Behavioural Supports Ontario (BSO)

Presented to the joint conference of:

The Canadian Coalition for Senior’s Mental Health &
The Canadian Academy of Geriatric Psychiatry

Presented by:

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In partnership with:
changing the conversation; a new way of thinking, acting and behaving

a. new ways of bringing...
   - policy to practice and practice to policy
   - science to service and service to science

b. changing directions changing lives | a conversation on three models for change
   - planning and implementation
   - capacity building and
   - primary care
The Behavioural Supports Ontario (BSO) Project enhances health care services for older adults who demonstrate complex and challenging “responsive” behaviours associated with mental health, dementia, addictions and/or other neurological conditions; when they require and wherever they live (at home, in long-term care, or elsewhere).

BSO is a comprehensive system redesign; an approach that breaks down barriers, encourages collaborative work, shares knowledge, fosters partnerships among local, regional and provincial agencies and speaks to a new way of thinking, acting and behaving.

BSO creates a system that ensures people are treated with dignity and respect, in an environment that supports safety for all, and is based on high quality and evidence-based care and practices.

BSO provides clients with the right care, in the right place and at the right time.

BSO is not a new service but rather, a catalyst for change.
Bringing **policy to practice and science to service**

The BSO model is comprehensive; broad in its inclusion of all points of care and flexible in its application to communities of different sizes: better integration and collaborative transitional services, has resulted in better care, better health outcomes, and better value.

**Phase 1**
Defining the why and the what

**Phase 2(a)**
Testing the model & developing the supports, accountability structures and action plans

**Phase 2 (b)**
Implementation, exchange and evaluation

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**Pillar 1**
System Coordination and Management

**Pillar 2**
Interdisciplinary Service Delivery

**Pillar 3**
Knowledgeable Care Team and Capacity Building
seven keys to success

1. Define the complex population.
2. Define the “Why” and the “What” through a provincial framework.
3. Provide mechanisms to support “How” the framework is implemented locally:
   - Knowledge exchange opportunities
   - Improvement Facilitators
   - Quality improvement approaches
   - Risk and change management.
4. Introduce rapid timelines.
5. Embed multi-level accountability.
6. Create / use standardized tools, protocols and measurement to support implementation.
7. Embed continuous channels and processes to connect to, learn from and collaborate with provincial and local initiatives.
Target Population:
Older adults at risk or with complex health care challenges over time, with responsive behaviors as a result of mental health, dementia neurological disorders and/or addictions
And their caregivers.

Person and caregiver direction interdisciplinary collaborative cross-sectoral care (From prevention to high-risk)

Translation Within Service System Clusters
Prevention, Early Detection and Primary Care
Acute Decline in Community
Complex High Risk and High Need

System Management

Capacity Building
Capacity Enhancement Model

a new learning approach for a new health care population & system

Better Skills – Better Care – Better Value

Capacity enhancement model and tools, addressing the new population, the challenge of moving knowledge to practice and embracing an evidenced informed approach (the 97 vs. 3 percent)

- Capacity Building Roadmap (CBR)
- Behavioural Education and Training Supports Inventory Decision Making Framework (BETSI)
- Person-Centred Team-Based Service-Learning (PCTBSL)

All…

- are examples of high quality tools and resources
- enable Local Health Integration Networks to focus on capacity building investments that maximize their return on investment
- demonstrate money well spent and appropriately spent on capacity building investment
- are based on fostering a system that treats people with dignity and respect, in an environment that is based on quality evidence-based, patient-centered care and practice and, most importantly, supports safety for all.
Twelve **Core Competencies**, the new skill set of the behavioural health worker, include:

1. Knowledge
2. Person-Centred Care Delivery
3. Clinical Skills (incl. assessment, care planning and intervention)
4. Field-based Quality Improvement and Knowledge Transfer
5. Change Management Skills
6. Leadership, Facilitation, Coaching and Mentoring
7. Cultural Values and Diversity
8. Prevention and Self-Management
9. Resiliency and Adaptability
10. Collaboration and Communication
11. Technology Skills
12. Professional Work Ethics
Person-Centred Team-Based Service-Learning (PCTBSL)

PCTBSL enables continuous, evidence informed practice and systems change.

