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

Behavioural Supports Ontario 14 LHIN Models Guide – May 2017

Developed in collaboration between the BSO Provincial Coordinating Office & Central East BSO

The Behavioural Supports Ontario (BSO) initiative was created to enhance health care services for older adults in Ontario with complex and responsive behaviours associated with dementia, mental illness, substance use and/or other neurological conditions. The initiative also provides enhanced family caregiver support in the community, in long-term care or wherever the patient and/or family care partner(s) reside.

Basic Team Descriptions:

Across the province, there are currently four basic types of BSO funded behavioural support teams: (1) Embedded; (2) Mobile; (3) Community; and (4) Cross-Sector. In addition, some regions have implemented BSO positions in (5) Acute Care and others have launched (6) Behavioural Support Units (BSUs). Listed below are basic descriptions of each of the aforementioned model components.

1) Behavioural Support Embedded Teams:

Term that describes BSO staff or teams that are located within LTCHs (e.g., PSWs, RPNs, RNs, Recreational Therapists) that are funded to support the delivery of care for residents presenting with responsive behaviours. These staff members are sometimes referred to as “BSO Champions”; responsible for leading, coordinating and spreading effective strategies for residents experiencing responsive behaviours in that LTCH. In some LHINs, all LTCHs have embedded BSO Staff (e.g., Waterloo Wellington LHIN, South West LHIN, Central West LHIN) while in others, only a portion of LTCHs have Embedded BSO Staff (e.g., Central East LHIN, North East LHIN). The number of BSO FTEs embedded in LTCHs across the province ranges from 0.1 FTE to 7.0 FTEs per LTCH.

2) Behavioural Support Long Term Care Mobile Teams:

Term that describes behavioural support teams that are led by a lead organization that delivers outreach support to 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 (e.g., Erie St. Clair LHIN, Hamilton Niagara Haldimand Brant (HNHB) LHIN); while in others, the lead organization is a hospital or other health care organization. In some LHINs, there is one 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 part of the region (e.g., Central LHIN).

3) Behavioural Support Community Teams:

Term that describes 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 Seniors’ Mental Health, Geriatric Mental Health Outreach or CCAC team structures (e.g., Toronto Central LHIN, North Simcoe Muskoka LHIN).

4) Behavioural Support Cross-Sector Teams:

Term that describes behavioural support teams that are funded to support BSO patients and care partners wherever they reside (i.e., LTC, Community, Acute Care, etc.). These teams are sometimes linked within existing Seniors' Mental Health/Geriatric Mental Health Outreach teams, CCAC or Specialized Geriatric Services structures (e.g., North East LHIN, Waterloo Wellington LHIN).

5) Behavioural Support Dedicated Acute Care Positions:

Term that describes behavioural support staff or teams that support patients presenting with responsive behaviours in the acute care sector. These staff are also often responsible for building capacity with other acute care staff members. In some LHINs, these staff travel to multiple acute care sites (e.g., HNHB BSO's Clinical Leaders); whereas in others, they are embedded to support one acute care site (e.g., Champlain BSO's Geriatric Psychiatry Behavioural Support Nurses). While some acute care centres receive BSO support from Cross-Sector BSO teams that have the ability to support patients and families anywhere across the continuum, only a few regions have dedicated Acute Care positions.

6) Behavioural Support Units (BSUs)

Term that describes specialized units with a unique service arrangement for LTC that expand the role they play in the continuum of care. These units wrap higher intensity care around residents with complex responsive behaviours. These residents can come from hospitals (where they are often in ALC beds), LTC, or the community. As the behaviours stabilize, the extra care requirements gradually taper off and the resident can return to their LTC home or to the community. Behavioural Support Units range in size between 8-32 beds. Three of Ontario's five BSUs are currently supported with BSO funds.

