TO: Mayor and Members  
Board of Health  
WARD(S) AFFECTED: CITY WIDE

COMMITTEE DATE: September 17, 2012

SUBJECT/REPORT NO:  
Memorandum of Understanding - Behavioural Supports Ontario (BOH12028) (City Wide)

SUBMITTED BY:  
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RECOMMENDATION:

That the Medical Officer of Health be authorized and directed to sign the Memorandum of Understanding for the Behavioural Supports Ontario Project (BSO) between the City of Hamilton and the Hamilton BSO Cluster, as requested by the Hamilton, Niagara, Haldimand, Brant Local Health Integration Network (HNHB LHIN) in a form satisfactory to the City Solicitor.

EXECUTIVE SUMMARY

Several health reports have indicated a need to review the current healthcare system. The reports indicate that the system often operates in silos creating barriers for clients and their families.¹

Don Drummond, in his recent report, regarding the healthcare system, described the change that is needed as “a broad revamping of the system that makes the parts work better together, so that the whole is greater than — or at the very least equal to — the sum of the parts”.²
The HNHB LHIN, in partnership with all Ontario LHINs, is moving to enhancing services for older Ontarians with complex and responsive behaviours focusing on how all resources, new and existing can be realigned (system redesign). The intent is to create a health care service model that is client-centric, improves the health of the population and the person’s health care experience, while promoting a sustainable healthcare system.

The Community Mental Health Promotion Program (CMHPP) as part of the Mental Health and Street Outreach Service (MHSO) in the Clinical and Preventive Services Division of Public Health Services (PHS) is 100% funded by the LHIN to provide service to individuals 16 and up that live with a diagnosed mental illness and/or are homeless. The LHIN, in their Memorandum of Understanding (MOU) is asking the Mental Health and Street Outreach Service to agree to participate in the system redesign as an Integrated Community Lead (ICL) (Appendix A).

The Behavioural Supports Ontario (BSO) project identifies two types of Integrated Community Lead (ICL) agencies:

1. **ICL:** Agency that provides services that may include personal support, navigation, respite etc. Examples of ICLs are Community Care Access Centre, Dementia Alliance, Catholic Family Services etc. An agency that has been identified as the lead agency for a client is referred to as a Principal ICL (PICL).

2. **ICL Contributing Agency:** Agency that provides services limited to a specific activity/function i.e. meals on wheels, transportation.

The Mental Health and Street Outreach Service currently provides navigation services to older individuals with a diagnosed mental illness and/or homeless. It is not anticipated that this will result in a significant change to our current practice or the need for additional resources at this time.

Alternatives for Consideration – See Page 5

<table>
<thead>
<tr>
<th>FINANCIAL / STAFFING / LEGAL IMPLICATIONS (for Recommendation(s) only)</th>
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**Financial:** None at this time. Participation in the BSO project will be required for funding in the Multi-Service Accountability Agreement (MSAA) in 2014.

**Staffing:** Staff will attend training sessions provided by the LHIN BSO project.
Legal: Legal Services agrees that the MOU is not a legally binding agreement. They recommend that inclusion of language that states this explicitly. Legal also advised that PHS determine whether the other agencies named in the MOU are planning or have signed the agreement. All parties, with the exception of the City of Hamilton have signed the agreement to date.

HISTORICAL BACKGROUND (Chronology of events)

In August of 2011, HNHB LHIN announced, that along with Ontario’s other 14 LHINs, they would be enhancing services to improve care for seniors who exhibit behaviours associated with complex and challenging mental health, dementia or other neurological conditions. The LHIN identified that one of the services that will improve care is the BSO project. The BSO project focuses on providing quality care for individuals with these conditions, in an environment that is based on safety, high quality, evidence-based care and practice.

One of the goals of the BSO project is to ensure that staff working in health care settings – such as long-term care homes, community services and hospitals – are supported in caring for seniors with complex mental health needs.

The intent is for the BSO project to be a collaboration between LHINs, Alzheimer Society of Ontario, Health Quality Ontario, and the Ministry of Health and Long-Term Care.

