

North Simcoe Muskoka **LHIN**

Behavioural Support System Action Plan

October 14, 2011



Submitted on behalf of the NSM BSS Action Plan
Working Group

By Debbie Islam, NSM BSS Project Lead

ACKNOWLEDGEMENTS

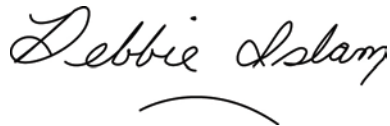
Upon notification that the North Simcoe Muskoka (NSM) LHIN was selected as an Early Adopter LHIN for the Behavioural Supports Ontario Project at the end of August 2011, the NSM Behavioural Support System (BSS) Action Plan Working Group kicked into high gear to develop an Action Plan that we believe will have a significant impact on older adults with cognitive impairments due to dementia, mental health, addiction or other neurological conditions and associated responsive behaviours residing in the NSM LHIN.

This BSS Action Plan reflects the amazing enthusiasm, commitment, vision and courage that our local leaders have contributed towards the redesign of a system of care that will better support all seniors, including those with complex and challenging behaviours, living in our communities. I would like to acknowledge and sincerely thank the members of the BSS Action Plan Working Group for their hours of work and deliberation.

I would also like to acknowledge our broader community stakeholders for their valuable advice and feedback at the two day Value Stream Mapping session and at the stakeholder engagement events.

This is an exciting time in the history of our local health care system and we welcome the opportunity to put our plan into action!

Sincerely,

A handwritten signature in cursive script that reads "Debbie Islam". Below the signature is a simple, thin, curved line.

NSM BSS Project Lead

CELEBRATING SUCCESS

As a LHIN selected by the Ministry of Health and Long-Term Care to be an early adopter of the Behavioural Supports Ontario (BSO) Framework, the NSM LHIN turned to its community stakeholders to develop a plan of action that will significantly improve those experiences of older adults with complex and challenging behaviours and their caregivers.

The NSM BSS Action Plan was developed by a dedicated team of experienced leaders from long-term care, primary care, acute care, and community support services that have a shared understanding about the needs of the population and strong motivation to effect transformational change.

NSM BSS Action Plan Working Group August – October 2011



NSM BSS Action Plan Working Group August – October 2011: From L to R: Valerie Armstrong (NSM CCAC), Patti Reed (BSS Project Manager), Valerie Powell (PRC - CGMH), Gail Scott (Waypoint/BIRT), Janice McCuaig (Trillium Manor LTCH), Lorna Tomlinson (Wendat), Debbie Islam (Alzheimer Society of Greater Simcoe County; Project Lead), Louise Bajurny (Red Cross), Ulla Rose (VON), Ann-Marie Kungl-Baker (NSM LHIN Staff Lead).

Missing from the photo: Dana Naylor (RVH), Dr. Andrea Moser (Algonquin FHT), Dr. Kerstin Mossman (Barrie CHC), Dr. Brent Elsey (Barrie & Community FHT), Jane Sinclair (County of Simcoe), Julia King (Jarlette Health Services), Julie Lawson (Red Cross), and Shannon Brett (NSM BSS Improvement Facilitator).

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EXECUTIVE SUMMARY

The focus of the NSM LHIN Behavioural Support System (BSS) project is on older adults with cognitive impairments due to dementia, mental health problems, addiction or other neurological conditions and associated responsive behaviours who are at the 'tipping point'. This means, seniors living in the community or in a long-term care home experience an acute decline or change in behaviour to the degree that it puts themselves and others at risk, and changes the environment to the degree caregivers are unable to safely manage the individual with behaviour(s) and express an urgent need for additional supports.

Behavioural Support System Value Statement:

"I AM A PERSON, HEAR ME, CARE WITH ME, KEEP ME WELL"

The Value Statement is the touchstone for the planning, processes and services associated with the delivery of care through the BSS Action Plan in conjunction with the provincial Behavioural Supports Ontario (BSO) Framework principles. The statement equally values the older adult with complex and challenging behaviours and the caregiver (family member or support staff).

The significance of the person/patient-centred value statement is described below:

"I am a person" means that one must remember that I am an individual with life experiences, beliefs, traditions, needs, wants and dreams; not a diagnosis or a behaviour.

"Hear me" means that one should take the time to listen and learn from my experience, understand my needs and why I am behaving the way I am, figure out what I am communicating.

"Care with me" means that we are in this together; care for me with respect and dignity but also with me in self-determining my goals and give me the information and tools I need to help myself (adheres to the best-practice principles of the Ontario Chronic Disease Prevention and Management Framework).

"Keep me well" means that one must continue to promote health and wellness and delay disability in order to improve my quality of life and to help me remain at home as long as possible.

There are three core components to the BSS Action Plan required to effect system change.

1. SYSTEM NAVIGATION

The BSS Action Plan outlines a governance and accountability structure that is entrenched within the NSM LHIN *Care Connections* 10- year integrated health system plan. It is based on cross-agency and cross-sector collaboration and the development of formal partnerships to build sustainability and continuous quality improvement. Leadership is maintained through a BSS Project Steering Committee and Regional Operations and Quality Improvement Working Group with support from a *System Manager* and a *Regional Medical Advisor* to engage key stakeholders in service delivery and knowledge transfer.

System coordination and management will be facilitated through a central intake function and a 1-800 number so that partners in the system know where to quickly and easily access additional supports. An electronic registry of client information will be maintained centrally with up to date information and a single plan of care.

2. MOBILE BEHAVIOURAL TEAMS (MBTs)

There are relatively few behavioural support services across the care continuum for older adults living in North Simcoe Muskoka. The Working Group members reviewed the current state of service delivery and identified isolated islands of excellent care throughout the geography of the region. With new investments, the BSS Action Plan strives to enhance and leverage the existing service system and promote integrated service delivery and system support with the creation of interdisciplinary Mobile Behavioural Teams (MBTs). The MBTs will provide in-reach to the long-term care homes and outreach to families in the community to facilitate timely access to the assessment, treatment and management of responsive behaviours and to avoid unnecessary visits to the emergency department.

3. REGIONAL PSYCHOGERIATRIC SERVICES

Older adults with cognitive impairment due to dementia or mental illness with associated severe and high risk behaviours have limited access to regional psychogeriatric services. The BSS Action Plan promotes more efficient and effective uses of these scarce and costly resources through clear clinical pathways, open communication and a collaborative/shared care approach to supports.

*Implementation of the provincial BSO Framework to achieve better health for older adults with challenging behaviours demands honest rethinking of how agencies work together. Creating an integrated network of autonomous services demands commitment. To truly effect system redesign and transformational change demands courage. The champions of this report believe that putting the BSS Action Plan into practice offers a once in a lifetime opportunity to **be courageous, be revolutionary, and be real** in improving outcomes for persons with responsive behaviours, their families/caregivers, health providers and the health system – and they are passionate about meeting any demands to achieve success.*

INTRODUCTION

In 2008, NSM LHIN brought together champions for senior's health integration from across all sectors (long-term care, specialized geriatrics, Aboriginal health, primary care, hospital, CCAC, palliative care, caregiver support) to form a LHIN-wide *Seniors Health Regional Action Group (SHRAG)*. Using Aging at Home funding, SHRAG identified weaknesses in system coordination across agencies and across sectors. They developed a vision and an integrated health system design for specialized geriatric services that builds on existing services and promotes strong linkages between sectors (see Appendix A: Vision for an Integrated Regional Seniors' Health Program in North Simcoe Muskoka, July 2009).

In 2010, the second strategic plan of the LHIN identified the design of a better health system as a key priority. On March 31st, 2010 the NSM LHIN launched the [Care Connections, Partnering for Healthy Communities Project](#) with the vision:

“A healthy population supported by our North Simcoe Muskoka health system – a respectful, accessible, and coordinated collection of health services that, when needed, provides the necessary care and works with people to help them manage their own health.”

On February 28th, 2011, a 10-year [Health System Design Report \(February, 2011\)](#), was released which articulated the short-term (year 1-3) initiatives of focus which will build upon existing momentum, identify significant areas of need, and contribute to system-wide progress. The implementation of a Behavioural Support System (BSS) was identified as a Care Connections area of focus supported by operational oversight structures mandated to provide leadership and work collaboratively through a shared governance model in specific priority areas.

The above reports were the foundational documents used to guide and advise the governance and accountability structures outlined in this action plan.

Behavioural Supports Ontario Framework for Care

PILLAR #1: SYSTEM COORDINATION AND MANAGEMENT

To truly effect system redesign and implementation of the Behavioural Supports Ontario (BSO) model, it is necessary to involve all the major stakeholders within the system and to formalize activities across sectors and organizations, creating an integrated network of autonomous services held accountable under one governing mechanism.

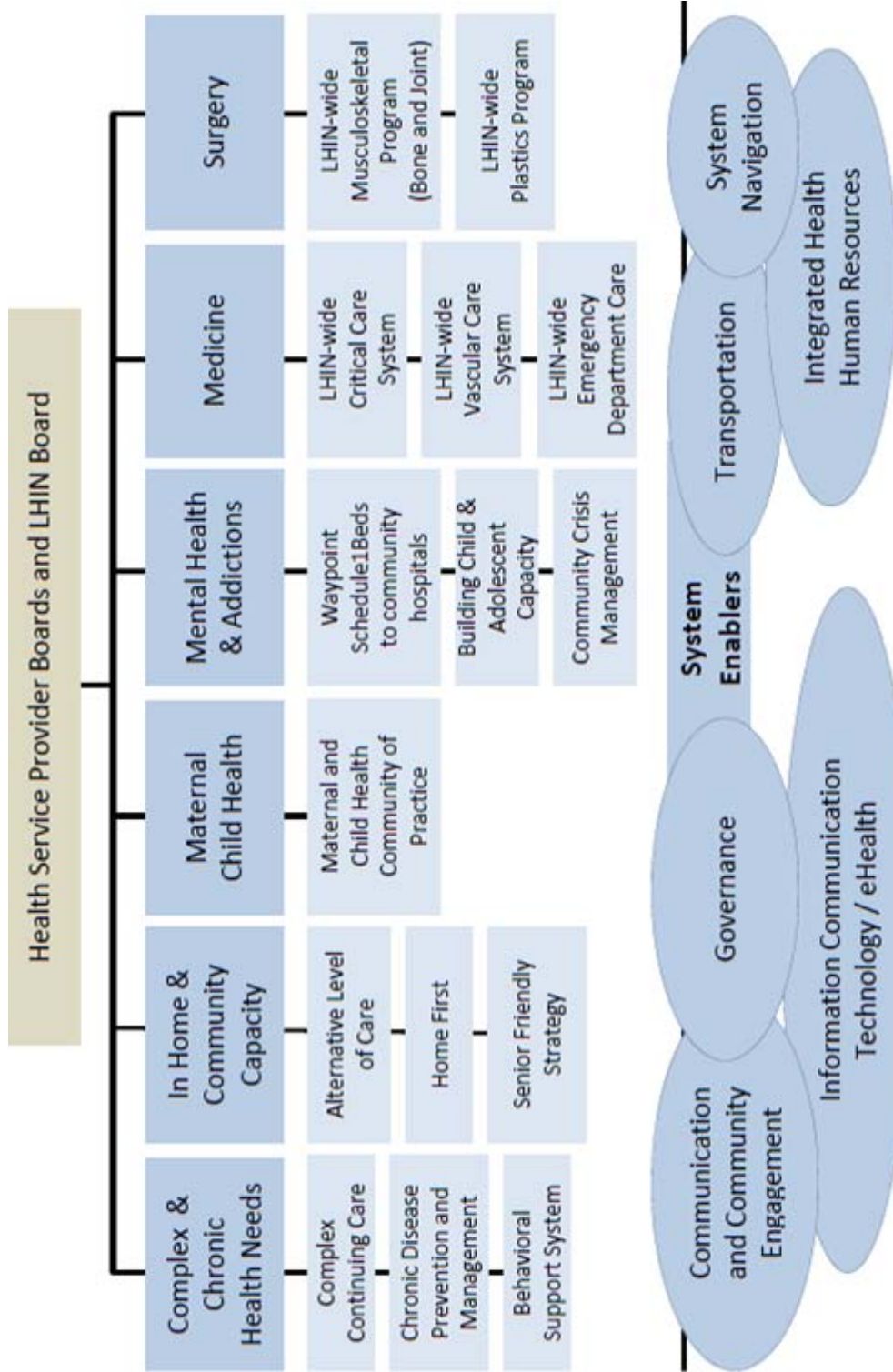
GOVERNANCE & LEADERSHIP

Care Connections is structured with six Coordinating Councils of which the Complex and Chronic Health Needs Coordinating Council (CCHNCC) is responsible for overseeing the implementation of a LHIN-wide Behavioural Support System (BSS) model to better care for this specialized population. The CCHNCC is accountable to the NSM LHIN Leadership Council (see Figure 1). The Council's overarching purpose is to design and implement a comprehensive and coordinated complex and chronic health needs care system for the residents of North Simcoe Muskoka.

