Aging in place: System planning done differently – Beyond LTC beds

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LAND ACKNOWLEDGEMENT

Session outline

Why Aging in Place?

Explore Aging in Place Promising Practices

Present an Aging in Place Success Story in New Brunswick

Test a Common Measurement framework for Integrated Health and Social Innovations

2021-26 Strategy

OUR PURPOSE

To shape a future where everyone in Canada has safe and high-quality healthcare.

OUR HOW

Working with people across the country, we:

- Find and promote innovators and innovations
- Drive rapid adoption & spread of quality and safety innovations
- Build capabilities to enable excellence in healthcare
- Catalyze policy change

OUR FOCUS

- Care of older adults with health and social needs
- Care closer to home and community with safe transitions
- Health workforce retention and support

QUALITY & SAFETY PERSPECTIVES

- Lived experience of patients, caregivers and communities
- People in the workforce
- Value
- Culturally safe and equitable care
- First Nations, Inuit and Métis priorities

OUR VALUES

- Partner meaningfully
- Innovate courageously
- Act with integrity
- Be inclusive

Healthcare Excellence Canada

We work with diverse partners to shape the future of quality and safety and build a better healthcare system. **Together**. Because we believe everyone across the country deserves excellent healthcare.

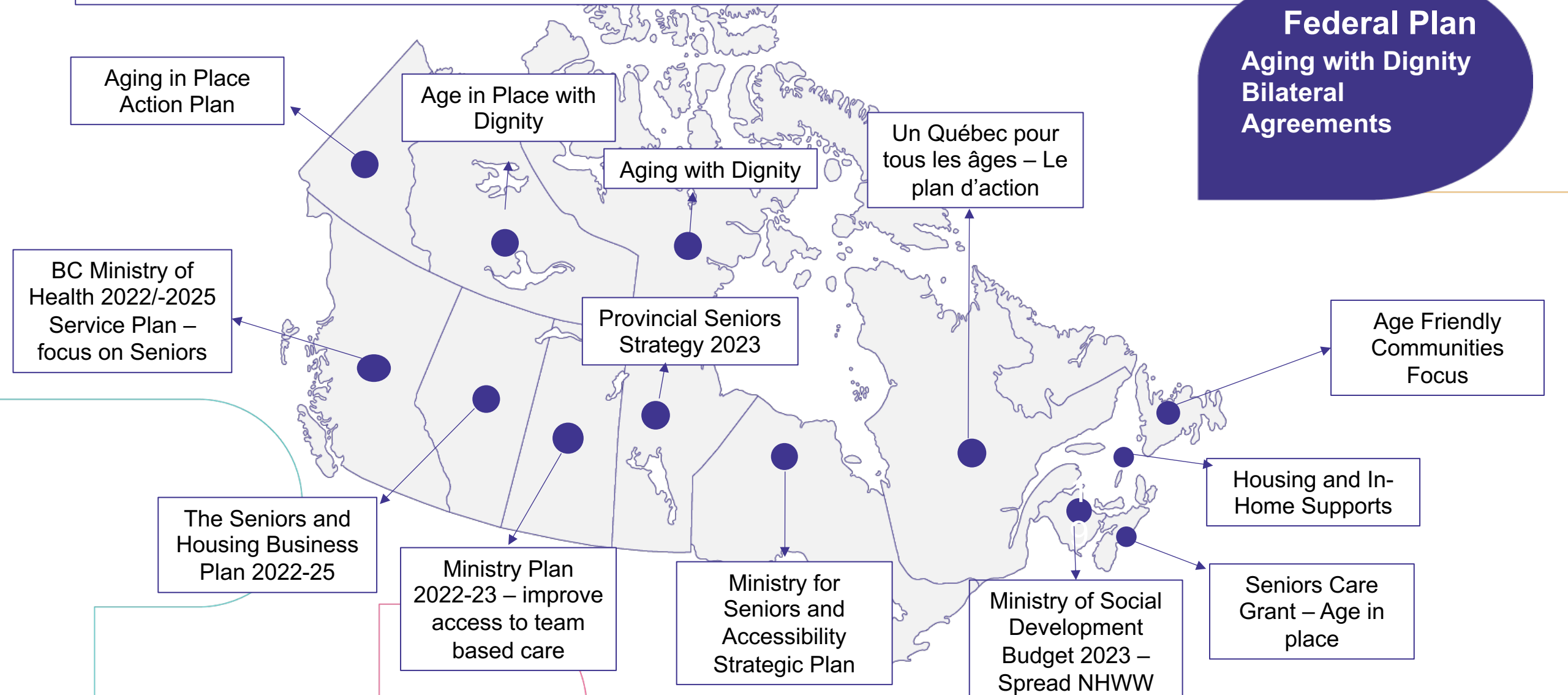
Why Aging in Place

The Need to Support Shift Towards Aging in Place

- Shifting demographics and an increasingly older population who live with two or more chronic conditions
- Recognition that health is determined by many factors including the social and structural déterminants of health
- Promoting healthy aging can have a significant impact on health outcomes and health systems costs
- Integrating health and social services to address complex needs help health system issues (such as ED visits, utilization)

Source: CIHR Institute of Aging Strategic Plan 2023-2028 Reframing Aging – Empowering Older Adults (cihr-irsc.gc.ca)

Provincial/Territorial/Federal Action Plans



Aging with Dignity: A shared Federal/Provincial/Territorial Priority

F/P/T agreements to support “aging with dignity” close to home

Improve access to home and community care and support safe clong-term care

Common Emerging Themes

Aging with Dignity agreements provides support to improve access to home care, community care or care in a safe long-term care facility for seniors today and tomorrow.

