North West **LHIN**
RLISS du Nord-Ouest

North West Local Health Integration Network
Behavioural Supports Ontario
Action Plan

"Care for me always as I live my life as I value and understand it to be"

December 15, 2011

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

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North West LHIN Action Plan Action Plan Two-Page Executive Summary

1. Identify your Plan's target population. For this population define their location and provide a bulleted list of key system challenges.

Over 60% of LTCH residents in the North West LHIN have a diagnosis of dementia or Alzheimer's disease; 2.3% have a psychiatric disorder and 0.9% have acquired brain injury (ABI). The proportion of seniors with dementia exhibiting challenging behaviour in residential care (58%) was more than double the rate seen in home care (27%). Given current service capacity targeting the populations with psychiatric disorders and ABI, and considering recent investments targeting specialized services for the ABI population and the planned introduction of behavioural beds through the Centre of Excellence for Integrated Seniors Services in 2014 that will serve the needs of the broader BSO target population, the North West LHIN is focusing the immediate-term BSO Action Plan on the target population as follows:

- Older adults exhibiting behaviours who can be safely and effectively managed in their current residence in the community, LTCH and hospital, and who without enhanced care interventions, would be at risk of developing unmanageable responsive behaviours (these behaviours could be unpredictable, volatile, and/or aggressive, wandering, pacing, poor impulse control, intense vocal disruption/repeat vocalization, and inappropriate sexual behaviours).
- Older adults exhibiting responsive behaviours that cannot be safely and effectively managed, who pose a risk to self and others and who reside in the community, LTCH and/or hospital (ALC)

This population represents over 10% of the population 65+ in the North West LHIN, and distributed as follows[1]:

- 2530 individuals in the District of Thunder Bay (~11% of the total District and City of Thunder Bay population 65+)
- 386 individuals in the District of Rainy River (~11% of the total District of Rainy River population 65+)
- 671 individuals in the District of Kenora (~9% of the total District of Kenora population 65+)

Key system challenges related to this target population in the North West LHIN include:

- Lack of integrated and coordinated system approach resulting in provider focus rather than client focus and difficulty accessing specialized expertise given distribution of target population throughout multiple sectors
- LTCHs and community-based outreach teams struggle to provide intensity of care required by target population (i.e. implementation of care plans developed by psycho-geriatricians and outreach teams) due to limited resources
- Current outreach services challenged to provide timely assessments to target population in LTC and community which could reduce avoidable transfers to emergency department or institutionalization
- Lack of standardized knowledge of care approaches for target population throughout continuum of care drives inconsistencies in discharge planning, care planning and appropriate transitions
- Long wait times in hospital for initial placement to LTC (average wait time is > 40 days ALC for target population)

2. BSO Framework Pillar 1: *From the list in 1. above*, summarize how your Action Plan will address the service gaps through cross-sectoral collaboration and new/enhanced partnerships.

The North West LHIN BSO Action Plan will develop new and strengthen existing key linkages and cross sectoral partnerships throughout the region to facilitate integrated care across the continuum for the target population through development of care pathways, common training for front line staff and a commitment to client centred care quality improvement. Through the formalization of a Regional Behavioural Health Service (RBHS), the North West LHIN will be improving the coordination of the service delivery system with formalized system accountability agreements and cross-sector partnerships to drive system and care coordination and collaboration through ongoing quality improvement.

Through Memorandums of Understanding across sectors, the RBHS will oversee shared cross-sector inter-professional staffing models (i.e. CCAC resources partnered with LTCH resources) and alignment of existing community based resources including Psycho-Geriatric Teams, Nurse Led Outreach Teams, telemedicine nurses, OTN resources and Aging at Home initiatives including Intensive Case Management, System Navigation and First Link. Further, the RBHS will be required to assume a leadership role in system coordination and ongoing quality improvement initiatives, leading change initiatives aimed at improved service delivery models, and development and dissemination of common toolkits across sectors. Finally, the RBHS will be expected to leverage existing partnerships with education/research organizations including Lakehead University's Centre for Education and Research on Aging to strengthen partnerships with family/caregiver support services to incorporate leading practice and consumer feedback into proposed system changes.

3. BSO Framework Pillar 2: *From the list in 1. above*, how does your Action Plan enhance the care for your target population by taking advantage of opportunities to create or expand interdisciplinary service delivery?

The BSO allocation for the North West LHIN is $1.23m. This funding will be used to better coordinate and enhance interdisciplinary service delivery under the umbrella of the Regional Behavioural Health Service model, with 60% allocated to expanding outreach and community support services, and 40% allocated to create a specialized inpatient service as follows:

- **1 New Regional Behavioural Health Services Care Coordinator**. This new position will be responsible for regional system coordination and ongoing quality improvement initiatives across regional behavioural health services for the target population, including management of RBHS resources, development of care pathways and will lead change initiatives related to regional system improvements and changes to practice for the BSO target population.
- **1 New CCAC Case Manager.** This role will be housed in the Regional Behavioural Health Service and will serve as the regional CCAC resource for specialized assessments and will enhance and inform existing intensive case management capacity for the target population. This resource will also be a key contributor to the development of regional care pathways and will serve as a regional champion for quality improvement initiatives at the CCAC in relation to the BSO target population.
- **1 New Public Education Coordinator.** This position will enhance existing public education coordination efforts through the Alzheimer's

[1] Ontario Health Quality Ontario

Society, focusing on quality improvement and appropriate use of system resources by all sectors. This role will coordinate physician engagement, which is key in the North West LHIN to change practice related to the BSO target population. This role will also provide regional PSW peer to peer support.

- **1 New RN and 4 New PSW FTEs to enhance existing resources in the Districts of Kenora and Rainy River**. This team will provide mobile outreach and telemedicine support in regional LTCHs and enhance existing community outreach support, leveraging existing virtual psycho geriatric assessment and linking in with the virtual ward at the RBHS.
- **4.2 New PSW and 1 new Therapeutic Recreation FTE(s) in Thunder Bay**. This team will enhance existing mobile outreach in LTCH, supplementing the newly expanded Nurse Led Outreach Team and existing psycho geriatric outreach teams operating in LTC, hospital and community through operation of a virtual ward at the RBHS.
- **1.4 New RN, 3.5 New RPN, 2.8 New PSW and .7 New Therapeutic Recreation FTE(s) in Regional Behavioural Health Services Specialized Unit.** This team will enhance existing staffing compliment in secure 24 bed resident home area in Hogarth Riverview Manor, which will transition to the Centre of Excellence for Integrated Seniors Services in 2014, as part of planned behavioural beds. This will serve as a regional transitional resource for individuals requiring specialized treatment with the expectation that enhanced community based resources are no longer sufficient to meet the needs of the individual. The expectation is that clients will return to originating destination (i.e. community or LTCH) upon completion of treatment program.

This model is dependent on regional alignment of existing resources to support the work of the RBHS, including Nurse Led and Psycho-geriatric Outreach Teams, regional Psycho-geriatric Resource Consultants, Physiotherapists, CCAC Intensive Case Managers, Telemedicine Nurses and physician resources, including access to Geriatric Psychiatrist(s) and Medical Directors. The collaborative service delivery model will be reinforced through LHIN level Service Accountability Agreements and Memorandums of Understanding with the RBHS.

4. **BSO Framework Pillar 3: *From the list in 1. above*, which initiatives in your Plan will foster more knowledgeable care teams and build the capacity of current and future professionals?**

Functional based human resource planning will be essential to ensure a very skilled workforce with high levels of knowledge and expertise are available to meet the multiple interacting needs of the physical, intellectual, emotional and functional needs of the target population. To achieve this end, the North West LHIN Action Plan incorporates:

- **New Inter-Professional Team Training** incorporating PIECES, U-First, GPA, Montessori, PRC and AKE Support
- **Enhanced Regional Geriatric Outreach Services** to supplement current inter-professional service delivery model and build capacity (i.e. enhanced PSWs providing transitional support will build capacity across LTC homes).
- **Additional OTN services** to facilitate 'bedside' consultation with the RBHS inter-professional team, assessments, education and knowledge transfer throughout the LHIN.
- **Enhanced Public Education** to build capacity in community and acute care sectors regarding the target population. This enhancement will also provide PSW peer support and knowledge exchange to increase capacity.
- **Collaboration with Lakehead University Centre for Education and Research on Aging** to leverage emerging knowledge, approaches and evaluation frameworks to better understand and serve the target population.

5. **How will implementation of these initiatives be guided by the principles of continuous quality improvement? (Examples might include adherence to the client value statement, tracking improvement measures, QI leadership and resources, etc)**

The implementation of the North West LHIN BSO Action Plan will align with the Client Value Statement *"Care for me always as I live my life as I value and understand it to be"* will inform implementation and continuous quality improvement as follows:

1. The SAA with providers receiving direct BSO funding will support the future vision of system-wide care delivery models and inter-professional collaboration, and will hold the providers accountable for adoption of leading/best practice (i.e. implementation of care plans, timely access to and deployment of outreach resources) in the aim of reducing avoidable transfers. Further, the SAA will require the RBHS to lead ongoing quality improvement and facilitate system-wide improvements for the target population.
2. The RBHS provider will develop MOUs with regional health service providers that reflect the BSO objectives, and require ongoing participation in quality improvement initiatives led by the RBHS, including PDSAs.
3. SAAs with other providers (including LTCH, community support services and hospitals) will reflect BSO objectives, RBHS MOU, and align with LHIN strategic directions including effective use of system resources, commitment to continuous quality improvement and a commitment to providing the appropriate care in the appropriate setting.

Throughout each of the Quality Improvement initiatives, the Improvement Facilitator and RBHS Care Coordinator will work together on QI initiatives to sustain the BSO Principals to Life, including: Behaviour is Communication; Practices Value Diversity; Collaborative Care; Systems are Coordinated and Integrate; A Culture of Safety is promoted; Accountability and Sustainability is defined and ensured.

Behavioural Supports Ontario Framework for Care Pillar #1

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

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

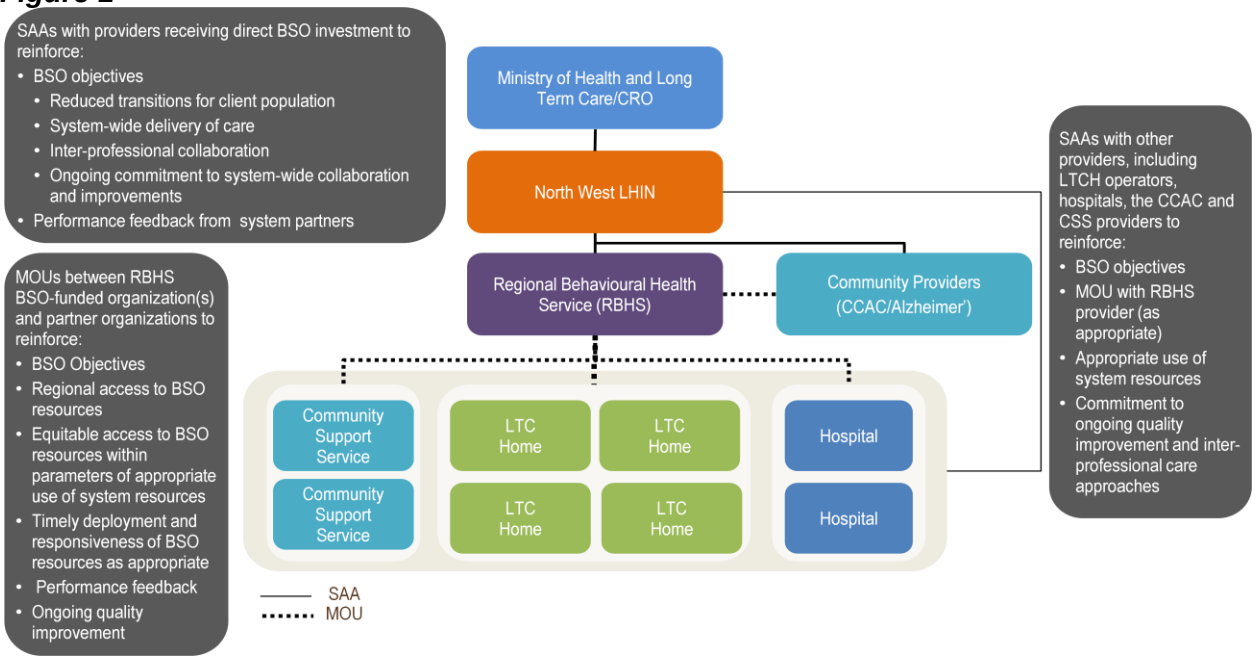
The overarching goal for the North West Local Health Integration Network Regional Behavioural Health Service Model is to improve and simplify access for the client to the appropriate services in a timely manner. The services will be client centered, consistent with the principles and best practices in design, operation and development for individuals/clients requiring responsive behavioural management. To effect and support system change, the following four core strategies are required;

- System Navigation- standardized care pathways, referral processes , and assessments
- Enhanced Regional Mobile outreach Services
- Capacity building for health human resources
- The designation of a specialized unit within a Long-term Care Home

The four core strategies described above will allow for streamlined access to the appropriate services for the older adult with responsive behaviours. These care service delivery strategies are vital for equitable and timely access to the right provider and the right service.

The following accountability structure will be in place to help ensure successful achievement of desired outcomes through the implementation of the Behavioural Supports Ontario framework:

Figure 1



The Centre of Excellence for Integrated Seniors Services (Centre of Excellence for Integrated Seniors' Services) is a progressive senior's health initiative and will serve as a component of the Regional Behavioural Health Service Model across the continuum of care throughout the North West LHIN.

The Centre of Excellence for Integrated Seniors' Services Steering Committee established a Regional Behavioural Health Centre of Excellence for Integrated Seniors' Services Working Group in 2008 comprised of inter-sectoral partners both urban and rural. The purpose of the group was to provide advice on access, service delivery and target population. The working group, in consultation with the North West LHIN commissioned an environmental scan which identified current services available and gaps in the system for the specified target population.

The North West LHIN future state action plan is a multi-pronged strategy built upon significant engagement across multiple sectors over the last 3 years via the Centre of Excellence for Integrated Seniors' Services working group; with validation of the design plan from the 2-day Value Stream Analysis session in December 2011. The Value Stream Analysis session included point of care staff from different sectors across the region, physicians, and care givers. The Value Stream Mapping participants validated the earlier planning work and included additional information about system gaps as it relates to service coordination and collaboration. Collective information is collated and presented as key themes.

Gaps and Weaknesses Identified Within the Current North West LHIN System:

- System Integration and Coordination:
  - Lack of centralized assessment and intake process that inhibits timely and efficient access to services and support
  - Silo'd discharge planning resulting in problematic transitions along the continuum of care, or in some cases, resulting in clients not receiving the most appropriate care in the most appropriate setting in a timely manner (e.g. Older Adults with Dementia currently residing in an Acute Care setting)
  - Limited specialized capacity further compounds challenges to accessing appropriate care in appropriate setting (i.e. clients with acquired brain injury currently residing in hospital setting)
  - Confusion among clients and caregivers regarding system navigation
  - Current practice does not facilitate early intervention
  - Geographic barriers further impact access
  - Inconsistent knowledge base and exchange in relation to behavioural supports across providers
  - Client transitions further complicated by multiple sector involvement with different working patterns, knowledge and approaches to client care
  - Current workforce skill set does not always support the needs of the target population; curriculum could be revised to better serve the target population
  - From a performance perspective, lack of knowledge highlights a key element needed in the future system redesign as it relates to admission avoidance, emergency department diversion and pro-active management before clients and their care-givers experience a crisis

Further, the recent Behavioural Supports Ontario Value Stream Analysis in the North West also highlighted:

- Communication
  - Lack of clear communication between Health Service Providers (HSPs) (Long-term Care, Acute Care, Primary Care, and Community Services) regarding the specific clients unique plan of care
  - Duplication of history taking and assessments; clients and caregivers are often telling "their story" more than once
  - Clients and caregivers are finding it difficult to talk to health care professionals
  - Plans of care are incomplete or are not updated regarding the care interventions of the client from a sending or receiving facility (i.e. Long-term Care Home to the Emergency Department)
  - Multiple providers and professionals involved in a single journey leading to problem management as opposed to "client-centered care"
  - There is no common electronic assessment that crosses sectors and follows the client's care journey from the community, CCAC, Emergency Department, Acute Care Admission, Discharge Planning and Long Term Care This includes lack of technology to aid in the sharing of client information

- Stigma Associated with Responsive Behaviours
  - Clients have difficulty accessing care across the system, in particular placement into a Long-term Care setting
  - Staff forgetting to be empathetic to the client and caregiver
  - Lack of engagement with the client and caregiver in care planning
  - The assumption the client is intending to assault, rather than the behaviour has a meaning
  - A culture of blame versus a culture of safety
  - Inconsistent definitions and approaches to client/family centered care
  - Lack of capacity to address cultural diversity and change management

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

Since the initial work completed by the Centre of Excellence for Integrated Seniors' Services Working Group, the North West LHIN has introduced a number of structures to better coordinate client care. Examples of structures and networks that improve system coordination for the Behavioural Supports Ontario target population include:

- North West LHIN Behavioural Supports Ontario Project Team
- Nurse Led Mobile outreach Team
- Integrated System Steering Committee (formally Home First Steering Committee)
- Joint Discharge Operations Team
- Centre of Excellence for Integrated Seniors' Services Steering Committee
- Seniors Community Psychiatric Program
- Geriatric Assessment Program
- Family Health Teams
- Hiring of a Primary Care Lead-Physician

Further, the Regional Long Term Care Administrator's Committee and the Community Support Network are provider led networks encouraging system collaboration.

