

Home and Community Care

An Introduction to Community Based Health Services



Fraser Health - Home and Community Care

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Introduction

Our health, as individuals and as a community, is one of the most significant factors affecting our quality of life.

Health Care services in British Columbia are delivered through six regional health authorities. The Fraser Health Authority is the largest in British Columbia and one of the largest in Canada, providing acute care hospitals and community based residential, assisted living, home health, mental health and public health services to more than 1.44 million residents from Burnaby to Hope.

Fraser Health recently set an ambitious Strategic Plan in motion to deliver health services that are dynamic, responsive, sustainable, and able to meet the diverse and changing needs of our communities.

In our efforts to improve and enhance health services, we have learned from our own experiences, as well as the experiences of other communities. We have developed partnerships and continue to seek out community leaders to work with us to champion better health for all members of our society. Opportunities for more research and learning are becoming available to us as we foster working relationships with medical teaching campuses in the pursuit of best practices.

This booklet is designed to provide an overview of one of the major components of our Strategic Plan - the enhancement of Fraser Health's Home and Community Care Services. We welcome and encourage you to talk with us about how we can work together to bring Better health and the Best in health care to your family and community.

Putting the Strategy into Action

Fraser Health's Strategic Plan is based on a "continuum of care" model that provides excellence in treatment, delivered through a wide range of service options and varying levels of care. This model effectively responds to the diverse and changing needs of our constituents while also making the best possible use of our resources. Further, it facilitates the realization of our goal to provide the right services, at the right time, in the most appropriate setting.

Home and Community Care services include home health care, assisted living, residential services for people with complex health care needs, and end of life care.

Partnerships

Collaborative planning with all levels of government and ongoing partnerships with public service providers, private businesses and non-profit organizations will all play a crucial role in further implementing Fraser Health's Strategic Plan. We are committed to sharing information, listening to new ideas and suggestions, and fostering open dialogue. We value your input and encourage you to contact us.

For More Information

Fraser Health is divided into three Health Service delivery areas: Fraser North includes the communities of Burnaby, New Westminster, Coquitlam, Port Coquitlam, Port Moody, Anmore, Belcarra, Pitt Meadows, and Maple Ridge; Fraser South includes the communities of Delta, Langley, Surrey, and South Surrey/White Rock; and, Fraser East includes the communities of Abbotsford, Agassiz, Chilliwack, Mission, and Hope.

To contact Fraser Health in your community check the Blue Pages of your telephone book under Health Authorities or contact our Corporate Office at:

**Suite 300, 10334-152A St.
Surrey, BC V3R 7P8**

**604.587.4600
Toll Free 1.877.935.5669**

You may also wish to visit our website at www.fraserhealth.ca to access the following companion resource documents:

- *The Fraser Health Strategic Plan*
- *Respect, Support, and Enable: Guiding Principles for Residential Care*
- *When Your Care Needs Change... Moving to a Residential Care Facility*
- *Independent Living - Creating Choices for Life*

In Conclusion

The strategic initiatives implemented to date have already begun to show the desired results. The many fields of service and levels of care are more integrated and effective, and our budget is balanced. As we continue to introduce new projects and programs we are building capacity along the desired continuum of care and furthering our primary goal - Better health. Best in health care.

Grappling with various forms of arthritis, Elizabeth's days don't always go as planned. In the past, a Community Health Worker visited Elizabeth at specific times during the week. While the assistance was beneficial, help wasn't always available when she needed it most.

With the implementation of Cluster Care, on days when Elizabeth's arthritis flare-ups are severe, she gets the additional attention she needs, and when she is managing well, her Community Health Worker can spend more time with clients who are having a more difficult day.

In Fraser Health communities where the Cluster Care model has been fully implemented, client satisfaction is high. In addition to the bonus of more effective client care, there are financial benefits as well. Cluster Care employees spend less time traveling and clients are able to stay in their homes longer because of the ability of Home Health to assess and intervene more frequently. The Cluster Care model of service delivery is being introduced in communities across Fraser Health, where sufficient client numbers make it feasible.

Campus of Care is a term used to describe a complex of co-located facilities with varying levels of care. Transitions can be particularly difficult for seniors and others with special needs. By making it possible for people to “age in place” and remain in familiar surroundings, close to their friends and other supports, transitions are more easily managed.

The Hawthorne Complex in the Tri-cities area, when complete, will offer 56 cottage style housing units for dementia care, 70 assisted living units, and 75 long term residential care beds. Hawthorne is one of the first Campuses of Care in Fraser Health. Partners are currently being sought to develop eight similar complexes in various communities.



