# Raising the Profile Project


Building links between Community-Based Seniors' Services and the Health System

# *The MOH Funding for this Project*

*How can the Community-based Seniors' Services Sector be integrated with the MOH's strategic plan for seniors' care?*

# March 2017 Action Plan from the MOH

*While it is not the governments role to provide for all quality of life considerations, there are many existing community supports that can and should be engaged to support the care of seniors from a holistic perspective along with health care services…This requires us to rethink some of our healthcare practices in the healthcare system concentrated on interventions and cures.*

# Challenges to Collaboration from the Health System Perspective

- Lack of awareness of the range of programs offered by Community-Based Seniors' Services (CBSS) sector and the increased focus on health prevention and promotion.
- CBSS can also be difficult to navigate in larger centres, and many services not available in smaller and even larger communities.
- These services are not part of the "core" mandate of health system and when the gov't expectation is to reduce costs these are often the first services to go.
- Uncertainty about the quality of the programming provided by the CBSS and their limited capacity to evaluate results.

# Challenges to Collaboration from the CBSS Perspective

- Community-based seniors' services, particularly non-profits, increasingly see people with higher needs and are keen to develop innovative programs in response to changing needs…but lack of long term stable funding makes this challenging.
- Committed to working more closely with the health system…but have difficulties in establishing stable relationships, essential to building effective partnerships.
- CBSS are often expected to rely on volunteers to provide services in situations where there is not enough paid staff to support the volunteers and/or where the use of volunteers is not possible.

# Why address these challenges? And why now?

- Rapid growth in the aging population and the evidence that healthcare costs and utilization can be better controlled with more attention on health promotion and prevention (i.e. upstream intervention to reduce downstream utilization)
- The tie to the "core" mandate of the health system is that these upstream interventions improve health outcomes for **older adults living with chronic conditions** and those at **risk of frailty.**

# Looking at the Research Evidence

- *Longitudinal Study of Aging* in Beijing evaluated the impact of health deficits (e.g., diseases, cognitive function, etc.) and protective factors (e.g., marital status, socioeconomic status, social and recreational activities, etc.) on health status and mortality in Chinese seniors. The authors found that for seniors at risk of frailty, possessing more protective factors was associated with lower risk of decline in health and mortality of from 13 to 25 percent. (Wang et al. 2014)

- The relationship between health and income inequality is well established including in areas such as: diabetes, heart attacks, falls and self-reported mental health (CIHI, 2015)

# Long Standing Partnership Between the City of Kamloops and Interior Health

- Began in 2008 and focused primary prevention for people at risk or with a chronic condition.
- Located at the municipal recreation centre, it is 10 - 12 week program: includes exercise, mental health support and nutritional counselling.
- Funding for staff from Interior Health(IH): facility space provided by the City.
- Physician referral needed to participate: clinical services provided by IH multi-disciplinary team and exercise program provided by City.
- Subsidy available to reduce costs to participants and many opportunities for people to stay connected after the program ends.
- Evidence of improvement in mental health and reports of reductions in emergency room visits.

# A Newer Partnership in a Smaller Community

Port Alberni and surrounding area:

- *Echo Sunshine Club* is a seniors' club supported by Parks and Rec. staff offering twice weekly exercise classes for seniors with mobility problems.
- Integrated Community Services (an Island Health Outreach Program) provides seniors with free passes to these exercise classes.
- *Better at Home* provides transportation to seniors who need it to access the exercise program.

Goal of Partnership: To support low-income and rural seniors with chronic health and mobility challenges to access programming.

# A Structured Wellness Model

TAPS (Therapeutic Activation Program for Seniors), Creston

- TAPS is a wellness program utilizing a model similar to an adult day program. It fills a gap in the health care continuum, serving seniors who are isolated and unable to independently access community programs, but who don't qualify for health authority adult day programming.

- Participants are interviewed prior to starting the program, provided with transportation, and usually attend 2 or 3 days a week. The typical day includes a nutritious lunch, a physical activity and an educational/recreation activity.

- Interior Health provided funding a number of these programs up until about 2005 when they were phased out. The Creston program is the only one to survive.

***"Suddenly I have a life… I now know people…The exercises helped a great deal. I do activities I don't do at home, and I get hugs which is very important when you're alone."*** participant

# An Emerging Model… but no Sustainable Funding

A number of newer programs for people with higher needs, who do not qualify for home and community care (HCC), but who require more structured programming.

- Mt. Waddington: combined community and HCC adult day program initiated by the Division of Family Practice…on-going funding not secured
- Parkgate Community Services: adult day care program for seniors with early dementia…referrals from case managers, long wait list
- Campbell River: volunteer run senior centre for higher needs seniors, supported by the city and with chair exercise provided by Parks and Recreation
- Richmond: 2 programs that don't have funding to continue: *Wellness Connection Program* funded by VCH from 2008 to 2014 at Minoru and *Music Work Program* where funding was provided to the West Richmond Community Centre for one year through New Horizons.

West Vancouver Activity Centre, *Keeping Connected Program* is the exception. It supports over 500 seniors, who are struggling with some kind of a loss who can't access programming on their own, with more than 15 different weekly programs, including telephone reminders, one to one support, various kinds of exercise options, transportation

# A Fraser Health Authority Initiative

CARES, *Community Action and Resources Empowering Seniors*

- Family physician identifies patients who are at risk of frailty. A health care provider completes a Comprehensive Geriatric Assessment that generates a Frailty Index (FI).
- A wellness plan is developed that focuses on the goals the senior identifies as most important to their health and quality of life.
- A volunteer wellness coach from *Self-Management British Columbia* paired with the senior to help them achieve their goals by tracking their progress, providing encouragement and motivation, and connecting them with community resources.

# Why Spread CARES?

*Results reported are based on 39 CARES participants who completed the Comprehensive Geriatric Assessment at both the baseline and 6-month follow-up periods.*

BASELINE  6 MONTH FOLLOW UP

**30% increase**
Walking independently
27 › 35

**67% increase**
Exercising frequently
15 › 25

**29% increase**
Balance within normal limits
21 › 27

**19% increase**
No supports needed
32 › 38

**59% increase**
Health attitude
17 › 27

**11% increase**
Socially engaged
28 › 31

There was a statistically significant **decrease in the frailty index (FI) score** in seniors participating in CARES.

**0.032**
decrease from baseline to 6 month follow up

EQUIVALENT TO 2 LESS HEALTH PROBLEMS AT FOLLOW UP

# Examples of Successful Integration

A small regional health system in Germany invested in heavily in health promotion and prevention for people living with chronic health conditions, including funding to support seniors to access physical activity programming and connect to community-based services. Over five years, the region realized significant health improvements and cost savings.

Restorative care is a multi-disciplinary model for delivering home health services which includes educational and rehabilitation resources to support seniors to better manage their health challenges, improve their functional capacity and re-engage with community. Resulted in increased independence for seniors, reduced use of health services and lower costs overall costs.

# What Would a More Connected Wellness-Oriented Future for Seniors Look Like?

- Access to services in the seven core areas in every community: (1) Nutritional Supports, (2) Wellness Programs, (3) Physical Activities, (4) Recreation, Education and Arts Programming; (5) Information and Referral; (6) Transportation and (7) Affordable Housing.
- Primary Care and Home and Community Care Staff would know about these services and “prescribe” them as appropriate.
- There would one person from health authority in each community whose primary responsibility would be the bridge between the health system with the CBSS sector.
- CBSS sector would be recognized as a sector provincially. There would have resources to support capacity building of programs and services that have a proven track record, are cost effective and result in health improvements.