Healthy Aging Alberta (Community-Based Seniors Serving Sector) Non-medical Supports Program Final Report

Project Implementation: April 1, 2022 to March 31, 2023

To support Alberta's health care system, Healthy Aging Alberta (backboned by United Way of Calgary and Area (UWCA)) administered and stewarded an investment in three projects to provide non-medical community supports for older adults. The projects were in geographic areas with high demand for health-promoting non-medical services, a high number of older adults, and hospitals that experienced capacity challenges during the COVID-19 pandemic. Communities with high readiness where existing community-based services for older adults could be rapidly deployed were identified. Three collaboratives 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) that supported overall project implementation.

Community Selection and Investment

The ability to provide the highest impact for older adults to remain at home, either once they returned home from being hospitalized or to prevent them from entering/re-entering the hospital, was a critical consideration, given the capacity of hospitals during this stage of the pandemic.

Information about population demographics and hospital capacity was gathered from data provided by Alberta Health Services with data from Temporary Service Disruptions & ICU Updates, the Government of Alberta and the Alberta Regional Dashboard.

This background research and the criteria on sector readiness were combined to provide recommended communities for investment. Following the determination of appropriate community and organizational criteria, Healthy Aging Alberta designed an RFQ to source a consultant to facilitate the Community of Practice to establish a consistent approach across all funded programs and ensure all grant recipients collected data in a standardized manner to inform project outcomes.

Following developing selection criteria and identifying the top communities in need, Healthy Aging Alberta distributed $159,000 equally amongst three recipients in Calgary, Red Deer, and Edmonton.

The following organizations were involved at each site:

- **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 in Calgary is a long-standing group of organizations providing home supports to older adults, and service delivery is broken up according to geographic regions of the city.
- **Red Deer: Golden Circle Senior Resource Centre**
    - The Golden Circle Senior Resource Centre is well-established in Red Deer. The scope of this project expanded their service delivery to Red Deer County, in particular, the community of Blackfalds.

Edmonton: JFS (Jewish Family Service) Edmonton, Sage Seniors Association, Edmonton Seniors Coordinating Council (ESCC)

- The Collaborative in Edmonton was formed specifically for this project to more effectively reach the older adults that would benefit from this project.

Supporting Establishment of Referral Pathways with Healthcare

Each grant recipient was at a different stage of relationship development with healthcare staff, with a spectrum of experiences highlighted throughout the project. Calgary was able to advance further existing relationships, particularly with hospital and Primary Care Network sites and family physicians. Edmonton developed stronger relationships with Home Care and hospital sites, while Red Deer was building new networks with health care staff in Red Deer County that had not previously existed.

Each project site was transparent in sharing the successes and challenges of successfully building referral pathways with health care to take in older adults that appropriately fit the criteria of this project.

Community of Practice

Healthy Aging Alberta determined that a Community of Practice would be beneficial in supporting funded organizations by bringing them together and providing an opportunity to learn from one other about their specific programs and service delivery and share in the successes as well as learn from any challenges or barriers that were experienced through the project design and implementation phases.

At the start of the Community of Practice, the participants discussed giving the project a meaningful name that would describe the work they were doing and its relevance to older adults. The name chosen for this work was Aging in Community Supports.

This CoP met eleven times throughout the project, around two distinct areas: planning and evaluation development and implementation and learning. Participants and the evaluator helped to co-create data collection criteria through an evaluation framework aligned with the Healthy Aging Framework. Working from both frameworks provided data collection and reporting guidelines for each project and the opportunity to communicate the outcomes of the project by using a common language.

While healthcare staff did not attend the Community of Practice, the project participants regularly provided updates on the relationship-building occurring in each community with stakeholders in the health system, including hospital sites, Primary Care Networks, Home Care staff, and family physicians.

Each Community of Practice meeting was attended by a representative from the government, which was beneficial for the organizations involved to be regularly connected and allowed for meaningful conversations to elaborate on project implementation and receive immediate feedback, particularly around ensuring data variables were meaningful. Participants commented positively on the opportunity to build a more collaborative relationship between community-based senior-serving organizations and the government.

Data Collection Criteria and Results

Demographics

A total of 424 unique clients were supported throughout this project, with intakes completed for 173 older adults in Edmonton, 174 in Calgary, and 77 in Red Deer.

The initial mandate of the project was to serve older adults 65 years of age and older. However, it was determined that there was a significant gap in services for people aged 55-64 years, and as a result, this age demographic was included in this project. Due to this change, the most significant number of clients served (114 people, or 27% of all reported ages) in any one age category falls between 55 - 64 years of age, followed by the 80+ age category with 92 people, or 22% of all reported ages. Most of the older adults served (305 people, 73% of all reported ages) were still 65 and over. Furthermore, the project sites identified a need for more services for older adults aged 55 to 64. Overall, the intended priority target group was reached, as well as contributing to a recognized gap for the younger age group.

Age Range of Clients Reported at Intake

Site	50-54	55-64	65-70	71-74	75-80	80 +
Calgary	1	75	33	17	22	24
Edmonton	0	29	35	28	29	51
Red Deer	0	10	16	13	20	17
Total	**1**	**114**	**84**	**58**	**71**	**92**

Across all sites, most clients identified as female (207 people, 61% of reported gender) and single (174 people, 70% of reported marital status). Additionally, 49 clients indicated being an immigrant or refugee, 24 said being a visible minority, and 11 reported being Indigenous. However, only 20% of all clients said they were Indigenous, considered themselves a visible minority and/or were an immigrant or refugee. It should be noted that this demographic variable was optional, as were all demographic categories. This low level of disclosure may be due to discomfort in providing this information.

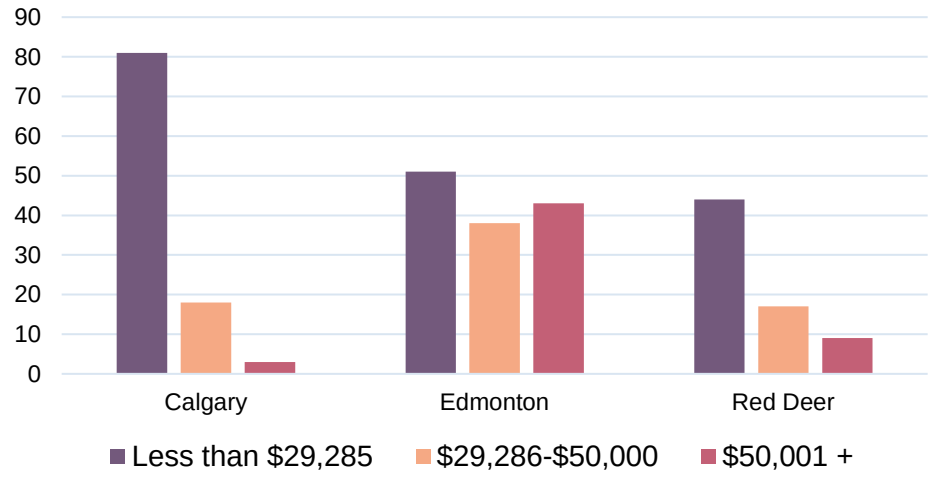
Gender of Clients Reported at Intake by Site

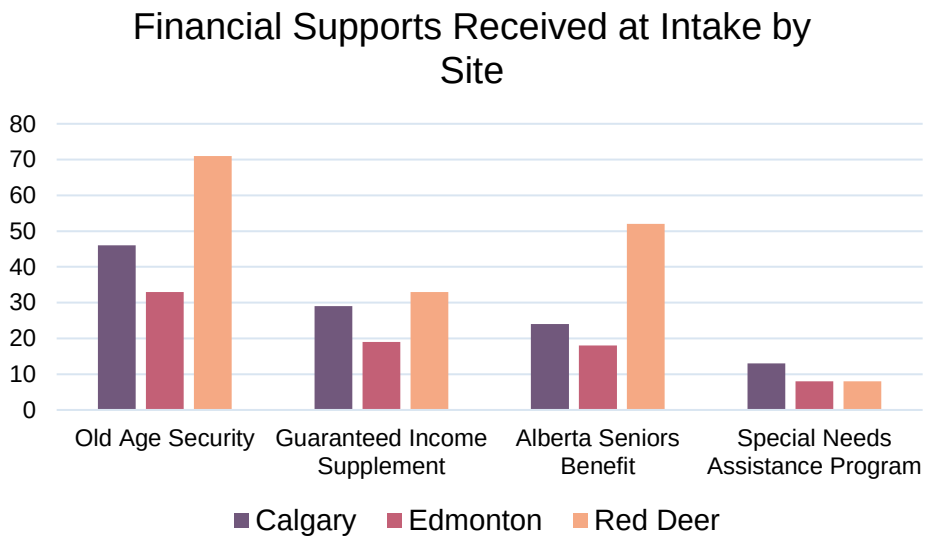
Site	Female	Male	Nonbinary
Calgary	56	40	1
Edmonton	105	65	0
Red Deer	46	30	0
Total	**207**	**135**	**1**

Marital Status of Clients Reported at Intake by Site

The level of income self-reported by older adults indicates that the majority of those served had an income of less than $29,285 (176 people, 58% of all reported). Old Age Security was reported as being received by 150 older adults (65% of total self-reported), and Guaranteed Income Supplement by 81 clients (35% of total self-reported). Additionally, 94 people (76% of the total self-reported) were receiving Alberta Seniors Benefit, and 29 clients (24% of the total self-reported) were using the Special Needs Assistance program.

