HEALTHY & POSITIVE AGEING INITIATIVE

International models of support coordination services (SCS) in five OECD countries – An Evidence Brief

June 2020

The Healthy and Positive Ageing Initiative (HaPAI) is a joint research programme led by the Department of Health with the Health Service Executive, Age-friendly Ireland, and The Atlantic Philanthropies.

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PREFACE

This report was completed by the Healthy and Positive Ageing Initiative (HaPAI) which is a research programme led by the Department of Health in association with the HSE, Age-Friendly Ireland, and The Atlantic Philanthropies. The HaPAI was established in order to achieve Goal 4 of the National Positive Ageing Strategy (1): *Support and use research about people as they age to better inform policy responses to population ageing in Ireland.* National Goal 4 involves two objectives:

- Continue to employ an evidence-informed approach to decision-making at all levels of planning; and
- Promote the development of a comprehensive framework for gathering data in relation to all aspects of ageing and older people to underpin evidence-informed policy making.

The HaPAI is also aligned with several goals and actions of Healthy Ireland – A Framework for Improved Health and Wellbeing 2013-2025 (2), the national framework for the improvement of population health and wellbeing, and the WHO's Active Ageing: A Policy Framework (3) which provides key policy proposals for enabling active ageing in our societies. The HaPAI commenced in 2015 and is operational in a number of different areas of activity:

- The development of national indicators of older people's health and wellbeing, leading to the 2016 publication of a biennial report on the health and wellbeing of older people in Ireland.
- The establishment of a research fund to commission targeted additional research to fill identified data gaps required to cover all indicators, relevant to the design or configuration of future services and supports for older people; and
- At a local level, the development of indicators using either national data broken down to the county level where possible or additional data collected locally and published in a series of county reports in selected counties.

EXECUTIVE SUMMARY

This evidence brief provides a description of international models of support coordination services (SCS) in five OECD countries, including the United Kingdom, United States, Canada, New Zealand, and Australia. The purpose of this brief is to assist with the implementation and policy development regarding action 5.7 (support) of the joint policy statement "Housing Options for Our Ageing Population", and to provide sufficient evidence on the international approaches to support coordination for the Department of Health to consider.

RESEARCH QUESTIONS

- What is support coordination?
- What support coordination models are used in other countries?
- What is the current profile of support coordination services in Ireland?

KEY FINDINGS

Definitions of support coordination

Definitions of support coordination and related terms shared several common elements and were underpinned by the principles of prevention, person-centred support, and collaboration and partnership. We developed a working definition based on these common elements:

> *A capacity-building and person-centred support service that enables older people aged 65+ to live independently in their homes and communities for as long as possible, by providing housing-related advice, and support with navigating different systems including housing, social, and community health services. Furthermore, it is a preventative and interventional support service aimed at enhancing the well-being and quality of life of older people by improving the housing conditions in which they live.*

International models of support coordination

- **United Kingdom:** *Floating Support* is the most common community-based preventative support model in the UK. It falls within three service types including outreach services, low-intensity support, and high-intensity support. Funding is provided by the Supporting People governmental program. *Local Area Coordination* (LAC) focuses on utilising community resources and building community connections and aims to reduce dependence on professional services. They are not linked to any service and are based in a geographical area of up to 12,000 people. There are no formal eligibility or assessment criteria.
- **United States:** *The Area Agency on Aging* (AAA) model is long established in the U.S., operating for over 50 years. AAAs are either public non-profit or private agencies and can be embedded in local government agencies or operate as

independent non-governmental organisations. Service coordination, information, referral, and outreach are the primary functions of AAAs.

- **Canada:** *Senior Services Society* is an independent non-profit organisation that links older people with a range of non-medical support services. Provides a range of one-on-one housing support including outreach, information on housing, and linkage with repair/modification services. *Naturally Occurring Retirement Community-Supportive Service Programs* (NORC-SSP) are locally run grassroots partnerships between residents in NORCs and service providers. The model aims to coordinate care and support and facilitate collaboration among stakeholders for the integration of medical, health, and social services, as well as non-medical housing-related supports.
- **New Zealand:** *Needs Assessment and Service Coordination* (NASC) is a government-run program designed to assess the needs of people with disabilities and older people, as well as providing service coordination. Services are either delivered directly by dedicated services of the District Health Board, by an independent third-party assessment agency, or by a combination of providers. A key feature of the NASC model is its link with Equipment and Modification Service providers and assessors.
- **Australia:** *The Assistance with Care and Housing* (ACH) sub-program is a government-funded program provided to help older people living in insecure housing or facing homelessness, with navigating and accessing services. The Government introduced the *Aged Care Navigator* (ACN) trial to support older adults to make informed choices about their aged care needs. ACN trials were rolled out across Australia in 2019 to test different models to support people to navigate the aged care system.

Basket of Services

Following a review of the services provided by each of the models, several key supports were identified:

- Advice on housing and welfare rights
- Advice on how to address poor housing conditions (i.e. maintenance and repairs)
- Support with filling out forms and claiming tax benefits
- Signposting and referral to relevant housing organisations and other local and existing services in the community
- Support with accessing services and navigating health and social care systems
- Social support and companionship

COVID-19 and support coordination in Ireland

- In response to the COVID-19 pandemic in Ireland, the government developed a National Action Plan, setting out a society-wide response and mobilisation of resources across government and community sectors.
- In line with the National Plan the Department of Rural and Community Development (DRCD) in partnership with governmental and community

organisations, developed a Community Response Action Plan which aims to coordinate the community response to COVID-19.

- The DRCD launched the “Community Call” to link local and national government with community and voluntary sectors to coordinate community support. This initiative includes COVID-19 Community Outreach (CCO) which is coordinated by The Wheel and Irish Rural Link and funded by the DRCD. The CCO links and supports the work of community and voluntary organisations.
- Marginalised groups including Roma and Traveller communities, homeless people, refugees, and asylum seekers living in direct provision are disproportionately affected by the virus. Several third sector organisations across Ireland are trying to ensure that these communities are protected and supported.

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CHAPTER ONE

INTRODUCTION

Policy context, research purpose and overview

1. INTRODUCTION

POLICY CONTEXT

The National Positive Ageing Strategy for Ireland (2013) (1) sets out a vision for ageing and older people in Ireland and outlines the national goals needed to promote positive ageing. Community participation, mental and physical wellbeing, security, and research were identified as the four national goals of the strategy. The third goal (security) relates to 'Ageing-in-Place' and highlights the need to create age-friendly communities that "enable people to age with confidence, security and dignity in their own homes and communities for as long as possible" (p.19).

In line with this strategy, the joint policy statement "Housing Options for our Ageing Population" was published by the Department of Housing, Planning and Local Government (DHPLG) and the Department of Health (DoH) and a Steering Group comprised of DHPLG, the Health Service Executive (HSE), the City & County Mangers Association (CCMA), Age Friendly Ireland (AFI), the Housing Agency, the Centre for Excellence in Universal Design (CEUD), and key stakeholders who provided guidance and expertise on drafting the policy statement (4). The policy statement outlines the actions needed to meet the growing demand for appropriate and age-friendly housing and support people to live in their own homes for longer. It provides a policy framework by which the Government and relevant agencies, and national positive ageing stakeholders can develop and promote a variety of housing options and choices for older people in Ireland, including housing-with-care and supported housing. Overall, 40 actions were included to make progress under the themes of data gathering, collaborative working, delivering choice, support services, comfort and safety, and maintaining momentum (4). To deliver on these actions an Implementation Group was established, including the two Departments (DoH and DHPLG), the HSE, local authorities and other key stakeholders[1]. One of the key actions under the theme of support services is action 5.7, which aims to

> *Promote the use of Support Coordination Services to ensure that a collective approach to the provision of services is delivered at a local level. This will include mapping and signposting of all local services such as home supports, befriending, meals on wheels, transport services, activities, services, health and wellbeing programmes, specialist services, training and education and technology supports (p.33).*

This research brief has been completed by the Healthy and Positive Ageing Initiative and on behalf of the Steering Committee, in order to provide international evidence to support and inform progress under action 5.7. The primary aim is to provide sufficient information on the international approaches to support coordination, for the policy unit in the DoH to take a view and decide on the best approach to support coordination for Ireland.

[1] First Report of the Implementation Group on Housing Options for our Ageing Population Policy Statement: first_report_of_the_implementation_group.pdf. p.4.

PURPOSE

The evidence brief provides a summary of the international evidence relating to support coordination services (SCSs) for older people and in the context of housing with support[2]. It focuses on the approaches to support coordination taken by five comparable countries including the United States (US), the United Kingdom (UK), Australia, New Zealand, and Canada. These countries were chosen based on their membership of the Organisation for Economic Cooperation and Development (OECD), of which Ireland is a member, and due to them sharing relatively similar health and social care systems.

Three research questions guided the evidence brief:

1. What is support coordination? – This includes a summary of the definitions, principles, and benefits of, and rationale for support coordination as provided in the international ageing research and policy literature.
2. What support coordination models are used in other countries?
    a. What are the aims of the model?
    b. How does it operate?
    c. What services are provided?
    d. What governance approach is used (including structure, partnerships, funding mechanisms)?
3. What is the current profile of support coordination services in Ireland?

OVERVIEW

The evidence brief is presented in five sections. The next section (Section 2) provides a summary of the methodology. This is followed by Section 3 which provides the findings from the literature regarding the first research question: What is support coordination? and Section 4 presents the findings from a search of the literature regarding the second research question: What support coordination models are used in other countries? Section 5 includes a brief overview of support coordination in Ireland in light of Covid-19 and Section 6 concludes the brief.

[2] It is important to note that support co-ordination services also exist for other policy areas, such as family and child supports, but these are not reviewed in this brief.

CHAPTER TWO

METHODS

Literature search protocol, search criteria and screening process

2. METHODS

An Ovid database search was carried out using the key term 'support coordination service', which yielded 4,767 results. This result indicated that the search was too broad for the scope of this research, as a result, the search criteria was refined, and a repeat search was undertaken. This search yielded 157 results; however, after screening each result no relevant literature was identified. Due to the limited number of resources found from these searches it was decided that searching on Google search engines would be the best approach to take and that grey literature sources (e.g. reports, websites, policy documents) would be the most suitable sources for this research topic. Two strategies were used to search for grey literature: 1) Google search engines, 2) targeted website search.

