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Erie St. Clair Local Health Integration Network

Behavioural Supports Sustainability Plan

Merle from Leamington

Ontario
Erie St. Clair Local Health Integration Network
Réseau local d'intégration des services de santé d'Érié St. Clair

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........Holding the Gains......
Gary Switzer, Chief Executive Officer,
Erie St. Clair Local Health Integration Network

The Behavioural Supports Ontario (BSO) Initiative is a significant step forward in delivering higher quality care that is more sensitive to the needs of older adults with responsive behaviours. The Erie St. Clair Local Health Integration Network (ESC LHIN) BSO initiative focuses on client needs, as well as the families who are in many cases the primary caregivers. It can be challenging for these caregivers, as they are often called upon to make decisions on behalf of their loved one. The Erie St. Clair BSO model works to provide supports for caregivers in desperate need of help as they try to cope. The ESC LHIN investment of $2.4 million dollars is helping us to implement the three pillars of the provincial strategy.

1. **Improve System Coordination** so that clients and families are better linked to the care and supports they need, when they need it.
2. **Provide Interdisciplinary Care** with specialized teams who understand how to care for people with responsive behaviours. In Erie St. Clair, we have invested in:
   - Four long-term care lead teams
   - Three system navigators
   - Expanding three Geriatric Mental Health Outreach Teams (GMHOT)
   - A Community Care Access Centre (CCAC) Case Manager devoted to alternate level of care (ALC) patients with responsive behaviours

The ESC LHIN intends to build upon the success demonstrated by the CCAC ALC Case Manager in Windsor/Essex by investing in this model for the Chatham-Kent and Sarnia/Lambton communities.

3. **Build System Capacity** to date over 750 providers in Erie St. Clair received specialized education and training by the BSO Knowledge Exchange Coaches. The ESC LHIN continues to build system capacity by leveraging a “hub and spoke” model with 30 long-term care homes throughout our region.

As a result of measured system improvements, the ESC LHIN is investing an additional $200,000 in annualized base funding in 2013-14 to sustain BSO, hold the gains achieved, and continue to improve local health care. In short, BSO in Erie St. Clair is delivering on our LHIN’s vision of better care, better value, and better experiences for clients and their families.

Let’s Make It Happen!

Gary Switzer,
Chief Executive Officer

1.a Senior and Clinical Leadership Structures

During the past year the ESC LHIN has implemented several organizational and clinical leadership structures to sustain the Behavioral Supports Initiative.

Clinical Collaborative Groups
The ESC LHIN established three Clinical Collaborative Groups, one per county. Membership is comprised at the front line level for Long-Term Care Lead Teams, Client Intervention Workers, CCAC ALC Case Manager, Geriatric Mental Health Outreach Teams, and System Navigators. The Clinical Collaborative(s) includes a complex case resolution (CCR) mechanism which is inclusive by bringing other health care providers to the table on a case by case as needed process. The Clinical Collaborative(s) is co-chaired by the ESC LHIN BSO Regional Coordinator and the Psycho Geriatric Resource Consultant (PRC). From a sustainability perspective the Clinical Collaborative Groups have embedded the Plan, Do, Study, Act (PDSA) Cycles as a standing agenda item. It is noteworthy that the BSO Clinical Collaborative(s) are process orientated focusing on client flow, information needs/gaps, barriers and collective problem solving. See Appendix 1: Terms of Reference Clinical Collaborative.

Erie St. Clair BSO Governance Committee
The ESC LHIN established an overarching Governance Committee co-chaired by the community lead agency the Alzheimer's Society of Chatham-Kent, Chief Executive Officer (CEO), Mary Ellen Parker, and the Erie St. Clair BSO Lead, Dawn Maziak. The Governance Committee is comprised of Directors / CEO's from:

- Five LTC Lead Home Teams
- Three Geriatric Mental Health Outreach Teams
- Three Alzheimer's Chapters
- CCAC and
- Client Intervention Workers

The Governance Committee provides an overarching mechanism for system level problem solving and performance monitoring on a quarterly basis. See Appendix 2: Erie St. Clair BSO Governance, Terms of Reference.

