Champlain **LHIN**

Champlain Behavioural Support System Action Plan

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Ontario
Local Health Integration Network

Champlain LHIN

Tel: 613.747.6784

Toll-free: 1.866.902.5446

Fax: 613.747.6519

1900 City Park Drive, Suite 204, Ottawa, Ontario K1J 1A3

www.champlainlhin.on.ca

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Executive Summary

Introduction

The Champlain LHIN received close to $3,800,000 in annualized funding to develop a regional action plan towards the implementation of a support system for older adults with responsive behaviours. This project is part of the larger provincial initiative (Behavioural Supports in Ontario [BSO] Project) with a total investment of $40,000,000.

The action plan is a product of extensive work completed by the Champlain Behavioural Support System (CBSS) Project Team in November and December 2011.

The Care Story

Bill and Theresa Thomas have been married for 58 years. They live in their home in Embrun, and their three children live in town. Bill was diagnosed with Alzheimer's disease three years ago. For the past three days, he has become very agitated and aggressive towards Theresa and is refusing to take his medications. Theresa is feeling really discouraged.

This evolving care story sets the context for the re-design of the Champlain Behavioural Support System (CBSS). As demonstrated in other high performing healthcare systems[1], the sharing of a compelling care story can be a powerful tool to maintain a person-centred focus in health system re-design[2].

Planning inputs for the CBSS re-design include:

- *Planning initiatives that preceded the launch of the BSO project,*
- *Dialogue among* **CBSS Project Team** *members, which includes stakeholders from across Champlain, and*
- *A two-day, value stream mapping* exercise with service providers identifying key opportunities for system improvement*

The care story is used throughout this planning process to maintain a focus on the needs of older adults and their caregivers who will benefit from an improved CBSS.

** = "A value stream can be defined as all the steps – both value added and non value added – required to take a product or service from its raw materials state into the waiting arms of a happy customer."*[3]

The Need

There is a pressing need to improve the CBSS. In their current settings, many older adults with responsive behaviours lack the support needed to address their behaviours. This can result in an escalation of the responsive behaviours, which may lead to an emergency response and possibly an admission to hospital. Often, the individual's responsive behaviour is exacerbated in this unfamiliar setting, which increases the chance of the individual being designated Alternate Level of Care (ALC). Once in ALC, the individual has an increased likelihood of a longer stay than patients without responsive behaviours. All the while, the root cause (responsive behaviour) is unaddressed.

[1] See Baker et al High Performance Health Systems such as, Jonkjoping and the story of Esther available at http://www.longwoods.com/content/20133

[2] Leading Lean: A Canadian healthcare Leaders Guide accessed on Dec. 3, 2011 at http://www.healthsectorstrategy.ca/downloads/HQ_vol12_no3_Fine.pdf

[3] http://lssacademy.com/2008/02/08/value-stream-mapping-overview/

The Response

The re-design of the CBSS is a multi-year planning and quality improvement initiative to address this need. The initiative involves addressing improvements in three pillars of the system:

1) *System Coordination and Management*
2) *Integrated Service Delivery, and*
3) *Knowledge Exchange and Capacity Building.*

The initiative was launched with a new investment of annualized funding targeted at providing:

- *Nursing and personal support workers within the LTCH sector ($2.57M), and;*
- *Additional healthcare personnel ($1.21M) "…to provide services as members of mobile behaviour teams, with responsibilities across the care continuum, as team members in behavioural support units within LTC homes, and/or community services in support of the implementation of the BSO project."*[4]

This Action Plan identifies eight **Action Areas** (see below) as the best first steps to improve the CBSS. The vision of a high performing CBSS will be realized with:

- *The integrated system structure of the CBSS Project Steering Committee*
- *The enhancements of services through new resources and capacity building within existing resources*
- *The identification of the Royal Ottawa Mental Health Care Group (The Royal) to act as the lead agency for the CBSS, coordinating the new system enhancements across Champlain.*

The intended outcomes of the CBSS are to ensure that those with responsive behaviours, like Bill, are provided the right support at the right time and place to reduce the negative impact of responsive behaviours on their quality of life:

- *Keeping clients in a preferred setting*
- *Reducing inappropriate transfers to emergency departments / hospitals and more intensive settings*
- *Delaying the need for more intensive services, and*
- *Reducing inappropriate lengths of stay in hospital.*

[4] Schedule "F", Terms and Conditions for additional healthcare personnel, appended to MOHLTC letter re: Amendment to the Ministry-LHIN Performance Agreement 2010-2012 – New Behavioural Staffing Resources for the BSO project.

Action Areas

The improvement of the CBSS is based on three pillars and eight action areas:

Pillar 1: System Coordination and Management

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

Action Area 1	**Improve System Integration** through a system-wide review and re-alignment of existing information and referral resources.
Aim	Improve access to information - when and where one needs it - to facilitate informed choices about supports. Wherever one turns for support, s/he will promptly be directed to supports that meet the need(s).

Action Area 2	**Improve System Integration** through a system-wide review and re-alignment of existing client assessment and information exchanges (client care file, patient record).
Aim	• Decrease the number of repeat assessments and histories so the client spends more time getting the support needed. • Increase access to important and timely information at the point of care, enabling the care team to co-manage the care plan more effectively, whereby the client experiences greater continuity.

Action Area 3	**Improve system integration** through a review and redevelopment of an integrated, wrap-around response (all services work together, in and out of hospital, to contribute to the individual's care plan) that enhances transitions at the inpatient point of care.
Aim	• Through a more effective partnership between community and inpatient services: o *Decrease the number and duration of inappropriate admissions to hospital related to responsive behaviours.* o *Decrease the duration of appropriate hospitalizations.* • Explore a better response to younger clients with neuropsychiatric disorders or acquired brain Injury, who experience responsive behaviours and are often hospitalized as a last resort - even though the hospital environment does not meet their needs.

Pillar 2: Integrated Service Delivery

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

Action Area 4	**Improve Interdisciplinary Service Delivery** through review and re-alignment of existing community services.
Aim	Leverage current service resources so a prompt response is delivered in the community that addresses response behaviours and averts escalation to a crisis. *There will be a new investment of $695K to hire healthcare personnel to respond to this need.*

Action Area 5	**Improve Interdisciplinary Service Delivery** through enhancing resources in the LTCH sector to allow for prompt. on-site responses to responsive behaviours and build capacity across the LTCH sector.
Aim	• Improve the ability to address responsive behaviours in the LTCH sector by enhancing services and building capacity • Reduce the escalation of responsive behaviours and reduce the need for emergency responses or potential hospitalization. *There will be a new investment of +$2.3M to hire nurses and personal support workers in LTCH to respond to this need.*

Action Area 6	**Improve Interdisciplinary Service Delivery** through the establishment of a Specialized Behavioural Support Unit (SBSU).
Aim	• Enhance the range of services by creating one SBSU in Champlain that can respond to individuals with highly challenging responsive behaviours who require longer periods of stabilization. • Effectively stabilize the individual's behaviour and support the transition to an appropriate residential environment. *There will be a new investment of +$749K to hire nurses, personal support workers and other healthcare personnel to establish the SBSU in an existing LTCH setting.*

Pillar 3: Knowledge Exchange and Capacity Building

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

Action Area 7	**Improve capacity building** through enhancing engagement, knowledge exchange and capacity building in the primary healthcare sector.
Aim	• Improve knowledge exchange and engagement between the primary healthcare sector and resources for responsive behaviours. • Improve responses to people with responsive behaviours within the primary healthcare setting so they and their caregivers can make better choices and have improved access to related support.

Action Area 8	**Improve capacity building** through a review and re-alignment of current capacity building initiatives to meet the enhanced needs of current and new staff within the LTCH and community sectors.
Aim	• Improve knowledge exchange and capacity building targeted at effective management of responsive behaviours • Prepare new staff to meet core competencies for the CBSS • Create sustained opportunities for service learning that expand from the CBSS across the LTCH and community sectors.

Next Steps

Between December 2011 and March 2012, the LHIN will work with the regional lead (The Royal), and all service partners to implement the Action Plan. This will include:

- *Identifying specific resource allocations to be made available to each LTCH across the region, based upon number of residents*
- *Defining the roles, core competencies and indicators of success for all new and re-designed services within the CBSS*
- *Developing a new partnership agreement between The Royal and the Peter D. Clark Centre**
- *Developing revised protocols and partnerships between The Royal, LTCHs, and all appropriate partners**
- *Developing revised protocols and partnerships between community psychogeriatric service providers and all appropriate partners*
- *Developing revised accountability agreements, where appropriate, for all partners in the CBSS*
- *Hiring new staff associated with the enhancements who meet core competencies related to the new roles and ensure access to services in French, as required**
- *Providing skill development and training for the new and current staff consistent with their new roles.*

** = The development of the SBSU (Action Area 6, above) will be complemented by an LTC-outreach enhancement in a Francophone milieu through Action Area 5 to ensure access to enhanced level of service in French.*

Introduction

Older people with cognitive impairments due to mental health problems, dementia, or other neurological conditions often exhibit responsive or challenging behaviours such as aggression, wandering, physical resistance and agitation. These behaviours are a major source of distress to the person with the behaviour, their family and/or caregivers and others providing support.

