

Hamilton Niagara Haldimand Brant **LHIN**  
**RLISS** de Hamilton Niagara Haldimand Brant



**"I am who I am, so help me continue to be me"**  
*Behavioural Support Ontario (BSO) Action Plan*  
**November 2011**

# Imagine a health system where you....

Give your health history  
**once**

Have  
easy to understand information  
to help you make informed choices

Have  
**one test**  
that is shared among your providers

Have  
**24 hour access**  
to a primary care provider

Know your doctor receives  
timely information  
about you from others

Can make an appointment for a  
visit to a clinician, a diagnostic  
test or a treatment  
**with one phone call**

Have a  
wide choice  
of primary care providers who can  
give you the time you need

Get the right care  
at the right place  
at the right time

**HNHB LHIN ...the works**  
to get you there

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# Executive Summary

## Executive Summary

The aim of the HNHB LHIN Behavioural Support Ontario Action Plan is to implement sustainable initiatives which will result in improved quality of life and quality of care for seniors with challenging and responsive behaviours regardless of where they live. Clients with responsive behaviours have complex needs that require special expertise and support to successfully transition within and across health care sectors.

The HNHB LHIN Action Plan has identified improvements which will result in a desired future state by addressing current gaps and duplications in the system and enhancing and reconfiguring existing services. This future state will address the client's needs and support client and family-directed care along the continuum. The improvement plans have been developed based on the following client value statement:

***"I am who I am so help me continue to be me"***

Creating a LHIN-wide cultural shift which defines value and develops improvements as seen through the eyes of the client and their families requires formal partnerships and accountabilities between sectors and providers, and is essential for success and sustainability.

Key improvement strategies for the HNHB LHIN Action Plan include; capacity building for primary care to effectively manage clients in the community; a centralized information and referral process designed to link the client/family with appropriate services; the establishment of an integrated community lead agency model to coordinate services and create a single point of contact for clients/families; and interdisciplinary mobile teams in the community and long term care who will build capacity and support smooth transitions for clients across the system.

Ensuring system sustainability will be accomplished by leveraging the quality improvement capacity across the LHIN and disseminating and implementing standardized best practices. Innovation and best practices will be applied at the organizational, system and individual/client level while being tailored to meet local needs and build on existing services. Organizational culture and leadership that embraces innovation will be essential to the sustainability of the HNHB LHIN BSO Action Plan.







# Introduction

In August 2011, the Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) was identified, along with three other Ontario LHINs, as an Early Adopter LHIN (EALHIN) to implement the Behavioural Supports Ontario (BSO) Framework and operational program model<sup>1</sup>. This approval marked the beginning of phase 2 of the BSO project.

The first phase of the BSO project (Phase 1) involved the development of a principle-based Framework of Care that would mitigate the strain and improve outcomes for persons with challenging behaviours, families health providers and the health care system. The Frameworks overarching principle is **Person and Caregiver** directed care. The three core elements of the Framework referred to as its pillars are:

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

To guide local health system redesign of behavioural support services within the BSO Framework, LHINs were required to develop an Action Plan. The Action Plan identifies local service gaps, resources, and the improvement plan/strategies that need to be implemented to advance the local health system to the future state envisioned within the BSO Framework.

This document details the HNHB BSO Action Plan that was developed under the leadership of the HNHB LHIN BSO Project Committee (Committee). The Committee was comprised of cross sector and cross LHIN representation from LHIN agencies/organizations with expertise in the identification, assessment, care and management of individuals and their caregivers with responsive behaviours. Refer to Appendix A for Committee membership.

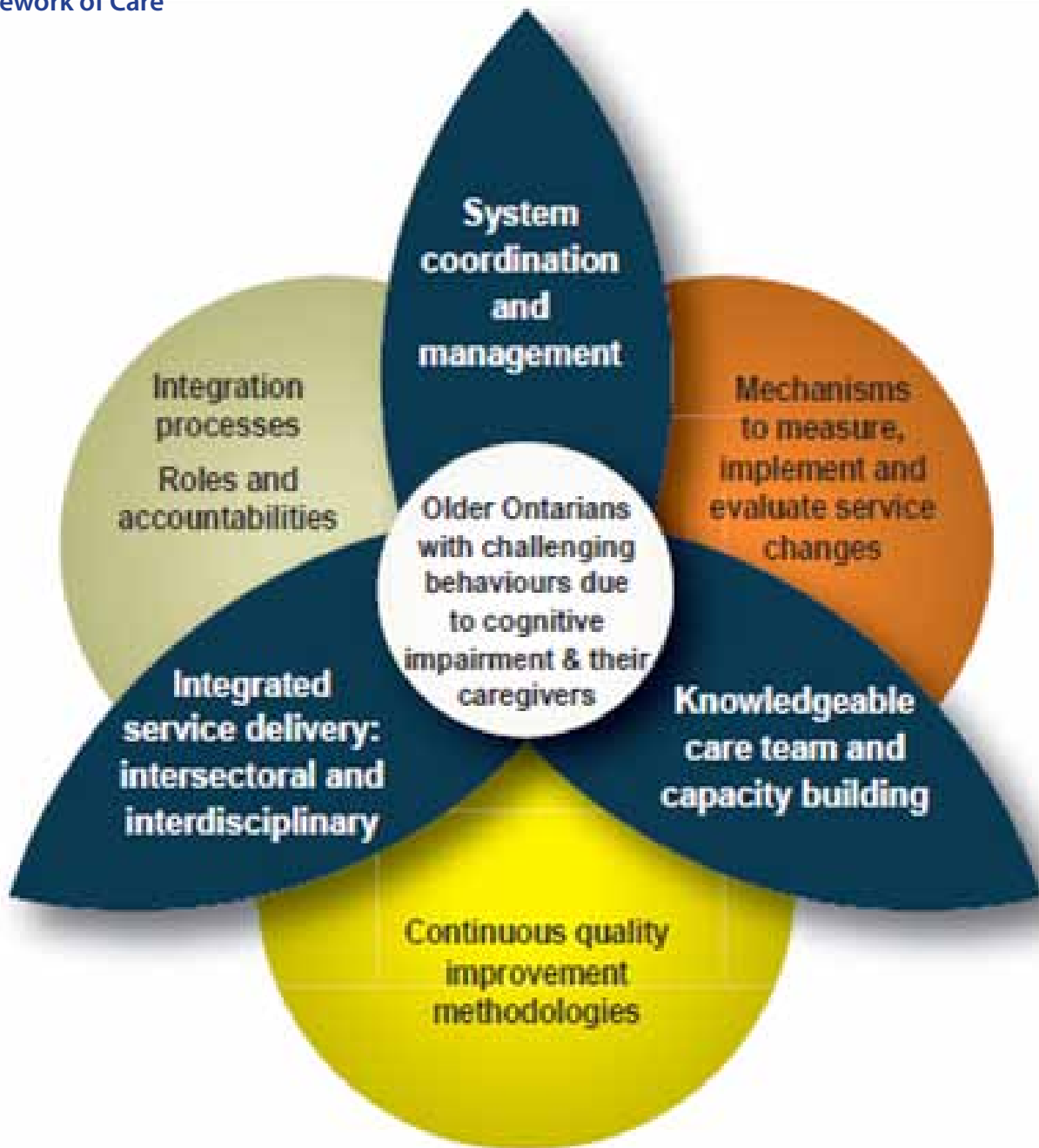
The HNHB Action Plan was submitted and reviewed by the BSO Provincial Resource Team and Health Quality Ontario Team. Each of these teams provided feedback which was then incorporated into this plan.

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<sup>1</sup> Behavioural Supports Ontario, Implementation Kick Off Presentation, Alzheimer Society Ontario, Alzheimer Knowledge Exchange, Ontario LHINs: August 2011

<sup>2</sup> Ontario Behavioural Supports Systems, A Framework for Care. Alzheimer Society Ontario, Alzheimer Knowledge Exchange, Ontario LHINs :January 2011.

## The Framework of Care



Source: BSO Kick off Presentation August 2011



## Introduction (continued)

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

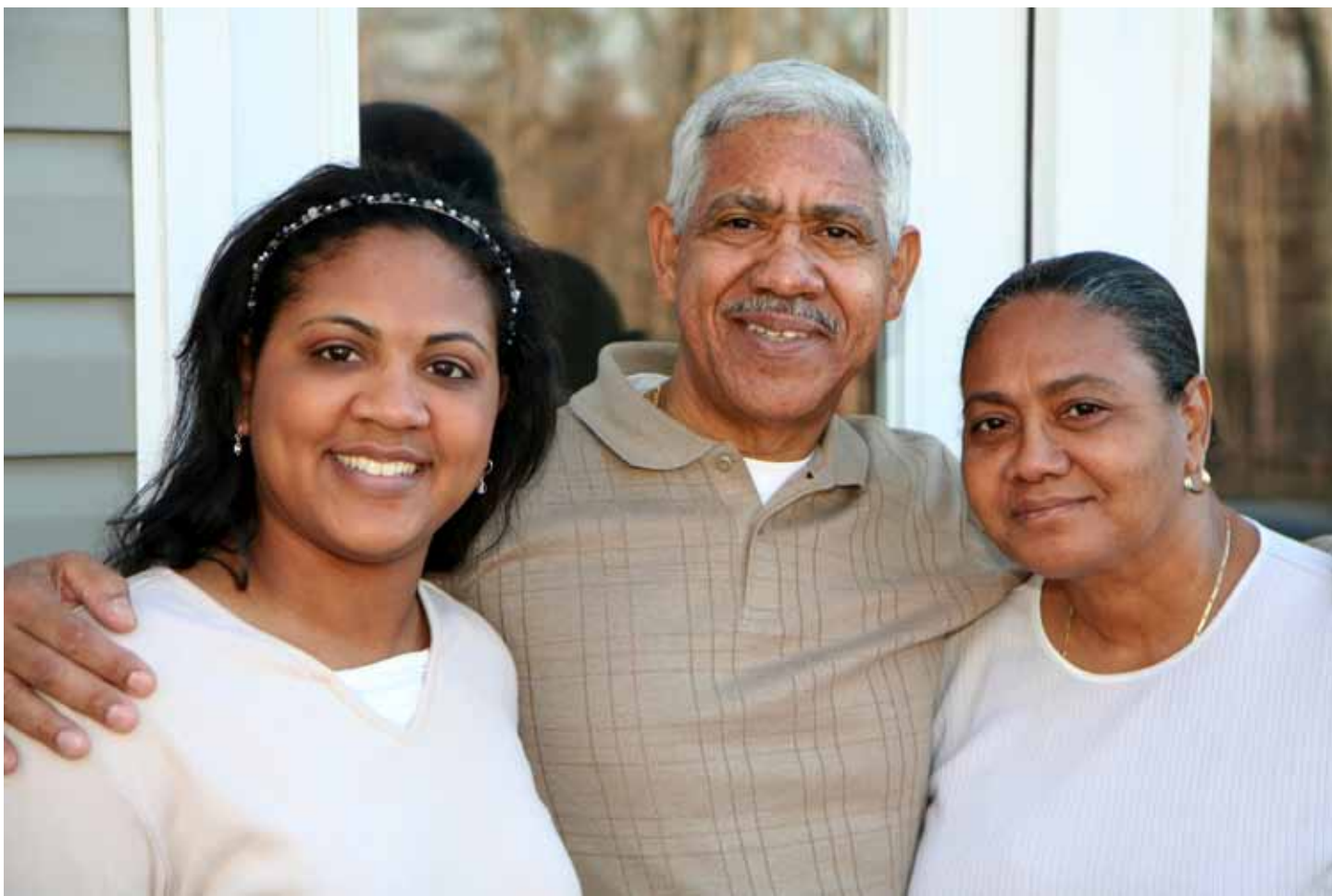
- consulted with LHIN health service providers (HSPs) through focus group discussions<sup>1</sup> and individual meetings, the Chair of the Family Council Network Four in order to gain the consumer's perspective, and with established LHIN Geriatric Networks
- completed a review of available data specific for individuals with behavioural issues (refer to Appendix B)
- through the LHIN supported a Value Stream Mapping Session lead by Health Quality Ontario
- reviewed reports/reviews that had previously been completed, which provided insight on this population within the HNHB LHIN, including:
  - HNHB LHIN Alternate Level of Care (ALC) Steering Committee Hard to Service Working Group Draft Report
  - Cancer Care Ontario July 2010 survey of individuals waiting in hospital ALC
  - Report from the Geriatric Access and Integration Network Council, 2008
  - HNHB LHIN Geriatric Services Planning Advisory Group (PAG) to the Clinical Plan Steering Committee<sup>2</sup>

Information obtained from these reviews assisted the Committee to identify areas along the continuum of care that were key to improving client/caregiver experience and system performance.

<sup>1</sup> Focus Group with seventy-five HSPs met regarding unmet needs, service gaps and inefficiencies in the system of care for individuals with responsive behaviours (HNHB LHIN September 13, 2011).

<sup>2</sup> Advice of the Geriatric Services PAG to the HNHB LHIN Clinical Services Planning (CSP) Steering Committee, June, 2009. Priorities for Specialized Geriatric Services in the Hamilton Niagara Haldimand Brant LHIN: Brief Report, C. McCaig and S. Burns, July 2008.





## Pillar 1: System Coordination and Management



## System Coordination and Management

A review of the current system revealed that, in order to improve the client and caregiver experience, LHIN health service provider (HSPs) would need to restructure how they provide care, and that system change needs to occur from the point of the client's initial contact with primary care for a behavioural issue, and during key care transition points along the continuum.

