MANAGING AT HOME

A Study of Sooke Seniors Planning to Remain in their Own Homes

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Our thanks go out to Pacific Centre Family Services Association who assisted us in the design phase of the study, and helped us to effectively reach out to prospective participants. We also wish to acknowledge the Sooke Region Community Health Initiative (CHI) for their time, advice, and in-kind assistance. CHI also helped us to recruit Seniors through the Sooke Region Resources website (http://www.sookeregionresources.com).

The cooperation of the above organizations and the help we received from each individual indicates that together we *can* build an age-friendly community and support healthy aging in place.

Executive Summary

'Aging in place' is a priority for Seniors all across the country as they deal with the multiple mental and physical challenges of living longer in a complex rapidly changing culture. As the population ages, government and health providers at all levels face the challenge of ensuring that Canadian Seniors have access to the resources and relationships they need in order to live full and well supported lives. This in-depth study of Seniors in the District of Sooke, where population growth is high due to housing development and in-migration, attempts to understand the fundamental resources that are required by Seniors if they are to maintain their independence and quality of life.

The *Managing at Home* study was the result of a partnership between the District of Sooke, the Sooke Region Community Health Initiative, the Sooke Region Volunteer Centre, the West Coast Family Medical Clinic, the South Island Division of Family Practice, and Island Health. Its aim was to reach out specifically to Sooke Seniors who identified themselves as "in need of additional services and supports in order to remain in their homes". The study took an integrative approach, recognizing the importance of each and all of the multiple determinants of health. It also acknowledged the value of natural, community, and professional networks and the potential of their individual and combined roles in improving health outcomes.

Forty-seven Seniors participated in the *Managing at Home* study. These individuals ranged in age from 58 to 90 years of age. A significant number of Seniors lived alone and almost one fifth did not have enough money to manage day-to-day. Many Seniors had difficulty completing activities of daily living with and without the help of other people, including home repairs, housework, gardening and meal preparation. Many Seniors still drove their own cars, but transportation posed a problem for those Seniors who did not like to drive often or after dark, or were not able to drive at all. Although many Seniors had established social support networks, the ability of these network to fill gaps on a regular basis varied. Few Seniors expressed interest in "friendly visiting" services but focused instead on getting help with practical issues like finding community resources and grocery shopping.

Unlike many Seniors in Sooke, all but one of the study participants had a family doctor. Seniors were generally satisfied with the care they received for the complex health problems they identified. Based on the data and selected protective and risk factors, 10 of the Seniors in the study appeared to be at higher risk of experiencing future problems than the remaining 37. The results in this area are preliminary and warrant further investigation.

Recommendations from the *Managing at Home Study* are as follows:

1. Develop a "basket of services" for Sooke seniors that provide help with home repairs, housework, gardening and meal preparation.

2. Address the transportation needs of Sooke Seniors and Seniors in surrounding areas, prioritizing driving for medical appointments, grocery shopping, social participation, and recreation.

3. Develop an information and outreach capability, that provides Seniors with information about financial assistance including assistance for homeowners, and services including those available through Home and Community Care. This may require the use of a "navigator" to assist Seniors to find the resources they require.

4. Expand local, community based research to address the needs of Sooke Seniors with different characteristics and requirements, and from different parts of Sooke region.

It is our intention that the *Managing at Home* study will inform the future provision of Seniors' services in the Sooke region, and identify practical ways in which we can support Seniors to live full and rewarding lives as they age.

PART 1: Introduction

In November of 2013 a community forum was held in Sooke to assess the needs of Sooke region residents for primary health care services. The forum was sponsored by the *South Island Division of Family Practice (SIDFP)* as part of Stage 1 of the province wide "A GP for Me" initiative that aimed to evaluate the needs of individuals and communities for family physicians. The District of Sooke provided the venue for the forum, and the *Sooke Region Community Health Initiative (CHI)* assisted with promotion and community engagement. Primary health care services have been a longstanding priority of CHI and, in the past few years, of the District of Sooke, which had established a Mayor's Advisory Panel on Community Health and Social Initiatives in 2012. It is well recognized by both organizations that the health and well-being of Sooke residents is directly linked to their participation in all aspects of their community, and that the District, CHI and other groups have an interest in identifying health, social and recreational needs and supporting access to services and new initiatives.

The November 2013 forum served as a catalyst for CHI and the District to establish the *Primary Health Care Services Working Group (PHCSWG)* in December 2013. The PHCSWG was chaired by former Mayor Wendal Milne, and brought together diverse organizations with a shared commitment to improve local health care service delivery including CHI, the Sooke Region Volunteer Centre, the West Coast Family Medical Clinic, the South Island Division of Family Practice, Island Health, and the District of Sooke. The PHCSWG met for one year in order to create an action plan to identify and address health care service gaps and priorities in the Sooke region. The PHCSWG continued to solicit community input, expanding its consultation to include other stakeholder groups.

The health and well-being of Seniors was prioritized by the PHCSWG and other stakeholders. The population of the District of Sooke was 11,694 in 2011[1]. Forecasted growth is significant and is estimated to be 76.7% from 1996-2026[2]. For the period 2012-2013 Sooke was the fifth fasted growing community in BC[3]. According to population statistics from the 2011 Census Profile[4], approximately 3,105 people, or 27%, in Sooke are 55 years of age and older. Although the Sooke population has a younger median age than many other communities in BC[5], the needs of Seniors warrant investigation, in that they comprise over one quarter of all residents of Sooke. In particular, the PHCSWG was interested in Seniors who wished to remain in their own homes but faced challenges that made it increasingly difficult for them to do so. It was thought that if more could be learned about this sub-population and their needs, then more could be done to support their independence.

The aim of the *Managing at Home* study was to reach out to Sooke Seniors who identified themselves as "in need of additional services and supports in order to remain in their homes". These Seniors were asked to describe the non-medical and medical resources that they had available to them, as well as the resources and supports that they needed. The study took an integrative approach, recognizing the importance of each and all of the multiple determinants of health. It also acknowledged the importance of natural, community, and professional networks and the potential of their individual and combined roles in improving health outcomes. It is anticipated that this study will serve as a springboard for action, leading to service development and/or further in-depth investigation of questions that arise from this exploratory work.

PART 2: Research Methods

Seniors themselves were viewed as the best source of information on their non-medical and medical needs and resources, and since it was not possible to select Seniors' randomly, a non-probability convenience sampling technique was used in this study. Seniors were invited to volunteer for in-depth interviews of 1 to 1.5 hours in duration that would be conducted by a research associate. Recruitment of Seniors was done through advertisements in the local Sooke News Mirror newspaper, posters that were placed around town, and word-of-mouth. Seniors were offered a $20 honorarium to show our appreciation for their participation in the study.

Forty-seven (47) Seniors living within the District of Sooke volunteered to participate in the interviews. Participants signed consent forms indicating that they were willing to be involved in the study, and were assured of the confidential and anonymous nature of the interviews. Interviews were conducted in participants' homes, and it was up to each participant if other people were present when the interview was conducted.

Each interview began with a series of questions about the individual. Seniors were then interviewed about their current activities of daily living; the adequacy of their current resource base; their social participation; support requirements; health, and their interest in accessing specific medical and non-medical resources. Each of these topics is described in more detail, below.

