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Jurisdictional Review

Overview of Policy Programs for Dementia and Co-Existing Complex Needs for Residents and their Caregivers: Ontario

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The views expressed by the authors are not intended to represent the views of the North American Observatory on Health Systems and Policies.

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About

The North American Observatory on Health Systems and Policies (NAO) is a collaborative partnership of interested researchers, research organizations, governments, and health organizations promoting evidence-informed health system policy decision making.

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List of Abbreviations

ADRD	Alzheimer's disease and related dementias
ALC	Alternate level of care
BSO	Behavioural Supports Ontario
BSO PCO	BSO Provincial Coordinating Office (BSO PCO)
ECFAA	*Excellent Care for All Act*
HHR	Health Human Resources
HSPRN	Health System Performance Research Network
HQO	Health Quality Ontario
LHIN	Local Health Integration Network
LTC	Long-term care
LTCHA	*Long-Term Care Homes Act*
MOHLTC	Ministry of Health and Long-Term Care
OMA	Ontario Medical Association
ON	Ontario
QI RAP	Quality Improvement Reporting and Analysis Platform
RGPs	Regional Geriatric Programs

Introduction and Background

This report summarizes the findings of a jurisdictional review that aimed to identify core elements of three policy programs—Health Links, Behavioural Supports Ontario (BSO), and First Link—that support people in Ontario living with dementia and other complex health and social needs and their caregivers. The results of the review are intended to inform future interviews with program stakeholders including senior program administrators at the policy level, junior program administrators, additional personnel responsible for implementing the program, and if possible, program recipients. The results of this review will be assessed for accuracy and comprehensiveness through these key informant interviews.

The jurisdictional review was undertaken to develop: (1) a high-level assessment of publicly available information on the programs, including program websites, government websites, media releases, para-governmental websites and peer reviewed literature; (2) a more detailed examination of the literature to identify program elements and environmental contexts; and (3) recommendations on possible candidates for key informant interviews.

This work is part of a broader comparative study of policy programs for people living with dementia and co-existing complex health needs in five North American jurisdictions: British Columbia, Ontario, Newfoundland and Labrador, Vermont, and New York State. The purpose of the broader study is to examine and assess the key features of policy programs in these five jurisdictions that address the health and social needs of people living with dementia and coexisting complex conditions and their unpaid caregivers.

Methods

The scope of this review was delineated by the name of each policy program of interest: Health Links, BSO, and First Link. For the purposes of this project, the documents collected needed to refer explicitly to these programs in the Ontario context. We used the following search strings in scholarly and tertiary databases: Health Link* and Ontari*; Behavioural Support* and Ontari*; First Link* and Ontari*. We employed program names within quotation marks, " " (e.g., "Health Links"), in custom searches of government websites and para-governmental organization websites (e.g., Health Quality Ontario). We also conducted scholarly reviews of official program websites (e.g., www.behaviouralsupportsontario.ca) and hand-searched key papers for additional sources. See **Appendix A** for further details on the specific search terms and sources.

The primary output of the broader study is to identify and synthesize the features of policy programs across jurisdictions based on the elements of a program model outlined by Rose (2005). These policy program elements are:

- **Laws and regulations**: The criteria for determining how services are to be delivered and the conditions for being a recipient of services;
- **Organizational setup**: The specific organizations that are involved in the delivery of services and their linkage with each other in delivering (or not delivering) on the objectives of the policy;
- **Personnel**: The type and distribution of human resources involved in delivering the services;
- **Money**: The amount and distribution of funding devoted to the functioning of the services;
- **Program outputs**: The specific activities and outcomes that will represent the performance of the program functions;
- **Program recipients**: The eligibility criteria that specify the types of individuals to be recipients of the services; and,
- **Goal(s)**: The ultimate outcome(s) the program is intended to achieve overall.

Our analysis will also specify three additional features of the policy programs not included in Rose's (2005) methodology:

- **Policy initiatives, guidelines, and strategic frameworks:** The political strategies and policies in place to support the development and implementation of the program;
- **Information management and evaluation**: The ways in which health information systems are incorporated into service delivery; and,
- **Leadership and priority setting**: The priorities of the program leaders at the policy level.

The above framework of policy program assessment guided our analysis. We used an excel spreadsheet to organize the documents, using one sheet per program. After each document was reviewed, the text that pertained to the program element was copied and pasted into the appropriate category, and the corresponding source text was documented in the spreadsheet. Some excerpts fell into multiple program elements and were documented accordingly on the spreadsheet.

Analytic Overview

Brief Summary of Selected Policy Programs

The following policy programs selected for this study are intended to improve the care provided to people living with dementia and co-existing complex needs and their caregivers: Health Links, Behavioural Supports Ontario (BSO), and the First Link program. Below we present a brief overview of each program.

Health Links

Ontario introduced the Health Links initiative in 2012. The Health Links are flexibly structured collaborations between organizations that receive funding from Ontario's Ministry of Health and Long-Term Care (MOHLTC), but are managed by independent health care organizations (Fairclough et al., 2016). The Health Links were created in an attempt to produce coordinated care plans that underpin enhanced management for patients living with complex needs (MOHLTC, 2015b). The Health Links have generally included collaborations across hospital, primary, and community based care settings (MOHLTC, 2015b). The ultimate goal of the Health Links is to reduce hospital admissions by enhancing the management of complex needs in community-based settings through inter-professional primary care (MOHLTC, 2015a). There are currently 82 Health Links in the province (MOHLTC, 2015b).

Behavioural Supports Ontario (BSO)

The BSO was not designed to be a new program but rather to leverage and enhance existing resources, including: specialized geriatric services, geriatric mental health outreach teams, community support services, geriatric emergency management nurses, inpatient geriatric assessment units, primary care-based memory clinics, adult day programs, Alzheimer Society education, counselling, and a variety of other support programs (Gutmanis et al., 2015). It appears that BSO aims to be a multisectoral program as it leverages existing programs in multiple related sectors such as mental health, primary care, hospital care, long-term care (LTC), and specialty care (e.g., psychiatry) (Gutmanis et al., 2017).

The Regional Geriatric Programs (RGPs) are an example of an exisitng program that contributes to the BSO initiative. RGPs are a network of geriatric services that assess and treat the functional, medical, and psychosocial needs of seniors (Regional Geriatric Programs, 2014). RGPs are involved with the planning, development, implementation, and evaluation of the BSO program (Regional Geriatric Programs, 2014).

While not a primary focus of this review, understanding how the BSO program is compared to the Health Links in the literature, is a helpful exercise to understand program element comparisons. A report by Reed (2013) included a table (see **Table 1**) that highlights some similarities and differences between the BSO and the Health Links programs. We highlight this figure because it suggests that there may be policy synergies between the programs that need to be examined.

