South East **LHIN**

1B

A model *for* Health:

Behavioural Supports Ontario Action Plan

re-designing local health supports for Ontarians with responsive behaviours

Revised 26 Oct 2011
Re-Submitted 28 Oct 2011
For Distribution

Ontario
Local Health Integration Network

Part 1B: Notice to Reader

This is the second of two submissions to the Ministry of Health and Long-Term Care (MOHLTC) as part of the LHIN's Behavioural Supports Ontario Action Plan. This submission, responds to specific questions which describe the South East LHIN's planning and implementation activities to redesign psycho geriatric care services to better serve the needs of older Ontarians. This document should be read in the context of the entire submission.

Should you require a copy of the entire submission, please contact us at:

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Part 1A MOHLTC Action Plan Template (submitted 4 OCT 2011) Table of Contents

1B (This Document) MOHLTC Action Plan Template: Responses to questions 8 – 17

Submitted 14 OCT 2011. Includes current drafts-in-progress of operational and implementation planning materials; demonstrating the South East's overall operational readiness for program launch in FY2011-2012 Q4

Revised 26 OCT 2011. Draft one-time fiscal budget inserted.

Part 1B - Table of Contents

Q.8 What training and knowledge transfer services/processes are presently in place for professionals working with this population?

Q.1(a) What Quality Improvement Capacity / Resources are available to the redesign project

Quality Improvement is embedded in Roadmap

The LHIN's Regional Clinical Services Roadmap project (which is the framework under which the redesign will occur) has at its foundation, a quality improvement methodology. Consequently, the rationale behind the LHIN's BSS project, its aims, measures, change strategies and implementation are predicated on the change management 'model of improvement' methodology. The extension of our existing approach provides an immediate LHIN-wide contextual framework for discussing goals, objectives, opportunities and challenges that would otherwise need to be painstakingly built.

Mobile teams will have a mandate as "change agents"

With a mandate to align resources to better meet the needs of the target population , the mobile teams will be developed with health system quality improvement, in support of better care for this population, as one of their core objectives. Additionally, quality measures, based on the expected positive outcomes of services redesign, will enable the teams, the steering committee, the lead provider and the LHIN to monitor the progress of our work, make course corrections where results are not as expected, and demonstrate to stakeholders and the ministry the overall success of this project.

Senior LHIN expert resources participated in development

Over the formative development of the BSS plan, senior LHIN staff, with experience in health systems design, LEAN methodology, and the implementation and evaluation of quality improvement processes has been directly involved in the conceptualization, concept development, and operational planning for the redesign. This degree of interaction in all material phases gives the LHIN confidence that the redesign and our implementation approach are sound, and that the expected improved outcomes will materialize.

System impacts expected from both formal and informal change management activities

With a commitment to drive change through continuous quality improvement, the mobile teams will serve not only as teachers and mentors but also as catalysts to their peers to evolve their clinical practice to higher standards. As the mobile teams demonstrate approaches and model appropriate interaction with clients with responsive issues, clinicians will begin to adopt similar approaches, thereby improving the patient experience through cultural osmosis. Where leadership by demonstration fails motivate necessary change in the continuum of care, honest and open communication with staff and leadership at the HSP will commence to identify and quantify any barriers to change and participate in the development of a collaborative plan to reduce/eliminate them.

Embedded QI resources

In support of the overall redesign objectives, Providence Care will be permanently assigning 0.5 FTE Quality Improvement Facilitator to the mobile teams.
The IF, informed by the objects of the redesign, the hospital's enterprise-wide Quality Improvement Plan, and supported by the hospital's QI team (4.0 FTEs) will ensure the ongoing commitment to:

- effective, quality improvement using LEAN methodologies and principles, etc.
- monitoring and follow-up on adverse events
- QI coaching of quality teams using core competencies in root cause analysis, failure modes effects analysis, risk mapping, PDSA process, etc.
- documented Quality Improvement Plans are in place in areas/units/ facilities where the mobile teams operate
- disseminate the SE LHIN client value statement : "Hear me, guide me, protect and understand me"

Q.8 (b) Behavioural Support expertise available to program

Provincially-acknowledged clinical leadership

The LHIN is fortunate to have a provincially-recognized expert in responsive behaviour as our clinical lead for this project. **Dr. Ken Le Clair,** clinical director of Providence Care's Regional Psychiatry Program and is the Departmental Chair of Psychiatry at Queen's University has led the development of this redesign from the outset.

