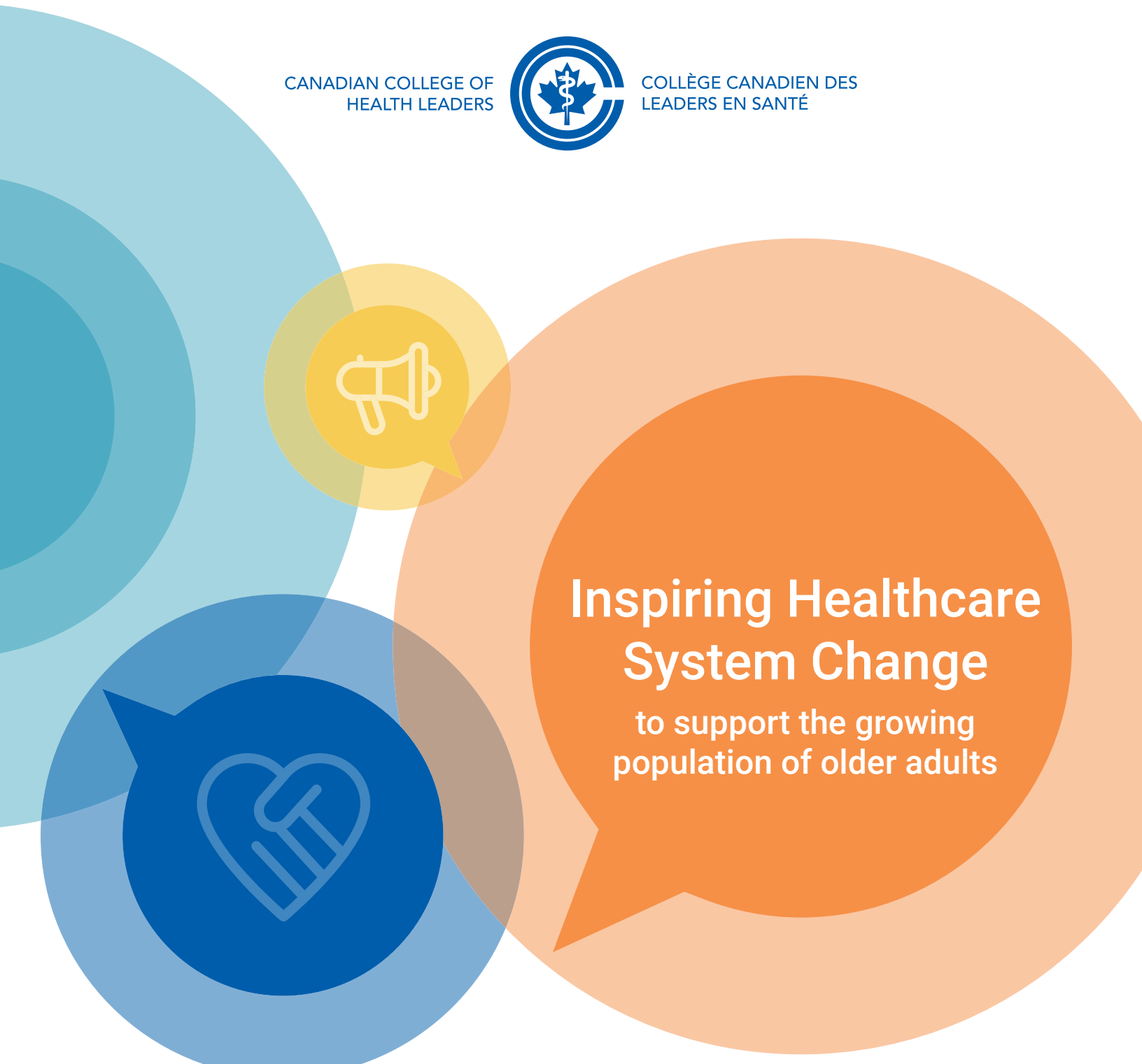
CANADIAN COLLEGE OF HEALTH LEADERS

COLLÈGE CANADIEN DES LEADERS EN SANTÉ



Inspiring Healthcare System Change

to support the growing population of older adults

CCHL National Conversation Executive Summary

Prepared by Brenda Lammi
Senior Vice-President, Professional and Leadership Development
& Amy O'Brien
Director, Governance and Member Engagement

