Aging Well in Northern, Rural, and Remote Communities:

Successes and challenges in addressing the effects of social and geographic isolation on seniors’ well being
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Setting research priorities in seniors’ care

Theme #1: Home care
- Conference dialogue
- Clarifying the issue
- Research directions

Theme #2: Access
- Conference dialogue
- Clarifying the issue
- Research directions

Theme #3: Supporting seniors in their homes
- Conference dialogue
- Clarifying the issue
- Research directions

Theme #4: Creating an age-dignified society
- Conference dialogue
- Clarifying the issue
- Research directions

Theme #5: Interprofessional teams
- Conference dialogue
- Clarifying the issue
- Research directions

Theme #6: Informal caregiving: family members and volunteers
- Conference dialogue
- Clarifying the issue
- Research directions

Next Steps
BCNAR is one of eight Health of Population Networks supported by the Michael Smith Foundation for Health Research

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The conference planning committee thanks our partners whose support added to the success of this conference:
Message from the Conference Chair

As we are all increasingly aware, northern British Columbia’s population is aging. Population demographics are shifting and are expected to shift further in the coming years. As the time to retire approaches, more and more northerners are deciding to remain in their home communities, rather than traveling south. And we expect, and are determined to have, a good quality of health and life in our later years. Thus, looking at how to best meet the basic needs of an older population is very much on the agenda.

But meeting basic needs is only the beginning. There is an unmistakable drive to create an environment that goes beyond basic needs, an environment in which older residents can flourish and have the means to contribute to their fullest potential. A palpable momentum is building. The enthusiasm to create such an environment is reflected in the significant level of activity apparent in seniors’ organizations across the north, the increasing inclusion of aging issues in post secondary education, growing research undertakings on varied aspects of aging, and emerging attention from all levels of government, as well as from the private sector. It is also reflected in the wide range of organizations in the north coming together to organize aging-related events such as this conference and several other events, including:

- A Dialogue on Seniors’ Issues held in October 2007.
- Two workshops on aging issues, featuring Dr. Gloria Gutman, in May 2008.

This conference was organized to create a forum for dialogue among researchers, community groups, older citizens, health service planners and care providers working in northern BC. Specific objectives include:

- Identifying successes and challenges in creating the conditions for aging well in rural, remote and northern communities.
- Identifying and addressing the effects of social and geographic isolation on seniors’ health and access to health services.
- Showcasing success stories and challenges through examples from seniors, service providers, and academic and community-based researchers.
- Identifying research priorities and bringing together potential research teams tasked with developing competitive research proposals arising from conference deliberations.
- Ensuring that conference proceedings and future research findings are made available to inform health policies, planning and service provision for older adults in northern BC.

These are ambitious, but I believe attainable, objectives, given the enthusiasm of all the contributing organizations and conference participants. Our numbers and commitment make us a formidable force for change.
On behalf of the BC Network for Aging Research, I would like to acknowledge the support and efforts of all conference partners—the University of Northern British Columbia, Northern Health, the BC Rural and Remote Health Research Network, Network Environments for Aboriginal Research in BC, the BC Home Community Care Research Network and the Prince George Council of Seniors—and thank the members of the Conference Planning Committee.

I look forward to continuing our work together over the coming months and years. Healthy aging is definitely on the northern agenda. The *Aging Well in Northern, Rural and Remote Communities* conference provides a unique opportunity to collectively move that agenda forward!

*Dawn Hemingway, MSc, MSW, RSW*

Co-Leader, BCNAR

Associate Professor and Chair, School of Social Work, University of Northern British Columbia
Conference at a glance

Welcome
- Dawn Hemingway, Associate Professor, Social Work, University of Northern BC (UNBC); Co-leader, BC Network for Aging Research (BCNAR)
- Lynn Beattie, Professor Emeritus, Division of Geriatric Medicine, University of BC (UBC); Steering Committee Member, BC Home and Community Care Research Network (HCCRN); Co-leader, BCNAR

Keynote panel
- Cathy Ulrich, President and Chief Executive Officer, Northern Health (NH)
- Alex Michalos, Chancellor and Emeritus Professor, Political Science; Director, Institute of Social Research, UNBC
- Bev Christensen, President, Prince George Council of Seniors

Realities and challenges in northern BC
- Leona Nielson, Cree Language Instructor, First Nations Studies Program, UNBC; Culture Teacher, Headstart Program, Native Friendship Centre
- Neil Hanlon, Associate Professor, Geography Program, UNBC
- Marilyn Wheeler
- Bev Christensen
- Tim Rowe, Executive Director, Home and Community Care, NH

New approaches and initiatives
- Rod Schellenberg, Project Manager, Home and Community Care and Primary Care, NH: Integrated health network for at-risk seniors
- James Chan, Research and Evaluation Coordinator, Northern Interior Health Service Delivery Area: Improving health care through technology (Pixalere wound care management system)
- Mary Henderson Betkus, Regional Clinical Leader, Home and Community Care, NH: Benefits and potential of RAI

Greetings from the Lieutenant Governor
- The Honourable Stephen L. Point
What do we know from research?

- Greg Halseth, Professor, Geography Program, UNBC: Lost in translation: Policy, research, and practice issues around aging well in rural and remote places
  (Authors: Greg Halseth, Neil Hanlon, Laura Ryser, UNBC)

- Laurie Ringaert, Project Director, Measuring Up the North: Measuring Up the North
  (Authors: Laurie Ringaert, P. Harris and T. Healy)

- Dawn Hemingway: Promoting seniors' well being using the seniors’ mental health policy lens
  (Authors: Penny MacCourt and Dawn Hemingway)

- Neil Hanlon: Analyzing home care assessment data in a geographic information systems framework
  (Authors: Neil Hanlon and Mary Henderson Betkus with Ashleigh Desbiens, Dana Pidherney and Britta Stakelbeck)

What do we need to know?

- Facilitated dialogue session: Moderator Lillian Bayne, Lillian Bayne and Associates

Team building

- Conference participants joined thematic clusters to discuss the priority themes that emerged during the event and to:
  - Clarify issues
  - Discuss what is needed to address the issue
  - Identify who needs to be involved in addressing the issue
  - Recommend research directions
Introduction

This event provided a forum for researchers, community groups, seniors, health service planners, and care providers working in northern BC to:

- Explore and address the effects of social and geographic isolation on seniors’ well being and ability to access health services.
- Showcase success stories and identify challenges for aging well experienced by seniors, service providers, and academic and community-based researchers in rural, remote and northern communities.
- Identify research priorities and bring together potential research teams to develop competitive research proposals arising from conference deliberations.
- Ensure conference proceedings and future research findings are broadly shared to inform health policies, planning and service provision for older adults in northern BC.

This report describes presentations from the conference, participants’ discussions, and key themes for aging and health research that emerged during the conference.

Conference proceedings were facilitated by Lillian Bayne, an independent consultant working in health policy, planning and research, who engaged participants in dialogue and synthesized the research themes that emerged during their discussions.

Summary of research themes
Six theme areas for research to support aging well in northern, rural and remote communities were developed during the conference:

- **Home care** – Existing home care programs are too inflexible to meet individual needs. Seniors need more comprehensive, flexible and responsive services.
- **Access** – Greater understanding is needed of the barriers to accessing services in the north, particularly for seniors living in isolated communities. Examining how other jurisdictions address this issue may offer solutions that are adaptable to northern BC.
- **Supporting seniors in their homes** – Physical accessibility, transportation options and flexible care and services are needed in homes and communities to support seniors’ independence for as long as possible.
- **Creating an age-dignified society** – Communities need to recognize and value seniors, and create mechanisms for engaging all stakeholders, including seniors, to identify needs and take action to create change.
- **Interprofessional teams** – Partnerships, collaboration, education, and changing attitudes among different disciplines are crucial to providing patient-centred care. Northern BC offers opportunities for engagement that do not exist in an urban environment.
Informal caregiving: family members and volunteers – Unpaid family caregivers help support aging seniors in the community, and need financial, respite and educational support to optimize their role. Volunteers also help with day-to-day activities. Health care providers can learn about the benefits of intergenerational support from First Nations communities.

Conference participants worked in small teams to define these theme areas and identify research directions in each area. The details begin on page 27.

Opening remarks

Dawn Hemingway, MSc, MSW, Associate Professor, Social Work, UNBC; Co-leader, BC Network for Aging Research

This conference created an opportunity for participants—seniors, service providers, elected officials, educators, researchers, and other community members—to discuss the challenges and successes of caring for an aging population in northern British Columbia. People in northern BC, who are increasingly deciding to remain in the north into their retirement years, are giving voice not only to the need for health services, housing and other basic necessities, but also their desire to participate in the broader task of creating age-friendly communities for themselves and for generations to come. Numerous community events, innovative service provision projects, along with increased university and community-based research, are all part of a growing movement to address the needs of aging residents.

