

McMaster Health Forum

Master Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at regional/provincial levels and at national levels, the Forum harnesses information, convenes stakeholders and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions and communicate the rationale for actions effectively.

About citizen panels

A citizen panel is an innovative way to seek public input on high-priority issues. Each panel brings together 10-14 citizens from all walks of life. Panel members share their ideas and experiences on an issue, and learn from research evidence and from the views of others. The discussions of a citizen panel can reveal new understandings about an issue and spark insights about how it should be addressed.

About this brief

This brief was produced by the McMaster Health Forum to serve as the basis for discussions by a citizen panel about meeting the future home and community care needs of older adults in Ontario. This brief includes information on this topic, including what is known about:

- the underlying problem;
- three possible options to address the problem; and
- potential barriers and facilitators to implementing these options.

This brief does not contain recommendations, which would have required the authors to make judgments based on their personal values and preferences.

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Key Messages

What's the problem?

- Meeting the future home and community care needs of older adults is challenging because:
 - the needs of older adults and their caregivers vary widely, especially with a growing number living with multiple chronic health conditions;
 - current programs lack coordination and don't meet the needs and preferences of older adults; and
 - planning for and implementing the system we'll want and need in 25 years takes time, resources and commitment from many players.

What do we know about three options for addressing the problem?

- **Option 1:** Designing a system that meets the needs of older adults who make it to 85 in good health
 - Evidence indicates that personalized needs assessments, tailored supports and referrals to more specialized care, home visiting by geriatricians or nurses, efforts to prevent falls, exercise, and nutrition education may be beneficial for helping older adults continue to live independently, reduce physical decline, improve safety, and avoid nursing home admission
- **Option 2:** Designing a system that meets the needs of older adults who have two or more chronic health conditions but still enjoy a good quality of life
 - Providing home care improves overall quality of care and quality of life, and reduces hospitalizations, emergency-department visits and premature mortality
 - Providing patient education, family-oriented interventions, home telehealth and e-health/information technology have been found to improve patient and caregiver knowledge and health outcomes
- **Option 3:** Designing a system that meets the needs of older adults who are socially isolated and suffering from many chronic health conditions
 - There is mixed and inconclusive evidence about models of care designed specifically for people with multiple chronic health conditions and who are socially isolated

What implementation considerations need to be kept in mind?

- Barriers to implementing these options might include challenges related to the difficulty of shifting resources to the community, supporting coordination among multiple sectors, as well as ensuring that individuals and the system have the ability to pay for needed home and community care
- Facilitators to implementing these options might include recent investments from the province of Ontario to improve home and community supports, increased use of technology, and emerging and innovative approaches to providing coordinated care for people with complex needs.



There is a need to spark a broad-based public conversation about how to transform our health system to care for an aging and increasingly diverse population.

The context:

Why is meeting the future home and community care needs of older adults a high priority?

>> Ontario's population is aging, and helping these older adults be healthy and live at home and in the community for as long as possible is a top priority for the Ontario health system.

Scenario 1

- **John, 85, and Mary D., 84, are retirees living in their home. In general, they would both say that their health is good or very good. They are independent in their activities of daily living and are still socially active within the community.**

Scenario 2

- **Syed H., 75, is a widower with a history of arthritis, hypertension and mild asthma. Despite his multiple chronic health conditions, he still enjoys a good quality of life. He lives with his daughter and her family in a rural area. He is a first-generation immigrant and English is his second language.**

Scenario 3

- **Julia W., 72, has Type 2 diabetes and has had some trouble with depression. In recent months she had issues with stability and frequently fell. She increasingly needs assistance with daily living activities and in adhering to her complex drug regimen. She lives alone in a small apartment and has no immediate family to provide support.**

These scenarios illustrate the wide range of home and community care needs that older adults in Ontario may require to stay healthy, manage their chronic conditions and stay in their homes. In general, these scenarios can be thought of in relation to three different populations:

1. older adults who make it to age 85 in good health;
2. older adults who have two or more chronic health conditions but still enjoy a good quality of life; and
3. older adults who are suffering from many chronic health conditions and are socially isolated.

