Working Together for Healthy Aging in Alberta:

Seniors Forum Recommendations

Alberta College of Family Physicians

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Contents

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Introduction

In the next 20 years, it is estimated that the number of Canadian seniors will double from five million (2009) to over ten million (2036), representing a demographic growth significantly more rapid than the national population (est. 34 million to 44 million).[1] As the first of the Baby Boomer generation turned 65 in 2011, this demographic grew to ~15% across the country, representing a ~87.5% increase of 8% since 1971;[2,3] in Alberta alone, the number of seniors continues to grow by over 50 individuals a day. By 2031, the entirety of this generation, with an age span of over 40 years, will have reached age 65[2] and represents an aging population of significantly diverse individuals with varying abilities, skills, interests, levels of education, personal wealth, living arrangements, and health status.

As this accelerated demographic shift or "rising tide"[4] of older adults continues, Canadian health care must be prepared to meet the varying needs and values of the aging population. While the growth of this demographic is expected to slow beginning in 2031,[3] the senior population accounts for ~45% of provincial health care spending. As not only the most frequent users of the system, seniors are also the most complex as they "tend to stay longer, consume more resources for the same procedures, and rely on more services,"[3] with the average per-capita expenditure increasing each year of life after age 65.

Though the escalation of health care costs is without dispute, it seems the attribution of those rising costs purely to older adults may be overstated[4] and compounded by reports that more than three-quarters of seniors have at least one chronic health condition, experience barriers to accessing available seniors care programs, and have increased incidences of dementia, financial constraints, and limited assistance in returning to the community following hospital stays. While there are possible correlations between the increases in the rates of chronic illnesses and shifts in lifestyle behaviours (e.g. obesity leading to diabetes), it may be more likely the result of better screening and early diagnosis. Therefore, more effective treatment (for conditions such as hypertension, breast cancer, prostate cancer),[5] or what has been called a "compression of morbidity"[4] where individuals are staying healthy longer—not living longer—requires more intensive care for a shorter period of time before death.

Alberta College of Family Physicians' (ACFP) Connection to the Issue

Research[6] shows the importance of primary care and the family physician's office—when compared to other health care settings—has been overwhelmingly noted as the primary port of entry into health care in a given month. The family physician's office, therefore, is the setting that has the potential "to affect the largest number of persons," and a person's age is a strong predictor of the likelihood of receiving health care.[6-8] Indeed, when compared to other age groups,[6,7] seniors received care in larger proportions in all care settings with the exception of emergency departments.

As the voluntary family physician membership organization—and provincial Chapter office of the College of Family Physicians of Canada—the ACFP supports more than 4,800 family physicians across the province in providing high-quality health care to their patients. One of the ACFP's past committees (2001—2014) focused on seniors care and served a role in the education of family physicians around seniors health, models of care, advocacy, research, and communication. Members of the now-disbanded Advisory Committee on Seniors Care believed that current health planning should emphasize collaborative partnerships between community caregivers, thereby assisting patients and improving access to resources in the community.

The Committee believes that those measures would improve both the quality of care and quality of life for seniors living either at home or in facilities, allow prevention and early detection of illness before significant problems arose, [6,7] and reduce the dependence on the acute care environment as a conduit for access to health care. A 2012 Policy Paper[9] by the ACFP outlined six recommendations, one of which stated that "appropriate health providers should be involved in all planning and in decisions related to program development for community seniors care." It was this recommendation that resulted in the 2014 collaborative stakeholders forum: Working Together for Seniors Care in Alberta.

The health system faces increasing pressures in the acute care environment, where many seniors wait for alternate levels of care in hospital beds. While we have made some significant advances in improving care for frail seniors in the community environment, there are opportunities for enhancement of care through system change and realignment of resources.[9]

Hosted and facilitated by the ACFP, the 2014 forum aimed to create a common voice, identify areas of collaboration, develop a plan to mobilize existing organizations, and formalize the ongoing working relationships between those organizations. Invited speakers provided background on the current state of seniors care and, together with participants, the challenges, gaps, and opportunities were identified, and a catalogue of the available services, programs, and resources was developed. Participants then formulated a vision of a desirable future for seniors care, detailing what would be ideal for this demographic and the systems that would support them. Three outcomes were identified and adopted as ACFP action items:

1. Build a coalition,
   a. This coalition was later self-identified as the Alberta Seniors Care Coalition (ASCC),
2. Educate family physicians,
   a. In collaboration with the ASCC, the ACFP developed a conference focused on models of care,
   b. The ACFP also committed to hosting a Seniors Spotlight in their monthly e-newsletter and to provide seniors care sessions at the Annual Scientific Assembly (ASA),
3. Create a forum synopsis,
   a. Summarize gaps in care, identify opportunities in care, and provide recommendations.

The forum was foundational in enabling a framework for positive changes in the care of seniors and was integral in forming the ASCC. The ASCC brings together the experience and expertise of the varied partners and networks—government and public agencies; private, not-for-profit, and voluntary sectors; advocacy groups; and community partners—involved in seniors health care in Alberta. The members of the Coalition bring together a valuable expanse of perspectives and help facilitate discussion on how to collectively address and improve seniors health care province-wide. Building on existing strategic directions, the ASCC's goal is to foster a coordinated and aligned approach to meet the demands of the changing health care needs of Alberta's aging population today and into the future and, as such, identified three significant strategies to meet these demands:

1. Enabling a common vision,
2. Integration, collaboration, and knowledge translation,
3. Person-centred aging.

Building a Desired Future by Understanding the Aging Population and Health Care Demands

The vision created by participants of the forum examined the existing health care system and current challenges faced by our aging population. Where health care services are only as good as the ability of individuals to access them,[3] and despite being one of the better systems, there are mounting pressures that require an examination of the type of care, funding, and proportion of services required to support Canada's aging population.[5] Further, the competing demands placed on primary care physicians present barriers in the provision of preventative care to patients.[8]

An essential component of the approach to help Canadian seniors remain healthy and independent as long as possible is to identify and implement measures for wellness and health promotion.[3] The extent to which the aging population impacts the health care system depends on two things: How the system is defined, organized, and accessed, and our attitudes as a society towards aging and the elderly.[10] With the overwhelming desire of seniors (and their families) to see a shift from institutionalized care to increased community supports, a variety of programs are necessary to engage seniors, provide education, and encourage exercise,[10-12] in support of the "lifelong process of optimizing opportunities for improving and preserving health and physical, social, and mental wellness, independence, quality of life, and enhancing life-course transitions."[4] However, we must not overlook that primary care physicians are both in a unique position to provide preventative health services, and are also perceived as "highly credible sources of information"[8] paramount to the health and well-being of patients and their health efforts.

The rise of comorbidities has significant implications for the health care system. In 2008, approximately one-half of seniors reported having 1-2 chronic conditions, and one-quarter reported having three or more. Health care's increased ability to treat chronic conditions means that most seniors are living with, rather than dying from, these conditions.[3]

Will Future Generations be Healthier?

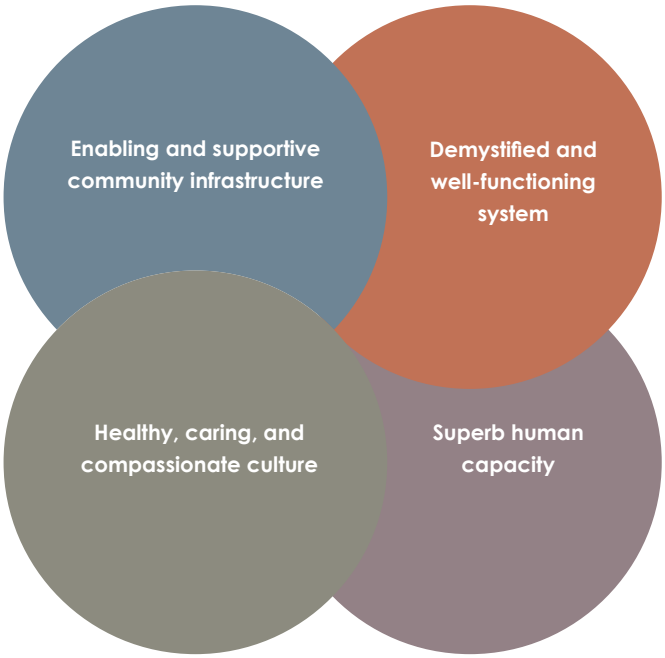
Predicting the future, though, is difficult and the challenge is to ensure that we use our expanding knowledge base to anticipate future needs to design and deliver the best possible services and supports.[12] One perspective[5] is that the Baby Boomers will be healthier seniors than previous generations because they are better educated, wealthier, exercise more, smoke less, and are more knowledgeable of healthy lifestyles; alternatively, they are engaging in poorer eating habits and have higher rates of obesity contributing to poorer health trajectories. Additionally, an inability to work, experiencing isolation due to ageist attitudes, and other such factors all contribute to seniors illness and declining health, which results in individuals living in the community often finding it difficult to maintain their independence due to the lack of available support services.[4]

Before seniors grow beyond the capacity of both the existing care systems and available services for future generations, effective programs must be designed.

