Central **LHIN**

Central LHIN Behavioural Support Ontario Action Plan

December 15, 2011

Ontario
Local Health Integration Network

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Introduction

In August 2011, Central Local Health Integration Network (LHIN) initiated planning of the Behavioural Supports Ontario (BSO) Framework and operational program model.[1] This marked the beginning of Phase II of the BSO project.

The first phase of the BSO project (Phase I) involved the development of a principle-based Framework of Care designed to improve outcomes for persons with challenging behaviours and support their families and health providers. The Framework's overarching principle is ***Person and Caregiver*** directed care. The three core elements of the Framework (pillars) are:

- Pillar 1- System coordination and management
- Pillar 2 - Integrated service delivery: intersectoral and interdisciplinary
- Pillar 3 – Knowledgeable care team and capacity building

To guide local health system redesign of behavioural support services within the BSO Framework, LHINs were required to develop an Action Plan. The Action Plan identifies local service gaps, resources, and the improvement plan/strategies that need to be implemented to advance the local health system to the future state envisioned within the BSO Framework[2]. A copy of the Central LHIN BSO Executive Summary, November 28, is attached as Appendix A.

This document details the Central LHIN BSO Action Plan that was developed under the leadership of the Central LHIN Behavioural Support Planning Group (Planning Group). The Behavioural Support Planning Group was established as a transitional planning group to guide the development of the Central LHIN Behavioural Support Services Action Plan in October 2011 and is accountable to the Central LHIN (see Appendix B for a list of members and terms of reference). The Planning Group was comprised of cross sector and cross LHIN representation from LHIN agencies/organizations with expertise in the identification, assessment, care and management of individuals and their caregivers with responsive behaviours. It is intended that this group will cease once a Behavioural Support Steering Committee (BSSC) is in place.

Key considerations for planning activities in the Central LHIN include high population growth and an aging population. The anticipated increase for those age 65+ over the next ten years is 52%, over 10% greater than the provincial average over the same period (Central LHIN 2010-11 Annual Report). In addition, Central LHIN is geographically diverse: although the LHIN is primarily urban – about 70% of the population resides in North Toronto, Vaughan, Richmond Hill and Markham – there is a significant rural region to the north which can represent a challenge to residents when accessing services. The residents of the Central LHIN are also culturally diverse, with the highest proportion of immigrants in the province and twice the provincial average of visible minorities. Central LHIN is home to a small population of Aboriginal/First Nations people and approximately 3.2% of the population is Francophone.

Currently in Central LHIN, there is an absence of a coordinated integrated system of care, managed through formalized partnerships with assigned accountability for the clients'/caregivers' care needs. As a result, there is fragmentation and lack of knowledge of existing services, duplication of efforts, inconsistent communication among the service providers and sectors and lack of integration with services traditionally outside of the health system (police/EMS). There is also a lack of capacity and

[1] *Behavioural Supports Ontario, Implementation Kick Off Presentation, Alzheimer Society Ontario, Alzheimer Knowledge Exchange, Ontario LHINs: August 2011*

[2] *Ontario Behavioural Supports Systems, A Framework for Care. Alzheimer Society Ontario, Alzheimer Knowledge Exchange, Ontario LHINs: January 2011.*

expertise to treat this complex population. In addition, across all Central LHIN hospitals there are clients waiting alternate level of care (ALC) for appropriate placement. From July to October 2011, 13% of people ALC for more than 30 days and waiting for placement to LTC were identified as having specialized behaviour needs (See Appendix C).

Guiding Principles

- Person- and caregiver- directed approach.
- Equitable, coordinated access to behavioural support services.
- Simplified access to appropriate services in a timely fashion.
- High quality care

In developing this Action Plan, the Planning Group was guided by healthcare leaders with expertise in responsive behaviours. In addition, to gain greater insight into the gaps and weaknesses of how existing services were meeting the needs of clients with responsive behaviours and their caregivers, the Planning Group:

- consulted with LHIN health service providers (HSPs) through existing network tables and individual meetings with long-term care homes, CCAC, mental health and addictions providers and medical directors.
- collected Central LHIN stakeholder feedback on the proposed key elements in the Action Plan through an electronic survey (80 responses):
- hosted a Value Stream Mapping Session lead by Health Quality Ontario:
- reviewed reports/reviews that had previously been completed, which provided insight on this population within the Central LHIN and assisted in the development of the Action Plan, including:
    - Central LHIN Alternate Level of Care Report, November 2011
    - Long-term Care- Mental Health Framework, Toronto Region, How to Guide, 2006
    - For Our Aging Population and Addressing Alternate Level of Care, Report Submitted to the Minister of Health and Long-Term Care, Dr. David Walker, Provincial ALC Lead, June 30th, 2011

Quality Improvement

A Behavioural Support Quality Task Group will be formed and supported by the Central LHIN *BSO Improvement Facilitator.* The Task Group will implement integration activities identified by the Behavioural Support Steering Committee (BSSC). The Improvement Facilitator will serve as a local source of improvement expertise and function as the key point of contact with Health Quality Ontario (HQO). The role of the Improvement Facilitator includes the responsibility for development and coordination of Quality Improvement activities within the LHIN and the behavioural support service providers. The Improvement Facilitator will work closely with colleagues in buddy LHINs to transfer knowledge.

Through the Value Stream Mapping exercise in November 2011, participants (see Appendix D) developed an ideal future state to illustrate how a person with responsive behaviours and their caregiver living in the community can be supported across the continuum of care. Through the value stream mapping process, many improvement ideas were captured and documented into early 'charters' for change. These charters will be revisited by the Behavioural Support Quality Task Group for scope definition, prioritization and confirmation of timelines. Change teams are proposed to be developed through the duration of the project to complete activities tied to change ideas, including use of plan, do, study, act cycles (e.g. HQO Tools for Quality Improvement Teams).

Pillar #1: System Coordination and Management

System Coordination and Management

To effect the necessary system redesign and implementation of the Behavioural Supports Ontario (BSO) model**,** it is necessary to involve all the major stakeholders within the system and to formalize activities across sectors and organizations, through the creation of a governance mechanism. ***All providers, the people our providers care for, and the communities we serve, are our partners in this initiative.***

Key Gaps Identified in System Coordination

Current identified gaps for behavioural services include:

- Absence of a coordinated integrated system of care, managed through formalized partnerships with assigned accountability for the clients/caregivers care needs. As a result there is, fragmentation and lack of knowledge of existing services, duplication of efforts, inconsistent communication among the service providers and sectors and lack of integration with services traditionally outside of the health system (police/EMS)
- Lack of a centralized intake process to provide timely access to the appropriate services and supports.

Health Service Providers Supporting System Coordination

Central LHIN health service providers (HSP) with expertise in the care of individuals with responsive behaviours, have demonstrated leadership across the continuum of care through the establishment of informal partnerships to improve access to behavioural support services, refer to Appendix E. While these partnerships, for the most part, are informal and exist at the sub-LHIN level, they can be leveraged to facilitate equitable, coordinated access to behavioural support services through the implementation of a formal governance and accountability structure.

In order to enable LHIN-wide success and improve system coordination, a shift in culture is required. A cultural shift which defines value and develops improvements as seen through the eyes of the client may require formal partnerships, collaboration and accountabilities between sectors and providers. This requires an extensive community engagement process which is limited by the timelines associated with this phase of the Behavioural Support Ontario initiative. It is proposed that over time existing sub-LHIN integrated care models be connected through formalized accountability and standardized processes and protocols to form a coordinated LHIN-wide Behavioural Support System. BSO-funded resources will be allocated to existing service providers to enhance current structures and build on current initiatives.

The future state is intended to achieve client and family-directed care while addressing the client's needs throughout the continuum of care. Existing initiatives in Central LHIN that could be included in a new governance framework include: Geriatric Emergency Management Nurses, Nurse Led Outreach Teams, Geriatric Mental Health Outreach Teams, behavioural support beds in long-term care and crisis services. In addition, there are important initiatives such as; Residents First, the ER/ALC Strategy, First Link, Home First and Senior Friendly Hospital strategy that could be associated with the initiative. A community engagement plan will be developed to outline how to recruit new and existing partners to participate in the planning and implementation of a coordinated care pathway across the continuum.

Governance and Accountability Structure

Behavioural Support Steering Committee (BSSC)

The Behavioural Support Steering Committee (BSSC) will have the governance authority that is ultimately accountable for the development, delivery and monitoring of an integrated regional system of behavioural support services (BSS) (See Figure 1). It is intended that the Behavioural Support Steering Committee will provide a platform and structure to facilitate the development of clinical and service delivery activities intended to build better health outcomes for older adults with challenging behaviours across the Central LHIN (see Appendix F for specification on the role). Membership on the Behavioural Support Steering Committee will be comprised of leaders who provide direct behavioural support services to older adults within their organizations and members who are not performing direct service delivery.

Once operational it is intended that the Behavioural Support Steering Committee (BSSC) will provide governance and oversight to behavioural support services to achieve strategic alignment of BSO activities with Central LHIN priorities, including quality. Until the Behavioural Support Steering Committee is operational, the Central LHIN will directly oversee the functions of the Behavioral Support Planning Group and provide guidance, oversight, alignment and coordination with all relevant and related networks, partnerships and service providers.

