

# Notes from the Editor-in-Chief

IN THE LEAD paper, Williams et al. consider “aging at home” as an important option for care for older persons. Included in their discussion is not only *what* to do but also *what not* to do in relation to older adults in the home. The authors review findings from national and international research and identify three guiding principles and several recommendations for integrating care in the home for older persons.

One of the recognized challenges for industrialized nations is to sustain overstretched healthcare systems as the proportion of elderly in the population grows. The authors review public and political concerns regarding access to and sustainability of care, and their conclusions suggest the following:

- Healthcare expenditures are continuing to increase steadily.
- New and costly medical technologies and drugs are continuously being developed.
- There are rising public expectations about an individual’s right to access care in a timely fashion.
- There exists a growing population of older people who live longer and have chronic care needs.

Williams and colleagues explain that policy makers are challenged to respond to the needs for healthcare for new generations of older persons, while also answering this generation’s increasingly vocal demands to live independently.

Aging at home as a policy in Ontario is offered as an alternative to the “tendency to abandon older persons to their own means” and to “warehouse’ them in institutions.” The goals of aging at home include supporting the well-being and maintaining autonomy and quality of life for older persons and their caregivers in their own homes or in a home-like environment. Aging at home policies seek to address cost-effectiveness and sustainability of care by

maintaining older persons’ health status and functionality at the highest possible level.

The authors indicate that there has been little or no success with aging populations in stand-alone or healthcare systems that are fragmented. They discuss the necessity of integration across various healthcare components to achieve accessible, higher-quality, cost-effective care. This need was advocated 10 years ago by the Ontario Health Services Restructuring Commission.

Healthcare spending is rising faster than the rate of inflation in all industrialized countries. Despite higher spending, patients still experience lengthy wait times in hospital emergency services and elective surgeries, as well as long wait lists for long-term care. Additionally, gaps exist between different healthcare services, including hospitals, primary healthcare and nursing homes as well as home help, day care and residential care in various regions. Such gaps create challenges when caring for older people with multiple needs.

While medically necessary services are fully insured under Canada’s publicly funded universal healthcare program (medicare), when services are delivered outside of hospitals or by healthcare workers other than doctors, this care may not be covered. Nursing care and prescription drugs are a vivid example of this type of gap. Ontario provides a variety of high-quality services that are publicly funded on the basis of need, but still has a fragmented community-based support system for aging-at-home services. Access to professional home care services is available through a network of publicly funded community care access centres (CCACs); these are fully insured, and services are given without cost (e.g., nursing, social work and rehabilitation therapy), but there is no universal entitlement to such services. A large proportion of such services are provided to post-acute care patients, and fewer services are provided to those with chronic needs.

Two initiatives recently introduced in Ontario to help take the province in a new direction are described. The first was to establish 14 Local Health Integration Networks with the charge of planning, funding and monitoring providers such as hospitals, CCACs, community support agencies, community-based mental health and addiction services and long-term care facilities. The second initiative is the four-year aging-at-home strategy. This strategy is designed to allow older people to continue to be independent in their own homes and lead healthy lives.

An adaptation of the “balance of care” (BoC) research methodology is used to determine why some older persons are able to live at home successfully while others are not. The BoC method suggests that the probability of aging at home is determined by both demand and supply factors, including the individual’s needs and characteristics on the demand side, and the access and availability of needed care on the supply side. Where such care is available, older persons are likely to successfully age at home. By using this method, the authors concluded for Ontario that (1) 20–50% of older persons on wait lists for long-term care could age at home safely and cost-effectively if given access to home and community care services, (2) people’s inability to perform basic functions such as transportation and medication management influence their placement on a long-term care wait list and (3) to age at home, a person must have the ability to manage multiple services and providers and have access to home and community care services. Additionally, the authors found that, when given a choice, older persons prefer to age at home.

Although Williams et al. are convinced that integrated care is essential for older persons and other vulnerable populations, there is no agreement as to how this should be achieved. The authors outline three guiding principles – know whom you serve, know

what works for whom and see the big picture – and several recommendations for better integration, summarized below.

*Recommendation one: put older persons at the centre.* Instead of serving as bystanders while a doctor determines the plan for care, it is recommended that patients be at the centre of their care. This can be achieved through self-management, co-management or broad consultation with experts, and patients and caregivers serve as the basis for the decision-making. Patient-centred healthcare contributes to more cost-effective care and allows patient interest and goals to outweigh provider interest and political exigencies.

*Recommendation two: include caregivers.* In contrast to patients treated on an episodic basis, it is recommended that aging at home emphasize the needs of the caregiver in the care plan. Aging at home focuses on the context surrounding the patient. The authors explain that caregivers are often the first line of integration, and they, too, require support.

*Recommendation three: stratify and target needs.* The authors emphasize picking targets and focusing integration initiatives on those targets. They describe the Kaiser-Permanente “triangle” of care, explaining that the bottom level represents the majority of patients who can care for themselves and their condition while aging at home, the middle level represents those with more complex conditions who require some specialist care and multidisciplinary healthcare teams and the top level represents the minority of patients who have various healthcare and social care needs and are the most intensive users of hospital care.

*Recommendation four: appropriately manage care.* Williams et al. suggest managing care from the bottom up and organizing care around patients’ and caregivers’ needs. They stress the importance of multidisciplinary teams that include primary care. Benefits to appropriately managing care include work satisfaction for case managers as they have

greater flexibility, and greater satisfaction for the primary caregiver as less time is spent on coordinating and finding needed services. The authors note that there are various ways to manage care, and supported self-management work best for those with minimal needs.