Sponsored by Roche

CANADIAN COLLEGE OF HEALTH LEADERS
COLLÈGE CANADIEN DES LEADERS EN SANTÉ

Inspiring Healthcare System Change to Support the Growing Population of Older Adults

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

- **Dr. Samir K. Sinha**, MD, DPhil, FRCPC, AGSF
- **Laura Tamblyn Watts**, CEO, CanAge
- **Ron Beleno,** Caregiver Advocate

See the panelists' complete biographies.

To read the summary of Part One, click **here**.

Part Two: CCHL National Conference Concurrent Session

Part Two was a 90-minute in-person session at the CCHL National Conference in Toronto. The session featured a panel of experts who provided insight on how leaders can organize the health system and its resources to care for aging Canadians through their own lenses. Throughout the session the audience was given the opportunity to contribute through polling questions. Insights and viewpoints from the panel and contributions from the audience will be synthesized and, along with the summary from Part One, will guide the Part Three local sessions.

Panelists

- **Arden Krystal,** President & CEO, Southlake Regional Health Centre
- **Lesley Myles,** Executive Director, Seniors Palliative and Continuing Care, Alberta Health Services
- **Jasneet Parmar,** Professor, Dept of Family Medicine (Lead Caregiver Centered Care Initiative), U of Ab
- **Jillian Alston,** Geriatrician, St. Michael's Hospital and Unity Health

See the panelists' complete biographies.

To read the summary of Part Two, click **here**.

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.

CANADIAN COLLEGE OF HEALTH LEADERS
COLLÈGE CANADIEN DES LEADERS EN SANTÉ

PART TWO

Expert Panel and health leader audience contribution summary

The panelists were asked to share what made them decide to do the work they do.

The panelists indicated that they have a passion for their work and advocacy. They believe that people should be able to age safely at home, that everyone deserves care, and to be cared for. They want to contribute to the health system, and they have seen successes in other countries and want to recreate these care models.

The audience was asked to share, through a poll, what made them decide to do the work they do.

There were a variety of answers, many of them had the same themes.

Themes:

- Wanting to care for people at their most vulnerable and when they need it most.
- To improve the quality of life for Canadians
- To help or make a positive impact on the health system and for patients and their families.
- Have a history of caregiving or relate on a personal level through their own lived experience.
- Saw this as work that was challenging, interesting, and possible to make a difference.
- Able to make a direct impact for the most underserved people in our communities.

The panelists were asked: *Let's imagine 2030 – what will healthcare for older Canadians look like through the lens of your current role? How will we know if we are making progress?*

Leaders would be focusing on social determinants of health. Dr. Jillian Alston shared that she started going into Toronto shelters in 2020 during the COVID-19 pandemic. We need to be able to reach the frail and those with cognitive and mobility issues where they are. Older adults in shelters are seen but overlooked. Her belief is that geriatrics should be a required specialty in medical school as geriatricians are a rare breed. Canada needs more supportive shelters and homelessness prevention efforts for older adults, as there are a lot of barriers for older adults who are experiencing homelessness for the first time due to issues from aging, such as unrecognized cognitive issues. If we are doing well in 2030, we will be focusing on what we can do to influence the social determinants of health.

We would listen to older adults and ask them what they want. The hospital is not a good location for many older adults: they need to be in whatever location they call home, and our job is to facilitate this transition. Ms. Arden Krystal shared that her organization, Southlake Regional Hospital, ran a pilot program to bridge the gap between hospital and the patient's community by not only addressing the patient's medical needs but also providing support for mental health, addictions, and other social determinants of health. Programs like this should be copied, be the norm and be influenced by finding out what the patients need and want.

