Mississauga Halton **LHIN**

Behavioural Support Ontario (BSO) Action Plan

December 2011

Ontario
Local Health Integration Network

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Introduction

The challenges associated with effectively meeting the health care needs of Ontario's elderly population have been well documented. Perhaps the most challenging needs are experienced by older individuals who also demonstrate responsive behaviours often associated with advancing dementia, mental health or other neurological conditions. For these individuals and their families or caregivers, the road to accessing, and receiving appropriate services at the right time and in the right place can often be described as lonely and stressful.

In January 2010, the Ontario Ministry of Health and Long-Term Care introduced the Behaviour Support Service (BSS) Project and funded work to develop a principle based framework that would assist in system redesign to support older individuals experiencing responsive behaviours and their families or caregivers. This was identified as Phase 1 of a multi-phase initiative. This work led to the development of the documents entitled "Behaviours have Meaning" released in October 2010, and "Ontario Behavioural Support Systems; A Framework for Care", released in January 2011. Both documents present a number of key framework principles and foundational pillars that are necessary to create a supportive and effective service system and are listed below.

Framework principles

Person and caregiver-directed care is the overarching principle:

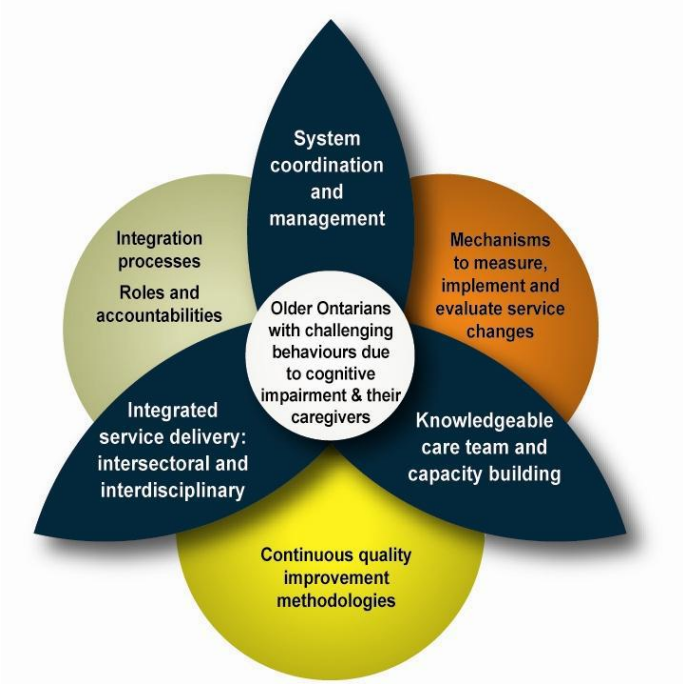
- Everyone is treated with respect and accepted "as one is"
- Person and caregiver/family/social supports are the driving partners in care decisions
- Respect and trust characterize relationships between staff and clients and care providers

Supporting principles bring these concepts to life for those making daily decisions about care:

1. **Behaviour is communication**: Behaviours are an attempt to express distress, solve problems or communicate unmet needs. They can be minimized through interventions based on understanding the person and adapting the environment or care to satisfy the individual's needs.
2. **Diversity**: Practices value the language, ethnicity, race, religion, gender, beliefs/traditions, and life experiences.
3. **Collaborative care**: Accessible, comprehensive assessment/interventions include shared interdisciplinary plans of care that rely on input and direction from the client and family members.
4. **Safety**: A culture of safety and well-being is promoted where older adults and families live and visit and where staff work.
5. **System coordination and integration**: Systems are built upon existing resources and initiatives. Partners to enable access to the range of needed, integrated services and supports.
6. **Accountability and sustainability**: The accountability of the system, health and social service providers and funders to each other is defined and ensured.

BSO Framework for Care

The following diagram graphically displays the BSO Framework for Care



Reference: Ontario Behavioural Support Systems; A framework for Care, January 2011

The accomplishments of the work completed during phase one of the BSS Project resulted in the Minister of Health announcing in August of 2011, Phase 2; the Behavioural Supports Ontario (BSO) Project. The project was described as;

> "The BSO Project was created to enhance services for Ontarians with behaviours associated with complex and challenging mental health, dementia or other neurological conditions wherever they live. The goal of the project is system wide reform that ensures these individuals are treated with dignity and respect in an environment that supports safety for all and is based on high quality and evidence-based care and practice."

Within the project framework all fourteen Local Health Integration Networks (LHINs) are required to develop action plans that would identify opportunities to improve the existing service system supporting the target population as well as plans for the allocation of new resources to fill identified service gaps. Provincially, a total of $40 million to support new staffing resources was allocated to the project. Approximately two thirds of the funding is directed towards supporting the long-term care sector and the remaining one third directed toward community based resources.

Within the project plan structure, four LHINs were identified as early adopters that would proceed in the planning process prior to other LHINs. These LHINS were mandated to provide guidance and mentorship to the remaining ten LHINs in the development of their action plans and ensure that plans would be based upon best practice and quality improvement methodology. A support system for all LHINs, comprised of a Provincial Resource Team, Central Reporting Office, Alzheimer Knowledge Exchange and Health Quality Ontario was established to guide and assist each LHIN in development of their local action plan and future implementation of their plan.

The Mississauga Halton Local Health Integration Network (MH LHIN) covering the communities of Oakville, Milton, Halton Hills, Mississauga and West Etobicoke, represents the second smallest geographic LHIN area however the fifth largest population base amongst LHINs. Within the next ten years it is projected that the growth in seniors' population will be second greatest in the province. The MH LHIN is in a unique position that it has already made strategic and targeted investments through Aging @Home initiatives such as the creation of a Specialized

Behavioural Support Unit within a Long Term Care setting, Seniors Geriatric Mental Health Outreach Teams (SMHOT), Nurse Practitioner Stat program and expanding community networks. These investments were targeted to address the needs of seniors with complex healthcare needs and alleviate Emergency Department and Alternate Level of Care pressures. The MH LHIN is looking to leverage these previous investments to expand its services as it relates to the BSO project.

Appendix 1 and Appendix 2 illustrate the communities within the MH LHIN, location of LTCHs, population distribution and density for people aged 75 years and over and the distribution of LTCH beds per 1000 people aged 75 years and over. The MH LHIN has the lowest distribution of LTCH beds per 1000 people aged 75 years and over when compared to both the provincial average and other LHINs.

Within the MH LHIN a BSO Advisory Committee was established to provide advice to the MH LHIN in the development of the local BSO Action Plan. The following plan is the result of 6 weeks of intense, energized activity on the part of key inter-sectoral/interdisciplinary service providers and caregivers who recognized and seized the opportunity to influence and lead meaningful system change. Success will be defined by the ability of this project to build capacity within the existing system and affect a cultural shift in the care of the target population within the LHIN by focusing on person and caregiver-directed service delivery.

The journey has only just begun as this action plan presents a test of concept that reflects the unique characteristics and resources existing within the MH LHIN community. The following action plan incorporates information received through value stream analysis of the current service system and identification of a future state process map. The process also involved a community and stakeholder engagement strategy comprised focus groups and surveys of caregivers, long-term care homes (LTCH) involving corporate representatives and community based service providers.

This action plan presents opportunities to leverage and improve existing resources and a plan for allocation and implementation of new staffing resources to address service gaps and limitations identified during the planning exercise.

Mississauga Halton LHIN BSO Action Plan

BSO Framework for Care Pillar #1: System Coordination

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

1. ***What are the current gaps and weaknesses in system coordination across cross-agency, cross-sectoral collaboration and partnerships preventing 'seamless' care?***

   Information that identified current system gaps was initially captured through the value stream analysis exercise with significant input by one previous caregiver and one current caregiver identifying their lived experiences. Additional information was gained through focus groups and surveys with other caregiver groups (adult day program caregiver focus groups, Alzheimer Society of Peel caregiver support groups, LTCH family councils) and also with a group of community based service providers (Mississauga Halton Dementia Network).

   It was identified that there were gaps in knowledge of existing services and how to access these services. The knowledge gap was identified to exist within the following three groups; primary care, service providers and individuals and families seeking support. Even though service providers may be aware of other organizations providing services to the target population there was a lack of accurate knowledge of service specifics, such as eligibility, and referral process. It was mentioned by various caregivers that family physicians were not knowledgeable of all services available but they were seen as a valuable access point to gain information from others.

   There is a current lack of communication between service provider agencies, including primary care as to common client service and health care status. Families and caregivers expressed frustration with repeatedly being asked for similar information or not having service information passed between service providers and organizations. In this discussion it was mentioned that there is a lack of common or standard assessment processes.

   As people transitioned between service providers and sectors (i.e. between community, acute care and long-term care), caregivers expressed a lack of support and lack of continuity of care. In some situations, especially when transitioning between the community and long-term care sectors, there were perceived barriers such as privacy provisions within the Long-Term Care Homes Act, 2007 that prevented information sharing or support between organizations.

   Service providers were identified as having different degrees of knowledge and understanding of dementia and other cognitive impairments. There is also an identified gap around strategies to manage responsive behaviours or support caregivers as they experienced responsive behaviours of their family members. This gap in service provision is significant and will be addressed through this project.

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

      Within the MH LHIN there are several structures to assist with coordination and linkage. When initially formed these groups were primarily sector specific but through cross linkage supported by the LHIN, they are now more intersectoral and provide opportunities for enhanced collaboration between service partners.

      - ALC Operations Group – hospital, community service, CCAC, LTCH, Nurse Practitioner involvement
      - LTCH Administrator and Director of Care Networks – primarily LTC but representation of hospitals, CCAC, outreach teams (GHMOT, ABI, NP)
      - MH Dementia Network – community, CCAC, LTCH
      - LHIN Board of Director Governance to Governance Network – quarterly meetings of HSP governance representatives
      - MH LHIN Leadership Collaborative – Sr. leaders representing all health service areas within the LHIN
      - MH LTCH Physicians Network – working with NP outreach program

- System Integration Group for Mental Health and Addictions (SIGMHA)
- Sheridan Villa Specialized Behavioural Services Unit Admissions and Discharge Team – outreach services, community support services, LTCH, hospital based seniors mental health services, CCAC
- Seniors Mental Health Outreach Team Advisory Committee – community support services, CCAC, LTC, SBSU, hospital partners
- MH LHIN annual Knowledge EXPO – representation on all HSPs to learn of LHIN funded services and initiatives

b. How will structures be modified to improve coordination?

Structures will be modified to improve service coordination in a number of ways:

- Within each committee MH BSO initiative will be listed as a standing item for discussion and information sharing. Memberships will be examined to ensure that each group has full cross- sectoral representation.
- Knowledge exchange between HSPs will be examined to strengthen and ensure understanding of agency service characteristics and linkages.
- There is the potential of developing a common care pathway built upon integration of community services and institutional services. There is opportunity to leverage existing care pathways as a model i.e. cardiac self care pathway.
- There is opportunity to enhance service access by developing or revising protocols and processes. These can be used to identify issues when individuals that are served by community supports, access hospital ED services. This will provide the ability to redirect the individual to existing or new services that more appropriately meets their care needs.
- In order to better support individuals through service transitions there is opportunity to leverage the existing CCAC intensive case management program or the GEM nurse program in the ED, to expand their mandates to include the BSO target population.
- There also exists opportunity to leverage current initiatives supporting the Integrated Assessment Record (IAR) project to improve communication of client information between service providers and health care professionals.