Operational Lead

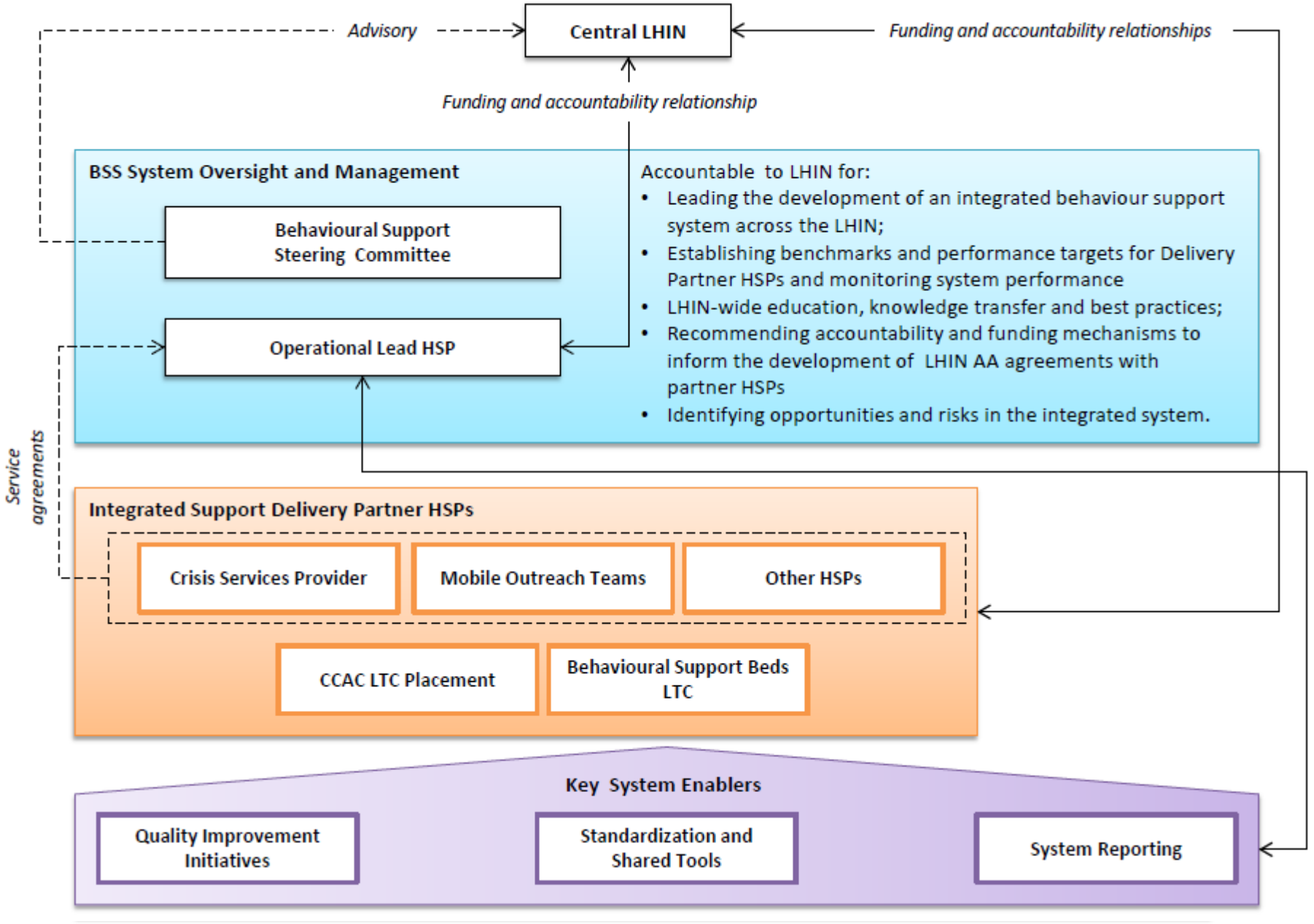
The framework proposes the establishment of an Operation Lead (single health service provider) that is guided by Behavioural Support Steering Committee to support the roll-out and implementation of the Behavioural Support Services Action Plan across Central LHIN. The Operational Lead HSP will not hold any additional authority over the governance or operations of the system but will be a member of the BSSC. The Operational Lead will also be responsible for the clinical and day-to-day operations of crisis services and mobile behavioural teams.

The Operational Lead will have a memorandum of understanding (MOU) with each of the providers with BSO-funded mobile behavioural team that will clearly articulate accountabilities and service delivery requirements. There will also be partnership agreements with “non-direct care” providers who provide a component of service within the behavioural support action plan. The Operational Lead will also be responsible for leading the BSSC**,** coordinating data collection, communication, and project management.

Primary Care

Access to timely primary care is an important constant in managing responsive behaviours across the full care continuum; prevention, assessment, diagnosis, treatment, ongoing management and follow-up. The LHIN-wide collaboration of primary care and behavioural support services will be championed through the dedicated resource of a part-time *Regional Medical Advisor*. The role of the Regional Medical Advisor is pivotal in gaining support from LTCH Medical Directors and community primary care providers to better understand the unique needs of older adults with responsive behaviours and to implement best practice approaches to care. For example, the Regional Medical Advisor would work with the BSO LTC Medical Lead, local LTCH Medical Directors, Psychogeriatric Physicians and Geriatricians, Primary Care Lead, and Emergency Department Lead to disseminate leading practice to reduce Emergency Department transfers, minimize the use of restraints, and encourage appropriate use of psychotropic drugs and other medications.

Figure 1: Central LHIN Regional Behavioural Support Services DRAFT Governance Framework



Pillar 2: Interdisciplinary Service Delivery

People with responsive behaviours are often marginalized and stigmatized; providers may be uncomfortable, feel unsafe or lack confidence in how to offer the best care; caregivers may be too stressed or exhausted to collaborate in the care plan. There is an identified absence of a coordinated integrated system of care, managed through formalized partnerships with assigned accountability for the clients'/caregivers' care needs. As a result, fragmentation and lack of knowledge of existing services, duplication of efforts, inconsistent communication among the service providers and sectors and lack of integration with services traditionally outside of the health system (police/EMS) are commonly identified issued. With this in mind, over thirty Central LHIN stakeholders representing long-term care, community support services, acute care, primary care, first responders and tertiary care attended the Value Stream Mapping session held in November, 2011. Through their work, they created a future state map and the value statement below from the perspective of the client or the caregiver that shall remain a touchstone for all of the efforts and decisions moving forward to implement the BSO Project in Central LHIN (See Appendix G).

The following value statement highlights client's needs and supports client and family-directed care along the continuum:

"I am more than my behaviour. Learn who I was, understand who I am and show me dignity and respect."

Target Population

The target population for the BSO Project in Central LHIN is older adults and their families (caregivers), at risk and/or have complex health care challenges over time, with responsive behaviours that may be a result of mental health, neurological disorders, dementia and/or addictions, who experience a crisis living in the community or long-term care home, requiring episodic care, and those individuals transitioning across care settings who require specialized ongoing support. The transition points are from home (or LTCH) to special geriatric outreach team (if available), acute care or behaviour unit (if capacity exists).

Care across the Continuum

Central LHIN has the unique advantage of having several relatively discrete models of care in use for patients with responsive behaviours (see Pillar III for details). It is our intention to build on the successes of each program; seek opportunities to transfer those successes to other parts of the LHIN; and through our work, continue to find clinically sound and effective ways to provide high quality, timely and appropriate care.

There are several key areas of focus that will address issues in accessing supports across the continuum (See Appendix H for a process map):

Improve transitions in care

As is the case elsewhere in Ontario, people with responsive behaviours are most frequently failed by the system at the transition points between providers. Client transfers are left primarily to the client and/or caregiver, and often if instructions are not clear, or there is an administrative problem in the process, this can be enough to stop the client/family from proceeding.

System accountability through a single regional point of contact

While operationally managed by distinct health service providers, part of the implementation of behavioural support services in Central LHIN is to use a collaborative approach developed to date to establish a governance framework for behavioural support services. Local performance obligations in memorandums of understanding (MOUs) can create the infrastructure for regional clusters of health leaders to advance quality and care goals for clients as well as proactively address transitions in care issues to minimize gaps in care.

Timely and equitable access to services

Over the course of the next year, as new services are being deployed regionally, an associated program profile will be developed for each new area receiving services, which will include indicators for service volumes to be provided. The service volumes will align with the LHIN's understanding of population need and will be reviewed semi-annual to ensure that programs align with this need.

Standardization of Assessments

Central LHIN will leverage already available assessment services like the PIECES assessment, Mini Mental state examinations and diagnostic outreach services. Furthermore, once standardized assessments are determined provincial or through our quality improvement processes, it is proposed that LTCH staff and all stakeholder partners will receive additional training in the standardized assessment with the double goal of improving the timeliness and quality of the assessment and reducing the number of client assessments required throughout the care journey.

Service Description

The Behavioural Supports Services Action Plan builds upon and enhances existing behavioural support services in the Central LHIN. As described earlier, the system has a governance framework outlining the administration of the system (i.e., Behavioural Support Steering Committee, Operational Lead, and Behavioural Support Quality Task Group). The overarching goal for the people receiving support through the Behavioural Support System is: ***To simplify access to appropriate services in a timely fashion.***

There are three core service delivery components required to effect system change:

1. Crisis Services
2. Mobile Behavioural Teams
3. Behavioural Support Beds in Long-term Care Homes

The introduction of a centralized intake, screening, triage and referral function, integrated interdisciplinary service networks managed through crisis services, local Mobile Behavioural Teams and specialized behavioural support beds in long-term care are vital to equitable and timely access to the right providers for the right service when it is needed.

