BEHAVIOURAL SUPPORTS ONTARIO

ANNUAL REPORT 2017-18

A YEAR OF ACCOMPLISHMENTS

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Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

MESSAGE FROM THE BSO PROVINCIAL COORDINATING OFFICE

Welcome

The compilation of the BSO Annual Report provides us with the exceptional opportunity to truly reflect on BSO's accomplishments year after year. In looking back on 2017-18, we were overjoyed with the numerous achievements, both regional and provincial, and there is no doubt that we have a lot to celebrate!

From the successful proposal for the creation of 'Best Practice Guidelines for Substance Use among Older Adults', to the launch of the Person-Centred Language and the Behavioural Education and Training Support Inventory initiatives, not to mention nearing the completion of a new standardized Dementia Observation System (DOS), it has surely been a productive year.

The BSO Lived Experience Advisory released their 'Making Connections Guidelines' and BSO Evaluation projects made strides as well with the onboarding of 14 organizations onto to the BSO Applied Health Research Question Project. Meanwhile, referrals for BSO support across the province grew 23.9% and the number of education/training sessions delivered soared by 56%.

At the very center of these accomplishments, we remain firmly grounded in the delivery of person and family-centred care for older adults with complex behavioural health needs. We hope that each of you will join us in commemorating these wonderful achievements as you peruse our 2017-18 Annual Report!

BSO Provincial Coordinating Office

Below you will find a picture of the PCO Team supporting BSO's grounding pillars!

Team members, from left to right:

Debbie Hewitt Colborne
Project Advisor

Katelynn Viau
Project Coordinator

Tina Kalviainen
Strategic Communications Specialist

Monica Bretzlaff
Manager

Acknowledgements

The BSO Provincial Coordinating Office (PCO) wishes to express sincere appreciation to the following individuals and groups for their continuous leadership and commitment to BSO:

- All individuals and their significant others, representing the lived experience, who continuously inspire us.
- Donna Cripps, BSO PCO LHIN Lead Champion &
  Dr. Ken LeClair, BSO PCO Lead Physician Advisor
- BSO LHIN Leads & BSO Clinical/Strategy Leads
- BSO Committee/Advisory Co-Chairs, Ontario Best Practice Exchange Collaborative Co-Leads & Leaders of BSO Working Groups
- BSO PCO's host organization, the North Bay Regional Health Centre
- brainXchange
- All members of our Committees, Advisories, Collaboratives & Working Groups
- All of BSO's valued partner organizations across the province

BSO STEERING COMMITTEE

PURPOSE

To advise and guide the accountability structure for BSO which prioritizes the centrality of person and family-centred care and fosters the lean implementation of system-wide best practices.

MEETING FREQUENCY

Quarterly

BSO PCO LEAD COLLABORATOR

Monica Bretzlaff

MEMBERSHIP

29

CHAIR

Donna Cripps
CEO
HNHB LHIN

"The BSO Steering Committee continues to play a pivotal role in driving the priorities of the BSO initiative and the BSO PCO. This past fiscal, in addition to providing supportive advice on BSO-related projects, the committee focused a considerable amount of energy towards continuing to inform future recommendations for the Ontario Dementia Strategy. It continues to be a great pleasure to bring together BSO's key partners and stakeholders to share our hopes and visions for enhancing behavioural health care from a person and family-centred approach and I look forward to continuing to do so in 2018-19"

– Donna Cripps

BSO IMPACT PROJECTS (PP. 11- 17)

BSO INNOVATION PROJECTS (PP. 18-42)

BSO INTEGRATION PROJECTS (PP. 43-51)

ONTARIO DEMENTIA STRATEGY ENGAGEMENT (P. 47)

2017-18 BSO FUNDING HIGHLIGHTS (P. 46)

BSO OPERATIONS COMMITTEE

PURPOSE

To champion BSO at a system and operational level, including supporting activities that foster integrated service delivery and prioritize person and family-centred care. Informed by available evidence and experience-based learning, The BSO Operations Committee is the conduit to connect activities across the province and promote ongoing alignment with other provincial initiatives.

MEETING FREQUENCY

Bi-monthly

BSO PCO LEAD COLLABORATOR

Katelynn Viau, Debbie Hewitt Colborne & Tina Kalviainen

MEMBERSHIP

52

CO-CHAIR

Monica Bretzlaff
Manager
BSO Provincial
Coordinating Office

CO-CHAIR

Kathy Peters
Former Strategic Lead
HNHB BSO

"It has been quite the fruitful year for the BSO Operations Committee! From informing priorities for the Ontario Dementia Strategy, to brainstorming new BSO investment implementation plans, all alongside ensuring the continued progress of our key projects, there is no doubt that our meeting agendas were always plentiful. Kathy and I both wish to express sincere thank you to all of the BSO LHIN Leads, BSO Clinical/Strategy Leads and BSO PCO/brainXchange Team for your continued idea generation, generous feedback and sharing of your regional celebrations with the BSO Operations Committee." – Monica Bretzlaff

BSO IMPACT PROJECTS (PP. 11- 17)

BSO INNOVATION PROJECTS (PP. 18-42)

BSO INTEGRATION PROJECTS (PP. 43-51)

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BSO LIVED EXPERIENCE ADVISORY

PURPOSE

To advise and guide BSO projects through the lens of lived experience and provide a virtual platform for people to connect through shared experiences.

MEETING FREQUENCY

Monthly
(alternating videoconferencing and live typed chats)

MEMBERSHIP

130

BSO PCO LEAD COLLABORATOR

Katelynn Viau

CO-CHAIR

Dr. Rhonda Feldman
Mental Health Clinician
The Cyril & Dorothy, Joel & Jill Reitman Centre for Alzheimer's Support and Training

CO-CHAIR

Sharon Osvald
Lived Experience Facilitator
BSO Provincial Coordinating Office
brainXchange

"I feel very proud of the work the BSO Provincial Lived Experience Advisory has accomplished this year. Drawing on their knowledge and experience, they have collectively completed the 'Making Connections Guidelines', giving health care providers the right tools, in the right place to speak for people who may not be able to speak for themselves. The Advisory has also grown this year to be recognized as a reliable advisory voice, providing their input on provincial projects such as The Senior Friendly 7 and re-design of the Dementia Observation System. I look forward to being a part of their great work in the year ahead."
– Sharon Osvald

MAKING CONNECTIONS RECOMMENDATIONS (P. 27)

DEMENTIA OBSERVATION SYSTEM PROJECT (P. 24)

ONTARIO DEMENTIA STRATEGY ENGAGEMENTS (P. 47)

Lived Experience Live Chats:

The BSO Lived Experience Advisory continued to host live typed chats in 2017-18 on the third Wednesday of every second month from 7:00pm – 8:30pm. Listed below are the live chat dates, topics, hosts and partners. All live chats are hosted by Sharon Osvald (see above) & Katelynn Viau (Project Coordinator, BSO PCO).

DATE	TOPIC	HOSTED IN COLLABORATION WITH
April 2017	Enabling active participation in primary care.	Dr. Ken LeClair (Geriatric Psychiatrist & BSO Clinical Advisor) & Pam Hamilton (P.I.E.C.E.S.™ Canada Consult Group)
June 2017	Successes and challenges of Ontario's Adult Day Programs: Informing the Ontario Dementia Strategy	Michael Campo, Former Senior Policy Advisor, Partnerships and Consultation Unit, Capacity Planning and Priorities Branch, MOHLTC
October 2017	Providing better acute care for individuals with cognitive impairment.	Dr. Sarah Mitchell, Assistant Professor, Division of Neurology, Department of Medicine at Sunnybrook Health Science Centre
December 2017	Emotional fatigue during the holiday season.	BSO Lived Experience Advisory Members
February 2018	The Regional Geriatric Program of Toronto's Senior-Friendly 7 Framework.	Dr. David Ryan, Director of Education & Knowledge Processes, Regional Geriatric Program of Toronto, Assistant Professor, Faculty of Medicine at the University of Toronto and Consulting Psychologist at Sunnybrook Health Sciences Center.

BSO SYSTEMS PERFORMANCE & EVALUATION ADVISORY

PURPOSE

To inform the ongoing measurement and evaluation of BSO activities and outcomes.

MEETING FREQUENCY

Quarterly

MEMBERSHIP

19

BSO PCO LEAD COLLABORATOR

Katelynn Viau

CO-CHAIR

Jonathan Lam
Manager
Health System Performance
Health Quality Ontario

CO-CHAIR

Melissa Reid
Term Commencing: April 2018
Project Manager
Central East
Behavioural Supports Ontario

CO-CHAIR

Shirley Sabovitch
Term Ending: February 2018
Quality Improvement Facilitator
Central East
Behavioural Supports Ontario

"The BSO Systems Performance & Evaluation Advisory has made tremendous progress this past fiscal in measuring BSO impact through both ongoing and new initiatives. Each quarter, the Advisory has provided valuable insight in 'telling the story behind the numbers' from a variety of perspectives. In addition, two new initiatives, the BSO AHRQ & Qualitative Stories Analysis Projects, are underway. The results of these evaluations will further our understanding what effect BSO teams are having on those that they support. I am looking forward to seeing these evaluation projects come to fruition in 2018-19. Finally, thank you to all the members and the BSO Provincial Coordination Office for their dedication and contributions to the Advisory!" – Jonathan Lam

BSO ACTIVITY TRACKING (P. 11)

BSO APPLIED HEALTH RESEARCH QUESTION PROJECT (P. 15)

BSO QUALITATIVE STORIES ANALYSIS PROJECT (P. 17)

BSO KNOWLEDGE TRANSLATION & COMMUNICATIONS ADVISORY

PURPOSE	To bring leaders and experts in the fields of research, education, capacity building, knowledge translation and communications together to further advance and sustain the BSO Pillar 3: Knowledgeable Care Team and Capacity Building.
MEETING FREQUENCY	Quarterly
MEMBERSHIP	38
BSO PCO LEAD COLLABORATOR	Debbie Hewitt Colborne

CO-CHAIR

Julia Baxter
Community Outpatient and Outreach Program Manager
Seniors Mental Health
St. Joseph's Healthcare Hamilton

CO-CHAIR

Dr. Birgit Pianosi
Associate Professor
Gerontology Department
Huntington University

"Working with leaders in dementia care through the Knowledge Translation & Communications Advisory has provided me as a Gerontology professor with new learning opportunities. My teaching and research have become more aligned with practice, thus benefiting my own work and my students' as well."
– Dr. Birgit Pianosi

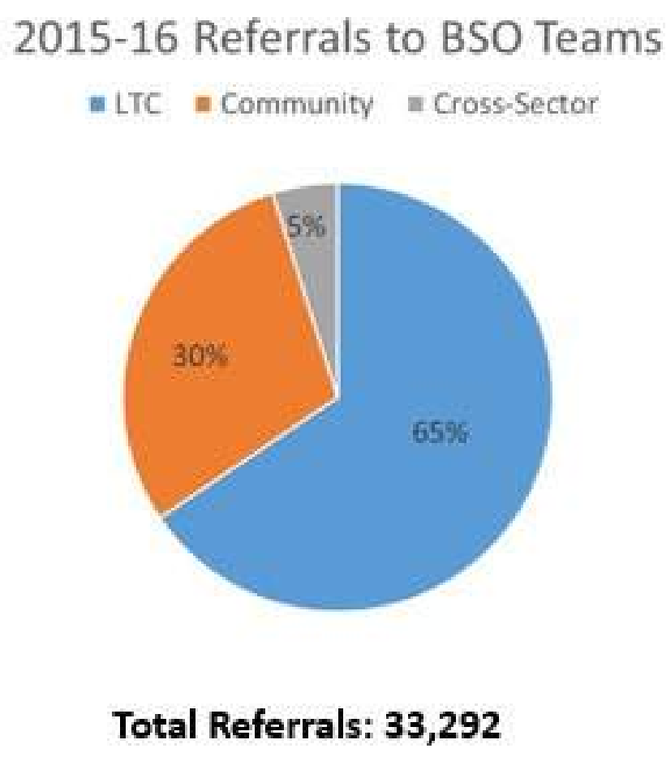
PROJECTS & INITIATIVES: IMPACT

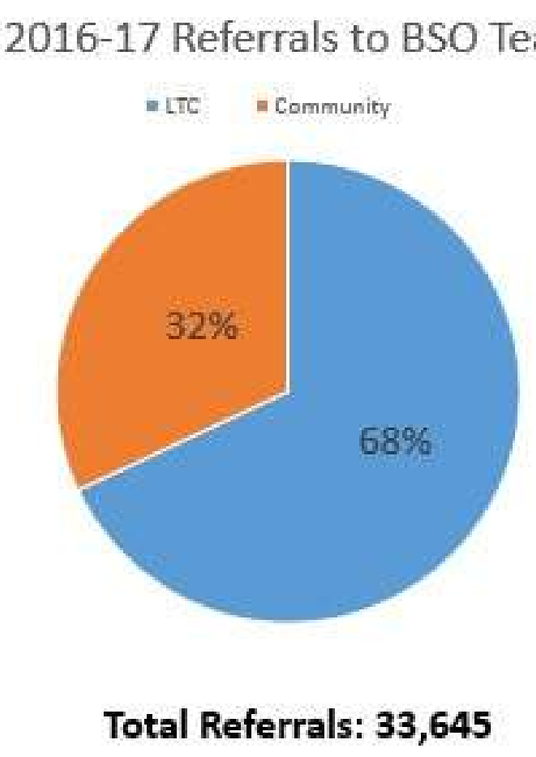
BSO ACTIVITY TRACKING: 2017-18 QUANTITATIVE DATA OVERVIEW

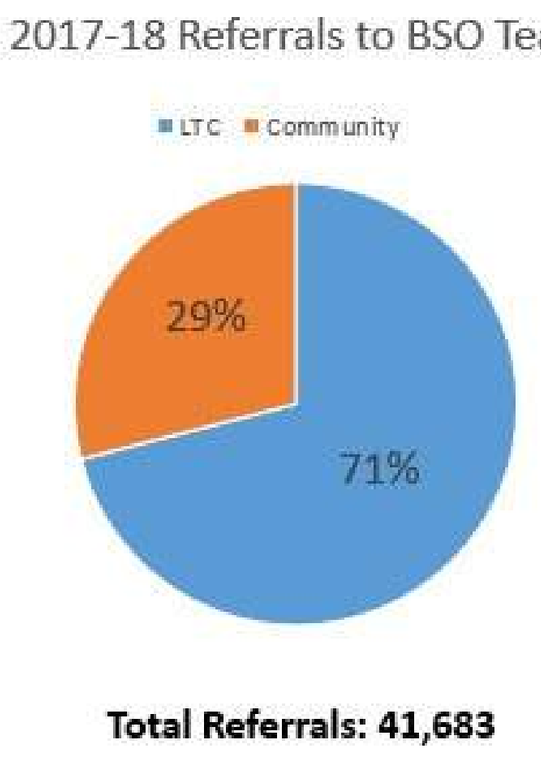
BSO Activity Tracking captures the support provided by all BSO staff, regardless of how they are funded. Each quarter, all 14 LHINs submit their data to the BSO Provincial Coordinating Office where it is reviewed and collated for submission to the **Ministry of Health and Long-Term Care**'s (MOHLTC) **Licensing & Policy Branch – Long-Term Care Homes Division**. New to 2017-18, the data is also submitted to the MOHLTC's **Capacity Planning & Priorities Branch** in order to assist in the monitoring of the Ontario Dementia Strategy investments into the BSO initiative.

Over the 2017-18 fiscal year, the BSO initiative accepted a total of **41,683** referrals for support across sectors; representing a **23.9% increase** in referrals compared to 2016-17 (n= 33,645). Amongst these referrals, **71%** (n= 29,433) originated **from LTC** and the other **29%** (n= 12,250) came from **outside of LTC**; grouped together under the term '**community**' which includes private dwellings, retirement homes, acute care, etc. The overall growth in referrals to BSO in 2017-18 is attributed to two primary factors: (1) the **growing demand** for BSO services due to an aging population; and (2) recent **BSO investments** (2016-17 & 2017-18) resulting in the growth of BSO teams and greater availability of BSO Staff.

