Keeping Seniors Well

Community Engagement Summary

West Vancouver August 10, 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 is intent on the development of a new model of care that will better meet the needs of seniors.

A forum held in West Vancouver on Monday, August 10, had an attendance of 40 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 client 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.

After Hours

Family Doctors, Nursing Care and Clinics

- Need to keep emergency departments for emergencies
- Need GPs /family doctors to extend hours and offer evening and weekend appointments
- Family Doctor needs to be part of the care team

- need clinics open in the evening with evening and weekend
- Need a centrally located one stop after hours clinic
- "after hours the only option is emergency"
- Need Hospitalists to go to people's homes (mobile services)
- Need after hours RNs to visit clients in their homes
- Need to promote use of 811 Health Link line
- RN case managers connected with primary care providers
- Need family doctors to make house calls
- After hour on-call MD aware of patient cases
- Medeo online technology office to office with MDs and case workers
- Redirecting seniors from emergency GPs

Community based Resources

- need to access to affordable community services
- need a multi service facility/clinic to meet a number of health and social needs
- Peer/companion support
- Access to phone support
- Volunteers to talk
- Reading material after hours
- Need 24 hours on-call

Respite and Daycare

- Need more daycare spaces for seniors (there is a waitlist at Margaret Fulton centre)
- Provide respite 24 hours available in client's homes
- Expand hours at Margaret Fulton Centre
- Respite care needed in middle of night
- Rest for caregivers who are burnt out
- Family caregivers saves money but they can't access support after hours and on weekend

Client centred care

- Better client/worker ratios
- Tailored to client needs; not just 2 days/week
- Look at overall care of client. Acute/home/community work in silos currently and need to work together rf for the clients benefit
- Difficulty getting to transport
- Quick transit to visit after hours clinic
- Need continuity of services and personnel/staff

Community Services

Collaboration, Coordination and Communication

- Needs expansion of the services
- Need to be linked and coordinated with health care services
- Existing community health services do not communicate with doctors (majority of the time) and it is very confusing for clients/caregivers
- Need for integration with all available resources

Funding

- Community based services need additional funding. These are less costly than hospital based services.
- There are currently long waits for mental health services

Education and Support

- The Seniors Coalition has services for seniors but how to get the information out to them?
- Increase emotional support for caregivers
- Need to have a face to face/in person information source

Access

- Access to information for about community based services for seniors is not known to VCH Home Health
- Large caseloads for case managers. Unable to keep reasonable contact with clients
- Reduce confusion of how to access services; make it easier for seniors and their family members
- Need for a SW @ NS community to co-ordinate services
- Access services for clients of West Vancouver to remove barriers for people with low income/people of all ages
- The current referral process is "murky"; who do you refer. Need for clarity and one access number to call
- Need a single access point for patients for all services
- Need to have a single form for family doctor's to refer patients to community services
- Need a comprehensive assessment for all clients done by GP to determine needs
- "Socialization is a challenge – I try to go to adult day programs whenever I can."

Discharge and Transitions

Information and Instructions

- Need to have who to call, where to go for equipment, help and other needs and what is needed before discharge occurs.
- Need instructions to connect seniors to community based services
- Caregivers have anxiety without proper discharge planning. Need to provide better information and instructions and support for caregivers
- Health care staff need to take time while people are in emergency to provide clear instructions for discharge so they leave confident about what they need to do next and who to call if they have questions.
- Have an advocate with the seniors-Someone to listen to instructions/directives

Post Discharge and Follow up

- Need to be followed up after discharge to make sure seniors are ok and if they need anything
- A poorly planned discharge leads to readmission to emergency
- Need to consider 48 hours of private assistance that could avoid hospital admissions
- Need to have more Discharge Coordinators as they are very important to transition
- Appropriate assessment to measure the capacity of patient - Ask the right questions
- Lots of anxiety during transition, need more social work follow-ups
- Service: could patients/other ask to be checked-up on?
- After hours availability. Someone to call if needed.
- Communication with GP on discharge is needed.