2. ***What governance and accountability structure will be in place?***

In order to ensure overall service and system accountability the MH LHIN will utilize a number of supportive system management strategies.

The first is to ensure that there is effective oversight of implementation of the BSO project within the MH LHIN, the MH LHIN BSO Advisory Committee with have direct linkage and report to the MH LHIN Leadership Collaborative. This mechanism will allow for ongoing regular reporting on progress with meeting action plan milestones and ability of the initiative to meet pre identified performance indicators.

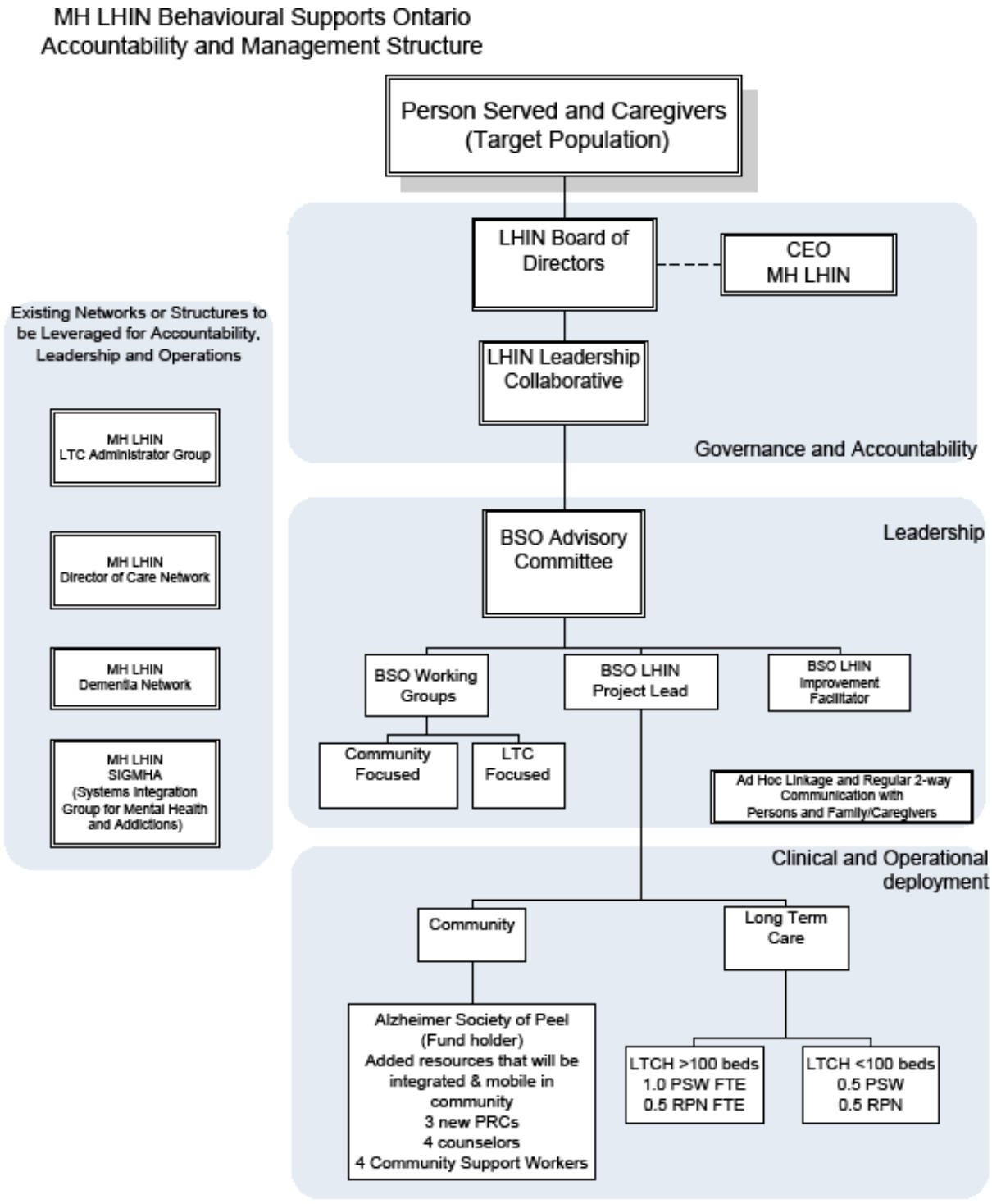
The committee will have a revised project charter that will clearly identify partner roles, expectations and reporting structures and timeframes. Similar project charters will be required for any working groups implemented in specific action areas to clarify mandate and performance expectations.

The MH LHIN BSO Advisory Committee will provide leadership accountability to the project and support organizational collaborations, a subsequent operational level will support direct service linkage and development of service process flows to support the individual and caregivers during their service journey between organizations. The operational committee will also support care pathways to provide support for individuals as they transition from service to service to meet individual needs.

The MH LHIN will also ensure accountability of the use of funding provided to HSPs through the development of service accountability agreements that will become an addendum to the existing LSAA or MSAA with the organization. Service accountability agreements will identify the use of the funds provided, performance indicators to be reported on and clear service expectations. A clear reporting schedule will also be provided.

Accountability mechanisms between organizations as in Memorandum of Understandings or Service Agreements will ensure organizational support to allow mobile or outreach teams to provide service in various environments beyond that of their host organization.

Accountability and Management Structure



3. ***Name your partners for system coordination (e.g. CCAC).***

A list of partners for system coordination is provided below:

- Inga Mazuryk, Administrator Sheridan Villa, Region of Peel
- Scott Faraway, Manager, Behavioral Services, PHDABIS
- Mary Compton, Peel Crisis Services
- Lori Brown, Coordinator, NP STA, Credit Valley Hospital
- Julie Wong, Administrator, Northridge LTCH
- Margaret Bouillon, Extendicare
- Julia Baxter, St Joseph's Hospital, Manager GMHOT
- Christopher Rawn-Kanes, CEO Alzheimer Society of Peel
- Faith Madden, Manager Placement Services, MH CCAC
- Ann Sterling, Director, Client Services, MH CCAC
- Pat Mohani, Manager Seniors Mental Health Team, Trillium Health Services
- Doris Burns, PRC, Trillium Health Services
- Janice Cox, Family member
- Radhika Subramanyan, CMHA, Halton
- Marie Hoy, CMHA, Halton
- Marion Penko, PRC, GMHOT
- Karen Parsons, Peel Addictions and Rehabilitation Centre
- Cathy Raiskums, Manager, Discharge Planning, Halton Health Services
- Laurie Maratovich, Halton Region
- Rob Low Project Lead, MH LHIN
- Sean Weylie, Improvement Facilitator, MH LHIN

a. How have the partners collaborated on previous projects?

Within the MH LHIN there exists a positive track record of collaboration amongst HSPs. In 2009, a Behavioural Support Unit Steering Committee was established by the MH LHIN to identify need, explore and guide the development of a behavioural serviced unit at Sheridan Villa, a LTCH in Mississauga. The committee, representing, hospitals (discharge planning and inpatient clinics), CCAC, LTCHs, LTCH outreach services (GMHOT, NP, ABI services) and the LHIN, identified opportunities for linkage and support to leverage existing services to build upon existing community resource and allow their support to the operation of the unit. Leverage opportunities included use of existing outreach services, linkage with hospital psychiatric support, linkage with NP program for complex medical conditions, receiving LTCHs to work with program to accept transferring residents and work with SBSU staff to support transition and knowledge transfer of behaviour management strategies.

Other examples include the development of a restorative care service model in a LTC home to support the timely discharge from hospital for patients to regain functional abilities to return to their home in the community rather than experience premature LTCH placement or lengthy ALC stays in hospital. Collaboration involved hospitals (rehab services, discharge planning), CCAC, LTC, NP program.

The implementation of a nurse practitioner services working in LTCH to provide acute episodic supports for LTCH residents to prevent avoidable transfers to the hospital emergency departments is another example of collaboration within our LHIN area. The implementation and future expansion of the NP STAT program to support all 27 LTCHs in our area required the collaboration and assistance of many partners including LTCHs, physicians, LTCH ownership, MH CCAC and local hospitals.

b. What were the outcomes?

In each example cited above, the results have been very positive. For Sheridan Villa the behavioural unit was established in September 2010 and became the first Specialized service unit in the province recognized

under the LTCHA 2007. A third party evaluation of the unit has identified the success experienced in the first 8 months of operation, as well as opportunities for further improvement. The evaluation is available for review on the MH LHIN website.

The RESTORE program operated in a LTCH has demonstrated success in assisting individuals to regain functional abilities following lengthy hospital stays and returning to their homes in the community. This program has assisted the LHIN to reduce both ALC numbers in hospital and ALOS for ALC patients.

The NP STAT program has been able to demonstrate improved acute episodic services for residents that have lowered the rate of transfer to ED from LTCH. The success of this program has fostered other initiatives to investigate other opportunities that LTCH can implement best practice and collaborate with other groups to support individuals with heavier care needs and provide increased quality of care on site.

In all three areas the successes have been built upon the effective collaboration and involvement of the various partner organizations.

c. List the executive sponsors who will have potential responsibility for meetings, chairing a steering committee, ongoing leadership and engagement, etc

- Bill MacLeod, MH LHIN, executive sponsor
- Rob Low, MH LHIN, BSO Project Lead
- Sean Weylie, MH LHIN, IF
- Scott Faraway, PHDABIS, Advisory committee Co-chair
- Inga Mazuryk, Community Services Manager, Region of Peel, Advisory Committee Co-chair
- Christopher Rawn-Kanes, CEO, Alzheimer Society of Peel

BSO Framework for Care Pillar #2: Interdisciplinary Service Delivery

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

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

Building on Value Stream Mapping Activity (VSMA) and other community consultations there were several challenging areas on the service continuum where access to service and support was identified as problematic for the target population (persons served and their caregivers).

While primary care was acknowledged by many in our community as a key central resource to support and further develop, defining specific activities beyond awareness and linkage were seen as out of scope for this first phase of our BSO initiative. A commitment was made to build on the learning's and strategies developed by other LHINs, and to foster the BSO agenda within our LHIN with primary care.

The significant role of family/caregivers was acknowledged. We heard from both families themselves and other stakeholders that it was critical they are supported to gain knowledge of relevant diseases, strategies for management, what services and supports are available and how to access them. We also heard that there are persons in the target population living in the community who may live alone and may not have available caregivers. The MH LHIN Value Statement created during the VSA exerccise was ***"Hear me, understand me and support me to live my life to the pullest potentail".***

The Community Care Access Centre was identified as a foundational health system resource supporting access to relevant services. It was also acknowledged that persons and families may seek assistance by calling various other health service providers when looking for help. Consultations noted that there are gaps in knowledge, awareness and skills of health system providers within the current service continuum relevant to helping identify the needs of persons served and their caregivers and matching/linking to timely support and service. For this reason the philosophy of "no wrong door" was reinforced in our planning. While specific activities may focus and build on the information and referral role of CCAC, helping to strengthen the "access role" of all health service providers across the continuum was also seen as important.

