Central West **LHIN**
RLISS du Centre-Ouest

Central West LHIN

Behavioural Supports Ontario Project

Action Plan

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Version 2.0

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

Executive Summary

The Central West LHIN BSO service will leverage existing services and make strategic investments with the intention to create a seamless continuum of care to support persons with responsive behaviours. The full continuum of the BSO service will include:

- Single access phone number (will join the provincial initiative)
- Standardized care plans and common assessment forms and the IT platforms to support shared viewing (will join the provincial initiative)
- Community-based mobile crisis teams (existing)
- Psychogeriatric Resource Consultants (PRCs) that support the community agencies and liaise with primary care providers, one covering Dufferin/north Peel, one covering Peel/Brampton and one covering north Etobicoke/Malton/south-west Vaughn. (new)
- Mobile teams that support Long-Term Care Homes (LTC). Each team is made up of a PRC and existing nurse practitioners and is assigned to a group of homes. (new) The mobile teams supporting LTC homes will be made up of three existing PRCs and two new positions.
- Geriatric Outreach Program and psychogeriatric resources based at William Osler Health System.
- In-house behaviour champions in Long-Term Care Homes This new position will be the in-house expert on behaviour response techniques and will be available to provide coaching, care planning, or hands on care as needed. (new)
- Training of LTC staff, community-based staff (crisis, day program), care givers, primary care, EMS staff, hospital staff in responsive behaviour. Existing programs include PIECES (regulated staff) and GPA (non-regulated staff), UFIRST. (existing, to be expanded)
- Inpatient resources in medicine at Headwaters Health Care Centre, Advanced Care for Elderly (ACE) unit at Osler and the Geriatric Mental Health Unit at Osler (existing)
- Respite and crisis beds (existing)
- Primary care practitioners (existing)
- Two Alzheimer Societies including First Link (existing)
- Community-based services such as day programs, supportive housing, education, case management, etc. including programs supporting diverse cultures (existing)
- Long-Term Care Home based Behavioural Support Unit (existing)

- CCAC community resources for in-home support and system navigation (existing),
- CCAC-based BSO Network coordination (new).

The following investments will be made to augment existing resources to create a full continuum of care for persons with responsive behaviours:

Two new PRCs for Long-Term Care Homes: cost $186,000.
Two new PRCs in the community: cost $173,387
Long-Term Care Home in house behaviour champions: cost $1,321,034
Crisis Support RPN: cost $73,140
BSO System Coordination: cost $144,000

Twenty six and a half new positions at a total cost of $1,897,561

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Introduction and Context

The Behavioural Supports Ontario (BSO) Project is a partnership of the Ministry of Health and Long Term Care, North Simcoe Muskoka, the Alzheimer Society of Ontario, Alzheimer Knowledge Exchange and is supported by Health Quality Ontario. Bernie Blais, CEO North Simcoe Muskoka LHIN and Ruth Hawkins, Assistant Deputy Minister, Health Systems Accountability and Performance Division are co-sponsors.

The target population for this province-wide initiative is:

"Older people with cognitive impairments due to mental health problems, addictions, dementia, or other neurological conditions (who) often exhibit responsive or challenging behaviours such as aggression, wandering, physical resistance and agitation."

The first phase of the project was completed in October of 2010 and a report entitled Behaviours Have Meaning was prepared and circulated. The report describes:

- The target population, their lived experiences and a business case for action
- A proposed systems framework for care
- A better experience for patients and their care givers

The Report identified seven reasons for immediate action:

1. The number of people with responsive behaviours are increasing
2. Challenges are experienced across all health sectors and services
3. Significant costs are incurred
4. Best practices could be more systematically adopted
5. Existing initiatives can be leveraged
6. Stakeholders are ready for change.

The Ministry of Health And Long Term Care allocated $40 million province-wide to support the BSO project. Kickoff for Phase 2 of the project occurred in August 2011 with the naming of four early adopter LHINs. Late adopter LHINs, including Central West LHIN, began work on the project in October 2011.

In October 2011, the Central West LHIN received $1.9 million in annual base funding for the BSO project. This funding was targeted for the hiring of 10 Registered Nurses or Registered Practical Nurses and 14 Personal Support Workers for the long term care sector. A separate fund for other health professionals eligible to work in any health sector was also received.

Central West LHIN BSO Proposal Development

The Central West LHIN BSO proposal is designed around the "Three Pillars Foundation for an Older Adults' BSO". These three pillars are:

1. **System Coordination** which ensures a seamless experience for the older adult and their caregiver.
2. **Interdisciplinary Service Delivery** which includes outreach and support across the continuum to ensure equitable and timely access to the most appropriate provider.
3. **Knowledgeable Care Team and Capacity-building** which strengthens the capacity of current and future professionals through education and focused training.

At a Behavioural Supports Ontario value stream mapping exercise held on November 21 and 22nd Central West LHIN health service providers developed the following value statement to guide the development of the local BSO project:

"I am a person, I matter, listen to me, know me support me…"

The Central West LHIN presented the provincial BSO initiative to the Services for Seniors Core Action Group who determined that a project steering committee be formed to develop. The Steering Committee membership was drawn from health service providers who care for seniors with responsive behaviours. The membership of the BSO Steering Committee is found in Appendix A.

The following activities and engagements helped to inform the development of the Central West LHIN BSO Action Plan:

- Services for Seniors Core Action Group consultation
- Mental Health and Addiction Services Core Action Group consultation
- Central West Long-Term Care Home Network consultation
- On-line survey of all Central West Long-Term Care Homes and Community Support Agencies
- Data gathering from CCAC and hospital discharges
- Two day value stream mapping exercise
- Long-Term Care Home administrators meeting
- Weekly meetings of the Central West BSO Steering Committee
- Application of the Health Equity Impact Assessment Tool

This BSO proposal is consistent with multiple components of the Central West LHIN's second Integrated Health Service Plan – 2010 - 2013.

Mental Health and Addictions

"We have a vision of an expanded community-based, consumer-centred mental health and addictions services system….."

Services for Seniors

"We have a vision for a "seniors-friendly health care system built on the needs of seniors and their caregivers that is coordinated and easy to navigate….."

Diversity and Equity

"We have a vision for a health system that values ethno-cultural diversity….."

ER/ALC

"ER/ALC issues cannot be addressed by focusing on the Emergency Department alone. It requires a systems approach, within individual organizations, and across health service providers."

BSO Framework for Care Pillar #1: System Coordination

Coordinated cross-agency, cross-sectoral collaboration and partnerships based on clearly defined roles and processes to facilitate 'seamless' care.

Current Gaps and Weakness

The Central West LHIN has identified the following gaps and weaknesses in responsive behaviour system coordination across agencies, sectors and partnerships through on-going collaboration with health service providers, surveys, specific engagements and the value stream mapping process undertaken specifically for the BSO project in November 2011.