Support

- Need Volunteers to guide/accompany and support seniors through emergency and discharge
- Pressure felt by families to get patients out when they don't have the support
- Patient unsure of what support is required; if it's good enough
- Need to provide additional support to those seniors with most complex needs/biggest barriers. Who does this? The Discharge Coordinator? Is enough info provided?
- Need to ensure seniors are able to make trip home? Do they money, right frame of mind, are they going to be safe, do they food at home? Not just medical needs for a good transition to home.

Timeliness

- Is discharge driven by need to get bed? This does not feel patient centred
- Need to connect with next provider to ensure warm hand over and follow-up
- Transitions happen too fast and patients are not ready and then have a crisis
- Do doctors have time to do discharge activities?
- Need to have supports and services in place before discharge or moving to next stage of care.
- Need to ensure regardless of time of day that services and supports are in place.

Caregiver Support

- Caregivers capacity needs to be assessed to ensure they can support after transition
- Caregivers need to know about resources
- Provide supports to caregivers upon discharge to prevent readmissions
- Need to provide a detailed care plan
- Discharge coordinator doesn't have the time to spend the time needed with the caregiver

Messaging

- Heard seniors say they feel they were not meant to be in hospital/ED, didn't feel welcome there
- There is pressure on family members to get seniors out of hospital. They were made to feel guilty that their loved one was in hospital and not at home
- Think about how the messages sound to seniors and their families and how they make them feel

Family Doctors

Access

- Difficult to find a family doctor or to know which doctors are accepting new patients.
- GP is the hub but spokes are broken, no leverage (e.g.: access to specialists)
- If doctor moves or senior moves it is expensive to travel to see doctor
- After hour access:
- Some GPs very good and will make time for urgent cases
- Some people would go to hospital if GP not available
- Walk-in clinics helpful after-hours
- Shortage of GPs for seniors and complex clients
- GPs reaching retirement age
- Can VCH employ more GPs for complex clients?
- Home visits would be very helpful
- Not consistent
- GPs with hospital privileges. Majority don't have this
- Need to have proactive care with a focus on prevention
- Other practitioners focus on proactive care (e.g. NPs)
- Reviews of GPs
- Drop-in sessions with GP in community (outreach program) e.g. at library
- Make access easier where everyone can come easily
- After-hours access is a problem
- 811 nurse line is wonderful
- Not helpful to tell seniors to go "online" when many don't have computers or access
- What is available after hours for medical care or advice? Helpful to know

Relationship

- "My doctor is always trying to prescribe meds, managing well on her own through exercise, diet"
- Important to have a good doctor that you can talk to
    - Doesn't prescribe unnecessarily

- Advocates good diet
- Listens to you and works with you on a plan

- Need to find someone who is a good fit for you

Alternatives

- NPs conducting home visits; NPs excellent and proactive
- NPs attached to GPs
- Repeated referrals a waste of time for f/up specialist appointments
- Walk-in clinic: for less urgent issues
- Can we hire psychiatrists/psychologists for MH issues if GPs not comfortable with this?
- Could be MH worker as well

Competencies

- MH: GPs not always comfortable dealing with MH
- Interview new GP if GP retiring soon
- GPs need increased awareness of community services

Collaboration

- More communication between GPs and Home Health
- Personal relationships between Home Health and GPs
- Meetings between GPs and Home Health care staff to get to know each other
- Share info between Home Health and GP's
- A "them vs us" mentality between GPs and community care providers
- Partner with community organizations
- Libraries are community hubs and wanting to offer other services

Funding

Administration

- Subsidize private support
- Blanket funding based on need
- Link funding to needs assessment
- Funding information needs to be centralized
- Support money based on income and not necessarily based on need
- Give funding to families so they can administer
- Money to families directly versus to VCH would work with some but not for others. Would need an able caregiver team
- Funding is a barrier for GPs to see complex clients
- "I would like to know more about health care related income tax deductions from CRA or another body. My Chartered Accountant is very good with private business knowledge but did not seem to know much about healthcare related deductions.".

