Changing Directions
Changing Lives
Challenging and Responsive Behaviors
A Cross Provincial Dialogue

"There is nothing so Powerful as an idea Whose time has come"
Victor Hugo

THANK YOU,
Alberta, and Congratulations in
Moving together for Health care Transformation
Who, Challenging and Responsive; It's going to take all our wisdom resources and courage for change. It's time for a new conversation, partnerships, and the way we think and do things.

How Our Conversation the Road Ahead

Moving forward together

Changing directions, changing lives together

It's the crossroads that is the future to igniting innovation, discovering new knowledge, and making meaningful change.

"The best way to predict the future is to invent it"

Allan Kay
"The future is here. It's just not widely distributed yet"

William Gibson

Our Goal
Responsive Behavior in the 21st Century
Making them a Fading memory
Promoting Quality of the Life across the Age span by providing person directed integrated services, quality care and bending the accelerating cost per capita curve

The Road Ahead
Situation
Why are we here
19th century health care
A New reality
The intersection of advocacy and cost is aligned
Strategy
The BSO experience lesson learned
Solution
Learning leveraging leading together CDRAKE and a National exchange
Why we're here

Imagine what could be…

When you envision *yourself* getting older, what are some things that you want?

Imagine the world as you want it to be as you get older…

Who Believes

- We are doing the best we can in Prevention, Early Detection, Connection and Support for our adult population who are at risk for age related comorbidities and associated mental health addictions dementia and responsive behaviors.
- Our present approach is desirable and sustainable.
Who Believes

- The present approach is providing Older Canadian Citizens and their caregivers at risk or with complex health care challenges with responsive behaviors the best health care experience?
- Our approach to skill building and quality care can be improved?
- We are surfacing and using our present health care resources effectively and efficiently?

Levels of Challenge and Corner Stones to Change Beyond the Numbers

- Community (Stigma, Broad Determinants of Health)
- Health Care and Related Systems
- Organizations / Teams
- Direct Care (Teams) Human Resources
- Targeted groups (Diversity) (Offord D)

The Knitting of Quality Services at the point of care driven by the individual and family is the key to success

Every Door is the right door From intake and triage to access and transition
Prevention reducing the risk, early detection support and connection
Why are we Here,
Is addressing Responsive Behaviour a way
to Learn and Meet Priority Health Care
Directions

- Is it aging and behaviour or is it complex chronic
  conditions, and the way it changes how we see, think
  and act the challenge?
- Is it Behaviour in Long term Care that’s the challenge
  or is it cross sector and broader community
  responses?
- Is it responsive behaviour only or is it a vehicle for
  priority health care, to learn, to solve?

Population
We are
Privileged
to serve

- Older adults at risk or with complex health care challenges over
time, with responsive behaviors as a result of mental health,
dementia neurological disorders and or addictions
- Their caregivers

A prototype for health care transformation

tipping point
cluster population

1 Community primary care
2 Acute decline in community
3 High risk and High need
The Challenge: Different Population Clusters and opportunities

Rethinking Global to Health: Cluster Targeted Team-based approaches

Prevention and Early Detection and broad determinants

Intermediate Tipping Point

High Risk
- Cost
- Use
- Need

There is seldom now a simple sore throat anymore

-Mike Slade

Starting with the most complex clients (Long term care), testing integration and embedding in other populations

Incubator to drive the tightest integration, test and learn

Embed Learning's to all population and develop standards of care within and across settings
Is it Aging, Dementia and Mental Health or Chronic Disorders

CIHI 2011

- Health care use, of those 45,65, 85 with no chronic condition is the same
- Chronic illness regardless of age means more services
- Once you have 3 or more on average six times more health visits

Complexity and Chronic illness in Older Adults

- 82% of those aged 65 and older have one or more chronic conditions
- 43% have three or more (Wolf J.L et al JAMA 152 2269-2276)
- After age 50 likelihood on being disabled by disease doubles every 5 to 7 years

Health Care Priorities
Target High Service Users

www.Agingresearch.com
Challenges and costs

60% of Health costs are from 10% of the population over 5 years, Recent ICES data