Leadership Structures
The ESC LHIN has appointed the Mental Health and Addiction, Health System Design Manager as the BSO Lead. From a clinical front line perspective, the ESC LHIN has provided new annualized base funds in order to sustain the BSO Regional Coordinator, Christina Stergiou. This position was formerly referenced in the BSO Action Plan as the Erie St. Clair BSO Project Manager. In recognition of the capacity building needs the ESC LHIN has provided base funding for a BSO Regional Education Coordinator, Lina DeMattia. This position was formerly referenced as the Knowledge Exchange Coach. These two key positions are the ***"eyes and ears"*** of the LHIN and are based at the BSO Community Lead Agency (Alzheimer's Society Chatham-Kent).

System Mechanisms for Sustaining BSO

1. BSO initiative is a standing agenda item at the three county level Long-Term Care Home (LTCH) Administrators quarterly meetings
2. Residents First BSO Change Package
3. BSO is embedded into providers Service Accountability Agreements

1.b Leadership Contact Information

The Erie St. Clair LHIN BSO Lead is Dawn Maziak, Health System Design Manager.
Contact Information: Dawn.Maziak@lhins.on.ca or by phone 1-866-231-5446 extension # 3213.

2.Quality Improvement

The ESC LHIN has invested significant time and staff resources to sustain quality improvement capacity for BSO. The ESC LHIN Health System Performance Manager, Janet Reddam is the dedicated BSO Lead Improvement Facilitator. The ESC LHIN will work with our Clinical Collaborative (s) and Governance Committee as it relates to implementing the United Kingdom, NHS – Institute for Innovation & Improvement package into our processes. Concrete ESC LHIN QI sustainability processes and practices include:

1. Front Line training and implementation of Plan, Do, Study, Act Cycles.
2. LHIN-wide implementation of Resident's First BSO Change Package for 35 LTCHs. This initiative is co-facilitated with Health Quality Ontario.
3. Developed tracking tools for continuous quality improvement. Tracking and monitoring includes education uptake by the 35 LTCHs. The ESC LHIN has dedicated a portion of new annualized base funding for continuous education and BSO training. Our capacity aim includes establishing train the trainers for "U First" and "PIECES" in each LTCH.
4. Quarterly performance reports rolled up in a Score Card format for the BSO Governance Committee.
5. Older adults with responsive behaviors deemed ALC are monitored on a LHIN-wide basis by a CCAC snap shot. See Appendix 3. This information flows to the BSO CCAC Lead who can optimize the BSO Case Manager role in Windsor-Essex.
6. Tracking tools and contingency/control plan is monitored by the BSO Regional Coordinator in concert with the LHIN BSO Lead and BSO IF.

3. Measurement and Accountability

3.a The Erie St. Clair LHIN has identified primary and secondary core indicators. Primary refers to process level indicators tracked on a monthly basis that are critical to ensuring that our teams are on track. Secondary indicators focus on system level capacity and quality. It is noteworthy that primary and secondary indicators are currently tracked. See Appendix 4.

Primary Indicators (Monthly)

1. Time to respond: This indicator is tracked by the System Navigators, the LTC Lead Teams and the Geriatric Mental Health Outreach Teams. See Appendix 5 Contingency Control Plan.
2. Number of LTC re-referrals within 30 days of client being served by BSO Teams. This process indicator is used by the system navigators to monitor if our Teams are discharge/closing the case too quickly. (Manual by System Navigators)
3. Number of ALC patients with responsive behaviours by hospital. (Manual by CCAC)

Secondary Indicators (Monthly)

1. Family and LTCH satisfaction with the ability to manage behaviors in home environment. Implemented upon the closure of a case file managed by the System Navigator and or LTC Lead Home/Geriatric Mental Health Outreach Teams. (Legacy Indicator).
2. Number of referrals from community by referral source to Geriatric Mental Health Outreach Teams. (Manual from the GMHOT PRC Leads).
3. Number of BSO education/training sessions implemented and attended. (Manual by Regional BSO Education Coordinator).