Core Components in the Behavioural Support System

One feature of the Central LHIN Behavioural Support Services Action Plan is to develop a governance framework that includes a clustered model of service delivery that is accountable for a coordinated LHIN-wide Behavioural Support System. The Operational Lead will be responsible for the coordination of crisis services and mobile behavioural teams as outlined above.

Crisis Management Services

The goal is to establish a common crisis service with a single number to call, telephone support and a mobile response (when required). Investigating the current capacity of crisis beds and transitional

supportive housing will continue throughout implementation of the project. The BSS Action Plan will enhance existing crisis services as there are several different crisis services currently operating in different areas in the LHIN including:

- **310-COPE**- providing a range of crisis response services throughout York Region including telephone mental health crisis support, mobile behavioural outreach response (when required) to adults and children, enhanced mobile response in partnership with the York Region police force (as needed), short-term Community Crisis Support Beds – 24 hours day/ 7 days a week.
- **Seniors Crisis Access Line:** Single point of access for seniors in mental health and addictions (MH&A) crisis who reside in the Toronto (e.g. age related cognitive problems, depression/anxiety, suicidal thoughts, elder abuse concerns, or life adjustment difficulties, etc) where immediate assistance is needed in accessing supports to help stabilize the crisis situation, available 7 days/week.
- **Emergency Department Diversion Project:** Operating in North York to provide a quick response to individuals presenting in the Emergency Department at North York General Hospital and Humber River Regional Hospital experiencing mental health related crises, and who can be supported safely in the community.

BSO Crisis Services could include:

- Assistance in stabilizing age-related behavioural challenges
- Risk/safety behavioural assessments
- Immediate referrals and linkages to mobile behavioural teams
- Immediate referrals to respite services, crisis beds and transitional supportive housing
- Support for family and caregivers
- Translation support

Mobile Behavioural Teams (MBT)

The second key component in the Central LHIN BSS Action Plan is to build on current outreach and specialized behavioural services and expertise to establish interdisciplinary mobile behavioural teams (MBT) for immediate short-term and ongoing support to keep clients at home and to smooth transitions across the system. Building on a clustered model of service delivery, the MBTs will align with the boundaries used for the Nurse Lead Outreach Teams (NLOTs), creating three clusters/teams across Central LHIN (See Appendix I). Each mobile team will have an identified lead HSP and build upon the local capacity to address responsive behaviours in the place where people live. As well, each team will include a core complement of team members that will be deployed in LTCHs and in the community (as determined by the Early Adopter LHIN Kaizan Event on Mobile Behavioural Teams). Consideration to the range in culturally diversity in different areas across the LHIN will be important in the hiring and training of individuals on the teams.

The ultimate vision is that the expertise currently accessible through outreach teams, resource consultants, transition teams and knowledge transfer teams may be redeployed to support the mobile behavourial teams; supplemented where necessary by new resources. Over time, some resources may be re-deployed across the three clusters according to volume demand to address local needs. The intended outcome is that the improved coordination of care is expected to reduce duplication of efforts, improve client experience and outcomes, improve transitions of care, increase provider satisfaction and expertise and enhance system sustainability. This will improve the capacity for specialized assessments, support and treatment for those who would otherwise have been transferred to the Emergency Department of the local hospital.

The clustered approach will allow for easy access to this support system for when clients/residents are in crisis through the use of a single number for each of the three teams. This will enable a single point of access but allow for multiple modes of entry -referrals (by health care professionals, crisis services, primary care & telephone access) will include clients who are not yet connected to the system.

Each of the three Mobile Behavioural Teams will provide:

- short-term 24/7 on call support
- direct care to clients on request
- direct support and coaching to long-term care home staff and to individuals and families in Long-term Care Homes and in the community,
- urgent support to protect both residents/clients, long-term care home staff and caregivers.
- ongoing support and coaching either directly on an ongoing basis with a identified Case Manager Lead or through existing outreach teams
- partnerships with the local emergency medical services (EMS) and police departments

With a mandate to align resources to better meet the needs of the target population, the mobile teams will be developed with health system quality improvement, as one of their core objectives. Additionally, quality measures, based on the expected positive outcomes of services redesign, will enable the teams, the steering committee, the operational lead and the LHIN to monitor the progress of our work, make course corrections where results are not as expected, and demonstrate to stakeholders and the ministry the overall success of this project.

Behavioural Support Beds in Long-term Care Homes

Central LHIN is seeking to expand the number of specialty behavioural support beds model after a successful pilot at Cummer Lodge Long-term Care Home. The specialty behavioural support beds will be expanded for a total of 24 beds, in up to three homes, located across the LHIN to enhance geographic access.

The pilot program at Cummer Lodge includes eight designated specialized behavioral beds within a 32-bed secure unit. The model allows the residents to become established in a LTC home setting and when stabilized, be transferred to another unit in Cummer Lodge or another home of their choosing that can support their ongoing care needs. The beds target residents who need complex care who may have been originally rejected by other LTC homes, are waiting in hospital designated alternate level of care (ALC), or who have no other options in the current health care system to accommodate their needs.

The beds will be comprised of residential and respite levels of care. To meet resident needs, the selected LTC homes and the Central CCAC will develop discharge plans, where appropriate at time of admission for all residents admitted to the beds. Working with residents and their families ensures efficient transfer to a LTC home of their choice when they no longer require the intensity of care in the specialized beds. Thus flow through is maintained and clients don't remain in the bed when they no longer need the intensity of care.

Pillar #3: Knowledge Care Team and Capacity Building

Leveraging Current Knowledge Transfer Processes

Information Technology

Central LHIN residents and resources are spread out across a large geographic area and information technology is key to disseminating or sharing timely and relevant information to support practice, and in keeping people connected and promoting partnerships to enhance services.

Ontario Telehealth Network

Telemedicine is a system solution that supports the redesign and integration of health care delivery in Ontario. It is an enabler of the province's strategy to provide fair and equitable access to care and it is increasingly utilized by health care providers to support the integration of patient care along the continuum and improve the overall productivity of available health human resources. Telemedicine (clinical, education and admin) is accessible across 49 sites in the Central LHIN. Fourteen of these sites currently host patients for clinical telemedicine consultation. Through OTN's webcasting services, education and training events can be recorded and made available in an extensive archive library that is accessible on-line to the learner 24/7.

The OTN webinar service also provides relatively easy access to medical consultations between LTCH Medical Directors and family physicians or to specialty geriatric resources. The BSO project will leverage and expand these existing relationships. Six of the forty-six LTCHs in Central LHIN have OTN equipment in the home and are using it to connect with experts in the LHIN and across the province. Note: The clinical capacity of OTN will be further enhanced with the in-year (2011/12) investment of five Registered Nurses/Registered Practical Nurses to support health service delivery in Central LHIN.

E-Learning Tools and Resources

There are excellent e-Learning tools and resources available on-line to address mandatory and voluntary training needs for regulated and unregulated staff. These include:

- The Geriatrics, Interprofessional Practice and Interorganizational Collaboration (GiiC) Toolkit developed by the Regional Geriatric Programs in Ontario offers online modules in geriatric care, including behavioural supports, which are easily accessible for health professionals in the field.
- The NSM Dementia Network developed an e-Learning series for unregulated staff and family/caregivers entitled *Me and U-First!* (www.u-first.ca) that is available free on-line in English and French.
- The Centre for Mental Health and Addictions (CAMH) knowledge exchange offers resources for primary care, addictions and mental health specialists, and patients and their caregivers in areas of screening, assessment, treatment, early intervention and continuing care.
- The Registered Nurses of Ontario RNAO Best Practice Guidelines, e-learning, Care Plans and Implementation tool kits will be valuable tools in the development, implementation and sustainability of the BSO project.
- Other resources include the Toronto Dementia Network, the Canadian Coalition for Senior's Mental Health, Senior's Health Research Transfer Network (SHRTN), the Ontario Center for Elder Abuse, and Surrey Place Centre for Adults with Developmental Delay.

Quality Improvement (QI)

The BSO project has one half-time Improvement Facilitator dedicated to supporting a collaborative, team-based approach to effect change management. The Improvement Facilitator will leverage the expertise of the identified *Resident's First* Improvement Facilitators in long-term care homes as well as the PIECES trained staff and champions of other initiatives (including RNAO Best Practice Coordinator, CCAC Professional Practice Leads, primary care providers with expertise in geriatric care, GEM nurses in ED, Nurse Led Outreach Teams and Psychiatric Resource Consultants) to implement the change management processes for behavioural supports in LTCHs and in the community. The Improvement

Facilitator will also leverage change ideas, standard work and protocols and tools from the Early Adopter LHINs. Note: Once the Action Plan is approved the specific change projects identified through the Value Stream Mapping exercise will be reviewed by the Behavioural Support Planning Group/BSSC and the BSO Improvement Facilitator to assign priority and to determine the change indicators and measures for success.