Senior's Activities of Daily Living

The purpose of the "Senior's Activities of Daily Living: Capacity and Resources" section of the interview was to gather information from Seniors on the extent to which they were able to perform basic activities, and the extent to which they believed they could either perform these activities themselves or were adequately resourced (supported) by other people to complete them. Seniors were asked to discuss ten (10) specific activities of daily living and indicate the extent to which they performed these activities independently. If they did not perform these activities themselves, they were asked if the help they were provided with in order to complete these activities was adequate. The rating for the extent to which they were adequately resourced was: NR (Not Required – activity performed independently); F (Fully and adequately resourced by another person); P (Partially but not adequately resourced by another person); N (Not resourced at all).

The Senior's Activities of Daily Living: Capacity and Resources scale is an adaptation of the widely used Instrumental Activities of Daily Living Scale (IADL) by Lawton and Brody[6] and the University of Nebraska Geriatric Assessment Centre IADS Scale.[7] The concept of "resourced" was drawn from the ALSAR-Revised 2[8]. In this scale, a resource is defined as *support for task accomplishment extrinsic to the person*.

Social Participation, Loneliness, and Social Support

Social participation was examined using a simple table that allowed participants to describe their involvement with a number of different groups. Loneliness was assessed using a short scale designed specifically for that purpose [9]. A measure of social support was developed by selecting key indicators from the longer social support survey developed by Sherbourne and Stewart[10].

Non-Medical Requirements

Reports completed as part of the Better at Home study, including the "Better at Home for Victoria's West Shore"[11] and the "Better at Home Parksville Community Development Report"[12], were used to generate a list of non-medical requirements of Seniors. Participants were asked an open ended question about their needs which was followed up with specific prompts drawn from these reports.

Medical Requirements

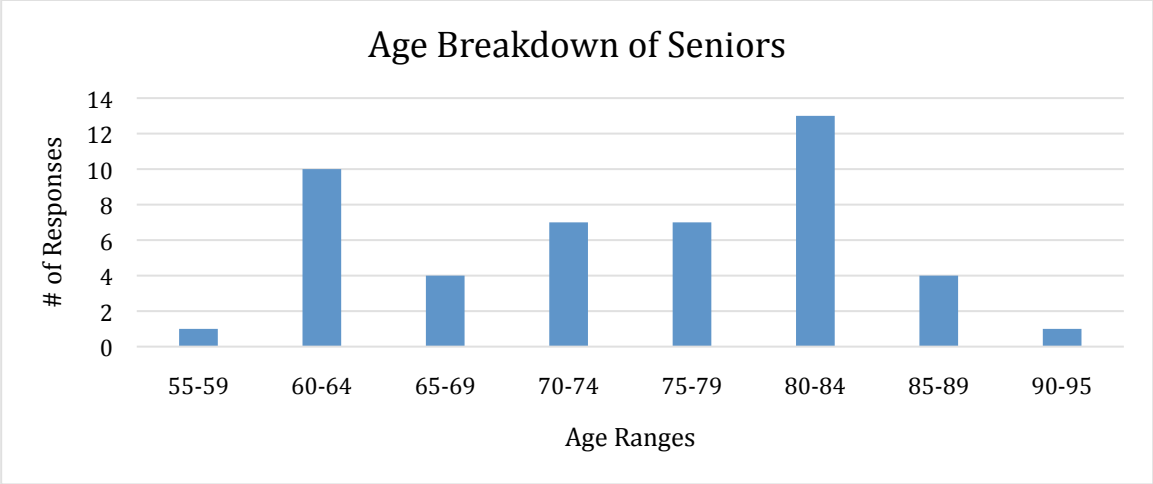
Participants were asked to rate their own overall health status and indicate if they had received help for a long term health condition or physical or mental health disability in the past 12 months. They were also asked to identify and comment on the severity of their main long term health condition. The condition prompts were drawn from the 2012 General Social Survey.[13]

Building on the work completed by the South Island Division of Family Practice in 2013, questions about participants' access to a family physician were included in this study. Questions of particular interest to Sooke physicians and to the District of Sooke addressing current diagnostic services were also included in the interview guide. The closing question was open ended, asking participants if there were other medical services they believe they needed in order to remain in their own homes.

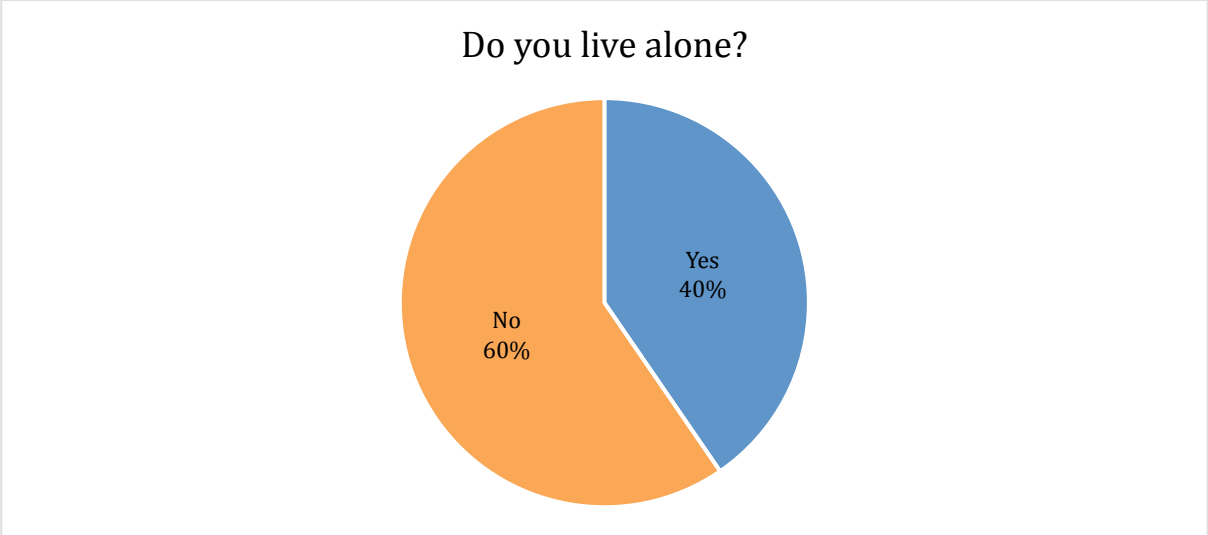
PART 3: Results from the Study

Demographic Information

Of the 47 Seniors who volunteered for the study, a majority (72.3%) were women, while men made up 27.7% of the respondents. The average age of the participants was 74.5, with the oldest participant being ninety (90) years old, and the youngest fifty-eight (58). The age breakdown of the study participants is provided below.



