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## CREATING AN AGE-FRIENDLY ONTARIO

OHCA Position Statement

### *Introduction*

Ontario's growing, active senior population is a testament to a progressive health care system and to our success as a society. Seniors play an invaluable role in their own families and contribute significantly to the social fabric of their communities. One of the greatest health care priorities facing our province is the need to respond to the changing societal norms regarding seniors' expectations to live and age independently in their own homes. While seniors of the future are predicted to be among the healthiest in history, it is also known that the likelihood of developing chronic conditions increases with age and can compromise the prospect of independence. As a result, the health care system must re-tool to respond to the needs of our growing senior population so they can remain in the home and community setting.

The Ontario Home Care Association (OHCA) believes that Ontario's provincial 'aging at home' strategy is an exciting opportunity for health system partners to address this important societal issue. New funding can be used to create leveraged change within the health system as it begins to actively turn its attention to innovative ways of helping seniors live at home for as long as possible. Operationalizing the strategy will however create challenges for the current system. Determining where and how to allocate resources in order to attain innovative, new pathways of care that support independent living will require careful consideration and a willingness to change current practice. Simply investing in the status quo and the numerous programs already in place, will not achieve the broad directional change contemplated by the 'aging at home' strategy.

OHCA recommends that the funds supporting the strategy be targeted to specific 'at risk' populations where the greatest benefit in terms of continued independence can be achieved. All initiatives must be supported by rigorous evaluation that addresses specific outcomes related to system utilization, cost, quality of life and clinical status. The lessons learned and successes achieved can then be used to inform a broadening of the strategy, ultimately expanding beyond the MOHLTC to other ministries so that an age-friendly Ontario can be created.

## *Independence and Aging*

Most, if not all people, wish to remain independent during their older years. Successful aging requires a holistic approach – avoiding disease and disability; maintaining cognitive ability; and engaging with life.<sup>1</sup> One of the most significant and least desirable outcomes for a community-dwelling senior is to be prematurely institutionalized<sup>2</sup> because of the lack of home and community care based health and social support options. Locally, each LHIN now has the opportunity to support effective collaboration by health care partners so that even the frail person can remain at home, living with supports to enjoy independence and dignity in later years.

### *Who is 'at risk' for loss of independence and why?*

Growing numbers of community-dwelling seniors are 'at risk' for loss of independence because they need more help than is currently available in the health care system to age at home. A clearly identifiable trigger point for imminent loss of independence occurs when families decide, with the support of the Community Care Access Centre or family physician, to activate the search for placement for the senior to a retirement or long term care facility. This activity is often initiated for individuals at the 'fringe' - those needing a little more support than offered within the community system and not really requiring the full scope of services offered in the facility. It is at this point where enhanced and focused services delivered in the home could make a major difference in the quality of life for both the senior and their families.

There are many sub-sets of 'at-risk' seniors with a diversity of medical problems, living circumstances, and cultural and language issues. While the 'aging at home' strategy cannot address all of them equally, it can make strategic funding interventions for locally identified groups. Enhanced funding and focused coordination of care should be applied to mitigate the risk factors for loss of independence so that living at home, even with significant challenges, can become a true reality for aging Ontarians.

### *Chronic and Disabling Physical Conditions*

Seniors with chronic conditions and very disabling physical limitations requiring help with everyday activities such as housework and meal preparation are at imminent risk of institutionalization due to falls and other adverse events.<sup>3</sup> Elderly single cognitively impaired women with physical dependence and

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<sup>1</sup> Rowe, J. W., & Kahn, R. L. *Successful aging*. *Gerontologist*, 37, 433–440, 1997

<sup>2</sup> For the purposes of this paper, institutionalization is understood to be a setting where decision-making related to ADLs (such as meals, baths and bedtimes) are outside of the control of the individual

<sup>3</sup> Wilkins, Park, "Chronic Conditions, physical limitations and dependency among seniors living in the community" Statistics Canada, 1996 and Fletcher, PC and Hirdes, JP, "Risk Factors for Falling Among Community-Based Seniors

depression are also identifiable as high-risk for institutionalization.<sup>4</sup> Investment in supportive care to enable optimum functioning for individuals at the ‘fringe’ can help to tip the balance of care to the community thereby avoiding the often rapid dependence on others which arises out of care in other settings.

### *Seniors with Dementia*

Dementia is one of the major risk factors for loss of community-dwelling status. Several randomized trials of mental health interventions with medical patients over the age of 75 showed that those in the intervention group had improved physical function, few readmissions to hospital and nursing homes.<sup>5</sup> Supporting individuals with early stages of dementia is compassionate and potentially effective to maintaining independence and dignity for individuals.

