Keeping Seniors Well

Community Engagement Summary

North Vancouver August 11, 2015

BACKGROUND

Sometimes seniors, with difficult health conditions, may end up going to an 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 out their final days. 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 on the North Shore. The goal is to develop better ways keep seniors well in their home and community. We want people to experience a better quality of life. In order to do this Vancouver Coastal Health (VCH) need to hear from patients, their families and their caregivers in order to inform a new model of care.

COMMUNITY ENGAGEMENT PROCESS

Community Engagement (CE) was asked to support engagement of seniors, and their families in order to inform a model of care that provides for the needs of seniors and keeps them safe and healthy in their homes while reducing the need for them to go to the emergency department for care.
We wanted to hear their experience and what their needs are. A series of forums were planned in order to have a conversation with seniors, their families and those in the community that provide care and support to them. The goal was to understand what their care currently looks like, and hear what is needed to provide better care. With this input VCH

VCH is intent on the development of a new model of care that will better meet the needs of seniors.

A forum held in North Vancouver on Tuesday, August 11, had an attendance of 72 people with a mix of seniors, their family members, community agency representatives, physicians and health care providers.

The forum began with participants being 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. The needs expressed were then themed into topics of discussion, which all participants were involved in, with each participant having the opportunity to discuss three topics during the forum.
Clients, patients and family caregivers that could not attend the forum were invited to share their stories and care needs via one on one discussion either by phone or in person. Eleven clients and caregivers, living on the North Shore, participated and shared their feedback through this option.

SUMMARY of DISCUSSION

This is a summary of the discussion, grouped under each of the main topics, as decided on by participants.

Community Based Resources

Navigation Support

- Patient/client navigation is needed to support people to find resources
- How do we get all the available information on one place and made available to those who need it?
- Community Health Centre or a hub for information is needed
- Home bound people don't know what is out there
- Only mail the relevant info. Can be overwhelming

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- need to be have access to a seniors directory through a workshop
- need a way to discern what is relevant information at each stage of need.

Access

- need a central place with a hub of services open 24 hours
- need a place to go for after hours services for e.g. x-rays etc.
- Social workers or nurse practitioners or family doctors as needed for clients who are can travel to a central service and not go to the emergency department
- Clients end up in ED because that is the only after hour option
- One stop phone #
- Seniors/stop – for legal/health and other services

Advocacy and Awareness

- Changes in services/funding needs to be discussed by involving profit/non-profit governments – clients
- On the North Shore there are many resources . Need to raise awareness with VCH staff and physicians of available resources
- Ongoing communication is needed among groups regarding existing resources
- Communication with real estate agents or condo owners to reach clients not known to the system

Discharge Planning

Preparation and Follow up

- Early hospital risk factor assessment
- Better co-ordination with community. Enhance connection between hospital and community
- "Better at home:" need better co-ordination and planning
- Check-in/follow-up calls, coordinator, physician follow-up
- Co-ordinate with team and proactive approach, social worker visit before discharge
- 1:1 follow-up visits
- need to confirm there is care/caregiver at home
- Community coming into hospital to assist with discharge
- Discharge planning with patient/caregiver being able to voice their needs
- Co-ordination of lab work
- Outstanding test and follow-up of completion
- GP needs to follow-up. Need better communication between GP and hospital
- Wound care management at home

Information and Communication

- there is a lack of planning prior to discharge home
- Lack of notice of discharge, better communication
- Start discharge planning when admitted. Currently in place, but not used
- Need team assessment
- Make sure patient/caregiver understands instructions

Timeliness

- seniors are being discharged to early
- Discharge without proper assessment
- Assess home before discharge
- Make sure appropriate to send person home
- Discharge Friday 5:00 PM – no weekend services
- Discharge with adequate time and not make it a surprise for senior and caregiver
- "I went to the emergency departments with my husband who is 85 and has dementia; we had to wait for 7 hours before we were seen by a doctor"

Support

- following discharge there should be a 24 hour number to call
- Training required for emergency staff to better support seniors
- Need intermediate support via a chronic issues clinic, Rehab hospital, convalescent hospital
- Increase staff/discharge planning team
- need better discharge tools
- need typed/written notes, given to family members/caregivers
- Breakdown in medication management
  - Adherence of medication after discharge
  - GP uninformed of discharge medications
- Patients needs information number to call as a fail safe

Home Support

Training and Education

- More training for home support workers e.g how to recognize abuse, loneliness, mental health, dementia, behaviour, chronic disease (more robust and/or ongoing training)
- Home support training for family/caregivers
- Need companionship care as for children with special needs for accompanying them
- Need home support workers who can deal with special needs (dementia)
- Need for counseling at home for caregiver and patient
- Better work environment for home care workers for staff retention
- More training in chronic disease management
- Expand the scope of support workers
- Need more therapists
- "More training is needed for healthcare providers. They need to be more caring and compassionate. We are not clones, we are individuals, human beings and providers should respect our individuality."

