

### BSO ACTION PLAN - Pillar #3

The 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 #3: Knowledgeable Care Team and Capacity Building Strengthen capacity of current and future professionals through education and training to transfer new knowledge and best practice skills for continuous quality improvement.**

8. What training and knowledge transfer processes are presently in place for current and future professionals to disseminate new knowledge and best practice skills relating to behavioural supports?

**PIECES:** “Putting the P.I.E.C.E.S (Physical, Intellectual, Emotional, Capabilities, Environment, and Social components) Together” is a provincial learning strategy designed to enhance the ability of Regulated Health Care professionals in the LTCH to meet the care requirements of individuals with increasingly complex physical and cognitive/mental health care and associated responsive behaviours. It provides a common vision, language and approach to the care of older people in the LTC sector developed through a comprehensive, system-wide approach to education. It was developed through a comprehensive system-wide approach to education in response to the need for very skilled knowledgeable and sensitive staff that understand, observe, interact, support, and collaborate with others to improve quality of life and decrease the burden of illness of residents with dementia and responsive behaviours. The education program design is grounded in the research of adult learning theory, human performance technology and organizational development. It is a performance improvement approach that follows a train-the-trainer model. There are several PIECES programs and trained staff in the CE LHIN and training has been delivered throughout the LTC sector.

**U-First Program:** Offers training to unregulated care providers in how to improve the quality of the interaction between the formal care provider and the person living with the Alzheimer's disease and other dementias. The U-First program helps care providers to:

- UNDERSTAND the behaviour changes in a person with dementia;
- FLAG possible changes seen in the person;
- INTERACT with skill and understanding;
- REFLECT and report the behavior;
- SUPPORT the person with dementia and their family caregiver; and
- involve the TEAM in caring for the person with dementia.

**Psychiatric Assessment Services for the Elderly (PASE):** The PASE program offers services to clients in the counties of Peterborough, Northumberland and Haliburton and the City of Kawartha Lakes – the North East Cluster. The team is comprised of psychogeriatric resource consultants, nurses, social workers, an occupational therapist and consulting geriatric psychiatrists. The mandate of the program includes education and training for staff in long-term care homes and in agencies that

serve community dwelling clients.

**Durham Region Psychogeriatric Resource Consultant (PRC) Program:** The Durham Region PRC program operates out of Ontario Shores and is designed to meet the educational needs of health care staff across the three clusters of the CE LHIN working in LTC facilities, Community Service agencies and Homecare organizations including the CCACs. Their focus is on staff working with people suffering behavioural disorders associated with a dementia or related disorders and Seniors with mental illness who have significant functional limitations and require complex care. They specialize in the translation of knowledge to practice using both didactic education and case based learning. As part of their role in supporting education, the PRCs are also involved in the formation of Dementia Networks in the Durham Region.

**Alzheimer Societies of Durham Region and Peterborough:** Part of a network of 39 Alzheimer Societies in the province, these two organizations provide support and education programs for people with Alzheimer Disease and related dementia and their family and professional caregivers. They work with local agencies and care homes to meet the needs of people with dementia.

**Dementia Network Coordinating Group-Central East (DNCG-CE):** Designed to improve the system of care for individuals with Alzheimers Disease and Related Dementias (ADRD), their families and caregivers by creating networks of service providers, clinicians, caregivers, agencies, and health related organizations. They work to enhance service delivery, education, research and planning while striving to improve the responsiveness of the local health care system and the accessibility to services in order to provide continuous coordinated care for individuals with ADRD. As part of their role in educating staff and caregivers the DNCG-CE facilitated the Behavioural Support System (BSS) learning collaborative during phase 1 of the BSO project.

