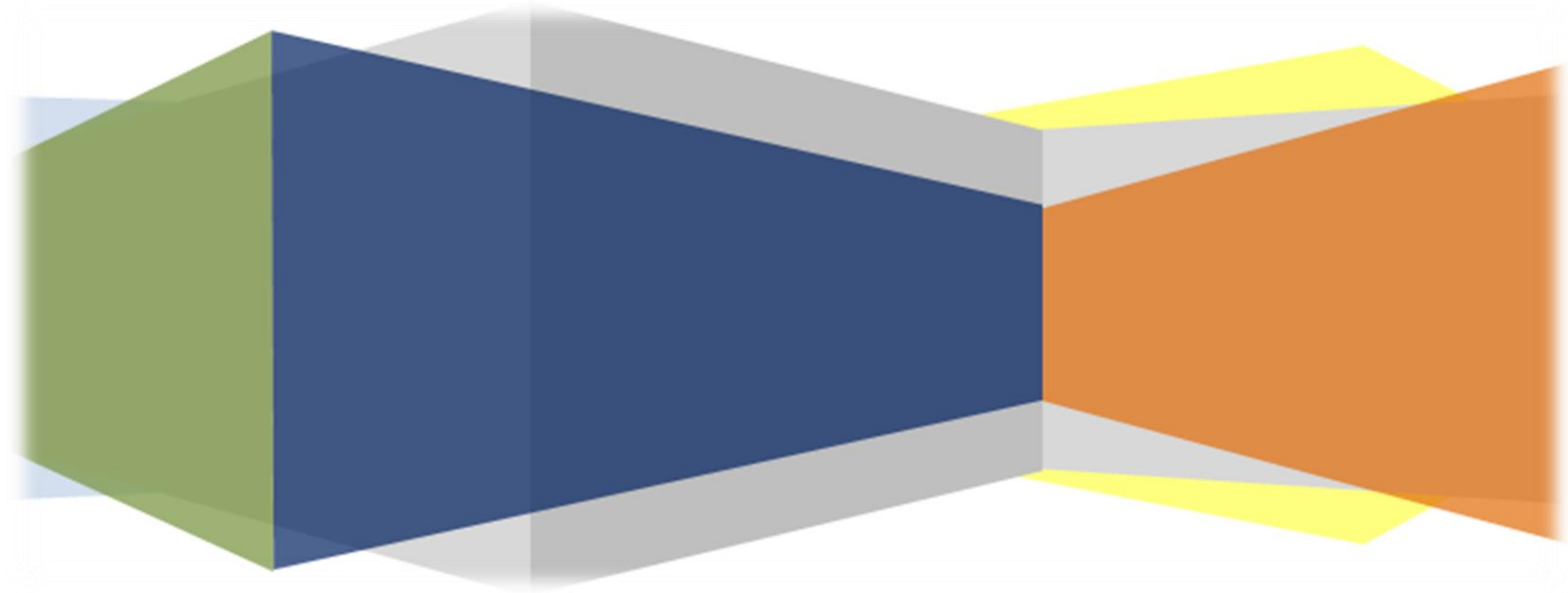
Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Behavioural Supports Ontario Provincial Coordinating Office

Annual Report

2015-16



brainXchange

North Bay Regional Health Centre
Centre régional de santé de North Bay

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

Message from the Provincial BSO Coordinating Office Team

Welcome

(From left to right): **Katelynn Viau** (Project Coordinator), **Monica Bretzlaff** (Manager) & **Debbie Hewitt Colborne** (Project Coordinator Advisor). *Not pictured:* **Tina Kalviainen** (Project Assistant – returning in November 2016)

The Behavioural Supports Ontario (BSO) Provincial Coordinating Office (PCO) welcomes you to our first annual report as a re-emerged provincial coordinating body for the BSO initiative. The following document portrays numerous accomplishments made across each of the Local Health Integration Network (LHIN)'s BSO initiatives and at the PCO over what has truly been an exciting year of collaboration, communication and construct.

Significant strides continue to be made in enhancing the behavioural healthcare system for patients and families supported by BSO; all while the number of individuals requiring BSO support continues to grow across all sectors. Despite challenges in meeting growing demand, BSO provincial partners consistently work together to improve system coordination, deliver excellent integrated care and enhance knowledge and capacity across sectors. Pivotal to all of this work has been our ongoing commitment to person and family-centred care, as informed by individuals with lived experience. As we move into 2016-17, we are eager to focus on BSO impact, innovation and integration – three themes collectively identified as paramount areas of focus to promote the ongoing growth and sustainability of the initiative.

Acknowledgements

The PCO wishes to take this opportunity to express sincere appreciation to the following individuals and groups:

- Our host organization, the North Bay Regional Centre, for your support of the BSO PCO
- Triple-LHIN Advisory: Donna Cripps, Louise Paquette, Terry Tilleczek, Jill Tettmann; and Dr. Ken LeClair and David Harvey for your valuable leadership
- BSO Steering Committee Members for your ongoing dedication and guidance
- BSO Lived Experience Advisory for your wisdom and perspectives which lead to new thinking
- BSO Systems Performance & Evaluation Advisory for your commitment to finding ways to measure BSO impact and success
- BSO Strategy Leads and BSO LHIN Leads for your collaboration and passion for excellent care for older adults across the continuum of care
- brainXchange – for being our primary collaborators without whom the Ontario Best Practice Exchange would not be where it is today
- Our many other partners and provincial organizations with whom new collaborations have been initiated and solidified

Thank you!

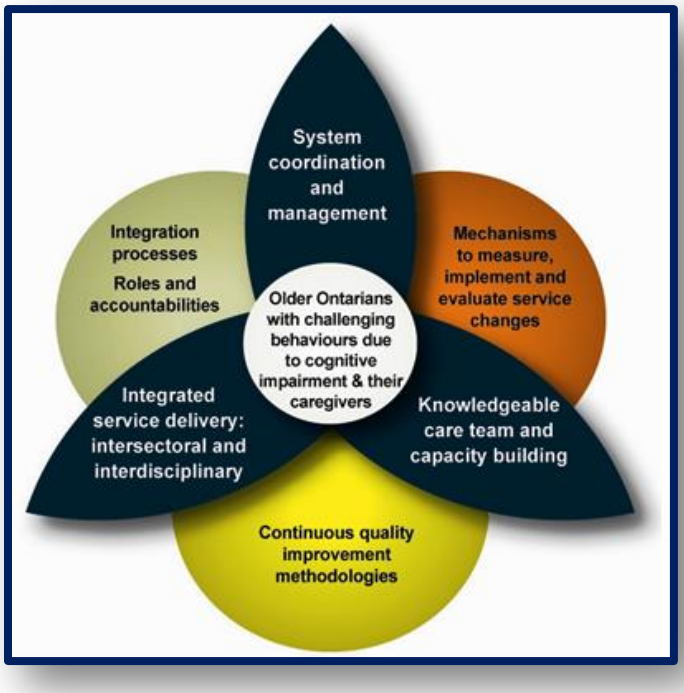
Behavioural Supports Ontario Provincial Coordinating Office Annual Report

April 1, 2015 – March 31, 2016

Introduction

From April 2015 to March 2016, the Behavioural Supports Ontario (BSO) initiative continued to make significant achievements in the enhancement of the behavioural support system for older Ontarians presenting with responsive behaviours. The following annual report collectively demonstrates accomplishments carried out by all 14 BSO initiatives and the BSO Provincial Coordinating Office (PCO). It also includes an overview of next steps to support the continued growth and evaluation of BSO.

During the 2015-16 fiscal year, each of the LHINs focused on continuing and expanding upon their goals originally outlined in their BSO Action and Sustainability plans. Provincial Activity Tracking continued using a revised list of metrics developed by the Activity Tracking Working Group and BSO Websites were launched in collaboration with the Ontario Association of Community Care Access Centres (OACCAC) and *thehealthline.ca* Information Network. Over the course of the year, the initiatives have made significant strides in knowledge and capacity enhancement which became evident by the growing mainstream implementation of BSO best practice strategies and tools across the sectors. BSO team-supported transitions to enhance care across the continuum also played a major role in improving overall system coordination and enhancing the patient and family experience. Such innovations percolated into a knowledge exchange opportunity occurring in March 2016 whereby such stories were brought to life; many of which incorporated into this report.



To actualize significant patient-family and system impact requires inclusive advancement of BSO's three Pillars: I) System coordination and management; II) Integrated service delivery: Intersectoral and interdisciplinary; and III) Knowledgeable care team and capacity building.

Re-Emergence of a Provincial Coordinating Office (PCO)

The beginning of the fiscal year was met with a provincial announcement – the re-emergence of a BSO PCO. Following an endorsement from the LHIN CEOs, Donna Cripps (CEO, HNHB LHIN) announced that a single provider had been funded to oversee a set of provincial BSO objectives and that the North Bay Regional Health Centre was selected as the lead agency. The BSO PCO is funded by three LHINs (Hamilton Niagara Haldimand Brant, North East and North Simcoe Muskoka) and was provided with the following list of objectives for 2015-2017:

1. To collect activity tracking information and share it with the LHINs and with the MOHLTC
2. To collate legacy indicators and share the results with the LHINs and the MOHLTC
3. To develop collaboratives for the purpose of sharing innovative practices across the continuum of care and identify promising practices to providers throughout Ontario
4. To prepare a short summary report annually that provides a snapshot of each LHIN's BSO achievements
5. To work with the Alzheimer Society of Ontario and other provincial associations, in a collaborative way, to better the care for people experiencing responsive behaviours

The BSO PCO Team was hired as of June 11, 2015 and is comprised of 1.7 FTEs in addition to a 0.5 FTE stipend which is provided to support the work of its primary collaborators – brainXchange. The following graphic illustrates the Provincial BSO structure:

FIGURE 1: Provincial BSO Structure (2015-17)

Triple LHIN Senior Advisory

The BSO Triple LHIN Senior Advisory is comprised of senior-level representation from the three BSO PCO funding LHINs: Hamilton Niagara Haldimand Brant, North Simcoe Muskoka and North East. The advisory meets on a bi-annual basis with the BSO PCO to discuss the current state of the initiative and to provide direction on the work of the other provincial BSO Advisories and various projects.

(From left to right): **Terry Tilleczek** (Senior Director, Policy and Health System Planning, North East LHIN); **Louise Paquette** (Chief Executive Officer, North East LHIN); **Donna Cripps** (Chief Executive Officer, Hamilton Niagara Haldimand Brant LHIN); and **Jill Tettmann** (Chief Executive Officer, North Simcoe Muskoka LHIN)

Steering Committee

SEP 8

The Provincial BSO Steering Committee launched in September 2015 with the purpose of advising and guiding the accountability structure for BSO. The committee meets on a quarterly basis and brings together key thought leaders from stakeholder organizations across the province such as: the Alzheimer Society of Ontario, Health Quality Ontario, Ontario Community Support Association, Murray Alzheimer Research and Education Program, Community Care Access Centre and Ontario Long-Term Care Association. This committee is co-chaired by Donna Cripps (CEO, HNHB LHIN) and Cathy Hecimovich (CEO, CW CCAC), with David Harvey (Chief Public Policy and Program Initiatives Officer, Alzheimer Society of Ontario) as alternate co-chair. This past year, the committee finalized its Terms of Reference and welcomed presentations from the following sectors: long-term care, community, behavioural support transition units and acute care. The committee also engaged with Health Quality Ontario to discuss the development of Quality Standards for individuals living with dementia in long-term care and the MOHLTC on the ongoing development of the Ontario Dementia Strategy. Logistical and clinical support for this committee is provided by the BSO PCO.

Operations Committee

The BSO Operations Committee (comprised of BSO Clinical/Strategy Leads, BSO LHIN Leads and brainXchange) continues to meet on a bi-monthly basis. These meetings are organized and supported by the PCO and co-chaired by Monica Bretzlaff (Provincial BSO Manager & NE BSO Manager) and Christine Walter (Program Evaluation Coordinator, Champlain LHIN).This year, the committee welcomed presentations from: the MOHLTC Health Analytics Branch (BSO Legacy Indicator), Health Quality Ontario (Development of Quality Standards for

Behavioural Symptoms of Dementia), MOHLTC Capacity Planning and Priorities Branch (Ontario Dementia Strategy), etc., and discussed the ongoing development of projects such as the BSO websites, activity tracking and the Ontario Best Practice Exchange, all of which are included in this report.