Consistency and Continuity

- The time allotted and spent with a person is too short; need more time
- Too task focused not responsive to client needs
- "The care workers do tell me that there are people who are worse off and that I should be pleased with what I get."
- Sometimes home support does not show up at appointed time
- "One hour of care never is one hour. Travel time is included in that hour so in fact my mother only receives about 30-40 minutes of care."
- Language barriers especially with hearing impaired seniors
- Leverage funding based on what people can pay to ensure equity in services
- Home support is very restrictive now and very limited in what they can do (an "hour" of service = 40 minutes in actual time)
- "We have had to go to private care for 24 hour care following an episode and this was so professional and far superior and client centred then the home support through VCH. I found out it is the same provider so not sure why it is so different."

Mental Health

- Need mental health home support for seniors
- Need to build relationships/social component, especially with mental health
- Some home workers not comfortable with patients with mental health

Access

- More money into home support than crisis care
- need to provide respite in home to relieve caregiver
- need to provide families with a map that explains the flow of services and has resources listed to support the various stages of the "geriatric journey"
- "The rules of VCH and system and what a family can access for their family members are so confusing."

- Financial benefit/incentive for family caregivers (ex. Tax break)
- need to encourage public/private collaboration
- help individuals fund their own home care
- The difference in wages between institutions vs home care results in good staff leaving homecare to work in facilities
- "It seems you could get more accomplished if you have a crisis occur and then you get services quickly then to try and navigate through the system and access services in a proactive way."

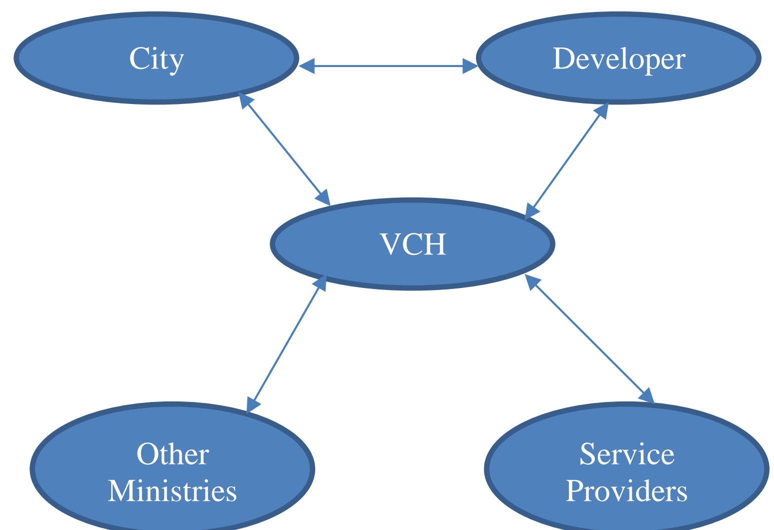
Client centred

- Need for housekeeping services
- Provide a spectrum of services to meet needs via a collaborative team
- Wrap services around the client in a coordinated and client centred way
- People don't think they are ready for or need home support so wait for crisis
- Need to provide clients and caregivers information about all available services
- Need for clear care plans with a visual chart a flow chart that tells you who can do what and what their scope of practice is

Housing

Housing Spectrum

- Stable housing is critical
- Patient/client does not move
- Moves/transitions = issues
- Need more/different supportive housing in between known options e.g. Mental health housing, Step down
- No mental health housing for Seniors. Adult Mental Health facilities are inappropriate
- Accommodating facilities: what do they need to be able to provide mental health housing options. Look at planning for new and augmenting existing to accommodate mental health clients
- "Affordability" -> Housing – low cost, not just rent controlled
- Increase public-private partnerships to ensure adequate housing
- Intentionality by VCH to partner with ministries, local gov't, developers to create housing options



Supportive Services

- "Supporting their mental health needs while allowing them to age in place"
- Disparity between rich/poor seniors
- Low cost options needed (psycho-social benefits…meals, programs, personal attention…)
- People at home need programs
- Bringing services to the patient, not moving the patient (to multi-use facilities)
- Better co-ordination of services through a lead person/role
- Assessing those in temporary housing regularly to ensure services are adequate and housing is appropriate
- Clusters care models of housing offer flexibility in service delivery
- "Experts" assessment vs what patient wants creates tension
- Expand the palliative program; leverage this model which works well (timeliness of response)
- Look at DTES approach for hard to reach patients

