Central East **LHIN**

Behavioural Supports Ontario Action Plan: EXECUTIVE SUMMARY

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Ontario
Local Health Integration Network

Central East Local Health Integration Network Behavioural Supports Ontario (BSO) Team

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Central East LHIN Behavioural Supports Ontario Action Plan

The Behavioural Supports Ontario (BSO) Project was created to enhance services for Ontarians with behaviours associated with complex and challenging mental health, dementia or other neurological conditions wherever they live – at home, in long-term care, or elsewhere. The goal of the project is system-wide reform that ensures these individuals are treated with dignity and respect in an environment that supports safety for all and is based on high quality and evidence-based care and practice. The provision of these services in long-term care homes must comply with the requirements under the *Long-Term Care Homes Act, 2007* relating to, amongst others, plan of care and responsive behaviours.

The Central East LHIN completed an Action Plan articulating our local approach to serving a behaviourally complex population directing these new resources toward targeted service enhancement among identified health service providers. During the development of the Action Plan, the LHIN benefitted from quality improvement guidance by Health Quality Ontario (HQO), knowledge transfer and knowledge exchange resources provided by Alzheimer Knowledge Exchange (AKE) and BSO knowledge transfer conferences.

The Central East LHIN believes it has a sound and results-oriented Action Plan that will result in positive changes for people requiring support with behavioural issues. The experts and frontline workers engaged in our Value Stream Mapping process, the BSO Advisory Committee and the BSO Design Team have discussed opportunities for improvement throughout the continuum of care from prevention and health promotion to tertiary treatment in all care settings. Our initial focus on long-term care provides an opportunity to leverage existing resources that are already available in this sector and to distribute and leverage new nursing and personal support worker resources with the funding provided by the Province.

As agreed by the Four LHIN Early Adopter Steering (FLEAS) Committee and HQO, our plan provides more detail on one important component of care (namely the care provided to residents within long-term care homes [LTCHs]) and seeks to leverage the knowledge gained by other early adopter LHINs who focused on community care first. It is worth noting that it was our Design Team that chose to focus on LTC as an outcome of the SIPOC (Suppliers, Inputs, Processes, Outputs, Customers) exercise led by HQO quality improvement coaches who were charged with coordinating the Value Stream Mapping and Analysis (VSMA) processes across 4 LHINs to avoid duplication and ensure coverage across the entire system. The Long-Term Care (LTC) focus targets an identified current need and future growth in this resident population and aligns with the available human resources and LTCH funding policy. Nonetheless, in this document we have enhanced the description of the LTCH portion of the BSO model and further described components of our community model.

The BSO Design team recognizes there is a need to balance a quality improvement “bottom up” approach (which optimizes the opportunity for system change) and an expert driven “top down “ approach (which highlights apriori decisions across the full breadth of the project scope). In a project with compressed timelines

it is difficult to strike the balance of the need to communicate the robustness of the model to decision makers without compromising the requirement for buy-in from providers at the frontline.

The BSO Design Team and Central East LHIN appreciate the strong support for the Action Plan that was articulated by HQO and are proud of the willingness of our key stakeholders to embrace the quality improvement methodology.

Central East LHIN BSO Integrated Care Team

The BSO Integrated Care Team will ensure equitable timely access for seniors struggling with challenging behaviours to a comprehensive basket of specialized psycho-geriatric services through an interdisciplinary team that works with a designated number of LTCHs.

The Plan builds on existing initiatives: Home First, Senior Friendly Hospital, Geriatric Emergency Management (GEM), Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT), First Link etc. BSO is an opportunity to build on these existing related investments, and to others including Residents First, Home First and the ER/ALC Strategy.

