Behavioural Supports Ontario

The Role of the Erie St. Clair CCAC BSO Care Coordinator in the Hospital Setting (Windsor Site)

BSO Care Coordinator Role

- Targets patients who are deemed Alternative Level Care (ALC) in hospital or trending towards ALC from Long-Term Care and present with behavioral barriers
  - (i.e. responsive behaviors related to mental health, addictions, dementia or other neurological conditions)
- Develops quality, timely and cost effective individual plans for service providers with a person-centered focus
- Provides enhanced, integrated and cross-sector services

BSO Care Coordinator (CC) Role Overview

- Completes an extensive behavioral assessment
- Collaborates with hospital inter-professionals
- Ensures that caregivers are linked seamlessly to specialized services
- Provides assessment information, guidance and recommendations to the LTC receiving home
- Alerts the BSO System Navigator based at the Alzheimer Society for “guardian angel” role which provides support to caregivers throughout the continuum of the journey to ensure both their needs and the patient’s needs are being met

System Flow and Integration

- Built upon existing processes within the Erie St. Clair CCAC
- CCAC Hospital Care Coordinators will contact/refer patients who have an ALC designation, identified barriers and exhibit responsive behaviours
- Destination can be community or long-term care
- Continued follow-up until stabilized in new permanent destination

System Flow and Integration…continued

BSO Care Coordinator Role

- Contacts the patient's family to book assessment
- Reviews the patient's chart/collaborate with hospital unit staff to determine resources patient has received while in hospital, for example, hospitalist, psychiatrist, and/or specialized services (i.e. Geriatric Mental Health Outreach Team) & the outcomes of interventions
- Completes the extensive *Behavioural Assessment Tool* identifying responsive behaviours that require interventions

