Inaugural Edition - Spring 2012

Toronto Central LHIN Compass

Transforming the system for your health

SPOTLIGHT

A Daughter's Devotion

When an informal caregiver spends more than 10 hours a week caring for a loved one, the risks mount for burnout. How one TC LHIN initiative is helping to save the body – and mind – of informal caregivers. Read More +

FEATURED STORIES

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How a Behaviour Support Program at Baycrest is helping two college sweethearts reconnect and manage life with dementia. Read More +

Listening to the Beat of a Community

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UPCOMING EVENTS

Toronto Central LHIN Board of Directors' Meeting

When: June 6, 2012, 3:15 pm to 5:15 pm
Where: Board Room, Toronto Central Local Health Integration Network, 425 Bloor Street East, Suite 201, Toronto, ON M4W 3R4

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Health Equity Impact Assessment (HEIA) Delivering Quality: High Impact Equity Planning in Challenging Times

When:May 28th, 2012
Where: 900 Bay Street, OntarioRoom, 2nd Floor Toronto, ONM7A 1R3 Read More +

TC LHIN NEWS

TC LHIN Welcomes New Primary Care Advisors

Meet TC LHIN's Primary Care Advisors

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Hello World. Meet Ontario's Senior Friendly Hospital Initiative

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Patient Destiny

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Urban Aboriginal Diabetes Research Project

A new report – a year in the making – highlights the need for a new model of care to address one of Toronto's most vulnerable and hidden populations Read More+

SEEN & HEARD

Faith Malach, Executive Director, Centres for Mental Health & Memory and Neurotherapeutics on Behavioural Supports Ontario. Read More +

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A Daughter's Devotion

When an informal caregiver spends more than 10 hours a week caring for a loved one, the risks mount for burnout. How one TC LHIN initiative is helping to save the body - and mind - of informal caregivers

Reminiscing about her relationship with her mother brings tears to the eyes of 69-year old Petroula Soklaridis.

"My mother means everything to me," said Petroula Soklaridis, caregiver. "She was a good mother. She did everything for me. And now I want to give her what she needs."

Soklaridis' mother, Eleni Vafiadou, is 94-years old.

Vafiadou's mind is still sharp.

Her wit is still intact.

But she is tormented by chronic health problems, including congestive heart failure, diabetes and hypertension – conditions that can send her to the local ER at a moment's notice.

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Petroula Soklaridis, 69 with her mother, Eleni Vafiadou, 94.

These days, Vafiadou, a Greek immigrant lives with Soklaridis and her husband, Bill. She needs her daughter's constant care - from bathing, to using the bathroom to making her meals.

"I have become her nurse," said Soklaridis. "I take care of her. I decide for her – and that's her life. It's very difficult for me and it's a huge responsibility. But I wouldn't have it any other way."

For now mother and daughter agree that staying at home is the only choice.

"The longer the family is able and willing to take care of a frail elderly person at home, the better it is for everyone," said Françoise Hébert, Ph. D., CEO, Alzheimer Society of Toronto. "Loving home care with appropriate supports if and when they are needed is a highly cost effective way for a community to care for seniors who can't manage alone like they used to."

"Taking care of my mother is a 24-hour job," said Soklaridis. "Sometimes I feel tired, depressed, even guilty when I leave her."

When informal caregivers, like Soklaridis, spend more than 10 hours per week taking care of a frail relative or friend there is an increased risk for burnout and stress.

Eleni Vafiadou enjoys knitting.

Toronto Central LHIN recognized that something needed to be done to improve the wellness and quality of life for informal caregivers like Soklaridis. So TC LHIN approached the Alzheimer Society of Toronto to lead an innovative pilot project designed to relieve the stress and increase the resiliency of at-risk caregivers.

And so, the *Caregiver Framework for Seniors Pilot Project* began to take shape.

“This project is different because the caregiver and the specially-trained care coordinator have a face-to-face chat about the stresses of caregiving,” said Hébert.