The need to identify how to meet the future home and community care needs of older adults has attracted a lot of attention in part because:

- in the next two decades, the number of Ontarians aged 65 or older is expected to double, those 85 and older to quadruple, and those 100 and older to triple;(12)

- 63% of Canadians selected home and community care as a top priority in healthcare for older adults;(14) and
- 43% of adults over the age of 65 have two or more chronic conditions.(15)

In particular, meeting the needs of people with multiple chronic health conditions has attracted a lot of attention in Ontario, in part because:

- managing multiple chronic health conditions is part of the daily life of a growing number of Ontarians;
- having multiple chronic health conditions significantly affects people’s quality of life, their ability to work, and their risk of dying prematurely;(16)
- people who have multiple chronic health conditions have complex needs that are difficult to meet in a coordinated way;(16) and
- two out of every three dollars spent on healthcare goes to those living with multiple chronic health conditions.(17)

This brief was prepared to support the discussion by a citizen panel about meeting the future home and community care needs of older adults in Ontario. The input from the citizen panel will help to guide the efforts of policymakers, managers and professional leaders who make decisions about our health system. It will also be used by the Ontario Association of Community Access Centres (CCACs) in their continued efforts to provide optimal home and community care to older adults in Ontario.

Glossary

Chronic health condition

A health problem requiring ongoing management over a period of years or decades (e.g., asthma, cancer, depression, diabetes and heart disease).(1)

Home and community care

Services to help people receiving “care at home, rather than in a hospital or long-term care facility, and to live as independently as possible in the community. Home and community care is delivered by regulated health care professionals (e.g., nurses), non-regulated workers, volunteers, friends and family caregivers.”(3)

Unpaid caregiver

An individual who is providing unpaid and ongoing care or social support to a family member, neighbour or friend who is in need due to physical, cognitive or mental health conditions.(6)

Primary care

The first level of contact with the health system provided primarily by family doctors (e.g., office visits and house calls).

Self-management

“An individual’s ability to manage the symptoms, treatment, physical, psychosocial, and lifestyle changes inherent in living with a chronic condition.”(8) It empowers patients and prepares them to manage their health and healthcare.(9;10)

Box 2

>> Health system in Ontario

- Medical care provided in hospitals and by physicians is fully covered by Ontario's publicly funded health system.
- Care and support provided by other healthcare providers such as nurses, physiotherapists, occupational therapists and dietitians are typically not covered by the health system unless provided in a hospital or long-term care setting or in the community through Community Care Access Centres, Community Health Centres, Family Health Teams and other designated clinics.
- Other healthcare and community services such as prescription drug coverage, community support services and long-term care homes receive partial public coverage in Ontario, which requires citizens to pay for the uncovered portion on their own or through private insurance.
- 14 geographically defined Local Health Integration Networks (LHINs) have responsibility for the planning and funding of healthcare in their respective regions, and for ensuring that the different parts of the health system in their region work together.
- 14 Community Care Access Centres (CCACs) – one for each LHIN – have responsibility for connecting people with the care they need at home and in their community.
- 644 not-for-profit community support services (CSS) agencies provide services to support more than 800,000 community-dwelling Ontarians (most of which are older adults). Assistance provided includes personal support (e.g., for household tasks), services provided as part of supportive housing, Meals on Wheels, transportation, and respite and adult day programs.(2)
- 54 Health Links (of an anticipated total of 90) mobilize the delivery of integrated care for those with complex needs.



The number of older adults in Ontario is expected to double over the next two decades, and the majority will be living with at least one chronic disease or condition.(2)

The problem:

Why is meeting the future home and community care needs of older adults challenging?

>> Meeting the future home and community care needs of older adults is challenging because their needs vary widely, and because those with the most complex issues account for a large proportion of spending on healthcare.

In this section, we highlight some factors that contribute to the problem and that require careful consideration.

