Erie St. Clair **LHIN**
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Responsive Behaviours Action Plan

December 15, 2011

Ontario
Erie St. Clair Local Health Integration Network
Réseau local d'intégration des services de santé d'Érié St. Clair

Acknowledgements

During the fall of 2011 the Erie St. Clair Local Health Integration Network (ESC LHIN) received approval from the Behavioural Support Ontario (BSO) Project Team to move forward with the development of a Responsive Behaviours Action Plan.

The ESC LHIN Responsive Behaviours Action Plan will provide enhanced, integrated, and cross-sectoral services to meet the needs of older adults with cognitive impairments due to dementia, mental health issues, addictions, and neurological conditions associated with responsive behaviours living in the community and Long-Term Care Homes (LTCHs). We believe that our action plan will provide new and enhanced supports for caregivers who are the unrecognized heroes of our health care system.

Our action plan reflects the enthusiastic contributions of local health care leaders from across our LHIN who eagerly provided their insights, experience, and vision for a new system of care for seniors with complex conditions and for their caregivers. I would like to acknowledge the cross-sector of providers who willingly gave their time and invaluable advice during the two-day Value Stream Mapping (VSM) Sessions. Across the continuum of care, ESC LHIN providers expressed the need and readiness for system level change.

A special acknowledgement to the two amazing caregivers who kept the VSM group grounded in the reality of how and why our health care system needs to change. Their contribution and courage by sharing their personal stories resulted in a Client Value Statement (CVS) that will be an anchor for implementing our action plan into concrete sustainable change.

Thank you,

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ESC LHIN Value Stream Mapping Team

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The Current State:

1) Identifying gaps and weaknesses in system coordination, across agencies and sectors preventing seamless care.

Despite investments from the Ministry of Health and Long-Term Care's (MOHLTCs) Alzheimer's Strategy into programs such as Psycho-Geriatric Resource Consultants (PRC), Public Education Consultants (PEC), PIECES, and U-First Training, LTCHs continue to experience challenges in meeting the needs of residents with responsive behaviours. Predominant issues include:

1. Increasingly complex residents with co-morbid conditions in addition to cognitive impairments
2. High turnover of staff with responsive behaviour training (e.g. PIECES, Gentle Persuasion, and U-First)
3. The very real day-to-day work load pressures faced by LTCHs

During the Aging at Home (AAH) initiative, the ESC LHIN invested over $2.9M in cross-sector support services that would enhance the lives of seniors including those with cognitive impairments. Service capacity limitations were addressed first, followed by investments in new clinical supports such as Geriatric Mental Health Outreach Teams (GMHOTs), Geriatric Emergency Medicine (GEM) Registered Nurses (RNs), and the First Link Program. While these services are highly valued, the present community state is characterized by system gaps in coordination and cross-sector collaboration remains a challenge.

Pillar 1

System Coordination, Coordinated Cross-Agency, Cross-Sectoral Collaboration, and Partnerships Based on Clearly Defined Roles and Processes to Facilitate Seamless Care.

The BSO model developed three foundational pillars and each pillar includes proposed essential elements. The following descriptive information responds to each of the BSO questions demonstrating how the ESC LHIN system redesign will align with the foundational pillars, our CVS, and new guiding principles.

On November 14, 2011 the ESC LHIN hosted a Behavioural Supports Planning Day. Over 55 health care leaders from across the Erie St. Clair region and across sectors attended. Representation included professionals from:

- LTCHs
- Erie St. Clair Community Care Access Centre (CCAC)
- Community Support Services (CSS)
- Complex Continuing Care (CCC) and an acute care hospital
- Community Health Centres (CHC) including a physician
- GMHOT
- Emergency Department (ED) GEM RNs
- Alzheimer's Societies – First Link, Day Programs, and Respite
- Schedule One psychiatric facilities
- Community Mental Health and Addictions
- Elderly persons centres
- Advocacy agencies (elder abuse)

Primary Aims of the ESC LHIN BSO Kick-off

- Inform key providers about the BSO initiative
- Provide base-line data demonstrating the magnitude of the population with responsive behaviours and the systemic impact (e.g. Alternative Level of Care (ALC) days, LTC Resident Assessment Instrument (RAI), ED visits and utilization of LTCHs High Intensity Needs Funding)
- Facilitate cross-sector planning tables to engage in discussions identifying system gaps, weaknesses, and opportunities for future state redesign
- Orient cross-sector participants about the two-day VSM sessions to be held in partnership with the South West LHIN (SW LHIN) and Health Quality Ontario (HQO)
- View the system through the eyes of the client resulting in five CVSs
- Identify cross-sector and front-line champions to act as **"future change agents"**

On November 28-29, 2011 the ESC LHIN participated in a VSM session. The session was attended by 30 participants representing:

- Caregivers (two)
- LTCHs front-line staff - Personal Support Worker (PSW) and RNs
- GMHOTs
- ED GEM RNs
- CSS Coordinators
- Erie St. Clair CCAC Placement Coordinator, Case Managers, and RNs/PSW from Bayshore, one of the Erie St. Clair CCACs brokerage agencies
- Primary care (CHC)
- Adult Day Programs, First Link, and specialized community respite services for people with dementia (three Alzheimer's Chapters)

The VSM participants validated the earlier planning work and included additional information about system gaps as it relates to service coordination and collaboration. Collective information is collated and presented as key themes.

Gaps and Weaknesses Identified in System Coordination and Collaboration

- There are no standardized or consistent approaches to address the needs of older adults with responsive behaviours. Collaboration and coordination is limited, and for the most part informal. The ESC LHINs geography may be a contributing factor explaining why promising practices in one community are not being leveraged or spread to the others. There are distinct differences between rural and urban availability of services

Multiple Points of Entry into the System with No Centralized Intake

- There is confusion and a lack of knowledge amongst providers about the services available to the target population. This realization across sectors clearly illustrated how clients and their caregivers are confused, frustrated, and lack information when they are seeking help
- Caregivers often times are not equipped, have limited time, and/or are too tired to navigate the system. Some clients are placed on multiple waiting lists and by the time they receive care, the person with responsive behaviours has escalated to a crisis tipping point. Thus, many clients' enter the system through the ED
- From a performance perspective, lack of knowledge highlights a key element needed in the future system redesign as it relates to admission avoidance, ED diversion and pro-active management (before clients and their caregivers experience a crisis)

Lack of Common Assessment and Shared Care Plans

- Multiple assessment tools are used resulting in clients and their families "***telling and repeating their stories".*** Critical client information regarding changes in health status is not being transferred with the client
- LTCHs stressed that many residents with responsive behaviours are accepted for admission. However, the LTCHs are not made aware of behaviours in advance. This lack of communication has at times impeded trust between LTCHs and the local CCAC
- There is no common electronic assessment that crosses sectors and ***follows the client's care journey*** from the community, CCAC, ED, acute care admission, discharge planning, and LTC
- Lack of technology to aid in the sharing of client information and restrictions from Personal Health Information Protection Act (PHIPA) are barriers
- Care plans are developed by where the client eventually ends up in the system. ESC LHIN providers expressed a keen desire to implement one common, integrated assessment and care plan
- Assessment is intrinsically linked to an agencies mandate. Providers noted that the ***"client must fit the criteria of service – not the other way around".*** In other words, ESC LHIN current state is not client-centered

Lack of a Common Language across Sectors

- Providers use different terminology to describe the same client's presenting issue/responsive behaviours. Defining client need varies from agency to agency and sector to sector

Need for On-Going Cross-sector Education and Training

- LTCHs expressed satisfaction with PIECES and U-First training however, other sectors such as ED - GEMs, CCC, Schedule One facilities, CSS, and CHCs have not had access to this training
- LTCHs with staff retention issues emphasized the need for on-going education for PIECES, U-First, Gentle Persuasion, and Montessori. Education and training should also **extend beyond "formal" providers** to include volunteers, LTC housekeeping, and dietary staff as well as families/caregivers

Lack of Consistency across Sectors in Providing Services (24/7)

- A significant barrier is the lack of 24/7 services. Hospitals and specifically, EDs are 24/7, thus attracting clients. However respite, day programs, other CSS supports, and primary care do not provide services on the weekends/evenings
- The system is not driven by the client's needs rather the health care system is based on out-dated models and limited funding to address the current demographics changing needs. A key driver of this initiative and for AAH is the "aging of the baby boom generation". System redesign is timely

Transitional Points

- Transition points in the system are problematic due to inconsistent information flowing from the Erie St. Clair CCAC to LTCHs. Transition points such as discharge planning are restricted to weekdays. The implementation of Home First will result in a culture shift for hospitals. Within the Home First framework, it is imperative that other sectors are also redesigned to meet the needs of people with responsive behaviours who will be discharged home
- Transitional points must provide the receiving community agency/LTCH with appropriate information, coaching, and ideally an interdisciplinary team approach to meet the needs of clients. Changes in the environment are known to trigger "responsive behaviours". An effective transitional system redesign will mitigate risks associated with environmental changes

Geriatric Mental Health Outreach Teams

- The ESC LHINs AAH investment included enhancements for mobile GMHOTs. Enhancements were made to include additional interdisciplinary team members such as PRC, RN, Occupational Therapist (OT) and Social Work. The PRC role existed in one county and was developed through AAH funds for the remaining two counties. The three teams serve three counties in the Erie St. Clair region.

While LTCHs expressed satisfaction with the services; limitations are noted in the team's ability to respond to community-based clients with responsive behaviours. Further, the teams are not yet using standardized tools nor have critical care paths and formal protocols been developed with partnering agencies. These needs are addressed further in this action plan

Lack of Specialized Resources and Linkages to Primary Care

- The ESC LHIN is limited by a lack of geriatricians, specialized and trained physicians, and Nurse Practitioners (NPs)
- The AAH investment also includes the First Link Program provided by three Alzheimer's Chapters across the Erie St. Clair region. Despite this investment, stronger linkages with the primary care sector remain a challenge. It is noteworthy that the ESC LHIN is the third highest LHIN in Ontario for lack of primary care physicians.

Untapped Potential Resources

- Providers noted that respite and/or convalescent LTCH beds could be redesigned to provide stabilization for people with responsive behaviours with the aim of discharging the client back home or into the mainstream LTC population
- Similarly, ED GEM RNs noted that there are "no crisis respite" services when client stabilization is needed and/or short-term relief for caregivers suffering from exhaustion
- Adult Day Programs are restricted in scope by following '**A Social Model of Care'.** Adult Day Programs currently do not have the RNs or trained PSW resources to meet the needs of clients with colostomy, catheter, or insulin injections etc. This limitation results in the Day Program clients being discharged prematurely

Future Tertiary Care

- In November 2011, the divestment process resulted in transferring 59 Tertiary psychiatric beds from Regional Mental Health Care (RMHC), in the SW LHINs area of London to Windsor Regional Hospital (WRH) in the Erie St. Clair region. Within the 59-bed complement, a unit of 17 Geriatric-Psychiatry beds, and an additional unit specific to assessment will be available. This divestment process dates to the 1997 Health Services Restructuring Commission (HSRC). The ESC LHIN is faced with the unique **opportunity to build a true continuum of care and critical care paths** from community, the ED, acute care Schedule One facility to Tertiary specialized long stay care back to the community or LTCH

1a) What are the current structures in place to provide LHIN-wide coordination of services (e.g. networks, partnerships, etc)?

Currently the ESC LHIN has created several formal entities to support system planning and implementation including:

1. Home First
2. Mental Health and Addictions Network
3. LTC – CSS
4. ED/Med Group
5. ALC Network
6. Acute – Tertiary Mental Health Steering Group
7. Falls Prevention
8. Rehabilitation Network
9. Aboriginal Network
10. French Language Services Entity
11. Diabetes Network

Informal Entities Include

1. Geriatric Mental Health Committees
2. GEM Network
3. Elder Abuse Committee
4. Dementia Network
5. Mental Health Access Committees
6. LTC Facility Operators Groups
7. Decision Support Group (data)
8. Nurse Led Outreach Teams (NLOTs)
9. Chronic Obstructive Pulmonary Disease (COPD) CHC/CCAC Rapid Response Teams
10. Transportation Network

1b) How will structures be modified to improve coordination?

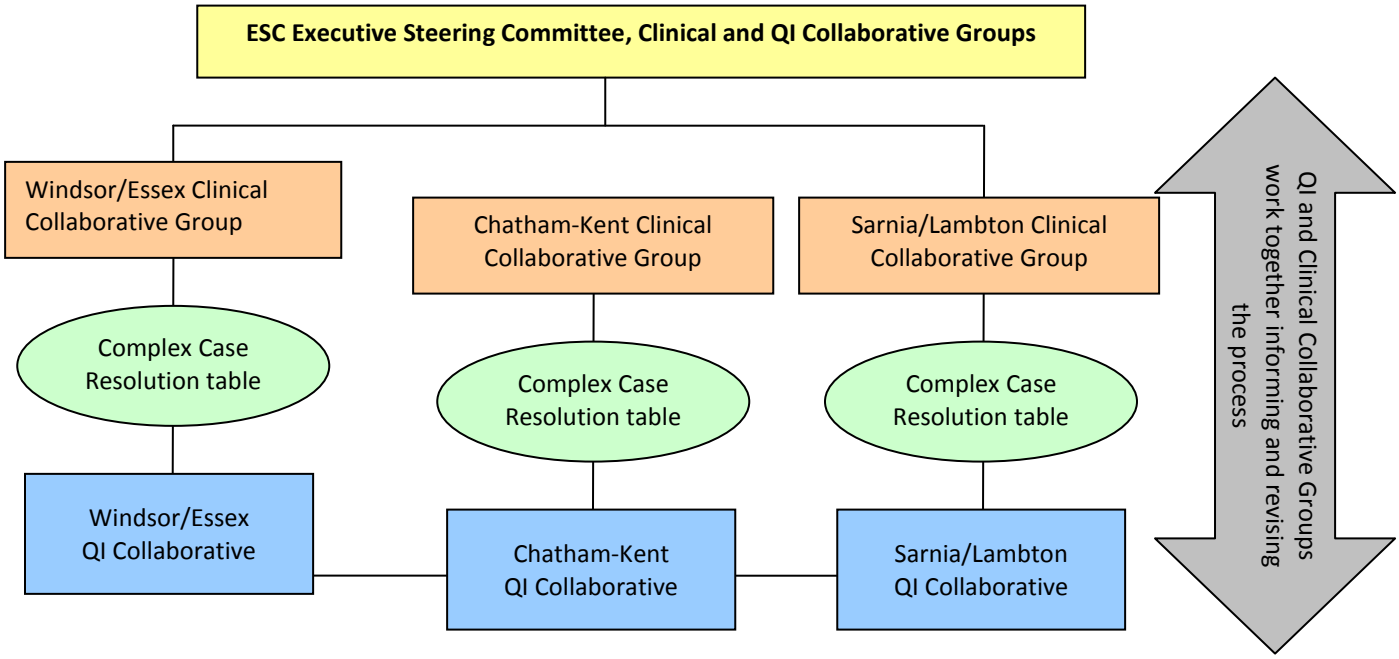
There are a number of examples of formal and informal partnerships in Erie St. Clair region. Partnerships for the most part are informal and meet at the county sub-LHIN level. Future, system coordination and redesign will be addressed at three levels:

