Developing a Behavioural Support System for Older Persons with Responsive Behaviours in the South West LHIN

Action Plan: Part A

April 5, 2012 (revision)
South West Local Health Integration Network (LHIN)

Behavioural Supports Ontario (BSO) Action Plan – Part A

The South West LHIN Behaviour Support System (BSS) Steering Committee developed this action plan with consultation from care providers, educators, and researchers with expertise in responsive behaviours. Various provincial mental health reports and guidelines were reviewed. In addition, to gain a greater understanding of the gaps within existing services providing care for older adults with responsive behaviours the committee:

- Developed a stakeholder engagement strategy which comprised sending a survey to each of the 78 Long-Term Care (LTC) Homes, Adult Day Programs (ADP), Alzheimer Societies, and the specialized outreach teams which provide services to LTC Homes and community across the South West LHIN.
- Conducted focus groups with ADPs and the Alzheimer Societies.
- Consulted each of the BSS, geriatric cooperatives\(^1\) to provide suggestions/recommendations to enhance the system of care locally and LHIN wide.
- Facilitated discussions at a community engagement session with over 150 LTC home participants as well as through follow-up teleconferences as directions emerged.
- Conducted a Value Stream Mapping exercise with over 30 healthcare partners (including caregiver and frontline input).
- Compiled and reviewed available data (see Appendix A) for individuals with responsive behaviours across the South West LHIN.
- Reviewed reports and guidelines including:
  - Mental Health Commission of Canada (2011). Guidelines for Comprehensive Mental Health Services for Older Adults in Canada.
  - Erin Finley, Elizabeth McCarthy, and Michael Borrie, Regional Geriatric Program (2011) A Summary of Senior Friendly Care in South West LHIN Hospitals

\(^1\) The Behavioural Supports System Project was funded through Year 3 Aging at Home Dollars to develop a Behavioural Support System across the South West LHIN for Older Adults and their Caregivers with Responsive Behaviours. Five Geriatric Cooperatives have been formed across the LHIN. Geriatric Cooperatives have a community advisory role and cross sector membership. This project will be described in further detail throughout this document.
The information collected assisted the BSS Committee to identify areas along the care continuum that were key components to improving the patient/client and their caregivers’ journey through the system of care.

**BSO Framework for care Pillar #1: System Coordination.** Coordinated cross-agency, cross-sectoral collaboration and partnerships based on clearly defined roles and processes to facilitate “seamless” care.

1. System coordination gap and weakness analysis: identify impediments to seamless care related to cross-agency and cross-sectoral partnerships.

A review of the current health system across the South West LHIN revealed that in order to improve the patient/client and caregiver experience system transformation is required. System change needs to be broad and occur at all transition points across the care continuum.

**Key Gaps in System Coordination Identified:**

- Limited access to specialized expertise providing comprehensive assessment, intervention, care planning and follow-up. Additionally, current geriatric mental health mobile outreach teams are overwhelmed by the demand for their services. The South West LHIN encompasses a large geographic area with a 69% urban and 31% rural mix. In 2008/2009, seniors (>65 years of age) accounted for 19.1% of the South West LHIN’s total population (Bronskill, 2010). It is anticipated that the number of seniors over the age of 65 years will increase in each of the three planning areas across the South West LHIN by 2022 with the northern and southern areas experiencing the greatest increases. Northern areas currently do not have equal access to specialized services as most specialized services are located in the southern portion of the LHIN where 70% of the population resides.

<table>
<thead>
<tr>
<th>Planning Area</th>
<th>Seniors (&gt;65) 2012</th>
<th>Seniors (&gt;65) 2022</th>
<th>% Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>North (Grey Bruce)</td>
<td>34,108</td>
<td>46,353</td>
<td>36%</td>
</tr>
<tr>
<td>Central (Huron Perth)</td>
<td>24,125</td>
<td>31,620</td>
<td>31%</td>
</tr>
<tr>
<td>South (London, Middlesex, Elgin, Oxford, Norfolk)</td>
<td>99,345</td>
<td>136,144</td>
<td>37%</td>
</tr>
</tbody>
</table>

**Source:** Jim Whaley. (2011) “The Time is Now: A Plan for Enhancing Community Based Mental Health and Addiction Services in the South West LHIN.

- Inconsistent and inadequate evidence-based education and service learning for health care providers working with older adults who may exhibit responsive behaviours (e.g. LTC home, community, hospital, primary care, etc). Lack of Enhanced Psychogeriatric

---

2 Dr. Walker in the “Caring for Our Aging Population and Addressing Alternative Level of Care” report (p.6) Recommends that Cross System Responsiveness is required for Special Needs Populations, Specifically, Older Adults with responsive behaviours who need knowledgeable care providers.
Resource Consultants (EPRCs), PIECES (Physical, Intellectual, Emotional, Capabilities, Environment, Social & Cultural) trainers and other specialized expertise to disseminate and leverage evidence based practices.

- Lack of coordinated intake and triage processes to provide timely access to appropriate services and supports. As a result:
  a. Care providers and caregivers are unsure of who to call or what services and assistance is available to them.
  b. Clients and caregivers (who are often ill equipped) are required to navigate the system on their own\(^3\), which may result in caregiver fatigue.
  c. Clients often wait several weeks or months to access specialized services in their local community (especially rural areas).
  d. Clients many not receive the most appropriate care from the most appropriate provider in a timely manner.

- Health Human Resources: lack of coordinated human resources recruitment plan, particularly those skilled in care of older adults. Recruitment of health human resources is a real challenge due to the shortage of nurses, allied health professionals, and personal support workers across the South West LHIN. With the recent funding of multiple healthcare initiatives, recruitment and retention of staff is a serious issue compounded by competitive recruitment practices and salaries and unionized versus non-unionized environments.

- Insufficient use and uptake of technology and telemedicine to provide care. Prior to 2011, one out of 77 LTC Homes (7500 beds) had access to Ontario Telemedicine Network (OTN). Through the Aging at Home-funded BSS project, approximately 45% of LTC Homes will have OTN equipment in their homes. Numerous Family Health Teams (FHT), Community Health Centres, Hospitals, and Community Care Access Centres (CCAC) also have OTN equipment. There continues to be a gap in motivating healthcare providers to use technology for care delivery and education. The creation of business processes and the development of an education and marketing strategy will be required to facilitate the increased use of OTN and telemedicine to spread resources across the LHIN to ensure equitable and timely access to care.

