INTRODUCTION

Taddle Creek & Women's College Hospital's Family Health Teams hosted a 'Navigating Available Support for Seniors & Caregivers' seminar on June 6, 2017. At the request of over 70 participants, here is a summary of the four panellist's talks, responses to questions asked, key takeaways and where to obtain more information.

SPEAKER #1: Stephanie Long-Riley, Psychogeriatric Resource Consultant to Primary Care (PRC-PC) for the Toronto Central Local Health Integration Network (TC LHIN)

SUMMARY OF TALK

PRC-PC Role

The PRC-PC role was created as part of the Ontario Behavioural Support for Seniors Program in response to the growing needs of our aging population. The goal of the program is to increase the capacity for care of older adults throughout the system with *psychogeriatric conditions*, specifically those with dementia and behavioural challenges. Some services are community-based and others are in hospital or long-term care homes. My role, more precisely, is to support Primary Care Practitioners (i.e. family doctors, nurse practitioners, allied health) caring for older adults with mood disorders (depression/anxiety), dementias and also behavioural disturbances arising from dementia (e.g. agitation, hallucinations and wandering). I am a systems navigator for family doctors and health teams. I help identify services and resources for their patients with these conditions and also for their caregivers.

Importance of your Family Doctor (FD)/Nurse Practitioner (NP)

It is important to have an understanding of what senior services are out there, but more importantly, you need to involve your family doctor or your Family Health Team to determine what services are appropriate for your situation. It is not an easy system to navigate and physician referrals are often necessary.

Most FDs/NPs are able to diagnose uncomplicated dementia and other mental health conditions; however, they may refer you to a geriatric or psychogeriatric specialist for several reasons: if there is uncertainty about a diagnosis, if it is complex or unusual, if you have a history of mental illness, or perhaps if you request a second opinion. Your FD/NP can also refer you to the most appropriate service or specialist – based on your symptoms, your geographic location, the urgency, etc.

Programs in the TC LHIN

The TC LHIN is rich with clinics/programs which can make navigation trickier. Here is a sampling of the types of clinics/programs available:

Geriatric Medicine Clinics	
Providers: Geriatricians	Service: Complex medical and/or cognitive issues
Geriatric Psychiatry Clinics	
Providers: Geriatric Psychiatrists	Service: Primarily mental illness and cognitive issues

Memory Clinics
Providers: Geriatricians Service: Memory/dementias
Geriatric Addiction & Mental Health Programs
Providers: Geriatric psychiatrists & counsellors Service: Addictions/mental health
Home Visiting Programs
Community Psychogeriatric Outreach Teams
Community Behavioural Support Outreach Team
Community Outreach Programs in Addictions
Inpatient Programs
Inpatient psychiatry
Specialized behavioural support units

You are the expert in what is going on with you or your care partner – however, your FD/NP and/or your Family Health Team are crucial to determining the right path/services for you and quarter-backing your ongoing psychogeriatric needs.

Caregiver Support

Other panellists today will focus on caregiver resources; however, I would like to tell you about one that is specifically for caregivers of people with dementia. The program is called the Reitman Centre CARERS Program and is located at Mt. Sinai Hospital. It provides both ongoing individual counselling and a 10-week therapeutic skills-training group. In the group, caregivers learn and practice skills and strategies to cope with the behavioural and emotional symptoms of dementia using simulated patients. I also recommend a booklet for caregivers from the Reitman Centre called “60 TIPS - Strategies to help you care for yourself while caring for a family member or friend with dementia”. It has excellent suggestions for caregivers for maintaining their own health, communicating with someone with dementia, managing stress, and system navigation. Here are four key system navigation tips I think are particularly important for caregivers and the person with the illness:

