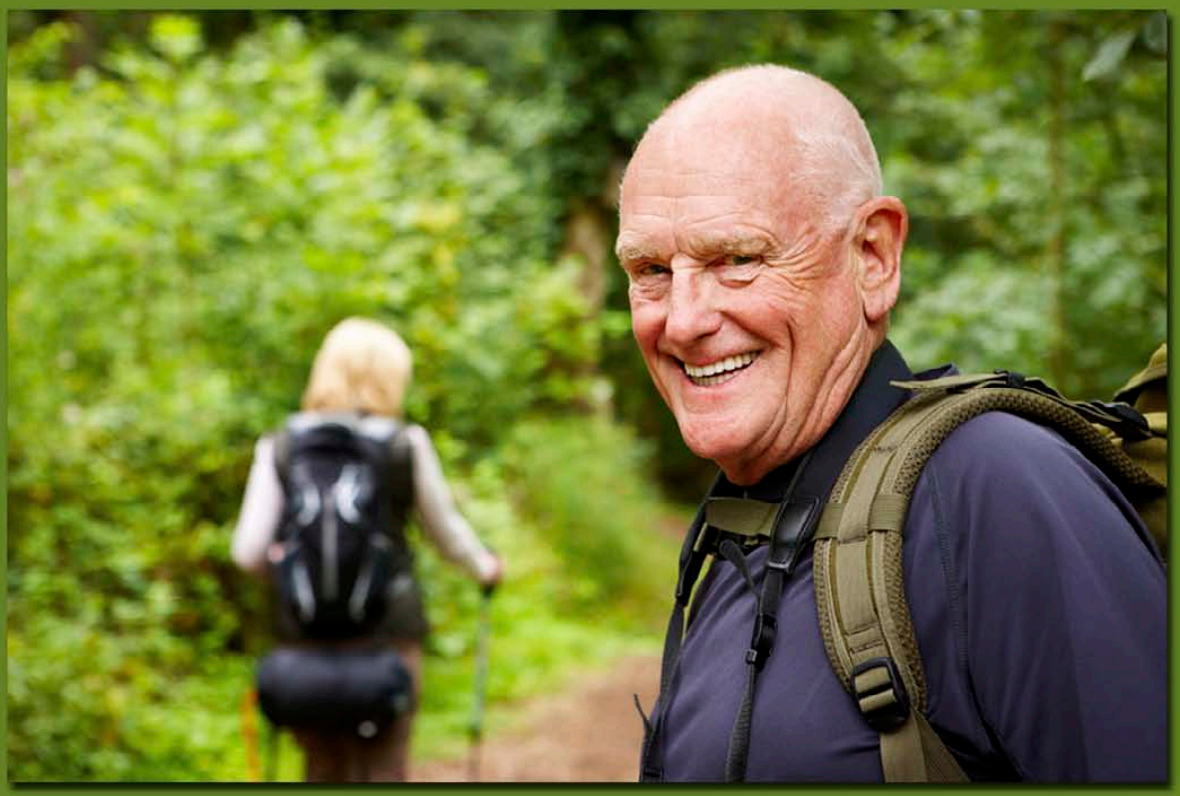
HEALTHY AGING IN RURAL NORTHERN ONTARIO

EXPLORATION, DISCUSSION, INSIGHT



NOVEMBER 28, 2013
FORUM PROCEEDINGS

RURAL ONTARIO INSTITUTE

Centre for Rural and Northern Health Research
CRaNHR
Centre de recherche en santé dans les milieux ruraux et du nord

Ontario

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Thank you to Dr. Wayne Warry and the staff at the Centre for Rural and Northern Health Research, Louise Paquette, Terry Tilleczek and the staff of the North East LHIN, and all of our presenters for contributing to the success of this rural forum.

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Ontario

1.0 ABOUT THE ORGANIZERS

The **Rural Ontario Institute** was established in 2010 through the merger of The Ontario Rural Council and The Centre for Rural Leadership. Reflecting the expertise and legacy of our founding organizations, ROI's mandate is to develop leaders, initiate dialogue, support collaboration and promote action on issues and opportunities facing rural Ontario. To this end, ROI works to amplify the voices of stakeholders in rural and remote communities in the province.

The **Centre for Rural and Northern Health Research** (CRaNHR) conducts interdisciplinary research on rural health with a view to improving health services, and enhancing understanding of the health care system. Its research program focuses on transforming health policy, systems and practice to improve health equity for rural, remote, Aboriginal and Francophone populations.

2.0 FORUM THEME

Ontario's rural population is already older than the provincial average. As the number of rural seniors continues to grow, are we ready to support them with effective healthcare services as they age? Supporting healthy aging among seniors living in rural and remote areas of Northeastern Ontario was the discussion theme during a full-day rural forum held in Sudbury on November 28, 2013.

In Northern Ontario, 18% of the population is 65 years or older, compared to the provincial average of 14.6%. As such, complex chronic illnesses and sensitive mental health issues will continue to increase demand on caregivers and health care professionals to provide comprehensive, culturally-appropriate care.

Together, CRaNHR and ROI developed a forum program to accomplish three goals:

1) Raise awareness of the issues faced by rural and remote communities surrounding health and aging

2) Connect rural practitioners working on these issues to foster shared learning

3) Connect leaders from different sectors, including government around these issues so they can make more informed decisions

Researchers and practitioners spoke about the key issues facing rural and remote communities in Northeastern Ontario. In total, 82 participants from across the North East region participated in the day. Those in attendance represented health educators and students, health care practitioners, administrators and health promoters in the public and non-profit sectors. For a complete list of organizations represented, see APPENDIX I.