Home and Community care

Expansion of home and community care services to meet the needs of older adults .

Long-Term Care

Strengthen the quality and safety of long-term care through different levers including standards, and oversight.

Health Human Resources

Increase staffing and strengthen workforce stability to respond to growing needs and complexity of care.

Palliative Care

Enhance end-of-life care for clients and their families and support additional training for health workers in end-of life-care.

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What does Aging in Place mean to you?

ⓘ Start presenting to display the poll results on this slide.

What we know about aging in place

- Most Canadians (96%) want to age where they call home, in the community
- Promoting healthy aging can have a significant impact on health outcomes and health systems costs
- Limited capacity to meet the growing demand for long-term care.
- One in 10 people who enter long term care could have been cared for at home with formal support
- Primary drivers
  - Challenges with health system navigation
  - Financial barriers
  - Responsiveness
  - Access to specialized services
- Northern, rural and remote communities tend to have fewer formal supports available

Primary drivers for early entry into LTC

Caregiver Factors

"Not having access to appropriate resources leaves me distressed and burned out as I am trying to fill the gaps"

Assessment in Hospital

"I applied for home care services but was admitted to hospital before being assessed. They said that my only option was to move to LTC as I became too frail and malnourished"

Out of Pocket Expenses

"I could not afford to pay privately for the extra support I required. My only option was to move to LTC"

Lack of Access to Appropriate Home Care

"I receive home care services but some of my needs are not met because they do not give me the choices of the services they provide me"

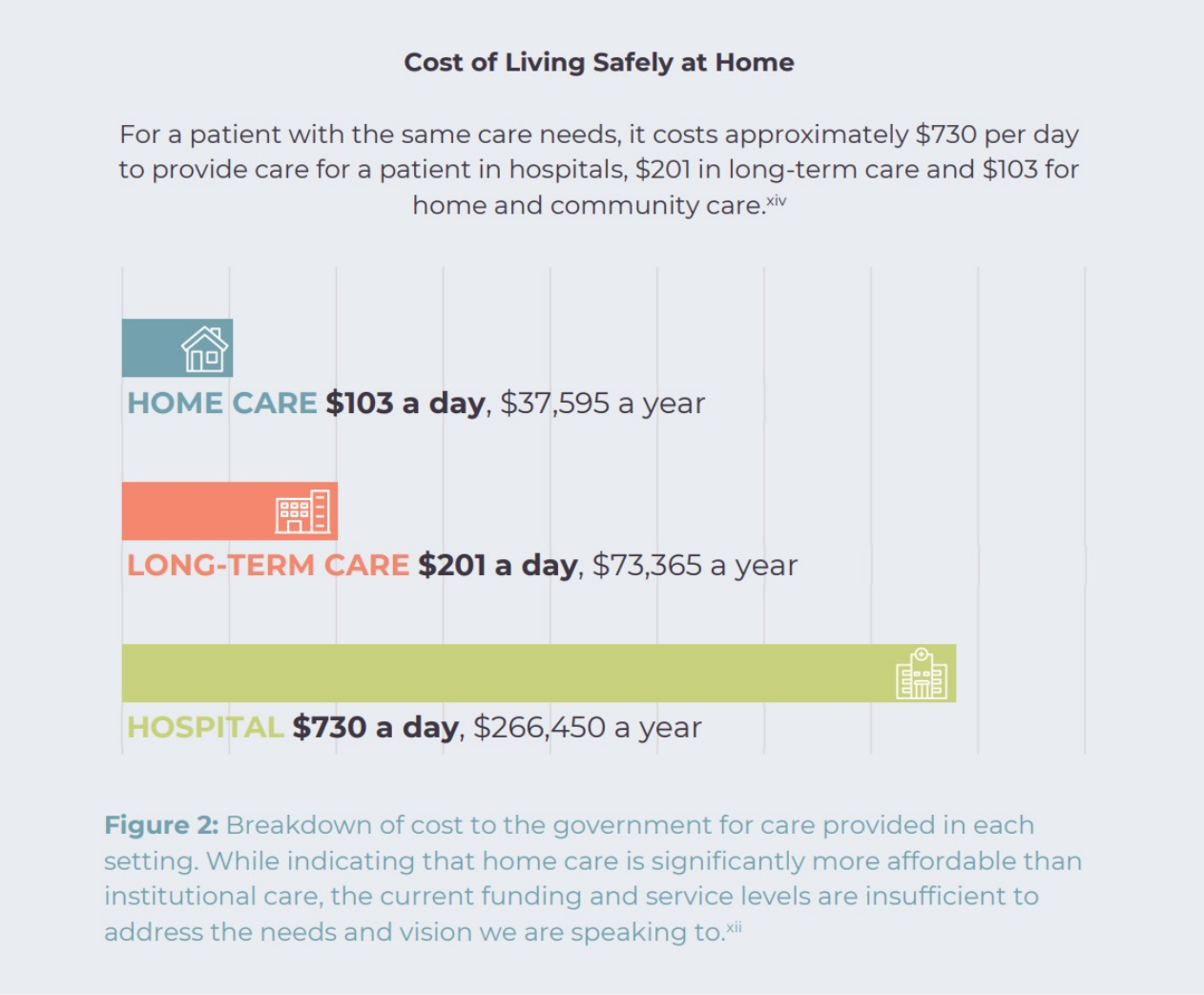
Lack of Support for Clinical Issues

"I need help with mobility and I get confused with my medication. They told me that I required too much support and could not live at home anymore"

