Toronto Central LHIN

Behavioural Supports System Action Plan

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Ontario
Local Health Integration Network

Contents

Background

In the fall of 2011, the Toronto Central Local Health Integration Network (TC LHIN) along with 13 other Ontario LHINs, embarked on a journey to implement the Behavioural Supports Ontario (BSO) Framework. This marked the beginning of phase 2 of the BSO project.

The first phase of the BSO project (Phase 1) involved the development of a principle-based Framework of Care that would mitigate the strain and improve outcomes for persons with challenging behaviours, families, health providers and the health care system. The Framework's overarching principle is *Person and Caregiver* directed care. The three core elements of the Framework referred to as its pillars are:

Pillar 1- System coordination and management

Pillar 2 - Integrated service delivery: Intersectoral & interdisciplinary

Pillar 3 – Knowledgeable care team and capacity building

To guide local health system redesign of behavioural support services within the BSO Framework, LHINs were required to develop an Action Plan. The Action Plan identifies local service gaps, resources, and the improvement plan/strategies that need to be implemented to advance the local health system to the future state envisioned within the BSO Framework.

This document details the TC LHIN BSO Action Plan that was developed with guidance of the TC LHIN BSO Advisory Committee. The Committee was comprised of cross sector representation from LHIN health service providers with expertise in the identification, assessment, care and management of individuals and their caregivers with responsive behaviours.

The TC LHIN Action Plan was submitted and reviewed by the BSO Provincial Resource Team and Health Quality Ontario (HQO) Team. The TC LHIN Action Plan was approved and is now in the process of implementation.

Introduction

In developing this Action Plan the TC LHIN Behavioural Services Advisory Committee was guided by healthcare leaders with expertise in responsive behaviours. In addition, to gain greater insight into the gaps and weaknesses of how existing services were meeting the needs of clients with responsive behaviours and their caregivers, the Committee:

- Completed of a current state review of behavioural support services in the TC LHIN, including a review of available data specific for individuals with behavioural issues (Appendix A)
- Reviewed existing services, recent related projects, programs, reports and surveys
- Leveraged insights gained from an HQO led a Value Stream Mapping Session

This information assisted the Committee to identify areas along the continuum of care that were key to improving client/caregiver experience and system performance.

Guiding the Advisory Committee planning were the following planning principles:

Care is person and family-focused

Care includes ethno-cultural sensitivity and culture-specific planning

Ensures sustainability through centralized steering, guidance and leadership

Is a system resource which is built on existing resources and successful programs/services

Promotes inter-disciplinary care, inter-organizational collaboration and system-wide integration

Addresses gaps identified through various stakeholder engagements

Ensuring clarity of the roles and accountabilities of the various sectors across the system in serving this population

Includes prevention strategies to help keep older adults in the community

Promotes quality service through improved transitions across the BS care continuum

Leverages existing quality improvement processes and lessons learned to inform improvement and sustain enhanced services and quality.

Target Population

The Target population of this Action Plan are:

1. Older adults with responsive behaviours that are not manageable with usual interventions, who post risk to self and others and have crossed the threshold of safe effective care management (in community, LTCH and/or hospital ALC setting). The transition points of care include:
    a. Home setting (include retirement home and supportive housing) to crisis BS services
    b. Home setting and LTCH to police, EMS or ED
    c. Home setting and LTCH to hospital including specialty hospital
    d. Acute care and or home setting to LTCH or behavioural support unit in hospital
2. Older adults with responsive behaviours that are safely and effectively managed in their current setting in the community, hospital or in LTCH, and who without appropriate supports are at risk of developing unmanageable behaviours. The transition points of care include:
    a. Home setting to community crisis services or BS outreach supports and/or day programs
    b. LTCH with supports from GMHOT and PRC
    c. Repeated transfer of clients from LTCH/community to ED if behaviours escalate
    d. Acute, post acute/tertiary care and transfer clients to LTCH or home

BSO Framework for Care Pillar #1: System Coordination

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

Current State

There is a wide spectrum of behavioural supports available in the TC LHIN, many of which operate through project-specific or population-specific partnerships and committees.
Seniors focused programs include:

- **Community Navigation and Access Program (CNAP):** The CNAP project is leading the development of infrastructure, tools and processes necessary for a seamless system of care for seniors in TC LHIN. Funded through the AAH strategy, CNAP is laying the foundation to improve and streamline access to services for seniors provided by the Community Support Services (CSS) sector. This initiative is supported by an Executive Committee and a Network comprised of the 33 CSS providers in the TC LHIN.
- **The Seniors Crisis Access Line (SCAL) Pilot Project (SCAL):** SCAL provides a single point of access for seniors in mental health and/or addictions (MHA) crisis who reside in the TC LHIN community. SCAL is supported by a partnership of four crisis services providers who work collaboratively to provide this single point of access for psycho-geriatric crisis services in the TC LHIN.
- **Integrated Care Project For Seniors with Complex Needs (ICCP**): ICCP is a cross-sectoral, integrated client care model that targets frail seniors with complex medical, physical, cognitive and social conditions that require ongoing support to remain in the community. This project focuses on the roles and accountabilities of each provider at key transition points of each client and caregiver's journey as they move through and interact with the system. It will enhance and support their care experience by building stronger relationships within the care team to meet the needs of the client. This initiative is also supported by an Implementation Committee comprised of various sector leads.
- **Coordinating Centralized Access to Senior Specialty Psychiatry Beds (CASS):** CASS is a coordinated access system to access the hospital specialty psychiatric beds at three local hospitals. The cornerstone of the CASS Program is formal working relationships between specialty hospitals and with community MHA service providers, LTCHs hospitals and the TC CCAC. The three participating specialty hospitals work together to successfully implement the project and ensure consistency across the three hospital programs.

In addition, CCAC Case Managers are presently taking up various coordination roles to:

- Facilitate LTCH intake, transfer and placement in the community.
- Work in acute care hospital EDs to facilitate and link follow-up services

- Facilitate discharge of inpatients in acute care back to the community or process LTCH placement

Other networks include:

- LHIN-led sector leadership meetings are held quarterly with all TC LHIN funded sectors (hospital, CCAC, LTCH, CSS, MHA) to discuss system-wide issues, to discuss models of care, to highlight examples of local integration, and to review sector performance on key indicators and discuss performance improvement opportunities.
- GMHOT teams and the Psycho-geriatric Resource Consultants (PRC) informally meet quarterly to liaise, share experience, information and promote best practice. LTCHs and CCAC are also represented in this structure.
- There are regular meetings of LTCHs and CCAC
- Collaboration among the CCAC, GMHOT teams, PRCs and hospitals occurs but is often informal and uncoordinated.
- There is a network of 28 MHA supportive housing providers, many of whom provide services to seniors; a coordinated access point for these units has been developed and referred to as coordinated access to supportive housing (CASH).
- The Toronto Regional Geriatric Program (RGP) is part of a provincial network of RGPs. The Toronto RGP team played a clinical leadership role in the TC LHIN's and subsequently provincial Senior Friendly Hospital Strategy.
- The Toronto Branch of the Alzheimer's Society is situated in the TC LHIN and is part of a provincial network of providers who are a key resource to the BSO program.
- The Toronto MH-ER Alliance is a partnership of the Toronto adult hospitals with emergency departments which provide supports to clients with MHA issues. They collaborate on system level planning, data collection and program development. The Alliance has been engaged in a number of the initiatives funded by the LHIN which benefit the target population.

Despite the various networks and alliances, it is acknowledged that an overall coordination system that drive system services towards common goals of addressing the needs of the target population does not currently exist and is required to help support improved client focused outcomes.

Gaps in System Coordination

The TC LHIN has an extensive number of specialized resources which provide supports to older adults/seniors with responsive behaviours. They include acute care and specialized hospital resources, long-term care supports, education/knowledge exchange services, supportive housing service and community based outreach teams.

However, there is insufficient inter-sectoral collaboration, integration and support across the TC LHIN providers as many of the current behavioural supports programs and services were established in isolation over time. Though health service providers (HSPs) often attempt to bridge these gaps, the outcome often falls short of meeting needs of patients. The TC LHIN has developed many partnerships by collaborating on innovative programs to serve older adults with complex behaviours. System level coordination to maximize effective and efficient service delivery and to create a seamless care continuum

is lacking despite these partnerships. These programs often work in silos making it difficult and confusing for clients, their care givers and health service providers to access. Clients and their caregivers often find it difficult to identify appropriate contacts and/or are unaware that certain programs exist. This can lead to poor prevention of avoidable behavioural problems and crisis situations.

- **Lack of Clarity:** Historically there has been a lack of clarity with respect to the roles and responsibilities of the various HSPs that provide care to this population. Findings from the current state assessment revealed that there are many different providers across the system serving the target population and their responsibilities sometimes overlap or leave unanticipated gaps which can lead to challenges with respect to client transitions.
- **Communications:** Poor communication among care providers and a lack of standardized tools often lead to problematic client transitions, service delays, unnecessary transfers and/or admission to a higher level of care. This also results in clients and their caregivers having to repeat their medical history to different providers as they are assessed multiple times in isolation, and often results in a failure to receive timely access to needed services and intervention.
- **Cultural Competency:** There is insufficient capacity to address cultural diversity in the psycho-geriatric and addiction care system. The roles and responsibilities of programs and leadership in ensuring responsiveness to cultural diversity are poorly defined and there is no systematic strategy for addressing the needs of older adults with responsive behaviours in culturally diverse communities especially among first generation immigrants.

Improving System Coordination

Close to 60 psycho-geriatric, MHA and other HSPs, as well as caregivers participated in the TC LHIN Advisory Committee and/or the Value Mapping Exercise. These groups concluded that immediate changes are needed to improve system coordination and integration, and highlighted that this could be facilitated by leveraging current resources and improved coordination of HSPs to help ensure the provision of services to the target population in a seamless manner along the care continuum.

Several strategies will be implemented to improve coordination and integration across the system for older adults with complex and responsive behaviours:

At a system-level: TC LHIN Behavioural Supports Implementation Committee

To ensure sustainability of an integrated Behavioural Supports "system", a Behavioural Supports Implementation Committee will be established. This cross-sectoral committee comprised of behavioural support service delivery and behavioural supports management experts together with quality improvement experts, clients and their caregivers will be key partners for the newly designed coordinated behavioural supports system. This committee will leverage and collaborate with the existing ICCP Committee to implement "shared responsibilities" and "philosophical shifts in practice" to help achieve improved system integration. Representatives of the other relevant networks described in will also be engaged through this process.

