Capacity Building and Sustainability
Strategies for Regulated Health Professionals

What Works?

Carol Ward MD
February 20, 2014
Objectives

By the end of this presentation the participant is expected to be:

- Familiar with the three major foundational supports of a behavioural support network
- Able to list three components of what works in building capacity for regulated health professionals
- Be familiar with recent BC initiatives to enhance capacity among regulated health professionals
The Journey of Mrs. Tertiary
(A Tale of Transitions)

- 80 years old, rural LTC
- **Dx:** Major Neurocognitive Disorder – Alzheimer & Vascular with related Behavioural and Psychological Symptoms of Dementia (BPSD)
- PHx: Early onset Major Depression (recurrent), Delirium
- Significant medical co-morbidity:
  - Recurrent UTI
  - Constipation
  - Chronic back pain (back sx)
  - Small vessel ischemic changes – CT Head
  - Hypertension
  - Parkinsonism (vascular)

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The Journey of Mrs. Tertiary
(A Tale of Transitions)

- **Transfer 1: “Aggressive”**
  - **LTC**: staff injured, high dose Haldol
  - **Acute Care**: multiple antipsychotics
  - **Tertiary Care**: discharged on no antipsychotics, individualized care plan

- **Transfer 2: “Aggressive”**
  - **LTC**: staff injured, high dose Haldol
  - **Acute Care**: multiple antipsychotics
  - **Tertiary Care**: discharged no antipsychotics, individualized care plan
The Journey of Mrs. A

- Transfer 3: “Just want to make sure she’s stable”
  - LTC recurrent UTI, pain – high dose olanzapine, morphine, gravol
  - Acute Care Haldol
  - LTC stops Haldol
  - Tertiary Care
    Why isn’t this working?

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## Improving B.C.’s Care for Persons with Dementia (Acute Care/ER)

- Drs. Donnelly/McElhaney – focus group review of healthcare professionals/caregivers and their opinions for improving care

<table>
<thead>
<tr>
<th>Acute Care</th>
<th>ER</th>
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<tbody>
<tr>
<td>Person centered approach</td>
<td>Triage</td>
</tr>
<tr>
<td>48/5</td>
<td>Screen for delirium</td>
</tr>
<tr>
<td>Consumer feedback</td>
<td>Assess behaviours’ origins &amp; follow standard approaches to management</td>
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<tr>
<td><strong>Least restraint</strong></td>
<td>Caregivers</td>
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<tr>
<td><strong>Assess and manage behaviours</strong></td>
<td>Educate</td>
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Reality Check
National Behavioural Support System Project

Guiding Principles and Recommended Components for a Behavioural Support System

CDRAKE (2011)
Where to start the discussion on capacity building and sustainability for regulated health professionals?

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Behavoural Supports Ontario
www.BSOPrject.ca

Alzheimer’s Knowledge Exchange Resource Centre
www.akereresourcecentre.org

Early adopter LHNs
BETSI
(Behavioural Education and Support Inventory)

In-House BSO Teams

BSO Interim Evaluation
(Hay Group Health Care Consulting)

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Three Pillars Foundation for an Older Adults’ Behavioural Support System

System Coordination | Interdisciplinary Service Delivery | Knowledge Care Team & Capacity Building

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Foundation for an Older Adults’ Behavioural Support System

System Co-ordination

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The WHO MIND Project
Key Recommendations For Service Organization
Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery

(Brodaty et al. 2003)

Tier 7: Dementia with extreme BPSD
Tier 6: Dementia with very severe BPSD
Tier 5: Dementia with severe BPSD
Tier 4: Dementia with moderate BPSD
Tier 3: Dementia with mild BPSD
Tier 2: Dementia with no BPSD
Tier 1: No dementia
Geriatric Psychiatry – Continuum of Care

BRODATY MODEL OF SERVICE DELIVERY
(MJA 2003 VOL 178,231-234)
(Int J Geriatric Psychiatry 2006;21:645-653)

PRIMARY
(COMMUNITY)

TIERS 1 – 4
Geriatric Mental Health Outreach Program or Geriatric Outpatient Consultation or Collaborative Care with Primary Care Physician

TIER 5
Geriatric Mental Health Outreach (Interdisciplinary Collaborative Care)