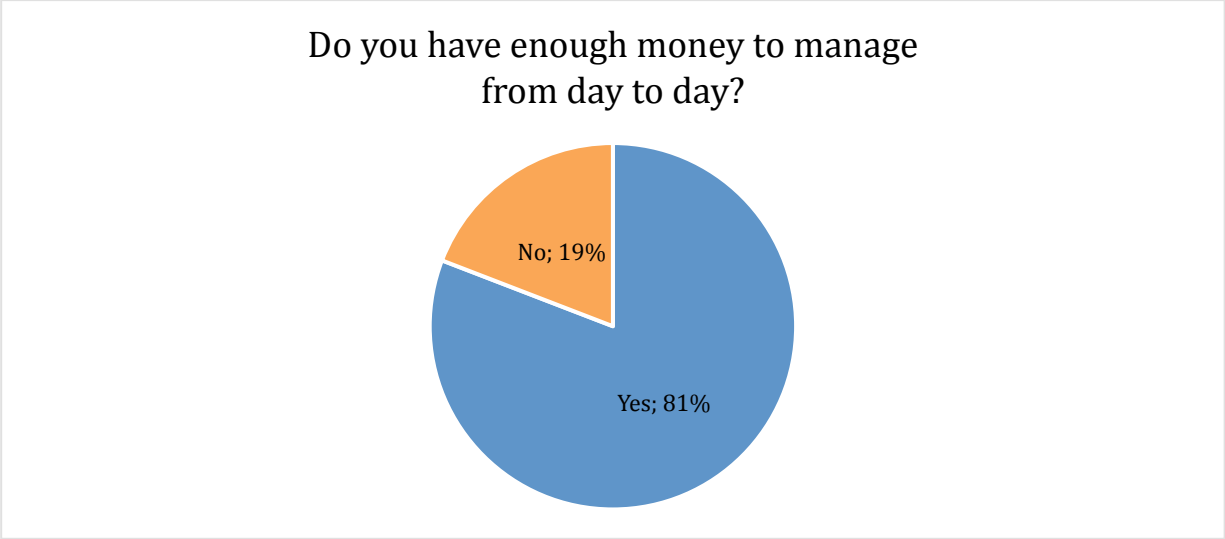
Around 51% of the Seniors were married (47%) or in common-law relationships (4%), while 38% were widowed and 11% were divorced. Approximately forty percent (40.4%) of the Seniors in the sample indicated that they lived alone.



"Living alone" is considered a risk factor for many adverse health outcomes[14]. Of interest, this figure is almost double the percentage reported in the 2011 National Household Survey[15] for District of Sooke Seniors. This could indicate that the Sooke Seniors' who live alone were more likely than other Seniors to express concern about their ability to remain in their own homes (and to volunteer for this study).

Of the 59.6% of Seniors who lived with other people, most lived with their spouse (77.4% of this group), while the rest lived with their adult children (12.9%), other relatives (6.5%) or a roommate (3.2%). In a few cases, a Senior lived with more than one of the above (for instance, their spouse and adult children in the same house). All of the Seniors interviewed lived in either an apartment or a house (including mobile homes). None of the participants had spouses who were living separately in nursing homes.

Most of the Seniors were retired (83.7%), although a few still worked (8.2%). In some cases they were "mostly retired" but still doing occasional work to make ends meet. Most of the Seniors felt they had enough money to manage day-to-day (80.9% reported this), although this often came with some caveats. For instance, two of the participants felt they had enough money currently, but were concerned this would no longer be the case once they stopped receiving disability payments. Others expressed general anxiety about their financial future.



Of the 19.1% who said they did not have enough money to manage, many cited the insufficiency of CPP, OAP and/or GIS payments as being part of the reason. At least two of the participants regularly borrowed money from friends to get by each month, and one said she had been living off credit cards for the past year.

In many cases, Seniors "cut corners" to make their money last. One Senior used her woodstove more regularly as a way to reduce electricity costs. Another had stopped driving to reduce her monthly costs.

Senior's Activities of Daily Living

Seniors were asked about their ability to perform various daily tasks, as well as how well resourced they were for any activities that they had difficulty performing. “Resourced” was used, in this case, to mean supported or assisted by another person. If a Senior was fully resourced for a given task, that meant they received adequate help in that area, and didn't require any extra assistance.

The first way in which the Activities of Daily Living data can be examined is in terms of the self-reported ability of Seniors to complete a task themselves, or with the help of another person. The ability to get things done was assigned a score of 3, 2, 1, or 0. A score of 3 was assigned if a task was performed completely, a score of 2 indicated that some aspects of the task was performed, a score of 1 indicated that very few aspects of the task were performed, and a score of 0 was assigned if the task was not performed at all.

The following table shows how many Seniors reported that each daily activity was accomplished completely (3), partially (2), minimally (1), or not at all (0).

Activity	3		2		1		0	
	#	%	#	%	#	%	#	%
Meals	37	79%	6	13%	2	4%	2	4%
Housekeeping	23	49%	17	36%	4	9%	3	6%
Laundry	36	77%	2	4%	5	11%	4	9%
Shopping	36	77%	5	11%	3	6%	3	6%
Finances	37	79%	8	17%	0	0%	2	4%
Transportation	40	85%	1	2%	6	13%	0	0%
Medication	40	85%	7	15%	0	0%	0	0%
Telephone	45	96%	2	4%	0	0%	0	0%
Home Repairs	4	9%	25	53%	18	38%	0	0%
Gardening	7	15%	18	38%	12	26%	10	21%

As the table indicates, most of the Seniors were able to make calls, take their medication and arrange their own transportation. Many participants were already operating at some level of adaptation to health or physical challenges, either by performing difficult tasks more slowly (two participants noted this in the case of laundry), reducing the number of things they had to do every day, or simply no longer dealing with some things (as one woman said about her inability to garden, “Mother Nature is my gardener now”). Home repairs, gardening, and housework were the areas that presented difficulties to the most people. Of significance, 21% of the Seniors were not completely able to prepare their own meals.

When the concept of “resourced” is examined, it is possible to determine how extensively people rely on support or assistance to get daily activities accomplished.

Activity	Not Required		Fully Resourced		Partially Resourced		Not Resourced	
	#	%	#	%	#	%	#	%
Meals	29	62%	3	6%	15	32%	0	0%
Housekeeping	16	34%	13	28%	17	36%	1	2%
Laundry	33	70%	8	17%	6	13%	0	0%
Shopping	32	68%	6	13%	8	17%	1	2%
Finances	36	77%	7	15%	4	9%	0	0%
Transportation	34	72%	3	6%	10	21%	0	0%
Medication	38	81%	7	15%	2	4%	0	0%
Telephone	45	96%	0	0%	2	4%	0	0%
Home Repairs	3	6%	23	49%	19	40%	2	4%
Gardening	5	11%	26	55%	11	23%	5	11%

As data in the above table indicates, there are many activities for which people do not appear to require extra assistance (Not Required Column). However, in order to accomplish the tasks of daily living to a satisfactory level, there are other areas where assistance is both required and provided (Fully Resource Column). Most notably, 55% of Seniors require and receive assistance with gardening, 49% with home repairs, 32% with meals, and 28% with housekeeping. In some instances, the assistance that Seniors receive is not guaranteed, and if these arrangements were to fall apart, they would be unable to get specific tasks accomplished.