A core principle of this new system design is the active participation of all HSPs, clients and their caregivers to achieve the best outcomes. The committee will adopt a "shared responsibility" model to collectively deliver seamless service to clients and caregivers along the care continuum. The model will include identification of a "functional/sectoral leads" to facilitate and advance the role of "change agents". Under the leadership of the lead HSP (described below), these leads will have the responsibility of initiating and promoting coordination of specific functional activities by networking and enhancing system-wide coordination with one another throughout the LHIN.

Each lead will be chosen as a champion and expert in their own specific area of function and/or service sector. These individuals will network and work closely with their peers and represent their peers in bringing specific ideas and work plans to the Behavioural Supports Implementation Committee table. They will promote close collaboration with other functional leads and groups to help develop formal and informal partnerships and seamless processes, identify common tools and best practices to advance the system and enhance system communication and coordination. This committee will also identify and help define and recommend roles and responsibilities for each sector with respect to better addressing the needs of this population and will be responsible for reviewing and providing recommendations on enhancing the model of integrated service delivery in the community for this population.

"Diversity" and "Health Equity" are overarching foci of our behavioural supports system coordination. Each Functional/Sectoral Lead will be a key contributor to the development of action strategies for culturally sensitive services and programs for the diverse and underserved populations living in our urban setting. These principles and ground-up efforts will build cultural competency among care providers, and help provide equitable and culturally appropriate services to meet the diverse and unique needs of the target population.

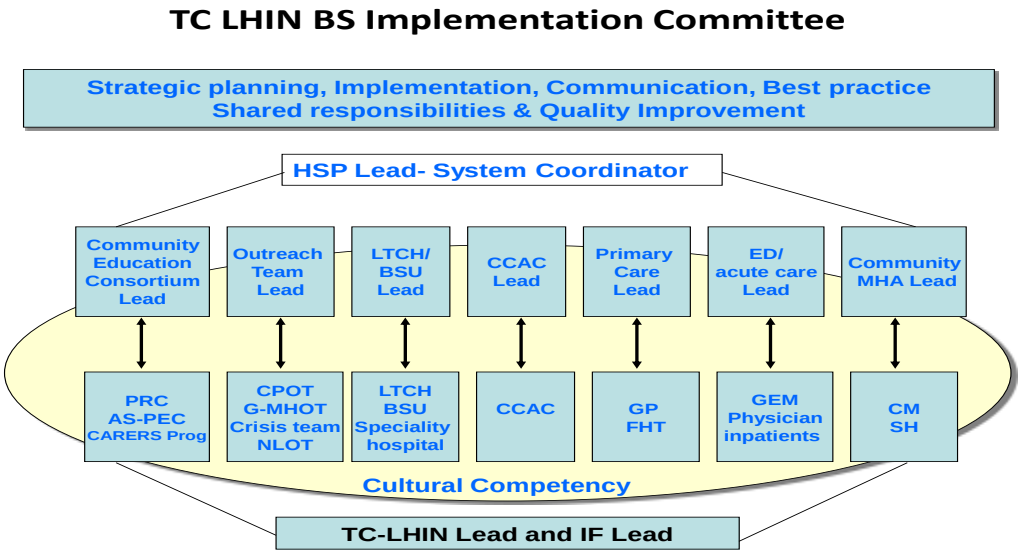

Figure1: TC LHIN BSO Implementation Committee

At an operational-level: A coordinated access point of access for community behavioural support services

An existing coordinated access psycho-geriatric crisis line and inter-disciplinary mobile crisis support model for individuals with behavioural issues will be enhanced to improve access to community behavioural support services. Extending beyond crisis support, the enhancements will include information and referral supports for clients, caregivers and health service providers seeking BS services. It will also continue to include crisis counseling and dispatch of mobile BS crisis services as appropriate.

At the point of care: Integrated LTCH outreach teams and community outreach teams

Two proposed models of outreach will enhance coordination of services at the point of care.

a) **In Long-Term-Care Homes(LTCH):** integrated LTCH outreach teams will be implemented at one site and will coordinate with existing LTCH outreach supports (GMHOTs, PRCs) to collaboratively assess, consult and provide indirect support to the LTCH staff in the care and management of identified clients. They will act as care navigators, specializing in integrating services at the point of care and in mobilizing experts to support the situation. They will also be responsible for streamlining outreach processes in LTCHs, and working with the outreach teams to clarify roles and responsibilities. They will function as a key resource to LTCH staff, particularly to the behavioural response nurse identified by each facility. Given their core competency with respect to behavioural support services, they will build the capacity of the LTCH teams that they engage to help enhance the skill-set of LTCH staff.

b) **In the community:** Three Community Outreach Providers (CPOPs) with behavioural support expertise will be linked with the TC CCAC Seniors Enhanced Care (SEC) Program to provide specialized behavioural support expertise to these teams. They will also work with the SEC Care coordinators to make referrals to other appropriate supports as required (e.g. Community Psycho-geriatric Teams (CPOTs), and provide education and training supports and other MHA services as needed. The CPOPs are intended to provide additional behvarioural support capacity in the community to help address identified gaps. They will support the SEC teams with the provision of system navigation support for clients with behaviours and their caregivers along the care continuum in the community. They will further support, liaise and partner with existing crisis teams, MHA providers, and CPOTs to develop an integrated pathway for clients.

Governance Structure

There will be three mechanisms for accountability for the behavioural support system at the local level (see Figure 2 below).

TC LHIN

The LHIN will maintain overall responsibility for the TC LHIN BSO initiative through our funding accountability with the Ministry of Health and Long-Term Care and the memorandum of understanding with the CRO. Through a defined project charter and funding letter, the LHIN will delegate implementation responsibility and accountability to Baycrest as the HSP lead (see below).

The LHIN will continue to provide leadership for this strategy to promote system integration, assist in cultivating and encouraging a culture of partnership and collaboration and will support and provide direction to the Implementation Committee to achieve its defined goals.

In addition, all HSPs receiving funding for this initiative and other key stakeholders (e.g. lead for coordinated access line) will enter into accountability agreements with the TC LHIN through project charters and funding letters which will outline the funding, key responsibilities, deliverables, milestones and performance indicators related to the implementation of the TC LHIN BSO initiative. Through these charters, each organization will be accountable to the TC LHIN for the successful implementation of their respective component of the BSO project. These HSPs will also be members of the TC LHIN BSO Implementation Committee.

HSP lead- Baycrest

The TC LHIN has appointed Baycrest as the lead for the TC LHIN BSO Strategy. Selected through an expression of interest process to identify potential partners for the implementation of this strategy, Baycrest most closely met the criteria developed by the Advisory Committee. They will be charged with the accountability for the implementation of both major pieces of the strategy (Behavioural Support Unit implementation and rollout of the new Outreach capacity). Baycrest is already a key player in the delivery of psycho-geriatric services and hosts a number of programs and services (e.g. memory clinics, in-patient psycho-geriatric units, a specialized behavioural support unit in hospital, a GMHOT team, and a CPOT team).

In addition, Baycrest has recently been appointed one of three LTCH Centres of Learning, Research and Innovation in Ontario which will champion innovative approaches to senior's care and disseminate lessons learned to providers of LTC across Ontario. The teaching unit will have an academic focus on education of interdisciplinary team members; e.g. RN, RPN and PSW. It is a significant resource in the TC LHIN that is very well positioned to align with and to leverage existing limited often inadequate resources in this area. Finally, Baycrest has recently been assuming a leadership role for three key quality initiatives on behalf of the TC LHIN; the Falls Prevention strategy, the Senior Friendly Hospitals best practice toolkit initiative (in a co-chair capacity), and the identification of system level indicators for the LTCH and CCC sectors.

Through their accountability agreement, project charter and funding letter with the TC LHIN, Baycrest will be accountable for the implementation and oversight of the TC LHIN BSO Strategy. The majority of the TC LHIN allocation of human resources will be provided to Baycrest as described in a later section of this report. Baycrest will hire a System Coordinator /Manager to lead the overall implementation and to work closely with the BS Implementation Committee to help catalyze system innovation, integration and coordination, act as a change agent and connector to organize committee functions, reach out to the BS system LHIN-wide, and engage, motivate, liaise and collaborate with Functional/Sectoral Leads.

TC LHIN BSO Implementation Committee

The cross-sectoral committee described above will be accountable to the TC LHIN through Baycrest as lead HSP for this strategy. Membership will include TC LHIN Project Lead, QI Lead, health service provider leads and sector leads from across the continuum of care. This committee will be responsible for overseeing the BSO Action Plan implementation, promoting best practices, change management, liaison

with peers and monitoring of the outcomes and performance of local BSO program partners on an ongoing basis.

The Implementation Committee will assume the responsibility to test various new designs through small tests of change, evaluate change strategies and performance of service coordination and collaboration across the care continuum The goal is to optimize existing resources and service capacity already in the system and to share responsibility in order to align and integrate existing efforts and services with new resources.