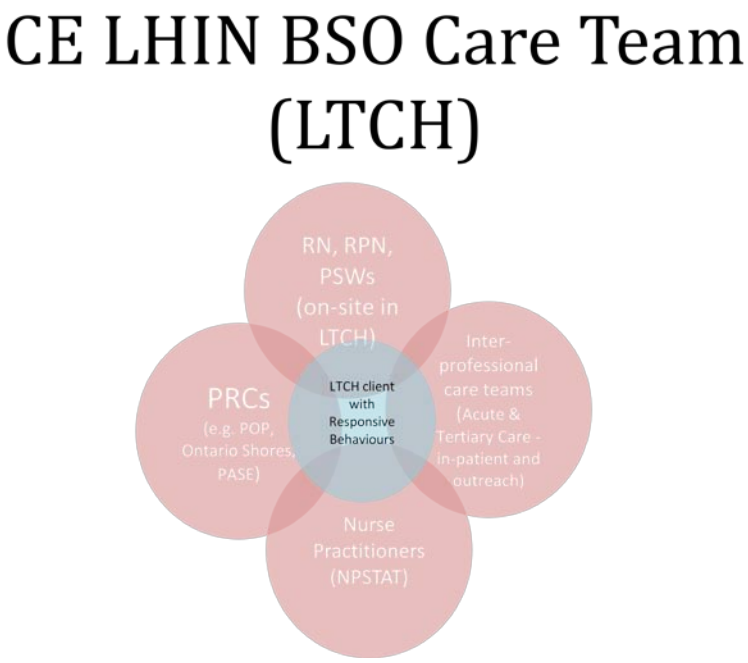
The inter-professional BSO Care Team will function as a "virtual" team in each of the service hubs identified and will be comprised of a number of professionals including Occupational Therapists (OT), Physical Therapists (PT), Behaviour Therapists, Physicians, Nurse Practitioners, Psychogeriatric Resource Consultants, Behavioural Support nurses, and Personal Support Workers.

Although the BSO Integrated Care Team will be comprised of the professionals listed above, these staff will not be employed in a single agency but rather will collaborate to implement a comprehensive care plan and a standard education program for all members of the 'virtual' team so both clients and providers can benefit from the advantages of the new pathway of care as described in the Future State Value Stream Map.

For example, it is expected that the behavioural supports for LTCH residents will include an acute care team from a local hospital; a nurse practitioner from NPSTAT; behavioural support nurses and PSWs from Long-Term Care (including the new human resources); and psycho-geriatric resource consultants from local agencies that provide education and training. These practitioners will be expected to form an accountable and unified team around clients within identified LTCHs and complete quality improvement projects to map out new patterns of care and collaboration that will meet the requirements of the Future State.

- Acute Care Team: provides both outreach to long-term care and in-hospital care when required. This team includes psycho-geriatricians, behavioural nurses, OTs, PTs and Behaviour Therapists.
- NPSTAT Nurse Practitioner: provides timely response to LTC to conduct assessments for residents with escalated behaviours and initiate medical care as appropriate;
- Behavioural support nurses and PSWs: will provide dedicated in-house care over evening and weekend hours when possible and serve as an expert resource for education and capacity building opportunities; and
- Psycho-geriatric resource consultants to provide expert input to care plans and education opportunities.

Although initiatives that have developed from previous Central East LHIN investments in seniors care - GEM (Geriatric Emergency Management) Nurses, Geriatric Assessment and Intervention Network (GAIN) and activities related to the Home First philosophy - may not be formally represented on the BSO Care Team for LTC, some will be directly involved in the community model and staff experienced with these initiatives will definitely be valued members of the Improvement Teams. Similarly, existing experts in the community will be thoroughly integrated in the quality improvement team during the service redesign process for the BSO model in both LTC and the community.



Central East LHIN was one of the early adopter LHINs for the Residents First Program and has continued to provide leadership and support to the Central East Long-Term Care homes that have been active in the program. Thirteen homes participated in Quality Improvement Collaboratives and over 50 are currently engaged in the Leading Quality component of the Residents First program. The Central East BSO Project Lead is also the Residents First Lead, Chair of the Residents First LHIN Lead Working Group and a member of the Residents First Steering Committee. Information and insight learned through the Residents First program, established relationships and regular meetings with the Central East QI Coach have and will continue to inform the BSO planning and implementation process with information, lessons learned and other insights to how a quality improvement process design can positively impact the success of the BSO project.

Long-Term Care Home Model of Care

The Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW) identified in the Ministry funding letters will be deployed to 13 LTCHs within 3 clusters across Central East. The staff will be dedicated to the BSO initiative and will be expected to serve as members of the BSO Integrated Care Team and relevant improvement projects designed to meet the Future State. Details are provided in the HR

Deployment and Budget. Non-LTCH staff include behavioural support therapists, PRCs, NPs, BSO System manager/coordinator and social workers/community behaviour support.

