April 2013 to May 2013

It has been a full year since the HNHB implemented the Behavioural Supports Ontario (BSO) models. The current focus is on efforts to sustain the BSO models to improve the quality of care and quality of life for this vulnerable population. In addition, continued implementation to stabilize each of the models is a key priority for this current year. The feedback from health service providers and clients is critical to the ongoing evolution of the models.

HNHB LHIN engaged over 80 health service providers through a half-day event and small focus groups to discuss how to sustain the BSO models and opportunities to make improvements. See the results in the 15 page Sustainability Plan

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

BSO Community Models

One of the community BSO models, BSO Connect, has been establishing itself as the single point of entry where services are pulled toward the client with a "warm connection" to the appropriate service provider for that particular client and family. Clients and their families are sharing how BSO Connect has simplified the process of finding appropriate services in a timely manner.

BSO Connect was able to appropriately link 459 BSO clients to needed services in their community

"BSO Connect successfully established a warm connection for a caregiver residing outside of the province who was attempting to navigate the Ontario Health System to assist his mother who was in crisis. One call to BSO Connect resulted in a warm connection to COAST, and the caregiver indicated he was 'more at ease' and that he had 'made the right call to the right agency without having to make multiple calls'." - Jocelyne Lebel BSO Connect Champion, Information and Referral, CCAC in HNHB LHIN

There is ongoing engagement of key agencies to continue to implement the Integrated Community Lead (ICL) model. Understanding how to integrate the functions of the ICL into existing roles, discussing challenges, sharing common tools and participating in quality improvement efforts is happening through local discussions among agency front-line staff and leaders.

Regional ICL 'hub' meetings to put the functions into practice

During the BSO Community Outreach Team's (COT) first year of existence, the local teams managed to respond, diffuse and prevent over 700 crises situations involving older individuals presenting with active responsive behaviour. What makes this team different from the regular local crisis services is their specialized training in geriatrics and holistic management of responsive behaviour. The team's ability to go where the client is and assess the behaviours as they happen, their ability to stay with the client and their families and model techniques to de-escalate and prevent future occurrence of behaviour all contribute to a better care experience for the clients and their families.

"Navigation of the social services and medical system can be a challenge for professionals like myself who have been working within the system for over 16 years. The BSO COT staff became the lead in system navigation, connecting people with supports and services. The staff accompany people to their appointments, share client-related health information with the various services providers and relieve the client and their families from the task of re-telling their stories over and over again through multiple assessments to get the services they deserve." - Dana Vladescu, Manager-BSO Community Outreach Team, Alzheimer Society, HNHB LHIN

978 clients benefited from navigational supports through the centralized referral process and the mobile community crisis worker linking the clients to services

BSO Long-Term Care Model

BSO Long-Term Care Mobile Team received 1317 referrals and provided over 8669 client-based services to residents.

The Long-Term Care Home (LTCH) Mobile Team continues to work with LTCH staff in managing the responsive behaviours of residents and assisting with resident transitions to and from the LTCH.

"We work with the residents, families, and care teams to assist in the transition process – reducing the risk of responsive behaviours both during and after the transition." In keeping with the action plan to support caregivers, the Mobile Team delivered 2481 skill building and modeling sessions in this past year. *"We assist and encourage staff to utilize their knowledge about their residents in order to collaboratively develop recommendations based upon a person centred approach."* – Terri Glover, Manager – BSO LTCH Mobile Team.

While much work has been completed to develop and implement the BSO models to date, we will continue to perform quality improvement initiatives throughout the sustainability phase to ensure our leaders, community partners and health service providers continue to build on the gains made. Only through continued collaborative efforts by all stakeholders will the models continue to provide improved experiences for the BSO clients and families. ***For Primary Care Practitioners, the HNHB LHIN Primary Care Toolkit is now available online.***

Learn More

- BSO in HNHB LHIN
- BSO Provincial Website
- HNHB Sustainability Plan
- BSO Final Implementation Report Including Q4

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.

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