In relationship to the Long Term Care Sector, the transition to Long Term Care (e.g. crisis placement from community, placement from community home, placement from hospital etc.) was identified as a time of vulnerability. Additionally, once a person resided in Long Term Care scenarios were highlighted where the resident may be at risk of or actively demonstrating responsive behaviour putting themselves and/or others (e.g, co-residents, families, staff, etc) at risk. System resources, internal and external to the Long Term Care Home sector, currently exist to provide assistance however our consultations uncovered opportunities to further develop and strengthen access to these supports and outreach services.

a. ***What high risk population is currently underserved and will be a focus of this project? What are the transition points for this population?***

The focus is on older persons who are at risk of or demonstrating responsive behaviours that have cognitive impairment due to dementia, mental illness, addiction or other neurological conditions that live in a community setting (e.g. own home, supportive housing etc.) or in a Long Term Care Home. There are multiple pressure points or examples of under-service highlighted in both sectors. We are also focusing on the person's family/caregivers that may be at risk or suffer consequences from a range of perspectives e.g. health and wellness, safety, social, environmental, economic, spiritual. Other stakeholders and partners linked to the proposed improvement activities include health system providers across the multiple sectors of care persons and their family/caregivers turn to for service and/or support.

There are multiple transition points within the healthcare system which the target population may experience, dependent on the need and/or situation. While there are many points of transition, our value stream mapping, consultation and BSO Advisory Group have chosen to focus on:

- Attempting to increase the support system for persons and caregivers while in the community; this can be perceived as a transition from "caring alone" to involving others in the care through either in-home (e.g. in home care) or out-of -home support (e.g. adult day service).
- Transitioning the person from their community home to their home in a Long Term Care setting
- Persons in a Long Term Care Home setting at risk of or demonstrating responsive behaviour and accessing internal and/or external behavioural support resources as needed; while not our primary focus, it was also noted that if the current situation could not be stabilized in the current LTCH setting, the person may need an alternate setting for assessment and intervention.

All of the above transitions need to consider the family/caregiver impact and context as well. From the onset of our BSO planning there has been agreement to try and look at this initiative from the context of our local health system perspective. We are cognizant of the challenge to realistically define and scope out specific improvement plans that are achievable and that will begin the process of incremental positive system change.

b. What opportunities exist to leverage the strengths and address the gaps in service continuum for behavioural support services?

Through Aging At Home funding the MH LHIN has made strategic investments in community and Long Term Care settings which will be leveraged and include the following selected examples:

- NP-STAT program – each of the 27 LTCHs within the MH LHIN have access to a Nurse Practitioner 24/7; while the primary function focuses on physical health needs and repatriation support from acute care to LTC, the NPs have been accessed to assist in ruling out physical causative factors and care planning for complex residents with behavioural issues
- Geriatric Mental Health Outreach Programs – while the MH LHIN is served by more than one GMHO teams, the MH LHIN has encouraged steps toward integration or a common service approach; all LTCHs have assigned GMHOP clinicians and there are processes in place to access the current services on urgent and non-urgent bases; the GMHOPs also serve persons in community settings as well and thus can assist in transitioning clients from community to Long Term Care or from Long Term Car to appropriate alternate assessment settings (e.g. Behavioural Support Unit, Tertiary Care)
- Peel Halton Dufferin Acquired Brain Injury Service (PHDABIS) – while the ABI population is not specifically included in our target population, the learning's and the knowledge resources of the ABI funded service targeted for seniors in Long Term Care settings or seniors transitioning to LTC from

hospital and the augmentation of specialty trained PHDABIS staff assist with care routines where there are behavioural risks, will be a significant asset.

- Sheridan Villa Specialized Behavioural Support Unit (SBSU) – 19 bed Long Term Care-based assessment and individualized behavioural support intervention unit for persons with dementia and responsive behaviour from their community home, hospital or long term care settings; transitional support to and/or from the unit is a core service of the SBS unit and the model builds on the support and services of community partners (e.g. Alzheimer Society, acute care hospitals, SMHOPs)

There are additional AAH initiatives that interface with the target population and they too will be factored in to the planning and implementation processes (e.g. Geriatric Medicine Outreach Services, Home First, etc.). While the MH LHIN has a solid array of quality services along the service continuum, there are a number of opportunities to better optimize and maximize the current services to promote enhanced quality, responsiveness, safety and value for the person and their family/caregiver.

In the Value Stream Mapping Activity and other consultations, the need for increased training, knowledge transfer and performance improvement activities amongst cross sector health service providers was reinforced. The MH LHIN will leverage the resources, skills, the creativity and the enthusiasm of the Psychogeriatric Resource Consultants (PRCs) who are able to provide case-based and topic specific training and learning opportunities and to develop strategy and partnerships for organizational, community and system development with a focus on the community and Long Term Care sectors.

The MH LHIN has a very strong Alzheimer Society presence and solid service delivery evidenced by the increasing person and caregiver demand on service, the outreach into community homes, the community leadership and cross sector partnerships and the continuum of education, support, and respite services (e.g. Nora's House, Adult Day Services) provided. Additionally, there is a good base of LHIN-based Networks or focused Task Groups within the MH LHIN whose mandate interfaces with the met and unmet needs of the BSO target population. As part of the engagement and change management plan for our BSO activities, a process was initiated to meet with the various Network groups (e.g. LTC Administrators, Dementia Network, Directors of Care, etc.) to inform them of the provincial BSO direction and begin a dialogue related to needs for change, opportunities for partnership and strategies to improve, in a Quality Improvement (QI) context. The inter-organizational and inter-sectoral relationships of our diverse BSO Advisory Group and subsequent working groups will also be leveraged – members will be encouraged to be ***champions of change*** at the point of service, within their teams, organizations and at the system level. In our planning and consultations various representatives spoke of learning's (e.g. Resident First and the successes of QI champions and peer-to-peer PSW modeling) and future opportunities (e.g. CCAC led value stream mapping within the various services linked to CCAC processes).

The BSO Advisory Committee developed a project charter to increase the voice of the person/family/caregiver in identifying areas of unmet needs and to create opportunities for persons/caregivers to contribute to the planning and making of system improvements. We are fortunate to have a very skilled and articulate family member on our BSO Advisory Group. As an Advisory Group we have demonstrated that we do value the lived experience as we created the time to have conversations with individual caregivers and/or caregiver groups to inform them of this initiative and seek their guidance and ongoing participation. This meaningful activity served to anchor and inspire the future actions. This is a key area to be further developed, sustained and leveraged.

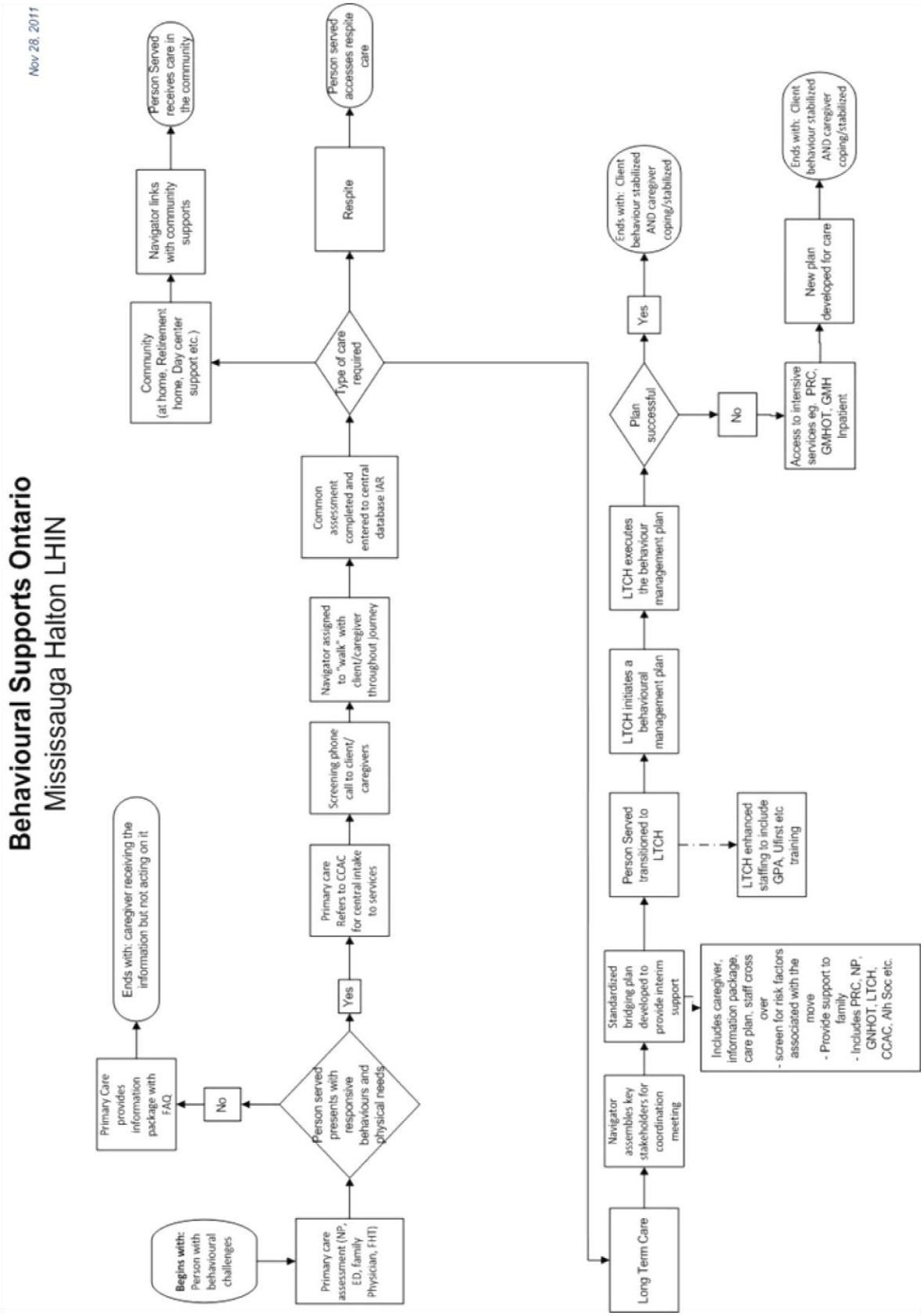
c. Will both rural and urban population issues be addressed?

The Mississauga Halton LHIN boundaries include a south-west portion of the City of Toronto, the south part of Peel Region, and all of Halton Region except for Burlington, which is part of the Hamilton Niagara Haldimand Brant LHIN. While we are predominantly an urban population with small amount of rural in the northern half of the LHIN, both rural and urban needs will be met using the "no door is the wrong door" approach to accessing services. The services will be coordinated across the LHIN. Existing services have demonstrated pre-existing commitments to equity of access to services across the LHIN. What the MH LHIN may lack in size is made up in population density in specific areas and cultural diversity.