Challenges in system navigation

People exhibiting responsive behaviours and their caregivers experience challenges in navigating the health care system, especially during emergency situations. Most do not know where appropriate services are located resulting in delays in accessing the service at the right time. There is a need to ease system navigation, and connect clients with the right care when they need it.

Gaps in services targeting responsive behaviours

Multiple agencies in the Central West LHIN care for people with responsive behaviours. When behaviours reach a "tipping point" and exceed the capacity of the current care givers, whether they are at home or in a LTC, a transition is required. These transitions can be problematic if the next level of care is either not available locally or there is a waiting list. This creates a gap in the care continuum. If the responsive behaviour becomes unmanageable the default response is to have the person taken to an emergency department where they may be admitted, or assessed, treated and send back to their place of residence. Clients sometimes leave the emergency department not knowing if the follow up services are available or whom they should get in touch with to follow up. People with responsive behaviours often end up admitted in hospitals where they wait for LTCs that are willing to accept them with their having a history of behavioural challenges.

Multiple assessment tools and variations in care planning

People with responsive behaviours receive multiple assessments as they transition through the health care system requiring people and often their care givers to repeat their health histories several times. There is a need for all care providers to access existing assessments and communicate care plans at each transition points, so that the plans follow the patient throughout the continuum. There is also the need to integrate data from the different assessment points in order to manage variations in care plans, and standardize assessments.

Inconsistent services provided and training

A large number of informal care givers (family, friends) provide clients care in the community. A large percentage of them lack formal knowledge or skills, and receive little or no guidance from formal care givers. Many formal care givers have inconsistent levels of training in behavioural management techniques.

The need for seamless transitions and discharge planning

As a person with responsive behaviours moves from one care provider to another it is essential that the transition be well managed. Currently, these transitions occur haphazardly with valuable information not passed resulting in delays and necessitating additional assessments. If a client's behaviours have been successfully managed in hospital and they are ready for discharge back to LTC or the community, they need support to ensure successful transitions. The receiving staff in LTC, or the informal caregivers, needs the tools that will enable successful transition of care. Robust discharge planning will support smoother transitions.

Overwhelmed formal and informal caregivers

Care givers have reported being exhausted, overwhelmed and frustrated when managing persons with responsive behaviours in crisis. Their care giver demands place them at high safety risks because of the substantial interactions they have with clients in managing complex responsive behaviours such as verbal and physical aggression, wandering and agitation. The caregivers also neglect their own needs while caring for the clients, which alleviates the stress, worsens the situation.

Long-Term Care Homes manage responsive behaviours using a variety of techniques. Additional resources can be obtained through the High Intensity Needs process, but this process cannot provide immediate assistance. Keeping the resident with the behaviours safe as well as caring for other residents can be overwhelming in a crisis.

Existing Components of a Behavioural Response System

The Central West LHIN has funded a number of programs and services to support senior's health including many that care for seniors with responsive behaviours. Funding for these program has come from a variety of sources include base funding and Aging at Home. The following programs and services currently exist and will be leveraged in applying the new BSO funding:

Community-based Mobile Crisis Teams

The southern portion of the Central West LHIN is serviced by two mobile crisis teams – Peel Crisis Services Crisis outreach and support team (COAST) and Mobile crisis of Peel (MCOP). Dufferin County is serviced by a mobile crisis team operated by Trellis.

Geriatric Outreach Teams

The Geriatric Outreach Program at the William Osler Health System is funded to provide seven nurse practitioners to the long term care community. This program is backed up by Osler's Geriatric Program which includes geriatricians, geriatric nurses, a pharmacist, social worker and occupational therapist.

Psychogeriatric Outreach

William Osler Health System also operates a psychogeriatric outreach program that consists of a psychogeriatrician and a psychogeriatric nurse. These services are available to Long-Term Care Homes across the LHIN.

Emergency Departments

William Osler Health System operates two emergency departments at Etobicoke General and Brampton Civic Hospital. Both departments are staffed with Geriatric Emergency Medicine (GEM) nurses. Headwaters Health Care Centre also operates an emergency department with a GEM nurse as well as a transitional crisis worker.

Geriatric Mental Health Beds

William Osler Health System operates a 12 bed geriatric mental health unit. Persons with responsive behaviours with a mental health etiology may be admitted to this unit.

Geriatric Medicine Inpatient Unit

William Osler Health System operates an Advanced Care for the Elderly (ACE) inpatient unit. Persons with responsive behaviours with a suspected medical etiology may be admitted to this unit.

Medicine Inpatient Units

Both the William Osler Health System and Headwaters Health Care Centre operate medical inpatient units. Persons with responsive behaviours related to delirium or dementia may be admitted to these units.

Long-Term Care Homes

The Central West LHIN has 23 Long-Term Care Homes. In a survey conducted for the BSO project homes reported that up to 60% of residents exhibited responsive behaviours.

Long Term Care Behavioural Support Unit

Residents from the Central West LHIN are eligible for admission to the 19 bed unit behavioural support unit located at Sheridan Villa in Mississauga.

Primary Care

The Central West LHIN has two Community Health Centres, seven Family Health Teams and a hospital-based family medicine program located at the William Osler Health System. Multiple family practice groups also service the LHIN.

Community Support Services

The Central West LHIN is serviced by many community based agencies who are funded, in whole or in part, to service seniors with responsive behaviours. Services include supportive housing, family support, education, case management, adult day programs. Some services are unique to the diverse cultures found in Central West LHIN.

Alzheimer Society Programs

The two Alzheimer's societies in Dufferin (Rural) and Peel currently have education coordinators to provide education to the community. Both programs offer First LINK services as well as case management and family support.

Psychogeriatric Resource Consultant

The Central West LHIN has three funded Psychogeriatric Resource Consultant (PRC) positions. One position is based with the Regional Geriatric Program of Toronto and a second is sponsored by the Regional Municipality of York. The third PRC position was filled in mid-November 2011 and is based at the William Osler Health System.

Respite beds and safe beds

Respite beds for persons suffering from responsive behaviours related to Alzheimer's are available at Nora's House, operated by the Alzheimer's Society of Peel. A "safe bed" is available for Dufferin residents at Peace Ranch in Caledon.

Central West Community Care Access Centre (CCAC)

The Central West CCAC provides home care, case management and system navigation

Central West LHIN Action Plan Elements

The Central West LHIN will augment the existing programs and services with the following elements to complete a full continuum of services for people with responsive behaviours.

Single Access Phone Number

Central West LHIN proposes a single phone number to call as a first point of contact to the system when a care giver experiences acute responsive behaviours which are

beyond their capability. A number of LHINs across the province have suggested a similar approach. Meanwhile the Central West LHIN will use the 310 CCAC in its jurisdiction for responsive behaviours, as it awaits the provincial initiative.

