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)

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**

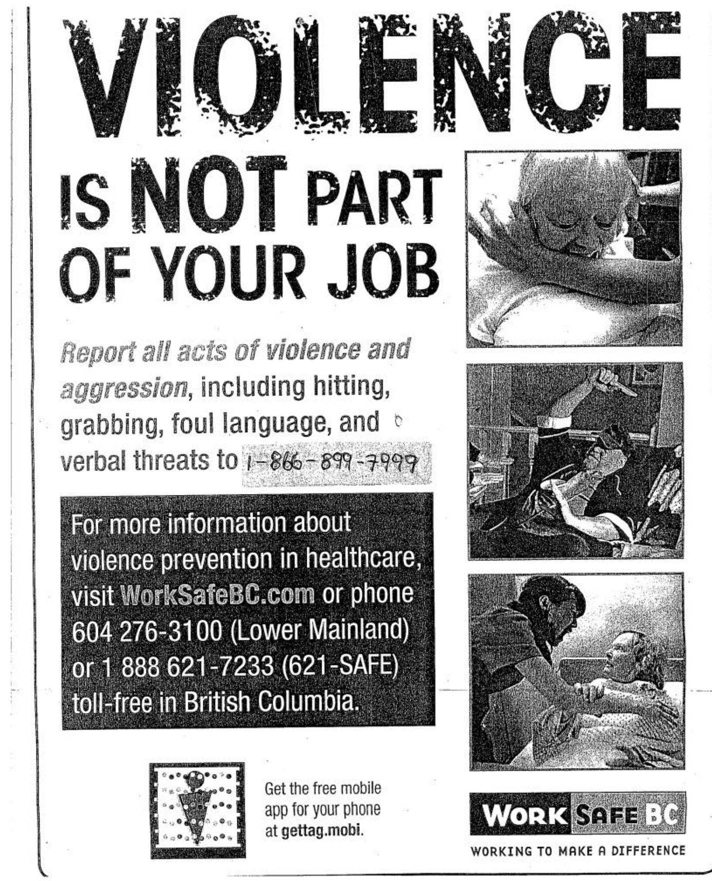
Why isn’t this working?

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

Acute Care	ER
Person centered approach	Triage
48/5	Screen for delirium
Consumer feedback	**Assess behaviours' origins & follow standard approaches to management**
Least restraint	Caregivers
Assess and manage behaviours	**Educate**

Workplace Health & Safety



Reality Check

INSIDE HARPER'S SUPREME COURT MISSTEP P.16

MURDER IN THE NURSING HOME P.40

KATY PERRY'S CANADIAN SONGWRITER P.59

FESCHUK'S FAVOURITE NEW GADGETS P.65

MACLEAN'S

2013 ONLINE PUBLISHING AWARDS

BEST TABLET EDITION

CANADA'S NATIONAL M

JANUARY 27, 2014

National Behavioural Support System Project

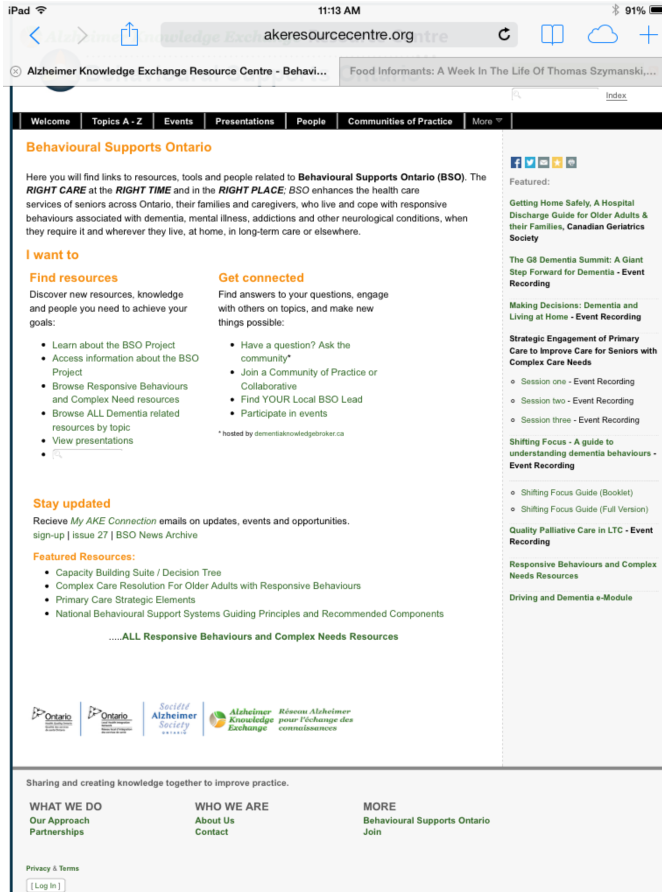
Guiding Principles and Recommended Components for a Behavioural Support System