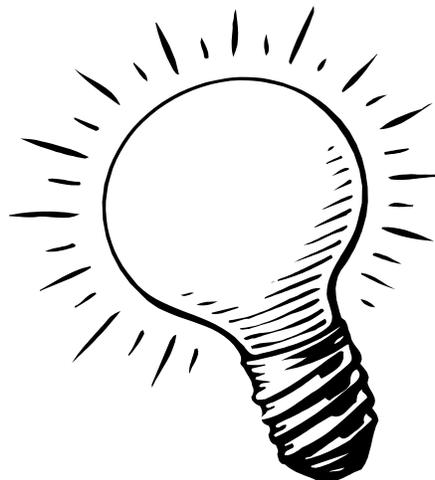
A new generation of older adults

Future home and community care for older adults will need to take into account that, in general, they:

- are more comfortable with technology;
- have different expectations for a health system (namely one that engages them and adapts to their needs and preferences); and
- are more culturally diverse.(18)

These new realities pose challenges and opportunities for how to adapt our existing system. For example, progress towards implementing technology in the healthcare system has been slow.(19) Also, not all older adults have access to information and communication technologies and/or may not be comfortable with using it. Expectations among older adults for a system that prioritizes home and community care,(14) and that emphasizes flexibility and choice will also require significant changes (namely, a move away from care being provided in hospitals and long-term care homes). Lastly, barriers to care due to language, cultural or other differences such as one's sexual orientation can occur if the system is not culturally sensitive. Such barriers may not only limit access to needed care, but also may lead to isolation, dependency and poverty.(14;20)

These challenges could in part contribute to a lack of confidence in the health system found in a recent poll conducted for the Canadian Medical Association. The poll estimated that 60% of Canadians “lack confidence in the current health system’s ability when it comes to caring for Canada’s ageing population. Those most concerned include women, Canadians between 35 to 54 years old, and Canadians already caring for an elderly person outside their home.”(14)



A growing number of older adults with multiple chronic health conditions

Chronic health conditions are a significant and growing challenge in Canada. An analysis conducted by the Health Council of Canada found that 29% of Canadians had one chronic health condition, 15% had two chronic health conditions, and 11% had three or more. Amongst those who are considered to be the sickest Canadians, 70% have two or more chronic health conditions.(21)

The number of people living with multiple chronic conditions is most concentrated among older adults. For example, it has been found that 71% of adults in Canada aged 60-79 had two or more chronic health conditions as compared to 13% among those aged 20-39. Data from Ontario indicates that 43% of older adults are living with two or more chronic health conditions, and the risks grow steadily with age.(15;22)

People living with multiple chronic health conditions are more likely to experience the following consequences:

- disabilities;
- poor quality of life;
- greater social isolation;
- high healthcare utilization;
- high out-of-pocket costs; and
- increased patient burden.(23)

Current programs and services often lack coordination, and do not completely meet the needs and preferences of older Ontarians

Coordinating the range of home and community care needed by older adults is challenging. This is particularly true for those living with complex chronic health conditions that often require care from many providers in different settings, resulting in care that is fragmented.(16) For instance, a patient with diabetes, multiple sclerosis and emphysema may need to seek care from a different doctor for each condition, in addition to a primary care provider who could coordinate their overall care. These various healthcare providers

may be in different settings and may not effectively communicate with each other.(24;25) The same patient also likely requires care provided in their home, help with transportation to and from appointments, perhaps help with preparing meals, as well as help with maintaining their home. The patient may also benefit from other community supports like community day programs and Meals on Wheels. While many of these supports may be available, they are not always provided in a coordinated way, resulting in gaps between what is needed and provided.

Caregivers are essential but also need support

In 2012, it was estimated that 8.1 million Canadians provided care to a family member or friend with a long-term health condition (most commonly cancer) or aging-related needs.(26) As a report from the Canadian Medical Association pointed out, “much of the burden of continuing care falls on [unpaid] caregivers. More than one million employed people aged 45-64 provide informal care to seniors with long-term conditions or disabilities and 80% of home care to seniors is provided by [unpaid] caregivers [in Canada].”(27)

The many roles that unpaid caregivers play are crucial and include any or all of the following:(28)

- providing emotional support;
- accompanying patients to medical appointments;
- reporting or managing side effects;
- giving medicines;
- keeping track of medicines, test results and papers;
- providing physical care (e.g., feeding, dressing and bathing);
- coordinating care;
- keeping family and friends informed; and
- making legal and financial arrangements.