We call this behaviour "responsive," because it is a reaction to circumstances related to the person's condition or a situation in his or her environment – not random, meaningless aggression or agitation. People with responsive behaviours and their caregivers need high levels of support, but sadly, it is often inadequate or non-existent. The number of people with cognitive impairment is growing, placing further strain on individuals and the healthcare system. Fortunately, solutions are within our reach.[5]

The Behavioural Supports in Ontario (BSO) Project is a collaboration among the 14 Ontario Local Health Integration Networks (LHINs), Alzheimer Society of Ontario, Health Quality Ontario and Ministry of Health and Long-Term Care (MOHLTC). It aims to improve the lives of older Ontarians with responsive behaviours associated with complex and challenging mental health, dementia or other neurological conditions living in long-term care homes (LTCHs) or in independent living settings.

The MOHLTC recently announced $40M of funding for BSO whereby each of the LHINs received funding and in-kind resources to support system change - both at the LHIN regional level and across the province. Through this initiative, each LHIN will apply quality improvement strategies to inform tailored plans of action for their region.

The Champlain LHIN is investing $3,785,900 to enhance services for Champlain seniors with responsive behaviours by investing in local initiatives that will improve their care.

The *Champlain Behavioural Support System Action Plan* provides direction for the effective use of these resources, and guides system re-design efforts to improve the lives of people with responsive behaviours and their caregivers.

"We know Ontario's population is aging and that the number of seniors with dementia and other complex health needs is going to increase. Patients deserve to be managed with sensitive care. The Behavioural Supports Ontario Project – the first of its kind in Canada and only one of a handful in the world – will support this vulnerable population."[6]

- Deb Matthews
Minister of Health and Long-Term Care

[5] Ontario Behavioural Support System Newsletter, January 2011, http://www.akeresourcecentre.org/BSOResources

[6] Champlain LHIN press release, August 2011, http://champlainlhin.on.ca/Page.aspx?id=6242

Context

The Care Story

An effective way to maintain a person-centred focus in health system design is to frame all planning dialogue in the context of a compelling and realistic care story.[7] With this in mind, the initial planning meeting of the CBSS Project Team began with a review of Bill's care story. Throughout the planning process, participants often reflected on Mr. and Mrs. Thomas to ask "How would the Thomases feel about the current supports and the re-designed system?"

Planning participants were asked to think of Bill as their own family member to ensure planning topics stay focused on the client's best interest. While the initial care story was brief, subsequent dialogue among project team members expanded the story, bringing Bill to life, and serving as a constant reminder of the reason for this important work. The initial care story was:

Bill and Theresa Thomas have been married for 58 years. They live in their home in Embrun, and their three children live in town. Bill was diagnosed with Alzheimer's disease three years ago. For the past three days, he has become very agitated and aggressive towards Theresa and is refusing to take his medications. Theresa is feeling really discouraged.

Re-telling Bill's story at the Champlain value stream mapping* exercise (facilitated by Health Quality Ontario) led to the following value statement as a framework for planning:

"Listen to me, understand me, respect me and you will know me."

* = *"A value stream can be defined as all the steps – both value added and non value added – required to take a product or service from its raw materials state into the waiting arms of a happy customer."*[8]

[7] See Baker et al High Performance Health Systems such as, Jonkjoping and the story of Esther http://www.longwoods.com/content/20133

[8] http://lssacademy.com/2008/02/08/value-stream-mapping-overview/

Current State

Current services for Bill include:

- *Primary healthcare access points in all communities, including 11 community health centre service sites, 21 family health teams and more than 1,000 family practitioners*
- *1 Champlain Community Care Access Centre (CCAC) (30 service sites)*
- *58 community support agency service sites*
- *33 mental health service sites*
- *26 addiction service sites*
- *Community psychogeriatric services from providers throughout the region*
- *Psychogeriatric resource consultants throughout the region*
- *Geriatric Emergency Management Nurses at 9 emergency department sites*
- *Nurse-led outreach teams in Ottawa, serving 18 LTCHs*
- *Mobile crisis mental health services that serve seniors throughout the region*
- *62 LTCHs*
- *20 hospital service sites, including one specialized mental health centre with inpatient psychogeriatric services (The Royal).*

System Challenges

The Thomases have a close relationship with their family physician and may have a range of services available in their community. While they do their best with what they know, they do not know where to turn for support when Bill's behaviour reaches a tipping point. Over Bill's care journey, he may be hospitalized, sometimes through the emergency department (ED). He may have an extended hospital stay as a result of his responsive behaviours, and if medical needs require it, he may be placed in a complex continuing care (CCC) service. Bill may be living in a LTCH where his responsive behaviours may require enhanced interventions. The figure, below, depicts a hierarchy of indicators that relate to the care journey the Thomases may experience.

Bill is one of an estimated 16,000 people in Champlain living with some form of dementia[9], Approximately 5,000 of these individuals live in LTCHs in Champlain[10]. Like other seniors, an individual with dementia could be admitted to hospital for a variety of medical reasons; however, those with dementia tend to stay longer in hospital in an ALC status than those without. Patients with dementia account for almost one-third of ALC days in hospital, with an average length of stay twice as long as other ALC patients.[11]

[9] CIHI Report: Caring for Seniors with Alzheimer's disease and other forms of Dementia, August 2010
[10] IBID
[11] Walker, Morris and Frood, "Alternate level of care survey in Canada: A summary". Healthcare Quarterly, 12(2), 21-23, 2009.

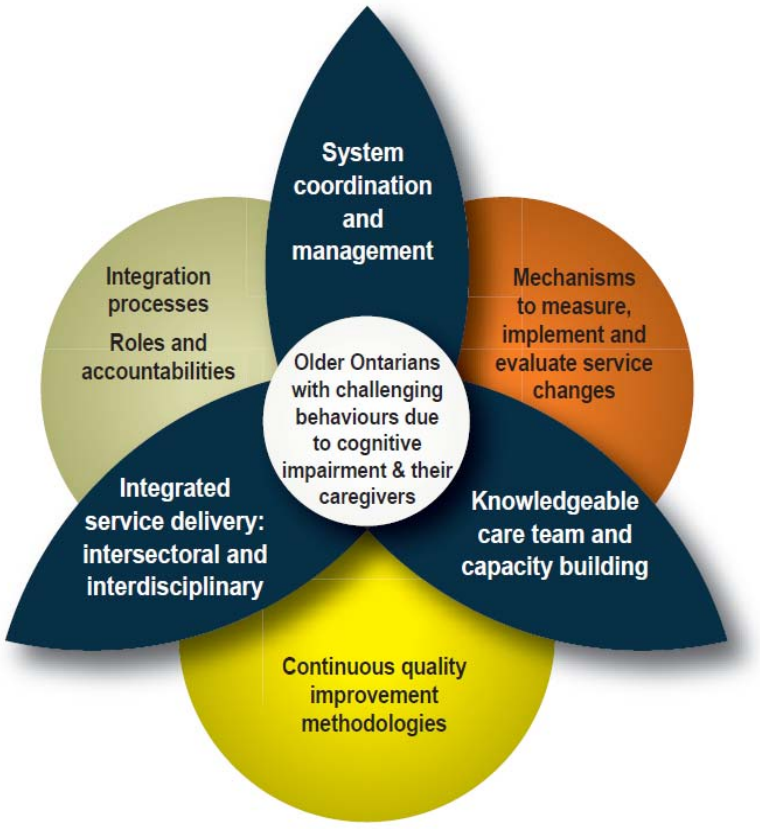
System Opportunities

The provincial BSO project was initiated to develop behavioural support systems in each of the LHINs to meet the needs of clients like Bill. The project involves re-design of the current system of services, in conjunction with an enhancement of resources. It has a framework based around three pillars:

1) *System Coordination and Management*
2) *Integrated Service Delivery*
3) *Knowledge Exchange and Capacity Building.*

BSO Project Framework for Care:

As a provincial initiative, the BSO project benefits from a provincial coordinating office and significant support from Health Quality Ontario and The Alzheimer Knowledge Exchange. Four "early adopter" LHINs (Central East, Hamilton Niagara Haldimand Brant, North Simcoe Muskoka, South East) initiated their planning and implementation activities in advance of the remaining LHINs to transfer lessons learned. In addition, a value stream mapping[12] exercise focused on the conceptual act of planning on the very real experiences of Bill and his peers (learn more about this provincial initiative at the Alzheimer Knowledge Exchange website, akeresourcecentre.org/BSO).