Income Range at Intake by Site





While 72% of all older adults reported their income levels, only 55% reported receiving federal benefits, and 29% reported receiving provincial benefits. It is unknown whether those who did not state they were receiving either federal or provincial benefits were eligible and had not applied or were in the process of applying or if they chose not to report this data.

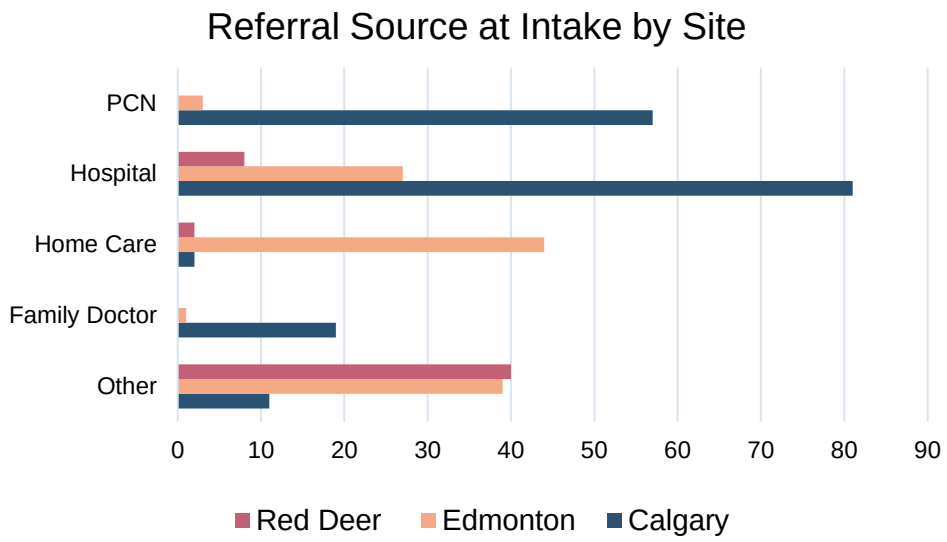
Referral Sources

One of the goals of this project was to build and/or strengthen relationships between the community-based seniors serving and the healthcare sector. In particular, the Project focused on older adults who were discharged from the hospital or may be at risk of being hospitalized or having to access the emergency room.

Each site faced unique circumstances regarding its readiness and ability to engage with healthcare providers. Calgary has well-established referral pathways with health, and they received referrals from health from the start of the project, in particular from hospital sites (81 of a total of 170 clients, or 47% of all intakes) and Primary Care clinics (57 clients, or 34% of all intakes).

Edmonton received most referrals from Home Care via Home Care Case Managers at Home Care Networks (44 of a total of 114 clients, or 39% of all intakes), followed by ‘other’ referrals (39 clients, or 34% of all intakes) which were older adult self-referrals.

Red Deer clients were mainly referred through the CBSS organizations, with 40 clients accessing the project this way from a total of 50 clients (80% of all intakes) due to challenges establishing new relationships during the short period of the Project with health in Red Deer County. Due to the Project being a new “pilot” and because that was not an existing relationship with The Golden Circle Senior Resource Centre, a referring relationship was not established before the end of the Project. This is elaborated on in greater detail throughout the final report.



Generally, there is positive evidence of leveraging relationships with local healthcare providers to identify and refer older adults to receive support through the project.

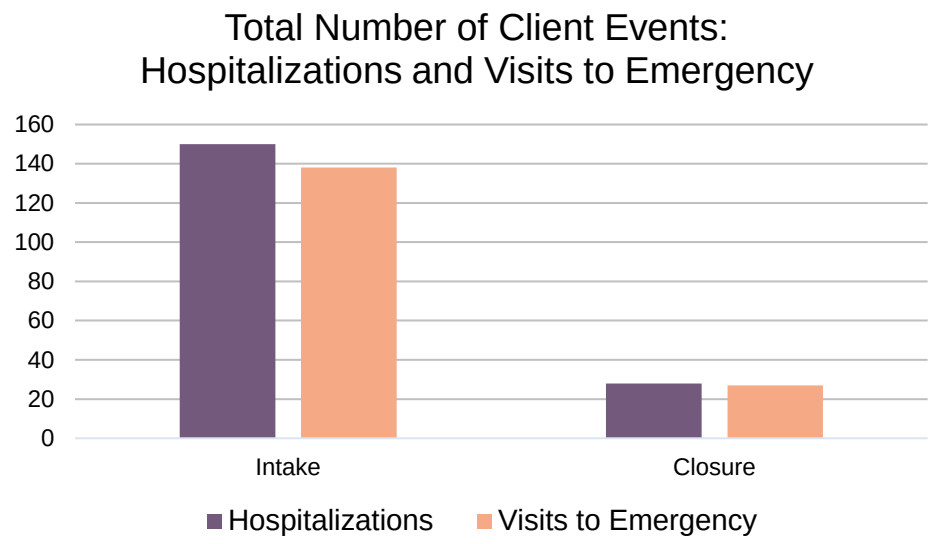
Hospitalizations and Emergency Room Visits

Another major outcome of this project was to seek a decline in hospitalizations and visits to the emergency room due to the provision of non-medical community and home supports.

In the six months leading up to their initial intake into the project, of the 424 clients that were enrolled, they had reported being hospitalized a total of 150 times and admitted to emergency 138 times. Note that a client may have been hospitalized and sent to the emergency room.

When the project finished, closures were completed with a total of 241 older adults. Of those 241 clients, hospitalizations were reduced to 28 instances, and emergency room admittances were reduced to 27 instances in the previous six months.

Total Number of Client Events: Hospitalizations and Visits to Emergency



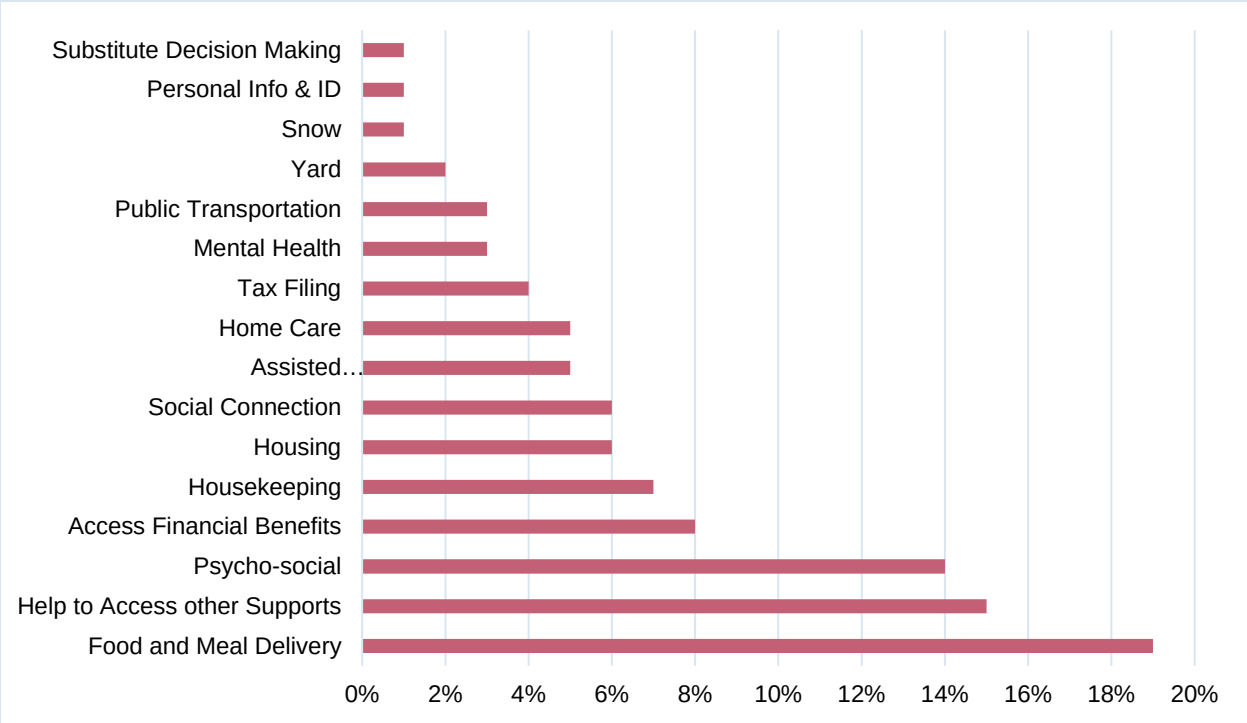
Community-Based Supports Accessed and Received by Clients

Evaluating the types of services requested and accessed by older adults throughout the project's duration is evidenced below. While a myriad of community and home supports exist to support older adults to live at home successfully, the ones noted in the chart were tracked explicitly as they were either directly provided by one or more of the sites involved or were determined to be beneficial in understanding the overall mental and physical wellness of clients.

Of the services that were tracked, the top five requested services by older adults are as follows:

1. Assisting with **food security,** including tasks such as meal prep and/or delivery, was the most requested service by older adults, accessed a total of 247 times, or 19% of all accessed services.
2. Providing **support to access other supports** that allow them to age at home was provided with a total of 197 times or 15% of all accessed services.
3. Clients needing **psycho-social supports** was the next most requested service for older adults, who received this service 180 times (14% of all accessed services).
4. **Accessing financial benefits** was requested 99 times (8% of all accessed services).
5. Older adults utilized **housekeeping** services 90 times (7% of all accessed services).