Six Mobile based Teams

A key element of the Central West BSO Action Plan is the development of five mobile teams to service Long-Term Care Homes and two teams to service community-based programs and services. The teams will be divided according to geography with a team servicing Dufferin County (both long term care homes and community agencies), a pair servicing Peel/Brampton and the third pair servicing north Etobicoke/Malton/south-west Vaughn. These teams will have clear roles and accountabilities with the mandate of enhancing service delivery as they collaborate across the sectors.

Each of the five long term care mobile teams will consist of a Psychogeriatric Resource Consultant (PRC) and a nurse practitioner. The three additional PRCs will be new positions funded through the BSO funding while the nurse practitioner is an existing resource based out of William Osler Health System. Each of the mobile teams will be responsible for a specific number of long term care beds.

The community-based teams will also consist of a PRC and Nurse Practitioner and will service community agencies (e.g. supportive housing, day programs) as well as liaise with primary care practitioners. The two community-based PRCs will be new positions funded through the BSO program.

The PRC will provide:

- Consultation for staff, promote smooth transitions, facilitate transfer of knowledge to practice
- Capacity development, facilitate linkages between agencies, foster connections
- Education, identify needs, develop education plans, formal and informal education, on the job coaching.
- System navigation.

Each PRC will have lead expertise in one of the following areas (diversity, brain injury, primary care, and dementia)

The nurse practitioner will provide a range of services for all residents and clients and will be available to assist in the care of residents with responsive behaviours.

These mobile teams will have the support of existing psychogeriatric nurse, geriatric medicine nurse, pharmacist, occupational therapist, social worker, geriatrician and a geriatric psychiatrist based at William Osler Health System. The teams will liaise with the BSO Network Coordinator and the CCAC case managers to ensure that clients are followed throughout the system.

Standardized Assessment and Care Planning Tools

The mobile teams and other care providers will transition to standardized approaches that incorporate best practices through comprehensive interdisciplinary assessments and interventions. The care plans will be client specific, recognizing the client's uniqueness, history, life story, and the fact that one solution does not fit all. The Integrated Assessment Record project is currently underway and may form the underpinning for this initiative.

Behaviour Champions

Each Long-Term Care Home or group of homes in the Central West LHIN was eligible to apply for an in house behaviour champion. Twenty one of twenty three homes applied for, and received funding for, a Behaviour Champion. This net new position may be a nurse, personal support worker or other health care worker depending on the needs of the home. This new position will be the in-house expert on behaviour response techniques and will be available to provide coaching, care planning, or hands on care as needed. The behaviour champion will work closely with the PRC and nurse practitioner to ensure smooth transitions of residents as the move from hospital to Long-Term Care Home.

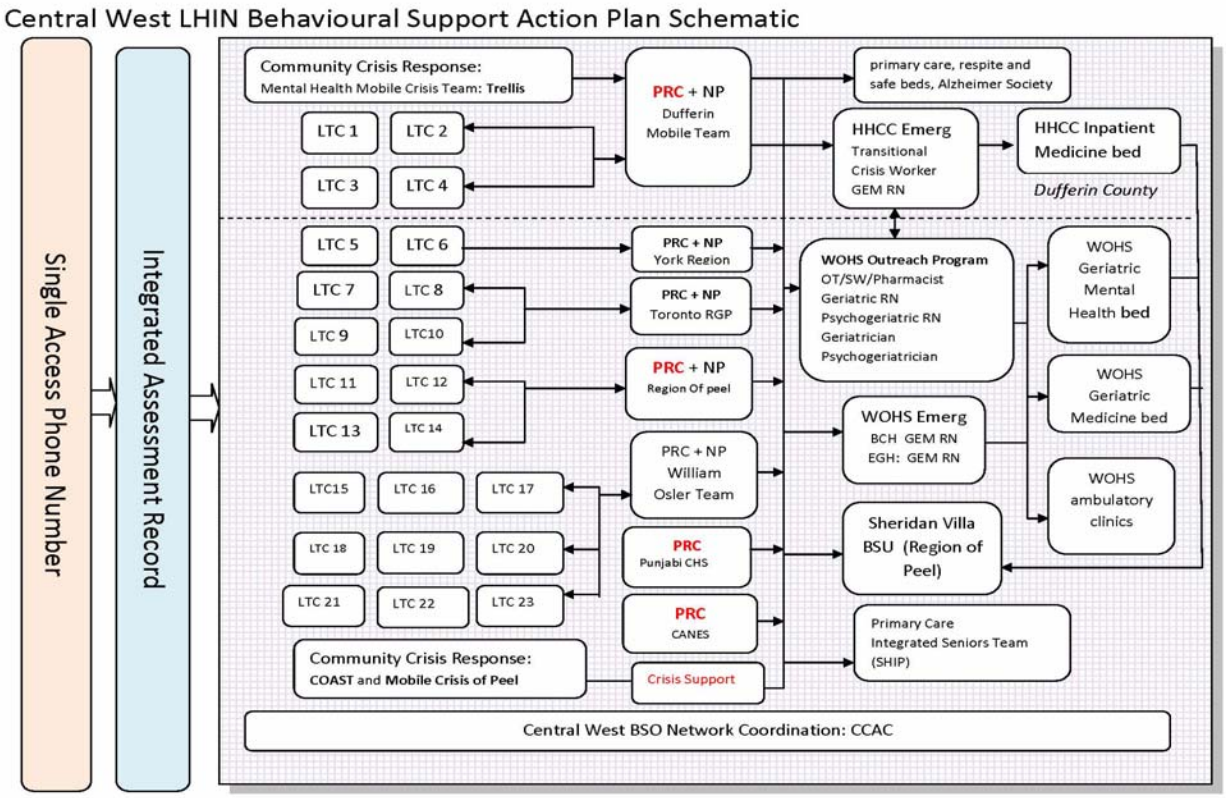
Enhanced Crisis Response

A registered practical nurse with specific training in geriatric responsive behaviours will be added to the crisis service in the southern portion of the Central West LHIN. This added resource will liaise with the existing crisis services as well as the PRCs and nurse practitioners.

Behaviour Supports Network Coordination

The CCAC will employ a Network Coordinator position. This person will function as the overall network coordinator for the project within the Central West LHIN. The role will include system navigation, case finding and waitlist monitoring, regular communication with all PRCs, and responding to requests from any 310 CCAC calls.