Additionally, Dr. Dallas Seitz, an associate professor of psychiatry at Queen's University and a member of Providence Care's Geriatric Psychiatry Services will be working with Dr. Le Clair to ensure that the program meets both its change management and patient outcome targets for this vulnerable population.

A cadre of professionals with experience in this service model will form the mobile teams

Providence Care has been trialing iterations of the Mobile Team concept for several years. The redesign provides the opportunity to merge the skill sets of providers currently working in disparate teams, resulting in mobile teams that can provide a cohesive and coordinated care. The following is a summary listing of the types of models the hospital has implemented and what skill sets they will bring to the mobile teams.

Services / Programs	Service / Program Objective(s)
○ Mobile Interprofessional Coaching Team, (MICT) ○ Inter-sectoral-Mobile Interprofessional Coaching Team (I-MICT) ○ Mobile Interprofessional Coaching Team II (MICTii)	… ensure the timely exchange of information about responsive behaviours among sectors and professions

Services / Programs	Service / Program Objective(s)
○ Community High Intensity Treatment Team (CHITT) – a best practice model for providing residential care to people with mental illness.	… develop and implement a psycho geriatric equivalent which would support seniors with long-standing mental illness, addiction, dementia, with co-morbidities

Services / Programs	Service / Program Objective(s)
○ Ad-hoc support and assistance for people living with responsive behaviours – provided by the urgent needs staff at Providence Care (MHS)	… priority is to extend the reach of these services beyond existing boundaries

Services / Programs	Service / Program Objective(s)
○ Tier II/III mental health services divestment activities – the LHIN is monitoring the implementation of HSRC Directions regarding the former Provincial Psychiatric Hospitals in Kingston and Brockville	… leverage the experience of placing long-stay mental health patients into community and LTCH settings to advance BSS capacity

The members of these teams come to their new roles pre-prepared with specific strategies and approaches that will make significant and sustainable improvements patient care.

Q.8 (c) How will training efforts be focused to optimize the creation of knowledgeable care teams in both the behavioural supports and quality improvement dimensions?

The Capacity Enhancement Plan (attached as an appendix to this submission) provides a detailed approach to staff development which fully accounts for teams that are knowledgeable in both these dimensions. The plan, based on the principle that understanding the person in context is crucial in order for information to be fully received, focuses on:

- Methods for aligning and testing knowledge transfer and skill building capacities, as they pertain to professional, urban, and rural populations.
- Framing change management and knowledge transfer positively; focusing on 'what works' and how to expand, rather than 'what doesn't and how to fix'; which also provides the learner an existing model with which they have experience to use to advance their capacities in other areas
- Teaching that quality and knowledge transfer is an iterative process comprised of discovery, integration, development of new knowledge and application into daily practice.

Quality improvement training will occur in two ways depending on the target audience, their QI projects and their potential for further capacity in quality improvement:

- Direct Education (half or full-day sessions delivered to a group or individual)
- Service Learning (i.e. QI Teams will receive "just in time" training as required)

Q.8 (d) What knowledge transfer structures/pathways currently exist within that can be used for this project?

Health Professionals Engagement: Clinical learning and professional development

Health practitioners within the South East LHIN have organized themselves into networks which support the evolution of clinical improvement, continuing education and other activities to generally advance the care of older residents, including those

with responsive behaviours. Comprised of both institutional and community based providers, this network will form an important part of the intelligence gathering for the redesign and will ensure that knowledge transfer opportunities are maximized.

