Advancing inclusion and quality of life for Canada's seniors: A nursing perspective on healthy aging

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PRIORITIES	RECOMMENDATIONS
Aging well in place	#1. Support aging in place with a National Home Care Plan. #2. Support aging in place with enhanced caregiver support. #3. Promote community-based care by nurses and interprofessional health teams.
Age-friendly communities	#4. Ensure safe, affordable housing for Canadian seniors. #5. Ensure seniors have access to affordable transportation. #6. Remove communication barriers with creative use of Information Technology.
Dying well	#7. Link a pan-Canadian Palliative Care Strategy to a National Seniors' Strategy.

Considerable differences exist amongst Canadian seniors in relation to their quality of life, due to factors such as social isolation, unsuitable housing and inadequate home care support. Social determinants of health (SDH) are those conditions in which people are born, grow, live, work, age and die[1], such as housing, education, income, and social status. Social inclusion and SDH are key to healthy aging; a failure to adequately address these influences can lead to negative health consequences such as the development and worsening of chronic conditions[2-4]. For example, seniors in poverty are more likely to be exposed to inadequate housing and unhealthy nutrition, which can spiral into diseases such as diabetes or depression. When ***aging well in place*** is held as an overarching aim, countermeasures to address the SDH can reduce health inequities and excessive spending. As nurses, we know that an *upfront*, upstream approach addressing social determinants of health not only improves health outcomes but is also considerably more cost effective than paying 'downstream' for consequences.

What do nurses' voices lend to healthy aging?

Nurses are the eyes and ears of health care, practicing in a variety of settings and interacting with a large sector of seniors, observing what works and what does not. This front-line work allows nurses to obtain a pulse on Canada's health and social systems and observe first-hand challenges encountered by vulnerable seniors. Nurses regularly witness negative consequences of social isolation and SDH across care settings. Within Canada, we are a body of nearly 300,000 Registered Nurses linked with positive patient, provider and organizational outcomes[5] as we contribute to policies, programs and partnerships to support social inclusion and quality of life for seniors in Canada[6].

Why does social inclusion matter?

Social inclusion of seniors is an important indicator of healthy aging, yet research shows that an estimated 30% of Canadian seniors are at risk of becoming socially isolated[7]. Risk factors for social isolation include: being 80 years or older; chronic illnesses, rural living, Indigenous backgrounds, lack of transportation, poor mobility, living alone, limited contact with children and family; reduced income; and critical life transitions[8]. McLaughlin et al.[9] report older men, in particular, maintain less extensive networks than older women, leaving them more vulnerable to social isolation as they age.

Consequences of social isolation include decreased health outcomes and functional decline, increased hospitals admissions and even increased mortality rates[10]. Loneliness and lack of social networks contribute to increased depression amongst seniors[11]. Anticipating and responding to these risk factors will not only reduce the prevalence of social isolation, but also significantly reduce health care costs.

Personal Story contrasting Scotland and Canada – Barbara Hall, RN

I missed that first telltale sign of dementia. In 2007, during a visit to Canada from her native Scotland, my mom, Mary, an independent and active 77-year-old, could not remember my instructions on how to use the local bus. This odd occurrence heralded a trajectory I could not have anticipated. Over the next two years, this trajectory unfolded insidiously. Regular phone conversations became shorter and more repetitive, and I began to rely on my sisters to fill me in on events from home. Testing soon confirmed - Alzheimer's was robbing my mom of her memory and her ability to take care of herself. I was torn. I desperately wanted to go home to Scotland to help take care of my mom, but I had a husband and son, a job and responsibilities I couldn't abandon. Matters were further complicated by my father-in-law, John's, diagnosis of dementia here in Canada.

John had been living independently with mild vascular dementia for quite some time before his quiet existence came to a crashing halt. A master at covering his memory problems, he carried a small notebook in the top pocket of his shirt..."his brain" he joked. John lived alone in a small apartment, yet took great delight in driving over to our house every month for a family dinner and "sleepover". In 2009, John arrived at our home for Thanksgiving dinner and a sleepover as a physically robust 86-year old but, after succumbing to a mild heart attack, sadly never returned to his own home.

It was at this point where, I am sorry to say, ***our family's experiences of Canada's and Scotland's health systems diverged****. Whereas my mom in Scotland experienced comprehensive, wraparound care that allowed her to remain safely*

in her home for many years, John, here in Canada, went from being admitted to a local hospital to spending the remaining 4 years of his life in a nursing home. Whereas Scotland's health system anticipated my mom's changing needs, Canada's could not. Residential care was presented to us as the only option, and John's simple wish to remain in his own home was deemed an impossibility.

