Catalyst Initiative:

Ontario's Best Practice Exchange

Full Report

February 2016

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Background

Ontario's Best Practice Exchange is an exciting initiative that is moving forward emerging and best practices related to geriatric mental health, dementia, substance use and neurological conditions. Seven working groups, referred to as 'Collaboratives' have been established that bring together thought leaders, innovative thinkers, various experts and people with Lived Experience from across the province.

The 7 Collaboratives:

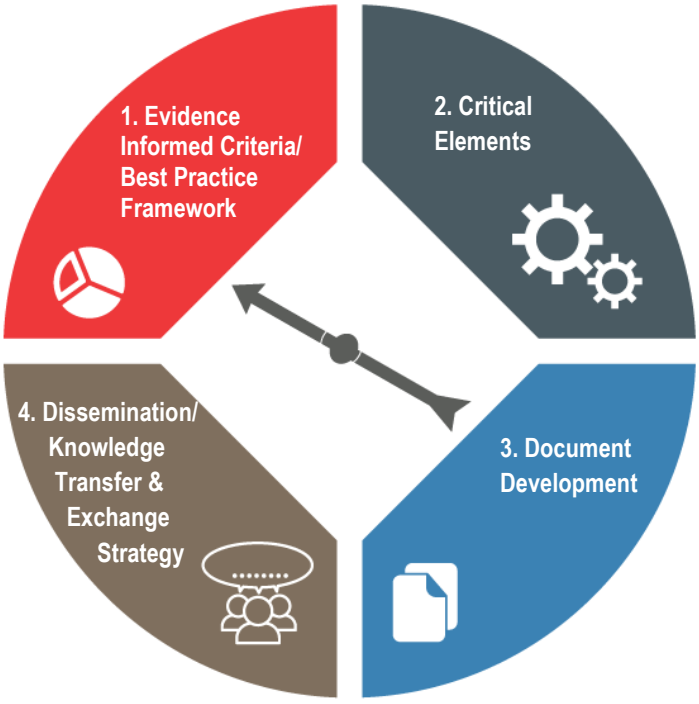
- Person & Family-Centred Care
- Antipsychotics
- Behavioural Supports Mobile & Inter-Agency Teams
- Behavioural Support Transition Units
- Health Links & Primary Care
- Substance Use
- Tertiary Care & In-patient Specialty Services

Since the summer of 2014, these Collaboratives have been working together to uncover the current practices related to their topic and looking at how these practices are, or could be, person and family-centred.

Defining the Lived Experience

Lived Experience refers to the experience of living with dementia, mental health, substance use and/or neurological disorders or the experience of being a care partner of an individual with these conditions. Examples of care partners may include family members, friends, etc., who play or played an active role in supporting an individual living with the above conditions emotionally and/or physically.

Best Practice Development Barometer



This work was done in partnership with the brainXchange and facilitated by **Kathy Hickman** and **Jillian McConnell** (Knowledge Brokers at brainXchange). Each Collaborative also had access to an advisor: **Dr. Ken LeClair** (Geriatric Psychiatrist, Queen's University, Clinical Consultant: Geriatric Psychiatry, Royal Ottawa Hospital & Providence Care Senior Mental Health Programs), **David Harvey** (Chief, Public Policy and Program Initiatives Officer, Alzheimer Society of Ontario), or **Julia Baxter** (Manager, Seniors Mental Health Outreach Programs, St. Joseph's Healthcare Hamilton). This work helped the Collaboratives to identify where on the Best Practice Development Barometer their Collaboratives were and how they might move forward to develop more person and family-centred best practices.

In order to officially launch the Collaboratives and gain further insight into their work from other stakeholders, an idea was presented to have all of the Collaboratives come together for an in-person event and thus, planning for Ontario's Best Practice Exchange Catalyst Event began.

As the primary goal of the Collaboratives is to create person and family-centred best practices, it was essential that the work be truly informed by the voices of people with Lived Experience. Individuals living with dementia, mental health, substance use and/or neurological disorders and their family/friends were invited, not only be active participants in the day, but equal partners. The involvement of those with Lived Experience was supported by the Alzheimer Society of Ontario who provided funding support to cover participation costs. Participants with Lived Experience were nominated by the 7 Collaborative co-chairs, members of the steering committee and/or local Alzheimer Societies and were personally invited. They were given the opportunity to call into a teleconference meeting two weeks before to the event to hear information about what to expect and to share their ideas about how they could be supported to participate. Special efforts were also made to make sure that participants with Lived Experience were comfortable throughout the day of the event and that they had opportunities to share their ideas.