Central West LHIN Behaviour Supports Ontario Project System Map



Abbreviations

BCH: Brampton Civic Hospital site of Osler
BSU: Behavioural Support Unit
CCAC: Community Care Access Centre
EGH: Etobicoke General Hospital site of Osler
GEM RN: Geriatric Emergency Medicine Registered Nurse
LTC: Long-Term Care Home
NP: Nurse Practitioner
PRC: Psychogeriatric Resource Consultant
OT: Occupational Therapist
SW: Social Worker
RN: Registered Nurse
SHIP: Supportive Housing in Peel

Improved Discharge Planning

Clients discharged from acute care settings will have comprehensive follow up care plans that are consistent and facilitate seamless transitions. The development of the care plans will involve input from families, the individual and the care givers and will include discharge planning. Information about discharge issues and possible needs following discharge will be provided to the individuals, caregivers and families before and during discharge. Receiving caregivers will be trained and supported during transitions and discharge to ensure smooth transitions. The mobile PRCs will work with the in-house behaviour champions to effect smooth transitions.

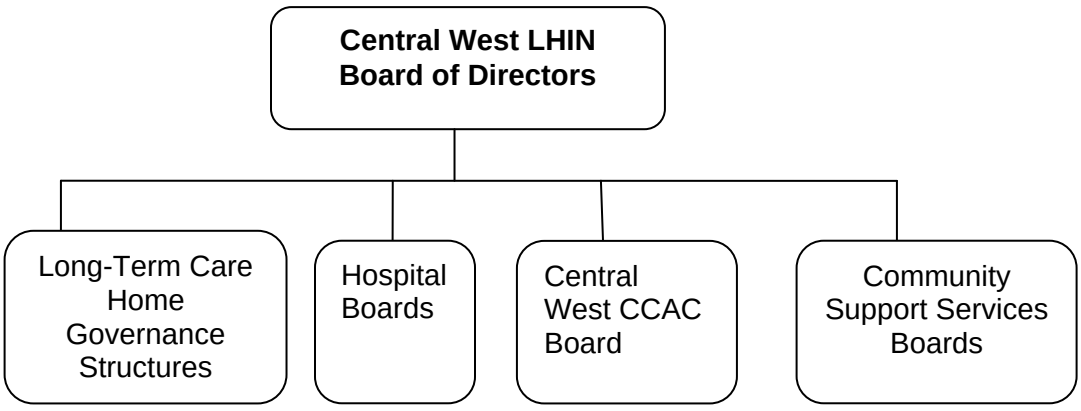
Governance and Accountability

The Central West LHIN has existing structures that provide LHIN-wide collaboration of services all of which address services for persons with behavioural challenges. These structures include:

- Services for Senior Core Action Group
- Mental Health Services Core Action Group
- Diversity Core Action Group
- Patient Flow Task Force
- Long Term Care Network
- Governance to Governance meetings

Individual components of the Central West LHIN BSO project will be accountable to the administration and governance structure of their host organizations. Each host organization will have an accountability agreement with the Central West LHIN which, eventually, will incorporate the various BSO deliverables and measures.

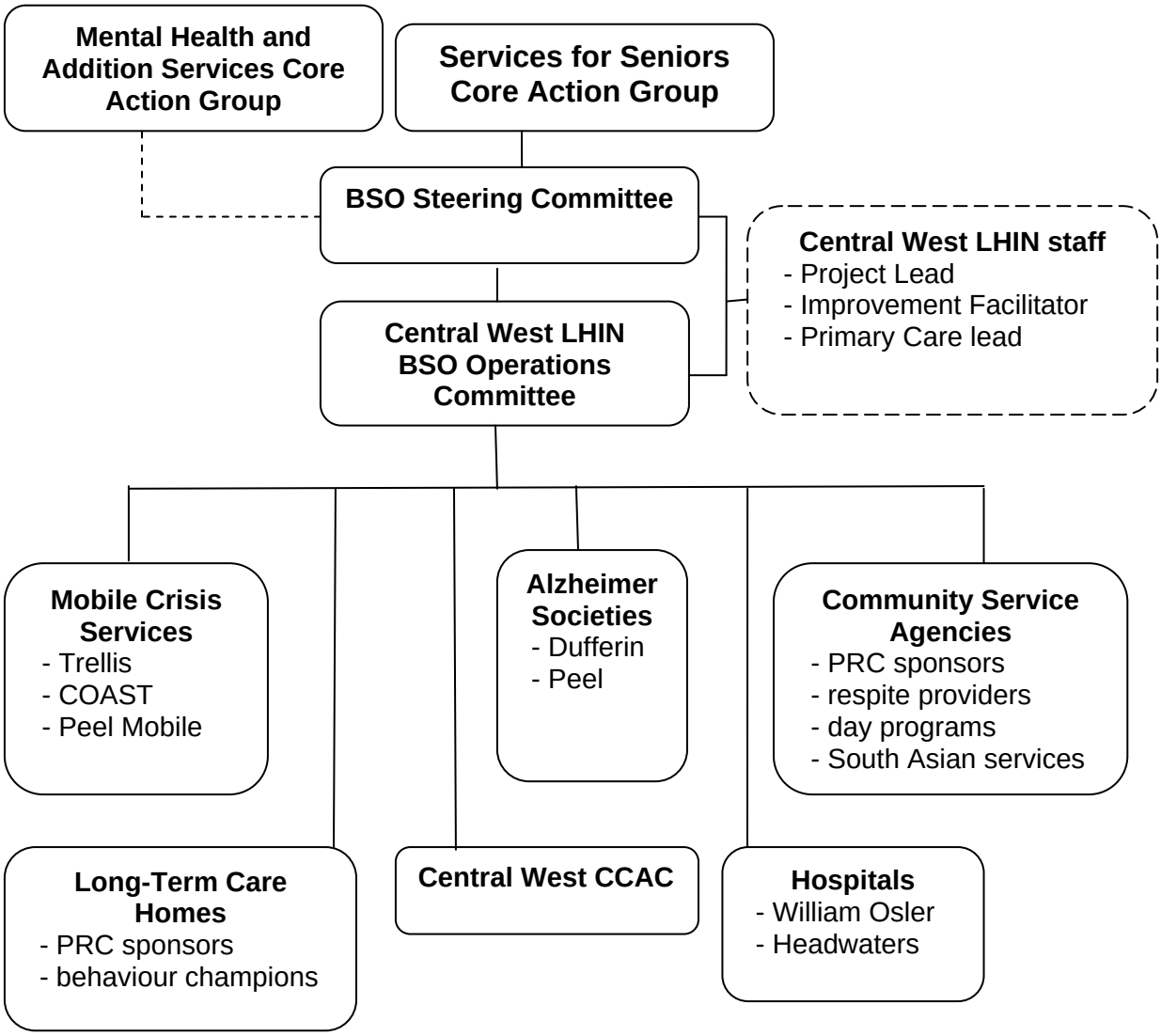
BSO Accountability Structure



BSO System Management and Operations

The Executive Sponsor of the Central West LHIN BSO Project is the Chief Executive Officer of the Central West LHIN, Mimi Lowi-Young. Operationally, the BSO project is sponsored by the Central West LHIN Services for Seniors Core Action Group with regular liaison provided to the Central West LHIN Mental Health and Addition Services Core Action Group. The BSO Steering Committee was originally formed in October 2011 to provide leadership in the development of the Central West LHIN BSO Action Plan. This Steering Committee will now assume a policy leadership and strategic planning role for the BSO project. Membership of the BSO Steering Committee will be augmented with the addition of the Central West LHIN Primary Care Lead once that position has been filled. Original membership is shown in Appendix A.