Building on Current Capacity

There are many existing processes that will support knowledge transfer and dissemination of best practices related to behavioural supports among current and future health care providers across the Central LHIN that we intend to leverage through the BSO initiative. Organizations that provide training/education for health care professionals include:

- Alzheimer Societies' education and knowledge transfer activities for public and providers, particularly through Adult Day Programs, Public Education Coordinators and First Link.
- The Regional Geriatric Program (RGP)-Toronto activities that support and coordinate physician education, capacity building and knowledge exchange, such as PRCProgram of Toronto's Behavioural Support Training: Leaning Objectives, Curriculum and Evaluation.
- Psychogeriatric Resources Consultants in York Region.
- Resident's First knowledge transfer activities in the long-term care (LTC) sector.
- BSO LHIN-wide communications plan across all 14 LHINs. BSO Knowledge Exchange activities.
- The long-term care homes (LTCH) Centres of Learning, Research and Innovation, while not within our LHIN, will provide a source for new knowledge, best practices and learning opportunities for current and future professionals, that will be shared with all LHINs. This knowledge, once transferred into practice, we believe will have a direct impact on our target population in the management of clients with responsive behaviours.

Current Behavioural Support Expertise and Partners for Capacity Building

The Regional Geriatric Program (RGP) of Toronto

The RGP supports health care professionals in Toronto and surrounding regions in the provision of interdisciplinary, senior-friendly, and evidence-based care that optimizes the function and independence of seniors and their ability to age in place. The RGP supports a network of 28 participating organizations whose services span the continuum of hospital and community based care, including all five large public hospitals in the Central LHIN.

Integrated Psychogeriatric Outreach Program (IPOP)

The Psychogeriatric Consulting Service supports Long Term Care Facilities in York Region and Community Support Agencies that serve people who exhibit difficult or aggressive behaviours. Consultants operate in a continuum of care model and serve as a link between inpatient, specialty and community resources, among others.

Psychogeriatric Resource Consultant Program

The Psychogeriatric Resource Consultation Program in Toronto is comprised of an interdisciplinary team of health professionals providing educational knowledge to practice services to those providing care to people with a dementing illness in the city's long-term care facilities, community service agencies and CCACs. The team collaborates with ongoing related initiatives such as the provincial PIECES and UFirst! Curriculum initiatives and the dementia networks and finds opportunities to facilitate inter-sectoral collaboration in dementia care and seniors mental health.

The primary role of the PRC's work is educational and developing staff and organizational capacity to provide care for seniors with responsive behaviours related to complex physical, cognitive and mental health needs. The PRCs facilitate the transfer of knowledge to practice through formal and informal onsite staff development.

Alzheimer Society of York Region

The Alzheimer Society of York Region has been actively supporting individuals and families coping with Alzheimer's disease and related disorders since 1985. They work collaboratively and in partnership with different agencies within the Region of York to service the needs of families and individuals living with Alzheimer's disease and related disorders. As a result, the Alzheimer Society of York Region has partnerships with nine D.A.Y. programs within the Region of York.

Registered Nurses Association of Ontario – Long-Term Care (LTC) Best Practice Coordinator

The Long-Term Care (LTC) Best Practice Coordinator role was introduced to the LTC sector as a pilot project funded by the Nursing Secretariat in 2005. In Central LHIN the Long-Term Care (LTC) Best Practice Coordinator supports LTC Homes in adopting evidence-based practices that will support systematic and consistent approaches to providing quality care for residents.

BSO Early Adopter LHINs

The Alzheimer Knowledge Exchange BSO Project website offers provincial expert resources and facilitates ongoing knowledge exchange and knowledge transfer among families, caregivers, educators, and health providers in the field. Hamilton Niagara Haldimand Brant (HNHB) LHIN is leading a Primary Care Subcommittee which is developing strategies to engage primary care practitioners and provide opportunities to enhance their knowledge and skills in providing care for people with complex, challenging behaviours.

Seniors Health Research Transfer Network (SHRTN)

The provincial Senior's Health Research Transfer Network (SHRTN) has an active Community of Practice (CoP) in behavioural supports with leadership from the local knowledge brokers; Penny Hubbert (Regional Municipality of York) and Debra Walko (LOFT/Crosslinks). They ensure that the behavioural support health service providers are kept informed and that there is a continuous exchange of ideas and new knowledge to improve practice.

National Initiative for the Care of the Elderly (NICE)

The National Initiative for the Care of the Elderly is an international network of researchers, practitioners, students and seniors dedicated to improving the care of older adults, both in Canada and abroad and provides information and resources such as core competences in the care of geriatric patients with Dementia and Mental Health.

Canadian Dementia Resource and Knowledge Exchange (CDRAKE)

Canadian Dementia Resource and Knowledge Exchange is a network of people dedicated to improving the quality of life for persons with dementia and their family. Focusing on the national sharing of dementia resources and knowledge through in-person and virtual exchange to support relationships among industry, researchers, clinicians, policy makers, persons with dementia, and care partners.

Knowledge Transfer Protocols and Tools

Central LHIN proposes to strengthen capacity for current and future professionals through education and focused training. The BSO Project intends to enable the standardization of protocols and tools for consistent application in practice across the care continuum. Central LHIN will work with our buddy

LHINs to identify tools that are commonly administered across the province and find consensus on tools/protocols to set as a provincial expectation for use in the implementation of the BSO Framework. Given the diversity in Central LHIN, cultural competency training will be an important component to the any curriculum.

Consistent application of the best practice tools and protocols (both provincial and local) will be enabled by the hiring of the BSO Regional Program Manager: facilitating knowledge transfer, creating a centralized intake, triage and referral function with common risk screening and access mechanisms; and the roll-out of the Mobile Behavioural Teams across Central LHIN.

Activities related to the establishment of knowledgeable care teams will focus on building the capacity and processes that will facilitate ongoing learning and quality improvement. A learning strategy will be developed to target and coordinate training efforts at the point of care. The following strategies will be used:

- Mentoring and modeling, on-site case-based education and care planning, user-friendly job aids and organizational assistance with review and integration/embedding into program policy and procedure best practices.
- Local improvement teams will be trained and guided by the Improvement Facilitator and Operational Lead to apply quality improvement methodology as they use PDSAs to develop and test changes.
- LTCH staff will be trained to meet the mandatory core behavioural competencies as outlined in by the BSO project.
- QI capacity from Residents First Improvement Facilitators and LTCH staff will also be leveraged.
- Case based learning and consultation, and knowledge transfer through information sharing, the Mobile Behavioural Team will support the client and family by applying evidence-based learning/research, and delivering interprofessional mentoring designed to enhance care in Long-Term Care homes

In addition to the aforementioned processes, the BSO project will leverage the following mechanisms to disseminate new knowledge, processes and protocols to support the BSO project:

- Central LHIN-led mechanisms that support collaboration among stakeholders, including primary care and specialist clinicians, such as:
    - Mental Health and Addictions Advisory Network
    - Chronic Disease Management and Prevention Advisory Network
    - Primary Care Action Group
    - Health Equity Advisory Network
    - Complex Care Planning Group

Proposed Deployment of Behavioural Staffing Positions

Operational Lead

Central LHIN Behavioural Support Planning Table identified the need for a structure to oversee the day-to-day operations and monitor the performance of the implementation of the BSO Project. Outcomes are a collective accountability of all of the partner agencies funded through the Behavioural Supports Ontario Project.

To this end, several positions will need to be created in order to facilitate and resource the work and provide the operational leadership and credibility that the system will require. The key positions situated within the Operational Lead Agency who will be responsible for operations of the BSO include:

- 1 FTE BSO Regional Manager
- 0.2 FTE Regional Medical Advisor
- 1.0 FTE BSO Administrative Support
- 0.5 FTE Quality Improvement Facilitator (Central LHIN position)

The leadership team will be employed (with the exception of the Quality Improvement Facilitator) through the Operational Lead to the BSO Project (specific HSP is to be determined in negotiation with the Central LHIN).

Behavioural Support Beds in Long-term Care

The interdisciplinary team to support the specialty behavioural support beds for a total of 24 beds (in up to three homes) that will be located across the LHIN are as follows (specific HSPs to be determined in negotiation with the Central LHIN).

Positions funded through BSO

- 0.2 FTE LTC Medical Lead
- 4.0 FTE Registered Nurses
- 4.0 FTE Registered Practical Nurses
- 8.4 FTE Personal Support Workers
- 3.0 FTE Personal Support Workers (to support transitions)

Positions funded through other Central LHIN sources

- 1.0 FTE Psychogeriatric Occupational Therapist
- 1.0 FTE Recreational Therapist

Mobile Behavioural Teams

The following allocations build on the existing outreach and specialized services (specific HSPs to be determined in negotiation with the Central LHIN):

Positions funded through BSO for LTC Mobile Team

- 3.0 FTE Registered Nurses
- 9.0 FTE Registered Practical Nurses
- 17.6 FTE Personal Support Workers

Positions funded through BSO

- 3.0 FTE Crisis Workers
- 4.0 FTE Social Worker/Behavioural Therapists
- 6.0 FTE Intensive Geriatric Service Workers

Positions funded through other sources

- 4.0 FTE Psychogeriatric Resource Consultants
- Variety of positions on existing Mobile Behavioural Teams

Budget for Deployment of New Behavioural Resources

Note: the positions below and salary estimates are dependent on finalization of the model.