### Key Gaps Identified in System Coordination

1. Lack of a centralized intake process to provide timely access to the appropriate services and supports. As a result:
  - many providers and caregivers are unsure of who to call or what assistance is available
  - clients or caregivers (who are often ill-equipped for the task) are required to navigate the system on their own
  - clients are placed on multiple wait lists to access specialized care
  - clients may not receive the most appropriate care from the most appropriate provider in a timely manner.
2. Absence of a coordinated integrated system of care, managed through formalized partnerships with assigned accountability for the clients/caregivers care needs. As a result, clients and caregivers often experience care that is siloed, inconsistent in its delivery, delayed, duplicated or nonexistent.
3. Communication among HSPs (primary care, geriatric specialists, acute care, community agencies and long-term care (LTC)) specific to a client's health status or care plan is delayed, inconsistently shared or nonexistent. As a result:
  - the client and caregiver often have to repeat their history, medical problems and concerns many times
  - the client or caregiver does not receive timely access to needed services or supports
  - changes in the client's health status and/or care plan are not communicated, resulting in the need for more intense or higher level of care and possible transfer to another organization or emergency room (ER) visit
  - multiple client assessments are completed in isolation, and at different points along the client's continuum, instead of the creation an inclusive (common), accessible and comprehensive client record.

## LHIN Resources to Support System Coordination

HNHB LHIN HSPs across the continuum of care, with expertise in the care of individuals with responsive behaviours, have demonstrated leadership through the establishment of informal partnerships to improve access to coordinated care, refer to Appendix C. While these partnerships, for the most part, are informal and exist at a local sub-LHIN level, they will be leveraged to facilitate system coordination and equitable access to behavioural support services. In order to enable LHIN-wide success and improve system coordination a shift in culture is required. A cultural shift which defines value and develops improvements as seen through the eyes of the client will require formal partnerships, collaboration and accountabilities between sectors and providers.

Existing collaborative models will be reviewed to identify best-practice integrated models of care. These sub-LHIN integrated care models will be reconfigured and connected through formalized accountability and standardized processes and protocols to form a coordinated LHIN-wide Behavioural Support System. BSO funded resources will be allocated to existing service providers as additions to enhance current structures and build on current initiatives.

In addition, new and existing partners will be actively recruited to participate in the planning and implementation of a coordinated care pathway across the continuum for clients with responsive behaviours and their caregivers.

## Partnerships for Success

The HNHB LHIN and LHIN HSPs have a strong history of working collaboratively across LHIN geography and sectors. Recent examples of HSP collaborations are provided in Appendix D. While each example demonstrates successful partnerships, together they provide evidence that:

- there is a culture shift occurring across LHIN HSPs which is demonstrated by a greater willingness to collaborate and partner to improve system coordination
- improved coordination can reduce duplication, improve client experience and outcomes, increase provider satisfaction and expertise and lead to system sustainability.





## System Coordination Partners

The partners for system coordination will be comprised of HNHB LHIN HSPs and key stakeholders who are involved in the early detection, support and management of individuals (and informal caregivers) with responsive behaviours. These HSPs may provide information or care at any point along the continuum and will include:

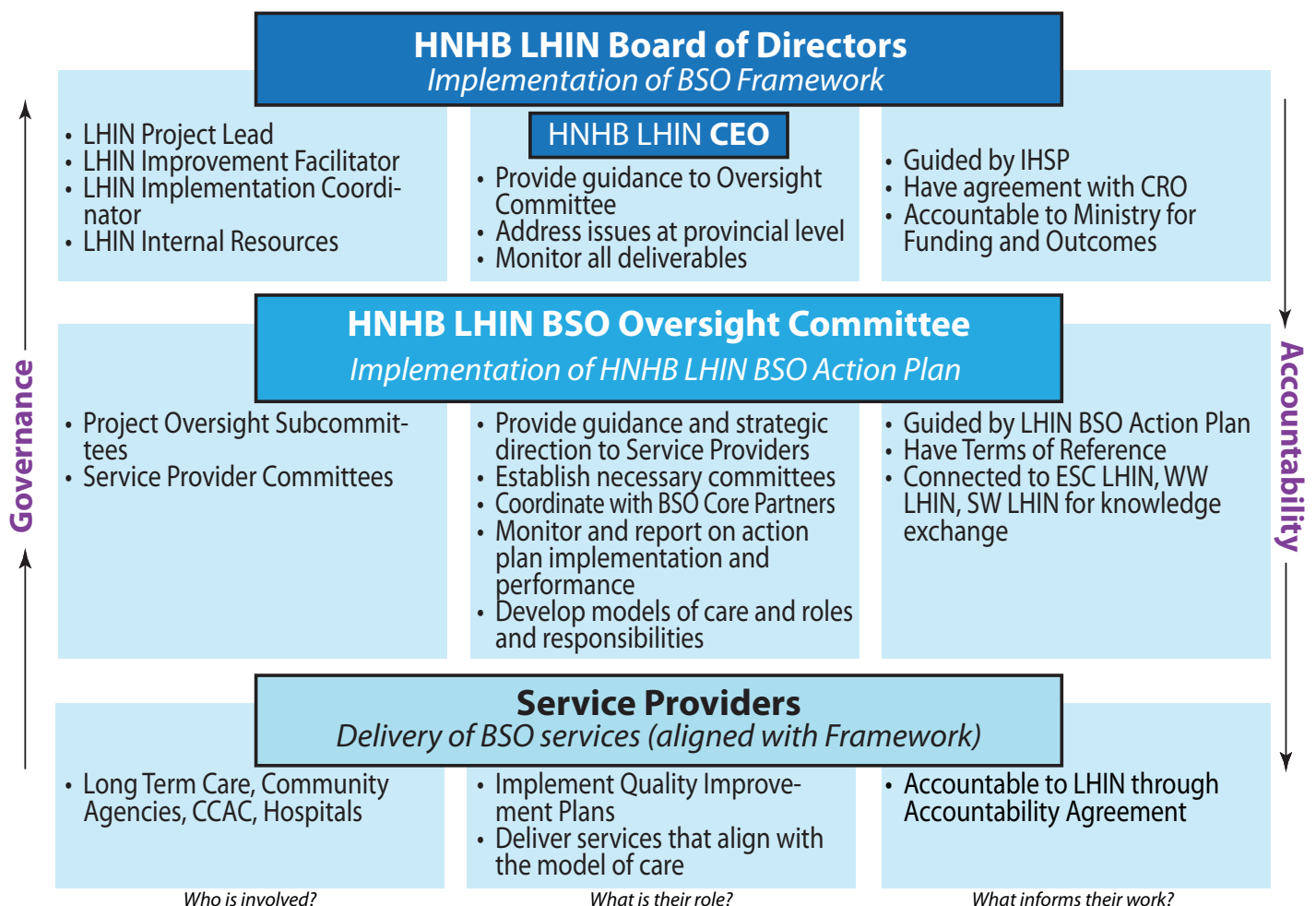
- Leaders from the HNHB LHIN's Alzheimer Societies and Geriatric Access and Integration Network, who will be engaged to identify opportunities to improve knowledge and awareness of the signs and symptoms of responsive behaviours for residents and providers, in order to facilitate early recognition and intervention.
- Primary care providers, who will identify standardized tools and processes that will assist management and care of their clients (and their caregivers) with responsive behaviours. The existing HNHB LHIN Primary Care Network will be leveraged to identify subcommittee membership with local leadership. The Primary care committee will establish a new collaboration among primary care providers and geriatric specialists to develop and implement the standardized tools and processes. HNHB Community Care Access Centre will collaborate with provider partners to develop a centralized intake and referral process that will enable timely access to behavioural support services.
- Community agencies will define a community-based collaborative model of care, where one agency will assume the role of the integrated community lead for the client/caregiver (as defined by specific criteria to be determined). The model will define clear roles and accountability for the partners. Community services could include adult day services, respite, and caregiver support and other services as needed.
- LHIN leaders in eHealth will work to identify and expedite processes that will improve the flow of information between HSPs. The HNHB LHIN is continuing to implement ClinicalConnect, a web-based tool that provides timely provider access to patient and client information, between hospitals, physicians and HSPs in the community.
- Providers from hospitals, specialized geriatric psychiatry services, community support services, long-term care homes (LTCH), mental health and addition services will be identified to develop a Mobile Interdisciplinary Behavioural Support Outreach Team Model for implementation in LTCHs and the community. Existing mobile resources in the community will be reviewed in order to determine where new BSO resources can be added to enhance present service provision.
- Providers within the LTC sector will determine governance for the Mobile BSO LTC Outreach Team Model. The LTC sector will build on existing Quality Improvement approaches, such as Residents First, and plan knowledge transfer for all LTCH staff.



## HNHB LHIN BSO Governance and Accountability Structure

The HNHB LHIN Board of Directors will maintain overall accountability for the implementation of the HNHB LHIN BSO Project, as detailed in the funding agreement between the LHIN and the Ministry of Health and Long Term Care (ministry). The LHIN has assigned the responsibility for the implementation of the HNHB LHIN's Behavioural Support Action Plan to the Committee, Co-chaired by the President of St. Peter's Hospital and the Administrator of Linhaven LTCH, who is also the Board President of the Alzheimer's Society of Niagara Region. Accountability for funding and deliverables associated with the funding is through funding agreements between the LHIN and those HSPs that will receive the funding. See Diagram 1 below for more information.

**Diagram 1: HNHB LHIN BSO Governance and Accountability Structure**







## HNHB LHIN BSO Governance and Accountability Structure (continued)

Committee membership is cross-sectoral, and is comprised of health care leaders with expertise in the management and care of individuals with responsive behaviours. The Committee will be guided by a Terms of Reference with clear deliverables developed by the LHIN. These deliverables will include a plan to transition their oversight role to a Management Committee by December 2012. The Management Committee will be comprised of HSPs funded to provide behaviour support services that will be accountable to the LHIN for the ongoing planning, coordination and performance of the HNHB LHIN Behavioural Support System. The Committee will be supported by an Implementation Project Lead, who will be responsible for liaising with the sub-committee, provider workgroups and other key stakeholders involved with the implementation of the HNHB LHIN BSO Action Plan. Refer to Appendix A for Committee membership.



## Pillar 2: Interdisciplinary Service Delivery – Outreach and Support Across the Service Continuum



## Identified Target Populations

This Action Plan has been developed to address two specific client populations.

1. Seniors with an unexpected behaviour change who require access to an integrated system of care for ongoing management and support to maintain them in the community.
2. Individuals who experience a crisis (related to a new change in responsive behaviour) in the community or LTCH, who require episodic care, and those individuals transitioning across care settings who require specialized support at the following key transition points from:
  - community to behavioural unit
  - behavioural unit to end destination (community or LTCH)
  - LTCH behavioural unit to tertiary behaviour unit and repatriation back
  - hospital to LTCH.

The focus of the HNHB LHIN value stream mapping was the client with responsive behaviours in the community.

## Transition Points for Identified Target Populations

### 1. *Individuals in the Community with Initial Behaviour Change*

These individuals are often at risk of hospitalization, unless linked to an integrated support system. The transition points are from home in the community to primary care, and to community care with supports. While this population is lower on the risk continuum, they do experience gaps in transition points between primary care and specialty geriatric services, primary care, and the appropriate linkage with community services and coordination among community services.

### 2. *Individuals in Crisis*

- a. Individuals living in the community (at home or LTCH) who escalate to a crisis responsive behaviour. The transition points are from home (or LTCH) to special geriatric outreach team (if available), acute care or behaviour unit (if capacity exists). While the focus of preventing further decline and optimizing health does not change, behavioural issues have surfaced, and a tipping point has been reached.
- b. Individuals with complex responsive behaviours requiring multiple cross-sector service agencies, including a tertiary behavioural specialty unit. The transition points are a LTC behaviour unit to a tertiary behaviour unit, or acute care hospital.

Of note, at risk and marginalized populations are those individuals within each of the categories above who may also be without primary care, homeless, in conflict with the law, etc. requiring additional advocacy and creative responses to their unique circumstances.

## Key Gaps Identified in Supports and Outreach

The information noted below was derived from the input of physician and non-physician specialists in geriatrics (medicine and geriatric psychiatry) and front line staff working in the community and in LTCHs.

### 1. *Primary and Specialized Care:*

- Timely access to personal and community support services is needed for individuals with responsive behaviours living in the community who may not otherwise be eligible for these services if they do not require assistance with the activities of daily living.
- Primary care providers aren't always able to identify individuals with responsive behaviours, which can delay these individuals and their caregivers in accessing appropriate services and supports in a timely manner.
- Primary care providers' unfamiliarity with the diagnosis and management of responsive behaviours may cause them to refer a high percent of their patient population with this condition to physician specialists. This can result in longer, and in some instances, overlapping wait lists.
- Limited access to specialized geriatric services, which can be a greater barrier to those living outside the Hamilton area.

### 2. *Community Support Services:*

- Limited readiness and/or capacity of community agencies to effectively respond to the needs of clients/caregivers with responsive behaviours.
- Community agencies have historically worked in silos with limited coordination among agencies, who serve a common client population.

### 3. *Key Transitions Points Across the Continuum of Care:*

- Clients with responsive behaviours have complex needs that require special expertise and support to successfully transition within and across sectors of care (e.g. from local hospital to LTCH, or to a specialized behavioural program, from the specialized program, back to LTCHs or home).
- Families need emotional support and education before, during and following transitions.
- LTCHs have limited capacity to readily accept individuals with a history of responsive behaviours, resulting in individuals experiencing long waits in hospital for LTCH placement.