Following an Operations Meeting virtual roundtable with the BSO LHIN Leads, a project was initiated to enhance collaboration across members of the Operations Committee. This initiative was led by Michelle Collins (Senior Lead, Health System Performance, Mississauga Halton LHIN) and Kirsten Farago (Long-Term Care Officer, Policy and Health System Planning, North East LHIN). This project aimed to better define the role of the BSO LHIN Leads on the Operations Committee and identify ways to optimize their presence at meetings. The first change involved a reorganization of the meeting agenda, whereby essential updates are provided in the first hour followed by an open discussion with the BSO LHIN leads.

Secondly, Michelle Collins and Kirsten Farago organized an in-person event in collaboration with the BSO PCO, sponsored by the *Alzheimer Society of Peel*, which brought together the BSO LHIN Leads, BSO Clinical/Strategy Leads and other key stakeholders (e.g., MOHLTC Capacity Planning and Priorities Branch & MOHLTC Licensing and Policy Branch) to discuss the current state of BSO models and gain insight into the development of the Ontario Dementia Strategy. This dynamic event took place on March 23, 2016 and had representation from each of the 14 LHINs. The value of bringing all 14 LHINs together to discuss model evolutions and overall BSO innovations was emphasized along with the need to continue to support the ongoing development of the Ontario Dementia Strategy.

Systems Performance & Evaluation Advisory

DEC 4

The BSO Systems Performance & Evaluation Advisory launched in December 2015 and was established to inform the ongoing measurement and evaluation of BSO activities and outcomes. Members of the committee include representation from the MOHLTC Health Analytics Branch, Alzheimer Society of Ontario and various BSO Clinical/Strategy Leads and BSO LHIN Leads, some of which were past members of the Activity Tracker Working Group. This advisory is co-chaired by Jonathan Lam (Manager, Health System Performance, Health Quality Ontario) and Shirley Sabovitch (Quality Improvement Facilitator, Central East BSO). Thus far, this group has defined its Terms of Reference and has engaged with the MOHLTC Health Analytics Branch and other organizations to begin to discuss possible evaluation strategies for the BSO initiative (see **Measuring BSO Impact & Legacy Measure Project**). Logistical and data/systems support for this committee is provided by the BSO PCO.

Knowledge Translation & Communications Advisory

MAY 6

The Knowledge Translation & Communications Advisory is currently under development with an anticipated launch date of May 6, 2016. The purpose of the Advisory will be: 1) to create a venue for knowledge exchange; 2) to support and foster the work of the Ontario Best Practice Exchange Collaboratives (see **Ontario Best Practice Exchange**); 3) to guide, assist, promote and enable knowledge translation of emerging and best practices; and 4) to identify and enhance BSO communication strategies with care partners across sectors.

Members of this advisory will include provincial leaders, people with lived experience and experts in the fields of education, capacity building, knowledge translation and/or communications.

Lived Experience Advisory

NOV
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The BSO Lived Experience Advisory launched in November 2015 and is a product of the Ontario Best Practice Exchange Person & Family-Centred Care Collaborative. Similar to previously established Regional Lived Experience Advisories in the North East LHIN & South East LHIN, the advisory brings together individuals diagnosed with dementia, mental illness, substance use and/or other neurological disorders and their care partners to bring ideas rooted in lived experience to the forefront and inform various activities related to BSO. In its first phase, the advisory was tasked to review the product outcomes from the September 25, 2015 Catalyst Event (see **Ontario Best Practice Exchange**) and assist in the determination of which three Collaboratives to accelerate forward. The advisory was also instrumental in informing the overall content of the BSO websites. In the coming months, this advisory will focus on methods by which to enhance system navigation and tools that best support the promotion of personhood. Logistical support for this committee is provided by the BSO PCO.

South East BSO Lived Experience Network Coordinator, **Sharon Osvald** and her **mother**

Central East (Durham) Community of Practice event participants review the new swim lane process map.

North Simcoe Muskoka Community BSO Team lead group in Laughter Yoga Session

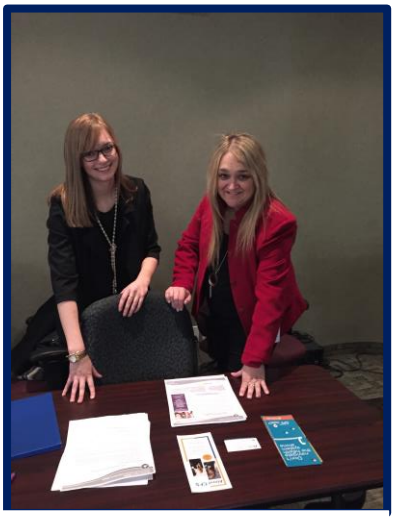
Strategic Objectives 1 & 2:
(1) Collect and report activity tracking information to share with the LHINs and MOHLTC; and (2) Collate legacy indicators and share the results with the LHINs & MOHLTC

Q1-Q4 Activity Tracker Data Highlights

Throughout the fiscal year, all 14 LHINs submitted their quarterly activity tracker data to be collated by the PCO prior to submission to the MOHLTC. The 2015-16 list of revised activity tracker metrics developed by the Activity Tracker Working Group (ATWG) included amendments such as the separation of BSO patients/families being supported by LTC BSO Teams from those supported by Community or Cross-Sector Teams and introduced metrics to capture BSO team-supported transitions.

BSO Teams across Sectors

While the models under which BSO initiatives operate differ across the province, there are four basic types of BSO teams **(See Appendix A)**. The following section provides an overview of the number of referrals received and patients/families served by each LHIN followed by the number of referrals received and patients/families served by BSO team type.



Hamilton Niagara Haldimand Brant's **Jennifer Siemon** (BSO Coordinator) and **Jocelyne Lebel** (BSO Connect) facilitate a BSO Integrated Community Lead Event in Hamilton where over forty front-line staff and managers from community service support agencies discussed how to collaborate and integrate their work to support BSO patients and their families living in the community.

Waterloo Wellington's LTC BSO 'Dining Room Noise Reduction' Project Team

TABLE 1: Total # of Referrals and Average # of Patients/Families supported by BSO across Sectors by LHIN (2015-16 Totals)

Metric	ESC	SW	WW	HNHB	CW	MH	TC	CEN	CE	SE	CHA	NSM	NE	NW	TOTAL
Total # of Referrals Across Sectors	2,170	4,423	1,485	5,983	1,501	2,693[a]	1,088	1,271	7,538	342[b]	2,408	485	1,711	194	**33,292**
Average # of Patients/ Families Supported each quarter across sectors	2,005	4,350	1,045	1,472[c]	1,530	4,769	236	369	3,633	117[d]	1,189	115	1,949	268	**23,047**

[a] Does not include total # of referrals to BSO Community Teams
[b] Does not include total # of referrals to BSO Community Teams
[c] Does not include patients carried over from previous quarters
[d] Does not include any patients supported by BSO Community Teams

TABLE 2: Total # of Referrals and Average # of Patients/Families supported by BSO Team Type (2015-16 Fiscal Totals)

BSO Team Type	# of LHINs submitting data	# FTEs			# of referrals	% of total referrals	*Average # of patients/ families supported each quarter	*Average % of total patients/ families supported each quarter
		BSO Funding	LHIN Leveraged	Total				
Long-Term Care Teams (i.e., mobile & embedded)	14	430.33	29.7	460.03	21,803	65.5%	**12,707**	**55.1%**
Cross-Sector Teams	3	21.8	13.2	35	1,648	4.9%	**1,582**	**6.9%**
Community Teams	11	74.35	79.65	154	9,841	29.6%	**8,758**	**38%**
TOTAL	-	526.48	122.55	649.03	33,292	100%	**23,047**	**100%**

* As the majority of the LHINs carry patients over from previous quarters to calculate the 'Total # of patients/families served' (i.e., active caseload) each quarter, it is not possible to obtain a total number of unique patients/families served for the fiscal year. In addition, not all LHINs count patient's family members separately.

Across the province, the BSO initiative received 33,292 referrals across sectors in 2015-16, with the majority (21,803; 65.5%) being triaged to BSO teams in LTC. A total of 9,841 patients/families were referred to BSO Community teams (29.6%) while the three LHINs with cross-sector teams received 1,648 new referrals, making up 4.9% of total referrals received. Each quarter, the 14 initiatives supported an average of 23,047 patients and families. LTC BSO Teams supported an average of 12,707 patients and families (55.1% of total # of patients/families supported) each quarter with 460.03 Full-Time Equivalent Employees (FTEs). BSO Community Teams supported an average of 8,758 patients and families each quarter (38% of total patients/families supported) with 154 FTEs. An additional 1,582 patients/families were supported each quarter by BSO cross-sector teams (6.9% of total patients/families supported) which were staffed by 35 FTEs. Caseloads of BSO Teams vary across sectors with LTC Staff supporting an average of 28 patients each and Cross-Sector Staff supporting an average of 45 patients each. Community BSO Staff support an average caseload of 57 patients each which speaks to the increasingly growing needs in this sector.

Across all BSO Teams, a total of 375,224 patient/family based services were delivered in addition to 143,659 patient-based services where a follow-up and review of outcomes occurred. A total of 147,974 provider-based services were delivered, whereby indirect support to BSO patients/families was provided through interactions and interventions between BSO teams and other health care providers.

Toronto Central's Transitional Behavioural Support Unit staff huddle and prepare for SBAR *(Situation, Background, Assessment, Recommendation)* reporting

As part of the revisions made to the 2015-16 activity tracker, the ATWG introduced 3 metrics to assist in beginning to capture BSO team supported transitions across the continuum. The three metrics are: 1) total # of transitions from acute to LTC; 2) total # of transitions from community (including private dwellings, retirement homes, supportive housing, etc.) to LTC; and 3) total # of transitions from community, LTC or acute care to tertiary mental health beds. BSO teams may support transitions in a variety of ways, including but not limited to the following activities: sharing of relevant documentation (e.g., behavioural assessments, care plans, etc.); organizing of and/or participating in a care conference(s) including various service providers and/or family members to discuss patient's responsive behaviours, care strategies and the transition process; developing transitional behavioural care plan(s) to assist LTC staff receiving patients from the acute sectors; coaching/training of staff specifically regarding patient's behavioural care plan prior to transition and/or during the transition; and/or following-up with LTC staff following the transition to discuss patient's status and provide ongoing coaching/training as required.

As these metrics were new to the activity tracker, approximately half of the LHINs were able to develop regional mechanisms and/or enhance their current data collection processes to be able to collect this information. By the end of the 2015-16 fiscal year, 7 LHINs were able to submit the first two transitions metrics with the third being submitted by 8 LHINs **(see Table 3)**. Overall, a total of 3,084 transitions were captured on the BSO Activity Tracker over the 2015-16 fiscal year.

TABLE 3: Total # of BSO Team-Supported Transitions (2015/16 Fiscal Totals)

Transitions Metric	# of LHINs submitting	# of transitions
total # of BSO team-supported transitions from acute to LTC	7	865
Total # of BSO team-supported transitions from community (including private dwellings, retirement homes, supportive housing, etc.) to LTC	7	1,841
Total # of BSO team-supported transitions from community, LTC or acute care to tertiary mental health beds	8	378
TOTAL:	**-**	**3,084**

Qualitative Story Framework and Emerging Themes

One of the other major changes made to the BSO Activity Tracker by the ATWG was the re-emergence of the collection of BSO qualitative stories on a quarterly basis. As many BSO successes are best depicted through a qualitative lens, the ATWG and PCO asked each LHIN to submit 1-2 qualitative stories each quarter along with their quantitative activity tracker data submissions. Using the primary themes extracted from the qualitative story submissions submitted by each of the LHINs in Q1 (2015-16), the PCO developed a Qualitative Story Framework which lists the most common themes found in BSO qualitative stories and how they align with of the three each BSO pillars **(see Figure 2)**.

The most common themes found in the 2015-16 qualitative stories were: (1) Non-Pharmacological Strategies and Interventions; (2) Interprofessional/ Intersectoral Collaboration; (3) Capacity Building; and (4) Transitions **(See Table 4)**.

Other themes that emerged from the stories that were not included in the 2015-16 Framework included: (1) Understanding Behaviour; (2) Personhood; and (3) Care Partner Engagement. These themes will be incorporated into the revised Qualitative Stories Framework for 2016-17.

A total of 75 qualitative stories were collected and shared with the MOHLTC.

