Healthy Aging In Rural Ontario
EXPLORATION, DISCUSSION, INSIGHT

FORUM PROCEEDINGS

October 29, 2013
Stratford, Ontario

ROI RURAL FORUM Gateway Rural Health Research Institute Ontario

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I. ORGANIZATIONS REPRESENTED

For contributing to the success of this Rural Forum, thank you to Gwen Devereaux, and Sheila Schuehlein from Gateway Rural Health Research Institute; Dr. James Mahone and facilitators Kelsey Lang, Faiza Omar, Nora Ackermann and Sierra Harris from the University of Guelph

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Ontario

1.0 ABOUT THE ORGANIZERS

The **Rural Ontario Institute** was established in 2010 through the merger of The Ontario Rural Council and The Centre for Rural Leadership. Reflecting the expertise and legacy of these founding organizations, ROI's mandate is to develop leaders, initiate dialogue, support collaboration and promote action on issues and opportunities facing rural Ontario. To this end, ROI works to amplify the voices of stakeholders in rural and remote communities in the province.

Gateway Rural Health Research Institute is Canada's first community-driven centre for rural health research. Health disparities between rural and urban communities are expressed in higher rates of heart disease, stroke, high blood pressure, diabetes and obesity among rural residents. Combined with the issues surrounding a chronic shortage of rural health professionals and an insufficient capacity of rural health research and teaching, these factors speak to the need for an institute focused on community-based rural health research and education. By partnering with Canada's leading academic institutions, community health centres and community organizations, Gateway helps to improve the health status and quality of life of rural Canadians.

2.0 FORUM THEME

Ontario's rural population is already older than the provincial average. As the number of rural seniors continues to grow, are we ready to support them with effective healthcare services as they age? Supporting healthy aging among seniors living in rural areas of Ontario was the discussion theme during a full-day Rural Forum held in Stratford on October 29, 2013.

75 people from across southwestern Ontario participated in the day. Those in attendance represented health care practitioners, administrators and health promoters in public and non-profit sectors, as well as for-profit retirement facility developers. For a complete list of organizations represented, see APPENDIX I.

This report summarizes "what we heard" during the rural forum. It contains a brief summary of speaker presentations as well as the verbatim facilitated table group discussion notes. It is intended to reflect and capture stakeholder perspectives and inform federal, provincial and municipal decision makers on the issues surrounding healthy aging in rural Ontario.

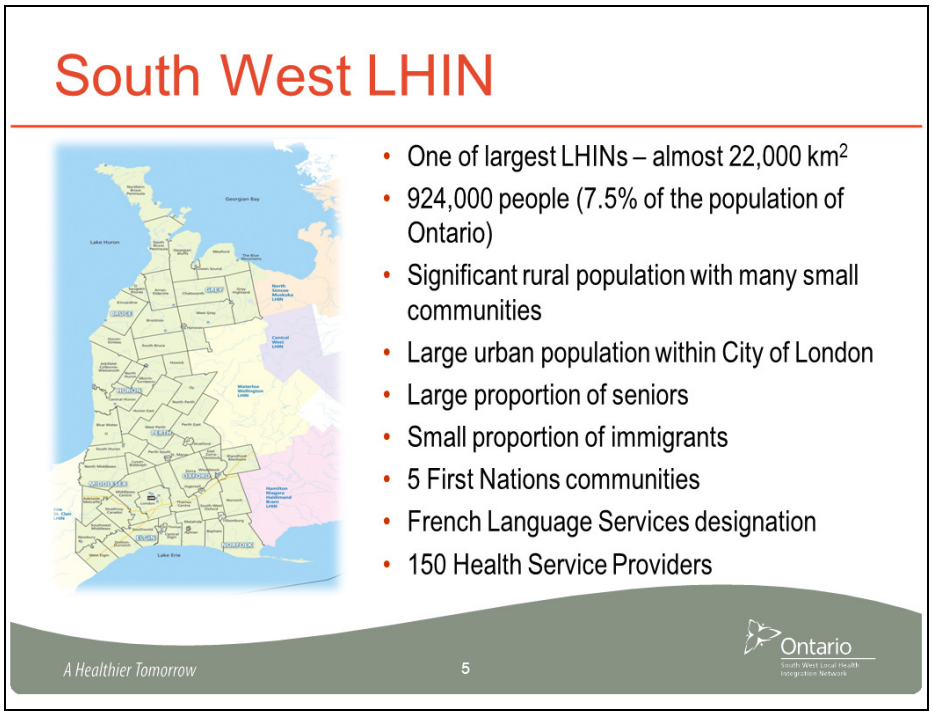
Mayor Dan Mathieson of the City of Stratford welcomed participants. His opening remarks highlighted several health and aging concerns shared by Stratford citizens including access to care and transportation challenges. He observed that these concerns must be more acute in communities that are smaller and more rural than Stratford.