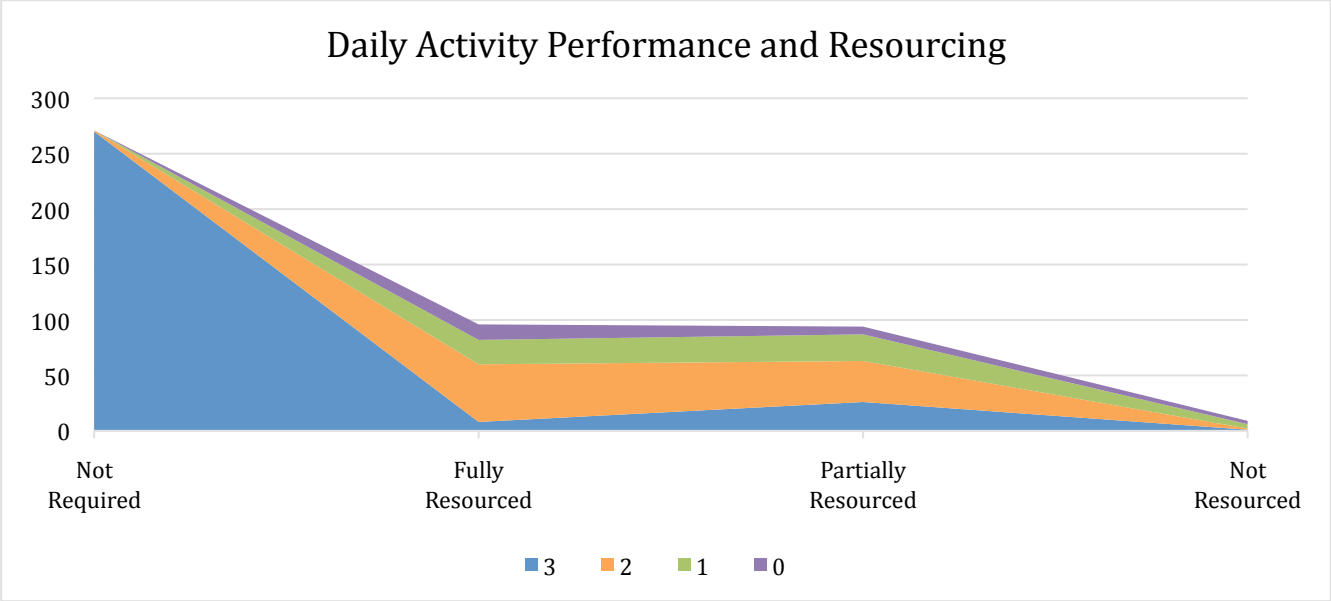
Home repairs presented a hurdle for quite a few people, as 44% said they both had some level of difficulty with this type of activity and were unable to get all the help they needed. Within this subset, the range of ability varied; some Seniors were still able to do minor repairs, while others were unable to change light bulbs without assistance. Housework was a similar issue, as 38% said they had trouble with or were unable to complete housekeeping tasks on their own and were insufficiently resourced in this regard. Gardening also has relatively high physical demands: 34% of the Seniors were having some level of difficulty with this task (from being unable to garden at all to still doing some tasks independently) and were either completely without help or only partially resourced. Meal preparation, is perhaps of more concern in that it directly affects health status, and 32% of seniors were not able to complete this task with or without help. Two of the respondents added that their level of ability to perform such tasks varied day-to-day due to the unpredictable nature of their health problems.

Challenges around transportation were also frequent: while 73% of the Seniors were still driving themselves or able to use public transportation without issue, 13 of these 35 respondents said they either never drive at night or avoid it as much as possible. Of those who were unable to travel independently, 21% were only partially resourced in this regard. A couple of Seniors mentioned relying on friends and neighbours for all transportation, and one mentioned that she can't use taxis because of the cost.

The interplay between the performance of daily activities and the extent to which people are resourced, or get the assistance they need to complete these activities, is graphically depicted below. The corresponding table that follows provides a further explanation of the

information in the figure.

The figure shows the number of daily activities that are completed successfully (285 activities depicted in blue). Most of these activities (270) are completed independently by the Seniors themselves. However, the remaining daily activities (165) were completed partially (orange area = 2), minimally (green area = 1) or not at all (purple area = 0). In fact, it appears that as Seniors come to rely on others to assist with daily activities, the completion of these activities declines.

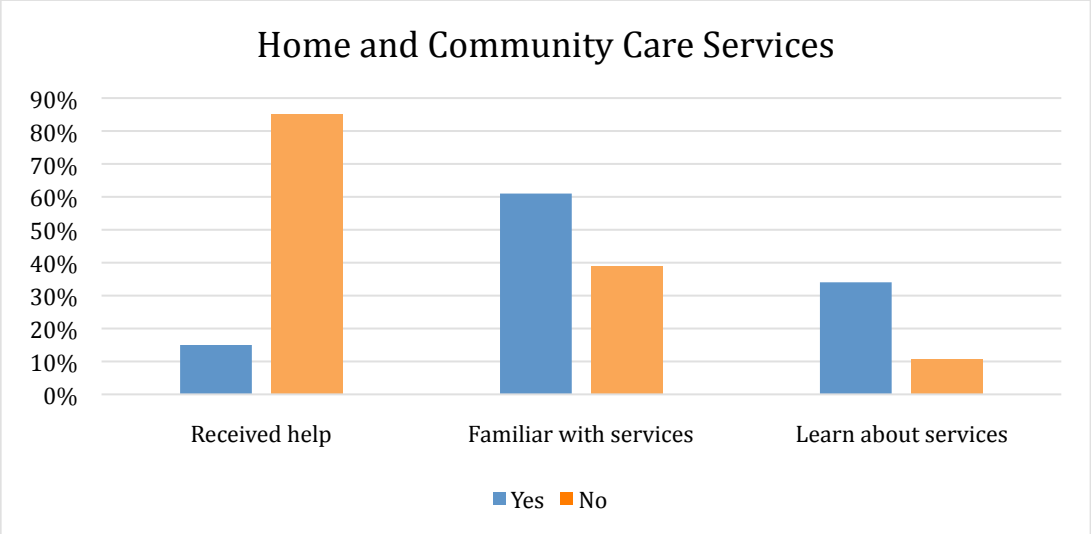


Performance of Daily Activities	Not Required		Fully Resourced		Partially Resourced		Not Resourced	
	#	%	#	%	#	%	#	%
3	270	57%	8	2%	26	6%	1	0%
2	1	0%	52	11%	37	8%	1	0%
1	0	0%	22	5%	24	5%	4	1%
0	0	0%	14	3%	7	1%	3	1%

Most of the Seniors (91.5%) had some kind of support network in place, but given the above data, it is no surprise that the involvement of other people in their support network varied considerably; from living with the person they relied on for help, to relying primarily on a family member in another province who visited once or twice a year. Of the help that people did have, 75.5% came from family members, primarily adult children and spouses, while 17% came from friends. One Senior relied on a sister to drive in from Victoria once a week to help her shower.

Seniors were also asked about any help they received from Island Health Home and Community Care, although only 14.9% had received this help in the past year. Some had

experience with this service via family members, but had not used the services themselves. There seemed to be a knowledge gap around Island Health Home and Community Care services, as 39.1% said they didn't know about the services or were unsure what assistance was provided and how to access it; 34% of all of the Seniors said they would like to learn more about Home and Community Care. This latter group represented 76.2% of those who were not familiar with the services offered by this Island Health program.



Social Participation, Loneliness, and Social Support

Social support and engagement with others are important factors in overall health. With this in mind Seniors were asked about their level of involvement with other people, and in various activities outside the home. Seniors responded to a question about eight different types of activities, including those involving family and friends, the church, sports and physical activity, other recreation, education, service clubs, their neighbourhood and community, and volunteer/charity work. Seniors indicated how often they engaged in activities, and the response options varied from *Never* to *At least once a day*. Results from this line of inquiry is summarized below.

