



Winnipeg Regional
Health Authority
Caring for Health

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santé de Winnipeg
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“The Provincial Continuing Care Strategy: Public Perspectives on Aging in Place”

Full Report

Local Health Involvement Groups

February 2016

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Section I

Report Summary

Introduction and Methodology

The 6 Local Health Involvement Groups (LHIGs) have been providing advice and their unique community perspectives on significant health issues to the WRHA Board for 13 years. They are comprised of 80-90 residents of the geographic community pairs that each Group represents. There is also some representation from the Boards of health organizations also located in the community areas of the Winnipeg health region. The Groups are diverse in terms of culture, socio-economic status, professional backgrounds, work experience, age, and gender. Members of the six LHIGs participated in an orientation session prior to beginning this year of meetings on topics that were recommended by the LHIG topic selection working group and then approved by the WRHA Board.

As part of broadening engagement beyond the Local Health Involvement Groups with cultural, linguistic, and vulnerable populations, the Aboriginal Health and Human Resources Committee of the WRHA Board also provided input on this topic. They provided input on the first meeting's questions only.

Background/Rationale for Exploring this Topic

The Local Health Involvement Groups were asked by the Board in September 2015 to spend two meetings (September to November 2015) providing their perspectives of potential actions for supporting healthy aging congruent with the Province's Continuing Care Strategy. This topic was recommended by the LHIG Topic Selection Working Group, comprised of LHIG members, Board Liaisons, Senior Staff, and staff supporting the LHIGs.

Public perspectives and ideas of how to operationalize this strategy are critical. Some LHIG members are seniors and/or live with a chronic illness or disability; others are caregivers, family members, friends, and neighbours of seniors or of people living with chronic illnesses or disabilities. As such, their insights and suggestions will help ensure that programs, services, and supports will safeguard dignity, be flexible, and provide the appropriate levels of support so that people can live independently and have a good quality of life for as long as possible.

First Meeting and Questions for input

The first meetings of the LHIGs began with background information about the province's Continuing Care Strategy and how input from the LHIGs would be used. The approach to addressing the question also included providing feedback on Action Area 1 (Helping people stay at home by investing in community supports) and Action Area 2 (Access to home care). The LHIGs were asked to consider the following when providing feedback on the Action Areas:

- What do these action strategies mean to you?
- What would they look like to you?
- What do you feel are appropriate strategies to promote independent living/aging in place? (what are ways to promote independence in the community (of seniors and those with chronic health conditions)
- Importance of ensuring sustainability – not brainstorming “wish list”, but considering most cost effective strategies, utilizing community resources
- Aligning services, supports, etc. with need – equity approach

- Dignity and choice, preference, flexibility
- Consider activities of daily living (like -- mobility, self-care, cooking, laundry, getting out into the community for shopping, recreation, etc.)
- 24 hour assistance
- Key issues that we feel would be important to consider while we age – living alone, mobility, chronic disease, involvement/role of family

The Downtown and Point Douglas LHIG was the first to meet. During this meeting, it was evident that more time was needed to focus on Action Area 1 and their feedback to the questions resulted in a modification of the questions for the 5 other LHIGs.

The remaining five LHIGs were asked to provide feedback to Action Area 1 only and Action Area 2 (Access to home care) was taken off the agenda. LHIG members were asked to provide feedback to the following questions:

1. What would have to be in place (family support, community support/ involvement, home care, other health supports) to enable seniors and people living with chronic conditions to age in place? (Keep in mind -- financial challenges, housing, mobility, support network, being a Newcomer, language and/or cultural barriers, personal health practices, coping skills, mental health and wellness, etc.)
2. What gaps do you see that could make it difficult to successfully age in place?
3. “The key to helping seniors/those living with chronic conditions to age in place is...”

The Aboriginal Health and Human Resources Committee of the Board held one meeting to provide input into the Continuing Care Strategy and provided feedback to the questions for Action Area 1 (Helping people stay at home by investing in community supports).

Second Meeting and Questions for input

At the second set of LHIG meetings, members received information and provided feedback on three additional action areas of the Continuing Care Strategy – Action Area 3 (Working together with health care partners to help people age in place), Action Area 4 (Improving options for community-based housing as alternatives to personal care homes), and Action Area 7 (Using information technology to improve the quality and co-ordination of care).

The process for getting input on the 3 Action Areas began with a large group discussion of the entire local health involvement group providing input on 3 questions, one per Action Area. For the second set of questions on the Action Areas, LHIG members participated in a world café, whereby, small groups would rotate through the questions (facilitated by staff or a LHIG member). The small groups would review the input left by the preceding group(s) then add additional comments to the flipchart.

Here are the questions (asked in the large group and world café) that LHIG members were asked for their input on:

Action Area 3: (Working together with health care partners to help people age in place)

- Who are the key partners (individual, family, community partners, health care system, etc.) to help people age in place? Large Group
- What are your ideas for how key partners should work together? World Café

Action Area 4: (Improving options for community-based housing as alternatives to personal care homes)

- What elements (design, support, rental rates, etc.) would be critical in community-based housing as an alternative to personal care homes? (Consider single family homes, multiple units, supportive housing, assisted housing, etc.) Large Group
- What are your ideas for innovative community-based housing options to enable seniors and those with chronic conditions to age in place? (Consider design, services, etc.) World Café

Action Area 7: (Using information technology to improve the quality and co-ordination of care)

- How do you think we can use information technology (within the health care system and in the community) to improve quality and coordination of care? Large Group
- What should we keep in mind when developing/using information technology to support aging in place? World Café

The Continuing Care Strategy

The Continuing Care Strategy was developed by Manitoba Health in collaboration with key stakeholders such as provincial committees, government departments, regional health authorities, private agencies, community groups and health care providers. It focused on matching the needs of individuals and their caregivers with local supports. The goal is to help people avoid unnecessary loss of independence and maintain quality of life through premature admission to personal care homes or hospitals. Actions may also help build and support a more sustainable health care system. The population targeted in this strategy are seniors and those living with chronic illnesses and disabilities.

Background/context

In 2010, about 13.6 per cent of Manitobans were aged 65 or older. This percentage is expected to double in the next 25 years. Serving a larger number of older Manitobans means that health authorities must plan ahead to address:

- more chronic disease;
- higher health care costs;
- Increasing cultural and linguistic diversity of the population served;
- maintaining quality and access to health care services; and
- increasing need for new technologies and treatments.

Most people with chronic illnesses or disabilities want to continue to live in their own homes independently and age in place. The goal is to ensure that people receive the right service at the right location at the right time so that they can live in their communities.

Aging in place means having the health and social supports and services you need to live safely and independently in your home or your community for as long as you wish and are able. (Health Canada)

Action Areas of the Continuing Care Strategy

Within the Strategy, 7 action areas were identified with some key goals and objectives stated.

Action Area #1

Helping people stay at home by investing in community supports and focusing on wellness, capacity building and restoration when delivering home care services

Action Area #2

Improving access to home care

Action Area #3

Working together with health care partners to help people age in place

Action Area #4

Improving options for community based housing as alternatives to personal care homes

Action Area #5

Ensuring there are enough long term care beds to meet the needs of Manitobans

Action Area #6

Developing innovative ways to deliver services to improve care for personal care homes residents

Action Area #7

Using special technology to improve the quality, co-ordination of care

Action Area One: Helping people stay at home by investing in community supports and focusing on wellness, capacity building and restoration when delivering home care services.

As a society, we need to change how we view aging. Elderly parents going into nursing homes is no longer an option (or wanted) for most of the population. We need to look at ways to support family members to age in place, maybe even look at options of moving in with family again.

(Member, St Boniface/St Vital LHIG)

LHIG members were asked what they felt needed to be in place – things like family support, community involvement/support, home care and other health services – that would enable seniors and those living with chronic conditions to age in place. From the discussions, key themes emerged. These have been ranked according to the overall number of comments made in each of the themes.

1. Community Involvement

Supportive and connected communities enable seniors and those living with chronic conditions to stay in their communities, to age in place. Utilizing natural connections between neighbours, like seniors looking out for one another on the same floor of a seniors' only apartment building or neighbours working together to meet their needs are examples of this.

A strategy such as hiring maintenance services in order to remain in their homes is an example of the importance and role that community can play. Older neighbourhoods often are planned in such a way that connections between people can happen naturally, whereas it can be more challenging in newer neighbourhoods.

It is important to focus on communities where people don't know their neighbours, have lost a sense of community. This hurts those who are aging, especially in suburbia. We need to create safe environments so that people can feel comfortable going out into their communities for socializing, etc.

(Member of Downtown/ Point Douglas LHIG)

LHIG members recommend that the WRHA develop partnerships within cultural or geographic neighbourhoods (like one floor of a seniors building) to support efforts underway that provide much needed social and other supports (like taking people to health care appointments). There is a role for community facilitators to support these efforts.

LHIG members also recommend that the WRHA look at opportunities for schools and other community organizations where partnerships can be developed with seniors and those living with chronic health conditions in their communities.

2. Family support and involvement

Families play vital roles in augmenting home care services, advocating for quality health care, and home maintenance support. This kind of care and support can be physically, emotionally, and financially challenging. Caregiver burnout is an issue for many – especially elderly spouses.

The level of success or effectiveness of family caring for an individual can be dependent on the support that they receive.

(Member, Seven Oaks/Inkster LHIG)

Concerns were raised within the discussions about those who either have no family or who are disconnected from their family. LHIG members recommend that the WRHA identify and offer support/advocacy to seniors and those with chronic conditions who do not have family or other natural supports.

The possibility of disjointed resource coordination is high when there is no family involvement. If a senior doesn't have family, they should have an advocate.

(Member, River East/Transcona LHIG)

LHIG members also identified a need for education and training, especially in the area of caring for family members with dementia.

Families start really wanting to care for loved ones in their own homes, often without the knowledge and skills to do so (like for dementia). They need more caregiver support as they get burned out very quickly. This will become more and more of a problem.

(Member, St Boniface/St Vital LHIG)

What about seniors who don't want any outside help, who are afraid of people outside their family? Before they get to the point of having to leave their home (for more supported housing or a personal care home, etc.), families need to start talking about where they might need to move to because of mobility issues, etc. Fear is a huge thing for many.

(Member, St Boniface/St Vital LHIG)

3. Language and Cultural barriers, Newcomer challenges

Given the increasing diversity of the population and that many who speak English as a second language find it increasingly difficult to speak English as they age, language and culture can create barriers for seniors and those living with chronic conditions. Health care and connectedness to their community are key issues.

LHIG members recommend that the WRHA partner with cultural and faith groups to promote services and programs that are available.

Older people should have a chance to have a conversation about what's out there. Many family members with significant language barriers are not comfortable having people come into their home but would be comfortable going to their temple or some other community gathering place and getting information in their own language. They are sometimes afraid to ask for help from their family, afraid to be a burden.

(Member, River Heights/Fort Garry LHIG)

LHIG members also recommend that the public is made more aware of the interpretation services that are available and about how to access them.

4. Information and help in navigating health services, supports, programs, etc. for seniors and caregivers

Information about resources, programs, and supports available to seniors was shared at the first set of LHIG meetings. Most were unaware of the magnitude of community-based resources and supports that are in place across the region. As such, accessing information about resources along with getting help navigating the health system was a priority to the LHIGs. LHIG members offered a range of suggestions for how existing programs and services are promoted. Many felt that offering information on the website in a way that was easier for people to find was important.

Knowing what's out there and where to search for it is key. Accessibility to information like the Seniors Guide, about services, information, etc. is critical. Having one point of contact for this information would be best.

(Member, St James/Assiniboine South LHIG)

What is needed is a process of connecting seniors to the services that they need. Many don't even know where to start. The process needs to be simplified.

(Member, Seven Oaks/Inkster LHIG)

5. Addressing social isolation/Mobility issues

Challenges with mobility and social isolation are connected but not always. Social isolation can also be caused by depression and furthered by a lack of connectedness to family, friends, and neighbours.

There is a need to check in on isolated seniors. I deliver meals and there are some seniors who receive meals but who are not eating. Home care workers could check in, keep an eye on them and share information about how they're doing. There is a need for companionship and to build trust. This happens by spending time with them – playing cards, chatting, etc.

(Member, River East/Transcona LHIG)

Programs that offer opportunities for socializing must be geared to the capabilities of the individuals. For example, the Day Hospital Program – the senior had more in common with the staff than the participants. When we look at these programs, we need to make sure that they are appropriate in terms of their abilities.

(Member, Seven Oaks/Inkster LHIG)

Addressing mobility challenges both inside of the home and being about to get out into the community, to health care appointments, etc. is also very important. LHIG members recommend that seniors are supported to address these issues. Making those modifications can be costly, and a barrier for many.

We need to address problems with Handi Transit. If family members are not available, people need to rely on Handi Transit (for appointments, shopping, socialization, etc.) Getting out is critical to staying happier, living longer.

(Member, River East/Transcona LHIG)

6. Socio-economic issues

LHIGs discussed the connection between poverty and well-being for seniors and those living with chronic conditions, especially as it relates to housing and the ability to have a healthy diet.

There is more illness and greater isolation when you are poor. It is difficult to have a proper diet, safe housing, and well-being overall. This is more so with seniors and there needs to be a concerted effort in the community to create opportunities to assist with navigating the health system and to decrease isolation. What about homeless seniors? Aging in place doesn't happen if you do not have a home. What is the provincial strategy for this population?

(Member of Downtown/ Point Douglas LHIG)

LHIG members recommend that subsidies for nutritious food be put in place.

The working poor or those who are retired without pensions have great challenges affording nutritious food. Even Meals on Wheels would be too expensive. There should be subsidies to ensure that they can eat properly.

(Member, St Boniface/St Vital LHIG)

Programming

LHIG members shared examples of programming in the community that they felt worked well and also identified where there were gaps. There is a lot of pressure on community organizations to meet the needs of seniors and individuals living with chronic conditions, but the funding has not matched the growing demand and service level provided.

More resources need to be shifted to community organizations to enhance services, especially in vulnerable communities. So that they can provide meals, drop-in programs, etc.

(Member of Downtown/ Point Douglas LHIG)

A number of LHIG members shared ideas about how to enhance the home care program with volunteers who could provide companionship, sit down to share a meal, etc. recognizing that the time that home care workers can spend with clients is restricted to tasks while the needs for companionship and socialization are unmet.

LHIG members also felt that transportation to and from community organizations was a barrier to many. Some kind of transportation needs to be offered to support their participation.

Areas to improve in home care and health services

LHIG members and members of the Aboriginal Health and Human Resources Committee discussed how home care and other health services supported aging in place. They also identified areas that could be improved. Some of the issues shared by the LHIGs included increasing flexibility in the amount of time and care provided to home care clients, having a staff person to coordinate care and support across programs for clients, better communication between health care providers and families, and the development of short term home care that people could receive very quickly when needed to get them through short term health challenges.

There needs to be greater flexibility and timeliness in the home care program especially for those living with a chronic condition. Their health changes over time and there needs to be flexibility in care to support the individual.

It would be extremely helpful to have a staff person whose job is to coordinate care and support across a variety of health programs.

(Members of Downtown/ Point Douglas LHIG)

What about pathways for home care – different streams for clients who have family support, who do not have family support, and with or without community support?

(Member, St Boniface/St Vital LHIG)

The WRHA should look at models from other countries, like the Netherlands, for examples of how community involvement and home care can collaborate to support aging in place.

In the Netherlands they are reinventing home care, engaging community members to support a senior or an individual with a chronic condition together with home care.

(Member, St James/Assiniboine South LHIG)

A number of LHIGs brought up the idea of “milestone” conversations that health care providers should have with their patients at certain ages throughout their lives. They would focus on prevention and staying healthy as they age along with planning in preparation for key health changes that may occur. These conversations could include connecting to community resources, considering changes in housing if relevant, and using home care and other health care so that they can remain in community.

