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Q4 Project Quarterly Reporting
Behavioural Supports Ontario - CRO
Page 1
Name of Project: Behavioural Supports Ontario Project

Reporting period: (Q4: January 31, 2012 to March 31, 2012)
Executive Summary

In Q4 the Behavioural Supports Ontario (BSO) Project transitioned from conceptualization and development to implementation and operation. As at end March 2012, the four Early Adopter LHINs have had approximately five months of implementation since their Action Plans were endorsed at the end of October. Next 10 LHINs have been implementing for almost three months. All 14 are already showing positive and meaningful system impacts that will change the way people living with complex and responsive behaviours across Ontario, including their families and caregivers, are cared for and supported.

The BSO project made dramatic gains on service redesign, health human resources recruitment and culture change in 14 LHINs. These gains have been built upon a foundation anchored on quality patient-centred care that is aligned with both Ontario’s Action Plan priorities and the Triple Aim of providing Better Care...Better Health...Better Value.

BSO breaks down barriers rather than perpetuating silos, encourages collaborative work rather than rivalry, shares knowledge rather than working independently, fosters partnerships among local, regional and provincial agencies and speaks to a new way of thinking, acting and behaving. This is a new culture. BSO is transforming service delivery systems in all LHINs. Q4 was about changing these mechanisms so that comprehensive service delivery outcomes can emerge through future reporting.

In Q4 BSO has been testing “the concept” – the framework – and developing new knowledge (Lessons Learned - Section 4.3). In Q4 LHINs put new tools, products and processes into development (Appendix B). At present success can be found in the anecdotes arising from rapid cycle deployment across all LHINs.

### BETTER CARE
- Central: “The positive change in my wife has been by leaps and bounds...caregivers are making a concerted effort to see what interests her and what she may need. This program has allowed her to regain her dignity.”
- HNHB: Continuing the use of a gentle approach, the BSO Team approached “Maria” to help her and within a few minutes she was getting herself dressed no struggle, no frustration no aggressive or responsive behaviours.
  - 262 new staff hired.

### BETTER HEALTH
- Dozens of new intersectoral improvement initiatives.
  - Erie St. Clair: a formal protocol for LTCH residents accessing psychiatric care overcomes workplace limits and distance to improve hospital discharge planning.

### BETTER VALUE
- 312 LTCHs with enhanced in-house behavioural supports.
  - Over 3,800 front line staff trained in behavioral supports.
  - Anecdotal evidence of reduced length of stay for LTC residents in hospital.
An immediate next step for the project is the development during Q1 of activity tracking processes for common service enhancements, including staff strength and clients served for each initiative (Quantifying BSO Activity – Section 2.4). Designed to augment existing reporting mechanisms, standardized activity reporting will reveal the escalation of activity linked to BSO that precedes measureable impacts in the project’s outcome indicators. Activity tracking will provide data for assessment of BSO impacts in the short-term until the BSO Evaluation begins in the medium-term to reveal changes in process indicators, and changes in system-level client outcome indicators in the longer term.

The Q4 report includes four chapters and four appendices, together providing a comprehensive review of progress up to and including March 31, 2012. Chapter 1 provides a general project overview including a look at the notable ingredients that have gone into BSO’s recipe for success over the past year. Sections 2 and 3 focus respectively on Quantitative results (including Behavioural Support Units, Health Human Resources and quantifiable BSO activity both direct and in-kind) and Qualitative impacts (including quality improvements arising from knowledge exchange, education and training). Section 4 covering Project Management includes a review of risks, opportunities and the lessons learned that will allow project participants to continue holding the gains.

When two roads diverge, a choice has to be made, and it takes courage to follow the one less travelled. BSO has chosen to act courageously - to embrace the need for change, and it has made all the difference.
1. BSO Overview

1.1 Project Description

The overall goal of the Behavioural Supports Ontario (BSO) project is to enhance health care for Ontarians with behaviours associated with complex and challenging mental health, dementia or other neurological conditions wherever they live—at home, in a long-term care home or elsewhere. Central to the success of the project is creating a system that ensures people 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 practices.

The $40 million provincial Behavioural Supports Ontario investment will allow local health service providers to hire new staff—nurses, personal support workers and other health care providers and train them in the specialized skills necessary to provide quality care to these residents/clients.

Project Reporting and Accountability

The North Simcoe Muskoka (NSM) LHIN is accountable to MOHLTC for leading the Behavioural Supports Ontario Project. In partnership with the Alzheimer Society of Ontario, Alzheimer Knowledge Exchange, and supported by the Health Quality Ontario, Project coordination and reporting is being led by the Coordinating and Reporting Office (CRO), NSM LHIN. CRO is responsible for the implementation and evaluation of the BSO project by ensuring consultation, liaison and oversight throughout the implementation of Phase 2 BSO project.

The Committee Structure Includes...

- Coordination and Reporting Office (CRO) Advisory Committee is the oversight group which has authority to make project-level decisions.
- Provincial Resource Team (PRT) is a clinical resource and advisory body for the CRO.
- Four LHIN Early Adopter Steering (FLEAS) Committee is a table for problem-solving and joint strategy among the four early adopters to support successful implementation. Next 10 LHINs are invited to participate at alternating meetings on subjects of common interest to all LHINs.
- Health Human Resources (HHR) Committee facilitates and supports the recruitment process provincially for the hiring of the health professionals.
- Data, Measurement and Evaluation Committee (DMEC) provides strategic direction to the Impact Assessment (“Evaluation”) of the BSO Project’s implementation phase (August 2011 – December 2012). DMEC provides subject matter expertise, strategic direction and recommendations to FLEAS Committee regarding project evaluation.
- Communications and Knowledge Exchange Working Group provides subject matter expertise, strategic direction and recommendations to the CRO on all matters related to communications and knowledge exchange.
- Long-Term Care Provider Advisory Council is a monthly forum for representatives of the Ontario Long-Term Care Association, Ontario Association of Non-profit Homes and Services for Seniors, Ontario Long-Term Care Physicians, the Ontario Association of Community Care Access Centres and the CRO. Members collaborate on the BSO project as it affects long-term care homes and CCACs with the goal of improving support to older Ontarians with challenging behaviours.
Recipe for Success

More often than not, many ingredients go into the making of a successful recipe. So too are there many components that go into the making of a successful project. BSO is no exception. Here are some of the many ingredients that have gone into the BSO recipe for success this past year.

<table>
<thead>
<tr>
<th>Ingredients</th>
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| **Environment & Culture** | Across the Province, there exists an appetite to create sustainable and meaningful change through BSO; and so it is, that the following ingredients have gone into the BSO recipe with great care:
| • Readiness for change and engagement - all organizations/sectors are driving the initiative.  
• Managing change - collaborate rather than being directive and task focused.  
• Align and leverage - existing government initiatives/priorities and leverage local initiatives.  
• Enthusiasm and commitment by key stakeholders - target population affects all parts of system and sees need for redesign.  
• Listen - to ‘voice of consumer’ at all stages.  
• Collaborate and communicate essential ingredients - buddy LHIN model, key stakeholders and service providers across system are all part of solution. |
| **Project Planning** | Recipes are mostly successful when planned out with clear understanding of what is needed and what to do if something goes wrong. And so, in as much as directions are a critical component toward the preparation of a recipe, so too is thoughtful planning necessary to the success of any project. The following are among the essential planning ingredients that have gone into the BSO recipe:
| • Project plan - with clear expectations, deliverables and realistic timeframes.  
• Timely access to information/knowledge transfer through project office and across LHINS.  
• Effective development and balance – with focus on all x3 Framework principles at the same time.  
• Capacity - to review work… Flexibility to alter/adjust plans… Ability to revisit decisions and course correct where correction needed. |
### Engagement of HSPs

Cooking for and by is never fun... cooking with and for others is. When you engage people to be part of the process, it just simply tastes better. Such has been the case with BSO whereby stakeholders from across all sectors and at all levels have come together to be engaged in a process – the crafting of a recipe, that will forever change the way in which we approach the care of people with responsive behaviours.

- Early engagement of LTCH sector including LTCH local networks, provincial associations.
- Invite senior level decision-makers from across sectors to the same table including primary and acute care sectors.
- Involve front-line LTCH staff and unions early in process and communicate early about roles of BSO workers i.e., in-house or Mobile teams.

### Process

You might want to create a memorable recipe, and have a plan to make it. But, the plan is in the process – the directions. Desire and preparation is not enough without a step-by-step process to get you there. This is the case with BSO:

- HQO level of support and Improvement Facilitator have been critical components to the project.
- Momentum was built and has been maintained, in part, through Value Stream mapping and Kaizen events – testing the models that demonstrated benefit to the client.
- Broad community engagement and ownership by stakeholders.
- Expert resources part of process to provide timely advice and direction i.e PRT.

### Teamwork and Knowledge Transfer

Sometimes, too many cooks spoil the broth. When you are preparing a meal for many people, operational effectiveness, along with quality output, is dependent upon the clear delineation of roles, responsibilities, accountabilities and outcomes. Such is the essence of effective teamwork at BSO:

- Leadership – objectively, from outside the LHINs to guide the project and assist with bringing partners to table.
- Internal strength – with dedicated resources to BSS project.
- Support of provincial infrastructure and unified provincial voice to manage and resolve issues.
- Buddy LHIN system, structured knowledge exchange opportunities
- LHIN-wide performance measures established across the Province.
1.2 Program Alignment with Government Priorities

The BSO Project aligns with the current direction and priorities of our Provincial Government. The BSO foundational framework for care and subsequent service redesign work mirrors the recommendations put forward in recent research and reports to ultimately result in better health, well-being and experience of individuals with ‘responsive’ or challenging behaviours. Key alignments include:

- Ontario’s Action Plan recently announced which includes the following priorities: keeping Ontario healthy, faster access and a stronger link to family health care, right care, right time, right place
- The Provincial Budget and the resources allocated within the budget to meet the needs of the population living with complex and chronic health conditions (the 1% of the population that currently takes 34% of Ontario’s health care budget) The target population of BSO is the population identified in the 1% - those living with health challenges, including cognitive, functional and mental illness.
- Dr. David Walker and Professor G. Ross Baker’s reports (2011) recommend system redesign to meet this population’s needs
- The Drummond Report makes recommendations for those individuals living with complex and chronic health conditions
- The Institute for Healthcare Improvement (IHI) – Triple Aim Framework – keeping the focus centred on the population’s care needs while working together to achieve better health, better care, better value for the health system supporting this population.

The BSO project is committed to improving the capacity for older adults to live independently and reduce readmission rates; thereby resulting in a better care experience for older adults and their families. To meet this end, the BSO project addresses a key Walker (2011) recommendation in Caring for Our Aging Population:

<table>
<thead>
<tr>
<th>Capacity Building</th>
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<tr>
<td>Some of the best recipes are those that have been passed down from generation to generation, built upon and improved through refinement of ingredients and the sharing of information over time. BSO is no different.</td>
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<tr>
<td>- The success or failure of capacity building approaches is not placed solely on the individual. Key environmental / organizational components that best support positive performance in the workplace, impact the equation.</td>
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<td>- Commitment to an ongoing sustainability plan for capacity building.</td>
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<td>- Learners need opportunities to apply new learning to practice and platforms to raise new issues and learning needs as they arise.</td>
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<td>- Opportunities for self directed and facilitated learning and individual and group learning need to be embedded.</td>
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<tr>
<td>- An incremental approach to capacity building- it is unlikely that anyone will be hired who is completely competent in all 12 core competencies after the first 3 months. This is an incremental approach that builds on previous learning.</td>
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<td>- Reflective opportunities throughout learning enable continuous self assessment and competency improvement.</td>
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Cross-System Responsiveness to Special Needs Populations: The ministry support creation of special units/programs in the community and LTC homes for seniors with special needs. Targeted investments should focus on adding new human resources specialized in responsive and challenging behaviours in LTC homes, developing and deploying mobile behaviour teams, and expanding services in the community.

Finally, to ensure a better use of health care dollars, the BSO project service redesign approach leverages existing investments to enhance care for the BSO target population. This process supports the objectives of multiple government priorities:

- Ontario’s Action Plan for Health Care (Matthews)
- Enhancing the Continuum of Care (Baker)
- Commission on the Reform of Ontario’s Public Services (Drummond)
- Provincial strategies including Seniors, Residents First and Aging at Home
- Excellent Care for All Act

1.3 Project Activities in this Reporting Period

Project-level Activities and Accomplishments

January Milestones

- January 9: 14 LHINs sign BSO Memorandum of Understanding describing CRO, Early Adopter and Next 10 roles and responsibilities
- January 15: Launch of on-line advertising campaign to support HHR recruitment.
- January 18-24: BSO reporting tutorials (Eclipse training) for Next 10 LHINs
- January 19: BSO webinar: 14 LHIN knowledge transfer exercise
- January 31: CRO submitted Q3 report to MOHLTC on behalf of CRO and 14 LHINs

A MODEL HOME

In September 2011 Fairhaven, an early adopter long-term care home in Peterborough, set out on a transformational journey to forever change the quality of care afforded residents who demonstrate responsive behaviours associated with dementia, mental illness and/or other neurological disorders. In six months, Fairhaven moved from conceptualization and development, to implementation and success.

Using a BSO standardized behavioural assessment tool and gathering data from resident care plans, residents and family members, it was determined over 50% of residents require support. Citing the promise of improved quality of life for all residents in the Home, an expected decrease in resident behaviours and a delayed need for more intensive services and support from the integrated health team, it is through a notable commitment to their training and development that new and existing staff are currently operating with enhanced skills, offering them an increased level of confidence in their abilities to manage the road ahead.

Fairhaven represents a snapshot of what is happening across the Central East LHIN where 13 early adopter long-term care homes were engaged early and are now acting as knowledge brokers with their peers. Over 20 new RNs/RPNs and PSWs have been hired in these facilities; over 800 front line staff have been trained to deal with responsive behaviours and Integrated Care Teams are operating in both LTCHs and the community.

- Central East LHIN
**February Milestones**

- February 2: Provider Council (OACCAC, OLTCA, OANHSS and OLTCP) met with BSO committee chairs and the CRO to discuss Terms of Reference, HHR issues, conference opportunities, the BSO evaluation and communications at the LHIN level.
- February 10: CRO launches a revamped monthly update, “BSO e-news,” for all BSO participants and stakeholders. Updates include client/caregiver stories, links to resources and key dates.
- February 16: All-LHIN in-person knowledge exchange event in Toronto. LHINs pursuing a Behavioural Support Unit returned on February 17 to participate in the BSU Think Tank.
- February 28: BSO Evaluation briefing for Next 10 LHINs, including review of indicator development, target population definitions and data sources.
- February 29: BSO Evaluation briefing for LTC-affiliated Associations, including review of the target population, data collection, and the Evaluation’s short- and long-term goals.