The Intersectoral Mobile Interprofessional Coaching Team (I-MICT) at Providence Care developed, disseminated and applied intersectoral knowledge, tools, curriculum and learning resources to assist in information and resource translation in seniors' mental health. The partnerships and relationships developed through this established the foundation for knowledge transfer and capacity building

Ongoing stakeholder engagement and development / leverage of knowledge communities

Targeted in-person and virtual exchanges in the past year created a network of stakeholders and supporters from across the LHIN geographic area. Members include LHIN staff, community providers, consumer support organizations like the Alzheimer Societies, primary, acute, and long-term care providers, the CCAC, and specialty mental health hospital staff (inpatient, outreach and crisis services).

In addition to formal and informal in-person knowledge transfer opportunities, access to OTN (both live and pre-recorded sessions) and internet venues (like webinars) will be employed to link health care providers across the south east; enabling opportunities for knowledge transfer and capacity building.

The Roadmap project has considerably increased the number of opportunities to collaborate and share knowledge and has broadened participation to include non-traditional partners, like police services, who also deal with this population of need. The scope and magnitude of collaboration is more impressive considering that the Roadmap was launched a little over a year ago.

Other pathways

Other pathways to transfer knowledge include:

- Clinical support arrangements for mental health from Providence Care to health service providers in the southern half of Lanark County and the United Counties of Leeds and Grenville.
- Clinical education opportunities sponsored by Queen's University.
- Effective and sustainable 'crosswalks' between cross-sector stakeholders; using 'cross-walk leads' to develop opportunities for knowledge transfer and capacity building opportunities.
- Existing capacity in QI linked to LTC Homes participating in Residents First and primary care teams participating in the Advance Access initiative

Q. 9 How does the program build on current system capacities and capabilities

Redesign, by definition, integrates programs and services

The intended outcome of this redesign is to ensure that people, resources and service offerings are properly aligned to meet the needs of people with responsive behaviours. This will result in integration activities, as defined by the *Local Health System Integration Act, 2006* as the expertise currently accessible through outreach teams,

resource consultants, transition teams and knowledge transfer teams will necessarily be redeployed to support the mobile teams; supplemented where necessary by new hires.

Under Aegis of Roadmap

As BSS falls under the Regional Clinical Services Roadmap, the existing governance and accountability structure will be used. The clinical work team is responsible for the development of the project with system partners and reports to the Roadmap Steering Committee.

Local Health System Coordination already underway with Roadmap

In our response to question two, the LHIN provides details regarding the Roadmap project. With a robust executive membership, dedicated project management resources, and extensive input from clinicians (through work teams) and the community (through ongoing engagement activities), the South East LHIN has a purpose-built change management infrastructure that will be leveraged to advance the redesign.

In addition to the Roadmap framework, the BSS clinical work teams will have access to an advisory group (appointed by the LHIN), comprised of individuals who are already engaged and committed to advancing BSS services. Areas/sectors represented on the advisory group include, health policy (LHIN), clinicians who care for this population, support organizations, people affected by the condition, and educators/researchers.

Operations and logistics

The LHIN has designated Providence Care at the lead health service provider and will amend all necessary service accountability agreements to include funding conditions, terms, metrics and targets for this project.

ER/ALC Support through Home First and other projects

The BSS project team has developed and maintained ongoing supportive working relationships with LHIN, CCAC, and hospital staff involved in addressing emergency department waits and reducing the incidence and prevalence of alternate level of care patient designations (ER/ALC).

Collaboration between implementation team and hospital/LHIN staff responsible for the ER/ALC strategy has already demonstrated value. The project team has gained valuable knowledge about the challenges inpatient units and ER staff face when presented with a person with responsive behaviours. These insights have and will continue to provide continuing opportunities for engagement and collaboration to develop sustainable solutions that support the system redesign, which will address:

- ~ Training for hospital staff on appropriate management of patients exhibiting responsive behaviours
- ~ Strategies to reduce/minimize/avoid triggering responsive behaviours
- ~ Joint development of supports for inpatient areas / ER including the screening tools for patients at high risk of developing responsive behaviours, assessment protocols, carepaths and diversion plans, as appropriate
- ~ Codification of clinical best practice into the above
- ~ STAT consults / support / referral for patients exhibiting responsive behaviours.

