Behavioural Supports Ontario
Final Implementation Report

Including Q4 2012/2013
(Period January 1 through March 31, 2013)
“By engaging primary care practitioners on the basis of their needs, by offering tangible solutions to better support their patients, and by connecting them with appropriate, meaningful and patient-centred resources, not only improves the care of older adults with complex care needs, it also integrates primary care as partners in the provision of care.”

- Dr. Andrea Moser, BSO Medical Lead, Central LHIN
Introduction

Behavioural Supports Ontario (BSO) exists to enhance services for older people with responsive behaviours linked to cognitive impairments, people at risk of the same, and their caregivers; providing them with the right care, at the right time and in the right place (at home, in long-term care or elsewhere).

Through development and implementation of new models designed to focus on quality of care and quality of life for this vulnerable population, a $40 million provincial BSO investment allows local health service providers (HSPs) to hire new staff-nurses, personal support workers and other health care providers, and to train them in the specialized skills necessary to provide quality care to these residents/clients.

Client-centered and caregiver-directed care where...

- Everyone is treated with respect and accepted “as one is"
- Person and caregiver/family/social supports are the driving partners in care decisions
- Respect and trust characterize relationships between staff and clients and care providers.

Supporting principles bring these concepts to life for those making daily decisions about care:

- Behaviour is communication
- Diversity
- Collaborative care
- Safety
- System coordination and integration
- Accountability and sustainability

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Transitions

BSO has been a project of transitions. It grew from a simple but profound concept: by coming together, in collaborative fashion, we could invent a better system of care for a population in need. Then it transitioned from conceptualization to development, adding new supporters along the way. So it is again, that together we face a transition from implementation to sustainability. As a project, this is BSO’s final report. As a catalyst for change, the best of BSO is yet to come.

Already our efforts have resulted in tens of thousands of client contacts across the province, giving clear proof that the project’s emphasis on delivering person-centred, high quality care is firmly entrenched. At BSO’s Sustainability Forum you took well-developed plans and strengthened them, making them more focused and more effective. As a result, our ability to sustain and build on our gains has grown exponentially. But the best-made plans are only as effective as they are well executed. It comes down to leadership and we all have a role to play moving BSO Sustainability Plans into action.

BSO cannot lose sight of high quality, patient-centred care. We must continue to break down barriers, encourage collaborative work and to seek out and partner with new and emerging stakeholders; to provide consistent, person-centred, high quality care by expanding across multiple sectors. We must continue to align and leverage our work with new and existing initiatives including bestPATH, Health Links, Ontario’s Seniors Care Strategy and the Long-term Care Task Force on Resident Care and Safety.

While we don’t have all the answers for the challenges we will encounter, I know the track record of our team and I am confident we will move forward with continued focus, commitment and resolve. We can be proud of what we already achieved and what is yet to come. BSO’s impact is radiating across all sectors of the health system, catalyzing service change across the province and in every care setting. This is where you can truly begin to dream of endless possibilities.

I want to thank each and every one of you for your incredible effort to date. It has been nothing short of remarkable. Your passion and dedication is inspiring, and I so look forward to the road ahead and the journey we will take together.

Donna Cripps
CEO, Hamilton Niagara Haldimand Brant
Local Health Integration Network (HNH LHIN) &
BSO Project Sponsor
Executive Summary

From January 1 to March 31 2013, BSO continued to enhance services for older people at risk with complex health needs and responsive behaviours due to or associated with mental health, addictions, dementia or other neurological conditions; and their caregivers.

This report is organized in three main sections - Project Overview, Quantitative outcomes and Qualitative outcomes. Together they describe BSO’s current state as of March 31, 2013.

During the current reporting period, CRO spread information, knowledge and awareness about the project through a variety of channels. The project also aligned with key provincial initiatives that also target older adults at risk, including Ontario’s Seniors Care Strategy and Health Links. AKE and CRO helped LHINs develop practical steps toward alignment with these two complementary initiatives.

LHINs made a clear move from implementation to operationalization of their action plans and evidence that BSO is making a difference is accumulating from a variety of data sources. Activity tracking, as well as success stories from all LHINs highlight patient-centred care and demonstrate success across all three pillars of care. The BSO Final Evaluation Report reinforces this impact and sheds greater light on our understanding of the how the BSO target population currently interacts with the health system and early evidence of the impact of BSO services and supports on these numbers.

The major focus of this quarter was on planning for sustainability and spread of BSO success. Supported by the CRO, PRT and the AKE, local project teams developed comprehensive LHIN sustainability plans to guide their activities in the coming months. In addition, collaborative measurement and evaluation strategies will ensure that the impact of BSO on mental health, service demand and overall health outcomes for the BSO target population is collectively understood.

As project funding concludes local project teams, linked through the provincial BSO Operations Table, will assume full responsibility for BSO leadership, reporting and sustainability.

The accelerated pace of change and demonstrated success of the BSO Project did not happen by accident. It was the result of the Ministry of Health and Long Term Care, project sponsors, project partners, LHINs, local project teams, provincial and local stakeholders all making a collective commitment to the vision of a better future.

Priming Primary Care

Uncertain, uninformed and, more often than not, people worried about seeing a change in their behaviour and their families generally turn to their family practitioners for answers. But for family practitioners those answers are hard to come by as they find themselves walking down similar uninformed and uncertain paths. With BSO sustainability and HealthLinks top of mind, the Central LHIN is reaching out to engage primary care and bridge this known gap.

In a recent survey of primary care providers across the Central LHIN, it was reported that they often feel ill-equipped to provide specific behavioural assessment or treatment interventions related to psychogeriatric needs. They are also ill-equipped to point patients and their families in the right direction to find the proper help/resources.

Dr. Andrea Moser, BSO Medical Lead and Patti Reed, BSO Program Manager have been directly engaging practitioners in their place of work to develop an understanding of their needs, and to provide information about local resources and services that are available to them and their patients. An integral component of current and future capacity building, knowledge sharing and overall BSO spread across the health care sector and community, Dr. Moser has successfully engaged with over 40 primary care providers who are clearly excited about the opportunity to learn as much as they can about the BSO target population.
1.1 Structure

The North Simcoe Muskoka LHIN is funded by the Ministry to lead the Behavioural Supports Ontario Project. Donna Cripps, CEO of the Hamilton Niagara Haldimand Brant LHIN, is the project’s Executive Sponsor.

In partnership with the Alzheimer Society of Ontario, Alzheimer Knowledge Exchange, and Health Quality Ontario, project coordination and reporting is led by the Coordination and Reporting Office. CRO is responsible for the implementation and evaluation of the BSO Project, ensuring consultation, liaison and oversight throughout the current implementation phase.

Committee structure includes...

- **Coordination and Reporting Office (CRO):** this Advisory Committee has oversight on the BSO Project and authority to make project-level decisions.

- **Provincial Resource Team (PRT):** a clinical resource and advisory body for the CRO.
  - **Education & Training SubGroup:** provides resources for the province and LHINs designed to support implementation of BSO Action Plans; notably, capacity enhancement through learning, knowledge transfer and development programs.
• **Fourteen-LHIN Contact Group**: a table for problem-solving and joint strategy among LHINs and the project’s funded partners – CRO, PRT, HQO and AKE.

• **Data, Measurement and Evaluation Committee**: provides strategic direction to the Impact Assessment of the BSO Project’s implementation phase (August 2011 – December 2012). In addition, the Data Committee provides subject matter expertise, strategic direction and recommendations regarding project evaluation to the Contact Group.

• **Communications and Knowledge Exchange Working Group**: provides subject matter expertise, strategic direction and recommendations to Contact Group and the CRO on all matters related to communications and knowledge exchange.

• **Long-Term Care Provider Advisory Council**: a monthly forum for representatives of the Ontario Long-Term Care Association, Ontario Association of Non-profit Homes and Services for Seniors, Ontario Long-Term Care Physicians, the Ontario Association of Community Care Access Centres and the CRO. Members collaborate with BSO on matters related to community and long-term care with the goal of improving support to the BSO population.

• **Operations Table**: The provincial Operations Table for BSO was endorsed as the “go to” resource for providing collective leadership to the BSO initiative at the Sustainability Forum March 19th. The group will consist of operational leads (e.g. Regional BSO Coordinator) from each LHIN who have a direct responsibility for overseeing the implementation of BSO at the local level, BSO Collaborative group Chairs, and LHIN representation. The Operations Table will maintain relationships with the LHINs through both local level connections and the LHIN provincial CEO table, to which the group will provide regular updates and from which they will gather information about LHIN priorities. Collaborative groups will inform and be informed by the work of the Operations Table. An Accountability Structure framework is being developed by the group to help define and guide the various relationships amongst the key stakeholders of BSO.

1.2 **Alignment**

BSO aligns with the current direction and priorities of our Provincial Government. The project is focused on providing the right care at the right time and in the right place.

The BSO Framework supports a wide range of recommendations brought forward in recent research and reports seeking better care, better health and better value.

Key alignments include…

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### Step Back to Step Up

At 85, “Maria” is an immigrant to Canada who’s second language is English, a loving mother and wife. Diagnosed with severe dementia she had been demonstrating a number of significant behaviours including wandering, restlessness, disrobing and hiding undergarments. In addition, Maria was known to sleep in the beds of other residents, hit staff and be resistive to direction, particularly when it came to personal hygiene. The team at Trilogy long-term care home in the Central East LHIN was at a loss and felt too close to the situation. It stands to reason; sometimes you need to step back to step up.

With her ability to offer new perspectives and armed with an array of BSO tools and tactics, Carol Coore, a BSO trained PSW, was able to assess Maria using the Resident Specific Behavioural Tracking Sheet (RSBTS), and to implement a care plan that involved special care conferences, family meetings and team huddles. It was soon revealed delirium was not the root cause of the behaviour. With significant changes to Maria’s medication, initiating Montessori activities and implementing standardized observation procedures the results were nothing short of remarkable.

> “Among her many behaviours, wandering was of particular concern,” said Carol. “Using the Dementia Observation System (DOS) and Behavioural Assessment Tool (BAT), to document the behaviour shift, Maria’s wandering decreased from, on average, 10 to 15 times per day, to less than 1 per day.

Using a gentle approach to disrobing, bathing and eating and taking part in Montessori activities have all helped to virtually eliminate Maria’s behaviours. Caregivers and staff have gained improved awareness of responsive behaviours and an appreciation of the importance placed on tools, collecting data and the support offered through the BSO team in the Central East LHIN.

> “Now I understand dementia better and I can enjoy time with my wife again,” said Maria’s husband. “I don’t have much concern. I have full faith in staff about her care.”
Living Longer... Living Well is Dr. Samir Sinha’s comprehensive report on how to help seniors stay healthy and live at home longer. The result of research and consultations from a broad spectrum of stakeholders, including BSO, recommendations cover health and wellness, social services, and community living for older Ontarians. A final report is expected in Q4.

Ontario’s Action Plan for Health Care includes the following priorities: keeping Ontario healthy, faster access, stronger link to family health care and right care - right time - right place.

The Provincial Budget allocates resources to meet the needs of people living with complex and chronic health conditions (about 1% of the population who consume 34% of Ontario’s health care budget). The target population of BSO is the population identified in the 1% - people living with health challenges, including cognitive, functional and mental illness.

The Drummond Report makes recommendations for those individuals living with complex and chronic health conditions.

The Institute for Healthcare Improvement (IHI) Triple Aim Framework keeps the focus centred on the population’s care needs while working together to achieve better health, better care, better value for the health system supporting this population.

Report of the Long-Term Care Task Force on Resident Care and Safety called for enhanced staff training in responsive behaviours that aligns with the BSO program in Recommendation 8. In addition, BSO directly addresses Recommendations 6 (Develop strong skilled managers and administrators), 13 (Direct-care staffing in Homes) and 14 (Support residents with specialized needs).

Dr. David Walker and Professor G. Ross Baker’s Reports (2011) recommending system redesign to meet this population’s needs. Notably, BSO is committed to improving the capacity for older adults to live independently and reduce readmission rates; thereby resulting in a better care experience for older adults and their families.

“Cross-System Responsiveness to Special Needs Populations - The ministry should support creation of special units/programs in the community and LTC homes for seniors with special needs. Targeted investments should focus on adding new human resources specialized in responsive and challenging behaviours in LTC homes, developing and deploying mobile behaviour teams, and expanding services in the community.” - Walker (2011) / Caring for Our Aging Population

The Midas Touch

Ability to provide weekly personal care (weekly bath) for one resident in LTC went from none/minimal over a period of a 26 weeks without family intervention (100% for 8 weeks) and to 57% in 7 weeks after a BSO intervention put in place by the Outreach nurse.