Despite their crucial role in supporting the health of older adults, practical, social, emotional, informational and financial support for unpaid caregivers is lacking or inconsistently available across the province.(29) This lack of support can have a negative impact on the physical and mental health of unpaid caregivers, on their personal and professional lives, as well as on the quality of care that they provide.(30)

The financial burden for the health system, patients and their caregivers

An aging population will result in more people living with chronic conditions, and this is very expensive for taxpayers. Analyses of high-needs users of the health system in Ontario (which means those with the highest healthcare spending but not necessarily with multiple chronic health conditions) have found that:

- 1% of the population accounts for 33% of healthcare costs;
- 5% accounts for 66% of healthcare costs;(17) and
- the estimated burden of chronic health conditions in Ontario amounts to just over 55% of total direct and indirect healthcare costs, and this is expected to rise.(31)

Therefore, it is increasingly important to find better ways to provide the care needed for those who have complex needs.

There is also significant financial burden for patients and their unpaid caregivers. Many often have to pay for additional home and community supports that are needed beyond what their local CCACs and CCS agencies can provide, such as rehabilitation therapy, nursing care, other types of home care, and transportation to medical appointments. Some turn to private insurance to pay for these services, but 20-30% of citizens do not have supplemental or employer insurance.(18) Also, low-income older adults spend close to 60% of their income on housing and food, resulting in many not being able to pay for transportation or needed home and community care. These findings are likely a key reason that a poll conducted by the Canadian Medical Association found that two-thirds of Canadians reported that they could not afford home or institutional care.(14)

Planning for and implementing the system we'll want and need in 25 years takes time, resources and commitment from many players

There have been some promising steps taken by several organizations and governments at all levels to meet the future care needs of older adults in Ontario. However, efforts of this kind take time, resources and commitment from many players to bring about change. Box 2 provides a list of a few recent initiatives.

Box 3

>> A few recent initiatives

- After consultations in 19 communities in Ontario with more than 5,000 older adults and 2,500 health, social and community care providers, the report *Living Longer, Living Well* was released in January 2013 and provided 166 recommendations (including improving access to home and community supports) to inform the Ontario Seniors Strategy.(2)
- The province of Ontario released a *Vision for Home and Community Care* that will be used to inform “a series of home and community care summits across Ontario to gather feedback from providers, patients and their families.”(4)
- The province has committed to investing \$750 million by 2015-16 to increase capacity to provide care after discharge from hospital.(5)
- 54 Health Links (of an anticipated total of 90 Health Links) have been launched in Ontario since December 2012 to mobilize the delivery of integrated care for those with complex needs.(7) Health Links are also designed to support local patient-care networks that are led by a coordinating partner, and to coordinate and optimize access to needed services.
- The Partners Advancing Transitions in Healthcare (PATH) project is currently being implemented by Northumberland Community Partnership by uniting “12 health social care organizations with patients and caregivers to identify care transition problems across Central East Ontario and work with a full range of service providers to redesign and improve experiences.”(11)
- A variety of other pilot programs that aim to improve the integration of care teams and education for providers, and provide more seamless transitions of care are currently underway in Local Health Integration Networks (LHINs).
- Home and community supports provided by CCACc and CSS agencies are moving to a model of collaborative care coordination based on a client’s level of need.(13)



We have selected three options (among many) for which we are seeking public input.

Options:

How can we address the problem?

>> To promote discussion about the pros and cons of potential solutions, we have selected three options for meeting the future home and community care needs of older adults in Ontario.

Many options could be selected as a starting point for discussion. We have selected three (among many) for which we are seeking public input:

1. Designing a system that meets the needs of older adults who make it to 85 in good health;
2. Designing a system that meets the needs of older adults who have two or more chronic health conditions but still enjoy a good quality of life; and
3. Designing a system that meets the needs of older adults who are socially isolated and suffering from many chronic health conditions.

The three options do not have to be considered separately. They could be pursued together or in sequence. New options could also emerge during the discussions.

In the following sections, we examine what is known about the pros and cons for each option, by summarizing the findings of systematic reviews of the research literature. A systematic review is a summary of all the studies addressing a clearly formulated question. The authors use systematic and explicit methods to identify, select and evaluate the quality of the studies, and to summarize the findings from the included studies.