5. ***Illustrate how your Action Plan addresses the continuum of services from primary to acute to community care based on system coordination across cross-agency, cross-sectoral collaboration and partnerships (i.e. preventative care in primary care and the community, individuals at the tipping point utilizing at least two health service agencies, etc.)? Attach a process map.***

   The Value Stream Mapping Activity (VSMA) carried out on November 14th and 15th resulted in the creation of the attached process map. The process map was developed from a scenario of a couple living in community, supported by family physician, followed by eventual linkages to community supports, followed by a change and increased service needs necessitating long term care placement on a crisis basis. Much of the discussion during the VSMA and in subsequent dialogue during BSO planning focused on the need to be proactive and attempt to prevent responsive behaviour where possible, however when it does occur, to be responsive to the needs of persons and their caregivers providing navigational support to facilitate access and competent service delivery and support if transition is a factor. While there was a tendency to focus on crisis scenarios, the group believed there was greater benefit at this time to build foundation and try to prevent crisis.

Future State Value Stream Map



The BSO planning activity for the MH LHIN was initiated just over 6 weeks ago and we are in the developmental stages of our conversations around opportunities for system re-design and are making system changes incrementally. The early process map from mid November will be used as a reference point and there are plans to re-apply the process mapping activity noting its utility at various macro and micro levels. The attached process map was a launch point that identified relevant process improvement opportunities and highlighted the three themes of: access, transition and service.

The following are elements of our Draft Action Plan:

BSO Pillar	Improvement Title	Reason for Improvement	Health Human Resource Allocation
2	Creation of mechanisms and strategies to increase the person/caregiver perspective throughout MH LHIN BSO planning and implementation	• While acknowledged as a valued element in practice health system planning initiatives often omit or overlook active persons/family involvement	
1	Creation and promotion of system navigation functions and supports within current health system	• In complex scenarios, families need advocacy and guidance for service linkage • There are a number of persons living alone in community who do not have active caregivers • Message through VSMA and BSO consultations and dialogue reinforced the need for more practical supports	Development and integration of Community Support Worker (4); CSW role taken from Client Intervention and Assistance (CIA) and Intensive Geriatric Services Worker (IGSW) functions
3	Increase support and behaviour management capacity of family caregivers	• Majority of care for seniors is provided by family/friend caregivers	Invest in more Family Counselors (4) through the Alzheimer Society noting their ability to provide individual or group or office or home-based education and support services
3	Increase knowledge and skills of health service providers in community and Long Term Care based settings	• Families stated that need service staff who are capable • Health service providers have expressed that they require more understanding, knowledge and skills related to their current and future roles and responsibilities relevant to the target group	Invest in more Psychogeriatric Resource Consultants (3) noting their cross sector roles in learning and development Embedded LTC-based BSO resources once trained will have a knowledge transfer responsibility through various mechanisms including service learning opportunities
2	Development and embedding of LTC dedicated behavioural support resources within existing 27 LTCHs that would link with external resources (e.g. NP STAT, PRC, GMHO)	• Residents, families and staff in LTC require increased support during transition to LTC, if resident presenting with signs of being at risk of responsive behaviour and especially when demonstrating responsive behaviour • LTCHs expressed need for stable resource to build from versus creation of more mobile external resources	Dedicated LTC allocation to include 22 PSWs and 14 nursing resources which will be deployed to all LTCHs within MH LHIN based on a formula governed by a memorandum of understanding

BSO Pillar	Improvement Title	Reason for Improvement	Health Human Resource Allocation
1	Increase primary care awareness of BSO and create opportunities to increase primary care knowledge of relevant service and supports for target population	Primary care noted by families as their central and key resource Strengthening primary care in this area will enable early detection n and appropriate referral as appropriate	
3	Establishment of tools (e.g. agreements, protocols, decision trees etc.) and best practices that would enable effective service response, communication and collaboration of resources	• MH LHIN has existing services along the continuum that we want to better align, and optimize • Tools and/or processes that enable clarity of roles, expectations, responsibilities, access to resources, and help promote standardization contribute to quality care and experience.	

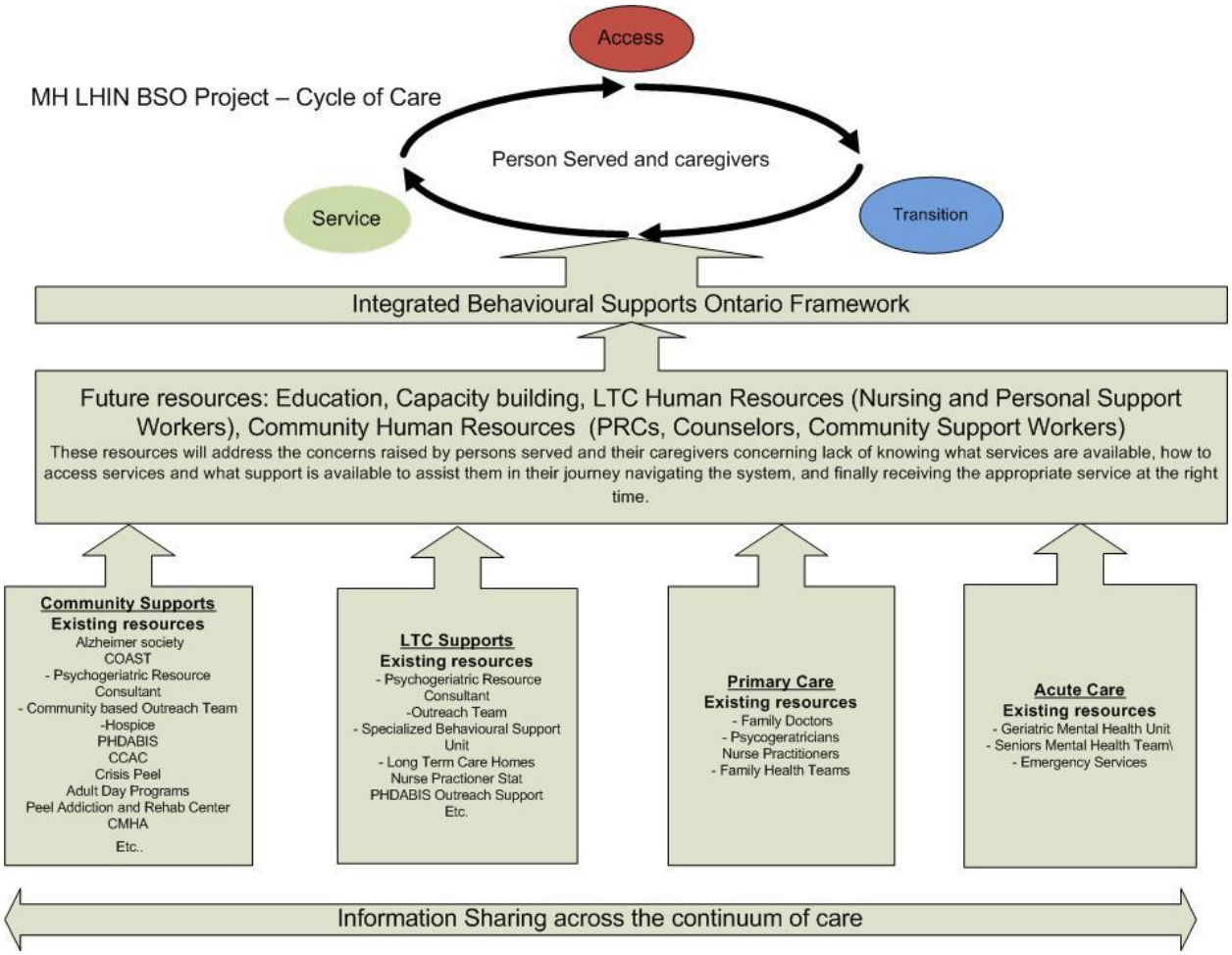
6. How will support across the service continuum be provided to ensure equitable and timely access to the right providers for the right service?

Throughout the BSO planning in the MH LHIN there is a clear message that existing services and resources within the current service continuum will be accessed and leveraged to ensure persons and their families/caregivers are served and supported by the right person, in the right place, by the right service, at the right time and in the right way. Where there have been identified gaps in that a service does not exist or possibly in the manner in which the service is delivered, we hope to begin to address those gaps through our above Action Plan. An ongoing environmental scan of what is currently in our service system will assist with this process. Additionally the ongoing engagement with persons and families/caregivers will provide meaningful input and guidance to this process.

There is a commitment to prevention and early intervention. We heard this messaging in our VSMA and in consultations that we need to instill processes and supports to help promote a culture change in this direction. Messaging within our activities also reinforced a "no wrong door" policy however we identified through hearing from caregivers that often they are left to navigate for them to find the right "door" and at times when they find the "right door" the experience trying to access the service is less than optimal. As part of a culture change toward prevention we also want to reinforce a welcoming, enabling and supportive atmosphere to the persons and families/caregivers that are experiencing this journey in our local health system and to uncover opportunities for continuous improvement in this area.

A key aspect of timely access to the right providers for the right service is being able to effectively assess and uncover the unmet needs. Strengthening family and health service provider understanding and knowledge of the meaning of the behaviour is an important first step. There is a commitment to build on and reinforce application of the training and learning opportunities that exist within the health system e.g. PIECES, Gentle Persuasive Approach to Dementia Care, U-FIRST. This will be achieved through responsive capacity building activities but also through the leveraging of existing resources such as NP STAT, GMHO and the Alzheimer Society that can model the application.

MH LHIN BSO Project Cycle of Care



Additionally having increased understanding of each other's resources, roles and responsibilities through various formal and informal methods, decision trees, communication tools or processes will help to guide the matching of unmet needs to services and supports and enable appropriate linkages and referrals to be made. MH CCAC has been very active in the BSO planning activity and has engaged in discussions as to how to further leverage the foundational role of the Community Care Access Centre and to strengthen the capabilities of the human resources within CCAC to best serve the target population.

Equity of access and service will continue to be a held value within our enhanced service continuum. Tracking and observational tools will be put in place to monitor aspects of equity that may include wait times, persons being denied service or experiences of barriers to service. Trends and themes related to equity will be brought forward to the BSO Advisory Group for discussion, review and development of responsive action.

a. Will there be supported behavioural assessment services?

Through our BSO Draft Action Plan we are focusing on those persons and families/caregivers living in community or in Long Term Care Home settings. It is acknowledged that in some form or another, behavioural assessment is many times currently taking place. Through environmental scan, planning activities and formal capacity building opportunities it is our goal to:

- Strengthen and appropriately align (e.g. reduce duplication, build on known quality information) the current behavioural assessment processes that are currently in use in community and Long Term Care settings

- Ensure the new resources integrated into the system are able to augment, respond to gaps in the behavioural assessment process (e.g. 1:1 observation of care, use of standardized tools and communication processes) and bring value added resource in this area.
- Promote and create easy mechanisms of access to existing specialized resources that will assist with assessing behaviours in more complex scenarios.

