NSM LHIN LEADERSHIP COUNCIL

February 8, 2012 – Update #12-2

BEHAVIOURAL SUPPORTS ONTARIO - *Quality Improvement in North Simcoe Muskoka*

"I am a person; hear me, care with me, keep me well."

Matt Snyder, Project Lead, Behavioural Supports Ontario (BSO) and **Shannon Brett**, Improvement Facilitator, NSM Behavioural Support System (BSS) project, provided Leadership Council with an update on the BSO project and an overview of the Value Stream Mapping and Kaizen events that have taken place as part of the local NSM BSS project. Shannon and Matt's presentations are attached to this update.

CARE CONNECTIONS

The Council agreed to move forward with the following motion:

> **That the NSM LHIN Leadership Council approves the terms of reference for the following five Coordinating Councils:**
>
> - **Complex & Chronic Health Needs**
> - **Mental Health & Addictions**
> - **ICT/eHealth**
> - **Surgery**
> - **In Home and Community Capacity**

Operations Committee Report

A review of the work of all LHIN-wide program coordinators is currently underway, after which a report and recommendations will be presented for consideration by the Leadership Council.

Work on performance frameworks, aims, indicators and targets is taking place for all 12 'areas of focus'.

In Home and Community Capacity (IHCC) Council

Elisabeth Riley, Chair of the IHCC Council identified key areas of focus that the Council and its associated project steering committees are working on:

Alternate Level of Care – a major information campaign has been developed for roll-out April 1st. The focus of the campaign is helping patients / clients / residents understand what can be done to either speed up recovery times in hospital so a patient can be discharged earlier, or determine what can be done in the community to prevent an individual from ever needing to be hospitalized in the first place.

Seniors Friendly Hospital – initial focus is on the NSM hospitals but the plan is to roll the initiative out to the community as well. The key theme identified by our hospitals is keeping seniors mobilized in hospital, not allowing them to deteriorate, will significantly improve patient outcomes.

Each hospital has identified activities that support this key theme. As examples, OSMH has the '600 Step Project' where recovering patients compete to walk 600 steps each day. CGMH and GBGH have volunteer programs titled 'Patients in Motion' where volunteers work with patients and physiotherapists to develop plans to mobilize patients to help them return to either their own home or a long-term care home.

The NSM Seniors Friendly Hospital program applied for and received a grant to build a 'community of practice' that will assist in the transfer of research knowledge into practice across all the NSM LHIN hospitals. In addition, our Seniors Friendly Hospital Coordinator, Ryan Miller, will be presenting at the Ontario Geriatric Association conference in April.

Home First – this initiative, originally launched at the Care Connections Spring Forum 2011, is being re-worked from its original focus of helping patients leave hospital and return back to their home environment in the community to now focusing on home as the right place and first choice even before needing the services of an acute care hospital.

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Complex and Chronic Health Needs (CCHN) Council

Paul Heinrich, Chair of the CCHN Council spoke to his Council and project steering committees activities for the past quarter:

Complex Continuing Care (CCC) **–**a recent success story for Complex Continuing Care shows that this regional program is now operating at 93% occupancy of true CCC patients. The CCC bed registry is still being improved upon. Natalie Bubela, CEO, MAHC, while noting that MAHC is the lead organization for CCC, pointed to an evolution in team work that has enabled this regional program to experience significant change. Evaluation of the repatriation of discharged CCC patients back to their sending hospitals will occur.
There will always be the need to balance the need for a patient to be as close to their home community as possible, with regional access to the three identified NSM CCC locations: MAHC, Bracebridge Site; GBGH and OSMH.

Behavioural Support System (BSS) – is in the midst of hiring RNs, RPNs, and other professionals to implement the NSM BSS Action Plan. Waypoint Centre for Mental Health Care, County of Simcoe and other providers are the organizations looking to hire new BSS staff. For further information on these job postings, visit the NSM LHIN website and click on 'Careers'.

Surgery Council

Linda Davis, Chair of the Surgery Council spoke to her Council and project steering committee activities for the past quarter:

Musculoskeletal (MSK) – the Council identified musculoskeletal needs as the Council's highest priority and the MSK project steering committee resulted. The committee will initially be completing an inventory of NSM resources, and developing an understanding of the reasons why some of our orthopaedic trauma patients (eg. fractured hips) need to access care outside of our LHIN.
The committee is being assisted by Dr. James Waddell and Rhona McGlasson of the Bone and Joint Network of Ontario. They have agreed to help develop a model of care for MSK in North Simcoe Muskoka by early spring.

The other piece of work that is being completed is the patient tracking system. This will allow patients needing orthopaedic care to be entered into the tracking system to ensure a coordinated approach to both emergent and non-emergent orthopaedic care.

Communications Council

Susan French, Chair of the Council reported on the activities that have taken place over the past quarter. The Council has appointed communication representatives on all Coordinating Councils to assist the Councils in identification of their communication needs. Project documents (terms of reference and charter) are in final draft stages. Aims, outcomes and measures are being worked on and will form part of the final charter document.
Communications associated with the voluntary integration of Schedule 1 adult acute mental health beds and the Alternate Level of Care communication campaign are two of the activities Council members have been involved in.