Pre-Proposal Collaboration between Providence Care and HSPs

As described above, the project team has demonstrated success by creating and maintaining closer working relationships with key staff members at HSPs LHIN-wide. By identifying clinically appropriate patient outcomes, recognizing approaches that work, and jointly developing strategies to increase clinical effectiveness where patient results are less robust, they have shown providers that our singular vision is to improve the care we provide.

Providence Care, the designated lead health service provider, has a history of successful collaboration with its community partners, area hospitals and the CCAC. Their most recent collaborative effort yielded a series of clinical decision algorithms (originally included in the LHIN's expression of interest), targeted continuing education programming, and QI driven service improvements.

Built on stable clinical and change management foundations

The program is built on three very stable psychogeriatric programs geographically spread across the LHIN. They are well supported by the health service providers operating them, and they have considerable experience dealing with this patient population.

The LHIN, through the Roadmap project, has also created a robust project management office, as well as skills and experience in the development and implementation of projects among LHIN staff. As this project falls under the aegis of the Roadmap, it will fully benefit from the existing infrastructure.

Q. 10 How is sustainability built into the redesign

Provincially-acknowledged clinical leadership

The LHIN is fortunate to have a provincially-recognized expert in responsive behaviour as our clinical lead for this project. **Dr. Ken Le Clair,** clinical director of Providence Care's Regional Psychiatry Program and is the Departmental Chair of Psychiatry at Queen's University has led the development of this redesign from the outset.

Additionally, Dr. Dallas Seitz, an associate professor of psychiatry at Queen's University and a member of Providence Care's Geriatric Psychiatry Services will be working with Dr. Le Clair to ensure that the program meets both its change management and patient outcome targets for this vulnerable population.

A cadre of professionals with experience in this service model will form the mobile teams

Providence Care has been trialing iterations of the Mobile Team concept for several years. The redesign provides the opportunity to merge the skill sets of providers currently working in disparate teams, resulting in mobile teams that can provide a cohesive and coordinated care.

Sole source of services

Sustainability of the project is assured as the existing modes of providing care will be transformed into the proposed model through the redesign. As there will only be one mode of program delivery, the mobile teams will be the sole source of this service within the LHIN.

Local Health System Coordination already underway with Roadmap

In our response to question two, the LHIN provides details regarding the Roadmap project. With a robust executive membership, dedicated project management resources, and extensive input from clinicians (through work teams) and the community (through ongoing engagement activities), the South East LHIN has a purpose-built change management infrastructure that will be leveraged to advance the redesign.

Q.11 How will knowledge transfer occur?

Knowledge transfer is expected through formal and informal interactions

With a commitment to knowledge transfer through the lens of continuous quality improvement, the mobile teams will employ a myriad of tools and techniques to both formally instruct and informally demonstrate and persuade those with whom they interact. They will not only serve as teachers and mentors but also as catalysts to their peers to acquire knowledge in response to an environment rich with ideas. As the mobile teams demonstrate the application of knowledge and provide informal training and mentorship, specific nuances to improve understanding and refine context will occur. Over time, clinicians will begin to adopt similar approaches, thereby improving the patient experience through cultural osmosis. Where this approach fails to inspire the acquisition and application of new knowledge in an individual, they will start to feel a rift as the culture evolves towards knowledge advancement and leaves them further and further out of step. Eventually this will result in the transition to professionals more closely aligned with the program objectives.

Q.12 Partners for Knowledgeable Care Team and Capacity Building

Behavioural Support Service Partners - originally framed as "System Coordination" Partners

(The LHIN has taken the liberty of amending this question. The way this question, and questions 3 and 12 were framed suggested some degree of disparity when there is little to none. In a model where interdisciplinary and inter-sectoral are key words to describe the model to be used, describing them separately seemed inconsistent with our objectives of this redesign).

All providers, the people our providers care for, and the communities we serve, are our partners.

Ultimately, every health service provider who provides services to people with responsive behaviours, as well as caregivers and family members will be our knowledge management and capacity building partners. Without them, there is no frame or context in which to develop a strategy, no one to transfer knowledge to, and no one to evaluate the degree of knowledge absorption (by which measure we can change the means of knowledge transfer, making it iteratively more absorbable).

