Winnipeg Regional Health Authority
Caring for Health

Office régional de la santé de Winnipeg
À l'écoute de notre santé

"The Provincial Continuing Care Strategy: Public Perspectives on Aging in Place"

Summary 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.

<u>Action Area #1</u>

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

<u>Action Area #2</u>

Improving access to home care

<u>Action Area #3</u>

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

<u>Action Area #4</u>

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.

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

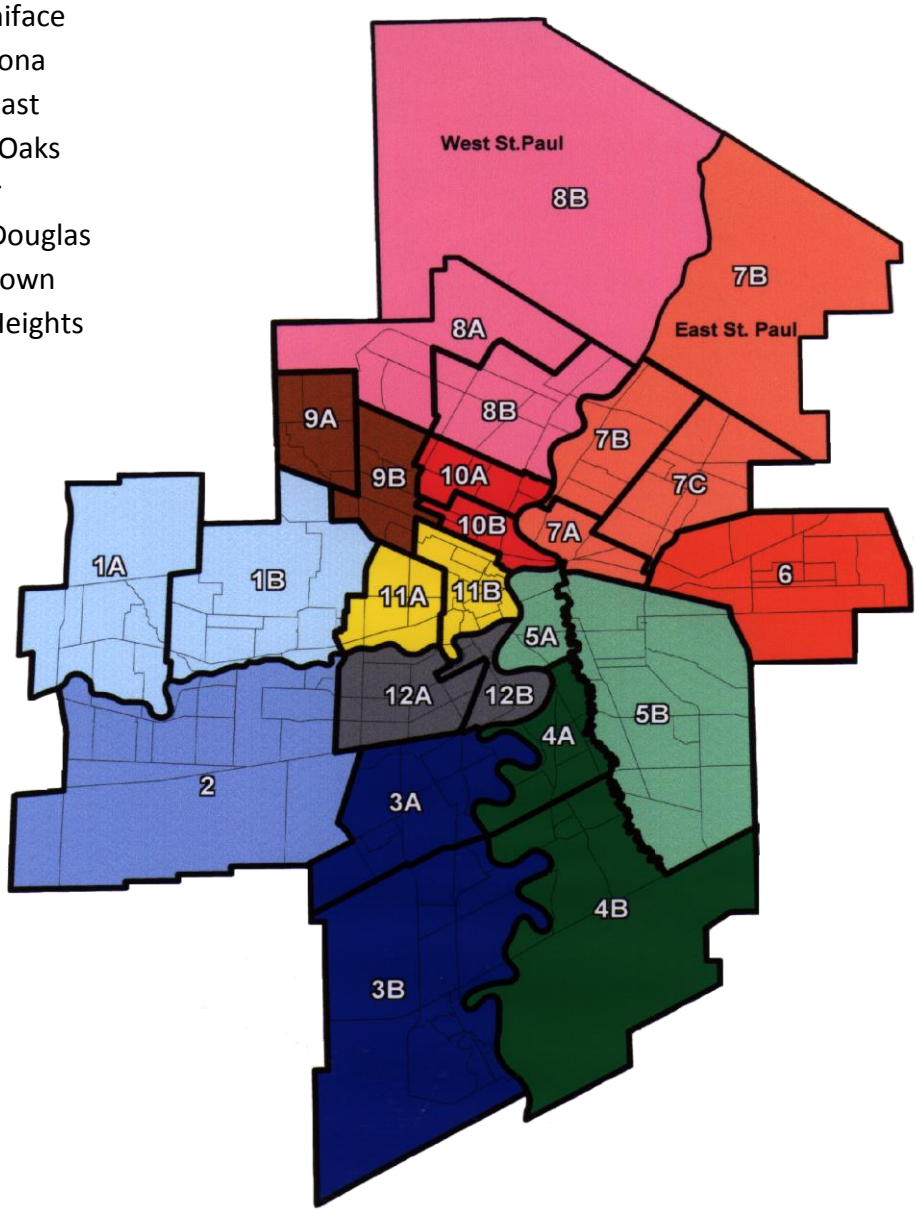
3. To me, the key to supporting seniors and those with chronic conditions to age in place is….

- 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
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