1. Governance and System Management
2. Clinical Level
3. QI, Knowledge Exchange, and cross-sector training

Governance and System Management

1. Creation of the ESC LHIN Responsive Behaviours Governance structure
2. Memorandums of Understanding (MOU) will aid in role clarity and expectations amongst the partners. Service agreements from the ESC LHIN will be implemented to formalize accountability and overall system management
3. Realigning local Geriatric Planning Tables through direct reporting mechanisms to the over arching ESC LHIN Responsive Behaviours Governance structure
    - The local **Geriatric Planning Tables will evolve into collaborative groups** with a new LHIN-wide mandate and commitment to provide client-centred care within a collaborative culture of behavioural support. Membership will be enhanced and reflect cross-sectors including LTCH Lead Teams; CSS; Alzheimer's Society Chapters; primary care including CHCs, FHTs, and Nurse Practitioner Led Clinic (NPLC); Erie St. Clair CCAC/discharge planning, acute and Tertiary care
    - Building upon the VSM process, on-going QI strategies include testing implementation practices and evaluation (Plan, Do, Study, Act (PDSA) model cycles) will be formalized by aligning QI Collaborative Groups with the Clinical Collaborative Groups (please see Figure 1)
4. A Project Manager and Knowledge Exchange Transfer Coach will act as a conduit for the ESC LHIN Responsive Behaviours Governance Structure, clinical, and QI collaborative groups

Figure 1: ESC Responsive Behaviours Executive Steering Committee



Clinical Level

- Existing GMHOTs will be renamed and reconfigured through formalized system processes as well as, standardized clinical practices and Knowledge Exchange. The new Integrated Responsive Behaviours Mobile Teams (**formerly known as GMHOTs)** will be formed through integrating existing (expanded) and new resources including secondment/in-kind dedicated wraparound positions from CCAC, CSS, Client Intervention Programs, and Alzheimer Society Chapters.
- The Integrated Responsive Behaviours Mobile Teams will provide standardized assessments, cross-sector treatment plans with an emphasis on rapid response to address client escalation/de-escalation triggers, treatment/stabilization, and follow-up for older adults with responsive behaviours who reside in the community and LTCHs.
- In addition, a full menu **or wraparound supports** from the community sector will be leveraged and integrated with the mobile team to ensure that community based clients and caregivers remain in their homes with supports. Service linkages through future formal agreements include but are not limited to the following list:

  Wraparound supports include

  - Friendly Visiting and security checks
  - CCAC Case Management
  - Specialized in-home respite services for people with cognitive impairments
  - Day Programs and First Link Programs
  - Client Intervention programs
  - Meals on Wheels and transportation

- This action plan will ensure that coordinated clinical care pathways are developed and modified through QI PDSA cycles as a means of monitoring change and sharing critical lessons learned. Care paths will be formalized through protocols and recognize the uniqueness of each geographical culture, system resources, limitations, and needs. A **common assessment tool kit** and **education/training** endeavours will be developed and implemented by the teams. In this manner, providers will begin to speak the same language when discussing shared clients or clients who are transitioning through the continuum
- The Integrated Responsive Behaviours Mobile Team will **interface** with the LTCH Lead Teams in the delivery of clinical services, transitional supports for **"buddy" LTCHs,** and for continuous peer mentorship including Knowledge Exchange. Five LTCH Lead Teams will be responsible for **"transitioning, clinical interventions, and coaching"** neighbouring LTCHs. The LTCH Lead Teams will assume a leadership role in the development of LTC resident care plans and any PDSA modifications to the care plan – referred to as **"Maintenance Plans"**
- Unique aspects of geographical hubs will be addressed through ESC LHIN Community Engagement led activities to ensure that responsive behaviour services are **"culturally informed".** (e.g. Aboriginal, Francophone, rural and multi-cultural, ethnic needs (urban)). The ESC LHIN Leads for Francophone

and Aboriginal populations will be leveraged to ensure that cultural sensitivity and awareness are integrated into this new model of care

- **Transitional points** will be **integrated and coordinated with CCAC** and Hospital, the Integrated Responsive Behaviours Mobile Teams and the LTCH Lead Teams. The integration will be enabled through dedicated, trained resources (new hires, integration, in-kind/secondment).
- The ESC LHIN eHealth Lead will champion **"one electronic health record**" and explore **developing a client register** which identifies and tracks the client and caregivers progress and journey. A client register would allow for longitudinal QI opportunities and, identifying the next cohort of clients as an "early identifier". In an effort not to duplicate process, the ESC LHIN eHealth Lead will ensure that the above endeavor is consistent with Provincial eHealth strategies. The ESC LHIN eHealth Lead has had prior success implementing a "clinical viewer". A clinical viewer is a means of sharing client information in a read only format

QI, Knowledge Exchange, and Cross-sector Training

- The ESC LHIN will leverage existing knowledge and expertise of the three Alzheimer Society Chapters including expansion of the PRC and PEC roles as a key driver for providing on-going support for families and LTCH staff during responsive behaviour resident's care plan development, episodes, and reviews.
- The Alzheimer Society Chapters will provide U-First, PIECES, and Gentle Persuasion approaches for 35 LTCHs, the Integrated Responsive Behaviours Mobile Teams and LTC Team lead members, hospital staff, primary care providers, CSS, and CCAC including planning for employee turnover. Accountability to the ESC LHIN includes measures such as number of educational sessions and number of staff newly trained, reported monthly upon implementation of this action plan. As the project evolves, quarterly reports will be submitted to the ESC LHIN. Education and training will be provided in a phased, manageable approach.
- The teams will have trained resources for QI leadership. QI score cards with run charts and PDSA will be reviewed monthly for shared learning's across the region. Caregiver satisfaction feedback through focus groups will be implemented quarterly. Rapid Cycle Improvement Plans will be a standing agenda item at the sub-committee level overseen by the ESC LHIN QI Manager and the new Responsive Behaviours Executive Steering Committee.

Governance and Accountability Structures

2.0 What Governance and Accountability Structures will be in place?

The Erie St. Clair Board of Directors will maintain overall accountability for the implementation of the ESC Responsive Behaviours action plan, as detailed in the funding agreement between the ESC LHIN and the MOHLTC. The ESC LHIN has assigned oversight responsibility and system management to the new Responsive Behaviours Executive Steering Committee. Membership is across sectors at the leadership/decision making level. (**please see Appendix A - Terms of Reference (TOR) and Membership).**

The Responsive Behaviours Executive Steering Committee is directly interfaced with clinical collaborative and QI groups. Knowledge transfer and decisions will flow from the Executive to the clinical and QI collaborative groups as a continuous communication process.

Accountability for funding and the deliverables associated with the funding is through service agreements between the ESC LHIN and Health Service Providers (HSPs)/Lead Agencies that will receive funding or integration directions. The Executive Steering Committee members agree that representation to funders (ESC LHIN) will be as "one collective voice".

The Executive Steering Committee will be guided by our CVS and principles, alignment with the Provincial BSO framework and TOR with clear deliverables and timelines developed by the ESC LHIN. Examples of deliverables include:

1. Oversee the development, implementation, and monitoring of the action plan including clinical collaborative and QI groups
2. Ensure cross-sector MOUs are developed, monitored, and revised as needed
3. Develop LHIN-wide communication briefs that will be posted on the ESC LHIN website
4. Embed the ESC LHIN Responsive Behaviours CVS and Guiding Principles into all elements of service delivery; ensuring that a client-centred approach is implemented and families/caregivers are treated as "equal" partners throughout the care journey

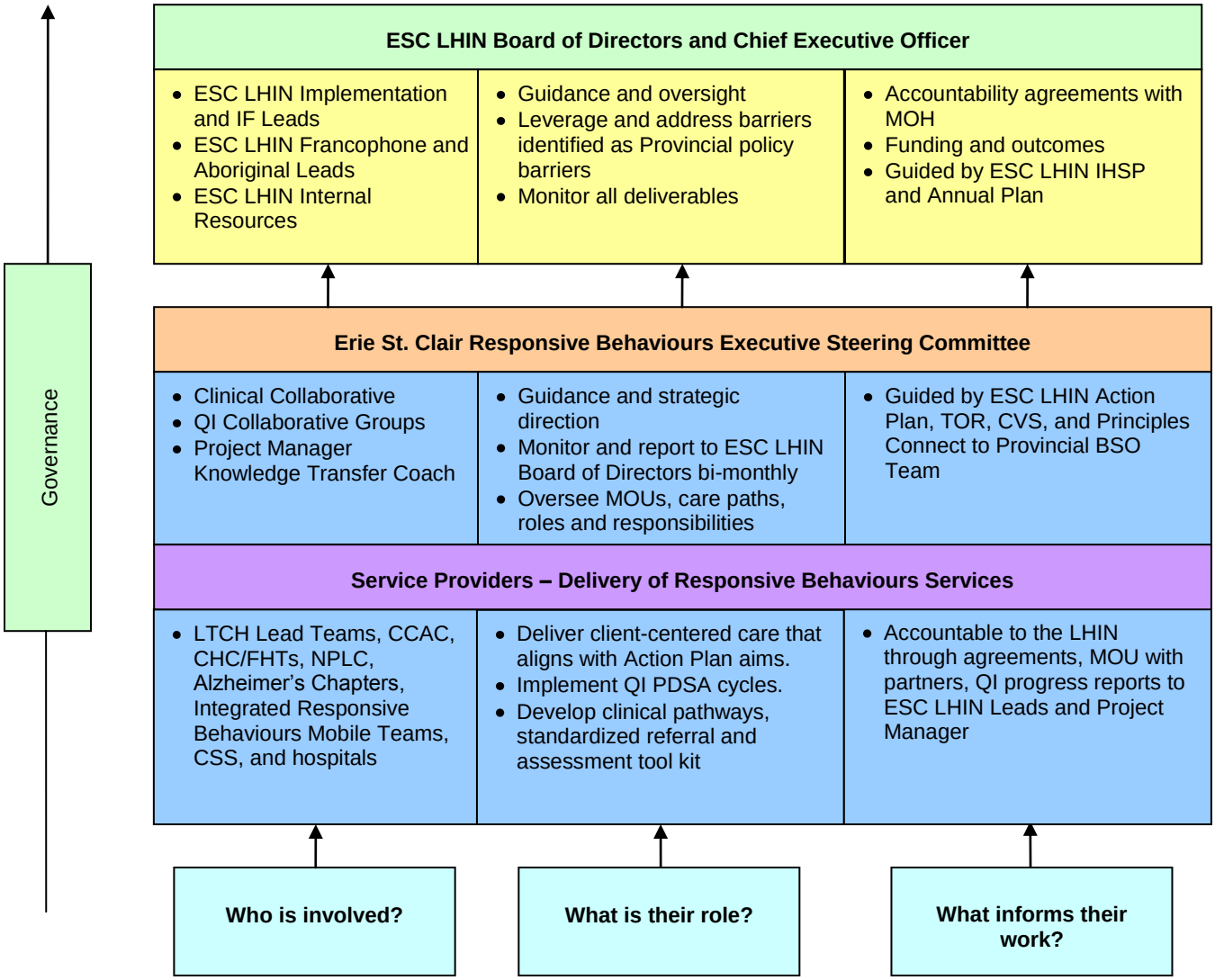
The Responsive Behaviours Executive Steering Committee will be charged with providing implementation progress reports on a bi-monthly basis to the ESC LHIN Board. The Executive Steering Committee will receive on-going support from ESC LHIN staff specifically, the Implementation and QI Leads.

A Project Manager and Knowledge Exchange Transfer Coach will support the Executive Committee as a conduit linking to the clinical and QI Collaborative groups. As the new model becomes ingrained into ESC LHIN HSP culture, the Executive Steering Committee will transition to a monitoring function **(Please see Figure 2).**

Erie St. Clair Responsive Behaviours Guiding Principles

1. Every door is the right door
2. Least intrusive intervention, closest to home, and minimal transition points
3. Consistent providers – using the most appropriate service levels
4. Strive for a system that asks clients and families what they need and provide flexible services based on the response
5. Identify, respect, and incorporate cultural norms throughout the care journey
6. Empower clients and caregivers to make informed choices
7. On-going communication with families throughout the care process
8. Communication across the system so people are informed and expectations are clear – case conferences/wraparound team discussions to aid integrated care across the continuum
9. Pro-active early prevention and early detection – minimize and prevent crisis situations

Figure 2: ESC LHIN Responsive Behaviours Framework



Decision-making

The Executive Steering Committee will use a consensus decision-making process. Consensus is an agreement that all stakeholders can support, built by identifying and exploring all parties' interests and assembling an agreement which satisfies these interests to the greatest extent possible. Using a consensus approach, members are not simply for or against a decision, rather **all parties will be "heard".** As such, individual decisions are replaced with creative alternatives and compromise with synthesis. To further strengthen the Governance model, a **conflict dispute mechanism** will be developed and **"spread" to the clinical level** as a means of ensuring consistency and commitment to the overarching Responsive Behaviours Model.

3.0 Who will be the Partners for System Coordination?

The partners for system coordination will be comprised of Erie St. Clair HSPs and key stakeholders involved in early detection, primary care and/or clinical management of individuals with responsive behaviours and their caregivers. These providers may provide information or care at any point along the continuum. Providers include:

- 35 LTCHs (including five Lead Homes)
- Three Integrated Responsive Behaviours Mobile Team (formerly GMHOTs)
- Three Alzheimer's Society Chapters
- Four CHCs (twelve CHC sites)
- Nine Family Health Teams (FHTs) and three NP Lead Clinics
- Three Schedule One Hospitals (Hôtel-Dieu Grace Hospital (HDGH), Chatham-Kent Health Alliance(CKHA), and Bluewater Health (BWH))
- One Tertiary hospital (WRH)
- Regional Mental Health Care, London
- Psychiatrists and family physicians
- CSSs including Client Intervention program
- One Community Care Access Centre
- GEM RNs and CCAC ED and Hospital Case Managers
- Geriatric Assessment Program (GAP) WRH
- One LTC NP Outreach Team
- Two Canadian Mental Health Associations (CMHAs) and three Peer Support Programs
- Emergency Medical Services (EMS)
- Police Services specifically: one HELP Team and one COAST Model
- SWOGAN program

Core Partners for System Coordination Include

- Three Alzheimer's Society Chapters
- Erie St. Clair CCAC Specialized Case Managers and a NP
- Three Integrated Responsive Behaviours Mobile Teams and their psychiatrists
- 35 LTCHs, including five Lead Homes
- Three Client Intervention Services
- Five hospital corporations – with eight sites includes Schedule One and Tertiary (WRH and RMHC, London)
- Primary Care (CHCs, FHTs, NPLCs)
- LTC NP-led Outreach Teams

3a,b) How have the partners collaborated on previous projects and what were the Outcomes?