Although patients are capable of incorporating some lifestyle and health behaviour changes without physician involvement,[8] the collaborative efforts of the patient and physician (and care team) are becoming increasingly essential; indeed the lifestyles of the aging population are a significant factor in both causing and exacerbating chronic conditions and diseases. Before seniors grow beyond the capacity of both the existing care systems and available services for future generations, effective programs must be designed for accessibility and inclusiveness of those most at risk of health and social issues if the health care system is to combat the current epidemic of obesity, mental illness, addictions, and social problems that today's seniors face.[10-12]

The Desired Future

Now is the time to identify and carefully design the services and programs that are essential today and into the future to meet the needs of an aging population. While the vision and strategy may be overwhelming in scope and complexity, the focus must centre on creating an adaptive and responsive environment for change instead of small adjustment to the existing system because, ultimately, health behaviours are adaptable. There is an imperative need for enhanced planning and strategic actions; the challenge is to decrease the spending growth without compromising access to quality care, all the while developing an efficient and sustainable system. While the outcomes matter greatly,[10,11,13] they do not outweigh the importance of maintaining fairness in accessibility and scope of care to the seniors of today to provide for those of tomorrow. The immediate need for a short term "fix," therefore, aligns with the long term "solution."



The vision created by the participants of the Working Together for Seniors Care in Alberta invitational forum included current, future, and bridging elements that could be grouped into four overarching areas:

1. An enabling and supportive community infrastructure,
2. A demystified and well-functioning health care system,
3. The superb human capacity to support seniors,
4. A healthy, caring, and compassionate culture that promotes respect and independence for seniors.

An Enabling and Supportive Community Infrastructure

An enabling and supportive community infrastructure embraces a holistic approach[2,11] to the design of the senior-supportive community: Housing, social services, and health care, with a mixed-use urban design.

An ideal infrastructure would feature access to intergenerational, family- and age-friendly communities complete with recreation facilities, well-lit and easily navigable foot paths, and easy access to the outdoors, transportation, and amenities (e.g. banks, post office, grocery stores). Additionally, the boundaries of and ability to move beyond the "facility" would be removed to create a separation of care from the environment, which may include extending the services of home-based care, such as the provision of intravenous antibiotics so that seniors don't have to enter acute care facilities to access these services. Notably, improvements to access and supports for independent living and end-of-life care must also be made.

We must strive to eliminate the notion held by older adults that they are a burden to their families and communities, and commit to creating a system that works for the elderly by being responsive, flexible, and supportive.[10] Ultimately, we must work to ensure that Canadians of all ages live in communities that support their well-being throughout their lifespans so that they can continue to enjoy the familiar social, cultural, and spiritual interactions that enrich their lives, even if their health may be compromised in later years.[10]

We must work to ensure that Canadians of all ages live in communities that support their well-being throughout their lifespans.

A Demystified and Well-Functioning Health Care System

Aging Canadians have a strong desire to remain in their own homes as long as possible and, given the choice, many would prefer an early hospital discharge followed by provision of in-home services and supports[10] over the alternative. In the current health care system, transitions between services and supports are frequently complex, confusing, and frustrating for those who need to access them and, as such, a critical need exists to create a more effective strategy not only for seniors but all individuals who require access to care. Available services and supports should be easy to understand and navigate in order to find out what is available and supported, ultimately providing friendly, seamless, and timely transitions between home and/or care settings.[2,10,13,14]

Creating a demystified and well-functioning health care system involves studying programs that work and incorporating aspects of these programs into new opportunities. By acknowledging that there are successful existing programs, a new model of care can be adapted to suit the current demographic challenges. Such programs include Alberta's Alternative Relationship Plan (ARP), BC's A GP for Me, and the Canterbury Model of Care. Regardless, of the specific demographic or population, skilled staff, technology, equipment, programming, and physical environments are required and, as there is variability in staffing models across care sectors, opportunity exists for alignment to support the diverse needs of clients.[14] While the public, together with the various levels of government, should provide encouragement and the necessary supports for the elderly to continue to live in their own homes and communities, a major part of these supports lie in the financial arena.

As a means to facilitate positive change to the current health care system consideration needs to be given to a funding model that follows the individual and their care needs regardless of place of residence (e.g. rural/urban, home/institution, etc.). In addition, consideration should also be given to increases in caregiver benefits (e.g. tax credits, allowance, etc.) to assist and support family members who take extended unpaid leave from work to care for their loved ones, lessening caregiver burden. Finally, continued advocacy for senior-friendly communities which promote and support independence and aging in place.

With respect to the technicalities of seniors medical care, forum participants noted the importance of accurate measurement of and reporting on patient care and satisfaction, highlighting that improvements can be made in electronic medical records (EMRs) and medication reconciliation, elder protective services, and in the implementation of existing guidelines for those with multiple co-morbidities. Recognizing the emotional, physical, social, and financial burdens experienced by seniors as they age, the need exists for a clear and comprehensive plan that demonstrates value for spending within the system at all levels. Forum participants also noted significant value in evidence-based care, team-based care, and patient-centred care.

The Superb Human Capacity to Support Seniors

If seniors are to live out the last years of their lives with respect, dignity, compassion, peace, and appropriate, competent care, families require preparation and assistance to adapt to their evolving needs across the continuum of aging and living arrangements.

A large part of converting vision into action is acknowledging and including the superb human capacity that exists to support seniors. Where health professionals are "good at telling seniors what they need but are not good at getting people what they need,"[2] there must be a proactive way to manage care of the aging population in the community.

Challenges and opportunities exist in providing timely assessments and reassessments, effective medication management, clear communication of and access to information, and support of informal caregivers and volunteers.[11] Additionally, the sheer size and inherent complexity of the health care system introduces challenges that prevent smooth transitions, making it more difficult to communicate across the various care settings. This generates an opportunity for the provincial government to highlight the programs and services that are currently available by creating a publication geared toward seniors, their families, and all those involved in the various care roles.

The forum prompted an additional and significant idea that public education should exist at all levels related to the care of the elderly, beginning in elementary school and progressing through post-secondary and continuing education. It is imperative to convey the message that more than just the family can play a role in seniors care and that it is, in fact, the whole community that plays a role in a senior's ability to stay at home longer in self-managed care environments. This will acknowledge that, with community support, families will be better able to access available services to assist them in coping with the emotional, physical, and financial needs as their elders become dependent, all the while remaining in the community and their homes as long as possible and, when supportive care is needed, the systems of care in place must be designed in such a way to be responsive, respectful, person- and family-centred in order to promote optimal quality of life.[11]

A Healthy, Caring, and Compassionate Culture

While autonomy and independence for seniors should be primary in focus, there must be balance between autonomy or independence and safety. The trend of declining institutionalization in the elderly population is promising however, concern exists that there may be a large number of Canadians living at home with suboptimal care.[10] There is inherent risk for seniors staying at home (e.g. potential isolation or reduced capacity for home and self care) and remaining independent as long as possible, but they should not be without the ability to stay happy and healthier longer, and live and die well. Forum participants recognize that public values and culture are changing with respect to seniors care.

Features of a vision that supports seniors and the care systems that support them are a healthy, caring, and compassionate culture; a culture where seniors are able to safely remain in their homes as long as possible, connected to those people that are important to them. In this culture of care and compassion, all care is culturally sensitive and seniors are not subject to ageism.[10] The need exists to work towards ensuring that Canadians of all ages are able to remain in communities that support their well-being, even though their health may be compromised or their physical and/or cognitive abilities impaired,[10] and where absent family members still desire involvement in the treatment and care plans of their loved ones.[14]

In realizing this vision for the future, the patient as a person becomes the focus, as opposed to the task, where the health care system and society strive for a community that not only offers care services, but fosters caregivers.

In its current state, the Canadian health care system is ill-equipped to address the needs of the growing population.[2] As a result, communities must be at the very foundation of any strategy to build innovative processes and care models.[15] Therefore, the primary goal should be to unite with one voice to call for and support the implementation of changes in the care provided to seniors across all organizations and at all levels of the health system.

Response to the Desired Future

By uniting as one voice, empowering and engaging seniors, and defining goals from a senior's perspective,[2] the Alberta health care system can expect increased system-wide sustainability resulting from the decreased demand for emergency and care resources for the aging population, and increased inclusivity of seniors in their communities. In doing so, Alberta seniors can expect:

1. Support in maintaining optimal health as the elderly age,
2. Increased health promotion and disease prevention,
3. Increased awareness and education on how seniors can access health care and community programs and services,
4. Increased access to a range of care services that enable the aging to reside in an environment appropriate for their circumstances,
5. Increased patient experience of care (including quality and satisfaction) through network integration and community activation.