- Seamless transitions and collaboration is an issue (primary care, acute care, geriatric specialists, community care, LTC Home). The absence of a shared electronic patient record often leads to inadequate sharing of patient/client information and poor communication between care providers. As a result, the client/caregiver may experience inadequate care that is siloed, inconsistent and delayed, thus creating stress and frustration for the client and caregiver as they must repeatedly retell their story and re-advocate for their needs.

- Up to this point in time, primary care (Family Physicians and FHTs, Family Physicians in LTC Homes) has not been effectively engaged in the Behaviour Support Systems Project across the South West LHIN and is not represented on the Steering Committee. The South West Community Care Access Centre (SW CCAC) has been actively engaged in this project, and is not an identified gap. Stronger linkages need to be made with primary care and champions identified.

\(^3\) At our Value Stream Mapping Session, all 3 Caregivers agreed they were forced to navigate the healthcare system on their own, and noted that they would have benefited from numerous services if they had known about them.
• Primary care needs to be engaged to provide sufficient proactive care for the geriatric population with multiple co morbidities. “The primary care system needs to ensure that access to primary care is made a priority for seniors living at home or housebound”.  

• Clinical pathways, protocols, and standardized assessments need to be developed that can enhance communication across sectors, and facilitate timely assessment and transitions across care.

• Prior to the BSS Project, a serious gap was identified in that only 0.5 “designated” FTE Psychogeriatric Resource Consultants remained from the original funding from the 2000-01 Alzheimer Strategy across the South West LHIN.

• Very little data is currently being collected on this target population and data are captured in different ways. A sustainable way to collect data is needed across Ontario.

• Senior specific addiction services currently do not exist within the South West LHIN despite the growing need.

The South West LHIN believes these gaps can be minimized and/or eliminated through the three BSO Pillars: system coordination and management, integrated service delivery, and knowledgeable care team and capacity-building.

a. What are the structures in place to provide/support LHIN wide coordination of services?

Through Aging at Home funding, the St. Joseph’s Health Care London Regional Geriatric Psychiatry Program at Regional Mental Health Care of London was identified to perform LHIN-wide coordination for the South West LHIN’s BSS Project. A BSS Steering Committee and a Project Lead is in place to ensure the LHIN-wide implementation of the BSS project. The aim of the project is to develop a behavioural support system for older adults with responsive behaviours. (See Placemat - Appendix A). Five geriatric cooperatives have been formed in each local area. The cooperatives have an advisory function and are co-chaired by a Schedule 1 Director, and Community Representative (e.g. Executive Director, Alzheimer Society, or Director of Care, LTC Home). Cooperatives have cross-sector membership representing all transition points within the continuum of care. Local gaps in service wait lists, human resource shortages and pressure points are discussed and local solutions to the issues are identified. Cooperatives will also play a key role in developing education and capacity-building strategies. Each cooperative is supported by an EPRC who collaborates with other EPRCs across the LHIN to ensure consistency in evidence-based approaches to education for care teams and continuity in application and of assessment tools. The EPRC will link with other specialized geriatric services (includes both geriatric medicine and geriatric psychiatry).

• **St. Joseph’s Health Care London (SJHC)** is an academic health sciences centre which has demonstrated leadership through patient care, teaching and research. SJHC has a successful history of forming innovative partnerships with its community partners, area hospitals, and the CCAC to provide a high level of care.

• **Regional Psychogeriatric Program (RPP)**, SJHC London, is a specialized mental health outreach service that works with local care providers to enhance the care of older adults who are challenged with mental health problems such as depression, psychotic disorders and dementia. RPP improves community access to geriatric psychiatry expertise including delivery of direct clinical consultation, assessment, care planning,
and follow-up. RPP works closely with local care providers to build their capacity through evidence based education.

- **Regional Mental Health Care (RMHC), Geriatric Psychiatry Program**, SJHC London provides tertiary geriatric mental health care for aging clients/patients who suffer from severe mental illness, with a focus on assessment, treatment, rehabilitation, transition support, illness prevention, family/community support and education. The Interdisciplinary Teams provide a bio-psychosocial approach to care, which encompasses the mental, physical, spiritual, cultural, psychological and social aspects of aging. Ambulatory, Outreach and inpatient services are offered. Established expertise in the transitioning complex and stable patient with mental health issues from tertiary care and LTC Home through the Discharge Liaison Team (DLT). The experience with transitioning patients will be transferred across the continuum of transitioning patients. The RPP and the Geriatric Psychiatry Program share the same Program Director.

- **Specialized Geriatric Services (SGS)**, SJHC London is an umbrella term to identify a range of medical and mental health services that focus on the care of the elderly. SGS provides a range of medical and mental health services which includes inpatient, outpatient, specialized geriatric medicine clinics (e.g. aging brain and memory, mild cognitive impairment), and outreach services for the frail elderly across both the Erie St. Clair (ESC) LHIN and the South West LHIN that specialize in the assessment, intervention, and management of older persons with functional decline, frailty, and complexities.

  - **Regional Geriatric Program (RGP)** provides a comprehensive network of specialized geriatric services which assess and treat functional, medical, and psychosocial aspects of illness and disability in older adults who have multiple and complex needs. Working in collaboration with primary care physicians, community health professionals, and others seek to meet the needs of the most frail and vulnerable seniors serving both ESC LHIN and the South West LHIN.

  - **South Western Ontario Geriatric Assessment Network (SWOGAN)** was developed by Specialized Geriatric Services in 2000 under the direction of the Ministry of Health and Long-Term Care (MOHLTC). SWOGAN is a leader in comprehensive geriatric assessment, consultation, education/capacity-building, research and evaluation. The network links geriatric/psychogeriatric assessment teams across 10 counties within ESC and South West LHINs. SWOGAN partners include the CCAC, Hospitals, primary care physicians, Alzheimer Societies. SWOGAN is a cross-sector interdisciplinary model that facilitates cross-sectoral collaboration and partnerships. The Network is comprised of interdisciplinary outreach teams who are supported by SGS, based at SJHC London, Parkwood Hospital and Geriatric Medicine and Geriatric Psychiatry at The University of Western Ontario.