Access

- Accessing housing options quickly if barriers at home (e.g. stairs)
- Bridge housing or mobility aids
- Mobility issues, senior decline while in hospital
- Transportation support (to prevent isolation)
- Large gaps in housing options available
- Barriers to access assisted living as seniors must fit all the criteria and many don't e.g can't have a mental health diagnosis, can't smoke.
- Affordability is a challenge and assessing income to determine what is available to a seniors is difficult for nurses. Coordination with government where this info can be accessed. Financial assessment is awkward
- "VCH not in the business of housing…" but do the assessments

Palliative Care

Access

- Extend time/length of support
- remove any age restrictions
- More palliative beds!
- More money for funding

Awareness and Education

- Community support good orientation could be better
- need to provide knowledge and ongoing education of what is available
- Change stigma/perception around "palliative care"
- Look at the definition of palliative
- Make palliative more appealing vs invasive treatments with focus on comfort vs longevity
- Change toward palliative model is happening
- Talk more openly about palliative care
- Do people know about the option of palliative care?
- More info session on palliative. Come early and educate
- Need to spread EVERY DAY COUNTS program which is geared to adding quality to life. Helps people live well. 6 session modules – education for palliative patients and families

Coordination and Collaboration

- Better communication between hospital and palliative care team (smoother transition)

- need to ensure that family meetings occur prior to discharge
- Model of palliative care could be applied to other settings
- Why do complex patients transfer back to hospital?
- Better co-ordination for palliative patients so they don't end up in emergency
- "I have no idea what stage of Alzheimer's disease my mother is at. It would be great to have a 1 – 3 year plan to be able to anticipate my mother's needs going forward."

Supports

- Need social worker in community to support palliative
- What about those who have no family/support? How is the level of support determined?
- Treat all complex care seniors as you do palliative
- More flexibility of care in palliative care
  - i.e. Symptom management
- More flexibility for respite care
- Less drugs and more support is needed
- Support for families to deal with stress while their loved one is palliative
- What support is available for residential care palliative patients?
- Recognize patients are palliative sooner to minimize wait for support and provide better management and less crisis intervention

Primary Care – Family Doctor

Coordination and Collaboration

- Big cities are broken and fragmented in terms of services. Learn from small towns
- need continuity of care with walk-in physicians
- Team-based care that is mobile and has diagnostic services
- need continuity and integration of care
- Free-standing clinics don't take responsibility for the patients that walk-in and this puts the burden on acute
- No communication between walk-in clinic GP and the regular GP (currently the ruling is charged and both GPs are communication-classification)
- Need better communication between the family doctor and other healthcare providers for better care
- Need more support for physicians to provide home support – joint visits with a case manager
- Partner physicians with someone (case manager) who have knowledge on the services/programs available
- Medication safety and how to report adverse
- reactions

Access

- Co-ordination of services and assistance with navigation of a client that comes in
- No family doctor available when someone moves from city to city
- support integration of specialist services
- A co-located clinic in the community that is a one-stop for all healthcare services e.g Caledonian clinic (Nanaimo)
- Need more after-hour services
- Improved accessibility to services (transportation burden)
- Many people still do NOT have a family doctor
- Walk-in clinics have hours not suitable to population, often closed on weekends -> then must go to ER and wait
- Electronic health records – a system that can link all providers to the same information
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- need to ensure continuity of care when the family doctor retires or leaves
- Workload issues for family doctors
- Family doctor only allow one question/concern or there is a time limit. This does not work for seniors.
- GPs are asking for payment in advance for reports/time/services
- When you find you can get all questions/concerns answered and all tests in emergency why not go there
- need more doctors. find ways to attract them to the North Shore
- need to address language barrier

Alternatives

- Using nurse practitioners to ease burden of doctors
- Make nurse practitioner role more prominent in the team-based care
- A team-based environment with communication between the healthcare providers
- Geriatric physicians vs general practitioners specialized care that understands the elderly
- Funding structure for nurse practitioners
- Group medical visits
- Referrals to outpatient clinics (for NS etc.) to reduce load of acute services

Promoting Wellness

Awareness and Education

- Lack awareness of emotional coaching and programs such as Keep Well, which need better funding. Need to promote to
  - Patients
  - Providers
  - Community
  - GPs
- Need to have all info/resources centralized
- Need to empower community resources
- No announcements when key contacts change
- Programs that summarize all available resources but could not be updated and people don't know about it
- Lack of awareness of websites with all the information