FIGURE 1: TRENDS IN BSO REFERRALS 2015-2018







PROVIDING SUPPORT TO INDIVIDUALS

The provision of support from BSO Teams across sectors primarily includes the following activities:

- ✓ assessment and documentation of an individual's responsive behaviours;
- ✓ development or modification of a tailored behavioural care plan aimed at reducing the incidence and prevalence of responsive behaviours;
- ✓ the implementation of the new behavioural care plan in collaboration with key partners;
- ✓ the ongoing monitoring of the behavioural care plan with necessary modifications being made based on the person's responsiveness to BSO interventions;
- ✓ provision of coaching and training to other staff in order to maintain the new plan; and
- ✓ the implementation of strategies to ensure adherence to the new plan.

Since many individuals remain associated to a BSO caseload over a number of quarters, BSO teams across the province are also requested to submit caseload data on a quarterly basis. **In 2017-18, the average caseload of a LTC BSO teams grew 31%,** with an average quarterly caseload of 20,685 LTC residents across the province. **In the community, the average caseload per quarter decreased 14%** to 8,586 individuals. It is anticipated this may be due to demands exceeding available support and the need to discharge individuals to other community services.

PROVIDING SUPPORT TO FAMILY CARE PARTNERS

In addition to providing direct support to individuals presenting with, or at risk for, responsive behaviours, BSO teams provide support to family care partners across sectors. This provision of support can include a number of activities such as:

✓ the delivery of information about responsive behaviours, dementia, complex mental health, substance use and/or other neurological conditions;
✓ specific coaching on approaches, strategies and techniques for preventing or responding to responsive behaviours;
✓ provision of information about other available supports, services and resources, etc.

The collection of data pertaining to family care partner support began in **2016-17** with a total of **39,100** individuals being supported (data from 11 LHINs). In **2017-18**, the total number of family care partners supported grew to **54,771**, representing a **21.5%** increase in **LTC** once the data is adjusted to account for the growth in number of LHINs submitting the metric (n= 38,061; data from 14 LHINs). In the **community**, the number of family care partners supported grew **27%** once data adjusted to account for the decrease in the number of LHINs submitting this metric (n= 16,710; data from 10 LHINs).

TRANSITIONS

Transitions continue to be a priority for BSO teams as the physical movement from one environment to another can often result in the presentation of responsive behaviours amongst the BSO target population. BSO teams support transitions in many ways, including:

✓ sharing of relevant plans, assessments and other documentation to the receiving team;
✓ organization of/participation in behavioural care conferences;
✓ development and execution of a behavioural care plan; and
✓ coaching/training the receiving team regarding strategies to best support the person; etc.

TABLE 1: BSO TEAM SUPPORTED TRANSITIONS (3 TYPES) (2015-18)

Measure	2015-16			2016-17			2017-18			Previous Years' Comparison	
	TOTAL	# LHINs	AVG	TOTAL	# LHINs	AVG	TOTAL	# LHINs	AVG	2015-16 - 2016-17	2016-17 - 2017-18
Total # of transitions from Acute to LTC	865	7	123.6	1359	11	123.5	1824	13	140.3	-0.08%	+13.6%
Total # of transitions from Community \to LTC	1841	7	263	2480	12	206.6	3351	13	257.8	-21.4%	+24.7%
Total # of transitions from Community, LTC OR Acute Care to Tertiary Care Mental Health Beds	378	8	47.3	622	12	51.8	590	13	45.4	+9.5%	-12.3%

Table 1 demonstrates overall trends in the provision of transitional support for three different types of transitions. It is important to note that BSO teams support a number of different cross-sectoral transitions beyond these three types of transitions, however, these three were deemed essential to capture quantitatively. As outlined in the table, which has been adjusted to account for the growing number of LHINs submitting these data, transitions **from Acute to LTC** and **Community to LTC** have grown **13.6%** and **24.7%** respectively. Transitions from **Community into LTC** remain the **most common** type of transition supported by BSO teams since 2015-16. In an opposing trend, the overall number of BSO-supported transitions into tertiary care decreased in 2017-18 by **12.3%**. This decrease is being attributed to: **(1)** the growing capacity of BSO Teams in LTC to support residents in their current environments; **(2)** the absence of beds available in tertiary care to transition into; and **(3)** the availability of other specialty services across sectors to assist in supporting individuals to remain in their current environments.

KNOWLEDGEABLE CARE TEAMS AND CAPACITY BUILDING

In order to monitor BSO's third pillar of Knowledgeable Care Teams and Capacity Building, BSO Teams across the province collect data related to education and training. This data largely captures the efforts provided by Psychogeriatric Resource Consultants aligned with the BSO initiative and other BSO Team Members that play a role in clinical and behavioural education to build capacity amongst all types of teams that support the BSO target population.

TABLE 2: EDUCATION SESSIONS AND NUMBER OF PARTICIPANTS (2016-18)

Measure	2016-17		2017-18		Previous Years' Comparison
	TOTAL	# LHINs	TOTAL	# LHINs	2016-17 - 2017-18
Total # training sessions provided through a BSO realignment/ initiative	8204	14	12790	14	+56%
Total # of attendees receiving training/education through a BSO realignment/initiative	96803	14	119668	14	+24%

In 2017-18, the total number of education/training sessions grew **56%** (n=12,790) with an overall **24% increase** in total number of participants attending an education/training session (n= 119,668). This growth is attributed to the BSO in LTC Funding Re-design for Education/Training whereby LHINs may allocate a defined percentage of their BSO investment towards these activities on an annual basis. Anecdotally, this is believed to have resulted in efficient yearlong planning in comparison to previous years whereby many LHINs and partners awaited the availability of funds in the fourth quarter. In addition, a portion of this growth is also due to the need to train new BSO staff, which were hired in 2017-18 as a result of the new BSO investments.

The BSO Provincial Coordinating Office also collects data from **Behavioural Support Transition Units** (BSTUs) that are fully or partially funded with BSO in LTC Investments. In 2017-18, this included four BSTUs: **(1)** Baycrest's Apotex Centre Transitional Behavioural Support Unit (Toronto Central LHIN), **(2)** Cummer Lodge's Behavioural Support Unit (Central LHIN); **(3)** Finlandia Village's Enhanced Care Seniors Support Program (new as of 2017) (North East LHIN); and **(4)** Hogarth Riverview Manor's Regional Behavioural Health Series (North West LHIN). A summary of these data are featured in Table 3 below.

TABLE 3: BEHAVIOURAL SUPPORT TRANSITION UNIT (BSTU) DATA: 2017-18

Measure	Q1	Q2	Q3	Q4	Total
Total # of clients on wait list	32	32	26	33	123
Total # of Referrals	56	45	50	50	201
Total # of Admissions	**19**	**15**	**14**	**16**	**64**
Total # of Admissions by Source					
# from LTCH	4	0	3	2	9
# from community	0	3	2	7	12
# from hospital	10	7	5	3	25
# from tertiary mental health	1	0	3	2	6
# from out of region (hospital+ LTC+ community)	6	7	1	2	16
# other (please provide details/explanation)	0	0	0	0	0
Total # Discharges	**15**	**12**	**17**	**16**	**60**
Total # of Discharges by Disposition					
# to LTCH	4	5	3	2	14
# transferred to another unit within LTC Home that houses the Specialized Unit	8	4	7	8	27
# to community	0	0	2	1	3
# to hospital	0	0	1	0	1
# to tertiary mental health	0	0	0	0	0
# to out of region (broken down by hospital, LTC, community, not specified)	0	2	1	1	4
# to forensic unit in jail	0	0	0	0	0
# died	6	1	4	4	15
Total Length of Stay (LOS) in the BSU	312.61	421	317.19	347	349.4
Length of Stay (LOS) (Clinical (days)	218.09	265.425	261.81	289.25	258.6
LOS ALC (days)	209.63	235.825	124.75	119.9	172.5
% Occupancy in BSU	98.03%	98.67%	99.88%	99.03%	98.9%

BSO APPLIED HEALTH RESEARCH QUESTION (AHRQ) PROJECT

PURPOSE

To determine BSO's impact on patients' behavioural health status and overall health care system use. Using existing health administrative data, this project will describe characteristics of individuals receiving BSO support and explore relevant data elements to better understand the effect of the initiative on residents/patients across sectors from a quantitative perspective.

BSO PCO LEAD COLLABORATOR

Katelynn Viau

CO-LEAD

Dr. Frances Morton-Chang
Former Post-Doctoral Fellow
Institute of Health Policy Management and Evaluation
University of Toronto

CO-LEAD

Kevin Walker
Research Associate
Health System Performance Research Network (HSPRN)
Institute for Health Policy, Management and Evaluation

CO-LEAD

Dr. Walter Wodchis
Professor
Institute of Health Policy Management & Evaluation
University of Toronto
Research Chair in Implementation and Evaluation Science
Institute for Better Health, Trillium Health Partners

EVALUATION PROJECT OVERVIEW

In the fall of 2016, the BSO Provincial Coordinating Office submitted the following Applied Health Research Question (AHRQ):

"What impact does the BSO initiative have on the behavioural health status and health outcomes of the patients it supports?"

The Institute for Clinical Evaluative Sciences (ICES) agreed to address this question with design provided by the HSPRN. This project is the first BSO evaluation project to use past patient data to determine BSO impact. Following the submission of past BSO patient data (i.e., OHIP Number, Date of Referral to BSO, Date of Discharge from BSO) from 14 different organizations hosting BSO Teams across sectors, ICES will link the information to a variety of health administrative datasets to compare patient outcome measures prior to receiving BSO support and the effect after the initiation of BSO interventions.

KEY EFFORTS AND ACCOMPLISHMENTS (2017-18)

- Data Sharing Agreements developed with all 14 organizations across 5 LHINs who are participating in the BSO AHRQ Project.
- AHRQ Project Team presented project overview at BSO Systems Performance & Evaluation Advisory Meeting (June 2017).
- All Data Sharing Agreements were signed by January 2018; following which, organizations began transferring data to the Institute for Clinical Evaluative Sciences which was completed by the end of Q4.
- Data analysis to begin in early 2018-19 with results expected in September 2018.

BSO QUALITATIVE STORIES ANALYSIS PROJECT

PURPOSE

To determine BSO emerging, promising and best practices using BSO Staff-written qualitative stories (2015-18).

BSO PCO LEAD COLLABORATOR

Katelynn Viau

CO-LEAD

Dr. Frances Morton-Chang
Principal
Morton-Chang Consulting

CO-LEAD

Dr. A. Paul Williams
Professor
Institute of Health Policy, Management and Evaluation, University of Toronto

EVALUATION PROJECT OVERVIEW

In connection with the BSO AHRQ Project (pp. 15-16), the key aims of this qualitative evaluation are to identify BSO emerging, promising and best practices at the local level; ingredients essential to success; and how practices in one region, can potentially be scaled and spread in others. Stage 1, Part 1 of the project consists of conducting a targeted review of previous evaluations and studies appraising the BSO initiative. Stage 1, Part 2 of the project will draw on findings from a targeted review to inform thematic analysis of over 200 qualitative stories submitted by BSO staff across all 14 LHINs from 2015-18.

KEY EFFORTS AND ACCOMPLISHMENTS (2017-18)

Stage 1, Part 1 of the project was completed at the end of March 2018. Key findings included a range of positive outcomes for individuals referred to BSO, their family care partners, care providers and the overall health care system. The BSO initiative has resulted in care teams being better prepared to work together and make connections to other providers; lower hospitalization rates for BSO target populations living in long-term care homes; improved point-of-care education, staff assessment and management of resident behaviours in LTCHs; improved care outcomes.

Stage 1, Part 2 will begin in early 2018-19 with the analysis of over 200 BSO qualitative stories submitted by BSO Staff across the province.

PROJECTS & INITIATIVES: INNOVATION

ONTARIO'S BEST PRACTICE EXCHANGE

SUBSTANCE USE COLLABORATIVE

PURPOSE

To bring together health care professionals, leaders and individuals with lived experience to promote person and family-centred best practices related to substance use with older adults.

MEETING FREQUENCY

Monthly

MEMBERSHIP

53

BSO PCO & BRAINXCHANGE LEAD COLLABORATORS

Debbie Hewitt Colborne & Jillian McConnell

CO-CHAIR

Jane McKinnon Wilson
Geriatric Systems Coordinator
CMHA Waterloo Wellington

CO-CHAIR

Cathy Sturdy-Smith
Manager Specialized Geriatric Service
CMHA Waterloo Wellington

CO-CHAIR

Tiffany Symes
Vulnerable Seniors Community Service Lead
CMHA Waterloo Wellington

CO-CHAIR

Marilyn White-Campbell
Geriatric Addiction Specialist
St. Joseph's Health Center Guelph
COPA/Reconnnect, CMHA Waterloo Wellington

KEY EFFORTS AND ACCOMPLISHMENTS (2017-18)

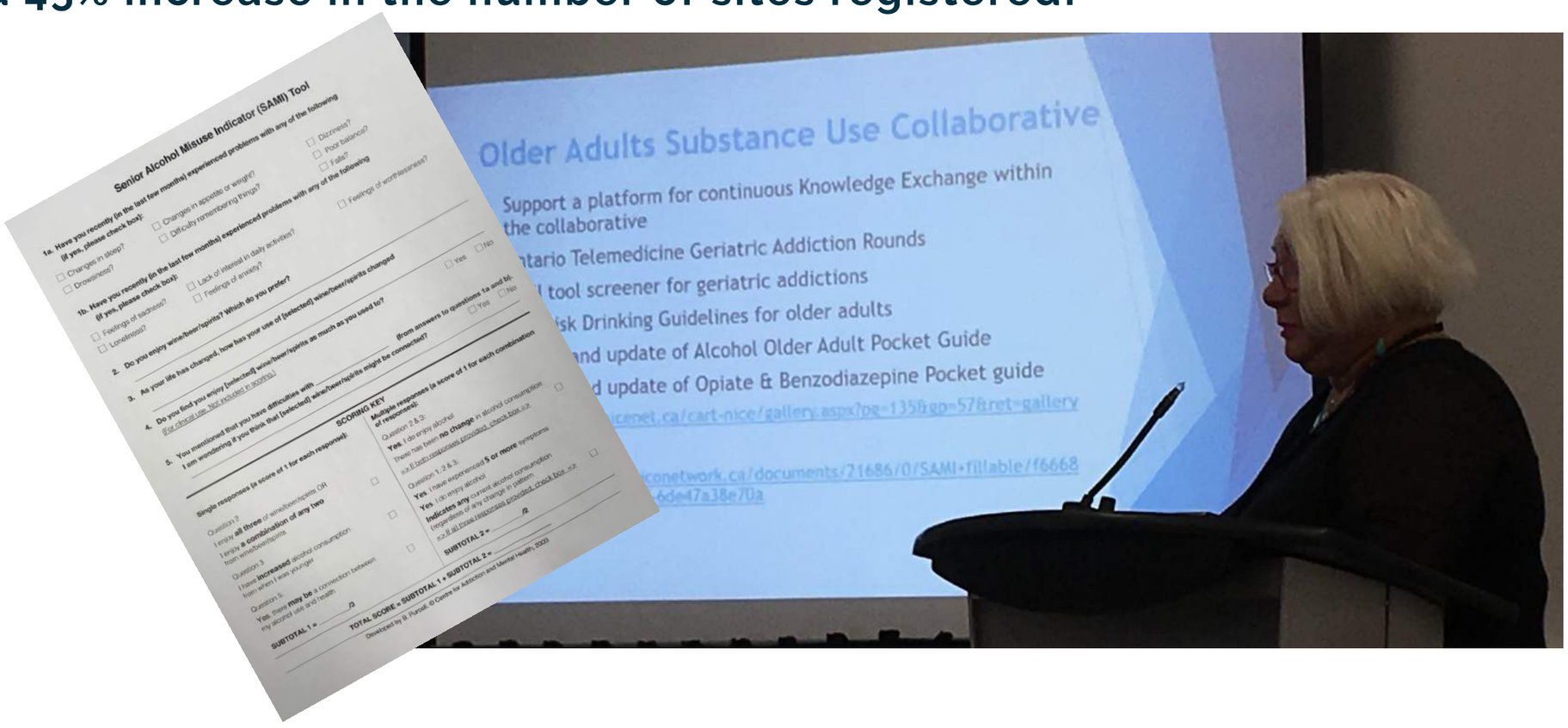
- In April 2017, the Collaborative celebrated success in a proposal submitted to the Public Health Agency of Canada to fund the development and spread of Best Practice Guidelines (BPG) related to substance use and older adults (including alcohol, opiates, benzodiazepines and marijuana). The Canadian Coalition of Seniors Mental Health (CCSMH) was named the lead organization. Working groups established and extensive work completed in reviewing the literature and developing the guidelines. Release of the finalized BPG pending.