Under the broad Complex and Chronic Health Needs Coordinating Council is the Behavioural Support System (BSS) Project Steering Committee. Through the Care Connections structure, the Behavioural Support System is a priority project that is inter-related across priority Councils (e.g., In-Home and Community Capacity Council and Mental Health and Addictions Council) for common issues, knowledge transfer and shared learning. In recognition of the interdependency and impact of system enablers, six additional councils were established to support system redesign. They include Governance; Information Communication Technology/eHealth; Transportation; System Navigation; Integrated Health Human Resources; and Communication and Community Engagement. These System Enabler Councils are LHIN-wide, cross-sectoral and reflective of LHIN and non-LHIN expert resource groups that support the activities of the Care Connections Coordinating Councils and their respective Project Steering Committees (e.g., BSS) and are integral supports to the successful roll out of the local BSS Project.

The role of the BSS Project Steering Committee is to assume policy leadership and strategic planning in the development and implementation of the BSS Framework in the NSM LHIN. The executive sponsor and chair of the BSS Project Steering Committee is Ms. Debbie Islam, Executive Director of the Alzheimer Society of Greater Simcoe County with responsibility for ongoing leadership for the first three years (2011-13) of this identified priority in the NSM LHIN strategic plan. Broad membership is inclusive of family members/caregivers, long- term care homes (LTCHs), primary care, acute care, community support services, CCAC, mental health services and others. It was formally established in October 2011. The BSS Project Steering Committee is serving as the cornerstone of the capacity-building process by emulating a collaborative planning process, developing and monitoring integration strategies, and resolving potential conflicts in the service system.

Figure 1: Care Connections Coordinating Councils and Implementation Teams



The BSS Project Steering Committee (see Appendix B for Terms of Reference) is accountable to the Complex and Chronic Health Needs Coordinating Council to:

- Ensure alignment of the NSM LHIN BSS strategic direction with the provincial BSS Framework;
- Monitor the implementation of the annual BSS operational plan to ensure it maintains the principles of the BSS Framework;
- Monitor specific performance indicators, benchmarks and metrics for continuous quality improvement;
- Approve common standards and integrated policies and protocols;
- Monitor the annual regional financial operating plan;
- Ensure equitable allocation and utilization of resources across the NSM LHIN;
- Identify and make recommendations to address service delivery issues and/or resource needs;
- Establish and maintain open and effective communications and linkages with all parties and stakeholders;
- Manage conflict resolution and appeal processes;
- Ensure access to legal/ethical resources when required; and
- Ultimately be accountable for the development and delivery of an integrated regional BSS system.

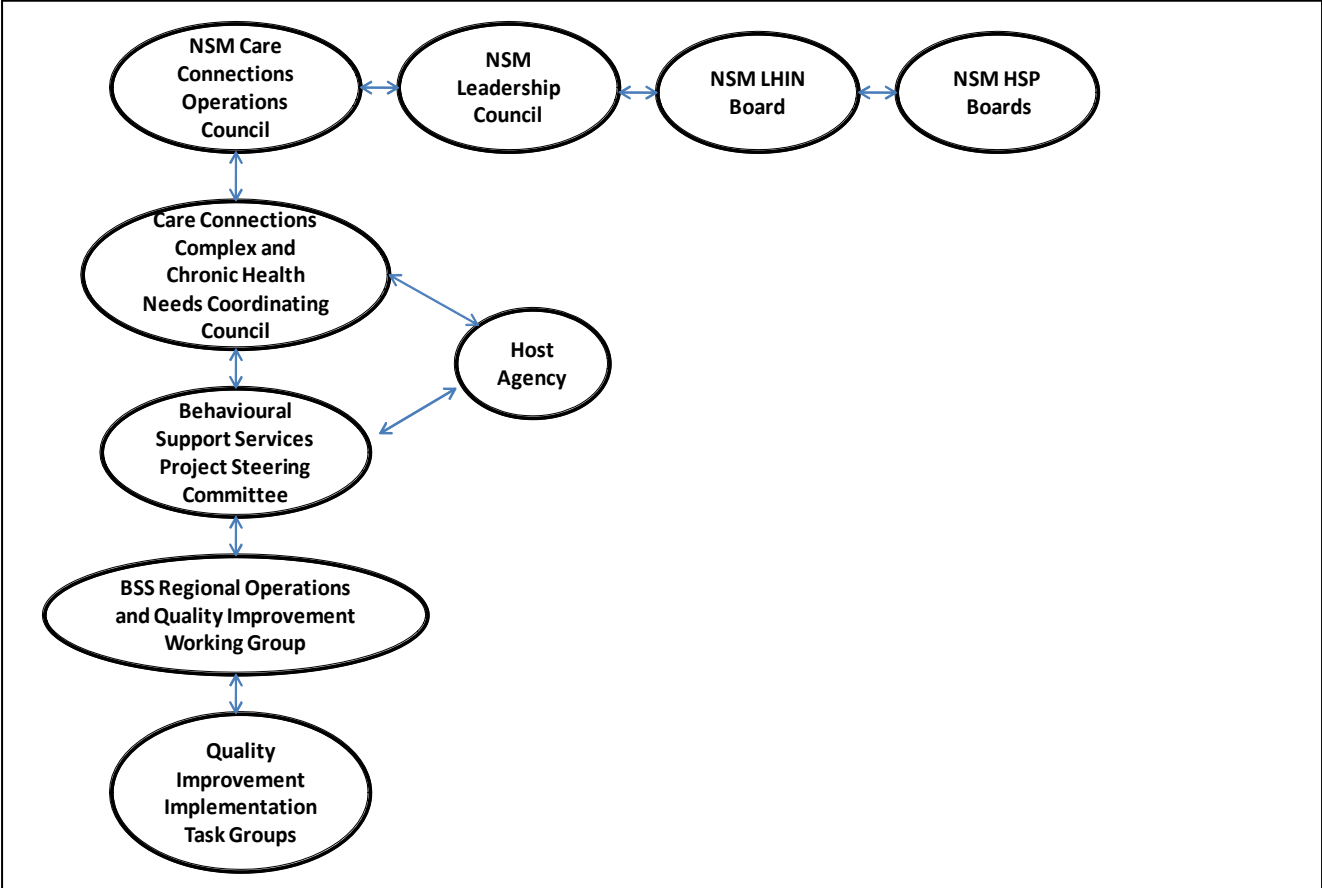
The BSS Project Steering Committee will be supported in its mandate by a ***BSS Regional Operations and Quality Improvement Working Group*** and such other task groups as may be created from time to time for specific purposes (see Figure 2).

The Working Group is a *new* group that will be incorporated into the existing organizational structure to support the roll-out and implementation of BSS across the NSM LHIN. The Working Group will be responsible for the clinical and day-to-day operations of behavioural support services. Membership will be comprised of leadership from clinical and operational direct service providers who are primarily responsible for the delivery of behavioural services to older adults within their organizations. The Chair of this Working Group will be the individual that is recruited into the administrative leadership role of *System Coordinator*.

Access to timely primary care is an important constant in managing responsive behaviours across the full care continuum; prevention, assessment, diagnosis, treatment, ongoing management and follow-up. The LHIN-wide collaboration of primary care and behavioural support services will be championed through the dedicated resource of a part-time *Regional Medical Advisor* (geriatric physician lead). The physician role of the Regional Medical Advisor is pivotal in gaining support from LTCH Medical Directors and community primary care providers to better understand the unique needs of older adults with responsive behaviours and to implement best practice approaches to care. For example, the Regional Medical Advisor would work with local LTCH Medical Directors, Primary Care Lead, and Emergency Department Lead to ensure LTCHs quickly adopt proven methods to reduce

Emergency Department transfers, minimize the use of restraints, and encourage appropriate use of psychotropic drugs and other medications.

Figure 2: NSM Governance Structure



The BSS Regional Operations and Quality Improvement Working Group will be supported by the NSM LHIN *BSS Improvement Facilitator* who will ensure that a continuous quality improvement approach (plan, do, study, act) is used to implement integration activities identified by the BSS Project Steering Committee.

The Improvement Facilitator will serve as a local source of improvement expertise and functions as the key point of contact with Health Quality Ontario (HQQ) for the project. The role of the Improvement Facilitator includes the responsibility for development and coordination of Quality Improvement activities within the LHIN and the behavioural support service providers. The Improvement Facilitator will apply this knowledge to the Behavioural Supports project to support local implementation and spread to other partner/buddy LHINs. Task teams will be developed through the duration of the project to complete activities tied to change ideas including use of plan, do, study, act cycles (e.g., [HQO Tools for Quality Improvement Teams](#)).

The BSS Regional Operations and Quality Improvement Working Group members are mutually accountable to the BSS Project Steering Committee to:

- Support the development of an integrated BSS that provides person-centred, timely, equitable access, high quality, evidence-based services in an efficient, effective and sustainable manner. Further,
 - Develop annual regional goals and objectives (Annual Service Plan) for the BSS and monitor and report progress toward those ends;
 - Identify core indicators and a common framework for collecting data and put in place a performance scorecard; and
 - Identify and make recommendations for continuous quality improvements in the delivery of BSS services.
- Identify or build on existing innovations in the delivery of an integrated BSS across the health continuum, in alignment with the Behavioural Supports Ontario (BSO) Framework for Care (2011). Further,
 - Establish or build on existing best practice clinical standards of care, common screening, intake, assessment, discharge tools;
 - Develop and implement integrated policies and protocols;
 - Develop and implement regional education and staff orientation; and
 - Ensure continuous knowledge transfer to other buddy LHINs and NSM LHIN Coordinating Councils and Project Steering Committees.

Provider members of behavioural support services will have service and funding agreements in place that clearly articulate accountabilities and service delivery requirements for their organization.

PILLAR #2: INTEGRATED SERVICE DELIVERY

People with responsive behaviours are often marginalized and stigmatized; providers may be uncomfortable, feel unsafe or lack confidence in how to offer the best care; caregivers may be too stressed or exhausted to collaborate in the care plan. With this in mind, over thirty NSM LHIN health service providers representing long-term care, community support services, acute care, primary care and tertiary care attended the Value Stream Mapping session held in September, 2011. Through their work, they created the following value statement from the perspective of the client or the caregiver that shall remain a touchstone for all of the efforts and decisions moving forward to implement the BSS Project.