Erie St. Clair HSPs have a history of working collaboratively at the regional and sub-LHIN level. Examples of partnerships that have enhanced service coordination and concrete next steps towards further alignment with the action plan include:

GMHOTs and Schedule One Hospitals

At the sub-LHIN level, GMHOTs have developed informal processes to aid in the successful transition of LTC residents admitted for acute psychiatric care back to LTCHs. In one county, the team members are from a different hospital than the Schedule. This is noteworthy, as an excellent example of how union concerns were successfully addressed placing the needs of the client first. This process requires leveraging to all of the ESC LHIN Schedule One hospitals and Integrated Responsive Behaviours Mobile Teams.

Future Endeavours of the ESC LHIN Responsive Behaviours Action Plan Include

- Formalizing the clinical process by creating **care paths and implementing formal agreements with LTCHs,** that outline the processes for residents transitioning from the Schedule One back to LTCH with clinical supports from the LTC Lead Team and Integrated Responsive Behaviours Mobile Teams
- With the addition of new **Tertiary services transitional protocols** will be developed clearly outlining roles and responsibilities. The new Tertiary services as per the HSRC are for residents of Windsor/Essex and Chatham-Kent. RMHC, London (SW LHIN) provides Tertiary supports for residents of Sarnia/Lambton. The current service delivery structure for older adults with responsive behaviours includes partnerships with Southwestern Ontario Geriatric Assessment Network (SWOGAN). To ensure standardization across ESC LHIN, cross–LHIN partnerships will be maintained and formalized through agreements

Erie St. Clair CCAC and CSS

With the recognition of the need to streamline the referral process for seniors living in the community, CCAC developed, implemented, and standardized a referral tool known as CA2. The CA2 tool utilization is monitored by CCAC in partnership with the CSS sector. This successful initiative has resulted in increased referrals for the CSS sector and a communication mechanism to keep CCAC Case Managers informed. The CA2 tool will be examined as it relates to the "**wraparound supports"** for older adults with responsive behaviours who reside in the community.

ESC LHIN Quarterly Forums

The Quarterly Forums are a highly successful endeavor initiated by the ESC LHIN. The Forums provide a communication venue for cross-sector HSPs to network and learn about new initiatives as well as promising practices.

Community Mental Health Access Committees

Community-based mental health providers have developed a centralized point of entry into the mental health system based on the level of client need (Ontario Common Assessment of Needs (OCAN) tool). In Chatham-Kent and Sarnia/Lambton, the Access Mechanism is for the entire mental health system. Membership is comprised of CMHA Lambton-Kent (LK), Schedule One, and the Assertive Community Treatment (ACT) Team Leads.

In Windsor/Essex, the Access Mechanism was disbanded for a number of years due to limited capacity and wait lists. Within the past year, the Windsor/Essex mental health and addiction stakeholders reconvened focusing on clients deemed **"hard to serve".** The clients are identified at any point within the system: CMHA Windsor/Essex, ACT Team, Schedule One, withdrawal management services, supportive housing, homeless shelters, and by psychiatrists. On the one year anniversary, the Windsor/Essex Hard to Serve Access Committee reported reviewing 50 individuals with a Serious Mental Illness and/or concurrent disorder. This cross-sector process will be replicated and leveraged for older adults with responsive behaviours who are clinically complex, have multiple co-morbid conditions, or deemed **"complex cases requiring resolution. (Please see Figure 1).**

Diabetes Advisory Network

CHCs, hospitals, and the ESC LHIN joined forces to standardize the referral forms and processes for people with diabetes in the Erie St. Clair region. Prior to this Advisory Network, diabetes teams operated in isolation.

Promising New Initiatives - Telemedicine

In January 2012, the ESC LHIN will receive funding for 15 Full-time Equivalent (FTE) Telemedicine RNs/Registered Practical (RPNs). This initiative will leverage the use of Ontario Telemedicine Network (OTN) further by ensuring that the earlier ESC LHIN investment ($100,000) for OTN equipment is now utilized by dedicated staff.

The Telemedicine initiative will roll out focusing on two population groups. Please note that older adults with responsive behaviours **may be identified through either channel.**

1. Six Telemedicine RNs/RPNs FTEs will be based in five EDs focusing on people with mental health or addictions issues
2. Nine Telemedicine RNs/RPNs FTEs will be leveraged for chronic disease management. This includes placing resources at CCAC, the Diabetes Regional Centre, Oncology, and the Renal Dialysis Centre

Residents First

The mission of Residents First is to build QI capacity in LTC, so that the quality of each resident's care is the best in Canada and comparable to leading jurisdictions in the world. Residents First is led by HQO collaborating with the LTC sector and LHINs. The model for Residents First includes leadership training, Improvement Facilitator (IF) training, collaborative projects for QI and LEAN process redesign. The ESC LHIN has partnered with the SW LHIN in these collaborative and the IF trainings. This collaboration has created strong capacity in QI within the LTC sector in both LHINs. Also, to guide the process improvement efforts, HQO has developed evidence-based change packages to assist the implementation of QI. One of the change packages includes Responsive Behaviours and our teams are eager to leverage this change package to assist in the redesign of services for this population.

Home First

Home First is in the early stage of implementation. This initiative includes geographical implementation teams based in three counties with cross-sector membership. Key processes and successes from Home First will be leveraged as it relates to older adults with responsive behaviours that are designated ALC. Home First is also leveraging QI tools such as fishbone diagrams, priority matrices, PDSAs, and VSM.

3c) List the Executive Sponsors who will have potential responsibility for meetings, chairing a steering committee, on-going leadership, and engagement.

- Brad Keeler, Co-Chair, ESC LHIN Responsive Behaviours Executive Steering Committee; and Senior Director, Delivery and Implementation, ESC LHIN
- Mary Ellen Parker, Co-Chair, ESC LHIN Responsive Behaviours Executive Steering Committee; and Executive Director, Alzheimer's Society Chatham-Kent

PILLAR 2

Interdisciplinary Service Delivery, Outreach, and Support Across the Service Continuum to Ensure Equitable, and Timely Access to the Right Provider for the Right Service

4) Where in the service continuum is access to supports and outreach services a problem?

1. **Point of entry**/access is confusing for providers, clients, and caregivers
2. **Preventative linkages with primary care** need to be strengthened **and formalized**
3. Transitional points **from the ED** to the "right" community providers. Lack of knowledge regarding "who is the right provider"
4. **Transition at the point of discharge** from hospital to the community and/or LTCHs. Particularly for clients with responsive **behaviours deemed "complex"** and difficult to manage safely in a LTCH setting
5. **The tipping point/crisis** – current access point is the ED. ED GEMs and CCAC ED Case Managers have identified a need for **crisis respite beds**
6. Adult Day Programs discharge community-based clients due to an inability to meet their medical needs. Often times, this leads to a crisis or a premature admission to LTCH
7. Lack of cross-sector collaboration and coordination for client's with escalating behaviours in the community in terms of **"complex case resolution process"**

THE FUTURE STATE:

4a,b) What high risk population is current underserviced and will be a focus of this Action Plan? What are the transition points for this population?

Responsive Behaviours Target Population

The target population is older adults with cognitive impairments due to dementia, neurological conditions, mental health issues, addictions, chronic co-morbidities, and who have communication or comprehension impairments, and their caregivers. Responsive behaviours may include: verbal or physical aggression, exit seeking/wandering, physical resistance to care, and agitation.

Target Population Locations

1. Older adults with responsive behaviours living in the community **and** LTCHs experiencing an **unexpected, escalating behavioural change crisis.** This population group often presents in acute care and the end point is either **ALC designation** and/or admission to CCC
2. Individuals with responsive behaviours who are **"transitioning"** from the ED, acute care, Schedule One or Tertiary psychiatric facilities back to their home or to LTCH including a LTC secured unit (new LTC placement or existing resident)
3. **Families/caregivers** - Regardless of the clients place of residence (community or LTCHs) caregivers will be supported throughout the client's journey. This includes after the client's death by ensuring that caregivers and families are made aware of bereavement support programs provided in their community

Additional High Risk Populations Identified by ESC LHIN HSPs

A deeper scoping identified seven population groups deemed complex and potentially difficult to manage. Low socio-economic status may be a common factor for all of the population groups identified.

1. Older adults with a serious mental illness (schizophrenia, bipolar disorder) and dementia. Particularly those with unpredictable aggressive behaviours
2. Older Adults with an Acquired Brain Injury (ABI)
3. Older Adults with a dual diagnosis and dementia (e.g. Down syndrome and Alzheimer's disease)
4. Older immigrant adults with responsive behaviours who are hard to reach due to language barriers
5. Older adults with responsive behaviours who are Aboriginal, Francophone or from other cultural, ethnic groups
6. Older adults with cognitive impairments and Diogenes Syndrome (hoarders)
7. Older adults with responsive behaviours in rural communities who do not reach out for help or are not aware of where to turn for assistance

Key Transition Points for the Target Population

This action plan has been developed to address three specific transition points.

Note: Caregivers are included as "clients" and supported through each of the three streams.

- **Point of** entry for clients with an acute change in responsive behaviours
- **Tipping Point Crisis** - ED → transition back to community or LTCHs including LTC secured units
- **Discharge and transition from** acute care or Schedule One, or Tertiary psychiatric beds → to community or LTCHs (including a LTC secured unit)

4 c) What opportunities exist to leverage the strengths and address the gaps in the service continuum for behavioural support services? Will both rural and urban population group issues be addressed?

This action plan builds upon existing partnerships and prior investments by implementing three core service delivery components to effect system change:

1. Centralized **Access**/Point of Entry – Alzheimer's System Navigation in collaboration with CCAC as it relates to "shared" clients
2. **Clinical interventions and system transitions** - CCAC Transitional Point Leads, Alzheimer's System Navigation, Integrated Responsive Behaviours Mobile Teams, and LTCH Lead Teams
3. **Embedded knowledge transfer** and capacity building interfaced with QI facilitators (**discussed in Pillar 3)**

Centralized Access and Alzheimer's System Navigation

- The introduction of a **centralized toll-free point of entry** using a phased approach will include a live response utilizing a common risk screening tool, triage, and referral to the most appropriate provider. The intake and referral function will be conducted by **Alzheimer's System Navigators** who will case find using a common risk screening tool and initiate referrals to the Integrated Responsive Behaviours Mobile Team and the five LTC Lead Teams for clinical interventions. In circumstances where the client is already receiving CCAC Case Management services and a sudden, behavioural change occurs it is expected that CCAC and the Alzheimer's System Navigators will work closely together
- Consistency and continuity are paramount service components for providing quality care for seniors with cognitive impairments. As client needs change, knowing where and how to access appropriate services is confusing, frustrating, and can lead to hospitalization or premature placement in LTCH. Families and caregivers will be supported throughout the process by Alzheimer's System Navigators. Throughout the Erie St. Clair behavioural support services engagement, the need for System Navigators as a "guardian angel" for caregivers was a repeated theme. The ESC LHIN will leverage the existing mandate, experience, and skills of three Alzheimer's Society Chapters to assume this expanded role
- The centralized access point is inclusive of LTCHs requiring services for residents experiencing **their first significant acute behavioural change**. These residents are **new** referrals and not previously linked to the LTCH Lead Teams or the Integrated Responsive Behaviours Mobile Teams. Differing rural and urban needs will be addressed
- Building upon the existing mental health system, after-hours and week-end crisis response in the ESC LHIN will explore partnering with CMHA LK as it relates to leveraging **call-transfer** technology. This agency currently operates a 24/7 crisis line and has clinical experience as an existing GMHOT serving 10 LTCHs in Sarnia/Lambton. The existing crisis line could be leveraged to provide after hours support LHIN-wide **using a phased implementation approach.** Additional funding from the ESC LHIN may be required to operationalize the call-transfer technology

Functions of the Alzheimer's System Navigator

1. Telephone intake and case finding. Deploying appropriate resources as indicated by the risk screening tool (please see VSM). This includes working in partnership with CCAC Case Managers with clients that are experiencing their first acute behavioural change. Together, the CCAC Case Managers and the System Navigators as a team will address the needs of older adults with responsive behaviours and their caregivers
2. Contact and refer to Integrated Responsive Behaviours Mobile Team and LTC Lead Teams as required ensuring that appropriate client and caregiver information is provided regarding the reason for the referral, existing supports, caregiver level of burden/stress, types of responsive behaviours, and any known trigger. As well, coping strategies that have successfully been used in the past, but are now ineffective
3. Upon the caregiver Power of Attorney (POA) consent, the Integrated Responsive Behaviours Mobile and LTC Lead Teams will provide client information to the Alzheimer's System Navigator for recording in a Central Repository and Clinical Viewer which will be phased in technology, championed by the ESC LHIN eHealth Lead
4. In collaboration with primary care models and First Link Programs ensure that caregivers/families are informed about local support and/or educational groups including individual counseling sessions. Arrange first appointments as required. Links with **"wraparound" resources** as needs are identified by the caregiver (e.g. security checks, friendly visiting, respite supports, CCAC and primary care appointments)
5. Provide caregivers/families with self-management skills – tips and tools.
6. Upon implementation of the after-hours call-transfer technology, the Alzheimer's System Navigator will receive this information and deploy teams as the case requires (e.g. community/LTCH)
7. The **Alzheimer's System Navigator is the primary link for caregivers** throughout the journey. This includes when the client has transferred to LTCHs. Caregivers will be provided with referrals for support and/or educational groups, individual counseling including bereavement counseling as required. The Alzheimer's System Navigator in collaboration with CSS - Friendly Visiting and security checks will ensure that follow-up contact with caregivers is implemented and maintained
8. The Alzheimer's System Navigator is a key role that is integrated with the Responsive Behaviours Mobile Teams, the LTCHs Lead Teams, and the Erie St. Clair CCAC Specialized Case Managers

Integrated Responsive Behaviours Mobile Teams

- As previously discussed, there are three county-level GMHOTs. Members of these teams include: RNs, OTs, and Social Workers, the PRCs are embedded in the team as either RNs or Social Workers. Each of the three teams has a Lead Geriatric Psychiatrist. These teams will be **enhanced through integration, secondment/in–kind, and new resources** (discussed further in question 9)
- In addition, the teams will be interfaced with the five LTCH Lead Teams and the ***wraparound support*** from key providers in the community
- A **Complex Case Resolution Table** will be developed and membership will be fluid based on individual client need. Members may include Schedule One facilities, Tertiary long stay psychiatry, community mental health housing/CMHA Case Managers, The Assertive Community Treatment Teams (ACT Teams), LTCHs, physicians, psychiatrists, and the Erie St. Clair CCAC. **Please see Figure 1** which shows the interface between the clinical collaborative group, the Complex Case Resolution Table, and QI collaborative group as they link up to the Executive Steering Committee

