Healthcare Excellence Canada

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Enabling Aging in Place Promising Practices: Home Visits to Vancouver's Elders (Home ViVE)

Vancouver CoastalHealth

The following promising practice was prepared following interviews with the Home ViVE team during the fall of 2023. Healthcare Excellence Canada (HEC) would like to formally acknowledge the generosity of the Home ViVE team in sharing their skills, knowledge, expertise and experiences to form this promising practice.

About Healthcare Excellence Canada

Healthcare Excellence Canada (HEC) works with partners to spread innovation, build capability and catalyze policy change so that everyone in Canada has safe and high-quality healthcare. Through collaborations with patients, essential care partners and people working in healthcare, we turn proven innovations into lasting improvements in all dimensions of healthcare excellence.

HEC focuses on improving care of older adults, bringing care closer to home and supporting pandemic recovery and resilience – with quality and safety embedded across all our efforts. We are committed to fostering inclusive, culturally safe and equitable care through engagement with different groups, including patients and essential care partners, First Nations, Métis and Inuit, healthcare workers and more.

Launched in 2021, HEC brings together the Canadian Patient Safety Institute and the Canadian Foundation for Healthcare Improvement. We are an independent, not-for-profit organization funded primarily by Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

150 Kent Street, Suite 200
Ottawa, Ontario, K1P 0E4, Canada
1-866-421-6933 | info@hec-esc.ca

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HEC honours the traditional territories upon which our staff and partners live, work and play. We recognize that the stewardship of the original inhabitants of these territories provides for the standard of living that we enjoy today. Learn more

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Model description

Home ViVE (Home Visits to Vancouver's Elders) is a Vancouver Coastal Health (VCH) initiative that, since 2008, has been providing integrated home-based primary care, nursing and rehabilitation services to a diverse population of moderate to severely frail homebound older adults in the Vancouver area.

Situated within a primary healthcare model, the Home ViVE team is staffed by a primary care team of family physicians and nurse practitioners who provide longitudinal 24/7 care to a panel of frail older adult clients unable to access usual primary care due to moderate to severe frailty.

Clients are mainly referred by staff working in Vancouver's home care teams. Frailty is a multidimensional syndrome of loss of reserves (energy, physical ability, cognition, health) that gives rise to vulnerability and is highly associated with older adult age.[1] According to the Canadian Institute for Health Information, one-quarter of seniors aged 85 and older report moderate, severe or total limitations in activities of daily living, with the most common limitation being an inability to walk or use the washroom without help.[2] It is estimated that 5.6 percent of the general population is homebound as a result of frailty, and primary care medical health services are poorly designed for these individuals.[3]

The **objective** of Home ViVE is to provide older adults with the necessary primary care and other support so they may remain in their homes for as long as possible. The program also seeks to reduce the number of unnecessary emergency department (ED) visits and hospital admissions, reduce the length of stay in hospital before home discharge, delay residential care[4] admission and/or support death at home.[5]

A **core element** of the Home ViVE program is to provide clients with the choice to receive care and/or die at home or in a hospice facility. Currently, many older adults who are terminally ill will receive treatment and/or die in a hospital or long-term care home. Home ViVE seeks to support individuals who want to remain at home for as long as possible while maintaining dignity and providing social, medical and health support needed to align with their wishes.[6]

Once a client is approved for the program, they are assigned a family physician or nurse practitioner who delivers primary care services, with additional support from registered nurses, physical therapists, occupational therapists and rehabilitation assistants. The Home ViVE team nurses work closely with clinicians and other allied health professionals to offer timely visits for urgent situations and end-of-life care. Furthermore, the Home ViVE team helps bridge and