[12] Leading Lean: A Canadian healthcare Leaders Guide as of Dec 3, 2011 at http://www.healthsectorstrategy.ca/downloads/HQ_vol12_no3_Fine.pdf

Value Stream Mapping Outcomes

During the two-day, value stream mapping exercise, the team identified a number of challenges to, and opportunities for, CBSS improvement. The following table identifies the aims of system improvements from the perspectives of the:

- *Client and their caregiver*
- *Staff providing support, and*
- *Organization responsible for the service.*

The "Wins" of System Re-design

Wins for the Person	Wins for Staff	Wins for Organizations
Better outcomes*	Caregivers safety*	Recruitment & retention*
Stay at home as long as possible	More knowledgeable staff*	Recognition*
Timely interventions	Preferred workplace	Efficient transition
Support caregivers	Less workload	Safety
Increase independence	Job satisfaction	Better use for money
Empowerment	Easier for staff	Cost reduction
Less frustration	Efficiency	Sustainability
Less crisis placement	Empowering staff	Increase morale of organization
More safety	Better productivity	Successful accreditation
Benefit from best practice guideline	Makes my life easier	Better results – performance indicators
Fewer ED visits	Fewer incidents/more safety	Increase communication
	Decrease stress, burnout, depression	Accountability
	Performance best practice guideline	Facilitate access to LTCH / appropriate care
		Fewer incidents
		Application of best practice

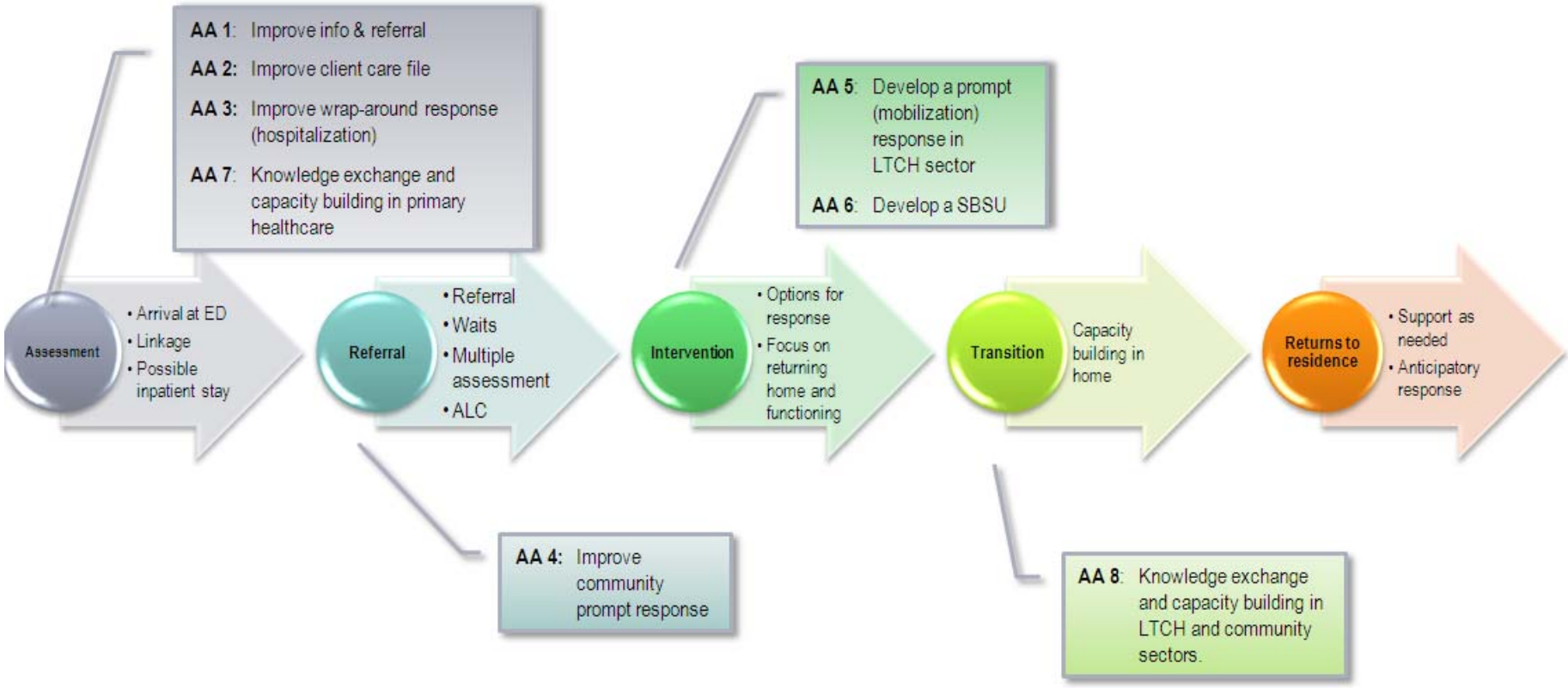
**= most commonly identified in each category.*

The value stream mapping team also identified ways in which the six principles of an improved CBSS can be realized:

Principle	Example of how this can be included in the future state
1) Behaviour is communication	• Ask about background, values, history, preferences & communicate this to providers • Friendly approach when assessing • Go through a process to problem solve, analyze behaviour • Know the persons history, story, voice • Culturally sensitive care in own language
2) Practices value diversity	• Francophone assessment care provider • Equal care in urban & rural areas • Raising awareness of special needs at provider level • Different cultures have to collaborate to avoid unwieldy systems that re too diversified
3) Care is collaborative	• Standardized training on “circle of care’ for purposes of communication & collaboration • Common language r/t behaviour, meaning, interventions, care planning • Open communication with all members of the team involved with clients care • Opportunity for all to provide info & to have it recorded in an accessible fashion
4) A culture of safety is promoted	• Ensure that BSO providers take an approach of support without criticism when trying to help caregivers & care providers • Educated staff/frontline workers re: responsive behaviours • Risk assessments, resources, tools are shared • Supports at the right time, for the right person at the right place
5) Systems are coordinated and integrated	• Seamless communication between people & institutions • Review memberships & mandate of existing coordinating mechanisms & formalize reporting mechanisms with LHIN • Organizations are aware of other resources to partner well • Tools / forms that bring forward key priorities and inform assessments to consider in providing next service • Shorten incoming data to pertinent info
6) Accountability and sustainability is defined and ensured	• Simple/short satisfaction questionnaires surveys for families & care providers and for capable individuals • Continue PC referring services survey (5 questions) • Continued coordination by LHIN to ensure standards are across LHIN • Evaluations that allow monitoring of progress & are not burdensome to complete • Knowledge of mandate/mission of all organizations, resources involved – to avoid duplication or missing resources • Care pathways defined & implemented by all

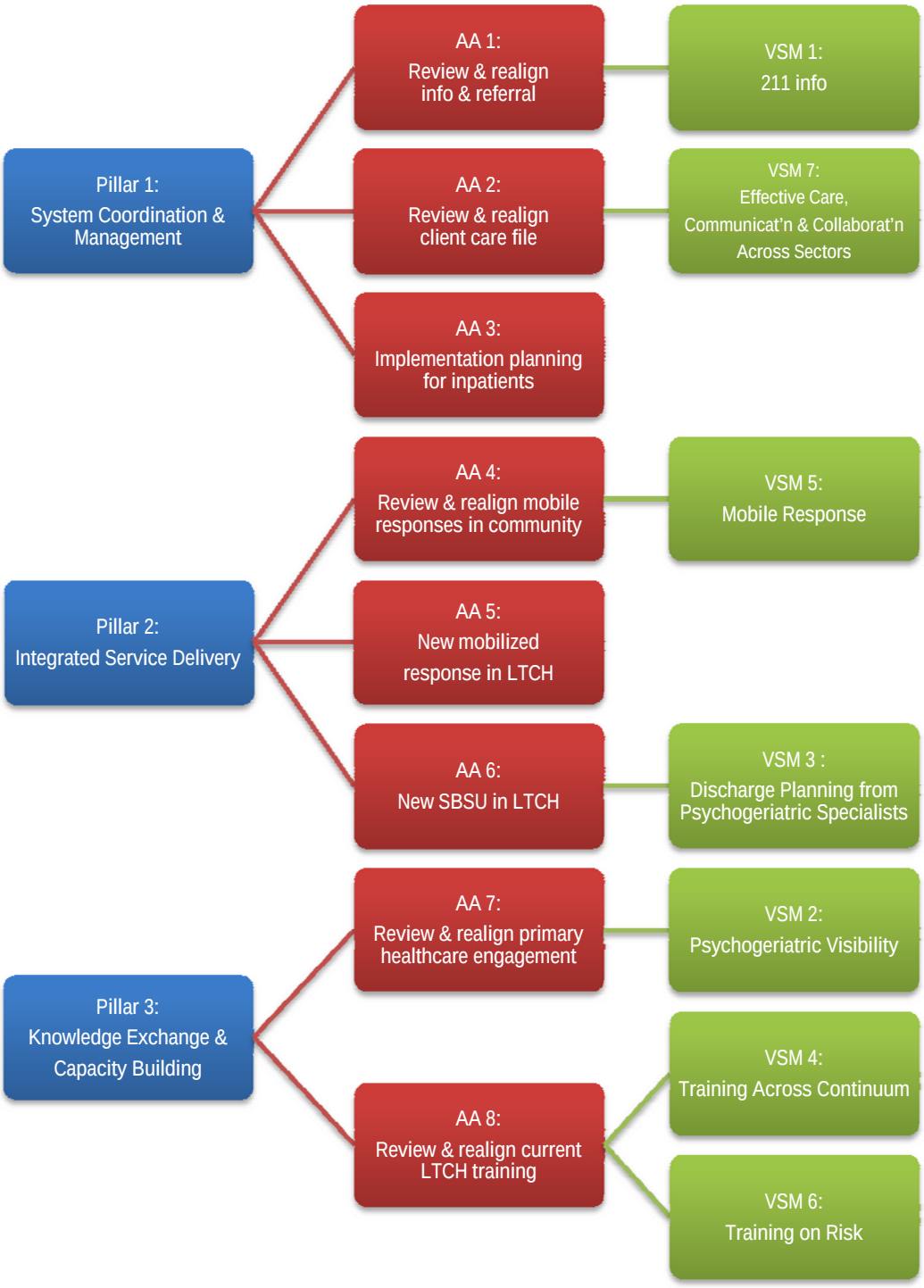
Process Map with General Elements and Eight Action Areas

Dialogue among CBSS project team members, preceding planning and the value stream mapping exercise started explorations with this current state process map:



Value Stream Mapping Targets and Action Areas

The results of planning-to-date suggest eight actions areas as the best, first steps to improve the CBSS. These align well with the seven improvement projects identified through the value stream mapping process. The following diagram shows the relationship among the Pillars, Action Areas (AA 1-8, below) identified, and the quality improvement projects identified in the value stream mapping (VSM 1-7, below) exercise.