The image shows a collection of handwritten notes on a whiteboard or flipchart, organized into two columns. The left column lists various values and needs, while the right column lists corresponding service requirements. A separate card in the foreground contains a value statement.

| Customer Values | Proper equipment |
|--|-------------------------|
| Dignity & Respect | Someone who care |
| Access to service | Fun/happiness |
| Quality of life | Transparency of process |
| Function | Not being rushed |
| Independence | Sharing |
| Participation in decisionmaking | Be seen & heard |
| Time being valued | Coordination |
| Support | Work |
| Safety | Caregivers |
| Cost savings | Respect |
| Timeliness of response | Education |
| Honesty/Disclosure | Value |
| Information | Information |
| Help coordinating appts/help getting there | Options |

Customer/Client Value Statement

I AM A PERSON,
HEAR ME,
CARE WITH ME,
KEEP ME WELL

TARGET POPULATION

The focus of the NSM LHIN BSS project is older adults with cognitive impairments due to dementia, mental health problems, addiction or other neurological conditions and associated responsive behaviours who are at the 'tipping point'. This means, seniors living in the community or in a long-term care home experiencing an acute decline or change in behaviour to the degree that it puts themselves and others at risk, and caregivers unable to safely manage the behaviour(s) who express an urgent need for additional supports.

SERVICE GAPS

The NSM LHIN commissioned a report on the current availability of health-funded behavioural support services in long-term care and compared it to the current best practice models for service delivery across the continuum of care ([Integrated Specialized Behavioural Health Supports Program of NSM](#), July 2008). This report identified the gaps in service for older adults with responsive behaviours and the areas of strength within the service system. Since 2008, the provincial *Aging at Home* initiative has provided targeted funding to reduce or eliminate some of these service gaps; however, older adults with responsive behaviours continue to be underserved.

SERVICE DESCRIPTION

The BSS project will build upon and enhance existing behavioural support services in the NSM LHIN. The system has a coordination-type integrating mechanism for the administration of the system (i.e., BSS Project Steering Committee), and a fully-integrated service delivery system. The overarching goal for the people receiving support through the Behavioural Support System is:

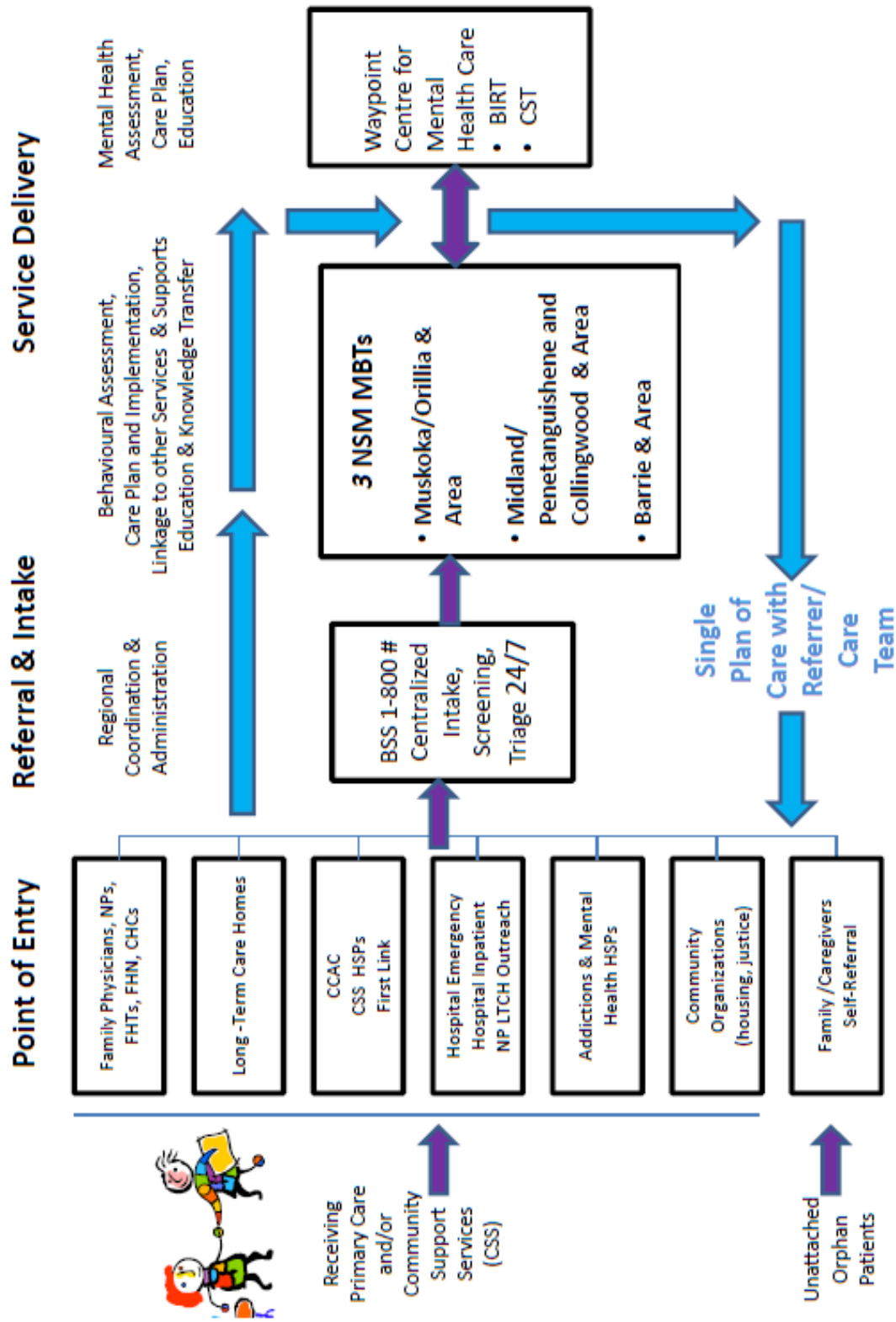
To simplify access to appropriate services in a timely fashion.

There are three core service delivery components required to effect system change:

1. System Navigation
2. Mobile Behavioural Teams
3. Regional Psychogeriatric Services

The introduction of a centralized intake, screening, triage and referral function, integrated interdisciplinary service networks managed through local Mobile Behavioural Teams and streamlined access to psychogeriatric services are vital to equitable and timely access to the right providers for the right service when it is needed (see Figure 3).

Figure 3: NSM Service Delivery Design for Behavioural Supports



CORE COMPONENTS

1. System Navigation

Consistency and continuity of care are critical to providing quality care for seniors with cognitive impairments and associated responsive behaviours. Knowing where and how to access appropriate care is often unknown or confusing to the clients and to the health service providers; or if known, services may be untimely, unavailable or even non-existent in the NSM LHIN.

Centralized Intake, Screening, Triage & Referral

The goal of the NSM LHIN BSS priority is to simplify access and timeliness to the range of needed services and supports. It is proposed that the BSS project do the following:

- Establish a **single point of entry** within NSM CCAC for centralized intake access to comprehensive BSS services through a 1-800 number (answered live); utilize common risk screening tools and one common referral form accepted by all behavioural support services in the system.
- Redirect after-hours and weekend telephone response using telephone call-transfer technology to the Behavioural Intervention and Response Team (BIRT) at the Waypoint Centre for Mental Health Care (BIRT currently operates 24/7 in response to calls from LTCHs). BIRT will notify Centralized Intake re: new callers or the local Mobile Behavioural Team re: current clients to request immediate follow-up on the next business day.
- BSS supports are available to all persons providing care across the care continuum including: primary care providers, LTCHs, CCAC, community support service agencies, and acute care. The BSS is established as an adjunct/resource to the service system and is not intended as a first contact/intake point for clients or families directly; however, families who do not have a primary care provider¹ or prior involvement in the health system may access the 1-800 number in an urgent situation.

The centralized intake site will utilize a **standardized telephone screening assessment tool**² with referral criteria to triage calls/referrals and determine the urgency of response.

¹ As a popular retirement community the NSM LHIN has a number of older adults who have moved into the area while maintaining the family physician from their former residence outside the LHIN; they do not have a local primary care provider and remain orphan patients.

² Standard risk screening tools already exist and will be reviewed regarding leverage for adoption/system consistency.

The BSS Central Intake Coordinator (dedicated FTE resource) must be a person with specialized knowledge and expertise in seniors' health and behaviour management, and have a clear understanding of available behavioural support services to triage the client/family/provider to the right service for a timely response.

The centralized intake site will conduct a telephone assessment to:

- Assess the risk to determine the urgency of the call and whether or not emergency or short-term immediate service is required; and
- Determine the referred person's eligibility for behavioural support services; if ineligible, the Intake Coordinator will actively support³ referral to services that are more appropriate.

The risk screening tool will trigger the appropriate response (triage) to address the immediate needs of the caller:

- **Low risk:** provide counseling, telephone reassurance, offer tips and tools for managing the situation
- **Low to medium risk:** Link with peer support services, Warm Line, First Link[®], informal supports; make next day appointment with the primary care provider for follow-up
- **Medium to high risk:** Considered an urgent situation; the Intake Coordinator will immediately notify the closest geographic Mobile Behavioural Team to schedule a face-to-face behavioural assessment at the location of client within the next 24 – 36 hours for follow-up and ongoing assessment/support
- **High risk:** Emergency situation and connect with mental health crisis response services or emergency services.

If the call is from an acute care setting (emergency department or inpatient unit) the Centralized Intake Coordinator will immediately notify the NSM Behavioural Intervention Response Team (BIRT) at the Waypoint Centre for Mental Health Care, which will schedule a face-to-face comprehensive behavioural assessment within 24-36 hours.⁴

The centralized intake site will house a central computerized ***Client Registry*** with an integrated client health record containing client and family history, diagnosis, existing

³ "Active referral" indicates contacting the referral source on behalf of the caller and ensuring a quick response to address their needs; for example, this may be scheduling an appointment with a health service provider for the next day.

⁴ This is a proposed 'new' and expanded role for BIRT regarding the service in hospital settings in addition to outreach to LTCH sector in NSM.

services and supports (formal and informal), prior assessments, and current treatment status re: complex health care and behavioural needs.

The BSS Project will investigate success and learning from the 'Doorways Project' and potential expansion to include the BSS target population.

The NSM LHIN has successfully piloted intranet portal technology, called Doorways, with addictions and mental health agencies, hospitals, and community physicians across a four LHINs partnership with eHealth Ontario. This private and confidential portal provides access to a complete history of clinical information for each patient/client shared amongst authorized users from a number of different care providers. This one 'Doorway' gives health providers the opportunity to add information at any time. Access to current client assessment information helps to better address the needs of the client and determine the most effective interventions in a timely manner without duplication of effort. For more information see Appendix C and the [NSM eHealth Webpage](#).

2. Mobile Behavioural Teams

It is proposed that the NSM LHIN be subdivided into three geographic 'clusters' of equitable services organized into an interdisciplinary team of behavioural supports for older adults – termed Mobile Behavioural Teams (MBTs). The north will be served by the Muskoka Orillia & Area MBT, the west will be served by the Midland/ Penetanguishene and Collingwood and Area MBT, and the south will be served by the Barrie & Area MBT (see Appendix D). Each MBT will have primary responsibility to serve the community residents, long-term care homes (see Appendix E), primary care providers and acute care hospitals within their geographic area however, it is recognized that the boundaries must remain fluid as clients/families may receive services in more than one area within the NSM LHIN⁵.