To answer the first question, Google scholar and advanced Google searches were carried out using the following search terms either individually and/or in combination: 'support coordination service(s)', 'coordinator', 'housing', 'support', 'service', 'model', 'principles', 'benefits', 'ageing in place', 'older people', 'older persons', 'older adults', 'seniors' and 'elderly'. It is important to note that the terms 'older person' and 'older people' were used to describe this population throughout this evidence brief as they are the recommended and preferred terms over 'seniors' and 'elderly' (5). However, the latter terms occur frequently in the literature and therefore were included as key search terms in this brief to minimise the risk of omitting relevant sources. Several new terms and phrases of relevance were encountered after the initial search, including *floating support, housing-related support, service coordination, local area coordination, case management, and service navigation.* These terms were also included in the keyword search of relevant literature.

The first 10 pages (n = 100) for each search were screened for eligibility and relevance using the title and description underneath and relevant literature was bookmarked and saved in a folder. After screening the content section, executive summaries and/or abstracts of each reference for the terms 'support coordination', references peripheral to the main focus of the research topic and those that were inaccessible were eliminated. The literature consisted primarily of governmental and organisation reports and websites and the search also yielded some relevant journal papers (n = 11), which were included in this brief.

For the second research question, a repeated Google search including the countries under review was undertaken. To screen each one of these references in full, a predetermined set of inclusion/exclusion criteria was applied to ensure that the literature was focused. Table 1 shows the search criteria used to develop the search strategies and screen relevant literature. Literature published between 2000-2020 that focused on housing-related support for the older population was included. It was acknowledged that SCS models in different countries might cover several populations (e.g. young people, people with disabilities), therefore, these items were included on the basis that they also covered services for older people.

Literature that exclusively referred to health, social, personal, or medical care were excluded as the focus was on housing-related support. Again, the first 100 references were screened for eligibility. References from the previous search (Question 1) that were of relevance to the second research question were also referred to in this section.

TABLE 1. SEARCH CRITERIA

Criterion	Detail
Population	• *Inclusion:* Focused on housing-related support services for older people. • Support coordination services in some countries might cover several population groups (e.g. young people, people with disabilities, low socioeconomic status etc.) including older people. • The literature on these services was included where older people were one of the population groups.
Services	• *Inclusion:* Housing-related support services (not health/social/personal care provision). Housing support services may be provided alongside health and social care services by organisations in some countries, therefore these were considered. • *Exclusion:* Described services solely related to health, social, personal, or medical care.
Countries	UK, US, Australia, New Zealand, Canada.
Year	Publications limited to the years 2000-2020

Following an initial search to identify relevant organisational and governmental websites publishing information and documents relevant to the topic, a targeted search of relevant websites from each country was undertaken (see Appendix 1). The same methodological process was used to answer the third research question (What is the current profile of support coordination services in Ireland?). A google search was undertaken using a combination of the following key terms; 'covid-19', 'support', 'coordination' and 'older people'.

CHAPTER THREE

FINDINGS PART 1

Definitions, principles, rationale, and benefits of support coordination

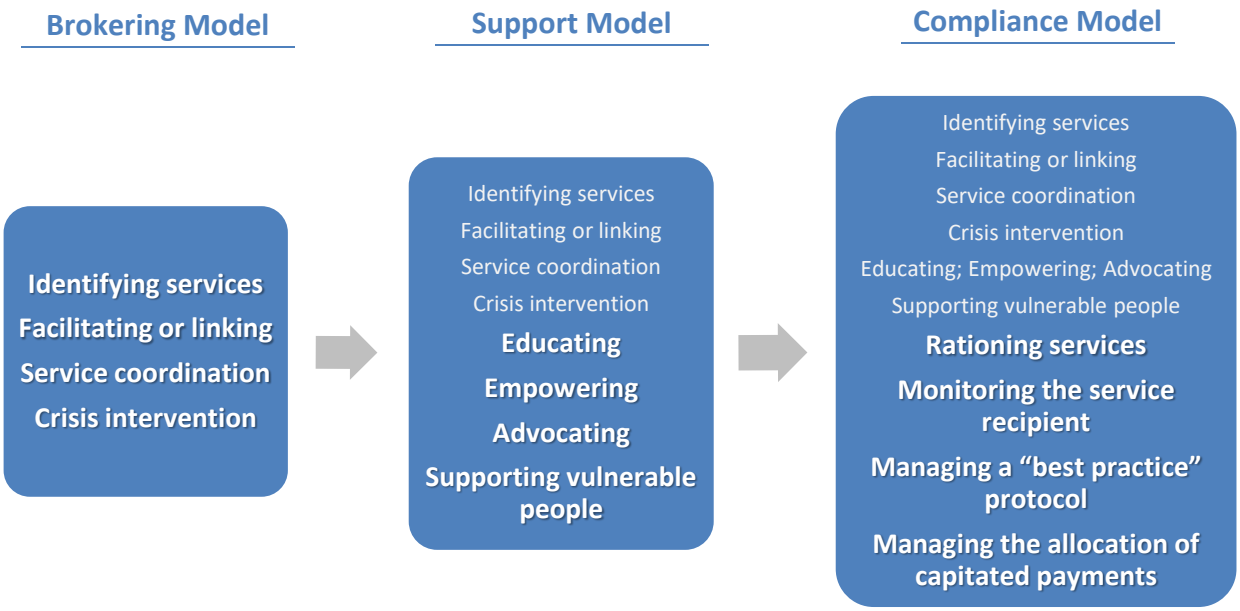
3. FINDINGS PART 1: Definitions, Principles, Rationale and Benefits of Support Coordination

This chapter focuses on the definitions, principles and evidence for support coordination and seeks to answer the first research question (What is support coordination in the context of housing-related supports for older people?).

SUPPORT COORDINATION MODEL

Support coordination is strongly linked to case management which is one of the most widely known community-based approaches to care and support within health and social care services (6–8). Case management is defined as "the activities undertaken by a service provider on behalf of an individual or family that needs multiple services, facilitating their movement through the service delivery process" (6). Over the years, the provision of care has shifted from institutional care toward community care, which is a more holistic approach to care that goes beyond a focus on a person's clinical needs, toward addressing the social, emotional, physical, and intellectual needs of the individual. As a result, case management as a service has evolved and different terms such as 'service coordination' have come to the fore (6). Service coordination is defined as "goal-orientated and individualised supports focusing on improved self-sufficiency for the persons served through assessment, planning, linkage, advocacy, coordination, and monitoring activities" (9). Three different service coordination models have been proposed: 1) Brokering, 2) Support, and 3) Compliance (see Diagram 1). The functions of the Brokering Model include identification of services, linking to services, coordination of multiple services and crisis intervention. The Support Model, in addition to carrying out brokering functions, aims to empower, and educate service users and to provide support to isolated individuals. The third, Compliance Model includes both brokering and support functions. The term compliance is used as one of the primary functions of this model and relates to monitoring that the service user is complying with appointments and to ensure that there are no problems that may lead to the need for additional services. This also involves monitoring service provider delivery, assessment, processes and outcomes (6). This evidence brief is primarily concerned with the Support Model of service coordination.

FIGURE 1. SERVICE COORDINATION MODELS AND FUNCTIONS



DEFINITIONS OF SUPPORT COORDINATION

A review of the literature revealed that the term 'support coordination' is not widely used in the context of housing supports for older people. Definitions primarily related to supports or services in the area of disabilities in Australia and the US (10–18) (see Appendix 2). Many of the definitions found in the disability area describe support coordination as capacity-building support that involves assisting the individual to gain access to and navigate a range of services. For example, the National Disability Insurance Agency (NDISA) in Australia define support coordination as:

> *Assistance to strengthen participant's abilities to connect to and coordinate informal, mainstream, and funded supports in a complex service delivery environment. This includes resolving points of crisis, developing capacity and resilience in a participant's network and coordinating supports from a range of sources" (14 p.3).*

Only five definitions of support coordination specifically relating to housing were identified. As an example, the Supportive Housing Association of New Jersey defines support coordination as "a funded service that assists individuals in gaining access to needed program and state plan services, as well as needed medical, social, educational and other services" (19). Furthermore, another organisation in the US described the role of the support coordinator as follows:

> *Support Coordinators are primarily responsible for assessing individual needs, developing plans for support to help reach individual outcomes, linking people to services and resources, and monitoring whether services are helping achieve intended outcomes. When it comes to integrated,*

> *independent housing, the responsibilities are very similar. Support coordinators convene the person-centred planning team and "coordinate" with members of the team to ensure a person's plan for housing is fully implemented* (20).

A list of all the definitions can be found in Appendix 2. Five key elements of support coordination were identified based on a review of these definitions: a person-centred approach; crisis prevention and intervention; capacity building; guidance and advice; and improving quality of life. In order to develop an operational definition of support coordination specific to housing-related support, other related terms, and models in the area of housing support sharing these elements were reviewed.

Our review found that two other terms were more commonly used to describe this type of service in the various countries under review. These included Floating Support and Local Area Coordination (LAC). The following section provides a brief description of these related terms; these will be described in greater detail in chapter two.

Floating Support

Floating Support was the most frequently encountered term in the literature on this topic, particularly literature from the UK. It is defined as a housing-related support service that provides low-level and preventative supports to different vulnerable populations, including older people (aged 65+). It differs from general housing support services in that it is community-based support that is not permanently attached to accommodation which is more typical of 'sheltered' housing. A range of housing-related support is provided, such as advice on housing and welfare rights, help with claiming benefits, support with accessing services and networking with specialist agencies, as well as emotional and social supports such as befriending. The primary aim of the service is to support independent living and improve a person's quality of life (21–26).

Local Area Coordination

Similar to Floating Support, Local Area Coordination (LAC) aims to support independent living through self-advocacy. LAC originated in western Australia, but the service is also in existence in parts of the UK. An emphasis is placed on locality and building an individual's capacity to live independently by drawing on family and community resources and forging local relationships. Local area coordinators support people of all ages who may be vulnerable due to age, disability or mental illness and help individuals to seek non-health-service solutions and build connections in the community before directing them to services. They also assist with service navigation (housing, health, social and financial systems) (27–31).

PRINCIPLES

Support coordination is driven by the concept of ageing-in-place (32–34) which can broadly be defined as "the ability to live in one's own home and community safely,

independently, and comfortably, regardless of age, income, or ability level" (35). Support coordination is underpinned by principles that support independent living and ageing-in-place including the principles of prevention, person-centred support and partnership and collaboration.

Prevention

The principle of prevention and early intervention is an important component of the support coordination model and is a key factor in enabling older people to retain their independence for as long as possible. Preventative support services for older people are designed to prevent further deterioration of a person's circumstances, prevent social isolation by enhancing community support, prevent illness or injury by improving their home environment and mental and physical wellbeing and reduce the demand on the care system by delaying or preventing early hospital admissions (36–40).