FIGURE 2: BSO Qualitative Story Framework 2015-16

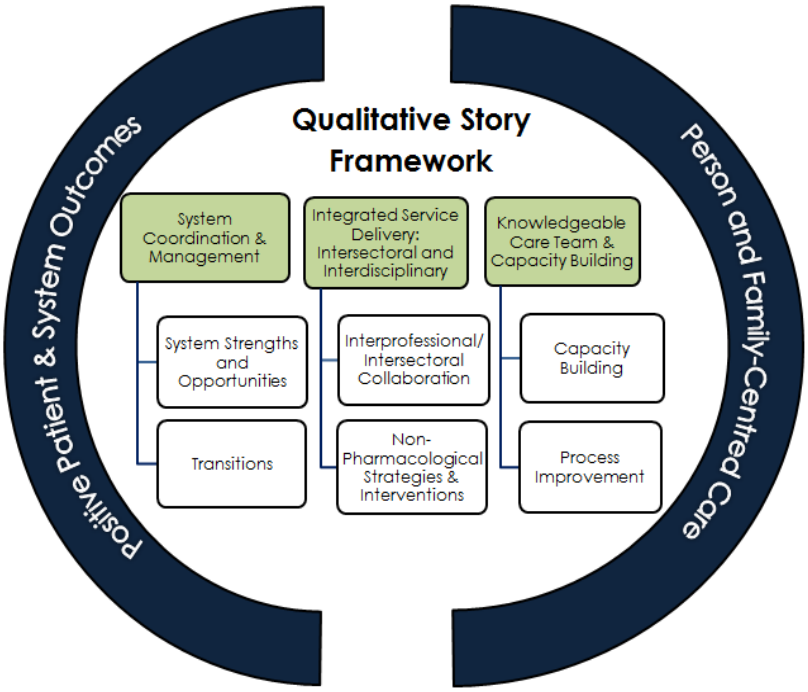


TABLE 4: Qualitative Story Submissions & Themes 2015-16

Theme	Q1	Q2	Q3	Q4	Total (themes)
System Strengths and Opportunities	3	3	2	1	**9**
Transitions	6	4	5	10	**25**
Interprofessional/Intersectoral Collaboration	3	6	12	18	**39**
Non-pharmacological Strategies and Interventions	15	7	16	12	**50**
Capacity-Building	-	7	13	11	**31**
Process Improvement	2	3	1	-	**6**
Total (Submissions)	18	15	22	20	**75**

Activity Tracker Refresh Project

The BSO PCO worked closely with the MOHLTC Licensing and Policy Branch to revise the provincial activity tracker for BSO from July 2015 – February 2016. The purpose of the BSO Activity Tracker is to collect information that highlights both the context and environment in which BSO models operate across the province and capture the overall growth and spread of the initiative.

A decision was made to re-format the activity tracker based on the 3 BSO pillars: I) System Coordination and Management; II) Integrated Service Delivery: Intersectoral and Interdisciplinary; and III) Knowledgeable Care Team and Capacity Building. The ability to capture BSO Health Human Resources and describe how individuals are able to access BSO services in each of the LHINs was emphasized, along with the need to capture the number of care partners being supported by the initiative. Metrics aimed at collecting the number of training sessions delivered to enhance knowledge and capacity among professional care providers were also re-instated. The MOHLTC Licensing and Policy Branch consulted with the MOHLTC Home and Community Branch for further insight into the community-related data elements. Subsequently, a decision was made to separate BSO patients by sector, rather than by which team they were being supported by. The following three metrics were removed from the activity tracker: 1) Total number of patient-based services delivered; 2) Total number of patient-based services where a follow-up and review of outcomes occurred; and 3) Total number of provider-based services delivered. Additionally, the Behavioural Support Transition Unit metrics were revised to align with the Specialized Unit Annual Reporting already in place.

The refreshed activity tracker will be launched for Q1 (2016-17) and reassessed on an annual basis.

Measuring BSO Impact & Legacy Measure Project

Following a presentation at the inaugural BSO Systems Performance & Evaluation Advisory meeting from the MOHLTC Health Analytics Branch, the advisory began to strategize how to best move forward with measuring BSO impact. The advisory first recognized that the BSO Legacy Measure – change in behavioural symptoms among Long Term Care Home (LTCH) residents, is helpful, yet limited by its sector specificity (i.e., excludes BSO patients outside of LTC) and current inability to identify BSO patients among all LTC residents. As such, the advisory began to focus on possible project options that could assist in truly determining BSO's impact across sectors. In order to do so, the advisory engaged with Dr. John Hirdes (Senior Canadian Fellow, interRAI and Professor, University of Waterloo) to begin discussing project options as well as exploring how other similar programs and initiatives have measured their impact without the availability of program flags/identifiers in current health data systems. Concurrently, the MOHLTC Health Analytics Branch is retrieving the BSO Legacy Measure (which captures all LTC residents) for both the 2014-15 and 2015-16 fiscal years. Upon receiving the data in August 2016, the PCO will search for trends and share the data with relevant stakeholders.

Highlighting each LHIN's Achievements

The following section details each LHIN's primary achievements related to BSO over the 2015-16 fiscal year. Each LHIN was also asked to select both provincial and regional (if available) metrics to highlight and include a qualitative story from the past year.

1: Erie St. Clair (ESC) 2015-16 Highlights

Initiatives/Programs/Achievements

Responsive Behaviour Roadmap and Behaviour Assessment Checklist: Implemented to assist LTC staff to quickly and efficiently identify, assess and support a patient presenting with responsive behaviours and provide a clear step-by-step path. Education has been created and provided to LTCHs about utilization of this document and its completion is required for making a referral to BSO. This document has successfully been added to *Point Click Care* systems in multiple LTCHs.

LHIN-Wide Review of the BSO Strategy: The BSO strategy review was an excellent opportunity to analyze successes and gaps in our program and address them with a clear focus on improving our patient experience.

Increase in LTC, Hospital and Partner Rapport: Accomplished through increased communication and connection with BSO teams and the Regional Coordinator as well as through participation in the BSO review process. This included continued broadening of BSO partnerships, such as a special needs working group, a community vulnerable population identification/support group and ongoing engagement with criminal justice system partners. This has also been reflected in more successful and positive transitions between LTC, hospital and community.

Staff Retention and the Addition of a Nurse Practitioner Role in Chatham Kent: Retention rate of core BSO staff has been very high, resulting in consistent and knowledgeable care.

High Reporting Compliance by BSO Internal Champions: BSO internal champions reached 100% reporting compliance.

Qualitative Story

Description: P.Z. is a 75-year old man with four supportive children. This resident had an extensive stay at the hospital prior to being admitted to the LTCH on 03/03/2016. Dementia unspecified and ABI were among his admitting diagnoses. BSO Lead Team had first seen this resident on 03/04/2016 while at the LTCH. Staff in the LTCH documented 37 physically responsive episodes over the 3 weeks Mr. Z was in their home involving 24 staff members. A care conference was held 03/16/2016 at the LTCH. On 04/30/2016, an educational/informational session was held on the unit of the LTCH, led by a BSO PRC and the Team Lead. During this time, it was discovered that there had been medication changes that had occurred at the hospital prior to admission to LTCH. Upon further investigation into hospital records, it appeared that these changes had been made 2 days prior to his discharge from the hospital as he was exhibiting signs of possible extrapyramidal symptoms and his behaviours appeared to be escalating.

Impact: The patient was readmitted into the hospital on 04/04/2016 for stabilization. The BSO PRC advocated for readmission to the hospital with support from the RN from the hospital based on the above mentioned concerns. In addition to the advocacy, the BSO PRC supported the transition and acted as the communication lead throughout this process. The hope is that this man will be able to return to the LTCH, keeping in mind that his bed will only be held for 60 days.

Lessons Learned: LTCHs need to request care plans from hospitals in order for progress continue in the new environment. BSO is in an optimal position to support this communication and transition process. Communication continues between BSO (in this case, the PRC) and the hospital regarding progress made and plans for discharge.

Quotes: "I am a unique individual, worthy of respect, dignity and quality care"

Highlighted Metrics	
Provincial Activity Tracker	**Regional Activity Tracker**
• Average # of patients/families supported each quarter in LTC: **1,656** • Total # of referrals to LTC BSO Teams: **1,607** • Total # of patient and/or family-based services delivered in LTC: **51,148**	• Total # of structured learning events delivered by the Regional Education Coordinator: **78** • Total # of participants trained by the Regional Education Coordinator: **880**

2: South West (SW) 2015-16 Highlights

Initiatives/Programs/Achievements

Geriatric Cooperative Evaluation: To promote inter-sectoral collaboration, Geriatric Cooperatives were developed in the South West Local Health Integration Network (LHIN) (four in 2012 and an additional one in 2015). The Geriatric Cooperatives mandate is to build upon local capacity, to plan for the provision of services to older adults with responsive behaviours (RBs) and, in their advisory capacity, promote care provider skill capacity building. First evaluated in 2012, and then again in 2015 using the Partnership Self-Assessment Tool, developed by Center for the Advancement of Collaborative Strategies in Health (http://tinyurl.com/hypdejq) the findings suggest that the Cooperatives have remained in the "work zone" in all areas evaluated by the tool (synergy, leadership, efficiency, administration and management, and sufficiency of resources). Results have been used to identify partnership needs (e.g., an orientation manual for new Cooperative members) and to tailor end-of-meeting evaluations.

LTC Quality Improvement Strategy: In partnership with the Enhanced Psychogeriatric Resource Consultants (EPRCs), the BSO Program Team created a P.I.E.C.E.S.™ -based assessment tool that will be completed by the Long-Term Care Home (LTCH) BSO embedded staff prior to a visit by the South West BSO Mobile Team. To assist with the onboarding of new members, a LTCH BSO Embedded Staff Orientation binder was created and shared with all 79 homes. Ongoing formal /informal educational opportunities have been provided to front-line LTCH staff and leaders. The annual LTCH collaboration event brings together BSO champions from across the LHIN promoting peer-to-peer learning and sharing of best practices.

Special Projects: A number of reports that will guide future BSO work were accepted by the local BSO Steering Committee including a South West LHIN Dementia Strategy and a South West LHIN Addictions Strategy. Building on the monies invested in OTN units across the LHIN, the OTN optimization project developed key resource tools now posted on *HealthChat.* Seven outreach clinicians were trained in Problem Solving Therapy, enhancing community accessibility to a psychotherapeutic modality. Members of a LHIN-wide advisory group will be submitting a proposal to the MOHLTC that will request official Behavioural Support Unit designation for an existing specialized care unit as well as the development of additional units. As part of this multi-phase project, working group members visited and interviewed homes interested in housing a BSU. In partnership with local *Health Links* leads, the BSO Operations team provided a workshop to Huron/Perth community participants on how to interview older adults with responsive behaviours (inclusive of dementia and mental health). Primary care capacity to provide exemplary care to older adults with responsive behaviours was enhanced. Twenty-one physicians attended "BPSD: Applying the P.I.E.C.E.S.™ Framework." Another initiative within the long term care home sector supported environmental enhancements targeted to reduce responsive behaviours such as painted wall murals to disguise exits and to create calming scenes.

HealthChat Enhancements and BSO Mini-Sites Updates: In an effort to promote a culture of measurement and accountability, enhancements have been made to the South West BSO *HealthChat* platform, the data submission platform currently being used by the 100 BSO-involved agencies. As well, the mini-sites project website content was reviewed by the local Steering Committee, who look forward to sharing the information with future clients.

Qualitative Story

Description: An older male living in a LTCH who struggled with communication difficulties was frustrated by these challenges. When distressed, he tended to call out to staff. The South West BSO mobile team implemented communication strategies (e.g. use of whiteboards, gestures, visual cues) that enabled him to effectively communicate his needs and to have further control over his care decisions. These strategies have led to a decrease in RBs including fewer daily vocalizations (>10/day) to almost none (0-1/day).

Impact: Through improved awareness of the resident's mental health needs, care was improved by managing RBs which contributed to an increased quality of life for the patient.

Highlighted Metrics	
Provincial Activity Tracker	**Regional Activity Tracker**
• Total # of referrals to BSO Teams across sectors (LTC & Community): **4,423**	• Total # of discharges for both BSO LTC and Community: **3,531** • Total # of BSO Overnight stays provided by Adult Day Program: **1,541**

3: Waterloo Wellington 2015-16 Highlights

Initiatives/Programs/Achievements

BSO Collaboration Day: Event was attended by 35 of 36 LTCHs, the Community Responsive Behaviour Team, and other Specialized Geriatric Services Team members. This event highlighted the value of partnerships and work toward integration of services.
Geriatric Addictions: In order to build capacity in the area of Geriatric Addictions, monthly Ontario Telemedicine Network Geriatric Addictions Rounds were launched in collaboration with the Centre for Addiction and Mental Health. Included in these rounds are educational workshops (e.g. 'Opiates and Older Adults') and consultative services for those working across sectors.
Standardized Behaviour Worksheet: Launched in May/June 2015, the Standardized Behaviour Worksheet provides a consistent approach to understanding and identifying responsive behaviours (RBs) while using the P.I.E.C.E.S. model. This worksheet is now used to support patients transitioning between levels of care (e.g. LTC and hospital).
Primary Care Memory Clinics Partnership: The Community Responsive Behaviour Team is integrated with the memory clinic model across WW as assessors and to provide support to the person and care partner during appointments. The team provides education about RBs to care partners and assists on an ongoing basis (e.g. with care strategies or with system navigation) as needs for formal referrals are identified.
Partnership and Process Improvement: Ongoing collaboration with the Specialized Geriatric Services Centralized Intake Team to increase capacity in providing virtual assessments and triaging to the right service at the right time, including geriatric medicine, psychiatry, community BSO and Memory Clinics (pilot program).

