Vancouver Division of Family Practice
A GPSC initiative

Vancouver CoastalHealth

Partners in Care: Navigating Resources for Frail Seniors

DATE: March 13th, 2024

VANCOUVER PRIMARY CARE NETWORKS

Overview

TIME	ACTIVITY
6:05 – 6:10pm	Welcome, Territorial Honoring
6:10 – 6:20pm	Presentations • PCN Interprofessional Team • VCH Vancouver Community Health Services
6:20 – 6:55pm	Case Studies & Q&A
6:55 – 7:00pm	Short Break & Transition
7:00 – 7:45pm	Presentations • Family Caregivers of BC (10min) • BC 211 (10min) • Nidus Registry (10min) • Public Guardian & Trustee (15 min)
7:45 – 7:55pm	Panel Q&A with Community Presenters
7:55 – 8:00pm	Wrap Up and Close

Territorial Honoring

Today we want to humbly and respectfully acknowledge that we are gathering on the traditional and unceded territories of the Coast Salish peoples, including the Squamish, Musqueam, and Tsleil-Waututh Nations.

We pay our respects to their elders, past and present, and extend our gratitude for allowing us to work and meet on this land. We recognize the enduring relationship that exists between Indigenous peoples and their territories.

As we meet here today, let us reflect on our shared responsibility to respect and uphold the rights of Indigenous communities, protect their cultures, and support their ongoing struggles for justice and self-determination.

Musqueam Nation

Squamish Nation

Tsleil-Waututh Nation

Seniors & Frail Elder Committee

Committee Members:

- Dr. Lisa Weger, Chair
- Dr. Taki Galanopoulos – Board Liaison
- Dr. Jamil Salim Hirji
- Dr. Darwin Wan
- Dr. Ruchika Shukla
- Dr. Greg Tobert
- Dr. Alex She

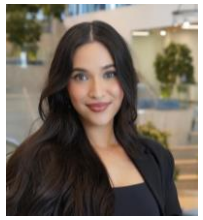
Staff Support:

- Jaimie Ashton – Director of Special Projects
- Samy Assen – Program Administrator

PCN Team

Community Network Managers

Tasha Cameron
PCN 1 – City Centre
Downtown, West End, and Fairview



Anupama Hettiarachchi
PCN 2 – Centre North
Northeast False Creek, Downtown Eastside, and Grandview Woodland
PCN 3 – Northeast
Hastings Sunrise, Renfrew Collingwood, and Cedar Cottage

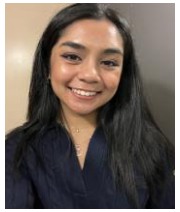
TBD
PCN 6 – South
Oakridge-Marpole, Sunset, Victoria-Fraserview and Killarney

Sarah Elliott
PCN 4 – Westside
Shaughnessy-Kerrisdale, West Point Grey, UBC, and Kitsilano
PCN 5 – Midtown
South Cambie/Riley Park, Kensington, and Mount Pleasant

Tess Walton
PCN Director

CNM Support Team

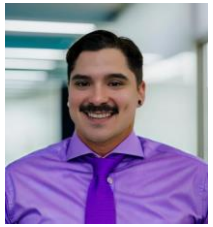
Chalani Kulasekera
PCN Program Coordinator



Berrender Kaur Johal
PCN Program Administrator

PCN Engagement Team

Saori Yamamoto
PCN Engagement Manager



Adrian Bustamante
PCN Engagement Coordinator

Vancouver Division of Family Practice
An FPSC initiative

Vancouver Coastal Health

PRESENTERS:

Brian Richter, PCN Operations Manager

and

Amy Schuster, PCN Clinical Operations Supervisor

Vancouver PCN Interprofessional Team (IPT)

What services make up the IPT?

Vancouver PCN Interprofessional Team

Principles

- Team-Based Care
- Continuity of Care
- Patient Centered Care
- Timely and Relevant Care

Goals

- Improve Quality of Patient Care
- Increase Provider Support
- Increase Provider Capacity

Parameters

- Mild to Moderate Patient Conditions
- Attached Patients
- Short Term Intervention
- 19 Years and Older

Vancouver PCN Interprofessional Team (IPT)

Current IPT Resources

IN-CLINIC PCN RESOURCES

Role	Clinics
Pharmacist Co-location	12

CURRENT IPT CAPACITY

Number of providers who have access to IPT	465
Number of clinics currently accessing IPT	92

CENTRALIZED PCN RESOURCES (IPT)

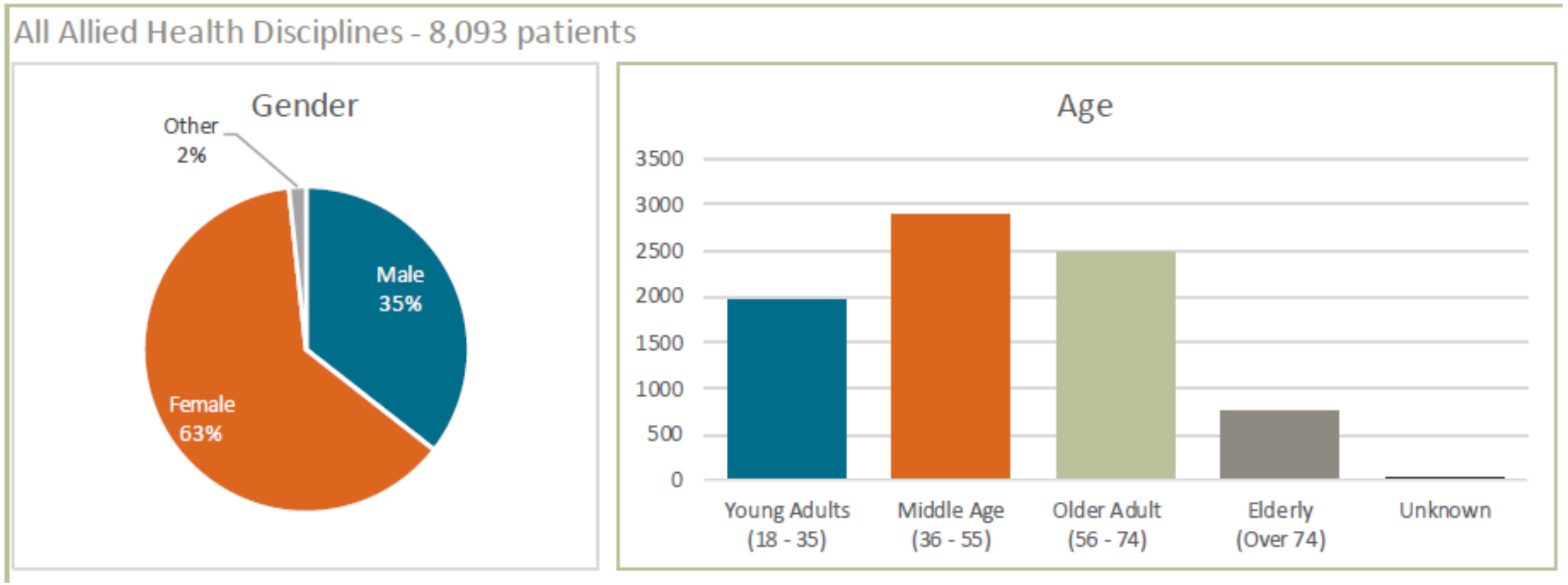
Role	FTE
Clinical Counsellor	16
Social Worker	14
Registered Dietitian	12
Clinical Pharmacist	6
Occupational Therapist	3

= approximately 50% of primary care clinics in Vancouver have access

How Does the PCN IPT Supports Patients?