Also important to LHIG members, is education and training health care professionals, especially those studying medicine about the aging process, and to not see it as a medical condition, but a phase of life.

Aboriginal Health and Human Resources (AHHR) Committee

When the AHHR Committee of the Board met to provide input on aging in place, they identified the following issues as most important – addressing social isolation and mobility challenges, family support/ involvement, language and cultural barriers, and the emotional/mental health aspect of aging.

Accessibility in housing is key and has dynamics that you would never think of. An elderly fellow with a disability (living in a hotel) was unable to get up to open the door to home care staff and had to leave his apartment door open. This caused many safety issues for him and he experienced numerous break-ins and thefts as a result.

Committee members also discussed the importance of family support and involvement and the necessity of the system to monitor and support caregivers.

There can be a house of cards, waiting to fall. Spouses are sometimes not 100% healthy. If we're depending on family, they need to be prioritized as well.

At the end of the first meeting, LHIG members were asked to share what they felt was most important for the WRHA to consider to supporting aging in place. Here are a few of their comments.

To me, key to helping seniors and those living with chronic conditions to age in place is...

*...collaboration of government and private sectors to provide community support services that includes health, education, and basic services to support aging in place
(Member of Downtown/ Point Douglas LHIG)*

*...individual and defined yet flexible health plans that include family members, health care, and social supports
(Member, River East/Transcona LHIG)*

...an open dialogue with aging community about what needs to happen
(Member, River Heights/Fort Garry LHIG)

...cultural sensitivity because it creates a sense of belonging so that everyone can feel like they belong
(Member, Seven Oaks/Inkster LHIG)

...education for seniors and caregivers on everything from preventative care, caring for loved ones to financial issues and how to navigate the system
(Member, St Boniface/St Vital LHIG)

...one point for information about health care, resources, supports, etc. for seniors -- somewhere to start
(Member, St James/Assiniboine South LHIG)

...prioritizing the individual and providing patient-centred care, then they will be able to age in place
(Member, Aboriginal Health and Human Resources Committee)

Action Area 3: Working together with health care partners to help people age in place

Who are the key partners to help people age in place?

LHIG members were asked to consider who the key partners would be that support individuals to age in place. LHIGs identified two levels of “teams” of key partners. The first, was the health care team that included the individual at the centre (senior or person living with a chronic condition), family members, health care professionals – especially the family physician and home care. Natural supports are invited, (friends, neighbours, etc.) if they play an important role in the individual’s life and well-being. If the individual is reliant on community-based health or social programs (seniors or chronic disease organizations), it may be appropriate to have staff participate in key planning meetings.

If the individual has no family and is unable to make decisions for their care, it might be appropriate to involve someone from the Office of the Public Trustee.

Family really must be considered a key health care partner. When people are aging in place at home, family does as much if not more than health care providers, like home care workers.
(Member, St Boniface/St Vital LHIG)

The key partners of the team depend on the needs and circumstances of the individual – based on an assessment. This membership can change over time, relative to their needs.
(Member, St James/Assiniboine South LHIG)

For the homeless and hard to house seniors, it would be important to include staff from shelters, programs that the individual is attending, and homeless initiatives on teams.
(Member of Downtown/ Point Douglas LHIG)

LHIGs explored a more macro level of partnership that assessed and responded to community level (and even regional level) issues that impact peoples’ ability to age in place. For example, a community approach/partnership could be residents of the floor of a seniors building, seniors who own homes on one block of homes, a neighbourhood, community area, up to, and including, the entire Winnipeg health region.

The community team members would include the individuals/seniors at the core. Based on what the needs of the members, others could be invited to participate. This entails a community development approach, assessing needs – like home maintenance, transportation, advocacy/support for health care appointments, safety issues, etc. The goal would be to develop programs for the community that are affordable. There could be a role for WRHA staff to support these kinds of initiatives.

Other community level partnerships could involve organizations that provide services to seniors, community centres, chronic disease organizations, educational institutions, government, mental health organizations, language and cultural groups, and food security groups.

Ideas for how key partners can work together collaboratively to support aging in place

The partners need to identify the changing needs of the individual and respond with appropriate services and supports. Effective communication between health care providers and the family is critical to their involvement in caring for a family member and as a core member of the team.

The first step is to identify key partners needed for that individual.

(Member of Downtown/ Point Douglas LHIG)

There needs to be effective communication between family and health care staff.

(Member, Seven Oaks/Inkster LHIG)

The electronic medical record needs to be more accessible to partners within the team providing care. Need to ensure that key members have access to the information – especially family, doctor, and home care. The key challenge to open sharing of information is the Personal Health Information Act (PHIA) and the range of how it is interpreted by those working in health care. PHIA can cause additional challenges for families trying to support loved one with mental health issues, in particular.

Team members need to be aware of any changes in the health of the individual and share with other members in order to support them. Communication and collaboration is key and members' roles need to be understood by all members of the team. In doing so, they will avoid overlap or duplication of services.

Key partners/organizations need to be able to communicate with one another relative to the needs of the individual. If on employment income assistance, the social worker needs to be able to communicate and coordinate with the health care partners involved.

People often have trusting relationships with their social worker that they might not have with their family doctor. How can this relationship be utilized to address and meet their needs?

(Member of Downtown/ Point Douglas LHIG)

Long term planning is very important. Individuals and families need to plan for changing physical and mental abilities so that when necessary, adjustments to their home (to make it more accessible) or moving to more accessible housing with additional supports can happen in a timely way.

LHIGs also discussed the importance of ensuring that support and advocacy for vulnerable seniors who do not have family or natural supports is in place, especially for the transition from hospital back to community. One member from the St James-Assiniboine/Assiniboine South LHIG had experience with an initiative in Montreal called the "Somebody Project" that advocated and supported vulnerable seniors making those transitions to ensure that they didn't fall through the cracks.

Action Area 4: Improving options for community based housing as alternatives to personal care homes

What elements are critical in community-based housing that would enable people to age in place?

Enabling seniors and those living with chronic conditions to age in place requires housing environments and social supports that meet their needs and are adaptive to their changing health.

LHIG members were asked to think about what design and social support elements would be important to consider when developing housing for seniors and those with chronic conditions.

Overall, the following elements were important to all of the local health involvement groups:

- Accessibility throughout – ramps and elevators instead of stairs, wider door openings, larger bathrooms to allow for modifications, etc.
- Affordable options in the community – like multi-income housing
- Common areas that allow for socializing, meal preparation, etc.
- On-site home care
- Advocate/tenant support within the building/community
- Location – safe and convenient for grocery shopping, access to recreation, etc.
- Access to transportation
- Services like shovelling and yard maintenance, where appropriate
- Help with home repair
- Allow for pets
- Green space that allows for connection to nature, gardening, etc.
- Meal programs (healthy food) that can be purchased – flexible
- Opportunities to be actively involved based on ability and interest – like cooking, gardening, wood working, etc.
- Suites for family or friends to use when they visit

Innovative Ideas for community-based housing options to age in place

LHIG members offered a range of innovative housing for seniors and those with chronic conditions. They recommend that the government provides support for groups to develop housing concepts – like cooperative, intentional/co-housing.

LHIGs also stress the importance that housing be appropriate to the level of ability of the tenants/community members; getting the right level of support is key to aging in place.

It is also important that a tri-government health and housing strategy be developed to support aging in place. This must be a long term commitment – more than 4 years.

Here are some of the ideas shared during the LHIG meetings:

- Conversion of garages to bathrooms or main floor suites – adapting homes so that you can age in place
- Intentional housing with public and private spaces for all ages – could be as small as 6 families and as large as 200.
- Swing suites – housing that has “suites” attached to the main unit to allow for elderly parent or adult child to live beside. This can be kept open or be more private.
- Intergenerational housing – younger and older people living together can help each other out.
- Incentives and grants to stay and modify your home.
- Flexible housing support options that include laundry, meals, etc. – with units that meet a range of abilities – from assisted to full care.
- Set up a buddy facility where individuals share a single family home together and hire a house keeper, etc.

Action Area 7: Using special (information) technology to improve the quality, co-ordination of care

How can information technology be used (within the health care system and within the community) to improve quality/coordination of care and support aging in place?

Electronic medical records, e-chart and other database software systems that health providers use to document patient's health histories to coordinate care are incredibly important and all of the LHIGs are strongly supportive of continued efforts to continue to roll out this health information technology across the entire health care system. Many noted that some family physicians have chosen not to participate, which is very disappointing and surprising to LHIG members. LHIG members continue to ask for some level of access into their own medical records.

Patients should be empowered to access information about their own health – like accessing their electronic health record in read only format. Or, they could sit with their provider to review electronic updates to their health record.

(Member, St James/Assiniboine South LHIG)

LHIG members were also very interested in seeing a clearinghouse of information for health, home care, and seniors' services in the community, etc. under one website for the Winnipeg region. A number of LHIGs discussed the idea of using simple apps for tablets, smart phones, etc. that would be easy to use and provide community specific information along with apps with information on specific chronic conditions.

Other opportunities to use information technology to improve the coordination of care and support aging in place included using video conferencing (like Skype) for connecting with health care providers at home if there are mobility issues, using assistive technology for people with hearing or visual impairments and software like, Life Line, home monitoring, reminders to take medication, and automatic shut off for stoves, etc. The applications used would need to be specific to the individual and be adjusted as their needs change.

Social media was also viewed as a very helpful tool to keep seniors connected.

Use Facebook, Twitter, email, etc. to connect with others. This would be especially helpful for isolated seniors. It could be used with health care providers as well.

(Member, Seven Oaks/Inkster LHIG)

What should the WRHA and others keep in mind when developing and using information technology to support aging in place?

LHIG members made a number of suggestions to ensure that information technology be successfully used.

Number one; make sure that whatever is developed is easy to use. A couple of LHIGs recommended developing a dashboard of apps for seniors and those living with chronic conditions. Also very important, was ensuring access to education and training – possibly partnering with seniors organizations and/or organizations that provide home computer training in community settings.

LHIGs also felt that it is important to research how others have developed and use similar systems – look at leading institutions and organizations. When determining an appropriate approach, LHIG members suggest that a needs assessment be carried out using focus groups across the city.

And, in terms of moving forward on the issue of having access to electronic medical records, LHIG members recommend that the privacy laws be reviewed and possibly amended. These laws are currently seen as a barrier to empowering patients.

Recommendations to the WRHA Board and Senior Leadership

The LHIGs recommend the following:

1. That the WRHA develop partnerships with cultural and geographic neighbourhoods (like one floor of a seniors building) to support efforts underway that provide much needed social and other supports. There is a role for community facilitators to support these efforts.
2. That the WRHA identify and offer support/advocacy to seniors and those with chronic conditions who do not have family or other natural supports.
3. That the need for education and training, especially in the area of caring for a family member with dementia, be addressed.
4. That the WRHA partner with cultural and faith groups to promote services and programs that are available for seniors and those living with chronic conditions.
5. That the public is made more aware of the interpreter services that are available and about how to access them.
6. That subsidies for nutritious food be put in place.
7. That more resources need to be shifted to community organizations to enhance services, especially in vulnerable communities, because funding has not matched the growing demand and service level provided.
8. That innovative models from other countries be considered. For example, in the Netherlands community involvement and home care are working together to support aging in place.
9. That incentives and grants for modifying homes so that they are more accessible are provided.
10. That health care providers have “milestone” conversations with their patients at certain ages throughout their lives.

11. That communication challenges between health care and social services be addressed. If the individual is on employment income assistance, the social worker needs to be able to communicate and coordinate with the health care partners involved.
12. That a health and housing strategy be developed to support aging in place. This must be a long term commitment – more than 4 years.
13. That patients have some level of access into their own medical records.
14. That a clearinghouse of information for health, home care, seniors' services in the community, etc. be established under one website for the Winnipeg region.

Section 2

Notes from LHIG Meetings

Downtown and Point Douglas Local Health Involvement Group

Continuing Care Strategy – Meeting One Notes

Action Area 1: *Helping people stay at home by investing in community supports and focus on wellness, independence, and restoration when delivering home care services*

1. What would have to be in place (family support, community support/ involvement, home care, other health supports) to enable seniors and people living with chronic conditions to age in place?

- Keep in mind -- financial challenges, housing, mobility, support network, being a Newcomer, language and/or cultural barriers, personal health practices, coping skills, mental health and wellness, etc.

Changing society's perspective on aging

- We are now dealing with things that we haven't had to in the past – living much longer, new territory

Family support/involvement – challenges

- Families need to recognize the length of time it takes to organize services (home care, respite, etc.) – can take months

Community Involvement

- Need to be able to provide all of the supports that the WRHA cannot provide
 - Look to community agencies to assist with delivering services to support aging in place, on a larger scale
- Establish support groups in the community – social support, counselling, advocacy/support to connect to services for more assistance
- Building strong relationships with the community – aging is viewed differently across ethnic/cultural groups
 - WRHA should reach out to diverse communities – what can each community do to support aging in place?
- Building healthy community starts with building relationships
- Schools could partner with seniors – should also be high school, university – seniors can teach too – companionship flows both ways

Emotional side of aging

- Mental health -- people need to feel useful, needed, wanted – especially those without families – or, they will go into a serious decline – passing along life experiences, teaching – is an excellent way to boost mental health

Socio-economic issues

- Financial stress – when a family member has to become primary caregiver – must choose between meeting financial responsibilities and helping to support a parent/family member – are our workplaces ready to address this, to support employees so that they can care for family member?

Language and cultural barriers, Newcomer challenges

- Immigrants – exposing them to other cultures other than their own fosters understanding, knowledge, etc. – never too old to learn, develop new friendships
- Balance of responsibilities – especially in ethnic communities
- Every culture has different approach to how to deal with aging/elders in their community
 - For example, role of grandparents to care for grandchildren is facilitated/ supported by immigration process – when they are no longer able to play this role, there is a loss of sense of duty/value

Addressing social isolation

- More activities, decrease isolation – more activities to improve chronic disease conditions
- Winters are hard on mental health
- Visitors, assist with contacting family

Information and help in navigating health services, supports, programs, etc. for seniors and caregivers

- Aging baby boomers know how to advocate – how can we nurture this in aging Newcomers and in Aboriginal communities?

Programming

- Shifting more resources to community organizations to enhance services – especially in vulnerable communities – to provide meals, drop-in programs, etc.

Areas to improve in home care/health care services for seniors

- Home care workers - -would be a hard job – should be support for them – this strategy depends on a strong work force
- More collaborative approach happening at hospitals and community organizations – looking at “frequent flyers” at ER’s – need to do more of this – provide support in community, reduce pressures on hospitals
- Volunteer program – home care visitors?

Housing

- I’m living this, I’ve had choices taken away from me – I need respect, not lip service, being given some choices, being treated fairly (especially with Manitoba Housing)

2. What gaps do you see that could make it difficult to successfully age in place? (LHIG members participated in small group discussions)

Family support/involvement – challenges

- Need to identify most pressing gaps and fill them – it is about more people providing more support – not about more money

Community Involvement

- Budgets to many community organizations, like neighbourhood resource centres has decreased
- Public education/outreach to provide true community support – a societal goal
- Important to focus on communities where people don't know their neighbours, have lost sense of community – this especially hurts those people who are aging – especially in suburbia – need to create safe environment so that people can feel comfortable to go out into their community for socializing, etc.
- Have been talking about this for 30 years – more supports in community – this requires a major shift in thinking about resource allocation

Socio-economic issues

- Marginalized population – more illness, greater isolation – difficult to have good diet, well-being – this is more so with seniors – there needs to be a concerted effort in community to create opportunities to assist with navigating the health system – volunteer companions to decrease isolation
- Seniors – homeless population – aging in place for special populations – what are their options? Don't fit within this provincial strategy.