Lack of Access to Specialized Services

"After my fall incident, I was unable to return home as I would have required the services of a rehab team that were not accessible in home care"

Value of Providing Care in Community



Source : How to Bring Health Home and Stabilize Ontario's Health Care System, 2022.
How to bring health home & stabilize Ontario's health care system.pdf (SE Health)

Impacts of Providing Care in the Community

Initial Outcomes

- Self-efficacy
- Collective efficacy
- Sense of Community
- Greater social support and reduced isolation
- Greater access to supports

Intermediate Outcomes

- Individual benefits such as better physical health and psychosocial wellbeing
- Community benefits such as increased connections between partners and community

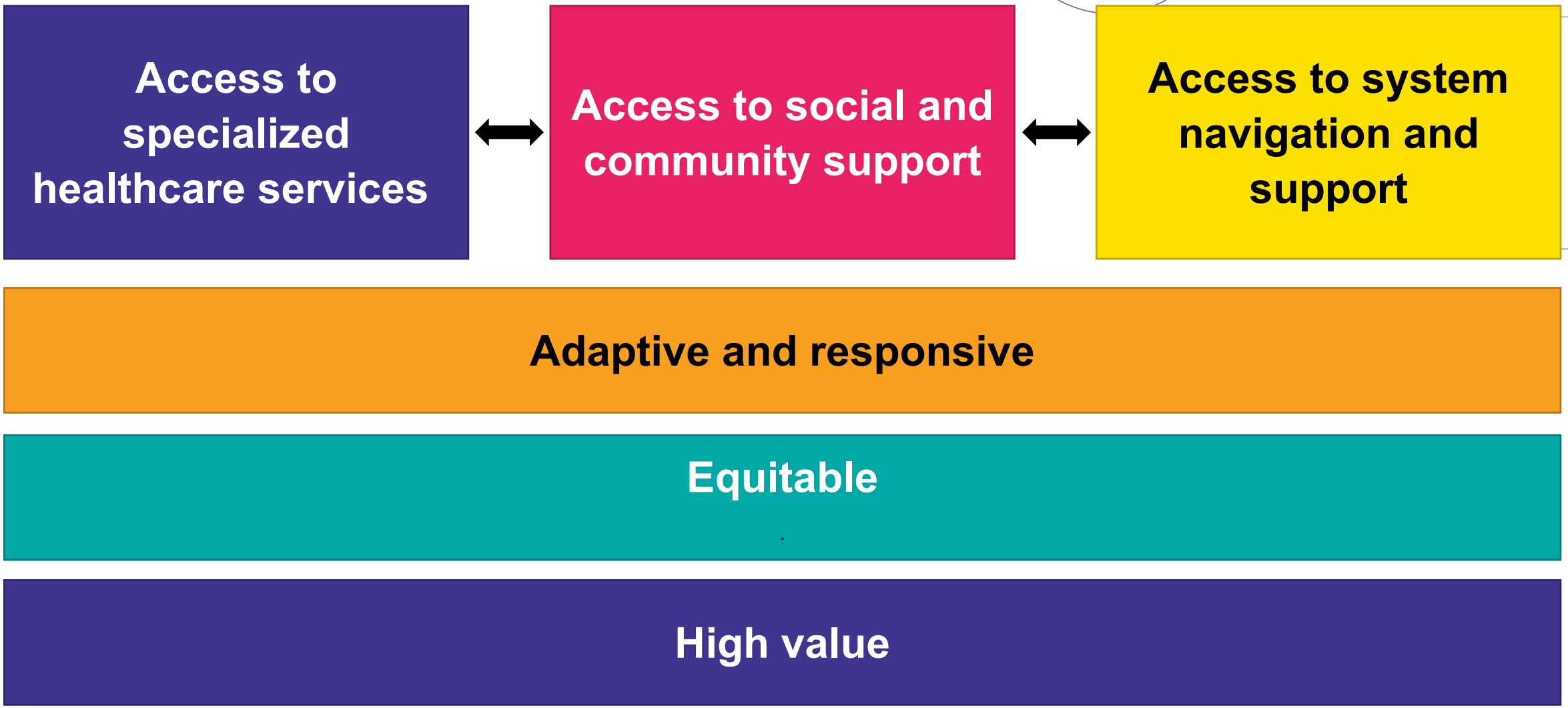
Aging in Place

- Appropriateness of entry to LTC
- Emergency department use
- Hospitalizations

Outcomes

- Death at home or in Community*
- Home Care Services Helped The Recipient Stay at Home *
- Caregiver Distress

Aging in Place Principles



Promising Practices

Long-term care

Nursing Home Without Walls

Paramedicine

CP@Clinic

Renfrew County Community Paramedicine

Social and private housing

Ottawa West Aging in Place

Toronto Integrated Service Model

NORCs/Oasis

Health Authorities

Burlington OHT Community Wellness Hub

Primary care

Home ViVE

Community

Social Prescribing

Compassionate Communities

CARES Model

CP@clinic

Access to specialized healthcare services

The CP@clinic program completes health assessments and connects older adults with necessary health services and community resources to enable older adults to manage health conditions and promote overall health

Access to social and community support

The CP@clinic program reduces social isolation by offering services in communal settings, providing opportunities to connect and interact with peers and increasing self-efficacy and resiliency through education and health-management strategies.