3.b&c Accountability processes for BSO is at the system and process / operational levels.

System Level: The Erie St. Clair LHIN has built BSO reporting and maintaining human resources into the Service Accountability Agreements for core BSO providers. Core refers to the GMHOT, the Client Intervention Workers and CCAC ALC Case Manager. The Long-Term Care Home Service Accountability Agreement (L-SAA) is the venue used for the five LTC Lead Homes as well as the new hub and spoke mode. The hub and spoke provides 30 LTCH each with approximately $31,000 annualized base. These new dollars are from the residual funds from the LTC Lead Teams and the new ministry funds dedicated for personal support workers.

Process/Operational Level: The ESC LHIN will maximize the Clinical Collaborative Groups and the Governance Committee as it relates to PDSA cycles, complex client resolution tables and overall score card levels. In terms of monitoring the system via contingency/control plans the most important indicator is time to respond process steps are below. See Appendix 5.

Step One: The System Navigator is responsible for implementing the tracking tool at the point of referral. The tool is designed to self populate.

Step Two: Regional BSO Coordinator receives the completed time tracking sheet from the System Navigator monthly or when an issue is red flagged as imminent. Regional BSO Coordinator tracks volumes by county and team for trends.

Step Three: Regional BSO Coordinator submits monthly roll up with trends to BSO LHIN Lead and Improvement Facilitator for monthly discussion. The report is brought back to the BSO teams by the BSO Regional Coordinator via the Clinical Collaborative Groups.

In the event that a target is missed and red flagged as urgent the BSO LHIN Lead is notified for immediate action.

Step Four: In the event of an imminent risk situation/repeated missed targets the BSO LHIN Lead is responsible to follow up at the director level. All pertinent information will be gathered prior to initiating dialogue. As an example, missed targets could happen if a given team is experiencing significant surges in overall volumes. At this point it is a system capacity issue that the ESC LHIN monitors and brings forward to the Governance Committee and internally via the LHIN Senior Directors/CEO level.

4.Training

The ESC LHIN has a robust education and training process with 750 inter professional health human resources trained to date. Modules include GPA, U-First, PIECES, Non-Violent Crisis Intervention and Cognitive Behavioral Therapy/Motivational. The process for new staff to be trained is as follows:

1. Individual's names are cross referenced with existing Public Educational Coordinators (PEC) from the Alzheimer's chapters and LTC Homes with respect to prior training. The types of training and the date are documented. If specific modules have been requested the BSO Regional Education Coordinator moves to step three.
2. The BETSY tool is used at the "organizational level" by PRC and the BSO Regional Coordinator to identify specific needs and any trends. This process allows us to understand and to plan appropriately to meet their needs.
3. The individual receives an email notification about upcoming BSO modules and registration information. See Appendix 6 BSO Educational Implementation Plan for 2013 / 14.

5. Collaboration and Communication

Based on the implementation of our BSO initiative, the Erie St. Clair LHIN would recommend the following items to other LHINs for consideration.

1. Embed Psychiatrists into the Geriatric Mental Health Outreach Teams and the LTC Lead Home Teams as a critical "team member". During the Aging at Home process the ESC LHIN provided funds specifically for psychiatry GMHOT team consults. This funding pot will be further enhanced (13/14) to ensure that psychiatrists and the LTC Lead Home Teams function at the highest level possible. The clinical teams (GMHOT and LTC Lead Homes) provide "consultation recommendations" to the psychiatrist. The psychiatrist reviews the recommendations as they may relate to medication changes. The psychiatrist is not the most responsible physician. Therefore, the psychiatrist then consults further re case findings with the family physician or LTC home physician.
2. Lessons learned; early engagement with primary care is essential. As a LHIN this step was not at the front end of the planning process. We have attempted to engage physicians on a large scale during our official BSO Kick Off Event, on October 31 2012 with Dr. Ken Le Clair. Unfortunately, physician attendance was not optimal.