BSO Websites

http://www.behaviouralsupportsontario.ca/RegionalSite

	Current BSO Models (prior to release of 2016-17 Enhanced Funding) (i.e., BSO Base Funding + LHIN-leveraged funding)				**BSO Models Enhancements** (i.e., 2016-17 Enhanced Funding)			
LHIN	**Long-Term Care (LTC)**	**Community/Cross-Sector**	**Dedicated Hospital BSO Resources**	**Other**	**Long-Term Care (LTC)**	**Community/Cross-Sector**	**Dedicated BSO Hospital Resources**	**Other**
Erie St. Clair Pop: 640,228 # of LTCHs: 36	**Embedded:** 3.9 FTE NUR & 13.5 FTE PSW spread across all LTCHs **Mobile**: 4 mobile teams comprised of 1.0 FTE RN, 1.0 FTE RPN & 1.0 FTE PSW each support all LTCHs	**Cross-Sector:** 3 Geriatric Mental Health Outreach teams each comprised of Psychogeriatric Resource Consultants (PRC), Social Work, Nursing, Occupational Therapy (OT) & Nurse Practitioner (NP) support patients across all sectors (two streams: 1 LTC, 1 Community)	2.4FTE Acute Care BSO Positions (Hotel Dieu Grace Healthcare, CCAC Chatham-Kent Health Alliance & Blue Water Health)	3.0 FTE System navigators 1.0 FTE Regional Education Trainer/Coach 1.0 FTE Regional Coordinator	**Embedded**: Adding 7.0 FTE to current embedded model (now including Social Work & Recreation Therapy)	**Cross-Sector** Adding 1.5 FTE Specialized Social Therapist Workers	0.8 FTE Hospital Navigator	
South West Pop: 962,539 # of LTCHs: 78	**Embedded:** 0.11-1.0 FTE NUR & 0.1-1.0 FTE PSW in each LTCH	**Cross-Sector:** 5 teams support patients in community and long-term care and also support transitions across all sectors including acute care + 0.5 FTE Social Work positions at 6 Alzheimer Society Chapters **Community:** Enhanced staff in Memory Clinics Enhanced Adult Day Programs providing overnight respite	London Health Sciences Centre is piloting a dedicated hospital transition team for 1 year.	5 Enhanced Psychogeriatric Resource Consultants (4.0 FTE). QI Facilitator (1.0 FTE) Program Analyst (1.0 FTE) 1 FTE; Project Consultant 0.8 FTE; Coordinator, Regional Development & Education for Seniors' Mental Health (0.4 FTE; integrated with shared funding with Regional Psychogeriatric Program SJHC London 0.6 FTE). Geriatric Psychiatrist (0.8.FTE). Psychologist (1 FTE)	**Embedded:** Funding provided to all 78 LTCHs to enhance NUR, PSW positions or to introduce Rec. Therapy/Behavioural Therapists positions	**Cross-Sector:** Funding provided to all 6 Alzheimer Society Chapters for additional Memory Clinic staffing resources		

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Waterloo Wellington Pop: 781,944 # of LTCHs: 36	**Embedded:** 0.11FTE – 1.15 FTE NUR & 0.13 – 1.54 FTE PSW in each LTCH	**Cross-Sector:** 13 FTEs: Community Responsive Behaviour Team (linked with Specialized Geriatric Services) provides support to BSO patients in the community. Team comprised of Social Work, OT, Rec. Therapy, Geriatric Addictions, Clinical Intake, Quality Improvement & Knowledge Transfer Psychogeriatric Resource Cosultants			**Embedded:** Adding 7.0 FTE spread across all LTCHs		added 1.5FTE to their PRC complement with the aim of increasing support to the acute care sector	
Hamilton Niagara Haldimand Brant Pop: 1,457,789 # of LTCHs: 86	**Mobile:** One employer with 5 Teams supporting all LTCHs; each comprised of 1.0 FTE RN, 2.0-4.0 FTE RPN & 3.0 – 9.0FTE PSW	**Community:** Community Outreach Team comprised of 11.0 FTE and 1.0 FTE Manager	3.0 FTE BSO Clinical Leaders serving all 17 sites	2.0 FTE HNHB LHIN Strategy Team 1.0 FTE Navigation & referral "BSO Connect"	**Mobile**: Adding 6.0 FTE BSO Transitional Leads focusing on high risk patients requiring intensive transition support during LTCH admission	**Community:** Adding 1.0 FTE Community Outreach Worker Adding 1.0 FTE Geriatric Specialist focused on Retirement Homes	Adding 1.0 BSO Clinical Leader	