1. If you or someone you live with is diagnosed with a psychogeriatric condition, do not be afraid to book more time with your FD/NP to ask what this means for you, what the future may hold, and to request referrals or information on resources, education and support for a particular condition(s). Talk about your wishes with the people who may eventually be looking after you.
2. Learn about and get connected to available community services and supports early on, even if you do not need them yet (e.g. help with meals or respite; find out which agencies in your area provide these services and have a number handy).
3. Plan ahead before a crisis occurs. Ask your FD/NP about the progression of your (or the person you are caring for) particular illness and what to expect. This way you can plan for what you will do before a crisis. For example, a person diagnosed with early dementia needs to know that he/she will eventually need to stop driving and be encouraged to explore other transportation options early on, as well as be ready to implement them.
4. When you have an appointment with the FD/NP, make a list of changes that you notice related to the condition (e.g. needing help to take medications), services you are using, and 1 or 2 pressing concerns. Ask concise questions rather than waiting

to be asked. Be realistic about what can be accomplished in one visit and request referrals to other supports and services.

QUESTION

1. What problems do you encounter working with seniors with psychogeriatric issues?

The two biggest "problem" areas I encounter in seniors mental health have to do with declining cognitive abilities and behavioural symptoms of dementia. Firstly, cognitive problems such as memory loss and reduced insight into one's capabilities can make it very difficult for a person to recognize they need help or accept supports, and/or to realize they are at risk (e.g. when driving, when cooking). This becomes even more of a problem when there is no Advance Care Plan (ACP) or no Power of Attorney (POA) to express patients' wishes when they cannot speak for themselves. It can make caring for someone very difficult, especially when you want to respect his or her autonomy and dignity. The second biggest issue I encounter is behavioural symptoms of dementia - such as verbal or physical aggression, calling out, suspicion, paranoia, resistance to care, etc. – which are often called 'responsive behaviours'. The behaviours are believed to be a means of communicating an unmet need (such as hunger, pain, boredom) or a response to circumstances in the environment that might be frustrating, frightening or confusing to a person with dementia (e.g. stranger bathing them). Responsive behaviours are a major source of distress for family caregivers and can negatively impact the caregiver's health, as well as precipitate early admission to long-term care for the person with dementia.

KEY TAKEAWAY

Be proactive and unafraid! Knowledge is power. If you have any concerns about your mood, memory or mental well-being, do not wait hoping it will resolve or just attribute it to "normal aging" - see your FD/NP and discuss it.

TO FIND OUT MORE

Caregivers
https://www.mountsinai.on.ca/care/psych/patient-programs/geriatric-psychiatry/dementia-support/caregivers-and-family-members-caring-for-someone-dementia/carers/reitman-centre-carers-program

https://www.mountsinai.on.ca/care/psych/patient-programs/geriatric-psychiatry/prc-dementia-resources-for-primary-care/dementia-toolkit-for-primary-care/caregiver-support/60-tips-electronic-version-530.pdf

---

SPEAKER #2: Julia Kundakci, Social Worker at Taddle Creek Family Health Team

SUMMARY OF TALK

Taddle Creek Family Health Team's Mental Health Program is comprised of three social workers that offer a variety of different services, including individual counselling, group therapy, case management, workshops and more. Our social workers work closely with community support agencies to ensure seamless delivery of care. Our case

management service is defined as the collaborative process of assessment, planning, facilitation, care coordination and advocacy for resources to meet an individual's and family's comprehensive health needs. We work with individuals and families to help them find and get connected to resources that will meet their physical, emotional, and psychological needs in the most meaningful way possible. Speak with your Primary Care Provider to learn more about the Mental Health Program at Taddle Creek FHT.

Toronto Seniors Helpline (TSH)
TSH is a joint initiative led by the Community Navigation & Access Program, WoodGreen Community Services, Toronto Central CCAC and over 30 community agencies across Toronto. This new phone line is making it easier for Toronto seniors, their caregivers and their health care providers to access home care, crisis services and other support seniors need. This inbound service offers access to a full range of services for seniors and is fully staffed 365 days a year. Recognizing Toronto's diversity, the line is also TTY (text telephone) accessible and interpretation services are available. Aside from offering emotional support and telephone counselling, the TSH can bridge individuals to a program called Crisis Outreach Services for Seniors (COSS). This program is for adults 65 and up in mental health and/or addictions crisis (including dementia). COSS offers mobile crisis intervention and counselling to older adults; short-term intensive case management; harm reduction and concurrent disorders service; limited primary care and nursing; and mental health and addictions assessment, counselling and referrals. If you are interested or know someone who may benefit, simply call the Toronto Seniors Helpline (416-217-2077) today to learn more and to reach a variety of services and supports.