3.0 KEY MESSAGES EMERGING FROM PRESENTATIONS

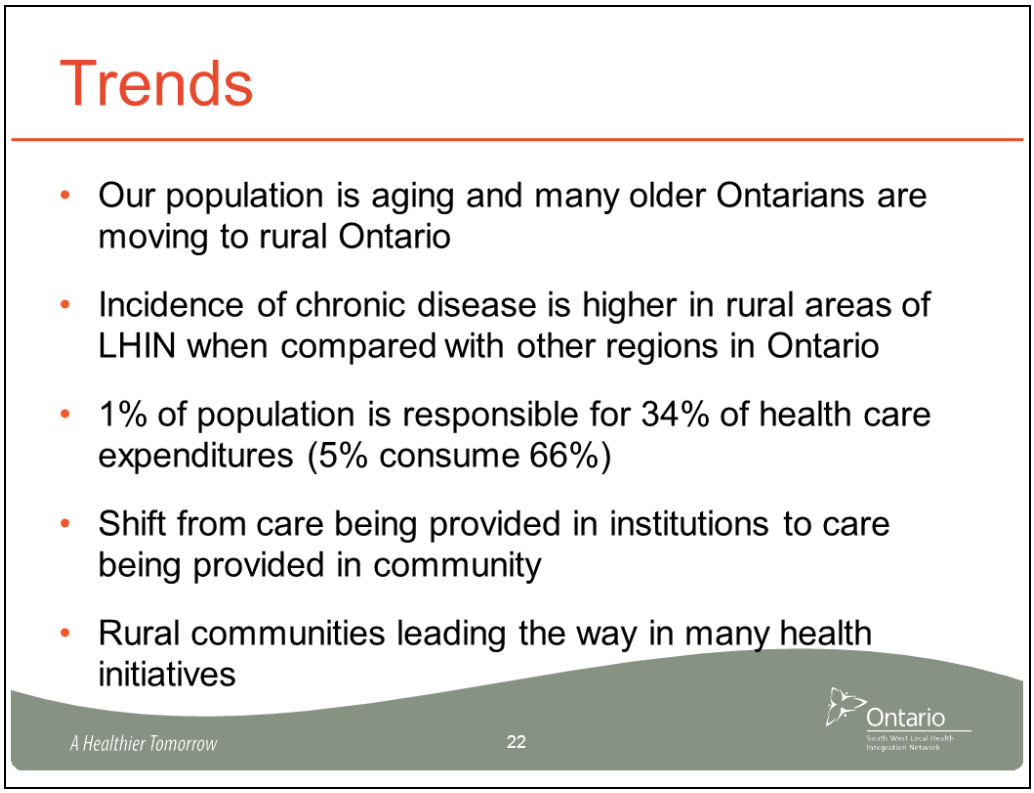
3.1 Michael Barrett

CEO, South West Local Health Integrated Network

Presenting: *Healthy Aging in Rural Seniors*



The job of the LHINs, in collaboration with health service partners, is to transform the health system to better meet the needs of people in their regions. According to Statistics Canada almost 16% of the population residing within the South West LHIN is 65 and older, up from 14.6% in 2006. It is projected that by 2021, seniors will make up 20.5% of the South West LHIN's population. In addition to this, 30% of the LHIN's population lives in rural areas.