To move forward in a united and effective way, recommendations must be developed in a coordinated and collaborative manner with an inclusive sense of partnership regardless of member organization size, all the while being mindful that partnership does not mean that all duties and responsibilities are divided equally, but rather each partner participates with an equitable voice and is responsible for its unique attributes and contributions.[15] As a result of this partnership, the ASCC member organizations can first and foremost achieve an increased ability to influence policy making and the per capita reduction of health care costs for seniors through:

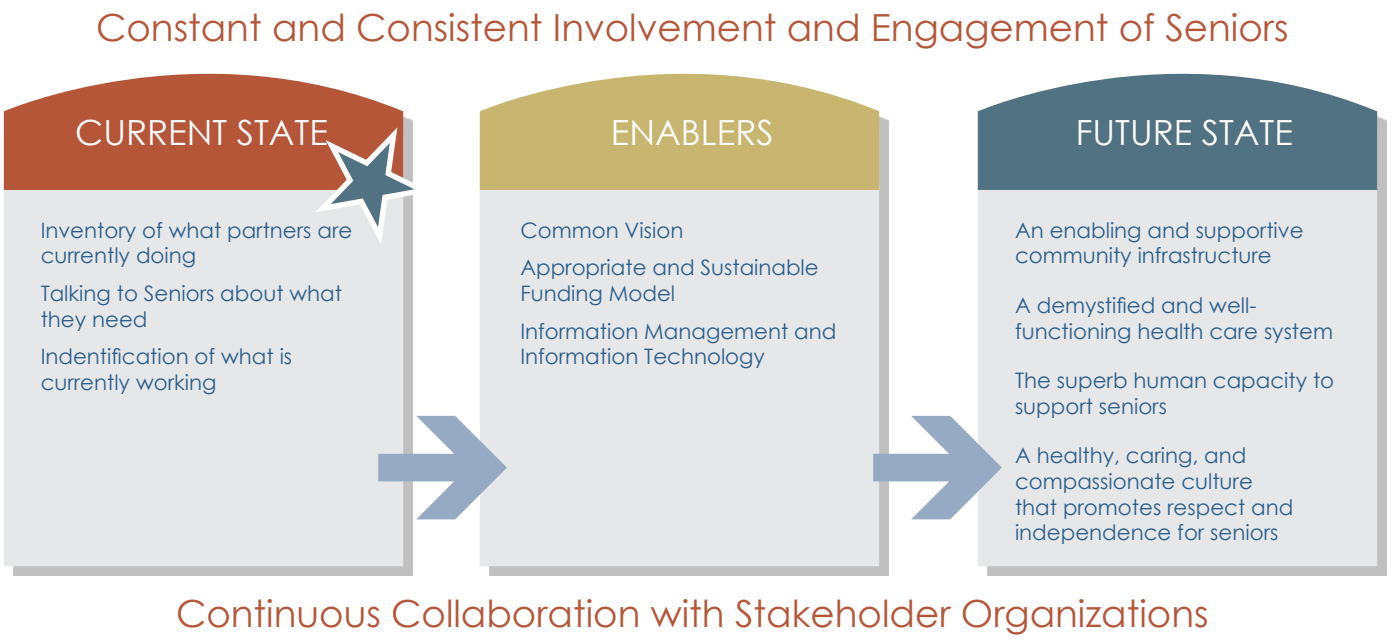
1. Enhanced ability to identify opportunities for coordinated action,
2. Improved ability to eliminate barriers to coordinated action,
3. Improved coordination and integration of policies, programs, and initiatives, and
4. Enhanced ability for members to use data to guide policy, programs, and quality improvement.

First Steps in Achieving the Vision

In identifying and creating recommendations for achieving this vision, three strategic priorities emerged from discussion at the forum. It is important to note that none of these recommendations stand alone, rather there is much overlap and inter-reliance between them.

	STRATEGIC PRIORITY		
RECOMMENDATION	**TOWARD ENABLING OUR COMMON VISION**	**TOWARD INTEGRATION, COLLABORATION, AND KNOWLEDGE TRANSLATION**	**TOWARD PERSON-CENTRED AGING**
	Establish an appropriate funding model to enable multiple models of care	Catalogue all services, programs, and resources available; Close the gaps and provide easy service access and guidance for elders, their families, and providers	Involve and engage seniors in the creation of their own futures and the design of new environments and infrastructure
	Implement information management and the information technology to ensure continuity, avoid duplication, increase awareness, and improve seniors' health outcomes	Continue to collaborate with all stakeholder organizations to create and sustain momentum toward a better future for aging in Alberta	Enable appropriate and accessible care for all seniors in their community and at home when appropriate
	Support and provide education on care of the elderly to all stakeholders to enable a collaborative approach and shared understanding	Advocate for the advancement of a common and compelling vision through collaborative, consistent, and persistent messaging	Challenge society to take the responsibility to build and inspire age-friendly communities

From the three identified strategic priorities, nine recommendations were determined. The combination of the nine recommendations and implementation in a concerted manner would foreseeably result in the integrated, well-functioning health care system that Forum participants conceptualized.


Constant and Consistent Involvement and Engagement of Seniors
CURRENT STATE
Inventory of what partners are currently doing
Talking to Seniors about what they need
Indentification of what is currently working
ENABLERS
Common Vision
Appropriate and Sustainable Funding Model
Information Management and Information Technology
FUTURE STATE
An enabling and supportive community infrastructure
A demystified and well-functioning health care system
The superb human capacity to support seniors
A healthy, caring, and compassionate culture that promotes respect and independence for seniors
Continuous Collaboration with Stakeholder Organizations

Recommendations

Recommendation One:

Involve and engage seniors in the creation of their own futures and the design of supportive environments and infrastructures

All goals for future care planning should be defined from the senior's perspective with the aim of achieving a community of engaged seniors.[2] Without the involvement of individuals receiving the care services,[6,7] the system runs the risk of being informed and designed by those unaware of the actual and perceived needs of the aging population. This is not to say that all stakeholders should not have equal input and/or commitment, but that service users (present and future) must be consulted and involved in the decision-making process.

In transforming the current health care system, two fundamental features are necessary:[2]

Clinical Best Practices

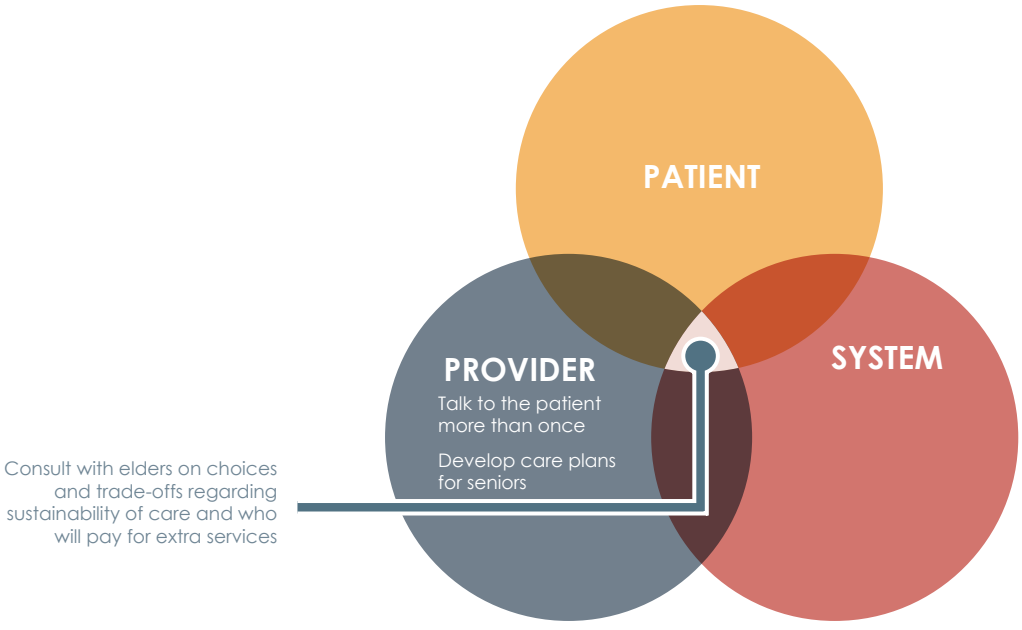
Includes strategies for recruitment, retention, and training to ensure adequate, knowledgeable and sustainable human resources for care of the elderly. Features include:

- Adequate human resources to facilitate greater interprofessional approaches to care
- Capacity building to improve competence in geriatric care among all providers
- More proactive and preventative access to specialist consultation and follow up

Coordination Best Practices

Includes better coordination amongst components of the health care systems, and also externally with other health, social, and human services. Features include:

- Improved communication, continuity of care, and coordination between providers, health care sectors, and clients
- Improved access to services and care, particularly during care transitions
- Improved system navigation for seniors (both clients and caregivers) and health care providers