We envision future engagement to entail leveraging our three BSO Psychiatrists, existing First Link Coordinators and the Health Link Initiative.

6.Provincial Tables / Collaboratives

The Erie St. Clair BSO Regional Coordinator currently attends the following:

- Central Intake Enhanced Access
- Mobile Teams and the
- Operations Table.

7.Future Collaborative Involvement

The Erie St. Clair LHIN envisions continued involvement with other LHINs through the above tables. The operations table will be critical to our future endeavors.

8.Assess the Current State and Identify Remaining Service Gaps

The Erie St. Clair LHIN BSO Client Value Statement is ***"I am a unique individual, worthy of respect, dignity and quality care".*** In order to assess the current state against the LHIN's BSO Action Plan the following groups were engaged:

1. The Three Clinical Collaboratives (face to face)
2. Thirty Five Long Term Care Homes (teleconference - includes the Lead Teams)
3. The BSO Governance Committee (face to face)
4. Fifteen Caregivers with "lived experience" five from each county were interviewed by the system navigators. See Appendix 7 Engagement roll up.

Trends and Themes: The following trends and themes are highlighted in a table format aligned with activities that the LHIN has already initiated or is in process of implementing.

Needs/Gaps	LHIN Activities (Existing) or Planned
Physician engagement / BSO Champions needed. LTC Homes Physicians not implementing recommendations	• In fiscal year 13/14 the LHIN will enhance BSO base funds for psychiatrists. • **Action** - Prior to allocating the above mentioned funds, the ESC LHIN will meet with the Chief of Psychiatry (3) to discuss engagement strategies with LTC Home physicians and venues to reach broader community based Physicians. First Link existing resources require evaluation as it relates to stronger interfacing with BSO. Health Links is a key LHIN Initiative. Older adults with responsive behaviours are the top users of the health care system.
LTC Family Mentoring Groups – Resident & Family Councils	• Caregivers with lived experience raised some critical elements that have not been considered in the past. For instance, caregivers indicated that a ***"mentoring group"*** for family members who are going through the LTC admission process should be aligned with families who have already gone through this journey. In other words a "mentoring program".

Needs/Gaps	LHIN Activities (Existing) or Planned
	• **Action** The LHIN will appoint one RPN from each LTC Lead Home Team with the System Navigator to initiate a "road show" meeting with all 35 LTCH Resident & Family Councils to pursue this need further. We will also use this opportunity to better inform residents and families about BSO.
BSO Education / LTC/Other Sectors (Marketing and Communications)	• There is a consistent theme that caregivers and existing providers are not aware of the ESC LHIN BSO Education/ raining opportunities or the magnitude, of the number of providers to date that have participated. • **Action** The LHIN clearly has a responsibility to do a better job of informing the public and providers about BSO and our successes. We will appoint the BSO Regional Education Coordinator to work with the LHIN Communication Staff (initially) to implement a News Letter. The Newsletter will be posted on the LHIN web site and disseminated broadly to providers. We will request that each LTCH post the newsletter in public areas for families/caregivers to be informed.
Enhanced Access to Respite Services	• The LHIN has committed in total $170,000 in base funding to all three Alzheimer's Chapters and Lambton Elderly Outreach Services for enhanced respite for fiscal year 2013/14. This service is specific to older adults with responsive behaviors. We have also enhanced funding to the CK Alzheimer's Society for a fifth day program "day" to address capacity concerns. This funding includes a unique partnership with VON that allows for a RN to attend the ADP for medical monitoring needs as we are aware that client acuity has increased dramatically in the last few years' e.g. diabetic insulin checks, BP, weight, etc. This ADP model and partnership with VON is in the early planning stage for Windsor Essex.
CCAC Comments	• The lived experience feedback will be provided directly to the BSO CCAC Director. As previously noted, the LHIN intends to leverage the positive impact made by the Windsor Essex, CCAC ALC Case Manager by replicating this model in Chatham-Kent and Sarnia-Lambton.
Centralized Access / 1 800 & Clinical viewers	• The need for streamlined access and clinical viewers (read only for assessment reports across sectors) is a repeated theme echoed in the ESC LHIN Mental Health Strategic Plan. The LHIN is in process of prioritizing 67 "opportunities" within the strategic planning framework from a system perspective. Older adults/BSO are identified as a LHIN priority. We are in process of implementing a Provincial Pilot via Connex Ontario and OTN "next day" bookings for all mental health crisis calls starts spring 13/14. • Community referrals now flow directly to the GMHOT. This process is a deviation from our Action Plan however, it was the "original" process used by GMHOT. The rationale for this action includes capacity limitations with 3 system navigators, need for a timely response and family physicians initiating the referral for psychiatric consults. The LHIN will monitor the # of times the GMHOT initiates caregiver support via referrals to the system navigators.