Central West LHIN BSO Operations Committee



Health service providers who are responsible for the components of the BSO project will be invited to sit on an Operations Committee. All of the named health service providers currently have a relationship with the Central West LHIN and a history of working together on previous projects. This committee will be accountable to the BSO Steering Committee and will focus on information sharing, development of operational procedures, improvement activities and review and analysis of BSO project statistics and performance. This group will be led by the Central West LHIN Project Lead and supported by the Improvement Facilitator.

BSO Framework for Care Pillar #2: Interdisciplinary Service Delivery

Outreach and support across the service continuum to ensure equitable and timely access to the right providers for the right service.

Problem Areas

The Central West LHIN identified three problem areas: initial access to services, the transition points within the continuum of care, and inefficient discharge planning

Initial access to appropriate services

Although timely information and intervention is essential for effective behavioural supports, caregivers, unaware of what services are available, are usually faced with the challenge of navigating a complex health system without supports. Clients usually end up being placed on long wait lists, and may not receive the most appropriate care in a timely manner.

The transition points

Despite having multiple and often necessary assessments, lack of proper communication at transition points with regards to care plans results in clients having to repeat their medical histories several times, delay in access to appropriate supports, an increased need for more intensified services, or occasional medical discrepancies.

Also, while informal and formal caregivers have an important role in caring for the individual, the VSM exercise showed that families and care givers experienced increased anxiety and needed emotional support and education not only before access to service but especially at transition points.

Discharge Planning

Post discharge transitions can result in increased hospital re-admissions because of inappropriate or lack of follow ups after clients have been medically stabilized and discharged.

At Risk Populations

The Central West LHIN BSO Steering Committee identified two main at-risk populations: Clients in the community, and clients in Long-Term Care Homes. The value stream analysis exercise mapped their patient journey from their initial place of residence to the emergency department and back to their place of residence

Residents from Long-Term Care Homes

When these individuals experience acute responsive behaviour episodes that cannot be managed in their place of residence, their first transition point would be to the police and/or emergency medical services (EMS). These residents are then transitioned to the emergency department and many continue on into an acute care bed. After the individual is medically stabilized, the next transition point would be discharge back to the LTCH, often without efficient follow up care plans.

Clients in their home

This population includes individuals in the homes as well as those marginalized from the main stream society. When the individual is at a crisis point, the transition points are from home to the emergency department potentially via EMS, or from home to the mobile crisis teams, if the caregiver is aware of them, and then from there to the emergency department in acute care. After the individual is medically stabilized, the next transition point is discharge back to the place of residence.

Client from the Community

Some clients may be accessing programs such as day programs, supportive housing or may be in the care of a primary care practitioner. When the individual is at a crisis point, the transition points are from the office or program location to the emergency department, or to the mobile crisis teams, if the care giver is aware of them, and then from there to the emergency department in acute care, often by EMS. After the individual is medically stabilized, the next transition point is discharge back to the place of residence.

Special populations

The plan also targets individuals who may be completely unaware of services, have no supports, or may experience language or other barriers to main stream health care. Approaches to servicing this population will need flexibility towards their unique circumstances. The Central West LHIN applied the Health Equity Impact Assessment Tool (HEIA) as it developed the Action Plan.

A Continuum-wide Response

The proposed plan to augment the existing system using three existing PRCs and adding four new PRCs and 21 in-house behaviour champions will leverage the strengths in the current system, fill existing gaps and improve care across the continuum. The PRCs will provide the continuity from prevention through to care delivery in primary, acute, community and long term care environments. The combination of PRCs, nurse practitioners and in-house behaviour champions will provide a wide web of personnel with case finding capacity.

With the addition of PRCs affiliated with all Long-Term Care Homes, community agencies and primary care providers, a common approach to responsive behaviour education can be achieved. PRCs will be responsible for creating an education plan for each Long-Term Care Home and for providing training and coaching. This system-wide approach will ensure that all long term care providers have a common level of understanding and use common language when discussing responsive behaviours. Increased understanding of responsive behaviours and their triggers is a preventative strategy. Knowledgeable staff will be able to recognize behaviour triggers and remove them thereby avoiding escalation of behaviour to a crisis level.

The cadre of PRCs will be familiar with all aspects of the full continuum and will be able to draw on the services of the Osler Geriatric Outreach Program or Psychogeriatric Outreach program as appropriate. Familiarity with each other and the available resources will improve the timeliness of care. The PRCs will work with the staff of the inpatient units at Headwaters and Osler sites to ensure that patients with responsive behaviours being discharged are connected to the support systems necessary for their successful return. PRCs will work closely with CCAC case managers and discharge planners to ensure people are supported as they transition through the system. A PRC will have the knowledge and connections to arrange a behavioural assessment or complete geriatric assessment if required.

By having the community-based PRCs geographically located throughout the LHIN they will become familiar with the diversity of their population and intimately aware of the program and services available to meet the unique needs. They will be able to assist in directing people and their care givers to the right provider for the right service in a timely and equitable manner.

The addition of in-house behaviour champions will increase the capacity of a Long-Term Care Home to recognize and mitigate escalating behaviour, better manage behaviours which do occur and ensure a smooth transition if a resident is transferred to an acute care facility. In-house behaviour champions will work closely with the PRC and nurse practitioner team to care for residents with responsive behaviours and will assist in defining training needs of staff. In a crisis, the in–house champion will be available to intervene providing an additional set of hands.

The Behavioural Supports Coordinator at the CCAC is responsible for network coordination and system navigation. Callers to the 310-CCAC phone line with requests for assistance with responsive behaviours will be directed to the appropriate PRC for their geographic area. Mobile crisis services will have the capability of calling on a PRC/nurse practitioner team to assist in situations within the local community.

BSO Framework for Care Pillar #3: Knowledgeable Care Team and Capacity Building

Strengthen capacity of current and future professionals through education and focused training to transfer new knowledge and best practice skills for continuous quality improvement.

Educational Opportunities

The following programs and services are currently available to health service providers in the Central West LHIN to disseminate new knowledge and best practice skills relating to behavioural supports

1. The Alzheimer's Societies' of Dufferin and Peel provide education activities for public education, education tailored to families and to individuals, and training for health care professionals and staff. The programs are targeted to people with Alzheimer's disease and related dementia and their caregivers (both formal and informal)

2. The Regional Geriatric service provides information and education resources to assist health professionals in care of older persons The program is affiliated with the University of Toronto and builds capacity by making clinical tools and educational resources available to practitioners involved in geriatric care.