Functions of the Integrated Responsive Behaviours Mobile Team

- Provide comprehensive face-to-face standardized assessments using an interdisciplinary team approach. Assessment includes a case-finding approach for diagnosis - depression, delirium, or psychosis superimposed on the underlying cognitive impairment. Base-lines will be established for cognitive functioning, mood, and pharmacological intake that addresses the client's co-morbid conditions.
- Existing geriatric psychiatrist in collaboration with the client's primary care physician may recommend stopping, reducing, or adjusting psychotropic or anti-cholinergic dosages as a means of balancing the benefit and harms from these medications
- The Integrated Responsive Behaviours Mobile Team's goal is to recognize that many older adults with responsive behaviours and cognitive impairments have co-morbid conditions. The goal therefore, is to simplify the medication regimen and maximize self-management/stabilization. It is **not** the goal or intent of the Integrated Responsive Behaviours Mobile Team to ***"take over"*** the management of the primary care physician's client. Rather, their function acts as an additional resource to compliment the primary care clinicians' ability to provide excellent care to this complex population group
- Developing and implementing **Interdisciplinary Treatment Plans** with an emphasis on core triggers and concrete interventions to de-escalate behaviours. The treatment plan will be developed from a bio-psycho-social perspective that includes cognitive, affective and functional measures, behavioural symptoms, and stressors as well as prior coping mechanisms
- Monitoring and follow-up either in the community or LTCHs. Follow-up frequency varies from client to client and setting to setting. When the client resides in the community, monitoring needs to include the caregiver and specific questions regarding falls, home safety, driving, functional impairments/limitations, mood and cognitive/behavioural changes. As well, noting any changes in the clients'

health status, the environment and/or any significant recent losses (e.g. death of a family member or pet)

- The above information is documented and forwarded to the Alzheimer's System Navigator upon consent from the caregiver/POA for the centralized client repository and clinical viewer system
- Revising LTCH resident care plans as responsive behaviours may evolve. In collaboration with the five LTCH Lead Teams aid in the development of **Maintenance Plans** which are different from Resident's Care Plans as the focus is **on changing or new responsive behaviours** and de-escalating intervention techniques including suggestions for managing environmental factors

  NOTE to the Reader: Throughout the VSM sessions the "term*"* ***rapid response teams*** was used by participants. While this terminology reflects the need for **immediate clinical response** it is not included in the team title because it is currently used by ESC CHCs Chronic Disease Management (COPD) Rapid Response Teams

Erie St. Clair CCAC and System Transitions

- Erie St. Clair CCAC Case Managers are becoming embedded into the hospital structure. These invaluable resources will ensure that critical client information regarding responsive behaviours transitions smoothly to the Alzheimer's System Navigators and LTCH Lead Teams
- Using cross-sector knowledge transfers, some CCAC Hospital Case Managers will receive specialized education and training along side of the Alzheimer's System Navigators, Integrated Responsive Behaviours Mobile Teams, and LTCH Lead Team members. At the end of Phase One, the above HSPs will use a common language and become more cohesive as a cross-sector of providers working towards a common goal of **"seamless, informed, and coordinated transitions"**

Functions of the Hospital-based Erie St. Clair CCAC Specialized Case Managers

- Provide Erie St. Clair CCAC assessments and supplemental information as it relates to responsive behaviours
- In collaboration with the Alzheimer's System Navigator, ensure that caregivers are linked seamlessly to specialized support groups, individual counseling, educational groups, and on-going monitoring
- Based on the clients level of need and discharge destination, provide assessment information, advice, and recommendations to the receiving LTCHs
- Alert the Alzheimer's System Navigator when follow-up care is needed from the LTC Lead Teams and or the Integrated Responsive Behaviours Mobile Team
- ESC LHIN HSPs will recognize and respect the role of the Erie St. Clair CCAC Specialized Case Managers as the **"acute and Tertiary transition lead for older adults with responsive behaviours"**
- Erie St. Clair CCAC Specialized Case Managers (existing and new hire) will focus their sole attention towards older adults with responsive behaviours with an ALC status and their caregivers
- The Erie St. Clair CCAC Specialized Case Managers is a critical member of the Responsive Behaviours Model and considered a member of "core services"

LTCH Lead Teams

During the early stages of developing this action plan, ESC LHIN staff engaged 35 LTCHs in discussions and by issuing an **Expression of Interest** for becoming a LTCH Lead Team. Shortly after issuing the Expression of Interest the ESC LHIN developed a **decision making template** based on the following variables:

- Location of the home (County – urban/rural)
- Size of the home
- Existing secured unit
- Sufficient expertise with older adults with responsive behaviours
- Engaged LTC staff
- QI expertise
- Strong, supportive corporate structure

The Expression of Interest prompted a response from nine (or 26%) of the LTCHs in the Erie St. Clair region. Based on the decision making criteria, five LTCH Leads were selected. The LTC Leads are: Aspen Lake, Richmond Terrace, Riverview Gardens, Afton Park, and Trillium Villa. Please see maps showing the geographical area and selected LTCH Lead Teams.

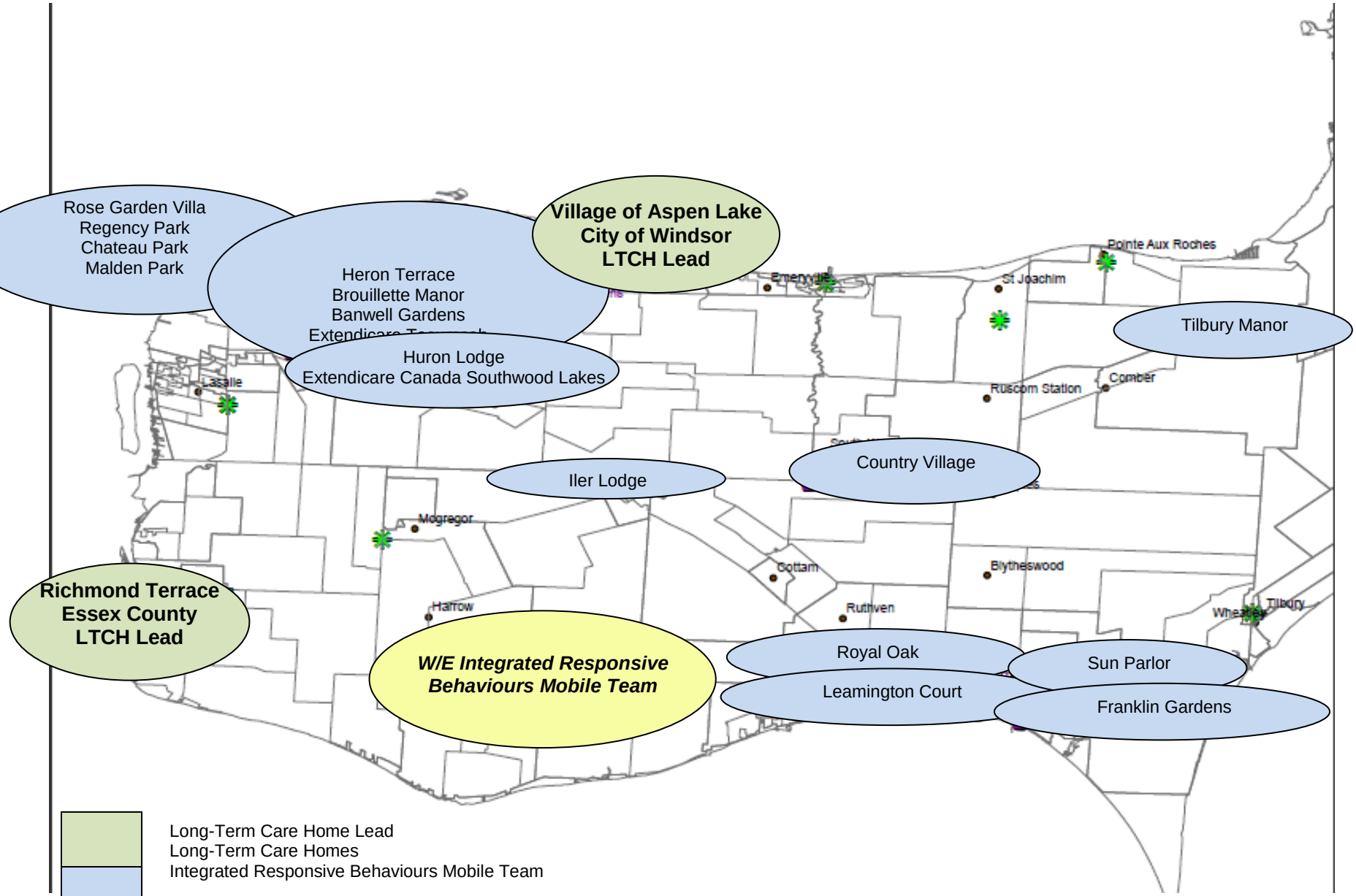
Functions of the LTCH Lead Teams

1. Aid in the transition of LTC residents with responsive behaviours (new or existing) from community or hospital to neighbouring LTCHs. Transitioning includes aiding their neighbouring LTCHs to stabilize the resident, **mentor LTCH staff** regarding triggers and intervention techniques, as well as providing time limited intense intervention prior to a neighbouring LTCH applying for High Intensity Needs Funding. The overarching aim is to **reduce the use of High Intensity Needs Funding** as well as **reduce the number of transfers to hospitals**. This will be accomplished by increasing overall skills and capacity. This endeavor includes interfacing at the clinical level with the Integrated Responsive Behaviours Mobile Team
2. Clinical interventions are conducted in collaboration with the existing LTCHs, and the Integrated Responsive Behaviours Mobile Team
3. Provide expert **clinical assistance** to their neighbouring **"buddy LTCHs".** This includes assessment, treatment planning, and revising the plan where needed. The LTC Lead Teams are the **"LTC experts".** Their clinical skills coupled with knowledge dissemination and QI expertise will build long-term, capacity in the Erie St. Clair LTCH sector
4. As the action plan evolves the ESC LHIN will **develop LTCH Stabilization Units** during Phase Two of this initiative (please see Implementation Timelines). The ESC LHIN has a history of working **cooperatively with the MOHLTC.** As a concrete example, our LHIN established 60 interim LTC beds in a Rest and Retirement Home setting. These additional LTC beds are compliant with the MOHLTC LTC Regulations and were needed to address the long-standing ALC crisis in Windsor/Essex. To further aid caregivers, the ESC LHIN recognized the need to provide coordinated, free of charge transportation services for caregivers

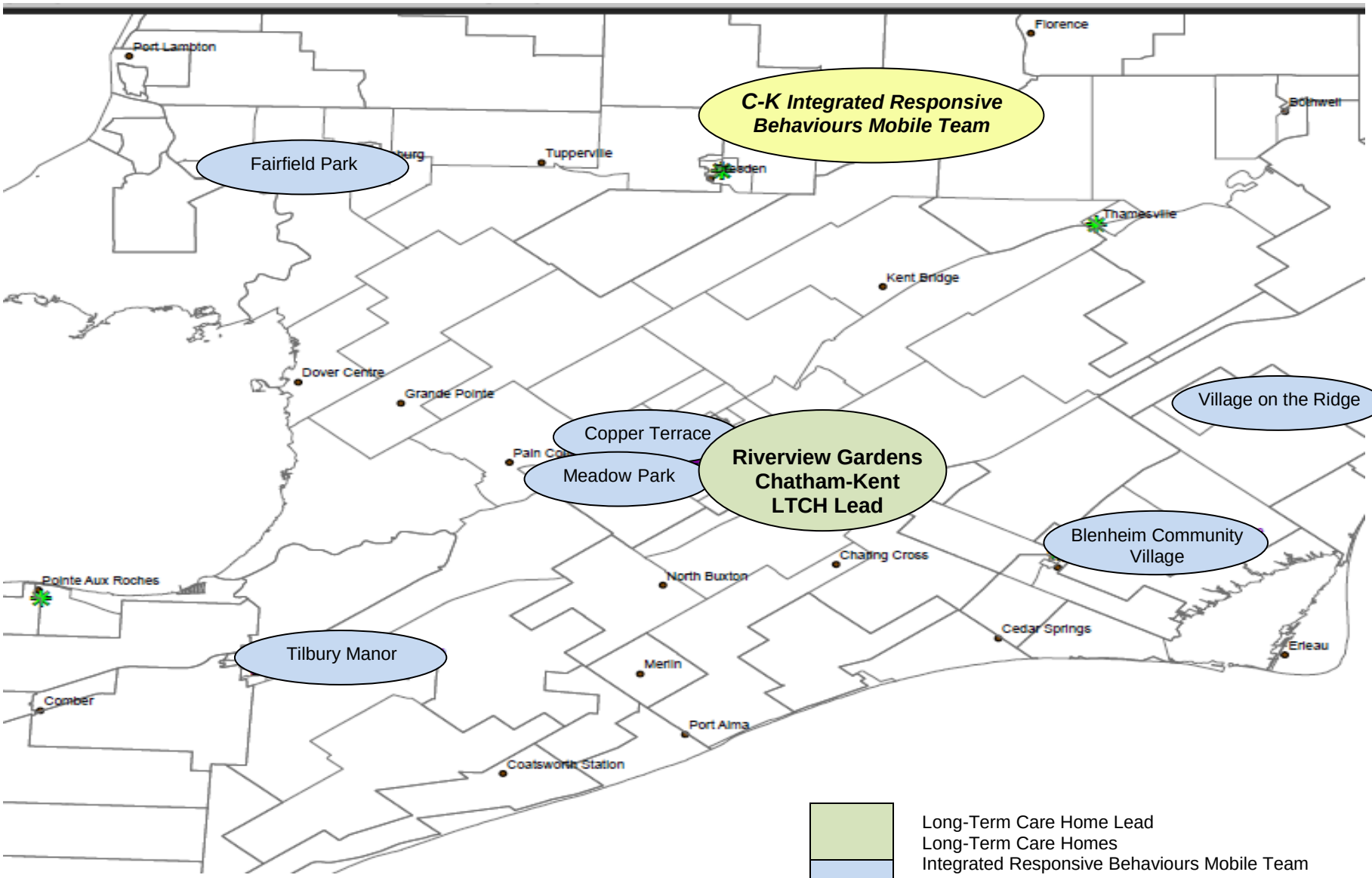
residing in the City of Windsor visiting their loved one in the new county beds. The Windsor/Essex Coordinated Transportation Strategy involved five providers working together to establish a central point of entry, back-up support, and linkages with other services as identified by the caregiver. To date, the Leamington Court beds and coordinated transportation service for caregivers is recognized as a "**Made in Erie St. Clair ALC Solution"**

5. The following maps show our three sub-LHIN counties aligned with the Integrated Responsive Behaviours Mobile Teams and the LTCH Lead Teams. **Note to the reader: due to limited space on the maps the Integrated Responsive Behaviours Mobile Teams are not located at their primary base**

