Waterloo Wellington **LHIN**

WATERLOO WELLINGTON LHIN BSO ACTION PLAN

Ontario

Waterloo Wellington Local Health Integration Network

Executive Summary

Background

The Waterloo Wellington Behaviour Supports Ontario Service (BSO) will serve older adults with complex and responsive behaviours associated with cognitive impairments due to complex mental health, addictions, dementia, or other neurological conditions and their caregivers. Processes will be put in place to identify and address distinct cultural and language needs in our community, including French language. The service will be provided in the individual's place of residence, community and long term care homes, and will include transitions within/between acute care settings to place of residence.

System redesign will adhere to the voice of the client:

> *"Please understand his/her behaviour and care needs at his/her home. He/She needs care and treatment today, and genuine assistance if he/she needs to move to a new home. We need to understand what services are available to help now and I need to know the next steps. We want to be confident that people care."*
>
> (Voice of the client- Waterloo Wellington Responsive Behaviour Support Services Working)

Program Overview

The Program Lead, St. Joseph's Health Centre, Guelph, will be accountable to the Waterloo Wellington Local Health Integration Network (WWLHIN) for the overall implementation, service delivery and outcomes of the Waterloo Wellington Behavioural Supports Services Program. St. Joseph's Health Centre will work in collaboration with the Waterloo Wellington Responsive Behavioural Support Services (WWRBSS) Working Group, Behavioural Support Services System Lead, Implementation Facilitator, Project Lead and intersectoral, transdisciplinary team to implement improvements across the continuum of care that addresses the voice of the client and key system gaps.

This will be achieved by:

- implementing effective system management processes to provide reliable and equitable delivery of care;
- implementing an intersectoral, transdisciplinary team to enable system efficiency and equitable access to comprehensive, safe services across the continuum;
- implementing intersectoral, transdisciplinary care teams to increase capacity and knowledge transfer to serve the target population.

New and existing indicators will be optimized to measure improvements and allow for further enhancements, if required. In addition, the evaluation process will align with the provincial evaluation to determine the following outcomes:

- **Reduced resident transfers** from Long-Term Care Homes (LTCHs) to acute or specialized unit for behaviours;
- **Delayed need for more intensive services**, reducing admissions and risk of Alternate Level of Care (ALC);
- **Reduced length of stay** for persons in hospital who can be discharged to a LTCH with enhanced behavioural resources

The Program Lead, in collaboration with the Waterloo Wellington Responsive Behavioural Support Services Working Group, will address gaps through cross- sectoral collaboration and new/enhanced partnerships. The areas identified for improvement include:

- Actively involve Primary Care at all levels of the continuum(care)
- Create a mobile regional Geriatric Service made up of existing resources and new resources with a strong link to Primary Care, Community Care Access Centre (CCAC), and community health service providers (HSPs).
- Harmonize Psychogeriatric Resource Consultant , Nurse Lead Outreach Team, and new BSO resources for LTCH and Community

Service delivery will be provided by an intersectoral, transdisciplinary team made up of existing and new resources as per the model below:

1) Intersectoral Long Term Care Home Team based in LTCHs:

- Behavioural Support Service: BSS Specialized LTCH RN/RPN(s)
- Behavioural Support Service: BSS Specialized LTCH PSW(s)

2) Intersectoral Mobile for Community and Long Term Care Home - New Resources:

- Advance Practice Nurse- Community and LTCH
- Occupational Therapist – Community and LTCH
- Social Workers
- Recreation Therapist
- Clinical Intake
- Specialized Primary Care Support

Integrated with Existing Resources:

- Primary Care
- Specialized Geriatric Services (SGS): Geriatric Medicine, Geriatric Psychiatry and Outreach Teams
- Geriatric Emergency Medical Management Nurses (GEM Nurse)
- Intensive Geriatric Service Workers (IGSW)
- Psychogeriatric Resource Consultants (PRC)
- Nurse Led Outreach Team (NLOT)
- Geropsychiatry Community Education Program (GECP)
- Acute Care Clinical Nurse Specialists (CNS)
- Long Term Care Home – PIECES trained Nurses; GPA and U-First Trained Staff
- Adult Day Programs
- First Link

The Program Lead, in collaboration with the Long-Term Care Homes and WWRBSS, will implement processes to address risk of mandate drift that includes:

- Building on the Residents First Peer-Peer PSW program
- Cross – sectoral and transdisciplinary training
- Common role descriptions across Long Term Care Homes that address uniqueness's within each home and geographical location;
- Memorandum of agreement with the Program Lead and individual Long Term Care Homes
- Memorandum of agreement with the Program Lead and Mobile Community resources
- Opportunities to extend mandates of existing resources that will be part of the intersectoral transdisciplinary team

The Schlegel Learning Research and Innovation Center (Schlegel LRIC) is in very formative stages of development. Planning and program development is underway. The Center represents an innovative partnership involving the Ontario government, postsecondary sector and Schlegel Villages and when developed will provide opportunities for research, training and innovation, contributing to improved care quality for seniors throughout WWLHIN and beyond. Key representatives from Schlegel were engaged prior to the submission of the WWLHIN Action Plan and they were in agreement with the proposed model.

The WWRBSS and Program Lead will work with key representatives from the Schlegel LRIC. Continuing to strengthen the communication and connections to the LRIC will ensure that initiatives undertaken through the BSO action plan will be understood by the leaders planning the services to be provided by this LRIC as well as the other two centers announced last fall (Baycrest and Bruyere).

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Pillar 1: System Coordination:

This pillar identifies the need for coordinated cross-agency,intersectoral collaboration and partnerships based on clearly defined roles and processes to facilitate 'seamless' care.

From the voice of the client and/or their family we heard about the following challenges:

- there are too many assessments
- the wait for service is too long
- the system is confusing, care processes and next steps are not clearly identified
- they experience fear and anxiety about the unknown

Current Gaps and Weaknesses in System Coordination

The Waterloo Wellington Responsive Behavioural Support (WWRBSS) Working Group is an intersectoral working group of the Waterloo Wellington Geriatric Services Network(WWGSN). WWRBSS was established in 2009 to address service gaps for seniors with dementia and responsive behaviours with a goal of working towards improving the experience of the client and/or caregiver.

To identify system gaps and weaknesses in system coordination, the WW RBBSS working group has undertaken: stakeholder engagement; client and caregiver engagement; process mapping; in collaboration with SHRTN Community of Practice for Addictions and Mental Health, community service mapping and voice of the client mapping; and most recently in collaboration with Health Quality Ontario, value streaming analysis. These analyses identified the following gaps and weaknesses in system coordination.

1. Service demand is not well understood: There are multiple, non integrated processes identifying individuals with behavioural needs. Multiple data bases exist without a common way of identifying individuals with responsive behaviours. While an estimation of need for services for people with responsive behaviours can be made, the lack of a standardized method of collecting information on the target population make it difficult.
2. Lack of understanding of each organization's/agency's role: There are overlapping roles and gaps in services intended to address the needs of this population. Navigating the system to find the right service is difficult for professional and even more so for individuals and caregivers. Similar services offered in different parts of the WWLHIN have different components making it difficult for those using the service to know what to expect. We currently have 16 different service types across the WWLHIN that a person with responsive behaviours can access.
3. Difficulty accessing services: Knowledge is lacking of who is most responsible for follow-up care for the individual with responsive behaviour and their family/caregiver in the community and/or following discharge from Emergency Department (ED) /Alternate Level of Care (ALC)/acute care to community.
   It is often unclear to those referring to the service or accessing the service what are the eligibility criteria. Specialty services are sometimes accessed based on relationships and 'best offer in the area' versus based on client need and a system approach resulting in inequitable access to service across the WWLHIN. Referral

processes are designed to 'push' versus a more preferred 'pull' to the next step for the person with responsive behaviour.

4. Services are not reliable and/or robust: Service providers are not able to respond in a timely way and may not respond to all of the issues. Providers of services are not able to reliably share information across the service continuum resulting in the client and/or family member needing to repeat their story as well as additional time on the part of the provider to collect the same information.
5. Gaps in service across the region include the following concerns: variable capacity of LTCHs' to support residents with responsive behaviours and/or their family/caregivers; variable supply of health human resources within LTCH; problematic transitions to LTCH; problematic transitions from acute care to place of residence; a transdisciplinary approach across the continuum of care involving various allied health providers. The LTC Homes in the WWLHIN have existing staffing vacancies for nurses and personal support workers.
6. Inconsistent Specialized Geriatric Services: Although Specialized Geriatric Services are available across the WWLHIN, there is considerable variability in the service and in the availability of geriatric specialist physicians, psychiatry and medicine, for the individual living in the community and in LTCHs.

Current Structures to Provide LHIN-wide Coordination of Services

The service providers within the communities which comprise the Regional Municipality of Waterloo and County of Wellington, and South Grey have a long history of collaboration and partnership in the delivery of services. The following structures are in place to support coordination of services.

- Waterloo Wellington Geriatric Services Network (WWGSN) – cross-sectoral, WWLHIN wide planning body
- Waterloo Wellington Geriatric Specialists – planning and system coordination group
- LTC Homes Network which includes LTC Homes and WWCCAC and others as required
- WW Addictions and Mental Health Network, Core Action Group – cross- sectoral group spanning the age continuum
- Waterloo Wellington Community Support Services (WWCSS) Network – planning/problem solving group for providers of community support services. Some subcommittees include:
    - Waterloo Wellington Easy Coordinated Access Working Group- streamlined referral and intake booking process for Community Support Services across the WWLHIN
    - Waterloo Wellington Adult Day Program (WWADP) Network - planning/problem solving group for adult day programs
- Wellington Specialized Geriatric Services - a collaboration of 3 agencies – WWCCAC, Trellis Mental Health and Developmental Services and St Joseph's Health Centre, Guelph with consultation clinics provided in some Long Term Homes
- Joint Specialized Geriatric Service offered in partnership by WWCCAC and Grand River Hospital in Kitchener Waterloo
- Cambridge Geriatric Medicine and Geriatric Psychiatry offered at Cambridge Memorial Hospital and clinics within Long Term Care Homes
- Geriatric Medicine hosted at St. Mary's General Hospital

- First Link provided across 3 Alzheimer Societies: Guelph – Wellington, Kitchener Waterloo and Cambridge

The WW RBSS Working Group a cross- sectoral working group of the WWGSN, has been working to design a system model of an intersectoral transdisciplinary team which integrates Waterloo Wellington Behavioural Support Services including existing services and the new WW BSS resources in order to improve the experience of the client and/or caregiver.

In addition, improving system coordination through the BSO Action Plan prior to the establishment of a major new service provider (LRIC) within the WWLHIN will allow the research and innovation within the LRIC to contribute to further system coordination improvements. Specifically, the BSO program will focus on ensuring standardized and comprehensive assessment, and greater integration between primary care, community services, and specialist programs. The LRIC will serve as a focal point for the implementation and dissemination of local models of system coordination and integration.

