South West LHIN

Developing a Behavioural Support System for Older Persons with Responsive Behaviours in the South West LHIN

Action Plan: Part B

April 5, 2012

(revision)

Ontario Local Health Integration Network

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?

There are many existing processes that support evidence informed knowledge transfer into clinical practice amongst current and future health care providers across the South West LHIN.

Organizations that provide direct training/education for healthcare professionals include:

- The Division of Geriatric Medicine, Department of Medicine at the University of Western Ontario (UWO) is committed to the advancement of research, teaching and clinical care. The Division currently consists of nine full-time academic geriatrician educator/researchers who provide support and education support to interdisciplinary health professionals, primary care physicians, undergraduate and post graduate medical students. Education, research and clinical care are the cornerstones of the program.
- The Division of Geriatric Psychiatry, The UWO's key role is to provide academic leadership within the Schulich School of Medicine & Dentistry, UWO. Functionally, the Division also contributes to clinical service provision and leadership by engaging the participation and contribution of individuals from a variety of related clinical disciplines. The Division is involved in ongoing activities for undergraduate medical education for medical students and postgraduate education in geriatric psychiatry for residents in the Department of Psychiatry. The Division participates in and is an active contributor to education of medical and nursing students at Schulich.
- Specialized Geriatric Services (SGS), St. Joseph Health Care London (SJHC), provides a leadership role for the South Western Ontario Geriatric Assessment Network (SWOGAN), which is made up of the Regional Geriatric Program (RGP) and the Regional Psychogeriatric Program (RPP). Education and capacity building across both South West LHIN and Erie St. Clair (ESC) LHIN are key functions of the Network. The following collaborative education events are offered through the SWOGAN Network, SGS, and Geriatric Mental Health Program:
    - SGS Interdisciplinary Grand Rounds – offered monthly to primary care, Long-Term Care (LTC) Homes, community agencies and hospital staff. Grand rounds are led by SGS (RGP & RPP). An interdisciplinary planning committee has been formed and made up of a variety of clinicians (Occupational Therapy, Nursing, Psychology, and Geriatrician). The Grand Round series is offered monthly and has been highly rated by participants. Topics have included: sleep disorders in the elderly, elder abuse, continence, cognitive impairment and falls prevention. The education sessions are conducted at Parkwood hospital and offered via Ontario Telemedicine Network (OTN) and webcast. All presentations are archived on the OTN website for one year. Each Grand Round session is evaluated and participants are asked to list future "hot" topics they would like presented.
    - SGS Fall Education Series – is a service learning series that is offered each fall. On average six to eight full-day to half-day sessions are offered. A planning committee comprised of cross sector partners come together to identify the topics, recruit speakers, plan and organize the series. Topics range from the 3 D's (delirium, dementia and depression) to pain management for the frail elderly. Each speaker is evaluated and a final report completed. Many sessions within the learning series is offered via OTN or webcast and is archived for

one year. This event is free for all participants, and typically attracts 30 to 50 interdisciplinary healthcare professionals from the South West LHIN and ESC LHIN.

- SWOGAN Team Exchange – is an annual knowledge exchange event for local and regional geriatric and geriatric mental health outreach teams providing care for the frail elderly across South West LHIN and ESC LHIN. This event provides opportunities for the clinical teams to come together to share best practices, lessons learned, and for professional development. A Physician and Leadership Breakfast meeting occurs each year, which connects the Primary Care physicians who support the local SWOGAN outreach teams with Geriatricians and Geriatric Psychiatrists. Updates on provincial initiatives, physician education and funding opportunities, best practice guidelines in geriatric care are discussed.
- Geriatric Medicine Refresher Day – is a widely popular annual education event that is in its 26th year. This event has grown significantly over the past several years with over 500 healthcare professionals from across Southwestern Ontario in attendance. The Geriatric Medicine Refresher Day provides professionals with opportunity to broaden their knowledge base, to refine specific skills, and to meet with others who share their concern in improving quality care to the elderly. The plenary sessions encourage interdisciplinary investigation of subjects common to all, while concurrent sessions provide medical updates and investigations of other topics in geriatric care. Topics are selected to appeal to a wide range of care providers including physicians, nurses, therapists, pharmacists, nutritionists, psychologists, social workers, researchers, educators, Occupational Therapists (OT), Physical Therapists (PT) and discharge planners, as well as people serving primarily in administrative positions. An interdisciplinary planning committee works together each year to plan, organize and successfully implement this event.
- Geriatric Psychiatry Symposium – is going in its 10th year. This is an annual education event that provides healthcare providers with an opportunity to learn about a variety of topics in geriatric mental health. Topics are selected to appeal to an interdisciplinary audience, and range from Mood and Anxiety disorders in Elderly, to supporting informal caregivers of individuals living with dementia and review evidence-based thinking regarding innovative interventions. Over 125 healthcare professionals attend this event yearly. The Symposium is planned in partnership with SJHC London (Geriatric Mental Health Program), London Health Sciences Centre (LHSC) and The UWO (Division of Geriatric Psychiatry). Other planning partners include the Alzheimer Society, Primary Care Physicians and the RGP.

- Geriatric Mental Health Program, SJHC London, provides various activities that support education and knowledge transfer for LTC homes, Hospitals, and community agencies. The Discharge Liaison Team (DLT) provides support for inpatients with complex, yet stable mental health needs that no longer require specialized hospitalization as they transition from hospital to a LTC home. The DLT team will assist LTC home staff in managing the resident's psychiatric symptoms, achieve an appropriate balance of service to create good community alternatives to hospitalization and provide quality of life for the resident in their chosen environment. The DLT currently play a key role across the South West LHIN in teaching LTC homes how to effectively manage older adults with responsive behaviours.

- Hospitals' regular department rounds, academic education days for medical staff and ongoing continuing medical education
- Resource and Behaviour Group - In 2008, there were conversations between health care providers (HCPs) from LTC homes and healthcare providers from the Outreach Teams with SGS, SJHC, London regarding the need for, and an approach to, increasing on-site capacity to care for residents with challenging mood and behaviour symptoms. To gain a greater understanding of the

needs of health care providers (HCPs) working in LTC homes and to enable them to effectively respond to residents with challenging mood and behaviour symptoms, a select group of SGS clinicians met with local investigators to create a research collaborative.

- While a large body of literature exists on how to deal with challenging behaviours in older adults, there is limited information on the front-line HCPs perspective. The goals of the study "An Investigation of Health Care Provider's Needs Related to Behavioural Issues in Long-Term Care" were to identify what was needed to improve care for LTC home residents with challenging behaviors and what supports were needed to provide quality care to these individuals.

