

BRINGING CARE HOME

AT-A-GLANCE



Applying the continuum of care
model to aging in place supports
for senior food security

Rónán Martel, MPH

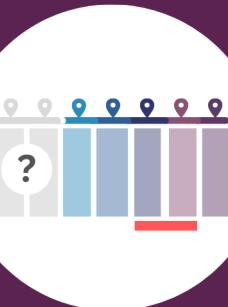
Executive Summary

The continuum of care is a useful tool for the province's goal of adopting a Home First model of care.



A continuum of care is a service planning tool that visually maps all the different components that make up complex prevention and care systems, such as those for cancer or HIV. Care continuums can identify where service gaps exist, as well as show how clients and data move throughout the system. This project piloted the care continuum's use for aging in place by mapping out food security supports for seniors aging at home in St John's, and found it to be a valuable source of insight into service gaps and steps for better system integration. Care continuums make a great addition to the province's toolbox as they take on the work of shifting our services and systems toward a Home First approach to healthy aging.

The first part of the continuum of care is currently missing.



When St John's aging in place programs related to food security are mapped along a spectrum of increasing levels of support, we can see that the first section of the continuum of care covering prevention and early risk identification is currently missing.

This means there are opportunities to do much more, much earlier to help people age in place in a state of food security.



Seniors are a demographic whose services greatly benefit from the system integration found in a continuum of care.

System integration refers to elements like client navigation services, shared data collection systems, and sector-wide collaboration to review what services are working and where changes need to be made.

Because of the dynamic nature of aging both across an individual's lifetime and across generations, system integration is vital for keeping senior services responsive to a population that's always changing.



Gaps in the continuum of care are filled by the emergency food sector, which can struggle to meet seniors' individualized medical and mobility needs around food.

The emergency food sector does critically needed work by providing a safety net for seniors aging at home when other food security supports are absent. However, as we age, we often develop highly complex, highly individual dietary needs: soft foods low in sodium, high-fibre foods that can be prepared with limited hand dexterity, etc. The current food bank model, already straining to work far beyond its capacity, lacks the resources to tailor groceries to each senior's mobility and medical dietary requirements. Developing robust food security programming for seniors supports broader movements within the emergency food sector toward adopting new models and finding new ways to make a lasting impact on food insecurity in our province.

St John's has the beginnings of a strong continuum of care.

This project found numerous strengths in the existing continuum of care. Home First approaches have been set as provincial policy, the health care system is actively in transition to incorporate more preventative social supports, social navigator staff positions are in development for the provincial health care system, the nonprofit sector is highly proactive and collaborative, and there is already a continually updated database of senior services, just to name a few.

All these building blocks create a strong foundation for St John's to become a leader in healthy aging in place.

Building a comprehensive continuum of care for aging in place can benefit seniors and the overall health care system.

Enhancing aging at home supports aligns senior services with senior preferences, and enables them to age in place in dignity and wellbeing. Home First approaches can also benefit the sustainability of the overall health care system. Investing in lower-cost, upstream services that keep seniors healthy at home longer can delay or eliminate the need for more expensive clinical interventions or resource-intensive Long Term Care facilities down the line. It's one more way to start shifting our spending to the "causes, not the consequences" of poor health (Health Accord NL).



WHERE WE ARE NOW



1 LIMITED PATHWAYS TO CARE

SELF-REFERRAL

Senior or caregiver learns about service and self-refers

ACUTE HEALTH EVENT

An acute health event leads to referral through a hospital discharge plan or similar

FAMILY DOCTOR VISIT

Note: Unavailable to those without family doctors

Family doctors who notice unmet needs and view this as within scope of practice provide referral/info on community support services

*ROUTINE HEALTH VISIT

**Any member of Community Team identifies unmet needs/risk factors during appointment and refers*

2 SELF-MANAGED NAVIGATION

With the exception of high-needs seniors linked to social workers, access to non-clinical supports is **self-managed by seniors or caregivers.**

The nonprofit SeniorsNL maintains the province's database of senior services and provides **referral supports** via staffed phone line and website, but identifying needs, researching services, enrolment, and navigation are self-managed.