Modifications to Improve System Coordination

Modifications include a redesign of existing services that will integrate the new BSO resources and develop an intersectoral transdisciplinary team. The Program Lead, St. Joseph's Health Centre, Guelph (SJHC), in collaboration with the WW RBSS, will address gaps through cross- sectoral collaboration and new/enhanced partnerships. The areas identified for improvement include:

- Actively involve Primary Care at all levels of the continuum of care
- Create a mobile regional Geriatric Service made up of existing resources and new resources with a strong link to Primary Care, CCAC , and Community HSPs. The link to primary care will include the WW Primary Care Clinical Resource Consultant and the new Primary Care Support Resource
- Harmonize Psychogeriatric Resource Consultant (PRC) , Nurse Lead Outreach Team (NLOT), Geropsychiatry Education Program (GCEP) and new BSO resources for LTCH and Community

Service delivery will be provided by an inter-sectoral transdisciplinary team made up of the new BSO resources integrated with existing resources:

New Resources
Intersectoral Long Term Care Homes staff located on site:

- Behavioural Support Service: LTCH RN/RPN(s)
- Behavioural Support Service: LTCH PSW(s)

Intersectoral Mobile for Community and Long Term Care Home

- Advance Practice Nurse- Community and LTCH
- Occupational Therapist – Community and LTCH
- Social Workers
- Recreation Therapist
- Clinical Intake
- Specialized Primary Care Support
- Behavioural Support Services System Lead (from existing resources- new role)

Existing Resources:

- WW BSS System Lead (role will be established from re-configuring existing resources)
- Primary Care
- Specialized Geriatric Services (SGS): Geriatric Medicine, Geriatric Psychiatry and Outreach Teams
- Geriatric Medicine Management Nurses (GEM Nurse)
- Intensive Geriatric Service Workers (IGSW)
- Psychogeriatric Resource Consultants (PRC)
- Nurse Led Outreach Team (NLOT)
- Geropsychiatry Community Education Program (GECP)
- Acute Care Clinical Nurse Specialists (CNS)
- Long Term Care Home – PIECES trained Nurses; GPA and U-First Trained Staff
- Adult Day Programs
- Alzheimer Societies First Link and Family Support Programs
- PIECES trained LTC Home Nurses and Community Staff
- GPA and U-First Trained LTC Home and Community Staff

The Program Lead, in collaboration with the Long Term Care Homes and WWRBSS, will implement processes to address risk of mandate drift that includes:

- Building on the Residents First Peer-Peer PSW program
- Cross – sectoral and transdisciplinary training
- Common role descriptions across Long Term Care Homes that address uniqueness's within each home and geographical location;
- Memorandums of agreement with SJHC and individual Long Term Care Homes
- Memorandums of agreement with SJHC and Mobile Community resources
- Opportunities to extend mandates of existing resources that will be part of the intersectoral transdisciplinary team

WWRBSS Working Group is considering the following objectives (adopted from SE LHIN) in the local program design:

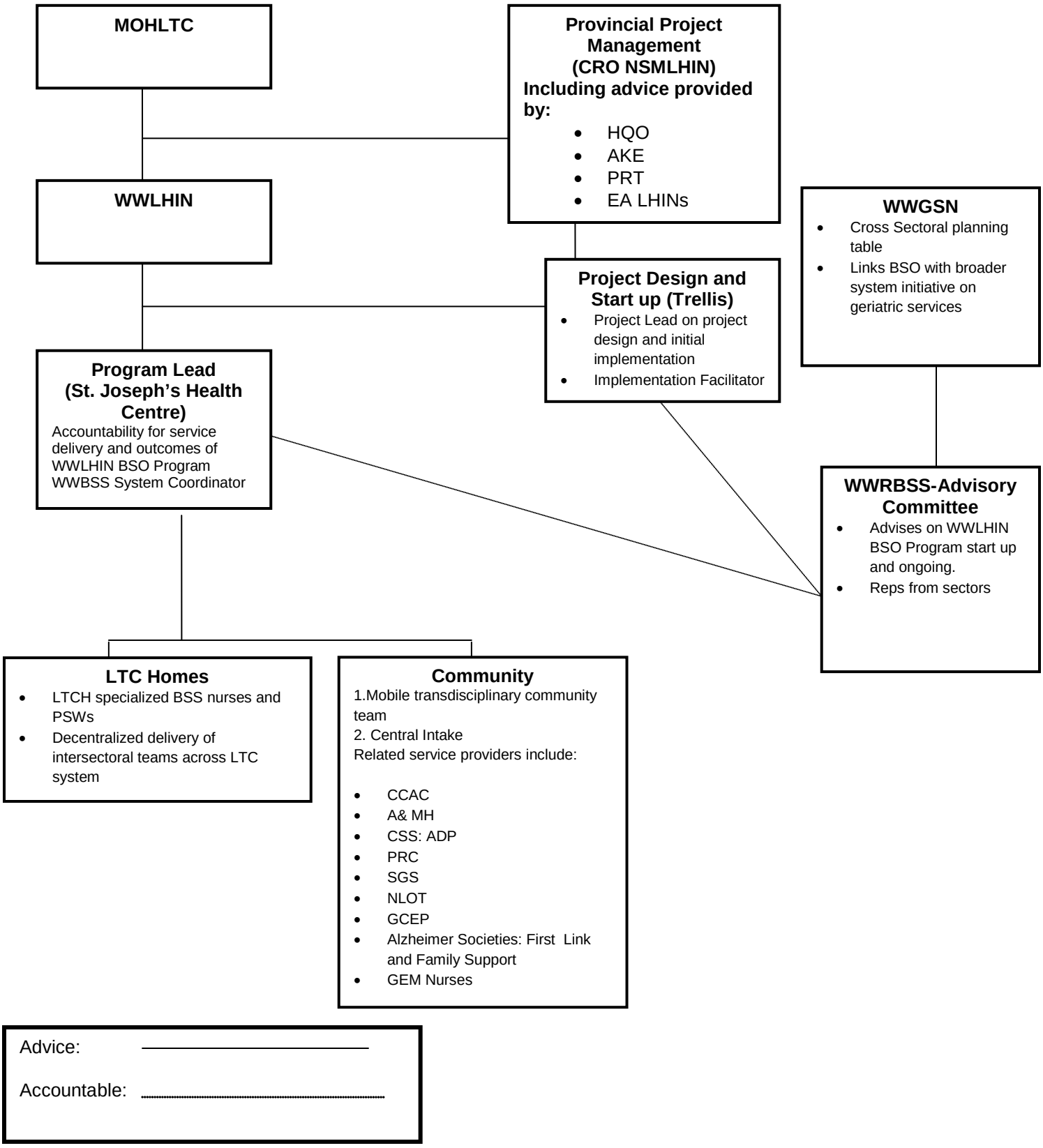
- To commit to a culture of behavioural support
- To adapt to better support a person- and caregiver- directed approach
- To embed sustainability, including prevention and early detection
- To articulate roles and functions within the context of the service continuum
- To analyze current skill sets and determine the opportunities for skill building
- To foster connections through partnerships and support
- To define and implement a quality improvement strategy for service provision
- To select an internal liaison resource to champion the service
- To implement standardized tools, protocols and common language across the continuum
- To capture the lessons learned and exchange that learning for system improvement

Governance and Accountability Structure

The WWLHIN has overall accountability for the WWLHIN BSO Project, as detailed in the funding agreement between the WWLHIN and the Ministry of Health and Long-Term Care (Ministry). The WWLHIN has assigned the roles and responsibilities of Project Lead and Implementation Facilitator to Trellis Mental Health and Developmental Services and overall accountability for the implementation and delivery of service to the Waterloo Wellington Behavioural Support Services Program Lead, St. Joseph's Health Centre including their executive leadership.

The Waterloo Wellington Behavioural Support Services Working Group, a sub-group of the Geriatric Services Network, will be the advisory committee to the Program Lead. The Project Lead and Implementation Facilitator are members of the advisory committee.

Diagram 1: WWLHIN BSO Governance and Accountability Structure



System Coordination Partners

The WW BSS System Lead will be accountable to the Program Lead, SJHC, who will work in collaboration with the Project Lead, Implementation Facilitator, and the WWRBSS working group. The WWLHIN BSO project will partner with the HNHB LHIN, Regional Geriatric Program (RPG) Central, and provincial resources (HQO, AKE, PRT) and access the work they have done to date in the BSS planning and development. The partners for system coordination will be comprised of cross-sectoral WWLHIN Health Service Providers (HSPs) and stakeholders who are involved in the early detection, support and management of individuals with responsive behaviours and their caregivers. The partners will provide the following roles:

- **SJHC** will be the Program Lead
- **HSPs** partners and clients and caregivers will collaborate to develop a centralized intake and referral process that will enable timely access to behavioural support services for clients and/or their caregivers and adhere to the voice of the client.
- **WWCCAC** will provide centralized intake and referral for the intersectoral transdisciplinary team as well as clients and caregivers.
- **WWLHIN wide SGS** teams will provide an integrated standardized responsive clinical intake which will involve a collaboration between the following providers: Trellis, SJHC, Cambridge Memorial Hospital, Grand River Hospital – Freeport site, WWCCAC
- **Primary Care**- Family Health Teams (FHT), SJHC Hamilton, OTN to streamline the current consultation service. Primary care providers will be involved in the development and implementation of the intersectoral transdisciplinary team and quality improvements. The existing resource, WW Primary Care Clinical Resource Consultant, and the new resource, Specialized Primary Care Support will assist with Primary Care engagement throughout the process and as part of the sustainability plan in addition to the Implementation Facilitator and Project Lead.
- **Acute Care** and the larger system: for common language; PIECES training; U-First and GPA training
- **24/7 Resources** to provide mobile crisis; GEM Nurses, Advanced Practice Nurses, Clinical Nurse Specialists, Overnight Stay Respite Program, Alzheimer Day Programs as part of the redesign will be a resource to assist Long-Term Care Homes and primary care
- **WWLHIN's Alzheimer Societies** including First Link, will be engaged to identify opportunities to improve knowledge and awareness of the signs and symptoms of responsive behaviours for the client and facilitate strategies for early recognition and intervention to assist the client, caregiver and intersectoral team.
- **eHealth** will work to identify and expedite processes that will improve the flow of information between HSPs. The WWLHIN is continuing to implement Clinical Connect, a web-based tool that provides timely provider access to patient and client information, between hospitals, physicians and HSPs in the community.
- **Long-Term Care Homes** (LTCH), Specialized Geriatric Services, Addiction and Mental Health Services, WWCCAC, Community Support Services, Hospitals, and individuals with responsive behaviours (where possible) and their families/caregivers will be involved in the development and implementation of the model. Existing mobile resources including 24/7 mobile crisis in the community will be reviewed in order to determine where new BSS resources can be added to enhance present service provision.
- **Community sector** and the LTC sector will build on existing quality improvement approaches such as, Residents First, for Long Term Care Homes and plan

knowledge transfer for all LTCH staff with a goal of providing seamless care. In addition, quality improvement plans focused on seamless care will be developed by the Implementation Facilitator and PDSA cycles will be implemented for QI sustainability.
- **Trellis** will re-evaluate existing use of funds to free up funding to be used for a WW BSS System Lead position.