For my mom in Scotland, the transitions with her dementia were gentler on her and our family, owing to the phenomenal support of appropriate care providers along the way. Yet, as is often the case, Alzheimer's does not exist in isolation, and my mom was diagnosed with endometrial cancer. Her hospital stay included a carefully-planned discharge back home and included six weeks of publicly-funded home care up to 3 times per day. This home support assessed her care needs and her safety to remain in her home. As my mom's dementia and cancer progressed, her care became increasingly complex. We worried about the potential for wandering. Although her residence had secure entry and a warden on duty during the day, night time worried us – how could we be sure she would not leave the building and become lost? I need not have worried because technology provided a solution to this concern. Her apartment was fitted with electronic sensors in every room - every movement was detected and logged on a website. If the front door was opened at night and no motion detected for a specified period, a team would be deployed to check on her. I could log into the website from Canada and tell whether she'd slept well overnight. I cannot stress how much reassurance this gave me and my family while facing advancing cancer on top of Alzheimer's. Most importantly, it allowed us to respect her desire to remain at home for as long as possible.

It was devastating to slowly say goodbye to two parents and, for our son, bewildering to know how to relate to two people who had been such a big part of his life when they no longer recognized him. However, it was the contrast of the two health systems that we struggled to reconcile. Scotland's health system anticipated (and met) my mom's changing needs, offering her dignity, enabling her to stay in her home for a long time. In contrast, Canada's health system seemed unable to offer the necessary home and caregiving support my father-in-law needed.

What lessons can we learn from Barb's parents?

The experiences of Barbara's mother in Scotland and father-in-law in Canada are starkly different, even though both aging trajectories included dementia. A key difference lay in the organization of home care support services, including house-keeping, with direct impact on quality of life. Specifically, for John, removal from his home and surrounding community led to social isolation. Without comprehensive community-based care, aging in place was not possible.

Aging well in place includes *universal access to a national home care program*. **Age-friendly communities** are linked to *active* aging, a key component to healthy aging. As we read in Barb's story, the value of communication and information technology must not be overlooked when considering seniors and aging. Finally, seniors deserve nothing less than **dying well**, with *a holistic palliative approach to end-of-life care.* Our recommendations relate to these three components of aging well in place, age-friendly communities, and dying well.

1.0 Aging Well in Place

1.1 Introduction

Nurses are enthusiastic supporters of positive aging that has seniors maintaining a positive attitude, keeping fit and healthy, and socially engaged as they age. Seniors make a significant contribution to the richness of Canadian life and the economy. Nurses maintain that supporting positive aging is a social responsibility[6]. Most seniors prefer to live at home—autonomous, active, and independent, surrounded by family and friends—as long as possible. Aging in place is defined as remaining "in community, either in their family homes, in homes to which they have moved in mid or later life, or in supported accommodation of some type, rather than moving into residential care"[12, p.2]. Aging in place allows the older adult to stay connected to their community through family members, friends, neighbours, religious congregations, or service agencies[13].

1.2 Community-based care

According to the British Columbia Ministry of Health[14, p.18], gradual health decline with aging is not a 'given', but rather, "punctuated by medical events as a person progresses with age". The startling reality is that each of these episodic events carries risk for hospitalization[i]. For seniors, this can result in a rapid loss of functional status and/or confusion, occurring as early as the second day in hospital.

As nurses, we see first-hand the suffering, isolation and deterioration associated with hospitalization. We strongly endorse expanded community-based care with integrated, interdisciplinary teams to prevent hospitalizations. Community-based care bridges seniors back to their homes in a timely manner after hospitalization, allowing earlier discharge and continuity of care between hospital and home. By addressing the SDH through the investment in home care services, we can mitigate "expensive hospital care and intensified home care needs"[15, p. 50]. We affirm the Canadian Medical Association's[16] assertion that a seniors' strategy should include national standards for community-based care.

RECOMMENDATION #1 - Support aging in place with a comprehensive and expanded National Home Care Plan.

- ❑ A pan-Canadian approach to universally-accessible and publicly-funded home care will support aging in place.
- ❑ Expansion of Medicare to include home care requires leadership and funding at a federal government level.

[i] We endorse appropriate and judicious short-term hospitalizations to address acute / sudden symptoms of advancing chronic disease. It is estimated that 15% of Canadian hospital beds are filled with patients (85% who are seniors) who are ready to be discharged but for whom there is no appropriate place to go. This bed utilization pattern translates into crowded ERs and surgical wait lists, and is costly to the taxpayer[18].

- ❑ The inclusion of home care into Medicare communicates a key message about an overdue shift from an illness-oriented, hospital-based model to a wellness-oriented, community-based model.