- Seventeen rural and urban LTC homes in Middlesex/London were invited to participate and data was collected from 12 homes during 18 audio-taped focus groups with LTC home front-line staff. Focus groups were run during day, evening and night shifts to ensure participation from all staff. The research design used a Qualitative Interpretive Descriptive approach (Thorne et al., 2004). Analysis focused on coding key phrases and themes that emerged from the data. Patterns within and between the transcripts were located, using a constant comparison approach. Six key themes were identified: place, organizational structure, resources, relationships, information communication technology and consequences. Findings also suggest that staff needed more accessible resources and that there was a genuine thirst for knowledge regarding how to best care for residents with challenging behaviors.

  - Promoting Knowledge Exchange around Healthy Aging and Aging at Home (AAH) – Aging population has implications for researchers, policy makers and practitioners. In Ontario, a key response has been the AAH initiative. To fully inform this agenda, "seniors" perspectives are needed. This two phase study was funded through an Ontario Research Coalition Early Researcher Award.

    Phase 1:

    - Fall 2009, focus groups with seniors from London, Thunder Bay and Kingston
    - Objective: To understand the meaning of AAH and home-based supports from the perspective of a sample of Ontario seniors

    Phase 2

    - October 2011, Invitational Knowledge Exchange Workshop, London, ON, organized in partnership between SJHC London, Lawson Health Research Institute Centre for Studies on Aging and Health, Providence Care/Queen's University, Kingston; Centre for Education and Research on Aging and Health, Lakehead University, Thunder Bay; Graduate Program in Health and Rehabilitation Science (Occupational Science), UWO
    - Objectives:
      - To showcase current research in the AAH discourse
      - To provide an opportunity to engage in the AAH discourse
      - To further develop the research base underlying the AAH strategy
      - To promote linkages between research policy and practice in AAH

- Alzheimer Societies' provide education for patients and families with dementia, particularly through the First Link Program which supports people with dementia and family/caregivers through individual and family counseling and support groups. Public Education Coordinators offer dementia specific education to professionals working with people with dementia in a variety of settings including long-term care homes, community agencies, supportive housing and retirement

homes. First Link Coordinators and Public Education Consultants are key roles within Pillar 3 of the BSO framework. Some of the training offered includes:

- Gentle Persuasive Approaches in Dementia Care (GPA), is an 8-hour interactive workshop for all staff (from nurses to housekeepers) that care for persons with dementia. This program utilizes a person-centered approach, and teaches participants how to respond to persons with dementia respectfully and with confidence and skill to effectively prevent and/or address responsive behaviours associated with dementia.
- U-First! is a proven and effective approach to working with people with dementia. Through dialogue and a case-based approach, learners will have more confidence in working with people with responsive behaviours. Training is especially designed for people working in community care, acute care, and long-term care. U-First stands for:

  Understand the behaviour changes in a person with dementia;
  Flag possible changes seen in the person;
  Interact with skill and understanding;
  Reflect and report the behavior;
  Support the person with dementia and their family caregiver; and involve the
  Team in caring for the person with dementia.

  - Residents First is a provincial initiative that supports LTC homes in providing an environment for their residents that enhances their quality of life through QI training, tools and resources customized to the LTC home sector that facilitates comprehensive and lasting change by strengthening the LTC sector's capacity for quality improvement. Across the South West LHIN, almost all LTC homes have reported some form of involvement with the Leading Quality component of Residents First which focuses on helping LTC home leaders prepare for the introduction and spread of quality improvement throughout their organization. As part of the Residents First initiative, 25 LTC homes have started developing "team learning collaboratives" and quality improvement training is being offered to over 40 staff. All LTC homes will be required to complete a quality improvement plan.
  - Alzheimer Knowledge Exchange (AKE) performs a key role for the BSO project by knowledge brokering, providing access to evidence based information, providing knowledge exchange opportunities (on-line, in person, social media), and supporting the development of topic specific communities of practice. AKE will perform a core component of an effective education and training strategy that will be rolled out across the South West LHIN in alignment with Pillar 3.

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

It is our aim to ensure all initiatives are guided by our **Client Value Statement** "I am a unique individual who wants to live fully with meaning and dignity throughout my life journey." Improvement measures are currently being reported quarterly to the South West LHIN for the BSS project. The BSS Steering Committee and Leadership structure, in partnership with the geriatric cooperatives, will be developing and implementing a quality improvement strategy as this was not incorporated into the BSS project. An evaluation committee was formed in January 2011 for the BSS project which meets on a regular basis. Quality improvement will be added to the role of this committee. A Quality Improvement Facilitator will be hired to support this component.

The following resources with knowledge/expertise in quality improvement will be leveraged:

- HQO BSO Coach

- BSO Improvement Facilitator
- BSO Project Lead
- Director, Evaluation and Research, SGS, SJHC London, who is the Evaluation Consultant for the BSS project and Chair of the BSS evaluation committee
- Residents First Improvement Facilitators
- Seniors Health Research Transfer Network (SHRTN) Community of Practice
- Primary care providers and their healthcare providers involved in previous quality improvement initiatives

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

Across the South West LHIN, there is numerous behavioural supports expertise including:

- Windermere Way, Enhanced Specialized Mental Health Unit, McGarrell Place, London (LTC Home) – The staff working within this LTC home has developed in-depth knowledge and expertise to effectively manage older adults with responsive behaviours. It is anticipated these staff will play a vital role in facilitating "service learning" for LTC homes, local and regional mobile outreach teams and their care partners.
- SJHC – Geriatric Psychiatry Program provides regional specialized geriatric psychiatric care for persons with moderate to severe dementia and complex behaviours in addition to providing local regional specialized psychiatry resource teams, such as: Regional Psychogeriatric Program (LTC home, Hospital and community focus), DLT (LTCH and Hospital focus), Geriatric Mental Health Outreach Team (community focus). These specialty outreach services are mandated to provide collaborative shared care for older adults with complex mental health and addictions. Working closely with their local supports, they provide specialized assessment, consultation, and treatment across the South West LHIN. Each of these outreach teams are supported by Geriatric Psychiatrists. In addition, these specialty teams have an education and capacity building role with their partners across the care continuum.
- SJHC – RGP is affiliated with the Division of Geriatric Medicine, UWO. The RGP is an interdisciplinary team which provides comprehensive geriatric assessments in homes, hospitals and long-term care facilities and provides recommendations to care providers, families and patients. This outreach team functions to enhance the care of frail elderly individuals throughout Southwestern Ontario (across South West LHIN and ESC LHIN) through clinical consultation, education, research, evaluation and community development. The team also plays a large role in the education of students and health professionals across the region.
- The RGP and RPP specialty outreach teams are part of the SWOGAN. This network links geriatric and geriatric mental health assessment teams in the ten counties of southwestern Ontario. The multidisciplinary teams link with local resources to provide assessment and treatment options in or near the client's home. The BSO initiative will link closely with the SWOGAN network.
- Alzheimer Societies of London-Middlesex, Elgin, Oxford, Perth, Huron, Grey-Bruce provide education for patients and families with dementia, particularly through the First Link Program which supports people with dementia and family/caregivers through individual and family counseling and support groups. Public Education Coordinators offer dementia specific education to professionals working with people with dementia in a variety of settings including LTC homes, community agencies, supportive housing and retirement homes.
- Alzheimer Outreach Services (ASO) of McCormick Home offers therapeutic recreational programming for people with Alzheimer's disease and related dementias. Their

interdisciplinary healthcare providers have highly developed skills and expertise to effectively deal with older adults with responsive behaviours that will be leveraged to facilitate knowledge transfer within the BSO initiative.