At a long-term care home in the Champlain LHIN “Juliet” was refusing baths from staff members and difficult to get out of her room. Upon discovery of her unwashed state Joanne, Juliet’s daughter, came weekly to give her mother a bath. While there was complete success over an eight week period, the solution was taxing on Joanne. When the attempt was made to revert back to staff taking the lead on bathing, Juliet’s behaviour returned. Rachida Bouabdillah, Geriatric Psychiatry Outreach Behavioural Support Nurse was brought in to assist.

Rachida learned two important things from Joanne; Juliet had a life-long hoarding habit and second, she was concerned about her finances. Translation; Juliet was fearful of leaving her things in her unlocked / unattended room while bathing and, on the subject of bathing in general, was unaware it was a provided service, one she
1.3 Coordination & Reporting Office

1.3.1 Project-level activities and accomplishments

**January (various)**
CRO, HQO and AKE hosted webinars and coaching calls for 14 local project teams completing BSO Sustainability Plans.

**January 23**
More than 100 callers dialed in for an OLTCA webinar introducing the Capacity Building Suite of BSO learning and development tools.

**February 8**

**February 13**
Approximately 120 researchers and long-term care professionals attended a BSO presentation at OLTCA Research Day. Four local BSO projects were also profiled as research/innovation posters.

**February 22**
PRT webinar (1 of 2): Sustainability Plan review and exchange.

**March 7**
BSO presentation to LHIN CEOs describing Sustainability Plans, ongoing measurement, conclusions from the Hay Group Evaluation of BSO outcomes, and the final project report to MOHLTC.

**March 8**
PRT webinar (2 of 2): Sustainability Plan review and exchange.

**March 19**
All-LHIN BSO sustainability forum in Toronto. The final BSO knowledge exchange event guided local project teams to good ideas from their peers and passed leadership roles to local project teams.

**March 20**
Leading national researchers and clinicians met in Toronto for the behavioural supports National Conversation and to update the BSS guidelines for care. Cooperation with Bruyere Research Institute supports the development of a multi-year academic investigation of BSO impacts.

**March 31**
End of project funding for CRO. Local project teams assume full responsibility for BSO leadership, reporting and sustainability.

1.3.2 New project supports

Legacy Indicators for standardization and reporting – DMEC endorsed a list of 14 “Legacy” indicators for use in all LHINs as a performance management tool and to create a quick reference for LHINs attempting to assess local BSO impacts in future. After discussion at DMEC, the all-LHIN Sustainability Forum and a decision webinar March 27, agreement emerged in favour of five Legacy Measures that would be standardized first for reporting

Right Care… Right Place

Since the BSO program was initiated in his facility Robert Campbell, Director of Care at Leisureworld Tullamore in the Central West LHIN has observed a 50% reduction in Critical Incident Reports being sent to the Ministry of Health over the past year. Escalations to Critical Incident are now being diffused before reaching that point. Notably, Campbell has noted that behaviors, once addressed or witnessed during his daily rounds, have decreased in frequency as well as in severity.

For Campbell one particular resident comes to mind when he thinks of BSO. “Carmen” a 61 year old resident had been in the home for over a year. Her behaviours would escalate to a point where staff had to no choice but to send her to the hospital, unable to cope with the disruptions and safety caused to staff, fellow residents and herself. With the help of BSO Champion Mena Alcoran and PRC Cheryl Graham, Carmen will still escalate, but with successful strategies now in place, staff have eliminated the need to send the resident to hospital.

“I have to thank Cheryl, Mena and BSO for the work they did with Carmen and have since gone on to do with many of our other residents,” said Campbell. “By preventing unnecessary hospital admissions reducing or eliminating the need to transfer our residents to hospital, we are better able to provide the right care in the right place.”

Equally important is that the work environment has improved. “Staff are feeling supported by the BSO program and have built more trusting relationships with our residents,” continued Campbell. “Better educated and informed, they are now able to better help residents, while not getting injured in the process. I am also equally convinced that without continued dedicated resources this initiative will fail. It needs the time and follow through to be sustainable.”
on a Ministry data portal. LHIN Collaborative and Health Analytics Branch will lead the process in Spring 2013 to document all five and launch reporting.

**Final Evaluation of BSO Impacts** – Hay Group Health Care Consultants assessed BSO impacts in four Early Adopter LHINs in a report submitted to CRO on March 31, 2013. Hay Group’s conclusions, methodology and measurement tools will inform future assessments of BSO’s impact. Early Adopters will develop a plan to circulate and promote the consultants’ final report for a wide audience in Spring 2013.

**Sustainability Plans** – LHINs consulted their BSO stakeholders in December, January and February to develop long-term Sustainability Plans for the local behavioural supports effort. CRO and PRT reviewed and endorsed all 14 Plans during all-LHIN webinars on February 22 and March 8. Each Plan is now the blueprint to embed and spread BSO into the day-to-day operations of the LHIN during the project’s next phase.

**Primary Care next steps** – BSO’s November in-person knowledge exchange event identified leading practices and critical service gaps for community-dwelling clients. Several LHINs will attempt to make these changes first with help from CRO, the Alzheimer Knowledge Exchange and the Provincial Resource Team. South West, Waterloo Wellington, Hamilton Niagara Haldimand Brant, Central West, Central, South East, North Simcoe Muskoka and Champlain LHINs met February 21 to discuss local opportunities to coordinate with Health Links.

**Additional PSW funding** – LHINs deployed $3.5M in additional funding for Personal Support Workers (PSWs) in long-term care homes. MOHLTC enhanced its allocation for BSO PSWs in December, restoring the FTE targets described in 2011 BSO funding agreements. CRO and the 14 LHINs requested this enhancement to close the gap between estimated salaries in the original funding formula and actual wage rates. In most LHINs, unspent 2012/13 surplus was used for training costs and training backfill once the full complement of PSWs has been hired.

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**Give Me Space**

At Blenheim Community Village in the Erie St. Clair LHIN, “Kurt” likes his space… sometimes, a little too much. Highly protective, Kurt has been known to become physically abusive to both staff and residents upon entering his room. By extension, he would often refuse care and so, the BSO team was asked to step in and assist.

Mindful of Kurt’s need for space, the team worked with staff to implement a variety of non-psychiatric interventions. “They were the most basic of strategies,” said Jennifer Huys, RN at Blenheim. “But, they were the most effective. They gave him his space, respect and the freedom of choice. Is that not something we all value and need?”

Together, the BSO team and staff made the decision to let Kurt sleep in, allowing him to have continental breakfast as part of his routine. Politeness was encouraged by invoking a “knock and wait” policy that allowed Kurt to invite people into his room. Culturally patriarchal, staff now make every effort to address Kurt before his wife. Stop signs and yellow tape have been placed outside of his room to act as a visual warning for fellow residents who might inadvertently wander in. Other measures include allowing Kurt as much choice as possible, asking permission to provide care and respecting his choice to decline, when providing care having all supplies within reach and ready to use thereby avoiding multiple trips in and out of his room, ensuring consistency of staff, approaching Kurt form the front due to his hearing deficit, and preparing his room for bed while he is in the dining room for supper.

As a result of these basic but important changes, residents and staff are now able to live in harmony. The BSO team was able to focus on behavior instead of resorting to medications that were not warranted, and Kurt has a better quality of life because of it. Kurt has considerably reduced his violent outbursts, is more cooperative and is in a better mood… most days. As a result, other residents are no longer at risk for physical violence. Kurt is more settled and more easily re-directable and notably, staff are no longer afraid of him reducing the risk that kinship would be withheld.
### 1.3.3 Q3 CRO Financial Report

**NSM LHIN Coordinating & Reporting Office**  
**BSO CRO Operations**  
For the Fiscal Year 2012/13

<table>
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<th>2011/12 (6 months)</th>
<th>Q1 2012</th>
<th>Q2 2012</th>
<th>Q3 2012</th>
<th>Q4 2012</th>
<th>2012/13 Total to 31-Mar-13</th>
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<tr>
<td>Ministry Operating Allocation</td>
<td>$500,000</td>
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<td>$166,667</td>
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</tr>
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#### Operating Expenditures:

- **Salary and Wages:**
  - 201,016
  - 88,118
  - 76,940
  - 92,887
  - 91,020
  - 345,054

- **Employee Benefits:**
  - 51,414
  - 18,000
  - 8,920
  - 18,862
  - 51,852

#### Transportation and Communication:

- **Communications (i.e. blackberries, teleconferencing):**
  - 20,000
  - 5,000
  - 5,000
  - 5,000
  - 4,000
  - 21,121

- **Staff Travel:**
  - 2,500
  - 1,572
  - 1,000
  - 812
  - 1,564
  - 5,812

- **Other (transport travel, procurement):**
  - 2,500
  - 1,572
  - 1,000
  - 812
  - 1,564
  - 5,812

- **Subtotal (Transportation and Communication):**
  - 27,500
  - 7,744
  - 6,533
  - 7,004
  - 9,087
  - 31,843

#### Services:

- **Accommodation:**
  - 16,000
  - 6,240
  - 6,300
  - 7,590
  - 6,970
  - 25,990

- **Research Analyst Support:**
  - -
  - -
  - -
  - -
  - -

- **Cross LHIN Funding:**
  - 100,000
  - -
  - -
  - -
  - 100,000

- **Consulting Services:**
  - -
  - -
  - -
  - -
  - -

- **Other Services (Evaluation Consulting):**
  - 20,000
  - -
  - -
  - -
  - 20,000

- **Other Services (Stakeholder Knowledge Exchange):**
  - -
  - 340
  - 323
  - -
  - 1,680

- **Training & Development:**
  - 26,000
  - 2,000
  - 323
  - 6,122
  - 1,000
  - 12,523

- **Meeting Expenses:**
  - -
  - 340
  - 323
  - -
  - -

- **Face to Face Forums - Toronto:**
  - -
  - -
  - -
  - -
  - -

- **Polling and Translation:**
  - 2,500
  - 1,500
  - 75
  - -
  - 4,275

- **Subtotal (Services):**
  - 186,000
  - 18,536
  - 22,532
  - 36,023
  - 210,755
  - 279,666

#### Supplies and Equipment:

- **IT Equipment:**
  - -
  - -
  - -
  - -
  - -

- **Office Supplies:**
  - 1,000
  - 36
  - 125
  - -
  - 262

- **Subtotal (Supplies and Equipment):**
  - 1,000
  - 36
  - 125
  - -
  - 262

**Total Operating Expenditures:**

500,000
116,972
117,982
145,049
325,314
709,297

**Operating Surplus (Deficit):**

0
48,098
48,708
21,617
-77,111
-42,083
1.3.4 LHIN action and sustainability plans

Final, CEO-signed Action Plans and Sustainability Plans are available on LHIN websites.

Central  Central East  Central West  Champlain  Erie St. Clair  Hamilton Niagara Haldimand Brant  Mississauga Halton  North East  North Simcoe Muskoka  North West  South East  South West  Toronto Central  Waterloo Wellington

1.3.5 LHIN sustainability planning

The project phase of BSO will come to a close on March 31st, 2013; however the breadth and depth of BSO has only just begun! To maintain the project’s momentum and success in the long-term, BSO dedicated Q4 to supporting and enabling systematic and specific LHIN level sustainability discussions and planning. This comprehensive process included the following steps:

Dec 2012 - LHIN Sustainability Plan Templates- LHIN leads receive a Sustainability Plan template with instructions about how to complete the plan.

Jan - Feb 2013 - Stakeholder Engagement- LHINs use ministry funding to reach out to and engage local stakeholders in discussions about the strategies and infrastructures needed to support BSO sustainability and spread. Many LHINs use the NHS assessment to guide these conversations.

Jan 2013 - Provincial Knowledge Exchange Webinars- BSO hosts two provincial knowledge exchange opportunities LHIN leads and champions. BSO project staff present to LHINs the key components of a successful sustainability plan. This discussion includes strategies for answering specific questions in the template, as well as opportunities to share innovative approaches to sustainability between LHINs.

Jan 2013 - Sustainability Checklist from PRT- As a follow-up to the provincial webinars, PRT creates a checklist (Fig. 1.3.5 – A) which outlines the key elements to be included in a sustainability plan. This checklist is shared with LHINs to guide their decision making.
Feb 2013 - CRO Review of LHIN Sustainability Plans- CRO reviews each LHIN Sustainability Plan and completes the PRT checklist. Plans and checklists are presented to PRT for their independent review. CRO also prepares a 1-slide summary of each LHINs plan. This summary is used during the online PRT review.