Addressing social isolation

- Companionship is key - home care can't provide this – don't have time

Mobility issues

- Programs and supports are only great if people can get around, access community supports
 - Access issues, mobility may be more difficult in rural communities, but there are transit issues here too

Areas to improve in home care/health care services for seniors

- Home care can be too task-oriented, not providing any companionship at all
- Home care worker training – how to nurture and foster relationships with clients – will improve clients' willingness to follow instructions from care workers. What is the cultural diversity of aging population? Can home care be flexible, diverse, culturally-oriented, and more cost effective?
- Amount of time that home care worker has to provide care – is an obstacle to good care – need for good training, building positive relationships with clients, more flexibility
- Training to home care workers/health care aides – more awareness of what they do/ issues that impact seniors, etc.

3. Key to helping seniors/those living with chronic conditions to age in place is:

- The development of a tri-government health and housing strategy to support aging in place (province, municipalities, federal) – true collaboration
- Long term commitment to health and housing strategy (more than 4 years)
- Flexibility and timeliness – living with a chronic condition – health changes over time and there needs to be flexibility to support the individual – system needs to respond in time
- Having an understanding of what systems are in place for seniors and those living with chronic conditions – knowing how and/or getting support to navigate (X2)
- Someone/somewhere to go to with skills to coordinate care/support across a variety of depts. (case management) X2
- Addressing social isolation – could be linking to supports, changing the environment
- Having facilities for individuals and families to participate in activities together
- Reinforce/return to multi-generational concept of family – secondary suites,
- Coordination, working relationship with government and private sectors to provide community support services – includes health, education, basic services to support aging in place

Downtown and Point Douglas Local Health Involvement Group

Continuing Care Strategy – Meeting Two Notes

Action Area #3: *Working together with health care partners to help people age in place*

1. Who are the key partners (individual, family, community partners, health care system, etc.) to help people age in place?

- Family
- Health authority
- Housing – tenant relations, building managers, etc.
- Neighbours
- Community
- There are some individuals who seclude themselves, are loners, solitary and block people out – will be hardest to reach
- Social clubs – chess, book, service clubs (Kinsman, Kiwanis, etc.)
- Seniors groups, bridge clubs
- Sports groups – running, swimming, etc.
- Spiritually oriented organizations – work with congregations and do outreach in the community
- Community volunteer groups and organizations– do outreach – can participate in doing outreach to others
- Home care – housekeeping and medical supports
- Subsidized housing – provincial, municipal
- Seniors housing – co-ops, intentional communities, etc.
- Programs/staff who assist with modification of housing to support aging in place
- Culturally specific seniors groups
- Homeless and the hard to house seniors – programs, shelters, initiatives
- Manitoba Health
- Federal government
- Family doctors
- Paramedics
- Fire fighters
- Police
- Postal carriers
- City services – keep an eye out on vulnerable neighbours
- Community nurses
- Office of the public trustee
- Organizations that are involved with physician-assisted dying issues, etc.

2. What are your ideas for how key partners should work together?

- Having partners identify the changing needs of the individual and responded with needed services and supports – understanding of whom to go to when something changes – like family, neighbours, others.
- Organizations need to communicate with each other relative to the needs of the individual – shared medical record
 - If on employment income assistance, social worker needs to be able to communicate/coordinate with health care system/staff involved
 - People may have developed trusting relationship with their social worker that they don't have with family doctor, etc. – how can this relationship be utilized to address needs?
- Burnout of health care workers, etc. – they stop caring, this is an issue
- Identify key partners – needed for that individual – they need to collaborate and communicate amongst themselves – streamline to avoid overlap, duplication
 - The priority should be to break through isolation (if they are isolated) then create channels of communication, plan of action with the individual
- Share information about how/who to connect with if you are aware of a vulnerable senior in your neighbourhood
- Seniors groups in community – are they responding to needs? Work to identify needs of seniors in communities.
- E-chart – should be more accessible to partners within the team providing care – can they access the information? Including family, doctors, home care, etc.
- Not every government department/service would have ability to access records – this is a challenge
- Priority – good communication between service provider and client/individual
- Using plain language across partners and with individuals and their families
- Linkages to secondary supports – community groups, that provide services important to their well-being
- Carry out a needs assessment of programs and services for seniors – they have done this in West Broadway community – what is the best way to serve seniors in the community? (Health services, activities, etc.) Successes? Find common approach.
 - Use results of the assessment to develop plan and work collaboratively
- Organization for people with intellectual disabilities – silo, and isolating themselves from the rest of the community
 - Need to break out of this
 - Training health care providers – to adapt care to people with intellectual disabilities
 - What information does the health care system need from us that is meaningful to health care providers?
- Innovative ways to reach marginalized, socially-isolated populations?
- Employer support of seniors aging in place/work places
- Senior, workplace – health and safety
- Unions

Action Area #4: *Improving options for community-based housing as alternatives to personal care homes*

- 1. What elements (design, support, rental rates, etc.) would be critical in community-based housing as an alternative to personal care homes?** (Consider single family homes, multiple units, supportive housing, assisted housing, etc.)
 - Density – makes delivery of supports easier – and provides options for socializing, walkability – doesn't necessarily need to be an apartment
 - Increased accessibility – more housing – the full range
 - New units – should be well constructed, shouldn't be too small
 - Allow pets – animals can be a healing influence for people
 - Healthy communities – more housing, broad range of housing
 - Potential for rooming houses – making them safer, etc.
 - Greener environments – community gardens
 - Access to healthy food
 - Alternative energy for homes
 - Security and safety
 - Well-designed – look good, lively, bright
 - Multi-income/mixed income housing – subsidized with market units
 - Built in ownership – not just temporary tenant
 - Having options to rent or purchase
 - Well managed housing with landlords who treat tenants fairly, etc.
 - Strong contracts that protect tenants – which supports modifications to units based on changing needs
 - Design – look at bathrooms in particular to reduce chance of falls, etc.
 - Swing suites – housing that has "suites" attached to main unit to allow for elderly parent or adult child to live beside – can keep open or be more private
 - Flexibility in size – to sell off parts of units when you don't need the whole unit anymore
 - Well planned environmental – considering daily activities of seniors – easier access to transportation, walkability, grocery stores
 - Activities opportunities to socialize
 - House keeping
 - Access to tenant resource coordinators

- 2. What are your ideas for innovative community-based housing options to enable seniors and those with chronic conditions to age in place?** (Consider design, services, etc.)
 - Ownership provides responsibility for maintaining the property
 - If you rent, how do you have shared responsibility for the property?
 - Mixed income model – wrap around supports in complex/community
 - Stop labelling/ghettoizing using terminology such as low income, seniors, etc. – do not have independence or responsibility
 - Services are close by or within complex (parks, groceries, community centre, gardens – like West Broadway)

- Density is important
- Need to be active in community or let them know about you
- Common spaces accessible and interactive, e.g. circle benches facing one another
- Provide people with things to focus on – senior lights, music
- Vast amount of work is done by a tenant resource coordinator does - -like Lion’s Place, Lion’s Manor
 - Get to know the seniors
 - Facilitator to support seniors
 - Clear role definition
 - Community resource program helps connect to food banks, employment, housing, etc.
- Access to health and social services navigator
- 444 Kennedy – Art Beat, music therapy – on second floor
- Multi-generational housing and mixed housing – not silos
- Feeling a sense of community, belonging
- Evaluation/assessment of building activities – improvements
- Checking in on residents who aren’t participating – to see if they are okay
- Seniors can opt in or opt out – their choice
- Get to know the tenants – tenant resource coordinators, support, some type of resources that can be deployed
- Tenant association – connect to community/neighbourhood renewal corps
- Green space – greenery energy – solar panels, winds mills, in floor heating, appropriately insulated
- Open air garden not just growing food only for themselves – a part of the community (e.g. raised gardens)
- Employment opportunities within their means (1-2 hours part ownership)
- Have garbage collection and mail services as it once was
- No studios – liveable space – does not meet everyone’s needs
- Assistance with cleaning, groceries, etc.

Action Area #7: *Using information technology to improve the quality and co-ordination of care*

1. How do you think we can use information technology (within the health care system and in the community) to improve quality and coordination of care?

- Scheduling, booking, coordinating services – lots of different platforms to use to do this – create efficiencies, pool resources; bring specialists to seniors’ blocks, etc.
- Figure out what you need in your own apps – by community – services, organizations , etc. useful for the individual – also apps for those with specific chronic conditions – including links to appropriate services, org’s, etc.
- PDF, internet accessible links – makes it super easy to access information to services, etc.

- Provide computers in seniors blocks, Wi-Fi access, etc.,
- Use iPods and smart phones for applications – many find those easier to use
- Use of tablets to show people how to care for themselves (foot care for example)
- Own personal medical file – part of the electronic med. Record - -that you have access to
- Tracking blood pressure – sending results
- Consider that some are computer literate and others won't be – make it easy to get information
- High tech carpet that track movement – can send alerts if someone falls or is dizzy –
- When developing, concerns that people won't know what they are buying into – needs transparency of disclosure

2. What should we keep in mind when developing/using information technology to support aging in place?

- Logic, reason – don't want dependence
- Hacking
- Make it easy (like Health Links-Info Santé) – type in for supports, one stop shop
- Use phones, email – 311 model but that actually works
- Talk to an actual human
- Apps that are specific and adjustable as needs change
- Training – users and service providers
- Informed consent
- Accessible language/different languages (function – multi-languages)
- Information “ownership” (access to information) – information loop back to individual and care provider
- Need a functioning, just in time bank of medical information
- Access to the tools/education
- E-alerts/bio feedback opportunities
- Linkages to social media
- Skype-face time – Tele-Health
- Biometric (*Biometrics* is the measurement and statistical analysis of people's physical and behavioral characteristics. The technology is mainly used for identification and access control, or for identifying individuals that are under surveillance)
- Desktop icon for links to health
- Caution: both and technology is an option, not a requirement
- Building partnerships to allow for ease of information sharing (community and WRHA)
- Community health consultation – not just health/government programs/services
- Appropriate provider fit -- comfort/relationships – app that includes accepting/specializing in issues
- Medical files – how to move – costs associated *need to follow – could technology make this easier?
- Self-help community on-line (system can help connect)
- Landline support as needed

- Health care – technology intermediaries – bring technology to people
- Continuing invitation to gather, learn, get support – presentations, documentaries – engage, expose, educate
- Software development needs to focus on ease of use

River East and Transcona Local Health Involvement Group

Continuing Care Strategy – Meeting One Notes

Action Area 1: *Helping people stay at home by investing in community supports and focus on wellness, independence, and restoration when delivering home care services*

- 1. What would have to be in place (family support, community support/ involvement, home care, other health supports) to enable seniors and people living with chronic conditions to age in place?**
 - Keep in mind -- financial challenges, housing, mobility, support network, being a Newcomer, language and/or cultural barriers, personal health practices, coping skills, mental health and wellness, etc.

Family support/involvement – challenges

- If a senior doesn't have family, they should have an advocate
- Education for families around dementia – families going through this, but don't know what they're dealing with – like sessions at Access Centres – how to support family member with dementia
- Increasing incidence of dementia – very hard for families to deal with
- Planning for changes as a result of aging – like broken hip – families need to plan ahead to figure out how they will work together to support an elderly family member – end up in hospital, with very little understanding of what to do, health care services available, etc.
- Insisting on educating family members – how to support them, info on the health care services they will be accessing, etc.
- Challenge of families – can be overwhelming, sometimes families think that the system will take care of everything – need a way to get buy in from families to share care
- Supporting caregivers – planning for those things that may happen to older family members – have resources to create family care plan/schedule, etc.
- Sharing info within family and with health care providers
- Supporting elderly relative who lives with family is a cultural tradition but can become too difficult at some point. This becomes distressing to the family if they feel responsibility. Need to ensure that caregivers are supported. –

Community Involvement

- Neighbourhoods are different now – used to be more aware of the needs of our neighbours – in Transcona – seems to be like that – neighbours helping neighbours
- Connect with others in your neighbourhood, who's in your neighbourhood, what are their needs, linking together, helping your neighbour

Socio-economic issues

- Financial challenges – lots of need, not enough dollars – lots of people could stay at home, but need more than what home care can provide

Addressing social isolation

- When you turn 65/70 – perhaps I might want someone to check in on me – sign up for list – for visiting or checking in on – visiting nurse or outreach – could be organized through Access Centre
- Companion/volunteer visitors – especially for those without family
- Isolated seniors, getting meal service but not eating – checking in, different home care workers, etc. keeping an eye and sharing information on how the client is doing
- Seniors without much family involvement, support
- Need for companionship, build trust, spend time, play cards, chat, etc.

Mobility issues

- Access in the home – will make it easier for client and home care staff (need to ensure wheelchair and hospital bed accessible)
- Transportation – need to address problems with Handi Transit – if family members not available, need to rely on Handi Transit (for appointments, shopping, socialization, etc.) – getting out is critical to staying happy, living longer

Information and help in navigating health services, supports, programs, etc. for seniors and caregivers

- Getting connected to home care at the hospital – with nurse, doctor, home care liaison, home care case coordinator, occupational therapist, physiotherapist, family, and me – was very good experience
 - Having everyone there was important – I was the reason that they were there
 - Felt cared for, looked after
 - This is great, really glad that they do this
- Need education and support to navigate the system
- Access Centres – provide links to community organizations and supports in the community – make them more accessible (hours)
- Aging person has a great variety of needs that need to be met – need to apply all kinds of resources to meet those needs – each person when they meet a certain age – have someone to help them meet their needs – shadow them – a paid position, 24 hours a day, keeps that person out of the hospital
- Someone who can direct you to the resources that you need, aware of your different health and social issues – confusing when there are many different things going on – case coordinator – for certain geographic area – aware of different resources
- Mobilizing resources and delivering – need more central hub of information –
- Community centre programs – many people unaware of what's available
- Preparing people for aging and what to expect, often people aren't interested until they are in the middle of and need the information

- Most of the resources that we need are there, it's just a matter of connecting people to them

Programming

- What about another service provided by volunteers to work with clients, that home care workers wouldn't do/or don't have time to do – meals, companionship
- Home based businesses that provide help to seniors – for those who can afford – volunteers to provide the same time of service that couldn't afford it – community org's are providing these services too
- Linking retired veterans with seniors – American program example
- Preventative side – at different ages – milestones – invite people to information sessions, etc.

Areas to improve in home care/health care services for seniors

- Home care – can max out on hours per week – need extra staff to assist with lifts, -- may need to look at increasing the max hours per client, in order that they can remain at home
- Add flexibility into the time allotment for home care – very brief – allow for flexibility of time allowed depending on need of the client at that time
- Depends on home care workers too – should spend time talking to the client
- What about when home care workers don't show up for their shift?
- When you age, you have more doctors, more specialists – need to ensure that care is coordinated, providers are aware of what each other is doing – electronic medical records - - avoid asking questions over and over
- Not all information is available to be shared electronically
- Bring notebook and write down what you learn at appointments, etc.
- Family physician should be at centre of care, ensuring specialists, diagnostics, etc. is coordinated with no duplication of service, etc.
- Nurses and doctors that go into homes – like public health nurse visits after babies are born – or, EPIC (emergency paramedics in the community) – some people cannot leave their home for care
- Patient-centred medical home – assign a worker, help explain what's happening with care, needs at home, specialists needed, etc. (US project)
- Could possibly work – through all phases of life, central point to access services

Housing

- In terms of efficiency and economies of scale – transitioning from single family homes to apartments – for buildings – could provide info sessions, health care, etc. share info on resources, etc.