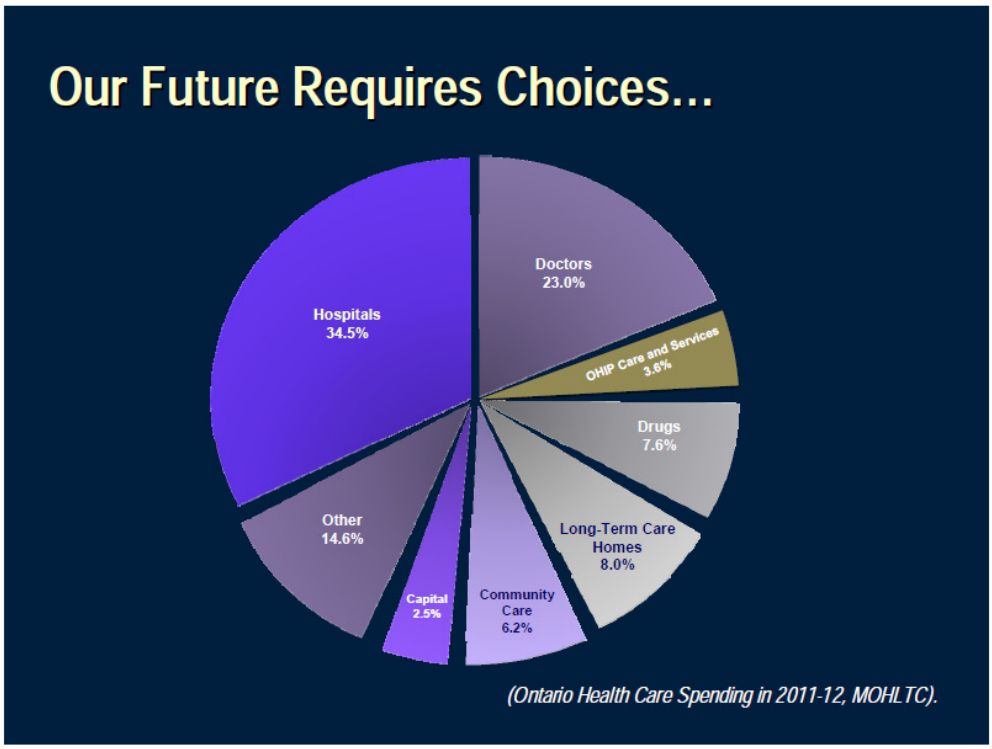
This report summarizes “what we heard” during the rural forum. It contains a brief summary of speaker presentations as well as the insights and observations from participants collected during facilitated table group discussions. It is intended to inform stakeholders, as well as federal, provincial and municipal decision makers on the issues surrounding healthy aging in rural and remote communities in Northern Ontario.

3.0 KEY MESSAGES EMERGING FROM PRESENTATIONS

3.1 Dr. Samir Sinha

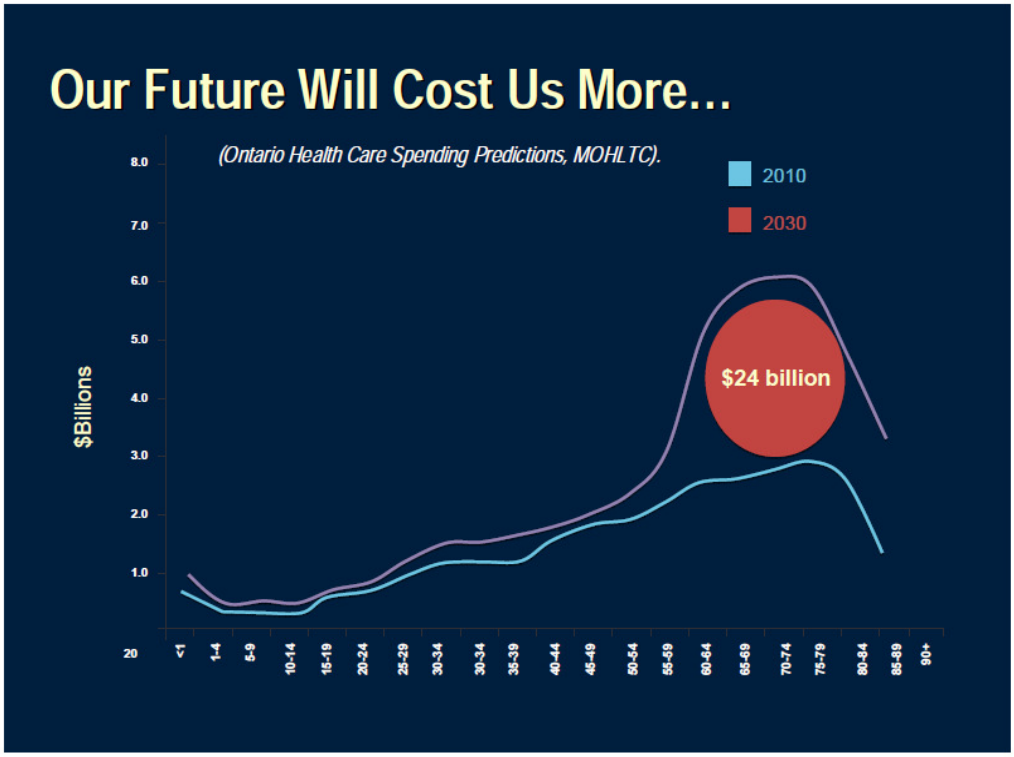
Director of Geriatrics, Mount Sinai Hospital & Provincial Lead for Ontario’s Seniors Strategy *Living Longer, Living Well*