Recommendation Two:

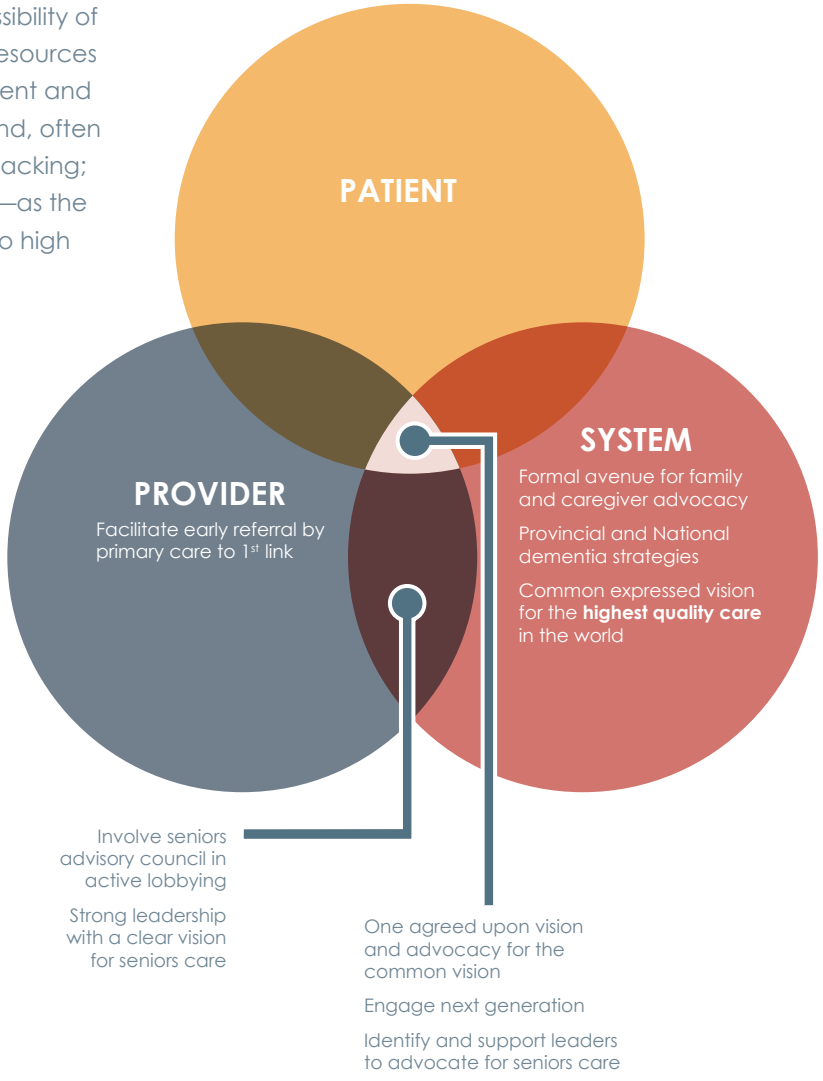
Advocate a common and compelling vision through collaborative, consistent, and persistent messaging

There are noted difficulties both in finding and accessing financial assistance for care, and the availability and accessibility of the information related to available services and resources varies.[16] Some noted challenges include, government and provider websites which are difficult to navigate and, often offer information that is out of date, unsuitable, or lacking; and diminished access to primary care physicians—as the first point of contact and/or entry into care—due to high demand and short supply.[6,7]

Additionally, current strategies of accessing information about care are heavily focused on technology-based platforms such as the internet which presents the potential to create additional barriers for seniors and/or low income individuals and families who may not have ready access to a computer or electronic devices. Further, it is acknowledged that often in rural areas, information may not exist in a compiled directory and, as a result, is passed on by word of mouth.[16]

Regardless of age, geographic location, income level, or multiple other factors, difficulties exist in finding, accessing, and understanding the range of programs and services available.

In 2007, ~12% of adults aged 45 years and older required care for a long term health condition or physical limitation. Of those individuals, 19% received **paid care** only through the formal health care system, 27% received **unpaid care** only (e.g. a friend or family member), and 54% received a combination of paid/unpaid care.[16] While caregivers might be provided with the initial information they require, they are often left to navigate the health care system on their own. Therefore, it may be reasonable to conclude that the number of individuals receiving only unpaid care are doing so because they are unable to navigate the system or do not have access to a primary care physician to support this process.



Recommendation Three:

Enable appropriate and accessible care for all seniors in their community and at home

Health is one of the most important predictors of life satisfaction and a pre-requisite for independence in advanced age.[11] Relevant studies support that the majority of adults remain independent and require minimal health care services throughout their lifespan, however others become increasingly unwell, frail, and dependent on the health care system. Healthy aging helps to alleviate health care system pressures[11] and is central to a sustainable, integrated system where older adults are capable of living longer, healthier lives. The current state of the Canadian health care system has been shown to be fragmented and very piecemeal,[2] with limited access and increasingly long wait times for services, and a grossly inadequate system for information sharing.

It is therefore recommended that a commitment toward the development of an integrated system of care rather than continuing to focus on individual components of health care is foundational to the transformational change needed in today's health care system.[4] An integrated system[10] which encompasses home care, long term care, and primary care, includes:

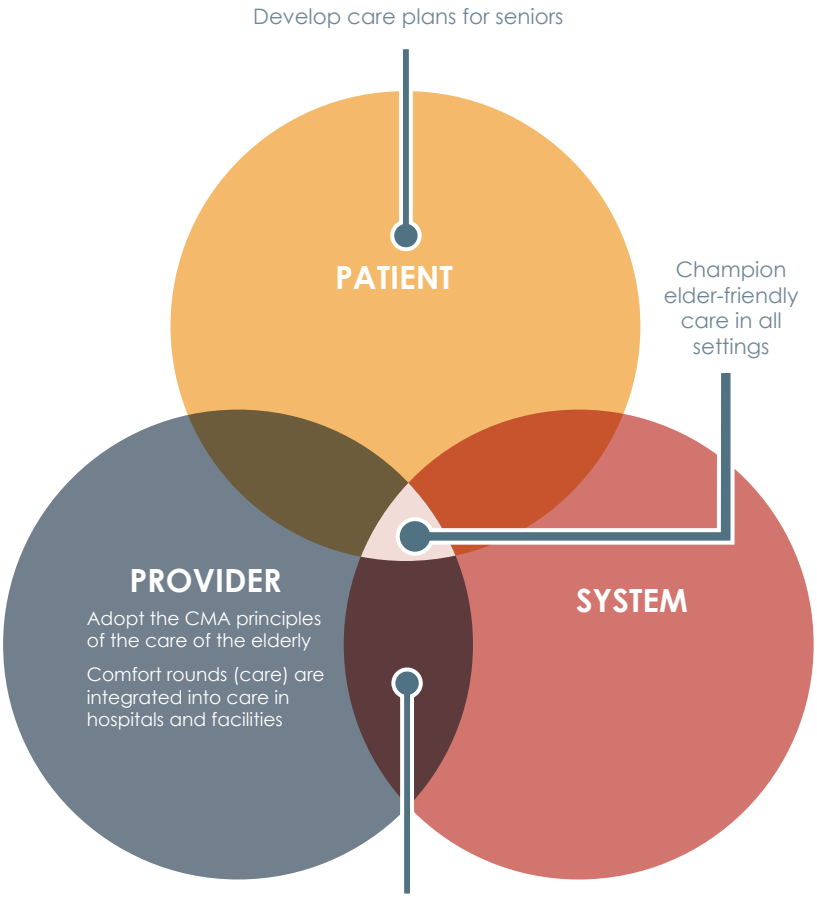
- Single entry point to the system,
- Case management,
- Geriatric assessment,
- Multidisciplinary team focus (providing the correct services in the right setting to meet client and family needs),
- Ability to transfer resources in order to meet needs,
- Focus on helping people remain in their homes and communities (thereby delaying or avoiding the need for institutionalization as long as possible).

Value for health care spending (in a broader sense) can only be achieved if the integrated system allows for cost effective trade-offs,[4] rather than perpetuating the current cycle of using more costly services (e.g. hospital or long term care facility bed) in place of less (e.g. home-based care).[6,7]

Vital to accomplishing the goal of a fully integrated health care system are:[17]

- A defined client group,
- Access to a wide array of services,
- Interdisciplinary case management,
- Active involvement of primary care physicians.