Services Needed to Prevent Hospitalization and/or Facilitate Discharge – All Sites



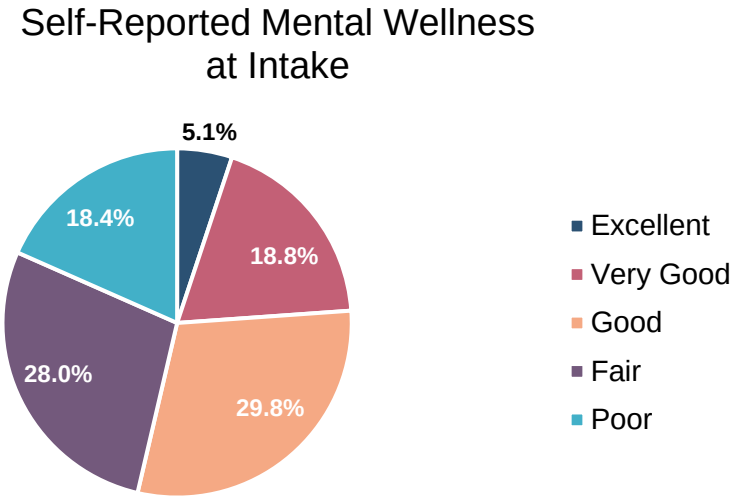
Outcomes and Connections to the Healthy Aging Framework

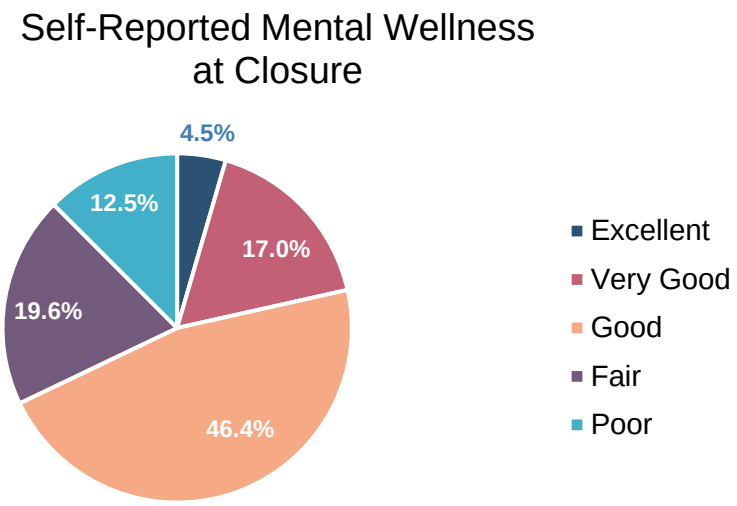
Project sites were introduced to the Healthy Aging Framework, and the following Impact statements contained within the framework aligned with evaluation criteria to determine the outcomes of this project:

Project Evaluation Criteria (self-rated by clients)	Impact
Mental and Physical Wellness	Increased capacity to live independently by enhancing physical and mental wellness
Confidence Living at Home	Increased ability to reside in the place that is appropriate for one's own circumstances
Feeling Lonely and Isolated	Reduced rate of isolation and loneliness
Quality of Life	Increased sense of purpose, belonging and ability to cope with change and life transitions

Mental Wellness

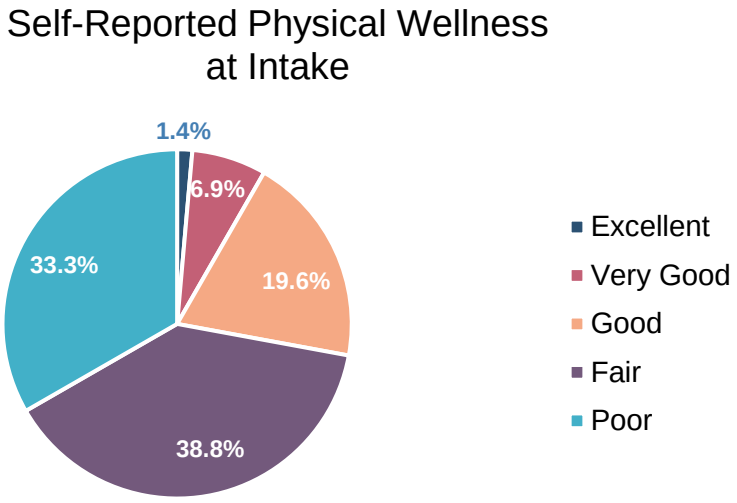
From intake to closure, clients' positive mental wellness ratings (excellent, very good or good) increased from 53.7% of self-reported responses to 67.9%, and their negative mental wellness ratings (fair or poor) decreased from 46.4% of self-reported responses to 32.1%. These numbers represent the percentage of total clients (at intake or closure who rated their mental wellness).

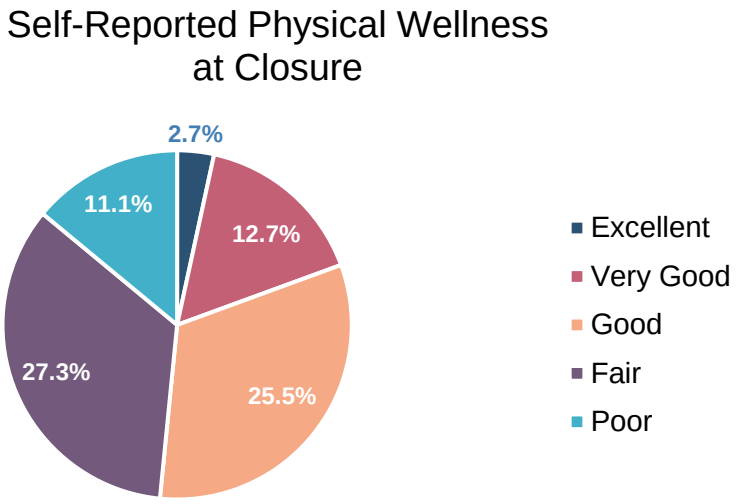




Physical Wellness

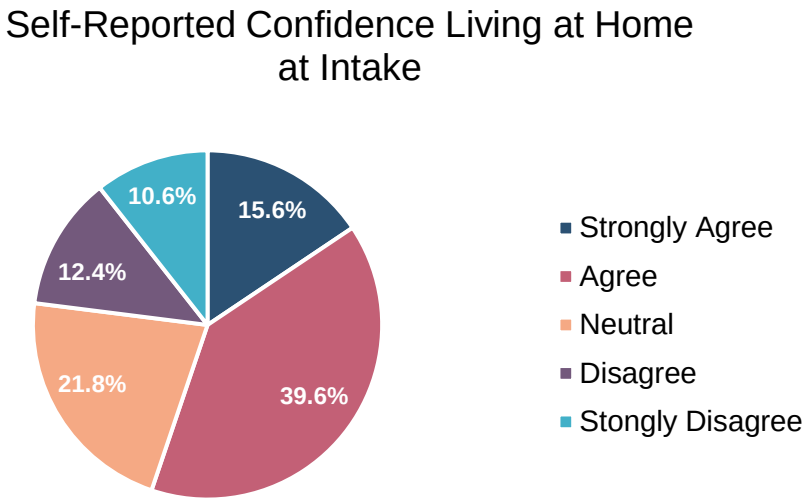
Clients' positive physical wellness rating (excellent, very good or good) increased from 27.9% of self-reported responses at intake to 40.9% at closure. In comparison, their negative physical wellness rating (fair or poor) decreased from 72.1% at intake to 59.1% at closure.

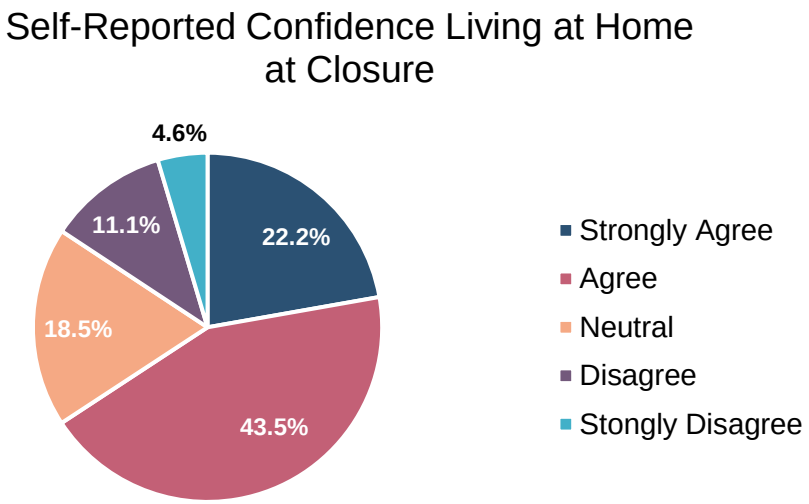




Confidence Living at Home

Clients' self-reported confidence in living at home improved from intake to closure, with positive confidence in living at home (strongly agree, Agree, Neutral) moving from 77.0% to 84.2%, and negative confidence in living at home (Disagree, Strongly Disagree) trending downwards from 23.0% at intake to 15.7% of self-reported clients.