HNHB LHIN QUICK FACTS

- for 2011-2012, HNHB LHIN is receiving $1.6 million in start up funding for the BSO Project
- behaviour has been identified by local hospitals as a barrier to facilitate placement of patients waiting in hospital to go to long-term care
- by 2018, the number of persons with dementia in the HNHB LHIN will increase by 20% to 26,000

The BSO project has established the following principles:

1. Everyone is treated with respect and accepted “as one is”.
2. The client and caregiver(s) are the driving partners in care decisions.
3. Respect and trust should characterize the relationships between staff and clients and among health care providers across systems.
These Framework Principles are anchored in the Behavioural Support Services (BSS) Framework Components:

1. System Coordination and Management:
   - supported transitions for persons
   - standard service protocols and referral system
   - shared system governance

2. Integrated Service delivery – Inter-sectoral and Interdisciplinary:
   - shared care / collaboration
   - cross-sector, system support teams

3. Knowledgeable Care Team and Capacity Building:
   - education and training
   - supportive learning
   - innovation, best practice

In June 2012, PHS received a MOU from the LHIN requesting our participation in the BSO project. The BSO program framework will be a requirement for funding within the next Multi-Service Accountability Agreement (MSAA) in 2014.

**POLICY IMPLICATIONS**

Do not anticipate a change in policies.

**RELEVANT CONSULTATION**

PHS consulted with the Niagara Public Health Dept, who offers similar services as the PHS Community Mental Health Promotion Program. Niagara has signed the MOU as a contributing agency.

PHS has consulted with community partners, listed in the HNHB LHIN. All listed parties have signed the MOU to participate in the BSO project.

**ANALYSIS / RATIONALE FOR RECOMMENDATION**

Currently, the Mental Health and Street Outreach Service is providing service to individuals with a mental illness and/or homeless that are elderly. Participation in the early stages of the BSO program development would provide the opportunity to shape
how the program evolves. The BSO offers a framework that would encourage health care agencies to work together to provide comprehensive services to vulnerable seniors.

In the future, it will be a requirement of all LHIN funded agencies to participate in the BSO project as part of future MSAA to maintain funding.

**ALTERNATIVES FOR CONSIDERATION:**
(include Financial, Staffing, Legal and Policy Implications and pros and cons for each alternative)

**Financial:** Not participating in the BSO project puts the City at risk of losing funding for LHIN 100% funded mental health and addiction programs. Loss of funding would have staffing implications and would decrease services to a vulnerable population.

**CORPORATE STRATEGIC PLAN** (Linkage to Desired End Results)


**Skilled, Innovative & Respectful Organization**
- More innovation, greater teamwork, better client focus

**Financial Sustainability**
- Financially Sustainable City by 2020

**Intergovernmental Relationships**
- Influence federal and provincial policy development to benefit Hamilton
- Maintain effective relationships with other public agencies

**Growing Our Economy**
- An improved customer service

**Social Development**
- Residents in need have access to adequate support services

**Healthy Community**
- Adequate access to food, water, shelter and income, safety, work, recreation and support for all (Human Services)
APPENDICES / SCHEDULES

Appendix A - Memorandum of Understanding to Report BOH 12028

References:


2Drummond, Don. Commission of the Reform of Ontario's Public Services: 2012. Queens Printer Ontario
MEMORANDUM OF UNDERSTANDING

BETWEEN

AbleLiving Services Inc.
Canadian Mental Health Association – Hamilton Branch
Catholic Family Services of Hamilton
City of Hamilton
Dementia Alliance
Dundas Community Services
Good Shepherd Centres
Hamilton Health Sciences Corporation
Hamilton Niagara Haldimand Brant Community Care Access Centre
March of Dimes Canada - Hamilton
St. Joseph’s Healthcare Hamilton
St. Joseph’s Homecare

(Hereinafter referred to as the Hamilton BSO ICL Cluster)

1. Behavioural Supports Ontario Program

   (a) Behavioural Supports Ontario (BSO) was created to enhance services for an older person who experiences complex behaviours wherever they live (at home, in long-term care or elsewhere), through the development and implementation of new models of care that focus on quality of care and quality of life for this person. Building capacity, enhancing existing services, and examining opportunities for service re-design through quality improvement principles are foundational elements of this work.