- Schlegel Villages/LTC homes – Glendale Crossing, London, Ontario: In partnership with the Research Institute for Aging and the University of Waterloo, Schlegel Villages are conducting practical, applied research at the facility and community level, to improve care and overall quality of life for seniors. LTCH staff is provided with enhanced training related to the health and well-being of older adults and their families to promote healthy aging. Development of innovative evidence based programs within this research environment.
- South West Community Care Access Centre (SW CCAC) Geriatric Resource Team (GRT) Case Managers provide comprehensive geriatric assessments in each local area and are supported by Primary Care Physicians with advanced training in care of the elderly.
- The Behavioural Supports System (BSS) Project, five seniors mental health and addictions response teams will be established/enhanced in each area and will consist of clinical nurse specialists and allied health (e.g. social work, occupational therapy). The seniors mental health and addictions response teams will be supported by a geriatric psychiatrist. These teams will provide timely response for referral sources dealing with older adults with responsive behaviours.
- The Southern Network of Specialized Care provides supports for adults aging with a developmental disability that experience mental health and behavioural issues.

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

An Education Consortium will be developed and lead by SJHC, Specialized Geriatric Psychiatry Services to ensure a LHIN-wide approach to capacity-building, leveraging existing specialized resources (Enhanced Psychogeriatric Resource Consultants, DLT, Regional Mental Health Care Geriatric Outreach Team, RGP, RPP, seniors mental health and addictions response teams, Alzheimer's Society). Strong linkages and cross-training opportunities will be developed as new initiatives are implemented. Interdisciplinary mobile outreach teams and specialized regional geriatric and psychogeriatric teams will collaborate with partners to create shared learning environments, disseminate co-created best practices and provide collaborative learning opportunities for direct care providers (LTC homes, primary care, CCAC). Enhanced Psychogeriatric Resource Consultants (EPRC) will play a leadership role in building capacity across the LHIN, and will work closely together to ensure continuity. Examples of training efforts include:

- Onsite case-based education and joint care planning
- Identification of LTCH staff who are PIECES (Physical, Intellectual, Emotional, Capabilities, Environment, Social and Cultural) trained. These LTC homes will become champions within their LTC home and will receive "refresher" training in PIECES.
- PIECES and GPA training will be provided to all BSO outreach team members, and all other existing outreach teams. LTC homes will also receive PIECES training, led and coordinated by the EPRCs.
- Identification of primary care providers trained in quality improvement methodologies that are willing to be early adaptors will test new tools and protocols.
- Local improvement teams will be developed by the Quality Improvement Facilitator and will apply quality improvement processes and PDSAs (Plan, Do, Study, Act) to develop and test changes prior to final implementation.

- New BSO outreach teams will be trained by existing specialized outreach teams. Self-directed learning packages will be developed and a learning mentor assigned. Opportunities for joint outreach visits, clinics, and case reviews will be provided as part of their orientation.
- A two-day BSO/BSS Team Exchange will be organized early in 2012 as a way to launch the program, provide networking opportunities with the existing teams, and for education and capacity building.
- Geriatricians and Geriatric Psychiatrists will provide education to Physicians (LTC home, primary care, etc.) through education, mentorship, webinars, case conferencing, and grand rounds.
- QI capacity from Residents First Improvement Facilitators and LTC home staff that participated in Residents First will also be leveraged.

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

In addition to the processes previously mentioned, the BSO project will leverage the following mechanisms to disseminate evidence-based practices, common practices and protocols to support the BSO project across the South West LHIN:

- South West Primary Care Network provides the necessary structure to connect primary care providers in the South West and is the primary conduit for programs and/or organizations needing to engage with the region's primary care providers.
- The newly formed LTC Home Network will assist the South West LHIN when they need consultation/recommendations related to LTC homes.
- SHRTN and AKE websites and local knowledge brokers/librarians are key sources of information on best practices and current research.
- The Advanced Gerontological Education (AGE) enterprise has developed a GPA in Dementia Care education program.
- Canadian Dementia Resource and Knowledge Exchange (CDRAKE) and the National Initiative for the Care of the Elderly (NICE) provide educational resources.
    - The SWOGAN will ensure that all educational activities compliment (not duplicate) other efforts at capacity building and that all resources are shared/maximized for training; existing communication mechanisms are already developed by SWOGAN will be utilized.

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

Build on what we already have

The BSO Project will be integrated into the existing AAH funded Behavioural Supports Systems (BSS) Project. A hub and spoke model will be utilized to ensure that the BSO LTC home positions are integrated into the five existing BSS mobile outreach teams across the South West LHIN. Specialized regional supports (RGP, RPP, Geriatric Psychiatry) will be linked with each of the mobile teams to enhance their ability to provide a timely response for older adults with responsive behaviours who live in their own homes or LTC homes. Common assessment tools, report templates and care strategies will be utilized by the mobile teams and their care partners. BSO LTC home-funded staff will support LTC homes only, which will enhance the existing mobile teams ability to expand into community and hospital to actively be involved and support transitions across care settings. It is expected that access to Geriatric services for Older Adults with responsive behaviours will be coordinated between the following agencies: CCAC Geriatric outreach teams, Nurse-Led LTC home outreach teams, SGS (RGP, RPP), and Regional Mental Health (Outreach teams, Discharge Liaison Team), Geriatric

Emergency Management (GEM) Nurses, Alzheimer Societies, Community Mental Health and Addictions Services. Mobile Teams will also keep abreast of Residents First, Home First, and Senior Friendly Care initiatives.

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, the caregiver, organization, community, etc.)?

Strong leadership and support by the Enhanced Psychogeriatric Resource consultants, Regional Psychogeriatric Program, BSS Project Lead and Improvement Facilitator for quality improvement and change management will sustain changes made. A BSO quality improvement and change management plan will need to be developed and implemented across the South West LHIN.

Existing knowledge transfer mechanisms will be utilized and leveraged to communicate the quality improvement, education, and change management plans. BSO Team Exchange events (1st one planned for winter 2012) will be optimal in sharing best practices and lessons learned in regards to the new service models and PDSA results.

Sustainability of the BSO will be facilitated by timely measurement within improvement projects, clear accountability and reporting requirements for health service providers affiliated with the BSO program and routine monitoring of key indicators to ensure the BSO program has the attention and priority of leaders.

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

Knowledge transfer will occur through formal and informal interactions between healthcare providers, clients and their families/caregivers in every setting across the South West LHIN. Quality improvement will be a key component that is integrated into the knowledge transfer process.

