge: what incentives will there be to get the right people to the development table?
- PSWs are intensive community resource- deploy as needed.

Section 6 Evaluation Findings

At the end of the event participants were asked to rate the event in various categories. 24 out of 67 participants completed an evaluation and findings are presented below:

Degree to which participants felt the exchange enabled them to…

- **Better understand what others are doing**
  - 95.8% Agreed
  - 4.2% Felt Neutral

- **Identify challenges and linkages, opportunities for new knowledge to enable them in their own area**
  - 75% Agreed
  - 20.8% Felt Neutral
  - 4.2% Disagreed

- **Identify next steps as a group for collaborative action**
  - 75% Agreed
  - 25% Felt Neutral
  - 4.2% Disagreed

- **This was valuable knowledge exchange opportunity**
  - 79% Agreed
  - 16.7% Felt Neutral
  - 4.2% Disagreed

Some next steps participants will take in their work/organization…
- Discuss definition of transitions (including clients and personal transitions)
- Effectively assess how integration is or is not happening
- Develop a Community value system map
- Primary care engagement
- Acute care engagement
- Spread action to local committees and influence agendas
- Change in language
- Recording good news stories
- Profile models used for primary care engagement in our area
- Feed information forward.

Best things about this knowledge exchange opportunity…
- Panel discussions were a great learning opportunity
- Meeting with BSO colleagues
- Great to hear what others are doing
- True focus on community as BSO has primarily focused on long-term care
- Learning from others' experiences
- Range of topics explored- how BSO can be employed
- Now realize how much good work is happening in BSO
- Collaborative nature
- Good networking opportunity
- Aims helped to structure concrete next steps.
- Common goals identified
- Renewed BSO energy

Other comments…

- Well organized
- Useful Exchange
- Identified steps to move forward
- Good location
- Great integration of AKE and HQO
- Good quality tools
- Facilitation in action
- Capacity building handout should have been included
- Too many acronyms
- Need time to ask presenters questions
- Breakout sessions too short- needed more guidance
- Accountability is crucial to sustain this work
- Need more concrete ideas and direction
- Let's do this again

Section 7 Current Innovations

The following innovations were shared during the event and in the pre-event survey.

Geriatric nurse with a Family Health Team-work involves assessments of senior population on a variety of levels, connecting with clients & caregivers and providing them information/direction to community resources for support, education, activation, respite, etc. As well as supporting our family physicians in re: dementia care resources, etc. Networking and collaborating with community partners is another key component of this position.

Psychogeriatric Resource Consultant (PRC) within a Geriatric Mental Health Outreach Team. Involves supporting staff in Long-Term Care and Ministry of Health funded organizations (e.g. Adult Day programs, Supportive Housing). Role with staff includes education, case consultation (assisting staff to understand the client and develop an effective care plan which may involve promoting linkages with other organizations) and community development. The staff supported by the PRC typically work with older adults who have dementia, mental health conditions, and/or substance use challenges.

North East Specialized Geriatric Services (NESGS) offers a comprehensive range of specialized clinical assessment and treatment plans for seniors with complex health needs. A physician referral is required. It also serves to provide expert resources for professionals and caregivers throughout Northeastern Ontario. http://sudbury.cioc.ca/record/SUD2290

Waterloo-Wellington Geriatric Resource Consultant for Primary Care. The focus of the role is:

1) Capacity building for staff about best practice approaches to caring for older adults.

2) Promoting the needs of primary care and ensuring primary care representation at system planning tables.

3) Assisting primary care with system navigation for patients liaised regularly with the Waterloo Wellington Geriatric Systems coordinator who is instrumental in system development for older adults.

PASE (Psychiatric Assessment Services for the Elderly, Peterborough Regional Health Centre) which is a Geriatric Mental Health Outreach Team (GMHOT) serving a large rural and semi-rural catchment area of Four Counties in the Central East LHIN. This includes the work of the Psychogeriatric Resource Consultants. In addition, clinical support for people with serious mental health problems living in the community and their caregivers is provided. Works closely with other service providers in system planning to enhance services and increase education to leverage skills and knowledge across treatment settings.

Day Program initiatives Alzheimer Society support services

Acquired Brain Injury Association and treatment teams out of Community Care Access Centres and Developmental Disability agencies.

Section 8 Conclusion & Next Steps

Many suggestions for action steps have been made that will require more collaboration between LHINs and provincial support. We want to ensure we are not duplicating the efforts that are happening across the province and use existing resources and initiatives to build a supportive network and tools as we continue to support persons with responsive behaviours and their families.

We know that others are doing great work in the community around behavioural supports and may not have had an opportunity to take part in this event; however we want to ensure everyone has a chance to connect, share and create.

How to stay connected…

The CRO and AKE have created an online hub for resources and staying connected: www.BSOProject.ca
You can also sign up for the monthly BSO E News: http://akeresourcecentre.org/BSO-News

Collaboratives, developed within BSO, are focused on:

- Behavioural Support Units
- Access & Flow (formerly Centralized Intake)
- Mobile Teams
- Primary Care

For more information and to connect with AKE knowledge brokers please visit: http://www.akeresourcecentre.org/Communities

The AKE and CRO are working to get this information back to the LHINs so we can support the integration of community initiatives in BSO. This includes collecting and building upon the existing resources and innovations in our communities.

In the meantime, this report can be considered a guideline for building capacity within the themes of Primary Care, Managing Transitions, Person-Centered Care and Integrated Care / Cross Sector Collaboration so you can see where your organization fits into this and what you already have developed and can share. This will help us to incorporate the suggested action steps into our plans together, evaluate and create lasting system change. Please also refer to the **Next Steps Checklist** for a specific breakdown of the aims and action steps.