CDRAKE (2011)

Where to start the discussion on capacity building and sustainability for regulated health professionals?

Behavioural Supports Ontario

www.BSOProject.ca



Alzheimer's Knowledge Exchange Resource Centre

www.akeresourcecentre.org

Early adopter LHNs

BETSI

(Behavioural Education and Support Inventory)

In-House BSO Teams

BSO Interim Evaluation

(Hay Group Health Care Consulting)

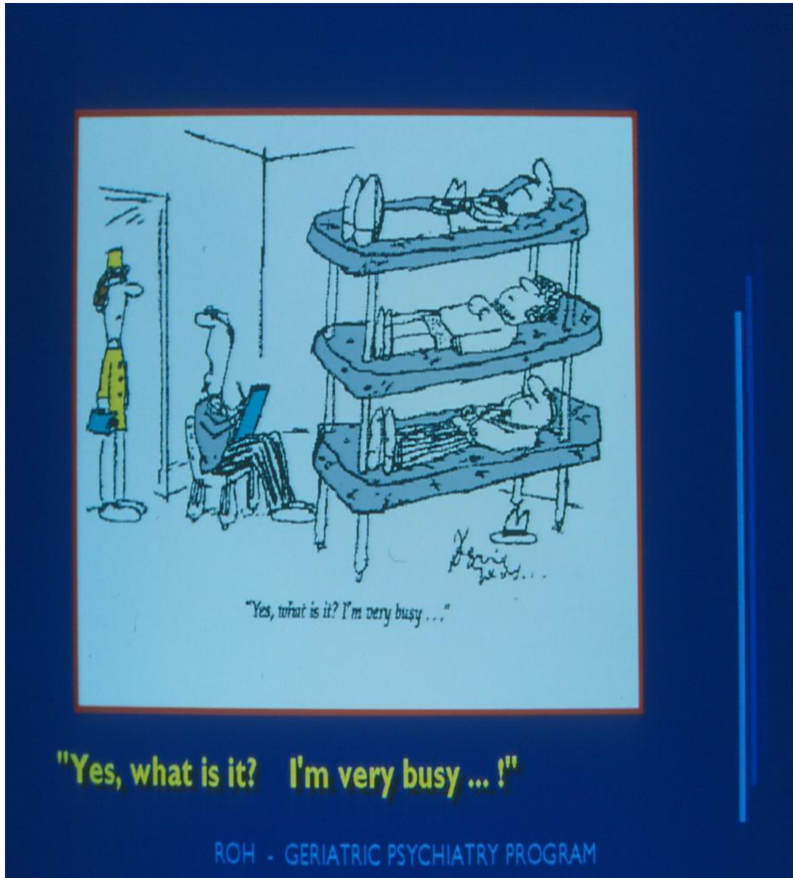
Three Pillars Foundation for an Older Adults' Behavioural Support System

Distance Learning Group: Ontario BSS July 2010

System Coordination	Interdisciplinary Service Delivery	Knowledge Care Team & Capacity Building