Previous Collaborations with Partners and Outcomes

The WWLHIN has a long history of partnerships and collaborations. Some examples of collaborative partnerships are:

- GEM Nurses: Acute Care ED, WWCCAC, SGS and Intensive Geriatric Services
- Intensive Geriatric Service Workers: SGS, GEM Nurses, WWCCAC, CSS and Acute Care
- Overnight Stay Respite Program: Sunnyside Home, ADP, WWCCAC, SGS, GEM Nurses
- Integrated Assisted Living Program (IALP): WWCCAC, CSS, housing providers, professional service providers, PSW providers, FHTs, University of Waterloo
- Seniors' Assisted Living and Seniors' Supported Housing: Guelph Independent Living programs, WWCCAC, and housing
- RGP and McMaster University
- Long-Term Care Homes with PRCs and NLOTs. Long-Term Care Homes and onsite SGS clinics. Memorandum of Agreements are in place with identified outcomes.
- Easy Coordinated Access is an integrated intake and referral collaborative partnership between WWCCAC and WW CSS agencies with accountability agreements. QI has been completed using a PDSA cycle and ongoing improvements are implemented.

Accountability agreements or Memorandum of Agreements are in place with partnerships between agencies. Quality Improvement (QI) was implemented and continues to be implemented using PDSAs in response to active involvement of clients, caregivers and community partners.

An integrated evaluation was completed by Dr. Carrie McAiney, McMaster University, on three of the above programs (GEMS, Sunnyside Overnight Stay Respite, IGSWs) and the outcomes demonstrated included: client and caregiver high level of satisfaction with service delivery in all area; positive impact on clients, and caregivers having timely access to IGSW, Overnight Respite Program, SGS, WW CCAC and Community Supports Services. Successful system integration shown by utilizing technology tools such as process book (enables appointment booking).

A first year evaluation of the IALP was completed by the University of Waterloo Ideas for Health Team led by Dr. John Hirdes. Results showed higher client satisfaction in comfort/environment and autonomy and early evidence of improved health outcomes, reduction in acute care utilization and ability to remain at home longer. Year two evaluation is nearing completion.

Regarding the work of LTCHs, PRCs and NLOTs, data collection has recently demonstrated a decrease in transfers from LTCH to ED and acute care and appropriate transfers to ED/acute care with PRC and/or NLOT being involved throughout the transitions within and across the continuum of care. The redesign builds on this model of service and will include a member of the intersectoral team 'walking with the client and their caregiver' during periods of transitions

Executive Sponsors (Chairing Steering Committee, Ongoing Leadership and Engagement)

- Program Lead: St. Joseph's Health Centre WW BSO Program role to the WWLHIN
- Steering Committee: Waterloo Wellington Responsive Behavioural Support Services Working Group. It functions as the BSS Advisory Committee and is co-chaired by PRCs.
- Trellis hosts the Project Lead and Implementation Facilitator who will be responsible for establishing and leading working groups in collaboration with the program lead and WWRBSS Working Group
- Waterloo Wellington Geriatric Services Network: Provides leadership in the identification, development, implementation and evaluation of strategies that will improve the system of care for older adults with complex needs and their families. It is co-chaired by a representative from a Long-Term Care /CSS (SJHC) and WWCCAC
- WW Long-Term Care Home Network: Provides leadership to assist with improving the system of care for residents and their families. Co-chaired by representatives from LTC Homes

Pillar 2: Interdisciplinary Service Delivery

Interdisciplinary service delivery encompasses interagency collaborative teams and services which will cross sectors and ensure that the right services and expertise are mobilized to provide care and enable improved transitions for the client and their caregiver.

Identified Target Populations

This Action Plan has been developed to address the following population:

- Older adults with complex and responsive behaviours associated with cognitive impairments due to complex mental health, addictions, dementia, or other neurological conditions and their caregivers.
- Older adults may be patients within acute care, residing in the community, or a resident in a Long Term Care Home
- The population may also include those at risk of developing responsive behaviours.
- The unique culture and language needs in our WWLHIN community, including French language, will be incorporated in service delivery

Transition Points for Identified Target Populations

Individuals will typically access behavioural support services:

1. When behaviours are increasingly difficult to support in the care setting whether the setting be home, retirement home, LTCH or hospital.
2. When the individual presents to the ED with responsive behaviour concerns.

3. When there is evidence that the older adult is at risk of developing responsive behaviours and/or caregivers present with support needs that are identified by partners for example: the Alzheimer Society Family Programs, First Link, Primary Care and/or Memory Clinics, WWCCAC, Long-Term Care Homes

Key Gaps Identified in Supports and Outreach

1. Unclear Service Categories
   There are overlapping roles in services intended to address the needs of this population but also gaps in service. Navigating the system to find the right service is difficult for professionals and even more so for individuals and care givers. Similar services offered in different parts of the WWLHIN have different components making it difficult for those using the service to know what to expect.
2. Eligibility is not communicated, including knowledge of who is most responsible for follow-up care for the individual with responsive behaviours in the community and following discharge from ED/ALC/acute care to community. Unclear eligibility criteria makes it difficult for referring sources. This makes the next step unknown to the client and/or caregiver causing confusion.
3. Services are not reliable/robust
   Services are not able to respond in a timely manner and may not respond to all of the issues. Services are not able to reliably share information across the service continuum resulting in missing information or duplication of information gathering.
4. Gaps in Service across the region
   Across the WWLHIN, there is significant variation in the capacity of LTCHs' to manage residents with responsive behaviours. Transitions to LTCH for this population tend to be problematic.
5. Inconsistent Specialized Geriatric Services
   Although Specialized Geriatric Services are available across the WWLHIN, there is considerable variability in the service and in the availability of geriatric specialists - psychiatry and medicine – for individuals living in the community and in LTCHs.

Opportunities to Leverage the Strengths and Address the Gaps

The Action Plan will develop a service model that addresses the needs of individuals in both urban and rural settings. Areas to be leveraged include:

Special Knowledge and Expertise:

- Physician specialists in geriatric psychiatry and medicine within the WWLHIN.
- WWCCAC providing WWLHIN wide services and case management
- Three Alzheimer Societies across the WWLHIN
- Psychogeriatric Resource Consultants (PRCs) who have existing roles within the system to develop knowledge, skills, partnerships and networks for the new WW BSS staff within the continuum.
- Nurse Led Outreach Team's (NLOT) service model and role in knowledge transfer.
- LTCH staff trained in PIECES (best practice learning and development initiative that provides an approach to understanding and enhancing care for individuals with complex physical and cognitive/mental health needs and behavioural changes), and Gentle Persuasive Approaches for Dementia Care.

- Aging at Home initiatives including Geriatric Emergency Medicine (GEM) nurses who work with emergency department staff to manage the care of complex seniors, Intensive Geriatric Service Workers, Overnight Stay Respite, Integrated Assisted Living Program, and Sunnyside Supportive Housing.
- Adult Day Programs
- Primary Care-Memory Clinics
- SMART (Seniors Maintaining Active Roles Together) wellness activation program offered by VON

The intersectoral transdisciplinary team will leverage these areas and an identified lead within the team will partner with the client and their caregiver at each point of transition and throughout the continuum of care to adhere to the voice of the client and decrease confusion, fear, number of assessments, increase knowledge and assist with access to information.

Successful Outreach Models:

- Psychogeriatric Resource Consultants (PRCs) who have existing roles within the system to develop knowledge, skills, PIECES training, partnerships and networks for the new BSS staff within the continuum.
- Clinical shared care models including Specialized Geriatric Services (SGS) staff who provide in-home and clinic based comprehensive assessment, behavioural management strategies, and intervention and secondary crisis intervention to this population in community settings and some LTCHs.
- Nurse Led Outreach Team's (NLOT) service model and staff expertise and knowledge.
- Intensive Geriatric Service Workers (IGSW) who work closely with GEM nurses, WWCCAC and SGS workers to support the complex needs of seniors living in the community.
- Integrated Assisted Living Program which provides 24/7 access to PSW (personal support and homemaking) services for seniors with complex health needs living in designated neighbourhood hubs across the WWLHIN

Mechanisms that Support Collaboration and Service Coordination:

- First Link Coordinator (AAH initiative) offered through the three Alzheimer Societies across the WWLHIN, who makes connections with primary and specialized care providers
- Centralized intake and referral, and with all aspects of the care system (i.e. hospitals, supportive housing, community agencies and LTCHs).
- Easy Coordinated Access to multiple Community Support Services
- Integrated Assessment Record (IAR) to access assessments
- Ontario Telemedicine Network (OTN) - located in hospitals, numerous community agencies and a few LTCHs across the WWLHIN.
- WWLHIN wide Coordinator roles including WW Geriatric Systems Coordinator, WW Geriatric Clinical Resource Consultant for Primary Care, WW Addiction & Mental Health Coordinator, Service Resolution Coordinator (Addictions & MH), and ABI System Coordinator

Core Components to Address Service Gaps Across Continuum of Care

The WWLHIN Action Plan will address service gaps through identified improvement plans. These improvement plans have been developed in response to the following client value statement, identified by WWLHIN health care providers through the WWLHIN's Value Stream Mapping process.

> *"Please understand his/her behaviour and care needs at his/her home. He/She needs care and treatment today, and genuine assistance if he/she needs to move to a new home. We need to understand what services are available to help now and I need to know the next steps. We want to be confident that people care."*
> (Voice of the client- Waterloo Wellington Responsive Behaviour Support Services Working Group")

The future state developed as part of the work of the RBSS Working Group and Value Streaming Analysis will be achieved through the WWLHIN Action Plan and will integrate new resources and reconfigure existing services. The future state will achieve client and family-directed care while addressing their needs throughout the journey across the continuum of care. See Appendix A for projected future state.

The goals of this plan are to improve the lived experience for the person with a responsive behavior(s) and their families throughout the journey. There are several key success factors within this plan which leverage existing structures to ensure sustainability and improved outcomes for clients with responsive behaviours.

These success factors include:

1. In collaboration with the Waterloo Wellington Primary Care Clinical Consultant and the new resources for Primary Care, build capacity within primary care to effectively support the clients and/or their caregivers within the community;
2. Capacity building for community and LTCHs to improve the clients experience and quality of life;
3. A centralized intake and referral process designed to link the client/caregiver with services that will meet their needs;
4. Clinical intake process to obtain the necessary information to proceed to the next step;
5. Intersectoral transdisciplinary outreach team(s) in the community and LTCHs and the establishment of best practice protocols to enable smooth transitions for clients and their caregivers to and from LTCH and;
6. Use of the PIECES framework to effectively share care plans relating to the person with a responsive behavior(s) and their families across the sectors and have a 'common language'.

