April 2012

April marks the next phase of the BSO project: Implementation, Integration and Evaluation. There is excitement among those who have participated and especially the BSO staff hired, as the models developed and evaluated through the last few months are implanted across the LHIN to benefit clients and their caregivers. All of the work accomplished through the first phase of the BSO project can be found in a report available at www.hnhblhin.on.ca.

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

---

Robert and Mary's Story

Robert and Mary live independently at home. Robert is the primary caregiver for his wife Mary, who experiences confusion and behaviour issues. After being diagnosed with diabetes and suffering a heart attack, Robert turned to BSO Connect for help with caring for Mary.

BSO Connect arranged for a Case Manager from the HNHB Community Care Access Centre (CCAC) to visit the couple to assess their needs. Upon arrival, the Case Manager noted Mary was exhibiting responsive behaviours and Robert appeared tired, resistant and frustrated. The Case Manager learned the couple had been visited by another agency for an assessment earlier that day.

Following the visit, the CCAC contacted other agencies involved in the couple's care. Now, the agencies are working together to coordinate scheduling and services to best meet Robert and Mary's needs.

Community

The Community Model is not dependent on new resources, but rather on taking a new approach as to how community agencies work together to better coordinate and integrate care for individuals with responsive behaviours*. The Community sub-committee continues to meet on a regular basis. Its three models are slowly being implemented across the five hubs within the LHIN. Continued evaluation of each model will be completed throughout the implementation phase.

Easier Access to Service
The HNHB Community Care Access Centre (CCAC) Information & Referral (I&R) staff are preparing for the BSO Connect implementation in May. An additional staff member has been hired for the existing team, acting as a champion for the BSO project and preparing for the roll-out of the model. The feedback from I&R staff, and community agencies that received the BSO Referral Form through the evaluation phase, has been used to modify the form.

Through the BSO Connect model clients will be provided support in accessing services and the BSO Referral will be shared with the agencies that will meet the needs of the client. This approach to linking clients and/or

caregivers to community programs or services will help to reduce the number of calls the client/caregiver needs to make. Information gained through the February trial period indicates that the majority of calls are made by caregivers. Through active referrals to community agencies, BSO Connect will improve the service provided to these individuals and it may help to minimize clients getting into crises.

Better Coordination of Service
The Integrated Community Lead (ICL) component is a key element in redesigning how community agencies collaborate for the benefit of the client *(see Robert and Mary's Story on page 1).* This approach to care delivery exemplifies the principles of the BSO Framework and is supported by a process where agencies working together to meet the needs of their collective clients formalize their roles and responsibilities within a collaborative framework.

The planning for implementation of all hub areas in June has begun, with the earlier start planned for the Niagara region in late May. Meetings with key ICL agencies to discuss the role of the ICL and sending letters to partnering community agencies will begin in May to help prepare for the introduction of this function within existing roles.

Increased Access to Crisis Support in the Community
The BSO Community Outreach Teams for each of the five areas, and the Team Lead, have been hired, received training and began orientation to their local crisis outreach teams. COAST Hamilton has begun introducing BSO staff through joint visits with clients in the community who were exhibiting responsive behaviours. By supporting a few clients through their crisis, transitioning them to longer-term community supports, the COAST and BSO staff has been determining the best approach for clients given the new expertise and help available with the addition of the BSO staff. The early learning from these joint outreach visits has fostered a new approach to this population, enhancing the existing crisis outreach to provide clients with an improved experience.

COAST Hamilton is fully implementing the BSO staff in May, continuing to evolve the model through understanding what will work best for the clients through collaborative, reflective discussions involving COAST and BSO staff. The Hamilton team is sharing their learning and tools with the LHIN's other four crisis teams for their full implementation starting in June.

Long-Term Care

The BSO long-term care home (LTCH) mobile team has been divided into five teams (hubs) across the LHIN and reaching out to LTCHs within their respective hubs. The teams are receiving orientation to the local LTCHs and are shadowing partnering geriatric outreach teams and psychogeriatric resource consultants as their case visits. The teams have finalized the central intake process that will be used in each geographic hub. This coordinated intake process to access outreach services will make it easier for LTCHs to access assistance for residents with responsive behaviours. The BSO teams will begin accepting new referrals in a staged rollout beginning May 2012.

As of April 30, 2012, 62 LTCHs signed Memorandums of Understanding with St. Joseph's Villa to participate in the BSO project and accept services from the BSO LTCH team.

The Niagara BSO staff participated in a PIECES education day, where PIECES trained staff from various LTCHs attended. Key benefits of the model include the sharing of feedback on the escalation protocol, the benefits of the BSO team in their effort to ***work with*** staff to reduce residents' responsive behaviour, and the peer-to-peer support.

Primary Care

Revisions to the toolkit have been made based on the feedback received in March, which included greater clarification to the introduction, revised flow diagram and removing tools that were not found to be of benefit. The process to develop and evaluate the toolkit was shared at an April conference, where interest arose by participants outside of primary care (i.e. CCAC Case Managers). Just as there may be interest in using the toolkit in settings such as retirement homes where other health care professionals can provide input, there may be benefit for organizations who visit clients in their homes. There may also be benefits for the BSO LTCH Mobile and Community Outreach Team to use the toolkit with clients.

BSO Connect, an aspect of the toolkit, will be evaluated from the primary care perspective through May to July, gaining information that may show improved links to agencies for clients and building capacity in the knowledge of services available for primary care.

In June the LHIN will be surveying primary care physicians to gain advice as to the gaps and opportunities to better serve individuals with responsive behaviours. The LHIN will also be establishing a Primary Care Collaborative, an opportunity to gain additional information on how to assist primary care providers to care for individuals in the community with responsive behaviours and their caregivers.

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.