3. The division of Geriatric medicine, Mc Master University educates and trains physician trainees from family medicine, internal medicine

4. The Central West CCAC Training and use of Resident Assessment Instrument-Home Care tool (RAI-HC), the common assessment tool for the CCAC includes questions and modules related to responsive behaviours

5. The BSO knowledge exchange activities site for all the LHINs and the BSO wide communication plan

6. The Alzheimer's Knowledge Exchange site community of practice link which provides information on the BSO project across province wide, mentoring, and builds collaborative partnerships with stakeholders

7. Residents First knowledge transfer activities in Long-Term Care Homes

8. The Long term care sector training which include managing seniors with responsive behaviours

9. The Psychogeriatric Resource Consultant provides behavioral management oriented education and consultation to Long Term Care and community agencies. The PRC supports care providers in delivering evidenced based interventions to help manage seniors with responsive behaviours

The BSO Operations Committee will monitor the need for educational programs and work with the PRCs and other resources to develop and deploy required resources. The Project Leader will routinely scan the literature and experience of others to monitor developments in the field of behaviour responses to identify new knowledge and share this with the BSO project participants. The Project Leader will continue an affiliation with other BSO Project Leads both formally and informally to capture and share lessons learned.

The Psychogeriatric Resource Consultants will provide behavioural management oriented education and consultation to Long-Term Care Homes and community service agencies. The education will be targeted to both current regulated and non regulated personnel on a regular basis and new hires during orientation. The PRCs will transfer knowledge and best practices in responsive behaviour management including non pharmacological management approaches such as P.I.E.C.E.S, U.F.I.R.S.T and Gentle Persuasive Approaches (GPA) The training will also include the informal caregivers such as family members. They will provide education that will enhance evidence based care and will incorporate the understanding that all behaviours have meaning.

A gathering of all BSO project staff including PRCs, nurse practitioners, behaviour champions and the hospital and community-based partners will be held annually. This event will allow for sharing of experiences and successes and group-wide education in the field of behaviour responses. The network of BSO project participants will also be used on a regular basis to share articles, lecture slides and conference proceedings.

Quality Improvement in Responsive Behaviours

The BSO Operations Committee will identify areas in need of improvement and report this information to the BSO Steering Committee. The BSO Steering Committee will work with the Central West LHIN Improvement Facilitator to develop an annual plan for improvement activities. The Improvement Facilitator will develop project charters for each improvement project and lead improvement activities utilizing the most appropriate quality improvement tools (e.g. value stream mapping, LEAN techniques, PDSA tools).

The Improvement Facilitator will work with existing QI experts embedded with the health service providers (e.g. Resident's First leads) to ensure a comprehensive approach to quality improvement. The improvement facilitator will be linked to the mobile teams to provide quality improvement expertise. The improvement facilitator will have ongoing support from the Health Quality Ontario and the 'buddy' LHINs.

Evaluation of the BSO Project

Sustainability of the BSO project will be ensured through continuous evaluation of the project. The BSO Operations Committee will set annual goals for the program and will monitor achievements. The BSO Operations Committee will conduct studies and surveys to obtain input from persons with responsive behaviours, their caregivers, service providers, staff of Long-Term Care Homes and community programs. Results of the evaluation will be used to make strategic adjustments to the project.

Central West LHIN staff will monitor the various measures of the BSO project including volume and satisfaction metrics as well as financial data to evaluate the value for money of the initiative.

Appendix C lists the measures that will be used to monitor and evaluate the BSO project. Baseline data will be collected as part of the project start up.

Staffing Resources

Central West LHIN received $323,900 for 2011/12 and $1,943,500 for 2012/13 in base funding. This is to support 10 RN or RPN positions ($763,300) and 14 PSWs ($560,000) and $619,900 for other health professionals.

On December 13, 2011, the Central West LHIN released four expression of interest (EOI) to the field. Two were aimed exclusively at the Long-Term Care Home sector and two to community –based agencies.

The Long-Term Care Home EOIs were requesting three LTCs, one each in Dufferin/north Peel, Peel/Brampton and north Etobicoke/Malton/south-west Vaughn to host a PRC. These staff will be registered nurses or registered practical nurses. The second Long-Term Care Home EOI invited LTCHs to apply for up to one net new position for a behaviour champion. This position could be a registered nurse, registered practical nurse, personal support worker or other health care worker.

The community agency EOIs were requesting two agencies, one in Dufferin/north Peel and one in Etobicoke/Malton/south-west Vaughn to host a PRC. These positions could be filled with any type of health care worker. The second community agency EOI invited services to apply for up to one net new position for a behaviour champion. This position could be a registered nurse, registered practical nurse, personal support worker or other health care worker.

Appendix A

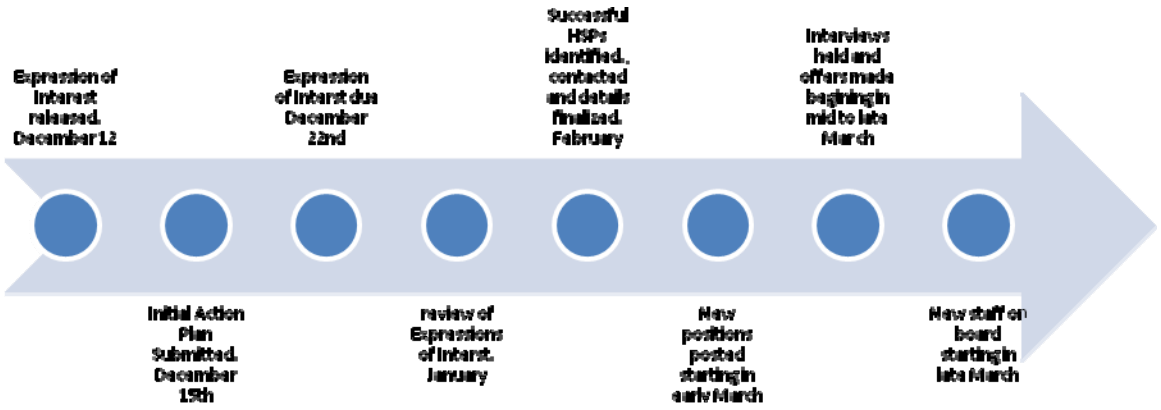
Central West Local Health Integration Network
Behavioural Supports Ontario Steering Committee Membership

The Central West LHIN would like to acknowledge the dedication and hard work of the following leaders from the long term care, acute care, Community Care Access Centre and community services sectors who shared their collective expertise in the development of this Action Plan.