- **Six Chapters of Alzheimer Societies** - The Alzheimer Societies work closely together and offer standardized First Link programs and public education programs for older adults with Alzheimer disease and their families/caregivers and with other community and social service providers specializing in dementia care (e.g. ADPs).

- **South West CCAC** - Provides access to community care and links people with a wide range of services and supports. The South West CCAC leads the Advanced Home Care Team including Nurse-led LTC Home Outreach Team, and the Geriatric Resource Team (GRT).
• **London Health Sciences Centre (LHSC)**, one of Canada’s largest acute-care teaching hospitals, also linked with The University of Western Ontario and the Academic Health Sciences Network in Southwestern Ontario, provides expert care to older adults who need acute tertiary care. A number of geriatric specialty programs operate at LHSC.

  o Geriatric Emergency Management (GEM) nurses operate out of the Emergency Departments (ED) at both University Hospital and Victoria Hospital. Because approximately 25% of ED patients who are 75 or more years of age have geriatric syndromes including falls, confusion, incontinence, failure to thrive, caregiver stress, EM nurses increase capacity for care of older adults in the ED, promote linkages with community service providers and provide expert care.

  o The Acute Care of the Elderly (ACE) unit within Medicine Services cares for patients over 75 years of age with presence of geriatric syndrome and acute illness. One of the goals of this 14-bed medical clinic teaching unit is to increase geriatric-specific knowledge among students in nursing, physical therapy, occupational therapy and medicine.

  o The Consultation Liaison (CL) Team at both University and Victoria Hospitals is a specialized service that provides timely consultation to older adults who are currently on either medical or surgical units who may be experiencing the “geriatric giants”.

  o Geriatric Mental Health Program operates as a specialty program within the Adult Mental Health Care Program, LHSC. This is an interdisciplinary team designed to provide geriatric psychiatry consultation, assessment and treatment to seniors and their families living in the community.

As a result of these programs, expertise in the care of those with delirium has been built throughout the hospital. In addition, expertise in delirium research has been developed.

• **Schedule 1 Hospitals** provide a leadership role for the aging at home funded BSS Project through the Seniors Mental Health and Addictions Response Teams. They include: LHSC, St. Thomas Elgin General Hospital (STEGH), Woodstock General Hospital, Huron Perth Healthcare Alliance (HPHA), Alexandra Marine and General Hospital (AMGH), and Grey Bruce Health Services (GBHS). Memorandums of Understanding (MOU) are in place for each Schedule 1 Hospital and SJHC London (lead agency). The MOUs clearly outline the roles and responsibilities of the partners and their accountabilities. GBHS has 14 geriatric mental health beds.

• **Home First** The South West LHIN has embraced a Home First philosophy that promotes safe and timely care to meet health care needs of patients and families in the most appropriate setting – “Every patient admitted to the hospital will be discharged home” – so that decisions about major changes in lifestyle, including moving to supportive housing or long term care, can be made from home, not from hospital.

• **South West LHIN Senior Friendly Hospital Strategy** aims to improve the health, well-being and experience of seniors in Ontario hospitals, helping them to get back home sooner. This initiative helps to reduce alternative level of care days by supporting older adults to transition to the right place of care after a hospital stay. With the aging of the baby boomers, more seniors will be accessing the healthcare system. In 2008/09 seniors 65+ accounted for 19% of the South West population (Bronskill, 2010). This substantial rate will continue to increase. The time has come to focus on hospital-wide, LHIN-wide and Ontario-wide strategies that support the health and recovery of senior patients. Many hospitals across the LHIN provide senior friendly care; however, none
have implemented a hospital-wide strategy to ensure that seniors’ needs are met. The alignment of “Senior Friendly” care principles with the BSO project is important and needs to be further explored.\(^5\)

**In the South West LHIN Seniors 65+ account for:**

- 73% of hospital days
- 82% of ALC days
- 20% of ED visits
- 61% of readmissions within 30 days

RGP Senior Friendly Surveys (2011)

- **South West Primary Care Network**
  provides the necessary structure to connect primary care providers in the South West and is the primary conduit for programs and/or organizations needing to engage with the region’s primary care providers.

  The Network is governed by the region’s primary care providers and has been supported, in part, by the South West LHIN. Membership of the Network represents the breadth of primary care practice both structurally (Family Health Team, Family Health Organization, Fee for Service) and clinically (Palliative Care, Cardiac Care, etc.) and, specifically, consists of Primary Care Leaders from the North, Central and South geographic areas of the South West LHIN and representatives from the Ontario Medical Association, Ontario College of Family Physicians and Nurse Practitioners’ Association of Ontario. The Network consists of ten members who commit to participate for two years. The South West LHIN Primary Care Lead and the Regional Lead for Diabetes co-chair the Network.

  The Network holds two face-to-face meetings and six web-based/teleconference meetings per year. Topics for discussion are brought forward or informed by the Network membership, South West LHIN portfolios and regional partners (i.e., programs and organizations that may support and/or use the Network). Depending on the topic, the South West LHIN will engage the Network for any of the following purposes: Inform and/or Educate; Consult; Involve or Collaborate.

- **South West LTC Home Network** – newly formed within the South West LHIN in November 2011. It is anticipated the network will be operational early 2012.

\(^5\) Based on the South West LHIN Senior Friendly Surveys (2011) conducted by the Regional Geriatric Program London
b. How will structures be modified to improve coordination?

The BSS Project was the ideal conduit through which the BSO funds could be flowed. The BSS project provides the infrastructure for the leadership, funding, system integration (geriatric cooperatives), capacity-building and education. Many successful partnerships and collaborations have been formed across the South West LHIN (e.g. CCAC, GEM, BSS Project, RGP, RPP, SGS, and SWOGAN) which are efficaciously facilitating system coordination and equitable access to behavioural support system support services.