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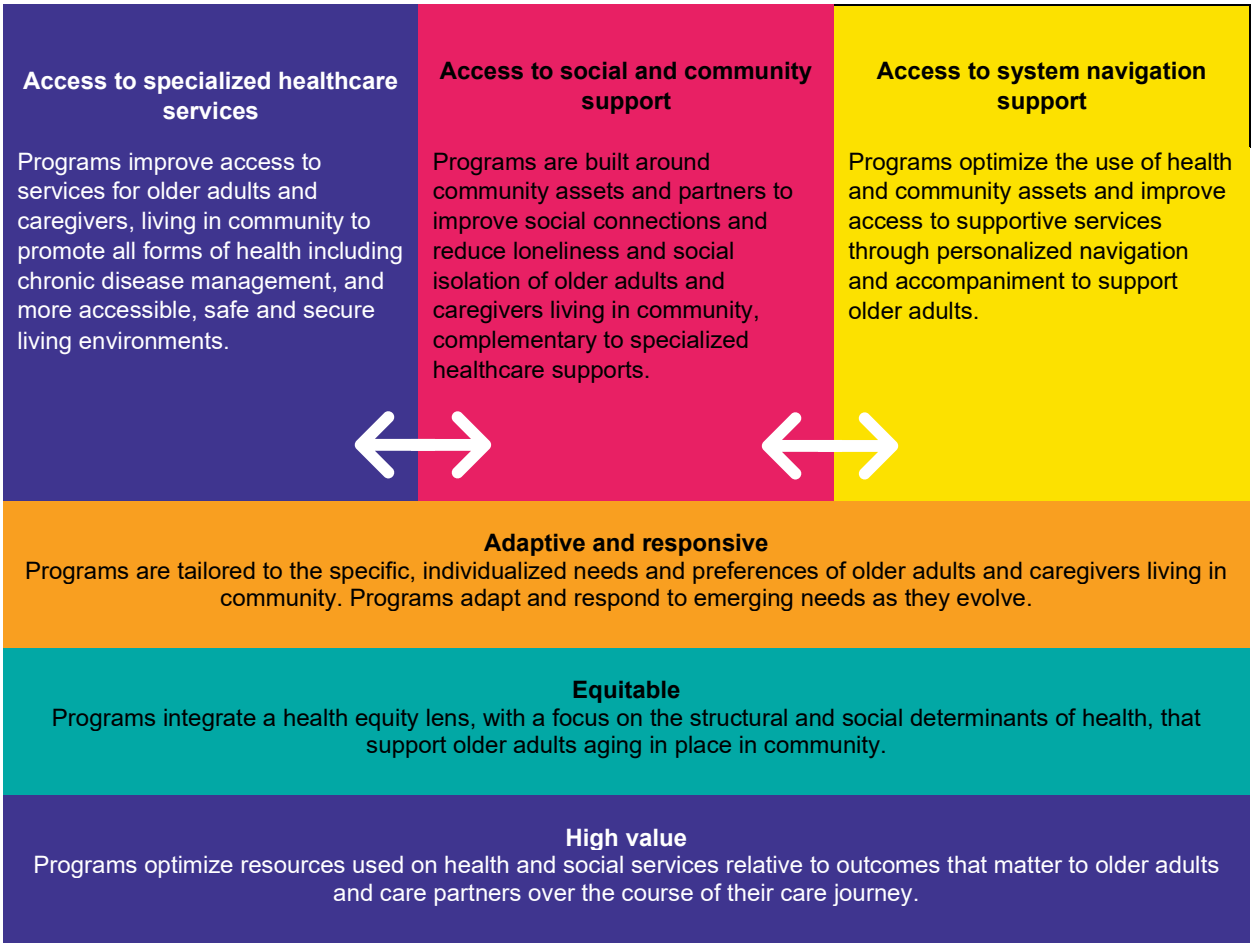
[1] McGregor, et al., 2018. A before-after study of hospital use in two frail populations.
[2] Canadian Institute for Health Information. (2011). Health Care in Canada, 2011: A focus on seniors and aging. Ottawa, ON.
[3] Ornstein KA, Leff B, Covinsky KE, Ritchie CS, Federman AD, Roberts L, et al. Epidemiology of the homebound population in the United States. JAMA Intern Med. 2015;175(7):1180–6.
[4] Residential care facility types in British Columbia include acquired injury, community living, hospice care, long-term care, mental health, substance use (British Columbia, 2022).
[5] McGregor, et al., 2018. A before-after study of hospital use in two frail populations.
[6] Interview with Home ViVE staff; November 17, 2023.

coordinate additional care provided by community home health units and mental health teams. The support that Home ViVE older adults receive varies and may include:

- appointment scheduling
- wound care
- physical rehabilitation
- independent living skills
- medication management
- transportation scheduling
- accompaniment to appointments
- emergency medical response services

Enabling Aging in Place principles

Person-centredness is a core philosophy of HEC's Enabling Aging in Place program. All the principles must be implemented in a person-centred way and reflect a deep understanding of community assets and the needs of older adults and their care partners.



The following reflects how Home ViVE fulfils HEC's Enabling Aging in Place program principles:

Access to specialized healthcare services – The Home ViVE team is staffed by a variety of allied health professionals who are available to all older adults if a need for specific services should arise. Home ViVE allied health professionals work with their counterparts in home care teams located across Vancouver to meet the needs of their clients.

