# HEALTHY AGING ALBERTA
# NON-MEDICAL SUPPORTS DEMONSTRATION PROJECT

Healthy Aging Alberta

## REPORT TO THE COMMUNITY
## EXECUTIVE SUMMARY

April 1, 2022 to March 31, 2023

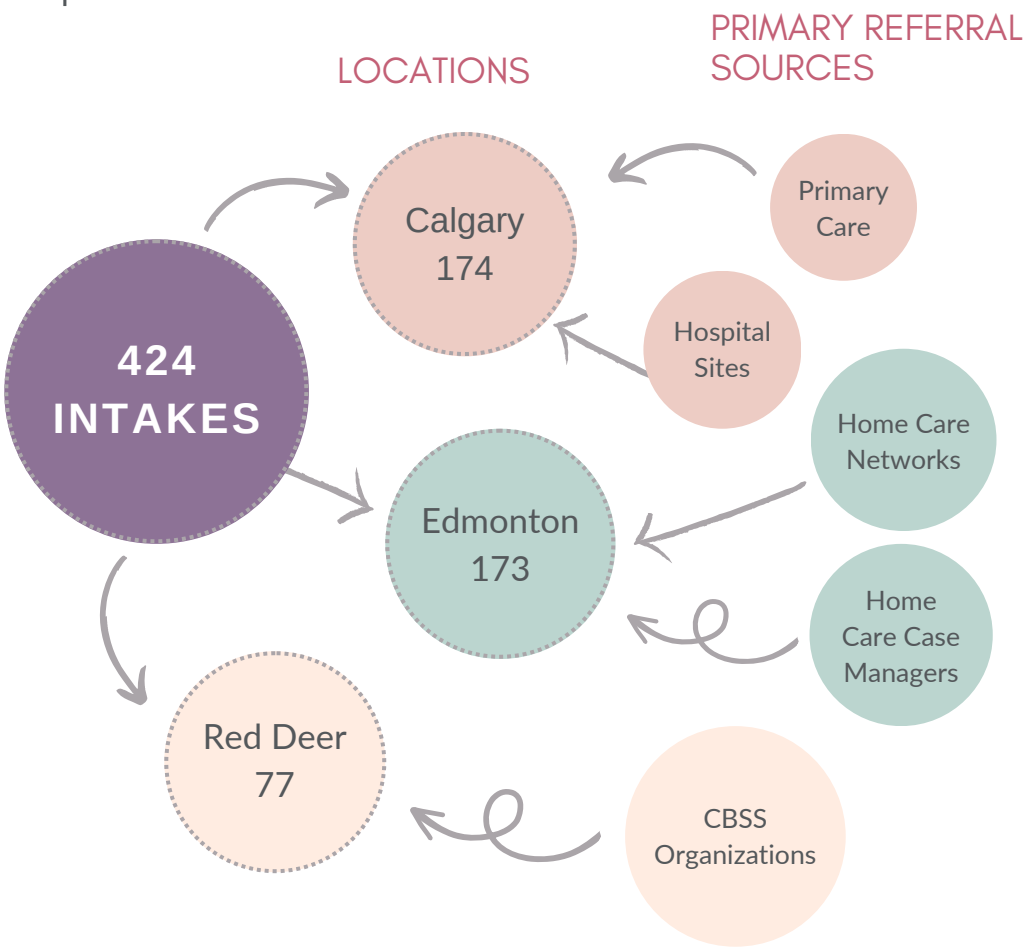
# INTRODUCTION

To support Alberta's health care system, Healthy Aging Alberta (HAA) (backboned by United Way of Calgary and Area) stewarded an investment in **three demonstration projects to provide non-medical community and home supports for older adults.**

The projects were in communities with:

- A high demand for health-promoting non-medical services.
- A high number of older adults and hospitals experiencing capacity challenges during the COVID-19 pandemic.
- Communities with high readiness where existing community-based organizations already leading the coordination of home and related community support services in their region were enabled to maintain and/or increase services.

This investment's regional and collective impact was assessed through a standardized data collection process established through a Community of Practice (CoP) named the Aging in Community Supports CoP that supported overall project implementation.




**Red Deer referrals were mostly from CBSS organizations due to challenges establishing new relationships during the short period of the project with health in Red Deer County.*

# GOALS

Support older adults to remain at home, either once they return home from being hospitalized or to prevent them from entering/re-entering the hospital

Develop a process for selecting existing investment programs, eligibility criteria, and reporting requirements.