4 key objectives guide the delivery of Home and Community Care Services:

- to provide the support necessary for clients to remain in their own homes for as long as possible;
- to provide at-home services to clients who would otherwise require admission to hospital or would stay longer in hospital than necessary;
- to provide assisted living and residential care services to clients who can no longer be effectively supported in their own homes; and
- to provide people who are nearing the end of their life, as well as their families, services at home or in a hospice or hospital setting.

The specific projects and initiatives necessary to realize these goals and objectives fall into two major categories. The first is Aligning Resources - putting in place the human resources, facilities and other assets needed to provide a full range of services now and in the future. The second is Managing for Effectiveness - providing the best possible care in a fair and cost-effective manner.

Aligning Resources

In order to meet the needs of a growing and changing population, we are rebalancing and adding to our resource base. This includes doctors, nurses, community health workers, social workers, therapists, and case managers. It also includes Adult Day Programs that provide health, social and recreational support as well as much needed respite for caregivers, and accommodation options such as Assisted Living, Residential Care and Hospice Care. Ensuring that we have sufficient capacity in each of these areas is a priority for Home and Community Care.

Home and Community Care services play a vital role in supporting people following a stay in hospital or after participating in active rehabilitation in one of our sites offering sub-acute care. Sub-acute care is one of the newer services offered by Fraser Health, and, while it is not directly under the umbrella of Home and Community Care, many patients do receive services at home once they have completed their sub-acute rehabilitation.

Sub-acute Care provides services for persons who are recovering from an acute illness or injury and are expected to regain a level of independence and return home. They no longer require the full services of an acute care hospital but are not yet able to be unsupervised and will make a speedier recovery with the benefit of ongoing medical supervision and intensive therapy.

Sub-acute care includes:

- accommodation
- meals
- personal hygiene
- physical and occupational therapy
- recreation
- 24-hour medical supervision
- administration of medications

Fraser Health is investing more than \$2 million dollars to increase our sub-acute capacity by almost 50% to 123 beds by the spring of 2005. We are also adding health care professionals to this level of care. The result of these initiatives will mean the ability to provide intensive rehabilitation for an additional six hundred (600) patients annually. Through targeted rehabilitation care, we expect to see shorter hospital stays and an increase in the number of people who are able to return home to an independent lifestyle.



John, age 58, has suffered a mild stroke. After three days in hospital, his condition has stabilized and remaining in hospital is of no further benefit. Going home however, would be problematic. John is unable to properly control his right arm or leg. He cannot drive his car or use his computer at work and has difficulty bathing and dressing. As a result of John's lifestyle, he is at risk for both further strokes and heart disease. The muscles in his arm and leg will start to deteriorate within a few days if he does not undergo intensive therapy.

During a short stay in a sub-acute unit, John receives physical therapy twice daily and assistance with planning to include more physical activity in his lifestyle. A nutritionist coaches John on choices for a healthy diet and meal planning. After 25 days, John has recovered sufficiently to return home and live independently. A physiotherapist visits John for several weeks until he is able to drive. When John returns to work, he sees a physiotherapist near his office on a regular basis. After three months, John has made a full recovery and with his modified lifestyle, will enjoy good health for many more years.

Managing for Effectiveness

At the same time that we are making major investments to increase and rebalance our Home and Community Care resources, we are also taking steps to ensure that we are managing these resources in the most efficient and effective manner.

Our goal is to standardize services across Fraser Health, implement best practices in all fields of service and to ensure that people who need services can access them, regardless of where they live.

Through adjusting our administrative and patient management processes, listening to our stakeholders, and planning for future needs, we have made significant strides towards this goal. Two examples are Cluster Care and Campuses of Care.

The Cluster Care program is an innovative, efficient and effective method for delivering personal care services in the community. In the past, Home Health clients were assigned to service providers based on caseloads. When one client's care ended, the Community Health Worker was assigned a new case. This method was useful in ensuring that each new client received services as soon as possible and that caseloads were evenly distributed. As communities grew however, workers were spending longer periods of time driving from one client's home to the next.

Now, when new clients are referred for Home Health services, their location as well as their health care needs is taken into consideration. Whenever possible, patients living in close proximity are assigned to a small group of workers. This might mean for example, that a Community Health Worker will spend the entire day at one or two apartment buildings where there is a high concentration of clients. This allows clients to have consistent workers in their homes, and the flexibility for one or more visits to each client depending on their needs that day.