The BSO/BSS mobile teams with the support of regional specialty outreach teams (RPP, RGP) will play a pivotal knowledge transfer role to ensure quality clinical practice at the bedside. They will take on the roles of change agents, mentors, and knowledge brokers. They will play a role in facilitating informal case-based and service-learning opportunities for healthcare providers in LTC homes, hospitals, primary care, and community settings.

Through clinical consultation, assessments, treatment, care-planning, and follow-up, the BSO/BSS mobile teams will facilitate the dissemination and utilization of evidence-based clinical assessment tools and evidence-based approaches to care through demonstration and modeling. Over time, healthcare providers in LTC homes, hospitals, and community settings will adopt these approaches, which will improve the client and caregiver experience.

Through the Education Consortium and the Geriatric Cooperatives, formal learning activities will be embedded across the South West LHIN in a coordinated manner.

12. Who will be the partners for Knowledgeable Care Team and Capacity Building?

- The partners for Knowledgeable Care Team and Capacity Building include:
- The University of Western Ontario
- Regional Psychogeriatric Program, SJHC London
- Regional Geriatric Program, SJHC London
- South Western Ontario Geriatric Assessment Network, SJHC London
- Regional Mental Health Care London – Discharge Liaison Team,
- Outreach Team, SJHC London
- Providers of Behavioural Support Services (seniors mental health and addictions response teams): SJHC London, London Health Sciences Centre, St. Thomas Elgin General Hospital, Woodstock General Hospital, Huron Perth Health Alliance, Alexander General Marine Hospital, Grey Bruce Health Services

- South West Community Care Access Centres – Geriatric Resource Teams, Nurse Led LTCH Outreach Team, Advanced Home Care Team
- Alzheimer Societies
- Community-Based Mental Health and Addictions organizations: Thames Valley Addictions Services, Choices for Change, Canadian Mental Health Association
- Primary care providers and networks
- South West LHIN LTCH Network
- South West Dementia Network
- Long-Term Care Homes

a. How have the partners collaborated on previous projects?

Please refer to 3b above

b. What were the outcomes?

Please refer to 3c above

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

The Co-Chairs of the BSS Steering Committee will have the responsibility to ensure ongoing meetings and the deployment of behavioural staffing positions for participating HSPs.

d. Describe how the HSPs will deploy staff to meet the established BSO framework for each LHIN

BSO resources will be allocated to support system redesign as follows:

LTCH Staff:

- The host LTC home will put out an expression of interest to local LTC Homes. Local LTC homes in different geographies across the LHIN will support the applications of nursing and PSW staff to provide services for a defined period of time for the Schedule 1 seniors mental health and addictions response teams in surrounding local LTC Homes. Services will be provided from the Schedule 1 locations or other LTC home locations in the South West LHIN. .
- A total of up to 10 FTE Health Care Personnel will be allocated across the South West LHIN to support an interdisciplinary BSS/BSO outreach team. To optimize funding, existing resources will be leveraged to support the enhanced BSO model. Projected staffing compliments include:
- Geriatric Psychiatrist (.8 FTE) to support the South West LHIN
- Psychologist (1 FTE) to support the South West LHIN
- Quality Improvement Facilitator (1 FTE) to support the South West LHIN
- Psychogeriatric Resource Consultant (1 FTE) to support southern portion of the South West LHIN
- Coordinator (1 FTE)
- Social Workers, Alzheimer Societies (3 FTE)
- Adult Day Programs (2.5 FTE)
    - The above staffing allocation is draft as further negotiations will need to occur. The BSS Steering Committee and identified host long-term care home will play key roles.

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

LTC home Staff:

- LTC home-funded staff will be integrated within the existing BSS Outreach Teams which work out of five Schedule 1 Hospitals across the South West LHIN. The South West LHIN covers a large portion of South Western Ontario from Lake Erie to the Bruce Peninsula, an area of 21,639 kilometres. This includes Bruce, Elgin, Grey, Huron, Middlesex, Norfolk, Oxford and Perth counties.
- The South West LHIN has 78 LTCH, with the highest number of LTC home beds in London and Middlesex (3247). The South West LHIN encompasses a large geographic area with a 69% urban and 31% rural mix.

Additional Healthcare Personnel:

Additional Healthcare Personnel will be assigned to SJHC London, Alzheimer Societies, and Adult Day Programs.

- SJHC London, Regional Psychogeriatric Program will receive the following positions which will be integrated within existing programs and services:
- Geriatric Psychiatrist (.8 FTE) (will join existing team of Geriatric Psychiatrists working out of Regional Mental Health Care London)
- Psychologist (1 FTE) to support the South West LHIN
- Quality Improvement Facilitator (1 FTE) to support the South West LHIN
- Coordinator (1 FTE)
- Enhanced Psychogeriatric Resource Consultant (1 FTE) to support southern portion of the South West LHIN
- Alzheimer Societies will receive (3 FTE) Social Workers to enhance the First Link programs
- Adult Day programs will receive (2.5 FTE) for overnight weekend relief

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

Staff roles and responsibilities will be identified by the BSS Steering Committee..

13. Enclose a summary timeline in a separate schedule. (see Appendix B)

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

Background

As per the BSO framework, the proposed approach is designed to:

- Promote a better understanding of the client, program and system level characteristics that underpin successful integrated health care delivery initiatives;
- Identify fundamental context or design factors and key transferable lessons to support the transfer of innovative and successful project models; and
- Produce and disseminate evidence of what has worked well and identify opportunities for improvement that exist at the project level to enhance the effectiveness and impact of the strategies being employed by the LHINs and their partners.

The evaluation strategy will try to determine if these goals have been met.

Further, the planned evaluation will:

- Establish baseline information in order to measure progress over time; and
- Measure the effects of improvements on clients, family members, providers, and the health system.

Finally, three priority outcomes have been identified by the Ministry:

- Reduced resident transfers from LTC homes to ERs/hospitals or behavioural units in situations where the resident can be treated in their LTC home setting;
- Delayed need for more intensive services (either in the community or LTC home setting), thereby reducing admissions to hospital and risk of becoming ALC; and
- Reduced length of stay for persons in hospital who can be discharged to a community or LTC home setting with appropriate supports (i.e. enhanced behavioural resources).

These outcomes will be included in the proposed evaluation.

Regional Indicator Working Group

In consultation with the BSO Data, Measurement and Evaluation Committee and others as appropriate, the South West LHIN evaluation committee will work with the Hamilton Niagara Haldimand Brant LHIN, as well as the Erie-St. Clair LHIN and the Wellington-Waterloo LHIN to identify the best strategies and analytic techniques to answer the project questions. In addition, proxy indicators and other data sources will be explored.

BSO population

Working with the BSO Data, Measurement and Evaluation Committee, the successful BSO evaluation vendor, and the regional early adopter LHINs, population-level indicators, that is to say those that are representative of high-level system outcome measures, will be developed. The goal is to develop measures that would be comparable across all LHIN using existing administrative data.

