How to Support Our Frail Elderly

Suggested Action Plan

June 2024

AdvantAge Ontario
Advancing Senior Care

Canadian Mental Health Association Ontario

HOME CARE ONTARIO

THE ONTARIO caregiver ORGANIZATION

Ontario College of Family Physicians

OCSA
Ontario Community Support Association

OHA Ontario Hospital Association
100 Years

OLTCA

Introduction

If we continue our current trajectory, there will not be adequate care for our elderly loved ones. Here's why:

There is a profound demographic shift underway. The 80+ population in Ontario is projected to more than double by 2040.

People want to age at home – yet one in five older adults today have complex care needs which make it very challenging. Plus, family and other loved ones taking care of older adults say they are burning out with 63% of caregivers saying they reached their breaking point last year but had no choice but to keep going.

Then couple this with more than 43,000 people in Ontario waiting for long-term care – more than the populations of a mid-sized town such as Bradford, Orillia, Stratford, Orangeville, or Leamington – with the waitlist for long-term care expected to grow to 48,000 individuals by 2029 based on population growth and complex care need trends.

Bottom line, there will not be enough long-term care beds for those who need them, even with the significant investments and historical commitments already made by the Ontario Government, and the commitment by long-term care homes to deliver on the Government's pledge to redevelop older homes and to create 30,000 new long-term care spaces.

Collectively, with leaders across our sectors, we have identified existing solutions that can be expanded to reduce the long-term care wait list, help more older people with complex care needs age at home, and to fast-track access to long-term care for those who really need it.

We look forward to working with you to expand solutions like these to support our growing, elderly population and offer ourselves as a resource to work collaboratively with you on supporting frail seniors in Ontario.

See appendix for more detailed data, plus avatars reflecting the needs of people requiring care.

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How to Support Our Frail Elderly

Expand services to enable people to live and age at home

- Home care
- Community care
- Primary care
- Rehabilitative care
- Mental health and addictions supports
- Digital technologies
- Long-term care community hubs
- Caregiver respite and supports

Bridge services to get people out of hospitals and back to a home

- More transitional care units

Expand supportive and affordable housing

- More seniors' units in existing housing

Prioritize those with highest need to access long-term care

- Fulfill commitment to redevelop/build allocated beds
- Expand community admissions

Why now:

- **Growing numbers of elderly people with complex care needs**
- **Most people want to age at home, if possible**
- **Many could have their complex care needs met at home with proper and increased supports, and for their caregivers too**
- **Caregivers are overburdened and buckling under the pressure of supporting their loved ones**

Ingredients for long-term sustainability:

- **Health human resources**
- **Real-time data and information exchange**
- **Ease of access and improved navigation**

11 Practical Solutions

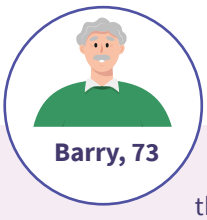
There are people on the long-term care wait list who could have their complex care needs met at home with proper and increased supports, while others need to be fast-tracked to long-term care.

Below we offer practical solutions that are currently at our collective fingertips as a health system, to support more than 43,000 people on the long-term care wait list.

The solutions cover four zones of focus.

- Expanding services that enable people to age at home.
- Prioritizing those with the highest needs to access long-term care and avoid admission to hospital.
- Bridging services to get people out of hospital and back to a home.
- Expanding supportive and affordable housing.

Expand services that enable people to age at home



Barry, 73

Barry was an educator in his rural community and one of the longest-serving principals at his local school board. He shared his love of the outdoors with his students, friends, and family. Until his sudden stroke, he spent his retirement hiking, fishing and hunting.

The stroke left him paralyzed on the right side, easy to tire, often confused, and increasingly depressed – which was devastating to him and his family. He requires a lot of care to return to a stable state and his family worries that a prolonged hospital stay will result in further deconditioning.

His wife and grown children are wondering when he can get stable enough to move onto rehabilitative care (and care that is near them), and how to care for him at home afterwards.