The South West LHIN has several initiatives and projects underway that are supporting the healthy aging of seniors.

Key Initiatives Improving Health of Rural Seniors

Sector / Program Area	Initiatives / Projects
Community Support Services	Exercise & Falls Prevention Transportation Accessibility Adult Day Programs
Primary Care	Health Links Primary Care Network & Leads
Acute	Emergency Departments (EDs) ED/MH Health Access & Flow Small and Rural Hospital Transformation Critical Care Community Stroke Rehabilitation
eHealth / Technology	ClincalConnect, SPIRE, eShift, eReferral
Cross Sector	Behavioural Supports Ontario

"It is imperative to discuss health and aging issues for rural seniors because it takes planning and partnerships to ensure the right health care services are in place to meet the needs now and in the future."

Michael Barrett
CEO, South West Local Health Integrated Network

3.2 Ryan Erb

Executive Director, United Way Perth Huron

Presenting: *Research on seniors, transportation, mental health and elder abuse collected by the local Social Research & Planning Council.*

Through the Social Research & Planning Council, the United Way Perth Huron looks at social planning and research in communities. They are focused on a 'community impact' model, which means shifting to the prevention of need for services.

With regards to elder abuse, the 2009 report called "Breaking the Silence" made three recommendations:

1. Create an awareness campaign on elder abuse
2. Consider establishing an elder abuse team
3. Convene stakeholders to discuss an action plan

United Way Perth Huron convened a Transportation Task Force. They surveyed the two counties and found there is a strong need for increased public translation for both regional and daily travel. To enable healthy lifestyle choices, transportation remains a significant issue in rural communities. Grocery shopping, going to recreation opportunities, important personal trips and medical trip to live well all translate into healthy aging. A summary of the 2013 Transportation Needs Survey can be found here: http://perthhuron.unitedway.ca/wp-content/uploads/2014/03/Executive-Summary-General-Transportation-Needs-Survey.pdf

If a family has a vehicle, it is frequently used to transport the primary income earner to work. The Easy Ride program administered under ONE CARE is a good program but the cost can still be prohibitive to some.

3.3 Sandra Hobson

Associate Professor, School of Occupational Therapy, Western University

Presenting: *Maintaining Daily Occupations Among Older Rural Ontarians*

"Occupation matters as it serves as a source of personal identity, it gives meaning to life, enables independent living and contributes to health and well being."

Sandra Hobson
Associate Professor, School of Occupational Therapy, Western University

Older adults may face challenges to maintain meaningful 'occupations' like physical, sensory, cognitive or financial capabilities. However, older adults living in rural areas also face transportation challenges and can have trouble accessing services.

Managing the risks of falling by taking reasonable precautions is important to maintaining occupation. This includes mitigating the fear of falling, which can be equally disabling and can even lead to falls due to inactivity.

Older adults want/need to remain in personally valued occupations, despite challenges related to age and/or location. Falls, fear of falling, and dementia can present additional challenges. They are encouraged to "Do what you can to remain engaged and utilize whatever resources are available to you."