Existing geriatric outreach team models (CCAC GRT, RPP, RGP, etc.) will be reviewed and best practices identified. It is important to leverage existing models and start with what works, making adjustments to ensure the full client spectrum is included, and then spreading the successful redesign across the South West LHIN. Cycles of quality of improvement will be utilized to find opportunities to collaborate together, Plan Do Study Acts (PDSAs), and continued value stream mapping will be conducted. Opportunities for cross-training and memorandums of understanding will be developed to strengthen coordination.

Coordination of intake and access across the LHIN will be enhanced and/or developed. Establishing standardized assessment tools and clinical protocols are priority areas for improvement as confirmed at the Value Stream Mapping session. Under the direction of the BSS Project Steering Committee, a Model of Care Committee has been formed to develop a list of primary and secondary assessment tools, clinical protocols, and intake/triage functions. For example, established educational programs and curriculum such as PIECES and Gentle Persuasive Approach (GPA) will be utilized.

Currently, a limited number of geriatric and geriatric mental health clinics across the South West LHIN offer timely assessment and follow-up, improving access to appropriate assessment diagnosis and treatment for LTC Home and community. Telemedicine via OTN will be used as often as possible to ensure timely and equitable access to specialty services.

An Education Consortium will be developed to ensure a LHIN-wide approach to capacity-building, leveraging existing specialized resources (Public Education Consultants (PECs), PRCs, SGS partners, Alzheimer societies, an affiliation with UWO and Fanshawe College researchers, educators and evaluators). Needs assessments and readiness surveys will be used to engage key partners. Key partners include the CCAC, Community Mental Health and Addictions agencies, Alzheimer Societies, LTC Homes, Hospitals, FHTs, Community Health Centres, ADPs, and The University of Western Ontario. This work will be led by the BSS Steering Committee, Project Lead, and the Geriatric Cooperatives.
2. **What governance and accountability structure will be in place?**

The South West LHIN Board of Directors will maintain overall accountability for the implementation of the South West LHIN BSO Project, as detailed in the funding agreement between the LHIN and the MOHLTC.

The implementation of behavioural service redesign, consistent with the BSO’s three foundational pillars of System Coordination; Interdisciplinary Service Delivery; and Knowledgeable Care Team and Capacity-Building, has been assigned to the existing South West LHIN’s BSS Steering Committee and RMHC London, SJHC London. They will continue to provide the strategic direction and leadership for the BSS project. SJHC will continue to provide its current coordination role and expand that role through the provision of additional LHIN-wide specialists and facilitation and deployment of LTC Home staffing resources. MOUs will be developed and/or amended with service providers and project partners to ensure clear roles and responsibilities, accountabilities, deliverables, and outcomes.

Given the coordination role that SJHC London currently contributes to the formation of a system of care for older adults with seniors with responsive behaviours and its current provision of care through 2 LTC Homes, tertiary seniors mental health, inpatient, and mobile teams services, and specialized services that include geriatric medicine, and geriatric psychiatry, it is recommended that SJHC receive the LTC Home investments and work collaboratively with the Schedule 1 Hospitals, LTC Homes, and other health care providers to locate and deploy staff and resources, to function as a single integrated team, to support older adults with responsive behaviours. Further articulation of roles, responsibilities and operational details will be confirmed.

Accountability will be ensured through ongoing data collection and outcome indicators will help inform future directions and further redesign.

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

Partners for system coordination will be comprised of all South West LHIN health service provider agencies and key stakeholders across the care continuum that provides services such as early detection, support and management to older adults with responsive behaviours and their caregivers.

Local health system coordination was already underway with the development of the BSS project across the South West LHIN. As mentioned previously, SJHC is charged with LHIN-wide coordination through its project lead and the BSS Steering Committee provides LHIN-wide planning and oversight (see draft organizational chart – Appendix E) to coordinate efforts to deploy services across care settings (e.g. hospitals, LTC Home, client homes, and other community settings, including primary care).

The BSS Steering Committee membership is cross-sectoral and is comprised of health care leaders with expertise in the management and care of older adults with responsive behaviours. This committee has been meeting on a monthly basis since July, 2010. The committee is guided by a Terms of Reference which is reviewed annually. Terms of Reference and minutes from meetings are available upon request. With the BSO initiative, additional long-term care representatives will be added to the Steering Team.

To improve timely and equitable access to specialty services, a review of current SJHC, Regional Mental Health Care, specialized tertiary geriatric and psychogeriatric outreach services (e.g. RPP, RGP, LHSC Seniors Mental Health Team), and mental health and addictions services will need to be undertaken to leverage existing models. Outreach services will redesign how care will be delivered across the South West LHIN with the goal to increase
role clarity, reduce duplication of services, and enhance capacity of some existing teams. Process maps for each program will be developed as key documents outlining access to particular types of services provided. Boundaries of current service delivery parameters will be reviewed and are anticipated to change for existing teams to ensure expertise is leveraged to meet the needs of older adults with persistent responsive behaviours and their caregivers across the South West LHIN versus being hubbed in areas where there is greater access to service.

LTC Homes and Family Physicians will be key partners in developing an integrated behavioral support system across the South West LHIN. We have local primary care champions through the SWOGAN network and Primary care leads will be identified and invited to join the BSS Steering Committee and local geriatric cooperatives. An engagement strategy will be developed, including SGS clinical leadership who have been working with local family health team champions around clinical service delivery models and optimizing quality patient care.

- **Schedule 1 Hospitals** – will continue to provide a leadership role for seniors mental health and addiction response teams. They include: LHSC, STEGH, Woodstock General Hospital, HPHA, AMGH, and GBHS.

- **LTC Homes** – The South West LHIN is in the process of creating a LTC Home Network whose business will be overseen by a small group of representatives who will form a Council. It is expected that this network will provide LHIN-wide guidance and assist to obtain LTC Home representation for focused improvement Behavioural Support initiatives. LTC Homes will also bring a substantial amount of knowledge forward related to particular residents, their LTC Home, and operational elements unique to the sector. Many LTC Home representatives are active participants on the Geriatric Cooperatives.