QUESTIONS

1. Are there advocates for seniors?

The Advocacy Centre for the Elderly (ACE) is a specialty community legal clinic that was established to provide a broad range of legal services to low-income seniors in Ontario. ACE is committed to upholding the rights of low-income seniors. ACE is managed by a community Board of Directors, at least half of whom are seniors themselves. Its purpose is to improve the quality of life of seniors by providing legal services, which include direct client assistance, public legal education, law reform, community development and community organizing. More specifically, lawyers at ACE provide direct legal services in a wide variety of areas such as advance care planning, elder abuse, home care, long-term care homes, pension/income, and retirement homes.

When you call, ACE staff will guide you through their intake process. The intake staff will either provide you with some information or refer your case to a lawyer for further assistance and consideration about whether ACE can assist you. However, ACE does not provide assistance in all areas of the law and if they are unable to assist you directly, they will make every effort to refer you to someone who can.

If you are calling ACE requiring urgent legal advice and their office is closed, you can contact the Law Society Referral Service at 1-855-947-5255 or 416-947-5255 (within the general Toronto area). The Law Society Referral Service is designed to provide callers with up to 30 minutes of consultation either by phone or in person at no charge.

2. Are there services to fill CCAC gaps in the community?

There are many services in the community that help fill the gaps and meet your practical and ongoing psychosocial needs. There are several community-based agencies such as Dixon Hall, Central Neighbourhood House, WoodGreen Community Services, Family Service Toronto and many others that offer a package of services including: ongoing counselling, day programs, Meals On Wheels, exercise programs, caregiver support, housing support, medical escort services, etc. There are also programs geared toward specific senior needs. For instance, seniors with Alzheimer's and/or dementia can access social, recreational and therapeutic activity programs through Baycrest. Many agencies such as Second Mile Club or Sunshine Centre for Seniors also offer daily drop-in fitness classes, parties, and social and recreational activities and events. There are also volunteer-based programs such as friendly visiting programs that provide friendship and shared activities with those who feel isolated or those who have a physical/emotional/mental health condition for whom companionship may offer additional emotional and practical support. Although many community programs and services do exist, navigating the system to find them can be quite the challenging task. To get started remember to,

- ✓ *Call **Seniors Helpline (416-217-2077)** to speak with a representative who will connect you with the information you need OR will refer you to social work services that can assist you in exploring all the options*
- ✓ *Refer to **torontocentralhealthline.ca** to identify which health services, geographically, are available to meet your needs*
- ✓ *Speak with your primary care provider to explore options together*

KEY TAKEAWAYS

Life transitions are hard! They may be accompanied by feelings of grief, being overwhelmed and helplessness. Reflecting on what your unmet needs might be or how your values may have shifted in recent years is key to identifying resources to meet your needs in the most meaningful way possible.

Build your tribe! Know who your trusted key players are and think about delegating roles to them as you see fit. Stay informed, know your rights and exercise them. Remember - you have the right to raise your concerns with your family or your health care team without fear of interference, coercion or discrimination.

TO FIND OUT MORE

Advance Care Planning
http://www.advancecareplanning.ca

Advocacy Centre for the Elderly
http://www.advocacycentreelderly.org

Toronto Seniors Helpline
http://4seniors.org/
www.torontocentralhealthline.ca

SPEAKER #3: Effie Galanis, Resource Care Coordinator at Toronto Central Local Health Integration Network Community Care Access Centre (CCAC), now Toronto Central Local Health Integration Network (LHIN)

SUMMARY OF TALK

Changes at the CCAC

The CCAC provides a first point of contact for public access to government-funded home care, community services and long-term care homes. We deliver home and community healthcare and provide system navigation to connect you to other services available in your community, including connection to a primary care provider through our Health Care Connect program.