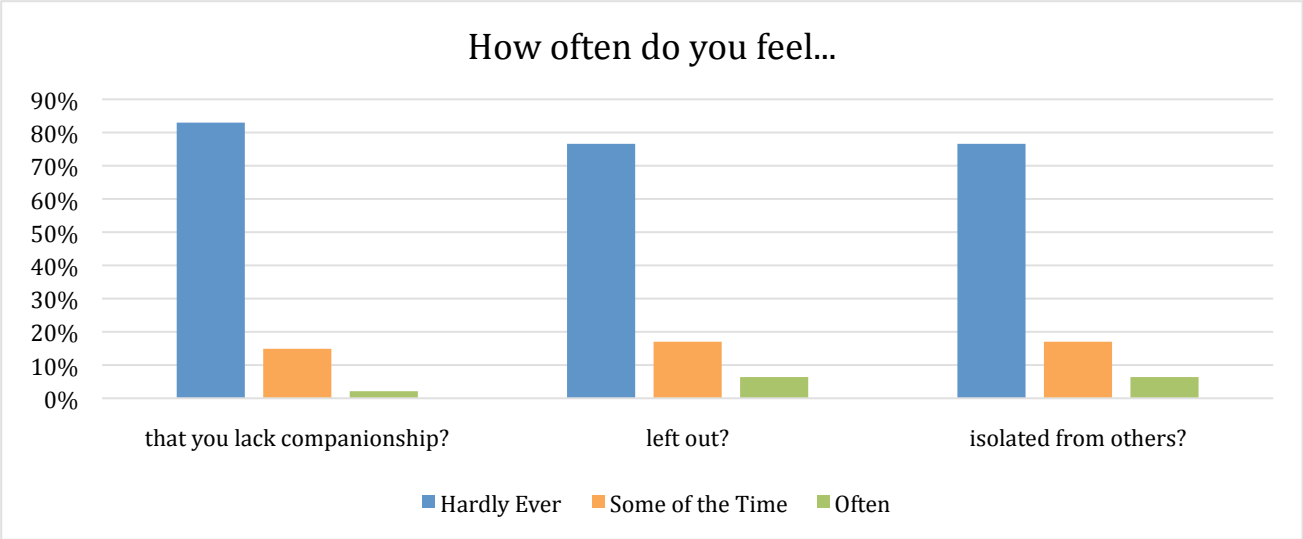
Activity	At least once a day 5		At least once a week 4		At least once a month 3		At least once a year 2		Never 1		Average
	#	%	#	%	#	%	#	%	#	%	
Family or friendship activities	8	17%	33	71%	3	6%	3	6%	0	0%	4.0
Church or religious activities	0	0%	6	13%	5	11%	4	9%	31	67%	1.7
Sports or other physical activities	13	28%	20	43%	3	6%	0	0%	11	23%	3.5
Other recreational activities	1	2%	21	47%	9	20%	4	9%	10	22%	3.0
Educational activities	0	0%	2	4%	5	11%	4	9%	36	77%	1.4
Service clubs	0	0%	1	2%	7	15%	1	2%	38	81%	1.4
Neighbourhood, community or professional associations	0	0%	8	17%	10	21%	1	2%	28	60%	2.0
Volunteer or charity work	1	2%	8	17%	12	26%	4	9%	22	47%	2.2

Of the 47 Seniors interviewed, 70.2% saw friends and/or family members at least once a week, 17% saw friends and family once a day, while 6.4% reported contact only once a month and 6.4% once a year. Participation in service clubs and neighborhood, community, or professional associations was significantly lower, with 80.9% never taking part in service clubs and 59.6% never participating in any of the aforementioned associations. Church attendance was also low, with 67.4% never attending church or engaging in activities such as church choirs or committees. A few of the respondents qualified this by indicating they would like to attend services, but had been unable to find a local church that suited their needs.

Few people reported attending educational activities; 76.6% of the participants said they never did educational things outside the home (some mentioned being avid readers, but this was always at home). Volunteer or charity work was more varied, with 2.1% engaging in these activities daily, 17% once a week, 25.5% once a month, and 8.5% once a year. At least three (3) of the respondents said that they regularly babysat for family members of neighbours. The remaining 46.8% did no volunteer or charity work, although at least one participant mentioned a desire to do so despite her current lack of involvement. A majority of the Seniors did some kind of regular physical activity (27.7% daily, 42.6% weekly, 6.4% monthly) however this usually involved walking. Of concern, some did not engage in other recreational activities which is directly related to health and well-being. Seniors were also asked about their participation in any other activities not already mentioned in the survey, and 46.7% reported that they engaged in other activities at least once a week (2.2% daily, 20% monthly, 8.9% yearly, and 22.2% never). These other activities included concerts, woodwork and model building, travel, bridge, and a booth at the farmers' market.

Several people said that they had reduced all types of social contact because of poor health and limited mobility. One person pointed out that he was easily fatigued, which made it difficult for him to leave the home, and another reported that they could not stand for very long which made it impossible to participate in activities they used to enjoy. Social contact was clearly important for many of the Seniors, one of whom said he sometimes thought being in a nursing home might be preferable to his current situation, if only for the person-to-person contact it would provide.

Seniors were also asked about loneliness and emotional support. Perhaps as a result of the fact that 60% of the Seniors lived with a husband, wife or family member, 83% said they hardly ever lacked companionship, and 76.6% hardly ever felt left out or isolated from other people.



Many of the Seniors who did live alone talked about having a network of friends and family members they could reach out to if necessary, although some respondents did struggle with loneliness and isolation: 17% felt that they lacked companionship some of the time or often, and 23.4% said they felt left out or isolated some of the time or often. One respondent said she felt isolated partly because she had only moved to Sooke recently, and therefore hadn't had time to get to know many people yet. Others mentioned the loss of a spouse, distant family, and mobility or health issues as factors contributing to isolation and loneliness.

The Seniors' responses to questions about the emotional and practical support they received from other people were a little more varied. Nearly half (48.9%) said that there was always someone available with whom they could have a good time and get their mind off things, 34% said they had this support available most of the time, while only 10.6% reported "some of the time". When asked if they had someone who understood their feelings, 42.6% said yes, always, and 40.4% said most of the time, with 12.8% saying only some of the time. Similar numbers came up when asked if they had someone who made them feel wanted or loved – 38.3% said all the time, 40.4% said most of the time, and 17% said some of the time. Of the people who reported having little to no support in these areas, one said she didn't "feel [she] need[s] emotional support", while another Senior said she tends to cope with any emotional distress by watching television because she has few external supports to turn to.

Seniors also felt that they had quite a bit of practical help available to them, with 27.7% saying they had this support available all the time, 40.4% most of the time, and 25.5% some of the time. However, the available help doesn't always fulfill every practical need, and some Seniors also mentioned a desire not to become a burden by asking their friends and neighbours for assistance too often, even if these were the same people they listed as being available to them.

Non-Medical Requirements

During this part of the interview process, Seniors were asked to identify the services they believed they needed if they were to remain in their homes for a longer period of time. With the exception of "snow shoveling", the *Managing at Home* study questions included the "basket of services" that were described in the *Better at Home for Victoria's West Shore* report referenced earlier[11]. In addition, Seniors were asked about personal care, help scheduling or coordinating things, help with finances, pet care, meal planning and preparation, help finding community resources, and help advocating for services. Study participants were also asked if there was any "other" non-medical help that they required.