Professor Hemingway explained that in order to make a measurable contribution to the work already being undertaken, the BC Network for Aging Research is providing three seed grants of $3,500 for conference participants who wish to come together to develop research funding proposals for projects that will inform future planning, policies and programs directed at aging well in northern, rural and remote communities.

Lynn Beattie, MD, FRCPC, Professor Emeritus, Division of Geriatric Medicine, UBC; Co-leader, BCNAR; Steering Committee Member, BC Home and Community Care Research Network

Dr. Beattie noted that the issues, challenges and successes discussed at this conference will help identify how to better serve an aging population. She acknowledged the Michael Smith Foundation for Health Research (MSFHR) for enabling this opportunity to network and identify issues that need to be addressed through research.

Dr. Beattie also welcomed participants on behalf of the BC Home and Community Care Research Network steering committee, which is also funded by MSFHR. HCCRN works in partnership with BC universities, health authorities, and organizations like the Alzheimer Society to achieve its mandate of addressing gaps in health knowledge for seniors in home and community care.
Keynote panel

The keynote panel speakers provided an overview of some opportunities and issues involved in optimizing seniors’ healthy aging in northern BC.

Providing health services for seniors in Northern BC

Cathy Ulrich, President and CEO, Northern Health

The population in the north is aging faster than other areas of the province. Even though many northern communities historically attracted younger populations, this demographic is shifting. Unfortunately, much research is focused on urban issues because, until recently, aging populations were larger in urban areas. Consequently, understanding the needs of people aging in rural settings is new territory. The directions from this conference will be shared with the NH executive team.

Ms. Ulrich focused on three areas from NH’s perspective:

- **Continuum of services for seniors in the region** – NH has a small population spread across a huge geographic area. Services are sometimes more expensive to deliver in small northern communities than larger locations. The challenge is how to spread limited resources across the region. The only way is though partnerships with municipal governments, other organizations, and people in the community. In some areas, NH has the mandate to lead; in others, NH operates as a partner.

  For example, with BC Housing’s initiative to provide residential care beds, assisted living units and supportive housing in the province, NH has been looking at facilities across the region to reconfigure, upgrade and increase capacity. A few years ago, NH had no assisted living, but units are opening this year and next in the north. NH worked with the Province on the formula used to allocate beds. Research data would have been helpful to guide this process, but was not available. So NH used the health status of seniors to make the case for shifting the formula and getting more resources for assisted living and residential care.

  Other opportunities for action and research include home support, respite and palliative care. NH is given a certain amount of home support resources. Research can help identify how best to use these resources to help people stay independent as long as possible. For example, NH added about 80 adult daycare and caregiver respite spaces in the last year. As NH builds residential capacity, respite and palliative care beds need to be included in facilities, as well as end of life care in the community. NH depends on best practice research to know how to best deliver services and educate providers.

- **Embarking on Care North** – Care North is a primary health care initiative designed to improve access in communities across the north. NH is considered a provincial leader in primary care, but this care has not always been well integrated or coordinated. The Care North vision is for everyone to have access to a primary care multidisciplinary team, including a physician. As seniors age and encounter chronic diseases, primary care access becomes more important to ensure issues are dealt with early. This collaborative project is underway in three communities now, with plans for expansion. Service providers come together to learn what works best, and integrate this learning into practice. This approach can reduce more expensive acute care use and improve patient and provider satisfaction.
Creating healthy communities – NH has an important role, but is not the only player in creating healthy communities. Partnerships are critical to success. Some questions include how we create healthy communities, what they look like, what NH’s role is, and what role health promotion plays. Strong volunteer networks are also critical to ensure seniors have opportunities to socialize and age well.

Comparative surveys on health and quality of life among older people

Alex Michalos, PhD, Chancellor, Emeritus Professor, Political Science; Director, Institute for Social Research and Evaluation, UNBC

The Institute for Social Research and Evaluation, a partnership between UNBC and the City of Prince George, has conducted surveys each year since its inception in 1998.

Dr. Michalos explained that a 1999 survey was replicated in 2005 to compare seniors’ perceptions of health and quality of life and see whether conditions got better or worse in the region (called Northern Interior Health in 1999, which was smaller than the current region, so researchers attempted to match the same area). The average age in 2005 was 68, compared to 69 in 1999. The age range was 55 to 96 in 2005, and 55 to 97 in the earlier survey. There were other similarities as well, so the samples matched well.

The surveys examined change in four areas: self-reported health, general worries and concerns related to aging, feelings about being victimized and defensive behaviours in response, and satisfaction with life. The questionnaire asked seniors about their health status in eight dimensions:

- **Physical functioning** – Do seniors experience limitations, including bathing and dressing, due to their health, or can they do most activities, including the most vigorous, without limitations due to health?
- **Physical role limitation** – Do seniors have problems with work or other daily activities due to physical health, or have no such problems?
- **Bodily pain** – Do seniors experience severe, limiting pain, or no pain or limitations?
- **General health** – How do seniors rate their health from poor to excellent (using a five-point scale)? Results correlate well with actual morbidity and mortality.
- **Vitality** – Do seniors feel tired and worn out, or energetic?
- **Social functioning** – Do seniors experience difficulty with normal social activities due to physical or emotional problems, or can they engage in social activities?
- **Emotional role limitation** – Do seniors have problems with work or other daily activities because of emotional problems, or have no such problems?
- **Mental health** – Do seniors experience feelings of nervousness and depression all the time, or do they feel peaceful and happy?
- **Reported health transition** – Do seniors believe their general health is much worse now than a year ago, or much better than a year ago?

The results show that the 2005 group had generally better health than the 1999 group. Seniors were also asked to rate their satisfaction with their housing, family relations, living partner, life as a whole, friendships, health, religion or spiritual fulfillment, financial security, government officials, quality of life, overall happiness, and caregiving role, if relevant. Satisfaction with health, financial security and provincial officials increased somewhat in 2005; otherwise, the results were similar for 1999 and 2005.
Only one case was statistically different between men and women: in general, men were happier with their living partner than women were.

As well, the 2005 group generally thought crime was less of an issue than the 1999 group. Seniors identified automated phone services that prevent them from speaking to a real person as a significant frustration. And some went out less in winter for fear of falling on snow or ice.

Eighty-six percent of seniors said they have someone to talk to, and 99% have someone to count on if they’re in trouble. This finding shows that most seniors have someone in their life who cares about them.

**Focusing on seniors’ health and abilities**

*Marilyn Wheeler, Author, The Robson Valley Story, McBride*

Ms. Wheeler challenged how we generally identify people as elderly by their age, suggesting instead that we consider the state of people’s health and abilities. This way, some people will be thought of as healthy, some as needing a bit of help, and some will be ill and in need of support.

Ms. Wheeler described Robson Valley as a long, narrow Rocky Mountain trench with one way in and one out. Until 1970, there was no road to Prince George. People were isolated and tended to move to more populated places like the Okanagan or Victoria as they aged and retired. When a road was built, this situation changed and people started to stay.

However, there was no place for residents to move as they became frail, so community members asked for long term care and got some beds designated. This change has caused a subtle shift in attitudes, where people now have an expectation that getting older means they will end up decrepit and require long term care.

Ms. Wheeler suggested that a focus on wellness and prevention seems missing and is necessary. Although emphasis was placed on creating healthy communities in the 1990s to prevent illness and deterioration, the health system seems to have moved back to an acute care mindset, without funding prevention and healthy living.

**Attitudes and issues facing seniors in northern BC**

*Bev Christensen, President, Prince George Council of Seniors*

During her time as a reporter at the *Prince George Citizen*, Ms. Christensen attended a number of aboriginal gatherings and admired the respect shown to elders. She suggested we can learn from aboriginal cultures about respect and recognition for the value of elders, people who have lived in and served the community for a long time.

Ms. Christensen reported on issues recorded by the Prince George Council of Seniors: seniors facing increasing rents; looking for more affordable housing; needing help to move, mow the lawn, shovel snow, or clean the house; needing help to care for their parents; being separated by illness after many years together, because couples do not fit facility criteria to be together; maintaining themselves with meagre support. Many seniors are confused and worried about the future, because the supports in place for their parents do not appear to be in place for them. Although council members can answer questions and refer people, they know seniors will discover waiting lists for housing and unaffordable rents, and get lost in telephone answering systems.
Ms. Christensen expressed concern about the stigma attached to being old and how seniors are being blamed for living too long; for example, for delays in hospital care and surgery, when the reason for backlogs is not enough residential, community and home care. Aging people living at home are being asked to maintain themselves with a minimum amount of support.

Ms. Christensen asked conference participants to consider investigating attitudes among young people and professional care providers towards seniors, and monitoring what is happening in homes where people are caring for themselves.