Each MBT will build upon the local community capacity to address responsive behaviours in the place where people live. The goal is to keep people in their home environment and to remain connected with their current supports to preclude reliance on emergency departments as the first point of entry into a system of care. Based on the overarching principle that person and caregiver-directed care is maintained at all times, people will be provided the education and information to participate in decisions about their care plan and to learn about alternatives such as peer support and self-help. The service response is expected to fit the person and not require the person and caregiver to fit the service.

Each MBT will have a home base of operations located in their geographic area to host weekly clinical meetings and client/family meetings, and to facilitate central communication and information-sharing; however, team members are expected to travel across the LTCHs

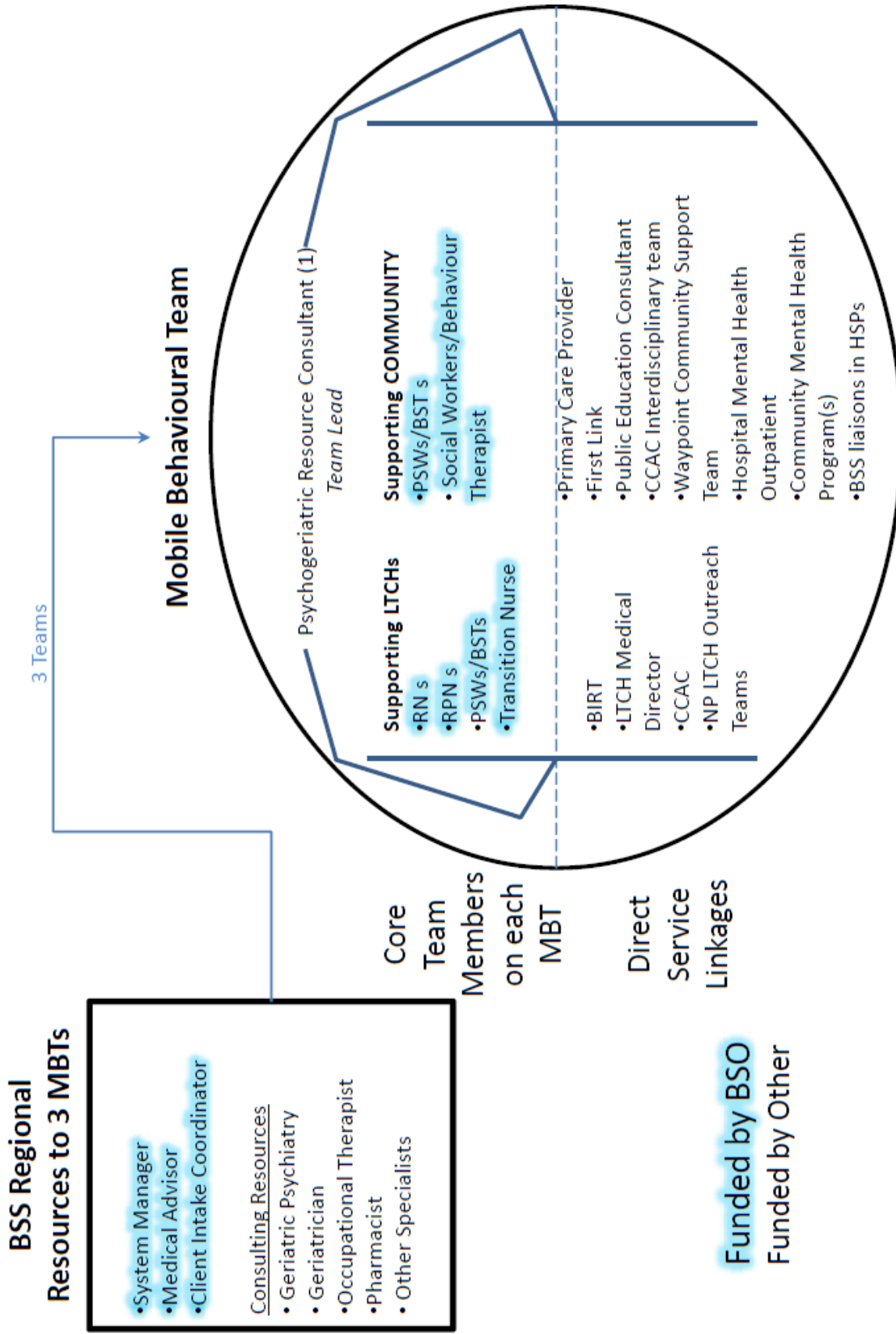
⁵ With client consent, referrals may be actively supported to the BSO providers in operation in other LHINs as individuals may seek services outside the NSM LHIN.

and community sites as required. All MBTs will meet regularly to support knowledge exchange.

Each Mobile Behavioural Team will include a core complement of team members that serve older adults with complex needs and responsive behaviours wherever they reside in their geographic area. Some team members will be deployed in LTCHs and some in community although they work as a single unit of behavioural resource and expertise (see Figure 4).

In Figure 4, the health human resources highlighted in blue will be funded through the BSS investment in NSM. The non-highlighted positions will leverage existing services through formal service agreements and Memorandums of Understanding outlining clear roles, responsibilities and accountability (e.g., pharmacist consultation through LTCHs) and/or access to other funding sources.

Figure 4: Mobile Behavioural Team Members



Note that the proposed plan to deploy some MBT members either to LTC homes or to community sites is structured such that we can achieve our goal for available and accessible mobile behaviour supports while remaining within the parameters of the current LTCH legislation and regulations. The MBT is designed in this way should the legislative/policy barrier be removed in the future, then the MBT staffing in the LTCHs can be mobile into the community with a greater breadth and depth of scope.

The NSM LHIN currently funds two experienced full-time Psychogeriatric Resource Consultants (PRCs) that provide ongoing education and case-based training to the LTCHs and service providers in the region. It is proposed that the PRC be identified as **MBT Lead** with the continuing responsibility to provide ongoing education and additional new responsibilities to include:

- Supporting the work of the PIECES trained staff and the new Community and LTCH Behaviour Technicians to problem solve, apply and test evidence-based care procedures in the care plan;
 - Coordinating behavioural support services within the MBT area;
 - Acting as the key contact person and liaison with Centralized Intake, Triage and Referral;
 - Facilitating weekly MBT meetings in area and networking with other two MBTs; and
 - Continuing to support regional committees and structures (i.e. Dementia Network) and new committees/workgroups as required.
- The Centralized Intake and Triage will notify the MBT Lead closest to where the person lives re: a new referral or re-admit referral. A face-to-face visit (client's home, LTCH) from a member of the local geographic Mobile Behavioural Team (MBT) to conduct a comprehensive behavioural assessment⁶ will be done within 24-36 hours.
 - It is recommended that the MBT hours of operation be 11 am to 7 pm and MBT members work flexible schedules according to the needs of the individuals they are serving.
 - It is expected that the MBT assign an Assessor and a MBT Behaviour Support Technician who will meet with the person and family together (either in the community or LTCH) to look at the presenting behavioural needs, urgency, safety risks and complete a comprehensive behavioural assessment.
 - The role of the MBT assessor will be the responsibility of one of the RNs deployed to the LTCHs and the role of the Behaviour Support Technician will be one of the Personal Support Workers (PSWs) also deployed to the LTCHs.

⁶ This assessment will build upon prior assessments and information when available and make every effort not to duplicate work that has already been done by other health professionals.

- In the community, the role of the MBT assessor will be an allied health professional recruited to the team (e.g., Social Worker, Behaviour Therapist, RPN). The role of the community Behaviour Support Technician will be an unregulated position (e.g., Behavioural Science Technician, PSW, Social Service Worker, etc.).
 - Once the behavioural assessment is complete, the MBT assessor and Behaviour Support Technician will collaborate with the rest of the MBT, the caregiver and the referring agency to develop a care plan. If the individual is receiving services or supports from other resources (formal or informal), with client consent they may be invited to participate in developing the care plan.
 - The Behaviour Support Technician will provide ongoing follow-up and case management as required, for example, if no other supports are in place to be responsive.
- Individuals (and their families) receiving BSS services will have an individualized single plan of care developed through the shared inter-professional practice of their care team (including common assessment tools, shared assessment results, continuous communications, assigned case manager and a primary contact person within the team).
 - If the individual and/or caregiver do not have in-home supports in place, the same Behaviour Support Technician will continue to support the person/family and implement the care plan for up to six months. If other community support services are already in place, the Behaviour Support Technician will coach the personal support staff on how to implement the care plan. The Behaviour Support Technician will provide continuity of care across the continuum (including in and out of hospital or LTCH) until the individual/caregiver feel supported and able to manage the behaviour on their own.
 - Similarly, if a resident in a LTCH has responsive behaviours, the LTCH Behaviour Support Technician will support the in-home Personal Support Workers with hands-on support in the implementation of the behaviour management strategies outlined in the care plan.

*The aim of the NSM Behavioural Support System is to engage and actively support the individual/caregiver and front-line workers in the community, including LTCHs. One of the objectives in achieving this aim is to ensure that the care plans are respectful, least intrusive, relevant, feasible, and successful in managing responsive behaviours to reflect the **principle of person-centered care** and yield safe, quality care in NSM.*

- Each MBT will work closely with the original referral source to link with the appropriate services in the community and to enable continuous feedback on the implementation of the care plan. Any change in status (physical, mental, psychosocial) or new reports/assessments will be maintained on the Central Registry portal for timely, shared communication among health service providers.
- Ongoing communication with the referring agency/primary care provider facilitates the return to care once the behavioural support services are no longer required.

Each MBT will have the same core staffing and offer a consistent service approach as determined by the BSS Regional Operations and Quality Improvement Working Group. Service linkages with other health (and non-health) service providers will be developed locally according to the culture and context of the sub-LHIN region.

Each MBT team would be comprised of the following core members/disciplines:

| | |
|---------|---|
| 1 FTE | Psychogeriatric Resource Consultant (PRCs) – Team Lead* |
| 1 FTE | Registered Nurse (in LTCHs only) |
| 2-3 FTE | Registered Practical Nurses/Activationists (in LTCHs only) |
| 4-5 FTE | Behaviour Support Technicians (PSWs) (in LTCHs only) |
| 1-2 FTE | Community Behaviour Support Technicians* (Behavioural Science Technician/Social Service Worker/Gerontology) |
| 1 FTE | Wendat Transition Program Behaviour Nurse* |
| 1FTE | Social Worker/Behaviour Therapist/RPN* |

**BSO funding required for new/additional positions to leverage current complement.*

Each MBT will be expected to make direct service linkages through formal and informal agreements at the local level including but not limited to the following programs/services:

- CCAC Interdisciplinary Teams
- Home First (Wait at Home/Stay at Home)
- Community Support Services in-home RNs/RPNs and PSWs
- Hospital Discharge Planners
- Alzheimer Society First Link® Coordinator
- LTCHs Medical Directors
- Primary care Physicians and Nurse Practitioners – FHTs, Community Health Centers
- Nurse Practitioner-Led Hospital Outreach Teams
- Mental Health and Addiction HSPs
- Integrated Regional Falls Program
- Palliative Care Network
- Crisis, 911 Emergency and Police Services
- 211/CCAC
- Muskoka Senior's Health Team
- Elder Abuse Networks in Simcoe and Muskoka

If behaviours continue to escalate or remain unmanageable with the current resources in place, the MBT may refer to more specialized psychogeriatric supports.

3. Psychogeriatric Services

The Waypoint Centre for Mental Health Care (formerly Mental Health Centre Penetanguishene) Geriatric Services Program located in the NSM LHIN has been in operation for many years. It provides psychiatric services to people over 65 years of age who are presenting with serious psychiatric illness, dementia and/or challenging aggressive behaviours.