Person-centred support

Support coordination also uses a person-centred approach whereby supports are orientated toward the individual and their needs (36,39,41,42). It emphasises the value of older people as important members of their community, seeing them as active citizens and not merely as passive recipients of services (43). This approach is linked to the concept of self-determination which refers to a person being able to make autonomous decisions and take control of defining the direction of their lives (22,43,44). Essentially, support coordination enables self-determination by assisting older people to make informed choices and self-direct supports and services (17,25,39,45,46).

Collaboration and partnership

One of the primary roles of support coordination is to link individuals to relevant services and to develop and strengthen partnerships between other housing support services, local authorities and voluntary organisations (30,34,47). Maintaining independent living not only involves housing support but involves a collaborative approach between a range of other wrap-around services, creating a broad and robust resource network of local supports (47). In addition, collaboration with individuals and families accessing the service is central to providing individualised and person focussed support. Listening to and involving older people in the process and ensuring that they have all the information needed to make informed decisions about the services they need and receive is necessary for building their capacity (48).

SERVICE RATIONALE

Ireland has an ageing population with a growing number of older people living in mainstream housing and as a result, there has been an increased focus on ensuring that older people receive the support needed to remain living at home. However, evidence shows that older people are not always satisfied with the support they

receive (49). A report by Fox et al (2015) (49) on the housing and support needs of older tenants living in Clúid Housing (an approved housing body in Ireland) found that the needs of tenants in mainstream housing compared to sheltered housing were not being met. Participants in the study reported that there is a lack of access to, and information on services in the area, as well as a need for help with home maintenance and repair and more access and engagement with social activities in the area.

Housing and the physical condition of a home plays an important role in the health and wellbeing of individuals, particularly for vulnerable populations including older people (50). The Centre of Ageing and Research Development in Ireland (CARDI) showed the link between housing and health using the example of fuel poverty (50). Fuel poverty is defined as spending 10% or more of your income on heating your home to a level that is safe and healthy and is caused by the interaction between the high cost of fuel, low income and poor home energy inefficiency (51). Therefore, fuel poverty is high among low-income households that may not be able to afford to adequately heat their homes, and in homes that are poorly insulated (52).

Almost half of older people live in houses that were built before 1960, and these dwellings are typically poorly insulated and are likely to lack an efficient central heating system (51). Research by The Irish Longitudinal Study on Ageing (TILDA) found that fewer older adults living in houses built pre-1919 have central heating, and 27% of these rely on alternate heating methods, compared to adults living in homes built after 1919 (55). They also found that central heating is less likely in Local Authority Housing or private rented accommodation (68%) compared to owner-occupied accommodation (83%) (55). Older people living alone are also at a greater risk of fuel poverty than those who are living with others (53). Almost one-third (29%) of people aged 65 and over in Ireland live alone (51), and 36% of these experience fuel poverty (54).

In the same study by TILDA, older adults who reported difficulty with heating their homes had poorer self-rated health and were more likely to report clinically relevant symptoms of depression and chronic pain (55).

BENEFITS

Evidence has shown that improving housing quality (i.e. conditions of housing) through home adaptations and assistance with maintenance and repairs, can both benefit health services by reducing the level of admissions to residential and acute care and benefit the individual by improving their health and overall quality of life (56). For example, a study by the Joseph Rountree Foundation (56) found that 62% of older people felt safer in their homes and 77% reported a positive effect on their health following adaptations. Another report by Public Health England in 2018 revealed a 23% reduction in falls as a result of home adaptations (57). One of the primary functions of support coordination is to facilitate and increase access to housing services such as home adaptation and meal delivery services, therefore, support coordination can play a key role in preventing or delaying the onset of conditions that require more extensive care (43). Furthermore, support

coordination is a vehicle for broader system reform and service integration. Support coordination shares many similarities with LAC and several reports have shown the broad benefits associated with this type of service (28). A report by the Local Area Coordination Network (28) in the UK highlighted the benefits of LAC using results from 14 independent evaluations that were carried out on different LAC programmes over eight years. They proposed that coordination services benefit society at three levels: 1) Systems, 2) Community/personal and 3) Social (Table 2).

TABLE 2. FINDINGS FROM LOCAL AREA COORDINATION OUTCOME EVALUATIONS (28)

Level	Benefits
Systems-level	• Visits to GP surgery and A&E. • Dependence on formal health and social services. • Referrals to Mental Health Team and Adult Social Care. • Safeguarding concerns, people leaving safeguarding sooner. • Evictions and costs to housing. Smoking and alcohol consumption. • Dependence on day services. • Out of area placements by bringing people home
Community/personal level	• Increased informal and valued supportive relationships – reducing isolation. • Increasing capacity of families to continue in a caring role. • Greater confidence in the future. • Better knowledge and connection with the community. • Improved access to information – choice and control. • Better control over their health. • Better resourced communities. • Support into volunteering, training, and employment. • Preventing crises through early intervention and supporting people who do not meet statutory eligibility criteria. • Improved access to specialist services.
Social level	• Social return on investment (SROI): • LAC generates at least £4 of social value for every £1 invested

CHAPTER FOUR

FINDINGS PART 2

Models of support coordination in five comparable countries

4. FINDINGS PART 2: Models of Support Coordination in Five Comparable Countries

This section presents the findings on the international approaches to support coordination in the countries under review. A brief overview of the statistics on population ageing and health and social systems in each country is given followed by an overview of support coordination models.

UNITED KINGDOM

Background

The UK has a rapidly growing older population, there are almost 12 million people aged 65 and over, with 3.2 million aged over 80 and 1.6 million over 85 (58). According to an All-Party Parliamentary Group (APPG) report, 96% of older people in the UK live in mainstream housing and many would prefer to live independently in their homes as they grow older (59). The number of people aged 65 and over is set to increase by more than 40% within 20 years and the number of households with people aged 85 years and above is increasing faster than any other age group (60). This poses a major challenge for housing, health, and social services.

More than half of older people are living with chronic health conditions or disabilities that affect their daily lives (60). Older people disproportionately live in poor-quality, inaccessible, and unadaptable housing which further impacts their health and places increased demands on public services. Therefore home care and support are particularly important to prevent deterioration of their conditions (59). Only 0.6% of older people live in housing-with-care (61), it is becoming increasingly difficult for older people to access care and services, and the number of delayed discharges due to a lack of support is significantly costing the NHS (62). While there is clear evidence (61) showing the link between poor housing conditions and long-term health conditions, and a lot of discussion around housing and support for older people, there is still very little integration between the two. For example, there is limited mention of housing, adaptation, and repair in the NHS Long Term Plan. Furthermore, local housing strategies don't reflect the measures that could be taken by housing authorities to improve the housing conditions of older people (59).

Health care services such as community nurse services and GP visits are provided and paid for by the NHS. Most of the care and support services for older people in England are provided by local authorities, charges for these are dependent on the financial capacity of the person and some services are free of charge. Charities and private support service organisations also provide these services to older people in their homes who are not eligible to access local authority provided support services. Local authorities offer a range of housing adaptation schemes to assist with home

improvements such as low-cost loans and grants. Non-for-profit home improvement agencies assist eligible homeowners or private residents to carry out a range of improvements to the home (22,63).

The Care Act 2014 places housing at the heart of the definition of wellbeing for older people and places responsibility on local authorities to work alongside partners to enhance and support the wellbeing of local people (61,64). With a shift toward more integrated approaches to housing support, a Health and Housing Memorandum of Understanding to support joint action was agreed between governmental departments and agencies including the Association of Directors of Adult Social Services (ADASS), the NHS, Public Health England (PHE), the Homes and Community Agency (HCA) and other housing and health organisations (61). Since then, across the UK there is a growing evidence base supporting action for housing options for older people. A report from the Communities and Local Government Committee (2017) promotes the value of housing information and advice in supporting older people to make informed choices, stating that information and access are fundamental to helping older people to age-in-place (64). Furthermore, the report states that a holistic approach should be adopted with the provision of advice which covers a variety of issues relating to housing for older people such as repairs and maintenance, home improvement agencies, housing options and moving home, care options and signposting to relevant services and agencies for advice on housing finance.

SCS models

The integration of public health at a local level with social care, planning and housing, transport and leisure aims to keep people socially connected and enable them to remain independent in their homes. Housing-related support can play a key role in preventing a decline associated with ageing and in delivering care that is integrated (58). Currently, the Government allocates funding to local authorities for housing support for vulnerable populations under the Supporting People (SP) programme and according to the Department of Communities and Local Government, approximately 825,000 people avail of these services in the UK. However, funding is limited, and more government investment is needed to increase the capacity of services such as home improvement agencies to offer preventative services (38). Coordination of housing-related support in the UK is typically provided by Floating Support services and a more recent SCS model that has come to the fore in the UK is Local Area Coordination:

Floating Support

Aims

Floating Support is a model commonly used to provide housing-related support to various vulnerable populations in the UK including older people. It is broadly defined as a preventative support service that is "provided in the recipient's home...it can be ongoing but is often intended to be for a limited period with an

emphasis on developing the service user's independence through practical tasks. It does not include personal care" (37 pp.12-13). Floating Support services fall within three broad service types including (59):

- Outreach services: functions as a bridge between excluded groups and more intensive support services.
- Low-intensity support: a form of case management used to sustain existing housing where there is an unmet support need that might act as a barrier to independent living.
- Higher intensity support: direct support from multidisciplinary teams.

Operations

The above supports can be provided together or as discrete services. For example, one housing support service can provide a mix of these services for varying levels and types of need. Floating Support can also be combined with other housing-related support services including handyperson schemes and community alarm systems (59). Services are provided by various partners across the public, private and voluntary sectors and the role is typically carried out by a support worker (59).

To avail of the service, the service user must normally meet the following criteria: aged 65 and over; resident in the locality; in need of housing-related support to maintain independence; living in any form of tenure except sheltered housing; willing to work with a support worker and play a role in the process. The service is typically for socially excluded, vulnerable and hard to reach populations (60). Access to the service is usually through self-referral, but referrals can be from any source including social services, housing providers and health services (37). On receipt of a referral, the provider will carry out a needs assessment in the persons home, within 10 days of the referral (60). The basket of services (59) provided is listed below.

Basket of services

- Support planning
- Advice on housing rights and responsibilities
- Welfare rights advice
- Information on local facilities
- Accessing services
- Help with claiming benefits, budgeting, paying bills and debts.
- Learning to plan meals, shop and cook.
- Networking with specialist advice and support agencies to meet individual needs.
- Help with completing forms and tackling red tape.
- Advocacy
- Befriending and emotional support

Governance

Most Floating Support services are funded by the Supporting People programme (also known as the Housing-related Support programme). Supporting People is a government programme that was established in 2003 to create coherent policy and funding for housing support for vulnerable populations. Programmes are delivered by local authorities who determine how they distribute funds, which is based on local need. Strategic decisions are made by a commissioning body which is a partnership of local authorities, health, and probation. The commissioning body is supported by service providers and users and in each locality, there is a Supporting People team that delivers services and oversees contracts (61).