- **South West CCAC** – will collaborate with health service providers to ensure clients have timely access to community care. The South West CCAC Advanced Home Care Team including the Nurse-led LTC Home Outreach Team and the GRT will be fully integrated into the menu of services available for older adults with responsive behaviours and their caregivers.

a. **How have the partners collaborated on past projects?**

**Working Across both South West LHIN and ESC LHIN, the following projects have been successfully implemented:**

- SGS and the MOHLTC led the development of the SWOGAN Network in 2000. The SGS (RGP and RPP) clinicians provided orientation and intensive training for the startup of the enhanced geriatric teams working out of CCAC. Recruitment of the Care of the Elderly primary care doctors that support the local geriatric outreach teams. The SWOGAN network became a conduit for the ongoing education, training, and mentorship of new clinicians providing care for older adults (GEM, NPs).

- SWOGAN Team Exchange – is an ongoing annual event that has been organized for more than ten years through partnership with SGS, RGP Program, Regional Psychogeriatric Program, CCAC GRTs, and CCAC Nurse Practitioners, GEM nurses, Alzheimer Societies, and Physicians. Healthcare providers from both the ESC LHIN and the South West are in attendance. The SWOGAN network was developed by SGS with the mandate for clinical consultation, assessment, education/capacity building, research and evaluation.
GiiC (Geriatrics, Inter-professional and Interorganizational Collaboration) was developed in partnership between the five RGPs of Ontario and the Centre for Education & Research in Aging & Health at Lake Head University. This project was funded by the MOHLTC for the purpose of developing capacity for primary care professionals to provide effective inter-professional and collaborative shared care for seniors across the Province of Ontario. The RGP led the implementation of the GiiC Project across both the ESC LHIN and the South West LHIN. The aim of the project is to increase the capacity of primary care (FHTs) to provide evidence-based care for the frail elderly. A GiiC toolkit was developed and comprises of a set of tools in geriatrics, inter-professional practice and inter-organizational collaboration. Each set includes:

- Topic overviews and quick facts
- Clinical tools and algorithms
- Client/Patient self-assessment tools
- Patient/Client/Family handouts
- Teaching case studies
- Quizzes
- Slide materials that can be used to build capacity on teams

The GiiC toolkit can be found at [www.sagelink.ca](http://www.sagelink.ca)

SGS Grand Rounds - an interdisciplinary team of health care professionals from the RGP, RPP, Alzheimer Society, Geriatric Medicine, Geriatric Psychiatry work together to plan the grand round series. These are very popular sessions commonly attended by primary care, LTC Home, Hospital, and CCAC. Grand Round presentations are archived on the OTN website for one year and are also presented via webcast.

Meal on Wheels London – transportation has been identified as a serious issue. Meals on Wheels has developed partnerships with London Hospitals and Community agencies to provide elderly patients with disabilities who are unable to use public transit and have limited access to other means of transportation rides to medical appointments.

b. What were the common outcomes?

The common outcomes of the examples listed above are knowledge transfer and capacity building, strong cross sectoral collaboration and partnerships, shared resources and expertise.

Through the SWOGAN evaluation, the following outcomes were achieved:

- Increased patient quality of life
- Models of Care – direct and indirect
- Common assessment tools project
- Delirium project – resulted in a change in evidence-informed practice (e.g. optimized delirium care)
- Increased knowledge of geriatric giants

c. List the executive sponsors who have the potential responsibility for meetings, chairing a steering committee, ongoing leadership and engagement?

SJHC London will have the coordination function for the BSO project. The existing BSS Steering Committee will provide leadership and strategic direction to the implementation of the
The Steering Committee is Co-Chaired by Jennifer Speziale, Director, Mental Health, SJHC London, and Shelley McCorkell, Executive Director, Alzheimer Society Elgin- St. Thomas; Geriatric Cooperatives have been formed at the local level and will assume an advisory function.

BSO Framework for care Pillar #2: Interdisciplinary Service Delivery. Outreach and support across the service continuum to ensure equitable and timely access to the right providers for the right service.

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

The service continuum for those with responsive behaviours is challenging. A person may need prevention and health promotion in the community to minimize disease progression along with additional supports at times to assist with transitions to different services. For example, transitional supports may be required as patients move from acute care to home and home to day programs.

Timely and equitable access to specialized geriatric and geriatric mental health outreach services has been considered to be a serious issue across many care settings. As part of the value stream mapping process, particular focus was given to clients at intermediate risk living in a LTC Home or in their own home. The Value Stream Mapping and analysis process mapped the current state of the client journey including all the transition points, wastes and value-added processes. This process identified a lack of integration of current services, a lack of identified system navigation supports, and problems related to timely and equitable access to existing outreach and specialist services. The team then mapped the Future State model and will continue to incorporate elements of the BSO framework pillars into its future state redesign.

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

- The high risk population that this project will serve are the moderate and complex population, older adults who are at risk, and their caregivers.
- Older adults with behaviours associated with complex and challenging mental health, addictions, dementia or other neurological conditions.
- These behaviours include aggression (most prevalent behaviours identified include: resisting help with personal care or medications), wandering, agitation and others.
- Families/Caregivers are also at risk for developing burn out and depression and are a fundamental component of this project and must be included as part of the target population.

The focus of the South West LHIN value stream mapping was the client with responsive behaviours in the community or LTC Home.

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

The South West LHIN Action Plan will develop service models that address the needs of older adults with responsive behaviours and their families/caregivers.
• A hub and spoke model will be utilized to ensure that the BSO LTC Home (RN/RPN, PSW) funded positions will be an integral part of the seniors mental health and addiction response teams that provide behavioural resource and service-learning functions for the LTC Home sector. They are integral and integrated into the five existing BSS mobile outreach teams working out of Schedule 1 Hospitals across the LHIN. Specialized regional supports (RGP, RPP, and Geriatric Psychiatry) will be linked with each of the mobile teams to enhance their ability to provide a timely response for older adults with responsive behaviours who live in their own homes or LTC Home. Building on the DLT model and experience in providing 24/7 care to LTC Home will be explored.