Integration

- promotion of wellness is different and not connected to the medical model of care provide client centred programs
- Connect all the different programs through an holistic approach
- There are confidentiality issues that limit VCH and community agencies from working together to support a client

Access

- Physicians good resource to provide info but don't have the time
- Need to connect seniors with the right resource/build the relationship even if there's no immediate need
- Not clear how to navigate through the organization's contacts
- Provide a go-to-person for seniors to directly manage their care and health promotion activity
- VCH to provide a point person for a community based resource to communicate with about a client
- Lack of funding, instability, fragmentation of programs; need to rely on grants to keep programs going in community
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- Cultural barriers to adopt wellness habits/practices
- need options to traditional exercise programs
- Programs that worked well now receive less funding. This does not make sense
- Need of funding for the transportation
- Important to define wellness according to patients and organizations
- More client centred support, peer on peer support
- Need of more group based programs in the community
- How to reach isolated seniors who cannot access these programs

Adult Day Programs and Caregiver Support

Safety

- Caregivers don't always disclose client has dementia becomes our responsibility
- If someone accompanies them, they can come otherwise we need to decline them. If client is not appropriate for program it puts everyone at risk (other clients and staff)
- Need commitment and willingness to partner with VCH; don't want unregulated services/programs; need a true partnership
- "I am not trained to provide care to my Mom. I had hip surgery and was recovering and needed to pick up my Mom from the floor."
- If non-profits funded properly, there would be a safe place for caregivers to leave clients
- Lifeline service (relatively inexpensive) and a good service
- "I am concerned about the safety of respite beds. One facility I went to had 6 respite beds and 22 complex care beds with only one RN and one aide overnight for all 28 beds. This did not inspire confidence."

Access

- Need more than Monday to Friday 9-5; flexible e.g. drop-in respite
- Waitlists, must book min/week
- Parkgate (private, low cost, $30/day), two half mornings
- Public $10/day if subsidized
- Many young clients with early onset dementia who are physically fit so program is not appropriate
- Target early Alzheimer's clients
- Nothing available for acquired brain injured clients
- HandyDART not a good service for frail clients
- Public Adult day Programs at Margaret Fulton and West Van community centre are full
- Many private programs but many people can't afford them
- Challenge to book a respite bed (need to book far in advance
- Private and public respite available but limited spaces (6 beds)

Options

- Need creativity and flexibility in programming
- "When a person's needs fall outside the normal range of services it is like they are being forced to fit in to preexisting services. There needs to be exceptions and flexibility that is responsive to the client in a way that is client centred and meets the client where they are at."
- Look at innovative programs in other jurisdictions
- "I need some creative options. Someone to come and walk with my husband, spend time with him. Allowing him some freedom while being monitored."

Information and Support

- Need to know what services are available
- Not enough info about caregiver support/education -> more education
- GPs should be a primary source of info for services
- offers a break for caregivers
- MH clients need more one-on-one support
- Need extra support that exceeds volunteer capacity
- "I have called on family members to offer some respite to me. If I had a week of respite I am not sure what I would do with that. It would be lovely to take my daughter away on a trip."
- When needs increase it is difficult to move clients to new program as they have bonded and want to stay with their group
- Need to know what programs are available for caregivers to avoid burn out. They are not professionals so respite is critical
- Ability to provide overnight respite
- Flexibility (# of hours/days, days of week)
- Financial support for caregivers e.g. tax breaks
- Support to drive to appointments
- Alzheimer's society a good resource
- "I need more support in the home and for respite than I am getting now. I do not get much sleep as my husband does not sleep through the night."

Coordination and Administration

- Co-ordinate care more closely between clinicians at Adult day programs
- "The billing system for adult day programs is so confusing. I cannot figure out what is being billed for and what I am paying for."

Timeliness

- Clients decline while on waitlists, need to provide service in a timely manner
- First contact often when caregiver has reached crisis point and then it's a long wait for service, need to help before a crisis – be proactive
- Adult day programs should have ability to be more responsive to urgent requests
- Need more adult day programs so that caregivers can have a break to avoid burnout
- Good relationship with GP will facilitate early referrals

DEFINING BETTER CARE

At the forum participants were invited to offer ideas, related to each of the topics discussed, that if implemented could define better care for seniors.

