North East **LHIN**
RLISS du Nord-Est

North East Local Health Integration Network Behavioural Supports Ontario

Action Plan – January 2012



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

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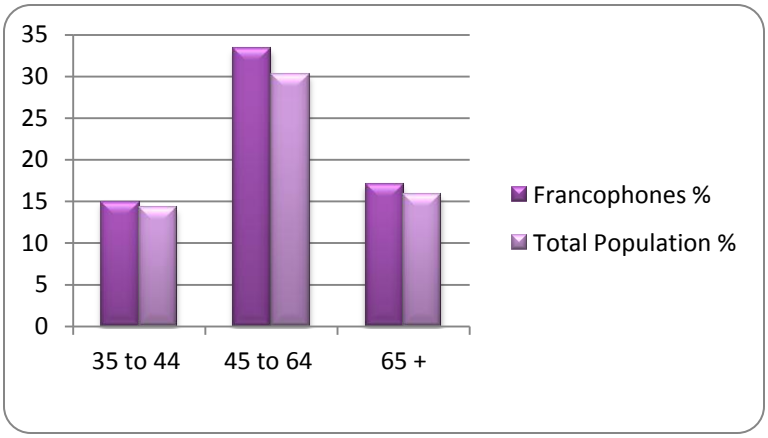
North East Local Health Integration Network Background

The North East Local Health Integration Network (NE LHIN) covers a vast geography, accounting for approximately 40% of the land mass of Ontario. Planning is done in four distinct 'HUB' areas – Algoma, Cochrane, Sudbury/Manitoulin/Parry Sound and Nipissing/Temiskaming. In addition, we also provide service to the Hudson and James Bay Coasts.

The average age of the population in the North East (NE) is greater than that of the rest of Ontario, as there is a higher proportion of individuals aged 65 and up. Furthermore, 24% of the population is Francophone, while 10% have an Aboriginal identity.

Population by Age Group – North East



Source: Statistics Canada, Census of Population, 2006

The NE LHIN funds 186 Health Services Providers (HSPs), which include:

- 25 Hospitals;
- 42 Long-Term Care Homes (LTCHs);
- 64 Community Support Services Agencies;
- 1 CCAC with 6 main branches and 14 satellite offices;
- 6 Community Health Centres; and
- 48 Mental Health and Addictions Agencies.

The NE LHIN geography, demographics and cultural and linguistic attributes require that health services planning be done in innovative and creative ways, engaging local, district and regional providers.

(Please refer to Appendix 1 for a map of the NE and Appendix 2 for a map of LTCHs)

The NE LHIN Vision

Health and Wellness for All …
through an innovative, sustainable and accountable system

The successful implementation of the NE LHIN vision relies on the shared responsibility to deliver quality health care programs and services across northeastern Ontario. An integrated, patient-focused health care system can only be realized when all HSPs and organizations work together with a common approach. The NE LHIN will continue to strengthen its partnerships to allow for a cohesive approach to *health and wellness for all.*

Listen	Our intention: You will be heard
Integrity	Responsible and accountable for living our values
Proactive	Anticipate needs and opportunities – and act appropriately
Equity	Opportunity for health and wellness for all
Serve	Include northeastern Ontario geographic, cultural, demographic, and linguistic health & wellness needs in all activities

Executive Summary

The aim of the NE Behavioural Supports Ontario (BSO) Action Plan is to 'create an integrated and coordinated system of care for older adults with complex needs due to responsive behaviours as a result of mental health problems, dementia and addictions'. This initiative will serve as the foundation to build upon quality of life, improved system efficiencies and quality of care.

North East Behavioural Support System Value Statement

"As partners in care, we commit to and expect compassionate, timely and person-centred care."

This value statement forms the cornerstone for the key elements of the NE BSO Action Plan, which include coordinated intake & referral; enhanced system navigation; specialized interdisciplinary responsive behaviour teams (RBTs) linked with both long-term care (LTC) and community; the establishment of an integrated lead agency model to coordinate services, build knowledge and capacity; and the support of seamless transitions for individuals across the system.

To ensure a system transformation occurs and is sustainable, the expectation is that all of the partners in care that are involved in supporting this population: embrace the new model of service and support system redesign; standardize best practices, clinical protocols and care pathways; commit to innovative, sustainable, and formal partnerships and shared accountabilities; and maintain open communication. By leveraging the Quality Improvement (QI) capacity across the NE LHIN through this shared-care approach, the client experience will be enhanced and system improvements will be realized.

Through a formalized expression of interest process, LTCHs that demonstrate alignment with the BSO model will be selected to receive funding for the Nurses and Personal Support Workers (PSWs).

Enhanced Behavioural Support Services will be systematically provided in the LTCHs, in private dwellings and Assisted Living locations. The services will also be extended to acute care settings including transitional care units, complex continuing care and geriatric rehabilitation. The services of existing providers will be enhanced and complemented, providing for increased capacity to support individuals with responsive behaviours. In addition to the LTCH resources, our Action Plan identifies enhancements to Seniors Mental Health (SMH) Programs, Psychogeriatric Resource Consultants (PRCs), Alzheimer's Caregiver Education and Community Care Access Centre (CCAC) intake.

As the Regional Tertiary Care Specialized Program for the NE, the North Bay Regional Health Centre (NBRHC) will be the lead agency for the BSO Project. As the lead provider, the NBRHC will employ a Regional Coordinator that will be responsible for system management, inter-organization collaboration and capacity building. The NBRHC will be responsible for the creation of a BSO Network for the NE that will bring all BSO-funded providers together to create common practice.

The current key system challenges that our action plan will address are:

- the multiple assessments to which the clients are often subjected and the lack of appropriate assessments in other circumstances;
- the long waiting lists for services, especially Specialized Geriatric and Mental Health (MH) supports;
- the referrals to specialized services, which are uncoordinated or often not initiated due to the capacity issues;
- system breakdown regarding timeliness of response in supporting older adults with responsive behaviours;
- the refusal of providers to support clients in their current environment and refusal to take them back;
- the inappropriate Emergency Department (ED) visits/admissions, with behaviour as the sole reason for the visit;
- the inappropriate use of 911 to get Police to respond to older adults with responsive behaviours; and
- the limited/inconsistent means of early detection and management of issues.

(Please refer to Appendix 3 for a schematic of the Action Plan)

Through the enhancement of PRCs in the NE, the Action Plan will address the issue of both the lack of assessments and multiple assessments, and access to referrals and disjointed referrals. The Action Plan will increase the number of PRCs from three to a total of six for the region. The key function of the PRCs will be system navigation and support to address the urgent need for specialized services. Strategy for a common intake and access will address the system challenge of uncoordinated referrals to specialty supports. The PRCs will be complemented by adding local Responsive Behaviour Clinicians (RBCs) that will support the regional capacity to develop RBTs in order to optimize system collaboration by leveraging and linking existing services toward a common vision.

Stipends will be used to engage Care of the Elderly (CoE) physicians and specialists throughout the NE that will enhance skills and help ensure a common approach.

The additional human resources in LTCHs, through the additional Behavioural Supports nurses and PSWs, will increase the capacity of that sector to support individuals in their residential setting and minimize the inappropriate transfers to acute care/EDs.

A key responsibility of the LTCH nursing and PSW staff will be to become the resident experts in responsive behaviour supports and to be key contacts for their respective LTCH staff in need of coaching in order to provide improved care to residents of LTCHs. The increased staff will improve the capacity of the LTCH to address the individualized need of this population while caring for older adults in their current setting and avoiding the often very disruptive transfers to other programs. The BSO staff in the LTC homes will be the conduit and formal linkage to external BSO and other specialty resources.

The enhanced Behavioural Supports will be delivered with an interdisciplinary and collaborative approach by aligning the additional human resources with existing services in our community. Most notably the NE PRCs, SMH Programs, North East Specialized Geriatric Services (NE SGS) and the Alzheimer Societies will work with the Behavioural Supports Nurses to deliver services. In each of the NE's four HUBs, or planning areas, there will be fully integrated teams that will determine first response, services required, development of a comprehensive care plan and follow up. It will be the role of the PRCs to monitor the development and implementation of the client care plans and provide ongoing education and support to providers.

The Behavioural Supports Registered Nurses (RNs)/Registered Practical Nurses (RPNs) allocated to LTCHs will have the necessary skills to support residents with responsive behaviours through current and refreshed training in the *PIECES* framework and Gentle Persuasive Approach (GPA), as a minimum standard. The PSWs will be trained in *U-First!* and be coached by the Behavioural Supports Nurses. Other best practice initiatives will be promoted to enhance capacity such as GiiC and Montessori. Enhanced PRCs and RBCs will work in concert with local SMH Programs to serve the elderly person with responsive behaviours in a coordinated manner and in the least intrusive way. System wide training will be created by a Knowledge Exchange and Capacity Building Working Group to educate the multiple sectors on the common intake, service coordination, availability of services and protocols.

The client value statement, *"As partners in care, we commit to and expect compassionate, timely and person centre care"*, will serve as the key guiding principle in the implementation of the Action Plan. The collection of data on the number of individuals with dementia waiting for placement and the number of individuals from LTCHs visiting the ED will begin to inform the work to develop the appropriate measurements for the Behavioural Supports Project. The NE LHIN BSO Improvement Facilitator (IF) will support the development of a Regional Quality Improvement (QI) structure that will guide the QI process and the outcome measures. A working group made up of QI experts in the NE will be recruited to participate in the project by lending their knowledge and sharing of resources.

Introduction

Within our communities across the NE, there have been a number of planning initiatives to address the needs of older adults that the system has been challenged to serve because of responsive behaviours. The most significant concern is the ability to support older adults that pose a significant threat to their own safety and to the safety of others. At times, hospital admission is the default and once that happens, there is great difficulty in facilitating the discharge from hospital and as a result, the alternate level of care designation is initiated. In extreme situations, the individuals end up calling the hospital their home. In large part, this is related to an increasing elderly population, increasing incidences of Alzheimer's, decreases in long-term psychiatric beds, increasing pressure to move patients from acute care settings (Building Better System, 2007), and the lack of capacity in the community to provide the necessary supports.

It is recognized that there are sub-populations of individuals that are hard to serve. In addition to older adults with dementia and or related MH issues, there are other sub-populations of younger adults. Although this group is not included in the target population for the BSO Project, these sub-populations include individuals with developmental disabilities, acquired brain injuries, substance abuse and MH issues.

Individuals that exhibit responsive behaviours are often sent to the hospital for treatment, support, supervision and to protect their safety and the safety of others. It has long been recognized that the hospital is not the most appropriate long-term solution to this issue, although there are limited alternatives for this hard to serve group.

Throughout the NE, service providers have been working towards system change for individuals with responsive behaviours. The Sudbury Community Responsive Behaviours Working Group (2007), of the Integrated Community Long-Term Care Committee, submitted a report to the NE LHIN with recommendations for focused investments to support this population. The Sudbury ALC plan outlines recommendations for increased funding to better serve this population.

In the District of Nipissing, health care leaders collaborated to research and report on the needs of older adults with mental illness. The aim of the report was to achieve a more responsive service system for this population. The report was submitted to the Ministry of Health and Long Term Care (MOHLTC) and the newly formed NE LHIN. The Interim Strategies Working Group (2006) in North Bay continues to identify improvements and required investments to support this population. Through *Aging at Home* funding, the NBRHC was allocated $500,000 to develop an RBT for the District of Nipissing. This team

will work directly towards enhancing the system for that district and will be integrated with the BSO NE Regional Working Group.

Future investments in behavioural supports recommended for the District of Nipissing, Sudbury and Sault Ste. Marie include specialized Behavioural Supports Units, as articulated in the ALC Plan.

In Sault Ste. Marie, the community has had recent engagement activities regarding BSO and has collected input from the various providers in the acute care, community support services and LTC sectors. The input has been instrumental to the development of our model.

The Sault Ste. Marie NE LHIN ALC plan has specific allocations for Behavioural Supports. These investments include funding for RBTs, as well as funding for a future Behavioural Supports Unit.

Aboriginal and French Language Services

Providing culturally appropriate services in the NE is an important consideration when planning and delivering services, and a priority of the NE LHIN's Integrated Health Services Plan. In the NE, the Francophone and Aboriginal populations are significantly higher than in other areas of the province.

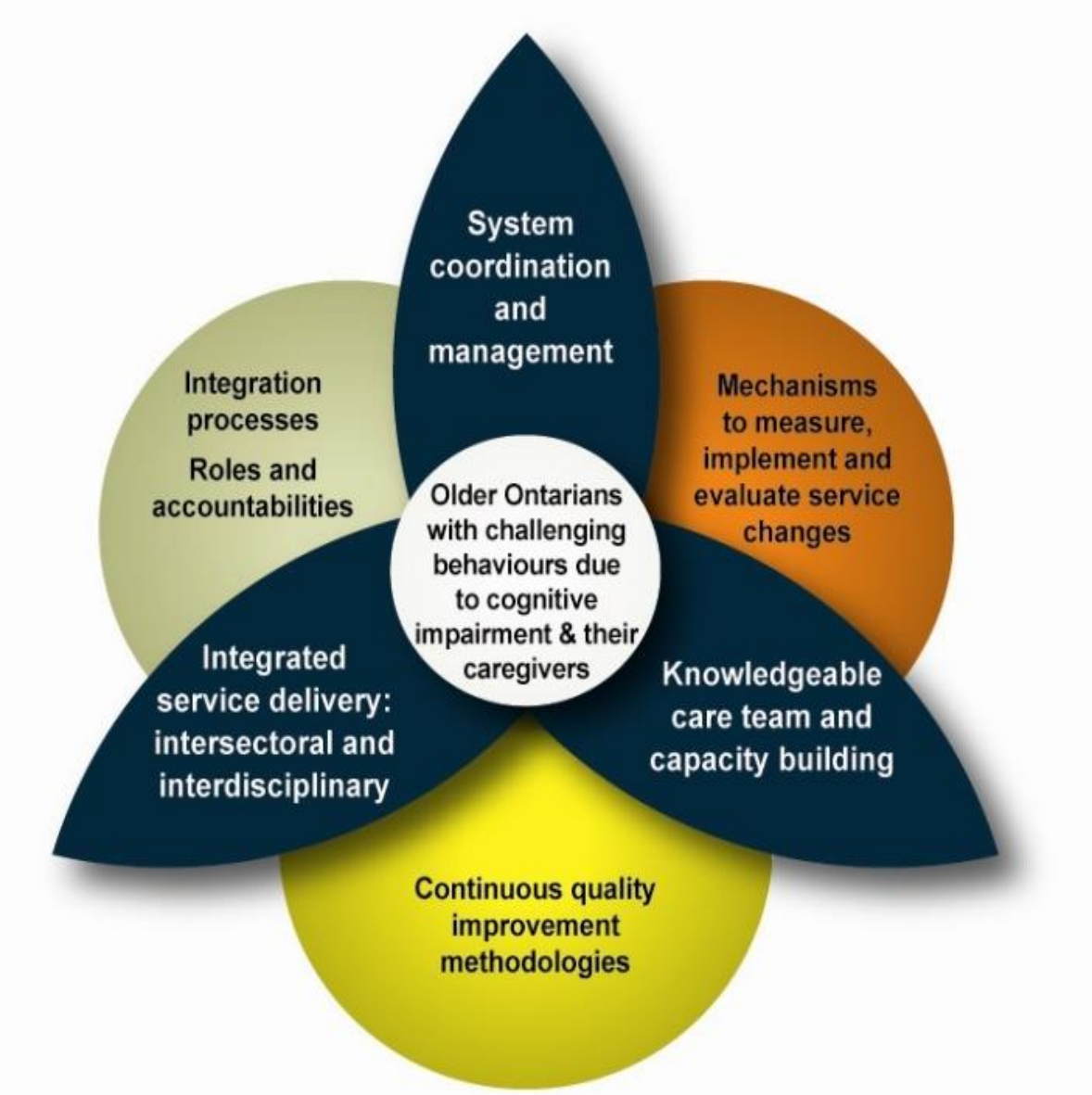
	Population in 2006	Mother Tongue French	% of Total Population Mother Tongue French	Aboriginal Identity Population	% of Total Population Aboriginal Identity Population
North East Local Health Integration Network	**551,691**	**125,080**	**22.7%**	**51,920**	**10%**
Ontario (Province)	**12,160,282**	**488,815**	**4.0%**	**242,490**	**2.0%**

HSPs that are located in an area of the NE that is designated under the *French Language Services Act* must provide services to the Francophone population they serve. Of the 186 HSPs in the NE, 68 are identified for the provision of French Language Services and 36 are designated under the *French Language Services Act*.