**Alzheimer Knowledge Exchange (AKE):** The role of the AKE for the BSO project includes supporting the learning needs of people seeking practice change and to facilitate quick and easy access to the best knowledge for continuous quality improvement by:

- Providing access to quality information;
- Knowledge brokering;
- Providing knowledge exchange opportunities (in-person, online, and using social media);
- Supporting the development of topic-specific communities of practice; and
- Mentoring and supporting the use of collaborative technology for meaningful exchange
- Stimulate, support and share innovations in dementia care by:
  1. Capturing and sharing lessons learned
  2. Initiating research innovation as informed by practice or knowledge gaps
  3. Supporting innovation in health policy
- Build and strengthen collaborative partnerships between stakeholders and foster direct links between knowledge users and producers by:
  1. Linking researchers, decision makers, and care providers for mutual benefit and collaborative leverage
  2. Linking online resources for centralized, coordinated access to information

In line with the third pillar of the BSO and in a bid to build capacity and create a knowledgeable care team the AKE provides knowledge exchange opportunities with a goal of supporting person-directed care, prevention and early detection; implementation of standardized best practices in behavioural health; and continuous quality improvement. The Knowledge Exchange opportunities provided by the

AKE is a core component of effective education and training and helps strengthen the capacity of family caregivers and professionals. Through exchange, caregivers and professionals can enhance their learning experience by leveraging the knowledge gained from applying education in real-world care practice. Learning of and discussing promising practices, creating supportive learning infrastructures and foster collaboration between individuals, teams, organizations, systems, and nurturing innovation will support the efficient and effective use of the human resources in the health system and help caregivers make informed choices.

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

**Health Quality Ontario (HQO):** HQO has been instrumental in leading QI processes related to the Behavioural Support Ontario Project at Central East including the project scoping and SIPOC meeting and the Value Stream Mapping and Analysis session. The HQO QI Coach (Patsy Morrow) assigned to the CE LHIN has been providing QI expertise and support to the LHIN and has been available to support the planning phase of the project. It is expected that HQO will continue to provide support to the Improvement Facilitator and the Improvement Teams as necessary. Members of the improvement teams that will be working on the twelve identified Improvement projects will also be trained in QI methodologies.

**Central East LHIN staff:** The **Quality Improvement Facilitator** trained by HQO in BSO specific QI methodologies is available as an in-house resource to support the Improvement Project Teams. The **Project Lead** is a graduate of the IHI Improvement Advisor Professional Development Program and will provide leadership to the BSO project and oversight to all aspects of the BSO quality improvement process. In addition, the Project Lead is the chairperson of the provincial LHIN Lead Working Group for the quality improvement training program HQO is rolling out across the province – Residents First.

**Residents First:**

Thirteen of the 68 long-term care homes in Central East participated in phase 1 of the quality improvement Collaboratives and had improvement facilitators trained by HQO. Quality Improvement Facilitators in LTCHs selected for the first phase of BSO implementation will be leveraged to support, train and assist Improvement Teams in achieving their project aims. Furthermore, almost all LTCHs have reported involvement with the Leading Quality component of Residents First which focuses on helping LTCH leaders prepare for the introduction and spread of quality improvement throughout their organization.

**LEAN:** The LEAN quality improvement methodology has been promoted and supported by the Central East LHIN through both the ALC and ED Task Group Reports and the funding of ED Process Improvement Programs at every CE LHIN hospital. Hospitals have embraced the LEAN methodology and some have been identified as leaders across the province and are repeatedly asked to speak at LEAN conferences. LEAN has been embraced to varying degrees by a number of HSPs in Central East including the CCAC.

**Other QI Capacity:** Hospital and CCAC inter-sectoral partnerships at four hospitals for the **FLO Collaborative** trained a number of staff in QI methodology; **Dementia Network Coordinating Group – Central East** received QI training from HQO to help develop an improved model for preventing behavioural issues.

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

A variety of specialized psychogeriatric professionals exist in the LHIN. They include Psychiatrists, Psychogeriatricians, Psychogeriatric Resource Consultants (PRCs), PIECES trained nurses, Nurse Practitioners and other specially trained staff. Often they work together in interprofessional teams or collaborate interprofessionally to provide specialized care to individuals requiring support for responsive

behaviours.