- Presented a symposium titled 'Geriatric Addictions: Development of a Provincial Collaborative and the Road to creating National Guidelines' at the Canadian Academy of Geriatric Psychiatry (CAGP) conference (November 2017).

- The Collaborative worked to make the SAMI (Senior Alcohol Misuse Indicator) assessment tool readily accessible to clinicians. Working in partnership with the Centre for Addiction and Mental Health (CAMH), the SAMI was built on the CAMH Portico and available for public download as a fillable pdf form (https://www.porticonetwork.ca/tools/clinical-tools/sami-screening-tool). Tracking of the site showed over 1700 views of the SAMI portico webpage in the first 8 months!

- In November, the Collaborative organized an educational event (webinar) to support the uptake and use of the Senior Alcohol Misuse Indicator (SAMI) with speaker Dr. Bonnie Purcell (Collaborative member and author of the SAMI). The webinar was very well attended with 229 participants. 76% of participants noted that they planned to use the Senior Alcohol Misuse Indicator (SAMI) in their practice and that they had gained confidence through the webinar to utilize the SAMI tool.

- The Collaborative provided ongoing support in promoting and tracking monthly Geriatric Addictions OTN Rounds. These efforts saw a growth in registered sites across the province, growing from 86 to 125 when comparing the 2016/17 and 2017/18 seasons. That's a 45% increase in the number of sites registered!



"The Substance Use Collaborative is so very proud to be such catalyst for change, to be championing substance use, to be part of main stream for screening of substance use in older adults, and educating front line staff with our Geriatric Addiction Rounds. We are delighted to be part of this change at the provincial and national level with the national clinical best practice guidelines."
– Marilyn White-Campbell

BEHAVIOURAL SUPPORT INTEGRATED TEAMS (BSIT) COLLABORATIVE

PURPOSE

To bring together health care professionals, leaders and individuals with lived experience to promote person and family-centred best practices related to substance use with older adults.

MEETING FREQUENCY

Monthly

MEMBERSHIP

50

BSO PCO & BRAINXCHANGE LEAD COLLABORATORS

Katelynn Viau & Jillian McConnell

CO-CHAIR

Teresa Judd
Director
Central West BSO

CO-CHAIR

Patti Reed
Program Manager
Central BSO

"We know unplanned transitions increase stress and worry for the individuals experiencing the move and their care partners which adversely affects their health status. I am excited with the work of the BSIT Collaborative to determine the critical elements and practical actions for safe, seamless care across the health continuum that will greatly improve the patient experience."
– Patti Reed

KEY EFFORTS AND ACCOMPLISHMENTS (2017-18)

- **Finalized the Behavioural Support Integrated Teams Transitions Model and presented it at the 2017 Health Shared Services Ontario Conference.**

- **Identified BSO's critical elements for supporting patient transitions from community into Long-Term Care from the perspective of the person, their family, and health care providers before, during and after the transition. Identified resources to support this transition.**

BEHAVIOURAL SUPPORT TRANSITION UNITS (BSTU) COLLABORATIVE

PURPOSE

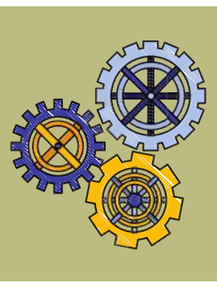
To bring together health care professionals, leaders and individuals with lived experience in order to promote person and family-centred best practices related to BSTUs.

MEETING FREQUENCY

Monthly

MEMBERSHIP

87



BSO PCO & BRAINXCHANGE LEAD COLLABORATORS

Debbie Hewitt Colborne & Jillian McConnell

CO-CHAIR

Karin Adlhoch
Manager
Resident Services
Cummer Lodge

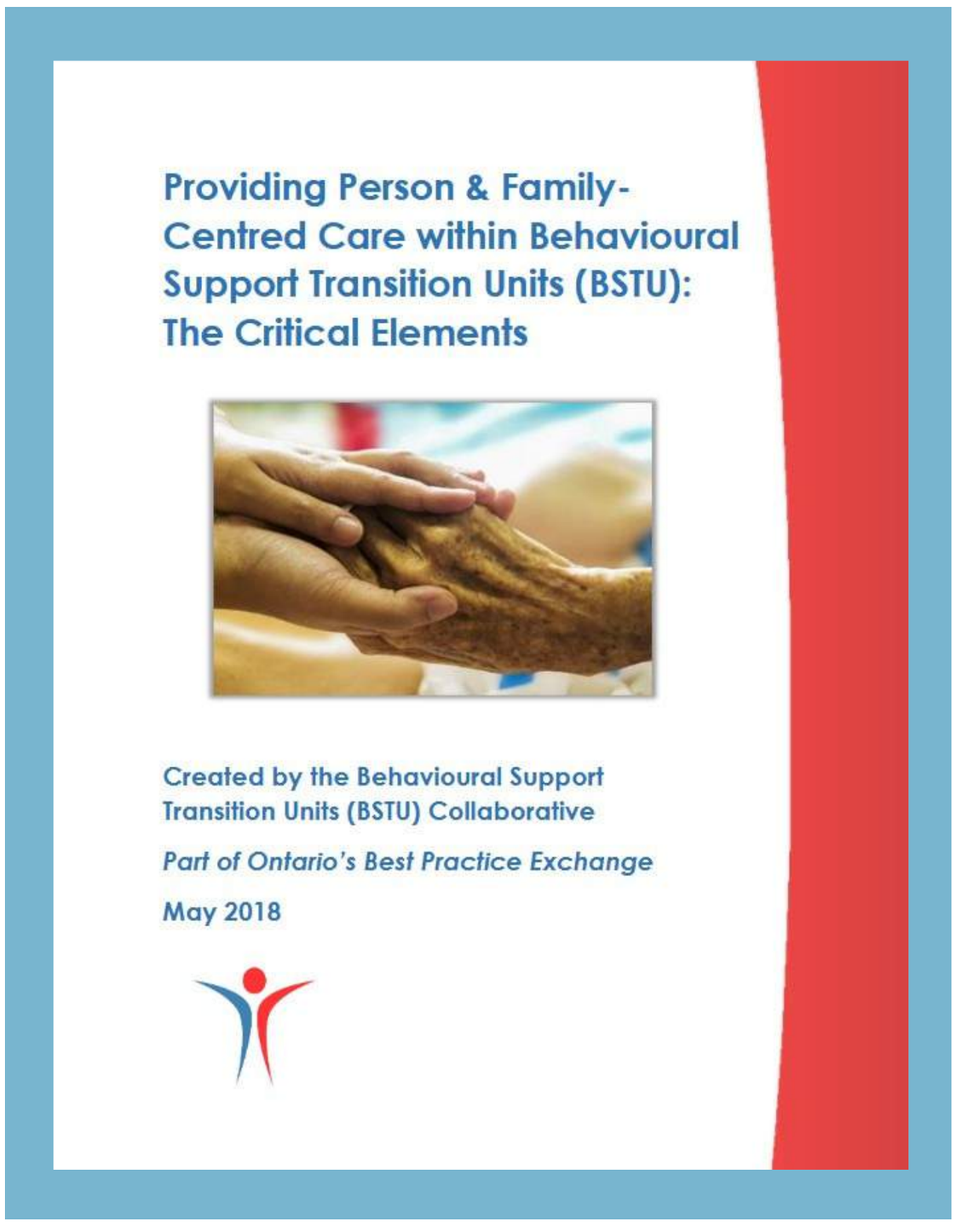
"The BSTU Collaborative continues to offer an important venue for people working in long-term care, in the community, in other healthcare environments and for those with lived experience as caregivers, to work together to improve the lives of adults who exhibit responsive behaviours. This province-wide discussion, and the resulting documents produced by the Collaborative, remain crucial to improving support to this community. This is made possible with the support of Behavioural Supports Ontario and the brainXchange, it is truly a collaborative endeavor." – Karin Adlhoch

CO-CHAIR

Mary-Ellen Parker
Executive Director
Alzheimer's Society of Chatham-Kent

"I am extremely proud of the BSTU Collaborative for producing such a valuable, well-received document in the BSTU – The Critical Elements. With the generous help of Jillian, Debbie and Monica at the BSO Provincial office, this group produced a document that will live on for some time. Special thanks to all members of the collaborative for their informed contributions to this year's project. We are excited about what lies ahead!" – Mary Ellen Parker

After months of gathering and compiling information regarding the BSTUs across Ontario, in June of 2017, the Collaborative released a report titled: 'Environmental Scan of Ontario's Behavioural Support Transition Units' (Click here to access).



Collaborative meetings were utilized to identify the critical elements in providing person & family-centred care throughout a person's stay in a BSTU. An initial draft of the report was created prior to the end of the 2017-18 fiscal year, with release of the finalized document in May of 2018 (Click here to access).

KNOWLEDGE TO PRACTICE COMMUNITY OF PRACTICE (COP)

PURPOSE

To bring together professionals across Ontario who have a shared passion for capacity building and fostering knowledgeable healthcare teams. The CoP promotes the utilization of the Knowledge to Practice Process Framework to guide knowledge to practice work.

MEETING FREQUENCY

Monthly

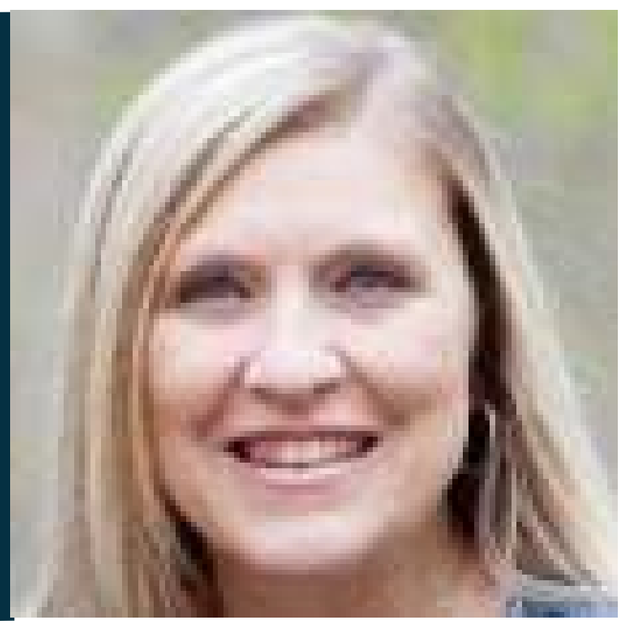
MEMBERSHIP

185

BSO PCO & BRAINXCHANGE LEAD COLLABORATORS

Debbie Hewitt Colborne, Tina Kalviainen & Jillian McConnell

CO-CHAIR



Lina DeMattia
Regional Education Coordinator
Alzheimer Society of Chatham-Kent
Erie Saint Clair LHIN

CO-CHAIR

Marion Penko
Pyschogeriatric Resource Consultant
St. Joseph's Healthcare Hamilton
Halton Geriatric Mental Health Outreach Program

"The Knowledge to Practice CoP, through regular web meetings, continues to build our understanding of and skills in using the provincially adopted Knowledge to Practice Process Framework. CoP Members and provincial BSO working groups have shared their initiatives, being receptive to suggestions for enhancements based on a knowledge to practice lens. These discussions have assisted in the draft of a knowledge to practice job aid for educators and organizations to use in planning." – Marion Penko

KEY EFFORTS AND ACCOMPLISHMENTS (2017-18)

- The CoP collectively gained more understanding of the Knowledge to Practice Process Framework by using meetings to walk through examples of knowledge to practice work.
- Various leaders of BSO projects/initiatives gathered ideas and suggestions from the CoP members.
- A worksheet was drafted to support the use of the Knowledge to Practice Process Framework by CoP members in their clinical work.

DEMENTIA OBSERVATION SYSTEM (DOS) PROJECT

PURPOSE

To bring together professionals across Ontario who have a shared passion for capacity building and fostering knowledgeable healthcare teams. The CoP promotes the utilization of the Knowledge to Practice Process Framework to guide knowledge to practice work.

MEETING FREQUENCY

Monthly

MEMBERSHIP

20

BSO PCO LEAD COLLABORATOR

Debbie Hewitt Colborne

CO-CHAIR

Debbie Hewitt Colborne
Project Advisor
BSO Provincial Coordinating Office

CO-CHAIR

Dr. Lori Schindel Martin
Associate Professor
Daphne Cockwell School of Nursing
Ryerson University

"The DOS Working Group is an example of what can happen when an inter-disciplinary group of professional collaborators come together to converge their individual knowledge and expertise about responsive behaviour documentation toward a common goal of a single, useful and accessible DOS. Our work will improve the capacity of point-of-care staff to make effective decisions about the impact of non-pharmacological and other interventions of people living with dementia who experience responsive behaviours."
– Dr. Lori Schindel Martin

KEY EFFORTS AND ACCOMPLISHMENTS (2017-18)

The DOS Working Group is an interprofessional team (including researchers, educators, psychiatrists, psychologists and front-line clinicians) who have worked collaboratively on the following tasks:

- **Conducted a literature review in relation to behaviour observation.**
- **Completed an environmental scan that produced 48 DOS versions provincially and nationally. These DOS versions were analyzed (noting their best features and innovations) which informed the establishment of critical elements for the new standardized DOS.**
- **Engaged over 280 health care professionals and individuals with lived experience on working drafts of the new standardized DOS. These included:**

- **Two focus groups with key external stakeholders (Nov. 2017).**
- **Workshop participants at the Canadian Academy of Geriatric Psychiatry (CAGP) conference through an interactive workshop titled 'Development of a Standardized Version of the Dementia Observation System (DOS): An Interprofessional Collaboration' (Nov. 2017).**
- **165 participants of a brainXchange webinar titled: "Strengthening the Dementia Observation System (DOS): Seeking Your Contributions to the Standardized Version and Next Steps!" (Feb. 2018). Received 137 feedback surveys in follow-up to the webinar noting significant support of the new DOS, along with suggested revisions.**
- **BSO Lived Experience Advisory (March 2018).**
- **Refining drafts of the new standardized DOS based on stakeholder feedback.**
- **Planning the implementation trial of the drafted standardized DOS in multiple clinical sites in the late spring of 2018.**

PERSON-CENTRED LANGUAGE INITIATIVE

PURPOSE

To create a set of Commitment Statements, informed by the authentic voice of persons with lived experience, to promote the consistent use of person-centred language.

MEETING FREQUENCY

Total of 5 expert panel meetings, including one held in person.

MEMBERSHIP

50

BSO PCO LEAD COLLABORATOR

Tina Kalviainen

CO-CHAIR

Kate Ducak
Project Officer
Schlegel-UW Research Institute for Aging (RIA)

"Working together with the Expert Panel members and other experts among the groups of people that BSO serves on the Person-Centred Language initiative has been an enlightening journey. I have enjoyed gathering diverse views and resources and collaboratively combining them into the Person-Centred Language commitment statements and toolkit that we are eager to share this Fall!"
– Kate Ducak

CO-CHAIR

Gagan Gill
Public Policy & Programs Analyst
Alzheimer Society of Ontario

"It has been a wonderful experience working with members of the Expert Panel to bring together so many diverse experiences to this initiative. It is exciting to see this work progress towards the release of the final commitment statements and toolkit in the Fall. Looking forward to seeing the use of more person-centred language in the future!" – Gagan Gill

KEY EFFORTS AND ACCOMPLISHMENTS (2017-18)

- **The time-limited expert panel was able to fulfill one of BSO Knowledge Translation and Communications Advisory's terms of reference objectives to critically reflect and provide recommendations regarding language and communications used by BSO and its key stakeholders.**
- **Over the course of a year, the expert panel was able to create a living document in the shape of Person-Centred Language Commitment Statements informed by the authentic voice of persons with lived experience to promote the consistent use of person-centred language that is appropriate, respectful, life-affirming and inclusive.**
- **A report, including relevant resources in the form of a toolkit to further the knowledge on the topics of language and communication, will be released in the fall of 2018.**

BEHAVIOURAL EDUCATION AND TRAINING SUPPORTS INVENTORY (BETSI)PROJECT

PURPOSE

To update the Behavioural Education And Training Supports Inventory (BETSI).