Feb - Mar 2013 - PRT Review of LHIN Sustainability Plans- LHINs join PRT in an online discussion and review of their Sustainability Plan. During this time, LHINs expand on core components of their plan and respond to questions from PRT. Following the call, PRT discusses each plan and moves to endorse all LHIN Sustainability Plans.

Mar 2013 - 10 Steps to Successful Sustainability (PRT Consolidated Review) - PRT consolidates their feedback shared during the review process into one resources entitled 10 Steps to Successful Sustainability (Fig. 1.3.5 – B). LHINs receive this document and are asked to consider how their Sustainability Plans could be strengthened in these targeted areas.

Mar 2013 - BSO Sustainability Forum- BSO hosts a provincial in-person event to discuss sustainability. This forum is an opportunity to celebrate success to-date and share strategies to ensure sustainability within each of the pillars of care (i.e. System management and leadership, Inter-professional service delivery and capacity building). LHINs identify action steps they will take to include outcomes of this provincial discussion in their local work.

Mar 2013 - Final LHIN Sustainability Plans- Based on PRT feedback and the outcomes of the provincial forum, LHINs revise and strengthen their sustainability plans as needed. LHIN CEO’s approve final plans and post these on LHIN websites. A package of all 14 LHIN plans will be submitted to the Ministry.

Mar 2013 – BSO Operations table refocuses with an ongoing mandate in 2013/2014 to coordinate and continue to link the local projects and establish provincial minimums. See the BSO Operations table accountability and Management Structure (Fig. 1.3.6)
1.3.6 Provincial Resource Team (PRT)

During Q4 the PRT surface promising practices, provided advice and direction to support the development of LHIN sustainability plans and developed a project blueprint to inform subsequent provincial-level planning and direction.

Surface Promising Practices

During Q4 the PRT aimed to surface local promising practices so that other LHINs could learn from and build on the success of others. Building on previous conversations about primary care engagement, PRT offered their support to the development of a common and comprehensive approach to engaging this sector. In partnership with the Alzheimer Knowledge Exchange, PRT supported the gathering of LHIN level promising practices and contributed to the development of five evidence-informed and provincially endorsed components to support a comprehensive and sustainably primary care engagement strategy. See Appendix A.

Inform Sustainability Planning

In February and March 2013 PRT reviewed, provided feedback on and endorsed 14 LHIN Sustainability Plans. In addition to the online review of each plan, PRTs provided the following documents to support LHIN planning and revisions:

- Sustainability Plan Checklist (Fig. 1.3.5 - A).
- 10 Keys to Sustainability Success (Fig. 1.3.5 - B) | Consolidated PRT feedback of LHIN Sustainability Plans.

Provincial Planning

Though the context of BSO has been unique, the success is replicable. Throughout BSO, PRT has had a unique view of the project, offering response and insight on implementation approaches, as well as recommendations on emerging provincial themes and topics. As a final resource, PRT has packaged the transferrable components of the project into a Prototype for Success (See Appendix B). This resource has been developed to inform and guide the development of future provincial projects with similar scope.

BSO at its Best

“Hal”, a longtime resident at Lakeland LTC home in the North East LHIN, had seen a slow decline of his physical health over the past few years. His cognitive impairments added to the complexity of his care. Staff began reporting an increase in physically aggressive behaviours when providing personal care to Hal, and within two months his behaviours resulted in harming two staff.

Referred to the in-home BSO team, Hal was immediately assessed using DOS, ABC, medication review and behaviour charting. The team also took over Hal’s personal care so that different interventions could be tried. A variety of intervention measures ensued including...

- Rolling two face cloths and placing one in each hand (so he is less likely to reach out and grab the staff).
- Making sure only one person to speaks to Hal at a time (as too many voices caused agitation).
- Ensuring one person for care until he needs to be lifted (too many staff giving care caused agitation)
- Explaining what is going to take
- Asking before doing.

Combined, these interventions have significantly decreased Hal’s physically responsive behaviours which have continued for the most part remain at this decreased level (with only minor fluctuations) for a period of one year. No other staff injuries have been reported which further proves the success of the interventions.

Over the past year, thanks to the BSO Team’s interventions, “Hal’s” physically responsive behaviours have declined significantly (as evidenced by the attached run graph) improving his quality of life and the safety of staff at the Northeastern Ontario long term care home. The interventions created by the in March 2012, continue to be effective in reducing Hal’s physically responsive episodes with no more injuries reported by staff.
1.3.7 Knowledge Exchange

In the fourth quarter, the Alzheimer Knowledge Exchange (AKE) supported Knowledge Exchange activities within the BSO project in the following ways.

Support existing and newly hired health service providers to develop core competencies and to refine and apply practice models emerging from the BSO project.

In Q4 the AKE...

- Continued to spread awareness about BSO Capacity Building tools, in particular The Road Ahead to support individuals, teams or organizations in their continual development of the 12 BSO recommended Core Competencies. It describes a selection of strategies to support learning to enable decision-making about how, why and with whom they plan their continued capacity building. Efforts included 2 online knowledge dissemination sessions with members of OANHSS and OLTCA.

Build the capacity of families to effectively participate in the care of persons experiencing responsive behaviours.

In Q4 the AKE...

- Continued to work with an Advisory panel to develop a Resource Guide for family members, friends and co-residents of those experiencing responsive behaviours in a long-term care setting. The guide is designed to develop knowledge and skills related to responsive behaviours. The toolkit has been developed using a combination of research and practice-based evidence as well as lived experience and a final document will be available by March 31st through the AKE Resource Centre.

Identify and disseminate best practice concepts, tools and resources.

In Q4 the AKE...

- Hosted an online discussion for those involved (or interested in becoming involved) in local Health Links planning and implementation. This conversation provided an opportunity to learn about local Health Links initiatives across the province, how BSO has been involved to-date in Health Links planning (as identified by participants through a pre-session survey) and to strategize about how to strengthen the partnerships between BSO and Health Links. 30 people from LHINs and HSPs involved in BSO across the province took part and identified key messages about the importance of BSO acting as a key partner in the planning and implementation of Health Links and determined next steps for moving forward. Summary notes from the discussion were distributed to a broad group including 14 LHIN Contact Group, Operations Table, PRT, and Mobile Teams Collaborative members.
- Worked with a group of LHINs who have indicated working with primary care as a local priority to identify the strategic elements to working with primary care effectively, map specific local initiatives that fall within these elements and capture critical success factors in order share these with other LHINs. A recommendations tool (including an inventory of local BSO primary care initiatives) was developed and approved by PRT See Appendix A

Open Submission from BSO Team Member

At my first meeting with a new referral to the Community Mobile Support Team in the NSM LHIN, I realized how much the whole behavioural health system had been a support to this specific person and his spouse.

Cognitively impaired, “Andrew” had been living with his spouse in their own home and had been demonstrating periodic episodes of responsive behaviours of a serious nature. After seeking medical intervention and subsequently being stabilized, the NSM CCAC Coordinator completed an assessment of the person’s goals and needs. During this assessment it was flagged that Andrew may like to try increasing the amount of meaningful activity in his day by re-engaging in the local day away program. The CCAC also flagged that his spouse was interested in increasing her knowledge and skills in working with some of his episodes of responsive behavior. That was when the referral came through.

After the BSO MST met Andrew and his spouse, the couple continued to express the goal of re-engaging in the day away program. The amazing team at the day away program was able to welcome Andrew into the program less than 5 days after he expressed an interest in attending.

Also, during the initial visit with the BSO MST and thanks to the FirstLink program, Alzheimer Society support counselors and groups, Andrew’s spouse was able to demonstrate a solid understanding of behavior and the progression of dementia. Following sessions with Andrew’s spouse will most certainly leverage her current understanding and coping skills with Andrew’s episodes of responsive behaviours.

At our recent Sustainability Forum, there was a resonating message that everyone has a role to play as BSO moves forward. This is the type of collaboration we have talked about, looked for and now found in the NSM LHIN. I know we all have a role to play and I know that this team will step up to the many challenges that lie ahead.

Jennifer Keresztesi,
Occupational Therapist, BSO MST, NSM LHIN
Bath-Time Stats are Ebbing

Between April and December 2012, St. Andrew’s Terrace in the Waterloo Wellington LHIN has seen a 36 per cent reduction in responsive behaviours during bathing times, thanks largely to the home adopting the Alzheimer Society’s Bathing Without Battles protocols. The Cambridge long-term care home has several stories illustrating the program’s success in reducing agitation for residents, which, in turn, enhances quality of life.

Registered Nurse Cindy Craig is a member of the home’s BSO team and cites the example of one resident who would yell and pinch staff members at every bath time, which would result in the resident not getting a bath. The resident’s behaviours began upsetting her family because they had never seen this side of her. The home’s BSO team knew something had to be done.

During a team “huddle,” it was discussed that the resident was experiencing leg pain and was arguing with staff members when they tried to get her out of bed in the morning. What the team decided on was to let the resident stay in bed as long as she wanted and to administer medication to relieve her pain.

Using Bathing Without Battles’ “four hands, one voice” approach, a strategy for communicating with residents, team members calmly asked the resident to have a bath, provided her with clothes so she could participate in the process as much as possible, and gave her compliments on her appearance. As a result of these interventions, the resident was happy and would allow staff members to bathe her.

“Before BSO everything was a battle with (the resident); it didn’t seem to matter what approach was taken,” says Lisa, one of the staff members involved with the resident’s care. “Now, responsive incidents are rare (and) she is more receptive to bath care. It is all in the approach, and keeping her regular person doing care. If the time is taken to discover what her unmet need is and help her resolve that, she will most often be receptive to showering or having care at that time. Before the BSO staff intervened, I couldn’t even get her to the shower. After (the interventions were used), she participates and helps.”

- Began working with OANHSS to plan an Education Day for their members focused on responsive behaviours for their members. The event is tentatively scheduled to take place in late May.

Provide Knowledge Transfer and Exchange (KTE) support to BSO Collaboratives:

In Q4 the AKE...
- Supported the BSO Operations Table including 2 online and 1 face-to-face meeting.
- Developed a needs assessment report summarizing results of a survey completed by Operations table members. Results were used to better understand each other’s roles, successes that can be built upon, mutual challenges to work collaboratively to solve and to determine priority next steps for the group.
- Began work to build an updated Inventory of LHIN-by-LHIN BSO initiatives through the Operations Table.
- Supported the Operations Table to develop a process to begin examining Complex Care Resolution processes in order to identify opportunities to improve these processes and make recommendations for implementing these locally.
- Provided an opportunity for Operations Table to meet face-to-face to discuss sustainability and their leadership role for BSO. The group agreed to formalize a sustainability structure and to act as the “go to” table to support the transition as other resources wind down. They will maintain a relationship with LHINs through their LHIN BSO contact and through common reporting to the LHIN CEO table. BSO Collaboratives will feed into this process through representation of Collaborative leads at the Operations meetings.
- Facilitated Mobile Team testing of standardized metrics.
- Supported the BSU, Mobile Teams and Access and Flow Collaborative working groups to begin visioning in order to determine short, mid and long-term goals and requirements for sustainability including membership and leadership structures for these groups as current leads transition to new roles.

Supporting BSO Sustainability

In addition to the above activities, the AKE supported local and collective sustainability planning. One of the ways this was accomplished was by supporting 2 LHIN-wide Sustainability webinars to build skill in and facilitate the sustainability planning process.

The AKE also planned and hosted with CRO an all-LHIN Sustainability Forum to support discussion around sustainability and moving BSO forward at the local and provincial levels which took place March 19 in Toronto. Objectives for the session included:

- Share and exchange ideas, insights and opportunities regarding sustainability plans
- Adjust and/or enhance planned approaches
- Turn plans into action.

The three BSO Pillars provided structure for the day as the more than 90 participants involved in implementing BSO from across the province and other provincial stakeholders looked at how to continue to build on the successes of BSO.
both individually and collectively. Participants discussed System Coordination through the lens of Ensuring Effective Leadership. After hearing about leadership models being implemented across the province they discussed the strengths and risks associated with each along with strategies to minimize risks related to including or not including a particular element of a strong leadership approach. LHINs then refined their Sustainability plans based on what they learned and decided on steps to put their leadership plan into action. Provincial stakeholders took the time to discuss the collective action steps needed to ensure effective leadership. These were shared with the whole group and a critical conversation about how to continue to move BSO forward together ensued.

Participants then had an opportunity to hear about how the various components of a strong capacity building plan are being implemented across the province and consider what more they needed to strengthen and put into place their local capacity building plans.

Integration and Innovation in Service related to Complex Care Resolution, Innovations and Integration with Primary Care, Access and Flow, Behavioural Support Units, and Mobile Teams was addressed through focused small group discussion looking at what is already being done well, what more could and should be done and development for an actionable goal for each.