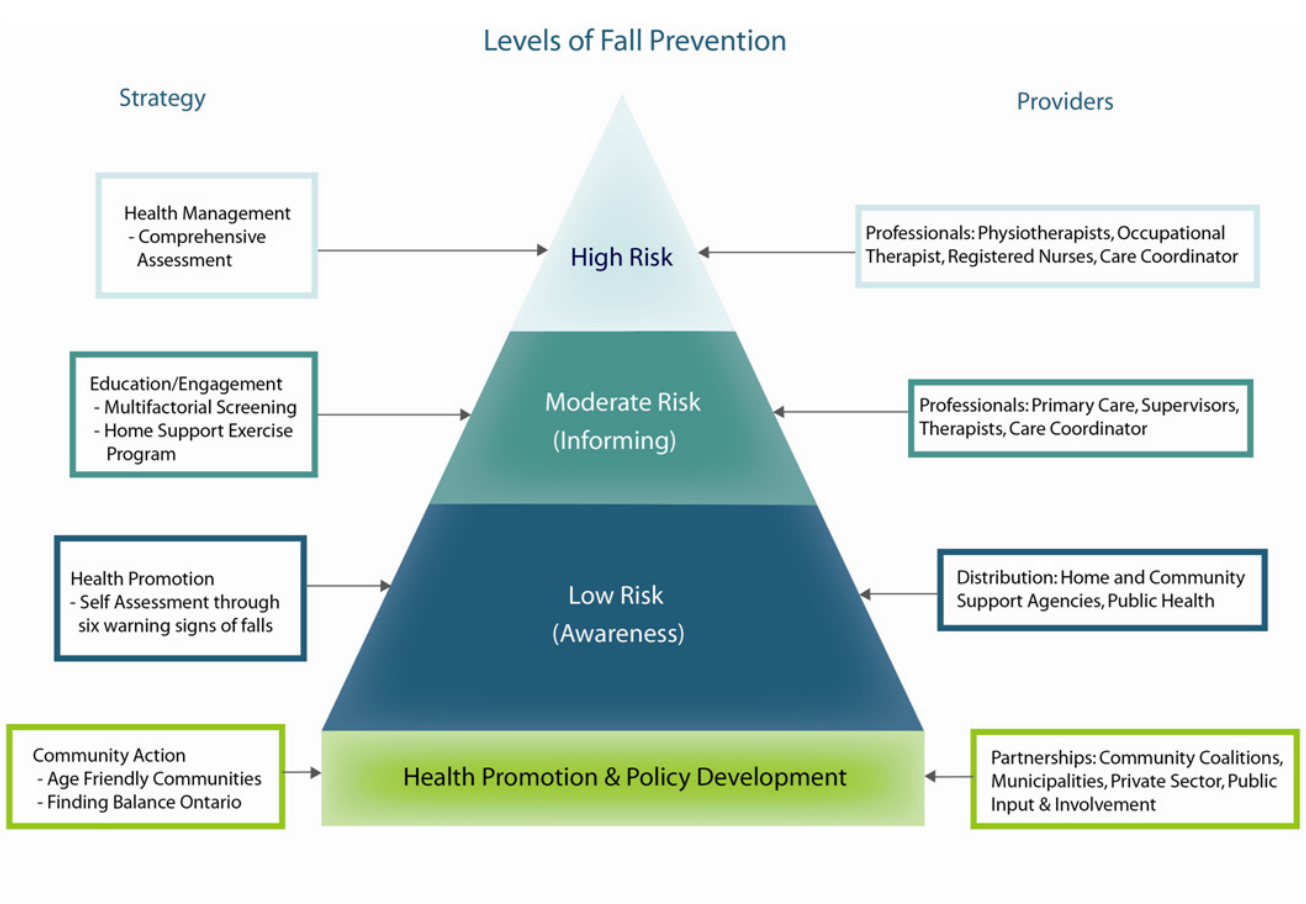
3.4 Lynda Bumstead

Public Health Manager, Grey Bruce Public Health

Presenting: *Grey Bruce Falls Prevention and Intervention Program*

The goal of the program is to address the needs of older adults, who are at various risk levels of falling, through an integrated system of services in Grey Bruce based on a continuum of evidence-based initiatives.

To foster healthy, safe living at home, the program aims to:
1) Develop timely intervention to prevent falls, reduce falls and complications due to falls
2) Optimize partnerships to integrate health service delivery
3) Focus on total health (prevention, screening, identification, assessment, treatment, management, follow up and necessary support)



Since its launch in 2009, the program has demonstrated progress towards its goal. Approximately 255 older adults have completed a comprehensive assessment, of which, 47% reported fewer falls during the previous 90 days. Over 260 participants have been involved in Age Friendly Forums and 222 clients have been referred to the Home Support Exercise Program. The Finding Balance website was launched in March, 2012 and provides tools and resources for both older adults and their care givers.