Ontario's Best Practice Exchange Catalyst Event

The Catalyst Event was held at the Toronto Airport West Hotel on September 25, 2015.

There were **145** participants including **34** individuals with Lived Experience.

Representation:

Sectors

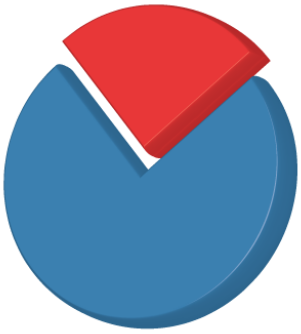
- Government Agencies (e.g. Ministry of Health, Health Quality Ontario)
- Non-government Agencies
- Community
- Long Term Care
- Retirement Home
- Hospital
- Tertiary Care

Professionals

- Physicians & Psychiatrists
- Administrators (e.g. managers, directors, senior leadership)
- Researchers
- Policy Developers
- Educators
- Front line staff (e.g. nurses, social workers, personal support workers)

Lived Experience

- Individuals with dementia, mental health disorders & substance use conditions
- Family members
- Older Adults



Acknowledgements

- **Julia Baxter** (St. Joseph's Healthcare Hamilton) for hosting the event.
- The **brainXchange** and **Behavioural Supports Ontario (BSO) Provincial Coordinating Office** for supporting the event.
- **Alzheimer Society of Ontario** for financially supporting the inclusion of people with Lived Experience.

Opening Remarks

Terry Tilleczek (Senior Director, North East Local Health Integration Network) provided a welcome to the event on behalf of the Ontario Local Health Integration Networks (LHINs) and Behavioural Supports Ontario Provincial Coordinating Office which is located in the North East LHIN.

Dr. Ken LeClair (Geriatric Psychiatrist, Queen's University, Clinical Consultant: Geriatric Psychiatry, Royal Ottawa Hospital & Providence Care Senior Mental Health Programs) shared the story behind the development of Ontario's Best Practice Exchange and the associated Collaboratives.

David Harvey (Chief, Public Policy and Program Initiatives Officer, Alzheimer Society of Ontario) described the role of the Alzheimer Society of Ontario and brainXchange in the development of the Collaboratives.

Highlights from the Lived Experience Panel

The Person & Family-Centred Care Collaborative held a plenary session titled “Person & Family First”. The session consisted of Lived Experience panel members sharing their experiences with health care services across Ontario.

The panel included three individuals with Lived Experience (**Hanni, Sandra** and **Dan**) who were joined by **Amy Lang** (Director, Patient, Caregiver and Public Engagement, Health Quality Ontario), **Monica Bretzlaff** (Manager: North East Behavioural Supports Ontario (BSO), Provincial BSO, Senior’s Mental Health-Regional Consultation Service, Devonshire) and **Sharon Osvald** (Lived Experience Network Coordinator, Providence Care Behavioural Support Services).

Each panellist provided their perspectives on what person and family-centred care means to them. They shared details of experiences where they both received and did not receive person and family-centred care.

Hanni described person and family-centred care as the ability for care providers to be able to listen to what their patients’ needs are and act upon their wishes as much as possible within their scope of practice. She added that health care professionals who want to provide person and family-centred care often take the extra step to connect the patient to other organizations, service providers and/or agencies to ensure a complete circle of care.

Photo of panellists (from left to right): Sharon Osvald, Kathy Hickman (facilitator), Dan, Monica Bretzlaff, Sandra, Amy Lang & Hanni

Sandra echoed Hanni’s thoughts, emphasizing the need for health care providers to have listening skills. She shared that patients do not expect health care professionals to have all of the answers right away to every problem; they simply want to feel heard and be part of the health care process.

Dan emphasized how important family is for true person and family-centred care. He also shared his experiences of receiving different styles of support from heath care professionals throughout his journey. He added that having family as part of his circle of care helped him feel confident to move forward.

Amy Lang (Director, Patient, Caregiver and Public Engagement, Health Quality Ontario) described Health Quality Ontario’s development of new standards for the delivery of person and family-centred care for people navigating the health care system. Individuals with lived experience have been part of panels to help develop standards of care and share their stories. So far the team has learned that it is important to include Lived Experience Advisors in this kind of work and even more critical to engage them early in the process.