1. **Build capacity in homecare to meet high acuity needs:** There are approximately 730,000 seniors in Ontario who receive home care services each year. In addition, we're seeing the level of care complexity and care requirements substantially increasing over the last five years. New models of care at home with higher intensity supports have shown success in helping people to remain at home. Expanding these programs will deliver capacity to care for more people at home, plus it will enable the discharge of more people from hospital and the avoidance of facility-based care. New high acuity home care programs include High-Intensity Supports at Home (HISH for both LTC and Rehab); Hospital to Home such as the Southlake@home program; Neighbourhood Care Teams and programs similar to the US-based PACE (Program for All-Inclusive Care for the Elderly) model (sometimes called Community Wellness Hubs). High acuity care programs at home require integration with acute or primary care providers, integrated care management, significant and flexible support across disciplines (nursing, personal support work and therapy services), and collaboration with other community support services.
2. **Expand preventative community care to keep elderly people healthier longer:** Expanding community support services with a focus on upstream, preventative care will reduce and delay the need for institutional care, empower elderly individuals to age comfortably in their own homes, and result in significant savings. To achieve this, a comprehensive range of community support services that target the social

determinants of health is needed including enhancing wrap-around preventative and rehabilitative services such as assisted living services, Meals on Wheels, social and congregate dining, friendly visiting, exercise and physiotherapy programs, and adult day programs. Specifically, the Government's Assisted Living Service Policy could prioritize the expansion of these types of programs in regions with the longest waitlists for long-term care.

3. **Ensure all Ontarians have access to primary care services delivered by a team:** The data show that patients with complex medical needs require comprehensive care that is best managed by a team of interprofessional healthcare providers anchored by the family doctor. Team-based care is a leading strategy that will better support elderly people with complex care needs to remain at home. This includes patients having equitable access to primary care teams and for every care team member to practise to the full scope of their licence. While the Government of Ontario has started to invest in team-based primary care , there is more to do to ensure equitable access to the 75% of doctors and patients in Ontario who do not have access to team-based care[1]. An example of team-based care programs in Ontario, and that works with home and community care, is the Elder Care Program at the Bruyère Family Health Team. This program is registered nurse-led and supports family doctors and other team members by identifying frail elderly individuals with cognitive and functional decline and providing early care planning either in clinic or at home.

Abbie, 94

Abbie lives alone and has mild dementia, vision loss and kidney issues. She also falls frequently and has suffered a couple of fractures over the past few years. Since her last fall, she has been having much more difficulty with her mobility and with activities such as bathing, shopping, cooking, etc. Her only family support is her daughter who lives in another part of the province and comes to visit and help every other weekend. In between, her daughter is doing what she can by ordering prepared food online and paying for a weekly service to clean her mother's home and do the laundry. She is petrified to receive a call that her mother has fallen again and severely hurt herself.

Abbie is a patient of an outpatient kidney care clinic and connected to a social worker through this clinic. Her social worker has identified that Abbie needs more daily support if she is going to continue living at home.

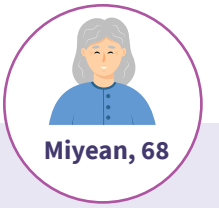
4. **Expand mental health and addictions supports:** Existing programs could be scaled further across the province so more of them are available in local communities for older adults. They include community mental health services like this one in Fort Frances; programs like Mood Walks and Living Life to the Full that promote physical and mental wellness as well as offer effective tools to help people manage their mental health; the Ontario Structured Psychotherapy program that provides cognitive behavioural therapy for people living with depression, anxiety and anxiety-related conditions; plus, a mental health course for primary care providers to increase their confidence in navigating patient conversations and the mental health and addictions landscape.

5. **Utilize digital monitoring technologies:** Leveraging digital technologies can help older adults and their caregivers feel safe and supported at home. One example is the remote care monitoring program at Toronto Grace Health Centre (TGHC) that uses an integrated service delivery model involving TGHC, Home and Community Support Services, and community caregivers. The program uses technology to address medical/non-medical health conditions and social determinants of health to support clients to remain safely at home. It also includes safety devices to a 24/7 call centre service that uses a triage system, GPS location, medication dispensing, home monitoring, and medical monitoring. Goals of the program include quicker discharge of patients that would have previously been assigned an alternate level of care designation and, expanding the range of patients who can be supported within their homes.

1 187 Family Health Teams ("FHTs"), serve more than 3.5 million people in over 200 communities in Ontario. 75 Community Health Centres ("CHCs") and 10 Aboriginal Health Access Centres ("AHACs") in Ontario, provide primary health care to over 600,000 Ontarians. 25 Nurse Practitioner-Led Clinics ("NPLCs"), serve about 100,000 patients.