First the target population diagnostic codes will need to be identified. A number of ICD-10 codes have been identified. These will be tested by the Ministry-approved Evaluation Vendor in January 2012.

Possible measures of acute decline that require institutional intervention that may be impacted through the BSO project may include:

- The proportion of emergency department (ED) or urgent care centre (UCC) visits among those 65 or more years of age that are for with older adults with mental health, dementia, or other neurological conditions (target population)
- The proportion of the total in-patient separations by acute and alternate level of care (ALC) lengths of stay (LOS) for the target population
- The proportion of the total ALC days that are for the target population
- The proportion of the target population that returned to their original living situation following an acute care admissions
- An examination of the health care trajectory of a “typical” person with the BSO associated health issues

Possible Data Sources:

- National ambulatory Care Reporting System (NACRS)

- Discharge Ambulatory Care Reporting System (DAD)

Business Intelligence Tool:

- IntelliHEALTH ONTARIO, Ontario Ministry of Health and Long-Term Care (available to LHIN data analysts)

Challenges

Preliminary analyses suggest that very few older adults are seen in the ED for ICD-10 codes thought to be associated with behavioral issues. This suggests that behavioral issues are grossly underreported in the NACRS data file. As a result, just using the ICD-10 codes in the NACRS database to identify those with behavioral issues will be very challenging. Further, a lower proportion of older adults than would be expected are discharged with diagnoses thought to be associated with behavioral issues. This again suggests that such issues are underreported in the DAD database.

Process and Outcome Indicators

LHIN-specific metrics that measure the development and the impact of the proposed seniors mental health and addictions response teams will be developed. Following the approval of the program logic model by the project steering committee, the local short-term and long-term data sources will be identified and data collection strategies will be developed. It is likely that new data collection processes will need to be developed in collaboration with the agencies receiving the service.

In addition, it is hoped that local agencies that serve a similar target population and collect data will be able to work together to develop a common data pool. For example, on entry to a long-term care home, the SW CCAC collects additional data on those who have a history of behavioral issues. In addition, ALC issues will be examined through reports generated by the SW CCAC as part of their ALC long-stay reviews. Through Residents First, Health Quality Ontario will be asking LTC homes to identify and then conduct quality improvement projects, some of which may deal with residents with responsive behaviors. The Southwestern Ontario Regional Geriatric Program Outreach Team collect information on clients served through this service. As well, the DLT, a group that operates out of RMHC London, promotes successful transitions between RMHC London and regional LTC homes, collect data on behavioral issues. Information collected by the local Alzheimer Societies will also be examined.

In addition to the development of quantitative indicators, additional information will be collected through focus groups. Interviews with consenting family members will help illuminate issues associated with the health care trajectory of older adults diagnosed with mental health, dementia or other neurological conditions. Also, the minutes of the Steering Committee will be reviewed to see if project milestones have been met.

Challenges

The way behavioral issues are captured varies by data source. It may be very difficult to create crosswalk between ICD-10 codes, DSM-IV codes and other classification systems. As a result, the same target population will not be identified.

Data sharing agreements may need to be developed and signed.

Possible Indicators by BSO Framework Categories

System Coordination

- Family/caregiver satisfaction
- Patient quality of life
- Number of repeat assessments

- ALC LOS

Interprofessional Collaborative Service Delivery

- Stakeholder awareness of BSO-funded team (possible collected through an on-line survey)
- Stakeholder satisfaction with BSO-funded team (possibly collected through focus groups)

Improved System Capacity

- % of staff with PIECES, GPA and U-First training in regional LTC homes

15. Attach your budget, work plan and resource plan. The resource plan will outline how and where registered nurses and personal support workers would be utilized.

See Appendix B, C, D. HHR spreadsheet is an attached document.

16. Who will be the representatives on the LHIN BSO Steering Committee?

- Jennifer Speziale, Co-Chair, Director, Geriatric Mental Health, RMHC SJHC London
- Shelley McCorkell, Co-Chair, Executive Director, Alzheimer Society Elgin
- Dr. Lisa Van Bussel, MD, FRCP, Chair, UWO Division of Geriatric Psychiatry,
- Physician Leader, Geriatric Psychiatry Program, Psychiatrist, Regional Psychogeriatric Program, RMHC London
- Dr. Beth Mitchell, Director, Mental Health, London Health Sciences Centre
- Elizabeth McCarthy, Director, Specialized Geriatric Services, SJHC London
- Dr. Iris Gutmanis, Director, Program Evaluation and Research, SGS SJHC London
- Magdalen Carter, MSW, RSW, Director, Alzheimer Outreach Services of McCormick Home
- Brenda Lambert, Vice President, St. Thomas Elgin General Hospital
- Pat Edwards, Director, Mental Health, Woodstock General Hospital
- Penny Cardno, Director, Mental Health, Huron Perth Health Alliance
- Cheryl Taylor, Vice President, Alexander General Marine Hospital
- Leah Hood, Director, Mental Health, Grey Bruce Health Services
- Julie Ridgewell, Regional Education Manager, Ontario Telehealth Network
- Anita Cole, Regional Client Services Manager - Community South SW CCAC
- Julie Girard, Team Lead, Planning and Integration, South West LHIN
- Kelly Simpson, Behaviour Supports Project Lead, Regional Coordinator, Regional Psychogeriatric Program, SJHC London
- Donna Ladouceur, Senior Director, Client Services for the South West CCAC
- Lynne Johnson, Director of Long-Term Care, County of Grey

End of Part B

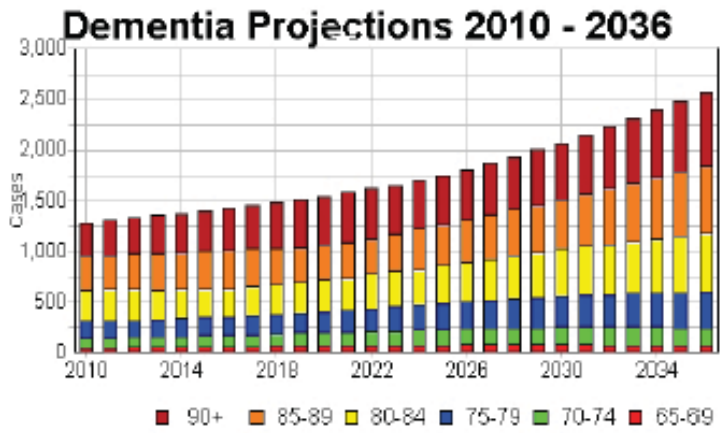
Appendix A – Performance, Measurement, and Evaluation Plan: Future State

Working with the Behavioral Support System Ontario (BSO) Data, Measurement and Evaluation Committee (DMEC) as well as the vendor selected by this committee to assist with the evaluation of the four Early Adaptor LHIN BSO strategies (Hay Group Health Consulting), a data matrix will be developed. In addition, process and outcome indicators that map onto this matrix will be confirmed. Both the provincial and the local evaluation committees will continue to look at the possibility of an economic impact assessment as well as strategies that will ensure an improved, sustainable data collection system.