Monica Bretzlaff (Manager: North East BSO, Provincial BSO, Senior's Mental Health-Regional Consultation Service, North Bay Regional Health Centre) is a co-chair for the Person and Family-Centred Care Collaborative. She described the work of the North East Lived Experience Network (part of North East BSO). This network connects individuals with Lived Experience every other month through the Ontario Telemedicine Network in order to share their experiences and talk about advocacy, education and other opportunities to change practice. As the North East is the provincial coordinating office for Behavioural Supports Ontario for the next two years, they are looking into developing a provincial-wide Lived Experience Network.

Sharon Osvald (Lived Experience Network Coordinator, Providence Care Behavioural Support Services) is a co-chair for the Person and Family-Centred Care Collaborative. Sharon is responsible for the Lived Experience Café on www.dementiacrossroads.ca; a website that gives a space for individuals living with dementia, mental health, substance use and/or neurological disorders and their care partners to share their experiences and advice on navigating the health care system.

Following the conclusion of the panel**, Dr. James Chau** (Care of the Elderly Physician, North East Specialized Geriatric Services; Regional Medical Champion, North East BSO), shared a story and song to send the participants into their morning sessions.

"Families WANT to help – They want to participate in health care decisions"

~Participant with Lived Experience

Antipsychotics Collaborative

Collaborative Objectives

- Surface the current landscape and activities in the area of antipsychotic prescribing practices in British Columbia and Alberta in order to shift Ontario's practices to focus more 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.

Co-Chairs:

Dr. Lisa Van Bussel
Dr. Andrea Moser

Advisor:

Dr. Ken LeClair

brainXchange Knowledge Broker:

Jillian McConnell

Highlights from the session

The Challenge (Weighing the risks):

- At times, responsive behaviours involve significant risk (e.g. risk of serious physical harm to self or others, hospitalization and compassion fatigue).
- There are risks involved with Antipsychotic use (e.g. negative side effects and increased risk of stroke and death).

"It was good to hear from others in the system and realize we have so many similar challenges"

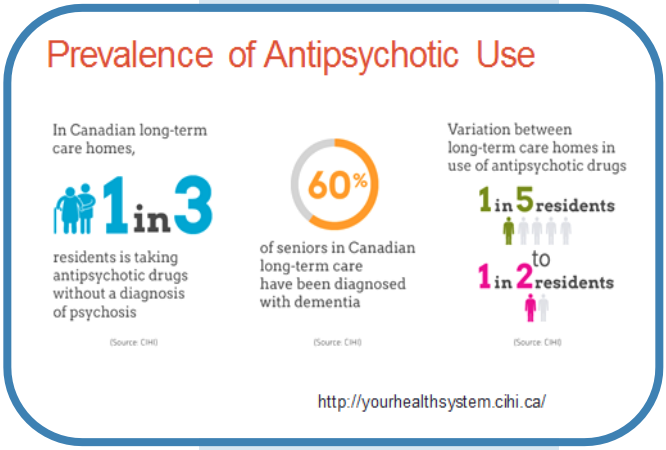
~ Participant

Current State:

- Canadian Institute for Health Information data.
- Health Quality Ontario report: Looking for Balance: Antipsychotic medication use in Ontario Long-Term Care Homes.

Current Initiatives & Practice Improvement Tools:

- Health Quality Ontario's Long Term Care Practice Report - provides confidential practice reports to physicians regarding prescribing and practice patterns.
- Centre for Effective Practice: The Appropriate Prescribing Demonstration Project – provides educational support related to appropriate prescribing in LTC homes.
- Alberta's Appropriate Use of Antipsychotics Toolkit for Care Teams.
- Deprescribing Guidelines for the Elderly.



Participants' Insights:

- Experiences of patients and their care partners need to inform work related to Antipsychotics - "Nothing about us, without us".
- Language is important. Words like "aggression" can be damaging.

Presentation available on the brainXchange website:
http://tinyurl.com/bxcAntipsychotics

Behavioural Supports Mobile & Inter-Agency Teams Collaborative

Collaborative Objectives

- Explain the critical framework that has been developed and why Behavioural Supports Ontario is evolving towards an amalgamated team model (internal and external teams) to support individuals and 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 throughout the community and facilitate transitions when required.
- 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.

Highlights from the session

Transitions in Care:

- Transitions in care occur when people move between different levels or care, different types of service providers and/or different settings.
- According to the Institute for Clinical Evaluative Sciences (ICES), “The expectation is that care providers meet the distinct needs of older adults while respecting their desire to live independently in their communities for as long as possible… For patients who experience transitions, good continuity of care is critical to ensure optimal outcomes”.