In addition, an identified current gap in the system is meeting the needs of older adults with mental health and addictions disorders and psychiatric conditions, with associated responsive behaviours. Since the initial work of the Centre of Excellence In SS Working Group, St. Joseph's Care Group will be developing a Specialized Mental Health Rehabilitation Program (SMHRP), slated to be in operation by 2014. Part of the SMHRP, will include services designed to support older adults with serious mental illnesses, co-existing issues including substance use and development issues and dual disorders. Individuals requiring inpatient care will access the appropriate level of service for a specific amount of time and will then be discharged back to the community, with support such as mobile outreach services. This service will also be a component of the Regional Behavioural Health Service Model.

Further, ongoing system needs analysis through Aging at Home, Home First, Balance of Care research and North West Long Term Case Services Plan have identified specific needs for the target population including the need for improved access to community-based respite services, system navigation and a more intensive approach to case management. Further, the North West LHIN has recognized the need for more assisted living for individuals with Acquired Brain Injury. In response to these local needs, the North West LHIN has made investments in the following areas to respond to this need:

- Introduced Family Directed Respite model in the Districts of Thunder Bay, Kenora and Rainy River
- Supplemented Respite services in the City of Thunder Bay
- Introduced Community Care Access Centre Intensive Case Management to enable case managers to focus more service on a smaller number of high needs clients
- Introduced Community Care Access Centre System Navigator role, operating in 5 seniors apartment building in the City of Thunder Bay
- Increased assisted living for individuals with Acquired Brain Injury
- Introduced the NICE Fund, enabling Community Support Agencies to access additional funding in exceptional circumstances to maintain individuals in the community and prevent unnecessary transitions to other sectors across the continuum (i.e. the emergency department). Recently this fund has been modified to improve accessibility and effectiveness.
- The implementation of the Home First philosophy

b. How will structures be modified to improve coordination?

The North West LHIN is in the final stages of developing a Health Services Blueprint, which actualizes the vision of the North West LHIN by building the case for health system transformation. The proposed health systems model will organize services and delivery of care at three levels within the North West LHIN: the local, district and regional or LHIN level.

At the local level, the Local Health Hubs will form the foundation for an integrated healthcare system and will plan and provide health care services based on the unique needs of the local community. Integrated District Networks will provide or arrange to provide a coordinated continuum of care to serve the health hubs in the district (example: surgical services). Each Integrated District Network will be a formalized network structure within each district which integrates the Local Health Hubs and a District Hospital.

At the regional level, Thunder Bay Regional Health Sciences Centre is the tertiary care hospital for the North West LHIN. In addition, specific regional health care programs within the North

West LHIN will be planned, coordinated and monitored with a LHIN wide mandate rather than at the local level. Regional programs will coordinate services across the LHIN to ensure that services are client-centred, integrated and provide a seamless client journey. They will include components of education, research, knowledge exchange, adoption of evidence-based practice and system navigation.

As the Regional Behavioural Health Service Model is formalized, the North West LHIN has identified Behavioural Supports Ontario as a natural fit for a regional program. The Centre of Excellence for Integrated Seniors Services is expected to become part of the Regional Behavioural Health Service Model, hosting both a regional virtual ward in addition to a specialized unit targeting the population identified in the Behavioural Supports Ontario framework. However, Centre of Excellence for Integrated Seniors' Services has been delayed and is currently scheduled to be operational in 2014. The North West LHIN has identified the need to initiate this component of the Regional Behavioural Health Service Model to address the needs of the target population.

As this new Regional Behavioural Health Service Model is implemented, a number of existing structures will be aligned with Behavioural Supports Ontario objectives, including but not limited to:

- Alignment of the Nurse Led Mobile outreach team serving 9 homes in the City of Thunder Bay with Regional Behavioural Health Service Model virtual ward, to provide initial assessment and build capacity throughout the system.

- Centre of Excellence for Integrated Seniors' Services Steering Committee will continue to oversee the development of the Centre of Excellence for Integrated Seniors' Services model. The Centre of Excellence for Integrated Seniors' Services Steering Committee will be informed by the North West LHIN Behavioural Supports Ontario Project Team as required to initiate cross-sector system-level change in relation to the target population

- Home First Steering Committee will monitor system performance against intended objectives of maintaining individuals in the community as appropriate, seamless transitions to an appropriate care setting along the continuum of care as appropriate; identify barriers experienced by the Behavioural Supports Ontario target population, and the Home First Operations Committee will conduct analyses of the barriers, improve processes to help remove barriers, and develop recommended system solutions to better inform the Steering Committee.

- Enhanced regional education to health service providers through the Public Education component of the First Link Program

- Seniors Community Psychiatric Program- With the enhanced HHR supports allocated through the Behavioural Supports Ontario project, an RN and PSW Mobile Outreach team employed by a Long-term Care Home provider will augment the current team structure. The enhancement aims to provide transitional support and knowledge exchange to other Long-term Care Homes. Across the North West LHIN the Psycho-geriatric Resource Consultant is a member of this program.

- Geriatric Assessment Program- The Regional Behavioural Health Service Model will align and leverage this program to meet the framework of Behavioural Supports Ontario. It has been identified that there is a gap in the current system related to early

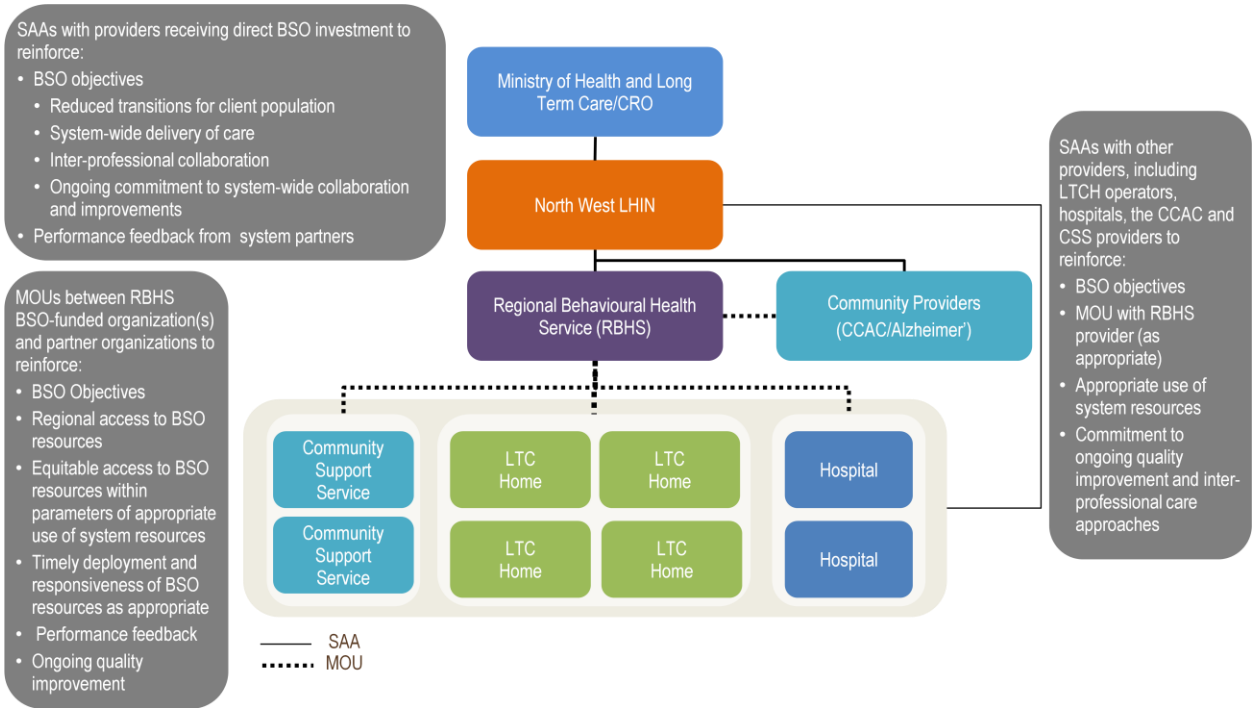
intervention and/or diagnosis. The program is currently comprised of a Geriatrician and two NPs. The Geriatric Assessment Program is a program to which general practitioners refer clients when there is a need for a Geriatric consultation. The Nurse-practitioner will conduct an assessment within the client's home. Following the initial assessment, an appointment is set up with the Geriatrician to further develop a plan of care.

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

a. *Accountability*

Through implementation of a three pronged approach, (illustrated in ***Figure 1***), the North West LHIN intends to leverage Service Accountability Agreements (Service Accountability Agreements) to measure system improvement and reinforce intended system changes related to the Behavioural Supports Ontario initiative.

Figure 1



First, the North West LHIN will negotiate Service Accountability Agreements with providers receiving direct Behavioural Supports Ontario investments that reinforce the Behavioural Supports Ontario objectives of improved client and caregiver experiences. Additionally, the Service Accountability Agreement will define practice changes by encouraging system-wide delivery of care and inter-professional collaboration, and will hold the providers accountable for adoption of leading/best practice (i.e. implementation of care plans, timely deployment of mobile outreach resources, timely assessments and timeliness/ease of access to the virtual ward inter-professional team) in the aim of reducing avoidable transfers and admissions to hospital or admissions/readmissions to the Regional Behavioural Health Service Model providers. To achieve this end, the Service Accountability Agreement will task the Regional Behavioural

Health Service Model with assuming a leadership position in ongoing quality improvement and facilitation of system-wide improvements for the target population.

St. Joseph's Care Group, Thunder Bay, will provide the leadership for the Regional Behavioural Health Service Model and will be accountable to the North West LHIN for the implementation of the Regional Behavioural Health Service Model, at the operational level. The regional Behavioural Health Service Specialized Unit is a component of the Regional Behavioural Health Service Model, and will be operated by St. Joseph's Care Group at Hogarth Riverview Manor (long-term care home). St. Joseph's Care Group will provide governance and oversight to the Regional Behavioural Health Support System and will be accountable to the North West LHIN. This accountability will ensure the Regional Behavioural Health Support System is aligned across the North West LHIN, and ultimately supports the framework and principles of the BSO project.

The North West LHIN will develop an accountability agreement and/or amend existing LSAAs to outline the expectations of the North West LHIN to St. Joseph's Care Group, that align with the schedules in the BSO Performance Agreement, as well as expectations including system sustainability. Until the Regional Behavioural Health Service is operational, the North West LHIN will directly oversee the functions of the Regional Behavioural Health Service Steering Committee and Operations Committee, and will provide guidance, oversight, alignment and coordination with all relevant and related networks, partnerships, entities and health service providers.

Further, the North West LHIN will leverage experience gained through other cross-sector initiatives such as Nurse Led Mobile outreach, with a requirement for regular cross-sector performance evaluation of the Behavioural Supports Ontario inter-professional care team (including both the in-house and mobile outreach teams) hosted by the Regional Behavioural Health Service Model Specialized Unit. This will enable partner organizations to provide feedback on the care experience being delivered in or to their sites by the Behavioural Supports Ontario inter-professional care team, access and perceived equity of access to the virtual ward, identify areas for quality improvement while reinforcing the expectation of equitable access to the team(s) across the region.

Second, the select group of Behavioural Supports Ontario-funded providers is expected, in turn, to develop Memorandums of Understanding (MOUs) with partner organizations accessing or reinforcing Behavioural Supports Ontario-funded resources that reflect the intended outcomes of the Behavioural Supports Ontario framework. It is expected these organizations will include but not be limited to: Long Term Care Homes both in the City of Thunder Bay and in the Region, hospitals and community partners including the North West CCAC, mental health and addictions service providers and the psycho geriatric mobile outreach team These MOUs will provide the context and parameters in which organizations across the continuum of care will access Behavioural Supports Ontario-funded services and staffing, including Regional Behavioural Health Service Model Mobile Outreach Teams, telemedicine (including virtual consults) and provide a framework for successful client transitions throughout the continuum of care.

Further, it is expected the MOUs will reflect the North West LHIN Strategic Directions, specifically related to: 1) Improved care experiences for the target population, 2) Provision of appropriate care in the appropriate setting as close to home as possible, 3) Effective use of health system resources and commitment to continuous quality improvement with the intention of:

- Reducing transitions (i.e. work with the Regional Behavioural Health Service Model inter-professional team and leverage resources to maintain client in current setting as appropriate)
- Facilitate system flow (i.e. actively work to reduce transitions and proactively seek repatriation from Regional Behavioural Health Service Model Specialized Unit once active treatment is complete)
- Actively promoting and enabling appropriate use of system resources (i.e. proactively assess and realign services to meet client needs based on current health status, rather than historic or perceived need)

To achieve this end, it is expected the MOUs will require ongoing participation and engagement in quality improvement initiatives led by the Regional Behavioural Health Service Model, including PDSAs, Lead and Kaizen events.

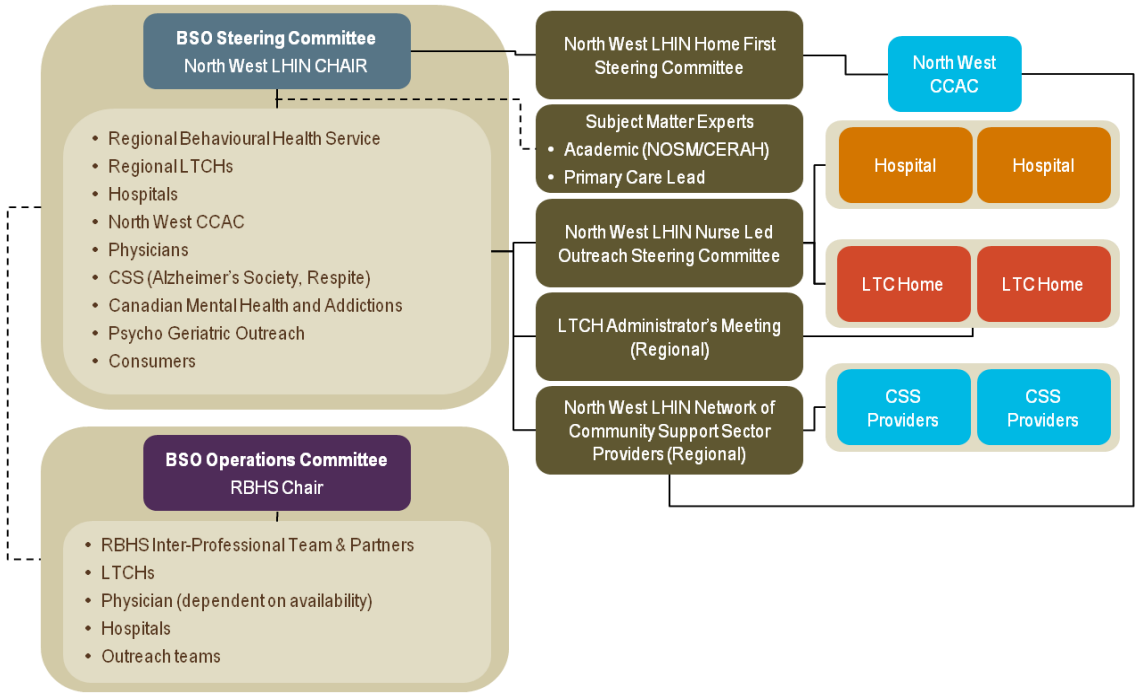
Third, Service Accountability Agreements between the North West LHIN and other providers not receiving direct Behavioural Supports Ontario investment at this point in time (i.e. other Long-term Care Home operators, hospitals, and community support services) will reinforce the intended system change resulting from Behavioural Supports Ontario investment. Specifically, Service Accountability Agreements with these providers will reflect Behavioural Supports Ontario objectives, MOUs with the Long-term Care Home Regional Behavioural Health Service Model provider as appropriate and key enablers of system flow linked to LHIN strategic directions including: 1) Improved client-care experience, 2) Effective use of system resources, 3) Commitment to continuous quality improvement and a commitment to providing the appropriate care in the appropriate setting.

b. Governance

Executive level governance across the system will occur through the existing structure of the Centre of Excellence for Integrated Seniors Services (Centre of Excellence for Integrated Seniors' Services) Steering Committee. The Committee, whose mandate is 1) to oversee system redesign of four Long-Term Care Homes in the City of Thunder Bay, including the amalgamation of two City Homes and two Long-Term Care Homes and regional behavioural health resources, including a specialized designated unit operated by St. Joseph's Care Group; 2) the introduction of 132 new supportive housing units for high risk seniors and 3) enhanced community based support services.