One of the NE LHIN's priorities is to work towards improving the health status of Aboriginal/First Nations/Métis people across northeastern Ontario, and to support services that align with regional, provincial, and federal health planning programs and service delivery structures to improve the health outcomes of this population. Throughout the NE, there are 37 HSPs that receive funding for the Aboriginal/First Nations/Métis population.

Action Plan

The NE Action Plan has been developed based on the provincial BSO framework, with a focus on the three pillars: System coordination and management; knowledgeable care team and capacity building; and integrated service delivery – intersectoral and interdisciplinary.



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. **Current gaps and weaknesses in system coordination across cross-agency, cross-sectoral collaboration and partnerships preventing 'seamless' care:**

The NE LHIN hosted its *Value Stream Mapping* (VSM) event on November 7 and 8, 2011. During the session, participants described the current state of the client journey for older adults with responsive behaviours. A participant offered an observation which best describes the current state:

"*We have a lot of great services in the North East, but we don't have a system.*"

System Coordination

At this time, there is no lead agency responsible for the treatment/coordination of services for individuals with responsive behaviours. Although many services exist to serve this population, these services tend to be uncoordinated. The services are based within "silos" and there are no clear roles or accountabilities for working towards a common goal. It is observed that the current service mandates stand in the way of system coordination.

This current state results in duplication of assessments which add to the challenge of effectively communicating urgent needs. There is also little interface in information communication technology and this contributes to poor or no communication and limited coordination with primary care services.

There are also weaknesses involving information sharing and the coordination of referral processes within the circle of care. Providers find it challenging to coordinate care if primary care is not involved. As an example, a provider in one of the communities expressed that a high percentage of residents on the LTCH waitlist in their community exhibit some form of mood/depressive symptoms. Additional feedback identifies the need for increased coordination between the CCAC and family physicians.

The SMH Programs offer community-based Psychogeriatric consultation services. These services are observably disconnected and not part of the existing continuum. This is another symptom of an uncoordinated system, which is compounded by the lack of defined care pathways and limited regional support from regional specialized services.

Availability of Resources

The availability of resources in the NE is an ongoing problem that concerns all stakeholders: HSPs, patients and their family members, as well as all residents of the NE. In smaller rural communities, the number of persons needing care may be smaller, but the urgency may be greater due to limited access to resources.

Throughout the NE, there is a need for additional human resources in a variety of professions, such as Psychogeriatricians and Geriatricians, General Practitioners, Occupational Therapists, Physiotherapists, Social Workers, Geriatric Emergency Management (GEM) Nurses, Nurse Practitioners and Registered Nurses. Most areas in the NE have difficulty recruiting professional staff. This lack of resources contributes to long waitlists for services. In addition, respite services for caregivers are limited. Within the current LTC system, there is a lack of positions dedicated to responsive behaviours.

Currently, access to a LTCH within this region is a challenge if responsive behaviours are present, resulting in an increased number of applicants with responsive behaviours being declined due to inappropriate environment and staff levels.

In addition to human resources, there are limited financial resources dedicated to SMH to form comprehensive and coordinated services.

The funding restrictions with the Ontario Drug Benefit Program have had an impact on the ability a hospital to discharge a senior.

There are limited resources to care for older adults outside of the LTCH. For example, there is limited access to Assisted Living services in rural areas. Persons with responsive behaviours are sometimes sent back to the community without the necessary education or supports.

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

There are many structures in place to provide LHIN-wide coordination of services:

- The BSO NE Regional Working Group, which was created to help develop the BSO Project for the NE
- The NE Regional ED/ALC Leadership Committee
- The Dementia Network Coalition, comprised of chairs from each Network located in the NE
- The NE SGS, consisting of Dr. Jo-Anne Clarke and an interdisciplinary team to provide geriatric services across the NE. Clients are referred by a physician and this program is linked to the SMH Programs in each area, as well as to the Geriatric Case Managers at the CCAC. There is also an Advisory Board of the NE SGS.
- The Network of Psychogeriatric Resource Consultants – The Northeast PRC Team is administered by the NBRHC. They are located in North Bay, Sudbury and Sault Ste Marie, and provide support to LTCHs and community providers and contribute to network and capacity building.

b. How will structures be modified to improve coordination?

The NE CCAC's placement coordination will be part of a BSO improvement project in order to create a better transition to a LTCH for this client group.

A common strategy for intake will be created for Behavioural Supports.

The NE SGS will be leveraged to support the BSO project by linking older adults with responsive behaviours to the Geriatrician and other allied health care professionals when appropriate. The goal of the NE SGS is to develop a comprehensive Geriatric Network in the NE. The RBCs and PRCs would be integrated with the Geriatric Network once it is established.

The current BSO NE Regional Working Group will be transformed into a governance body for Behavioural Supports with formal linkages and accountability to the NE Regional ED/ALC Leadership Committee.

The NE LHIN is undertaking an approach that will facilitate continued engagement with and among LTCHs. Four regional HUB groups will be formed across the region to identify and discuss opportunities/challenges pertaining to health system integration and transformation and to support linkages between LTCHs and local health systems. A regional group will be formed through representation of the NE LHIN HUB areas with the mandate of facilitating a regional dialogue with the NE LHIN and other regional service providers. The four NE LHIN HUBs are: Algoma, Cochrane, Nipissing/Temiskaming and Sudbury/Manitoulin/Parry Sound.

A stakeholder engagement plan is being developed to assist with the optimization of the existing structures. This will help determine roles, identify linkages and support opportunities for collaboration between the various stakeholders and the proposed leadership structure.

Implementation of the Integrated Assessment Record will improve communication and sharing of client information and will facilitate coordination of the BSO Project.

Finally, *Memoranda of Understanding* will be established between HSPs to solidify the shared accountability for Behavioural Supports.

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

The NE LHIN Board of Directors is responsible for the overall accountability of the BSO Project, as reflected in the accountability agreement between the NE LHIN and the MOHLTC. For the purposes of planning and implementing the BSO Project, the NE LHIN has created a cross-sectoral, cross-discipline regional working group. The BSO NE Regional Working Group has a mandate to provide local leadership, advice, guidance and support for the development and implementation of the LHIN-wide Action Plan. NE LHIN staff, HSP representatives and other local stakeholders involved

in dementia care for the elderly will collaborate on an array of comprehensive Behavioural Supports for the residents of the NE LHIN.

A formal linkage will be created between the North East Behavioural Supports Governance Committee and the North East Dementia Network in order to facilitate common client focus groups and other feedback sessions. The approach would be to bring caregivers and where appropriate clients into sessions for short term, very specific feedback. These sessions would take place where caregivers gather, i.e. existing Family Council groups in Long Term Care Homes and Family/Caregiver Support Groups in the community.

Targeted feedback sessions will also access existing structures such as the established consumer groups in the mental health system. The existing consumer groups have older adults with a mental health diagnosis that will inform the Behavioural Supports planning and implementation.

All members of the BSO NE Regional Working Group have shared accountability for contributing to the development of the regional Action Plan. The members will also function as the formal conduit between the working group and the NE Regional ED/ALC Leadership Committee. The BSO NE Regional Working Group is accountable to the NE Regional ED/ALC Leadership Committee.

The governance of the NE Behavioural Supports Project will evolve to support advancement of the future state once the plan has been approved. The future BSO NE Regional Governance Committee will include representatives from HSPs that are funded to provide Behavioural Supports Services. The NE LHIN will support the governance structure as part of the ED/ALC portfolio. The NE LHIN will provide governance support through the Project Lead and IF.

The NE LHIN BSO Improvement Facilitator will support the development of a Regional QI structure that will guide the QI process and the development of the performance measures. A working group made up of QI experts in the NE will be recruited to participate in the project by lending their knowledge and sharing of resources.

HSPs funded to deliver Behavioural Supports Services will have their accountability agreements with the NE LHIN amended to reflect the funding allocation, requirements for reporting, and specific performance measurements related to the three pillars of the Behavioural Supports framework.

(Please refer to Appendix 4 to reference the NE ED/ALC Regional Leadership Structure organizational structure and the BSO organizational structure)

3. Partners for system coordination

Ultimately, all partners in care who provide services with older adults that have responsive behaviours due to dementia, MH and/or addictions will form equally important partnerships for this initiative. Some of the key lead partners are:

- NBRHC – Tertiary Provider (PRCs/SMH Programs/Physicians) – Lead Behavioural Supports Provider;
- the lived experience (individual and/or caregiver);
- NE CCAC and associated community providers;
- NE SGS;
- SMH Outreach Programs (regional and district);
- Primary Care providers;
- LTCHs; and
- Alzheimer's Societies in the NE (First Link Programs).

a. Previous collaboration and outcomes:

- The NBRHC SMH Program, in collaboration with the NE SGS team, created an algorithm for a coordinated referral process resulting in streamlined referrals and integrated partnership opportunities *(Please refer to Appendix 5)*
- The NE CCAC and the SMH Programs worked together on a coordinated referral process, resulting in better communication and improved access for clients
- The North East Dementia Network Coalition continues to work on several initiatives that enhance knowledge, linkages and practice (e.g. Search is Emergency Regional Project, Regional Professional Development Webinars, Dementia & Driving Project, Regional Dementia Website)
- Complex Case Resolution Task Groups (Nipissing, Sudbury/Manitoulin, Cochrane, and Algoma)
  The Sudbury Community Responsive Behaviours Working Group (2007) collected information and submitted a report to the NE LHIN entitled *Community Responsive Behaviours: Recommendations & Feedback*. A forum preceded the compilation of the report whereby 160 stakeholders engaged to contribute to the development of recommendations. Key outcomes included the hiring of a geriatrician for the NE, development of NE SGS and enhanced partnerships/collaboration.

- In 2006, the Interim Strategies Mental Health Working Group, comprised of representatives of organizations from the District of Nipissing, produced a report entitled *Older Adults Living with Mental Illness: Achieving a More Responsive Service System in the District of Nipissing and the*

Northern Section of Northeast Parry Sound. Based on the comprehensive review of existing services and identified gaps, the report highlights recommendations and related costs/resources pertaining to a proposed local service delivery model for older adults living with mental illness aimed at:

- System Planning & Development;
- Building Community Capacity;
- Building Capacity in LTCHs; and
- Building Capacity in Acute Care Settings.

b. Executive sponsors

Executive sponsors who will have responsibility are as follows:

NE LHIN – Senior Director
NBRHC – Vice President
NE CCAC – Senior Director(s)
LTCHs – Administrators
Alzheimer Society – Chief Executive Officers

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. Gaps in service continuum access to supports and outreach services

Given the geographical challenges in our area, there is currently no seamless continuum of service delivery and there are access challenges at all levels of the continuum. The development of a coordinated transitional support system (in-reach/outreach) is necessary in all sectors.

Primary Care

- Absence of a family physician prevents access to many programs that require a physician referral and physician follow-up
- Nurse Practitioners cannot readily access services for clients who are not linked to physicians
- There is limited follow-up with a primary care physician after the individual is discharged from the hospital

Long-term Care

- In LTCHs, there are fewer trained individuals, less support, and a more crowded environment with a mixture of individuals with different needs
- Serious health human resources shortages (RN, RPN, and PSW) and/or lack of allied health professionals, such as Occupational Therapists, Physiotherapists, Social Workers, Behaviour Therapists, Recreation Therapists, etc.
- Limited access to LTCHs for older adults with a MH diagnosis and associated responsive behaviours
- Extended waitlists for LTCHs

Community Care

- Extended waitlists for services in the community (respite, adult day program, in-home supports, support and education)
- Limited funding for services necessary to maintain individuals at home (one-to-one intensive stabilization support)
- NE CCAC lacks human resources, especially in smaller communities. This lack in rural communities limits the ability to access these scarce essential services in these remote areas, in a timely manner.
- Referral from hospital to community (need to strengthen linkages to community support services)

Acute Care

- Lack of consistent access to ED Nurse-led outreach program
- Limited or lack of access to GEM Nurse
- Limited or lack of access to Identification of Seniors at Risk (ISAR) tool
- PIECES training mandate does not include acute care
- Lack of timely access to psychiatry in the ED

Specialized Care

- Lack of specialists (i.e. there is currently only one Geriatrician for all of the NE)
- Limited access to Geriatric Psychiatry throughout the region
- Lack of resources resulting in waitlists for regional SMH Programs
- The SMH Programs in the region need to be better coordinated; the rural population has more difficulty accessing these services
- Limited access to Geriatric Pharmacist consultation

Other Factors

- In the NE, the distance between communities can be a barrier to accessing services, as well as for the delivery of outreach services
- LTCHs with limited telecommunication connectivity (access to the Ontario Telemedicine Network (OTN)) can present a barrier to accessing services through telemedicine

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

In preparation of the VSM for the NE, and in consultation with the BSO NE Regional Working Group, the following high risk population was identified as the focus of the mapping exercise: *Older adults residing in a LTCH, community or acute care hospital who have demonstrated behaviours that have the potential to put themselves and others at risk. All previous attempts at intervention have failed.*

The following are key transition points for this population:

- From the community to a LTCH
- From the community, a LTCH, or acute care to a specialized team, including a specialized transition unit and repatriation back to the community or a LTCH
- From the community to a regional tertiary dementia bed and repatriation back to a LTCH
- From a LTCH to a regional tertiary dementia bed and repatriation back to a LTCH
- From a regional tertiary dementia bed to the optimal home destination

Accordingly, this Action Plan has been developed to address specific client populations:

- Older adults with an unexpected behaviour change who require access to an integrated system of care for ongoing management and support to maintain them in their home, whether it be in the community or LTCH. With health promotion and prevention being the primary focus, the key transitional gaps occur between primary care and specialty geriatric services, primary care, and the appropriate linkage with community services and coordination among community services.

- Individuals who experience a crisis that relates to a new, or changes in, responsive behaviour in the community or LTCH, who require episodic or intensive transitional care. The transition points are from LTCH (or home) to a special geriatric outreach team (if available), or acute care. While the focus of preventing further decline and optimizing health does not change, behavioural issues have surfaced, and a tipping point has been reached.

- Individuals who are at particular risk include those older adults that do not have a primary care provider, those that are homeless, and those with addictions. It will be essential to establish protocols that will provide additional support for older adults that have more complex social needs. In addition, given the population profile in the NE, at risk populations also include the Francophone population and the Aboriginal/First Nations/Métis population.

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

In order to help address the gaps in service continuum for Behavioural Supports services, existing structures, services and expertise will be leveraged. These include:

Specialized Expertise and Capacity Building

- PRCs who have existing roles within the system to develop knowledge and build capacity for new BSO staff in the continuum, and provide ongoing indirect specialty consultation and system navigation
- In-house resource champions in LTCHs and the community (trained in PIECES, GPA, *U-First!*, Montessori-based dementia care, GiiC, etc.)
- NBRHC (Tertiary MH) – Regional Specialized Dementia Care beds
- Geriatric MH Nurses and/or teams
- NE SGS
- Enhanced support for Care of the Elderly Physicians
- SMH Outreach Programs
- Alzheimer Societies (Public Education Coordinator)
- Algoma Public Health Mental Health Case Managers

Networks and Service Coordination

- First Link Program provided by Alzheimer Societies
- NE CCAC (knowledge and expertise in centralized intake and referral, and with all aspects of the care system (i.e. hospitals, supportive housing, community agencies and LTCHs))
- Educational institutions
- Local Case Review Teams
- Aging at Home programs
- Community Health Centres, Family Health Teams
- NE Dementia Network
- OTN located across the NE with potential for further development in LTCHs
- District and regional addiction/MH partners groups
- Local and regional Human Service Justice Coordinating Committee
- The Seniors Mental Health Integrated Service (SMHIS) was created in January 2009 with Health Accord Funding provided to the NBRHC to hire 1.6 Full-Time Equivalent (FTE) nurse clinicians to support the District of Nipissing. SMHIS offers support and specialty consultation in hospital (primarily complex continuing care) to the frontline health care team caring for older adults exhibiting a broad range of MH symptoms.