6. **Expand initiatives for long-term care to work in partnership to provide services to people living in the community:** People who work in long-term care are experts in caring for physically frail and cognitively impaired elderly people. Building on their seniors' care expertise, we have the opportunity for long-term care homes to work in partnership with others and become a hub of services to older adults living in the community, including slow stream rehabilitation for people with chronic conditions (to help them maintain activities of daily living and stay at home, or return home after a hospital stay); diagnostic supports; behavioural supports; and respite care for caregiver support.

7. **Strengthen respite, mental health, and peer support for caregivers:** For seniors to age at home they need the support of a family or friend caregiver. Almost half of Ontario's four million caregivers are living with the person they care for, meaning they are providing around-the-clock care. Caregiver burnout continues to rise with 63% saying they reached their breaking point last year but had no choice but to keep going. What caregivers say they need most is respite, mental health support, and peer support. There are community respite programs that exist like Caregiver Recharge Services at Bellwoods Centre, but these programs and services are not available in all communities. The Ontario Caregiver Organization (OCO) offers SCALE (Supporting Caregiver Awareness, Learning and Empowerment), a program delivered virtually to empower caregivers with practical information and skills to focus on their own mental health and well-being. The OCO's Peer Support Program offers virtual group and 1:1 peer support. By expanding SCALE and Peer Support, more caregivers could be reached including those without access to technology.



Miyean, 68

Miyeon currently lives on the streets in Toronto, has no children, and is estranged from her family.

She recently fell while sheltering in a downtown homeless shelter, was unable to get up, and experienced great pain.

The shelter's staff called for an ambulance who took her to the nearest hospital. She was diagnosed with a broken hip, was admitted to the hospital, and underwent surgery. As she recovered from her surgery, she became more confused and started to hallucinate. At first, hospital staff felt she was experiencing delirium, but soon discovered she had paranoid schizophrenia which had gone untreated.

Miyeon shared that she has always tried to avoid care for fear of "being put away". She currently remains in the hospital and is awaiting complex discharge planning.

Rupinder, 72

Rupinder, a 72-year-old widow, lives alone in a southwestern Ontario mid-size city. Her two children live abroad. She does not have a family doctor, so went to a local walk-in clinic when experiencing chest pain.

They immediately sent her to her local hospital's emergency department where she was admitted for heart surgery, followed by a two-week stay in the intensive care unit. She was then discharged home where she received help from her neighbours with shopping, cooking and cleaning, and received rehabilitative care through the hospital's cardiac rehabilitation program. Rupinder, however, did not progress as well as she could. She became very anxious because she was uncomfortable with the young male physiotherapist.

Rupinder was raped when she was 16 and was not believed by her family. After her husband passed, she found herself overwhelmed by memories of the rape, feeling afraid of young men, and "just being anxious". Following her cardiac event, her anxiety became more acute. Her children are trying to figure out how to help her from so far away.

Prioritize those with the highest needs to access long-term care and avoid admission to hospital.

8. **Fulfill the Government's commitment to redevelop 30,000 existing beds and build 30,000 new ones:** Long-term care homes are committed to delivering on the Government's pledge to redevelop older homes and to create 30,000 new long-term care spaces. The Government's 2022 enhanced capital program helped a number of building and redevelopment projects move forward. Yet some communities need additional supports and customized solutions due to significant economic and construction challenges – particularly homes in the Greater Toronto Area and in small, rural communities in Northeastern, Southwestern and Eastern Ontario. Their challenges include rising construction and labour costs, access to affordable land, zoning approvals, insurance risk, and unstable lender confidence. Data show that many homes may not be able to develop, representing about 20,000 spaces or 25% of the province's current long-term care capacity. Developing tailored solutions to help rural and urban homes overcome unique barriers is key to maintain long-term care capacity for those who need it.

9. **Expand admission to long-term care from the community:** Long-term care homes continue to work with the Government to support safe and appropriate admissions of alternate level of care patients from hospitals to long-term care homes. We also encourage expanding admission to long-term care for older adults living in the community with complex care needs by looking at opportunities related to the placement regulations, so we can fast-track elderly people's access when it is not safe for them to continue to be cared for at home.

John, 88

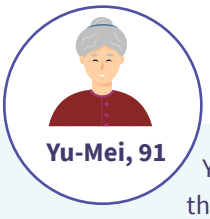
John's dementia is progressing and he is starting to exhibit angry responsive behaviors that have landed him in the emergency department on more than one occasion. These episodes are unsettling to his 61-year-old daughter who lives in the same mid-sized community. John also has had a lifelong struggle with alcohol.