Further, as outlined in ***Figure 2***, the Behavioural Supports Ontario Project Team will play a key role in the ongoing governance of Behavioural Supports Ontario implementation at a strategic level, while the Regional Behavioural Health Service Model will host operational meetings with partner organizations on a more frequent basis to foster and strengthen cross-sector working relationships and identify and monitor areas of improvement as they align to Behavioural Supports Ontario objectives. Additionally, Behavioural Supports Ontario Project Team members represent cross-sector organizations throughout the region. The team members cross-pollinate committees throughout the North West LHIN, and as champions of this new service delivery model will further reinforce the Behavioural Supports Ontario changes in practice across sectors.

Figure 2



3. Name Your Partners for System Coordination

The North West LHIN's Behavioural Supports Ontario partners for system coordination include:

- *North West CCAC*
- *St. Joseph's Care Group* (2 Long Term Care Homes, Psycho-geriatric Mobile outreach team, 1 Post-Acute Hospital, Mental Health Programs)
- *Revera* (5 Long Term Care Homes)
- *City of Thunder Bay* (3 Long Term Care Homes, 1 Assisted Living Site)
- *Thunder Bay Regional Health Sciences Centre* (Acute Mental Health Services)
- *Community Support Services* (The Alzheimer Society, Wesway, Canadian Mental Health Association, Brain Injury Services of Northern Ontario)
- *Hospitals and Long Term Care Homes* (in the Districts of Rainy River, Kenora, Thunder Bay, and Thunder Bay District)
- *Ontario Telemedicine Network*
- *Consumer Representatives*

Collaboration Experience & Outcomes:

As outlined above in ***Figure 2***, our partners for system coordination build upon well-established existing partnerships. Participants at the North West LHIN's Value Stream Analysis identified a commitment to collaboration as a regional strength. Further one of the physician participants at our Value Stream Analysis has previously identified this commitment to inter-sectoral and inter-professional collaboration as a key contributing factor to the success of local initiatives.

Examples of previous collaborations involving partners identified above include:

- **Home First Thunder Bay:** Home First Steering Committee established in September 2010 chaired by the North West LHIN represents a formal partnership between Thunder Bay Regional Health Sciences Centre, St. Joseph's Care Group and the Community Care Access Centre on multiple levels. Executives across all four organizations entered a joint accountability agreement in the form of a project Charter signed off by CEOs of all four organizations. The Home First Steering Committee includes director level representation from these organizations, and is further supplemented by additional partners including physicians and long term care administrators. The Operations and Joint Discharge Planning Teams reflect an even closer partnership of these organizations and also include community partners such as Alzheimer Society, Wesway Respite, Assisted Living Providers, Long Term Care Homes, Brain Injury Services, Handicapped Action Group and Saint Elizabeth Health Care. Together the partners have identified system, practice and process barriers, and committees continue to work on removing barriers and improving the quality of life of residents in the North West LHIN.

  Results: Alternative Level of Care in the City of Thunder Bay has decreased by an overall 36% and Alternative Level of Care Waiting for Long-term Care in hospitals has decreased by 37% from September 2010 to November 2011.

- **Home First Kenora:** Leveraging toolkits, structures and lessons learned from the initial implementation of Home First in Thunder Bay, Home First is being implemented in Kenora, where partnerships between Lake of the Woods District Hospital and North West Community Care Access Centre are illustrated by a recent joint community support service education session. Participation included Alzheimer Society, Pinecrest, Assisted Living provider, and the Sunset Family Health Team. These providers have agreed to participate in an Inter-facility committee aimed at facilitating community access to care, identifying barriers to care and collaborating on solutions.

  Results: Proof of concept and refined implementation toolkit demonstrate knowledge spread in the North West LHIN resulting in expedited implementation timeline and quality improvement approach to managing change.

- **Nurse Led Mobile outreach Team:** Thunder Bay Regional Health Scien**ces Cent**re (TBRHSC) employs a three-member inter-professional nursing team comprised of NPs and RNs operating in five Long Term Care Homes in the City of Thunder Bay. Through an inter-professional, cross-sector Steering Committee including membership from TBRHSC, Nurse-Led Outreach Team, Long-term Care Homes and physicians, the Nurse-Led Outreach Team has identified and implemented numerous improvements across the system, including: transfer procedures to better facilitate transfer to and repatriation from hospital; changes to lab work procedures to minimize time and cost by establishing new protocols with laboratory service providers and working to professional scope of practice.

  Results: Q1 2011/12 activity represented 35% fewer transfers to the Emergency Department and 45% fewer admissions compared to Q1 2010/11, despite the team increasing operations from three Long-term Care Homes to five over the course of the year. Given the success of the team, TBRHSC and the Nurse-Led Outreach Team Steering Committee have aligned a separate NP resource operating in four other Long-

term Care Homes in the City of Thunder Bay with the Nurse-Led Outreach Team and funding has been increased to provide coverage at all 9 Long-term Care Homes 12 hours a day/7 days a week, commencing Q3 2011.

- **Ontario Telemedicine Network:** The majority of the partners listed above regularly leverage well established Ontario Telemedicine Network linkages for care provision and case conferencing/ administration work. Ontario Telemedicine Network site coordinators meet monthly to discuss opportunities for collaboration and new methodologies to further enhance service and improve client experience.

  Results: Over 20,000 patient visits via telemedicine in 2010 in the North West LHIN, not including administrative meetings.

- **Telehomecare for Chronic Heart Failure and Chronic Obstructive Pulmonary Disease:** Recognizing the need to address the high rate of readmission and repeat Emergency Department visits in the population with CHF, the North West LHIN identified Telehomecare as a model for care delivery to this target population. Thunder Bay Regional Health Sciences Centre is the health service provider. Phase one of the initiative has fostered regional partnerships between the North West LHIN, Thunder Bay Regional Health Sciences Centre, Ontario Telemedicine Network, and Primary Care. Phase Two expansion will incorporate: Family Health Teams; Regional Hospitals; Northern Nursing Stations and long term care homes.

  Results: Early indicators show a substantial decline in rates of readmission for CHF of 33% in the first reporting quarter. It is anticipated there will also be reductions in Emergency Department visits and length of stay. A similar program for COPD has been implemented with the partners.

- **Ontario Telemedicine Network Tele-Psychiatry:** Canadian Mental Health and Addictions (CMHA) in the districts of Kenora and Rainy River have leveraged Ontario Telemedicine Network to provide specialized psycho-geriatric services to clients in their respective communities. To achieve this end, since 2002, CMHA has included Dr. David Conn, Geriatric Psychiatrist from Baycrest Geriatric Centre in the community mobile outreach team. Dr. Conn provides weekly consultation sessions on a rotating basis in each of the communities via Ontario Telemedicine Network, providing community based services including client assessment, case consultation and education. For each client assessment, CMHA encourages participation from the local inter-professional team, including physicians, other health care providers and informal caregiver supports.

  Results: Since September 2002 to present, Dr. Conn has provided 440 consultations via Ontario Telemedicine Network, including 348 client assessments, 31 case consultations and 61 educational consultations. Client, caregiver and employee satisfaction surveys consistently score over 90%, indicating the local success of the program. Finally, in a commitment to ongoing Quality Improvement, in 2010, the District Mental Health Services partnered with Baycrest Centre/ Dr. Conn on a research project to evaluate geriatric psychiatry in northern communities using Tele-health.

- **Ontario Diabetes Strategy: Expanding Access to Primary Care through Mobile Services:** The North West LHIN identified the need for improved access to diabetes care in several communities across the North West LHIN region. The NorthWest CHC, an experienced provider in the use of mobile units, worked with the North West LHIN to draft a proposal to expand service, resulting in the introduction of primary care services and foot care to the targeted population in 9 rural communities.

  Results: The success of the project has led to a request from the Ministry for additional staff to be added to the mobile unit.

- **North West LHIN Wide Falls Collaborative:** The North West LHIN contracted with St. Joseph's Care Group to complete a three year Falls collaborative with the aim of reducing the number of falls with injury in the population 65 years and older. As HQO rolled out the Residents First initiative provincially, the North West LHIN was well positioned as an early adopter and subsequently the two initiatives were merged as one. This initiative is an example of partnership between HQO, St Joseph's Care Group and 36 other health service providers including long term care homes, hospitals and community agencies. Specifically, roles within the initiative were as follows:
  - HQO : provided IF support and QI capacity
  - St. Joseph's Care Group: provided administrative support and some IF capacity. Coordinated the collaborative and evaluated the project
  - North West LHIN: supported and guided the project

  Results: Significant reductions in fall-related injuries in organizations, process improvement in the identification of fall-risks and built enhanced capacity for quality improvement in participating organizations.

Executive Sponsorship

Finally, at an executive level, sponsorship, leadership and championing change will continue to be led by the Centre of Excellence for Integrated Seniors' Services Steering Committee and reflected in the work of the RBHP operations group. As outlined above, the Centre of Excellence for Integrated Seniors' Services Steering Committee is co-chaired by:

- **North West LHIN:** Laura Kokocinski, CEO
- **St. Joseph's Care Group:** Tracy Buckler, CEO

Throughout the first year of implementation (through to December 2012), the North West LHIN will continue to provide leadership and support to the North West LHIN Behavioural Supports Ontario Project Team in its advisory and design capacity to ensure system-wide alignment, coordination of services and forge linkages and system partnerships as appropriate.

The North West LHIN internal Behavioural Supports Ontario team will continue to support the Project Team through the following staffing model:

Executive Sponsor: Susan Pilatzke, Senior Director Health System Transformation
Project Manager: North West LHIN Project Management Office
Project Lead: Meaghan Sharp, Behavioural Supports Ontario Project

Performance Lead: Liisa Simi, Senior Consultant Health System Performance
Improvement Facilitator: Nicole Brown, Senior Consultant Health System Transformation
Analyst: James Anderson

Behavioural Supports Ontario Framework for Care Pillar #2

Interdisciplinary Service Delivery Mobile outreach and support across the service continuum to ensure equitable and timely access to the right providers for the right service.

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

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Mobile Outreach Services

Access to mobile outreach services is currently considered to be least favourable across all sectors in the system. A recent environmental scan within North West LHIN, identified that a client/individual who is exhibiting responsive behaviours in their current living environment, that could pose risk to self or others, can wait for up to two weeks to be assessed by the current mobile outreach services. Currently, the Seniors Community Psychiatric Program (Seniors Community Psychiatric Program), District Mental Health Services for Older Adults and the Nurse Led Mobile outreach (NLO) teams provide support and guidance to Long-term Care Homes related to behavioural management, however resources are limited and there is an inability to provide timely access. This is in part due to limited operational hours of these teams Monday–Friday 9am-5pm, and limited resources. Presently within the North West LHIN there is only one Geriatric Psychiatrist, which often requires Long-term Care Homes to receive consultation outside of the North West LHIN. If a crisis occurs in a Long-term Care Home, the resident is often transferred to the Emergency Department (Emergency Department) for assessment and intervention. If a crisis was to occur in the community, the client would present to the Emergency Department and could be admitted. This leads to long wait times as Alternative Level of Care in hospital (average wait time is >40 days Alternate Level of Care [Alternative Level of Care]). The Seniors Community Psychiatric Program within the City of Thunder Bay has 31 Long-term Care Home clients exhibiting responsive behaviours on their caseload in addition to 12 clients in the acute-care setting and 12 clients in the community setting.

The Mental Health Services for Older Adults in the Districts of Kenora and Rainy River, identified that client caseloads are increasing, in addition to the vast geographical region to cover provide mobile outreach service and support. At the present time, the Districts of Kenora and Rainy River mobile outreach service serves a large population of seniors with on-average of 27% being over the age of 55.

Supports in Long-term Care Homes

Responsive behaviours are one of the most common factors delaying admission to Long-term Care (Long-term Care) Home placement in the North West LHIN. Long-term Care Homes in the North West LHIN are often challenged to provide appropriate support to residents with responsive behaviours. Reports indicate that the proportion of seniors with dementia exhibiting

any challenging behaviour in residential long-term care is 58%, as compared to 28% in home care. This ultimately impacts effective management of responsive behaviours, and employees in Long-term Care Homes do not always possess adequate knowledge and training (skill sets) to provide care and support to residents with responsive behaviours.

It is evident that older adults with responsive behaviours either in Long-term Care or in the community are underserved in the North West LHIN. A recent North West LHIN analysis of Alternative Level of Care long-stay cases (greater than 318/550 days) revealed that 15 Alternative Level of Care long-stay patients require placement to a behavioural long-term care unit. North West LHIN Long-term Care residents are sent to the Emergency Department then the responsive behaviour exceeds what can safely be managed in the current Long-term Care setting. If a Regional Behavioural Health Service Model l Specialized Unit was operational, it would immediately reduce Alternative Level of Care days by 5,475, based on the assumption that 15 patients could transition to a Regional Behavioural Health Service Model Specialized Unit.

In addition, the Centre of Excellence for Integrated Seniors' Services Working Group found that many individuals with responsive behaviours wait for placement to Long-term Care in the acute and post-acute setting as Alternative Level of Care >40.

Supports for Community Services

Wesway Respite Services currently has a total of 47 individuals with Alzheimer Disease and related dementia waiting for respite and 17 of these individual have associated responsive behaviours**.** Wesway receives approximately one referral per month from the East of Thunder Bay and approximately two referrals per month from the West of Thunder Bay from the North West CCAC. In the Kenora/Rainy River Districts currently 27 individuals waiting for services have Alzheimer Disease or a related dementia and associated responsive behaviours. In the District of Thunder Bay there are currently ten individuals waiting for respite service, and five have Alzheimer Disease or a related dementia with associated responsive behaviours.

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

The target population for the North West LHIN Behavioural Support System is the older adult who exhibits responsive behaviours that cannot be safely and effectively managed, who pose a risk to self and others and who reside in the community, Long-term Care Home and/or hospital (Alternative Level of Care), and the older adult exhibiting behaviours who can be safely and effectively managed in their current residence in the community, Long-term Care Home and hospital, and who without enhanced care interventions, would be at risk of developing unmanageable responsive behaviours. These behaviours could be characterized as unpredictable, volatile, and/or aggressive, wandering, pacing, poor impulse control, intense vocal disruption/repeat vocalization, and inappropriate sexual behaviours.

The target population includes the older adult with mental health, addictions, and neurological conditions who exhibit associated responsive behaviours. This population will be served by the implementation of the Regional Behavioural Health Service Model within the North West LHIN. This will be achieved by:

- The enhancement of current mobile outreach teams (rural and urban) who will focus on providing support to those individuals exhibiting responsive behaviours in the

community. The services include: the Seniors Community Psychiatric Program, Older Adult Mental Health Mobile Outreach services.
- The alignment of mobile outreach services with current programs (rural and urban) to optimize the client experience and minimize transitions. For example: Brain Injury Services of Northwestern Ontario, older adult mental health addictions support worker within the Sister Margaret Smith Centre, St. Joseph's Care Group, North West CCAC, Wesway Respite Services, (to support clients in long-term care, hospital or community settings), the Regional Behavioural Health Service Specialized Unit.
- The alignment and enhanced partnership with acute care inpatient mental health services.
- The alignment with primary care teams, including family health teams.

It is important to note that two additional value stream mapping sessions are scheduled for the end o f January and early February, 2012, to map out the current and future states related to the management of a behavioural crisis in the community. This includes individuals with mental health, addiction, and neurological conditions, to gain further understanding of how best to align services across the Regional Behavioural Health Service Model for this population.

This population, represents over 10% of the population 65+ in the North West LHIN, and is distributed throughout the region as follows[2]:

- 2530 individuals in the District of Thunder Bay (~11% of the total District population 65+)
- 386 individuals in the District of Rainy River (~11% of the total District population 65+)
- 671 individuals in the District of Kenora (~9% of the total District population 65+)

Within the North West LHIN, over 60% of Long-term Care Home residents have a diagnosis of dementia or Alzheimer's disease; 2.3% have a psychiatric disorder and 0.9% have acquired brain injury (ABI).

Transitional points for this target population were identified in the Future State Model from the North West Value Stream Mapping Session (**Figure 3** on page 24). Transitional points can include;

- Transfer to a Long-term Care home from the Emergency Department or hospital setting:
- Transfer to the Emergency Department from either a Long-term Care Home, or community setting (which includes private residence and supportive housing), and primary health team (family physician/family health team) ,specialized outpatient services (such as the Geriatric Assessment Program) or via Nursing Outpost Station in the remote communities of the North West LHIN)
- Transfer to an acute care unit or hospital setting from the Emergency Department (probable Alternative Level of Care)
- Transfer back to original Long-term Care Home or another Long-term Care Home
- Transfer back to the community (private residence and supportive housing)

[2] Based on target population data in 2010 and Ministry of Finance population data for 2010.