Qualitative Story

Description
Background: Patient is a 95-year-old man with moderate Alzheimer's Dementia living alone in his home and supported by his two daughters who visit on weekends as well as a supportive tenant living in the basement. The patient felt strongly toward staying in his home and there was significant concern that he may become agitated during a possible transition to LTC. The patient would often call family multiple times a day expressing anxiety and confusion.
Intervention: The patient was gradually introduced to an adult day program (ADP) which provided socialization, a nutritious meal, and much needed routine. A LTC application was initiated and was linked to the same building as the client's day program. The BSO team was involved to help address resistance to supports and build positive associations with LTC by touring and receiving positive feedback from other residents. The BSO Community, BSO LTC, family, a close friend and ADP staff met in advance of the transition to develop a transition day plan.
Impact: Patient transitioned successfully into his LTCH and family reported feeling great relief knowing that their father was in a safe environment with caring staff. The family also reported a significant reduction in the number of phone calls received expressing anxiety and confusion.
Lessons Learned: There is great power in building upon a patient's existing daily routines. There are also great benefits to close communication and planning across sectors and maintaining a patient-centred strength based approach.

Highlighted Metrics	
Provincial Activity Tracker	**Regional Activity Tracker**
• Total # of referrals received by BSO teams across sectors (LTC and community): **1,485** • Average # of patients/families supported each quarter across sectors: **1,045**	• % of LTCH residents on BSO Caseload: since 2012, an average of **10-13%** of WW LTCH residents have been supported by internal (embedded) BSO staff.

4: Hamilton Niagara Haldimand Brant (HNHB) 2015-16 Highlights

Initiatives/Programs/Achievements

BSO Hospital Clinical Lead: HNHB LHIN introduced to their BSO Strategy, the ***BSO Hospital Clinical Lead***, which supports individuals with or at risk of responsive behaviours in acute care. The Clinical Leads work with the patient, family, hospital staff and others to understand that 'behaviours have meaning', develop an individualized behavioural plan, and collaborate with community partners to ensure a safe and well-planned discharge. Two BSO Clinical Leads supported 257 inpatients, of whom 14 were diverted from a specialized Behaviour Health Unit and discharged to appropriate care settings.

BSO Integrated Community Lead and Health Links - *A New Partnership Building on Philosophies and Synergies:* The BSO Integrated Community Lead (ICL) is an approach to care that identifies one agency to be the primary lead to help clients navigate the system, reducing the need for the patient and care partner to tell their story more than once. Given the natural synergies with the Health Link model of care and ICL, the local Health Link and BSO leaders developed a plan for scale and spread of the collaborative and coordinated ICL approach to care for complex clients in the community.

BSO Expertise to Support New Models of Care - *Transitional Program for Patients with Cognitive Impairment and Responsive Behaviours*: BSO Strategy partnered with a community agency in the implementation of a new 12 bed Transitional Care Program for patients with responsive behaviours. This program provides a transition period for adjustment from an institutional to a community setting. The BSO Clinical Leads play a key role in the identification and transitional care planning of patients entering the program, while the BSO Community Outreach Teams and BSO LTC Mobile Teams support the patients during their stay and eventual transition into other longer term living arrangements. As represented in this visual depiction, continuity in behavioural care planning, that follows the patient in any setting, ensures care providers understand the meaning behind the behaviours, and are equipped with appropriate and person-centered strategies.

Qualitative Story

Description

Background: Cindy was a patient on an acute mental health unit. She had been living with Paranoid Schizophrenia, cognitive impairment, and the responsive behaviours of calling out, threatening, belligerence, and refusal to accept care. When Cindy felt very out of control she would physically strike out at others.

Intervention: With the support of the BSO Clinical lead Cindy was accepted to 1 LTC home's waitlist. Pro-active transition planning included: facilitating a multi-stakeholder transitional care conference; preparing patient for the move by nurse-escorted visit to the LTC home; agreeing for hospital and LTC staff and physicians to collaborate following the transition.

Outcome: Almost 27 months after her hospital admission, Cindy was transitioned to LTC Home where she remains with the support of hospital and BSO partners.

Impact: Access to acute mental health services increased, while Cindy is now supported in a home-like setting.

Lessons Learned: Giving all partners a voice and planning appropriately takes time and effort, but the results are worth it.

Quotes: "It is comforting to know that there is someone like [BSO] working to assist this segment of our population"- Family

Highlighted Metrics	
Provincial Activity Tracker	**Regional Activity Tracker**
• Total # of patient-based services delivered across sectors: **57, 379** • Total # of transitions supported by BSO service models: **1,421** • Total # of patients supported across all sectors: **5,889**	• BSO Connect served **1,498** callers and connected 100% of them to an Integrated Community Lead Agency; **919** (61.3%) had no services before calling • Since implementation of the BSO Hospital Clinical Leads the average alternate level of care length of stay/patient with behaviours decreased from **46** days to **31** days

5: Central West (CW) 2015-16 Highlights

Initiatives/Programs/Achievements

Launched the Behaviour Support Transition Nurse Program: Facilitating hospital based transitions to LTC and community
Adult Day Program Process Improvement: Included a process change in which all patients presenting with responsive behaviours (RBs) are pre-screened.
Crisis response services committee: Included representation from crisis services, mental health, police services and the Community Car Access Centre.
Tall Pines IDEAs Project for BSO: Project involved increasing dementia awareness in LTC and building capacity with family care partners and substitute decision makers.
Geriatric Cognitive Screening Workshop for LTC: Capacity building, education on standard cognitive assessment tools

Tall Pines IDEAs BSO Project (from left to right): ***Christine Pellegrino*** *(Psychogeriatric Resource Consultant);* ***Teresa Judd*** *(Director, Central West BSO);* ***Carla Braid*** *(Tall Pines LTCH Champion); and* ***Liezle Trinidad*** *(Tall Pines LTCH Director of Care)*

Qualitative Story

Description
Background: In October 2015, the newly launched Behaviour Support Transition Nurse program received a referral to support a transition and discharge Mr. M from a hospital setting to LTC. The patient was presenting with wandering, agitation, looking for his wife, and restraints were being used.
Intervention: During the first visit, his wife was worried and distressed. She was also showing symptoms of compassion fatigue, guilt, and feeling unconfident to make the right choices regarding her husband. At this time the patient had been in hospital for almost six weeks. Over the subsequent days the transition nurse completed a P.I.E.C.E.S. review with the multi-professional healthcare team, physician consults were arranged, and the transition nurse worked with staff to identify causes for the patient's behaviours; such as pain, and how to manage and reduce the number of incidents. The patient's wife became empowered as she learned how to recognize pain as a trigger and source of his responsive behaviours.
Outcome: With improved pain management, the incidents of anger towards the patient's wife and staff decreased. The nursing staff were eager and willing to embrace learning how to complete and use the Dementia Observation System Tool as part of monitoring the patient and his responses to medication changes and non-pharmacological approaches. On the day of the transition the transition nurse was able to bridge the gap and provide hospital based information related to the patient's care that the LTCH found extremely helpful upon discharge.
Impact: (1) Education and empowerment for the patient's wife, healthcare staff at the hospital and the nursing students, (2) Engagement with the discharge planner as pivotal in referring to the Behaviour Support Transition Nurse and Health Care team, (3) Importance of training different interventions and following up on recommendations to see how their efforts are making a difference in the quality of patient-centered care.
Quotes: The acute care resource nurse shared the following: "With your help we have learned to manage Mr. M's behaviours, and although he still has incidents, they are much easier to handle and predictable". LTCH staff shared the following: "Through all of the transitions along the way it was a journey of change, a journey of support and a journey of care."

Highlighted Metrics
Provincial Activity Tracker
• # of BSO team supported transitions from community (incl. supportive housing/ retirement homes) to LTC: **407**
• # of new referrals received for CW BSO Community Teams: **620**

6: Mississauga Halton (MH) 2015-16 Highlights

Initiatives/Programs/Achievements

BSO Ongoing Targeted Education: Through regular newsletters which include an educational component and success stories, topic specific webinars available for new and existing staff (e.g. "Understanding Delirium: Prevention, Detection, and Client Perspective" and "RNAO Client Centred Care") and annual BSO team exchanges where learning and networking with cross sector agencies were facilitated.

Non-Pharmacological Interventions in LTC are encouraged through MH LHIN Funded Resources: Resources made available are based on LTCH identified needs as well as in the literature. Resources are provided with the expectation of a quality improvement approach. This is facilitated in each LTCH by the Psychogeriatric Resource Consultants (PRCs) through education and then through an in person LHIN-wide networking event.

MH LHIN BSO Newsletter (July 2015)

Case Consults and Responsive Behaviour Education Training for LTCH Staff : Education regarding various mental health diagnosis, the use of antipsychotics, Montessori approaches, U-First training and more is being provided to healthcare providers of those with dementia, chronic mental illness and developmental disabilities.

Building a Relationship with the Halton Aphasia Centre: Goal is a continued partnership to build resources and enhance capacity of BSO staff utilizing technology-based communication tools and to provide education to front line staff regarding aphasia.

Organized the Behaviour Collaborative: Behaviour Collaborative is a MH LHIN organized collective made up of community partners affected by responsive behaviours (RBs). This group is designed to enhance behaviour services, create awareness of resources, and streamline care provisions for patients and families. This collaborative also looks at enhancing current processes and supporting new services.

PRCs Co-Facilitated Gentle Persuasive Approach (GPA) Education to Sheridan College: Sheridan College PSW and Nursing students are given the opportunity on an ongoing basis to be educated on GPA methods.

Expanded Educational Opportunities: ReCharge Respite PSW staff have the opportunity to receive full-day RB training.

Qualitative Story

Description

Background: A female resident presented with verbal RBs including accusing staff and co-residents of physical assault (e.g. hitting and attacking her) as well as physical RBs including pouring drinks on staff and co-residents. The resident would wear a scarf in an effort to hide bruises which were not present.

Intervention: A Pain Consultant determined that pain could be a factor influencing the presentation RBs. The Pain Consultant recommended changing the timing of the resident's medication rather than increase the dose. LTCH staff members also had an open dialogue with the resident's daughter who provided insight into her mother's past which helped staff understand the underlying meaning behind the residents' accusations toward male co-residents.

Impact: The staff reported that the resident is now easily redirected and RBs are minimal with physical RBs eliminated altogether.

Quotes: "This is a great example of internal work and external collaboration. It is also a reminder that targeted timing of medications can be an effective intervention".

Highlighted Metrics

Provincial Activity Tracker

- Total # of referrals to LTC BSO Teams: **2, 693**
- Total # of provider-based services delivered in LTC: **10, 232**
- Total # of patient and/or family-based services delivered in LTC: **5,141**

7: Toronto Central (TC) 2015-16 Highlights

Initiatives/Programs/Achievements

The TC LHIN Behaviour Support Education Day: This event was held on March 24 2016 at Baycrest Health Sciences and was attended by 116 participants. The event aimed to increase the knowledge and comfort of health care providers in delivering high quality dementia care and to improve awareness of Behaviour Support Services across the continuum of care with an emphasis on transitions between settings and teams. Participants provided positive feedback via an evaluation survey.

Health Links Coordinated Care Planning: The Behavioural Support for Seniors Program (BSSP) teams (Community Behaviour Support Outreach Team [CBSOT], LTC Behavioural Support Outreach Team [BSOT], and Behavioural Support Unit [BSU]) received training on Health Links Coordinated Care Planning (CCP). The CBSOT had successfully developed 10 CCPs in 2015/16. The CCP was leveraged for bringing clients, families and healthcare teams together for a goal-directed, collaborative approach to care planning, implementation and monitoring.

Trialling New Technologies: The CBSOT has trialed video capturing to record and communicate successful strategies for working with patients and uses this technology to simulate presence for communication between patients and loved ones.