- Short Term Goal Oriented Care
- Education
- Self-Management and Behavioral Strategies
- Quality of Life Promotion
- Quality of Life Promotion
- Evidence Based Decision Making
- Assessment and Brief Intervention
- Linkage to Community Resources and System Navigation

IPT Patient Demographics



PRESENTERS:

Kristen Farquharson, Director Operations &
Program Lead, Older Adult Mental Health
&
Larissa Sandve, Manager Older Adult Mental Health & STAT Centre

Vancouver Community Health Services

Partners in Care: Navigating Resources for Frail Seniors

Vancouver Division of Family Practice

March 13, 2024

Vancouver CoastalHealth | one VCH

Home & Community Care Services

- Home and Community Care services provide a range of support and services for people with acute, chronic, and palliative health care needs such as home health services, mental health services and home support.
- These services are intended for people who have ongoing or chronic health issues requiring support to continue to live safely at home.

Home Health Services

The Home Health interdisciplinary team provides personalized care with the goal of promoting independence. Client and families are connected with one or more of the following clinicians:

- Case Manager
- Community Health Nurse
- Ambulatory Care Nursing (services provided in a clinic setting)
- Occupational Therapist
- Physiotherapist
- Social Worker
- Dietician
- Speech Language Therapist
- Spiritual Health Practitioner

Additional Services

The Home Health clinician may refer them to the following programs if necessary:

- Home Support Services
- Overnight Respite
- End of Life/Palliative Care
- Choice in Support for Independent Living (CSIL)
- Adult Day Program
- Speech-Language Pathology & Swallowing Assessment Services
- Medical Equipment Provision Program (MEPP)
- Long Term Care

Other VCH Community Services

Additional community based services that do not require being a Home Health client include:

- Acquired Brain Injury Services
- Home Oxygen Program
- Short Term Assessment & Treatment Program for Seniors
- Medical Assistance in Dying

How to Get Connected

Please ensure your client meets these minimum requirements:

General Eligibility Criteria:

- A resident of British Columbia
- A Canadian citizen or has permanent resident status
- Needs care:
  - After release from the hospital
  - At home to prevent client from going to the hospital
  - For a life-limiting illness

Vancouver

Tel (604) 263-7377

Fax (604) 267-3419

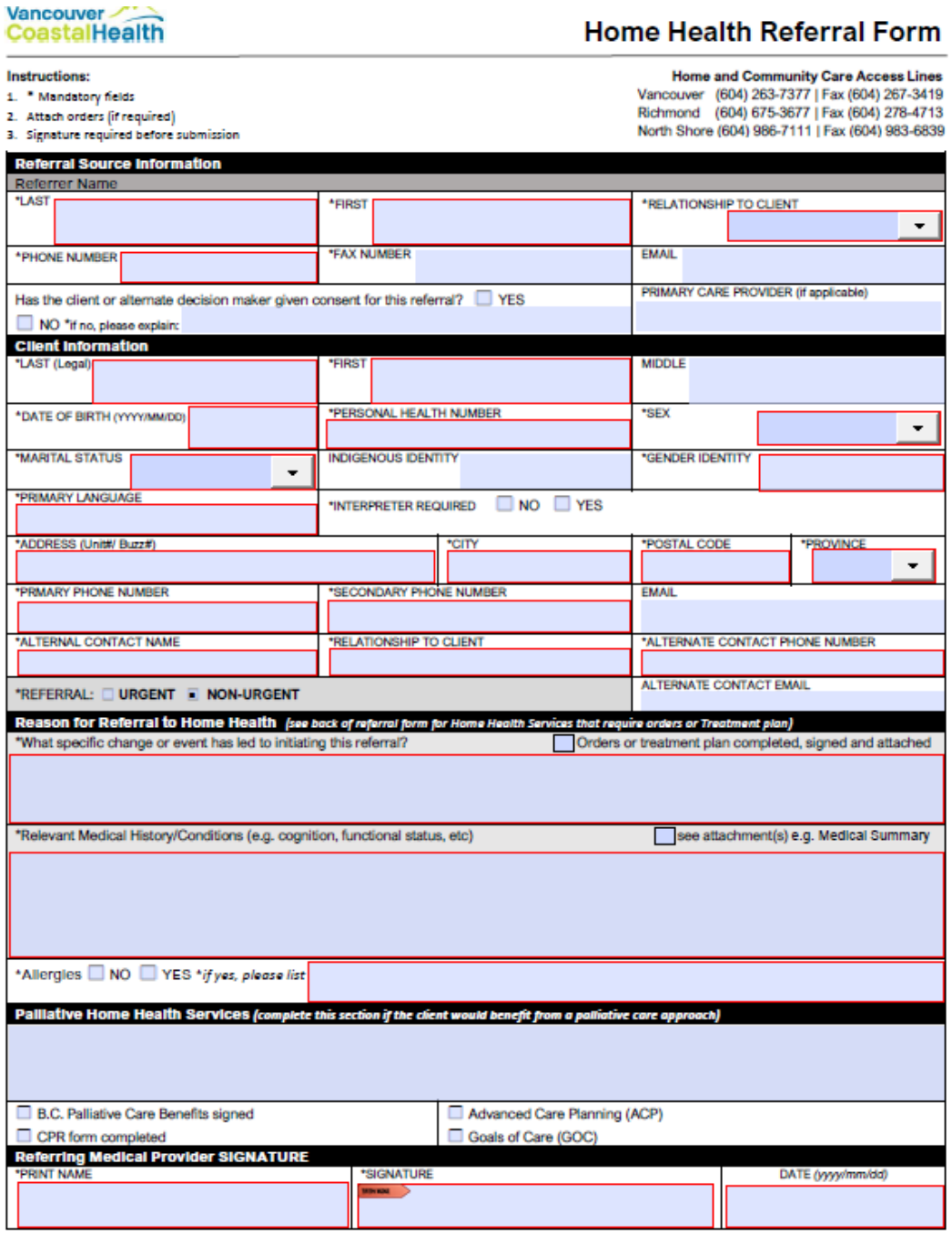
VCH Home & Community Care Access Lines

Comprehensive Assessment

- On referral, our Home Health Intake teams conduct a comprehensive assessment using a standardized intake assessment tool (*InterRAI-Contact Assessment*) to determine appropriate attachment to Home Health services and urgency of first visit.
- This assessment is performed with the client/family/caregiver via PHONE.
- Following this assessment, the Intake Clinician will send notification to the referring medical provider of the assessment outcome.
- For clients determined to benefit from Home Health services, our Intake team will connect the client with the local home health team and outline contact details.

Home Health Referral Form

New referral form will be available on Pathways BC March 28th.



