A community approach to elderly healthcare

Canadian health expert **Dr Marita Kloseck** discusses her work with frail older individuals, and the important role that communities can play in improving their health and wellbeing

Over the next few decades, the global number of elderly people needing medical attention is set to rise. What major concerns are associated with this trend?

While older individuals are living longer and in better health than ever before, for many advanced old age brings a different set of challenges including multiple morbidities, functional limitations, physical and mental frailty and social isolation – all at significant cost to healthcare systems. We know that providing care in the community promotes a better quality of life for individuals and is cheaper for healthcare systems. Brief hospital stays, short visits to family doctors and even the occasional visits by community nurses don't work for individuals with multiple co-morbidities, or decreased physical and cognitive abilities to deal with the many issues they face. We need a system for monitoring frailer, older, at-risk individuals, quick response, and an ongoing continuum of care for people who are unstable. Chronic disease management is a challenge. Having multiple chronic diseases is one of the greatest threats to independent living. The current self-management approach does not work for frailer individuals, therefore, a collective community approach, where the 'whole' greatly exceeds the sum of the parts, has much to offer in these circumstances.

Your research programme focuses on the development of innovative models of care for older people living in the community. What kinds of challenges do you face in the course of this work?

There are three major challenges we consistently encounter. The first of these is that geriatric expertise is typically housed in hospitals, and hospitals are constrained by budgets. Our approach was to use hospital-based professionals with expertise in geriatrics to educate community-based providers – but for changes to occur system-wide an alternative approach and different funding models are required. The second challenge is that the success of community development approaches depends upon a shared vision, shared decision-making and negotiated change – this can be difficult for organisations that typically have top-down structures. Finally, within communities of seniors 'young' old can provide

support, mentoring and monitoring for their frail neighbours – but inevitably, the 'young' old become the 'old' old, and a mechanism for ongoing recruitment is crucial for sustainability.

Have you undertaken any significant collaborations in the process of delivering this programme?

Academic collaboration is key in this area; solid evaluation frameworks are increasingly expected by funders, but rarely achieved. More than academic collaboration, however, we emphasise community collaboration. Seniors are a powerful resource for their own health, and communities of involved seniors can provide valuable strategies to optimise health, independence and extend the 'reach' of healthcare systems. They are our partners in the truest sense.

What is the underlying theory driving this programme? What insight do you hope to gain from Naturally Occurring Retirement Communities (NORCs)?

One's environment becomes increasingly important with advancing age, thus theories of person-environment fit, and competence and environmental press, along with the active ageing framework endorsed by the World Health Organization, underlie our community development work. The characteristics of NORCs can provide many valuable insights for other community initiatives; with their concentrated populations of older people, sense of community and strong social networks, they tend to attract a wide range of seniors. NORCs are ideally suited to promote both the giving and receiving of support, and we can learn much from their location, design and management.

In what ways does your approach to this research differ from that taken by other investigators?

Working hand-in-hand with seniors in their home environment on issues that are of importance to them helps build stronger relationships and is much more successful than the usual 'parachuting in and out' of researchers in community settings. Our approach is always the same: we create an advisory committee with community, business, health and academic representatives. To ensure buy-in and build trust we develop a common vision, specific to each community, with negotiated consensus on priorities and shared action planning. We then build a shared learning partnership environment where seniors both learn and teach their peers. We identify residents willing to become Community Advocates for priority topics identified, and use a community learning approach that sees seniors learning about specific health issues and resources and teaching their peers. Local businesses provide infrastructure and training resources, and community health professionals and educators share expertise, uniting to train seniors. Businesses, in return, learn to better respond to the needs of their ageing customers. It's really a win-win situation!

Ageing **gracefully**

The ageing population is an unprecedented challenge for healthcare, but one group of researchers at **Western University** has developed a solution that will benefit both the health system and patients

HEALTHCARE SYSTEMS WORLDWIDE are facing challenges. The tremendous task of providing healthcare for ever growing populations can seem to be insurmountable and unaffordable. Advancements in clinical procedures and an increased ability to detect diseases are adding more patients to the already long lists of those waiting for treatment. In countries like the UK and Canada, where public funding makes healthcare available to all, there is the added hurdle of providing this vital service on a tight budget.

These overstretched systems are about to be challenged further. As baby boomers join, and rapidly expand, the elderly population, many healthcare systems will find they are not adequately equipped to respond. Despite this long predicted challenge many community resources and healthcare services have not evolved to meet the changing needs of elderly people, especially the oldest-old. Studies reveal that the needs of elderly people living in the community are frequently unmet. Common conditions ranging from falling to memory loss and depression often go unnoticed and untreated.

THE AGE OF AGE

In light of these foreseeable challenges the goal ahead is to change the way that health services are provided to older people. Currently geriatric expertise is housed behind the walls of institutions. A collaborative system of care between hospitals and communities is needed. In Canada the healthcare system responds to acute illnesses such as pneumonia or a hip fracture following a fall. The health of elderly individuals can be unstable, and sometimes a fairly simple problem can lead to a downward spiral and a state of dependency. Early intervention and ongoing monitoring, for example, might prevent the fall that caused the hip fracture. Ideally, healthcare in the future will be provided in the community, within the homes and communities of elderly individuals with easily accessible information and services. Approaches that require limited input of resources are critical, as even a comparatively small cost would soon become unmanageable when scaled with the growth of the elderly population.