The development and application of evidence-based knowledge and skills surrounding behavioural assessment in community and Long Term Care settings will be put in the context of quality improvement activities so that we are able to effectively gage change and respond to our observations. Additionally it will be reinforced that we have a collaborative commitment to effectively respond to the assessment information and develop, implement and evaluate person-centered prevention and intervention strategies.

b. How will a comprehensive geriatric assessment be conducted?

The concept of comprehensive or holistic assessment will continue to be promoted and skills developed. There are many opportunities where the person and their family/caregiver may interface with a health service provider who may be in a position to detect the need for and ensure a comprehensive geriatric assessment is conducted. We want to increase the appropriate likelihood that this occurs – we want to reduce missed opportunities. Capacity building along the service continuum will reinforce the message that prevention and effective management of responsive behaviour begins with a thorough assessment.

There are existing resources within our current health system that are recognized for comprehensive geriatric assessment in more complex scenarios (e.g. NP STAT, Seniors Mental Health Services- outreach or clinic based , Geriatric Medicine Services - outreach or clinic-based, local primary care physicians specializing in Care of the Elderly or who have specialized Memory Clinics). Through our BSO activities we will embed a community development approach to foster and promote awareness of these existing resources and where appropriate or needed, develop tools that will assist in the decision making of when and how to access these more specialized resources. We will also help to define what a comprehensive assessment is in the context of the target population and will consider the development or accessing already developed decision trees or job aids to help guide the process.

Additionally in our proposed model we are both embedding new resources within the current infrastructure and creating defined linkages with the existing specialized resources to provide mentoring, support, modeling and an intersectoral team approach in the areas of behavioural assessment, comprehensive geriatric assessment and responsive service and care planning.

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

Community development and capacity building opportunities will reinforce mechanisms for identification. We will be reinforcing the concepts of noting change(s) in the person's function/ability/behaviour and bringing these observations forward to someone who can act on them. We want to build on and appropriately access existing resources and skills within the current health system and in addition, make the appropriate connections to enhanced or specialized services.

In the context of the target population we want to communicate the message that persons who are facing transition are vulnerable to experiencing responsive behaviour and thus promote prevention through preparation, 2-way communication and responsive interventions. Additionally we will be communicating to families/caregivers and health service providers that those who could benefit from behavioural support services are also those who are "at risk". We will be creating strategies to build knowledge and awareness of "at risk" factors to help promote a proactive versus reactive stance and response. Persons who are actively demonstrating responsive behaviours are more easily identified however the challenge will be to ensure a person centered and systematic approach guides our actions.

Both in community and in the Long Term Care setting we will build on and strengthen existing mechanisms of identifying someone needing assistance. This will be a specific operational issue to be addressed by the working groups.

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

In the context of "no door is the wrong door" we will promoting a culture where if someone presents or it brought forward as a potential recipient of the service however is not identified as part of the target population will we attempt to link them to the right service. There are persons in our health system whose needs are either to a degree of uniqueness or complexity that they do not "fit" into existing services. There has been early discussion in our BSO group, that as part of the health system development we may want to catalyze a process to collaboratively review and try to respond as a system to those scenarios where complexity complicates matching unmet needs to service and support.

Further education on "who does what" and tools to guide people to the right door the first time will also decrease inappropriate referrals. MH CCAC will continue to act as a foundational resource for information and service referral. There is a commitment also to track those persons who request service however "do not meet criteria" in order to track themes, better understand the presentations and develop responsive actions as needed.

Additionally we have noted that it is our hope that individuals with behavioural issues due to other conditions such as Acquired Brain Injury, Dual Diagnosis or those who may be younger in a Long Term Care setting will benefit from developed structures, processes and relationships within the context of the BSO planning and implementation. We will also be fostering open communication with a range of related service providers recognizing the opportunity and value of exchanging experiences and knowledge of use of resources within the system.

e. How will individuals in crisis be supported?

Within MH LHIN we have 2 crisis service system and both are actively engaged in the BSO planning and activities. There is a commitment to build "senior savvy" capacity and strengthen relationships and processes between the general crisis system and existing resources that are responding to urgent and non-urgent service requests and many times faced with crisis situations.

Development of the operational guidelines related to areas such as what is a crisis, how to triage service needs in the context of crisis, urgent and non-urgent and how to respond to crisis, who can help in a crisis and how to prevent crisis will be developed. This work will be done in collaboration with existing resources leveraging the experience and knowledge of current practices and situations. The defined community and Long Term care working groups will be charged to define mechanisms that will address crisis support in the context of the resources. In line with our culture of prevention we will also be fostering development of crisis and contingency planning.

7. Name your partners for interdisciplinary service redesign.

- Julia Baxter, Manager Geriatric Mental Health Outreach Programs, St. Joseph's Healthcare Hamilton, Co-Chair MH Dementia Network, Co-Lead SHRTN Community of Practice Seniors Mental Health, Dementia, Addictions and Behavioural Issues
- Rob Low, MH LHIN, BSO Project Lead
- Sean Weylie, MH LHIN, IF
- Scott Faraway, PHDABIS, Advisory committee Co-chair
- Inga Mazuryk, Community Services Manager, Region of Peel, Advisory Committee Co-chair
- Christopher Rawn-Kanes, CEO, Alzheimer Society of Peel and Co-Chair of MH Dementia Network
- Laurie Brown, NP stat, MH Adult Day Service Network
- Marion Penko, Psychogeriatric Resource Consultant, St. Joseph's Healthcare Hamilton, GPA Master Trainer and Chair, SJHH Geriatric Psychiatry Quality Council
- MH LHIN LTCHs

a. How have the partners collaborated on previous projects? What were the outcomes?

St. Joseph's Healthcare Geriatric Mental Health Outreach Program has collaborated to:

- Host formal staffing secondments with staff from Long Term Care, acute general psychiatry, Community Care Access Centre and the Halton Crisis Outreach and Assessment Support team (COAST) increasing cross sector knowledge and strengthening service linkage relationships
- Partner with addiction agency (ADAPT) to formally integrate and collaborate to provide geriatric addiction services embedded in geriatric mental health service developing concurrent disorder service capacity amongst providers and increasing opportunity for service access and assistance
- Partnered with CCAC and Long term Care partners to generate new knowledge, provide education and develop learning resource (e.g. DVD, learning package, assessment tool) on theme of relocation stress
- Work toward a common approach to clinical intake and service delivery of geriatric mental health outreach services with MH LHIN

Other examples would include:

- Establishment of the Sheridan Villa Behavioural Support Unit including development of admission, Discharge and Transfer criteria and a interdisciplinary team.
- Alzheimer Society working with ER and crisis admission of Nora's House
- Adult day Service Network working with CCAC to streamline access to service also ADS has also developed communication tools to share and exchange person centered strategies and relevant information that might be helpful to Long Term Care staff to ease the person's transition from community to LTC and help to prevent responsive behaviour

b. List the executive sponsors who will have potential responsibility for meetings, chairing a steering committee, ongoing leadership and engagement, etc.

- Bill MacLeod, MH LHIN, executive sponsor
- Rob Low, MH LHIN, BSO Project Lead
- Sean Weylie, MH LHIN, IF
- Scott Faraway, PHDABIS, Advisory committee Co-chair
- Inga Mazuryk, Community Services Manager, Region of Peel, Advisory Committee Co-chair
- Christopher Rawn-Kanes, CEO, Alzheimer Society of Peel

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

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

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

Within the MH LHIN there exist a number of opportunities for capacity building and knowledge transfer in both the long-term care and community service areas. Within the action plan there is recognition of these existing resources and intent to leverage opportunity for future capacity building. These supports include:

- Psychogeriatric Resource Consultants (PRCs) associated with Trillium Health Services, Halton Health Services and the Geriatric Mental Health Outreach Team to provide training in PIECES and U-First programs to LTCH staff and community service providers. Knowledge transfer can also occur through individual mentoring and modeling in the review of individual case studies.
- Resources provided through the Alzheimer Society of Peel for the education and knowledge transfer sessions for both caregiver groups as well as service provider agency staff.
- Quality improvement transfer of knowledge through existing activities such as Residents First, in LTC.

- Community based agencies who have participated in accreditation processes and their implementation of quality improvement strategies to improve service quality for their clients.
- Knowledge transfer sessions through the Alzheimer Knowledge Exchange
- Capacity and transfer of best practice information by nurse practitioners in LTC as well as other outreach supports including Geriatric Mental Health Outreach Team, Seniors Mental Health Outreach Team and ABI behavioural support services provided through Peel Halton Dufferin Acquired Brain Injury Services. Capacity building with these organizations is often individual case based learning and demonstration as compared to formal education sessions.
- BSO knowledge exchange activities and collaborative website.
- Knowledge Exchange opportunities through the Canadian Dementia Resource and Knowledge Exchange (CDRAKE)
- MH LHIN Knowledge Expo which is an opportunity for local HSP staff to hear about and share information concerning new and existing services provided within the MH LHIN and strategic investments made by the MH LHIN.
- Recurring staff training programs within LTCHs such as "the 3D's, - Dementia, Delusion and Delirium" , Gentle Persuasive Approach, Hush no Rush
- Regular Orientation programs for LTCH and community agency staff.
- SHRTN Community of Practice for outreach teams
- RNAO Community of Practice related to responsive behaviours

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

Within the MH LHIN we have seconded a full time Quality Improvement Facilitator dedicated to the BSO project. The incumbent has received formal QI training through the Residents First project. The MH LHIN Project Lead although not formally trained is familiar in the use of quality improvement strategies. In addition there is also one staff member with formal training in Lean 6-SIGMA and one formally trained Quality Advisor. Both individuals area available to the BSO project for consultation and support. Quality Improvement support will also be provided through the BSO QI Coach provided through Health Quality Ontario and linkages with the Resident First Improvement Facilitator through Health Quality Ontario.

LTCHs involved in Residents First will also have in house Quality Improvement Facilitators that will be able to assist with internal BSO quality improvement plans. As well as local QI resources within each LTCH, those homes associated with a corporate structure also have internal Quality resources that will be identified and leveraged for support.

For community agencies that do not have formal Improvement Facilitators trained and in place, there has been a requirement within the LH LHIN MSAAs that all community agencies participate in formal accreditation. Through this process all agencies are required the implementation of internal quality improvement processes and therefore will have a base level of information that will be able to be expanded upon and leveraged.

b. What behavioural supports expertise is currently available to support BSO within the LHIN?