NEXT STEPS

Monthly Meeting – Wednesday, March 14, 2012 from 4:00 – 7:00 p.m. If you have any questions, please feel free to contact the LHIN at northsimcoemuskoka@lhins.on.ca.

Behavioural Supports **Ontario**

Behavioural Supports Ontario

Leadership Council briefing,

February 8, 2011

Ontario
Health Quality Ontario

Alzheimer Knowledge Exchange

Alzheimer Society
ONTARIO

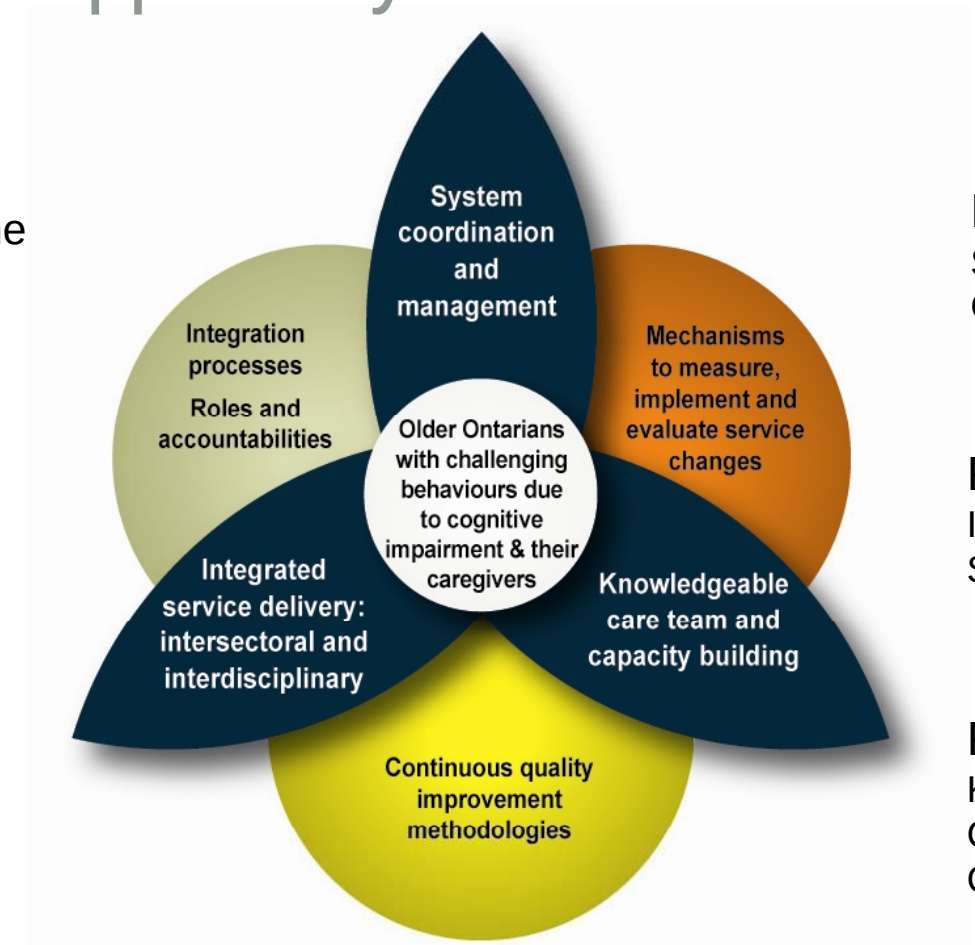
Ontario
Local Health Integration Network

The Behavioural Supports Ontario Vision

- *Health Minister Deb Matthews – "Ontario Behavioural Support Systems Project – the first of its kind in Canada and only one of a handful in the world – is meant to keep more people at home and out of long-term care facilities for as long as possible, and to reduce the use of medication and restraints for patients who are already institutionalized"*