Gather regional information about service demand and sector readiness.

Provide grant funding to organizations to deliver non-medical services and supports.

Build and/or strengthen relationships between CBSS and healthcare sectors.

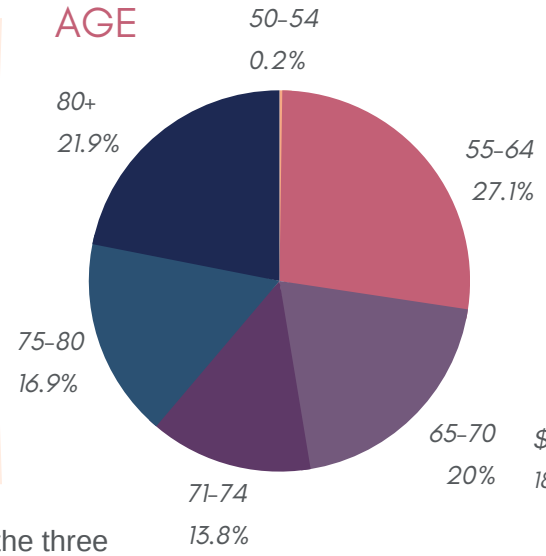
Establish referral mechanisms.

Develop a Community of Practice to support collaboration, share successes, and learn from challenges or barriers. CoP members have regular connection to government.

Most clients were **FEMALE** and **SINGLE.** **84 clients** indicated being an immigrant, refugee, visible minority and/or Indigenous.

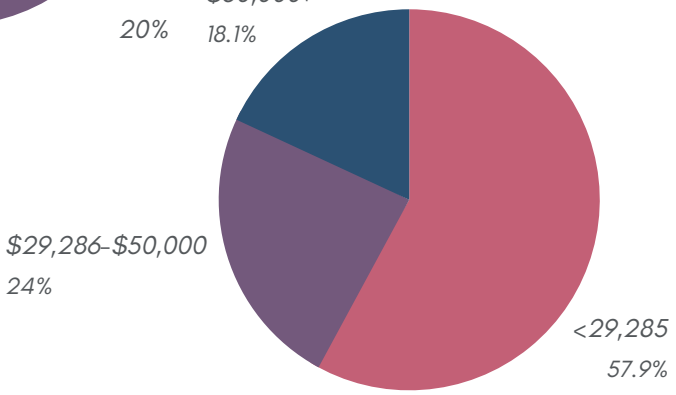
Of the 72% who reported income levels, the majority had an income of **less than $29,285,** and the majority were **receiving some form of financial support** (provincial and/or federal).

## AGE




*To provide services to a vastly underserved population, the project's age of eligibility was expanded to include older adults from 50 to 64 years.*

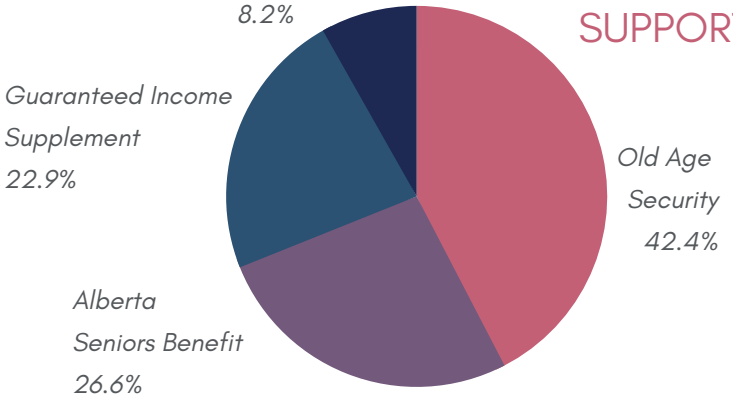
## INCOME




**HAA distributed $159,000** equally among the three communities:

- **Calgary:** The Way In Network collaborative consists of carya, JFSC (Jewish Family Service Calgary), Calgary Seniors' Resource Society, and Calgary Chinese Elderly Citizens' Association. The collaborative is a long-standing group of organizations providing home supports to older adults, and service delivery is provided according to geographic regions of the city.
- **Red Deer:** The Golden Circle Senior Resource Centre is a well-established seniors center and home and community supports provider. The scope of this project expanded their service delivery to Red Deer County, in particular, the community of Blackfalds.
- **Edmonton:** JFS (Jewish Family Services) Edmonton, Sage Seniors Association, Edmonton Seniors Coordinating Council (ESCC). The Edmonton collaborative was formed specifically for this project to more effectively reach the older adults who would benefit from coordinated supports.

