OPINION

Moving beyond bricks and mortar in long-term care

by K. Jennifer Ingram, MD, FRCPC

The pandemic is shining an uncomfortable spotlight on how Canada cares for its seniors. Ontario's long-term care residents account for more than half of the province's COVID-19 related deaths—a grim statistic that underscores the urgent need for a new approach. The time has come to move away from bricks and mortar solutions for the complex health-care needs of our seniors. When medical conditions create frailty and disability, it should be possible for individuals to manage at home or in the community with family members involved.

In a more effective modern model, government supports would be less focused on building additional long-term care facilities and more focused on the care itself—bringing together the skills and services required to assist seniors who have complex care needs, wherever they may live.

For the past decade, my colleagues and I at the Kawartha Centre in Central East Ontario have been involved in the development and implementation of an innovative health-care delivery model for complex seniors in the community, with considerable success.

The model known as GAIN, Geriatric Assessment and Intervention Network, is comprised of 12 hospital and community-based interprofessional teams in the communities of East Scarborough, Durham, Haliburton, Peterborough, Kawartha Lakes and Northumberland counties—a geographic area that is home to about 12 per cent of Ontario seniors.

GAIN teams are staffed by skilled geriatric assessors including nurse practitioners, geriatricians, pharmacists, physiotherapists, occupational therapists, social workers, community-care coordinators, behavioral support clinicians and personal support workers. In some areas, emergency medical services, dieticians, and care of the elderly GPs are also involved. These interdisciplinary teams provide astute analytical and thoughtful skills needed to help seniors and their caregivers navigate the challenges they may face in their unique journey.

Dr. Jennifer Ingram

When requested by a patient, family member, physician or community organization, the GAIN team assembles its resources to assess the senior and family, and develop a comprehensive plan of care. In addition to diagnoses, often including unnoticed dementia, the GAIN teams address safety, mobility and medication issues. The team explains the complexities and possible future outcomes of specific medical concerns and works with the senior and their family to plan for life changes ahead. The GAIN

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team marshals resources from available community supports such as adult day programs, the local Alzheimer Society, Meals on Wheels, and driving services to name a few.

The aim is to help the senior maintain their function and independence so they can continue to live in their own home.

GAIN involvement can be triggered by worrisome hospital discharges, frequent hospital stays or emergency room visits.

Families who have sought this kind of coordinated care for a loved one say it has been a gift.

Loretta Mauro is a 60-year-old retail manager who retired three years ago to care for her 83-year-old mother, Lina, in her home near Peterborough. Loretta says the program has given her the skills and assistance she needs to keep Lina at home. "I'm keeping her here as long as I can," Loretta told me. "I'm not giving up on her. I'm not giving her up to dementia."

Initially, when Loretta noticed changes in her mother, she put cameras in the home where Lina had been living alone. Witnessing safety concerns, Loretta moved Lina into her home, but struggled to cope until the GAIN team stepped in.

The GAIN team's diagnosis of Lina's dementia, with difficult behavioral issues, set off a series of interventions that included medication changes. The GAIN team personal support workers (PSW) and behavioural nurse worked with both Loretta and the visiting community PSWs—approved for three visits a week for four hours at a time—to use consistent techniques specifically designed for Lina. Before the pandemic, Lina also benefited from an off-site day program focused on activities for adults living with dementia.

Today, Loretta and Lina live contentedly despite Lina's lack of language and her full-care needs.

Even for individuals living alone, GAIN has been able to develop a similar plan using friends, day programs and visiting family. Without this focused team-based approach, these seniors would be residents in a hospital awaiting long-term care for years.

Other jurisdictions in Ontario have also implemented team-based approaches to frail senior care. To my knowledge, this is the first time that a large geographic area, with an aging rural constituency, has been analyzed for need first, with the resources to follow. A blank slate allowed creativity and innovation.

The GAIN program was designed to be embedded in community health services readily available to local seniors. It uses community professionals, not occasional visiting teams. It was groundbreaking when the program was created 10 years ago. And it has proven to be an attractive drawing card for geriatric specialists, care of the elderly GPs, and other senior care professionals to relocate to this area, further bolstering our depth of service.