Local Health System Coordination = immediate knowledge transfer partners and a means to deliver

In our response to question two, the LHIN provides details regarding the Roadmap project. With a robust executive membership, dedicated project management resources, and extensive interaction with clinical and medical staff from across the region, the South East LHIN has a purpose-built infrastructure that makes all providers partners in the development of knowledgeable care teams and building capacity.

Beyond the existing formal and informal means described above, we are partnering with Queen's University to provide the academic and research components implicit in the building of knowledgeable care teams and developing capacity. The university is fully affiliated with Providence Care and is fully aware of the importance of successfully transferring this and future knowledge to current learners as well as professionals already engaged in their careers.

Q.13 Describe the deployment of staff for the redesign project

A full deployment plan is provided for in the Human Resources Plan provided as an appendix to this submission.

Each team is comprised of:

RN(EC):	1.00 FTE Nurse Practitioner to provide overall leadership and team support
RN/RPN:	3.69 FTE (provides coverage during business week and off hours emergency coverage)
PSW:	5.71 FTE (provides 24/7 coverage)

** 0.39 FTE Psychiatrist allocated to support each team*
**0.17 FTE Quality Improvement Facilitator allocated to support each team*

A regional coordinator and FTE psychiatry support provide overall coordination to ensure LHIN-wide consistency and reach.

The key deployment features for this redesign project include:

- **East**
  - Team 1 will be responsible for supporting the needs of clients and health service providers within the eastern third of the LHIN (comprised of the southern half of Lanark County, and the United Counties of Leeds and Grenville
- **Centre**
  - Team 2 will be responsible for supporting the needs of clients and health service providers within the central third of the LHIN (comprised of the City of Kingston, and the counties of Frontenac and Lennox and Addington.
  - As this is also the site of Providence Care's Mental Health Site, the newly formed Behavioural Health Inpatient Unit will be located in Kingston as a regionally-based resources accessed through the mobile teams
- **West**
  - Team 3 will be responsible for supporting the needs of clients and health service providers in the western third of the LHIN (comprised of Hastings and Prince Edward Counties).

Q14. Project Timeline

2011 -2012	**Human Resources**		**Capacity Enhancement**
Month	*Activity*	*Span*	*Activity*
October	Finalize positions, number of positions and status required Develop, revise, finalize job descriptions for each Post, advertise positions throughout SELIHN and other cities including Toronto, Ottawa and Sudbury Post, advertise positions throughout SELIHN and other cities including Toronto, Ottawa and Sudbury Providence Care sponsored career fair/open house Contact key educational partners and community partners to advise of initiative and open positions Develop interview booklets and scoring (including pre-screen questions)	Activities commence	Hire Knowledge Broker, Project Coordinator and Support Begin to identify protocols, frameworks, resources, tools and programs to support capacity building across the core competencies Create detailed curriculum for new hires, existing staff, organizational leaders, individuals, caregivers and volunteers Purchase and set up LMS; appropriate supportive technology as needed Create a detailed evaluation plan Identify existing staff in service learning positions and those critical to implementation who will be trained as coaches Identify platforms for engagement of persons, caregivers and volunteers Identify key organizational leaders from across the system Begin identified Quality Improvement strategies from Value Stream Analysis Identify target audience and sites for QI projects and education Service learning for local improvement teams (**ongoing)** Continue to seek input from health consumers and their caregivers (**ongoing**)

2011 -2012	**Human Resources**		**Capacity Enhancement**
Month	*Activity*	*Span*	*Activity*
			Share outcomes of local BSS conversations hosted by the Mental health, Addictions and Behavioural Issues Community of Practice Begin to identify BSS protocols and tools and populate online knowledge platform (**ongoing**) Develop and implement a BSS communication plan for the South East to enable stakeholders to receive information and engage in exchange (**ongoing**) Develop and implement plan for engagement with Champlain, North West and North East (**ongoing**)
November	Screen applications; preliminary interviews; second in-person interviews; panel selects candidates and verbal offers of employment made Notice periods; CPIC; Vulnerable Sector Screen; reference checks; dependent on above – written offers made	Through to March 2012	Begin training of existing staff as 'coaches' of BSS best practices Begin training of organizational leaders Ongoing QI strategies as prioritized from the Value Stream Analysis progressing from testing to implementation Conduct QI education sessions and provide ongoing service learning to build QI capacity
December	Employment starts		Begin training new staff **contingent on recruitment plan for new hires** Begin curriculum programs with persons, caregivers and volunteers