- High Cost groups:
  1. Older women
  2. Dementia
  3. Tipping point before hospital
  4. Discharge

Challenges and costs

Ontario Health, 1 percent 34 percent of the health expenditures

Asthma congestive heart failure and diabetes combines cost less in Ontario hospitals than dementia

More than one third of fractured hips presenting to hospital are people with dementia and also one over one third of people in ALC have dementia

![Graph showing ALC Days relative to the average by Proportion of Cumulative Risks, 'Big Ont. Hospital', 2008-09](image-url)
Challenges across Sectors

- ALC 23 days with dementia average 10 days
- Survey of Ontario ALC 17% of hospital beds half waiting LTC #34 percent dementia
- LTC 65 percent mental health and dementia with mental health
- Home care 1 in 5 30 percent behavioral
- Behavior/delirium 12 percent on admission 23 percent develop delirium /48/5

Identification of the Challenges for LTC Consumers Across the Health Service Continuum Throughout their Health Career

...Before and After the tipping point

11 Community primary care
2 Acute decline in community a
3 High risk and High need
Challenges Across sectors
Primary and Community

Upstream opportunities - community and primary care populations

Is it also important to prevent, provide early detection and intervention support and connection to the right service at the right time for the right reason

Facts relevant to primary and community care

Diversion and Disposition

- Pre-hospital case recognition of ALC patients; never used CCAC services was 100% greater for persons with Dementia (Pos 2008)
- There is a lack of knowledge of community options, many persons not diagnosed or not recorded (Mezey and Mason 2008)
- Dementia is leading cause of admission to LTC (Behavior, Function major causes) (Medical Advisory Secretariat 2009)

Facts Relevant to Primary care

1. Comorbidity is central component of dementia depression care even before the diagnosis (costs in primary care those who eventually had dx dementia compared to those who did not 1.5 billion dollars more in USA ;
Brain scans of person with a mutation that causes early-onset Alzheimer’s disease at 5-year intervals - evidence of amyloid accumulation (warmer colors) up to 20 years (far left) before the expected onset of symptoms (far right). 

G Miller Science 2012;337:790-792

Rising Tide: The Impact of Dementia on Canadian Society

A study commissioned by the Alzheimer Society

What the report says: how to stem the tide, its primary care

The report tested the impact of four potential intervention scenarios:

- Prevention: increased physical activity
- Prevention: diet and lifestyle program
- Support: caregiver training and support
- Support: system navigation

All showed potential for dramatic reductions in number of cases and or economic impact over the next 30 years.
Prevention
Almeida et al
Cross Sectional Study; 20,677 community Dwelling Aussies
> 60 yrs (Depression by PHQ – 9)

- Results Depression associated with
  1. Older Age
  2. Childhood adverse events
  3. Adverse lifestyle (i.e. Physically inactive)
  4. Intermediate Health Hazards (i.e. obesity, diabetes)
  5. Co Morbid Medical Conditions
  6. Social / Financial
  3% for no Risk 80% of all

Evidence supports morbidity compression

- 2,300 college alumnae aged 60+ followed annually x 20 years (1986-2005)
- Maintenance of normal weight, routine exercise and non-smoking
- Low, medium and high-risk based on number of factors present
- Tracked morbidity, disability and mortality
- Results: Low-risk subjects had onset of moderate disability delayed by 8.3 years compared with high-risk; substantial difference in mortality 247 vs 384/10,000 patient years

other Side of the Mirror, Caregivers
Responsive Behavior
Tipping point
In 2002, 23% of Canadians aged 45–64 provided care to seniors. Of this group, 70% were also employed (General Social Survey, 2002).

- On average, these Canadians provided 23 hours of unpaid caregiving per month (29 hours for women, 16 for men)
- 27% of those aged 45–64 with children at home also cared for seniors.