As of June 7, 2017, the responsibility for the people, care and services of the Toronto CCAC was transferred to the Toronto Central Local Health Integration Network (TC LHIN). Being part of the LHIN will make it easier for us to work with other health care providers, like family doctors, so that clients experience a more integrated health system. The people delivering care and the contact information you have to reach them will not change.

MYTH: *Toronto Central LHIN only provides home and community care to seniors.*
TRUTH: *Our services are available to people of all ages in order to allow them to live independently in their homes for as long as possible. We support clients across the lifespan with varying degrees of health conditions.*

For instance, we support the following population groups:

- Seniors who find it difficult to manage day-to-day care needs on their own
- Adults with chronic illnesses who require education to support self-management of their condition (e.g. telehomecare program)
- Children with severe health problems who need medical assistance in their homes and schools or require respite for their parent caregivers
- Individuals nearing the end of life and in need of palliative home care services

The primary role of a Care Coordinator is to assess eligibility for care/services – not all clients referred are eligible. Eligibility requirements include:

- Client has Ontario Health Insurance Plan (OHIP) – our nursing, personal support and therapy services are fully covered by OHIP and are provided at no cost
- Client must reside in the geographical area of the LHIN from which they are requesting services – if you are unsure of which LHIN to call to make a referral, you can call 310-2222 (no area code required) to be redirected to the appropriate one
- Client needs cannot be met on an outpatient basis. This is important because if there is a community-based option that can be accessed to support the client/family need, this will be recommended and the client will be referred appropriately (e.g. diabetic clients attending a diabetes education centre instead of having a nurse come to the home)

MYTH: *Only a doctor can refer someone to Toronto Central LHIN for home and community care.*

TRUTH: *A referral for services can come from anyone – doctor, hospital, emergency medical services, family member, friend, neighbour, and even the client themselves.*

You can make a referral to the Toronto Central LHIN by calling 416-506-9888. When calling, you can anticipate a live-answer response - we are available 7 days a week, 365 days a year. Our Care Coordination Support Team will take information about the nature of your call, including the reason for your referral. This allows us to triage and prioritize calls/referrals so that we can respond appropriately to urgent and time-sensitive requests. On average, we receive 500 calls per day for local health information and referrals. You can anticipate a call back from a Care Coordinator at our Client Services Centre within 48 hours (depending on volume) to complete an intake assessment and determine eligibility for care and services. Based on the outcome of this assessment, if eligible, the Care Coordinator may arrange urgent and necessary care in the home or community (e.g. nursing clinic) or may request a community care coordinator to complete a comprehensive in-home assessment to develop a plan of care. You can expect that your community care coordinator will:

- Talk to you about your personal health needs and make recommendations about care options available
- Develop a plan of care specifically for you that includes different services and supports that you may need (both home- and community-based options will be explored and presented)
- Work with all members of your care team, including your family doctor, family members, pharmacist, community services and home care staff to ensure that you get the care you need, when you need it

Long Term Care (LTC)

In the TC LHIN, there are 37 LTC homes that operate at about 99% capacity on any given day. Wait times for admission vary from weeks to years depending on the individual facility waitlist, bed availability and client care need. These conditions make it almost impossible to accurately predict how long someone may wait to access a long-term care bed. This further highlights the importance of a comprehensive home and community support plan to ensure that the client and family care needs can be supported safely in the community for as long as possible.