Windsor/Essex Long-Term Care Homes

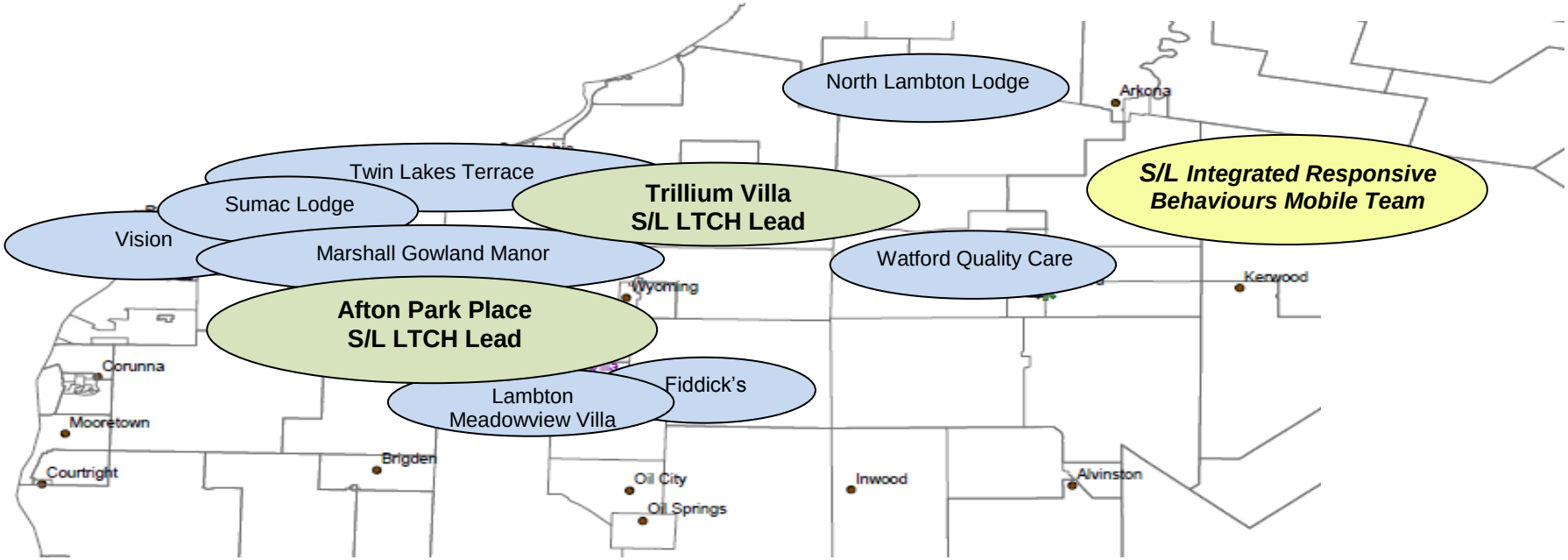


Chatham-Kent Long-Term Care Homes



Sarnia/Lambton Long-Term Care Homes

Long-Term Care Home Lead
Long-Term Care Homes
Integrated Responsive Behaviours Mobile Team



LTCH Lead Teams and Implementation

The ESC LHIN recognizes that the LTCHs have unique cultures and have legitimate concerns about health human resources. Concerns range from:

- Collective bargaining and unions
- Workplace Safety and Insurance Board (WSIB) coverage
- Clear roles and responsibilities
- Clinical supports and Knowledge Exchange provided prior to "going live"
- Ensuring partnership agreements exist with "buddy LTCHs"
- Transportation, computer, Blackberry unit (initial start up costs)
- New hires versus unionized employees - who have the needed skill set and expertise (recruiting costs)
- Stabilization beds and the need to comply with the LTC Regulations
- Building upon this service delivery model in a phased approach by developing specialized "Behavioural Support Units"

In consultation with our Lead BSO "buddy" (Hamilton, Niagara, Haldimand, Brant (HNHB)); the ESC LHIN will establish a LTC Implementation sub-committee composed of the five LTCH Lead Teams. This sub-committee will be supported by the ESC LHIN Implementation and QI Leads and the Senior Director who is also the Co-Chair of the Executive Steering Committee. The sub-committee's primary aim is to work through the above concerns in a time frame that allows for thoughtful discussion and resolution.

5) Illustrate how the action plan addresses the continuum of services from primary, to acute, to community care-based on system coordination across agencies, across sectors, and partnerships (e.g. preventative care in primary care and the community, individuals at the tipping point - attach a process map.)

Primary Care as a First Point of Entry and Memory Clinics

- Primary care is recognized as an important point of entry into the system for early detection, prevention, and on-going care management. First Link Programs funded through three Alzheimer's Society Chapters have formed partnerships with CHCs and some FHTs
- The Alzheimer's Society in Chatham-Kent in collaboration with the CKHA GMHOT provides Memory Clinics open to the general public for early detection including individuals who do not have a primary care provider. The public has responded very positively to this level of engagement. Memory Clinics will continue to be supported by the ESC LHIN and leveraged to reach small rural villages and tightly knit urban, ethnic geographical pockets
- From a performance perspective, the ESC LHIN will track the number of Memory Clinics and their location as a means of tracking new referrals and public education endeavours. Linkages with primary care providers will be enhanced to ensure all nine FHTs and three NP Led Clinics are aware of the First Link Program resource.

Memory Clinics will evolve as a means of reaching the Francophone and Aboriginal population groups

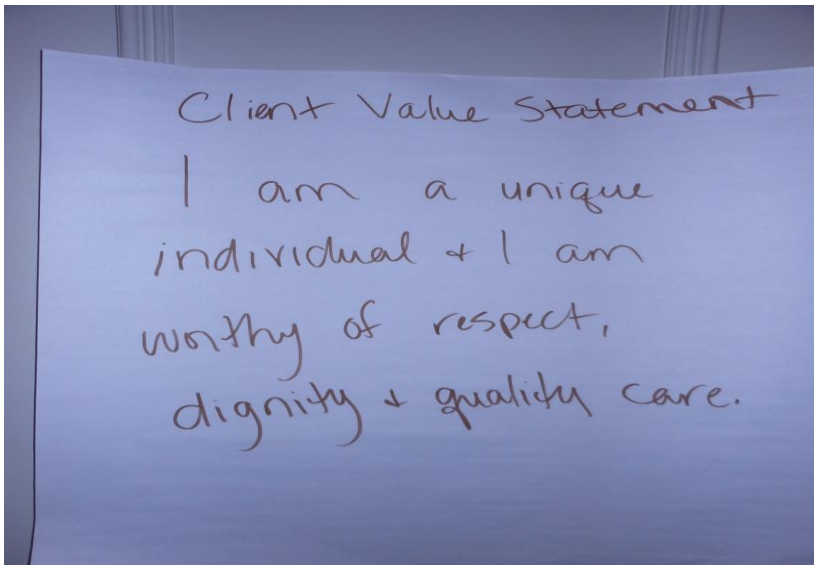
Coordinated Access and the Broader Continuum of Care

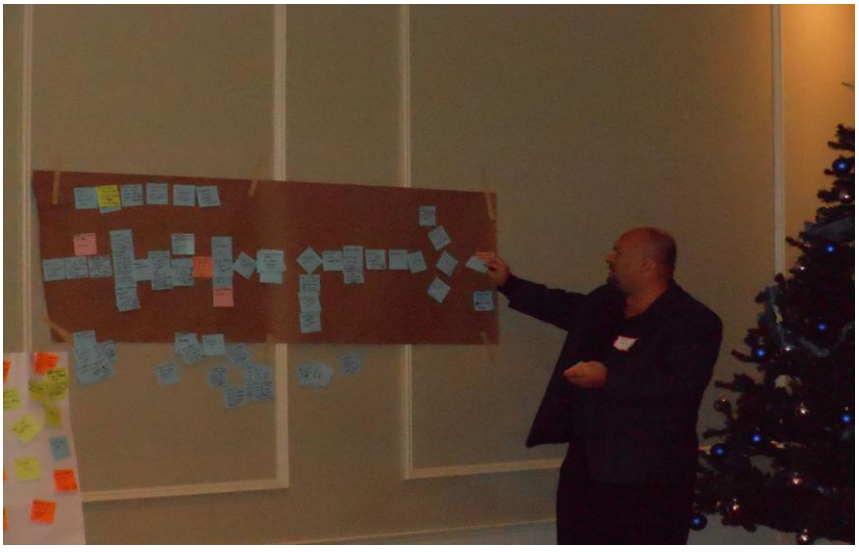
- The point of entry will **initially** be through three new System Navigators based at the Alzheimer's Societies. Using a phased approach, the toll-free number will be implemented and communicated to key provider stakeholders and the general public. The Alzheimer's System Navigator is a new resource and will be highly skilled and knowledgeable about seniors with responsive behaviours as well as system resources. This new function will provide telephone intakes and referrals based on the client's level of risk
- **Low Risk –** Provide counseling, guidance, and support. Link clients/caregivers to warm lines, First Link Programs and assist in making appointments with primary care practitioners, CCAC Case Managers, and other community resources
- **Medium Risk –** Provide counseling, support, and guidance. Clients/caregivers are monitored by the Alzheimer's System Navigator in collaboration with CCAC Case Managers, "**leveraging CSS wraparound partners"**, the Integrated Responsive Behaviours Mobile Team, and primary care providers
- **Medium to High Risk** - Considered a high priority. The Alzheimer's System Navigator will notify the Responsive Behaviours Mobile Team closest to the client's home to provide an on-site, face-to- face assessment. If the call is from a LTCH, the LTCH Lead Team is identified as their **"Mentoring Buddy"** will be deployed. If the client/caregiver/LTCH staff are not safe the Alzheimer's System Navigator will advise to contact EMS or Police (HELP/COAST Model)
- **High Risk** – Emergency situation, the Alzheimer's System Navigator will contact EMS and/or Police preferably the HELP Team or COAST. The Police - Mental Health Crisis Response Teams are experts in defusing crisis, volatile situations, and are envisioned to partner with the Integrated Responsive Behaviours Mobile Team and LTCH Lead Teams. The Alzheimer's System Navigator may also notify the closest ED regarding impending arrival of the client and caregiver
- **Acute Care or ED Call** – In these circumstances, the Alzheimer's System Navigator will contact and deploy the Integrated Responsive Behaviours Mobile Team when clients are **returning to their home in the community**. If the client is returning to a LTCH, the LTCH Lead Team will be contacted. Assessment and treatment will be initiated by either team in collaboration with CCAC Specialized Case Managers and/or hospital discharge planners
- As this action plan evolves, the Alzheimer's System Navigators will be resourced with OTN Telemedicine equipment in order to communicate with the new ED Mental Health and Addictions and Chronic Disease Management Telemedicine RNs throughout ESC LHIN. In Phase Three of this action plan, the ESC LHIN will investigate the cost to enable all LTCHs with Telemedicine OTN equipment. Currently, two LTCHs (Riverview Gardens and Copper Terrace) have OTN equipment. The rapidly developing technology and cost reductions around OTN will be a key factor in expanding this component

System Redesign

- This action plan is based on the premise that the current continuum of care is not effective in meeting the needs of older adults with responsive behaviours. Evidence supporting this premise was received from a cross-sector of HSPs throughout Erie St. Clair. The intended outcome of this action plan system redesign is to ensure that resources and services are properly aligned to meet the needs of older adults with responsive behaviours and their caregivers. This will occur by the ESC LHIN implementing integration activities, as defined by the ***Local Health System Integration Act, 2006.*** Current resources not linked, coordinated, or previously accessible to meet the needs of the target population will be re-deployed, seconded, or supplemented by new hires to achieve the goals of this action plan. Service changes will be formalized through agreements with the ESC LHIN
- Our CVS is a means of "grounding" this action plan and future system changes

The ESC LHIN Responsive Behaviours Action Plan CVS





The ESC LHIN VSM includes two streams – one specific to primary care and community as well as from the tipping point **(Please see Figure 3, next page).**

Responsive Behaviours: Erie St. Clair LHIN Future State

01-Dec 11

Erie St. Clair Responsive Behaviours Guiding Principles

1. Every Door is the Right Door
2. Least Intrusive intervention, closet to home and minimize transition points.
3. Consistent providers-using the most appropriate service levels.
4. Strive for a system that asks folks what they need and provide flexible services based on what is heard from clients and their families.
5. Identify, respect and incorporate cultural norms throughout the care journey.
6. Empower clients & care-givers to make choices.
7. On-going communication with families throughout the care process.
8. Communication across the system so people are informed and expectations are clear-case conferences/wrap around team discussions to aid integrated care across the continuum.
9. Pro-active early prevention and early detection-minimize & prevent crisis situations.

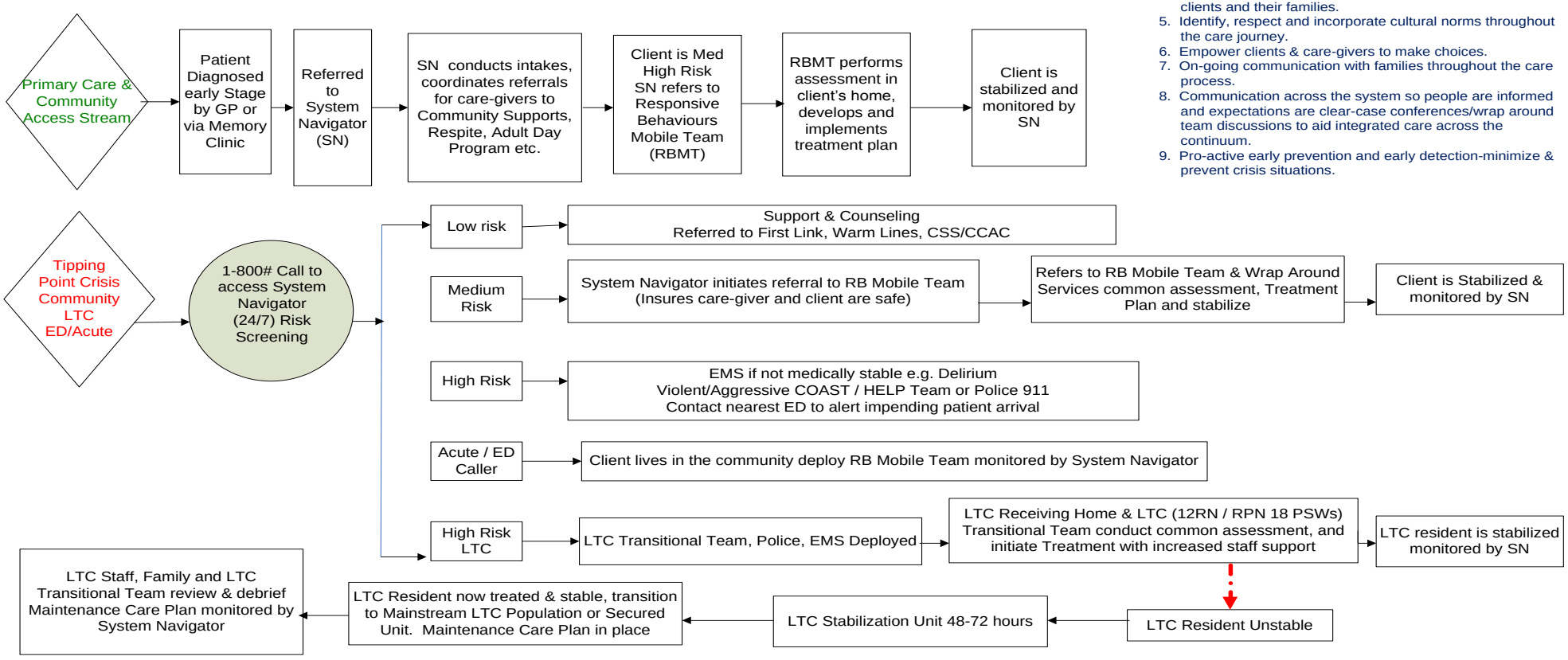


Figure 3

6) How will support across the service continuum be provided to ensure equitable and timely access to the right providers for the right service?