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Central West Pop: 935,304 # of LTCHs: 23	**Embedded:** 0.5-1.0 FTE NUR OR 1.0 FTE PSW in each LTCH	**Community:** 2.0 FTE PRCs support community partners, assisted living and retirement homes 1.0 FTE PRC primary care 1.0 FTE PRC South Asian Population 0.5 FTE Adult Day Program Champion 1.0 FTE Crisis MH Geriatric Nurse **Cross-Sector:** 2.0 FTE Geriatric Behaviour Support Transition Resource Nurses linked with CCAC		1.0 FTE BSO Coordinator/Director	**Mobile**: Introducing 2.0 FTE Neuro Behavioural NPs (primary function is to support transitions across all sectors including acute care)	**Community:** Adding 1.0 FTE Crisis Mental Health Nurse		
Mississauga/ Halton Pop: 1,258,379 # of LTCHs: 28	**Embedded:** 0.5 FTE NUR and/or 0.5FTE-1.0 FTE PSW in all LTCHs	**Community:** 6.0 FTE Community Support Workers in Adult Day Programs BSO Outreach Counsellor supports family care partners in the community			**Embedded :** Adding 2.4 FTE RPN, 4.3 FTE PSW & 1.2 FTE Rec. Therapy to embedded model	**Community:** Adding 1.1 FTE System Navigator (to support individuals coming into acute care from either LTC or the community) Adding 1.0 FTE Counsellor Adding 0.5 FTE Community Support Worker		

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LHIN	**Long-Term Care (LTC)**	**Community/Cross-Sector**	**Dedicated Hospital BSO Resources**	**Other**	**Long-Term Care (LTC)**	**Community/Cross-Sector**	**Dedicated BSO Hospital Resources**	**Other**
Toronto Central Pop: 1,281,363 # of LTCHs: 36	**Mobile:** 1 team comprised of 8.0 FTE NUR & 17.0 FTE PSW supports all LTCHs	**Community:** 3.0 FTE Community Behavioural Support Outreach Team (linked with CCAC) supports BSO patients in the community 2.5 FTE Crisis Service Enhancement	2.0 FTE Behavioural Support Specialists serve individuals below 65 in LTC and those over 65 in acute care. 2.0 FTE Case Managers and 3 FTE PSWs Behavioural Support Transition Resource (via LOFT Community Services) support patients designated ALC who present with responsive behaviours	Behavioural Support Unit at Baycrest's Apotex Centre (23 beds) 1.0 FTE PRC for Primary Care 1.0 FTE Social Work Education 1.0 FTE Clinical Psychologist	**Embedded** Introducing BSO embedded model in a portion of LTCHs (exact homes and # of FTEs TBD)	**Community:** Adding 2.5 FTE to Community Behavioural Support Outreach Team		
Central Pop: 1,895,091 # of LTCHs: 46	**Mobile**: 3 teams, each comprised of 1.0 FTE RN, 4.0 – 5.0 FTE RPN & 6.0-7.0 FTE PSW support all LTCHs	**Community:** 3 teams, each comprised of 2.3 FTE Social Work, 1.2 PSW FTE & 1.0 Team Leader 1.0 FTE Behavioural Therapist shared by all 3 teams) to support individuals and care partners wherever they reside (outside of LTCH)	*New LHIN base funding being used for Behavioural Support Transition Resources to support 6 hospitals across Central LHIN *(NOT BSO FUNDING*)*	Behavioural Support Unit at Cummer Lodge (16 beds) 0.2 FTE Medical Advisor (Primary Care) 0.2 FTE Medical Advisor (LTC)	**Embedded:** Introducing embedded model in 6 LTCHs: 1.0 FTE RPN & 0.6 FTE PSW each	**Community:** Adding 3.0 PSW FTEs to mobile tams (1 FTE PSW each)		