### *Coordination Challenges of the System*

Many seniors are particularly vulnerable to the lack of coordination and communication between different sectors in the health care system.<sup>6</sup> Recent hospitalization and poor transition planning following discharge from acute care is a known precursor of loss of independent living.<sup>7</sup> This occurs because appropriate supports to enable a durable discharge are not planned and communicated to the next caregiver. An integrated and effective health system addresses the transition points of care and works to ensure safe and consistent bridging of services and/or sectors.<sup>8</sup>

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*Using Home Care Services”, The Journals of Gerontology Series A: Biological Sciences and Medical Sciences (57:M504-M510) 2002*

The Journals of Gerontology Series A: Biological Sciences and Medical Sciences 57:M504-M510, 2002

<sup>4</sup> J Woo, SC Ho. An Estimate of Long Term Care needs and identification of risk factors for institutionalization, Journals of Gerontology Series A: Biological Sciences and Medical Sciences, Vol 55, Issue 2 M64-M69, 2000

<sup>5</sup> Burns, A, Denning, T and Baldwin, R BMJ Volume 332, 31 March 2001 (4a)

<sup>6</sup> McWilliams, CL, *Achieving the Transition from Hospital to Home: How Older Patients and their Caregivers Experience the Discharge Process*, Working Paper Series, Thames Valley Family Practice Research Unity Paper #93-1, December, 1993)

<sup>7</sup> Hollander, M., and Chappel, Final Report of the National Evaluation of the Cost-Effectiveness of Home Care, Health Transition Fund 2002).(2a)

<sup>8</sup> VanderBent, S, Ontario Home and Community Care Council, “Transition Planning in Health Care Systems: Key Quality Processes and Outcome Measures” *HealthCare Quarterly*, June 2004

### *Improved Medication Management for Seniors*

Studies have shown that seniors are particularly susceptible to the effects of drugs and incorrect complex medication regimes which may result in adverse events such as institutionalization or hospitalization.<sup>9</sup> Programs such as Ontario's MedsChek and the integration of the pharmacist onto the primary care team lend themselves to proactive assessments and interventions of those with characteristic presentations, such as confusion and falls.

### *Group support for families and caregivers under stress*

Families and caregivers that have gone beyond their physical and emotional ability to cope are more likely to consider institutionalization of a senior. This occurs because families are expected to bear the greatest burden of care for a senior loved one. The current home care system depends heavily on family and friends to provide the majority of continuous care and support in the community and this is unsustainable for many families.<sup>10</sup> Research has shown that family counseling and mental/emotional health support for caregivers can reduce the rate of institutionalization for some groups of seniors with Alzheimer's disease.<sup>11</sup> Investment in planned respite that addresses the caregivers' needs and acknowledges their importance to keeping our elders at home is critical to ensuring the sustainability of the caregiver role.

### *Activities of Daily Living & Socialization*

The ability to remain at home is in large part determined by an individual's ability to manage their living circumstances, whether it is a house in a rural or urban setting, in an apartment or assisted living environment. Social isolation and escalating fears about safety risks can prompt the family and/or the health care team to recommend an institutional option. The work of maintaining a home, cleaning, snow shoveling, and home repairs can become too difficult for seniors and their families. Research has shown that the balance of care can be tipped to remaining at home when supports that address isolation and simple assistance with home maintenance are provided.<sup>12</sup>

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<sup>9</sup> Hogan, D, Maxwell, CJ, Fung, TS, Ebly, EM "Prevalence and potential consequences of benzodiazepine use in senior citizens: Results for the Canadian Study of Health and Aging" *Canadian Journal of Clinical Pharmacology*, Vol 10 No 2 Summer 2003

<sup>10</sup> Naleppa, MJ. Families and the Institutionalized Elderly, *Journal of Gerontological Social Work*, Volume : 27 Issue : 1 / 2, 1994 (p.87)

<sup>11</sup> Mittelman MS, Ferris SH, Steinberg, G. Shulman, E, MacKell, JA, Ambinder A, and Cohen ,J "An Intervention that delays institutionalization of Alzheimer's disease patients: treatment of spouse-caregivers" *The Gerontologist*, Vol 33, Issue 6 730-740 1993

<sup>12</sup> Challis, D and Hughes, J "Frail old people at the margins of care: some recent research findings" *British Journal of Psychiatry* 180 126-130 2002

### *Evaluation – The critical need to identify key learnings*

In operationalizing the new strategy the LHINs must thoroughly examine the current outcomes for seniors and choose an identified key population that would benefit from innovative and/or additional supports (risk estimated care). Broadened eligibility criteria and programs for ‘at risk’ seniors (triaged coordination packages) must be linked to specific measurable outcomes (such as the avoidance of institutionalization or specific hospital presentation and admission; and planned deaths at home).