25% of caregivers report that their work is affected by their caregiving responsibility (females more affected)

- The economic value of caregivers’ unpaid eldercare to the Canadian economy is estimated to be over $5 billion and between $6-9 billion for all caregivers (chronic and palliative care) unpaid work

hours spent on informal care is expected to more than triple

The time Canadians will be providing in informal care
Levels of Challenge and Corner Stones to Change Beyond the Numbers

- Community (Stigma, Broad Determinants of Health)
- Health Care and Related Systems
- Organizations / Teams
- Direct Care (Teams)
- Human Resources
- Targeted groups (Diversity) (Offord D)

Triple Jeopardy
“Ageism and dementia/mental illness and behavior
The Many Hidden Faces, The Collective Opportunities

Reflections
Old …………………… 2 words to describe
Mentally ill/dementia……………… 2 words to describe
Addiction …………… 2 words to describe
Old, Mentally ill demented and … 2 words Substance misuse

“It will affect most of us”
Stigma
“Get your own house in order”

Negative attitudes
- Failure of Diagnosis
- Lack of Treatment, medical surgical conditions
- Involving people in decisions
- Premature placement

Benbow S.
Hosp. Medicine
2000 vol 6, no.3

The Challenges across International Boundaries

SYSTEMS FAILURE
CAPACITY FAILURE
PREVENTION AND EARLY DETECTION FAILURE

Norway

The Health Care Reality

- It is estimated that between the years 2020 and 2030, 75% of health providers' time will be spent on older people

Evidence informed

- Shared expertise:
  - Person lived experience
  - Professional expert about disease, practice, knowledge, and literature

I know me.
I know stuff.

7 Health care Provider Challenges

- Prevention, early detection (respond vs reflect)
- Persons team
- Acute care to continuing care skills
- Reductionist to multiple causes, different times, different causes
- Competencies, balance of heart, hand, and head
- The knowledge exchange and improvement science skills
- Have or obtain four quadrant-based skills

Four Quadrant Person and Family Directed care Challenge

- Responsive behavior
- Function
- Psychiatric cognitive
- Multiple medical providers and services
Evolution of Health provider

Knowledge Worker from hierarchical to Network Weaver
“Knowledge Broker in You”
(Sarah Clark)

The Challenges across International Boundaries

SYSTEMS FAILURE
CAPACITY FAILURE
PREVENTION AND EARLY DETECTION FAILURE

Norway
“The Situation is distorted when the Population is defined as the Problem... Rather the Problem is best defined as those factors which have created the gulf between the needs of the population and the approaches to address these needs.”

- Cohen

The Why's
It time our services moved from health care by body parts to people

18th Century Health Care in the 21st Century

The System; We Live and Work In

“Sorry, but I'm the only one on duty today.”

William
The Challenges And Trends

• 18th Century Health Care in the 21st Century (From Acute to Chronic and Complex)
• Provider Care Driven (Consumer Partnership)
• People Divided into PIECES with Programs
  Following this reality
  (Need for connectivity and integration)

The Transformation

FROM

Illness orientation

• prevention not a priority
• a solo provider approach
• Provider, disease centred
• reactive and episodic care
• limited role for individuals in management

A System Involving
Health Care Organizations
Individuals and Families
Communities

TO

Wellness orientation

• prevention at all points of continuum
• an integrated, interdisciplinary care team approach
• patient centred
• proactive, complex, continuing care
• individuals empowered for self-management and part of care team

Rowing harder doesn’t make a difference if your going the wrong way

Insanity is doing things the way we’ve always done them, and expecting different results.”
Behavioural Support System,
A Call for Action

- No. At risk and increasing
- Challenges across sectors
- Persons and families deserve better quality experiences
- Significant costs
- Recognized best practices
- Opportunities for leverage of existing initiatives
- Readiness

BSO Overview

BSO is a comprehensive system redesign; an approach that breaks down barriers, encourages collaborative work, shares knowledge, fosters partnerships among local, regional and provincial agencies and speaks to a new way of thinking, acting and behaving.

BSO is creating a system that ensures people are treated with dignity and respect, in an environment that supports safety for all and is based on high quality and evidence-based care and practices.