Action Plan

Pillar 1: System Coordination and Management

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

Seamless Care

System development through Ontario's healthcare is characterized by an incremental approach to addressing discrete needs. As a result, many services and organizations with multiple service mandates form a patchwork-quilt of responses for Bill. When Bill and Theresa first reach out to the system, this patchwork quilt may appear as a great range of options. This patchwork quilt makes it difficult to know where to turn for the right support at the right time. For example, included in the patchwork are a number of telephone information access points (i.e., 211, 310-CCAC, Tele-health Ontario), but when a prompt response is required, how do the Thomases know where to access the information they need? ***Action Area 1 is a system integration initiative aimed at improving this situation.***

Once Bill gains access to services, he and Theresa often need to complete multiple assessments, repeating their history to a number of individuals. Everyone acknowledges that some multiple assessments are necessary, particularly for dynamic situations; however, Theresa and Bill feel frustrated with the number of times they need to repeat the same information. Why isn't the previously provided information shared at the next point of care? Why is the gathered information not particularly useful to the Thomases in making *their* decisions? Many initial - and some repeat - assessments may be necessary to define the best plan of care. From the LEAN [13] perspective, however, the customer seeks a service to get what they need, not to be assessed for what they need. In this way, all assessments can be viewed as something to be eliminated (LEAN Type 1 waste) or something necessary but needing to be streamlined (LEAN Type 2 waste)[14]. ***Action Area 2 is a system integration initiative aimed at improving this situation.***

At some point in his care journey, Bill may present at the ED and/or be admitted to hospital. While his hospital visit may be for a medical concern normally requiring hospitalization, his responsive behaviours make his condition difficult to manage in the ED or through a hospital outpatient service. As a result, Bill is more likely to be admitted. Once admitted, his responsive behaviours may escalate because he is in an unfamiliar environment.

Bill needs prompt access to supports that aid him in a return to his residence, averting or minimizing an inpatient stay. The hospital may not be equipped to support Bill in a rapid return home, but other community services can be of assistance. Unfortunately, these are not always available when Bill needs them; at the point of care. Ideally, these community services would have been available to Bill before a trip to the ED became necessary. In the future, community and hospital services will ideally

[13] "…lean means creating more value for customers with fewer resources." http://www.lean.org/whatslean/

[14] Thinking Lean in Healthcare as of Dec 3, 2011 at http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_043753.hcsp?dDocName=bok1_043753

form an interdisciplinary, wrap-around, prompt response to ensure Bill receives the care he needs to manage behaviours while his medical needs are addressed. ***Action Area 3 is a system integration initiative aimed at improving this situation.***

Bill may also present with a major medical problem requiring hospitalization. He may gain access to the best medical care; however, his responsive behaviours may be exacerbated, and as a result, poorly managed because behaviour supports are lacking. Bill's medical issues are resolved while his behavioural issues are not - and a lengthy hospital stay is likely. Patients with dementia account for almost one-third of ALC days in hospital, with an average length of stay twice as long as other ALC patients.[15] This does little to help Bill and Theresa manage his responsive behaviours, and represents a significant barrier to patient flow within the system. Again, this is a point in the care process where an interdisciplinary, wrap-around response is required. ***Action Area 3 is a system integration initiative aimed at improving this situation.***

In exploring Bill's care journey, many stakeholders identified that Bill will be joining other younger individuals with significant responsive behaviours in a range of settings such as LTCHs, acute inpatient and CCC.

The focus of this phase of the CBSS and new investment under the BSO project is on older people with behavioural responses. Younger individuals with significant responsive behaviours (due to neuropsychiatric disorders, acquired brain injury and other etiology) are recognized as having significant, unmet needs.

Meeting those needs likely requires creating a new setting that would also avoid some of the risks associated with co-locating younger people with responsive behaviours with individuals like Bill. ***Action Area 3 is a system integration initiative aimed at exploring this situation further.***

Partners for System Coordination and Management

The incremental development of services in Ontario has created a complex constellation of organizations, services, functions, mandates, inclusion and exclusion criteria that make it difficult to navigate the system. At first glance, it may appear that a structural solution is needed: create a single point of access for Bill. Alternatively, the current situation can be seen as a complex adaptive system[16] which may lend itself to functional solutions (i.e., create a shared vision, culture, common language, common tools and shared accountability[17]) to ensure Bill has access to the services he needs.

[15] Walker, Morris and Frood, "Alternate level of care survey in Canada: A summary". Healthcare Quarterly, 12(2), 21-23, 2009.

[16] Health Care as a Complex Adaptive System: Implications for Design and Management accessed on Dec. 3, 2011 at http://www.ti.gatech.edu/docs/Rouse%20NAEBridge2008%20HealthcareComplexity.pdf

[17] Governance and Management Roles in Transforming and Integrating Independent Organizations within Interdependent Local Health Networks accessed on Dec. 3, 2011 at http://www.longwoods.com/content/16446

In this model, there is no single door for Bill to enter the system. Instead, "no door is the wrong door"[18] for him to enter. To achieve this, the CBSS will be improved by collaborating on tools and processes for:

- *Information and referral*
- *Common client care file*
- *Common language*
- *A shared vision, supported through shared knowledge exchange and service learning, and*
- *Shared accountabilities through common indicators that focus on the experience and outcomes of clients like Bill.*

Service partners will collaborate across the LHIN and province to leverage the opportunity for building a common language and common tools, etc.

Champlain partners in system coordination have evolved organically from the patchwork quilt of programs and services. Caring providers have always shared a common interest in and commitment to meet Bill's needs. At times, resource limitations and mandate restrictions have stood in the way of this common commitment. Networks of service providers formed to address the needs of Bill and Theresa. The Champlain LHIN and a number of its region-wide organizations have led the development of these partnerships. The ED/ALC Steering Committee has led the way in addressing integration challenges at the transitions related to hospital. The Champlain CCAC has a particular focus in improving partnerships that involve the coordination of services across the care continuum.

The Action Plan establishes specific lead roles for the LHIN, CCAC and ED/ALC Steering Committee regarding improving the CBSS integration. Partners from across the care continuum will be leveraged through pre-existing networks to address integration challenges. The effectiveness of these partnerships has been demonstrated in the successful roll-out of system-wide strategies, like Aging at Home. Such system-wide strategies support and reinforce the new emerging, common culture of quality that transcends organizational boundaries.

Action Areas 1-3 outline the partnership responsibilities needed to address **system coordination** improvement. Action Areas in Pillars 2 and 3 will also leverage pre-existing networks and regional resources to enhance collaboration and system integration while addressing improvement in these areas. In particular, The Royal was identified as the lead agency within this phase of system re-design. The Royal has outreach responsibilities and/or partnership arrangement across the region, including supports in the LTCH sector and the Psychogeriatric Resources Consultant Program. It will play a lead role, in concert with mental health and LTCH partners, in implementing the re-designed services in:

- *The LTCH sector, and*
- *Knowledge exchange and capacity building through service learning.*

LTCH stakeholders identified The Royal as the preferred choice for regional lead in these areas, with its long history of successful cross-sectoral regional partnerships.

