Vancouver Coastal Health Richmond
Keeping Seniors Well Forum – *Confirming a New Approach to Care*
February 9th - Summary Report

Background

Sometimes seniors, with difficult health conditions, may end up going to the emergency department for health care because they are unable to get the care they need in their home or community. We know that for seniors, home is often the best place to manage health conditions, recover from illness, and live their lives. Vancouver Coastal Health is committed to delivering quality health care services in the most appropriate care settings. Health Authorities in the province have been asked by the Ministry of Health to develop a better approach to providing care for seniors with difficult health conditions. At Vancouver Coastal Health we are focusing on three communities and Richmond is one of them. The goal is to develop better ways to keep seniors well in their home and community. We want people to experience a better quality of life.

Community Engagement Process

Three community engagement (CE) forums were held in Richmond. The focuses of the first two forums were ***Identifying Needs*** and ***Defining Better Care*** for seniors and their families and/or caregivers***.*** The first forum, held on January 26th was facilitated in 3 languages: English, Cantonese and Mandarin. The second forum took place on February 4th with Cantonese and Mandarin speaking seniors and their families who are not currently receiving home health services from VCH.

In addition, patients and family caregivers, who were not able to attend the above community events, were invited to share their stories and care needs through telephone interviews. Interpreters were recruited and coached to carry out the interviews with Chinese speaking patients and/or family members.

Four significant themes emerged from the information and feedback gathered from the participants who attended the forums and/or through telephone interviews. The themes include:

1. Health Professional Care
2. Enhanced Homes Support Services for Seniors
3. Enhanced Services for Family Caregivers
4. Socialization and Awareness of Resources

This information also helped shape the design of a high level draft of a new model of care for seniors.

A third and last forum was held on February 9th. The focus was on ***Confirming a New Approach to Care.*** This event was also facilitated in English, Cantonese and Mandarin. Participants were asked to provide feedback on the four themes and the high level draft of the new proposed approach to care. The following two questions were asked:

- Would the new approach impact your care or the care of a loved one and make it better?
- Is anything missing?

A summary of the participants is described on Table 1.

Table 1: Summary of Community Engagement Participants

Category	Jan. 26	Feb. 4 (Cantonese & Mandarin)	Feb. 9	Interviews
Patients/Clients	26	42	29	English: 25 Cantonese or Mandarin: 10
Caregivers/Family	23	3	13	
Community Agencies	15	0	11	
Physicians	6	3	1	
VCH Staff	13	5	20	
Community Engagement Advisory Network Reps	2	0	2	

Below is a summary of the input and feedback gathered at the final CE Forum on February 9th.

Theme 1: Health Professional Care

What could better care look like—*what we heard from you…*

CLINICAL CARE

- Coordinate services between client/family, family doctor and healthcare providers.
- Locate health care team in one place (e.g. Family Doctor, Nurse Practitioner, OT, Social Worker, Dietitian, Pharmacist).
- Provide help with decision making around staying at home or going into a facility.
- Provide support earlier on in disease; share prevention and wellness resources.
- Improve standards of care for geriatrics.
- Improve dental care and foot care for seniors.
- Decrease waits for MH programs.
- Educate providers on dementia care.
- Maintain connection to Family Doctor, including when moving to a facility.

ACCESS TO CARE

- Provide more health professional visits in the home.
- Provide better access to care to prevent ED visits.
- Provide more phone and internet consults.

BETTER TRANSITIONS

- Develop a care plan that prepares for changes and transitions and addresses discussion about end of life.
- Provide better explanation of hospital discharge plan to Patient/Caregiver.

Proposed new approach to care for seniors

- Understand and respect patient's autonomy, culture and language.
- Patient and their needs are at the center & works in partnership with Family Doctor and healthcare team.

- Patients receive the majority of their care in the Primary Health Home and not the hospital.
- Patient has one care coordinator.
- Patient has a core health care team (e.g. Family Doctor, nurse, social worker) and other health care providers are invited in depending on the patient's needs (vs. referring patient "out" for services).
- Shift in culture to wellness, prevention and proactive care.
- Primary Health Home offers:
    - Help from your team by phone, 24 hours, 7 days a week.
    - Home visits by health professional if needed.
    - Education and coaching to help manage your health condition.
    - A shared care plan is jointly developed by the team and the patient; this one care plan is shared throughout the patient's journey in the health care system. Care plan is private and confidential.
    - Review of medications.
    - Partnership and connection to community organizations to support social and wellness needs, including educational needs if appropriate.
    - Quality of life discussion and advance care planning.
- Proactive case finding, including identifying isolated seniors and connecting to appropriate services.
- Provide a plan around patient's health trajectory – "a life plan".
- Same day access to GPs.
- Educate healthcare providers about community resources available in the community so they aware and can refer patients.
- Provide better access to healthcare for seniors on low income; i.e. monetary supports for dental, eye and foot care and/or medication.
- Ensure one number to call; want to be able to contact GPs via phone or internet 24/7.
- Be advocate for senior & community partners (e.g. provide letter of support to community partner when agency is applying for grants).