While integration may seem a daunting task, it is possible. Denmark's Skaevinge Project[18] remains the "gold standard" for care, featuring 24-hour integrated health and social care for all citizens, regardless of area of residence. Since the pilot projects in the 1980s, this respectful, cost-effective care has demonstrably improved the health status of citizens, reduced hospital beds, and lowered operational expenditures in Denmark, all while the senior population (75 years and older) experienced a 30% increase.[18]

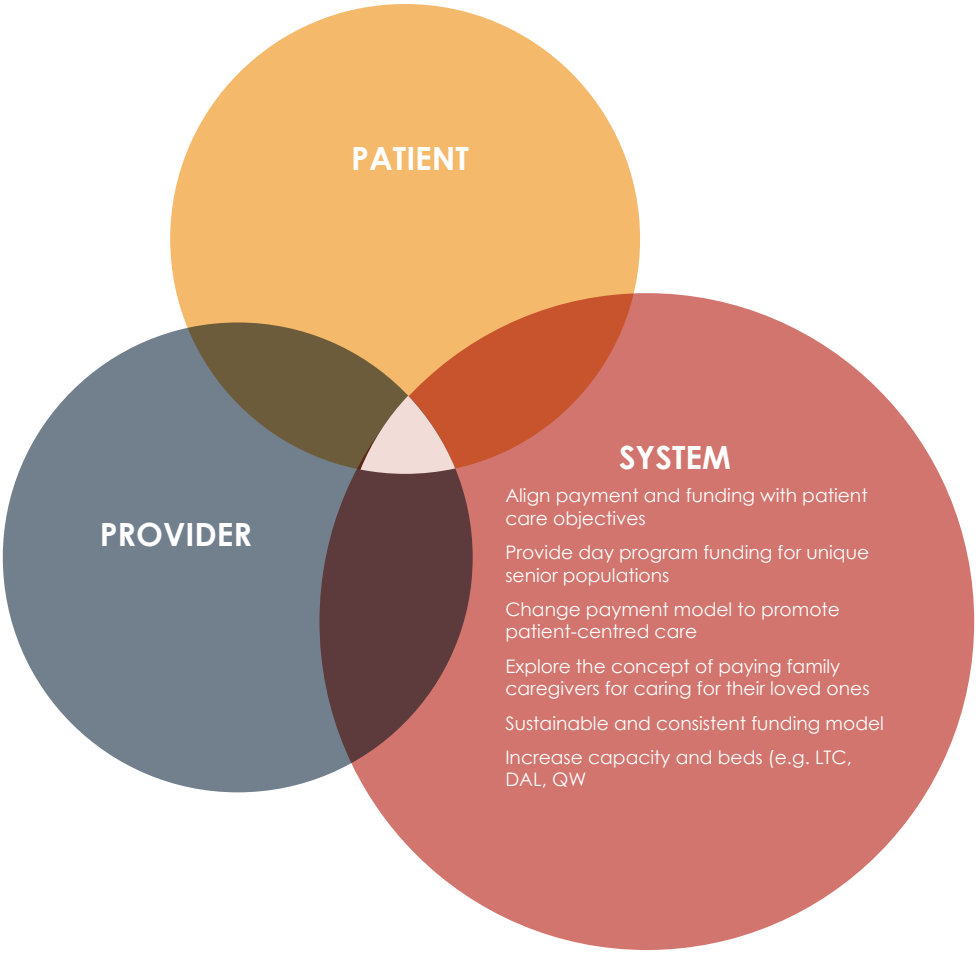


Recommendation Four:

Establish an appropriate funding model to enable multiple models of care

Integrating care is a mechanism for increasing value for health care spending by reducing waste and duplication, however, two outstanding issues in Canada affect progress towards improved care of the elderly:[17]

1. Funding for home and/or community support is the "poor cousin"[17] to funding for hospital and residential long term care despite reported waitlists in every province for one or more home and/or community care service, and
2. During the ten year period between 1994 and 2004, home care spending increased faster than the number of patients and a mix of services changed where provincial home care programs reduced the ongoing supports available (e.g. grocery shopping, meal preparation, laundry and housekeeping services) in the home in favour for those with nursing or personal support needs.[17]



In Alberta,[16] approximately 376,000 people provide care for other individuals which accounts for ~80-90% of the care required by people with long term conditions. While the informal caregiver role saves the formal health care system billions of dollars each year, it is often invisible and receives little or no support; however, given the changing demographics (aging Baby Boomers, decreasing family sizes), it is foreseeable that there will be significantly fewer individuals available to provide care to their parents or spouses as they age. Coupled with increased life expectancy and an increase in the proportion of older adults with chronic diseases, the potential exists for an immense burden to be placed on the current health care system, including not only more office visits, but hospital stays.[7]

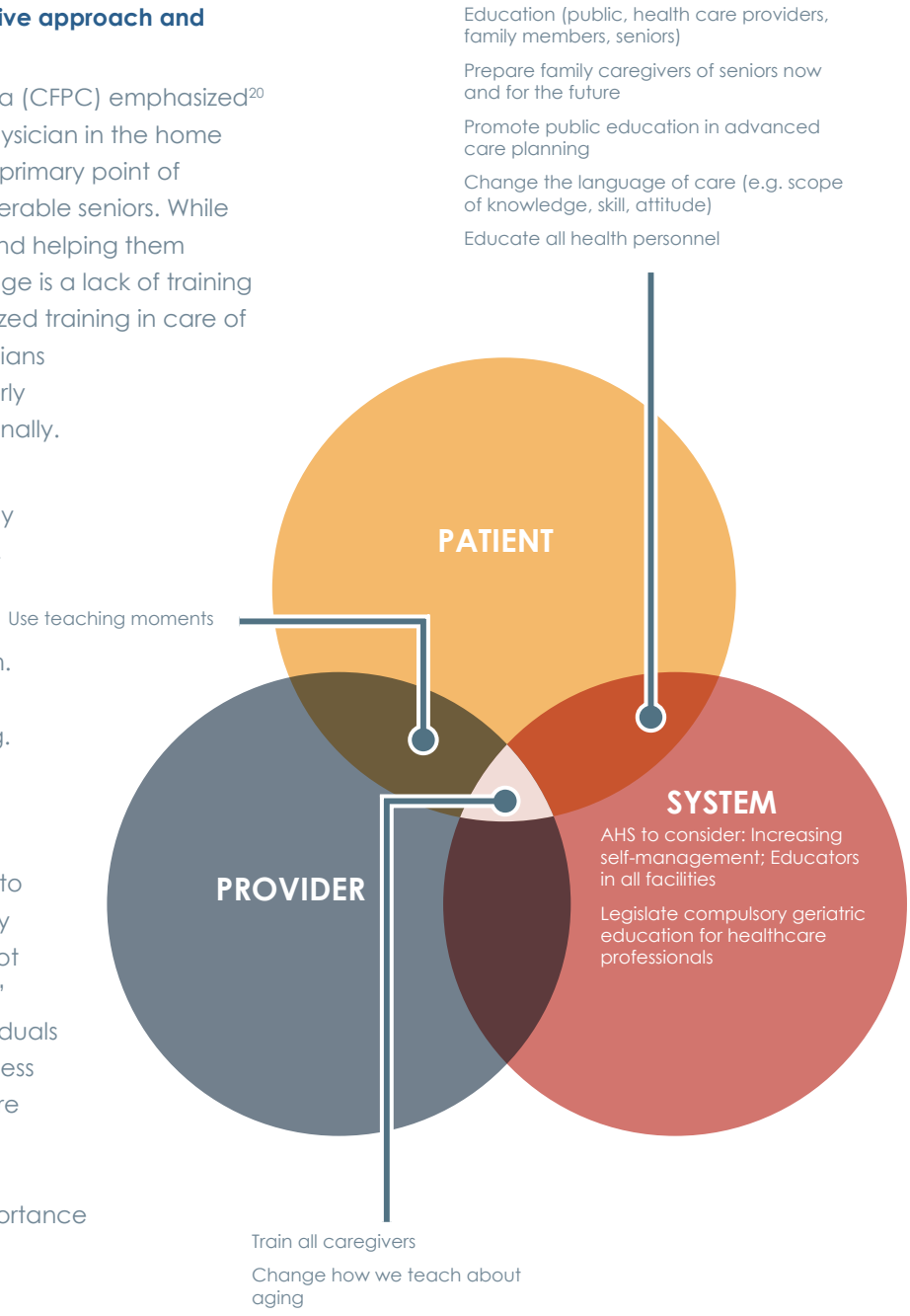
The current funding structure prevents many individuals who require assistance from accessing the programs because they don't "quite fit,"[16] and we are left facing increased costs for care and the ineffective use of resources.[19]

Recommendation Five:

Support and provide education on care of the elderly to all stakeholder groups to enable a collaborative approach and shared understanding of this area of care.

The College of Family Physicians of Canada (CFPC) emphasized[20] the importance of the role of the family physician in the home care team because they are typically the primary point of contact in the health care system[6] for vulnerable seniors. While advocating for services for their patients and helping them navigate the system, the persistent challenge is a lack of training across Canada for physicians with specialized training in care of the elderly. In 2007,[20] only 130 family physicians were trained in additional care of the elderly and there were only 211 geriatricians nationally.