Needs/Gaps	LHIN Activities (Existing) or Planned
LTC Protocols Repatriation	• Our BSO Teams while still in the early stages of development have identified this need as a high priority as per CCR and ALC trending residents. We believe that the appropriate venue for discussion will be with the 30 LTC Homes "hub and spoke" model. The LTC Homes are keen to use the BSO resources initiating this policy must be flexible enough to keep the LTC Homes engaged and to allow for the understanding/identification of "some" residents who truly do require higher levels of care.
LTC Specialized Behavioural Units	• We are in the early stages of discussing SBU with LTCH that are designated "D". This means that Richmond Terrace, Copper Terrace and Aspen Lake (new facility) have the potential to include these units into their blueprints early on in the planning stages.
NP / Physician Assistants	• In Windsor-Essex, some LTCH have access to a NPLOT. In Chatham-Kent (CK), as part of their GMHOT, a Physician Assistant Model is showing great promise. We will be evaluating the PA impact on the 7 CK LTCH as it relates to potential future investments for Windsor Essex & Sarnia/Lambton.
White Boards in LTCH	• As a one-time funding investment the LHIN will discuss utilization of white boards during the March Residents First BSO Change Package Meetings. Preliminary dialogue indicates that this communication venue would be used for QI and the LTC/GMHOT BSO clinical resources.
LTC Recreation Needs	• Repeatedly we are seeing early success by engaging existing LTC recreational staff with the BSO process. As a clear benefit, we will explore future, funding potential for adding 1 FTE recreational staff for each LTC Lead Team (4).

Other Initiatives: As articulated in the Seniors Strategy BSO interfaces with a number of other key initiatives. For example:

1. **Tele Home Care:** links with existing Tele Med RNs who are assigned to the Mental Health and Addiction population groups.
2. **Health Links:** in Windsor-Essex we are in the early stages of designing a Health Link specific for people with mental health and addiction issues who reside in the Inner City area. Many are homeless or at risk of homelessness. The Chatham-Kent Health Link is more generic in nature with a strong emphasis on chronic disease management. People with dementia or other neurological conditions as top users of the health care system will be included as an embedded partnership. It is noteworthy, that Erie St. Clair LHIN is not an early adopter for Health Links.
3. **Primary Care:** Health Links are evolving; the LHINs are actively engaging Community Health Centres, Family Health Teams and NP Led Clinics. Opportunities to interface BSO via First Link Coordinators (redesign current program) and creation of memory clinics are timely.

Closing Statement:

In closure, thank you for the opportunity to provide the Provincial Coordinating Team with the Erie St. Clair LHIN BSO Sustainability Plan. This plan is the cumulative outcome from our BSO clinical and leadership structures, our 35 LTC Homes, LHIN performance staff, the BSO Regional Coordinator and Educational Coordinator. The fifteen caregiver interviews clearly reinforced our client value statement as well as outlining future opportunities.

We look forward to continued opportunities for improved, high quality care for older adults with responsive behaviors as well as ensuring that our caregivers are treated with the respect and dignity that they deserve.

While Erie St. Clair has made significant gains during the past year we clearly recognize that we have only begun the journey toward sustainable, systemic change.

Dawn Maziak,
Erie St. Clair LHIN, BSO Lead

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