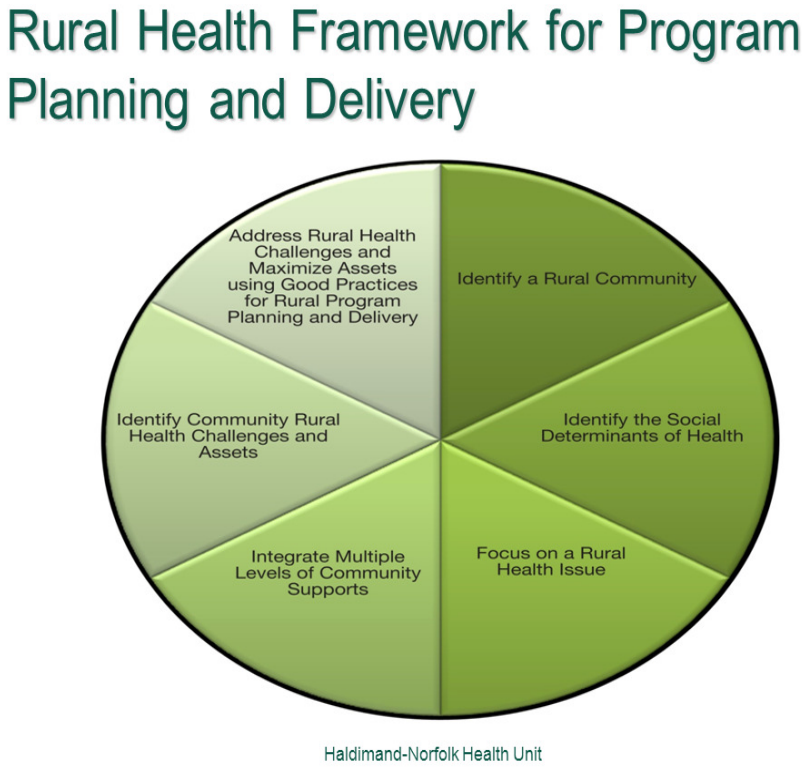
Ongoing challenges remain in administering the program. For example, data collection processes can be complex and require rigorous effort; there are few transportation options between municipalities; and there are limited resources to promote the program and its services.

3.5 Deanna White

PhD candidate, University of Waterloo

Presenting: *A Rural Framework: The Implications For Program Service Planning And Delivery*

This Rural Health Framework provides an evidence-based method to embed a rural health lens in planning and decision making. This is needed to ensure that rural programs and services address unique challenges of living, working and playing in rural Ontario.



Key Element 1: Identify a rural community

- There are many definitions of rural; select the defining criteria that is most important for a program (e.g. whether it be population density or geographic isolation, commute time, etc.)

Key Element 2: Review the Social Determinants of Health

- Review the social determinants of health and select the predominant determinants in this chosen area to guide program decisions (i.e. social environments, income and social status, education and literacy, employment/working conditions, physical environment, lifestyle behaviours, culture, biology and genetic endowment, social support networks and gender)

Key Element 3: Focus on rural health issue

- Determine what the rural health issues are in the community
- Conduct population health assessments - what are the priority populations?
- Conduct surveillance – what are their priority issues?
- Research and evaluate - Are the issues stable or getting worse?

Key Element 4: Integrate multiple levels of community supports

- Use multiple levels of support from different sectors (e.g. community organizations, government as well as health care). Seek out shared interests and values to make successful collaboration more likely

Key Element 5: Identify community rural health challenges and assets

- Use social determinants of health to conduct this analysis
- Challenges can be identified by understanding personal experiences of the target population
- Assets are the advantages present within, and attributes of, a community (strong sense of community, lots of volunteers, abundance of green spaces, etc.)

Key Element 6: Address Rural Health Challenges and Maximize Assets using good practices

- Identify the best practices that can be replicated in the future, e.g. does the program developed use appropriate language (i.e. simple and culturally appropriate), does the timing reflect community realities (e.g. crop harvest), have community assets been maximized (e.g. natural or built assets)?