2. **What gaps do you see that could make it difficult to successfully age in place?** (LHIG members participated in small group discussions)

Family support/involvement – challenges

- Disjointed resource coordination – especially when there is no family involvement

Community Involvement

- Creating a sense of community
- Value of a strong community

Socio-economic issues

- Low income – those receiving employment income assistance/government pensions – financial challenges
- Financial issue – especially renovating your home to make it more accessible – there are grants, only if you make \$24,000 or less
 - RAP program – provides \$16,000 each – which is okay if you are on a disability – need to remain in your home for at least 5 years

Addressing social isolation

- Isolation of communities (not easy to access services)
- Intergenerational contact and relationships to prevent social isolation – adult day programs with transportation
- Social supports – big gap – addressing isolation – otherwise there will be mental health issues

Mobility issues

- Lack of accessible/affordable transportation
- If you do not or cannot drive, other forms of transportation can be expensive (taxi), and many communities have poor public transport infrastructure.
- Mobility of services and equipment – having to leave home to get the essential treatments that you need
- Physical barriers - -house/apartment not equipped for aging, changing mobility

Information and help in navigating health services, supports, programs, etc. for seniors and caregivers

- Lack of information, available services not well advertised.
- Not knowing what's available – need for “service navigators” – someone who can guide you to what you need -- one stop contact point who can oversee all of your needs
- Handbook for seniors and their families – education, resources -- will increase awareness
- Lack of education – people don't know what is out there and how to access it
- Link to all information in one place
- Lack of awareness in public of programs – if they don' t know about them, they won't use them

Programming

- Lack of preventative programs and services
- Increased access to day programs.
 - Support Groups
 - Seniors programs
 - Chronic illness
 - Health and Wellness

Areas to improve in home care/health care services for seniors

- Local community health resource center
 - A “one stop shop” to access local health resources both public and non-profit.
- Culturally aware/sensitive support services.
- Decentralizing some types of services or treatments into more communities
- Big gap – communication between various health care providers and families
- EHealth – are all medical records available to all health service providers?
- Gap – doctors not embracing patient/family-centred care
- All medical files in US are available, no matter where you are
- Volunteers at doctors’ offices, hospitals, etc. that can help you when you are there – it is happening, but need more of this
- Welcoming environment
- Giving them time to explain themselves, what their needs are
- Home care – addressing medical needs and helping with house keeping
- Problem when home care workers don’t show up for their shift – what about having people on-call to replace shifts?

3. Key to helping seniors/those living with chronic conditions to age in place is:

- A relationship that is trust oriented – between senior and health care provider
- Access to resources (x2)
- Communication with family and health care providers
- Bringing services into the home
- Economies of scale in bringing mobile services to communities
- Centralized access to resources
- Getting communities connected to programs, in various ways, connecting people together
- Individual and defined yet flexible plans that include family members, health care and social supports
- Finding others going through the same thing, finding a support group – social connections – could be for elderly person or caregiver
- Meeting their medical needs first, then their social needs.

River East and Transcona Local Health Involvement Group

Continuing Care Strategy – Meeting Two Notes

Action Area #3: *Working together with health care partners to help people age in place*

1. Who are the key partners (individual, family, community partners, health care system, etc.) to help people age in place?

- Person receiving care/aging in place
- Home care coordinator
- Family members
- Social work might involved
- Occupational therapist
- Family doctor
- Home care staff - -nurses, health care aides, home care support workers,
- Person who could be assigned to watch over/mentor – could be a home care worker, companion – when a high level of support was needed
- Meals on wheels / meal support program staff, volunteers
- Community groups who provide support for daily living – laundry, etc.
- Friends
- Faith groups
- Neighbours
- Day hospitals
- Organizations that provide programming for seniors, etc. – like Age and Opportunity
- Good Neighbours Active Living Centre
- Volunteers – friendly visitors
- Heart and Stroke
- CNIB
- Canadian Diabetes Association
- Alzheimer's Society
- Language and Cultural groups – like Indian and Metis Cultural Centre, Francophone Centre
- Seniors groups
- Independent living facilities – seniors' housing blocks
- Veterans
- Financial services groups to help with taxes, investments, fill out forms – community financial services
- Legions
- Mental health organizations, counselors
- Addictions organizations
- Senior Resource Finders – provide information on services and help people navigate the services

- EK YMCA
- Seniors groups, senior-based volunteers
- Concordia pool, city of Winnipeg rec centres
- Community garden programs
- EK garden club
- Trails
- Library
- Bridge groups, etc.
- Transcona horticultural society
- RE and Transcona historical society
- Pain clinics
- Alternative health care = massage, acupuncture, etc.
- University of Winnipeg – free programming on Saturdays
- Handi Transit
- Taxi's
- Transit
- Volunteer drivers
- Grocery delivery, other shopping support – and volunteers to take people shopping
- Seniors buildings – buses, take people shopping, etc.
- Nutrition, dieticians
- Public trustee

2. What are your ideas for how key partners should work together?

- Helpful to have workshops all to brainstorm/discuss team meeting – what does collaborate mean?
- Data collection re: client's needs done prior to the team meeting to develop a plan for the patient/client, then can get the ball rolling.
- Assess needs & focus on ways to stay active/healthy/-wellness.
- Proper communication/sharing the needs that the person needs so everyone is aware.
- Find ways to connect family members who are not in the same location (i.e. out of town/province)
- Focus on what the objectives/goals are.
- Interview/assessment to find out what the goals are/objectives are.
- Identify someone who can oversee if changes happen (? homecare).
- Awareness of organizations that would play a role.
- Central Information Hub like, "311" by phone or online.
- Navigator
 - A meeting for key partners for that client - goal setting – list of things to do
- Better discharge planning
- Transitional points – “something has changed with needs” i.e. – hospital to home – to generate support.

Action Area #4: *Improving options for community-based housing as alternatives to personal care homes*

3. What elements (design, support, rental rates, etc.) would be critical in community-based housing as an alternative to personal care homes? (Consider single family homes, multiple units, supportive housing, assisted housing, etc.)

- Accessibility – renovations might have to be done – mobility in the home –like accessible bathrooms, handrails, ramps into homes, no stairs
- Income assistance/rent assistance
- Transitional – living space that can be flexible and accommodate changing needs and abilities X2
- Enough space that people can still socialize in their own space – still have space for medical needs – hospital bed, etc.
- Companion, home care workers, might be okay during day but need someone at night – to meet individual needs of the person – home care or privately hired
- Help with outside maintenance – shoveling, maintenance, lawn care – private, etc.
- Help with cooking and housekeeping
- Ability to keep your pet (any pet)
- Supportive/assisted housing – flexible so that people can stay longer and not have to move into a personal care home
- Adequate parking
- Located in area close to public transit
- Victoria life line

4. What are your ideas for innovative community-based housing options to enable seniors and those with chronic conditions to age in place? (Consider design, services, etc.)

- Co-op housing (single family dwellings)
 - Similar age, health, needs
- Live-in companion care (need more)
- Student assisted homecare
 - Student lives with person in need of care
- Matching immigrant families with seniors/ people with health needs (“adopt a family”)
- Take advantage of seniors’ knowledge (don’t limit companion programs to younger companions)
- Intergenerational activities – e.g. daycare centre with seniors’ housing or seniors’ day programs.
- Ethnic based housing options (not exclusive – clusters of small groups units in a multicultural)
- Co-housing – building an intentional community of people who want to support each other as they age.
- Providing financial incentive/assistance to choose community housing.

Action Area #7: *Using information technology to improve the quality and co-ordination of care*

3. How do you think we can use information technology (within the health care system and in the community) to improve quality and coordination of care?

- Importance of sharing information face to face – of lessons learned, health care services, etc.
- Resident monitoring tech programs to keep track of how people are doing in own homes – safety, falls, movement/lack of movement
- Development of a profile on each person on their needs - -medical, etc. – database – within health care system – electronic health records
- Software to review individual records – to look for people home alone who might be vulnerable – link up to community org’s who can provide services, etc.
- Database – would contact family if there is an issue – give approval beforehand – so that their health info can be shared with specific people
- Automated reminders for appointments, medication, etc.

4. What should we keep in mind when developing/using information technology to support aging in place?

- Universal platform, pharmacy.
- User-friendly; need someone to learn from
- Financial costs – subsidy?
 - Must be affordable – for low income
- What some consider an IT “Toy” – can make someone’s life more convenient/livable.
- Need education so it is accessible (i.e.) to know what exists and how to use it.
- “444” for seniors (like City of Winnipeg “311”)
- Do cost/benefit analysis to show installing these preventative IT measures would save WRHA money in long-term/overall
- Disconnect as seniors may not be able to use/learn how to use this technology
- Need to trust the system
- Narrow the gap
- Need better communication tool as “talk”
- Communication tools are better/easier for people to learn.
- Technology can be positive tool for helping with change
- Need to deal with privacy issues, especially if device get stolen or lost (thumbprint ID)
- Online version of “Seniors without Walls”
- Re-enactment “training videos”
- Comfort levels with technology monitoring – do not always assume that technology always makes things better

River Heights and Fort Garry Local Health Involvement Group

Continuing Care Strategy – Meeting One Notes

Action Area 1: *Helping people stay at home by investing in community supports and focus on wellness, independence, and restoration when delivering home care services*

1. What would have to be in place (family support, community support/ involvement, home care, other health supports) to enable seniors and people living with chronic conditions to age in place?
 - Keep in mind -- financial challenges, housing, mobility, support network, being a Newcomer, language and/or cultural barriers, personal health practices, coping skills, mental health and wellness, etc.

Changing society's perspective on aging

- Need societal shift – people are afraid to age – we need to celebrate aging
- Knowledge of seniors in our communities gets discounted – cultural views of seniors are negative – need to change this perception, cherish knowledge, elders
- Should be offering programs at universities geared to offering care, etc. to seniors – there needs to be more people trained to care for aging population
- Baby boomers generation – different than generation before – shouldn't lump everyone together

Family support/involvement – challenges

- Caregiver support – counseling services for them, need support from workplaces so that they can take time to help/support family member

Community Involvement

- Community mentors available – to sit with newcomers, seniors, to help them connect with supports in the community – lack of awareness of what's out there
- Utilizing natural support groups – natural groups form – large building – lots of seniors, about 80% elderly – don't know how to support one another – help each other out with groceries – informal support – natural supports in the building, but don't know how to formalize/structure it – get to know neighbours on the floor - -people helping each other out – if there was some way to help sustain each other, so they could age in place together (community development volunteer)
- Older neighbourhoods – with grocery stores, etc., people socialize, etc. – can be very supportive
- Newer neighbourhoods don't have that
- Seniors living downtown – no grocery stores
- Losing sense of community in neighbourhoods

- Need to proactively meet your neighbours – find ways to connect, can we identify “connectors” in neighbourhoods to support this? Would be part of supporting aging in place

Language and cultural barriers, Newcomer challenges

- Newcomers – lots of seniors in their homes, but no home care there – some families take responsibility – that maybe their culture, but they need extra support – especially need help/support for how to support their family member – taking for appointments, etc.
- Diverse cultures – challenges to provide services
- Older people should have a chance to have a conversation about what’s out there – family member with significant language barrier – wouldn’t be comfortable having people come into the home, maybe going to the temple, and sharing information in preferred language, or other community gathering place – sometimes afraid to ask for help from family, afraid to be a burden
- Interpretation services are available – like many other supports – people are just not aware of these supports and how to access them

Addressing social isolation

- How is mental health related to isolation? Lack of connectedness within in community.
- People are separate from one another in communities, don’t ask for support – very challenging environment to be able to work with re: supporting people to age in place

Mobility issues

- Getting people to doctors’ appointments, etc. can be big burden – mobile services to help with that – would be great

Information and help in navigating health services, supports, programs, etc. for seniors and caregivers

- Would be helpful to have some way that people could plan before others are making decisions for them – many people aren’t asking the questions, planning before they need support – especially if there are significant health issues, like Alzheimer’s, and they can’t speak for themselves
- Assume people want help at this point, need to have a discussion to see if they want support, if they decline – do we bring in social workers, etc. to speak to them
- Need central info place to go to for information about what supports are out there

Programming

- Viable community options – reliance on private industry to take care of some of this – private for profit versus community-based non-profit or government run programs

Areas to improve in home care/health care services for seniors

- Caregiver burden – cost of parking at CancerCare to support loved one – hundreds if not thousands of dollars

- Specific milestones – have had different discussions with parents, doctors – should doctors have an aging and health conversation with their patients at a certain age – health and wellness, aging at home versus personal care home, changes in physical/mental health, Alzheimer's, etc.
- Support for mothers with new babies – is exceptional – what if at certain points, milestones as we age – talks about what's available, phone number, etc. to access information, ask important questions to see how they are doing

Housing

- Seniors living in housing that they can't afford, and have to look at different options

2. What gaps do you see that could make it difficult to successfully age in place? (LHIG members participated in small group discussions)

Changing society's perspective on aging

- We treat aging as an event
- Gap – we need a process to help all of us plan ahead - -e.g. planning ahead of expected changes in how we live as we age

Socio-economic issues

- Nutrition, high food prices, affordable food = more health, food security
- Poverty – access to medication, transportation, health equity
- Macro/micro – macro poverty, health equity, poverty leads to most health problems, micro - -link up together, helping each other

Information and help in navigating health services, supports, programs, etc. for seniors and caregivers

- Info: communication internal/external to WRHA - -messaging not always clear, staff don't know about services – don't like "authority" in WRHA –Awareness of resources is lacking
- Resources available to everyone – gaps in knowledge
- Gap in understanding what people can access – do not know they can access many services without a referral

Areas to improve in home care/health care services for seniors

- Not just up to health authority – who do we need to partner with? To get services in place, incentives for businesses, idea of centralizing – takes services out of community, collaboration with services (in Sweden – this takes place – like snow clearing in winter)
- Preventative conversations about aging in place and healthy aging (standardized conversations/visits)
- Lack of advanced care planning
- Waitlists are long for a variety of diagnostic testing, surgery, and treatment
- Availability of home services – like mobile cancer treatments
- Home caregiving team on the same page – help people make their own decisions

- Understanding cultural differences
- We are too dependent on doctors
- Spending money for healthy aging rather than institutions
- Reallocate some resources at front end -- not only at the back end
- Need fundamental shift in leader's decision-making – policy in thinking about aging – need more global thinking amongst medical practitioners

Housing

- Housing – not built for aging population, no accessibility, stairs, too much to retrofit, part of building codes, able bodied bias
- Gap in versatility of recreation and housing options – need to continue to modernize services
- Landlord/housing awareness
- Continue to advocate for regulations re: accessibility, buildings, etc. – also need more inspectors

3. To me, the key to helping seniors/those living with chronic conditions to age in place is:

- Community champions
- Greater communication, sharing information about supports and resources available (X2)
- Support for caregivers (X4) – respite, transportation, training in how to care and support for loved ones
- Food security
- Collaboration – not just up to health authority, many shared responsibilities
- Preventative health and screening (X2)
- Open dialogue with aging community about what needs to happen
- Housing regulation and accessibility

River Heights and Fort Garry Local Health Involvement Group

Continuing Care Strategy – Meeting Two Notes

Action Area #3: *Working together with health care partners to help people age in place*

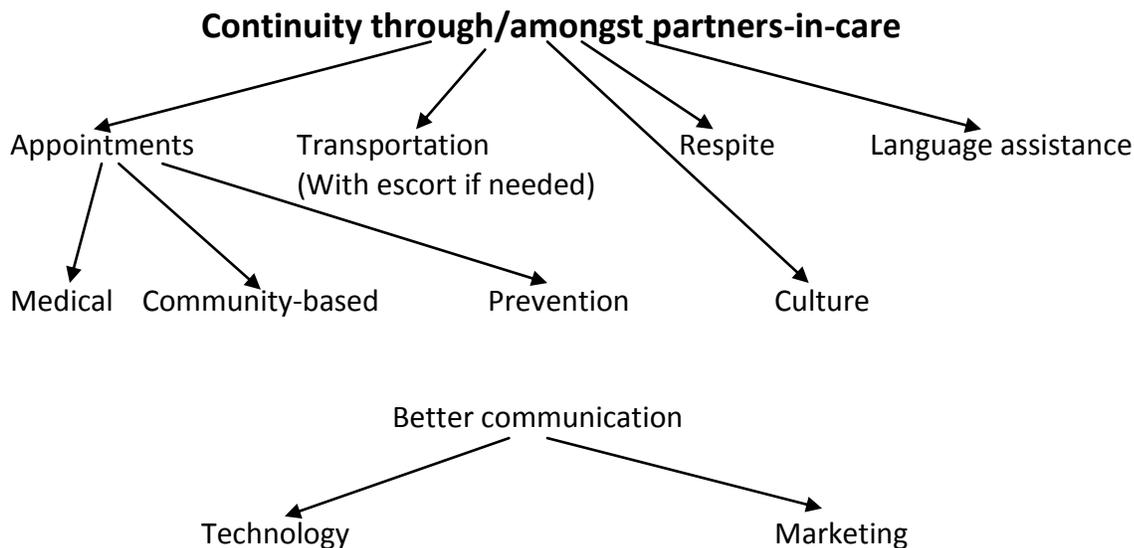
1. Who are the key partners (individual, family, community partners, health care system, etc.) to help people age in place?