Long-term Care Personnel

Human Resources (Salary + Benefits @20%)	Fiscal Budget Feb/12 –Mar/12	Annualized Budget 2012/13
Registered Nurse (7.0 FTE @ $99,308)	$115,860	$ 695,159
Registered Practical Nurse (13 FTE @ $64,010)	$ 138,689	$ 832,135
Personal Support Worker (29 FTE @ $40,000)	$ 193,331	$1,159,988
TOTAL	$ 447,800	$ 2,687,300

Additional Healthcare Personnel

Human Resources (Salary + Benefits @20%)	Fiscal Budget Feb/12 –Mar/12	Annualized Budget 2012/13
Regional Medical Director (0.2 FTE @ 70,000)	$ 11,667	$ 70,000
LTC Medical Lead (0.2 FTE @ 70,000)	$ 11,667	$ 70,000
Crisis Worker (3.0 FTE @ $67,200)	$ 33,600	$ 201,600
Social Worker/Behavioural Therapist (4.0 FTE @ $90,000)	$ 60,000	$ 360,000
Intensive Geriatric Service Worker (6.0 FTE @ $64,133)	$ 64,133	$ 384,797
BSO Regional Manager (1.0 FTE @ $144,000)	$ 24,000	$ 144,000
BSO Administrative Support (1.0 FTE @ $56,400)	$ 9,400	$ 56,400
TOTAL	$ 214,500	$1,286,800

Performance Measurement and Evaluation Plan

A performance, measurement and evaluation plan is evolving and will be focused on measuring success of individual improvement projects as well as overall process and outcome measures. The Central LHIN will comply with the overall evaluation strategy of the BSO Model which is being determined centrally, led by a sub-committee of the 4 LHIN Early Adopter Steering Committee - the Data, Measurement and Evaluation Working Group. The Central LHIN will be monitoring the three indicators set out by the Ministry of Health and Long Term Care for the BSO project as well as additional process measures.

1. Reduce resident transfers out of LTC to any other care provider with the primary or main reason being a "behaviour".
   - Number and rate of transfers to the ED, Acute care, specialized psychogeriatric care units will be calculated as a baseline and will be measured to show overall impact of the BSO program within individual LTCHs and for the clusters and Central LHIN overall.

2. Delayed need for more intensive services, reducing admissions and risk of ALC
   Relevant indicators that will be monitored in line with this include:
   - # of residents with escalated responsive behaviours who are assessed and treated in the LTCH;
   - # of averted transfers;
   - # of admission and/or re-admissions to acute care for residents with responsive behaviours; and
   - # of admission and/or re-admissions to specialized psychogeriatric care units for residents with responsive behaviours.

3. Reduced length of stay for persons in hospital who can be discharged to a LTCH with enhanced behavioural resources.
   Relevant indicators that will be monitored in line with this include:
   - Average LOS of LTCH residents admitted to hospital for responsive behaviours; and
   - Number of Alternative Level of Care (ALC) days related to responsive behaviours for LTCH residents.

Other indicators that will be developed and monitored (including baseline measurement) by the Central LHIN BSO project include resident/family/caregiver experience and provider/staff satisfaction.

Data sources will include NACRS, DAD, CIHI and others available through Intellihealth. Data will also be obtained from other sources within the LHIN such as Central CCAC databases, LTCH records, and Hospital databases. For some indicators, data will come from surveys (e.g. staff satisfaction).

Closing

The system redesign goals of the provincial BSO Framework and the vision to achieve seamless transitions across the continuum, simpler access to health services, cross-sector integrated service delivery, earlier intervention to promote health, and building capacity through knowledge transfer are foundational blocks for an improved system of geriatric care for *all* older adults.

To catapult the system towards this vision and further leverage the BSO Project investments Central LHIN has added complementary system resources in 2011/12 to better support seniors including:

- Expansion of Ontario Telemedicine Network (OTN) with five new RN /RPN positions for clinical consultation;
- Increased funding of sessional fees for clinical expertise and knowledge transfer; and
- Expansion of Nurse Lead Outreach Teams for long-term care homes.

Additionally, there are potential opportunities in Central LHIN to further the vision. Examples of opportunities currently being explored include:

- Emergency Department Diversion Program for Mental Health and Addictions will provide community crisis and short term support services for patients with Mental Health and concurrent disorders
- CCAC expanded role in supportive living for high risk seniors, complex continuing care, rehabilitation and adult day programs.

The case for change is self-evident: we need to transform the way we currently provide care and services for this complex population of people. The key stakeholders in Central LHIN are committed to move forward to create better health, better care and better value for the older adults with behavioural challenges and their caregivers. They are ready to build on the current investments in programs aimed at supporting older adults, to continue to develop and apply their quality improvement skills to identify where the problems are and to work together across sectors to find innovative and lasting solutions.

Summary Timeline: December 2011 to June 2012

TASK	Dec-11				Jan-12					Feb-12				Mar-12				Apr-12				May-12				Jun-12				Ongoing
	1	2	3	4	1	2	3	4	5	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	
Staffing - HHR																														
Invite EOI from LTCHs re: Behavioural Support Bed																														
Select LTCHs for behavioural support beds																														
Invite EOI from community providers for crisis services and mobile outreach teams																														
Recruit for all positions																														
Develop job descriptions and post positions																														
Monitor the hiring of new staff																														
Leverage/monitor training of new and existing staff based on previous successful models e.g. PIECES																														
BSO Beds in LTC																														
Work with selected homes to implement the Cummer Lodge model																														
Engage support services/partnerships																														
Development of roles and responsibilities for each team/discipline																														
Monitor posting and hire additional staff if required																														
Crisis Service and Mobile Outreach Teams																														
Work with Operational Lead and Mobile Teams Leads in the development of cluster model																														
Engagement and leverage of existing outreach teams																														
Engage support services/partnerships																														
Development of roles and responsibilities for each team/discipline																														
Monitor posting and hire additional staff if required																														
Improvement Projects																														
Identify QI projects and change teams																														
Implement and monitor QI strategies																														
Collaborate with buddy IFs and Improvement Coach																														
Education																														
Use existing curriculum with any necessary complements for training new hires																														
Monitor and address ongoing training needs.																														

Evaluation																														
Identify data measures, baseline indicators for QI and BSO (in conjunction with the CRO and 14 LHINs)																														
Collect baseline data																														
Ongoing data collection																														
Knowledge Exchange																														
Knowledge Exchange with other early adopter LHINS																														
Knowledge Exchange with Buddy LHIN																														
Testing and implementing PDSAs from early adopter LHINS																														
Community Engagement																														
Revise community engagement plan																														
Seek feedback from stakeholders																														

Appendix A: Central LHIN Behavioural Support Ontario Executive Summary- Provincial Resource Table

1. Identify your Plan's target population. For this population define their location and provide a bulleted list of key system challenges.

The target population for the BSO Project in Central LHIN is older adults and their families (caregivers), at risk and/or have complex health care challenges over time, with responsive behaviours that may be a result of mental health, neurological disorders, dementia and/or addictions, who experience a crisis living in the community or long-term care home, requiring episodic care, and those individuals transitioning across care settings who require specialized ongoing support. The transition points are from home (or LTCH) to special geriatric outreach team (if available), acute care or behaviour unit (if capacity exists). The future state is intended to achieve client and family-directed care while addressing the client's needs throughout the continuum of care.

Key System Challenges

- There is fragmentation and lack of knowledge of existing services, duplication of efforts, inconsistent communication among the service providers and sectors and lack of integration with services traditionally outside of the health system (police/EMS). There is also a lack of capacity and expertise to treat this complex population. In addition, across all Central LHIN hospitals there are clients waiting alternate level of care (ALC) for appropriate placement. The lack of a centralized intake process to provide timely access to the appropriate services and supports is also a challenge.

2. BSO Framework Pillar 1: ***From the list in 1. above***, summarize how your Action Plan will address the service gaps through cross-sect oral collaboration and new/enhanced partnerships.

It is proposed that over time existing sub-LHIN integrated care models be connected through formalized accountability and standardized processes and protocols to form a coordinated LHIN-wide Behavioural Support System. This requires an extensive community engagement process which is limited by the timelines associated with this phase of the Behavioural Support Ontario initiative. A community engagement plan will be developed to outline how to recruit new and existing partners to participate in the planning and implementation of a coordinated care pathway across the continuum

It is intended that the Behavioural Support Steering Committee will provide a platform and structure to facilitate the development of clinical and service delivery activities intended to build better health outcomes for older adults with challenging behaviours across the Central LHIN

- The Behavioural Support Steering Committee (BSSC) will have the governance authority that is ultimately accountable for the development, delivery and monitoring of an integrated regional system of behavioural support services (BSS) (see page 6 for details).
- Membership will be comprised of leaders who provide direct behavioural support services to older adults within their organizations and members who are not performing direct service delivery.

The framework also proposes the establishment of an Operation Lead (single health service provider) that is guided by Behavioural Support Steering Committee to support the roll-out and implementation of the Behavioural Support Services Action Plan

- The Operational Lead HSP will not hold any additional authority over the governance or operations of the system but will be a member of the BSSC.
- The Operational Lead will have a memorandum of understanding (MOU) with each of the providers with BSO-funded mobile behavioural team that will clearly articulate accountabilities and service delivery requirements.
- There will also be partnership agreements with "non-direct care" providers who provide a component of service within the behavioural support action plan.