From the time of referral, you can anticipate that the application process will take at least a couple of weeks as there is a series of steps and processes that needs to be followed, including (but not limited to):

a) A home visit to complete a comprehensive assessment of care needs and determine eligibility for accessing a long-term care bed
b) Provide client/family with counselling and information about LTC homes, what they can expect in LTC, as well as a list of options and choices
c) Clients and families are strongly encouraged to arrange tours with LTC facilities prior to adding as a choice – it can take time to arrange and accommodate scheduling availability or pre-established tour dates/times
d) Complete an application for LTC

e) Primary Care is required to complete a health assessment to accompany the application for LTC – some physicians may require the patient to come to the office to be assessed in person before the form is completed

QUESTIONS

1. What about services in languages other than English?

Client information is available in French and English on the home and community care website of Toronto Central Local Health Integration Network (LHIN). Clients who wish to receive care and services in French are assigned to a French-speaking care coordinator and care providers. Other languages are supported through the use of our translation services (for both telephone and in-person assessments). These individuals are trained to provide translation services in health care settings. As care coordinators, we also leverage our community partner agencies to support communication in languages other than English and French. Upon intake, clients are asked their primary/preferred language for service so that we can accommodate you.

2. My aging parents do not live in Toronto, but I do. Can I access Toronto Central LHIN for long-term care centres in Toronto for them?

Individuals or their families should contact the LHIN in the area where the individual needing care lives to request an assessment of eligibility for long-term care. That LHIN will also assess for eligibility of home care services and will develop a plan of care to support individuals until placement services can be arranged. When applying for long-term care, individuals can apply to any facility in the province, regardless of where they live in Ontario.

3. When a referral to the palliative team is made, how long does it take for an initial assessment by the team?

The palliative care team of the Toronto Central LHIN operates as an integrated care team with care coordinators, nurse practitioners, palliative physicians and service providers. When a referral is made to the palliative team, the team will review the referral and triage based on urgency on referral, client/family need, and team involvement. The referral will also be assessed based on uncontrolled symptom management, prognosis and acute end-of-life needs. We will endeavor to see patients within 2 business days if a referral is urgent and the referring physician/NP has contacted the palliative physician directly to discuss the reason for urgency. If the referral is not urgent, we endeavor to see new referrals within 1-2 weeks based on team and client/family availability.

A referral to the team can be made by completing the Palliative Common Referral Form (TPCNet form) by the referring physician or NP. This includes accompanying medical documentation: consult notes, scans, medications, labs etc.

4. Can someone get hospice-type support at home for end-of-life stage?

Yes. Toronto Central LHIN palliative care team supports clients to live and die in the place of their choice, and often this is in their own home surrounded by loved ones. Toronto Central LHIN is part of the care solution, and care is available at night as well as during the day, but care professionals are not in the home all the time. Family or

friends will also need to provide care. Our palliative care team also supports clients and families to apply for and transition to a residential hospice or palliative care unit if that becomes their place of choice.

5. How does a senior get help if they are the support system to a child with mental health issues?

The Toronto Central LHIN provides care and services to clients of all ages. Our Information and Referral team (416-506-9888) can connect you to appropriate community-based support options or to a referral system.

6. Can a doctor at a walk-in clinic access and guide a patient through the community networks?

The Toronto Central LHIN will accept referrals for home and community care from anyone, including a physician at a walk-in clinic. You can also refer yourself or a family member. The degree to which the physician is able to assist an individual with navigating and connecting to community-based care and services will depend on the individual doctor's awareness of available supports and willingness to refer. Seeking primary care from your family doctor is always most ideal for good continuity of care.

7. Are the pharmacies able to see your list of medications if you visit another pharmacy in an emergency?

The provincial Drug Profile Viewer (DPV) is available and can be accessed by any pharmacy. This database primarily provides information about medications that have been taken in the past, from which pharmacy they were dispensed, and who prescribed the medication. This is not an automated system and relies on individual pharmacies to check the database for historical information. The best way to reduce the risk of possible medication errors is to ALWAYS dispense your medications through ONE pharmacy. Community pharmacists are able to review and reconcile medications with pharmacists in their clinic, and if needed, in the patient's home.