Vancouver CoastalHealth

Home Health Referral Form

Instructions:
1. * Mandatory fields
2. Attach orders (if required)
3. Signature required before submission

Home and Community Care Access Lines
Vancouver (604) 263-7377 | Fax (604) 267-3419
Richmond (604) 675-3677 | Fax (604) 278-4713
North Shore (604) 986-7111 | Fax (604) 983-6839

Referral Source Information

Referrer Name

*LAST | *FIRST | *RELATIONSHIP TO CLIENT

*PHONE NUMBER | *FAX NUMBER | EMAIL

Has the client or alternate decision maker given consent for this referral? ☐ YES ☐ NO *if no, please explain:

PRIMARY CARE PROVIDER (if applicable)

Client Information

*LAST (Legal) | *FIRST | MIDDLE

*DATE OF BIRTH (YYYY/MM/DD) | *PERSONAL HEALTH NUMBER | *SEX

*MARITAL STATUS | INDIGENOUS IDENTITY | *GENDER IDENTITY

*PRIMARY LANGUAGE | *INTERPRETER REQUIRED ☐ NO ☐ YES

*ADDRESS (Unit#/ Buzz#) | *CITY | *POSTAL CODE | *PROVINCE

*PRIMARY PHONE NUMBER | *SECONDARY PHONE NUMBER | EMAIL

*ALTERNAL CONTACT NAME | *RELATIONSHIP TO CLIENT | *ALTERNATE CONTACT PHONE NUMBER

*REFERRAL: ☐ URGENT ▪ NON-URGENT | ALTERNATE CONTACT EMAIL

Reason for Referral to Home Health *(see back of referral form for Home Health Services that require orders or Treatment plan)*

*What specific change or event has led to initiating this referral? ☐ Orders or treatment plan completed, signed and attached

*Relevant Medical History/Conditions (e.g. cognition, functional status, etc) ☐ see attachment(s) e.g. Medical Summary

*Allergies ☐ NO ☐ YES *if yes, please list*

Palliative Home Health Services *(complete this section if the client would benefit from a palliative care approach)*

☐ B.C. Palliative Care Benefits signed
☐ CPR form completed
☐ Advanced Care Planning (ACP)
☐ Goals of Care (GOC)

Referring Medical Provider SIGNATURE

*PRINT NAME | *SIGNATURE | DATE (yyyy/mm/dd)

Older Adult Mental Health & Substance Use

The Vancouver Community Older Adult Mental Health and Substance Use (VC OA MHSU) Program serves older adults (generally aged 65 and older) with:

- Mental health conditions and/ or problematic substance use that co-occur with psychiatric, medical, social, emotional or cognitive concerns, which have an adverse effect on function, health status and/ or quality of life, or
- A progressive dementia (at any age) and complicated by moderate to severe behavioural and/ or psychiatric symptoms.

OA MHSU Services

Services offered are based on individual's clinical needs:

- Geriatric Psychiatric assessment, consultation, and treatment
- Case Management and care coordination
- Medication review and monitoring
- Therapeutic groups
- Psychoeducation and family support
- Substance Use Counselling

Hours of operation: Monday to Friday 8:30-4:30, excluding statutory holidays. Referrals can be submitted directly to the VC OA MHSU Program.

604-709-6785 (Intake Line)

Case Study 1 -Herman

80 y.o. Male - brought into his family physician's office by his daughter for a medication refill

Medical History:

- COPD, CHF and T2DM
- Isolated and lonely

His wife died a year ago and he now lives alone in an apartment - his daughter lives in Vancouver and sees him once a week. She is a single mother with three children. He needs help with grocery shopping and finds it increasingly difficult to go for his daily walk around the park. His daughter mentions that he has lost weight (he admits that he often forgets to eat.) He doesn't get out much and is sleeping more. He says there is just no reason anymore and feels hopeless. She is worried about his general health.

Partners in Care: Navigating Resources for Frail Seniors

Case Study 1 Patient Journey Map (3-6 months) - Early to Moderate Frailty

MARCH 2024

Meet Herman

- 80 years old
- Lives alone
- Daughter is caregiver with limited time
- Isolated & lonely
- Chronic conditions: COPD, CHF, T2DM

Herman's daughter brings him to his Primary Care Provider for a medication refill. He is having difficulty doing his daily walks and he often forgets to eat. He is staying in and sleeping more. He is feeling hopeless.

Primary Care Provider speaks to Herman about PCN IPT and how they can help. Herman agrees to getting help and Provider sends a referral requesting CC and OT support

IPT Intake Clinician reaches out to Herman to discuss needs and goals and speaks to Herman's daughter (with permission). CC & OT support confirmed, and appointments are booked.

CC works with Herman on low mood and feelings of hopelessness. Sessions take place over 3 months. Modalities used would be based on the fundamental reasons for low mood.

OT & CC work collaboratively to develop behavioral activation strategies. OT further explores and assesses Herman's sleep, ADLs, iADLs. Help develop smart goals around sleep hygiene and daily activity schedule.

Internal referral to SW to support social connection. SW will identify community resources based on Herman's needs, values & interests. SW works with Herman around Advance Care Planning based on Herman's values & willingness to engage.

CC & OT assess that Herman may benefit from RD to explore calorie and nutrient dense foods. Low energy is restricting meal prep & exercise.

CP can support by reviewing meds to see if they are contributing to his mood, sleep or energy challenges. Could then speak with Herman and/or Provider about any recommended changes to meds.

OT – Occupational Therapist
CC – Clinical Counsellor
SW – Social Worker
RD – Registered Dietitian
CP – Clinical Pharmacist
ADL – Activities of Daily Living
iADL – Instrumental Activities of Daily Living

AT DISCHARGE: Herman has clear post-IPT plan which includes community resources, mood/ energy/sleep improvement, ongoing structures to ensure he can maintain gains. Thorough and clear discharge summary sent to provider.

ACCESSING COMMUNITY SUPPORTS

- Family Caregivers of BC – can provide support to Herman's daughter
- 211 BC - Help with resource and service navigation
- Nidus Registry – Advance Care Plan ensures Herman's healthcare wishes are upheld should he no longer been able to speak for himself

Case Study 2 -Herman

85 y.o. Male – daughter brought father to family physician's office for hospitalization follow-up

Medical History:

- COPD, CHF and T2DM
- two recent falls
- admitted to hospital 2X in the last year for an exacerbation of his CHF

He still lives alone in an apartment - his daughter is trying to see her father more often but is experiencing caregiver burnout. He is not taking his medication regularly, isn't safe cooking or bathing on his own anymore, and with his last visit to the hospital, they said he should be wearing compression stockings. His daughter mentions that he has started to lose weight again and is sleeping most of the day. He is still a large man, and she can't mobilize him on her own. He says he misses going to the community center, but it is too much for him.

Partners in Care: Navigating Resources for Frail Seniors

Case Study 2 Patient Journey Map – Moderate to Severe Frailty

MARCH 2024

Herman's Journey

- 85 years old
- Still living alone
- Two recent falls
- Admitted to hospital 2X in the last year due to exacerbation of CHF
- Daughter experiencing caregiver burnout

5 years later, Herman's daughter brings him to his Primary Care Provider following hospitalization. He is not taking his medication regularly, isn't safe cooking or bathing on his own. He is losing weight and sleeping most of the day. He is having mobility issues and more homebound.

Primary Care Provider assesses and refers to Home Health Services for case management assessment, fall & home safety assessment and possible initiation of home support services.

Home Health Clinicians can support goals of care conver-sations to ensure care plans are reflective of personal values & decision making.

Explore interest in Adult Day Program. Clients typically attend 2 or more days/week.
Services offered:

- Therapeutic social and recreational activities
- Special events & seasonal celebrations
- Falls prevention education and movement classes
- Health status monitoring (weight, blood pressure and nutrition)
- Dementia support and pain management
- Caregiver support including respite

Additional community supports such as Meals on Wheels or volunteer visitors could be explored

ACCESSING COMMUNITY SUPPORTS

- Family Caregivers of BC – support daughter with caregiver burnout
- 211 BC Help with resource and service navigation
- Nidus Registry – Advance Care Plan (ACP) ensures Herman's healthcare wishes are upheld should he no longer be able to speak for himself

Case Study 3 - Lena

78 y.o. Female – living independently with 80 y.o. husband in their family home

Medical History:

- hypertension, atrial fibrillation, T2DM
- recently discharged from hospital
  - admitted for urosepsis and protracted delirium, assessed by geriatric psychiatry and given a diagnosis of major neurocognitive disorder (likely vascular type)

Her husband is struggling to accept the diagnosis. They have been fiercely independent, but he has noticed a significant change in her memory & behaviour. She is often agitated, anxious, & can be aggressive. She is also up through the night, so he is not sleeping. He has also stopped driving due to an accident isolating them & making getting to appointments harder. They have no surviving family.