“They discuss various options and come to an agreement plan to address the situation – not only through conventional services, but based on out-of-the-box thinking.”

The care is centred on what the caregiver needs and not on what the system thinks the caregiver needs.

As a result of the early successes of this project, the TC LHIN provided funding to expand the project to an additional 150 at-risk caregivers, bringing the total to 300.

The Toronto Central CCAC Seniors Enhanced Care program is an eager partner in this project. Through the program, specially trained care-coordinators were asked to select five caregivers, like Soklaridis, from their caseload, who are at a high risk of burnout.

Together with their care-coordinator, the caregivers selected for this project discuss what might help to relieve their stress and agree on an individualized care plan. The project has allocated an average of $1,500 to implement the care plan for each caregiver.

“Every caregiver is unique and so is every recipient – their needs are unique as well… so the Caregiver Project allows them to be creative and flexible,” said Jade Yung, Care Coordinator, Toronto Central CCAC.

“We trust the professional judgment of the care coordinators and we ask them to think outside-the-box in negotiating the individualized care plans with the caregiver,” said Hébert.

For example, if the two agree that one way of relieving the caregiver’s stress would be to hire a family member or a neighbhour to take care of their spouse for several hours a week, then the project will fund that expense.

Most caregivers in the program opt for respite care by hiring a family member, friend or neighbour to care for their spouse or parent. Also often selected are incontinence products, transportation or a combination of those things.

Natalie Warrick coordinates the project for from the ground up. She has seen firsthand how this project empowers both the caregivers and care coordinator.

“With funding going to solutions selected by the caregivers themselves, they feel their voice is heard and they understand that their contribution is valued,” said Natalie Warrick, project coordinator.

Both caregivers and health service providers like Hébert and her team at the Alzheimer Society hope the project continues beyond the pilot phase.

“We want to know that this program helps to reduce stress and increases the resiliency of the caregiver,” said Hébert.

“At least in theory, this should improve the quality of care that they provide for their family member and we firmly believe that it could result in major savings for the health care system.”

With the TC LHIN expansion of project funds, the Alzheimer Society of Toronto is now reaching out beyond the CCAC to recruit at risk caregivers from Mount Sinai’s Reitman caregiver program, as well as caregivers identified as being at risk by COPA, St. Stephen’s Community House, St. Christopher House, Les Centre D’Accueil Heritage and the Alzheimer Society’s own professional counselors who constantly deal with at-risk family caregivers.

Petroula and her husband, Bill enjoy a cup of coffee together

Soklaridis chose to receive three extra hours of personal support worker care per week with her funding – roughly the time to watch a Hollywood blockbuster. But for her, she says that three hours is like a mini-vacation.

"I would rate it a 10/10 that's for sure," said Soklaridis. "How can I not, especially if that time gives me more freedom and peace of mind. As much as I love my mother, I can't be with her 24 hours a day."

What does she do with some of her new-found free time?

Laughingly, she admits to sitting down with her husband Bill for coffee – something she rarely did before she was enrolled in the *Caregiver Framework Project.*

More Information:

To learn more about Senior Friendly Hospitals in the TC LHIN, please **click here.**


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Frank and Harriet's Story

How a Behaviour Support Program at Baycrest is helping two college sweethearts reconnect and manage life with dementia

Frank and Harriet Liebmann – college sweethearts and soulmates.

"He was a sweet man, a reliable man," said Harriet Liebmann about Frank, her husband of 50 years. "I loved the creativity in him and he certainly had a wild streak."

Harriet and Frank Liebmann met in teacher's college.

She was a spritely young woman from Montreal.

He was a refugee from Hungary who spoke very little English.

They became college sweethearts.

And after college they raised a family.

She became an artist.

He became a teacher and businessman – eventually starting a swim school where he taught scores of kids.

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Today, Frank, now 77, lives at Baycrest.

Frontal temporal dementia (FTD) has changed is life and his ability to live in the community with his wife.

It is a degenerative condition where the frontal lobe of the brain starts to shrink over time.