2011 -2012	Human Resources		Capacity Enhancement
Month	*Activity*	*Span*	*Activity*
January	Orientation with go live expected for end of month		

Q15. Performance Measurement and Evaluation Plan

Local indicator working group

The South East LHIN BSS performance measurement group has been established to support indicator development and collaboration with relevant stakeholders. Its membership includes representation from the LHIN (knowledge management team), Providence Care, the CCAC as well as representation from HSPs participating in the redesign.

The group will ensure that its work aligns with that of the provincial data measurement and evaluation group as it adapts frameworks for performance measurement, indicators and evaluation strategies to the BSO initiative.

Preliminary work plan:

Stay current on action plan submission and work at the provincial level to ensure that indicator development supports local activities and aligns with provincial direction.

Ensure that any proposed indicators are valid/supportable by assessing data availability, quality, validity and relevance.

The LHIN's knowledge management team will collaborate to develop and recommend a standard set of measures to be considered for further development, which may include strategies for improved data collection and measurement and reporting strategies.

Report on activities to the Early Adopter Steering Committee as well as other LHINs on a proposed Evaluation Framework.

Support the preparation of the provincial RFP that aims to establish and compute the measures proposed by the provincial BSS Performance and Evaluation Workgroup.

Engage successful RFP respondent to implement evaluation and performance measurement strategies.

Indicator development

The starting points for development of indicators for the SE LHIN BSS Performance and Measurement Group include clarification on the target population for BSS and review of the three measures proposed by the MOHLTC. The specifics of the definition are important for determining whether any data sources, related attributes and frequency of reporting match

the criteria outlined for the BSS target population as well as the parameters of the BSS initiative. Review of the provincial measures is critical to ensure that what is being proposed can satisfactorily evaluate the impact of BSS efforts. The identified measures are:

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

Consideration will then be given to indicators proposed by regional health system providers. As with the provincial indicators importance, computation, reliability, validity, timeliness, responsiveness, data quality, trend and target setting potential will all be assessed. Comparison to provincial indicator frameworks will also be made to ensure consistency and standardization of indicator development. To the extent possible indicators that support continuous improvement or program development strategies will also be considered for inclusion.

In advance of our work with BSS staff in this regard, the LHIN is developing a set of 'probable' indicators which will be provided to the various teams as options to be considered:

<u>Evidence of System Coordination:</u>
- Family/Caregiver satisfaction involvement
- Caregiver Burden
- Patient/Caregiver Quality of Life
- ALC LOS for Individuals being Discharged Home
- ED/Acute Care visits without prior MH contact
- Time to first CCAC visit following ER/Acute care discharge
- Transitions between home/Acute Care/LTC
- Number of redundant/duplicate assessments

<u>Evidence of Inter professional Collaborative Service Delivery</u>
- Knowledge of BSS in Primary Care
- Awareness and Referral of CCAC/Alzheimer Society Services in Primary Care
- Delay in Time from Referral to First BSS Contact

<u>Evidence of Improved System Capacity</u>
- Knowledge and skills for front-line providers
- Quality of Care