As previously discussed, this action plan will establish protocols, service agreements (MOUs), and formalized structures to ensure that the target population and their caregivers are supported across the continuum in a coordinated and seamless manner. Key points in the continuum include:

- **Early identification** - (First Link Programs, CCAC, primary care providers, psychiatrists, increased public awareness, and Memory Clinics)
- **Intake** - Alzheimer's System Navigators in partnership with CCAC Specialized Case Managers for existing community-based shared clients and older adults with responsive behaviours who are transitioning across the continuum of care
- **Clinical interventions** through the Integrated Responsive Behaviours Mobile Teams and LTC Lead Teams
- **Crisis response** through existing resources such as, ED PATs, GEM RNS, HELP/COAST – Police and Mental Health Providers, community-based mental health crisis services and new specialized resources (e.g. Behavioural Teams, LTC Lead Teams, and System Navigators)
- **System transitions** through CCAC Specialized Case Managers in collaboration with Alzheimer's System Navigators, and CSS wraparound Partners
- **Monitoring** (Alzheimer's System Navigators in collaboration with primary care providers/CCAC Case Managers, and CSS (e.g. security checks and Friendly Visiting)
- **On-going caregiver support** and counseling (Alzheimer's System Navigators and broader Alzheimer's Society services)
- As a **"safety net"** the action plan includes a **Complex Case Resolution Tables.** Individuals who are complex and not receiving the "right service" may be referred to this Table of cross-sector experts who will be charged with ensuring that "no one falls through the cracks"

6a,b) Will there be supported behavioural assessment services? How will the comprehensive geriatric assessment be conducted?

Regardless of the client's location, the CCAC Specialized Case Manager, the Alzheimer's System Navigator, Integrated Responsive Behaviour Mobile Team, and the LTCH Lead Teams will use common and shared standardized assessment tools.

Standardized assessments will be conducted face-to-face, on-site wherever the client resides (community, LTCH) or by CCAC Specialized Case Managers as required to support the client's transition from acute to community or LTCHs. The Alzheimer's System Navigator will work in partnership with CCAC Case Managers, monitoring community-based shared client's experiencing an acute escalating behavioural crisis and supporting their caregivers. Throughout this action plan, standardized assessments are emphasized. At the same time, it is imperative to stress that each client and their

caregiver is unique. Preserving the client's dignity and providing client-centred care means **"balancing standardization with sufficient clinical flexibility".**

Geriatric Assessments are also provided by Erie St. Clair GEM RNs based in the in five EDs and by one program restricted to the Windsor/Essex area known as the GAP. The GAP is an invaluable resource however it is not LHIN-wide. In partnership with Parkwood Hospital and WRH, the ESC LHIN has been actively involved in recruitment efforts for a geriatrician. As this model evolves and if recruitment efforts are successful future discussion is needed regarding "spreading" the GAP program to the other two counties. The GAP has a strong clinical foundation coupled with the Integrated Responsive Behaviours Mobile Team and geriatric – psychiatry in-patient beds to become a Regional Geriatric Assessment Service.

Standardized assessments will include leveraging **"wraparound resources"** from the CSS Sector. This includes tapping into a prior ESC LHIN investment ($300,000 annualized base funding) for **specialized respite services for older adults with cognitive impairments** living in the community. The recipients of the funds include three Alzheimer's Society Chapters and Lambton Elderly Outreach Services.

As the ESC LHIN Telemedicine initiative evolves, assessments will occur through video conferencing equipment.

6c) How will people with complex and challenging mental health, dementia, or other neurological conditions who could benefit from behavioural supports be identified?

The target population will be identified through the following key providers:

- Primary care physicians/First Link Programs
- Alzheimer's Society Chapters
- Erie St. Clair CCAC Case Managers including Specialized Case Managers charged with transitioning clients
- Families/self referrals through Memory Clinics, news releases, and communication briefs prepared for the public
- The tipping point/crisis, referrals from GEM RNs and/or CCAC ED Case Managers
- EMS and Police Teams (HELP and COAST)
- CSS
- Psychiatric Crisis Teams based in the ED
- LTCHs

6d) How will individuals not identified as part of the population for this service be directed to the right providers for the right service?

As previously discussed, this action plan will establish protocols and formalized structures for the target population and their caregivers. As the model evolves and becomes ingrained into provider culture, service elements have the potential to be replicated to "other" complex neurological population groups such as ABI and dual diagnosis.

Individuals who are not identified as "older adults with responsive behaviours in the community, LTCHs or transitioning between sectors and their caregivers" will be re-directed "to the right service." The leads for ensuring appropriate referrals occur are CCAC Specialized Case Managers and/or the Alzheimer's System Navigator. This action plan will ensure that a high fidelity to the Behavioural Support Services Model and Target Population Groups is sustained at the same time as honouring the principle **"every door is the right door"**.

6e) How will individuals in crisis be supported?

Depending on the setting older, adults with responsive behaviours and their caregivers will be supported by:

Emergency Department

- Older adults in crisis entering the system by the ED will be supported by existing ED Psychiatric Assessment Teams (PATs) and/or GEM RNs. People may enter the ED by EMS or by the Police (HELP/COAST model). Depending on the level of crisis, the individual may be admitted to the Schedule One psychiatric facility for care

Community

- Older adults in crisis in the community, who are already receiving services from CCAC Case Managers, will be referred to the Alzheimer's System Navigators or if the situation is acute and not safe, the client will be directed to go to the ED. The Alzheimer's System Navigator will implement a risk screening intake **(see VSM)** and based on level of risk deploy the Integrated Responsive Behaviours Mobile Team for immediate intervention. If the crisis relates to "elder abuse" the existing Client Intervention workers will intervene
- Older adults who are **not** "formally" linked to CSS, Alzheimer's Society or CCAC services may contact their primary care providers or the Alzheimer's System Navigator directly as outlined in the VSM

Long-Term Care Homes

- Residents in crisis will be initially assessed by the responsible LTCH. If the situation is deemed unmanageable and not safe, the LTCH resident will be transferred to the ED or the HELP/COAST Team may be deployed
- Depending on the level of risk, the LTCH will contact the Alzheimer's System Navigator who will conduct the level of risk intake and deploy the LTCH Lead Team. The Alzheimer's System Navigator will ensure that all pertinent information is provided to the LTC Lead Team **"assigned as their neighbouring LTC buddy"**

7) Name your partners for interdisciplinary service redesign.

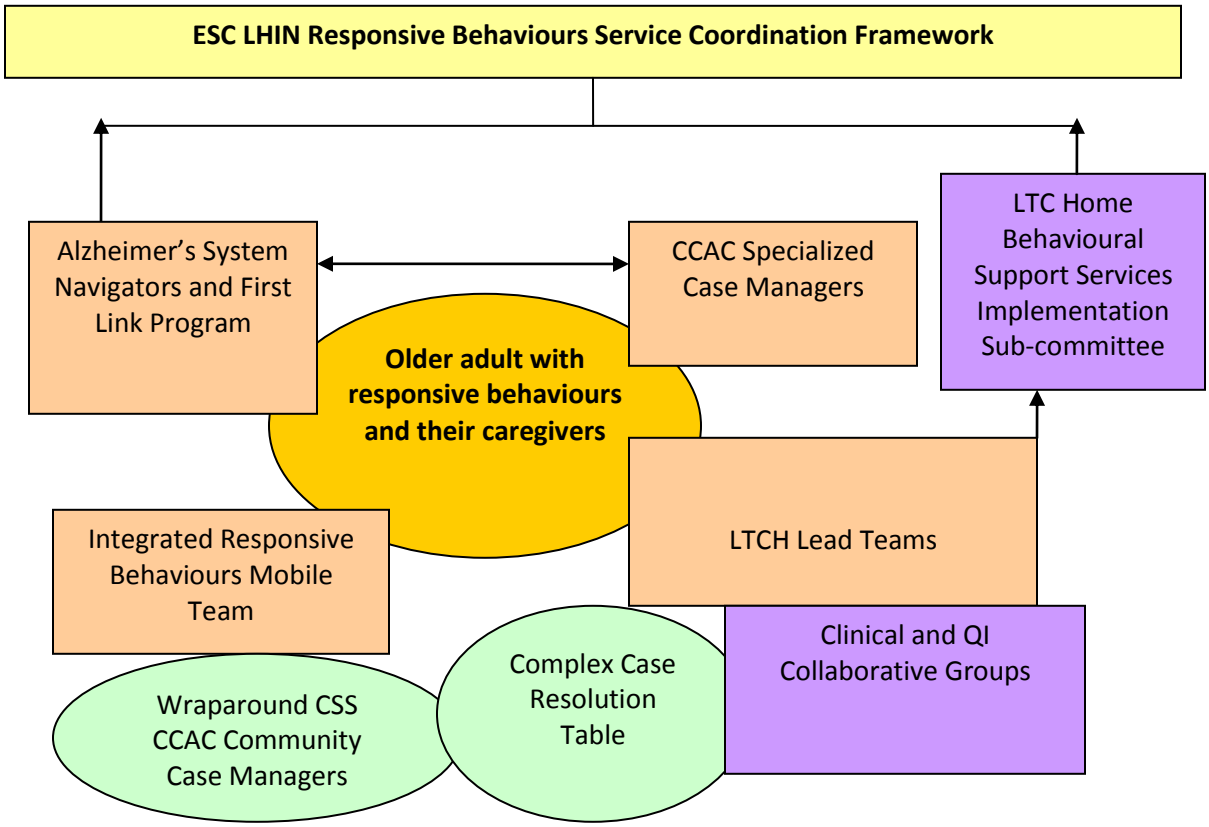
The Executive Steering Committee comprised of a cross-sector of health care leaders responsible for interdisciplinary service redesign. The Executive Steering Committee representation includes:

- The LTCH Lead Teams
- Alzheimer's Society Chapters Executive Directors
- Directors of the Interdisciplinary Responsive Behaviours Mobile Teams
- CCAC representative(s)
- CSS Leads including Client Intervention
- Primary care
- Hospital Schedule One and Tertiary
- ESC LHIN Senior Director of Delivery and Implementation

As previously discussed the existing Geriatric Planning Groups will be reconfigured to include **a broader cross section of providers** hence, the "wraparound component". In addition, the Collaborative Group will form a sub-group known as **"Complex Case Resolution Tables".** The Complex Case Resolution Tables will be implemented on a case-by-case basis with an open, fluid membership depending upon the clinical needs of the client and caregiver.

Figure 4: ESC LHIN Responsive Behaviours Service Coordination Framework

This figure shows the interface between key stakeholders for service coordination and redesign. Note that the client and care-giver are at the heart of the model.



7a,b) How have the partners collaborated on previous projects and what were the outcomes? What were the outcomes?

Examples not previously cited include:

- **NLOTs in Windsor/Essex is** composed of 1.5 NPs serving five to six LTCHs identified as requiring additional support due to ED utilization. The NPs perform duties consistent with their full scope of practice, including assessments to avoid admissions to ED, reassessments when patients return from hospital, staff education, follow-up of residents from LTCH admitted to hospital and assist transition back to the LTC facility. The NPs also provide education to family members, especially on issues related to Advanced Directives, and work in partnership with LTCH Medical Directors to perform specific interventions assigned and which fall within NP scope of practice
- In-Home Respite Care program provides caregivers with the much-needed break to attend to their own needs or appointments while the person with dementia is cared for by a trained PSW. Personal supports include social stimulation, medication and meal support, bathing, toileting, and help with minor household chores (e.g. keeping the bathroom clean or washing dishes to promote continued hygiene). Responsive behaviours can also be reduced as a result of these services as trained staff, provide evidence-based individualized care honouring the uniqueness of each client while providing the caregivers the time to de-stress. **A partnership between CCAC and the Alzheimer Society In-Home Respite Care Program** has resulted in maximizing available supports. Examples include Alzheimer Society In-Home Respite Care being added to CCAC supports via contracted agencies to complement the number of hours each client qualifies for via the CCAC assessment or CCAC supports being added after the client progresses, further into the disease warranting bathing supports. This collaboration promotes continued dialogue between providers and the caregiver to address changes that may result in a crisis state

7c) List the Executive Sponsors who will have potential responsibility for meetings, chairing a steering committee, ongoing leadership and engagement etc.

- Brad Keeler, Co-Chair, ESC LHIN Responsive Behaviours **Executive Steering Committee;** and Senior Director, Delivery and Implementation ESC LHIN
- Mary Ellen Parker, Co-Chair, ESC LHIN Responsive Behaviours **Executive Steering Committee;** and Executive Director, Chatham-Kent Alzheimer's Society
- **LTC Behavioural Support Services Implementation Sub-Committee** will be chaired by the Lead LTCH
- **Clinical Collaborative Groups** will be chaired by the existing Geriatric Mental Health Committee chairs
- **QI Collaborative Groups** will be co-chaired by the ESC LHIN Quality and Performance Lead and selected providers with QI experience

Pillar 3

Knowledgeable Care Teams 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 QI.

8) What training and knowledge transfer process are presently in place for current and future professionals to disseminate new knowledge and best practice skills relating to behavioural supports?

8a) Current behavioural support expertise includes:

- Three Alzheimer's Society Chapters – Adult Day Programs, First Link Programs, Social Worker providing caregiver support, and educational groups, individual counseling, and specialized in-home respite services provided by trained PSW
- PECs and PRCs
- 22 individuals trained in Gentle Persuasive Approach (GPA)
- One trained coach for Montessori
- GAP in Windsor (has limited access to geriatrician)
- Three GMHOT and their Psychiatrist Leads
- GEM Nurses (10 RNs in five EDs)
- Selected Family Physicians and NP with enhanced training
- CCAC Specialized Geriatric Assessor
- New 17-bed Unit Geriatric Psychiatry Unit (WRH)
- GAP (WRH)
- Linkages between the ESC LHIN and the University of Windsor, School of Medicine will foster the development of new behavioural course work for future professionals
- Chiefs of Psychiatry will aid in knowledge transfer of this action plan through the development of specialized "virtual workshops". In the past, the Psychiatrists have provided workshops focusing on delirium for GEM's, CSS providers, CCAC ED Case Managers, and CHC representatives
- Grand Rounds are in place for Schedule One facilities that include community-based Mental Health professionals from CMHAs
- The ESC LHIN has developed a strong relationship with the Ontario Medical Association Area Tables. The College of Family Physicians of Ontario and Registered Nurses Association of Ontario (RNAO) have guidelines and Continuing Medical Education (CME) for responsive behaviours associated with delirium, depression in older adults, dementia, and managing psychosis. Future education and training specific to physicians will be leveraged through these venues
- SWOGAN and RMHC, London as it relates specifically to the Sarnia/Lambton Community

8b) What quality improvement (QI) capacity is currently available for this program (e.g. how many individuals with QI expertise will be supporting BSO within the LHIN)?