Access to system navigation and support

The CP@clinic program supports system navigation by providing information, direction and referrals to community resources and health services. If appropriate, older adults are supported with direct referral services.

Adaptive and responsive

The CP@home program is an adaptation available to older adults who cannot attend a CP@clinic session in communal spaces or where communal spaces are unavailable within the housing unit. The support offered by paramedics is responsive to individual health-assessment results and the available evidence and resources in their community.

Equitable

The CP@clinic program is provided for low-income older adults living in community housing. It provides enhanced access to preventative health services that are proportionate to the level of need among older adults living in social housing.

High value

An economic evaluation estimated that for every $1.00 spent on the CP@clinic program, the emergency care system sees $2.00 in benefits while demonstrating improved quality of life for older adults living in social housing. This means that emergency care resources, which are limited, can be reallocated and older adults are able to access the care they need.

CP@Clinic Impact and Outcomes

911 calls

On average, the number of monthly ambulance calls was lowered by 19– 25 percent in buildings with CP@clinic compared to buildings without the program.

ED visits

Initial findings from a RCT suggests a cost benefit to implementing the CP@clinic program. It is estimated that for every $1.00 spent on the CP@clinic program, the emergency care system sees $2.00 in benefits

Quality of life

CP@clinic program has improved participants' quality-adjusted life years (QALY) leading to improved coping skills and increased resiliency among participants.

Staff experience

Paramedic staff find their role fulfilling because they can use their skills to help vulnerable populations in ways other than responding to emergency calls

Social Prescribing

Access to specialized healthcare services

The Seniors' Community Connector links older adults and caregivers to providers from community health and social service agencies to enable them to manage health conditions and promote overall health and well-being

Access to social and community support

A comprehensive assessment identifies the needs based on health concerns in order to connect them to social support resources alongside specialized services for specific non-medical health needs.

Access to system navigation and support

The Seniors' Community Connector facilitates access to community services and resources by providing transportation, accompaniment, language and culturally appropriate support

Adaptive and responsive

. A comprehensive assessment helps uncover the social and community support needs that are the root cause of an older adult's health concerns. Wellness plans are tailored to an older adult's unique needs and preferences and are modified as their capacities evolve and change

Equitable

The Social Prescribing Program provides a pathway for healthcare providers to address the social determinants of health that affect aging in place. It is free for all older adults, and referrals and support are proportionate to the level of need of the older adults who are referred to the program..

High value

The Social Prescribing Program efficiently uses system resources by capitalizing on the resources available in local communities to support the non-medical health needs of older adults..

Social Prescribing Impacts and Outcomes

Community connectors links older adults and caregivers to community health and social services

Provides social health initiatives to counter social isolation and loneliness to older adults and their caregivers

Social Prescribing Programs optimize resources used on health and social services relative to outcomes that matter to older adults and care partners over the course of their care journey.

Empowers the local community to respond to the needs of an aging population and increases knowledge on health-related issues important to aging in place and healthy aging for older adults and their caregivers

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What are the most pressing issues that are preventing you from thinking differently about health system planning in support of aging in place?

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Group Discussion

Context: All provinces and territories have strategies focused on supporting older adults, ability to age in place, with dignity and this resonates with most Canadians.

Discussion Questions

1. Identify your most pressing issues (e.g HHR, data, evidence, policy, funding models etc) to enable older adults to live at home with care that meets their level of health and social needs.
2. Discuss your needs with respect to these issues to support a shift in how you plan services to support older adults to age in place.

New Brunswick Experience: The spread of Nursing Home Without Walls (NHWW)

From Pilot Project to Provincial Program...

Nursing Home Without Walls (NHWW) programs are hosted by nursing homes to support older adults living in the community by leveraging existing nursing home resources

