

## ACTION PLAN TEMPLATE – Pillars # 1 and #2

### Central East Local Health Integration Network

October 5, 2011

The Behavioural Supports Ontario (BSO) model has three foundational pillars and each pillar includes proposed essential elements. Describe in your answers to the following questions how your Action Plan implements Service Redesign in a manner that is consistent with the three foundational pillars.

#### **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.**

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

Presently, LTC homes located in the Central East Local Health Integration Network (CE LHIN) are limited in their ability to appropriately support people with difficult to manage Behavioural issues. This is in part due to a lack of comprehensive resources to support the homes in their environments to manage these behaviours effectively and partly due to staffing capacity within the Long-Term Care homes themselves. Programs such as Geriatric Mental Health Outreach Teams (GMHOT), Geriatric Assessment and Intervention Network (GAIN) and Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT) are assisting Long-term Care Homes (LTCHs) to care for these residents, but at this time, there are insufficient resources to provide timely access and sufficiently reduce transfers to the emergency department (ED).

The CE LHIN Behavioural Supports Ontario Design Team noted through the Value Stream Mapping and Analysis (VSM&A) exercise that reporting and communication of client information for LTCH residents who must receive care from a variety of health care professionals across sectors is neither standardized nor consistent. In addition, it was noted that there is no a standardized process for discharge or transition planning of clients back to their home in long-term care following the completion of hospital-based care should that be required.

Collaboration and coordination of services is sometimes hampered by the large geography and variety of providers and services that can be involved in providing supports to seniors who require enhanced care for behavioural issues. Across Central East LHIN there is no standard or consistent approach to this specialized care limiting opportunities for leveraging existing resources and sharing of knowledge, best practices and consistent clinical care. Similarly, there is a lack of standard access, resources and capacity across the LHIN and so access to services is not equitable.

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

Currently the Central East LHIN has created several entities to support system planning and implementation including the following:

1. Hospital Vice President / Chief Nursing Officer network
2. Geriatric Assessment and Intervention Network
3. Primary Care Working Group
4. Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT)
5. Home First Steering Committee
6. Dementia Network Coordinating Group - Central East
7. Vascular Aim Coalition
8. Central East Executive Council

b. How will structures be modified to improve coordination?

**Standardized Reporting and Communication** was identified as an improvement area that requires its own project charter as well as a required element of each of the other priority Improvement Areas and will be one of the Improvement Projects undertaken early in the process. The goal is to have a standardized record accompany a resident from their LTC home, through their acute journey, to any tertiary setting, and then be a part of the discharge/transition planning and accompany them back to the LTCH. A primary tenet of the BSO Team (previously identified in Future State Value Stream Map as “Wrap Around” team) will be design of the team “around the client” such that the team is defined from the viewpoint of the client and not any given provider who happens to be employing the team member(s). This newly conceived structure will ensure improved reporting and communication among team members and stakeholders.

New and existing partnerships and networks will be utilized to support the quality improvement change exercises at every level of the system and will provide direction and advice as appropriate.

### **1. Hospital Vice President / Chief Nursing Officer network; Primary Care Working Group; Vascular Aim Coalition and Central East Executive Council**

These entities are primarily responsible for providing advice to the Central East LHIN on the design and implementation of priority projects across the LHIN. To varying degrees, these networks have or will be engaged to provide advice on the design and implementation of the BSO Future State Model.

*Existing CE LHIN partnerships, working groups and networks will be utilized to support the quality improvement change exercises at every level of the system and will provide direction and advice as appropriate.*

### **2. Regional Specialized Geriatric Services Entity (newly formed and under development)**

Northumberland Hills Hospital (NHH) in Cobourg has been selected by the Board of the Central East Local Health Integration Network to be the host agency for the new Central East LHIN Regional Specialized Geriatrics Services (RSGS) entity. The entity will lead the development and implementation of a new model for providing specialized geriatrics services for residents in Central East communities. The goal of the Regional Specialized Geriatrics Services (RSGS) model, first

presented to the LHIN Board in May, is to ensure that seniors can access a seamless system of care that is organized around their needs and improves their quality of life.

It will build on the significant investments that have already been made in the LHIN for programs such as Geriatric Emergency Management (GEM) Nurses in the emergency departments, Nurse Practitioners caring for patients in local long-term care homes (NPSTAT), the new Geriatric Assessment and Intervention Network (GAIN) clinics in the LHIN's large hospitals, Senior Friendly Hospital initiatives and the introduction of "Home First" which, through the leadership of the Central East Community Care Access Centre, has seen over 4,000 clients discharged from hospital to home with enhanced home care supports.