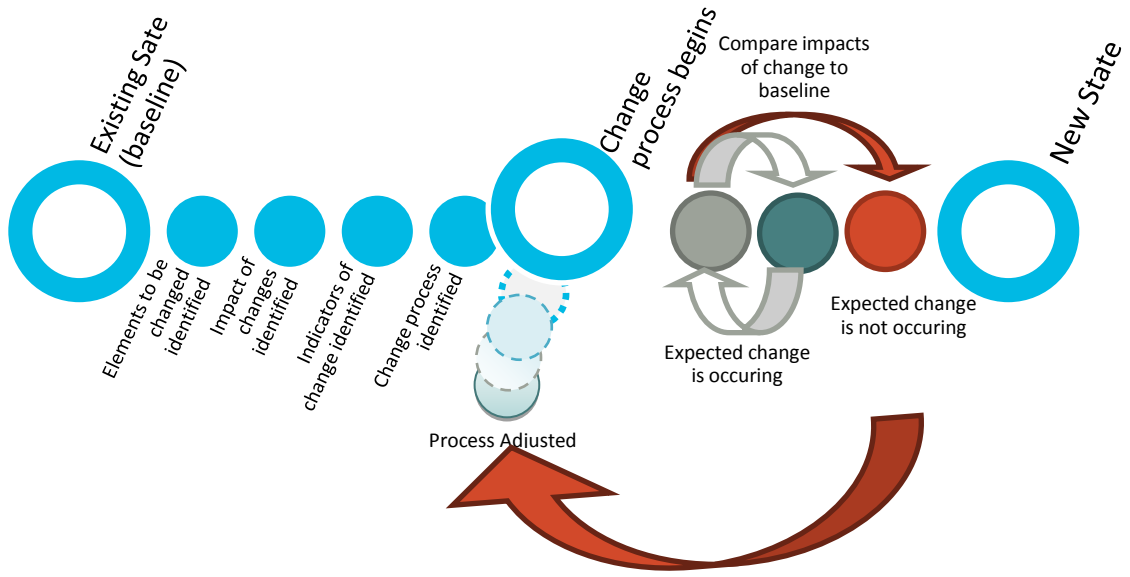
Monitoring and Evaluation Process

This schematic shown below provides a template for all performance, measurement and evaluation of processes in the redesign. It is useful as it demonstrates a common approach to addressing performance measurement in all three pillars, and each layer of evaluation can be overlaid with another; enabling evaluation in multiple facets simultaneously.

For instance, the implementation of Mobile Transition Teams could have:

- One performance evaluation path for system coordination (how seamless is it now? how seamless will it be once we are done?)
- Another performance evaluation path for service delivery (how equitable and timely was access before? How equitable and timely is access now?)
- And a third Knowledgeable Care Team and Capacity Building
- And possibly a fourth (or more) measuring ancillary benefits like 'readiness for change' before and after interaction with BSS framework

Performance, Measurement and Evaluation of Processes



Indicators of performance with respect to change management need to be developed with the team that is implementing the change. This assures that the indicator is well understood, is agreed that a change in the indicator is indicative of change towards the New State, and that everyone is 'pulling in the same direction'.

Once indicators have been selected, targets for each are set, as well as review periods for each indicator.

Risks and Mitigation Strategies

There is strong consensus among the SE LHIN BSS Measurement and Evaluation group that there would be major challenges trying to accomplish all that has been set out in the work plan before the end of the fiscal cycle. It was also noted that the time constraints may result in aspects that might be overlooked or dependent components lagging behind others and causing a bottleneck of deliverables before the end of the year. Of particular concern is whether the selected consultant from the RFP can confirm the final measures and provide estimates for local evaluation within the given timelines.

Given these constraints the SE LHIN BSS Measurement and Evaluation group will begin the process of identifying available datasets and deriving methods that can be used to estimate a manageable selection of the measures proposed at both the provincial and local levels. All efforts would be made to ensure that these are consistent with provincial recommendations and the selected consultant. Limitations of the data and/or methodology will be noted so that the local teams understand how the results can be interpreted and applied. This strategy would however ensure that there would be a mechanism for evaluating any impact that could be estimated from available data. Since the strategy only takes available data into consideration there would not be means of conducting any program evaluation if the requisite data does not exist or is not sufficiently timely given the parameters of the BSS project.

Q16. Budget, work plan and resource plan

Estimated annualized costs

A complete budget and work plan is provided for in the Draft Operational Implementation Plans provided as appended to this submission. The following is a summary of the estimated annualized costs which may change subject to the finalization of the Design Plan. A detailed summary of staff deployment to the Mobile Transition Teams is provided in the Human Resource Management Plan.