### 4. *Episodic Support and Crisis Management:*

- Many LTCH residents have complex behaviour issues that can escalate and result in a crisis transfer to a hospital ER. The lack of on site specialized episodic support, and assistance in the management of the client's behaviour, results in an ER transfer and a reluctance of the LTCH to accept the resident back from hospital following treatment.
- Similarly, individuals with responsive behaviours living in the community, frequently present to the ER when caregivers are burned out and/or community-based supports are unavailable or not accessed. ER physicians have noted that these individuals are the most challenging cohort of patients.







## Opportunities to Leverage System Strengths to Address Gaps

The Action Plan will develop service models that address the needs of both the HNHB LHIN's urban and rural populations. Areas to be leveraged include:

### ***Special Knowledge and Expertise:***

- Physician specialists in geriatric psychiatry and medicine within the HNHB LHIN.
- Four Alzheimer Societies across the HNHB LHIN - support Psychogeriatric Resource Consultants (PRCs) who have existing roles within the system to develop knowledge, skills, partnerships and networks for the new BSO staff within the continuum.
- LTCH staff trained in Gentle Persuasive Approaches (GPA) and P.I.E.C.E.S. (Physical, Intellectual, Emotional Health, Care, Environment, Social). PIECES is a best practice learning and development initiative that provides an client-centred approach to understanding and enhancing care for individuals with complex physical and cognitive/mental health needs and behavioural changes.
- The functions of the Intensive Geriatric Service Workers (IGSW), Gatekeeper, Supports for Independent Living (SIL), Case Management Support workers and Client Intervention and Assistance (CIA) workers that sporadically exist within LHIN agencies.
- There is opportunity to standardize name, host agency, service function and linkages within the system to increase awareness, access and quality of service.

### ***Successful Outreach Models:***

- Nurse Led Outreach Team's (NLOT) service model and staff expertise and knowledge.
- Clinical shared care models including Geriatric Mental Health Outreach (GMHO) staff who are established within the HNHB LHIN and provide mobile comprehensive assessment, behavioural management strategies, and intervention and secondary crisis intervention to this population in LTCHs and community settings

### ***Mechanisms that Support Collaboration and Service Coordination:***

- HNHB Community Care Access Center (CCAC) knowledge and expertise in centralized intake and referral, and with all aspects of the care system (i.e. hospitals, supportive housing, community agencies and LTCHs).
- Four Alzheimer Societies across the LHIN, which includes resources such as First Link Coordinators who make connections with primary and specialized care providers
- Regional Geriatric Program-Central (RPG).
- Ontario Telemedicine Network (OTN) - located in 26 LTCHs across the HNHB LHIN.



## Core Components that will Address Service Gaps Across the Continuum of Care

The HNHB LHIN Action Plan will address service gaps through identified improvement plans. These improvement plans have been developed in response to the following client value statement, identified by HNHB LHIN health care providers through the LHIN's Value Stream Mapping process.

### ***"I am who I am so help me continue to be me"***

The HNHB LHIN Action Plan will develop a future state through the enhancement and reconfiguration of existing services. The future state will achieve client and family-directed care while addressing the client's needs throughout their journey along the continuum of care. See Appendix E for projected future state as identified through the value stream mapping process. This continuum extends from early identification and management, to a change or crisis in the community and LTC setting, including the potential need for a transition to a specialized behavioural support unit. Please refer to Diagram 2 on page 22.

The goals of this plan are to maintain the older adult's level of functioning in their current environment, to limit decline, and the need for increased services and support. There are several key success factors within this plan which leverage existing structures, to ensure sustainability and improved outcomes for clients with responsive behaviours.

These success factors include:

- capacity building for primary care to effectively manage these clients within the community
- a centralized intake and referral process designed to link the client/family with services that will meet their needs.
- the establishment of an integrated community lead agency to coordinate services and create a single point of contact for clients and families
- interdisciplinary mobile crisis management and outreach teams in the community and LTCHs and the establishment of best practice protocols to enable smooth transitions for clients to and from LTC
- capacity building for community and LTC to improve the clients experience and quality of life.





## Areas that will be the Focus of Improvement Plans

This action plan addresses the following areas that will be the focus of improvement plans:

### ***Public Awareness and Preventative Care through:***

- Leveraging existing resources to increase public awareness of the signs and symptoms of responsive behaviours, to enable early detection and appropriate referral.

### ***Primary Care through:***

- The HNHB LHIN Physician Lead, who will lead a primary care subcommittee to identify, test and implement protocols and tools for the management of clients with responsive behaviours
- The recruitment of a Project Lead for 4 months, funded through BSO, to support the development, planning and implementation of protocols and tools for primary care
- An agreement on standardized best practice protocols and tools for primary care to facilitate diagnosis, management, and appropriate referrals to specialty services and/or community services/agencies for clients with responsive behaviours
- Identification of protocols for primary care to continue to manage client care, ensure consistency, and prevent crisis for clients after care is transferred from a geriatric specialist
- A process to connect marginalized seniors who do not have primary care to enable early intervention and support.

### ***Community Care through:***

- An enhanced CCAC gateway navigator role for populations with responsive behaviours who may not meet current requirements for CCAC services
- Building off existing expertise at First Link for intake and referral and collaborating with the CCAC to strengthen the existing structure
- A central CCAC BSO intake and referral process, which will support and assist the client/family with access to appropriate services
- An integrated community lead agency with formalized roles accountable to coordinate community services for the client to facilitate seamless care, prevent duplication, and eliminate gaps in service
- A mechanism to share information and ensure client status updates are provided to primary care from community services/agencies and geriatric specialists
- Explore the potential for CCAC to maintain open files for persons identified with responsive behaviours, to enable access to an existing client record, preventing duplication.

### ***Enhanced Day Treatment by:***

- Linking those with responsive behaviours to the most appropriate adult day programs, to promote optimal functioning in the community.

***Crisis Management in the Community:***

- Clients in the community who experience a crisis will be managed by interdisciplinary mobile crisis teams, who will establish strategies and a plan of care specific to the needs of the client, to maintain the client in their home, and prevent an avoidable ER visit and possible admission.

***Respite Care by:***

- Including the BSO mandate into the terms of reference for the community planning tables which include Community Support Services (CSS) providing respite care
- Including CSS providing respite care as one of the integrated community lead agencies.

***Long-Term Care through:***

- The establishment of an inventory of services available to LTCHs for support and management of individuals with responsive behaviours
- The development of a pathway to enable a seamless transition of care to and from LTC, based on the client's perspective, to decrease the potential for escalation of behaviours.

***Crisis Management in LTC through:***

- The development of protocols and best practices to prevent and respond to escalation of responsive behaviours to enable standardization across the HNHB LHIN
- Interdisciplinary mobile resource teams who will establish strategies and a plan of care specific to the needs of the client in LTC, to prevent crises, provide outreach to build capacity and prevent client transfer to a higher level of care.
- Interdisciplinary mobile resource teams who will consult with acute care, for those clients with LTCH placement challenges.

***Behavioural Support Units (BSU) through:***

- The development of a client-focused plan, which will include strategies to successfully transition the client from the BSU into LTC or the community
- Define the role of the BSU in the care path continuum.

***Common Client Record:***

- The full implementation of ClinicalConnect across the HNHB LHIN will enable all HSPs to have access to this common client record, to improve quality of care and promote consistency
- Explore the opportunity to use the Integrated Assessment Record (IAR) for this target population.

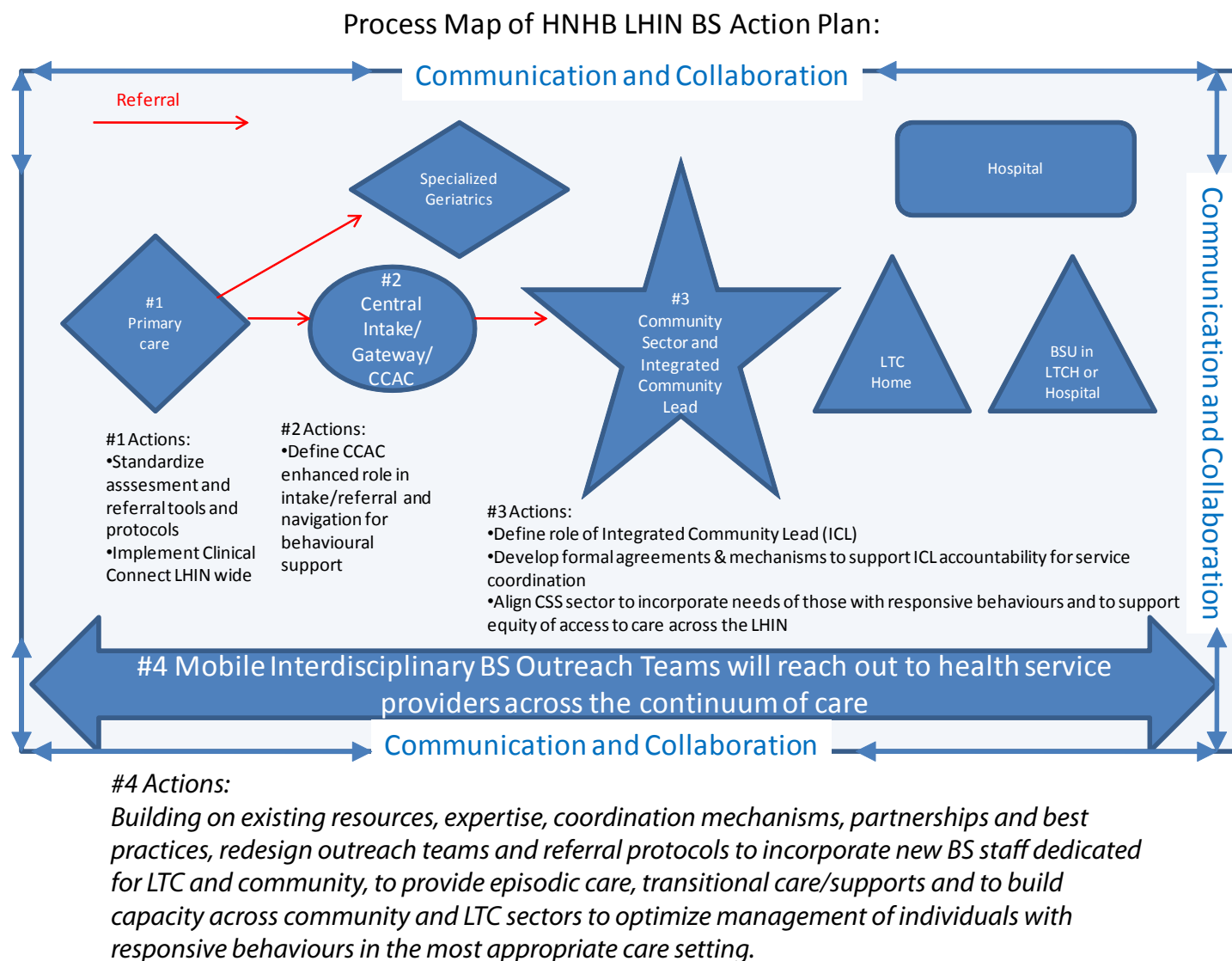
***Knowledgeable Care Team and Capacity Building through:***

- Interdisciplinary mobile outreach/crisis teams and leveraging existing resources who have the capacity to share best practices with and transfer knowledge to direct care providers (family and health care professionals) regarding management and de-escalation of responsive behaviours.



## Diagram 2: Process Map of the HNHB LHIN Behaviour Supports Action Plan

The following process map identifies four of the initial priorities of the HNHB LHIN Action Plan. These priorities will guide improvement planning for the development of the strategies to address gaps in service.



## Strategies to Address Service Gaps: Equitable and Timely Access to the Right Providers and Care

The following processes will support timely and equitable access to the right care by the right provider:

- Establishment of protocols and tools for primary care to ensure accurate diagnosis and timely and appropriate referrals.
- Enhanced role of the HNHB CCAC to provide a gateway to the appropriate community support services in a timely manner to prevent clients with responsive behaviours from being placed on wait lists, and being referred to inappropriate services.
- Establishment of a behavioural support intake and referral process will ensure equitable and timely access to the right providers for the right service.
- Creation of an integrated community lead agency with clearly defined roles and accountabilities, which will prevent duplication, inappropriate referral or lack of service for the client/family.
- Establishment of sub-LHIN service hubs for the deployment of community and LTCH interdisciplinary mobile crisis/outreach management teams, to ensure equitable access for crisis management across the HNHB LHIN. In the community, these teams will complement existing mobile outreach teams. In LTC, these teams will ensure timely access to crisis prevention and management with follow up care/plans.



### ***Access to Behavioural Assessment Services***

A behavioural support intake and referral process will provide timely linkages to appropriate behavioural assessment services. Each geographic service hub will include mobile interdisciplinary care teams with outreach capacity and crisis management service delivery.

These care teams will have the knowledge and expertise to provide behavioural assessments, establish an individualized care plan, and provide follow up for clients in the community and LTCH. Each care team will leverage the existing support, and build on the expertise of Psychogeriatric Resource Consultants (PRC), GMHO Program staff, NLOT members, CSSs, the Regional Geriatric Program, RAI-CHA, CIA, IGSW, and SIL. The care teams will also increase and sustain specialized assessment capacity in the community and LTC through ongoing knowledge exchange.

### ***Access to Comprehensive Geriatric Assessments***

Primary care providers with access to best practice tools and protocols will have the knowledge and resources to conduct an initial standard geriatric assessment. Clients who require a more comprehensive assessment will be referred to geriatric medicine and/or geriatric psychiatry services, which offer a range of clinic-based or mobile/home-based assessment services.

There will be a standardized approach to obtain a comprehensive geriatric assessment for residents of LTCH.