- The ESC LHIN has approximately 70 to 80 individuals from LTCHs trained as IFs through Residents First and enrolled in other QI processes via HQO
- In addition, the ESC LHIN Quality and Performance Manager is trained in LEAN, Triple Aim methodology, is an Institute for Healthcare Improvement (IHI) Advisor, and is the Responsive Behaviours IF
- The Erie St. Clair CCAC has participated in many QI initiatives including Flow Collaborative, Integrated Client Care Project (ICCP), and VSM
- All of our hospitals have undertaken various LEAN initiatives and formal Ministry funded performance improvement programs
- The ESC LHIN IF will engage, lead, and mentor the Responsive Behaviours key stakeholders by developing QI Collaborative Groups (one per county) and leveraging HQO Responsive Behaviours Change Package. Using a PDSA model, the clinical care pathways and implementation of this action plan will be revised as required to ensure that "lessons learned" are spread from one group to another. Resources from HQO will be leveraged as much as possible to support the Responsive Behaviours model
- Primary care providers and staff from six CHCs and FHTs have been involved in numerous Quality Improvement Plan (QIP) collaboratives and learning communities to learn and apply QI methodology in their efforts to improve access, efficiency, diabetes screening and management, cancer screening, and the screening and management for hypertension. Their knowledge and experience with QI will be leveraged and built upon for this project

8c) How will training efforts be focused to optimize the creation of knowledgeable care teams with both behavioural and QI capacity?

This action plan intends to leverage the knowledge and role of existing PEC and PRCs. Our aim is to hire one Lead Knowledge Exchange Transfer Coach. The existing Public Education Consultants will work closely with the Coach. In a phased approach, knowledge transfers, core competencies, and QI measures will be embedded as a continuous process. **Phase One of this initiative will focus on capacity building for our core HSPs**.

1. Alzheimer's System Navigators, PRC, PEC, and CCAC Specialized Case Managers
2. Three Integrated Responsive Behaviours Mobile Teams including PRC expansion
3. LTCH Lead Teams (12 RNs/RPNs, and 18 PSWs) wraparound supports – CCAC NP, Client Intervention workers, and CSS coordinators

Drawing upon existing expertise and best practices the core HSPs will be trained or refreshed in the following modules:

- PIECES and U-First
- GPA
- Montessori
- Crisis intervention
- LEAN philosophy and QI PDSA cycles

While many of the core HSPs listed on the previous page have training and expertise working with people with responsive behaviours, it is imperative to ensure that a standardized approach is implemented as per core competencies. Existing PECs and the Knowledge Exchange Transfer Coach will focus their attention during phase one on building capacity within the LTC Home sector. The ESC LHIN IF and existing QI coaches will provide structured workshops ensuring that QI is embedded in clinical care.

Upon confirmation that the core HSPs are **"knowledge ready",** broader cross-sector knowledge transfers will occur in **Phase Two.** Stakeholders include:

- Primary care (CHCs, FHTs, NLPC)
- CCAC Community Case Managers
- CSSs
- LTCHs registered and non-registered staff
- Hospital GEMs, selected Schedule One and Tertiary staff

After the second wave of education and training for providers has occurred, planning will begin for a **wider public education strategy.** The Alzheimer's Society Chapters have laid the groundwork for a broader public education and awareness strategy. Examples include:

- Radio campaigns geared towards caregivers in need of support
- Secondary School essays with awards issued for scholarship bursaries to the students selected University or College. (**Please see Appendix B Essays).**

8d) What knowledge transfer structures/pathways currently exist within the LHIN that can be leveraged in support of the BSO project?

- First Link Programs provide CME speakers and training to allied health care professionals
- Existing Grand Rounds can be expanded to include additional organizations and professionals
- Montessori training
- Alzheimer's Society of Ontario and Canada Best Practice Guidelines
- Alzheimer's Society Chapters PEC and Dementia Networks
- Geriatric psychiatrist workshops previously provided for GEM RNs and CCAC ED Case Managers can be leveraged to include additional stakeholders and geared to "specific educational needs identified by the core HSPs"

9) Describe how your Action Plan builds on current capabilities and capacity (e.g. tools, resources, partnerships, AAH Initiatives).

This action plan builds upon the following AAH structures:

1. Further PRC enhancements for the Integrated Response Behaviours Mobile Team
2. Leveraging the current and future partnerships between First Link Programs and primary care models. The ESC LHIN funded First Link Programs in year three of AAH for each of our counties
3. Educating and training for 10 GEM RNs and CCAC ED Case Managers
4. Integrating and leveraging Client Intervention workers in the provision of community-based crisis intervention for hard to reach population groups and as Elder Abuse experts
5. Ensuring that **enhanced CSS investments** are leveraged to community-based clients with responsive behaviours and their caregivers (e.g. security checks, Meals on Wheels, transportation, etc.)
6. Linking the specialized in-home respite services for people with dementia to the BSO action plan. The ESC LHIN invested $300,000 annualized base funding towards this need in 2011/2012 fiscal year

10) How is sustainability of the service redesign embedded in the process through education and knowledge transfer and other mechanisms?

This action plan is sustainable as a system and service redesign through the accountability agreements between the ESC LHIN and the HSPs receiving the funding. Partnership agreements are viewed by the ESC LHIN as long-term sustainable contracts that will be monitored and revised as needed by the ESC LHIN. Further sustainability is built into the Governance structure as per the Executive Steering Committee reporting implementation progress to the ESC LHIN Board of Directors.

Implementation progress is inherently linked to knowledge transfers and QI processes. The ESC LHIN Implementation Lead, QI Manager, and the Senior Director accountable for Delivery and Implementation are responsible for overseeing all aspects of the action plan including monitoring uptake and any issues that may arise will be addressed using a conflict resolution approach.

In addition to the BSO $2.4 Million core funding, we will ensure sustainability of this model through **additional investments**. Specific investments include:

- Start up cost for new hires (e.g. computers, blackberry units)
- Transportation of the Teams will be provided by the ESC LHIN as a separate funding envelope
- Education back-fill will be provided to LTCHs if “existing” staff are leveraged to assume this new role
- Urgent priorities will include a small amount of funds for WSIB concerns
- Internal resources will provide leadership, monitoring, data analysis, and QI knowledge capacity

- ESC LHIN Francophone and Aboriginal Leads will ensure that the Responsive Behaviours core HSPs receive information pertaining to "cultural needs and practices"
- ESC LHIN Community Engagement staff will ensure that wider public engagement occurs as a satisfaction measure for caregivers and to gauge the level of public knowledge about this endeavor. The ESC LHIN webmaster will ensure that all pertinent communication briefs are posted. As the initiative ramps up, clinical and QI collaborative groups will be further enabled by a ESC LHIN chat room
- Funding for local recruitment endeavours or job fairs
- Funding for Responsive Behaviours new staff and programs that are integrated will be formally addressed by accountability agreements that include "protected funding"

Total additional funds provided by ESC LHIN is $125,000

The ESC LHIN recognizes that "some" new structures and roles (e.g. Alzheimer's System Navigators, CCAC Specialized Case Managers, and the centralized access system will require additional funds). The centralized toll-free number needs are consistent with the ESC LHIN vision for a redesigned Mental Health System. In January of 2012, the ESC LHIN will embark on a Mental Health Strategic Plan that includes defining the "right" service levels for Tertiary care, Schedule One hospitals including out -patient services and community-based mental health. The Strategic Plan will strengthen community capacity at the same time as creating a sustainable mental health system, this includes equitable access and a centralized crisis line that is supported by "trained respondents". Benefits from the Mental Health system redesign will interface with aims identified in this action plan.

11) How will knowledge transfer occur (e.g. Best Practices, protocols, standardization)?

Standardization of clinical practices through pathways, formal protocols, and service agreements are embedded throughout this action plan. Knowledge Transfers will occur in an organized phased approach with reporting to the overarching Governance Structure and the ESC LHIN. The Knowledge Exchange Transfer Coach is responsible for tracking uptake of educational modules for core HSPs including LTCHs. Ongoing reference to Knowledge Exchange and follow-up with leading LHINs and communities will assist in developing and using Best Practices.

11a) How will lessons learned be captured and shared?

As shown in Figure 5, Clinical and QI collaborative groups will be charged with ensuring that PDSA change cycles are communicated and spread from one county to the next. A broader communication package to HSPs and the general public is the responsibility of the Governance structure. The ESC LHIN will ensure that regular communication briefs and bulletins are posted on our website. In this manner all providers and the public will be informed of progress, changes and lessons learned are disseminated. The ESC LHIN will also ensure that it is a contributor to Knowledge Exchange where it develops information for broader use. In addition, the ESC LHIN will reassemble original members from the 2011 VSM including the two caregivers along side of new stakeholders and care-givers; as

a means of reviewing the new current state. Insights obtained through this process will be incorporated into the evolution of the ESC LHIN BSO model.

12) Name your partners for knowledgeable Care Teams and Capacity Building

- University of Windsor Medical School students supported through residency or internship
- Alzheimer's Society Chapters, PEC, PRC, and Knowledge Exchange Transfer Coach
- CCAC
- Primary care (CHCs, FHTs, NPLC)
- LTCH
- Canadian Mental Health Associations
- St. Clair College PSW and Nursing Programs
- University of Windsor School of Social Work, Psychology, and Nursing
- Hospitals Schedule Ones/Tertiary
- ESC LHIN Chiefs of Psychiatry Group
- Ontario Medical Association Area Tables
- ESC LHIN Francophone and Aboriginal Leads
- HQO/Alzheimer's Knowledge Exchange (AKE)
- BSO ESC LHIN Leads and QI facilitators

12a,b) How have the partners collaborated on previous projects and what were the outcomes?

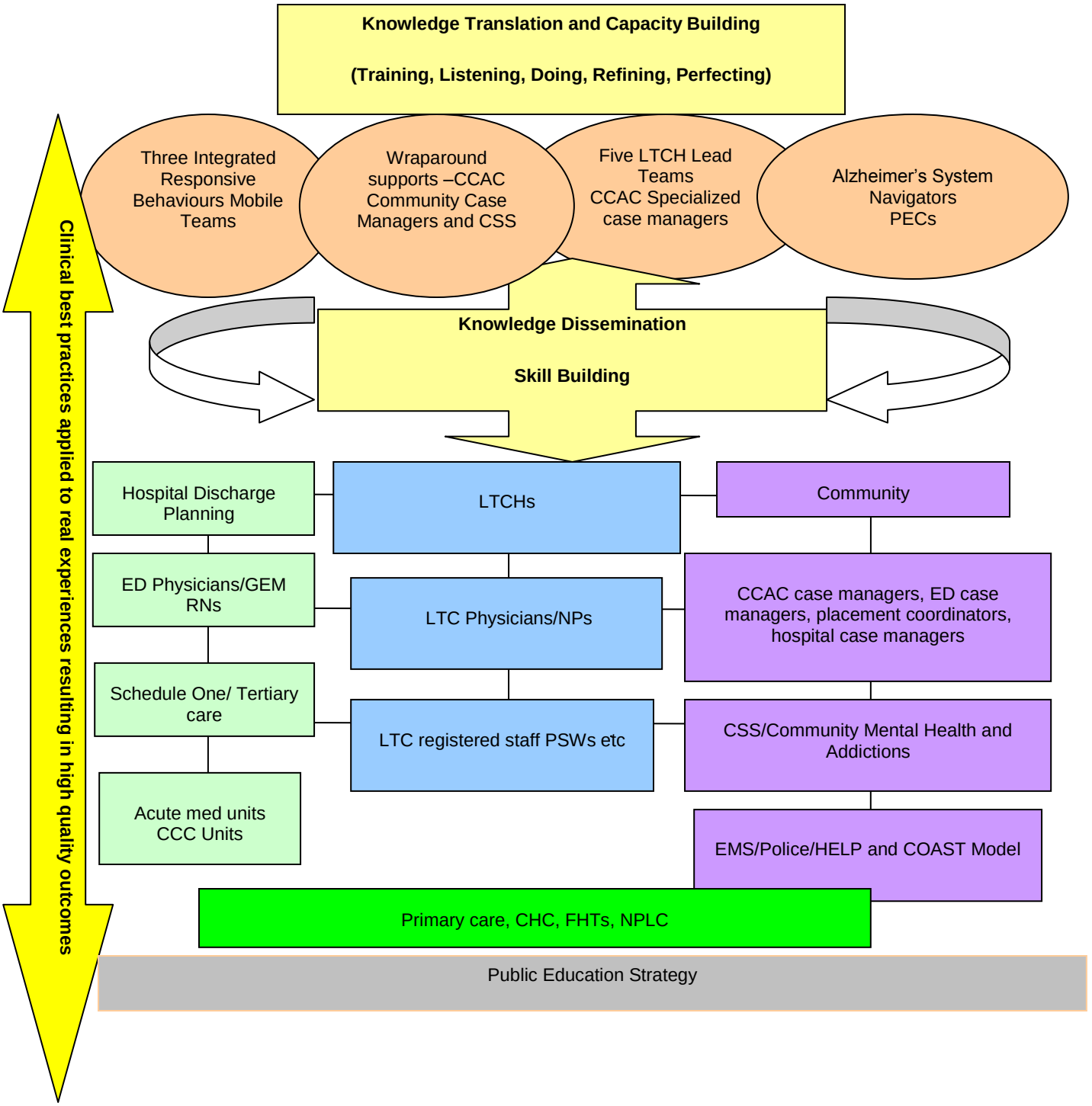
- St. Clair College Personal Support Worker, Nursing Programs work with the CSSs Sector to enhance training or diploma bridging
- School of Social Work clinical practicum's
- University of Windsor Medical School students supported through residency or internship at primary care sites, hospitals including Tertiary, and Schedule Ones
- University of Windsor Nursing Program clinical practicum's in hospital, primary care settings, and LTCH

Examples of Partnerships Not Previously Discussed

- The University of Windsor School of Business and Leamington District Memorial Hospital (LDMH) conducted a study for acute elderly patients who had a fall during their admission stay. The outcome from this collaborative relationship was a significant reduction in falls through heightened awareness by nursing and hospital clinical staff as well as LDMH investment of "high-low beds". To date, LDMHs low rate for falls is maintained
- In 2010/2011 the Erie St. Clair CCAC and four CHCs partnered with the Asthma Resource Group and MOHLTC Chronic Diseases Program. The combined efforts of the stakeholders include developing a sustainable interdisciplinary team approach to address the needs of older adults with COPD. A QI approach towards "team development" and clinical care path was implemented. To date, continuous lessons learned are anticipated to be "spread" to the elderly population with congestive heart failure
- Through AAH funds, four CHCs partnered with existing community based Falls Committees and Public Health Units. One of the key aims of the Falls Prevention Program is to provide home safety assessments for seniors who live in the community and are deemed high risk. A small amount of funding was provided for the CHC OTs for "grab bars". **As a "risk indicator" older adults with cognitive impairments** is identified by the ESC LHIN as one of the eligibility criterion. Through collaboration with Hospital GEM RNs and CCAC Hospital Case Managers involved in discharge endeavours, older adults with cognitive impairments deemed at risk of a fall receive grab bars (free of charge) if needed and a home safety assessment. This CHC innovative service is not a duplication of CCAC, as the clients are "not" receiving CCAC services. Further, the CHC OTs and CCAC Case Managers have developed partnerships to ensure seamless "hand offs" when warranted

Figure 5: Knowledge Translation and Capacity Building

This figure illustrates the stakeholders involved in knowledge transfers and capacity building.