Within the LHIN there are a number of existing behavioural supports expertise that can provide support to the BSO project. These include:

- Trillium Seniors' Mental Health Outreach Team (SMHOT)
- St. Joseph's Geriatric Mental Health Outreach Team (GMHOT)
- Sheridan Villa, Specialized Behavioural Support Unit
- Psychogeriatric Resource Consultants
- Alzheimer Society of Peel
- Nurse Practitioners supporting LTC homes
- Peel Halton Dufferin Acquired Brain Injury Services (PHDABIS)

- LTCHs with Dementia specific units or programs
- Consulting Psychiatrists supporting LTCHs.
- CMHA Halton and CMHA Peel
- Peel and Halton Community Relations Police Officers
- Hospital based seniors mental health service inpatient unit at Trillium Health Services
- Physicians supporting LTCHs

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

The development of a comprehensive training and knowledge transfer strategy has been identified as a major action plan project charter for development to support local BSO implementation. A working Group will be formed in early January to identify requirements for and create a formal work plan. Training will be provided to both staff within the new BSO positions as well as existing staff in both the LTCH and community sectors. As capacity building has been identified as a major component in the draft action plan, the MH LHIN has identified that additional one-time funds will be made available to LTCHs to assist with back fill of staff participating in training events. Community agencies are able to access training support through existing funding programs to support staff training events.

Within the model for the deployment of new BSO resources, additional PRC staff has been identified. With the introduction of these new resources additional capacity building support will be entrenched for both LTCHs and community agency staff. Training for BSO will be identified as a recurring training for LTCH / agency staff and requested to be part of regular HSP training calendars and will also be identified as a component for orientation of new staff.

It has been identified that the strategy should incorporate a mix of training strategies in order to allow maximum opportunity for capacity building for existing staff. Recommended modalities include;

- Individual case based instruction including modeling of best practice strategies
- Community BSO Resource Team will receive training through existing resources such as, PRC, Alzheimer Society, GMHOT, Sheridan Villa SBSU staff
- LTCH BSO staff will receive training through PRCs, Sheridan Villa SBSU,
- Video based or web based training programs
- Instruction in recognized best practice programs such as PIECES and U-First, GPA, Montessori Dementia Care
- PRC resources to conduct training in both the LTCH and community agency settings for staff

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

Within the MH LHIN there are a number of knowledge transfer structures and pathways that will be leveraged to support the BSO Project. Existing PRC resources do provide training support primarily to LTCHs and this will be enhanced within the BSO action plan to increase the amount and timeliness of support to LTCHs as well to community agencies who provide PSW services.

Supporting LTCHs there is also formal linkage between the NP STAT program and the Directors of Care in LTC. At a meeting on December 14th dedicated to behavioural services it was identified that a standing item related to behavioural services and best practices. This will also be supported in the MH LHIN LTC Leadership Forum.

Exiting outreach teams exist that support knowledge transfer. These include the Geriatric Mental Health Outreach Teams (GMHOT) in Halton and north Mississauga, Seniors Mental Health Outreach Team (SMOT) supporting south Mississauga, NP STAT program providing nurse practitioner services in LTC and outreach ABI services to LTCHs supporting individuals with acquired brain injuries. (Although not formally part of the target population, learnings can be transferred to the BSO target population). Knowledge transfer occurs though case based situations and identification of current best practices.

Knowledge transfer is also available through the transfer of individuals to regular LTCH settings from the Sheridan Villa Specialized Behavioral Support Unit.. As individuals are transferred back into LTCHs established care pathways and behaviour management methodologies are provided and modeled for the receiving LTCH staff.

Other structures that will be exist include;

- Dementia care education through the Alzheimers Society
- Alzheimer knowledge exchange website
- CDRAKE
- MH LHIN Knowledge Expo for sharing of service information for local HSPs
- MH LHIN Community Service Provider forum – opportunity to share information with community based providers
- Local Dementia Network
- MH LHIN website

9. Describe how your Action Plan builds on current capabilities and capacity (e.g. tools, resources, partnerships, Aging at Home initiatives, etc.)?

The MH LHIN action plan builds upon current system capacity and initiatives. Specific to behavioural supports the MH LHIN has made strategic investments in this area such as the provision of outreach teams to support individuals living in LTCHs and the development of the first Specialized Behavioural Support Unit under the specialized unit provisions of the LTCHA, 2007. All of these resources have been identified as part of the broader local BSO virtual team and as well many have representation on the MH LHIN BSO Advisory Committee. With these services in place the action plan focuses upon the imbedding of services into LTCHs that will support the structures necessary to achieve the results desired and support spread of information and capacity building. Existing partnerships that havae been formed to support these initiatives will also be part of the broader BSO framework for the MH LHIN.

By building capacity within the LTCHs to support in place individuals with responsive behaviours there will be an increased capacity for these existing programs to support individuals who cannot be supported through services of lesser intensity. Through this approach people will be able to receive the appropriate service at the right time in the right location. These existing supports are will also be fundamental in future knowledge exchange / capacity building strategies building upon existing relationships with staff within LTCHs and in the community.

The Residents First initiative has also been identified as an existing area to be leveraged and built upon. Quality improvement strategies employed though Residents First will be leveraged to support activities implemented through BSO. Use of existing in house resources trained in quality improvement will be identified and incorporated within the BSO quality improvement plan.

10. How is sustainability of the service redesign embedded in the process through education and knowledge transfer and other mechanisms (e.g. towards, the individual, caregiver, care team, organization, community, etc.)?

Sustainability of the service redesign is embedded through the creation of the oversight / advisory structure existing of strategic HSP representation involved in BSO. Accountability structures such as accountability agreements where funding is provided or Memorandums of Understandings and project charters to define roles and expectations where services are working together to support the needs of common individuals. Quality improvement activities and reporting requirements are to be implemented that provide for the ongoing assessment and evaluation of BSO initiatives in order to meet identified expectations. Quality improvement processes such as PDSAs, decision trees and fishbone diagrams will all be employed to support evaluation processes and make process corrections that redirect where necessary.

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

a. How will lessons learned be captured and shared?

Knowledge transfer will occur through many processes including;

- Sharing of success through regular meetings of LTCH and community BSO staff
- Support through the LHIN IF to promote collaboration opportunities and share info
- Development of a compressive communication strategy to include success stories and identified best practices
- Opportunities for information transfer though existing forums of partner organizations with the creation of a standing item to provide BSO updates
- Use of AKE and BSO collaboration spaces
- Participation of partner organizations within communities of practice organized by SHRTN or RNAO

12. Name your partners for Knowledgeable Care Team and Capacity Building (e.g. university).

Future collaboration partners may include the University of Toronto, Mississauga Campus, Sheridan College - Sheridan Elderly Research Centre (SERC) and McMaster University. Locally we will also build upon existing structures that exist with Sheridan Villa Specialized Behavioural Services Unit, the Pyschogeriatric Resource Consultants and the NP Stat program to assist in our plan to support knowledgable care teams and support overall system capacity building.

a. How have the partners collaborated on previous projects?

Previous examples of collaboration exist in the areas of geriatric psychiatry and geriatric medicine with providing opportunities for mentorship for program residents and students. This has occurred in the areas of medicine, psychiatry and nursing within MH LHIN hospitals.

Existing networks such as the local Dementia Network have reached out to neighboring educational centres such as the Sheridan Elderly Research Centre to establish linkages for sharing of information and cross linkages.

b. What were the outcomes?

As the direct outcome of these collaborations we have been able to provide opportunity for sharing of current information and best practice within the participating programs. Collaborations have also assited with creating new learning opportunities for not only staff within participating agencies but also for seniors who are clients fo their services. Through direct linkage with SERC, agencies have become partners in research activities to evaluate new practices to and approaches to support their client groups.

c. List the executive sponsors who will have potential responsibility for meetings, chairing a steering committee, ongoing leadership and engagement, etc.

Executive sponsors would include

- Bill MacLeod, MH LHIN, executive sponsor
- Rob Low, MH LHIN, BSO Project Lead
- Sean Weylie, MH LHIN, IF
- Scott Faraway, PHDABIS, Advisory committee Co-chair
- Inga Mazuryk, Community Services Manager, Region of Peel, Advisory Committee Co-chair
- Christopher Rawn-Kanes, CEO, Alzheimer Society of Peel
- Julia Baxter St Joseph's Hospital GMHOT,
- Lori Brown, NP STAT
- Pat Spadiforia, SERC

13. Describe the deployment of behavioural staffing positions for participating HSPs.

a. Describe how the HSPs will deploy staff to meet the established BSO Framework for each LHIN.

After much debate and consideration at the Advisory committee level, it was determined that there was no appetite to create a system of "have and have not's". It is therefore decided that the LTC allocation will be spread across all the Long Term Care Homes in the LHIN to assist with the capacity building at the home level. The community funds are to be distributed to help support the community and the LTCH through education, hands on support and navigation roles. The following is a break-down of the allocation of funds. Please refer also to the HHR document attached.

Long Term Care Deployment of Funds

Homes over 100 beds (22 homes)	Homes under 100 beds (5 homes)
1.0 FTE PSW	0.5 FTE PSW
0.5 FTE RPN	0.5 FTE RPN
$79,500 annualized per home. They allocate across the two positions	Allocation of $40,000 from LTC funding with the remaining funding being allocated from the community portion
Total allocation of funds	$1,946,182

Community deployment Funds

Position	#	cost	total
Psychogeriatric Resource Consultants	3	$ 102,000.00	$ 306,000.00
Community Counselors	4	$ 74,000.00	$ 296,000.00
Community Support Workers	4	$ 65,000.00	$ 260,000.00
PSW for LTC	2.5	$ 32,607.20	$ 81,518.00
			$ 943,518.00
Funding available			$ (943,518)

b. If more than one HSP is participating in each LHIN, describe how each of the positions will be distributed and provide your rationale.

i. The funding will be distributed to the LTCH to be able to hire the staffing that is set out above. The rationale is that each LTCH will then have extra human resources to effect a systemic change in the management of Responsive Behaviours. The extra staffing hours will allow the home to develop Quality improvement strategies around managing responsive behaviours, provide capacity building opportunities to other staff and have a direct link to the Psychogeriatric Resource Consultant (PRC) assigned to their home.

ii. The community resources are distributed as follows:

- PRC – with increased dollars there will now be 5 PRC's serving the MH LHIN. The LTC homes will be assigned geographically to the 5 different individuals. The PRC will provide consultation and education to the LTCH in order to assist them with managing responsive behaviours. The PRC will also provide support to community resources in the same geographic area. This is anticipated to assist in the coordination of resources in each of the 5 geographic areas. The 5 PRC's will also be able to network amongst themselves to access resources out of their catchment area or across LHINs
- Counselors – the 4 new counselors will be based out of the Alzheimer's Society of Peel. They will assist with the navigation function for those who are in the community. They are also to be used to

access resources for those persons served in the community. The counselors will have access to the PRC resources to provide education to those community organizations that require it.

- Community Support Workers (CSW) – The 4 FTE will be attached to the Alzheimer Society of Peel and will be deployed as the counselors identify a need for them. The CSW role is to provide direct hands on support to the caregiver in a time of need. Some of the functions could be: assistance with appointments, crisis over night help, etc. These roles will be more clearly defined by the BSO Advisory Committee in early 2012.

c. Describe the specific roles and responsibilities of the behavioural staffing positions.

i. Registered Nursing Staff – Quality improvement coordinator/BSO Coach responsible for ensuring that quality improvement activities around the project are being coordinated and that outcomes are beneficial to the person served. Capable of reviewing documentation and suggesting new interventions. Coordinates QI activities such as PDSA cycles, root cause analysis, process mapping, data collection and analysis. Assisting LTCH staff with problem solving during responsive behaviours and supporting staff in prevention of responsive behaviours.

ii. PSW – additional trained staff that is available to assist with responsive behaviours throughout the home. Could be deployed when the home is admitting a person with responsive behaviours to assist with the transition into LTC. Person will be a "BSO champion" within the home and will model appropriate interventions as required.