Conclusions and Learnings

The programs and services provided by each site are noted to have had a positive impact both on the decrease in hospitalization and emergency room admission rates, as well as an improved state of mental and physical well-being and increased confidence for older adults to live at home when provided with the home supports they require to do so successfully.

Over the course of the project, the three sites completed intakes with 424 older adults to gather demographic information and identify needs and services to support their well-being. Overall, the top services older adults needed to remain living well in their homes and communities were supports with food security, assistance to access other supports, psychosocial supports, accessing financial benefits, housekeeping, accessing social connection opportunities, assisted transportation, and assistance with accessing housing.

Expanding the project's initial age of eligibility to include older adults from 50 to 64 years and broadening the referral sources to include those from community-based organizations working with older adults increased the number of clients served.

There are limited services available for the demographic that is 55 to 64 years of age, whether that is financial assistance, access to housing, help with food security, etc. The collaborative goal in Calgary has been to build their knowledge base about what is available for this age group and identify the gaps in service. Moving forward, they are looking at providing frontline staff with information sessions on resources frequently referred to (e.g., applying for Assured Income for the Severely Handicapped or Income Support). Additionally, due to the complexity of the cases encountered during the project, providing additional training and education specifically around mental health and addiction was needed and provided for frontline staff.

Overall, client outcomes improved, most notably self-reported measures of mental and physical health and confidence living at home, and the number of hospital admissions and emergency visits decreased from intake to file closure. Project staff were able to develop rapport with older adults participating in the project, thereby identifying potential cases of social isolation and connecting them to relevant resources in the community.

Since the beginning of the project, there have been eleven Community of Practice (CoP) meetings, with representation from each site, Healthy Aging Alberta and the government, to foster collaboration and learning. When reflecting on the CoP, members shared that they increased their knowledge of this work in different areas of the province, and the collaboration positively impacted their practices. All sites reported improved collaboration within their own projects and noted enhanced referral and communication pathways with the health system and other community-based organizations.

Frontline staff were included in a Community of Practice meeting near the end of the project in February 2023. This was noted as providing great value as they provided insights into the challenges of data collection, in particular, the ability to gain the trust of older adults they are working with to provide answers to the questions being asked. While basic demographic data could be collected at the time of intake, some criteria were gathered after building a more solid relationship with the older adults they were working with. 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 useful.

Collaboration is often an effective method of ensuring older adults receive the support they need. Throughout the duration of the program, it has consistently been clear that taking the time to build trust and relationships is crucial to a functioning, collaborative project. This was particularly noted in Edmonton, where collaboration was utilized to implement this project. The community-based partners involved had historical and current relationships on numerous initiatives, which was helpful but also potentially confusing. Shared goals over clients and good communication were recognized as helpful, as well as recognizing the importance of face-to-face meetings for introductions with community partners.

Another key learning was brought forward by the Golden Circle Senior Resource Centre, which noted a significant service gap and inequity for older adults not living in an urban setting. Access to programs and services is far more challenging when older adults live in an area that does not have a direct service provider and/or the clients don't have access to reliable transportation, natural supports or the financial means to get to the place where programs and services are being provided. The desire of those older adults living in more rural settings to age in their community is a critical factor in healthy aging, and more needs to be done to support their ability to do so.

The project has also proven to be a learning ground for future investment in the Community and Home Supports Provincial Model, in particular, related to data collection and measurement. As noted previously, this project used aggregate data, which limits the ability to follow individual client journeys throughout the project and impacts the depth of analysis that can occur. The Provincial Model will utilize unique client data and will be able to more effectively speak to the positive impacts of community and home supports on individual clients.

Future Considerations and Recommendations:

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

- **Provide sustainable long-term funding**. Short-term projects make relationship-building and effectively servicing older adults challenging, influencing staff retention and the momentum sites have in place with this approach. The short-term timeline is a barrier to establishing stable relationships with other sectors, service providers, and the older adults themselves, building referral mechanisms, and enhancing service coordination between health and social sectors.

- **Support the time necessary for collaboration**. All project sites noted significant time invested in collaboration at the site level, which needs to be appropriately resourced. The CoP served as a worthwhile investment to ensure future work can build on the learnings developed in this project. A project manager would help coordinate communication between sites, do targeted networking, and share information effectively.

- **Ensure adequate staff positions to address complexity**. Sites noted the need for more support workers and dedicated case managers, especially for handling complex cases. Complex clientele requires additional time for case managers to build and maintain relationships with the clients, often requiring several additional visits, as well as to coordinate and communicate with multiple services from varied sectors (e.g., legal, health, housing, and social supports). Additional staff would also enable sites to address referrals in a timelier manner.

- **Raise the senior income eligibility threshold.** This would ensure that more older adults can qualify for the Alberta Seniors Benefit and Special Needs Assistance program. The seniors who

are just above the income cut-off for the Special Needs Assistance program must cover the total cost of services, which can be challenging for many.

- **Allocate dollars for a crisis/emergency fund.** There is a need to support clients experiencing emergencies (e.g., food security issues, financial issues, eviction, prescriptions, incontinence supplies, assistive device repairs) and additional funds required to support older adults living on a low-income to meet their basic needs.

- **Create specialized services.** As previously noted, sites identified an increased complexity of client needs, specifically those with hoarding disorders, dementia, and mental health issues. Insufficient funding or services with limited or no capacity to address these types of issues result in increased wait times for specialized services, contributing to the inability to respond with immediate support.

- **Track individual client data at the project level.** Given the time limitations of this project, the CoP decided to capture site summary or aggregate data and not individual client data. While this gave insight into the intake, six months, and closure, it did not capture individual client journeys, which would be useful for deeper analysis. Despite this limitation, the current project fostered capacity building related to data collection and evaluation across the sites involved, information to suggest project impact and pragmatic insights for use in future projects of a similar nature.

- **Follow up and track clients who leave the program** or cannot finish to better understand hospital admissions and emergency visits data for future projects. Future projects could compare the average number of visits to the hospital and emergency in this age group in the general population to those in this type of project. Furthermore, consider if the pandemic and re-opening of services have impacted emergency visits, hospital admissions, and overall client health.

Appendix A: Organization Reflections and Feedback

Was the project implemented as intended?

Calgary

The program was implemented in partnership through the Way In Network. Each network agency added additional outreach workers for the specific project. The project expanded the age eligibility to align with the other provincial programs. By expanding the age eligibility this provided opportunity to identify the gap in service for the 55+ age group in the Calgary community. Uptake of referrals from the health community came as expected although continued presentations and connection with referrals pathways is ongoing due to turnover.

Red Deer

The Golden Circle offers various services for seniors, empowering them to continue to live in their homes and communities. All programs and services promote social inclusion and healthy, active aging which supports older adults in the community to age well in the place that is right for them. The ability for rurally located individuals to stay in their homes is vastly different when these support services are not available in their community. We have dedicated a significant amount of resources to providing these essential System navigation services (e.g. government form help, connection to health services, assistance with ensuring maximizing financial potential, accessing both internal programming and services specific to the individuals' needs as well as making referrals to other agencies who provide programming and services that we do not) and non-medical community supports to seniors residing in the community to help them to maintain their health and avoid unnecessary hospital or emergency visits.

While we anticipated a much larger client load immediately, we found that a lot of time had to be taken on building relationships than anticipated. Despite the fact that our organization has been serving older adults in Red Deer and the surrounding area since 1977, those rural communities unfamiliar with our services were initially slow to recognize the benefits of the program and begin to access it. The entire team dedicated to this project spent a significant amount of time building relationships with neighbouring municipalities, FCSS regional offices, other Community Based Senior Serving Organizations and individuals in the community. The amount of time connecting with the community to overcome the initial suspicion of why the organization was suddenly appearing in these communities and the subsequent acceptance and excitement about what we were offering was a true success story. We have been included in regional interagency meetings that we had not had table space at before, as well as we were able to secure office space within the Blackfalds FCSS office. They became a strong partner with us in facilitating connections with the Blackfalds community.

We were successful in building relationships, advertising our services, recruiting service providers/volunteers to provide the services offered, learning about each specific community, what is offered, what is needed, addressing gaps, and trying to build on those gaps (IE: recruiting people to provide Home Maintenance in specific communities and connecting them with seniors who need this support).

Community-based senior serving organizations like ours that rely heavily on government funding are often at risk of losing funding to provide these essential services which then leaves those individuals that we have supported without adequate resources. It is our hope that the connections made in these smaller communities will provide future opportunities for us to continue to provide these supports as well as to eventually expand them.

Edmonton

The original implementation plan intended for all referrals into the Aging in Community project to come through Home Care for seniors recently discharged from hospital. However, it took significant time for the relationship and referral process to be fully developed between Home Care and the project, resulting in very few referrals coming in during the start of the project. This meant the project was relatively confined in the beginning stages when it perhaps could have been more broadly circulated. Eventually the referral process was changed to allow for seniors to self-refer into the project. Eligibility parameters expanded to include these seniors at risk of hospitalization to prevent admission or readmission to the hospital, allowing the project to reach a greater number of seniors.

It was identified that there had been some lack of clarity initially about the role of ESCC, there wasn't funding for a backbone role or Project Coordinator beyond an evaluation component. As a result, the duties emerged for ESCC, and it was recognized the role of partnership coordination was critical. As a backbone, ESCC played the role of convenor, facilitator, brokering relationships with AHS, communicator, and data compilation. The backbone role needs to be recognized and funded.

