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Reducing Behaviours With In-Home BSO Teams

Ontario Long Term Care Association
May 31, 2016

Presentation Overview

1. Introduction to the Ontario Long Term Care Association
2. Overview of the long-term care environment in Ontario
3. Behavioural Supports Ontario (BSO)
    a) Overview of survey findings
    b) Analysis of findings
4. Case study of an in-home BSO team's success

Who We Are

- The Ontario Long Term Care Association is the largest association of long-term care providers in Ontario and Canada, and the only association that represents the full mix of long-term care operators – private, not-for-profit, charitable, and municipal.

- Member homes are funded and regulated by the Ontario Ministry of Health and Long-Term Care.

- We represent nearly 70% of Ontario's 630 long-term care homes, located in communities across the province. Our members provide care and accommodation services to more than 70,000 residents annually.

Ontario Long Term Care Association Members

- Total Active Membership:
  - 434 homes (69% of Ontario total)
  - 51,037 beds (65% of Ontario total)
  - 90 independent operators (1 home only), and another 20 have three or less homes and 250 or less beds
- Of 434 Association Member Homes:
  - 356 are privately owned (99% of Ontario total)
  - 63 are non-profit/charitable (42% of Ontario total)
  - 15 are municipal (14% of Ontario total)

Long-Term Care in Ontario

- 627 are homes licensed and approved to operate in Ontario.
- 57% of homes are privately owned, 24% are non-profit/charitable, 16% are municipal.
- More than 40% of long-term care homes are small, with 96 or fewer beds.
- Of these small homes, about 41% are located in rural communities that often have limited home care or retirement home options.
- More than 300 long-term care homes (approximately 30,000 beds) were built to design standards dating back to 1973 and require renovations or to be rebuilt. In October 2014, the government announced a renewed capital redevelopment plan for long-term care homes and this planning work is underway.

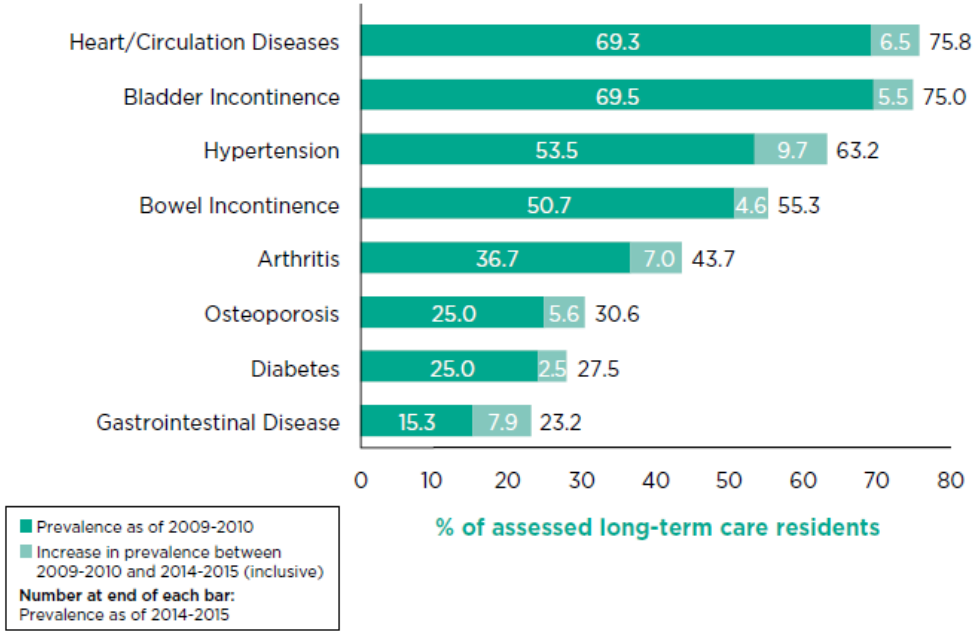
Long-Term Care in Ontario - Continued

- 76,569 long-stay beds are allocated to provide care, accommodation and services to frail seniors who require permanent placement.
- 690 convalescent care beds are allocated to provide short-term care as a bridge between hospitalization and a patient's home.
- 363 beds are allocated to provide respite to families who need a break from caring 24/7 for their loved one.
- The median wait time for long-term care is 83 days.
- Wait list for long-stay beds as of May 2015 was at 23,443.

Sources: Excerpted from This is Long-Term Care 2015 by the Ontario Long Term Care Association. Data references are available in the report.

Rapid Change, Dramatic Impact

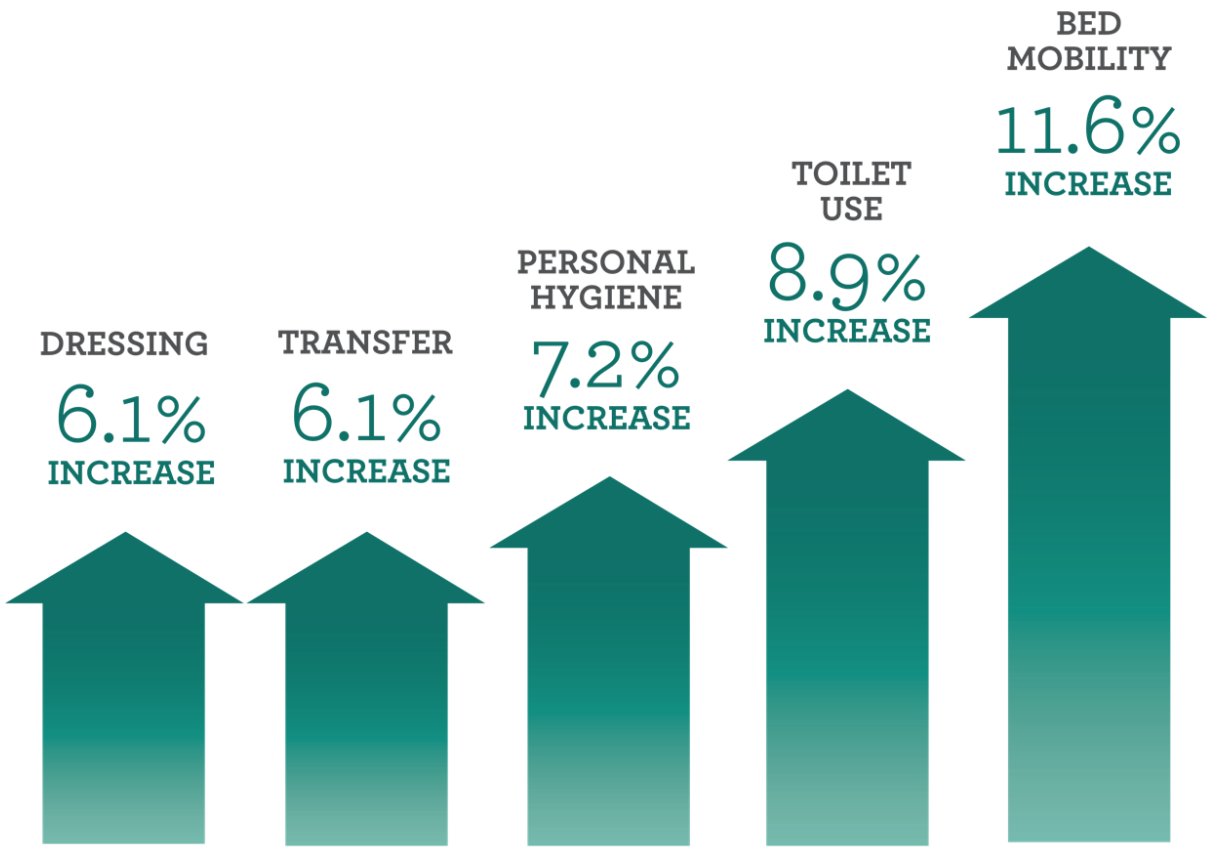
- Since 2010, only seniors with **high** or **very high** care needs are eligible for long-term care in Ontario.
- Significant changes in resident profiles – now coming into long-term care at a later stage of life, with more complex health issues and are more physically frail.