Community Based Resources

- Advocacy for people who are alone
- Better communication on what services are available on the North Shore
- MORE community based resources/rehab services
- Having a mobile senior 1 stop with information for seniors with various organizations or where seniors frequent (e.g. hair dressers/GP offices)

Discharge Planning

- Better discharge planning from hospital to home
- Support for patients in hospital (planning and discharge)
- Proactive engagement for people with disabilities in preparation for hospital discharge
- More support for aboriginal community being discharged through coordination with First Nations health services

Home Support

- Consistency and constancy of home support workers and delivery of service
- Training for home support workers
- Better stability of services provided at home and consistent caregiver
- Community health nurses doing more home visits (broaden scope of what CHNs provide at home)
- More mental health home support
- More funding to home and community care
- More hours for home support

Housing

- Different housing models with flexibility to be client centred
- Planning and integration between all providers to support client
- Seniors mental health housing
- Crisis stabilization program for psychiatry
- Support for people with dementia and their caregivers

Palliative Care

- There is a wonderful home palliative care program. Provide this same model for other seniors' programs
- Create connections and communication between clients, caregivers and service providers
- Create consistency in Palliative program
  - respect DNR
  - reduce wait times in Emergency for patients that are palliative
- have social worker in community to support palliative
- Change stigma/perception around "palliative care"

Primary Care – Family Doctor

- Community clinic with multiple co-location services to ease transportation challenges and improve relationships
- More hours for radiology diagnostics
- Other locations for diagnostics after hours
- Walk-in clinics open on weekends
- Clinical care in home
- Place for clients to get care when they are in urgent needs and don't have one regular family doctor
- Integration and planning between primary care physicians and families/caregivers
- Provide team-based care

Promoting Wellness

- Funding to community based programs
- Need more music in residential care facility
- Transfer of funding from acute to community
- Help people to take responsibility for nutrition
- Social programs, education to support this
- Support for emotional component e.g counseling

Adult Day Programs and Caregiver Support

- More adult day programs
- More geriatric psychiatry programs
- Financial support for caregivers
- Reduce waitlists for day centres for seniors who are declining
- More tools for caregivers self-care
- More spaces, flexibility and access to adult day programs and respite
- Innovate by partnering with private or community partners

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 be the next step to determine what better care could be for seniors with difficult health conditions. The next forum will take place August 19th.

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Leader, Community Engagement
Vancouver Coastal Health,
August 14, 2015

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Keeping Seniors Well in the Community

An Invitation to Develop a Better approach to Seniors Care in the Community

Sometimes seniors, with complex health conditions, may end up going to the emergency department for health care because they are unable to access services outside the hospital. We know that for seniors, home is often the best place to manage health conditions, recover from illness, and live their life. 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 review and develop a better approach to access and providing a range of services for seniors with difficult health conditions. At Vancouver Coastal Health we want to start with two communities, the North Shore and the Vancouver West End/Fairview Slopes area. The goal is to develop better ways to keep seniors well in their home and community. We want people like Estelle (read Estelle's Story) to experience a better quality of life.

In order to do this, Vancouver Coastal Health wants to hear from patients, their families and their caregivers. We want to hear their experience and what their needs are. We are planning forums over the summer, to have a conversation with seniors, their families and those in the community that provide care and support to them. We want to understand what the current gaps in the network of available services are and hear what is needed to provide better care. With this information we will develop a (new model) way to provide care health care.

We are asking you to be part of this planning and development process.

Please consider attending two forums. The first in the area nearest you and the second combined forum:

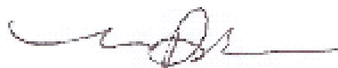
- ***Identifying Needs Forum*** **– West Vancouver – Monday, August 10th – 1:30 to 3:30 pm**
- ***Identifying Needs Forum*** **– North Vancouver – Tuesday, August 11th – 1:30 to 3:30 pm**
- ***Confirming a New Approach to Care Forum*** **– North Shore - Wednesday, August 19th – 1:30 to 3:30 pm**

We hope you will attend and find this opportunity as exciting as we do.

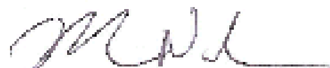
If you are able to attend this session, please **RSVP by returning this email or calling 604.244.5101**. Please include in your reply, your full name, organization and phone number. Details of the location will be provided upon confirmation of your attendance.

If you are unable to attend but are interested in sharing your health care experiences and ideas, please contact **Belinda Boyd, Leader, Community Engagement 604.244.5101** to arrange time to connect with you.

If you would like more information or have any questions, please contact Belinda Boyd, Leader, Community Engagement 604.244.5101.



Mary Ackenhusen
President and Chief Executive Officer
Vancouver Coastal Health



Mike Nader
Chief Operating Officer
Vancouver Coastal Health