Successfully applying this framework takes time. Whereas a *Desktop Assessment* of existing data sources can be completed in a few days, a *Comprehensive Assessment* involving extensive research and community/sector consultation can take months.

3.6 Shelley McPhee-Haist

Manager, Communications and Fundraising
ONECARE Home and Community Support Services

Presenting: *ONE CARE programs supporting healthy aging in the region.*

ONE CARE Home and Community Support Services was formed in 2011 when three community-based, charitable non-profits came together to meet the demands of the evolving Health Care Environment (Stratford Meals on Wheels and Neighbourly Services, Town and Country Support Services and Midwestern Adult Day Services).

ONE CARE was created in response to the understanding that Community Support Services need to play a different role in supporting the health care system, including building capacity and integrating services to respond to client needs.

onecare
Home & Community Support Services

onecaresupport.ca

ONE CARE Mission

ONE CARE Home and Community Support Services provides home and community services to support and strengthen the health, independence and quality of life for individuals and their families in the community.

We help older people and people with health challenges live at home within a network of caring support and in a caring community.

ONE CARE serves over 5,000 clients in Huron, Perth and surrounding areas. The majority of people served are over 65 years of age. Most have issues of declining health – including chronic illness and/or cognitive impairment. Most live in their own homes and communities with the support of ONE CARE's services.

Research indicates that people want to remain at home for as long as possible, and if given a choice would prefer early discharge from hospital followed by provision of home care. There is also evidence that people do better at home.

ONE CARE has 313 staff including Personal Support Workers (PSWs), home help workers, program assistants, drivers and kitchen help. As well, there are client supervisors, staff who schedule services, staff who coordinate programs and business/administrative services staff. Last year, over 1,000 volunteers contributed more than 59,000 hours of care.

ONE CARE's transportation services are provided through the EasyRide program, which is offered to seniors, including frail elderly and persons with disabilities in Huron and Perth Counties. EasyRide provides transportation for medical appointments, treatments and hospital discharge (in and out-of-town), adult day programs, grocery shopping, errands and social activities. Service is based on individual needs and provided both to clients who can transfer independently and those with mobility limitations.

ONE CARE has 150 screened, trained volunteer drivers who use their own vehicles. In addition there are 14 agency operated wheelchair accessible vehicles, three passenger vans and coordinated taxi service. Fees for service apply and financial subsidy may be available.

Last year ONE CARE assisted 1,896 clients with 62,000 rides. The rides delivered included: dialysis (5%), other medical (30%), shopping/errands (25%), day centre programs (10%), social (30%).

ONE CARE is funded by the Ministry of Health through the SW LHIN and through the CCAC contract:

- 38% of program revenues come from the CCAC contract,
- 42% of revenues are from the SW LHIN for the Community Support Programs.
- The remaining 20% of revenues from client fees and other fundraising activities, including special events and grants

3.7 Dr. Andrew Kirk

Professor and Head of Neurology, University of Saskatchewan, and Neurologist with the Rural and Remote Memory Clinic

Presenting: *Caring for Rural Seniors with Dementia*

Dementia does not refer to a specific disease. It is a general term for a range of symptoms that point to a decline in mental abilities severe enough to interfere with daily life. The Canadian Alzheimer's Society refers to the increasing incidence of dementia and the impact it will have on Canadian society as the 'rising tide'.

Dementia is often incorrectly referred to as "senility", which reflects a formerly widespread but incorrect belief that serious mental decline is inevitable and a normal part of aging. No form of dementia should be considered as a natural part of the aging process.

Symptoms of mild cognitive impairment (MCI) and dementia can be challenging to recognize early on for families, and is often is attributed to normal aging. Some people feel that a diagnosis of dementia carries a stigma and because of this, early diagnosis and intervention is often delayed. Families too often seek help when they have reached a crisis point.