His family doctor, who is about to retire, has been his main source of care. John's daughter has been trying to find another family doctor for her dad but is bumping into family physician shortages in their community. She is also nervous about inviting her father to come live with her and her husband.

John is currently being assessed for long-term care. His daughter has been warned about the long wait list.

Bridge services to get people out of hospital and back to a home.

10. **Expand transitional care units:** More transitional care units are needed and in regions with high rates of elderly alternative level of care (ALC) patients with complex care needs, to enable these patients to move out of hospital by helping them rehabilitate back into the community or into long-term care. Three pilot transitional care examples include The Ottawa Hospital/Extendicare Transitional Care Unit; The Schlegel Villages Transition Program for people with high risks (e.g., with frequent or severe behaviour expressions), and the Providence Transitional Care Centre. Common traits across these programs include therapeutic care, rehabilitation, socialization, and more activity and stimulation, leading to significant improvement and opportunities to then transition to home or conventional long-term care. They also improved healthcare system flow by moving people designated as ALC out of hospital, plus realized cost savings because the cost per day was much less than a daily hospital stay.



Yu-Mei, 91

Yu-Mei and her husband immigrated to Canada (Toronto) about 70 years ago. They eventually raised three children, two of which now live on the West coast with their spouses and kids. Her husband passed away two years ago.

Yu-Mei has always believed she needs to remain as active as possible. Yet a recent fall in her family home sent her to hospital with a broken hip. She failed to regain her strength after surgery and soon began showing signs of advancing dementia, causing her single son living in Toronto (and who often travels abroad for work) to realize that her needs were beyond his or his siblings' abilities.

Expand supportive and affordable housing

11. **Expand existing supportive and affordable housing to help elderly people to continue to live in the community:** Seniors' supportive and affordable housing refers to a combination of housing and supports that enables older adults to live as independently as possible in their community and that accommodates people of varying abilities who require assistance. It is an opportunity in the continuum of care for seniors in Ontario who cannot afford retirement housing or private home care, and who are not able to find their way into long-term care. Increasing the number of units within existing affordable housing and adding a seniors' stream to the Government's supportive housing programming is a solution.

Key to the success of expanding many of the models highlighted above will be the stabilization and expansion of health human resources across the province, in both urban and particularly rural areas – and in the longer-term, the enablement of real-time patient data and information exchange and improved system navigation.

Appendix

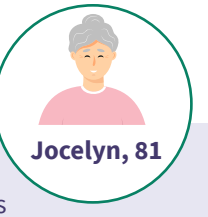
Data and Assumptions

What we know or can confidently assert about the more than 43,000 people on the long-term care wait list:

- Today, more than 43,000 people are waiting for long-term care. This waitlist has nearly doubled over the past 10 years and is expected to grow, adding 1,000 people per year and reaching 48,000 by 2029.
- The majority of the waitlist are located in urban settings (75%).
- Most people want to age at home, if at all possible, and for as long as possible.
- There are people on the wait list who could have their complex care needs met at home with proper and increased supports, and for their caregivers too.
- The majority of the hospital alternative level of care population is waiting for LTC (approximately 40% of all ALC days in acute care were for long-term care in 2021/22).
- Contributing to this is limited home and community care services, primary care, mental health and addiction supports, rehabilitative services, and caregiver supports.
- Many of the people on the long-term care wait list receive some level of home care, but some do not. It is uneven.
- A significant number of people on the waiting list have some sort of cognitive impairment (as seen by the 76% of all newly admitted residents to long-term care experiencing mild to severe cognitive issues).
- Traditional home care providers are not funded to provide any sort of dementia care even though they are in the home.
- Given the number of long-term care beds, the vast majority of people on the wait list will likely never enter long-term care and require ongoing care in a home setting.

What we know or can confidently assert about aging seniors who need long-term care:

- Aging seniors continue to want to remain at home or a retirement setting as long as possible.
- One in 5 seniors over the age of 80+ have complex care needs that currently can only be safely met in long-term care. Expanding home and community care, primary care, mental health and addiction supports, rehabilitative services, and caregiver supports is key.
- Of those entering long term care in 2021/22:
  - 60% of new residents require a high level of care.
  - 75% residents had three or more different medical conditions.
  - 89% of people needed support with activities of daily living.



Jocelyn, 81

Jocelyn is Franco-Ontarienne, communicates best in French, and lives in a small rural community. She also has diabetes which has progressed to the point where she is dependent on dialysis. She relies heavily on her eldest son (who has complex health issues too) to help navigate her healthcare needs, which includes traveling three times a week to and from the hospital for dialysis.

