South East
LOCAL HEALTH INTEGRATION NETWORK
RÉSEAU LOCAL D'INTÉGRATION DES SERVICES DE SANTÉ
du Sud-Est

48 Dundas Street West , Unit 2
Belleville, ON
K8P 1A3
Tel: 613-967-0196
Fax: 613-967-1341

48 rue Dundas Ouest, unité 2
Belleville, ON
K8P 1A3
Tél : 613-967-0196
Téléc : 613-967-1341

Highlights of the Aging at Home Planning Session

Close to sixty participants, from communities across the south east, took part in a full-day planning session for aging at home on November 28th, in Selby. The session was hosted by the Frontenac-Kingston Council on Aging and the South East LHIN. The majority of seniors who participated in the October 11th Seniors' Forum were also able to take part in this second closed consultation session. All health care sectors were represented at the session, either through their organizations or networks.

The objective of this session was to look at the "how," i.e., at a concept and infrastructure designed to meet the guiding principle and seniors' priority for supported living services. The session was also intended to get the view and opinions of participants, as to which considerations should come into play when determining who should come first, and which needs/services must be met and what, for now, might not be in the basket of services. The session involved:

- An overview of what has happened so far and what inspired the concept and infrastructure for supported living;
- Presentations from:
  - Neil Allen, Program Coordinator, Independent Living Centre Kingston, on the ***Self-Managed Attendant Services – Direct Funding Program*** (funded by the Ministry of Health and Long-Term Care and administered by the Centre for Independent Living, in partnership with the Ontario Network of Independent Living Centres);
  - Lynn Moore, Community Services Consultant, Ministry of Community and Social Services/Ministry of Children and Youth Services, on the ***Special Services At Home Program***, administered and funded by the Ministry of Community and Social Services/Ministry of Children and Youth Services; and
  - Steve Antonopoulos, Area Counsellor, Veterans' Affairs, Kingston District Office, on the ***Veterans' Independence Program***, administered and funded by Veterans' Affairs Canada.
- Round table discussions, which focused on the following topics:
  - Determining whether an integrated care delivery model for aging at home makes sense in the south east.

- If we can’t afford services for everybody who wants and needs them, which considerations should help us pick who comes first?

- If we can’t meet every need and provide every service, which services are absolutely necessary and which ones, for now, could be left out?

The concept of having a broad range of existing service providers and agencies acting as access points to aging at home services, and having one of them act as a regional management centre to help coordinate and simplify service delivery was met with wide approval. Participants also liked the idea of a flexible, individualized program allowing seniors to choose from a menu of services, and of having help if they need it, from professional service navigators. They also felt that seniors living in rural areas, who are disadvantaged, living by themselves, are not currently receiving services, the most elderly and the frailest, should come first.

Below is a summary of the consolidated feedback from the session, organized by discussion topic.

First Topic: Determining whether an integrated care delivery model for aging at home makes sense in the south east.

Questions for Discussion	**Comments by Table**
The first topic for discussion included the following questions, as well as a discussion about strengths and pitfalls: o Seniors, can you see yourself using this model or arranging care for a loved one, friend or acquaintance? o Do you like the idea of having multiple access portals? o Do you like the idea of having a choice; of being able to self-manage your care or receive help with locating services?	Five out of eight tables, said yes to all questions. Tables 2, 5 and 7 said yes, and provided the following comments: o Table 5 said they could see themselves using this type of model to arrange care for a loved one, friend or acquaintance but also said that a need must exist. Perhaps there should be a “flag” or “trigger” once a senior reaches a certain age (perhaps 75), if there is a need for CCAC service or CCAC referral, if the senior has had a recent emergency room or hospital stay, or if there is a family concern. This group also liked the idea of multiple access portals, but said that lots of education would be required (e.g., through doctor’s offices, church clubs, and voluntary organizations) because the information must be widely available and user-friendly to book at their convenience. o Tables 2 and 7 raised concerns about having multiple access portals. They said that some portals may not have the critical mass and resources to apply to be a portal or to become one with new dollars. They thought that for some portals this would mean shifting to a new and potentially far away access

	point. A suggestion would be limit the number of portals or to make them mobile for ease of access. Another concern related to the level of cooperation that would be required among all service providers to establish multiple portals and the level of resourcing, training and education that would be required so that portal staff and the public understand the role of portals. They noted the importance of maintaining a standardized message and process, so that accessing services does not become overwhelming. o Table 5 liked the idea of being able to self-manage their care, but noted a potential for abuse and the need for a built-in quality assurance, so that this new system is not designed to save money but rather to improve the quality of life and safety of seniors. Table 7 also liked the idea of being able to self-manage their care, however they raised a concern about the potential for elder abuse. They also thought it was critical that seniors retain the ability to identify at what point they need to access the formal health care system (CCAC, hospital, etc.).