There would be choice for where patients live and staff trained to create a better community for older adults. Ms. Lesley Myles spoke to the realities of not enough resources and an increasing number of seniors entering our acute care system. She spoke of various initiatives adopted in Alberta such as the "Destination Home" Program and "Enhancing Care in the Community." These initiatives are designed to care for people in their home, wherever home may be. Since their introduction, the initiatives are demonstrating that more older adults can stay home for longer, which is good for them and necessary for the system. However, many more initiatives like these need to be done as systems cannot keep up with the increasing demand for facility living. By 2030 we need to see a change in attitudes towards caring for the aging population and be more open to innovations such as increasing use of technology.

Collaboration between primary and home care is key to providing care at the right time and in the right place. Dr. Jasneet Parmar shared that there is complexity and frailty within the community. Most older adults are thriving but if they experience comorbidities, the system is not set up to care for them in the home. The goal should be to see patients in the home within 1-2 weeks. Premature institutionalization should be frowned upon and if older adults end up in the emergency room, this shows a failure of the home care system. There are organizations that exist in the community, and we need to partner with the services that give care within the community.

The audience was asked to share, through a poll, what are the best ways that leaders can support other leaders.

There were a variety of answers, many of them had the same themes.

Leaders could:

- Share through resources, barriers and successes experienced, best practices, identified champions and experts.
- Hear and be heard through regular connection points and being open with each other in a safe environment.
- Create coalitions for change through engagement with government, agencies of care and other partners. Do not wait for someone to collaborate with you, instead look for co-creation starting points.
- Challenge assumptions such trialing improvements, thinking as a whole system, take risks, be open to shifting resources and not thinking as an individual organization and the funding implications.
- Make decisions with the patient in mind and you can never go wrong.

Rapid-Fire Questions

Each panelist was then asked unique questions in a rapid-fire format.

Ms. Arden Krystal was asked: How would shifting to home care affect acute care?

Ms. Krystal shared that health leaders need to find a way to solve more than one problem at the same time through partnering. The goal should be to partner with community resources and work directly with patients and families to learn what they think will provide them with a better quality of life at home.

Dr. Jillian Alston was asked: We have heard of the significant role of caregivers in the system, who provides care for older adults without a support system?

Dr. Alston shared that this is a huge gap in the system. There are significant numbers of older adults that do not have family support. There are agencies available within the system but there are barriers to accessing the support. Organizations like COTA are excellent resources but there are waitlists. There needs to be a bridge between personal care and home care that supports older adults without a family caregiver.

Dr. Jasneet Parmar was asked: On the caregiving theme – what is the financial benefit of caregiving on the health system?

Dr. Parmar confirmed that it is the family caregivers that are helping the system meet the targets set out by the government. It is very attractive for the government to say that the goal is to reduce wait times, but we do not ask how we are going to make that happen and often it is on the back of family caregivers. If we expect family caregivers to sustain the system, we need to partner and support them.

Ms. Lesley Myles was asked: How would leaders influence the reallocation of funds to home care?

Ms. Myles believes that having conversations like this session is the beginning of influencing change. It is key to have the right people at the table including home care, acute care, physicians, government, experts and users of the system. We need to influence the government health ministries, start from scratch and not be territorial about funding.

The panelists were asked: *Can you provide specific suggestions on what leaders may do to influence the change that we have been talking about?*

Panelists suggestions:

- Responsible and responsive advocacy.
- Flattening the hierarchy so everyone can contribute input (care providers, government, families, patients) as we need to work together to determine solutions.
- More research to identify what needs to be done, look to experts to expand the conversation.
- Be receptive to the success of others and spread and scale successful programs.
- Focus on storytelling to influence the health ministries who do not understand the complexity of the system. When you tell stories you can clearly see the challenges and potential changes to make an impact.
- Account for older adults when creating policies. Consider who else we are excluding?
- Need to determine who we need to partner with, for example have conversations with shelters and determine if there are other organizations that could help to expand capacity.