Source: Canadian Institute for Health Information, *Continuing Care Reporting System (CCRS 2009-2010 and CCRS 2014-2015)*

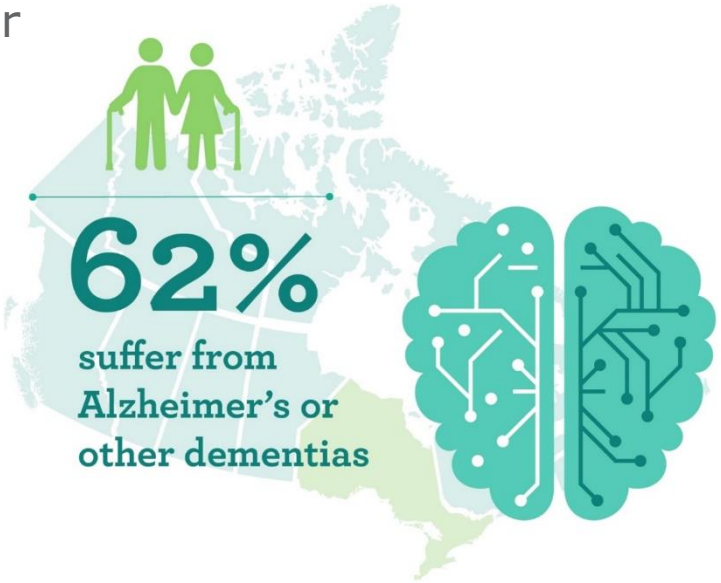
Rapid Change, Dramatic Impact

- Residents need more extensive support with daily activities than five years ago.



Rapid Change, Dramatic Impact

- Persons living with later stage dementia are a core population for LTC:
  - 62% of residents live with Alzheimer's disease or other dementias; nearly 1/3 have severe cognitive impairment.
  - 46% of residents exhibit some level of aggressive behavior.
- 40% of residents have a psychiatric diagnosis such as anxiety, depression, bipolar disorder or schizophrenia.
- Dual diagnosis (e.g., dementia coupled with a psychiatric diagnosis) is increasing at 11% per year.
- 97% of residents have 2 or more chronic diseases.



Sources: Excerpted from This is Long-Term Care 2014 and This is Long-Term Care 2015 by the Ontario Long Term Care Association. Data references are available in the report.

Building Capacity for Better Dementia Care

- In 2012, the government announced funding for Behavioural Supports Ontario (BSO).
  - Specialized teams of providers work with staff to identify triggers and put plans in place to mitigate negative incidents.

- Three BSO models of care: in-home, LTC home-based mobile, and single mobile team for all homes:

  - Mobile BSO teams work with several homes, often resulting in significant delays.

  - In-home BSO teams work directly with residents, daily, to reduce stress and identify their triggers to stop behaviours before they happen.

Building Capacity for Better Dementia Care

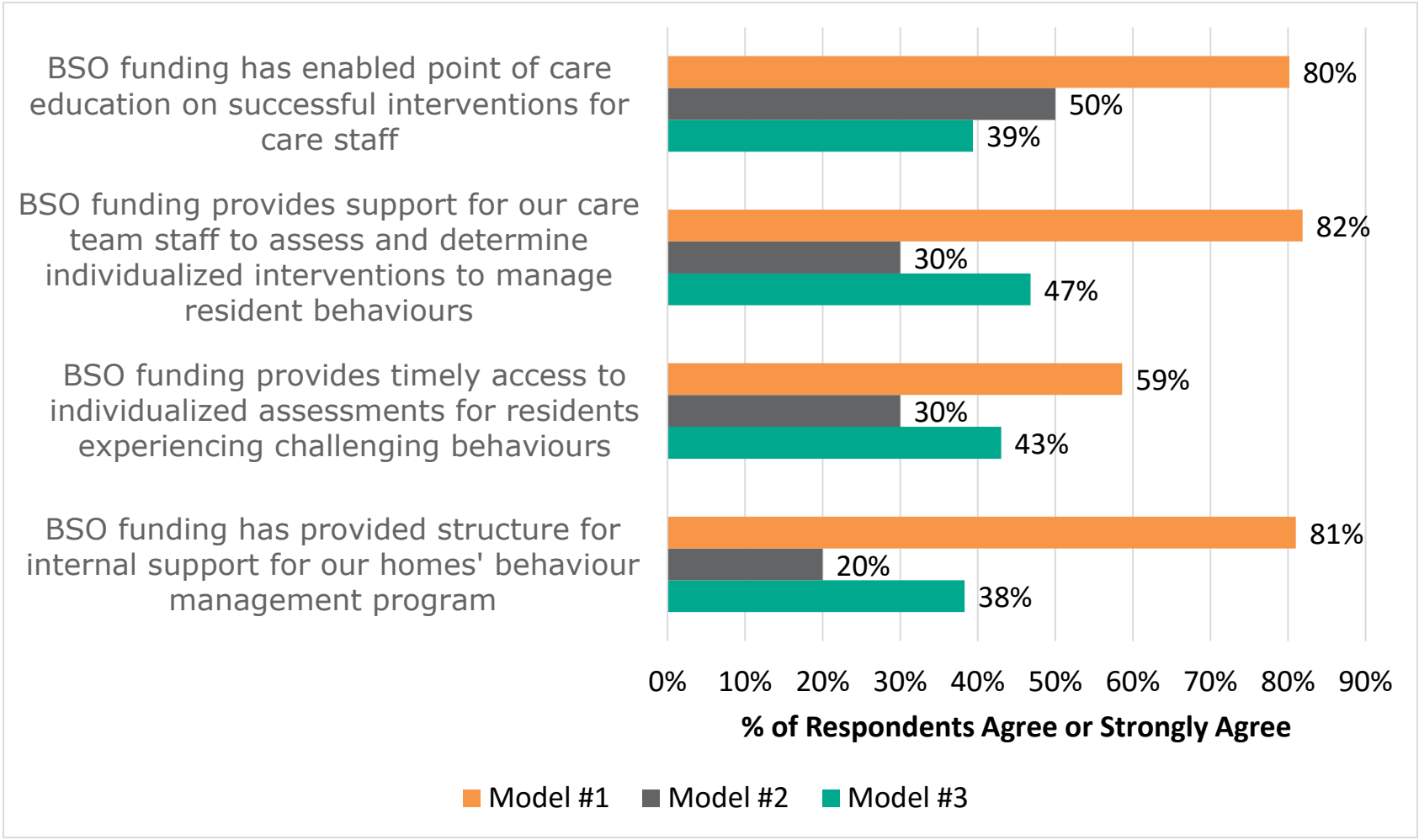
- We know in-home supports are working very well. Two examples:
  - Since receiving funding for a BSO team in 2013, one home has experienced a 40% reduction in physically aggressive behavior and a 75% reduction in physically aggressive responsive behaviours.
  - Since the implementation of a BSO team in 2013, another home found incidents of resident-to-resident aggression have dropped by more than 70%.
- Yet only 1/3 of long-term care homes currently have access to in-home BSO.
- Association survey to gather data evidence to support the in-home model and attain more funding.