The three local MBTs may access geriatric psychiatry services (outpatient and inpatient) upon referral to Waypoint Centre. *All referrals must be forwarded through the MBT to ensure that prior behaviour management/treatment strategies have been implemented unsuccessfully and that a more intensive level of intervention is required.*

Community resource to all three MBTs:

- **Waypoint Centre Community Support Team (CST):** The CST provides psychiatric outreach assessment and treatment recommendations on a consultative basis in the community. Services are provided by a team of RNs, psychiatrists and a community support worker.

LTCHs and Acute Care resource to all three MBTs:

- **Waypoint Centre Behavioural Intervention Response Team (BIRT):** BIRT was implemented through Aging at Home funding to provide immediate support to LTCHs in the management of residents with severe behaviours related to cognitive impairment and contributes to divergence from emergency room visits/admissions. BIRT is a specialized team with both psychogeriatric and behavioural expertise. Through Waypoint Centre, BIRT is closely linked to additional mental health and psychiatric supports. The on-site support is intended to “wraparound” the existing care team within the LTCH.
- **Waypoint Centre Geriatric Services Inpatient Program:** The inpatient program has 26 beds and provides inpatient psychiatric assessment, consultation, recommendations and education regarding seniors with mental illness and/or dementia with behavioural complications. The multidisciplinary team is comprised of a variety of specialized healthcare professionals including psychiatrists, social workers, occupational therapists, and rehabilitation support staff who work together with other hospital staff and community services as needed. Admission is expected to be no longer than three months.

With the introduction of the MBTs, it is anticipated the clinical expertise of BIRT will be more efficiently utilized in LTCHs for residents with severe behaviours and that the new behavioural support staff in the system will support the implementation of behavioural interventions more effectively. This plan envisions that BIRT will expand to support hospital emergency departments and inpatients designated ALC with a destination to LTCH delayed discharge due to behaviours.

MOVING FORWARD

The system redesign goals of the provincial BSO Framework and the vision to achieve seamless transitions across the continuum, simpler access to health services, cross-sector integrated service delivery, earlier intervention to promote health, and building capacity through knowledge transfer are foundational blocks for an improved system of geriatric care for *all* older adults.

To catapult the system towards this vision and further leverage the BSS Project investments the NSM has added complementary system resources in 2011/12 to better support seniors including:

- Expansion of Ontario Telemedicine Network (OTN) with ten new RN positions for clinical consultation;
- Increased funding of sessional fees for clinical expertise and knowledge transfer; and
- Expansion across Muskoka of Seniors Health Teams.

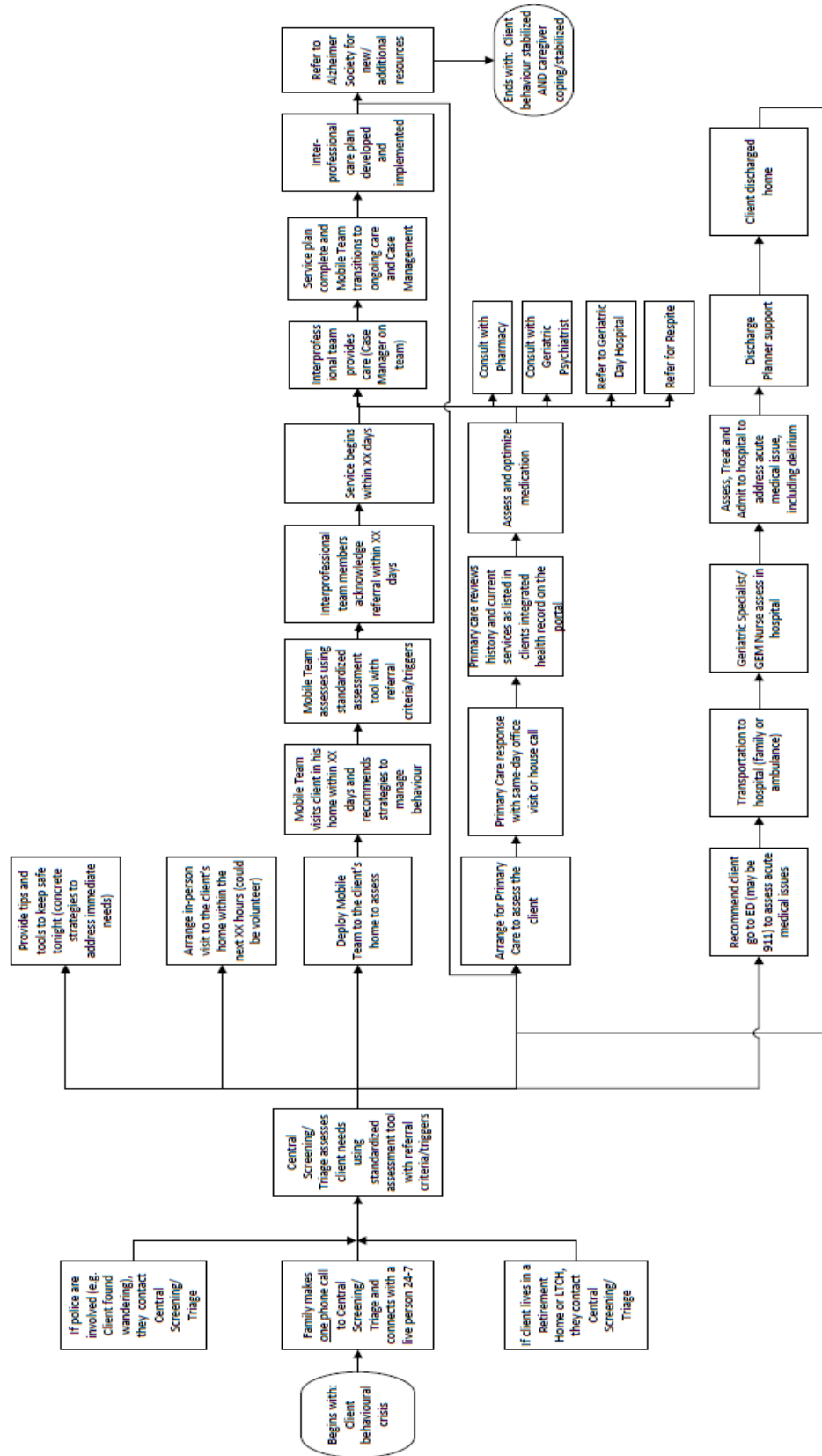
Additionally, there are potential opportunities in NSM to further the vision. Examples of opportunities currently being explored include:

- Alternate Funding Program (AFP) for focus of practice care of the elderly physicians pending availability;
- CCAC Rapid Response Nurses to provide service to older adults with complex care and responsive behaviours in the community; and
- CCAC expanded role in supportive living for high risk seniors, complex continuing care, rehabilitation and adult day programs.

VALUE STREAM MAPPING

Through Value Stream Mapping, participants (see Appendix F) envisioned an ideal future to illustrate how a person with responsive behaviours and their caregiver living in the community can be supported across the continuum of care. Participants intentionally selected a fictional family that were unattached to any support services outside the home and where the caregiver was feeling unable to cope and desperately seeking help at 11:00 at night (see Figure 5).

Figure 5: BSS Future State



Founding service delivery principles most important to the NSM BSS future state identified by frontline staff are reflective of the following:

- The client's family is a key partner, whether the client lives at home or in a LTC home;
- Services are about the senior, not where the individual/client lives or a diagnosis;
- Staff continuity is ideal (e.g., the same PSW, LTCH staff, contact for each discipline);
- The minimum service/intervention to resolve the issue is preferred;
- The interdisciplinary team follows the flow of the client; and
- Emergency rooms do not address behaviour, they should be accessed for acute medical issues, including delirium.

Through the value stream mapping process, many improvement ideas were captured and documented into early 'charters' for change. These charters will be revisited by the Regional Operations and Quality Improvement Working Group for scope definition, prioritization and confirmation of timelines. Organizational leads will be identified for each change idea and will work closely with the Improvement Facilitator using lean methodology to implement and evaluate the impact of each change idea. This process will result in rapid cycle improvement. North Simcoe Muskoka will work closely with the identified Early Adopter LHINs using a provincial approach to process improvement.

PILLAR #3: KNOWLEDGE CARE TEAM AND CAPACITY BUILDING

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

LEVERAGING CURRENT KNOWLEDGE TRANSFER PROCESSES

Information Technology

NSM LHIN has a largely rural geography in and around cottage country with five hospitals (seven sites) situated in small urban centres and it has a higher than provincial average number of seniors and number of people with chronic illness. With residents and resources spread out across the area, information technology is key to disseminating or sharing timely and relevant information to support practice, and in keeping people connected and promoting partnerships to enhance services.

There are 52 Ontario Telemedicine Network (OTN) two-way videoconference sites across the NSM LHIN. Health service providers frequently utilize OTN videoconferencing for clinical consultation with out of region specialists and webcast services⁷ to participate in training and education. Through OTN's webcasting services, education and training events can be recorded and made available in an extensive archive library that is accessible on-line to the learner 24/7. (For example, evening or overnight staff may access archived OTN presentations or other recommended e-Learning opportunities during 'down time' on their shift to promote continuous learning.)

One of our local family physicians, Dr. K. Mossman, leads a committee of health professionals who plan and deliver a monthly OTN series called "Geriatric Insights". This series is a live video cast with local experts on topics of interest that is recorded and archived for future reference.

The OTN webinar service also provides relatively easy access to medical consultations between LTCH Medical Directors and family physicians or to specialty geriatric resources. Although OTN videoconferencing sites are not yet available in LTCHs, several sites are spread throughout NSM for close to home access (see Appendix G)

Note: The clinical capacity of OTN will be further enhanced with the in-year (2011/12) investment of ten Registered Nurses to support health service delivery in NSM.

Finally, the OTN web conferencing service facilitates a collaborative meeting space to connect people and share from across the region.

There are excellent e-Learning tools and resources available on-line to address mandatory and voluntary training needs for regulated and unregulated staff. For example, The

⁷ OTN webcasts are available to any learner/participant who has a computer with internet access.

Geriatrics, Interprofessional Practice and Interorganizational Collaboration (GiiC) Toolkit developed by the Regional Geriatric Programs in Ontario offers online modules in geriatric care, including behavioural supports, which are easily accessible for health professionals in the field. The NSM Dementia Network developed an e-Learning series for unregulated staff and family/caregivers entitled *Me and U-First!* (www.u-first.ca) that is available free on-line in English and French.

Quality Improvement (QI)

The BSS Project has one full-time Improvement Facilitator (IF) dedicated to supporting a collaborative, team-based approach to effect change management. Continuous quality improvement will be imbedded into all levels of the BSS Project through full membership of the Improvement Facilitator on the *Regional Operations and Quality Improvement Working Group* (see responsibilities of the Working Group in Pillar 1). The Improvement Facilitator will provide leadership and coaching in QI to the implementation Task Groups that are established by the Operations and Quality Improvement Working Group to achieve successful outcomes for this project.

The BSS Quality Improvement Facilitator will leverage the expertise of the identified *Resident's First* Improvement Facilitators in long-term care homes as well as the PIECES trained staff and champions of other initiatives (for example, RNAO Best Practice Coordinator, CCAC Professional Practice Leads, primary care providers with expertise in geriatric care) to implement the change management processes for behavioural supports in LTCHs and in the community. Note: Once the Action Plan is approved the specific change projects identified through the Value Stream Mapping exercise will be reviewed by the Operations and Quality Improvement Working Group and the BSS Improvement Facilitator to assign priority and to determine the change indicators and measures for success.

Current Behavioural Support Expertise

Psychogeriatric Resource Consultants

The NSM LHIN currently has two full-time experienced and well-established Psychogeriatric Resource Consultants (PRCs) that have long served the Simcoe County (pre-LHIN catchment area) caregivers in long term care homes, CCAC/homecare and community service agencies for this target population. (With the creation of the NSM LHIN an additional part-time PRC serves the Muskoka area and is funded through the North East LHIN.)