In addition to the teams described under section 8 above - Psychiatric Assessment Services for the Elderly (PASE); Durham Region Psychogeriatric Resource Consultant (PRC) Program; Alzheimer Societies of Durham Region and Peterborough; and the Dementia Network Coordinating Group-Central East – the Central East LHIN benefits from expertise found within the Psychogeriatric Outreach Program (POP), the Ontario Shores Centre for Mental Health Sciences (Ontario Shores),

**Ontario Shores Centre for Mental Health Sciences (Ontario Shores):**

Ontario Shores provides consultation and assessment to five schedule 1 hospitals on request and tertiary care to patients with extreme behavioural issues. Staffing includes 5 psychogeriatricians and a wide range of interdisciplinary teams including PRCs who provide Psychogeriatric Outreach services to 12 LTCHs and schedule 1 hospital in the Durham Region.

**Acute Geriatric Mental Health Inpatient Unit:** Dedicated 12-bed specialized units each in The Scarborough Hospital and the Peterborough Regional Health Centre. Both units are staffed with interdisciplinary teams.

**Psychogeriatric Outreach Program (POP):** The POP at The Scarborough Hospital funded by the CE LHIN is an inter-disciplinary team that includes three psychiatrists. The team provides assessments, treatment recommendations and inpatient care for residents of the 12 LTCHs in Scarborough when needed and also attend the LTCHs on a regular twice-monthly basis to provide case review and follow-up support to LTCH staff.

**Internal Psychogeriatric Consultation teams:**

- Operating at The Scarborough Hospital (Birchmont) - Psychogeriatric consultation are handled by psychiatrists assisted by Registered Nurses.
- Operating at the Peterborough Regional health Centre- Mental Health Consultation Liaison team (including adult geriatric psychiatrist and Social Worker) provide significant percent of the service/care to older adults with serious mental illness (SMI) and dementia-related behaviour issues. One full time Clinical Nurse Specialist and one part-time psychiatrist also serve as a resource to the Ross Memorial Hospital.

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

By its nature, the quality improvement methodology supported and promoted by Health Quality Ontario ensures care teams will be knowledgeable in both behavioural support and quality improvement. Through the Value Stream Mapping and Analysis process our key stakeholders have identified 12 priority improvement projects that will have the greatest impact on moving our system from the current to the future state. As Improvement Teams are assembled to tackle these projects the membership of the teams will be primarily front line staff who deal with people with behavioural issues, primarily in long-term care. Given that one of the primary strategies in Central East (which is also a priority improvement project) is to **Provide Appropriate and Comprehensive Training for Staff in LTC**, the QI process will create care teams knowledgeable in both behavioural support and quality improvement. Although the exact mechanisms of the behavioral support knowledge transfer will be an outcome of the improvement project, existing knowledge exchange and training entities will be leveraged to support the emerging BSO model.

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

A number of knowledge transfer structures/pathways are known to exist. Although they vary in the degree to which they related to behavioural supports, they provide mechanisms for knowledge exchange and information sharing:

- Evidence Exchange Network - EE-Net (formerly Ontario Mental Health and Addictions Knowledge Exchange Network – OMHAKEN)
- ED Avoidance Coalition - Durham and Northeast MHA Coalition to avoid ED repeat visits
- Dementia Network and Coordinating Group
- Mental Health and Addiction Network
- Concurrent Disorders Network of Durham
- Human Service and Justice Coordinating Committee: Durham and Northeast - Serves to connect health and justice services in order to increase integration of services for people with MHA issues.
- Specialized Network of Care: Durham and Northeast - Network that includes MH and MCSS funded services for those with Developmental Disabilities. Serves to connect two sectors in order to increase integration.
- Ontario Federation of Community Mental Health and Addictions Programs - Network of MH and A Providers across the Province
- Scarborough Quadrant - Network of MH and A providers in Scarborough
- OTN network of providers – a physical structure. Also, a community of practice will be formed as part of accountabilities for new investment in telemedicine nursing which could support BSO program.

As part of the QI process, current gaps and overlaps in current structures/pathways will be identified. As well, it is expected that other formal and informal structures/pathways will be identified as the Improvement Teams implement the QI projects and learn details of current practice from the front line staff.