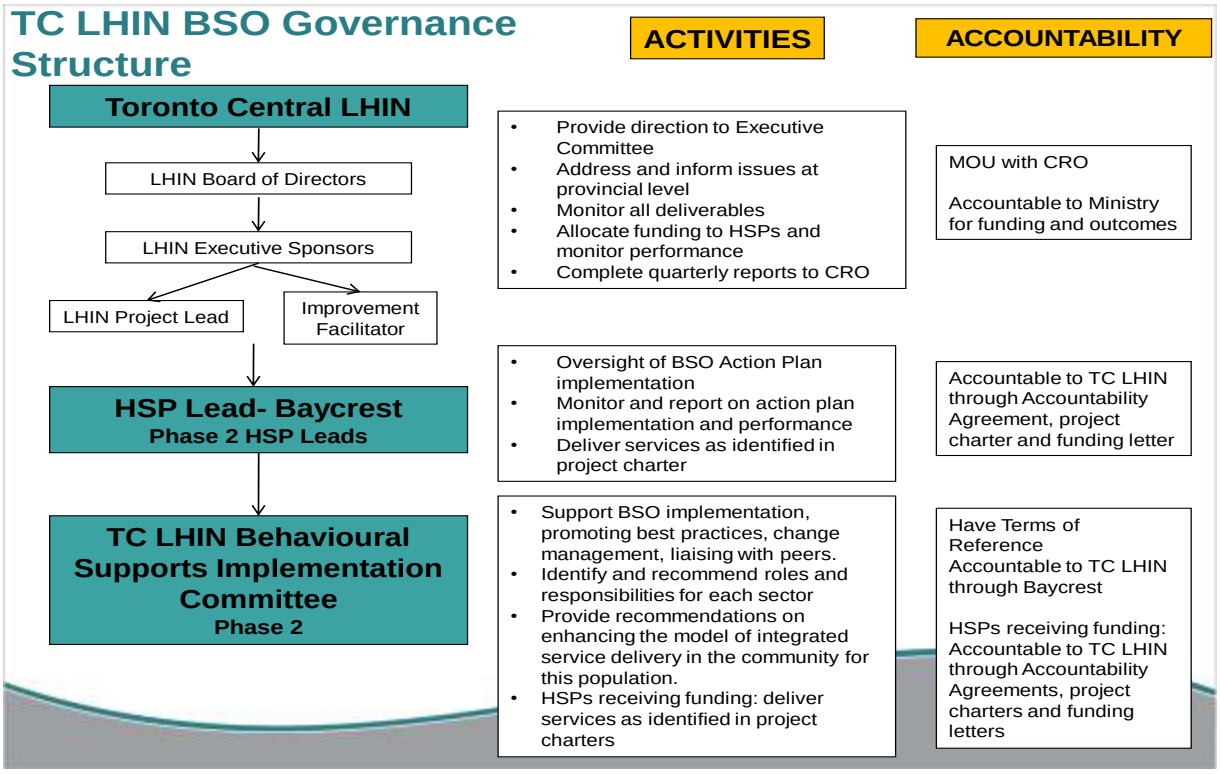

Figure 2: TC LHIN BSO Governance Structure

Partners in BSO Implementation:

Baycrest will assume the role of HSP sponsor/lead on behalf of the TC LHIN. They will be accountable to the TC LHIN for the implementation of the strategy. This includes providing leadership to, and chairing the implementation committee, driving and monitoring system level changes.

Behavioural Supports Outreach Teams:

- 11 GMHOT teams providing outreach and support to the 36 LTCH
- Two nurse-led outreach teams (NLOTs) based at UHN and Toronto East General Hospital
- Three mobile community crisis teams (Gerstein Centre, St. Elizabeth Healthcare and WoodGreen Community Services)

- Four Community Psycho-geriatric Outreach Teams (CPOTs) based at Baycrest, CAMH (PACE), Sunnybrook and West Park with additional support from Community Outreach Program in Addiction (COPA) that provide outreach BS services in the community

- The proposed community outreach and LTCH mobile outreach teams based at Baycrest

LTCH: The 9 LTCHs that expressed interest in participating in the BSO strategy will be key partners to implement and test the LTCH outreach model. In addition, Baycrest with the new specialized behavioural support unit (see Pillar 2), will be a key partner from the LTCH sector. This will expand to include the 37 LTCHs in our LHIN, post the evaluation of the 'small tests of change' with the 9 organizations in question.

Specialized geriatric mental health inpatient programs: There are 88 specialty geriatric mental health hospital beds in three hospital-based specialty behavioural units (Baycrest, CAMH, and Toronto Rehab) as well as the Coordinated Access to the Seniors Specialized Psycho-geriatric services (CASS) office that coordinates access to these units.

Education/Knowledge to practice:

- Representation from the 9 Psycho-geriatric Resource Consultants (PRCs) who provide education, mentoring and teaching to health service providers.
- Alzheimer Society of Toronto provides education and mentorship to caregivers and the public education and training for PSW in the community
- The Cyril & Dorothy, Joel & Jill Reitman Centre for Alzheimer clinical support and training at Mount Sinai Hospital provides knowledge-to-practice training and supports to caregivers, health professionals and CCAC Case Workers
- Baycrest's new LTCH Centre for Education, Research and Innovation

TC CCAC: responsible for coordination at various points of care along the continuum

ED: geriatric ED physician champions, GEM nurses

Acute/tertiary/complex continuing care (CCC): representatives from CCC, CAMH and acute care hospitals

Community Mental Health and Addictions Providers: Community Outreach Programs in addictions (COPA, and Supportive Housing Providers

Clients, families and caregivers

Diversity: champions, care providers from diverse ethno-cultural communities

There have been formal and informal collaborations and partnerships among HSPs serving the Behavioural Supports care continuum. The following are key examples of strong interdisciplinary collaborations:

- The LTC-MH Framework Project that brought together many of the partners described above to develop a Framework which was subsequently implemented in phases throughout LTCH, hospitals and the community.

- The Centralized Access to Seniors Specialty Hospital Beds (CASS) Project works in close collaboration with specialty hospitals, CCAC and LTCHs.

- The ED-GMH Program Implementation to EDs in all TC-LHIN acute care hospitals. The project has promoted collaboration between Emergency medicine and psychiatry. It has involved GEM, GMHOT, CCAC, LTCH, nurse led outreach team and BS educators.

- The ICCP Project that collaborates with primary care, acute care, psycho-geriatric services, CCAC services, LTCH and community services and Psycho-geriatric training programs.

- Community Navigation and Access Program (CNAP): a network of over 30 not-for-profit organizations, working together. The network developed and implemented a coordinated access model with one phone number to help improve access to serve delivery across Toronto.

Collaborations between service providers to date have augmented mutual understandings of roles and responsibilities, working processes and relationships between sectors and HSPs. All sectors are becoming more aware of key stakeholders in the system and are working together to improve behavioural support services for the targeted population. There is increased awareness of available programs and services targeting this population, there is improved communication between the various partners (e.g. LTCH and hospital EDs). Key stakeholders have realized the importance of working together to develop a seamless process for serving the target population.

It is encouraging to observe health service providers enthusiasm in working together and commitment to strive for improved services for the target population.

BSO Framework for Care Pillar #2: Interdisciplinary Service Delivery

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

The Ministry of Health and Long Term Care (MOHLTC) Toronto Regional Office's 2006 LTC-Mental Health Framework Report recommended a framework that provided a solid foundation for improving services and addressing care needs for this population. Initiatives implemented shortly after the release of this report included alignment of all GMHOTs to the 85 long-term care homes (LTCHs) across the City of Toronto and the identification of behavioural support nurses in all LTCHs.

Subsequently projects funded through the Toronto Central LHIN including the Aging at Home (AAH) strategy were implemented to continue to address system gaps, including high support housing, transitional housing, Mental Health and Addictions (MHA)crisis teams, MHA crisis line, coordinated access to specialized MH assessment and treatment beds, coordinated access to psycho-geriatric services, psycho-geriatric screening tools in emergency departments, integrated care teams for high risk frail seniors.

Along the care pathway of older adults with behavioural issues, there are areas where access to behavioural supports and services can be improved, including in the community, in LTCH and at transition points along the continuum. From the clients and families' perspectives, it is hard to see that in the current system "every door is the right door" or that every door can lead them to an appropriate level of BS service in a seamless manner.

Gaps in Service Delivery

For older adults living in the community:

- **Older adults and their caregivers often experience the system as fragmented**:
  - Many older adults and/or their caregivers do not have enough information about how and where to get different types of BS services at the right time. There is not a coordinated access point to find out where and how to access BS services.
  - There often is no consistent POC coordinator or care provider forcing the client and family caregivers to be their own "care connector" negotiating with various providers who are essential to accessing the care system including their own family physician, CCAC, various community agencies, and institutionally based acute, specialty and chronic care resources.

- **There is a lack of specialized community behavioural support capacity:**
  - Access to community behavioural outreach services is limited and inconsistent across the TC LHIN. For example, access to mobile crisis outreach support is limited in the west-end of the TC LHIN.
  - Many individuals with behaviours are waiting in the community for LTC, with limited and inconsistent follow-up and/or specialized supports.
  - Access to community BS services may be temporary and are not at the appropriate level. Transitioning from one service to another is also inconsistent depending on the availability of resources. For example, community mobile crisis outreach teams often see clients longer than the suggested timeline (6 weeks) due to a lack of availability of ongoing longer-term community outreach supports.
  - There is often a waitlist for services and the wait time is often unknown. This is a very unsettling feeling for the clients and their families as they struggle with the already emotionally difficult decision of seeking higher levels of care such as a LTCH.
  - In certain instances, there are insufficient workforce skills to support the target population. Primary care and other community health service providers require enhanced consultation, support and knowledge to skillfully manage and support the target population.
  - Lack of capacity to address behavioural issues related to addictions both in the community and LTCH.

The needs of younger patients with significant behavioural disturbances secondary to brain failure such as, ABI or dual diagnosis are not being adequately met within the current continuum of care.***Note: the needs of these populations will be addressed through a separate but aligned behavioural support strategy*

- **Lack of caregiver support and respite services:**
  - Many families/caregivers experience fatigue and burn out. Some caregivers do not have the relevant knowledge and skills to support their family members with significant responsive behaviours at home. Although programs, such as those offered by the Alzheimer Society of Toronto, the Reitman Centre at Mount Sinai exist to provide caregiver education and support, they may not be aware of these resources or be able to access such services.
  - In such instances, these providers tend to use the ED when the client's responsive behaviours become unmanageable although it is not necessarily the best provider for them. When the clients go to the ED they often have difficulty remembering or communicating information on medications, co-morbid conditions, DNR orders etc. Thus the outcome of ED visits is often unsatisfactory and the intervention non-specific to the problem.

For older adults <u>living in LTCH</u>:

- **Lack of specialized behavioural support capacity in LTCH:**
  - Many individuals are denied admission to LTCH due to their behaviours that cannot be managed through the level of care currently provided in existing LTCH settings. These individuals are often refused admission to LTCH due to their behaviours. Often, the LTCH is not prepared or perceived

as not up to the standard to accept, stabilize and manage these clients. As a result many clients are kept in acute care settings unnecessarily.