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

The North West LHIN Behavioural Supports Ontario Action Plan will develop new and strengthen existing key linkages and partnerships throughout the North West region (both rural and urban) to facilitate care across the continuum for the targeted population through development of care pathways and standardized assessments. The Regional Behavioural Health Service Model will introduce a coordinating function, tasked with the development of new formal system accountability partners to drive system coordination, collaboration, and ongoing quality improvement.

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

Through Memorandums of Understanding across sectors, the Regional Behavioural Health Service Model will oversee shared inter-professional staffing models (i.e. Community Care Access Centre resources partnered with Long-term Care Home resources) and alignment of existing community based resources including Psycho-Geriatric and Nurse Led Mobile outreach Teams, telemedicine nurses, Ontario Telemedicine Network resources and Aging at Home initiatives including Intensive Case Management, System Navigation and First Link.

Further, the Regional Behavioural Health Service Model will assume a leadership role in system coordination and ongoing quality improvement initiatives among providers, as well as leading change initiatives aimed at improved service delivery models, including the development and dissemination of common toolkits and communication resources.

Finally, the Regional Behavioural Health Service Model providers will be expected to leverage existing partnerships with education/research organizations including Lakehead University's Centre for Education and Research on Aging to strengthen partnerships with family/caregiver support services and incorporate leading practice and consumer feedback into proposed system change and creates the evaluation framework for the Regional Behavioural Health Service Model.

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

"Care for me always as I live my life as I value and understand it to be."

The North West LHIN future state action plan is a multi-pronged strategy built upon significant engagement across multiple sectors over the last 3 years via the Centre of Excellence for Integrated Seniors' Services working group; with validation of the design plan from the 2 day Value Stream Analysis session in December 2011. The Value Stream Analysis session included point of care staff from different sectors across the region, physicians, and care givers. The North West LHIN strategy includes:

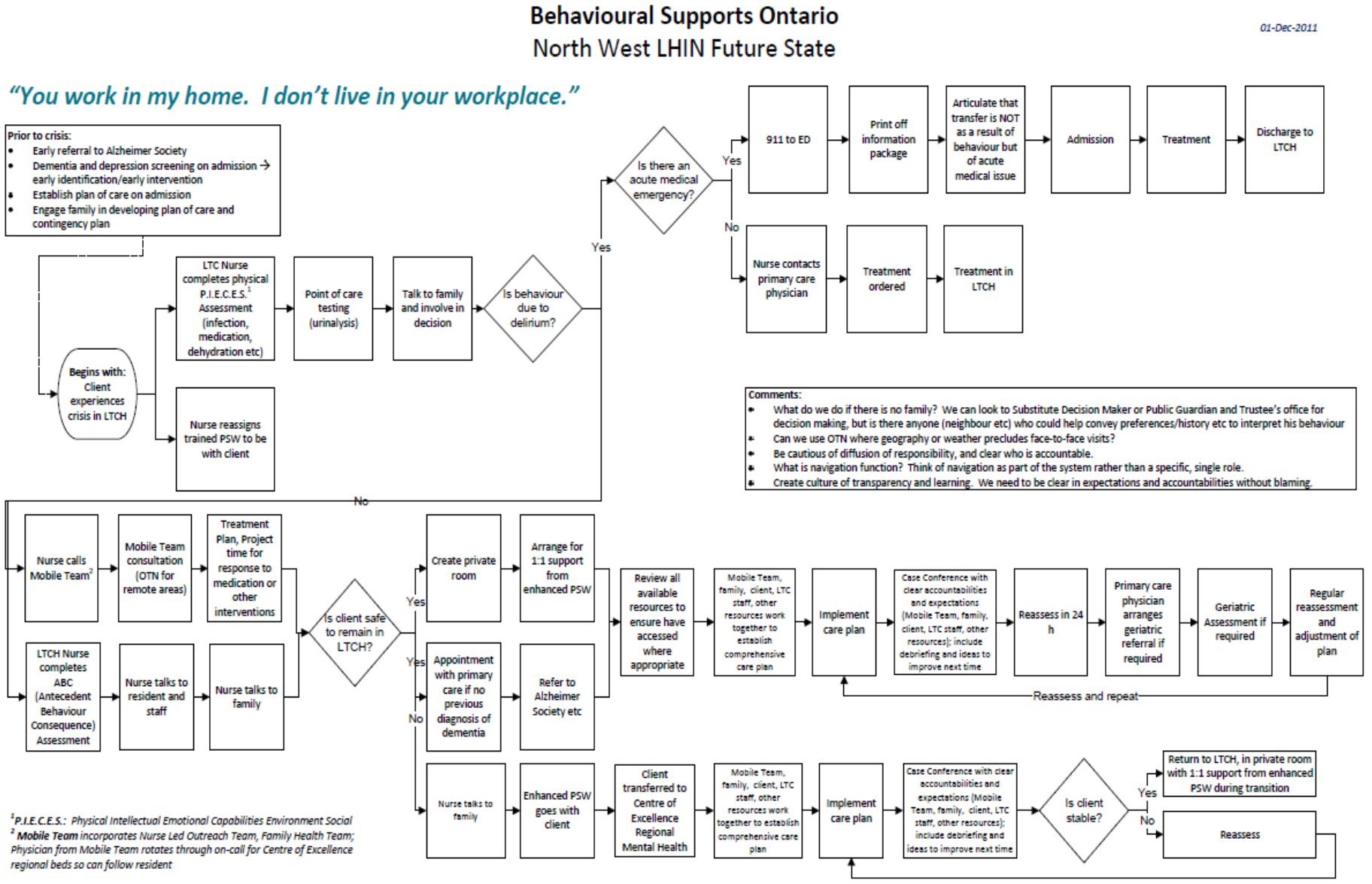
1. Enhancing and supporting current mobile outreach teams to focus on the crisis in the community and in current setting (i.e. acute care, supportive housing and Long-term Care Home)
2. Capacity building via health human resources including education for the manageable crisis in community and Long-term Care Home.
3. Creation of a Regional Behavioural Health Service Model, physical and virtual mobile outreach teams in the City of Thunder Bay and virtual wards in the region.

The Value Stream Analysis process (**Figure 3**) illustrated to the Project Team the gaps in the current system and identified strategies to move forward to create a cross-sectoral, inter-professional and coordinated approach to care for the target population. The future state model represents only one stream: crisis in Long-term Care and returning to the client's home in Long-term Care.

Recognizing the future state only represents one stream focused on long term care, two additional Value Stream Analysis sessions will occur in late January 2012. These sessions are required to further identify gaps in the current state specific to community and transition points across the North West LHIN. The two Value Stream Analysis sessions will focus on the following streams:1) Crisis in community and managing the behaviour in community (urban/rural), 2) Transition from physical unit back to home (i.e. Long-term Care or community) (urban/rural)

Following completion of the above future state designs the North West LHIN Improvement Facilitator will create a complete map of the continuum of care for this population; synthesizing areas for further collaboration, partnerships and quality improvement.

Figure 3


Behavioural Supports Ontario
North West LHIN Future State
01-Dec-2011
"You work in my home. I don't live in your workplace."
Prior to crisis:
Early referral to Alzheimer Society
Dementia and depression screening on admission → early identification/early intervention
Establish plan of care on admission
Engage family in developing plan of care and contingency plan
Begins with: Client experiences crisis in LTCH
LTC Nurse completes physical P.I.E.C.E.S.[1] Assessment (infection, medication, dehydration etc)
Point of care testing (urinalysis)
Talk to family and involve in decision
Is behaviour due to delirium?
Nurse reassigns trained PSW to be with client
Is there an acute medical emergency?
Yes
911 to ED
Print off information package
Articulate that transfer is NOT as a result of behaviour but of acute medical issue
Admission
Treatment
Discharge to LTCH
No
Nurse contacts primary care physician
Treatment ordered
Treatment in LTCH
Comments:
What do we do if there is no family? We can look to Substitute Decision Maker or Public Guardian and Trustee's office for decision making, but is there anyone (neighbour etc) who could help convey preferences/history etc to interpret his behaviour
Can we use OTN where geography or weather precludes face-to-face visits?
Be cautious of diffusion of responsibility, and clear who is accountable.
What is navigation function? Think of navigation as part of the system rather than a specific, single role.
Create culture of transparency and learning. We need to be clear in expectations and accountabilities without blaming.
No
Nurse calls Mobile Team[2]
Mobile Team consultation (OTN for remote areas)
Treatment Plan, Project time for response to medication or other interventions
LTCH Nurse completes ABC (Antecedent Behaviour Consequence) Assessment
Nurse talks to resident and staff
Nurse talks to family
Is client safe to remain in LTCH?
Yes
Create private room
Arrange for 1:1 support from enhanced PSW
Yes
Appointment with primary care if no previous diagnosis of dementia
Refer to Alzheimer Society etc
No
Nurse talks to family
Enhanced PSW goes with client
Client transferred to Centre of Excellence Regional Mental Health
Review all available resources to ensure have accessed where appropriate
Mobile Team, family, client, LTC staff, other resources work together to establish comprehensive care plan
Implement care plan
Case Conference with clear accountabilities and expectations (Mobile Team, family, client, LTC staff, other resources): include debriefing and ideas to improve next time
Reassess in 24 h
Primary care physician arranges geriatric referral if required
Geriatric Assessment if required
Regular reassessment and adjustment of plan
Reassess and repeat
Is client stable?
Yes
Return to LTCH, in private room with 1:1 support from enhanced PSW during transition
No
Reassess
[1] P.I.E.C.E.S.: Physical Intellectual Emotional Capabilities Environment Social
[2] Mobile Team incorporates Nurse Led Outreach Team, Family Health Team; Physician from Mobile Team rotates through on-call for Centre of Excellence regional beds so can follow resident

North West LHIN Strategy

I. Enhancing and supporting current mobile outreach teams to focus on the crisis in the community and in current setting (i.e. acute care, supportive housing and Long-term Care Home)

Leveraging existing multi-sectoral programs such as Nurse Led Mobile outreach, First Link, Seniors Community Psychiatry Program and District Mental Health Services for older adults, the North West LHIN partners will develop standardized assessments, referrals, decision trees and care pathways with a goal of early identification and communication focused on the individual with responsive behaviours and care givers throughout the continuum of care. Enhancement of the mobile outreach teams across the North West LHIN will be achieved via the additional HHR allocation to the community and Long-term Care.

During the Value Stream Analysis session participants identified a number of areas for improvement and collaboration in community *prior* to crisis, including early referral to Alzheimer Society. In addition, the use of mobile outreach teams (listed as mobile teams on the future state map), which include NLO, Family Health Teams and physicians were identified as current service gaps and an area of opportunity for expanded system linkages.

The North West LHIN strategy supports the Behavioural Supports Ontario Principles:

- Care is collaborative
- Behaviour is communication
- Accountability and Sustainability of the System

"Using community care before crisis"
"No Silos"
Take blame out of the discussion - "behaviour is failed communication"
North West LHIN Value Stream Analysis – Dec. 2011

II. Capacity building via health human resources including education for the manageable crisis in community or in the Long-term Care Home

The complexity, diversity and changes in the way individuals with responsive behaviours access care from the Regional Behavioural Health Service Model, requires a skilled workforce. The need for a range of skilled individuals who can work collaboratively in an inter-professional model of care is required to support the often multiple interacting needs of the target population. A functional priority human resource plan will be developed that includes an intense education and training of the inter-professional team, leverages existing knowledge experts (such as PIECES, trained Psycho-geriatric Resource Consultants, inter-professional care models through the NOSM) to train and educate current and future health human resources in effective management of responsive behaviours. The plan will include methods of building capacity and sustaining desired system changes.

Value Stream Analysis participants identified staff training as a critical success factor. Additionally, ongoing knowledge exchange and training of existing tools such as the Physical Intellectual Emotional Capabilities Environment Social (P.I.E.C.E.S) as well as, early collaborative care planning with the family.

Strategy supports the Behavioural Supports Principles:

- Care is collaborative
- Behaviour is communication
- A Culture of Safety is promoted
- Practices value diversity
- Accountability and Sustainability

"Tailor communication strategies to audience to promote increase understanding"
"Team includes all partners"
"Family respected as part of the team"
North West LHIN Value Stream Analysis – Dec. 2011

III. Creation of a Regional Behavioural Health Program, physical and virtual mobile outreach in the City of Thunder Bay and virtual wards in the region.

The Centre of Excellence for Integrated Seniors' Services working group in conjunction with the Behavioural Supports Ontario project team and validation through the December 2011 Value Stream Analysis illustrated the need of a physical unit to be one component of the new Regional Behavioural Health Service Model. The specialized until will be operated by St. Joseph's Care Group. Extensive collaboration with regional partners will occur in order to develop and sustain the virtual ward.

The Regional Behavioural Health Support Specialized Unit is a component of the Regional Behavioural Health Service Model of the North West LHIN. Within a shared model of care, the Regional Behavioural Health Service Specialized Unit will provide in-patient services, and will be a key component of the multi-pronged system approach. It will also serve as a resource for clinical skill development, knowledge transfer, quality improvement strategies for system partners (including the consumer and caregiver), and will align existing services to ensure timely and efficient services to the consumer, in an effort to avoid duplication. The role of the Regional Behavioural Health Service Coordinator and the North West CCAC Regional Case Manager will play a vital role in system management, and consumer and caregiver navigation.

The Regional Behavioural Health Service Specialized Unit will link with the following cross-sectoral services for consumer services and knowledge exchange:

- Geriatric Assessment Program (Outpatient Services within a Complex Care setting)
- Mental Health Services and Emergency Department (Thunder Bay Regional Health Sciences Centre)
- Nurse-led Outreach Teams (Long-term care and Acute Care Sector)
- North West CCAC (Community Sector)
- Alzheimer Society of Thunder Bay (Community Sector)
- Seniors Community Psychiatric Program (Community Sector)
- Canadian Association of Mental Health (Kenora/Rainy River Community Sector)
- Long-term Care Homes (Long-term Care Sector)
- Supportive Housing and Assisted Living (Community Sector)
- Nursing Stations (Health Canada)
- First Nation Committees

Although, the specialized unit is located in the City of Thunder, this unit is accessible to all residents of the North West LHIN, when behaviours are unable to be managed safely in the individual's home community. The virtual component will help keep individuals at home in their community.

The virtual ward will support regional mobile outreach teams and Long-term Care Homes to access expertise, support, and advice with the intent to help the individual, care givers, and health care providers manage behaviours as close to home as possible (i.e. home or Long-term Care) via Ontario Telemedicine Network.

The Value Stream Analysis session validated the use of mobile outreach teams in the City of Thunder Bay and the region with a specialized unit for those clients who are unable to be managed safely in their home or community. Collaboration on care plans with city/regional mobile outreach teams is essential to successfully transition the client back home (i.e. home, regional community, or Long-term Care).

