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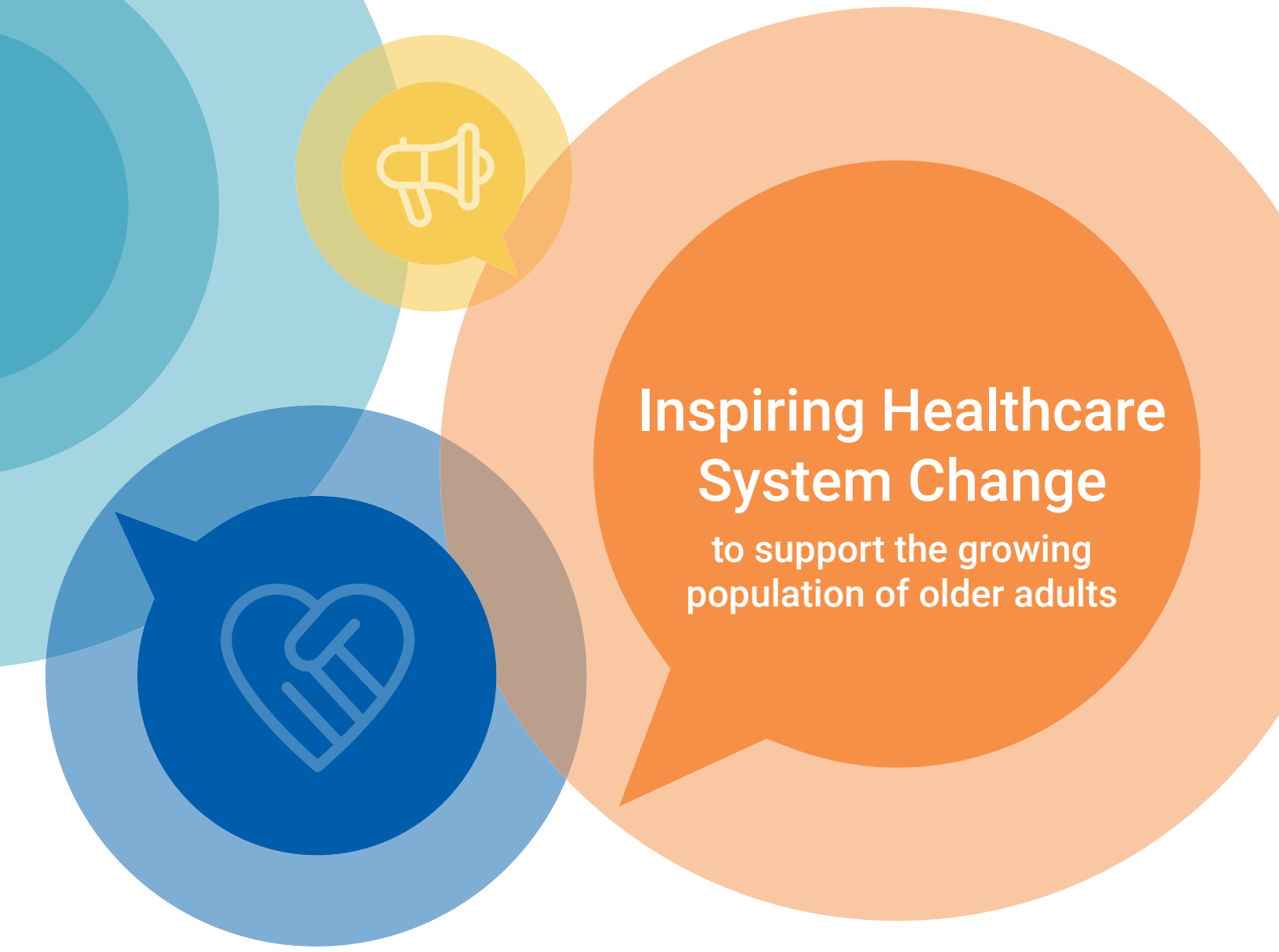

Inspiring Healthcare System Change

to support the growing population of older adults

CCHL National Conversation Executive Summary

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National Conversation Executive Summary

Background on the National Conversation

The CCHL National Conversation is an opportunity for CCHL members and health leaders from across the country to learn more about and contribute to advancing thought leadership on a priority topic facing health leaders with the intention to support effective health leadership within and beyond the CCHL community. We aim to achieve this by gathering our members in an expert-informed dialogue on a specific priority topic facing Canadian health care, collecting thoughts on the leadership skills required to address the topic, and by disseminating a white paper of the National Conversation through networks across Canada.