Referral Targets: The LTC BSOT has exceeded targets for referrals, clients and contacts in 2015/16. The CBSOT has exceeded targets for clients and contacts where 3 FTEs are providing approximately 1000 - 1200 visits annually.

Transitional Behavioural Support Unit (TBSU): Following a mandatory third evaluation, the Ontario Ministry of Health and Long-Term Care has designated the unit without time limit in July 2015.

Qualitative Story

Description

Background: The BSOT collaborated successfully with LTC staff in implementing strategies to support a resident presenting with calling out behaviours which enhanced capacity building and excellent rapport between BSOT and LTC and reduced the intensity and frequency of resident's responsive behaviours (RBs).A new resident to a TC LHIN LTCH, Ms. L., was referred to the BSOT because she was exhibiting calling out behaviours and seeking constant requests for help from staff. Ms. L. is 84 years old and was observed to be calling out for help throughout the day, especially during the evening shift.

Intervention: The BSOT was able to involve staff through staff huddles and collaborate in finding strategies that could be beneficial in reducing Ms. L's calling out behaviours. Through these staff huddles, coaching, and constant communication with the unit staff, recreation staff, the Director of Care and the Social Worker of the LTCH, the implementation of two successful non-pharmacological interventions were possible: 1) doll therapy; and 2) iPod project.

Outcome: Due to the BSOT's support and focus on capacity building, LTC staff successfully implemented the aforementioned strategies continuously. As a result, Ms. L's behaviours decreased significantly in intensity and frequency and she was able to be discharged from BSOT.

Quotes: PSW B. suggested BSOT does not feel like an "outreach team" from the outside, but more like part of the team.

Highlighted Metrics	
Provincial Activity Tracker	**Regional Activity Tracker**
• Total # of referrals to LTC BSO Teams: **500** • Total # of patients supported in Community: **512**	• Through the work of the Educational Consortium in TC LHIN, **1,605** participants attended certified training activities such as Dementia Care Training Program, Behavioural Support Training Program, GPA, U-First! and Palliative • Primary Care PRC has engaged **535** Primary Care Practitioners in consultations in 2015-16. • The Mobile LTC BSOT team served **431** unique clients in 2015/16, surpassing the annual target of **400** unique clients

8: Central (CEN) 2015-16 Highlights

Initiatives/Programs/Achievements

Raising Awareness: Engaged over 250 care partners in the community through face-to-face dialogue to raise awareness about BSO and gather first-hand knowledge about priority issues from the patient and care partner perspective.
Development and Implementation of Cross-Sector Complex Case Resolution (CCR) Toolkit: This includes the CCR Review Panel Terms of Reference and membership, process protocol with urgent response timelines, referral and intake process/forms, transparent meeting and decision-making format, and 30 day follow-up.
Embedded Ontario Telemedicine Network (OTN) into Model of Care within LTCHs: Created clinical protocols and intentional connections to specialists and developed a local Central LHIN Telemedicine Physician Directory; improved access to physicians by 45% at one hospital alone; hosted 10 monthly LTCH-OTN Community of Practice Education Sessions on various topics via OTN.
Behavioural Support Transitional Unit (BSTU) (16 beds): Cummer Lodge LTCH received 102 referrals (48% from acute care, 34% community, 16% LTC; 2% Other); average number of days between achievement of clinical days to discharge from BSTU decreased by 38.27% in 2015/16.

Qualitative Story

Description

Background: Mr. B a is 61-year-old man who immigrated from South America 10 years ago. He has a Master's degree in Engineering and Finance, is married with three children in university and was diagnosed with frontal-temporal lobe dementia 5 years ago. He was recently admitted to the BSTU from hospital with responsive behaviours (RBs) (e.g. is intrusive to other residents at mealtimes, is very difficult to redirect, exhibits social and sexual disinhibition, and Obsessive Compulsive Disorder behaviours).
Intervention: The BSTU was proactive in involving the Behavioural Support System LTC Mobile Support Team (BSS MST) to prepare for a transition to LTCH; BSS MST met with Mr. B and BSTU staff prior to the move. The BSTU provided a Behavioural Tip Sheet with strategies. BSS MST shared strategies with the Administrator and the Director of Care of the LTC home *prior* to Mr. B's placement. BSS MST oriented staff to the environmental needs of Mr. B including PSW, dietary and housekeeping staff.
Outcome: After the 12 weeks of service, the LTCH removed the 1:1 High Intensity Needs Funding Staff and there were no hospitalizations or 911 calls. Mr. B continues to live and do well in his new home and has begun to socialize with others. There have been no re-referrals since he was discharged from the BSS MST.
Impact: Individuals and families experience smooth and successful transitions in care when there is open and honest communication between families and staff from both discharge and admission sites and enough notice is given prior to placement in order to prepare for and potentially prevent RBs.
Lessons Learned: LTCHs are found to be more receptive to accepting someone with RBs if they know that the BSS MST is available for on-site support for the new resident and the LTCH staff over several weeks to assist with the transition.

Highlighted Metrics	
Provincial Activity Tracker	**Regional Activity Tracker**
• Total # of referrals received by BSO teams across sectors (LTC & community): **1,271** • Average # of patients/families supported each quarter across sectors: **369**	• Only **2%** of BSO clients with responsive behaviours were transferred from a LTCH to the hospital due to responsive behaviours while active with the BSO mobile support team (transferred due to delirium, mental health issues) • Over **200** patient transitions from community, acute and tertiary care to LTC were supported by BSO Teams

9: Central East 2015-16 Highlights

Initiatives/Programs/Achievements

Quality Improvement Initiatives: Updated the high level LTC Value Stream Map to a detailed, user-friendly cross-functional format and created a companion Process Description Document as well as developed a customized Behavioural Assessment Tool (BAT) for community BSO clinician utility.
Capacity Building: Ongoing evaluation of Validation Therapy as a potential course to be added to the core curriculum and continued learning through the BSO Community of Practice.
Development and Validation of Key Central East CCAC Metrics: To support planning and a better understanding of the BSO population moving through the care continuum including: (1) percentage of LTC waitlists for clients with responsive behaviours (RBs); (2) percentage of clients with RBs admitted to LTC; (3) percentage of all patients with RBs who applied to LTC and had their application refused; (4) percentage of patients with RBs whose LTC application was refused of all refused LTC applications; (5) percentage of Central East CCAC clients with RBs without LTC referral; and (6) number of Central East patients waiting for an out-of-region Transitional Behavioural Support Unit.
Hosted Three (3) Student Practicum Placements: (1) A Masters of Public Health Student from Lakehead University studied the needs, gaps, and services available to support informal care partners of persons with dementia from their own perspectives as well as that of community services and health care providers in the Durham Region. Research findings provided support and insight in to the Central East regional dementia strategy. (2) Trent University Registered Nursing students evaluated publicly reported MOHLTC inspection data related to the RB protocols triggered by Resident Quality Inspections, complaints and critical incidents. The findings provided insight into care planning gaps and have potential to inform BSO program outcome measures with further study.

Qualitative Story

Description
Background: Riverview Manor Long Term Care Facility in Peterborough was interviewed by Chex Television regarding their "Music Corners" program for residents with RBs.
Intervention: Susanna Kelusky (RPN), Logan Burrows (PSW) and Michelle Bellefontaine (PSW) developed the "Music Corners" program at Riverview Manor LTC Facility. Residents were asked about their favourite music and the BSO team collected CDs donated by staff members to match residents' choices. The team then created two areas in the home where people can gather to enjoy music. If a resident with cognitive impairment presents with responsive behaviours, staff can direct them towards the music. In addition to the music, music corners have records and books with musical facts and trivia residents can enjoy.
Impact: The impact that music can have on people with dementia is well-documented.
Quotes: "We have a certain resident who really likes jazz and when he is upset or restless, we can direct him to the music." – Riverview Manor Long Term Care Facility Staff Member

Highlighted Metrics

Provincial Activity Tracker	Regional Activity Tracker
• Total # of referrals received by BSO teams across sectors (LTC & community): **7,538** • Average # of BSO patients/families supported each quarter across sectors: **3,632.8**	• Average % of residents with new or worsened responsive behaviours (RBs) who received a change in treatment in 2015/16: **35%** • Average % of LTC residents with RBs being actively supported with BATs: **16%** • Average % of LTC residents with new or worsened RBs initiating a BAT: **20%** • Average % of LTC residents with new or worsened RBs receiving new order prescriptions: **32.5%**

10: South East (SE) 2015-16 Highlights

Initiatives/Programs/Achievements

Leading High Performing Teams: A joint learning initiative brought together LTCH Leadership and Behavioural Support Liaisons with Behavioural Support Services (Outreach, PRC, and Mobile Response Team) with the objective of fostering a culture of behavioural support and developing an in-house Behavioural Support Team in each LTCH.
Lived Experience Network: Developed a sustainable network of persons with lived experience; gathered over 300 lived experience stories from across the SE with the objective of being an advisory voice for planning, design, and implementation of a system of care that is person and family-centred.
Knowledge Exchange Network: Ongoing development of a knowledge exchange platform to support capacity enhancement and shared learning across the system.
Integrated Teams: Mobile Response Teams (MRTs) joined the behavioural support services in existence (Outreach and PRC). This past year has focused on role clarity and providing an integrated service through a shared care model with LTCHs. Outreach-specialized consultation: Assessment and recommendations; PRC Consultation: education and development; *MRT:* Direct hands on support to provide transitional support, urgent behavioural support, and assist and model support for responsive behaviours (RBs).
Development of a *Regional Behavioural Support System Advisory Committee*: Working together across the continuum of care to ensure stakeholder observation and input into the behavioural support services across the continuum of care (Seniors Mental Health Outreach and Behavioural Support, Behavioural Support Transition Unit, Behavioural Support Intensive Care Unit).
Developing Behavioural Support Networks (one in each geographic region for a total of 3): Developing support networks to support the work of the LTCH in-house Behavioural Support Teams, this network will bring together LTCH Behavioural Support Liaisons and Behavioural Support Services. The objective is to bring people, ideas, and developed resources together for networking, shared learning, and co-creating processes and systems that will foster a culture of behavioural support.

Qualitative Story

Description

Background and Intervention: The Behavioural Supports Services (BSS) Integrated Team, which includes a Mobile Response Team (MRT), Psychogeriatric Resource Consultant (PRC) and Seniors Mental Health Outreach (SMHO) collaborated with the LTCH's Behavioural Support Liaison and other members of their in-house team to support a resident with a complex illness and associated RBs. In partnership, using a resident and care-partner directed approach, shared goals of care and specific resident-centred care strategies were developed such as the use of a daily agenda for the resident and a visual medication chart listing descriptions of each medication and its purpose. This patient was presenting with verbal and physical RBs.
Impact: The outcome for the resident was a predictable routine and a feeling of control. The patient's agitation and other RBs were stabilized. The resident and the LTCH staff are now in a shared care routine which has decreased RBs.
Lessons Learned: As always, the MRT has found the concentrated time they have to dedicate to the one patient provides them with a greater ability to understand the underlying cause to the patient's distress and develop successful strategies in a timely manner. The integration of MRT with other Behavioural Supports (PRC and SMHO) was paramount to the success.

Highlighted Metrics
Provincial Activity Tracker
• Total # of referrals to LTC BSO Teams: **342**
• Total # of patient/family-based services delivered in LTC: **8,336**
• Total # of provider based services provided in LTC: **4,311**

11: Champlain (CHA) 2015-16 Highlights

Initiatives/Programs/Achievements

4th Annual PSW Education and Networking Day – February 22nd, 2016: The Geriatric Outreach Behavioural Support Team brought together 78 PSW Champions to a workshop titled "Personality Dimensions: Understanding Yourself & Others" with Murray Comber. PSW Champions were also asked to bring a poster to highlight the BSO initiative in their LTCH (see below). The individual creativity of the BSO initiative in various LTCHs was fabulous!

Qualitative Story

Description

Background: The Champlain LHIN has collaborated with one of their geriatric psychiatrists and the Ottawa Mindfulness Clinic for clinical supervision to offer an 8-week mindfulness group for senior care partners of patients with dementia or psychiatric illness. This program has been run twice a year for 2.5years.