TIER 6
Psycho geriatric In-Patient Specialized Residential Care

TIER 7
Intensive Specialty Service

SECONDARY

Acute Care Hospital Ger Psych In-pt beds

TERTIARY

Tertiary Acute Ger Psych In-pt

Tertiary Rehabilitation

Tertiary Residential

Geriatric Psychiatric Day Hospital (Intensive Ambulatory Treatment)

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Foundation for an Older Adults’ Behavioural Support System

Interdisciplinary Service Delivery

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Interdisciplinary Service Delivery

- Level I/II evidence to support the effectiveness of inter-disciplinary outreach services that utilize a liaison-style approach to residential facilities

- Increased effectiveness of geriatric psychiatry inpatient admissions with post-discharge community follow-up

(Draper B. 2004)
Evidence Demonstrating that a Geriatric Psychiatry Outreach Liaison Service to LTC Can Reduce In-patient Admissions (Ward C. & Rivard M., 2005)

**Liaison:**
- 1.2% patients in LTC required admission to geri psych inpatient service

**Consultation:**
- 3.2%

Prevent 4 admissions per year; cover cost of outreach RN
Service Delivery Models & Proposed Model

Core Components of an Integrated Mental Health Service System for Older Adults

Staffing Benchmarks for Specialized Seniors Mental Health Services
Geriatric Psychiatry – Continuum of Care

TIERS 1 – 4
Geriatric Mental Health Outreach Program or Geriatric Outpatient Consultation or Collaborative Care with Primary Care Physician

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Psycho geriatric In-Patient Specialized Residential Care

TIER 7
Intensive Specialty Service

Home/Assisted Living
Long Term Care (LTC)
Long Term Care Special Care Unit (SCU)

Acute Care Hospital Ger Psych In-patient beds

Tertiary Acute Ger Psych In-patient

Tertiary Rehabilitation

Tertiary Residential

Geriatric Psychiatric Day Hospital (Intensive Ambulatory Treatment)

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BRODATY MODEL
OF SERVICE DELIVERY
(MJA 2003 VOL 178,231-234)
(Int J Geriatric Psychiatry 2006;21:645-653)
What works?
Capacity Building & Sustainability for Regulated Health Professionals

- **Staff education, training & coaching**
- Develop practical evidence-based resources
- Use of quality indicators & evaluation

(Collett et al. 2009, Moyle et al. 2010, Gibson et al. 2010)
“Only after we understand the behaviour can we meaningfully manage the problem”

(PIECES Consultation Team 02-10-03)
P.I.E.C.E.S.
www.piecesescanada.com

- Physical
- Emotional
- Intellect
- Capabilities
- Environment
- Social
P.I.E.C.E.S.

What is it?
A Model for Collaborative Care and Changing Practice

Who are the Target Groups of Learners & Participants?
Regulated Health Care Professionals (RN, RPN, NP, OT, PT, SW) and their associated programs and organizations (internal and external) and the people they serve

Who is the Population it Addresses?
- Individuals complex physical, cognitive/mental needs and behaviour changes
P.I.E.C.E.S. Approach

Provides:

- **Common** vision and set of values
- **Common** language and knowledge for communicating across the system
- **Common** yet comprehensive approach for thinking through problems
- Tools and methods to support a **collaborative** care approach
P.I.E.C.E.S.™
A Model for Changing Practice

P.I.E.C.E.S.™ Leadership & Performance Improvement Program for Senior Leaders

P.I.E.C.E.S.™ Education Programs for Regulated Staff

Foundation for Practice Change:
Common vision, language and approach
Remember! Always use the problem solving 3 question template!

1. What has **Changed?** Think atypical!
2. What are the **Risks & Causes?**
3. What is the **Action?**
   - [ ] Investigation
   - [ ] Interaction
   - [ ] Intervention
P.I.E.C.E.S. Applications
(Regulated Health Professionals)

- Residential care
- Home and Community Care
- Acute Care
- Geriatric Mental Health Outreach Teams
- Other ie. Neuropsychiatry

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Why P.I.E.C.E.S for Tertiary?  
(Kamloops P.I.E.C.E.S. Demonstration Project)

- Patients with complex physical, cognitive/mental health and behavioural issues
- Enhance quality inter-disciplinary care
- Workplace health & safety
- Develop leaders in geriatric mental health