Topic

How might leaders organize the healthcare system and its resources to care for the aging Canadian population? The focus of the conversations could include the roles of community care, social services, home care, long-term care, family care-giver support, levels of care (primary, secondary, tertiary), as well as the impact of equity, diversity, and inclusion, to explore the changes required and identify the role of health leaders.

Part One: National Virtual Conversation

Part One was a two-hour virtual session including a panel of experts followed by small group discussions with support by the Chapters and sponsor representatives. Small group discussions will focus on health leadership priorities and skill requirements. Perspectives and insights shared during the discussions will be synthesized and will inform a white paper that will inform Part Two.

Panelists

Ron Beleno
Ron is an experienced family caregiver to his late father who lived well with Alzheimer's for over 10+ years while partnering with his senior mother during their journey to help them age at their home and community. He is an advocate in the dementia and aging communities with expertise in technology, aging in place, caregiving, and patient engagement. Ron is the co-chair for AGE-WELL's Older Adults and Caregiver Advisory Committee, which is Canada's aging and technology network where he received their honorary fellows award for 2020. He is an advisor and presenter for groups such as the Alzheimer and Dementia Societies across Canada, an advisor with the Centre for Aging & Brain Health Innovation at Baycrest, a Coach with Healthcare Excellence Canada, a Patient and Family Advisory Member with the Toronto Dementia Research Alliance, a Board Member with the Ontario Strategy in Patient-Oriented Research Unit (a Provincial SPOR) and many more.

Laura Tamblyn-Watts
Laura Tamblyn Watts is the Founder and CEO of CanAge, Canada's national seniors' advocacy organization. Laura is a passionate advocate on a variety of urgent issues affecting older Canadians, including long-term care and home care, financial security, elder abuse, health care, ageism and inclusion of marginalized communities. Laura previously served as Chief Public Policy Officer at the Canadian Association of Retired Persons before establishing CanAge at the onset of the Covid 19 pandemic. Since then, CanAge has emerged as a go-to media commentator and trusted voice for Canadian seniors, underscored by Laura's more than 20 years' experience defending the rights and dignity of older people as a lawyer and thought-leader. She is a member of the CSA National Long-Term Care Standards Advisory and Technical committees, and an expert in long-term care and residents' rights.

Dr. Samir Sinha
Dr. Samir Sinha is a passionate and respected advocate for the needs of older adults. Dr. Sinha currently serves as the Director of Geriatrics at Mount Sinai and the University Health Network Hospitals in Toronto and was recently appointed the Peter and Shelagh Godsoe Chair in Geriatrics at Mount Sinai Hospital. In 2012 he was appointed by the Government of Ontario to serve as the expert lead of Ontario's Seniors Strategy. He is also an Assistant Professor in the Departments of Medicine, Family and Community Medicine, and the Institute of Health Policy, Management and Evaluation at the University of Toronto and an Assistant Professor of Medicine at the Johns Hopkins University School of Medicine.

A Rhodes Scholar, after completing his undergraduate medical studies at the University of Western Ontario, he obtained a Masters in Medical History and a Doctorate in Sociology at the University of Oxford's Institute of Ageing. After returning to pursue postgraduate training in Internal Medicine at the University of Toronto, Dr. Sinha went to the United States where he served as the inaugural Erickson/Reynolds Fellow in Clinical Geriatrics, Education and Leadership at the Johns Hopkins University School of Medicine.

Dr. Sinha's breadth of international training and expertise in health policy and the delivery of services related to the care of the elderly have made him a highly regarded expert in the care of older adults. He has consulted and advised hospitals and health authorities in Britain, Canada, the United States and China on the implementation and administration of unique, integrated and innovative models of geriatric care that reduce disease burden, improve access and capacity and ultimately promote health.

PART ONE

Expert Panel Summary

The panelists were asked to comment on:
What would the Canadian health system look like if it were to care for older adults effectively, efficiently, and properly?