Table 1. Comparison of BSO and Health Links

Behavioural Supports Ontario	Health Links
Exciting initiative built upon provincial framework with identified target population, guiding principles and informed by research and practice-based evidence	Excitement and optimism to enhance care; built upon integrated care model with identified target population, guiding principles, and informed by research and practice-based evidence
Early Adopters (4 LHINs) working together with fast roll-out to rest of province	Early Adopters (23 organizations) working together with fast roll-out to rest of province
Development funding provided by MOHLTC; based on voluntary self-organizing groups; lead agency model; designed to encourage greater collaboration among existing providers for higher quality of care	Development funding provided by Ministry; based on voluntary self-organizing groups; lead agency model; designed to encourage greater collaboration among existing providers for higher quality of care
Action plans created through community engagement; customized to local context and resources	Business plans created through community engagement; customized to local context and resources
Focus on coordination Share and learn from each other in province; non-competitive	Focus on coordination Share and learn from each other in province; non-competitive (provincial Health Links group and local sub-LHIN groups meeting together)
Information management practices shared between all Health Link participants Identified measures for tracking improvements for specified patients	Identified measures for tracking and improvement Close affiliation with Health Quality Ontario
Commitment from Ministry to reduce barriers to implementation and to respond in a timely fashion	Commitment from MOHLTC to reduce barriers to implementation and to respond in a timely fashion

Adapted from Reed (2013)

First Link

The First Link program connects people living with dementia and their caregivers to appropriate services at diagnosis. The First Link program was developed in Ottawa, where the Alzheimer Society of Ottawa partnered with the Champlain Dementia Network (McAiney et al., 2009). In 2008, Ontario's 38 Alzheimer Societies were funded to offer First Link across 12 of Ontario's 14 Local Health Integration Networks (LHINs) (Morton-Chang, 2015). The program is a collaboration between the Alzheimer Society, primary care providers, and other health professionals (McAiney et al., 2009). The services currently include: connecting people to the local Alzheimer Society, linking patients to other health and social service providers in their community, and helping them find resources to manage issues such as "decision-making, adjusting to the loss of a driver's license, financial planning, power of attorney, and long term care placement" (Alzheimer Society of Canada, n.d.). A 2016 evaluation of First Link revealed that over 60,000 individuals have been referred to the program since its inception (Alzheimer Society of Ontario, 2016).

General Findings

Laws and Regulations

Laws and regulations refer to the criteria for determining how services are delivered and the conditions for being a recipient of services (Rose, 2005). We did not find any laws and regulations that specifically set out the criteria for determining how services are to be delivered and the conditions for being a recipient. However, the scan did reveal laws and regulations that may be important in understanding the policy context of the Health Links, BSO, and First Link programs. We suggest that in particular, three statutes: the *Patients First Act* (2016), *Excellent Care for All Act* (ECFAA; 2010), and *Long Term Care Act* (LTCHA; 2007), may be relevant to one or more of these programs (see **Table 2**). In the following sections we briefly summarize the regulations and describe how they may (or may not) be relevant to the policy program(s).

Table 2. Laws and regulations

	Health Links	BSO	First Link
***Long-Term Care Homes Act* (2007)**	n/a	✓	n/a
***The Excellent Care for All Act* (2010)**	No explicit implication	✓	n/a
***The Patients First Act* (2016)**	✓	n/a	n/a

LTCHA (2007)*:* All long-term care (LTC) homes in Ontario are governed by the LTCHA (2007).

ECFAA (2010): The ECFAA, which came into law in June of 2010, requires health care providers to "put Ontario patients first by strengthening the health care sector's organizational focus and accountability to deliver high quality patient care" (MOHLTC, 2015a). The ECFAA requires all hospitals to implement an annual quality improvement plan and to make the plan accessible to the public. While the policy programs included in this scan are not hospital-based, we highlight how the policy programs may be influenced in the post-ECFAA era.

The Patients First Act (2016): In December 2016, Ontario passed Bill 41, the *Patients First Act*. Bill 41 amended the *Local Health Integration Act*, 2006. The *Local Health Integration Ac*t was the legislation that separated out Ontario into 14 LHINs that were responsible to plan, fund, and integrate health care services within regional boundaries across the province. The introduction of Bill 41 mandates the creation of LHIN sub-regions. The following section of Bill 41 pertains to the creation of LHIN sub-regions:

> *14 (1) Section 15 of the Act is amended by adding the following subsection: and plans for the geographic sub-regions of a local health system in order to achieve the purposes of this Act.*

Additionally, the *Patients First Act* (implemented in April 2017) mandates the absorption of the agencies responsible for delivering home care services (Community Care Access Centres) into the LHINs. Under the *Patients First Act*, the LHINs are responsible for home care delivery and some primary care practices. Given the change in governance and administration of services due to the *Patients First Act*, it is important to understand if there are any implications for the implementation and/or delivery of the three policy programs under study in this review.

Policy Initiatives, Guidelines, and Strategic Frameworks

Policy initiatives, guidelines, and strategic frameworks are salient political strategies and policies in place to support the development and implementation of programs (Rose, 2005). We identified seven strategies that may relate to one or more of the policy programs in this scan, summarized in **Table 3**.

Table 3. Policy initiatives, guidance, and strategic frameworks

Strategy	Health Links	BSO	First Link
Ontario Strategy for Alzheimer and Related Dementias (1999) and Transition Project (2004)	n/a	Pre-dates BSO	Pre-dates First Link
Ontario's Dementia Strategy (2017)	n/a	✓	✓
Aging at Home Strategy (2007)	n/a	n/a	✓
Residents First (2009)	n/a	Yes	n/a
Open Minds, Health Minds (2011)	✓	Yes	n/a
Ontario's Action Plan for Health Care (2012)	✓	n/a	n/a
Patient's First: Action Plan for Health Care (2015)	✓	n/a*	n/a*

Ontario Strategy for Alzheimer and Related Dementias (1999) and Transition Project (2004): From 1999–2004, Ontario deployed an *Alzheimer and Related Dementias* strategy that was followed up by the *Transition Project* (2004–2007). The aims of the strategy (MOHLTC, 1999) were to enhance:

1. Staff education and training
2. Physician training (mentor programs)
3. Increasing public awareness, information, and education
4. Planning for appropriate, safe, and secure environments
5. Respite services for caregivers
6. Research on caregiver needs
7. Advance directives on care choices
8. Psychogeriatric consulting resources
9. Co-ordinated specialized diagnosis and support
10. Intergenerational volunteer initiative

Ontario was the only province in the country with a provincial dementia strategy. The Ontario Strategy was well-received by stakeholders and had positive evaluations (Morton-Chang, 2015). Post-strategy, there were continued investments in day hospitals, psychogeriatric resource consultants in LTC homes, public education coordinators at Alzheimer Societies, and some education for formal care providers (McAiney, 2005). The strategy was unable to meet all of the objectives within the five-year frame and, as a result, the newly elected Liberal government implemented the Alzheimer Strategy Transition Project in 2004 (Alzheimer Strategy Transition Project, 2006). The Transition Project had four priorities:

1. The Alzheimer Knowledge Exchange (AKE)
2. Regional dementia networks
3. A roundtable on future planning for people with Alzheimer's Disease and related dementia
4. A provincial Alzheimer group

After the Transition Project concluded in 2007, governmental support for disease-specific programming was gradually phased out and funding was directed towards broader seniors' programs (Morton-Chang, 2015).

Ontario's Dementia Strategy (2017): In spring 2017, the government announced a new provincial *Dementia Strategy* that has the following priorities:

1. Increasing access to adult day programs and transportation
2. Enhancing caregiver respite services
3. Expanding behavioural supports
4. Improving the coordination of care
5. Continuing to invest in health care providers' education
6. Raising awareness about dementia risk factors and reducing stigma

Announced in the 2017's budget, Ontario proposed the investment of $100 million over three years towards this strategy. It appears that the MOHLTC considers the strategy to be a component of Ontario's Patient's First action plan (MOHLTC, 2015c).

Aging at Home (2007)*:* In 2007, Ontario implemented the *Aging at Home* strategy where $1.1 billion was invested into community-based services for seniors and caregivers. The aim of this strategy was to support seniors so that they may live independently in their own homes (MOHLTC, 2007). The province's LHINs administered the *Aging at Home* strategy by expanding home and community services such as professional home care and community supports (Williams et al., 2009). A portion of the *Aging at Home* funding was dedicated to services that were seen as innovative approaches to seniors services, for example, services that were targeted for cultural groups, and programs for marginalized and at risk seniors (MOHLTC, 2007).