Behavioural Supports System Model

First Phase:
Consultative; develop the Framework for Care



Pillar 1:
System Coordination

Pillar 2:
Interdisciplinary Service Delivery

Pillar 3:
Knowledgeable Care Team and Capacity Building

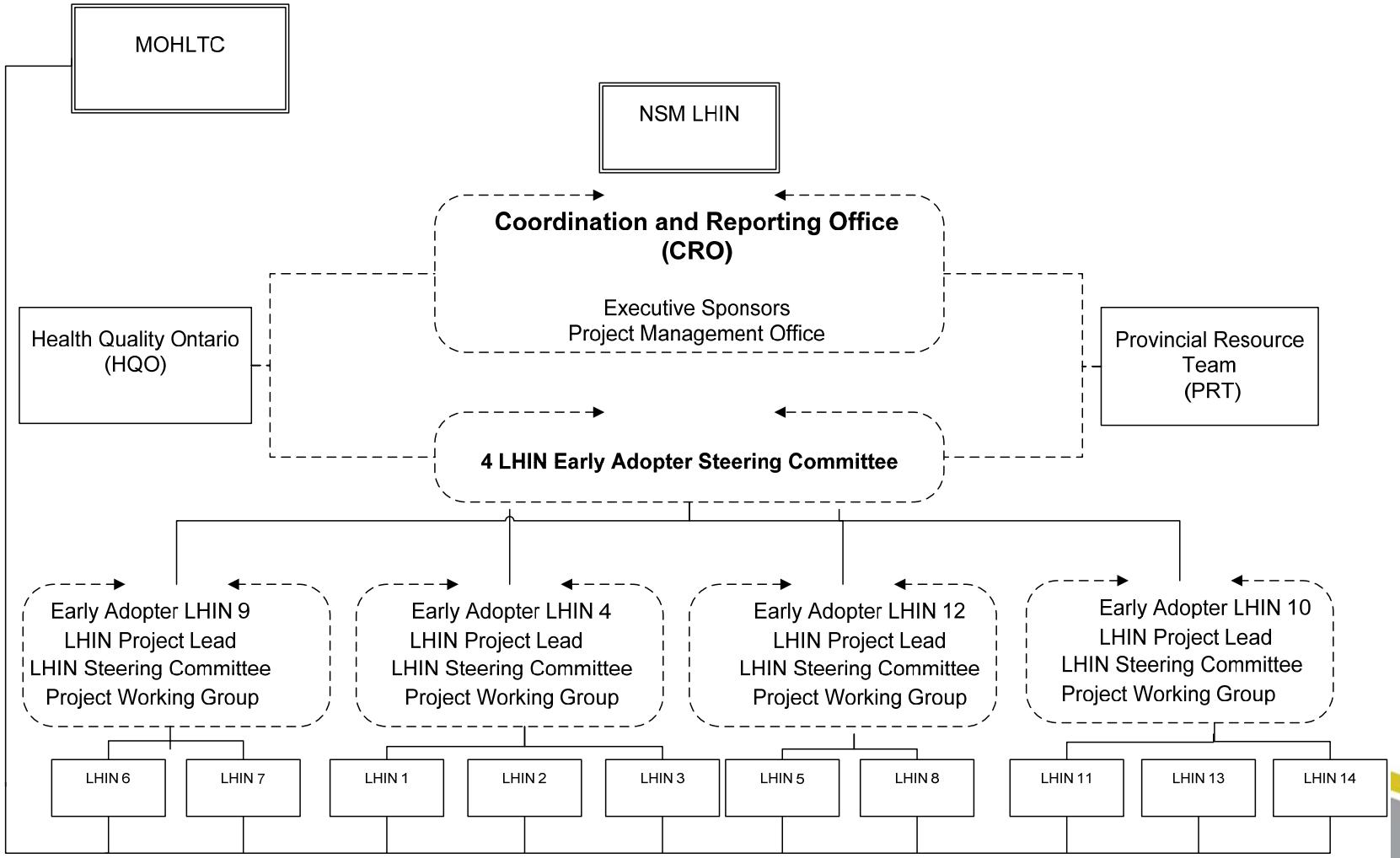
Second Phase:
Implement the Framework in 14 LHINs

BSO Implementation

The Ministry of Health and Long-Term Care (MOHLTC) is funding the implementation of the BSO Framework to develop new care pathways and clinical tools, and share these lessons province-wide based on the overarching principle of person- and caregiver-centered care. Implementation begins in four Early Adopter LHINs.

- All LHINs will receive funding to hire health human resources to support the implementation of the framework (as per funding letter)
- Early adopter LHINs receive $750,000 in funding to implement the framework and share lessons learned with remaining LHINs
- 100s of new FTEs invested across 14 LHINs using a funding formula to ensure equitable distribution

NSM LHIN assumes project management responsibility for BSO implementation



* BSO implementation structures and funded partners defined in Appendix A

Implementation is guided by the LHIN-wide Action Plan

The Action Plan in each LHIN describes the entire local investment in behavioural supports. A LHIN Action Plan describes what will change, when, and how.

Several success measures must be considered during Action Plan development:

- **Reduced resident transfers** from LTC to acute or specialized unit for behaviours;
- **Delayed need for more intensive services**, reducing admissions and risk of ALC;
- **Reduced length of stay** for persons in hospital who can be discharged to a LTC Home with enhanced behavioural resources

<u>Plan components</u>

BSO funding for health human resources is one of the tools at a LHIN's disposal to address service gaps and opportunities for integration that emerge during the Action Planning process.

Building on existing initiatives is the key to service integration for the BSO target population:

Provincial initiatives – Excellent Care for All, Residents First, Mental Health & Addictions Strategy, Provincial Falls Initiative, etc.