Partners in Care: Navigating Resources for Frail Seniors

Case Study 3 Patient Journey Map – Onset of Dementia

MARCH 2024

Meet Lena

- 78 years old
- Lives in family home with 80-year-old husband
- Recent hospital discharge – urosepsis, protracted delirium
- Diagnosis of major neurocognitive disorder (vascular)
- Chronic Conditions: hypertension, atrial fibrillation, T2DM

Lena's husband is struggling to accept the diagnosis. He has noticed a significant change in her memory and behavior. She is often agitated, anxious and can be aggressive. She is up at night, so he is not sleeping. He has stopped driving due to an accident. They have no surviving family.

Primary Care Provider previously referred to Home Health Services. Lena is connected to a case manager, receives home support for bathing assistance and attends an ADP two times per week.

Over the past several months, Lena has become incidentally more physically responsive to other participants at the ADP and refuses personal care from community health workers.

Primary Care Provider has completed an assessment and ruled out potential medical causes for Lena's worsening mood and behavior. A SSRI has been started as a first line approach to addressing mood and responsive behavior.

After a 6-week trial of a SSRI, Lena continues to present with sleep disturbance and agitation. Home Health has ceased home support as she and her husband refuse the service. Referral is made to the OA MHSU Program for assessment & treatment of dementia symptom, care planning and caregiver support.

After 6 months, further complications have arisen including a 3kg weight loss and frequent falls. Lena's husband's health is failing. A referral is made to the Short-Term Assessment and Treatment Inpatient Unit for a comprehensive geriatric medical and psychiatric assessment & treatment.

ACCESSING COMMUNITY SUPPORTS

- Family Caregivers of BC – support Lena's husband with caregiver resources
- 211 BC Help with resource and service navigation
- Nidus Registry – Advance Care Plan ensures Lena's healthcare wishes are upheld should she no longer be able to speak for herself
- Public Guardian & Trustee – available to support if needed (no ACP and substitute decision maker)

BREAK

Let’s take a 5 minute break!

- **Stretch your legs**
- **Get a refreshment**

After the break we’ll hear about community resources to support frail seniors and caregivers

PRESENTER:

Jaimie Ashton, Director Special Projects
Vancouver Division of Family Practice
on behalf of
Family Caregivers of British Columbia

Family Caregivers
of British Columbia

FAMILY CAREGIVERS OF BC

Family Caregivers of British Columbia
Let us help

- Non-profit charity dedicated to the well-being of family caregivers.
- Serving across B.C. since 2010, as part of the Ministry of Health's Patients as Partners Initiative.
- Three pillars: caregiver support, education and engagement and collaboration.

CAREGIVER SUPPORT

- Support Line: 1-877-520-3267
- Informational, referral & navigation
- Support groups
- Caregiver coaching
- Online resource center
- Virtual support circle

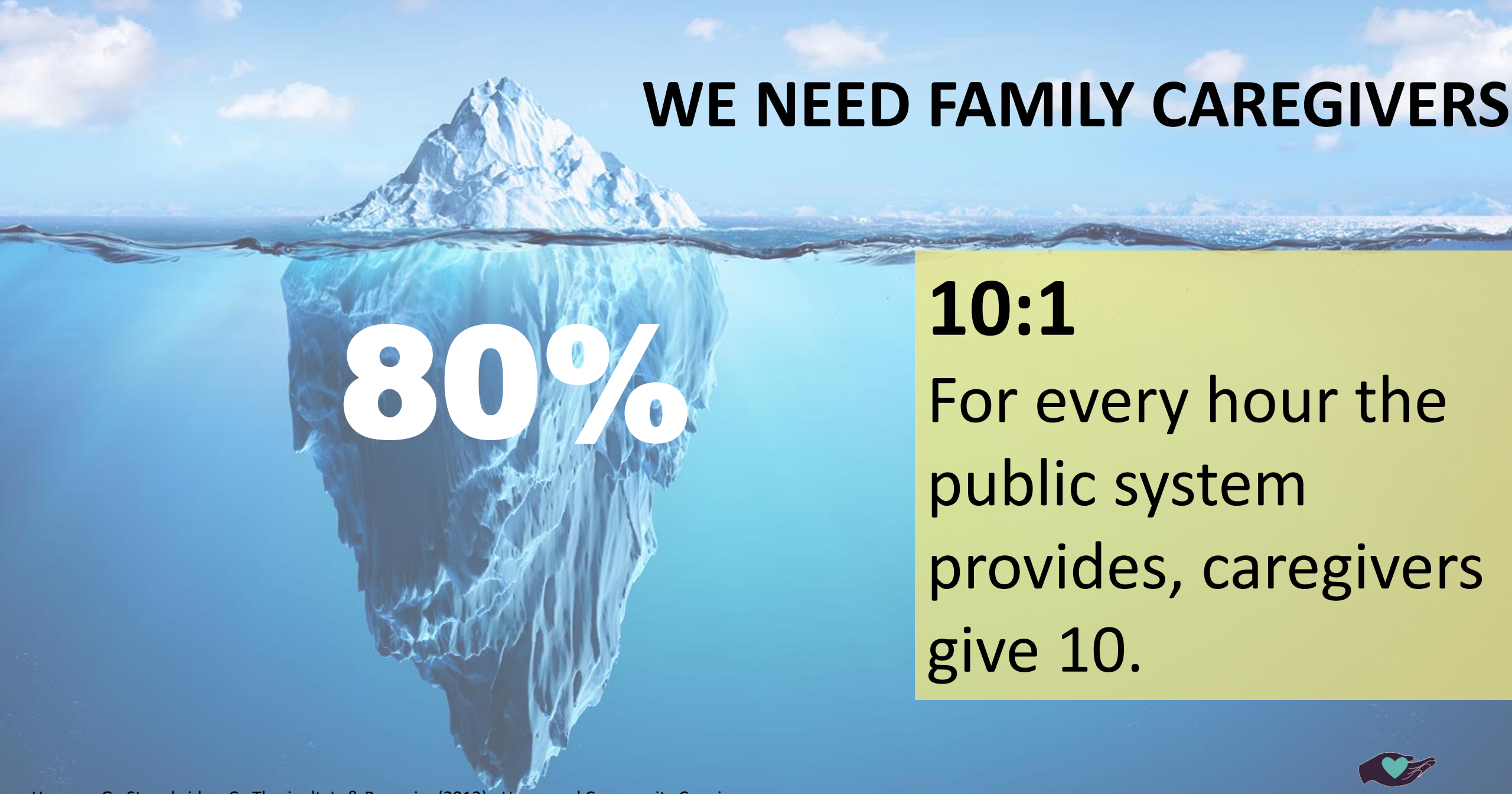
EDUCATION

- Resource library: webinars and podcasts
- Newsletter publications, e-news, articles and blogs
- Support group facilitator training
- Outreach to community groups

ENGAGEMENT AND COLLABORATION

- Caregiver engagement quality improvement health policy
- Participation in health committees
- Collaborations: condition specific org, health authorities, Ministry of Health research, etc.

WE NEED FAMILY CAREGIVERS



10:1

For every hour the public system provides, caregivers give 10.

Hermus, G., Stonebridge, C., Theriault, L. & Bounajm (2012).. Home and Community Care in Canada: An Economic Footprint. Conference Board of Canada.

