Integration of BAP in Island Health

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Vancouver Island Health Authority

Local Health Areas (LHA)

61 Greater Victoria
62 Sooke
63 Saanich
64 Gulf Islands
65 Cowichan
66 Lake Cowichan
67 Ladysmith
68 Nanaimo
69 Qualicum
70 Alberni
71 Courtenay
72 Campbell River
84 Vancouver Island West
85 Vancouver Island North

Vancouver Island North 85
Campbell River 72
Vancouver Island North 85
Campbell River 72
Vancouver Island West 84
Courtenay 71
Qualicum 69
Alberni 70
Nanaimo 68
Ladysmith 67
Gulf Islands 64
Lake Cowichan 66
Cowichan 65
Saanich 63
Sooke 62
Greater Victoria 61

Home & Community Care Clients

Total: 13, 659 (January/2015)

2014 Home Care Redesign Project

Single Paper Client Record	Interprofessional Team
Single Client Plan (My Health Plan)	Single Initial Client Assessment

SCRIPT

My Health Plan

Goal:

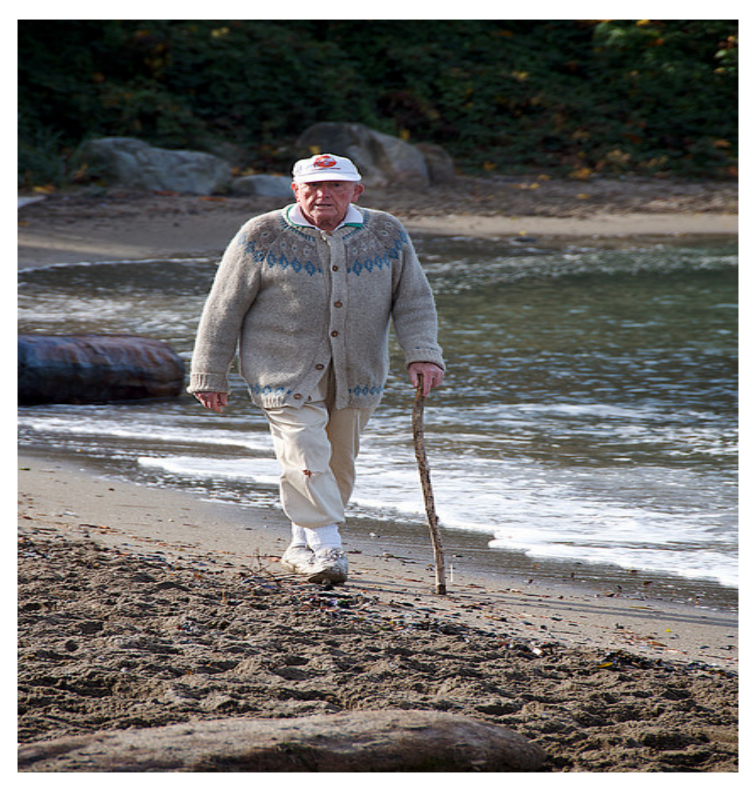
- To develop and implement a care plan that will be reflective of client goals, wishes, and beliefs and can be shared with the client/family and community partners
- To support clients to self manage their health with clear goal setting and action planning: See Document
- Education: Included 2 hour Brief Action Planning Education

Strengths of Approach in Home Care

- Helps Seniors Focus on what they are interested in and what’s important to them
- What language is used key to interaction: most seniors don’t understand what “goals” mean or how to answer the question of “What is your long-term goal?”
- Helps the team know where to focus energy and guides the interaction

Brief Action Planning in Practice

Mr. Dumbldorf



Mr. Dumbldorf

- 94 year old man living in own home with home supports twice daily.
- Lifelong active gentleman; daily walking up long, steep, gravel driveway to catch bus to pool to swim up until 2 years ago.
- Gradual but noticeable decline in stamina and endurance over past year, but continued to mobilize around bed/living/dining area with 4ww.
- Completing SAIL exercises with supervision.
- Had two bouts of flu this winter which left him requiring 2 person assist with pivot transfer bed to chair, chair to commode. Also sustained painful skin tear to (L) shin . Floor lift from HCC brought into home as a precaution.
- As health stabilized and started to improve, PT engaged client in brief action planning to identify goals with associated actions client wished to take

Mr. Dumbldorf’s My Health Plan

- **Overarching goal: Remain in home with supports of CHWs and family**.
- Barriers to this identified as being able to maintain transfers and mobility.
- **Goal #1**: to start walking again rather than just pivot transfers bed to chair.
- **ACTION**: Walk bed to chair or bed to commode (8ft) 3 x/day with CHW assistance
- **Goal #2**: Return to eating meals at the dining table
- **ACTION**: Walk at least one way to or from the table for meals once a day (15ft) with CHW or daughter.
- **Goal #3:** Maintain social contacts with old friends
- **ACTION:** Daughter-in-law to book wheelchair taxi for them to meet for lunch or tea and cards with friend every two weeks.

- Agreed to follow up in two weeks with rehab and CHW’s or family could contact sooner if concerns.

Brief Action Planning in Practice

Mrs. Waldorf

Mrs. Waldorf

- 69 year old Lady with diabetes, trauma to R leg in workplace accident 7 years ago and PTSD.
- Previously very active; had lived on sail boat for several years but had struggled since workplace injury with PTSD, depression and severe (R) leg pain with limited mobility
- Hospitalized in September 2014 with Right CVA and discharged home to trailer Nov 2014
- Mobilizing 400m with walker. Decreased coordination and balance as a result of CVA and moderate fall risk.
- Open vascular wound (R) great toe being seen by HCN.
- Mrs. Waldorf overwhelmed by state of home on discharge – 7 years of clutter and disorganization.
- Unable to use walker in home due to clutter so using walking pole and walls for stability.

Mrs. Waldorf's My Health Plan

- **Pre-discharge goal: Return to Trailer**.
- **ACTIONS**: Have friends clear walkways in house, friends to pick up recommended equipment from Red Cross, SW to assist with organizing finances, to get electrician to assist with issues to power in trailer.
- **Immediate Goal once home: "Not lose my toe"**
- **ACTION**: Wear proper footwear in the home, follow wound care support by home care nursing, get information from health care team re: diet to support diabetes care and wound healing
- **Goal #2: Gain enough strength to walk to my mailbox to get my mail everyday**
- **ACTIONS:** Walk daily to end of driveway with 4 w/w; Increase 2x driveway length after 5 days; attend outpatient physio appointments to improve strength and get set up with handidart to attend to those appointments
- **Goal #3**: **Clear Clutter in House to make it safe to move around**
- **ACTION**: Request assistance from Better at Home Program; continue with support from mental health team

Benefits

- Helped the client and family see very specific steps they could take to make some gains in function; originally had assumed that current level of function was the new normal

- Breaks down information into specific bite size pieces to focus which has been important for clients to be able to continue moving forward rather than being overwhelmed and giving up altogether

- Opportunity for education to Community Health Workers on how to provide support-optimize function!

- Targeting the right clients very important:
  - Mr. Dumbldorf was a Lifelong believer in staying active; was easily able to follow along with the questions, especially around “confidence with the goals”

Learning So Far

- Brief Action Planning works!
- Having the right clients to engage
- Timing of interaction key: many clients coming from hospital with acute issues
- Case Managers who are able to develop relationships are more successful with approach
- Workload pressures impacts opportunities for further integration
- Follow-Up piece: how long do we stay involved?

Questions?

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THANK YOU