Jocelyn also has poor eyesight and is beginning to feel more isolated. She is not confident stepping out on her own to spend time with her friends and is challenged doing her favourite activities such as reading and gardening. Her son thinks she also may be suffering from depression and with all that is going on, is deeply worried about how he can continue to support her.

  - 75% of people required eight different medications, with 30% requiring 13 or more.
  - 76% of people had mild to severe cognitive issues, an increase of 25% since 2011.
- 91% of seniors would prefer to stay at home if they were on a waitlist for a long-term care facility, and additional supports could be provided to keep them at home or living with a family member.
- 84.6% of respondents in households who received home care stated that the services were very helpful in allowing them to stay at home.

What we know or can confidently assert about caregivers supporting older seniors:

- 50% of care recipients are over the age of 75.
- Almost 50% of caregivers have been providing care for over 2 years.
- 41% of caregivers provide care for problems associated with old age or frailty.
- Although they say they are coping better in 2022 (post-COVID) than in 2021, approximately half of the caregivers feel tired (66%), anxious (56%), overwhelmed (53%), burnt out (50%), frustrated (47%), and depressed (41%).
- 65% of caregivers say they are concerned that they will not be able to handle all of their caregiving tasks going forward.

Joseph, 68

Joseph is from Slovakia, moved to Ottawa with his parents when he was 40 years old, and lives alone now that both his parents have passed. Slovak is his predominant language.

Joseph has schizophrenia, plus challenges with hoarding and aggression. Neighbours have noticed that he has become depressed and more isolated since his last parent passed. They sense that he may need help with activities of daily living and with his medication management too. Some have also expressed concerns about the possibility of Joseph trying to die by suicide, based on some comments he has made in his uneven English while encountering him on the street. They are wondering who can support him.

- 63% of caregivers say they reached their breaking point last year but had no choice but to keep going.
- Almost 50% of the care recipients have used in-home care services in the past year.
- One third of caregivers do not have access to much needed respite care.

What we know or can confidently assert about our health system:

- Some regions are experiencing even more profound health human resource shortages than others and across the full continuum of care (primary care, hospital, long-term care, home care, community care, mental health services etc.).
- People on the long-term care wait list are putting significant pressure on primary care providers, our emergency rooms (ER) and urgent care centres (UCC) and hospitals. 55% of those waiting has visited the ER or a UCC in the last year; 53% had been admitted to hospital.
- Over the course of the past 3 years (2021-present), there have been more than 40 hospital department closures across the province; some temporary, other permanent and all citing staffing shortages (both doctors and nurses).
- We need much more capacity in home and community care, primary care, mental health services, rehabilitative services, and long-term care and to support older seniors with complex care needs.
- Community care services such as adult day programs have extensive waitlists.
- The vast majority of referrals to home care require personal support for activities of daily living yet currently, only 60% of these referrals are accepted upon first offer due to the complexity and hours required to care for these patients.
- Nearly 2.3 million Ontarians are without a family doctor, and approximately 1 in 4 Ontarians (4.4 million) are projected to be without one by 2026.
- Nearly 1.7 million Ontarians have a family doctor over age 65 and poised to retire.
- The 80+ population in Ontario is projected to more than double by 2040, and patients will need more complex health supports. Many retiring physicians take care of a large proportion of complex and socially vulnerable patients.

In Summary:

- Older seniors are living with more and more complex care needs.
- Most people want to age at home, if at all possible.
- There are people on the long-term care wait list who could have their complex care needs met at home with proper and increased supports, and for their caregivers too.
- Caregivers are overburdened and buckling under the pressure of supporting their loved ones.
- Seniors need more capacity across sectors to meet the complex care needs of those waiting for long-term care (primary care, home care, community care, mental health services, rehabilitative services, long-term care, assisted living, etc.)

Caregiver

Arun, 33

Arun, who is 33 and married, helps to care for his 80-year-old grandmother because she is unable to take care for herself. He spends a few hours a week caring for her and has done so for the past few years. But he finds it difficult to balance these responsibilities with his busy career and is stressed about how to support his family while providing care. While he has the support of other family members, which allows him to take breaks, he feels overwhelmed, burnt out and unable to take on any more responsibility than he already has. He often feels he is not appreciated for the work he does, which can lead to feelings of depression and the wish to leave it all behind.