Presenting: *Ontario’s Seniors Strategy - Considerations for Rural and Northern Communities*



Ontario Health Care Spending in 2011-12, MOHLTC

The way in which cities, communities, and our health care systems are currently designed, resourced, organized and delivered, often disadvantages older adults with chronic health issues. As well, increasing numbers of Ontarians want to age in place, either in their own homes or their home communities. Factor in a rising number of seniors in the province and it is apparent that the current health care delivery system needs to change.



Ontario spending prediction showing a $24 billion cost increase by 2030 to meet the expected health care demands under the current health care delivery structure (data provided by MOHLTC)

Given the future challenges, Ontario's Seniors Strategy sets out recommendations that could support older Ontarians to stay healthy and independent longer in life.

Northern Ontario has a higher proportion of older people than the rest of the province. Smaller communities sometimes lack the care-giving professionals and mix of services they need to support aging in place. However, Dr. Sinha believes that there is tremendous potential to meet these challenges within the existing overall health care spending allocation.

To support aging-in-place strategies, he recommends several courses of action:

1) More investment in health promotion and prevention in older Northerners. Examples include the NE CCAC *Falls Prevention Strategy*, and the NE's publicly funded vaccination program.

2) Ensure all older Ontarians have access to the primary care provider they need, including identifying Community Health Centres, Aboriginal Health Access Centres, Family Health Teams across the province that have capacity to take on older patients. Encouraging the uptake on new provisions that support more physician house calls will be important as well.

3) Strengthen and prioritize current and future investments in home and community care and supporting caregivers. For example, leverage the 4% increases in home and community care funding support to buy care that is needed and supports aging in place.

4) Expand the traditional scope of practice and bring care options closer to home. For example, support nurse-practitioner led clinics, community paramedicine and personal support worker (PSW) training within rural and northern communities.

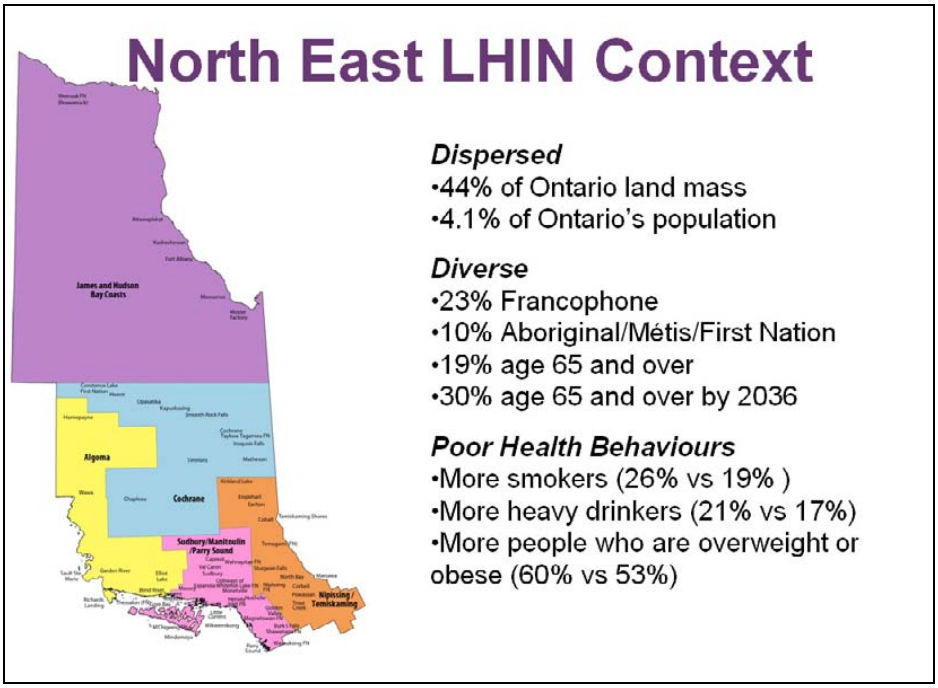
5) Understand supportive housing as an under-utilized model of care that could keep our health care system sustainable, which requires a true partnership between Ministries, Municipalities and LHINs.

6) Explore and re-image the roles of hospitals and long-term care homes in rural and northern communities – when the hospital or long-term care home is the only local care facility, what should its role be in supporting the needs of its aging population.

3.2 Terry Tilleczek

Sr. Director, Policy and Health System Planning, North East LHIN

Presenting: *System Transformation to Enable Healthy Aging in Rural and Northern Ontario*



Overview description of NE LHIN

North Eastern Ontario is a unique jurisdiction that presents several health care delivery challenges. Over the next 20 years, the NE LHIN is projecting a 65% increase in the number of seniors. There is increasing emphasis on meeting forecasted needs of seniors with respect to community-based care, more coordinated care and transitions of care.