BSO Member Survey – Objective and Approach

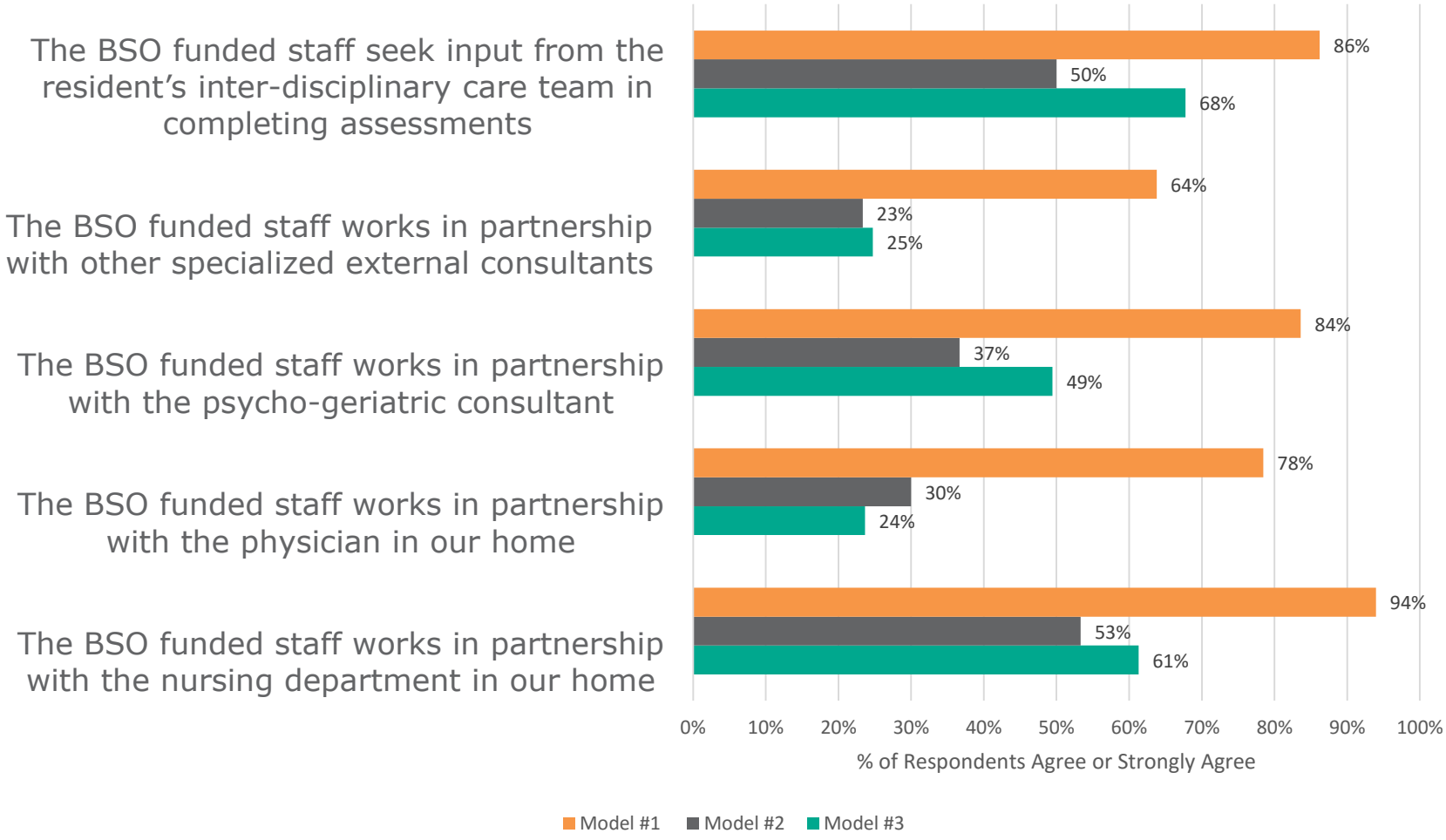
- The Association conducted a member survey (province-wide) in Summer 2015, with the goal of identifying any differences among the three BSO models of care (in-home, LTC home-based mobile and single mobile team for all homes) in relation to key aspects of care:
  - Care planning and provision
  - Collaboration and team building
  - Home-level resident outcomes

- Survey used a five point Likert scale measuring agreement/ disagreement with statements related to aspects of care and yes/no responses to statements related to home challenges such as admission, and management of responsive and chronic mental health behaviours.