Not all systematic reviews are of high quality. We present the findings from systematic reviews along with an appraisal of the quality of each review.

- High-quality reviews: conclusions drawn from these reviews can be applied with a high degree of confidence.
- Medium-quality reviews: conclusions drawn from these reviews can be applied with a medium degree of confidence.
- Low-quality reviews: conclusions drawn from these reviews can be applied with a low degree of confidence.

Option 1 – Designing a system that meets the needs of older adults who make it to 85 in good health

This option might include:

- a range of basic home and community supports (e.g., help with household activities) that can be drawn from to help meet individuals' specific needs;
- opportunities for continued social engagement; and
- opportunities to engage in activities that promote good health

The most relevant reviews we identified about this option found that:

1. personalized needs assessments, tailored supports and referrals to more specialized care help older adults live independently;(32)
2. home visiting by geriatricians and/or by nurses that provide geriatric assessment and follow-up, helps reduce physical decline and nursing home admissions;(33)
3. efforts to prevent falls help to keep older adults safe in their homes;(34-37)
4. exercise helps to improve balance,(38) promote mental well-being,(39) and prevent falls;(34) and
5. nutritional education and advice can help improve physical function.(40)

Option 2 – Designing a system that meets the needs of older adults who have two or more chronic health conditions but still enjoy a good quality of life

In addition to what is included in the first option, this option might include:

- home and community supports to provide help with needed care for chronic diseases; and
- approaches to help older adults to manage their own health and care.

Many reviews have evaluated approaches to providing home and community supports, and we identified two reviews as being most relevant to this option. A medium-quality review found that combining in-home care that provides a range of supports with telemonitoring (that is, remotely monitoring patients who are not at the same location as the healthcare provider) improves the overall quality of chronic disease management.(41) Another medium-quality review found that in-home care helped to improve activities of daily living and quality of life, as well as reduce hospitalizations, emergency-department visits and premature mortality.(42)

Approaches that support and prepare older adults to manage their health and care generally focus on improving “an individual’s ability to manage the symptoms, treatment, physical, psychosocial, and lifestyle changes inherent in living with a chronic condition.”(43) The most relevant reviews that we identified related to this type of approach found that:

- patient education (e.g., teaching sessions, group discussion and written materials) for people with long-term conditions increases physical functioning, illness knowledge and the patients’ belief in their own ability to manage their health;(44)
- family-oriented interventions (e.g., by providing education about chronic health conditions and address family functioning) improve physical and mental health outcomes in patients and caregivers;(45)
- home telehealth (that is, delivering health-related services and information via telecommunications technologies while the patient is at home) has been found to be acceptable to patients and providers,(46) reduce re-hospitalization and length-of-stay in hospital,(46) and improve health outcomes for specific chronic diseases such as diabetes and ;(47) and
- e-health/information technology interventions in general have had positive effects on supporting individuals in managing their own health and care.(46;48-50)

Option 3 – Designing a system that meets the needs of older adults who are socially isolated and suffering from many chronic health conditions

In addition to what is included in the first and second options, this option might include:

- coordinated approaches to care that draw on the Chronic Care Model (see below for a description of the model) but are specifically tailored to meet the needs of the most complex patients in the system;
- intensive home and community supports that coordinate the range of care needed, including in-home care where possible;
- opportunities to re-engage socially; and
- support for unpaid caregivers.

We found very few systematic reviews examining the effectiveness of models of care specifically for people with multiple chronic health conditions. These reviews found mixed and inconclusive evidence about their effectiveness. However, a recent medium-quality review found that these types of models are at least comparable to, or more beneficial than, usual care.(51)

Other medium- and high-quality reviews we identified found that:

- focusing on particular risk factors or on areas where patients with multiple chronic health conditions have difficulties were more effective than those with a broader focus;(52)
- interventions targeting more specific changes to how care is delivered (e.g., integrated treatment programs coordinated by case managers or individualized pharmaceutical care plans implemented by multidisciplinary teams) were more effective as compared to those with a broader focus (e.g., case management or changes in care delivery);(52)
- “complex and multifaceted pharmaceutical care” (e.g., outreach interventions by pharmacists, or screening of automated drug alerts by pharmacists visiting nursing homes) reduced inappropriate medication use and adverse drug events;(53) and
- combining multiple approaches for helping health professionals share decisions with patients (e.g., educating health professionals and providing materials to support patient decisions) are promising,(54) but benefits for improving health outcomes were unclear.(55)