**March Milestones**

- March 1: Provider Council (OACCAC, OLTCA, OANHSS and OLTCP) met with BSO committee chairs and the CRO to discuss use of HHR surplus for training backfill, demand models for proposed Behavioural Support Units, a summary of implementation approaches in 14 LHINs, current HHR headcounts, the BSO Capacity-Building Roadmap and the process for BSO project Q & A’s.
- March 6: BSO update to MMC-CEOs highlighted the BSO approach to implementation, early success stories and opportunities for BSO-style collaboration in future.
- March 13: One-time BSO Clinical Advisory Panel convenes to review a working definition of the BSO target population in administrative databases.
- March 31: Hay Group submits Interim Report on (1) system capacity to collect and analyze data, (2) the BSO target population and their use of health services, (3) a quantitative evaluation framework, and (4) a qualitative evaluation framework.

**PIECING IT TOGETHER**

A puzzle, like any project, has many pieces that must come together in just a certain way; the placement of each allowing for the building of the bigger picture. Each placement, in of itself, is a success. And so it is that Champlain, along with its partners across the Region – over 65 involved in planning and implementation, has begun the process of carefully and successfully placing all of its “BSO pieces” in place to reveal the big picture.

A methodically planned, patient-centric, behaviour-focused strategy is leveraging new investments for behavioural supports by both increasing supports and transforming existing services to focus on the responsive behaviours of older individuals. With the help of the lead agency – The Royal Ottawa Mental Health Centre, existing service agreements between outreach nursing resources and LTCHs are being revised to recognize an enhanced focus on behavioural supports. And, with the addition of over 30 new FTE’s, enhanced behavioural supports in the community setting are also being deployed.

Changing mindset is an integral piece of the puzzle, and the acceptance of lead and community agencies to take a behavioural approach for new and existing staff is a notable success; one of many that are being placed into position, one piece at a time.

- Champlain LHIN
Summary of New Project Supports Developed in Q4

1. **LHIN progress reporting to CRO** – Regular progress reporting to CRO began in all LHINs January 31. NSM LHIN provides free access to on-line Eclipse software, plus training and troubleshooting for staff who will use this tool to keep CRO and the Ministry up to date. A separate and complementary process for quarterly reporting to the Ministry, through CRO, runs in parallel four times this year to build on the data collected in Eclipse.

2. **Strategic communications** – CRO is building up its capability for strategic, province-wide BSO communications. Recruitment of a provincial communications specialist began in March. The Specialist will implement the BSO provincial communication plan circulated to 14 LHINs in January to reach province-wide audiences, and 14 LHINs with their responsibility for local key messages to local audiences.

3. **Collaborative Working Groups** – Change projects and service enhancements planned for more than one LHIN are getting new collaborative working groups to share the load among LHINs, pass tools and resources more easily, and to accelerate knowledge transfer. An Early Adopter LHIN takes the lead role in each group, and tailors the approach to meet the needs of the other LHINs participating with ongoing help from HQO and AKE. In most cases the lead LHIN opens their local discussion about implementation up to others who wish to share lessons, tools and research.

4. **Facilitated process for BSU development** – Five LHINs that describe a BSU in their Action Plan completed a multi-step process in Q4 to develop the local model thoroughly. HQO guided all five through a Root Cause Analysis, leading up to a Pareto exercise (to identify high-priority tasks that promise the highest impact on BSU outcomes) and the Think Tank on February 17 with provincial BSU experts. Three-day LHIN-wide Kaizen events occurred in all five LHINs between February 27 and March 23; dates vary by LHIN. The BSU Collaborative Working Group convened in March and meets bi-weekly.

5. **QI Integrated Workplan** – In cooperation with LHIN Improvement Facilitators, HQO developed and scheduled its support to Quality Improvement work in 14 LHINs from April to December. Local initiatives with provincial impact will receive targeted HQO support, while other HQO resources will be directed toward “Applied QI Science” webinars, collaborative working groups and training to expand the Improvement Facilitator talent pool. LHINs will rely on their Improvement Facilitator to participate fully in QI activities; all LHINs have confirmed they will continue to fund the position (either full- or part-time) into the new fiscal year.

6. **Unspent HHR for backfill** – The ministry granted LHINs the latitude to use unspent HHR funding for backfill when non-BSO staff attend behavior training (P.I.E.C.E.S., Gentle Persuasive Approach, Montessori, etc). BSO salary dollars may only be used for salary backfill, not the actual cost of training or related materials. A February 13 memo from Bernie Blais explained this option to LHIN CEOs, and detailed Q & A’s developed by CRO have been circulated since to Project Leads.

7. **FMB year-end cutoff** – CRO coordinated with the Performance Improvement & Compliance Branch and Financial Management Branch of MOHLTC ahead of year-end cut-off dates to ensure HSPs received appropriate and timely payment of 2011/12 funding for new BSO Health Human Resources.

8. **HHR Reporting** – CRO coordinated frequent and detailed requests for HHR recruitment head counts. CRO and Project Leads continue to fine-tune the reporting process in Eclipse to reduce the effort required to collect and tabulate this data.
9. **CHARTrunner Licenses** – CRO purchased two-year, concurrent-user licenses for Statistical Process Control software that local BSO project teams will use to analyze outcomes of local change projects. CHARTrunner software will be accessed by all 14 LHINs, with training offered by HQO to all local Improvement Facilitators.

### Coordination & Reporting Office Financials for Q4 and Year-End

<table>
<thead>
<tr>
<th>NSM LHIN Coordinating &amp; Reporting Office</th>
<th>BSO CRO Operations</th>
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<tbody>
<tr>
<td>For the Fiscal Year 2011/12</td>
<td>Budget</td>
</tr>
<tr>
<td></td>
<td>2011/12</td>
</tr>
<tr>
<td></td>
<td>(8 months)</td>
</tr>
<tr>
<td>Ministry Operating Allocation</td>
<td>$ 500,000</td>
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</tbody>
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#### Operating Expenditures:

**Salary and Wages**

- 156,333
- 40,842
- 61,446
- 78,938
- 181,226

**Employee Benefits**

- 39,166
- 7,269
- 11,707
- 23,351
- 42,327

**Transportation and Communication**

- Communications (i.e blackberries, teleconferencing) 1,600
- Staff Travel 10,000
- Other (Participant travel, recruitment) 10,000

**Subtotal (Transportation and Communication)**

- 21,600
- 680
- 10,977
- 25,481

**Services**

- Accommodation 9,600
- Advertising -
- Consulting Services (Project Evaluation) 80,000
- Other Services (toolkit development) 50,000
- Other Services (Alzheimer's Knowledge Exchange) 40,000
- Other Services (Knowledge Transfer) 40,000
- Other Services -
- Professional Stipends 30,000
- Meeting Expenses 10,000
- Printing and Translation 10,000

**Subtotal (Services)**

- 269,600
- 703
- 41,026
- 106,564
- 148,293

**Supplies and Equipment**

- IT Equipment 9,000
- Office Supplies 2,300

**Subtotal (Supplies and Equipment)**

- 11,300
- 1,505
- 20,885
- 21,890

**Total Operating Expenditures**

- 500,000
- 49,494
- 126,662
- 243,061
- 419,218

**Operating Surplus/(Deficit)**

- 0
- 117,173
- 40,005
- 76,395
- 80,782
**Status of Action Plans**

LHIN CEOs sign the final Action Plan after PRT, HQO, and CRO endorse their submission and any reviewer conditions have been discharged. Twelve of fourteen LHINs submitted signed finals to CRO in Q4 and CRO forwarded these to MOHLTC for reference. Action Plans are posted to the BSO Collaboration Space to support information sharing among LHINs, and each LHIN posts its final Action Plan to the LHIN website for the purposes of public disclosure and accountability.

Final, CEO-signed Action Plans have not yet been submitted by two LHINs, Erie St. Clair and Mississauga Halton, where service agreements with HSPs named in the Plan are not yet in place. In the meantime draft Action Plans endorsed in December by PRT, HQO and CRO remain an accurate guide to BSO activity in those two LHINs. CRO continues to work with both LHINs to complete this accountability step in both LHINs.

**Provincial Resource Team (PRT)**

During Q4 the PRT shifted from a review to a resource body, focusing on three areas of strength and contribution to the provincial direction and local implementation of the BSO project. These include: enabling exchange and mobilizing action, providing advice and consultation and facilitating awareness and access to information and resources. Outcomes specific to these areas of focus are listed below.

**Enabling Exchange & Mobilizing Action**

1. **Education & Training Sub Group:** In an effort to build on previously developed resources (i.e. BSO Core Competencies and the BSO Capacity Building Roadmap) an Education and Training Subgroup of the PRT was initiated to develop a complementary framework. This framework will enable LHINs to:
   a. Assess their educational needs;
   b. Understand how education and training programs align with the BSO target population, BSO core competencies, and each other;
   c. Select appropriate learning and development programs to meet those needs; and
   d. Consider key strategies to ensure programs lead to change in both skills and practice.

2. **Advisory Council for Clinical Consultation:** To ensure the proposed BSO evaluation indicators were both robust and comprehensive, PRT mobilized a one-time advisory council of provincial champions for clinical consultation and guidance.

3. **LHIN Update process to PRT:** A 4-month rotation schedule and exchange process were developed to:
   a. Use the PRT as a resource to help link LHINs to additional information, resources and people that may help inform LHIN work
   b. Surface promising practices, lessons learned and new resources being generated locally to guide provincial direction and success
   c. Obtain comment and feedback from PRT on current approaches and priorities
   d. Uncover provincial themes so that PRT can mobilize opportunities for coordinated dialogue and/or action

   This process began at the end of March 2012.
**Advice & Consultation**

1. **Scope of Provincial Collaboratives:** PRT facilitated the development of four provincial collaborative on topic which crossed multiple LHIN action plans (i.e. Mobile Teams, Behavioural Support Unit, Primary Care, Common Tools and Enhanced Access and Centralized Intake). Terms of Reference were shared with PRT guidance and advice regarding the scope and direction of each. Under suggestion from the PRT, the Behavioural Support Unit Collaborative was initiated earlier than planned to align with provincial deliverables and priorities related to this component.

2. **Questions from the Field:** In response to a request generated by the Behavioural Support Unit Collaborative, PRT provided comments, resources and clinical information to inform the development of BSU indicators to be put forth on behalf of this collaborative to the Ministry.

In addition, the PRT acted as a resource body to inform one LHIN on copyright issues related to assessment tools.
**Mobilize the Flow of Information**

1. PRT continues to contribute content and resources to the monthly BSO E-News.
2. Based on their roles within the health system, and extensive personal networks, PRT members are able to keep each other appraised of related resources, developments, initiatives, funding opportunities, presentations, promising practices and issues arising from local implementation.

**Knowledge Exchange**

In Q4 the Alzheimer Knowledge Exchange provided tools and leadership to enable the diffusion of opportunities, innovation and mutual learning throughout the BSO community. Key highlights include:

- Developed and launched the monthly BSO eNews blast to all project participants
- convened a day-long, all-LHIN Knowledge Exchange event (February 16) and the BSU Think-Tank (February 17)
- Led the development of the Capacity Building Roadmap (see Appendix A)
- Hosted and fostered the ongoing development of a virtual exchange community in the on-line BSO Collaboration Space
- Proposed or developed conference presentations and posters to raise the BSO profile among the practitioner and research constituencies affected by the BSO project in Ontario.

**BELIEVE**

It’s often said that to truly believe something, you must see it with your own eyes. Suggestively, for family members and health care providers living with and caring for people who exhibit responsive behaviours, this statement holds a regrettably disproportionate degree of truth. In HNHB, Maria is in her 80's and lives in a LTCH. The staff have resigned themselves to understanding she is not a morning person and that it is always going to be a challenge – a struggle, to get her ready for breakfast on time.

One morning, as Maria woke up, the PSW that normally cares for her came into her room as she always does. But this time, she did so with the BSO team. On entering the room, the team greeted Maria who was slowly getting out of bed. Immediately her care worker took hold of her arm and brought her to the bathroom. In no rush, Maria mumbled something under her breath, pulled away from her PSW and sat on the toilet seat in her gown and slippers. The BSO team motioned to the care worker to retrieve Maria’s undergarments and clothing. Without hesitation, Maria folded her arms and stared at the floor.

The BSO team took her clothes and gently showed Maria each article one at a time. Not saying a word, she reached out and placed the clothes on her lap, examined her brazier and held it with the hooks facing out. Continuing their use of a gentle approach, the BSO team then approached Maria to help her unfasten the hooks, and within a few minutes she was getting herself dressed; no struggle, no frustration, no aggressive or responsive behaviours. Using a similar approach for toiletry and hygiene care, the BSO team modeled strategies and techniques to help Maria get ready for the rest of her day… that started with breakfast, on time. A somewhat surprised PSW untrained in behavioural supports said “Why does she do that for you and not for me? She must be having a good day.” The next week, the same LTCH sought a referral to the BSO Team for another resident.

As of end March, HNHB, an Early Adopter LHIN, has successfully served over 50 clients, trained over 550 LTCH and BSO staff and has 86 LTC Homes with access to in-house behavioural supports operating within its Region – 63 of which have signed MOU’s as of April 20. Believe it… there is something great happening in HNHB before our very eyes.

- HNHB LHIN
BSO Impact Assessment (BSO Evaluation)

Between January and March 2012, the activities of Hay Group consultants were primarily focused on the successful delivery of the next 4 deliverables identified for the BSO early Adopter LHINs Service Redesign Initiative. High level activities undertaken in Q4 associated with each of the deliverables are described below:

Deliverable 3: System Capacity to Collect and Analyze Data

The indicators to be reported on in the March 31st report were meant, primarily, to be based on indicators identified in Deliverable 2 “Indicator Matrix and Logic Model” that was submitted on January 3, 2012. As the BSO project progressed however, it became clear that some of the indicators identified in the initial matrix needed to be revisited. The impetus for this review was three-fold: QI initiatives being developed by HQO as part of the “Residents First Initiative”, feedback from the Provider Council as well as feedback obtained during one-on-one consultation sessions with the early Adopter LHINs. In subsequent meetings, the DMEC directed Hay Group to present proposed evaluation criteria for indicators to be reported in the March 31st deliverable. Through an iterative process, the DMEC agreed on 22 indicators that were considered to be feasible for inclusion in the March report. Hay Group consultants presented the DMEC with a data dictionary for each of the proposed indicators and baseline reporting of these indicators has been included in Chapter 7 & 8 of the Interim Evaluation Report.

The iterative process of identifying, defining and confirming indicators to be reported on in the March report provided a number of insights into the current and potential ability of health service providers to monitor and assess the impacts of implementation of BSO initiatives. A summary of these findings as well as specific recommendations to support enhancement of data and the ability to measure impacts and outcomes for the BSO population are described in Chapter 5 of the Interim Evaluation Report.

