Katahdin-area Thriving in Place

Needs Assessment Findings

Prepared for the Katahdin-area TiP Collaborative
by
UMaine Center on Aging
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Thriving in Place

"The ability to live in one's own home and community safely, independently, comfortably, and with dignity, regardless of age, income, or ability level. “Home" is broadly conceived and defined by the individual. "Independence" means the level of independence needed and desired by the individual and does not exclude the ability to have supports for thriving in place."

Maine Health Access Foundation Priorities

- Through the TiP partnerships, health care providers, community-based organizations, and other partners implement innovative, collaborative, community-based strategies that meet the health care needs of adults with chronic health conditions and improve linkages and coordination with community supports that are closely related to achieving positive health outcomes (such as housing, transportation, home and community services, family and friend care giving supports, volunteer networks, and opportunities for community engagement).

How we determine community needs

- Interviews with community members
- Surveys with people serving community members
- Existing evidence about community needs

State Plan on Aging

Priorities for aging and disability services

- Educate and improve access to existing health and community long term services and supports.
- Support individuals to remain safely in environment of their choice.
- Encourage active and healthy lifestyles and community engagement for aging and disabled adults.
- Protect the rights and safety of aging and disabled adults.
- Ensure data integrity, quality, and access to services for aging and disabled adults.

http://www.maine.gov/dhhs/oads/trainings-resources/documents/STATEPLANONAGING2016-2020DRAFT.pdf