Working as a collaborative also required additional project staff time between the Edmonton project partners, adapting processes and roles across organizations as required and ensuring documentation processes are aligned. JFSE continued to adjust its staff complement to accommodate case management needs as well as recruitment and hiring of Home Support workers to meet the home support needs. This highlights the operational and financial agility required for community organizations that deliver services through grant funding.

To what extent have the following outcomes been achieved?

Increased Collaboration

Calgary

Calgary shared that the CoP demonstrated the importance of a collective voice across the province to impact change and provided opportunities to align with other projects. The CoP also helped organize the provincial projects to collect the same data to help demonstrate the collective impact. As a participant in the CoP shared, it was encouraging and validating that we are not alone, that we are all experiencing similar challenges/trends and the learnings provided through the practice was valuable. A challenge is making sure that there are all stakeholders at the table (e.g., front line, referring partners, health care, community partners, funders, gov't, etc.) and that there are sufficient resources provided to cover the time commitment

The Calgary project/collaborative: The Way In Network (TWIN) is an ongoing and long-term commitment. This collaborative meets monthly with supervisors and leadership of each agency to maintain relationships, trouble shoot, and connect to make sure all TWIN partners are all moving in the same direction. Frontline staff participate in a community of practice with a purpose of providing support with case consults, resourcing, and training opportunities (e.g., mental health trainings, harm reduction)

Red Deer

Red Deer commented that the CoP was a good sounding board to share experiences, challenges, and successes of each site. It was helpful to hear the similarities between sites and was a great opportunity to network and share best practices and resources across agencies to streamline forms and processes within the organization.

Golden Circle has utilized office space in the Blackfalds FCSS office and have attended different programming within that community to connect with people including Blackfalds Seniors Cheemo Club. The Golden Circle team attended FCSS interagency meetings in many surrounding communities to share our information, resulting in more rural community awareness, opportunities to recruit service providers/volunteers and referrals to our program. We have also attended community information nights in rural community settings. Golden Circle staff had the opportunity to present at local library information sessions, and senior drop-in centres in rural communities. These promotional efforts resulted in opportunities for collaboration, building awareness of offered supports, connecting with each community and connection with the older population. Golden Circle also made concerted efforts to connect with healthcare providers by attending meetings and giving presentations at hospitals as well as connected with the Seniors Outreach Nurse for Red Deer, Red Deer County and Penhold. These efforts resulted in our agency being able to have our updated information in healthcare settings and with healthcare providers. This information also resulted in increased communication with healthcare providers/social workers in healthcare and increased referrals from this.

Edmonton

Edmonton noted that although time-consuming, the CoP has been valuable in multiple ways, particularly as it relates to building and improving processes. It was a great opportunity to hear from other parts of the province about the challenges they were experiencing and how they were being navigated, especially since these challenges were often similar across organizations and projects. This informed their processes, and they made changes to their initial project. It was also interesting to hear about the variety

of types of referrals that other projects were receiving. Rural communities, for example, seemed to be getting many referrals surrounding addictions, which may have reflected the types of support that were already available or not available near the project site. This sheds light into the geographical gaps that may exist across the province and helps to inform process to be relevant to the individual context of the project and location. Despite this need for contextual specificity, it was also good to touch base with other sites to ensure that general project processes were somewhat uniform, so that reporting between projects could be meaningfully aggregated, but also compared to show difference. Clarity on reporting processes often came from the CoP.

Edmonton also noted that having structured meetings with a clear agenda was helpful. Having a provincial project manager who coordinated the communication between various sites of the COP was a great way to maintain the connections in the future, to do targeted networking, and to share information efficiently.

Having strong, collaborative relationships has been imperative to the success of this project and smooth delivery of services. The building of trust and relationships was crucial on multiple levels. The community-based partners had historical and current relationships on numerous initiatives, which was helpful but also potentially confusing.

The Edmonton partners have been able to rely on one another to be quick with communication, which has been valuable for case planning, especially relevant for seniors who have time-sensitive needs upon discharge from hospital. Getting to know one another better has also meant that Sage, JFSE, and ESCC can work to be good community partners, fostering reciprocal relationships that met the needs of their organizations and the seniors served. Communication between agencies, participants and referral sources have been important to ensure no gaps in service, but also no duplication of services.

Front line case managers in partner organizations in Edmonton met regularly between the larger group meetings to get insight and share and learn about other resources for clients. The work of the project was supported by the other staff members taking on significant increase in workload to accommodate the meeting and connection times as well as support and orient new staff - launching and ramp up time was resource heavy. This speaks to the need for funders involved with grant projects to recognize and value the staff time devoted to collaborative efforts.

In December 2022 the Aging in Community partnership contracted an external consultant to lead, document, and facilitate a reflective process intended to strengthen the partnership as it transitioned into the Social Prescribing Project partnership. More specifically, the partners wanted to identify any existing issues or concerns within the original partnership and determine what could be done to strengthen working relationships (old and new) to set up the new partnership for success over the next year. Moving forward, eleven recommendations were made on strengthening relationships and building the foundation for the Social Prescribing Project.

Enhanced Referral and Communication Pathways

Calgary

Building and maintaining our referral pathways from the acute care sites is still a challenge. This is mostly due to staff turnover at these sites which requires continued presentations and information sessions about the program and referral process. Moving forward we are identifying other possible referral opportunities including AHS transition services or Community Paramedic Program in Calgary. We want to make sure we are a part of the conversation of resources available when someone is going to be

discharged back into the community. Calgary also has strong support of the PCN's in our region. We are committed to continuing to expand and maintain all our referring partnerships.

Red Deer

The Golden Circle has struggled with maintaining consistent connections with healthcare professionals and getting current information to key services/health providers. With a multi-community service area, we try to keep the referral process simple in that a simple call in to request services is sufficient, however, ensuring the right people have access to our information has been a challenge.

The Golden Circle does not have a formal referral form that can be used at a health care level, which might assist healthcare professionals in discharge planning from health care settings. This is an item that has been identified by leadership as a key item to develop to make the process as simple for health care providers as possible.

There appears to be frequent staff turnover/department change in Central Zone health care settings, so Golden Circle is often resharing our information to new staff. Maintaining regular contact is a challenge.

We found success including our service information in community newsletters, recreation booklets, and community bulletin boards. Our program was so well received in Red Deer County that they have given us full page free advertising for the Aging in community project in their last three Community Activity Guides.

Edmonton

It became clear through the project duration that having a centralized access point was beneficial for healthcare, and a key outcome of the project in Edmonton. As a result, healthcare professionals only need to remember one number to call (Sage) to learn about or refer their older patients who need community supports. This saves health professionals time finding those supports and connecting seniors themselves. This program seemed to give healthcare some confidence that they could rely on community organizations to connect seniors to important resources that would support them to age well in community and prevent readmission to hospital. It is recognized that a senior, even if they are provided information about what was available, often need support in connecting to community resources. It was good for healthcare to know that there were programs in community providing the navigation services for seniors.

It has been indicated by the partners that meeting with the clients before they are discharged from the hospital would result in a higher number of successful referrals, but the unpredictable date of discharge was a barrier, as well as inability to send an Intake worker immediately after the referral to the hospital due to limited staff capacity.

Some other enablers for connecting with healthcare in this project included having role clarity and a strong understanding of what supports are available in healthcare and community, as well as having the structure and connections to communicate between sectors effectively. AHS and the project case managers worked in a complementary manner to better understand the client needs and better support them. Overall, the collaboration experience with AHS was very positive: AHS representatives were flexible and supportive. Even though prior relationships with AHS were beneficial, when you start a new project, it takes time for awareness to translate into changed behaviours. This became evident in the initial slow uptake in referrals from AHS.

What were the project successes, challenges, and lessons learned?

Successes

Calgary

The strength and history of The Way In collaboration and previous relationships with Primary Care Networks helped with the success of developing formal referral pathways for the Aging in Community Supports pilot. Referrals from different referring partners increased including additional PCNs, acute care sites, community partners and other health professionals. Presentations to diverse serving agencies and population groups were provided by the Diversity worker. As a network there is a commitment to continue promotion of the program with our referring partners and others. Due to the complexity of this work the network is looking at implementing strategic hiring of staff who are skilled with complex case management to avoid burnout and turn-over. In addition, the network is also looking at providing strategic education opportunities for front-line staff that include mental health and addiction training as well as implementing an acuity scale to help with managing complex case-loads.

Red Deer

One of the biggest successes of this project was the ability to not only connect with older adult individuals in rural communities and be able to provide them with important services and resources to allow them to age in community, but we were able to build relationships with other agencies and municipalities as well. Making connections with those who rural agencies and people who are directly connected with older people in our rural communities was critical in reaching more individuals requiring support. We had a lot of success with building relationships with these rural communities after we were able to get past the initial skepticism of what we were doing in these communities.

The older adults aging in rural settings were able to identify to the team what areas they needed more support in and get those supports set up. In the past getting supports set up rurally were challenging and the typical response was for the person to move and now the older adult is presented with more options to age in the place of their choosing versus having to leave. Though the Aging in Community project, we have been able to provide essential in-home supports to a population of people who would otherwise have to look at moving to an unfamiliar new community in order to access support due to low or no accessibility in their current community or to simply go without.

We are fortunate in that our services are adaptable to each community that we have served based on the community and identified need for each service.