13) Describe the deployment of behavioural staffing positions for participating Health Service Providers.

It is understood that formal structures must be in place to oversee the day-to-day operations and monitor the performance of the implementation of this action plan. In this regard, new positions will need to be created, duplication of services will be addressed through integration activities and further enhancements will occur through in-kind, secondment formalized through amended accountability agreements.

By streamlining existing successful structures and resources we will minimize the number of clinical assessments and optimize the overall care experience for older adults with responsive behaviours and their caregivers.

This action plan adopts the concept of BSO being locally led with overarching governance, guidance, and support at the regional level. Embedded in this approach is the understanding that each of our sub-LHIN communities are at various stages of development, knowledge, and come with their own unique culture. As a common denominator, the system redesign will leverage our CVS and Provincial supporting principles.

Provincial Supporting Principles

- **Behaviour is communication**
- **Diversity** – practices value the language, ethnicity, race, religion, life experiences
- **Collaborative care** – accessible, comprehensive assessment/interventions include shared interdisciplinary plans of care that rely on input from family members
- **Safety** - a culture of safety and well-being is promoted
- **System coordination and integration –** systems are built on existing resources and initiatives
- **Accountability and sustainability**

Role of the Community Lead Agency

The Community Lead Agency will provide centralized administration, back office support and BSO leadership at the Executive Steering Committee level. It is important to acknowledge that the Lead Agency is an equal partner in the model. The role of the Lead Agency will be articulated further in ***a BSO shared Governance Memorandum of Understanding.***

Roles and Responsibilities Include

- Project Management (in-kind) support for implementing this action plan
- Collaborative leadership, standardization, and monitoring of the deployment of new positions such as the Alzheimer's System Navigators, PRC and Knowledge Exchange Transfer Coach
- Back office support includes financial reporting to the ESC LHIN
- In collaboration with the ESC LHIN webmaster, ensure that web-based resources and communication briefs (prepared for the ESC LHIN Board of Directors and CEO) are posted and communicated broadly

- Develop partnership agreements as it relates to deploying PRC staff to the Integrated Responsive Behaviours Mobile Teams. As well as, agreements with the Windsor/Essex and Sarnia/Lambton Alzheimer's Society Branches for deployment and standardization of the Alzheimer's System Navigators role

The benefits of one Lead Community Agency include minimizing administrative functions and accountability to the ESC LHIN through one agency. **The Lead Community Agency is the Alzheimer's Society of Chatham-Kent.** The ESC LHIN adopted this standardized and sustainable approach from our BSO Buddy LHIN (HNHB). The Lead Agency functions and service agreements will be evaluated by the ESC LHIN after one year of the model being implemented.

Prior to describing the Integrated Responsive Behaviours Mobile Team and the LTCH Lead Team complement, it is imperative to first describe the intended integration activities, in-kind secondment agreements as critical value-added elements of this action plan.

Integration

The ESC LHIN will formally integrate two programs as a means of reducing duplication and achieving a long-term sustainable Responsive Behaviours Model.

Mental Health Older Adults Program (MHOAP) Based at WRH

- The MHOAP is a CSS funding envelope that provides community-based interdisciplinary care for older adults with mental health issues. Concurrently, WRH had former CSS funding for a PRC and psychiatric who provide clinical and educational supports for 18 LTCHs and selected Rest and Retirement Homes in Windsor/Essex. Selected refers to Retirement Homes identified by the ESC LHIN as having high rates of ED visits for dementia/behavioural reasons. Through AAH funding enhancements an additional RN and psychiatric enhancements created the Windsor/Essex GMHOTs. These two programs report to the **same** Mental Health Director at WRH. The MHOAP and GMHOT will be **formally integrated into one structure** known as: **the Windsor/Essex Integrated Responsive Behaviours Mobile Team** responsible for serving the target population as discussed in this action plan. The ESC LHIN will ensure that the budgets are combined, FTEs, and disciplines accounted for and Multi-sectoral Service Accountability Agreement (M-SAA) accountability agreements amended to reflect the above changes

Lambton Geriatric Assessment Program Based at BWH

- This program has eroded slowly over the past three years to augment funding needs of the ED Crisis Team. As of today, this "program" now consists of 1 FTE who provides community assessments for older adults with cognitive impairments. This resource is highly valued by physicians in the Sarnia/Lambton community
- Concurrently through AAH funds, CMHA LK Branch received funding for an interdisciplinary GMHOT including psychiatry supports. The GMHOT services older adults with responsive behaviours who reside in 10 LTCHs in Sarnia/Lambton. As a means of further strengthening this action plan and reducing **"duplication of services",** the ESC LHIN will issue a formal integration notice to BWH "integrating" the funding and this Health Human Resources (HHR) FTE

resource will be transferred to CMHA LK. The existing GMHOT will change to incorporate this new FTE resource as well as expanding service delivery to include community-based older adults with responsive behaviours. The existing partnerships between the BWH employee and physicians will be maintained while strengthening the CMHA LK Integrated Responsive Behaviours Mobile Team structure.

Secondment/In-kind Positions

- The ESC LHIN will issue new service agreements with the recipients of the AAH Client Intervention CSS funding namely: Lambton Elderly Outreach, Family Service Kent, and Citizen Advocacy. These three CSS agencies provide Client Intervention for older adults with a multitude of issues ranging from: homelessness, elder abuse, and Diogenes syndrome. As part of the AAH mandate, the Client Intervention workers were charged with "transitioning LTC residents deemed medically stable and had a desire to return to the community". Many of these residents, while meeting the LTC eligibility criteria at the time of admission, become medically stable and increasing depressed expressing a strong desire to return home. To date the number of successful transfers has decreased. The ESC LHIN will leverage the crisis and unique skill sets of Client Intervention workers (one per county) as a two-day per week in-kind secondment to the Integrated Responsive Behaviours Mobile Team. The ESC LHIN will formalize these changes in an amended M-SAA

Erie St. Clair CCAC New Hire, Secondment/In-kind Positions

- This action plan builds upon existing strengths and best practices. To date, the Erie St. Clair CCAC has embedded themselves into the hospital structures clearly demonstrating capabilities as system transitional leads. In recognition of the long-standing ALC crisis in Windsor/Essex, the ESC LHIN will provide funding to the CCAC for one FTE Specialized Case Manager. As previously discussed, this worker is considered part of the "core HSPs" and will receive specialized BSO training. The Specialized Case Manager will float between three sites (WRH, HDGH, and LDMH) leveraging OTN equipment whenever possible with a focused mandate of transitioning ALC designated older adults with responsive behaviours as their primary portfolio
- The ESC LHIN will second, as in-kind resources, two (.5) existing CCAC hospital case managers in Chatham-Kent and Sarnia/Lambton as part-time equivalent. These two part-time positions will receive specialized BSO training and knowledge about older adults with responsive behaviours. The ESC LHIN will work closely with the Erie St. Clair CCAC Senior Directors and CEO to ensure that case loads are manageable. Currently, ALC volumes for patients with responsive behaviours do not warrant a full FTE for C-K and S/L. With this said, the ESC LHIN is mindful that if additional volumes occur and value added is demonstrated through reduced ALC rates that additional funding may be required later
- In addition, the ESC LHIN will second a Erie St. Clair CCAC NP based in Chatham-Kent as a resource to the CK LTC Lead Team. Currently, the seven LTCH in Chatham-Kent do not have a dedicated NP. This in-kind resource was raised by CCAC as a "gesture of collaboration" and "maximizing current resources during the VSM sessions. The level of in-kind hours of care per week will be

determined and arranged between Erie St. Clair CCAC and the ESC LHIN during Phase One of this action plan

New Positions

- The functions and key responsibilities of the Alzheimer's System Navigators, CCAC Specialized Case Managers, the Integrated Responsive Behaviours Mobile Team, and the LTCH Lead Teams have been outlined in previous sections of this report. New positions not previously articulated are described below followed by a brief synopsis of the in-kind resources leveraged for the wraparound function

Project Manager, Capacity Needs

- The Alzheimer's Society Chatham-Kent will provide in-kind a Project Manager for one-year to support achieving the deliverables of this action plan. The Project Manager will report to the ESC LHIN BSO Executive Steering Committee. The individual selected is a highly trained MSW, experienced and knowledgeable with respect to the target population, system resources, and caregiver needs. As a means of "filling" the social work void, the ESC LHIN will provide funding to the Alzheimer's Society Chatham-Kent to hire (one year contract) a BSW Social Worker who will provide caregiver support groups and educational sessions

Knowledge Exchange Transfer Coach (New Hire)

- This is a new role and position. Given the BSO training needs, an existing Alzheimer's Society staff may choose to apply for this LHIN-wide role. Conversely, a new candidate may also be suitable. This position will be posted. The Knowledge Exchange Transfer Coach will be trained in QI principles and methodologies therefore this new position will embed QI into BSO training

Alzheimer's System Navigators (New Hires)

- These are new roles and positions. Given the role as previously defined in this action plan, existing Alzheimer's Society staff may choose to apply. Conversely, a new candidate may also be suitable. These positions will be posted.

Wraparound CSS Support (In-Kind/Secondment)

- As discussed key resources from existing CSS agencies will be asked to work closely with the Integrated Responsive Behaviours Mobile Team. The role includes being knowledgeable about the full menu of supports available for community based older adults with responsive behaviours and their caregivers for their geographical area. The wraparound function will be scheduled at minimum once per week as **"case consultations"**. The CSS wraparound experts may rotate. This role includes offering suggestions to the Integrated Responsive Behaviours Mobile Teams, CCAC Specialized Case Managers, and the Alzheimer's System Navigators. Future leveraging of the CA2 tool will occur and the wraparound function may include contacting CSS colleagues to arrange services to meet specific client and caregiver needs (e.g. security checks conducted on the weekend etc). The ESC LHIN anticipates that this role will evolve and become more defined over the course of time

Long-Term Care Home Lead Teams

In consultation with five LTCHs selected as Leads, one LTCH, Aspen Lake has committed to being the interim fund holder. This arrangement is time limited to allow for group discussion concerning Human Resource logistics. The ESC LHIN will formalize an agreement with Aspen Lake as it relates to the funds.

Collective Aims and Responsibilities of the Core Service Providers

(Core Providers include: Alzheimer's System Navigators, CCAC Specialized Case Manager, Client Intervention workers, CSS, Integrated Responsive Behaviours Mobile Teams, LTCH Lead Teams, and wraparound supports)

- Engage in collaborative problem-solving to address the needs of older adults with responsive behaviours and their caregivers
- Commit to a process of continuous improvement within the Responsive Behaviours model of care
- Participate in on-going education and Knowledge Exchange related to best practices in the provision of care for older adults with responsive behaviours and their caregivers
- Ensure that the family/caregiver are included as "equal" partners in care
- Embed sustainability including early prevention and detection into the day-to-day structure of primary care providers, LTCHs, and for community based caregivers
- Commit to implementing standardized care tools, protocols, and MOUs that clarify roles, responsibilities, and functions
- Foster a culture of collaboration with the collective goal of placing the client and caregiver at the centre of service delivery

Key Deployment Features

- This action plan builds upon the existing foundation of GMHOTs, expertise and knowledge from three Alzheimer's Society Chapters and leverages CCAC as a key ALC transfer lead for older adults with responsive behaviours
- As discussed, a Lead Community Agency Approach will be utilized. Key positions will have standardized job descriptions e.g. Alzheimer's System Navigators and PRC
- Service agreements/MOU's between the Lead Agency and providers will be developed and monitored by the ESC LHIN. Outcome measures will be incorporated into the MOU's. All performance indicators are monitored by the ESC LHIN QI and Performance Manager
- Five LTCHs with identified expertise and leadership encompass a critical role in this redesign
- Resources not previously coordinated are solidified through the team structures
- Please see tables outlining the teams by geographical area

City of Windsor and Essex County

This geographical area includes two Lead LTC Homes, one for the City of Windsor and one for the County of Essex, existing resources, integration, new hires, and secondments. Note there are 18 LTC Homes in Windsor/Essex.

Resources	FTEs	HSP	New/Integrated/ In-kind–Seconded/ Existing
Alzheimer's System Navigator	1	Alzheimer's Society Windsor/Essex	New secondment through Lead Agency to W/E Branch
CCAC Specialized Case Manager	1	CCAC	New
GMHOT includes Psychiatrist	2.5	WRH	Existing
PRC	1		New secondment through Lead Agency
MHOAP	7.5		Integration
Client Intervention	Two days per week	Citizen Advocacy	Existing in-kind/secondment
CSS Wraparound	One day per week for case consultations	Rotates between CSS agencies	Existing/in-kind
RN, RPN, and PSW	TBD	Aspen Lake LTCH	New hires
		Richmond Terrace LTCH	

Municipality of Chatham-Kent

This geographical area includes existing resources, new hires and secondments, and one Lead LTCH (Municipal Home for the Aged). Note there are seven LTCHs in Chatham-Kent.

Resources	FTEs	HSP	New/Integrated/In-kind /Seconded/Existing
Alzheimer's System Navigator	1	Alzheimer's Society Chatham-Kent	New hire
PRC	1		New secondment to CKHA from Lead Agency
BSW	1	Capacity needs	One year contract
CCAC Specialized Case Manager	.5	CCAC	In-kind NP supports LTCHs
CCAC NP	TBD		
GMHOT includes psychiatrist	3.1	CKHA	Existing
Client Intervention	Two days per week	Family Service Kent	Existing In-kind/secondment
CSS Wraparound	One day per week for case consultations	Rotates between CSS agencies	Existing/In-kind
RN, RPN and PSW	TBD	Riverview Garden LTCH	New hires

Sarnia/Lambton

This geographical area includes two LTC Lead Teams, existing resources, integration, new hires, and in-kind/secondments resources. Note there are 10 LTCHs in Sarnia/Lambton.

Resources	FTEs	HSP	New/Integrated/In-kind /Seconded/Existing
Alzheimer's System Navigator	1	Alzheimer's Society Sarnia/Lambton	New secondment through Lead Agency to S/L Branch
CCAC Specialized Case Manager	.5	CCAC	In-kind/secondment
GMHOT includes psychiatrist	3.5	CMHA LK	Existing
PRC	1		New secondment through Lead Agency to CMHA LK
BWH 1 FTE	1		Integration from BWH to CMHA LK
Client Intervention	2 days per week	Lambton Elderly Outreach	Existing In-kind/secondment
CSS wraparound	1 day per week case consultations	Rotates between CSS agencies	Existing/In-kind
RN, RPN and PSW	TBD	Afton Park LTCH Trillium Villa LTCH	New Hires