One of the first goals for the RSGS entity will be to work with the LHIN organization, hospitals, community representatives and other health service providers to establish a shared governance model that will organize and co-ordinate the delivery of health services to ensure better health outcomes for frail seniors across the Central East LHIN.

*The activities of the BSO project will fall under the oversight of the RSGS entity and will align with the goals and investments that have already been made to support seniors requiring specialized services.*

### **3. Home First**

*Home First* is a philosophy that promotes safe and timely care to meet healthcare needs of patients and families in the most appropriate setting - "Every patient admitted to the hospital will be discharged home" – so that decisions about major changes in lifestyle, including moving to supportive housing or long term care, can be made from home, not from hospital.

In September 2010, the Central East LHIN began to implement a *Home First* philosophy, in partnership with the Central East Community Care Access Centre (CECCAC), all Central East LHIN hospitals and Central East Community Support Service agencies - Community Care Durham; Community Care Peterborough; Trans Care (Scarborough) – Lead Agency; Community Care Northumberland; Community Care Haliburton; Community Care City of Kawartha Lakes. A Home First Steering Committee comprised of representatives from the hospital, Community Care Access and Centre (CCAC) and Community Support Services (CSS) sectors oversees the partnership and within a philosophy of continuous quality improvement promotes the seamless care of seniors who present to emergency departments across the CE LHIN.

*The Home First Steering Committee will continue to consider integration and coordination of services among the hospital, CCAC and CSS sectors and transfer knowledge and 'lessons learned' to the BSO project.*

### **4. Senior Friendly Hospital**

The Senior Friendly Hospital strategy aims to:

- Improve the health, wellbeing and experience of seniors in Ontario hospitals, helping them get back home sooner and healthier.
- Improve seniors' ability to live independently and stay out of hospital.
- Enhance the value of health care dollars.

- Help reduce ALC through supporting people to transition to the right place of care after a hospital stay.
- Promote quality improvement initiatives that can be included in hospital Quality Improvement Plans as part of Excellent Care for All.

As a first step, each hospital assessed their successful seniors' initiatives, and identified opportunities for improvement and action. All adult hospitals in Ontario have completed a Senior Friendly Hospital assessment. Summary reports for each LHIN were developed in collaboration with the Regional Geriatric Programs of Ontario.

*The alignment of the BSO project with the Senior Friendly Hospital strategy is obvious and will be explored with each hospital individually to ensure alignment of processes and to leverage existing resources and opportunities.*

## **5. Geriatric Assessment and Intervention Network (GAIN)**

- Regional Program - project managed centrally by Lakeridge Health:
- Supported by inter-disciplinary teams at each site
- Hospitals are supporting the clinic investment by establishing geriatric medical units (ACE) that will enable direct access to in-patient capacity for frail seniors
- Impact on Alternate level of Care/Emergency Department Wait Times
  - An alternative destination for avoidable ED visits (referrals from community)
  - Shortening of ED visits that do happen (referrals from ED)
  - Prevention of avoidable admissions
  - Specialized care for target population

*The GAIN clinics will be a critical source of expertise and resources and will complement the development of the processes and supports within the BSO project. GAIN members will be asked to participate in the ongoing quality improvement processes within CE.*

## **6. NPSTAT**

The NPSTAT program is supported by a Steering Committee comprised of service providers from the CCAC, long-term care homes (administrators, Directors of Care, Managers and physician consultants), a hospital and the CE LHIN. The Steering Committee has developed and supported a 3 hub service model of standardized care across the long-term care, hospital and CCAC sectors and facilitated a standardized mobile, outreach approach to delivering clinical care in long-term care homes. The experience, resources and expertise developed within the NPSTAT program will be extremely valuable in designing Behavioural Support Teams and mobile diagnostic response to LTCHs.