Local Area Coordination

Aims

Local Area Coordination (LAC) is a practical assets-based approach that emphasises "people's and communities' assets and not simply needs" (29 p.4). It is a person-centred service that supports vulnerable populations including older people, with a focus on preventing the need for formal service intervention by finding local supports. This means that instead of accessing or signposting people to services they can build community relationships that allow them to stay independent (26). The model uses a 'bottom-up' approach and is driven toward wider system change – shifting power away from professionals towards people and communities (29).

Scotland was the first country in the UK to use this model, starting in the early 2000s, local authorities began providing local area coordinators for people with disabilities. England and Wales followed suit in the years to come with the emergence of the 2014 Care Act, NHS Five Year Forward, the Localism Act, the Well-being of Future Generations Act (Wales) (29). LAC programmes have gradually expanded throughout the UK and there are now 12 programmes and 90 coordinators working across England and Wales (26,62).

The primary principles underpinning this approach are citizenship; relationships; information; gifts (all that individuals, families and communities bring); expertise (the knowledge held by people and their families; leadership (the right to plan, choose and control the direction of your life); and services (27).

The approach aims to make an impact at three levels; the individual, family, and community level; the systems level; and the strategic level (29). The overall aims are to:

- Prevent or reduce demand for costly services.
- Build community capacity and resilience.
- Support service reform and integration

At the individual, family, and community level it aims to:

- Reduce a person's dependence on professional services.

- Support people to find non-service solutions.
- Create and build supportive personal networks.
- Ensure access to information and connections to existing local resources.
- Improve health and wellbeing and self-management of health.
- Promote and develop self-determination and control.
- Build more resourceful communities.

The aims at the systems level are to:

- Shift from crisis intervention to prevention through local solutions.
- Move toward strength-based capacity building.
- Increase choice and range of services.
- Consolidate local partnerships and joint working between LAC coordinators, services, communities, and organisations.
- Build connections through social prescribing.

At the strategic level, the goals are to:

- Reduce dependency on formal service-based solutions.
- Create linkages between services.
- Build individual and community resilience.

Operations

Local area coordinators are not linked to a particular service (29). They are place-based, working in a defined geographical area of up to 12,000 people and typically support 50-65 individuals and their families in this area (35). They approach vulnerable individuals, such as those who are isolated in the community or at risk of needing professional services (26). They do not provide services directly but rather support individuals to link with community and family supports before referring them to statutory services. The coordinator will also assist them with accessing, navigating, and choosing formal services in the locality if these are required (26). The process involves an initial joint conversation with the individual to identify their vision for how they want to live their lives. This involves interests and resources such as family, friends, and community, and developing and building support networks. It is up to the coordinator to map community resources and identify gaps in community support and enhance local partnerships with businesses, community, and voluntary organisations (29).

LAC services can be accessed by people of all ages including those with complex needs and unlike other pre-existing statutory roles, it does not involve formal assessment processes or have eligibility criteria (26,35). A person in the area can contact their local coordinator, or be introduced by family, friends, community organisations or statutory services (29).

Basket of services

In the context of housing-related support, coordinators help with navigating housing which involves liaising with Councils and Housing Associations,

accompanying people to housing options, providing housing arrears advice, providing advice on how to address poor housing conditions (i.e. maintenance and repairs) and supporting people to move to suitable housing. They also take on a range of other activities including (29):

- Organising drop-ins, lunch-ins, and coffee mornings
- Support for appointments and visits
- Navigating financial systems
- Companionship
- Navigating health and social systems
- Advocacy
- Signposting to social activities

Governance

A LAC Network was established to support the learning and development of the model in the UK and assist with the implementation of the model in new areas (63). Typically, a leadership group consisting of different service/organisations oversee the implementation and development of the model in an area (64). For example, in the London Borough of Havering, the leadership group has representation from the following:

- Adult Social Care
- Children's Social Care
- Commissioning
- Public Health
- Housing
- Culture / Libraries
- Community Development
- Community Safety
- Clinical Commissioning Group
- GP Confederation
- North East London NHS Trust
- Metropolitan Police
- Department of Work and Pensions

This group meets monthly and is responsible for making decisions on implementation and ensuring resources are available for the successful delivery of the programme. The group works with the community and residents who decide on the vision for the project and select the coordinator (64).

NEW ZEALAND

Background

Like many other developed countries, New Zealand has an ageing population (older people aged 65+), and this age group is predicted to double by the late 2030s, with older people making up 22% of the population (65). Also, an increasing number of older people live in their own home (66). This poses challenges for the provision of health and social care and home-based support services for older people (67). The Ministry of Health 'Healthy Ageing Strategy' (2016) outlines the strategic direction for the next 10 years for the delivery of health and social services in New Zealand. The strategy's vision is that people age well, live well, and have a respectful end of life in age-friendly communities. It details a plan of integration and collaboration between health and social sectors to provide care and support to older people in their communities to support independent living (68). The key themes are prevention; healthy ageing and resilience; improving rehabilitation and recovery of acute conditions; improving support for older people with complex needs; and respectful end-of-life care (69).

The central government is responsible for health policy in New Zealand. The health system is predominantly a publicly funded system, with services provided by public, private and non-governmental sectors. The main source of funding is through taxation (82%), the Accident Compensation Corporation (ACC, a social insurance scheme) contributes 8.4% toward funding and private payments represent 16.8% of total health expenditure (67). Secondary and tertiary care (treatment of severe conditions) are mostly provided by publicly-owned hospitals, with a small private hospital sector providing specialised care. Primary health care services are provided by medical, nursing, and allied practitioners. The non-governmental sector is a key player in the delivery of health services, offering fully or partially funded primary health care services, community-based health services and disability support services and many disability support services apply to older people (67). Funding for support services for older people aged 65 and above are separated from services for people under 65: The Ministry of Health plans and funds support services for the under 65s while funding for the over 65s is provided by New Zealand's 20 District Health Boards (DHBs), who purchase services from non-governmental service providers (66).

DHBs across New Zealand have started using an International Residential Assessment Instrument (f) to determine eligibility for supports and to assess whether an individual needs various types of supports. This assessment tool is coupled with the use of a Restorative Home Support (RHS) delivery model, which is the main new support service model in New Zealand. Weir states that "a restorative home support approach aims to meet an individual's daily needs as well as promoting activity and independence" while also supporting "a range of positive outcomes…such as improving functional outcomes, improving quality of life and reduced rates of institutionalism" (70).

The focus of the model is on improving service user's independence but also on developing a minimum standard of education and training as well as a career path for social workers, regular review for service users, appropriate assessment, individualised goal setting, enhanced communication between social workers and coordinators, functional rehabilitation, and involvement of health professionals in assessments and reviews (71).

Support services for older people include a range of services such as health promotion, vocational and social services, home-based support services, nutritional services (i.e. Meals on Wheels) and Needs Assessment and Service Coordination (NASC) (72).

SCS model

Needs Assessment and Service Coordination (NASC) model

Aims

NASC services are organisations contracted by the Ministry of Health to work with people with disabilities of all ages and older people (generally over 65) to help identify their strengths and support needs, outline what support services are available and determine their eligibility for Ministry-funded support services (73). The role was created under the Health and Disability ACT (1993) (74). NASC services for people with disabilities allocate Ministry-funded support services, while NASC services for older people allocate DHB-funded support services (75,76). There are NASC services for each DHB in New Zealand (75).

Operations

Referrals to NASC are typically made by GPs, other multidisciplinary teams, family, or self-referral. Following a referral, NASC assess the eligibility of the individual using the interRAI assessment tool (77) (Contact is made within two days of receipt of the referral form and this contact is either by phone, letter, or visit. The purpose of the need's assessment is to gather information about the individual's needs and strengths, to determine what help and support are already in place and what support is needed most to improve quality of life. If a person is not eligible for DHB-funded services NASC will link them to the appropriate services.

To avail of the service, you must be a New Zealand citizen or resident who is eligible for publicly funded health or disability services under the New Zealand Public Health and Disability Act 2000 (78). The Ministry of Health's definition of an eligible older people is "someone who has been identified as having an age-related disability which is likely to continue for a minimum of six months and result in a reduction of independent function to the extent that ongoing support is required". (75)

NASC coordinators link people to services via contracted providers to meet their assessed needs and continue to monitor and review their situation at regular intervals to ensure the support received continues to support their needs. If a change is needed in the type of support, a review will be provided on demand (78).

Basket of services

The type of services that NASC coordinators link individuals to include but are not limited to the following services:

- Homebased support services (i.e. personal care; household management)
- Meals on Wheels
- Day care
- Carer support
- Respite care
- Home maintenances and repairs

Governance

NASC agencies, managers and other members are assisted by the NASC association who provide leadership and assistance with the implementation of New Zealand foundation documents, the Treaty of Waitangi and the New Zealand Disability and Health of Older People Strategy. Their objective is to ensure that NASC functions are centred around the needs of service users and that functions are integrated in an intersectoral way, as well as focusing on the process and outcomes of functions. The association has an executive who arranges quarterly meetings for members where any concerns, challenges or interests are discussed. Each NASC organisation have associate memberships which allow attendance at the meetings (75).

Service linkages

NASC is attached to all services for older people. It has long-established links with ageing organisations that provide information on housing-related support services such as Age Concern, as well as links with home repair and maintenance organisations. The Ministry of Health requires active engagement between NASC organisations and Equipment Management Services (EMS) providers and EMS Assessors. EMS, such as Enable New Zealand, provide free and subsidised equipment and modifications to people with disabilities and older people. EMS assessors are allied health therapists and other professionals employed by DHBs, NGO's and private organisations. They are responsible for assessing individuals, considering a range of options that meet the individual's needs, determining whether they meet the eligibility criteria for equipment and modifications, consulting with the EMS provider, discussing options with the service user and reviewing solutions to ensure needs are met. EMS providers receive requests from assessors and are responsible for providing advice to assessors on access and eligibility criteria and potential solutions, providing equipment and modification services, asset management such as tracking, maintaining, and reissuing equipment, and managing budgets (79,80).

The Ministry of Health guidelines for engagement between NASCs, EMS providers and assessors emphasises person-centred and collaborative planning between the three bodies to deliver the most suitable options to the individual and achieve cost-effective service delivery. Indicators for liaison include individuals with behavioural

needs, high cost/complex housing needs, degenerative conditions, high-cost support packages, carer stress and people with Long Term Support-Chronic Health conditions. The need for collaboration may be mandatory or flexible based on the person needs, however, if the person meets more than one indicator this requires mandatory joint communication and planning (80).