**Realities and challenges in northern BC**

A second panel session followed the keynote speakers at the conference. Five presentations examined the realities and challenges of delivering care for seniors in northern BC.

**Issues elders encounter in northern BC**

*Leona Nielsen, Cree Language Instructor, First Nations Studies Program, UNBC; Culture Teacher, Headstart Program, Native Friendship Centre*

Based on her experience working with the Prince George Métis Elders Society, Ms. Nielsen described some of the issues elders face in northern BC:

- Elders encounter language barriers using automated phones systems, and would often hang up and call her because they did not know what the messages said.

- Housing was the biggest issue. Elders had difficulty getting up and down stairs and keeping warm in their homes. Elders want their own home care system among aboriginal people in the community. But elders live in Métis housing in separate areas of Prince George, so they are alone, don’t socialize, and feel isolated and lonely. Ms. Nielsen made home visits and ran errands for elders who wanted company.

- Caring for elders is also a concern:
  - Ms. Nielsen visited elders in hospital, and took other elders to visit, when working family members did not have enough time. She was involved in social activities, travelled with elders to an elder conference, took care of elders, helped obtain mobility and other devices like a cane, wheelchair or emergency response buttons for elders living alone.
  - In northern Saskatchewan, elders used to be well looked after in the community by an older daughter or grandchild, not sent to a nursing home. Ms. Nielsen adopted some grandmothers in the community, gathering water, chopping wood, and grocery shopping for them.

- Transportation is another concern for elders without a vehicle. Elders in Prince George got a bus and would try to organize a day out, but not everyone wanted to go on the same day. Consequently, Ms. Nielsen would often transport elders to the physician, shopping, or wherever they wanted to go.
Realities and challenges for northern researchers

Neil Hanlon, Associate Professor, Geography Program, UNBC

Dr. Hanlon explained that researchers in northern BC face similar realities and challenges to community groups and health care practitioners in the north:

- Researchers are small in number and spread thinly, with a gap between curiosity-driven basic research and the need for more applied research. Fixing the balance takes time.

- Researchers deal with smaller numbers and concentration of seniors in northern BC, which can pose problems. Much research training assumes an urban population with large numbers to find statistical associations, so scientists must look for other types of research and research approaches in the north. One way to deal with this challenge is to do research that follows people for a long period of time.

- Some types of administrative and research support are weak or non-existent, while other areas (such as getting proposals together) are remarkably strong for a university of UNBC’s size and population base. Nevertheless, researchers in northern BC need a do-it-yourself attitude compared to their city colleagues, and have to partner with others to be successful. The benefits of this networking emerge over time.

- Northern BC is remote from the centres of policy making and research agenda setting, much of which is done in the Lower Mainland and Ottawa, so staying up to date and connected can be an issue. Journals and electronic media help, but networking in person is more challenging.

Despite these challenges, Dr. Hanlon noted there is no shortage of research questions and topics to explore. In many ways, northern BC is at the forefront of what’s new in aging research in rural and remote communities. Some highlights include:

- Many researchers seek current data on what is happening in the community and area, so establishing a data repository would be valuable, with an agreement between NH and UNBC. Some effort is underway to start planning a repository, which will be very helpful for research and lessen requests to NH and community partners to locate data.

- NH recently created an office of research and evaluation to build capacity and create partnering opportunities, which should meet some of the need for applied research that can improve service delivery.

- NH and UNBC have also developed a seamless ethics review process, which ensures many perspectives are brought to bear on proposed research, confidentiality and privacy are protected, research is ethical, and paperwork is reduced.

Dr. Hanlon hopes to expand research opportunities between NH and UNBC to increase capacity for knowledge exchange. He believes the best feature for researchers working at UNBC is the opportunity for true collaboration with community groups, a tremendous advantage for researchers in matching research efforts to what communities need.
Barriers to access in isolated, rural communities

*Marilyn Wheeler, Author, The Robson Valley Story, McBride*

Ms. Wheeler discussed some of the differences in access to services between northern, urban communities like Prince George and isolated, rural communities, which have fewer services. People in isolated communities face barriers to getting help when it is needed. An ambulance can take an hour to reach an isolated community, if there’s a road. Not everyone has a phone or power, although cell phones have made communication easier in some places.

Small health issues can become bigger problems if not attended to. For example, if someone can’t walk well and falls on ice, breaks an ankle, and ends up in hospital losing muscle tone, there’s no physiotherapy when they go home in these rural areas.

Consequently, Ms. Wheeler advocated for a menu of home care services based on needs, rather than wasting resources having different providers for various activities in such a large geographic area.

Research to support aging well

*Bev Christensen, President, Prince George Council of Seniors*

Ms. Christensen suggested conference participants consider three aging research themes:

- **Examine seniors’ understanding of access to home care and housing** – Many seniors are confused about changes made to home care, and unfairly hindered in their ability to plan for extra costs as a result. In addition, seniors generally believe they can move to accessible, safe, affordable housing when needed, but this type of housing is not readily available and new housing is not being built for the aging population in northern BC. Seniors reach a crisis point and don’t know where to go. Researchers need to identify seniors’ misunderstandings about what support is available. The Council of Seniors is preparing a survey, with UNBC support, to identify seniors’ housing needs in the area, and participants were encouraged to complete the survey.

- **Identify caregiver needs for support** – Since the intermediate care home in Prince George closed, support for seniors has shifted to an informal system where a spouse, family member or friend is expected to care for the senior at home, without training and with limited support or respite. Ms. Christensen said the council hears about caregivers burning out and sometimes getting sick themselves, and suggested we need to assess how caregivers are maintaining themselves. She also recommended planning take place to address the increasing incidence of dementia in the aging population.

- **Survey attitudes towards seniors** – Seniors should feel entitled to care, respect and understanding, and should be valued. Yet seniors encounter disrespect from some young people and health professionals. Ms. Christensen suggested a survey be conducted of attitudes towards seniors to determine what damage is being done, and to illuminate the issue of respect and understanding in the community toward seniors.
Planning for future home and community care needs

Tim Rowe, Executive Director, Home and Community Care, NH

Planning for home and community care services in northern BC must examine population, geography, economic factors, and service delivery models:

- **Population challenges** – Growth in the north is going to at least double in next 15 to 20 years. The largest percentage growth in the seniors’ population in BC is in the north.

  Northern BC also has many rural and remote communities. Very few have a population of 10,000 or more, and many have a population of 1,000 to 10,000. Providing services to all of these communities is challenging. Many First Nations people live in small, isolated communities. And NH has a large aboriginal population: about 15% of the total.

  People tend to die earlier in the north than in other areas of the province, which means seniors in NH need to access services at a younger age than elsewhere.

  Mr. Rowe explained that NH must identify needs and modify services to meet needs, such as providing more support for seniors at home, as well as developing specialized services to meet growing needs, such as the increasing demand for dementia care, serving younger people with physical challenges, and supporting people with addictions who are living longer. NH must also address a recruitment and retention challenge of fewer people working in health care in northern BC.

- **Geography** – The NH region is huge, bigger than France, which presents tremendous challenges. People travelling in the region can encounter snow banks two-storeys high or slides that completely block access.

- **Economic factors** – Northern BC is dependent on a natural resource-based economy, which fluctuates significantly over time. With less economic diversity comes greater vulnerability. How does NH take the impact of this variability into account when planning services? As well, economies of scale are always difficult in northern communities.

  Health care in BC currently accounts for 48% of the budget, which Mr. Rowe suggested is not sustainable for the future. If costs grow, we have to change the system or increase taxes.

  Environmental issues like the pine beetle problem have a huge economic impact in the north. The north has longer, colder winters, and warmer summers with greater risk of fire. How do environmental issues impact health care planning?

- **Service delivery models** – NH needs to consider different service delivery models like the Care North primary health care program. NH also needs to promote self management, and provide resources that enable people to care for themselves independently, or with help from family and friends, more efficiently.

  Employing technology is a key component of health service delivery in northern communities. And partnerships are critical. NH must work with organizations at the municipal, regional and voluntary levels.

NH is in a good position to address issues like changing population characteristics and needs, positive and negative social and community impacts, and environmental risks.
New approaches and initiatives

Three presenters outlined innovative projects underway to enhance care delivery for older adults in northern BC.

**Care North: Building an integrated health network for at-risk seniors**

*Rod Schellenberg, Project Manager, Home and Community Care and Primary Care, NH*

Northern Health is developing an integrated health network for primary care called *Care North*. In the current system, the first point of care is primarily the family physician. Mr. Schellenberg explained that Care North will broaden this focus to improve care for at-risk seniors living in the community, so care is focused on their needs and health status.

- **Vision statement** – Care North will provide every resident with a “primary care home” that ensures access and comprehensive, coordinated care. This approach will be centred around a physician, but builds on that relationship with multidisciplinary teams. The physician and HCC case manager work with the senior and caregiver on a coordinated care plan. The goal is to change seniors’ experience of the health system and build healthier communities.