Client Centred

- Prohibitive private living costs: hours vs needs
- Funding for specific services (foot care) would lead to saved money (i.e. dental care)
- Complex homecare system explained by volunteers

Coverage

- Need support and funding to help with paying for
  - Adult diapers
  - Walkers
  - Preventative care
  - Hearing care supplies
- Lower income being hit hardest
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- Trouble getting home support, adult daycare and residential
- House rich/large house but no money to pay for services

Services

- Less support from case managers for more people
- More funding for seniors mental health programs
- Physical and mental wellness go together
- Money needs to go for supporting seniors staying home
- Margaret Fulton Centre not being used 24 hours
- Establish and information resource centre
- Provide intermediary care (not just docs)
- Need for Physio and nurse practitioner
- Need Specialized care visits
- More home support hours for those that can stay home

- After "assisted living" and before residential care there is a gap
- Money for family caregivers support as they are saving the system money
- Promote community resources that are already there

Home Support

Consistency and Frequency

- Need for Home support consistency in the caregivers
- More home support partially funded like it used to be
- Consistency for theday and time that home support is provided and constancy in the same level of support
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- Home support should be divided into smaller time modules
- "Consistency in care providers is much needed in my condition. It's difficult for me to help them orientate each time."
- Consistency in caregivers going into 1 building (efficiency)
- Cluster visits for home support workers
- Private vs public home support have big differences in
  - Consistency in services, caregivers, duties, scheduling
  - Choice in services based on need (redirection of funds)
  - Workload of caregivers, demand

- "I find that our per diem is quite high for the service my wife receives"
- reduce number of providers so as not to have multiple providers
- Respect and adhere to parameters in intake for home support

Communication and collaboration

- Collaboration between private care and public care to ensure consistency,
- Information in client book is confusing to read and follow especially for people with 2nd language. It is fragmented and too detailed. Keep it simple!
- Lack of communication between client/case managers/team
- Need to inject more private options
- "It's hard for me to be understood due to my illness. It is hard for me because I have communication challenges. I use an iPhone."

Adaptability and Client Centeredness

- Respect and adhere to parameters in intake
  - Need to honour religious freedom
  - Psychosocial/spiritual needs are not met

- Need to tailor the care to unique individuals
- Care needs to adapt with the client
- Look to other models and take best practice and learning
  - What has worked?
  - What hasn't?

Resources and Information

Access

- Need to provide Information similar to "Seniors Help Line"
- Eliminate language barriers for Farsi speaking community to improve health care through better communication
- Partnering programs for caregivers and clients
- Preventing senior's isolation through knowledge of resources
- need to offer tours for residential care facilities
- address language barriers. Most of the information is in English
- ensure information is in plain language
- If info on the website, not many people know how to access
- Info translated is not always correct
- Need to provide translation and interpretation services
- When family interprets or translates they may not know the terminology and be able to explain it to the senior
- You just do not know the resources that are out there – how, where to access
- Need to promote the services
- Library and intake providers help. However, awareness of this is limited
- How many seniors are able to access and process info. Need it to be simple! Health literacy is important
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- Home health intake is very challenging. Who do you call?
- Seniors help line was very helpful; what happened to it?
- Need education for physicians so they can lt patients know about resources

Transportation

Availability and Access

- HandyDART late or doesn't show. Can't wait for HandyDART
- Booking in advance (4 days) can be challenging for short notice appointments
- No money for HandyDART
- Cognitive challenge to deal with HandyDART
- Long wait times - need more HandyDART or taxi vouchers
- New people don't know about HandyDART
- North Shore HandyDART doesn't go to Vancouver
- need to allocate temporary parking to bring people from car to emergency department
- More handicapped parking is needed
- need more parking spots at West Van ambulatory clinic. Parking spot not close enough to clinic.
- Seniors are missing appointments due to transportation/access to clinics
- Need affordable, reliable, readily available access to transportation and parking
- Need longer than 15 minute temporary parking to stay with patient until admitted- coudl there be a valet service?
- Need more volunteer drivers but insurance is expensive as need to increase liability and volunteer drivers are not paid or reimbursed
- Volunteer driver may not be able to help physically to support people to get in and and out of vehicle. Need "more than a driver"

- Need navigation support for HandyDART
- Public and private partnership for transportation (e.g. Parc)
- Need transportation for socialization
- need coordinator for transportation for senior patients
- Need special spots close to clinic (access)
- Need a temporary close parking passes for scheduled appointments
- Parking at hospital
- Paying for time in advance (cannot predict). End up paying too much time or increase money ticket
- concerned that money for parking goes to private company other than hospital
- Stressful figuring out machine payment and worrying about time and money. Better to use a system like YVR where you take ticket on arrival and pay for usage at exit by machine
- Mobility issues make it difficult to access taxi
- "Mobility is a huge issue for me, I try to walk with a walker but it is very difficult"

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.