While the number of visits[6,7] to the primary care physician's office have remained fairly consistent in the years spanning 1961-2001, an increasingly important component in the delivery of health care services is the involvement of the allied health care team. While the consistency of the visits may be largely driven by personal preference[7] (e.g. the primary care physician is the trusted health care individual[8]), the delivery of preventative health services by the care team in a clinical setting has the potential to reduce many common causes of morbidity and mortality,[8] preventative services are not routinely discussed during "sick" or "acute" office visits, which are typically when individuals seek out appointments.[7] Therefore, regardless of whether the involvement of all allied care team members is formalized as guidelines or protocols,[8] or initiated during lifestyle interventions, we cannot overlook the importance of all roles[8] in the medical home.

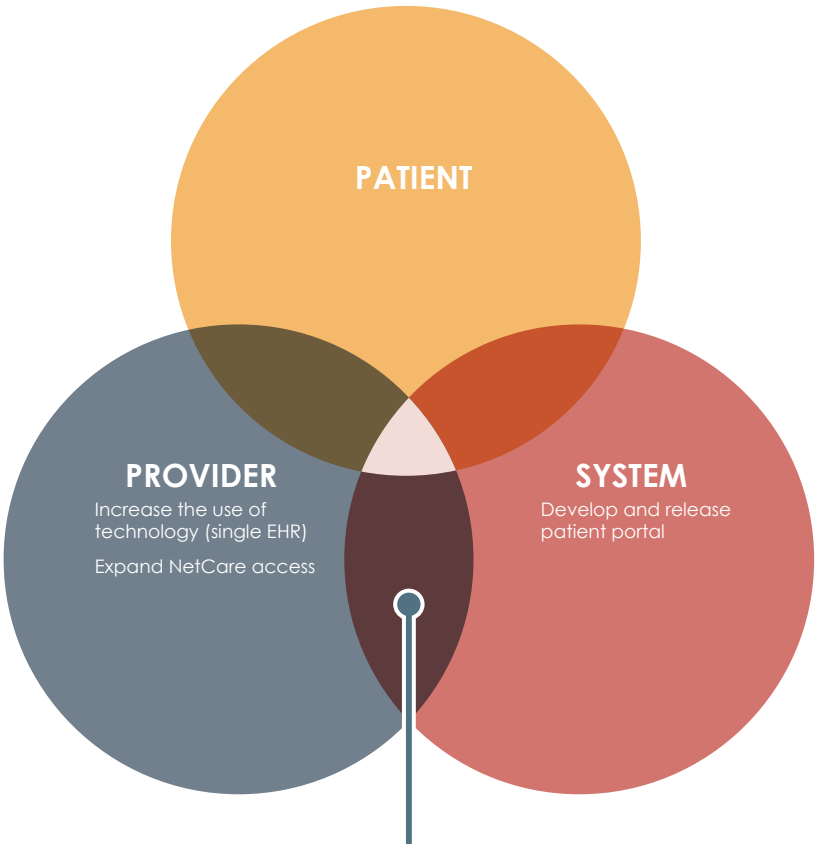


Recommendation Six:

Implement an information management system to ensure continuity, avoid duplication, and increase awareness to improve seniors' health outcomes

The family physician's knowledge base spans from birth to death; if an individual is going to see one medical professional at any given stage of life, it is likely that medical professional is going to be a family physician. In order to enable primary care physicians to effectively do their jobs and ensure that no one gets "lost" in navigating the health care system, there is an ever-increasing need to integrate the system, improve technology, and improve communications.

A concerted effort from all stakeholders is necessary to ensure that health outcomes for the seniors population are improved. While it is not ideal to place the responsibility on any one group of care professionals, it may be reasonable to identify family physicians as the shepherds of care based on the frequency of which office visits occur.[6,7]

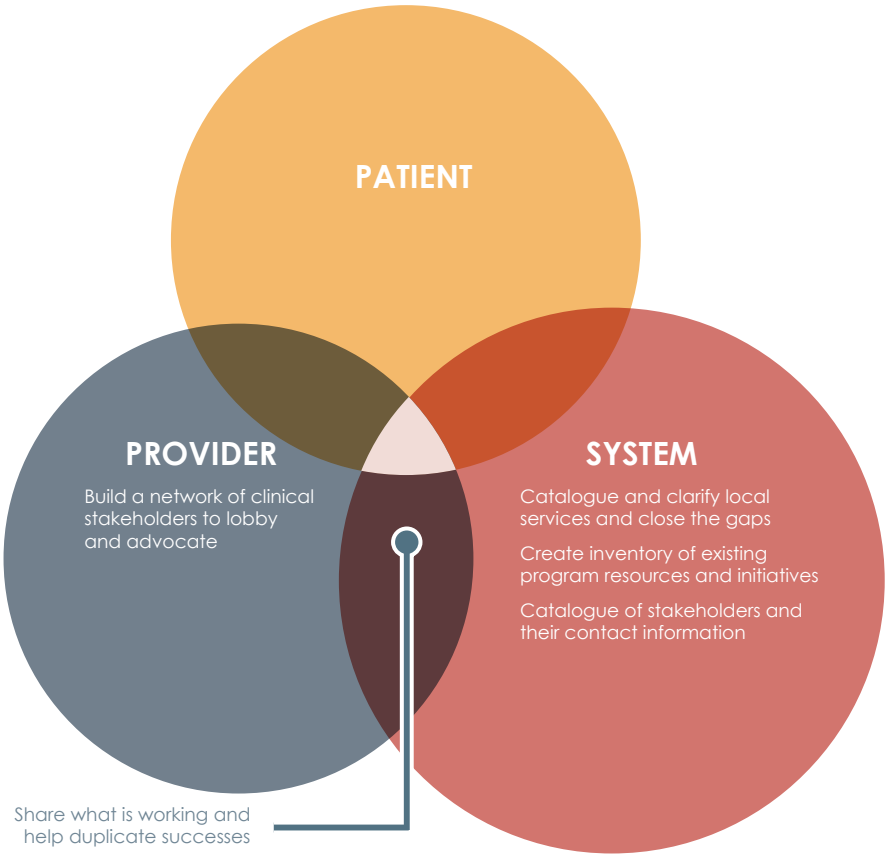


Recommendation Seven:

Create a directory of all services, programs, and resources available to seniors and provide ease of service access and navigation for seniors, their families, and care providers

Relevant research has shown the current health care system to be fragmented and uncoordinated, often resulting in negative incentives, a lack of accountability, and significant service gaps among the numerous challenges in its navigation.[2] With multiple points of entry and service delivery influenced by available contracted services—rather than patient need—redundant assessments, inappropriate use of costly services, long wait times for available services, and inadequate transmission of information, the system as it exists does not follow administrative best practices.[2] Ideally, system commitments and policies would be facilitated by a single or highly coordinated model of administration and single funding pool.

The opportunities for partnerships are varied and creative as age-friendly initiatives have massive potential to bring stakeholders together around the challenges and possibilities of building a more integrated system. In order to weave together the many threads towards a common goal of an effective integrated system, we need to identify the needs of the seniors population and design a system that aims to meet those needs. Care delivery systems built without consideration of the end user will continue to result in a fragmented and difficult to navigate construct no different from the system we are currently proposing be improved.



Recommendation Eight:

Support a societal culture focused on inspiring and creating age-friendly communities

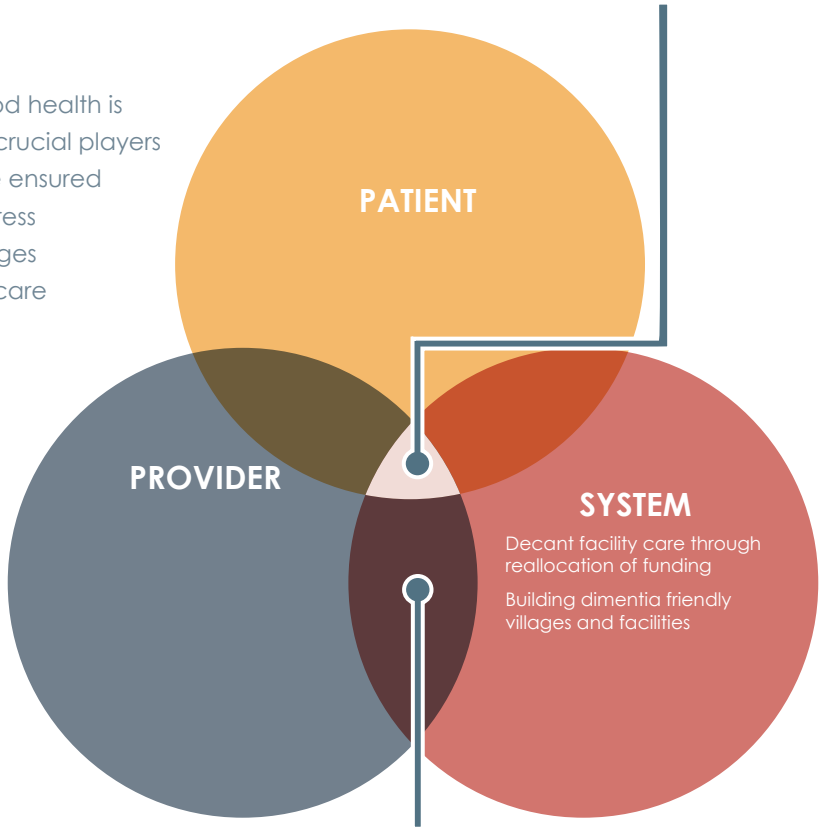
Studies have shown that the health of seniors is intricately linked to their life experiences and good health is essential from individuals and societies,[19] and as crucial players in the community, their contributions can only be ensured if they enjoy good health and societies that address their needs.[11] To compensate for the many changes associated with aging, seniors need a system of care designed to promote optimal quality of life with supportive and enabling living environments where care delivery is accessible, responsive, respectful, and person- or family-centred.[11]

One of the keys to maintaining quality of life[19] is to sustain the abilities of seniors to participate in meaningful activities and social networks. Combatting ageism, promoting health- and age-friendly communities, adopting an integrated system of care delivery[19] and increasing the capacity for geriatric care in the primary care setting with a multidisciplinary approach[2] are all essential components of facilitating aging in place.