- Individual – senior and/or person with chronic condition
- Employer
- Families – some families want to be involved, take leadership roles, and others don't – need to be flexible to both
- Health care professionals
- Medical services outside of health care system
- Handi transit
- Transportation – including taxis, buses
- City – accessibility of streets, sidewalks, snow-clearing
- Community oriented services
- Medical supply/equipment stores
- Pharmacist
- Architects – making indoor spaces accessible – making it a priority
- Spiritual care partners – temples, churches, mosques, etc. – programs, supportive environments
- Neighbours – some want to be involved, some don't
- Financial resources – departments – CPP, EIA, disability, etc., banks
- Financial services – accountants (income tax clinics, for example), budgeting, planning, etc.
- Landlords, building residency branches
- Members of Parliament, other political representative
- Addictions services
- Community Centres
- Engineers
- Residential tenancy
- Home care workers
- Food security – nutritionists (esp. related to learning how to eat for chronic conditions), community kitchens, etc.
- Non-profit organizations – in general in terms of advocacy
- Mental health counselors
- Volunteer organizations that engage seniors to volunteer in their communities
- Family doctors
- Geriatric specialists
- Nurses – public health, nurse practitioners, physician assistants
- Social workers

- Informal supports – friends
- Pets, pet therapy
- Optometrist

2. What are your ideas for how key partners should work together?

- Make a Facebook page (social media) to connect
- Needs to be coordination role – i.e. health care professional administrator
- More integrated system, database with an identification number, keeping track of services to avoid duplication
- Coordinated systems
- Changing mindset to be more collaborative/open-minded
- Team leaders – patient –centred care
- Keeping track/support, connecting people, being aware of services – aging in place program – not everyone would want/need this
- Advocator role – what are the needs of the clients/patients?
- Coordinator would work when person ready
- Role of family physician and team – physician assistant/nurse practitioner



- Like aging in place program – have kits, things you need to connect to services, making a plan for aging in place
- Aging in place advisor – more independent, can advocate for second opinion – can give them options, inform of services
- Respite – support workers to families to assist with doctors’ appointments, bed bug treatment – broad health issues and needs
- Having a working relationship, building trust between key partners – need to even out power between non-profits and health care and government

- Prevention – information on aging in place – healthy physical activity and nutrition

Action Area #4: *Improving options for community-based housing as alternatives to personal care homes*

1. What elements (design, support, rental rates, etc.) would be critical in community-based housing as an alternative to personal care homes? (Consider single family homes, multiple units, supportive housing, assisted housing, etc.)

- Non-profit org's – in general in terms of advocacy
- Mental health counsellors
- Volunteer org's that engage seniors to volunteer in their communities
- Family doctors
- Geriatric specialists
- Nurses – public health, nurse practitioners, physician assistants
- Social workers
- Informal supports – friends
- Pets, pet therapy
- Optometrist
- New home developments – every house should be designed to be accessible and flexible – for those who lose mobility – should be standard – both inside and outside
- Many people have to move into the city from rural areas – because services/support isn't available
- Personal space and privacy
- Put the “personal” into home care staff – more continuity

2. What are your ideas for innovative community-based housing options to enable seniors and those with chronic conditions to age in place? (Consider design, services, etc.)

- Funding to increase accessibility of homes, rentals
- Create physically attached infrastructure to accommodate transition through continuum (i.e. personal care home attached to assisted living)
- Full service “micro” communities – multi services within one building
- Updating building costs
- Avoiding redundancy in capital investment and duplication
- Location – not just where the next available bed is
- Long term spaces to accommodate different needs, groups
- Rural needs versus urban needs
 - More personnel, services, home care, care coordinator of access
 - More new infrastructure to meet growing communities (e.g. Headingly, Sage Creek)

Action Area #7: *Using information technology to improve the quality and co-ordination of care*

1. How do you think we can use information technology (within the health care system and in the community) to improve quality and coordination of care?

- Can only be done if there is a coordinator – to support people sharing health information, like blood pressure – with health care provider
- Manitoba e-health – built the systems – database, electronic medical records, e-charts, etc.,
- Remote health care services – video health conference with physicians – Could get care from home and link to physician
- Not all people will have ability/technology to enable different kinds of IT options
- Health Links/Info Santé – should be used more, especially seniors – good for privacy, if you have mobility issues
- Tools for monitoring loved ones – sensors that detect movement
- Temperature detectors that could detect fires
- Voice activated systems – for those with upper body mobility issues, sight impaired

2. What should we keep in mind when developing/using information technology to support aging in place?

- Promoting means of accessing technology (e.g. internet phones)
- High and low technology options (video conferences versus phone calls)
- Individual empowerment – know own health, navigating system
- Nurse practitioners/physician assistants as primary providers
- Make medical practices more current (electronic medical records)
- More visible and available assistive technology (e.g. lifeline, Siri like activation, automatic shut offs for stoves, etc.)
- Resource navigators – technology can be overwhelming
- Virtual navigators
- Privacy
- Individual differences
- Opportunities with public/private partnerships
- Keep in mind the importance of personal care
- Keep in mind people who are not first language English or French (cultural diversity)
- One database, all services communicating together under one identification number, file sharing
- Amended privacy laws so it's not hindering services (currently a big barrier)
- Involving youth as ambassadors/volunteers to helping aging population

Seven Oaks and Inkster Local Health Involvement Group

Continuing Care Strategy – Meeting One Notes

Action Area 1: *Helping people stay at home by investing in community supports and focus on wellness, independence, and restoration when delivering home care services*

- 1. What would have to be in place (family support, community support/ involvement, home care, other health supports) to enable seniors and people living with chronic conditions to age in place?**
 - Keep in mind -- financial challenges, housing, mobility, support network, being a Newcomer, language and/or cultural barriers, personal health practices, coping skills, mental health and wellness, etc.

Family support/involvement – challenges

- Family support – needs to be appropriate level of training on the health issues experienced by their elderly family member.
- Level of success or effectiveness of family caring for an individual can be dependent on the support that they receive – need effective communication between family and health care staff.
- Older couples – when a spouse is unable to continue to provide care, there can be consequences for the other – like cooking, etc.
- Idea of advocates – like social worker, case worker
- Need more hands on with senior than just once a year – when family is not there to take on that role. For those without families actively involved this is really important

Community Involvement

- Involvement of clergy/faith leaders – process where WRHA meets with faith leaders – WRHA would get wealth of info – issues relevant to members of their faith – get a dialogue going
- Involve/engage seniors by having such activities as "seniors forums", "seniors Q's & A's sessions", "seniors lecture series", "seniors meet and greet sessions", and "seniors decision making sessions with representatives from government, hospitals, personal care homes, et cetera". In other words bringing them physically to the table to become active participants to the entire process and items of interest to them.

Emotional side of aging/mental health issues

- Emotional well-being as well as mental health
- Need to recognize isolation, need for socializing – find ways to support and provide opportunities – might be cultural groups
- Mental health issues of men – aging related
- Gwen Sector – has staff who specialize in this area

Language and cultural barriers, Newcomer challenges

- Cultural, faith – dealing with people who are aging, with chronic illness, have suffered loss, etc. – often they find emotional well-being by going back to their culture, faith – perhaps need to engage the faith community about these needs in the population
- Family doctors who both speak different languages. Difficult for seniors to understand strong accents. Importance of having family doc that understands you and you understand them is critical.
- All of those aspects of communication, especially family members new to Canada with language barriers – don't understand what's going on – health -- staff need to have awareness of this – and those new to Canada need better information on how the system works, etc.
- Those with dementia/Alzheimer's often lose ability to speak English (if it is an additional language) so need to address this, language barriers
- Cultural groups for seniors – like Filipino Seniors Group, Gwen Sector– get information about supports, resources, etc.
- Can the WRHA more actively provide info to cultural, faith groups – put up posters, present/share information about resources for seniors?
- Need to be aware and sensitive of gender related issues for faith groups – re: caring for men/women
- Need to be sensitive to cultural differences – definition of family – need to be aware in order to provide the best care

Addressing social isolation

- Physical support, emotional support, and the socializing support element for seniors
- Socializing – has to be geared to the capabilities of the individuals – like the Day Hospital – senior had more in common with the staff than the participants – when we look at these programs, need to make sure that they are appropriate in terms of their abilities

Information and help in navigating health services, supports, programs, etc. for seniors and caregivers

- The process of connecting the seniors to the services that they need – neighbours without families – have been helping them – don't even know where to start to connect them – simplifying the process
- Don't know the questions to ask when you need services, supports
- Seniors groups could bring in speakers to share info about resources in community
- Asking students/volunteers from toastmasters to share info
- Depends on each group's leadership – not always open to new ideas, issues to discuss/sharing info, etc.
- Directory of services

Programming

- What options when seniors want more support – but, now only meals – need more support
- Programs, options for activities for seniors

- Faith groups – have seniors groups that do leisure activities (not always well organized, well programmed)

Areas to improve in home care/health care services for seniors

- Access to a variety of treatment modules – i.e. pain clinics, address sense of alienation and loneliness – different programs, maybe even by telephone, video conferencing
- Home care program needs to be reviewed – have heard that there are some gaps in services that they provided, that they rush through appointments. What about enhanced home care that meets emotional needs of clients.
- Better background checks on staff.
- More supervision of home care staff. Lack of flexibility re: meeting requests of clients.
- Ability of the health care worker to communicate effectively with the family is particularly important – attitude surrounding the communication.
- Health care staff will sometimes not share information because of PHIA – perhaps not aware that permission has been given to family member to receive health information.
- Would be good if home care staff could spend more time with clients – hurrying clients through tasks right now. Maybe need more staff.
- Part of the difficulty – if there is a shortage of workers, faced to do a lot within a short period of time – forcing them to push people along – impacts their dignity, beyond their ability to cope with that process – need to be flexible, and provide more time when needed based on the ability of the client
- Short term home care that you can get immediately to get you through short term health changes to support individuals at home with daily living activities
- Hospitals working hard to develop effective release to care program
- Transit time between home care appointments

Housing

- Appropriate housing – needs to be appropriate to their level of ability, their needs - - getting the right level of support will be key to aging in place

2. What gaps do you see that could make it difficult to successfully age in place? (LHIG members participated in small group discussions)

Changing society's perspective on aging

- Political reality – successful between public and politicians
- Values of seniors is diminished
- Communication around seniors is not valued
- Some cultures don't place a high value on caring for seniors

Family support/involvement – challenges

- By admitting one person to the hospital – what about the partner/the rest of the family - - leaving them vulnerable, if they don't know how to ask for help
- Supports for caregiver/sandwich generation, mostly women in the family

Socio-economic issues

- When did we get away from aging in the home? –
- Financial incentives to modify home to age in place – expenditures in general

Addressing social isolation

- Support network – especially elderly living alone – why don't they have a "neighbourhood watch" for seniors?

Mobility issues

- Handi-transit – mobility – what services are out there -- that are more appropriate for one's needs?

Information and help in navigating health services, supports, programs, etc. for seniors and caregivers

- Lack of knowledge of resources
- More communication around live in caregivers and immigration
- Accessibility of information/services for seniors
- When it comes to the health care system, a lot of people do not know how it works
- Knowledge of support systems and programs that are available – people just don't know what's out there
- WRHA could reach out to the individuals getting ready to retire and let them know what services are out there – not happening right now

Programming

- Edible food from meals on wheels – needs more variety

Areas to improve in home care/health care services for seniors

- More effective communication needed between stakeholders
- Better use of funds
- Prioritize the service and needs of seniors
- Payment for medication not covered by Manitoba Health
- Home care service (gaps)
- Being more proactive versus reactive – but there is no money to pay for it – focus on prevention
- More options for medical/health needs (e.g. "wish clinic" at Mount Carmel Clinic?)
- Communication issues — elders are afraid to speak up

Housing

- Arlington House facilitates spectrum of persons with different needs
- Upkeep/maintenance of the home to alleviate worry of maintenance
- Getting appropriate housing

3. Key to helping seniors/those living with chronic conditions to age in place is:

- Effective communication between providers, individuals, families, etc. – so that their efforts will work towards the improvement of the system (X2)
- To place a higher value on seniors – to put this value back
- Financial support – so that they can live at home longer – may cost a lot of money, and live unsafely because they can't afford – like modifications to their home (X2)
- It is far cheaper to augment a residence than to pay for the costs associated with caring for that individual in a hospital.
- Creating a respectful individualized care plan (X2) don't know what you need until the time comes – communication needs to be there when you set this plan up
- Access to information about services, etc. and supports available – in plain languages and in multiple languages so that the information is accessible (X3)
- For them to be able to have optimal care with minimal disruptions to their daily lives
- Support for the caregivers – that family needs support too – sandwich generation
- Cultural sensitivity – creates a sense of belonging – need to feel like you belong

Seven Oaks and Inkster Local Health Involvement Group

Continuing Care Strategy – Meeting Two Notes

Action Area #3: *Working together with health care partners to help people age in place*

1. Who are the key partners (individual, family, community partners, health care system, etc.) to help people age in place?

- Important partners – universities and Red River Community College– train health care providers, engineers, etc. – ensure in the curriculum, designing homes, uniqueness of aging for people with disabilities is addressed when providing services, training of lab tech, doctors, etc. – senior care important focus
- Housing developers – not currently designing homes to age in place – should be meeting about designing to meet needs of seniors –
- Province – building codes
- Family who has knowledge to communicate concerns about loved ones – what about those who don't have the awareness or means to access services, no advocates, -- if we're talking about partners in health care system – can we involve media – promote the services more?
- City of Winnipeg – any new development, infill – planning approval – they could ensure that new development, infill – certain % of homes would be accessible, provide tax breaks, etc.
- Pharmacists – home deliveries, prescriptions,
- Cultural associations – big source of support
- Churches, other faith groups
- Seniors agencies
- Neighbourhood watch program
- Neighbours
- Training for family members who take care of family members at home – so that they feel competent – health care partnership – region or MB health
- Programs/insurance to cover cost of home modifications
- Family – especially as an immigrant – if you sponsor parents – 10-20 years responsible to care
- Talking about best serving the individual – falls into the responsibility of the family – tremendous stress for the family – need process to recognize stressors of family – and then provide direction and assistance
- New housing journey – modifications for aging in place, programs for new immigrants - - maintenance and renovation
- Family doctor – would notice changes in health
- Respite home care should key partners
- Community clubs
- Friends

- Schools
- Age and opportunity
- Supports for the family – to give them support, vent, etc.
- Physiotherapists – visiting
- Home care
- Social workers
- Utilities – programs, city staff, etc. that interact with seniors
- Postal workers

2. What are your ideas for how key partners should work together?

- Policy statement for aging in place – cross departmental working committees, keep end goal in sight
- Change educational curriculums to address issues related to aging – for health care workers
- Open and honest communication between all stakeholders
- Be aware of statistics and trends
- Consistency of legislation and regulations
- Collegiality, respect
- Collaboration
- Identify office of advocate
- Schedule team (specialized care) meetings
- Central hub (like Cancer Care)
- Sharing of information
- Client-focused activities
- Social support for the individual as well as their families and other support system (like faith community, for example)
- Having families, friends encourage participation in activities

Action Area #4: *Improving options for community-based housing as alternatives to personal care homes*

1. What elements (design, support, rental rates, etc.) would be critical in community-based housing as an alternative to personal care homes? (Consider single family homes, multiple units, supportive housing, assisted housing, etc.)