The primary role of the PRCs work is educational and developing staff and organizational capacity to provide care for seniors with responsive behaviours related to complex physical, cognitive and mental health needs. The PRCs facilitate the transfer of knowledge to practice through formal and informal on-site staff development.

Through a consultative model, the PRCs have built capacity throughout the system to better support the person with responsive behaviours and the caregiver. PRCs promote and work with the PIECES model and teach the PIECES program to regulated care providers and supervisors. There are PIECES-trained staff in LTCHs and in community support

agencies who work with the PRCs to promote person-centred care and quality service delivery.

The PRCs are also qualified as Gentle Persuasive Approach (GPA) coaches and U-First! facilitators, delivering these programs to front-line workers, often in collaboration with other trained coaches and facilitators in NSM.

PRCs collaborate with other training resources to develop and deliver customized training to meet the learning needs of individuals in long-term care and in the community

Public Education Coordinators

Each Alzheimer Society Chapter employs one of three full-time Public Education Coordinators (PECs) who provide public education and promote awareness of dementia; as well as facilitate caregiver and support groups for persons with dementia and their caregivers. Understanding the progression of the disease and effective communication skills can reduce caregiver stress and keep families intact for an extended time. PECs work closely with the PRCs to develop customized education programs for LTCHs, CCAC and community support agencies.

In addition, each Alzheimer Society Chapter employs Support Counsellors to provide information and support (such as behaviour management strategies) in one-on-one meetings with families and individuals with dementia.

Wendat Psychogeriatric Transition Service

Wendat employs Behaviour Nurses to facilitate the successful transition of people from in-patient hospital care to a long-term care home. Once the person is admitted to the LTCH the Wendat Behaviour Nurse concentrates her/his effort in mentoring and coaching the front-line staff to implement behavioural strategies to manage risk and/or diminish the responsive behaviours. The Behaviour Nurse maintains her work alongside the LTCH staff until the new resident feels comfortable and settled in the home.

Waypoint Centre for Mental Health Care⁸

Through Aging at Home funding the *Behavioural Intervention Response Team* (BIRT) was created to provide a collaborative approach to managing severe behaviours in the long-term care setting as an alternative to hospitalization. The BIRT is recognized as a best practice model that is unique to the NSM LHIN. The BIRT members go on-site into the LTCH to assess and develop recommendations for least intrusive interventions to support the person and staff to remain safe in the living environment.

⁸ Not yet included at this phase of the BSS Project are the behavioural support resources and clinical expertise provided at Waypoint Centre and through the Centralized Network of Specialized Care service individuals with a dual diagnosis and responsive behaviours.

The Waypoint Centre currently offers psychiatric outreach assessment and treatment services to individuals and families wherever they live (in the community, long-term care homes or hospital) through a geriatric outreach Community Support Team (CST) with mental health expertise provided by a team of registered nurses, psychiatrists and a community support worker.

Specialized Geriatric Medicine

The NSM area employs two Geriatricians (Orillia and Barrie) who are currently working at capacity. The Geriatricians work closely with primary care providers and other health service providers to exchange knowledge and clinical consultation. Orillia Soldiers' Memorial Hospital provides the one Geriatric Day Hospital in NSM LHIN.

Primary Care

The NSM LHIN is fortunate to have local expertise in primary health care for the elder population who are active participants in the BSO Project. The local leads for the physician group, Dr. Andrea Moser and Dr. Kerstin Mossman, have delivered curriculum on primary care and patients with responsive behaviours⁹ that offers MAINPRO® (Maintenance of Proficiency) credits to engage family physicians in evidence-informed practices.

CCAC recently developed a *Cognitive Assessment and Care Management Service*. This service is provided by an Occupational Therapist to work directly with families to develop care strategies and problem-solve managing responsive behaviours in the community.

Dementia Network

The NSM LHIN has a well-established *NSM Dementia Network* with broad membership from across all sectors (see www.dementianetworksc.org/nsm.html) and working subcommittees including the Education/Training Standards Task Group. This group organizes workshops on various topics related to persons with Alzheimer's disease and related dementias (ADRD) throughout the year that are promoted through a regular communiqué to all members. The Education Task Group also plans and hosts a well-attended annual conference with registrants from within and without the NSM LHIN.

Seniors Health Research Transfer Network (SHRTN)

The provincial *Senior's Health Research Transfer Network* (SHRTN) has an active Community of Practice (CoP) in behavioural supports with leadership from the local knowledge brokers; Gail Scott, BSS Project Team member (Waypoint Centre) and Debbie Islam, BSS Project Lead (Alzheimer Society of Greater Simcoe County). They ensure that the behavioural support health service providers are kept informed and that there is a continuous exchange of ideas and new knowledge to improve practice. The SHRTN CoP

⁹ The curriculum was developed through the Ontario Alzheimer Strategy in conjunction with the Ontario College of Family Physicians.

offers open membership to an avenue for ongoing information sharing, discussion, knowledge exchange and problem-solving.

SHRTN also has a Psychogeriatric Resource Consultants CoP with over fifty members that share information, best practice knowledge and successes in practice with their peers across the province.

Creating Knowledgeable Care Teams

Regional BSS Operations and Quality Improvement Working Group

The members on the regional BSS Operations and Quality Improvement Working Group are key stakeholders in the delivery of behavioural support services. As the BSS Project evolves the members will interact across professions and across sectors to exchange knowledge about practice, collaboration and creative problem-solving. Activities, outcomes and lessons learned will be documented and shared across the health system.

Mobile Behavioural Teams (MBTs)

The BSS Project investment in health human resources will be directed towards the creation of three Mobile Behavioural Teams (MBTs) in NSM LHIN. The MBTs will provide urgent support to primary care providers, caregivers, community services providers, and LTCHs during a person's acute decline or behaviour change such that caregivers feel unable to safely manage.

Implementation of the three skilled MBTs with core competencies in behavioural supports located across the NSM LHIN ensures timely access to coaching or mentoring opportunities. Direct on-site hands-on support offers practical "teachable moments" in the living environment where the person with complex needs is presenting with responsive behaviour.

The three geographic MBTs will provide continuous learning opportunities in three ways:

- i) in a liaison and partnering role across providers and across sectors;
- ii) in a coaching and mentoring role with hands-on support for front-line staff; and
- iii) in an education and skill-building role.

i) BSS Liaison

One of the fundamental principles of change management is to gain the meaningful involvement of the people who will be most impacted to assist in its implementation. The MBT will liaise with health service providers across the health continuum to build partnerships and an understanding of their function in advancing the objectives of BSS in the new service system. The MBT will leverage the expertise and leadership of the designated PIECES trained staff and GPA Coaches that are currently in place to strengthen their role in knowledge transfer.

The current state in NSM is that there are behavioural supports available across the region provided by various agencies. However, access to behavioural supports varies throughout the region; waitlists for services can be lengthy and there is a lack of

consistent approach to behavioural interventions across the LHIN. Promoting knowledge exchange and best practices related to BSS with targeted learners across sectors will build extended capacity throughout the system.

The BSS Project will encourage health service providers serving older adults to identify a BSS Liaison leader(s) within their organization who will be the primary contact for information and knowledge exchange with the MBT; and, become a founding member of a broad virtual network of collaborative care in behavioural support. All designated BSS Liaison Leaders will be offered education in the foundational BSO principles of person-centred care, PIECES core curriculum, best practices in inter-professional care, and the concepts of quality improvement activities.

ii) Coaching and Mentoring

Each MBT will have the same core staffing and offer a consistent service approach as determined by the BSS Regional Operations and Quality Improvement Committee. Service linkages with other health (and non-health) service providers will be developed locally according to the culture and context of the sub-LHIN region.

Each MBT team would be comprised of the following members/disciplines:

| | |
|---------|---|
| 1 FTE | Psychogeriatric Resource Consultant – Team Lead |
| 1 FTE | Registered Nurses (in LTCHs) |
| 2-3 FTE | Registered Practical Nurses/Activationists in LTCHs only |
| 4-5 FTE | Behaviour Support Technicians (PSWs) in LTCHs only |
| 1-2 FTE | Community Behaviour Support Technicians (Behavioural Science Technician/Social Service Worker/Gerontology) |
| 1 FTE | Wendat Transition Program Behaviour Nurse |
| 1 FTE | Social Worker/Behaviour Therapist/RPN |

The PRCs play a pivotal role in the knowledge transfer processes in the BSS Project. They are identified as the Mobile Behavioural Team (MBT) Leads, with the current responsibility to continue the ongoing education and the individual case-based training for LTCH and community health providers, plus new responsibilities including:

- supporting the work of the PIECES trained staff and the new Community and LTCH RNs and Behaviour Technicians to problem solve, apply and test evidence-based care procedures in the care plan;
- coordinating behavioural support services within the MBT area in conjunction with the Waypoint BIRT and Community Support Team and other behavioural support providers in the region;
- acting as the key contact person and liaison with Centralized Intake and Triage;
- facilitating weekly MBT meetings in area and networking with other two MBTs; and
- continuing to support regional committees and structures (i.e., Dementia Network) and new committees/workgroups as required.

The RN/RPN and PSW (in LTCHs) or Social Worker/RPN and Behaviour Technicians (PSW in the community) will work in duos to meet with the resident and primary care staff. Behaviour assessments will be conducted by regulated health professionals. A

single plan of behavioural care will be established in consultation with the person with responsive behaviours and caregiver/care staff, other affiliated professionals/services (e.g., CCAC, attending physician), and the MBT with recommendations provided to manage the responsive behaviours. Using tracking tools and with support from the Quality Improvement Facilitator, the health service providers will collaborate in a team approach to monitor the effectiveness of the plan of care and adjust as necessary. The PSW will work within the established care plan and model the practical application of the behaviour management strategies to the primary caregiver.

With the natural in-situ modeling of best practice the PIECES trained staff will gain more experience and the skill level of the internal staff within organizations can be enhanced. With the support of the mobile behavioural teams, front-line staff will gain more experience and the skill level of front-line staff within organizations can be optimized. Over time, staff at all levels of the organization will become more confident about approaches and methods to support individuals with responsive behaviours and the need for more intrusive interventions (such as removing a person from their living situation) can be minimized.

It is important to note that in assessing behaviours the linkage with primary care is essential to rule out behaviour as a response to a medical issue (such as pain, medication effect, infection) or delirium. The primary care provider is an integral member of the circle of care throughout the person's journey across the care continuum.

When the interventions of the PRCs, BSS MBT members and PIECES trained staff are unable to manage the severity of behaviours, they may access the BIRT or Community Support Team geriatric outpatient resources of the mental health facility at Waypoint Centre for Mental Health Care.

Before a person is referred to BIRT, it is expected that the MBT has been involved and some preliminary behavioural strategies have been tried. BIRT accepts and screens intake referrals 24/7 and will go to the LTCH within 24 hours of admission to assess and develop a care plan.

Further, with the introduction of the new resources of MBTs it is anticipated that the increased capacity will allow BIRT to provide clinical services to more people with severe behaviours because the MBT will have already assessed, documented and tried behavioural management approaches prior to their involvement. The BIRT may potentially shorten their days of involvement because they can leave their care plan recommendations with the knowledge that the MBT members are available to help the caregiver implement the care plan and monitor the efficacy of the interventions.

Through the BSO Project the services of BIRT will be expanded to provide behavioural assessment and care plan recommendations to acute care settings (emergency and in-patient) throughout the NSM LHIN.