Access to timely primary care is an important constant in managing responsive behaviours across the full care continuum; prevention, assessment, diagnosis, treatment, ongoing management and follow-up. The LHIN-wide collaboration of primary care and behavioural support services will be championed through the dedicated resource of a part-time *Regional Medical Advisor*.

3. BSO Framework Pillar 2: From the list in 1. above, how does your Action Plan enhance the care for your target population by taking advantage of opportunities to create or expand interdisciplinary service delivery?

Crisis Management Services

The goal is to establish a common crisis service with a single number to call, telephone support and a mobile response (when required). Investigating the current capacity of crisis beds and transitional supportive housing will continue throughout implementation of the project. The BSO Action Plan will enhance existing crisis services as there are several different crisis services currently operating in different areas in the LHIN

Mobile Behavioural Teams

Building on current outreach and specialized behavioural services and expertise to establish interdisciplinary mobile behavioural teams (MBT) for immediate short-term and ongoing support to keep clients at home and to smooth transitions across the system. Building on a clustered model of service delivery, the MBTs will align with the boundaries used for the Nurse Lead Outreach Teams (NLOTs), creating three clusters/teams across Central LHIN. Each mobile team will have an identified lead HSP. As well, each team will include a core complement of team members that will be deployed in LTCHs and in the community.

Behavioural Support Beds in Long-term Care Homes

Central LHIN is seeking to expand the number of specialty behavioural support beds model after a successful pilot at Cummer Lodge Long-term Care Home. The specialty behavioural support beds will be expanded for a total of 24 beds, in up to three homes, located across the LHIN to enhance geographic access. The beds will be comprised of residential and respite levels of care. To meet resident needs, the selected LTC homes and the Central CCAC will develop discharge plans, where appropriate at time of admission for all residents admitted to the beds. Working with residents and their families ensures efficient transfer to a LTC home of their choice when they no longer require the intensity of care in the specialized beds. Thus flow through is maintained and clients don't remain in the bed when they no longer need the intensity of care.

4. BSO Framework Pillar 3: From the list in 1. above, which initiatives in your Plan will foster more knowledgeable care teams and build the capacity of current and future professionals?

Central LHIN residents and resources are spread out across a large geographic area and information technology is key to disseminating or sharing timely and relevant information to support practice, and in keeping people connected and promoting partnerships to enhance services. Ontario Telemedicine Network is a system solution that supports the redesign and integration of health care delivery that will be leveraged. In addition, the use of e-Learning tools and resources available on-line to address mandatory and voluntary training needs for regulated and unregulated staff.

Central LHIN proposes to strengthen capacity for current and future professionals through education and focused training. The BSO Project intends to enable the standardization of protocols and tools for consistent application in practice across the care continuum. Central LHIN will work with our buddy LHINs to identify tools that are commonly administered across the province and find consensus on tools/protocols to set as a provincial expectation for use in the implementation of the BSO Framework. Given the diversity in Central LHIN, cultural competency training will be an important component to the any curriculum.

5. How will implementation of these initiatives be guided by the principles of continuous quality improvement? (Examples might include adherence to the client value statement, tracking improvement measures, QI leadership and resources, etc)

- Adoption of the Central LHIN client value statement and the development of improvement plans grounded in the value statement.
- Leverage quality improvement capacity across the LHIN and disseminating and implementing standardized best practices in alignment with the Central LHIN Quality Action Plan.
- HQO training for the Improvement Facilitator and support from our "buddy" LHIN in the development of improvement plans and rapid cycle tests of change. The Improvement Facilitator will work with LHIN providers to transfer knowledge of quality improvement tools, track improvement measures and identify best practices related to behavioural supports.

Appendix B: Central LHIN Behavioural Support Planning Group Members

Name and Title	Organization
Mary Compton Director, Crisis Services	Saint Elizabeth Health Care
Mary Ann Daniels Director of Care	Aurora Resthaven Nursing Home
Yvonne Dobronyi Director of Transitional Care	Responsive Management Inc.
Susan Fagan Administrator	Simcoe Manor Home For The Aged
Christa Harvison Senior Manager, Client Services - Community	Central CCAC
Ashley Hogue Senior Planner – BSO Project Lead	Central LHIN
Joanna Holley Community Behavior Therapist	Ontario Shores Centre for Mental Health Sciences
Penny Hubbert Manager, Seniors Community Programs	York Region Newmarket Health Centre
Jim Hughes Program Manager	Behaviour Management Services of York and Simcoe, York Central Hospital
Carolyn Lemsky Clinical Director	Community Head Injury Resource Services of Toronto (CHIRS)
Louise Lorenc Superintendent Clinical and Community Programs	York Region Emergency Medical Services
Annette Marcuzzi Director	Central LHIN
Jennifer Pimek Director of Resident Care Operations	Ukrainian Canadian Care Centre
Barbara Renton Director of Nursing Care	Harold and Grace Baker Centre
Jennifer Scott Director, Placement Services	Central CCAC
Andrea Sinclair Program Manager - Case Mgmt, Seniors Case Mgmt	Canadian Mental Health Association - York Region Branch
Susan Steels Clinical Leader, Geriatric Outreach Team	Southlake Regional Health Centre
Noreen Sullivan Counselor, Community Withdrawal Management Services Program	Addiction Services for York Region
Victoria vanHemert Senior Director	Central LHIN
Debra Walko Director of Seniors' Services	LOFT Community Services
Dawn Williams-Wasylenki Social Worker	Southlake Regional Health Centre

Central LHIN Behavioural Support Planning Group Terms of Reference

PURPOSE
To provide local leadership, advice, guidance and support for the development and implementation of the LHIN-wide Behavioural Supports Ontario Action Plan for Central LHIN.

BACKGROUND
The Behavioural Supports Ontario (BSO) Project will implement the BSO Framework for transforming the health care system for Ontarians with behaviours associated with complex and challenging mental health, dementia or other neurological conditions by supporting local initiatives that will improve care. The focus is on providing quality care for individuals with these conditions, in an environment that is based on safety, high quality, evidence-based care and practice.

One of the goals of the BSO project is to ensure that staff working in health care settings – such as long-term care homes, community services and hospitals – are supported in caring for seniors with complex mental health needs. The provincial Behavioural Supports System model has three foundational pillars which will be introduced and evaluated through this process including: system coordination and management, integrated service delivery and knowledgeable care team / capacity building.

GOALS, OBJECTIVES AND DELIVERABLES
- Support the development of an integrated Behavioural Support System (BSS) plan that provides person-centred, timely, equitable access, high quality, evidence-based services in an efficient, effective and sustainable manner ;
- Identify innovations in the delivery of an integrated BSS across the health system continuum, in alignment with the Ontario BSS Framework for Care (2011);
- Leverage local structures wherever they exist in the development of the local BSS;
- Provide advice on the development of a local communication and community engagement plan to meet the needs of Health Service Providers, general public and Ministry of Health and Long-Term Care.
- Identify and address barriers and provide enablers for success to execute the implementation plan;
- Provide advice regarding the next level of priorities for BSS and for development of future system capacity;
- Provide advice on the local QI design and efforts;
- Provide advice on the development of a local evaluation plan of the BSO Project and review progress of the implementation plan in achieving aims;

ACCOUNTABILITY
The Behavioural Support Planning Table is accountable to the Central LHIN.

CONFLICT OF INTEREST
Individual members of the Project Planning Table shall identify prior to any discussion any potential, real or perceived conflict of interest. If the Planning Table deems that there is a real, potential or perceived conflict of interest, that Planning Table member must remove him/herself from the discussion.

FREQUENCY OF MEETINGS
Meetings will be every week or as determined by the chair. Meetings will be 2-hours in duration. Teleconference and/or videoconferencing will be made available for others to participate. Ad-hoc teleconference calls will be held, as needed. Discussion via e-mails may occur, as required.

ROLE OF THE CHAIR
The chair of this Planning Group will be responsible for facilitating the meetings and providing leadership. Agenda and meeting materials will be issued in advance of meetings.

QUORUM
A quorum will be met with half plus one of the members in attendance and when the chair or their delegate is present.

MEMBERSHIP
The Planning Group will reflect representation from all LHIN funded and non-LHIN funded health service providers and non-health providers as required to provide expertise and diverse perspectives related to the continuum of care for the target population. An individual member may represent multiple constituents.