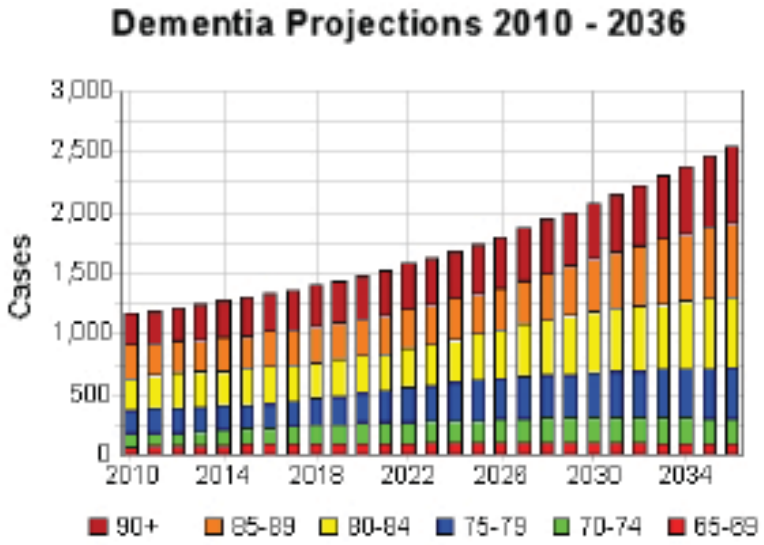
Performance, Measurement and Evaluation Plan: Future State

Number 16: Dementia projections for the counties, regional municipalities, and census divisions of Ontario (using CSHA prevalence data). Robert W. Hopkins, Ph.D. April 2010 PCCC Mental Health Services Kingston, Ontario.

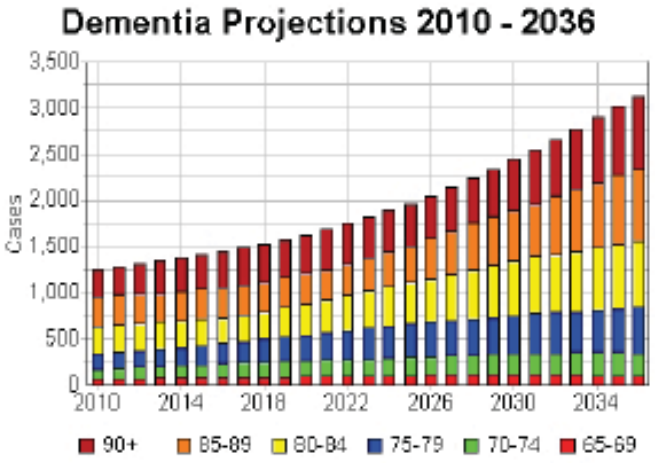
Perth County



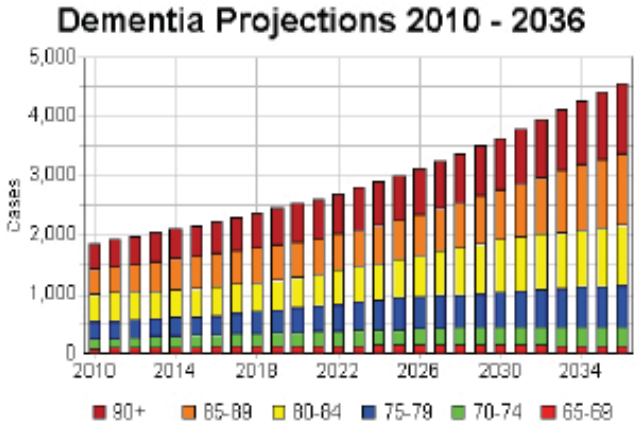
Bruce County



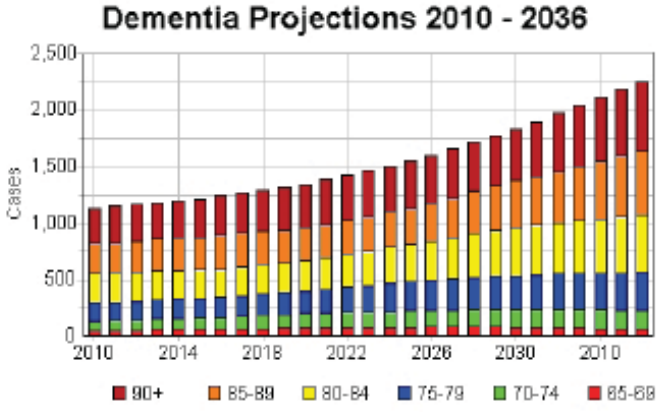
Elgin County



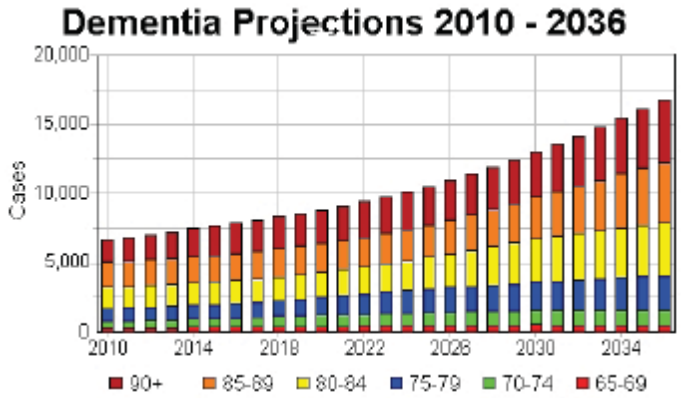
Grey County



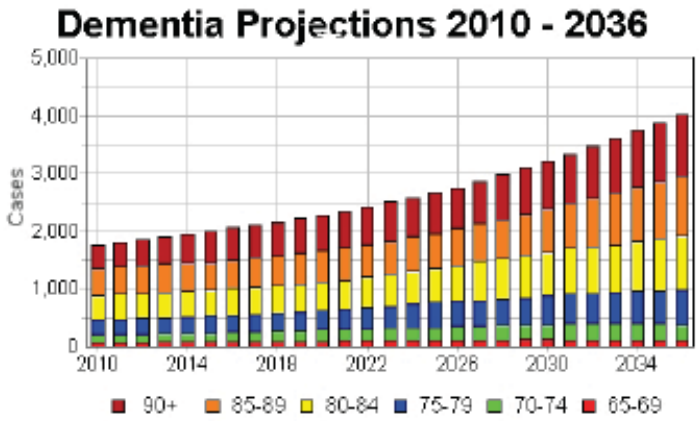
Huron County



Middlesex County



Oxford County



Hospitalizations, Fiscal 2010/2011

For South West LHIN residents, who are 65 or more years of age, there were a total of 34,337 hospitalizations.