- Accessible bath rooms
- Storage areas that accommodate freezers
- Laundry on same floor as living
- Ramps instead of stairs – eliminate stairs
- Wide hallways, door ways
- Heights of counters
- On-site home care – 24 hour availability

- Emergency push buttons
- Meal program that you can purchase
- Make sure that individuals and families are aware of and understand the range of housing options available – pro’s and con’s – how do you decide which is most appropriate? Education and communication
- Affordability
- security
- Location – to transportation, grocery stores, pharmacies, etc.
- Access to transportation
- Grocery store delivery
- Attaching new seniors developments to malls – grocery, medical clinics, etc. – can access without going outside
- Area for families to come and visit, multi-purpose room
- Better education about what services are available in your home – home care and other services
- Advocate – in community, building – to support seniors
- Office of an advocate for seniors – track trends
- Availability of leisure activities and ability to connect with others who have same interests
- Flooring versus carpeting
- Furniture design – appropriate for aging in place
- Supports to help with the development of seniors housing – like cooperative housing – help groups develop housing for seniors
- Cultural housing – for groups that don’t feel comfortable in “mainstream” housing for seniors, personal care homes
- Lighting and sound in the homes – for emergencies, etc.
- Doorbells – with options for making louder
- Recognize that some are for profit and some not for profit
- Review standards in legislation for housing design and delivery – seniors –ensure those standards are being met

2. What are your ideas for innovative community-based housing options to enable seniors and those with chronic conditions to age in place? (Consider design, services, etc.)

- Facilities surrounded by all ages and accessibility to all
- Paying guest – boarding house – group living, offered meals
- Walking clubs at malls
- Common room
- Natural lighting
- Ability oriented involvement
- Graduated assistance
- Seniors, aging oriented housing development (village concept)
- Self-directed care concept
- Ensure security

- Ensure affordability with quality and safety
- Socialization
- Leisure activities
- Transportation
- Location, location, location
- Opportunity for continuing learning on site
- Hobby shops (like wood working)

Action Area #7: *Using information technology to improve the quality and co-ordination of care*

1. How do you think we can use information technology (within the health care system and in the community) to improve quality and coordination of care?

- App that your health care providers have access to – appointments, prescriptions, etc. – notification system
- Cultural sensitivity app – health care workers could access to look up info
- EMR – update with new prescriptions, etc. – link to ERIK kit app
- ERIK kit – put on computer – emergency responders can pull on their computer
- Medic alert – should more affordable for seniors
- Use SKYPE for doctors’ appointments
- Better software program for scheduling home care workers
- Use Facebook, email, twitter to connect with others – for isolated seniors, use with health care providers too
- Victoria life line
- Technology – to use – if individuals fall, etc.
- Technology that can track various things to improve safety – automatic stove turn off, etc.

2. What should we keep in mind when developing/using information technology to support aging in place?

- Focus on the supports to use information technology – not appropriate to expect seniors to be tech savvy – this is evolving
- Lack of internet access – cost, lack of interest, lack of technical support (24 hour)
- In-depth consultation with stakeholders/key partners
- Meaningful technology – relevance
- Client-focused
- Most app developers – senior’s requirements are not a priority – may lack understanding /compassion
- Supports for learning curve of technology and support physical limitations
- Support for language differences
- Be sensitive towards individual’s privacy

- Education to technology/introductory course to technology – computer courses, manufacturing considerations
- Ensuring cyber security is built into any program for aging in place
- Cross generational links built into technology
- Age appropriate educators – seniors teaching seniors

St Boniface and St Vital Local Health Involvement Group

Continuing Care Strategy – Meeting One Notes

Action Area 1: *Helping people stay at home by investing in community supports and focus on wellness, independence, and restoration when delivering home care services*

- 1. What would have to be in place (family support, community support/ involvement, home care, other health supports) to enable seniors and people living with chronic conditions to age in place?**
 - Keep in mind -- financial challenges, housing, mobility, support network, being a Newcomer, language and/or cultural barriers, personal health practices, coping skills, mental health and wellness, etc.

Changing society's perspective on aging

- Social change – how we view caring for the elderly – currently – view that parents get older, go into nursing home – but, not an option for most anymore – need to change this, inform the public – changing the view to supporting elderly to age in place – more – moving in with family – seen more as an option again

Family support/involvement – challenges

- Family support – families start really want to care for loved ones in their own homes, often without the knowledge/skills to do so (like for dementia) – need more caregiver support – they get burned out very quickly – this will become more and more of a problem --need programming to help them with financial, care, and other areas – don't know where the resources are, how to manage multiple problems – need more free educations to support loved ones
- Support if there is no family, or if family doesn't want to be involved – needs to be paid workers to help – if there are cognitive issues – need trained staff – to help with activities of daily living
- Family support for aging individual – what if they don't have family, or family lives in another city – need info on maintaining health, access to services, like grocery delivery – support for the individual who wants to live on their own
- Should be regular scheduled time for caregiver (respite) to avoid burnout – should plan right away for this – from the diagnosis
- Financial ability of caregiver to modify home to adapt to needs of loved one
- Can be a financial burden for caregiver
- Need to support family member, help them feel comfortable – we should be educating families about how to address this issue, how they can be involved
- Ultimately the system will be looking to families to support aging in place
- Families may need to get information about how to watch for medication issues – not taking medication, etc. -- can include pharmacist in that plan

- Challenge of family supporting loved ones – with medical appointments, etc. --- support, ask questions, write down directions, etc. – issues with accessing information

Community Involvement

- Tap into your community – adopt a parent through school system, faith groups to provide support to caregiver
- Get young people involved from the school system (adopt a grandparent, for example)
- Used to have neighbourhood watch program – how can we involve people in the neighbourhood – to check in on elderly neighbours, get back to the community support, have tea, share baking, etc. –
- Door knockers – at seniors’ blocks – check on neighbours
- How do we do this in buildings/neighbourhoods that don’t have as many seniors?
- People tend to age together in their neighbourhoods – so they know each other and can connect with one another
- Building community, recognizing when an elderly neighbour needs help
- Block parties – should be seen as part of building healthy community

Emotional side of aging – fears, concerns

- What about seniors who don’t want any outside help – afraid of people outside of their family
- Fears – afraid of change, people coming in who are “strangers” – home care
- Before they get to point of having to leave their home – start talking about their options – where they might need to move to because of mobility issues, etc. – fear is a huge thing for many
- Emotional side of aging – feeling of loss, independence – not being able to drive and do other things that they used to be able to – have supports to be able to address that – losing their friends

Socio-economic issues

- Working poor, retired without pension – can’t afford good meals – even meals on wheels would be too expensive – should there be subsidies for this to ensure that they can eat properly?

Language and cultural barriers, Newcomer challenges

- Language – very important – seniors – may lose ability to speak second language (English) so they need supports to help them with language barriers (Francophone, Newcomers)

Addressing social isolation

- Men’s groups – from churches, etc. – to get men together for meals, socializing -- service clubs
- Like, computer courses – provide meals, can talk to one another, create friendships

Mobility issues

- Financial ability of caregiver to modify home to adapt to needs of loved one

Information and help in navigating health services, supports, programs, etc. for seniors and caregivers

- Gap – public doesn't know who to talk to, connect to get information about services, etc. – a navigator to help people connect to health and community-based services (social workers, for example)

Programming

- Adult day programs – a lot of really good ones – like Lion's Place – difficult for seniors who live further away to get to these programs – especially in the winter – Handi Transit issues/problems – need to work on providing transportation to get them to those programs – keep them active, connected, etc.
- Trying to develop programs – seniors helping seniors – just leaving the workforce – encourage to get involved when they are capable – to give back
- Meals on Wheels – fantastic program – people want meals, but mostly want interaction/conversations – for many there is no one in their life
- Congregate meals – in communities (not just seniors buildings)
 - Non-profit organizations providing programs, etc. for seniors

Areas to improve in home care/health care services for seniors

- Pathways – for home care (different streams – with family, without family, with community support)
- Needs of elderly – especially organizing/supervising medication where there is some dementia
- Need to be able to spend more time (home care, community services/ supports) with seniors – they really want that human connection, chance to visit
- Some seniors not wanting to share information – makes it difficult to support them – staff need to know that if the patient gives permission, they can share info with natural supports
- Pickle ball – very popular new activity
- Seniors papers – Age and Opportunity – provide info on services, resources, etc.
- Issues with discharge, trying to get home from being hospitalized at Deer Lodge Centre

Housing

- Housing – difficulty selling homes

2. What gaps do you see that could make it difficult to successfully age in place? (LHIG members participated in small group discussions)

Challenges in how health care/home care services are delivered

- Under-staffed, over worked health care workers
- Recruitment, retention, training – like dealing with difficult people
- Home care models – looking at models in different places, adopting “best practices”
- Case manager – network/interpreter/navigator/health care advocate
- Wellness centre – equity, accessible to people

- Bring activity to home care – virtual version
- Individually based by need – not happening right now
- Financial – home care – private services cost a lot – affording services that they need, want to keep their money for their kids

Changing society's perspective on aging

- Awareness is a gap – where the population is going? Are we doing enough as a society to prepare for aging population

Family support/involvement – challenges

- Lack of commitment/engagement of younger generations
- Cross-generation care
- Family and community
- Respite for caregiver

Community Involvement

- Need empowerment of community
- Lack of community gatherings
- Religious institution engagement
- Corporations could be petitioned to include aging populations in foundations for charity
- Banks and other institutions, it may be beneficial for them

Emotional side of aging

- Not feeling like seniors are contributing and being involved, this leads to depression and health issues

Socio-economic issues

- Financial challenges - -many without pensions
- Financial management/budgeting skills
- Socio-economic factors
- Financial abuse is a problem – banks need to be aware

Addressing social isolation

- Social support/interaction to prevent isolation

Mobility issues

- Mobility to programs

Information and help in navigating health services, supports, programs, etc. for seniors and caregivers

- Communicate – how our health care system works – what is out there, how do you get service, benefit
- Using pathways, navigation assistance
- Education – how to access

- Navigation tool – what resources exist?
- Foot care – making it common knowledge

Programming

- Caps on programs – i.e. day hospitals – can only attend to 8 weeks
- Senior programming
- Lawn/snow services
- Help – home maintenance supports
- Workshop tools – cooking for one, shopping on a budget
- Type or amount of programs may not be applicable/appropriate
- Society will have hard time sustaining good programs as population ages

3. Key to helping seniors/those living with chronic conditions to age in place is:

- Better understanding of their needs
- Having supportive relationships – whether it be family or someone else
- Improved working conditions to retain home care workers
- Important to make sure they feel that they are still worthwhile, self-value, feeling that they are still valuable
- Education for seniors and caregivers from everything from preventative care, caring for loved one, financial issues, etc. so that they can navigate the system better
- Communication and transparency – making sure we aware of how they are doing so that we can support them, provide care to help them – otherwise we don't know how they're doing, they become isolated
- A physical environment that supports their mobility, being able to care for something else – promotes cognitive dev., self-worth
- Knowledge and understanding of resources and of the process to access those resources – navigate and capitalize on what's there
- If person is cognitively able to contribute – make sure you are looking at everything from their perspective – patient-centred
- Going to centres like Reh-fit – for exercising, socializing across generations – for wellness – how can you make this more equitable? Should be centres like this for everyone

St Boniface and St Vital Local Health Involvement Group

Continuing Care Strategy – Meeting Two Notes

Action Area #3: *Working together with health care partners to help people age in place*

1. Who are the key partners (individual, family, community partners, health care system, etc.) to help people age in place?

- Family can really be considered a key health care partner – when people are aging in place/at home – as much as any other home care partner – can do as much or more than a home care worker – have to be brought in as partners
- Family need to be able to have an opportunity to be trained in the areas of care needed – develop skills
- Impossible for staff to replace family in personal care homes – families need to remain involved, in caring, looking after loved ones
- Non-government organizations – health organizations, charities – have grassroots approach, information to help keep people in the community longer – community partners – Canadian Diabetes, Alzheimer’s – and other organizations that support healthy aging – nutrition, exercise
- What about those who don’t have families
- Faith organizations – could provide spiritual support
- Aboriginal communities – chief and council – hire home makers to work with elders to provide services, support – community members – family, not family
- Universities, etc. to take classes – doing things to keep your brain active
- Physicians/all home care providers – change perception of aging, build more skills to care for elderly – medical students
- Dentistry – what about those without coverage, who can’t afford?
- Friends – social networks that people have
- The individual themselves -- keep themselves active – socially, keep involved, etc. – options available in the community – building a support system for when they need it
- Stores – grocery stores and other businesses – that provide supportive services to those who are aging in place – need to increase awareness of these services
- Need to ensure that people are aware of services, etc. available
- What about people who can’t afford delivery of groceries, etc.? Or can’t afford to go to gyms, etc.? Need to find alternatives so that people can utilize and age in a healthy way
- Financial advisors to help them get the best return on their income – to manage their retirement income, investments – options for remaining in home, selling their home, etc.
- Someone to help navigate/advocate for them – utilizing resources, etc., especially if there is some impairment – knowing how to fill out insurance forms, etc.
- Public safety – police, EMS – can promote healthy community – create safe communities for people to age in place, inform of scams

- Health Links/Info Santé
- Health professionals – pharmacists, dieticians, family doctor, optometrist, dentist, any professional involved in providing care/preventive programs

2. What are your ideas for how key partners should work together?

- Communicate often (always)
- Being aware of each stakeholder's role
- Dovetailing efforts; complementing versus competing, no silos
- Culture of collaboration
- Employing different ways of communication
- Systematize information through
- Creation of a model, not a new structure
- There's no such answer as "no". Let me find someone to help you.
- Protocol/line/channel of services
- Formal coordination for gathering and providing programs available within facilities and centre's
- Create a health care team for the individual and family members and professions
- Provide seniors with opportunities to be helpful and valued
- Mental health improves with physical ability
- Legal planning services
- Aging in place – begins when you are young
- Public trustee acts as an agent more specific and measureable criteria
- Portray seniors in a positive light in regards to aging
- Partners to include more than formal providers (i.e. family and friends)
- Promoting healthy lifestyles early in life with the intent to age in place and maintain a better quality of life
- Promote/advertise existing services
- Integrate with school system – i.e. offer credit for students working with seniors
- Private companies can promote the concept of retaining older employees as "consultants"
- Private services offered specifically to the elderly (competition would drive down costs)

Action Area #4: *Improving options for community-based housing as alternatives to personal care homes*

1. What elements (design, support, rental rates, etc.) would be critical in community-based housing as an alternative to personal care homes? (Consider single family homes, multiple units, supportive housing, assisted housing, etc.)

- A lot of the assisted living places are for profit – pay for services that you want/use – very expensive

- Flexible approach/choice in what services that you pay for – can choose instead of having to pay for more than they need?
- Have kitchenettes – so that people can do basic cooking if they choose to
- Intergenerational – younger and older people living together – can help each other out
- Healthy and tasty meals provided – in those housing options where meals are provided
- In own homes – people are not necessarily eating healthy – have the ability to have help with meal preparation – like community kitchens
- Visit-able homes – designed so that people in wheelchairs can visit --- age in place, people with less mobility can visit
- Accessible home - design – washrooms, etc. – everyone can benefit – young families with kids – strollers, etc.
- Amending building code – all 2 storey + buildings must have elevators
- Affordability
- If government sees a cost savings to keeping people in their homes – incentives to stay
- housing units need to address one’s lifestyle – flexible – need to be able to afford to make the modifications needed to stay in your home
- Building housing – close to transportation, stores, etc. – not in the suburbs – thought to where seniors housing is built
- Safety – feeling of safety in community so that they can get out into the community
- Access to transportation – restrictions with Handi Transit – need to address restrictions, improve flexibility, etc.
- Family supports
- Community supports
- Services like shoveling snow, cutting grass, etc.