Deliverable 4: Report on BSO Population & Use of Health Services

Perhaps the most significant and resource intensive activity of Hay Group consultants in Q4 was the development of a process and algorithm to identify the target population for BSO initiatives in administrative databases for the purposes of project evaluation. While administrative data obtained from OHMRS, CCRS, MDS and RAI-HC measure client/resident behaviours, administrative data from the acute care sector (DAD/NACRS) focuses on medical diagnosis. Building upon set of diagnosis that had been identified earlier by the Director, Evaluation and Research of Specialized Geriatric Services at St. Joseph's Health Care London, Hay Group consultants proposed a complementary approach to test and refine a list of acute care diagnoses using acute care inpatient data linked by patient health number with RAI records containing explicit documentation of diagnoses. Members of the clinical advisory panel reviewed the consultant recommendations and modified the list on the basis of their clinical experience. This resulted in a revised list of ICD-10-CA diagnoses to be used with acute inpatient (DAD) and emergency (NACRS) data to identify potential behavioural patients (included in Appendix A of the Interim Report.)

Hay Group consultants worked with Ministry staff to obtain access to de-identified patient record data (acute and community) that was used to inform the analysis and support the development of an overview of the BSO population and the use of health services in Ontario.
Deliverable 5: Formative or Qualitative Evaluation Findings

In early March, 2012, Hay Group representatives had 1-on-1 meeting with EA LHINs to gather findings about their experience with the way the BSO Service Redesign initiative was designed, organized and governed; the experiences within the early adopter sites with the types of services/activities/improvements planned or being developed; the challenges encountered when implementing the BSO framework; as well as preliminary/early findings from health care providers and clients in the BSO target population and their family members about their experiences with the care received in the areas targeted in the BSO service redesign. Consultants also obtained feedback on data collection activities that were underway at the EA LHINs and the extent to which EA indicators corresponded to the indicators that were being developed at the project level. The findings from these activities are summarized in Chapter 7 of the Interim Evaluation Report. The Chapter also reports on baseline findings for process indicators that were identified by the DMEC for the March 31st report as well as a framework for the collection of qualitative indicators to be included in the December 31st report.

Deliverable 6: Summative or Quantitative Evaluation Findings

Summative/Quantitative evaluation findings were to describe 1) impacts of the service redesign activities across the 4 early adopter LHINs, based on the common indicators (in the areas of client/family experience, population health, organizational health, and health system levels) identified in the BSO indicator matrix and 2) impacts of the service redesign activities based on the LHIN-specific indicators identified in the matrix.

A subset of the 22 indicators approved by the DMEC for March 31st reporting relied on CIHI DAD, NACRS, and RAI data. It was acknowledged that because of the lags in access to the administrative data, the results reported in the Interim Evaluation Report would be useful as baseline measures only, since most BSO action plans in the four Early Adopter LHINs were in the very early stage and the time period the administrative data would cover would predate implementation of the BSO initiatives. Baseline findings of these indicators are presented in Chapter 8 of the Interim Evaluation Report.

Other Consultant Activities:

Additional engagement activities that Hay Group consultants participated in included the facilitation of a webinar with the remaining 10 LHINs to share the project logic model and draft indicator matrix that had been presented to CRO on January 3rd. As well, the Provider Council meeting generated considerable discussion about the timing and characterization of the evaluation activities.

Next Steps:

The DMEC is currently in the process of reviewing and providing feedback to the Interim Evaluation Report that was provided to the CRO on March 3st. Hay Group consultants will incorporate feedback from the DMEC and CRO into a revised report Interim Evaluation Report. Over the coming months, the consultants will review each of the indicators included in the March report and identify opportunities for refinement. The development of tools, structures and processes to support the collection of qualitative indicators will also be confirmed.
1.4 Health Quality Ontario and the QI agenda in Q4

HQO Priorities

From January to March 2012, quality improvement efforts have focused on developing and testing change ideas within the continuum from Primary Care to Specialized Behavioural Support Units. Coaching time was dedicated to facilitating kaizen events, consulting with teams to provide methodological direction and reinforce QI rigour, and building capacity among the local Improvement Facilitators to independently lead this work. All 14 LHINs have been working on their Action Plans, so there has been opportunity to learn from one another and accelerate progress through sharing of information. A family of QI measures was defined and aligned with the evaluation measures with the intent of using the infrastructure of the Collaborative Working Groups for ongoing review.

<table>
<thead>
<tr>
<th>Collaborative Working Group</th>
<th>Participating LHINs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile Teams</td>
<td>ESC, SW, HNHB, MH, TC, CE, CH, NSM, NE, NW</td>
</tr>
<tr>
<td>BSU</td>
<td>ESC, SW, HNHB, MH, TC, CE, CH, NSM, NE, NW</td>
</tr>
<tr>
<td>Primary Care</td>
<td>ESC, SW, HNHB, MH, TC, CE, CH, NSM, NE, NW</td>
</tr>
<tr>
<td>Centralized Intake</td>
<td>ESC, SW, HNHB, MH, TC, CE, CH, NSM, NE, NW</td>
</tr>
<tr>
<td>FLEAS</td>
<td>Early Adopter LHINS</td>
</tr>
</tbody>
</table>

It is important to note that the work of translating the Action Plans to practice has not focused on the creation of new clinical tools. There are many validated tools already in existence, so the focus has been on building processes for reliable delivery of evidence informed practices (where “reliable delivery is defined as failure free performance over time”). For example, a kaizen event in February created an assessment toolkit that embeds existing validated tools (DOS, KSBA, etc) into practice at key, consistent moments in the trajectory of care. This allows the tools to be hardwired into practice and the teams to build a common understanding of the assessments required and their interpretation. Given that care will span many years in most cases, this becomes a reasonable approach to defining the care path.
2. Project Impact

2.1 LHIN Service Redesign Investment

<table>
<thead>
<tr>
<th>LHIN</th>
<th>2011/2012 Allocation</th>
<th>2011/2012 Expenses</th>
<th>2011/2012 Recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central East</td>
<td>750,000.00</td>
<td>512,951.05</td>
<td>237,048.95</td>
</tr>
<tr>
<td>Hamilton Niagara Halidmand Brant</td>
<td>750,000.00</td>
<td>407,690.49</td>
<td>342,309.51</td>
</tr>
<tr>
<td>North Simcoe Muskoka</td>
<td>750,000.00</td>
<td>583,727.46</td>
<td>166,272.54</td>
</tr>
<tr>
<td>South East</td>
<td>750,000.00</td>
<td>476,355.59</td>
<td>273,644.41</td>
</tr>
<tr>
<td>North East</td>
<td>72,000.00</td>
<td>72,000.00</td>
<td>0.00</td>
</tr>
<tr>
<td>North West</td>
<td>72,000.00</td>
<td>62,972.25</td>
<td>9,027.75</td>
</tr>
<tr>
<td>Central</td>
<td>57,000.00</td>
<td>31,373.00</td>
<td>25,627.00</td>
</tr>
<tr>
<td>Champlain</td>
<td>57,000.00</td>
<td>57,000.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Central West</td>
<td>57,000.00</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>Erie St. Clair</td>
<td>57,000.00</td>
<td>47,495.00</td>
<td>9,505.00</td>
</tr>
<tr>
<td>Mississauga Halton</td>
<td>57,000.00</td>
<td>39,821.84</td>
<td>17,178.16</td>
</tr>
<tr>
<td>South West</td>
<td>57,000.00</td>
<td>54,735.00</td>
<td>2,265.00</td>
</tr>
<tr>
<td>Toronto Central</td>
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<td>57,000.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Waterloo Wellington</td>
<td>57,000.00</td>
<td>57,000.00</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>3,600,000.00</strong></td>
<td><strong>2,460,121.68</strong></td>
<td><strong>1,082,878.32</strong></td>
</tr>
</tbody>
</table>

2.2 BSU Process

**Behavioural Support Units**

Five LHINs have identified Behavioural Support Units as a primary component of realizing their action plans. In Q4 a six-step process was undertaken to enable these LHINs to: identify their current state, understand their population, share promising practices and common challenges related to this topic, establish BSUs within a continuum of local services, develop and define QI measures and establish a BSU collaborative working group.

**Step 1 & 2:** Late in January, LHINs participated in a Root Cause Analysis to understand, at a local level the issues that drove the decision to include a Behavioural Support Unit in the Action Plan submitted by the LHIN, as well as identify the causes that are most likely to lead to a perceived need for admission to a Behavioural Support Unit. By then conducting a Pareto Analysis, LHINs quantified at a local level the issues perceived to result in a client needing to be admitted to a Behavioural Support Unit and reached consensus on the specific issues to be addressed via BSU or alternative solution.

**Step 3:** Priorities identified by each of the 5 LHINs were compiled to identify common issues across LHINs and to prioritize content for the February 17th Think Tank.

**Step 4:** To share evidence and experiences of those who have established Behaviour Support Units, including their success/impact, and their reflections on effective alternatives, a 1-day Think Tank was held on February 17th for stakeholders from each of the 5 LHINs. The exchange was designed to inform LHINs about the evidence (“best practice” thinking) and experiences related to their prioritized issues.

**Step 5:** In late-February and early-March, HQO facilitated Kaizen Events in each of the 5 LHINs to develop local solutions that will provide alternatives to Behavioural Support Units.

**Step 6:** In late-March Mississauga-Halton LHIN took a lead role in establishing a BSU Collaborative Working Group composed of representatives from the 5 affected LHINs, with QI facilitation, for ongoing sharing of learning to accelerate change.
### 2.3 HHR Investment

#### Overview

The $40.37 million Provincial Behavioural Supports Ontario (BSO) investment focused on local health service providers (primarily long-term care homes) hiring and training new staff – Nurses, Personal Support Workers and other health professionals in the specialized skills necessary to provide quality care to Ontarians with complex behaviours.

Each LHIN’s Action Plan outlined the local approach to deploy specialized resources to provide a range of behavior supports across the care continuum.

A number of underlying factors emerged which influenced the decision about how to most effectively distribute and leverage the new resources. These included the following:

- Number of Behavioural Support Services effectively working in an outreach capacity to support LTC Homes (e.g. mobile or interdisciplinary teams);
- Equity and integration of existing services within the geography of the LHIN area;
- Ability to leverage existing services within the LHIN area;
- Willingness and interest of the LTC homes to receive funding (i.e. salaries and benefits covered but not ancillary costs) and participate in the BSO program or pilot the approach; and
- Established leadership structure and infrastructure within the LHIN service system.

As a result, there were three general types of approaches that were used by the LHINs in allocating the Nurse and PSW resources to enhance services and increase capacity for LTC Homes in a LHIN area. The three approaches are briefly described below and then further detailed in the accompanying charts. While the approaches are somewhat different, the overall goal in all LHINs remains the same in serving persons with complex behaviours.

It should also be noted that the funding policy allows for the Other Health Professional allocation to be used in the LTC Homes as well for other types of positions (e.g. Social Worker, Registered Dietician, Physician Consultation Services, Recreational Therapists, or Occupational Therapists as well as Nurses and PSWs). Some LHINs have used this funding to increase their

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**THE WHOLE IS GREATER THAN THE SUM**

Knowledge sharing is not about giving and/or getting something; interplay typically reserved for the simplicity of information sharing. Knowledge sharing occurs when people have a genuine want to help each other develop new capacities.

In Mississauga Halton, the hiring of new HHRs is well underway and, with 27 LTCHs participating in the BSO initiative, the wealth of opportunity for knowledge sharing – the interactive education of new and existing staff on the techniques, methods, strategies and combined experiences / lessons learned that will transform the way by which care for individuals presenting responsive behaviours is provided, is ever-present.

In March, the Knowledge Exchange and Capacity Building working group completed 18 sessions of education in 20 days, with a total of 278 participants engaged in active knowledge transfer and educational training. This activity has allowed for the development of a base that will be built upon as new BSO resources begin their positions working with existing staff.

MH has also taken a leadership role as collaborator/knowledge broker, facilitating a forum for LHINs considering the development of a SBSU. It represents an opportunity for other LHINs to work together and leverage the learning from the MH LHIN experience.

When individuals enter into relationships where the whole is greater than the sum of its parts, they invariably will come away better off – richer, because of it. Such is the case for BSO in MH.

- Mississauga Halton LHIN
number of Nurse and PSW positions to ensure an equal distribution of positions across the LTC Homes or added other disciplines to the outreach teams to support the LTC homes. Many LHINs have already provided funding to LTC homes through other initiatives. (See charts for more details.)

**Chart 1: Lead/Host LTC Home Model for Mobile Outreach Teams**

This model/approach has a Lead or Host LTC Home being selected through an ‘Expression of Interest’ process to receive funding from the LHIN to employ the LTC Nurses and PSWs and provide interdisciplinary outreach support to the other LTC Homes in the LHIN area.

The Lead Home is responsible for recruitment, hiring, Health Human Resource (HHR) management, delivery and oversight of the BSO LTC Home Mobile Team or Outreach Program across the service area. The Host home is responsible for all aspects of the HHR recruitment, management and deployment and links with the existing outreach service provider which will oversee the service delivery component.

Both types of outreach will be offered through telephone on-call support or in-person short-term support to LTC Homes. The mobile teams can provide scheduled and episodic support, transitional support across care settings, knowledge transfer and skill building capacity through case-based learning and consultation, and mentoring. The LTC home mobile teams are usually arranged geographically through ‘hubs’ or ‘clusters’.

A Memorandum of Understanding (MOU) is typically developed between the Lead LTC Home with the other LTC Homes in the LHIN area. In the case of the Host LTC Home, an agreement is also developed with the outreach agency responsible for some or all aspects of service delivery.

**Chart 2: Allocation at the Individual LTC Home**

This approach is usually adopted where a LHIN has established mobile/outreach teams across the LHIN area that already supports all or some of the LTC homes in behavioural management. The approach allows capacity-building at the home level by having an on-site dedicated resource (eg. in-house resource or behaviour champion). The method for distribution of resources may be based on the size of the LTC home and/or expression of interest on the part of LTC Homes. In

---

**THE ROAD LESS TRAVELLED**

It takes courage to change and if ever there was a project that required a cultural shift to address behaviour one might suggest the BSO project was it. Breaking down barriers rather than operating in silos, working collaboratively rather than individually, sharing knowledge rather than pushing and/or pulling information, partnering with agencies locally, across regions and across the Province; it all speaks to a new way of thinking, acting and yes… behaving.

In NE, an estimated 140 clients have already been served by BSO-funded services. But what cannot be lost is what it took to get there; to make this outcome a reality. Over 520 staff trained; 13 LTHCs with enhanced in-house behavioural supports; early engagement of stakeholders through the work of the Regional BSO Working Group; QI support from HQO; support and sharing of information from Early Adopter LHINs and the PRT; regular/structured BSO teleconferences, webinars, training, updates; and perhaps most importantly, a recognition for the need and willingness to change.