Family Caregivers of British Columbia

The Impact of Caregivers on the Health Care System

By partnering with & supporting caregivers, the benefits to healthcare providers include:

- Patient healthcare adherence to recommendations
- Understanding of patient needs, symptoms and behaviours
- Improved therapeutic relationship

The ability of caregivers to provide care, results in increased patient health, decreased rates of hospitalization and a delay in the need for long-term care placement

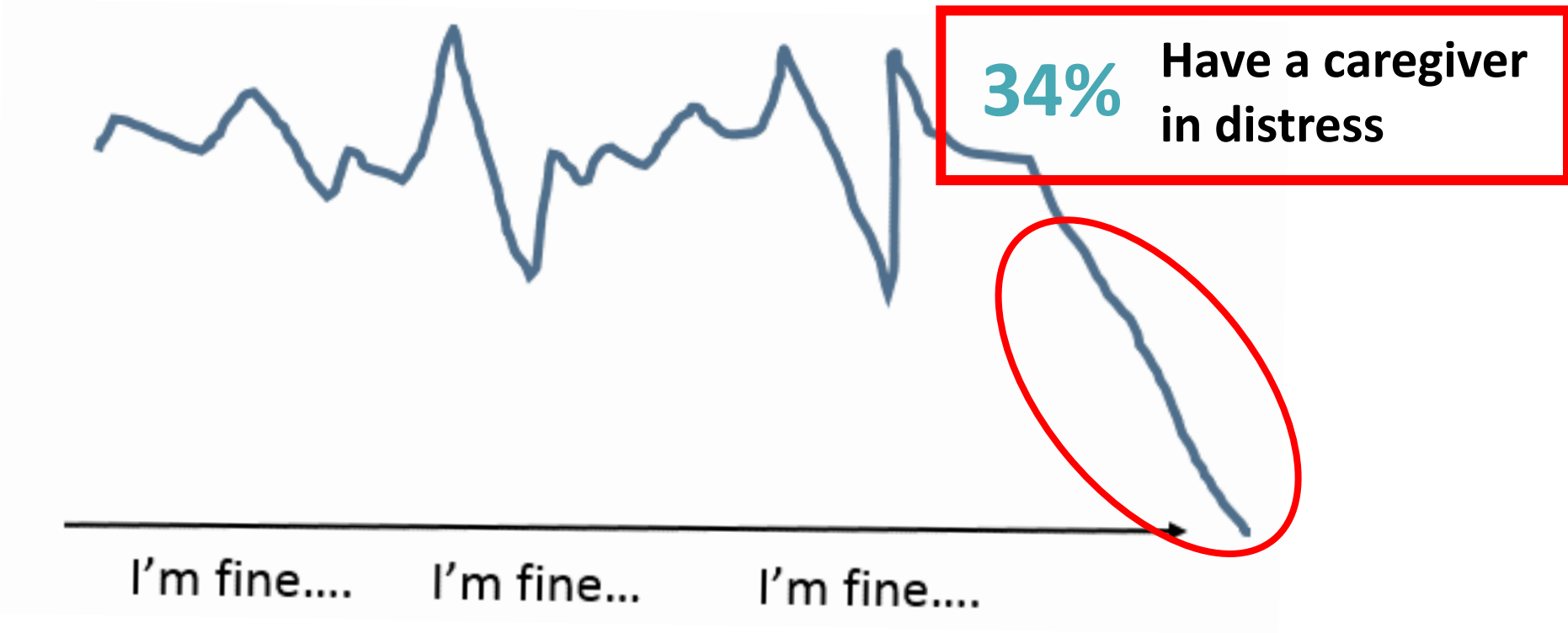
Dern & Heath, 2004

Coleman et al., 2006

Family Caregivers DON'T self-identify

Their focus is naturally on the care recipient

Seeing them = providing them with tools that will create confidence in their role and connection to community supports.



Family Caregivers of British Columbia

Referring Family Caregivers

Family caregiver is supporting a care recipient with complex needs

Heath care professional provides a Caregiver Rx - after discussion and with permission

1

Consent Referral is made and FCBC follows up with family caregiver

2

Caregiver Rx is given to family caregiver who initates contact with FCBC

FCBC connects with family caregiver and provies support, information & referral and follow-up

REFER, PROVIDE INFORMATION, AND SUPPORT

Pathways™

Caregiver Support Line

Caregiver Support, Condition Specific Support, Disability Services, Home Care, and Seniors Services

Provided by Family Caregivers of BC

Informs, supports, and educates on issues of concern to family caregivers. Offers one-to-one support in person, or province-wide via a toll-free phone line.

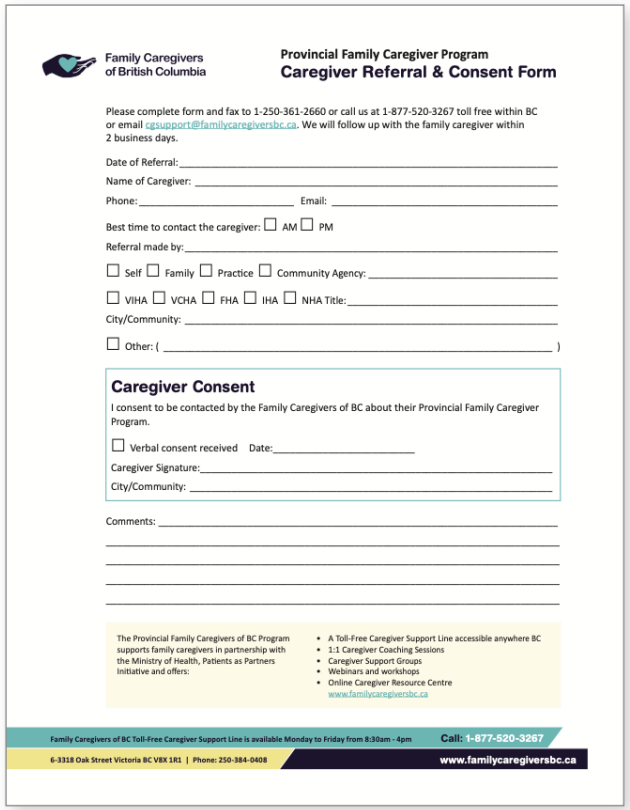
BC Caregiver Support Line 1-877-520-3267
Trained staff offer direct support to family caregivers by providing 1:1 emotional support, information, assistance in navigating the healthcare system and connections with community resources. Family Caregivers of BC further offers Caregiver Support Groups, Caregiver Coaching, Educational Materials, Podcasts, Webinars and Workshops. Detailed info on services offered at www.familycaregiversbc.ca

Submit Online Referral Form: https://www.familycaregiversbc.ca/get-help/caregiver-referral-form/ The caregiver will receive a call from Family Caregivers of BC within 2 business days.

Provides emotional support, helps to navigate the healthcare system and information and referrals on community resources. Appointments can be booked for a caregiver coaching session or support can be provided over the phone.

Consent Referral

FCBC initiates contact



Family Caregivers of British Columbia

Provincial Family Caregiver Program
Caregiver Referral & Consent Form

Please complete form and fax to 1-250-361-2660 or call us at 1-877-520-3267 toll free within BC or email cgsupport@familycaregiversbc.ca. We will follow up with the family caregiver within 2 business days.

Date of Referral: _____

Name of Caregiver: _____

Phone: _____ Email: _____

Best time to contact the caregiver: ☐ AM ☐ PM

Referral made by: _____

☐ Self ☐ Family ☐ Practice ☐ Community Agency: _____

☐ VIHA ☐ VCHA ☐ FHA ☐ IHA ☐ NHA Title: _____

City/Community: _____

☐ Other: (_____)

Caregiver Consent

I consent to be contacted by the Family Caregivers of BC about their Provincial Family Caregiver Program.