After Hours

- access to after business hour services and supports
- More daycare spaces
- More respite care beds
- Extended hours offered at Margaret Fulton Centre
- Better and more communication between caregiver and daycare

Community Services

- More mental health programs and counseling for seniors
- Increased emotional support for seniors
- Community bathing program offered more often
- Coverage for diabetic foot care
- A community social worker

Discharge and Transitions

- provide doctor notes when discharging from hospital
- shorter wait times in emergency for seniors
- Written discharge instructions provided at hospital
- 48 hours of private assistance on discharge that could avoid hospital admissions
- Ask the right questions before dischargign to ensure the senior is safe and not at risk to readmit
- Target with increased services and support those seniors with most complex needs/biggest barriers
- Don't make patient feel like they are just taking up space in emergency or hospital
- Service that patients/caregivers could ask for that has someone (nurse) check up on them after discharge
- Proper assessment to occur that includes medical and non-medical needs
- comprehensive information provided to prepare for discharge and where resources can be located

Family Doctors

- Family doctors to provide proactive care
- Attach at risk seniors to a family doctor
- have after-hours access to GP
- More GPs doing home visits
- More time available for doctor visit (more than one issue)
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- Community health nurses connect with family doctors for home visits
- Greater collaboration between GPs, HH and community stakeholders

Funding

- Funding for volunteer support for seniors (reinstate funding)
- widen parameters of home support funding
- Funding for rehab services reimbursement coverage in full
- Publicly funded home support to family then they can self-direct to agency

Home Support

- Create consistency in the practice and provision of home support services
- improve communication between home support and clients/caregivers/doctors

Resources and Information

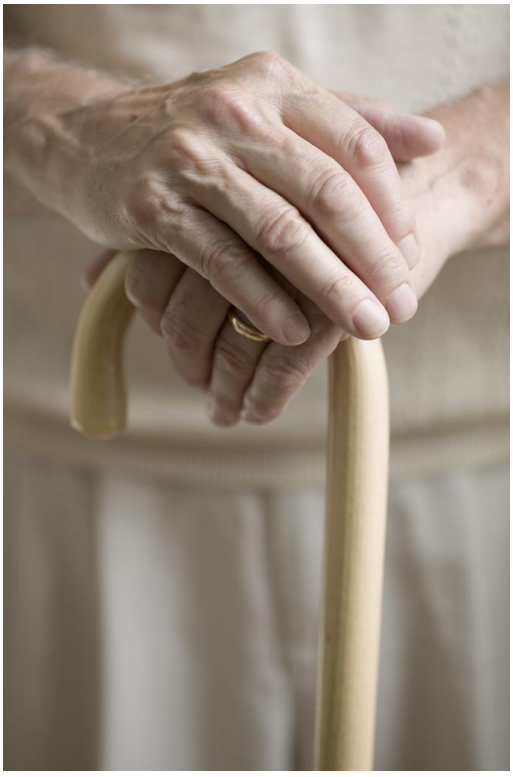
- Provide tours for residential care facilities
- create an Information similar to "Seniors Help Line"
- Eliminate language barriers for Farsi speaking community
- provide more programs for caregivers and clients
- Prevent senior's isolation
- increase knowledge of resources e.g library services, online resources
- use local newspapers to get information out
- use simple language on materials
- reduce confusion and complication of using automated phone services makes more difficult for seniors
- Educate physicians about available community programs to assist patients
- raise awareness of 811

Transportation

- Special parking or valet for people dropping off at emergency departments
- Temporary and easy access to taxi savers and HandyDart to facilitate a short term need
- More availability of transportation options
- provide financial support for caregivers who are transporting seniors
- Need affordable, reliable, readily available access to transportation and parking
- More volunteer drivers and offer supports for Insurance costs

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 developing a model of care that provides better care for seniors with difficult health conditions. The next forum will take place August 19th.



Prepared by: Belinda Boyd
Leader, Community Engagement
Vancouver Coastal Health,
August 14, 2015

Vancouver CoastalHealth

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