MEETING FREQUENCY

Bi-weekly

MEMBERSHIP

7

BSO PCO LEAD COLLABORATOR

Katelynn Viau

CHAIR

Patricia Boucher
Executive Director
Advanced Gerontological Education

“The BETSI working group has made significant progress over the past year. This is an exciting venture which will further contribute to continued learning in the area of dementia and mental health care for clinicians and care providers. I want to thank all of the hard work of the Committee members: Faith Malach, Katelynn Viau, Patti Reed, Maureen O’Connell, Tiffany Symes and Monica Bretzlaff.”
– Patricia Boucher

KEY EFFORTS AND ACCOMPLISHMENTS (2017-18)

The Behavioural Education and Training Supports Inventory (BETSI) was originally created in 2012 to support the implementation of knowledgeable care teams and build knowledge and skill capacity for care providers serving BSO’s target population.

- **Working Group emerged in July 2017 to revise the document and explore opportunities to enhance its use.**
- **Released a BETSI User Survey which received 106 responses detailing how the BETSI has been used in the past across sectors and ways in which it may be improved. The survey also solicited recommendations for new courses to be considered into the updated BETSI.**
- **Reviewed the list of education/training programs to determine which were still being offered and added new programs to be invited to apply for inclusion in the new BETSI.**
- **Revised the BETSI Form to be circulated to over 25 course representatives to apply to be included in the new BETSI.**
- **Met with the Regional Geriatric Program – Central to begin to discuss the possibility of developing a BSO stream of the Geriatric Certificate Program based off of the new BETSI.**

MAKING CONNECTIONS RECOMMENDATIONS

PURPOSE

To develop recommendations to enhance the use of personhood tools across sectors.

MEETING FREQUENCY

Bi-monthly (Lived Experience Advisory Agenda Item)
(Approximately 5 meetings)

MEMBERSHIP

Approximately 30

BSO PCO LEAD COLLABORATOR

Katelynn Viau

CO-CHAIR

Dr. Rhonda Feldman
Mental Health Clinician
The Cyril & Dorothy, Joel & Jill Reitman
Centre for Alzheimer's Support and Training

CO-CHAIR

Sharon Osvald
Lived Experience Facilitator
BSO Provincial Coordinating Office / brainXchange

KEY EFFORTS AND ACCOMPLISHMENTS (2017-18)

The development of recommendations to enhance and increase the use of personhood tools to improve clinical care across sectors surfaced as a priority goal for the advisory upon the advisory's inception in 2016.

Over the course of 4 meetings and one evening live chat, Lived Experience Advisory Members discussed:

Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Which elements of personhood are most helpful to surface to inform care planning and delivery across sectors?

When should information about personhood be documented and how often should it be updated?

Who would the information about personhood be most helpful for?

Where should the information about one's personhood be shared, displayed and/or stored?

How can persons and families promote the use of information gathered from the tools?

What tools currently exist to surface elements of personhood that can be used in different sectors?

Following the conversations, the recommendations were written into the report: Making Connections: Recommendations to enhance the use of personhood tools to improve clinical care across sectors. (Click here to access).

The recommendations were first disseminated in a dedicated webinar in collaboration with the South East Knowledge Exchange Network and brainXchange on February 26, 2018. They will be continue to be disseminated in 2018-19 using a number of strategies.

Erie St. Clair (ESC)

2017-18 Funding Implementation Highlights & Impact:

• **BSO Internal Champion Education Funds:** Each of the 36 LTCHs in Erie St. Clair was provided education funding for their BSO Internal Champions. This funding was to be used to provide ongoing core competency education, such as: P.I.E.C.E.S, U-First and GPA, however, LTCHs were also encouraged to explore other relevant education and training.

• **BSO Internal Champion Enhancement:** LTCHs were able to bolster their existing BSO Internal Champion teams through increased funding, by increasing hours, expanding shifts to encompass evenings and weekends, or by adding new and innovative roles to their teams. Flexibility created the opportunity for each LTCH to approach their BSO Internal Champion complement from an individual perspective. This has provided increased support for our clients internally in our LTCHs.

• **BSO Core Teams Education Funds:** Through ongoing BSO Education Funds, core teams were able to obtain core competencies for any new staff, and were also offered Palliative Care and Compassion Fatigue Workshops to enhance their robust knowledge-base.

Key Project Outcomes, Achievements & Celebrations

• On March 1, 2018, BSO collaborated with ESC LHIN to present a **Palliative Care education day** for BSO Core Teams and Internal Champions. The full-day workshop featured presentations by experts in the field of Palliative Care, and offered practical and relevant information for our BSO teams. **68** participants attended.

• **BSO LTC Lead Teams** increased their presence in most ESC LTCHs by **meeting regularly** with **BSO Internal Champion teams**. These meetings provided opportunity to connect as a collaborative team on a regular basis to review shared clients, recommendations and updates, as well as put additional focus on the identified successes and challenges unique to each home. This allowed the BSO Internal Champions to collaborate, at their discretion, with their BSO LTC Lead Team peers in order to create effective strategies to encourage continued success of BSO Internal Champion teams. With a collaborative approach, the goal is to elevate client care to encompass a more seamless and consistent approach, drawing on the knowledge and experience of multiple teams and disciplines.

• BSO Regional Coordinator and three System Navigators have played an active and ongoing role in the development of Humber College's **Systems Navigation Graduate Certificate** course. This has been an incredible opportunity to share our experience and knowledge about the importance of this multi-faceted role, especially as it pertains to our clients and care partners.

"I was very excited to be a part of a new BSO project where all Long-Term Care Lead Team PSWs took part in a Knowledge to Practice initiative, involving Compassion Fatigue Education and support for point of care staff in our homes."
- BSO Team Lead PSW

South West (SW)

2017-18 Funding Implementation Highlights & Impact:

• **Enhanced BSO supports in LTC**: the 78 LTC homes in the South West received funding to enhance existing embedded LTCH staffing models. The new funding increases dedicated BSO PSWs, Registered Practical Nurses/Registered Nurses (RPN/RN), and other health care provider positions.

• **Development and implementation of the Geriatric Ambulatory Access Team (GAAT)**: result will be streamlined centralized coordination functions for geriatric assessment within London Middlesex. A soft launch was held in May 2018.

• **Enhancing regional coordinated access**: through Dementia Strategy funding, increased administrative support will enhance centralized coordinated access across the LHIN.

• **Full review and re-alignment of Alzheimer BSO resources**: the re-alignment ensured that Alzheimer Societies had social workers utilizing a consistent model of care across the LHIN to support individuals and their family care partners when transitioning into, out of , or within LTCHs.

Key Project Outcomes, Achievements & Celebrations

The Family Transition Program at Woodingford Lodge in Woodstock serves seniors waiting for a permanent placement into LTC. It is predicated on a supportive transition model of care, which allows the person to visit the LTCH, and thereby live the LTC experience prior to admission. By implementing the program, Woodingford has invited upcoming residents to participate in its varied programs and enjoy meals in its communal dining settings. Additionally, by employing an interdisciplinary approach, Woodingford offers upcoming residents care, if necessary, from a dietician and/or occupational- and/or physio- therapist with the aim of developing a comprehensive chart in preparation for admission day. Woodingford projects that the ease of the transition process will decrease the anxiety that seniors typically experience on the first day at the LTCH; decrease the need to contact after-hours practitioners for assistance with responsive behaviours; decrease the number of transfers to hospital for responsive episodes; and increase the use of non-pharmacological therapies. What is more, Woodingford prioritizes supporting family members as they go through the process of separation from their loved one. Essentially, the Family Transition Program is designed to alleviate strain, support practitioners and community partners, and facilitate a smooth transition to LTC living.

Decreasing Opportunities for Responsive Behaviour at Country Terrace Long Term Care Home: Country Terrace LTCH, supported by OMNI Health Care, began a journey to review and transform their organizational processes for supporting residents with responsive behaviours. Selected LTC staff members and the regional South West BSO team participated in, lead, and championed a 6-week Quality Improvement Project focused on reducing the frequency of responsive incidents that occur within the LTCH, and increasing understanding of a behavioural supports philosophy of care across staff and teams.
Implementation and evaluation are ongoing; however, signs of change are emerging at Country Terrace LTCH. Admission processes are smoother and less onerous on staff, residents and families; recreational programs are now available for residents during high-risk transition times to decrease opportunities for responsive behaviour; point-of-care charting is enabling accurate and timely documentation of resident mood, triggers, and preferences for care; and front-line staff are starting to feel supported to reach out and utilize the spectrum of support teams available for managing responsive behaviour.

Waterloo Wellington (WW)

2017-18 Funding Implementation Highlights & Impact:

System Coordination and Management - Process Improvement & Partnership

As part of the 2017 WW LHIN BSO One-Time funding enhancement, a **0.5 FTE BSO Clinical Intake Clinician** was established. This resource enabled the allied health clinician to join the current high functioning WW BSO Clinical Intake team.

The Waterloo Wellington **Centralized Coordinated Clinical Intake Service** is comprised of Allied Health Clinicians (Nursing, Occupational Therapy and Social Work) , who provide virtual clinical client assessment by accessing clinical information from four clinical databases; who work in partnership with primary care and Specialized Geriatric Services (SGS) to determine the most appropriate specialized geriatric service; and who, through the virtual clinical assessment, determines the priority of the referrals while ensuring that referred agencies receive the client's most current and relevant information.

This unique service model, designed to trigger **early identification and intervention**, reduces the fragmentation of social and health services and addresses the request made by the residents of Waterloo Wellington to reduce and/or eliminate, the need to repeat the telling of their health information, and lived experience journey.

In addition, and at the request of the WW LHIN, part of the BSO One – Time Program funding was used to engage Grand River Hospital's Specialized Geriatric Assessment and Neurobehavioural Unit (GAU & NBU) to **explore opportunities** for **quality improvement**, **seamless transitions** across the continuum of health care services, and **capacity building** to enhance knowledgeable care teams to improve care and quality of life, for GAU, NBU and BSO populations.

The WW BSO **partnership** with Grand River Hospital's Geriatric Assessment and Neurobehavioural Assessment units **identified several opportunities** to sustain the cross sector collaboration, and build on each team's internal strengths and resources to create **integrated access** to SGS services resulting in reduced redundancy of system referrals for the shared client population. These opportunities will be further explored in the coming year.

Key Project Outcomes, Achievements & Celebrations

The WW BSO Review Working Group was tasked with steering a **Review of the BSO Program** in Waterloo Wellington to better understand if the needs of older adults with responsive behaviours are being adequately met across Community, Long-Term Care and Acute Care. This review led to the BSO **community** team developing a **Performance toolkit** and the LTCH sector reviewing the previously developed **BSO LTCH Performance toolkit** (2014). Both toolkits will incorporate **Health Quality Ontario Dementia Quality Standards**. A **full report of the toolkits will be highlighted in the 2018/19** reporting term.

Psychogeriatric Resource Consultant (PRC): the 6 month **evaluation of the role of BSO PRCs** in **acute care** was completed. The evaluation identified the PRC role as having the greatest impact when involved in direct case consultation, staff education and patient transition facilitation. The PRCs will continue to work with the hospital sector to incorporate the feedback provided by the evaluation.

" The virtual assessment provided by the BSO Centralized Clinical Intake Program of Waterloo Wellington demonstrated reduced assessment redundancy and increased communication across the system, providing coordinated support for clients."

- Kate Kobbes, Program Director CCC and Rehab Grand River

Hamilton Niagara Haldimand Brant (HNHB)

2017-18 Funding Implementation Highlights & Impact:

• **Four Transitional Leads have been added to the HNHB BSO program.** These regulated health professionals support clients before, during and after their move to LTC. Family members of clients served by Transitional Leads assigned the service an average rating of 4.8/5 (with higher scores indicating greater satisfaction), and 100% of the 45 family members who provided feedback would recommend the service to others. A staff member in LTC said: "The transition from community to LTC home is a sensitive time. Having access to supports that make the move easier and more personal has been a gift."

• **BSO staff now have a regularly scheduled presence in 60% of the 86 LTC homes LHIN-wide.** The remaining homes have access to BSO support through a mobile consultative model. Modifications to the LTC model have ensured that services continue to be delivered effectively, efficiently, and in response to feedback.

• **Consistent and predictable education funding catalyzed a partnership between the HNHB BSO Strategy and the Regional Geriatric Program – Central (RGP-c).** Spaces in the RGP-c's Geriatric Certificate Program (GCP) are made available to LTC staff on an annual basis. Graduates of the GCP come away with improved knowledge and confidence in supporting the BSO population, and the ability to build capacity in their colleagues.

Key Project Outcomes, Achievements & Celebrations

• BSO Connect was awarded the **2017 Service Award for Geriatric Excellence** (SAGE Award) in the Team Category.

• Last year, the HNHB BSO Strategy **collaborated with learners** to evaluate selected clinical practices. Partnership with a Master of Science in Nursing student from McMaster University illuminated the longer-term impacts of education about responsive behaviours upon staff working in Acute Care. A Bachelor of Science student from Brock University evaluated a 'Transitional Care Plan' document used by BSO teams to share vital information between formal care providers. This work generated helpful recommendations to improve the document. Working with learners not only improves facets of our BSO models, but also cultivates young professionals' interest in working with the BSO population.

Jocelyne and Sue, BSO Connect Representatives, with the 2017 SAGE Award.

"This support was invaluable and certainly made the transition far more positive than we had anticipated" - Family member, about the BSO Transitional Lead

Central West (CW)

2017-18 Funding Implementation Highlights & Impact:

LTC Funding Enhancement of BSO LTC Registered Staff

- 2 larger LTCHs have 2 FTEs **RPN** level of nursing.

- Remaining homes with PSW support hired additional RPNs .3-.5 FTE to provide **off-hours support** for residents and staff. This provided increased leadership support and liaison between the staff and the families.

- BCBA and BT partial FTE 0.8 and 0.3 hub and spoke model for our Sienna Corporate Care Communities. – **Shared resource** across 6 homes.

Education Events

- Dufferin County - focused on mental health assessment and suicide prevention in the elderly.
- Region of Peel - focused on cognitive assessment and leadership development, Teepa Snow Positive Approaches to Care and Hand over Hand.

Community Expansion, one time dollars for Alzheimer's agencies.

- Community caregiver events focused on Adult Day Service waitlists.
- Transportation and caregiver respite.
- Enhancement of Montessori-based programs and kits.

Key Project Outcomes, Achievements & Celebrations

- Support and augmentation of the **Dementia Care Matters Model** at Malton Village Region of Peel Home.

- Complex case review process and support for **Adult Day Services** ongoing reach into the community with Home and Community Care.

- June of 2017 Community Nursing, PSW and Rehab Services received **education** on Dementia, Delirium and Compassion Fatigue.

- August of 2017 **Healthy Brain Symposium** for Community Health Partners
  - **Multidisciplinary**, Dietary, Nursing, Mental Health. BSO Transition Nurses, Geriatric Outreach, Social Work , HQO- Dementia Standards, RNAO and CMHA
  - The open house symposium created an opportunity for **networking** with new and existing community partners.

Central West BSO Network
"Making a difference to all of our community partners and families."
BSO Community Healthy Brain Symposium. Focused on healthy eating for brain health and preventive illness.

Mississauga Halton (MH)

2017-18 Funding Implementation Highlights & Impact:

• With additional ministry investment in 2017/18 the Mississauga Halton LHIN took the opportunity to revisit the BSO Strategy and redefine our approach. In collaboration and engagement with key system partners and stakeholders, **BSO 2.0** was conceived. BSO 2.0 is a more regionalized approach to the BSO program to support the **7 Mississauga Halton LHIN sub-regions** in a standardized, consistent, and sustainable manner that is aligned with the ministry mandate and improves the ability of service providers to meet the needs of this special population. Each sub-region will have a dedicated BSO team to support the residents within that region across the care continuum, regardless of the sector they are placed in.