First Nations/Aboriginal/Métis

In keeping with the need to provide culturally appropriate services, our regional services delivery model must align with First Nations (FN) communities in the NE. The availability of the specialized resources must be communicated with the FN Health Directors, and the appropriate access points determined.

Formal referral protocols and standards need to be developed in order to support older adults in FN communities. Currently, specialty services are referred to, although not in a systematic, person-centred, or standardized fashion.

Close attention will be paid to the principles of wellness that enable the individual, their families and the community to understand and contribute to the care plans. It will be essential that the individual health needs have a broader social context in the communities and that there is an engagement of the different generations.

Existing planning bodies, such as the NE LHIN Local Aboriginal Council, will be appointed to provide the mechanism to offer broad education and promotion of the Behavioural Supports Project to FN communities.

French Language Services (FLS)

There are opportunities to leverage existing strengths to address the needs of Francophones and their caregivers. In the Primary Care sector, there are five Community Health Centres that are Francophone or bilingual. As a large number of the clients are older adults, these centres will be key partners in identifying clients in the community with responsive behaviours or at risk of developing responsive behaviours. Their role in Primary Care, Health Promotion and Disease Prevention will be leveraged to help in the redesign of an integrated continuum of care for our target population.

The large number of HSPs identified for FLS or designated under the *French Language Services Act* will be key strengths in meeting the needs of the Francophone population. An FLS human resources plan for BSO staff will be developed to help guide the hiring of staff that are best able to serve the clients, wherever they reside. Specifically, the FLS capacity of LTCHs will be leveraged to help address the needs in this sector.

As part of continued engagement for the NE LHIN's BSO Project, the newly created French Language Health Planning Entity and the NE LHIN FLS Team will be consulted in order to determine their role in identifying the needs of Francophones within this target population.

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 VSM exercise held in the NE identified the future state for the provision of a seamless continuum of behavioural support services in the NE *(Please refer to Appendix 6 for a Diagram of the Future State)*. The key elements of a transformed system include:

   - A comprehensive care plan that provides the right care in right place, at right time, by the right provider for older adults identified with responsive behaviours and for those who are at risk;
   - A safe place for the older adult and caregiver/provider during crisis;
   - Appropriate, timely coordinated referrals and assessments;
   - Providers with the capacity to safely meet the needs of the individual with responsive behaviours and the tools to prevent the escalation and intensity;
   - Ongoing monitoring of care plans for individuals at risk;
   - Improved risk identification and management;
   - A formal network for education and knowledge exchange;
   - Prevention/diversion from escalating to a crisis point;
   - Enhanced capacity building for primary care to effectively manage these residents/clients;
   - A centralized intake and referral process for Behavioural Supports designed to meet client, family and service needs; and
   - The establishment of best practice protocols to enable smooth transitions throughout the system, including the formalization of RBTs (in-reach/outreach).

   From the mapping exercise, five improvement projects were identified to help achieve and support the future state for a comprehensive behavioural support system:

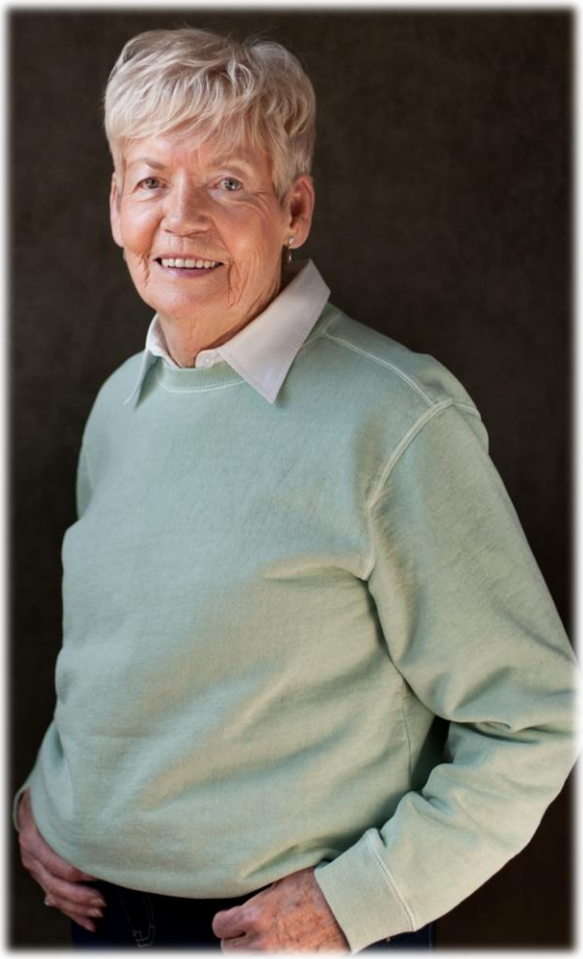
i) **Create a standardized process to transition to and/or from LTCH** in order to promote a seamless transition of admission to and/or from LTC for residents and families for the prevention of adjustment issues, to develop relationships, gather the data, and facilitate knowledge transfer that will help to ease transition.

ii) **Create standardized care plans** inclusive of the Personhood Profile, PIECES framework and common process for knowledge exchange. This will help provide client centered care and will focus on prevention of responsive behaviours.

iii) **Knowledge and Capacity Building**: Build capacity and manage staff shortages; enhance use of common knowledge, language and vision; train staff well prior to hiring; create focused charting that is easy to use and reflects actual status; and prepare staff adequately to feel confident in using best practices, common language and common approaches.

iv) Create a place of safety for the person and their care giving system:

- Establishment of a centralized intake and referral process to ensure equitable and timely access to the right provider, for the right service at the right time
- Development of a common practice protocol *(Please refer to Appendix 7 for a Sample Reference)*
- Through the NE CCAC, there is a potential to create a mechanism to share information and maintain open current files for persons identified with responsive behaviours in order to prevent duplication
- Private room at LTC facility that is staffed if needed
- Intense RBT within the LTC facility, coordinated with an external transitional team
- RBT including various existing and BSO leveraged HSPs including RN/RPN, RBC (e.g. behavioural therapist, Occupational Therapist), PRC, PSW – direct support care 24/7, SMH Outreach, NE SGS, Alzheimer Societies, Physicians, NE CCAC (intake and geriatric case managers). The RBT would be available to support patients/families/HSPs within ALL levels across the continuum of care.
- Specialized stabilization beds also supported by the RBT and tertiary care that allow direct admittance and discharge care planning (including repatriation agreements) developed prior to admitting to the specialized bed, along with transitional support throughout the continuum
- Transitional outreach from RBT back to LTC facility or community



v) Critical Incident Debriefing Process in Long Term Care:

- Support employees in a way that reduces the distress from being involved in the responsive behaviour incident
- Support the client/caregivers through the incident and maintain communication
- Evaluate the incident and reflect on lessons learned
- Reflect on and learn from any systems/processes that were initiated in advance of or in response to the responsive behaviour (i.e. Code White, Police, Emergency Medical Services, clinical documentation)

A high level System Improvement Model is included to help demonstrate the NE LHIN's vision of how the BSO project will function across the four HUB regions for system improvement (*Please refer to Appendix 8*).

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

a. Will there be supported behavioural assessment services?

Yes, through an identified BSO algorithm, including a centralized Behavioural Support intake and referral process, timely and equitable service access will be ensured.

b. How will a comprehensive geriatric assessment be conducted?

This service is currently being provided through various HSPs. However, the redesigned system will be inclusive of a coordinated system approach. Through an initial standardized screening tool, there will be a common approach to guide the most appropriate comprehensive assessment plan. The mode of assessment will be regularly reviewed through ongoing QI activities.

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

This population will be identified through the following strategies:

- Health promotion, prevention, early detection through increased public awareness and capacity building for professional care givers in LTC and the community
- Enhanced system navigation and support through a centralized intake and referral process and standardized protocols supported by the RBTs

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

Individuals will be directed through the centralized intake and referral coordination and the First Link initiative, along with a regional philosophy that embraces the concept of "every door is the right door". Ideally, anyone who needs care and presents themselves to a provider within the NE LHIN will be directed to the appropriate provider or system navigator.

e. How will individuals in crisis be supported?

Older adults in crisis situations will be supported differently depending on the care setting and the type of crisis. Existing protocols are in place that dictate response uses and agreed upon approaches. These protocols work for most settings, but may require augmentation based on increased Behavioural Supports in the NE. For example, enhancing staff in LTC through increased nursing and PSWs will mean less reliance on community resources such as SMH.

Community

- Individuals and families in crisis in the community who are already receiving service with an integrated community lead agency will contact that agency, and if determined necessary, the agency will initiate the crisis response plan. This will involve a mobile team response.

- Individuals not currently receiving service or on a case load may contact their primary care physician, mobile crisis team (where available), or present at the nearest ED. Depending on the level of crisis, they may be admitted or the GEM nurse (where available) and/or CCAC Case Manager in the ED will initiate a community support service plan in consultation with the RBT.
- Care plans will be adjusted accordingly

LTCH

- Individuals in crisis in LTCHs will initially be assessed and care plans adjusted by the LTCH staff (Behavioural Supports Nurses, PSWs, and others who have obtained increased knowledge and skills specific to this population as part of this action plan) in consultation with the LTCH Medical Director
- In situations where the resident's condition (crisis) has escalated beyond the skills of the LTCH staff, the LTCH will initiate the crisis response plan, which may involve referral to the RBT
- There will be an expectation of timely response (e.g. within 72 hours) of the RBTs
- As a plan for ongoing continuous QI, engaging with existing crisis service providers to enhance knowledge translation and system coordination with RBTs

7. Who will be the partners for interdisciplinary service redesign?

Ultimately, every partner in care (including the client, care givers and family members, and those who provide services to people with responsive behaviours) will be our system redesign partners. The following list includes the key partners, although this list is not intended to be all encompassing:

- Individual with responsive behaviours and their caregivers
- NE LHIN BSO staff
- NBRHC
- NE CCAC
- SMH Programs
- NE SGS
- LTCHs
- Alzheimer Societies
- Canadian Mental Health Association

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

(Both questions are addressed in a single response)

The inter-collaborative work in which NE LHIN providers have engaged has resulted in a greater understanding of the different resources, prompted the establishment of partnerships with different

sectors, and established a broader shared accountability amongst providers, resulting in efficiencies across the health care system.

Through the increase in training and development of frontline employees, an increased level of confidence and competence is evident by the level of comfort with older adults with responsive behaviours and the ability to work with specialty services like the PRCs. In most situations, the pivotal element is the sustainability of interdisciplinary service delivery. Ultimately, it is the improved experience for the client for which we are striving.

The BSO NE Regional Working Group has cross-sector representation, comprised of health care leaders with expertise in the management and care of individuals with responsive behaviours, as well as consumer representation. The working group will expand membership and increase expertise through the establishment of Behavioural Supports Task Groups and Provider Level Committees. These committees will identify the models of care; define roles, responsibilities, protocols, and standards; and identify the necessary formal processes that need to be implemented. The expanded partnership will include primary care.

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

Executive sponsors who will have responsibility are as follows:

NE LHIN – Senior Director
NBRHC – Vice President
NE CCAC – Senior Director(s)
LTCH – Administrators
Alzheimer Society – Chief Executive Officers

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?

- PIECES and *U-First!* training – Most LTCHs have provided this training for some of their staff, although they do not have the time to apply their knowledge and train others. There needs to be a dedicated individual, not an added responsibility.
- PRC interactive case-based learning
- GPA training for all sectors in health care
- GiiC regional training workshops through NE SGS
- Biennial Northeast Geriatric Care Conference (regional working group)
- Face-to-face conference opportunities
- First Link Learning Series through NE Alzheimer Societies (in person and via OTN)
- Alzheimer Society Public Education Coordinators
- Student placements in community care settings
- Alzheimer Knowledge Exchange (AKE) webcast conferences
- BSO Website – NE LHIN portal for BSO Project
- North East Dementia Network Coalition webinars
- Ontario Prevention of Elder Abuse Network – Northeast
- Seniors Health Research Transfer Network (SHRTN)
- NE LHIN Website
- The Northern Ontario School of Medicine (NOSM) through OTN offers videoconference education credit courses and events on a range of topics
- The colleges and universities offer several programs relevant to the BSO Project
- Annual Regional SMH/PRC Study Day hosted by NBRHC in alternating district locations

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)?

The BSO IF for the NE LHIN will be the individual who will receive the QI training to support the BSO. The IF will be supported by the NE LHIN QI Working Group comprised of internal decision support staff and other QI experts throughout the NE. In addition, the NE LHIN IF will link with other LHIN IFs as needed and with the IFs from the mentor LHINs. Task teams will be developed throughout the duration of the project for implementation and monitoring of redesign principles and outcome measures. The following site will be referenced as a key portal to access common Health Quality Ontario tools: http://www.ohqc.ca/en/qi_teams.html.

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

- There are currently three PRCs in the NE. All three provide education, consultation and support to LTCHs and community agencies within their catchment areas *(Please refer to Appendix 9 – PRC Pamphlet)*
- The SMH Outreach Services provide direct Psychogeriatric consultations for residents in LTCHs and in community in response to referrals initiated by the Physician or Nurse Practitioner
- There are two tertiary units at the NBRHC (15 regional specialized dementia beds at the Kirkwood Site in Sudbury and 16 SMH assessment beds in North Bay)
- NE SGS provides comprehensive geriatric consultation and education throughout the NE and works in collaboration with other specialty services
- Alzheimer Society First Link Program, linking the caregiver with the appropriate supports
- There are a number of physicians throughout the region with CoE specialty
- Psychiatric expertise exists through permanent positions and locums

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

Upon hiring of the RBT staff, an orientation plan will be developed based on employee knowledge, level of expertise, and previous working experience in order to meet the expectation of the positions. Members of the team will receive training from the PRCs on PIECES, *U-First!*, GPA, etcetera and coaching by the clinical staff of the SMH Outreach Team. Staff will be expected to maintain their professional knowledge of best practices in responsive behaviour approaches. QI measures will be incorporated as part of the RBT's approaches. The core competencies for working with the behaviourally complex population will be incorporated into all positions funded through this action plan.

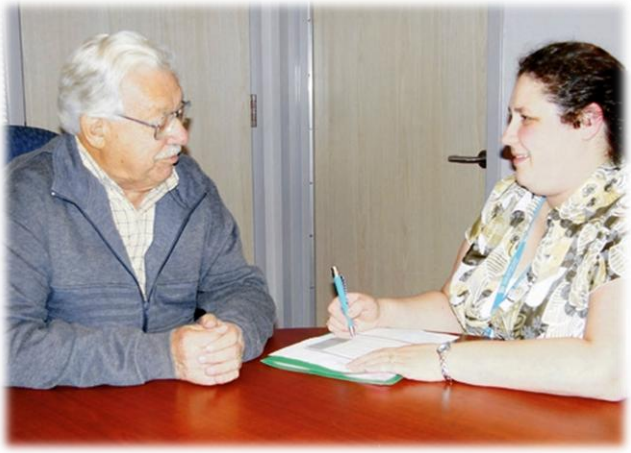
d. What knowledge transfer structures/pathways currently exist within the LHIN that can be leveraged in support of the BSO Project?

The SMH Program of the NBRHC currently provides knowledge transfer and builds capacity by providing training and clinical support to Nurses working in local HSPs. The NBRHC PRCs provide ongoing formal and informal education, training and case-based consultation to the LTCHs and community agencies throughout the region. In addition, the NE SGS team promotes regional educational opportunities such as the GiiC forums. As for the "lived experience", the Alzheimer Societies throughout the NE promote necessary essential education and support for caregivers. The NE CCAC provides an information and referral service (live phone and online) with reference to LHIN-wide resources for older adults, their families, professional staff and the public. All of these services interact with LTCH teams at various levels. Additional PRC positions will augment the accessibility of specialized resources for support/training of the RBTs

and training of the in-house LTCH Behaviour Support resource staff. Furthermore, the addition of RBCs and funding for caregiver education will leverage opportunities for interactive knowledge exchange throughout the system.