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

The Action Plan builds on current capabilities through existing health service providers and recent LHIN investments in Aging at Home which were previously described under sections 1 and 3. Most relevant to the BSO project are the Geriatric Assessment and Intervention Network (GAIN), Geriatric Emergency Management Nurses (GEM), Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT) and Home First.

All current providers and services with an accountability to the Central East LHIN that contribute to the care of seniors with behavioural issues will be expected to align to the emerging BSO Model in Central East. In so doing, their attention and resources will be leveraged to support the development and implementation of the model and the provision of care and coordination of services for clients and families requiring behavioural support. In each community the current capabilities, capacity and resources will be different and we will rely on the quality improvement methodology to identify what can be leveraged locally to support the model and move care providers to the future state. All aspects of practice will be considered in each instance – education and training for staff; collaboration and coordination among providers; increased and enhanced inter-professional human resources; linkages and partnerships among long-term care, hospitals, community care and primary care; and spread and sustainability – to ensure a successful care model.

10. How is sustainability of the service redesign embedded in the process through education and knowledge transfer and other mechanisms (i.e. towards, the individual, caregiver, care team, organization, community, etc.)?

It has been our experience that the best mechanism for ensuring sustainability is success and the best mechanism for achieving success is the use of a quality improvement methodology. Therefore, we will relentlessly pursue increasing and spreading the level of quality improvement training, knowledge and implementation in all our health care providers, particularly those closest to providing hands on care. The QI strategy embeds sustainability into service redesign.

As a specific example, one of our first improvement projects is the development of BSO Care Teams. Team members will not be employed by a single provider but will be a team built around the client. The design of the BSO Care Team supports team building and continuous QI by building the team around the patient and having providers regardless of their sector or employer relationship responsible for patient care. This design also facilitates knowledge transfer and sustainability of the model as the diversity of the team enhances its stability, reducing its vulnerability to competing pressures of individual employers or sectors.

Existing knowledge transfer structures/mechanisms described in Section 8 above will be utilized to communicate and community engagement strategies will continue to be employed including stakeholder events such as the CE LHIN BSO Stakeholder Event on September 26<sup>th</sup> and a planned event for all HSPs in February.

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

11. How will knowledge transfer occur (e.g. best practices, protocols, standardization, etc.)?  
a. How will lessons learned be captured and shared?

The Quality Improvement process will incorporate best practices into the service redesign at each level of improvement. Since the nature of quality improvement is to utilize the expertise of the teams at the ground level, it will also provide some knowledge transfer and articulation through new processes. Ongoing quality improvement will necessitate the teams observing their process and outcome indicators to understand what is working well for the residents and seeking out best practices for continual redesign where required. One specific area of focus identified by the Improvement Team is around the implementation of the care plan created in LTC homes. It was acknowledged that although the MDS-RAI system is utilized for assessment and care planning, the way in which the staff implement the care plan is extremely variable across the sector and even from resident to resident in terms of effectiveness. The Improvement Team will seek to help LTC staff to reliably apply best practices and critical thinking to the implementation of care plans, and in particular for those residents at high risk of experiencing responsive behaviours.

Reporting tools will be standardized and common language used across the service providers and professions that will be involved in the care of the client with responsive behaviours and is in fact one of the priority improvement projects identified by the Value Stream Mapping and Analysis project. As with all the improvement projects, existing knowledge transfer mechanisms such as those outlined under Section 8 above will be leveraged to ensure maximum distribution of information and knowledge.

## 12. Who will be the partners for Knowledgeable Care Team and Capacity Building (e.g. university)?

In Central East we will maximize existing expertise and knowledge available from within health service provider organizations as well as external resources such as the Alzheimer's Knowledge Exchange. As BSO Care Teams are developed and other improvement projects are implemented state of the art (science?) information will be made available to project teams so they can determine what is most relevant and valuable in local settings across the CE LHIN. We are very aware that there is no such thing as "one size fits all" across such a diverse population with a variety of provider and expert resources and will use small tests of change to determine what behavioural support practices and strategies for capacity building result in the best outcomes for local residents.