Promising Practice- Integrated Support Teams In Long-Term Care:

- Internal Behaviour Resource Teams (e.g. designated behaviour-trained staff – may be nurses, social workers, activation staff, personal support workers, directors of care, etc.) working in collaboration with External Mobile Resource Teams (e.g. outreach teams such as behaviour support outreach, – psychogeriatric nurse-led, palliative care, and Psychogeriatric Resource Consultants).
- There is no single model or approach that best supports integrated care; personalized centred care is individually designed with the person (versus a set design in which the person must fit).
- Good communication and meaningful relationships between those receiving care and those delivering care is mandatory for success.

Co-Chairs:

Patti Reed
Teresa Judd
Penny Hubbert
Valerie Powell

Advisor:

Dr. Ken LeClair

brainXchange Knowledge Broker:

Jillian McConnell

Presentation available on the brainXchange website: http://tinyurl.com/bxcTeams

Behavioural Support Transition Units Collaborative

Collaborative Objectives

- Learn about existing successes, challenges and person-centred approaches.
- Gather input on significance of these practices (what themes emerge, what do they tell us about what matters?).
- Develop critical elements for Behavioural Support and Transition Units (BTSU).
- Share critical elements.

Highlights from the session

- Currently there are 6 Long-term care BSTUs in Ontario
- Goals of BSTUs:
  - To reduce inappropriate length of stay in hospital
  - To prevent avoidable emergency room visits and hospitalizations
  - To send or return residents to a care home after successful treatment
- A framework to look at the different parts of a BSTU has been developed. It focuses on: prior to admission, at admission, during stay, at transition/discharge and staff resources and the environment. Participants looked at what is important to think about for each part of the Framework
- Issues before, on admission, during stay and at discharge include:
  - The need to define common admission criteria
  - Making sure roles of BSTUs is clear for referring agencies
  - Collaboration and sharing of patient information with community partners at referral stage and at time of transition
  - Family involvement (partners in care) and support
  - Develop person centred care plans that involve all partners (for transfer with person)
- Examples of what is important about staff resources include:
  - Consistency of staff is important
  - Experienced, trained and skilled staff are needed
  - Team work essential
- Examples of what is important about the environment (including social space and physical environment) include:
  - Understand who the person is and what their needs and goals are
  - Need to take away triggers of behaviour
  - Home like setting is important

Co-Chairs:

Sophie Sapergia
Regrets:
Adrienne Bell-Smith

Advisor:

Dr. Ken LeClair

brainXchange Knowledge Broker:

Kathy Hickman

Presentation available on the brainXchange website: http://tinyurl.com/bxcTransition

Health Links & Primary Care Collaborative

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.

Highlights from the session

Goals of Health Links:

- Better outcomes for patients and their families.
- Improved patient and provider experiences.
- Reduced utilization of hospitals to lower overall cost.

Integration and Coordination of Care Requires:

- Integration at the system level: integrating sectors and organizations; and better collaboration between health and social service providers.
- Coordination of care at the patient level: Health Links begin by focusing on patients who have the most complex needs (e.g., high medical and social needs).

How can we ensure Coordinated Care Planning is person & family centred?

- Ensure all involved understand the purpose of Coordinated Care Plans.
- Make use of Skype or other similar technology to encourage family involvement from a distance.
- Give patients time to complete sections of the form at their own pace.
- Ensure that Health Links Coordinators have time to listen to patients.
- Training for health professionals to change the way they think about delivering health care.

Co-Chairs:

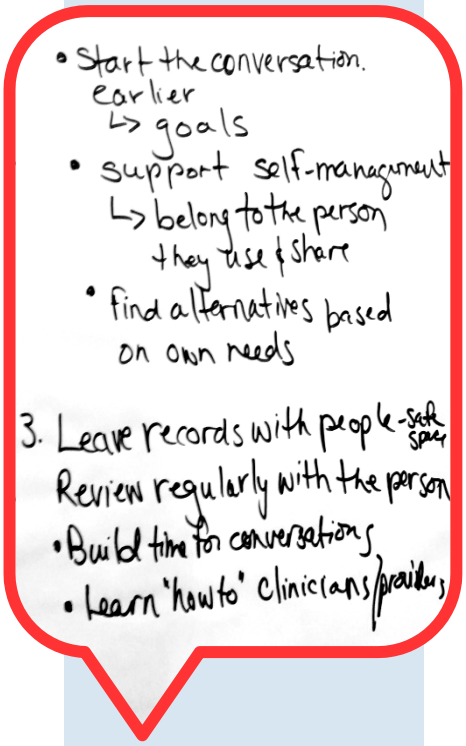
Dr. James Chau
Annie Campbell on behalf of Mary Woodman (regrets)