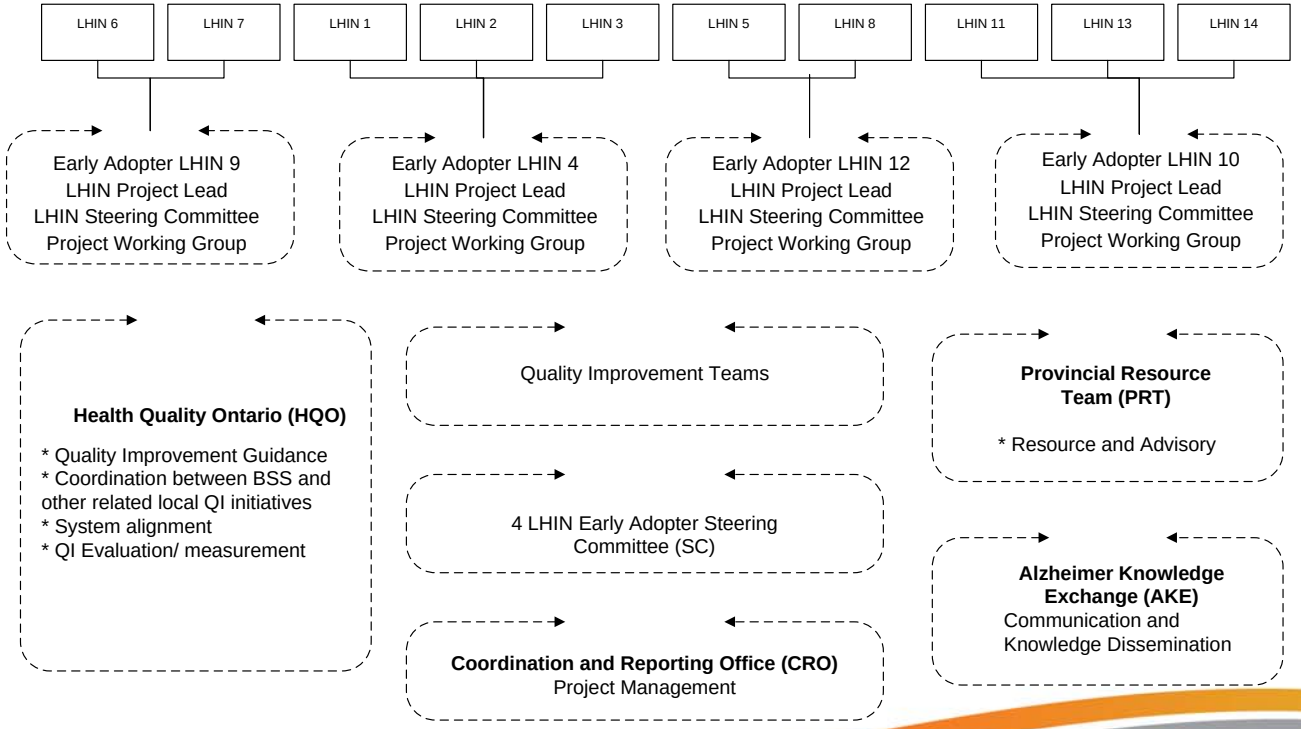
Existing – ER/ALC investments, GEM nurses, Alzheimer's Knowledge Exchange, Home First, etc.

Local priorities – Aging at Home, Seniors Models of Care, Nurse-Led Outreach Teams, etc.

CRO and BSO-funded partners support each LHIN

BSO features structured assistance to all LHINs and extensive knowledge transfer

- HQO quality improvement curriculum and coaching
- AKE-sponsored knowledge transfer at the provincial level
- Buddy system coaching and knowledge transfer locally
- Centrally coordinated HHR and communications assistance



A formal evaluation in four Early Adopter LHINs will assess the BSO Framework and the outcome of BSO investments.

BSO Timeline of Key Dates

October 14, 2011	Early Adopter Action Plans complete
December 15	Next 10 LHIN Action Plans complete
March 31	HHR hiring complete in all LHINs Service Redesign funding ends Unspent 11/12 BSO funding recovered
December 2012	Evaluation complete Funding for CRO ends

BSO Implementation Structures and Funded Partners

- **Health Quality Ontario (HQO)**: provide quality improvement expertise including coaching, alignment with related QI initiatives, and advice related to QI evaluation and measurement.
- **Alzheimer Knowledge Exchange (AKE)**: knowledge exchange activities and coaching/support to local Project Teams as it relates to knowledge transfer, translation, dissemination and exchange.
- **Coordination and Reporting Office (CRO)**: responsible for the implementation and evaluation of the BSO Project. CRO will ensure effective consultation, liaison and oversight throughout implementation.
- **Provincial Resource Team (PRT)**: a resource and advisory body for the Coordination and Reporting Office. PRT members bring subject matter expertise, intimate knowledge of the BSO Framework and a clear vision for improved support for older Ontarians with challenging behaviours.
- **Early Adopter LHINs**: implement the BSO framework first, mentor/coach designated LHINS to assist in rapid cycle improvements, and evaluate outcomes for dissemination province-wide.
- **Next 10 LHINs**: implement the BSO framework based on knowledge transfer, dissemination and lessons learned from the Early Adopter LHINs

Thank you!

Matt Snyder
Project Lead, Behavioural Supports Ontario
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North Simcoe Muskoka LHIN

Quality Improvement Behavioural Supports System

Leadership Council Presentation

February 8, 2012

Ontario
Local Health Integration Network

Quality Improvement

- **Definition:**

  "the combined and unceasing efforts of everyone -- to make the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning)"

Batalden & Davidoff. *"What is 'quality improvement' and how can it transform healthcare?"*. BMJ's Quality and Safety in Health Care 2007

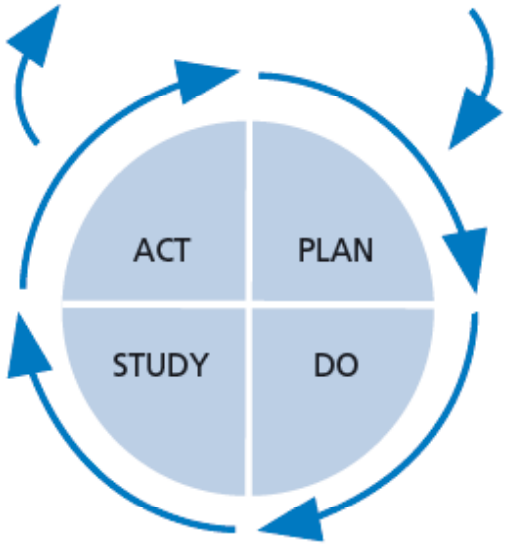
Model for Improvement

AIM → What are we trying to accomplish?