Residents First (2009)*:* The quality improvement initiative, *Residents First*, was launched in 2009 by the former Ontario Health Quality Council (now part of Health Quality Ontario [HQO]). It is a provincial project that is designed to increase the capacity of front-line staff and leaders in the LTC sector to acquire new skills and promote performance improvement (MOHLTC, 2014).

Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy (2011): In 2011, Ontario launched *Open Minds, Healthy Minds: A Comprehensive Mental Health and Addictions Strategy* with the aim "to support mental health throughout life, from childhood to old age, and to provide the integrated services and support that Ontarians need if they experience a mental illness or addictions" (MOHLTC, 2011). While this strategy does not explicitly include Health Links, BSO or First Link, the it does refer to "seniors" mental health as an area that needs attention and improvement.

Ontario's Action Plan for Health Care: Better patient care through better value from our health care dollars (2012): The provincial government's strategy document *Ontario's Action Plan for Health Care* (2012b) stated a system-wide goal was "better integration" with sectors including primary care, community care, hospitals, and LTC working together. The strategy also documents an aim to implement "local integration reform" to "meet the needs of a growing population with multiple, complex and chronic conditions" (MOHLTC, 2012, p. 12).

Patients First: Action Plan for Health Care (2015): The four pillars of *Patients First: Action Plan for Health Care* (2015) are: 1) "access—improve access-providing faster access to the right care; 2) connect services—delivering better coordinated and integrated care in the community, closer to home; 3) inform—support people and patients, providing the education, information and transparency they need to make the right

decisions about their health; and 4) protect—protect our universal public health care system, making decision based on value" (MOHLTC, 2015c, p. 6–7).

Organizational Setup

Organization refers to the organization(s) that are responsible for the output of a policy program (Rose, 2005) and their linkage(s) with each other in delivering (or not delivering) on the objectives of the policy. Ultimately, Ontario's MOHLTC oversees the strategic direction for the three policy programs. The MOHLTC provides funding to the LHINs who are responsible for operationalizing policy programs.

Money

Money refers to the amount of funding devoted to the functioning of services. Our scan did not reveal any publicly available documents that detailed the amount of money the government spends on the policy programs. We reviewed Ontario's Public Accounts reports from 2010-2015 and none of the reports included the line item "Health Links", "Behavioural Supports Ontario", nor "First Link".

Summary of Findings by Program

Below we present a summary of findings for each of the selected policy programs based on the framework elements. A table comparing each policy program can be found in **Appendix B**, and additional information for each program are presented in **Appendices C–E**.

Health Links

Laws and Regulations

There was no publicly available information connecting how the *LTCHA* (2007) may have impacted the design and delivery of the Health Links.

***ECFAA (2010)**:* While we have not found any documents that explicitly describe the implications of the *ECFAA* on the Health Links, we postulate that this Act was influential in its development. Given that Health Links was implemented in 2012, only two years after *ECFAA* was introduced, we suggest that it is important to explore the implications of this Act on the development and implementation of this policy program and we intend to explore this during the next phase of key informant interviews.

***Patients First Act (2016)*:** The LHINs have worked closely with the MOHLTC to facilitate a more seamless patient experience across the health care sectors (Evans et al., 2014). The LHINs were charged with implementing and managing the Health Links initiative. The overall vision of the Health Links is to integrate and/or "strengthen, coordinate, and integrate primary care with home and community care" (MOHLTC, 2015e). The *Patients First Act* also mandated the creation of sub-LHIN regions. The Health Links program similarly takes a local approach to integrated care in sub-geographies in Ontario. As such, we suggest it is important to explore whether these sub-regions are compatible with the LHIN regions.

Policy Initiatives, Guidelines, and Strategic Frameworks

There was no publicly available information that discussed how the *Ontario Strategy for Alzheimer and Related Dementias* (1999), the *Alzheimer Strategy Transition Project* (2004), the *Dementia Strategy* (2017), the *Aging at Home Strategy* (2007), *Residents First Strategy* (2009), or *then Open Minds, Healthy Minds: Ontario's Comprehenisive Mental Health and Addictions Strategy* (2011) may have impacted the development and implementation of the Health Links.

***Ontario's Action Plan for Health Care: Better Patient Care Through Better Value from our Health Care Dollars* (2012):** Although the Health Links was still in its early stages of implementation in 2012, this initiative exhibited some of the philosophy behind the intent of Health Links. The action plan describes how a sub-population of Ontario's patients who need to be better served: "the one per cent of the population that accounts for 34 per cent and the ten per cent of the population that accounts for nearly 80 per cent of our health care spending" (MOHLTC, 2012, p. 12). The emphasis on better care for "high-cost" patients is one of the guiding principles of the Health Links. Moreover, the concepts of better integration of care and local health reforms, as stated in the action plan, are aligned with the Health Links goals.

***Patients First: Action Plan for Health Care* (2015)**: One of the pillars of this strategy is "access" and the Health Links program was touted in this action plan as a good example of how Ontario's health system is working on improving access (MOHLTC, 2015d). Improving access or providing "faster access to the right care" is here defined as:

> *[W]hen the hospital, the family doctor, the long-term care home, community organizations and others work as a team, patients with multiple, complex conditions receive better, more coordinated care. Providers design individualized care plans, and work together with patients and their families to ensure they receive the care they need.* (2015d, p. 9)

As reflected in this quote, the Health Links program's goal of care coordination and integration is aligned with Ontario's overall health system strategy.

Organizational Setup

In the Health Links initiative, the MOHLTC works together with the LHINs and HQO to deliver the program. **Table 4** describes the relationships between the three agencies and outlines their responsibilities. HQO is an arm's-length agency that guides quality-improvement initiatives and reports on health performance for all health sectors across the province. Essentially, the MOHLTC guides the strategy, the LHINs fund and are accountable for the individual Health Links, and HQO supports data collection, performance measurement, and the development of best practices.

Table 4. Organizational Setup for Health Links

Organization	Responsibilites
MOHLTC	• Sets the strategic direction for Health Links • Provides overall funding to the LHINs • Oversees the overall performance of the Health Links initiative to guide strategy • Facilitates operational success by implementing provincial-level tools and supports
LHIN	• Sets regional priorities for Health Links and ensures alignment with provincial priorities • Funds Health Links in accordance with priorities • Maintains overall accountability for Health Links performance, LHIN by LHIN • Drives operations through implementation of plans and supports for adoption of provincial tools • Identifies and implements regional supports and tools as required
HQO	• Supports data collection, timely reports, and analysis • Leads systematic identification of emerging innovations and best practices • Increases rate of progress through standardization of best practices across all Health Links • Supports inter-Health Link sharing of lessons learned on regional or pan-provincial basis • Connect LHIN Health Link leads (see following section) with other relevant provincial quality initiatives

Table adapted from (Fairclough et al., 2016)

Each Health Link has a lead organization that is accountable to the LHIN for the Health Link's performance (MOHLTC, 2016). Initially, organizations who took on the lead role of a Health Link were pre-existing service provider organizations and were comprised of a variety of organizations including hospitals, Community Health Centres, Family Health Teams, and community support service agencies. As of November 2015, all new Health Links were led by hospitals, LHIN home care, or primary care teams. A primary care team can be a Family Health Team, Nurse Practioner-Led Clinic, Aboriginal Health Access Centre, Community Health Centre, or a Family Health Organization (MOHLTC, 2016). All Health Link Lead Organizations are responsible for functions of governance, establishment, operations, and performance (see **Appendix C** for details). Health Link partner organizations can also share in the responsibility of these functional areas through formal arrangements such as Letters of Cooperation.