North Bay Regional Health Centre was identified early on as the lead provider for the NE Behavioural Supports project. Two key staff members were identified as subject matter experts and they contributed over 240 hours to framing the action plan for the North East. Meanwhile, the development of the NE BSO Action plan was supported by a dedicated multi sector group of leaders from across the North East who contributed a combined total of over 140 hours to providing direction and advice to the project team.

It takes courage to take the road less travelled and that is the road taken by North East.

- North East LHIN
some LHINs, a number of the LTC homes receive the funding for resources based on expression of interest. These selected LTC Homes will act as team leads and serve a cluster or hub of homes in proximity to them. There are variations of this approach which are outlined in more detail in Chart 2.

**Chart 3: Behavioural Support Units**

A total of four LHIN areas are proposing transitional Behavioural Support Units in addition to selecting outreach services or capacity building resources at the individual LTC Home level. Four LTC Homes totaling 75 beds have been selected for designation as specialized units subject to approval under the Long-Term Care Homes Act, 2007. This is in addition to Sheridan Villa in MH LHIN which is currently approved to operate 19 LTC beds. A summary of the selected LTC homes and proposed Behavioural Support Units are outlined in Chart 3.

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**VIRTUALLY ANYTHING IS POSSIBLE**

Some people would suggest you do not need technology to implement an effective knowledge exchange program. On some level they are probably correct because fundamentally knowledge exchange/sharing is about people. But, in today’s increasingly complex and technologically driven world technology, in many ways, has made knowledge sharing a reality, if in the very least by closing the geographic gap for people who would have otherwise never had the ability to share.

BSO is about innovation, thinking outside the box and a new way of collaborating for patient-centered care. So, it should come as no surprise that embedded within the future plans of North West, lays the intent for a “Virtual Ward.”

Consider if you will an elderly woman living at home, whose primary caregiver is her elderly spouse. Suffering from dementia and congestive heart failure, she begins to exhibit signs of distress. Alarmed and anxious, instead of calling 911, her husband is able to call a 24hr number that connects him to a “virtual ward”. An appropriate assessment is made and practitioner sent to the home to assist the patient and ease her husband’s anxiety. Meanwhile, the home visit kept the patient out of a potential long wait in the ER and/or admission.

A cross-functional, collaborative virtual team would, in effect, take the best elements of behavioural supports to the community in much the same way as MST’s and BSU’s in the hospital setting. While BSO is still in its infancy and its full impacts as yet unknown, it is already showing great signs of promise. And, as a catalyst for inspirational ideas such as this, one might suggest that virtually anything is possible.

- North West LHIN
## BEHAVIOURAL SUPPORT RESOURCE IMPLEMENTATION APPROACHES
### FOR LONG-TERM CARE HOMES

**CHART 1**

**Lead & Host LTC Home Model for Mobile Outreach Teams**

<table>
<thead>
<tr>
<th>LHIN</th>
<th>Lead LTC Home Funding Agreement with LHIN</th>
<th>Host Home</th>
<th>LTCH Nurse/PSW Allocation</th>
<th>Description of Delivery Model for LTCHs</th>
<th>Behavioural Support Unit (BSU)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HNHB</td>
<td>St Joseph's Villa</td>
<td>41 19 Nurses 22 PSWs</td>
<td>BSS consists of 41 RNs, RPNs and PSWs placed in 5 newly created Interdisciplinary Mobile Teams hired by the lead home and geographically placed across 5 long-term care homes (LTCH) designated as “hubs”. The “hub” home will provide the office space and equipment/furniture to permit the mobile team to provide BSO services (scheduled and episodic support, transitional support across care settings i.e. hospital to LTCH, and capacity building) for individuals with complex and responsive behaviours across 86 long-term care homes. Memorandum of Understanding (MOU) developed outlining parameters of program for participating LTCHs and lead home. LTCHs to sign the MOU to access the resources. Addendum to MOU also signed by “hub” LTCHs.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>SE</td>
<td>Providence Care</td>
<td>30 12 Nurses 18 PSWs</td>
<td>BSS consists of 30 nurse and PSWs hired by lead home for 3 newly created interdisciplinary mobile behavioural support teams deployed across the LHIN. The Mobile Response Teams provide short-term urgent support, knowledge transfer and skill capacity - building for 38 LTCHs. Three LTCHs will act as “home base” for the 3 Mobile Teams serving the LHIN geographic area and will provide accommodation and equipment to the outreach teams. Cooperation Agreement has been developed jointly between Providence Care and the partnering LTCHs and will shortly be shared with LTCHs for signing to access services. The program will roll out in a phased approach.</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

Q4 Project Quarterly Reporting
Behavoiural Supports Ontario - CRO
<table>
<thead>
<tr>
<th>LHIN</th>
<th>Lead LTC Home Funding Agreement with LHIN</th>
<th>Host Home</th>
<th>LTCH Nurse/PSW Allocation</th>
<th>Description of Delivery Model for LTCHs</th>
<th>Behavioural Support Unit (BSU)</th>
</tr>
</thead>
</table>
| 3 TC | Baycrest Centre of Excellence            |           | 34.54                    | ● BSS consists of 20 RNs, and PSWs hired by the lead home to provide outreach support teams to 37 LTCHs in a phased approach to implementation. Nine LTCHs selected through Expression of Interest (EOI) to implement and test outreach model and then implement across remaining LTCHs.  
 ● LTCH outreach teams will work in partnership with Geriatric Mental Health Outreach Teams (GMHOT), PRC programs and the LHIN’s nurse led outreach teams to provide direct urgent support, knowledge transfer and skill capacity-building.  
 ● LTC Centre of Learning, Research and Innovation at Baycrest leveraged along with new BSO services to implement education, training and best practice dissemination strategies across the TC LHIN area.  
 ● MOUs to be developed between lead home and participating homes and existing outreach teams. | Baycrest - 23 transitional beds. (enhancement of existing LTC for the 23 beds, with the addition of: 3.24 RNs, 1.4 RPN, 6.72 PSW’s, 1 Social worker, 1 Recreational Therapist, additional physician services) |
| 4 NW | Hogarth Riverview Manor, St. Joseph’s Care Group |           | 15                       | ● BSS consists of enhanced interdisciplinary service delivery with expansion of outreach services to supplement the Nurse Led Outreach team and existing psychogeriatric outreach teams across the LHIN service area including the use of telemedicine and OTN resources.  
 ● The virtual ward component of the North West LHIN Regional Behavioural Health Service, will support regional mobile outreach teams, long-term care homes, community and hospitals, to access expertise, support, and advice with the intent to help the individual, care givers, and health care providers manage behaviours as close to home as possible, via Ontario Telemedicine network.  
 ● Almost 40% of PSW and nurse resources will be dedicated to increasing staffing for the BSU which will serve as a regional resource in Thunder Bay.  
 ● MOUs to be developed among partners. | Hogarth Riverview Manor - 24 transitional beds. (enhanced specialized Nursing and PSW care and Recreational Therapist) |
<table>
<thead>
<tr>
<th>LHIN</th>
<th>Lead LTC Home Funding Agreement with LHIN</th>
<th>Host Home</th>
<th>LTCH Nurse/PSW Allocation</th>
<th>Description of Delivery Model for LTCHs</th>
<th>Behavioural Support Unit (BSU)</th>
</tr>
</thead>
</table>
| 5 ESC  | 4 LTCH Lead Teams                      | 1-Aspen Lake, 1-Richmond Terrace (Windsor/Essex) | 30 12 Nurses 18 PSWs     | • Based on Expression of Interest (EOI) for 35 LTCHs, 4 LTCH Lead Teams selected to provide transitional support, clinical interventions and coaching to 'buddy' homes. Two approaches emerged for deploying resources based per capita ratio with Windsor-Essex (18 LTCH) receiving 60% of the funds; Sarnia Lambton (10 LTCH and Chatham-Kent (7 LTCH) 20% of funds respectively. The two LTCH Leads in Windsor Essex will have a core complement of (1 RN, 1 RPN and 1 PSW) per Home. The remaining resources will be allocated to LTCH in Windsor Essex. The Sarnia-Lambton LTCH Leads have a core compliment of (shared) 1 FTE RN, 2 RPNs and 2 PSW. No additional resources will flow to SL LTCH. All Lead teams will interface with the existing Integrated Responsive Behaviours Mobile teams across the LHIN areas as well as strong linkages with 3 Alzheimer's System Navigators.  
• MOUs to be developed in each of the three sub-LHIN areas between the 4 Lead LTCH Lead Teams, buddy LTCHs as well as - community resources mentioned above. | N/A                         |
| 6 NSM  | Early Adopter                          | Georgian Manor - County of Simcoe Homes LTCH responsible for recruitment, hiring and HHR management | 23 10 Nurses 13 PSWs     | • BSS consists of 10 RPNs and 13PSWs hired by Georgian Manor to provide 3 new BSS Mobile Support teams for the 28 LTCHs across NSM LHIN. The LTCHs will work with the existing community outreach teams (Waypoint) which will oversee the service delivery component. The teams will be deployed geographically across the area and will provide back-up on call and on-site support, knowledge transfer and skill capacity building and mentoring. Specialized supports will also be linked with each of the mobile teams.  
• MOU developed between County of Simcoe and participating LTCHs. LTCHs to sign MOU to access services.                                                                 | N/A                         |
<table>
<thead>
<tr>
<th>LHIN</th>
<th>Lead LTC Home Funding Agreement with LHIN</th>
<th>Host Home</th>
<th>LTCH Nurse/PSW Allocation</th>
<th>Description of Delivery Model for LTCHs</th>
<th>Behavioural Support Unit (BSU)</th>
</tr>
</thead>
</table>
| 7    | Central                                  | York Central Hospital, LTCH (operational lead agency) Responsible for recruitment, HHR management | 49 20 Nurses 29 PSWs | • BSS consists of 3 mobile support teams (app 30 nurses/PSWs hired by host home) organized in 3 geographic “hubs” across LHIN area to provide interdisciplinary outreach services to 46 LTCHs and align with existing outreach boundaries led by LOFT Community Services. The 3 Mobile Support teams will link with existing crisis services and provide transitional and in-home practical supports to LTCHs and the community.  
• York Central Hospital will oversee the BSO mobile support teams in terms of how they will link with existing specialized behavioural services in the development of a system of behavioural support.  
• MOUs, will build on the existing MOUs with LTCHs have with current outreach services. | Cummer Lodge, City of Toronto – 16 transitional beds (enhanced specialized nursing care and range of allied professionals) |
| 8    | SW                                      | St. Joseph’s Healthcare London (operational lead agency) Responsible for recruitment, HHR management | 33 15 Nurses 18 PSWs | • St. Joseph’s has recently been selected to be the host LTCH. The 15 nurses and 18 PSWs will be recruited through an expression of interest (EOI) process to local LTCHs and their staff within defined geographic areas of the SW LHIN to join mobile outreach teams of 5 existing Schedule 1 hospitals. Specialized regional supports will also be linked with the mobile teams.  
• MOUs to be developed between the host LTCH, Schedule 1 hospitals and the local LTCHs. | N/A |
### BEHAVIOURAL SUPPORT RESOURCE IMPLEMENTATION APPROACHES FOR LONG-TERM CARE HOMES

#### CHART 2

Allocation at the Individual LTC Home Level

<table>
<thead>
<tr>
<th>LHIN</th>
<th>LTC Nurse/PSW Allocation</th>
<th>LTCHs</th>
<th>Description of Delivery Model for LTCHs</th>
</tr>
</thead>
</table>
| **1** CE Early adopter | 42.70, 20.20 Nurse, 22.50 PSW | 13 LTCHs – The Wynfield; Ballycliffe; Community Nursing Home, Pickering; Streamway, Cobourg; Fairhaven; Riverview Manor; Caressant Care McLaughlin, Victoria Manor; Shepherd Lodge; Yee Hong; Trilogy LTC Residence, Bendale Acres; Seven Oaks | - The CE LHIN BSO focus is distributing and leveraging new resources within the LTCHs while providing the opportunity to also leverage existing services in a more focused, coordinated and efficient way. An Expression of Interest (EOI) was issued to the 70 LTCHs across the CE LHIN area.  
- A total of 13 Early Adopter LTCHs were selected across 3 clusters (North East, Durham, Scarborough) and have hired their nurses and PSWs dedicated to the BSO initiative. This will provide hands-on staff to capacity build at the LTC home level and provide care to the BSO residents including modeling effective practices within their own homes and to other LTCHs.  
- Each selected LTCH has entered into a funding agreement with the LHIN to provide BSO services, collaborate with other LTCHs and provide leadership through Quality Improvement activities. They also play a knowledge broker and mentoring role with non-funded LTCHs in providing training and education. In addition, there are integrated care teams including acute and tertiary care providers, psycho-geriatric resource consultants, and nurse practitioners who are expanding the number of service agreements with LTCHs and continue to support the homes through outreach. |
| **2** NE | 33.00, 14.00 Nurse, 19.00 PSW | Extendicare (Great Northern, Tendercare/ Van Dale) Blind River; Elliott Lake; Extendicare (Timmins/ Kapuskasing) Cassielhoms; Algonquin; Extendicare (York/ Falconbridge)Pioneer Manor, City of Sudbury; Lakelands LTC Services Corp | - The focus of the NE LHIN is to strengthen the foundation for intersectoral collaboration and integration. An EOI was issued to the 42 LTCHs across the NE LHIN area in order to capacity build at the individual LTC level.  
- A total of 11 LTCHs have now been selected from the 4 hub areas (Algoma, Cochrane, Nipissing/ Temiskaming, Sudbury/Manitoulin/Pary Sound) and are hiring 33 nurses and PSWs. (funding added from other sources to add more FTEs) This will provide hands-on care within homes for residents with complex behaviours and will allow for full integration of the BSO Responsive Teams. The existing outreach teams will be strengthened by doubling the number of Psychogeriatric Consultants from 3 to 6 and making the outreach resources more accessible to the rural areas.  
- Each selected LTCH has entered into a funding agreement with the LHIN to provide BSO services. |
<table>
<thead>
<tr>
<th>LHIN</th>
<th>LTC Nurse/PSW Allocation</th>
<th>LTCHs</th>
<th>Description of Delivery Model for LTCHs</th>
<th>BSU In Action Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Champlain</td>
<td>37.00 16.80 Nurse 20.20 PSW</td>
<td>61 LTCHs eligible to receive funding for part of a PSW position to be dedicated to BSO and designated as a ‘champion.’ Host LTC Home (the Royal Ottawa Place) is employer for the Behavioural Outreach Nurses.</td>
<td>- The BSO focus has been on capacity building at the individual home level and enhancing and aligning outreach and psychogeriatric services with the selected PSW champion and Lead nurse.&lt;br&gt;- Each LTCH received funding agreement with the LHIN for a portion of the PSW funds and the majority of homes have signed back the agreements. (The formula for funding is based on approximately 1 FTE equivalent PSW for 300 beds and requires the PSWs to have the BSO core competencies for a PSW.) There is a MOU with each home and the Royal, the lead agency and LTCH, which outlines the role of the PSW and the LTC Nurse who will also serve as the contact person with the outreach teams. The Royal who provides the outreach services is almost doubling the RN complement. Over 25 behavioural outreach nurses in long term care homes who form teams with the PSW champions in each home and who are supported by psychogeriatric consultation will serve the entire catchment LHIN area. The champion PSW’s role will also include mentoring other PSWs on staff in partnership with the outreach resource and the LTC home nurse. Most PSW champions are being recruited from within and their regular duties back-filled when they are acting as champions.&lt;br&gt;- The proposed 12 bed Behavioural Support unit will be an enhancement of existing staff and is being developed in collaboration with the other LHINs, HQO and Champlain partners.</td>
<td>12 transitiona l beds</td>
</tr>
</tbody>
</table>