## **Strategies to Address Service Gaps: Equitable and Timely Access to the Right Providers and Care (continued)**

### ***Access to Behavioural Support Services for Individuals with Complex and Challenging Mental Health, Dementia and other Neurological Conditions***

The Action Plan allows for increased public and provider awareness of the sign and symptoms of the above conditions in a variety of settings. Based on their care setting, clients with these conditions will be linked to the appropriate services as needed.

Community – (Supportive Housing, own home etc.):

- Increased public awareness, family members or caregivers will be able to identify changes in behaviour earlier, which will allow them to follow-up with their primary care provider who following an assessment, will connect them to the centralized intake and referral process for behavioural support services in the community.
- Standardized protocols will enable primary care providers to complete an initial assessment, and refer if necessary, to specialized geriatric services.

LTCH

- Building capacity in LTCH staff to recognize the above conditions will help facilitate timely referrals for assessment and care planning of residents.

### ***Access to Right Care for Individuals Outside of Target Population***

This Action Plan standardizes an approach to early identification, assessment and management for the target population that is transferable to other population groups. The mechanisms established to support the implementation of this action plan can be leverage to support other populations. Individuals with behavioural issues due to other conditions such Acquired Brain Injury (ABI) or Dual Diagnosis will benefit from the system of care developed through the BSO project.

## Strategies to Address Service Gaps: Support of Individuals In Crisis

The crisis management strategy will depend on the care setting of the individual. Protocols utilizing best practices for the management of escalation of responsive behaviours will also be established and implemented LHIN-wide.

### Community:

- Individuals in crisis in the community, who are already on service with an integrated community lead agency, will contact that agency and if determined necessary, the agency will initiate the crisis response plan, which will involve a mobile team response.
- Individuals not on service may contact their primary care physician or present at the nearest emergency department. Depending on the level of crisis, they may be admitted, or the CCAC Case Manager in the ER will initiate community support service plan.
- In both these situations, following resolution of the acute crisis, their care plan will be reassessed and adjusted as needed.

### LTCH:

- Individuals in crisis in LTCHs will initially be assessed and care plans adjusted by the LTCH staff (who have obtained increased knowledge and skills on this population as part of this action plan) in consultation with the LTCH Medical Director.
- In situations where the resident's condition (crisis) has escalated beyond the skills of the LTCH staff, then the LTCH will initiate the crisis response plan which may involve referral to the LTCH mobile team.





## Strategies to Address Service Gaps: Partners in Interdisciplinary Service Redesign

HNHB LHIN providers are increasingly working collaboratively across sectors and disciplines, which has resulted in:

- increased inter-organizational service awareness, inter-sectoral partnerships, shared accountability and system efficiencies
- increased staff confidence and competence in applying relevant knowledge and skill
- developed mechanisms that sustained interdisciplinary service delivery
- enhanced or satisfying service experience for seniors and their family/ caregivers
- improved population health, quality of care and system sustainability.

Refer to Appendix D for examples of examples of interdisciplinary and intersectoral collaboration.

The BSO Project Committee has cross sector representation comprised of health care leaders with expertise in the management and care of individuals with responsive behaviours and a consumer representative. The Committee will expand membership and increase expertise through the establishment of BSO Oversight Sub-Committees and Provider Level Committees. These committee's will identify the models of care, define roles, responsibilities, protocols, standards and identify the necessary formal processes that need to be implemented. The expanded partnership will include primary care.



## Pillar 3: Knowledgeable Care Teams and Capacity Building





## Knowledge Exchange Capacity

There are many existing processes that will support knowledge transfer and dissemination of best practices related to behavioural supports among current and future health care providers across the HNHB LHIN.

Organizations that provide training/education for health care professionals include:

- The Division of Geriatric Medicine, McMaster University educates and trains physician trainees from family medicine, internal medicine and other specialties who will provide care to patients with responsive behaviours. This medical teaching program is well-positioned to disseminate new knowledge and best practice evidence related to behavioural supports to these learners.
- Alzheimer Societies' education and knowledge transfer activities for public and providers, particularly through the Psychogeriatric Resource Consultants (PRC), Public Education Coordinators and First Link.
- The Regional Geriatric Program (RGP)-Central activities that support and coordinate physician education, capacity building and knowledge exchange, such as 'Grand Rounds' – these are regular events sponsored by RGP-Central and hosted at one of the LHIN's teaching hospitals, whereby local or visiting geriatric specialists provide presentations to medical staff and medical learners on new knowledge and best practices in geriatric care. These Grand Rounds are accessible to all other HNHB LHIN hospital sites through the Ontario Telemedicine Network (OTN).
- Hospitals' regular department rounds, academic/education days for medical staff and ongoing Continuing Medical Education (CME) events.
- The HNHB CCAC's '3-D' training (delirium, dementia and depression) for Community Care Access Centre (CCAC) and community support services staff who work with clients with responsive behaviours.
- The HNHB CCAC's training and use of the RAI-HC tool which includes questions/modules related to responsive behaviours.
- Residents First knowledge transfer activities in the long-term care (LTC) sector.
- BSO LHIN-wide communications plan across all 14 LHINs.
- BSO Knowledge Exchange activities among early adopter LHINs and across the remaining LHINs.
- Advanced assess and efficiency in primary care provided by Health Quality Ontario (HQQ).
- Geriatric Mental Health Outreach (GMHO) training and knowledge transfer processes include mentoring and modeling, on-site case-based education and care planning, user-friendly job aids and organizational assistance with review and integration/embedding into program policy and procedure best practices.

The long-term care homes (LTCH) Centres of Learning, Research and Innovation, while not within our LHIN, will provide a source for new knowledge, best practices and learning opportunities for current and future professionals, that will be shared with all LHINs. This knowledge, once transferred into practice, will have a direct impact on our target population in the management of clients with responsive behaviours.



## Quality Improvement Capacity

The HNHB LHIN BSO Oversight Committee has identified the establishment of a QI Subcommittee as a BSO project priority. The Oversight Committee will leverage LHIN provider expertise in QI and behavioural support services in determining membership. Other HNHB LHIN resources with knowledge/expertise in QI that will support the project include:

- HQO BSO Coach
- BSO Improvement Facilitator
- BSO Project Lead
- BSO Implementation Project Lead
- HNHB LHIN Director Quality and Risk Management
- HNHB LHIN Information Controller
- HNHB LHIN Physician Lead, Clinical Health System Transformation
- Residents First Improvement Facilitators
- Integrated Client Care Palliative (ICCP) Program – Wound Care Improvement Facilitator
- ICCP – Palliative Care Improvement Facilitator
- Seniors Health Research Transfer Network (SHRTN) Community of Practice
- Primary care providers and their staff within the LHIN involved in previous improvement projects who received QI training from QIIP and HQO
- Six Nations Family Health Team (FHT) providers and staff involved in previous improvement projects who received QI training from QIIP.

Quality Improvement training for the Improvement Facilitator from HQO has occurred and continues with ongoing coaching in the development of improvement plans and rapid cycle tests of change. The Improvement Facilitator will work with the BSO QI Subcommittee, LHIN providers and the BSO Implementation Project Lead to transfer knowledge of quality improvement tools and identify best practices related to behavioural supports.



## Behaviour Supports Expertise Capacity

Refer to Appendix C



## Building Knowledgeable Care Teams with Behavioural and QI Capacity

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

- Mentoring and modeling, on-site case-based education and care planning, user-friendly job aids and organizational assistance with review and integration/embedding into program policy and procedure best practices.
- Identification of primary care providers trained in QI methodologies that will test new tools and protocols and transfer this knowledge to other providers in the LHIN.
- Local improvement teams will be trained and guided by the Improvement Facilitator and Implementation Project Lead to apply quality improvement methodology as they use PDSAs to develop and test changes prior to implementing changes, which lead to improvements.
- Mobile crisis/outreach teams in the community will be trained by existing outreach teams from Alzheimer Societies and GMHO. These teams will share their expertise with newly hired staff through training and mentorship, educational forums, webinars, case conferencing and sharing of best practices.
- Mobile crisis/outreach teams in the LTCH sector will be trained by experienced health professionals at T. Roy Adams, St. Peter's Behavioural Health Program and SJHH. These health professionals will provide education through direct training, mentorship, educational forums, webinars, case conferencing and sharing of best practices.
- Physician specialists in geriatric psychiatry and medicine will also provide training to mobile crisis/outreach team members in both the community and LTC.
- LTCH staff will be trained in PIECES and Gentle Persuasive Approaches (GPAs) to improve their skills and knowledge regarding the management of clients with responsive behaviours.
- QI capacity from Residents First Improvement Facilitators and LTCH staff from homes that participated in Residents First will also be leveraged.
- Existing public education activities and mechanisms will be enhanced to provide public awareness of the signs and symptoms of responsive behaviours. (e.g., newsletters, website, speakers' series, etc).

## Leveraging Existing Knowledge Transfer Structures/Pathways

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

- HNHB LHIN-led mechanisms that support collaboration among primary care and specialist clinicians, such as:
  - HNHB LHIN Primary Care Network
  - HNHB LHIN Medical Leaders Group
  - Committees and networks that are working to develop LHIN-wide, integrated clinical programs for vascular, thoracic, complex care, rehabilitation, obstetrics, diagnostic imaging services, etc.
  - ALC Steering Committee.
- HNHB LHIN Community Engagement Strategy
- SHRTN\* and Alzheimer's Knowledge Exchange (AKE)\* websites and local knowledge brokers/librarians are key sources of information on best practices and current research.
- The Advanced Gerontological Education (AGE)\* enterprise has developed a GPA in Dementia Care education program.
- Canadian Dementia Resource and Knowledge Exchange (CDRAKE)\* and the National Initiative for the Care of the Elderly (NICE)\* provide educational resources.
- The Older Adult Programs and Services Database (OAPSD) hosted by RGP-Central, is a joint project of the Geriatric Access and Integration Network (GAIN) and the Dementia Networks of Brant, Hamilton, Haldimand Norfolk, Halton and Niagara which provides information on the services available to older adults in the HNHB LHIN. This web-based database enables health care consumers and providers to:
  - Locate health and community support programs and services in local communities across the HNHB LHIN.
  - Easily navigate the health and community services system.
  - Gain awareness of the services available within the LHIN health service organizations.
- The CCAC's Information and Referral service provides live phone and/or internet access and reference to LHIN-wide resources for seniors, their families, professional staff and the public.
- OTN video-conferencing capabilities at all hospitals, all CCAC branches and Community Health Centres (CHCs) and in 26 LTCHs will support interdisciplinary education, training and consultation across this LHIN.
- Web-based and in class certification courses through a number of academic institutions across the province/country.
- HNHB GAIN.
- Nurse Led Outreach Teams (NLOTs).
- Niagara Geriatric Services Collaborative.
- RGP-Central's Annual Geriatric Assessment and Cognitive Tools Training Workshops.

\*Refer to Appendix F for information about each of these.







## Building on Partnerships

Earlier sections of this Action Plan include detailed descriptions of the existing partnerships that will be leveraged to facilitate implementation of this Action Plan. We have made reference to cross-sectoral collaboratives, communities of practice (CoP) and health service provider (HSP) partnerships that will be called upon to collaborate in the development, testing, implementation and sustainability of improvement plans arising from this Action Plan. More specifically, key stakeholders who currently participate in these collaborative mechanisms will be recruited to contribute their expertise to time-limited BSO Oversight Subcommittees that will create detailed improvement plans, test these plans through PDSA cycles, and implement the plans. The transfer of knowledge regarding new models of care and care processes will be guided by the BSO Management Committee's knowledge exchange plan. Key stakeholders will be well-positioned to function as 'change agents' to help disseminate new/best practices across organizations and the broader health care system.

## Building on LHIN Special Initiatives, Programs and Tools

The HNHB LHIN Action Plan will build on the following initiatives, programs and tools:

### ***Aging at Home Initiatives:***

Specialized geriatric services (SGS) including:

- Enhanced and Expanded Specialized Geriatric Services Haldimand Norfolk (H-N). This is a community-based program for seniors with complex mental health issues, dementia, cognitive impairments, etc. which is located at Community Addiction and Mental Health Services H-N. This program provides specialized geriatric assessment, consultation, treatment, and education to clients in their homes, supportive housing, in LTCH, Rest and Retirement homes and hospitals with an interdisciplinary team that includes: geriatricians, geriatric psychiatrists, geriatric nurses, social workers and Intensive Geriatric Service Workers (IGSW). The IGSWs are outreach workers who assist high risk seniors in accessing health care and community support services to help them to remain living independently in the community.
- Expansion of Specialized Geriatric Services in Niagara. The addition of clinical and case management staff to the SJHH Niagara GMHO team (geriatric psychiatry) and the NHS Geriatric Services program (geriatric medicine) has increased capacity in these two programs to improve access to SGS in Niagara. The SJHH GMHO Niagara team is based in St. Catharines, but provides outreach to seniors in the community and in LTCH across Niagara. The NHS geriatric medicine program is based in Niagara Falls, and provides outreach to seniors in their homes, as well as in community settings such as CHCs, Adult Day Services and FHTs in Niagara on the Lake, Fort Erie, Welland and St. Catharines.