Ron Beleno shared that caregivers are often the storytellers of the health system experiences, describing what it feels like to navigate the system through their lived experience. Mr. Beleno chose to answer the question from an emotional perspective – what we will feel in a health system that cares for older adults effectively, efficiently, and properly - and suggested that we will feel trust, confidence, and hope.

Trust

Trusting the system will change the narrative of health system experiences. Users of the system need to be able trust the system to reduce hesitancy, doubt, and concerns regarding the existing lack of reliability.

There are currently many inequities in the system, and it is essential that change takes place to improve trust that users will be treated fairly regardless of background, skin colour, ethnicity, level of education, gender identity, sexuality, religious affiliation, and/or geographical location.

Confidence

It is essential that patients, families, and caregivers have confidence in the system. Confidence that the system will support them on their health journey and confidence that users will experience effective, efficient, and proper care.

Hope

Creating a system that is effective, efficient, and that properly cares for aging Canadians would create hope for everyone in Canada, no matter who you are, that you will be well cared for as you age.

Laura Tamblyn Watts responded to the question by reflecting on key areas of concern for the members at CanAge .

A health system that is effective, efficient, and that provides proper care for older Canadians would be **age inclusive**. Meaning that the system would make users of the system better and not worse.

While this sounds obvious, Ms. Tamblyn Watts explained that the current system was not designed for chronic illness, long term care, or for people living longer, let alone with frailty. People with a broken leg will leave the system cared for and better off. By contrast, the outcomes for an older adult who has taken a fall are dire. Their chances of getting a hospital acquired illness are profound; their concern for whether they will get adequate pain management is real; the question of whether they will return home or not is valid. Because we have such inadequate home care systems or aging in place supports, they may end up waiting in limbo, in some alternate level of care.

The system would have adequate specialists – in a broad sense. Ms. Tamblyn Watts shared that data from the Canadian Institute for Health Information (CIHI) indicates that Canada had approximately one pediatrician for every 2,100 children and youth, and in the same year, had approximately one geriatrician for every 21,000 seniors. Dr. Samir Sinha shared that the New York Times referred to geriatricians as a rare and endangered species and that there only about 350 in Canada. The data also showed that this number is going down, not up, because geriatricians are retiring and are not being replaced. The system needs the right number of specialists which also includes all registered health professions, personal support workers and health care aides, neurologists, people working in dementia care and so on.

The system would also be anti-ageist. For example, medications and prescriptions need to be routinely reviewed for older adults and ensure that we are including older people in health studies.

Dr. Sinha believes we need to organize the system according to the needs of an aging population by **increasing funding to home care,** and that we have not right sized the system to provide the right care in the right place at the right time. The best example of this is alternate level of care (ALC) numbers at the height of the pandemic, in which one in four hospital beds in Ontario were being used by someone waiting to go somewhere else for their care. Most of those were to go to their own homes with home and community care or a rehabilitation setting.

Another system improvement includes appropriate and **mandatory geriatric health care provider education**. Many medical schools in Canada do not require geriatrics as a core part of the training, it will become mandatory at the University of Toronto as of 2025. The Canadian population has been aging for a long time, and yet not all doctors, nurses, and other health professionals have expertise in providing geriatric care for older people. The health care provider needs to have the knowledge about what is important for older people and their families, and to be age inclusive.

We need to think about our older patients and caregivers as partners in care. In geriatrics, we now are leading with the idea of 4 M's of age-friendly care (what Matters, Medication, Mentation, and Mobility), that starts with asking older adults and their caregivers what matters most to them. Age friendly care is about recognizing that caregivers are essential partners in care. The value of caregivers was highlighted during the pandemic when they were shut out of long-term care and hospital settings, and it became obvious the amount of care actually provided by caregivers that was not necessarily acknowledged.

The second question asked the panelists to explore *short-, medium-, and long-term actions on how to achieve the changes needed in the health system to achieve the priorities listed in the responses to the first question.*

Short-term actions

Shared Decision Making

Two panelists identified **shared decision making** as a quick and easy action for health care leaders and professionals to prioritize. Health leaders cannot assume that older adults do or do not want certain types of treatment, nor assume that they do or do not want lifestyle parameters imposed upon them. Health leaders need to ask older people what they want and provide clear scenarios to inform the decision making.