AUSTRALIA

Background

In recent years, the Australian Government has followed a policy direction of ageing-in-place and healthy ageing. This has led to more of an emphasis being placed on supporting older people in their homes through the provision of home care and support services (81). Home and community care and support services for older people are provided by Commonwealth, State/Territory, and local programmes, third sector programmes and private non-profit and for-profit organisations (81). The main strands of community care include the Commonwealth Home Support Programme (CHSP) which provides support services such as Meals on Wheels, health, home and housing support and the Home Care Packages Program which is an amalgamation of Community Aged Care Packages and the Extended Aged Care at Home Packages (81,82). Home Care Packages offer more intensive support such as nursing and clinical services (82). While these programs exist, accessing and navigating the aged-care system in Australia remains a challenge for older people, with multiple points of entry and a variety of sources and information about aged care. In 2013, My Aged Care portal was established to provide a single point of entry and gateway to access government-subsidised services whereby people could obtain information about aged care and services in the locality such as home-based supports (83). Home-based supports are provided outside of residential settings, where support is provided in the home of private renters (84).

SCS models

People with disabilities under the age of 65 can avail of home-based supports and housing-related support coordination under the National Disability Insurance Scheme (NDIS), however, if you develop an age-related disability and are over 65, you are ineligible for the NDIS but can receive support through the Commonwealth aged care system (85). The CHSP helps older people access entry-level support services to live independently and safely at home (84). The program includes four main service sub-programmes: Community and Home Support provides entry-level support to older people to remain living at home for as long as possible and includes supports such as; Meals on Wheels, personal care, home maintenance and modifications, social support and transportation; Care Relationships and Care Support is available to maintain care relationships between carers and recipients; Assistance with Care and Housing (ACH) supports are provided to vulnerable groups who need help with navigating and accessing appropriate services; Service System Development to help aged care services meet CHSP aims (84,86,87).

Assistance with Care and Housing (ACH) sub-program

Aims

The ACH program is specifically for vulnerable groups who need support with navigating and accessing appropriate services (84,87). It is aimed at people aged 60 years and above (50 years for Aboriginal and Torres Strait Islander people) with low-income status, for people who are homeless, at risk of homelessness or have insecure housing tenure and for prematurely aged people aged 50 years and over (45 for Aborigines and Torres Strait Islanders). Life experiences such as homelessness, drug abuse and military service can cause premature ageing (88).

Service providers who deliver assistance with care and housing must follow these principles (89):

ACH services will:

- Coordinate and link support for service users
- Provide opportunities for cooperative working between associated services.
- Coordinate a service response to ensure needs are met.
- Interact with multiple services across sectors.
- Ensure rapid and flexible response and individualised service delivery.
- Have strong community links.
- Have access to translation and interpreting services to support service users.

Basket of services

While home modifications, Meals on Wheels services and social support are provided by Community and Home Support services the ACH program provides a range of other housing supports including (90):

- Help to find suitable housing.
- Providing transport to view properties.
- Assistance with the paperwork required to apply for a tenancy or social housing.
- Understanding the requirements of a new tenancy and access to loans
- Assistance with arrangements to relocate.
- Providing links to assist retention of a new tenancy, where required.

The range of support includes:

- Case management
- Investigating alternative housing options
- Advocacy
- Liaison and referral to health, community care, welfare, and social support services
- Assistance to maintain or build local support networks.
- Operations

The majority of ACH service providers are non-profit organisations such as charitable and voluntary organisations, as well as housing authorities (90). Support is often carried out by a support worker and is offered to people living in all housing types ranging from independent (public/private) accommodation to supported housing (90). It is a needs-based program with no time limit on service provision,

however, if permanent or long term assistance is required, a referral will be made to relevant services (90).

To access the service all service users should be registered with My Aged Care. The My Aged Care call centre and website is typically the first point of contact for people seeking information about Commonwealth-subsidised services (88). Service users are screened and assessed over the phone by staff in the centres who can refer them for a face-to-face assessment to determine eligibility for government-funded services (91). Service providers will work with My Aged Care and the Regional Assessment Service (RAS) who assess the individual's needs using a standardised assessment tool called the National Screening Assessment Form (NSAF). RAS operates at a regional level in all states and territories and provides linking support to older people where their circumstances might impede their ability to access services (84,92).

However, stakeholders continue to have reservations around the accessibility of the RAS system, the timeliness of the system, and the consistency and quality of the assessment process (92). As a result, the government introduced the Aged Care Navigator (ACN) trial and outreach services, independent of aged care providers to assist hard to reach populations with navigating and accessing services (83). The ACN trial is testing various types of services and activities to help people learn more about government-supported aged care programs and how to access them. The Council on the Aging (COTA) Australia in partnership with 30 organisations are piloting and evaluating 62 navigator activities across the country and will report back to the Australian DoH in June 2020 (93).

Governance

ACH service providers are funded by the government. Since the beginning of 2018 service providers funded under the CHSP must adhere to several conditions to provide a greater focus on activities and supports that promote independence and wellness and provide more choice for service users. A full list of these conditions as well as service provider and government responsibilities are outlined in the CHSP Programme Manual (2018 – 2020).

Aged-care navigator trial

The ACN program is based on a Support Worker model for older people. It is a relationship-centred model that adopts a holistic approach to support. The role involves referral, linkage to, and navigation of, services; the provision of education and information; advocacy; emotional and practical support (83). The service is for older people, families, friends, and others who want to link with services. The service is particularly aimed at populations who; live remotely or in rural areas; have a diverse cultural background; have limited access to the internet and technologies; are vulnerable, isolated, or disadvantaged; are experiencing poor mental health or dementia or are unlikely to seek support (94).

Operations

Several different organisations were invited to participate in the ACN trial including community and information hubs. Community hubs are volunteer-run hubs in the local community, while information hubs provide targeted information in a person's area and are typically run by aged care experts and volunteers. In some cases, individuals are referred to support workers who can provide more specialist support in person or over the phone (93). The Housing for the Aged Action Group is one of the information hubs in Australia delivering the ACN trial and is the only Australian organisation specialised in the housing needs of older people (95). The organisation describes itself as "an Information Hub, providing locally targeted information to people who face barriers to access and vulnerable people through seminars, tailored information, face-to-face support, peer support, assistance with forms and outreach" (96).

Navigators target older people in need, such as those facing language barriers or other difficulties, to ensure they receive support and information. Support can be provided face-to-face, online or via the telephone. Each trial location is different for each area and is designed to meet the needs of their particular community. To access the service, contact can be made directly with an aged care navigator.

Basket of services

Community hubs and information hubs such as HAAG provide a range of services including:

- Community workshops and information sessions
- Assistance with filling in forms
- Contacting My Aged Care
- System navigation
- Providing fact sheets, handouts, and other resources
- Outreach services to support those who cannot come into the centre.
- Group support sessions
- Individual support sessions

CANADA

Background

The delivery of services for older people in Canada is complex and challenging (97). Older people (65+) are the largest growing age group representing 16.9% of the population in Canada and this percentage is expected to increase to 24% by 2036 (98). The majority (92%) of older people live at home in mainstream housing or independent living accommodation, with the remaining in institutions (99). Canada's ageing population has important implications for healthcare needs and housing and related services (100).

Although there has been a reorientation of health care delivery from institutional care toward home and community-based care in recent years, there is a consensus that the home and community needs of older Canadians are not adequately being met (101). This is due to the complexity of the healthcare system, underfunding of support services, inconsistency in the delivery of care and support and a lack of coordination (102). Canada's healthcare system consists of 10 provincial and 3 territorial healthcare systems and federal funding is provided to healthcare services in provinces and territories that adhere to the Canada Health Act – Canada's federal legislation for publicly funded health care insurance (103). The services that are covered under the act include "medically necessary" services such as hospital and physician care (104), but home care and support services are absent from the act and provincial and territorial governments are not formally obligated to provide a minimum basket of services in the same way as medically necessary services (105,106). This has led to the underfunding of important services for older people. Home care services include personal care, respite care, rehabilitation and physical therapy and nursing services while home supports include transportation and meal services, home maintenance and repair, and information services to help older people access services and programs. Home supports are designed to complement and are often provided by home care services (107). These services are key in enabling older people to live independently in their homes.

According to the Canadian Healthcare Association, four models of service delivery have evolved across the country, which highlights the inconsistency and variation in the delivery of home/community care and support. In Saskatchewan, Manitoba, Nunavut, the Northwest Territories, Quebec, Prince Edward Island and Yukon a public provider model is adopted, whereby government employees directly manage and deliver home care and support services. In British Columbia, New Brunswick and Newfoundland professional services are delivered by governmental employees and home supports are provided by private agencies. In the third model adopted by Alberta and Nova Scotia, both public and private employees provide home care services and home support services are contracted out. Finally, in Ontario, Community Care Access Centres (CCAC) coordinate services, but all home and support services are contracted to private agencies (108).

As well as underfunding and variations in service delivery, there is also a lack of systematic coordination and integration of non-acute support services in the

community and there is also a lack of awareness about what services are available to older people (102). In the context of housing, the delivery of related support services for older people involves many different organisations, agencies, and associations and there is a lack of service coordination in place which makes it difficult for older people to access and navigate services. There does not exist a single housing-related SCS for older people, but several models and services that provide information, resources, and assistance with accessing services in the community, were identified. These include the NORC-Supportive Service (NORC-SSP) model and the Senior Services Society model.

SCS models

Senior services society model (BC)

Aims

The Senior Services Society is a non-profit agency that provides older people aged 60+ with guidance and information on housing options and supports in Lower Mainland, British Colombia (BC) and has been in operation since 2006. The service is an amalgamation of the Seniors Housing Information Program Society and the Western Society for Seniors Citizens Services in BC. It is primarily a coordination service that connects older people with a range of support programs and services to enable them to live in their homes for as long as possible (109).

Operations

Referral to the service can be made through self-referral or through family, friends, or other agencies, where contact is made over the phone with a support coordinator. Housing providers can also be added to the service directory or the website by contacting the service. This is free of charge and requires the completion of a form. Housing providers listed as 'Assisted Living' providers must be registered with the Assisted Living Registrar. Information on housing-related services and support is provided on the service's website such as information on how to get an assessment for home-based supports (i.e. personal care) or how to find a housing repair service. A support coordinator will also support individuals to access these services and refer them to relevant services (109).

Basket of services

The organisation links people to a range of services:

- Support services including Meals on Wheels and Better at Home programs that provide non-medical services such as grocery shopping, light housekeeping, home repair and transportation. They also directly provide support services such as assistance with tax and form completion, social programs, and annual tax clinics.
- A range of one-on-one housing navigation services including outreach, information on housing types, temporary housing, and loan programs. They

connect older people with modification and home repair services such as Housing Adaptations for Independence.
- Community education programs are also provided to older people and members of the public such as workshops on housing and housing navigator training.