The Rural and Remote Memory Clinic, which receives funding from the Saskatchewan Ministry of Health, provides clinical services such as diagnosis of MCI and dementia among rural and remote residents of Saskatchewan. The objectives of the memory clinic study are to increase the availability and accessibility of dementia care in rural and remote areas, to determine the acceptability of the one-stop clinic and of Telehealth versus regular follow-up, and to develop culturally appropriate assessment protocols for assessment of dementia in aboriginal older adults. The focus is on diagnosis and management of atypical and complex cases of suspected dementia, where an interdisciplinary team assessment is most needed.

Designed to minimize travel time for rural residents, integrated, one-day clinics allow patients to receive a CT scan and assessment by a neurologist, neuropsychology team,

physical therapist and dietician. The clinic follows a family-centred approach where family members are invited to participate. Following the interdisciplinary rounds at the end of the day, patients and family members are provided with information about the probable diagnosis, feedback based on the assessments, and recommendations care.

4.0 ROUND TABLE DISCUSSIONS

Forum participants engaged in facilitated small group discussions to share their thoughts and observations on the issues surrounding healthy aging in rural communities. The following notes are provided verbatim from each small group.

GROUP #1
Issues identified by the group for discussion:

- Personal costs for services
- Public interest/education (ie. falls prevention)
- Measuring success – funding, effectiveness
- Long-term sustainability of support systems
- System navigation
- Communicating and awareness of services - marketing

Issue chosen to be discussed: System Navigation
Factors contributing to this issue:

• Differing levels of literacy regarding information technology among users • Relationships with caregivers • Program continuity (name changes) • Cultural factors/shift, ie. acceptance of aging • Communication considerations • Tangibility • Too many “players” in the game • Challenges for caregivers – lack of support • Eligibility criteria	• Confusion over costs • Energy needed to navigate the system • Reliance on volunteers • Reliance on non-formal structure • Separation of care options (silos) • Crisis management, which links to prevention • Holistic approach – integration of services • Lack of local connection • Time to build relationships • Sheer amount of info

Actions that could improve the situation / remove barriers

• Improving partnerships and knowledge streams • Early intervention/ prevention • Continuing to see home/ community care as a part of health care • Invest in home care • Evaluate current system navigation process (approach evaluation from a client perspective) • Simplify and be more consistent with names, criteria, etc • Awareness of process • Specific role to help navigate • Telehealth system for community support	• More baskets, less silos • Client centred decision making • Centralization of physical offices • More partnerships on projects • Ensure quality and consistency of projects • Solution: setup a task force comprised of ROI, Gateway, pharmacists, frontline health practitioners • Assess existing effort (eg. 211, Telehealth), find out who is not being served • Pay attention to local organizations. For example, if your curtains aren't open by 9 am and closed by 9pm, we'll come and check on you

GROUP #2
Issues identified by the group for discussion:

• How do we reduce duplication of services, increasing efficiency? • System navigation: we should move to a system of one phone number, one organization access of the system by clients? • We need to increase awareness of services in rural areas; current promotion programs reach the same people who come out to public education programs; how do we reach those in real need? Be proactive with newspaper/radio, door-to-door vs waiting until a crisis • Sustaining and resourcing (Human & Financial) innovations in care • Limited services, access issues = transportation challenges	• Lack of focused resources on health promotion vs treatment • How to make healthy aging interesting, appealing? • How to reach isolated seniors • Improved awareness of community resources • Falls risk assessments • Appropriate referrals • Isolated seniors – kids moving away • Costs to delivery; two tier system 1) those that can afford it, 2) those that can't • Growing population • Changes to eligibility programs, funding • Assessment – seniors falling through the crack

Opportunities

- Prevention – education on nutrition, lifestyle, alternative choices
- Using the resources available more efficiently, to be more proactive with awareness and education
- Volunteers – assets
- Partner and align priorities with others (community, organizational)
- Intergenerational communities, social connectedness are assets in rural communities

GROUP #3

Issues identified by the group for discussion:

- Difficult to engage families/communities with education and knowledge
- Denial/ stigma
- Lack of services/ trained people/ support
- Disclose income
- Economic pressure/ bad quality of services

Contributing factors, challenges and opportunities:

• Transportation • Staff shortage • Getting people involved • People accepting offers/services • Raise awareness • Services lacking quality • Continued partnerships • Promoting people to stay at home • More examples of healthy aging • Promoting services/resources • Connect/coordinate agencies and service providers • Better coordination of volunteers • Raise awareness and spread information • Economic status • Education • Service availability	• Coordination / linkage • Pride/privacy/anonymity • Denial/ ignorance • Culture • Personal choices • Advertising • Lifestyle • Food industry • Individual is responsible for health care • Wrong priorities (spend as little money on food as possible) • Politics • Involvement of key players (eg. doctors) • Passionate people • Patient motivation, ie. one side effect then they never take the pills again

Actions that could improve the situation/ remove barriers

- Targeting the most vulnerable – using a social determinant of health model
- Integration of health team and care providers
- Patient health literacy
- Health literacy assessment
- Connecting rural and urban health professionals
- Before thinking of having health care database, we need to develop how each clinic can keep up their own charts
- First Nations, things that will work for other cultures or are culturally sensitive
- Have classes that teach patient how to improve their scores

GROUP #4

Issues identified by the group for discussion:

- Rural residents have lower educational attainment so patient health literacy is lower, e.g. there is poor compliance with medical directives and pharmacist prescriptions
- Access for most vulnerable or isolated clients – how do we reach them?
- Poor communication between rural physicians and urban specialists
- No single patient record that providers can share
- Lack of patient awareness about the expanded role of pharmacists
- Rural transportation problems

Issue chosen to be discussed: Patient Health Literacy

Possible solutions:

- Physicians and primary care teams need to implement a health literacy screening tool for rural residents – there are some already available
- Patients scoring low on literacy screening, should be offered more one-on-one support and education time by the team
- Develop strategies to support patient empowerment/motivation so that patients take more control of their health record and their 'health care journey'
- Primary care team should direct patients to specific internet websites to ensure they are finding reliable information about their condition
- Health education and health literacy needs to be part of school curriculum

GROUP #5
Issues identified by the group for discussion:

• Public health systems does not reflect older adults • Creating awareness of retirement to plan better • Knowledge transfer • Unemployment • Community support • Family live away from home • How to find out service available in different areas • Key challenge – Effective Navigation for older rural adults • Some organizations, ie public health do not address adult issues	• Budget Constraints • Family Health Teams (marginalizing patients) • Knowledge creation prior to being admitted to hospitals • System fragmentation, complexity, inconsistency • Competing mandates • Little collaboration • Language literacy and cultural diversity • Stigma • Mechanisms

Actions that could improve the situation/ remove barriers

- Assess existing efforts (ie. Telehealth, CCAC, 211) – what is working, what can be improved
- Paying attention in our local communities (eg. volunteer programs)
- Task force / collaborators: Gateway, ROI, Universities, Public Health, passionate individuals
- Ontario municipal social services
- Pharmacists as front line educators
- General practitioners / physicians
- Healthy literacy assessments to know whether to scale down the language, so we know if patients are being understood

APPENDIX I - ORGANIZATIONS REPRESENTED

Gateway Rural Health Research Institute
University of Guelph
Huron County Health Unit
Stratford Family Health Team
South West Local Integrated Health Unit
Alzheimers Society of St. Thomas
Grey/Bruce Health Unit
Elgin County Health Unit
Future Health Services
Beattie Haven Retirement Community
Alzheimers Society of Perth County
St. Joseph's Health Care London Parkwood Hospital
United Way Perth Huron
University of Western Ontario
University of Waterloo
Red Cross
Perth District Health Unit
Hemophilia Society of Ontario
Community Care Access Centre
ONE CARE
Southwest Ontario Aborigional Health Access Centre
Grand Bend Community Health Clinic
Alzheimer Society of London
Victorian Order of Nurses - Middlesex, Elgin, St. Thomas
Zehrs Pharmacy
Ministry of Rural Affairs
North Huron Council
City of Stratford
Western University
Rural Ontario Institute