Wage Parity for Health Care Professionals

Another short-term action that would provide stability to the system is **wage parity for health care professionals**. Part of the health human resource shortage in social and community services is due to the movement of professionals into higher paying roles in acute care. Australia, New Zealand, and other European systems have been working towards creating wage parity. Care, such as ALC, is happening in the hospitals because there are more professionals with the highest salaries. Parity in pay would influence the distribution of health professionals across the system so that the right care can be provided in the right place.

Appropriate Medical Screening

Screening older adults in an unbiased way and not in a way in which assumptions are being made about quality of life and models of care. For example, sexually transmitted diseases and infections are skyrocketing in older populations, particularly in those that are widowed or divorced, however appropriate screening for this population may not be prioritized. Health professionals need to ensure that sexual assault and consent is also part of the screening conversations.

The health system does not test mental capacity until something has gone wrong, so completing evidence-based and appropriate mental capacity baseline tests should be implemented, which would also contribute to de-stigmatization.

Prioritize Caregivers

A required leadership action is to agree that **caregiving is the next frontier for Canadian public policy**. Almost everyone is, will be, or will need a caregiver. Caregivers are in the community and in the workplace. Caregivers should be supported with policy changes that do not necessarily mean more money, but with flexibility and creative solutions. One solution is the provision of evidence-based toolkits that, for example, support caregivers in knowing what questions to ask and how to navigate the system. This empowers caregivers and provides them with tools to move forward with confidence.

Medium-Term Actions

Increased Funding for Home and Long-Term Care

With immediate **increased spending on long-term care and home care**, Canada will directly experience significant improvements on alternative levels of care numbers and a reduction of people being prematurely institutionalized. There are currently too many people waiting in the wrong location and unable to get to the right location. Canada spends a lower proportion of their health care budget compared to other OECD (Organization for Economic Co-operation and Development) nations on long-term care and home care.
There was an experiment in Ontario beginning in 2011-2012 in which home and community care spending increased annually by five percent. The increased spending allowed those eligible for long-term care to be supported in their homes instead of in long-term care institutions. There are currently around 121 000 older adults who are eligible for long-term care in Ontario being cared for in their homes versus 79,000 at the onset of the increased spending. The cost to care for those in their homes is $1.4 billion versus $6.4 billion that would be spent to care for them in long-term care.

The current system of health and housing does not make sense. Ninety-five percent of older people in Canada will never live in a congregate environment, whether that be a retirement home and/or long-term care. Federal health transfers for seniors' care should not be in competition with acute care as both types of care are essential. We need to rethink what it means to age in place and how the health system can support it because people want it, and it is affordable.

Technology

A focus to **improve access to and use of technology** in the caregiving community to help with day-to-day activities would influence system change. Organizations such as AgeWell, Canada's technology and aging network, support older Canadians and their independence.

Mandatory Geriatric Education Including Mental Capacity Assessment and Culturally Appropriate Care

Mandatory geriatric education in our health professional curriculum is essential. The education of health professionals needs to ensure that graduates have the knowledge and skills they need to know how to approach care for older adults and include caregivers, not miss diagnoses, and to provide the right care, in the right place, at the right time.

Mental capacity is the number one thing we worry about as we age and most people who have had dementia in their family are afraid of it for themselves. Mandatory geriatric education needs to also include consent and capacity assessment protocols.

We are increasingly aware of the health disparities that occur between different members of our population. People who are Indigenous, people of colour, members of the LGBTQ2+ community, and new Canadians sometimes receive different levels of care. Mechanisms need to be put in place to ensure that health professionals have the skills they need to provide **culturally safe and appropriate care**.

Long-Term Actions

Outcome Focus

A shift in system priorities initiating the redistribution of resources focussed on outcomes is needed. Outcomes include promoting health, maintaining independence, and aging at home. The current system focusses on and rewards medical tasks, for example, how many hip replacement surgeries have been completed. The shift to prioritizing outcomes has begun slowly in Ontario with the introduction of Ontario Health Teams as a mechanism to get everyone working together, but the funding mechanisms are not yet being adjusted.

Creating more integrated care requires a paradigm shift that includes more integrated leadership in which all services are organized in a system as opposed to separate silos that try to collaborate.

This thinking is not new; however, inertia does not allow us to move forward and figure out how to move the barriers preventing shifts to prioritize the right care, in the right place, as the right time. Instead, we continue to see the quality outcomes of our system slip. Compared to other health systems in the world, Canada is not keeping up on the right policies and other innovations to be comparable and achieve good outcomes for our older adults.