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

Through the Behavioural Supports funding, there is an opportunity to improve the functioning of existing partnerships, current capabilities and initiatives within the NE LHIN to create an integrated BSO system. The transfer of knowledge regarding new models of care and care processes will be guided by the BSO NE Regional Working Group and task groups. Key stakeholders will be well-positioned to function as 'change agents' to help disseminate new/best practices across HSPs and the broader health care system.



The BSO Project will enable the standardization of protocols and tools for consistent application in practice across the care continuum. Furthermore, the NE LHIN will collaborate with the other LHINs to implement tools that have been set as a provincial expectation for use in the implementation of the BSO Framework.

The BSO NE Regional Working Group and subsequent task groups will review locally developed tools and resources currently in use among Behavioural Supports providers in the NE to determine a common suite of evidence-based tools for the screening, assessment, and care planning for Behavioural Supports.

In conjunction with the establishment of a BSO System Coordinator, PRCs and RBCs will promote and ensure the consistent application of the best practice tools and protocols (both provincial and local). Creating a centralized intake, triage and referral function will create common risk screening and access mechanisms.

Aging at Home Programs

Aging At Home funding allocated to the District of Nipissing in July 2011 will be leveraged to build the RBT for that area and will be integrated into the regional Behavioural Support System.

NE CCAC Geriatric Case Managers – As part of the RBT, the existing CCAC Geriatric Case Managers will play a key role in assessment and service coordination for complex cases as part of an integrated BSO system. They will also be a primary resource to the BSO coordinated intake and referral staff.

ED/ALC

The NE ALC Plan recommends new investments in Behavioural Supports across northeastern Ontario *(Please refer to Appendix 10 – NE ALC Plan)*.

Tools and Resources

The Action Plan will optimize opportunities to improve system coordination, information exchange, interdisciplinary care, knowledge exchange and QI through the following tools and pathways:

- Setting of regional standards for education and training by leveraging and promoting existing best practice clinical resource materials that have been developed nationally (e.g. The Canadian Coalition for Seniors' Mental Health guidelines and job aids) and provincially (PIECES RIA, GPA to Dementia care, *U-First!*, Montessori Educational Materials)
- OTN will be used to optimize resources across the region, especially in remote communities
- Development of the NE Dementia Network Regional Website
- LHIN Priority Setting and Decision Making Framework Toolkit

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.)?

Clinical Leadership

The lead HSP for the NE Behavioural Supports redesign is the NBRHC. As the Regional Tertiary Specialty Care provider, the NBRHC has existing regional and provincial linkages that will contribute to the sustainability of this system redesign. As the leading provider, the NBRHC will be responsible for the development of a knowledge exchange strategy for the NE.

The NE LHIN is fortunate to have, within their mentor LHIN, access to a provincially recognized expert in responsive behaviour as the clinical lead for this project. **Dr. Ken Le Clair**, clinical director of Providence Care's Regional Psychiatry Program and Departmental Chair of Psychiatry at Queen's University, has led the development of this redesign from the outset. Dr. Le Clair has visited the NE on numerous occasions, including a recent keynote address on inter-collaboration at the 2011 NE Geriatric Care Conference, wherein he engaged over 200 participants in an interactive BSO focus group exercise. He continues to lead opportunities for further growth and development in this initiative.

The HSPs funded to hire staff with the Behavioural Supports funding or any other funding dedicated to serve this population will have to possess or work towards attaining the core competencies for working with the behaviourally complex population as developed by the Coordination and Reporting Office.

The core competencies will be leveraged as a common element that each sector will have in their position descriptions. The BSO NE Regional Working Group will create a knowledge exchange task group that will create a plan for the NE that will include common curriculums and standards for education.

Funding allocated to community providers for PSW training will be leveraged for the Behavioural Supports Project. Currently in the NE, there are funds devoted specifically to core and enhanced PSW training within the community sector. The Knowledge Exchange Working Group will liaise with the NE LHIN Personal Supports Occupation Training Committee to identify the appropriate mechanism to access the PSW training funds.

NE LHIN System Coordination

With executive leadership from the NE LHIN, the NBRHC, the NE CCAC, and providers at the local level, along with a project management approach and extensive input from the clinical perspective and the community, the NE LHIN will be positioned to facilitate change management and system integration.

The proposed governance structure for our Action Plan will assist in the sustainability of the developed Behavioural Support System for the NE. Through the structure of the BSO NE Regional Working Group there will be a task group for knowledge exchange and capacity building.

Accountability

HSPs that receive funding through this initiative will have system accountability incorporated into their amended accountability agreements with the NE LHIN. The amended accountability agreements will include BSO staffing models, roles and responsibilities (education and capacity building), commitment to an ongoing learning strategy, requirement to participate in knowledge exchange forums, and ongoing performance and reporting.

The BSO NE Regional Working Group will formulate formalized memoranda of understanding, partnership, and other appropriate agreements that will focus all providers on system accountability.

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 be integrated into the NE Behavioural Support System as part of the commitment of the care partners to serve older adults with responsive behaviours. Using the principles of QI, all members of the RBTs will be employed to impart knowledge on the best client-centred approach to service delivery. The internal LTCH nurses and PSWs will be resident experts and will provide formal and informal job coaching. External supports will be deployed for complex situations. In the long term, the core competencies for Behavioural Supports staff will be the core competencies for all staff.

As part of the BSO structure, a Knowledge Transfer/Capacity Building working group will be established to research evidence-based best practices, development of client-centred protocols, and standards for education and training both at the HSP and post secondary levels. The work of this group will be shared with all sectors, with a focus on those providers serving older adults with responsive behaviours.

12. Who will be the partners for Knowledgeable Care Team and Capacity Building (e.g. university)?

a. How have the partners collaborated on previous projects?
b. What were the outcomes?
c. List the executive sponsors and lead agency who will have responsibility for meetings, chairing a steering committee, ongoing leadership and engagement, etc.?

(All questions are addressed in a single response)

All HSPs who provide supports to older adults with responsive behaviours, as well as caregivers and family members, will form our Knowledge Exchange and Capacity Building Working Group.

We will also engage the formal educational institutions and/or programs, such as Laurentian University Gerontology Program, to provide academic and research opportunities implicit in the building of knowledgeable care teams and enhancing capacity.

The NE LHIN will provide leadership in order to promote partnerships with all providers to support the development of knowledgeable care teams and capacity building. Formal survey tools targeted to client/caregiver satisfaction will be initiated to evaluate the training BSO employees and caregivers receive to support the older adult with responsive behaviour. Surveys will be tailored to caregivers to determine the effectiveness of different training opportunities and the overall capacity building.

Feedback from the surveys will be used to formulate follow up improvement plans. Training programs will be modified taking into account the client feedback.

Ongoing cross-sectoral training is taking place in many communities across the NE. Collaborative training includes:

- PIECES
- GPA
- One-to-one coaching using the expertise of the PRCs and SMH Programs
- Technology such as OTN has been used to provide extensive training for remote communities
- There has been some training done by the NE SGS, led by Dr. Jo-Anne Clarke
- The PRCs in the NE are part of the Seniors Health Research Transfer Network and they host annual knowledge exchange events for all MH professions in the NE who work with the older adult population
- The Alzheimer's Societies in the NE provide extensive training for family members and caregivers

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.
b. If more than one HSP is participating in each LHIN, describe how each of the positions will be distributed and provide your rationale.
c. Describe the specific roles and responsibilities of the behavioural staffing positions.

(All questions are addressed in a single response)

The NE LHIN service delivery model is based on achieving an optimal shared care vision that addresses individual needs along the continuum of care from point of contact throughout the journey of the lived experience. Existing resources will be complemented by the allocation of new Behavioural Support System redesign resources.

There is a shared understanding that a regional structure must be in place to oversee operations and monitor the performance of the ongoing implementation of the BSO Project. Outcomes will be a collective accountability of all partner agencies funded through the BSO Project. These new positions will allocate resources to provide operational leadership and credibility that will be essential to positive system transformation. The key positions on the leadership team responsible for operations of the NE BSO Project include:

- 0.5 FTE BSO LHIN Project Lead (NE LHIN employee)
- 1 FTE Quality Improvement Facilitator (NE LHIN employee)
- 1 FTE Regional System Coordinator/Navigator
- Regional Medical Advisory Panel (Geriatric Pharmacist, CoE Physician, Geriatrician, Geriatric Psychiatry)
- 0.5 FTE Responsive Behaviour Regional Administrative Support

NE LHIN BSO Project Lead Key Responsibilities

The project leads participated in the VSM exercise to help identify the gap between the current state/model of care and a desired future state that incorporates the critical components and standards identified in the BSO model.

With this plan to guide them, the project leads worked with the IF to develop this Action Plan, based on the output of the VSM. They will work collaboratively to co-lead the improvement team to develop, test, and implement the change ideas. They will contribute to the development of plans to support full implementation, spread and sustainability across their organizations.

With support from the IF, the project leads will be expected to submit weekly Leadership Reports outlining their progress, outcomes, process, and balancing measures.

NE LHIN BSO Quality Improvement Facilitator Key Responsibilities

The IF will be the local source of improvement expertise and will receive training from Health Quality Ontario. She will apply this knowledge to the BSO initiative to support implementation in the NE.

The IF will participate in the preparatory analysis with participating organizations prior to the VSM. Along with the project leads and other team members, she will engage in the VSM and contribute to the development of the improvement plans.

The IF will be responsible for developing an implementation plan based on the output of the VSM and for facilitating and supporting concurrent improvement initiatives as determined by the implementation plan. She will guide the planning and execution of Plan-Do-Study-Act (PDSA) cycles and will document the team's improvement journey. She will collate, integrate and synthesize real time data for process, outcome and balancing measures, and will assist the team in interpreting the data and taking appropriate action. The IF will lead the development of weekly leadership reports and review these with the improvement teams and executive sponsors.

The IF will also be responsible for supporting the transfer of lessons learned and QI knowledge gained during their NE LHIN activities to the other LHINs.

NE BSO System Coordinator Key Responsibilities

Under the leadership of the BSO NE Regional Working Group and lead HSP, the NE BSO System Coordinator will:

- provide the overall administrative leadership in the implementation and coordination of the regional BSO Project;
- ensure that within the available resources, the Behavioural Supports System core components are in place and functioning according to the agreements, including centralized intake and referral;

RBTs; access to specialized Psychogeriatric resources; and streamlined access to primary care, tertiary care, acute care, and long-term care;
- establish clear referral pathways and improve transitions across the care continuum;
- ensure the standardization of tools and protocols across the NE;
- identify system barriers;
- establish and maintain strong and positive cross-sector partnerships between all care components to promote service integration and system change within the Behavioural Supports model;
- establish linkages with other providers in the NE and other provincial BSO supports; and
- identify system issues and areas for improvement, together with the QI facilitator.

BSO Medical Advisory Panel Key Responsibilities

Under the leadership of the BSO NE Regional Working Group, the Medical Advisory Panel will:

- work with the BSO leadership to support and enhance quality of care;
- provide education and peer support regarding older persons with responsive behaviours to LTCH Medical Directors and attending physicians to support rapid adoption of evidence-based practice; and
- liaise with acute care and geriatric psychiatry to address system issues and quality of care. It is recognized that the support and contributions of the BSO Medical Advisory Panel and geriatric pharmacist champions and advocates are essential to gaining support from physicians and in the delivery of a quality Responsive Behaviour Support system of care.

  Note: The initial BSO Project investment of funds is quite limited. Therefore, an identified stipend amount has been allocated for the NE.

BSO Administrative Support Key Responsibilities

Under the direction of the BSO System Coordinator, Administrative Support will:

- provide support to the System Coordinator and Medical Advisory Panel in clerical activities such as coordinating meetings and managing supporting correspondence, quarterly reports, communications to all partners, etc.;
- manage the NE BSO Portal and BSO collaboration space for information sharing;
- work in collaboration with NE CCAC Central Intake to centralize client information and generate aggregate data reports as required by the RBTs; and
- Support the various BSO working groups in tasks such as recording and disseminating minutes. The leadership team will be employed (with the exception of the Quality Improvement Facilitator and NE LHIN BSO Project Lead) through one HSP that operates as a lead host agency to the BSO Project (specific HSP to be finalized in negotiation with the NE LHIN).

BSO Lead HSP Key Responsibilities

The lead HSP will provide the central administration function of the regional BSO Project, including staffing for the leadership team, within the terms of the agreement provided by the NE LHIN.

The lead HSP will provide:

- overall management of the regional BSO Project, web resources, and internal and external communication;
- back-office support (including such functions as payroll, human resources, financial reporting, and legal counsel); and
- physical office space for administrative personnel that includes furnishings, computers, telephones and the infrastructure to support these functions.

Resources from the Caregiver Policy Lens will be used by North Bay Regional Health Centre as the lead BSO provider. This resource will assist HSPs to develop programs that support caregivers, develop policies for Behavioural Supports that place increased value and support on caregivers, and provide a way to review policies and programs for potential unintended negative effects on caregivers. Please visit website for further information http://caregivertoolkit.ca/.

It is important to note that the lead HSP will not hold any additional authority over the governance or operations of the system. The lead HSP will be an equal partner at the BSO NE Regional Working Group; they do not own the service/program. As an equal partner, the lead HSP would sit on the BSO NE Regional Working Group and the relationship between BSO providers, the lead HSP, and the governance authority would be articulated in NE BSO *Governance Memorandum of Understanding*.

BSO HSPs' Key Responsibilities

Each LTCH and HSP will retain their own staffing/hiring and deploy dedicated staff to the BSO Project through written agreements with the lead HSP in a matrix management structure. This means that the BSO team will be comprised of employees from multiple providers. Employees will be part of the BSO system-wide initiative that will dictate work flow, priorities, and pressures. Personnel providing services within the regional BSO Project will remain employees of their respective organization, subject to its rules, collective agreements and personnel policies and procedures. All BSO-funded HSPs will agree that the personnel providing BSO services are employed and

accountable for the purposes of fulfilling roles and achieving outcomes defined and approved by the BSO NE Regional Working Group (*This funding model allows BSO personnel to maintain their seniority within their own organization and continuity in their work*).

Responsive Behaviour System Intake Coordination Key Responsibilities

- Receiving calls/referrals and assessing the level of immediate risk to persons with responsive behaviours and family/caregiver(s) and/or service provider(s)
- Providing telephone screening to determine eligibility for service
- Using 310-CCAC
- Completing a triage of the urgency of the response and scheduling follow-up appointments with appropriate referrals (e.g. primary care provider, local RBT, community support service, etc.)
- Tracking data and monitoring the volume of demand as required

Responsive Behaviour Teams (RBT)

The model developed for the NE includes an RBT in each of the four HUB planning areas. Each RBT will be launched with a consistent core group of professionals as determined by area of need, population and geographical allocation. While some of these positions will be new through the BSO funding, the Responsive Behaviour Team will be enhanced with existing positions. The nursing and PSW positions allocated to LTCHs will be used exclusively for the implementation of the BSO project and will be an integral part of the RBTs.

As a core, the RBTs will include a RBC, the PRC, Nurses and/or Nurse Practitioners, and PSWs from LTCHs. Complimentary to the core team are clinicians from SMH, Geriatric Case Mangers, clinicians from the NE SGS and appropriate Community Support Services such as the Alzheimer Society.

Through the funding allocation to Alzheimer's Societies in Sudbury, Algoma, North Bay and Timmins a Behavioural Supports Technician will be hired to work with older adults with responsive behaviours and their caregivers. The Behavioural Supports Technicians will work to support individuals in the four communities and their respective surrounding communities. The Behavioural Supports Technician will provide the one on one link to the older adult with responsive behaviour and the caregiver.

All members of the RBT (including Nurses and PSWs in LTCHs) will work collaboratively to establish common care protocols and standards, knowledge exchange, training, and performance measurement and evaluation.

To optimize funding, existing resources will be leveraged to support the new BSO system redesign. Please refer to the Human Resources Deployment Plan (See Appendices) for a detailed account of these allocated resources. Please note that the current staffing allocation is draft and will be further developed and adjusted by the BSO NE Regional Working Group. Over time, some positions may

be redeployed across the region according to volume demand to address specific needs and meet expected outcomes.