Areas that will be the Focus of Improvement Plans

The action plan components that will be the focus of improvement plans:

1. Capacity building for primary care to effectively support these clients within the community
    - Where telemedicine assessments are provided, increase access and simplify the process for FHTs.

- Actively involve Primary Care at all levels of care; develop a consistent WWLHIN wide person-centered approach to preventing and managing responsive behaviours

2. Capacity building for community and LTCHs to improve the client's experience and quality of life
   - Create LTC in-home BSS Nurses and PSWs who can mentor, model, coach, facilitate in the moment teaching and model critical thinking
   - Utilizing the PIECES tool to address activation needs of the target population
   - Harmonize PRC role within LTCHs across WWLHIN with other services, for example, Nurse Led Outreach, Geropsychiatry Community Education Program, and WW BSS resources
   - The new BSO resources along with the redesigned model which includes PRC, NLOT, GEM Nurses, Clinical Nurse Specialists and LTC Home staff, will be identified as an inter-sectoral BSS team.

3. A centralized and clinical intake and referral process designed to link the client/family with services that will meet their needs
   - Create a regional approach to accessing Geriatric Specialty Services
   - Simplify and centralize the referral process including the referral form for specialist services
   - Build on the learning from Easy Coordinated Access to multiple community support services to improve access to services across the continuum of care

4. Regional Geriatric Service integrated with the Mobile Community BSS Transdisciplinary Resource Team in the community and LTCHs that promotes an intersectoral team and the use of best practice protocols to enable smooth transitions for clients and families by:

   - Creating strong links to Primary Care, WWCCAC , Specialized Geriatric Services, CSS (community- focus on ADP and Respite), LTCHs, Acute Care, and existing mobile LTCH services (PRC, NLOT, GCEP). This would include a member of the inter-sectoral team "walking "with the client and their caregiver throughout the journey

   - Building on successful local approaches (ECA)

   - Design processes that create 'pull' to the next resource in a timely manner; surrounding individual and their family with effective an team: interdisciplinary , access to information about the client at each point along the continuum; new BSS resources to include LTCH BSS RN/RPN, LTCH BSS PSW, Social Work (SW) Occupational Therapy (OT), Advanced Practice Nurse (APN), Geriatric Specialty Services.
   - Integrate into the system redesign a 24/7 support for LTCHs and the community.

5. Utilize the PIECES framework to effectively share care plans relating to the person with a responsive behavior(s) and their families across the sectors

    - Integrate a system wide approach of PIECES training that supports knowledge transfer, change in practice and person centered approach to care

Strategies to Address Service Gaps:

Equitable and Timely Access to the Right Providers and Care

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

- Centralized Referral Process which simplifies the referral process and ensures equitable and timely access to appropriate services.
- Integration and clarification of roles for service providers involved in behavioural management
- Redesign of Regional Specialized Geriatric Service which simplifies processes and service categories for the stakeholders, senior and their families/caregivers
- Improve reliability of availability of telemedicine assessments: Enable any FHT to book a telemedicine assessment from a shared pool of psychiatry telemedicine appointments.
- Implementation of WWLHIN Intersectoral Transdisciplinary Team that includes the Mobile Community BSS Transdisciplinary Team and LTCH BSS resources to support behaviour management in the community and in LTCHs.
- Build on existing capacity and expertise of PIECES trained nurses, GPA and U-First in LTCHs and establish BSS full time leaders in LTCHs.
- Establish subgroups of WWBSS Working Group to address health human resources including integration of new BSS resources, transfer of knowledge and evaluation

Access to Behavioural Assessment Services

A behavioural support centralized intake and referral process will provide timely linkages to appropriate behavioural assessment services. An integrated approach between the Behavioural Support Service and Specialized Geriatric Services will provide an assessment by the most appropriate service provider. The Behavioural Support Service will leverage the existing support, and build on the expertise of Psychogeriatric Resource Consultants (PRC), Specialized Geriatric Services staff, Nurse Led Outreach Team (NLOT) members, Community Support Services (with a focus on ADP and Overnight Stay), and RAI/InterRAI tools. The Behavioural Support Service will also increase and sustain specialized assessment capacity in the community and LTCHs through ongoing knowledge exchange.

Access to Comprehensive Geriatric Assessments

Primary care providers can access Memory Clinics which utilize best practice tools and protocols for an initial standard geriatric assessment. Clients who require a more comprehensive assessment will be referred to Specialized Geriatric Services (including geriatric medicine and/or geriatric psychiatry services), which offer a range of clinic-

based or mobile/home-based assessment services. There will be a standardized approach to obtain a comprehensive geriatric assessment for residents of LTCHs.

Access to Behavioural Support Services for Individuals with Complex and Challenging Mental Health, Dementia and other Neurological Conditions

Implementing the Action Plan has the potential to result in increased public and provider awareness of the sign and symptoms of the above conditions in a variety of settings. Based on their care setting, clients with these conditions will be linked to the appropriate services as needed.

Access to Right Care for Individuals Outside of Target Population

Implementing the Action Plan has the potential to result in referrals for individuals outside of the target population. Through the referral process and based on their care setting, these clients will be linked to the appropriate services as needed.

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Support of Individuals In Crisis

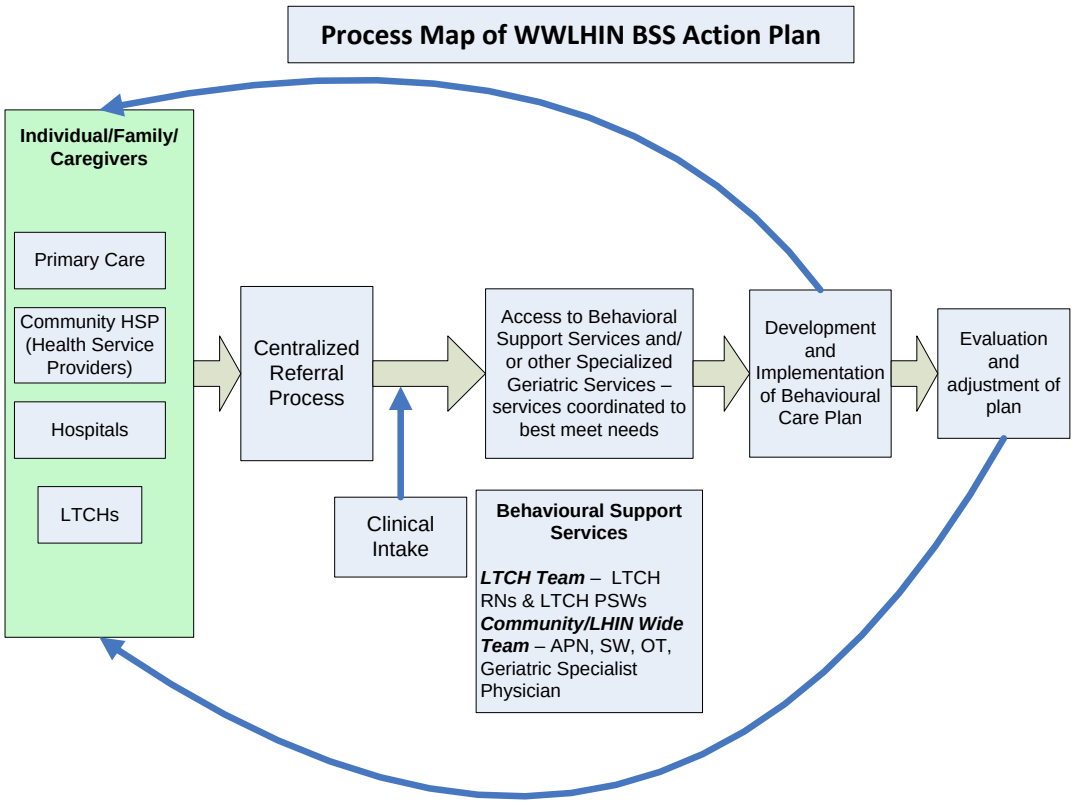
The crisis management strategy will depend on the care setting of the individual. Protocols utilizing best practices for the management of escalation of responsive behaviours will also be established and implemented LHIN-wide. Care plans will provide a contingency plan for each individual with a responsive behavior and their family/caregiver who will know the next step thereby alleviating fear and anxiety. There will be a review of the existing 24/7 WW crisis service to determine opportunities to support the target population.

Community:

- The Behavioural Care plan developed for the individual will include contingency plans to address escalation of behaviours and crisis situations.
- Individuals without a Behavioural Care Plan (not receiving service) will contact their primary care physician or the Mobile Crisis Service or present at the nearest emergency department. Depending on the level of crisis, the situation may be deescalated by primary care or Mobile Crisis or they may be admitted to a hospital, or the WWCCAC Case Manager in the ED will initiate a community support service plan.
- In both these situations, following resolution of the acute crisis, the care plan will be reassessed and adjusted as needed.

LTCH:

- Individuals in crisis in LTCHs will initially be assessed and care plans adjusted by the LTCH staff (who with an increase in FTE within the LTCHs, have obtained increased knowledge and skills to support this population as part of this action plan) in consultation with the LTCH Medical Director.
- In situations where the resident's behaviour has escalated such that it poses a risk to the resident, other residents, and/or staff then the LTCH will initiate the crisis response plan.



Adherence to the voice of the client: *"Please understand his/her behaviour and care needs at his/her home. He/She needs care and treatment today, and genuine assistance if he/she needs to move to a new home. We need to understand what services are available to help now and I need to know the next steps. We want to be confident that people care."* (Voice of the client- Waterloo Wellington Responsive Behaviour Support Services Working Group")

Partners in Interdisciplinary Service Redesign

WWLHIN providers are increasingly working collaboratively across sectors including Addiction and Mental Health, Community Support Services, Primary Care, Long-Term Care Homes, Acute care, WWCCAC and other disciplines. Some examples of collaboration are:

- Wellington Specialized Geriatric Services - a collaboration of 3 agencies – WWCCAC, Trellis and St Joseph's Health Centre, Guelph, with a centralized intake for geriatric mental health and geriatric medical services

- Joint Specialized Geriatric Service offered in partnership by WWCCAC and Grand River Hospital in Kitchener Waterloo with co-location of services
- Cambridge Geriatric Medicine and Geriatric Psychiatry offered at Cambridge Memorial Hospital and clinics at Long Term Care Homes
- Geriatric Medicine hosted at St. Mary's General Hospital
- Consultation Clinics in LTCHs – partnership between LTCH and Specialized Geriatric Service (MH) (Wellington)
- Geriatric Psychiatry and Geriatric Medicine delivered through OTN services for rural Wellington FHTs in partnership with Trellis and Hamilton Health Sciences Centre
- LHIN wide GEM nurse team deliver services in individual hospital EDs
- WW Intensive Geriatric Support Worker (IGSW) service provided in partnership between Trellis, CSS, WWCCAC, Specialized Geriatric Services and GEM nurses
- Geriatric Community Education Program (GCEP) provided in partnership between Homewood Health Centre, Trellis and LTCHs (Wellington)
- Project Wisdom is a collaboration between Immigrant Services Guelph-Wellington and Trellis to better address the needs of the immigrant population
- Waterloo Wellington Easy Coordinated Access Resource Center provided in collaboration with WWCCAC, Alzheimer Society of Kitchener and Waterloo and WW Community Support Services.
- Centre for Addiction and Mental Health in partnership with Trellis has a role in education, mentoring and coaching

The WWRBSS has cross sector representation including primary care comprised of health care leaders and community support services (ADP) with expertise in the management and care of individuals with responsive behaviours and access to consumer representatives through the Alzheimer's Society. Building on the learning from our 'buddy' LHIN (HNHB LHIN), the Working Group will expand membership and increase expertise as needed through the establishment of sub-committees.