The North West LHIN Strategy supports the Behavioural Supports Ontario Principles:

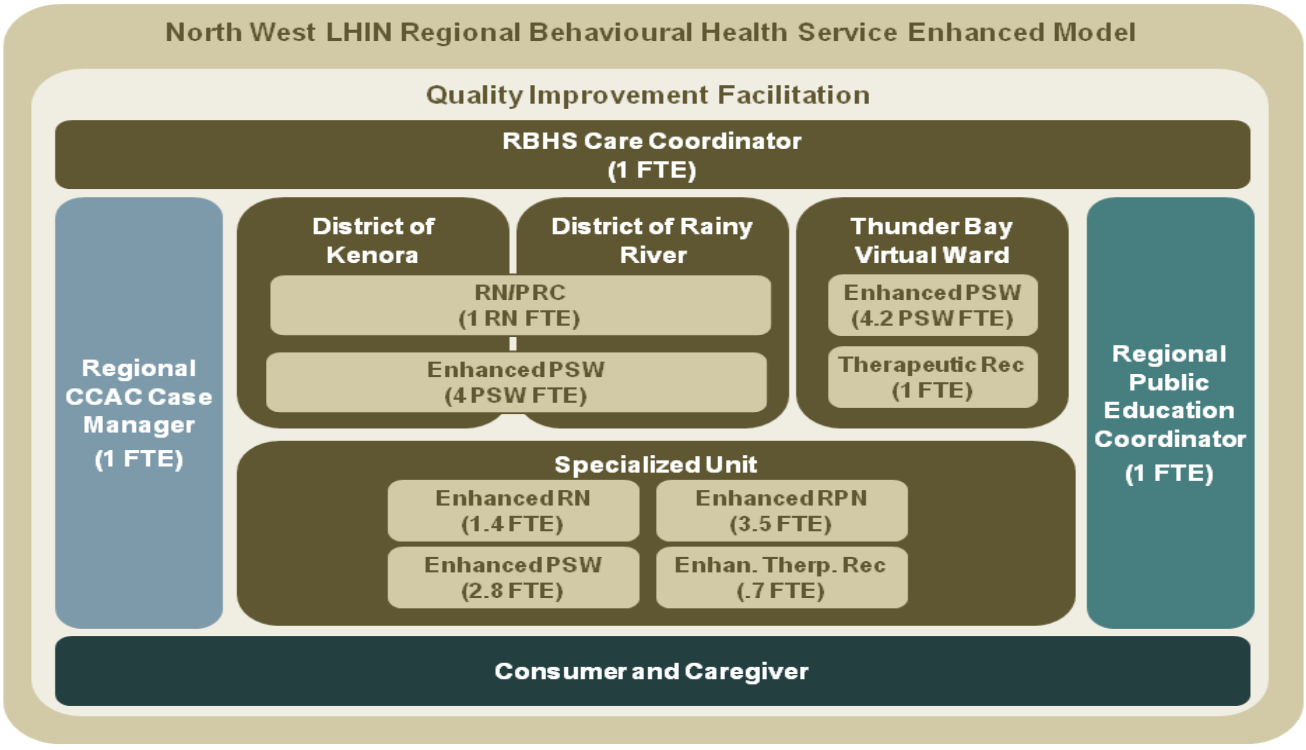
- Systems are coordinated and intergraded
- Accountability and Sustainability

"Using family council to promote communication between family and Long-term Care"
"Staff training for P.I.E.C.E.S and U.F.I.R.S.T"
"Knowledge transfer and capacity building – what works and what doesn't"
"Knowing the person holistically – culture and religion…"
North West LHIN Value Stream Analysis – Dec. 2011

IV. Change Management & Continuous Quality Improvement Strategy

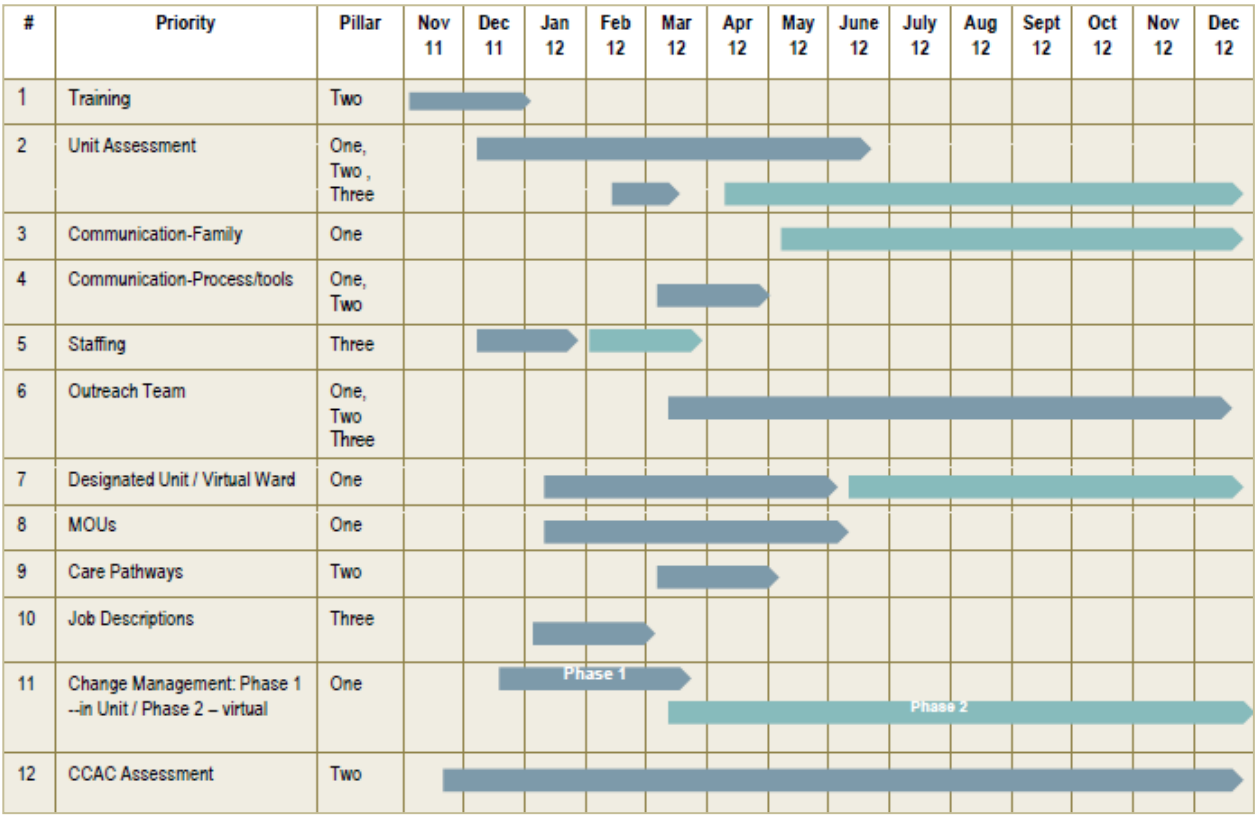
The North West LHIN has a dedicated full time Improvement Facilitator who will work closely with the Regional Behavioural Health Program Care Coordinator and teams to develop understanding, knowledge, and capacity to perform continuous quality improvement (see ***Figure 4***). In addition, the IF will utilize existing knowledge capacity from Resident's First to foster a continued change and focus on QI.

Figure 4



The North West LHIN Improvement Plan (***Figure 5***) outlines the plans and timelines arising from the first Value Stream Analysis session. The Improvement Facilitator will coach the development of process, outcome and balancing measures with the Regional Behavioural Health Service Model Care Coordinator and care teams to ensure system flow with appropriate care, at the appropriate time in the appropriate setting. The Improvement Facilitator is responsible to assist in the development of PDSA cycles, Kaizen events, and monitor continuous quality improvement via status calls/ meetings, follow – ups and feedback on a weekly basis. The Improvement Facilitator and Regional Behavioural Health Service Model Care Coordinator will focus efforts initially in the City of Thunder Bay with the mobile outreach teams and physical ward, then spread to the regional mobile outreach teams and virtual wards. The QI work plan is outlined in the master Behavioural Supports Ontario work plan in question16.

Figure 5



The Improvement Facilitator and Regional Behavioural Health Service Model Care Coordinator will work together on QI to sustain the Behavioural Supports Ontario Principals to Life:

- Behaviour is Communication
- Practices value Diversity
- Collaborative Care
- Systems are Coordinated and Integrated
- A Culture of Safety is promoted
- Accountability and Sustainability is defined and ensured

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

The overarching goal for the North West LHIN Regional Behavioural Health Service Model is to improve and simplify access to the appropriate service across the system in a timely manner, with care close to home as possible. To effect system change, the following four core strategies of care are required;

- System Navigation- standardized care pathways, referral processes , and assessments
- Enhanced Regional Mobile outreach Services
- Capacity building for human health resources
- The designation of a specialized unit within a Long-term Care Home

The four core strategies of care described above will allow for a streamlined access to the appropriate services for the older adult with responsive behaviours. These care service delivery strategies are vital for equitable and timely access to the right provider and the right service across the care continuum.

a. Will there be supported behavioural assessment services?

It is relevant to note that for individuals/clients who exhibit responsive behaviours, both clinical assessments and treatments are required, but effective psychosocial and specific interactional approaches are critical.

Comprehensive assessments including diagnostic tests will be conducted in a phased manner across all sectors, to determine the cause of the responsive behaviours. This includes developing standardized assessments tools to be utilized by staff in the community, North West Community Care Access Centre, acute care and Long-term Care Homes. Once standardized tools are developed, it will be expected that all staff will educated on the tools. This ensures consistency and decreases the number of “stories” that clients and caregivers have to tell. The following tools currently in use will be leveraged:

- Mini Mental Status Examination (MMSE)
- PIECES
- Dementia Observation Scale (DOS)
- Cohen Mansfield Agitation Inventory (CMAI)
- ABS (The Aggressive Behaviour Scale)
- Clock Drawing Test
- Client Assessment Instrument-Minimum Data Set (RAI MDS 2.0)

The Centre of Excellence for Integrated Seniors’ Services RBHP Working Group was given the task to review other assessments tools that could be utilized in the assessment of the target population across sectors. The group recommended the following:

- SIG E CAPS (sleep, interest, guilt, energy, concentration, appetite, psychomotor, suicidal)
- Mica (Montreal Cognitive Assessment)
- GDS (Geriatric Depression Scale)
- BARS (Brief Psychiatric Rating Scale)

It is important to note, that although standardized assessments aim for a consistent approach to care for the target population, it is evident that all clients are unique in their needs. Therefore, consideration needs to be given that assessment tools are tailored to the individual client's needs. This aligns with the North West LHIN value statement: "*Care for me always as I live my life as I value and understand it to be".*

b. How will a comprehensive geriatric assessment be conducted?

Comprehensive assessments including diagnostic tests will be conducted in a phased manner to determine the cause of the responsive behaviours, utilizing an inter-professional approach, maximizing scopes of practice to avoid duplication of effort. It is important for medical conditions to be ruled out such as delirium, urinary tract infections, that can often be a primary cause for a responsive behaviour. It is expected that staff assigned to complete assessments in the client's current living environment will complete the initial assessment to rule out a medical condition. This includes community staffing, Long-term Care Home staff, and the Nurse-Led Outreach Team. If client's responsive behaviours have not deescalated after the initial assessments, referrals will be made to the Seniors Community Psychiatric Program/District Mental Health Services, and the Geriatric Assessment Program (Geriatrician and NPs), for further assessment and treatment as needed. The assessment will either be conducted within the current living environment of the client or via Ontario Telemedicine Network.

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

Part of the North West LHIN Action Plan will be to develop a standardized referral form for the target population, to be used across the continuum of care in both rural and urban settings. In conjunction with the referral form, a decision tree/algorithm will be developed to ensure that timely access occurs in the most appropriate setting. A recommendation is to develop a telephone/referral line for use by individuals, caregivers and professional health care providers in both rural and urban settings to use. The individuals/staff tasked with the triage responsibilities via the referral line, will follow the same decision tree/algorithm. All health service providers, family/caregivers and the public will receive communication and education (where applicable), regarding the decision tree/algorithm and referral line services. A community engagement and communication strategy will be developed, regarding the North West LHIN Regional Behavioural Health Service Model action and implementation plan. This alignment focuses on the partnership across the continuum of care.

Individuals presenting with responsive behaviours that are either new or have escalated in intensity may be identified in the following scenarios:

- An individual presenting to the Emergency Department, primary health care team or to the Geriatric Assessment Program with a caregiver will be triaged and referred to the most appropriate setting using the algorithm/decision tree.
- A resident in a Long-term Care Home. Staff in conjunction with the resident's family/caregiver will assess the behaviour and based on the initial assessment, will refer to the most appropriate team or setting using the decision tree/algorithm. For example, the referral may be to the Seniors Community Psychiatric Program/Mental Health Services mobile outreach team, Psycho-geriatric Resource Consultants, the Nurse-Led Outreach Team, the Geriatric Assessment Program (GAP), the Transitional Regional

Behavioural Health Service Model (TBRHS) –specialized unit or the Emergency Department if the there is an underlying medical condition that cannot be managed with the resources in the Long-term Care Home or the Nurse-Led Outreach Team.

- An individual in a community setting (private residence, supportive housing) that either staff, family/caregiver have noticed a substantial change in the individual/clients behaviour. Staff and/or family/caregiver can utilize the referral line for further guidance/ support, regarding next steps to assess and treat. The proposed Social Worker employed by CCAC, housed in the Regional Behavioural Health Service Model Specialized Unit, may also identify escalating behaviours.
- A client in a hospital setting will be assessed to rule out underlying medical conditions. If the behaviours are still present and escalating, the hospital team will refer to the decision tree/algorithm to assess and treat.

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

Increasingly, younger individuals with neuropsychiatric challenges are requiring support both within the community, Long term care and hospital systems. These include clients with longstanding psychiatric illnesses that will grow old, 15% of individuals with dementia have been identified a recent Rising Tide Document as being under the age of 65. In addition, clients with acquired brain injury and Huntington's disease are presenting with responsive behaviours. Practiced based evidence has increasingly identified the need for recognizing these characteristics and aligning services to support these realities.

In an effort to support this population (individuals identified above), the Regional Behavioural Health Service Model within the North West LHIN will provide support and care for the individual in their current setting, and develop the necessary plan of care, and as appropriate, referrals. The decision tree/algorithm will incorporate this population so that clear care pathways and transition points for all populations with associated behaviours will be considered.

In addition individuals will be directed to community based services that currently exist within the North West LHIN. Current services include:

- Brain Injury Services of North Western Ontario (BISNO)
- North West CCAC
- Wesway Services-Respite
- Mental Health and Addiction Services-SJCG

It is important to note that the future Seniors Mental Health Rehabilitation Program (slated for operation in 2014 by SJCG), will provide additional support services to this target population.

e. *How will individuals in crisis be supported?*

Individuals including caregivers in crisis will be supported via the following avenues;

- The Alzheimer Society of Thunder Bay offers the First Link Program through the enhancement to the Public Education Coordinator position. Individuals and caregiver's who experience a crisis in the community, Long-term Care Homes, and hospital settings will be supported.

- The telephone/referral line and the potential alignment with the Dementia Network's Provincial Hotline, for support and guidance, will primarily be for the individuals in the community setting (both rural and urban).

- The North West Community Care Access Centre Social Worker allocated to the Regional Behavioural Health Service Model will have an Intensive Case Management Role. This role will support individuals and caregivers in the Long-term Care Home, community (rural and urban and hospital settings).

- The Seniors Community Psychiatric Program/District Mental Health Services (DMHS) mobile outreach teams, which include the Psycho-geriatric Resource Consultant role, will support individuals and caregivers in the Long-term Care Homes, community (rural and urban and hospital settings), via an inter-professional team approach to care.

- Regional Behavioural Health Service Model l Specialized Unit will support individuals, caregivers and health care providers in the Long-term Care Home, community and hospital settings, both rural and urban. The support includes transitional support from the unit to Long-term Care Homes via PSW mobile outreach and leveraging current mobile outreach team resources such as Seniors Community Psychiatric Program/DMHS (linkages with the acute care hospitals, in the North West LHIN region will support transition and admission to the Regional Behavioural Service Specialized Unit)

- Nurse-Led Outreach Team provides support for the residents, caregivers/families and health care providers in the Long-term Care Homes and acute care settings. The Nurse-Led Outreach Team is currently operational in the COTB. It is anticipated with the expansion to the Nurse-Led Outreach Team, that the Nurse-Led Outreach Team will align their roles with the Regional Behavioural Health Service Model, and provide consultation to the rural Long-term Care Homes within the Regional Behavioural Health Service Model Specialized Unit via Ontario Telemedicine Network.

7. Name your partners for interdisciplinary service redesign.

The partners for interdisciplinary, inter-professional redesign for the implementation of a Regional Behavioural Health Service Model will be those partners currently involved in delivering services to older adults with responsive behaviours and those involved in system coordination as outlined in question 3. Such partners include:

- Nurse Led Mobile outreach Team
- St. Joseph's Care Group
- Thunder Bay Regional Health Sciences Centre
- Canadian Mental Health Association
- Northern Ontario School of Medicine (NOSM)
- Seniors Community Psychiatry Program/District Mental Health Services for Older Adults
- Long Term Care Homes (Long-term Care Home)
- North West CCAC
- Health Quality Ontario (HQO)
- North West LHIN Improvement Facilitator
- Geriatric Assessment Program

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

- Seniors Community Psychiatric Program/District Mental Health Services for Older Adults: These two teams (employed by SJCG and CMHA) are comprised of professionals such as RNs, RPNs, OTs, SWs, Psycho-geriatric Resource Consultants, Geriatric Psychiatrists and physicians. The composition of the team has significant benefits to the individual with responsive behaviours within the community, hospital and long term care sectors, by providing mobile outreach support to the client and caregiver within their current living environment. The team has also began to build capacity for health care providers, teaching techniques and skill sets to meet the individual needs of each client. It is expected that this team will further enhance its service linkages to the clients as part of the Regional Behavioural Health Service Model.

- NOSM: NOSM received funding through HealthForceOntario's Inter-professional Collaboration fund, to enhance inter-professional service delivery within the North West LHIN. NOSM developed two inter-professional models: 1) Facilitating Leadership in Inter-professional Care (FLIC) and 2) Students Partnering in Inter-professional Care and Education (SPICE). The two models can be applied to all sectors across the continuum of care in their daily practice. Many partners listed above including Long-term Care Homes have participated in learning sessions offered by NOSM, such as enhancing inter-professional service delivery, team building and understanding the benefits of ensuring each profession is working to full capacity within their scope of practice. The Regional Behavioural Health Service Model will provide this resource to support further development of the inter-professional team.

- Long-term Care Homes/HQO(Residents First): It is important to note that the role of the current Improvement Facilitators in Long-term Care Homes will be an asset to the initiation of the North West LHIN Behavioural Supports Ontario Improvement Plan. These roles were developed in conjunction with the Residents First Initiative and with the North West LHIN-wide Falls Collaborative. Participating long term care homes continue to demonstrate a decrease in the rate of falls within the Long-term Care Homes. These teams utilized QI methodologies such as Plan Do Study Act cycles to make system improvements. Building upon current wisdom and expertise in the system for inter-professional approaches to care will be enhanced.