- **Lifespan view of care** – This model considers people moving through different phases of life, from being well and healthy, to having episodic health problems, chronic conditions, frailty and palliative care.

- **Integrating care** – Patients experience the health system in episodes, such as breaking a leg, developing a chronic condition, visiting a specialist, or using home care, with a series of providers coming in and out of their home and lives. As care becomes more complex, multiple care plans are currently developed, with no one coordinating that care. The logical point to bring these elements together is building on the existing relationship with a family physician, rather than starting a new program for frail seniors.

Care North will develop a coordinated, multidisciplinary, proactive approach around the family physician to deliver client centred care, with 24/7 responsibility for supporting seniors to remain in the home of their choice. This approach should help seniors avoid hospital stays that can have a negative impact on their health and improve quality of life.

- **Measuring results** – The initiative takes an incremental approach to change, with local, frontline teams setting, testing and evaluating measures, using six steps: defining a population of interest; gathering data on this population, such as gaps in care; setting targets for improvement; building a team to meet the needs of the population, based on the data, gaps in care and targets; measuring results; and assuming collective responsibility. Key measures include coordinated care planning for each senior; effective, community-based response to crises; increased independence and quality of life; and improved acute care utilization.

- **Defining frail seniors** – Care North uses the Canadian Study on Health and Aging clinical frailty scale, with simple descriptions physicians and nurses can use (very fit, well, well with treated co-morbid disease, apparently vulnerable, mildly frail, moderately frail, severely frail), and ways to support people as functional needs increase.
▪ **Progress** – Frail elderly collaboratives have been set up in Fort St. John, Prince George and Prince Rupert, with Smithers and Burns Lake starting in April 2008. Twenty family physicians are participating and creating registries of all seniors in their practices.

NH is still developing and testing this approach, but so far seniors and caregivers love the model. Instead of reacting to crises, care providers have time to plan for care issues and be responsive to seniors’ needs.

**Improving health care through technology (Pixalere)**

*James Chan, MA, Research and Evaluation Coordinator, Northern Interior Health Service Delivery Area*

NH is conducting evaluation research on Pixalere, a wound care management system, to determine whether this technology is useful for northern health care settings, and, if so, how to best implement the system across the health authority. Northern Health serves a large geographic area, and like other rural and remote health care providers, must make the most efficient use of specialist care providers. Pixalere holds promise for providing improved health care in the north.

▪ **Home care wound treatment** – Mr. Chan explained that Pixalere is designed to enhance wound care when patients are treated at home. For example, pressure ulcers can occur when people are bedridden for extended periods, and cause patients protracted pain if the wound does not heal quickly. Furthermore, this type of wound can be very expensive to treat, increasing nursing time up to 50%, according to the literature. Demand for wound treatment will increase with our aging population.

▪ **Current treatment issues** – Literature reveals that wound care treatment assessments are not generally standardized, measurements are not consistent, and often there is minimal tracking and reporting (paper charting is also sometimes illegible). NH wants to standardize treatments in order to improve care and efficiency.

▪ **How Pixalere works** – The name derives from “pix,” a slang term for pictures, and “alere,” Latin for healing. Pixalere software is a secure, web-based, wireless application that enables nurses to:
  - Take a digital photo of the wound in a patient’s home and upload the picture.
  - Enter assessment information into an electronic chart.
  - Transmit the photo and chart to a wound care specialist, who makes recommendations for treatment, saving treatment time and alleviating suffering.
  - Facilitate tracking treatment outcomes over time.

▪ **Evaluating Pixalere** – Several health authorities have used and reviewed Pixalere:
  - A Fraser Health assessment (2002) found that Pixalere resulted in reduced administration costs, quicker assessment times, increased access to wound care specialists, more standardized charting, greater ability to track dressing costs, and greater convenience for patients who did not have to leave home. Some technological challenges were encountered.
  - WebMed (the developer of Pixalere, 2004) compared Pixalere users to traditional wound care in another community, and reported overall wound healing time was reduced by 32%.
- A pilot project (2005) in Interior Health found 92% of staff thought Pixalere improved quality of wound management and 91% of clients were comfortable with its use; nurses were split on whether costs or heal times were reduced; specialists saved time not having to discuss wound conditions on the phone; and reduced travel time increased the number of consultations. However, double charting occurred in homes and at the office.

- And a Capital Health study (2005) found a high degree of staff and client satisfaction, a 40% increase in wound care specialist consults, decreased travel time for specialist nurses, shorter consultation times, and more appropriate referrals to physicians, along with some technological and product tracking challenges.

**NH pilot** – Pixalere has been piloted in Quesnel to see if the technology meets NH needs. Community home care nurses were trained in using the software, camera and tablet computers, as well as wound care management. Preliminary evaluation findings include:

- Implementation: About 89% of nurses using Pixalere thought the training they received was sufficient, all users experienced some problems, 66% required support, approximately one month is needed to gain competency, and users made several recommendations to modify the software.

- Impact on charting: About 56% agreed that Pixalere improves understanding of patient care compared to paper charting, and approximately 89% agreed it improved charting efficiency.

- Nursing satisfaction: Almost 89% found the equipment difficult to transport, 89% thought Pixalere made their job easier, and 56% thought it helped them provide better patient care (33% undecided). Pixalere had the greatest impact on workload at initial implementation and during transport. Nurses reported the technology had the most positive impact on simple wounds and follow-up wound care.

In closing, Mr. Chan noted that Pixalere technology allows access to a specialist nurse no matter where patients are located, and enables standardization to ensure more consistent care delivery and the adoption of clinical practice guidelines. The results of the pilot program evaluation indicate this product is useful, and NH will now complete a second phase of the study examining outcomes in more detail.

**Benefits and potential of RAI**

*Mary Henderson Betkus, RN, Regional Clinical Leader, Home and Community Care, NH*

Ms. Henderson Betkus explained that RAI is a “residential assessment instrument” developed by an international group of researchers, and used across BC. This evidence-based umbrella of tools includes home care, mental health and palliative assessment. In May 2004, NH implemented the RAI home care assessment tool for all case managed clients in home and community care. Case management aims to provide a variety of service options to maintain individuals with chronic health problems and frailty in their homes as long as possible, and to prevent them from going to residential care.
• **Benefits of RAI** – The data collected for home care provides a comprehensive assessment of functional strengths and what help people need. Benefits can be maximized if assessments are computerized, because several algorithms are embedded in the tool and can be combined to automatically tabulate outcome measures such as cognitive performance, ADLs (activities of daily living), medication use, informal and formal supports, and pain scale. For the first time, this information provides a picture of the seniors’ population in NH.

• **Potential of RAI** – The data can be used to inform HCC program planning, development and restructuring, frontline clinical decisions, and organizational redesign.

• **Top three diseases** – NH now has data showing hypertension, arthritis and diabetes are the top three diseases in case management. Results are divided for small, isolated rural communities, moderate sized rural communities, and large rural communities. Before RAI, NH did not have this type of precise client information.
  - Hypertension: In small communities, 24% of case managed clients have hypertension, in moderate 18%, and in large 20%.
  - Arthritis: Small communities 51%, moderate 58%, and large 50%
  - Diabetes: Small communities 24%, moderate 25%, and large 24%.

• **Frail elderly clients** – RAI was used to collect data on frail clients as well, defined as:
  - Having a diagnosis of more than two diseases and showing deficits in IADLs (instrumental activities of daily living), such as getting groceries, managing medications and doing laundry; or
  - Showing deficits in IADLs and ADLs, such as getting dressed, feeding themselves, and going to and from the bathroom.

Using this definition, 89% of HCC clients in small, rural communities are frail elderly, 36% of these clients live alone, and 30% of their primary caregivers are showing distress.

In moderate sized rural communities, 85% of clients are frail, 42% live alone, and 19% of their primary caregivers experience distress.

And in large rural communities, 90% of HCC clients are frail elderly, 36% live alone, and 25% of caregivers are distressed.

The data raises questions about what programs need to be developed or changed to support frail elderly and reduce caregiver distress, and how RAI can be used to evaluate effectiveness.

• **Cognitive performance scale (CPS)** – RAI data shows the percentage of primary caregivers experiencing distress caring for clients with a CPS of two to four (showing signs of cognitive difficulties, moderate cognitive difficulties, and significant cognitive decline) and incontinence:
  - Small rural communities: 49% of caregivers show distress caring for someone with cognitive difficulties, and 21% caring for someone with incontinence.
  - Moderate sized rural communities: 22% are distressed coping with CPS, and 17% with incontinence.
Large rural communities: 31% are distressed coping with CPS; 22% with incontinence.

Ms. Henderson Betkus noted that other health authorities, which are predominantly urban, have 84% of HCC clients who are frail elderly, compared to 89% in predominantly rural NH.