Personnel

The Health Links program appears to leverage existing health human resource (HHR) structures and encourages them to work in different ways. The central focus of the Health Links, as a clinical intervention, is "coordinated care management" where patients with complex needs are identified by health care professionals and then a coordinated care plan is developed among an interdisciplinary team of providers linked with the patient (Health Quality Ontario (HQO), n.d.).

Program Objectives/Outputs

The Health Links program aims to coordinate care for patients living with complex needs (MOHLTC, 2015b). Health Links has gone through three phases of indicator development to measure this aim. The three phases are: (1) operational program indicators, (2) results based indicators, and (3) evaluation based indicators. Initially, the Health Links program looked at the following two operational program indicators:

- Number of patients with a coordinated care plan developed through the Health Link; and
- Number of patients with regular and timely access to a primary care provivider (MOHLTC, 2016).

In the second quarter of 2015/16, the MOHLTC required three results-based indicators:

- Reduction of 30-day readmissions to hospital;
- Reduction of home care visits referral time; and,
- Reduction in the number of emergency department visits for conditions best managed elsewhere (MOHLTC, 2016).

Moving forward, the MOHLTC planned to look at evaluation-based metrics including:

- Enhance the health system experience for patients with the greatest health care needs;
- Achieve an alternate level of care (ALC) rate of 9% or less; and,
- Reduce the average cost of delivering health services to patients without compromising the quality of care (Seaman & Dionne, n.d.).

Program Recipients

When Health Links was initiated in 2012, the target population were "high-cost users," who are typically seniors with two or more chronic conditions, and have multiple care providers (Angus & Greenberg, 2014). High-cost users account for a disproportionate amount of total health spending in Ontario. The Health Links program aims to target the top 5% of users of the health system, who comprise 66% of health spending (Wodchis et al., 2016). A major challenge at the outset of Health Links was how to identify the target population (Angus & Greenberg, 2014). In August 2015, the MOHLTC presented new guidelines on a common protocol for identifying "high-cost user patients" using the following characteristics:

- Patients with four or more chronic/high-cost conditions,[1] including a focus on mental health and addictions conditions, palliative patients, and the frail elderly;
- Economic characteristics (low income, median household income, government transfers as a proportion of income, unemployment); and
- Social determinants (housing, living alone, language, immigration, community, and social services etc.) (MOHLTC, 2015c).

[1] See Appendix C for a list of selected conditions that are chronic and/or high cost as per the MOHLTC.

Goals and Vision

The overall goal of the program is to improve integrated care for patients with multiple conditions and complex needs. The role of a Health Link is to organize and coordinate care at the patient level to improve patient experiences and outcomes (Hamilton Niagara Haldimand Brant Local Health Integration Network, 2013).

Information Management and Evaluation

HQO supports the Health Links program's information and evaluation through its Quality Improvement Reporting and Analysis Platform (QI RAP). QI RAP is a common, integrated platform for data reporting and analysis of quality-improvement measures. QI RAP enables the sharing of results across LHINs and Health Links to promote transparency and inter-organizational learning (Health Quality Ontario, 2015).

While the Health Links program has an integrated platform for reporting, it does not have a common infrastructure in place for sharing of patient information across providers. A report conducted by the Health System Performance Research Network (HSPRN) highlighted information technology (IT) infrastructure challenges among three Health Links (Gutberg et al., 2017). The lack of a common IT infrastructure limits the Health Links' ability to collaborate across providers and deliver coordinated patient care (Gutberg et al., 2017).

Leadership and Priority Setting

The initial implementation of Health Links has been characterized as a "low rules" policy approach (Angus & Greenberg, 2014; Evans et al., 2014; MOHLTC, 2016). The idea is that low rules or "simple rules" fosters a facilitative leadership model that enables organizations and providers to create, learn, and innovate (Evans et al., 2014). Research carried out by the Ontario Medical Association (OMA), a membership organization that represents the interests of Ontario physicians, suggests that this low-rules environment with few structural and governance requirements coupled with voluntary participation and flexible funding resulted in successful clinician leadership and engagement in Health Links (Keresteci, 2013). However, a study by Gutberg et al. (2017) on three Health Links in the Central LHIN revealed challenges in engaging family physicians because of a lack of time, the geographic dispersion of physician practices, and the resource constraints of solo practitioners (compared to physicians in Family Health Team models). We suggest that there needs to be further interrogation of the concepts of clinician engagement, leadership, and priority setting.

While at the outset, there were few top-down policies and guidelines, as Health Links matures, the MOHLTC has implemented more specific priorities starting in the 2015/16 fiscal year. These priorities are captured in the *Advanced Health Links Model* comprised of four policy and operational areas:

1. **Standardization** to support common understanding of the target population, common measurement, and common governance and accountabilities across all Health Links;
2. **Performance management and oversight** to enhance accountability for performance by strengthening the performance management framework;
3. **Funding model redesign** to support LHIN accountability, the scale-up of operations around the province and to realize true value to the system; and,
4. **Wider system integration** to enable adaption and alignment with other ministry and government priorities (MOHLTC, 2016)

Behavioural Supports Ontario (BSO)

Laws and Regulations

There was no publicly available information about how the *Patients First Act* (2016) may have impacted the implementation and delivery of the BSO.

***LTCHA (2007)*:** Regulation 79/10 made under the LTCHA came into force on July 1, 2010. Section 54 of the LTCHA Regulation 79/10 is entitled "responsive behaviours":

> *All of the following must be developed to meet the needs of residents with responsive behaviours:*
> - *Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.*
> - *Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.*
> - *Resident monitoring and internal reporting protocols.*
> - *Protocols for the referral of residents to specialized resources where required.*

A key report evaluating the BSO initiative by Dudgeon and Reed (2013) refers to the LTCHA as a component of the policy environment for the program.

***ECFAA (2010)*:** Our scan identified that the ECFAA is relevant to the BSO program. Dudgeon and Reed's (Dudgeon & Reed, 2013) evaluation of the BSO highlighted how the Act was germane to the policy environment of the BSO (see **Appendix D** for a table summarizing their analysis). A key report that evaluated the BSO program stated that ECFAA's patient-centred care philosophy and the use of quality-improvement strategies were central to the BSO's initiatives (Behavioural Supports Ontario, 2010). Gutmanis et al. (2015) also state that the ECFAA was a component of the policy environment for BSO's implementation plan for intersectoral and interdisciplinary service delivery.

Policy Initiatives, Guidelines, and Strategic Frameworks

There was no publicly available information discussing how the *Aging at Home Strategy* (2007), the *Ontario's Action Plan for Health Care* (2012), and the *Patients First: Action Plan for Health Care* (2015) may have impacted the development and implementation of the BSO program. However, it is reasonable to infer that the *Action Plan* (2015) influenced the BSO program, given that "improving dementia support" was a key variable for consideration when working to improve access to care.

***Ontario Strategy for Alzheimer and Related Dementias* (1999) and *Transition Project* (2004):** These pre-date the implementation of the BSO program. However, resources that the BSO program leverages, such as, the Alzheimer Network Knowledge Exchange, and psychogeriatric consultants in LTC homes, emerged out of these two strategies. Thus, we suggest that it is important to explore the policy legacies of both strategies on the development and implementation of the BSO program.

***Ontario's Dementia Strategy* (2017):** This includes annual funding for BSO (MOHLTC, 2017). We were unable to ascertain the nature of this funding, thus it is important to explore further whether it is inflationary, etc.

***Residents First* (2009):** The BSO has been described as a "quality improvement initiative" (Gutmanis et al., 2017) that leverages existing quality improvement programs. A component of *Residents First* is

performance-improvement training, an initiative that is offered in conjunction with the BSO's project to facilitate education for health care providers (Health Quality Ontario, n.d.).

Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy (2011): The Behaviours Have Meaning: Results from Phase 1 (2010) report produced by the BSO program highlighted how this mental health strategy created "an environment supportive of change." The report provided an overview on how Ontario has made investments to support programming for seniors living with dementia. However, these supports did not specifically target programming for addressing responsive behaviors, a primary focus of the BSO.

Organizational Setup

There are 14 BSO units that correspond to LHIN geographies, and one BSO Provincial Coordinating Office (BSO PCO). The BSO PCO is funded by three LHINs: (1) Hamilton Niagara Haldimand Brant, (2) North East, and (3) North Simcoe Muskoka. Representatives of these three LHINs are responsible for providing direction on the work of BSO units across the province. The BSO program is provincially led by the Provincial BSO Steering Committee, a Triple LHIN Seniors Advisory, and a LHIN CEO Executive Committee.

Other committees and advisories include the Operations Committee, Lived Experience Advisory, System Performance and Evaluation Advisory, and Knowledge Translation and Communications Advisory. The provincial BSO structure and organizational setup are described in **Appendix D**.

Personnel

Due to the multi-faceted nature of the BSO initiative, the types and distribution of HHR varies across the program. There are three models of care that predominate in the direct delivery of the BSO initiative:

1. In-home BSO teams are where a team of one or two BSO staff, typically a registered nurse or registered practical nurse and a personal support worker, works on-site and is dedicated to the residents of one LTC home;
2. A sub-LHIN mobile team model is where multiple LTC homes within a LHIN sub-area are served by one BSO team that travels to homes to provide service; and
3. A mobile team model is where the team is located in one LTC home but serves all LTC homes across the LHIN (Grouchy et al., 2017).

Program Objectives/Outputs

The BSO Program aims to enhance the health care services of older people who live with responsive behaviours linked to cognitive impairments, and their caregivers. The indicators used to measure this aim are:

- Reduced resident transfers from LTC to acute or specialized unit for behaviours and reduce unnecessary admissions to hospital;
- Delayed need for more intensive services, reducing admissions and risk of alternative level of care; and
- Reduced length-of-stay for persons in hospital who can be discharged to a LTC home with enhanced behavioural resources (Reed, 2013).

Program Recipients

The BSO initiative targets patients who are "older adults with complex and responsive behaviours associated with cognitive impairments due to complex mental health, addictions, dementia, or other neurological conditions and their caregivers" (Behavioural Supports Ontario, 2010 p. 5). BSO initiatives are delivered in LTC homes, independent living settings, and acute care environments (Behavioural Supports Ontario, 2010).

Goals and Vision

The aim of the BSO program is "to reduce the burden of care and improve outcomes for persons living with responsive behaviours" (Gutmanis et al., 2015). Individuals with dementia, mental health, substance use, and/or other neurological disorders may exhibit actions, words, and gestures termed responsive behaviours, in response to their personal, social or physical environments (Behavioural Supports Ontario, 2017).

Information Management and Evaluation

All 14 LHINs send activity tracker data quarterly to the BSO PCO, including:

- Total number of referrals across the sector; and
- Average number of patients/families supported (Behavioural Supports Ontario, 2010).

Our scan revealed different datasets that the BSO draws on for program evaluation including: the BSO Activity Tracker, the Alzheimer Society of Ontario's "Community-Dwelling Individuals with Dementia" dataset, and a BSO legacy measure dataset.

Leadership and Priority Setting

While our scan did not reveal any documents pertaining to MOHLTC-level policy priorities, we found information regarding program-level priorities.

The BSO's PCO is responsible for the implementation and the evaluation of the BSO program. The BSO Framework of Care follows three provincial pillars (see figure in **Appendix D**):

1. System Coordination and Management
2. Integrated Service Delivery—Intersectoral and Interdisciplinary
3. Knowledgeable Care Team and Capacity

First Link

Laws and Regulations

There was no publicly available information suggesting the relevance of the LTCHA (2007), ECFAA (2010), the *Patients First Act* (2016), and their impact on the implementation, delivery, or design of the First Link program.

Policy Initiatives, Guidelines and Strategic Frameworks

There was no publicly available information highlighting how/if the Residents First Strategy (2009), the Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy (2011), and

the Ontario's *Action Plan for Health Care: Better Patient Care Through Better Value from our Health Care Dollars* (2012) may have impacted the development and implementation of the First Link program.

***Ontario Strategy for Alzheimer and Related Dementias* (1999) and *Transition Project* (2004):** These initiatives pre-date the implementation of the First Link program, which intends to connect people to Ontario Alzheimer's Society chapters. The Ontario Alzheimer Society is an organization connected to both the dementia strategy and the transition project. Thus, we suggest that it is important to explore the policy legacies of these two strategies to understand how they influenced the development and implementation of the First Link program.

***Ontario's Dementia Strategy* (2017):** This initiative includes support for educational resources through the Alzheimer's Society called *Finding Your Way*, a resource about safety in the community (MOHLTC, 2017). We did not find any further information about how this strategy may have impacted the development and implementation of the First Link program.

***Aging at Home* (2007):** This program involved Ontario's provincial government funding 29 Alzheimer Society chapters to deliver First Link (McAiney et al., 2010).

***Patients First: Action Plan for Health Care* (2015):** The First Link program was not specifically referred to in this initiative, however, the focus on "improving dementia support" as a means to improve access to care was likely a relevant classification that may have impacted the relevance of the First Link Program.

Organizational Setup

First Link is administered by the Alzheimer Society of Ontario. The environmental scan revealed that 29 local chapters of the Alzheimer Society deliver the program.

Personnel

The First Link program is a referral-type approach to care delivery. Each local chapter of the Alzheimer Society employs "First Link Coordinators." We were unable to find information on the total number of coordinators in the province and other HHR information (e.g., the types of health care professional who qualify as a First Link Coordinator).

Program Objectives/Outputs

The First Link program aims to connect people living with dementia and their caregivers to appropriate services at diagnosis. The program outputs include: linking diagnosing primary care providers with the Alzheimer Society, increasing primary care providers' understanding and awareness of community resources for the management of dementia, increasing the coping and confidence for self-management of people living with dementia and their caregivers, and improving the coordination of care for people living with dementia (McAiney et al., 2010). See **Appendix E** for a First Link program logic model for details of specific program-level activities and outcomes.

Program Recipients

The First Link program targets individuals with dementia and their family members as early as possible in their disease trajectory, with the goal of providing them comprehensive and coordinated services (McAiney et al., 2010). First Link is designed to connect primary care providers with the Alzheimer Society and other

community services in dementia education and outreach efforts; thus, recipients of the programs could also include primary care physicians and other allied health professionals, diagnostic and treatment services, and community service providers (McAiney et al., 2010).

Goals and Vision

The overall goal of First link is to:

> [I]*ncrease understanding and effectively reduce the personal and social consequences of ADRD* [Alzheimer's disease and related dementias] *by enhancing and strengthening the linkages between primary care physicians, other healthcare providers, diagnostic and treatment services, community service providers and the Alzheimer Society, increasing access to progressive education and comprehensive and coordinated support earlier and throughout the disease process for individuals with dementia and their family caregivers, as well as promoting, facilitating and supporting education for healthcare providers*. (McAiney et al., 2012, p. 25)

Information Management and Evaluation

Our scan did not reveal any details on information management, assessment, and evaluation for the First Link program.