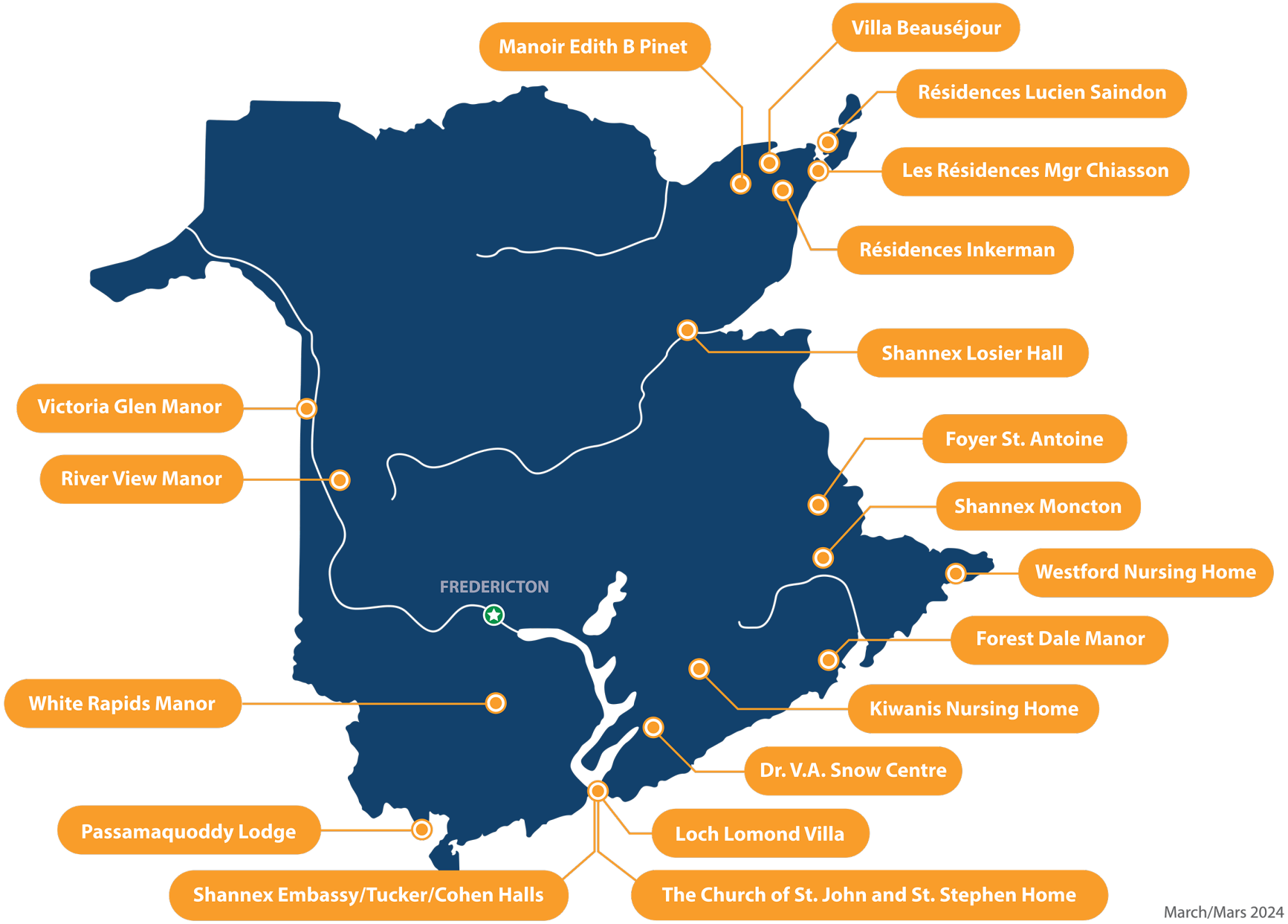
(e.g., physical resources, relationships with communication organizations, knowledge of community and aging)

Goals of a NHWW program

- Improve access to supports and services to age in place
- Offer social health initiatives to counter social isolation and loneliness
- Increase knowledge on healthy aging
- Encourage local communities to become Age Friendly Communities

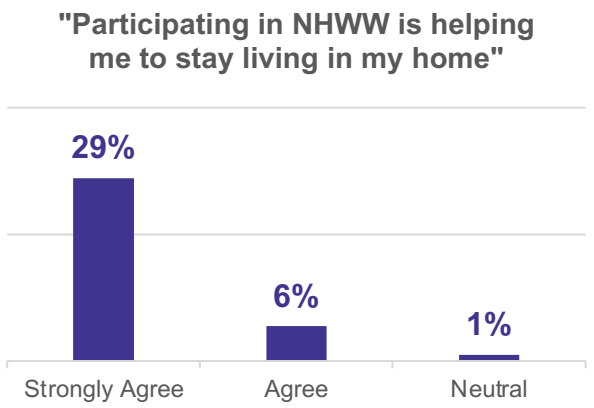
What can NHWW supports look like?