The QI process to enhance inter-professional practice was first described in a Gantt Chart and in a table that described each of the original 13 projects identified at the VSMA session. The Gantt Chart was updated in the submission of Pillar 3 and has again been modified by the Design Team. Once approval has been received the Improvement Teams will be formed, project charters and schedules will be updated and work will begin.

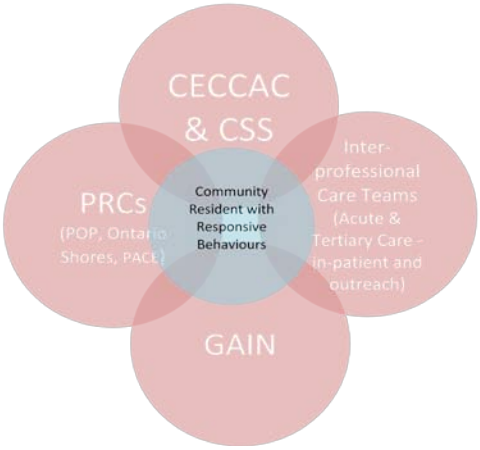
It has been the overwhelming sentiment in all engagement activities to-date that the BSO Model of Care provides an opportunity for existing resources to become focused, coordinated and efficient. Rather than being provider focused, the Central East Action Plan is based around the individual client and articulates a process to bring existing resources to bear on the delivery of the Future State. Only through the rigorous processes of QI can the details of inter-home collaboration be implemented. Furthermore, funded LTCHs are expected to collaborate with both funded and non-funded homes within their geographic area for training and education. These expectations will be articulated in the funding letters for all homes receiving BSO funding and the mechanisms for this collaboration will be identified going forward.

Community Component of BSO Model

In addition to learning from the experience of other early adopter LHINs, the Community Component of the Central East LHIN BSO model will be informed from the lessons of the LTCH client model. As the LTCH model evolves many processes will be developed and implemented that will be repeatable for the community. For example, results from priority improvement projects such as Develop Training, Education and Support; Create "Virtual" BSO Team; Comprehensive Assessment and Process; Develop Plan and Implement Care; Discharge / Transition Planning and Support Family Education and Coping can be directly applied to shaping the care of community clients and the roles of community-based care givers.

The BSO Integrated Care Model for the Community will have a similar structure to the LTCH model. The client will be at the centre of the model with the BSO Integrated Care Team "wrapped around" the client. The main components of the Team will include the Acute/Tertiary Care (inpatient and outpatient) and Psychogeriatric Resource Consultants just as with the LTCH model. Hence, these team members will be able to build on their knowledge and new processes gained through the development and implementation of the LTCH BSO Integrated Care Team and transfer that experience to new Community BSO Integrated Care Team members. The NPSTAT and LTCH Behavioural Support human resource components of the LTCH model will be replaced by Geriatric Assessment and Intervention Network (GAIN) and the Central East Community Care Access Centre (CECCAC), Community Support Services and other community resources (such as the Alzheimers Society's First Link Program) in the Community model. Just as with the LTCH model, the Community model will leverage existing programs to support the planning and functioning of the Integrated Care team.

CE LHIN BSO Care Team (Community)



The CECCAC has a long history of supporting seniors with behaviours who reside in the community. As the system navigators, CECCAC Case Managers assess, identify and link seniors with challenging behaviours to appropriate resources and programs within the community, refer clients for psycho-geriatric assessments, outreach, mental health programs and support services, and devise individualized care plans to meet the needs of the client, substitute decision-maker and family.

CECCAC also acts as a resource and provides direction to their partners such as LTC Homes, Hospitals and community agencies surrounding issues of Consent and Capacity for LTC and the management of clients with challenging behaviours.

As stated under Section 1, “GAIN clinics will be a critical source of expertise and resources and will complement the development of the processes and supports within the BSO project [particularly as the project expands to include the Community]. GAIN members will be asked to participate in the ongoing quality improvement processes within Central East [and are participating on the BSO Advisory Committee and Design Team]”; and “First Link will provide knowledge exchange, information and coordination services for client groups aligned with the BSO project [and will be actively involved in the improvement projects as the program expands into the community]”.

In addition to those mentioned above, programs with new investments such as the Assisted Living Services for High Risk Seniors ($2.5M annualized new funding in 2010/11) will be included in the development and implementation of the BSO Model in the community.

As an example of existing links with current community programs and providers, the GAIN is now building out relationships with primary care providers in the Central East LHIN for scheduled and emergent assessments and follow-up. In Q1, the four GAIN sites combined received 240 referrals from primary care.