Leadership and Priority Setting

Our scan revealed little information about the policy priorities of leaders at the MOHLTC. However, reference was made about the program as a part of the government's mental health and addictions initiatives. A news backgrounder issued by the MOHLTC cited the First Link program as a mental health and addictions support service under the umbrella of the *Aging at Home Strategy* (MOHLTC, 2010).

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Appendix A. Search Strategy

Table A1. Jurisdictional Review Search Strategy

Websites and Reports	Other grey literature	Scholarly literature
"Health Links" in a Custom Google search: health.on.gov.ca:"Health Links" "Health Links" in a Custom Google search: Hqontario.ca:"Health Links" Health link* and Ontari* in a Custom Search Engine for Canadian Public Health Information: http://www.ophla.ca/customsearchcanada.htm "Health Links" in Ontario Budget Annual Reports (2010-2017)‡	Health Link* and Ontari* in the Canadian Business and Current Affairs Database	Health Link* and Ontari* in Proquest Health Link* and Ontari* in Google Scholar Health Link* and Ontari* in OVID Medline
Scholarly review of: http://www.behaviouralsupportsontario.ca/ Scholarly review of: http://brainxchange.ca/ "Behavioural Supports Ontario" in a Custom Google search: health.on.gov.ca:"Behavioural Supports Ontario "Behavioural Supports Ontario" in a Custom Google search: Hqontario.ca:"Behavioural Supports Ontario" Behavioural support* and Ontari* in a Custom Search Engine for Canadian Public Health Information: http://www.ophla.ca/customsearchcanada.htm "Behavioural Supports Ontario" in Ontario Budget Annual Reports (2010-2017)‡	Behavioural Support* and Ontari* in the Canadian Business and Current Affairs Database	Behavioural Support* and Ontari* in Proquest Behavioural Support* and Ontari* in Google Scholar Behavioural Support* and Ontari* in OVID Medline
Scholarly review of: http://www.alzheimer.ca/en/on/We-can-help/First-Link "First Link" in a Custom Google search: health.on.gov.ca:"First Link" "First Link" in a Custom Google search: Hqontario.ca:"First Link" First Link* and Ontari* in a Custom Search Engine for Canadian Public Health Information: http://www.ophla.ca/customsearchcanada.htm "First Link" in Ontario Budget Annual Reports (2010-2017) ‡	First Link* and Ontari* in the Canadian Business and Current Affairs Database	First Link* and Ontari* in Proquest First Link* and Ontari* in Google Scholar First Link* and Ontari* in OVID Medline

‡ Reports available online at:
http://www.fin.gov.on.ca/en/budget/ontariobudgets/2017/budget2017.pdf;
http://www.fin.gov.on.ca/en/budget/ontariobudgets/2016/papers_all.pdf;

http://www.fin.gov.on.ca/en/budget/ontariobudgets/2015/papers_all.pdf
http://www.fin.gov.on.ca/en/budget/ontariobudgets/2014/papers_all.pdf
http://www.fin.gov.on.ca/en/budget/ontariobudgets/2013/papers_all.pdf
http://www.fin.gov.on.ca/en/budget/ontariobudgets/2012/papers_all.pdf
http://www.fin.gov.on.ca/en/budget/ontariobudgets/2011/papers_all.pdf
http://www.fin.gov.on.ca/en/budget/ontariobudgets/2010/papers_all.pdf

Appendix B. Program Comparison

Table B1. Program Comparison by Program Element

Program Element	Health Links	BSO	First Link
Laws and Regulations: *Criteria for determining how services are to be delivered and the conditions for being a recipient of services*	*ECFAA* (2010) *Patients First Act* (2016)	*LTCHA (*2007) *ECFAA* (2010)	No information available
Policy Initiatives, Guidelines and Strategic Frameworks: *Key political strategies and policies in place to support the development and implementation of programs*	Ontario's Action Plan for Health Care: Better Patient Care Through Better Value from our Health Care Dollars (2012) Patients First: Action Plan for Health Care (2015)	Ontario Strategy for Alzheimer and Related Dementias (1999) and Transition Project (2004) Residents First (2009) Ontario's Mental Health and Addictions Strategy (2011) Ontario's Action Plan for Health Care: Better Patient Care Through Better Value from our Health Care Dollars (2012) Patients First: Action Plan for Health Care (2015) Ontario's Dementia Strategy (2017)	Aging at Home Strategy (2007) Ontario's Action Plan for Health Care: Better Patient Care Through Better Value from our Health Care Dollars (2012) Patients First: Action Plan for Health Care (2015) Ontario's Dementia Strategy (2017)
Organizational Setup: *Specific organizations involved in the delivery of services and their linkage(s) with each other in delivering (or not delivering) on the objectives of the policy*	82 Health Links administered by 14 LHINs MOHLTC–LHIN–HQO partnership Helath Link lead organizations in every LHIN sub-regions: Hospitals, Community Health Centres, Community Support Agencies, Family Health Teams Voluntary self-organizing groups, lead agency model Early Adopters (4 LHINs)	LHIN partnerships with the Alzheimer Society of Ontario, Alzheimer Knowledge Exchange and Health Quality Ontario BSO Provincial Coordinating Office (BSO PCO)—one central coordination office Voluntary self-organizing groups, lead agency model	29 local chapters of Alzheimer Societies Anyone can make a referral to the Program: patients/family caregivers, formal service providers etc.

		Early Adopters (23 organizations)	
Personnel: *The type and distribution of human resources involved in delivering the services*	Health Link region administrative personnel Utilizes existing HHR across health sectors to implement coordinated care management	BSO Coordinating office administrative staff: 1. In-home BSO teams are where a team of one or two BSO staff (typically a registered nurse or registered practical nurse and a personal support worker) work on-site and is dedicated to the residents of one LTC home. 2. A sub-LHIN mobile team model is where multiple LTC homes within a LHIN sub-area are served by one BSO team that travels to homes to provide service. 3. A mobile team model is where the team is located in one LTC home but serves all LTC homes across the LHIN.	First Link coordinators employed by Alzheimer Societies Primary care providers and other community service providers make referrals to the program
Money: *The amount of funding devoted to the functioning of services*	No information available	No information available	No information available
Program Objectives/Outputs: *The specific activities and outcomes that demonstrate performance of the program*	• Number of patients with a coordinated care plan developed through the Health Link • Number of patients with regular and timely access to a primary care provider • Reduction of 30-day readmissions to hospital • Reduction of in home care visits referral time • Reduction in the number of emergency department visits for conditions best managed elsewhere	• Reduced resident transfers from LTC to acute or specialized unit for behaviours and reduce unnecessary admissions to hospital • Delayed need for more intensive services, reducing admissions and risk of alternative level of care • Reduced length of stay for persons in hospital who can be discharged to an LTC home with enhanced behavioural resources	• Enhance linkages between the Alzheimer Society and diagnosing primary care physicians and other health care providers (e.g., allied health professionals), diagnostic and treatment services, and community service providers • Increase understanding and awareness among family physicians and allied health professionals of assessment and management of ADRD, the role of the Alzheimer Society and the First Link program, and other