<p>| WW | 26.72 13.30 Nurse 13.42 PSW | All 35 LTCHs allocated both Nurse and PSW positions to increase behavioural support expertise. | - The BSS model is designed as an intersectoral transdisciplinary team and builds on the strengths of the existing service system. The focus is to provide an in-home increase of FTE’s for Nurses and PSWs that are dedicated to the provision of specialized behavioural support service expertise. The funding is based on resources for both positions divided by number of WWLHIN Long Stay Beds as of Dec. 2011. Homes are recruiting for the positions and then backfilling the FTE position. A funding agreement is in place with the WWLHIN and the Program Lead, St. Joseph’s Health Centre Guelph (SJHCG).&lt;br&gt;- Each home will build ‘in-home’ capacity of FTE staffing through education, mentoring, coaching, facilitating, teaching, modeling and critical thinking. The BSO staff in the LTCH will be a member of the BSO WWLHIN Community Mobile team along with allied health care professionals and a Nurse Practitioner that will serve the target population across the continuum. St. Joseph’s Health Centre (Guelph) is the program lead accountable for service delivery outcomes and will establish MOAs with each Long Term Care Home. | N/A |</p>
<table>
<thead>
<tr>
<th>LHIN</th>
<th>LTC Nurse/PSW Allocation</th>
<th>LTCHs</th>
<th>Description of Delivery Model for LTCHs</th>
</tr>
</thead>
</table>
| 5  CW | 20.50  
10.00 Nurse  
10.50 PSW | 21 homes allocated an in-house behavior champion. (Nurse, RPN or PSW position) | • The BSS model leverages existing services and makes investments to create a full continuum of care to support persons with responsive behaviours.  
• It creates an in-house behaviour champion position in LTCH to provide coaching, care planning and hands on care as needed and to act as linkage with the outreach teams. An Expression of Interest (EOI) was sent to all 23 LTCHs. Twenty one homes responded and funding was provided for 1 FTE in 20 homes and .6 in the smallest LTCH. The homes made the decision on whether to hire a RN, RPN or PSW. All the positions have been allocated with the majority being RPNs or PSWs. A funding agreement is in place for each LTCH with the LHIN.  
• Four new Psychogeriatric Resource Consultants (PRC) are being hired as part of the outreach teams to support the LTCHs. The 4 new PRCs will work with 3 existing PRCs and the existing nurse practitioners. This will translate into 5 outreach teams serving LTCHs and 2 teams serving community-based programs. The teams are divided according to geography (Dufferin County and North Peel; Peel/Brampton and North Etobicoke/ Malton/ South-West Vaughn. |

| MH  | 34.50  
13.50 Nurse  
21.00 PSW | All 27 LTC homes allocated additional Nurse and PSW based upon bed size. | • The BSS model leverages existing services and resources within the current service continuum and builds upon capacity and initiatives. It was determined that the LTC allocation would be spread across all 27 LTCHs to assist with capacity building at the individual home level. Allocations were based upon the size of the home and current existence of dedicated behavioural support staff. Twenty one (21) LTCHs over 100 beds received 1 FTE PSW and .5 FTE RPN. Two homes with existing already existing dedicated Behavioural support staff received an additional 0.5 FTE RPN. Three (3) LTCHs under between 80 and 100 beds receive .5 FTE PSW and .5 FTE RPN positions. Two homes below 80 beds will receive 0.5 RPN only.  
• The rationale is that each LTCH will have extra Human Resources to effect a systemic change in the management in responsive behaviours including partnering in Quality Improvement strategies, providing capacity, building opportunities to other staff and having a direct link to the PRC assigned to their home. |

Central West residents have access to the 19 bed BSU at Sheridan Villa  
Existing 19 BSU at Sheridan Villa
HHR Hires

The fourth quarter, as noted above, was focused on hiring qualified health professionals to provide services to the target population. Recruitment had begun mid-December for two of the Early Adopter LHIN areas. As of December 31, 2011, only one new BSO nurse had been hired.

Since the end of December there have been extraordinary efforts put forward by the LHINs and their local service providers to hire the right new staff for their positions. The final count as of March 31, 2012 has resulted in a total of 262.3 FTEs being hired by March 31st.

CRO has tracked the metrics related to numbers hired through the Eclipse tracking tool.

The following chart outlines the FTE commitments and breakdown of the new hires by type of position and LHIN.

<table>
<thead>
<tr>
<th>LHIN</th>
<th>Nurse FTEs (LTC only)</th>
<th>PSW FTEs (LTC only)</th>
<th>Add’l FTE</th>
<th>Nurse FTEs (LTC only)</th>
<th>PSW FTEs (LTC only)</th>
<th>Add’l FTE</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erie St. Clair</td>
<td>12.00</td>
<td>18.00</td>
<td>9.00</td>
<td>4.00</td>
<td>4.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South West</td>
<td>15.00</td>
<td>18.00</td>
<td>10.00</td>
<td>2.50</td>
<td>2.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waterloo Wellington</td>
<td>13.33</td>
<td>13.42</td>
<td>7.90</td>
<td>6.10</td>
<td>7.00</td>
<td>5.00</td>
<td>18.10</td>
</tr>
<tr>
<td>Hamilton Niagara</td>
<td>19.00</td>
<td>22.00</td>
<td>14.00</td>
<td>19.00</td>
<td>19.00</td>
<td>13.00</td>
<td>51.00</td>
</tr>
<tr>
<td>Haldimand Brant</td>
<td>10.00</td>
<td>10.50</td>
<td>6.00</td>
<td>6.00</td>
<td>2.00</td>
<td>1.00</td>
<td>9.00</td>
</tr>
<tr>
<td>Central West</td>
<td>13.50</td>
<td>21.00</td>
<td>11.00</td>
<td>7.00</td>
<td>11.00</td>
<td>10.00</td>
<td>28.00</td>
</tr>
<tr>
<td>Mississauga Halton</td>
<td>15.64</td>
<td>18.90</td>
<td>11.50</td>
<td>1.00</td>
<td>18.50</td>
<td>26.00</td>
<td>50.00</td>
</tr>
<tr>
<td>Toronto Central</td>
<td>20.00</td>
<td>29.00</td>
<td>15.40</td>
<td>6.00</td>
<td>15.40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central</td>
<td>12.00</td>
<td>18.00</td>
<td>6.33</td>
<td>6.00</td>
<td>11.00</td>
<td>5.00</td>
<td>22.00</td>
</tr>
<tr>
<td>Central East</td>
<td>16.80</td>
<td>20.20</td>
<td>10.40</td>
<td>15.00</td>
<td>13.00</td>
<td>2.00</td>
<td>30.00</td>
</tr>
<tr>
<td>South East</td>
<td>10.00</td>
<td>13.00</td>
<td>10.20</td>
<td>2.00</td>
<td>3.00</td>
<td>10.00</td>
<td>15.00</td>
</tr>
<tr>
<td>Champlain</td>
<td>13.00</td>
<td>20.00</td>
<td>9.75</td>
<td>8.00</td>
<td>13.00</td>
<td>3.00</td>
<td>24.00</td>
</tr>
<tr>
<td>North Simcoe Muskoka</td>
<td>6.00</td>
<td>9.00</td>
<td>6.70</td>
<td>2.00</td>
<td>2.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>196.47</td>
<td>253.52</td>
<td>142.18</td>
<td>90.30</td>
<td>101.50</td>
<td>70.50</td>
<td>262.30</td>
</tr>
</tbody>
</table>
Recruitment Advertising Strategy

In order to attract a wider pool of eligible professionals, CRO worked with Tamm Public, the LHINs’ Vendor of Record for advertising agency services and launched a multi-tiered branding approach online. The approach of using an online ad, which when clicked by the jobseeker took them directly to a central LHIN website and then on to their preferred geographic location was supported by the LHINs as a means of broadening the area of search.

The online ad began running January 16, 2012 in Metroland online newspapers, Canoe Online Network, Hospital News, Longwoods and Google Adwords. Advertising ran until March 31, 2012. The coverage was timed to match recruitment, geo-targeting the catchment area of the four Early Adopter LHINs and then expanding to include Next 10 LHINs based on their readiness to recruit.

By early February, CRO raised concerns about the visibility of the online ad in Metroland and Canoe Network. The advertising agency felt the two-month run combined with geographic phasing and the need to cover multiple diverse markets made the online option the only viable option and the least costly compared to running a print ad. One Globe & Mail ad, for example, would cost $10,000.

Given the limited visibility of the ad in Canoe and Metroland properties, CRO decided to halt advertising in those outlets. Tamm statistics confirmed disappointing viewer results and few clicks through to BSO recruitment information. It should be noted however that there were some successes including the hire of a nurse from Vancouver who responded to a Canoe online ad.

After Canoe and Metroland were cancelled, Longwoods and Hospital News ran to March 19th and Google Adwords ran to the end of March. The Google Ad words (e.g. Nursing jobs, PSW jobs, Social Worker positions, Behaviour Support Workers) proved to be effective (over 300,000 clicks) and resulted in a number of clicks through to various LHIN BSO web pages and interested jobseekers. The revised cost for the strategy was reduced from $38,120.00 to $25,005.00 (see Appendix D for breakdown of costs).

Recruitment Process

After MOHLTC announced its initial target of 700 new health professionals allocated among the 14 LHINs, it became clear that the FTE commitments required adjustment to reflect market average salaries in the various geographic areas of the province. This resulted in cumulative FTE commitments from the 14 LHINs being adjusted to a total of 586.85 for the three categories of staffing (ie Nurses, PSWs and Other Health Professionals).

Recruitment Tools

Significant activity in the fourth quarter was devoted to recruiting and training new staff to provide services to older persons with complex behaviours. The HHR Committee that was formed to support the rollout of HHR in November, 2011 developed tools to support recruitment. The Q3 report describes in more detail the products including the 12 Core Competencies, Standardized Job Descriptions and Job Postings and Competency-based types of interview questions which were made available to support the recruitment of new resources.

Capacity-Building

In January, Alzheimer’s Knowledge Exchange (AKE) in collaboration with the HHR Committee developed a Capacity Building Roadmap for health service providers to use primarily with the new BSO staff. The purpose is to assist the LHINs and their local service providers as they build...
knowledgeable care teams to serve older adults at risk of, or with complex behaviours. The tool provides a framework for service providers to help organize their approach to training new staff and supports their orientation over the first 6 months. It aligns training activities in the first 6 months with the 12 core competencies. (See Appendix A for the Capacity Building Roadmap.)

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**ON THE MOVE**

For many LHINs the Mobile Support Team (MST) or Mobile Response Team (MRT) model is the model of choice, either in whole or in part. South East, an Early Adopter LHIN which to date has served approximately 31 clients through BSO-funded services, has completed collaborative development of systems, processes and roles connected to the implementation of regionally integrated and managed geographically deployed mobile teams. They did so using recognized Quality Improvement methodologies (LEAN, RCA, FMEA), including defining and mapping Mobile Response Team (MRT) functioning, 24/7 Access and Triage, Care Pathways, and staged implementation of core roles and responsibilities for service implementation with LTC Homes.

Of 73 staff trained from BSO-funded sources, 34 or approx 87% are engaged with the MRT which is being deployed by Providence Care at three host LTCHs in Kingston, Brockville and Trenton. Engagement/conversation with partners and stakeholders was deemed to be the most critical factor, resulting in a very quick adoption of service learning opportunities between LTCHs and the MRT. LTCHs were actively involved in the development of priorities for service implementation and provided direction on which functions should be implemented and in what order. This provided MRT staff direct involvement with LTCHs and the initiation of peer-to-peer contact and learning opportunities. The deep desire of South East’s LTC Home partners to create an effective service was very essential to the success of the work.

Having been invited into 25 of 38 Homes to actively complete LTC Home directory, and Environmental scans, this truly is a Mobile Team that is “On the Move”.

- South East LHIN
2.4 Quantifying BSO Activity

Direct Impacts of BSO Project to March 31/12

LHINs report a wide array of quantitative impacts from their 2011/12 BSO investments. Although client interactions have only begun in a handful of LHINs, BSO-sponsored service enhancement and expansion is being implemented across the province. Process indicators such as the number of Long-Term Care Homes reporting enhanced in-house behavioural supports, or the number of staff trained, are clear indicators of LHIN success implementing their Action Plans in Q4. These process indicators point to dramatic increases in client contacts are ahead in 2012/13.