C. Ward Tertiary Mental Health IHA

Foundation for an Older Adults' Behavioural Support System



System
Co-ordination

The WHO MIND Project

Key Recommendations For Service Organization

Low

High

FREQUENCY OF NEED

Long-stay Facilities & Specialist Services

Community Mental Health Services

Psychiatric Services in General Hospitals

Mental health services through PHC

INFORMAL Services

Informal Community Care

Self-care

QUANTITY OF SERVICES NEEDED

High

Low

COSTS

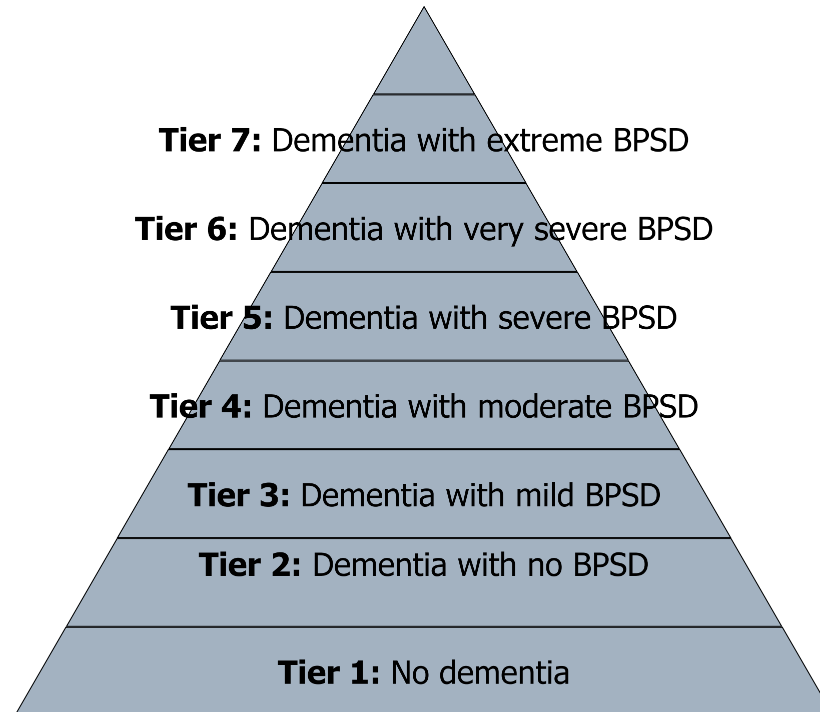
World Health Organization

The WHO MIND Project: Mental Improvement for Nations Development

Department of Mental Health & Substance Abuse, WHO Geneva

Behavioural and psychological symptoms of dementia: a seven-tiered model of service delivery

(Brodaty et al. 2003)



Geriatric Psychiatry – Continuum of Care

C. Ward Tertiary Mental Health IHA

Foundation for an Older Adults' Behavioural Support System

Interdisciplinary
Service
Delivery

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

www.mentalhealthcommission.ca/seniorsguidelines

- 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

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.piecescanada.com

- **P**hysical
- **E**motional
- **I**ntellect
- **C**apabilities
- **E**nvironment
- **S**ocial

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

Why P.I.E.C.E.S for Tertiary?

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

Hillside Centre
Tertiary Acute Facility

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

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

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)

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'

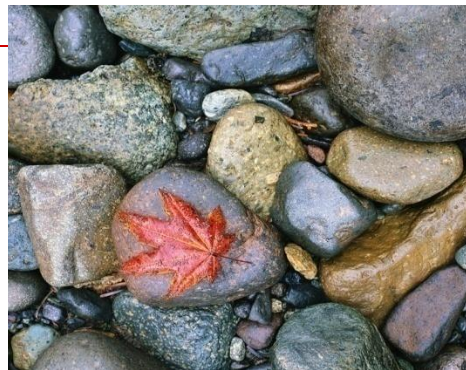
By Kathy Tomlinson, CBC News
Posted: Feb 8, 2011 6:16 AM PT
www.cbc.ca/news/credit.html

The Antipsychotic Concern

- 2002, 2004, 2006, 2007 – Health Canada Advisories, about mortality risk and adverse reactions antipsychotic use - risperidone only approved medication for BPSD use
- 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.)
- 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.
- Missing information: how long? for what condition? Prn use or regular? Actual use vs presciptions

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

What is the purpose of the BC BPSD Algorithm?