The Working Group will also work with LRIC to ensure interdisciplinary care providers have access to expertise and learning opportunities inherent in the practice-relevant research and training that will be conducted and produced through the center. For example, the Schlegel LRIC, in collaboration with Conestoga College, plans to develop learning modules in interprofessional practice for Long Term Care. Specific areas of expertise include program evaluation, health information management and informatics, exercise and kinesiology, dementia care, and chronic disease management. There will be ample opportunities for clinical education for students in health sciences, medicine, nursing and personal support workers, as well as undergraduate and post-graduate research opportunities.

WW Behavioural Support Service (BSS) Model

The WW Behavioural Support Service (BSS) Model is designed as an intersectoral transdisciplinary team and builds on strengths and successes across the continuum, community to long-term care. The model is :

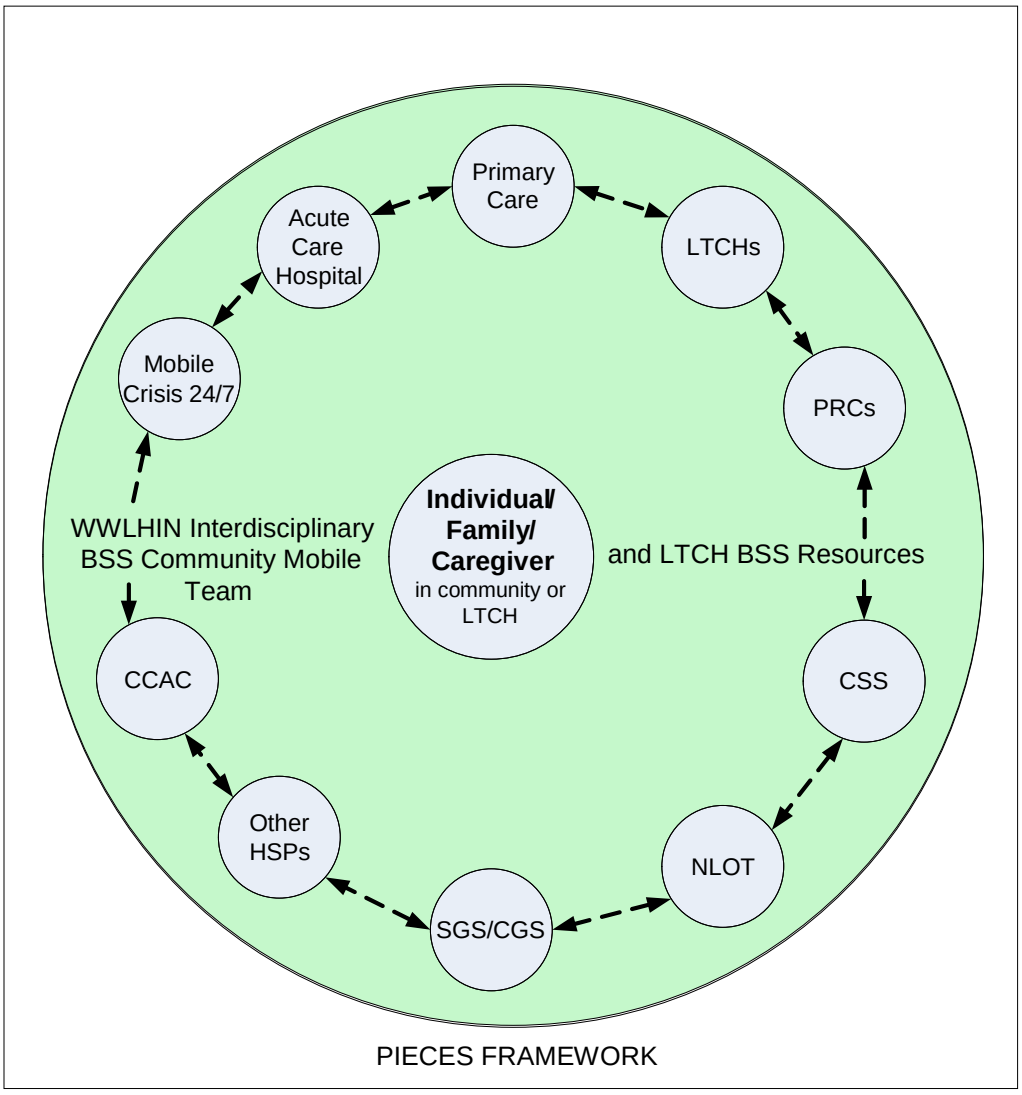
- Long-Term Care Homes (LTCH) - In home increase of FTE of RNs/RPNs and PSWs dedicated to the provision of specialized behavioural support service expertise. LTCH will have also be a member of the WWLHIN transdisciplinary BSS Community Mobile Team as described below.

- WWLHIN Mobile Community BSS Transdisciplinary Team will integrate existing resources and new resources, and will serve the target population across the continuum of care (including acute, community, LTCH, primary care). Community means place of residence and community support agencies, such as, Adult Day Programs and Overnight Stay Respite.

The above model will build on the PIECES (Physical, Intellectual, Emotional, Capabilities, Environment, Social) and GPA (Gentle Persuasive Approach) U –First frameworks to:

- Assist with the development of a consistent, WW LTCH, person-centered approach to preventing and supporting individuals with responsive behaviours and their caregivers/families
- Assist LTCH to build specialized behavioural support expertise 'in-home' capacity of FTE staff, through mentoring, coaching, facilitating, in-the-moment teaching and modeling critical thinking
- Assist with an integrated approach across the continuum of care
- Centralize access to the WWLHIN Mobile Community BSS Transdisciplinary Resource Team that will be integrated with existing resources

WW Behavioural Support Service(BSS) Model



Adherence to the voice of the client: *"Please understand his/her behaviour and care needs at his/her home. He/She needs care and treatment today, and genuine assistance if he/she needs to move to a new home. We need to understand what services are available to help now and I need to know the next steps. We want to be confident that people care."* (Voice of the client- Waterloo Wellington Responsive Behaviour Support Services Working Group")

Pillar 3: Knowledgeable Care Team and Capacity

Clients and their caregivers will benefit from the strengthened capacity of current and future professionals through education and focused training to transfer new knowledge and best practice. The development of skills and effective use of quality important tools and processes for continuous service improvement within and across sectors will better serve clients and/or their caregivers.

Knowledge Exchange Capacity

There are many existing processes that will support knowledge transfer and dissemination of best practices related to behavioural supports across the WWLHIN.

Organizations that provide training/education for health care professionals include:

- Alzheimer Societies' education and knowledge transfer activities for public and providers, particularly through the Public Education Coordinators and First Link.
- Alzheimer Societies Support Groups: Early Dementia, Family and Caregiver
- Long-Term Care Home Family and Resident's Councils
- Psychogeriatric Resource Consultants (PRC)
- Nurse Led Outreach in consultation with PRC
- Waterloo Wellington Geriatric Emergency Management Clinical Resource Consultant
- Waterloo Wellington Primary Care Clinical Resource Consultant
- Primary Care - Geriatric Psychiatry 'Rounds' – OTN in collaboration with FHT and Trellis
- Center for Addiction and Mental Health – Toronto (CAMH)
- The Regional Geriatric Program (RGP)-Central activities that support and coordinate physician education, capacity building and knowledge exchange, such as 'Grand Rounds' – these are regular events sponsored by RGP-Central and hosted at one of the WWLHIN's teaching hospitals, whereby local or visiting geriatric specialists provide presentations to medical staff and medical learners on new knowledge and best practices in geriatric care. These Grand Rounds are accessible to service providers through the Ontario Telemedicine Network (OTN).
- Hospitals' regular department rounds, academic/education days for medical staff and ongoing Continuing Medical Education (CME) events.
- Geropsychiatry Community Education Program for LTCH and retirement homes
- Training and use of RAI/InterRAI tools by the WWCCAC and CSS with possible use by other service providers in future which includes questions/modules related to responsive behaviours.
- Residents First knowledge transfer activities in the LTCH sector.
- BSO pan-LHIN communications plan across all 14 LHINs.
- BSO Knowledge Exchange activities across all LHINs.
- Knowledge transfer from Early Adopter LHINs
- Assessment and identification of efficiencies in primary care provided by Health Quality Ontario (HQO).
- Training provided as part of the implementation of Memory Clinics in primary care.
- SHRTN Community of Practice actively promotes knowledge transfer.
- Murray Alzheimer Research and Education Program (MAREP)

It is envisioned that the WWRBSS advisory committee working with the Schlegel LRIC will develop clinical learning units for the new LTC home associated with the LRIC, with the benefits leveraged and realized across all Waterloo Wellington LTC Homes. For example, a Personal Support Worker training course specifically designed for Long Term Care is one of the proposed programs for the Schlegel LRIC. This course is anticipated to launch in about 2015, with learning needs assessment and curriculum development to occur prior to that time. The LRIC, in partnership with Conestoga College, is very interested in connecting with the BSO project as part of the Learning Needs Assessment and curriculum development process.

It is anticipated that the Centre for Family Medicine, affiliated with the McMaster deGroote School of Medicine, will also be involved with the Schlegel LRIC, providing opportunities for trainees in family medicine.

Quality Improvement Capacity

The WWRBSS Working Group will establish a QI Subcommittee.