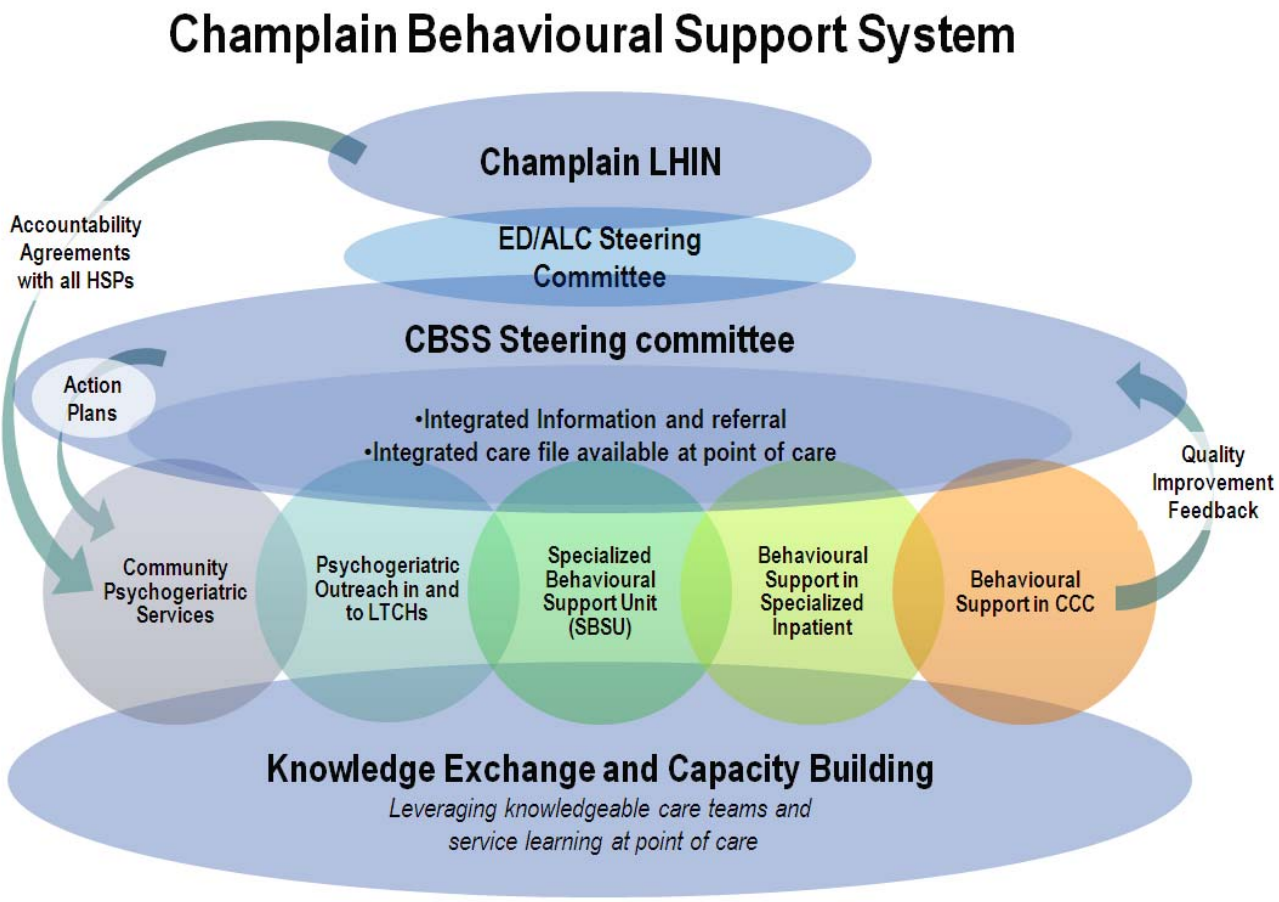
[18] See example policy submission accessed on Dec. 3, 2011 at http://www.ontario.cmha.ca/admin_ver2/maps/emergency_department_wait_times_submission_20080722.pdf

Governance and Accountability Structure

The Champlain LHIN led the development of this Action Plan, under the guidance of the CBSS project team. To confirm the Action Plan's intended impact on system priorities and enlist additional support from system leaders, the Action Plan will be presented to the ED/ALC Steering Committee.

Upon the completion of this phase of the Action Plan, the project team's membership and terms of reference will likely be reviewed and re-aligned to the role of a steering committee. Members of the steering committee would be responsible for implementing the plan and providing management advice regarding the CBSS resources for which they are accountable. The French Language Health Planning Entity (Réseau) has been an active participant in the CBSS project team and will continue as a member of the CBSS project steering committee.

Support for the governance and accountability structure is provided by an implementation project lead resource from the Champlain LHIN. The accountability agreements between the LHIN and its health service providers will establish the accountability for specific deliverables defined through the CBSS project.



Action Areas 1 - 3

Action Area 1	**Improve System Integration** through a system-wide review and re-alignment of existing information and referral resources.	
Aim	Improve access to information - when and where one needs it - to facilitate informed choices about supports. Wherever one turns for support, s/he will promptly be directed to supports that meet the need(s).	
Scope	A number of resources exist to meet this need. At present, it is assumed that additional resources are not required. A review of current resources will: • *Identify improvement opportunities through re-alignment, and* • *Create a knowledge exchange opportunity across the care continuum about how to make current services more effective.*	
Indicators	1) Increased client satisfaction with information received 2) Enhanced re-direct to appropriate services, regardless of entry point. 3) Increased provider satisfaction with, and knowledge of, resources.	
Partners	Champlain LHIN, CCAC, community services, primary healthcare stakeholders. Providers across the care continuum, 211, 310-CCAC, Tele-health.	
Executive Sponsorship	Champlain LHIN and CCAC partnership	**Time Frame:** Feb - Dec 2012

Action Area 2	**Improve System Integration** through a system-wide review and re-alignment of existing client assessment and information exchanges (client care file, patient record).	
Aim	• Decrease the number of repeat assessments and histories so the client spends more time getting the support needed. • Increase access to important and timely information at the point of care to enable the care team to co-manage the care plan more effectively, whereby the client experiences greater continuity.	
Scope	Many assessments are done on behalf of clients and many may be necessary but, from the client's perspective, they are interested in getting support, not assessments. A review and re-alignment will create an opportunity to align assessments, reduce duplication and create a common language across different points within the care continuum.	
Indicators	1) Decreased in unnecessary repeat assessments 2) Improved timely access to relevant information at the point of care 3) Increased use of common language and common tools to enhance care collaboration	
Partners	Champlain LHIN, CCAC, eHealth initiatives.	
Executive Sponsorship	Champlain LHIN, CCAC	**Time Frame:** Feb - Dec 2012

Action Area 3	**Improve System Integration** through a review and redevelopment of an integrated wrap-around response that enhances transitions at the inpatient point of care.	
Aim	• Through a more effective partnership between community and inpatient services: o *Decrease the number and duration of inappropriate admissions to hospital related to responsive behaviours* o *Decrease the duration of appropriate hospitalizations.* • Explore a better response to younger clients with neuropsychiatric disorders or acquired brain injury who experience responsive behaviours and are often hospitalized as a last resort – even though the hospital environment does not meet their needs.	
Scope	The hospital environment has resources to respond to acute situations; however, resources may not be well aligned to meet the needs of a person with responsive behaviours. Additionally, coordination between hospital services and community services can be improved by focusing on transition points through a behavioural support lens. A review and re-development of services should identify opportunities for improved linkages. Leveraging current mechanisms to facilitate transitions will improve services without significant new investments. Explorations and improvements associated with a younger population are out of scope regarding new resources associated with the BSO Project.	
Indicators	1) Reduced inappropriate hospital admissions related to responsive behaviours 2) Reduced inpatient lengths-of-stay related to responsive behaviours 3) Improved linkage and coordination at points of care among community services and hospital inpatient services 4) Improved knowledge related to better practices to address the needs of a younger population with responsive behaviours.	
Partners	Members of the ED/ALC Steering Committee, community services	
Executive Sponsorship	Champlain LHIN	**Time Frame**: Feb – Dec 2012

Action Area 3 is linked to:

- *Action Area 6 (SBSU)*
- *Action Area 5 (mobilized response in LTCHs) and*
- *Action Area 4 (prompt response through community services).*

As CBSS services in the community and LTCH sectors are enhanced, these sectors will partner more effectively with hospitals. For example, when community and LTCH behavioural support clients go to hospital, they will receive a wrap-around response. Challenges will remain for hospital patients not identified with a community service or LTCH. Further planning and development within Action Area 3 will develop a response to this population.

Pillar 2: Integrated Service Delivery

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

Target Populations and Target Transition Points

The care story of Bill illustrates the high-risk circumstances of older people with responsive behaviours that have been identified through previous planning, the dialogue among CBSS project team members and the value stream mapping exercise. These include:

Target 1:

Early in Bill's care journey, his responsive behaviours are becoming challenging for Theresa to manage. She has not had the opportunity to prepare for this current situation and is unsure where she should turn for support.

Later, Bill's responsive behaviours have escalated. Theresa is at a point of not being able to meet Bill's needs with usual supports. She could support Bill if provided with a prompt intervention from behavioural support that de-escalates the behaviour, adapts the environment and builds capacity to address future anticipated behaviours. ***Action Area 4 is an Integrated Service Delivery initiative aimed at this target.***

Target 2:

Later in the care journey, Bill is living in a LTCH and his responsive behaviours have recently escalated. The LTCH is at a point of not being able to meet Bill's needs with usual supports. They would be able to support Bill if provided with a prompt intervention from new enhanced behavioural support that de-escalates the behaviour, adapts the environment and builds capacity to address future anticipated behaviours. ***Action Area 5 is an Integrated Service Delivery initiative aimed at this target.***

Target 3:

At another point in Bill's care journey, he is living at home or in a LTCH but has experienced significant and escalating behaviours that cannot be managed within the current environment. At the moment of significant behaviour escalation, he may be at home, in his LTCH or may have been hospitalized in acute care or CCC as a result of his medical and behavioural needs. He will likely require more intensive, specialized behavioural support within a LTCH over an extended period. Following an initial phase of stabilization, Bill may be supported in a less intensive environment with appropriate supports, environmental adaptations and capacity building. ***Action Area 6 is an Integrated Service Delivery initiative aimed at this target.***

Target 4:

At another time in Bill's care journey, he has a medical issue that may require hospitalization. His responsive behaviours are difficult to manage in an ED or hospital outpatient setting and he may be hospitalized. However, this hospitalization may have been averted if there were a prompt response available at the point of care from community services. The hospitalization could also be significantly shortened if community services and/or LTCH services are immediately involved in the care plan. ***Action Area 3 is a service integration initiative aimed at this target.***

Target 5:

At another point in Bill's care journey, he has a major medical condition that requires hospitalization. Once in the unfamiliar setting, Bill's responsive behaviours escalate. As a result, it is more difficult to manage Bill's behaviour and prepare him for a return home (whether his own or a LTCH). Within the current system, it is unfortunately expected that Bill will stay longer in hospital and about twice as long in ALC compared to others without responsive behaviours. ***Action Area 3 is a service integration initiative aimed at this target.***

Target 6:

In exploring Bill's care journey, many stakeholders identified that Bill will be joining other younger individuals with significant responsive behaviours in a range of settings such as LTCHs, acute inpatient and CCC. Younger individuals with significant responsive behaviours due to neuropsychiatric disorders, acquired brain injury or other etiology are not the focus of these CBSS improvements and out of scope for new investment under the BSO project. However, this group of individuals poses a significant challenge to the system, and will likely require a new response and possibly, a new setting. Improvements in this area will benefit this population and individuals like Bill by reducing the risks associated with combining populations with different needs in the same settings. ***Action Area 3 is a service integration initiative aimed at this target.***

Strengths and Gaps in the Current Care Continuum

At present, 211 health care organization sites throughout the Champlain region provide residents with the vast majority of their healthcare. All but the most specialized care is available. Nonetheless, geographic and demographic realities create challenges to equitable access for all care. As a result, Champlain healthcare organizations share a long tradition of collaboration and adapting services to meet needs.