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Central East Pop: 1,617,165 # of LTCHs: 68	**Embedded:** 0.5-3.0 FTE NUR & 0.5-3.5 FTE PSWs in 18 LTCHs	**Community:** 10.0 FTE RPN part of Geriatric Assessment and Intervention Network (GAIN) Team 2.0 FTE RPN support Primary Care Memory Services		2.0 FTE Quality Improvement Facilitators 1.0 FTE Regional Manager	**Embedded:** Expanding embedded model by 9.5 FTE (7.5 RPN and 2 PSW) in an additional 10 homes (embedded model now in 28 of 68 LTCHs) (covering 50% of LTC beds in LHIN)	**Community:** Adding 2.0 FTE RPN BSO Clinician on 2 additional GAIN teams		
South East Pop: 498,166 # of LTCHs: 21	**Mobile:** 3 teams each comprised of 1 FTE RN, 2.8 FTE RPN & 6.0 FTE PSW support all LTCHs			1.0 FTE Regional Director 1.0 FTE Clinical Resource Project Coordinator Lived Experience Network Coordinator Knowledge Exchange Coordinator	**Embedded**: Introducing embedded model in 6 LTCHs: RNs, RPNs, PSWs, SW, Rec. Therapy			

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LHIN	**Long-Term Care (LTC)**	**Community/Cross-Sector**	**Dedicated Hospital BSO Resources**	**Other**	**Long-Term Care (LTC)**	**Community/Cross-Sector**	**Dedicated BSO Hospital Resources**	**Other**
Champlain Pop: 1,332,506 # of LTCHs: 61	**Embedded:** 0.2-1.0 FTE PSW in each LTCH	**Community:** 6.5 FTE Geriatric Psychiatry Outreach Team	2.0 FTE RN Geriatric Psychiatry Behavioural Support Team - supporting individuals presenting with responsive behaviours at the ED and inpatients. They collaborate with the BSO outreach teams to support transitions out of acute care.		**Mobile:** Introducing 5.7 FTE Behavioural Science Technicians (Behavioural Therapist Resources)		Adding 2.4 FTE RN Geriatric Psychiatry Behavioural Support Nurses	
North Simcoe Muskoka Pop: 485,738 # of LTCHs: 28	**Mobile:** 3 Teams each comprised of 3.0-4.0 FTE NUR & 5.0-6.0 FTE PSW support all LTCHs	**Community:** 3 dyads (comprised of 1.0 FTE registered staff (Social Work or OT) each & 1.0 FTE PSW each (total: 6FTEs)		1.0 FTE RPN Transitional Nurse 1.0 FTE RN Intake Worker 0.2 FTE Medical Advisor 1.0 FTE Behavioural Support System Coordinator	**Mobile:** Adding PSW FTEs & Psychometrists to mobile teams	**Community:** Adding RN to Community teams	Introducing Behaviour Success Agents	One-time funding for Antipsychotic Lead Trainer

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LHIN	**Long-Term Care (LTC)**	**Community/Cross-Sector**	**Dedicated Hospital BSO Resources**	**Other**	**Long-Term Care (LTC)**	**Community/Cross-Sector**	**Dedicated BSO Hospital Resources**	**Other**
North East Pop: 562,035 # of LTCHs: 42	**Embedded:** 0.6-3.0 FTE NUR & 1.5-4.0 FTE PSW embedded in 14 LTCHs	**Cross-Sector:** 4 Integrated Response Teams (IRTs) [3.125FTE - 7.125 FTE linked with Seniors' Mental Health, comprised of: PRCs, Clinicians, Behavioural Support Facilitators (BSF) (for family care partner support), NP & CCAC support patients across sectors (one team located in each hub)	2.0 FTE BSO Clinicians	1.0 FTE Regional Manager 1.0 FTE Clinical Intake Specialist & 0.5 Admin (Centralized Intake) 0.2 Medical Specialty Stipend		**Cross-Sector:** 1.5 FTE Rural Clinician Enhancing Behaviour Support Facilitator Role (care partner support) provided via Alzheimer Society		Behavioural Support Transition Unit under development (8 beds)
North West Pop: 235,883 # of LTCHs: 9	**Mobile:** 2 teams comprised of 4.2 FTE PSW total (led by PRCs)	**Cross-Sector:** 2.0 FTE PRC & 4.0 FTE PSW		Behavioural Support Unit at Hogarth Riverview Manor [32 beds] 1.0 FTE Public Education Coordinator 1.0 FTE Sys. Navigator	1.0 FTE PRC Thunder Bay 1.0 FTE PRC Kenora/Rainy River 1.0 FTE PRC Terrace/Schreiber/Marathon 1.0 FTE PSW Mobile Outreach Team City of Thunder Bay			0.4FTE RN for Behavioural Support Unit

BSO Contacts- LHIN by LHIN

List current as of February 2017 however, subject to change. Please contact the BSO Provincial Coordinating Office at provincialbso@nbrhc.on.ca for an updated contact list.