☐ Verbal consent received Date: _____

Caregiver Signature: _____

City/Community: _____

Comments: _____

The Provincial Family Caregivers of BC Program supports family caregivers in partnership with the Ministry of Health, Patients as Partners Initiative and offers:

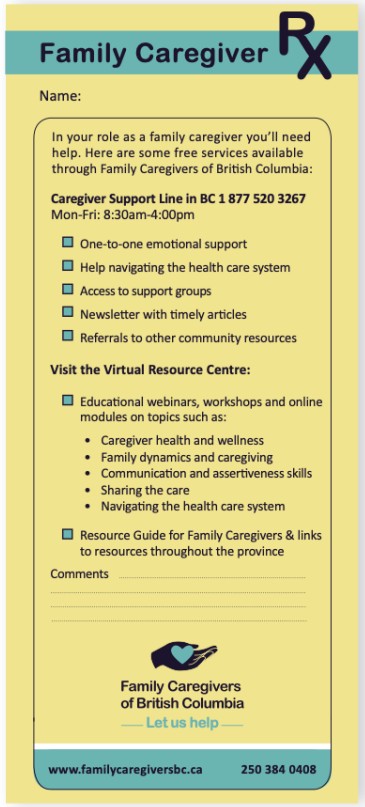
- A Toll-Free Caregiver Support Line accessible anywhere BC
- 1:1 Caregiver Coaching Sessions
- Caregiver Support Groups
- Webinars and workshops
- Online Caregiver Resource Centre www.familycaregiversbc.ca

Family Caregivers of BC Toll-Free Caregiver Support Line is available Monday to Friday from 8:30am - 4pm Call: 1-877-520-3267

6-3318 Oak Street Victoria BC V8X 1R1 | Phone: 250-384-0408 www.familycaregiversbc.ca

Caregiver Prescription

Family caregiver calls FCBC



Family Caregiver Rx

Name:

In your role as a family caregiver you'll need help. Here are some free services available through Family Caregivers of British Columbia:

Caregiver Support Line in BC 1 877 520 3267
Mon-Fri: 8:30am-4:00pm

- One-to-one emotional support
- Help navigating the health care system
- Access to support groups
- Newsletter with timely articles
- Referrals to other community resources

Visit the Virtual Resource Centre:

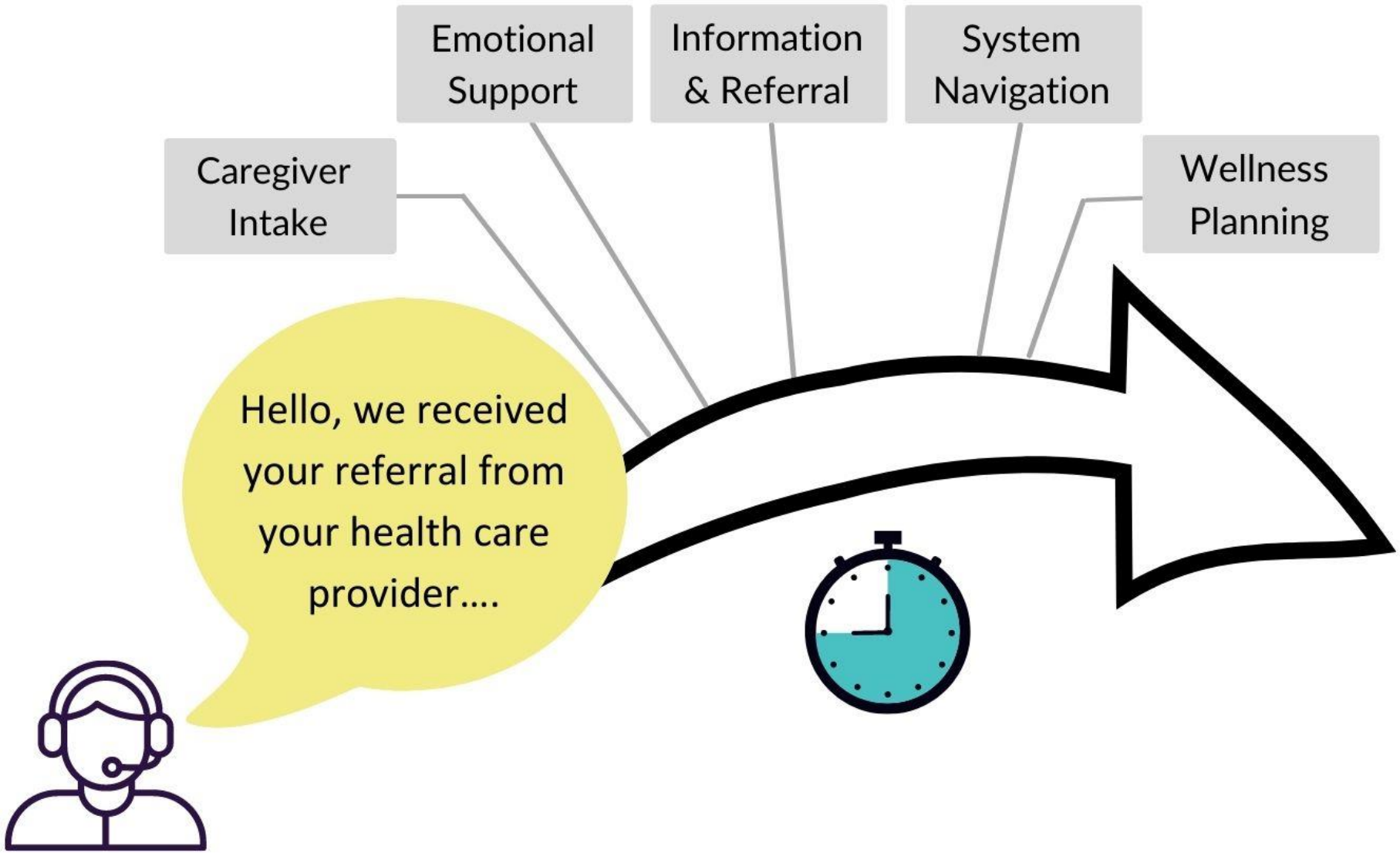
- Educational webinars, workshops and online modules on topics such as:
  - Caregiver health and wellness
  - Family dynamics and caregiving
  - Communication and assertiveness skills
  - Sharing the care
  - Navigating the health care system
- Resource Guide for Family Caregivers & links to resources throughout the province

Comments

Family Caregivers of British Columbia
Let us help

www.familycaregiversbc.ca 250 384 0408

What Happens When a Health Care Provider Refers a Family Caregiver?



