Vancouver Coastal Health
Keeping Seniors Well Forum - *Defining Better Care*
August 12, 2015 - Summary Report

Background

The purpose of the forum was to determine what better care could look like for seniors with complex health conditions based on the 8 main themes/gaps identified at the July 29th Keeping Seniors Well Forum. The forum was organized in two parts:

1. Within each of the 8 themes or topics, participants were asked to prioritize the areas which they believed if improved on could have the greatest positive impact to seniors
2. Provide ideas and solutions for what better care could look like so that seniors don't have to go to the emergency department

Gaps in Clinical/Medical Care

Priorities to focus on:

- Access to care outside regular business hours
- Location of services in proximity to where seniors live
- Increase knowledge of services available in the community that people don't know about it
- Create integrated care – currently providers seem to provide care in a disconnected way
- Increased training/education for home support workers
- Affordability of medications/food/laundry services
- Case managers and their communication with clients
- Socialization and connecting seniors to their community to increase their safety and well being

What could better care look like?

- Provide a 24 hour a day and 7 day a week service, including on call family doctors, that could respond to seniors need for care or someone to talk to when clients have an urgent need
- Be responsive to the client needs and provide the level of care that clients need, including regular contact and surveillance
- Promote/market services and programs available to the public, GPs, Community providers/agencies for example everyone should receive information about HealthLink 811
- Educate patients/families around self-care and self-management
- Provide telehealth services, monitoring services and speciality services in the home such as intravenous treatment
- Ensure coordination of the care plan between client/family and health care providers such as home health, mental health, family doctors and specialists. Include planning for services such as laundry and cleaning that will enhance and support the health of the senior.
- Collaborate with volunteer programs/peer support to address socialization/loneliness. Example Big Brother, Big Sister like model whereby a senior is matched with youth

Transitions from Hospital

Priorities to focus on:

- Timely and appropriate care with a focus on increased services for convalescence and rehab when discharged home
- Planning for and communication with community supports 2-3 days prior to discharge; planning for discharge to begin when patient is admitted
- Increased knowledge and awareness of resources and services available in the community for seniors and family members/caregivers so that seniors don't have to go to hospital
- Coordination and communication between hospital and community health staff, family doctors/or facility when a patient is admitted to hospital, hospital care received and the plan of care upon discharge.

What could better transitions look like:

- Family doctor and case manager are notified when their patient is admitted to hospital
- Case manager follows patient in while they are in hospital and is part of the discharge planning process
- Include family doctors, patients and caregivers in discharge planning.
- Proactive planning of care on discharge; inform patients of the intended discharge date and what they and their caregivers will need to prepare for in advance
- Patient and family member/caregiver receives discharge plan and education around care instructions, a home check list that includes review of potential problems and what to do and who to call. Instructions are both verbal and written – simple plain language
- Sufficient hospital beds available so that patient/family member in not told "we need your bed"
- Case manager has time to connect as required with client while in hospital , at discharge and after discharge and is available for client to connect with
- Case manager and family doctor continue to connect with patient and address needs throughout hospital stay, at discharge and after discharge
- Provide a transition-like care home – "*step down from hospital*" to improve care and encourage rehabilitation to prepare for being home again

Downloading to Community Agencies AND Funding Structures and Task Focused

Priorities to focus on:

- Adequately funded housekeeping services. Services that have been cut or policy changes to guidelines results in less directly funded services for some seniors and some clients are not able to pay privately which results in dirty sheets/clothing, dirty dishes, and unkempt homes that put clients at risk for falls and hospitalization. Lack of resources results in focus on putting out fires rather than taking preventative steps.
- "Better at Home" (BAH) is an alternative but with long wait-lists and payment expected. Some clients still cannot afford the costs. BAH incurs debt if client cannot pay. In addition BAH staff is not well trained to handle challenges related to mental health issues or dementia.
- Close the gaps in awareness for clients, family members and community agencies on how and where to access health funded services.
- Bring resources to where seniors are
- Guidance and support for isolated seniors. Often seniors are not viewed as a whole person and their needs are not need appropriately.
- Increase consultation/collaboration between VCH and community agencies

What could better care delivered in community look like?:

- Reinstate housekeeping, cleaning, laundry services and increase funding through allocating funding resources differently
  - Funding based on best possible outcome for client
  - Ensure equity between different regions in the city
- Create a collaborative approach to a client's care with every service; health authority and community based, Everything under one umbrella/centralize – work as a team
- Develop and make available a booklet or resource that contains all services and programs along with step by step guidance to explain what can be accessed and is provided free or through payment.
- Support for clients and caregivers in the form of a navigator that supports them through all stages of their care. Explore existing and successful models of transition out of hospital such as what MOSAIC does with the role of navigator who helps new immigrants to access resources in the community