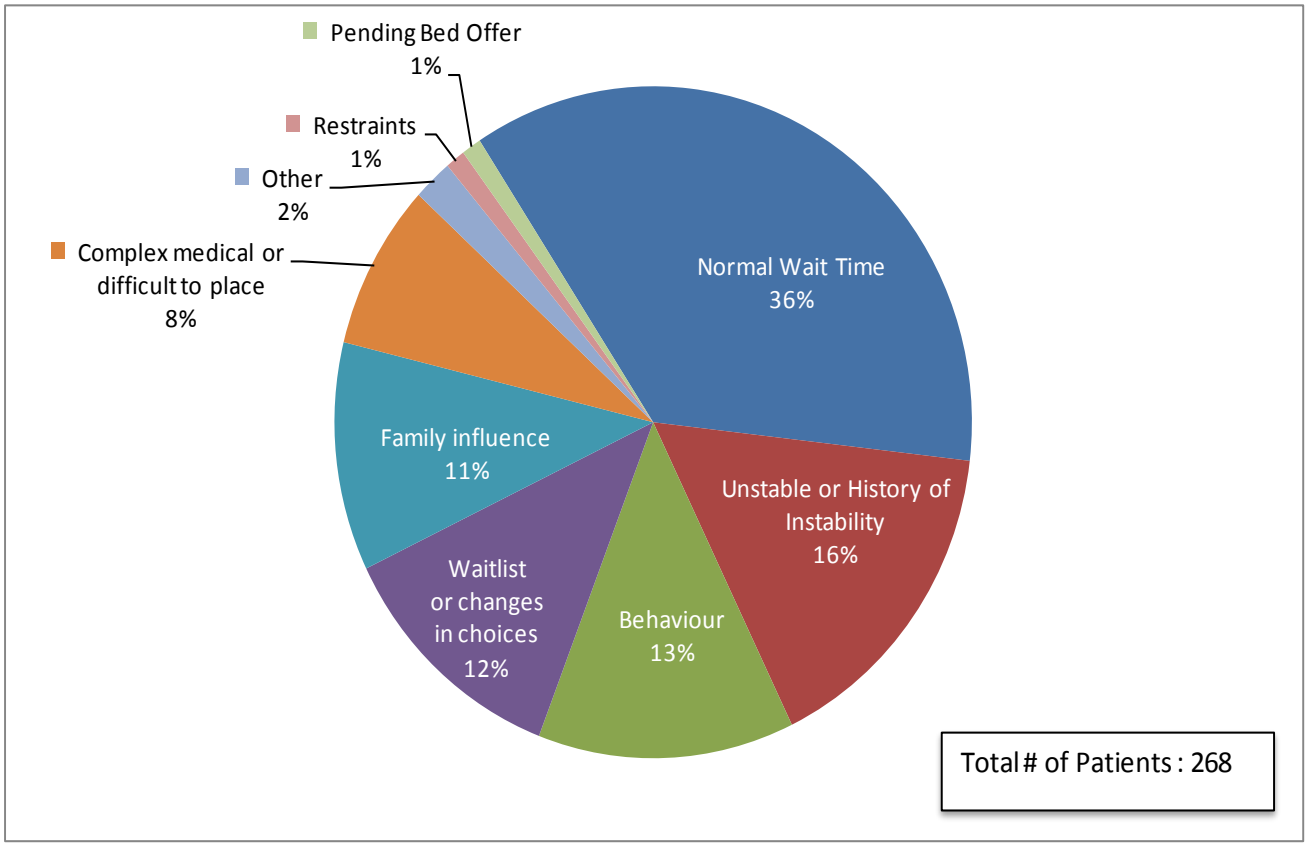
Alternates will be at the discretion of the chair.

From time to time there may be a need to involve ad hoc groups or individuals which reflect the target population, the geographic areas of Central LHIN, and affected organizations.

MEMBER RESPONSIBILITIES

- Attend meetings as scheduled;
- Review materials and participate in group discussions at the meetings;
- Participate in subcommittee working groups as required;
- Engage and follow up with respective LHIN and Behavioural Support Planning Group;
- Provide leadership and support for group recommendations;
- Bring a broad system level perspective to the table; and
- Leverage power, influence and authority at whatever level possible to advance the work of the BSO Project

Appendix C: Reasons for Greater than 30 Days ALC waiting admission to LTC in Central LHIN Hospitals: July - October 2011



Appendix D: Central LHIN Value Stream Behavioural Support Ontario Project Value Stream Mapping Event, *November 21 & 22, 2011*

Abdolmaleki, Ferdane	Registered Nurse	Harold and Grace Baker Centre
Badsha, Jennifer	Mental Health Case Manager	Central CCAC
Blaik, Jennifer	Psychogeriatric Resource Consultant	LTC Homes & Community Agencies in York Region
Bohac, Tamara	Central CCAC Placement Department	Central CCAC
Brar, Sukhi	Psychogeriatric Outreach Team	Humber River Regional Hospital
Bruinse, Valerie	GEM Registered Nurse	Southlake Regional Health Centre
Buck, Margaret	RN, Senior Crisis Management Nurse	Community Crisis Team in North York and Etobicoke
Cleland, Michelle	Nurse, Geriatric Outreach Team, YCH	York Central Hospital
Croteau, Marilie	CMHA Case Manager	Canadian Mental Health Association - York Region Branch
Dean, Karen	Supervisor, Crisis Response Program	York Support Services Network
Deonandan, Lolita	Manager	Harold and Grace Baker Centre
Floro-White, Mary	Planner	Central LHIN
Gambell, Ros	Manager, Medicine and Patient Flow Nativators	Southlake Regional Health Centre
Hennigar, Samantha	Patient Flow Navigator	Southlake Regional Health Centre
Hogue, Ashley	BSO Project Lead	Central LHIN
Holley, Joanna	Community Behavior Therapist	Ontario Shores Centre for Mental Health Sciences
Kassam, Robyn	Seniors Safety Officer	York Region Police
Kelleher, Collette	Crisis Worker and coordinator of Seniors Crisis Access Line	Seniors Crisis Access Line
Lessard, J. E.	Geriatrician	
MacKenzie, Stephanie	Social Worker	Behavioural Intervention Response Team Waypoint Centre for Mental Health Care
Meunier, Catrine	Medical Director	Newmarket & Maple Health Care Centres
Nemisz, Leslie	First Link Coordinator	First Link

Orlando, Shobha	Intake Coordinator	Community Head Injury Resource Services of Toronto (CHIRS)
Pat Owens	Discharge Planner	Stevenson Memorial Hospital
Pimek, Jennifer	Director of Resident Care Operations	Ukrainian Canadian Care Centre
Premich, Sharlene	Social Worker	York Region
Rajendran, Nirmala	Social Worker	Inpatient Mental Health and Addictions Unit - Humber River Regional Hospital
Saulnier, Suzanne	Program Director	LOFT Community Services
Spearen, Chris	Paramedic Captain	York Region EMS
Sukhai, Satya	Psychogeriatric Community Clinicians	Ontario Shores/York Region
Sullivan, Noreen	Counselor, Community Withdrawal Management Services Program	Addiction Services for York Region
Trivedi, Init	ED/ALC Coordinator	Central LHIN
Ubell, Andrea	Senior Manager, Programs & Client Services	Alzheimers Society York Region
Wax, Linda	Teletriage Practitioner	Seniors' Health Centre, NYGH
Williams-Wasylenki, Dawn	Social Worker	Southlake Regional Health Centre

Appendix E: Central LHIN Partners in System Coordination to Support the Behavioural Support Project

- **Regional Geriatric Program – Toronto: NLOT, PRC Program, Geriatric Outreach Teams, GEM**
  The RGP supports health care professionals in Toronto and surrounding regions in the provision of interdisciplinary, senior-friendly, and evidence-based care that optimizes the function and independence of seniors and their ability to age in place. The RGP provides the operational support for two initiatives that span Central LHIN including geriatric emergency medication (GEM) nurses and nurse lead outreach teams (NLOT) in partnership with the Central LHIN hospitals. They also have linked the geriatric mental health outreach team (GMOT) at North York General Hospital and the Psychogeriatric Resource Consultant (PRC) to the programs that they lead throughout the city of Toronto.

- **Central CCAC**
  The Central CCAC is responsible for providing safe, quality health services to clients in their homes, as well as connecting people to additional health and community resources. They have led many successful initiatives that were dependant on establishing partnerships including home first, balance of care, medication management and placement coordination for convalescent care and interim LTC beds.

- **North York General Hospital – Emergency Department Diversion Project**
  North York General Hospital is leading a program focused on improving the coordination of care delivery between acute care and community-based supports, to provide timely, quality care. Individuals who present at the emergency department at both North York General and Humber River Regional hospitals with mental health or concurrent disorder are assessed and provided with the option of community crisis or short term support services, including peer supports, as an alternative to possible admission or lengthy stay in the emergency department. They have established partnerships to build the continuum of care with: Saint Elizabeth Health Care Community Crisis Response Program, Lance Krasman Centre, Toronto North Support Services and Bayview Community Services.

- **SHRTN Collaborative- Mental Health, Addictions and Behavioural Issues Community of Practice (CoP)**
  This fall, with the support of Health Quality Ontario, members of the Mental Health, Addictions and Behavioural Issues CoP from across the province and specifically in Central LHIN are came together to continue the conversation on behavioural support services and how to create interactive exchange experiences *to think creatively and differently* about practice, partnership, capacity building, collaboration and integration.

- **Health Quality Ontario: Residents First**
  Residents First is one of the most comprehensive and innovative quality improvement (QI) initiatives in Canada. This provincial initiative supports long-term care homes in Ontario in providing an environment for their residents that enhances their quality of life. In Central LHIN, a Health Quality Ontario Improvement Coach is strengthening the long-term care sector's capacity for quality improvement and facilitating partnerships across the Central LHIN 46 LTCHs.

- **Centralized Access Program**
  The Centralized Access Program provides coordination of case management services, information and service navigation, peer support, eligibility assessments, and individualized short term support to clients with mental health and addictions conditions across Central LHIN. This initiative is led two lead health service providers: York Support Services Network and Toronto North Support Services.

- **LOFT Crosslinks - Crosslinks Street Outreach Van**
  Crosslinks Street Outreach Van is the essential hub of a service delivery model formed in October 2008. The Network is a partnership of regional social service providers forming a comprehensive and coordinated network of services enabling a holistic approach to support for the homeless.