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

Throughout the first year of implementation (through to December 2012), the North West LHIN will continue to provide leadership and support to the North West LHIN Behavioural Supports Ontario Project Team in its advisory and design capacity to ensure system-wide inter-professional service delivery and coordination of services and forge linkages and system partnerships as appropriate. It will be expected that new working groups will be formed to steer further development of the Regional Behavioural Health Service Model with representation from the partners listed above.

The North West LHIN internal Behavioural Supports Ontario team will continue to support the Project Team through the following staffing model:

Executive Sponsor: Susan Pilatzke, Senior Director Health System Transformation
Project Manager: North West LHIN Project Management Office
Project Lead: Meaghan Sharp, Behavioural Supports Ontario Project
Performance Lead: Liisa Simi, Senior Consultant Health System Performance
Improvement Facilitator: Nicole Brown, Senior Consultant Health System Transformation
Analyst: James Anderson

Behavioural Supports Ontario 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?

It is important to note that the participants at the North West LHIN Value Stream Mapping Session developed the phrase “You Work In My Home. I Do Not Live In Your Workplace”. This is a powerful message that speaks to the fact that all partners/staff in the Regional Behavioural Support Service Model need to be client and caregiver focused in all approaches to care. An aim of the inter-professional educational plan for the health human resources is to optimize the management of psychosocial and responsive behaviour symptoms through the use of pharmalogical and non-pharmalogical (example: enhanced therapeutic recreation and psycho-geriatric resource consultants) approaches to care.

Functional-based human resource planning will be essential to ensure a very skilled workforce with high levels of knowledge and expertise available to meet the multiple interacting needs of the physical, intellectual and emotional and functional needs of the target population. The shift of emphasis will be from direct care provision to collaborative evidenced informed practitioners; designing a client and caregiver focused model of care, requires transformational change. The model of care for the Regional Behavioural Health Service Model, aims to empower the client and caregiver, in turn it empowers the point of care staff to build their capacity to respond appropriately. Maximizing each professional’s skill set to full capacity and the inter-professional care model is paramount to success.

The following is a list of existing training and knowledge transfer processes that are in place to support dissemination of new knowledge and best practice skills relating to behavioural supports:

PIECES: “Putting the P.I.E.C.ES (Physical, Intellectual, Emotional, Capabilities, Environment, and Social Components) Together. This educational component is designed to enhance the ability of regulated health professionals to understand clients with increasingly complex physical and cognitive needs that are associated with responsive behaviours. It provides a common

vision; language and approach to the care of the older adults. The program is grounded in the research of the adult learning, theory and human performance technology and organizational development. It is a performance improvement approach that follows a train-the-trainer model. Within the North West LHIN, there are PIECES programs and staff trained on PIECES in the Long-term Care sector and all Psycho-geriatric Resource Consultants within the North West LHIN are PIECES trained and are coaches as well.

MONTESSORI: The Montessori Method was originally designed for children; however this method can be utilized for older adults with cognitive impairments. Utilizing the Montessori tools, it provides older adults with an opportunity to use their hands and five senses to activate and stimulate their minds. It is a source of creativity and comfort. It helps clients feel more secure and confident and less angry and frustrated. Within the North West LHIN, there are Montessori staff trained, particularly Therapeutic Recreation staff.

Gentle Persuasive Approaches (GPA): The GPA curriculum addresses how to reframe challenging behaviour to be interpreted as self-protective or responsive behaviour that occurs as a result of unmet needs. GPA encourages staff to assess the meaning of behaviour and work alongside the client. Within the North West LHIN there GPA trained staff, including the Psycho-geriatric Resource Consultants (trained as coaches) and PSWs employed in Long-term Care Homes.

U-First Program: The U-First Curriculum offers training to unregulated care providers on how to improve the quality of interaction between the formal care provider and the client with Alzheimer's disease and other dementias. Within the North West LHIN, there are U-First trained staff, including the Psycho-geriatric Resource Consultants (trained as coaches) and several PSWs.

Psycho-geriatric Resource Consultant: The Psycho-geriatric Resource Consultant resources within the North West LHIN operate out of the Seniors Community Psychiatry Program and the District Mental Health Services for Older Adults. The Psycho-geriatric Resource Consultants act as advisors, educators and facilitators, to Long-term Care Home, community support agencies and at times hospitals.

Seniors Community Psychiatry Program (SPCC) and District Mental Health Services for Older Adults : Both teams are comprised of Psycho-geriatric Resource Consultant, RN, RPN, SW, OT, physicians and consulting geriatric psychiatrists. The team offers services to the City of Thunder Bay and region. These services include education and training for point of care staff in Long-term Care Homes and in the community, as well as support to caregivers.

Alzheimer Society of Thunder Bay: The Alzheimer Society of Thunder Bay provides support and education for people with Alzheimer's Disease and related dementias and their caregiver and health care providers.

Nurse Led Mobile outreach Team (Nurse-Led Outreach Team): The Nurse-Led Outreach Team is comprised of 2 NPs and 1 RN.
The team provides consultation, assessment and education in the Long-term Care Home setting.

RNAO/ Long-term Care Best Practice Coordinator: The role of the Best Practice Coordinator is to enhance knowledge transfer in the geriatric sector, improve quality of care and resident

outcomes in Long-term Care Homes, and support staff by assisting to improve quality of work life. For example: the best practice guideline entitled “Delirium Depression and Dementia”

Alzheimer Knowledge Exchange (AKE): The role of the AKE for the Behavioural Supports Ontario project is to support the learning needs of people seeking practice change and to facilitate easy access to best practices and knowledge. The AKE provides knowledge exchange opportunities with a goal of supporting client centered care, prevention and early detection, implementation of standardized best practices in behavourial health and continuous quality improvement.

Centre for Education and Research on Aging and Health (CERAH) and Lakehead University: CERAH and Lakehead University are considered subject matter experts in changing the system to meet the needs of individuals with responsive behaviours. A two-year study is currently concluding, outlining the dementia context and issues in rural North Western Ontario (E. Wiersma, Lakehead University). There were many issues related to responsive behaviours and dementia, including a clear lack of awareness and education among health service providers about dementia and responsive behaviours, a lack of support for caregivers, inappropriate placements (ie. acute care, early Long-term Care placement, unsecured units), lack of home and community care services, and continuity of care issues. Other researchers at Lakehead University have been researching various issues related to dementia, from caregiver burden to palliative care. Researchers from Lakehead University will continue to work with health service providers to identify gaps in services and evaluate the effectiveness of interventions.

Lakehead University, as an institution training future professionals, has the potential to build capacity training related to responsive behaviours and dementia through its Dementia Studies certificate as well as in various professional and health-related programs, including nursing, public health, health sciences, gerontology, social work, and psychology.

The Geriatrics Inter-professional Practice and Inter-organizational Collaboration Toolkit builds capacity for care of the older adult in family health teams and community health centres. The tool kit consists of quick facts, clinical tools and algorithms, self assessment tools, handouts for clients/families, case studies and quizzes, and slide materials used to build capacity between teams

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

The North West LHIN has a dedicated full time Improvement Facilitator with LEAN expertise who will work in conjunction with the HQO coach to develop additional quality improvement fundamentals and capability. The North West LHIN IF will maximize existing QI expertise via IF’s through Residents First in thirteen long term care homes and system partners in the North West LHIN region experienced with QI via the FLO Collaborative.

The LHIN-Wide Falls Prevention Program and Wounds Management Program quality improvement initiative for example, funded in Years 2 and 3 of Aging at Home, involved health service providers from over 30 organizations representing sectors including acute care, long-term care and community. These partners worked together to better integrate and coordinate care across the system, to achieve greater consistencies in clinical practice, and develop quality improvement capacity throughout the region. Additionally, eligible seniors were supplied with

falls prevention equipment (i.e. hand rails for bath) to help maintain independence at home in the community.

The North West LHIN is a leader in developing the Regional Falls Prevention program. The program has now been linked to Health Quality Ontario's Residents First initiative, currently being implemented in long-term care homes across Ontario. Falls and wounds are two common conditions experienced by seniors that contribute to emergency department visits and admission to hospital.

b. What behavioural supports expertise is currently available to support Behavioural Supports Ontario within the LHIN?

Currently within the North West LHIN, there are specialized psycho-geriatric resources. Presently, these resources work in an inter-professional collaborative model providing specialized services to the target population. It is expected that these resources will continue to practice within a collaborative inter-professional model aligned with the Behavioural Supports Ontario framework. The resources include;

- Psycho-geriatric Resource Consultants, which are a component of the mobile outreach teams both rural and urban
- Seniors Community Psychiatry Program (Seniors Community Psychiatric Program): this team is comprised of Psycho-geriatric Resource Consultants, OT, SWs, RNs, RPNs, Case Workers and Managers, Physician and a Geriatric Psychiatrist.
- District Mental Health Services for Older Adults Kenora/Rainy River: The team is comprised of Psycho-geriatric Resource Consultants, SW and consulting Geriatric Psychiatrists.
- PIECES, U-First, GPA trained staff
- Alzheimer Society-Public Education Coordinator
- GAP- Geriatrician and NPs
- Dementia Network of North West Ontario

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

The North West LHIN has dedicated a full-time Improvement Facilitator to facilitate QI knowledge exchange sessions across the region; The IF is a resource for the LHIN by assisting teams with fundamentals of QI education and capacity building for future projects. Attached is the North West QI work plan outlining additional Value Stream Analysis session to identify current state for additional streams for this client population (i.e. living in community (urban/rural) with a responsive behaviours, transitioning from specialized unit back to community (urban/rural). The North West LHIN IF will work in partnership with the North West LHIN HQO Coach and IFs from within HSPs across all sectors to maximize current expertise.

Psycho-geriatric Resource Consultants: The Psycho-geriatric Resource Consultants are involved in the Dementia Network within the North West LHIN. To align with the Behavioural Supports Ontario framework, the Psycho-geriatric Resource Consultants will train and coach the Regional Behavioural Health Service Model teams on the PIECES, U-FIRST, GPA and Montessori concepts. This includes the FTEs associated within Long-term Care and the mobile outreach teams, the Community Care Access Centre Social Worker, the Nurse-Led Outreach Team and the Alzheimer Society community team. The Psycho-geriatric Resource Consultants

will also spread knowledge about leading practices across all sectors, with a goal to building enhanced, collaborative evidence- informed practitioners

Seniors Community Psychiatric Program and District Mental Health Services for Older Adults: The North West LHIN Behavioural Supports Ontario Action Plan will leverage existing resources to provide onsite, "at the bedside" education to point of care staff and caregivers, within the Long-term Care Home, hospital and community sectors (rural and urban).

Alzheimer Society Thunder Bay: Enhancements to the current capacity of the Public Education Coordinator will support knowledge exchange regarding behavioural supports, to community providers, primary care, acute care sectors and caregivers. This role will be certified in U-First, PIECES, and GPA. The Value Stream Analysis session indentified that there is a culture of blame not a culture of just safety to point of care staff after a critical event. The Public Education role, in combination with all partners of the Regional Behavioural Health Service Model will develop a peer to peer network to support debriefing after an incident. Debriefing tools will be developed for use by all sectors.

Nurse-Led Outreach Team: This team will build knowledge capacity using the Behavioural Supports Ontario framework, and will provide timely consultation; support and education related to the target population within the Long-term Care Home and acute care sectors.

Ontario Telemedicine Network: Provide "bedside" education/knowledge exchange from the Regional Behavioural Health Service Model Specialized Unit to Long-term Care Homes, community and hospitals across the region, and will link to inter-provincial experts such as: Seniors Health Research Transfer Network, AKE, and educational presentations. When providing specialized Psycho-geriatric services, it is essential to access specialists to support their learning needs whenever they are in their respective communities. Geriatric Psychiatrists from Baycrest Geriatric Centre have been a part of the North West LHIN community mobile outreach team since September 2002, providing weekly consultation sessions on a rotating basis in each of the communities via Ontario Telemedicine Network tele-health, and is available for client assessment, case consultation, and education.

The Dementia Education Needs Assessment (DENA): tool will assist in identifying gaps in education and knowledge related to the target population. It will be important to have role clarity of education providers to avoid duplication.

It is important that education and knowledge transfer builds on inter-professional, inter-sectoral collaboration and provides the development of a learning service that will enable continued quality improvement, and provide infrastructure for research and education.

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

It is important to mobilize and leverage the collective wisdom and resources that are currently available within the North West LHIN as listed below:

- Nurse Led Mobile outreach Team (Nurse-Led Outreach Team) – Situation, Background, Assessment and Recommendation (SBAR) tools
- SHRTN –Communities of Practice
- RNAO BPGs- Depression, Delirium and Dementia Best Practice Guideline
- Ontario Telemedicine Network of providers

- Resident's First
- The Geriatrics, Inter-professional Practice and Inter-organizational Collaboration
- Centre for Education and Research on Aging at Home
- North West LHIN Wide Falls Collaborative
- The Centre of Excellence for Integrated Seniors' Services Working Group
- Home First
- Flo Collaborative

It is expected that as part of the QI process, that current gaps and duplications in the current system of structures will be identified. It is also expected that new structures/pathways will be developed in practice as part of the QI process and Improvement Plans, with the aim of ensuring inter-professional collaboration and consistency across the all sectors.

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

Building upon the Behavioural Supports Ontario framework the North West LHIN Behavioural Supports Ontario Action Plan aims to have providers and resources with existing accountability agreements with the LHIN, contribute to the care of the older adults with responsive behaviours (aligned with the Regional Behavioural Health Service Model).

- Nurse-Led Outreach Team: It will be expected that this team will expand its current educational, consultation and assessment mandates within the Long-term Care Home sector and will align with the Behavioural Supports Ontario framework and current mobile outreach resources such as Seniors Community Psychiatric Program, and proposed mobile outreach services. This team will continue to provide mobile outreach support and will further enhance their role in early identification of responsive behaviours (identified as a current gap in the system).

- Home First Steering Committee: It will be expected that this committee will continue to monitor system performance against intended objectives of maintaining individuals in the community as appropriate, and seamlessly transitions the client to an appropriate care setting along the continuum. Where barriers are identified in relation to the Behavioural Supports Ontario target population, the Home First Operations Committee will conduct an analysis of the barriers, improve processes to help remove barriers, and develop recommended system solutions to.

- Psycho-geriatric Resource Consultants: It is expected that the Psycho-geriatric Resource Consultant role will continue to play a vital role in building knowledge across the continuum of care. This knowledge transfer will occur via education (PIECES, U-FIRST, and GPA), caregiver support, and building upon existing partnerships with the Psycho-geriatric Resource Consultant role across sectors.

- The Geriatrics Inter-professional Practice and Inter-organizational Collaboration Toolkit: The Regional Behavioural Health Service Model will leverage tools, presentations and clinical pathways The Geriatrics Inter-professional Practice and Inter-organizational Collaboration Toolkit developed to support knowledge transfer to health care providers and caregivers to meet the individual needs of the target population.

- GAP: It is expected that the partnership with the GAP team (employed by SJCG), will enhance their role in service delivery for the target population, with an emphasis on early diagnosis and intervention, across the continuum of care and will align with the Behavioural Supports Ontario framework and current and proposed partnerships (Seniors Community Psychiatric Program, Nurse-Led Outreach Team and enhanced mobile outreach services) as part of the Regional Behavourial Health Service.

- Seniors Community Psychiatric Program and District Mental Health Services for Older Adults: It will be expected that these teams will continue to provide enhanced services to the target population across the continuum of care, with the proposed enhancements of health human resources to support extended mobile outreach services. Current assessment tools, education, clinical pathways, and plans of care will be leveraged. The team will continue to ensure that the mobile outreach service is provided to the client and caregiver within their current living environment to decrease multiple transitions across multiple sectors and care providers.

- Inter-professional care model- It is expected that the implementation of the Regional Behavioural Health Service Model will leverage the current models and tools for the inter-professional care from the Facilitating Leadership in Inter-professional Care and Partnering in Inter-professional Care and Education models. The implementation of the plan will also leverage upon current best practice guidelines through Registered Nurses Association of Ontario related to inter-professional care, delirium, depression and dementia care.

- Telemedicine Nurses Initiative: With the recent provincial funding for the enhancement of Telemedicine nurses, the North West LHIN allocated funds to support Telemedicine Nurse Resources to service the target population. This aim is to provide enhanced behavioural health management to support the individuals experiencing acute episodes of responsive behaviours. The resource will be accessible through the current partnership with Ontario Telemedicine Network.

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.)?

Quality Improvement (QI) Methodologies are one mechanism for ensuring sustainability for process redesign, as it is a way to measure and achieve success. The implementation of a Regional Behavioural Health Service will ensure that all partners and providers (including care givers via Family Councils etc), will be included in the spread of QI through training and education. This will be achieved through work with the North West LHIN IF, North West LHIN HQO Coach and the North West LHIN RNAO Best Practice Coordinator.