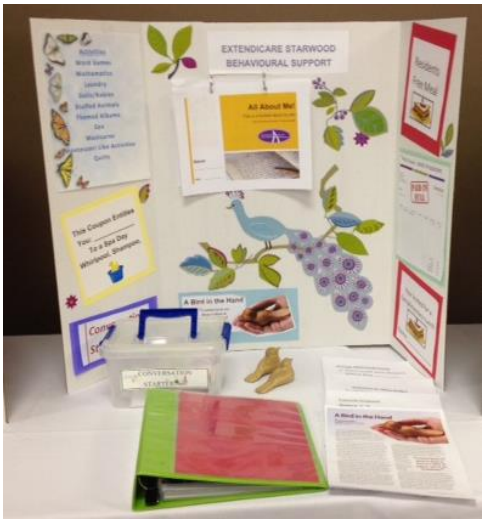
Impact: Participants have developed mindfulness skills that have allowed them to change their approach to difficult situations when providing care. These skills have increased their sense of competency as care partners and they now feel better equipped to cope with their current situations and feel more hopeful about the future. There is increased acceptance which contributes to their own wellness and helps them to care for themselves.

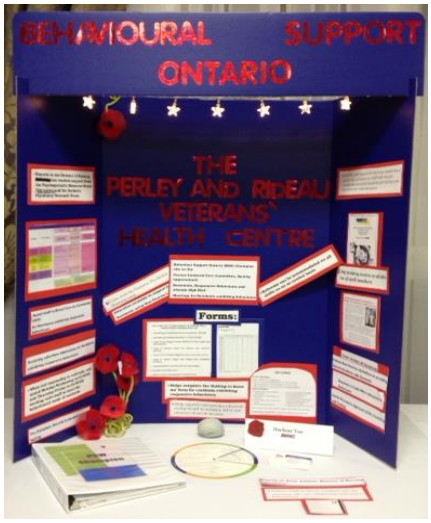
Lessons Learned: As group facilitators, we have learned that the group process brings about growth of participants into a cohesive unit. This, combined with the shared experience of being a care partner, brings about an awareness that the challenges participants face in their roles are very human, making them more acceptable, and breaks their isolation.

Quotes:

- "Hearing others talk about their experiences, insights, difficulties and sticking points, brought home, tangibly, how we all struggle with allowing ourselves to be human, to be who we are." – Participant
- "I was part of a 'likeminded' people." – Participant
- "Focus on compassion; it is really needed in our context and life at this time." – Participant

Highlighted Metrics
Provincial Activity Tracker
• Total # of patient/ family-based services delivered in LTC: **23,115**
• Total # of new referrals received by cross-sector team (serving both LTC and community): **374**





12: North Simcoe Muskoka (NSM) 2015-16 Highlights

Initiatives/Programs/Achievements

Creation of the Behaviour Task Force: There is a strong focus on behaviours and the creation of a Behaviour Task Force to inform Specialized Geriatric Services (SGS) in the NSM LHIN.
Complex Case Resolution (CCR): After many years of piloting, the submission of a briefing note and prioritization of a Behavioural Support Services Advisory Committee, the Behaviour Task Force of SGS has assisted in refining and approving a formal CCR process with two levels of review which are currently being tested.
PDSA of a Cohen-Mansfield Inventory on Admission, when there is a Change and upon Discharge: To provide more information regarding the outcomes of interventions, BSO initiatives in NSM and other LHINS are currently using the CMAI, which may contribute to both an individual outcome measure and a broader NSM and BSO outcome indicator.
Consent and Capacity: A script was developed and tested in willing LTCHs. The purpose was to enhance conversations with families about behaviour at the time of LTC placement. The NSM LHIN has been working with the Community Care Access Centre (CCAC) as results show that these conversations need to take place before placement.
Transitions: PDSAs show success in the transition of patients from community teams to LTC teams.

Qualitative Story

Description
Background: A patient was referred to the Mobile Support Team (MST) for verbal and physical responsive behaviours (RBs) during transfers and incontinent product changes.
Intervention: Causes for responsive behaviours (RBs) included: need for repositioning and perineum care, pain, difficulty understanding tasks, visual impairment, bright lights, dyspnea and rushed approaches. The MST worked with the LTCH staff to identify these triggers and develop strategies to decrease RBs. The MST identified that the patient was presenting with trouble breathing while in certain positions due to Chronic Obstructive Pulmonary Disease (COPD) and noticed signs of moderate to severe pain. The MST recommended pain medication to be administered to the patient one hour prior to care along with other non-pharmacological recommendations.
Impact: The patient's physical and verbal RBs decreased once pain was managed. Non-pharmacological interventions included providing the patient with an item to hold onto during care tasks (e.g. a pillow) and providing education on palmar grasp reflex.
Lessons Learned: Pain is difficult to identify in advanced stages of dementia as it is not always verbalized. Pain can be expressed in multiple ways and pain management plays a vital role in reducing the opportunity for RBs. Pain management and non-pharmacological interventions improve overall comfort and quality of life.

Highlighted Metrics
Provincial Activity Tracker
• Total # of referrals to the Community: **213** • Total # of BSO-supported transitions from community to LTC: **9**

13: North East (NE) 2015-16 Highlights

Initiatives/Programs/Achievements

Provincial Coordinating Office (PCO): North Bay Regional Health Centre became the lead agency for the BSO PCO in April 2015.

NE BSO Aboriginal Strategy: Since 2013, NE BSO has partnered with the NE LHIN, the Centre for Rural and Northern Health Research, Northern Ontario School of Medicine, and N'Mninoeyaa Community Support Services to implement a strategy to provide better care for individuals and their care partners in Aboriginal communities across the region. Outcomes from 2015-16 include: an increase in the overall number of referrals to BSO from Aboriginal communities; training for over 500 staff from Aboriginal communities in workshops (e.g., PIECES, U-First!, PSW Champion); NE LHIN sponsored Indigenous Cultural Competency training for NE BSO staff; and a BSO-Aboriginal Kaizen event was held to develop a "Cultural Diversity and Inclusion" core competency.

Centralized Intake and Electronic Referral System: launched its central online referral system at www.nebso.ca

NE BSO-Paramedicine Collaborative Capacity Building Project: Spotlight on the 3 Ds: In an effort to enhance community capacity, decrease risk and increase direct access to specialty service coordination, NE BSO recently engaged in a BSO-Paramedicine project sponsored by the NE LHIN. BSO provided training on the 3Ds (Dementia, Delirium and Depression) to over 150 Paramedics and collaborated to create a brief screening tool and direct BSO referral pathway for Paramedics in the Sudbury hub. Following this training, there has been an increase in direct referrals from Emergency Medical Sservices and *potential* decrease in emergency department presentations. NE BSO continues to work on sustaining these positive outcomes with the aim to spread across the NE.

Inter-Agency "Cross-Sector" Clinical Huddle Collaboration: PRCs act as hub conduit leads (4 hubs in NE LHIN) to bring NE BSO inter-agency team members together x1/week for BSO clinical rounds. Weekly huddles take place virtually within each individual hub involving cross-sector team members to ensure ongoing quality integrated service delivery.

Spread of Consistent BSO Tool Application: PIECES of my Personhood, PIECES Framework, including a focus on the Cohen-Mansfield Agitation Inventory (pre & post measure) has been implemented across all NE BSO teams in the NE. This ensures "common language" and enhances knowledge in the creation and ongoing evaluation of individualized care plans.

Qualitative Story

Description

Background: BSO was engaged with an older adult living in acute care for 400 + days due to both physical and behavioural complexities. The BSO Integrated Response Team (IRT) worked with the acute team to develop a creative care plan. Despite many of the positive outcomes, some extreme behaviours persisted, of which the environment was noted to be a contributing escalating factor. The BSO team worked with the acute team to refer to tertiary care. With many of the current effective care strategies in place and a more conducive physical environment, the BSO IRT and tertiary team further developed a plan for transition to LTC. The team arranged for in-reach opportunities with the LTCH staff prior to transition. Furthermore, the same BSO clinician followed alongside the individual throughout all aspects of each care transition, as leveraged by all active care partners along the way.

Outcome: Successful placement for this individual in a LTCH; decreased care partner compassion fatigue; increased cross-sector collaboration; decreased system demands and overall increased quality of life for this individual/family.

Impact: In this case, 'success' was a result of consistency, persistence, collaboration and dedication!

Highlighted Metrics	
Provincial Activity Tracker	**Regional Activity Tracker**
• Total # of referrals received by BSO Team across Sectors: **1,711** • Total # of transitions supported by BSO service models: **559**	• Average decrease % on Cohen-Mansfield Agitation Inventory post-NE BSO discharge: **76.51%** • Total # of Personhood Assessments completed: **1,025** • Total # of Baseline Zarit Interviews completed with Family Care Partners referred to NE BSO: **248**

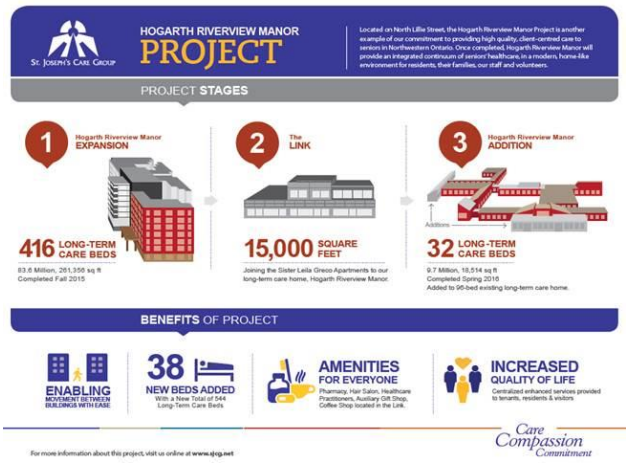
14: North West (NW) 2015-16 Highlights

Initiatives/Programs/Achievements

NW Regional Behavioural Support Unit (BSU) Expansion: On February 19, 2016 the NW Regional BSU moved to the newly expanded Hogarth Riverview Manor site, expanding the unit to a 32 bed unit from the original 24 bed unit. By April 2016 this unit was at full capacity and providing services for 8 additional patients.

MOHLTC Designation of a Specialized 32 Bed Unit: Regional Behavioural Support Unit (also known as: Regional Behavioural Health Service (RBHS) Specialized Unit), Daffodil, located within Hogarth Riverview Manor is situated in Thunder Bay. This unit includes a 16 bed active side and a 16 bed transitional side. All resident rooms are private and there is additional space in the design allowing for increased exploration and increased space between residents.

Ongoing Development of a Comprehensive Client-Centred Model: Model includes an interprofessional model of care including a most responsible physician, geriatric psychiatry services, a virtual ward, therapeutic recreation, Nurse Practitioners, a Psychogeriatric Resource Consultant, a Mobile Outreach Team (MOT), and capacity building for health human resources.



Hogarth Riverview Manor Expansion Project Poster

Additional Funding Resources: Resources are supporting partnership with the Alzheimer Society of Thunder Bay Public Education Program to further enhance the capacity of health service providers across the NW LHIN through education and training.

Qualitative Story

Description

Background: A 76 year old patient was admitted to RBHS Specialized Unit in January 2015 from a retirement home. The resident presented with significant responsive behaviours (RBs) such as physical and verbal RBs directed at staff members.

Intervention: The patient stayed on the RBHS Specialized Unit until September 2015 during which time a specialized care plan was developed along with non-pharmacological strategies for management of RBs. Strategies were shared with all staff and family members and the patients RBs became more manageable. The patient was discharged and reunited with his wife in another LTCH with support from the MOT. The RBs had returned after one month and the RBHS was contacted as well as the MOT. Staff at the new LTCH were provided with education (from the Alzheimer Society) and support in regard to the care plan and within two months the resident had settled into the new LTCH and no longer needed support from the RBHS.

Impact: The patient was able to receive interprofessional, specialized and therapeutic interventions with an emphasis on non-pharmacological behaviour management which resulted in significant positive changes in the patient's RBs.

Highlighted Metrics
Provincial Activity Tracker
• Total # of patient-based services where a follow-up and review of outcomes occurred in long-term care: **254**
• Total # of referrals to the behavioural support unit (BSU): **45**
• Total # of BSU referrals from Acute Care: **23**
• Total # of BSU discharges to LTC: **9**
• Average length of stay between admission to the BSU and achievement of clinical goals: **145 days**

Strategic Objective 3:
To develop collaboratives for the purpose of sharing innovative practices across the continuum of care and identify promising practices to providers throughout Ontario

Ontario Best Practice Exchange

Development of 7 Collaboratives

The Ontario Best Practice Exchange is an exciting initiative that is moving forward emerging and best practices related to geriatric mental health, dementia, substance use and neurological conditions. Seven working groups, referred to as "Collaboratives" have been established to bring together thought leaders, innovative thinkers, various subject matter experts and people with lived experience from across the province.