- Simple, comprehensive one stop resource
- An interactive and decisional resource tool to guide interdisiplinary 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)

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

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bcbpsd.ca

BPSD Algorithm V16 Final Version Nov8.pdf

Accommodating and Managing Behavioural and Psychological Symptoms of Dementia (BPSD) in Residential Care **Nov8, 2013(V16)**

Part 1: Interdisciplinary Decisional and Practice Support for BPSD

Assessment

Person with Dementia has Behavioural & Psychological Symptoms of Dementia (BPSD)
(Identify and document baseline behaviour in neutral terms with collateral input)

Best Practice Tips:
- Encourage involvement and education of family/caregiver/substitute decision maker in the life of the older person with dementia, including decision-making process
- Involve all members of the resident's care team throughout the decision-making process

Is there severe urgent risk for safety of resident, care staff or others? Or is this an acute change?

Yes → Emergency
- Consider delirium or exacerbation due to ongoing, active medical problem(s)
- Least restraint

Contact Physician
- Medications for emergencies
- SBAR for BPSD
- Refer to Part II

No → Assess **Behaviour** using appropriate assessment tool

Evaluate for possible **Antecedents** (triggers)

Evaluate the **Consequences** of the behaviour (resident and others) and document.

Depression Screening Tools | Cohen Mansfield Agitation Inventory (CMAI) | Dementia Observation Scale (DOS) | Resident Assessment Instrument (RAI) 2.0 - Changed Outcome Scales? (eg. Pain, CPS, DRS, ABS, ADL etc). New CAPS/RAPS | Evaluate Progress Notes for behavioural events

Problem Solving

Analyze data from Behaviour Assessment to determine possible cause(s) and triggers
(Engage Resident/Family/Substitute Decision Maker)
P I E C E S[1] (P.I.ECES)

PHYSICAL
- Common physical changes in dementia
- Unmet Needs
- Medical co-morbidity/ change in medical condition
- Medication/side effects/ Polypharmacy
- Pain
- Falls

INTELLECTUAL
- Common Intellectual Changes in Dementia
- Communication

EMOTIONAL
- Common Emotional changes in dementia
- New and/or past history of mental illness

CAPABLITIES
- Residual strengths and abilities
- Progressively lowered stress threshold
- Communication

ENVIRONMENT
Consider proper:
- Signage
- Lighting
- Colour scheme
- Over and under stimulation
- Change in routine
- Relocation
- Other

SOCIAL
- Isolation
- Loneliness
- Boredom
- Task focused non-supportive care approach
- Multiple losses
- Life Story
- Social Network
- Cultural heritage

Care Planning/Evaluation

Create an individualized care plan of specific non-pharmacological interventions that addresses modifiable causes of behaviour
(Engage Resident/Family/ Substitute Decision Maker)

Mitigate antecedents

Mitigate consequences

Educate staff and family

Monitor behavioural response to planned strategies
Consider how RAI CAPs triggered and outcome scales have changed

Improvement
- Continue to monitor for any changes
- Decreased intensity, frequency, duration
- Document improvement and adjust plan of care as required
- Monitor and evaluate

No Improvement
- Review plan
- Adjust strategies
- Implement revised plan; monitor and evaluate

PART II

Interdisciplinary consultation with relevant teams as needed

1 P.I.E.C.E.S. Consult Group (2006). Putting the P.I.E.C.E.S. Together: A Model for Collaborative Care and Changing Practice 6th Edition(R). Canada. with acknowledgement of the authors.

www.bcbpsd.ca

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BPSD Algorithm V16 Final Version Nov8.pdf

Accommodating and Managing BPSD in Residential Care

Part II – Reassessment with Family Physician or Nurse Practitioner for BPSD

Assessment

Clinical Assessment
- untreated medical conditions
- review current medications / side effects

Consider initiating or continuing current ChEI / Memantine treatment for Alzheimer's Disease.