Adherence to the voice of the client: *"Please understand his/her behaviour and care needs at his/her home. He/She needs care and treatment today, and genuine assistance if he/she needs to move to a new home. We need to understand what services are available to help now and I need to know the next steps. We want to be confident that people care."* (Voice of the client- Waterloo Wellington Responsive Behaviour Support Services Working Group")

The WW RBSS Working Group will leverage WWLHIN provider expertise in QI and behavioural support services in determining membership of the QI Subcommittee. The project will also leverage the expertise of the 'buddy' LHIN (HNHB) and Health Quality Ontario. Other WWLHIN resources with knowledge/expertise in QI that will support the project include:

- BSO Improvement Facilitator
- BSO Project Lead
- HQO BSO Coach
- WW Geriatric Systems Coordinator
- WW Primary Care Clinical Resource Consultant
- WWLHIN Executive Lead and Community Services Lead
- WWLHIN Communications Team
- WWLHIN Systems Design and Transformation
- WWLHIN eHealth
- WWLHIN Performance and Accountability
- WWLHIN Geriatric Specialty Physician Lead
- Residents First Improvement Facilitators and LTCHs staff trained in Residents First
- WWCCAC
- Seniors Health Research Transfer Network (SHRTN) Community of Practice
- Primary care providers and their staff within the WWLHIN involved in previous improvement projects who received QI training from QIIP and HQO
- Partnership with RGP Central and Hamilton Health Sciences
- "Buddy LHIN" HNHB LHIN

Quality Improvement training for the Improvement Facilitator from HQO has occurred and continues with ongoing coaching in the development of improvement plans and rapid cycle tests of change. The Improvement Facilitator will work with the RBSS Working Group, WWLHIN providers and the BSS Implementation Project Lead to transfer knowledge of quality improvement tools and identify best practices related to behavioural supports.

Behavioural Supports Expertise

- An outreach Specialized Geriatric Service is available in Wellington, Kitchener Waterloo and Cambridge. Each service has an outreach team which includes one or more geriatric specialists.
- Adult Day Programs : Specifically the Alzheimer and Integrated Day Programs
- Two inpatient mental health programs providing services for individuals with dementia and responsive behaviours – Homewood Health Centre Program for Older Adults and Grand River Hospital Seniors Mental Health Program.
- Specialized inpatient geriatric services at Grand River Hospital – the GAU (Geriatric Assessment Unit), the NBU - Neurobehavioural Unit.
- PRCs (Psychogeriatric Resource Consultants)
- Advance Practice Nurses: Acute Care and GEM Nurses
- Geropsychiatry Community Education Program provides GPA training (Wellington)
- LTCH staff

Building Knowledgeable Care Teams with Behavioural and QI Capacity

Activities related to the establishment of knowledgeable intersectoral care teams will focus on building the capacity and processes that will facilitate ongoing learning and quality improvement. A learning strategy will be developed which will target and coordinate training efforts at the point of care which will improve the client experience.

The following strategies will be used:

- Organizational culture and leadership that embraces innovation will be essential to establish and sustain a learning strategy for BSS across the WWLHIN.
- Engagement and support from both the senior and clinical leaders are critical to ensure support for improvement plans and overcome barriers
- Mentoring and modeling, on-site case-based education and care planning, user-friendly job aids and organizational assistance with review and integration/embedding into program policy and procedure best practices
- Identification of health service providers (HSPs) trained in QI methodologies to transfer this knowledge to other providers in the WWLHIN.
- The BSO Implementation Facilitator and HQO Coach will guide the BSS partners to apply quality improvement methodology.
- The new BSS staff will be trained by existing geriatric service providers including outreach teams and day programs. These teams will share their expertise through training and mentorship, educational forums, webinars, case conferencing and sharing of best practices.
- All staff working with responsive behaviours will be trained in PIECES and Gentle Persuasive Approaches (GPAs) to improve their skills and knowledge regarding the management of clients with responsive behaviours. A training plan will be developed

to support front line staff with training and transfer of knowledge. QI using PDSA cycles will be implemented to measure outcomes.

- QI capacity from Residents First Improvement Facilitators and LTCH staff from homes that participated in Residents First will also be leveraged.
- Through the Alzheimer Society, existing public education activities and mechanisms will be enhanced to provide public awareness of the signs and symptoms of responsive behaviours. (e.g., newsletters, website, speakers' series, etc).
- Adult Day Programs: Staff , Participants and Family/Caregiver will be leveraged to assist with knowledge transfer
- Long-Term Care Homes: Residents, Family/Caregiver and Staff will be leveraged to assist with knowledge transfer
- Waterloo Wellington BSS System Lead role will support QI opportunities and share the learning from the Aging at Home QI initiatives.

Foster more knowledgeable care teams and build the capacity of current and future professionals by:

- Adherence to the client voice and know what to expect next; Create single/shared educational brochure for all WWRBSS services for use by professionals, hospitals, community and LTCH providers, clients and families/caregivers. Information to access services will be streamlined and adhere to the voice of the client.
- Integration of the transfer of knowledge of the new BSO resources into current system through the WWBSS-Education working group.
- Integration of the PIECES model of service and existing care paths relating to Dementia, Delirium and Depression across the continuum and within the new BSO framework.
- Building on the work of the PIECES program to develop a common language and approach to understanding and managing responsive behaviours across the systems of care.
- Training front line staff in PIECES, GPA, U-First to assist with a continuity of care and common language WWLHIN wide.
- Building on Montessori Training and Outcome opportunities across the continuum
- Collaborating with SHRTN Community of Practice, implement best practice trainings and knowledge exchange events across the system: primary care, community, acute care, ED and LTCH.
- Building on the work of the Memory Clinics and First Link: Develop integration opportunities with the Alzheimer Societies, Primary Care Clinical Consultant, Memory Clinics, Acute Care, LTC, Geropsychiatry Education Program and PRCs to create an education program for caregivers and professionals that address the need to know where to go for services and what to expect.

Leveraging Existing Knowledge Transfer Structures/Pathways

In addition to the aforementioned processes, the BSS project will leverage the following mechanisms to disseminate new knowledge, processes and protocols to support the BSS project:

- WWLHIN-led mechanisms that support collaboration among primary care and specialist clinicians, such as:
    - WWLHIN Primary Care Network

    - WWLHIN LTCH Medical Directors
    - Committees and networks that are working to develop LHIN-wide, integrated clinical programs; e.g.; Palliative Care
    - Memory Clinic Education opportunities
- WW Addiction and Mental Health Network, Core Action Group (CAG)
- WW Geriatric Service Network
- WW Responsive Behavioural Support Services Working Group
- WW Long Term Care Home Network
- WW Dementia Network
- WW Community Support Services including ADP Network
- WW Clinical Services Network (Hospital VP/CNE, CCAC, LTC, CCC, HHC)
- SHRTN* and Alzheimer's Knowledge Exchange (AKE)* websites and local knowledge brokers/librarians are key sources of information on best practices and current research.
- SHRTN Community of Practice Mental Health and Addictions
- Canadian Dementia Resource and Knowledge Exchange (CDRAKE)* and the National Initiative for the Care of the Elderly (NICE)* provide educational resources.
- The WWCCAC's Information and Referral service provides live phone and/or internet access and reference to WWLHIN-wide resources for seniors, their families, professional staff and the public.
- OTN video-conferencing capabilities at all hospitals, all WWCCAC branches and Community Health Centers (CHCs), Family Health Teams (FHTs) and some LTCHs will support interdisciplinary education, training and consultation across the WWLHIN.
- Web-based and in class certification courses through a number of academic institutions across the province/country.
- RGP-Central's Annual Geriatric Assessment and Cognitive Tools Training Workshops.
- Meetings at LTCH(s) and smaller homes to assist with knowledge transfer
- Seniors Services Networks and LTCH residents' councils provide local tables for community engagement with clients and/or their caregivers to refine our local model.

Building on current capabilities and capacity

In addition to what has been discussed to date, the project will build on the learning from implementation and evaluation of the following initiatives:

- WW Adult Day Program Review
- CCC Review
- WW IGSWs (Intensive Geriatric Service Workers) Evaluation
- WW GEM nurses Evaluation
- Overnight Stay Respite Program Evaluation
- WW Memory Clinics
- WW Aging at Home – Guelph Independent Living – PSW program (in progress)
- WW Integrated Assisted Living Program Evaluation
- OTN – geriatric specialist and primary care
- Consultation Clinics (Wellington)
- WWLHIN Geriatric Lead report: Developing an Integrated System of Care for Frail Seniors in Waterloo-Wellington

Additional programs which serve clients with behavioural issues include:

- Adult Day Programs for individuals with dementia.
- Overnight Stay Respite – for individuals with dementia/behavior issues and caregivers.
- Alzheimer Societies' 'First Link' programs – link recently diagnosed dementia clients to services.
- Alzheimer Societies Family Support, Education Programs and Early Onset Support Groups
- Programs for homeless and vulnerable adults including seniors such as offered at The Working Centre, The Drop-In Centre

The Action Plan will optimize opportunities to improve system coordination, information exchange, transdisciplinary care, as well as knowledge exchange and quality improvement through the following tools:

- Clinical Connect
- Ontario Telemedicine Network
- Integrated Assessment Record
- Common Assessment
- Easy Coordinated Access
- Leverage and promotion of existing relevant learning and clinical resource materials that have been developed nationally (e.g. CCSMH Guidelines and job aids), provincially (PIECES, GPA to Dementia care, U-First, Montessori Educational, and locally (e.g. RGP-C Blogger, care pathways and algorithms, etc.)

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

Quality Improvement is the driver of system change/reconfiguration within Long Term Care Homes and the community. Attaining and building on small successes through the development of quality improvement plans facilitated by the implementation facilitator will assist in embedding changes into the system. Organizational culture and leadership that embraces innovation will be essential to establish and sustain a learning strategy for BSS services across the LHIN. Engagement and support from both the senior and clinical leaders are critical to ensure support for improvement plans and mitigate barriers. Sustainability of the service redesign is embedded in the governance structure, through accountability agreements, performance measurement and reporting and policy integration. The Implementation Facilitator, Health Quality Ontario, including Residents First for LTCH, will provide opportunities for strengthening the QI culture and provide leadership with a goal of sustainability and increase knowledge with an understanding that this is the new way of delivering care across the sectors.

Governance Structure

The Governance structure assigns accountability for the implementation and sustainability for the WWLHIN BSO Action Plan to the WWLHIN BSO Program Lead with the WWRBSS as the Advisory Committee. The deliverables of the RBSS Working Group will be to establish processes that support:

- ongoing assessment and evaluation of the WWLHIN BSO service model for its impact on the client, caregiver, healthcare provider (individual and organization) and system
- the transfer (and uptake as appropriate) and exchange of knowledge and skills to providers of behavioural support services.

Accountability

Outcomes specific to the WWLHIN Behavioural Support delivery model will be incorporated into the existing accountability agreements the WWLHIN has with its health service providers and with the Program Lead Agency. These will include BSS staffing models, roles and responsibilities (educations and capacity building), commitment to an ongoing learning strategy, requirement to participate in knowledge exchange forums and ongoing performance and reporting. The Implementation Facilitator will partner with Long Term Care Homes and community to determine QI that adheres to the 'voice of the client'.

Policy Development and Integration

Best practice procedures for supporting clients with responsive behaviours and their families/caregivers will be created to support the implementation of the changes that have been developed and tested through each of the improvement projects. These may include revised role descriptions, standardized training, best practices and documentation. New processes will build on existing practices and integrate new knowledge generated from the improvement cycles to improve the clients' experience.