Governance

The service is funded by federal, provincial, and municipal governments of BC, regional health authorities, housing authorities and a private health insurance association. An administrative team are responsible for the day-to-day functioning, implementation and coordination of services and report to the CEO. Staff members on the administrative team include an office administrator and event coordinator, financial administrator, operations manager, and resource development officer. The organisation is supported by over 80 volunteers and is governed by a volunteer Board of Directors. Governance includes five Board meetings per year and participating in one of the standing committees (Executive; finance; policy; membership; nominating). Older people can become a member of the program, but membership is not a requirement of participation in any of the services or programs (109).

The NORC-supportive service program

Aims

The NORC-Supportive Service Program (NORC-SSP) is a wraparound service for older residents located in mainstream housing with a high concentration of older people, otherwise known as Naturally Occurring Retirement Communities (NORCs) (110,111). It is an innovative service delivery model that aims to coordinate care and support and facilitate collaboration among stakeholders for the integration of medical, health and social services, as well as non-medical housing-related supports (110).

Basket of services

- Care planning, case management and service coordination/navigation
- Health care management (health promotion and disease prevention)
- Medical and rehab services
- Nutrition and fitness
- Mental health counselling
- Personal care
- Educational social and recreational activities
- Home repair and modification
- Transportation

Operations

To be eligible for assistance from a NORC-SSP, the individual must be a resident of the area, aged 60 years and over and live in a NORC community. Once a person resides in a NORC, they can apply to the support program via an administering agency (112). Services are offered on-site or in the community and aim to address needs that are not typically managed by government programs such as social connection, system navigation and assistance with accessing benefits and entitlements, among others (113). The core services tend to reflect the specific needs of the tenants and consider the characteristics of the surrounding community. The model does provide some health services directly but is predominantly a preventive model that aims to increase access to ancillary services, overcome fragmentation and avoid institutionalisation (107,110). An on-site coordinator who is trained as a Personal Support Worker is responsible for the day-to-day running of services as well as determining eligibility for support and informing and linking residents to services in the community (113).

Governance

NORC-SPPs are a public-private partnership between older residents, housing administrators, health and social service providers, home repair and adaptation partners and government agencies (107,110,114). Programs receive funding through private-public partnerships, including support from the government, foundations, housing providers, and individuals' contributions (114). A key aspect of the model is the involvement of older residents, who play an important role in the governance and operations of the program. A lead agency oversees budgeting, operations, and service delivery, is responsible for funds and reports to an advisory board. A health partner provides nursing services consisting of health promotion, medication management, health monitoring, communication, and primary care. A social service partner provides social work supports and case management, which is the main coordination service connecting tenants with benefits and entitlements, providing mental health supports, monitoring health changes, and assessing home safety. A building manager acts as the housing partner and is responsible for the maintenance and repair of tenants' homes. Local community groups and organisations assist with transport and social visits. The advisory board includes representatives from all constituency groups (107).

NORC SSP Canada

An example of this model in Canada is the OASIS Senior Supportive Living Inc. which is a grassroots program for older people living in a NORC in Ontario. A group of older tenants living in a residential apartment building in the area co-created a participatory model for ageing-in-place in partnership with the landlord and the South East Ontario Local Health Integration Network (LHIN). The landlord was responsible for modifying the space to provide communal spaces for social activities and the LHIN funded onsite coordination of person-centred support services for the tenants (111,115).

UNITED STATES

Background

The older population is projected to grow rapidly in the US, and while older people's preference is to remain living at home in their communities, challenges to accessibility, housing affordability and poor coordination and linkages between services make it difficult for older people to age-in-place. The Joint Housing Centre for Housing Studies estimates that the number of people aged 65 and over will increase from 48 to 79 million over the next 20 years. Furthermore, the JCHS projects that by 2035, 1 in 3 households will be headed by people aged over 65 and households aged 80 and over will account for 12% (17.5million) of all households (116,117). The availability of community support services is critical to allow older people to remain connected and supported in their communities (116).

Due to the increasing size of the older population, there has been a growing demand for home and community-based supports (HCBS) in the US. The supportive services program is a government-funded program that was established under the Older Americans Act (OAA) to help older people to age-in-place and to avoid early admission to long term care (118). Unlike other programs under the OAA, this program funds a wide range of services including access services (i.e. information and assistance and transportation) as well as home and community-based long-term services and supports (i.e. personal care, homemaker assistance and adult day care services) (119). HCBS services are often delivered by Senior Centers, Area Agencies on Aging (AAAs) or local government agencies (120).

The OAA also established an "aging network" consisting of a federal Administration on Aging, State Agencies and AAAs. AAAs are designated to act as the main coordinating body for the development and implementation of HCBS services that are tailored to the individual needs of the local community.

SCS model

Area Agencies on Aging

Aims

The National Association of Area Agencies on Aging (n4a) mission is to ensure that older adults can live independently and with dignity in their home of choice or their community for as long as possible (30). Therefore, n4a not only supports ageing-in-place but is also driven toward supporting ageing in the community. AAAs were established under the OAA in 1973 to serve as local on-the-ground coordinating bodies that would assist people with finding, connecting to and receiving services (30). The OAA also established Title VI, Grants for Indian Tribal Organizations in 1978, which serves the same function to older people from Indigenous communities (121). The main functions of AAAs are to advocate for, plan, coordinate and implement programs that promote maximum independence and dignity in a home environment with appropriate support services for older people (119).

AAA is a generic term used to refer to this type of service, but the names of local AAAs can vary. AAA providers are either classified as a county, city, regional planning council or council of governments, private, or non-profit (121,122).

Basket of services

AAAs directly provide the planning, coordination and implementation of support services including home-delivered meals, non-medical/medical transportation, home modifications, and maintenance, caregiver support, personal care assistance, legal assistance, and adult day services, among others. AAAs typically contract other agencies and organisations to provide these services (30,119). They also provide the following services:

- Information, referral, and linkage to services
- Outreach services
- Case management including assessment and development of care plans and benefits.
- Counselling (help resolve complaints about care)
- Ombudsman programs

Operations

AAAs will assess the needs of people in the community and address any unmet needs by organising and coordinating the resource base of existing community-based organisations as well as public and private providers. AAAs work alongside more than 20,000 service providers to ensure that supports meet the needs of older people and they also monitor and evaluate the quality of the delivery of services (30). Providing an access point for ageing services for older people is another important function of AAAs (119). This is done by providing direct access to information and referral services, and to outreach services such as public education, to help people identify, understand, and effectively use local services (119,123). The role is carried out by Information, Referral and Assistance Specialists who are trained to assist people in locating and accessing services including linkage with service providers (124). All AAAs have local hotlines or websites providing people with information and assistance. Local AAAs can be found by entering a ZIP code into the Eldercare Locator website which is a free national service funded by the U.S. Administration for Community Living administered by n4a (123).

Governance

There is an agency in each state in the U.S. designated by its governor to plan and coordinate services and develop a state-wide plan on ageing and administering the Older Americans Act (OAA) programs. State agencies divide the state into planning and service areas, and for each local planning and service area, there are designated AAAs that develop area plans on ageing. Some state agencies operate as AAAs in areas of a smaller geographic size or smaller population density (119). The area plan outlines the needs and proposed recommendations for programs and services that are targeted to the needs of older people. An advisory board provides input into the

development and implementation of the area plan and receives input from residents, service users and providers to ensure that the programs are tailored to their needs. Area plans are updated every few years to reflect emerging trends (123). The governance of AAAs varies widely. There are over 620 AAAs existing in communities across the U.S., 39% of these are part of independent non-profit organisations such as the United Way, 28% are in county government agencies, 26% are part of the council of government or a regional planning and development agencies and the remainder are part of city government and other affiliations (30). Under the OAA, funding is provided to AAAs and Title VI programs through federal, state, and local funds (121).

CHAPTER FIVE

FINDINGS PART 3

COVID-19 and support coordination in Ireland

5. FINDINGS PART 3: Covid-19 and Support Coordination in Ireland

The following section seeks to answer the third research question (What is the current profile of support coordination services (SCS) in Ireland?). It provides an overview of the evolving nature of SCS in Ireland in light of COVID-19 and includes the actions taken by the government and the community and voluntary sector in response to the crisis.

The impact of the COVID-19 pandemic on the global population is extensive, and older people are particularly susceptible to the effects of the virus (65). From the outset, health authorities and governments warned that the pandemic would disproportionately affect the older population and global trends over the last two months have confirmed this. In Ireland, people aged 65 and over represent 26% (n = 6,146) of confirmed cases up until and including May 15th (66), and the prevalence of the virus in this age group (65+) is higher (1% of the total population aged 65+) compared to any other age group, with a lower prevalence rate of 0.6% found in both the 25-54 and 55-64 age groups (67,68). The public health advice for older people in Ireland has been to self-isolate and 'cocoon', which involves staying at home and reducing face-to-face contact with other people as a protective measure against the virus (69), in addition to handwashing, physical distancing, and practising respiratory etiquette. While these public health measures are crucial, they may have long term consequences for the social, mental, and physical wellbeing of older people. Furthermore, the virus spotlights existing and emergent barriers to accessing support services for older people (70).

Older sub-populations, including older people within homeless, migrant, Roma and Traveller communities are even more vulnerable to the virus and face additional barriers to receiving and accessing services. The COVID-19 NGO Group – a formation of over 20 NGOs convened by Community Work Ireland in response to the crisis – have recommended that special attention should be given to those experiencing poverty, inequality, discrimination and social exclusion (71,72).

GOVERNMENT AND COMMUNITY RESPONSE

A National Action Plan to address the COVID-19 outbreak in Ireland was published by the government in March 2020, setting out a society-wide response and mobilisation of resources across government and society to tackle the spread of the virus (73,74). The National Public Health Emergency Team (NPHET), which is leading the public health response to COVID-19, announced the establishment of a Vulnerable People Subgroup (75). This subgroup was set up to guide the preparedness, measures and actions needed to protect vulnerable groups in society (75). Operational considerations and decisions are beyond the role of this subgroup and are dealt with by outside agencies and Government Departments (76). The term 'vulnerable people' includes older people, people with disabilities, mental health service users, people with an underlying illness, children in care and people

accessing social inclusion services (77). Members of the subgroup include government departments, state agencies, local authorities, local development companies and a network of community and voluntary organisations (75). The Department of Rural and Community Development (DRCD) in partnership with the above groups, developed a Community Response Action Plan to complement the National Plan, which aims to coordinate the community response to COVID-19. The Community Response Action Plan includes 3 key actions (74):

- Coordination and promotion of volunteering
- Providing practical community supports for older people.
- Launching a helpdesk facility in the DRCD to assist smaller community groups with queries.