• The **Embedded LTC BSO Teams** in the Mississauga Halton LHIN have undergone a **redesign** as part of BSO 2.0. **New BSO roles** with enhanced job descriptions were developed, seeing each LTC home have at least 1.5FTE dedicated BSO teams, consisting of a BSO Team Lead and BSO Team Assistant(s).

• The **BSO Community** teams also received further enhancements with the **creation of** dedicated **BSO Acute Care Teams**. Acute Care Behavioural Consultants and Behavioural Intervention Specialist roles were developed to support the **2 hospital** organizations within our LHIN. The additional investment also allowed the Mississauga Halton LHIN to develop a **central intake** for BSO through enhancements to the Alzheimer Society of Peel; First Link Program.

Key Project Outcomes, Achievements & Celebrations

• **27 of the 28 LTC** homes have the **new BSO Lead** role in place and **71% of the LTC** homes have the **BSO Assistant** role in place.

• The BSO **Central Intake** is up and running and has assessed **261** new referrals and triaged **249** of them to BSO services, as well as facilitated **63** referrals to consulting specialists.

• Both of the hospital organizations in the Mississauga Halton LHIN have dedicated BSO resources to support the acute care sector. Year-to-date, they received a total of **95 referrals** and have been able to support a total of **19 transitions** out of hospital. The remaining **76 are awaiting placement** to LTC and or a specialized behavioural support unit.

Mississauga Halton BSO Community Team

• 2017/18 was **a year of change** and new investments for BSO in the Mississauga Halton LHIN. We look forward to seeing and providing more outcomes, achievements and celebrations as BSO 2.0 continues to roll out.

Toronto Central (TC)

2017-18 Funding Implementation Highlights & Impact:

- **Expansion of the In-House Behavioural Support Lead Model:**
This included increasing the number of FTEs and LTCHs provided with access to an In-House Lead (**24/36 LTCHs**). The implementation leveraged the 2016/17 initial In-House Lead Model work plan including standard job descriptions, recruitment tools, training for In-House leads, training for Behavioural Support Resource Teams (BSRT) and launch of a TC LHIN In-House Lead Community of Practice.

- **Recruitment and implementation of funded In-House Leads in 24/36 TC LHIN LTCHs:**
Full implementation of the mandatory and LHIN specific tracking completed in wave 1 and 2 LTCHs. Standard training was provided by the Regional Geriatric Program (RGP) Psychogeriatric Resource Consultants (PRCs) to all In-House Leads and BSRTs.

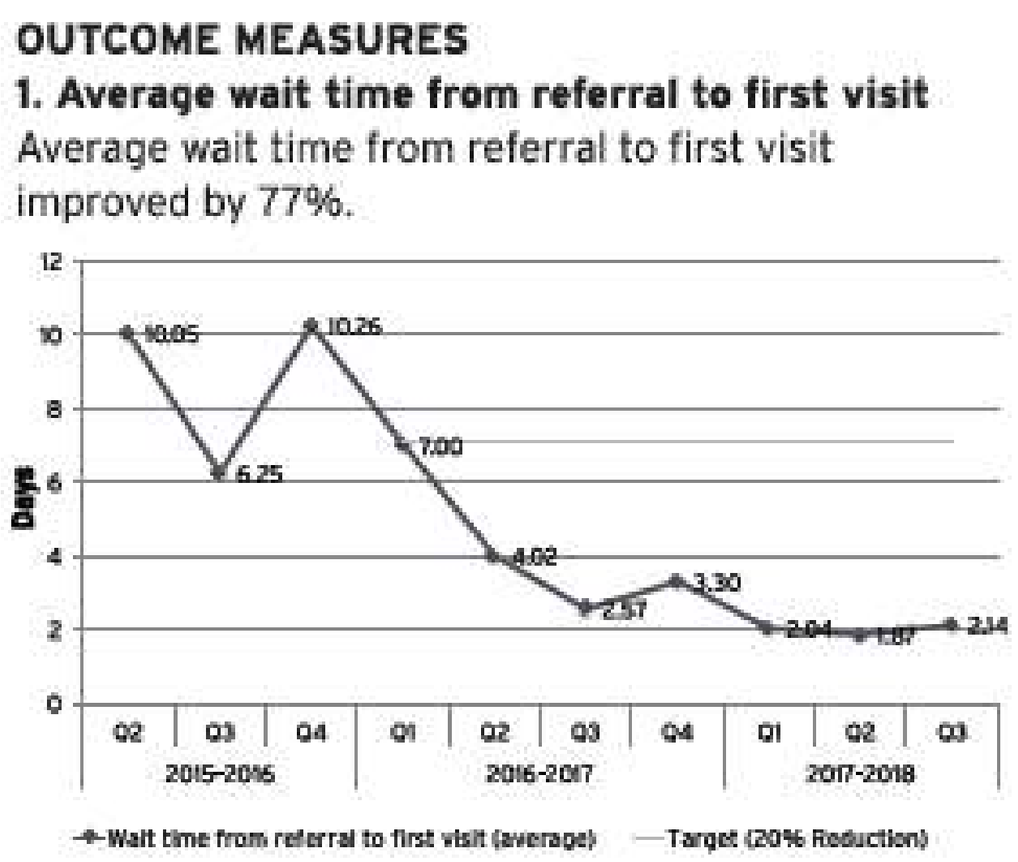
- **Completion of Wave 1 In-House Lead Evaluation with formal Report.**

Key Project Outcomes, Achievements & Celebrations

- **Quality Improvement Project for LTC Behaviour Support Outreach Team (BSOT):**
This project was completed in Q4 of 2017/18. It was initially piloted in 3 LTCHs and expanded to all 36 homes. Key outcomes included a **reduction in average wait time** from referral to first visit **by 77%** or from 7 days to 2.14 days.

- **Quality Improvement Project for Community Behaviour Support Outreach Team (CBSOT):** This project is well underway as the team has met on several occasions to develop and formalize a **new standardized** comprehensive assessment tool and behaviour care plan. The teams have also **mapped an ideal future state** for the pathway for care which will be implemented in the fall of 2018.

"Behaviour support lead program is new at our home and started just last year. It has run very well with the person that has been leading the program. This role allows for better communication with family Staff and others. There has been in-services, huddles and coaching for staff and others."
- Wave 1 In-House Behavioural Lead Evaluation Focus Group Participant



LTC BSOT Quality Improvement Project: Wait Time Results

CBSOT Quality Improvement Project: Mapping Exercise

Central (C)

2017-18 Funding Implementation Highlights & Impact:

• **18/46 long term care homes now have internal dedicated Behavioural Support Resource Team Leads** to work collaboratively with the Behavioural Support Services Mobile Support Team within an integrated, interdisciplinary blended team for optimal care.

• Funded **2 FTE Behaviour Therapists** to provide weekly case consultation to LTC BSS Mobile Support Team members; assists in analyzing ABC and DOS documentation to determine functions of behaviour.

• Introduced **BSO Central Coordination** function in the community with one-time fiscal funding; consulted with North East LHIN and Waterloo Wellington LHIN for lessons learned; hosted local stakeholder engagement sessions and incorporated recommendations into a new streamlined access intake and referral process with plans for a phased-in approach to expand beyond community referrals for BSO only to include central intake for BSO in long-term care (2018/19) and beyond BSO to other specialized geriatric services (2019/20).

Key Project Outcomes, Achievements & Celebrations

• Over **14,000 registrants** completed education in **BSO core competencies** including, but not limited to, P.I.E.C.E.S. , GPA, Montessori Methods, Validation Techniques, Mental Health First Aid for Seniors and Teepa Snow Positive Approach to Care. Increased local capacity and sustainability by funding PRCs to become **certified instructors** in Teepa Snow Positive Approach to Care; Mental Health First Aid for Seniors; P.I.E.C.E.S.; ASIST (suicide prevention) and GPA Coach.

• Successfully implemented monthly **Behavioural Rounds** with internal and external team members in each directly funded LTCH (**18**) within integrated/blended team model.

• Under leadership of Alzheimer Society of York Region and support of CLHIN, BSO supported the **development of a Caregiver Support Framework** that was co-designed with caregivers. The Framework aims to help health care providers across sectors to engage with, listen to, empower and support caregivers.

• BSO and RGP Toronto co-chaired the **founding** of a **Central LHIN Regional Seniors Care Network** (formerly called Specialized Geriatric Services) to support frail older adults with multiple and complex medical and psycho-social problems and their caregivers across sectors. The Seniors Care Network is mandated to provide leadership and structure towards a system of services that are integrated, sustainable, accessible, evidence-based, person-centred and continuously improving.

LTC, Community & Hospital Behavioural Support Services Team: a dedicated group of RNs, RPNs, Social Workers, PSWs and other Behaviour Specialists that work collaboratively across sectors

Central East (CE)

2017-18 Funding Implementation Highlights & Impact:

• **Thirty- five LTCHs successfully recruited and hired new BSO RPNs.**
- Permanent funding provided to 17 LTC homes.
- Temporary funding provided to 18 LTC homes.
- Early Adopter LTCHs, Psychogeriatric Resources Consultants (PRCs) and BSO Program Office provided orientation for new staff.

• **Through new funding implementation in Quarter 3, several key indicators significantly increased over previous quarters:**
- Behavioural assessments for the newly funded homes **increased by 24%**;
- Accepted referrals **increased by 13%**;
- Patients supported **increased by 16%**; and
- Family/informal care partners supported **increased by 78%** (note: this is also partially attributed to improved data collection methods, but a large part is a result of the reach of new staff).

• **Community one-time funding** to support enhancements to community dementia programs, for behavioural supports at home and to provide central coordination of service resulted in two key initiatives – **Adult Day Program** enhancements and development of the **BSO Coordinated Access Model**.

Key Project Outcomes, Achievements & Celebrations

• Extensive **capacity building** (**3863** participants attended **295** education sessions) included a focus on mental health education at Community of Practice events and through introduction of Mental Health First Aid for Seniors training.

• Hosted a **Student Practicum** to identify community mental health resources for seniors.

• **Evaluation Framework** developed in collaboration with Seniors Care Network programs.

• **Engagement with hospital partners** to better identify BSO patient needs:
- Through Senior Friendly Care Committee review of Health Quality Ontario Quality Standards for Behavioural Symptoms of Dementia;
- Lakeridge Health START project;
- Behavioural Assessment Tool trials with four hospitals (6 units); and
- Electronic Behavioural Assessment Tool (BAT) project for LTC to add an electronic version of the Central East Behavioural Assessment Tool to Point Click Care (PCC) which links with Point of Care (PoC).

"Both my husband and I are very grateful for the support for an additional day at Northview Day Program. It gives a purpose to our day and my husband is stimulated by the activities and contact with other people. It gives me an opportunity to attend appointments and do the many chores that need to be completed."
- Adult Day Program Client's Care Partner

South East (SE)

2017-18 Funding Implementation Highlights & Impact:

• **An additional 5 LTCHs in the SE were provided funding to enhance their in-house Behaviour Support Team:** Total FTEs 8.85 (4 FTE RN/RPN 4.85 PSW).

• **11 out of 36 LTCHs now have in-house Behaviour Support Teams alongside the established 3 Mobile Response Teams (MRT):** the SE has developed a blended model of BSO care in LTC (total FTEs for the BSO Blended Model-54.15 FTEs).

• **The impact has been realized quantitatively as well as qualitatively.**

• **Plans for BSO integration days have begun with goals of role articulation and an algorithm for the blended model of BSO care.**

Key Project Outcomes, Achievements & Celebrations

South East Knowledge Exchange & Capacity Enhancement Strategy includes:

A. SE Knowledge Exchange Network hosted by brainXchange.ca and included a webinar series and collaboration spaces for the 3 SE Behaviour Support Networks.

Webinar topics included:

1. The Last Taboo: Sexuality, Aging, & Dementia
2. Post Stroke Depression
3. Making Connections: Personhood Tools
4. Addressing Abusive Behaviour in LTC
5. Dementiability Implementation in LTC
6. Caring for residents in LTC with Fronto-temporal lobe dementia

B. On-line course hosted by the Centre for Studies in Aging and Health Providence Care Sagelink

5 Module Course: Team Based Person-Centred Care for people with Responsive Behaviours

Modules included the following topics:

1. Communication
2. Collaboration
3. Team skills and roles
4. Conflict in the workplace
5. Personhood Tools

This online course was a pilot with 56 participants from MRT and 11 BSO funded LTCHs. Feedback from the pilot will be integrated into the course and the goal is to offer this course more broadly to all 36 LTCHs and new MRT members.

C. Dedicated funding for Capacity Enhancement opportunities. We have developed a Virtual LTC Advisory Group to provide input on how funding is used to enhance the system of care.

Champlain (CH)

2017-18 Funding Implementation Highlights & Impact:

• **Funding for Champlain was directed to front-line staff in our LTCHs:** With this, every LTCH in Champlain (both urban and rural areas) were given a **minimum of** a **0.4FTE PSW** allocation. Impact: staff retention, more BSO time leading to better resident care, staff teaching, mentorship and collaboration; and improved morale.

• **The annualized BSO education funding, combined with contributions** from our Champlain Dementia Network (CDN) partners allowed for an **increase of training sessions** and more diversity in the topics. Furthermore, these specialized education sessions were offered to LTC staff and caregivers as well! For staff, the evaluation of this education showed that it increased their capacity. It also helped them create autonomy as an individual while learning how to be a team member. Their skills have been refined, and overall they felt that they were able to have more empathy and strengthened communication. Both staff and caregivers felt empowered, understood and acknowledged through these education sessions. Caregivers were given a sense of community having been brought together on a few occasions to learn and share.

Key Project Outcomes, Achievements & Celebrations

• In the 2017-18 fiscal, we provided **education to over 500 attendees** (such as LTC, acute care & Adult Day Program staff as well as caregivers) at 5 large education sessions of which were provided in collaboration with our CDN members. Furthermore, **over 4500** individuals received training/education through a BSO realignment/initiative.

• The Champlain LHIN now has **over 30 Teepa Snow Trainers** spanning across our urban and rural sub-regions. These trainers will be disseminating their knowledge in LTC, community, day hospitals, and acute care. We will be evaluating the impact of this and look forward to sharing our results!

Champlain Area Geriatric Psychiatry Outreach Team Members, BSO nurses, Behaviour Therapists and BSO Program Evaluation Coordinator

"The end result includes a rise in staff confidence in their role of supporting and caring for the resident and in turn the resident experiences an increase in quality of life".

- Champlain LTCH sharing their experience of how education through the BSO alignment has increased capacity and morale among their staff, leading to better resident care.

North Simcoe Muskoka (NSM)

2017-18 Funding Implementation Highlights & Impact:

Hiring of 2.5 FTE RNs and 2.0 FTE RPNs:

- The addition of these resources to our Behavioural Support Services (BSS) team allowed for the implementation of **5** fully supported **sub-geographic regions** within the LHIN to support **LTC**.
- This aligned with our BSS redesign as well as the design for Specialized Geriatric Services (SGS) in NSM.
- The addition of the 2 RPNs allowed for more **Primary Clinicians** (RNs & RPNs) within the BSS team, allowing the RNs to take on some additional capacity-building work.

Key Project Outcomes, Achievements & Celebrations

- **Orientation/training** for new BSS staff was completed.
- Comprehensive **education strategy** was put in place between December 2017 – March 2018. Events included a focus on applying P.I.E.C.E.S. in practice and compassion fatigue. Additional staff in the region were trained in the Positive Approach to Care approach (Teepa Snow).
- Funds were provided to NSM LTCHs to help support **additional education** for direct care staff and additional care time for the homes' P.I.E.C.E.S. leads.
- **Four videos** were developed for SGS staff to support training and orientation including a focus on communication techniques for persons with dementia, information on concurrent disorders and addictions and a presentation by Dr. Daniel on antipsychotics.
- NSM SGS website was linked to the **NSM BSO mini-site** and additional work done to the SGS site to enhance BSS content.
- BSS staff **orientation framework** was developed.
- Seniors Mental Health **curriculum was developed** to support in-region training.
- NSM BSS **Performance Monitoring & Evaluation Framework** draft was completed.

- Operational and best practices **plan** for a **Transitional Behaviour Support Unit** (TBSU) in NSM was completed and **submitted to the LHIN.**

North East (NE)

2017-18 Funding Implementation Highlights & Impact:

• **New BSO funded resources within 13 additional LTCHs** who previously did not have embedded resources. While most are still within the orientation/development phase of their programs, the initial uptake of the internal teams has been very supportive and beginning to see positive outcomes and creative team solution finding to support older adults with responsive behaviours.