The providers and resources available within CE LHIN have been described in several Sections above and we will focus on spreading existing knowledge and restructuring current services to maximize capacity and improvement for BSO clients. Capacity will also be enhanced through the nursing, personal support worker and other health care professional health human resources. Longer term strategies of ensuring appropriate behavioural support training for students in post-secondary education may be pursued with institutions which exist with our LHIN – Trent University, Sir Sanford Fleming College, Durham College, University of Ontario Institute of Technology – but this focus is seen as being more appropriately addressed at the provincial level.

- a. How have the partners collaborated on previous projects?

Please refer to Question 3.b. above.

- b. What were the outcomes?

Please refer to Question 3.c. above.

- 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 and 3, until the RSGS entity is operational, the Central East LHIN will directly oversee the functions of the CE LHIN Advisory/ Steering Committee and Design Team. The LHIN will also have the responsibility for meetings and providing ongoing leadership and engagement.

## 13. Describe deployment of service capacity positions for participating LTCHs

Participating LTCHs will be selected based on the results of a Readiness Assessment Survey which was announced at our initial stakeholder engagement session on September 26<sup>th</sup> and notified to our 68 LTCHs. In Central East LHIN, we are responsible for funding LTCHs to hire 20 nurses (RNs or RPNs) and 30 PSWs.

Key principles of our strategy include deployment of resources in each of our three CE LHIN clusters; building a critical mass of BSO positions within defined geographical areas to ensure efficiency, backup, training, and knowledge exchange; and providing sufficient resources to ensure extended coverage in evenings and weekends.

- a. Describe how the chosen LTCH(s) will deploy staff to meet the established BSO Framework for each LHIN.

There are currently 68 LTCHs with a total of about 9600 LTC beds spread across the three clusters in the CE LHIN. LTCHs selected to host staff will deploy them in a manner that will ensure the future state BSO

process map is achieved. Details of the deployment will be determined through the improvement project process but some key characteristics of the roles have been identified through the VSMA process.

- BSO nurses and PSWs (BSO staff) will be members of the BSO Care team for residents within their LTCH
  - BSO staff may be required to support homes other than their own home
  - Work schedules will incorporate evening hours to ensure onsite support after the day shift and during weekends
  - BSO staff will play a key role in enhancing staff knowledge and ability to care for residents with behaviours
- b. If more than one LTCH is participating in each LHIN, how will each of the positions be distributed and what is your rationale.

To date we have received 20 completed surveys from LTCHs who are interested in hosting behavioural support nurses and PSWs and more than one LTCH will be participating in the CE LHIN. We are reviewing homes against a set of criteria which includes the following:

- number of residents who could be described as having “behaviours”;
- identified need for additional support to address ongoing challenges;
- participation in HQO’s Residents First program;
- existing formal QI efforts to improve residents’ care experience;
- senior management support for implementation of CE LHIN BSO Action Plan;
- Medical Director willingness to participate or allow home to participate in BSO Action Plan;
- participation with our nurse practitioner outreach team program – NPSTAT;
- geographic location;
- willingness to partner with other providers both within the LTCH sector and in other sectors;
- existence of quality improvement capacity including trained Improvement Facilitators; and
- willingness to meet the extensive list of accountabilities set out in the funding letters from the Ministry of Health and Long-Term Care.

### Additional Information

14. Enclose a summary timeline in a separate schedule.



BSO Gantt  
Chart-CE.pptx



CE LHIN BSO  
Funding Action Plan

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

Performance, measurement and evaluation plan is evolving and will be focused on measuring success of individual improvement projects as well as overall process and outcome measures. Furthermore, the CE LHIN will comply with the overall evaluation strategy of the BSO Model which is being determined centrally, led by a sub-committee of the 4 LHIN Early Adopter Steering Committee - the Data, Measurement and Evaluation Working Group. Two Central East LHIN staff are members of the Working Group, including our Decision Support Consultant, who continues to work on sourcing and accessing all relevant data.

The Central East LHIN will be monitoring the three indicators set out by the Ministry of Health and Long

Term Care for the BSO project as well as additional process measures.