### **Programs:**

Additional programs which serve clients with behavioural issues include:

- Adult Day Programs for individuals with dementia.
- Respite care – both in home and outside the home, for individuals with dementia/behavior issues and caregivers.
- ‘Wellness Supportive Living Programs’ – provide assisted living and other services to high risk seniors in supportive housing and in their homes.
- Support for Independent Living – community mental health nurses and other health professionals/non-professionals serve isolated seniors living in the community.
- Gatekeepers programs in Hamilton and Niagara – these client intervention and assistance (CIA) programs have a unique mandate and legal ability to intervene with seniors who have been identified by people in the community as ‘at risk’, (e.g., seniors with dementia, other cognitive impairments, Diogenes syndrome, etc. who are living alone and in poor health). CIA outreach workers can bring services directly to isolated seniors in their homes without client consent. These programs have proven to be effective in connecting high risk seniors to services in the community that they wouldn’t have accessed without this intervention, (e.g., CCAC).
- Alzheimer Societies’ ‘First Link’ programs – link recently diagnosed dementia clients to services.

### **Tools:**

The Action Plan will optimize opportunities to improve system coordination, information exchange, interdisciplinary care, as well as knowledge exchange and quality improvement through the following tools:

- Clinical Connect.
- Ontario Telemedicine Network .
- Integrated Decision Support Tool (Refer to Appendix G)
- Leverage and promotion of existing relevant learning and clinical resource materials that have been developed nationally (e.g. CCSMH Guidelines and job aids) , provincially (PIECES, GPA to Dementia care, U-First, Montessori Educational Materials, and locally (e.g. RGP-C Blogger, care pathways and algorithms, etc.).







## **Sustainability of Service Redesign through Education and Knowledge Transfer and Other Mechanisms**

Organizational culture and leadership that embraces innovation will be essential to establish and sustain a learning strategy for BSO services across the LHIN. Engagement and support from both the senior and clinical leaders are critical to ensure support for improvement plans, mitigate barriers and supply an initial location to pilot PDSA tests of change. Sustainability of the service redesign is embedded in the governance structure, through accountability agreements, performance measurement and reporting and policy integration.

### ***Governance Structure***

The Governance structure assigns accountability for the implementation and sustainability for the LHIN BSO Action Plan to the Oversight Committee. The deliverables of the Oversight Committee will be to establish processes that support:

- ongoing assessment and evaluation of the LHIN BSO service model for its impact on the client, caregiver, healthcare provider (individual and organization) and system
- the transfer (and uptake as appropriate) and exchange of knowledge and skills to providers of behavioural support services.

As the Action Plan is implemented, the Oversight Committee will transition its oversight role to a Management Committee. This Management Committee will be accountable to the LHIN for the ongoing planning, coordination and performance of the HNHB LHIN Behavioural Support System.

### ***Accountability***

Expectations specific to the LHIN Behavioural Support delivery model will be incorporated into the existing accountability agreements the LHIN has with its health service providers. These will include BSO staffing models, roles and responsibilities (educations and capacity building), commitment to an ongoing learning strategy, requirement to participate in knowledge exchange forums and ongoing performance and reporting.

### ***Policy Development and Integration***

Standardized policies and procedures for the management of clients with responsive behaviours will be created to support the implementation of the changes that have been developed and tested through each of the improvement projects. These will include revised role descriptions, standardized training, best practices and documentation. New processes will build on existing practices and integrate new knowledge generated from the improvement cycles to improve the clients' experience.

## Sustainability of Service Redesign through Education and Knowledge Transfer and Other Mechanisms (continued)

### ***Improvement Plans, Performance Measurement and Reporting***

Stakeholder engagement will be obtained prior to the development of each improvement plan ensuring that clients/families, staff, physicians and organizations across sectors with expertise and/or those affected by a change will directly contribute to the development of a sustainable plan.

Terms of Reference will be developed for each improvement subcommittee with approval from the Oversight Committee. Each TOR will detail the goals, deliverables and accountabilities of the subcommittee. Each subcommittee will contain local leadership and include a consumer where appropriate and available. The improvement subcommittees will ensure improvements are integrated into performance so that new ways of working become the norm, resulting in positive outcomes for clients with responsive behaviours. Sustainability will be achieved by creating a clear link between the improvement plans and the organizations' vision and goals.

The use of PDSA rapid cycles of change will reduce waste and ensure improvements are identified, refined and then spread throughout the LHIN. Each improvement plan subcommittee will determine a sustainability plan, which includes knowledge sharing and ongoing data monitoring. As noted above, the ongoing data monitoring will be integrated into HSPs' quality improvement plans and service accountability agreements.

### ***Communication***

A communication plan will be a key component of the LHIN's BSO Action plan and will be developed to align with the cross-LHIN communication plan. Communication and learning strategies will be identified for each improvement plan to promote sharing of best practices, LHIN-wide spread and sustainability of the Action Plan.





## Knowledge Transfer

Knowledge transfer will successfully occur through alignment with the learning strategy and Action Plan by leveraging existing and new BSO resources to support uptake of new knowledge, protocols and best practices at the organizational and system levels. This new knowledge will be translated, adapted and tailored into existing structures and processes, resulting in new ways of practicing with improved health outcomes for clients and enhanced system performance.

The learning strategy will be applied at:

The Organizational level by:

- Building capacity for service providers such as primary care.
- Capacity building for community services and LTCH staff through mobile teams.
- Sharing best practices through planning tables, communities of practice, forums, etc.
- Supportive learning infrastructures, both human and technological, which will enable timely access to new knowledge and human resources to support and improve quality of care.
- Assessing readiness for improvement with staff regarding knowledge of the benefits of the improvement, local adaptability of the improved process and sustainability of the change.
- Mobile outreach teams (community and LTC) who will collaborate and share knowledge regarding best practices, innovation and resources to promote standardization and access to care.
- Translating, adapting and tailoring new knowledge into existing structures and processes.

The System level by:

- Standardization of protocols such as the development of pathways for seamless transitions between sectors.
- Communities of Practice, networks, forums and local tables who will share innovative ideas through the implementation of new research, point of care improvements and collaboration.
- The BSO Oversight Committee, guided by the improvement plans will evaluate the most effective and efficient use of health human resources and transfer this knowledge into action to ensure appropriate allocation of these resources to result in an improved client experience.

## Knowledge Transfer (continued)

### ***Capturing and Sharing Lessons Learned***

The LHIN Quality Improvement Facilitator in conjunction with the HQO coach and the Implementation Project Lead will identify and theme key learnings and share these with the BSO Oversight Committee, the Coordinating and Reporting Office (CRO) and other LHINs via knowledge exchange (KE) activities. Inter-LHIN knowledge transfer activities will be led by early adopter LHINs in collaboration with their 'buddy LHINs' (e.g., Waterloo Wellington, Erie St. Clair and South West LHINs) and undertaken via tele/video-conference and face to face meetings.

These activities will focus on best practices approaches to:

- Behavioural support system planning and redesign to support improved coordination.
- The roles and recruitment of health human resources to support an interdisciplinary approach across the system of care.
- Capacity building across the system to support sustainability.
- The management of clients with responsive behaviours.

Identifying similarities between the HNHB and buddy LHINs will enable knowledge transfer through common themes and supportive structures. Barriers to knowledge transfer will be identified to enable the development of strategies to integrate improvement plans into local context by other LHINs.







## Knowledge Transfer (continued)

### ***Partners for Knowledge Exchange and Capacity Building and their Successes***

Examples of partner collaborations to support capacity building are:

- Primary care providers:
  - Partnered with the LHIN in establishing a diabetic foot care program with high risk individuals. Sharing resources through a collaborative practice increased the programs capacity and sustainability.
  - Participation in a project piloting a risk screening tool to identify seniors at risk of poor health/hospitalization for refer to CCAC.
  - Participated in the development of the LHIN's Clinical Service Plan (CSP) through participating or leading Planning Advisory Groups.
- Successful Aging series - presentations led by RGP-Central with key note speakers from geriatric specialties who speak to community groups and stakeholder organizations regarding older adults' health challenges, how to self-manage with chronic conditions and when required, how to successfully navigate the health care system.
- LTCH Network Forum – biannual forums to advance education among LTCHs regarding current challenges in the LTC sector.
- Integrated Client Care Projects (ICCP) - led by CCAC, these are interdisciplinary quality improvement planning initiatives specific to client populations, (e.g., wound care, palliative care).
- Consumer participation in the HNHB LHIN BSO Project.
- HNHB LHIN Focus Group with front line staff from community and long term care regarding the service gaps, duplications and inefficiencies for clients with responsive behaviours.

Refer to Appendix C and D for partners for knowledge exchange and capacity building within the LHIN.

As a result of the above collaboration there is:

- Greater awareness among public and providers regarding system gaps and lack of coordination among services for individuals with responsive behaviours.
- Primary care providers are now actively engaged in HNHB LHIN-led activities.
- Identification of specific opportunities for improvement, including a greater focus on quality improvement initiatives.
- Enthusiasm among providers and consumers to participate in improvement planning activities.

## Deployment of HNHB LHIN Behavioural Support Staffing Resources

The HNHB LHIN BSO Service Delivery Model is based on achieving client/family centered care and addressing the client's needs along the continuum of care from clients initial contact with a health provider or health system for a behaviour issue to the client being stable with a viable care plan in their home (home in the community or a long term care home). BSO resources will be allocated to support the system redesign as follows:

### **LTCH BSO Staff:**

- BSO staffing designated for LTCHs will be deployed at five LTCHs across the LHIN (sites and number to be confirmed following resolution of LTCH issues raised with the CRO). The LHIN has 86 LTCHs across 7,000 square miles. Allocating staff into geographical hubs will improve responsiveness of team to respond to requests for behavioural support and foster capacity building and collaboration across health care sectors within their geographic area (Refer to Appendix H).
- Staff will be deployed to LTCHs within an interdisciplinary team model of care. Each team will include Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSWs). Nursing staff RN/RPN ratio will be 20/80.
- The LHIN-wide LTCH mobile model will have one registered nurse designated as the LTCH mobile Team Lead with accountability for the day to day operation of the teams in accordance with the service delivery model, as well as current LTCH policy, legislation and regulations.
- These staff will work collaboratively with the Community BSO Mobile Team for the purposes of establishing care processes and standards, knowledge exchange, training and performance measurement and evaluation.
- LTCH BSO interdisciplinary team will be deployed to other LTCHs throughout the LHIN to provide:
  - Episodic and/or crisis support for LTCH residents with behaviour crisis/ issues that the LTCH cannot manage.
  - Transitional support of residents with behaviour issues (or history of behavioural issues ) across care settings who require specialized support at the following key transition points from:
    - the community to a behavioural unit
    - a behavioural unit to end destination (return to a community or LTCH)
    - a LTCH behavioural unit to tertiary behaviour unit and repatriation back
    - a hospital to LTCH.
- Education, knowledge exchange and capacity building.





## Deployment of HNHB LHIN Behavioural Support Staffing Resources (continued)

### ***Additional Health Care Personnel:***

The LHIN projects allied health resources equivalent to 14.9 full time equivalent (FTE) positions will be allocated across the LHIN to support an interdisciplinary mobile care team response. To optimize funding existing resources will be leveraged to support the new mode. Projected staffing compliment consists of:

- Community Team Lead - Master Level Nursing or Social Worker (1 FTE)
- Community Team liaison coordinator (1 FTE)
- CCAC Intake Coordinator (1 FTE)
- Psychogeriatric Resource Consultants (2 FTE)
- Social Workers (2.4 FTE)
- Geriatric Service Workers (3 FTE)
- Nurse Practitioners (2 FTE)
- Registered Nurses (2.5 FTE)

The above staffing allocation is draft and will be further developed and adjusted by the Subcommittee for the Role and Responsibilities the Community Mobile Teams.

The additional health care staff will be deployed by HSPs to support the coordinated pathway identified in the action plans and clients experiencing crisis in the community:

- Resources will be assigned to CCAC to support a central referral and intake process.
- Resources will be assigned to work collaboratively with selected LHIN funded HSPs to provide crisis response to clients in the community

At initial implementation of the project the additional health care personnel will be assigned to three health provider agencies.

- The majority of the staff will be assigned to a community provider that provides services in three geographic areas of the LHIN (Dementia Alliance). This will allow the staff to be deployed easily.
- One staff will be assigned to the CCAC potentially to support the centralized intake process.
- Two staff will be assigned to a Hamilton Health Sciences Centre, as the LHIN expects these staff to be initially seconded into the project to lead the development of the team.

Please refer to Diagram 3 and Table 1 on the next pages for the LHINs improvement plans across the continuum of care.

BSO staff roles and responsibilities will be identified by the BSO Service Delivery Model Role and Responsibilities Subcommittee, which is currently being established.