3 INCOMPLETE SPECTRUM OF COMMUNITY SERVICES SUPPORTED BY EMERGENCY FOOD SECTOR



*Aging-in-Place Planning

*Planning Materials

*In-Home Accessibility Assessment

*Trained Aging-in-Place Staff at HSNL

*Proactive Risk Factor ID

*Automatic Age-Specific Assessment

*All Community Team Staff Trained in Risk ID

*Outreach Targeted to High-Risk Life/Health Events

Addressing Risk Factors

Home Modifications

Dietitian Services

Occupational Therapy

*Social Prescribing

Transportation Support

Accessible Public Transit

Senior Van Service

Bus routes to major stores

Community Gardens

Grocery Support

Delivery Services

Mobile Markets

Community Kitchens

Meals at Senior Events

Faith-Based Orgs

Community Meals

Day Programs

*Universal Senior Lunch Program

Community Kitchens

Meals at Senior Events

Faith-Based Orgs

In-Home Meals

Meal Delivery

Private Home Care

Private Home Care Subsidies

Financial Support for Informal Caregivers

*Service currently unavailable

Emergency Food Sector

Old Age Security and Guaranteed Income Supplements

FOOD SECURITY: CONTINUUM OF CARE FOR AGING IN PLACE SERVICE VIEW | CURRENT SERVICE LANDSCAPE IN ST JOHN'S

WHERE WE WANT TO GO



1 ACCESSIBLE PATHWAYS TO CARE

SELF-REFERRAL

Senior or caregiver learns about service via outreach and self-refers

ROUTINE HEALTH VISIT

Any member of Community Team identifies unmet needs/risk factors during appointment and refers

ACUTE HEALTH EVENT

An acute health event leads to referral through a hospital discharge plan or similar

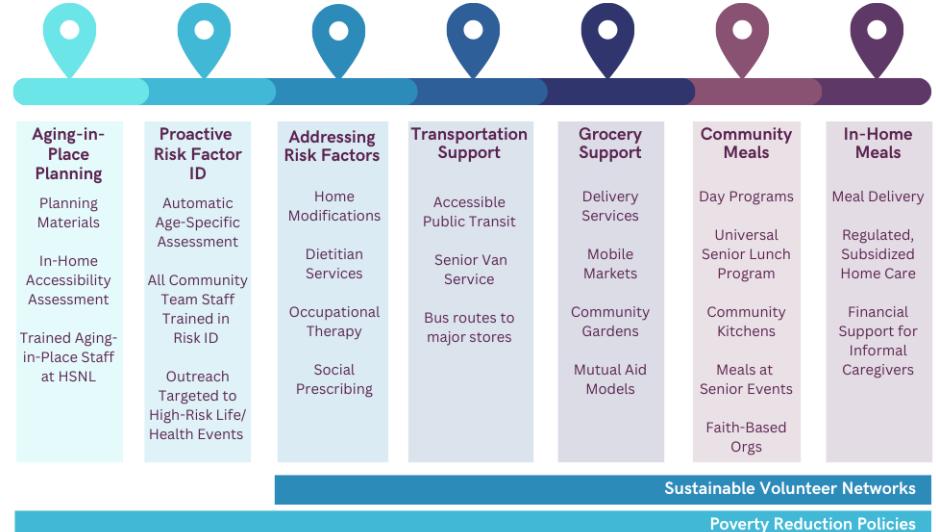


2 SUPPORTED NAVIGATION

Social Navigators partner with seniors to identify what supports would enable them to continue to age at home. Because aging is dynamic, these partnerships continue over time so new services can be matched to changing needs.



3 FULL SPECTRUM OF COMMUNITY SERVICES SUPPORTED BY POVERTY REDUCTION POLICIES



FOOD SECURITY: CONTINUUM OF CARE FOR AGING IN PLACE

SERVICE VIEW | HEALTH ACCORD MODEL

[Report Excerpt]

Service Gaps and Suggested Services

During interviews, local stakeholders were provided with a handout that listed evidence-based senior food security interventions and programs collected during the initial literature review.

The following tables summarize feedback on which services are missing, and which are available but lack enough capacity for local demand.

Note: Respondents were not limited to services named on the handout.

Figure 7. Service Gaps: Missing Services

Level	Service
Aging in Place Planning	Resources (materials and dedicated staff) to guide aging in place planning
Proactive Risk Factor Identification	Assessment and early identification of unmet community/home-based needs
Grocery Access	Non-profit Sector: Free/Low-Cost online and phone-based grocery delivery services
Grocery Access	Relevant nutrition information in online shopping interface (diabetes-friendly, low sodium, soft food diet, etc.)
Volunteer Network	Volunteer coordination infrastructure to match volunteers to individual seniors
Volunteer Network	Supportive resources (gas stipend, honorarium, etc.) to aid in recruiting and retaining volunteers