And in its wake, leaves a person experiencing uncharacteristic behavior, difficulty speaking and impaired thinking.

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And in its wake, leaves a person experiencing uncharacteristic behavior, difficulty speaking and impaired thinking.

FTD strikes younger people – sometimes people in their 40s.

Today in Toronto, roughly 39,244 people live with dementia. According to the Alzheimer Society of Toronto, by 2031, that number will jump to 64,056 people living with the illness.

Frank was officially diagnosed 10 years ago, but Harriet recalls early moments when she knew something was not quite right.

Trouble was, the Liebmanns were challenged to find the appropriate services for care.

“FTD affects people who are younger – their spouses are younger, children are younger and they don’t fit well with other dementia programs as they serve folks that are 10,20, 30 years older,” said Dr. Sidney Feldman, Chief of Family and Community Medicine and Executive Medical Director, Residential & Aging at Home program at Baycrest.

About five years after he was diagnosed, Frank lost his ability to drive. So it was Harriet who brought him to various community programs designed to serve indivuduals with cognitive impairment.

Frank’s behavior worsened until finally he was deemed unable to manage in the community programs.

“He was insulting others, putting his foot out to trip them, knocking the cane out of their hands, very uncharacteristic behavior for a sweet man,” Harriet remembered, as she grappled with Frank’s increasingly aggressive behavior and her inability to manage it.

“Frontal lobes of the brain are responsible for executive functions, sequencing and organizing,” added Dr. Feldman.

And as FTD progresses, people living with the disease become increasingly prone to inappropriate behaviours.

Harriet Liebmann with Dr. Sidney Feldman, Chief of Family and Community Medicine and Executive Medical Director, Residential & Aging at Home program at Baycrest.

Enter Baycrest.

At Baycrest the Liebmanns met many knowledgable staff who identified Frank's condition.

Soon he was in a one-of-a-kind day program that started to make a difference.

The Baycrest Community Day Centre for Seniors also helped Harriet care for her husband, providing tips to help her manage her husband's illness.

Baycrest was the right fit for the Liebmanns.

"It becomes like a broken telephone, I had to interpret Frank's condition for different professionals," said Harriet, referring to her ordeal before coming to Baycrest.

"I have been hooked up with Baycrest and it has changed my life, everybody just talks to each other and communicates," she added.

For the Liebmanns, this communication and the resulting continuum of care was key.

And it is this type of communication and access to a continuum of connected services and supports that is at the core of the Toronto Central LHIN's *Behavioural Supports Program*– one that Baycrest is now helping to lead.

Frank and Harriet share a moment at Baycrest's Apotex Centre where Frank currently resides.

Health service providers across the LHIN, including local hospitals, long-term care homes, community care providers, the Alzheimer Society of Toronto and other providers are working with Baycrest to help strengthen and enhance the services and supports that are available for adults living with behavioural challenges, like the the Liebmanns.

"With the LHIN-wide behavioural supports program the hope is that it will provide the same kind of continuity we provide patients and caregivers at Baycrest, in a broader

way across the LHIN," said Dr. Feldman.

The TC LHIN behavioural support program will complement programs like those at Baycrest and people like Frank and Harriet will be able to readily access these services across the TC LHIN.

What's unique about the Behahviour Supports Program is that it brings all the components of the system together - acute care, long-term care, community agencies, mental health, patients and caregivers – to support the the same group of patients. This program will challenge everyone to think differently and deliver resources in new ways for people with behavioural challenges.

Through enhanced access to services and supports, increased caregiver education and training and system collaboration, the program will ensure that patients and their caregivers have the supports they need.

In his room at Baycrest's Apotex Centre, a long term care facility, there are momentos that show Frank in younger days.

There is the school trustee campaign poster that hangs on his door; the figure of a swimmer – no doubt a fading reflection of his past life as a swim coach and history teacher.

During his prime, he even taught Dr. Feldman's children how to swim.