Responsive Behaviour Nurse Practitioner (new position)

The Nurse Practitioner role functions within the Standards of Practice for Extended Class, as set out by the College of Nurses of Ontario, to provide direct clinical care as the Most Responsible Health Care Provider to the registered patients within the RBT. S/he will function at full scope of practice, providing ongoing care and continuity of care to patients through service in collaboration with the Most Responsible Physician; lead a quality, integrated system of care for older persons with cognitive impairment and changes in behaviour, in collaboration with the patient and/or caregiver(s); demonstrate commitment to ensure the safety of fellow workers, patients, volunteers and visitors; and support a culture of safety and prevention of adverse health events in this organization. Further, s/he must reflect the cultural sensitivity of the local population that the team serves.

Additional Information

14. Enclose a summary timeline in a separate schedule.
(Please refer to Appendix 11)

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.

NE LHIN BSO Performance, Measurement and Evaluation Plan

The MOHLTC identified the following three performance metrics as measures of success for the BSO Framework:

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

The NE LHIN BSO Action Plan includes the creation of a Regional Quality Improvement Working Group to help guide the performance, measurement and evaluation of the BSO Project for the NE. The working group, comprised of expertise in the area of data and information management within the NE LHIN, as well as within other HSPs across the region, will review and validate the proposed indicators and help develop additional indicators as required. The BSO Logic Model and the work of the Provincial Data and Evaluation Working Group will help guide development of the NE LHIN's final BSO Performance, Measurement and Evaluation Plan. A tree diagram is included in *Appendix 12* to help demonstrate how the NE hopes to accomplish its BSO aim.

Existing Data to Support the Provincial Measures of Success

- **NE LHIN ALC days** – In the North East, the percentage of ALC days was at 32.9 as of Q1 2011-2012, with a target of 17%
- **Number of visits to the ED from a LTCH** – For 2010-2011, there were a total of 2,237 ED visits from a LTCH. When extracting the visits with a diagnosis related to mental health, there are 52 visits for the same period, or 2.3%.
- **Number of distinct clients with either Dementia or Alzheimer's awaiting Placement**

(Excludes the Interim placed clients and those waiting for preferred – As of November 24, 2011)

	Assisted Living Residence	Hospital	Private Dwelling	Retirement Home	Grand Total
Kirkland Lake		12	6	3	21
North Bay		32	44	6	82
Parry Sound		13	12	1	26
Sault Ste. Marie		33	59	19	111
Sudbury	1	28	117	37	183
Timmins		46	38	2	86
Grand Total	1	164	276	68	509

Sources

- MOHTLC – IntelliHEALTH ONTARIO
- HQO
- NE CCAC

Challenges

- To have clear definitions of the measures
- Ensuring that the project outcomes can be measured by the indicators

Proposed Outcome & Process Measures

Outcome measures help us to know if the changes made are helping us achieve our goal, while process measures indicate whether or not the processes are being followed. The following proposed measures will need to be confirmed and validated by the Quality Improvement Working Group.

Outcome Measures

- # and % of older adults with responsive behaviours who interface with the BSO Team who continue to live safely at home (or LTCH)
- # and % of caregivers who feel supported, as per a follow-up call from the BSO Team
- # of days between ED visit with most responsible diagnosis of Alzheimer's or dementia
- # of ED visits with most responsible diagnosis of Alzheimer's or dementia

Process Measures

- # of health care providers that report using standardized assessment for older adults with responsive behaviours
- # of clients referred appropriately across the spectrum of NE LHIN services by Central Intake

Proposed Balancing Measures

Balancing measures are additional metrics that help us know if improvement changes lead to unintended consequences for the person, the caregiver(s) or the health system. The following balancing measures are proposed and will be confirmed and validated by the Regional Quality Improvement Working Group

- Type of adverse event reported as a result of maintaining the client at home with the BSO Team
- Days between adverse events notes as a result of maintaining the client at home with the BSO Team (t-chart)

Improvement Plans

At the NE LHIN's VSM, five improvement plans were identified to help create and support the future state for the Behavioural Support System for the NE, and draft project charters were developed. For each improvement project, a team will be created to help implement the plan. Each team will be comprised of a project lead, an executive sponsor (to ensure organizational participation) and other members selected for their knowledge and expertise of the proposed improvement.

The Model for Improvement

The development and implementation of the improvement plans will use a variety of quality improvement tools shared by Health Quality Ontario, such as the PDSA cycles, Kaizen Events, Fishbone Diagrams, the 5 Why Analysis, etc. The model for improvement will define the aim, identify the measure and propose a change. The change can then be tested on a small scale using the PDSA cycles until the change is ready to be more widely implemented.

There are two levels of measurement for the improvement plans. The first level of measures is the PDSA level measures that help identify whether or not the change being tested in each cycle reflects an improvement. The second level of measures is project level measures, which will also help evaluate whether or not the change is an improvement.

Project Level Measures

For each Improvement Project, a number of measures have been proposed and will be confirmed by the project team. The measures will include outcome, process and balancing measures. Examples of these measures include:

- Staff retention in LTC facilities
- # of family/resident with adjustment issues
- # of accurate care plans

- # of staff sick days (pre- and post-change)

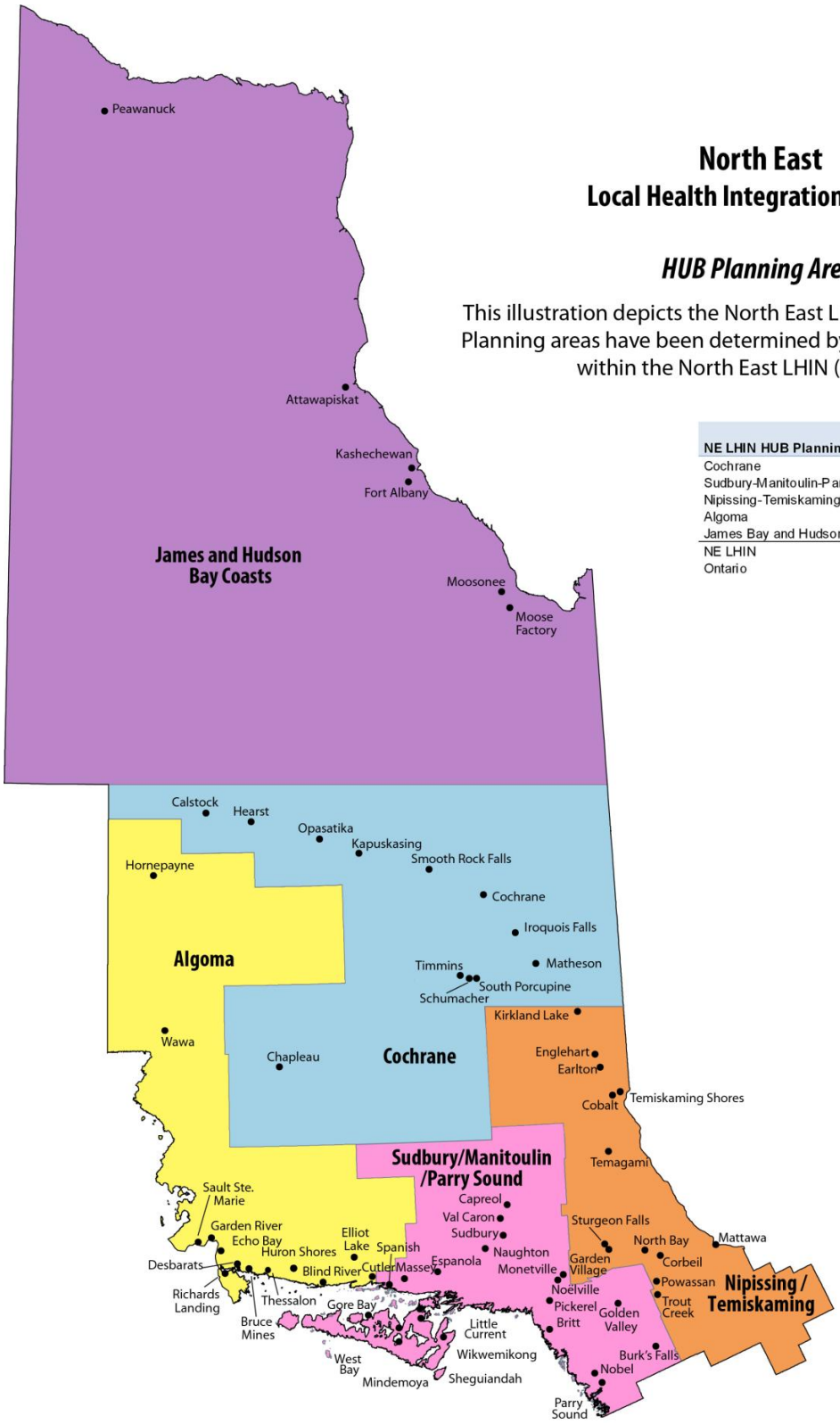
Baseline Measures

For each of the measures that will be used for the NE LHIN BSO Project, a baseline measure will be determined prior to implementation of the Action Plan.

16. **Attach your budget, work plan and resource plan. The resource plan will outline how and where registered nurses and personal support would be utilized.**
    (Please refer to Appendix 13)

17. **Who will be the representative(s) on the LHIN Steering Committee?**
    (Please refer to Appendix 14)

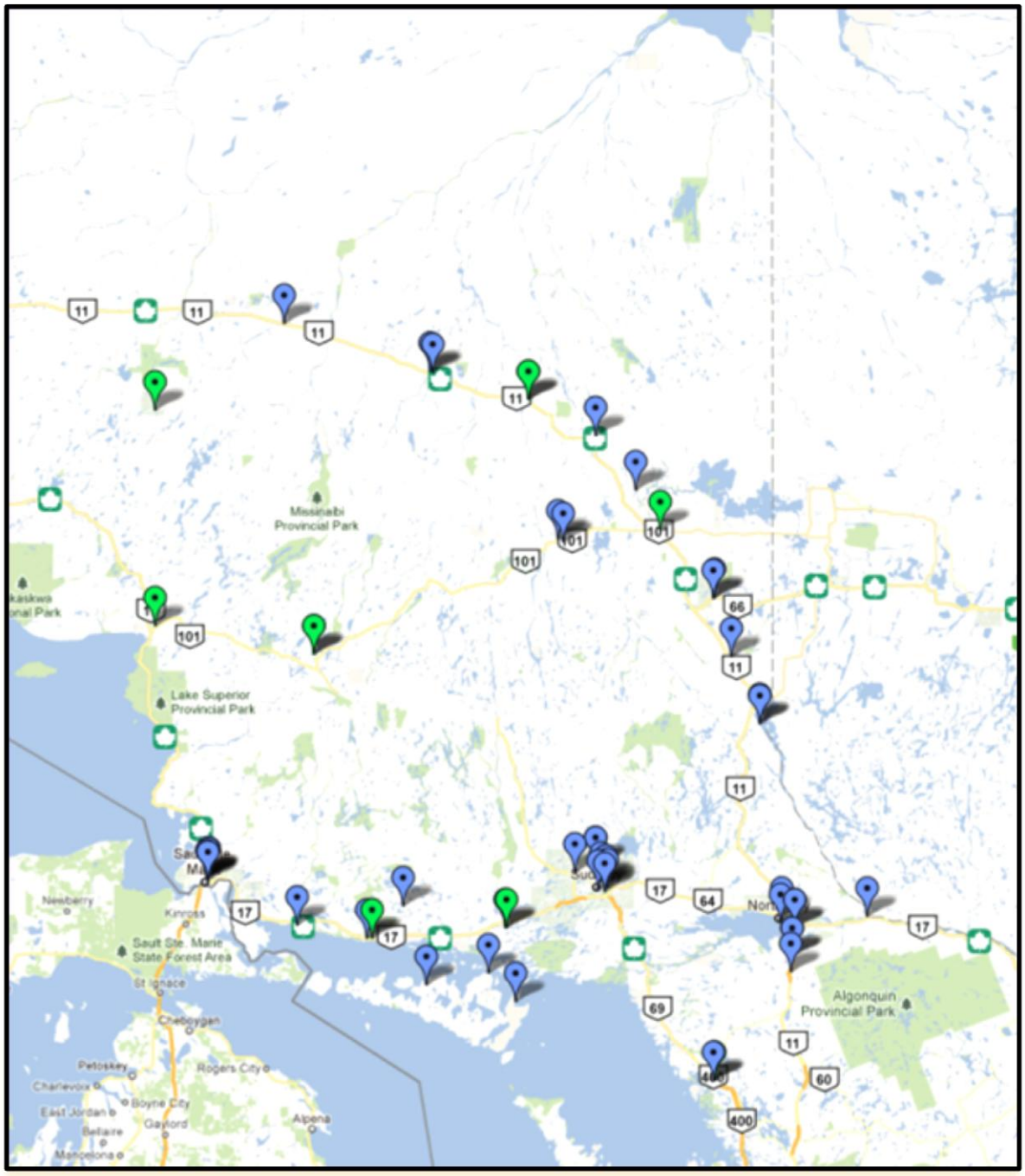
Appendix 1



NE LHIN HUB Planning Areas	Population in 1996	Population in 2006
Cochrane	90,851	80,825
Sudbury-Manitoulin-Parry Sound	230,075	223,083
Nipissing-Temiskaming	130,455	125,843
Algoma	125,455	117,461
James Bay and Hudson Bay Coast	5,323	4,032
NE LHIN	582,159	551,691
Ontario	10,753,573	12,160,282