*The NPSTAT Clinical Director is a member of the Advisory Committee, Design Team and 4 LHIN Early Adopter Steering Committee and will have a key role in testing models of clinical assessment and patient flow in carrying out our quality improvement tests. Training and staff capacity building will also be a key deliverable of the NPSTAT program to the BSO model of care.*

As discussed above, the Team will create a standardized methodology for reporting and communicating information across the continuum of care. A standard reporting tool will be developed across the continuum of care and technological solutions will be pursued wherever possible in the short-term and through alignment with provincial and LHIN-wide IT solutions in the long term. If it is possible to adopt a common reporting tool, the characteristics of the ideal/standard reporting tool will be defined. Existing reporting tools currently being used by relevant HSPs within the LHIN will be reviewed to identify and adopt any that meets the specified standards. This common reporting tool will eliminate the problem of inconsistent or inadequate information when a client is transitioning across the continuum. As well a 24/7 access line will be created to enable homes access specialized care for their clients as well as for easy referral.

## 7. First Link Program

The First Link Program offers coordinated support, education and linkage to individuals with dementia and their families/caregivers as soon as possible after the point of diagnosis through the continuum of the disease. The primary objective of First Link is to provide comprehensive and coordinated services by identifying and reaching out to individuals and their caregivers as early as possible in the disease process.

*First Link will provide knowledge exchange, information and coordination services for client groups aligned with the BSO project.*

## 8. Dementia Network Coordinating Group - Central East (DNCG-CE)

The mission of the Dementia Network Coordinating Group is to develop knowledge and skills and identify challenges and quality improvement activities for the CE LHIN working with the Dementia Networks of Scarborough (Toronto), Durham and HKPR and is engaged with service providers to facilitate the development of the Behaviour Support System Learning Collaborative. *The DNCG - CE will facilitate the coordination of the BSO project through collaborative planning and knowledge transfer among all stakeholders.*

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

Regional Specialized Geriatric Service (RSGS) entity, Central East LHIN BSO Advisory Committee, Central East LHIN BSO Design Team, Central East LHIN, Health Quality Ontario (HQO)

Once operational the RSGS will provide governance and oversight to SGS services including the BSO program on behalf of the CE LHIN and its providers and ensure the BSO activities are aligned across the LHIN. The RSGS will receive reports from the BSO Advisory Committee and Design Team and facilitate coordination with other related initiatives across Central East.

Until the RSGS entity is operational, the Central East LHIN will directly oversee the functions of the Advisory Committee and Design Team and ensure as much as possible guidance, oversight, alignment and coordination with all relevant and related networks, partnerships, entities and service providers.

The Central East LHIN BSO Executive Lead, Project Lead, Project Manager and Improvement Facilitator(s) will lead the implementation of the Quality Improvement Action Plan and inform the local structures and the CRO of progress. The BSO Improvement Team will also provide secretariat support to the Advisory Committee and Design Team. The HQO Coach and the Quality Improvement Facilitator will also support BSO quality improvement related change management strategies across the LHIN. This will involve the creation and overseeing of small project groups that will plan and implement each change idea/improvement plan. The Measurement and Evaluation working group together with the Improvement Facilitator will be supporting accountability through ongoing performance measurement.

### 3. Who will be the partners for system coordination?

The primary partners for system coordination will be all the health service providers involved in supporting the Future State Behavioural Support Model including the following:

- Psycho-Geriatric Outreach Program (POP)
- Ontario Shores tertiary care hospital
- Psycho-Geriatric Consultants (PRCs)
- CECCAC
- LTCHs
- Residents First Program and Improvement Facilitators
- Other HSPs
- Hospitals
- NPSTAT
- PIECES trained nurses
- Alzheimer Society Durham
- Central East Dementia Network
- GAIN
- Psychogeriatric Community Response Program (PCSP)
- Other Psychogeriatric Outreach Programs
- Psycho-geriatricians
- Alzheimer's Knowledge Exchange
- Others

The role of many of these partners was described under section 1.b above.

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

Examples of Collaboration:

1. **Dementia Network Coordinating Group - Central East (DNCG-CE):** Representatives from different clusters across the LHIN came together in 2010 to facilitate the behavioural support system (BSS) learning collaborative in engagement with Service Providers across the LHIN as part of the phase 1 of the BSO project.

The Network has undertaken quality improvement training and developed a Value Stream Map for the disease prevention/health promotion segment of the behavioural supports care continuum.