"He knew thousands of children, he remembered their names and they would invite him to their birthdays," said Harriet.

These days Frank cannot remember his four-year old grandson's name and has to be continually introduced to him.

"He has become less and less connected to reality and only lives in the moment," said Harriet. "He can't remember the past--so no regrets, he doesn't think about the future – so no worries, the present is here and it is beautiful."

"Their world shrinks and becomes extremely small," says Dr. Feldman, referring to memory loss among FTD patients.

Since coming to Baycrest, Harriet too, has found the supports she needs. She meets with other caregivers and spouses of FTD patients. Her experience has strengthened her and she hopes to inspire and encourage others.

"I am in the process of writing a book about t the spouse's journey," said Harriet. "I have to write it and share it right here."

These days, Harriet says she is grateful.

She is grateful to emerge intact and credits her connection to Baycrest.

“I just have to document this - to help others understand the impact of the disease on the family.”

More Information:

For more information on TC LHIN’s BSO Project, please **click here**

Listening to the Beat of a Community

Reconnected the people of St. James Town with local, community-based health care

St. James Town sits in the heart of downtown Toronto.

Its pulse is measured by the incredible diversity and strong social and cultural networks of the 16,000 plus residents who call one of the 18 high-rise towers in North St. James Town home.

“St. James Town has a unique sense of identity,” said Ravi Subramaniam, long-time resident and community worker.

And when fire broke out in a 24th floor unit at 200 Wellesley St. E in September 2010, the community came together to help roughly 1200 people who were displaced.

Yet while the six-alarm blaze brought people together, it also exposed how many people in the neighbourhood were facing health challenges.

A community with a high concentration newcomers, low-income households, seniors living alone and others facing complex health issues, St. James Town is a unique neighbourhood with unique needs.

The TC LHIN initiated and funded *Health Access St. James Town* as a strategy to fill health care gaps and better coordinate the vast array of health and community services that St. James Town residents need. TC LHIN selected St. Michael’s as the project lead working with a range of agencies serving St. James Town including Toronto Community Housing, CCAC and the United Way.

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Health Access St. James Town is an important initiative that is working to build a new level of collaboration and coordination between service providers and community members.

While challenging, Health Access St. James Town offers an opportunity to create a model that works for not just St. James Town but also other diverse, high density neighbourhoods across the city.

By linking services together the initiative will make it easier for people to access the health services that they need close to home, without having to go through multiple hurdles.

And by building networks of health care providers that work closely together in the neighbourhood, services can be delivered sooner and more efficiently.

This will benefit everyone.

In the past, the St. James Town neighbhourhood has been studied a great deal, so there is a lot of quantitative data available.

Consulting the community about health care services that are relevant to them and then figuring out how to implement the services is at the core of what *Health Access St. James Town* is about.

To residents, this kind of approach is empowering and will help to build the community.

Ravi Subramaniam moved to Canada from Sri Lanka more than 20 years ago. His family settled in St. James Town and he has called the neighbhourhood home since then.

In 2002, Subramaniam became part of the St. James Town Network - a group of service providers and concerned residents who shared the same goal: to improve the health, well-being, quality of life and personal development of residents of the St. James Town community.

By 2006, the group created “The Corner.”

Last year, the group celebrated the opening of St. James Town Community Corner – a place where both tenants and service providers can collaborate to meet the needs of the people in the neighbhourhood, especially those living with chronic health issues or facing social isolation and barriers to service.

The “Corner” is supporting the *Health Access St. James Town* team. The Corner has already demonstrated what collaboration between residents, who understand the neighbourhood better than anyone, and service providers can do in St. James Town.

“To encourage the uptake of services, one needs to bring services to the community and make the services relevant to them- not just primary health, but other health services too,” said Subramaniam.

“Bringing services to the community–services that people actually want and need – helps to build a sense of belonging and ownership.”

In turn, the people would go to these services, build a relationship with the health service provider.

“This sense of familiarity cultivates trust and for this community. It’s so important,” said Subramaniam.

