Vancouver Coastal Health
Keeping Seniors Well Forum – *Confirming a New Approach to Care*
August 26, 2015 - 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 in their home community that meets their needs. 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 want to start in the West End and Fairview Slopes area. 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

At the first forum, ***Identifying Needs,*** held August 19th participants were asked to identify their current needs in order to stay safe and healthy in their homes and not need to seek care in the emergency department. At the next forum, ***Defining Better Care,*** held August 12th. The needs expressed were themed into 6 main topics for further discussion and participants were asked to state what would define better care in each of these areas;
1) Gaps in Medical Care 2) Transitions from Hospital 3) Downloading to Community Agencies 4) Care in the Home 5) Services for Family Caregivers 6) Clients Having to pay for Services

At the last forum, ***Confirming a New Approach to Care,*** held August 26th the feedback on what would define better care was grouped into 4 main themes;
1) Health Professional Care 2) Enhanced Home Support Services for Seniors 3) Enhanced Services for Family Caregivers 4) Socialization and Awareness of Resources.
The themes helped shape or inform the concept model of care. Participants were asked to consider the proposed model and answer 2 questions:

1. Would the new approach presented actually impact your care?
2. Would your care improve?

Participants were asked to confirm if this proposed approach would improve care as well as highlight concerns or add components to the model.

Next Steps

The ideas, feedback and confirmation of the draft model will continue to support the design of a new approach to care for seniors in the west End and Fairview Slopes area. This information will be taken forward to VCH staff and the Keeping Seniors Well Reference Group. The Reference Group will be made up of those seniors, family caregivers, and community based agency staff that participated in the forums and identified as wanting to continue to collaborate with VCH in the development of a new model of care. VCH Staff in collaboration with the Reference Group will confirm a new model of care to take forward for implementation.

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1. Health Professional Care

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<tr><th>What could better care look like?

What we heard</th><th>Proposed new approach to care for seniors</th><th>Will your care improve?</th></tr>
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○ Coordination of services between client/family and family doctor, Home Health staff, Mental Health & Addiction staff and specialists; Work as a "team" – collaborative approach to client's care

○ View the whole person and be responsive to the clients' needs and level of care they need including regular contact

○ Stay connected to the patient/family (even though patient may not be "eligible" for home health services)

○ Focus on self-care/self-management

TRANSITIONS

○ GP and Case Manager (CM) are notified when their patient is admitted to hospital

○ CM and GP continue to connect with patient/family in hospital, are part of the discharge planning & follow up after discharge

○ Patients/family receives discharge plan
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➢ Look for/Identify seniors who are 70+ living with moderate to complex health conditions including frailty in GP practices, Home Health and Mental Health & Addiction programs, ED and hospital, and community-based programs
• Develop a registry of eligible clients reflective of complexity and care needs

➢ Ensure frail seniors have a patient- centered Primary Care Home which means a team of care providers
• Central to the Primary care home is the GP practice where they see their regular family doctor with timely access to other providers (care team members)e.g. nurse, PT, OT, dietitian, mental health and addiction service providers as needed; GP team has ability to ramp up services as needed
• Patient centred, comprehensive assessment and whole person care including self-management support
• A Care Coordinator (one point person) in collaboration with GP, follows patients across care settings
• Home Support Workers function as part of the team
• Team identifies 3-4 specialists that are key to frail/homebound patients; Specialists are
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▪ Yes - If the client knows the care team and the care is coordinated and the plan is known to all providers and the client and family
▪ If there is a "'quarterback" for the patient/client someone who is in direct contact with the client and their family/caregivers. This person could change as the complexity of the client care needs change.
▪ If the team can increase intensity of care as needed e.g. if care professional is needed for mental health & addiction issues
▪ The clinicians from team have access to the client chart and are familiar with client
▪ There is a number to call for help to answer to questions or if the client has anxiety

Issues/Concerns/Comments:

○ Clients brushed off or rushed by care providers e.g. Case Manager and Home Support Worker; no personal connection, no recourse for clients if they have issues
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and education around care instructions (a home check list that includes review of potential problems – what to do and who to call. Instructions are both verbal and written and simple/plain language) ○ Provide a transition–like care home "*step down from hospital,* to encourage rehabilitation to prepare for being home again ○ Sufficient hospital beds available so that patient/family is not told "*we need your bed*	considered part of the team • GP and other care providers able to do home visits ***Care planning and management*** • Team develops care plan based on patient's goals of care • Assistance in developing Advance Directives • Support for chronic disease and medication management • Support for patient self-management • Improved access to ambulatory service, IV, wound care ➢ 24 hour a day and 7 day a week support from the Primary Care Home team for clients when needed ➢ Single point of access - one number to call for help ➢ A clinician from the team is on call and has ability to do face to face visit if needed ➢ Adult Day Program (ADP) in city centre • Structured socialization, caregiver respite and support for activities of daily living as needed • Primary Care Home team (doctor, nurse, etc.) can go into the ADP location to see patients ➢ Medical Respite in the community • Short stay, sub-acute setting that a patient can access from the community to avoid unnecessary ED visit and for convalescent care • Short term assessment and stabilization	with these care providers ○ Client saw Case Manager once in 4 years ○ GP rarely talks to Case Manager ○ Capacity is an issue with one home support worker having to see 10+ people a day ○ Access to specialists is a challenge ○ Help lines such as 811 all say call 911 ○ A lot of people do not have a GP ○ Limited time given by GP's to complex patients even with incentives - alternate payment for GPs needed so they can take ○ time with patients as needed ○ Adult Day Program – too regimented or not appropriate for various levels of physical and cognitive ability

	• Primary Care Home team has direct admit to Medical Respite ➢ Transitions across Continuum of Care; Supportive discharge from ED and hospital • Care Coordinator from Primary Care Home follows client in ED, hospital and other care settings • Care Coordinator participates in discharge planning • SPH and VGH Geriatric Emergency Nurse links back to GP/Primary Health Care Team **<u>Enablers - what needs to change</u>** ⇨ Review of MoH policies regarding Home Support ⇨ Training for clinicians including home support workers e.g. Geriatric care, total person care, high competency in Chronic Disease Management, dementia care, palliative care team building, communicating and collaborating as a team. ⇨ One number to call for help after hours and weekends; explore using 811 structure ⇨ Public education – shift culture of going to emergency	

2. Enhanced Home Support Service for Seniors

What could better care look like? What we heard	Proposed new approach to care for seniors	Will your care improve?
○ Reinstate more funding for housekeeping, cleaning and/or laundry services ○ Ensure Home Support Workers (HSW) are an integral part of the team of providers ○ Provide standard orientation to each client/family re what to expect re services delivered by HSWs (for example: may not be possible to keep to one HSW, but will try and minimize number) ○ Train HSWs in "customer service" approach and how to interact with seniors in a respectful way ○ HSWs are flexible regarding task that they can do for clients. Follow similar program known as "*Talk before Task*" where clients' needs are foremost and HSW ask "*How are you and what can I do for you?"* ○ There is one lead who provides a holistic approach to care, has flexibility re HSW hours, is accountable and coordinates and	➢ Ensure frail seniors have a patient- centered Primary Care Home • Central to the Primary care home is the GP practice where they see their regular family doctor with timely access to other providers (care team members)e.g. nurse, PT, OT, dietitian, mental health and addiction service providers, Home Support as needed; GP team has ability to ramp up services as needed • Home Support Workers function as part of the team • A Care Coordinator (one point person) in collaboration with GP, follows patients across care settings • Team develops care plan based on patient's goals of care **Enablers - what needs to change** ⇨ Review of MoH policies regarding Home	▪ Yes if there are created different jobs for medically trained home support workers versus companionship, non-medical services ▪ Yes if there time allotted to coordinate client care and share comprehensively among a care team ▪ Yes if there is consistency among care team would help to reduce miscommunication and improve coordination - consistency in home support is key to understand a change in a client's normal state ▪ Yes if case managers remain in contact in times of wellness and not just in times of crisis ▪ Home support is critical and allows clients to carry on and living a better life ▪ One person following client across the care continuum will ensure someone can bring context and background of client ▪ Printout of meds is important to have on hand for hospital, specialist, etc. ▪ Better access to medical records for all care providers to see complete picture of client ▪ Yes if there is the ability to quickly and easily share information, single patient

communicates care ○ Create communication mechanism for clients so that they know who to call in case there are concerns about home support help	Support ⇨ Training for Clinicians and Home Support Workers e.g. Geriatric care, total person care, high competency in Chronic Disease Management, dementia care, team building, communicating and collaborating as a team. ⇨ One number to call for help after hours and weekends; explore using 811 structure ⇨ Public education – shift culture of going to emergency	record ▪ Yes if Community rounds about complex clients are implemented ▪ Yes if there is more use of electronic tools eg. Skype **Issues/Concerns/Comments:** ○ Some clients have the skeleton of a team that provides services but better collaboration and coordination would enhance the client's care ○ Ensure home support worker s have the right skill set for the client's needs ○ Qualifications (eligibility criteria) of home support workers needs to be reviewed ○ More critical thinking skills needed by HSWs ○ Care coordination should respect seniors wishes, build trust ○ Fee for service payment structure may make it difficult for GPs to spend time collaborating ○ Older physicians with many seniors may not be open to this new model ○ Difficult to find full service family GPs – who will take on this work? ○ Need to ensure seniors are attached to a GP ○ Pharmanet should indicate when prescription runs out

3. Enhanced Services for Family Caregivers

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<tr><th>What could better care look like?