2. What are your ideas for innovative community-based housing options to enable seniors and those with chronic conditions to age in place? (Consider design, services, etc.)

- Flexible options to include meals, laundry, and other types of services (like Kekinan)
- Combination housing – assisted to full care
- Provide accessible or onsite transportation in order to allow for people to access and utilize
- Intergenerational housing to promote well-being (adopt a grandparent)
- Smart housing with built-in technologies, Wi-Fi, etc.
- Assistive technology (voice command)
- Choice of urban/rural settings
- Equal access urban/rural
- Integrated care services
- Remote attendance – button to push, check in service
- Emotional and social support
- Set up “buddy facility” – 2 or 3 bedroom facility – sharing one house keeper
- Common room in apartment setting – can go to socialize
- Design new buildings with fitness facilities

- Community kitchen within it
- Suite on site for family/friends staying overnight
- Seniors living near schools so that there can be shared programming
- Grandma swim program in North End – can this be replicated in other areas?
- Sharing best practices – developing a system to do this
- Tax incentive to build a granny suite
- Policy makers consulting with the architect and engineer to get the best design

Action Area #7: *Using information technology to improve the quality and co-ordination of care*

1. How do you think we can use information technology (within the health care system and in the community) to improve quality and coordination of care?

- Tracking health issues of individuals and communication – using data to make more informed decisions
- Coordination between health care providers – pharmacists, doctors’ visits – tracking and trending – macro
- Protecting privacy and confidentiality
- Assistive technology – people with hearing impairment, visual impairment
- Manage health care staff who are providing services to seniors buildings, etc.
- Cable companies – provide information for seniors on a community channel –
- Kiosk access in lobbies at seniors buildings – computers for residents to use who don’t have computers
- Providing basic skills on using computers – Skype, Facebook – to stay in touch with family, friends – address isolation
- Video communication through Skype – health care visits, can assess how the person is doing , more personal, quicker than going to visit
- On-line hub – seniors helping seniors – post services, social opportunities

2. What should we keep in mind when developing/using information technology to support aging in place?

- Corporations to donate computers to seniors facilities
- Cost, affordability
- Ease of use, training for adult learners
- Privacy-protection against scams
- PHIA
- Assess needs for technology
- Assistive devices visual/hearing
- On-going evaluation of system
- Research experience of others using similar systems
- Consider how people access information technology – individually and as a group

- Developing system options – passive – getting information, active – engaging or managing information (patient and provider)
- Keep face to face contact -- checking in on people
- Tailor it to their needs
- Keep it simple
- Dashboard for seniors with relevant links/messages
- Software specific to seniors
- Familiar look and feel
- Seniors information technology or support centres
- Partnering with groups who offer courses
- Video series on YouTube – free
- How to market the idea of using information technology?
- What type of technology will best fit?
- Integrating technology into the living space
- Develop use, track technology to update health professionals
- Develop system to store data
- Develop technology to automatically collect and store data
- Find third party to develop and integrate technology
- Driverless cars
- Big learning curve – still many seniors not using computers

St James-Assiniboia and Assiniboine South Local Health Involvement Group

Continuing Care Strategy – Meeting One Notes

Action Area 1: *Helping people stay at home by investing in community supports and focus on wellness, independence, and restoration when delivering home care services*

- 1. What would have to be in place (family support, community support/ involvement, home care, other health supports) to enable seniors and people living with chronic conditions to age in place?**
 - Keep in mind -- financial challenges, housing, mobility, support network, being a Newcomer, language and/or cultural barriers, personal health practices, coping skills, mental health and wellness, etc.

Changing society's perspective on aging

- Stress the positives of staying home
- We need to do our own planning – planning ahead, think about what we will need to do as we age

Family support/involvement – challenges

- Connections, not just with the family – from outside, impartial,
- Family won't be there forever, so need to connect them to others – otherwise will end up having to leave home – only used to receiving care from family
- Many without family living close by – very difficult, can connect by Skype
- Struggle for families traveling to care for parents
- Experience with home care was very good, but parents wouldn't say when they needed something, needed help – really need family or someone who really knows you – to understand needs, etc.

Community Involvement

- Other cultures – could learn from those who honour their elderly
- Snowbirds going down to the states – something similar could be done – supporting one another, services close by
- “Uber” approach – handy man, shopping, transportation – volunteers who would respond to requests
- Foster program for children – what about foster program for seniors? Using part of your home, suite – would need proper training
- Different attitudes in communities about our relationships with others – like the elderly – helping a neighbour shovel their side walk
- Snow angels – help someone and shovel their snow
- Whole other layer that speaks to the culture of how we can better serve older populations – grocery stores, etc. – outside of the health care system

Emotional side of aging

- Importance of understanding mental health state of someone – they usually won't ask for help, really want social interaction

Addressing social isolation

- Many who don't have any support
- Animals and seniors is so important – companionship and comfort

Mobility issues

- Age and Opportunity – safety aid program – assess safety of home, risks, connect with organizations that can provide safety devices for reduced cost
- Modifying senior's home to accommodate family member to move in and help care for them

Information and help in navigating health services, supports, programs, etc. for seniors and caregivers

- Need someone to help advocate for them
- Knowing what's out there and where do you search for it – key
- Website where you can plug in your “variables” – age, pet, physical condition, etc. – and then it could show you the possibilities in your communities

Programming

- Neechi Commons – car share program – can call to get someone to drive you for groceries
- Banking can be difficult

Areas to improve in home care/health care services for seniors

- Access to home care – not aware that they can refer themselves, little info available on website, many do not use
- Should connect into home care earlier – integrate, get used to other support earlier – she can transition into the next stage when she needs it
- Reinventing home care – Netherlands – Free Press article – “neighbourhood care” – 10 to 12 people support neighbours who are seniors together with home care
- Medication – consistent and followed through on – need an approach to support that medication is taken appropriately – home care – come in and give medication with a cup of tea
- Blister packs for medication
- Home care needs to be a little more consistent – in terms of when they show up for appointments

Housing

- Many stay in their homes for as long as possible until they are physically unable to
- Conversion of garages to bathrooms or main floor suites – adapting your home so you can age in place, in Ireland
- Granny suites

- Rent out part of your home
- Importance of knowing policies of supportive housing, etc. – like allowing cats
- Transitioning from your home to a smaller place – what do you do with all of your stuff? Need to buy smaller furniture – costs, etc.

2. What gaps do you see that could make it difficult to successfully age in place? (LHIG members participated in small group discussions)

Family support/involvement – challenges

- Exploitation by family? A possibility; elder abuse

Emotional side of aging

- Mental health support needed

Socio-economic issues

- Aging in place – financial difficulties
- Disability funds often cut off at age 65
- You must reapply for old age and guaranteed income supplement – not everyone may know that
- Gaps/knowledge of what provincial/federal funding covers
- Gap – not having a plan of action, banking – banks have different policies

Addressing social isolation

- Isolation, hearing difficulties, lack of social connectedness
- Lack of support network (family, friends)
- If a senior is single and living in their own home it is hard to prepare and eat a meal for one person that provides all the nutrition needed on a daily basis, and they tend to skip the meal or eat the wrong things because it is easier with less mess. It is often cheaper also. When seniors lose teeth and it is too expensive to get dentures or bridges, they are not able to eat certain things and tend to perhaps eat more processed foods or certain groups of foods that again are not the best choices.

Mobility issues

- What about special needs – physical, mental disabilities – regardless of age? Housing supports and knowledge of these

Information and help in navigating health services, supports, programs, etc. for seniors and caregivers

- Knowledge of supports/opportunities
- Single access point with an individual answering the phone – gap – knowledge of services available for seniors, not knowing what services cost
- Gap – lack of awareness that a seniors guide exists

Areas to improve in home care/health care services for seniors

- Auditor General's report – inconsistency, pay of minimum wage a barrier to recruitment of good staff
- Considered intrusive by some patients
- Better training needed of home care staff
- Need for smaller workloads – tight scheduling
- Don't read files, just show up
- Mental health issues not understood by staff
- Flexibility – like laundry, underpaid equals lack of initiative
- Attitude of patients sometimes an issues, some reject homecare
- Language barriers that some staff have
- Re-evaluation of role of home care program
- Visit Minnesota - -see what they're doing
- Change job description – enable staff to use initiative
- Nursing – different from house keeping
- Communication – home care and hospital – difficult
- Eligibility criteria for home care and other services – are they too strict? People don't always fit into "boxes"
- Gap – awareness of need for health care directive
- Lack of back-up plan for home care services when situation arises
- National pharmacare plan – gap – should have one
- Coordination of services – needs to improve
- Proper and affordable dental care and nutrition counselling are things that would help seniors stay in their own homes.

3. To me, the key to helping seniors/those living with chronic conditions to age in place is:

- Addressing social isolation
- Accessibility to information (like seniors' guide) – services, information, etc.
- One point for information – where to start (X2)
- Access based on eligibility criteria to programs and services
- Ensuring that we address needs of people who fall between the cracks – especially those with chronic conditions
- Financial concerns (X2)
- High cost of medications and other medical devices
- Revaluing and improving home care

St James-Assiniboia and Assiniboine South Local Health Involvement Group

Continuing Care Strategy – Meeting Two Notes

Action Area #3: *Working together with health care partners to help people age in place*

1. Who are the key partners (individual, family, community partners, health care system, etc.) to help people age in place?

- Spouses
- Family – children
- Power of attorney
- Friends
- Local businesses – pharmacies, grocery stores – who deliver
- Banks
- 55+ buildings – supervisor, boards, etc.
- Tenant resource coordinators
- Intentional communities
- Churches and other faith groups
- Neighbours
- Neighbourhood watch groups – check in on vulnerable neighbours
- Postal carriers
- Transportation – Handi transit, taxi’s, programs that transport seniors and others to appointments – like Cancer care program
- Meals on Wheels
- Victoria life line
- Individual/ person who is aging in place
- Programs for seniors and others
- Adult day programs
- Community centre programming
- Volunteer centre
- Age and Opportunity – and other organizations serving seniors
- Home care
- Physician
- Physiotherapists
- interpreters
- Postal carriers
- Transportation – Handi transit, taxi’s, programs that transport seniors and others to appointments – like Cancer care program

2. What are your ideas for how key partners should work together?

- Community-based councils or teams – at the macro or community level – comprised of business, community organizations, faith groups – role – to identify needs of a seniors community and work to develop plans and address needs
- Define objectives – for example, good food, security, etc. – goals for the community and ways for everyone to participate (community development approach)
 - Decrease isolation, give meaning/purpose – importance of trusted/known person – business, etc.
- Communities of seniors with common characteristics – like widows – with similar needs – can have home/yard maintenance provided for group
 - Bring in same business to do work – affordable, trusted, known
- **Team – health care**, etc. – around the individual – everyone knows who’s involved – family, physiotherapy, massage, home care, etc. – need someone to coordinate
 - The membership of the team depends on the needs/circumstances of the individual – based on assessment – figure out who the key partners are at the particular time – membership can change over time
- **Community team**, based on what the members of the community need – maintenance, safety, shopping, transportation – to doctor’s appointments, etc. – social connections, meals, out for social events, etc.
- Team around the individual – identify costs for various services
- Goal – develop programs for community, keep costs low
- Key – to have coordinator – one of the members of the health care team
- Might not need coordinator – if there are clear roles/processes for the team to follow
- Community-based team – work together collaboratively without coordinator
- Involvement of the individual depends on their cognitive ability – they are in charge if they are capable
- Family and senior – doing long term planning is important – plan for changing physical/mental abilities – make adjustments to house or move to more accessible housing
- Community program – to advocate for vulnerable seniors without support to help transition from hospital to home – “somebody project” in Montreal is a great example of this – for those who fall through the cracks
 - Faith and/or community organizations can do this – in cooperation with the WRHA, hospitals – beds filled with people who weren’t able to move home
- Role of neighbours and friends in assisting those without family to support and advocate for them – shopping, socializing, moving into new home
- Volunteer program – connected to hospital – advocacy and discharge planning and support
- Be a good Samaritan!

Action Area #4: *Improving options for community-based housing as alternatives to personal care homes*

- 1. What elements (design, support, rental rates, etc.) would be critical in community-based housing as an alternative to personal care homes? (Consider single family homes, multiple units, supportive housing, assisted housing, etc.)**
 - Combination of private and public spaces
 - Range of rents
 - Regulation of rents – even private so that it will be affordable as you continue to live there
 - Special facilities, design features to keep people living with Alzheimer’s safe
 - Government support of some kind
 - Environmental – good ventilation, windows that open, free of mold, building materials, etc. without chemicals, etc.
 - Maintenance
 - Design features that minimize chance of falls – materials and design
 - Overall construction of buildings – should prohibit quick fire spread
 - Government regulations re: design, safety, etc.
 - Supervision
 - Opportunities for activities, meaningful ways to spend time
 - Visiting pets
 - Ability to have pets
 - Exercise options
 - Good visitor parking
 - Special training to handle seniors with complex needs, challenging behaviour (dementia, results of medication, etc.)
 - Social life – ways to connect with others
 - Good food
 - Entertainment
 - Security
 - Free internet – so they can use Skype, for example
 - Computer training
 - Visiting physician, nurse practitioners
 - Home care teams
 - Hairdresser
 - Mobile grocery stores
 - Visiting library
 - Meals and meals for visitors
 - House-keeping
 - Problem of seniors buildings becoming isolated from the rest of the community – ways to connect with the broader community – like schools
 - Snow banks in the yard for children to toboggan on
 - Bird feeders

2. What are your ideas for innovative community-based housing options to enable seniors and those with chronic conditions to age in place? (Consider design, services, etc.)

- Ground level access to own place (no stairs)
- Community-driven – interacting with people of all ages – all involved together
- Windows – to view all community activity
- Chance to have interaction daily
- Being actively involved with housing community – garden, cooking...based on ability and interest – based on purpose and value (not just sitting)
- Alzheimer’s community – ability to stroll safely in their community and doing something useful and interesting in own “town”
- Pharmaceutical companies – fund towards housing costs
- Seniors village – store, hair dresser, recreation, kitchen, sunroom, foot care, facial, pedicures, etc.
- Seniors cooperative
- Model like Manitoba Eastern Star
- Extra supports in current home
- Elevator – must have good fire regulations to get individuals out safely with mobility problems
- Having task to run “community” or “cooperative”
- Chronic conditions – people with similar conditions in same housing complexes to provide peer support – mental functions the same
- Seniors cooperative – like “Golden Girls” – supporting and living together in one home – own one house
- Accessible and safe housing – grab bars, walk-in shower, wide doorways, higher toilets, etc.
- Government regulations – private and public
- Safety standards – decrease falls
- Location – access outside to walk, nature-connection, coffee shop, garden, flowers, etc.
- Exercise class (based on evidence)
- Intentional housing – public and private spaces – for all ages – can be as small as 6 families or as large as 200 families – building a community!
- Connection with nature and animals, connection with farms (garden, chickens, etc.)

Action Area #7: *Using information technology to improve the quality and co-ordination of care*

1. How do you think we can use information technology (within the health care system and in the community) to improve quality and coordination of care?