<table>
<thead>
<tr>
<th>LHIN</th>
<th># of Clients Served</th>
<th># of Front-Line Staff Trained</th>
<th># of LTCHs with enhanced In-house Behavioural Supports (March 31/12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erie St Clair</td>
<td>-</td>
<td>176</td>
<td>4</td>
</tr>
<tr>
<td>South west</td>
<td>-</td>
<td>96</td>
<td>-</td>
</tr>
<tr>
<td>Waterloo Wellington</td>
<td>48</td>
<td>121</td>
<td>35</td>
</tr>
<tr>
<td>Hamilton Niagara Halidmand Brant</td>
<td>57</td>
<td>557</td>
<td>86</td>
</tr>
<tr>
<td>Central West</td>
<td>-</td>
<td>-</td>
<td>21</td>
</tr>
<tr>
<td>Mississauga Halton</td>
<td>-</td>
<td>278</td>
<td>27</td>
</tr>
<tr>
<td>Toronto Central</td>
<td>-</td>
<td>133</td>
<td>-</td>
</tr>
<tr>
<td>Central</td>
<td>-</td>
<td>856</td>
<td>-</td>
</tr>
<tr>
<td>Central East</td>
<td>14</td>
<td>862</td>
<td>13</td>
</tr>
<tr>
<td>South East</td>
<td>31</td>
<td>73</td>
<td>25</td>
</tr>
<tr>
<td>Champlain</td>
<td>-</td>
<td>-</td>
<td>60</td>
</tr>
<tr>
<td>North Simcoe Muskoka</td>
<td>-</td>
<td>200</td>
<td>28</td>
</tr>
<tr>
<td>North East</td>
<td>140</td>
<td>520</td>
<td>13</td>
</tr>
<tr>
<td>North West</td>
<td>-</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>290</strong></td>
<td><strong>3874</strong></td>
<td><strong>312</strong></td>
</tr>
</tbody>
</table>

Note: Wide variations among LHINs reflect the stage of implementation for various LHINs
In Kind Contributions

By design, BSO leverages existing investments in seniors, care transitions, ER/ALC and more to maximize the return for older adults and their caregivers. The program is a catalyst for service transformation and investment that exceeds the BSO allocation for Service Redesign and Health Human Resources. In this spirit, BSO implementation has been enhanced in all LHINs by financial and in-kind contributions as follows:

<table>
<thead>
<tr>
<th>LHIN</th>
<th>LHIN Funding From Non-BSO Sources</th>
<th>In Kind Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erie St. Clair</td>
<td>$300,000.00</td>
<td>14 service providers involved, countless hours, passion and commitment</td>
</tr>
<tr>
<td>South West</td>
<td>$525,214.00</td>
<td>60 service providers, 35 mtgs, 97 hours from HSPs (15 reps x 4 cooperatives)</td>
</tr>
<tr>
<td>Waterloo Wellington</td>
<td>$94,250.00</td>
<td>250 in-kind hrs, 61 HSPs, 32 mtgs 98 mtgs, 22 teleconferences + weekly mtgs with project sponsor</td>
</tr>
<tr>
<td>Hamilton Niagara</td>
<td>$0.00*</td>
<td>3,395 hours, 170 HSPs involved -70 mtgs to plan service care models, 22 days for live testing</td>
</tr>
<tr>
<td>Halidmand Brant</td>
<td></td>
<td>27 + HSPs, 10mtgs,20hrs</td>
</tr>
<tr>
<td>Mississauga Halton</td>
<td>$130,000.00</td>
<td>37 HSPs, 120 in-kind hours averaging 3-4 mtgs month</td>
</tr>
<tr>
<td>Toronto Central</td>
<td>$145,000.00</td>
<td>500 hrs by lead agency, 175 hrs project staff, 5 mtgs</td>
</tr>
<tr>
<td>Central</td>
<td>$250,000.00</td>
<td>19 HSPs in BS Planning Group –meet biweekly Nov –Jan/13, Many hours/ many organizations</td>
</tr>
<tr>
<td>Central East</td>
<td>$60,000.00</td>
<td>56 HSPs, 23 mtgs, bi-weekly 3 hr mtgs, $80,000 in kind support-7+months</td>
</tr>
<tr>
<td>South East</td>
<td>$0.00**</td>
<td>42 HSPs, 95 events/mtgs, over 2000 volunteer hours</td>
</tr>
<tr>
<td>Champlain</td>
<td></td>
<td>65 HSPs, 20 mtgs, 500 volunteer hours</td>
</tr>
<tr>
<td>North Simcoe Muskoka</td>
<td>$45,945.00</td>
<td>42 HSPs, 80 –QI, 130-LTCH &amp; community over 4,900 volunteer hours</td>
</tr>
<tr>
<td>North East</td>
<td>$1,087,833.00</td>
<td>Lead agency + 13 LTCHs, 380 hrs</td>
</tr>
<tr>
<td>North West</td>
<td>$1,000.00</td>
<td>5 QI days, 750 volunteer hrs</td>
</tr>
</tbody>
</table>

Total for 2011/12 $2,639,242.00 Minimum of 13,000 volunteer hrs, over 600 HSPs

* HNHB $246,000.00 (12/13)  
** SE $120,000.00 (12/13)
CRO to Enhance and Standardize Activity Reporting in Q1

The need to standardize activity reporting became apparent in Q4. LHIN progress reporting in the online Eclipse tool and templates for quarterly reporting to the Ministry allow CRO to compile an exhaustive catalogue of BSO-funded initiatives without revealing similarities, cost comparisons or relative scale. Differences in on-the-ground service mix are not apparent from LHIN to LHIN. Although multiple LHINs might develop similar initiatives, these trends in service delivery are obscured without standard definitions and nomenclature.

Rudimentary activity tracking through the BSO Impact Assessment has already begun in four Early Adopter LHINs. For example, Hay Group’s Interim Report of March 31, 2012, records the implementation of mobile teams as follows:

<table>
<thead>
<tr>
<th>LHIN</th>
<th>Mobile Teams - Community</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hired</td>
</tr>
<tr>
<td>NSW LHIN</td>
<td>9</td>
</tr>
<tr>
<td>HNHLHIN</td>
<td>5</td>
</tr>
<tr>
<td>BE LHIN</td>
<td>5</td>
</tr>
<tr>
<td>CE LHIN</td>
<td>n/a</td>
</tr>
</tbody>
</table>

During the April-June reporting period, CRO will work with HQO, PRT, Hay Group and the LHINs to standardize activity tracking across additional service types and all 14 LHINs. In many cases Collaborative Working Groups for Mobile Teams, BSUs, Primary Care Integration and Enhanced Access/Centralized Intake have already agreed to definitions and categories of implementation approach. Leveraging these discussions will enable standardized reporting in the BSO Project’s highest priority areas first, and provide a template to expand the process to other areas of BSO activity.

Agreed nomenclature and definitions that apply in all LHINs are a crucial first step toward an accurate tally of BSO services by type and function. Reliable province-wide counts for a wider range of BSO initiatives will facilitate impact assessment, cost comparison and projections of return on investment. CRO commits to incorporate standardized activity tracking into existing LHIN reporting tools, supported by standardized definitions and classification for various investments described in LHIN Action Plans.
3. Qualitative Support of Project Outcomes

3.1 Updated HQO Activity Summary

Quality Improvement in Q4

Moving forward from the completion of the Value Stream Analysis in all 14 LHINs (September 2011 for the Early Adopter LHINs, and November 2011 for the remaining 10 LHINs), there was an effort to accelerate progress by leverage the learning of those engaged in similar work. To this end, Collaborative Working Groups were initiated early in 2012 to align with each of the key change ideas. Led by an Early Adopter LHIN (with the exception of the Behavioural Support Unit Working Group that is led by Mississauga Halton given its prior experience), each group established Terms of Reference in mid-February, and started meeting regularly shortly thereafter. While the intent of the Collaborative Working Groups is to learn collectively, local context is reflected and there is no requirement to produce a single "provincial solution".

<table>
<thead>
<tr>
<th>Collaborative Working Group</th>
<th>Lead LHIN</th>
<th>Participating LHINs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>HNHB</td>
<td>ESC SW WW HNHB CW MH TC C CE SE CH NSM NE NW</td>
</tr>
<tr>
<td>Centralized Intake</td>
<td>NSM</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Mobile Teams</td>
<td>SE</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
<tr>
<td>Behavioural Support Units</td>
<td>MH</td>
<td>✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓</td>
</tr>
</tbody>
</table>

Through a series of kaizen events, an array of tools and processes has been created for each of these change ideas. Each one of these elements constitutes a “ramp” of Plan-Do-Study-Act (PDSA) cycles, meaning that at any given time, there may be up to 79 concurrent pieces of improvement work moving BSO toward achieving its aim.

- Primary Care Toolkit - 8 elements
- Centralized Intake - 7 elements
- Mobile Support Team - 16 elements
- Behavioural Support Units - 21 elements
- Common Assessment Toolkit - 27 elements
The Value Stream Analyses examined the high level map outlined below, with each LHIN focused on a specific segment of the client journey. This has allowed the local challenges to emerge in detail and be addressed through the design of the future state.

First change in behaviour that causes concern for client/family/caregiver

Behaviour managed; client remains at home with viable care plan; caregiver satisfied with help

Challenging new/escalated behaviours

Behaviour managed; client remains at home with viable care plan; caregiver satisfied with help

Tipping point: new/escalated behaviours

Client admitted to Long Term Care

Challenging new/escalated behaviours

Behaviour stabilized; client stays in or returns to LTCH; no longer a risk to self or others

Primary Care (in Community and in Long Term Care) Collaborative Working Group

Centralized Intake Collaborative Working Group

Mobile Support Teams (Community and Long Term Care) Collaborative Working Group

Behavioural Support Units (transitional)
The Primary Care Toolkit was established to provide guidance to clinicians so that they can provide comprehensive care to patients with Mild, Moderate or Severe Responsive Behaviours.

It was tested by HNHB in January 2012, with recommendations for specific circumstances for optimal use.

North Simcoe Muskoka LHIN will begin testing in the next quarter.
Centralized Intake and Mobile Support Team Collaborative Working Groups

Though led by North Simcoe Muskoka LHIN and South East LHIN respectively, there is a natural linkage between Centralized Intake and Mobile Support Team Collaborative Working Groups. In December 2011, there were four concurrent kaizen events hosted by the Early Adopter LHINS to develop tools and processes to enable consistent response from Mobile Support Teams to support residents who live in Long Term Care. Between January and March, testing continued, along with adaptation to a community environment. Central East LHIN evolved into away from a Mobile Support Team to an Integrated Care Team, and Central LHIN began actively developing and testing elements to meet their local context given the inclusion of a transitional Behavioural Support Unit in their Action Plan.

Referral, Intake and Triage*
- Current Entry Points: Spectrum of Outreach Services
- Referral Form
- Risk Triage Referral Tool
- Central Intake: one number to call (by hub)
- Decision Algorithm: MST deployment
- Safety Plan: Immediate Safety & Care Plan
- LOFT Care Plan including risk algorithm

Mobile Support Team Care (Community)
- SBAR to communicate to Centralized Intake
- Strategies and Interventions (care) plan
- Transition Tool
- Debrief and evaluation of plan

Mobile Support Team Care (LTC)
- Criteria to call Mobile Team (internal resources first)
- SBAR to communicate to Centralized Intake
- Team composition
- Treatment Plan
- Debrief with staff and evaluation of plan

Transition from Mobile Support Team
- Pre-discharge meeting and contingency plan
- Transition planning process
- Client information package
- Consult with external resources
- Capacity building for LTC and Community

Communication Strategy – team presentations re: BSO
Q&A Document through Collaborative Working Group

* Centralized Intake Collaborative Working Group
## Summary of Development and Testing by LHIN

*(Only those actively involved in Q4 are listed below)*

<table>
<thead>
<tr>
<th>Mobile Support Teams Tools and Processes Developed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral, Intake and Triage* (Centralized Intake)</td>
</tr>
<tr>
<td><strong>HNHB</strong></td>
</tr>
<tr>
<td>Current Entry Points - Spectrum of Outreach services – criteria to call</td>
</tr>
<tr>
<td>Referral Form</td>
</tr>
<tr>
<td>Risk Triage Referral Tool</td>
</tr>
<tr>
<td>Central Intake – one number to call (by hub)</td>
</tr>
<tr>
<td>Decision Algorithm: MST deployment</td>
</tr>
<tr>
<td>Safety Plan – Immediate Safety and Care Plan</td>
</tr>
<tr>
<td>LOFT Care Plan/Individual Support Plan/Behavioural Plan including risk algorithm</td>
</tr>
</tbody>
</table>

### Mobile Support Team Care – Community

| SBAR to communicate to Centralized Intake | ✓ | ✓ | ✓ |
| Strategies and Interventions (care) plan | ✓ |
| Transition Tool | ✓ |
| Debrief and evaluation of plan | ✓ | ✓ |

### Mobile Support Team Care – Long Term Care

| Criteria for LTCH to call Mobile Team (internal resources first) | ✓ |
| SBAR to communicate to Centralized Intake | ✓ | ✓ |
| Team composition | ✓ | ✓ | ✓ |
| Treatment Plan | ✓ | ✓ | ✓ |
| Debrief with staff and evaluation of plan | ✓ | ✓ | ✓ |

### Transition from Mobile Support Team

| Pre-discharge meeting & contingency plan | ✓ | ✓ | ✓ |
| Transition planning process | ✓ | ✓ | ✓ |
| Client Information Package | ✓ | ✓ | ✓ |
| Consult with external resources | ✓ | ✓ |
| Capacity Building for LTC and Community | ✓ |

### Across the Continuum

| Communication strategy – team presentations re: BSO | ✓ |
| Q&A through Collaborative Working Group | ✓ |
Behavioural Support Units: Collaborative Working Group

Developing and Testing Change Ideas

Each kaizen event was designed to incorporate a transitional Specialized Behavioural Support Unit into a system of care. Over the course of the five kaizen events, the following products were created. Kaizen participants commented on the richness of the discussion during the events, and the ability to create actual tools that would define the roles of the SBSU within a broader context. There was recognition that the process of starting the SBSU is much more complicated than might appear on the surface, so it was essential to have this opportunity to collaborate with other sectors. Direct providers engaged in the process, ranging from outreach nurses to long term care housekeeping staff to geriatric psychiatrists to CCAC Case Managers, were excited to be involved; caregivers participated and provided the “reality check” from the perspective of those with lived experience.
Summary of Development and Testing by LHIN

<table>
<thead>
<tr>
<th>Specialized Behavioural Support Units</th>
<th>Central</th>
<th>Champlain</th>
<th>Mississauga Halton*</th>
<th>North West</th>
<th>Toronto Central</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tools and Processes Developed</td>
<td></td>
<td></td>
<td>(one day event to refine current practices)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determine Eligibility to SBSU</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criteria Matrix – Spectrum of Outreach Services</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Post-kaizen</td>
<td></td>
</tr>
<tr>
<td>Decision Tree – Services across the continuum</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Post-kaizen</td>
<td></td>
</tr>
<tr>
<td>Eligibility, Admission and Discharge Criteria</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Post-kaizen</td>
<td></td>
</tr>
<tr>
<td>Discharge Care Meeting in Geriatric Psychiatry Unit</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Post-kaizen</td>
<td></td>
</tr>
<tr>
<td>Admission to SBSU</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admission Process</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Post-kaizen</td>
<td></td>
</tr>
<tr>
<td>Bed Vacancy Form</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Post-kaizen</td>
<td></td>
</tr>
<tr>
<td>Pre-admission script</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Post-kaizen</td>
<td></td>
</tr>
<tr>
<td>Process for Bed Offer to SBSU</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Post-kaizen</td>
<td></td>
</tr>
<tr>
<td>Letter of Agreement (family)</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Post-kaizen</td>
<td></td>
</tr>
<tr>
<td>Fact Sheet for Families</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Post-kaizen</td>
<td></td>
</tr>
<tr>
<td>Role of Geriatric Psychiatric Outreach Team in Safe Transitions</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Post-kaizen</td>
<td></td>
</tr>
<tr>
<td>Care in SBSU</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admission Survey</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Post-kaizen</td>
<td></td>
</tr>
<tr>
<td>Case Reviews in the SBSU</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Post-kaizen</td>
<td></td>
</tr>
<tr>
<td>Family Meetings in SBSU</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Post-kaizen</td>
<td></td>
</tr>
<tr>
<td>Navigation Visual Management board</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Post-kaizen</td>
<td></td>
</tr>
<tr>
<td>Discharge Planning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge Process for SBSU</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Post-kaizen</td>
<td></td>
</tr>
<tr>
<td>Discharge Readiness: Risk Assessment</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Post-kaizen</td>
<td></td>
</tr>
<tr>
<td>Transition plan from BSU to individual’s home</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Post-kaizen</td>
<td></td>
</tr>
<tr>
<td>Transition checklist</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Post-kaizen</td>
<td></td>
</tr>
<tr>
<td>Admission to LTC after SBSU Discharge</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Post-kaizen</td>
<td></td>
</tr>
<tr>
<td>Orientation package for Long Term Care Homes after a Transitional BSBU stay</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Post-kaizen</td>
<td></td>
</tr>
<tr>
<td>Across the Continuum</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequently Asked Questions</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Post-kaizen</td>
<td></td>
</tr>
<tr>
<td>Transitioning the beds to create space for the SBSU</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Post-kaizen</td>
<td></td>
</tr>
</tbody>
</table>
Common Assessment Toolkit: North Simcoe Muskoka LHIN

Initially, there was interest in forming a fifth Collaborative Working Group to establish a Common Assessment Toolkit. The North Simcoe Muskoka LHIN has been working toward a standardized process for each of the eight service elements from “prevention and early detection” through to “Debrief and Evaluation”. At this time, work remains local, though in the future there may be an opportunity to collaborate and share learning.
Next Steps: From Testing to Implementing

When LHIN based teams redesigned the client journey and supports as part of their Value Stream Analysis, they identified change ideas to address the gap between the current state and desired future state. At that time, their approach to translating the Behavioural Supports Ontario Framework from concept to action was untested, so their “degree of belief” that a specific change would lead to an improvement was lower.