- Only 2% of the total LTCH capacity in the TC LHIN is currently providing specialized behavioural supports in three 'dementia units' across 36 LTCHs. In addition, 19 homes have a secured unit without additional supports/programming.
- The capacity and competency of staff managing responsive behaviours differ from one LTCH to the next. Not all LTCHs utilize available resources such as outreach support from advanced specialized programs. Current methods of education and learning often do not translate knowledge to practice nor make robust changes in work/practice culture to effectively serve the target population. In such cases, residents with unmanageable behaviours are often sent to the ED or be admitted to an acute care or specialty hospital in order to stabilize these behaviours. It has been found that older adults with responsive behaviours admitted to acute care wards often have prolonged stays and worse outcomes that those with intact cognition (Dementia in the acute hospital, Sampson et al. 2009).

At transition points across the continuum of care:

- Many older adults with behaviours that are referred to other facilities in the care continuum (e.g. from acute care to rehabilitation care/complex continuing care/LTCH/convalescent care/or speciality hospitals) are often denied admission by the receiving facilities because of behavioural concerns and are then designated ALC. Overall, denials due to behaviours account for 9.9% of all denials. The denials range from 0% in Convalescent Care (CC) to 49% in LTCH (Sources: RM & R Summary of Denial Reasons for all Combined Sectors – April 2010-February 2011). This is often due to a lack of communication and standardized tools to support the transitions across sectors and/or real/perceived lack of capacity to address the client's needs at the receiving site.
- The client's relevant medical and responsive behaviours are often poorly documented in the transfer notes from one facility to another. There is little or no baseline responsive behaviour information to inform the receiving team of the behavioural problems. Of particular importance is the well documented data that show that delirium, a marker of high risk of mortality and a potent cause of behavioural disturbance is unrecognized in 2/3 of cases.
- There often is no consistent POC coordinator or care provider forcing the client and family caregivers to negotiate the system on their own.

We heard from caregivers that one contact/ relationship to support system navigation and timely and appropriate access to services across the continuum are essential. The value stream mapping exercise with health service providers and family members identified the need for a more integrated and collaborative system at the point of care in the community as a key piece of the model.
The followings key quality elements were used in the development of the action plan and system redesign:

- Ensure the client's perspective - involve clients/care giver in service planning and delivery
- Easy and friendly access to service
- Maintain clients at home, reduce unnecessary transfer

- Mobilize coordinated outreach services to clients
- Deliver timely, consistent and appropriate services
- Use data and performance measures to inform improvement
- Cross-sectoral coordination and integration
- Culturally sensitive and competent

Improving Service Delivery

The future TC LHIN behavioural support system leverages existing programs, services and resources to enhance, redesign and implement new services and realize a system of care that is person-focused, that addresses client and caregiver needs throughout their journey along the care continuum. There are several programs serving the target population and supporting their caregivers. There is also a new level of eagerness and willingness across the system to build on these services to improve the overall system of care for older adults with complex and responsive behaviours.

Building on these resources and the motivation of the sector, the TC LHIN will address the gaps by:

- Improving coordination and reducing fragmentation of the community BS system to ensure more equitable and timely access to services
- Increasing specialized community capacity/outreach to support individuals to stay in their existing environment, reduce or prevent unmanageable behaviours
- Increasing specialized behavioural support capacity in LTCH
- Improving caregiver education and support
- Increasing workforce skills and training for providers across the continuum
- Reducing and/or improving transitions across the continuum

The TC LHIN BSO Advisory Committee ensured that the client's perspectives guided the planning and design of the Action Plan by inviting caregivers to participate in all aspects of the planning and by leveraging the Value Statement developed in the Value Mapping process:

"Recognize my past, and help me find meaning in my present"

Building on all of these factors, the key gaps will be addressed by:

Improving coordination and reducing fragmentation of the community BS system to ensure more equitable and timely access to services:

A **coordinated access call-line** will be developed to improve access and system navigation. This line will allow clients, caregivers and health service providers in the community to directly and easily access to the system and appropriate supports. The call line will use an established service decision algorithm to activate the appropriate level of services

- For enquiries, information requests and less urgent needs, the access line will provide information, assist clients in navigating the system, and identify and refer clients to appropriate behavioural support services and programs (e.g. link to education and training, connect with CNAP for community support services, link to MHA or CCAC supports, etc.)
- For urgent, immediate needs clients, counseling will be provided over the phone to attempt to de-escalate the situation. If this approach is not successful, a response from the mobile crisis team will be activated to conduct a rapid assessment and escalate to urgent services as required.

This access line was a recommendation identified at the value stream mapping session to improve access to the behavioural support system and improve system navigation for clients and their caregivers in the community. The TC LHIN will leverage an existing coordinated access line (e.g. CNAP for access to seniors' community services and SCAL for psycho-geriatric crisis supports only; the CCAC access and information line and the Toronto 211 service). All of these lines will be reviewed to determine the most appropriate mechanism to incorporate this new line. The LHIN will leverage and expand existing services with additional resources and better linkage with newly re-designed Community Outreach to coordinate a LHIN-wide program.

Increasing specialized community capacity/outreach to support individuals to stay in their existing environment, and reduce or prevent unmanageable behaviours

Community capacity is proposed to be enhanced in two areas:

Enhancement of community mobile crisis services:

Though mobile inter-disciplinary psycho-geriatric crisis outreach supports currently exist in the TC LHIN, a gap in crisis supports has been identified in the west end of the LHIN. Selected through the EOI process, WoodGreen Community Services will expand their current mobile crisis inter-disciplinary team that provides services in the East end to ensure coverage in the west end of the LHIN. 2.5 FTE crisis workers and a 0.5FTE NP will be hired to support this expansion. This team is directly linked to an existing psycho-geriatric crisis telephone line and is dispatched when phone counseling is not sufficient.

Community-based psycho-geriatric outreach provider (CPOP):

Three FTE CPOPs will be employed by Baycrest and will be linked to the three TC CCAC Seniors Enhanced Care (SEC) teams in the East, West and Central areas of the LHIN. The SEC teams currently provide intensive case management to support 2500 complex high needs seniors, of which 80% have some form of cognitive impairment and at least 40% have complex responsive behaviours. Using a non-pharmacological approach, these CPOPs will provide specialized behavioural clinical assessment, develop a behaviour management plan for the client, family and care providers, provide advice and consultation to the care team, work collaboratively with the psycho-geriatric teams, provide caregiver education and support, and work with PRCs and LTCH staff to develop transitional plans when the need for LTCH support is identified. They will also work with the SEC Care coordinators to make referrals to other appropriate supports as required (e.g. Community Psycho-geriatric Teams (CPOTs), education and training supports and other MHA services as needed).

The CPOPs are intended to provide additional behavioural support capacity in the community while improving coordination, to support system navigation for clients with behaviours and their caregivers along the care continuum in the community. They will support the CCAC SEC teams and liaise and partner with crisis teams, MHA providers, and CPOTs to develop an integrated pathway for clients. The CPOPs will use standardized tools, established decision algorithm and pathway to connect and interact with other partners to ensure consistency and smooth transitions. This new resource is aligned with the recommendations identified at the Value Stream Mapping day to enhance behavioural support expertise and support system navigation of the BS system for clients and caregivers in the community.

Since these CPOPs will be employed by Baycrest, they will also be able to access the various supports available through this network of care including the educations consortium (described in Pillar 3), and other specialized behavioural support resources.

Increasing specialized behavioural support capacity in LTCH

Two approaches are proposed to be taken to increase LTCH capacity to address the needs of older adults with complex and responsive behaviours.

LTCH Outreach Teams (LTC-OT):

These outreach teams will take on multiple roles, including coordination, consultation, support and knowledge transfer to initially support the 10 LTCHs that expressed interest in participating in the TC LHIN BSO strategy.

This enhanced specialized mobile team will leverage and expand existing specialized BS consultation, support and knowledge transfer functions currently provided by the Geriatric Mental Health Outreach Teams (GMHOT) and PRCs to provide additional capacity, support and hours of service (e.g. evening and weekend coverage). This is a significant "pull" strategy and correction to ensure services are available when required, by maximizing existing and enhanced resources to support LTCHs so that the high risk residents can still stay where they are and avoid unnecessary transfer to inappropriate high intensity level of service. The LHIN plans to ensure client-focus approach versus the traditional provider focused approach to care. By doing so the LHIN is well aligned with it quality focus.

These teams will be based at Baycrest Jewish Home for the Aged, Apotex Centre and will be an extension of the proposed behavioural support unit (see below). These LTC-OTs will respond to case-by-case requests from the 10 other LTCHs for assistance with residents who present with unmanageable behaviours. These teams will be tasked with coordinating the other LTCH outreach supports (GMHOTs, PRCs) to collaboratively assess, consult and provide indirect support to the LTCH staff in the care and management of specific clients. Examples of potential activities include: mentoring staff as they develop and/or execute clients' care plans, review Medication Administration Record (MAR), review intervention items and process, perform environmental assessment, assist with applications for High-Intensity Needs Funding, and connect with other appropriate resources. The goal of this approach is to reduce transitions for residents, to assist residents to stay in their current setting and to build behavioural support capacity across the LTCHs.

The LTC-OTs will also take a leading role to:

- Act as a care navigator, specializing in integrating services at the point of care and in mobilizing experts to support the situation.
- Streamline outreach processes in LTCHs, clarify roles and responsibilities of various outreach teams and to integrate outreach services in LTCH;
- Promote partnerships and mitigate fragmentation;
- Provide education, skill-building, and mentorship to LTCH staff on a case-by –case basis to build capacity within the LTCH
- Act as "change agents" adopting change management tools to foster a BS culture system-wide and to continuously test, evaluate and improve LTCH outreach strategies.

To effectively transfer knowledge to practice, the mobile teams will actively liaise with existing Behavioural Support Staff in each LTCH, provide specialized support to the staff providing direct care to individuals with behaviours (RNs, RPNs and PSWs), spearhead and mentor best practices, and promote knowledge exchange while building capacity of the team members.

The LTC-OTs will be coordinated by a highly skilled RN with the ability to liaise, mentor, coach and engage with LTCHs, GMHOT, PRC and other key partners including primary care, ED, acute care, community and other new initiatives designed in this action plan. The Team Lead is intended to possess advanced clinical assessment skills, advanced knowledge of the specialty resources (e.g. specialty hospital resources, intensive management units in the LTCH homes, best placement options for managing behavioural disturbances). The LTC-OT Lead will be complemented with a skilled team of RN and PSW who demonstrate the core competencies identified through this initiative and the compassion and attitude to work with older adults with responsive behaviours.

