Inter-agency Behavioural Support Mobile Teams

Critical Components for Success

"The Question is not Embedded vs. Systems Mobile Teams --It's Both"

Working document

Inter-agency Behavioural Support Mobile Teams and Internal Teams (Embedded)

Introduction

The Behavioural Supports Ontario initiative's major purpose and mission is to improve the quality of life and decrease the burden of illness of older adults at risk or with complex health challenges with responsive behaviour associated with dementia, mental health and addictions and neurological disorders.

The Behavioural Supports Ontario initiative and services are dedicated to enable change to the health care system within and across sectors. The initiative, therefore, is identified as a catalyst for change, not a new service.

The foundations for this initiative to enable redesign of our health system for better health, better care and better value was based on the Behavioural Supports Ontario principle-based, evidence-informed framework which embraces person- and family-powered health and health care as the fundamental outcome. In addition, the BSO framework's major purpose is to provide a person- and family-directed integrated quality health care system for the target population through:

(1) Service coordination;

(2) Capacity enhancement;

(3) Knowledge exchange and continuous quality improvement.

The Service, Interagency Mobile Teams (IMT) and Internal Teams (Embedded)

Interagency Mobile Teams working with Internal Teams/resources were identified as one "service approach" to achieving the BSO mission and mandate and to implement the BSO framework to achieve health care systems transformation.

The process for implementation of the Interagency Mobile Teams involved flexibility of implementation by various LHINs, taking into account the importance of the context and culture of each LHIN. This was done, however, within the context of a structured BSO framework, provincially, and an expectation of functional fidelity, i.e., that the Interagency Mobile Teams with the LTC Home resources would provide a set of functional outcomes consistent across the province.

Over the past two years, various approaches have been "tested" using a "Rapid prototype approach" to service redesign.

This report provides the emerging consensus on critical elements and functions of the Interagency Mobile Teams working with internal resources to support (1) capacity development,

(2) to enable better support and services, and (3) improved skills within Long-Term Care Homes, between Homes and the Home within the health care and community systems.
The critical elements that have emerged have been derived from an analysis of what matters and successful methods drawn from the various models. The approach has embraced more recent thinking on health service design that puts models as a mechanism to understand what matters and what methods and strategies are critical to health service transformation, and that the models themselves are an opportunity for learning and development, not an end to themselves in regards to moving forward with health care delivery improvements.

Foundations and evidence used to support the identification of critical elements:

(1) Review of the literature on collaborative care and integrated care.

(2) Models from other health care populations where changes in the way people think, feel and behave are a critical part of the service system that supports them, including focusing in on strategies and approaches that are successful for people with complex chronic disease.

(3) A LHIN review of all 14 LHINs, drawing out the critical elements in their intra-agency and inter-agency teams.

(4) Targeted evaluations of the various models which included both qualitative and quantitative research.

Functions of the Inter-agency Mobile Teams and Internal Teams

Through the evidence-informed approach and based on Inter-agency mobile and Internal Teams (Embedded) or resources, the following functions have been identified as critical elements.

A// Long-Term Care Individual Home Functions/Outcomes and Critical Elements

(1) Effective practices for responsive behaviour aligned with the context and culture of each Home is necessary.

(2) Support for families and care providers is fundamental.

(3) Learning and development at the point of care for all individuals who interact with the individual with responsive behaviours is an important enabler.

(4) Continued translation of emerging best practices, both clinical as well as service design using a collaborative mentorship shared care and service learning approach is critical.

(5) An internal resource dedicated to the triple hat functions of (a) support, (b) service improvement, and (c) capacity development enabled by senior leadership and alignment

of incentives is critical.

(6) Continuous development, spread and sustainable change of the LTC Home practices.

(7) Continuity of the person team within the Home and the Home within the Health Care Systems.

Long-Term Care Home Within the Systems, Functions/Outcomes and Necessary Elements

(1) Effective transitions between sectors, system partnership and contact-based service transitions.

(2) Mobilizing external resources and services in the health care system for effective, timely support requires mobile teams working with internal resources;

(3) Learning goals:
   a. Continued learning and knowledge exchange from between Long-Term Care Homes; and from specialty services requires vehicles for Knowledge Exchange and Health System Mobile Teams.

(4) Developing effective collaborative (inter-agency) service learning activities between Homes and specialty services enables effective support, knowledge transfer and internal and systems service improvement.

(5) Common vision, language and approach by the Health System, i.e., tools, processes for shared solutions and support.

Four Critical Elements for Success

(1) Internal responsive behaviour resource/team plus;

(2) Health care mobile services and specialty services, which are acceptable and accessible;

(3) Organizational support for the role and time commitment of Interagency Mobile Teams and internal resources/teams, including support for implementing direct point-of-care support, knowledge translation and service improvement within Homes and between Homes and the health care system;

(4) Health care system support and leadership and alignment of incentives.

Risks Associated with Lack of one component, i.e., Internal and/or External Interagency Component only

Internal Resource Team only

(1) Mandate drift and the hand-off phenomena, i.e., internal teams responsible only for responsive behaviour, not all the Home staff and organization.

(2) Ineffective continuous transfer of emerging knowledge in clinical practice and service improvements from other Homes and from knowledge from specialized services.

(3) Effective transitions between sectors.

(4) Effective use of external resources.

(5) Support for cross Long-Term Care learning.

External Resources Mobile Team Only

(1) Effective collaboration.

(2) Lack of effectiveness of translating of new knowledge into day-to-day practice within the context and culture of the Home.

(3) Inability to realize effective service improvement strategies within Homes and between sectors.

(4) Lack of understanding and ineffective translation of new knowledge, the knowing to doing gap.

Specific Critical Elements for Specific Functions

(1) Transition. Within the review of the various LHINs and analysis of the literature and experience from across Canada, the following four elements were identified. (The SEEK elements are:) for effective transition

i. Service, Behaviour, and clinical plan
Transitions that provide one plan, one team, one service for the individual in transition, both a clinical as well as a behavioural and service coordination plan.

ii. Emotional; providing the important support for both the resident and the family in their transition from one sector to the other in terms of person and family.

iii. Environment; understanding and appreciating and ensuring an environmental match between the two agencies or organizations, i.e., Hospital setting to Long-Term Care, Home to Long-Term Care, etc..

iv. Knowledge translation approaches which include a three-phased process of support, knowledge exchange and transfer to the immediate health care team in the Long-Term Care facility and then spread to the organization as a whole.

(2) Internal Team, External Team and Specialty Collaboration

i. Importance of focusing in on learning goals, person- and family-centred approach and collaboration/mentorship, coaching, (joint caring).

ii. Elimination of observation as an approach with a focus on bi-directional mentorship, joint support, education and service improvement.

Evaluation

The importance of evaluation in a Rapid Prototype Approach to systems redesign has emerged through the last 18 months. Critical evaluation approaches can best be identified through the STAR model (see attached) which embraces various databases which can be triangulated to ensure continuous evaluation of relationships, improvements and clinical outcomes, ensure timely data for timely changes in approach, development and sustainability.

Next Steps

Identifying evidence from lived experience research that supports service change and practice based evidence form now 2 years of experience in Ontario

Establishment of prov learning collaborative and development of revised and refined critical framework for standardized practice and policy (part of the catalyst best practice initiative

Data Measurement and Evolution

The Triad

Health Care Experience, Clinical Systems Outcomes