Edmonton

Connecting Vulnerable Seniors

The Aging in Community project has provided an opportunity to ensure that gaps in services and supports are filled for seniors who are released from the hospital. Seniors don't always know what type of supports are available to them in the community, and when they return home without supports, they may be at greater risk of readmission. Even for seniors that have awareness of the supports available to them, the process to access the supports can be complicated and overwhelming, particularly in the vulnerable period immediately post-discharge. This project has supported these seniors to get connected to the resources and supports they need to remain safe and healthy in their own homes.

Meeting Practical and Social Needs

By connecting seniors to practical supports like housekeeping or transportation, the door is opened to identify social needs that many individuals are less likely to disclose before a relationship is built. Many seniors are open to discussing their specific practical needs that support day-to-day tasks but are less willing to openly discuss their social and mental health needs. This project has allowed for staff to develop rapport with participating seniors, thereby identifying potential cases of social isolation, and connecting seniors to relevant resources in the community.

Access to Subsidized Supports

Most of the seniors participating the project are low-resourced - they are living with low-income and have few or no social supports. Seniors with extremely low income can access supports through Alberta Seniors Benefit (ASB), but those under 65 years of age are not eligible for these supports – leaving a huge gap in service access for seniors aged 55-64, as well as seniors of all ages who do not have sufficient income to meet their needs but are not eligibility for ASB and other supports. The project has helped to fill this gap by providing sliding scale cost or free housekeeping and other supports to seniors otherwise ineligible for this type of support. The subsidy covered meals, food vouchers, transportation and housekeeping. These supports are invaluable in ensuring the wellbeing of seniors to support recovery from hospitalization and to prevent deterioration of health and wellbeing that puts them at risk of hospitalization.

Organizational Capacity Increased

By working to connect seniors from various geographical communities with local supports and services, project staff have built awareness of the supports offered in various Edmonton neighbourhoods. This increased capacity flows throughout the organization, as other social work programming can benefit from the greater awareness of community level supports for seniors. This allows the whole organization to better meet seniors where they are at, physically or otherwise, as well as to support seniors to be more connected to and explore their own neighbourhoods.

JFSE reported an increased case management capacity to address complex cases and to serve seniors aged 55 – 64, whereas prior, those services started at age 65. As well, there needed to be an increased home support capacity at JFSE to meet the home support needs for Aging in Community project clients.

Relationships with Healthcare

The project has helped grow and solidify relationships with Home Care, specifically between AHS and community case managers. There is not only a stronger understanding of the Home Care role, but Home Care also has a stronger understanding of the role and value of community-based seniors serving organizations. Although community social work has been done for years, it is now more recognized through this project, effectively highlighting the benefits of the community in supporting seniors to age well in their homes.

New Community Partnerships Built

To address Home Support worker demand for project clients at JFSE, a bridge to newcomer employment needs and increased partnership with Multicultural Health Brokers was created. The ability to connect to often highly skilled newcomer populations looking for work who may be potential Home Support workers to address project needs and Home Support staffing challenges was beneficial.

Challenges

Calgary

The Aging in Community Supports program in Calgary had many intakes that involved mental health challenges and chronic addiction concerns (e.g. long term alcohol usage) which require intensive case management. The program also saw a high number of intakes that reported financial insecurity (e.g. rental arrears, utility arrears, food insecurity, transportation limitations). It is a future recommendation that programs build this into future budgets for front-line staff to access on behalf of clients.

Additionally, another challenge that the Calgary project found was there were 83 referrals to the program that did not turn into intakes due to a variety of reasons including: client declining service at initial intake call, after connection with worker, moved out the city, moved to palliative care, or deceased. The network is looking at our intake process for Aging in Community supports and examining if there are processes that can improve client engagement.

Red Deer

A primary challenge in the Red Deer in achieving project goals was the ability to connect to the various departments within the Hospital and other health care providers. This may be an issue specific only to Central Zone given that the Hospital serves a large geographic region comprised of many communities.

We were able to make great strides in connecting with rural health (doing presentations, dropping off information, attending community events etc.), but continued funding of a person dedicated to rural supports would support the maintenance of that relationship as well as ensuring older adults in rural communities are able to enjoy the same access to services and supports as their urban counterparts would assist in creating and maintaining relationships. The creation of a standard referral form/process for healthcare providers might be a tool to be considered which may be an outcome of the Social Prescribing Project currently underway.

One key challenge for our site was getting our information to all of the rural centres. Not just from the geographic position, perspective of having to cover a large area. Our staff had the opportunity to attend several different community events to meet directly with people and try to engage with them to access supports. People were naturally suspicious of our agency trying to provide supports to rural areas, being concerned that we were attempting to take over the supports the community already might offer. Our team spent a lot of time assuring people that our supports were there to compliment/enhance the supports each rural community might already offer or to address the gaps that might be there. For example, Blackfalds has the Bolt Bus that is available to people to take to Red Deer to connect with city transit, but it isn't available for people to get to specific addresses or outside of Red Deer if needed. Our transportation program has been used for older adults to attend medical appointments in Calgary/Edmonton and in Red Deer with door-to-door availability.

Another example of services might be rural grocery delivery, we were able to support one grocery store in creating a grocery delivery program based on ones in Red Deer, however, Penhold and area does not have access. We attempted numerous times to connect with a local grocery chain to discuss setting up a grocery delivery program without success. We have been able to offer grocery delivery to our closest southerly rural clients from the grocery delivery program in Red Deer we run.

Organizing our efforts to reach each community was challenging in that we advertised our available services while actively recruiting for volunteers and service providers. There is currently a greater demand for service providers than there are providers available. The services we offer and struggle to provide are

Home maintenance (yard care, snow removal, housekeeping and home maintenance) and supportive transportation. This is due completely to challenges in recruiting individuals to perform the services as opposed to there not being a need in the area. We continue to actively recruiting people to provide these services in each community but it takes time due to the screening process for these positions (vulnerable sector checks, interviews, reference checking and coordinating matches with individuals). Addressing food security in each community was very community specific to what was available and what we could offer. Part of our intake process is nutrition screening and providing resources to address concerns. We had a huge learning curve to learn each rural setting, what was in place already and then setting up supports. For example, meal deliveries and grocery delivery.

Another challenge was that a year goes by faster than you realize. Just as we seem to get organized and well-connected, the time limited funding for this grant project concluded.

Edmonton

Managing Complex Cases:

Some of the cases referred in were extremely complex, which did not necessarily align with the goals of the project. For example, several challenging hoarding referrals with multiple complexities were received. Cases where hoarding is present often involve housing insecurity, financial insecurity, and health and safety concerns. Other complex cases involved cognitive challenges, which make all steps in accessing supports more challenging for both the senior and project staff. Complex cases like this take up significant staff time, which meant that we were spread very thin and were not able to use staff resources as effectively as we had hoped. This concern was brought forward to Home Care, and the staff time required for these cases was expressed. The challenge is that the need for hoarding behaviour supports for seniors is so large, and Sage is known as the organization with the expertise needed to offer these supports. Although the project wasn't meant to necessarily address such complex needs, the needs remain: 24 participants were considered complex cases throughout the duration of the project, some of whom were experiencing hoarding behaviours on top of other complex challenges. If hoarding behaviours aren't addressed, then no amount of housing, financial, or other social supports can truly meet the needs of these seniors. As is often the case, we learned that we needed to work creatively and rely on our partnerships and existing connections in order to meet the complex needs of these seniors within the parameters of the project.

Timing of Referrals

At times, we received referrals from Home Care for seniors that really needed immediate post-discharge support but were already back at home and at elevated risk for readmission due to lack of appropriate supports. We learned that it is crucial for the healthcare system to contact the project *before* the senior is released and involve project staff in collaborative case meetings. This would allow staff to better understand the needs of the senior and make sure they can be connected to the relevant supports before they return home. A challenge is that, with limited resources, we would not have the staff capacity to attend such case meetings and would need to heavily rely on healthcare to make the referral at the appropriate time, with respect to the senior and their unique needs.

Initial Contact with Seniors

Many seniors recently released from hospital are overwhelmed with everything going on in their lives and taking one more call from Aging in Community staff added to this sense of feeling overwhelmed. This makes it challenging to get in touch with these folks in a timely fashion, illustrating the need for transitional discharge support to bridge the gap between release from hospital and connection to the

project. Seniors also didn't always understand what the Aging in Community project was or why project staff were phoning. Because they were overwhelmed with their situation, they may have forgotten what the referral was for and how it could support them. We found it best to address concrete, daily living needs first, like housekeeping supports or transportation. These needs were better understood by participating seniors and supported them to have their higher needs met first. Addressing these needs first also allowed for staff to build rapport and trust before assessing the senior for social isolation or mental health needs and made it so staff were not just another person on the phone with a list of questions to be answered. Promotional documents were also simplified to assist seniors in self-referring when they felt less overwhelmed.

Staff Recruitment and Shifting Roles

Staff recruitment into the positions at both JFSE and Sage Seniors Association remained difficult. This aligns with current economic and job market volatility, and high rates of job vacancies. Recruitment, hiring, orientation and training of case managers/social workers, and home support workers was time consuming and necessary to meet project needs placing at times undue burden on the organization but well worth the effort.

Shifting staff demands and role changes were challenging. Additional staff time was required when the criteria for entry was broadened. In addition, full-time support was needed within JFSE's Home Support Program - coordination to accommodate the increasing client numbers as the project progressed and aassistance with home support worker recruitment because it was very time-consuming. They had to reassign roles to support the project management. JFSE also reported difficulties with incorporating the Aging in Community project into the existing JFSE's case management model. Team meetings were held on an ongoing basis to address this issue and make necessary adjustments.