Each individual had the opportunity to identify what they believe to be the keys to success for BSO. The day was ended with remarks from Cathy Hecimovich and Helen Angus who reinforced the importance of partnership between BSO and Health Links. A full report from the day will be available on the bsoproject.ca website after March 31st.

Evaluation results indicate that overall, participants found value in this opportunity. In particular, they appreciated the opportunity to celebrate success, learn from other LHINs, be introduced to the current state and future vision of the project (new stakeholders) and collaborate to reach a stronger provincial approach.

The AKE will support BSO Sustainability by reviewing the outcomes and actions from this forum as well as local LHIN plans to determine common themes and areas where knowledge transfer and exchange support may benefit both local implementation and maintenance of provincial momentum. In collaboration with the BSO Operations Table, AKE will aim to act as a central touch-point, facilitating ongoing conversations and shared solution finding related to BSO.

National BSS Forum
To support the sustainability, spread, and sharing of best practices, BSO also supported a national roundtable on behavioural support systems and mental health services/strategies for seniors held in Toronto on March 20th 2013. This meeting was co-funded by the BSO and the Mental Health Commission of Canada and was coordinated by the Canadian Coalition for Seniors’ Mental Health. Participants brought perspectives from policy, NGO, government, research, and clinical settings and representation was present from:

- British Columbia

A Family Affair
BSO is as much about taking care of the caregiver(s) as it is the patient, a point recently reinforced in the Toronto Central LHIN.

Diagnosed with severe dementia, “Robert” would pace constantly, experience incontinence, drool continuously and was unable to speak. Meanwhile, Robert’s wife “Eleanor”, herself afflicted with chronic health issues and a variety of mental health and addiction issues, was acting as his lone caregiver. Struggling with acceptance of the degree to which Robert’s condition had deteriorated, she was agonizing over every attempt to find respite for herself, immediately regretting her decision to turn down a LTC crisis bed when it was offered. She reported feeling overwhelmed with her responsibilities.

Having completed the RC CARERS program, Eleanor was introduced to Dr. Feldman at a drop in maintenance meeting. Dr. Feldman began weekly telephone therapy with Eleanor as it was difficult for her to attend these sessions in person.

Since working with Dr. Feldman, Eleanor reports feeling supported in her decisions and she is making positive efforts at self-care. She says her feelings of being overwhelmed with the demands of her caregiving role have decreased.

Modifications to the existing RC interventions, by offering higher frequency and greater availability of therapeutic contact, are meeting the needs of the HRCG population.
Representatives from Nova Scotia, Newfoundland and New Brunswick were unable to attend but have expressed interest in moving forward with this initiative. National organizations were also present including the Neurological Health Charities of Canada, the Parkinson’s Society and the Canadian Dementia Research and Knowledge Exchange (CDRAKE). Additionally, the Public Health Agency of Canada joined briefly via teleconference.

The conversation for the day was grounded in two national frameworks, the Mental Health Commission of Canada’s Guidelines for Comprehensive Mental Health Services for Older Adults, and the CDRAKE National Behavioural Support Systems Project: Guiding Principles and Recommended Components.

Representatives also offered insight into their provincial contexts and tailored their updates to highlight the design of any provincial initiatives, the testing involved, the implementation plan and strategies to support sustainability and spread. Representatives from the AKE and BSO provided an in-depth summary of the BSO initiative and reported on the outcomes of the March 19th Sustainability Forum. The afternoon sessions were tailored to discuss in depth service-strategies and system improvement, person and recovery focused care, service coordination and systems management, and capacity enhancement. An attendee facilitated each session with expertise in the area, including expertise from the BSO.

The outcome of this meeting is a strengthened network of clinicians, researchers, government, and NGOs who are interested in system transformation in seniors’ mental health and behavioral support systems. Participants have expressed interest in an ongoing conversation, focused on sharing best practices and strategies. The Canadian Coalition for Seniors’ Mental Health is creating an inventory of relevant resources and will be working with CDRAKE to facilitate ongoing conversations with the network.

“At critical junctures in developing and launching BSO, the Ministry of ... has been there as a leader and partner. The Ministry took risks along with all of us because they too saw that the need was great and the readiness for change, apparent. Continuing Ministry support enables BSO services to improve and adapt so that together we can better serve the people whose lives are enhanced through contact with the people who provide these services.”

David Harvey,
Co-Chair Alzheimer Knowledge Exchange
The project’s investment in measurement and evaluation expanded in winter 2013. Long-running initiatives to gauge BSO impacts were completed (the Hay Group Evaluation, quarterly Activity Tracking, development of Legacy Measures), and several enhancements were undertaken as well.

Final Evaluation
In March, 2013 Hay Group submitted a final BSO Evaluation. This report summarizes evaluation findings of the BSO service redesign in the four Early Adopter LHINS (Hamilton Niagara Haldimand Brant, North Simcoe Muskoka, South East and Central East). The available data in the report only captures very early BSO impacts. Because Early Adopter LHINs entered the program before so-called “Next 10” LHINS, the former had the benefit of new and redesigned BSO services somewhat sooner. Service impacts and client outcomes would therefore be expected first in Early Adopter LHINs, which is consistent with Hay Group observations. The Final Evaluation Report also provides the measurement tools and baseline data to assess BSO impacts in future.

Peer Review
To validate conclusions presented in the BSO Final Evaluation Report two external peers were invited to review the report. Their comments, including additional considerations and conclusions will accompany the submission of the BSO Final Evaluation Report.

Legacy Measures
In Q4 the legacy measurement group met and developed a list of 14 Legacy Measures. DMEC endorsed these as the complete picture of BSO impact in any LHIN. The 14 legacy measures are as follows:

1. Rate of CTAS 4/5 ED visits for behavioural residents of LTCHs.
   a. community-dwelling
   b. from LTC
2. Rate of acute care hospitalization (clients and episodes) of behavioural residents of LTCHs
3. Institutional ALC days per population by age group and patient residence type (community, LTCH, other institution)
4. % of applications denied due to responsive behaviours
5. % of residents whose behavioural symptoms worsened
6. % of residents with verbal, physical or social behaviour affecting others
7. Critical incidents associated with resident behaviour per 100 LTCH beds
8. % and number of CCAC clients waiting for placement in LTCH categorized as behavioural clients
9. Number of people newly diagnosed with dementia receiving written and verbal information about their condition, treatment and the support options in their local area
10. Average/median wait time for respite service for behavioural clients
    a. in-home
    b. out-of-home
    c. Adult Day Program
11. RAI measures of mental health wellness in community:
    a. prevalence of negative mood

Notable Notables
- The average acute length of stay for the BSO target population was much longer than the figure for non-BSO when BSO began
- The ALC length of stay was even longer
- In emergency departments, the BSO target population is disproportionately more complex and costly, and much more likely to be admitted for an inpatient
- The notional value of health care delivered to people with responsive behaviours in all settings including the acute sector is estimated at slightly more than $5B in 2011/12.
- Considering the large gap in demand between BSO and non-BSO populations, and the scale of the current investment, even relatively modest improvements on 2011/12 figures represent important savings for the system.

1.3.8 BSO Measurement and Evaluation

The project’s investment in measurement and evaluation expanded in winter 2013. Long-running initiatives to gauge BSO impacts were completed (the Hay Group Evaluation, quarterly Activity Tracking, development of Legacy Measures), and several enhancements were undertaken as well.
b. prevalence of social isolation

12. Satisfaction of clients/families requesting behavioural support services with access to services
13. Provider assessment of impact of initiatives on ability to manage behavioural population
14. Family satisfaction with ability to manage behaviours in the home environment

Though most LHINs have identified one or more legacy measure as part of their sustainability plan, BSO data is not yet standardized from one LHIN to another. Valid comparisons across boundaries will depend on common indicators, definitions and datasets. In March the 14 legacy measures were presented to participants at the BSO Sustainability Forum. Through discussion during this event, and further consultation, LHIN leads decided to proceed with standardized reporting on the following as a first group of measures:

1. Rate of CTAS 4/5 ED visits for behavioural residents of LTCHs
   a. community-dwelling
   b. from LTC
2. Institutional ALC days per population by age group and patient residence type (community, LTCH, other institution)
3. Rate of acute care hospitalization (clients and episodes) of behavioural residents of LTCHs
4. % of applications denied due to responsive behaviours
5. % and number of CCAC clients waiting for placement in LTCH categorized as behavioural clients
6. Satisfaction of clients/families requesting behavioural support services with access to services

Standardized, accessible legacy measures will support consistent measurement at reduced cost, comparison over time and among peers, system accountability for key success factors, performance improvement of key success factors and consistent decision-making about deployment.

Peer-reviewed manuscript

Developed as another Behavioral Supports Ontario (BSO) initiative knowledge translation strategy, three co-chairs of BSO standing committees (Dr. Iris Gutmanis, Dr. Ken Le Clair and David Harvey), the BSO Project Lead Matt Snyder, and Research Consultant Loretta M. Hillier co-authored “Behavioural Supports Ontario: A Framework for Transforming the System of Care for People with Responsive Behaviors.”

The manuscript submitted to Healthcare Policy for review in February 2013 is currently under review.

In this paper the BSO initiative is described as an evidence and experience-based provincial framework created to support an integrated cross-sectoral system of supports and services focused on improving outcomes for persons living with responsive behaviors, their families, care providers and the health care system. The accomplishments to date, project challenges and key success factors are described. Replicable in other jurisdictions, BSO demonstrates that large scale quality improvements can be achieved through capacity development and system transformation.

Evaluation of the Integrated Decision Support dataset in HNHB LHIN

The Hamilton Niagara Haldimand Brant (HNHB) LHIN has access to a local Integrated Decision Support business intelligence tool that makes it possible to link client data across available datasets (HNHB CCAC data, hospital and Discharge Abstract Data) . Renewed BSO funding from MOHLTC in Q4 of 2012/13 included a requirement that the Coordination and Reporting Office leverage this unique HNHB resource to enhance the existing evaluation of BSO impacts.

Four objectives were defined for this focused, local evaluation:
1. Utilizing the new “flag” created during implementation to identify the BSO target population within the IDS tool
2. Enhance the descriptive characteristics of the BSO eligible population
3. Evaluate before-and-after utilization of acute care resources for people receiving BSO services
4. Assess the capabilities and potential of a more detailed, future evaluation using IDS data

Despite the full support of HNHB LHIN, HNHB CCAC, and the stewards of the IDS business intelligence tool, it was not possible to recruit a data specialist to complete the IDS evaluation initiative before the earmarked funding expired on March 31, 2013. HNHB LHIN has expressed its interest to complete items 1-4 above in 2013.
Both Qualitative and Quantitative outcomes are important to BSO for distinct reasons. Quantitative outcomes, such as those provided in Section 2 of this report, provide statistical insight into where the project is positioned against a variety of its targets/deliverables i.e., patient impacts, HHR recruitment and the training of both new and existing staff. The information that follows paints a numerical picture of BSO.

2.1 Investment in HHR

The MOHLTC’s $40.37M Provincial BSO investment has focused on the hiring, by local Health Service Providers (primarily long-term care homes), of new staff – Nurses, Personal Support Workers and other health professionals, and the training of both new and existing staff in the specialized skills necessary to provide quality care to Ontarians with complex behaviours.

Each LHIN’s Action Plan outlined a local implementation approach to deploy a range of specialized behavioural supports across the care continuum. There were three general approaches that emerged:

- Lead/host LTC Home Model for Mobile Outreach Teams
- Allocation at the individual LTC Home level
- Specialized Behavioural Support Units

While approaches vary depending on geography and existing resources, the overall objectives are the same - maximize services for persons with challenging and complex behaviours associated with dementia, mental illness and other neurological disorders. These approaches were detailed in the quarterly report submitted to the ministry April 30, 2011- (See Behavioural Supports Ontario Q4-Quarterly Report January 1,2012 – March 31,2012. Section 2.3 HHR Investment pp 20 – 29)
There is No “I” in Team

A long-term care facility in the South West LHIN reported that a resident had been “inappropriately” interacting with numerous female residents. A referral to the BSO team requested assistance with assessment and the provision of recommendations regarding treatment approaches for Joseph’s responsive behavior.

Following an initial assessment that included urinalysis MMSE and MOCA, Joseph was admitted to a Schedule I Hospital with one-to-one observation. DOS charting was implemented and a medication review was conducted by the hospital Pharmacist and Psychiatrist.

In collaboration with the inpatient team, the BSO team developed a treatment plan to address client individual care needs. Montessori activities were introduced with the client during his inpatient stay and his medication regime was modified.