The future of health care in St. James Town could mean bringing more services into people’s homes, into their buildings, into safe, familiar locations like schools, libraries, community centres. Whatever the outcome, it will involve health service providers, residents and other community organizations working more closely together.

The challenge appears daunting. But with leadership and a dedicated community , *Health Access St. James Town* will make a difference in the lives of local residents today and become a model of the future for neighbourhoods across Toronto.

2012 HEIA Forum - Delivering Quality: High Impact Equity Planning in Challenging Times

2012 EIES Prestation de soins de qualité : Planification de l'équité à impact élevé en périodes difficiles

Monday, May 28, 2012 from 8:30 AM to 4:00 PM (EDT)
Toronto, Ontario

HEIA Health Equity Impact Assessment

EIES Évaluation de l'impact sur l'équité en matière de santé

Ticket Information

TYPE	END		QUANTITY
2012 HEIA Forum - 2012 EIES Prestation	Ended	Free	**Sold Out**

Registration for this event has now closed. For questions please contact the organizers at: HEIA@ontario.ca

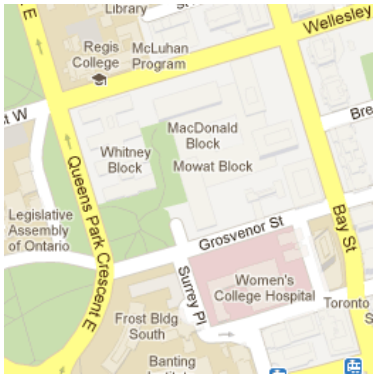
Event Details

Delivering Quality:

High Impact Equity Planning in Challenging Times

Date	Monday May 28th, 2012
	8:30 a.m. – 9:00 a.m. Breakfast and Registration

When & Where



2012 HEIA Forum
MacDonald Block, Ontario Room
900 Bay Street, 2nd Floor
Toronto, Ontario M7A 1R3
Canada
Monday, May 28, 2012 from 8:30 AM to 4:00 PM (EDT)

Add to my calendar

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Time	9:00 a.m. – 4:00 p.m. Conference (lunch will be provided)
Location	900 Bay Street, Ontario Room, 2nd Floor Toronto, ON M7A 1R3
Who should attend?	• Cross-sectoral stakeholders that have an interest in health equity • Those who are involved in decision making and planning • Those with a commitment to improving the quality of health care and reducing health disparities ✓ Health Care Stakeholders ✓ Local Health Integration Networks ✓ Public Health Units ✓ Community Agencies ✓ Government Policy/Planners ✓ Researchers ✓ Health Service Providers ✓ Health Practitioners
How do I register?	Pre-registration is required to confirm your attendance at this session. Space is limited so we encourage you to sign up as soon as possible via: 2012heiaforum.eventbrite.com
Is there a cost?	There is no cost; however, you must register in advance to confirm your seat.
Questions?	Please contact Jessica Brcko at jessica.brcko@ontario.ca or 416-212-2218.

Prestation de soins de qualité :

Planification de l'équité à impact élevé en périodes difficiles

Date	Le lundi 28 mai 2012
Heure	De 8 h 30 à 9 h – Petit déjeuner et inscription De 9 h à 16 h – Conférence (un lunch sera servi)
Lieu	900, rue Bay, salle Ontario, 2e étage Toronto (Ontario) M7A 1R3
Qui devrait participer?	• Intervenants de différents secteurs s'intéressant à l'équité en matière de santé • Personnes ou organismes participant à la prise de décision et à la planification • Personnes ou organismes œuvrant à l'amélioration de la qualité des soins de santé et à la réduction des inégalités en matière de santé ✓ Intervenants en santé ✓ Bureaux de santé publique ✓ Organismes communautaires ✓ Réseaux locaux d'intégration des ✓ Chercheurs ✓ Fournisseurs de services de santé ✓ Professionnels de la santé ✓ Planificateurs de la politique

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Comment s'inscrit-on?	Une préinscription est requise pour confirmer votre présence à cette séance. Le nombre de places étant limité, nous vous encourageons à vous inscrire le plus rapidement possible sur le site : 2012heiaforum.eventbrite.com
Est-ce gratuit?	La participation à cette séance est gratuite, mais vous devez vous inscrire d'avance pour confirmer votre place.
Des questions?	Si vous avez des questions, veuillez communiquer avec Jessica Brcko à jessica.brcko@ontario.caou 416-212-2218.