Evaluation must be longitudinal with observational studies being conducted at specific points in time such as 6, 12 and 24 months following the introduction of risk estimated care, and triaged coordination packages.<sup>13</sup> Observing the seniors targeted with additional funding at key intervals will yield important qualitative and quantitative key learnings related to the introduction of care that is calibrated to address known risk factors.<sup>14</sup> On-going results from this process will yield further evidence supporting the efficacy of an enhanced and strengthened home and community care system and justify policy change and further funding allocations.<sup>15</sup>

### *OHCA Recommendations*

The OHCA Board of Directors believes that an enhanced and broadened role for home and community care is necessary within each LHIN to ensure the success of the new strategy. The Association urges the LHINs to consider the following recommendations as they deploy their resources for the ‘aging at home’ strategy:

#### **1. Balance care to the community so that seniors who are ‘on the fringe’ can stay at home**

- Increase home care service maximums and introduce greater flexibility to the service allocations in order to provide enhanced care to ‘at risk’ seniors – those on the fringe of admission to an institution

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<sup>13</sup> Weissert, WG, “Predicting Elderly People’s Risk for Home Placement, Hospitalization, Functional Impairment and Mortality: A Synthesis, *Medical Care Research and Review*, Vol 57, No. 3 259-297) 2003

<sup>14</sup> Brennan, P and Croft, P. “Interpreting the results of observational research: chance is not such a fine thing” *British Medical Journal* 309 727-730 1994

<sup>15</sup> Black, N, “What Observational Studies Can Offer Decision Makers” *Department of Public Health & Policy, London School of Hygiene & Tropical Medicine*, London, UK

- Complete the provincial roll-out of the InterRAI Contact Assessment (CA) to quickly identify ‘at risk’ seniors who require comprehensive assessment and case management. On completion of the RAI HC – case managers to incorporate the MAPLe (Method for Assigning Priority Levels) in prioritizing and allocating resources to help people age at home
- Expand and redefine the meaning of ‘respite care’ so that it responds more appropriately to the expressed needs of families and caregivers that have exhausted their physical and emotional ability to care for their loved ones.
- Provide more meals, transportation and social supports as part of structure of care offered within the home care system through the CCACs

## **2. Invest in collaborative efforts by health system partners that will keep seniors at home**

- Support more publicly funded supportive housing<sup>16</sup> with coordinated baskets of service coordinated by the CCAC through the publicly funded home care system
- Integrate mental health support and rapid access to community psycho-geriatricians for seniors and their caregivers into the formal home care service delivery process offered through the CCACs
- Strengthen the linkages to family doctors, family health teams and community pharmacists in order to achieve specialized medication management for seniors with complicated and chronic medication regimes<sup>17</sup>
- Partner with acute care, family health teams and CCACs to create ER avoidance initiatives, such as Enhanced Home Care Program<sup>18</sup> and Quick Response Programs which have been proven to be very successful

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<sup>16</sup>The MOHLTC definition for Supportive Housing is a location where organizations may be responsible for providing services to a number of service recipients who live in their own units and housing is not a component of the service. Organizations providing these service will ensure their staff in various locations are onsite and accessible on a 24-hour basis.

<sup>17</sup> The Community Pharmacist in Home Care, June 2006, OHCA

<sup>18</sup> South West Community Care Access Centre, retrieved October 2007, <http://www.ccac-ont.ca/Content.aspx?EnterpriseID=2&LanguageID=1&MenuID=19>

- Explore the creation of ‘elective’ medical admissions to community hospitals to allow seniors an intentional short stay into the acute care sector to receive coordinated assessments, stabilization and planned return to the community.
- Reduce the fragmentation of community based activities (transportation, meals and bathing) and leverage a more coordinated care delivery system within the home and community care team that is efficient and integrated.
- Support cross-sectoral roundtables that engage the broader social system in planning age friendly communities

### **3. Build research and evaluation into any initiative funded through the strategy**

- Introduce key quality processes to measure improvements in transition planning for seniors leaving the acute care system
- Require that recipients of funding have a sustainability plan for broader system function embedded into their proposals
- Ensure that the Home Care Research & Knowledge Exchange Chair is involved in supporting research related to this strategy

### **4. Expedite the implementation of information technology to enable data capture and more efficient care delivery by all members of the health team**

## **Conclusion**

The ‘aging at home’ strategy provides an opportunity to demonstrate that leveraged changes will improve the system and help seniors to remain independent at home. The OHCA believes that the LHINs have a unique opportunity to advance Ontario’s transformation agenda. With focussed investment strategies and evaluation, Ontario can demonstrate that a robust home and community care system can make a significant difference in the everyday lives of seniors and their families.

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The OHCA, *the voice of home care in Ontario*, represents Canadian home care service organizations that deliver quality home care to Ontarians through the province. The OHCA advocates for a strong, dependable and accessible home and community care system for Ontarians. OHCA members are accredited through the Canadian Council on Health Services Accreditation (CCHSA) or the International Standards Association (ISO)

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