Consider pharmacologic treatment for BPSD
- behaviour is dangerous, distressing, disturbing, damaging to social relationships and persistent
AND
- has not responded to comprehensive non-pharmacologic treatment plan, including removal of offending drugs

Interdisciplinary consultation with relevant specialist teams(e.g. Geriatric Psychiatry, Pain Specialist, etc.)

Is behaviour likely to respond to medication?

No: these behaviours are not likely to respond to medication

Return to Part I

Medication Options

Yes: These behaviours may respond to medication and benefits outweigh the risks

Contact resident/family/substitute decision maker and obtain informed consent prior to initiation of pharmacological treatment (document and provide family/SDM with information)

Continue to follow individualized care plan for BPSD

SLEEP DISTURBANCE
Sedatives

ANXIETY:
SSRI
Trazodone
Benzodiazepine

PSYCHOSIS:
Atypical Antipsychotics
Typical Antipsychotics
ChEI (First line intervention for Lewy Body, Parkinson)

AGGRESSION: (Physical/Verbal)
Atypical Antipsychotics
Typical Antipsychotics
Other

DEPRESSION:
SSRI
SNRI
NaSSA

Care Planning/Evaluation

Regularly monitor effectiveness of treatment, side effects, titrate dose (review with residential care team and family)

Educate staff and family

In consultation with resident/family/SDM decide if therapeutic goals are met

Continue to provide individualized care plan for BPSD

Reassess the need for continued therapy

Do not stop psychotropic medication when prescribed for another indication besides behaviour e.g.. Schizophrenia, Bipolar, Major Depression

Discontinue medication if possible

Monitor for recurrence / emergence of BPSD

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Accommodating and Managing BPSD in Residential Care

BPSD Algorithm

Part1
Interdisciplinary Decisional Support for BPSD

- **Assessment**
- **Problem Solving**
- **Care Planning / Evaluation**

Part 2
Reassessment with Family Physician or Nurse Practitioner for BPSD

- **Assessment**
- **Medication Options**
- **Care Planning / Evaluation**

Evaluate | Flow Chart

Key Features- Practice Supports

Information about Physical/Chemical Restraints

Provincial BPSD Clinical Algorithm Review Working Group

Use of Medications and Restraint
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[1]
Chemical Restraint versus Treatment: 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**. This should not be confused with medications used to treat drug responsive behavioural/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 [2].
Consider the following: • A restraint may be used in an emergency without consent[3], 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.[4] • 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.
Any use of restraint must be documented, monitored and reassessed.
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.
See your health authority/organizational policy about use of restraints

[1] Residential Care Regulation – see www.bclaws.ca

[2] Australian Government (2004). Decision-making tool: Responding to issues of restraint in aged care. Australian Government: Department of Health and Ageing. Retrieved April 5, 2012 from http://www.health.gov.au/internet/main/publishing.nsf/Content/AE6A3DEC50534D27CA256F4700752CFF/$File/decisiontool04.pdf; as cited by Interior Health draft policy

[3] Residential Care Regulation S.74(1)a

[4] Residential Care Regulation S.77

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

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)

Age at first psychiatric hospitalization

(Annual Hillside Research Report 2012/13)

C. Ward Tertiary Mental Health IHA

The mean Neuropsychiatric Inventory (NPI-NH) total score at admission and discharge by program

(Annual Hillside Research Report 2012/13)

Program	Admission	Discharge
Geriatric	78	25
Neuro	40	18

Y-axis: Average NPI total score (0–90); X-axis: Program

C. Ward Tertiary Mental Health IHA

Psychotropic profiles (%) at admission and discharge

(Ward C. & Wu C, Poster, CAGP, Banff, 2012)

Medication	Admission	Discharge
Antidepressants	58%	30%
Antipsychotics	94%	55%
MoodStabilizers	36%	27%
BedtimeSedatives	49%	39%
Antianxiety	15%	21%
Stimulants	0%	0%
Acetyl	18%	9%
NMDA	6%	9%
Antiparkinsonian	3%	3%
AntidepressantAug	3%	6%
Total	100%	76%

Y-axis: Percentage (0%–120%); X-axis: Medication

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.ccsmh.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)

Seniors Health Strategic Clinical Network www.albertahealthservices.ca

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