“There was no one individual more responsible for Joseph’s care than another. The team was truly multidisciplinary in its approach to client-centred care,” said Patty Wells, BSO RN. “The BSO Staff, inpatient mental health team, hospital Psychiatrist, LTC Home Director of Care and Alzheimer’s Society all met together with Joseph’s family to review his history, challenges and treatment approaches.”

Joseph was successfully returned to his LTCH within a week of admission to the hospital, along with the support of an additional staff who provides one-to-one care for 4 hours during his peak high risk time. Other resident’s safety has increased. No incident reports have been recorded since the client’s return to the facility and, no responsive behaviors have been exhibited.

2.1.1 HHR hires

During Q4 LHINs continued to support local Health Service Providers to ensure the best possible BSO staff were recruited for this initiative.

Detailed information about FTE commitments and new hires in each LHIN is recorded in Table 2.1.1.

The total number of FTEs including the new PSWs hired through additional PSW funding as of March 31st is 603.88. This number also reflects the change in type of professionals hired in the ‘Other Health Professional’ category which allowed for more professionals within the available funds.

2.1.2 Recruitment delays and mitigation

Recruitment Delays

In BSO’s Q1 Report, four main reasons were cited for recruitment delays related to the hiring the LHINs targeted HHR. CRO remained in contact with LHIN Project Leads to uncover and address specific causes.

Of these four cited reasons, all have been addressed by the 14 LHINs resulting in 100% hires of the targeted HHR in LTC homes (excluding the new PSW targets).

Staged Recruitment

Recruitment in most LHINs is staged; a manager or coordinator is hired first at an HSP, who then leads recruitment of the others. This approach is especially common for new service teams and in “host” or “lead” homes where an Action Plan concentrates local resources.

Change or Delays with Service Provider

Several LHINs were unable to reach agreement with a HSP they intended to fund. Restarting negotiations with another HSP introduced several months of delay for positions that had been earmarked for those employers.

Shortage of Resources

- Recruitment challenges for nursing in some parts of the province especially Northern and rural areas
- Challenges with hiring part-time contract positions for both nursing and PSWs.
Delayed agreements

- LHIN-HSP negotiations were slowed in winter 2012 by disagreement over the funding available for non-wage costs. Almost all agreements were concluded early this spring, largely by adding funds from non-BSO sources to the BSO allocation. Those HSPs are recruiting now.
- Union issues delayed agreements with 2 LTCHs.

Mitigation

As of December 31, 2012, Erie St Clair and South West LHINs were still recruiting a large proportion of their HHR targets. Through their respective mitigation strategies both LHINs report 100% completion of their Action Plan targets.

Central East LHIN is still recruiting for 2 FTEs in the community. Staged recruitment and longer than expected process to finalize provider type has delayed this recruitment; however permanent hirings are expected to occur through Q1 and Q2.

CRO has continued to work with the LHINs to mitigate any additional risks identified during the implementation process.

Getting Engaged With BSO

Representatives of four long-term care homes visited Leisureworld Caregiving Centre - Streetsville Site, in the Mississauga Halton LHIN, as an opportunity to network and learn from the home’s BSO team. The focus of the site visit was to see how staff can engage in and with the BSO initiative. As identified by BSO Personal Support Worker Jose Olivares “If you have the support of your staff, you are likely to be successful with your interventions.

Denise Perennec-Stein, Associate Director of Care at Leisureworld Streetsville stated that “changing the approach to care for those residents who are affected by dementia and other conditions that cause agitation, requires the support and participation of all staff members.” A springboard for participation is knowledge sharing and so, as BSO looks toward to a sustainable future, a number of activities have already been taking place at the Leisureworld Streetsville site since formation of the BSO team last summer.

Among them, a “virtual experience” where approximately 50 team members lived as though they were residents. The team was outfitted to experience sensory in addition to other challenges to see what may be the triggers for agitation. “The day was pretty empowering as team members were sensitized to being in the residents’ shoes,” said Perennec-Stein.

In addition, an in-house video showing BSO team members interacting with residents was also created and shared with all staff. The video highlights special care tips that the BSO team developed to support staff in intervention planning. It also provided a bigger picture of their work and interactions with residents.

Some other efforts include the development of translation cards which will be used by staff members to communicate more effectively with residents who speak different languages. In addition a psychogeriatric resource consultant has been working with the registered team members on being able to provide more in-depth documentation of behaviours. Mentoring among staff members and the BSO team is ongoing.

Both Perennec-Stein and Olivares say the work is yielding positive results, with a drop in responsive behaviours and noticeable changes in many residents. “Looking at BSO’s progress to date, awesome work has been done,” said Perennec-Stein. “Efforts to further deepen an understanding that there is meaning behind residents’ responses will continue. This is a key component to sustaining the gains we have seen thus far; to unlocking enhanced quality of care.”
2.1.3 PSW Funding

LHINs received additional base PSW funding on December 20, 2012 to support the recruitment and retention of PSWs as an integral part of the BSO initiative. These funds were given in recognition of current salaries for PSWs and the need to increase funding to enable LHINs to meet their original PSW target provincially of 300 PSWs. Accountability agreements between the MOHLTC and LHINs for the New Behavioural Staffing Resources have been amended to include this funding. Once LHINs meet their FTE targets, the remaining funding, if any, can be used to train LTC staff (nurses, PSWs and/or additional LTC healthcare providers) in LTC Homes.

Following the announcement in mid-January, LHINs have been working with their selected LTC homes to roll out the PSW funds as quickly as possible to meet their original estimated PSW targets and then utilize the remaining funding for training purposes. The CRO has been working with the LHINs to optimize the staffing mix based on their local circumstances. It should be noted that there are a few LHINs that will be slightly less than their identified targets based on current salaries of their PSWs.

The number of new PSWs hired as of March 31, 2013 is 57.75 of 85.75 estimated PSW positions required to reach the provincial target of 300. Given the timing of the announcement in January and the average time required to fully complete the recruitment process (on average 8 weeks), it is anticipated that the remaining hires will occur over the next few months.

Table 2.1.1 – BSO FTE Hires and Staff Trained (as at March 31, 2012)
2.2 Activity Tracking

LHINs agreed to standardized definitions of their major BSO investments to better reveal trends and common approaches across LHIN boundaries. A first set of indicators were also selected, to be expanded and enhanced in future reporting cycles. A picture of project-wide resource deployment and relative priorities begin to emerge. Agreed nomenclature and definitions that apply in all LHINs are a crucial first step toward an accurate tally of BSO services by type and function. In future, reliable province-wide counts for a wider range of BSO initiatives will facilitate impact assessment, cost comparison and projections of return on investment.

Sound the Alarm

There is an unequivocal connection between responsive behaviours and falls in long-term care homes across the province and certainly across the North West LHIN. In addition, restraint use is often among the highest for residents with responsive behaviours. In preparation for the Specialized Behavioural Support Unit in the North West LHIN, Hogarth Riverview Manor recognized the demand for a restraint-free environment that proactively works to reduce falls.

With the support of in-house Quality Improvement Facilitators who received training through the regional Resident’s First/BSO Kaizen event, a strong inter-professional contingent of employees gathered to investigate the safe and effective use of bed and chair alarms.

Fashioned around quality improvement methodology, the group worked to establish processes for: AIM, MEASURE and CHANGE. Fishbone diagrams, the 5 Whys Tool, and a Quality Board prompted excitement around the collection, discussion and analysis of data. The BSO team applied PDSA cycles to further guide the implementation of: an alarm integrity audit, pre-start checks on all alarm systems and education sessions for new and existing staff. During a recent North West LHIN Quality Improvement Webinar, the preliminary QI successes were shared to a network of more than 50 improvement facilitators.

Data gathering on these interventions is early and ongoing. However, it is clear this renewed focus on quality at Hogarth Riverview Manor will have a positive impact on patient care. Staff members are excited about the quality improvement work and are actively participating in the process in a real and tangible way.

“While quantitative results are imminent, we know restraint use has already gone down and we are attributing this to the increased knowledge and confidence that staff report in applying and monitoring the bed and chair alarms.”

Tanya Shute
Manager, Regional Behavioural Health Service
St, Joseph’s Care Group
The total time from call to first response from Mobile Team in TC has decreased from 120 to 48 hours. This is a result of improved communication and well established processes that allow the teams to respond more quickly.

In Q4, 100% of clients referred to the mobile team in North Simcoe Muskoka received a follow-up discussion between the mobile team and the referring organization/individual; this target is up from 54% in the previous quarter. This demonstrates NSM's commitment to supporting and enabling smooth transitions and warm hand-offs in their region.

244 referrals were made to the Central LHIN mobile team in Q4 (compared to 188 in Q3). This number could be attributed to both an increased awareness of the service available and as a demonstration of the demand within the system of care.

705 provider based services were delivered in the NW in Q4. This number increased exponentially from the previous quarter due to the implementation of the mobile teams in Q3 and the continued roll-out of these teams to new long-term care homes. Referral numbers continue to increase now that word is getting out that the teams are in place and as good results are communicated.
Over and above the 700 individuals who participated in GPA, PIECES, Montessori, UFirst, CPI, BSTP and DCTP training sessions in Q4, more than 100 primary care practitioners engaged in formal education sessions and 51 individuals participated in a ‘Build-a-Behavioural-Support-Resource Team’ a new training session for LTCHs developed by the Toronto PRCs.

In Q4 the South East officially launched their Learning Management System and offered enhanced opportunities for PRCs to provide effective capacity enhancement training to LTCH staff. These investments resulted in 269 staff participating in structured learning events during the quarter and have provided a new e-learning approach to capacity enhancement.

In Champlain, 40 activities were completed aimed at improving service and quality of care to the BSO target population. These activities included: 3 Value Stream Mapping activities, storyboard; impact evaluation of enhancements to Ottawa LTCH Outreach team; PSW Champion follow-up survey; Sustainability Planning meetings; SBSU Team-building, process and implementation meetings with entire team.

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In Q4, South West LHIN hired 39 FTE on-site nurses or PSWs dedicated to behavioural issues in Long-Term Care homes. This investment has resulted in 440 clients being supported by the mobile team.

After adjusting their implementation model, South West LHIN hired 39 FTE on-site nurses or PSWs dedicated to behavioural issues in Long-Term Care homes. This investment has resulted in 440 clients being supported by the mobile team.

The number of service improvement activities completed in Waterloo Wellington in Q4 across both LTC and the community. In the community these activities have improved the ability to coordinate intake and improve system flow, the ability in primary care to refer in a timely manner, ability of client and family to know the next step. These improvement activities provide opportunities to address region wide differences in wait times, ensure service is provided at the right time and place, and enhance successful partnerships.

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Capacity enhancement training program

Comprehensive behaviours training strategy for new and existing staff in LTC, Community and acute sectors.

ESC in fiscal year 12/13 provided capacity enhancement and training to 1,205 individuals. Capacity enhancement included GPA, U First, PIECES, Montessori, non-violent / crisis intervention, motivational counseling and cognitive behavior therapy training.

1,419 new staff in Q4 were trained as the Regional Education Coordinator orchestrated several key events, most notably the U-First train-the-trainer event in February. This work built on the efforts of the Psychogeriatric Resource Consultant who continued to train large numbers of staff. The BSO has resulted in training and knowledge exchange to a level previously unheard of in the North West LHIN and has resulted in a noticeable difference in practice according to Long-Term Care administrators in the North West LHIN.

197 The number of service improvement activities completed in Waterloo Wellington in Q4 across both LTC and the community. In the community these activities have improved the ability to coordinate intake and improve system flow, the ability in primary care to refer in a timely manner, ability of client and family to know the next step. These improvement activities provide opportunities to address region wide differences in wait times, ensure service is provided at the right time and place, and enhance successful partnerships.
Increased professional skill development and confidence have increased recognition of BSO clients in Central West, enabling their Behavioural Support Champions to serve **3305** clients in Q4.

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### Other mobile or regional specialist roles

<table>
<thead>
<tr>
<th></th>
<th>Totals Q1</th>
<th>Totals Q2</th>
<th>Totals Q3</th>
<th>Totals Q3</th>
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**# staff hired (cumulative FTEs)**

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<td>78.25</td>
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**# clients served**

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<th>5 LHINs</th>
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<td></td>
<td>1147</td>
<td>2591</td>
<td>3217</td>
<td>5932</td>
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### Behavioural Support Champions in LTC

Specialized role on staff at a long-term care home responsible to lead, coordinate and spread effective strategies for responsive behaviours in that facility.