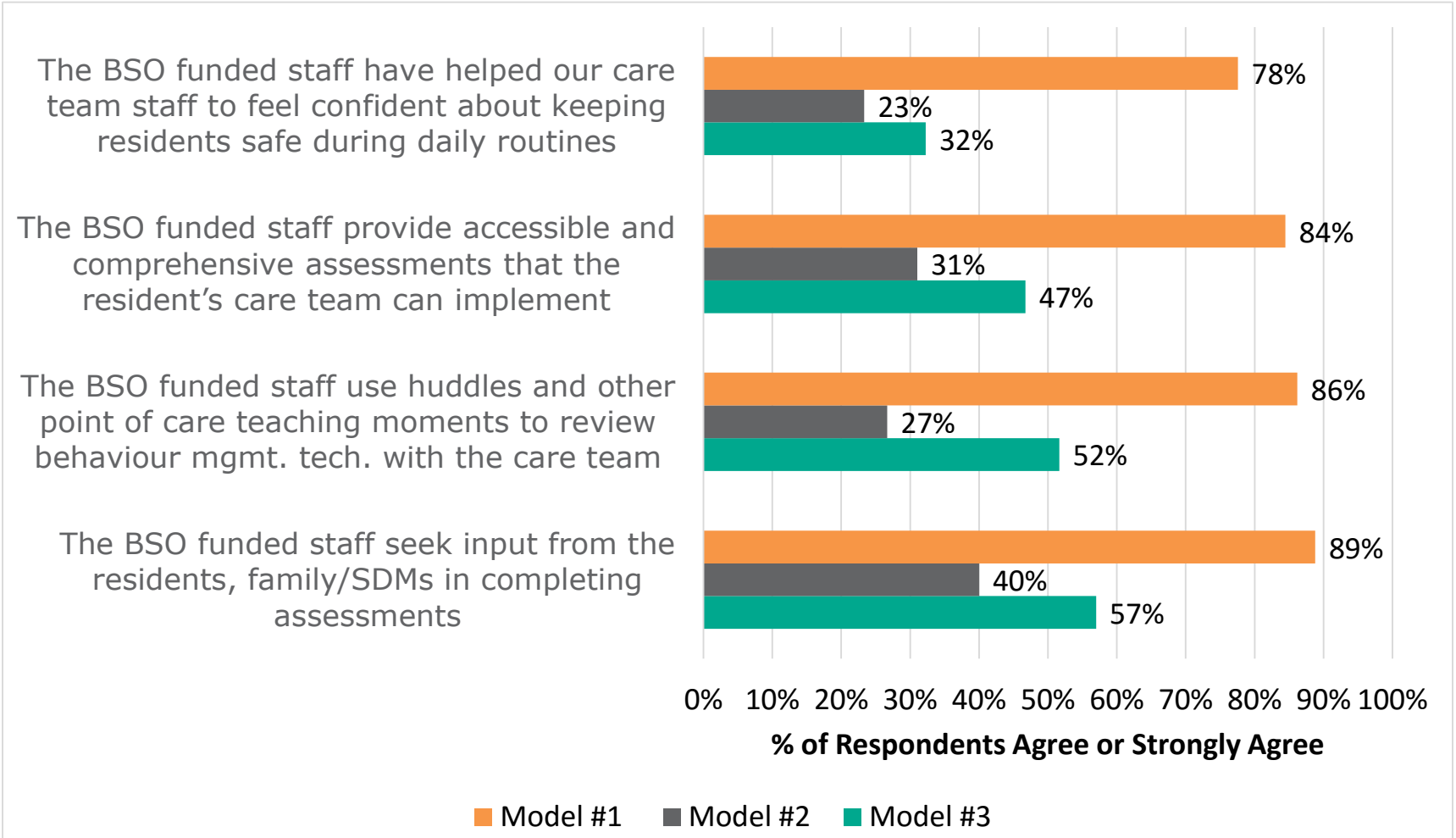
Findings: Care Planning and Provision



Findings: Collaboration and Team Building



Findings: Collaboration and Team Building – Continued



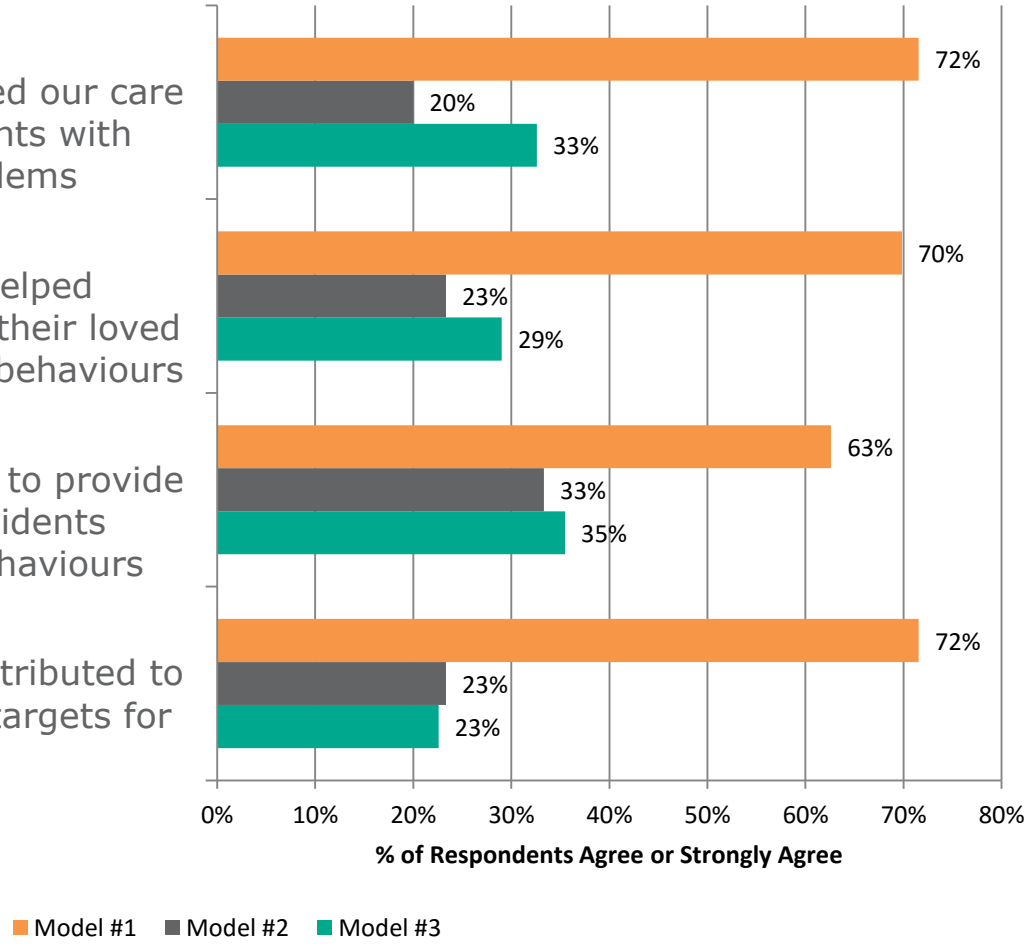
Findings: Home-Level Resident Outcomes

The BSO funded staff have helped our care team to better manage residents with chronic mental health problems

The BSO funded staff have helped families/SDMs better understand their loved one's challenging and responsive behaviours

The BSO funded staff are able to provide timely assessments of residents experiencing challenging behaviours

The BSO funded staff have contributed to the care team meeting its QI targets for worsened behaviour



General Findings

- Almost 3 years after implementation, staff directly involved in ensuring the safety and comfort of residents have strongly indicated their belief/opinion that the in-home model outperforms the mobile teams across all key measures related to care planning, provision, collaboration, team building and home-level outcomes.