Inga Mazuryk	Region of Peel
Wendy Beattie	Tall Pines Long-Term Care Home, Region of Peel
Amanda Coulter	Faith Manor
Karyn Lumsden	Central West CCAC
Nancy Saxton	Central West CCAC
Elaine Griffin	Alzheimer Society of Dufferin
Mary Wheelwright	Headwaters Health Care Centre
Valerie Quarrie	Dufferin Oaks
Annette Keep	Alzheimer Society of Peel
Leslie Nagoda	Supportive Housing in Peel
Laurie Wolfsen	William Osler Health System
Ruth Woodman	Supportive Housing in Peel
Wendy Edwards	William Osler Health System
David Colgan	Central West LHIN
Mark Edmonds	Central West LHIN
Suzanne Robinson	Central West LHIN
Nafula Tindi	Central West LHIN

Appendix B

Central West LHIN Behavioural Supports Project Timeline



Appendix C

Outcomes and Measures

Outcome	Measure	Current	Expected
Client • Quicker access to service • Improved client experience **Long Term Care** • Increased LTC intake of behavioural challenged clients • Reduced ER visits • Reduced number of adults admitted in acute care • Reduced readmissions to Acute care **Community** • Quicker access to service • Clients feel supported **Hospitals** • Reduced ALC of clients with responsive behaviours • Reduced LOS of clients with responsive behaviours • Reduced ER	Indicator • Crisis response time • Mobile team composition • Teams hours of operation • Satisfaction scores o With crisis response o After crisis support in place • # of waitlisted clients at CCAC with behavioural issues • # of ER visits due to behavioural challenges • # of LTC admitted to acute care due to behaviours • # of readmissions to acute care due to behavioural responses • Crisis response time of mobile teams • After crisis support in place • # of ALC days due to behaviours • # LOS days due to responsive behaviours • # ER Visits due to responsive behaviours in target group		

visits due to responsive behaviours **Formal and Informal caregivers** • Increased capacity to manage behavioural challenges • Increased caregiver support during transitions and post crisis • Improved family experience **PRC Training Programs** • Increased number of persons trained in responsive behaviours	• Number of nurses trained in managing responsive behaviours • Number of PSWs trained in managing responsive behaviours • Number of other personnel trained in managing behavioural challenges • # of informal care givers trained • Informal caregivers (e.g. Family) satisfaction scores • Caregiver satisfaction scores • Types of training provided • Number of homes with education plans • Frequency of training		

<u>Accountability</u>

- Lead agency will be accountable to the LHIN board in delivering the above indicators

Appendix D

BSO Project

Two Page Summary

fFor Provincial Resource Team Check In

Behavioural Supports **Ontario**

Central West LHIN Action Plan
Action Plan Two-Page Executive Summary
Preliminary Proposals for PRT Check-in
Deadline for submission: November 28, 2011

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

Central West LHIN has a population of 798,038[I] of which 8.97% are over the age of 65. The projected rate of growth of the over 65 age cohort between 2006 and 2016 is 57%, the fastest in the province. There is a distinct urban/rural split in the population with the southern portion of the LHIN the most populous and with 49% of this population being new Canadians with a multitude of diverse background. Francophone's make up 1.3% of the population and first nations make up 0.6%. There are over 3400 residents in 23 long term care homes.

The Central West LHIN's target population is older adults with cognitive impairment due to mental health, dementia, addictions or other neurological conditions, and their caregivers. These adults often exhibit complex responsive behaviours such as physical and verbal aggression, resistance, wandering, and agitation which heighten the risk for the individual exhibiting the behaviour and those living with him/her as well as those providing care.

The key system challenges include:

- Challenges for residents/patients /caregivers/families in navigating the system especially during emergency situations
- Gaps within existing resources in providing service targeted at managing responsive behaviours
- Overwhelmed formal and informal care givers due to challenges experienced while managing responsive behaviours.
- Variations in care planning and assessment tools
- Gaps in training and education of personnel to effectively meet the unique needs of the target population
- The need for seamless transitions and effective discharge planning

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

Improved system navigation
A single phone number to call as a first point of contact to the system when an individual experiences acute responsive behaviours which are beyond their capability. Long-Term Care Home (LTCH) and community-based Psychiatric Resource Consultants (PRCs) will assist clients/residents in transitioning from one facility, agency or home to other care locations. PRCs will work with existing CCAC managers and their contract staff to ensure persons with responsive behaviours and their caregivers are transitioned effectively. The three community-based PRCs (including one targeted to the diverse population) will liaise with primary care practitioners and community agencies (e.g. day programs) to improve care and transitions.

Enhancing existing resources
The plan proposes enhancing and augmenting existing interdisciplinary mobile teams to respond to emergency crisis situations related to responsive behaviours both in the community and in LTCHs. Due to the varying characteristics in geographic locations within the Central West LHIN (rural and urban), the plan proposes three mobile teams based in LTCHs and three based in the community, deployed across the entire LHIN who service the different sectors (LTCHs, community, and with linkages to the primary care and acute care sector). These teams will have clear roles and accountabilities with the mandate of enhancing service delivery as they collaborate across the sectors.

Standardizing assessment and care planning tools
The mobile teams will utilize standardized approaches that incorporate best practices through comprehensive interdisciplinary assessments and interventions. The care plans will be client specific, recognizing the client's uniqueness, history, life story, and the fact that one solution does not fit all.

Effective discharge planning
Clients discharged from acute care settings will have comprehensive follow up care plans that are consistent and facilitate seamless transitions. The discharge planning will be facilitated and coordinated by in-house behavioural champions in collaboration with the CCAC and the PRCs.

ALL SUBMISSIONS: Do not exceed two pages maximum

Ontario Health Quality Ontario

Alzheimer Knowledge Exchange

Alzheimer Society ONTARIO

Ontario Local Health Integration Network

Central West LHIN Action Plan
Two-Page Strategic Summary
Preliminary Proposals for PRT Check-in
December 2, 2011