Over the past three months, they have been developing and progressively testing changes in a variety of contexts. As testing continues, there is an expectation of increasing evidence to support the changes that will effectively move the LHIN toward the overarching Aim:

By December 2012, we will improve the care experience and quality of life for individuals with responsive behaviours and their caregivers throughout the province of Ontario by:

- Pillar 1 Creating effective system management processes to provide reliable and equitable delivery of care
- Pillar 2 Ensuring intersectoral service delivery to enable system efficiency and equitable access to comprehensive, safe services
- Pillar 3 Increasing capacity and creating knowledgeable care teams.

Moving forward, they will continue to use the Collaborative Working Groups to provide a forum for collective reflection and learning and to begin to articulate recommendations for sustainability and spread.

Additional Tools and Care Pathways

The following Quality Improvement Initiatives are also being undertaken to create system-wide improvements for older persons with responsive behaviours and their caregivers through system redesign. They are highlighted in addition to the major work of the Collaborative Working Groups which all LHINs are participating in to some degree depending on their need to align with the key change areas. It should be noted that some of the LHINs have dates set in the spring of 2012 for their Kaizen events and/or Value Stream Mapping to define new work processes, protocols and care pathways to be developed in their areas. A summary inventory of tools and processes described above appears at Appendix B.

Central East LHIN

The visual tracking board (whiteboard) and the common tracking tool called the behavioural assessment tool are being tested across all LTC homes.

Hamilton Niagara Haldimand Brant LHIN

- HNHB identified 5 priority improvement plans in order to create system wide change utilizing many PDSA cycles and testing in live settings with actual clients. This experience with clients provided rich data from which improvements continue to be made that show positive outcomes for target population. Models have evolved that will be revised through PDSA cycles with LHIN wide implementation by October, 2012. In addition to the Primary Care Toolkit initiated by HNHB, and the Community and LTCH Mobile team QI activities outlined above through the collaboratives, HNHB is also focusing on a single point for clients to access services or information (BSO Connect process) and the Integrated Community Lead model (ICL).
- BSO Connect is designed to provide a singular point of entry for clients through centralized intake and active referrals and linkages. It builds on C CAC’s current mandate and infrastructure role as a single point of contact and will roll out this spring in the Niagara area, after testing and evaluation (performance metrics being finalized) the model will be implemented across the 5 regions of HNHB. Ongoing evaluation of this plan as part of the BSO Community Model to occur from October to December 2012.
- The Integrated Community Lead (ICL) is an approach where a single community service provider is identified for clients/caregivers and coordinates and plans community services to meet their care needs. Piloting and testing has occurred in conjunction with BSO Connect and confirmed that the pilot can improve client experience through improved coordination and reduction of duplication. A client care planning template is being developed and through further testing and development, go-live implementation is targeted for June to September in some of the areas that demonstrate readiness. Ongoing evaluation as part of the BSO Community Model to occur based on predetermined performance metrics from October to December 2012.

North Simcoe Muskoka LHIN

- Family/caregiver access to respite. Caregiver focus groups held to determine respite needs. Follow up BSS training for respite and transportation providers to be held in May.
- Caregiver support/information/resources. Telephone survey completed with 80+ service providers re: BSS supports. Website in BSS being developed with 211/ Community Connections and CCAC.
- Waypoint (lead agency) Behavioural Intervention Response Team (BIRT) tested process to support acute care patients with responsive behaviours with aim of minimizing use of restraints and improve patient experience in 3 hospitals (4 sites); testing to continue into April, 2012.
Waypoint streamlined admission/discharge to appropriate level of care; tested new intake/discharge process in consultation with family and LTCH to reduce length of stay at Waypoint. Result: shorter ALOS with 3 residents to date.

**Erie St Clair LHIN**

- Development of a formal protocol for LTCH residents accessing psychiatric care and also being discharged back to the home with supports from the Geriatric MH Outreach team. Formal presentation to the LTCHs in June.

**Southwest LHIN**

- Standardized Assessment Tools Work Group – a working group is compiling evidence based standardized assessment tool kit to be used by the Seniors Mental Health and addictions Response Teams to reduce variance. The assessment toolkits will also be developed for LTC Homes, primary care, and community agencies (e.g. ADPs, Alzheimer's societies) Clinical protocols and decision trees are being completed to guide implementation.

**Waterloo Wellington LHIN**

- A new care pathway was created for clients with responsive behavior living in their homes to successful transition to a LTCH with viable care planning
- Development of Quality Improvement plans related to BSO resources for each LHIN. Homes have set targets for the number of Plan-Do-Study-Act (PDSA) cycles that they intend to achieve each quarter.
- Completion of a literature review for evidence based protocols, care pathways and education packages
- BSO clinical intake integrated with Specialized Geriatric Services (SGS) clinical intake redesign which includes a regional approach with PDSA cycles and access to completed RAI assessments.
- Streamlined access to SGS for Primary care in Family health Teams using OTN with PDSA cycles included in the process

**Mississauga Halton LHIN**

Work has been initiated with the Alzheimer Society and community day programs to identify opportunities to streamline reporting and data collection and process flow for accessing service of new BSO Community Support Workers. This work will result in new common care pathways being implemented.

### 3.2 Capacity Building

The third pillar of the BSO Framework for Care speaks to capacity building and a knowledgeable care team as critical components to support service redesign. The vision for how BSO would support each of these components at a project level is to provincially link and align capacity building elements, but do so in a way that enables LHINs to adapt components based on the learning needs and unique context of their region.

To support capacity building of new hires, the Alzheimer Knowledge Exchange and HHR work group spearheaded the development of a BSO Capacity Building Roadmap. The tool provides a framework for LHINs to help organize their approach to training new staff and supports their orientation over the first 6 months. It can be used to create LHIN-level capacity building plans, or to test the robustness of existing capacity building plans. This framework enables LHINs to consider what skills are needed,
how those skills can be gained and when it is critical to have specific skills in place by aligning the 6 month training activities with the BSO 12 core competencies.

### 3.3 Education and Training

Throughout Q4 the provincial project team has been working with LHINs to position education and training programs within a broader approach to capacity building, as outlined in the Roadmap above.

During Q4 the HHR Committee fielded questions to help LHINs make the link between LHIN-level education and training efforts and the BSO Core Competencies. Though local education and training activities were beginning, some LHINs identified that they needed help choosing which education and training programs would best meet the learning needs of their new hires. People intuitively knew which programs to chose but were unable to assess how these programs matched with the BSO target population and core competencies, as well as where there might be gaps in learning that still needed to be filled. In an effort to support ongoing and sustainable decision making at a LHIN-Level with respect to education and training programs, an Education and Training Subgroup of the PRT was initiated at the end of Q4. This group will develop a complementary framework which will enable LHINs to:

- Assess their educational needs;
- Understand how education and training programs align with the BSO target population, BSO core competencies, and each other;
- Select appropriate learning and development programs to meet those needs; and
- Consider key strategies to ensure programs lead to change in both skills and practice

### 3.4 Unspent HHR for training backfill, training counts

**Ministry Grants Discretion to Use Unspent HHR Allocation on Training**

In December, CRO asked the ministry for discretion to use surplus BSO salary finding to backfill for staff to attend behavioural supports training. The ministry concurred with the interpretation of the funding policy that allowed the use of unspent salary dollars for backfill during behavior support related training for PSWs and for Other Related Professionals. The funding policy

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**LIVING WITH DIGNITY**

Brian used to worry about the phone calls he would receive two or three times a week from Cummer Lodge, a long-term care home in North York where his wife, Joann, resides. Inevitably, the caregiver on the other end of the phone would recount an "incident" involving his wife, who was prone to outbursts of anger. Joann’s feelings and expressions were due to progressive dementia caused by Huntington’s disease, a degenerative brain illness. All would unexpectedly change when, in 2011, Joanne was invited to participate in Central’s Behavioural Support Bed pilot project.

The BSO project has allowed local health care providers to hire new cross-functional staff/teams - 11 new full time staff since February of this year, and to train new and existing staff - over 850 to date, in the specialized skills necessary to provide quality care for people with responsive, often complex and challenging behaviours.

Brian believes his wife is getting the right behavioural support care because the program focuses on the unique needs of the individual and, in little more than a year, he has seen significant improvement in his wife’s behavior since Joann was admitted to the program.

“The positive change in her has been by leaps and bounds, Caregivers are making a concerted effort to see what interests Joann and what she may need, such as doing crafts or other activities. This program has allowed my wife to regain her dignity.”

- Central LHIN
clearly indicated that the funding for new BSO-funded professionals cannot be used to support operating (e.g. administration) or education costs. The communication on this interpretation occurred in February which provided limited time to implement other training programs opportunities.

After approval, the majority of LHINs moved quickly to offer front-line training to as many eligible LTC home and community staff as possible. There have been very focused and intensive training programs for new hires including BSO training for front-line staff. A total of over 3,500 front-line staff have had the opportunity to be trained to deal with responsive behaviours in addition to the new BSO hires e.g. First, P.I.E.C.E.S, GPA, Montessori.

The capacity-building nature of these training programs have empowered staff to help change the culture and improve the care and services for older persons with challenging behaviours.
3.5 Tools for Quality Improvement: CHARTRunner

“How will we know if a change is an improvement?” is one of the foundational questions in the Model for Improvement (Langley, Nolan, Nolan, Norman, Provost and Moen, 2009). Recognizing that the ability to definitively interpret changes in data over time is the “gold standard” for evaluating quality improvement efforts, CRO purchased four concurrent-user licenses for CHARTrunner, a user-friendly Statistical Process Control software application.

These licenses will be accessed by all 14 LHINs, with training offered by HQO to all local Improvement Facilitators. This enhanced skill will allow them to generate control charts, synthesize results from a family of measures, and interpret the information to make recommendations for next steps. It will enable decision making to focus efforts toward achieving improvement targets, demonstrating this through the data, and eliminating errors that commonly occur when teams either over-react to random variation or under-react to evidence of a true change. This skill will be transferable to any initiative and will bring a new level of rigour to quality improvement.

Provincially, there is some familiarity with this application since CHARTrunner was selected for use in the FLO Collaborative and Integrated Client Care – Wound Care initiatives (both sponsored by the Ministry of Health and Long Term Care). This consistency allows for training modules to be developed, refined and shared, and assists in orientation of senior leaders to the interpretation of the data.
## 4. Project Management

### 4.1 Changes to Project Governance Structure

There were no changes to the project Governance Structure in Q4.

### 4.2 Risks and Mitigation Strategies

<table>
<thead>
<tr>
<th>Risk</th>
<th>Outline</th>
<th>Mitigation Strategies</th>
<th>Implemented (Y / N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hiring</td>
<td>Identified as a risk in the Q3 Report, satisfying hiring targets remains a notable challenge for a number of LHINs across the Province. The BSO project is one of many projects, internal and external to the Provincial Government, looking to hire quality HHRs from a finite talent pool.</td>
<td>Monitor recruitment challenges and develop local strategies depending on issues.</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discuss and develop strategies with associations.</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Open up discussions with ONA and RNA re: recruitment strategies.</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Continue knowledge sharing.</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Leverage and coordinate existing Provincial and HSP HR resources.</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop &quot;Buddy System&quot; recruitment pools.</td>
<td>N</td>
</tr>
<tr>
<td>Measurable Outcomes in Admin. Data</td>
<td>System-level BSO impacts are unlikely to become apparent in administrative data until 2013.</td>
<td>Detailed reporting on, and evaluation of, process measures linked to key MOHLTC system measures.</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Through the BSO Impact Assessment, develop and validate a Quantitative Evaluation Framework that is available for ongoing monitoring after BSO Phase 2 concludes.</td>
<td>Pending by Q3</td>
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<td>Implementation Delays</td>
<td>Depending on the service model adapted by the LHIN, hiring, contract and/or negotiation delays, may require implementation plans to be pushed back. Issues are LHIN-specific and are being treated on a case-by-case basis.</td>
<td>Implement thorough &quot;activity tracking&quot; to isolate service impacts across all LHINs.</td>
<td>Pending in Q1</td>
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<td>Control the controllable: Focus on alignment, integration, training and development of existing HCPs and their resources.</td>
<td>Y</td>
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<td>Do what you can, when you can: Assess timelines against service models for potential deviations from plan.</td>
<td>Y</td>
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<td>Knowledge broker: explore the potential for shared resources through the creation of &quot;Buddy HSP's&quot; within respective LHINs.</td>
<td>In some cases</td>
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<td><strong>Limited Scope</strong></td>
<td>There is growing community and HSP pressure to address the disparity between the disproportionate deployments of resources to LTC vs. the broader BSO demographic as a whole.</td>
<td>Assess the current state of additional sectors and what resources will be required / available to meet the service need.</td>
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<td>Leverage/align BSO activities with other LHIN initiatives that target the BSO demographic such as programs that target individuals with dual diagnosis, people living in community with or without recent hospitalization.</td>
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<td>Expansion will involve enhanced support to Primary Care providers, inter-institutional transfer and collaborative care (hospitals, community services, etc.). Lessons learned working with the LTC sector will be utilized in work with other sectors in accomplishing this expansion.</td>
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<td><strong>Sustainability</strong></td>
<td>As the project has moved from development to full implementation, there is a need for a supporting infrastructure to sustain the program and its key linkages and successful elements. The development of permanent operational protocols that will outlive the CRO must be considered.</td>
<td>Further integration of related new and existing programs such as Nurse Led Outreach Teams, Nurse Practitioner initiatives, Home First, Elder Friendly Hospitals, Seniors Health Strategy, Primary Care Alternate Funding Strategies, Virtual Ward Initiatives and other ER/ALC initiatives.</td>
<td>N</td>
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<td>Establish and identify mechanisms that ensure ongoing bilateral accountability at the leadership and service delivery levels through the cooperative agreement, the interagency QI events (Kaizens) and the BSO Liaison Staff in the LTC Homes.</td>
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<td>Define BSO related education requirements for sustainability and implementing the plan.</td>
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<td>N</td>
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<td>Ongoing sustainable Learning platforms including learning management systems and tools.</td>
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<td>Identifying funding from within the LHINs health service provider allocation to address the operational funding required to sustain the program moving forward.</td>
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<td>N</td>
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<td>Processes/Protocols: Est. of a working group to begin exploring QI’s that focus on sustainability.</td>
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<td>N</td>
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### 4.3 Lessons Learned

To continue to learn from and build on success to date, the BSO project has committed to embedding an ongoing process to surface lessons learned. On a regular rotation schedule each LHIN will be invited to a meeting with the Provincial Resource Team to provide an update on local implementation to date. Part of this process requires that the LHIN also reflect on and identify lessons learned throughout implementation and planning. To this end, the following tables reflect a ‘living document’ which will continue to be updated and added to throughout BSO project implementation.