- In-home model of BSO funding most closely approximates the quality goal of "consistency of care."

- In-home BSO staff are likely better placed to promote and sustain practices supporting person-centred care and change the culture from a focus on carrying out custodial tasks to a focus on integrating the resident and/or their family into directing care than mobile teams.

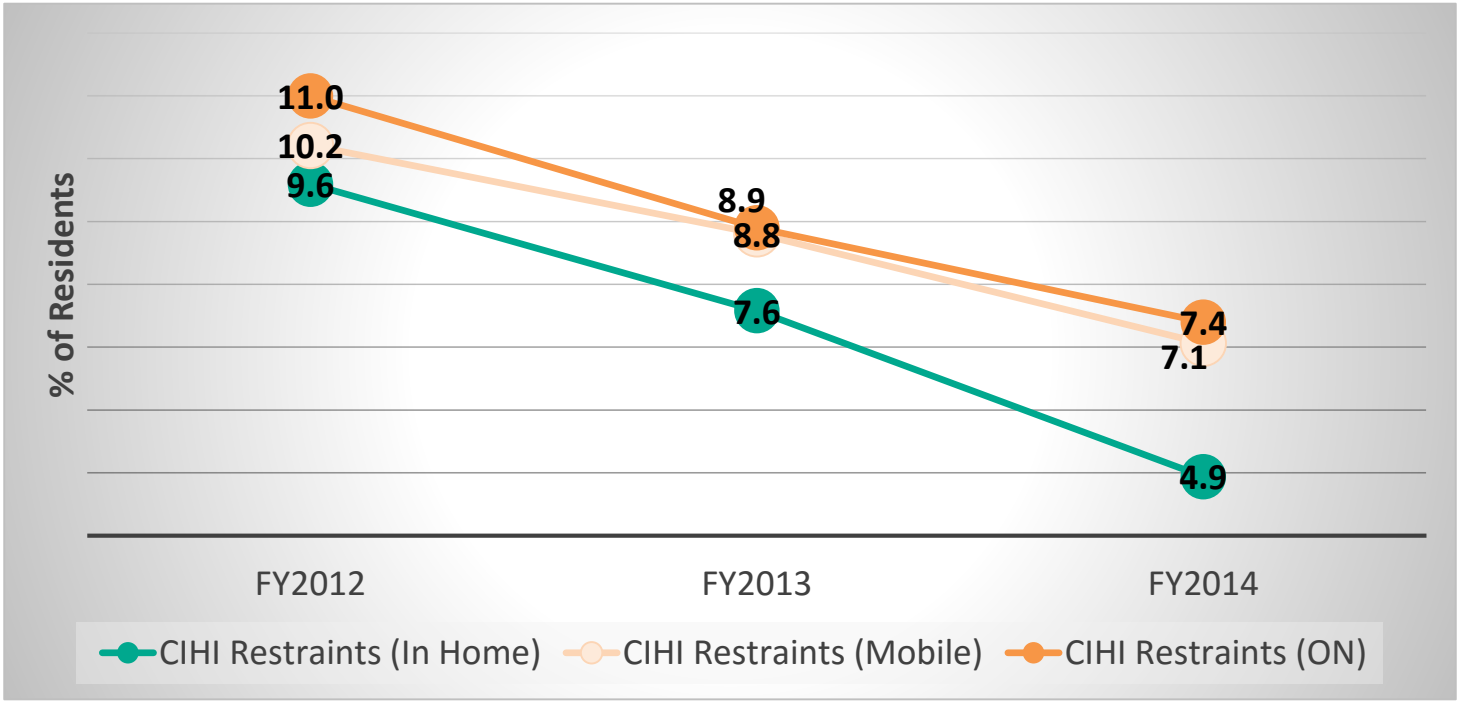
Deeper Analysis: Home-Level Findings

- We identified 3 LHINs where in-home BSO programs have been implemented (MH, CW, and WW LHINs – 87 homes) and 5 LHINs where mobile BSO programs have been implemented (NSM, HNHB, Central, TC, and SE = 235 homes).

- Analysis looks at a comparison of the performance of these two groups of homes using the CIHI indicators (restraints and inappropriate antipsychotic use), and a weighted average of MDS 2.0 aggressive behaviour scores (ABS) over the period from FY2012 to FY2014.
  - Significance testing was completed for FY2012 and FY2014 for the two CIHI indicators: use of restraints and potentially inappropriate use of antipsychotics.

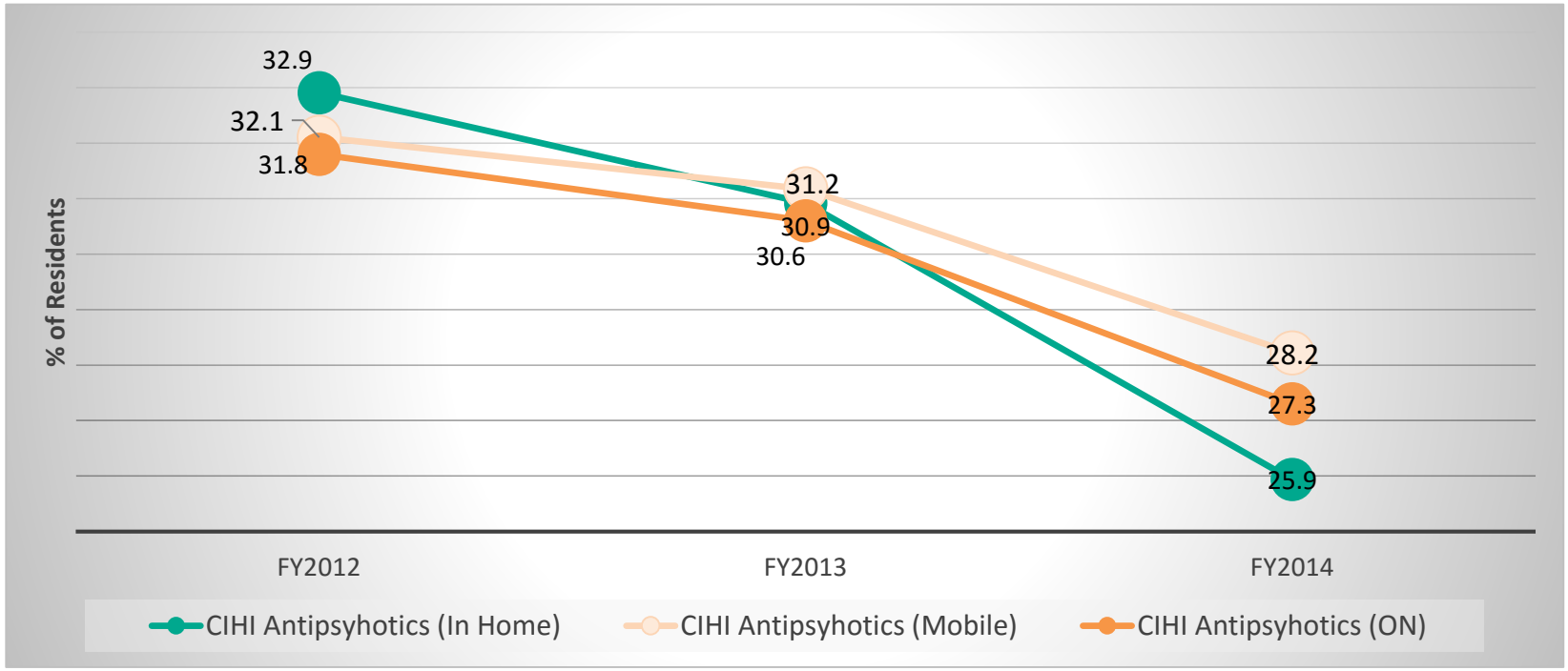
Note: Analysis does not provide or describe why there are differences in the performance of these two programs and is limited to the above LHINs and homes.