Sustainability of the Regional Behavioural Health Service, will be evaluated and monitored through measurements as a component of the improvement plan, clear accountabilities and reporting requirements for all partners, (as outlined in Question 2) and the regular monitoring of key indicators and performance measures (as outlined in Question 15), to ensure that key stakeholders and leaders recognize the importance of this cultural change. As part of the key indicators and improvement plan, an evaluation strategy will be developed and implemented to

measure success and satisfaction from a client, caregiver, care team, organization and community perspective.

Current knowledge transfer structures and mechanisms (as outlined in Question 8); will be utilized to build upon communication and community engagement strategies.
This includes the use of the following resources:

- Ontario Telemedicine Network of partners
- Senior's Health Research Transfer Network Communities of Practice
- Alzheimer Knowledge Exchange Collaborative Space
- LHIN Communication
- Centre for Education and Research on Aging and Health
- Northern Ontario School of Medicine

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

To meet the aim of shifting the emphasis from direct care provision to collaborative evidenced-based care by all practitioners, knowledge transfer methods will occur through the utilization of the following:

- Ontario Telemedicine Network – Regional Behavioural Health Service Model Specialized Unit as a "virtual ward" will support knowledge-Transfer across all sectors and at the bedside consultation and assessment requests.
- Train the trainer approaches (Psycho-geriatric Resource Consultant, PSW/RN mobile outreach)
- In class education
- Use of QI methodologies to spread knowledge and test ideas
- Standardized assessment and common referral forms
- Standardized approaches to care that are client-centered (GPA, PIECES/U FIRST)
- Best Practices through RNAO BPG coordinator, AKE, SHRTN
- Clinical pathways and plans of care
- Consistent staff assignments (when applicable) to ensure consistency of care.
- The use of common language/definitions with the target population

a. How will lessons learned be captured and shared?

Lessons will be captured and shared through the development of a communication strategy which will include the following:

- Alzheimer Society to share stories through the network that is to be developed
- North West LHIN publications
- The development of a culture of learning, which allows for constructive debriefing opportunities to review cases and learn from them.
- Reporting mechanisms
- Communities of Practice
- QI methodologies through the North West LHIN IF and HQO Coach
  AKE collaborative Space

- Lakehead University's Centre for Education and Research on Aging is expected to strengthen partnerships with family/caregiver support services to incorporate leading practice and consumer/caregiver feedback into the proposed system change.

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

With the implementation of the Regional Behavioural Health Service Model, the North West LHIN will leverage existing wisdom and expertise available within HSPs, as well as external resources. As teams/care providers are developed and enhanced resources are established across the continuum, education and training opportunities will be identified and developed in conjunction with key partners, such as:

- Lakehead University
- Centre of Excellence for Research on Aging at Home
- St Joseph's Care Group
- Alzheimer Society
- Confederation College
- Psycho-geriatric Resource Consultants
- Seniors Community Psychiatric Program/ District Mental Health Services for older adults
- Registered Nurses Association of Ontario
- Health Quality Ontario
- Thunder Bay Regional Health Sciences Centre
- Northern Ontario School of Medicine

The partners will focus on spreading existing knowledge, in addition to restructuring current services and delivery methods, to help build capacity across the continuum of care while ultimately improving the care of the older adult with responsive behaviours.

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

- Centre of Education and Research on Aging at Home has collaborated on recent projects and initiatives such as:
  - Developing core competencies for Personal Support Workers,
  - North West LHIN Wide Falls Collaborative,
  - Palliative Care in Long-term Care,
  - Personal Support Worker Leadership.
  - Provides an infrastructure for research and education for pre and post students involved in collaborative inter-sectoral care.

- Lakehead University/NOSM has collaborated on recent projects and initiatives such as:
  - Inter-professional models of care (FLIC and SPICE),
  - Outcomes to date have been more consistent approaches to care, regardless of sector,
  - Maximize the scope of practice of each individual, within a team approach.

- Alzheimer Society of Thunder Bay (First Link) is a North West LHIN funded program that has collaborated on recent projects and initiatives such as:
  - Encouraging and empowering aging at home for seniors living with the challenges of Alzheimer's or related dementia,

  - Provides referrals and linkages to services and support in the community as early as possible in the disease process.
  - In the first year of the program, First Link provided over 75 seniors and family members with coordinated access to information, education and support by enhancing partnerships and linkages between primary care providers (i.e. family doctors), diagnostic and treatment services, and community service providers. By Year 3 of Aging at Home the number of First Link clients had expanded to over 150.

- HQO has collaborated on recent projects and initiatives such as; the North West LHIN-wide falls collaborative, and Residents First. The outcomes of these initiatives are as follows:
  - Partner collaboration to prevent the occurrence of falls, through environmental changes, medication reviews and ultimately reviewing and enhancement resident plans of care (Residents First).
  - Participating Homes continue to demonstrate a decrease in the rate of falls within the Homes.
  - Utilizing QI methodologies such as PDSA cycles to make change, learn and move forward.

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

Throughout the first year of implementation (through to December 2012), the North West LHIN will continue to provide leadership and support to the North West LHIN Behavioural Supports Ontario Project Team in its advisory and design capacity to ensure system-wide knowledgeable care teams and capacity building coordination of services and forge linkages and system partnerships as appropriate. It will be expected that new working groups will be formed to steer further development of the Regional Behavioural Health Service Model with representation from the partners listed above.
The North West LHIN internal Behavioural Supports Ontario team will continue to support the Project Team through the following staffing model:

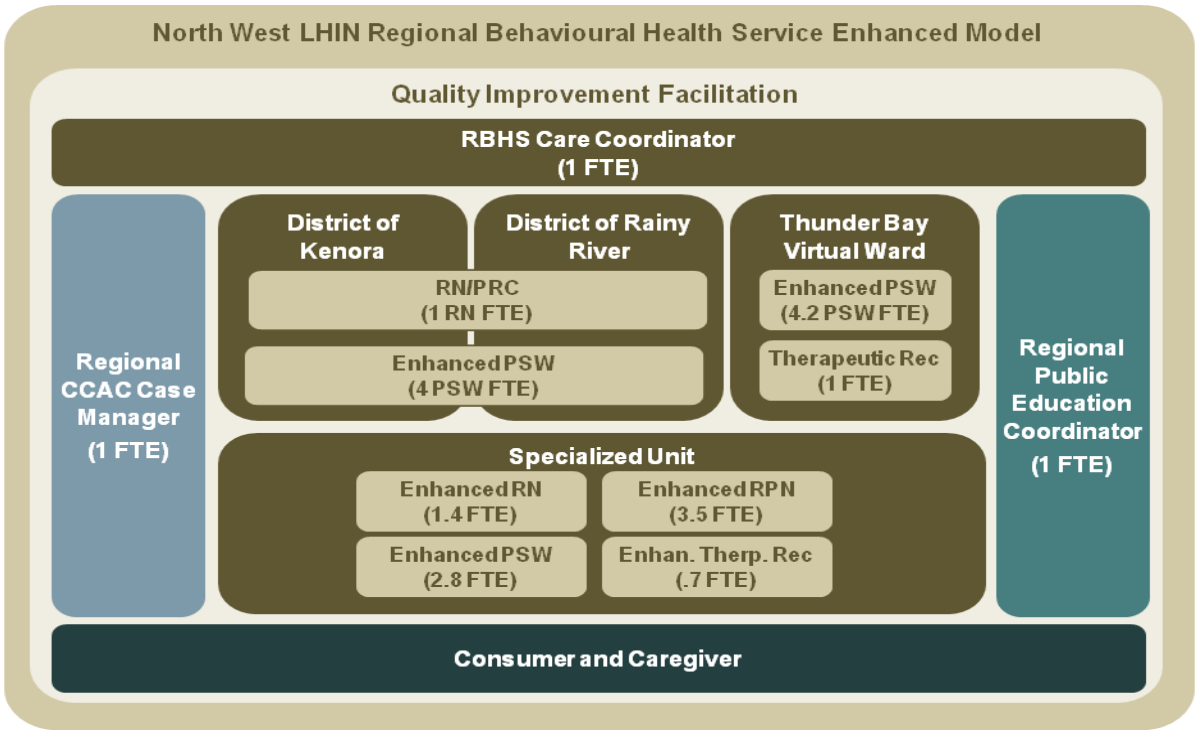
Executive Sponsor: Susan Pilatzke, Senior Director Health System Transformation
Project Manager: North West LHIN Project Management Office
Project Lead: Meaghan Sharp, Behavioural Supports Ontario Project
Performance Lead: Liisa Simi, Senior Consultant Health System Performance
Improvement Facilitator: Nicole Brown, Senior Consultant Health System Transformation
Analyst: James Anderson

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

The North West LHIN received $1.23 million for the implementation of a Regional Behavioural Health Service Model to enhance health human resources. Sixty (60%) will be allocated to community resources, and forty (40%) to the Long-term Care Home sector. The diagram below illustrates the deployment of human health resources to participating HSPs. The participating HSPs are SJCG, North West CCAC, and Alzheimer Society of Thunder Bay.

It is understood that there will be formal structures in place to oversee the day to day operations and monitoring of the implementation of the North West LHIN Regional Behavioural Health Services Model. It is expected that as new positions are created, duplication of services, role clarity and deployment of health human resources (e.g. from the Regional Behavioural Health Service Model Specialized Unit to the urban and rural community and acute care settings for outreach services) will be evaluated as per the Behavioural Supports Ontario project and memorandums of understanding with health service providers.

Figure 4



Specifically, 7 of the 9 allocated PSW FTEs will be assigned to the Regional Behavioural Health Service Model Specialized Unit

- 2.8 FTEs will enhance the current compliment on the specialized unit to allow for an effective resident to staff ratio.
- 4.2FTE will be allocated to the Regional Behavioural Health Service Model Specialized Unit, and deployed as a mobile outreach resource to other Long-term Care Homes within the City of Thunder Bay
- 2.0 FTEs will provide a mobile outreach resource to the rural Long-term Care Homes.

Of the 6 allocated RN/RPN FTEs;

- 1.4 RN FTEs will be allocated to the Regional Behavioural Health Service Model Specialized Unit to enhance the current compliment on the specialized unit for an effective resident to staff ratio.
- 3.5 RPNs will be allocated to the Regional Behavioural Health Service Model Specialized Unit to enhance the current compliment on Willow Grove for an effective resident to staff ratio.

- 1.0 RN/ Psycho-geriatric Resource Consultant (rural) FTE will be allocated to the Regional Behavioural Health Service Model Specialized Unit to enhance Psycho-geriatric Resource Consultant resources in the rural community.

Additional Health Care Personnel;

- Regional Behavioural Health Care Coordinator- 1.0 FTE allocated to the Regional Behavioural Health Service Model Specialized Unit.
- Case Manager/Social Worker- 1.0 FTE allocated to the North West CCAC
- Public Education Coordinator enhancement- 1.0 FTE allocated to the Alzheimer Society of Thunder Bay.
- Therapeutic Recreation- 0.7 FTE allocated to the Regional Behavioural Health Service Model Specialized Unit to enhance the current compliment on the specialized unit for an effective resident to staff ratio.-1.0 FTE allocated to the Regional Behavioural Health Service Model Specialized Unit for City of Thunder Bay Mobile Outreach resource

Volunteer Model- the consumer representation on the Behavioural Supports Ontario Project team, identified volunteer resources need to be part of the Regional Behavioural Service Model. The role of the Volunteer would best support and guide the individual/client and caregiver through their unique journey. The Volunteer model would be designed in consultation with system partners, to ensure the model meets all relevant legislative requirements. The model would be designed similar to the Hospice Northwest model that supports clients and caregivers through their end of life journey. It will be expected that the Volunteers receive education and training (as necessary) to align with the Behavioural Supports Ontario framework. The North West LHIN Behavioural Supports Ontario Project team, in principle agreed with the importance and necessity for this model. It will also be expected that implementation and improvement plans will be developed to help design this model.

a. ***Describe how the HSPs will deploy staff to meet the established Behavioural Supports Ontario Framework for each LHIN.***

- **St. Joseph's Care Group** will be the HSP for the Regional Behavioural Health Service Model including the specialized unit and some mobile outreach resources. $1,150,507 will be allocated to SJCG for the employment of these Health Human Resources:

  -<u>Regional Behavioural Health Service Model Specialized Unit</u>: The HHR allocated to the specialized unit will enhance the current compliment on the unit for an effective resident to staff ratio.
  - 1.4 FTE RN,
  - 3.5 FTE RPN
  - 2.8 FTE PSW
  - 0.7 FTE Therapeutic Recreationalist (It is expected that these staff will be champions in environmental design, programming and Montessori approaches to care.)

These staff will have received intense education/training (as outlined in schedule G of the Behavioural Supports Ontario Performance Agreement), to safely and effectively manage current residents and future residents with responsive behaviours. It is expected that these staff will be "knowledgeable experts" for addressing the target population in the Long-term Care Home setting and across sectors.

-Regional Behavioural Health Service Model Mobile Outreach Resources:

- 4.2 PSW and
- 1 RN FTEs will be allocated to the specialized unit for a mobile outreach service
- 1.0 Therapeutic Recreationalist

These staff will provide transitional care and knowledge exchange to Long-term Care Homes and will closely align with existing mobile outreach resources (Seniors Community Psychiatric Program) in an effort to avoid duplication and to ensure that all professional scopes are maximized at full capacity. These staff will receive intense education/training (as outlined in schedule G of the Behavioural Supports Ontario Performance Agreement), to safely and effectively manage responsive behaviours, and to become change agents for system re-design.

-RBHP Clinical Care Coordinator:

- 1.0 FTE will be allocated to the Regional Behavioural Health Service Model Specialized Unit.

The care coordinator will provide clinical expertise and leadership skills in navigation, while facilitating the Regional Behavioural Health Service Model in the North West LHIN. The care coordinator will manage and provide support the Regional Behavioural Health Service Model Specialized Unit. The position will align with the North West Regional Community Care Access Centre Case Manager as a system partner to support client navigation. This position will receive intense education/training (as outlined in schedule G of the Behavioural Supports Ontario Performance Agreement), to safely and effectively manage current and future residents who exhibit responsive behaviours, and to become change agents for system re-design. It will be expected that this position will receive education/training on QI Methodologies and align with the North West LHIN IF

- **North West Community Care Access Centre:**

-Regional Community Care Access Centre Case Manager:

- 1.0 FTE will be allocated to the Regional Behavioural Health Service Model Specialized Unit

The case manager will provide system navigation (including waitlist management for the specialized unit) and intense case management (across all sectors) and provide support to caregivers. This position is part of the inter-professional team, and will play a key role in the development of standardized assessment tools, and referrals aligned with the Long-term Care Home Resident Assessment Instrument Coordinator for care plan development. The case manager will be knowledgeable in psychosocial supports for caregivers/clients in the community, Long-term Care and acute care settings.

- **Alzheimer Society of Thunder Bay:**

-Public Education Coordinator:

- 1.0 FTE will be allocated to the Regional Behavioural Health Service Model Specialized Unit

The Public Education Coordinator will continue to align with the First Link program, Wesway Respite services, and primary care providers. Enhancements to the current public education

coordinator will allow for improved knowledge transfer between acute care, Long-term Care and community settings, in alignment with the Behavioural Supports Ontario framework and the implementation of the Regional Behavioural Health Service Model. It will be expected that this position will develop and facilitate a peer to peer support network for staff to allow for debriefing after incidents, and to continue to provide client and caregiver support.

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

- **North West Regional Community Care Access Centre Case Manager**: The North West Community Care Access Centre is aware of the legislative requirements for quarterly assessment within the Long-term Care Home Act and with Community Care Access Centre regulations. North West Community Care Access Centre is an essential partner for assessing eligibility and discharge for current and future behavioural support services, and manages the waitlist for Long-term Care and will be expected to manage the waitlist for the Regional Behavioural Health Service Model Specialized Unit. This role will be pivotal in ensuring the provision of intensive case management for clients in the community, Long-term Care Homes and hospitals to avoid institutionalization and duplication of efforts, by providing system navigation support. In addition, this role will provide psychosocial supports to both the individual/client and the care giver.

- **Alzheimer Society of Thunder Bay**: This role will be leveraged to enhance public education efforts in community, primary care, hospital and Long-term Care settings. A current gap that has been identified is the lack of education regarding the target population and the current supports available in the community.

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

It will be expected that all Human Health Resources within the Regional Behavioural Health Service Model will be committed to the overarching philosophy and framework of the Behavioural Supports Ontario project and the North West LHIN Behavioural Supports Ontario Action Plan. The HHR will also demonstrate person and caregiver focused care.

- **PSWs** within the Transitional Regional Behavioural Health Unit: The additional FTE allocation will enhance the current compliment on the specialized unit, to provide an effective and safe resident to staff ratio. All point of care PSWs will have received intense education/training (as outlined in schedule G of the Behavioural Supports Ontario Performance Agreement and alignment to the PSW Core Competencies), to safely and effectively manage residents with responsive behaviours, by providing individualized activities of daily living and personal care. It is expected that these staff will be “knowledgeable experts” for addressing the target population in the Long-term Care Home setting and across sectors.