Human Resource Deployment and Budget

The review and analysis of human resource allocation was approached in two parts: I. LTCH – RNs, RPNs and PSWs; and II. Other Health Care Providers.

I. Long-Term Care Homes – over 40 of the 70 LTCHs in Central East LHIN were represented at the BSO Stakeholder Engagement Event held on September 26th where all HSPs in Central East were invited to attend. Providers were informed of the BSO project, presented the quality improvement processes to-date including the future state value stream map and quality improvement plan, and LTCHs were invited to submit "readiness assessments" if interested in hosting BSO staff. This invitation was extended to all LTCHs in Central East.

Review of Selection of LTCHs followed a five step process:

1. Readiness Assessment - The readiness assessment asked a serious of questions aimed to provide information on the experience of the home with respect to behavioural support services, quality improvement, and partnerships, and the ability and willingness to hire staff and participate in the BSO program. Submission required both the CEO/ED and Medical Director sign-off.
2. NPSTAT in-depth survey – NPs asked specific in-depth questions of LTCH staff for homes affiliated with the NPSTAT program and provided details of experiences working with LTCHs across Central East.
3. Key Informant Interviews – Key informants from Psychogeriatric outreach services, NPSTAT and the CECCAC were interviewed to determine willingness, cooperation and results of LTCHs across Central East.
4. Geographic analysis – Geographic location and size of each LTCH was a key consideration in determining distribution of resources according to need and ability to participate in and contribute to the development of the BSO model locally.
5. Review of Compliance Issues and Refusals – Once a short list of eligible LTCHs was established, the Compliance record of each home was reviewed to determine if any care issues had occurred which would indicate inappropriateness or lack of readiness of a home to participate in BSO. Similarly, the recent track record for homes refusing clients with behaviours was investigated to determine willingness and capability of supporting the targeted client group.

The extensive selection process has resulted in the identification of 13 LTCHs that fit the selection criteria. Provision of RN/RPN and PSW staff to these homes will directly support care for over 2400 residents including over 1000 with identified behavioural issues.

Details of deployment of HR and funding to LTCHs are attached.

Budget for Deployment of New Behavioural Resources - 3 Cluster Model

Cluster	Number of Targeted Long-Term Care Homes	# of Residents	# with Behaviours	Percent with Behaviours (%)	Total RPN/RN to be deployed (FTE)	Total PSW to be deployed (FTE)
Durham	3	505	117	23.2	2.5	3
North East	5	701	403	57.5	8.2	9.3
Scarborough	5	1250	526	42.1	9.5	10.2
	Total	2456	1046	42.6	20.2	22.5
Funding Totals					$1,527,300	$1,200,000

Of the 13 homes selected, 9 participated in the Residents First Quality Improvement Collaboratives, 5 homes have an identified staff member filling the Improvement Facilitator role and all homes currently participate in the Leading Quality component of the Residents First program. Furthermore, all 13 homes have signed memorandums of understanding with NPSTAT. These negotiated agreements will facilitate participation of these Homes in the BSO design phase and in the provision of care by Nurse Practitioners as contemplated by the BSO Future State.

II. Other Health Care Providers

The list of other health care providers (non-LTCH) to be funded was informed by the Value Stream Mapping and Analysis exercise and the early work of the BSO Design Team in identifying members for the BSO Integrated Care Team.

Funding for Other Healthcare Professionals has been allocated to the Central East Community Care Access Centre; staffing complement, hiring process, and timing will be informed and confirmed through the engagement of Integrated Care Teams in their quality improvement projects. Other Healthcare Professionals staffing details are described in the table below.

Allocation of Additional Healthcare Personnel

Human Resources	Funded Health Service Provider	FTE
System Manager/Coordinator	CCAC	1.0
Administrative Support	CCAC	1.0
Improvement Facilitators	CCAC (1 per CE LHIN cluster)	3.0
Nurse Practitioner - NPSTAT	CCAC	3.0
Psychogeriatric Resource Consultant	CCAC (1 per CE LHIN cluster)	3.0
Behavioural Therapist/Social Worker	CCAC (1 per CE LHIN cluster)	3.0

Further Details

- Individual funding letters will clearly describe the accountabilities of providers in order to ensure the accountabilities of both the LHIN and HSPs are met according to the requirements set out in the letter to the Central East LHIN CEO re: "Amendment to the Ministry-LHIN Performance Agreement 2010-2012 – New Behavioural Staffing Resources for the Behavioural Supports Ontario Project".