CIHI Indicator: Restraints Use in LTC



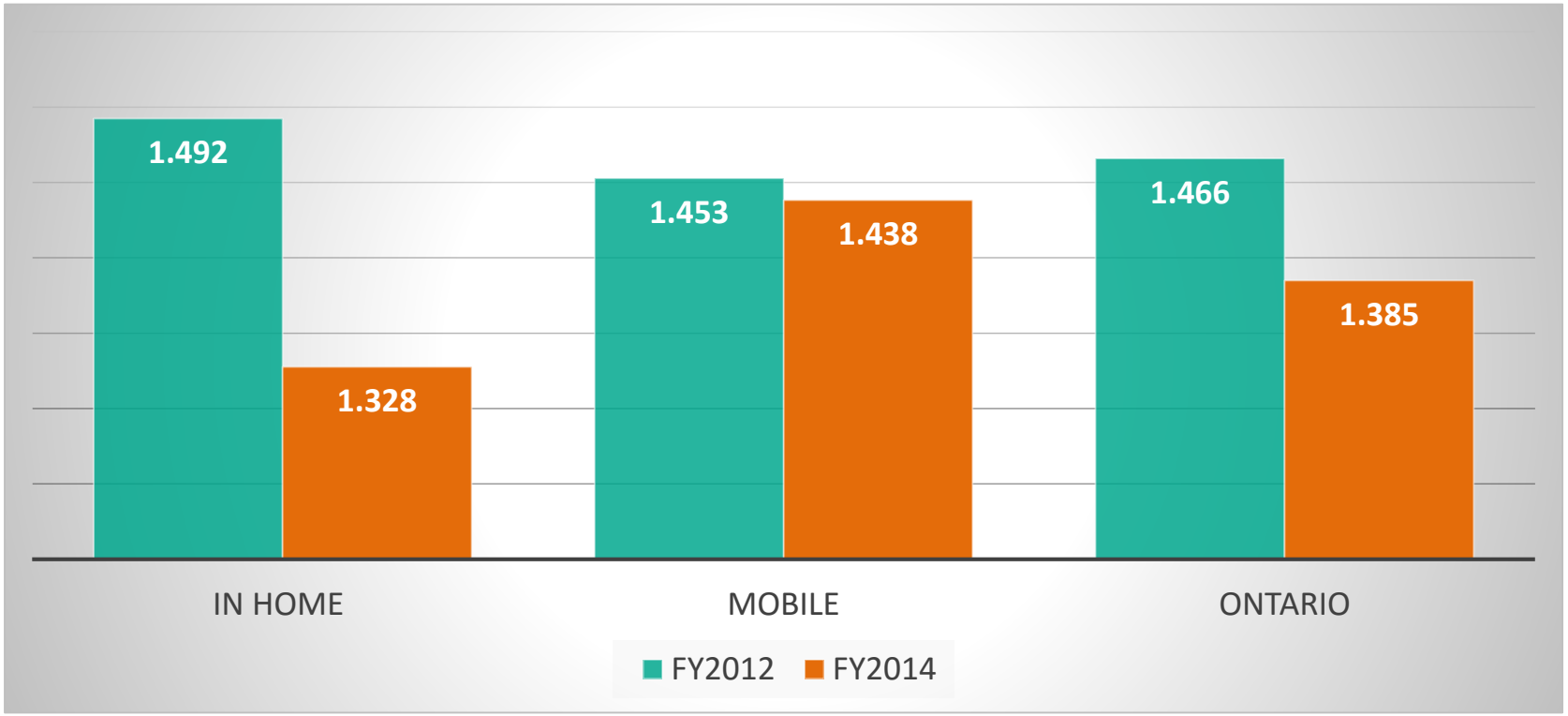
- Although there were no significant difference in the restraints indicator in FY2012 between the mobile BSO team homes and in-home BSO team homes, they were significantly different in FY2014 ($p<0.05$).

CIHI Indicator: Potentially Inappropriate Use of Antipsychotics in LTCH



- Although there were no significant differences in the antipsychotics indicator in FY2012 between mobile BSO team homes and in-home BSO team homes, they were significantly different in FY2014 ($p<0.05$).

Weighted Average Aggressive Behaviour Score (ABS)



*Calculated based on internal analysis of LTC Resident's RAI MDS assessment. ABS range from 0 to 12 where 0= no aggressive behaviour to 12 = very severe aggressive behaviour.

- There were significant differences in weighted average ABS between mobile BSO team homes and in-home BSO team homes in FY2014 ($p<0.05$).

Percentage of Resident Assessments with ABS of 6 or More

*Calculated based on internal analysis of LTC Resident's RAI MDS assessment. ABS 6 or more indicates very severe aggressive behaviour

The Success of In-Home BSO: A Case Study

- In this home, more than 45% of residents were on antipsychotic medications just two years ago.
- A part-time BSO team was funded in the home, who created 4 "stations" with activities that residents could explore daily to provide stimulation, reduce restlessness:
  - Dresser and mirror in lounge area with scarves, bracelets, hats (mainly females live in this unit), to provide tactile stimulation and familiar activity.
  - Nurses' station is decorated with framed album covers and hosts music area featuring music from decades past.
  - Dining hall has selection of Montessori items, such as books, sorting items, lacing cards, etc., to keep residents busy while waiting for meals.
  - Doll nursery was developed with opportunities for residents to bathe, care for and dress dolls, gaining unmet needs: Doll Therapy.