Q&A on panel presentations

Following these presentations, conference participants asked several questions:

1) With an increase in dementia coming, will responsibility fall under seniors’ care or mental health? Adult mental health has been taken away in Burns Lake, which now has responsibility for children’s mental health only, but care providers are seeing increasing dementia. Is this issue being addressed?

In NH, 30% of clients have a CPS of three, or moderate dementia, so this can be identified as an issue. Dementia is growing issue everywhere, and collective responsibility is required in all settings across the continuum: residential, acute, home, community care, the family physician, and mental health all need to be involved.

This issue is arising with the integrated health networks. The solution is not always to create a new specialized program for this particular population. Instead, Care North wants to build around the primary care physician, providing adequate support for the physician to meet the needs of that population. The physician would identify patients in the practice with dementia needs, and perhaps other professionals need to join the larger care team around the physician.

HCC services don’t provide help for people with impaired IADLs, which is particularly the dementia group. These seniors need help with shopping and meal preparation. But if they don’t need help with bathing, they don’t qualify.

Many of the issues discussed in NH and the integrated health network group reflect the original specifications for the continuing care division in BC, and much has been eroded. BC was the first province in Canada to have a standardized assessment system, LTC1 (long term care 1), similar to RAI. It was a paper-based system, but worked. RAI is a more sophisticated system that will enable better data collection. But BC has data going back to 1978, because clients were followed for 15 years using LTC1. RAI should be able to build on that data and do some excellent research.

Also, the Council of Seniors should talk to Canada Mortgage and Housing Corporation about a tool called Seniors Independence in Rural Cities, which contains the kind of questions needed in a survey on seniors housing, and can be adapted for Prince George.
2) Is there an opportunity to share what you are learning in the integrated health network initiative with other communities? How can work in one community be translated for others?

NH is using the Institute for Healthcare Improvement model to empower local teams to address gaps. For example, a physician and home and community care staff are working together in Prince Rupert to develop a common care plan. This team has to rely on emergency and acute care for after-hours response in the community, and decided to share the plan with these providers. This type of approach was not a priority for Prince George and Fort. St. John though. However, Burns Lake and Smithers want to work towards the Prince Rupert model, so the practices are being shared with these communities.

The initiative is still at the stage of initial learning and relationship building, but the goal is to share the lessons learned with other teams to do further development and embed them as permanent changes.

3) How can we frame research to address and change the socio-cultural values of elders in our culture?

A number of different research streams consider this issue, such as quality of life research and community preparedness for aging, and provide a way to ask questions about how we value seniors. The effort we put into community services and resources to better support the aging population is a clear reflection of these values. The north has many resource communities that were built and expanded when lots of young workers flooded to the area. Now, 30 to 40 years later, these communities have to be retooled, and research is needed from many perspectives to answer questions about how to help communities respond to changes. There are many opportunities for community-based research, and we should bring in people from the arts and humanities, as well as the health and technology sectors, to ensure greater engagement from a variety of perspectives and disciplines.

Greetings from the Lieutenant Governor

The Honourable Stephen L. Point

Lieutenant Governor Stephen Point spoke about the conference focus on elders, aging and access to health services, and noted a number of changes he has witnessed over the years. Baby boomers are getting older and people are living longer. This has raised questions and concerns in government, as people all across the country wonder about the issue of an aging Canadian population.

Canada is a country of many colours with people from all across globe. At one time, aboriginal people lived off the land and, in those days, elders were a tremendous source of knowledge. There is a stark contrast between remembering how elders were valued so highly then and, today, seeing some being abused and neglected. What has happened? Time has taken its toll as people moved from living off the land to small communities with many people on welfare and a subsistence lifestyle. As a result, what’s happening to elderly aboriginal people across Canada has happened to the larger society as well.

At one time, we heard elders tell stories of our history and young people were educated by the passing on of this knowledge. My great-grandfather lived to be 100 and my great-grandmother to 115, and there was a great love of elders in those days. Then that system of education was taken away with residential schools.
As we moved from tribal people living off the land to living in towns like Prince George, the poverty, substance abuse and changing role of elders has taken a great toll on our people, and I wonder if our value system has changed. Do we value our elders in the same way as we once did?

When the settlers first came, families all lived together on farms and took care of elderly people at home. As we’ve moved from groups of people living together to nuclear families, we see fewer young people at home taking care of their older folks and more centres where elders are cared for. Responsibility for elders has shifted from the family to the state. Maybe we could evaluate whether that change is good, because, as the aging population doubles in the next 10 to 15 years, health care costs will rise as well. We have to think ahead about how we will manage the care of elders.

For aboriginal people, the question of shifting jurisdictions raises a different issue. For aboriginal people, health care is a federal responsibility, but is a provincial responsibility for others. Often aboriginal people can fall through cracks.

Trust is a barrier to getting good health service. It is hard for elders to trust because they have been through so much. My great-grandfather saw the first settlers arrive. Police came to put children into school, government officials arrived to say aboriginal people had to live on reserves, and diseases wiped out many villages. One year we had 50 funerals in my village; we know about death and loss.

Service delivery to aboriginal people, who sometimes feel they are getting different treatment, is also an issue. It would be nice if someone would go to the communities and ask how people feel about the delivery of services. As you begin to consider aging, treatment and medical services, keep in mind equal treatment for everyone, and lend an ear to find how aboriginal people are receiving services.

As we look forward to the future, I hope we can improve services to our elderly and ensure that there are proper care facilities and affordable housing, that our values and ethics toward the elderly continue to improve, and awareness of their needs grows. The role of the elderly has changed in last 100 years and, with better understanding, maybe we can make some changes for the better.

What do we know from research?

The final panel session at the conference focused on current research projects aimed at improving the health and well being of seniors in northern BC.

Lost in translation: Policy, research and practice issues around aging well in rural and remote places (Authors: Greg Halseth, Neil Hanlon, Laura Ryser)

Presenting: Greg Halseth, Professor, Geography Program, UNBC

While we know a great deal about coping with issues of aging, Dr. Halseth pointed out that knowledge from other settings doesn’t always work in small communities, and approaches in rural towns do not always get translated into policy.

- Challenges – People on the frontline and caregivers know that finding the right mix of services is challenging. People often have to go to formal and informal service providers and make the connections between providers on their own. Researchers want to move knowledge forward, but those with the information aren’t always open to sharing it.
Recent seniors’ studies – Needs assessments, focus groups, interviews and surveys with northern seniors have found that keeping seniors healthy and happy in their own homes is an obvious driver for research and policy. We know independence makes seniors’ quality and length of life better and longer, and reduces long term care costs, but the way we apply policy undermines seniors’ ability to stay happy and safe at home.

Healthy home supports – Support helps avoid premature institutionalization: home care, nursing visits, house cleaning, home and yard maintenance (not being able handle maintenance has a great impact on mental health and quality of life), winter driveway maintenance, access to food and medicines, and transportation. Home support providers come from the private, public and voluntary sectors, with an increasing role for volunteers, especially in rural communities, because economic change has often meant children go elsewhere to work and are not around to provide support.

Access to services – People in rural and remote communities understand limits to service provision, but also pay taxes for reasonable access. Fraser Health and Vancouver Coastal Health face a challenge with the volume of services, while NH has challenges with everything: growing demand, need for space, distances. Technology such as telemedicine is a terrific tool, but is supposed to assist clients and care providers, not reduce budgets for centralized administrators.

Caring for caregivers – This is a neglected facet of service provision. Activities at federal and provincial levels are looking at offloading costs onto volunteers and communities, without looking at supports for the people bearing these costs. However, some local research is broadening knowledge in this area.

Training for care providers – Professional care providers need training to help them deal with changes in the aging population. Travel costs should be covered and training rooted in the realities of seniors’ needs and generalist practice in northern communities. Make use of mentors, drawing on an emerging body of retirees with a career’s worth of experience. Coordination is needed among providers and professions, because, right now, individuals have to carve out their own care agendas for parents or loved ones.

Supporting age-friendly houses and towns – Land use planning and construction industries have a great deal of information on how to make more appropriate and safe houses and towns for northern locations. We need to coordinate this information and share it with people taking action in our communities. Access and mobility in houses and home maintenance are crucial to creating age-friendly houses. Many small, age-friendly towns have changed how they deal with infrastructure, and businesses have a role to play.

Dr. Halseth suggested the crux of the challenge is paying attention to the context of rural, small town aging in both research and policies. Much of what can be done is already known. Work is needed in communities and in research to mobilize this knowledge, but we can take action now, and quickly have an impact on aging well in rural and small towns.
Community design can have a powerful impact on health, well being, and ability to participate and contribute to the community. Design can also exclude and discriminate.