Panel Dialogue

The panelists were then asked *what health leaders might do to influence policy change*.

Organizational Innovation

Dr. Sinha spoke about the significant amount of influence health leaders have within their locus of control. When an organization strategically prioritizes integrated care within the community, health leaders then have permission and a mandate to initiate conversations and change, despite lagging provincial and federal policies.

Leaders, as they initiate innovative change, must measure, and monitor the outcomes to indicate either a change in course if needed or the required evidence to support and influence investment, policy change, and/or replication in other communities.

Patient and Caregiving Leadership

With the movement towards patient inclusion over the past few years, Mr. Beleno spoke to the increase of co-designing of models of care and that there are leaders within the patient and care-giving space who can be at the table, not only to tell their stories but to influence innovative models of care that may influence policy change.

Ageism within Equity, Diversity, and Inclusion Priorities

Mobilizing ageism to be included in all equity, diversity, and inclusion conversations is a simple action for health leaders to take to improve the services provided to older Canadians. Ms. Tamblyn Watts shared that the World Health Organization and the United Nations identify ageism as the single most prevalent form of discrimination in the world. Statistics Canada found that 56% of Canadians are profoundly ageist. Studies have been completed on ageist attitudes as individuals enter and leave health professional education programs such as medical, nursing, social work, and others. The studies found that people are somewhat ageist as they enter the education system, and even more ageist upon graduation. This would be unconscionable if it were other types of discrimination.

In addition to ageism, Ms. Tamblyn Watts encouraged health leaders to activate around aging and intersectionality. She shared the example that the average age of death for the non-Indigenous population is around 83 or 84. However the average age of death in Indigenous communities in Canada is 63. When you consider that the definition of older Canadians is anyone over the age of 65, the geriatric system is missing an entire population.

This is even more profound when you add that older adulthood is considered 45-50 for the rough and unhoused, 50 for those incarcerated, and 50 for those with developmental disabilities. There are new populations of older adults that have never accessed geriatric health services before, such as those with gender confirmation surgery or those with rare diseases who are now living longer. Health leaders are encouraged to think of age and ageism within the context of equity, diversity, and inclusion as well as through the lens of intersectionality.

A question from the audience asked the panelists *the impact of the changing cultural landscape in Canada on the impact of aging.*

The audience was reminded that if someone comes to Canada within ten years of becoming an older adult, they are ineligible for the basic pensions (Canadian Pension Plan and Old Age Security) and may also not be able to access health care or might be tethered to an abusive sponsor.

Health leaders need to consider culturally accessible care to be more than services available in a variety of languages. Health professionals need to deeply embed and understand cultural differences and priorities, and challenge assumptions that we know what people want. It is probable that the existing programming makes the system, and those working in it, ageist.

Dr. Sinha questioned how the system acknowledges LGQBT+ older adults. This population experiences new and unknown people entering their personal space after a lifetime of safe living, to provide care. There may be cultural and attitudinal mismatches and a safe space is no longer guaranteed. Some may go back into the closet in long-term care for these reasons. Other older patients who are holocaust or residential school survivors may develop dementia, and as they live with dementia their older memories may resurface and they may begin reliving these traumatic and unfathomable experiences. The health system needs to be prepared to properly care for these older adults.

Mr. Beleno closed the panel by stating that patient and caregivers are cheering for health leaders to lead the change and bring the required action to make the system better for everyone.

Leadership Actions

The second half of Part One asked participants, all of whom were CCHL members, to respond to specific questions on the role of health leaders in aligning actions to better serve older Canadians.

Question 1: What can health leaders do in the short term to improve the health system for older adults?

Lead Self

- Reflect on your own biases on aging.
- Adopt an age-positive philosophy and approach.
- Become a champion and partner for change in support of older people and the caregiving journey.
- Recover from pandemic burnout.
- Build capabilities for effective communication with older adults and caregivers.

Engage Others

- Encourage and facilitate reflection and planning to overcome systemic inertia.
- Recruit champions.
- Establish shared decision-making processes.
- Develop skill-support structures and know the staff, families, and caregivers to align and ensure appropriate care.
- Develop different ways to share knowledge with clinicians due to time constraints.
- Seek feedback to learn from patients and families.