We also identified medium- and high-quality reviews that found several benefits for providing a more intensive form of homecare. Specifically, these reviews found that:

- home-based primary care (providing comprehensive and ongoing primary care in the home) has been found to substantially reduce emergency department visits, hospitalizations, hospital beds days of care, long-term care admissions, and/or time spent in long-term care;(56)
- “hospital in the home” (the delivery of care in the patient’s home as a substitute for being in hospital) can reduce premature mortality, hospital readmission rates, burden on caregivers and costs, as well as improve patient satisfaction with care;(57)
- home follow-up after hospital admission is more likely to reduce readmission;(58)
- coordination of services that are tailored to individual patient needs following discharge from hospital reduces the length of stay required in hospital and readmission rates for older adults in hospital with a medical condition;(59)
- the cost to provide care to someone in their home is generally less than the costs associated with placement in a long-term care setting.(60)

We also found one medium-quality review that evaluated approaches for addressing social isolation and loneliness in older adults. This review found that the most effective approaches are those that:

- were developed based on existing theory in the field;
- offered social activities and/or support in a group format; and
- involved older adults as active participants.(61)

Lastly, a recent high-quality review looked at a range of supports for unpaid caregivers of people with dementia.(62) The most promising approach identified in the review were those that combined educational (for example educational materials or feedback/advice about dementia and its complications) and supportive (for example, telephone or group support with professionals or other experienced caregivers) interventions. These interventions were also found to be helpful on their own. Specifically, educational supports help to improve caregiver-burden symptoms such as depression or feelings of isolation. Also, telephone or group support helps to improve caregiver confidence and capacity to relax when providing care.

In addition to these findings, we outline here the Chronic Care Model to help spur reflection about how care for those with chronic conditions could be organized and delivered as part of this option.(9;10) This model identifies six key characteristics of a health system that encourages high-quality management of chronic health conditions.(16) These six characteristics could inspire the discussions of the citizen panel.

<p style="text-align: center;">Self-management support</p> <ul style="list-style-type: none"> • Helping patients to manage their own health and care • e.g., providing information, emotional support and strategies for living with chronic health conditions 	<p style="text-align: center;">Decision support</p> <ul style="list-style-type: none"> • Helping providers and patients make informed decisions • e.g., encouraging the use of medical guidelines and tools to help patients make decisions
<p style="text-align: center;">Delivery of care</p> <ul style="list-style-type: none"> • Making sure that patients receive efficient and effective care • e.g., clarifying roles among healthcare teams, providing case management, or providing care that patients understand and that fits their cultures 	<p style="text-align: center;">Clinical information systems</p> <ul style="list-style-type: none"> • Organizing patient and population data to facilitate more efficient and effective care • e.g., an electronic health record that provides reminders for providers and patients, and monitors the performance of healthcare teams and the broader health system
<p style="text-align: center;">Health system changes</p> <ul style="list-style-type: none"> • Creating a culture, organizations and mechanisms that promote safe and high-quality care • e.g., encouraging leadership across the health system to bring about change, developing agreements to facilitate care coordination within and across organizations 	<p style="text-align: center;">Community resources & policies</p> <ul style="list-style-type: none"> • Mobilizing resources in the community to meet the needs of patients, resources that are not necessarily part of the health system • e.g., forming partnerships with community organizations to fill gaps in services, or advocating for policies to improve patient care

Summarizing what we know about the three options

In the following table we summarize what we know about each of the three options.