TC LHIN's Primary Care Physician Advisors

Dr. Yoel Abells, Dr. Phil Ellison and Dr. Tara Kiran have been named as the Toronto Central (TC) LHIN's Primary Care Physician Advisors.

The three Toronto-based family physicians are now on board and will play an instrumental part in our efforts to strengthen primary care for patients.

The Toronto Central LHIN is developing a regional primary care strategy and the Advisors will be key contributors to and lead engagement of primary care physicians and stakeholders in support of the strategy.

We are now initiating the first phase of the plan - a current state assessment of primary care to understand needs and gaps across the system.

Over the coming months you will hear more from the TC LHIN and our Primary Care Physician Advisors about this planning process.

About TC LHIN's Primary Care Physician Advisors:

Dr. Ellison has practiced family medicine in downtown Toronto for over 30 years. His current roles include staff physician in the Department of Family and Community Medicine at the University Health Network (UHN), Medical Advisor to the Toronto Central Community Care Access Centre, and Director of Quality Improvement for the Department of Family and Community Medicine, University of Toronto.

Dr. Kiran is a staff physician and researcher at the Department of Family and Community Medicine at St. Michael's Hospital with extensive experience working with marginalized inner city populations. Dr Kiran currently serves as the clinical lead for the Ontario Diabetes Strategy and was previously the H1N1 Primary Care Lead and the Diabetes Primary Care Lead for the TC LHIN. Dr. Kiran was one of the recipients of the Canadian College of Family Physician's Award of Excellence in 2010.

Dr. Abells currently practices family medicine at Mount Sinai Hospital and the Humber River Regional Hospital and is the medical director of the Forest Hill Family Health Centre. Dr. Abells has been a medical columnist for the *National Post* as well as a medical consultant for media, television and film. Dr. Abells has been very active in the profession and was once the Chair of Family Physicians Toronto. He is an Associate Professor with the University of Toronto's Department of Community and Family Medicine.

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International Spotlight on Ontario's Senior-Friendly Hospital Initiative

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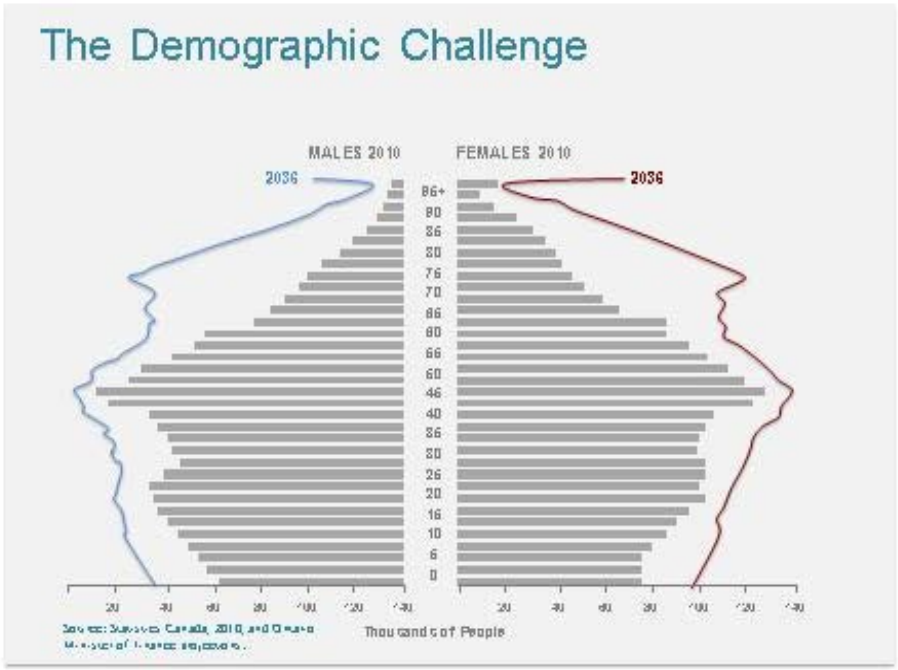