• **Integration of new allied health roles with the 2017-18 LTC investments** (e.g., Recreational Therapy, Social Work).

• **Enhancement to NE BSO Central Intake** (0.5 FTE Clinical intake specialist and 0.5 FTE Admin.): acting as a leader across the province sharing the successes from our own experiences with other LHINs.

Key Project Outcomes, Achievements & Celebrations

• **Teepa Snow Certified Positive Approach to Care** Workshops - 8 NE sessions

• BSO/Seniors Mental Health Integrated Clinics **supporting the James Bay Coast** (June 7, 2018) & planning underway for in-person trip in September 2018.

• Central Intake Team: Currently processing about **70 to 90 referrals a month** and have continued to enrich our **Clinical Intake Reports** by gathering information from various sources to better support our clinical teams. The enhanced Clinical Intake Reports facilitate ease of access to timely information required for assessment which results in quicker response rates, reducing duplication of services, and coordinating services to allow staff to meet with clients and address needs promptly.

• Enhancement to **Specialized Consultations: 81** Care of the Elderly consultations were facilitated through Central Intake and **32** Geriatric Psychiatry consultations within the 2017/2018 fiscal year.

North East LTCH Resident participating for the first time in activities due to increased support and coaching provided by the LTC BSO Team. Upon hearing about his participation, his wife stated:

"J'ai retrouvé mon mari!"

I found my husband.

NE BSO Central Intake Team

North West (NW)

2017-18 Funding Implementation Highlights & Impact:

• In 2017-2018 **the complement of Personal Support Workers and Psychogeriatric Resource Consultants (PRC) was increased** to support further coverage in the City of Thunder Bay and in the districts of Kenora and Rainy River across the North West LHIN including the communities of Manitouwadge and Geraldton.

• **BSO Education and Training initiatives** were supported through partnership with the **Centre for Education and Research on Aging and Health** (CERAH) at Lakehead University and increased capacity is being built to support **Living the Dementia Journey** from the Research Institute on Aging (RIA) and the Murray Alzheimer Research and Education Program (MAREP).

• A new model to better support Long-term Care Homes in the City of Thunder Bay was implemented with **PRCs being specifically allocated in a semi-embedded way.** The new complement of PRCs in the City of Thunder Bay has allowed for 3 FTEs to be split between 6 LTCHs. 1 is focused on the largest home which includes the Specialized Behavioural Support Unit (SBSU); 1 is dedicated to 3 LTCHs owned and operated by the same company, Southbridge; and 1 is dedicated to 1 municipal home and another smaller home operated by St. Joseph's Care Group. This means there is ongoing support from the same PRC in the LTCHs. As a result there is the **ability to be responsive and build capacity** amongst staff teams by **being more visible**.

Key Project Outcomes, Achievements & Celebrations

• NW LHIN BSO Program Evaluation was conducted by the researchers from the **Centre for Education and research on Aging and Health (CERAH)** at Lakehead University.

• Increasing **Health Human Resources** capacity in the East of the Region with PRCs was a relatively small investment, but can be considered a strong acknowledgement from the Steering Committee that the needs in this part of our Region are unique, as population data and the number of LTC beds alone do not accurately reflect the actual need. The Steering Committee acknowledged that the **investment of PRC resources** can play a strong role in supporting people to **stay as close to home as possible** for care.

CERAH
Centre for Education and Research on Aging & Health

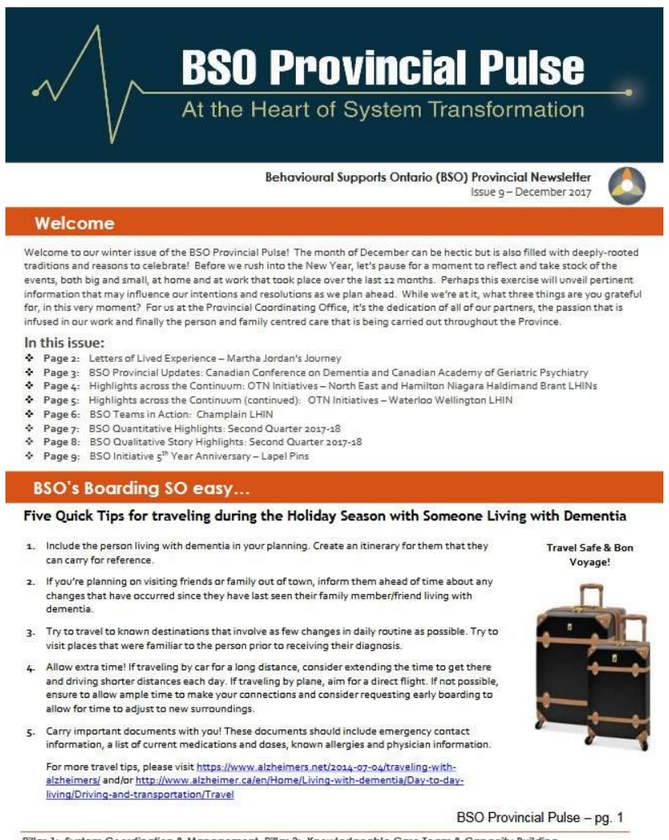
PROJECTS & INITIATIVES: INTEGRATION

BSO - CELEBRATORY 5 YEAR ANNIVERSARY PINS

In November 2017, the BSO Provincial Coordinating Office provided each LHIN's BSO Leaders with BSO pins to distribute to their staff across sectors. The BSO PCO Team hopes that BSO staff across the province wear their pins with pride and wishes to thank all of the BSO Staff across the province for their continued dedication to the BSO initiative!

E-NEWSLETTER: THE BSO PROVINCIAL PULSE

The BSO Provincial Pulse newsletter continues to be well-received by its current 500+ subscribers. Each newly curated issue released is being passed along as confirmed by new members signing up in quarterly increments all year long, including those identifying themselves as residing out-of-province.



BSO Provincial Pulse
At the Heart of System Transformation

Behavioural Supports Ontario (BSO) Provincial Newsletter
Issue 9 – December 2017

Welcome

Welcome to our winter issue of the BSO Provincial Pulse! The month of December can be hectic but is also filled with deeply-rooted traditions and reasons to celebrate! Before we rush into the New Year, let's pause for a moment to reflect and take stock of the events, both big and small, at home and at work that took place over the last 12 months. Perhaps this exercise will unveil pertinent information that may influence our intentions and resolutions as we plan ahead. While we're at it, what three things are you grateful for, in this very moment? For us at the Provincial Coordinating Office, it's the dedication of all of our partners, the passion that is infused in our work and finally the person and family centred care that is being carried out throughout the Province.

In this issue:

BSO's Boarding SO easy…

Five Quick Tips for traveling during the Holiday Season with Someone Living with Dementia

1. Include the person living with dementia in your planning. Create an itinerary for them that they can carry for reference.
2. If you're planning on visiting friends or family out of town, inform them ahead of time about any changes that have occurred since they have last seen their family member/friend living with dementia.
3. Try to travel to known destinations that involve as few changes in daily routine as possible. Try to visit places that were familiar to the person prior to receiving their diagnosis.
4. Allow extra time! If traveling by car for a long distance, consider extending the time to get there and driving shorter distances each day. If traveling by plane, aim for a direct flight. If not possible, ensure to allow ample time to make your connections and consider requesting early boarding to allow for time to adjust to new surroundings.
5. Carry important documents with you! These documents should include emergency contact information, a list of current medications and doses, known allergies and physician information.

Travel Safe & Bon Voyage!

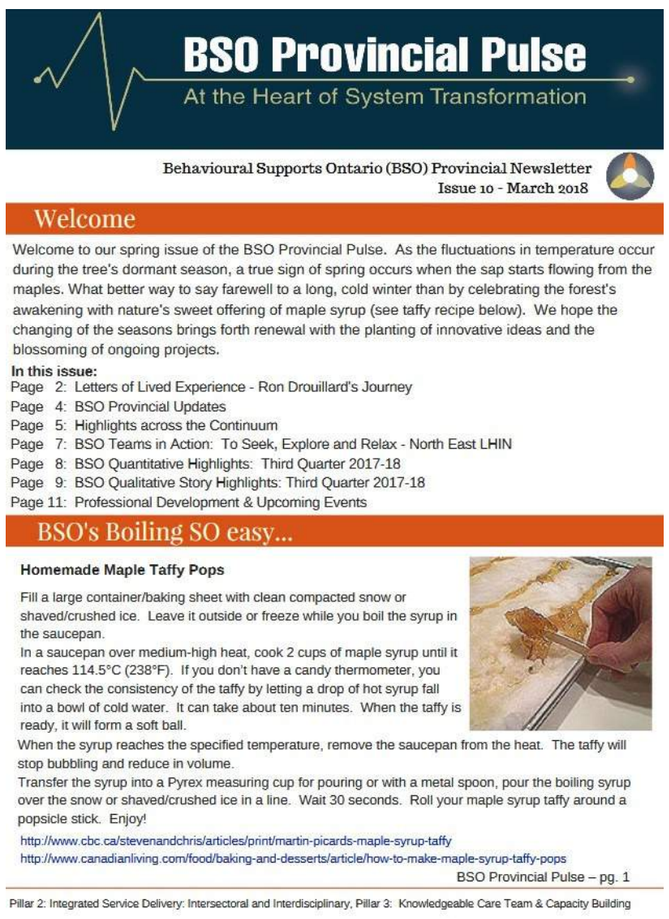
For more travel tips, please visit https://www.alzheimers.net/2014-07-04/traveling-with-alzheimers/ and/or http://www.alzheimer.ca/en/Home/Living-with-dementia/Day-to-day-living/Driving-and-transportation/Travel

Pillar 1: System Coordination & Management, Pillar 3: Knowledgeable Care Team & Capacity Building

December 2017 – Issue 9

"Congratulations on an excellent publication! The themes, content and graphics are outstanding!"

Audrey Devitt
Waterloo Wellington Geriatric System Coordinator
Canadian Mental Health Association
Waterloo Wellington & St. Joseph's Health Centre Guelph



BSO Provincial Pulse
At the Heart of System Transformation

Behavioural Supports Ontario (BSO) Provincial Newsletter
Issue 10 - March 2018

Welcome

Welcome to our spring issue of the BSO Provincial Pulse. As the fluctuations in temperature occur during the tree's dormant season, a true sign of spring occurs when the sap starts flowing from the maples. What better way to say farewell to a long, cold winter than by celebrating the forest's awakening with nature's sweet offering of maple syrup (see taffy recipe below). We hope the changing of the seasons brings forth renewal with the planting of innovative ideas and the blossoming of ongoing projects.

In this issue:

BSO's Boiling SO easy...

Homemade Maple Taffy Pops

Fill a large container/baking sheet with clean compacted snow or shaved/crushed ice. Leave it outside or freeze while you boil the syrup in the saucepan.

In a saucepan over medium-high heat, cook 2 cups of maple syrup until it reaches 114.5°C (238°F). If you don't have a candy thermometer, you can check the consistency of the taffy by letting a drop of hot syrup fall into a bowl of cold water. It can take about ten minutes. When the taffy is ready, it will form a soft ball.

When the syrup reaches the specified temperature, remove the saucepan from the heat. The taffy will stop bubbling and reduce in volume.

Transfer the syrup into a Pyrex measuring cup for pouring or with a metal spoon, pour the boiling syrup over the snow or shaved/crushed ice in a line. Wait 30 seconds. Roll your maple syrup taffy around a popsicle stick. Enjoy!

http://www.cbc.ca/stevenandchris/articles/print/martin-picards-maple-syrup-taffy
http://www.canadianliving.com/food/baking-and-desserts/article/how-to-make-maple-syrup-taffy-pops

Pillar 2: Integrated Service Delivery: Intersectoral and Interdisciplinary, Pillar 3: Knowledgeable Care Team & Capacity Building

March 2018 – Issue 10

"Thank you for sharing another excellent newsletter – I so enjoy reading them and sharing with our BSO Teams. Ron's story is very touching!"

Jennifer Siemon, MSc (OT), OT Reg. (Ont.),
Coordinator
Behavioural Supports Ontario HNHB LHIN
Hamilton Health Sciences – St. Peter's Hospital

Want to subscribe to the Provincial Pulse?
Visit: http://brainxchange.ca/bsopnewsletter.aspx.
Provide your contact information and click "Subscribe Now".

You may access previous issues by visiting:
http://www.behaviouralsupportsontario.ca/45/Newsletters_Other_Announcements/

brainXchange

The team members at brainXchange continue to be key collaborators and facilitators of the BSO initiative. Behind the scenes, brainXchange works closely with the BSO Provincial Coordinating Office to provide leadership and infrastructure support to many of the provincial initiatives.

Dr. Dallas Seitz
brainXchange Co-Lead
MD PhD FRCPC
Division Head, Geriatric Psychiatry
Associate Professor
Department of Psychiatry
Queen's University
Providence Care - Mental Health Services

Lisa Salapatek
brainXchange Co-Lead,
Chief Program and
Public Policy Officer,
Alzheimer Society of
Ontario

Jillian McConnell
Knowledge Broker and
Knowledge Mobilization
Lead

Karen Parrage
Resources and
Information Technology
Coordinator/Webmaster

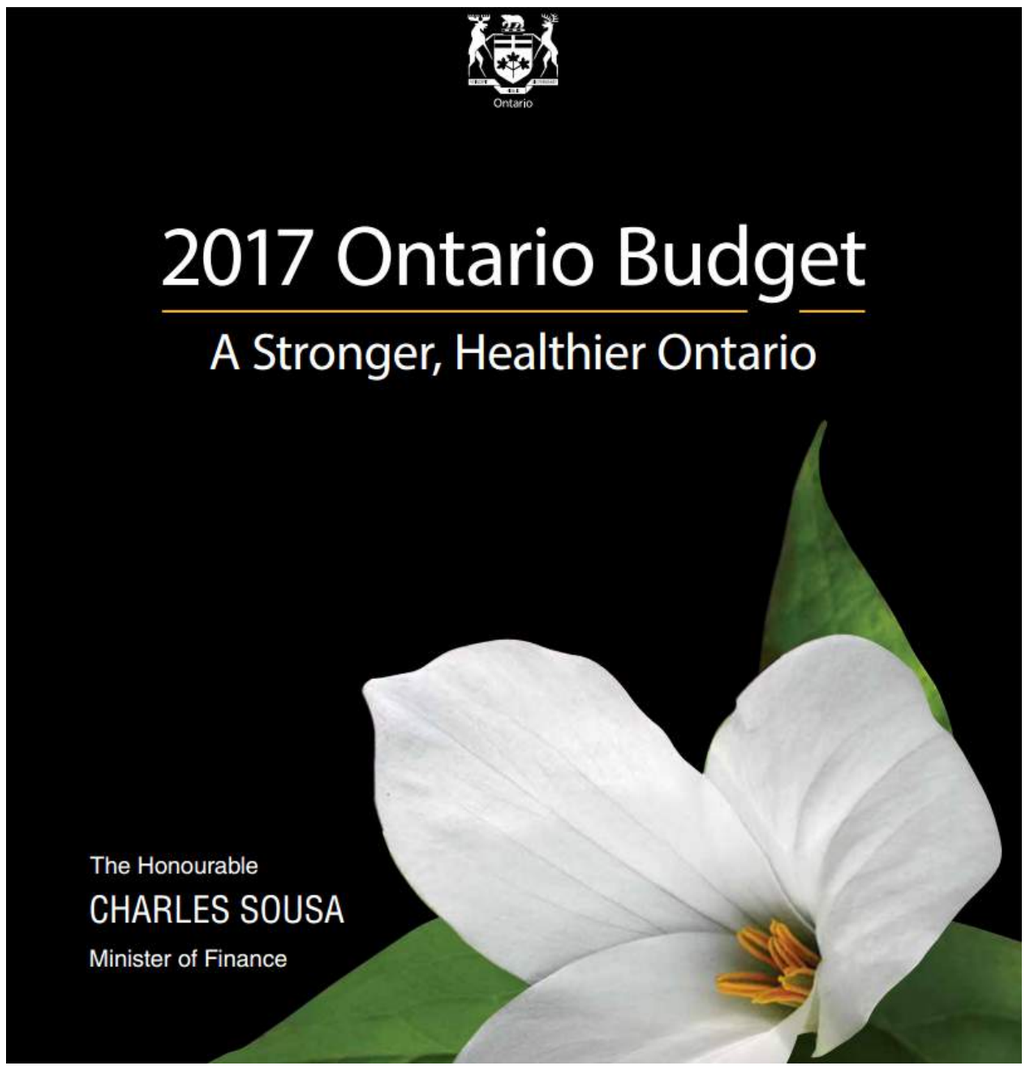
Gagan Gill
Knowledge Broker

- **Jillian McConnell provides essential support to the Ontario Best Practice Exchange Collaboratives and the Knowledge to Practice Community of Practice (CoP) alongside representing brainXchange on the BSO Operations Committee and the Knowledge Translation & Communication Advisory.**
- **Karen Parrage plays an important role in the creation and maintenance of the on-line collaborative space for the BSO Advisories, Committee, Collaboratives, Community of Practice and Working Groups.**
- **Gagan Gill provides consistentency and facilitation as co-lead of the Person-Centred Language Initiative.**
- **Dr. Dallas Seitz and Lisa Salapatek provide valuable leadership and guidance in facilitating knowledge exchange which has been conducive in building and strengthening collaborative partnerships between valued staff, partners and stakeholders. Lisa also represents the Alzheimer Society of Ontario and brainXchange on the BSO Steering Committee.**

2017-18 BSO FUNDING HIGHLIGHTS

The 2017-18 fiscal year proved to be another exciting year in regards to increasing the capacity of BSO Teams with two new investments: (1) $10M for BSO in LTC; and (2) $1.43M for the establishment of BSO Central Coordinating Mechanisms (Ontario Dementia Strategy).