**# staff hired (cumulative FTEs)**

<table>
<thead>
<tr>
<th></th>
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<td>89.48</td>
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**# clients served**

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<tr>
<td></td>
<td>768</td>
<td>3176</td>
<td>4523</td>
<td>5204</td>
</tr>
</tbody>
</table>

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### BSU

Transitional specialized support for persons whose responsive behaviours have become unmanageable in their current setting and for whom available supports have not been successful in management of the behaviours of concern. The goal of the unit is to stabilize behaviours and support transition until residents return to their home, which may be in another long-term care home or in the community. The unit provides a higher level support model than is currently available in other LTC homes. Length of stay parameters are set by each individual BSU based on resources available.

**# staff hired (cumulative FTEs)**

<table>
<thead>
<tr>
<th></th>
<th>5 LHINs</th>
<th>5 LHINs</th>
<th>5 LHINs</th>
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<td></td>
<td>21.4</td>
<td>26.2</td>
<td>42.72</td>
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**# clients served**

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<th>5 LHINs</th>
<th>5 LHINs</th>
</tr>
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<td></td>
<td>38.4</td>
<td>36.4</td>
<td>38.4</td>
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</table>

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**Mean LOS Clinical (days)**

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<tr>
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<th>5 LHINs</th>
<th>5 LHINs</th>
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<td></td>
<td>374</td>
<td>55</td>
<td>355.5</td>
<td>0</td>
</tr>
</tbody>
</table>

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### The average length of clinical stay at the Cummer Lodge, the Central LHIN 16-bed Behavioural Support Unit, decreased this quarter from 738 days average (Q3) to **355.5** days average. This can be best attributed to the hard work of the staff to move younger people with Huntington’s Disease with long lengths of stay to more appropriate care. In Q4 the BSU further evolved to a “real” BSU with transitional beds serving the BSO target population.

---

### 871

The number of clients served in Champlain by PRCs, geriatricians, psychogeriatricians and the geriatric psychiatry National Support Unit nurses. The complementary and supportive services provided by these staff enabled more comprehensive approach to care and addressed more complex issues.
<table>
<thead>
<tr>
<th>Totals Q1</th>
<th>Totals Q2</th>
<th>Totals Q3</th>
<th>ESC</th>
<th>SW</th>
<th>WW</th>
<th>HNB</th>
<th>MH</th>
<th>CW</th>
<th>TC</th>
<th>Central</th>
<th>CE</th>
<th>SE</th>
<th>NSM</th>
<th>Champlain</th>
<th>NE</th>
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<td>6 LHINs</td>
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<td>7 LHINs</td>
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<td>x</td>
<td>58</td>
<td>813</td>
<td>43</td>
<td>594</td>
<td>48</td>
<td>159</td>
<td></td>
</tr>
<tr>
<td># calls meeting criteria for BSO teams/services</td>
<td>-</td>
<td>646</td>
<td>1651</td>
<td>1715</td>
<td>-</td>
<td>105</td>
<td>693</td>
<td>765</td>
<td>-</td>
<td>330</td>
<td>976</td>
<td>976</td>
<td>-</td>
<td>0</td>
<td>430</td>
<td>4</td>
</tr>
<tr>
<td># calls to intake from community</td>
<td>-</td>
<td>646</td>
<td>1651</td>
<td>1715</td>
<td>-</td>
<td>105</td>
<td>693</td>
<td>765</td>
<td>-</td>
<td>330</td>
<td>976</td>
<td>976</td>
<td>-</td>
<td>0</td>
<td>430</td>
<td>4</td>
</tr>
<tr>
<td># calls to intake from LTC</td>
<td>-</td>
<td>646</td>
<td>1651</td>
<td>1715</td>
<td>-</td>
<td>105</td>
<td>693</td>
<td>765</td>
<td>-</td>
<td>330</td>
<td>976</td>
<td>976</td>
<td>-</td>
<td>0</td>
<td>430</td>
<td>4</td>
</tr>
<tr>
<td># calls navigated to another service</td>
<td>562</td>
<td>14</td>
<td>23</td>
<td>10</td>
<td>-</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>-</td>
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<td>2</td>
<td>3</td>
<td>-</td>
<td>0</td>
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<td>3</td>
</tr>
<tr>
<td>System Navigator</td>
<td>4 LHINs</td>
<td>4 LHINs</td>
<td>4 LHINs</td>
<td>4 LHINs</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>160</td>
<td>201</td>
<td>428</td>
<td>578</td>
<td>178</td>
<td>363</td>
<td>19</td>
</tr>
<tr>
<td>Dedicated coordinator responsible to plan appropriate complementary services throughout a patient’s journey. Includes centralized access to BSO resources (incl. Mobile Support Teams) &amp; could include short-term support by Intensive Geriatric Services Worker until one or more referrals is complete.</td>
<td>4 LHINs</td>
<td>4 LHINs</td>
<td>4 LHINs</td>
<td>4 LHINs</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>5 LHINs</td>
<td>5 LHINs</td>
<td>5 LHINs</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Common assessment toolkit</td>
<td>Development of a common minimum set of assessments (standardized assessment) for people with responsive behaviours across the service continuum. The toolkit outlines the service events, process steps, common assessment tools and pathways. The local Mobile Support Team will provide education to service providers on the use of the toolkit, interpretation and application of the tools and pathways.</td>
<td>5 LHINs</td>
<td>5 LHINs</td>
<td>5 LHINs</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>612</td>
<td>3251</td>
<td>1593</td>
<td>1622</td>
<td>440</td>
<td>271</td>
<td>105</td>
</tr>
</tbody>
</table>

This number reflects 180 connections made through BSO Connect and 183 made through the BSO Community Outreach Team IGSW. Of the 180 calls to BSO Connect, 66% of these clients had no previous services involved when they reached out for help for services. This demonstrates the model of BSO Connect being one access point to connect clients into the system, linking them through a process that ensures the clients are supported by longer-term supports and not left to navigate the system for themselves.

In the South East, BSO Connect (the first 24/7 access and response to service in Ontario) is based on a philosophy that services are actually engaged, or ‘pulled towards’ the client. Access continues through the leveraging of existing services (e.g. Outreach, Mobile Team, etc.), however a growing amount, 17% of all access to Behavioural Supports in the South East, now comes through BSO Connect.

In the early adopter LTCHs in CE, 105 residents now have an individual care plan that is understood by all member of the care team. The tool assists the team in understanding behaviour triggers in order to develop & implement appropriate interventions.

In the North East 159 calls were received through a centralized access number that met the criteria for BSO services. This is more than double the calls received in Q3, indicating that the communication strategies were successful in informing care partners of the services available as well as how to access services through the central intake process.

212 clients were assessed in North Simcoe Muskoka using a common assessment toolkit. This toolkit enabled all Mobile Support Team members to use common tools; to compare with results from other providers, and to ensure that all necessary (or relevant) assessments are completed while avoiding duplication.
In Erie St-Clair 24 clients were served by 1 FTE CCAC ALC BSO coordinator serving 3 hospitals. Of this number, 29.1% or 7 clients were repatriated from hospital to long-term care, retirement home or to the community. 

Erie St-Clair engaged 12 new and existing partner organizations to support the collaborative review of complex care cases. This complex care resolution process addressed and mitigated system gaps and ultimately resolved 39 complex care cases.

Each of the 78 Long Term Care Homes in the South West completed a QI workplan to guide the implementation of BSO within their Long Term Care Homes. Each workplan includes an AIM statement and outlines activities and deliverables to help guide implementation. During a collaboration day in September, LTC Homes will present visual story boards to highlight the successes they achieve within the first 6 months.

HNHB conducted 9 tests of change in Q4. These spanned systemic level solutions (e.g. adjusting BSO models and approaches as well as transition processes at hand-off between pilot and mobile teams), service processes (e.g. BSO communication with front line staff), and person-centered care delivery (e.g. environmental changes, palliative cart, improved activity space and addressing issues of over-crowded dining rooms). Taking a quality improvement approach to these issues has enabled HNHB to identify issues, test solutions and adapt approaches that will guide the ongoing development of both the HNHB Long-Term Care Model (i.e. embedded model within the mobile model) and build awareness and capacity with Long-Term Care staff. Combined, the testing provides engagement for all staff to take part in understanding how the changes can help to reduce behaviours and improves the quality of life for all residents.

The NE partnered with 15 new organizations in Q4. With 37 total organizations collaborating as an integrated care team, the client and family will see seamless care transitions across health services and settings in the NE.
Visual communication boards are now in operation in 47 of Central East LTC homes. These white boards support and enable early identification of new or escalating behaviours so that care teams can communicate and collaborate quickly to determine interventions.

28 LTC homes in Mississauga Halton have used the Capacity Building Roadmap in combination with other BSO tools to guide their regional, organizational and individual capacity building activities- making sure staff have the knowledge and skills required to meet the needs of the BSO target population.

Mississauga Halton conducted 95 outreach events or presentations this quarter. These presentations in LTC homes and within our community agency partners demonstrate that MH is committed to fostering an integrated system of care that wraps services and supports around the client to ensure that BSO is sustainable.

110 events took place in Central West this quarter. These included new outreach and presentations in the acute care and community sectors, demonstrating deliberate BSO spread and engagement with new stakeholders at the frontline in the areas of developmental services, mental health, ethics and senior friendly hospital planning. Capacity building and integration will be the outcome of this approach towards BSO clients supported holistically in the health care sector.
Chapter 3
Qualitative

Where quantitative outcomes depict an at-a-glance summary of what is happening, qualitative outcomes provide the how. Section 3 paints the picture of how the project is responding to immediate realities, anticipating upcoming needs and immediately applying lessons learned to accelerate and sustain change.

3.1 Quality Improvement

3.1.1 BSO collaborative working groups

Access and Flow

The Access and Flow collaborative had one meeting during the fourth quarter to review the work plan goals. At this time, the group identified that many emerging topics overlapped with those emerging at the Mobile Teams Collaborative. The group discussed the merits and opportunity to blend with the Mobile Team Collaborative and moved this suggestion to the BSO Operations Table meeting for discussion. Leads of both the Access and Flow Collaborative and Mobile Teams Collaborative have committed to connecting in the next quarter to explore what this merger might look like.

Mobile Team

The Mobile Team Collaborative is in a period of revitalization as it looks at the potential for increased reach (with increased membership) and increased “interprofessionalism” (with the incorporation of other collaboratives). Focus has been placed on incorporating a more holistic approach; new ways of engaging with other collaboratives.

In Q4, the Mobile Team Collaborative also worked to trouble-shoot and effectively create LHIN-specific sustainability plans, surface key lessons that could be used moving forward, and reaffirm the learning activity indicators that promote service capacity and systems improvement.
Letting Go

There is something so incredibly nurturing about kids who, as grown-ups, go on to take active care of their parents. Such was the case with “Grace” who had devoted her life to taking care of her parents, whom were nothing shy of her entire world. She had taken care of her father who had, in years past, been taken by a terminal illness and had, in recent years, been living with her mother in the family home.

Having finally come to accept that she could no longer provide her mother with the quality of care she both needed and deserved, Grace was so appreciative of the BSO Team’s initial visit to meet her mom. Specifically, it was time for Grace to let her mom embark on a new journey in LTC as she herself was growing older, tired and unable to provide proper care. Grace’s knowledge and experience of her mom’s needs was invaluable to a successful admission. The BSO Integrated Care Team spent several hours listening to her concerns and sharing ideas. Her mother became very comfortable with the team and was able to engage with them with laughter and music. The BSO Team staff left this first encounter feeling blessed, with hugs from both mother and daughter.

“You agonize over who to leave your children with and yet, it is not often the case that such stress is felt when deciding who to leave your parent with. This was not the case for Grace,” said Lynda Paul, RN, KFLA BSOMRT. “Grace was filled with an assortment of emotions that only come from emotional investment. She cried… she laughed… and in the end felt so much better and appreciated that the time was taken for the visit.”

For Grace, a scary experience became less frightening... not perfect, but better. Her mom remains in LTC, transitioning with assistance from the collaborative efforts of the BSO Integrated Care Team and LTCH.

“Letting go can be a traumatic event. BSO strives to ensure that such events are less traumatic for the patient and the family caregiver who, while their loved one is often slipping away, remains fully aware of what is happening to their mother, their father, their sister, brother, son, daughter… and the list goes on. Letting go is not easy… we are just trying to make it easier.”

- Lynda Paul, RN, KFLA BSO MRT

Behavioural Support Units

The Behavioural Support Units (BSU) Collaborative did not meet in Q4. The group plans to reconvene in Q1 of 2013/2014 with additional participants from LHINs now considering the development of a BSU.

3.2 Capacity Building

During Q4 there has been a continued local focus on training new staff, and a provincial focus on sustaining the gains and planning for anticipated needs as implementation continues.