Maine Shared Community Health Needs Assessment and County Health Rankings

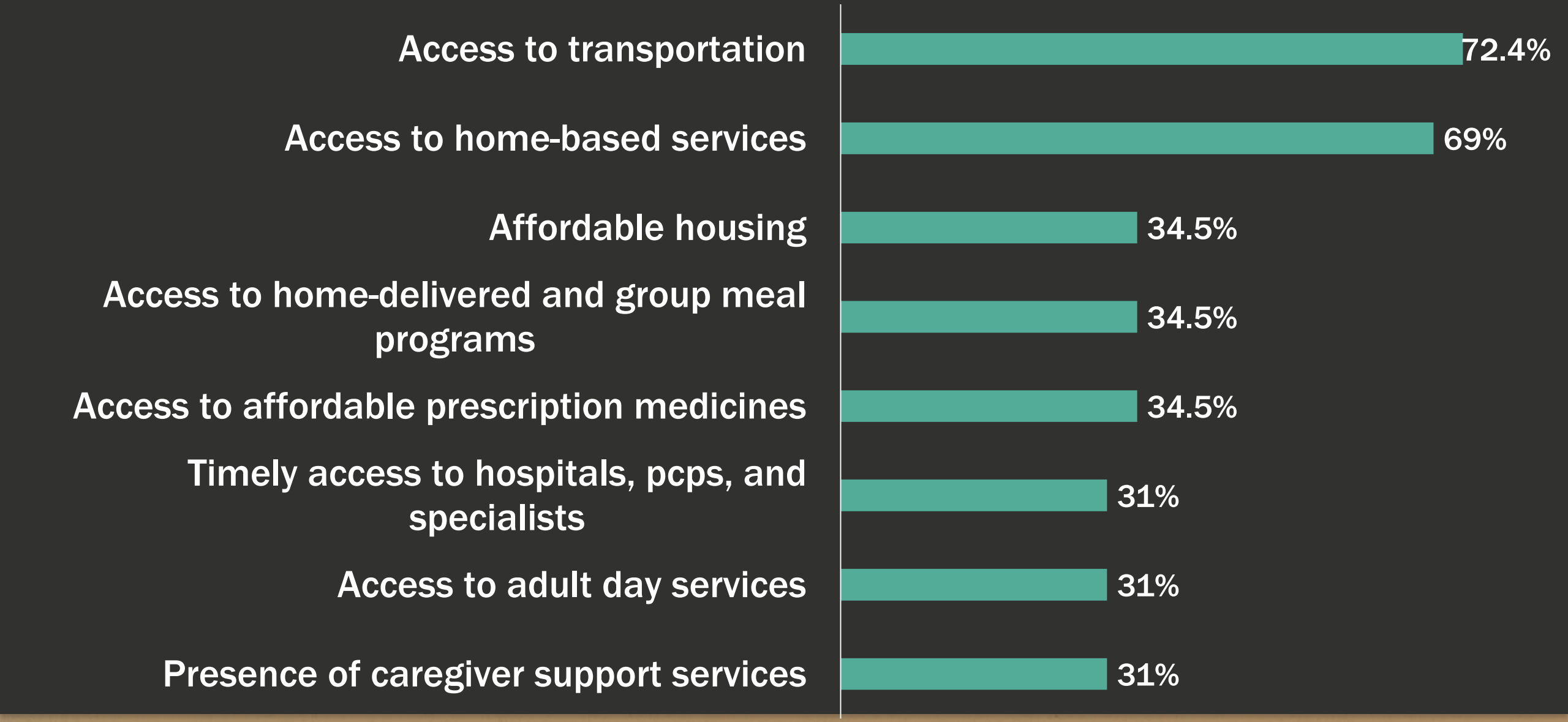
Major Health Issues in Penobscot County

Economic	General Health	Chronic Disease
• Poverty • Low median income	• High fair to poor health • High overall mortality rate	• Cancer • Lung cancer • Cardiovas. • Diabetes

ED/Hospital Visits	Physical activity	Food
• COPD • Cardiovas. • Stroke • Diabetes	• High sedentary lifestyle	• Low score on food environ. index

http://www.emhs.org/Community-Benefit/CHNA.aspx
http://www.countyhealthrankings.org/

% of Providers Identifying Community Need (N = 30)



Systems Challenges

People and organizations are knowledgeable of the range of services that are available to people with chronic conditions or disabilities.	**46.4% Disagree**
Systems are in place to facilitate data sharing for monitoring, surveillance and evaluation between people and organizations	37% Disagree
People and organizations collaborate on the development of key health messages to support healthy living and self-management of chronic conditions.	32.1% Disagree

Systems Challenges

Systems are in place to support information and referral between primary care providers, public health, home care and acute care for chronic condition prevention and management.	**28.6% Disagree**
Systems have been developed to support service integration across the continuum of chronic condition prevention and management services.	28.6% Disagree
People and organizations are addressing stigma as a barrier to those with chronic conditions and disabilities accessing needed services	28.6% Disagree

Organizational Challenges

- Conducted surveys with 13 agencies serving Northern Penobscot
- 7 of 12 organizations identified transportation as a major barrier for accessing their services
- About ¼ of the most requested services from responding agencies had minor waitlists. Meals on Wheels had the largest reported wait list (75-100 people)
- State waiting lists for home and community-based services were identified as a challenge
- Lack of direct care workers and volunteers was the second most identified barrier to service access

Community Member Interviews (N = 36)

Demographics	
Average Age	73
Age Range	21 - 90
Male	35%
Female	65%
Lives in own home or apartment	100%
Lives alone	55%
Lives with another person	45%

- Generally high satisfaction with existing services, concerns about communication with medical providers
- Utilizing informal supports and adaptive equipment are significant ways people adapt to illness/disability
- Limited knowledge of available services
- Significant challenges:
  - Transportation and mobility (especially in winter)
  - Social isolation

Importance of informal supports

What services or supports are you currently using to help with managing your chronic condition or disability?

- My friends and family, religion.

- My wheelchair and my walker; none really, at this point, use my children. I don't use any agencies, as long as I have my son's I don't really like calling anyone else.

- Nothing now, I have my friend, but she is not always available. I don't really like calling anyone else, and I don't know of anyone else to call. (Not aware of any service agencies in the community to help her).

- My daughter does a lot for me: She takes me to the doctors, the store, and the bank. I have that other outfit (CHCS??) come in 3 days a week; Monday, 3 hours, Wednesday, 2 hours, Friday, 2 hours and they help out with some of the things I need to get done around the house.

Use of adaptive equipment

How have you adapted your home and life to help you with managing your chronic condition or disability?

- No stairs, shower handles, cell phone through SafeLink.

- Don't have stairs, arranging furniture so a wheelchair can go through. I have a lid opener. I would like a long grabber. I have a walker.

- Handles in bathroom. I have oxygen and wider doors for wheelchair.

- I have old age, some trouble getting around, but have a wheelchair and a walker to use inside. Too unsteady on my feet, and afraid I was going to pass out. I have trouble hearing as well, can only hear out of one ear.

Challenge: Transportation

- I cannot drive out of town easily, and when I do I am anxious. I usually deal with this by not going. Easier to not go than be nerved up about the outcome, can't remember too well.

- Not being able to do what I would like to do, like driving, my memory is going as well and that is very frustrating when I see people I know but cannot remember their names. I always worry about falling.

- I have relatives and friends that I rely on - but hate to bother anyone - they all have families - how long will they be able to help me?