   (b) Established BSO Framework Principles:
      i. Everyone is treated with respect and accepted “as one is”.
      ii. The client and caregiver(s) are the driving partners in care decisions.
      iii. Respect and trust should characterize the relationships between staff and clients and among health care providers across systems.

These Framework Principles are anchored in the Behavioural Support Services (BSS) Framework Components:

   i. System Coordination and Management:
      • supported transitions for persons
      • standard service protocols and referral system
      • shared system governance.

   ii. Integrated Service delivery – Inter-sectoral and Interdisciplinary:
      • shared care / collaboration
• cross-sector, system support teams.

iii. Knowledgeable Care Team and Capacity Building:
• education and training
• supportive learning
• innovation, best practice.

(c) The BSO population is defined as: older adult with cognitive impairments due to mental health problems, addictions, dementia, or other neurological conditions [who] often exhibit responsive or challenging behaviours such as aggression, wandering, physical resistance and agitation.\(^1\)

(d) The objectives of the BSO Integrated Community Lead (ICL) Model includes:

i. **Improving client, family and public experience** with services along the continuum of care

ii. **Improving/increasing support for caregivers of individuals** with behaviour issues living in the community.

iii. **Reducing avoidable emergency room visits** for individuals living in the community with behaviour issues

iv. **Building health system capacity** for the care of individuals (and caregivers) with behaviour issues.

(e) The Hamilton Niagara Halimand Brant (HNHB) Local Health Integration Network (LHIN), in collaboration with HNHB LHIN healthcare leaders with expertise in responsive behaviours, developed an Action Plan (Plan) based on the BSO Framework Principles, that when implemented, would result in improved quality of life and quality of care for older individuals with challenging responsive behaviours. The Plan seeks to address current gaps and duplications in the health care system and enhance and reconfigure how existing services are provided to better meet the needs of the client and caregiver.

(f) To implement the BSO Project within the HNHB LHIN, an Oversight Committee was established that is accountable to the LHIN Chief Executive Officer. The HNHB BSO Oversight Committee has identified the Integrated Community Lead (ICL) Model as an integral component of the BSO HNHB LHIN Action Plan.

2. Definitions

a) The Hamilton BSO ICL Cluster are established agencies that receive funding from the HNHB LHIN to provide HNHB LHIN residents with care and support in the communities where they live. These include agencies within the Community Support Sector, Mental Health and Addiction Sector and the Community Care Access Centre (CCAC).

b) For the purposes of this MOU, the agencies listed above will be referred to as the Hamilton BSO ICL Cluster.

3. Purpose of this MOU

a) The Hamilton BSO ICL Cluster is entering into this MOU to establish their mutual agreement with respect to their participation in the HNHB LHIN BSO ICL Model, as described in Appendix A within the Hamilton area.

b) This MOU details the roles and responsibilities of the Hamilton BSO ICL Cluster as outlined in Appendix A.

4. Participating Agency Obligations

(a) The Agency confirms that it is a participant in the Hamilton BSO ICL Cluster.

(b) As a participant, the Agency will operate in accordance with the parameters of the ICL Model.

5. Conditions

(a) As a newly-introduced and evolving service model, it is understood that model parameters may be adjusted and/or revised. Such adjustments and/or revisions will be identified and approved by the HNHB BSO Community Subcommittee and HNHB LHIN BSO Oversight Committee, and may or may not affect the scope and action of this MOU.

(b) Participating agencies will be duly updated as to any affective adjustments or revisions in a timely fashion, and will be consulted where and when appropriate.

(c) The ICL Cluster will partner with the HNHB LHIN with regards to the ongoing stewardship and development of the model. The ICL Cluster agrees to collect, maintain and make available relevant information as deemed appropriate to this function.

6. Termination

A participating agency may terminate their participation in the BSO Project at any time, for any reason, upon giving sixty (60) days Notice to the participating agencies and the HNHB LHIN, provided that the Notice is accompanied by:

a) a Transition Plan, acceptable to the participating agencies that indicates how the needs of the agency’s BSO-specific clients will be met following the termination and how the transition of the clients to new support services will be effected within the Notice period.