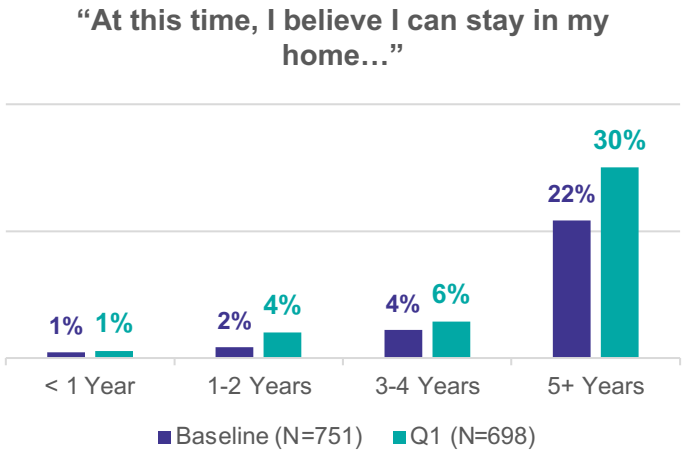
Nursing Home Without Walls Locations

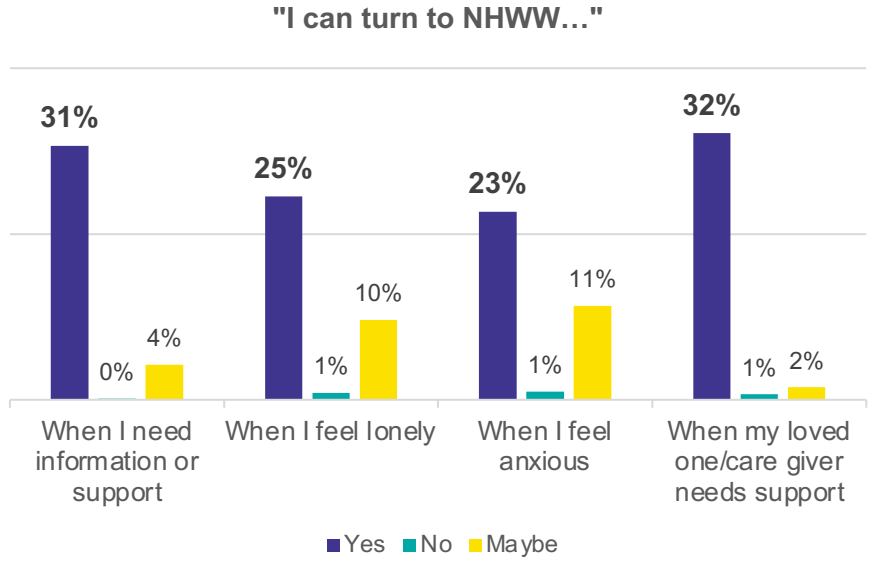


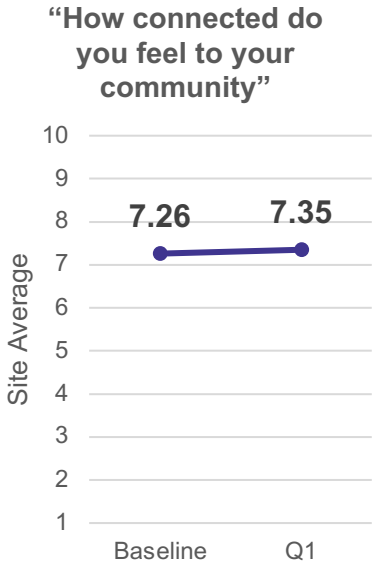
March/Mars 2024

NHWW Outcomes









"NHWW is one of the best new projects... I am extremely fortunate to be a part of this program. They have helped me in so many ways! I encourage anyone over the age of 60 to apply. You will not be disappointed!"

The client has stated many times that without [NHWW], she would have ended up having to sell her home and move into the Nursing Home.

NHWW provided him with transportation to the appointment. His doctor sent him directly to Moncton where he ended up having four stents put in. Because of this intervention he did not have a heart attack or worse.

“This program...has been a god sent to me, it has allowed me to get to and from my medical appointments without any stress at all! Knowing I will arrive on time for these has not only reduced my stress levels but has me looking forward to getting the care I so desperately need. I cannot say any more amazing things about NHWW, I am grateful to be a part of this!”

Nursing Home Without Walls

Access to specialized healthcare services

NHWW programs support non-medical needs such as instrumental activities of daily living. NHWW programs also help facilitate access to medical care such as through transportation to medical appointments.

Access to social and community support

NHWW programs provide social and community support for clients through friendly visits, phone calls, community outings, meal programs, etc

Access to system navigation and support

NHWW navigators support system navigation and provide accompaniment to older adults and their care partners.

Adaptive and responsive

NHWW navigators support clients in determining their personal needs and support them to access the appropriate services based on there needs.

Equitable

NHWW programs have been delivered in rural and remote communities, in areas that are traditionally underserved by other community supports.

High value

NHWW programs promote efficient resource utilization by supporting clients to access existing services in the community as well as responding to unmet needs with additional services.

NHWW Impact and Outcomes

Ensures that older adults and their families have access to appropriate services and information related to aging in place

Provides social health initiatives to counter social isolation and loneliness to older adults and their caregivers

Prevents some non-urgent visits to the emergency department or medical after-hours clinics. For example, the preliminary results indicate that 33.5 percent of NHWW participants said the program helped prevent them from having to access these medical visits and suggests that 219 visits were prevented

Empowers the local community to respond to the needs of an aging population and increases knowledge on health-related issues important to aging in place and healthy aging for older adults and their caregivers

Discussion

Context: Planning assumptions about how to organize, fund, deliver and evaluate care shape our models of care and data we collect/report.

Thinking about current & future health and social needs of older adults with complex conditions, the potential of promising practices to help older adults age in place, and commitments from all levels of government to support aging in place….

Discussion Question:

1. What can health system planning look like in the future; beyond LTC beds – to support aging in place and appropriate entry into LTC as part of a continuum of integrated health and social care as we get older?
    1. What can be done immediately?
    2. What is working well that can be strengthened?
    3. What are the examples of this future state that are already happening?

Health and Social System Impacts

What we know…

1 in 10 people who enter long-term care could have potentially been cared for at home with formal support (CIHI). The primary drivers for this outcome are:

- Challenges with health system navigation
- Financial barriers
- Responsiveness
- Access to specialized services

e.g., reliability of staff, consistency of staff, flexibility of services, respite services for care partners

e.g., social and emotional support, on-call support, language and cultural services, help with non-medical needs

Additionally, **northern, rural and remote communities tend to have fewer formal supports available** to support older adults living in the community compared to their urban-dwelling counterparts.

Aging in Place Impacts on Key Health System Metrics

- Delayed entry to LTC
- Reduction in unnecessary ED visits
- Improvement of quality of life including decreased social isolation
- Improvement in health and social service access and utilization
- Improvement in staff ability to make improvements in how they do their job
- Decreased care partner burden

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What else should we be measuring in terms of impacts?

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Measuring Impact

The Opportunity : How to measure and evaluate social innovations in health with a view to changing systems and ensuring sustainability

The Idea : Development of a **Common Measurement Framework**

- Focus on the community health perspective
- Grounded in *outcomes* based on the quintuple aim
- Leverages what is feasible to measure and what is already being collected to include indicators that matter
- Target audience includes decision makers, funders, boards and leaders across the health and social systems

Framework Goals

The proposed framework would capture four goals under four domains.

The focus would be on creating healthier people and systems.