Specifically regarding Bill's needs, a full continuum of services currently exists in the service design, including:

a) *Supported behavioural assessment services through inpatient and community services*
b) *Comprehensive geriatric assessment through inpatient and outpatient services*
c) *Identification of people with complex and challenging mental health, dementia or other neurological conditions, who could benefit from behavioural support services through assessment, referral and case finding in the community sector*

d) *For individuals not identified as part of the population for the service, guidance to the right providers for the right service through assessment and referral in the community and inpatient sectors*

e) *Support for individuals in crisis through mobile mental health outreach and EDs.*

Even so, the current service design does not have the capacity to respond promptly to the six targets, above:

- *Psychogeriatric outreach services to LTCHs are able to maintain a regular schedule of consultations and can sometimes respond via telephone consultation; however, they are unable to respond promptly to all situations requiring onsite presence.*
- *A lack of access to a SBSU means individuals remain in hospital and suffer high-risk situations in the community and LTCHs.*
- *Across the region, community psychogeriatric service providers have waiting lists.*
- *Hospital resources are dedicated to medical care, not behavioural needs. As a result, individuals in hospital with behavioural needs are difficult to manage.*

The Action Areas outlined in this plan target these priority gaps in the system.

The Champlain region is a mix of rural and urban settings, with population densities ranging from 10 to 4,000 people per square kilometre[19].

[19] Based on Census 2006 (Statistics Canada).

Champlain represents a significant francophone population:

- *Four in ten residents speak French[20], and*
- *One in five has French as a mother tongue. In some communities, such as Prescott-Russell, the numbers are as high as three in four[21].*

Our region is also home to more than 30,000 First Nations, Inuit and Métis people[22]. One in twenty Champlain residents arrived in Canada within the last ten years[23]. Champlain's diverse population is most striking when considered at the community level; the needs of each community can vary greatly. Service planning and system re-design are founded in a population-need based approach and must address Champlain's diverse needs.

Each local service enhancement is adapted to the specific population it serves. At times, there is not a critical mass of services to meet specific, individual needs. To meet those needs, service providers collaborate across community boundaries and care sectors**.**

In the Champlain LHIN, as a fundamental component of service quality and safety, there is a responsibility to create behavioural support services in French. The specific needs of Francophone clients and families must be recognized and addressed in compliance with the *French Language Service Act***.**

[20] IBID
[21] IBID
[22] Based on Census 2006 Aboriginal Identity population (www.statcan.gc.ca/bsolc/olc-cel/olc-cel?catno+12-592-XIE&lang=eng) plus on-reserve registered Indian population for Akwesasne (which did not participate in Census 2006).
[23] Between 1996 & 2006 Census.

Continuum of Services: Primary, Acute and Community Services

Previous planning, the dialogue among CBSS project team members, and the value stream mapping exercise all reviewed the continuum of services from primary to acute to community care, seeking to leverage system coordination, collaboration and partnerships. To demonstrate this relationship, the following table maps the Action Areas defined in the plan to points along the care continuum.

Point on the Care Continuum	Relevant Action Area:	Intended Outcomes:
Primary Healthcare	**Action Area 1** System integration through improved information and referral	Improved access to information for client and provider.
	Action Area 7 Capacity building through knowledge exchange	Enhanced knowledge of resources in the primary healthcare sector. Improved transitions from primary healthcare to supports for responsive behaviours.
Community Services	**Action Area 4** Improved service delivery through alignment of services to prompt needs	Improved speed of access to community services, when needed.
LTCH	**Action Area 5** Enhanced service delivery through enhanced behavioural support in LTCHs	Improved capability to manage responsive behaviours in LTCHs.
	Action Area 6 Enhanced service delivery through the establishment of SBSU(s)	Improved capability to manage responsive behaviours of those requiring a longer term period of stabilization.
	Action Area 8 Capacity building through knowledge exchange and service learning	Improved capacity to manage responsive behaviours that spreads from enhanced resources to all resources.
Hospital *(Acute and CCC)*	**Action Area 3** System integration through review and wrap-around response for inpatient and community services.	Improved flow from community to hospital and back.
Across the continuum	**Action Area 2** System integration through review and re-alignment of assessment and information exchange to ensure information follows the individual.	Reduced unnecessary repeat assessments. Relevant information readily available at the point of care.

Partners for Interdisciplinary Service Re-design

Past Practice and Outcomes

Each Action Area for integrated service delivery re-design identifies the relevant partners and executive sponsors. Collaborative networks exist at the regional and local levels to address the needs of seniors and individuals with responsive behaviours. Community services, hospital services and the psychogeriatric resources consultants, etc. are active participants in the networks. Partners have successfully collaborated on planning previous service re-design.

The Royal, CCAC, Peter D. Clark Centre and Champlain LHIN collaborated closely on the development of a model for a SBSU. In particular, The Royal was identified as the lead agency within this phase of system re-design. The Royal has outreach responsibilities and/or partnership arrangements across the region, including supports in the LTCH sector and psychogeriatric resource consultants. The Royal will play a lead role, in concert with mental health and LTCH partners, in implementing the re-designed services in the LTCH sector and in knowledge exchange and capacity building through service learning.

Action Areas 4 - 6

Action Area 4	**Improve Interdisciplinary Service Delivery** through re-alignment and enhancement of existing community services	
Aim	Leverage current service resources so that a prompt response can be delivered in the community to address responsive behaviours and avert escalation to a crisis	
Scope	Re-design currently offered services to create a prompt response. Resource enhancements are required to achieve service aims. Partnerships will be enhanced to improve a wrap-around response for current clients who enter hospital.	
Indicators	1) Improved identification and triage of individuals who require prompt priority access to community services. 2) Improved access times so that a prompt community service response is a viable alternative to a crisis or emergency response.	
Partners	Champlain LHIN, Aging at Home leads, CCAC, community psychogeriatric service providers, mobile mental health outreach services, psychogeriatric resource consultants	
Executive Sponsorship	Champlain LHIN, community psychogeriatric service providers throughout Champlain	**Time Frame:** Dec 11- Feb 12

Three of the four current community psychogeriatric service providers in Ottawa, Prescott-Russell and Stormont, Dundas and Glengarry are designated to provide services in French under the provision of the *French Language Services Act*. Each of these organizations will integrate their additional human resources in their designation plan.

Although community psychogeriatric service providers in the area of Renfrew County are not designated to provide services in French, planning will seek ways to ensure access to services in French to meet the needs of the francophone population. The accountability agreement between the LHIN and health service providers will include measures related to the access to services in French.

Action Area 5	**Improve Interdisciplinary Service Delivery** through enhancing resources within the LTCH sector to allow for a prompt on-site response to responsive behaviours and build capacity across the LTCH sector	
Aim	• Improve the ability to address responsive behaviours in the LTCH sector by enhancing services and building capacity • Reduce the escalation of responsive behaviours and reduce the need for emergency responses or potential hospitalization	
Scope	Enhancements will be deployed within the LTCH sector. Opportunities for partnering across homes and with regional lead will be secured to maximize coverage of the new resource. Partnerships will be enhanced to improve a wrap-around response for current clients who enter the hospital Enhancements will expand current service delivery and will be leveraged to build capacity through service learning ***Note:*** *Action Area 5 is dependent on continued access to peak High Intensity Needs funds to bridge the gap between usual support and the prompt outreach response.*	
Indicators	1) Improved staff responses to responsive behaviours 2) Enhanced capacity that expands beyond new resources to recognize and better manage responsive behaviours across the sector 3) Reduced need for crisis or emergency response and reduced transfer to hospitals, related to responsive behaviours	
Partners	Champlain LHIN, The Royal, Residents First leads, CCAC, LTCHs, community psychogeriatric service providers, psychogeriatric resources consultants	
Executive Sponsorship	Champlain LHIN, The Royal, LTCHs throughout Champlain	**Time Frame**: Dec 11 – Feb 12

Within Ottawa, Prescott-Russell and Stormont, Dundas and Glengarry, several LTCHs are designated to provide services in French under the *French Language Services Act*. Therefore, proficiency in French will be included as a required qualification in the job description of the human resources providing supports to francophones. The accountability agreements between the LHIN and the health service provider will include measures related to the access to services in French.