Clinical Care in Home AND Consistency of Caregivers

Priorities to focus on:

- Consistency of care givers/providers to reduce high turnover. When different people come to the client's home each time there is no sense of team or knowledge of who is the leader of the team and no connection with the case manager. Clients always having to repeat their story and their needs.
- Access that is not fragmented. Currently different agencies provide different services and services that are not client driven; the rules are sometimes too rigid to meet client needs
- improved access to clinical care in the home including family doctors doing home visits, and help/support with mobility equipment
- Improved coordination and communication with case manager; case manager does not communicate with other care providers

What could better care in the home look like?

- Provide an orientation to each client and their families on the approach to home support; explain that it may not be possible to keep to one home support worker, but will try and minimize number. Create communication mechanism for clients and families so they know who to call case if there are concerns about the home support workers.
- Develop and deliver training to home support workers in "customer service" and how to provide services and interact with seniors in a respectful way
- Approach care of seniors as a "team" with home support worker as an integral part of the team. Develop care plan that is reflects client's needs and is easy to understand/simple. Clearly define who the lead person is for that seniors care, the client and their family should know who is in charge.
- The lead provides holistic/proactive care, has flexibility to provide home support hours, is accountable and coordinates and communicates care.
- Home support workers would be able to be flexible regarding tasks that they can do for clients. They should be able to respond to client needs and ask them "*what do you need me to do for you today?"*
- Increase access to direct medical care including family doctor home visits. Family doctors will ask patients and family members "what do you know about your condition" and "what matters to you"

Services for Family Caregivers

Priorities to focus on:

- Information on programs such as respite beds, Assisted Living, Adult day programs; currently there is little help available to navigate the system or to understand the various roles of staff in the system.
- Getting sufficient respite beds and Adult Day Centres that patients/families desire/want and are appropriate. Current concerns about safety, the quality of care and lack of programs for high-functioning clients.
- More flexibility in hours for respite in the home
- Respite care needs to be available earlier
- Family caregivers need to be valued and acknowledged – no one asks *"How can we help you? "*

What could better services for family caregivers look like?

- Promote information on resources and help with navigation and how to access resources like respite care
- More Adult Day Centres or social programs in the community that also provide respite and are intergenerational, allow pets, are inviting and relevant to the client's needs and address transportation and provide education to the family. Provide funding to also include medical support
- Provide transportation support to caregivers and clients. Either direct transport for funding relief for family caregivers.
- Match volunteers with clients for visiting and to provide relief to caregiver
- Increase funding re longer-term respite stay that is located outside the hospital and is welcoming/inviting
- Create care plan for the client and the caregiver with a focus on planning ahead for respite in order to avoid caregiver burn out
- Use plain language and clear explanations to describe services available and clearly define the roles of health care staff and their scope of practice and care

Clients Paying for Services

Priorities to focus on:

- Support to understand the system and what is funded and what is not. A clear path to what services are avialbe and when
- Enough funding to meet basic needs for meals, cleaning, and simple daily tasks that are difficult or challenging for senior and many cannot afford personalized, tailored care. Assistance with light housekeeping, banking, and shopping, walking services. Some seniors can afford to pay extra for these service but many cannot.
- Advocacy and support for seniors who have no family members living close by or at all. Provide an advocate they can call when in need before a crisis occurs.
- Private services for household and personal care that is connected to health care services and family doctor.

What would better care look like for clients having to pay for services?

- Keep seniors centers opened every day and for longer hours
- Have health care providers focus on overall quality of life not just tasks related to care. View the whole person and their needs
- Build in program such as *Talk before Task* (Toronto) where client needs are foremost. Have home support workers as "*How are you and what can I do for you?"*
- Case managers and health services to stay connected with client – even though client is paying privately for services. Check in/provide support and help to streamline the process and navigate through the service's and what the client needs
- Include social components in Assisted Living/Assisted Housing
- Increase funding for Better at Home
- Change Ministry policy to be more flexible around Assisted living and who can access
- Government to provide long term care insurance
- Educate public on what the costs are; educate high school students to plan (financially) for old age.

Next Steps

This feedback will be used to support discussion at the next forum on the topic of ***Confirming a New Approach to Care***. This forum will take the suggestions and ideas generated from the August 12th forum to confirm care that will be better for seniors and support them and their families to find appropriate care in their home community and not have to seek care in emergency departments. The next forum will take place Wednesday, August 26th.