This model will initially be tested with the 10 LTCHs that submitted an expression of interest to participate in this strategy, with the intention of expanding this service to all LTCH once it has been tested and enhanced using quality improvement tools.

The second strategy is the development and implementation a <u>23-bed transitional Specialized Behavioural Support Unit (BSU)</u> at the Baycrest Jewish Home for the Aged, Apotex Centre:

<u>Model:</u>

- This unit is proposed to provide <u>transitional</u> high-support specialized care for individuals whose responsive behaviours have become unmanageable in their current setting (e.g. hospital, community, LTCH) with an estimated LOS of five months. For clients in LTCH, this unit will support individuals whose needs cannot be supported even with support from the LTC-OT and other outreach supports. The goals are to stabilize the resident's behaviours and to support their transition to a more appropriate destination (community or standard LTCH unit).
- Baycrest was selected through an EOI process. This organization has a 23 bed locked/ dementia unit that will be leveraged to provide a higher-level of support for individuals with unmanageable behaviours. They have significant experience and knowledge in providing services to the target

population and have many resources that can be leveraged to support the implementation of this unit, including specialized hospital programs, a GMHOT team and a CPOT team. As previously mentioned, they have also been recently designated as one of three LTCH Centres of Learning, Research and Innovation in Ontario.

- Clearly defined admission and discharge criteria have been articulated to guide the flow of clients in and out of these units and through the ***intensive BS care continuum*** (LTCH regular unit, BSU and geriatric specialty hospital beds). The ***intensive BS care continuum*** is an integrated path for clients to transition and flow in and out of their cycle of manageable-unmanageable behaviours. The advisory committee has defined initial criteria that will support client flow to/from regular LTCH beds to the LTCH BSU and/or the specialized hospital BSUs.
- The intake/transfer/discharge process will be facilitated by a trained, designated CCAC Manager and will be supported by POC providers at the referring and receiving facilities with additional coordinated involvement of the CPOPs and/or GMHOT team.
- Best practice tools and methods designed to assess behaviour type, frequency and intensity will be used to evaluate clinical status and to set objective standards to determine clients' readiness to transition to a more appropriate level of services.
- The BSU will be enriched with innovative and stimulating programs to stabilize and avert unmanageable behaviours.
- The designated GMHOT, the LTC-OT, the CCAC and the BSU Unit Manager will facilitate and support any necessary transfers of clients to the ED with relevant clinical and behavioral history notes and medication administration record. They will serve as the connector to relate required information and connect with the ED, GEM to receive and support the clients back with clear instruction on intervention and medication.
- If the client needs to be admitted to the hospital as an inpatient, a continued dialogue between the BSU team and the hospital ward is maintained. When the client is ready to be discharged back to the BSU or originating LTCH, the GMHOT, the LTC-OT and the BSU team will work with the hospital discharge planner to support the client's transfer back with minimal interruption.

<u>Staffing</u>:

- The unit is proposed to be staffed with a highly skilled specialized inter-disciplinary team with advanced intensive behavioural support knowledge, skills, experience and compassion. Core staff categories include RN, RPN, PSW, SW, RT.
- The regulated to non-regulated staffing ratio will be higher than regular LTCH units. It will be enhanced from a ratio of 20:80 in regular LTCHs to 40:60 in BSU.
- The BSU is proposed to be staffed with a Unit Manager. Beyond his/her clinical and administrative roles for the unit, she/he is a motivator, mentor, liaison and change agent to foster a BS culture for the unit. He/she will promote standards and best practice, motivate commitment from staff and promote job satisfaction by ensuring a safe, professionally stimulating and rewarding work environment. This manager will also be responsible for liaising and coordinating with appropriate outreach supports, including the GMHOT team and/or specialized services at Baycrest hospital.

Environment:

- The unit environment will strive for best-practice design including being a self-contained locked unit, with behavioural support design such as special lighting, colour schemes, floor design, furniture, signage, wandering space, and special door design for exit-seeking persons.
- This unit will be supported by advanced specialized case management and consultation within the unit and link closely with designated GMHOT and PRC visit this LTCH.
- *Of note, this unit will require a 'specialized unit' designation from the MOHLTC and will need to be designated under the transitional care framework in order for clients to be able to transition in/out and ensure flow through the unit.*

Reducing and/or improving transitions across the continuum

It is anticipated that through the enhancements noted above, including enhancement of the mobile crisis outreach teams, additional community outreach supports and LTCH outreach, clients will be better supported in their current environment and will help prevent avoidable transfers to higher levels of care. In instances where care needs cannot be addressed, it is anticipated that the new partnerships and roles/responsibilities of the outreach teams will assist with supporting client transitions across the continuum of care.

Small tests of change with systematic evaluation and improvement strategies: service redesign will be implemented in phased approaches to allow for systematic evaluation and change using QI tools and strategies. This will support successful implementation and sustainability of the model by leveraging successes and addressing ineffective approaches. To sustain the newly designed service, an enabling environment and culture across the system and within organizations is required to foster new learning, and support innovation.

In addition, quantitative and qualitative evaluation methods will be built into the implementation. The TC LHIN will ensure performance metrics are included in each phase of implementation

The following process map leverages pieces of the Value Stream Mapping map that focused primarily on the community and builds in the other pieces of the continuum (e.g. hospital, LTCH).

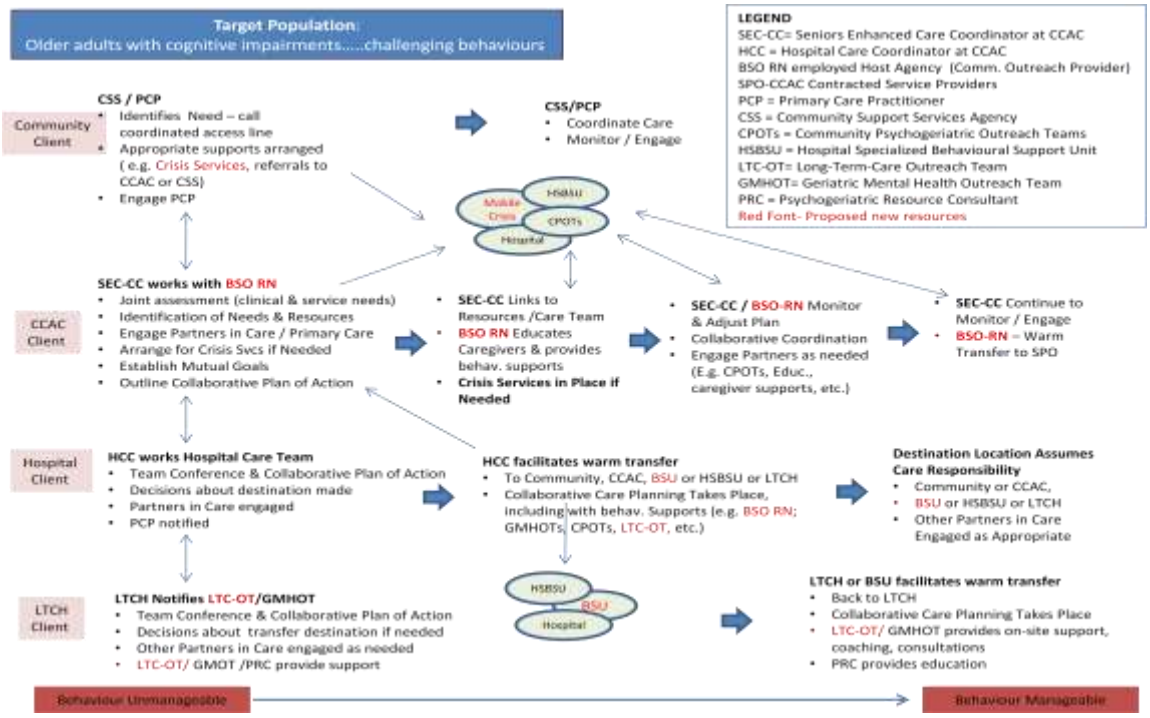

Figure 3: Process Map of BS Continuum of Care

Figure 4 below provides a more system-level picture of how the resources will ensure care will be improved for clients and their caregivers.

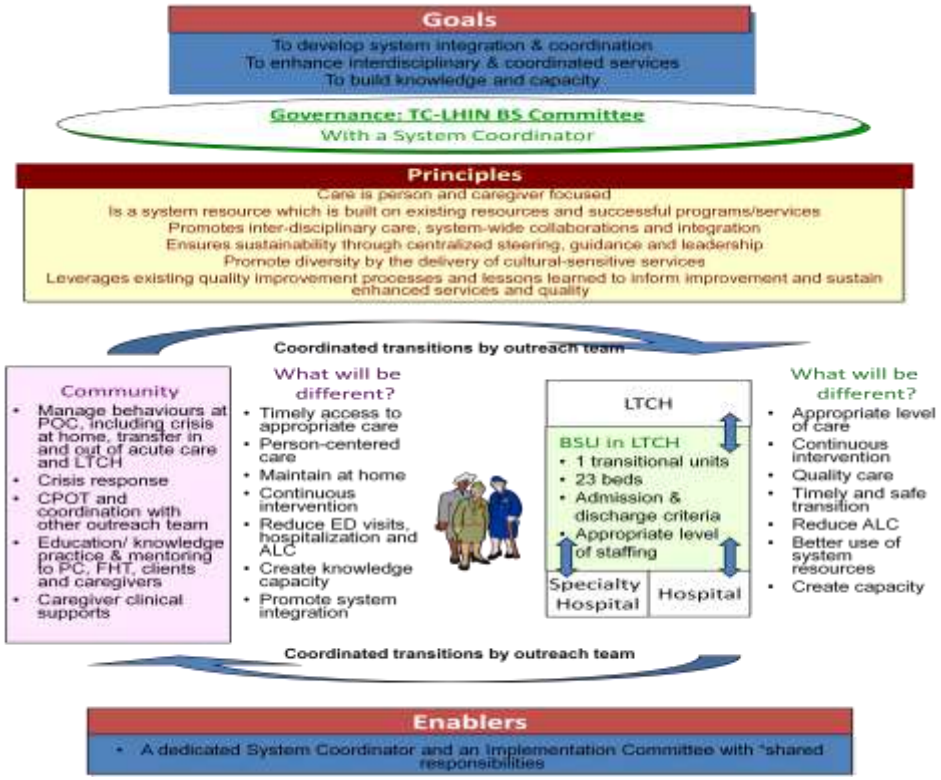

Figure 4: Behavioural Support System Diagram

Strategies To Address Service Gaps

The following processes will support timely and equitable access to the right care by the right provider:

Access to behavioural assessment services

Behavioural assessments services are already provided at various points of contact. For example, all ED front-line teams have implemented the ED-GMH protocol to apply ED appropriate assessment tools following an established algorithm to early identify responsive behaviours. Existing CPOT and GMHOT, CCAC and LTCH all have various assessment tools to diagnose and monitor behavioural issues.