Hillside Centre  
Tertiary Acute Facility

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P.I.E.C.E.S. Steering Committee

- **Tertiary**
  - C. Ward (co-chair)
  - S. Mitchell (co-chair)
  - S. da Silva (sponsor)
  - M. Mackinlay
  - C. Wu (Evaluation)
  - J. Dobson

- **Elderly Services Program**
  - B. Prystawa
  - R. Samson

- **TRU**
  - B. Paterson (Dean of Nursing)

- **Acute**
  - D. Chaplain
  - J. Howie

- **Residential**
  - M. Hazel

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P.I.E.C.E.S. Leadership Committee
(Kamloops P.I.E.C.E.S. Demonstration Project)

P.I.E.C.E.S.
“It’s what we do.”

(P.I.E.C.E.S. Cohort Evaluation)

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P.I.E.C.E.S. & BC Initiatives

- Kamloops Demonstration Project (IHA, 2012)
- Provincial Residential Care (2013)
- Provincial Tertiary Mental Health (2014)
What works?
Capacity Building & Sustainability for Regulated Health Professionals

- Staff education, training & coaching
- Develop practical evidence-based resources
- Use of quality indicators & evaluation

(Collett et al. 2009 Moyle et al. 2010 Gibson et al. 2010)
B.C. senior drugged against family's wishes

‘Dementia patient given risky anti-psychotic drug to control behaviour’

By Kathy Tomlinson, CBC News
Posted: Feb 8, 2011 6:16 AM PT
www.cbc.ca/news/credit.html

December 2011 – BC MoH Review of antipsychotic drug use in residential care facilities;

Plan B (April to June 2010) indicated 50.3% residents (n=30,032) prescribed an antipsychotic.

June 2009 – CIHI Analysis in Brief released, 2006-07 data - 37.7% of seniors in nursing homes were using antipsychotic drugs (Manitoba, NB and P.E.I.)

Missing information: how long? for what condition? Prn use or regular? Actual use vs prescriptions
History of the BC BPSD Algorithm

- Original work written in 2010 for the Phased Dementia Pathway in IHA – Elisabeth Antifeau & Carol Ward;

- BC MOH - Best Practice Guidelines for Accommodating and Managing BPSD in Residential Care (Oct 2012);

- Jan 2013 – August 2013: Consensus BPSD Algorithm Working Group

"The evidence indicates that successful management of BPSD requires care providers to understand and accommodate BPSD, not control it".

IH Phased Dementia Pathway

Antifeau & Drance
What is the **purpose** of the BC BPSD Algorithm?

- Simple, comprehensive one stop resource

- An interactive and decisional resource tool to guide interdisciplinary care when faced with the behavioural and psychological symptoms of dementia;

- Provides care staff, family physicians & clinical experts with access to:
  - Best Practice recommendations for assessment, care-planning and medications recommendations in a logical flow;
  - Evidence based assessment tools
  - Clinical references and information (e.g., which behaviours respond to medications, and which don’t)

Antifeau & Drance
Who worked on the Algorithm?

- Chaired by Elisabeth Antifeau
- MOH support: Anna Gardiner
- Inter-professional group
  - Nursing
  - Family Practice, Geriatric Medicine & Psychiatry
  - Residential Care Directors of Care
  - Administrators
  - Pharmacy
  - Mental Health Workers
  - Educators
- Representatives from each health authority
- Consensual decision-making process

(Best provincial project/process I have been involved with related to MOH in past 25 years)
www.bcbpsd.ca

C. Ward Tertiary Mental Health IHA
www.bcbpsd.ca

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Key Features - Practice Supports

Information about Physical/Chemical Restraints
Provincial RPPUC Clinical Algorithm Review Working Group

<table>
<thead>
<tr>
<th>Use of Medications and Restraint</th>
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| A restraint means any chemical, electronic, mechanical, physical or other means of controlling or restricting a person in care’s freedom of movement, including accommodating the person in care in a secure unit.