Healthier People

Include health promotion (empowerment) principles for people and communities

Healthier Public Systems

Quality improvement needs for health and social systems.

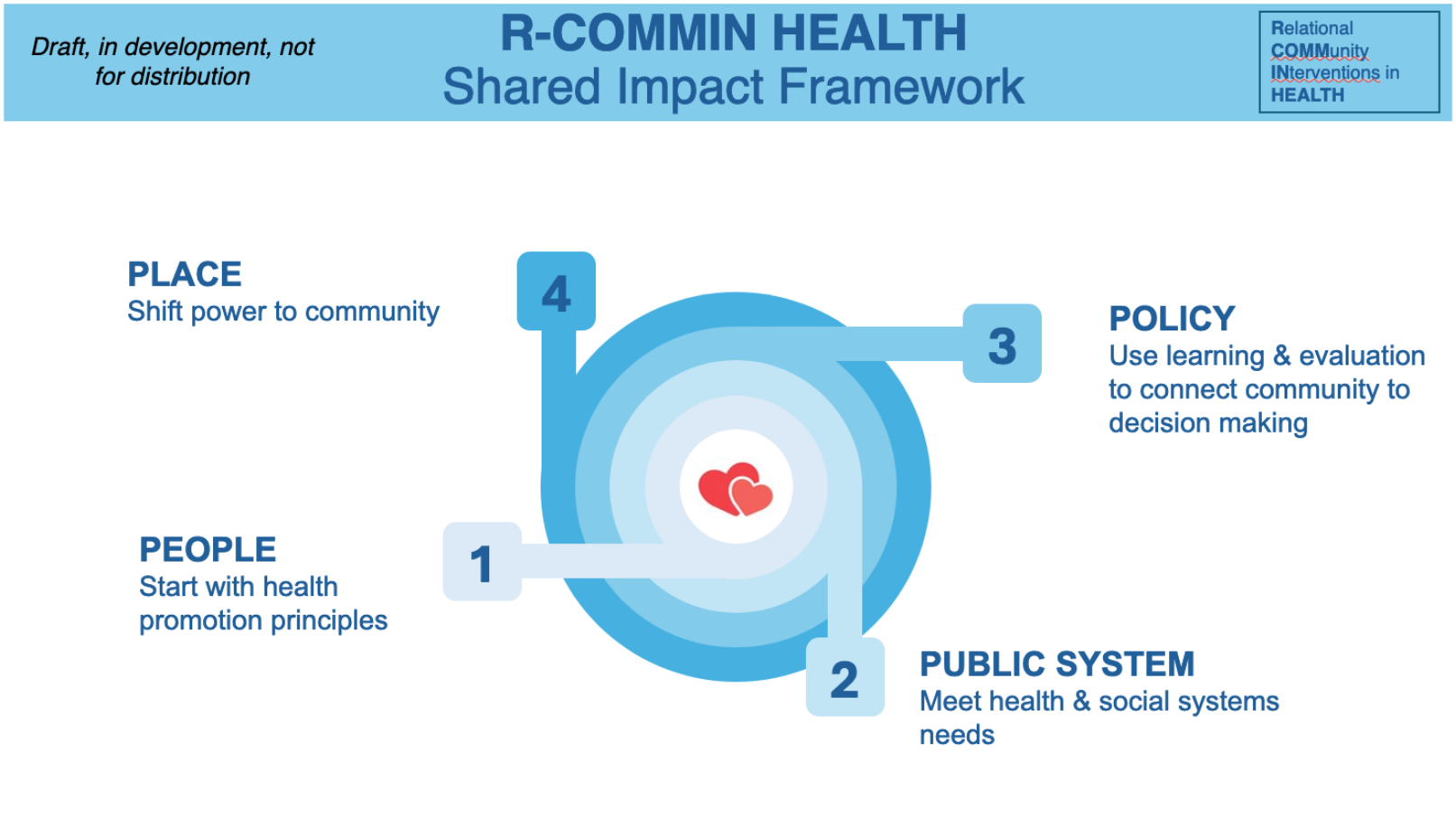
Learning Health Policy Systems

Connect communities and decision makers.

Healthier Places

Shift power and resources to community, in context.

Relational Community Interventions in Health Framework*



Framework Domains

Domain	Overview	Potential Indicators
People: meeting the needs of participants and their communities	Better health promotion through strengths-based health promotion and focus on self determination	Self determination measures (autonomy, competency) PREMs and PROMs
Public Systems : meeting the needs of health and social systems	Improvements in the quintuple through strengths-based health promotion and focus on self determination	Quintuple aim Integrated heath and social care Cultural safety Financial indicators
Policy-practice learning : meeting the needs of learning health policy systems	Better connections between community health and decision makers	Use of findings to inform policy and practice changes
Place: meeting the needs for resilient local infrastructure by shifting power, funds to community (in context)	Community as recognized, resourced part of health and social systems	Community ownership and control of resources Ethical governance

Activity: What do you think?

In response to the framework:

I like: Aspect(s) you like

I wish: Aspect(s) that could be done differently/improved

I wonder: What questions remain?

1-2-4-All

Resources and Opportunities

- HEC promising practices :

  Promising Practices for Enabling Aging in Place (healthcareexcellence.ca)

- CDA (Canada's Drug Agency)
  - Canada's Drug Agency will deliver evidence to help decision-makers understand the most relevant reasons that people in Canada are unable to age in their home or community; as well as guidance from their Health Technology Expert Review Panel on strategies to support equitable aging-in-place initiatives.
  - In early July, the draft guidance will be posted on the CDA website for feedback from interested parties. The final guidance report will be published in August.
  - CDA and HEC will host a webinar in support of the launch of the guidance.
  - Subscribe to CDA's Weekly Summary email digest to receive notifications about the feedback opportunity.