Source: Statistics Canada 2010, and Minister of Finance Ontario projections

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Camille Orridge, CEO Toronto Central LHIN speaks to the importance of Senior Friendly Hospitals at Ontario Hospital Association's 2nd Annual Conference. April 2, 2012

It is no secret.

Ontario's population is growing older.

And this aging demographic has serious implications for patients and families – and it has implications for hospitals and the health care system.

Seniors are three times more likely to be hospitalized, and make up over 60 per cent of all hospital stays.

And according to Dr. Barbara Liu, Executive Director of the Regional Geriatric Program of Toronto, seniors' functional abilities tend to decline the longer they stay in hospital.

Instead of returning to their home or community, these seniors can end up losing the ability to walk which in turn increases their length of stay; increases their need for post-acute care, and ultimately increases their chance of needing long-term care.

This is not good for their health or the health of the system.

So the stage is set for **Ontario's Senior Friendly Hospital Initiative**

In fact, just this month, Ontario presented its Senior Friendly Hospital Initiative at the recent **International Forum on Quality & Safety in Health Care**

The work was presented as a **poster** that was seen by more than 3,000 delegates from more than 80 countries.

"We were quite pleased when we were notified by the conference organizing committee last November," said Ken Wong, Resource Consultant, Regional Geriatric Program of Toronto. "The work was coordinated by the Regional Geriatric Program of Toronto, but it was a collaborative effort from all Regional Geriatric Programs in Ontario."

"This presentation has given us an important opportunity to share information with colleagues and opinion leaders from around the world," said Wong.

Also, launching in the next few weeks is the **SFH Promising Practice Toolkit.** Thanks to the tremendous efforts of a Provincial Working Group co-chaired by the Regional Geriatric Program of Toronto and Baycrest, the new toolkit will be a key resource to share knowledge and evidence about strategies that work.

"This toolkit will keep a spotlight on the Ontario's Senior Friendly Hospital Initiative," said Wong.

More Information:

To learn more about TC LHIN's Senior Friendly Hospital strategy, please **click here**


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Delegations to the Board

Community involvement is an essential part of everything we do as Local Health Integration Networks (LHINs).

The Toronto Central (TC) LHIN engages with members of the public and stakeholders in a variety of ways. One of the important ways that members of the community can interact with the Toronto Central LHIN Board of Directors is through presentations and discussions at the public Board meetings.

At every Board meeting there is at least one presentation by a stakeholder or community group invited by the LHIN to discuss topics that relate to priority health issues in the TC LHIN.

Further, the LHIN is introducing a policy to formalize and clarify the process for stakeholders and community members to request to present to the Board during regular Board meetings and education sessions.

The ***Delegations at Toronto Central LHIN Public Board Meetings Policy*** provides an additional way for the Board to hear a spectrum of viewpoints.

To download the Delegations at TC LHIN Public Board Meetings Policy, please **click here.**

To download the TC LHIN Delegation Application, please **click here.**

If you have any questions, please contact the TC LHIN's Corporate Coordinator Sue Robertson at sue.robertson@lhins.on.ca.

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Meeting with Patients: their experience and perspectives

Patient Destiny and the Toronto Central LHIN co-hosted a day with patients and caregivers who receive services in the Toronto Central LHIN on December 7, 2011. The session brought together a cross-section of patients and caregivers to discuss their experiences, perspectives and ideas for improvement and change.

Participants talked about their fears, frustrations, gratitude and hopes. Most of all, they offered inspiration and concrete ideas that will help us achieve a better health care experience for all.

