Catalyst Initiative:
Ontario's Best Practice Exchange

September 25, 2015, Mississauga ON
Toronto Airport West Hotel

Collaborative Summary / Objectives:

Person and Family-Centred Care:

Co-Chairs:

- **Monica Bretzlaff**, Manager: North East BSO, Provincial BSO, Senior's Mental Health-Regional Consultative Service Devonshire
- **Sharon Osvald,** South East Lived Experience Coordinator, Providence Care

Advisor: David Harvey, Chief, Public Policy and Program Initiatives Officer, Alzheimer Society of Ontario
Knowledge Broker: Kathy Hickman, Education Manager, ASO & Knowledge Mobilization Lead, brainXchange

Collaborative Objectives:

- This collaborative will focus on ensuring that all emerging practices in the other 6 collaborative areas are developed with a person and family-centred focus.
- Will lead the morning's plenary session where individuals with lived experience will be asked to describe what 'person and family-centred care' means to them and to provide examples of when they have and haven't received person and family-centred care.
- Highlight examples of how understanding and including lived experience perspectives as well as using person centred best practices are being put into everyday practice and influencing policy.
- Identify other practices, policies and initiatives that incorporate lived experience in meaningful ways and explore how/why these are person-centred.

Anti-psychotics:

Co-Chairs:

- **Dr. Lisa Van Bussel**, Geriatric Psychiatrist, Regional Psychogeriatric Program, Physician Leader,Geriatric Psychiatry Program, Parkwood Institute & St. Joseph's Hospital (London)
- **Dr. Andrea Moser**, Baycrest Centre for Geriatric Care

Advisor: Dr. Ken LeClair, Geriatric Psychiatrist, Queen's University, Clinical Consultant: Geriatric Psychiatry, Royal Ottawa Hospital & Providence Care Senior Mental Health Programs
Knowledge Broker: Jillian McConnell, Knowledge Broker & Mobilization Lead, brainXchange

Collaborative Objectives:

- Surface the present landscape and activities in the area of antipsychotic prescribing practices in British Columbia, Alberta and shift the conversation to an approach in Ontario that focuses on person and family-centred best practices, with the help of recent documents and established guidelines about antipsychotic use (e.g., Health Quality Ontario's Looking for Balance Report).
- With the primary focus being the use of antipsychotics in long-term care, we want to learn how to support persons diagnosed and their families in their understanding of what are appropriate uses for these medications and what would be the best way to begin discussions regarding their use.

Behavioural Supports (Mobile & Inter-Agency Teams):

Co-Chairs:

- **Patti Reed**, BSO Program Manager, SW York Region
- **Teresa Judd**, Director of BSS, Client Services Central West CCAC
- **Valerie Powell**, Behavioural Support System Coordinator, North Simcoe Muskoka
- **Penny Hubbert,** Chair of the BSO of CLHIN, Caregiver

Advisor: Dr. Ken LeClair, Geriatric Psychiatrist, Queen's University, Clinical Consultant: Geriatric Psychiatry, Royal Ottawa Hospital & Providence Care Senior Mental Health Programs
Knowledge Broker: Jillian McConnell, Knowledge Broker & Mobilization Lead, brainXchange

Collaborative Objectives:

- Provide a brief background on Behavioural Supports Ontario (BSO) framework and highlight the 2-3 years of work that has been done previously via the surfacing of experiential and best practices re: mobile teams.
- Explain the critical framework that has been developed and why the BSO is evolving towards a combined-team model (Internal & External teams) to support individuals / teams that work specifically with those who present with responsive behaviours – so that people can be supported where they are, receive access to organizations / services through out the community and support movement / transitions when necessary.
- Describe and define "Transitions" and explain why we are drilling down further on this particular issue as the focus of the workshop.
- Identify the critical elements for experiencing successful transitions using the combined team approach across sectors and across providers; from the perspective of persons with lived experience and from the perspective of providers within the health care team.
- Determine the skills, services and supportive structures within the team that is needed to best serve the person with responsive behaviours and their care partners.
- Examine how we can best use the BSO framework to help guide the discussion re: service coordination; capacity enhancement and knowledge exchange and continuous quality improvement.

Behavioural Support Transition Units (BSTU):

Co-Chairs:

- **Adrienne Bell-Smith**, Manager Behaviour Support Transition Unit (BSTU), Senior Strategy Lead, Quinte Health Care
- **Sophie Sapergia**, Practice Lead - Dementia Initiatives, Seniors Health Strategic Clinical Network, Alberta Health Services

Advisor: Dr. Ken LeClair, Geriatric Psychiatrist, Queen's University, Clinical Consultant: Geriatric Psychiatry, Royal Ottawa Hospital & Providence Care Senior Mental Health Programs
Knowledge Broker: Kathy Hickman, Education Manager, ASO & Knowledge Mobilization Lead, brainXchange

Collaborative Objectives:

- Share the Behavioural Support Transition Units (BSTU) framework and learnings about current practices within existing units.