Achieve Result

- Identify evidence-based assessment tools to share between sectors, versus developing new ones.
- Eliminate age/ageist statements in resource material and elsewhere.
- Implement appropriate assessment protocols (baseline, screening, and so on).
- Speak up on the inequalities of resources/fundings/policy in care for older adults.
- Provide better supports directly in the community.
- Guarantee hours for staff to keep them.
- Ensure succession planning for leaders engaged in senior care.

Develop Coalitions

- Work collaboratively for safe transitions (hospital to home, home to LTC, and so on).
- Identify what is and is not working within your own system before comparing to others.

Systems Transformation

- Influence the inclusion of age-positive strategic actions within organizational strategic planning.
- Incentivize home care and support caregivers/families.
- Support those that choose to not use traditional hospital-based services.

Question 2: What can health leaders do in the medium term to improve the health system for older adults?

Lead Self

- Sustain self confidence in leadership; own your leadership role

Engage Others

- Develop skills of teams to understand the needs/wants of older people and their aging preferences.
- Require cultural awareness/sensitivity training.
- Require competency assessment training.
- Require dementia-care training.
- Empower front line health professionals to provide person-focused care.

Achieve Result

- Introduce the use technology to prepare for visits and for system navigation to promote self-care.
- Develop recruitment and retention strategies for health human resources.
- Address capacity issues by examining accessibility and system planning.
- Re-allocate funding.
- Enable leaders at all levels to influence change.
- Identify approaches to care and well-being instead of reactive methods and systems of care (e.g., paramedical services for well-being and maintenance of health)
- Communicate a clear shared vision.
- Use social media and engaging graphics to showcase research.

Develop Coalitions

- Fund community- and home-based programs.
- Influence integrated dialogue within your locus of control.
- Co-design models of care through engagement with patient/family networks, embed in policy.
- Track outcomes of care-sharing.
- Find out what is working in Canada.
- Apply lessons from countries with better outcomes (i.e., Nordic countries).

Systems Transformation

- Advocate for practice standards with educational institutions and regulatory bodies regarding aging and sub-population intersections.
- Advocate for the elimination of the need for older adults to pay for fees not covered by provincial programs.
- Advocate for a shift towards mandatory geriatric education for medical students, nursing, and regulated health professions.
- Make those with developmental disabilities eligible for geriatric services.
- Advocate for wage parity across all sectors, including long-term care.
- Hold a national conversation about funding and decision making.
- Empower leaders at all levels to influence change within their locus of control.
- Advocate and enable, if within your locus of control, the expansion of community paramedicine services.
- Customize the system to be flexible and reflect the needs of the diverse and ever-changing needs of clients.

Question 3: What can health leaders do now to influence long-term improvement in the health system for older adults?

Lead Self

- Influence!
- Challenge the status quo and lead change.
- Learn about the required transformation.

Engage Others

- Engage with policy makers, end users, and clinicians.
- Address the biases that are entrenched in various levels of care.
- Develop processes to understand the changing needs and preferences of older adults.
- Maintain lines of communication and team work to enable change.

Achieve Result

- Establish case costing to determine the most efficient care models (i.e., home care vs institution)
- Work to change the narrative and metrics to ensure that the system is focused on the short/medium/long terms.
- Encourage a system that promotes and integrates healthy aging and illness prevention.
- Initiate a realistic resource plan for housing in rural and remote communities.
- Build succession planning for initiatives.
- Advocate for improved technological capability to enable better connectivity across the country.