Advisor:

David Harvey

brainXchange Knowledge Broker:

Kathy Hickman



Presentation available on the brainXchange website:
http://tinyurl.com/bxcHLPC

Substance Use Collaborative

Collaborative Objectives

- Build on the work of the existing community of practice for Geriatric Addictions to province-wide capacity.
- Increase the understanding of Geriatric Addictions/Substance Use among health care professionals (including front-line) and community care partners.
- Identify best practice treatment and supports for older adults living with substance use disorders.
- Build on successful regional strategies, models and products (e.g. pocket guides) for older adults living with a substance use disorders and their families using the framework pillars of BSO.
- Discuss how we can build on and strengthen these ideas through the Community of Practice on Geriatric Addictions to ensure a person and family-centred approach.

Highlights from the session

- Waterloo Wellington Geriatric Addictions Steering Committee has made a difference in increasing the understanding of geriatric addictions/substance use among health care professionals in the community.
- The Waterloo-Wellington strategy has worked because they went to the people for their input on how to develop it:
  - Started with knowledge and trickled down to service delivery and system coordination.
  - The Addictions world didn't understand the Specialized Geriatric world. Cross-training workshops were developed to better understand the needs, obstacles and objectives of each group. Brought people together, particularly those with lived experience, and asked "what's working?", "what's not?", "how should we move forward?"
- Developed province-wide Ontario Telemedicine Network Geriatric Addiction rounds that take place once a month; Addiction Medicine or Geriatric Psychiatry provide a provincial wide "Lunch & Learn".
- Knowledge – need for standardization (and consistency) across the province.
- Advantages to building cross training relationships.
- Need to categorize gaps and find common themes.
- Further the work of Community Outreach in Programs Addictions College.
- Need to reconnect with Community of Practice (CoP) regarding Additions in older adults.
- Participants in attendance expressed interest in joining the CoP.
- Waterloo Wellington has developed a short eLearning module on geriatric addictions.
- National Initiative for the Care of the Elderly Geriatric Addictions Tools.

Co-Chairs:

Cathy Sturdy Smith
Marilyn White-Campbell
Jane McKinnon Wilson

Advisor:

Julia Baxter

brainXchange Knowledge Broker:

Jillian McConnell

Presentation available on the brainXchange website:

http://tinyurl.com/bxcSubstanceUse

Tertiary Care & In-patient Specialty Services Collaborative

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.

Insights from the session

The Tri-Organization's Community of Practice Working Groups include: 1) Point of Care, 2) Lived Experience, and 3) Measurement.

Point of Care (Working Group):

- Sharing common care experiences in this specialized area.
- Opportunity to learn what is possible from each other's approaches.
- Need for risk assessment, risk management and risk measurement.
- Need to understand family members' perception of risk.

Patient and Family Lived Experience (Working Group):

- Understanding the patient and family experience is critical.
- Gaining this understanding through phone surveys with family members.

Measurement (Working Group):

- Measurement tools in tertiary geriatric psychiatry units include: 1) the Resident Assessment Instrument for Mental Health (RAI-MH); 2) the System of Classification of In-patient Psychiatry (SCIPP)
- Cognitive Disorders SCIPP groupings do not accurately reflect the population served on tertiary geriatric psychiatry units as many important items in the RAI-MH are not included in the SCIPP score.

Additional Insights:

- Need to develop strong, meaningful partnerships with families, where there is an understanding of the experiences of families and of the person with dementia and severe mental illness
- Find ways to improve how the complexity of the tertiary care population is being captured.
- Families want to help improve care and want opportunities to contribute.

Co-Chairs:
Julia Baxter
Dr. Maxine Lewis

brainXchange Knowledge Broker:
Jillian McConnell

"The conversation was very rich and exposed the many areas of improvement in how we collaborate in our health care system."

~Participant

Presentation available on the brainXchange website: http://tinyurl.com/bxcTertiary

Ontario's Dementia Strategy

Indira Naidoo-Harris (Halton MPP and Parliamentary Assistant to the Minister of Health) provided participants with an overview of the development of Ontario's Dementia Strategy that she is leading. She commended all participants for coming together in one forum, stating that the inclusion of people with Lived Experience with health care providers and other stakeholders is essential in moving this type of work forward. She shared the strategy's objectives and the work to date.