Theme 2: Enhanced Home Support Services for Seniors

What could better care look like—*what we heard from you…*

- Ensure home support workers speak the same language as the client and can communicate effectively.
- Educate home support workers to be sensitive to the needs of the patients and flexible with work-related tasks.
- Review possibility of providing laundry, cooking, cleaning, recreational activities (e.g. walk with seniors) and companionship.
- Provide education and training to home support workers about frailty, cultural sensitivities and special needs such as dementia.
- Provide patients, families and caregivers with a mechanism to provide anonymous feedback about service without fear of negative repercussions.

Proposed new approach to care for seniors

- Increase hours allocated to meet the needs of the patients.
- Ensure consistency and quality of care, including with private contracted services.
- Focus on needs, not tasks (be more flexible regarding the care needs of the patient).
- Empower the home support worker to become an active part of the patient's care and report back to the team regarding health related issues that come forward.
- Support continuous learning programs for home support workers to enhance their skills including

dementia care and in-house respite care. In addition, address interpersonal skills to improve understanding and empathy about client's health and functionality.
- Provide a feedback mechanism for clients and families and/or co-workers that is safe and implemented on a regular basis. Feedback may be in a written form such as a survey or verbal whereby patient/family is contacted by a third part to do an evaluation and provide feedback. Both approaches available in Chinese.
- Communicate and be clear regarding the worker's job description/tasks – this will help address patients/families expectations. Have language options available to better support client and family.
- Use a standard approach in communicating about the patient's care (e.g. a logbook).

Theme 3: Enhanced Services for Family Caregivers

What could better care look like—*what we heard from you…*

- Provide culturally appropriate services in the language of need.
- Develop skills of caregivers to care for their loved ones' physical and emotional needs.
- Help caregivers plan for the trajectory of care (what to expect, how to plan and prepare for it).
- Increase respite services and provide more options such as long term, overnight, in-home, urgent/emergency requests.
- Be flexible in time and range of activities available in adult day programs that address a wide variety of needs (e.g. dementia).
- Make respite process less complicated.
- Provide a central point of contact (one key person) that family connects with.
- Provide help to caregivers early on and not when patient is in crisis.
- Educate and train staff to support the needs of a wide range of clients.

Proposed new approach to care for seniors

- Patient and <u>family/caregiver</u> are at the center of care.
- Enhance respite & adult day programs to provide relief for caregivers, including for seniors under 70 years old. Provide culturally and language appropriate service.
- Identify and proactively monitor cognitive impairment and provide necessary support before it escalates.
- Connect caregivers with peer support networks.
- Provide a "Caregivers network or support group" – with targeted funding attached.
- Provide discounted fares for recreational services for caregivers to bring their loved ones.
- Add respite services under *Adult Day Program* heading to the model of care.

Theme 4: Socialization and Awareness of Resources

What could better care look like—*what we heard from you…*

- Provide easy access with one number to call where people can ask questions in language of need (in particular Cantonese and Mandarin).
- Provide guidance through the system to support the family through the process to understand different options available.
- Use seniors appropriate forms of communications such as mail outs, flyers, newspapers, radio, shopping centres kiosks (staffed by volunteers).
- Provide information on prevention, support, Alzheimer's/dementia.

- Teach patients and families how to properly care for equipment (e.g. walkers) as equipment can be expensive to replace.
- Educate caregivers about resources available to them such as websites, newsletters and support groups.
- Provide training on technology for clients and family members.

Proposed new approach to care for seniors

- Partner with community organizations and City of Richmond to enhance programs for seniors and caregivers. Variety of approaches for socialization is needed.
- Increase access to subsidized recreation and community centre programs, including offering transportation.
- Be mindful of the word socialization – what does it mean? Use plain and pleasant language.
- Some seniors only go to the doctor therefore ensure office practices are informed regarding seniors and caregivers on resources and programs (e.g. 211, 811).
- More access to wellness programs for those with chronic diseases at a younger age rather than "senior".
- More information on *Advance Care Planning.*
- Deliver resources in language appropriate services.
- Promote and link to services already available in the community.

Next Steps

The ideas and feedback gathered will be taken forward to the Richmond Seniors Prototype Working Group for final development of a model. A *Keeping Seniors Well Reference Group* will be established with participation from seniors, family caregivers, and community based agency staff that attended the forums and expressed interest. The purpose of the reference group is to continue to provide input during the implementation phase of the new proposed approach to care which is expected to begin in the Spring, 2016.