Presentation to:

Ontario Behavioural
Support System Project

Introduction

- The **Ontario Behavioural Support System Project** aims to improve the lives of older adults with complex and responsive behaviours associated with cognitive impairments due to complex mental health, addictions, dementia, or other neurological conditions and their caregivers.
- These adults may be living in long-term care homes or in independent living settings or receiving care in acute care environments.
- The first phase of the project (Jan-Oct 2010) is complete and a report has been prepared
- Once finalized, the report will be available on the website www.bssproject.ca
- The presentation today will outline key elements of the report including a brief overview of the project, proposed system model and contemplated next steps.

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Part 1

BSS PROJECT OVERVIEW

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Activities Leading to the BSS Project

Date	Activity
April 2009	Early leaders from across Ontario convened in Toronto and identified and advanced knowledge in 18 currently existing BSS programs which are showing promising results. Working group created to follow up on recommendations
Nov 2009	BSS Project received one time funding for phase 1
Dec 2009	A Mental Health & Addiction Strategy, BSS roundtable consultation was held in Toronto. Over 80 representatives from all sectors and communities attended and provided input as a foundation to the BSS Project- Phase 1.
Feb 2010	BSS Project kickoff webinar with over 400 participants
Jan-Oct 10	BSS project phase 1 completes its work

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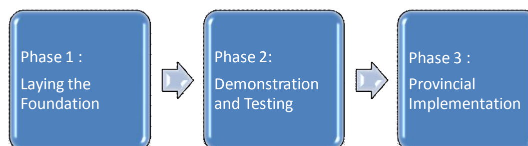
BSS Project Phases



- Phase 1 Project leadership was provided by:
  - ***Co-Executive Sponsors-*** *Bernie Blais*, CEO North Simcoe Muskoka Local Health Integration Network (NSM LHIN) and *Kenneth Deane*, ADM, Health System Accountability and Performance Division, MOHLTC
  - ***Partners***- Alzheimer Society of Ontario (ASO) & Alzheimer Knowledge Exchange (AKE) & Divisions of the Ministry of Health and Long-Term Care (MOHLTC).
  - ***Supported by-*** Ontario Health Quality Council
- Phases 2 (demonstration and testing) and Phase 3 (provincial implementation) are contemplated at this time

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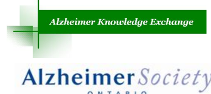

What has informed the first phase?

- Types of Information
  - *Lived Experience*
    - "Conversations about Care" over 100 caregivers consulted on how the system should work
    - Lived experience member on BSS leadership team
  - *Practice Based information*
    - Seniors Health Research Network Community of Practice regional forums regional forums were held over the summer. Facilitated by members of Ontario Health Quality Council and attended by approximately 200 cross sectoral field opinion leaders.
  - *Research*
    - Rapid Evidence Review- literature review looking at best practices in behavioural support services research focusing on review articles
- Local, National and International reach
  - *Inventory of Projects*
    - initial inventory of projects from across Ontario focused on target population
  - *Ontario BSS Virtual Advisory Panel*
    - 40-50 volunteers who were given opportunity to comment on draft model, rapid evidence review
  - *National BSS Initiative*
    - 3 meetings with group representing all provinces and territories
- Conversations with opinion leaders in targeted sectors
  - Acquired Brain Injury; Aging and Developmental Disabilities; ED ALC panel lead; Community Outreach Programs in Addictions; neurological health charities groups; ministry leaders

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Now is the time for action

- This is an important target population
  - The numbers of people at risk for responsive behaviours is increasing
  - Significant costs are associated with managing behaviours
  - The person and family require better quality experiences
- The system needs to change, and current investments should be aligned and integrated for this population
  - For example, investments in Aging at Home, Alzheimer's Strategy, Resident's First, ED ALC
  - Recognized best practices could be more systematically adopted
- There is stakeholder readiness to move forward
  - Challenges are experienced across all health sectors and services
  - Already have grassroots support of the SHRTN effort and some system capacity in quality improvement

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Part 2

ELEMENTS OF PROPOSED SYSTEM MODEL

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Principles to Guide System Model

Overarching Principle

The principle of **person and caregiver directed care** has been put forward as a key, overarching principle that needs to be reflected strategically as well as in day to day practice. All persons must be treated with respect and accepted “as one is”, the older person and caregiver/family/social supports have a central voice and are the driving partners in the care and life goal decisions.