What we heard</th><th>Proposed new approach to care for seniors</th><th>Will your care improve?</th></tr>
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○ Promote information on respite resources and how to access

○ More Adult Day Centres or social programs in the community that will also service as respite to caregiver and are inviting and relevant to client's needs and address transportation and provide education to the family. May also include funding for medical support

○ Match volunteers with clients for visiting – this will provide respite to caregiver

○ Increase funding re longer-term respite stay that is located outside the hospital and is inviting

○ Plan ahead for respite to avoid burnt out
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➢ 24 hour a day and 7 day a week support from the Primary Care Home team for clients when needed

➢ Single point of access - one number to call for help

➢ A clinician from the team is on call and has ability to do face to face visit if needed

➢ Adult Day Program (ADP) in city centre

➢ Structured socialization, caregiver respite and support for activities of daily living as needed

➢ Medical Respite in the community

➢ Short term assessment and stabilization

➢ Primary Care Home team has direct admit to Medical Respite

➢ Partner/Collaborate with community agencies

➢ To develop one central source of information on community resources and build awareness among GPs, MOAs, VCH staff, and patients
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▪ Yes if my GP is going to work with the team. There needs to be a fundamental change in primary care to have GP working directly with the home care team.
▪ Yes if family caregivers are involved in care coordination and are considered part of the team
▪ Yes if there is flexibility for respite either short term or long term that really meets needs of client and family caregiver
▪ Overnight respite – should be patient centered, inability to provide respite at night is a big barrier and is a factor in placing people prematurely to Residential Care.
▪ Yes if there is access to 24/7 service to call as needed Who do I call? Who knows my story?
▪ Yes if there is a Team coordinator that will navigate after hour help support
▪ Yes if ADP meet the needs of clients attending and run different programs (most clients there have dementia)
▪ Yes if family care giver is involved at ADP/ and are provided education
▪ Yes if the case manager is given the navigation role and their caseloads are reduced
▪ Yes if the client team has access to the client record
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	➢ To develop/expand programs that better address socialization and isolation ➢ Explore/collaborate with senior centres to expand hours **<u>Enablers - what needs to change</u>** ⇨ Review of MoH policies regarding Home Support ⇨ Training for Clinicians and Home Support Workers e.g. Geriatric care, total person care, high competency in Chronic Disease Management, dementia care, team building, communicating and collaborating as a team. ⇨ One number to call for help after hours and weekends; explore using 811 structure ⇨ Public education – shift culture of going to emergency	▪ Yes if within the medical home the team consider the whole person including their social needs ▪ Yes if there is better discharge follow-up plans with caregiver receiving detailed info and education of the discharge plan ▪ Yes if the caregiver is connected and coordinating care with the home care team ▪ Yes if the Palliative care team is part of the circle of the Medical home. **Issues/Concerns/Comments:** ○ Take into account clients values when services are coordinated ○ Overnight respite – should be patient centered, inability to provide respite at night is a big barrier and is a factor in placing people prematurely to Residential Care. ○ Follow palliative care system – is a good system, all clients with chronic diseases should have same kind of access. ○ Care giver support group service is not for all clients – some don't like to attend. Team coordinator should be able to council/educate clients/caregivers to promote attendance at caregiver support gr.(they don't know what they don't know) ○ I was distressed to know that ADP spaces are being decreased, it is a false money saving tactic ○ Need for better collaboration regarding issues of transportation to services and programmes ○ Need for more support for clients with early dementia ○ Consider having clients going to structured

		camps – respite can be of different types – respite provided at home setting and also the provision of a weeklong camp which would be respite away from home for seniors. Charity organizations involvement to provide respite outside the home should be considered. ○ Caregiver may need financial help, (single moms and working) ○ Need for a companion type help for clients to go out in the evening – too afraid t to step out at night by themselves (working people may like to volunteer in the evening. ○ Increase in down loading of services to the family caregivers – need to assess the capacity of the care giver (in one instance, client's home support was cut down since daughter moved in town) ○ Need a map of who is involved in client's care, what their roles are, who does what in the health system – who to communicate to. ○ Client's individualized care/client centered, tailored to person's needs ○ Is there an account of how much care is provided by family members? ○ Family is what is defined by the client - good friends could be a chosen family ○ Need to look at the funding allocation differently - group budget for clients attached to a medical home? ○ What about other younger clients with complex conditions, why is the cut off is 70+ population? ○ Medical supplies should be made available at home after discharge from the hospital.