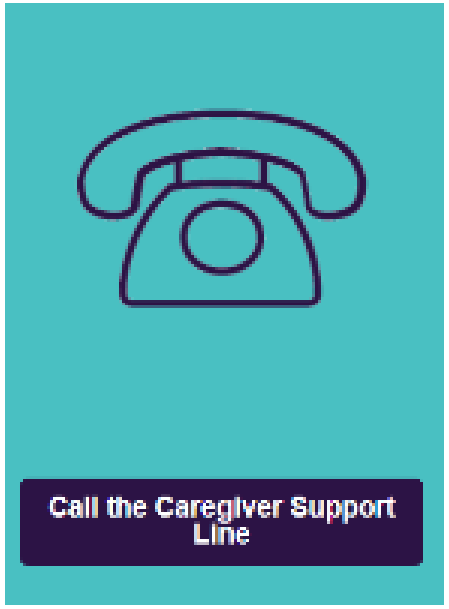
CONNECT

COMMUNITY RESOURCES

Family Caregivers of British Columbia

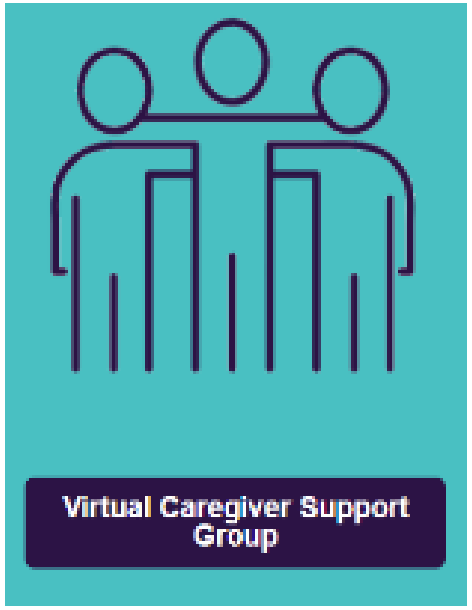
DIRECT CAREGIVER SUPPORT

for those caring for frail seniors



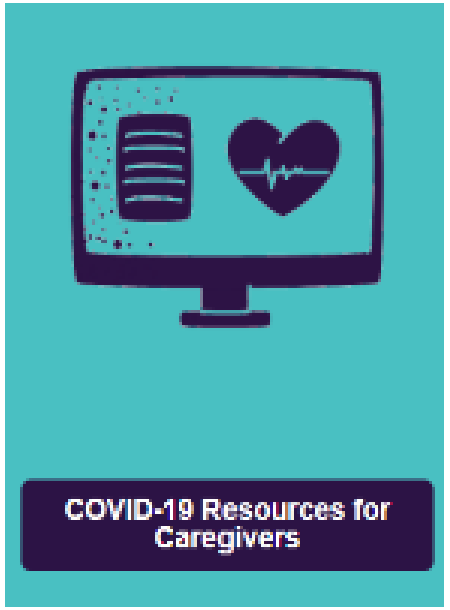
BC Caregiver Support Line

1-1 Caregiver Coaching sessions



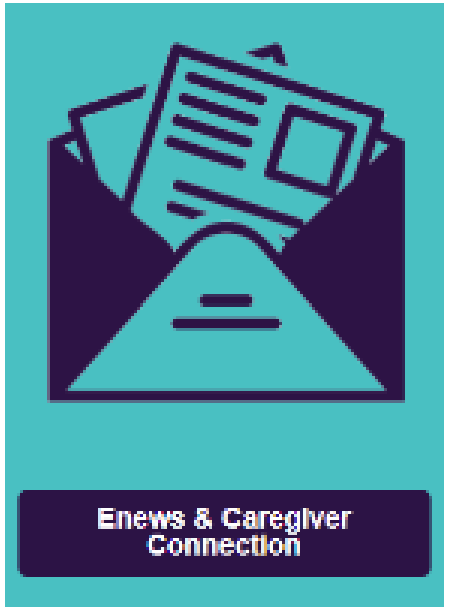
Support Groups

Peer Workshops online & in-person



Resources for caregivers

Theme-based, audio, videos, articles, etc



E-news

Caregiver Connect Newsletter

CAREGIVER SUPPORT LINE

Caregiver Toll-Free Support Line

1-877-520-3267, Mon-Fri 8:30am – 4pm

- 1-1 Emotional Support
- Help with navigating the health care system
- Access to support groups
- Referral to community resources
- Access to caregiver coaching (5 sessions)

Health Care Providers can also call our line for information

Family Caregivers of British Columbia

Family Caregivers of British Columbia

How to Order Caregiver RX Resources

Click here to use our easy-to-use order form

- We will receive an email with your order
- We will mail out all the resources to you or your clinic – free of charge

PRESENTERS:

Genny Krikorian, Marketing & Communications Coordinator Helpline Services

211 British Columbia®

211 British Columbia®

United Way British Columbia

Working with communities in BC's North, Interior, Lower Mainland, Central & Northern Vancouver Island

2-1-1

connects you to non-emergency community health and social services in your area

3-1-1

connects you to non-emergency municipal services, programs and information

8-1-1

connects you to healthcare workers who can provide health advice and information

9-1-1

responds to life or property threatening emergencies

* Not Available in all communities.

United Way British Columbia

Working with communities in BC's North, Interior, Lower Mainland, Central & Northern Vancouver Island

LIFE CAN BE HARD.

FINDING HELP CAN BE EASY.

Dial or Text 2-1-1

United Way

211

British Columbia
Supported by the Province of British Columbia

211

HELP STARTS HERE

Dial or Text 2-1-1

bc.211.ca

We help you find services and support for all of life's challenges.

240+ Languages
Free | Confidential | 24/7

United Way British Columbia

Working with communities in BC's North, Interior, Lower Mainland, Central & Northern Vancouver Island

Reasons - Top 5 - Seniors 65+ - Vancouver	
Housing and Homelessness	Immediate Shelter
	Information on Housing
Health	Home Support
	Dental Related
	Medical Related Equipment
Income & Financial Assistance	General Income Assistance
	Rental Assistance
	Utilities/Bill Assistance
Basic Needs	Food & Meals
	Clothing
	Furniture/Household Items
	Hygiene/Grooming
Legal and Public Safety	Legal Advice
	Landlord/Tenant
	Victim Services
	Police Services
	Courts
	Guardianship

Top 10 Resources Referred - Seniors 65+ - Vancouver	
Agency	**Resource**
Seniors Services Society of BC	Seniors Housing Navigation, Information, and Outreach
411 Seniors Centre	411 Seniors Centre
Ceridian Cares	Ceridian Cares
Jewish Family Services (JFS)	Better at Home - Vancouver (Kerrisdale, Oakridge, Marpole, Dunbar, Southlands)
Seniors First BC	Seniors Abuse and Information Line (SAIL)
Vancouver Coastal Health (VCH)	VCH ReAct
Ministry of Health (MOH)	Office of the Seniors Advocate
West End Seniors' Network (WESN)	Kay's Place
Vancouver Coastal Health (VCH)	Home and Community Care - Vancouver Central Intake Line
Ministry of Health (MOH)	HealthLink BC

"Sometimes having someone take the time to make you feel like you matter is a tremendous feeling that inspires hope."

211 Caller

United Way
British Columbia

Working with communities in
BC's North, Interior, Lower Mainland,
Central & Northern Vancouver Island