> "*Changing demographics impact how we deliver services, how we access services, and where services are offered.*"- Terry Tilleczek

As outlined in the 2013-2016 Integrated Health Service Plan (IHSP), the NE LHIN has four priorities over the next three years:

1) Increase primary care coordination
2) Enhance care coordination and transitions to improve patient experience
3) Make mental health and substance abuse treatment more accessible
4) Target the needs of culturally diverse population groups

> *"Upsetting the status quo creates anxiety…yet to meet health care needs today and in the future, change is essential."* - Terry Tilleczek

There are three primary enablers helping to move forward in the priority areas of the IHSP:

1) Electronic health record opportunities such as the *North Eastern Ontario Network* (NEON) common hospital information system, *Physician Office Integration* (POI) system, and *Telehomecare*.
2) Realignment and system transformation initiatives, including:
   a) Health System Funding Reform and Quality Based Procedures. For example, as of 2015/16, 70% of funding envelope for hospitals with the remaining 30% will be based on global funding.
   b) Health Links/Health Hubs are two relatively new models at the clinical care level that foster greater collaboration between providers for patients. The NE LHIN ultimately envisions 11 Health Links in addition to Health Hubs, to benefit high users of health system.
   c) Supporting Dr. Sinha's senior's strategy *Living Longer, Living Well* through a number of initiatives including exploring specialized geriatric services, community capacity planning and the unique needs of Aboriginal People.
   d) Shifting toward more community-based care, and away from institutional-based care. This means care is provided in community or home settings first, and institutional settings are used only when needed.
   e) Physiotherapy reform, including increasing access for seniors to in-home physio provided through CCAC, community exercise/falls prevention classes; community-based clinics, etc.
3) Recruitment and retention of health human resources. Small and rural communities are faced with challenges such as: recruitment and retention of staff, access to services, critical mass, varying service levels, etc. and often have to work together to maximize available resources. There is recognition of the need for change in small, rural communities and for this reason, the NE LHIN is leveraging local planning voices and assisting with enhanced collaboration efforts to enable improved patient care.

3.3 Dr. Kristen Jacklin

Associate Professor of Medical Anthropology, Northern Ontario School of Medicine

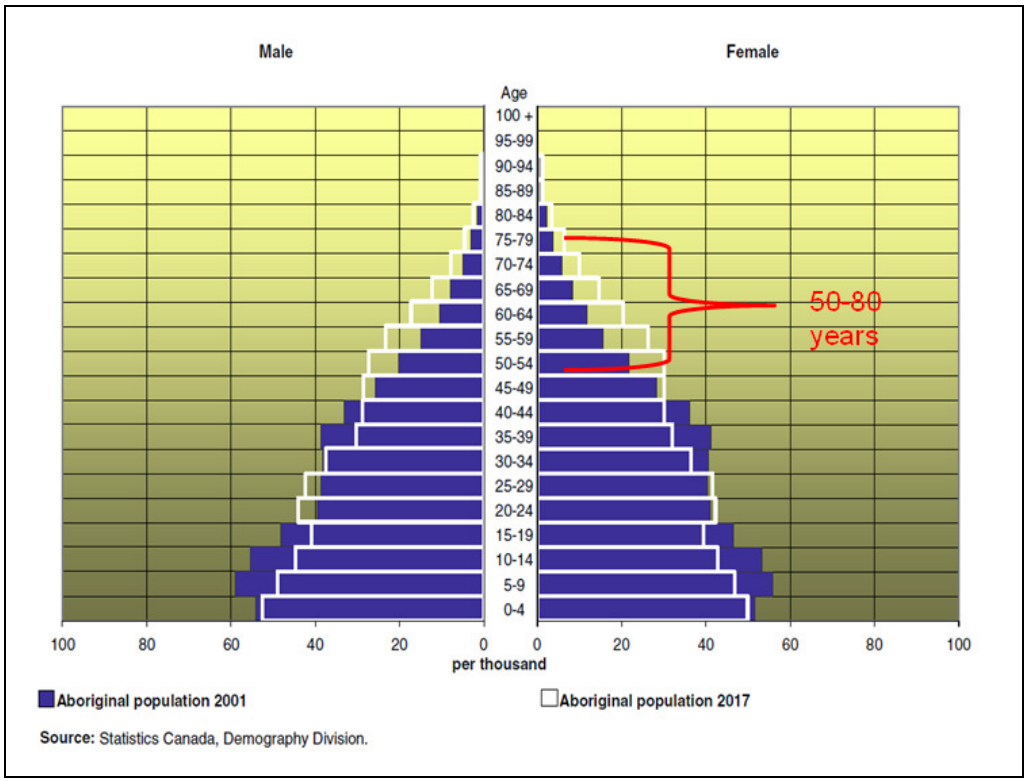
&

Karen Pitawanakwat

R.N./Care Coordinator, Nahndahweh Tchigehgamig Wikwemikong Health Centre Home and Community Care

Presenting: *Perspectives on Aboriginal Aging and Dementia*

In First Nations communities, the number of individuals aged 55-64 reporting three or more chronic conditions is 3.5 times higher than non-First Nations people; rates of dementia are reported to be 34% higher than the non-Aboriginal population and rising more quickly; and 45% of the 65+ population report fair/poor health with 69% having activity limitations. Population projections suggest a demographic shift happening that will see a large increase in numbers of Aboriginal peoples in the 50-80 year old groups, which will significantly impact health services delivery. An increase in the service needs for age-related dementia is expected.