- Gather feedback on the framework and current practices from research/policy, practice and lived experience perspectives so that we can better understand how to support individuals and their families before they enter these units, during their stay, and their transition back into long-term care or home.
- Discuss how to develop best practices about the units' environments (both physical and social).
- Begin discussions about the significance of current successes, challenges and person-centred practices in BSTUs (what are the themes and what do they tell us?).
- Determine next steps toward the development of critical elements.

Health Links / Primary Care:

Co-Chairs:

- Mary Woodman, Project Manager, Quinte Health Link
- Dr. James Chau, North East Specialized Geriatric Services; Regional Medical Champion, NE BSO

Advisor: David Harvey, Chief, Public Policy and Program Initiatives Officer, Alzheimer Society of Ontario
Knowledge Broker: Kathy Hickman, Education Manager, ASO & Knowledge Mobilization Lead, brainXchange

Collaborative Objectives:

- Move toward a shared understanding of what Coordinated Care is and why it is a beneficial person-centred practice.
- Develop strategies surrounding the coordination of care for individuals who are seeing multiple providers and how to simplify a person's experience with the overall goal of better care.
- Identify best practices in coordinated care planning that are person and family-centred.
- Explore ways to begin to use/enhance use of Coordinated Care Plans in Primary Care and Health Links for older adults with complex care needs due to mental health, substance use, dementia or other neurological conditions.
- Surface other processes and tools for Coordinated Care Planning, while emphasizing that the intention of the work done at the in-person event will be exploratory – sharing and scanning for existing practices and resources with the goal being to move toward identifying critical elements over time.

Substance Use:

Co-Chairs:

- **Cathy Sturdy Smith**, Manager, Specialized Geriatric Service, CMHA, Waterloo Wellington Dufferin
- **Marilyn White-Campbell**, Geriatric Addiction Specialist, CMHA Waterloo Wellington Dufferin
- **Jane McKinnon Wilson**, Waterloo Wellington Geriatric Systems Coordinator, CMHA Waterloo Wellington Dufferin

Advisor: Julia Baxter, Manager, Seniors Mental Health Outreach Programs - Brant, Hamilton, Halton and Niagara, St. Joseph's Healthcare Hamilton - Seniors Mental Health Service
Knowledge Broker: Jillian McConnell, Knowledge Broker & Mobilization Lead, brainXchange

Collaborative Objectives:

- Build on the work of the Community of Practice for Geriatric Addictions:
- Increase the understanding of Geriatric Addictions / Substance Use among health care professionals (including front-line) and community care partners
- Identify best practise treatment and supports for older adults living with substance use disorders.
- Provide an overview of successful regional strategies, models and products (i.e. pocket guides for older adults living with a substance use disorders using the framework pillars of Behavioural Supports Ontario
    - System Coordination - Coordinated cross-agency, cross-sectoral collaboration and partnerships based on clearly defined roles and processes to facilitate seamless coordinated care.

- Interdisciplinary Service Delivery - Outreach and support across the service continuum to ensure equitable and timely access to the right provider for the right service.
- Knowledgeable Care Team and Capacity Building - Strengthen capacity of current and future professionals through education and focused training to transfer new knowledge and best practice skills for continuous quality improvement.

- Explore how we can build on and strengthen the Community of Practise on Geriatric Addictions to ensure a person and family-centred approach

Tertiary Care / In-patient Speciality Services:

Co-Chairs:

- **Julia Baxter**, Manager, Seniors Mental Health Outreach Programs - Brant, Hamilton, Halton and Niagara, St. Joseph's Healthcare Hamilton - Seniors Mental Health Service
- **Dr. Maxine Lewis**, Clinical Head of Geriatric Psychiatry, St Joseph's Hospital, Hamilton, Associate Professor, McMaster University

Knowledge Broker: Jillian McConnell, Knowledge Broker & Mobilization Lead, brainXchange

Collaborative Objectives:

- Continuing the work that has been initiated by this established (2014) tri-organization collaborative and its 3 associated universities, we are looking to move this work forward reinforcing patient and family first, with a focus on high needs groups with complex behavioural health issues who need the services and supports offered by specialized geriatric mental health care
- An overview of previous work including survey responses of individuals/families who have had experience in a tertiary geriatric psychiatry behavioural unit will be provided.
- We will discuss point of care (the care that is delivered at the bedside) with an emphasis on patient safety as it pertains to a person and family-centred approach.
- We will share perspectives and gather input related to describing and measuring the unique needs, experiences and resources associated with this complex population and its carers.