Appendix 2

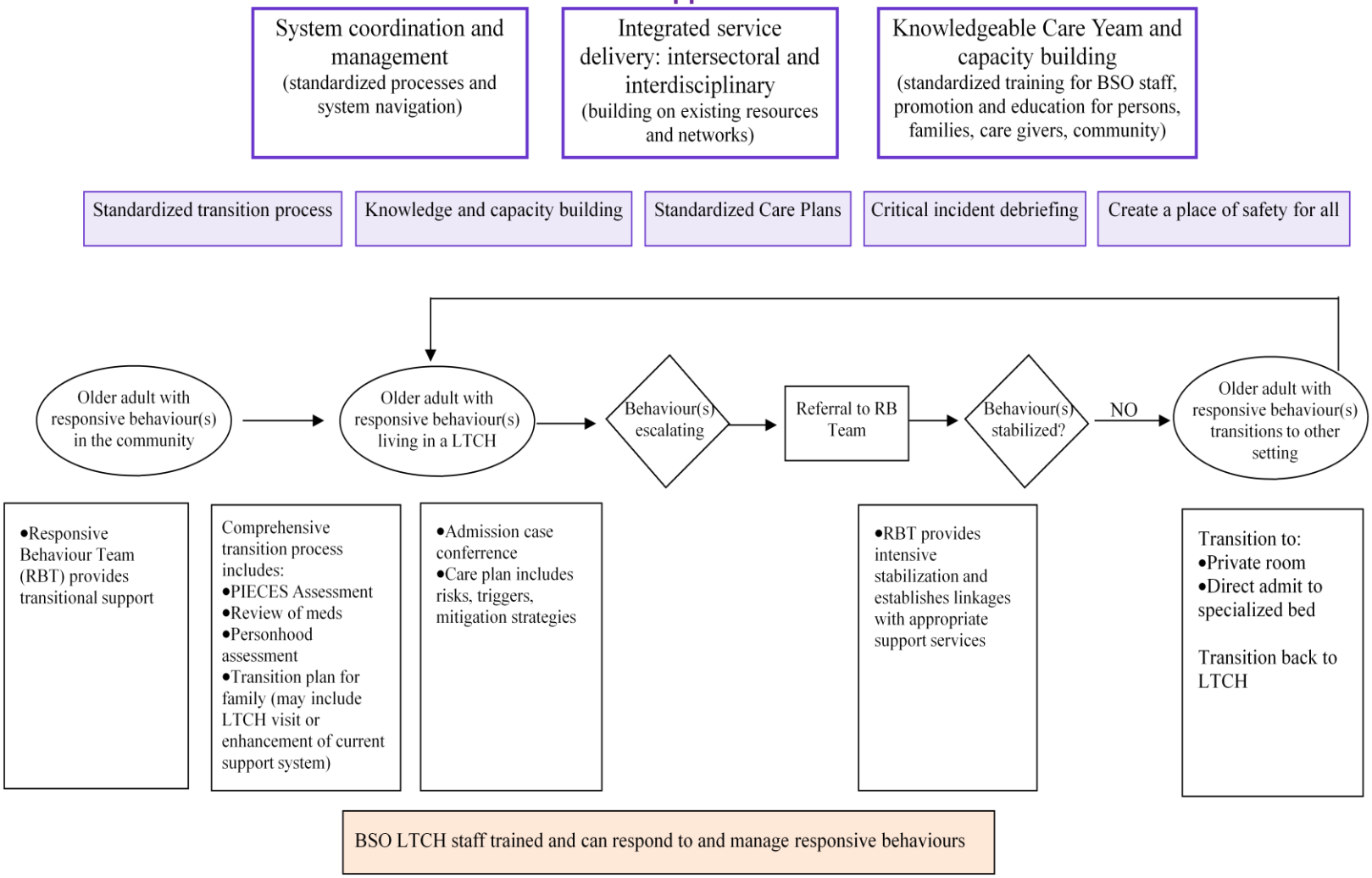
Long-Term Care Homes in the North East



Appendix 3

BSO Action Plan Schematic

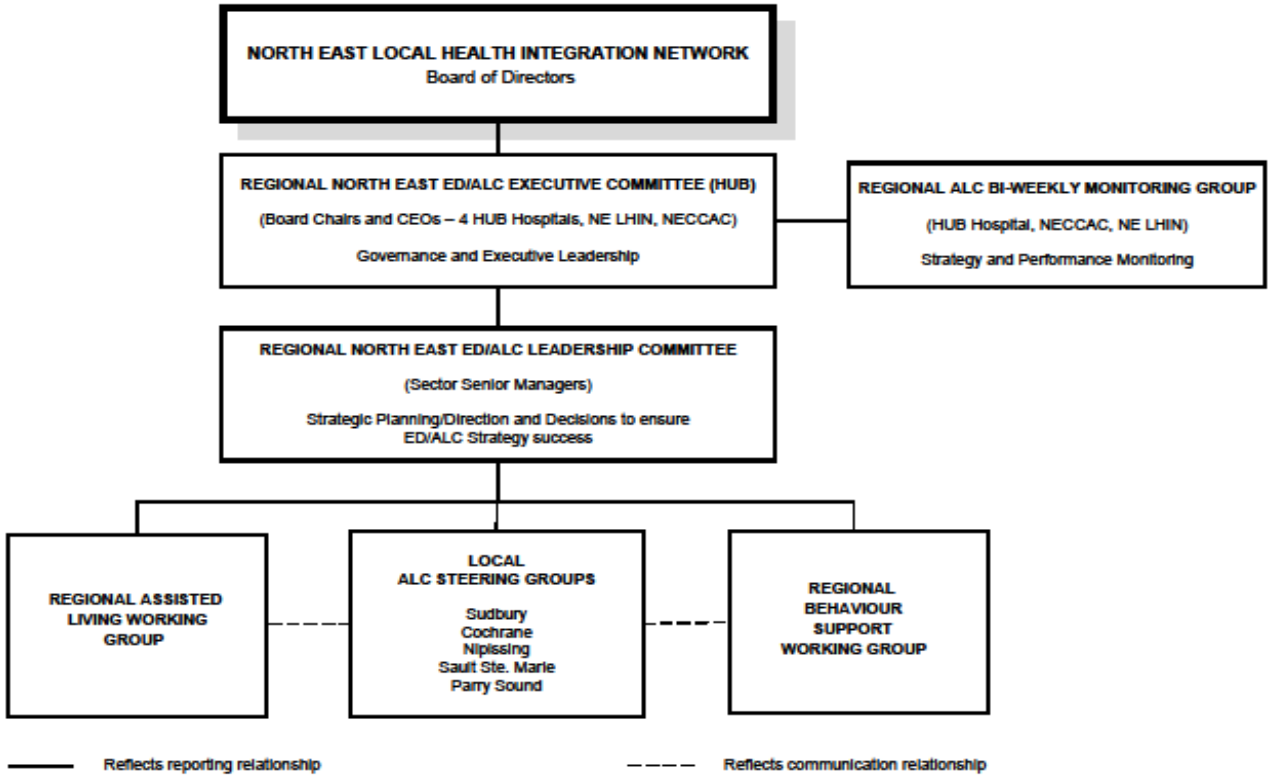
North East Behavioural Supports Action Plan Overview



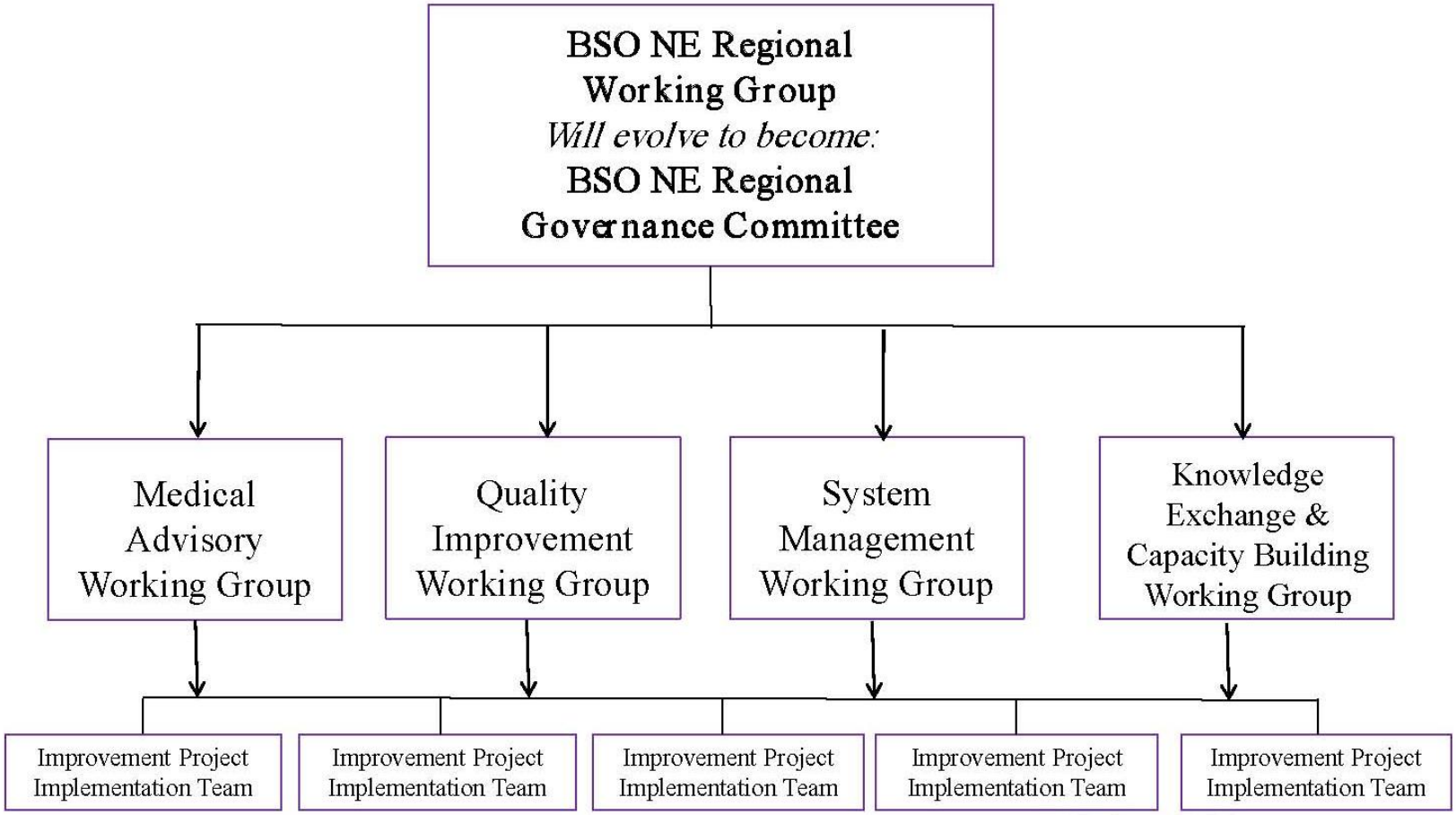
Appendix 4

NORTH EAST ED/ALC
REGIONAL LEADERSHIP STRUCTURE

November 30, 2011 v3



BSO Organizational Structure



Appendix 5

ALGORITHM PROCEDURE

for

Referrals of Common Patients

between the

Seniors' Mental Health Program – Regional Consultation Service (SMHP-RCS)

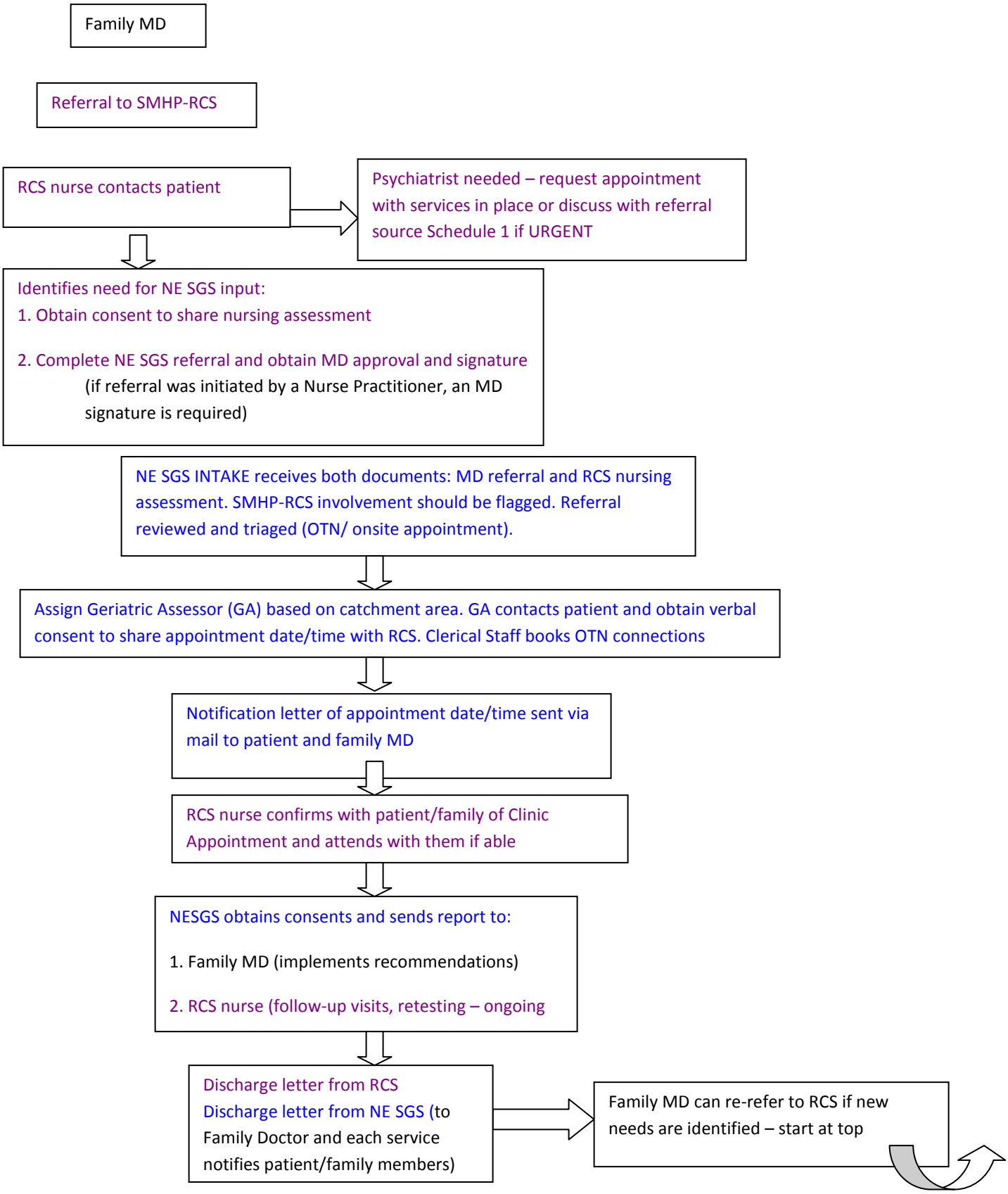
Northeast Mental Health Centre and District Transfer Payment Agencies

and

North East Specialized Geriatric Services (NE SGS)

DRAFT #2 – March 12, 2010

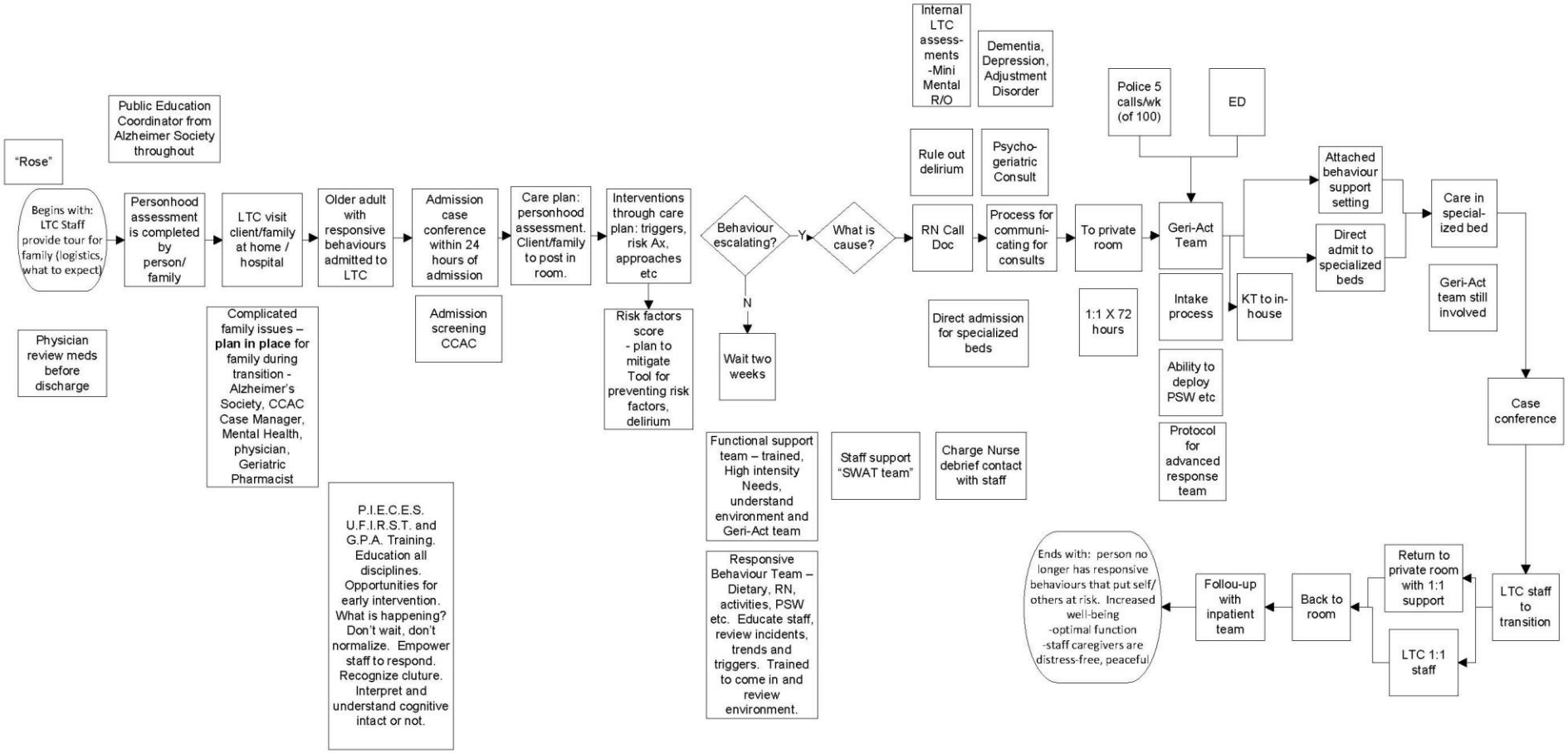
Algorithm to Assist Both Services with Processing Referral Requests