* * * * * * *
By signing below, the Agency Representative asserts that:

(a) they have the authority to bind the Agency
(b) that the Agency confirms their understanding of the ICL Model
(c) that the Agency confirms their participation in the HNHB LHIN BSO ICL Model.

Please indicate your participation:

BSO Cluster ICL Agency (see page 2): ☐

ICL Contributing Agency (Agencies that would not assume a Principle ICL role - see page 8): ☐

________________________________________________________
Organization

________________________________________________________
Name

________________________________________________________
Position

________________________________________________________
Signature

________________________________________________________
Date

*Note – The final agencies participating in the cluster will be confirmed in the MOU that is returned to you including all of their signatures.
APPENDIX A

HNHB BSO INTEGRATED COMMUNITY LEAD (ICL) MODEL

The ICL Model is an “approach” to providing services where a single community service provider is identified for clients and their caregivers to coordinate and plan community services that meet their care needs.

Objectives:
The ICL is an identified agency that will function as a single point of contact for BSO clients with a focus on:
- developing and executing a reflective care plan based on the needs of the client
- assisting clients to navigate the broader system
- coordinating the delivery of community-based supports and services.

Description:
The model was developed to build on existing resources and expertise with a focus on capacity building. LHIN community agencies serving BSO clients within a specific LHIN geographic area will work collaboratively to support clients living in the community through the BSO ICL approach.

The ICL Model operates on the philosophy that ‘no door is the wrong door’; as such, clients, caregivers or health service providers may engage an agency directly or connect via the BSO Connect². Once services have been requested, the identified ICL agency determines if the client would be best supported through the BSO Community model; if not, then this ICL agency ensures that the client is actively linked with an appropriate agency or service, through a warm transfer, and not “discharged to nothing”.

The expected outcomes for the client and their caregivers will be that they will have improved experiences with transitions between care settings and within the broader system. Additionally, clients/caregivers will be accessing relevant and effective services and supports in a timely fashion, and there will be reductions in duplication of services and assessments from participating agencies.

In general, improved collaboration and coordination lead to improved outcomes for clients and their caregivers, avoid emergency department visits/hospitalizations, and early admission to long-term care.

The ICL model includes agencies, which based on the scope of services provided, would be identified as an:
- ICL agency that provides services that may include personal support, navigation, respite etc. Examples of ICLs are Community Care Access Centre, Dementia Alliance, and Catholic Family

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² BSO Connect is a singular point of entry for clients, caregivers, Health Service Providers and other agencies to assist individuals with behavioural issues as defined by the BSO Framework. Beyond its centralized intake role, the process evolves a step further towards active referrals and linkages, creating a “warm” connection for clients.
Services, etc. An agency that has been identified as the lead agency for a client is referred to as a Principal ICL (PICL)
- ICL Contributing Agency, one that provides services that are limited to a specific activity/function i.e. meals on wheels, transportation.

Criteria for identifying a PICL include:
- community health service providers (HSP) that has or has had significant experience with the client with regards to understanding and or addressing their care needs
- community HSP that provides the services that meets the clients immediate care needs, and has capacity to accept the referral (client and or caregiver has not previously accessed a community agency)
- community agency has signed the ICL MOU.

Criteria for Appropriate Change in PICL Agency:
- the care plan changes resulting in the identification of a new PICL
- needs of the client exceed the capacity, scope, mandate and/or expertise of the current PICL
- the service provided by the PICL ran its predicted course, and has completed its care objective
- another service/agency has entered the collaborative and is considered to be a more appropriate.

Process for Change in PICL:
- If the PICL is the sole agency providing services to the client/caregiver and has determined that they are unable to continue to meet the care needs of the client, the PICL will ensure the client is transitioned to another ICL that can assume the PICL role.
- If the PICL is one of several agencies involved in the client’s care plan, but based on the client’s care needs, cannot continue in the PICL role, it is the responsibility of this agency to schedule a meeting with the area ICL Cluster members to identify a new PICL that will transition to the role.
- Outgoing PICL will notify all health service providers involved in the clients care of change in PICL, including the client’s Primary Care provider and BSO Connect if appropriate.
- Documentation specific to the PICL role must be transitioned to the incoming PICL.
- The client and/or caregiver must be fully supported through the transition.