What strengths and pitfalls do you anticipate with this approach?		
Table	**Strengths**	**Pitfalls**
1	Strengths included: choice in the degree of help that may be needed; help is provided at the local level – from people seniors will know and trust – and it allows seniors to retain their independence.	Pitfalls included: the potential for confidentiality issues regarding the sharing of medical information and/or personal information; reservations from providers to take on regional management due to resources, monies, and adequate staffing; the amount of work involved in setting up a regional management centre; and the allocation of adequate financial resources. A point raised for further consideration included the need to advertise to allow seniors to know where to access portals (services may be "hidden" if advertising is done incorrectly).
2	Strengths included: accessibility, provided that there is a proper balance of portals (SE LHIN is a large geographic area and there is potential for lack of services in some areas, also elders have difficulty with transportation); choice, self-management,	A pitfall included the potential for abuse because of multiple portals (e.g., one senior visiting five portals to get more services). A point raised for further consideration included the dependence on service providers and their cooperation for the portals (e.g., doctors making time in their busy schedules).

	financial component, and designation of client as low, medium, or high, which will help to move the person through the system more efficiently. Points for further consideration included using postal codes as a way of organizing portal locations and the need for a built-in evaluation process to enable a reassessment of services and to gauge if seniors were well received.	
3	This table felt that this type of system would promote non-competitive flow, co-operation, and continuity, and that the concept itself was a really good idea, because it would allow seniors (particularly those with travel and mobility problems) to take advantage of "one stop shopping," thereby improving efficiency.	Pitfalls included: the "fudge factor" in the promised $17 million; the costs of setting up the program; the long-term sustainability, and whether aging at home would be cut after three years. This table felt that there may be a risk in relying on the volunteer sector and having volunteers going into seniors' homes without adequate training. Points for further consideration included: the cost of training; the potential for this program to become bureaucratic; the need for an on-going assessment of services; how we can augment the role of CCAC services and/or clarify roles vis-à-vis CCAC; and conducting a pilot project in rural and urban areas, prior to regional implementation.
4	Strengths included: empowerment for seniors; an increase in self-esteem, dignity, self control and independence, because of the different levels of support; no distance barrier, because of multiple portals; local portals would know their seniors allowing for a personal attachment, and seniors would feel more comfortable in their own community; takes into account the uniqueness of each senior (their needs and wants); increases the potential for seniors to come forward to ask for help, if they need it; offers consistency and flexibility, especially when	Pitfalls included: ensuring consistency across all portals, and the potential for lack of communication between clients and portals without proper advertisement; what it would cost to build the infrastructure; the potential for a lack of consistency, standardization and duplication of services because of multiple portals (with no single identifiable Aging at Home portal); and seniors being taken advantage of because they take on the risks that come with independence. Points flagged for further consideration included: avoiding complicated electronic answering systems; and the need for regional and local level education.

	people move (only the portal changes, not the plan) making individual plans portable.	
5	Strengths included: the system is local and accessible; and there is a buffer to retain seniors' independence and sense of self. This table felt that the program would offer more self-control regarding risk management and options.	Pitfalls included: the potential for abuse and the possibility that the system may become rigid and inflexible over time. A point flagged for further consideration included whether the program would allow for an increase in funding in situations where the need is greater or if more time is required.
6	Strengths included: proximity to community; and giving seniors the opportunity to direct their own care, determine what services they need and mobilize that "circle of care." This table felt that local portals could help to increase in the knowledge of services that currently exist. They felt that this model was an adaptation of the way that business is conducted in institutions and a step towards a truly "client-centered" type of care. They also felt that this model would encourage much-needed communication between professionals and seniors, and help to redefine the reliance on emergency departments.	Pitfalls included: the need to staff portals and for funding to train staff; how do we ensure that seniors know that these services are available. Points flagged for further consideration included a role for the Power of Attorney to self manage by proxy; a fee for this type of service; the possibility that this may lead to a two-tiered system; the long-term sustainability of this project; and values and expectations evolving for when the program is assessed in 5-10 years.
7	Strengths included: a locus of control to mental and emotional well-being; multiple options (but need to be clear about what is available in this basket of services); an improved quality of life; the potential to lower the rate of costs on the system and for emotional companionship. This table felt that clear communications would be of paramount importance so that the public is aware of the portals. They also felt that the need to simplify access and the onus that	Pitfalls included: the personal liability of seniors if they hire someone to prepare their meals or do outdoor work, and they are injured on the job; and how to properly train these individuals.