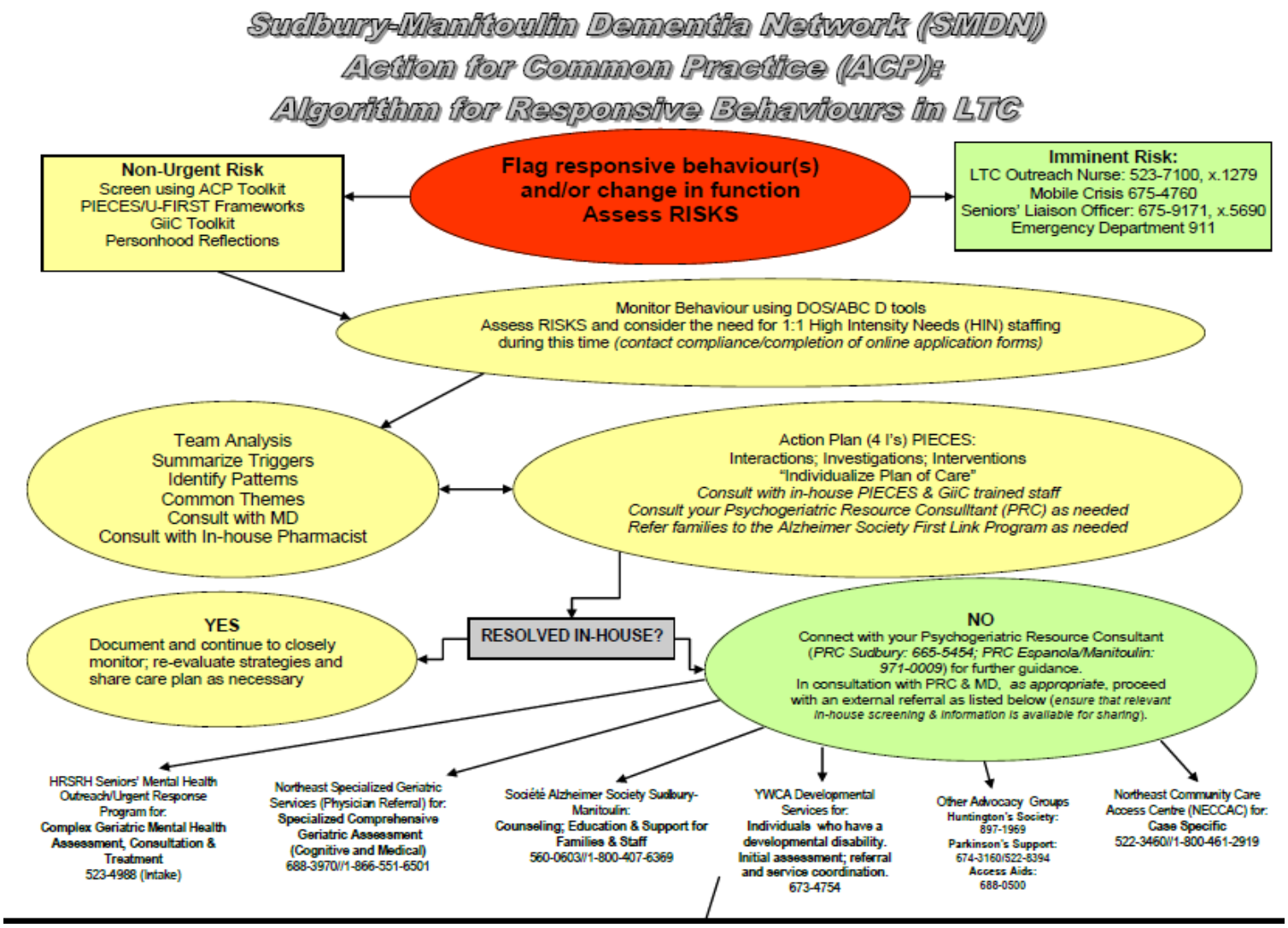
Appendix 6

Behavioural Supports Ontario
North East LHIN Future State

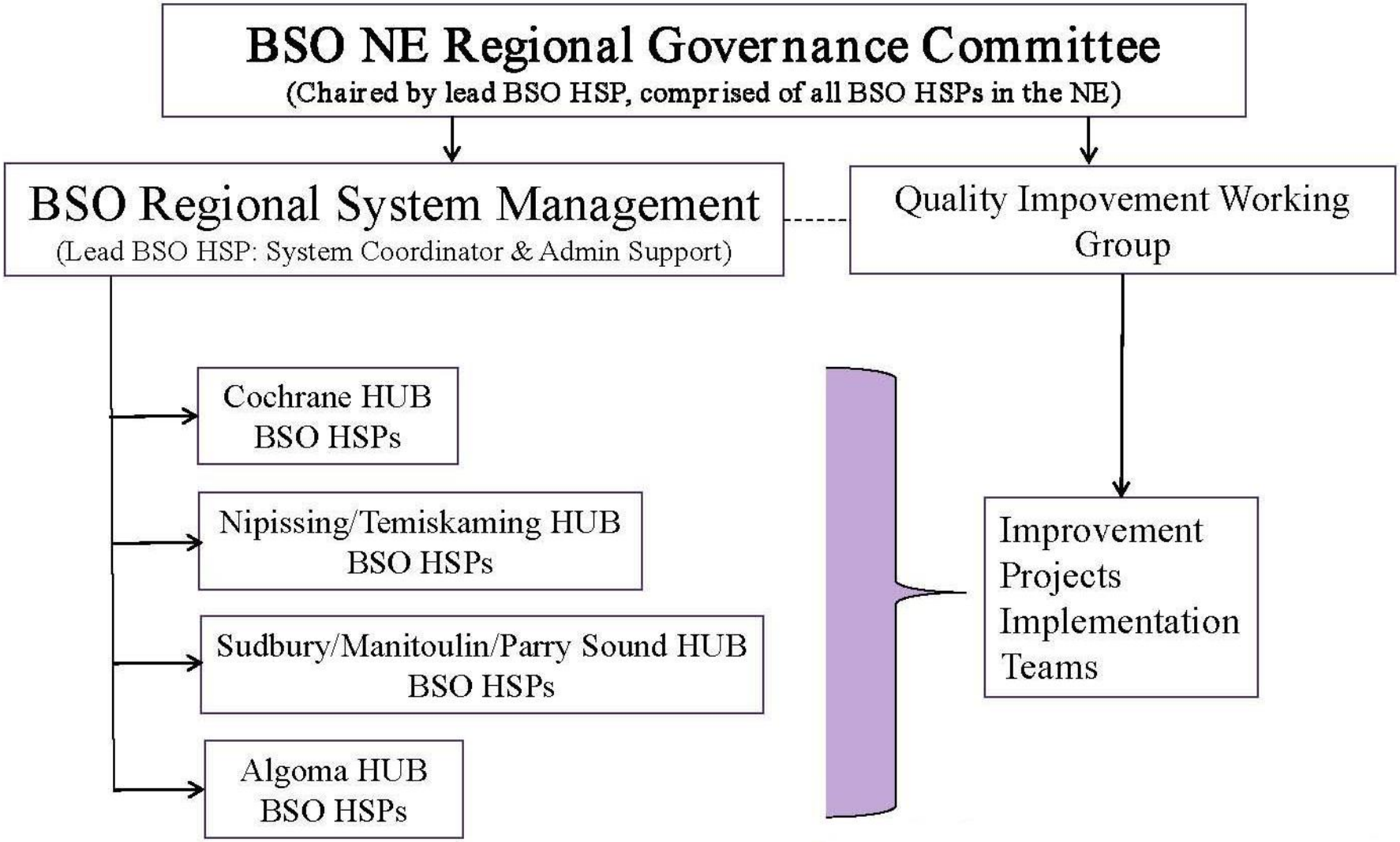
08-Nov-11



Appendix 7


Sudbury-Manitoulin Dementia Network (SMDN)
Action for Common Practice (ACP):
Algorithm for Responsive Behaviours in LTC
Non-Urgent Risk
Screen using ACP Toolkit
PIECES/U-FIRST Frameworks
GiiC Toolkit
Personhood Reflections
Flag responsive behaviour(s) and/or change in function
Assess RISKS
Imminent Risk:
LTC Outreach Nurse: 523-7100, x.1279
Mobile Crisis 675-4760
Seniors' Liaison Officer: 675-9171, x.5690
Emergency Department 911
Monitor Behaviour using DOS/ABC D tools
Assess RISKS and consider the need for 1:1 High Intensity Needs (HIN) staffing during this time (contact compliance/completion of online application forms)
Team Analysis
Summarize Triggers
Identify Patterns
Common Themes
Consult with MD
Consult with In-house Pharmacist
Action Plan (4 I's) PIECES:
Interactions; Investigations; Interventions
"Individualize Plan of Care"
Consult with in-house PIECES & GiiC trained staff
Consult your Psychogeriatric Resource Consulltant (PRC) as needed
Refer families to the Alzheimer Society First Link Program as needed
YES
Document and continue to closely monitor; re-evaluate strategies and share care plan as necessary
RESOLVED IN-HOUSE?
NO
Connect with your Psychogeriatric Resource Consultant (PRC Sudbury: 665-5454; PRC Espanola/Manitoulin: 971-0009) for further guidance.
In consultation with PRC & MD, as appropriate, proceed with an external referral as listed below (ensure that relevant in-house screening & information is available for sharing).
HRSRH Seniors' Mental Health Outreach/Urgent Response Program for:
Complex Geriatric Mental Health Assessment, Consultation & Treatment
523-4988 (Intake)
Northeast Specialized Geriatric Services (Physician Referral) for:
Specialized Comprehensive Geriatric Assessment (Cognitive and Medical)
688-3970//1-866-551-6501
Société Alzheimer Society Sudbury-Manitoulin:
Counseling; Education & Support for Families & Staff
560-0603//1-800-407-6369
YWCA Developmental Services for:
Individuals who have a developmental disability. Initial assessment; referral and service coordination.
673-4754
Other Advocacy Groups
Huntington's Society:
897-1969
Parkinson's Support:
674-3160/522-8394
Access Aids:
688-0500
Northeast Community Care Access Centre (NECCAC) for:
Case Specific
522-3460//1-800-461-2919

System Improvement Model



PRC PROGRAM COMMITMENT

"The role of the Psychogeriatric Resource Consultant (PRC) is to support local long-term care homes, Community Care Access Centres and MOHLTC funded community support agencies, that provide care for persons with dementia, other complex physical and mental health needs and associated responsive behaviours."

*Please note that the PRC does not provide direct clinical assessments or direct care for your clients. The PRC team is available to assist you to further develop these clinical skills and knowledge so that you and your team may do this even better than you do already!

CONTACT YOUR PRC TEAM IN THE NORTHEAST REGION

Arlene Gear
(705) 971 - 0009
arlene.gear@nbrhc.on.ca

Heather Hawrelluk
(705) 471 - 4038
heather.hawrelluk@nbrhc.on.ca

Bob Spicer
(705) 499 - 6143
bob.spicer@nbrhc.on.ca

www.nbrhc.on.ca

Regional Outreach Program
North Bay Regional Health Centre

Programme régional de services d'approche
Centre régional de santé de North Bay

Psychogeriatric Resource Consultants

What is a Psychogeriatric Resource Consultant?

An interprofessional team from varied disciplines (e.g., Social Work, Nursing), that have knowledge and experience in best practices related to the support of seniors with mental illness and dementias.

There are over 50 PRCs located throughout the province, sponsored by a variety of agencies (i.e. North Bay Regional Health Centre).

Appendix 10

Excerpt – NE LHIN ALC Action Plan 2011/12

Continuum	Project	Description	Geographic Focus	Start Date	Impact Date	Metrics		Accountability		Comments and/or Status Update
						Behavioural	Output	LHIN Staff	Project Lead	
	Behavioural Support Systems	Mobile Responsive Behaviour Teams: To build on, and collaborate with existing outreach teams. Integrated collaborative intake and referral that would ensure that: appropriate pathways are provided; clients are supported in their existing environments where possible; and health care partners are supported to address the needs of individuals with responsive behaviours.	NB, TBD (rural and urban areas)	Dec 2011 Feb 2012	March 2012 March 2012	Individuals receive appropriate level of care in a safe environment	Reduction in LTCH referrals to ED / hospital for behavioural residents	T. Tilleczek	V. Scarfone	
		Enhanced Staffing: The North East region will be allocated funding for 13 full time nurses and 20 full time personal support workers in LTCHs.	NE (rural and urban areas)	Feb 2012	March 2012	Individuals receive appropriate level of care in a safe environment	Reduction in LTCH referrals to ED / hospital for behavioural residents	T. Tilleczek	V. Scarfone	Health human resource challenges may impact the implementation schedule.
	Peritoneal Dialysis in LTCHs	Training and support for staff in LTCHs to care for patients requiring peritoneal dialysis.	SSM	Dec 2011	Dec 2011	Individuals receive appropriate level of care in a safe environment	ALC long-stay situations are avoided	M. O'Connor	M Paluzzi S. McEachern	Collaboration between SAH and Extendicare SSM
	Multi-Sectoral ALC Long Stay / Hard to Serve Service Coordination Committees	Local committees established in HUB catchment areas to develop discharge service plans for hard to serve / long stay ALC patients and those patients at risk of becoming long stay. To involve hospitals, CCAC and community providers in each HUB area.	SDBY, SSM, NB TMNS	Feb 2011 April 2011 TBD Sept 2010		Greater collaboration among providers	ALC long-stay situations are avoided	T. Tilleczek	K. Bechard C. Monico K. Bechard C. Monico	