There are opportunities to incorporate current, evidence-based practices and emerging practices into the desired future of health care. The successful integration of care requires all partners and partner organizations to understand how to collaborate effectively[2] while engaging seniors, families, and communities in both self-care and care planning. As a desirable health care delivery system should fully support self-managed care through access to quality services and continuity of care over a lifetime, ultimately supporting living and dying well with continuous supports and services in place.

Senior advocate in all urban planning

Increase societal responsibility and social awareness for elder-friendly communities



Build age-friendly communities (e.g. walkable)

Medical Home in community that includes the frail elderly

Create socially-built environments that enable aging in place

Determine model for best practice in LTS and fund accordingly

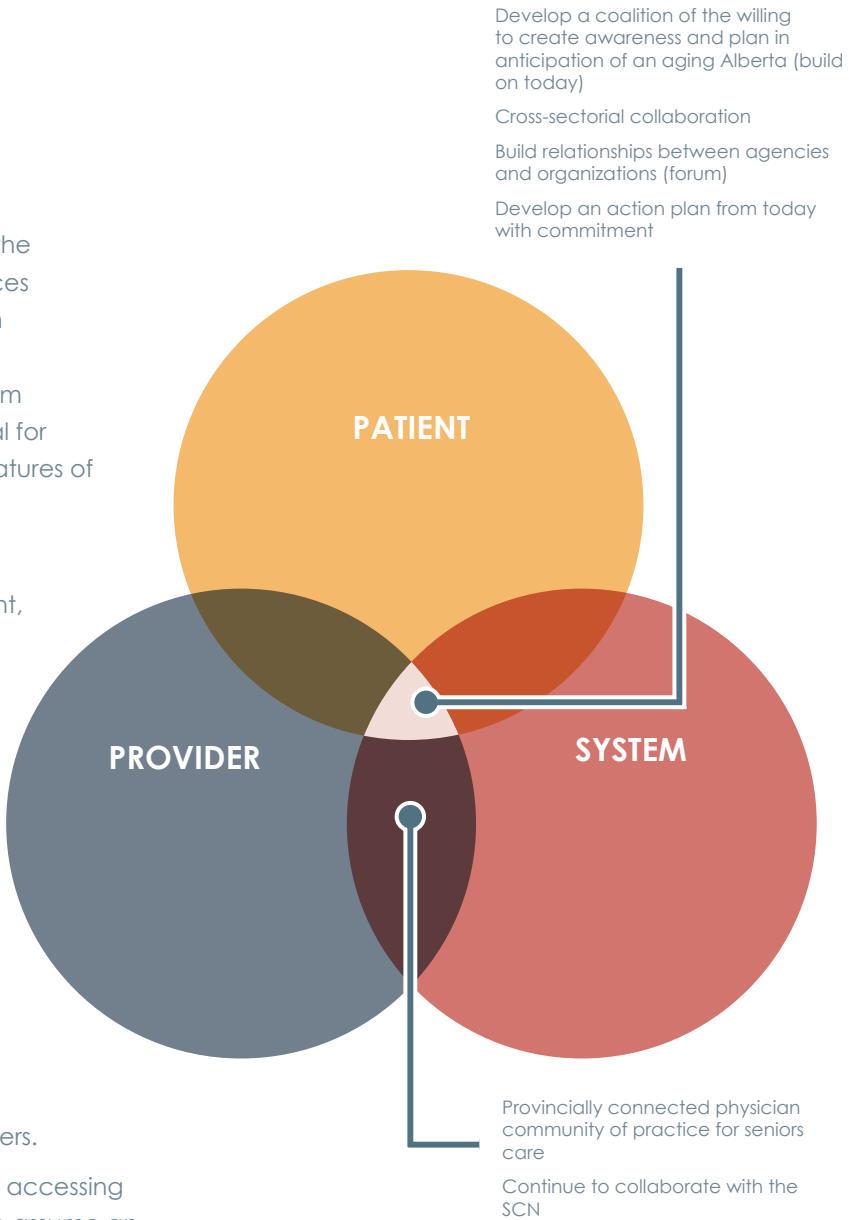
Recommendation Nine:

Continued collaboration with all stakeholder organizations to create and sustain momentum toward a better future for aging Albertans.

One strategy[2] to ensure that seniors can access the most appropriate medical and community services at the most appropriate time is to provide system navigation support through the medical home.[20] The system navigator role directly promotes system integration and therefore has significant potential for improving the outcomes for seniors. Common features of the role include:[2]

- Discharge and care planning,
- Medication reconciliation and management,
- Service or care provider access and coordination,
- Skilled home visits and/or phone support and/or availability,
- Liaison between medical and community services,
- Assessment and management of health issues,
- Patient and caregiver education on self-management,
- Patient advocacy,
- Collaboration with other health care providers.

As the primary point of contact[6,7,20] for individuals accessing the health care system, family physicians need to assume an active, central role in building the system of the future. However, it is equally important to recognize that a fully integrated system includes all stakeholders and allied health care professionals from the start, many of whom support seniors in the clinical setting in a navigator role.



Steps to Achieving the Vision

While the number of individuals visiting a family physician's office has not changed dramatically over the past 40 years,[6,7] the actual landscape of care looks drastically different than it did three decades ago and is sure to undergo significant changes in the foreseeable future.[7,12] However, any change that encourages the understanding of any individual on the aging population will require new perspectives such as respecting and honouring age rather than experience alone. Canada, like other countries,[4] can provide appropriate care services if the will to do so exists, however cultural shifts around aging—what is needed to support an aging population, what it should cost, and who should provide this support—need to involve communities and stakeholders at all levels and across all demographics.

Canada can provide appropriate care services if the will to do so exists.[4]

This shift in accepting new perspectives on aging must be supported by increased awareness and training, and should incorporate the preferences of seniors.[12]

One of the biggest hurdles that many seniors face is their own personal definition of what they are "capable" of[19] and other ageist attitudes are major contributing factors to systematic barriers and stereotypes of "burdensome older adults." Changed perspectives, however, need to occur across the age spectrum: Seniors must be informed, empowered, and able to embrace resiliency while children must be engaged in learning about older people and a community of intergenerational and cultural diversity.[19] Through the availability of educational resources (e.g. mandatory care of the elderly training), online learning, and social media platforms can be used to inform, support, and train both informal and formal caregivers and facilities, whether the specific demographic is seniors, their families, or the general public.

Opportunities Abound

There is an overarching opportunity to continue the forum discussion with diverse stakeholder groups with a goal of seniors' improved access to appropriate and timely care. There are numerous opportunities to improve awareness around needed resources and training, initiation of focused commitments through partnerships, and changes to policies, methods of care, and additional resources. These opportunities are not without challenges in ensuring that the existing knowledge of anticipated future needs are used to both design and deliver the best possible care, services, and supports.

Strengthening the provisions of primary care is essential to securing the health of older adults.