	this places on all service providers should be articulated as well, because it needs to be easy for seniors to access care other than aging at home services.	
8	This table felt that, done correctly, an aging at home program could reduce the duplication of services, offer better "coverage" across the region, increasing accessibility, and lead to the potential identification of ALL needs.	They cautioned that this type of program could get really big and expensive, and to start with one or two pilot projects.

Second Topic: If we can't afford service for everybody who wants and needs them, which considerations should help us pick who comes first?

All tables felt that the most vulnerable seniors should be given priority access to services. Considerations raised by discussion groups in deciding who should come first included the following:

- low income;
- low or no family or community support;
- frail elderly;
- geographically isolated seniors;
- seniors abandoned by caregivers;
- seniors with chronic diseases;
- seniors who have had previous problems with falling;
- seniors suffering from depression;
- seniors ineligible to other services;
- seniors close to requiring nursing homes or hospital care;
- seniors unable to go home after being hospitalized;
- seniors who do not currently receive services; and
- mutually supportive couples (services would benefit two individuals in the household).

Points raised for further consideration included:

- Difficulties in identifying the patient population because of people's changing needs.

- Ensuring that any new program does not duplicate or jeopardize existing services and support systems in the community.
- Additional funding should be available to seniors in rural communities, since fewer services are available and costs of service delivery may be higher.
- Everyone should have access to navigation assistance for aging at home services.

Suggestions included:

- Creating a common assessment tool outlining a set of objective criteria to determine the seniors that need help the most;
- Developing a needs assessment mechanism based on frailty, geography, socio-economic status, and co-morbidities to identify our most vulnerable seniors;
- Developing two categories of care: crisis/urgent need and the generally well, which we can help to keep in good condition.
- Building up public health services that promote good health and keeping people well instead of fixing the problem after it happens (would require a flexible system and the need to access formal and informal systems).
- Starting pilot projects in both rural and urban communities.
- Offering "packages" with different timelines regarding duration, for example, less funding over the long term and increased funding for time-limited high needs.

Benefits mentioned included:

- A needs-based priority setting of clients would identify what activities of daily living the senior can still perform (e.g., are they able to take their medications, is the caregiver healthy enough to assume that role).

Third Topic: If we can't meet every need and provide every service, which services are absolutely necessary and which ones could be left out?

Discussion groups felt that all services were critical, and would depend on individual needs. They felt that essential services, such as food, shelter, heat, and security, should be available to every senior and that additional services should be available and based on individual needs. Some groups felt that services that maintain mobility and activities of daily living, as well as services that increase access to social support and peer support, were essential. A couple of groups indicated that it was difficult to put forward a generic list of services, when each person's needs are different. Another group indicated that the following services be left out of the basket: general recreation; vacations; home adaptations; retirement homes; nursing homes; home maintenance (repairs); and security systems.

Examples of services to be provided included:

- Meal preparation/meals on wheels;
- A surveillance or check-in system to help with home care, such as friendly visits;
- Housekeeping, laundry, transportation and shopping services (including banking and paying bills);
- Grounds' maintenance and snow shovelling;
- Respite care;
- Monitoring medications, home assessments;
- Physiotherapy;
- Occupational therapy;
- Assistive devices;
- Personal care, such as bathing and foot care;
- Therapeutic social services for isolated seniors;
- Fitness and socializing;
- Self-care facilitators within small communities, retirement homes, etc., focusing on self help.

Points raised for further consideration included the following:

- New models for respite should be flexible and provide realistic alternatives to LTC and services not funded elsewhere that will promote independence.
- Personal care at home should include funding allocated for caregiver training and support, as well as money management.
- Piggyback services, if possible, e.g., combine meals on wheels with recreation/health promotion (e.g., a meal club program run by and for seniors).
- Efforts should be made to ensure that services are not duplicated with those provided by the CCAC.