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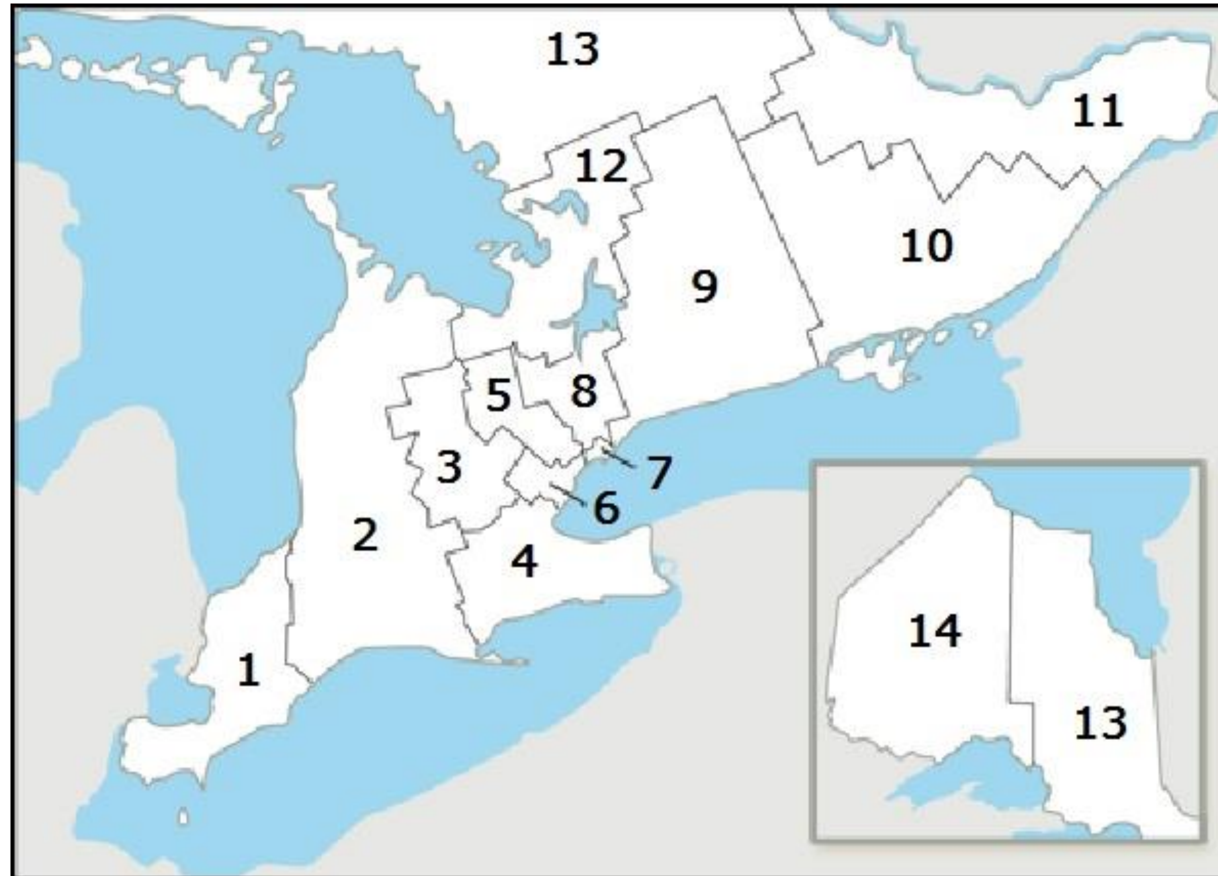

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