- **Universal design** – Ms. Ringaert explained that universal design creates places all people can use, regardless of age, ability or size. The environment can be a barrier or facilitator to participation. Northern communities were not originally thought of in terms of universal design, and are just now looking at barriers. For a person in a wheelchair, stairs are an environmental handicap and could be a barrier for others.

People are often segregated in a community because of its design. Transportation is an issue in rural and remote communities, and driving may not be an option for someone with a disability. Rather than segregating seniors housing, universal design could be incorporated in all housing in the community.

Design is a public health issue. Isolation, depression, lack of participation and exercise, falls, institutionalization, and difficulty for caregivers all have to do with design. A liveable community allows people to be engaged in all aspects of the community and be valued.

- **Measuring Up the North** – MUTN began in August 2007 to create disability friendly, senior friendly, and more universally designed communities for all citizens. This project was created by and for the north by the North Central Municipal Association, BC Paraplegic Association, BC Healthy Communities, and 2010 Legacies Now.

The goals are increasing employment for people with disabilities and seniors, improving accessibility, building accessible tourism, creating places where people can continue to live, and attracting others to live here.

MUTN created the “10 by 10” challenge to have ten percent more people with disabilities working by 2010. MUTN is also part of a 2010 Legacies Now accessible tourism initiative. Accessible tourism is big business: 54 million people with disabilities in the US spend $13.6 billion annually on accessible travel, and places all over the world are looking to attract this business. And visit-able housing is being promoted, with one entrance that has no step, wider doors and a bathroom on the main floor. This model would enable people to stay in their homes and visit each other.

Forty-one communities have signed up. Each has an NCMA liaison, a community liaison (someone with a disability or a senior), and a committee to engage the community in discussions; conduct community assessments of the neighbourhood, businesses, recreation, hospitality and transportation; set targets and strategic plans; and, ultimately, develop age and disability friendly policies for official community plans.

MUTN is developing a network forum for discussing community issues at www.measureupthenorth.com. Participating MUTN communities are listed on the website, with projects such as improving sidewalks, parking, bus stops, housing, snow clearing; installing elevators in public buildings; and developing a system for the hard of hearing in a cultural centre. Many communities are examining policies as well. Ms. Ringaert noted that everyone benefits from building more liveable, inclusive communities, including seniors.
Promoting seniors’ well being using the seniors’ mental health policy lens

(Authors: Penny MacCourt and Dawn Hemingway)

Presenting: Dawn Hemingway, Associate Professor, Social Work, UNBC; Co-leader, BCNAR

The BC Psychogeriatric Association (BCPGA) developed the seniors’ mental health policy lens as a best practice in seniors’ mental health, with funding from the federal government. Professor Hemingway explained that the lens provides a framework for evaluating policies, programs and service delivery, using a set of questions to identify potential negative and positive impacts on the well being of older adults (available at www.seniorsmentalhealth.ca).

Although the association is based in BC, the seniors’ mental health policy lens is a national project, and is being used in various communities across country. BCPGA seeks to increase the use of the lens in its home province of British Columbia, and is available to work with any organizations wishing to do so.

- *Rationale for the policy lens* – A number of factors prompted the development of this tool: ageism, the prevalence of mental health problems in Canada, little input from seniors in policy development, the neglect of the psychosocial component in the biopsychosocial model, and the fiscal implications of having policies and programs that don’t meet needs.

- *Developing the policy lens* – Focus groups with seniors, clinicians and planners helped to develop the framework. The lens examines what seniors across the country said would meet their needs to maintain overall wellness, including the:
  - Diverse needs, circumstances, and aspirations of vulnerable sub-groups.
  - Multiple determinants of health including physical and social environments, gender, income and social status, social support networks, culture, personal health practices, coping skills, and health services.
  - Accessibility.
  - Social participation and relationships.
  - Seniors’ independence, self-determination, dignity and security.
  - Cost/benefits of supporting seniors.
  - Cumulative life effects on seniors.

- *Using the policy lens* – Policy makers, program managers, clinicians, seniors’ advocacy groups, health care professionals and educators in nursing, social work and community health can use this tool to identify strengths and areas for change. The policy lens is flexible enough to apply in regions across Canada, including northern, rural and remote communities. The process involves:
  - Providing a brief description of the policy being reviewed.
  - Using a template to examine whether the policy meets needs.
  - Analyzing responses to determine whether more information is needed or the policy should be accepted, revised or changed. A cumulative score shows how well the policy meets needs.

The tool enables people to check on issues of importance in the north: social supports, access to appropriate care, safety, accessibility, affordability, transportation.
Expected benefits – A number of pilot projects are underway with seniors’ organizations, advocacy groups and mental health services across the country to determine whether the policy lens is helpful. This work will be finalized by fall 2008. Some of the anticipated benefits include:

- Identifying policy biases that could lead to negative impacts.
- Involving people affected by policies.
- Increasing accountability.
- Reducing barriers.
- Leading to more appropriate services.
- Broadening knowledge of how social determinants affect seniors’ well being and mental health.

Analyzing home care data in a geographic information systems framework
(Authors: Neil Hanlon, Mary Henderson Betkus, Ashleigh Desbiens, Dana Pidherney and Britta Stakelbeck)

Presenting: Neil Hanlon, Assistant Professor, Geography Program, UNBC

Dr. Hanlon reported on the use of geographic information systems to illuminate client profiles from home care assessment data in northern BC. Northern Health and UNBC are collaborating on this project.

- Home and community care assessment – Research data comes from the Minimal Data Set – Home Care (MDS-HC), a clinical assessment tool that is part of the larger RAI. Mary Henderson Betkus discussed in the “New approaches and initiatives” session. The MDS-HC captures all case managed clients, identifying factors like functional and cognitive ability, informal supports and medication use. Case management determines eligibility for different types of support like home care, adult day centre, respite care and assisted living.

- Geographic information systems (GIS) – Geographic issues like distance, low population density, and reliance on informal support have tremendous influence on home and community care, so bringing the data into a GIS framework can shed light on client profiles and characteristics. GIS are computer-based systems that can store, integrate and analyze data, and display relationships among many objects at once.

- Collaboration – NH shares home care data with UNBC. Protocols were sent to UNBC and NH research offices to obtain ethics approvals. Three activities were launched:
  - Generate service area profiles of clients, distances traveled, and population characteristics.
  - Use road network analysis to create indices of HCC access.
  - Explore associations between levels of access and patterns of formal and informal care utilization.
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- **Preliminary impressions** – Students have been setting up the data, so the project cannot yet report a lot of findings, but initial impressions and issues included:
  - Protocols were established to ensure records remain confidential.
  - Postal code linkage was used to bring in the data; however, some postal code areas are large and NH has small numbers, so caution is required in analyzing and reporting findings.
  - Some software and hardware issues need to be resolved.
  - Service area profiling is underway and results should be available soon.

- **Maps** – Maps have been developed of service area catchments for each health centre, with coloured dots representing case managed clients for each centre. The principal message is that NH has some very dispersed client distribution, so some centres may serve small numbers, but people are very scattered, which has a big impact on how often case managers can see people.

- **Future directions** – Dr. Hanlon noted that this collaboration is just beginning and the next steps include:
  - Using GIS techniques to look at different levels of access to the full suite of services and how this may influence formal and informal care. Client population characteristics will be analyzed for differences, such as the mix between paid and unpaid care, depending how close people are to full service centres.
  - Looking for an alternative to postal codes in smaller communities. The team hopes to fine tune geographic reference points, and then find ways to aggregate the data to protect confidentiality.
  - Exploring avenues of knowledge translation between UNBC and NH to support using basic and applied research for service planning and decision making.

**Q&A on panel presentations**

Conference participants asked a couple of questions following these presentations:

1) **What is the timeline for the data collection collaboration between NH and UNBC toward a data repository?**

   Work on the data repository is still in the planning stages, and no timing has yet been set for a roll out, although some effort is underway to develop a menu of indicators and statistics for a population level profile of utilization and health outcomes. NH and UNBC will continue to collaborate, and, ideally, some preliminary findings could be available in the fall, with a report in 2009. NH and UNBC are just beginning to demonstrate the potential benefits of what can be explored using this data. Recommendations will include future development, but this type of project takes time.

   NH has two large RAI databases, but is at the initial stages of looking at the data collected for clients. Bringing UNBC onside helps NH analyze data in the context of providing services across the geography of northern BC. However, no decision has been made on how the information will be published or made more broadly available.
2) Are we going to be able to do something in two days that will make a difference to people? Some seniors require care to remain, not only healthy, but alive and not at-risk at home. NH provision of services is restricted to what the provincial government allows. Home care is only delivered by home care workers. Other people can clean; therefore, home care workers are not allowed to and it’s the same with cooking. So a blind person who cannot cook, but can take medications and bathe, cannot have home care services.