Statistics Canada (2005) ***Projection of the Aboriginal populations, Canada, provinces and territories 2001-2017***

Aboriginal people in the North East region hold cultural understandings of dementia that differ from western biomedical understandings. In the North East, Aboriginal communities recognized dementia as an emerging health issue in 2007 prompting research on this issue. An overwhelming number of study participants shared an understanding that age-related dementia

is something natural, normal and as something that is culturally understood as part of one's journey in life. Participants also said that it could be brought on or hastened by several physiological (e.g. co-morbid disease), psychosocial (e.g. stress, trauma), indigenous factors (e.g. not living a good life). Most agreed that the current scale of dementia is a new problem, and it did not exist at this magnitude before. Because it is 'new' problem to many communities, there are many information needs not being met.

Formal dementia care is underutilized in most Aboriginal communities where most people did not seek care from formal health care providers. Those who did go for assessments found them culturally inappropriate, and prescription medication for dementia was generally not trusted.

> *"Our Health Care System Challenge: To find respectful and appropriate approaches to health care that honour cultural understandings of illness and a person's personal journey around the medicine wheel while at the same time ensure individuals and families benefit from appropriate early interventions and care giving support."* - Dr. Kristen Jacklin

Family care giving was considered appropriate but is challenged by complexities arising from several factors:

A) Dementia in Aboriginal people is most often co-morbid with multiple chronic illness (e.g. diabetes, cancer, arthritis)
B) Most households face inadequate housing, finance and transportation
C) Multiple health care jurisdictions make it difficult for Aboriginal people to access care and medical supplies/prescriptions
D) Services are not geared to Aboriginal people limiting access to culturally appropriate knowledge, education and training for families
E) Medical services are often deemed inappropriate and lacking sensitivity to Aboriginal culture

3.4 Dr. Birgit Pianosi

Chair of Gerontology Program, Huntington University;
Chair, Ontario Interdisciplinary Council for Aging & Health (affiliate of COU)

Presenting: *Perspectives on Gerontology Education for Health Care Professionals*

Caring for older adults requires special knowledge and, therefore, the curriculum of health and human service programs need to be adjusted to include gerontology/geriatrics education. Gerontologists have a depth of knowledge and expertise that applies to many aspects of life and work beyond the health field, including age friendly environments and workplace programs.

Many jobs require registration with a professional body that exemplifies competencies are met and that there is a responsibility beyond the employer to behave in a professional, competent manner. The clinical and policy expertise of the profession that will be leading the next 'evolution' of health care directions needs the recognition and acknowledgement by society and policy makers as a "specialist" and this is provided/supported by the recognition of the designation "gerontologist."

> "*A 2008 survey of the gerontological content in Canadian nursing programs revealed that only 2.4% of faculty with master's degrees and 6.0% of faculty with doctoral degrees had a gerontological focus*." - Dr. Birgit Pianosi

There are several core competencies of practitioners that need to be ensured by the profession. For example:

- Advocate for older adults to obtain quality services
- Conduct a geriatric assessment
- Evaluate the effectiveness of practice and programs in achieving intended outcomes

However, these competencies and education requirements are not currently reflected in job applications. Ontario needs a multiple education system response to ensure that gerontologists are providing the level of professional care required by their patients, such as:

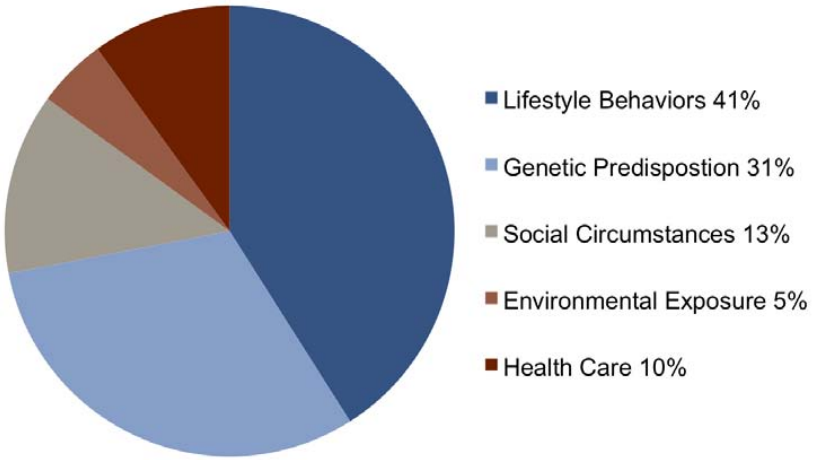
- Health care professionals need to demonstrate competence in care of older adults for licensure
- Direct-care providers are inadequately trained so standards must be established
- Both older adults and their family caregivers must be integrated into the team and provided information and training
- Gerontologists must be professionalized/regulated

3.5 Dr. Janet McElhaney

Senior Scientist at Advanced Medical Research Institute of Canada and Health Sciences North Volunteer Association Chair in Geriatric Research

Presenting: *Perspectives on Healthy Aging in Rural Northern Seniors*

Chronic diseases are very common in older adults and we need to understand the determinants of health and disease progression.