The Success of In-Home BSO: A Case Study

- This home's BSO team also develops behavioural management strategies for individuals:
  - They work with residents and families to identify triggers of challenging behaviours and then work with staff to develop and implement approaches to reduce or eliminate residents' distress.

- As a result, within one year of the BSO team's arrival:
  - Antipsychotic medications were reduced by almost 50%.
  - Residents have been experiencing and exhibiting much lower rates of agitation, restlessness and conflict.
  - Culture of the home has completely changed – now much more proactively resident-centred.

Good News for Long-Term Care

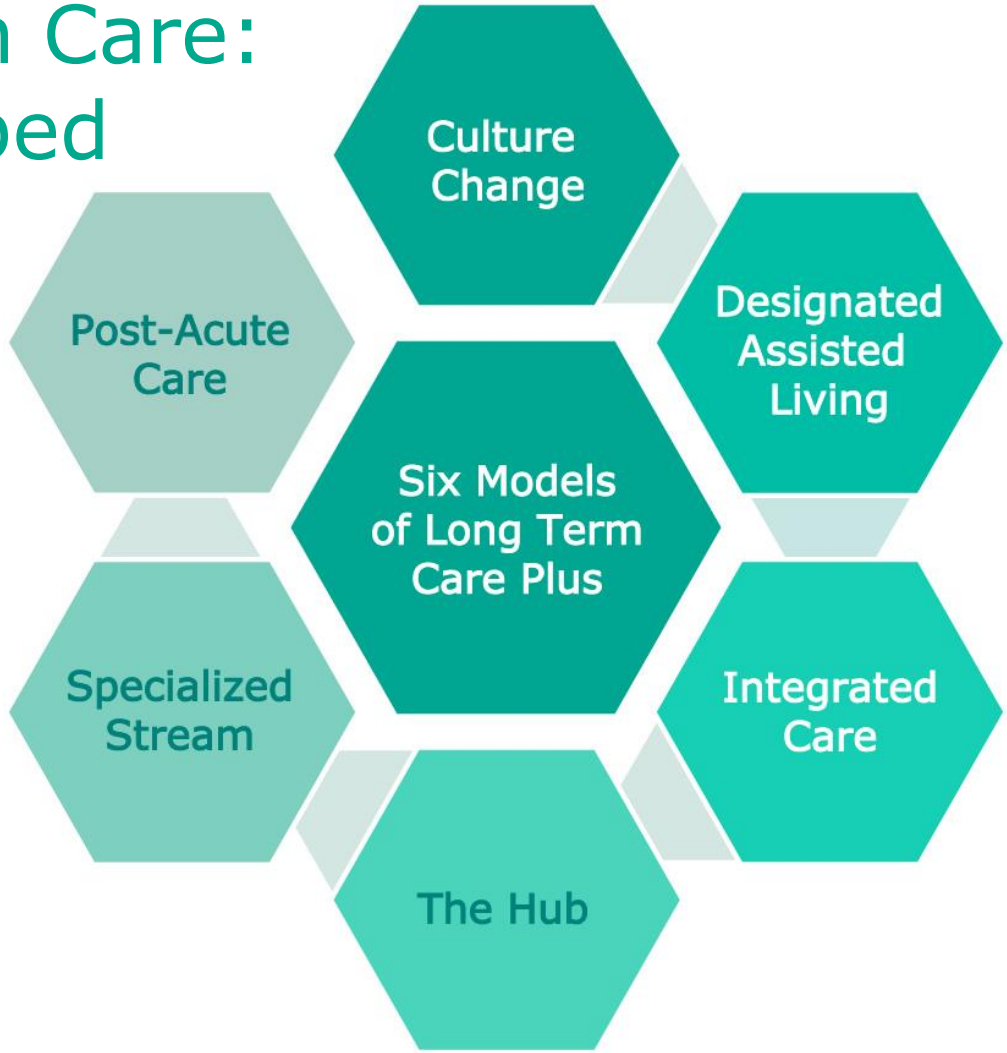
- Our support for the government on its existing BSO program, combined with our research data and analysis, showed a need for more specialized supports for residents in long-term care.

- In response to the Association's research and ongoing advocacy efforts, the 2016 Ontario Budget provided for new investments in BSO, of $30 million over the next three years ($10M annually).

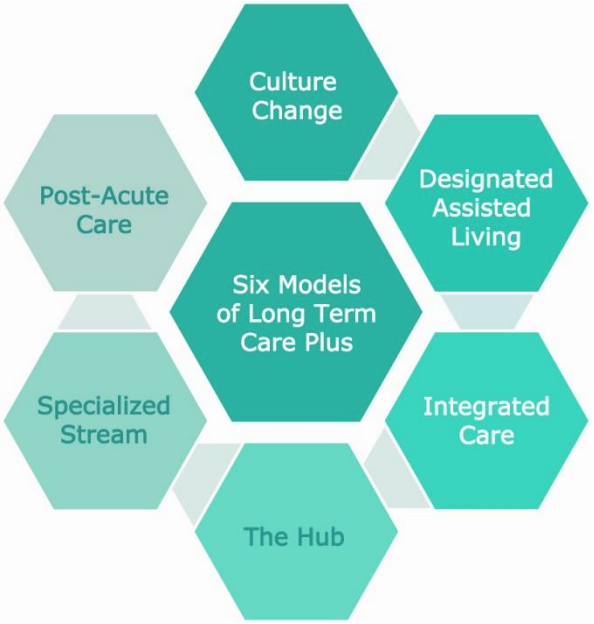
- Different stakeholders have different views as to how these funds should be spent; the Association is awaiting the funding letters to provide confirmation and clarity as to how the funds will be allocated.

- We believe future funding increases in long-term care will be geared toward specialized populations, focusing on the specific type of residents we are serving, rather than general funding increases.

Long-Term Care: An Untapped Resource



Long-Term Care *Plus*



SPECIALIZED STREAM MODEL

- A higher level of care for populations with special needs.
- Includes those with late stage dementia, severe mental illness and addictions, and those at end-of-life.
- Offers a blend of medical and social care, with an emphasis on specialized care, pain and symptom management, quality of life, and family support.

Long-Term Care *Plus*

POST-ACUTE CARE MODEL

- Short-term intensive nursing and rehab care for medically complex and injured or disabled older adults.
- Follows a hospital stay.
- Focus is on stabilizing or improving the person's condition so they could return home.