Option 1 – Designing a system that meets the needs of older adults who make it to 85 in good health
Summary of what is known about home and community supports and approaches for promoting good health
<p>The most relevant medium- and high-quality reviews we identified found that:</p> <ul style="list-style-type: none">• personalized needs assessments, tailored supports and referrals to care help older adults live independently;(32)• home visiting by geriatricians and/or by nurses that provide geriatric assessment and follow-up, helps reduce physical decline and nursing home admissions;(33)• efforts to prevent falls help to keep older adults safe in their homes;(34-37)• exercise helps to improve balance,(38) promote mental well-being,(39) and prevent falls;(34) and• nutritional education and advice can help improve physical function.(40)
Option 2 – Designing a system that meets the needs of older adults who have two or more chronic health conditions but still enjoy a good quality of life
Summary of what is known about enhanced home and community supports and helping older adults manage their own health and care
<p>Two medium-quality reviews found that:</p> <ul style="list-style-type: none">• in-home care combined with telemonitoring (that is, remotely monitoring patients who are not at the same location as the healthcare provider) improves the overall quality of chronic disease management;(41)• in-home care helped to improve activities of daily living and quality of life, as well as reduce hospitalizations, emergency-department visits and premature mortality.(42) <p>Several reviews evaluating approaches to help older adults manage their own health and care found that:</p> <ul style="list-style-type: none">• <u>patient education</u> for people with long-term conditions increases physical functioning, illness knowledge and the patients’ belief in their own ability to manage their health;(44)• <u>family-oriented interventions</u> improve physical and mental health outcomes in patients and caregivers;(45)• <u>home telehealth</u> has been found to be acceptable to patients and providers,(46) reduce re-hospitalization and length-of-stay in hospital,(46) and improve health outcomes for specific chronic diseases such as diabetes and ;(47) and• <u>e-health/information technology</u> interventions in general have had positive effects on supporting individuals to manage their own health and care.(46;48-50)
Option 3 – Designing a system that meets the needs of older adults who are socially isolated and suffering from many chronic health conditions
Summary of what is known about coordinated approaches to care, intensive home and community supports and opportunities to re-engage socially

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- Models of care specifically designed for people with multiple chronic health conditions have been found to be at least comparable to, or more beneficial than, usual care.(51)
- The following interventions were found to be beneficial for supporting people with multiple chronic health conditions:
 - patient-oriented interventions focusing on particular risk factors or on areas where patients with multiple chronic health conditions have difficulties;(52)
 - interventions targeting specific changes to how care is delivered by organizations (e.g., integrated treatment programs coordinated by care managers, or individualized pharmaceutical care plans implemented by multidisciplinary teams);(52)
 - complex and multifaceted pharmaceutical care (e.g., outreach interventions by pharmacists, or screening of automated drug alerts by pharmacists visiting nursing homes);(53) and
 - helping health professionals share decisions with patients (as a promising approach but still unclear in terms of benefits for health outcomes).(54;55)

Reviews relevant to this option also found that:

- home-based primary care (providing comprehensive and ongoing primary care in the home) has been found to substantially reduce emergency department visits, hospitalizations, hospital beds days of care, long-term care admissions, and/or time spent in long-term care;(56)
- “hospital in the home” (the delivery of care in the patient’s home as a substitute for being in hospital) can reduce premature mortality, hospital readmission rates, burden on caregivers and costs, as well as improve patient satisfaction with care;(57)
- home follow-up after hospital admission is more likely to reduce readmission;(58)
- coordination of services that are tailored to individual patient needs following discharge from hospital reduces the length of stay required in hospital and readmission rates for older adults;(59)
- the cost to provide care to someone in their home is generally less than that the costs associated with placement in a long-term care setting;(60)
- the most effective approaches for addressing social isolation and loneliness in older adults offer group-based social activities and/or support, and involve older adults as active participants.(61)
- combined educational and supportive interventions has been found to be the most promising approach for supporting caregivers of people with dementia.(62)

Implementation considerations

It is important to consider what barriers we may face if we implement the proposed options. These barriers may affect different groups (e.g., patients, citizens, healthcare providers), different healthcare organizations or the health system. While some barriers could be overcome, others could be so substantial that they force us to re-evaluate whether we should pursue that option.

The implementation of each of the three options could also be influenced by the ability to take advantage of potential windows of opportunity. A window of opportunity could be a recent event that was highly publicized in the media, a crisis, a change in public opinion, or an upcoming election. A window of opportunity can facilitate the implementation of an option.