8. My father-in law with dementia needs assistance to ensure he takes his medications daily. Can CCAC help?

An assessment of your father's care needs (i.e. condition, capability, supports, medications taken, etc.) would be required to answer this question properly. Identifying this concern as a care need during an assessment would allow a care coordinator to explore options and make recommendations for supporting medication management and compliance in the home (e.g. use of dosettes, blister packs, medication reminder dispensers). In some circumstances, it may be appropriate for a Personal Support Worker in the home to provide a medication reminder to clients, however PSWs are restricted from handling and administering controlled medications (i.e. narcotics) and are unable to manually dispense medications from bottles.

9. How does communication between Personal Support Workers and family members occur in the home (i.e. through a binder or checklist)?

The Personal Support Workers' charting in the home has been transitioned to an electronic record of personal care activities performed during visits in order to better

communicate with their provider agency/office. There has been much interest and activity in how we support communication with family members and other informal caregivers. We encourage clients and families to speak to their care coordinator to discuss a means of communication that is appropriate to their needs.

10. How soon will I be seen by a CCAC Case Manager after my discharge from hospital?

There are Toronto Central LHIN care coordinators in every acute care and rehab hospital in the Toronto Central and, if needed, an assessment will be completed in-person prior to discharge or by phone shortly after discharge to arrange the care and support needed. Clients who are already receiving home and community care from the Toronto Central LHIN are usually reassessed in the home within 1 week of discharge.

11. How can I get a case manager through a community centre?

Some Community Support Service (CSS) agencies have Social Work services that can assist with connecting clients/families to community-based care and can support navigation of our complex system. A referral can be made directly to the CSS agency by locating them by postal code through the TorontoCentralhealthline.ca website or by calling the Toronto Seniors Helpline at 416-217-2077.

12. "If you don't have a system navigator you will be in real trouble" – How do I get one of these system navigators? I am single and not rich. Will I have to pay?

I'm glad you recognize the value of case management and system navigation! That is what our care coordinators provide to our clients every day. Our care coordinators are registered health care professionals including nurses, social workers, occupational therapists and physiotherapists with training and experience in how to help our clients navigate the health care system and the community support services sector based on the priorities and needs of those clients. For a while now, home and community care in Toronto Central LHIN has been working with partners in other health care sectors to pioneer integrated care right at the point of care: the client's home. In fact, Toronto Central LHIN already has care coordinators linked to over 72% of primary care providers in our area. The new Patients First Act lays the foundation to improve those connections between primary care and home care, which will create a more integrated care experience for patients.

Individuals and families also have many tools to learn more about resources available. These include TorontoCentralHealthline.ca. This is managed by Toronto Central LHIN and is a website that is easily searchable. It includes many community service agencies, and services available both without charge and for fees. Our Information and Referral Phone Line can also help callers discover resources in the community (416-506-9888). Toronto Central LHIN is proud to be a partner in another resource: Toronto Seniors Helpline (416-217-2077).

13. How will the new organization change? At the top and lower down? Will more money be available for services?

No changes to home and community care have taken place as a result of the recent transition of CCAC to LHIN. But as Patients First progresses, opportunities for more integrated care will mean that primary care providers, interprofessional health care teams, hospitals, public health units, and home and community care providers will be better able to communicate and share information to ensure a smoother patient experience and smoother transitions. Recently, more funding has been made available for behavioural support services and caregiver respite support.

SPEAKER #4: Lydia Chan, Social Worker on the Acute Care for Elders (ACE) Unit, Mount Sinai Hospital, Sinai Health System

SUMMARY OF TALK

ACE Unit Philosophy

The ACE Unit is a General Internal Medicine Unit that provides acute medical care to the geriatric population. The healthcare team, staff and volunteers all receive geriatric training and education in order to meet the medical and psychosocial needs of elderly patients. In addition to the interprofessional team of physicians, nurses, physiotherapists, occupational therapists, and other allied health professionals, the ACE Unit has access to specialized services such as the geriatric medicine team and the geriatric psychiatry team. The ACE Unit also has a dedicated group of volunteers involved in the Maximizing Aging Using Volunteer Engagement (MAUVE) Program to promote social engagement and interaction for patients. These volunteers support the Occupational Therapists in running the weekly Montessori Method Group Therapy to promote health and active living for patients on the unit. While the care is designed for older adults, this holistic approach is spreading to other areas of the hospital.