2. **Geriatric Assessment and Intervention Network (GAIN):** By April 2011 specialized clinics were established at four of the largest hospitals in the Central East LHIN - Lakeridge Health Oshawa (opened October 27, 2010); Peterborough Regional Health Centre; The Scarborough Hospital - General campus; Rouge Valley Health System - Centenary campus. Although all clinics were established by April 1, 2011, clinics were at different stages of implementation during Q1 and modified volume targets were in place. Regardless, the clinics received a total of 687 referrals from the emergency department, the community (including primary care) and after hospital discharge and made 457 referrals to the CCAC. In addition, the four GAIN clinics completed a total of 531 comprehensive geriatric assessments (CGA) and 334 follow up appointments from April 2011 to June 2011.
3. **NPSTAT:** This multi-hub nurse practitioner outreach program is hosted by three individual health service providers with oversight from one Steering Committee with representation from each of the providers (hospital, long-term care home, Central East CCAC). The program has signed Memorandums of Understanding with over half of the long-term care homes in Central East and continues to have positive outcomes in reducing unnecessary transfers from long-term care to the emergency department.

Among the positive outcomes achieved by NPSTAT is the following summary for Q1, 2011/12:

- 38 LTCHs have signed MOUs with NPSTAT out of a total of 68
  - Q1 Total number of Direct Care encounters: 1337, with an ED diversion rate of 96%
  - Q1 ED hours saved: 3,010 corresponding to a savings of \$392,395 (based on estimate of \$330 per ED visit)
  - Demand for NPSTAT services is growing substantially as a result of increasing workload for existing NP's. Need for provision of evening and weekend NP outreach services has been identified. ALC transition activities are increasing as NPs facilitate earlier discharge and provide clinical support to the LTCH's when residents are repatriated.
- c. List the executive sponsors and lead agency who will have responsibility for meetings, chairing a steering committee, ongoing leadership and engagement, etc.

As stated under section 2, until RSGS entity is operational, the Central East LHIN will directly oversee the functions of the Advisory Committee and Design Team and ensure as much as possible guidance, oversight, alignment and coordination with all relevant and related networks, partnerships, entities and service providers. The Central East LHIN, through the BSO Improvement Team, will provide continued leadership and engagement and secretariat support to the Advisory Committee and Design Team.

Executive Lead: James Meloche Senior Director, Systems Design and Integration  
Project Lead: Brian Laundry, Lead, Quality Improvement and Evaluation

Project Manager: Vacant  
Improvement Facilitator: Gloria Duke-Aluko  
Improvement Facilitator (2): Vacant

**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.**

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

Access to supports and outreach services are considered to be less than optimal at many points in the system. However, as part of the quality improvement process the Design Team at the CE LHIN identified an intermediate risk client at a long-term care home (LTCH) as the client of focus. The CE LHIN Value Stream Mapping and Analysis process mapped the current state of the client journey including all the action steps, wastes and value-added processes. This process also identified problems related to access and outreach services.

The team then mapped the Future State model and has continued to build the Central East BSO Model based on the two days of work of our direct care stakeholders who know the client journey the best. This higher level process map identified the key steps in the desired process and the priority projects for addressing the gaps in access and services.

At present, there are capacity issues in the long-term care homes despite their interest in caring for residents with escalated behaviours with the LTCH.

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

The focus of this project is the long-term care resident who experiences a new or escalated behaviour that requires enhanced attention and care. The attached process map of our Future State Value Stream Map outlines the preferred client journey throughout the system including the transition points. This resident may experience a number of transitions as a result of this crisis, including a possible transfer to another bed within the long-term care home, a possible transfer to the ED, a transfer from the ED to acute care and probable ALC stay, possible transfer to a post-acute tertiary setting, and then transfer back to the LTC home.



Future State  
Map\_CE LHIN.docx

The senior population with responsive behaviours who are living in a LTCH or in the community are considered to be underserved. Although the first focus of the CE LHIN BSO project will be clients in long-term care homes, the lessons learned from the quality improvement process and PDSA (Plan, Do, Study, Act) cycles will be applied to the expansion of the system to serve the non-institutional population as well.

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

In the spring of 2011, the Central East LHIN, in partnership with Ontario Shores, commissioned an Environmental Scan of Specialized Geriatric and Psychogeriatric Services in the Central East LHIN. The project was conducted by the Distance Learning Group to get a big picture scope of how services are organized and delivered to meet the needs of the frail elderly and determine what and where health funded specialized geriatric programs/services and psycho-geriatric programs/services are currently delivered in the Central East LHIN.