# Diagram 3: Behavioural Supports Ontario Action Plan Tree Diagram

## Initial Focus of HNHB:

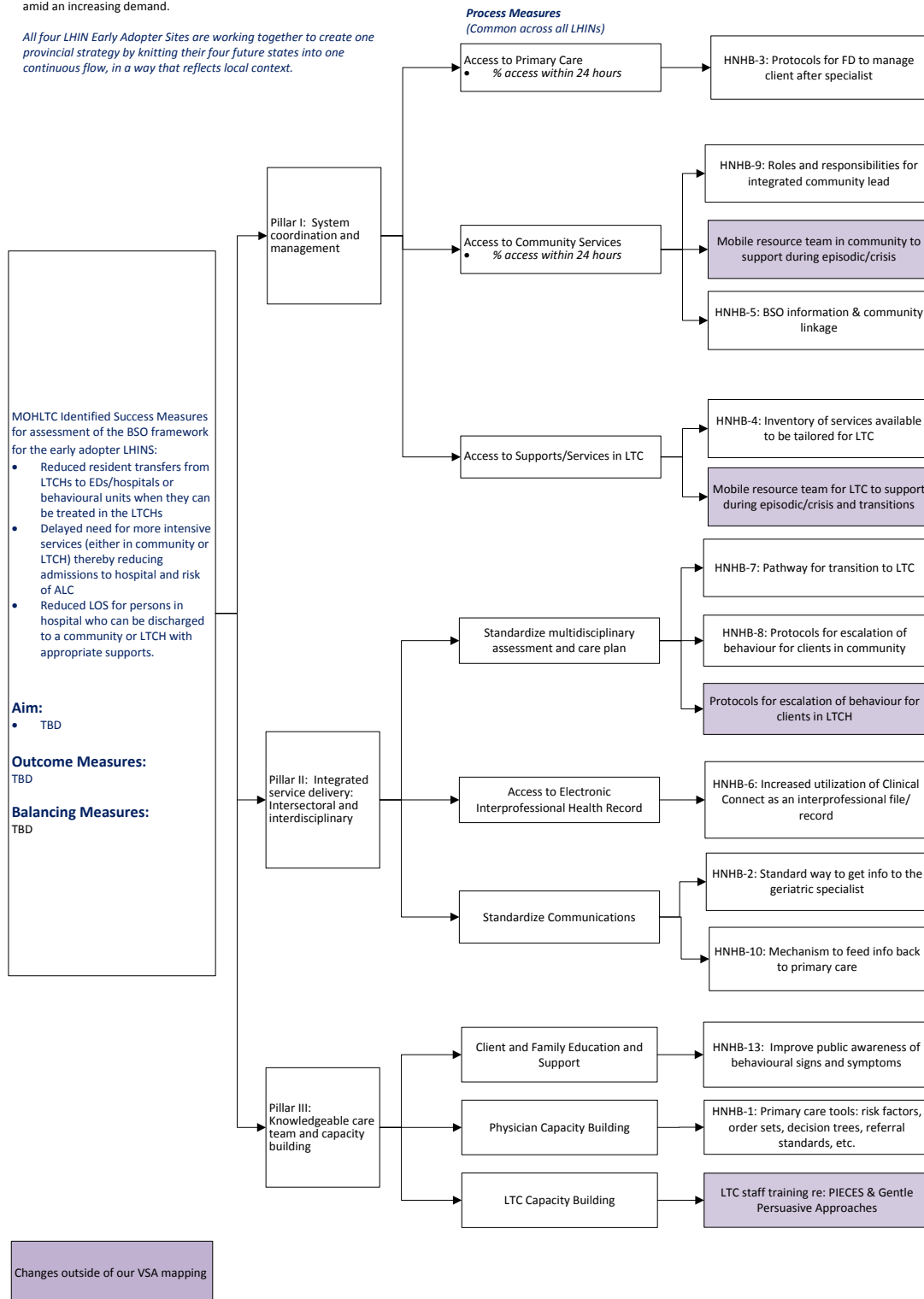
**Begins with:** Client with significant responsive behaviour in community  
**Ends with:** Client in @home@ (LTC or community) with viable care plan

Reason for Improvement: To improve the client and caregiver/family journey by providing seamless transitions across the continuum of care. To build capacity in an existing system of care; fostering sustainability amid an increasing demand.

All four LHIN Early Adopter Sites are working together to create one provincial strategy by knitting their four future states into one continuous flow, in a way that reflects local context.

## Change Ideas

(Specific to each LHIN)



In a tree diagram, reading left-to-right answers @how@, while right-to-left answers @why@



**Table 1: Draft Improvement Plans (in addition to VSM)**

		Reason for Improvement	Target Performance	Health Human Resource Allocation
Pillar 1: System Coordination and Management	Mobile crisis/outreach teams in the community to provide support for episodic/crisis management	Ensure timely access to a Behavioural Support interdisciplinary team resource for clients in the community who are in crisis  Crisis management in the community	Reduced avoidable ED visits  Client remains in their home with a viable plan of care and decreased anxiety for client/family  Improved client/family coping	Mobile interdisciplinary teams (NP, RN, SW, PSW, PRC) will be employed by a community agency and aligned to and work with existing teams in geographic hubs across the LHIN
	Mobile crisis/outreach teams in LTC to provide support during episodic/crisis management and transitions to and from LTC	Ensure timely access to a Behavioural Support interdisciplinary team resource for LTCH residents and staff for crisis management  Ensure smooth transitions to and from LTC/home to specialty behavioural units through standardized protocols and individualized care planning	Capacity building for LTCH and hospital staff  Reduced avoidable ED visits  Reduced ALC & hospital LOS  Client remains in the LTCH with a viable plan of care and decreased anxiety for client/staff/family  Improved client/family/staff coping  Smooth transitions to and from LTC	Mobile interdisciplinary teams (RN, RPN, PSW) will be hired by LTCHs, strategically located in 5 geographic hubs to ensure equal distribution across the LHIN

**Table 1: Draft Improvement Plans (in addition to VSM) (continued)**

		Reason for Improvement	Target Performance	Health Human Resource Allocation
Pillar 2: Integrated Service Delivery	Protocols for escalation of behavior for clients in LTCHs	Standardized and consistent protocols for management of responsive behaviors	Standard tools for staff to feel empowered to manage escalating behaviours	New BSO LTCH resources (RN, RPN, PSW) will develop, test and improve these protocols
		Capacity building for staff in LTC	Timely management of escalation of behaviours	
		Prevention and avoidance of injury	Prevention and avoidance of injury for staff and clients	
Pillar 3: Knowledgeable Care Team and Capacity Building	LTCH staff training re: PIECES and Gentle Persuasive Approaches	Capacity building for staff in LTC	Annual updates for existing staff	Mobile outreach (community and LTCH) teams will provide education and training for other LTCH staff as part of their role
		Standardized approach for clients with responsive behaviours in LTC	Orientation component for new staff	
			Clients will receive consistent approached in the management of behaviours	



## HNHB LHIN BSO Performance, Measurement and Evaluation Plan.

The Ontario Ministry of Health and Long-Term Care (ministry) identified the following three performance metrics as measures of success for the BSO Framework:

- Reduced resident transfers from LTC to acute or specialized unit for behaviours.
- Delayed need for more intensive services, reducing admissions and risk of alternate level of care (ALC).
- Reduced length of stay (LOS) for persons in hospital who can be discharged to a LTC Home with enhanced behavioural resources.

The BSO Data, Evaluation and Measurement Working Group has identified two types of indicators:

- Population-level indicators would be representative of high-level system outcome measures that would be comparable across LHINs.
- Process/tracking indicators could be LHIN-specific metrics that measure the development and impact of implemented health service coordination and delivery projects.

### ***Population-level indicators***

Population-level indicators would utilize existing hospital administrative data to measure and evaluate progress at a system level. An aim for these metrics would be to allow comparisons across LHINs. Indicators at this level mostly reflect the intermediate risk population where an older adult would experience crisis while living in the community or in a long-term care home.

### ***Hospital Administrative Data***

Indicators:

- Analysis for the following indicators will focus on (a) older adult patients who came to hospital from the community (i.e. were not transferred from another institution) and (b) residents transferred from long-term care homes.

Rationale:

- ED and inpatient hospitalization indicators identify older adults diagnosed with mental health, dementia or neurological conditions who sought or required intensive health care provision. By tracking where the patient came from (i.e. the community or LTCHs), resources can be allocated to address the needs of these individuals. In turn, improved patient care in the community or in LTC setting should reduce the need for hospital-based care. Discharge planning for higher intensity need patients should help reduce the time residents of long-term care homes spend as ALC in hospital.

*“For adults 65 years or older adults diagnosed with mental health, dementia or other neurological conditions” (known hereafter as “BSO Conditions”):*

- rate of emergency department (ED) visits made for BSO conditions per 1,000 ED visits for any condition made by persons 65 years of age or older
- rate of ED visits for BSO conditions per 1,000 HNHB LHIN residents 65 years of age or older
- rate of individuals making ED visits for BSO conditions per 1,000 HNHB LHIN residents 65 years of age or older
- rate of inpatient hospital discharges for BSO conditions per 1,000 inpatient hospital discharged for any condition made by people 65 years of age or older
- rate of inpatient hospital discharges for BSO conditions per 1,000 HNHB LHIN residents 65 years of age or older
- rate of individuals discharged from hospital per 1,000 HNHB LHIN residents 65 years of age or older
- acute and alternate level of care (ALC) lengths of stay for patients discharged to LTC
- % of inpatient discharged that spent time as ALC
- % of ALC days out of total inpatient days discharges
- Total # of ALC days amassed.

**Sources:**

- National Ambulatory Care Reporting System (NACRS)
- Discharge Ambulatory Care Reporting System (DAD)
- IntelliHEALTH ONTARIO, Ontario Ministry of Health and Long-Term Care. This Business Intelligence (BI) Tool is accessible to all LHINs.

**Challenges:**

- The BSO Data, Evaluation and Measurement Working Group is working towards establishing a standard definition for the older adult population coming into contact with the hospital system. This includes not only identifying an age cohort, but also a comprehensive list of conditions based on diagnostic information (ICD-10-CA codes) in the patient’s hospital record.
- Individuals exhibiting responsive behaviours and/or cognitive impairment would be more accurately captured using the Resident Assessment Instrument (RAI) set of tools as opposed to using ICD-10-CA codes. Currently, however, datasets that contain RAI data do not allow for the three provincially mandated measures to be addressed.
- Wait Time Information System (WTIS)-ALC data has recently been made available through iPort Access, Cancer Care Ontario. As such, it is not yet known how flexible the tool will be to leverage information for the BSO project.
- Not all LTC homes submit data to the Continuing Care Reporting System (CCRS). As such, it is not possible to make cross-LHIN comparisons using this dataset.







### ***Tracking/process indicators***

Tracking/process-level indicators would utilize existing data and also would require new data capture. Indicators of this type can be unique to each LHIN and can measure low, intermediate and high-risk individuals across the continuum of behavioural supports. Comparison of performance across LHINs might not be possible and/or appropriate using tracking/process indicators. Through the BSO initiative, several projects involving cross-sectoral collaboration and partnerships between health care organizations are being planned within the HNHB LHIN. Performance and evaluation metrics will be developed for these projects once they are closer to being operational. Community partner organizations such as the St. Joseph's Healthcare Hamilton-sponsored GMHO program, St. Peter's hospital and the HNHB CCAC are currently monitoring services they provide to older adults exhibiting responsive behaviours and/or cognitive impairment living in the community.

The HNHB LHIN acknowledges that understanding the patient, family and caregiver experience is an essential component of measuring and evaluating BSO initiatives. The LHIN will collaborate with the CRO, Health Quality Ontario (HQP) and the BSO Data, Evaluation & Measurement Working Group on the developing a process best suited to capturing these stakeholder perspectives.

### ***GMHO program***

- # of active patients by GMHO program location.
  - Breakdown by whether the patient is located in the community or in a long-term care home.
- # of individuals on waitlists by GMHO program location.
  - Breakdown by whether the patient is located in the community or in a long-term care home.

### ***St. Peter's Hospital – Geriatric Medicine and Geriatric Psychiatry***

- # of visits to physician clinics for geriatric medicine and geriatric psychiatry.
  - Data from previous fiscal years and projections for 2011/12 are available.

### ***HNHB Community Care Access Centre (CCAC)***

- # of clients with behavioural issues waiting for placement into long-term care homes.
  - Breakdown by where the client is waiting (i.e. in the community, in hospital, in another LTCH or out of the province).
  - Breakdown by clients waiting for placement by CCAC Branch.
- % of clients with behavioural issues waiting for placement into long-term care homes out of all clients waiting for placement.
- # of clients with behavioural issues not waiting for placement into LTCHs.
  - Breakdown by where the client is waiting (i.e. in the community, in hospital, in another long-term care home or out of the province).
  - Breakdown by clients waiting for placement by CCAC Branch.

### ***Business Intelligence (BI) Tool***

- Reporting systems utilized by each partnering organization.

#### Sources:

- GMHO program.
- St. Peter's Hospital – Geriatric Medicine and Geriatric Psychiatry.
- HNHB LHIN CCAC Client Health Related Information System (CHRIS).
- Resident Assessment Instrument – Home Care (RAI-HC).

#### Rationale:

- The data provided by partnering organizations provides insight into older adults in the living in the community or LTCHs that exhibit responsive behaviours and/or cognitive impairment. The services provided by these organizations help to prevent or reduce the need for more intensive health care for their clients or patients.

#### Challenges:

- Determining actual need in the community will continue to be a challenge. The data provided by partnering organizations provides a picture of need, but can only represent clients or patients that they have contact with.

### Baseline Data

The BSO Data, Evaluation and Measurement Working Group will be addressing the calculation of baseline data for this project. The period of time (e.g. fiscal year 2010-11) that baseline data represents is important as it will influence how performance is assessed. Further, future discussions will take place as to when meaningful and stable results could be expected as a result of implemented projects. For example, it is reasonable that increased efficiencies in identifying and diagnosing individuals exhibiting responsive behaviours and/or cognitive impairment could appear on the surface that more emergency department visits or hospitalizations are occurring. In actuality, however, an apparent increase in such hospital encounters could be the result of responsive behaviours and/or cognitive impairment being better identified and recorded in the data.

### In Conclusion

The HNHB LHIN Action Plan has identified strategies which will result in improvements in the quality of care and quality of life for clients with responsive behaviours. These strategies address the client's needs and support client and family-directed care along the continuum. Through the enhancement and reconfiguration of existing services the HNHB LHIN will create a LHIN-wide cultural shift which defines value and develops improvements as seen through the eyes of the client and their families and promotes formal partnerships and accountabilities between sectors and providers. This culture shift will be further strengthened through organizational leadership and LHIN-wide spread of innovation and best practices applied at the organizational, system and individual/client level while being tailored to meet local needs. Ensuring a sustainable system with improved access and positive outcomes for clients are the main aims of the HNHB LHIN Action Plan.