Improvement Plans, Performance Measurement and Reporting

Terms of Reference (TOR) will be developed for each improvement subcommittee in collaboration with the HNHB LHIN 'buddy LHIN' with approval from the WWRBSS. Each TOR will detail the goals, deliverables and accountabilities of the subcommittee. The subcommittees will be facilitated by the BSS Implementation Facilitator. Each subcommittee will contain local leadership. In addition to families/caregivers participating on sub committees, a combination of focus groups and individual interviews will be used to help develop the improvement plan and capture the consumer voice. The improvement subcommittees will provide leadership in the implementation of integrated improvements so that new ways of working become the norm, adhering to the 'voice of the client' and resulting in positive outcomes for clients with responsive behaviours and their family/caregiver. Sustainability will be achieved by creating a clear link between the improvement plans and the organizations' vision and goals.

The use of PDSA rapid cycles of change will identify opportunities to reduce waste and to make improvements. Each improvement plan subcommittee will determine a sustainability plan, which includes knowledge sharing and ongoing data monitoring. As noted above, the ongoing data monitoring will be integrated into HSPs' quality improvement plans and service accountability agreements.

The Implementation Facilitator will develop quality improvement measures building on the completed process mapping and value streaming analysis.

Projected Outcomes:

- Client, family, primary care and health care providers know where to go to for services for responsive behaviours
- Client/Family understands the behavioural service plan
- Client/Family/LTCH/Primary Care have a contingency plan that assists with successful management of WWBSS
- Client/ Family/Service Providers are directly involved in the successful transition throughout the continuum of care from community to LTCH (if LTCH is appropriate)
- Long-Term Care Home has satisfaction that they are able to meet the needs of the individual with responsive behaviours

Communication

A communication plan is a key component of the WWLHIN's BSO Action plan and has been developed to align with the pan-LHIN communications plan. Communication and learning strategies will be identified for each improvement plan to promote sharing of best practices, and sustainability of the Action Plan. The WW RBSS working group includes support from the WWLHIN Communications Team.

Knowledge Transfer

The WW RBSS will work with service providers to develop best practices and protocols. Together, they will develop a plan for standardizing these best practices and protocols across the WWLHIN. New knowledge will be translated, adapted and tailored into existing and redesigned structures and processes, resulting in new ways of practicing with improved health outcomes for clients and enhanced system performance.

Capturing and Sharing Lessons Learned

The Implementation Facilitator will identify and theme key learnings and share these with the RBSS, WWGSN, the WWLHIN and service providers as well as with other LHINs via knowledge exchange (KE) activities.

Partners for Knowledge Exchange and Capacity Building and their Successes

There are a number of examples of partner collaborations that support capacity building:

- Use of secondments to expand capacity
    - staff from Adult Day Programs to Specialized Geriatric Service (Mental Health - Wellington)
    - staff from HHC to Specialized Geriatric Service (Mental Health- Wellington)
- Co-location of staff
    - WWCCAC CGS team co-located at Freeport
    - IGSWs co-located in partner agencies
- Passport Day – an annual event that shares information across the continuum of care related to service provision in the WWLHIN
- PIECES/U-First and GPA (Gentle Persuasive Approaches) training provided for LTCH staff by staff from Specialized Geriatric Services
- Successful Aging series - presentations led by RGP-Central with key note speakers from geriatric specialties who speak to community groups and stakeholder organizations regarding older adults' health challenges, how to self-manage with

chronic conditions and when required, how to successfully navigate the health care system.
- Risk Management and Privacy Training provided for LTCH staff, CSS and primary care provided by Trellis
- Training regarding professional boundaries provided for Community Support Services staff by Trellis

Resource Plan and Deployment of Behavioural Support Staffing Resources

The WWLHIN BSO Service Delivery Model is based on achieving person centered care (target population) and addressing the client's and/or family/caregiver's needs along the continuum of care. An Expression of Interest was extended to our HSPs to establish an overall WWLHIN BSO Program Lead. This HSP will hold the accountability for the resources as well as the overall outcomes of WWLHIN BSO Program.

Long-Term Care Home Team
- BSS Long-Term Care Home Nurses – 9.52 FTEs (allocated across 35 LTCHs). A key focus of the plan is to increase specialized Behavioural Support RN/RPN FTEs in LTCHs
- BSS PSWs – 13.42 FTEs (allocated across 35 LTCHs building on the information contained in the report, "Building a Better System" April 2007). A key focus of the plan is to increase specialized Behavioural Support PSW FTEs in LTCHs

WWLHIN Intersectoral Transdisciplinary BSS Community Mobile Team (LHIN Wide Resource)

Social Work 2.0 FTE
Occupational Therapist 1.0 FTE
Advance Practice Nurse 1.0 FTE
Health Records Admin 1.0 FTE
Recreation Therapist 1.0 FTE
CCAC Intake and Referral 0.5 FTE
Clinical Intake 1.0 FTE
Primary Care Geriatric Specialty Support 0.4 FTE
WW BSS System Lead 1.0 FTE (existing resources system redesign)

LTCH Team:
- A nurse and PSW in each LTCH will be selected based on BSS criteria, including a focus on increasing FTEs, and trained for the additional responsibilities of the BSS role. (See Appendix B for BSS LTCH RN/RPN role and PSW role)
- Staff will be deployed in LTCHs within an intersectoral transdisciplinary team model of care. Each team will include Registered Nurse(s) (RN/RPN), Personal Support Worker(s) (PSWs). During periods of escalation or crisis, the contingency plan will be utilized. In situations where the resident's behaviour has escalated such that it poses a risk to the resident, other residents, and/or staff, then the LTCH staff, using the contingency plan can access additional supports through the WWLHIN Mobile Community BSS Transdisciplinary Team, including a process for 24/7 support. The care plan will focus on predictable behaviours.

- The LTCH BSS team will be integrated with the WWLHIN Intersectoral Mobile Community BSS Transdisciplinary Team and work collaboratively with the client and caregiver to:
    - establish care processes and standards,
    - exchange knowledge
    - carry out training and capacity building
    - carry out performance measurement and evaluation.

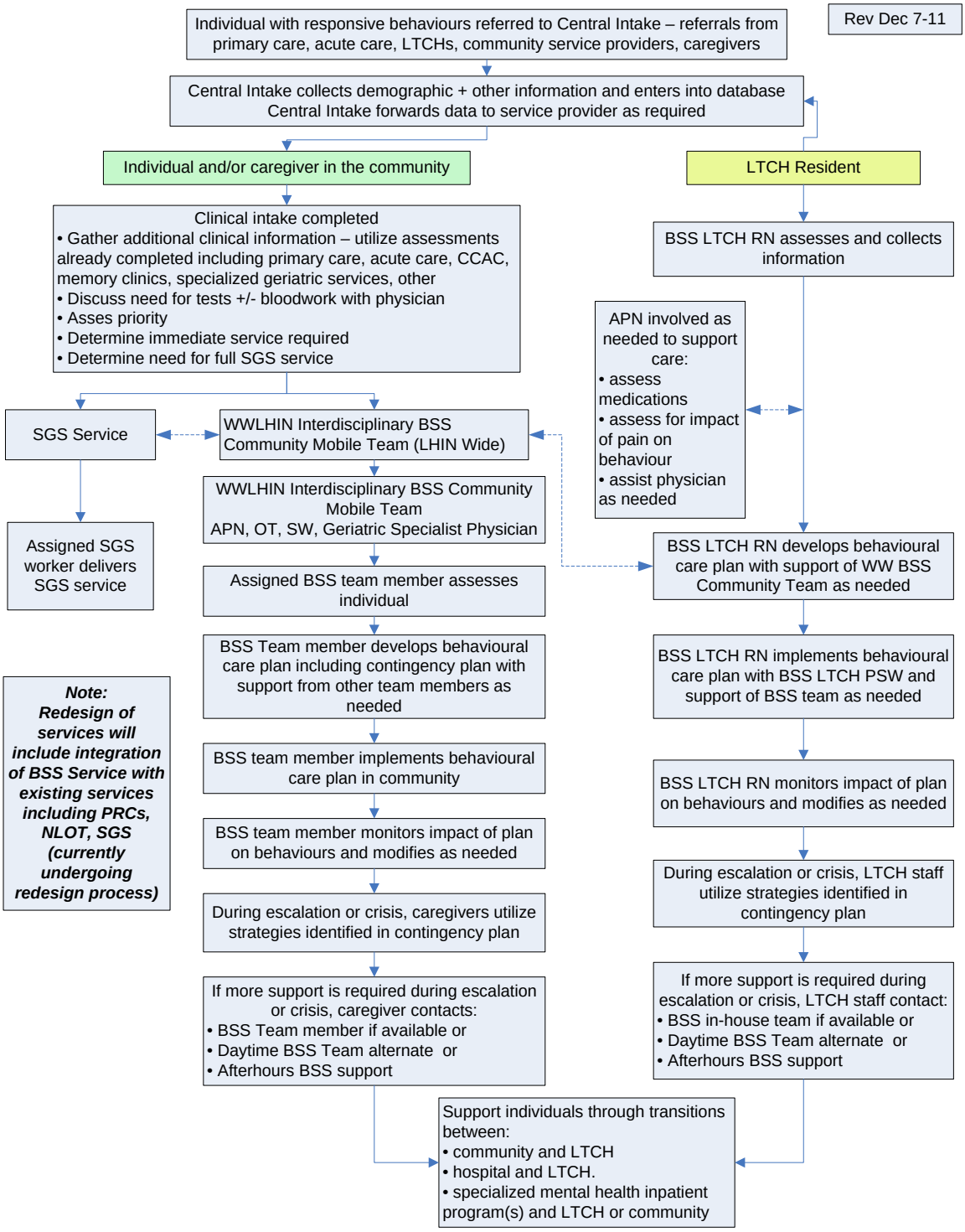
The client and caregiver will have active input into the care plan throughout each transition and reviewing of care plan.

WWLHIN Mobile Community BSS Transdisciplinary Resource Team – LHIN Wide Resource

- An Advance Practice Nurse (APN) will support the LTCH Medical Directors, primary care physicians and care teams particularly in the areas of medication management and pain assessment and management.
- The WWLHIN Intersectoral Transdisciplinary BSS Community Mobile Team provides:
    - In collaboration with other care providers and utilizing existing assessments,
        - In LTCH, provide support as needed to BSS LTCH RN in completing a focused behavioural assessment and develop a care plan including a contingency plan for escalation and crisis
        - In the community, complete a focused behavioural assessment and develop a care plan including a contingency plan for escalation and crisis
        - An identified lead who will 'walk with client and their caregiver' through transitions adhering to the voice of the client
        - Cross-training within the intersectoral transdisciplinary team
    - Episodic and/or crisis support for:
        - LTCH staff around the care of residents with behaviour crisis/issues as requested by LTCH
        - Community caregivers, hospitals and others around the care of individuals with behaviour crisis/issues as requested.
    - Transitional support of residents with behaviour issues (or history of behavioural issues) across care settings who require specialized support at the following key transition points between:
        - the community and LTCH
        - hospital and LTCH
        - a specialized mental health inpatient program and LTCH or the community
- The WWLHIN Intersectoral Transdisciplinary BSS Community Mobile Team will work collaboratively with the HSP partners and the client and caregiver to:
    - establish care processes and standards,
    - exchange knowledge
    - carry out training and capacity building
    - carry out performance measurement and evaluation.