Transformational Care of Persons with Complex Health Care Challenges
PCTBSL | a hybrid of foundational models of care

Person Centered Care

Inter-professional Care

Improvement Science

Change Theory

Service Learning

Knowledge Translation

Person knowledge and skills

Team knowledge and skills

Application
Tailored learning based on the **learner** and **function** at **point of care**

**STEP 1** - Define learners and core competencies

**STEP 2** - Identify specific service functions of learners at the point of service

**STEP 3** - Utilize value stream mapping and Kaizen approach to define the service elements of each function

**STEP 4** – Map a) the skills of the individuals, skills of the team, learning and development programs (BETSI), and b) supportive tools, protocols and frameworks.
Service Learning | creating effective continuous learning environments

- combines content knowledge with situational experience
- promotes team collaboration and exchange
- requires pre-determined learning objective
- involves active reflection
- catalyst for social change for vulnerable
- learning “on the job” not in the classroom
the impact of service learning

- Promotes Knowledge to Practice
- Increases individual and team skills
- Congruent with QI methodology

Learn → Apply → Reflect → Shift in Consciousness/Change Practice
Behavioral Supports Ontario
Primary Care Initiative in South Eastern Ontario

Dallas Seitz MD FRCPC
Queen’s University Department of Psychiatry
500,000 Canadians are currently affected by Alzheimer’s disease (AD) and related forms of dementia.

Primary care providers (PCPs), including family physicians and primary care nurses, provide majority of care.

Evaluation and management of AD is challenging for PCPs and quality of care could be improved to optimize outcomes for this population.
“Typical” primary care practice:
- ~ 1500 patients
- ~30 individuals with dementia
- 3 new cases per year
- 64% of individuals with dementia are not detected\(^1\)

Dementia has major impact on management of other chronic diseases

Financial impact of dementia on healthcare:
- $15 billion currently - $150 billion in next 30 years\(^2\)
- Health care costs 3 – 20 X higher than individuals without dementia\(^3\)
Canadian Consensus Conference on the Diagnosis and Treatment of Dementia


Cover range of dementia management from risk factors to severe dementia

Guideline papers published in Alzheimer’s & Dementia: 146 guideline recommendations, 178 pages

Quality of care could be improved through increased awareness and adherence to clinical practice guidelines

Dementia is commonly under-diagnosed in primary care settings\textsuperscript{1-3}

Dementia is often under-treated

- Use of cholinesterase inhibitors is low among community-dwelling adults with dementia despite being best support treatment\textsuperscript{4-5}

- Awareness of guidelines is limited\(^1\)
- Physicians identified guidelines need to be in accessible and available formats\(^1\)
  - Ex. Brief clinical cards, web-based formats.
- Physicians feel patients and caregivers should be involved in guideline development\(^2,3\)
- Physicians are unaware of community-based services\(^2\)

Interventions to improve dementia care

- Systematic review demonstrated that dementia quality of care can be improved through educational activities, especially when combined with dementia care manager support\(^1\)

- RCT involving educational sessions and implementation of SW dementia care managers\(^2\)
  - Intervention group had greater number of QIs performed vs. usual care (63.9% vs. 32.9%)
  - Intervention group received higher quality of care on 21/23 QIs vs. control group.

- RCT of nurse practitioner dementia care managers in primary care
  - Significant reductions in behavioral symptoms, increased patient and caregiver satisfaction with care.

3. Callahan C, et al., JAMA, 2006
Primary-Care

Dementia Assessment & Treatment Algorithm
- Develop knowledge tools to facilitate assessment and treatment of AD by PCPs based on best evidence.
- Transfer these knowledge tools into a variety of primary care settings in Ontario.
- Evaluate the effects of this intervention on dementia quality of care, PCP application of knowledge, and the patient-centeredness of care.
PC-DATA implementation

Two components…

- **PC-DATA education session and tools**
  - DBased on best-evidence
  - Protocol based care planning.