2,166 hospital separations had the diagnosis of dementia in at least one of the diagnostic fields. This suggests that 2,166/34,337 or 6.3% of all discharges among seniors involved someone living with a dementia.

Of acute inpatient discharges with dementia or Alzheimer's Disease in any diagnosis field, 41.7% came from the community, and of those who came from the community, 58.2% were discharged home.

Proportion of all Hospital Separations among those 65 or more years of age in which dementia was mentioned in any one of the 25 diagnostic fields captured in the Discharge Abstract Database

County	Total # of people 65+ yrs. of age	Total # hospital separations for those 65+ yrs.	Total # hospital separations for those 65+ with a diagnosis of dementia in any diagnostic field	% of all hospital separations for those living with dementia
Bruce	13,263	3,638	173	4.8
Elgin	13,434	3,250	177	5.4
Grey	18,646	4,227	196	4.6
Huron	11,283	3,164	219	6.9
Perth	11,933	2,864	130	4.5
Haldimond-Norfolk	2,309	465	21	4.5
Oxford	17,446	4,138	351	8.5
Middlesex	66,076	12,594	899	7.1
South West LHIN	154,390	34,340	2,166	6.3

It appears that there is considerable county-by-county variability in the proportion of hospital separations in which dementia was mentioned in any of the diagnostic fields. The estimate varied from a low of 4.5% of all hospital separations in Haldimond-Norfolk to a high of 7.1% in Middlesex/London. Considering that it is estimated that at least 6.5% of the population aged 65 or more years have dementia, one would expect that at least 6.5% of those who are 65 or more years of age who are hospitalized would also have dementia. This suggests that levels of identification and diagnosis require greater LHIN-wide consistency.

Appendix B –South West LHIN Action Plan Summary Timelines and Workplan

South West Funding and Action Plan Milestones (October 2011 -March 31, 2012)			Oct-11		Nov-11		Dec-11		Jan-12		Feb-12		Mar-12	
	Start Date	End Date	1st - 15th	16th -31st	1st - 15th	16th -30th	1st - 15th	16th -31st	1st - 15th	16th -31st	1st - 15th	16th -29th	1st - 15th	16th -31st
Stakeholder Engagement and Overview of the BSO Initiative	Nov, 2011	Dec, 2011												
Survey sent to LTCH and Outreach Programs	Nov, 2011	Nov, 2011												
Focus Group with Alzheimer Societies	Nov, 2011	Nov, 2011												
Focus Group with Adult Day Programs	Nov, 2011	Nov, 2011												
Consultation with Geriatric Cooperatives	Oct, 2011	Mar, 2012												
BSS Steering Committee - Full day meeting	Nov, 2011	Nov, 2011												
Presentation to LTCHs, followed by question and answers	Nov, 2011	Nov, 2011												
Teleconferences to update LTCH on BSO progress	Dec, 2011	Dec, 2011												
Value Stream Mapping Session (2 Day - Oct 28th, 29th)	Nov, 2011	Nov, 2011												
2 Page Executive Summary due to CRO	Dec, 2011	Dec, 2011												
Briefing notes and Reports for South West LHIN Board	Oct, 2011	Dec, 2011												
Presentation of Executive Summary to CRO, 14 LHINs and PRT committee, Dec 2nd, 2011	Dec, 2011	Dec, 2011												
BSO Action Plan -Part 1 and 2 due Dec 15th, 2011	Nov, 2011	Dec, 2011												
BSS Steering Committee - half day meeting	Dec, 2011	Dec, 2011												
Action Plan feedback from PRT, CRO, PRT	Dec, 2011	Dec, 2011												
Final Action Plan signed off by CEO	Dec, 2011	Dec, 2011												
Priority Project Improvement Teams established	Jan, 2012	Mar, 2012												
Lead agency for BSO confirmed	Jan, 2012	Jan, 2012												

South West Funding and Action Plan Milestones (October 2011 -March 31, 2012)			Oct-11		Nov-11		Dec-11		Jan-12		Feb-12		Mar-12	
	Start Date	End Date	1st - 15th	16th -31st	1st - 15th	16th -30th	1st - 15th	16th -31st	1st - 15th	16th -31st	1st - 15th	16th -29th	1st - 15th	16th -31st
Funding received for BSO LTCH staff and Additional Health Care Positions	**Jan, 2012**	**Jan, 2012**												
Stakeholder engagement - Update on BSO project	**Feb, 2012**	**Feb, 2012**												

South West LHIN GANTT CHART -December 2011 -March 2012												
Priority	**Project**	**Milestone**	**Pillar**	**1**	**2**	**3**	**Completion date**	**Status**	**Dec**	**Jan**	**Feb**	**Mar**
1	1	Hire BSO community and LTCH staff		x			31-Mar-12	Start date: Jan				
2	2	Integrate BSO staff with BSS seniors mental health and addictions response teams		x			31-Mar-12	Start date: Feb				
3	3	Development of Education Consortium - Develop orientation, training, education for BSO staff in LTCH and Community. Conduct needs assessment and readiness survey for LTCH and community)				x	ongoing	Start date: Feb				
4	4	Model of Care project team developed for seniors mental health and addictions response teams integrating BSO LTCH and Community (BSS project already started this work)			x		31-Mar-12	Start date; May 2011				
5	5	Coordinated intake and triage (BSS project already started this work)			x			Start date: May 2011				
6	6	Common assessment tools, protocols,				x		Start date: May 2011				
7	7	Key Stakeholder engagement				x		Start date: Jan 2012				
8	8	Public Awareness and Social Marketing				x		start date TBD				
		LEGEND:										
		BSO Framework for Care Pillars						**Status**				
		1. System Coordination & Management						complete				
		2. Integrated Service Delivery: Intersectoral and Interdisciplinary						In progress				
		3. Knowledgeable Care Team and Capacity Building						at risk				

Appendix C –South West LHIN Budget

Preliminary Expenditures and Estimates

LTC Home Funded Positions:

RN/RPN: $1,221,800

PSW: $960,000

Employee Benefits – estimated at 26% in salaries

If assume the highest salary rate and 26%, it is estimated that 7 RNs, 8 RPNs and 18.3 PSWs could be funded.

Range of FTE capacity to hire within parameters

Additional employee related expenses to be supported include:

- WSIB estimated at 3.2%
- Mileage, technology requirements

Additional employee related start up costs include:

- Office furniture/equipment/supplies

Additional Health Care Professionals:

St. Joseph's Health Care London
Geriatric Psychiatrist (.8FTE), Psychologist (1FTE), Quality Improvement Facilitator (1FTE), EPRC (1FTE) and Coordinator (1FTE)
4.8 FTE Total = $753,510 (includes benefits)

Alzheimer Societies
3 FTE Social Workers to enhance First Link Program

3 FTE Total= $187,560

Adult Day Program – Overnight Weekend Respite
2.7 FTE (RN/PSW, other) Total =$108,830

Appendix D South West LHIN BSO Health Human Resources Plan

A detailed description of how the up to 16 nursing and the up to 24 personal support workers will be utilized is also provided in responses to question 13 above.