MEASURE → How will we know if a change is an improvement?

CHANGE → What changes can we make that will result in improvement?

RAPID CYCLE IMPROVEMENT →



Langley, Nolan, Nolan,
Norman, Provost, Moen

BSO: What are we trying to accomplish?

Aim: By December 2012, we will improve the care experience and quality of life for individuals with responsive behaviours and their caregivers throughout the province of Ontario by:

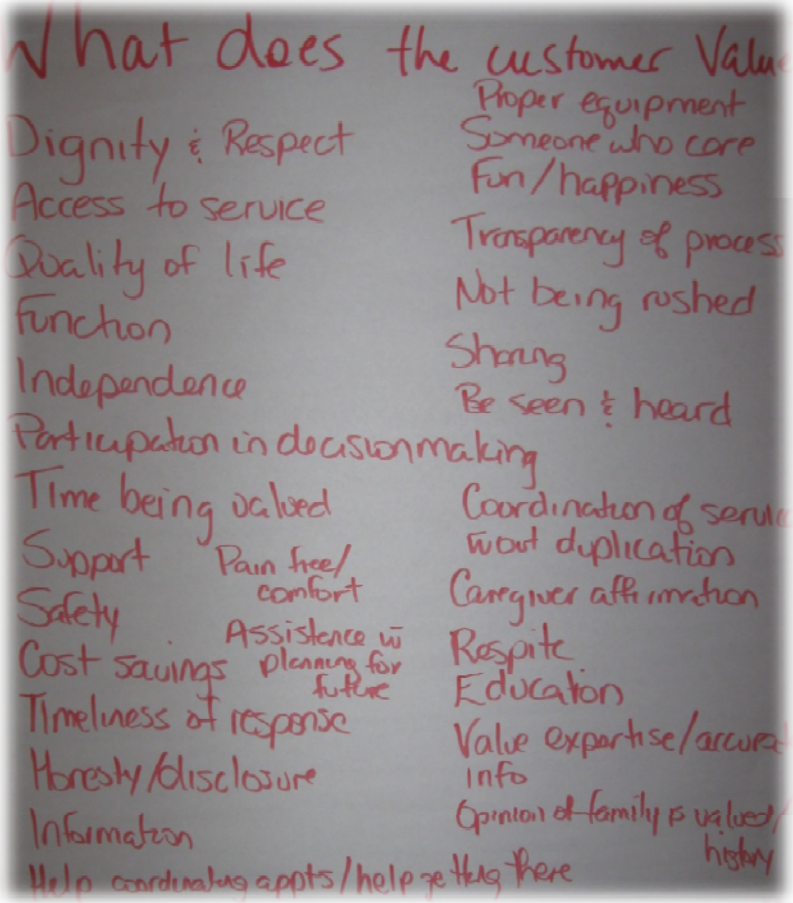
- Pillar 1: Creating effective system management processes to provide reliable and equitable delivery of care
- Pillar 2: Ensuring intersectoral service delivery to enable system efficiency and equitable access to comprehensive, safe services
- Pillar 3: Increasing capacity and creating knowledgeable care teams

But How?

North Simcoe Muskoka
Participants in Value Stream Mapping

Debbie Islam	Cathy Roelofsen	Robin Sanders	Alison Hamilton
Patti Reed	Brenda Lashbrook	Maureen O'Connel	Monica Ball
Ann-Marie Kungl-Baker	Julia King	Valerie Powell	Sue Simpson
Shannon Brett	Erin Cunningham	Bob Spicer	Mary Ann Wilmott
Lisa Markov	Girish Bansal	Stephanie MacKenzie	Barbara Henderson
Lorna Tomlinson	Grizelda Paterson	Gail Scott	Michelle Clifford-Middel
Karen Forget	Janice McCuaig	Stephanie Martin	Kathleen VomScheidt
Jeanette Webb	Kathy Skillings	Margaret Dollar	Rebecca Galliger
Michelle Reid	Sue Salway	Sharon Penrose	Hope Vandersluis
Leslie Nemisz	Lisa Robertson	Susan Clark	
	Mark Edmonds (CW LHIN)	Ashley Hogue (Central LHIN)	Susan Taylor (HQO Coach)

Specify Value from the customer's perspective - NSM



"I am a person;
hear me, care with me,
keep me well."