In April, The DRCD announced the "Community Call", to support the work of groups supporting vulnerable people. The initiative links local and national government with community and voluntary sectors to coordinate community assistance where it is needed and to mobilise and coordinate the volunteer base (78). In line with the Community Call, a national support helpline was established by ALONE, in partnership with the Health Service Executive (HSE) and Department of Health to provide a single point of contact for older people, and to develop a national model that other organisations and local authorities can replicate. This involves collaboration between An Garda Síochána, community partners, volunteers and Dublin City Council (79). The national helpline is to complement clinical advice and information provided by the HSE through their website and helpline (80). As well as this, each local authority has established a Community Response Forum. The forums represent a multi-agency approach comprising a range of organisations including the council, the HSE, County Champions, An Post, Community Welfare Service, An Garda Síochána and other State and voluntary organisations. Each forum provides the following services (81,82):

- Collection/delivery of food, essential household items, fuel, and medication
- Transport to testing centres, Clinical Assessment Hubs, GP, and hospital appointments.
- Social supports and engagement
- Delivery of meals
- Additional medical/health needs

Part of this initiative includes COVID-19 Community Outreach (CCO) which is coordinated by The Wheel and Irish Rural Link and funded by the DRCD. The CCO links and supports the work of community and voluntary organisations. It aims to help fill service gaps and identify the needs of older people to ensure that vulnerable people, including older people, have access to the highest quality information and support in their own homes. This role is carried out by a network of Community Champions who are located in 26 counties and have strong links with the local areas, have experience of engaging with community and voluntary organisations and are already in direct contact with individuals that the programme seeks to support. A Community Outreach Map has been developed to help people locate their local Community Champions, as well as local non-profits (83).

SUPPORTS FOR MARGINALISED OLDER PEOPLE

COVID-19 has disproportionately impacted marginalised groups including Roma and Traveller communities, people who are homeless and refugees/asylum seekers living in direct provision, and older people in these groups are particularly affected (72). The virus has exacerbated the marginalisation of these communities and has further highlighted the lack of adequate housing and housing supports appropriate to the needs of marginalised groups. Clusters of COVID-19 infection have been found in ethnic minority communities, among homeless people, and in Direct Provision centres. In April, the Peter McVerry Trust revealed that nine of its service users were diagnosed with the virus, with an additional 27 confirmed cases and 27 people cocooning (84). Furthermore, in May, the Minister for Health Simon Harris reported 164 cases of COVID-19 in direct provision centres, including nine clusters, with 10 people being hospitalised (85).

Pavee Point, a charity that supports Roma and Traveller communities, stated that these groups have been affected by poor housing conditions and overcrowding, making it near impossible to self-isolate. Pavee Point is engaging with the HSE and Department of Health to limit the impact of the virus on these communities and has set up a dedicated information helpline (86). Furthermore, following the Department of Housing Circular (02/20) all local authorities must ensure that basic services are provided to Travellers as well as additional measures where needed, to mitigate the spread of the virus, including (87):

- Extra toilets
- Running water
- Additional mobile accommodation/space where there is overcrowding.
- Extra refuse collection
- Access and egress on sites
- Additional units (either mobile homes on-site or houses elsewhere that will allow for self-isolation/ quarantine)

The high number of confirmed COVID-19 cases in direct provision centres has further highlighted the unsuitability of this accommodation. In March 2020, The Department of Justice added 650 new beds to the system to facilitate social distancing with an additional 850 beds being added in April, including 4 self-isolation units to provide off-site self-isolation to support ‘cocooning’ measures for the most vulnerable. Over 600 residents have been moved to new accommodation under the guidance of the HSE, this includes all people aged 65 and over. A national clinical telephone service has also been put in place in partnership with the HSE and Safetynet, to support them (88).

Similar measures by the government have been introduced in the case of homeless emergency accommodation. In March 2020, the Minister for Housing announced that the Dublin Region Homeless Executive, in partnership with the HSE had put provisions in place in the Dublin region for those needing to ‘cocoon’ and self-isolate, with an additional 560 beds being introduced (89,90).

Other third sector organisations across Ireland are trying to ensure that marginalised groups are protected and supported. For example, Crosscare Information and Advocacy Services provide information and advocacy support related to housing, homelessness, social welfare, immigration issues, health and wellbeing-related issues, emigration, returning emigrants and the asylum process, family reunification, citizenship, and support with integration. Other organisations assisting minority groups include Migrant Rights Centre Ireland (MRCI), Nasc, and Cairde, among others (91).

6. DISCUSSION

The overall purpose of this research brief was to provide a summary of the international evidence on support coordination services (SCS) for older people, with a focus on housing-related supports. We set out to answer two key questions: 1) What is support coordination? and 2) What support coordination models are used in other countries? (including the US, UK, Canada, New Zealand, and Australia). With the emergence of the COVID-19 pandemic, support for older people has become an even more pressing issue; therefore, this piece of research is particularly relevant. The following section presents a summary of the research findings.

The term support coordination is not widely used in relation to housing supports for older people, and many definitions pertained to the area of disabilities. Other terms related to support coordination include floating support, local area coordination, case management and service navigation. These models of support share many common elements and principles, out of which we developed a working definition of support coordination. On that basis, we have provided an evidence-informed definition of support coordination as:

> *A capacity building and person-centred support service that enables older people aged 65+ to live independently in their homes and communities for as long as possible, by providing housing-related advice and support with navigating different systems including housing, social and health services. Furthermore, it is a preventative and interventional support service aimed at enhancing the well-being and quality of life of older people by improving the conditions in which they live.*

The following table provides a summary of the key features of SCS models found in each of the five countries under review. This is followed by a description of the contents within the table, including a reference to both the shared and unique features of these models.

TABLE 3. SCS MODELS AND KEY CHARACTERISTICS

Country & Model	Aim/target group	Operations	Basket of Services	Governance
UK				
Floating Support	• Preventative support provided to vulnerable people incl. older people (65+). • The aim is to develop the service user's independence through practical tasks. • Includes outreach services, low-intensity support, and high-intensity support.	• Not attached to accommodation; provided in recipient's home. • *Providers:* organisations across all sectors • *Eligibility:* all tenures eligible excl. sheltered housing; age 65+; in need of housing support; local resident • *Referral:* self-referral or referral through other services • *Assessment:* assessed by a social worker at home within 10 days of referral	• Support planning • Advice on housing and welfare rights • Information on local facilities • Accessing services • Help with claiming benefits, budgeting, paying bills/debts, completing forms. • Learning to plan meals, shop/cook. • Networking with specialist advice/support agencies • Advocacy • Befriending	• Funded by the Supporting People governmental program. • Strategic decisions made by commissioning body (a partnership of local authorities).
Local Area Coordination (LAC)	• Person-centred preventative support for vulnerable people. • A bottom-up approach aimed at building community relations and supporting people to find non-service solutions. • The aim is to reduce people's dependence on professional services and create healthy and empowered communities.	• Not linked to a service; coordinator is placed in the local area of up to 12,000 people; Locate vulnerable populations. • *Eligibility:* no eligibility criteria; for people of all ages • *Assessment:* no formal assessment process • *Referral:* self-referral by contacting local coordinator or through family/ friends/community organisations	*Navigating housing* which involves: • Advice and support on housing issues. • Liaising with councils and housing associations • Accompaniment to housing options • Supporting moves to new accommodation *Other activities:* • Drop-ins/lunch-ins • Support for appointments/visits • System navigation • Companionship • Signposting to social activities	• A LAC Network supports the development and implementation of the model. • A leadership group with reps from involved groups/organisations oversee implementation in each area.
US				

Area Agency on Aging (AAA)/Title IV Grants	• Established under the Older American Act 1973 to serve as a local on the ground coordinating service for older people and to provide a central access point to services. • The aim is to support people to find and receive services in locality and to advocate for, plan, coordinate and implement programs that promote maximum independence and dignity in a home environment.	• AAA providers are either non-profit, government or council agencies designated by the state at a local level to assess unmet needs and coordinate existing services. AAA's work with over 20,000 support service providers across the US. • Contact local AAAs to access the service. A local AAA can be found by zip code or online. • *Eligibility*: Must qualify for government-funded programs • Information, referral, and assistance: assists with locating and accessing services	*Directly provide* the planning, coordination and implementation of support services and contract agencies that provide a range of support services (E.g. home-delivered meals; non-medical/medical transportation; home modifications and repairs; legal assistance; carer support etc) *Also directly provide:* • Information/referral/linkage • Outreach services • Case management; counselling • Ombudsman programs	• Funding through federal state and local funds. • AAAs are responsible for developing area plans; an advisory board oversees development and implementation with input from residents. • Governance caries widely as AAA providers range from independent non-profit, independent organisations to county government agencies
Australia				
Assistance with Care and Housing (ACH) subprogram	• A sub-program within the CHSP, for vulnerable groups who need help with navigating and accessing appropriate services. • For frail older people aged 60+ (50 years for Aboriginal/ Torres Strait Islander people). 50+ for prematurely aged people (45+ for Aborigines/ Torres Strait Islanders).	• ACH services are provided by organisations such as housing authorities and voluntary, charitable/ religious organisations. • *Eligibility:* service users should be registered on My Aged Care portal; support for all tenure types; must be in the vulnerable population category • *Assessment:* service providers work with My Aged Care and the Regional Assessment Service (RAS) who use the National Screening Assessment Form (NSAF)	• Help to find suitable housing. • Providing transport to view properties. • Assistance with the paperwork required to apply for a tenancy or social housing. • Understanding the requirements of a new tenancy and access to loans • Assistance with arrangements to relocate. • Providing links to assist you to retain the new tenancy, where required	• Service providers are funded by the CHSP under the Grant Agreement • In entering into this agreement with the government, service providers must adhere to all requirements outlined in the documents that comprise the Grant Agreement
Aged Care Navigator (ACN) Trial	• In 2019 the government introduced the	• Involves referral, linkage to, and navigation of, services;	• Community workshops and information sessions	The Council on the Aging (COTA) Australia in partnership with 30