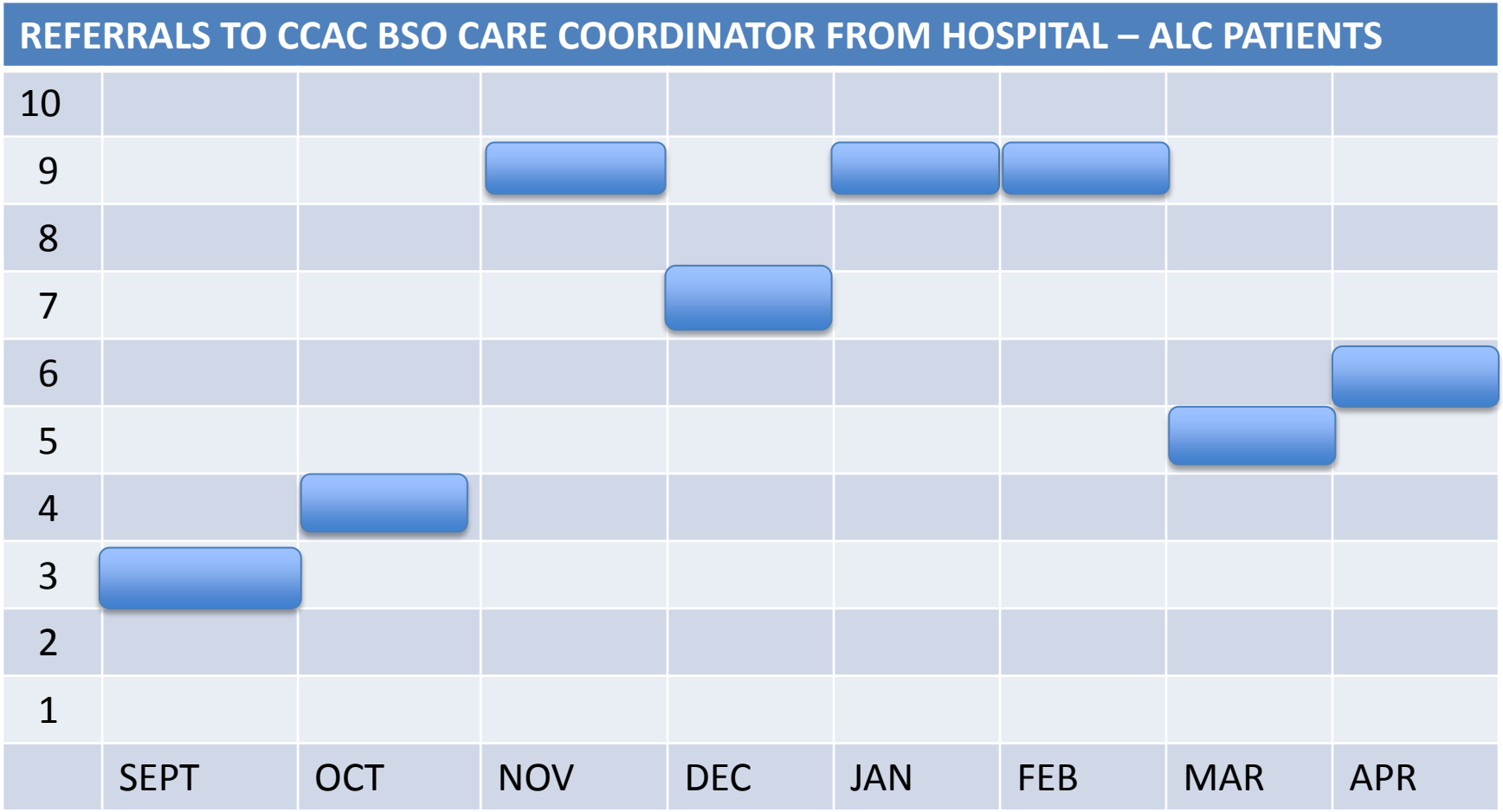
System Flow and Integration…continued

- Initiates the referral to BSO System Navigator who will support the caregivers and throughout the transition to LTC or community and can trigger the BSO LTC Lead Teams or GMHOT to assist with the transition at the new location
- Completes the RAI Assessment with the patient/family to determine care needs and allocates appropriate resources to the family/caregivers
- Provides education and support to the family and staff to effectively manage responsive behaviours while the patient transitions to their appropriate care setting (e.g., home, Retirement Home, LTCH)
- Discharges patient from caseload to Community CC or LTC when behaviours have been stabilized, as appropriate

BSO CC IMPACT

CCAC ALC BSO CARE COORDINATOR		AS OF APRIL 30, 2013 Q3	
	INDICATOR – Q3	**SEPT 2012 to APRIL 2013**	**COMMENTS**
1	TOTAL NUMBER OF PATIENTS REFERRED FROM HOSPITAL TEAM	53	DISCHARGES TO: LTC – 15; DECEASED - 6; PALLATIVE – 1; REST/RETIREMENT HOME – 3; HOME – 1; CCC - 1
2	TOTAL NUMBER OF PATIENTS ON CASELOAD	26	
3	TOTAL NUMBER OF PRESENTATIONS, ORIENTATIONS & OUTREACH	24	
4	TOTAL NUMBER OF PATIENT CONSULTATIONS WITH SN, GMHOT, LTC LEAD HOME, CCAC BSO TEAM	67	

IMPACT – SEPT 2012 – APRIL 2013



SUMMARY

Of the 53 Alternative Level of Care (ALC) BSO referrals, 19 or 35.8% of those were discharged to a LTC and/or community since the inception of the BSO program

NEXT STEPS
ESC-CCAC BSO PROGRAM EXPANSION

- Funding expansion for BSO Care Coordinators in Sarnia-Lambton and Chatham-Kent hospitals
- Target patients who are deemed ALC in hospital or trending towards ALC from Long-Term Care and present with responsive behavior barriers

The Future of BSO in the Community

December 2012 survey of ESC – CCAC community patients identified with responsive behaviours

(85 % respondents)

Sarnia-Lambton = 35

Chatham-Kent = 63

Windsor-Essex = 130

Success Story

- “Carla” was admitted to hospital with a urinary tract infection, experiencing a psychosis related to a decompensating condition
- The CCAC BSO Specialized Care Coordinator, in collaboration with hospital staff/physicians, recommended an alternative approach
- Within three months of referral to CCAC/BSO, Carla was discharged from hospital to a retirement home
- *“ If the BSO Care Coordinator had not recommended a change to my mother’s diet or the consultation of psychiatrist, my mother would not be where she is today”* – Carla’s daughter

Thank you!

QUESTIONS??