The 2017 Ontario Budget: A Stronger, Healthier Ontario announced additional BSO funding in LTC, bringing the total BSO in LTC Investment Commitment to $64M. New to 2017-18 was the consolidation of the various BSO funding streams, meaning that LHINs may now determine appropriate staffing mixes and are no longer tied to the previous set targets for BSO Nurses and Personal Support Workers. Furthermore, in order to support BSO's third pillar of Knowledgeable Care Teams and Capacity Building, LHINs are now able to allocate a small portion of their BSO in LTC funding towards education/training on an annual basis.



All 14 LHINs presented their implementation plans for this funding during an in-person BSO Operations Meeting in November 2017. Highlights of this funding include:

- **Expansion of BSO Embedded and LTC Mobile Teams to include Recreation Therapists, Behavioural Therapists and other Health Care Professionals**
- **Redesign of BSO Model to emphasize the scope of practice of the BSO Roles**
- **Launch of a new Behavioural Support Transition Unit**
- **Introduction of BSO Embedded Resources to new LTCHs**
- **Addition of Psychogeriatric Resource Consultants to build capacity in LTCHs**

The second 2017-18 BSO Investment came from the first year of the MOHLTC's Ontario Dementia Strategy. The purpose of the $1.43M investment is to enhance the alignment of BSO cross-sector resources via central coordinating office staffing. The allocation of flexible community funding to establish and/or enhance mechanisms for centralized BSO coordination in each region serves to enhance patient, family and health care provider access to BSO. These new roles act as a central point of coordination, supporting the intake and triaging of BSO patients across sectors, coordinating access to specialty consultations, maintaining the collection of regional & provincial metrics and ensuring accountability to the BSO mandate.

ONTARIO DEMENTIA STRATEGY ENGAGEMENTS

In alignment with the aforementioned investment, BSO remains firmly committed to supporting the ongoing development and implementation of the Ontario Dementia Strategy and wishes to acknowledge the Dementia Strategy Team at the MOHLTC Capacity Planning and Priorities Branch for their continued engagement in a number of forums in 2017-18:

DATE	TOPIC	AUDIENCE
JUNE 21, 2017	Ontario Dementia Strategy: Adult Day Programs	Lived Experience Advisory Live Chat
JUNE 27, 2017	Developing Ontario's Dementia Strategy	BSO Steering Committee
NOVEMBER 2, 2017	Ontario Dementia Strategy: Fall 2017 Update	BSO Operations Committee
NOVEMBER 14, 2017	Ontario Dementia Strategy: Fall 2017 Update	BSO Steering Committee
JANUARY 25, 2018	Ontario Dementia Strategy: BSO in the Community Investment	BSO Operations Committee
FEBRUARY 27, 2018	Ontario Dementia Strategy: Year 1 Update & Priorities for Year 2	BSO Steering Committee

KNOWLEDGE EXCHANGE HIGHLIGHTS

BSO's great work was highlighted at national and international conferences!

1. Canadian Conference on Dementia: Toronto, ON

Development of the PIECES of my Relationships tool.
Blind, M., Pitawanakwat, K., Jacklin, K., Piraino, E., & Bretzlaff, M. (November 2017).

2. Canadian Conference on Dementia: Toronto, ON

The collaborative approach to managing responsive behavioural symptoms of dementia.
Chau, J., Van Bussel, L., Bretzlaff, M., & Cadieux, S. (November 2017).

3. Canadian Conference on Dementia: Toronto, ON

An evaluation of the efficacy of behaviour therapy on deferring emergency department visits as a result of behaviour in dementia care.
Feltz, N. (November 2017).
(also at the ONTABA International Conference)

4. Canadian Academy of Geriatric Psychiatry Annual Conference: Toronto, ON

Development of a standardized version of the dementia observation system (dos): an interprofessional collaboration.
Iaboni, A., Van Bussel, L., Hewitt Colborne, D., Schindel Martin, L., & Fresco, F. (November 2017).

KNOWLEDGE EXCHANGE HIGHLIGHTS

5. Ontario Association for Community Care Access Centres Conference

Teams supporting teams: behavioural supports Ontario integrated teams transition model.
Judd, T. & Reed, P. (May 2017).

6. Regional Geriatric Program of Eastern Ontario Annual Conference. Ottawa, ON

Applied behaviour analysis (ABA) for dementia care: welcoming behaviour therapy into geriatric psychiatry.
Lončar, A. & Feltz, N. (October 2017). (also presented at the Canadian Conference on Dementia)

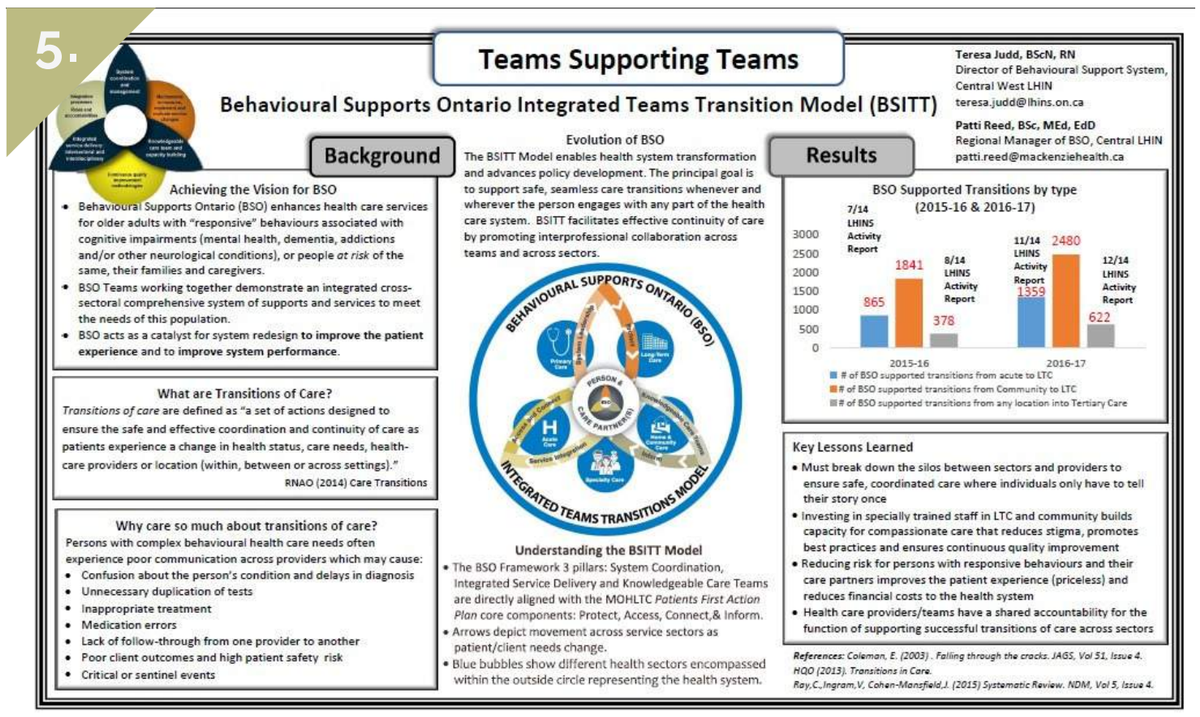
7. Canadian Conference on Dementia: Toronto, ON

A review of the Geriatric Psychiatry Behaviour Support Outreach team collaborative practice
Lončar, A., Punzalan, M., Lusk, J. (November 2017)

8. Canadian Academy of Geriatric Psychiatry Annual Conference: Toronto, ON

Ontario expands behavioural support teams for older adults in acute care: the champlain experience.
Rabheru, K., Wilding, L., Hula, V., Neil-McKenzie, M., & Sebehana, N. (November 2017).

5.



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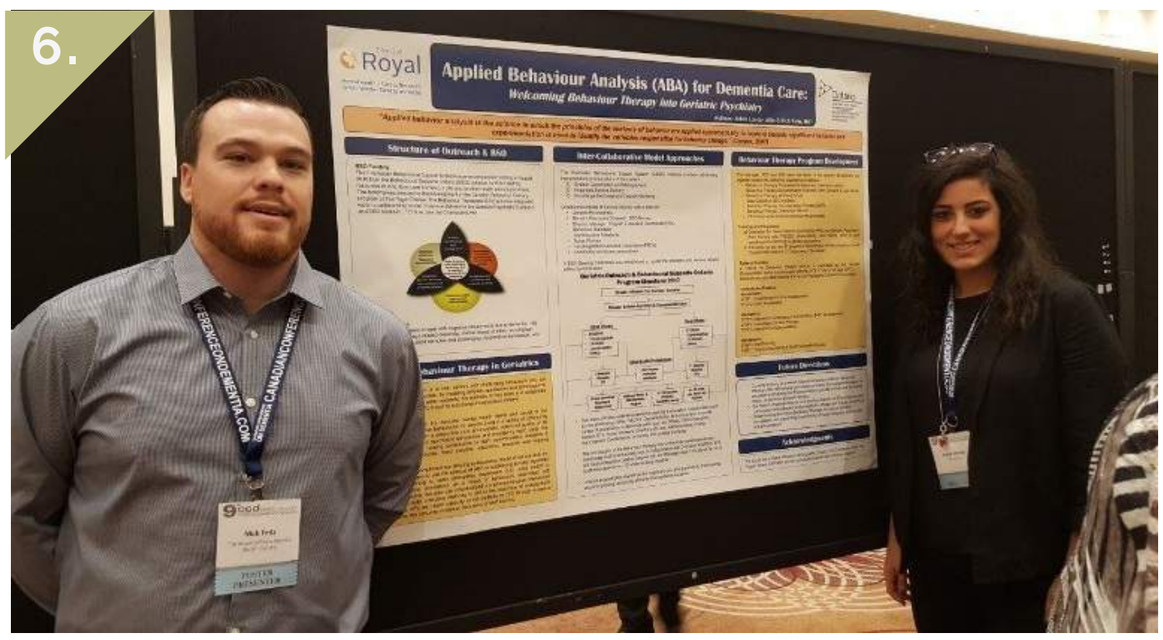

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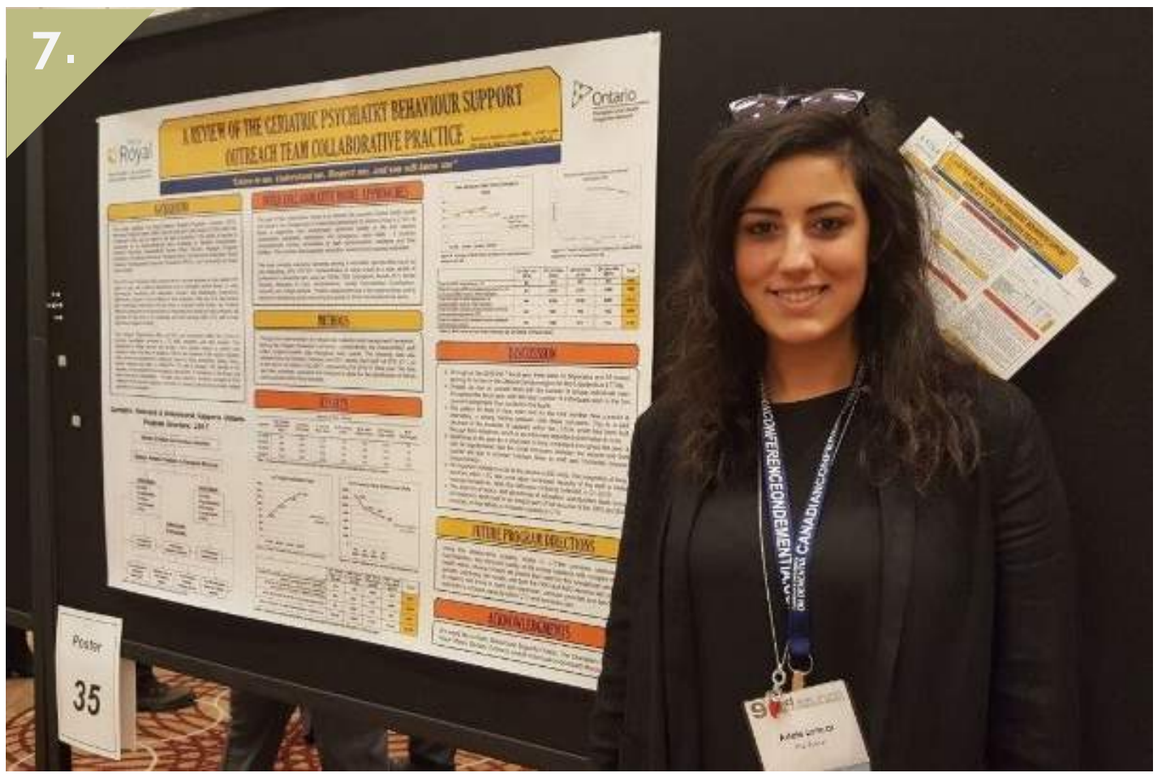

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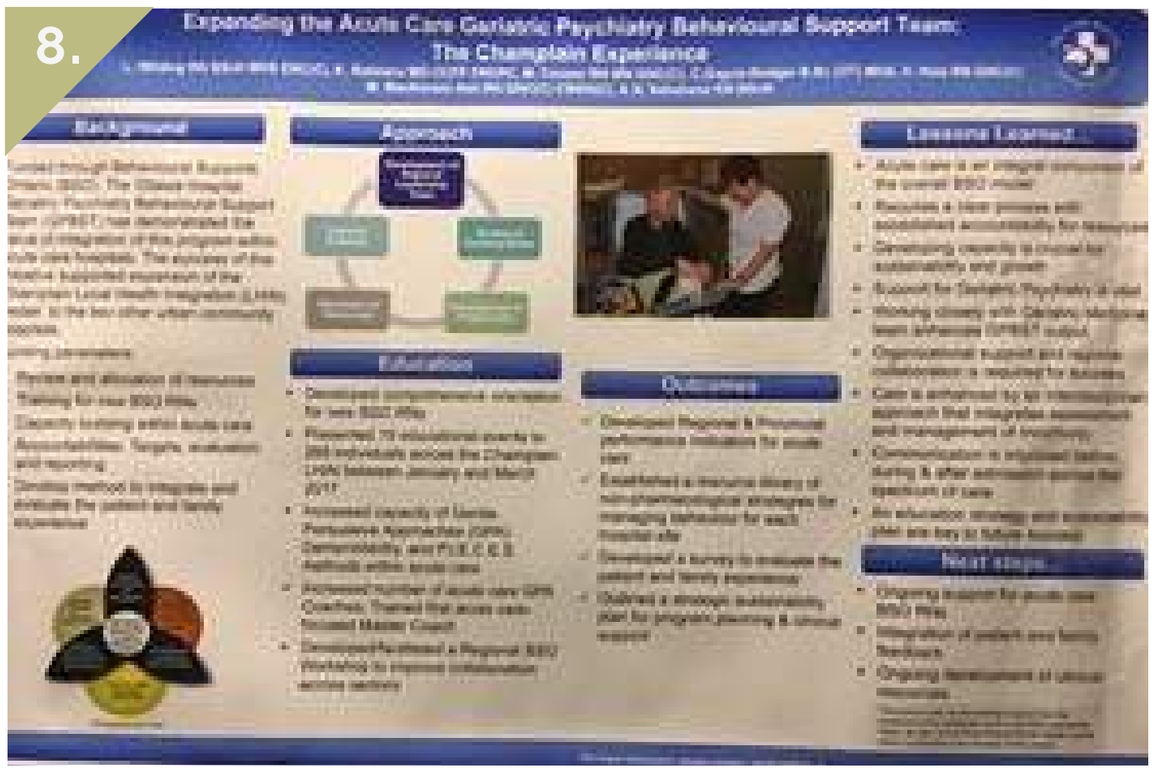