# Appendices

### Committee Membership

- Tom Hunter, Co-Chair, HNHB BSO Steering Committee, Board President Alzheimer Society of Niagara and Administrator Linhaven Home for the Aged, St. Catharines.
- Rebecca Repa, Co-Chair, HNHB BSO Steering Committee, President St. Peter's Hospital, HNHB LTCH Council.
- Julia Baxter, Manager, Geriatric Mental Health Outreach, St. Joseph's Healthcare Hamilton and Halton Geriatric Mental Health Program.
- Jane Beamer, Manager, T.R. Adams Regional Centre Dementia Care.
- Lisa Bishop, Executive Director, Community Addiction and Mental Health Services of Haldimand Norfolk.
- Mary Burnett, CEO, Dementia Alliance.
- Barb Busing, VP, Clinical Operations, HNHB CCAC and co-Chair HNHB LHIN ALC Steering Committee.
- Robert Gadsby, Chair – Family Council Network Four (FCN-4).
- Shawn Gadsby, President and CEO, St. Joseph's Villa, Hamilton.
- Kathryn Leatherland, Director, Client Services HNHB CCAC.
- Dr. Sharon Marr, Chair, HNHB Regional Geriatric Program – Central and Head, Division of Geriatric Medicine, McMaster University.
- Dominic Ventresca, Executive Sponsor, HNHB BSO Project, Director, Seniors Services, Region of Niagara and co-chair, HNHB LTCH Network.

### ***HNHB LHIN Staff Committee Members***

- Brain Bailey, Information Controller.
- Laurie Fox\*, Implementation Project Lead.
- Rosemary Frketich, BSO Improvement Facilitator.
- Lisa Muraca, Advisor, Funding and Allocation.
- Shirley Stewart, BSO Advisor Planning.
- Rosalind Tarrant, BSO Project Lead.

\*Joined the team November 7, 2011



### ***HNHB LHIN CCAC Data***

As of September 12, 2011 the HNHB CCAC reported:

- 947 clients with behavioural issues waiting for placement into LTC, of these:
  - 326 (or 35%) were living in the community (i.e. in their homes)
  - 504 (or 53%) were living in a LTCH (waiting transfer to another LTCH)
  - 114 (of 12%) were waiting in hospital for an alternate care setting
- 238 CCAC clients with behavioural issues not waiting for placement into LTC:
  - 193 (or 81%) are living in the community (i.e. in their homes)
  - 40 (or 17%) are living in a LTCH.

### ***Emergency Department Data***

- In 2010/11, there were 379 emergency department (ED) visits made by adults 65 years or older that had a most responsible diagnosis of dementia or Alzheimer's disease. An analysis of this data revealed the following highlights:
- In 264 ED visits (or in 70% of visits), the patient came to the ED from home, of which:
  - 145 (or 55% of visits) were discharged home
  - 99 (or 38% of visits) were admitted to hospital
- In 86 ED visits (or in 23% of visits) the patient was transferred from a LTCH to the ED, of which:
  - 57 (or 66% of visits) were discharged home
  - 26 (or 30% of visits) were admitted to hospital.

### ***Geriatric Mental Health Outreach (GMHO) Program***

As of September 8, 2011:

- There were 1,418 active patients, of which:
  - 967 (or 70%) reside in the community (i.e. in their homes)
  - 451 (or 30%) live in LTCHs
- There were 358 patients on wait lists, of which:
  - 276 (or 77%) reside in the community (i.e. in their homes)
  - 82 (or 23%) live in a LTCH

### ***Hospital Discharge Data***

In 2010/11, there were 288 hospital discharges for adults 65 years or older who had a most responsible diagnosis of dementia or Alzheimer's disease. An analysis of this data revealed the following highlights:

- In 208 discharges (or 72% of discharges) the patient came to the hospital from home, of which:

#### Discharge Destination:

- 97 (or 47%) were discharged to continuing care
- 57 (or 27%) were discharged home with supportive services
- 35 (or 17%) were discharged home without supportive services

#### Alternate Level of Care (ALC):

- 131 (or 63%) spent time as ALC. These cases spent:
  - A total of 5,329 days as ALC
  - An average of 41 days as ALC
  - 71% of their total time in hospital as ALC.
- In 50 discharges (or 17% of discharges) the patient was transferred from a LTCH to the hospital, of which:

#### Discharge Destination:

- 24 (or 48%) were discharged to continuing care
- 13 (or 26%) were discharged home with supportive services
- 9 (or 18%) died while in hospital

#### Alternate Level of Care (ALC):

- 29 (or 58%) spent time as ALC. These cases spent:
  - A total of 1,016 days as ALC
  - An average of 35 days as ALC
  - 72% of their total time in hospital as ALC.

## Appendix C: Current Structures/Programs to Support the Behavioural Support Project

***St. Joseph's Healthcare, Hamilton (SJHH) Geriatric Psychiatry Services*** provides regional specialized geriatric psychiatric care for persons with moderate to severe dementia and complex behaviours, and is linked to four community-based mobile geriatric mental health outreach programs. The outreach programs are mandated to provide collaborative shared care to seniors with complex mental health, addiction and behavioural issues living in independent settings, retirement, supportive housing or LTCHs. SJHH's outreach teams, which include PRCs, are systems and educational/learning resources working collaboratively with other providers to build capacity across the continuum of care to meet the complex needs of seniors and their families while providing specialized assessment, consultation, treatment, short-term specialty case management and intervention to communities throughout the HNHB LHIN area, in Halton and northwest Mississauga (Mississauga Halton LHIN).

***The T. Roy Adams Regional Centre for Dementia Care (BSU), Specialized Geriatric Community Re-engagement Program and Overnight Respite Program*** provides interdisciplinary assessment, inpatient treatment and respite care to individuals with a diagnosis of dementia whose behaviours cannot be managed in their present location in LTCHs, community or acute care and adjusts their plan of care so they can be repatriated to their preferred and appropriate care setting. The program's resources has indepth knowledge and expertise to enable capacity building and knowledge exchange.

***Regional Geriatric Program- Central (RGP)*** is affiliated with McMaster University and sponsored by Hamilton Health Sciences Corporation (HHSC). A range of specialized geriatric services are offered across the HNHB LHIN, including interdisciplinary teams with expertise in the care of the elderly, across the continuum of care. Most programs have a range of health care team members, including a specialist in geriatric medicine and/or psychiatry. The RGP works to promote evidence-based healthcare that optimizes the health, independence and quality of life of frail seniors. The RGP focuses on education, capacity building, knowledge exchange and translation, service improvement and collaboration across three LHINs, including the HNHB LHIN.

***HNHB Geriatric Access and Integration Network (GAIN)*** is a formal network that supports strategic and purposeful collaboration among stakeholders from across the HNHB LHIN area and across sectors. Stakeholders include specialized geriatric services providers, educators, funders, policy makers and researchers affiliated with seniors' health and community programs.

## Appendix C: Current Structures/Programs to Support the Behavioural Support Project (continued)

**St. Peter's Hospital, Behavioural Support Units (BSU)** provides LHIN-wide access to an inpatient, interdisciplinary behavioural health program for adults who exhibit challenging behaviours. This program collaborates with T. Roy Adams Centre in Niagara, and has established a formal mentorship and referral relationship for tertiary complex behavioural support. The program at St. Peter's also provides consultation with LTCH staff for clients returning from the tertiary centre to ensure continuity of care.

**Centre for Healthy Aging (CHA) at St. Peter's Site of Hamilton Health Sciences** offers ambulatory clinics, outreach, and therapy to older adults throughout Hamilton. Specialty services include geriatric medicine, geriatric psychiatry, osteoporosis, physiatry, physiotherapy, occupational therapy, speech language pathology, dietetics, chiropody, and complex seating. The Geriatric Psychiatry and Geriatric Medicine clinics engage a physician-case manager model to assess and treat patients with cognitive, physical and/or functional impairments. Outreach geriatric medicine and geriatric psychiatry services are also provided to patients in their homes or long-term care facilities. OTs2Go and Independence at Home programs provide community based services for falls assessment and prevention.

**Alzheimer Societies of Brant, Haldimand Norfolk, Hamilton, Halton and Niagara** are primary sponsors of Psychogeriatric Resource Consultants (PRCs) within the HNHB LHIN. The PRCs consult Adult Day Programs and LTCH on responsive behaviours and other geriatric issues. The four Alzheimer Societies also offer several programs and services to assist caregivers in relieving some of the stress and challenges associated with caring for people who have Alzheimer's disease and other dementias, and their educators provide specialized training to other health professionals on dementia and responsive behaviours (e.g. FHTs and medical students).

**LHIN 4 Dementia Network's** purpose is to further develop; an integrated system of care, which includes service delivery, education, advocacy and research for persons with dementia and their care partners. Membership includes representation from the care continuum including primary care, specialized geriatric services and the system of services that support persons affected by dementia.

**Niagara Geriatric Services Collaborative** provides an organizational framework for shared accountability to enable multiple service agencies to integrate the delivery of geriatric services to persons in Niagara. This intersectoral collaborative includes acute hospitals, specialized geriatric services, mental health and addition agencies, community support services (CSS), supportive housing agencies, LTCHs and the Community Care Access Centre (CCAC).



## Appendix C: Current Structures/Programs to Support the Behavioural Support Project (continued)

**Niagara Geriatric Complex Case Resolution (NGCCR) Forum** is an inter-agency collaboration model that was established as a mechanism to provide timely multi-agency reviews of cases with extraordinary care/service challenges or significant transitioning risks. The NGCCR Forum provides a service coordination function and a customized plan of care for clients who are served by two or more agencies. This often results in opportunities for system-wide improvement and coordination. The core team is comprised of representatives from CCAC, Community Mental Health, Niagara Health System (NHS) - Geriatric Assessment Program, SJHH GMHO, Seniors Community Programs, and T. Roy Adams Centre. Other HSPs are invited as needed.

**HNHB Community Care Access Centre (CCAC)** provides '3-D' training (delirium, dementia and depression) for CCAC staff and community support services organizations whose staff works with clients with responsive behaviours.

**Centre for Healthy Aging and HHS Centre with Geriatricians - Southern Network of Specialized Care** provides supports to those aging with a developmental disability that also experience mental health/challenging behavioural issues.

**The Geriatric Assessment Unit based at the Greater Niagara General (GNG)** site of Niagara Health System (NHS) in Niagara Falls, provides interdisciplinary, comprehensive geriatric assessments, treatment and rehabilitation services. Services are provided in an inpatient unit, outpatient clinics, and community-based clinics and in-home.

**The Specialized Geriatric Services program of Community Addiction and Mental Health Services of Haldimand and Norfolk** provides interdisciplinary, clinical assessment, consultation, treatment, education and practical supports seniors with complex mental health issues. Clients are seen in their own homes, retirement homes, LTCH, hospitals and in community-based settings.

**The Geriatric Mental Health Case Management service, Community Mental Health program, Public Health Department, Region of Niagara** serves seniors with serious and ongoing mental illness who live in the community and require education/assistance with life skills and activities of daily living and also need help accessing services.

**HNHB LHIN Sub-LHIN Community Collaboratives** have been convened across the HNHB LHIN to assume responsibility for intersectoral service planning, coordination and integration in the community sector. These collaboratives will be directed to incorporate the BSO target population, their service needs, and best practice models of care into their planning, coordination and integration processes over the next three months.

## Appendix D: Examples of LHIN Health Service Providers working collaboratively to improve system coordination

***Integrated Program for Complex Care across for the LHIN:*** HNHB LHIN hospitals and the CCAC have agreed to adopt new complex care definitions (restorative, behavioural and complex medical), that complex care beds are system beds and not hospital site-specific beds, and that access to complex care services will be through a centralized process.

***Integrated Regional Vascular Surgery Model at multiple sites:*** HNHB LHIN hospitals that provide vascular services have agreed to a regional model that includes a LHIN-wide Vascular Surgeon Group with cross privileges, surgeons moving to the patient and to the siting of regional-funded beds that are intended to facilitate a “No Refusal Policy”.

***Transportation Services - LHIN-wide Service Delivery Model:*** Agreement among LHIN-funded transportation agencies to participate in a LHIN-wide service delivery model with agreement from three agencies to enter into a Memorandum of Understanding.

***Behavioural Units:*** This partnership between St. Peter’s Hospital and T. Roy Adams Centre works together to manage individuals with responsive behaviours that need the resources of a behavioural unit.

***St. Joseph’s Geriatric Mental Health Outreach Program (GMHO):*** These teams collaborate with provider partners to support staffing secondment opportunities across sectors (LTCH, CSS, acute care, crisis and CCAC) to build capacity and foster an interdisciplinary approach to care. For example, GMHO has a partnership with NHS to provide Special Geriatric Services in the Niagara community which has increased access and decrease wait times for residents. In addition, SJHH GMHO has a formal partnership agreement with Halton ADAPT to offer integrated geriatric addiction assessment and support services.

***HNHB Nurse-Led Outreach Team (NLOT) to LTCH:*** The NLOT has agreed on a service model across LHIN LTCHs, collaborated on a quarterly performance report, agreed to target six main diagnoses, and identified capacity building strategies, including the introduction and provision of education to all LHIN LTCHs (86) on a pneumonia care pathway.

***Primary Care Providers:*** Primary care providers are currently participating in a project piloting a risk screening tool to identify seniors at risk of poor health/hospitalization for referral to CCAC.