This comment captures one of the challenges faced in NH. Terrace also identified these gaps and began a volunteer bureau, which other places can learn from. People volunteer services such as shopping and snow blowing. By funding a volunteer coordinator and a centre, the bureau receives requests for people who might fall through the cracks, and works with care providers to line up people who can provide this support. The small business community and private sector also play a role. In Terrace, if someone buys bars for the bathroom at Home Hardware, store staff will install them for free. Pharmacies will deliver medications and grocery stores will deliver food. These are some short term ways to make seniors’ lives better.

In addition, Measuring Up the North is a grassroots effort happening in many communities, so supporting the committees already in place can help make northern communities better places to live.

Hopefully, the conference will identify specific activities people can take to local governments, NH and communities. Too often, unpaid caregivers fill a vacuum and then caregivers end up sick themselves. It is important to examine what needs to be done to support caregivers. Some relatively small measures could make a big difference in offering support. It is not good enough to have standardized home support rules that do not allow providers enough flexibility to support individuals. How can policies and rules make more sense in rural and northern communities?

**Setting research priorities in seniors’ care**

Conference participants identified six themes for research priorities that will contribute to enhancing seniors’ care in northern BC:

- Home care
- Access
- Supporting seniors in their homes
- Creating an age-dignified society
- Interprofessional teams
- Informal caregiving: family members and volunteers

Conference participants worked in teams to develop these research priorities. Each theme is listed in this section with:

- Comments supporting the theme from the open dialogue session.
- Information on the issues and challenges associated with each theme.
- Research directions developed by the teams.
Research approaches
In addition, participants identified guiding principles for conducting research:

- Appropriate valuing of lived knowledge and experience.
- Not doing research for seniors, but with them; “nothing about us without us.”
- Building on and using existing knowledge.
- Learning from international experience in places like Europe, Japan, Scandinavian countries and Australia, while remaining conscious of differences in social welfare programs.
- Using qualitative and quantitative research, including participatory action research.
- Taking action as research is underway: piloting small projects with short term evaluations, and then implementing successes.

Theme #1: Home care

Conference dialogue
Conference participants’ comments about home care included:

- Home care flexibility needs to be addressed, because there’s a lack of action on issues that need to be dealt with right away.
- Home care workers are only able to do specific activities, but need flexibility to identify what support is needed, not just give someone a pill or bath. Seniors might need help with meals or dishes, but home care workers are not in that role now.
- Home care has been cut back and cut back since 1984. Granisle has a population of 360 people with 25% over age 65, and the community has only 15 hours a week allocated for home care.
- Waitlists for home assessments can create a safety issue. Seniors cannot get home support unless their medical and home situations have been assessed. But a shortage of people to do these assessments means seniors are placed on yet another waitlist, when they need help right away.

Clarifying the issue
This team discussed some of the characteristics of home care support:

- Home care involves three services: home care, home support, and homemaking, all of which need to be accessible and available to meet the particular needs of older adults.
- Providers need to be better at making programs meet the needs of individuals, not fitting individuals into programs.
- Currently, needs are not being met, as illustrated by emergency department use and backlogs for hospital beds.
- Services should be accessible and available to people from truly remote communities, but there is an issue of availability of staff in these areas. Recruitment and training are both necessary. Perhaps the ministries of health and advanced education could develop standardized curriculum, as standards differ across the province.
Depopulation of rural communities as people age in northern BC is intimately connected to informal caregiving, having an age-dignified society, and supporting seniors in their homes.

Economic circumstances in the north affect whether caregivers, such as children of aging parents, are around to provide support.

The following players need to be involved:
- Health authority managers and practitioners to listen and collect data
- Communities doing innovative projects (collect data on positive and negative experiences)
- Seniors’ organizations
- UNBC and NH researchers
- Different cultural representatives
- Government representatives with direct experience in their own family
- BCNAR/HCCRN/UNBC collaboration (BCNAR grants/HCCRN transition project)

Research directions

1) Use existing data and research on home and community care and homemaking to obtain information on what is happening in rural, northern communities and identify knowledge gaps (e.g., data from the Canadian Centre for Policy Alternatives).

2) Determine the degree to which needs are not met:
   - Review literature/identify what knowledge is needed.
   - Gather quantitative statistics on usage to assess how service use is affected by a lack of home care supports. (For example, are emergency statistics collected that capture reasons for presenting, such as lack of home care support?)
   - Gather qualitative data on personal experiences. (Interview service users and caregivers, paid and informal. Provide assurances of confidentiality and anonymity to allay any concerns of repercussions on service access. Ask what would enable seniors to remain at home.)

3) Determine what are the rights of all older adults to access services, and identify which policy/budget priorities might be impacted or need to be changed to meet these rights.

Theme #2: Access

Conference dialogue

Comments on the issue of access to care included:

- Access needs to consider transportation issues. Bring stakeholders together to discuss how to maintain seniors’ ability to remain independent at home and engaged in the community. For example, bring BC Transit and developers together to examine building age-friendly transportation and homes.

- Barriers to access remain. How do isolated persons access services and what can be done for them? Conduct pilot projects on how to get access to resources and services that do exist, to define what does not exist, and what the barriers to accessing services are.
Home care flexibility needs to increase. For example, one barrier to access might be getting information for an assessment to demonstrate need. Services need to be based on the ability of providers to build relationships with individuals to get this information.

**Clarifying the issue**

Some of the issues associated with access to care include:

- How do people negotiate their claim to appropriate care, and how can health services best facilitate access?
- The Candidacy Framework developed by the National Health Service Research Office in the UK includes seniors, as well as other groups, and is based on a formal, systemic review and synthesis of literature and policies. This model provides a comprehensive framework for looking at access in terms of the relationships and gateways people negotiate. The model considers how people identify their own need for care, how they access care, what the services are like, and whether referrals are appropriate.
- A policy/systems approach should recognize that some systems are functionally oriented (HCC) and some are diagnosis oriented (mental health) and the two don’t necessarily mesh. Providers need to figure out how to reduce barriers and work smarter.
- All players must be involved in partnerships, starting with seniors, family members, health authorities, municipalities, recreation centres, and policy makers. HCCRN would provide the lead in setting research questions.

**Research directions**

1) Review current evidence:
   - Review Candidacy Framework (Dixon-Woods et al. 2006). (Sharon Koehn to distribute report.)
   - Conduct a scoping review of literature, programs, policies and key informant interviews relevant to northern, rural and remote communities.
   - Develop an inventory of services/programs, with a focus on evaluation.

2) Build on existing initiatives, using the Candidacy Framework as a guide:
   - Map senior patients’ journeys based on an exercise conducted in Quesnel for diabetes patients, where patients describe how they accessed and experienced the system. (Use mapping exercises, community forums, accessing academics with funding and students.)
   - Evaluate the integrated health network initiative for correlations with Candidacy Framework outcomes/utilization findings.

3) Investigate BCNAR seed grant to develop a proposal for a larger project. (Joanna Pierce to lead this process.)
Theme #3: Supporting seniors in their homes

Conference dialogue

Some comments on supporting seniors at home included:

- There’s a lack of prevention and wellness programs for seniors. Hospitals used to have wellness days when nurses would check on seniors’ concerns and provide referrals if necessary. This type of approach could provide an opportunity to promote fall prevention and smoking cessation. The impact of wellness days could be measured longitudinally with a cohort.

- What is an adequate pension income for living in northern, rural and remote communities? The current formula might not be realistic given community, transportation and medical issues in the north. Research is needed on adequate incomes for seniors to live at home in NH.

- How can we best support seniors at home in the community? Let’s build on existing research, taking action on work that’s already been done.

Clarifying the issue

Team members clarified some of the issues associated with supporting seniors in their homes:

- Physical accessibility can be improved by:
  - Renovations funded by the Legion’s Poppy Fund, available for veterans and seniors, other service clubs, and Residential Rehabilitation Assistance Program (RRAP) grants, available through Canada Mortgage and Housing Corporation. (Use websites and newsletters to promote this information.)
  - Encouraging city planners to build more accessible homes for people with disabilities and make businesses more accessible.

- Transportation can be an issue for seniors:
  - Public bussing is not available in all communities.
  - Handy dart is available in some communities, but some do not run past 4:00 pm due to financial constraints.
  - People often rely on family, friends and volunteers to get around in smaller communities.
  - Adult day centres can pick up clients and will lend buses to other organizations.
  - Having community vans to pick people up would help.
  - Some seniors choose not to drive at night, in winter conditions, or for financial reasons. Lobbying is needed for a seniors’ discount on insurance, based on years of driving with a safe record.

- A mature drivers’ program could create an assessment checklist for safe driving habits that a friend fills in while driving with a senior. The senior can evaluate the results at home, and determine whether any areas require a lesson or more time behind the wheel.

