INTEGRATING CARE FOR SENIORS LIVING AT HOME

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Caring for Canada's aging population is a key public policy issue that is only going to become more pressing over the next decade. The majority of care for seniors takes place in private homes through a mix of predominantly female carers providing a myriad of health and social care services in the formal and informal sectors. This article explores how integrated care; including social services, health care services, and paid and unpaid care; is being used to address fundamental challenges to delivering home and community care services to Canadian seniors. The author argues that more attention should be paid to integrated care programs as a cost-effective method of delivering accessible, coordinated, high-quality care to seniors, particularly by evaluating their contributions using a gender-based analysis.

Enjeu clé des politiques publiques canadiennes, les soins qu'il faut apporter à une population vieillissante ne cesseront d'augmenter dans la prochaine décennie. Or la plupart de ces soins sont prodigués à domicile par différents « aidants », presque toujours des femmes, qui assurent toute une gamme de services de santé et sociaux relevant des deux secteurs formel et informel. L'auteure examine comment des soins intégrés, comprenant les services sociaux et les soins de santé, permettent de répondre aux défis majeurs suscités par les besoins grandissants des personnes âgées pour des soins à domicile et des services communautaires. Et elle propose de privilégier cette intégration en tant que méthode économique d'accès coordonné à des soins de haute qualité, tout en évaluant leur efficacité à la lumière d'une analyse comparative entre les sexes.

How to care for Canada's aging population in light of rising institutional care costs, persistent shortages of health human resources and the unsustainability of the current health care paradigm is a key public policy issue that is only going to become more pressing over the next decade. With the first of the baby-boom generation having turned 65 in 2011, deciding how to adapt the health care system and adjust the policies that govern it to meet the changing needs of the population are timely issues for Canadian policy-makers.

Canada is experiencing a demographic shift, with both the number and proportion of Canadians reaching age 65 set to increase over the next two decades. In response, concerns have been raised about the financial sustainability of Canada's publicly funded health care system. While the escalation in health care costs is not in dispute, population aging contributes relatively modestly to rising public-sector health care spending. In their paper "An Evidence-Based Policy Prescription for an Aging Population" (partly based on a 2011 IRPP study by Neena Chappell), Neena Chappell and Marcus Hollander suggest that it is not shifting demographics but factors such as increased medical interventions, the use of costly new technologies and increases in overall service utilization that will be the main cost drivers of the health care system over the next 10 years.

Persistent and costly problems such as the increasing number of elderly "bed blockers" stuck in alternative level of care (ALC) beds and the increasing frequency of seniors seeking care for chronic conditions through emergency rooms (ERs) make it essential for policy-makers to consider how the health care system should be adapted over the next decade to ensure that appropriate care can be provided to those in need.

The existing health care system is focused on one-time, episodic conditions by providing short-term interventions in a hospital setting or by a physician. However, this type of system is not adequate to meet the complex needs of seniors, nor is it cost effective for this population. Instead,

gerontological research suggests that a comprehensive continuing care system would be most appropriate for an aging population because seniors tend to require many types of care, at varying times, from different providers, in a variety of settings along the health care continuum. To ensure that the needs of seniors over the next decade will be met by the right programs and services at the right time, we will need to undergo a paradigm shift from a system that prioritizes episodic, short-term interventions to one that supports long-term, comprehensive care.

With 93 percent of seniors in Canada living in private households, home and community care are the most in-demand types of LTC, especially for elderly women. Home care utilization rates among women are more than 20 percent higher than those for men, stemming from the fact that women tend to both marry older men and live longer than men. Women are also more likely than men to have their care needs unmet. In addition, women have historically been responsible for the care work in private households. This trend persists in today's home and continuing care sector, with women making up the majority of paid and unpaid care providers. Care work continues to be devalued in Canada through a lack of respect and recognition, poor working conditions and inadequate remuneration, making home and community care a gendered issue.

Home care is typically provided to persons who require medical care, as well as personal care and/or homemaking help. Conversely, community care refers to the provision of social care services to persons who do not need support for specific medical issues. While differences in baskets of services, funding, eligibility requirements and delivery mechanisms may be the norm across Canada, it is clear that these types of care involve more than simply moving services that used to be provided in hospitals and doctors' offices into people's homes.

Home and community care exists at the interface between health and social care. The inextricable link between these types of care, when provided in the context of a private home, continues to present a challenge for policy-makers because of the tendency to dichotomize care into siloes — "health care" versus "social care." This way of thinking has long been institutionalized in Canadian policy-making, with health and social care typically being the jurisdiction of different government ministries, offered by different care providers, funded by different sources and governed by different legislation. For example, while transportation is not traditionally considered a "health" care service and is not under the jurisdiction of health ministries, legislation or providers, for a senior living alone the inability to access transportation can lead to poor nutrition, poor medication management, a failure to attend medical visits, premature functional decline and preventable illness, all of which can result in hospitalization or institutionalization.

International and Canadian research has shown that investing in home and community care helps maintain the health, well-being and autonomy of seniors and their carers and also moderates demand for seniors' care in more costly areas of the health care system (e.g., ER, ALC or residential LTC). Yet the home and community care sector in Canada remains very much in need of additional strategic investment from governments — in increased funding and policy and program development.

