A Behavioural Health Program in LTC

St. Joseph's Health Centre, Guelph

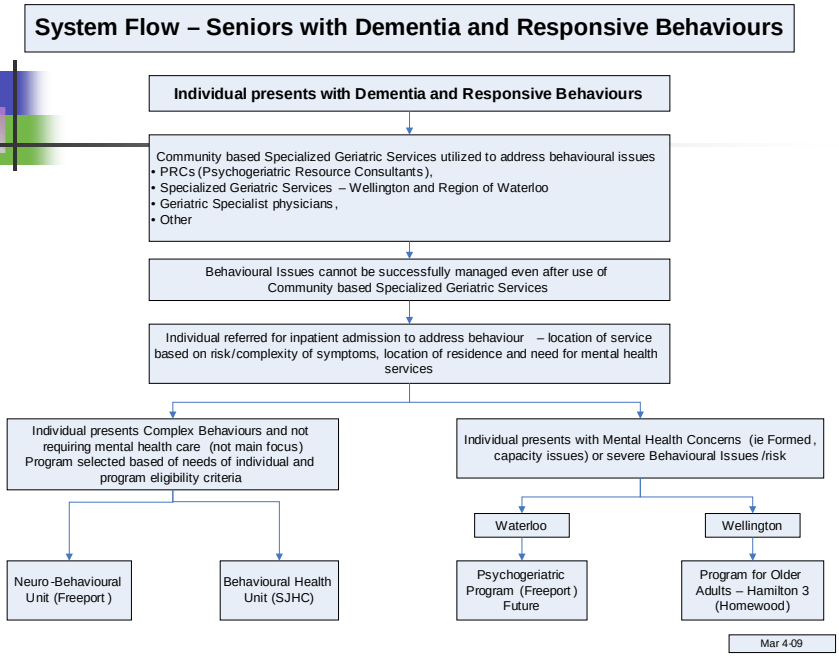
April 27, 2009

Background

- Program to address a gap in the current provision of services for individuals with dementia and disruptive behaviours
- Proposal development funded through 2008/09 Aging At Home dollars
- Program proposal submitted April 2009
- Proposed implementation within 96 LTC bed expansion to be opened Fall 2010

What is the Behavioural Health Program?

- A time limited assessment and treatment program for individuals with a diagnosis of dementia and disruptive behaviours
- Provided in a 16+16=32 bed LTC setting (SJHC, Guelph)
- Part of a continuum of services from community based specialized geriatric services to services provided in an inpatient mental health setting



Behavioural Health vs. Specialized MH Bed

Individuals with the following would require *Specialized Mental Health Inpatient services*

- Individual designated on a Form 1 under the Mental Health Act or at moderate-high risk of harm to self or other
- Individuals needing to be under Mental Health Act for protection of rights such as an individual with questions regarding capacity
- Behaviour that is more frequent, intense or unpredictable (i.e. very agitated)

Admission Criteria

- Eligible for LTC placement;
- Diagnosis of dementia;
- Medically assessed with medical needs that can be managed in the program;
- Behaviours that cannot be managed in current environment;
- Behaviours are complex in nature and require specialized management and resources
  - assessed in terms of predictability, intensity/severity, frequency and level of risk.
- Community based specialized geriatric resources used to assist in management without success
- Resident of WWLHIN catchment area.

Discharge Criteria and ALOS

- Behaviours have been stabilized for a defined period of time (typically last 4-6 weeks of a total 90 day LOS)
- Behaviours can be managed in the community or LTC home
- ALOS is expected to be ~90 days

Transition Support

- Transition Support RN works with LTC to facilitate transition to LTC or community
  - Work with staff in LTC
  - Transfer behaviour management plan (electronic)
  - Follow-up support
  - Access consultation as needed
- Pilot use of Videoconferencing in 3 LTC homes

Keys to Success

- Staff Selection/Training– critical to ensure training and skills to work with this population
- Specialized Resources - Nurse Practitioner; Geriatric Psychiatrist; Transition Support RN
- Transition Support at discharge
- Collaboration with community partners (LTC, CCAC, acute care, mental health, community)
- Maintain flow through service

Issues Encountered

- Pressure to accept individuals with any behavioural issue not just when associated with dementia
  - Needs/treatment of other behaviour populations may not/does not fit well with dementia group (eg ABI, mental health, developmental delay)
- Hold Bed or Priority Return
  - Balancing LTC rules, need to maximize beds, access to secure beds (especially in rural areas) and need to limit moves for resident

Issues Encountered (con't)

- Determining distinctions in care between different parts of the system
  - 'cut-off' points between various providers
- Placement of individuals who cannot return to regular LTC home
  - Need to ensure beds don't become blocked
- Role of program vs role of community based resources such as PRC in prevention
- Lack of published literature on this type of unit