Access to social and community support – The Home ViVE program seeks to provide care beyond just medical, including addressing social isolation and loneliness by engaging with older adults in their homes. Older adults are connected to social support resources alongside specialized services for their medical needs.

Access to system navigation support – The Home ViVE staff facilitates access to community resources by providing transportation, appointment scheduling, medication management and appointment accompaniment when needed.

Adaptive and responsive – The Home ViVE program is flexible so it can meet the needs of older adults as their end-of-life transition and home care needs progress. New treatment services may be brought on or discontinued, depending on the level or type of care required. The team is available 24/7/365 for unscheduled visits to clients as the need arises.

Equitable – By applying a health-equity lens, the Home ViVE program is able to address social determinants of health by improving and maintaining older adults' living environments as they transition to the end of their life. Acknowledging the importance of communication as a determinant of optimal safety and high-quality care, the team regularly deploys a virtual provincial language interpretation service to communicate with the approximately 30 percent of Home ViVE clients and families whose first language is not English.

High value The Home ViVE program efficiently uses system resources by maximizing home-based care options and engaging in iterative conversations to educate clients and family about the prognosis for frailty and what to expect in the future. Collaborate care goal-setting that factors in this understanding, with a commitment to 24/7 longitudinal care often results in decisions that alleviated the financial burden of hospital admissions, emergency services and long-term care home admissions while supporting clients and families' preference for home-based care.

Funding

The Home ViVE program is funded through Vancouver Coastal Health (VCH) with money provided by the British Columbia Ministry of Health. The VCH funds are used to fill a number of full-time positions, an office space (not used for patient visits), and for purchasing medical supplies. Physicians who work on a full- or part-time basis are paid through the fee-for-service

provincial payment plan. The Home ViVE program occasionally receives donations from an older adult or a family member and has received financial support from VGH & UBC Hospital Foundation for additional training in palliative and therapeutic harmonization.

The Home ViVE program also allocates a “compassionate fund” to be used for emergencies. For example, if a service provider is completing a home visit and notices no food in the refrigerator, emergency funds may be used to purchase food for the older adult.

Implementation

Assessing needs and assets: Using the Rockwood Clinical Frailty Scale as an indicator of the client’s level of need, and also through one-on-one conversations with the client and their family, the Home ViVE team is able to determine a suitable care plan. These meetings typically occur within the clients’ homes to help facilitate a personal relationship, better understand the older adults' living environments, and gain a more thorough understanding of their concerns and preferences as they relate to end-of-life care and advance care planning.

Home ViVE site team: Although the composition of a client’s Home ViVE care team will vary case-by-case, the Home ViVE team is composed of the following:

- family physicians
- nurse practitioners
- registered nurses
- physical therapists
- occupational therapists
- rehabilitation assistants
- secretary to provide administrative support
- medical and operational management support
- after hours on-call answering service

The secretary is employed full time in the office and is responsible for relaying messages between clients, families and providers, scheduling and recording minutes of regular team meetings, organizing mobile laboratory and specialist appointments, communicating the physician on-call schedule and ordering equipment. Physicians and nurse practitioners spend the majority of their time in the community seeing older adults in their homes. Other staff members are referred to an older adult at the request of their assigned Home ViVE family doctor or nurse practitioner and see them in their homes on a regularly scheduled basis and when needed.

Target population: While there is no age requirement, the Home ViVE program is open to older adults (generally 80+) living in the Vancouver area who may or may not be currently connected to home care and need help managing the activities of daily living due to moderate to severe frailty. Home ViVE clients remain within the program until they die or are discharged to a long-term care home, regardless of the timeframe. The client (and family) needs to agree to transfer care from their usual family physician to a Home ViVE primary care provider.

Enrollment: Older adults are referred to the program after the completion and submission of a Home ViVE referral form. The referral form includes demographic and family physician information, medical history, information on their current access to community supports, as well as an assessment using the Rockwood Clinical Frailty Scale.[7]

Older adults are mainly referred to the program by a nurse or social worker working in one of the community home care units who identifies a client who might benefit from the program and subsequently completes a referral form. Alternatively, older adults may be referred to the program through community family physicians and specialists, hospitals, and community mental health providers.

Once a new older adult has been referred to the program, they are assessed using the Rockwood Clinical Frailty Scale (CFS).[8] This semiquantitative tool is used to estimate an individual's degree of frailty on a scale of 1 (very fit) to 9 (terminally ill). Based on the older adult's level of need, determined through the CFS, an appropriate course of action will be determined.