Action Area 6	**Improve Interdisciplinary Service Delivery** through the establishment of a SBSU	
Aim	• Enhance the range of services by creating one SBSU in Champlain that can respond to individuals with highly challenging responsive behaviours who require longer periods of stabilization. • Effectively stabilize the individual's behaviour and support the transition to an appropriate residential environment.	
Scope	Enhanced resources will be deployed within the LTCH sector and include resources from other health professionals. A system admission and discharge sub-committee of the CBSS Project Steering Committee will be established to ensure individuals with the highest need will be considered a priority, particularly individuals currently within hospital.	
Indicators	1) Better outcomes for people with significant escalating responsive behaviours 2) Reduced incidents and emergencies within other LTCHs related to responsive behaviours 3) Better flow within the inpatient setting related to people with responsive behaviours	
Partners	Champlain LHIN, Residents First Leads, CCAC, The Royal, Peter D. Clark Centre	
Executive Sponsorship	Champlain LHIN, Peter D. Clark Centre, The Royal, CCAC	**Time Frame:** Feb 12 - Nov 12

This phase of the planning creates a SBSUs as a unique service offered to the population of Ottawa and as appropriate, Champlain. Therefore, it must have the capacity to offer these services to the 20% of the Champlain population who are francophone.

The SBSU in Ottawa will be required to submit a French Language Services Report to the LHIN. Planning for this unit will need to demonstrate how this service will serve the francophone population. In addition, resources under Action Area 5 will be targeted to a select LTCH that is currently serving higher needs residents in a francophone milieu to ensure that a level of support comparable to the SBSU can be provided. In all action areas, the LHIN will revise relevant accountability agreements to include measures regarding access to services in French.

Pillar 3: Knowledge Exchange and Capacity Building

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

Current and Future Training and Knowledge Transfer Processes

Champlain is an active participant in the BSO project. We will continue to leverage provincial developments to maximize knowledge exchange and capacity building within our region.

There currently exists in Champlain a full range of training and knowledge transfer processes to disseminate new knowledge and best practice skills relating to behavioural support, including:

- *Academic education and training through the colleges and universities within Champlain*
- *The Academic Health Council which has developed a Champlain-wide strategy to enhance inter-professional service delivery through education and service learning*
- *Service learning through the Academic Health Science Centers*
- *Provincial applied curriculum and case based learning through psychogeriatric resource consultants (P.I.E.C.E.S., Gentle Persuasive Approaches. etc.)*
- *Client-focused capacity building through community psychogeriatric service providers and outreach*
- *Caregiver focused capacity building through community services, such as the Alzheimer Society and First Link*
- *System knowledge exchange through networks at the regional level (Champlain Dementia Network, Regional Geriatric Advisory Committee etc.) and at the local level (Seniors' services, LTCHs and Community Support Services (CSS) networks).*

This existing infrastructure will be mobilized to implement and sustain specific knowledge exchange, education and service learning objectives for the CBSS. The current resource includes significant behavioural support expertise.

The existing infrastructure will undertake targeted knowledge exchange and capacity building activities within the final quarter of 2011-12 to optimize the creation of knowledgeable care teams and to put in place sustainable mechanisms for ongoing knowledge exchange and service learning. The targeted activity and the sustained initiative to build capacity through knowledge exchange and service learning will include:

- *Best practices, protocols, standardization, and*
- *Capturing and sharing lessons learned.*

The Champlain LHIN will work closely with peers across the province to maximize opportunities for sharing and standardization. ***Action Area 8 is a capacity building initiative aimed at this priority.***

Planning-to-date highlighted a priority need for enhancing knowledge exchange and capacity building within the primary healthcare sector. This need will be addressed by leveraging opportunities within the *existing and new infrastructures, such as:*

- *Alignment of the current infrastructure*
- *New points of access in primary healthcare, such as the Family Health Teams*
- *Valuable resource provided by the network of Community Health Centers across Champlain*
- *A lead resource in the new primary healthcare lead at the Champlain LHIN.*

Action Area 7 is a capacity building initiative aimed at this priority.

Quality Improvement Capacity

The Champlain LHIN appointed a Quality Improvement Facilitator to support quality improvement and capacity building in the CBSS. Health service providers within the Champlain LHIN also have significant organizational expertise in quality improvement, which will be linked into the CBSS. Success has been demonstrated through initiatives such as the Residents First strategy, indicating that quality improvement is becoming a common language across sectors, and services within Champlain. The CBSS will build on this emerging culture.

Sustainability of Service Re-design

Health service provider accountability agreements will be revised to include commitments to support knowledge exchange and capacity building for the CBSS. Ongoing collaboration with leads within education and colleagues across the province will ensure that best practice approaches will be continually refreshed and sustained.

Partners for Knowledge Exchange and Capacity Building

Each Action Area for knowledge exchange and capacity building identifies the relevant partners and executive sponsors. Collaborative networks exist at the regional and local levels to address needs of seniors and people with responsive behaviours. Community services, hospital services and the Psychogeriatric Resources Consultants, etc., are active participants in the networks.

Partners have successfully collaborated on previous knowledge exchange and capacity building activities. As a regional lead, The Royal will work with them to focus knowledge exchange resources to meet the needs of enhanced and re-designed services.

Action Areas 7 & 8

Action Area 7	**Improve capacity building** through enhancing engagement, knowledge exchange and capacity building in the primary healthcare sector	
Aim	• Improve knowledge exchange and engagement between the primary healthcare sector and resources for responsive behaviours • Improve responses to people with responsive behaviours within the primary healthcare setting so that individuals and their caregivers can make better choices and have better access to supports for responsive behaviours	
Scope	Through the use of existing capacity building infrastructure, target the primary healthcare sector to enhance early responses to people with responsive behaviours	
Indicators	1) Improved knowledge of primary healthcare providers regarding supports for responsive behaviours appropriate to their clients / patients 2) Increased engagement between the primary healthcare sector and supports for people with responsive behaviours 3) Increased knowledge and understanding for individuals and their caregivers regarding the appropriate options for addressing needs related to responsive behaviours.	
Partners	Champlain LHIN,LHIN primary healthcare lead, primary healthcare leadership across the LHIN, CCAC, Regional Geriatric Advisory Committee, psychogeriatric resource consultants, community services, province-wide BSO initiatives	
Executive Sponsorship	Champlain LHIN, Alzheimer Societies, The Royal	**Time Frame:** Jan - Dec 2012

Action Area 8	**Improve capacity building** through a review and re-alignment of current capacity building initiatives to meet the enhanced needs of current and new staff within the LTCH and community sectors.	
Aim	• Improve knowledge exchange and capacity building targeted at improved management of responsive behaviours • Prepare new staff to meet core competencies for the CBSS • Create sustained opportunities for service learning that spread from the CBSS across the LTCH and community sectors	
Scope	Through the use of existing capacity building infrastructure, target the new and current CBSS resources and build capacity to enhance service learning across the sectors	
Indicators	1) Improved knowledge and practice of staff within and relating to the CBSS 2) Improved capacity to respond to responsive behaviours leading to a reduction in crises and transfers	
Partners	Champlain LHIN, CCAC, Regional Geriatric Advisory Committee, psychogeriatric resource consultants, community sector, province-wide BSO initiatives	
Executive Sponsorship	Champlain LHIN, The Royal	**Time Frame:** Jan - Dec 2012

Deployment of Behavioural Support Staffing Positions

The development of the CBSS will require ongoing and sustained planning, implementation and a continuous improvement process over the next several years. This process includes:

- *Intensive planning and development in the first several months*
- *Before March 31, 2012:*
  - *Deployment of an immediate investment in health human resources*
  - *Intensive knowledge exchange and capacity building related to new health human resources*
- *Service review and re-alignment over the first year*
- *Ongoing capacity building, knowledge exchange and service learning that spreads from the new health human resources and the service re-design*
- *Ongoing quality improvement to refine and enhance services.*

The immediate and important step of initial deployment of new health human resources must be leveraged to ensure a sustained service re-design and improvements for people with responsive behaviours and their caregivers.

Action Area 6 *(Improve Integrated Service Delivery through the establishment of a SBSU)* outlines a priority target for new health human resources that fit within the parameters of the proposed new investment. A proposal has been developed for a partnership between The Royal and the Peter D. Clark Centre to establish a 12-bed SBSU. This action area will also include the capacity building aims in **Action Area 8** *(Improve capacity building through re-alignment of current capacity building infrastructure towards enhanced needs related to responsive behaviours).*

Action Area 5 *(Improve Integrated Service Delivery through enhancing resources within the LTCH sector)* outlines a priority target for new health human resources that fits within the parameters of the proposed new investment. The health human resource Investment for this action area will also include the capacity building aims in **Action Area 8**. To achieve the aims of Action Area 5, mobilized resources will be deployed across all LTCHs in Champlain, proportional to the current number of residents. While targeted to the LTCH sector, the mobilized resources will follow residents through hospitalizations and work in partnership with hospitals to wrap services around the individual and facilitate a prompt return to the most appropriate environment.

Action Area 4 *(Improve Integrated Service Delivery through re-alignment and enhancement of existing community services)* also requires investment of new health human resources from within the "additional healthcare personnel" proposed investment. This investment will enhance prompt response in the community sector so that community services are better able to address responsive behaviours before a crisis develops. While targeted to the community sector, community services will be re-aligned to follow clients through hospitalizations and work in partnership with hospitals to provide a wrap-around response for the individual facilitating a prompt return to the most appropriate environment.