BSO provides clients with the right care, in the right place and at the right time.

BSO is not a new service but rather, a catalyst.

At the core of the BSO Project is the want to create a system that ensures people are treated with dignity and respect in an environment that supports safety for all and is based on QUALITY, evidence-based, patient-centred care and practice.
Its Dangerous if we see an illness, Not a Person

-Mike Slade

Over arching Goal
Moving Toward Person and Caregiver Directed care, (before and after the tipping point and changing the way we think and do things as providers

What we have learned
Informing Educating Involving persons , the prime directive

- Does it make a difference or is it political correctness misplaced concern with touchy feely aspects of health care? No SCIENTIFIC BASIS AND OF LITTLE RELEVANCE IN CLINICAL CARE

(Angelina Coulter and Jo Ellis BMJ 335(7609)24 to 27)

Informing Educating and Involving

Outcome of 129 systematic reviews

- Impact patient knowledge and understanding of condition
- Impact on their experience and treatment
- Impact on use of health services and costs
- Impact on health behavior and health status

Bottom line robust finding with collaboration support of provider

Self Management and Prevention achieves new knowledge and quality practice

The average person spends 12 hours each year with their health care providers...

They spend 8,748 hours each year managing their own condition
Person and Family Driven
Every individual is a Universe of one

Informed decisions
Supportive care e.g. practical issues
Self management

Delivery model CDPM and Recovery
Peer support

Person directed care changing the conversation
Persons life

Strengths
Supports (wrap around)
Challenges

CARE MODEL

Community
Resources and Policies

Health System
Decision Support
Health Care Organization
Self-Management Support
Delivery System Design
Clinical Information Systems

Informed, Activated Consumer
Prepared, Proactive Practice Teams

Improved Outcomes
Person directed care changing the conversation
Persons life
Strengths
Supports (wrap around)
Challenges
What is an Authentic Partnership?

An Authentic Partnership...
- actively incorporates and values diverse perspectives and includes all stakeholders directly in decision making
- means working with not for others

Where did we
BSO | New knowledge or old Knowledge revisited
the key is in the interface between disciplines people
and sectors

Changing the conversation; a new way of thinking, acting and
behaving

New ways of bringing...
* policy to practice and practice to policy
* science to service and service to science

Changing directions changing lives | a conversation on
three models for change
* planning and implementation
* capacity building and
* Primary care

Process to connect policy practice
and evidence

The Conceptual Framework
Applied

Evidence informed

BSO Principle Based
Evidence Informed
Provincial Framework

Testing the Concept
(Provincial framework
refinement)

Implementation

Sustainability and Spread

All Regions, Buddy LHINs
Action Plans
Learning by doing LTC, Cross Sector

(Early Adopter's A.P.
Developing the Supports,
Structures, Tools, People [IF])
The BSO model is comprehensive; broad in its inclusion of all points of care and flexible in its application to communities of different sizes, better integration and collaboration, transitional services, has resulted in better care, better health outcomes, and better value.

**Phase 1**
Defining the why and the what

**Phase 2(a)**
Testing the model & developing the supports, accountability structures and action plans

**Phase 2(b)**
Implementation, exchange and evaluation

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**Target Population:**
 Clients aged at risk or with complex health care challenges over time, with responsive behaviors as a result of mental health, dementia, neurological disorders and or addictions

And their caregivers.

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**Pillar 1**
System Coordination and Management

**Pillar 2**
Interdisciplinary Service Delivery

**Pillar 3**
Knowledgeable Care Team and Capacity Building

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**the BSO formula**

A unique, LHIN rollout approach is proving to be one of the project’s great strengths:

- Thorough research and consultation produced a “Framework for Care” to guide system redesign and cultural change - panel of experts acted as reference on specific questions

- 4 Early Adopter LHINs first to implement, then share experiences with remaining 30 LHINs through “buddy system” approach

- Up-front investments in quality improvement training set the stage for change

- Persons with lived experience were engaged throughout the planning, implementation and evaluation processes

- Commitment to knowledge transfer and research interface and mutual benefit
seven keys to success