Creating a Hospital Care Plan

As a patient or a caregiver, it can be overwhelming and distressing to be in a hospital setting. Developing a Hospital Care Plan can alleviate some stress and anxiety for both the patient and his/her caregiver(s). Your Hospital Care Plan can be a simple notebook or binder containing important information, like a list of contacts (i.e. family physician and specialists), a list of past and upcoming medical appointments, a list of current medications/allergies and anything else that would be helpful for the hospital care team to know. Outlining your at-home routine, bringing in familiar items, and if appropriate, bringing in some home-cooked meals are items that can be included in your Hospital Care Plan. Invite loved ones, healthcare providers, staff and volunteers to work with you on your Hospital Care Plan.

Advanced Care Plan (ACP)

An ACP is talking about your wishes, values and benefits as they relate to your future healthcare. It is also about knowing who your future substitute decision-maker(s) (SDM) will be If decisions need to be made about your care in the future and you are not capable of making them yourself, healthcare providers will ask your SDM for consent. Preparing an ACP and sharing this information with the healthcare team is essential. It is strongly advised to have this done as soon as possible, so this does not become an added stressor if/when hospitalized.

QUESTIONS

1. How do I access palliative care services?

Any patient admitted to Mount Sinai Hospital is able to receive palliative consultations with a palliative care physician for the duration of their stay at the hospital. For patients in the community, The Tammy Letner Centre for Palliative Care offers a Home Care program where a physician can visit in the home. All physician visits are covered by OHIP. You can access palliative care units by either contacting your family doctor, the Toronto Central Local Health Integration Network (TC LHIN - formerly CCAC) or the desired palliative care unit.

2. In my experience, as a caregiver to my husband for 7 years, I have found it difficult to be recognized as part of the health team (e.g. ignored, bullied, etc.) when in the hospital or when working with the CCAC. What is being done to recognize the value of caregivers?

I'm sorry to hear that you had a terrible experience. It is hard enough to be a caregiver, let alone feel ignored and bullied. Caregivers have a wealth of knowledge and certainly have a lot to contribute to the care of an individual. Mount Sinai Hospital has implemented the FiCare (Family Integrated Care) model in their NICU and ICU and it is spreading to other units of the hospital, so hopefully improvements will be seen. I also recommend that you try to have an advocate on your side when in the hospital.

3. Is there a service to provide a companion for someone with anxiety/depression going to a medical appointment? The person is over 55 but under 65. The appointments are typically for very standard tests such as ultrasounds, not for meetings with a doctor to discuss results.

The Seniors Helpline serves those over the age of 55 and one of their services includes a medical escort service (a fee may be involved). If this individual has a family physician, psychiatrist or social worker involved, it may be worth discussing and developing a care plan together of how to support the individual in attending these appointments.

4. When you go to emergency department (ED), how do you ensure doctors know your health issues and history?

Going to the ED can be a very stressful time. If this is a Toronto-based hospital, most doctors have access to a system called Connect GTA where they would be able to access your past medical history. The pharmacist would also be able to access most medications you are taking. However, as part of any assessment, most doctors prefer to receive first-hand information. While it may be emotionally draining and exhausting to repeat your story again, hearing from the patient/caregiver directly avoids any misinterpretation.

KEY TAKEAWAY:

Create your Hospital Care Plan and your ACP today and share with loved ones and healthcare providers.

TO FIND OUT MORE:

Advanced Care Planning

https://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/poakit.php
http://www.advancecareplanning.ca/

Palliative Care
http://www.tlcpc.org/
http://www.torontocentrallhin.on.ca/forhsps/PalliativeCare.aspx
http://www.uhn.ca/PrincessMargaret/PatientsFamilies/Specialized_Program_Services/Pages/inpatient_hospice_palliative_care_directory.aspx