One objective of the Behavioural Supports Implementation Committee will be to review, identify, promote and test best practices including the use of standardized assessment tools, processes and supporting documentation to achieve a consistent, integrated and result-oriented approach of care.

Access to comprehensive geriatric assessment

A comprehensive geriatric assessment will be conducted by an inter-disciplinary team using standardized tools when a client accesses the behvarioural support system. All HSPs will complete an assessment or will refer the client to appropriate behavioural support programs/services to complete a thorough assessment to identify responsive behaviours as early as possible. Thereafter, ongoing assessments will be conducted periodically according to the individualized care plan during intervention. Care providers/ partners will ensure effective communication to avoid repeating unnecessary assessments and the development of independent care plans. The common goal for all HSPs is to provide a seamless and efficient care path with the participation of the clients and families.

Access to behavioural support services for people with complex and challenging mental health, dementia or other neurological conditions

Caregivers as well as health service providers in the community and in LTCH who know the clients will be best able to recognize behaviours or changes in behaviour that could require additional supports. In addition, there are tools available for HSPs that can assist in detecting behavioural concerns early in order to provide the appropriate interventions. It is also anticipated that the new behavioural supports capacity will have the skills and tools to support providers and caregivers across the system to identify appropriate clients given their core competency in this area.

Primary care providers will also be engaged by leveraging the ICCP Project's primary care collaboration path to develop processes for collaboration and identification of individuals who may require behavioural supports.

Access to Right Care for Individuals outside the Target Population

Providers within the BS continuum of care for older adults with responsive behaviours will be made aware of services and supports for individuals not identified as part of this strategy (e.g. younger adults and individuals with ABI or dual diagnoses), and will be conscious of how to link these clients to appropriate services. A second phase of the development of the TC LHIN BSO strategy will be to identify ways to align the strategies for these two populations.

With respect to the older adults, our plan supports individuals at risk as well as individuals who have unmanageable behaviours across the system. The intention is to create a system where "every door is the right door" for everyone and those individuals will be connected to appropriate services when they need it.

Support of Individuals in Crisis

In the community including own home, retirement home and supportive housing, clients, caregivers and HSPs can access the coordinated call-line to get connected to telephone crisis counseling and mobile crisis outreach services.

In LTCH: unmanageable and crisis situation (not requiring ED admission or police intervention) will be connected with the new LTC-OT and the LTCH's designated GMHOT team to assess and escalate to different level of care as required.

Partners in Interdisciplinary Service Redesign

TC LHIN providers are increasingly working collaboratively across sectors and disciplines which has resulted in:

- increased inter-sectoral partnerships, shared accountability and system efficiencies
- mechanisms that sustain interdisciplinary service delivery
- enhanced or satisfying service experience for seniors and their family/caregivers
- improved population health, quality of care and system sustainability

Refer to Appendix B for examples of examples of interdisciplinary and intersectoral collaboration and interdisciplinary partners .

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

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

Knowledge Transfer Capacity

Across the TC-LHIN, there are many established programs that support knowledge transfer, and dissemination of new knowledge and best practice relating to behavioural supports.

Organizations and institutions that provide direct training and education for professionals include:

- **Teaching hospitals:** There are four academic teaching hospitals, two large community teaching hospitals and three tertiary/rehabilitation care institutions which serve a small geographic area. Grand rounds and seminars, academic/education days for medical staff and ongoing Continuing Medical Education (CME) events are available for medical and interdisciplinary team of clinical staff.

- **Universities:** All seven adult hospitals in Toronto are affiliated with the University of Toronto and/or Ryerson University. Both academic institutions serve as training grounds for health care professionals, equipping them with knowledge and skills to work with the elderly population.
    - The Division of Geriatric Psychiatry at the University of Toronto provides a full spectrum of psycho-geriatric clinical services and education programs staffed by full-time academic Geriatric Psychiatrists.
    - At Ryerson University, a *Certificate in Gerontology* is offered to professionals working with seniors, and draws faculty from various disciplines. The Chang School of Nursing also offers courses such as *Gerontological and Geriatric Nursing* to share best practice evidence relating to the role of nursing in behavioural support.
    - A number of community colleges offer courses to prepare Personal Support Workers, Geriatric Workers and Recreation Therapist.
- **Psycho-geriatric Resource Consultants (PRC):** PRC from the Psycho-geriatric Resource Consultation Program of Toronto (PRCP) collaborate with the Alzheimer Society (Toronto chapter). There are 9 PRCs and each LTCH is assigned to a PRC. The PRC represent a learning resource for building capacity for frailty-focused care, and their primary role is to support health care providers in the delivery of inter-professional, senior-friendly, and evidence-based care. Specifically, PRC promote and teach the P.I.E.C.E.S. framework to health care providers, guiding them in the detection of risk and the identification of supports to address risk management issues. They also

review 3D's (Depression, Delirium, Dementia), and the U-First Training Program with personal support worker-level staff and their supervisors. PRC also work closely with the Geriatric Mental Health Outreach Teams (GMHOT) to build capacity throughout LTCHs.

- **Communities of Practice (CoP)**: Within the Seniors Health Research Transfer Network (SHRTN), CoP takes a leadership role in bringing health service providers together to support continuous knowledge exchange.
- **The Regional Geriatric Program of Toronto (RGP):** RGP is affiliated with the University of Toronto and aims to build capacity by making clinical tools and educational resources available to practitioners. They train professionals on the core competencies for specialized geriatric services and promote inter-professional and inter-organizational collaboration.
- **Emergency Department and Geriatric Mental Health (ED-GMH) Program:** This program is a practical geriatric mental health protocol supplemented with an e-learning education program, providing psycho-geriatric clinical and practical knowledge to current and future ED staff. The goal is have ED staff provide effective, appropriate and ethno-culturally sensitive care for seniors with responsive behaviours presenting at the ED.
- **Behavioural Support Nurse/staff**: A P.I.E.C.E.S. trained nurse in each LTCH assists in providing expertise at the local level in the areas of behavioural support skills and clinical support. This person also serves as a coordinator for the home to liaise with external service providers.
- **Reitman Centre CARERS Program:** *The Cyril & Dorothy, Joel & Jill Reitman Centre for Alzheimer's Support and Training at Mt Sinai Hospital* offers comprehensive caregiver services emphasizing specialized in-depth assessment and evidence-based intensive programs of therapeutic skills training for high-needs, at risk family caregivers and care recipients, using innovative systematic interventions/simulations, supplemented by a range of therapeutic support and counselling programs. Services include a fully integrated, comprehensive dementia care program that introduces the innovative use of standardized patients so that caregivers, guided by expert clinical coaches, will learn how to deal with common challenging situations. The Centre also trains health professional staff whose advisory and coordination roles engage them in support and capacity building of caregivers at home.
- **LTCH Centre of Learning, Research and Innovation*:*** As previously mentioned, Baycrest has recently been selected by the MOHLTC to establish a LTCH Centre of Learning, Research and Innovation. With the funding, Baycrest will create a sector-leading interprofessional Clinical Teaching Unit (CTU) for frontline long-term care staff to enhance their skills in best practices at the bedside. The unit will train students and health-care professionals from Baycrest and other long-term care facilities.

Quality Improvement Capacity

- **Health Quality Ontario (HQO):** HQO has been a key resource in the development of the TC LHIN BSO Strategy. The LHIN has been supported by a QI coach that has provided QI expertise and supported the action plan development. It is anticipated that this resource will continue to support the TC LHIN Improvement Facilitator (described below) in the implementation of the TC

LHIN BSO Action Plan. Hospitals: Quality Improvement is one core value of hospitals and health organizations throughout the TC LHIN. Each hospital has its own quality improvement department and designated staff working within their organization to measure performance, track trends and promote improvement. They often use PDSA cycle and/or Balanced Scorecard or other quality improvement model to improve quality within their organization.

- **Long-Term Care: There are De**dicated Quality Improvement Facilitators at each LTCH that will be leveraged to support the implementation of this strategy in LTCH.
- **QI strategies at Baycrest:** Under the leadership of the Quality, Safety and Best Practice portfolio, improvement of quality of services occurs at the organization and program level. Baycrest Apotex LTCH has a Residents First LEAN Facilitator, as well as two LEAN specialists on staff. Baycrest is also currently utilizing the LEAN methodology and effectiveness has already been observed by teams such as The Memory Clinic where the team is reducing wait times for clinic visits.
- **TC LHIN:** The TC LHIN has dedicated a Quality Improvement Facilitator for this BSO strategy to support a collaborative, team-based effort to continuously measure outcomes, identify gaps and opportunities and to effect and manage change. The designated individual will work with organizations at all levels to apply the quality improvement concept and tools to continuously strive for enhancement. The Improvement Facilitator will provide leadership and coaching to the Implementation Committee, throughout the implementation of the BSO Project on an ongoing basis.

At the LHIN level, there are also numerous quality initiatives that weaved quality improvement concept and processes into practice:

- **TC-LHIN's Quality Indicator Working Group** (composed of members of the LHIN's Health Professional Advisory Committee, Health Quality Ontario and other stakeholders) are conducting an analysis of existing quality indicators that the TC LHIN could consider adopting. The group is also looking at equity dimensions of quality indicators.
- The introduction of ***Excellent Care for All*** is one of the most important developments last year, making quality the central goal of the provincial health care system. The TC LHIN revisited its IHSP-2 and created an updated Strategic Plan to include ECFAA. There are three interrelated aspects: Quality, Equity, and System Capacity and Planning. The updated Strategic Plan builds on these access improvement strategies in IHSP-2 by focusing on raising the quality of care and reducing disparities in services and outcomes. The LHIN will also emphasize system capacity to ensure the organization and utilization of health care resources in a way that produces the greatest value for populations and promotes a sustainable health care system.
- **Others:** local QI resources (BS, IF, Residents First engaged LTCH, ED-PIP site experts, ED pay-for-results sites with experience with Kaizen, Lean) will be leveraged throughout local BS implementation to strength a local culture of QI.