Lessons Learned

Calgary

There are limited services available for 55-64 age group – whether that is financial, housing, food security, etc. The goal of the network has been to build our knowledge base about what is available for this age group and identify where the gaps in service are. Moving forward, we are looking at providing front-line staff with information sessions for resources that we are frequently referring to (e.g., applying for Assured Income for the Severely Handicapped or Income Support). Due to the complexity of the cases providing additional training and education specifically around mental heath and addition was needed and provided for front-line staff.

Red Deer

One of the biggest learnings through this project and specifically our Community of Practice connections was that there is a huge service gap and inequity for older adults not living in an urban setting. Access to programs and services is far more challenging when you live in an area that does not have a direct service provider and/or you don't have reliable transportation, natural supports or the financial means to get to the place where the programs and services are being provided. The desire of those older adults living in more rural settings to age in their community is a critical factor to healthy aging and more needs to be done to support their ability to do so.

We have learned that creating relationships with the existing community agencies is key to expanding into those areas. We have learned and been able to adapt to each rural community as needed. In hindsight,

allowing time to build these relationships was key and something we did not consider would take so much time to do.

Building these relationships also allowed our team to connect with older adults in need as the community partners we engaged with already had built relationships with them and had trust established. It takes time to connect with Older Adults in rural settings, get the information spread out to each setting and have people buy into the services we offered.

This pilot-project opportunity to expand our existing in-town programming to neighbouring rural communities has highlighted for not only us, but our neighbouring municipalities as well, that the need for the in-home supports offered through the Aging in Community project need to be made a priority.

Edmonton

Throughout the duration of the program, it has consistently been clear that taking the time to build trust and relationships is crucial to a functioning collaborative project like Aging in Community. The building of trust and relationships was crucial on multiple levels. The community-based partners had historical and current relationships on numerous initiatives, which was helpful but also potentially confusing. Shared goals over clients and good communication were recognized as helpful, and the importance of face-to-face meetings for introductions with community partners.

Although the AIC project started with an idea of what the processes would look like, trust helped to build these processes to be more relevant, effective, and efficient. Trust allowed for conversations about what was working and what wasn't working early on, so that things could change and improve accordingly. Once roles and responsibilities are clear, the next steps of the project moved much more quickly.

Flexibility is needed when piloting a project. Processes had to be simplified - a promotional poster was redesigned to help seniors access the project. JFSE had be flexible and adaptable on how a senior's needs were addressed (for example, had to outsource home support services when needed).

JFSE also underestimated the staffing required to meet the project's home support needs. A full time Home Support Coordination staffing was critical to meet increasing client needs as the project progressed and the need for more Home Support workers. All levels of the hiring process take time from recruitment through to getting the service in place: including advertising, screening, interviewing, police checks, and reference checks. Many Home Support workers already had other jobs and are only available piecemeal which didn't always match what the client needed. JFSE adjusted expectations and engaged more supports for the process. Increased tracking of skills, languages, areas of the city workers live in, were needed to make matching of workers and clients a more effective process. Alleviating costs to workers in readiness for limited hours and shifts was required, i.e., police checks and liability insurance. With so many variables the project required having a project manager position and holding regular and frequent team meetings to closely monitor the situation. Adequate supervision of project staff is necessary in order to provide them with support.

The backbone role for new projects needs to be recognized and funded. It was identified that there had been some lack of clarity initially about the role of ESCC, there wasn't funding for a backbone role or Project Coordinator beyond an evaluation component. As a result, the duties emerged for ESCC, and it was recognized the role of partnership coordination was critical. As a backbone, ESCC played the role of convenor, facilitator, brokering relationships with AHS, communicator, and of data compilation.

As mentioned previously, the Edmonton site engaged in a reflective process to strengthen their partnership. In December 2022 the Aging in Community (AIC) partnership contracted Periwinkle

Research + Evaluation as an external consultant to lead, document, and facilitate a reflective process intended to strengthen the partnership as it transitioned into the Social Prescribing Project partnership.

Eleven recommendations were made on strengthening relationships and building the foundation for the Social Prescribing Project. Three have since been prioritized: the drafting of a Memorandum of Understanding for the Social Prescribing Project which outlines the roles and responsibilities of ESCC and the partners, continuing to build relationships with key health system stakeholders to facilitate additional referral sources and confer additional stability and sustainability, and facilitated conversations between new community partners to develop a shared understanding of values and approaches to social prescribing.

Work progresses on each recommendation and learnings continue. We've recognized the need to engage professional assistance to help with the creation of a formal document (i.e., a lawyer for the MOU development). For Healthcare Stakeholders, we recognized the need to spend time educating Health Care Providers on existing projects to ensure they understand and how to access them. The referral pathways needed adapting for ongoing collaborative service delivery with Alberta Health Services. It takes time to build these networks and establish a common language. This will also support increased comfort to call and follow-up about complex client concerns. The community partners check in bi-weekly for updates, discussion on challenges & barriers with incoming referrals, processes on referrals and subsidies and how to support link workers.

The difficulty in gathering data at the end of the Aging in Community project was in part because of the inability to reach people which is always a challenge. Many clients aren't keen on sharing demographic information when accessing supports if they don't feel it is relevant to the support they need or feel it might exclude them from accessing that support (e.g., ethnocultural background, immigrant or refugee status, etc.). Following up with folks can be challenging if they don't have access to a phone or are uncomfortable returning calls; they might not answer because they do not recognize the number; they might not answer because they are no longer interested in participating or are feeling overwhelmed. Data collection was time-consuming for the staff and required ongoing adaptations of the internal databases.

What trends emerged during the project?

Calgary

- Inflation – higher requests for financial assistance as pensions or income support have not increased to match rising costs of living
- Housing security – high requests for support in applying for and accessing stable affordable housing for those with immediate housing needs (e.g. waitlists are incredibly long)
- Staff turn-over/burn out – due to the complexity and high needs of some clientele there has been some turn-over with staff
- Capacity of the community/external services providers that we refer to – e.g., long waitlists for volunteer run programs that assist with transportation or social connection.

In terms of addressing the complexity:

- Developing a role specific training schedule (e.g., mental health and addiction training, harm reduction training, etc.)
- Identifying skills/knowledge/experience needed for this role and hiring strategically to reduce staff turnover and burnout
- Tried different staffing models to “spread” the demands of the case loads although there has been varying levels of success

Red Deer

We actively offered supports while trying to set these supports up at the same time. It was extremely important to be connected with people, but they often then had to wait for us to get supports in place for them, as we recruited volunteers and service providers as soon as requests came in. Although people often had to wait for the needed service, they did receive regular check-ins from staff.

We have had a few complex cases come into our project. It has allowed our team to reflect on person centred service and meeting individuals where they are and has created opportunities for our team to connect with service providers/local agencies that offer supports to folks with complex needs and learn more about those supports. If we do not provide the support that the individual needed, we were able to provide information and resources to connect individuals to those organizations and agencies that are.

Edmonton

Inflation and the increasing cost of groceries has been a huge problem for seniors participating in this project and beyond. This has meant that food security resources need to be accessed more frequently, putting strain on available resources. The reduced ability to meet one’s basic needs has also created increased anxiety in many seniors, resulting in exacerbated mental health concerns.

As participants are often overwhelmed, connection to resources may not be immediate as contact may be delayed at participant’s request. Participants most in need of supports typically do not have the financial resources to engage service providers for the supports they require.

An increasing number of clients need transportation with assistance or companionship and wheelchair accessible vehicles. This service needs to be free or low cost as these individuals are extremely low income. Drive Happiness, a volunteer driver service, was a great support for this issue. There is not one solution that will fit every situation for transportation and affordable options are limited for low-income seniors who cannot take DATS or use a city bus.

Language and hearing limitations significantly increase the time spent with a client by their case manager. A significant number of clients referred to the project presented with both diagnosed and undiagnosed mental health issues. Even if they agreed to accepting mental health support, partners had extremely limited ability to provide subsidized counselling.

There has been a higher number of Russian and Ukrainian speaking clients due to the conflict in Ukraine: JFSE has historically been a place where Russian-speaking clients could receive assistance, but JFSE did not have capacity to serve many Ukrainian refugees, so they had to be referred elsewhere. There were a couple of Jewish Ukrainian families, whose cases were extremely complex due to recent trauma and dependent children living with them which required a family intervention.

What resources are required to sustain this work?

Calgary

Building in a crisis fund line on budgets for future projects would be helpful. The nature of community work is complex and having a fund that front-line can access without barriers (e.g. applications, wait times for external supports) would be helpful and would reduce pressures on agency's current internal resources.

Red Deer

One of the gaps for service our team struggles with daily is access to emergency funding. Sometimes the individuals we serve need access to emergency funding for a variety of different reasons (IE: damage deposit, transportation, medications, etc.). We have some options in Red Deer, but they are very specific, so often our rural clients do not fit the criteria. We do not have capacity in our existing budget for it so will be looking at either grant funding or a private donation to be able to create an emergency fund.

The older adult who is under the age of 65 is not able to access Seniors Benefits, but has the need for in home supports, does not have access to funding, subsidy etc. so often this is a huge barrier for the person needing the support to access the support.