	• Enhance the health system experience for patients with the greatest health care needs • Achieve an ALC rate of nine per cent or less • Reduce the average cost of delivering health services to patients without compromising the quality of care		community resources for individuals with dementia and/or their family caregivers • Increase understanding and awareness among individuals with dementia and their family members/caregivers of ADRD and community resources, and to increase coping and confidence of caregivers and self-efficacy for self-management • Improve coordination of care and linkages to community services for non-medical management issues from time of diagnosis through the duration of the disease
Program Recipients: *The eligibility criteria that specify the types of individuals to be recipients of the services*	Targets high-cost user patients, defined as: • Patients with four or more chronic/high-cost conditions, including a focus on mental health and addictions conditions, palliative patients, and the frail elderly (see Appendix C) • Economic characteristics (low income, median household income, government transfers as a proportion of income, unemployment) • Social determinants (housing, living alone, language, immigration, community and social services, etc.)	Targets older adults with complex and responsive behaviours associated with cognitive impairments due to complex mental health, addictions, dementia, or other neurological conditions and their caregivers. BSO initiatives are delivered in LTC homes, independent living settings, and acute care environments	Targets individuals with dementia and their family members as early as possible in their disease trajectory, with the goal of providing comprehensive and coordinated services
Goals and Vision: *The ultimate outcome(s) the program is intended to achieve*	Improving integrated care for patients with multiple conditions and complex needs Reduction in costs for high users of the health system	Reduce the burden of care and improve outcomes for persons living with responsive behaviours	Increase understanding and effectively reduce the personal and social consequences of dementia and related diseases

Information Management and Evaluation: *The ways in which health information systems are incorporated into service delivery and assessment or evaluation*	The Quality Improvement Reporting and Analysis Platform (QI RAP) provides a single, integrated platform for data reporting, and analysis of quality improvement measures	All 14 LHINS send quarterly activity tracker data to the BSO Provincial Coordinating Office: • Total # of referrals across sectors • Average # of patients/families supported Other datasets: • Alzheimer of Society of Ontario's "Community-Dwelling Individuals with Dementia" • BSO Legacy Measures	No information available
Leadership and Priority Setting: *Priorities of the program leaders at the policy level*	Initial implementation: "low rules" policy direction: to encourage change in the desired direction, experimentation and learning Challenges in implementing clinician engagement and leadership Business plans created through local, community engagement Health Links Advanced Model: • Standardization • Performance Management and Oversight • Funding Model Redesign • Wider System Integration MOHLTC role: Reduce barriers to implementation and timely response	Three Provincial Pillars: 1. System Coordination and Management 2. Integrated Service Delivery– Intersectoral and Interdisciplinary 3. Knowledgeable Care Team and Capacity Action plan created through local community engagement MOHLTC role: Reduce barriers to implementation and timely response	No information available

Appendix C: Health Links

Responsibilities of a Health Links Lead Organization

1. **Establishing Health Link's governance** which includes engaging core and supporting partners and crafting Letters of Cooperation as necessary to formalize arrangements

2. **Establishing a Health Link and developing the Health Link's virtual infrastructure**
   - Provide project management and administration responsibilities;
   - Define and identify the roles/responsibilities of the Health Link's partners;
   - Enable implementation of care planning processes, by working across the Health Link's partner organizations to define clinical flow of complex patients across organizations, and determine how the Health Link's infrastructure and networks will be organized to provide wrap-around, patient-centred care;
   - Develop a Health Link's business plan, in collaboration with their LHIN and Health Link's partners, the Health Link's lead organization will identify the resource requirements needed to achieve the Health Link's targets.
   - Ensure patient engagement; and,
   - Facilitate provider engagement.

3. **Health Link operations**
   - Work with the LHIN to identify the target population in accordance with guidelines;
   - Track the patient cohort;
   - Oversee care plan management/implementation;
   - Ensure the appropriate connection to health services and coordinated care planning;
   - Engage the network of providers within the Health Link to ensure providers have the necessary supports and resources they need to reach and service the target population, and ensuring there is a common understanding of the Health Link's objectives and priorities;
   - Adopt best practices to enhance implementation; and,
   - Ensure ongoing patient and provider engagement.

4. **Health Link performance**
   - Broker and setting targets with the LHIN and Health Link's partners where required or appropriate;
   - Ensure that the operational plan is achieved; and,
   - Report on performance to LHINs.

Over 2015/16, the ministry will work with LHIN leadership to embed the roles and responsibilities of the ministry, LHINs and Health Link's lead organization across all 2016/17 accountability instruments between: the ministry-LHIN, LHIN and Health Link lead organization, and Letter(s) of Cooperation between the Health Link lead organization and Health Link partner organization(s).

From Guide to the Advanced Health Links Model (MOHLTC, 2016a, p. 13-14)

Table C1. List of selected conditions that are chronic and/or high cost

1. Sepsis	28. Ischaemic Heart Disease
2. Brain injury	29. Cardiac Arrhythmia
3. HIV/AIDS	30. (Congestive) Heart Failure
4. Malignant Neoplasms (cancer)	31. Stroke
5. Blood disorders (anemia, coagulation deficits	32. Periheral Vascular Disease & Atherosclerosis
6. Coma	33. Influenza
7. Diabetes	34. Pneumonia
8. Cystic Fibrosis	35. Chronis Obstructive Pulmonary Disease
9. Mental health conditions	36. Athsma
10. Dementia	37. Ulcer
11. Substance-related disorders	38. Hernia
12. Schizophrenia & delusional disorders	39. Crohn's disease/colitis
13. Depression	40. Liver disease (cirrhosis, hepatitis, etc.)
14. Dipolar	41. Arthritis and related disorders
15. Anxiety disorders	42. Osteoperosis including pathological bone fracture
16. Eating disorders	43. Renal failure
17. Personality disorders	44. Low Birth Weight
18. Developmental disorders	45. Other Perinatal conditions
19. Huntingon's disease	46. Congenital Malformations
20. ALS (Lou Cehrig's disease)	47. Fracture
21. Parkinson's disease	48. Amputation
22. Multiple Sclerosis	49. Palliative care
23. Epilepsy & seizure disorders	50. Pain managemnet
24. Muscular Dystrophy	51. Hip replacement
25. Cerebral Palsy	52. Knee replacement
26. Paralysis and spinal cord injury	53. Transplant
27. Hypertension	

Notes: The conditions included are those that, (1) affect a large number of patients, (2) are risk factors for other chronic conditions, or (3) contribute to significant length of stay and/or cost in one or more health care sector.

Table adapted from MOHLTC (2017a, p. 29)

Appendix D: Behavioural Supports Ontario (BSO)

Figure D1. Ontario Behavioural Support System Model

Outcome	High performing person-centred health system through active interdisciplinary collaboration with equitable access to comprehensive and safe services and supports for persons with responsive behaviours anywhere in Ontario.		
Pillars	System Coordination	Specialized Service Delivery	Knowledgeable Care Team & Capacity Building
Core Elements of Service Delivery Model	1. System Management/ Accountability • Governance structure • Organizational Coordination • Regional System Coordinator role 2. Centralized Collaborative Intake & Referral	3. Mobile interdisciplinary Seniors Behavioural Supports Outreach Teams (SBSOTs) 4. Case Management and Transitional Supports 5. Enhanced Day Treatment and Respite Care 6. Specialized Residential Treatment (Behaviour Support Units)—short stay 7.Specialized Residential Treatment—long stay	8. Learning and Development • At point of care • At organization level • At system level for continuous quality improvement and built capacity through a skilled workforce
Policy Environment/ Implementation	LHIN-based Integrated Accountability Agreement Funding through Lead Agency	Person-centred care Integrated vertically & horizontally Mental Health Strategy Long-Term Care Home Act Excellent Care for All	Incent culture change through public reporting QI-OHQC,CHQI, QIIP Evidence-Informed Health Human Resources
Principles	System Coordination & Integration Accountability & Sustainability	Behaviour is Communication Person-Centred Care Diversity	Collaborative Care Safety
Vision	An Ontairo Behavioural Support System that demonstrates an integrated cross-sectoral comprehensive system of supports and services designed to meet the needs of people with responsive behaviours associated with complex mental healthissues, dementia or other neurological conditions.		