*Recommendation five: put enough tools in the tool kit.* The authors suggest providing enough services to allow a link between dissimilar organizations such as hospitals and home and community care agencies. This type of vertical integration is important for the proper use of community-based care in place of care in hospitals or other institutions.

*Recommendation six: be patient.* Williams et al. explain the distinction between integrated care (an end point or ideal model) and integrating care (a process of organizing and coordinating care to address needs). They suggest focusing on the process – integrating care – because there is always a way to improve, and beginning with modest steps.

*Recommendation seven: be mindful of local context.* The authors suggest that there is not a model that will work for every jurisdiction. They explain that some integration methods focus on a system level, others on organizations and still others on “virtual” integration. Considering geographical and ethno-cultural diversity is also important.

*Recommendation eight: protect community-based services.* The authors remind policy makers that the promise of aging at home and the sustainability of the system can be undermined by withdrawing community-based services.

In summary, the authors conclude that aging at home allows older persons the ability to live independently for as long as possible, and surely we all want that. Such initiatives can create positive benefits at individual and system levels and are politically neutral. Some plans demonstrate cost-savings, and others have shown better outcomes for older persons at a comparable cost to current efforts.

We have excellent commentaries that add both international and national perspectives to this topic. Mary Stuart and her colleagues from the US Department of Veterans Affairs and Empoli, Italy, begin our discussion with an interesting perspective on exercise. They describe the Empoli Adaptive Physical Activity Program, a community exercise program that was designed to increase the regular exercise levels of older adults. The value of regular exercise, especially for individuals with chronic conditions, has not been fully recognized as means of lowering body mass index and blood pressure and increasing bone density. This type of program is now widely used for persons with disabilities in parts of Italy and Switzerland.

Eigil Boll Hansen of the Danish Institute of Governmental Research outlines the system for integrated care for the elderly in Denmark. Local authorities provide care and help to individuals in their own home or assisted-living facilities. The purposes of the services are to prevent situations getting worse and to improve individuals’ ability to function while remaining at home. Services included are home help, home nursing, alarm systems and technical aids. These services are coordinated with hospital services, and incentives are provided to ensure that home care is seen as a valid substitute for hospitalization.

Nies Henk, Julie Meerveld and René Denis in the Netherlands describe the National Dementia Program which is specifically designed to improve dementia care, particularly the coherence among regional resources. This program focuses on the needs of patients and patients’ support systems through the use of regional patient panels which gather the experiences of dementia patients and their primary caregivers in plain language.

The Program of All-inclusive Care for the Elderly (PACE) is described by Grace K. Li and her colleagues as a successful approach to aging at home in the United States. The On

Lok Lifeways model has existed as a vertically integrated system in the San Francisco community for 38 years. It was started as a result of the recognition that the frail elderly were not getting the care they needed in the community. The PACE model has been replicated and now exists in 71 provider organizations in 31 states. There are certain eligibility requirements, and the profile of the average client is female and age 84 years, has 13 medical conditions, is dependent in some activities of daily living and has some cognitive impairment. The model uses interdisciplinary teams to provide comprehensive services to each individual.

Janet Lum and Ann Aikens describe the application of a PACE-type model to integrating community-based health and social care for older persons in a rural setting – North Renfrew Long-Term Care Services. Services include community support programs, supportive housing, long-term care beds and a 24-Hour Flexible In-Home Support Pilot program adapted from the “night patrol” system in Denmark. These authors describe the particular challenges of providing this type of service in a rural community that may not have the critical mass of services typically available in an urban centre.

Professor Réjean Hébert, dean of the Faculty of Medicine and Health Sciences, Université de Sherbrooke, outlines the approach taken in Quebec to shift the focus of care from hospitals to home care. He describes an autonomy support benefit plan, which would cover costs related to disabilities and would therefore be applicable regardless of where care is provided. An experiment has been conducted in one urban and two rural settings. There were over 1,500 participants who successfully demonstrated that the system was more efficient and effective, without an increase in costs.

In Vancouver, Judy Kelly and Alison Orr describe the Accountability, Responsiveness

and Quality for Clients Model of Home Support. This model works on providing cluster care for high-density housing by a team of community health workers. The system uses a set of quality and performance measures that are in alignment with the Canadian Council of Health Services Association’s Achieving Improvement Measurement dimensions of quality. Highlights of the measurement scheme and the evaluation are provided.

In our final report, David Pedlar and Wendy Lockheart describe Canada’s Veterans Independence Program for aging at home. This program was developed in 1981 to promote the independence of Second World War veterans. At that time, there were over half a million veterans, who clearly had a preference for aging at home. Although not all services are provided in every province, VIP offers a wide range of services including groundskeeping, housekeeping, meals, personal care, travel to medical appointments, home adaptation and special equipment. Strong features of the services include the recognition of the role of family caregivers, and self-management by the veterans of their own health needs.

In conclusion, it is clear from these reports that we all value the idea of growing old at home. Where there have been experiments either in Canada or abroad, the experience has shown that it can be done when the appropriate services are available. So, why has it not yet become the model of choice for governments or the most frequent mode of delivering services? Communities must be able to see this approach as an investment and a cost-effective way of providing services. Very soon the baby boomers will be demanding it!

Peggy Leatt, PhD  
Editor-in-Chief