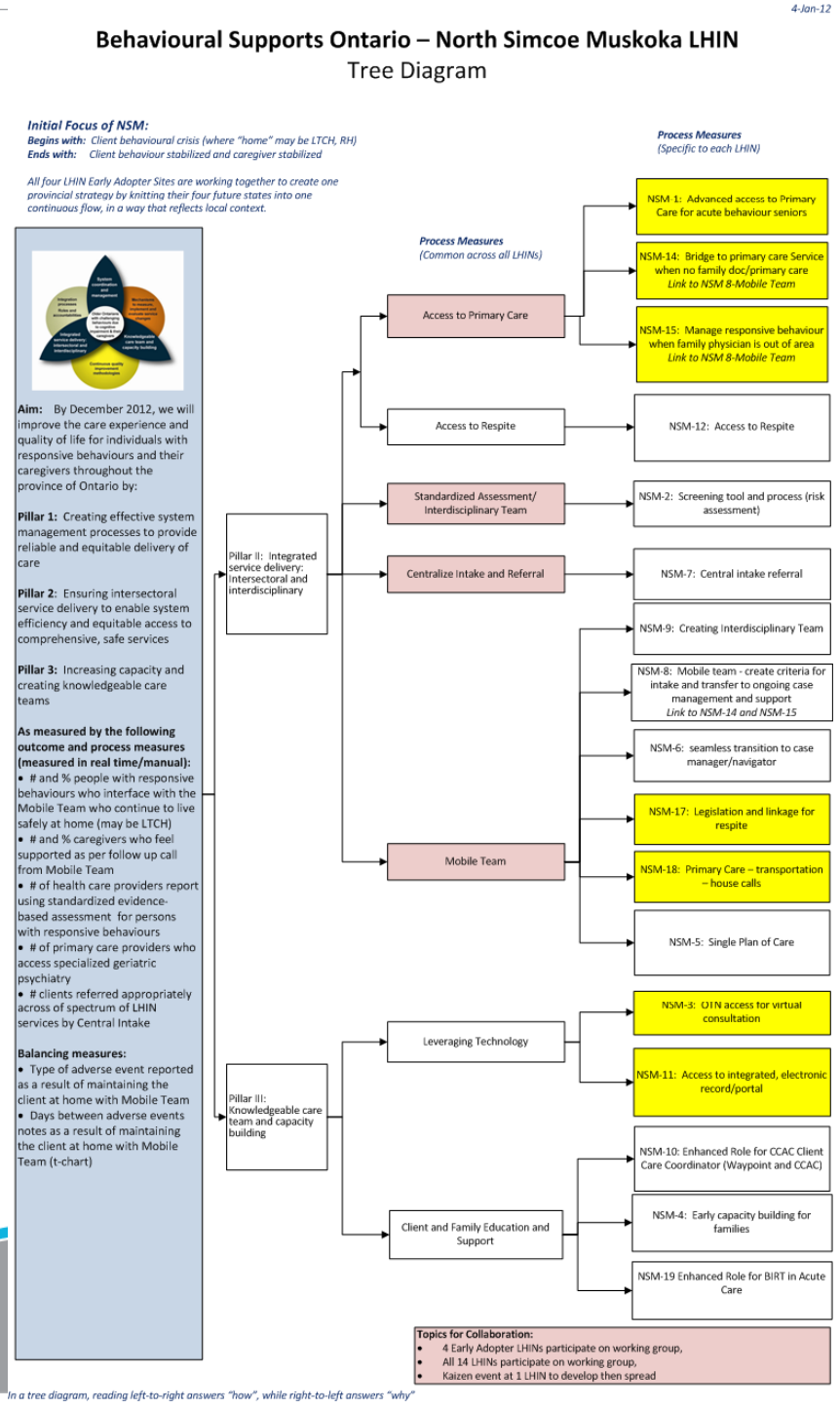
Current State Map – NSM

- Margaret is an 85 year old woman living at home with family support
- Mary lives in a Long Term Care Home
- Both have Dementia
- Both have early stage changes in behaviour, not early stage dementia, though for Margaret this is wandering/ exit seeking, while for Mary, it is intrusive behaviour.
- Caregiver identified behaviour as a challenge – frightened/afraid

BSO - Future State

Quality Improvement Change Initiatives

- Access to Primary Care
- Access to Respite
- Standardized Assessment
- Centralized Intake and Referral
- Mobile Team
- Leveraging Technology
- Capacity Building