Other proposed relevant principles include:

1. Behaviour is Communication

- Challenging behaviours can be minimized by understanding the person and adapting the environment or care to better meet the individual’s unmet needs.

2. Diversity

- Practices must value language, ethnicity, race, religion, gender, beliefs/traditions and life experiences of the people being served

3. Collaborative Care

- Accessible, comprehensive assessment and intervention requires an interdisciplinary approach which includes professionals from different disciplines, as well as the client and family members, to cooperatively create a joint, single plan of care.

Principles to Guide System Model cont.

4. Safety

- The creation of a culture of safety and well-being is promoted where older adults and families live and visit and where staff work.

5. System Coordination and Integration

- Systems are built upon existing resources and initiatives and encourage the development of synergies among existing and new partners to ensure access to a full range of integrated services and flexible supports based on need.

6. Accountability and Sustainability

- The accountability of the system, health and social service providers and funder to each other is defined and ensured

3 Pillars of the BSS Model

Pillar #1 ***System Coordination***	Pillar #2 ***Interdisciplinary Service Delivery***	Pillar #3 ***Knowledgeable Care Team and Capacity Building***
Coordinated cross-agency, cross-sectoral collaboration and partnerships based on clearly defined roles and processes to facilitate 'seamless' care.	Outreach and support across the service continuum to ensure equitable and timely access to the right provider for the right service.	Strengthen capacity of current and future professionals through education and focused training to transfer new knowledge and best practice skills for continuous quality improvement.

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The Essential Elements of each Pillar

	System Coordination	*Interdisciplinary Service Delivery*	*Knowledgeable Care Team and Capacity Building*
3 Pillars → Essential Elements	System Management/Accountability Governance structure Operations level coordinated network Regional System Coordinator role Integrated Collaborative Intake, Transitions & Referrals	***Collaborative/Shared Care Service Delivery*** ***Bio-Psychosocial Environmental Model*** ***Least restrictive and least intrusive approach*** **SUPPORTED BY:** Mobile Interdisciplinary Behavioural Support Outreach Teams Case Management and Supported Transitions Enhanced Day Treatment and Respite Care Specialized Residential Treatment (Behavioural Support Units)-short stay Specialized Residential Treatment – long stay	Learning and Development for continuous quality improvement and built capacity through a skilled workforce at point of care, at organizational level and at system level **Clinical** for prevention, management of responsive behaviours **Caregiver** support **Self- management** to help make informed choices **Capacity building** to create supportive learning infrastructures **Collaboration** within between individuals, teams, organizations, systems **Innovation** for cutting edge research and use of new technologies **Resource investment** to support efficient, effective use of scarce HR and evidence based resource decisions

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Part 3

PROPOSED NEXT STEPS

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Main Goals in Moving Forward

1. Improved Patient Experience
   - Primary objective is patient driven care – current system is not patient driven
   - Need to find ways to enhance caregiver supports
2. Improved System Performance
   - We are not measuring system performance in this area- need to develop system indicators
   - Better ways of providing care exist- system requires some standardization of practice and the protocols to support this

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A Proposed Phase 2: Implementation and Testing Some Assumptions

- **Modest new investment** is required to change performance since current investments have provided a good foundation.
- **Many innovative solutions exist**, but may not have been evaluated fully or spread across the province. Implementation must incorporate and build on these projects.
- **Standardization of practice** through the use and development of guidelines and protocols in key areas is required
- **Ontario needs to continue to take a leadership role nationally** on this topic
- **A quality improvement approach is necessary** to create the system changes across all sectors and to ensure implementation includes better handoffs, integration and transitions
- **Knowledge exchange occurs during the implementation** to facilitate spread of good ideas and ensure timely course corrections
- **Full coordinated evaluation is necessary** including system outcomes, creation of indicators and potentially new data collection including all phase 2 projects

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For more information

- Visit www.bssproject.ca for resources, links and updates
- E-mail your questions to: bss@alzheimeront.org

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