Current Behavioural Supports Expertise Capacity

- **Psycho-geriatric professionals,** such as Psychiatrists, Psycho-geriatricians, and PIECES trained HSPs work through the LHIN in various settings to support individuals with responsive behaviours.
- **PRCs** work closely with the GMHOT teams to build capacity throughout LTCHs. PRCs teach the PIECES program to HSPs to support the delivery of inter-professional, senior-friendly, and evidence-based care. GMHOT teams provide consultative support and expertise to LTCH staff to address the needs of residents with behavioural issues.
- **CPOT teams** provide consultative support and expertise in the community.
- **Alzheimer Society of Toronto:** AST hosts 2.5 FTE Public Education Coordinators (PECs) who provide public education and promote awareness of dementia. Five (5) counselors are host support groups for persons with dementia and their caregivers.
- **Reitman Centre for Alzheimer's Support and Training:** *(described above)*
- **Specialized Behavioural Support Units at CAMH, Toronto Rehab and Baycrest:** (previously described)
- **Specialized in-patient psycho-geriatric programs**

Building knowledgeable care teams with behavioural and QI capacity

There are various education and training programs currently available across the TC-LHIN. To ensure the creation of knowledgeable care teams with both behavioural and QI capacity, efforts will be made to integrate practical knowledge transfer processes. Different strategies will be employed in the different sectors:

For the community: A community education consortium (see Figure 5) will be created. This consortium will be a partnership between stakeholders who are currently providing existing education and training (e.g. Alzheimer's Society Toronto, Reitman Centre, PRCs, etc.) to coordinate and re-design curriculums for different care providers. Their mandate will include:

- Education for the general public to improve public awareness of the signs and symptoms of behavioural disturbances and to reduce stigmatization of the disease. The different channels for knowledge dissemination include newsletter, electronic communications, web-based seminars, speakers' series etc.
- Education for RNs, RPNs and PSWs working in community agencies and the CCAC. Specific curriculums with different approaches including hands-on practice, case studies, and simulation will be designed by leveraging existing programs and strategies.
- Education and information for primary care professionals (e.g. family physicians) and families about available resources in the community.
- Caregiver education: will provide caregiver support and training to address practical and emotional coping issues for caregivers and help to prevent caregiver burnout.

This partnership is a first step to integrate education and training services across the LHIN. This consortium will initially focus on education and training for providers in the community and for caregivers and the results will be monitored and evaluated through PDSA cycles with the goal of eventually expanding the consortium to include education and training resources for LTCH and hospital staff. Given that this consortium will be housed at Baycrest, there will be an opportunity to collaborate closely with the education and training strategy development for LTCH (described below).

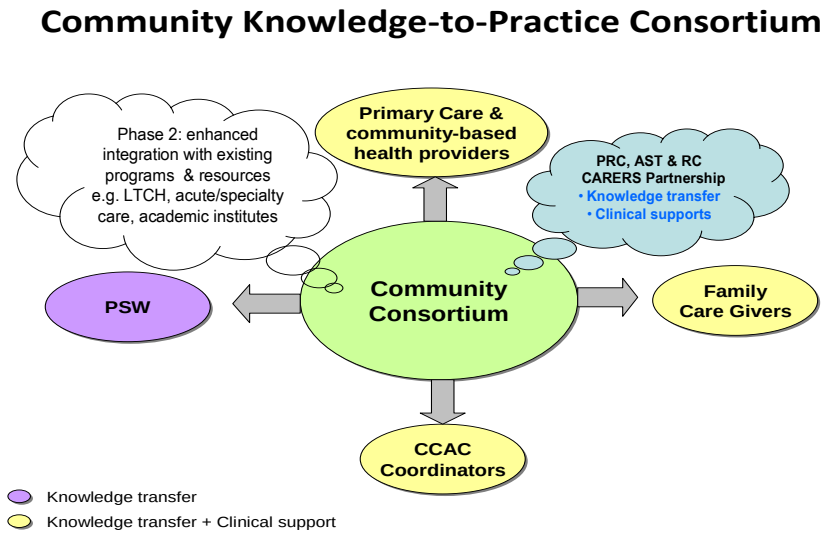

Figure 5: Education Consortium

For LTCH: With the LTCH Centre of Learning, Research and Innovation at Baycrest, this organization was a natural choice to lead education and training strategies for LTCHs. Along with the new BSU, the new LTCH outreach teams and this centre of learning, Baycrest will lead the development and implementation of education, training and best practice dissemination strategies for the outreach teams and across the LTCH in the TC LHIN in partnership with the GMHOT and PRC programs. Small tests of change will be key to the implementation of these strategies to ensure successful uptake of the training, and improvements in these strategies.

Leveraging knowledge transfer structures/pathways

The new education consortium and the new LTCH Centre of Learning, Research and Innovation at Baycrest will be key structures that will be leveraged to support knowledge transfer across the continuum.

These structures will also be supported by the resources that provide direct support to HSPs and caregivers (e.g. the LTC-OT, the CPOPs, the PRCs, the GMHOTs, etc.). Presently, the PRCs are the primary mentor and education broker supporting LTCH care staff; however the new LTC-OT, the CPOPs and the GMHOTs will be part of these knowledge transfer pathways to provide education and support to LTCH staff, community HSPs and caregivers.

Other education and knowledge transfer resources (e.g. the ED-GMH program in acute care) will also be reviewed to align and support the BSO strategy, to promote consistent, standardized use of tools and documentation, the use of common terminology to facilitate cross-sectoral communication and collaboration.

Finally, academic activities organized by teaching and academic community hospitals, the University Of Toronto Division Of Geriatric Psychiatry, the Centre on Life Course and Aging, and health professional associations, among others are abundant in this LHIN. There are numerous teaching rounds, conferences, case studies, education days, seminars and symposiums year round available to care teams and staff that could be leveraged to support education and training for the TC LHIN BSO strategy. In addition, many education programs are organized by SHRTN, BS CoP, and the Alzheimer Society.

The TC LHIN BSO Implementation Committee will be powerful structure to coordinate and integrate these knowledge transfer, training and skills development activities. The education consortium lead and the QI lead will work closely with the System Coordinator to develop a work plan to move toward an integrated partnership among all knowledge transfer stakeholders in the system.

Building on Partnerships

There are many resources, partnerships and other initiatives that have been leveraged to build the BSO Action Plan. Many were described throughout this report. Key resources include:

- **Education and Training resources:** The PRCs, the family/caregiver counseling program at the Alzheimer's Society of Toronto, the comprehensive caregiver services offered at the Reitman Centre CARERS Program at Mt Sinai Hospital, the Centre for Learning, Research and Innovation at Baycrest, the SRTN Community of Practice, and the Alzheimer's Knowledge Exchange resources will be leveraged to build the education consortium and enhance the provision of education and training services in the community and LTCH.
- **Specialized Behavioural Support Expertise:** The GMHOTs, CPOTs, specialized behavioural support units at CAMH/Baycrest/Toronto Rehab, specialized tertiary care services at CAMH, and specialized community crisis supports will all be leveraged to ensure a continuum of behavioural supports for the target population.
- **Aging at Home (AAH) Initiatives:** Several successful initiatives that provide services to the target population have been funded through the AAH strategy. These include supportive housing programs, a transitional high-support supportive housing program and the mobile crisis outreach teams described throughout this report. The BSO strategy will build on this last initiative to enhance crisis services in the community to ensure coverage across the TC LHIN. The TC LHIN BSO Implementation Committee will also leverage and collaborate with the ICCP project to implement "shared responsibilities" and "philosophical shift in practice" towards system integration.

Sustainability of Service Redesign through Education and Knowledge Transfer and Other Mechanisms

Many mechanisms embedded in the strategy will ensure sustainability of this service redesign:

- **Baycrest- accountability and leadership:** Implementation and sustainability of the program will be ensured through the appointment of a BSO program lead. This lead organization will be accountable for the achievement of the outcomes the TC LHIN has identified for its BSO strategy. Baycrest will not only be responsible for the successful implementation of this initiative but will also take a leadership role in knowledge dissemination, integration of services and in bringing key providers together to collaboratively ensure the success of this initiative. Capacity building will also be achieved by hosting the new resources at one site, with the expectation that these resources will continue to build knowledge and capacity across the sector as described throughout this report.

- **Implementation Committee- sectoral leadership:** The TC LHIN BSO Implementation committee will be established for project implementation and will continue to function on an ongoing basis, following the initial implementation. The committee will include 'functional/sectoral' leadership representation that will assume the role of 'change agents' to promote system level coordination and collaboration through peer engagement, implementation and evaluation of tests of change with the sectors and developing common processes.

- **Education and knowledge transfer:** A key to sustainable implementation is ensuring education and knowledge transfer strategies translate into practice. Critical elements to ensure knowledge translation into practice have been embedded in the service design and include:
    - Leadership
    - An enabling environment and learning culture
    - Management supports and champions
    - Motivation and knowledge-to-practice built into curricula
    - Quality improvement
    - A comprehensive orientation program
    - Ongoing learning reinforcement activities.

The partners for Knowledgeable Care Team and Capacity Building will include, but will not be limited to the following:

- Baycrest and the LTCH Centre of Learning, Research and Innovation
- Alzheimer Society of Toronto
- Reitman Center for Alzheimer's Support and Training
- PRC Program of Toronto (Regional Geriatric Program of Toronto)
- Division of Geriatric Psychiatry at the University of Toronto
- SRTN Community of Practice
- GMHOTs, CPOTs
- LTCH

- Community HSPs
- Families and caregivers
- QI Facilitators (HQO)

Deployment of TC LHIN Behavioural Support Staffing Resources

The TC LHIN BSO Service Delivery Model is based on achieving client/family centered care and addressing the client's needs along the continuum of care from clients initial contact with a health provider or health system for a behaviour issue to the client being stable with a viable care plan in their home (home in the community or a long term care home). BSO resources will be allocated to support the system redesign as follows (subject to change post final negotiations with lead provider, Baycrest):

For Community:

- WoodGreen's psycho-geriatric community crisis outreach service will be enhanced to serve the entire TC LHIN. This will include 2 FTE crisis workers and 0.5 FTE Nurse Practitioner.
- An enhancement of 3 Community Outreach Providers (registered nurses) at Baycrest will introduced and linked to the TC CCAC Seniors Enhanced Care program to provide direct consultation and care for older adults with behaviours in the community and to coordinate community BS services for these clients.