Partnerships: The Home ViVE program works closely with staff at the local Vancouver General Hospital (VGH), where the hospital has a dedicated physician and registered nurse who work within the emergency department to identify frail individuals who might benefit from Home ViVE services. Home ViVE is also closely connected to the community home care system across Vancouver and has developed informal partnerships with the following external groups and services:

- staff at local hospitals
- Western Union Seniors Network
- footcare nurses
- optometrists
- dentists
- medical specialists (e.g. geriatricians and rehab medicine specialists) willing to make home visits
- local rehabilitation/physiotherapists
- older adult housing units

Adaptations over time: The program has remained stable over time. However, the case mix of clients has become more complex over time.

[7] Clinical Frailty Scale: https://www.dal.ca/sites/gmr/our-tools/clinical-frailty-scale.html
[8] Ibid.

Evaluation and impact[9]

Emergency department visits

An evaluation of the Home ViVE program completed in 2018 demonstrated that after enrollment in the Home ViVE model of integrated home-based primary care, clients' emergency department rates and hospital admission rates stabilized compared to those enrolled in home care only, which had emergency department and hospital admission rates increase post-enrollment. The results suggest that an expansion of the home-based primary care program to homebound individuals unable to access usual primary care could be an opportunity to 'bend the curve' of increasing hospital use, thereby improving care, optimizing quality of life and reducing cost.[10]

Wait times

In an interview with Home ViVE staff, they indicated that wait times are approximately three months (90 days) from the time of referral to receiving services. However, wait times can vary depending on the current caseload.

Admission and discharge

Home ViVE staff indicated that, at any given time, they typically have around 400 persons receiving care. Using data collected by the Home ViVE team from 2018 to the present, the program sees an average of 150 admissions and 140 discharges (either due to death or transfer to long-term care) per year.

Transfer to long-term care

Using statistics provided by the Home ViVE team, approximately 45 people are discharged from the program and into long-term care annually. These transfers to long-term care, however, would not be considered early entry due to the baseline moderate to severe frailty admission criteria for Home ViVE clients at the time of admission to the program.

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[9] The evaluation and impact information shared is reflective of information that is currently available at the time of writing this promising practice. HEC would like to acknowledge that evaluation activities are an ongoing process for many promising practices and the type of data collected is influenced by program goals, the length of time the program has been implemented, and the level of resources available to support evaluation.

[10] McGregor et al. A before-after study of hospital use in two frail populations receiving different home-based services over the same time in Vancouver, Canada. 2018. BMC Health Services Research.

Keys to success

Patient choice

Building supportive relationships and providing choices are key elements of success. Building a strong and trusting relationship between staff and older adults is essential when working with end-of-life individuals, as these transitions can be very difficult. This foundation of trust allows the Home ViVE staff to understand what matters to clients, adequately advise on which treatments are likely to be effective when a client is frail and also prepare older adults and their families for the end of life. These relationships are a core element of the Home ViVE program, which allows clients and their families to understand the potential trade-offs of medical interventions, the choice to die where they want and the way they want to.

Flexible and responsive

During the COVID-19 pandemic, the Home ViVE program saw an uptake in services, increasing the number of clients under their care as well as increasing the number of home visits provided. During a time when at-home medical treatment was extremely difficult to facilitate (due to social distancing protocols for many older adults and/or immunocompromised persons), the Home ViVE program continued to provide the necessary in-person care for their clients.

The ability of the Home ViVE program to intake clients and provide face-to-face services during COVID-19 is testimony to strong relationships between team members focused on the shared goal of providing high-quality care to homebound older adults. These relationships have been developed through regularly scheduled monthly meetings and daily communication between team members. These communications are focused on peer-to-peer support for challenging clinical cases, system navigation and other knowledge sharing.

Key challenges

Silos of care

The siloing of care can be difficult for older adults and their care providers to navigate. Frequently, paramedic services are called to an older adult's home, and the older adult is taken to the hospital for an issue that could have been addressed at home. To help alleviate this unnecessary pressure on emergency departments and ensure that Home ViVE staff is engaged in the care of their clients, the program team has developed refrigerator magnets that provide the Home ViVE after-hours on-call number to family and clients. This encourages them to first phone their service in the event of a sudden change in medical status. Paramedic services are also encouraged to contact this number before transferring a client to the emergency department.