End of Life and Hospice Palliative Care

is supportive and compassionate care that seeks to improve the quality of life experienced by people in the end stages of a terminal illness. Care is provided wherever the client is living - at home, in hospital, hospice, assisted living, or residential care facility. End of life care is dedicated to preserving an individual's dignity while providing comfort and support. Taking guidance from the Canadian Hospice Palliative Care Association, the goal of End of Life Care is to "relieve suffering and improve the quality of living and dying."

Services include palliative care co-ordination, professional nursing services, advice on comfortable positioning and assistance with range of motion, counseling, home support and respite for caregivers. Palliative care services control or relieve symptoms so those facing death, and their families, can focus on the time they have together.

In partnership with Hospice Societies in communities across Fraser Health, hospice residence beds are being developed to support individuals who are nearing the end of their life, as well as their families. By the spring of 2005, Fraser Health will have doubled its current capacity, with 60 hospice beds in place.

Dan was diagnosed with inoperable cancer. An aggressive treatment regime was initiated causing severe side effects, but did little to halt the disease. Following a necessary four-week "rest" from treatment to strengthen Dan's immune system, he was reassessed. A team of specialists reviewed Dan's case and advised Dan and his family that further treatment would offer no hope of a cure. Without further treatment, Dan could expect to live for six to 12 months.

Further treatment would mean more devastating side effects: dizziness, nausea, and muscle weakness that would leave him bed-ridden for most of the remainder of his life. Dan and his family made the decision to explore palliative care.

A Fraser Health Home Health Nurse met the family and would remain a supportive contact throughout the coming months. For the first eight months, Dan traveled, visited relatives and spent time with his family. In the ninth month, Dan began experiencing more pain and rapid physical deterioration. He was taken to emergency several times because he was having trouble breathing.

With the assistance of their Home Health Nurse, Dan moved to a Hospice close to his home. Nursing care was available around the clock to help Dan manage his pain and periods of respiratory distress. Hospice Volunteers had done a wonderful job making the residence home-like and welcoming for family and friends. Dan's family was free to come and go as they wished and sometimes his wife stayed with him overnight.

As Dan approached his final days, he told a nurse that although he was quite comfortable there, he wished he could go back home to spend his last days in a familiar environment. Home-based services were put in place under the supervision of a palliative care physician, to facilitate Dan's final wish - to die in his own home, with his family beside him.

Home Health Care works with individuals, their families, other caregivers and community services to provide a range of health and support services which enable clients to remain in their own homes. Health care needs may be acute, chronic, rehabilitative or palliative.

In-home services, for eligible BC residents, may include:

- case management
- nursing care
- medication management
- social work
- rehabilitation therapy
- personal care
- end of life care

Services also include assessing requirements for adaptive aids and mobility equipment and ensuring that the home is arranged for individual needs and safety. In addition, Home Health works in collaboration with local community services to offer adult day programs and meal programs.

Home and Community Care health professionals strive to enhance a client's ability to care for themselves. Services complement and supplement, but do not replace, the assistance of families, neighbours, churches, and community groups.

Fraser Health is investing a further \$9.75 million dollars in Home Health Care to provide services to an additional 1000 home support clients over the next few years.

Improved access to care and support at home, where appropriate, can result in faster healing times, less risk of complications and a greater quality of life for clients with both post-acute and chronic needs.



Fred and Margaret are 75 years of age and live in their own home. Fred has arthritis, which has worsened over time. He is not able to bathe or dress himself and is dependent on a wheelchair for mobility. Margaret has debilitating osteoporosis. Lifting too much weight or having a fall may result in broken bones. Both have periods of confusion, occasionally take too much medication, and forget who to call for help with different needs. Their daughter Joan brings them a hot meal most nights after work and tries to help with household tasks on the weekends, but worries about her parents being alone if a fire or accident were to occur.

A Home Health Case Manager has provided a Community Health Worker three times a week for the past two years but he has notified his supervisor that the couple's situation is deteriorating. During a meeting with the couple, their daughter and their Case Manager, a standardized assessment is completed. All agree that Fred and Margaret need a greater level of care than can be provided for them at home.

Fred and Margaret move into a one bedroom Assisted Living apartment complex just two miles from their old home and still in close proximity to their neighbourhood friends and church. Because they require assistance with routine activities of daily living, each morning a Community Health Worker visits to help them get up, bathe, dress and take their medication. Fred is transferred into his wheelchair and Margaret is directed to the activity room for an exercise session that will help to strengthen her brittle bones.

At noon they make their way to the common dining room for a hot lunch and stay to take part in a recreation program. On pleasant days, they spend time in the courtyard and Fred has his own special garden box that can be tended to from his wheelchair. At 6:00pm they share dinner with their new community of friends then return to their apartment to enjoy a quiet evening.