Thank you/Merci!

CHIP IN!

Community
Health
Index of
Practical
INdicators


HEALTHY PEOPLE, HEALTHY COMMMUNITIES
SERVICE DELIVERY
Facility-based services
Community-based health promotion and health care services
HEALTH WORKFORCE
Facility-based health workers
Community-based, trained health workers (CHWs)
HOUSEHOLD PRODUCTION OF HEALTH
SOCIAL DETERMINANTS OF HEALTH
COMMUNITY ORGANIZATIONS
Including Community Health Volunteers (CHWs)
SOCIETAL PARTNERSHIPS
MEDICAL PRODUCTS, VACCINES, AND TECHNOLOGY
FINANCING
LEADERSHIP AND GOVERNANCE
INFORMATION, LEARNING AND ACCOUNTABILITY
LEGEND
HEALTH DETERMINANTS
ORIGINAL WHO BUILDING BLOCKS
EXPANDED OR ADDED ELEMENTS

Community Health Measurement Matters

- There are many community health initiatives across Canada
- These are often ignored or devalued
- Each is a little different – this is a strength!
- Many face challenges in collecting and using standardized data

What if we could capture their shared impacts in a feasible way?

Goals

The proposed index would capture four goals under four domains.

The focus is on creating healthier people and systems.

Healthier People

Use health promotion (empowerment) principles for people and communities

Healthier Public Systems

Improve quality for health and social systems.

Learning Health Policy Systems

Use evaluation to connect communities and decision makers.

Healthier Places

Shift power and resources to community, in context.

Domains

Domain	Overview	Potential Indicators
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The simplest possible approach

What (and how much) do decision makers and funders need to know?

+

What is feasible for implementers?

McGlynn (2003) Criteria for Selecting common measures of quality and system performance

- Linked to national goal(s)
- Clear and compelling use
- Parsimonious
- Minimal data burden
- Improve care delivery
- Inform stakeholders

An INDEX Approach:

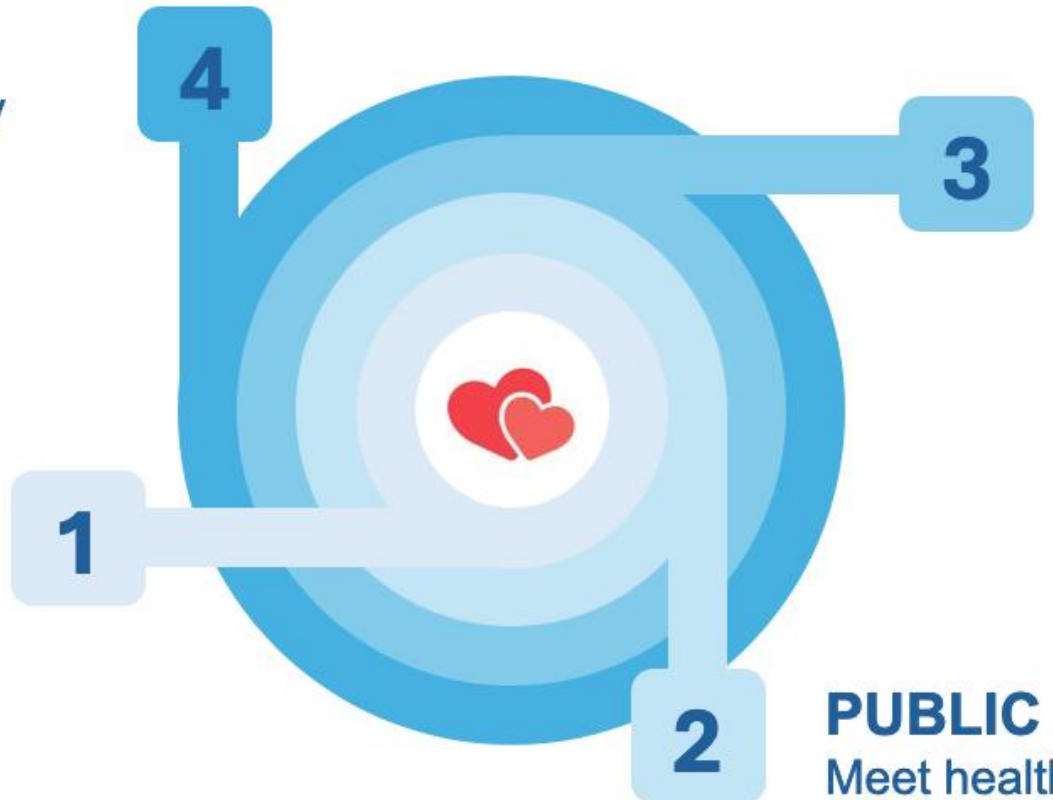
Using available data, evaluators rate projects using a simple scoring scale and the minimum viable number of criteria.

Indexing is a way to "standardize" data from diverse datasets and sources.

Are we improving...?

PLACE
Shift power to community

POLICY
Use learning & evaluation to connect community to decision making



PEOPLE
Start with health promotion principles

PUBLIC SYSTEM
Meet health & social systems needs

CHIP IN!

Community
Health
Index of
Practical
INdicators