The Waypoint Centre Community Support Team provides treatment recommendations on a consultative basis and follow-up is arranged based on the complexity of care issues. Through the new resources in the BSS Project, the psychogeriatric outreach Community Support Team will have access to the MBT to support the caregiver to implement the care plan once the assessment is complete.

The MBT members will have the opportunity for continuous learning by consulting with the psychiatric resources of BIRT on a case-by-case basis to support people with challenging behaviours and their caregivers. In addition, the MBT, in collaboration with the Most Responsible Physician involved with the person living with behavioural challenges, may access Waypoint's Community Support Team for psychiatric consultation.

iii) Education and Skill-building

Through the BSS Project, the PRCs will continue to provide provincial curriculum education (e.g., PIECES, GPA, U-First!) and case-based training on dementia and managing responsive behaviours to regulated staff in LTCHs and community agencies so that they may maintain persons in their place of residence.

To ensure that future health professionals gain the skills and knowledge to work with older people with dementia and mental health issues/responsive behaviours, the Dementia Network Education Committee tracks current health care curriculum, advocates for program improvements and presents to students on dementia, mental health and associated behaviours, and best practice models of care.

The PRCs deliver bi-annual PIECES training for new regulated staff hired throughout the region across the sectors and organize a calendar of training opportunities throughout the year.

Working within the interprofessional Mobile Behavioural Team will naturally create a supportive learning infrastructure for the Team members. Weekly case-based reviews for existing clients and new referrals offers an incubator for creative problem-solving and innovative thinking

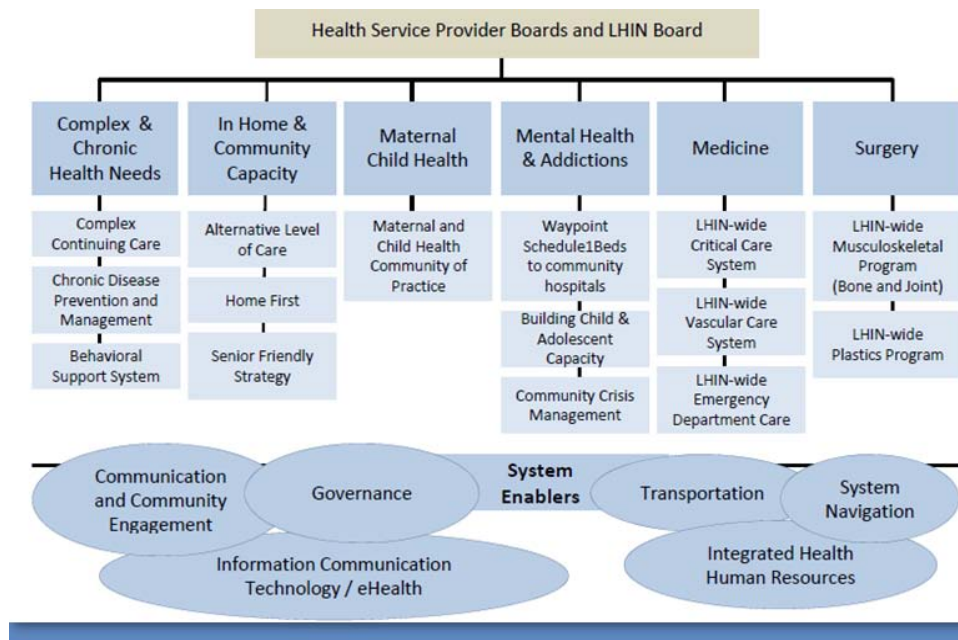
BUILDING ON CURRENT CAPACITY

Sustainability of Education and Knowledge Transfer for Organizations and Care Teams

There is incredible potential to build on existing partnerships, current capabilities and initiatives in the NSM LHIN which include but are not limited to the opportunities highlighted below.

- Care Connections Leadership Councils
The Behavioural Support System Project is fully integrated into an established leadership structure supported by the NSM LHIM. The Care Connections system design provides a mechanism for shared learning, planning, issues identification and decision-making across sectors and across the care continuum (Figure 6).

Figure 6: Care Connections Leadership Structure



- Regional Coordinators Group
There are several regional programs in the NSM LHIN such as the Integrated Regional Falls Program, Regional Dialysis Program, Regional Diabetes Strategy, Regional Stroke Strategy, Regional Complex Continuing Care, etc. The Regional Coordinators meet regularly to share resources (i.e., MOUs, service agreements) and problem-solve related issues. The BSS System Coordinator (new hire) will participate on this regional group to provide information and education re: behavioural supports across the whole system (and chronic illnesses).
- eHealth Ontario
NSM BSS Portal
Each registered member of the BSS Steering Committee and Regional Operations and Quality Improvement Working Group has access to a virtual BSS knowledge

exchange worksite. Members can share documents, host discussions, access and share resources, etc. in a common workspace at anytime 24/7.

Doorways

Doorways is an eHealth Ontario project that was successfully piloted for mental health consumers and health care providers across four LHINs (including NSM) working with Ontario's Community Care Information Management (CCIM) to establish a portal for service providers to securely share and access accurate health information electronically through a single point of access. The technology facilitates a common understanding of a client's needs and helps to improve the continuity of treatment and care across providers. The BSS Project key stakeholders can build on this initiative and develop a similar site for their client base.

- There are several well-established Networks/Committees in NSM with broad membership from health and non-health service providers that can inform the BSS Project and offer an excellent venue for knowledge transfer to support its successful implementation and sustainability. This includes (but is not limited to):
 - NSM Dementia Network
 - NSM Community Support Services Collaborative
 - NSM CCAC/Long Term Care Homes Committee
 - PIECES Collaborative Learning Network
 - Prevention of Seniors Abuse Network – Simcoe County and Muskoka
 - NSM LHIN Family Health Teams Committee

Sustainability of Education and Knowledge Transfer for the Individual and Caregiver

Through Aging at Home funding, the three Alzheimer Society Chapters in the NSM LHIN (Alzheimer Society of Greater Simcoe County, Alzheimer Society of North East Simcoe County, Alzheimer Society of Muskoka) currently share the employ of one full-time First Link® Coordinator and each Chapter employs one full-time First Link® Support Counsellor. The First Link® program is intended to provide access to comprehensive and coordinated services, education and caregiver supports 'up-stream' as early as possible after diagnosis to promote wellness and prevent cognitive decline.

The First Link® Coordinator builds relationships with referral sources in order to actively and formally link persons with dementia and their caregivers to the Alzheimer Society. The Alzheimer Society proactively supports referrals by reaching out to individuals and families (rather than waiting for a call).

The First Link® Coordinator will be closely linked with the BSS Project, and will connect community caregivers to Alzheimer Society education and support services staff to provide information, education and advice on behavioural management strategies.

The three Alzheimer Society Chapters in the NSM LHIN each employ one fulltime Public Education Coordinator (PEC). The PECs will be closely linked with the BSS Project and ensure that caregiver education is regularly scheduled and available in all areas of the NSM LHIN.

KNOWLEDGE TRANSFER PROTOCOLS AND TOOLS

The BSS Project will enable the standardization of protocols and tools for consistent application in practice across the care continuum. The NSM LHIN will work with the other three Early Adopter LHINs to identify tools that are commonly administered across the province and find consensus on tools/protocols to set as a provincial expectation for use in the implementation of the BSO Framework.

The Regional Operations and Quality Improvement Working Group will review locally developed tools and resources currently in use among behavioural support providers in NSM to determine a common suite of evidence-based tools for the screening, assessment and care planning for behavioural supports.¹⁰

Consistent application of the best practice tools and protocols (both provincial and local) will be enabled by the hiring of the BSS System Coordinator; creating a centralized intake, triage and referral function with common risk screening and access mechanisms; and the roll-out of the Mobile Behavioural Teams across NSM.

PARTNERS FOR KNOWLEDGEABLE CARE TEAMS AND CAPACITY-BUILDING

The Waypoint Centre for Mental Health Care has established a Research and Academics Department in affiliation with the University of Toronto. Two recent research studies include: 1) the management of severe aggressive behaviours, and 2) evidence-based risk assessment tools for practice.

Georgian College (located in Barrie) offers several relevant programs to the BSS Project; the Personal Support Worker, Developmental Services Worker, Social Service Worker, Addictions Treatment and Prevention, and Therapeutic Recreation programs. Georgian College also offers a Bachelor of Science in Registered Practical Nursing degree, in collaboration with the University of Ontario Institute of Technology, and a Bachelor of Science in Registered Nursing degree in collaboration with York University.

The Northern Ontario School of Medicine and the Ontario Telemedicine Network offer videoconference education credit courses and events on a range of topics; for example, the application of inter-professional and collaborative care to specific populations.

The Alzheimer Knowledge Exchange BSO Project website offers provincial expert resources and facilitates ongoing knowledge exchange and knowledge transfer among families, caregivers, educators, and health providers in the field.

¹⁰ The NSM CCAC and NSM Psychogeriatric Resource Consultants have developed an excellent RAI-MDS/PIECES combined assessment tool that maximizes the RAI data in the care of persons with dementia and associated behavioural change.

PROPOSED DEPLOYMENT OF BEHAVIOURAL STAFFING POSITIONS

It is agreed that a structure must be in place to oversee the day-to-day operations and monitor the performance of the implementation of the BSS Project. Outcomes are a collective accountability of all of the partner agencies funded through the Behavioural Supports Ontario Project.

To this end, several positions will need to be created in order to facilitate and resource the work and provide the operational leadership and credibility that the system will require. The key positions on the Leadership Team responsible for operations of the BSS include:

- 1 FTE BSS System Coordinator
- 0.5 FTE Regional Medical Advisor (alternate funding source)
- 1 FTE Quality Improvement Facilitator (NSM LHIN position)
- 1 FTE BSS Administrative Support

BSS System Coordinator Key Responsibilities

Under the leadership of the BSS Project Steering Committee:

- Provide the overall administrative leadership in the implementation and coordination of regional BSS Project
- Ensure that within the available resources the BSS core components are functioning in place including: centralized intake/referral; mobile behavioural teams; access to specialized psychogeriatric resources; streamlined access to primary care, acute care, long-term care
- Establish clear referral pathways and improve transitions across the care continuum
- Ensure the standardization of tools and protocols across NSM
- Establish and maintain strong and positive cross-sector partnerships between all care components to promote service integration and system change of BSS
- Establish linkages with NSM BSS providers and other provincial BSO supports
- Identify system issues and areas for improvement

BSS Medical Advisor Key Responsibilities

Under the leadership of the BSS Project Steering Committee:

- Work with the BSS leadership to support and enhance quality of care
- Provide education and peer support re: older persons with responsive behaviours to LTCH Medical Directors and attending physicians to support rapid adoption of evidence-based practice
- Support and facilitate continuous professional development in identified clinical areas
- Liaise with acute care and geriatric psychiatry to address system issues and quality of care

Note: It is recognized that the BSS Medical Advisor key champion and advocate is an essential role in gaining support from physicians and in the delivery of a quality Behavioural Support System of care. The initial BSO Project investment of funds is limited; therefore the NSM LHIN BSS Project Steering Committee is actively pursuing an alternative funding source for this position.

BSS Quality Improvement Facilitator Key Responsibilities

- Responsible for the development, planning and execution of concurrent improvement initiatives per the NSM LHIN BSS Action Plan
- Guide the planning and execution of change management initiatives with Improvement Teams
- Collation, integration and synthesis of data for process, outcome and balancing measures
- Work with Health Quality Ontario Coaches

Note: This is an NSM LHIN staff position (accountable to the LHIN) funded outside of the BSO health human resources investment.