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?
Six Geographically-based Mobile Teams The enhanced mobile teams include professionals from different disciplines and will function as responsive behaviour intervention teams. The LTCH-based teams will comprise of 1 FTE Psychiatric Resource Consultant and a nurse practitioner with a primary medical care focus. These teams have the support of existing psychogeriatric nurse, geriatric medicine nurse, pharmacist, occupational therapist, social worker, geriatrician and a geriatric psychiatrist. These teams will provide education and assistance with specialized client assessment and care planning leading to individualized care plans that respect client preference and caregiver and family input. The plan proposes three such teams in long term care and three based in the community. **Crisis Response Services** The mandate and geographic coverage of the existing crisis response services will be reviewed to ensure compatibility with the mobile teams. Quality improvement tools will be used to enhance the current service delivery.
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?
Improving on-site education As a preventative and management strategy, the six Psychcogeriatric Resource Consultants (PRC) will strengthen capacity of current and future professionals in LTCHs or the community. The PRCs will function as mobile educators and transfer knowledge and best practices in responsive behaviour management including non-pharmacological management approaches such as P.I.E.C.E.S, U.F.I.R.S.T, and Gentle Persuasive Approaches (GPA). The education provided will enhance preventative as well as evidence based care and will incorporate the understanding that all behaviours have meaning. **Behavioral Champions** Each of the long term care homes in Central West LHIN and community agencies can apply for an in house behavioural response "champion" who will be trained in responsive behaviours and will be available to provide hands on care when necessary. This person will also liaise closely with the regional PRC and NP team and will be the on-site go-to expert in responsive behaviours. **Increased training increases capabilities and improves patient flow** Increasing the level of training of all providers in all settings (community, long term care homes, and primary care) will improve the capacity to predict and avoid responsive behaviours, to assess and care for persons exhibiting responsive behaviours, and to recognize when further assistance is required. Increased training will allow homes to accept residents who have previously exhibited responsive behaviours with confidence. **Accountability** The governance structure of each organization involved in the BSO project will be accountable to the Central West LHIN Board of Directors and will have BSO measures incorporated in their accountability agreements.
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)
Central West LHIN client value statement "I am a person, I matter, listen to me, know me support me" will be the guiding principle during implementation to ensure that system redesign will incorporate the needs of clients, caregivers and families. Value stream analysis and mapping will be incorporated to eliminate inefficient processes and activities in the system redesign. Tests of change will be performed through Plan Do Study Act (PDSA) cycles to ensure continuous improvement during system changes. Other quality improvement techniques (LEAN, Triple AIM, Value Stream Mapping) will be utilized where appropriate to introduce and sustain change.

[i] Source 2006 census data from PHDB of MOH , June 2008

ALL SUBMISSIONS: Do not exceed two pages maximum

Appendix E

Health Human Resource Investment

Spreadsheet

BSO Action Plan Question 16

LHINs complete this template to report HHR investments in each fiscal year at the Health Service Providers name below.

									2012												
									January-March 2012						April - December 2012						
Transfer Payment Budget Entity (TPBE)	LHIN Name	Recipient #	Health Service Provider Name	Recipient Site	Program # (applicable only to Mental Health and Addiction)	Facility# (applicable only to Long-Term Care Homes)	Base/One-time Funding	Fiscal Allocation	Annual Allocation	Nurse FTEs	PSW FTEs	Other Health Professional FTEs	RN/RPN funding (NPC envelope) $	PSW funding (NPC envelope) $	Other health professionals funding	RN/RPN funding (NPC envelope) $	PSW funding (NPC envelope) $	Other health professionals funding used for Other health professionals (PSS envelope) $	Other health professionals funding used for RN/RPN (NPC envelope) $	Other health professionals funding used for PSW (NPC envelope) $	Other health professionals funding
NH	LHIN-CW	182782	1245556 Ontario Inc	Burton Manor		NH4494			$97,056	1			$16,176			$72,792					
MH	LHIN-CW	23	County of Dufferin	Dufferin Oaks		H11048			$73,681	1			$12,280			$55,261					
NH	LHIN-CW	43344	Holland Christian Homes In	Faith Manor		NH3424			$65,000	1			$10,833			$48,750					
NH	LHIN-CW	43344	Holland Christian Homes In	Grace Manor		NH4492			$65,000	1			$10,833			$48,750					
MH	LHIN-CW	3310	City of Toronto	Kipling Acres		H11308			$105,773	1			$17,629			$79,330					
NH	LHIN-CW	235965	Leisureworld (2063414 On	Brampton Woods		NH2887			$78,551	1			$13,092			$58,913					
NH	LHIN-CW	341503	Vigour Limited Partnership	LWCC Tullamore		NH1722			$59,436	1			$9,906			$44,577					
NH	LHIN-CW	235965	Leisureworld (2063414 On	Vaughn		NH4502			$52,211	1			$8,702			$39,158					
CH	LHIN-CW	3319	Regional Municipality of P	Vera M Davis		H23555			$80,814	0.5	0.5		$7,134	$6,335		$32,102	$28,509				
NH	LHIN-CW	3319	Regional Municipality of P	Malton Village		HF4440			$73,497	0.5	0.5		$6,781	$5,469		$30,514	$24,609				
NH	LHIN-CW	3319	Regional Municipality of P	Peel Manor		H11719			$73,497	0.5	0.5		$6,781	$5,469		$30,514	$24,609				
NH	LHIN-CW	3319	Regional Municipality of P	Tall Pines		H14439			$73,019	0.5	0.5		$6,701	$5,469		$30,155	$24,611				
NH	LHIN-CW	104332	488491 Ontario Inc Avalon	Avalon		NH3292			$45,755		1			$7,626			$34,316				
NH	LHIN-CW	132611	Chartwell Master Care LP	Pine Grove Lodge		NH3780			$50,834		1			$8,472			$38,125				
NH	LHIN-CW	343978	Revera Long Term Care Inc	Westside		NH2920			$48,000		1			$8,000			$36,000				
NH	LHIN-CW	104398	Extendicare (Canada) Inc	Brampton		NH2847			$48,000		1			$8,000			$36,000				
NH	LHIN-CW	104426	King Nursing Home Ltd	49 Sterne Str		NH1725			$27,000		0.5			$4,500			$20,250				
NH	LHIN-CW	235979	Leisureworld (2063415 On	Brampton Meadows		NH4446			$48,000		1			$8,000			$36,000				
NH	LHIN-CW	235965	Leisureworld (2063414 On	Etobicoke		NH4308			$52,210		1			$8,702			$39,158				
NH	LHIN-CW	343978	Revera Long Term Care Inc	Humber Valley terrace		NH3290			$48,000		1			$8,000			$36,000				
NH	LHIN-CW	103336	Oakwood Retirement Com	Sandalwood		NH2859			$55,700		1			$9,258			$41,775				
MT-HOSP	LHIN-CW	102725	Headwaters Health Care C	100 Rolling Hill		916			$97,500			1			$16,250						$73,125
CSS	LHIN-CW	100960	CANES Community Care	400-135 Queen					$94,672			1			$13,779						$71,004
CSS	LHIN-CW	391747	Punjabi Community Health	11730 Airport Road					$78,715			1			$13,119						$59,036
CSS	LHIN-CW	99868	Supportive Housing in Peel	969 Derry road					$73,140			1			$12,190						$54,855
CCAC	LHIN-CW	283696	Central West CCAC	199 County court					$144,000			1			$24,000						$108,000
CSS	LHIN-MH		Alzheimer Peel						$88,500			1			$14,750						$66,375
									$1,897,561	10.0	10.5	6.0	$126,848	$93,300	$96,088	$570,816	$419,962	$0	$0	$0	$432,395