Develop Coalitions

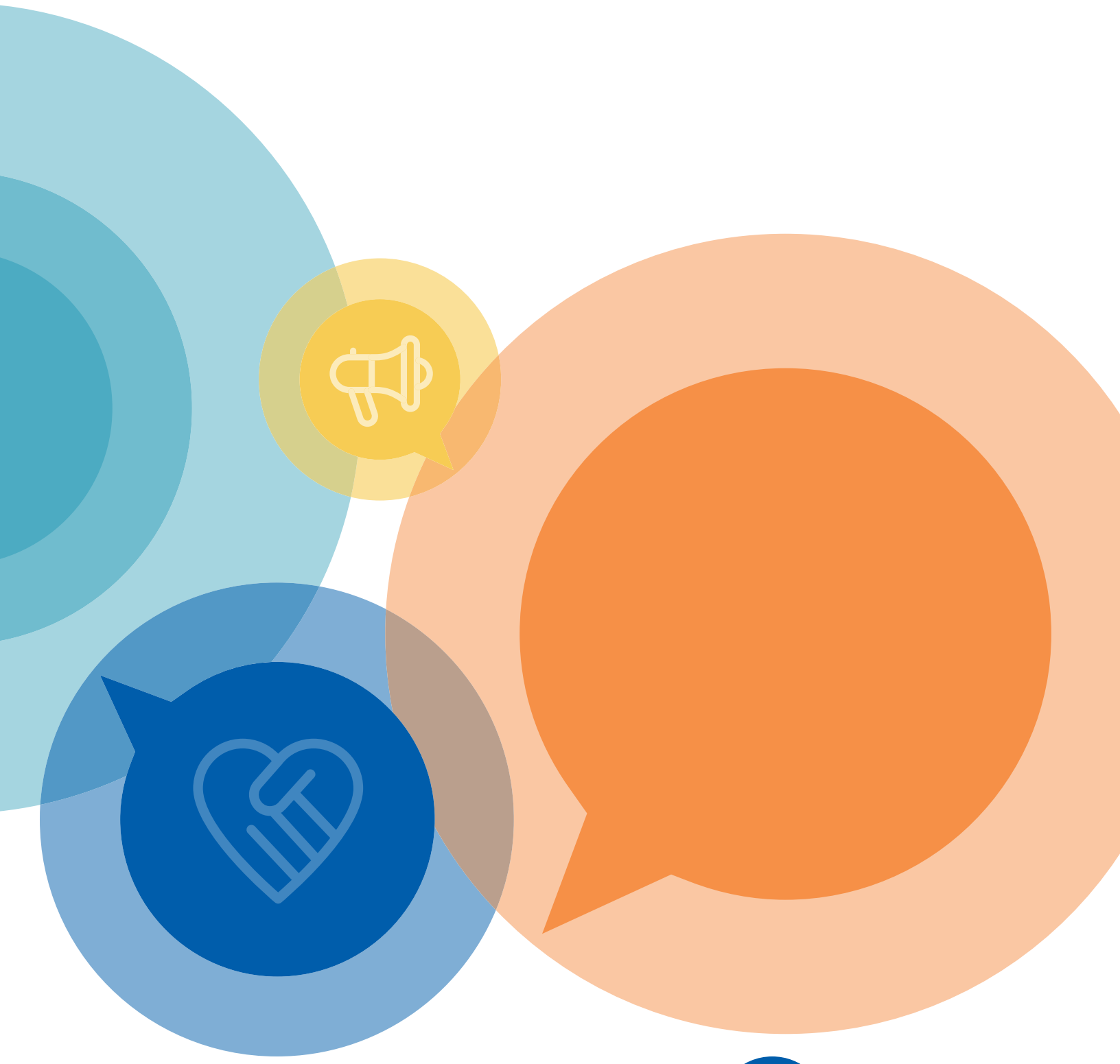
- Work with policy makers to overcome biases in policies that influence practice.
- Collaborate, share ideas, resources, tools, and methodology.
- Break down the health care silos that exist along the aging continuum.
- Promote cross-collaborative training enabling clinicians to work in a variety of settings.
- Participate in national workforce planning.

Systems Transformation

- Link organizational key performance indicators to outcomes and accreditation standards.
- Encourage funding policies to reflect the variety of aging experiences across demographics.
- Strategize to set an aligned vision and address funding and system-focus inequities.
- Identify multi-system changes that influence the social determinants of health.
- Study the impact of ageism and its' impact on the health journey.

Question 4: The last question asked participants to identify way in which the College may maintain momentum and contribute to sustainable change.

- Continue with national dialogues to promote aligned vision and collaboration.
- Create regional coalitions and discussion forums.
- Provide a platform for collaboration and dialogue (the Circle).
- Provide training and learning opportunities.
- Provide information to challenge assumptions and presumptions.
- Provide tools and information to support health leaders in influencing system change.
- Collect and share data on system improvements and lessons learned.
- Advocate for the health leadership voice that crosses federal and provincial jurisdictions.
- Recognize that meaningful change is a marathon, not a sprint.
- Set the vision.
- Develop partners across sectors and ministries.
- Lead a study tour of age friendly health and social care.



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