LTCH Staff:

- The South West LHIN has 78 LTCH across 21,639 square kilometers
- The host LTC home will put out an expression of interest to the local LTC homes.
- Local LTC homes will support the applications of nursing and PSW staff to provide services for a defined period of time for the Schedule 1 seniors mental health and addictions response teams funded by the Year 3 AAH initiative in surrounding local LTC homes.
- A total of five seniors mental health and addictions response teams have been implemented across the South West LHIN. Each of the five seniors mental health and addictions response teams will include Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW). Nursing staff RN/RPN ratio has yet to be determined
- Services will be provided from the Schedule 1 locations or other LTC home locations in the South West LHIN.
- The BSO LTC home-funded staff will provide a rapid response to LTC home, and be supported by other seniors mental health and addictions response team members. The EPRC will provide clinical leadership and education and capacity-building, and a Geriatric Psychiatrist will also be accessible LHIN-wide.

Additional Health Care Personnel:

The South West LHIN will be hiring approximately 10 FTE positions which will be allocated LHIN wide to both LTCH and community to support an interdisciplinary mobile team response. To optimize funding, existing resources will be leveraged to support the new model. Projected staffing to be recruited with the funding allocated to community positions will include:

- Geriatric Psychiatrist (.8 FTE)
- Psychologist (1 FTE)
- Improvement Facilitator (1 FTE)
- Psychogeriatric Resource Consultant (1 FTE)
- Coordinator (1 FTE)
- Social Workers (3 FTE), Adult Day Program (2.5 FTE)

Staff will be hired by the following organizations:

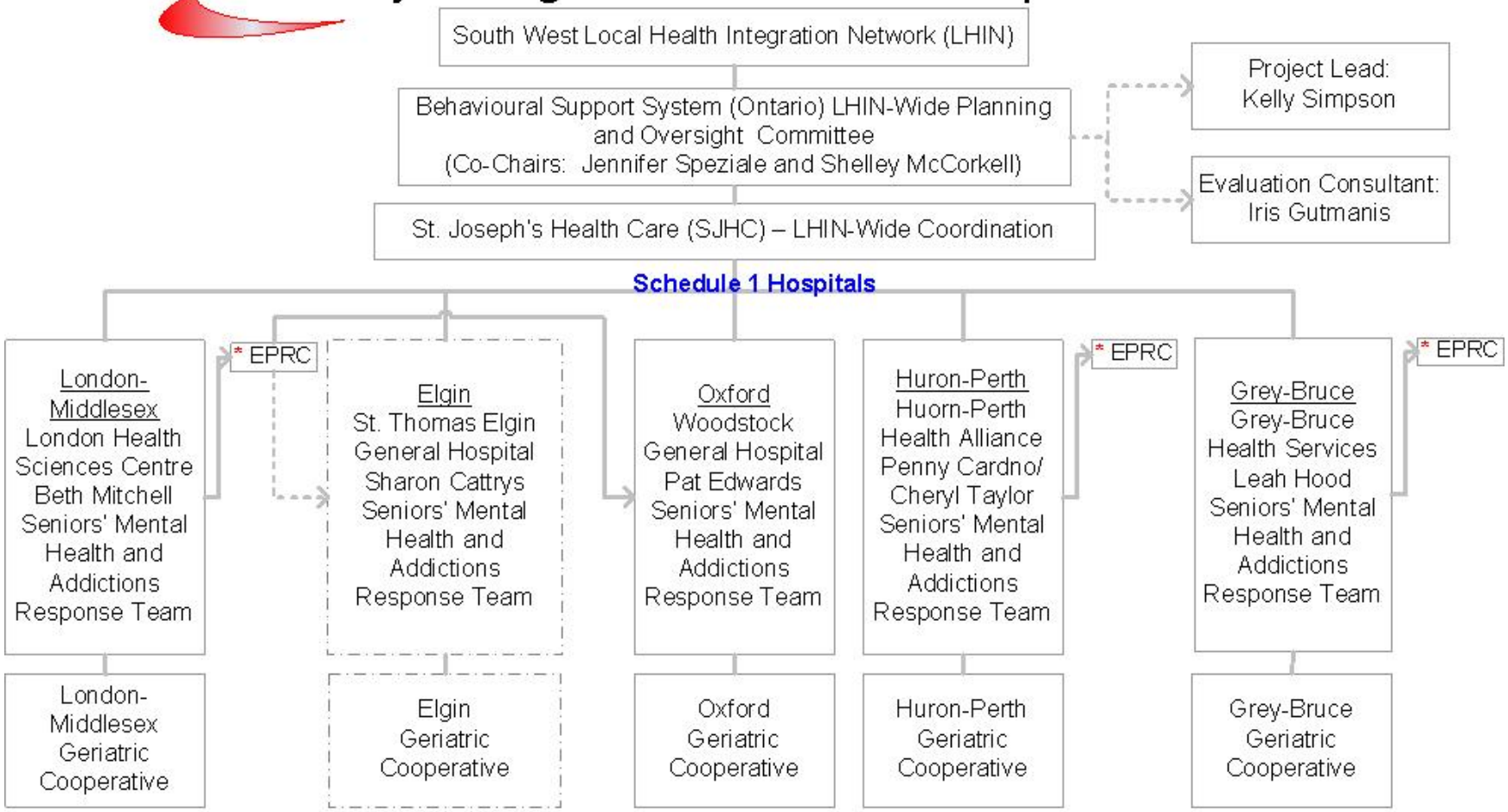
- The Geriatric Psychiatrist, Psychologist, EPRC and Improvement Facilitator, and Coordinator are planned to be employees of SJHC London. Specifically, they will become members of the Regional Psychogeriatric Program, which has a LHIN-wide mandate to provide clinical consultation, assessment and support, education and capacity building.
- Alzheimer Societies will receive the Social Work positions. These roles will enhance the First Link programs by providing additional support to families/caregivers in relieving some of the stress and challenges associated with caring for people with Alzheimer's disease and other forms of dementia. Adult Day programs will receive PSWs and Nurses to provide weekend overnight respite.

Appendix E

BSS Project Organizational Leadership Structure (Draft)

(see next page)

BSS Project Organizational Leadership Structure



Specialized LHIN-wide Services:
Regional Geriatric Program
Regional Psychogeriatric Program
SJHC Regional Mental Health Care (RMHC) Discharge Liaison Team
SJHC RMHC Outreach Team
Community Care Access Centre (CCAC) Geriatric Resource Teams (GRT)

Future State:
Long-Term Care Homes (LTCH)-Funded Team Members
Additional Health Personnel

* Enhanced Psychogeriatric Resource Consultant