	ACN trial and outreach services to assist hard to reach populations with navigating and accessing services. • Particularly aimed at older populations who live remotely/rurally; diverse cultural backgrounds; have limited access to internet and technologies; vulnerable, isolated, or disadvantaged; poor mental health/dementia; are unlikely to seek support.	the provision of education and information; advocacy; emotional/ practical support. • Support provided face-to-face, online or over the phone. Each trial location differs for each area and is designed to meet the needs of that community. • To access the service, contact can be made directly with an aged care navigator.	• Assistance with filling in forms • Contacting My Aged Care • System navigation • Providing fact sheets, handouts, and other resources • Outreach services to support those who cannot come into the centre. • Group support sessions • Individual support sessions	organisations are piloting and evaluating 62 navigator activities across Australia and will report back to the Australian DoH in June 2020
New Zealand				
Needs Assessment and Service Coordination (NASC)	• Orgs contracted by the Ministry of Health to help people with disabilities and older people (65+) to identify support needs, outline available services, and determine eligibility for Ministry of Health or District Health Board funded supports. • The role was created under the Health and Disability Act 1993. There are NASC services for each District Health Board in NZ.	• Coordinators link people to services via contracted providers to meet assessed needs and continue to monitor/ review their situation. • *Referral:* by GP, multidisciplinary teams, family, or self-referral • *Eligibility:* NZ citizen or resident eligible for publicly funded health/disability services • *Assessment:* using inteRAI tool; contact made within <2 days of referral	*Link to the following services:* • Homebased support services (i.e. personal care; household management) • Meals on Wheels • Day care • Carer support • Respite care • Home maintenances/repairs	• NASC services for older people allocate District Health Board funded support services. • Leadership and assistance with implementation supported by the NASC Association. • *Service linkages:* NASC linked with EMS assessors and providers.
Canada				

Naturally Occurring Retirement Community Supportive Service Program (NORC-SSP)	• Wraparound service for residents living in Naturally Occurring Retirement Communities • The aim is to coordinate, support and facilitate collaboration among stakeholders for the integration of medical, health and social services, and non-medical housing supports. • A preventative model aimed at increasing access to ancillary services.	• Services offered on-site. • Service delivery coordinated by an onsite coordinator. • *Eligibility*: Resident in NORC community; 60+ years	• Care planning, case management and service coordination/navigation • Health care management • Medical and rehab services • Nutrition and fitness • Mental health counselling • Personal care • Educational social and recreational activities • Home repair/modification • Transportation	• Funding from public-private partnerships. • A public-private partnership between residents, housing admins, service providers and governmental agencies. • Governed by residents, the lead agency, health partner, social partner, building manager, local community organisations and advisory board.
Senior Services Society	• Non-profit agency providing older people (60+) with guidance and information on housing options and supports in Lower Mainland BC. • An amalgamation of the Seniors Housing Information Program Society and the Western Society for Seniors Citizens Services in BC. • The aim is to enable independent living by coordinating and connecting older people to services.	• Admin team responsible for function, implementation, and coordination. • *Referral:* self-referral, or via family, friends of other agencies; contact made over the phone with a coordinator • *Eligibility:* 60+ and resident in BC • A coordinator supports access and referral to services.	*Links to a range of services:* • Non-medical services including transportation, meal delivery, grocery shopping, home repair and transportation. *Directly provide:* • One-on-one housing navigation including outreach, info on housing types, temporary housing, and loan programs. • Assistance with tax and form completion; annual tax clinics • Social/community education programs such as housing navigator training	• Funded by federal, provincial, and municipal governments of BC, regional health authorities, housing authorities and a private health insurance association. • Governed by the volunteer Board of Directors.

The SCS models in this evidence brief share several common features. Each model uses a preventative and person-centred approach to the provision of support, and all services aim to support older people to access information, to provide advice on housing issues and to provide linkage and referral to, and coordination of support services. They are all in part driven by the principle of ageing in place, with the overall goal of maximising independence and enabling older people to live at home in mainstream housing for as long as possible.

Referral processes involve self-referral or referral from other agencies for all models. Models in the US, Australia and New Zealand share similar eligibility and assessment processes. As these programs are run by the government, individuals must qualify for government-funded services and a standardised assessment tool is used to determine eligibility and individual needs. The eligibility criteria for all other models excluding Local Area Coordination (LAC), state that individuals must be 60-65 years old, must reside in the community or be categorised as vulnerable. In addition to these requirements, the Naturally Occurring Retirement Community-Supportive Service Program (NORC-SPP) model specifies that a person must live in a NORC community to avail of the program. In contrast with other models, LAC services can be accessed by people of all ages and there is no formal eligibility or assessment protocol. SCS models in Canada receive funding from both public and private entities including housing associations, governmental departments and agencies, and private organisations. In the US, Australia, New Zealand, and the UK (Floating support) funding is provided almost entirely by the government.

Each program provides several key supports such as service coordination, advice on housing and welfare rights, information on local and existing services in the community, help with filling out forms and claiming tax benefits, support with accessing services and navigating health and social care systems, and signposting to relevant services.

Some models provide additional services and have other unique characteristics. For example, the LAC model in the UK differs from some of the other models in that it uses a bottom-up community-led approach to support and aims to reduce people's dependence on services through using non-service solutions. As there is a focus on building strong ties between community members, LACs provide social activities such as coffee mornings and lunch-ins. The Senior Services Society and NORC-SSP programs also run social activities and community educational programs. Unlike the other models, the NORC-SSP model coordinates medical, health and social services in addition to non-medical supports, and some services are offered on-site in the NORC community. Furthermore, the Australian models are aimed at particularly vulnerable and disadvantaged older people such as those facing homelessness, therefore the services provided by these models are more focused on helping people find and secure suitable housing.

This evidence brief provides an overview of the different approaches and strategies used to coordinate supports for older people in different countries. With the emergence of the COVID-19 pandemic, older people may face additional barriers to accessing information and support. Therefore, now, more than ever, person-

centred, and preventative support coordination are needed to enable older people to continue living at home with their needs being met. Future research in this area could investigate the successes and challenges encountered for each of the models.

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APPENDIX

APPENDIX 1: WEBSITES USED FOR TARGETED SEARCH

Countries	Websites
UK	www.gov.uk www.ealing.gov.uk www.local.gov.uk www.nhs.uk www.bl.uk www.ageuk.org.uk www.housinglin.org.uk
Canada	www.canada.ca https://www2.gov.bc.ca/ www.toronto.ca www.seniors.gc.ca
United States	www.usa.gov www.aging.ny.gov www.aging.ca.gov www.hud.gov
Australia	www.housing.vic.gov.au www.sa.gov.au www.myagedcare.gov.au www.australia.gov.au
New Zealand	www.health.govt.nz www.ageconcern.org.nz
Other	www.who.int www.oecd.org

APPENDIX 2: DEFINITIONS OF SUPPORT COORDINATION

Citation & Location	Definition
Disability-related Support	
Victoria State Government (AUS)(92)	"Help with strengthening your ability to connect to and coordinate your funded, community and family supports. This includes helping you build the capacity you will need to navigate the NDIS and find the right providers to meet your needs"
DBHDD (USA)(14)	"Support Coordination Services identify, coordinate, and oversee the delivery of services and supports to enhance the health, safety, and general well-being of NOW and COMP waiver participants within the context of the person's goals toward maximum independence".
DSC (AUS)(10)	"Support Coordination is designed to be a time-limited support to build capacity during a time of major transition. For example, many NDIS participants now have Support Coordination built into their first NDIS plan as a way to build capacity to support them to understand and initially navigate the NDIS".
Somerville (AUS)(11)	"1. Support Connection: Short term assistance to identify and link you to service providers, negotiate service agreements and undertake monitoring and review activities. 2. Coordination of Support: Includes activities of Support Connection but provides longer-term assistance to build greater capacity and to ensure your services operate smoothly across a wide range of service providers. 3. Specialist Support Coordination: a short-term option available to people with very complex service coordination issues"
Mercy connect (AUS)(12)	"The Federal Government defines Support Coordination as 'a capacity building support to implement all supports in a participant's plan, including formal, mainstream, community and funded supports".
AASW National disability insurance agency (AUS)(16)	"Assistance to strengthen a participants ability to coordinate and implement supports and participate more fully in the community. It can include initial assistance with linking participants with the right providers to meet their needs, assistance to source providers, coordinating a range of supports both funded and mainstream and building on informal supports, resolving points of crisis, parenting training, and developing participant resilience in their own network and community".
Department of Health Louisiana (USA)(18)	"Support Coordination is a service that will assist beneficiaries in gaining access to all of their needed support services, including medical, social, educational and other services, regardless of the funding source for the services".
(USA) (93)	"Support Coordination is the service of advocating, identifying, developing, coordinating and accessing supports and services on behalf of individuals or assisting individuals and their families to access supports and services on their own"

Ageing and Disability (USA)(13)	"Support Coordination services are activities designed to assist an individual in accessing needed medical, psychiatric, social, educational, vocational, residential, and other supports essential for living in the community and in developing his or her desired lifestyle".
Aging and Disability Resource Connection Designation Criteria (USA)(94)	"Protocols for at least one partner organization to respond to consumers at-risk or with urgent needs; expedited links to expanded list of service partners; temporary service coordination for up to 90 days while a longer-term plan is identified. Can be provided as a component of options counselling or as an independent service".
Virginia Commonwealth University (USA)(20)	"An individual receiving DD Support Coordination shall mean an individual for whom there is a Person Centred Individual Support Plan (PC ISP) in effect which requires monthly direct- or in-person contact, communication or activity with the individual and family/caregiver, as appropriate, service providers, and other authorized representatives including at least one face-to-face contact between the individual and the Support Coordinator/Case Manager every 90-days"
(New Zealand)(95)	Service coordination: "Facilitating a process for people to identify their strengths, resources and needs; explore their support options; and access support services"
Housing-related Support	
Supportive housing association of New Jersey (19)	"Support Coordination is a funded service that assists individuals in gaining access to needed program and state plan services, as well as needed medical, social, educational and other services".
Victoria Commonwealth University (20)	**"**Support Coordinators are primarily responsible for assessing individual needs, developing plans for support to help reach individual outcomes, linking people to services and resources, and monitoring whether services are helping achieve intended outcomes. When it comes to integrated, independent housing, the responsibilities are very similar. Support coordinators convene the person-centred planning team and "coordinate" with members of the team to ensure a person's plan for housing is fully implemented".
(USA) (usa.gov)(47)	"..to assist elderly individuals and persons with disabilities in obtaining the supportive services they need to continue to live as independently as possible in their homes. The service coordinator plays a critical role in supporting HUD-assisted multifamily housing as a platform for financial security, physical security, social connections, and the delivery of long-term community based supportive services, especially for vulnerable populations such as the elderly and persons with disabilities"
Wesley institute (Canada)(15)	"Coordination of services covers a range of matters needed by individuals, by providers, or system-wide. It is partly about coordination of services across program categories and types of providers. It is about systems and routes of access to housing and services. It is also about coordination of more than one type of service needed by any particular client"
Region of Waterloo community services (Canada)(42)	Housing support co-ordination: "New and evolving local standards of practice. Promotes consistency of person-centred service – clarifies roles for staff, participants/tenants and the community"


HEALTHY & POSITIVE
AGEING INITIATIVE