- **Dementia Care Manager**
  - Assists PCP with application of the tools and protocols.
- Initial information session meeting with each PCP group to assess interest.
- Survey of educational needs assessment to focus on most relevant topics.
- Educational sessions
  - 60 – 90 minute Dementia Assessment and Treatment Algorithm (DATA) tool implementation workshop with PCPs
  - 1 hour follow-up session at study mid-point
  - Education based on CCCDTD guidelines (includes 2012 information).
- PC-DATA educational materials available on website and in PC-DATA manual.
Dementia Care Manager (DCM)
- Facilitate application of the DATA tool and provide support to PCPs
  - RN affiliated with geriatric psychiatry outreach program.

Assists PCP with assessment and management of dementia
- Assesses patient at PCP location (preferred) or in home
- Range of roles and functions are integrated into PC-DATA tool
- Shared decision making regarding referrals to community services and geriatric psychiatry consultation
- Communication via PCP electronic health record
- Approximately 1 full day/month for each 2 – 3 physicians.
Evaluation - Assessment of Cognition & Diagnosis

1. **Start**: Person with cognitive complaint, caregiver complaint, functional decline, age >65, failure of brief cognitive screening test

2. **Yes**: Test with MoCA

3. **No**: MoCA Score <=25/30?

4. **Yes**: Screening investigations and evaluation normal?

5. **No**: Functional Impairment Due to Cognition?

6. **Yes**: Dementia

7. **Yes**: Mild Cognitive Impairment

8. **No**: Cognitive decline or complaint, noticed by others?

9. **Yes**: Treat or optimize Retest

10. **No**: Contact Dementia Care Manager

11. **Link to resource**: Tool Available

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Primary Care – Dementia Assessment and Treatment Algorithm (PCDATA) Project
Initial management
Primary Care – Dementia Assessment and Treatment Algorithm (PCDATA) Project

PCDATA Ongoing Assessment and Monitoring

- Link to resource
- Tool Available
- Contact Dementia Care Manager

**START**
Is the person driving and unsafe to drive?

- **YES** Continue to Monitor and Reassess every 3-6 months
- **NO** Are there behaviors that pose a risk to the patient or others?

- **NO** On-road assessment Neuropsych testing, refer to specialist
- **YES** Address measures to reduce risks

- **UNCERTAIN** Are there additional safety concerns? (wandering, medications, fires, abuse)

- **YES** Address measures to reduce risks
- **NO** Is the individual capable of making decisions (treatments, finances, long-term care)?

- **NO** Is there a power of attorney or substitute decision maker available?
- **YES** Obtain informed consent from SDM or PGT

- **CONTACT** Public Guardian and Trustee

- **NOTICE** Notify patient and regulatory authorities of decision

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PCDATA

Ongoing assessment & monitoring

3
Primary Care – Dementia Assessment and Treatment Algorithm (PCDATA) Project
- **DATA Algorithms, information sessions, educations sessions, manuals, visit flow sheets and website complete.**

- **Initial information sessions with Primary Care:**
  - Completed: 17 family physicians, 10 nurses across 3 sites
  - Scheduled: 10 family physicians, 5 nurses in 2 sites
  - Ongoing recruitment: 15 family physicians, 8 nurses.

- **Education Sessions:**
  - Completed: 8 family physicians, 8 nurses, 1 SW.
outcomes

- Process evaluation of development and implementation
- Mixed methods evaluation
- Chart audit of dementia assessments by PCP before (3 years) and after PC-DATA implementation
  - Review of care process quality indicators, quantitative analysis
- Interviews with PCP and patient/caregivers who received care in PC-DATA sites
  - Experiences, facilitators and barriers to uptake of program
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<th>Member</th>
<th>Role</th>
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- CIHR Knowledge to Action Operating Grant
- KAL#114493
let’s continue our discussion!
For more information on Behavioural Supports Ontario please visit www.bsoProject.ca or contact...

Matt Snyder, BSO Project Lead at matt.snyder@lhins.on.ca

Also, stay tuned for more information about our…

Cross Country Conversation | A National Forum