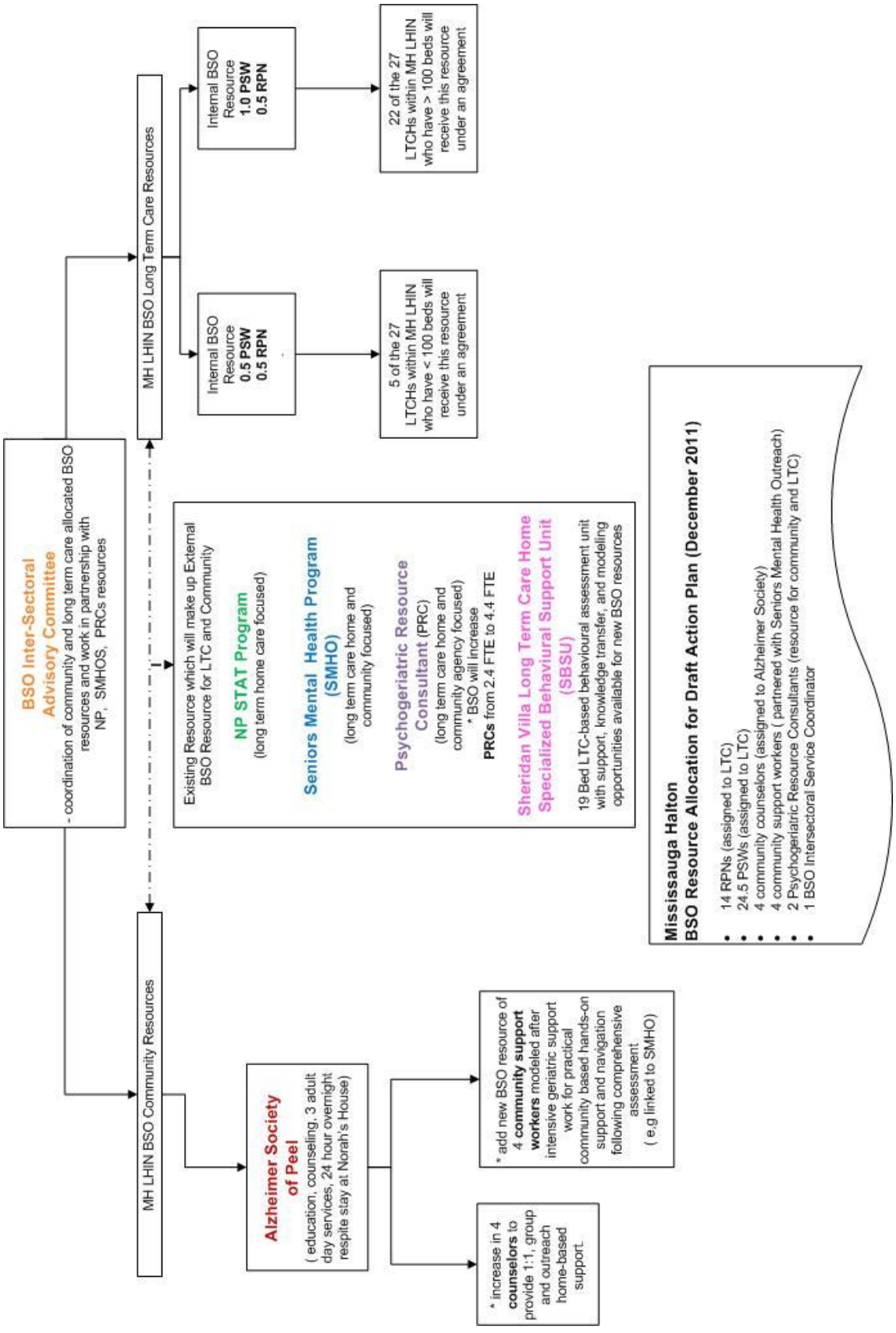
iii. PRC – responsible for supporting staff in the community and in LTC around responsive behaviours, providing education and being a liaison person between the community, acute care and the LTCH

iv. Counselors – provide navigation function to persons served in the community. Assist with accessing resources that will prevent admission to LTC or hospital as appropriate.

v. CSW – provide acute episodic support to caregivers in the community or in the LTCH thus potentially preventing transfer to alternate care setting.

The MOHLTC "Recommended Core Competencies for Health Human Resources Working with Behaviorally Complex Population" will be adapted and adopted as required.

MH LHIN Resource Deployment Model



Additional Information:

14. Enclose a summary timeline in a separate schedule.

- See Appendix 3

15. Outline your performance, measurement and evaluation plan. Describe the indicators and data sources, the calculation of baseline for each, and report on progress toward explicit targets.

The MH LHIN BSO project will be monitoring the outcome measures set out by the Ministry of Health and Long term Care for this project as well as additional process and balancing measures. As a result, each provider group will determine what process and balancing measures are required for each of their projects. These measures will evolve as the project evolves and may be different for each group depending on the change concepts the teams want to explore. It is vital the LHIN stays flexible on the measures, some teams may need to expand the measures it uses in order to better track changes in the system. The LHIN will need to ensure that the measures are congruent with the project outcome measures.

The BSO Advisory Committee will review the Measures in early 2012 to ensure that it meets the needs of the Project and is consistent with some of the data already being collected. This will ensure that existing systems will be leveraged and limited new work will be created.

The following 3 measures have been set by the MOHLTC. Additional potential measures are listed below the Provincial measures.

a. Reduce resident transfers from LTC to acute or specialized unit for behaviours.

b. Delayed need for more intensive services, reducing admissions and risk of ALC

c. Reduced length of stay for persons in hospital who can be discharged to a LTCH with enhanced behavioural resources.

Potential Additional measures as identified through the Value Stream Mapping exercise:

- # of residents with escalated responsive behaviours who are assessed and treated in the LTCH
- # of people on the CCAC crisis list with Responsive Behaviours
- # of ED visits due to primary reason listed as behaviours
- # of admission and/or re-admissions to acute care for residents with responsive behaviours
- # of staff trained to respond to responsive behaviours eg. PIECES, GPA, etc.
- # of CCAC applications with Responsive behaviours listed denied by LTCH
- # of Responsive behaviour incidents per month in LTCH classified under the categories of wandering, verbal outbursts, physical outbursts, socially inappropriate or disruptive behaviours and resistance to care.
- Average LOS of LTCH residents admitted to hospital for responsive behaviours
- Number of Alternative Level of Care (ALC) days related to responsive behaviours for LTCH residents
- # of residents transferred from LTC to Acute Care on a Form 1
- % of staff health and safety incidents that are attributed to responsive behaviours
- Average response time for mobile outreach team to person served
- # of persons served receiving counseling from case workers
- Average time from CCAC contact to placement to appropriate care setting
- # of visits to LTCHs by mobile care teams to provide enhanced assessment and treatment
- Person served and their care giver satisfaction rate with the services received
- # of referrals to Specialized Behavioural Support Unit (SBSU)
- Average length of stay at SBSU
- # of persons served with chemical restraints for behaviours
- % of persons served in LTC that have identified responsive behaviours

Each of the BSO project participants will be establishing a Responsive Behaviours team that will draft a project charter. The project charter will define the scope of the improvement project along with the measures they intend to monitor. A clearly defined AIM statement will guide the team with their journey. Data collection methods will be defined by each of the Improvement Teams and the LHIN will have access to data from NACRS, DAD, CIHI and others available through Intellihealth. Data will also be obtained from other sources within the LHIN like the CCAC databases, LTCH records, and Hospital databases. For some indicators like satisfaction the data will come from surveys.

Leveraging the Health Quality Ontario Resident First program will allow the providers the opportunity to develop Quality improvement Plans that are targeted and focuses on the issues within the providers' control. Use of Quality improvement tools such as Ishikawa diagrams, Plan Do Study Act cycles, process mapping etc. will be the foundation for quality improvement with the service providers. Data will need to be obtained to develop base-line measures. Currently there are data sources within the LHIN that will assist with the establishment of the baseline. The use of annotated run charts will be a key part to the improvement process as they will graphically display the improvement journey of each provider. The main goal is to be able to sustain the improvement and spread the learning's within and across organizations. Explicit goals will be set using conventional Quality Improvement target of achieving a 50% reduction in the measure. Evaluation of the outcomes and the project will take place at the Advisory Committee level.

16. Attach your budget, work plan and resource plan. The resource plan will outline how and the new behavioural staffing resources (e.g., RN/RPN, PSWs and additional healthcare personnel) would be utilized.

Please ensure that the funding available is clearly demarcated between April 1st-December 31st and January 1st-March 31st so that amounts being allocated to calendar year can be reconciled by the ministry. An Excel spreadsheet is enclosed for this purpose.