Fortunately, one programme in Ontario has already demonstrated that a solution is possible – and it has been doing so for almost 20 years. Dr Marita Kloseck is Director and Associate Professor at the University of Western Ontario's School of Health Studies, and has been in charge of the Aging and Community Health Research Programme for the last 17 years. The programme has been responsible for setting up a model shared learning community, bringing together partners from business and medicine as well as academia to work with a naturally occurring retirement community (NORC) with high health service utilisation. Perhaps most importantly, it has harnessed a cheap, efficient and readily accessible resource for the provision of healthcare to older people that has previously been untapped: the elderly people themselves.

PARTNERS IN HEALTH

Kloseck conducts applied research in seniors' homes and communities using an inter-sectoral collaborative community capacity-building approach, with a particular focus on actively engaging frail older individuals who have multiple co-morbidities and complex challenges to maintaining their independence. NORCs are usually home to a wide variety of elderly individuals, from newly retired active older individuals to those who are at-risk, to those who are very frail. Community care workers go some way towards delivering health services within this context, but the Ontario team has shown that the next step is peer-led healthcare. With minimal training, they found older people could become highly proficient at disseminating medical information to one another, and even providing assistance where necessary.

But peer-led healthcare is only one part of the shared learning partnership model that Kloseck champions. Within this model, local businesses and healthcare providers work together to ensure the wellbeing of the elderly – forming a collaborative

AN APPLIED RESEARCH LABORATORY FOR AGING AND COMMUNITY HEALTH

OBJECTIVES

To develop and test innovative models of collaboration between communities, health care providers and businesses to enable optimal ageing at home, in an economical way, for frailer older individuals

KEY COLLABORATORS

Dr Richard G Crilly (Geriatric Medicine); **Dr David W Holdsworth** (Medical Biophysics and Surgery, and Dr Sandy Kirkley Chair in Musculoskeletal Research, Robarts Research Institute, JuMP Joint Motion Program), Schulich School of Medicine, Western University, Canada

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network with NORC residents to work on issues of importance to the community. Businesses provide infrastructure such as space and other resources and care providers offer their expertise on a variety of topics. All are responsible for identifying and referring at-risk, frail individuals in the community, enabling faster support and treatment. When they first began working with the NORC in London, Ontario, the Ontario team found that residents had two major priorities: first, they wanted a health centre within the community that would provide health information that didn't require physician involvement, and second, they had great concerns about the personal safety risks associated with living alone. These concerns led the partnership to establish the Cherryhill Health Promotion and Information Centre, which today responds to more than 3,000 requests per year.

SPREAD THE WORD

Over time, Kloseck's research programme expanded to build the knowledge and skills of older community volunteers to teach their peers about the prevention and management of chronic diseases. Osteoporosis, a disease that usually strikes elderly women and makes their bones more porous, presents a huge health hazard for older people. A fractured hip, for instance, can lead to a lengthy hospital stay and surgery, and can often result in being placed in a nursing home. For these reasons, Kloseck chose osteoporosis as a trial to test the possibilities of a peer-led chronic disease prevention programme. The approach used health experts to provide older volunteers willing to become community advocates for osteoporosis with extensive training related to the disease, in the form of five two-hour courses. Following the training, the community advocates developed new easier to understand materials for their peers, which were then vetted by the experts for accuracy. An additional course focused on public presentation skills was also provided to community advocates.

Community advocates then re-entered the community, leading osteoporosis education sessions for their peers and providing personalised mentoring. They assisted their peers in arranging appointments with family physicians to obtain a bone mineral density (BMD) test, and ensured that they returned to their physicians to review risk, collect BMD results and obtain advice regarding treatment recommendations. Kloseck and her researchers, meanwhile, collected results of their own; in a randomised controlled trial evaluating this peer-led approach, they demonstrated a significant change in positive osteoporosis behaviours such as taking calcium and Vitamin D, exercising, talking with friends and neighbours about osteoporosis and returning to family physicians to discuss the condition.

A GROWING DEMAND

Over time, the Cherryhill Health Promotion and Information Centre, where this initiative began, has grown into the Cherryhill Healthy Ageing Program, which not only provides information and referrals but also a growing variety of health education programmes run by volunteer community members, with the support of health professionals. The Cherryhill NORC has become a model for other communities of seniors. In 2005 Kloseck and her collaborators received funding from the Canada Foundation for Innovation to expand the programme. The Ontario Ministry of Health also supports the Cherryhill programme with annual funding, staff and infrastructure. In 2006 it received the City of London Mayor's Recognition Award for significant community impact – and in 2008 it was recognised as an international best practice model in Sweden.

This model is a great achievement, in terms of its evident benefit to the local community, its improvements to health and minimal set-up costs; it has rightly attracted attention both within Canada, where it is the first of its kind, and internationally. The researchers' capacity-building approach also creates a robust knowledge sharing network and an immediate feedback loop enabling faster translation of research findings into practice – ensuring a bright future for the elderly people of Ontario, Canada, and perhaps the world.

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