Figure 8. Service Gaps: Capacity Issues

Level	Service
Addressing Risk Factors	Dietician services
Addressing Risk Factors	Occupational therapist services
Transportation	Senior-accessible public transportation to grocery stores
Grocery Access	Mobile markets at senior housing complexes and naturally occurring senior communities
Grocery Access	Access to traditional foods
Grocery Access	Business Sector: Online and phone-based grocery delivery services
Community Meal Support	Congregate meals outside Emergency Food Sector; "Universal School Lunch" Model
In-Home Meal Support	Meal delivery services at accessible price point
In-Home Meal Support	In-Home support staff trained in senior nutrition and preparation of local foods
Poverty Reduction	Income supports indexed to cost of living

Figure 9. Services and recommended by stakeholders

Improved Prevention	<ul style="list-style-type: none">• Aging in place planning support• Age-specific food security assessment• Occupational therapy services• Dietician services• Increased benefits and continuity of benefits upon turning 65• Senior-focused cooking skills classes• Programs in which seniors mentor younger generations on cooking and gardening skills
Home Care Services	<ul style="list-style-type: none">• Volunteer networks that can link community members to specific seniors• Home Care: Required training on senior nutrition information and preparation• Home Care: Revise scope of practice and expand workforce (i.e. remove meal support from Home Care Worker scope of practice and integrate meal-specific Home Chef positions)• Home Care: Program review• Home Care: Provincially managed workforce
Transportation Services	<ul style="list-style-type: none">• Senior-focused paratransit services
Grocery Supports	<ul style="list-style-type: none">• Mobile markets at senior housing complexes and naturally occurring senior communities• Grocery delivery programs<ul style="list-style-type: none">◦ Senior-friendly interfaces for private grocery store programs◦ Community-run, free/low-cost programs
Community Meal Support	<ul style="list-style-type: none">• Adult Day Programs• Universal Senior Lunch Programs• Community Kitchens
In-Home Meal Support	<ul style="list-style-type: none">• Subsidize meal delivery services• Shift to bulk meal delivery model

Figure 10. Services not recommended by stakeholders or recommended with caveats

Recommended with Caveats <i>Programs that can enrich a service landscape, but may be less accessible to low-income, isolated, and/or higher-needs seniors</i>	<ul style="list-style-type: none"> ● Community gardens <ul style="list-style-type: none"> ○ Pro: Strong benefits for physical, social, mental, and community health ○ Pro: Well-implemented and well-received especially in senior congregate living arrangements ○ Con: Impacts on food security are less clear ○ Con: May be less accessible to lower-income and/or disabled seniors ● Senior Cooking Classes <ul style="list-style-type: none"> ○ Pro: Well-received as part of community programming, social activities, skill sharing ○ Con: Low uptake by the specific demographics in need of cooking education (isolated seniors, widowers, home-bound seniors) ● Bulk Buying Clubs <ul style="list-style-type: none"> ○ Pro: Highly effective when arranged organically among friends or neighbours with established relationships ○ Con: Difficult for external groups to arrange among an unconnected group of people; often end due to lack of consensus on what to purchase (i.e. only works as a “bottom-up” intervention, ineffective when “top-down”)
Not Recommended <i>Programs that stakeholders actively advised against for St John's</i>	<ul style="list-style-type: none"> ● Budgeting classes ● Food skills classes for “doing more with less” ● Food hampers with pre-determined contents ● Food prescriptions <ul style="list-style-type: none"> ○ Unclear impact on food security ○ Functionally similar to food stamp programs in the United States with similar issues around lack of choice, stigma, and high administrative burden and costs

Interested in learning more?

Check out the full report, *Bringing care home: Applying the continuum of care model to aging in place supports for senior food security*, at the MUN Research Repository: <https://research.library.mun.ca/16768/>

Bringing care home provides an in-depth look at each piece of the continuum of care for senior food security, highlights local assets and challenges, provides recommended actions based on evidence-based practices and local stakeholder insights, and examines system-level changes that can help build a strong continuum of care for St John's seniors aging in place.

About the report

Bringing care home: Applying the continuum of care model to aging in place supports for senior food security

Rónán Martel, MPH | October, 2024

Abstract: Aging in place supports are a top priority for seniors and health system administrators alike. However, with a vast range of interventions and stakeholders, the landscape of aging in place supports is difficult for seniors and service providers to navigate. Collecting data and coordinating services is more challenging still. A continuum of care is a planning tool that maps out the spectrum of services for a particular need, enabling better patient navigation and service planning. This research piloted its use for aging in place services by developing a model and applying it to services that support food security for seniors aging at home in St John's, Newfoundland and Labrador.

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