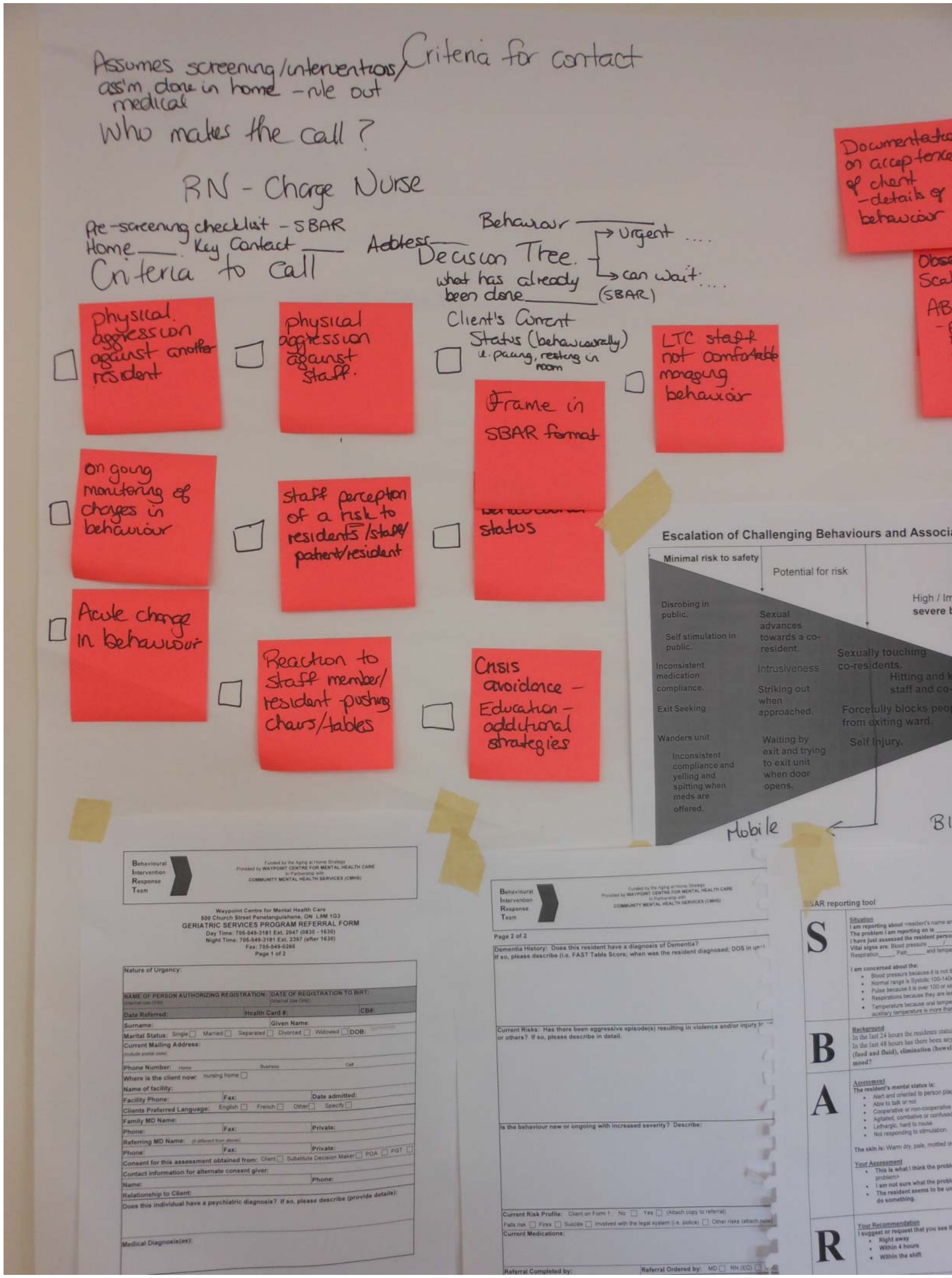
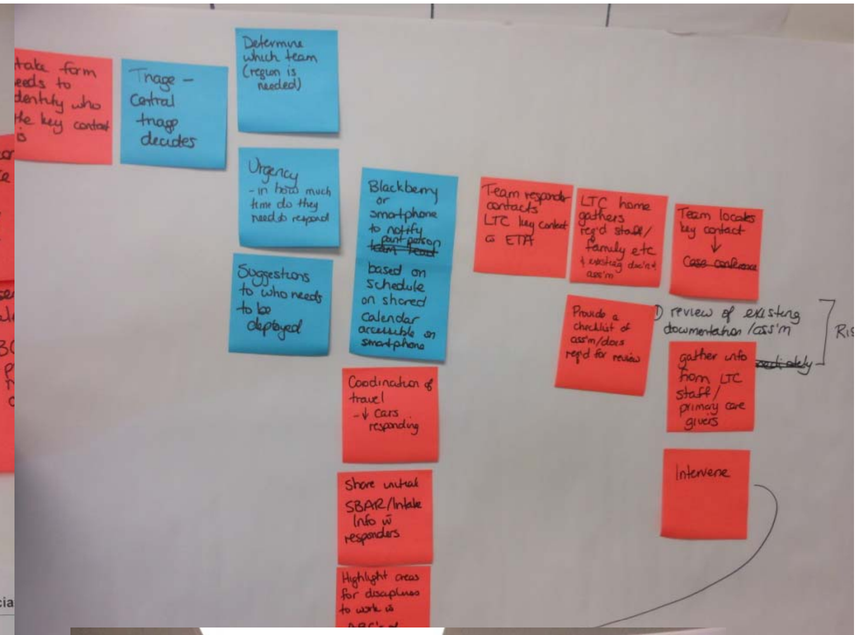
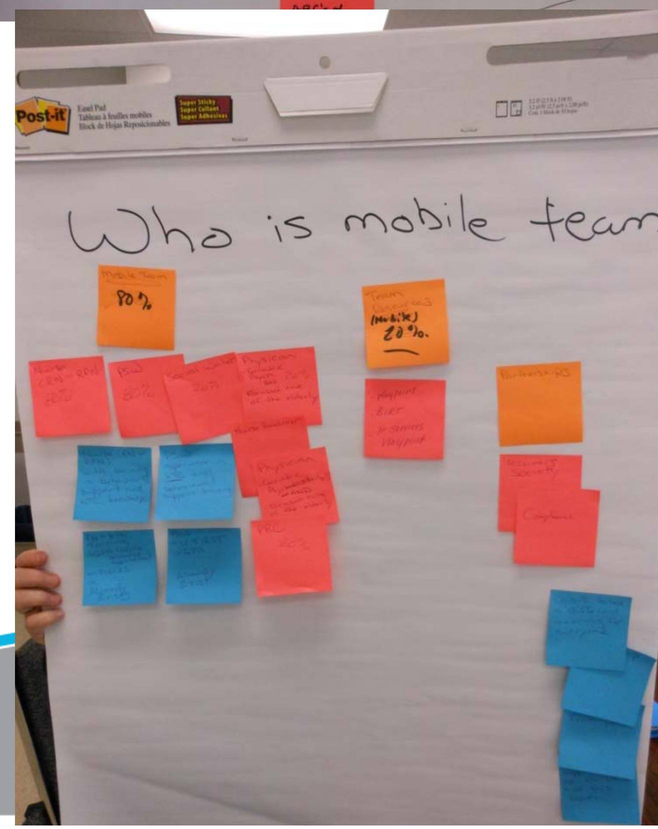