1. Define the “Why” and the “What” through a provincial framework. (The 1% accounting for the 34 percent)
2. Define and implement the how’s driven by the goals and priorities of the community sector with a cross sector and person centered approach using QI tools and approaches.
3. Provide mechanisms to support “How” the framework is implemented locally:
   - Knowledge exchange opportunities
   - Improvement facilitators
   - Redefine specialty services as a resource not a service
   - Risk and change management.
4. Introduce equal stakeholders
5. Multi-level accountability. And triangle of data and measurement
6. Create / use standardized tools, protocols and measurement to support implementation.
7. Continuous channels and processes to connect, learn, leverage, from and collaborate with provincial and local

Lesson Learned, Opportunities for Collaborative Development

- From global change to incremental using KE, co-creation and improvement science to change
- Turning on the functions driven by high impact, ease of implementation and readiness and driven by the target partner

Learning and Developing Together

- Three Pillar development essential for change
- Leveraging for success,
  - Alignment for support
- Opportunity driven risk mitigation by continuous exchange
- Learning from each other, Province and beyond
Pillar 2: Integrated Health care system transformation

Service Redesign (Delivery and Support)

• Mobile Inter agency response teams responsive, integrated, capable
• Complex care resolution coordinators and tables
• Navigators - Complex care resolution coordinators and tables
• Access and transition services
• Interagency transitional services between sectors
• Pathway protocol driven and resources and best practice tool supported

Service Redesign (Delivery and Support)

• Triple Hat Practitioners
• Use of Knowledge Exchange for Concept Development and Quality Improvement for Service Improvement
• Integrated third generation models (leaving shared and collaborative care behind shared)

Ways we did things may have been the best then. May now not be helpful and have unexpected consequences. MMSE? Outreach?

• False negative - ↑IQ, ↑education
• False positive - ↓IQ, ↓education
• Limited sensitivity to change
• Does not test executive/frontal functions
• Aggravation of back problems
Outreach

RACE
Rapid Access to Consultation
Expertise
(BC)

First 2500 Calls:
72% calls answered in 10 mins
90% of calls with <15 min length

Decrease Face to Face Consultations
60%
37% less Emergency Visits

Integrated 4th generation approaches

• Using the same vision language approach
• One team no longer intake and referral IP collaboration

“Your patients residents, people and caregivers are our patients” residents people caregiver”
Improving care (from shared care to collaborative care to integrated timely care)

- RCT of nurse practitioner dementia care managers in primary care
- Significant reductions in behavioral symptoms, increased patient and caregiver satisfaction with care.

Behavioral Supports Ontario
Primary Care Initiative in South Eastern Ontario

Dallas Seitz
MD FRCPC
Queen’s University Department of Psychiatry

Evaluation
Integrated Care (Keys)

- Timeliness (Urgent Response)
- Embedded
- Triple Hat Functions
- Navigation

Pillar 3: Capacity Enhancement and knowledgeable person and family care teams

Focus on the 97 and the 3%

Start with the person and family service and probable future state using virtual stream mapping among others

Define the skills of the person team

Define the skills of the individual learner in context of what they bring to the team

Use the core competencies heart hand and head

- Use knowledge and strategies that leave a continuing effective service learning environment and practice change

Pillar 3 Capacity Enhancement Framework and Toolkit for Health Care Transformation (the 97 vs 3 percent)

Person and practice based learning

Decision making framework for capacity building enabling person-centred team based knowledge to practice outcomes

- Capacity Building Roadmap
  Decision making framework for provider skill building

- Behavioural Education and Training Supports Inventory
  "BETSI" Decision Making Framework for learning and development programs

New addition to toolkit

The Road Ahead, identifying situations strategies and solutions for sustainability and spread | BSO/Gestalt /AKE
Behavioral Support Ontario
Health Care Transformed through Capacity Enhancement Toolkit

Shared Solution finding Frameworks
i.e. PIECES / UFIRST, GPA

Clinical Toolkits, College of Family Physician BPSD, CCSMH Best practice guidelines, algorithms