• Building on the SWOGAN project that explored standardized tools and the GiiC Project, common assessment tools, report templates and care plan strategies will be utilized by the seniors mental health and addiction response teams and their care partners. BSO LTC Home-funded staff will support LTC Homes only, which will enhance the existing mobile teams’ ability to expand into community and hospital to actively be involved and support transitions across care settings. It is expected that access to services will be coordinated between the following agencies: CCAC (access to GRT and Nurse Practitioner advanced home care team), SGS (RGP, RPP) and Regional Mental Health (Outreach teams, DLT), GEM Nurses, Alzheimer Societies, Community Mental Health and Addictions services. Mobile Teams will also keep abreast of Residents First, Home First, and Senior Friendly Care initiatives.

• Ontario Telemedicine Network (OTN) – located in 45% of LTC Homes across the South West LHIN. OTN to be utilized to facilitate equitable and timely access for urban and rural LTC Homes. The seniors mental health and addiction response teams will be well equipped to manage both rural and urban populations.

• Emerging champions within the care of the elderly working FHTs will be engaged in system design with the goal of improving quality of care. Physician specialists in geriatric psychiatry and medicine, and SWOGAN Primary Care Physicians with care of the elderly training within the South West LHIN will be leveraged to support this project. Medical Directors and Directors of LTC Homes need to be engaged.

• Community Support Services and six Alzheimer Societies across the South West LHIN including ADPs, First Link Program Coordinators, and Public Educators will be fully connected in with primary and specialized care resources.

• The Behaviour and Research Group (a select group of SGS clinicians) partnered with local investigators who met with The University of Western Ontario in London, the Research Institute of Aging in Waterloo, and Lambton College in Sarnia to create a research collaborative. Implementation science will be explored to understand the challenges in implementing best practice in LTC Homes (PIECES, GPA, etc.)
5. Illustrate how your action plan addresses the continuum of services from primary to acute care based on system coordination across cross-agency, cross-sectoral collaboration and partnerships. Attach a process map

The emerging theme from the value stream mapping exercise is that the existing outreach teams need a clear understanding about function and scope. The seniors mental health and addiction response teams will be able to move between community and LTC Home and hospital-based care depending on community need. This will avoid unnecessary escalation of a responsive behavior resulting in an emergency room visit or prolonged ALC situation.

To work across the care continuum the Additional Health Care Personnel (Psychiatrist, Psychology, Quality Improvement, and EPRC) will facilitate service learning across the system. The BSO LTC Homes (RN/RP, PSWs) will become part of the seniors mental health and addiction response teams and will provide timely service provision to LTC Homes. A bottom-up and top-down approach will be utilized.

The South West LHIN Action Plan will address service gaps through identified improvement plans. These improvement plans have been developed in response to the following client value statement, identified by South West LHIN health care providers through the LHIN’s Value Stream Mapping process:

“I am a unique individual who wants to live fully with meaning and dignity throughout my life journey.”

The South West LHIN Action Plan will implement its future state through the enhancement and reorganization of existing services. Implementation of the future state will build upon consecutive quality improvement initiatives to meet the needs of the client and family/caregiver in their journey throughout the continuum of care.

The following principles were identified during the value stream mapping process to develop the redesigned future state:

- Behaviour is communication
- Common understanding that there is meaning behind behaviour
- Have summary of client’s history available to all staff, use person-centred versus task oriented approach
- Practices value diversity
- French and English brochures
- Respect different cultural norms and identify how we approach clients
- Include family in the care planning—partners in the care
- Care is collaborative
- No “I” in team utilize multiple agencies
- No communication gap between shifts and sectors
- Everyone needs to know every door is the right door and know and agree to a process, common documentation, language

See Appendix A for future state map as identified through the value stream mapping process.

The goals of the action plan are to maintain the older adult’s level of functioning in their current environment, to limit decline, and the need for increased services and support. There are several key success factors within this plan which leverage and build upon existing structures, to ensure sustainability and improved outcomes for clients with responsive behaviours. This continuum extends from early identification and management, to a change or crisis in the community and LTC setting, including the potential need for a transition to a specialized behavioural support unit.
Key Improvement strategies were identified during the value stream mapping process. Implementation of the action plan will initially focus on the following strategies:

- **Knowledgeable Care Team and Capacity-Building**
  - An Education Consortium will be developed and led by SJHC London, GPP to ensure a LHIN-wide approach to capacity building, leveraging existing specialized resources (EPRCs, Regional Mental Health Outreach and DLTs, RGP, RPP, seniors mental health and addiction response teams and Alzheimer’s Society). Strong linkages and cross-training opportunities will be developed as new initiatives are implemented.
  - Interdisciplinary mobile outreach teams and specialized regional geriatric and psychogeriatric teams will collaborate with partners to create shared learning environments, disseminate co-created best practices and provide collaborative learning opportunities for direct care providers (LTC Home, primary care, CCAC)

- **Primary Care and Physician Engagement and Support**
  - Capacity-building for primary health care providers and physicians to effectively identify older adults at risk for responsive behaviours through education, introduction of common assessment tools. This will be facilitated through workshops, e-learning and time limited embedding of seniors mental health and addiction response team personnel to clinics to facilitate mentoring and just-in-time learning and application of assessment tools. This model may also improve mechanisms to ensure appropriate linkages to additional resources to foster the patients’ ability to remain at home.
  - Offering geriatric and geriatric mental health clinics in FHTs to build capacity
  - Identification of protocols for primary care to manage client care, ensure consistency, and prevent crisis

- **System Navigation** – was discussed and identified as a theme from the VSM session. The role of system navigation is to be embedded into all health care roles. Everyone is accountable for ensuring successful translation of knowledge and transition points create a continuum of knowledge and not a gap in information sharing. System navigation was identified by both family caregivers and clinical care givers as an area where individuals fall through the cracks.

- **Coordinated intake, triage, and improved access** are important elements of the system redesign using the “every door is the right door philosophy”. Pilot projects will be developed across the LHIN to test various models. Early adopter LTC Homes will also become labs for the development and evaluation for various models of care.