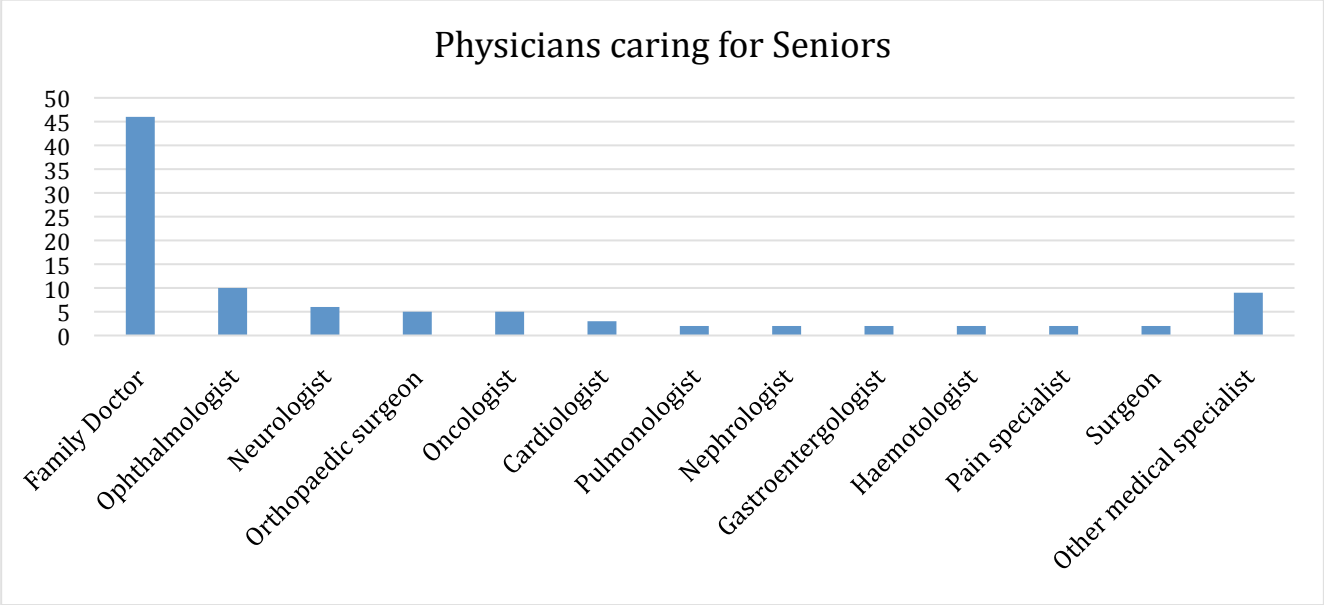
As the table below demonstrates, assistance with home repairs and maintenance, yard work, housework, and transportation were the areas where the most help was desired, with 59.6% of participants saying they would like help with outdoor/yard work, 68.1% asking for help with repairs/maintenance, 46.8% asking for help with housework, and 42.6% for help with transportation. Some Seniors also wanted help finding community resources (39.1%), advocacy (31.9%), help with shopping (31.9%), meal preparation and clean-up (25.5%), a companion for activities and to spend time with (14.9%), help with personal care (14.9%), financial guidance (12.8%), help with scheduling and filling out forms (8.7%), and pet care (6.4%). The list of other non-medical help that was requested included assistance with stairs and other outside mobility issues, ramps and/or bars for the house, other mobility aids such as a walker or wheelchair, a list of accredited workers to make hiring easier and safer, help with legal issues, a permanent and dedicated Seniors' Centre in Sooke, help with vehicle repairs, end-of-life planning, and assistance with computer use.

Non-Medical Requirements	Yes, need help	
	#	%
Home repairs or outdoor maintenance	32	68%
Outdoor or yard work	28	60%
Other non-medical help	24	51%
Help with light housework	22	47%
Transportation	20	43%
Help finding community resources	18	39%
Grocery shopping	15	32%
Help advocating for services	15	32%
Meal planning, preparation or clean up	12	26%
Friendly visiting or a companion to see and do things with	7	15%
Personal care	7	15%
Help with your finances	6	13%
Scheduling or coordinating things	4	9%
Pet care	3	6%

Medical Requirements

The final part of the interview dealt with medical concerns, focusing initially on access to and satisfaction with care. All but one of the 47 Seniors had a family doctor, and of those with doctors, 89.1% had been able to find a GP in Sooke. Given that some of the interviewees found out about the *Managing at Home* survey through posters placed in their Sooke doctor's office, these results are not representative of the experiences of all Seniors in the larger community.

Specialist use amongst participants was high, as 74.5% said they saw specialists, either regularly or as the need arose. Ophthalmologist was the most cited, followed by neurologist, orthopedic surgeon, and oncologist. Fourteen (14) of the participants had seen two or more specialists in the past year. A summary of the type of physicians who were caring for the Sooke Seniors in this study is presented in the table below.



Most of the Seniors interviewed were quite happy with their ability to access the care they needed. When asked specifically about their ability to access physician services, 85.1% were satisfied. The 14.9% who had been unable to get all the physician services they needed had a range of stories to tell: at least five (5) people specified that waits for surgery were too long, while others wanted to be able to see general practitioners and specialists closer to home. Other people related delays in non-surgical care, and one participant felt that she hadn't received enough follow-up care when it came to her physiotherapy appointments.

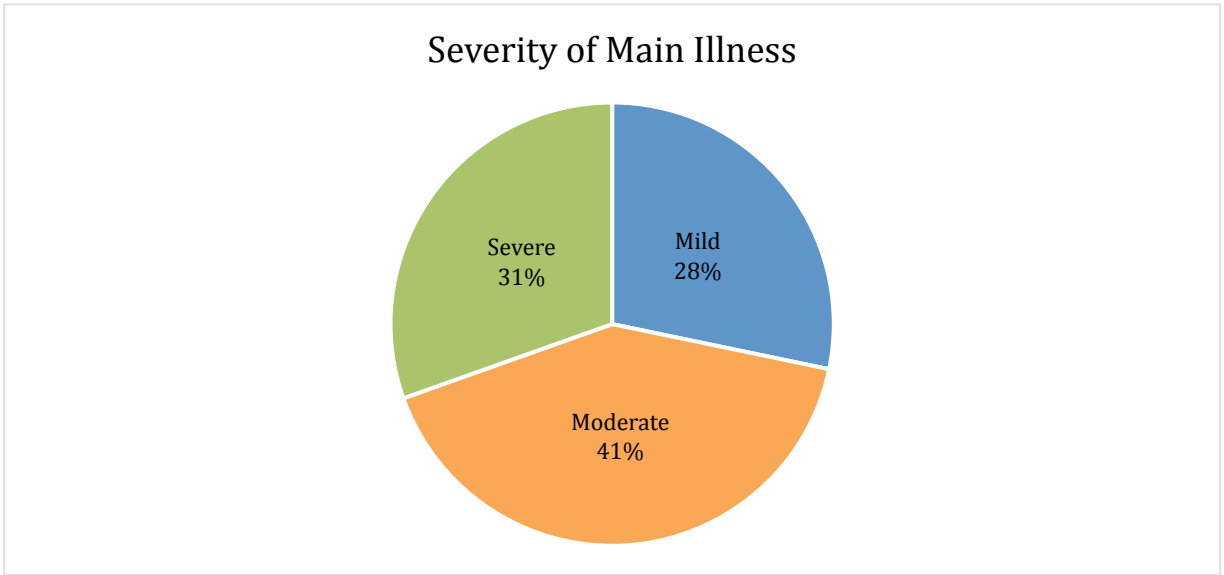
The interviews also explored self-reported health status. Participants described their health in positive terms, with 78.7% rating their own health as either Good, Very Good, or Excellent. 14.9% rated their health as Poor, while only 6.4% described their health as Fair. On the whole, Canadian Seniors report positive health status[16]. However, this is not the case for

seniors who experience disability, lower incomes and limited social support. The number of Seniors in this study who fell into these categories was insufficient to support further exploration of these relationships.