- From a governance perspective, the Central East LHIN BSO Project Lead is a member of and is responsible for ensuring the BSO Design Team completes the Action Plan and lead Implementation of an approved plan. The Central East LHIN Senior Director, System Design and Implementation, is the Executive Lead on the BSO Project and is accountable to the CEO and ultimately the Central East LHIN Board for the design and implementation of the project. Furthermore, the BSO Design Team will receive direction from and report to the BSO Advisory Committee (of which the Executive Lead is a member) which ensures a link to the Central East LHIN organization and its accountability processes as outlined above.

- Without reviewing every agency that was named throughout the Action Plan, it is safe to say that all or almost all have been engaged at some level in the development of the Plan. The 2-day VSMA session in Belleville was attended by over 30 Central East LHIN providers and several Central East LHIN staff. Providers were from Long-Term Care (6 homes; 13 staff); the community (Alzheimer's Society, 1 staff and CCAC, 2 staff); acute care (4 hospitals; 9 staff); tertiary care (Ontario Shores; 5 staff including a physician); NPSTAT (nurse-led outreach teams; 4 NPs). The BSO Design Team is drawn from an 18 member Advisory Committee and includes members from LTC (2); Acute Care (2); Psychogeriatric Outreach (2); Nursing Outreach to LTC (1) and the CCAC (1) and belong to organizations or networks outlined in Section #8 of Pillar 3 such as the following: Psychiatric Assessment Services for the Elderly;

Dementia Network Coordinating Group – Central East; Durham Region Psychogeriatric Resource Consultants Program; NPSTAT.

- The draft Future State Map and draft implementation plan was shared with over 100 health service providers from across Central East at a community engagement meeting and the participants were invited to submit questions, issues and ideas about the Central East LHIN BSO Action Plan. The 68 written responses have been collated, summarized and ranked by Cluster and have informed the development of the Action Plan.

- Our experience with other LTCH projects is that the level of the medical director's involvement is critical to success and that is the rationale for including the "medical director's willingness to participate or allow home to participate in BSO Action Plan" as one of our selection criteria.

- We had not contemplated using mobile teams that would serve both the LTC and community sectors but agree that clear accountability with the Ministry funding letters is required. There is a stated requirement for homes within geographic hubs to collaborate on building the Care Team and in planning for training and knowledge exchange as a priority improvement project (see BSO Gantt chart) – Develop Training, Education and Support (LTC staff). This collaboration is expected to spread to homes who will not be receiving additional HR resources as well.

- From the perspective of implementation of BSO into the LTC sector, we will continue to pursue the knowledge gap that exists for all LHINs about the actual rate of key indicators for behaviours such as, for example, ED transfers, use of High Intensity Needs Funds, Form 1 completions and police interventions. Our Current State Mapping exercises identified where protocols were non-existent or inefficient and we will definitely focus on completing standard protocols to ensure consistency of approach using best practices through the identified improvement projects (see BSO Gantt Chart): Comprehensive Assessment and Process (medications/behaviour); Develop Criteria and Process to Access Staff; Develop Plan and Implement Care (crisis and ongoing); and Standardize Reporting and Communication.

- From the community perspective, it has been an often discussed topic at the Behavioural Supports Ontario Design, Measurement and Evaluation committee that the actual prevalence of behaviours in the community is not known. Our anecdotal information from our Advisory Committee and key stakeholders confirms the reports from the Alzheimer's Society and elsewhere that suggests that there is a substantial and growing population within Central East. We will continue to collaborate with the other early adopter LHINs and pursue information through the CECCAC and primary care information sources to help describe the care needs of the community dwelling population requiring behavioural supports.

BSO Funded Long-Term Care Homes

<u>Durham</u>

- The Wynfield LTC
- Ballycliffe Lodge
- Community Nursing Home Pickering

North East

- Fairhaven
- Riverview Manor
- Caressant Care McLaughlin
- Victoria Manor Home for the Aged
- Streamway Villa, Cobourg

Scarborough

- Sheppard Village
- Yee Hong Centre for Geriatric Care
- Trilogy LTC Residence
- Bendale Acres
- Seven Oaks LTCH

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