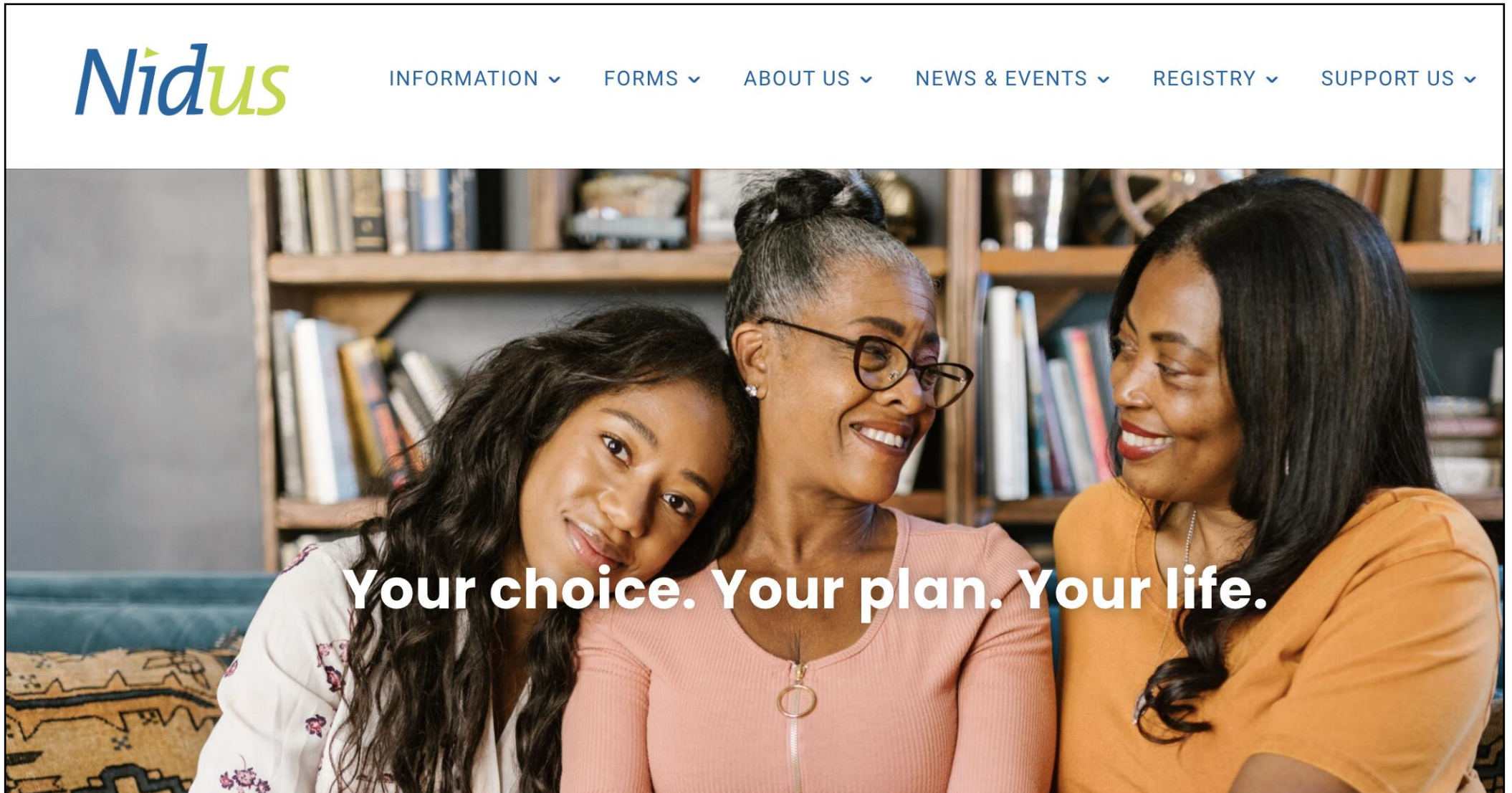
PRESENTERS:

Joanne Taylor, Executive Director

Nidus Registry

Nidus website - free information & RA forms

nidus.ca



Want personal help?

Free in-person appointment with Nidus-trained volunteer.

To book an appointment, please call **604-732-0812**.

Held at South Granville Seniors Centre (Vancouver)

(Seniors Centre may suggest $5.00 donation for doing bookings and providing meeting space.)

Nidus Personal Planning Resource Centre and Registry

Want safe, secure storage and 24/7 access?

Register and access important information and copy of documents.

Want to stay informed?

Subscribe to Nidus Newsletter (email)

nidus.ca/subscribe

Nidus Personal Planning Resource Centre and Registry

PRESENTERS:

Kevin Coughlin, Manager, Assessment & Investigation Services
Services to Adults

Public Guardian and Trustee of British Columbia

The Public Guardian and Trustee: Personal Decision Services

Partners in Care: Navigating Resources for Frail Seniors

March 13, 2024

Visit www.trustee.bc.ca or contact PGT for updates.

PGT Public Guardian and Trustee of British Columbia

About the PGT

The Public Guardian and Trustee ("PGT") is a corporation sole established under the *Public Guardian and Trustee Act* with a unique statutory role to protect the interests of British Columbians who lack legal capacity to protect their own interests.

Personal Decision Services

- Available to consult on complicated situations
- Makes health care and/or care facility admission decisions as:
  - Committee of Person
  - Temporary Substitute Decision Maker (TSDM) for health care decisions
  - Substitute Decision Maker (SDM) for care facility admission decisions
- Informed by Guiding Principles under Adult Guardianship Act

Accessing PDS services – Health care decisions

- Refer to the PGT for a health care decision when:
  - An adult is determine to be incapable of making the proposed health care decisions
  - The PGT is the adult's Committee of Person (rare)
  - There are no higher ranking family or friends who meet the criteria to act as TSDM
- Submit referrals for health care decisions by e-mail, telephone, or fax
- Visit PGT website

Accessing PDS services – care facility admission

- Health care providers responsible for obtaining consent refer to the PGT by referral form when::
  - An adult is determine to be incapable of making the decision
  - The PGT is the adult's Committee of Person (rare), OR
  - There are no higher ranking family or friends who meet the criteria to act as SDM
- Visit PGT website

What do PDS services look like?

- Assigned to a Regional Consultant for a decision
- Gather information to fulfill the legal obligations of a substitute:
  - Consult with the adult and any others wanting to support
  - Explore and consider prior capable and expressed wishes
  - Make a best interest decision
- Provide written notification of decision

Thank you!

Personal Decision Services
Local phone:604-660-4507
Toll-free:1-877-511-4111
Fax: 604-660-9479
Email: AIS-PDS@trustee.bc.ca

PGT Public Guardian and Trustee of British Columbia

Panel Q&A

Family Caregivers of British Columbia

Jaimie Ashton on behalf of FCBC

211 British Columbia®

Niina Niemi

Nidus Registry

Joanne Taylor

PGT Public Guardian and Trustee of British Columbia

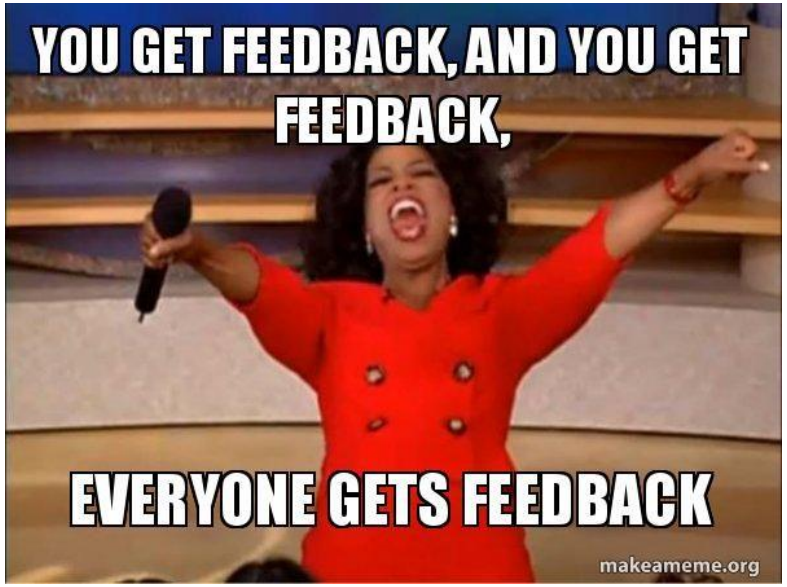
Kevin Coughlin

WRAP UP

- Slides and event recording will be shared once it’s ready
- We’ll review any questions posted on Menti and the posters and develop a Q&A
- We look forward to hosting more events around support for frail seniors in the future!

Please fill out our event evaluation

We value your feedback! Please scan the QR code below to fill out our event survey.



Vancouver Division of Family Practice
An FPSC initiative

Vancouver Coastal Health

Vancouver Division of Family Practice
An FPSC initiative

Vancouver Coastal Health

Thank You

VANCOUVER PRIMARY CARE NETWORKS