March 2012

March marked a milestone for the HNHB LHIN BSO Action Plan. Between December 2011 and March 31, 2012, more than 170 LHIN stakeholders worked together to develop and evaluate new ways of providing services to individuals with responsive behaviours* and their caregivers.

The new approaches to providing services focus on improving the client experience through the introduction of new roles, new tools, integrating into existing services and innovative collaborations. There was a positive impact on the clients involved in the early implementation trial period including: improvements in a client's responsive behaviours, ensuring a client with complex issues had a collaborative care plan developed, and supporting a client through a crisis to transition to longer term community supports.

Action Plan Highlights

- Single point of contact for individuals and caregivers to connect with multiple resources and services
- Organization to support individuals and caregivers by taking a lead role in coordinating programs and services across multiple organizations
- Mobile outreach teams to support individuals and caregivers in the community
- Mobile outreach teams to support individuals and caregivers in long-term care
- Toolkit for primary care providers to help them assess and manage patients with responsive behaviours

Josie's Story

Salim is an elderly gentleman who has Alzheimer's disease. Josie, his primary caregiver and wife, was becoming burnt out from the nightly routine of waking up frequently to find her husband wandering, attempting to leave the house. And often times, he did not recognize her. Josie's attempts at reassuring her husband and intentionally taking him for walks through the night were not always successful in helping her husband settle.

Crisis Outreach and Support Team (COAST) Hamilton referred the couple to meet with BSO staff. Together they explored options to meet the needs of Josie and Salim. BSO staff offered strategies to prevent Salim from wandering at night and helped to arrange for him to attend an Adult Day program, enabling caregiver relief for Josie. They also connected Josie with the Alzheimer Society for its 'Safely Home' program and connected her with other supports, including local groups, counseling, telephone support and a friendly visiting program.

Thanks to the support from the BSO staff, Josie feels more rested, remains healthy, and is enjoying her husband's company again.

Community

Easier Access to Service

BSO Connect (formerly known as the 'Gateway Model') provides individuals with responsive behaviours and their caregivers with a single point of contact to access community programs and services. During the early implementation phase, over a two week period BSO Connect received 18 calls, 17 of which were made by caregivers. Of these caregivers, 64% identified caregiver burnout/crisis as the reason for the call. The BSO Connect staff was able to link clients directly to lead agencies for follow-up support, addressing specific client needs through an active process of matching services to the client. Positive feedback on this single point of contact approach was received by both clients and caregivers.

Better Coordination of Service
The Integrated Community Lead (ICL) acts as the lead organization for coordinating care for clients and caregivers who are accessing programs and services across multiple organizations.

Over a two week period in February, the ICL received 19 new referrals – 13 referrals (68%) were directly from BSO Connect. Eight of these referrals required the ICL to work with with another agency to identify and coordinate a care plan to meet the client's needs. Six referrals resulted in a change in the ICL to one that would better meet their needs. The evaluation of this model during the early implementation phase showed that this approach has great potential to improve the client and caregiver experience through the improved coordination of service and reduced duplication.

Increased Access to Crisis Support in the Community
The BSO Community Outreach Team works with five existing crisis response teams across the LHIN. In Hamilton, the team works with COAST Hamilton. During the early implementation phase, the team received 20 new contacts and completed seven visits. The team worked with clients through their crisis, building trusting relationships to support them through the process of engaging community providers for longer term options. As an example of how the team worked with individuals to help them through a crisis period and set in place a plan to provide ongoing support, read 'Josie's Story' on page 1.

The early implementation phase showed that this approach has great potential to improve client and caregiver access to "just in time" support during a 'crisis' period and link them to the appropriate community services.

Long-Term Care

The Long-Term Care Mobile Team will provide scheduled and episodic support to staff of the LHIN's 87 long-term care homes (LTCHs) who provide care to residents with responsive behaviours.

During the early implementation phase, a BSO team visited two LHIN LTCHs. During the visit the team had an opportunity to work with a staff member to model gentle persuasive approaches (GPA) to deliver morning care to a resident. The staff member reported that the resident's responsive behaviour was reduced as a result of this approach to care.

To support capacity building within the homes, the LHIN approved funding for long-term care home staff to be trained in specialized approaches to caring for individuals with dementia. More than 600 frontline staff have completed the GPA training and GPA Coach or Montessori training, recognized best practice approaches to caring for individuals with dementia.

Primary Care

Throughout February, providers across six primary care practices within the LHIN evaluated the toolkit among eight patients. The goal was to evaluate the effectiveness in helping providers to identify and manage individuals with responsive behaviours. The tools identified for 'consideration' for primary care include cognitive and functional assessments, a tool that helps evaluate clients' behaviours, a checklist that serves as a reminder of the safety issues that can develop, and a tool that helps determine caregiver's stress level. They offered suggestions regarding investigations, treatment and management for these individuals with responsive behaviours and caregivers.

Primary care providers also suggested the toolkit could be used in other settings, such as retirement homes or where there is access to interdisciplinary teams who can conduct assessments, as it can be challenging in these

settings to send clients to external specialized clinics. This information will help guide next steps as the Primary Care sub-committee moves forward.

Learn More

- BSO Provincial Website
- BSO in HNHB LHIN

The Behavioural Supports Ontario (BSO) Project is about enhancing care for older adults and seniors with responsive behaviours and their caregivers. The HNHB LHIN's Action Plan outlines four key solutions to enhancing care locally. Four sub-committees have been developed to advance these solutions: ***Primary Care****,* ***Community****,* ***Long-Term Care*** *and* ***Human Resources****. The work of these sub-committees is being overseen by an Oversight Committee.*

***Responsive behaviours:** Includes pacing, wandering, verbal aggression, and physical aggression toward oneself or others.