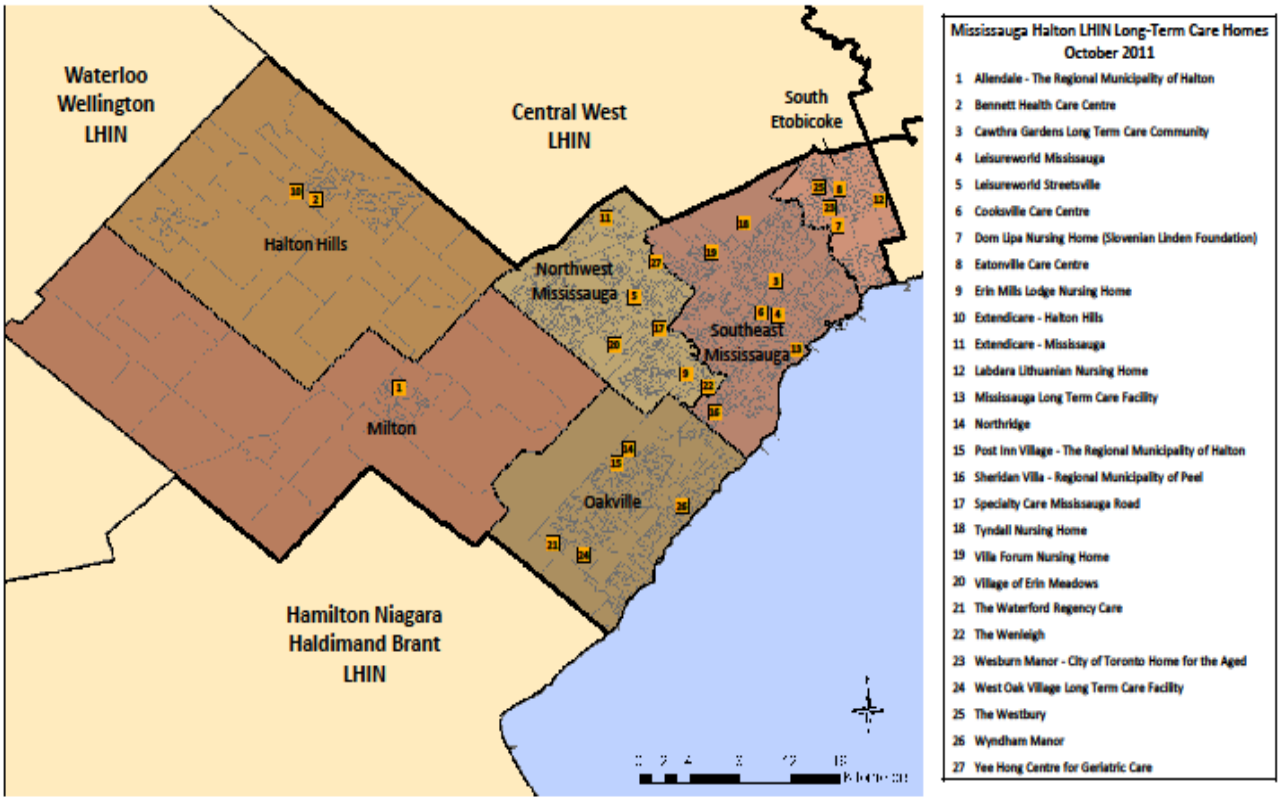
- See Appendix 4

17. Who will be the representative(s) on the LHIN Steering Committee?

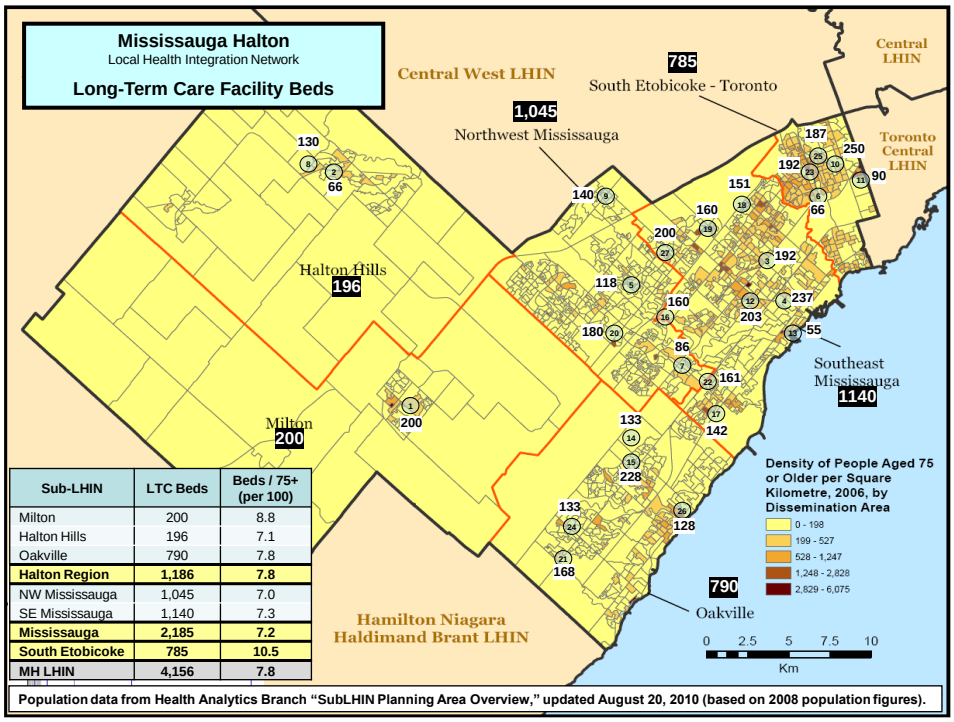
- Inga Mazuryk, Administrator Sheridan Villa, Region of Peel
- Scott Faraway, Manager, Behavioral Services, PHDABIS
- Mary Compton, Peel Crisis Services
- Lori Brown, Coordinator, NP STA, Credit Valley Hospital
- Julie Wong, Administrator, Northridge LTCH
- Margaret Bouillon, Extendicare
- Julia Baxter, St Joseph's Hospital, Manager GMHOT
- Christopher Rawn-Kanes, CEO Alzheimer Society of Peel
- Faith Madden, Manager Placement Services, MH CCAC
- Ann Sterling, Director, Client Services, MH CCAC
- Pat Mohani, Manager Seniors Mental Health Team, Trillium Health Services
- Doris Burns, PRC, Trillium Health Services
- Janice Cox, Family member
- Radhika Subramanyan, CMHA, Halton
- Marie Hoy, CMHA, Halton
- Marion Penko, PRC, GMHOT
- Karen Parsons, Peel Addictions and Rehabilitation Centre
- Cathy Raiskums, Manager, Discharge Planning, Halton Health Services
- Laurie Maratovich, Halton Region
- Rob Low Project Lead, MH LHIN
- Sean Weylie, Improvement Facilitator, MH LHIN

Appendix 1

Mississauga Halton LHIN Long-Term Care Homes



Appendix 2

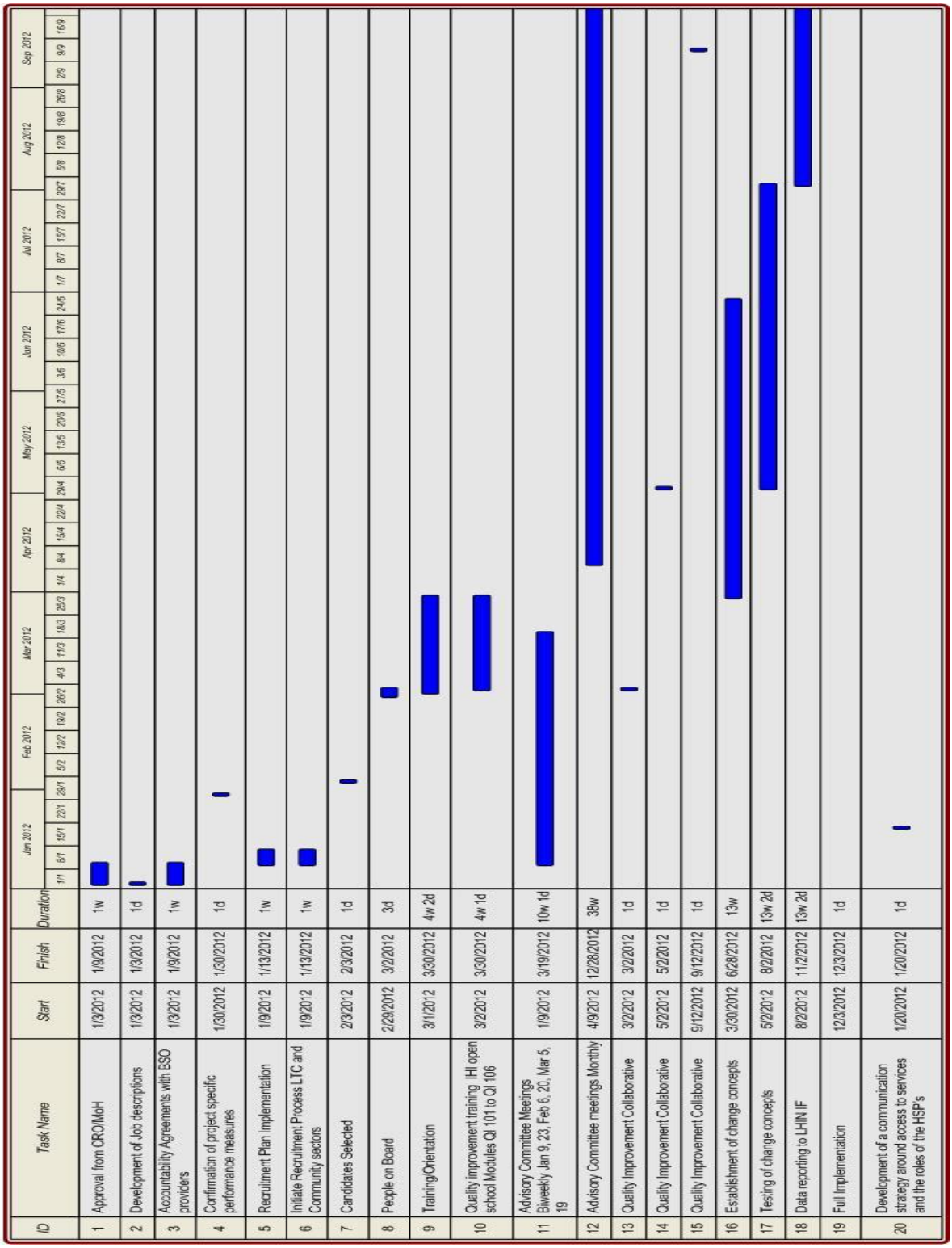


Sub-LHIN	LTC Beds	Beds / 75+ (per 100)
Milton	200	8.8
Halton Hills	196	7.1
Oakville	790	7.8
Halton Region	**1,186**	**7.8**
NW Mississauga	1,045	7.0
SE Mississauga	1,140	7.3
Mississauga	**2,185**	**7.2**
South Etobicoke	**785**	**10.5**
MH LHIN	**4,156**	**7.8**

Population data from Health Analytics Branch "SubLHIN Planning Area Overview," updated August 20, 2010 (based on 2008 population figures).

Appendix 3

MH LHIN – BSO PROJECT PLAN
PHASE II – Implementation



ID	Task Name	Start	Finish	Duration
1	Approval from CRO/MoH	1/3/2012	1/9/2012	1w
2	Development of Job descriptions	1/3/2012	1/3/2012	1d
3	Accountability Agreements with BSO providers	1/3/2012	1/9/2012	1w
4	Confirmation of project specific performance measures	1/30/2012	1/30/2012	1d
5	Recruitment Plan Implementation	1/9/2012	1/13/2012	1w
6	Initiate Recruitment Process LTC and Community sectors	1/9/2012	1/13/2012	1w
7	Candidates Selected	2/3/2012	2/3/2012	1d
8	People on Board	2/29/2012	3/2/2012	3d
9	Training/Orientation	3/1/2012	3/30/2012	4w 2d
10	Quality improvement training IHI open school Modules QI 101 to QI 106	3/2/2012	3/30/2012	4w 1d
11	Advisory Committee Meetings Biweekly Jan 9, 23, Feb 6, 20, Mar 5, 19	1/9/2012	3/19/2012	10w 1d
12	Advisory Committee meetings Monthly	4/9/2012	12/28/2012	38w
13	Quality Improvement Collaborative	3/2/2012	3/2/2012	1d
14	Quality Improvement Collaborative	5/2/2012	5/2/2012	1d
15	Quality Improvement Collaborative	9/12/2012	9/12/2012	1d
16	Establishment of change concepts	3/30/2012	6/28/2012	13w
17	Testing of change concepts	5/2/2012	8/2/2012	13w 2d
18	Data reporting to LHIN IF	8/2/2012	11/2/2012	13w 2d
19	Full Implementation	12/3/2012	12/3/2012	1d
20	Development of a communication strategy around access to services and the roles of the HSPs	1/20/2012	1/20/2012	1d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