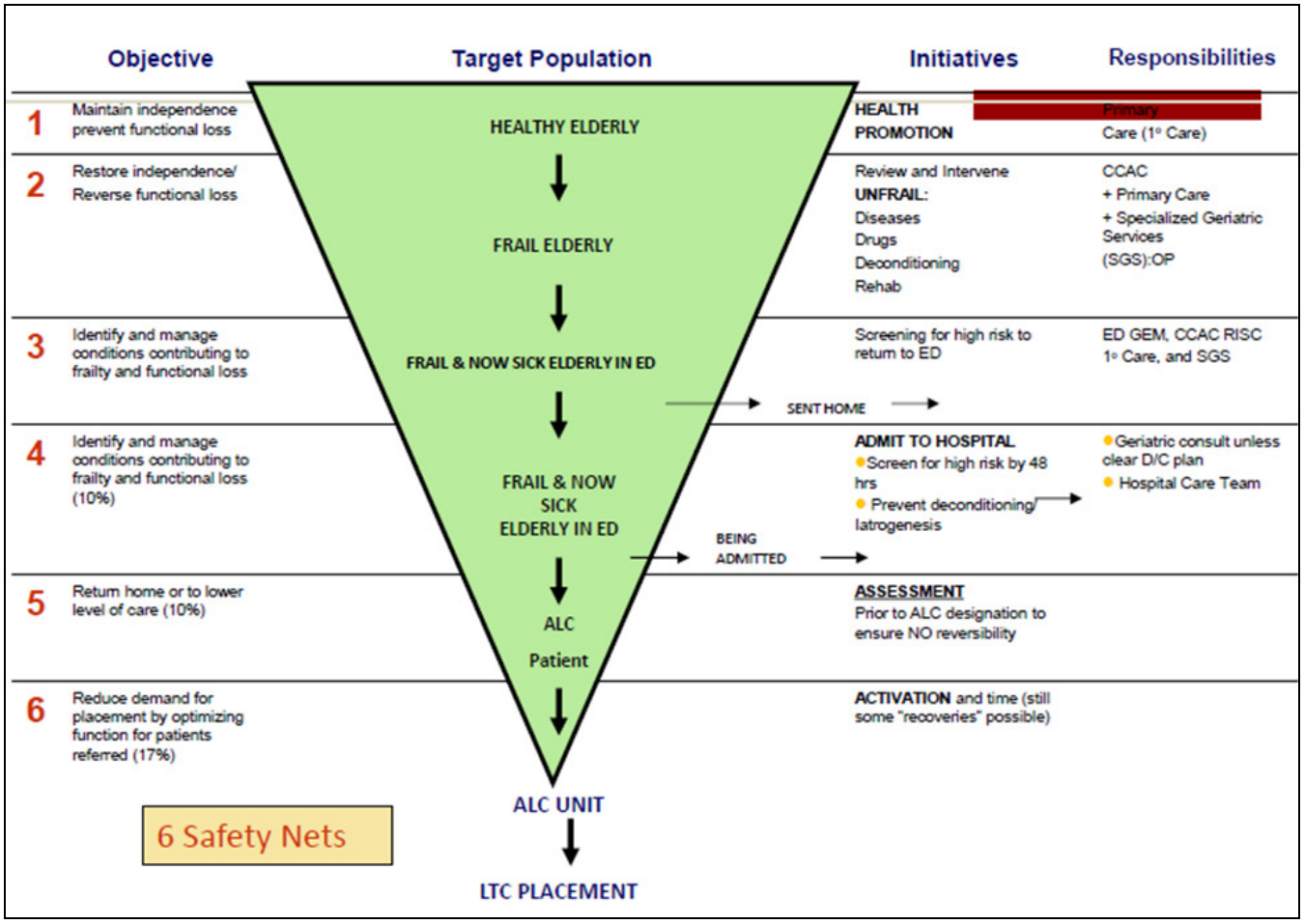
Contributors to individual health

Rural populations are generally older than urban counterparts. An aging population, economic difficulties and geographic isolation all contribute to health vulnerabilities. Furthermore, rural populations have a higher proportion of Aboriginal people compared to urban centres, which tend to have higher chronic disease rates and face added challenges of access to care. For example, Aboriginal People aged 55-64 report three or more chronic conditions, which is 3.5 times higher than non-Aboriginal people.

As lifespans increase, illness trajectories are changing, and people diagnosed with life-limiting or life-threatening illness can now live many years with their condition. A palliative approach to care should be expanded to seniors and include social support, advance care planning and effective pain and symptom management throughout the illness. A palliative approach could be integrated into care for people with chronic, life-limiting conditions and people who are frail and vulnerable to infections or falls that could hasten death.

3.6 Dr. Jo-Anne Clarke, Geriatrician MD FRCPC; Nathalie Bureau, B.Sc.N, Care Coordinator, CCAC; & Anadel Hastie, Chair of Mayor and Council's Seniors Advisory Panel