## FINANCIAL SUPPORTS



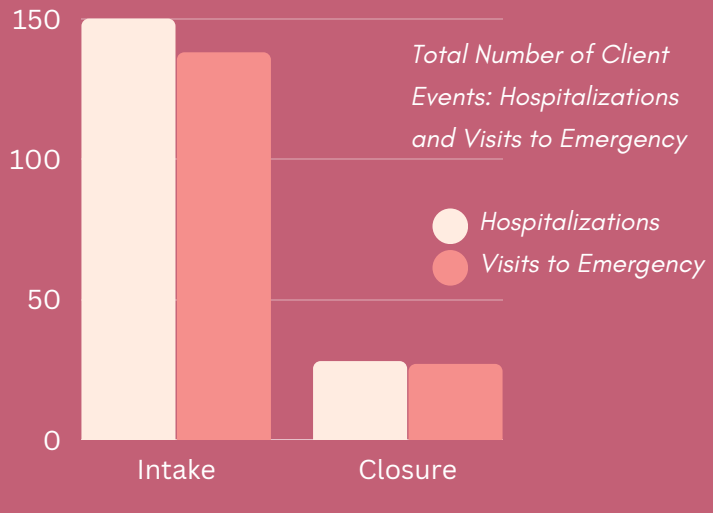

# OUTCOMES

### Hospitalizations and Emergency Room Visits

A primary outcome of this project was to reduce older adult hospitalizations and visits to the emergency room by addressing needs related to the social determinants of health through access to non-medical community and home supports.