The 7 Collaboratives:

- **Person and Family-Centred Care**
- **Antipsychotics**
- **Behavioural Supports Mobile & Inter-Agency Teams**
- **Behavioural Support Transition Units**
- **Health Links and Primary Care**
- **Substance Use**
- **Tertiary Care and In-patient Specialty Services**

Central's BSO Program Manager/ Behavioural Support Integrated Teams Collaborative co-chair **Patti Reed** introduces 'Transitions Group Exercise' at the September 25, 2015 Catalyst Event

Since the summer of 2014, the Collaboratives have been working to uncover the current practices and essential components of best practices in each of the above topic areas. Instrumental to their work is the conscientiousness of always asking "How might these practices be more person and family-centred?"

September 25, 2015 Catalyst Event and Associated Reports

The Ontario Best Practice Exchange Catalyst Event provided an opportunity to officially launch the work of the Collaboratives and involve numerous stakeholders, provincial partners and individuals with lived experience into this endeavor. The in-person Catalyst Event took place on September 25, 2015. A total of **145** participants attended, including **34** individuals with lived experience. The event was hosted by Julia Baxter (St. Joseph's Healthcare Hamilton) with the support of brainXchange and BSO PCO. In addition, the Alzheimer Society of Ontario financially supported the inclusion of people with lived experience.

The Executive Summary and Full Report of the Catalyst Event can be found on the brainXchange website: http://brainxchange.ca/Public/Resource-Centre-Topics-A-to-Z/Behavioural-Supports-Ontario.aspx

"I have not shared so openly with others in this type of setting before and that's because the people you brought together understood the importance of hearing the person's voice!" – Provincial BSO Lived Experience Advisory Member & Catalyst Event Participant

Accelerated Collaboratives

The Ontario Best Practice Exchange's next steps are focused on the development of tools, resources and knowledge exchange opportunities that promote person and family-centred best practices. This next phase is being led by each Collaborative's co-chairs with the support of the brainXchange and PCO. In an effort to better support the development of the aforementioned products (i.e., tools, resources) in a timely manner, three Collaboratives were selected to be 'Accelerated' for this next phase of the initiative. The following Accelerated Collaboratives have been and will continue to receive additional support provided by the brainXchange and PCO:

- **Substance Use** - Co-chairs: Marilyn White-Campbell, Jane McKinnon Wilson and Cathy Sturdy Smith
- **Behavioural Support Transition Units (BSTU)** - Co-Chairs: Mary Ellen Parker and Karin Adlhoch
- **Behavioural Supports Integrated Teams** (formerly called: Behavioural Supports Mobile & Inter-Agency Teams) - Co-Chairs: Teresa Judd and Patti Reed

Rather than having 'Person and Family- Centred Care' as a separate Collaborative, all of the Collaboratives are founded on the principle of Person and Family First and include members with lived experience. Perspectives from those with lived experience will be interwoven into the work of all of the Collaboratives through both the Provincial BSO Lived Experience Network and the Provincial BSO Knowledge Translation and Communications Advisory as well.

The work of Ontario's Best Practice Exchange is committed to honouring people, honouring partners and honouring possibilities!

[1]Strategic Objective 5:
Work with the Alzheimer Society & other key provincial associations in a collaborative way, to better the care for people experiencing responsive behaviours

The following section provides a snapshot of some of the key partnerships that have been established in this first year of the re-emergence of the PCO.

Alzheimer Society of Ontario

brainXchange

The BSO PCO has worked closely with brainXchange as its primary collaborators in supporting the work of the Ontario Best Practice Exchange. This partnership contributed to the successful Catalyst Event in September 2015 (both supporting Julia Baxter and the St-Joseph's Healthcare Hamilton Team), the final report and executive summary of the Catalyst event, furthering the work of the Accelerated Collaboratives and the development of virtual collaborative spaces to enable the Collaboratives to connect online.

The brainXchange has also been instrumental in supporting the development of the BSO provincial structure through the creation and support of virtual shared platforms. These online spaces provide advisory/committee members with a shared place to access and share their common documents (e.g. agendas, meeting summaries, etc.) and resources.

(from left to right): **Jillian McConnell** (Knowledge Broker); **Karen Parrage** (Resources Coordinator); **Dr. Ken LeClair** (Geriatric Psychiatrist & BSO Clinical Advisor); **David Harvey** (Chief, Public Policy and Program Initiatives Officer); and **Kathy Hickman** (Knowledge Mobilization Lead)

[1] Strategic Objective 4: Prepare a brief annual report that provides a snapshot of each LHINs' BSO achievements.

Alzheimer Society of Ontario BSO Funds Project

The BSO PCO assisted the Alzheimer Society of Ontario in launching a survey to gain a better understanding of their involvement with BSO. Working in collaboration with Philip Caffery (Research and Policy Analyst, Alzheimer Society of Ontario) the BSO PCO shared information about the BSO initiative (i.e., background, models) and provided some examples of how BSO funds have been used to enhance Alzheimer Society services (e.g., the development of BSO positions linked with Alzheimer Society chapters to support family care partners). Following the development of their survey and supporting documents, the BSO PCO provided further comment and feedback.

Erie St-Clair Behavioural Supports Ontario

Justice Sector Survey

In the summer of 2015, following a conversation held at a Provincial BSO Operations meeting, the PCO collaborated with Krista Schneider (Regional Coordinator, ESC BSO) in surveying the BSO Clinical/Strategy Leads regarding whether they were seeing an increase in BSO patients cases involving the justice sector and if so, what types of strategies and roles the BSO Lead and teams adopted in these instances. A total of 9 BSO Leads responded to the survey (64.3%) and Krista Schneider later shared the results of the survey with the Operations Committee.

Erie St-Clair BSO Team host Emotional Intelligence Training

Environmental Scan

The BSO PCO supported the ESC LHIN from September 2015 until March 2016 in a BSO environmental scan project that was led by Kimberley Arens (Masters of Social Work [candidate]) and Dawn Maziak (Health System Design Manager, Mental Health & Addictions Lead, ESC LHIN). The purpose of the scan was to better understand the ongoing successes and challenges related to the unique BSO models in each LHIN. The questionnaires were tailored to each LHIN's model and distributed during the fall of 2015; a response rate of 12 (85.7%) was achieved.

Health Quality Ontario (HQO)

Antipsychotics Benchmarking Project

The PCO was approached in January 2016 by the Health System Performance Branch at Health Quality Ontario (HQO) to assist in the development of benchmarks for the interRAI indicator 'potentially inappropriate antipsychotic use'. In order to inform their work, the PCO provided HQO with descriptions of BSO models along with a list of BSO-supported LTCHs, developed in collaboration with the 14 BSO Clinical/Strategy Leads.

Quality Standards for Behavioural Symptoms of Dementia

The BSO PCO reached out to Terri Irwin (Director, Quality Standards) and Erik Hellsten (Manager, Quality Standards Strategy) in October 2015 upon being informed of the development of Quality Standards for individuals presenting with behavioural symptoms of dementia in LTC. In the months following, the HQO Quality Standards Team shared updates with both the BSO Steering Committee

and BSO Operations Committee on the development of the standards before providing BSO stakeholders with the opportunity to review a first draft of the document in March 2016 prior to its public consultation release.

Quality Improvement Plans

In January 2016, the Quality Improvement Plans (QIP) Team at HQO shared the results of their 2015-16 review of the LTCH QIPs which aim to signal areas of importance for quality improvement and provide information about trends, best practices and experience with change ideas back to providers. In total, 370 (60%) of all 627 Ontario LTCHs mentioned a partnership with BSO in their 2015/16 QIP. BSO was the most frequently identified partnership in the the QIP's 'Integration and Continuity' Section.

Humber College

In March of 2016, Humber College reached out to the BSO PCO regarding their new Bachelor of Behavioural Science Program that is launching in September of 2016. Humber College was seeking BSO representation on their Program Advisory Committee for this new degree program to ensure that the program's content is reflective of the needs of older adults. Teresa Judd (Director of Behavioural Support System, Central West BSO) has welcomed and accepted this exciting opportunity to sit on the Program Advisory Committee.

Ministry of Health & Long-Term Care (MOHLTC)

Licensing and Policy Branch: Activity Tracker Refresh Project

The BSO PCO worked closely with the MOHLTC Licensing and Policy Branch on the development of a refreshed provincial activity tracker from BSO July 2015-February 2016 (see '**Activity Tracker Refresh Project'**).

Capacity Planning and Priorities Branch: Ontario Dementia Strategy

Since the launch of the Ontario Dementia Strategy, the BSO PCO has enabled opportunities for the MOHLTC Capacity Planning and Priorities Branch to liaise with BSO partners and stakeholders. The Capacity Planning and Priorities Branch has presented updates to both the BSO Steering Committee and BSO Operations Committee. Next, this team will further engage with BSO stakeholders at the upcoming in-person BSO Steering Committee meeting which will take place on May 31, 2016.

Telehealth Ontario

Development of BSO service Profiles

In February 2016, the PCO was approached by Kimberley Schlegel (Enhanced Psychogeriatric Resource Consultant, London Health Sciences Centre, SW) on behalf of a Telehealth Ontario Working Group that was looking to develop a protocol for when community-dwelling individuals call Telehealth regarding individuals presenting with responsive behaviours. In order to enhance system coordination and service access, the PCO worked in collaboration with the BSO Clinical/Strategy Leads to develop BSO Telehealth Ontario Service Profiles for each of the 14 initiatives.

BSO Communications Strategy

Provincial BSO Newsletter – the BSO Provincial Pulse

FIGURE 3: Provincial BSO Newsletter Header

The BSO provincial newsletter, the "BSO Provincial Pulse" launched its first issue in December 2015. Two issues have been published to date, with a plan of quarterly publications. The BSO Provincial Pulse is grounded in the BSO pillars and regularly features: BSO Impact Snapshots using qualitative and quantitative data, a BSO Team in Action highlight, updates regarding the Ontario Best Practice Exchange, a letter of Lived Experience, Professional Development Opportunities and feature initiatives being carried out by relevant provincial partners. The newsletter can be found on the brainXchange website where a subscription feature has been established. The BSO Provincial Pulse currently has over 300 readers subscribed.

I received the first Issue of the Provincial BSO Newsletter through a colleague. It is a wonderful wealth of information! **- Enhanced Psychogeriatric Resource Consultant**