Person / Family Toolkits MAREP by Us for Us
Family guides CCSMH

Person and practice based learning | a hybrid of foundational models of care

PerPle | operationalization

Tailored learning based on the learner and function at point of care

**STEP 1** - Utilize value stream mapping and Kaizen approach to define the service elements

**STEP 2** - Identify for each specific service functions the persons team skills required

**STEP 3** - Define core competencies for individual learners and team (capacity building roadmap)

**STEP 4** - Map a) the skills of the individuals, skills of the team, learning and development programs (BETSI), and b) supportive tools, protocols and frameworks c) service learning and other continuous effective learning structures (road ahead)
The Road Ahead
Supporting Sustainable Capacity Building
Service Learning Solutions

Ten Sustaining and Spreading Capacity Building Solutions

Identified by Practice, driven by Practice change
1) Collaborative effective person and family team learning service structures (huddles, Intersectoral forums, care planning)
2) Communities of Practice
3) On line environmental scanning (CCSMH, CDKTN, NICE, AKE)
4) Quality improvement strategies, algorithms, tools, protocols
5) Reflective practice both skills and service VSM, PDSA

Ten Sustaining Capacity Enhancement Solutions

6) Mentoring and Job shadowing
7) Knowledge Exchange event and Online Brokering (CDRAKE)
8) Provider Networks and learning collaborative (CAGP, CCSMH)
9) Facilitated learning programs (see BETS)
10) Case based and scenario based solution finding
BSO Core
B) Competencies (Roadmap)

1. Knowledge
2. Person-Centred Care Delivery
3. Clinical Skills (incl. assessment, care planning and intervention)
4. Field-based Quality Improvement and Knowledge Transfer
5. Change Management Skills
6. Leadership, Facilitation, Coaching and Mentoring
7. Cultural Values and Diversity
8. Prevention and Self-Management
9. Resiliency and Adaptability
10. Collaboration and Communication
11. Technology Skills
12. Professional Work Ethics

C) BETSI

Problem Solving Framework for Learning and development

Answering the questions
  a) Is education the answer
  b) Will I be able to
      move education to
      practice change sustain spread?
  c) What program would fit

Service Management

Multilevel Accountability

Continuous exchange and involvement of policy
practice and lived experience
Ie CRO PRT province region lead agencies
organizations to the system
Summary, Igniting Innovation and Lesson Learned
Keys to Success; Recipes for Failure

A// Provincial Define Why and What
    Regions do the Hows (context and culture)

B// High impact, ease of implementation
    Readiness (galvanizing the community)

C// Continuous conversations between Ministry,
    consumer groups, subject matter experts
    (clinicians, educators, researcher) (CRO, PRT)

D// Multi-level interactive accountability
    (functional fidelity)

E// Knowledge Exchange to Co-create

F// Quality Improvement to Guide and
    Define the Change and Engage the Sectors

G// Leverage Learning and Leading
    (it's all about alignment)

H// Speed
Keys to Success; Recipes for Failure

(I) Power of Networks and Perspectives
(J) Change Leadership

Its time to move

- From a health care by body parts to person directed care
- From problem based care to complex health care
- From skill building and focus from acute care in a chronic care world with more emphasis on prevention
- From solo and silo based practitioner and team based service to a persons’ intersectoral team based approach

Canadian Dementia Knowledge Translation Network (CDKTN)
National BSS: Guiding Principles and Components

What, who, why? Its time to move together to implement
WE HAVE ONLY JUST BEGUN

“The best way to predict the future is to invent it”

Allan Kay

How Wonderful it is that nobody need to wait a single moment before starting to improve the world

Anne Frank

If there were no Gaps we would not see the Light (Leonard Cohen)

“Some look at things that are, and ask why. I dream of things that never were and ask why not?”

George Bernard Shaw
Summary

- The Timing is Right and the Need Growing
- The Transformation is Essential
- The Models are Emerging and Converging
- Through Interprovincial exchange we will succeed because failure is not an option!!!