- Chat groups strictly for seniors – could offer through assisted living, etc.
- Skype to connect people with relatives, friends to address isolation
- Skype and other social media to talk to banks, government, etc.
- Clearinghouse of information for health, home care, seniors services, etc. – under one number/website
- WRHA television network – at sites – info on services, etc.
- Log in – to check in on how relative is doing – keep track of medications, how her care is going – would have to sign off on PHIA --- keep family informed and involved – would reduce issues between family and care providers
- Universal electronic medical record
- E-chart to keep track of care provided, diagnostics, etc.
- Keep record of who has seen residents, etc. – esp. for those with dementia
- Closed circuit television – to film residents in social activities – would then show after dinner
- Program to remind people to take medication
- Voice recognition software to text, email, etc.

2. What should we keep in mind when developing/using information technology to support aging in place?

- Loosen privacy act (PHIA) – passcode to release information
- Simple usage – plain language, common terminology
- Clear instructions and explanations but include medical terminology
- Maintain professionalism
- Drop down menus - -quicker, easier to use
- Forms easy to use
- Health care beliefs – DNR
- Have national links to information in application – e.g. DNR, religious beliefs, contact information, medications, special diets, avoid repeating story
- Security – right of people to access
- Automatically saves
- Access own health record - -read only
- Voice recognition
- Empower patients to access information – e.g. blood work and watch trends
- Sit with provider to review updates electronically – immediate information
- Central way of utilization of system – flag those repeatedly going to different clinics/hospitals
- Monitor medication prescriptions – avoid duplication
- Privacy – not wanting al to see health record

- Program in diagnoses – flag medications that cause a certain side effect “alert”
- Sharing information specialists and family doctor to better coordinate care
- Support in training and education to patients in using technology – too much information may misdiagnose yourself
- Prompts – points of information – e.g. individual has multiple myeloma – prompts to support groups, related information, diet, exercise, referral, services, safety
- User friendly WRHA website – updated, organized, intuitive, search menu enhanced
- Automated email/message information targeted e.g. aging and related information – consent to subscribe to this
- Look at leading institutions and organizations
- Needs assessment targeted focus groups – “right thing with the right people”
- Available in different languages

Appendix A

Local Health Involvement Groups Backgrounder for Topic One:

“Winnipeg Public Perspectives on Potential Actions for the Province’s Continuing Care Strategy”

The Local Health Involvement Groups have been asked by the Board to spend two meetings (September to November 2015) providing their perspectives of potential actions for supporting healthy aging congruent with the Province’s Continuing Care Strategy. This topic was recommended by the LHIG Topic Selection Working Group, comprised of LHIG members, Board Liaisons, Senior Staff, and staff supporting the LHIGs.

In their 2014-15 year of meetings, LHIG members provided input into the WRHA’s 2016-21 Strategic Plan. *Planning for an aging population* was one of the top five priorities that members felt the WRHA should focus over the next 5 years. (See Appendix 1)

Background on Continuing Care Strategy (excerpts from the Strategy)

The Continuing Care Strategy was developed by Manitoba Health in collaboration with key stakeholders, such as provincial committees, government departments, regional health authorities, private agencies, community groups and health care providers.

It focuses on matching the needs of individuals and their caregivers with local supports. The goal is to help people avoid unnecessary loss of independence and maintain quality of life through premature admission to personal care homes or hospitals. Actions may also help build and support a more sustainable health care system. The population targeted in this strategy is seniors and those living with chronic illnesses and disabilities.

These are the action areas of the strategy:

Action Area #1

Helping people stay at home by investing in community supports and focusing on wellness, capacity building and restoration when delivering home care services

Action Area #2

Improving access to home care

Action Area #3

Working together with health care partners to help people age in place

Action Area #4

Improving options for community based housing as alternatives to personal care homes

Action Area #5

Ensuring there are enough long term care beds to meet the needs of Manitobans

Action Area #6

Developing innovative ways to deliver services to improve care for personal care homes residents

Action Area #7

Using special technology to improve the quality, co-ordination of care

Local Health Involvement Groups input on the continuing care strategy

Public perspectives and ideas of how to operationalize this strategy are critical. Some LHIG members are seniors; others are caregivers, family members, friends, and neighbours of seniors or of people living with chronic illnesses or disabilities. As such, your insights and suggestions will help ensure that programs, services, and supports will safeguard dignity, be flexible, and provide the appropriate levels of support so that people can live independently and have a good quality of life for as long as possible.

This input will be extremely valuable to decision-makers, planners and service providers within the Winnipeg health region and at Provincial tables.

How will your input be used?

- The LHIG report will be shared with the Board.
- It will also be shared with planning tables and senior leaders in various programs that provide support for the aging population and those living with chronic illnesses and disabilities
- The report will also be shared with other providers of services to senior in the community.

How you will be exploring and providing input on the continuing care strategy

First Meetings: (September and October 2015)

- Background on Continuing Care Strategy
- LHIG members to provide input on – Action Areas 1 and 2

Second Meetings: (November 2015)

- LHIG members to provide input on – Action Areas 3, 4, and 7

Final Report

- Presented to Board in January 2016

Meeting Agendas/Questions

First Meeting (September to October 2015)

1. Brief background presentation on Continuing Care Strategy and how input from the LHIGs will be used.

Action Area # 1: *Helping people stay at home by investing in community supports and focus on wellness, independence, and restoration when delivering home care services*

Questions for input:

1. What would have to be in place (family support, community support/ involvement, home care, other health supports) to enable seniors and people living with chronic conditions to age in place?
 - Keep in mind -- financial challenges, housing, mobility, support network, being a Newcomer, language and/or cultural barriers, personal health practices, coping skills, mental health and wellness, etc.
2. What gaps do you see that could make it difficult to successfully age in place? To me, the key to supporting seniors and those with chronic conditions to age in place is....

Second Meeting: November to December 2015

Action Area #3 *Working together with health care partners to help people age in place*

Questions for input:

1. Who are the key partners (individual, family, community partners, health care system, etc.) to help people age in place?
2. How can these key partners collaborate/work together? Your ideas?

Action Area #4 *Improving options for community-based housing as alternatives to personal care homes*

Questions for input:

1. What elements (design, support, services, affordability, etc.) would be critical in community-based housing as an alternative to personal care homes? (consider single family homes, multiple units, supportive housing, assisted living, etc.)
2. What are your ideas for innovative community-based housing options to enable seniors and those with chronic conditions to age in place?

Action Area #7 *Using information technology to improve the quality and co-ordination of care*

Questions for input:

1. How do you think we can use information technology (within the health care system and in the community) to improve quality and coordination of care?
2. What should we keep in mind when developing/using information technology to support aging in place?

Appendix B

Notes from AHHR Committee on Continuing Care Strategy – Action Area 1

Monday, November 25, 2015

Action Area 1:

- *Helping people stay at home by investing in community supports and focus on wellness, independence, and restoration when delivering home care services*

1. In your perspective, what would have to be in place (For example, family support, community support/involvement, home care, other health supports) to enable seniors and people living with chronic conditions to age in place? (Keep in mind -- socio-economic issues, housing, mobility, support network, language and/or cultural barriers, personal health practices, coping skills, mental health and wellness, etc.)

- Metis – continuing care, home care needs, -- Manitoba Metis Federation has done considerable work looking at this
- Research on aging in place in northern communities --- spells out community level supports missing – lack of support, issues with transportation
- People moving in from other regions to receive home care here – issues of home care workers providing care they are qualified to
- In community, less control over what they are doing – less consistency in workers, training and support, and in attention to detail
- Best scenario – one primary home care worker going in, developing relationship, understanding unique needs
- How can someone living by themselves, allowing people into their home, how can they control the situation, ask for consistency in staff?
- If home care client speaks up – it is perceived as a behaviour issue – or if others advocate for them –
- Lack of flexibility – if people not happy – why not org home care yourself?
- Home care has great potential – cc connect into the community – but doesn't happen smoothly – have to facilitate continuity – lack of flow across the continuum
- Eligibility for palliative home care – frustrating – based on time line – can't access when you are first diagnosed
- There are lots of positive things happening in the community – home care workers advocating for their clients
- People can get lost – gaps
- Maintaining memories – important – not just a mental health issue --there are neurological issues happening – creates risks in their own homes – lack of resources, specialization to diagnose and intervention in order to maintain memory
- Accessibility, patient quality care – disabled community being consulted on a variety of issues right now
- Hearing disabled, with mobility issues – neighbours complaining because of noise – can be misunderstood –
- Accessibility in housing is key – has dynamics that you wouldn't have thought of
- Lack of accessibility through apartments – into bedrooms, bathrooms, etc.

- Safety concerns – have to leave doors open for home care to access
- Could use key lock boxes – leave key inside – affordability issues, etc.
- Churchill – only one home care worker – language barriers experienced by some clients
- Need is there – only allocate so many hours
- Many home care workers are part time home care and part time personal care home care – try to take lessons from one to another – doesn't work
- The better the home care worker – the greater the chance you'll lose them to something else that is easier
- Churchill – social isolation/stuck at home because of lack of sidewalks – if you're disabled you can't get out
- Rules are very strict to get extra care
- Be good to see the WRHA prioritize home care workers – to value you them, to invest in them – they we feel invested in, supported
- Lack of accommodation, flexibility in providing care
- Many different tasks – have pound limit maximum – workers were making decisions about how or whether or not to provide certain care – lifting, etc.
- people's' conditions can vary – sometimes are better sometimes do much less well – especially when you have conditions like MS
- As soon as home care program find out there is a spouse – home care takes a different position – spouse is expected to most of personal care – a lot more stress put on families to provide care
- Caregiver burnout isn't monitored
- There is respite care – to give caregiver a break
- Can be a house of cards – waiting for it to fall – spouses sometimes not 100 per cent healthy, etc.
- If we're depending on family to provide care – they need to be prioritized as well
- Research on informal care giving – Metis – perspectives of family, paid caregivers, etc.
- Issues around mobility, esp. in the winter – sidewalks not cleared properly – because it's not safe – getting out, grocery shopping, etc. becomes very difficult – become isolated.
- If you're at home, home owner – issues with maintenance – accessibility, affordability of getting work done – there are some grants for emergency repairs – most people unaware of these

2. What gaps do you see that could make it difficult to successfully age in place?

- Incredibly difficult to get around in wheelchairs – gets icy, very difficult to move, even on slight inclines
- In smaller towns, might not have side walk issue – people know each other, recognize who is a senior and helps with things that they can't do for themselves – like shoveling snow, etc. – would be great to see this happen in neighbourhoods in Winnipeg
- Casual workers who go and shovel snow (Churchill)
- Support services to seniors – offer maintenance support to seniors in Winnipeg –
- Social enterprise ideas – work experience, assist seniors – pair up isolated seniors with social enterprise workers to assist with maintenance, grocery shopping, etc.

- Seniors who isolate themselves because they are afraid to go out with cane, walker, etc. – feel vulnerable – see themselves as possible targets when they leave their homes
- Issues with malnutrition – not cooking real meals, become malnourished
- Skin frailty can result in ulcers – lots of different issues – in hospital
- Importance of foot care and other prevention services

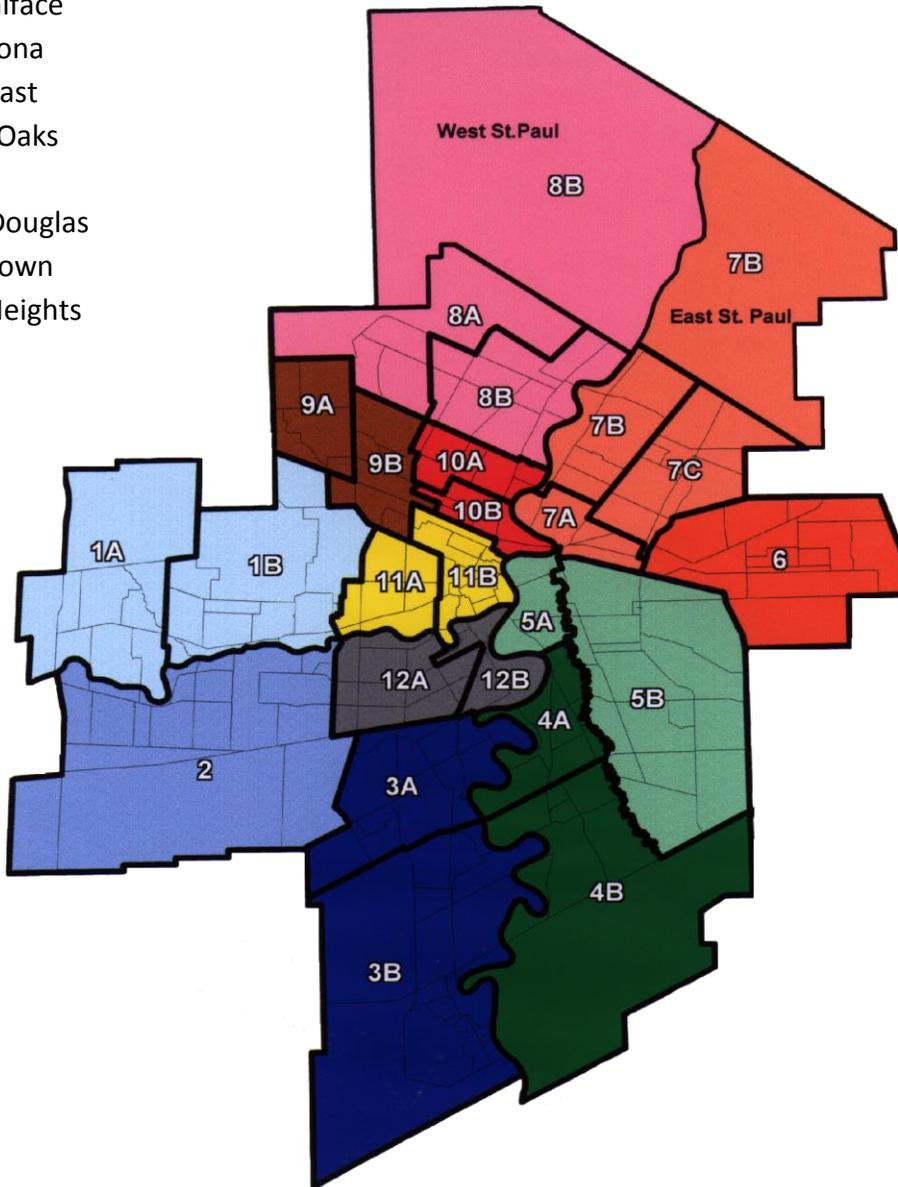
3. To me, the key to supporting seniors and those with chronic conditions to age in place is....

- Prioritization of the individual – that person is important, and them staying in the community is important – amount, type, consistency of services is key – if they are prioritized then care will be good and they will be able to age in place (patient-focused, client-centred)
- Enough resources and embedded in community
- Community wellness – community is part of the solution, along with extended family – redirect resources to keep people in their homes longer to help sustain the health care system
- Ensuring that there is proper resources allocated – supporting aging in place is a priority – do it well, otherwise they will end up back in the hospital if they are not adequately supported
- Includes spiritual community
- WRHA resolve concerns that individuals have – problems/barriers to aging in place – like the man who has to keep his door open in order for home care to come to his home – make sure that there is a solution, provide resources/support where necessary

Appendix C

Map of the Community Areas in the Winnipeg Health Region

- 1 St. James – Assiniboia
- 2 Assiniboine South
- 3 Fort Garry
- 4 St. Vital
- 5 St. Boniface
- 6 Transcona
- 7 River East
- 8 Seven Oaks
- 9 Inkster
- 10 Point Douglas
- 11 Downtown
- 12 River Heights



Appendix D

Acknowledgements
Members of the Local Health Involvement Groups
Board Liaisons to the Groups
Support Staff for Groups

Members of Local Health Involvement Groups 2015-2016

Downtown/Point Douglas Group

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Rob Santos
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Downtown/Point Douglas
River East/Transcona
River Heights/Fort Garry
Seven Oaks/Inkster
St. Boniface/St. Vital
St. James-Assiniboia/Assiniboine South

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