A list of potential barriers and windows of opportunity for implementing the three options is provided below. This table is provided to spur reflection about some of the considerations that may influence choices about an optimal way forward. We have identified the barriers and windows of opportunity from a range of sources (not just the research literature) and we have not rank ordered them in any way.



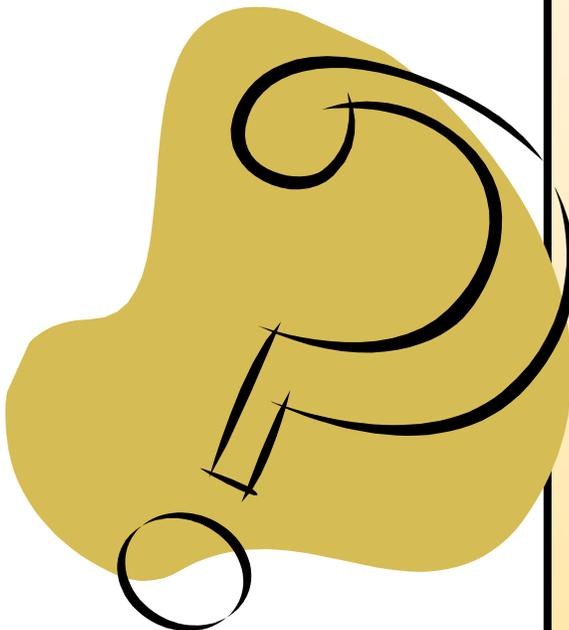
Option 1 – Designing a system that meets the needs of older adults who make it to 85 in good health	
Barriers	Facilitators
<ul style="list-style-type: none"> Decision-makers may need to change how care is delivered to better address the preference of older adults to stay at home for as long as possible, which means shifting resources to the community and ensuring coordination among multiple sectors 	<ul style="list-style-type: none"> Citizens and health workers may be better supported through the increased use of technology (e.g., by helping to manage care and connect individuals facing similar challenges to help prevent social isolation)
Option 2 – Designing a system that meets the needs of older adults who have two or more chronic health conditions but still enjoy a good quality of life	
Barriers	Facilitators
<ul style="list-style-type: none"> In addition to the barrier listed above, many older adults face financial barriers in accessing needed home and community supports given that they are currently only partially covered (or not covered at all) by the province. 	<ul style="list-style-type: none"> The recent release of a Vision for Home and Community Care and the planned \$750 million investment by the province for home and community supports seem to signal a willingness to engage in long-term planning and allocate needed resources.(4;13) Recent policy guidelines from the province focus on supporting the client care journey and working with clients as partners.(13)
Option 3 – Designing a system that meets the needs of older adults who are socially isolated and suffering from many chronic health conditions	
Barriers	Facilitators
<ul style="list-style-type: none"> In addition to the barriers listed above, decision-makers face difficult decisions about what types of home and community care will be covered and whether all or part of the costs will be covered. 	<ul style="list-style-type: none"> Emerging and innovative approaches, such as Health Links and PATH, which aim to support coordinated care for people with complex needs may provide a starting point for continued innovation.

Questions for the citizen panel

>> We want to hear your views about the problem, three options for addressing it, and how we can move forward.

This brief was prepared to stimulate the discussion during the citizen panel. The views, experiences and knowledge of citizens can make a great contribution in finding viable solutions to the problem.

More specifically, the panel will provide an opportunity to explore the questions outlined in Box 3. Although we will be looking for common ground during these discussions, the goal of the panel is not to reach consensus, but to gather a range of perspectives on this topic.



Box 4

>> What are the biggest challenges faced by:

- older adults who make it to 85 in good health?
- older adults who have two or more chronic health conditions but still enjoy a good quality of life?
- older adults who are socially isolated and suffering from many chronic health conditions?

>> What types of home and community supports do you think would be needed to support the needs of each of these populations?

>> What are potential barriers and windows of opportunity to implement these three options?

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Conflict of interest

The authors declare that they have no professional or commercial interests relevant to the citizen brief. The funders played no role in the identification, selection, assessment, synthesis or presentation of the research evidence profiled in the citizen brief.

Merit review

The citizen brief was reviewed by a small number of citizens, other stakeholders, policymakers and researchers in order to ensure its relevance and rigour.

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