Objectives:

- People are treated with respect at all stages of dementia.
- People will have access to the best information to make decisions about the care that they need.
- People will live well with dementia, with the supports that they need, when they need it.

Currently there is a consultation process taking place across the province through Round Table meetings. She encouraged participants to plan their own Round Tables and to invite her to join one!

Following the consultation process a draft framework will be developed. This framework will be shared at Town Hall meetings to get more input on the development of a provincial Dementia Strategy.

For more information email: dementiastrategy@ontario.ca

An interactive website is under development.

Reflections on the Day

"This group made the environment 'safe' for residents to share."

"You all made us feel important."

"I have not shared so openly with others in this type of setting before and that's because the people you brought together understood the importance of hearing the person's voice!"

"Included! We felt included as equals."

"Inspiring! To think that so many people are working so hard on our behalf."

Feedback from Residents from the Ontario Association of Residents' Councils (OARC):

"Empowering! The day gave me increased confidence to speak up at my home."

Other participant comments:

"I just wanted to share how much I appreciated being able to attend the Catalyst Initiative and connect with so many passionate individuals. It was a great experience."

"A good variety of people from all walks of the medical world and lived experience. Thanks!"

Thank you to everyone involved to making this event a tremendous success!

Professionals and individuals with Lived Experience came to together to listen, to contribute, to learn & work together for person and family-centred Best Practice in Ontario.

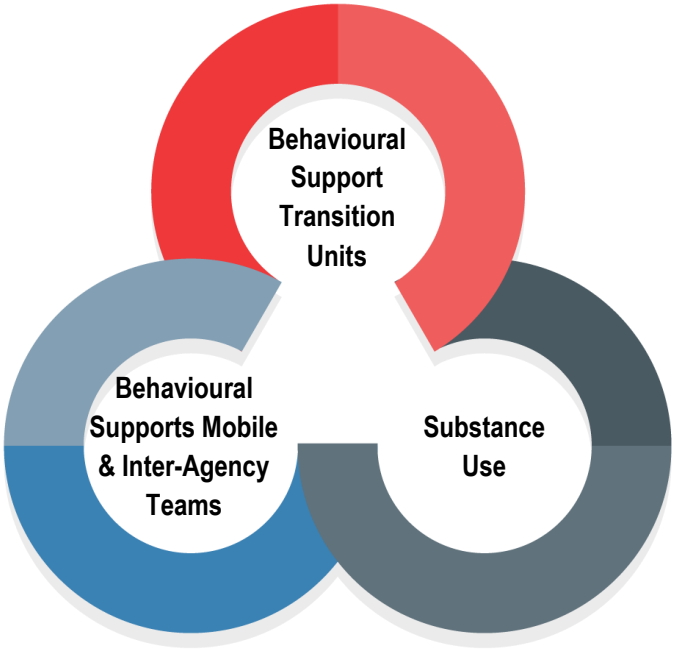
We celebrate the uniqueness of the Catalyst Event!

Next Steps

In planning next steps, it became apparent that there is a need to focus efforts on a few of the Collaboratives in order to move along the development and dissemination of tools and resources. These Accelerated Collaboratives will be provided additional supports in the months ahead by the Behavioural Supports Ontario Provincial Coordinating Office and brainXchange. The remaining Collaboratives will continue to have support in a second phase roll-out.

The decision regarding which Collaboratives to accelerate was made through the input received from a Catalyst Event participant survey, a Lived Experience follow-up teleconference and through discussions with each of the Collaboratives' co-chairs. Additional considerations included Co-chair workload priorities and other current partner initiatives.

The selected Accelerated Collaboratives



Rather than 'Person & Family-Centred Care' continuing to be a specific Collaborative, all of the Collaboratives will be founded on the principle of Person and Family First. Including the voice of the Lived Experience is essential as we move forward. We have learned from those with Lived Experience at the Catalyst Event and Ontario's Best Practice Exchange will continue to look for opportunities for those with Lived Experience to be actively involved in the work.

> **"The real voyage of discovery consists not in seeking new lands but seeing with new eyes"** ~Marcel Proust

How to get involved in the next steps:

Visit the Provincial Behavioural Supports Ontario web page for more information and resources:

www.brainxchange.ca/bso

Contact the Provincial Behavioural Supports Ontario Coordinating Office:

Phone: 1-855-276-6313

Email: provincialBSO@nbrhc.on.ca

The work of Ontario's Best Practice Exchange is committed to honouring people, honouring partners and honouring possibilities!

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

St. Joseph's Healthcare Hamilton

brainXchange

Alzheimer Society ONTARIO