This report titled ***Meeting with Patients: their experiences and perspectives*** is a result of the sessions with patients and caregivers. It will help to inform health system planning in the Toronto Central LHIN, including the Toronto Central LHIN's 2012-14 Strategic Plan and health quality and equity initiatives.

To access ***Meeting with Patients: their experience and perspectives***, please **click here**

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Urban Aborginal Diabetes Research Report

On February 24th, 2012, Anishnawbe Health Toronto, in partnership with the Toronto Central LHIN launched the Urban Aboriginal Diabetes Research Report.

- **Urban Aboriginal Diabetes Research Report (Dec 2011) - Full PDF Report**
- **To learn more about Aboriginal Community engagement in the TC LHIN, please click here**

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Faith Malach Executive Director, Centres for Mental Health & Memory and Neurotherapeutics, Baycrest on Behavioural Supports Ontario

What is BSO ?

BSO stands for Behavioural Supports Ontario and is a provincial strategy funded by the Ministry of Health and Long Term Care customized to the unique needs of each LHIN. The Strategy aims to improve the lives of Ontarians who experience complex and challenging behavriours due to dementia and other neurological conditions. These individuals may live in long term care homes, r independently in community settings or may be receiving care in an acute care setting.

The BSO project responds directly to the needs of clients, caregivers and health care providers by providing new resources dedicated to specialized supports, education and improved transitions across the continuum It will help build capacity within our complex system, increase consistency in the delivery of care, and help integrate the many exsiting services and care providers across the large Toronto-area system.

How does BSO directly benefit patients?

The TC LHIN BSO action plan addresses key areas identified for improvements and has been designed to improve coordination and reduce fragmentation of the community behavioural support system to ensure more equitable and timely access to services. Specialized community capacity and outreach will be provided to individuals so that they can stay in their existing environment. There will be increased specialize behavioural support capacity in long term care homes. Caregivers will be appropriately educated and supports will be enhanced to reduce or prevent unmanageable behaviours. Providers will receive workforce skills and training to help manage difficult situations they often face. Patients transitions will improve across the spectrum of care.

Currently, caregivers and families who have loved ones experiencing challenging and violent behaviours due to their condition, have very little choice other than coming into an in-patient acute care unit. Adding to the stress, burden and the challenge of having a loved one in distress, the family and caregivers have to navigate a complex system and understand the resources available.

The TC LHIN BSO Plan provides a number of answers by providing more options for clients, caregivers and health providers. With the TC LHIN BSO Plan, there will be a dedicated transitional Behavioural Support Unit (BSU) located within the long term care

Integration

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home at Baycrest in addition to new outreach teams that will support clients, families and health care providers in the community and in long term care settings. . These teams will enable the transition of clients from one place of care to another and will help to prevent unnecessary or prolonged hospitalizations, emergency department visits and in appropriate long term care admissions. In addition, an Education Consortium is being developed with key partners in order to integrate education and training services across the TCLHIN and to leverage existing education, training and knowledge supports. The consortium will include a focus on education and training for caregivers, primary care professionals, long term care teams and RNS, RPNS and PSWs working in the community.

Baycrest has been appointed by the TC LHIN as the Health Service Provider for leading the implementation of the TC LHIN BSO Program. A cross -sectoral Implementation Committee will be created to oversee the implementation of the BSO program in the TCLHIN. In addition, Baycrest will work closely with the many existing teams, providers, services and recognized leaders across the TC LHIN.

What makes BSO a good fit for Baycrest?

Baycrest was a logical leader and organization to appoint, as it is a key player in the delivery of psychogeriatric services and hosts a number of programs and services focused on improving outcomes for individuals with challenging behaviours. Baycrest is poised to leverage its existing capacity and build additional capacity. Our expertise helps to support our clients and their families by responding to their unique needs as they experience their journey through the continuum of care.

More Information:

For more information on TC LHIN's BSO Project, please **click here**