<table>
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<td><strong>LHIN BSO Project Team</strong></td>
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| • HNHB LHIN - Establishment of an internal LHIN staff project team consisting of 6 LHIN staff. Members of the LHIN internal project team included those LHIN staff that completed the expression of interest. This facilitated planning and development of the action plan.  
| • HNHB LHIN Identification of the improvement facilitator from LHIN staff, whose portfolio included LTC. This allows the LHIN to retain the learning and expertise for other LHIN projects.  
| • HNHB LHIN A dedicated BSO Project Committee with cross LHIN and cross sector representation with in depth knowledge of the system and how the system could function by eliminating gaps and duplications.  
| • HNHB - Inclusion of HNHB LTCH Council Co Chair on the BSO Project Committee.  
| • SE & NSM – Identification of Provider to lead BSO project and day to day operations  
| • A dedicated Improvement Facilitator and Project Lead.  
| • HNHB Implementation Project Lead dedicated to the BSO project with specific skills and knowledge to support the project. |
| **Quality Improvement Support** |  
| • HQO coaching and support and a culture of change and flexibility which decreased anxiety.  
| • Improvement Facilitator training from HQO and dedicated HQO coaches for the early adopter LHINs working closely with the Improvement Facilitators.  
| • Consistent tools and templates to support quality improvement.  
| • A dedicated Improvement Facilitator and Project Lead.  
| • HQO lead value stream mapping and QI process with inclusion of LHIN provider participation (shared knowledge of project and facilitated buy in with project goal).  
| • Ongoing HQO support for improvement projects. Value to identify ongoing supports among the LHIN to support the QI process in the first year.  
| • With the support of HQO, several kaizen events and hundreds of volunteer hours from 80+ experienced workers on the seven QI working groups, we have heightened the awareness of Lean methodologies across NSM LHIN and perhaps more importantly, there is a much deeper understanding about how “small tests of change” can positively impact their work and the patient/client experience through continuous improvement – this new learning has built capacity in NSM and will be sustained as new knowledge across projects beyond BSO/BSS in the years to come.  
<p>| • We participated in a Kaizen event in another LHIN on Enhanced Access/Intake. Lessons learned and tools developed will help the our LHIN with its own Standardized Intake/Referral process. |</p>
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| **Knowledge Exchange**| • An accessible knowledge exchange portal supported by the Alzheimer’s Knowledge Exchange and shared by all LHINs.  
• Inviting buddy LHINs to attend Value Stream Mapping.  
• Early adopter LHIN knowledge exchange events and webinars, resulting in each LHIN presenting their future state with an explanation of their improvement plans and how these would impact the future state. This also enabled themes to emerge and be classified as local LHIN level or provincial.  
• Weekly conference calls with our buddy LHINs to review challenges, share lessons learned and work to date. This has enabled information and existing tools to be shared by from HNHB to their buddy LHINs and from the buddy LHINs to HNHB. As well, sharing contacts to enable further knowledge exchange.  
• BSO presentations are being given at existing forums throughout the LHIN to increase awareness of the project, answer questions and enable engagement and sustainability.  
• There seems to be an excitement/willingness to start coordinating and sharing across the silos.  
• Support and sharing from PRT.  
| **Communication**     | • A provincial communication strategy.  
• A LHIN level communication strategy with physician engagement. The HNHB LHIN physician lead placed an article in the Hamilton Academy of Medicine November 2011 Executive Report.  
• Importance of communication to all clear definition of target population.  
• Inclusion of a virtual ward concept and building on OTN and telemedicine programming to increase capacity especially in the North.  
| **Project Management Support and Resources** | • A single project management tool, Eclipse, is being used by all LHINs for consistent monitoring and reporting of tasks and progress.  
• A standardized dashboard with reporting that is visible to all LHINs supporting a provincial approach and a platform from which to build upon. Funding to support temporary postings for Project Managers to support specific improvement plans.  
• Funding to support health human resources in LTC and the community.  
• A LHIN appointed Physician Lead who is engaged in leading one of the improvement plans.  
• It is critical to the success of a large project such as BSS to ensure that adequate resources are committed right up front. For example, NSM established a knowledgeable and committed group of service providers to develop the Action Plan and to oversee and guide the implementation of the project (the Interim Steering committee met bi-weekly throughout the entire project); hired an Implementation Coordinator to oversee the day-to-day project tasks/activities and ensure that deliverables were met on time and within budget; and created a skilled and experienced internal team to manage the project. The ministry funding for Early Adopter LHINs was instrumental in the ability to develop new processes and resources for system redesign.  
| **Planning**          | • Identification of risks and the development of strategies to mitigate these risks early on and throughout the process.  
• Project team members with knowledge, expertise and a vision of an improved future state.  
• Value of involving individuals who will be implementing change early in planning process.  
• Cooperative agreements let us work together, manage and adjust the service as we move forward in our LHIN.  
| **Consumer Participation** | • Inclusion of consumer (client or family) in planning change i.e. value stream mapping.  

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| LHIN Support                | • LHIN Board approval for financial support for indirect costs associated with LTCH mobile resource teams.  
                              • Many LHIN staff providing support for the BSO project.                                                                                                                                                                                                                       |
| LTCH Operations             | • Early engagement of LTCHs.  
                              • Early engagement with and support from the LTCH network at local level facilitated uptake of project eg HNHB used Network Council.  
                              • LHIN Identification of sole LTCH provider with them assuming responsibility of day to day operations eg SE LHIN.  
                              • The flow of funds is best consolidated within in 1 or 2 providers for greater standardization of salaries, personnel policies etc.  
                              • Ensuring that MOU’s are developed and in place between outreach teams and LTCHs.                                                                                                                                 |
| Early Identification of Risks/Challenges | • Early identification and elevation of LTCH funding policies allowed for CRO to elevate to MOH for timely resolution.                                                                                                                                                                                                                     |
| Stakeholder Engagement      | • LTCH folks enjoy smaller groups in order to feel more comfortable learning and sharing.  
                              • The BSS Project has brought senior level decision-makers from across sectors to the same table for the first time with a shared vision to provide better care for older adults with responsive behaviours as it is identified as a priority in primary care, acute care, long-term care and community care – individual organizations are beginning to realize their role as service provider within a system of care versus a siloed service sector.  
                              • Although it is not necessarily a new lesson, through the QI Working Groups we have put into practice the knowledge that one should involve the people that work on the frontlines that know and do the clinical work in the field and are most aware of how the system works (or not) across agencies and across sectors in developing new processes and in changing practices – this has resulted in high enthusiasm for the BSS project and shared accountability for its successful implementation.  
                              • At first, LTCH was hesitant (concerns about being evaluated). Through reassurance, building on existing trusting relationships & explaining BSO Project & Philosophy, agreement to participate in testing was accomplished.  
                              • “As co-chair of the HNHB LHIN LTCH Network Council, I was especially pleased to participate …. for the BSO project, the LHIN asked the Network Council for their input on implementing the project. This demonstrates the LHIN’s commitment to espouse the principle of involving the community and health service providers in the planning and implementation of important initiatives, such as the BSO project.”  
                              • “Community and health service provider members serving on the various committees, including the Mobile Team HR sub-committee, contributed in-kind, through many hours of work in order to meet objectives and deliverables. This was especially evident from the staff of the Lead Facility, St. Joseph’s Villa.” Operations Manager, LTCH.  
                              • “It was my pleasure to participate in the BSO LTCH HR subcommittee. It was rewarding to be a part of such a dynamic group. I had the opportunity to invite the newly hired staff into one of our LTC homes to spend the day and observe/interact with our residents and staff. The interaction, sharing and caring between my staff and the BSO staff was exciting to witness. I am confident that the BSO teams will be a welcome partner in our goal to provide the best care possible to our residents.” CEO, Health Care Corporation. |
| Implementation               | • Start small – the program will develop over time.  
                              • Celebrate all accomplishments.                                                                                                                                                                                                                                                                                                      |
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| **Timelines and Planning**  | - Encourage operational level input in the development of the project to identify operation issues and mitigation strategies - can then make informed decisions to adjust project deliverables.  
- Timelines that enabled more time for planning for both VSM and the action plan.  
- Need for a clear definition of who the target population includes, ie; who is “in” and who is “out”.  
- Have foundational elements RESOLVED prior to launch – ie; funding policy, tools resources.  
- If announcements are delayed then Timelines MUST be altered in accordance with launch and delivery.  
- Due to tight timelines the ability to fully plan for and understand the impacts to implementation were not appreciated. As a result, we are identifying challenges in moving forward until more operational details are determined.  
- Many parallel streams are occurring which are not in accordance with lean processes.  
- Timing of implementing improvement plans without confirmation of performance indicators and baseline data. |
| **Project Support and Resources** | - Communicate early and communicate often.  
- Dedicated administrative support for the project team identified at the start of the project.  
- Agreement on tools and templates for all LHIN submissions and presentations. |
| **Value Stream Mapping**     | - The ability to meet with attendants of VSM in advance to discuss process, expectations and management of emotions would have benefitted the attendants and decreased the anxiety at particular points in the process.  
- Invitations for VSM, ideally should have been based on cross sector, cross LHIN representation. Due to tight timelines invitations were given to more individuals than were necessary however this did result in a good cross representation of community, LTC and acute care as well as various positions within each organization.  
- Timing of QI should have been after the hiring of new staff so they could participate in the outcomes. |
| **LTCH Support**             | - Early engagement of key stakeholders i.e. LTCH.  
- LTCH funding allocations/LTCH funding policies.  
- More clarity required on funding letter and allocations around FTEs, it’s requirements and limitations. Ideally, issues should have been addressed before release. Suggested solution right after funding letter released would have been a face-to-face meeting including operational level resources.  
- Lost opportunity to identify LTCH Champions for BSO project and change  
- Required volunteer time to meet extremely tight timeframes from agency service programs has potential to burn out provider resources and negatively impact on their own performance targets. The expectations and deadlines may in turn negatively impact other aspects of the system.  
- LTCH staff are currently stretched and finding it difficult to meet the needs of the responsive behaviours within their homes.  
- Difficult to ensure BSO team are not called to the “floor” to assist with other tasks other than support for resident behaviors. Reinforce need with leadership in LTCHs to support and enhance dedicated roles of BSO workers so they can coach and teach other front-line staff to reduce challenging behaviours of and all reduced challenging behaviours result in positive changes noted by all front-line staff. |
### Opportunities for Improvement

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| **Health Human Resources**         | • Establish a provincial HHR steering committee early in the process to identify mitigating strategies for potential risks and barriers. Delay in the establishment and functioning of the 4 LHIN HHR committees resulted in the need to establish local HHR committees to adhere to timelines for the early adopter LHINs. A provincial decision making process with guidelines for the identification of the employer(s) of the new BSO resources would have provided structure and consistency at the beginning of the process.  
  • The flow of funds are best consolidated within one or two HSPs to standardize salaries, personnel policies etc.  
  • Some homes would have preferred ability to select type of HHR e.g. more RPNs as opposed to PSWs. |
| **Role Clarity**                   | • Clarify and resolve stakeholder roles – HQO vs. Nursing Secretariat vs. Associations vs. MOHLTC vs. LHINS vs. service providers.  
  • Greater clarity as to the role of CRO/PRT/HQO/LHIN at the beginning. While defined in a governance perspective – were not always clear from an accountability and roles/responsibilities perspective.  
  • This created tension in who is “driving” the process, and who is ultimately accountable. Ultimately, the LHINs are accountable for delivering on the Framework of the BSO – and sometimes this accountability was overshadowed in efforts to create consistency of a BSO Branded project. |
| **Operationalizing a Framework**   | • Significant energy was spent translating the original BSO Framework into an operational plan that navigated the requirements of the Framework and the funding and policy limitations provided the MOHLTC. Lesson learned: Provide more flexibility in bottom up approaches that are consistent in ends and principles, but allow for unique characteristics of delivery platforms.  
  • Action Plan Guidelines - repetitive and does not allow provision of clear plan. (EOI was better).  
  • Submitting an action plan in a response to question format – resulted in a final document that had to be reworked prior to sharing with providers, which required additional time and effort. In addition, to meet the funding requirements the endorsed document could not be substantially revised. As a result a third document will need to be prepared to share with general public.  
  • Need to continuously identify what BSO is or isn’t ie catalyst for change, not only a new service.  
  • Action Plan Guidelines – recommend a different format other than a series of questions so that a clear plan is developed. |
| **Implementation**                 | • Across the three clusters within our LHIN, the process was very much the same providing care to the BSO target population.  
  • Staff really see a need for change but didn’t necessarily feel empowered to make changes due to their current workload – no time to question the current process – just get it done… |