Appendix F: Behavioural Support Steering Committee - Roles and Responsibilities

The BSSC will provide overall system leadership including:

System Planning

- Obtain commitment to the philosophy and intent upon which the shared governance framework is founded.
- Obtain compliance of member health service providers with the Vision, Mission, Values and Principles for the BSSC, and standards set for behavioural support services.
- Lead the development of a region-wide Behavioural Support Services Strategic Plan and associated priorities.
- Obtain ongoing and proactive planning for the health needs of clients taking into consideration the changing demographic profile of seniors in the region.

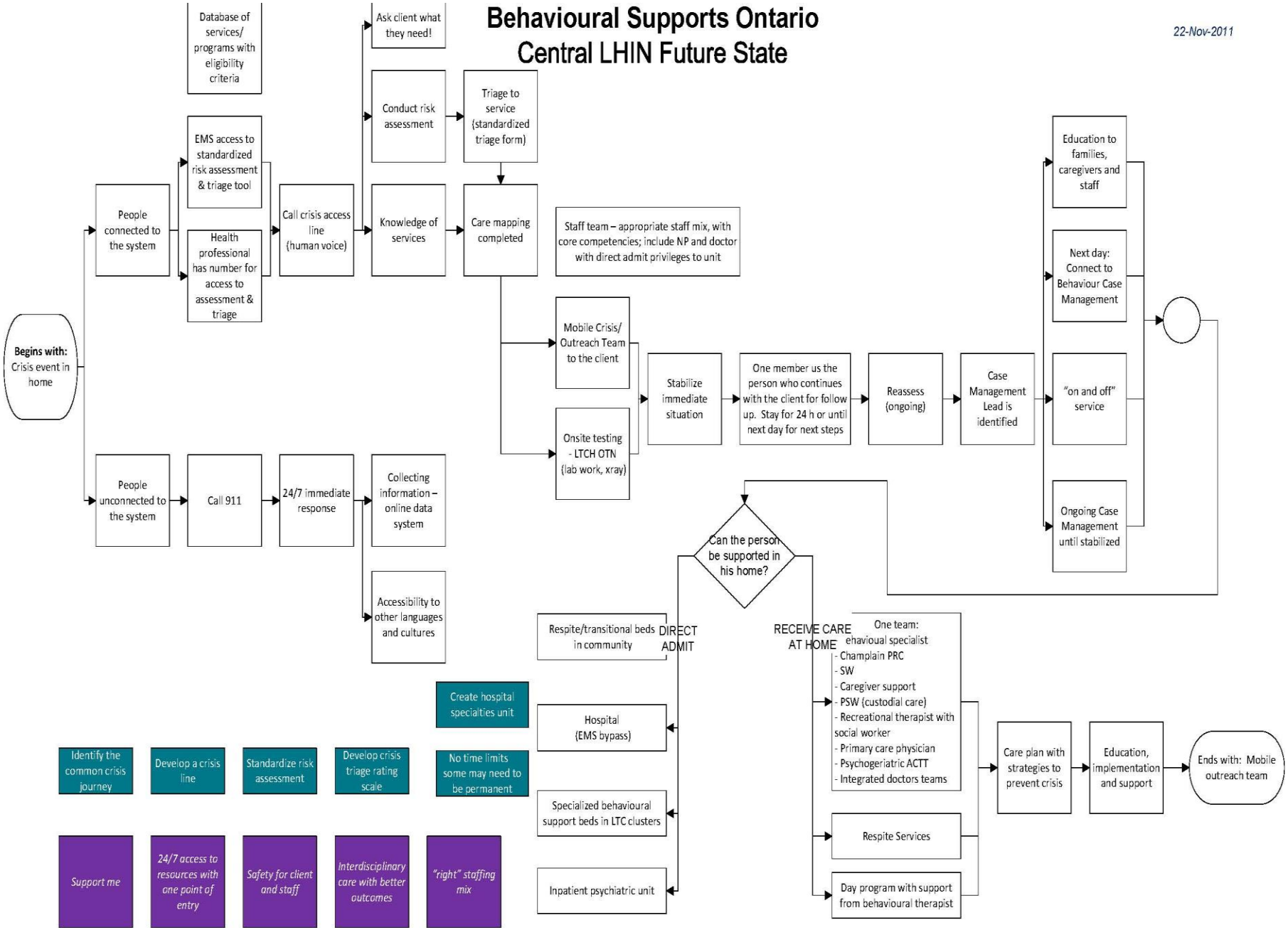
System Funding and Performance

- Negotiate annually with behavioural support service providers the deliverables and priorities for the upcoming fiscal year.
- Submit a BSS Annual Service Plan to the Central LHIN for approval.
- Review and endorse proposals for submission to the Central LHIN.
- Monitor performance of the system (financial, efficiency and quality) and overall accountability of BSS providers for service performance and quality standards, as per the MOU.

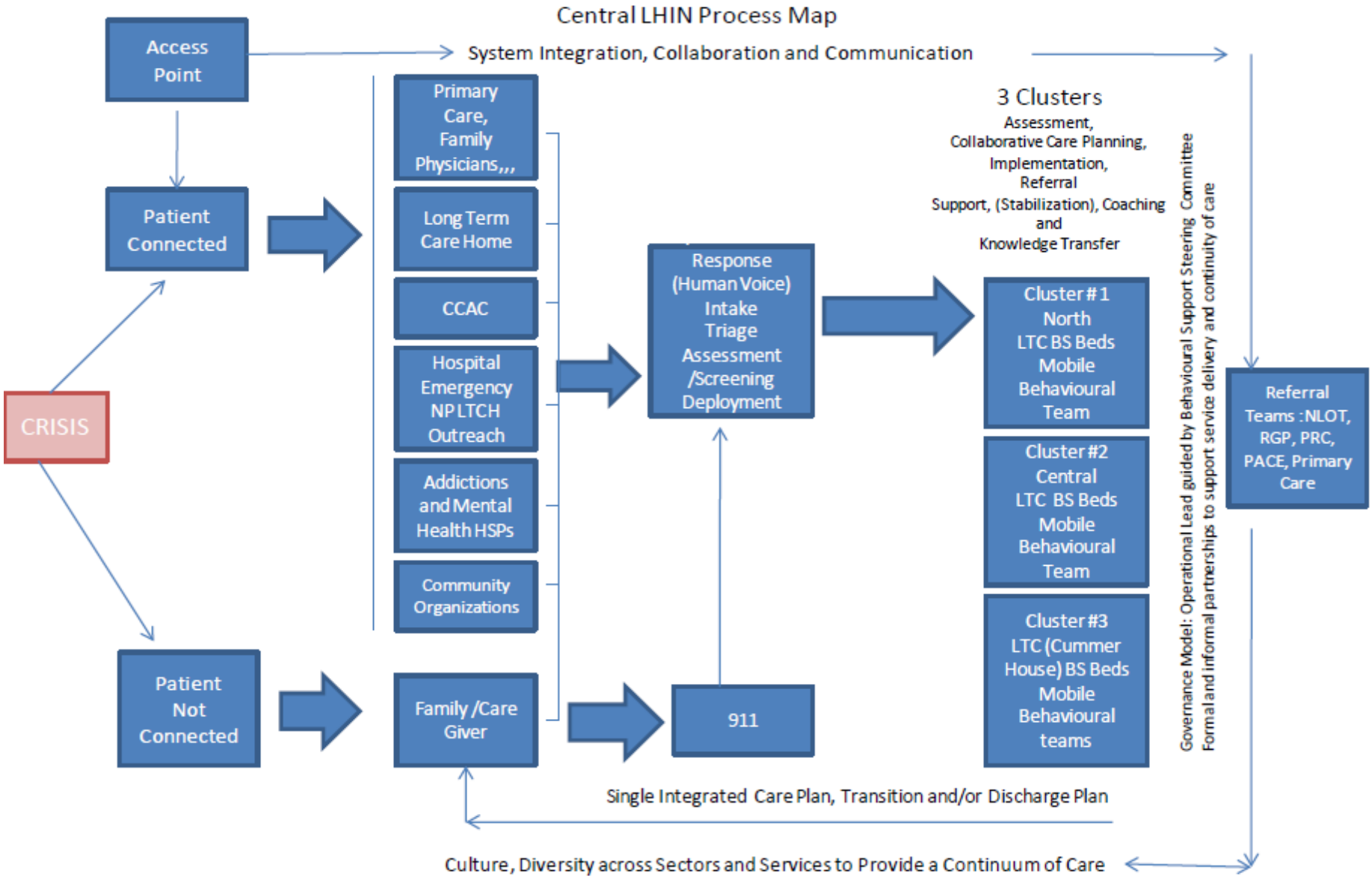
Advocacy, Communication and Education

- Advocate for the needs of older adults and promote the enhancement of specialized services to meet their unique health challenges.
- Champion health system changes that improve access to and delivery of health services for older adults, both locally and provincially.
- Engage members of administrative teams from service provider organizations through opportunities to participate in education to expand the working knowledge of senior administration related to BSS.
- Participate in community engagement activities related to behavourial support services and related issues in the Central LHIN.

Appendix G: Behavioural Supports Ontario Central LHIN Future State Map



Appendix H: Behavioural Supports Ontario Central LHIN Process Map



Appendix I: Central LHIN Nurse Led Outreach Team Cluster Map