Action Area 3 *(Improve system integration through a review and redevelopment of an integrated wrap-around response that enhances transitions at the inpatient point of care)* also requires investment of new health human resources; however, the constraints within the new funding do not permit the deployment of resources by hospitals in the inpatient setting. Other service investment and re-alignment will be considered to enhance hospital responses to responsive behaviours, which is presently creating challenges to prompt diversion and discharge. In the interim, enhancements to LTCH and community sectors will be leveraged to ensure current clients and residents are supported through hospitalizations with a wrap-around response that coordinates hospitals and LTCH / community services.

Priority Actions for 2011/12

Action Area 6	**Improve Integrated Service Delivery** through the establishment of a SBSU.		
Model	Resources ($749,881) directed to enhance current LTCH staffing to create one 12-bed specialized unit within a purpose-built bungalow at the Peter D. Clark Centre, in conjunction with enhanced staff from The Royal.		
Rationale	Enhance the range of services available within the LTCH sector by creating a unit that can respond to individuals with significant escalating responsive behaviours who require a longer period of stabilization. Effectively manage the individual's behaviour and facilitate the return to a residential environment by building the capacity in the future residential environment.		
Deployment	FTE (estimated) and Category	Role	Salary & Benefits (S&B), based on Ministry Funding and FTE targets*
RN/RPN FTEs in LTCHs	1 FTE RN Team lead	Lead team, manage unstable care plans, develop and deliver capacity building, facilitate admission and discharge. Service planning	$84,000
	2.8 FTE RPN	Deliver care, build capacity through service learning	$192,436
Personal Support Workers (PSWs) in LTCHs	4.2 FTE	Deliver care, build capacity through service learning	$168,000
Other healthcare personnel (LTCH)	1 FTE Recreation or RPN with programming responsibilities	Design and deliver therapeutic activation and individualized programming; build capacity among other staff through service learning	$72,847
	0.2 FTE Physician	Attending to unit and liaise with regional providers and care transition	$36,720
Other healthcare personnel (other**)	1 FTE outreach nurse	Consult on unstable care plans, develop and deliver capacity building, facilitate admission and discharge. Service planning. Linkage to inpatient and other resources. Evaluation.	$107,658
	0.5 FTE social work	Support families and facilitate care transitions	$51,500
	0.2 FTE psychiatrist	Consultation and facilitation of care transitions through weekly visits	$36,720

Funding Envelopes and Totals	RN/RPN LTCH	$276,436
	PSW LTCH	$168,000
	Other LTCH	$109,567
	Other	$195,878
	TOTAL	$749,881

* Ministry allocation and FTE target indicates a salary & benefits allocation of $40,000 for each PSW FTE and an average salary & benefits allocation of $76,363 for each FTE RN/RPN. To estimate separate allocations for RNs and RPN the average RN/RPN Ministry was increased by 10% for RN FTEs to $84,000 and decreased by 10% RPN FTEs to $68,727.

** to be provided by regional provider, The Royal

Action Area 5

Note: the success of this deployment depends upon the continued access to High Intensity Needs Funds to bridge between the moment of crisis and the prompt response.

Small teams serving all homes in Champlain with outreach nurses serving a cluster of 1-4 homes, and one or more identified PSW Champions in rotation at each home.

Action Area 5	Improve Integrated Service Delivery through enhancement of resources within the LTCH sector to allow for a prompt on-site response to responsive behaviours and to build capacity across the LTCH sector.		
Model	LTCH staff who can be mobilized from regular duties to respond to responsive behaviours. Supported by consultation from LTCH outreach services.		
Rationale	Improve the ability to address responsive behaviours in the LTCH sector by enhancing services and build capacity Reduce the escalation of responsive behaviours and reduce the need for emergency responses or potential hospitalization.		
Deployment	FTE (estimated) and Category	Role	S&B based on Ministry Funding and FTE targets*
RN/RPN FTEs in LTCHs	1 FTE RN Team lead, behavioural nurse, on-site and consultation to group of homes	The lead will support service system quality improvement and coordination	$84,000 x 14 =$1,176,000
PSWs in LTCHs	2 FTE PSW	Deliver care, build capacity through service learning	$40,000 x 2 x 12 =$960,000
Other healthcare personnel (LTCH)			
Other healthcare personnel (other)	1 FTE LTCH outreach service manager for all teams	Administrative management,	
	1FTE LTCH lead service system quality improvement and coordination	Coordinate services, develop QI plans, evaluate,	

Funding Envelopes and Totals	RN/RPN LTCH	$1,176,000
	PSW LTCH	$954,000
	Other LTCH	$ 0
	Other (all teams combined)	$210,000

* Ministry allocation and FTE target indicates a salary & benefits allocation of $40,000 for each PSW FTE and an average salary & benefits allocation of $76,363 for each FTE RN/RPN. To estimate separate allocations for RNs and RPN the average RN/RPN Ministry was increased by 10% for RN FTEs to $84,000 and decreased by 10% RPN FTEs to $68,727.

Action Area 4

Note: Planning benchmarks at the national level would suggest further significant enhancement of this resource

Action Area 4	Improve Integrated Service Delivery through review and re-alignment of existing community services		
Model	Review, re-alignment and enhancement of existing community services that respond to responsive behaviours so that a prompt response can be supported.		
Rationale	To improve responses by leveraging the current service resources so that a prompt response can be delivered through community services to address response behaviours and avert escalation to a crisis.		
Deployment	FTE (estimated) and Category	Role	S&B based on Ministry Funding and FTE targets*
RN/RPN FTEs in LTCHs	RNs		
	RPNs		
PSWs in LTCHs	PSW		
Other healthcare personnel (LTCH)			
Other healthcare personnel (other)	6.5 FTE outreach consultant / case manager / nurse / social worker / behavioural therapist per population distribution and benchmark gap: 4 FTE Ottawa, 1 FTE Stormont Dundas, Glengarry) *0.5 FTE Prescott-Russell, 1 FTE Renfrew	Respond promptly, consult on unstable care plans, develop and deliver capacity building, Service planning. Facilitate linkage across community, inpatient and other services.	$695,500

Funding Envelopes and Totals		RN/RPN LTCH	$0
		PSW LTCH	$0
		Other LTCH	$0
		Other	$695,000
		TOTAL	$695,000

*Opportunities exist to explore alignment of the part-time resources identified here for Prescott-Russell and the part time resources currently existing in Prescott-Russell in the psychogeriatric resource consultant role.

Intended Outcomes

Performance, Measurement and Evaluation Plan

In accordance with the BSO project and the funding directed towards behavioural support, the intended outcomes of this Action Plan include the system indicators of:

- *Reduced resident transfers from LTCHs to EDs / hospitals or behavioural units in situations where the resident can be treated in their LTCH setting*
- *Delayed need for more intensive services thereby reducing admissions to hospital and risk of becoming ALC*
- *Reduced length of stay for people in hospital who can be discharged to a LTCH with appropriate supports (i.e. enhanced behavioural support)*

It is intended that all of the Action Areas identified in this plan will contribute to improvements in the above system indicators through prevention, improved supports at the point of care and/or improved flow.

Each Action Area has its own set of broadly defined indicators identified within this plan (see Action Plan tables presented above) which will be refined through a collaborative process building on province-wide developments of the project (see indicator template in appendix). These indicators will align with the system indicators noted above.

In addition, each improvement initiative identified through the value stream mapping exercise has its own improvement indicators that will align with the system indicators above (see VSM improvement plans in appendix).

CBSS Project Team

Name	Title	Organization	Region	Sector
Dr Frank Molnar	Medical Director	Chair Champlain Dementia Network, Regional Geriatric Program of Eastern Ontario	Regional	Regional program
Nicole Robert Dr Gobessi,(delegate)	Executive Director	Geriatric Psychiatry Community Services of Ottawa.	Ottawa	Regional program
Greg Fougere	CEO	Perley and Rideau Veteran's Health Centre	Ottawa	LTCH
Dr Marie France Rivard Carol-Anne Cummings (alternate)	Psychiatrist	Royal Ottawa hospital Geriatric Psychiatry program	Regional program	Royal Ottawa Hospital
Bernadette Wren Michael Ralph (alternate)	Director Mental Health Services Pembroke Regional Hospital	Pembroke Regional Hospital	Renfrew County	Hospital
Marie Hélène Gérome	Director of planning	French Language Services Network of Eastern Ontario	Regional	Regional- Le Réseau
Sophie Parisien	Director, Client Services	Champlain CCAC	Regional	Regional program
Shelley Vaillancourt	Executive Director	Alzheimer Society of Cornwall & District	Eastern Counties	Regional Association
Sally Munroe	Director of care	Maxville Manor	Eastern Counties	LTCH
Judy Vokey-Mutch	*Discharge Planning Coordinator*	ALC Working Group And TOH	Regional and Ottawa	ALC working group-regional
Dr Kiran Rabheru Connie Colasante (delegate)	*Geriatric Psychiatrist*	The Ottawa Hospital Associate professor, Ottawa University	Ottawa and Regional	Hospital and University
Nicole Fulford	*Director of Care*	St. Patrick's Home of Ottawa Inc	Ottawa	LTCH
Dr. Alexandra Segal Liliane Locke (delegate)	*Neuropsychologist*	Bruyère Continuing Care	Ottawa	CCC
Chantal Séguin	*Project lead*	Champlain LHIN	Region	
Kevin Barclay	*Project Manager*	Champlain LHIN	Region	

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