HNHB LHIN
Behavioural Supports Ontario
Transitional Lead Program Update

St. Joseph's Villa LTC Home

June 27, 2017

Objectives

- Describe who are the Transitional Leads
- Who do they serve?
- Describe BSO LTC Transitional Lead (TACT model)
- How can they work best with community partners?
- Q & A, Open Discussion

Transitional Lead Positions

- Positions that support clients in community waiting for LTC placement with cognitive impairment and high risk responsive behaviours
- Regulated Health Professionals, 6 FTE total for LHIN
- Expertise, training, and skills in complex geriatric patient populations, comprehensive behavioural assessment and care planning, as well as teaching and leadership skills
- LHIN distribution:
  - 2 Niagara
  - 2 Hamilton
  - 1 Brant Haldimand Norfolk
  - 1 Burlington
- Will help fill a gap for clients awaiting crisis in community and help LTCHs better prepare and plan for admission of resident

Target Client Population Transitional Leads Will Serve

- Crisis Priority Ranking Score ≥ 3 (scoring for LTC admission)
- Category 1 in LTC placement *(estimate over 400 clients at any one time)*
- Target clients for this type of support will be considered based on: Physical & Verbal Behaviours, Socially Inappropriate, Diagnosis, Age, Substance Abuse, Social/Occupational History
- Referrals will be initiated by CCAC LTC Placement Coordinators but can be initiated by others

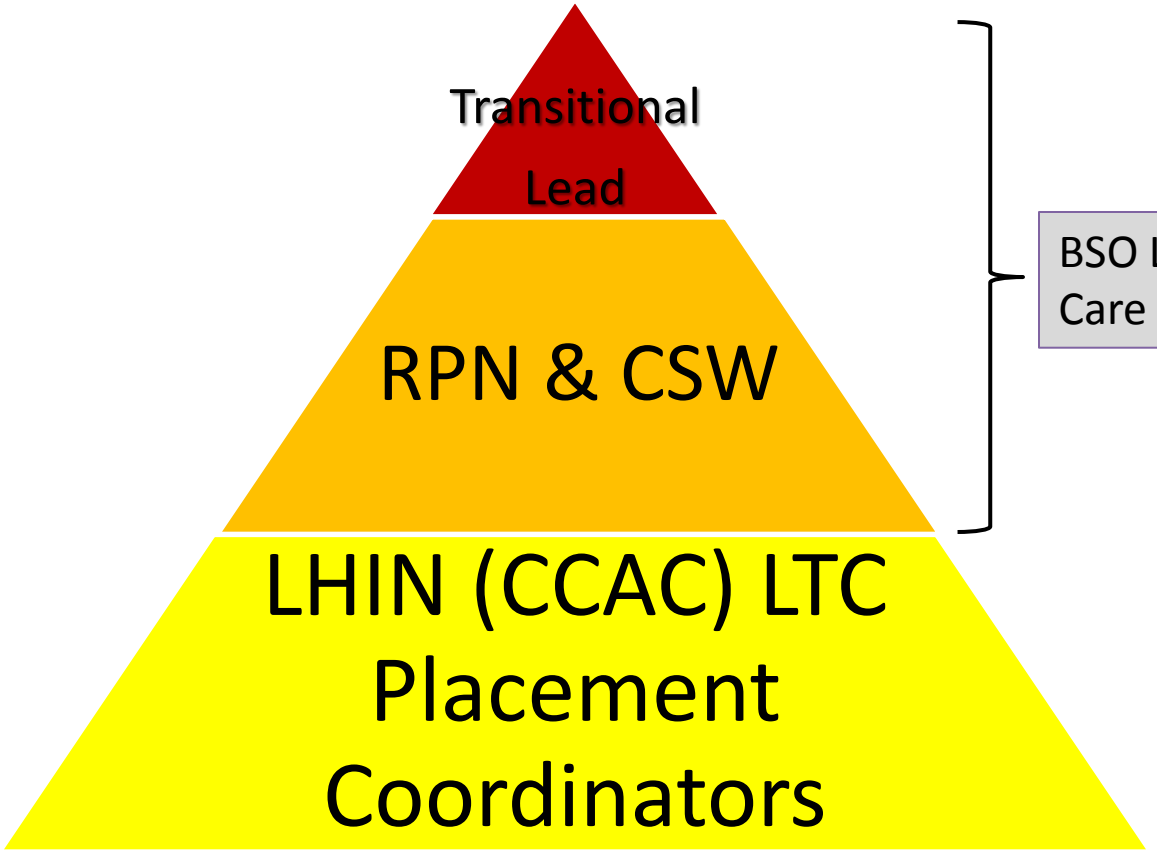
Who Leads the Transition into LTC?