PICL Agency

Roles and Responsibilities of PICL Agency:
The PICL agency will initially focus on:
- obtaining any existing information from the client and/or BSO Connect including whether the client has previously received community services
- ensuring that the client/caregiver understands privacy and consent considerations, and that the consent may extend to other agencies/services as care plan evolves, and that they may rescind their consent at any time
- exploring client’s current status with regards to decision-making capacity
- partners with the client and caregiver in building a complete understanding of their needs
- ensuring that the client is stable and supported
- develop a Home Package – a folder that may be located at the client’s residence with key information in the event Emergency Medical Services (EMS) or the BSO Community Outreach Team (COT) are engaged.
The PICL will then determine if that client is best supported by the PICL unilaterally, or if further external support would be appropriate. If external support is deemed appropriate, the PICL contacts other agencies to develop a working collaborative with a focus on developing and coordinating a care plan. The PICL agency is then responsible for monitoring the progress of the care plan, and ensures it is reflective of the client’s needs. Agencies collaborating in the care of the client are required to inform the PICL of any changes in the client health status, care plan or care provided by their agency.

**Managing the “Entry-to-Response Gap”**:  
This is defined as the period of time between the client’s entry into the system and their receipt of appropriate services, which may include necessary assessments. This delay can pose a significant crisis risk.

The objective of the ICL Model is to minimize/manage the risk across this gap, by engaging external resources as warranted by the PICL agency’s understanding of the risk. This may include:
- adapting/adjusting the home environment for a better level of safety and comfort (this may involve working with and/or negotiating with family)
- notifying and collaborating with family and formal/informal caregivers (including the family physician) to discuss the risk potential and potential intervention
- notifying outreach or existing crisis teams via a BSO Alert
- secure temporary or long-term support (e.g. PSW, short-term respite).

**Coordination and Collaboration:**  
Utilizing a person-centred approach to care, the PICL agency will work with the client and/or caregiver to:
- better understand and prioritize the needs – including emotional needs - of the client and how they are/are not being addressed
- focus on identifying “unmet needs” of the client through active referral
- understand the client’s hope, goals and their experience with services received to date, including successes, challenges and barriers
- develop realistic expectations
- emphasize the importance of stress reduction in the client, and the caregivers
- ensure that the client understands where they are at this point in the system and the potential path ahead (including timelines when/where appropriate)
- determine if the client requires additional support beyond the PICL - where additional support is required, the PICL will:
  - connect with other community service agencies to form a collaborative with the intent to develop and manage a care plan
  - facilitate the collaborative to explore the experience of clients in general regarding how to proceed through the BSO models from their initial entrance point.

**Care Plan Development:**  
The PICL oversees the development, coordination and monitoring of the care plan. Care planning may involve aligning multiple plans (as opposed to creating a singular plan). Themes and guiding principles behind care planning are:
- “how do we get the client to where they need to be?”

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3 BSO Alert is a document and/or information shared with outreach teams for clients who may be, or potentially be, at risk in the community. The ICL and the BSO Community Outreach Team would collaborate regarding the client, the situation of risk, and develop a plan to support the client through the potential crisis.
• focus on client need(s) identified, and not a pre-determined menu of services
• identify unmet needs should guide planning (e.g. caregiver stress, diagnosis and management, etc.)
• actively engage or “pull” services towards the client (as opposed to referring or “pushing the client towards the service)
• appropriately paced services
• avoiding duplication and complication
• bridging and leveraging services where possible
• promoting coordination wherever possible (e.g. supporting independent living (SIL) and HNHB CCAC visiting a client together)
• open exchange of information and knowledge in the interest of capacity building
• understanding the necessity to periodically extend service criteria to support this in serious/dire need.

ROLEs AND RESPONSIBILITIES BSO ICl CONTRIBUTING AGENCIES

Contributing Agencies to the ICL Cluster will:
• participate in providing client-specific information to the PICL coordinating the care for mutual clients
• participate in care plan development where formal client-specific collaboratives are formed
• notify PICL upon any changes to service delivery that impacts mutual clients
• notify PICL when there are changes in a client’s status that impact his/her ability to manage
• support clients who engage their agency as an access point to the system by ensuring the client is linked to appropriate services (‘warm connection’).