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<tr>
<th>Chemical Restraint versus Treatment:</th>
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<tr>
<td>When a medication is used with the specific intent to reduce a person’s mobility, or promote sedation beyond that required to establish a normal sleep cycle, then it is considered a chemical restraint.</td>
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| This should not be confused with medications used to treat drug responsive behavioral/neuropsychiatric symptoms associated with specific medical and psychiatric diagnoses. A medication prescribed as part of assessment and rational plan of care, whether on a scheduled or as needed basis, is a treatment, not a chemical restraint. |

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<tr>
<th>Consider the following:</th>
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| • A restraint may be used in an emergency without consent, if facility staff need to respond immediately, to preserve the person in care’s life, or to prevent serious physical harm to the person in care or others. If an emergency restraint is used this must be reported to the substitute decision maker after its use as this is a reportable incident.
| • In a non-emergency, a restraint may be used if there is agreement for its use in writing by the most responsible physician/nurse practitioner AND by the person in care or their substitute decision maker. |

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<th>Any use of restraint must be documented, monitored and reassessed.</th>
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<tbody>
<tr>
<td>A restraint must be reassessed at least once within 24 hours after first use. If the need for an emergency restraint continues after 24 hours, both the person in care or their close family member or substitute decision maker AND the most responsible physician/nurse practitioner must agree to its continued use.</td>
</tr>
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See your health authority/organizational policy about use of restraints

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1 Residential Care Regulation – see www.hcwa.ca
3 Residential Care Regulation 3.7.7
4 Residential Care Regulation 3.7.7
Call for Less Antipsychotics in Residential Care (CLeAR)
BC Patient Safety & Quality Council

☐ **Aim:**

Achieve a reduction of 50% in the **inappropriate** use of antipsychotics in participating facilities across the province through evidence-based management of BPSD for seniors living in residential care by Dec. 31, 2014

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What works?
Capacity Building & Sustainability for Regulated Health Professionals

- Comprehensive, integrated multi-disciplinary assessment
- Staff education, training & coaching
- Develop practical evidence-based resources
- **Use of quality indicators & evaluation**

(Collett et al. 2009 Moyle et al. 2010 Gibson et al. 2010)

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Age at first psychiatric hospitalization
(Annual Hillside Research Report 2012/13)

Age at first hospitalization

- 0-14
- 15-24
- 25-44
- 45-64
- 65+
- Unknown

Percentage

- Adult
- Geriatric
- Neuropsychiatric

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The mean Neuropsychiatric Inventory (NPI-NH) total score at admission and discharge by program (Annual Hillside Research Report 2012/13)
Psychotropic profiles (%) at admission and discharge
(Ward C. & Wu C, Poster, CAGP, Banff, 2012)

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Knowledge Exchange Platforms

- **In person** (ie. P.I.E.C.E.S., Practice Support Programs for Family Physicians, www.gpscbc.ca)

- **Webinar**

- **Collaborative technology** (social media, document sharing, web)

- **Communities of practice (CoP)**

  (Megan Harris, AKE)
A Knowledge Transfer Study of the Utility of the NS Senior’s Mental Health Network in Implementing Seniors’ Mental Health National Guidelines

- www.cccsmh.ca
- Case-based teaching modules
- Delivered by provincial health network (NS-SMHN)
- Increased access to local and regional change champions
- Formal health network model might promote knowledge transfer

(Bosma M. et al. CGJ 2011)

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Effective Knowledge Transfer at the organizational level requires:

- leadership ‘change champions’
- good facilitation
- active participation of stakeholders (academics, planners, NGOs, consumers, service providers)

(Chambers L. & Le Clair K., 2010)
# The Journey of Mrs. Tertiary

(A BC Tale of Transitions)

Capacity & Sustainability Strategies for Regulated Health Professionals

## Capacity
- Continuum of care (IHA)
- Comprehensive, integrated inter-disciplinary assessment
- Staff education ie. P.I.E.C.E.S., training & coaching
- Develop practical evidence-based resources ie, www.bcbpsd.ca

## Sustainability
- Formal network
- Focus on enhancing collaborative/shared care service delivery
- Continuous quality improvement/evaluation
- Role for academic centres (CanMEDS-Manager)
Canada Needs a National Dementia Strategy

Monetary Costs of Dementia in the United States

NEJM 2013;368:1326-34

- the total monetary cost of dementia in 2010 was between $157-$215 billion

- dementia among the diseases that are the most costly to society

- similar to direct health care expenditures for heart disease and significantly higher than cancer
The End