Panel Discussion: *Rural Health & Aging*

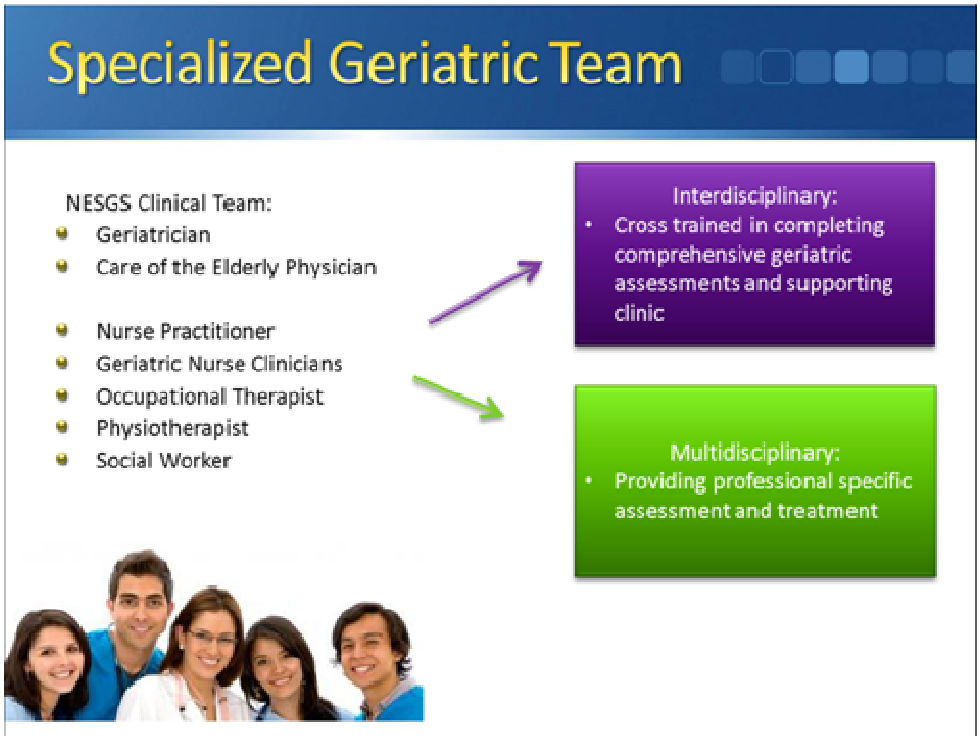


The key to changing the trajectory towards Alternative Level of Care is to target the populations early and to treat using the appropriate objectives.

The Seniors Strategy recommends that seniors are supported in their homes and not in healthcare institutions. Now fully supported by the North East LHIN, the North East Specialized Geriatric Services (NESGS) team includes two physicians, seven interdisciplinary clinicians and five academic and administrative staff for a total of 14 full-time employees, with an operating budget of approximately $1.3M.

Notwithstanding the progress in specialized geriatric services, a draft report applying population-based benchmarks to geriatrician human resource planning indicated a shortfall of 12 geriatricians, reinforcing the need for a dramatic increase in access to specialized geriatric services in the North East.

In response to these unmet needs, and in recognition of the geographic limitations for a single regional geriatric team, planning has been undertaken to support the development of local geriatric teams to function in coordination with NESGS, in the communities of Sault Ste. Marie and North Bay. Health Sciences North has also moved forward with its development of specialized geriatric services which include both inpatient and outpatient services. They have recently recruited an additional geriatrician for Health Sciences North with a dual academic and clinical role.



The following case study presents a typical scenario illustrating the journey of an elderly client through a senior-friendly community healthcare system.

- An 80 year old female adult living alone in her apartment in a seniors' building has a diagnosis of dementia, osteoporosis and hypertension.

- The client had no family support locally. Her only son lived in western Canada, and generally visited twice a year. She lived in a senior's complex where the neighbour and the superintendent provided some support.

- She was referred to the North East Community Care Access Centre (NECCAC) from NESGS for assistance with medication management. NECCAC referred the client to the Alzheimer Society for education and support. They worked with the son to obtain a Home Safely Bracelet for the client, which she wore most of the time with the encouragement of the care coordinator and her nurse from the Alzheimer Society.

- The client had a routine and when that routine was kept she was able to manage her activity of daily living and her day to day affairs such as grocery shopping and banking.

- The client initially declined the use of a medication blister pack. Multiple strategies were attempted in collaboration with the occupational therapist from the NESGS and CCAC nursing service to improve medication compliancy without a blister pack. These strategies were unsuccessful.

- After multiple visits, the CCAC staff member established trust and was able to convince the client of blister pack's benefits. The client agreed to have her medications blister packed by the pharmacy. The neighbour, who was a retired nurse, agreed to accept the blister pack as the client was not always home for the delivery.

- Despite having a blister pack she continued to have some difficulties managing her medication (i.e. forgetting to take them or double dosing). Again, due to the trusting relationship established with the CCAC staff member, the client accepted the recommendation to allow visits from a personal support worker (PSW) to provide medication cues on a daily basis.

- In dialogue with the service provider, the CCAC staff member was able to coordinate the same PSW to visit Monday to Friday at the same time, which contributed to the success of the client becoming compliant with her medication.

- The superintendent and the neighbour were supervising her intermittently during the day to ensure that she was not wandering and was dressing appropriately for the weather.

- As a care coordinator, the CCAC staff member visited her every 4-6 weeks to ensure that she had appropriate food in her fridge and would clean her fridge of any spoiled food as needed and also weighed her monthly to track any weight loss.

- As the client's dementia progressed there were concerns by all involved in her care that she would need additional transportation support to make medical appointments and continue with her daily activities. It was still her son's wishes to maintain his mother at home for as long as possible.

- The son agreed to setting up an account with a local taxi and assist with the cost of the taxi transportation for his mother to attend medical appointments. The CCAC staff member attended the medical appointments every 6 months with the client to ensure that all information was communicated to the practitioner.

- The pharmacy contacted the CCAC staff member when the client's medications were due for renewal and a staff member would arrange an appointment with her family practitioner to have them renewed. A good rapport was established between the client's practitioner and CCAC staff, who facilitated communication over the telephone with any concerns about the client.

- With all these supports and services in place the client was able to stay at home for an extra year. The client had two incidences where she was found wandering in the community and

was returned home by police. Retirement Home living was explored however the client could not afford the cost.