This model could easily be adapted across Ontario.

The National Institute on Ageing estimates that on average across Canada it costs $703 a day to look after a senior in hospital, $201 a day in long-term care, and $103 a day at home. It is important to recognize that 50 per cent of seniors are robust and do not use health-care resources beyond a minimal five-to-10 per cent of the Health Ministry budget. But the frailest of seniors—10 per cent of the population—utilize 50 per cent of our health-care resources.

This sobering realization suggests we need to think of an effective way to deploy services in a cost-efficient fashion. Remaining at home will always be more cost effective where possible. Given that 93 per cent of seniors live in the community, focusing our health-care resources on community dwelling seniors makes eminent sense.

GAIN was founded in 2011 with four hospital-based teams. Two years later, the then-LHIN funded an expansion to 10 community-based teams. An additional two rural community teams were added in 2015, as the population in the region aged and put pressure on the province's acute-care services.

The GAIN annual budget of $10 million for 12 teams supports a current caseload of about 6,000 frail seniors with 25,000 unique visits. This is a fraction of the cost of building LTC facilities to accommodate these individuals.

Space is so limited in long-term care that seniors in need wait two to five years or more for a spot, while others apply prematurely in fear of being lost in the system. At the same time, many families find home care services difficult

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– Dr. Jennifer Ingram

Photo credit: Dr. Cindy Hobbs

Dr. Jennifer Ingram (left) meets with elderly patient Lina and her daughter Loretta Mauro during a home visit. For the past decade, Dr. Ingram and her colleagues at the Kawartha Centre in Central East Ontario have been involved in the development and implementation of an innovative health-care delivery model for complex seniors in the community. The model known as GAIN, Geriatric Assessment and Intervention Network, helps seniors maintain their function and independence so they can continue to live in their own home.

to arrange—often dependent on the senior's willingness to accept help with bathing.

Seniors admitted to hospital may find returning home difficult, if not impossible. Identified as needing an alternate level care (ALC), such individuals occupy up to 34 per cent of all acute hospital beds in Ontario. Each of these people should be eligible to return home with all required supports.

Seniors want to stay in their homes. A 2017 Canadian Institute for Health Information (CIHI) report found that more than one-in-five seniors admitted to residential care could have remained at home with appropriate supports. A mismatch in capacity, demand and available services is a health care pressure point. It is a significant contributor to hallway health care for hospitals and wait-list health care for the community.

Almost eight million Canadians are turning 65 or older this decade and, by 2041, one-in-four people in Ontario will be 65+. At the same time, there is a rising tide of Canadians living with dementia. One-in-four seniors aged 85 and over has dementia.

GAIN teams work with primary care physicians to support the complex care needs of frail seniors, especially those with dementia. A 2015 Commonwealth Fund Survey of Family Physicians found that while almost nine-in-10 Canadian primary care physicians care for patients with dementia, only four in 10 felt well-prepared.

Last fall, the National Institute on Ageing found almost 70 per cent of Canadians over 65 reported that COVID-19 had changed their opinion about living in a nursing or retirement home. In fact, nine-in-10 Canadians surveyed said they intend to do whatever they can to stay active and maintain their optimal health and independence. I believe that caring for frail older adults is one of the most important jobs in the world, a sentiment echoed by the OMA in its recent submission to Ontario's Long-Term Care COVID-19 Commission.

Long-term care, as we know it, must change dramatically. The current situation is not what my patients want, nor what I want for myself or for my family.

It's time to divorce long-term care from the buildings and focus on the care. ■

Dr. Jennifer Ingram is an internal and geriatric medicine specialist; founder and medical director Kawartha Centre – Redefining Healthy Aging; consulting geriatrician Seniors Care Network; Ontario co-lead Research on Organization of Healthcare Services for Alzheimer (ROSA) Canadian Consortium for Neurodegeneration in Aging; and qualified investigator international pharmaceutical trials for Alzheimer disease.

Further Reading

OMA Interim Guidance to Ontario's Long-Term Care COVID-19 Commission
Visit: oma.org/ltc-guidance