Long-Term Care *Plus*

THE HUB MODEL

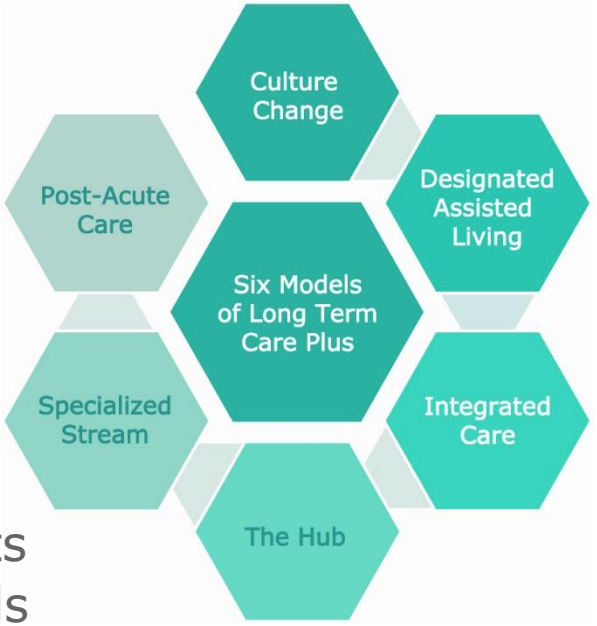
- Long-term care home is the centre for delivery of a wide range of seniors' services, some located in the home and others managed by the home.
- Could include primary care, chronic disease management, rehabilitation, adult day/night programs, and specialized geriatric services.
- Particularly well-suited to homes in smaller communities or rural and northern areas.

Long-Term Care *Plus*

INTEGRATED CARE MODEL

- Many long-term care providers also offer seniors' housing for older adults with varying levels of functioning.
- Providers that currently have these continuums of care could offer a variety of integrated health care and support services for seniors.

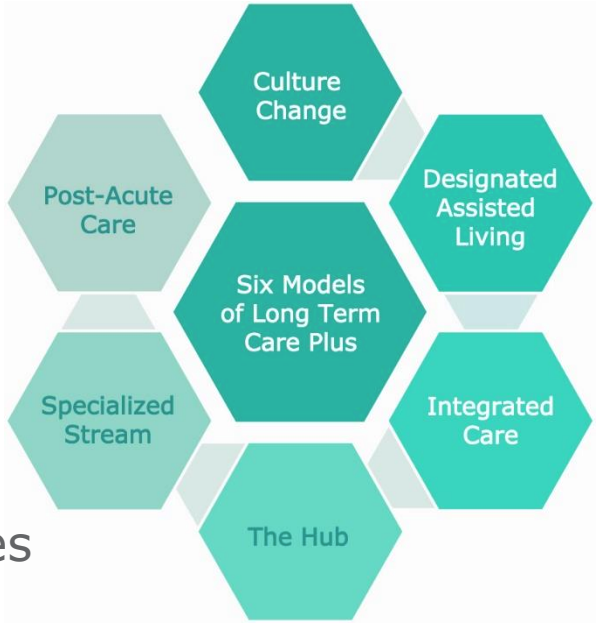
Long-Term Care *Plus*



DESIGNATED ASSISTED LIVING MODEL

- Long-term care homes are caring for residents with much higher physical and cognitive needs than even five years ago.
- Seniors with a lesser degree of physical and mental frailty need a protected environment where they can live independently with assistance and publicly funded services.
- Providers with excess capacity in retirement homes could designate units or floors within those buildings as supportive living hubs eligible for publicly funded services.

Long-Term Care *Plus*



CULTURE CHANGE MODEL

- Resident needs, interests, and lifestyle choices are at the centre of care.
- All residents, including those with dementia, participate in decisions about their care and surroundings, and exercise autonomy over their day-to-day lives.

HOME CARE/ COMMUNITY SUPPORTS | LONG TERM CARE | HOSPITAL CARE

DISCUSSION DRAFT

LONG TERM CARE HOMES: AN UNTAPPED RESOURCE

Putting Patients First with Long Term Care *Plus*

CDNs LIVING LONGER with chronic diseases and dementia

More than **23,000** on the long term care wait list

40% of ALC patients are waiting for long term care

AVERAGE COST PER DAY 2011/2012

$556: In the hospital, awaiting placement (Alternate Level of Care)

$510: Complex Continuing Care

$153: Long Term Care

33.3% of informal caregivers who are supporting home care patients expressed feelings of distress, anger or depression or were unable to continue providing care

In Ontario there is only one type of long term care home, offering 24-hour nursing and personal care. This model is not flexible enough to meet the needs of government, system partners, or the people who need care.

A Long Term Care (LTC) Expert Panel recommended six models of care that would correspond with the current needs of Ontario's seniors. All of these options can be applied as needed in each region to relieve system pressures and improve care for seniors.

POST-ACUTE CARE. Long term care homes would specialize in short term intensive nursing and rehab care for medically complex and injured or disabled older adults following a hospital stay. A team of health care professionals would focus on stabilizing or improving the person's condition so they could return home.

SPECIALIZED STREAM. These long term care homes would provide a higher level of care for populations with special needs including those with late stage dementia, severe mental illness and addictions, and those at the end of life. They would offer a blend of medical and social care, with an emphasis on specialized care, pain and symptom management, quality of life, and family support.

THE HUB. The long term care home would be the centre for delivery of a wide range of seniors' services, some located in the home and others managed by the home. Services could include primary care, chronic disease management, rehabilitation, adult day/night programs, and specialized geriatric services collaboratively delivered with hospital and community partners. This model taps into existing LTC programs and services, and centralizes care and expertise. It is particularly well suited to homes in smaller communities or rural and northern areas.

INTEGRATED CARE. Many long term care providers also offer seniors' housing for older adults with varying levels of functioning. In many cases, this housing is co-located with the long term care home. Homes that currently have these continuums of care with an established population, or within a defined geographic area, could offer a variety of integrated health care and support services for seniors.

DESIGNATED ASSISTED LIVING. In the last few years, long term care homes have been caring for residents with much higher physical and cognitive needs than in the past. Seniors with a lesser degree of physical and mentally frailty still need a protected environment where they can live independently with assistance. Organizations with excess capacity in retirement homes could designate units or floors within those buildings as supportive living hubs eligible for publicly funded services.

CULTURE CHANGE. Resident needs, interests, and lifestyle choices are at the centre of care. All residents, including those with dementia, participate in decisions about their care and surroundings, and exercise autonomy over their day-to-day lives.

These models may require additional staff, equipment and training, a different mix of staff, or changes to the physical environment — but they are all possible.

The right care at the right time in the right place for the right cost. BETTER CARE. Happier residents and families.

IMPLEMENTATION of MODELS WILL:

Put patients first and improve quality

Simplify consumer choice and improve access and accountability

Improve coordination and access to community-based services for older adults

Reduce unnecessary hospital visits and readmissions

Reduce the cost of post-acute care

ONTARIO LONG TERM CARE ASSOCIATION

Shaping the future of long term care.

Thank you

Questions?

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