Behavioural Education Training and Supports Inventory (BETSI)

The Education & Training Subgroup conducted stakeholder consultation in Q4 to inform an updated version of the Behavioural Education Training and Supports Inventory (BETSI) tool. The language of BETSI has now been expanded so that it is applicable and accessible to multiple health sectors including but not limited to: long-term care, community care, primary care and caregivers.

For more information on BSO’s Capacity Building Suite of tools and resources, please visit www.BSOProject.ca

Sustainability and Spread

Through sustainability planning in Q4 the BSO project has continued to support an embedded approach to capacity building. LHIN Sustainability Plans were reviewed to ensure structures and processes were identified to support ongoing and deliberate approaches to capacity building across the local system of care.

- Lynda Paul, RN, KFLA BSO MRT
APPENDIX A: Primary Care Strategic Elements

March, 2013

Recommended Components to Support Primary Care Engagement

Primary Care providers (physicians, practitioners and other staff who provide care in a primary care setting such as family health teams, community health centres, individual practitioner offices) play a central role in the care of seniors with multiple co-morbid conditions that interplay and can cause behavioural stress. The complexity of this population is increased by social supports (e.g. caregivers, dyads), as well as other health providers that need to be involved in care.

It is critical that those initiatives which target this complex population (e.g. Behavioural Supports Ontario, Health Links, Senior Strategy) engage and support primary care within the context of a broader integrated system in order to build competence in behavioural management and foster an integrated response to both prevention and complex care management.

As an opportunity to further define a standard approach to assessment, referral, and service delivery models, the Behavioural Supports Ontario Provincial Resource Team recommends the inclusion of the following critical strategic elements for a comprehensive primary care strategy.

- Primary Care Leadership
- Primary Care Engagement
- Education
- System Integration
- Tools & Processes to Support Patient Care

It is crucial that any strategy to engage primary care take a multi-pronged approach. The most effective strategies will include activities that fall under most, if not all, of the 5 strategic elements described below. While it is recommended that each element is included in LHIN primary care strategies, how this element is addressed will vary from LHIN to LHIN based on local needs. Appendix A provides a snapshot of current BSO primary care activities in the LHINs which address these 5 strategic elements. It is also recommended that LHINs continue to connect with and learn from each other as they test new approaches; and that supports such as the use of OTN, E-records and primary care champions are considered as enablers for any component. Finally, a successful strategy to engage the primary care sector will leverage and build on the relationships and linkages between primary care and other sectors that are critical to support this complex population (e.g. specialty services and geriatric psychiatry).

Any activities to address these components should address system accountability, interprofessional service delivery and capacity building processes and promote and support meaningful involvement of persons and families during planning and implementation.

01. **Primary Care Leadership:** Individuals or teams that have a designated responsibility for moving BSO Primary Care forward will be more likely to see continued momentum. Consider including primary care committees or human resources dedicated to supporting system navigation and consulting with, educating and connecting to primary care providers around issues related to care of patients with psychogeriatric needs (e.g. regional medical lead, a primary care consultant or even a psychogeriatric resources consultant (PRC) dedicated to the primary care sector).

**Keys to Success:**

- Make supporting Primary Care an integral part of an individual or committee’s responsibilities rather than leaving it to chance.
02. **Primary Care Engagement**: Primary care is often one of the first touch-points for older adults with responsive behaviours and their family caregivers. As such, it is imperative that primary care be included in a systemic strategy to support this population, and also that engagement with this sector is driven by shared solution finding. Consider specific events, consultations or other efforts to engage primary care in meeting the needs of this complex population. This could include providing information about existing BSO initiatives and how they support primary care goals, aligning with related initiatives such as Health Links, collaborating on projects of mutual interest (e.g. toolkit development), and working with primary care stakeholders to identify the needs of this population as well as their own needs to best support these patients.

**Keys to Success:**

- Engage primary care as partners and collaborators early in the development of initiatives to support those with complex care needs or the primary care sector itself.
- Ensure genuine engagement and consultation opportunities – demonstrate the value of their input!
- Consider initiatives / strategies that will fit into schedules of primary care providers.
- Select primary care providers who have a keen interest and engage them as early adopters (e.g. FHTs or CHCs who have expressed an interest or even individual champions within these settings).
- Foster relationships with your LHIN Primary Care Lead and other key decision makers to ensure BSO is on the Primary Care agenda.
- Leverage medical directors to connect to broader primary care community.

03. **Education**: Primary care is seeking opportunities for further education specific to complex needs of older adults with responsive behaviours, and their caregivers. Consider training opportunities for physicians, NPs, and interdisciplinary primary care team members around behavioural assessment and management. This could include formal training with targeted training events, CME workshops, journal clubs, case studies, case consultations or opportunities embedded into existing events and structures.

**Keys to Success:**

- Develop an understanding of the learning needs of target learners – What specifically do they need to know? What skills are needed?
- Incorporate interdisciplinary team learning opportunities whenever possible to foster team collaboration.
- Use a variety of learning strategies that are grounded in adult learning theory and the needs of target learners.

04. **System Integration**: With the integral role of primary care as the first touch point in care of those with complex needs, it is essential that we wrap services around primary care to enable better flow of information, referral and collaboration between Primary Care, specialist services and other community service providers. This could include specialty services, geriatric psychiatry, First Link, integrated records, client lead, memory clinics and integrated support for complex cases.

**Keys to Success:**

- Involve all partners across sectors in developing strategies for system integration.
- Ensure a person-centred approach to care informs all integration strategies.
- Embed mechanisms to link tertiary and specialized mental health work with primary care
- Explore opportunities and mechanisms for shared leadership models between specialty and tertiary care
05. **Tools & Processes to Support Patient care:** Primary care is seeking access to tools that will help them provide better in-the-moment care to patients with complex care needs and their families. Consider developing or providing access to standardized, best practice tools and processes to support care assessment and management. These could include low-tech solutions such as evidence-based toolkits, or hi-tech solutions such as OTN to support consultation and enable access to specialized resources.

**Keys to Success:**

- Understand what tools and processes are most needed by primary care providers
- Scan for existing tools and processes to avoid duplication. Then determine how existing resources fit the needs and adapt only as necessary.
- Use best practice evidence (research, practice-based and lived experience) when developing tools and processes.
- Ensure processes integrate Primary Care with other service providers and include all stakeholders in development.

**Snapshot of LHIN Activities, March 2013**

<table>
<thead>
<tr>
<th>01. Primary Care Leadership</th>
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</thead>
<tbody>
<tr>
<td>HNHB</td>
<td>• Primary Care Committee (collaboration of primary care and geriatric specialists)</td>
</tr>
<tr>
<td>WW</td>
<td>• Primary Care Clinical Consultant</td>
</tr>
</tbody>
</table>
| NSM | • Medical advisor - .2 FTE, non clinical  
• Establishing relationships with Health Links and Primary Care Network.  
• Medical Advisor Network in one region and Memory Clinic and Medically Complex Clinic starting in April |
| CL | • BSO Regional Medical Lead  
• Exploring relationship to Health Links; BSO Medical Advisor is keeping BSO on Primary Care Network agenda |
| CW | • PC focused PRC; CCAC primary care coordinators; Primary Care Medical LHIN Lead |
| NE | • BSO Regional Medical Lead and 4 other BSO Medical Hub Champions  
• NE BSO Medical Advisory cmt.  
• Sustainability via NE BSO Regional Medical Champion and Medical Hub Champions |

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<thead>
<tr>
<th>02. Primary Care Engagement</th>
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</table>
| HNHB | • BSO has been presented at the Primary Care Network Meeting. This group meets regularly and has representation from Primary Care Physicians across the HNHB LHIN. The LHIN Advisor, also the Improvement Facilitator is at these meetings with the assurance of making the links.  
• Meetings among the two LHIN Leads for BSO & Health Links, and the Implementation Leads of both projects to ensure a connection. The most important is building upon the existing models, such as the Integrated Community Lead (ICL) model for BSO – it is a close link to what is being shared as ‘care coordinators’ and this ICL model was also highlighted as a best practice in the Seniors Strategy by Dr. Sinha.  
• We have presented at two primary care conferences (Care of the Elderly – Perspective for Primary Care), McMaster Geriatric Medicine Grand rounds, the Regional Geriatric Program and other outreach to ensure BSO is presented, but that the primary care, geriatricians and geriatric psychiatry physicians have provided feedback.  
• We completed a Primary Care Survey for the HNHB, with 61 responses  
• In our sustainability planning, we sent a separate survey for the primary care committee from last year to ask their thoughts on sustainability, and met with 5 of the members in person  
• Ongoing involvement of a primary care (FHT) physician on the primary care toolkit over the summer and fall 2012, with more feedback recently to help us work to finalize and post the toolkit  
• McMaster University project - Occupational Therapists – interviewing key experts in primary care to ask about what models would work for the complex clients or those at risk; BSO Implementation Project Lead facilitating these meetings & listening in to understand the challenges. The OT Project will produce 11 papers and proposals with ideas, for which the LHIN will examine for whole or elements that can be incorporated.  
• Primary Care at planning system tables locally – BSO Kaizen events |
| WW | • Meetings with PC providers to identify their needs  
• BSS champions with CHC and specific FHTs,  
• Primary Care at planning system tables locally – BSO Kaizen events |
<table>
<thead>
<tr>
<th>NSM</th>
<th>VSM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Meeting with PC providers, community and LTC, re role of medical advisor and BSO – how to refer and how they can support - also how PC supports.</td>
</tr>
<tr>
<td></td>
<td>Plans to integrate BSO services with one Health Links. Entering discussion with others</td>
</tr>
<tr>
<td></td>
<td>BSS liaison champions with each HSP - including PC</td>
</tr>
<tr>
<td></td>
<td>BSO medical advisor has met with LHIN PC lead, FHTs and CHCs.</td>
</tr>
<tr>
<td></td>
<td>Attends BSS Kaizen events and Operations Committee. Advises to sub committees, e.g BSU</td>
</tr>
<tr>
<td>CH</td>
<td>Fostered a relationship with the primary care lead and other decision makers to ensure BSO is on the primary care agenda. The physician director of the dementia network is also a member of the Champlain Primary care table and the Champlain Behavioural Support System Steering Committee.</td>
</tr>
<tr>
<td>CL</td>
<td>Engaging with primary care teams 1:1 meetings re: BSO; identify supports, learning needs of primary care.</td>
</tr>
<tr>
<td></td>
<td>BSO Medical Advisor member of primary care network and HPAC</td>
</tr>
<tr>
<td></td>
<td>Plans to integrate BSO services with Health Links</td>
</tr>
<tr>
<td></td>
<td>Engaging FHTs and CHCs - meeting with those who expressed interest first, to be followed by remainders</td>
</tr>
<tr>
<td></td>
<td>BSO Medical Advisor has met with primary care LHIN lead, gave presentation re BSO to primary care network meeting, opportunity to continue engagement and link with monthly newsletter to primary care</td>
</tr>
<tr>
<td>CW</td>
<td>PRC imbedded in FHT</td>
</tr>
<tr>
<td></td>
<td>PC LHIN Medical Lead engaged in BSO governance committee</td>
</tr>
<tr>
<td></td>
<td>Health Links to integrate BSO framework</td>
</tr>
<tr>
<td></td>
<td>Primary Care Integrated Seniors Team (SHIP)</td>
</tr>
<tr>
<td></td>
<td>PC Care Coordinators CCAC; 10 FHT and PRC</td>
</tr>
<tr>
<td></td>
<td>LHIN Medical Primary Care Lead</td>
</tr>
<tr>
<td>MH</td>
<td>Engaging PC around development of new tools &amp; clinical pathways</td>
</tr>
<tr>
<td>NE</td>
<td>Medical advisory committee</td>
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<tr>
<td></td>
<td>Participation in Kaizens</td>
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<tr>
<td></td>
<td>Clinical Development Days</td>
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<tr>
<td></td>
<td>Meetings with PC providers</td>
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<tr>
<td></td>
<td>Integrated behaviour teams include physicians and NP’s</td>
</tr>
<tr>
<td></td>
<td>Primary Care Lead invited to attend BSO medical advisory cmt</td>
</tr>
</tbody>
</table>

### 03. Education

| WW   | via PC PRC |
|      | JN club with physicians and FHT members monthly |
| NSM  | 2 BPSD training sessions with MainPro credits – to 38 PC providers and LTCH medical directors. |
| SW   | Workshops currently being planned for spring 2013 for dementia BPSD targeting physicians. Primary care |
| CH   | Workshop planned for dementia BPSD targeting physicians. |
|      | Primary care engagement and targeted education sessions with interdisciplinary primary care teams |
|      | BSO Medical Advisor to speak at regional geriatric day (April) |