- **Standardized assessment and inter-professional care planning common language, ease of information sharing between caregivers and points of care (LTC Home and acute care; tertiary care) etc.**

- **Public Awareness and Social Marketing**
  - Leveraging existing resources to increase public awareness of the signs and symptoms of responsive behaviours, to enable early identification
  - Leverage the provincial BSO and other strategies (e.g. AKE)
  - Development of a public awareness campaign for clients and caregivers
6. How will support across the service continuum be provided to ensure equitable and timely access to the right providers for the right service?

- The BSS seniors mental health and addiction response teams will work across the continuum of care and provide timely and equitable access to LTC Homes, community, and hospital services.
- Establishment of consistent protocols and tools to ensure accurate diagnosis and timely and appropriate referrals.
- Establishment of a behavioural support intake and referral process will ensure equitable and timely access to the right providers for the right service.
- Enhancement of the hub and spoke model to ensure that the BSO LTC Home-funded positions are integrated into the five existing BSS mobile outreach teams working out of Schedule 1 Hospitals across the LHIN. Specialized regional supports (RGP, RPP, and Geriatric Psychiatry) will be linked with each of the mobile teams to enhance their ability to provide timely care. Each of the teams will have clearly defined roles which will avoid duplication, inappropriate referral, or lack of service for the client/family.
- 24/7 access to acknowledgement of referral or access to seniors mental health and addictions response team clinicians for immediate support and guidance, even if only virtual through OTN or even SMART phones (e.g. Apple iPhones®, Blackberry® devices).
- Involvement of seniors mental health and addictions response teams to ensure appropriate transition and discharge planning occurs early in the acute care admission process and that a transition plan is created in partnership with the receiving care giver (LTC Home). The goal would be to ensure a decrease in hospital Length of Stay (LOS) and appropriate discharge destination for the service recipient.

a. Will there be supported behavioural assessment services?

This service is already established and will be integrated into the redesigned model and be provided by regional specialists supported by our mobile teams.

b. How will a comprehensive geriatric assessment be conducted?

Comprehensive geriatric assessments are currently provided by the RGP, RPP, CCAC GRT and CCAC Nurse Practitioners. Assessments will be completed through integrated common assessment tools, common language, standardized protocols and assessments. These assessments currently occur in the client’s home, a clinic setting, or LTC Homes. It is anticipated these assessments may be able to be conducted via OTN. Clinical protocols will need to be developed and training provided for healthcare providers for the use of OTN or for assessments.

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

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

For individuals living in their own homes, primary care, CCAC and Alzheimer’s’ Societies (First Link), ADPs will initiate access to the seniors mental health and addictions response teams in their county as the need is identified through contact with existing services that are engaged in the care of these individuals.
d. How will individuals not identified as part of the population for this service be identified?

Individuals not identified as part of the service will be directed to access community based services and care providers that currently exist within South West LHIN. However, it is anticipated that these services will be improved through the knowledge exchange, best practices and learning that will develop from the system redesign efforts.

e. How will individuals in crisis be supported?

Moving forward, the model of care being developed will have an early identification and intervention focus for older adults at risk of responsive behaviours rather than a crisis or rapid response model. Using a health promotion approach, LTC Home staff will be able to quickly recognize individuals at risk of developing a responsive behavior earlier and will apply effective techniques and strategies (e.g. GPA) to prevent the behavior from escalating. Through training and ongoing capacity building crisis may be reduced and prevented.

On-site behavioural assessment, diagnosis and treatment where possible will be provided to older adults in LTC Home, hospital and community settings. The aim will be to bring the appropriate service to the individuals as much as possible. There will be the opportunity for on-site behaviour support staff as part of the seniors mental health and addictions response teams and a system will be put in place to enable timely access to the appropriate resources within the outreach team, including access to specialized care, to provide comprehensive assessment and treatment if needed.

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

- SJHC London
  - RMHC – Tertiary Services
    - Inpatient programs, DLT, Seniors Mental Health Outreach Team
    - RPP, RMHC, SJHC (SWOGAN Network)
    - Ambulatory Neuropsychiatry Clinic
  - SGS
    - RGP
    - SGS Strategic Planning Leadership Group
    - LINKAGES group
- LHSC
  - GEM Nurses (University Hospital and Victoria Hospital)
  - Geriatric Mental Health Program, LHSC
  - Centralized Emergency Psychiatry Services (CEPS)
- CCAC
  - CCAC GRT
  - Nurse-Led Long Term Care Home Outreach Team
  - CCAC coordinated intake services across South West LHIN
- LTC Homes
  - Mount Hope Centre for LTC
  - Grey County LTC Homes
  - Windermere Way, Enhanced Specialized Mental Health Unit, McGarrell Place, London (LTC Home)
  - McCormick Home
  - Other LTC Homes (TBD)
- Alzheimer Societies, First Link Program
- Southwest Dementia Network
• Alzheimer Outreach Services of McCormick Home – Family Support Programs, Adult Day and Overnight Programs
• Schedule 1 Hospitals – seniors mental health and addictions response teams.
  o They include: LHSC, STEGH, Woodstock General Hospital, HPHA, AMGH and GBHS.

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

BSO/BSS Steering Committee Co-Chairs:
  • Jennifer Speziale, Director, Geriatric Psychiatry, RMHC London, SJHC London
  • Shelley McCorkell, Executive Director, Alzheimer Society Elgin-St Thomas

End Part 1A
Responsive behaviours in LTCH

Assessments

Triggers for responsive behaviours

Hub of expertise - interdisciplinary care team

Plan of care (include clients + caregiver)

BSS team required?

Is urgent?

BSS in home clinic or assessment, diagnosis and treatment

Complete medical assessment (evidence based practices, needs, etc.)

BSS team required?

Y

Client back in home with plan of care

Update plan following consult

Adapt plan?

Y

Virtual case rounds

BSS in clinic or assessment, diagnosis and treatment

Is it urgent?

24/7 central intake & triage

Strategies to de-escalate

Call primary care provider

CCAC bridging plan – how to help caregiver tonight

Collaborative planning with interprofessionals

Reassessment follow-up

Contingency plan

Bridging – proactive connections across continuum to LTC transition

Plan of care

Clinic in LTCH (OTN)

BSS Team

Central Discussion (let caller know right away that they will hear from BSS team within 2 hours)

Informal supports in place (volunteer transport, go to doctor, etc.)