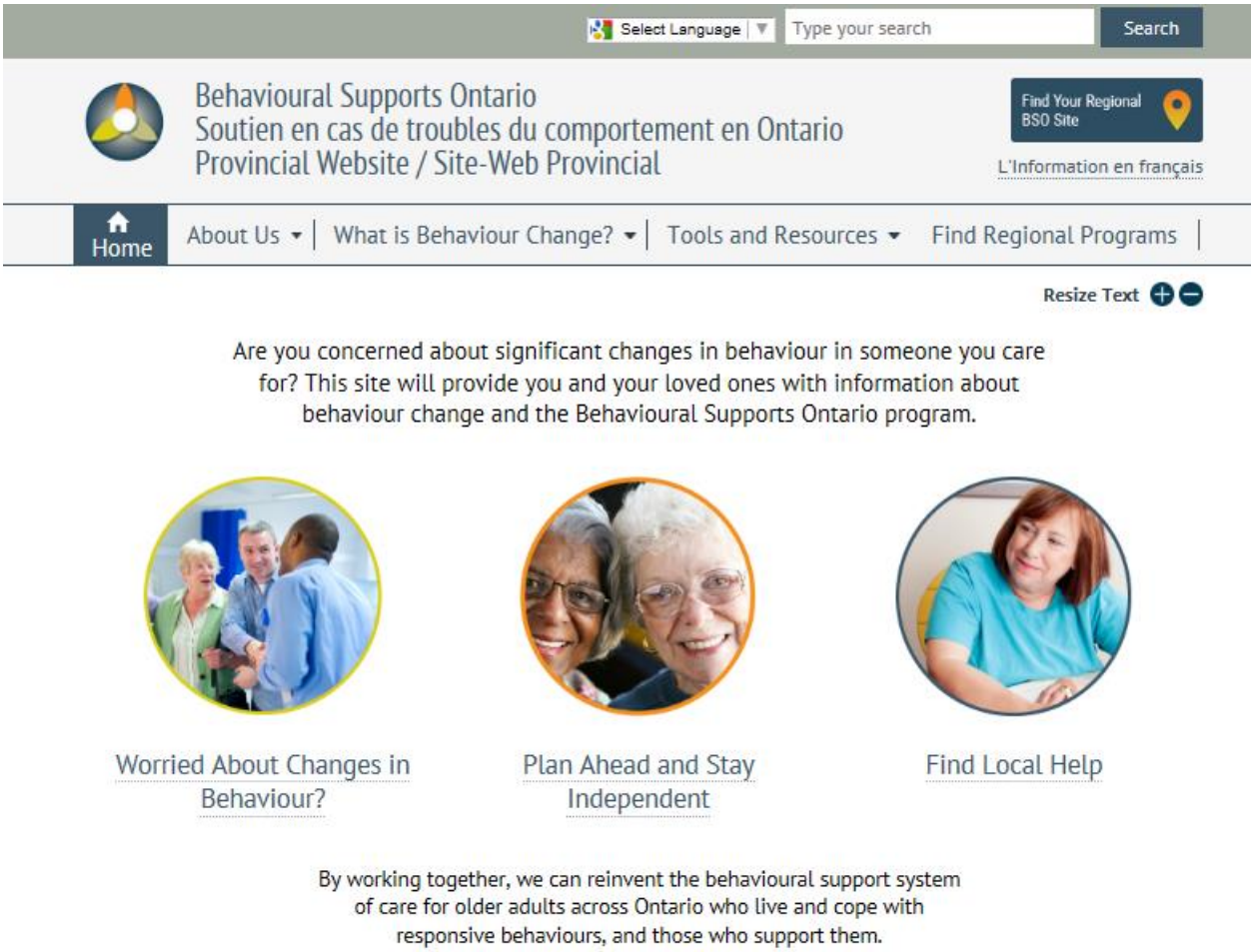
BSO Websites

Project Overview

The PCO, 14 BSO Clinical/Strategy Leads and BSO LHIN Leads worked in partnership with the OACCAC and thehealthline.ca Information Network to create a provincial BSO website, along with 14 regional BSO mini-sites geared to the general public since July 2015. Thehealthline.ca provides an online, single point of access for health and community services across Ontario. It is meant to be accessed by health service providers, consumers, system planners and primary care practitioners. Information available on the BSO mini-sites includes background details about the BSO initiative, information about behaviour change, health care programs and services and information about health topics and free health-related events. In order to guide the development of the content and design of the Mini-Sites, a smaller Mini-Sites Working Group was established who worked closely with thehealthline.ca Information Network team. Each mini-site includes default content developed by the PCO. Upon the announcement that the healthline.ca team had secured funding for official translation of the English Default Content, the PCO worked closely with

the Data Resource Administrator at thehealthline.ca Information Network to review the translated document. The BSO main site and the 14 Regional Mini-sites were launched in March of 2016. The main site can be found at www.behavioursupportsontario.ca. The BSO Regional mini-sites can be found through this main site or by visiting www.behavioursupportsontario.ca/RegionalSite.

FIGURE 4: Provincial BSO Website Homepage

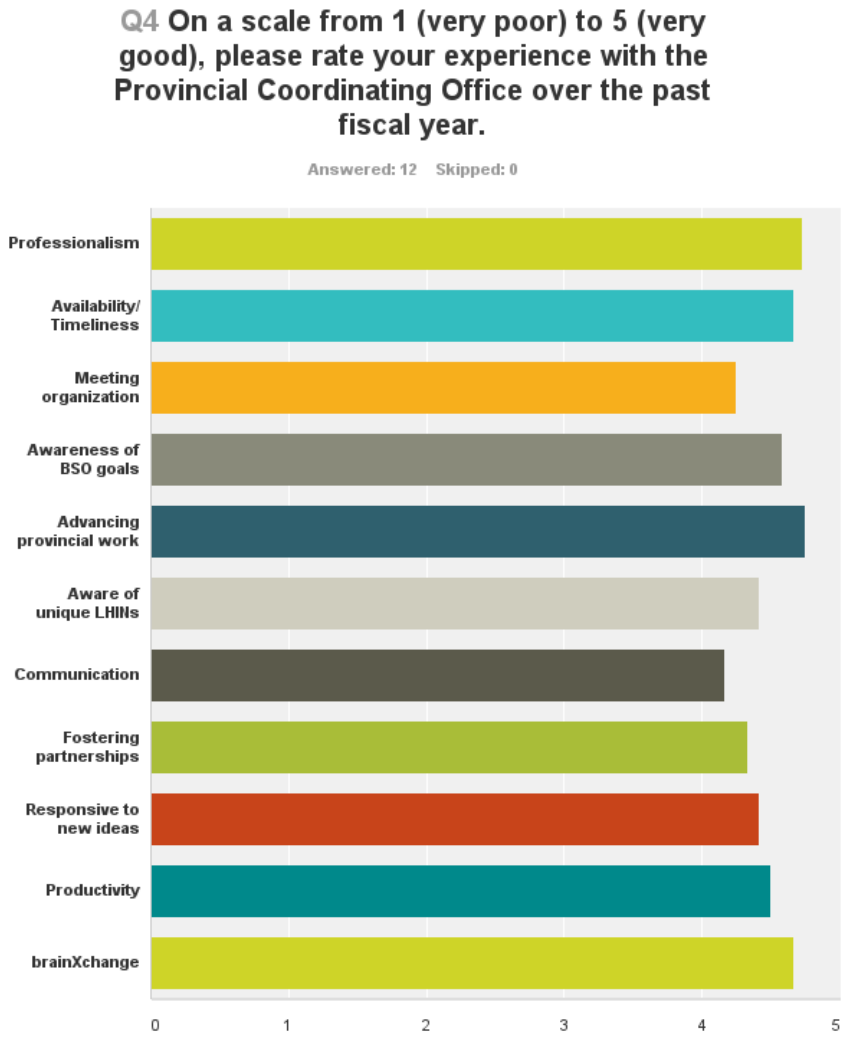


Provincial Coordinating Office Partner Feedback Survey

In May 2016, the PCO invited the BSO Clinical/Strategy Leads and BSO LHIN Leads to reflect on the PCO's first year in operation and provide feedback to inform continuous quality improvement and assist the PCO in setting priorities for the 2016-17 fiscal year. Respondents were asked to evaluate their experiences with both interacting and collaborating with the PCO and brainXchange, as well as provide comments on the PCO's perceived strengths, areas for improvement and priority areas of future focus (See **Next Steps**). The survey received a total of 12 responses; 8 of which were from BSO Clinical/Strategy Leads and 4 from BSO LHIN Leads.

The following table illustrates the responses received regarding the respondents' overall impressions of the PCO:

FIGURE 5: PCO Partner Survey Feedback Results



Eleven respondents elaborated on the points above, with two stating that the PCO provides a "centralizing function", with the ability to collect and aggregate information related to the provincial BSO vision and voice. The PCO has the "ability to be strategic and move BSO forward in alignment with provincial directions". Two other respondents commented on the PCO's ability to collaborate and make meaningful connections involving BSO in other work being carried out across the province (e.g., aligning with *Telehealth Ontario*'s vision to improve care coordination for those calling to inquire about responsive behaviours by developing BSO service profiles). Others commented on the PCO's excellent response time to questions and concerns, overall professionalism, advocacy work, coordination and communication and openness to suggestions.

Feedback from those involved closely with brainXchange was positive, with respondents emphasizing the great support received by brainXchange, especially the Knowledge Brokers. Others suggested that events that bring everyone together such as the Ontario Best Practice Catalyst Event (September 25, 2015) are needed in higher frequency to promote the forward momentum of the initiative, with clearly established goals in mind.

Seven respondents identified areas for improvement for the PCO to consider moving into 2016-17, with the majority focused on Communication. One respondent noted that meetings are sometimes scheduled on short notice and that a monthly calendar and/or reminder notifications may be helpful. Two other respondents voiced the need for the PCO to enable equal participation during meetings and provide more opportunities for regional and stakeholder differences. Clearer communication regarding the PCO work plan was also requested.


Disguised exits keep residents safe

"Hiding elevators with murals is known as a concealment design principle," explains Facilities Management project consultant Sarah Coelho. "The artist who painted the murals did an excellent job of interpreting our needs with the murals—she even painted a railing in the foreground so residents didn't feel like they could walk into the setting. It is so rewarding seeing the positive impact this is having on residents."

South West BSO Steering Committee secures funding for environmental enhancements for murals from the Southwest LHIN

Suggested Areas of Focus for 2016-17

The PCO also sought feedback from the BSO Clinical/Strategy Leads and BSO LHIN Leads regarding priority areas of focus for 2016-17. Among the nine responses received for this question, the following priority areas were suggested:

- Emphasizing program evaluation to assist in the determination of BSO impact and consistent implementation of the BSO legacy measure
- Continuing to align with other provincial project priorities such as the Patients First Initiative and the Ontario Dementia Strategy

- Lobbying for a BSO strategy that considers the delivery of care across the continuum with a special focus on transitions
- Expanding and evaluating current BSO core education curricula

Conclusion and Next Steps

As we enter our fifth year of the initiative and second year of the re-emerged PCO, we hope to continue to build on the momentum achieved thus far and focus on BSO **impact, integration and innovation**. Measuring BSO **impact** has been a priority area since the launch of the Behavioural Support System project, with such initiatives as the Hay Group Final Evaluation Report (March 2013) and BSO Strategy and Measurement of LTCH Residents "Legacy Report" (January 2015). Informed by this previous work, the Provincial BSO Systems Performance & Evaluation Advisory aims to enhance BSO's ability to measure its effect on patients and their families through system-wide implementation of impact measures capturing meaningful data.

The enhancement of current linkages and establishment of new opportunities for **integration** is essential to promote the continued growth of the initiative. Ongoing alignment with and provision of support to other provincial projects such as the Ontario Dementia Strategy (MOHLTC Capacity Building and Priorities Branch), Patients First Action Plan for Health Care (MOHLTC), Quality Standards for Dementia (Health Quality Ontario), etc., are imperative as they are primary drivers informing health care system transformation. Ongoing integration and partnership formation at local and regional levels are critical as well in order to continue to support BSO patients and families as they transition across and between sectors.

North East BSO Nurse Practitioner **Shannon Cadieux** (right) facilitates a Montessori-based activity with **Gert** (left)

The BSO PCO looks forward to the ongoing **innovation** emerging from the Ontario Best Practice Exchange Collaboratives and anticipates the dissemination of a variety of resources, tools and knowledge exchange opportunities. The development and sharing of best practices in key focus areas related to this initiative and the launch of BSO's Knowledge Translation & Communications Advisory is sure to build further capacity among BSO teams, health care professionals and other care partners. Essential to meeting this mandate is continuing to promote opportunities that foster new knowledge and inform the continued growth and evolution of the BSO initiative.

Ending the 2015-16 year in celebration, together with our provincial partners, the PCO expresses sincere appreciation for the new $10 million annual investment into BSO by the MOHLTC. This investment speaks to the importance of the initiative and overall readiness to further spread BSO best practices and strategies across sectors. Most of all, BSO remains committed to the delivery of person and family-centred care for older adults living with dementia, mental illness, substance use and/or other neurological conditions, their families and care partners. As a catalyst for positive change, BSO's ongoing success is ultimately a result of **people being passionate about other people.**

APPENDIX A

Four Basic BSO Team Types

a) Behavioural Support LTC Mobile Teams (7 LHINs):

Term that describes behavioural support teams that are led by a lead organization that recruits, trains and delivers outreach support in LTCHs throughout a region. In some cases, the lead organization is a LTCH delivering care to residents in other LTCHs subject to a formal Memorandum of Understanding. In some LHINs, there is 1 Mobile Team serving all LTCHs in the LHIN (e.g., Toronto Central LHIN) while in others, there are a few teams, each serving a particular region (e.g, Central LHIN).

b) Behavioural Support Embedded Teams (8 LHINs):

Term that describes teams that are located within LTCHs whereby dedicated staff (e.g., PSWs, RPNs, RNs) are funded to support the delivery of care for residents presenting with responsive behaviours. These staff are sometimes referred to as "BSO Champions", responsible for leading, coordinating and spreading effective strategies for residents experiencing responsive behaviours in that LTCH (e.g., South West LHIN, Central West LHIN).

c) Behavioural Support Community Teams (10 LHINs):

General term to describe community-based behavioural support teams funded to support BSO patients and family care partners residing in the community (including private dwellings, retirement homes, group homes, assisted living, etc.). The development of these teams was often a result of service enhancements and/or realignment of existing resources to ensure collaboration and seamless care transitions. Such teams are often linked within existing Senior's Mental Health, Geriatric Mental Health Outreach or CCAC team structures (e.g., Waterloo Wellington LHIN).

d) Behavioural Support Cross-Sector Teams (3 LHINs):

General term to describe Behavioural Support Teams that are funded to support BSO patients and family care partners wherever they reside (i.e., community, LTC, acute care, etc.). These teams are often linked within existing Senior's Mental Health/Geriatric Mental Health Outreach team structures (e.g., North East LHIN).