Figure adapted from Dudgeon & Reed (2013, p. 26)

Figure D2. BSO Provincial Structure (as of April 2016)

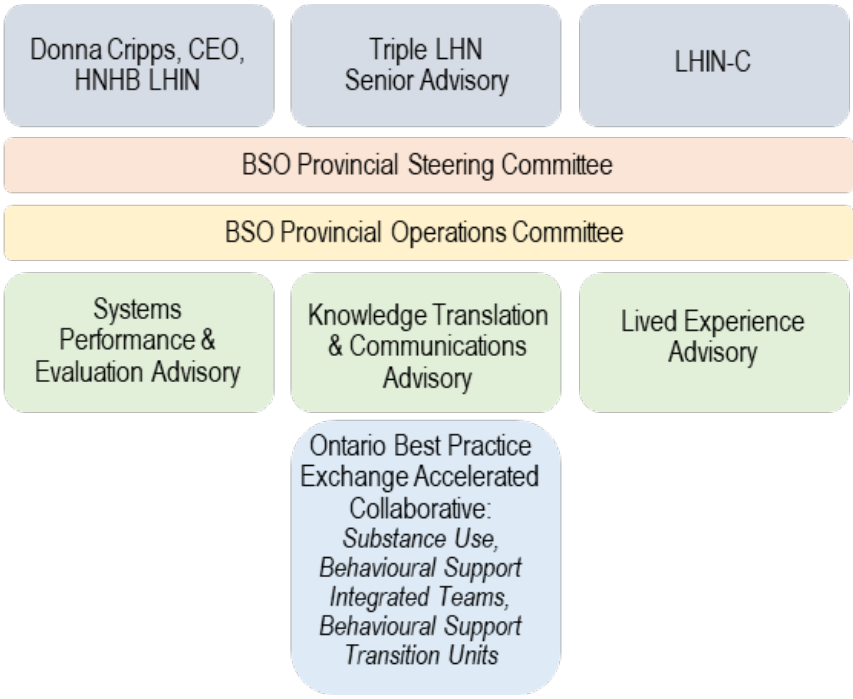

Figure adapted from Behavioural Supports Ontario (2017, p. 6)

Figure D3. BSO Framework of Care

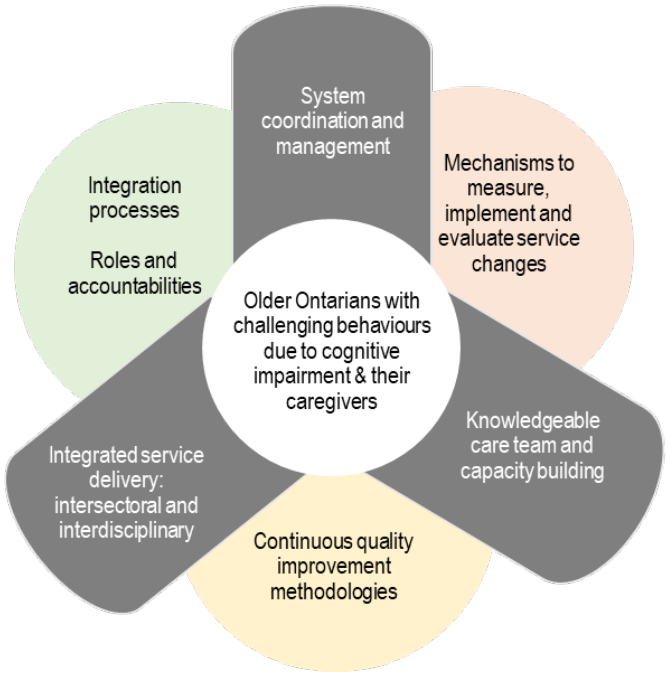

Figure adapted from BSO Provincial Coordinating Office (2016, p. 3)

Appendix E: First Link

Figure E1. Program Logic Model

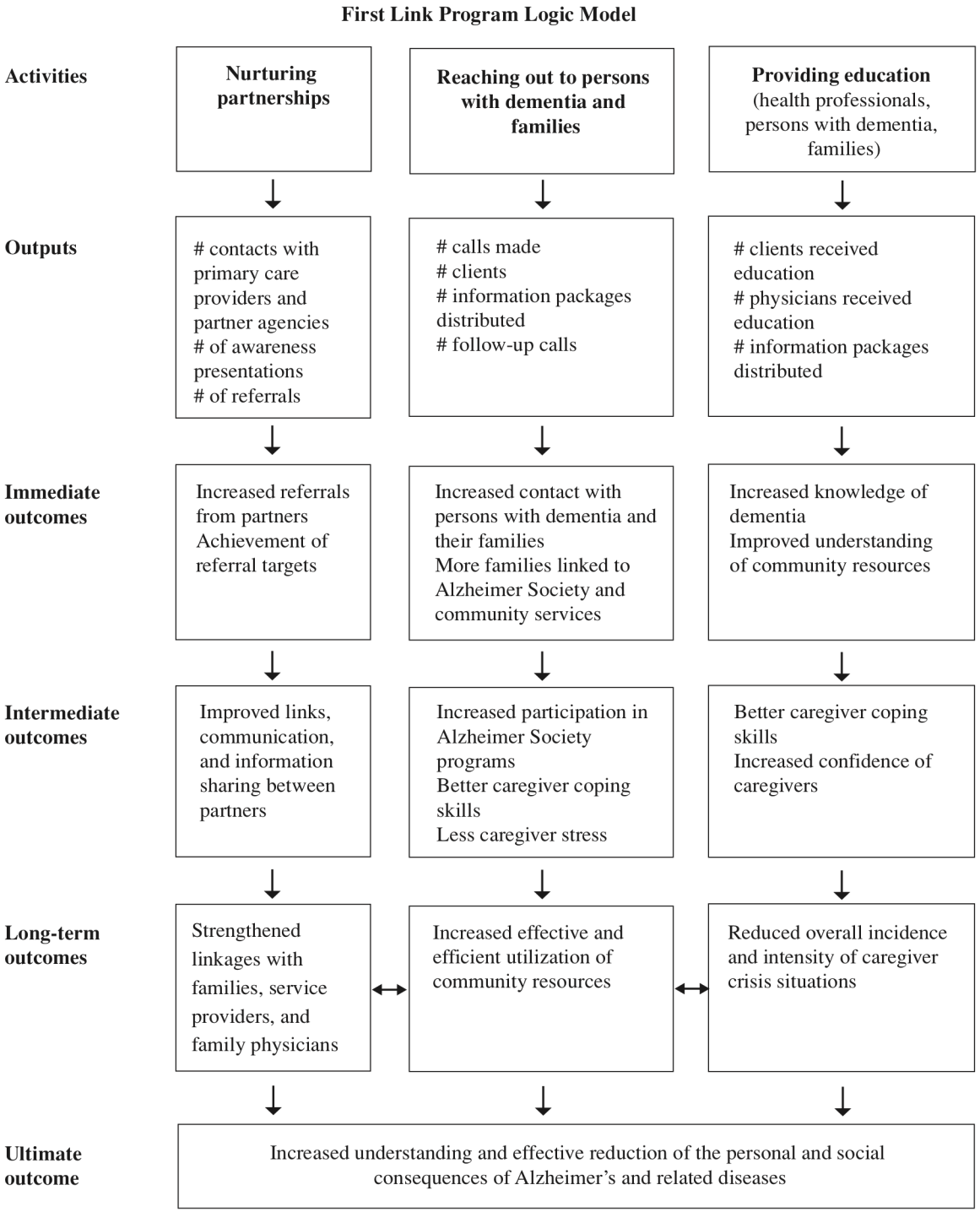

Figure obtained from Mcainey et al. (2008, p. 121)

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