In the previous 12 months, 95.7% of the Seniors had received care for an ongoing medical condition of some kind, most of them from their doctor and/or a specialist (only 9.9% specified that their care was from a nurse, massage therapist, or other practitioner). The conditions for which participants were receiving care were varied and are described in table form below, with the most common being arthritis (63.8% suffered from this), cardiovascular disease (42.6%), and diabetes (19.1%).

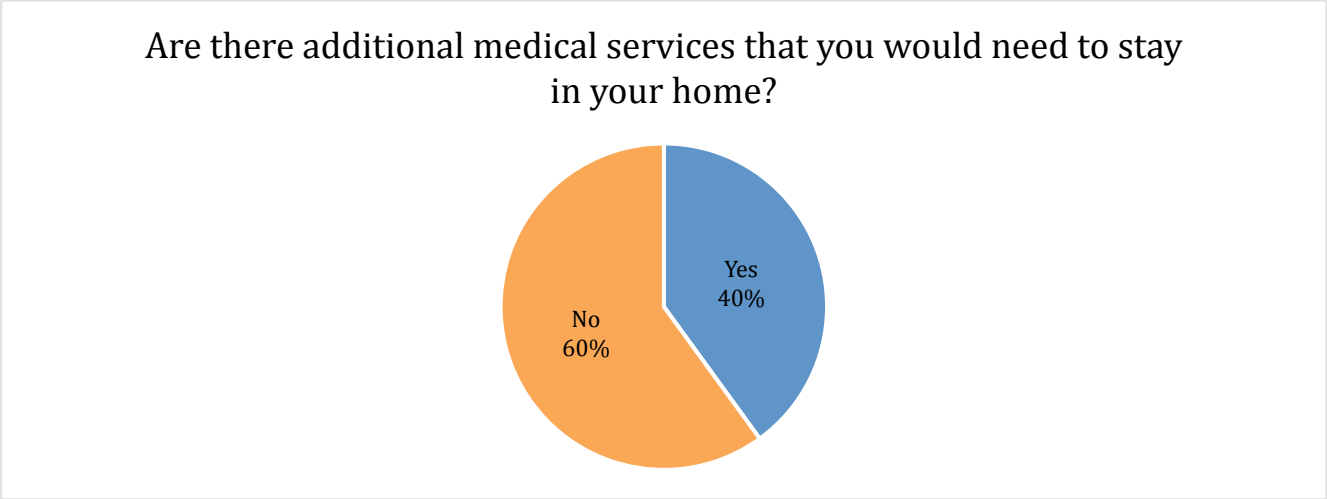
Disease	#	%
Arthritis	30	64%
Cardiovascular	20	43%
Diabetes	9	19%
Digestive	8	17%
Back	7	15%
Cancer	6	13%
COPD	6	13%
Neurological	5	11%
Injury from Accident	11	23%

Interestingly, despite the majority of respondents describing their health in positive terms, only 28.3% considered their health conditions to be “mild”, while 41.3% said it was “moderate”, and 30.4% said “severe”. Of those who had ongoing medical issues, 93.5% said they believed they would need more help or care during the next year.



The PHCSWG have been concerned about the availability and quality of diagnostic services in the Municipality of Sooke. Seniors were asked about diagnostic services generally, and not specifically about those in Sooke. Seniors reported frequent use of diagnostic tools such as blood work and x-rays, with 87.2% having used those services in the past year. Of those respondents, 85.4% said they had been able to get the tests done in a time and place that was convenient for them – the Seniors who were not satisfied in this respect (14.6%) mentioned having to drive into Victoria or the Westshore, long waits for appointments, and having a hard time getting an appointment that fit with a caregiver's schedule as barriers to accessibility.

Seniors were asked to specify if there were any other medical services that they would like to be able to access, at the current time or in the future, and 40% said yes – these included things like more affordable physiotherapy and massage therapy, more affordable dental care, access to better x-ray services in Sooke, transportation to and from medical appointments, and access to an occupational therapist or a similar practitioner to help make their home safer.



PART 4: Protective Factors and Risk Factors: Case Studies

Many of the Seniors who were interviewed were capable, self-reliant people who volunteered for this study because they faced specific challenges that they believed might adversely affect their independence. Others were experiencing more complex problems due to a host of factors that had the potential to affect their ability to cope in their home environment. Traits, situations or circumstances that contribute to positive outcomes can be described as protective factors that insulate Seniors against ill health or other negative outcomes. Risk factors, conversely, are attributes or circumstances that expose people to the potential of negative outcomes. Protective factors and risk factors affecting Seniors health and well-being are the focus of numerous reports and academic publications.[17] It was not our intention to identify all of these factors, nor was it feasible given our sample size.

We did, however, try to determine how many of the 47 Seniors experienced at least 3 of the following risk factors that are associated with negative outcomes: living alone; insufficient funds to manage day-to-day; social isolation from others often or some of the time; a moderate or severe health condition; and having received assistance from Home and Community Care (possibly indicative of a higher care requirement). Ten of the 47 Seniors experienced 3 or more of these factors, and 1 of these 10 Seniors experienced all 5 of the factors.

In addition to the above analysis of the qualitative data, two case studies were prepared. The first illustrates a Senior who appeared to be doing relatively well and who demonstrated a number of protective factors such as living with a spouse and having few financial concerns. The second case study is of an individual who demonstrated or experienced few protective factors, and who may be more vulnerable to poor health and social outcomes. Specific facts and characteristics of the Seniors were changed to protect their anonymity.

Case Study 1 (Protective Factors)

Lawrence is a 75-year-old man who lives with his wife in a small house that is walking distance from the centre of town. He and his wife are both retired, and find they still have enough to money to manage on a daily basis. They rely on each other for support with day-to-day things, and are able to hire for larger jobs when needed. Lawrence and his wife sold their much larger property a few years ago. This previous house was much farther away from shopping, friends, and essential services; their current house is both easier to maintain and closer to everything they need. Lawrence and his wife both cook a little, but also receive Meals on Wheels a couple of times a week, which they find very helpful when they are both too tired to prepare a full meal.

While Lawrence does have a few ongoing health conditions, his symptoms are well managed, to the point that he considers his health to be quite good. His long-time family doctor is located in Sooke, so he doesn't need to drive far for medical appointments. Lawrence is satisfied with the care he receives and feels well looked after. His wife also considers her health to be very good. Her biggest challenge is difficulty with steps, but luckily their house is single-level and Lawrence is usually around to assist her if necessary.