***LTCH Network Forum:*** This biannual forum advances education among LTCHs across the HNHB LHIN regarding current challenges in the LTC sector.

## Appendix D: Examples of LHIN Health Service Providers working collaboratively to improve system coordination (continued)

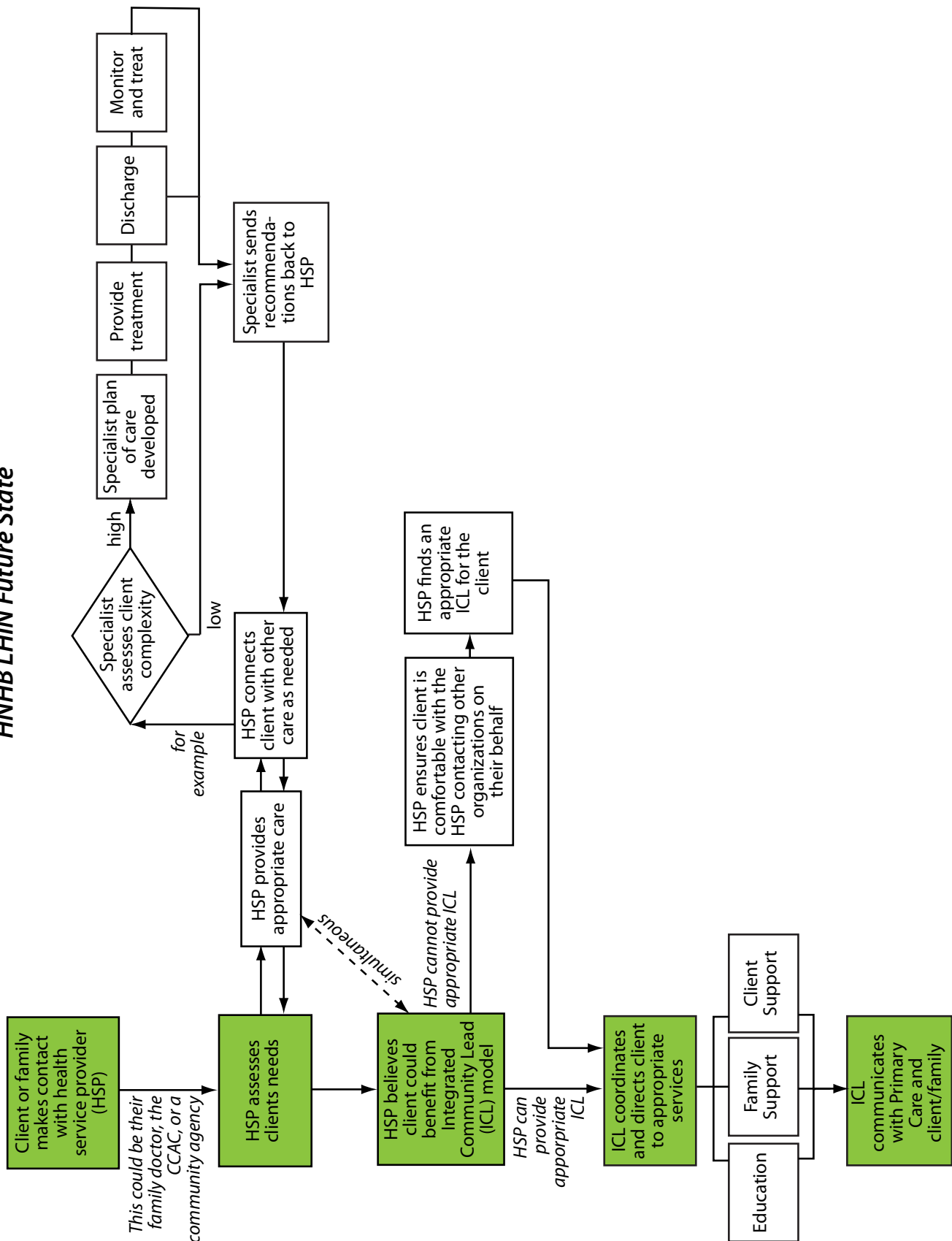
***Intensive Geriatric Support Worker (IGWS) Model of Care:*** The IGSW model was introduced in Haldimand Norfolk, and has been expanded to Brant and involves interagency collaboration (Community Addiction Mental Health, Alzheimer Society, CCAC, Grand River Community Health Centre, Brant Community Healthcare System)

***St. Peter's Hospital and T. Roy Adams, Community LTCH Behavioural Unit:*** See Appendix C for information.

***Niagara Geriatric Complex Case Resolution (NGCCR) Team:*** See Appendix C for information.

***Integrated Assisted Living and Wellness Programs for High Risk Seniors:*** Based in Niagara, these cross-sector partnerships have collaborated to create comprehensive, integrated and interdisciplinary service delivery models to support a common client population - high risk seniors living in the community. Partners include housing, education (a college program in applied health sciences), hospitals and the community health sector (i.e., supportive housing, assisted living (personal support, homemaking), adult day service, transportation, CCAC, meals on wheels, primary care, community mental health, etc.

***Psychogeriatric Resource Consultants (Alzheimer Society and St. Joseph's sponsored):*** They have created LTC-based PIECES Networks to build and sustain staff capacity, championed the development and use of learning aids, and offered creative learning opportunities to CCAC, assisted living and adult day program staff.





## Appendix F: Existing Knowledge Transfer Structures/Pathways

The SHRTN Collaborative is a network of networks – a partnership that includes the SHRTN Knowledge Exchange, the Alzheimer Knowledge Exchange (AKE) and the Ontario Research Coalition (ORC). These three partners work together to improve the health and health care of seniors in Ontario.

The Alzheimer Knowledge Exchange (AKE) is a network of people dedicated to improving the quality of life for persons with Alzheimer disease and related dementia. The AKE promotes and supports a knowledge exchange interface amongst researchers, educators, care providers (paid and non-paid), policy makers and stakeholder organizations working in dementia-related research, policy or care.

The Advanced Gerontological Education (AGE), located at St. Peter's Hospital and supported in part by RGP-Central, is a not-for-profit social enterprise that provides a variety of educational products to health care and social service workers who care for older adults accessing services offered by the care sector in the Hamilton community and across Canada.

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

National Initiative for the Care of the Elderly (NICE) is an international network of researchers, practitioners and students dedicated to improving the care of older adults, both in Canada and abroad.

## Appendix G: Performance, Measurement and Evaluation Plan: Future State

The HNHB LHIN is in a unique position insofar as we can leverage the HNHB LHIN Integrated Decision Support (IDS) tool to link community, ED, acute inpatient, and inpatient mental health data. For example, the CCAC assesses clients for a range of responsive behaviours and cognitive impairments using the Resident Assessment Instrument – Home Care (RAI-HC) assessment tool. CCAC data is submitted to IDS and can be analyzed to identify individuals who exhibit responsive behaviours and cognitive impairments not only to understand their interaction with the CCAC, but also to track them as they visit EDs or have inpatient hospital stays at any HNHB LHIN acute hospital. This initiative is near realization in upcoming weeks.

Current initiatives undertaken by the IDS team show promise in tracking individuals throughout the behavioural supports continuum—from assessment of responsive behaviours and/or cognitive impairment at the CCAC to admission to an specialized inpatient mental health facility. Ongoing discussions between the HNHB LHIN and the IDS team will determine the time frame for the availability of this report.

Indicators – “For CCAC clients diagnosed with mental health, dementia or other neurological conditions”:

- rate of CCAC service events for BSO conditions per 100 service events for all conditions
- rate of ED visits for BSO conditions per 100 ED visits for any condition
- rate of individuals that make ED visits for BSO conditions per 100 CCAC clients
- rate of inpatient hospital discharges for BSO conditions per 100 inpatient discharges for any condition made by CCAC clients
- acute and alternate level of care (ALC) lengths of stay for CCAC clients
- % of hospital discharges that spend time as ALC
- % of ALC days out of total inpatient days discharges
- total ALC days amassed

Sources:

- HNHB LHIN CCAC Client Health Related Information System (CHRIS)
- Resident Assessment Instrument – Home Care (RAI-HC)
- NACRS
- DAD
- Ontario Mental Health Reporting System (OMHRS)
- Business Intelligence (BI) Tool:
- HNHB LHIN IDS

## Appendix G: Performance, Measurement and Evaluation Plan: Future State (continued)

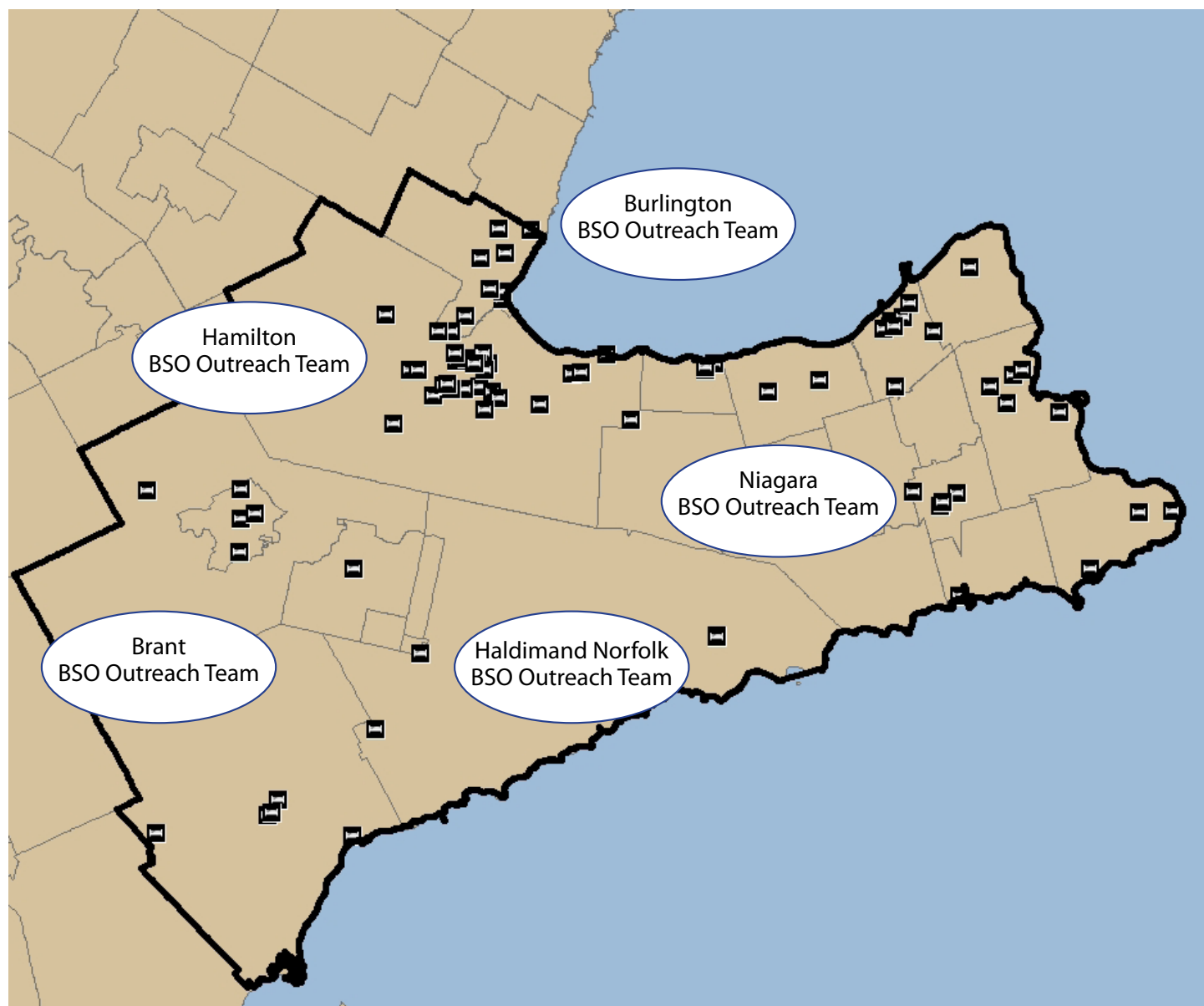
### Rationale:

- Identifying older individuals with behavioural issues and/or cognitive impairment using the RAI-HC tool is acknowledged by the BSO Data, Measurement and Evaluation Working Group as being more appropriate than using ICD-10-CA codes. From this departure, following an individual through his or her journey through the health care system would allow for a deeper analysis to be conducted at each stop along the way. Such analyses on a cohort of individuals would allow for the investigation of opportunities where improved and more efficient health care can be provided.

### Challenges:

- Following an individual through his or her journey through the health care system requires an assessment by the CCAC to be conducted; without this assessment, the individual can be neither identified, nor tracked.
- Requires technical configuration of the IDS system to make CHRIS data available for ad hoc analyses to end-users. The feasibility of implementation has been discussed with the IDS team and the HNHB LHIN is currently gathering the information required to move forward with this initiative.
- The collection and processing of OMHRS data is a current initiative of the IDS team. The HNHB LHIN confirmed with the IDS team that OMHRS data will be made available for analysis in the upcoming weeks. Phase 1 of implementation will be limited to data provided from St. Joseph's Healthcare-Hamilton which is a major tertiary centre for mental health the HNHB LHIN lead for hospital-based mental health. The time frame for being able to track those patients who first make contact with the health care system at the CCAC and eventually get admitted to a specialized inpatient mental health facility has not been determined.

## Appendix H: Distribution of LTC homes and BSO Mobile Team Resources



Total BSO positions to be distributed across HNHB LHIN:

- 6 Registered Nurses
- 13 Registered Practical Nurses
- 12 Allied Health Professionals
- 22 Personal Support Workers





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