## May-June 2012

Outlined in the HNHB LHIN's Behavioural Supports Ontario (BSO) Action Plan, the innovative models of care developed collaboratively among health care providers, stakeholders and citizens are now being put into practice. New ways of working on the frontlines and behind the scenes are resulting in better coordinated care and reduced duplication of services, smoother transitions between services, and enhanced access to services closer to home for individuals with responsive behaviours and their caregivers.

### *Karen and Ralph's Story*

After seven years of caring for her husband Ralph, who has dementia, Karen is beginning to burn out. Ralph needs help with everyday tasks like dressing and bathing, he often gets confused, is repetitive, and becomes anxious when his wife is not around. Admittedly Karen is stressed and both she and her husband are in need of some support.

Following a referral from Karen's family doctor to BSO Connect, a Case Manager from the Community Care Access Centre (CCAC) makes a home visit to assess the couple's needs. As the Integrated Community Lead (ICL), the CCAC is taking the lead in developing a plan and coordinating supports and services for the couple. Karen is very pleased with the plan in place, which includes caregiver relief for her and personal care and occupational therapy for Ralph.

### 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 when in crisis
- 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

## Community

The BSO Community Outreach Teams (COT) are now active across all five hubs in the HNHB LHIN: Brant, Burlington, Haldimand-Norfolk, Hamilton and Niagara. These BSO staff work with existing crisis teams to assist individuals who are in urgent need of help through a challenging situation. The staff also connect the individuals to longer-term supports. As of the end of June, the COTs received more than 125 calls collectively.

Now up and running in Niagara, BSO Connect has linked nearly 40 individuals to services in the community through agencies like the Community Care Access Centre (CCAC), Niagara Region Community Support Services and the Alzheimer Society of Niagara Region. BSO Connect is currently being implemented across the four remaining hubs: Hamilton, Haldimand-Norfolk, Brant and Burlington. Similarly, the ICL model is being implemented in Niagara and subsequently being implemented across the remaining four hubs.

## Long-Term Care

The BSO Long-Term Care Home Mobile Teams have been busy. To date, the teams visited and presented to more than 1,200 staff, residents and families at more than 80 long-term care homes. Through the existing intake system for geriatric outreach in each hub, the teams have been receiving referrals from the 82 long-term care homes that have agreements to participate in the BSO project.
For some complex referrals, the teams have been working closely with the existing Specialized Geriatric Outreach Teams and the Psychogeriatric Geriatric Consultants.

> ***"It is rewarding to partner with other teams to ensure the best quality care for residents,"***
> *-Dee Foley, RN and BSO Team Manager, Hamilton Hub*

The BSO Mobile Team Implementation Committee held its first meeting May 31, 2012. The committee includes representatives from the organizations providing central intake, long-term care homes, the CCAC, the Alzheimer Society/Dementia Alliance, hospitals, the BSO COT and Long-Term Care Home Mobile Teams, and the HNHB LHIN Nurse Led Outreach Team. The committee will meet monthly to provide insight, direction and leadership on the implementation and evaluation of the BSO Mobile Team model.

## Primary Care

The toolkit has been revised based on feedback from primary care providers and additional information will be sought on areas identified by these providers as gaps in supports and services for the BSO population. A survey will be sent to primary care physicians to gain their advice as to the gaps and opportunities to better serve the BSO population. The HNHB LHIN will also complete an environmental scan to understand the number and types of geriatric assessment clinics within the LHIN, and the number of physicians that have access to this type of resource. Based on feedback from primary care providers and in order to bridge the gap between primary care and specialists, the LHIN will explore an integrated care model that operates through a clinic-type setting for seniors with behaviour issues.

In September, the LHIN will establish a province-wide Primary Care Collaborative to gain further insight on how to assist primary care providers to care for the BSO population in the community. The Primary Care Collaborative will invite all Ontario LHINs to participate in sharing knowledge, and learnings developed, as a means to facilitate accelerated improvement. This Collaborative will be supported by a Health Quality Ontario (HQO) Quality Improvement Coach, and the material will be shared through the Alzheimer Knowledge Exchange (AKE) collaborative space.

## 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.*

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