Lawrence doesn't participate in very many organized recreational activities, but he gets regular physical activity (mostly walking), and sees his family and friends at least every few days. His children often come over for meals, special occasions like birthdays and holidays, or just to check in. He doesn't feel isolated or left out from the community, and knows that there is always someone available to support him both practically and emotionally. He and his wife are members of a church in Sooke, and can also draw on support from that community. One of his few concerns about the future is dealing with financial and legal matters as he ages, and whether his children would be willing and able to take care of those things if he is ever unable to. His wife is worried about how they'll get to appointments if either of them ever loses their driver's license, although currently their only limitation in that regard is that they find it challenging to drive at night, and try to avoid it. Luckily, their financial situation would enable them to take taxis if necessary, and their proximity to town also alleviates any transportation concerns somewhat.

Lawrence's situation is relatively strong because he has multiple external resources available to him, as well as the financial wherewithal to pay for any other help he may need. He's able to look ahead and plan for any future difficulties that might arise as he and his wife get older. He isn't isolated or lonely, he doesn't have significant mobility issues, and he's still physically able to do many of the things he enjoys. Although he does rely primarily on his wife for companionship and help with day-to-day tasks, neither one of them is in a caregiver position for the other, and he has other family members ready to step in. Lawrence's health is stable, he hasn't had any significant difficulties in accessing care, and he trusts his family doctor. Lawrence's network of support, his financial situation, and his current good health leave him in a secure position.

Case Study 2 (Risk Factors)

Agnes is a retired 66-year-old widow who has lived alone since her husband died 4 years ago. She has numerous health problems which cause her constant pain and fatigue, and make it difficult to walk and stand. Agnes relies on her adult son who lives in Victoria for occasional help with some household chores. Her younger sister, who also lives in Victoria, comes to Sooke twice a week to help her shower. Agnes cannot get in and out of the bathtub by herself, and has not been able to install grab bars, railings or a bath chair. She hasn't been able to access financial assistance because she finds doing paperwork challenging and confusing. Despite all of this, Agnes regularly babysits her school-aged grandchildren, who take the bus to her place from Victoria, when her son is at work.

Over the past few months, Agnes has experienced increased pain and more mobility problems. She hasn't been able to organize a wheelchair or a walker to help her move around the house. She previously hosted regular family dinners, but her levels of pain have now made standing to cook too painful. Other family members are too busy to take over her role, which means she sees less of her family than she used to, and feels helpless because she can no longer do something that connects her with her family.

With a reduced income since her husband's death, no savings, and the burden of a mortgage and car payment, Agnes has just enough money to get by most months, and can't afford the cost of significant repairs and alterations to her home. She is financially unable to hire help, which is why she relies on family as much as she does. She worries about being a burden on her family. Even with their assistance, she's unable to keep her house and yard to the standard she would like. She reports feeling a loss of control over her life.

Agnes spends a lot of time alone, watching TV. Although she still drives, shopping is difficult, and social events outside the home are rarely an option without assistance. She misses her friends and spends most of her time by herself, aside from family visits and a neighbor who occasionally comes by. Agnes says she often feels lonely and sad, and worries about the future.

Her experiences accessing medical care have been problematic. She couldn't get a local family doctor, and has to drive into Victoria for all medical appointments. Some of her symptoms are un-diagnosed, but she's reluctant to be hospitalized for more tests, because she's afraid they might find something else wrong. She also worries the doctors might take over the decision-making process, that they and the other hospital staff won't respect her wishes for independence, and that they will take her off the pain medications she's currently

on. Due to the uncertain nature of some of her health issues, she finds it hard to plan for the future because she feels things could change at any moment.

There are many factors contributing to Agnes' current situation. Her poor health makes independent living increasingly difficult, and contributes to greater social isolation. Her financial situation makes it hard for her to hire help to accommodate her physical limitations. Living alone makes her more vulnerable in the event of a crisis, and her mistrust of the health care system makes it harder for her to receive care. Her occasional role as caregiver to her grandchildren puts her in a position of responsibility she's not always physically able to handle, but which she's reluctant to give up because of the importance of helping out her family. Apart from grief over her husband's death, his loss has left her without a consistent emotional and practical support. Agnes is only partially resourced in most areas. If one of the people supporting her were unable to continue for any reason (illness, work, etc.), she would be even more isolated and at risk.

PART 5: Conclusions and Recommendations

The 47 Seniors who participated in the *Managing at Home* study ranged in age from 58 to 90 years, with an average age of 74.5. A higher than anticipated percentage of these Seniors (40%) lived alone. Almost one fifth of this group did not have enough money to manage day-to-day, and many others expressed financial concerns. Seniors' ability to successful complete activities of daily living, either independently or with help from people in their support network, was a major focus of the study. While participants were able to successfully complete many tasks, such as handling the telephone, taking their medication and dealing with their personal finances, gaps were identified. Home repairs, housework, gardening and meal preparation were problematic for many Seniors. Even when outside helpers were called in, some of these daily tasks were not adequately taken care of. In terms of meal preparation in particular, this may place some Seniors at risk of poor nutrition and consequent poor health. It follows then that these 4 areas were ones for which seniors requested additional assistance, although fewer Seniors asked for help with meal planning, preparation or clean up than for help with the other 3 areas.

Transportation is a complex issue in that although many of the 47 Seniors were able to drive, several did not like to drive at night or avoided driving as much as possible. Of those who could not drive, almost one quarter of the respondents were not always able to secure transportation. The implications of these problems in terms of simple things like attending medical appointments, getting to the grocery store, or getting out to visit a friend are significant for these Seniors. Almost half of the Seniors in the study asked for help with their transportation problems.

Social participation of the Seniors varied considerably. Some Seniors appear to be well connected to family and friends, while others did not appear to have opportunities to participate in outside activities, sometimes as a result of poor health and limited mobility. When asked directly about companionship and loneliness, almost one fifth felt they lacked companionship some of the time or often, and almost one quarter felt left out or isolated some of the time or often. Of interest, few requested "friendly visiting", focusing instead on getting practical help for things such as finding community resources, advocating for services and grocery shopping.

Seniors were asked if they had a family physician, and all but 1 Senior reported that they did. They also accessed specialist services. Seniors were satisfied with the care they were receiving. Over three quarters rated their own health as good, very good or excellent yet almost the same number identified a health problem that they considered to be moderate to severe. Almost all of the Seniors believed they would need help with their medical issues in the coming year.

Based on the data and selected protective and risk factors, 10 of the Seniors in the study appeared to be at higher risk of experiencing future problems than the remaining 37. These results are preliminary and warrant further investigation. However, they do introduce the concept of a continuum of need that should be pursued, keeping in mind that the Seniors who volunteered for the study, for the most part, function independently of the home health and social service net and might be prevented from entering the formal helping system if appropriate informal, community based resources are provided to them.

Recommendations from the *Managing at Home Study* are as follows:

1. Develop a “basket of services” system for Sooke Seniors that provides help, at minimum, with home repairs, housework, gardening and meal preparation.

2. Address the transportation needs of Sooke Seniors and Seniors in surrounding areas, prioritizing driving for medical appointments, grocery shopping, social connection, and physical activity.

3. Develop an information and outreach capability, that provides Seniors with information about financial assistance including assistance for homeowners, and services including those available through Home and Community Care. This may require the use of a “navigator” to assist Seniors to find the resources they require.

4. Expand local, community based research to address the needs of Sooke Seniors with different characteristics and requirements, and from different parts of Sooke region.

Endnotes

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