Contingency planning process

Responsive behaviour at home/community

Call 1-800-GETHELP (might be existing telephone # could link to 211, live transfer from other services, others could call on their behalf)

211 LHIN Future State

Responsive behaviours in LTCH

Assessments

Triggers for responsive behaviours

Hub of expertise - interdisciplinary care team

Plan of care (include clients + caregiver)

BSS team required?

Is urgent?

BSS in home clinic or assessment, diagnosis and treatment

Complete medical assessment (evidence based practices, needs, etc.)

BSS team required?

Y

Client back in home with plan of care

Update plan following consult

Adapt plan?

Y

Virtual case rounds

BSS in clinic or assessment, diagnosis and treatment

Is it urgent?

24/7 central intake & triage

Strategies to de-escalate

Call primary care provider

CCAC bridging plan – how to help caregiver tonight

Collaborative planning with interprofessionals

Reassessment follow-up

Contingency plan

Bridging – proactive connections across continuum to LTC transition

Plan of care

Clinic in LTCH (OTN)

BSS Team

Central Discussion (let caller know right away that they will hear from BSS team within 2 hours)

Informal supports in place (volunteer transport, go to doctor, etc.)

Contingency planning process

Responsive behaviour at home/community

Call 1-800-GETHELP (might be existing telephone # could link to 211, live transfer from other services, others could call on their behalf)
Developing a Behavioural Support System for Older Adults with Responsive Behaviours

Quick Stats:
- The number of Ontarians with dementia will increase 40% by 2020
- Provincially, 65% of Long-Term Care Home (LTC) residents have dementia or mental health and addictions issues, which increases their risk for responsive behaviours
- 36% of home care clients with dementia exhibit behavioral symptoms
- In 2016, over 21% of the population in Grey Bruce will be over 65 years (highest in South West LHIN)

Objectives: To improve the lives of older adults with responsive behaviours and their care partners due to mental health and addiction issues and/or Alzheimer disease and related dementia resulting in dementia living in LTC or in community settings.

Target Population: Older adults with behaviours associated with complex and challenging mental health, addictions, dementia or other neurological conditions living in LTC homes or community settings.

Project Summary: Seniors Mental Health and Addictions Response Teams will be developed across the SWLHIN to support LTC and community to manage responsive behaviours of older adults.

E-Health: Videoconferencing systems are being provided to LTC homes through an expression of interest process. Approximately 45% of all South West LHIN LTC homes will have this equipment by 2012.

Evaluation: An evaluation plan is being developed to measure clinical and process outcomes.

BSS Project Framework:

- Coordinated Clinical Service Delivery
  - Shared care approach
  - Standardized assessment tools and clinical protocols, centralized intake and triage
  - Case conferencing, consultation, onsite visit, videoconferencing

- Education and Capacity Building
  - Innovation and evidence-based practice
  - Implementation of a coordinated education strategy for LTC, community, caregivers

- Evaluation and Quality Improvement
  - Continuous quality improvement, system and client outcomes
  - Measure progress and outcomes, local and regional

Referral Process to Seniors Mental Health & Addictions Response Teams

- LTC or Community Referral
  - Inappropriate referral, does not meet criteria
  - Centralized intake and triage
  - May be appropriate; reviewed, risk/urgency determined
  - Clinical consultation, assessment, plan of care

Accomplished Milestones:
(July 2010 - September 2011)
- Steering Committee formed
- Project Lead hired
- Memorandums of Agreement with Schedule 1 Mental Health Facilities
- Year 3, AAH funds dispersed-March
- Geriatric Cooperatives formed in Grey-Bruce, London-Middlesex, Huron-Perth, Oxford counties
- Three Enhanced Psychogeriatric Resource Consultants (EPRC) hired - Sept 2011

Future Milestones:
- Seniors Mental Health and Addictions Response Teams recruited October - December 2011
- Centralized intake and triage systems enhanced/developed in all counties
- Seniors Mental Health and Addictions Response Teams receiving referrals by December 2011
- Coordinated education and capacity building strategy developed for South West LHIN to align with the Behavioural Supports Ontario (BSO) provincial strategy

Opportunities:
- To develop a shared vision for a better support system
- To enhance partnerships and service delivery models across the South West LHIN
- To provide seamless and timely access to care
- To align the work completed in the South West LHIN with the BSO provincial Project

Project Lead: Kelly Simpson,
Kelly.simpson@swhc.london.on.ca
519, 455-5110, ext. 47379
### Figure 1 South West LHIN Senior Friendly Hospital Initiative Participating Organizations

<table>
<thead>
<tr>
<th>Organizations &lt;60 Beds</th>
<th>Organizations &gt;60 Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Huron Hospital Association (SHHA)</td>
<td>Listowel and Wingham Alliance (LWA)</td>
</tr>
<tr>
<td>19 beds</td>
<td>70 beds</td>
</tr>
<tr>
<td>Single site</td>
<td>2 sites</td>
</tr>
<tr>
<td>Hanover and District Hospital (HDH)</td>
<td>Alexandra Marine and General Hospital (AMGH)</td>
</tr>
<tr>
<td>39 beds</td>
<td>78 beds</td>
</tr>
<tr>
<td>Single site</td>
<td>Single site</td>
</tr>
<tr>
<td>Alexandra Hospital (AH)</td>
<td>Middlesex Hospital Alliance (MHA)</td>
</tr>
<tr>
<td>39 beds</td>
<td>90 beds</td>
</tr>
<tr>
<td>Single site</td>
<td>2 sites</td>
</tr>
<tr>
<td>Tillsonburg District Memorial Hospital (TDMH)</td>
<td>South Bruce Grey Health Centre (SBGHC)</td>
</tr>
<tr>
<td>51 beds</td>
<td>107 beds</td>
</tr>
<tr>
<td>Single site</td>
<td>4 sites</td>
</tr>
<tr>
<td></td>
<td>Woodstock General Hospital (WGH)</td>
</tr>
<tr>
<td></td>
<td>121 beds</td>
</tr>
<tr>
<td></td>
<td>Single site</td>
</tr>
</tbody>
</table>