High Risk transition:
- Physically RBs
- Verbally RBs
- Socially inappropriate

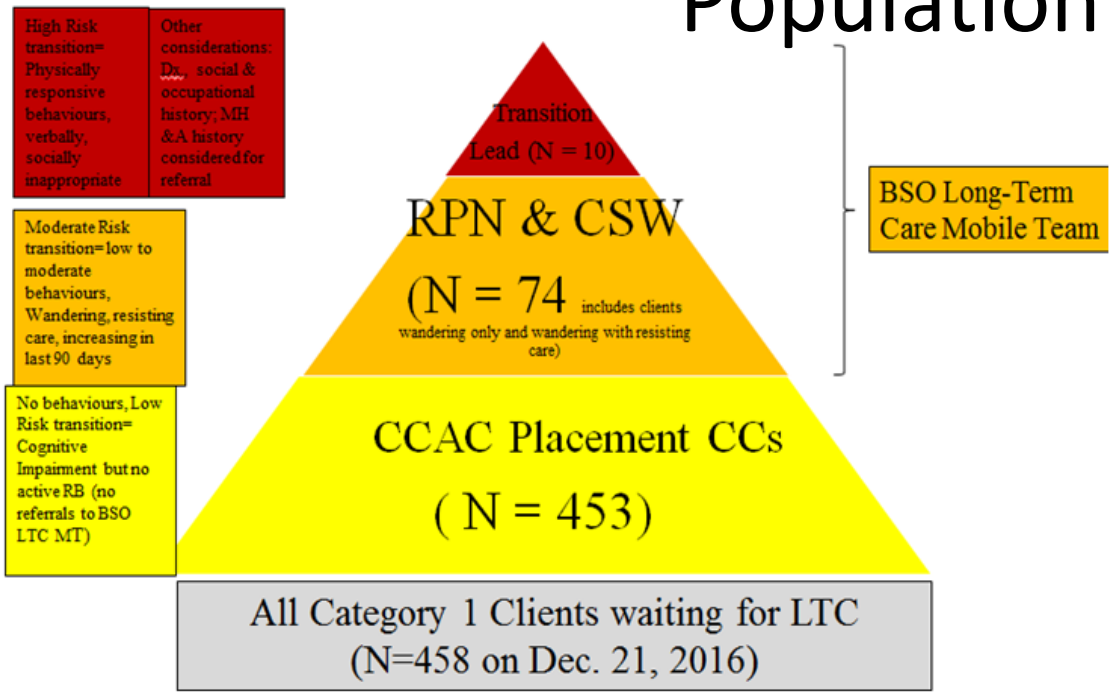
Other considerations:
- Age, Diagnosis, MH, substance misuse hx
- Social & occupational history

Moderate Risk transition:
- Wandering
- Resisting care
- Increasing behaviours in last 90 days

Low Risk transition:
- Cognitive Impairment but no active RB (no referral to BSO LTC MT)



Snapshot in Time of Target Client Population



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Transition Support to LTCHs by BSO Programs

Low to moderate risk clients: BSO LTC Mobile Team

- Arrive day of admission or soon after
- Spend additional time supporting resident and family to ease transition into new home
- Complete "All about me" tool, as well as PIECES assessment
- Put a behavioural care plan in place and discharge 2-4 weeks post admission to LTC if no concerns noted

High risk clients: BSO Transitional Lead

- Start assessing and planning for transition weeks before admission
- Collaborate and learn what is working well from providers in community, primary and speciality care, and develop a behavioural plan
- Facilitate a 'best match' for resident with family, HNHB LHIN and LTC
- Support day of transition to LTC and minimum 6 weeks post-admission
- Intensive support offered by BSO LTC MT as determined in Transitional Care Plan

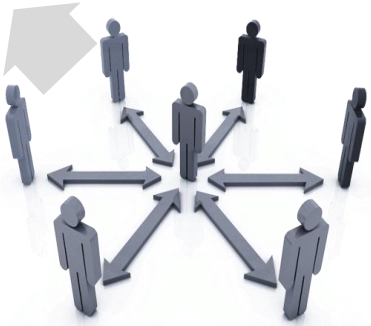
Hamilton Niagara Haldimand Brant Behavioural Supports **Ontario**
Soutien en cas de troubles du comportement en **Ontario** de Hamilton Niagara Haldimand Brant

BSO Support for High Risk Transitions

Transitional Lead Role

FINAL Version

Pull in resources to stabilize client



Transitional Lead works with community , primary care, and specialist care providers

Transitional Care Plan (TCP) is developed and shared with LTC Homes

Ongoing communication with LTCH staff, LTC partners, resident/SDM

Engagement of BSO Mobile Team; intensive support for resident first 6 weeks post admission

Support to avoid "Transition out" of LTC

PRE-ADMISSION TO LTC (*minimum 2 weeks, max. 4 months)

- Collaborate with client, family, SDM through face-to-face visits in the home from point of referral from CCAC
- Provide behavioural strategies to optimize client while waiting
- Collect medical, behavioural care plans, and other pertinent information from primary care , specialized geriatrics, health and social service partners, etc. who have supported the client and family in the community
- Conduct complex case conference with partners, ICL & LTC
- Analyze care plans, medical, cognitive, psycho-social, medication history to develop a collaborative "*Transitional Care Plan*" (TCP) that builds on clients' strengths
- Conduct on-site visit to LTC to discuss plan and prepare for admission

* Pre –Admission timelines are approximate

POINT OF TRANSITION

- Support transition to the greatest extent possible including support in the client's home (as needed/supported) on transition day, present for admissions at the LTC home
- LTC home aware of TCP, including medical, medications, and behavioural strategies
- Support for resident/family as required

POST-TRANSITION (minimum 6 weeks)

- Electronic documentation of assessments, recommendations, progress notes each visit
- Ongoing communication with LTCH, LTC partners and resident/SDM
- Work with BSO LTC Mobile Team & LTC behavioural champion to test behavioural strategies in LTC setting; model successful strategies with LTC staff
- Transitional Lead attendance at 6 week admission family meeting
- Support to avoid transition out of LTC

How this new support may impact clients in community?

- While awaiting LTC bed offers:
  - TLs will work with community, outreach, ICL partners to support high risk clients and further support clients and families to receive intensive behavioural management before entering LTC
  - More pre-planning with LTC homes to ensure “best match”

Areas of Opportunity

- How can Transitional Leads work with your teams to collaboratively:
  - support the client while in community?
  - reduce risk of behaviours causing an avoidable ED visit/hospital admission?
  - ensure plans of care follow the client into LTC setting?

QUESTIONS?