We also find that many seniors are not aware of what financial benefits they are receiving or know about the special needs assistance program under the Alberta Senior Benefit. We also struggle with seniors who have pets, who often have to rehome them prior to moving to a higher level of care. This can have devastating impacts to their wellbeing due to staying in a home too long and/or losing their companions. Preliminary conversations have been undertaken with the Central Alberta Humane Society to work in partnership with our older adult living facilities as well as to ensure their emergency boarding program information is shared with community-based senior serving organizations as well.

Edmonton

Although having a centralized intake was a strength of this project and helped to increase efficiencies, it also took considerable resources and time to act as that centralized access point, beyond what we initially anticipated for this project. This represents a potential gap in resources for similar work.

As we have reported previously, the lack of practical and specialized supports for seniors with hoarding disorder represents a huge gap in resources. There is a lack of specialized social work staff across the sector, meaning many of these complex hoarding cases get redirected to Sage, who has expertise through the *This Full House* program-but which has not been funded since 2020. Navigating extremely complex hoarding cases put significant pressure on the project as these individuals are otherwise a fit but could not be meaningfully supported without receiving concurrent and ongoing support for their hoarding behaviours.

Another resource gap is the ability of seniors to financially access in-home supports. Even with sliding scales and no-cost supports, resource deficits remain. This is especially the case with seniors who are low income and unable to financially meet their basic needs, yet do not meet the threshold for no-cost supports. Although grocery shopping services are helpful for many seniors, they do not help those who cannot afford groceries in the first place. The increased cost of living particularly affects those seniors.

Affordable companionship for home visits and transportation is also needed. Companionship is a service which could include people staying overnight or travelling with them to appointments.

To sustain this work, having financial resources to employ full time home support workers that can serve various clients. The subsidized home support services was provided for a couple of months only, after which not many clients will be able to continue to receive home support through JFSE. Hiring workers for a short period of time without ensuring work stability is a significant barrier to having enough home support staff.

Limited resources exist in the community to support both the clients and senior serving organizations to support individuals with various stages of dementia and mental health issues. Having more community case managers who would work with complex cases is needed. Best practice in case management is to have around 20-25 complex needs clients/full time case manager. JFSE was able to hire only one, very part time, case manager dedicated to this project, while having in total more than 25 clients.

Appendix B: Success Stories

Calgary

Story 1:

Loretta was referred to carya's Aging in Community Support (AICS) Program by a social worker at the hospital where Loretta recently had a major surgery. During home visits the social worker became concerned that Loretta's cognitive challenges limited her ability to complete day-to-day tasks and would struggle with independent living. An AICS program outreach worker began by completing a comprehensive in-home social work assessment and service plan to address Loretta's needs. This included working with Loretta to review her finances and find benefits for which she was eligible. The AICS outreach worker assisted with an application to Access Calgary for a low-income bus pass to allow Loretta to attend rehabilitation and social programs. In collaboration with the LINKS worker, Loretta worked hard to increase her independence by learning how to use phone apps, such as the City Transit app, despite her short-term memory loss. The AICS outreach worker helped Loretta to get food hampers and connected her to the Village Commons Community Hub where she now regularly attends programming. As a result of her perseverance and the AICS Outreach worker's support, Loretta expanded her access to opportunities that promoted her physical and emotional well-being, furthering her ability to live independently and build social connections. Loretta has begun to regain her self-confidence and to set goals for herself, such as returning to work when she is able.

Story 2:

The Aging in Community (AIC) program received a referral from a Primary Care Network social worker for Joseph when he was unable to pay for his diabetes medication. Upon further assessment the AIC program outreach worker identified that Joseph had been unable to pay his rent for a number of months and had a significant bank overdraft. As a result of a mistake on the forms, Joseph had not been receiving any of his entitled pensions since his retirement, two years earlier. With no natural supports close by and Joseph having limited English-language skills, the outreach worker initiated bringing on an interpreter through the local language line. The outreach worker worked closely with a pharmacy to ensure that Joseph was able to acquire his medication through an emergency fund until his pension was available. Through the Alberta Seniors Financial Assistance Program, the worker was able to connect Joseph with Nation Vision to receive free eyeglasses. Joseph and the outreach worker navigated the form issues with Service Canada and completed the landing papers to successfully have Joseph receive a retroactive pay and his ongoing monthly payments. With the retroactive funds, Joseph was able to pay off his overdraft and missed rental payments. Further, the outreach worker was able to support Joseph to move into a home that better met his needs. The dedicated and dynamic multidisciplinary team helped Joseph to start a new chapter in his life. Receiving monthly pension payments and moving into a new space meant he was also able to save up enough money to go back to his home country where he married his longtime partner and together they are working on bringing her to Canada.

Red Deer

Story 1:

Golden Circle had a referral from the County of Red Deer about a woman in her 70's living in a very secluded mobile home park about 15 minutes from the nearest community. She had no transportation and was often spending upwards of $80 to $150 in cab fare to get to medical appointments or purchase groceries. Prior to this, she had lost her license due to health conditions, and her natural community supports had either passed away or moved. She had also used a tax volunteer the prior year who had made an error on her taxes resulting in her benefits being cut substantially. Unable to carry groceries, and struggling with many barriers to accessing services, she had tried to navigate the issue on her own, however was still seeing a substantial decrease in her income and impact to her health. Our team was able to assist her to sort out the issues with her income and connect her to our supportive transportation program for medical appointments and escorted grocery shopping. This lady also started ordering from our frozen meal program and has addressed her food security challenges. This lady has two pets and would be unable to find affordable housing to accommodate living closer to supports, so accessing our services has deeply impacting her ability to remain independent.

Story 2:

Golden Circle supported a woman in her 70's who often attended the FCSS office Blackfalds in crisis. Her husband passed away in long-term care during the time we were working with her, and she was often overwhelmed and unable to function. Our team supported her to navigate the paperwork needed for the death of her husband, connected her with a tax volunteer, and has provided direction, resources, problem solving, and emotional support during this transition. The staff at the Blackfalds FCSS has reported that she has not attended their office in crisis and looks better than she has in the 5 years they have known her.

Edmonton

Story 1:

When James* was released from the hospital, he had multiple health concerns, the most pressing being a broken arm. James would require supports upon discharge, and was connected to Home Care to confirm the services he would need. AIC program staff at Sage was able to connect with James' case manager and confirm these services, so James could be assured that he would be able to receive continued in-home support.

James was transitioning from disability pension to senior pension, and was experiencing some income insecurity. He had concerns about the process of this transition and whether he would be able to afford to remain in his current housing. He was also unsure of what income supports had already been applied for, if they had been approved, or whether applications were required. AIC program staff corresponded with James and determined that some pension applications were needed, aside from Alberta Seniors Benefit. AIC program staff helped James apply for these, as well as the one-time federal rental assistance. He was then able to use this information to complete the affordability payments application as well. James is now receiving Alberta Seniors Benefit, and can now be supported to look into what he might access through the Special Needs Assistance Program.

James was already receiving some support from a neighbour who helps him with running errands and grocery shopping. He is managing with general housekeeping as he continues to heal. He might require some transportation assistance for upcoming medical tests, and through the AIC program is aware of Drive Happiness as an option to address this need. He has also explored some online opportunities for social interaction and staying connected with other seniors.

James has expressed gratitude to the AIC program staff for assistance in connecting him to financial supports and other community supports. He indicated how overwhelmed he felt immediately upon discharge from hospital, and how he would not have known the full breadth of services and supports available and how to access them if not for the AIC program.

*name changed to protect senior's anonymity

Story 2:

Bob* was discharged from the hospital with complex medical needs including short term memory loss. After visiting his home, it was determined that the current state of his apartment posed multiple safety risks due to clutter. Bob was staying at his neighbour due to this condition. This neighbour had taken on a caregiver role, and both reported extreme stress over this new situation and uncertainty over the future. The AIC worker assisted with a ASB funding application and accessed decluttering supports through Special Needs Assistance program. Bob was connected to Drive Happiness for upcoming medical appointments. The AIC worker explored a Community Geriatric Psychiatry (CGP) referral with both of them to deal with anxiety and depression around new situation. They were both agreeable. A Caregivers Alberta referral was given to the neighbour. The seniors have contacted the AIC worker multiple times to update and express gratitude for the CGP connection and resources. Bob was provided with a grocery card to assist with expenses, as they still preferred to cook their own meals.

*name changed to protect senior's anonymity

Story 3:

Betty* was enrolled in the AIC program after being hospitalized from a fall that resulted in a broken arm. Betty also had a history of alcohol addiction, which had resulted in her driver's license being suspended by her doctor. Having her license suspended and being unable to drive herself made Betty feel like she had lost her independence completely, creating feelings of anger and frustration.

As transportation was an important service need for Betty, AIC program staff were able to smoothly connect her to program partner Drive Happiness. AIC program staff followed up with Betty to discuss her experience with the program, and Betty expressed how pleased she has been with the transportation service provided by Drive Happiness. Since accessing Drive Happiness, Betty has started attending AA meetings and is now over 100 days sober. She reports that she is in a better state of mind and feels healthier. Betty's story highlights how transportation, a service that would seem to be unrelated to mental health and addiction issues, was necessary for her to begin addiction recovery. Drive Happiness and the connections made through the AIC program have helped Betty regain her independence, and she is grateful to have been referred into the AIC program.

*name changed to protect senior's anonymity