Kaizen Events

- Translated as “Transformation” – kai=change + zen=for the better
- A structured team exercise which focuses on creating more value and less waste in a given activity or process. → A kaizen event is a knowledge creation event.
- The event is aimed at making rapid improvements – make the changes during the event, measure to see if they work, revise and measure again.
- About trying to make things better – not perfect

What is a Kaizen Event?

- A kaizen event is a structured team exercise which focuses on creating more value and less waste in a given activity or process.
- A kaizen event involves knowledge creation, and allows a team to move from concept to action.
- The participants in a kaizen event are the people who do the work since they are the ones who understand the flow and the context for the change better than anyone else.
- Serves to truly engage staff, physicians and caregivers in co-creating the desired future state – far more powerful than any after-the-fact efforts to secure “buy in”.


Criteria for contact
Assumes screening/interventions/ass'm done in home - rule out medical
Who makes the call?
RN - Charge Nurse
Pre-screening checklist - SBAR
Home ___ Key Contact ___
Criteria to call
Behaviour → Urgent ...
→ can wait ...
Address Decision Tree
what has already been done ___ (SBAR)
Client's Current Status (behaviourally) i.e. pacing, resting in room
Documentation on acceptance of client - details of behaviour
physical aggression against another resident
physical aggression against staff.
Frame in SBAR format
LTC staff not comfortable managing behaviour
on going monitoring of changes in behaviour
staff perception of a risk to residents/staff/patient/resident
status
Acute change in behaviour
Reaction to staff member/resident - pushing chairs/tables
Crisis avoidance - Education - additional strategies
Escalation of Challenging Behaviours and Associa
Minimal risk to safety
Potential for risk
High / Imm
severe be
Disrobing in public.
Self stimulation in public.
Inconsistent medication compliance.
Exit Seeking.
Wanders unit.
Inconsistent compliance and yelling and spitting when meds are offered.
Sexual advances towards a co-resident.
Intrusiveness.
Striking out when approached.
Waiting by exit and trying to exit unit when door opens.
Sexually touching co-residents.
Hitting and k staff and co-
Forcefully blocks peop from exiting ward.
Self Injury.
Mobile
Behavioural Intervention Response Team
GERIATRIC SERVICES PROGRAM REFERRAL FORM
SBAR reporting tool
S
B
A
R

Intake form needs to identify who the key contact is
Triage - Central triage decides
Determine which team (region is needed)
Urgency - in how much time do they need to respond
Suggestions to who needs to be deployed
Blackberry or smartphone to notify
based on schedule on shared calendar accessible on smartphone
Team responds contacts LTC key contact c ETA
LTC home gathers req'd staff/family etc + existing docs/ass'm
Team locates key contact → Case conference
Provide a checklist of ass'm/docs req'd for review
1) review of existing documentation/ass'm
gather info from LTC staff/primary care givers
Intervene
Coordination of travel - ↓ cars responding
Share initial SBAR/Intake info w responders
Highlight areas for disciplines to work

Post-it
Who is mobile team
Mobile Team 80%
Team (mobile) 20%.

Common Tool Set Kaizen
February 1st and 3rd, 2012

Behavioural Support System Kaizen Events

- 4 LHIN Concurrent Kaizen Event – December 2011 to develop tools and processes for the new Mobile Teams (currently working on PDSA cycle 5)
- CCAC Waypoint Kaizen Event – December 2011 to develop tools and processes for an enhanced role for CCAC at Waypoint (currently on PDSA cycle 3)
- Standardized Assessment/Common Tool kit Kaizen – January 2012 to develop common tool set across the spectrum of behavioural support service 'events'

Where to next?

- The kaizen methodology has successfully sparked improvements in other areas of the early adopter LHIN BSO action plans.
- Develop a plan to spread Quality Improvement Methodology Tools and Processes across the Care Connections Areas of Focus
- April 2012 – Central East Stroke Network Value Stream Mapping