- Part of maintaining mental health is staying productive at home, being able to shop for groceries, and socializing. Home support is needed for these activities.
Some care challenges include:
- Flexible care is needed, with a broader spectrum of services, tailored to the needs of the individual.
- Confusion exists about what services are available.
- Small communities may not have a home and community care assessment team.
- Seniors have to be willing to accept available services. Sometimes providers attempt to initiate a service, the individual refuses, and then family members may be upset. As well, different cultures sometimes don’t permit personal care.

Communication can be challenging. Places to share information about services include community flyers in post boxes, doctor’s offices, dentists, grocery stores, post offices, churches and seniors’ wellness fairs.

It is important to talk to seniors about downsizing, changing needs and safety concerns, when they can still make choices, recognizing that people have their own perceptions of what they need.

Creative public policy can support partnering, stipends, mileage for service groups and volunteer drivers.

Communities need to revert to intergenerational support.

Some municipal initiatives include snow removal built into the budget for seniors (Fraser Lake); friends and relations assisting with renovations for accessibility (Bear Lake); building codes to ensure safe installation; and linking with the BC Forestry Network, which has a renovations fund.

Research directions
1) Research ways to better support seniors at homes in northern, rural and remote communities:
   - Review what has been done elsewhere in Canada, Europe, Japan, Scandinavian countries and Australia. Where/how have these questions been asked?
   - Talk with seniors:
     o What makes it easier for you to live in your home (physical accessibility, transportation options and/or home care/services)?
     o What makes it easier to do what you want in the community (socializing, grocery shopping, etc.)?

2) Study how to share information in communities:
   - Conduct a test intervention.
   - What is available in our communities (newsletter for seniors/website for service providers)?
   - Build on existing programs such as Measuring Up the North.
   - Evaluate results.
Theme #4: Creating an age-dignified society

Conference dialogue

Some of the discussion on the importance of creating an age-dignified society included:

- The definition of an age-dignified community is one that respects, values, and supports people of all ages as much as possible.
- An aspect of community change is empowering people, based on lots of input from seniors who live in the community.
- It’s important to get more input from aging seniors. One idea is a wellness forum to learn how to stay healthy, independent, and live longer at home.
- A broader concern is respect, understanding and appreciation of elders and their role in the community. What are the attitudes of youth and health professionals towards seniors?

Clarifying the issue

This group described some of the characteristics of an age-dignified society:

- An age-friendly community would reclaim a sense of family and neighbourhoods to include and value seniors’ knowledge and roles in society and all decision making.
- Research and services should not be done “for” seniors, but “with” seniors.
- Healthy communities include all ages, not just the young and active. Seniors are important too and have the right to choose to live with risks.
- Re-instate voice and control to seniors in the community, because many feel voiceless and, therefore, powerless.
- All service providers need gerontology education and training to better understand older people and their needs.

Research directions

1) Conduct an assessment of current attitudes and values towards seniors, particularly targeting youth, business people, professionals, leaders and seniors themselves.

2) Use participatory action research methodology to bring as many stakeholders as possible together to define research questions and develop an action plan for change:
   - Examine socio-cultural values to revalue people in society, build capacity with informal caregivers, and determine what community needs and priorities are.
   - Changing society is a big undertaking, so start with small initiatives that build on existing research and measure results.
   - Consider the effectiveness of using a theatre troupe to present issues in dramatic form.

3) Study whether an activity program like the federal campaign, ParticipACTION, could help change attitudes towards being active, elders and values.
Theme #5: Interprofessional teams

Conference dialogue

Comments on the importance of interprofessional collaboration included:

- Individuals need more comprehensive care plans—one plan does not fit all—and bringing ministries and agencies to work together could increase the individuality of care.
- How does an age-dignified society relate to health care? Maybe we have to help people navigate the system, coordinate our systems, and educate care professionals to be respectful and deliver client centred care.
- Services often get fragmented by a breakdown in communication between silos.
- It is important to get rid of the turf war between health and academia.

Clarifying the issue

The members of this group described some issues and characteristics for interprofessional collaboration:

- Interprofessional teams should work across sites to care for clients, and with collaborative respect for the whole team.
- Broader interprofessional teams could build links beyond health care into the community environment (e.g., seniors’ housing and advocacy groups).
- Interprofessional teams face formal and informal barriers; at present, many professionals do not talk or make collective decisions.
- Facilitating effective, team-based care requires:
  - Attitudinal change to create a new vision across paradigms.
  - Communication skills training.
- Information technology and telehealth can help create teams in different remote settings to share information and work together.
- Different levels of government all play a role in looking after seniors: federal, provincial and municipal.
- Collaboration should start when people are training at university or college.

Research directions

1) What knowledge exists on how to facilitate effective, team-based care? What are the best methods of working together to serve clients?

2) Does an interprofessional approach work? Evaluate whether/how well interprofessional teams work for providers and patients:
   - Conduct surveys with community-based seniors.
   - Do teams have a system to provide regular feedback on how the partnership is working, and to prevent issues or potential negative outcomes from arising?

3) Track and evaluate whether interprofessional education results in professionals staying in the north to work and in greater collaboration.
Theme #6: Informal caregiving: family members and volunteers

Conference dialogue

Comments on the role and importance of informal caregiving and volunteering included:

- The federal government offered childcare incentives for people staying at home to look after children. A similar financial incentive is needed for people who stay home looking after their parents. People caring for parents help alleviate the burden on the health care system, but may have to give up part of their salary to do so.

- A particular interest is more funding for educating caregivers and care workers. The Province should fund agencies handling downloaded responsibilities.

- Educate volunteers, and subsidize training and time off to care for others.

- How can we support caregivers to support seniors at home in the community?

- In Kitimat, seniors and students participated in activities together, and seniors learned computer skills. The project was a great success.

- Educate everybody to be part of a successful team, including the physician, family members and volunteers.

Clarifying the issue

This team described the challenges facing informal caregivers and volunteers:

- A problem arises with older seniors caring for frail seniors. A spouse who is a senior and the main caregiver for a partner with severe health problems cannot usually cope adequately with the 24-hour responsibilities. The situation can lead to abuse, neglect and friction for the couple, at a time when they should not have to cope with this type of pressure.

- The other end of the spectrum is a frail senior with no spouse or family, living alone. Self-neglect often results, with people living in messy or unsafe conditions. When does the health care system step in or even know?

- Some possible remedies include:
  - More adult daycare and respite centres. Some of these services are in place, but not necessarily in smaller communities.
  - A telephone tree involving family members and neighbours calling, so caregivers get several calls a day to keep them in touch.
  - A lifeline device can be useful, so caregivers can push a button when in trouble.
  - Technology can help seniors stay connected. Although lots of seniors are not computer literate, more are using computers. Getting seniors connected using email before they get frail can help keep them more engaged, interested and mentally active. And staying in touch lets others know they are safe as well.

- Most people prefer end of life care at home over hospice palliative care. Employment insurance should provide family caregivers with seven weeks of EI payments. Together, a number of family members—spouse, siblings or grandchildren—might be able to provide a longer period of comfort for someone in the end stages of life.

- Governments talk about relying on volunteers to care for seniors, but there is a shortage of volunteers. Most volunteers in the north are also getting older and may be wearing out.
Research directions

1) Conduct an educational pilot project for caregivers to find out what’s working and what’s not. When initiatives are shown to be effective, implement them more broadly.

2) Explore the impact of intergenerational relationships:
   - In aboriginal communities connecting elders and youth.
   - Connecting seniors with younger volunteers.

3) Investigate what can be learned and measured about volunteer support.

4) Investigate why a shortage of volunteers is developing.

5) Survey people to determine what would make volunteering attractive and rewarding. For example, what impact would the following have on volunteering:
   - Not wasting time with too many meetings
   - Matching volunteers’ interests and strengths to the task
   - Volunteer training in organizational philosophy
   - Targeting the right potential volunteers

Next Steps

- Many conference participants signed up for teams to further explore the priority research themes identified at Aging Well in Northern, Rural and Remote Communities.

After the conference, BCNAR initiated the following activities:

BCNAR Northern Health

- Began coordinating post-conference follow up discussions to build teams interested in identifying next steps and potential leaders in each of the research themes.

BCNAR Provincial

- Support teams via teleconference and Webex, and facilitate community workshops.

- Held a grants competition to support three teams in developing larger applications to the Canadian Health Services Research Foundation (CHSRF), Social Sciences and Humanities Research Council (SSHRC), or Canadian Institutes for Health Research (CIHR) emerging team grants:
  - Multidisciplinary teams with researchers and students from multiple sites (university, health authority and community-based) will be encouraged.
  - Priority will be given to new emerging teams.
  - Preference will be given to proposals that involve mentoring graduate students.
  - Priority will be given to proposals with a co-principal investigator model, where one co-PI has a proven success record with peer reviewed grants and the other does not need to.
  - The deadline for submissions is September 30, 2008; results will be announced one month later.

- Posted speakers’ presentation materials on the BCNAR website at www.bcnar.ca.