- **RPNs** within the Transitional Regional Behavioural Health Program: The additional FTE allocation will enhance the current compliment on the specialized unit, to provide an effective and safe resident to staff ratio. All point of care RPNs will have received intense education/training (as outlined in schedule G of the Behavioural Supports Ontario Performance Agreement and alignment to the RPN Core Competencies), to safely and effectively manage residents with responsive behaviours. It is expected that staff will provide guidance and support to the PSWs, and be “knowledgeable experts” for

addressing the target population in the Long-term Care Home setting and across sectors.

- **RNs** within the Regional Behavioural Health Service Model Specialized Unit: The additional FTE allocation will enhance the current compliment on the specialized unit, for an effective and safe resident to staff ratio. All point of care RNs will have received intense education/training (as outlined in schedule G of the Behavioural Supports Ontario Performance Agreement and alignment to the RN Core Competencies), to safely and effectively manage residents with responsive behaviours. It is expected that staff will provide guidance and support to the PSWs and RPNs via a coaching and mentoring approach, and be "knowledgeable experts" for addressing the target population in the Long-term Care Home setting and across sectors.

- **Therapeutic Recreationalists** within the Regional Behavioural Health Service Model Specialized Unit: FTEs will be allocated to the current compliment on the specialized unit, and as a component of a Mobile Outreach Resource. It is expected that these staff will be champions in environmental design, programming, and Montessori approaches to care. The Mobile Outreach Resource staff will apply the train-the trainer concept to partners across sectors in relation to environmental design, programming and Montessori approaches to care. Staff will receive intense education/training (as outlined in schedule G of the Behavioural Supports Ontario Performance Agreement), to safely and effectively manage residents with responsive behaviours.

- **Mobile Outreach PSWs (Rural and Urban):** The allocated PSWs to the Regional Behavioural Health Service Specialized Unit will provide transitional support, expertise and advice via physical and virtual means to Long-term Care Homes both within urban and rural settings. The mobile outreach PSWs will have received intense education/training (as outlined in schedule G of the Behavioural Supports Ontario Performance Agreement and alignment to the PSW Core Competencies), to safely and effectively manage residents with responsive behaviours. The Mobile Outreach PSWs will also receive facilitation and coaching training to effectively build capacity within Long-term Care Homes, via the "train the trainer" concept and to be change agents for system re-design. The Mobile Outreach PSWs will align in partnership with existing mobile outreach services such as the Nurse-Led Outreach Team, Seniors Community Psychiatric Program, and the District Mental Health Services for older Adults.

- **Mobile outreach RNs/Psycho-geriatric Resource Consultants (Rural):** The RNs/Psycho-geriatric Resource Consultants allocated to the Regional Behavioural Health Service Model Specialized Unit will increase the current 0.5 FTE RN/Psycho-geriatric Resource Consultant compliment to 1.0 FTE in the Rainy River/Kenora Districts. The Psycho-geriatric Resource Consultants position on a fulltime basis, will take on the role of team lead within the Kenora/Rainy River Districts for Regional Behavioural Health Service Model within the North West LHIN. This role would provide increased education, training, support and consultation within the Long-term Care Home, community and hospital sectors who serve clients/individuals who may exhibit responsive behaviours. The RNs/Psycho-geriatric Resource Consultant's would utilize existing resources and work closely with the Geriatric Mental Health Workers (DMHSOAP) to provide a detailed assessment of those individuals with challenging behaviours. Upon completion of the assessment, the RN/Psycho-geriatric Resource Consultant would support the caregiver and/or health care providers and the Mobile Outreach PSW resource to institute changes implemented within the plan of care.

Geriatric Psychiatry could be accessed if needed via Ontario Telemedicine Network either through regional consultation (virtual ward/ Regional Behavioural Health Service Model l Specialized Unit or provincial consultation. The Psycho-geriatric Resource Consultants would work closely with the Mobile Outreach PSW resource, to provide mentorship and coaching. The RN/Psycho-geriatric Resource Consultant for Regional Behavioural Health Service Model within the Kenora/Rainy River districts, would be the primary contact for the Regional Behavioural Health Service Model in the City of Thunder Bay.

- **Regional Behavioural Health Service Model Care Coordinator:** 1.0 FTE will be allocated to the Regional Behavioural Health Service Model. The position will require recent health care expertise and leadership/management skills. This role will be essential in navigating and understanding the Regional Behavioural Health Program within the North West LHIN. The role will manage and support the specialized unit, by providing leadership to the point of care staff. The role will align in partnership with the North West Community Care Access Centre Case Manager for system integration, engagement and client navigation. This role will have received intense education and training (as outlined in schedule G of the Behavioural Supports Ontario Performance Agreement), to safely and effectively manage residents with responsive behaviours. The role will report to the Director of Care of the long term care home that houses the specialized unit. The role will be expected to be a change agent, support and facilitate change management, have QI knowledge and will work closely with the North West LHIN IF and HQO Coach. The role will champion QI/IF at the unit level with, Long-term Care Home and system partners aligned with the Regional Behavioural Health Service Model.

- **North West Community Care Access Centre Regional Case Manager:** The FTE will be allocated to North West CCAC, however the position will be housed in the Regional Behavioural Health Service Model Specialized Unit. This role will be expected to provide system navigation and intensive case management (across all sectors) for the older adult with responsive behaviours. The position will be a knowledgeable expert in psychosocial supports for caregivers/clients in the community, Long-term Care Home and acute care settings. The role will be part of the inter-professional team and assist with the development and implementation of standardized assessment tools, referrals and care planning. The role will lead the spread of standardized assessments, tools and referrals across sectors. The role will align closely with the Psycho-geriatric Resource Consultants and be a part of the admissions and discharge team with the specialized unit.

- **Alzheimer Society-Public Education Coordinator:** The allocated funding will allow for the current Public Education Coordinator position to be a 1.0 FTE. Currently, the role is 0.5 FTE. The role will align with First Link services, Wesway Respite services, primary care, acute, Long-term Care Home and community settings to provide support, advice, guidance and educational needs. This position will support the client and caregivers within their current living environment, in particular clients that are newly diagnosed with the goal of providing supports to remain at home in the community. The position will have received intense education/training (as outlined in schedule G of the Behavioural Supports Ontario Performance Agreement) including QI methodologies, facilitation, counselling and coaching skills. It is expected that this role will provide training to partners across the continuum of care. The role will take on an enhanced role of a “peer to peer” support lead that allows for point of care to debrief about specific incidents.

Additional Information

14. Enclose a summary timeline in a separate schedule.

Please refer to North West LHIN Behavioural Supports Ontario Implementation Timeline attached.

Q14 - NW LHIN PMO Work Plan - BSO QI D

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.

As outlined in question 2 in response to system-wide accountability, the LHIN will implement a performance, measurement and evaluation plan as follows:

I. Service Accountability Agreements with health service providers receiving direct Behavioural Supports Ontario investment will not only reinforce the Behavioural Supports Ontario objectives of improved client and caregiver experiences, but also reiterate the need to change practices to encourage system-wide delivery of care and inter-professional collaboration. Specifically, the Service Accountability Agreement will support the need to develop system-wide delivery of care and inter-professional collaboration, and will hold the providers accountable for adoption of leading/best practice (i.e. implementation of care plans, timely deployment of mobile outreach resources, timely assessments and timeliness/ease of access to the virtual ward inter-professional team) with the aim of reducing avoidable transfers to hospital or readmission rates to the RBHP. To achieve these ends provisions will be set in the Service Accountability Agreements to ensure ongoing commitment to quality improvement, demonstrated through leadership participation in quarterly QI status meetings, leadership and staff participation in QI events including PDSA and Kaizen , staff training in IHI Open School (i.e. specifically for the RBHS Care Coordinator) and change management courses which may be offered by the LHIN, and a demonstrated commitment to ongoing QI, demonstrated by PDSA cycles.

   Further, the North West LHIN will leverage experience gained through other cross-sector initiatives such as Nurse Led Mobile outreach, with a requirement for regular cross-sector performance evaluation and management of the Behavioural Supports Ontario inter-professional team (including both the in-house and mobile outreach teams) hosted by the Regional Behavioural Health Service Model Specialized Unit. This will enable partner organizations to provide feedback on the care experience being delivered in/to their sites by the Behavioural Supports Ontario inter-professional team, identify areas for quality improvement and reinforce the expectation of equitable access to the team(s) across the region. The LHIN will also establish indicators related to the achievement of specific milestones/activities within certain timelines, during the implementation stage

over the first year of the project. In developing these indicators, the LHIN will leverage leading practice identified in early adopter LHINs.

II. Service Accountability Agreements between the North West LHIN and other providers not receiving direct Behavioural Supports Ontario investment at this point in time (i.e. other Long-term Care Home operators, hospitals, and community support services) will identify the intended system change resulting from Behavioural Supports Ontario investment. Specifically, Service Accountability Agreements with providers will reflect Behavioural Supports Ontario objectives, MOUs with the Long-term Care Home Regional Behavioural Health Service Model provider as appropriate, and key enablers of system flow linked to LHIN strategic directions in the following manner:

- effective use of system resources,
- commitment to continuous quality improvement (such as participation in IHI Open School and Facilitated Quality Improvement initiatives
- commitment to participate in PDSA cycles and other Quality Initiatives led by the Regional Behavioural Health Service Model)
- Commitment to providing the appropriate care in the appropriate setting (i.e. a focus on reducing potential for "Alternative Level of Care" within the RBHP).

As contracts are negotiated, specific reporting requirements and associated indicators will align with the objectives and reporting timelines set out in Schedule "I" of the Behavioural Supports Ontario Funding Letter.

Baselines will be established on historic system performance derived from CIHI or Intellihealth databases as appropriate and leveraging North West LHIN Alternative Level of Care data sets. Further, any metrics associated with intended system performance that are not currently measured or where a new service is being introduced (i.e. indicators related to LOS for the RBHS) targets will be identified based on leading practice research, experience in other LHINs and, ultimately, intended system flow and performance. Targets relating to Quality Improvement will be determined by the North West LHIN Behavioural Supports Ontario Team, in consultation with HQO as appropriate, and validated by the broader North West LHIN Behavioural Supports Ontario Project Team Targets will be formally monitored on a quarterly basis and will be supplemented by anecdotal evidence from the Behavioural Supports Ontario Project Team and Behavioural Supports Ontario Operational Team to enable the LHIN to evaluate the appropriateness of the new indicator and associated targets.

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

BSO allocation Dec 15 2011.xlsx

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

As outlined above, throughout the first year of implementation (to December 2012), the North West LHIN will continue to lead the North West LHIN Behavioural Supports Ontario Project Team in its advisory and design capacity to ensure system-wide alignment and coordination and forge linkages with other networks and partnerships as appropriate. The North West LHIN Behavioural Supports Ontario Project Team includes representation from:

- St. Joseph's Care Group Long Term Care
- Revera Long Term Care
- City of Thunder Bay Long Term Care
- Regional Long Term Care Providers
- Thunder Bay Regional Health Sciences Centre
- Saint Joseph's Care Group Post Acute Care
- North West CCAC
- City of Thunder Bay Psycho geriatric Mobile outreach
- District of Kenora and Rainy River Psycho geriatric Mobile outreach
- Wesway Respite
- Alzheimer's Society of Thunder Bay
- Physicians
- Consumers

Finally, at an executive level, sponsorship, leadership and championing change will continue to be led by the Centre of Excellence for Integrated Seniors' Services Steering Committee and reflected in the work of the RBHP operations group. As outlined above, the Centre of Excellence for Integrated Seniors' Services Steering Committee is co-chaired by:

- **North West LHIN:** Laura Kokocinski, CEO
- **St. Joseph's Care Group:** Tracy Buckler, CEO

See Appendix 1

Appendix 1: Behavioural Supports Ontario Project Terms of Reference

PURPOSE

To provide local leadership, advice, guidance and support for the development and implementation of the North West LHIN-wide Action Plan. LHIN staff, health service providers and other local stakeholders involved in dementia care for seniors will collaborate on comprehensive behavioural supports for the residents of the LHIN.

BACKGROUND

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 and Alzheimer related diseases or other neurological conditions and their caregivers is both a provincial and North West LHIN priority.

The Ministry of Health and Long-Term Care (MOHLong-term Care) recently announced the launch of The Behavioural Supports Ontario (Behavioural Supports Ontario) Project that will implement the BSS Framework for transforming the health care system for Ontarians for this population. The Project will facilitate seamless, inter-professional care for individuals with complex and responsive behaviours.

As a component of the Behavioural Supports Ontario Project, the MOHLong-term Care will be providing funding for health human resources for behavioural support staff into the Long Term Care (Long-term Care) sector. This will enhance service and care delivery to residents of Long-term Care with responsive behaviours. In addition, funding for allied health human resources outside of the Long-term Care sector will also be provided. This will allow for the creation of mobile inter-professional teams, localized clusters of behavioural services and community resources.

GOALS, OBJECTIVES AND DELIVERABLES

- Support the development and implementation of an integrated Behavioural Supports Ontario model in Long Term Care (Long-term Care) that provides person-centered, timely, equitable access, high quality, evidence-based services in an efficient, effective and sustainable manner, with emphasis on inter-professional collaboration and standardization;
- Identify innovations in the delivery of an integrated Behavioural Supports Ontario model across the health system continuum, in alignment with the Ontario BSS Framework for Care (2011);
- Provide advice on processes that support quality care and safe environments for the identified population;
- Identify and address barriers and provide enablers for success to execute the action plan;
- Review progress of the implementation plan in achieving aims;
- Provide input to quality improvement methodologies in relation to the Behavioural Supports Ontario model in Long-term Care;
- Provide advice on the evaluation framework to support the sustainability of the change initiatives;

REPORTING RELATIONSHIP

The North West LHIN Local Project Team will provide input to the internal North West LHIN Behavioural Supports Ontario Project Team which in turn reports to the provincial Behavioural Supports Ontario Coordination and Reporting Office (CRO).

FREQUENCY OF MEETINGS

Meetings will be held every 2 weeks or less frequently as determined by the chair. Meetings will be 2-hours in duration. Teleconference and/or videoconferencing will be made available to ensure access for participants outside the City of Thunder Bay. Ad-hoc teleconference calls will be held, as needed. Discussion via e-mails may occur, as required.

ROLE OF THE CHAIR

The North West LHIN Behavioural Supports Ontario Project Team will be responsible for facilitating the meetings and providing leadership through to March 2012, at which point the Chair will be reviewed. Agenda and meeting materials will be issued in advance of meetings. Participation in subcommittee working groups may be required. The structure of these subcommittee working groups and the meeting frequency will be based upon the project's needs. Alternates will be at the discretion of the Chairs.

MEMBERSHIP

The Project Team will reflect representation from all LHIN funded and non-LHIN funded health service providers and non-health providers required to provide expertise and diverse perspectives related to the continuum of care for the target population.

Each member will leverage their power, influence and authority at whatever level possible to advance the work of the Behavioural Supports Ontario Project.

MEMBER RESPONSIBILITIES

- Attend meetings as scheduled;
- Review materials and participate in group discussions at the meetings;
- Engage and follow up with respective LHIN and Behavioural Supports Ontario Project Team;
- Provide leadership and support for group recommendations;
- Act as a communication point to share project information as appropriate

Members will be 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 North West LHIN, and affected organizations. Additionally, an individual member may represent multiple constituents.

North West LHIN BSS Project Team				
	Member	**Title**	**Organization**	**Sector**
1	Paulina Chow	Vice President of Long-term Care Services	St. Joseph's Care Group (SJCG)	Long-term Care Home Sector
2	Mary Perkovic	Director, Acute & Rehabilitation Mental Health	SJCG/TBRHSC	Mental Health and Acute Care Sector
3	Dr. Patricia Lepage	Geriatric Psychiatrist	SJCG	Mental Health Sector
4	Joanne Lent	Executive Director	Roseview Manor	Long-term Care Home Sector
5	Wendy Kirkpatrick	Administrator	Grandview Lodge City of Thunder Bay	Long-term Care Home Sector
6	Paula Donylyk	Senior Director, Client Services	North West CCAC	CCAC
7	Cathy Covino	Senior Director, Quality and Risk Management	TBRHSC	Acute Care
8	Kevin Queen	Administrator	Kenora District Homes	Long-term Care Home Sector
9	Sandy Skirten	Director of Services	Canadian Mental Health Association Kenora	Mental Health
10	TBD	Consumer/ User of Service/ Lived Experience	Consumer/ User of Service/ Lived Experience	Consumer/ User of Service/ Lived Experience
11	Cindy Backen	Psycho-geriatric Resource Consultant,	SJCG Seniors Mental Health Mobile outreach Team,	Mental Health Sector
12	Alison Denton	Executive Director	Alzheimer's Society	Community
13		Primary care/ Family Physician	Physician	Physician (i.e., family physician and/or specialist)