The report mapped services by CE LHIN cluster – Scarborough, Durham, North East – and will serve as a starting point for identifying for the quality improvement teams where the current resources exist and how these services need to be coordinated, expanded or redesigned to meet the Future State model which includes both urban and rural populations.

Furthermore, the BSO Design Team has provided additional description of available services and the CE LHIN conducted a Readiness Assessment of all Long-Term Care Homes to determine which LTCHs were interested and able to support additional Register Nurse (RN), Registered Practical Nurse (RPN and PSW



CE  
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5. Illustrate how your Action Plan addresses the continuum of services from primary to acute to community care based on system coordination across cross-agency, cross-sectoral collaboration and partnerships (i.e. preventative care in primary care and the community, individuals at the tipping point utilizing at least two health service agencies. etc.). Attach a process map.

The Value Stream Mapping and Analysis (VSMA) process (see attached Future State) supported the Improvement Team to be able to better understand the gaps identified above and to suggest some strategies that will result in a more coordinated, interdisciplinary focus for providing care.

The key improvement strategies are outlined in the attached Gantt chart and were prioritized through the VSMA exercise and further refined by the Design Team. Furthermore, Draft Project Charters were completed for each of the 13 identified improvement strategies (projects) and these too are appended. There are some slight discrepancies between the project charters and the Gantt chart as a result of some high level changes suggested by the Design Team to streamline the improvement plan. These discrepancies will be resolved once the improvement teams are in place to support the development of each of the projects.



CE BSO Gantt  
Chart.pptx

The Action Plan is organized to help build the Future State and the initial priorities of the plan have created a two part strategy. One part will focus on building capacity in long term care and is supported by two of the improvement strategies outlined in the BSO Gantt Chart – Improvement Strategies (referred to as Milestones on the Gantt Chart): Project #1. Review and address frontline staffing levels in LTC and Project #2. Provide appropriate and comprehensive training for staff in LTC.

<b>Draft Improvement Plans</b>			
<b>Project</b>	<b>Title</b>	<b>Reason for Improvement</b>	<b>Target Performance</b>
1	Review and address frontline staffing levels in LTC	<ul style="list-style-type: none"> <li>• Increase staff resident ratio</li> <li>• Reduce occurrence of responsive behaviours</li> <li>• Improve quality of life</li> <li>• Increase support to staff and families</li> <li>• Reduce staff burnout</li> </ul>	<ul style="list-style-type: none"> <li>• Increase staff to resident ratio</li> <li>• Reduce system waitlist</li> <li>• Family support</li> </ul>
2	Provide appropriate and comprehensive training for staff in LTC	<ul style="list-style-type: none"> <li>• Build capacity</li> <li>• Consistent care and approach to behavioural support for staff in LTC</li> </ul>	<ul style="list-style-type: none"> <li>• Annualized training for repetitive knowledge and regular upgrade of existing and new staff</li> </ul>

The second part of the initial Action Plan focuses on organizing, coordinating and enhancing existing behavioural support services (including new staffing, if required) to provide a comprehensive “wrap around” service to support the in-house LTCH team and manage clients throughout their care journey both within and outside the LTCH.

<b>Draft Improvement Plans (continued)</b>			
<b>Project</b>	<b>Title</b>	<b>Reason for Improvement</b>	<b>Target Performance</b>
3	Create “wrap around” psycho-geriatric outreach team with access to specialized beds in each cluster	<ul style="list-style-type: none"> <li>• Ensure equitable timely access for seniors struggling with challenging behaviours to a comprehensive basket of specialized psycho-geriatric services through an interdisciplinary team that works with a designated # of LTCHs</li> </ul>	<ul style="list-style-type: none"> <li>• Equitable access to one consistent basket of services including beds</li> <li>• Reduced ED visits</li> <li>• Successful stabilization in LTCH</li> <li>• Improved on-call 24/7</li> <li>• Reduced ALOS</li> <li>• Increased likelihood of discharge home/ LTCH</li> </ul>

4	Create Mobile Diagnostic Team	<ul style="list-style-type: none"> <li>• Keep clients in their home</li> <li>• Provide timely access to diagnostic services and results</li> <li>• Standardized resource across LHIN for all LTCHs</li> <li>• Reduce unnecessary client transport</li> </ul>	<ul style="list-style-type: none"> <li>• Service within an hour of call</li> <li>• X-ray, ECG, Blood analysis, Urine dip</li> <li>• Quick turnaround time</li> <li>• 24/7 access to service</li> <li>• NP-led, physician back-up</li> </ul>
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Upon further consideration the Design Team merged Improvement Plan 3 and 4 into a single coordinated service - Behavioural Support Care Team.