SELHIN DRAFT STAFF DEPLOYMENT & ESTIMATED COST - MOBILE TRANSITION TEAMS - TOTAL FOR LHIN							
Position	**Schedule**	**New funding**		**PC Re-Alignment**		**Totals**	
		FTE	**Estimated Ongoing $**	**FTE**	**Estimated Ongoing $**	**FTE**	**Estimated Ongoing $**
TOTAL SOUTH EAST LHIN							
RN / RPN	Registered Nurse / Registered Practical Nurse	11.07					
PSW	Personal Support Workers	17.13					
Additional HC Personnel	System Manager/Regional Coordinator	0.33					
	Nurse Practitioners/Team Leads	1.33					
	Psychiatrist	1.07					
	Personal Support Worker	3.40					
	Quality Improvement Facilitator	0.50					
	Sub Total Additional HC Personnel	**6.63**					
TOTAL STAFFING SE LHIN		**34.83**	$2,377,727	3.35	$302,614	38.18	$2,680,341

Estimated one-time costs

The following table identifies the estimated one-time budget for the fiscal funding the SE LHIN received as an early adopter to support the Service Redesign component of the BSO Project. These estimates will change to reflect operational and implementation requirements as the project unfolds as well as provincial priorities to be confirmed by the Early Adopter Steering Committee.

DRAFT BSO South East LHIN 1-TIME BUDGET ESTIMATES Fiscal Year 2011/12			
Category	**Item**	**Estimated**	**Category Total**
Provincial Expenses	Participation in Learning Events		
	0.5 FTE Backfill for Knowledge Transfer and Exchange		
	Evaluation		
	Sub-total Provincial Expenses		
Project Management	Project Manager Expenses		
	Sub-total Project Management		
Health Human Resources	Temporary Full Time Recruitment & Staffing Specialist 4 months		
	PC specific career fair/open house and advertising for the event		
	Internet job postings x5		
	Career fair/open house printed materials		
	Pre-employment testing @ $50 each x90 tests		
	Rellocation assistance		
	Sub-total Health Human Resources		
Capacity Enhancement **Community Engagement** **Knowledge Exchange**	**Education and Training**		
	Existing Staff		
	PIECES (30 staff)		
	GPA (30 staff)		
	U-First (30 staff)		
	New Hires		
	Registered Staff (12): PIECES/GPA		
	Non-registered Staff (18): U-FIRST / GPA/ Support		
	Individuals / Caregivers / Volunteers		
	Persons/Caregivers (30 per region)		
	Volunteers (30 per region)		
	Organization Leaders		
	Organization Leaders		
	Sub-total Education and Training		
	Human Resources		
	1.0 FTE Project Coordinator		
	0.5 FTE Secretarial Support (.03 FTE)		
	0.5 Knowledge Broker		
	1.0 FTE Improvement Facilitator		
	Sub-total Human Resources		
	Additional Expenses		
	Consulting Services		
	Sub-Contract -Knowledge Translation Mentoring - Coaching		
	Learning Management System*		
	Travel & Accommodations		
	IT Supplies, Equipment and Infrastructure		
	Stakeholder Engagement (3 meetings X 3 district)		
	Protocol and Tool Development		
	Online Survey Software		
	Sub-total Additional Expenses		
	Sub-total Capacity Enhancement / Community Engagement /		
Estimated Expenses		**$ 900,000**	**$ 900,000**
Approved Allocation		**$ 900,000**	**$ 900,000**
BALANCE		**$ -**	**$ -**

Q17. LHIN Representatives on the Steering Committee

The SE LHIN and Providence Care as the designated lead provider of the redesign are represented on the Steering Committee:

Rick Giajnorio, SE LHIN, BSO Lead and Interim Project Manager
Cynthia Martineau, SE LHIN, BSO Executive Lead / Co-Director
Allen Prowse, Providence Care Co-Director

Appendices: Draft Operational Implementation Plans

Provided separately are the detailed draft Operational Implementation Plans that supplement the SE LHIN Action Plan part 1B:

System Design Plan
Capacity Enhancement Plan
Human Resources Management Plan