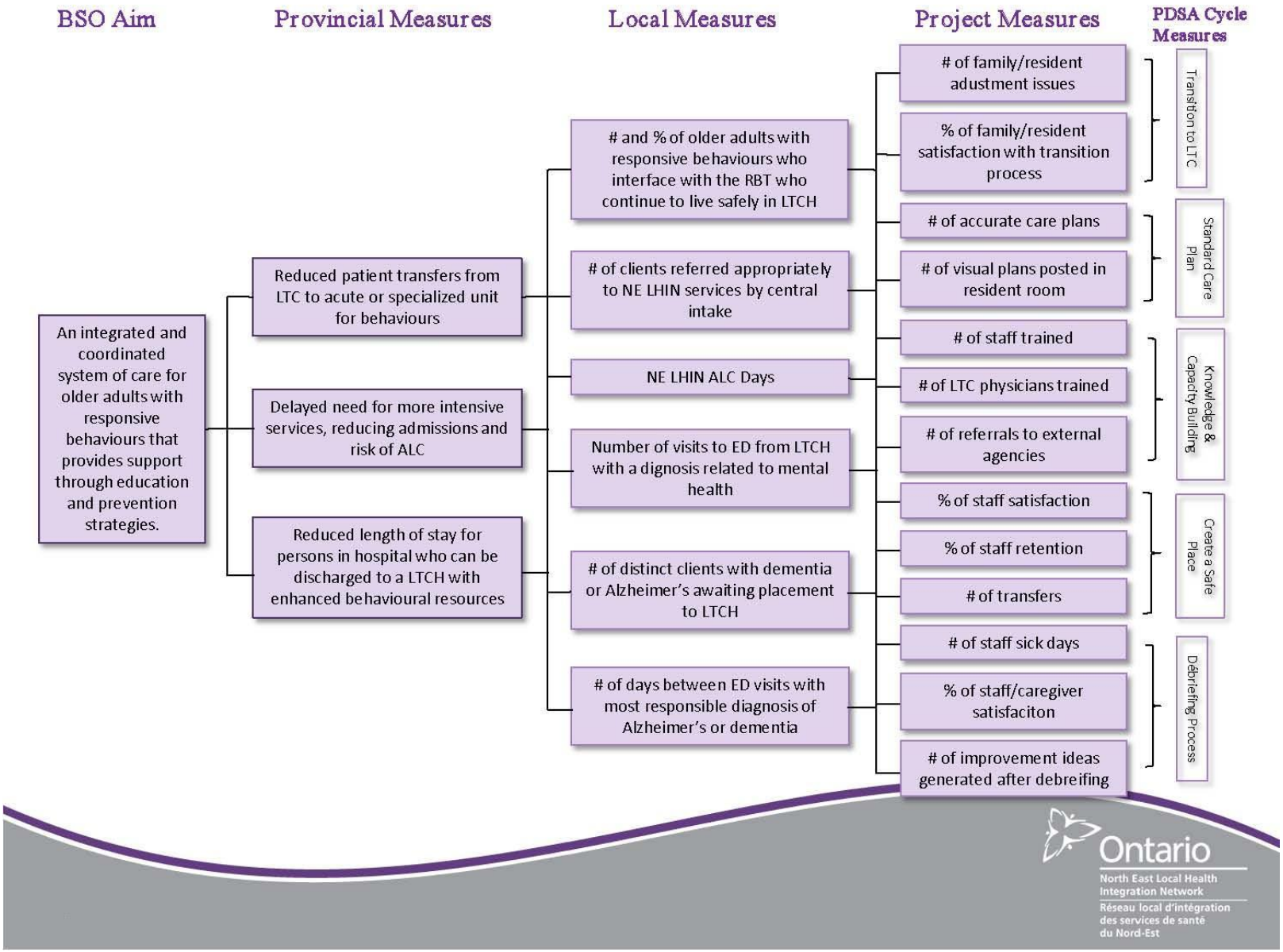
Appendix 11

NE LHIN BSO Work Plan Timeline

Activities	2011			2012													Comments
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Beyond	
Establish Working Group																	Established in September, 2011
Participate in Knowledge Transfer Events																	> Provincial discussions > Value Stream Mapping > BSO-led training sessions
Planning / Develop Action Plan																	**Based on the 3 pillars:** 1) System Coordination 2) Interdisciplinary Service Delivery 3) Knowledgeable Care Team / Capacity Building
Submit Action Plan to CRO																	> CRO - Coordination and Reporting Office > CRO will evaluate the Plan and comment on its consistency with the BSO Framework
Prepare and send Expression of Interest (EOI) for LTCH BSO funding																	Sent the week of Dec 5th
Review EOI and confirm funding																	Review of EOI based on established criteria. Confirmation will be sent to LTCH by beginning of January
Confirm Other funding																	Detailed in Resource Allocation in Action Plan
BSO staff recruitment and hire																	NE LHIN to participate in provincial recruitment strategy
Implement Action Plan																	Will commence once approved by CRO and NE LHIN
Establish NE LHIN BSO Governance Structure																	Will establish once structure approved
Create Regional Quality Improvement Working Group																	Experts in the field of quality improvement from the NE LHIN and across the regional health care system will be recruited to participate
Create Improvement Plan Teams																	Team membership will include an executive sponsor and members with the knowledge and expertise required to realize the improvement plans
Finalize Performance, Measurement and Evaluation Plan																	with the assistance of the working group
Implement Performance, Measurement and Evaluation Plan																	with the assistance of the working group
Finalize Improvement Plans																	with the assistance of the teams and the working group
Implement Improvement Plans																	see Improvement Plans Gant Chart

Appendix 12

NE LHIN BSO Performance, Measurement and Evaluation



Appendix 13

(A) BSO Budget

Positions	Total FTE	Salary & Benefits (per FTE)	Budget Feb-Mar 2011	Annualized Budget (2011-2012)
RN	13	76,362	165,451	992,706
PSW	20	40,000	133,333	800,000
PRC	1.75	95,000	27,708	166,250
Responsive Behaviour (RB) NP	1	125,338	20,890	125,338
RB Clinician	3	95,000	47,500	285,000
Reg Coordinator	0.75	100,000	12,500	75,000
Reg Admin Supp	0.375	52,000	3,250	19,500
Reg Intake	0.375	80,000	5,000	30,000
RB Caregiver ED/Supp	2	40,000	13,333	80,000
Physician/Geriatric Pharmacist Stipend			11,918	71,506
Total	**42.25**		**440,883**	**2,645,300**

(B) Resource Deployment by HUB

NE LHIN BSO Resource Deployment by HUB				
Algoma			**Funding Source**	
Position	HSP	**FTE**	BSO	Other
RN/RPN	LTCH(s)	4		305,444
PSW	LTCH(s)	5		200,000
PRC*	NBRHC	0.25		23,750
RB Clinician	AAA	1		95,000
Regional System Coordination	NBRHC	0.25	25,000	
Regional Admin Supp	NBRHC	0.125	6,500	
Regional Intake	NE CCAC	0.125	10,000	
RB Caregiver Education/Support	Alzheimer Society	1		40,000
Physician/Geriatric Pharmacist Stipend	TBD		23,838	
HUB Total		11.75	65,338	664,194

Sudbury-Manitoulin-Parry Sound			Funding Source	
Position	HSP	**FTE**	BSO	Other
RN/RPN	LTCH(s)	6	458,166	
PSW	LTCH(s)	10	400,000	
PRC*	NBRHC	1	95,000	
RB Clinician	HSN	2	190,000	
RB NP	HSN	1	125,338	
Regional System Coordination	NBRHC	0.25	25,000	
Regional Admin Supp.	NBRHC	0.125	6,500	
Regional Intake	NE CCAC	0.125	10,000	
RB Caregiver Education/Support	Alzheimer Society	1	40,000	
Physician/Geriatric Pharmacist Stipend	TBD		23,838	
HUB Total		21.5	1,373,842	0

Nipissing -Temiskaming			Funding Source	
Position	HSP	**FTE**	BSO	Other
RN/RPN	LTCH(s)	5	381,810	
PSW	LTCH(s)	7	280,000	
PRC *	NBRHC	1.25	23,750	95,000
RBT Clinician	NBRHC	3		299,663
Regional System Coordination	NBRHC	0.25		25,000
Regional Admin Supp.	NBRHC	0.125		6,500
Regional Intake	NE CCAC	0.125		10,000
RB Caregiver Education/Support	Alzheimer Society	1		40,000
Physician/Geriatric Pharmacist Stipend	TBD			23,837
HUB Total		17.75	685,560	500,000

Cochrane			Funding Source	
Position	HSP	**FTE**	BSO	Other
RN/RPN	LTCH(s)	2	152,722	
PSW	LTCH(s)	3	120,000	
PRC*	NBRHC	0.5	47,500	
RB Clinician	TDH	1	95,000	
Regional System Coordination	NBRHC	0.25	25,000	
Regional Admin Supp	NBRHC	0.125	6,500	
Regional Intake	NE CCAC	0.125	10,000	
RB Caregiver Education/Support	Alzheimer Society	1	40,000	
Physician/Geriatric Pharmacist Stipend	TBD		23,838	
HUB Total		8	520,560	0

Totals		**59**	**2,645,300**	**1,164,194**

In addition to existing 3 FTE PRCs in the NE

Appendix 14

Draft

North East LHIN Behavioural Support

Working Group Terms of Reference

1. Background/Context

The development of a Behavioural Support System (BSS) for older adults with complex and responsive behaviours associated with cognitive impairments due to mental health, addictions, dementia or other neurological conditions and their caregivers is both a provincial and an NE LHIN priority. The development of a BSS in the NE LHIN is identified as a priority within the Alternate Level of Care plans across the North East.

The Ministry of Health and Long-Term Care recently announced the launch of The Behavioural Supports Ontario (BSO) Project that will implement the BSO Framework for transforming the health care system for Ontarians for this population. The Project will facilitate seamless, interdisciplinary care for individuals with complex and responsive behaviours. The SE LHIN was chosen as one of four early adopter LHINs and will mentor the NE LHIN implement the BSO Framework.

1.1 Purpose

The purpose of the Working Group is to provide local leadership, advice, guidance and support for the development and implementation of the LHIN-wide Action Plan. LHIN staff, health service providers and other local stakeholders involved in dementia care for the elderly will collaborate on comprehensive behavioural supports for the residents of the LHIN.

1.2 Scope

The Working Group's efforts are intended to support the development of an integrated BSS that provides person-centred, timely, equitable access, high quality, and evidence-based services in an efficient, effective and sustainable manner. The Working Group will not be focused on the implementation of the Action Plan.

1.3 Authority

The Working Group does:

- Have the authority to share information about their organizations services, program management and operations.
- Have the authority to recommend on behalf of their organizations and sector, opportunities for collaboration / integration in the development of Behaviour Support services.
- Establish smaller task groups as required to exploring specific issues related to BSS.

2. Roles & Responsibilities

2.1 Role of the Working Group

The role of the Working Group is to:

- guide the preparation of the Project Charter;
- advise the NE LHIN on any changes to the agreed upon objectives (as may be necessary as the project proceeds) and how these changes may be accommodated with the project plans;
- address any issue that has major implications for the project; and
- keep the project scope under control as emergent issues force changes to be considered.

2.2 Responsibilities of the Working Group

The main function of the Working Group is to take responsibility for the business issues associated with the project. Specifically, the Working Group is responsible for:

- the development of the NE BSS Action Plan project charter
- provide expertise, advise, monitor progress and assist in the completion of the project milestones

2.3 Membership

The Working Group will be chaired by Valerie Scarfone.

The Working Group Membership will be composed of senior representatives from the following organizations/stakeholder groups:

2.4 Contact List

Name	Organization/Title	Representation	Email
COMMUNITY SUPPORT SERVICE PROVIDERS			
Sandra Gagnon	Alzheimer's Society	Cochrane	Sandra@alzheimertimmins.org
Carolyn Cybulski	Alzheimer's Society	Algoma	CarolynCybulski@alzheimeralgoma.org
Marion Quigley	Canadian Mental Health Association	Sudbury/Manitoulin	MQuigley@cmha-sm.on.ca
CLIENT/CAREGIVER REPRESENTATION			
Iona Edwards			Sharon.Langley@nbrhc.on.ca
Sharon Langley			Sharon.Langley@nbrhc.on.ca

HOSPITAL			
Monica Bretzlaff	North Bay Regional Health Centre – Kirkwood site	Sudbury and North East	MBretzlaff@NEMHC.ON.CA
Natalie Bellehumeur	North Bay Regional Health Centre	Regional Seniors' Mental Health Programs	Natalie.Bellehumeur@nbrhc.on.ca
David McNeil	Sudbury Regional Hospital	Large Hospitals	DMcNeil@hrsrh.on.ca
Anne Litkowich	West Parry Sound Health Centre	Parry Sound and Small Hospitals	ALitkowich@wpshc.com
SPECIALIZED PRIMARY CARE			
Kim Rossi Dr. Jo-Anne Clarke	North East Specialized Geriatric Services	North East	Kim.Rossi@city.greatersudbury.on.ca Jo-Anne.Clarke@city.greatersudbury.on.ca
Dr. James Chau	Care for the Elderly Physician Family Health Team	Elliot Lake	Jto.Chau@ontariomd.ca
Dr. Grant McKercher		North Bay	G.McKercher@nbrhc.on.ca
LONG TERM CARE HOME REPRESENTATION			
Shelly McEachern	Extendicare	Sault Ste. Marie	SMcEachern@extendicare.com
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Rebecca Ducharme	NE LHIN Administrative Assistant	North East	Rebecca.Ducharme@LHINS.ON.CA

2.5 Reporting Relationships

The North East BSO Working Group reports to the North East LHIN. Its members have *shared accountability* for contributing to the development of a plan for developing the regional action plan. The members will also function as the conduit between the Regional Working group and the NE ALC Leadership Committee.

The Project lead will be responsible for managing the development of the Action Plan on a day-to-day basis, in accordance with the overall guidance and direction established by the Working Group. Members are expected to bring a broad system level perspective to the table. From time to time there may be a need to involve ad hoc groups or individuals which reflect the target population, the geographic areas of the NE LHIN, and affected organizations. Additionally, an individual member may represent multiple constituents.
The Working Group will seek input on priorities from a wider group of project leaders and other stakeholders, including BSO, Coordinating Committee, and other LHINs.

2.6 Duration of Service

The members and chair of the Working Group will serve for a term of 12 months, and before that term is over the Working Group will review and propose any appropriate amendments in its mandate and membership.

2.7 Individual Roles

The roles of the individual members of the Working Group include:

- contributing to the development of the project outputs;
- representative respective sectors;;
- being genuinely interested in the initiative and the outcomes being pursued in the project;
- being an advocate for the project's outcomes;
- having a broad understanding of issues and the need for Behaviour Supports services planning;
- being committed to and actively involved in pursuing the project's outcomes
- ensuring the requirements of stakeholders are met by the project's outputs;
- helping to balance conflicting priorities and resources;
- providing guidance to the project team and users of the project's outputs;
- considering ideas and issues raised;
- reviewing the progress of the project, and
- acting as a communication point to share project information with their respective sector.

3. Logistics and Processes

3.1 Role of Chair

The Chair of the Working Group is responsible for:

- Chairing scheduled meetings;
- Assisting with the preparation of meeting agendas;
- Carrying the authority to keep order and maintain progress in line with the Working Group's agenda;
- Determining when consensus is reached;
- Facilitating a candid and full discussion of all key matters that come before the Working Group; and
- Ensuring that the committee has focused attention on the development and completion of the action plan.

An Acting-Chair may (should) be appointed in the event that the chair is not available to perform the role.

3.2 Frequency of Meetings

Initially and for the first few months the meetings are scheduled to be held every two-weeks starting on Oct 21, 2011.

(1.5 hour meeting every second Friday)
Once the Action Plan is submitted, the meetings should be scheduled often enough so that progress can be reported against a number of milestones. The timing for the meetings will be linked to key milestone dates. A meeting may occasionally be re-scheduled to align with a key milestone date.

3.3 Quorum and Decision-Making Process

Quorum shall be constituted as 6 members of the Working Group plus the NE LHIN representation.
Working Group decisions will be based on consensus. If consensus is not possible, the chairperson may call a vote. A simple majority of favourable votes of those members in attendance will be needed to resolve any issue requiring a vote.
Voting on important issues will be made available electronically to allow for full participation of all members.

3.4 Alternate Representatives to Meetings

In order to have continuity in information alternate representatives will NOT be permitted.

3.5 Minutes & Meeting Documents

Meeting notes and required notes will be recorded and reviewed by the Chair and the membership at the following meeting.

Appendix 15

BSO Principles of Redesign

- Every door is the right door
- The client's family and caregivers are key partners, whether the client lives at home or in a LTCH
- Client choice needs to be heard, even when we don't agree
- Services are about the individual, not where s/he lives or the diagnosis
- We need to be creative to address all client needs, even if it means we need to change the services offered or the eligibility for services
- Staff continuity is ideal – the same PSW, the same contact for each discipline, etc.
- Anyone who is uncomfortable with what they are doing should be able to access assistance/ consultation
- Plan opportunities to enable open communication/collaboration
- Debrief through the entire process (all actors) all along the continuum
- The minimum service/intervention to resolve the issue is preferred
- Intervene, don't just keep assessing
- The interdisciplinary team follows the flow of the client
- We need to bring service to the client rather than the client to service
- Avoid transitions, but support the client when there must be a change
- Emergency Rooms do not address behaviour. They should be accessed only for acute medical issues, including delirium

Appendix 16

BSO Logic Model

Ultimate Outcomes	Person and caregiver-centred system Equitable access to comprehensive, safe services Increased system efficiency Enhanced patient and caregiver experience		
Long-Term Outcomes	• Integrate services across continuum of care • Allocate resources geographically and across continuum based on need • Increase ability to recruit and retain needed personnel	• Equitable access across Ontario • Increased patient & caregiver satisfaction	• Increase capacity of providers to manage needs of BSS population • Establish a culture of service learning and innovation
Initial Outcomes	• Increase access through greater quality of intake & transition • Increase regional accountability for care • Improve ability to identify and respond to regional performance issues • Increase job satisfaction for health workers	• Enhance inter-sectoral and inter-disciplinary care delivery • Earlier identification and intervention • Reduce caregiver distress • Increased appropriateness of services for patients • Improve access to needed services • Reduced system inefficiency (ALC days, LTCH – hospital transfers, etc.)	• Increase knowledge of current approaches to care • Attain a consistent and high quality of care
Objectives	• Create supportive transitions for clients and families • Establish formal regional networks • Implement collaborative Information & Transition functions • Implement consistent, system accountability agreements	• Clarify roles and responsibilities for care • Implement transition to 'single plan of integrated care' • Redesign and expand mobile outreach teams to enhance direct care and transitions • Transition to core coordinators and Navigators • Improve access to respite care • Realign and implement specialized treatment capacity (in hospital and LTCH)	• Build and support communities of practice/knowledge exchange • Engage with educators to support training • Promote use of standardized education materials • Adopt multiple educational approaches
	System Coordination	**Interdisciplinary Service Delivery**	**Knowledgeable Care Team and Capacity Building**