Behavioural Support Care Team (wrap-around psycho-geriatric team)

- Inter-professional – e.g. Occupational Therapists, Physical Therapists, Behaviour Therapists. Physicians, Nurse Practitioners, Psycho-geriatric Resource Consultants, Behavioural Support nurses, Personal Support Workers
- Direct link with specialized acute care services and access to specialized beds in each cluster
- Client focused not provider defined team
- Alignment of existing services to new model of care
- Enhancement of expertise and capacity, as required

Existing services will be leveraged to support implementation of the future state BSO model and will either coordinate with or become members of the BS Care Team. Existing services have been identified through the previously described Environmental Scan and details continue to be gathered to support location of the first Behavioural Support Care Teams. This team will carry out on-site assessment either in person or via OTN as well as diagnostic testing to determine the cause of the escalation of behaviours by first focusing on potential medical reasons.

The standardization of a medical assessment will be developed and confirmed as part of the action plan and will probably include the use of NPs from the NPSTAT program if LTCH physicians are unavailable. Although the VSMA exercise originally identified the need for both a “Wrap Around Team” and a “Mobile Diagnostic Assessment Team” it was determined that the functions of the two proposed teams should be merged within the mandate of a single team – Behavioural Support Care Team. This team will support the resident from the crisis (escalated behaviour) throughout the treatment phase as described in the Future State process map. The BSO Care Team will assist the LTC home in management of behaviours from the earliest indication to prevent escalation, support the LTC staff to manage crisis behaviours in the home to prevent transfer and, in the case where transfer is most appropriate, will support the client across the continuum.

Other Improvement Plans that were listed under Pillar #2 by the teams participating in the VSMA session were the following:

Draft Improvement Plans (continued)			
Project	Title	Duration	Status
8	Standardized reporting and communication	2 months	Start time TBD
9	Key Stakeholder Engagement – Physician, Senior Management and Staff Buy In	Throughout	Start time TBD
10	Develop comprehensive discharge and transition planning for residents with responsive behaviours	3 months	Start time TBD
11	Identify and build alternatives when LTC is not an option	2 months	Start time TBD

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

Equitable and timely access will be partly addressed by increasing skill and capacity within LTCHs and also through the BSO Care Team improvement strategy which directly addresses the need for access to the right providers for the right service.

The Action Plan will also support the provision of and referral to appropriate services rather than available services. This will create opportunities for better linkages across the continuum to determine the most appropriate care setting, while developing the capacity of CCAC (and other) assessment teams, as well as LTC homes, to better understand what may be available as an alternative to LTC placement where appropriate. One of the improvement strategies identified at the VSMA session focused directly on the development of services for clients who cannot be managed within the identified Value Stream – “Identify and build alternatives when LTC is not an option”. The reason for the improvement aim is that there is a lack of appropriate care settings for specific hard to serve population types and the “exclusion criteria” is restrictive across sectors. Other alternative settings may be those that require less care if appropriate behavioural support care plans are in place and consultation and back up services are available when required e.g. supportive housing, retirement homes, assisted living (accessible and affordable).

The key to the provision of timely, equitable service provision for at-risk clients is in the ability of the providers to assess appropriately, understand the need of the resident quickly and have access to the appropriate settings. These are dependent on their capacity and competency to respond to behaviours as they occur, increase staffing to ensure risk is minimized to the resident and others while having time to address the behaviour and create knowledge around the behaviour and begin appropriate interventions and communicate a care plan. All of these will be supported by the creation of the BSO Care Team service and standardized discharge/transition planning.

In addition, the Improvement Team has noted the need for a standardized assessment process in LTC, supported by standardized reporting and communication processes so that all members of the multi-disciplinary care team across the continuum receive the same information in a timely manner.

a. Will there be supported behavioural assessment services?

Yes, we will leverage already available assessment services like the PIECES assessment, Mini Mental state examinations and BSO Care Team diagnostic outreach services. Furthermore, once standardized assessments are determined through our quality improvement processes, LTCH staff and all stakeholder partners will receive additional training in the standardized assessment with the double goal of improving the timeliness and quality of the assessment and reducing the number of client assessments required throughout the care journey.

b. How will a comprehensive geriatric assessment be conducted?