A key lesson from Paul Williams and Janet Lum's balance of care research in their article "Chicken Little? Why the Healthcare Sky Does Not Have to Fall," is that the presence of home and community care services at the local level is a necessary but insufficient condition for aging at home. Mechanisms for accessing, coordinating and managing multiple services and providers are equally important, particularly for seniors. To address this, some jurisdictions have introduced integrated care programs into the home and community care sector. In this context, integrated care can be understood as the process of connecting and aligning health and social care services and assisting the teamwork of paid and unpaid care providers into a coordinated continuum of care for seniors to maintain their health and autonomy while living in their home. While much of the high-profile work on integrated care to date has occurred at the systems level and has revolved around improving the acute care system and better integrating care subsystems along the continuum of care, many jurisdictions, both in Canada and abroad, have been experimenting with pilot projects intended to better integrate care for seniors at the individual level. A preliminary assessment of integrated care programs in Ontario and Alberta has indicated that, when introduced in the home and community care sector, these programs may have the potential to address some of the universal challenges of delivering health and social care to seniors in a coordinated way.

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In the current political climate of fiscal constraint and public sector downsizing, ALC reductions have been the primary focus of policy-makers who are looking to apply cost-saving measures to the health care system. However, when policy-makers treat home care as

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a money-saving substitute for hospital or residential LTC, they tend to ignore its potential to achieve cost savings by moderating the demand for more costly services in the first place. Although it is legitimate to use home care to relieve ALC or ER pressures, given that these are two of the least cost-effective places for seniors to get caught in the system, when publicly funded home care services are disproportionately allocated to people discharged from hospitals, it reduces the support available to those with chronic conditions who need preventative care in order to avoid institutionalization or acute care admission. While the ALC reduction and acute care substitution functions of home care are important, using home and community care for the purposes of LTC substitution and preventing institutionalization are also worthy endeavours that are often undervalued in government policy and funding decisions.

The Seniors Managing Independent Living Easily (SMILE) program, operated out of the South East Local Health Integration Network in Ontario and administered by the Victorian Order of Nurses, seems to be a good example of an integrated care program that aims to prioritize health promotion, disease prevention and LTC substitution. The SMILE program began in 2008 with the mission of empowering seniors by giving them access to home support services that were individualized to their specific needs. With funding from the Ontario government's Aging at Home Strategy, enrolled seniors are permitted to choose the health and social care services they feel they need in order to age in their homes in safety, health and comfort. There is a long list of seniors waiting to access SMILE; however, those who are able to join the program enjoy benefits such as a return of the responsibility for financing lower-level needs from the individual back to the state, and access to preventative monitoring by staff in order to anticipate future risks and care needs and to respond accordingly.

Another challenge encountered in home care delivery is the ability to coordinate the many professionals, paraprofessionals and other carers who provide a broad array of services

to seniors. The formal home care system represents about 20 percent of the services provided in the home care sector and can include medical care, help with activities of daily living (e.g., personal hygiene, dressing or feeding) and help with instrumental activities of daily living (e.g., house or yard work, medication or financial management, grocery shopping or transportation). The informal system includes support given by spouses, family members, friends and volunteers, and represents over 80 percent of the home help provided to seniors. A common characteristic of many integrated care programs is the use of an innovative approach to collaborative partnerships, often in the form of interprofessional teams, to aid with the organization of and communication between the many carers providing support and services to seniors living at home.

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The Interprofessional Model of Practice for Aging and Complex Treatment (IMPACT) clinic was an integrated care program introduced by a team based at Sunnybrook Hospital in Toronto in 2007. Although the original pilot project has concluded, the IMPACT model offers a starting point for thinking about how a multidisciplinary approach to teamwork could be used to provide care to elderly persons with complex needs. The main IMPACT intervention was a two- to three-hour appointment where a team of professional carers, in conjunction with the care recipient and a family carer, worked together in real time to assess and analyze the care recipient's medical, functional and psychosocial needs. This program attempted to streamline the assessment process by enabling the care recipient to see several practitioners at once; facilitating communication between carers by providing a forum for collaboration; and empowering care recipients and family carers through inclusion on the care team.

There is room for refinement of the IMPACT model, particularly in that, although it is essential for a home care team to have participation, support and validation from physicians, it is perhaps not necessary for the physician to be responsible for the leadership and management of the team. Likewise, the IMPACT team was dominated by regulated professionals. In contrast, the unregulated care providers, who undertake the majority of the social care work, spend the majority of time with the care recipient in their home and often develop some of the closest relationships with the care recipient, were not represented.

How to offer care that revolves around the care recipient remains a significant challenge when delivering care to seniors who live at home. In general, the health care system in Canada does not offer person-centred care. Instead, it requires patients to navigate the system and work around structural, provider and resource-based barriers in order obtain the care services they need. Person-centred care is focused on the individual needs of recipients, allowing them free and easy access to the care services they need, when they need them, without encountering the aforementioned barriers. Moving health care delivery away from the status quo and toward more person-centred care is a goal of many policy bodies, such as the World Health Organisation and the Organization for Economic Co-operation and Development. Integrated care programs could be a promising avenue for facilitating care services for seniors living in their homes by offering them an easily accessible basket of services that meets their individual health and social care needs.