While it is an opportunity to encourage risk taking by individuals, it is of utmost import to approve only those initiatives that are patient-centred with measurable outcomes. The first step is for federal and provincial governments to recognize the major components of the health care system—continuing care, hospital care, primary care, public/population health—and, by viewing them as part of a whole rather than individual components, necessitate significant change.[4] Strengthening the provisions of primary care is essential to securing the health of older adults who are most likely to benefit from a team-based approach that focuses on prioritizing continuous quality improvement and the five principles of care:[15]

1. Access,
2. Equity,
3. Choice,
4. Value,
5. Quality.

The creation of such a system in Canada would not be unprecedented, as exhibited by Australia, Denmark, Japan, and the state of Arizona (USA). The systemic approach, though identified as a challenge, also opens up opportunities to make changes in care and in policy development (e.g. developing an inventory of policies that impact seniors, the creation of guidelines and pathways to improve care, and standardizing practice). Value for investment in the broader health care system can only be achieved if the system of care delivery is truly integrated,[4] grounded in primary care, and reduces the likelihood of seniors becoming lost in attempts to navigate the system.[2]

Enhancing the scope of practice in different settings and looking to innovation using technology and models of care holds the opportunity to lower costs and increase efficiencies, allowing a transfer of resources to those seniors most in need. Health care systems should support self-managed care through home care with emphasis on individual responsibility for health, where personalized care occurs through the recording of health, social, and personal histories through well-designed systems based on quality and continuity of care over a lifetime and, ultimately, dying well with continuous and varied supports and services provided by the long term caregiver relationships offered by the medical home.[13]

A New Perspective on How to Achieve the Vision

Just as in full integration of the medical home[20] no one health care professional is isolated; it's important to both recognize and ensure that no one recommendation stands alone. The "overall stability in relationships" with the health care system and providers proposed more than 40 years ago[7] has not experienced much change, but varied and dramatic changes in the medical workforce are to be expected. While family physicians are still likely to be the primary point of care and the most common point of access to the system, it is not unheard of to anticipate another change in the landscape of health care (e.g. providers, population/ demographics, relationships between patients and care).[7]

Therefore, it is imperative that, in achieving the vision and building the integrated system, we recognize the many competing demands[8] placed on family physicians, not only by families and communities, but also those that may extend past the confines of the office. The demands inherent in primary care[8] need to be carefully considered at all stages of system development in order to improve medical access and supports, rather than create additional barriers to care and, in doing so, create a less effective health care system over all.

Population Aging as a Challenge and Opportunity

With higher rates of chronic disease than has been seen before and together with longer life expectancy despite complex health issues, modern medicine has weakened the link between illness and/or disability and morbidity.[5] Cultural shifts around seniors care struggle to keep up with rapid (and dramatic) demographic changes, perception of seniors services and system-based realities, and general attitudes about aging (whether positive or negative). These challenges have led to a health care system that is complex, unclear, and inaccessible for many of those who require its services the most.[14]

In order to improve medical practice, we must recognize the many demands (both provider and patient) placed on the system if we are to fully understand the current state of care. For those charged with making policy recommendations, we must acknowledge that primary care physicians are increasingly busy and in short supply and that it is highly unlikely that patient care would be improved by placing additional demands and burdens on those physicians without first minimizing or removing others.[8]

For seniors, it is increasingly difficult to understand—and navigate—the system from home-based care to hospital care to discharge and back.[2] Much of the aging population have care needs that are unique,

difficult, and multi-faceted, and thus transcend the existing system. As such, there is an unclear vision for continuity of care, resulting in multiple points of entry, silos of care, and a lack of clearly distinguished roles and responsibilities for key stakeholders, as well as duplication of services and added strain on an already stressed health care system. For seniors health care providers and professionals, the system lacks planning, advocacy, and a clear roadmap to coordinated services. Not only are these providers fatigued and increasingly susceptible to burnout from the constant miscommunication and call for change, they are a strained resource unable to reconcile the challenges put forth by the legal, religious, personal, and cultural arenas, resulting in an inability to do their work while at the same time bring about the needed change with an ongoing emphasis on the importance of person-centred care.[14,16]

The aging population represents a significant diversity of individuals with varying abilities, skills, interests, level of education, personal wealth, living arrangements, and health status. There is also a wide age spread—encompassing over 40 years—from the "youngest old" at 65, to the "oldest old" at 105 years and over, therefore the needs and values of these individuals must be a consideration as they differ across the populations' spectrum.[3]

Realizing this vision will take significant work from every individual and organization that has a stake in the future of seniors care in Canada. The challenges that seniors and care providers and professionals face will only increase in complexity and compound on an already faltering system. The cultural shift around aging needs to involve society at all levels and across all demographics; changes must encourage the understanding of the impact of the individual on the aging population, but must also be inclusive of whole communities, all levels of government, and the nation.

Call for a Nation-wide Approach to Change

In Alberta alone, where the number of seniors grows by over 50 individuals a day, it was predicted that as early as the end of 2015, seniors (65 years and older) would outnumber youth (14 years and younger) and, by 2030, the Alberta seniors population is projected to double to approximately one million. While there is time before the full weight of the aging Baby Boomer generation is realized,[5] the need for change is immediate, long-lasting, and far-reaching because, as this shift continues at its accelerated pace, Canadian health care services must commence preparations to meet the needs of the growing aged population not only in Alberta, but across the country.[5,15]

With the overwhelming desire of seniors and their families to see a shift from institutionalized care to increased home and community supports, a variety of programs need to be created to engage seniors, provide education about nutrition, and encourage exercise[15] in an environment of health promotion. It has been estimated that $1 spent on enhancing physical exercise results in a return on investment as $3.20 savings in medical costs, where the same $1 spent on health promotion—or the process of enabling people to increase control over and improve their health—yields a return on investment of ~$6-8 in health cost savings.[4] If a health promotion environment in the integrated system could effect a 20% decrease in falls alone, the system could potentially see ~7,500 fewer hospitalization, ~1,800 fewer permanently disabled older adults, and a health care cost savings of up to ~$138 million a year.

The medical home model[20] that involves all care professionals in the care plan makes steps toward preventative services and health promotion; however, these programs must be designed to be accessible and inclusive of those most at risk of health and social issues if the health care system is to combat the current epidemic of obesity, mental illness, addictions, and societal problems that today's seniors face before these issues grow beyond the capacity of both the existing care systems and available services for future generations.[20]

Getting to the Desired Future

There is an imperative for enhanced planning and strategic action, and ample evidence supporting the necessity of the first of many prescriptive steps. Now is the time to identify and carefully design the services and programs that are essential today and into the future and while the vision and strategy may be overwhelming in scope and complexity, they must not focus on small temporary fixes to the existing system but rather create an adaptive and responsive environment for change.[5]

A change that encourages the understanding of the impact of any individual on the aging population will require a renewed perspective of honouring age rather than experience alone.

One strategy to ensure that seniors can access the most appropriate medical and community services at the most appropriate time is to implement system navigation supports.[2] However, the challenge exists to decrease spending growth without compromising access to, or the quality of, care while developing an efficient and sustainable system.[21] While the notion of health care escalation is widely accepted, the challenge that the nation faces is how to minimize those costs while continuing to provide the high standard of care[22] that Canadians have come to expect.[21]

A change that encourages the understanding of the impact of any individual on the aging population will require a renewed perspective of honouring age rather than experience alone. Opportunities to implement the recommendations presented here, and achieve a new vision of seniors care are creative, varied, and numerous; overarching is the opportunity to continue building on the forum discussion with diverse stakeholders, seeking the common goal of seniors' improved access to appropriate care. Finally, while it is an opportunity to encourage risk taking by individuals and stakeholders alike, it is of utmost importance to approve only those initiatives that are patient-centred with measurable, replicable outcomes.

While the outcomes matter greatly, they do not outweigh the importance of maintaining fairness in accessibility and scope of care to the seniors of today to provide for those of tomorrow; seniors are both the affected demographic and the most important ally in the collective effort to design and implement health and public policy that best serves the needs of the aging population.[21] Therefore, there is an immediate need for a short term "fix" that aligns with the long term "solution" because, in the end, health care services are only as good as the ability of individuals to access them.[3]

Appendix A

2014 Forum Participants

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Vivian Ewa
Dr. Gail Ewasechko
Dr. Douglas Faulder
Dr. Karen Fruetel
Dr. Tobias Gelber
Dr. Guy Gokiert
Christene Gordon
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Carmen Grabusic
Judy Hardement
Isabel Henderson
Steve Horsman
Karen Hughes
Maggie Jackson
Dr. Allison Jerome
Dr. Paul Kivi
Cheryl Knight
Ryan Kozicky
Bonnie Launhardt
Grace Maier
Dr. Yasmin Majeed
Lynne Mansell
Dr. Noush Mirhosseini
Dr. Elisa Mori-Torres
Sheli Murphy
Dr. Maeve O'Beirne
Dr. John O'Connor
Dr. Olubunmi Oyebanji
Dr. Jasneet Parmar
Dr. Marie Patton
Terri Potter
Hon. Dave Quest
Dr. Duncan Robertson
David Sawatzky
Dr. Cathy Scrimshaw
Gordon Self
Dr. Jed Shimizu
Dr. James L. Silvius
Dr. Pat Smith
Dr. Valerie Smith
Tracy Sommerfeld
Wendy Steele
Dr. Jennifer Stickney-Lee
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Averil Suriyakumaran
Dr. Tolu Taiwo
Jody Tol
Dr. Jean Triscott
Dr. Diana Turner
Dr. Ann Vaidya
Dr. Adrian Wagg

Appendix B

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