4. Socialization and Awareness of Resources

What could better care look like? What we heard	Proposed new approach to care for seniors	Will your care improve?
AWARENESS OF RESOURCES ○ Develop and make available resource that contains all services and programs (including information about HealthLink BC/811) available in the community to public, health care providers, and agencies. **SOCIALIZATION** ○ Collaborate with community programs to address socialization and loneliness ○ Include social components in Assisted Living and Assisted Housing ○ Keep seniors centers opened every day and for longer hours	➢ Adult Day Program (ADP) in city centre ➢ Structured socialization, caregiver respite and support for activities of daily living as needed ➢ Partner/Collaborate with community agencies ➢ To develop one central source of information on community resources and build awareness among GPs, MOAs, VCH staff, and patients ➢ To develop/expand programs that better address socialization and isolation ➢ Explore/collaborate with senior centres to expand hours ➢ Explore/collaborate with Assisted Living and BC Housing re need to enhance social components **<u>Enablers - what needs to change</u>** ⇨ Review of MoH policies regarding Home Support ⇨ Training for Clinicians and Home Support Workers e.g. Geriatric care, total person care, high competency in Chronic Disease	**<u>Awareness of Resources</u>** ▪ Yes it makes sense to develop one central source of information on community resources and build awareness among GPs, MOAS, VCH staff, patients etc. ▪ Yes for advertising & marketing use multiple approaches (not just phone). Have a website/booklet, collaborate with 811 & 211 to strengthen it – make it functional. ▪ Yes if there was a way to educate family doctors about available resources **<u>Socialization</u>** ▪ Yes - this fosters socialization and “adds interest to my life” or “otherwise I would just watch more TV”. Many seniors just go to their room – “isolate” – people need places to go to socialize ▪ Yes if there are spaces in programmes made available for those people who are not in a not in a crisis situation but still need social interaction/stimulation

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	Management, dementia care, team building, communicating and collaborating as a team. ⇨ One number to call for help after hours and weekends; explore using 811 structure ⇨ Public education – shift culture of going to emergency	▪ Yes if there are programmes that includes intergenerational interaction. For example link with elementary students. One program that was successful including youth playing Bingo with seniors. Everyone had fun. Also, bring youth with seniors around gardening. ▪ Yes if the programmes Include clinical "supports" (such as a home care nurse or case manager that can be accessed at ADP or other programmes **Issues/Concerns/Comments:** **<u>Awareness of Resources</u>** ○ Have one single (depository) central source of information ○ Information is correct & accurate & has the right criteria for eligibility ○ "On-line chat" to find out senior issues/needs Also will engage with senior around other issues for example if issues around transportation etc., then person can address this too. ○ Large printed resource - make it simple & less complicated ○ Everyone needs more basic awareness of what a program or service is and what it can do for people ○ How about learning sessions for people to educate around resources? Could community agencies do this?

		Socialization ○ Need to ensure programmes are free or low cost ○ Consider using college students and/or UBC Pharmacy Students to provide help around computer skills ○ Have volunteers to provide one-to-one companionship ○ Why not consider ADP embedded in a community centre ○ To be mindful that some people prefer less structure and need to keep programmes flexible ○ Make sure “needs” are identified at the outset and that the program or activity is relevant to needs ○ Would like the focus to be more on exercise ○ Consider to keep programming accessible all year round, 7 days a week ○ Encourage “drop in” programs ○ Suggested hours 7:30 am to 7:30pm or 8:00pm ○ Need to ensure sufficient space for activity ○ Transportation needs to offered to and from ○ Seniors need supports to attend like a “buddy” system ○ Be mindful of social stigma ○ How do we draw engage more men (95% are females in programs) ○ Conduct an environmental scan of what

		programs are already in community and then enhance as needed ○ Look at the YMCA as a model for space and intergenerational programs offered ○ Include variety of programs, including intellectually stimulating sessions such as TED talks Meals. ○ Make sure that low cost transportation options & extended routes are offered with low cost meals available ○ Need a facilitator to engage and manage programs ○ Monthly calendar highlights that reflects or describes the specific activities offered. ○ Create a "Steering Committee" bringing in community partners – so we don't duplicate and we ensure we "steer" in the right directions ○ Engaging seniors as volunteer – find purpose in life ○ Need to have resources at the ready to direct seniors and their families if questions arise at family doctor or Home Health