1.3 Caregiver Support

Successful community-based care is heavily dependent on support from informal caregivers (unpaid family and friends). It is estimated informal caregivers provide 75 - 80% of the care seniors require at home, representing an estimated $3.5 billion in unpaid help[17]. BC Seniors' Advocate, Isabel Mackenzie, notes an increase in caregiver distress (defined as feeling distressed, angry or depressed) as supports available to unpaid caregivers are increasingly not keeping pace with the aging population[17]. We strongly agree with the conclusions of the CMA[18, p.13]: "Policy does not do enough to support people who provide unpaid care for seniors. Employment flexibility is limited and tax credits for unpaid caregivers are insufficient to cover costs; unpaid caregivers…burn out because of a lack of resources and supports".

The 2017 Federal budget extended the EI Compassionate Care Benefits and home care funding which will undoubtedly ease some of the caregiving burden. However, those who are not paying tax (Canada's poorest citizens) will not benefit from the caregiver tax credit as they would from a tax rebate. In addition, direct compensation through a means-tested caregiving allowance paid directly to caregivers providing extensive care would provide relief to caregivers and allow seniors to stay in their homes rather than in a hospital or long-term care facility[19].

RECOMMENDATION #2 - Support aging in place with enhanced caregiver support.

- ❑ The EI Compassionate Care Benefits should be amended to make the benefits a tax rebate rather than a caregiver tax credit. Additional direct compensation as a caregiving allowance paid directly to caregivers providing extensive care would provide relief to caregivers and allow seniors to stay in their homes.

1.4 Maximizing Contributions of Nurses and Interprofessional Teams.

An integrated care system allows most seniors to remain in their own homes, even those individuals who may have severe disabilities[13]. Primary care, home care, palliative care, community supports and specialist care must come together across community and hospital settings as an integrated team to provide care for seniors in their home. When hospitalization is unavoidable, similar collaboration must occur to offer seamless transitions supporting seniors to quickly return home.

Based on recent intervention research at two sites in B.C, we see the contributions that nurses can make on interprofessional teams to support aging well in place:

- ❑ **Langley Integrated Network of Care (LINC) Initiative**. One of the innovations from the initiative is the Geriatric Response Team (GRT) which provides team-based care for seniors who would most benefit from services being wrapped around them, providing longitudinal care delivered by a physician, geriatrician, nurse practitioner, registered nurse, licensed practical nurse,

occupational therapist, physiotherapist, pharmacist, social worker and spiritual health practitioner. Services include comprehensive geriatric assessments and early identification and management of the frail and elderly.

A 'Shout-Out' to Langley Geriatric Response Team and RN Naomi Agbebaku

RN Naomi Agbebaku, a GRT nurse and a Trinity Western University MSN graduate student, was recently featured in a Fraser Health "shout out" for her home visit to a senior patient experiencing gastrointestinal symptoms and confusion. She determined that the patient was experiencing symptoms from overmedicating and, together with the family physician and pharmacist, the senior's symptoms were resolved without hospitalization.

- ❑ **Nurse Debbie Initiative**. In the TriCities area of Vancouver, a multi-disciplinary wrap-around model of care with nurses (attached to GP practices) visiting seniors with complex medical needs in their homes. Goals of the Initiative include providing improved access to primary care for this vulnerable population and enabling them to live at home longer. Over a 12-month period, the salary of one RN was estimated to have avoided 37.1 hospital bed days and 1.1 emergency room visits *per patient,* with the total study resulting in 260 ED visits and over 8000 bed days avoided in a one-year time span[20]. The significant cost-savings of the Nurse Debbie Initiative are attributed to addressing the complex needs of high intensity users of the health care system.

These two studies show the immense value of health care professionals working to scope of practice as well as their integration into interprofessional teams. Scaling up interprofessional, integrated health teams will support aging well in place.

RECOMMENDATION #3 – Promote community-based care that maximizes contributions of nurses and interprofessional, integrated health teams.

- ❑ Health professionals must be encouraged to work to their full scope of practice on integrated health teams. Nurses, in particular, make tremendous contributions to these integrated health teams and are often at the point-of-care in the homes of seniors.
- ❑ A National Seniors' Strategy should ensure seniors have access to educated health care providers specifically trained in providing primary care, home care, palliative care, community support and seamless transitions from acute or convalescent care.
- ❑ Formal collaboration and shared accountability between multiple governmental ministries will be required to educate multidisciplinary care providers.

2.0 Age-friendly Communities

2.1 Introduction

Increasingly, cities and communities worldwide are making commitments to adapt their structures and services to the needs of their aging populations[1]. Including age-friendly communities in a national seniors' strategy will ensure Canada's seniors live safely, enjoy good health, and stay active for as long

as possible. Creating age-friendly communities is an upstream approach to meeting the challenges that come with aging. According to WHO[21], *active aging* is the process of optimizing opportunities for health participation in order to enhance quality of life as people age. A national seniors' plan that encourages active aging should include the promotion and development of accessible and inclusive communities.

Access to affordable housing, healthcare and technological communication advances support seniors' independence and are vital to the flourishing of age-friendly communities. Meeting the complex and evolving needs of our aging population will require concerted coordination and effort between municipalities, provinces and territories, with the federal government playing a key leadership role[22].