BSS Administrative Support Key Responsibilities

Under the direction of the BSS System Coordinator:

- Support the System Coordinator and Medical Advisor in clerical activities such as coordinating meetings, supporting correspondence, quarterly reports, communications to all partners, etc.
- Manage the BSS Portal for information sharing
- Centralize client information and generate aggregate data reports as required by the Mobile Behavioural Teams
- Support the BSS Project Operations and Quality Improvement Working Group in tasks such as recording and disseminating minutes, etc.

The leadership team will be employed (with the exception of the Quality Improvement Facilitator) through one health service provider (HSP) that operates as a host agency to the BSS Project (specific HSP is to be determined in negotiation with the NSM LHIN).

Role of the Host Agency

The host agency will provide the central administration function of the regional Behavioural Support System including staffing for the Leadership Team with the terms of the agreement with the NSM LHIN.

A host organization will provide the following:

- a. Overall management of the BSS, web resources and internal and external communication;
- b. Back-office support (including such functions as payroll, human resources, financial reporting, and legal counsel) and,
- c. Physical office space for administrative personnel that includes furnishings, computers, telephones and the infrastructure to support these functions.

The benefits of a host organization include:

- minimizing the additional infrastructure-related costs for the new BSS administration/operations; and
- providing an identifiable and accessible home base to carry out operations.

It is important that the host organization not hold any additional authority over the governance or operations of the system; the host agency will be an equal partner at the BSS Project Steering Committee; they do not OWN the service/program. As an equal partner, the host organization would sit on the BSS Project Steering Committee and the relationship between BSS providers, the host organization and the governance authority (Complex and Chronic Health Needs Coordinating Council) would be articulated in a *BSS Shared Governance Memorandum of Understanding*.

Each LTCH/HSP will retain their own staffing/hiring and deploy dedicated staff to the BSS Project through written agreements with the host agency in a matrix management structure. Personnel providing services within the regional Behavioural Support System Project will remain employees of their organization subject to its rules, collective agreements, and personnel policies and procedures. The partner organizations also agree that the personnel providing BSS services are employed for the purposes of fulfilling roles and achieving outcomes defined and approved by the Behavioural Support System Project Steering Committee. (This funding model allows BSS personnel to maintain their seniority within their own organization and continuity in their work.)

Centralized Intake, Triage and Referral

Free, multilingual public information and referral services (community, social, health, related government programs) may be accessed 24/7 by dialing 211 in NSM. The 211 services and North Simcoe Muskoka Community Care Access Centre have established a partnership to create seamless access to the CCAC health and personal support services. The BSS Project is designed to build upon this existing capacity and deploy one full-time health professional to the CCAC who has experience in geriatric care, in-depth knowledge of the behavioural supports in NSM, and an understanding of people with complex health needs and responsive behaviours.

Behavioural Support System Intake Coordinator Key Responsibilities

- Receive calls/referrals and assess the level of immediate risk to person with responsive behaviours and family/caregiver and/or service provider
- Provide telephone screening to determine eligibility for service
- Triage the urgency of response; schedule follow-up appointments with appropriate referrals (e.g. primary care provider, local Mobile Behavioural Team, community support service, etc.)
- Track data and monitor volume of demand as required

Mobile Behavioural Teams

The key responsibilities of the members of the Mobile Behavioural Teams (MBTs) have been outlined earlier in this submission. Continuing with our wish to leverage existing resources the complement of team members is comprised of existing health providers currently supporting older adults with complex health needs and responsive behaviours.

In order to move forward with equitable access to BSS supports throughout the region each MBT will be launched with a consistent core group of professionals. Over time, some positions may be re-deployed across the region according to volume demand to address local needs.

See the Budget to find an explanation of where investments are committed in order to create similar services across the NSM LHIN.

PERFORMANCE MEASUREMENT AND EVALUATION PLAN

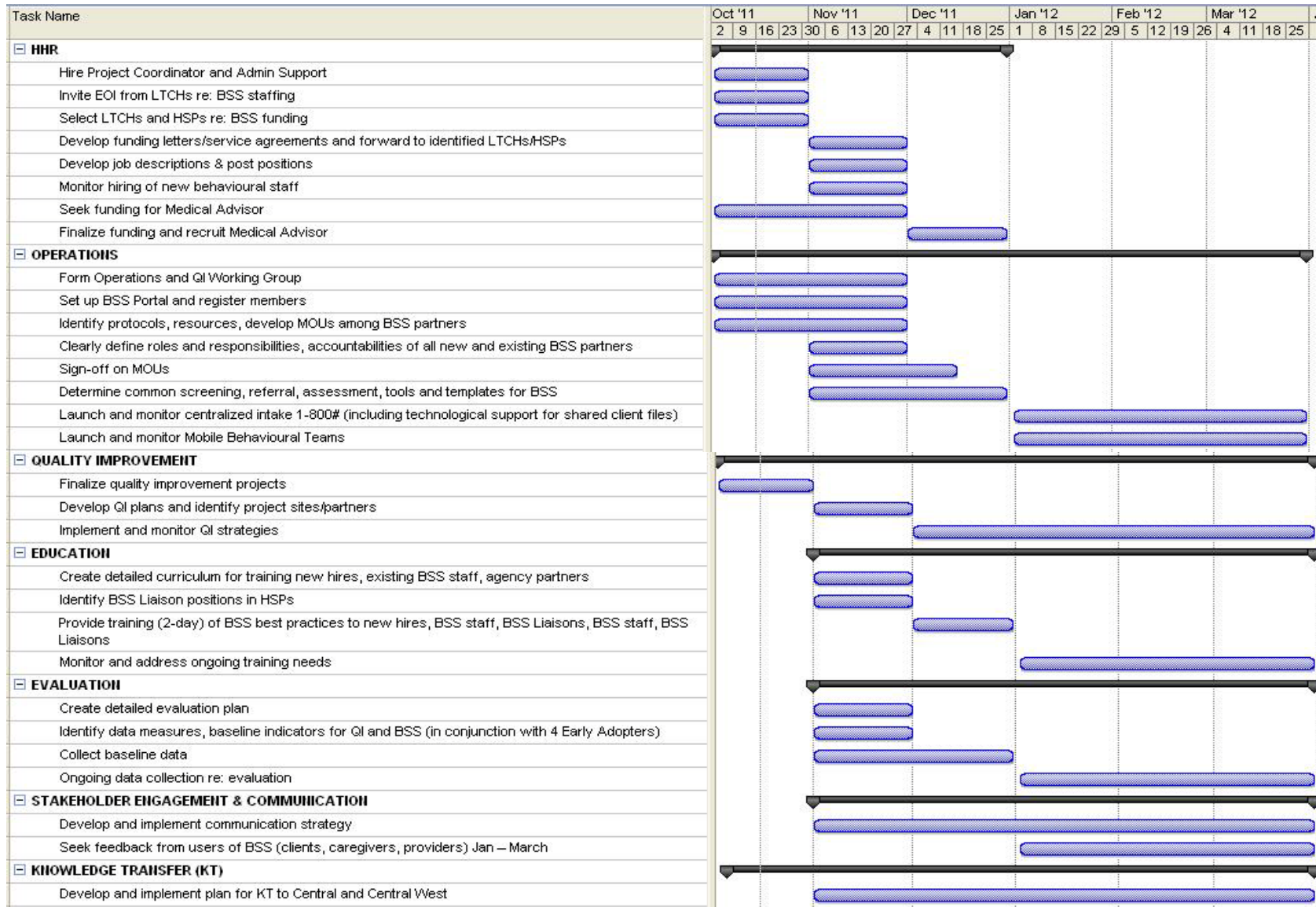
The quality improvement measures and evaluation plan will be determined by the BSS Action Plan Working Group by November 1, 2011. The members and BSS Improvement Facilitator will revisit the change management priorities developed at the Value Stream Mapping exercise in September. The Working Group will also review the performance measures that they are currently collecting on a monthly basis to find those most relevant to the BSS Project.

We will comply with any additional data measures/indicators that are determined through the provincial BSS Implementation Plan and as required by the provincial BSS Project Evaluation (2012).

BUDGET FOR DEPLOYMENT OF NEW BEHAVIOURAL RESOURCES

| Human Resources (Salary + Benefits @20%) | Fiscal Budget Nov/11 – Mar/12 | Annualized Budget 2012/13 |
|---|----------------------------------|--------------------------------|
| Host Agency (HSP to be determined): | | |
| 1 FTE System Manager/Coordinator | \$ 37,065. | \$ 88,945. |
| 1 FTE Administrative Support | \$ 21,666. | \$ 52,000. |
| HSP: NSM CCAC | | |
| 1 FTE Central Intake Coordinator | \$ 37,065. | \$ 88,945. |
| HSP: Collingwood General and Marine Hospital | | |
| 1 FTE Psychogeriatric Resource Consultant | \$ 37,065. | \$ 88,945. |
| HSP: Wendat Community Psychiatric Support Programs | | |
| 1 FTE Behaviour Transition Nurse | \$ 31,250. | \$ 75,000. |
| HSP: Alzheimer’s Society of Greater Simcoe County | | |
| 2.6 FTE @ \$75,000 Social Workers/Beh Therapists | \$ 81,250. | \$ 195,000. |
| HSP (to be determined): | | |
| 3 FTE @ \$50,000 Community Behaviour Support | \$ 62,500. | \$ 150,000. |
| Other Allied Health Professionals Subtotal: | \$307,861. | \$ 738,835. |
| Long Term Care Home(s) (minimum 1 to maximum 3 HSPs to be determined) | | |
| 3 FTE @ \$88,945 Registered Nurses (1 FTE per MBT) | | |
| | \$111,183. | \$ 266,835. |
| 7.33 FTE @ \$80,000 Registered Practical Nurses (2.4 FTE per MBT) | | |
| | \$238,818. | \$ 573,165. |
| 17 FTE PSWs @ \$40,000 per position (5.2 per MBT) | | |
| | \$283,333. | \$ 680,000. |
| Licensed Long Term Care Homes | Subtotal: | \$633,334. \$1,520,000. |
| NSM LHIN BSO Funding TOTAL: | | \$941,195 \$2,259,100. |
| Alternate Funding Source (to be negotiated) | | |
| 0.5 FTE Primary Care Medical Advisor | \$60,000. | \$ 120,000. |

SUMMARY TIMELINE: OCTOBER 2011 TO MARCH 2012



CLOSING

In closing, it is evident that the BSS project offers an amazing opportunity to harness the energy and commitment of so many people who are serious about creating a system of care for older adults with complex and challenging behaviours and their families. The past thirty-five days have been incredibly busy with many hours of meetings and discussion but it did not dampen anyone's enthusiasm – people have been working over twenty years to get to this day and they are ready to make this project a success. This is an exciting time in the history of our local health care system and we know that, "The best way to predict the future is to invent it ourselves."

Appendices

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|-------------|---|
| Appendix A: | Senior's Health Plan NSM July 2009 |
| Appendix B: | NSM BSS Project Steering Committee Terms of Reference |
| Appendix C: | Doorways Fact Sheet |
| Appendix D: | NSM LHIN Map – Catchment Areas for 3 Mobile Behavioural Teams |
| Appendix E: | NSM LHIN Table of Long-Term Care Homes by Beds and Geography |
| Appendix F: | NSM VSM Participants & Stakeholder Engagement Forums |
| Appendix G: | OTN Sites in NSM LHIN |

Figures

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|-----------|---|
| Figure 1: | Care Connections Coordinating Councils and Implementation Teams |
| Figure 2: | NSM Governance Structure |
| Figure 3: | NSM Service Delivery Design for Behavioural Supports |
| Figure 4: | Mobile Behavioural Team Members |
| Figure 5: | BSS Future State |
| Figure 6: | Care Connections Leadership Structure |