1. Reduce resident transfers out of LTC to any other care provider with the primary or main reason being a “behaviour”.

Number and rate of transfers to the ED, Acute care, specialized psychogeriatric care units will be calculated as a baseline and will be measured to show overall impact of the BSO program within individual LTCHs and for the clusters and CE LHIN overall.

2. Delayed need for more intensive services, reducing admissions and risk of ALC

Relevant indicators that will be monitored in line with this include:

1. # of residents with escalated responsive behaviours who are assessed and treated in the LTCH;
  2. # of averted transfers;
  3. # of admission and/or re-admissions to acute care for residents with responsive behaviours; and
  4. # of admission and/or re-admissions to specialized psychogeriatric care units for residents with responsive behaviours.
3. Reduced length of stay for persons in hospital who can be discharged to a LTCH with enhanced behavioural resources.

Relevant indicators that will be monitored in line with this include:

- a. Average LOS of LTCH residents admitted to hospital for responsive behaviours; and
  - b. Number of Alternative Level of Care (ALC) days related to responsive behaviours for LTCH residents.
4. Number of improvement projects initiated and completed.
  5. Number of visits to LTCHs by mobile care teams to provide enhanced assessment and treatment.
  6. Number of functioning BSO Care Teams.
  7. Number of LTCHs and residents supported by the BSO Model.

**Other indicators** that will be developed and monitored (including baseline measurement) by the CE LHIN BSO project include the following:

- Resident/Family/caregiver experience;
- Resident/Family/caregiver satisfaction;
- Provider/staff safety;
- Provider/staff satisfaction;
- Staff turn over; and
- Staff satisfaction.

Data sources will include NACRS, DAD, CIHI and others available through Intellihealth. Data will also be obtained from other sources within the LHIN like the CE CCAC databases, LTCH records, and Hospital databases. For some indicators like staff satisfaction the data will come from surveys.

First steps in the improvement project process will be identification of improvement that is targeted and the definition of process and outcome measures related to the improvement. The draft charters for currently identified projects include a list of draft indicators/measures for each of the plans.

Some of the proposed indicators may change before the implementation of the projects. Initial data will be collected prior to the implementation of the interventions forming the baseline data. The median of the data will be determined after 12 to 20 data points have been obtained as per proper quality improvement methods. The target for each measure will also be determined and continuous monitoring of the measures will be done in light of the median and the target. The intervention will be implemented incrementally with small test of change/improvement (i.e. PDSA cycles). Each intervention will be tested for sign of improvement and depending in the results it will be decided whether or not to adapt, adopt or abort a plan. The variations in the data will be monitored with Shewart Charts to determine if there is a 'shift', a 'trend', special cause or normal variations. A sustained positive trend will indicate improvement.

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

Work plan details have been outlined in the two attached Gantt Charts. The budget and resource plan details are being developed to meet funding accountabilities as per MOHLTC funding letters and for LTCH staff according to the process outlined under Section 13 above.

Details for deployment of "other health care professionals" will be informed by the Environmental Scan described in Section 4 above and by the early work of the improvement teams working on the BSO Care Team and Mobile Diagnostic Team projects which are being merged as one. Gaps identified in the Environmental Scan and the process of determining how to best meet future state processes will combine to identify the type, quantity and location of other health care professionals.

17. Who will be the representative(s) on the LHIN Steering Committee?

The CE LHIN has established a BSO Advisory Committee to oversee the BSO program. Members are drawn from the LTC sector, the CCAC, NPSTAT, PASE, acute care hospitals, Ontario Shores, Psychogeriatric Outreach Programs, Alzheimers Society, Demential Network Coordinating Group – Central East, and the Central East LHIN. Many members have multiple roles relevant to more than one aspect of the BSO project.

Executive Lead:	James Meloche Senior Director, Systems Design and Integration
Project Lead:	Brian Laundry, Lead, Quality Improvement and Evaluation
Project Manager:	Postion has been posted
Improvement Facilitator:	Gloria Duke-Aluko
Improvement Facilitator (2):	Vacant