2.2 Affordable Housing

One's housing and neighbourhood environment plays a key role in enabling or constraining persons as they experience functional decline due to aging or chronic diseases. Designing buildings and outdoor spaces with this in mind will enable the older adult to better adjust to these changes and maintain their independence.

Lack of access to affordable housing increases the likelihood of physical and mental health problems for older Canadians, and yet we have seen a steady decline in assistance available for low-income households and the provision of affordable housing[22]. Aging well in place is contingent upon safe, affordable housing.

RECOMMENDATION #4 - Ensure safe, affordable housing for Canadian seniors.

- ❏ The creation of age-friendly community standards and environments will support Canada's aging population and prevent the onset or worsening of disabilities.
- ❏ Educating seniors regarding fall prevention supports continuing independence.
- ❏ Home renovation subsidies, property tax deferral and grants home repairs support seniors in safely remaining in their homes. To facilitate this, all levels of government must work collaboratively alongside local non-profit organizations.

2.3 Accessible Transportation

Seniors must be allowed to travel safely and affordably wherever they want within their community[23]. Three-quarters of Canadians 65 years or older have a driver's license[24]. Seniors without a driver's license or access to adequate public transportation are at an increased risk for social isolation; there is a clear link between social participation and one's access to transportation, both of which can impact one's overall health outcome[23]. Restricted transportation mobility is an increasing concern as it pertains to the quality of life of seniors[25], inhibits active aging, and increases likelihood of social isolation.

RECOMMENDATION #5 - Ensure seniors have access to affordable transportation.

- ❏ Low-cost transportation options such as volunteer driver pools support seniors to attend recreational activities and appointments, enabling seniors to maintain their independence and mobility.
- ❏ Priority transit seating, discounted transit fares, or taxis with appropriately trained personnel support seniors in their need for accessible transportation.
- ❏ The accessibility of information regarding scheduling and booking public transportation must be enhanced by user-friendly information technology to prevent seniors waiting in inclement weather.

2.4 Information Technology and Communication.

One of the largest obstacles seniors face is accessing existing resources to maintain or advance their quality of life. The Internet represents a valuable avenue for accessing content and services that enhance seniors' social participation. Despite being the smallest group of Internet consumers, seniors comprise the fastest-growing group of users[26]. Utilization of information technology (IT) has enormous potential to overcome access barriers seniors face. Overcoming these hurdles will link Canadian seniors with affordable housing, transportation, health, financial and legal information.

RECOMMENDATION #6 - Remove communication barriers with creative use of Information Technology.

- ❏ User-friendly IT applications and training allow seniors easier access to up-to-date information such as volunteer-service pools, affordable housing inventories and public transit information.
- ❏ Internet training for seniors improves familiarity and ease-of-use with everyday technology and protects vulnerable seniors from Internet scams, hackers and fraudulent activity.
- ❏ Offering subsidized computers for seniors through libraries may reduce communication barriers.
- ❏ Online or telephone support services can augment support services such as mental health services.

3.0 Dying Well: End-of-Life Care

3.1 A Pan-Canadian Palliative Care Strategy

The topic of end-of-life is on the minds of Canadian seniors, who, despite living longer, are not immune to the natural effects of aging. This, combined with an increasing prevalence of chronic disease, necessitates the need for access to high quality palliative care services to facilitate "dying well". Canadian seniors aging with illness and increasing frailty are in a state of both living and dying, and this dying must be acknowledged as part of living. The average age of death in Canada is 74 years, and the number of Canadians dying each year is expected to increase to 65% by 2036[27].

How a country cares for its most vulnerable reflects its national values and priorities[27]. The majority of Canadians would prefer to die at home; at present, however, nearly ¾ die in hospitals, institutions designed for treatment and recovery[27]. Currently, end-of-life care consumes a disproportionate amount of healthcare resources, involving procedures that do not prolong life or benefit the individual but rather

increase suffering. It is estimated that 90% of Canadians will require care and support at the end of life, but only 16-30% of Canadians are estimated to have access to high-quality palliative care services[27]. When seniors do not have access to high-quality palliative care, they are left vulnerable and may be more prone to feeling burdensome to family or the health care system.

RECOMMENDATION #7 - Link a pan-Canadian Palliative Care Strategy to Canada's National Seniors' Strategy

- ❏ Linking a National Seniors' Strategy with a pan-Canadian Palliative Care Strategy will provide leadership to ensure that a shared-care model is coordinated, comprehensive and effectively administered across governmental sectors (e.g., Health, Public Health, Human Resources, Aboriginal Affairs, International Development, Transportation).
- ❏ A pan-Canadian Palliative Care strategy promotes the integration between primary, secondary and tertiary care, and provides common standards and tools to establish expectations.

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