- The son who was the client's power of attorney agreed that it was time to initiate a long term care home application to move the client to a nursing home to ensure her safety. Shortly after the application was completed, the client moved to a long term care home.

4.0 ROUND TABLE DISCUSSIONS

Forum participants engaged in facilitated small group discussions to share their thoughts and observations on the issues surrounding healthy aging in rural northern communities. The thoughts presented below emerged from those discussions. The collective perspective of each small group represents the views in the room, and not those of any one organization or individual. Similar issues identified by the groups emerged independently at different table discussions and have been merged together under subject headings to reflect the main ideas reported by the groups.

EQUITY

Due to the distances and densities across Northern Ontario, there is a lack of equitable access to health care services for patients. Local community health organizations have the potential to decrease these disparities but this solution has not yet been fully pursued. Support for community health organizations could come in the form of better connectivity between doctors and local service providers, LHIN funding for demonstration programs, having several smaller HUBs instead of fewer more centralized versions, or moving beyond the LINK and HUB model altogether and delegating responsibility to local community organizations.

There are also equity issues among health care providers, relating to compensation and professional development opportunities between those that work in hospitals and those that work in communities and differences in travel subsidies for PSWs from region to region. Addressing these inequities would help incentivize care provider recruitment in rural and remote northern areas.

PERSONAL SUPPORT WORKERS

PSWs are a critical part of Ontario's health care system. These individuals represent the front-line of patient care and are often the only regular point of contact that clients have with the health care system. The emotional and physical support that PSWs offer their clients is enormous, yet their role as health care providers is underappreciated and undervalued.

PSW wages, delegated responsibilities and abilities vary across the profession. PSWs are taught by nurses, but not necessarily gerontologists, so when they are deployed to care for seniors they may have knowledge or skill gaps in their training.

Recommendations for improving the PSW program in Ontario include:

1) Moving the role away from the medical model and towards community care.
2) "Professionalizing" the role through a series of regulated minimum standards of training and conduct.
3) Applying a consistent methodology for reimbursing mileage in rural and remote areas.
4) Raising the profile of the role as PSWs need more respect and understanding from the broader public of the challenges of their job.

EDUCATION/TRAINING

More and more Ontarians are expressing the desire to live at home throughout their senior years and to 'age-in-place.' However, there seems to be a lack of understanding regarding the financial and lifestyle implications associated with the homecare option. There is a need to educate Ontarians, well in advance of their senior years about what aging means (increased expenses, insurance, government funding, ease-of-pain and end-of-life care, psychosocial needs, transportation and mobility issues, financial planning, alternative living arrangements, etc). Ontario needs to institute mandatory geriatrics training for care providers. With better geriatrics training for frontline care providers, there will be more trust in others assessments. This will also improve the level of client-based service through more informed referral recommendations to patients. Revised education programs should include seniors who have the lived experience and can inform the process

Patients and frontline care providers should have more central decision making authority, and be empowered to make decisions. This can be partially accomplished by assisting clients, and especially seniors, with navigating the health care system as well as raising awareness and confronting the "uncomfortable" topics like palliative care.

More emphasis needs to be placed on promoting healthy lifestyles among seniors living in rural and remote regions. There are many barriers in place that prevent this including motivation, not having access to recreational facilities; driving at night or in bad weather; and cost. Solutions to overcoming these barriers include funding for online classes, designating community champions, employers providing a means of exercise activity at work, incentive programs and/or transportation subsidies. As well, better use of community resources that are idle or under-utilized like halls and arenas can be made.

IMPROVED COLLABORATION/COORDINATION

Given the expected rise in demand for seniors housing, Ontario needs better integration between health service providers, housing, and community/social service sectors.

The need to coordinate and collaborate effectively among health care organizations is a persistent system requirement. However, each organization has its own mandated jurisdiction and an independent set of accountabilities, which can create gaps affecting the quality and consistency of patient services. In the case of overlapping jurisdictions, there can also be an issue of effort duplication where patients are receiving the same services by different providers.

One way to overcome these issues is to have a central repository for patient records and referrals. With a centralized database, service providers can assess patient history and move towards a proactive regime of service provision.

However, there are barriers to developing a centralized database that include privacy and access issues; technology and compatibility issues, internet infrastructure in rural areas; buy-in among people/organizations resistant to change; and questions about overhead administration.

Given these challenges to creating a centralized repository, there is an increasing recognition that individuals need to own their own integrated health record. This record should not just be a medical record of pre-morbid history, but should also include lifestyle and social data that describe an individual's functionality.

APPENDIX I - ORGANIZATIONS REPRESENTED

NE Local Health Integrated Network
Centre for Rural and Northern Health Research
The Walford Sudbury (retirement home)
Manitoulin-Sudbury District Services Board
Health Sciences North
From Soup to Tomatoes (non-profit fitness for seniors)
Hope Air (charitable non-profit)
Laurentian University
Sudbury Meals on Wheels
Northern Ontario School of Medicine
Sudbury District Health Unit
Massey Clinic
NE Community Care Access Centre
Home Instead Senior Care
Manitoulin Health Centre
North Bay Regional Health Centre
Alzheimer's Society of Sudbury
Volunteer Sudbury
City of Greater Sudbury
Sante Sudbury
Red Cross
Canadian Hearing Society – Sudbury
March of Dimes
Cassellholme (retirement home)