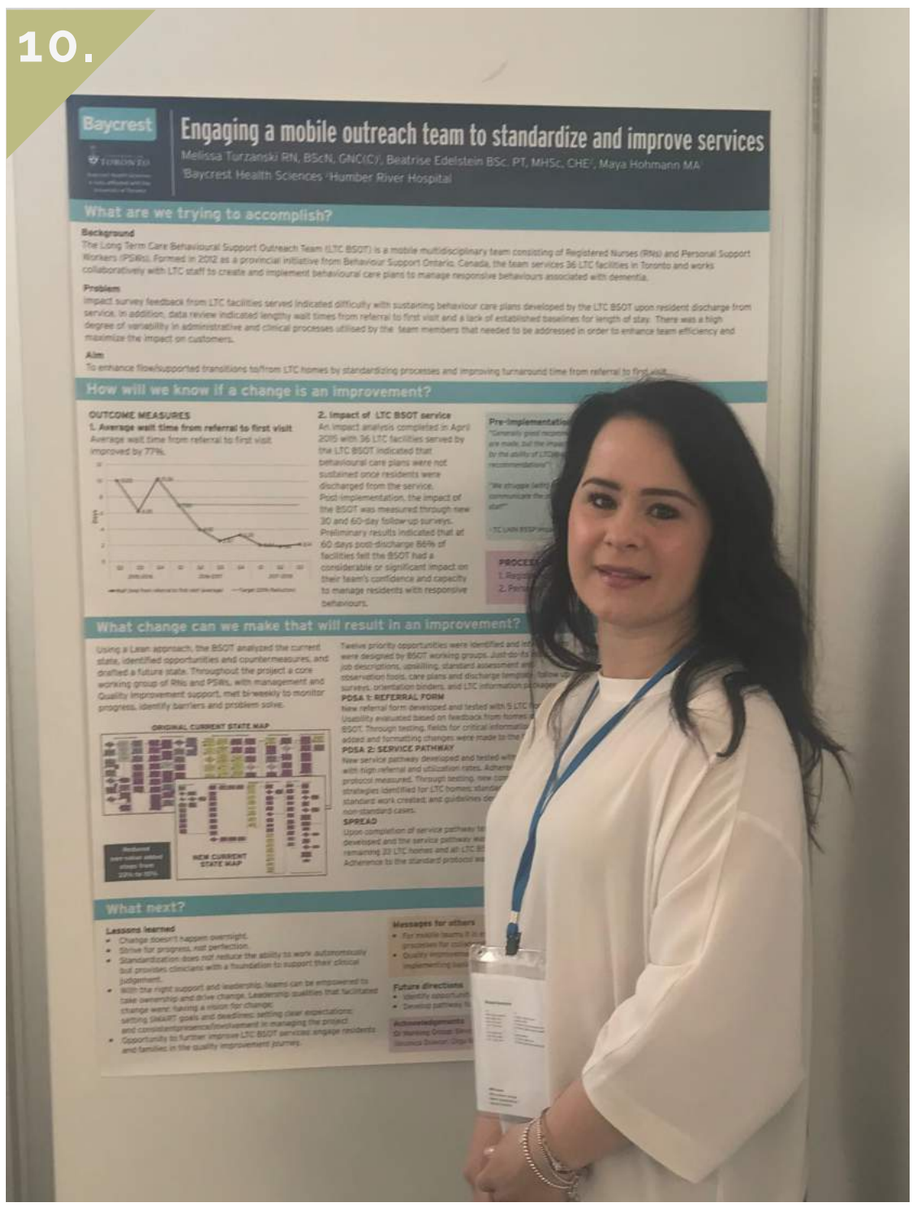
KNOWLEDGE EXCHANGE HIGHLIGHTS

9. Nursing Leadership Network of Ontario Conference. Toronto, ON

Managing Responsive Behaviours in Patients with Cognitive Impairment.
Siemon, J., Glover, T., McBride, M., & Kennedy-Brown, K.K. (March 2018).

10. International Forum for Quality and Safety in Health Care. Amsterdam, Netherlands

Engaging a Mobile Outreach Team to Standardize Services.
Turzanski, M. (April 2018).



11. Canadian Academy of Geriatric Psychiatry Annual Conference Toronto, ON

Geriatric Addictions: Development of a provincial collaborative and the road to creating national guidelines.
Van Bussel, L., White-Campbell, M., Purcell, B., Powell, S., & Conn, D. (November 2017).

12. Alzheimer Society of Ontario First Link Conference Toronto, ON

Effective Care Conferencing
Schneider, K. (March 2018).

MENTAL HEALTH FIRST AID FOR SENIORS

For the last couple of years, the BSO Provincial Coordinating Office has selected primary themes for staff capacity building, in consultation with various partners and stakeholders. This year, the focus was on Mental Health First Aid for Seniors. In collaboration with the Mental Health Commission of Canada, BSO hosted Mental Health First Aid Seniors sessions in the following LHINs: South West, Central, Central East, South East, Champlain and North East. That being said, a number of LHINs were early adopters and had already invested in improving mental health literacy by participating in courses and instructor training prior to this fiscal year.

Mental Health First Aid Seniors trains participants to effectively respond to an emerging mental health problem or crisis, until the situation is resolved or appropriate treatment is found. The course content and resource materials are based on best available evidence and practice guidelines and were developed in consultation with Canadian experts in the field of geriatric psychiatry. The curriculum was developed for the Mental Health Commission of Canada at Trillium Health Partners, a healthcare organizations which priorities seniors' health and wellness.

PARTCIPATING LHINS

- SOUTH WEST
- CENTRAL
- CENTRAL EAST
- SOUTH EAST
- CHAMPLAIN
- NORTH EAST

Mental Health Commission of Canada | Commission de la santé mentale du Canada

Mental Health First Aid Canada

TOPICS COVERED

- Seniors
- Mental Health First Aid
- Substance-related disorders
- Mood-related disorders
- Anxiety and trauma-related disorders
- Dementia
- Delirium
- Psychosis

CRISIS FIRST AID INTERVENTIONS FOR

- Substance overdose
- Suicidial behaviour
- Panic attack
- Acute stress reaction
- Psychotic episode
- Delirium

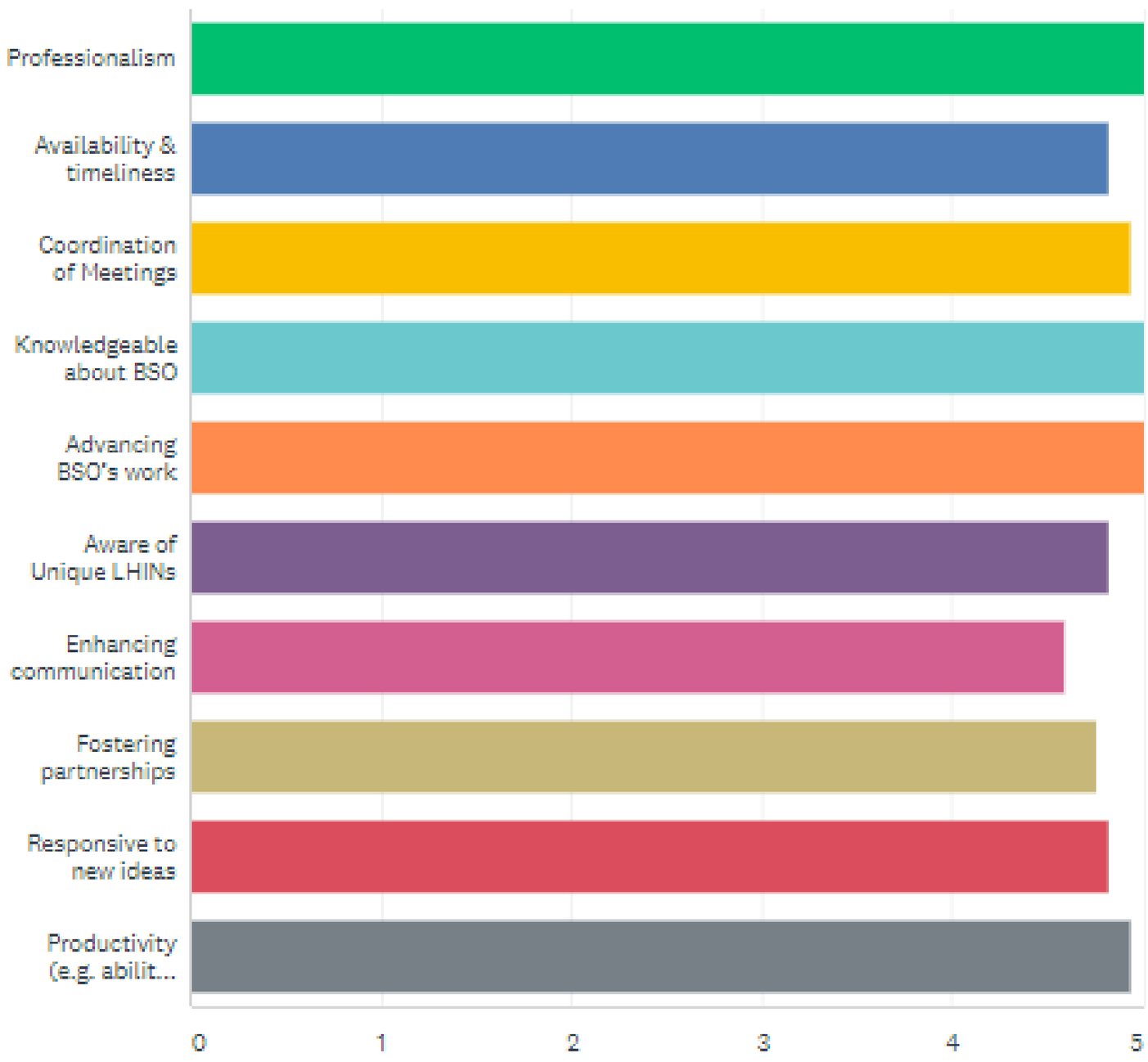
BSO PCO PARTNER FEEDBACK SURVEY

For the third consecutive year, the BSO PCO released a 'BSO PCO Partner Feedback Survey' to the BSO LHIN Leads, Clinical/Strategy Leads and Advisory/Committee/Collaborative/Working Group Co-Chairs. The purpose of the survey is to assist in continuous quality improvement and priority setting for the BSO PCO Team for future years. In answering the survey, respondents were asked to reflect and evaluate their experiences with both interacting and collaborating with the PCO and brainXchange, as well as provide comments on the PCO's strengths and areas for improvement.

This year's survey received a total of 17 responses from BSO LHIN Leads (n=4); BSO Clinical/Strategy Leads (n=8); Advisory/Committee/Collaborative/Working Group Co-Chairs (n=5).

On a scale from 1 (very poor) to 5 (very good), please rate your experience with the Provincial Coordinating Office over the past fiscal year.

Answered: 17 Skipped: 0



Since the re-emergence of the BSO PCO, feedback related to 'overall experience with the BSO PCO' (see table above) has ranged from 4 (good) to 5 (very good) on all categories. Of significance to note in these year's feedback is the fact that improvements were noted for all categories; most notably in 'Coordination of Meetings' and 'Fostering of Partnerships'. Other strengths noted included that all members of the BSO PCO are approachable, well-organized, positive, accessible and collaborative.

BSO PCO PARTNER FEEDBACK SURVEY - continued

In general, it was noted that the BSO PCO provides a 'go-to' central voice for LHINs for all matters concerning BSO, including accessing a variety of resources and disseminating information. When asked to comment on the value of the continued operation of the BSO PCO, respondents provided the following insight into the continued need for a BSO PCO:

"Without the provincial coordinating office, we as LHINs could lose sight of the big picture around care for this complex population. We learn from other LHINs and the PCO keeps us accountable to pay attention to our local work."

"The 'bird's eye view' that PCO brings to BSO programs across the province is invaluable. PCO represents one visible team that is an important liaison between broader provincial programs/ strategies and the individual LHINs. Having the PCO in place has helped provide guidance, organization and cohesion to all LHINs."

"The centralized coordination of the BSO PCO has facilitated and enabled strong partnerships between sectors. It has provided accurate and concise data analysis. It has allowed for standardized communication and consistent messaging regarding the needs of the vulnerable population being served."

"BSO PCO provides integral services in advancing dementia/mental health education across Ontario's health and community care sectors. The support, communication and coordination of committees has been extremely successful."

"Without the coordinating office there would be no centralized coordination of initiatives and models, no central repository for data; no coordinated alignment to Dementia Strategy... This would result in less coordination; connections across LHINs, provincial perspective, integrated efforts etc. It is a necessary investment to sustain and grow the strategy."

"The coordination and organization overall is the greatest asset. The projects and relationships increasing spread of BSO provincially would not be possible without the support of the whole team. We are privileged to have such a dedicated team with diverse skill sets. The team is passionate and continues to work towards quality improvement for our senior residents of Ontario and their care partners living with Dementia and cognitive impairment."

Areas for improvement noted in the survey include increased effort for evaluating BSO across the province, especially in consideration of regional intricacies. One respondent suggested regular quarterly or bi-annual meetings with each LHIN to touch base on local issues and opportunities. In addition, another respondent suggested that it would be helpful to have increased transparency regarding what initiatives will be taken on in the following year and to strengthen relationships between the LHINs.

CONCLUSION

A Sneak Peek into Exciting 2018-19 Funding Announcements

“The news in this years’ budget affirms the good work that all of you are doing.”

David Harvey, Former Chief Program and Public Policy Officer, Alzheimer Society of Ontario

BSO IN LONG-TERM CARE

On April 23, 2018, The Minister of Health and Long-Term Care announced that the Ministry will provide up to $11,634,600 in the 2018-19 funding year for specialized staffing resources in the long-term care (LTC) home sector. This includes $10,000,000 of new base funding for the 2018-19 year for BSO in LTC to supporting the hiring of additional BSO specialized staff.

Local Health Integration Networks (LHINs) have been allocated a proportional share of this total funding to hire additional LTC BSO staffing resources who will provide direct services and interventions to LTC home residents with, or at risk for, responsive behaviours associated with dementia, complex mental health, substance use, and/or other neurological conditions. Inclusive in this mandate are LTC residents with age-related neurocognitive conditions (such as early onset dementia) and support for family and professional care partners.

BSO IN THE COMMUNITY

Year 2 (2018-19) Ontario Dementia Strategy Funding includes $10.48 million for BSO in the Community. This funding will be used for the development of new community-based FTEs to complement BSO services for people living in the community sector, which may include people living in private dwellings, retirement homes, assisted living and supportive housing in addition to those currently receiving healthcare services in acute care, adult day programs/community dementia programs and those accessing respite.

The funding also supports the continuation and delivery of BSO cross-sector resources via central coordination office staffing (i.e., central intake). LHINs have been actively working on the plans in collaboration with partners/stakeholders and enhanced resources should be in play by Fall of 2018.

The future of BSO is looking so bright.
Together, let's continue to cultivate our collective synergies and engage people in achieving endless possibilities!

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