At 9:00pm, a Community Health Worker arrives again to help Fred transfer from his wheelchair into bed. Both Fred and Margaret have a personal alarm that is worn on their wrists during the day and placed at the bedside at night that can be activated if either of them needs immediate help.

Joan visits three times a week and can enjoy spending time with her parents instead of worrying about what might happen when she's not around.

Assisted Living units are a new and integral component of our overall Home and Community Care strategy, expanding options for seniors and people with disabilities who are able to live independently with regular assistance, but do not require 24-hour medical supervision in a hospital or residential care setting.

Assisted Living provides personal care and basic homemaking services in a private housing unit with a lockable door. The level and range of services varies between different complexes, and for different individuals, depending on individual needs and preferences. Units are available for singles and couples. Services typically include:

- two meals daily, snacks and beverages
- social and recreation opportunities
- laundry and light housekeeping
- emergency response system
- assistance with personal care



Recently opened Assisted Living units for seniors and people with disabilities have already proven extremely successful. In partnership with the Independent Living Program of BC and BC Housing, Fraser Health is leading the province in advancing this new component in the continuum of care. We will award contracts for a total of 1,176 Assisting Living units, many of which have already opened, with the remainder to be open in late 2006.

With the population of seniors expected to more than double over the next 25-year period, Assisted Living will play a very valuable role in supporting seniors to enjoy living with the greatest degree of independence possible.

When Katherine was diagnosed with early stage Alzheimer's disease her family was understandably concerned. A Fraser Health Case Manager met with them to explain the usual progression of the disease and some of the symptoms they would likely see. Katherine was occasionally forgetful but still seemed to be managing well and wanted to remain at home as long as she could.

Her children set up a schedule to ensure that they checked in with Katherine several times each day. They accompanied her to get groceries or run errands and took turns each evening to remind her to take her medication and lock the doors. This arrangement worked well for more than a year.

One day Katherine didn't answer the phone when her son called to check in. He quickly went to the house to see if she was ok, but didn't find her there. He called the other members of the family and checked with some neighbours but no one had seen Katherine that day. The police had to be called and it was several hours before Katherine was located. She had wandered several miles from home and when the police officer approached her, she was unable to give her name or remember where she lived.

Katherine's family took her to the doctor the following day and learned that the disease had begun advancing rapidly. She was at risk for more frequent wandering and increased loss of memory. All were concerned about Katherine's safety. The doctor advised Katherine's family to contact their Fraser Health Case Manager to discuss the change in Katherine's situation.

Katherine moved into a small Residential Care facility a few miles from her son's house. She has her own room and there is a dining room, lounge area and outdoor patio that Katherine and the other residents share. Katherine is free to walk around the living areas but the exit from the unit is locked and alarmed so that there is no fear of Katherine wandering away or leaving the complex without supervision. Her family visit frequently and take Katherine out to dinner once a week.

Residential Services provide 24-hour professional nursing care in a supportive environment for adults whose complex care needs cannot be met elsewhere.

Services include:

- safe and secure living environment
- skilled nursing care
- assisted meal service
- personal assistance with daily activities such as bathing / dressing
- recreational and activity programs

There are several issues facing us as we adjust our residential care resources to prepare for emerging needs:

- Many of the existing residential facilities are aging and inappropriately designed for today's standards. Issues such as heating and ventilation, electrical supply and inability to accommodate advancing technology present challenges.
- Few sites have single rooms, which provide more privacy and personal freedom than traditional two or four-bed rooms. Major renovations and new construction are called for.
- In addition, residents have increasingly complex care needs, requiring more skilled employees and specialized equipment.

Fraser Health currently oversees admissions to more than 7,000 complex care residential beds, mostly provided under contract by more than 60 private and not-for-profit agencies.

We have already accomplished a great deal in adding capacity to this field of care. We have undertaken surveys and held focus groups with a variety of stakeholders to establish guiding principles for the design and operation of any new construction. We have used the most recently available information to project the number of residential care beds that will be required across Fraser Health for the future, based on the distribution of population among communities. We have awarded contracts for the construction and operation of new facilities. More than 20 projects are underway for renovation or new construction. The result of these initiatives will increase overall capacity and rebalance distribution to better meet the needs of all communities.

We are also taking steps to provide very specialized care for younger adults with complex care needs, including a group home for people with brain injuries.

While Fraser Health funds the professional health services provided in Residential facilities, the total costs of 24-hour care, supplies and medications as well as meals and accommodation, is only partly subsidized. Everyone moving to a publicly funded care facility in BC is responsible for co-payment of fees based on a standardized assessment of after-tax income. This information is reviewed during the in-home assessment process.