Comprehensive assessments including diagnostic tests will be conducted in a phased manner to determine the cause of the responsive behaviours. LTCH staff will conduct appropriate initial assessments; the mobile outreach component of the BSO Care Teams (NPSTAT NP or other member of the BSO Care Team) will conduct medical assessments and diagnostic tests if the behaviour does not resolve to help in ruling out delirium due to underlying medical causes; and further assessment and treatment will occur depending on the nature of the cause of the behaviour. The comprehensive geriatric assessment will be provided either in person or via OTN.

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

LTCH staff or family members who are knowledgeable of the resident and their regular level of functioning will identify when the resident's behaviour has changed and a new or escalated behaviour is present. The staff will undertake measures to ameliorate the behaviour, contact other staff, ensure the safety of all residents and initiate standardized assessments.

Also, the BSO Care Team will be providing ongoing clinic services and follow up care visits to LTC on a regular basis and will be able to help staff assess and identify "at risk" clients in the LTCH.

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

Individuals not identified as part of the service will be directed to access community based services and care providers that currently exist within CE LHIN. However, it is anticipated that these services will be improved through the knowledge exchange, best practices and learning that will develop from the BSO Project. Community-based clients that access the emergency department and are subsequently admitted in hospitals where BSO Care Teams are affiliated will receive care from BSO Care Teams and benefit from the standardized discharge processes that support reintegration into the community or LTC. As appropriate community-based services and providers will be consulted and post-discharge care will be coordinated with the BSO Care Team discharge protocols.

7. How will individuals in crisis be supported?

Staff at the LTC will be able to quickly recognize individuals in crisis by noting when there is a new or escalated responsive behaviour. Through training and ongoing capacity building they will know what to do to stabilize a client and ensure the safety of all residents and when to call for additional support.

On-site behavioural assessment, diagnosis and treatment where possible will be provided to these individuals. The aim will be to bring the appropriate service to the individuals as much as possible. Clients will only be transferred out of the LTC for care if the responsive behaviour is due to a medical emergency, or if treatment for the cause cannot be offered on-site. There will be on-site behaviour support staff as part of the BSO Care Team in the LTCH, and a system will be put in place to enable quick and easy access to the appropriate resources within the BSO Care Team, including specialized care, to provide the comprehensive assessment and treatment if needed.

a. Who will be the partners for interdisciplinary service redesign?

The primary partners for interdisciplinary service redesign will be all the health service providers involved in supporting the Future State Behavioural Support Model and those involved in system coordination as described in section 3 above including the following:

- Psycho-Geriatric Outreach Program (POP)
- Ontario Shores tertiary care hospital
- Psycho-Geriatric Consultants (PRCs)
- CECCAC
- LTCHs
- Residents First Program and Improvement Facilitators
- Other HSPs
- Hospitals
- NPSTAT
- PIECES trained nurses
- Alzheimer Society Durham
- Central East Dementia Network
- GAIN
- Psychogeriatric Community Response Program (PCSP)
- Other Psychogeriatric Outreach Programs
- Psycho-geriatricians
- Alzheimer's Knowledge Exchange
- Others.

Of particular interest is the role that may be played by LTCH Improvement Facilitators that have been trained through the Residents First program. The Action Plan requires the initiation of multiple improvement strategies that all require knowledge and adherence to a quality improvement methodology and the Residents First Improvement Facilitators will be essential to supporting the implementation of the Action Plan as services and practices are redesigned.

b. How have the partners collaborated on previous projects?

Please refer to Question 3.b. above.

d. What were the outcomes?

Please refer to Question 3.c. above.

- e. List the executive sponsors and lead agency who will have responsibility for meetings, chairing a steering committee, ongoing leadership and engagement, etc.

As stated under section 2, until RSGS entity is operational, the Central East LHIN will directly oversee the functions of the Advisory Committee and Design Team and ensure as much as possible guidance, oversight, alignment and coordination with all relevant and related networks, partnerships, entities and service providers. The Central East LHIN, through the BSO Improvement Team, will provide continued leadership and engagement and secretariat support to the Advisory Committee and Design Team.

Executive Lead: James Meloche Senior Director, Systems Design and Integration

Project Lead: Brian Laundry, Lead, Quality Improvement and Evaluation

Project Manager: Vacant

Improvement Facilitator: Gloria Duke-Aluko

Improvement Facilitator (2): Vacant