The Alberta-based Comprehensive Home Options for Integrated Care of the Elderly (CHOICE) program is an interesting example of an integrated care program that promotes person-centred care by offering enrolled seniors a variety of home and day centre services that address their most common needs. In addition to support services offered in the home, the CHOICE program uses a one-stop health and recreational centre to provide seniors with easy access to a comprehensive package of services including a day health centre, recreational activities, health clinic, subacute care, transportation and emergency response. This program is operated through an interprofessional team that uses a combined approach of prevention, early intervention and frequent monitoring to match care services to each recipient based on their needs and navigates the system on their behalf in order to get these services delivered. Although CHOICE seems to be a promising model of how person-centred care can be provided to seniors, access to the program is quite limited and user co-payments are required to supplement provincial funding. The cost of participation in CHOICE nevertheless remains less than the cost of supporting a senior in an institutional setting.

Although it is helpful to consider the lessons of initiatives that aim to integrate home and community care from the ground up, this approach warrants additional research to determine if these types of programs would be able to address some of the other significant challenges within the home and community care sector that remain outstanding. In my view, the most pressing issue that remains

inadequately addressed is the need for further attention to, and support of, unregulated and informal carers. In their 2002 book, *Wasting Away: The Undermining of Canadian Health Care,* Pat Armstrong and Hugh Armstrong outline their guiding principle that the conditions of work are the conditions of care. This is especially applicable in the context of care provision in private homes. In Canada, home and community care continues to be provided in gendered, classed and racialized environments. Much of the care provided in private homes is strenuous work done by women working under isolated and sometimes dangerous conditions, yet this type of care work and the workers who do it remain undervalued. While it may be challenging to include unregulated workers (e.g., personal support workers [PSWs], home care aides or personal companions hired privately by care recipients or their families) in care teams and programs given their lack of professional organization and the precarious nature of their employment situations, it must be acknowledged that, of all the care workers in the formal system, it is the unregulated carers who provide both the largest quantity of care and the services that are the most immediately relevant to the daily health, autonomy and dignity of the care recipient.

Unregulated carers play an essential role in the lives of home care recipients and should be supported by policy-makers and other care providers to participate in home and community care programs, policies and care teams in a more meaningful way. The Participatory Action Research for Mental Health Guidelines in Long-Term Care pilot study at Baycrest Hospital in Toronto recently published the results of a promising pilot project, in which PSWs were invited to participate in interprofessional teams in long-term residential care settings. Policy-makers should consider implementing similar guidelines in home care programs in an effort to replicate this project's positive staff-related outcomes.

Social care providers are expected to provide seniors with the high-quality care we as a society feel our elders deserve. Indeed, studies have shown that the majority of these carers are deeply committed to the role they play in the lives of the seniors they work with. Yet government support remains inadequate in numerous areas of crucial importance to unregulated workers, including ensuring workplace safety; requiring higher staffing levels so carers have enough time to care for a senior to the best of their abilities; mandating ongoing training and professional development opportunities so carers are prepared to deal with the changing needs of the population they serve; and supporting increased job stability, security, fair remuneration and comparable benefits to carers doing similar work in other parts of the health continuum. Governments should prioritize improvements to the conditions of work of unregulated carers in home and community care to enable these workers to provide correspondingly high-quality care.

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A related challenge is the need for increased support for the informal carers providing elder care. Eighty percent of care to seniors living in their homes is provided by unpaid carers, and almost all home care recipients who have formal support also have informal support to help maintain their health and independence. Informal carers are typically a senior's spouse or children and studies show that these carers are overburdened. Almost one in five informal carers in Canada hase reported distress in their role. While a few integrated care programs have included some support for informal carers by, for example, including them in the creation of care management plans or offering them opportunities for respite care, additional support services are needed. The federal government has made progress on this issue with the introduction of Compassionate Care Benefits through Employment Insurance. However, more support for the provincial initiatives is required.

There are many ways that the availability and flexibility of respite care could be increased. For example, the hours for publicly funded adult day programs could be extended to cover the entire work day, which would allow informal carers the opportunity to keep, or return to, their formal employment if they wish to. Also, easier access to information, training and greater social supports for carers would be beneficial. Governments should consider incorporating a service like the Carering Voice Network that uses phone and Web-based tools to encourage learning and create virtual support between formal and informal carers into their existing home and community care strategies.

Home and community care is a policy area that is fraught with challenges, but it is critical to work toward resolving the issues if we are to meet the changing care needs of an aging population. Integrated care programs show promise as a method of overcoming some of the obstacles; however, more research is required to determine if these programs can be expanded to address some of the remaining gaps in service. In my view, more attention should be paid to integrated care programs as a cost-effective method of delivering accessible, coordinated, high-quality care to seniors, particularly by evaluating their contributions using a gender-based analysis in the context of private homes.

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