- Too unsteady on my feet, use a walker. I never go out except to get my hair done. I have a friend that goes to do some errands for me.

Challenge: Mobility

- I have to be very careful walking; winter scares me. I call one of my sons, I have two in-town.
- I am stuck inside, can't do anything I used to do.
- The winter time is tough, and being on this oxygen. I call my daughter, and have these girls (from CHCS??) that helps out with house work, groceries, getting my prescriptions. It is a difficult darn way to live, but I manage.
- Winter weather interferes with walking outside. I go to my church and walk area there for 1/2 hour.
- I have a challenging time with stairs. I step slowly, one at a time. I slide down to go down.

Challenge: Social isolation

- I have been very depressed lately, all my friends have died and I really have no one. Hate that I can't get out of the house.

- I like the idea of people receiving a call from someone with interest that I am well or just the contact it would ease the loneliness and break up a day. I am alone, and talking to someone might lessen this feeling.
- I live alone. It was and is a challenge to start over after the death of your spouse. Living is quite different when your spouses passes and needs to be overcome.
- I am stuck inside, can't do anything I used to do. I would love to have someone here with me. Lost my wife of 45 years 7 years ago, my life has never been the same.
- I think a "hotline" of some kind that shut-ins and people that live alone can receive a friendly voice daily to start off their day that otherwise might be down and a voice would be a pick-me-up.

Satisfaction with healthcare

Can you give an example of a medical appointment, hospital visit, or other experience with healthcare that you were unhappy with?

- Satisfied with medical care.
- No. Usually visits are consistent.
- I have never been unhappy with my health care.
- I am very happy with Dr. Dunstan and pretty much go along with the flow. The hospital is great.
- Sometimes when I see my doctor I feel like he is in a hurry; I have told him that as well, I don't like that feeling of being rushed when I feel sick, but he is a good doctor and I would not change.
- Dr.'s not listening to me, nurses not being compassionate.
- Overall, I am unhappy with follow-up from doctor after an appointment. They have a laptop computer and pay more attention to it than to me and personal care.

Caregiver Interviews (N = 9)

- Highlighted need for socialization for care recipient and opportunities for respite for caregiver
- Want more information about available services and supports in a convenient way

Challenge: Respite/ Socialization

- Socialization at home, some one to visit her…
- Respite care for time away or to attend support groups. Transportation services to help the caregiver to provide opportunities outside of the home for the person receiving the care.
- An adult daycare program where he could be at for a number of hours.
- Support groups for fibromyalgia, volunteers to help with household chores, errands, shopping.
- Volunteers to call person and check on them. Volunteers to come in to visit and take chronically ill person places - respite care. Other transportation modes for folks who can't afford Lynx or need transportation on days other than Mondays.

Challenge: Knowledge of supports

- A list with number and the agencies and what they do so one can call for particular question or need to get the answer.

- Knowing what resources are available.

- One place that can serve as an informational clearinghouse. Caregiver says something like a pamphlet, written in simple terms, that can be handed out in places the elderly or sick frequent that provides all types of contact information. Many elderly aren't tech savvy and won't use a computer (this caregiver's person still had a rotary dial phone) so something that is familiar, like a brochure or pamphlet, that they can hold and look at would be good. It is something their physician's offices could hand out to them and explain how to use it. Need to remember that in rural Maine there are many elderly who aren't tech savvy and don't read well so it needs to be clear, concise, and easy to use.

Summary of major needs related to thriving in place

- Building awareness of available services among providers and community members
- Reducing isolation
- Supporting mobility and access to transportation
- Promoting person-centered care
- Improving data sharing among agencies; information and referral between medical and social services.
- Improving food access
- Development of volunteer and homecare workforce
- Support for caregivers and family members, including respite.

MEHAF Priorities Revisited

- Through the TiP partnerships, health care providers, community-based organizations, and other partners implement innovative, collaborative, community-based strategies that meet the health care needs of adults with chronic health conditions and improve linkages and coordination with community supports that are closely related to achieving positive health outcomes (such as housing, transportation, home and community services, family and friend care giving supports, volunteer networks, and opportunities for community engagement).

Thank You!

- Needs assessment participants
- Maine Health Access Foundation
- Katahdin Shared Services/Jane McGillicuddy
- TiP Collaborative members
- Interviewers
- Kate Kinney, Graduate Research Assistant, Center on Aging
- UMaine student research team: Favour Akhidenor, Thomas Elie, Jeremy Robichaud