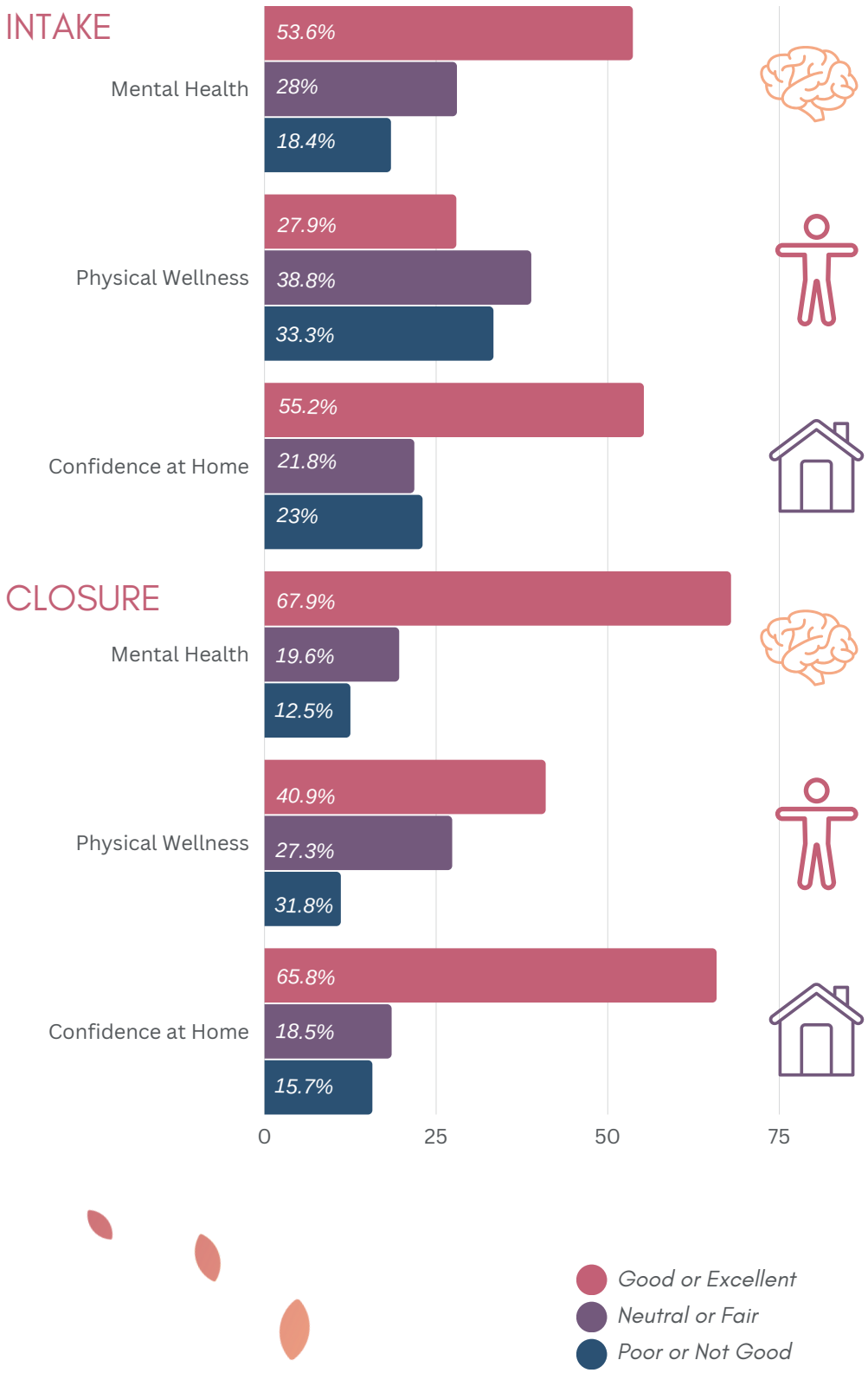
## TOP 8 SERVICES NEEDED

- **Food and Meal Delivery**
- **Housekeeping**
- **Help to Access Other Supports**
- **Housing**
- **Psychosocial**
- **Social Connection**
- **Access to Financial Benefits**
- **Assisted Transportation**



# FINDINGS

*From intake to closure, clients reported a positive increase in mental wellness, physical wellness, and confidence living at home. These are self reported values.*




## COMMON LANGUAGE

*The Healthy Aging Framework was used to communicate the impact of the work in the different projects using a common language.*

**Criteria:** Mental and Physical Wellness

**Impact:** Increased capacity to live independently by enhancing physical and mental wellness

**Criteria:** Confidence Living at Home

**Impact:** Increased ability to reside in the place that is appropriate for one's own circumstances

**Criteria:** Feeling Lonely or Isolated

**Impact:** Reduced rate of isolation and loneliness

**Criteria:** Quality of Life

**Impact:** Increased sense of purpose, belonging and ability to cope with change and life transitions

# CONCLUSIONS AND LEARNINGS

- There are limited services available for the 55 to 64 years of age demographic.
- CoP members shared that they increased their knowledge of this work in different areas of the province.
- All sites reported improved collaboration that positively impacted their practices.
- Involving frontline staff earlier in the process, particularly in designing the evaluation framework and increasing the success and overall standardization of the collection process, would be helpful as they provided valuable insights.
- Collaboration, shared goals with clients, and good communication between partners was constructive.
- Significant service gaps and inequity exist for older adults not living in an urban setting. Access to programs and services is far more challenging when clients don't have access to reliable transportation, natural supports, or the financial means to get to where programs and services are being provided.
- Overall, client outcomes improved, most notably their mental and physical health and confidence living at home.
- Hospital admissions and emergency visits decreased from intake to file closure.
- Project staff developed rapport with older adults participating in the project, thereby identifying needs and connecting them to relevant resources.

# MOVING FORWARD

Build knowledge base about services for ages 55-64 and identify the gaps in service for this age group.

Provide information sessions for frontline staff on resources frequently referred to.
Provide training and education for staff, specifically around mental health, addiction, and complex issues.

More supports for older adults living in rural settings to age in place.

Development of the Community and Home Supports Provincial Model will build on this initial data collection.

# FUTURE RECOMMENDATIONS

Based on the learnings, the Aging in Community Supports Community of Practice (CoP) recommends the following:

- Provide **sustainable long-term funding** to establish more stable relationships, referral mechanisms, and service coordination between health and social sectors.
- Resource the **time necessary for collaboration.**
- A project manager to help **coordinate communication between sites**, do targeted networking, and share information effectively.
- Ensure **adequate staff positions** are in place to address complexity with more support workers and dedicated case managers, especially for handling complex cases.
- **Raise the senior income eligibility threshold** so more older adults can qualify for benefits.
- Allocate **dollars for a crisis/emergency fund** to support clients experiencing emergencies.
- Create **specialized services for complex needs** such as hoarding disorders, dementia, and mental health issues to reduce wait times and costs.
- **Track individual client data** at the project level to capture individual client journeys for deeper analysis.
- Follow up and **track clients who leave/can't finish** the program to better understand hospital admissions and emergency visits.
- **Consider if the pandemic** and re-opening of services have impacted emergency visits, hospital admissions, and overall client health.