### 04. System Integration

<p>| HNHB | Common Client Record |
|      | Clinical Lead |
| WW   | Primary Care Memory Clinics |
| NSM  |Centralized intake |
|      |Working on common client record in one region. |
|      |Integrate support for Complex Cases |
| CL   | During engagement meetings providing information packages re First Link to primary care as was identified as need in primary care survey; advising of local specialized resources/teams |
| CW   | EMR |</p>
<table>
<thead>
<tr>
<th>05. Tools and Processes to Support Patient Care</th>
</tr>
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<tbody>
<tr>
<td><strong>HNHB</strong></td>
</tr>
<tr>
<td>• First Link to Primary Care</td>
</tr>
<tr>
<td>• BSO standard operations approach</td>
</tr>
<tr>
<td><strong>WW</strong></td>
</tr>
<tr>
<td>• evidence-based toolkit (safety checklist, assessment tools, decision trees, treatment/ Management suggestions</td>
</tr>
<tr>
<td>• OTN for Geriatric psychiatry clinic – Guelph and Rural FHT</td>
</tr>
<tr>
<td>• OTN for Geriatric Medicine – rural FHT</td>
</tr>
<tr>
<td><strong>SE</strong></td>
</tr>
<tr>
<td>• Primary Care Dementia Assessment &amp; treatment Algorithm (PCDATA)</td>
</tr>
<tr>
<td><strong>SW</strong></td>
</tr>
<tr>
<td>• OTN for Geriatric psychiatry clinic –Grey Bruce, Huron Perth, Oxford, Elgin, London Middlesex</td>
</tr>
<tr>
<td>• 54/78(69%) LTC have OTN</td>
</tr>
<tr>
<td><strong>CL</strong></td>
</tr>
<tr>
<td>• OTN for Geriatric Outreach Team with</td>
</tr>
<tr>
<td>• six rural LTCHs</td>
</tr>
<tr>
<td><strong>CW</strong></td>
</tr>
<tr>
<td>• Tools and processes to be developed; OTN used for medical clinics at acute care centres</td>
</tr>
<tr>
<td><strong>NE</strong></td>
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<tr>
<td>• OTN for Specialty consultations</td>
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</table>
Appendix B: Behavioural Supports Ontario- A Prototype for Success

The Behavioural Supports Ontario (BSO) project is enhancing care for older adults with, or at risk for, responsive behaviours due to a variety of complex conditions, including dementia and other neurological conditions, mental health needs and/or addiction. BSO is not a new service; rather it is a province-wide, evidence-based transformation of the healthcare system. The BSO Provincial Resource Team (PRT) has supported and enabled the LHINs through planning, implementation, sustainability and spread activities. This support included approval of original Action Plans, and more recent endorsement of LHIN Sustainability Plans. In addition, the PRT engaged in regular dialogue with the LHINs, offering advice on innovations, emerging issues and how to maintain the fidelity of the BSO Framework for Care. PRT has had a unique view of the project, offering response and insight on implementation approaches, as well as recommendations on emerging provincial themes and topics. The mandate of PRT will conclude on March 31st, 2013.

Though the context of BSO has been unique, the success is replicable. This final document packages the transferrable components of the project into a Prototype for Success. PRT offers this resource to inform and guide the development of future projects with similar scope.

**Provincial**
- **Co-Creation and Design**
  - Provincial Framework
  - Lived Experience
  - Provincial partnerships
- **Testing and Implementation**
  - LHIN-Based Implementation
  - Dedicated & Centralized Project Management
  - Dedicated & Centralized Project Oversight
  - Measuring Change
  - Provincial Committee Structure
  - Quarterly Reporting
  - Knowledge Exchange
  - Stakeholder Engagement
  - Alignment of Provincial Priorities
  - Resource Development
  - Early Adopters
- **Sustainability and Spread**
  - Sustainability Planning

**LHIN-Level**
- **System Coordination and Accountability**
  - Dedicated Human Resources
  - Governance
  - Stakeholder Engagement
  - Accountability Agreements
  - Communication Strategy
  - Alignment with Priorities
  - Lived Experience
- **Interdisciplinary Service Delivery**
  - Interdisciplinary Teams
- **Knowledgeable Care Teams and Capacity Building**
  - Continuous Quality Improvement
  - A Comprehensive Approach to Capacity Building
**Provincial Framework:** Collaboratively develop a Framework for Care which includes target population, guiding principles and pillars to support a comprehensive and integrated care system. Ensure this framework is informed by research, practice-based evidence and the lived experience of clients and families. Use this framework to guide all decision making.

This approach enables:
- Project champions and key stakeholders to be engaged at local and provincial levels
- The development of an evidence-informed business case
- A common framework to guide all provincial and regional project planning, decision making and implementation activities

**Lived Experience:** Engage clients and their caregivers to inform project co-creation and design, testing and implementation and sustainability and spread activities and decision making.

This approach enables:
- Project activities to be grounded in the front line experience of individuals and families
- Creative and collaborative solution finding

**Provincial Partnerships:** Identify and engage provincial partners. Leverage the unique expertise of provincial partners to support project activities and capacity building.

This approach enables:
- Partners to be sought out who provide specific expertise and are able to demonstrate leadership and champion the work at multiple levels (e.g. Ministry, Health Quality Ontario, provider associations, knowledge exchange networks etc.)

**LHIN-Based Implementation:** Allow LHINs to work with local stakeholders to develop their own Action Plans, detailing how they will apply the Provincial Framework for Care within their own unique context.

This approach enables:
- Planned activities to meet local needs
- Early buy-in and commitment to ongoing success
- All LHINs to remain grounded in a common approach

**Dedicated and Centralized Project Management:** Dedicate provincial staff/roles to coordinate and manage provincial deliverables.

This approach enables:
- A systemic view, rather than silos or sectors
- A direct liaison between LHINs and the Ministry
- Project deliverables to be delivered on time and within budget
- Centralized provincial communications
- Centralized support for knowledge exchange activities
Centralized Project Oversight: Establish a Coordinating and Reporting Office that has the authority to make project-level decisions and a Provincial Resource Team of experts to provide advice on provincial and LHIN level activities, innovations and issues.

This approach enables:

- Provincial level coordination of expertise
- A common language
- A coordinated approach to planning, implementation and spread

Measuring Change: Embed formative and summative evaluation processes at project inception. In addition to formal project evaluation, continue to develop and refine local measures using quality improvement methodology. Balance measurement and messaging between data and patient stories.

This approach enables:

- Local measures to be tested and refined through a continuous improvement process
- An understanding of the impact on health care
- Indicators to serve accountability processes and act as further catalysts for system redesign
- A basis for expanding and deepening data at different points of care

Provincial Committee Structure: Establish provincial committees which have targeted mandates / focusses (e.g. provincial oversight / advice, evaluation, communication, project lead, provider council, topic-specific collaboratives, capacity building, project implementation etc.)

This approach enables:

- Stakeholder burnout to be avoided by ensuring partners are engaged at the right time to provide reflection on the most appropriate area of focus
- Parallel work to happen across committees (divide and conquer)
- Provincial exchange, spread of innovation and shared solution finding
- Channels to seek advice of key stakeholders
- Multiple project communication channels

Quarterly Reporting: Establish a regular reporting schedule that includes project updates, qualitative and quantitative successes and risk mitigation strategies

This approach enables:

- A regular celebration of successes
- An opportunity to check-and-balance against proposed targets
- Cross-LHIN knowledge exchange
- LHIN and provincial level reflective practice
- A birds-eye comparison across LHIN-level implementation activities
**Knowledge Exchange:** Enable the two-way exchange of knowledge across LHIN boundaries using dedicated knowledge brokers and targeted exchange activities. Examples of activities and processes include:

- Provincial e-newsletter
- Provincial online collaboration space to co-create and share project documents
- In-person and online exchange events
- Topic-specific collaboratives
- Project committees

This approach enables:

- Boundary-spanning relationship building
- The spread of promising practices and sharing of lessons learned
- Course correction when needed
- Collaborative development of resources and tools
- Collaborative planning and decision making
- Sharing of project information

**Stakeholder Engagement:** Broadly engage stakeholders early and often.

This approach enables:

- An integrated approach to care
- Role clarity and a commitment from stakeholders

**Alignment of Provincial Priorities:** Deliberately identify opportunities for alignment with other emerging provincial priorities and initiatives.

This approach enables:

- Sustainability
- Sharing of success and lessons learned
- Integrated supports for a common target population

**Resource Development:** As common topics emerge, create evidence-informed provincial resources (i.e. checklists, tools, guides, roadmaps) to guide a common approach.

This approach enables:

- A common provincial approach to LHIN level planning and implementation
- Consolidation and spread of best practices
- Evidence-informed decision making

**Early Adopter:** Based on local readiness, identify a subset of early adopters to begin implementation. Include a requirement that early adopters guide subsequent implementation based on lessons learned.

This approach enables:

- Accelerated start up for those following early adopters
- An early and defined process for cross-LHIN exchange
**Sustainability Planning:** Initiate sustainability conversations early. Seek commitment to sustainability and spread activities through provincial and LHIN-level sustainability plans.

This approach enables:
- Sustainability structures to be identified and embedded early
- Long-term planning

**LHIN LEVEL**

**Dedicated Human Resources:** Provide funding for health human resources, as well as project management staff to oversee LHIN implementation

This approach enables:
- Rapid, successful and sustainable outcomes
- Discussions to stay focused on intent
- Connections between multiple and simultaneous components of BSO
- LHIN direction to stay grounded in local issues and opportunities

**Governance:** Establish a clear overarching governance structure and defined accountabilities. Assemble a strong steering committee which includes cross-sector champions who bring diverse perspectives

This approach enables:
- Shared leadership and accountability
- Evidence-based system planning

**Stakeholder Engagement:** Engage a broad cross-section of stakeholders early and often. Include the voice of the lived experience, policy makers, front-line care providers, administrator etc.

This approach enables
- Processes and service delivery to be driven by the needs of the community
- Stakeholders to actively share success stories and emerging issues

**Accountability Agreements:** Establish Memorandums of Understanding between health service providers to reinforce partnerships and articulate mitigation processes should the scope of activities change

This approach ensures:
- Bi-lateral role alignment and accountability
- A cross-organization commitment to quality patient care and shared service delivery

**Communication Strategy:** Establish a continuous communication strategy that includes clear messaging and multiple stakeholder touch-points

This approach enables:
- Local buy-in
- Clear role and service definition
- Relationship building

<table>
<thead>
<tr>
<th>Alignment with Priorities: Consider how the project fits within a broader system transformation. Establish clear linkages and alignments to other initiatives which address the same target population</th>
</tr>
</thead>
<tbody>
<tr>
<td>This approach enables</td>
</tr>
<tr>
<td>- The project to act as a catalyst for change, versus being seen as a new service</td>
</tr>
<tr>
<td>- Ongoing sustainability and integration</td>
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<table>
<thead>
<tr>
<th>Lived Experience: Engage clients and their caregivers to inform project co-creation and design, testing and implementation and sustainability and spread activities and decision making.</th>
</tr>
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<tbody>
<tr>
<td>This approach enables:</td>
</tr>
<tr>
<td>- A continuous check-and-balance to ensure activities, services and processes are person and family centred</td>
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<thead>
<tr>
<th>Interdisciplinary Teams: Establish interdisciplinary teams for a comprehensive approach to care. Consider both established teams, as well as fluid membership where members are engaged as needed through a shared care model.</th>
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<tbody>
<tr>
<td>This approach enables:</td>
</tr>
<tr>
<td>- Interprofessional mentoring and capacity building opportunities</td>
</tr>
<tr>
<td>- Comprehensive and multi-perspective care planning</td>
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<thead>
<tr>
<th>Continuous Quality Improvement: Embed quality improvement processes and methodology at all levels of the project. Engage all stakeholders in QI activities and build capacity across the system to initiate, support and evaluate small tests of change. Use QI processes to identify community needs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>This approach enables:</td>
</tr>
<tr>
<td>- A deeper understanding of how small tests of change can positively impact work and the client experience</td>
</tr>
<tr>
<td>- A mechanism to share successes and great ideas across LHINs</td>
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<tr>
<th>A Comprehensive Approach to Capacity Building: Establish dynamic processes that allow staff to learn skills, apply new knowledge into practice, participate in exchange opportunities as a way to learn from and share with others, and together generate new and innovative approaches to care. Consider capacity building activities for new and existing staff that span formal and informal learning activities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>This approach enables:</td>
</tr>
<tr>
<td>- Care providers to continuously build skills and improve service delivery- ensuring clients receive the best care possible</td>
</tr>
<tr>
<td>- Learning to be driven by and applicable within day-to-day practice</td>
</tr>
<tr>
<td>- Leveraging of expertise at all levels of care</td>
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