For the LTCH-Behavioural Support Unit and LTC-OT at Baycrest:

- Additional staff will be added to existing staffing on the existing 23 bed unit at Baycrest LTCH; this staff will also provide consultation and support to other TC LHIN LTCH on a case-by –case basis. The staffing compliment for the unit is intended to reach a staffing ratio of 40:60 regulated to non-regulated staff:
    - 7 Registered Nurses
    - 8 Registered Practical Nurses *
    - 18.9 Personal Support Workers**
    - 1 Social Worker
    - 1 Recreation therapist

**Of note, the model would have been better suited to a higher RN:RPN ratio, but given the resource allocation and Baycrests' salaries for RNs and RPNs, this was the allocation that maximized available resources. In addition, the model maximized the allocation of FTEs based on Baycrest's salaries for PSWs.*

For Community education consortium at Baycrest :

In partnership with PRC, AST and Reitman Centre CARERS Program), 3 FTE Registered Nurses will be hired

For BS System BS System Coordinator at Baycrest: 1 FTE Registered Nurse

In total, there will be 45 FTEs of various positions hired to support the implementation of this action plan. See Appendix C for more detail.
Though Baycrest is receiving the majority of the resources as the HSP lead, they are a system resource that will be used to support community service providers and LTCH. For example:

- The education consortium resources will be deployed through Baycrest but a key partner and lead for this piece of the strategy will be Mount Sinai hospital.
- The CPOP resources will be deployed through Baycrest, but will work closely with the TC CCAC Seniors Enhanced Care Program.
- The LTC-OT will be deployed at Baycrest, but will provide support to 10 LTCH and will work collaboratively with the GMHOTs and PRCs.

Performance Measurement and Evaluation:

The proposed measures will be focused on helping to assess and ensure the success of the newly designed models and initiatives of this BSO Project from "system", "operational", and "POC" levels LHIN-wide. In addition, the TC-LHIN will incorporate and comply with the provincial defined overall "performance measure and indicator tracking" recommendations to measure provincial performance of the BSO framework.

Through the Value Stream Mapping exercise and stakeholder planning meetings, we learned to be cautious in selection of measures. We aim to identify measures that will address system change, but also be *specific* and sensitive enough to identify population changes**.**

The following measuring indicators are proposed:

System Level Metrics:

EFFECTIVENESS/ QUALITY

- % decrease of long-stay ALC clients (from the targeted population)
- % decrease in avoidable ED visits by target population residing in LTCH
- % decrease in avoidable ED visits by target population residing in the community
- % decrease in LTCH placement of targeted clients (reflecting the # able to be better managed in the community)
- Turn-over rate of newly hired staff for the BSO Project

Operational Level Metrics:

PROCESS

- # of newly designed education programs for target population delivered
- # of people trained, grouped by: health professionals (RN, PSW and others), primary care, LTCH, CCAC, clients, caregivers

PERFORMANCE

- % BSO project deliverables met on time
- % BSO project delivered within budget

Point of Care Level Metrics:

RESPONSIVENESS

- % process timelines met (e.g. # hand offs within XX hrs/days- to be further defined)
- % Response times for outreach teams met (provider response times)

SATISFACTION

- Staff satisfaction survey
- HSP satisfaction survey
- % Improvement of client and care givers satisfaction- reported quarterly

The BSO Implementation Committee will be tasked with confirming the indicators identified above. They will clarify definition of indicators and data capture methodology, finalize baseline and recommend reporting processes, timelines and follow-up processes. Outcomes of the above measures will be shared with the implementation team to inform project progress and to develop group strategies for improvement as required.

Data sources will include NACRS, DAD, OMHRS and other available systems through Intellihealth/CIHI. Data will also be obtained from CCAC, LTCH and hospital databases. The performance evaluation process will leverage a quality improvement approach. These finalized indicators will also be incorporated into project charters with agencies receiving funding through this initiative.

APPENDIX A

TC LHIN Population Profile

The Toronto Central Local Health Integration Network (TC LHIN) has a population of more than 1.2 million residents, representing an extremely diverse range of cultures, languages, socio-economic and educational backgrounds.

The senior population of the TC LHIN (age 65+) comprises 14% of the overall population, slightly higher than the provincial average of 13.6%. The population over 85 years of age is the group that is increasing fastest and is projected to increase by 48.5% between 2005 and 2015 (Source: Intellihealth Estimates and Projections). These demographic changes are reflected in hospital utilization, with seniors aged 65+ accounting for 42% of hospital days, and 78% of alternative level of care (ALC) days in 2009/10 (Intellihealth: DAD).

About 20 % of older adults in the TC LHIN are living with mental health and/or addiction issues. The number is projected to increase by 21%, from about 15,000 in 2006 to about 19,000 in 2016. (Source: Intellihealth Estimate and Projections). This population poses special care and management challenges at various points in the system especially in LTCH settings. This raises important resource issues, such as the need for higher intensity care programs to meet the needs of this population, including individuals with responsive behaviours.

TC LHIN covers a relatively small geographic area, and has a very dense urban population. The LHIN is responsible for funding the highest concentration of health services in Canada and serves clients not only from the TC LHIN but from across the province. In 2010, approximately 54% of TC LHIN acute care discharges were from out-of LHIN residents and approximately 43% were from residents in one of the adjacent four LHINs (Central, CE, CW, MH) (Source: DAD, Intellihealth 2010). Many of our local health service providers host programs which have a regional, provincial, or national reach and mandates. Such services will provide an added benefit to the LHIN's Behavioural Supports Ontario (BSO) target population.

APPENDIX B

Examples of successful inter-disciplinary collaboration

- The alignment of GMHOT and PRC to each LTCH.
- The CCAC provides case management, transitional supports, hospital discharge planning and follow-up arrangements in collaboration with community, EDs, hospital and LTCH providers.
- The LTC-MH framework and the implementation of Behavioural Support staff in each LTCH
- ICCP Project
- COSS- the Crisis Outreach Service for Seniors located at WoodGreen Community Services. This inter-disciplinary community mobile crisis team is composed of outreach crisis workers, concurrent disorder harm reduction specialist, a nurse practitioner, an RPN and an addictions counselor from five different HSPs.

TC LHIN interdisciplinary partners:

- Clients, families and caregivers
- The crisis teams at Gerstein Centre, St. Elizabeth Healthcare and WoodGreen Community Services.
- The CPOPs at Baycrest
- The TC CCAC
- The 11 GMHOT teams
- The 9 PRCs (through the Toronto Regional Geriatric program)
- Baycrest LTCH and 10 other LTCHs
- The new BSU at Baycrest
- The new LTC-OTs at Baycrest
- Specialty hospitals (Toronto Rehab, CAMH and Baycrest)
- GEM nurses in hospital Emergency Departments
- Acute Care hospitals
- Complex continuing care hospitals
- Police
- Alzheimer Society, Toronto
- Reitman Centre Caregiver Program
- Community MHA providers
- Primary care and Family Health Teams

APPENDIX C

Roles and responsibilities of the behavioural staffing positions

Behavioural Staff Proposed	Lead HSP	Roles/Responsibilities
2.5FTE for community mobile crisis team: 2 FTE crisis workers 0.5 FTE Nurse Practitioner	WoodGreen Community Services	• Assess clients' need, develop and implement a care plan with both short and long term objectives • Provide specialized psycho-geriatric crisis support/ client stabilization • Provide addiction and harm reduction interventions • Provide intensive short term case management (for approximately 6 - 8 weeks) • Nursing and community support services
3 FTE Community Outreach Providers	Baycrest	• linked to the TC CCAC Seniors Enhanced Care program • will provide specialized behavioural clinical assessment and develop behaviour management plans for the client, family and care providers, • provide advice and consultation to the care team, • work collaboratively with the psycho-geriatric teams • provide caregiver education and support • Collaborate with PRCs and LTCH staff to develop transitional plans when the need for LTCH support is identified. • They will also work with the SEC Care coordinators to make referrals to other appropriate behavioural supports as required (e.g. CPOTs, education and training supports and other MHA services).
13.9 FTE for the Behavioural Support Unit RNs, RPNs, PSWs, SW, RT	Baycrest	<u>Unit Manager:</u> • Beyond his/her clinical and administrative roles for the unit, she/he is a motivator, mentor, liaison and change agent to foster a BS culture for the unit. • Will promote standards and best practice, motivate commitment from staff and promote job satisfaction • Will be responsible for liaising and coordinating with appropriate outreach supports, including the GMHOT team and/or specialized services at Baycrest hospital. <u>RN/RPN/PSW</u>: • A highly skilled specialized inter-disciplinary team with advanced intensive behavioural support knowledge, skills, experience that will provide additional supports to the residents on the unit <u>Social Worker:</u>

		• Will provide counseling, support to clients/ caregivers • Will work collaboratively with the CCAC to support client transitions in/out of the unit Recreational Therapist: • Will provide enhanced recreational and social programming including during evenings/weekends
22 FTE for LTC-Outreach Team RNs, RPNs, PSWs	Baycrest	Team Lead- responsible for: • coordination of teams and liaison with other outreach programs (e.g. GMHOTs, PRCs) • Streamlining outreach processes in LTCHs, clarify roles and responsibilities of various outreach teams and to integrate outreach services in LTCH RNs/PSWs- responsible for: • Coordinating with the other LTCH outreach supports (GMHOTs, PRCs) to collaboratively assess, consult and provide indirect support to the LTCH staff in the care of specific clients. • Supporting service integration at the point of care • Provide education, skill-building, and mentorship to LTCH staff on a case-by case basis to build capacity within the LTCH
3FTE for Community education consortium 3 FTE RN	Baycrest(in partnership with PRC, AST and Reitman Centre):	• These RNs will develop an interagency collaborative program and facilitate interagency processes to deliver a coordinated continuum of knowledge-to-practice, integration of care and caregiver support and skills training.
1FTE RN for BS System Coordinator	Baycrest	• Will provide overall project management and system coordination for this initiative • Will coordinate the Implementation Committee.

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