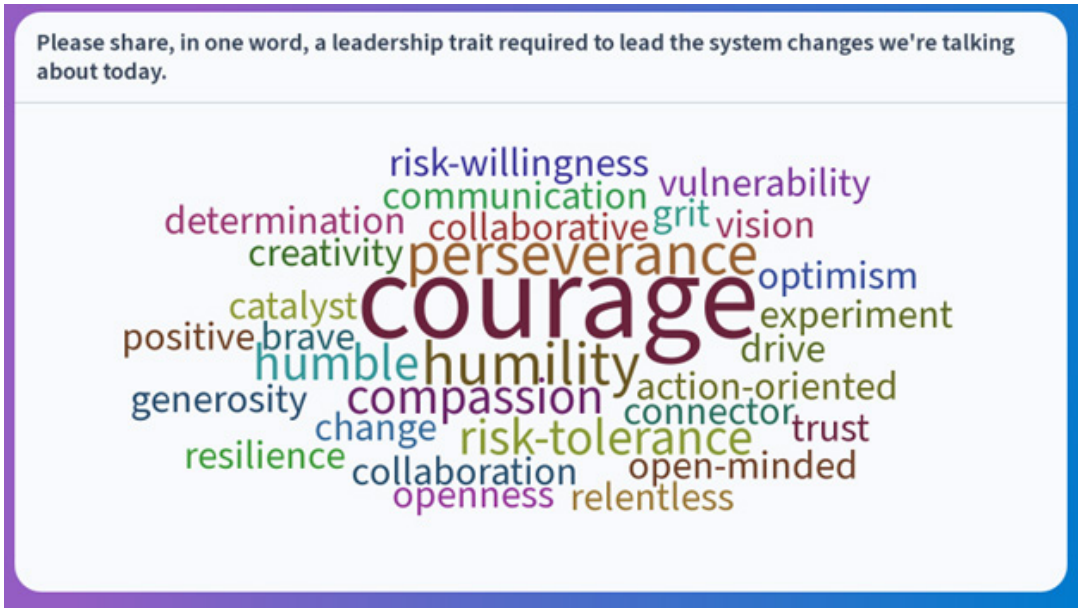
Dr. Parmar believes in the need for responsible and responsive advocacy but stresses the negative impact that irresponsible advocacy can have.

Ms. Krystal shared that she is frustrated with pilot projects and not seeing the spread and scale and reminded the group that the big risk is not taking a risk.

Ms. Myles suggested that to foster enthusiasm, consider having decision-makers experience the day-to-day of those working directly in the system. Have the people around the table walk in someone else's shoes for the day.

Dr. Alston reinforced the need to build capacity for front line workers not just in healthcare but in the social services.

The audience was asked via poll to:



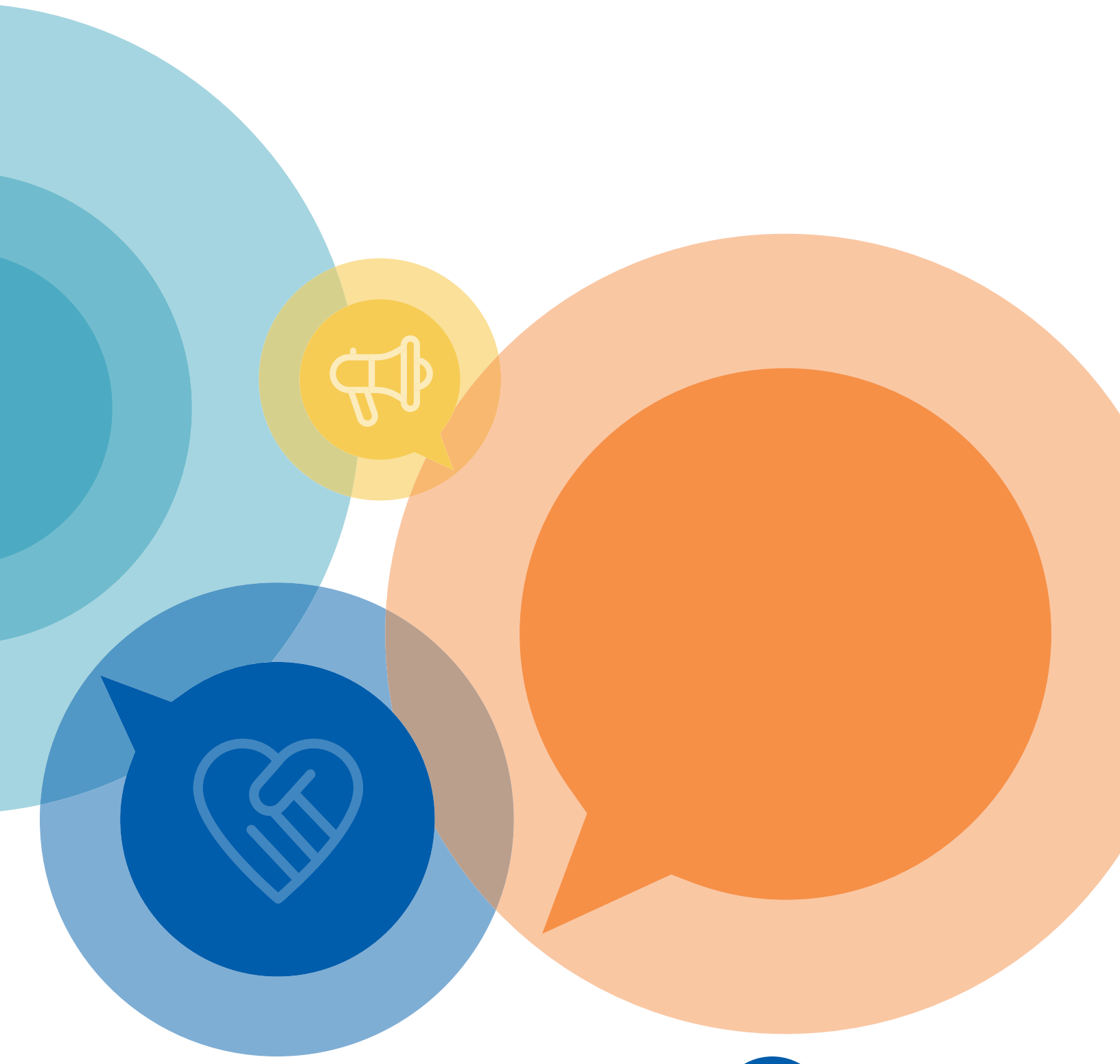
The panelists were asked: *One thing you hope that people in the audience do as a result of this conversation, what would it be?*

Dr. Alston answered that she hoped that the audience would really look at their policies and actions and determine if they are accounting for older adults. Consider where there are gaps and how we can make a change.

Ms. Krystal answered that she wanted members of the audience to start small and pick one area where they can make a difference and encourage enthusiasm. She also shared that she hopes the audience will speak loudly, as we no longer have the pandemic as a catalyst for change and we need to not have lost what we have learned.

Ms. Myles answered that we need to not forget about continuing care, take the moment now and do not wait for a crisis. She encouraged the audience that now is our time to be confident and speak up for seniors.

Dr. Jasneet answered that we need to have solution-focused discussions and not get overwhelmed by the problems. She reinforced that we need to create the right kind of services where the patients need them, but we need money and resources. This will require open discussions about allocating resources.



CANADIAN COLLEGE OF HEALTH LEADERS
COLLÈGE CANADIEN DES LEADERS EN SANTÉ

www.cchl-ccls.ca