The client and caregiver will have active input into the care plan throughout each transition and reviewing of care plan.

Waterloo Wellington BSS Service Overview



WWLHIN BSS Performance, Measurement and Evaluation Plan.

The Implementation Facilitator, as the driver of system change/reconfiguration, will work collaboratively with system partners (Primary Care, CSS, HSP, RGPc, HQO, clients and their family/caregivers) to implement a robust and reliable performance, measurement and evaluation system.

The Ministry of Health and Long-Term Care identified the following three performance metrics as measures of success for the BSS Framework:

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

Waterloo Wellington Qualitative and Quantitative Successes:

- Waterloo Wellington Staff Supporting Individuals with Responsive Behaviours and Their Families/Caregivers
  - Increased self–confidence
  - Reduced stress among staff
  - Reductions in the number of predictable responsive behaviours (individual and LTCH wide)
  - Evidence of successful implementation of QI across the continuum of care and measures to determine outcomes

The BSO Data, Evaluation and Measurement Working Group has identified two types of indicators:

- Population-level indicators would be representative of high-level system outcome measures that would be comparable across LHINs.
- Process/tracking indicators could be LHIN-specific metrics that measure the development and impact of implemented health service coordination and delivery projects.

Population-level indicators

Population-level indicators would utilize existing hospital administrative data to measure and evaluate progress at a system level. An aim for these metrics would be to allow comparisons across LHINs. Indicators at this level mostly reflect the intermediate risk population where an older adult would experience crisis while living in the community or in a long-term care home.

Hospital Administrative Data

Indicators:

- Analysis for the following indicators will focus on (a) older adult patients who came to hospital from the community (i.e. were not transferred from another institution) and (b) residents transferred from long-term care homes.

Rationale:

- ED and inpatient hospitalization indicators identify older adults diagnosed with mental health, addictions, dementia or neurological conditions and/or their family/caregiver who sought or required intensive health care provision. By tracking where the patient came from (i.e. the community or LTCHs), resources can be allocated to address the needs of these individuals. In turn, improved health care in the community or in LTCH setting should reduce the need for hospital-based care. Discharge planning for higher intensity need residents should help reduce the time residents of Long-Term Care homes spend as ALC in hospital.

The following is an example of data under evaluation and consideration in monitoring health care utilization for adults diagnosed with mental health, dementia or other neurological conditions (known hereafter as "BSS Conditions") :

- rate of individuals making ED visits for BSS conditions or as a significant contributing co-morbidity per 1,000 WWLHIN residents
- acute and alternate level of care (ALC) lengths of stay for patients with BSS conditions and/or co-morbidities discharged to LTC
- acute and alternate level of care (ALC) days for patients with BSS conditions discharged to LTC as a proportion of total # of ALC days amassed
- % of inpatient discharged that spent time as ALC
- % of ALC days out of total inpatient days discharges

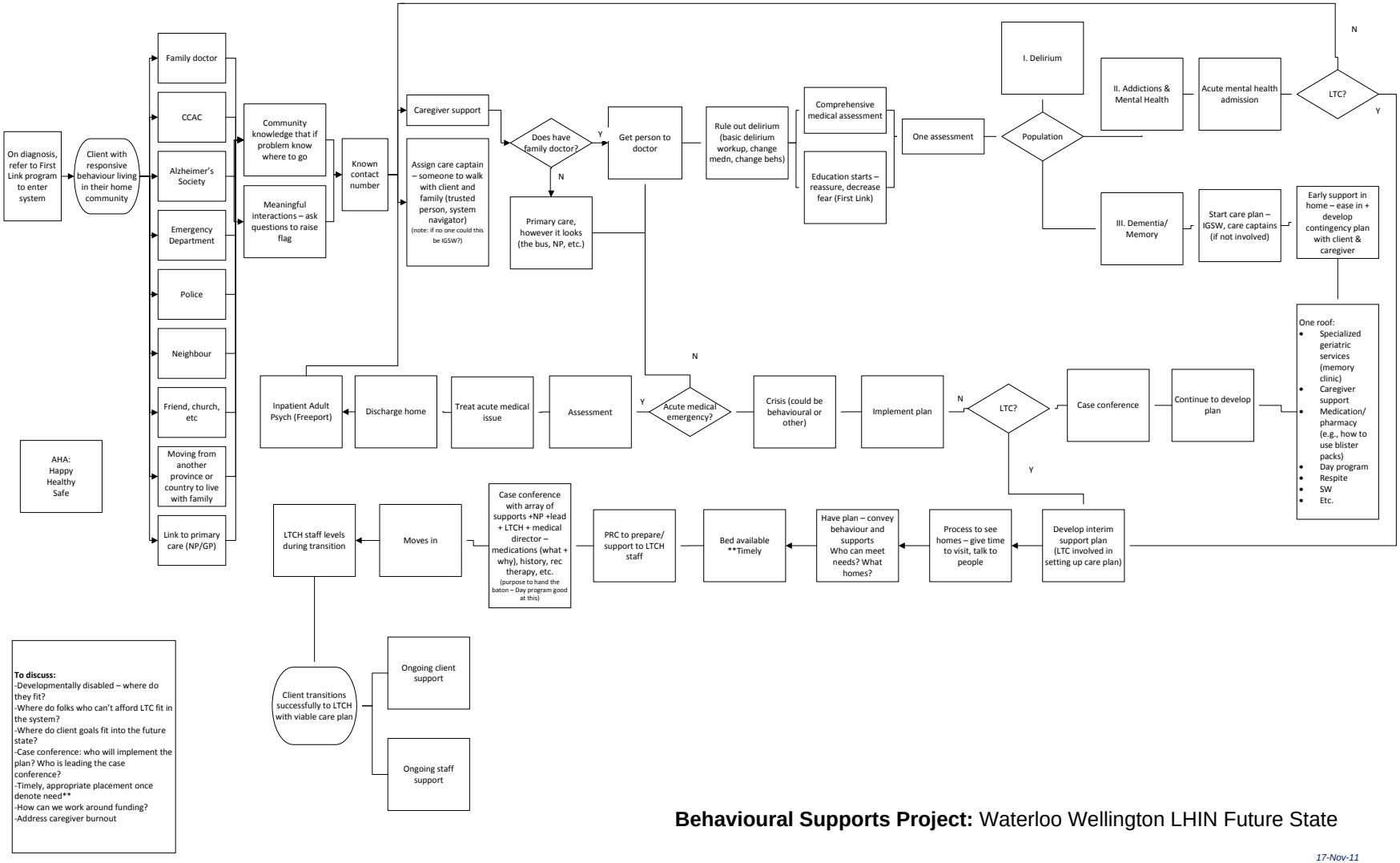
Sources:

- National Ambulatory Care Reporting System (NACRS)
- Discharge Ambulatory Care Reporting System (DAD)
- IntelliHEALTH ONTARIO, Ministry of Health and Long-Term Care. This Business Intelligence (BI) Tool is accessible to all LHINs.

Challenges:

- The BSO Data, Evaluation and Measurement Working Group is working towards establishing a standard definition for the older adult population coming into contact with the hospital system. This includes not only identifying an age cohort, but also a comprehensive list of conditions based on diagnostic information (ICD-10-CA codes) in the patient's hospital record.
- Individuals exhibiting responsive behaviours and/or cognitive impairment would be more accurately captured using the Resident Assessment Instrument (RAI) set of tools as opposed to using ICD-10-CA codes. Currently, however, datasets that contain RAI data do not allow for the three provincially mandated measures to be addressed.
- Wait Time Information System (WTIS)-ALC data has recently been made available through iPort Access, Cancer Care Ontario. As such, it is not yet known how flexible the tool will be to leverage information for the BSO project.
- Not all LTCHs submit data to the Continuing Care Reporting System (CCRS). As such, it is not possible to make cross-LHIN comparisons using this dataset.

Appendix A: Behavioural Supports Project: Waterloo Wellington LHIN Future State Journey for: Client with responsive behaviour living in their home to successful transition to LTCH with viable care plan



Behavioural Supports Project: Waterloo Wellington LHIN Future State

17-Nov-11

Appendix B: Intersectoral Transdisciplinary BSS Team Roles

Key Focus of BSS LTCH RN/RPN Role

- Assist with the development of a consistent, LTCH-wide, person-centred approach to preventing and supporting residents with responsive behaviours and their family/careprovider
- Build in-home capacity of the staff, through mentoring, modeling, coaching, facilitating, in-the-moment teaching and modeling critical thinking
- Will have a lead role in the care of the resident with responsive behaviours and their caregiver
- Will be the Long Term Care Intersectoral Team member for the 'larger' Transdisciplinary Insectoral BSS Team

The BSS LTCH RN/RPN will:

- Engage in discussion with the care team (including person/family) using PIECES 3-Question Template to explore responsive behaviours, as soon as they become known
- Gather and review information from many sources (i.e. CCAC, SGS, PRC, NLOT acute care consult notes, primary care) to gain a more complete picture of the resident
- Be a resource to the LTCH team (including family, physician, RAI- coordinator, pharmacist) in addressing responsive behaviours and developing behavioural care plans (especially if behavioural concerns are noted prior to admission) including identifying responsive behavioural triggers, strategies for care and a means of monitoring outcomes
- Ensure that care plans are implemented effectively by all staff – some supervisory/evaluative role here
- Ensure that "contingency plans" are developed with staff and family for each resident with responsive behaviour
- Liaise with mobile resources i.e. PRC, NLOT, BSS SGS
- monitor outcomes
    - Follow-up with care team regarding implementation of behavioural plan especially following escalation crisis
    - monitor achievement of performance measures

The BSS PSW

- Implement care plan specific components of care plan
- Mentor service delivery approaches
- Direct Care responsibilities and leadership responsibilities for identified residents with responsive behaviours and their caregivers
- Member of BSS Team
- Liaise with BSS RN/RPN

Will be the Long Term Care Intersectoral Team member for the 'larger' Transdisciplinary Insectoral BSS Team

The Community Transdisciplinary Team role descriptions are being developed by the working group and will build on existing roles within the community. The Specialized Support for Primary Care will be a purchase of service arrangement with Geriatric Specialists including psychology, neuropsychology and pharmacy as required.

Waterloo Wellington **LHIN**

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