Waterloo-Wellington Older Adult Strategy

Report II: A Framework for the Older Adult Strategy for Waterloo-Wellington

Submitted to the Waterloo Wellington Local Health Integration Network

November 30, 2018
**Acknowledgements**

We acknowledge and appreciate the leadership of Don Wildfong in this project. As Project Director he established the design and process for strategy development, facilitated numerous stakeholder engagement sessions, supported the Older Adult Strategy Advisory Committee and Reference Group, and was primary writer of Reports I and II.

**Outline**

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Briefing Note

Situation

Vexing challenges and persistent barriers are facing health system transformation, including those that threaten the betterment of an aging society.

Nevertheless, opportunities exist to reorient, better align and deepen the integration of care, services and supports for people as they age in our region.

This Framework is offered to help shape systems, services and supports across the WWLHIN sub regions to help best meet the evolving needs of all older adults in Waterloo Wellington over the next 10 years.

Background

Beginning in February 2018 and guided by the Waterloo-Wellington Older Adult Strategy Advisory Committee, the Research Institute for Aging (RIA), in collaboration with stakeholders, embarked on an extensive review and engagement process — listening to understand the needs, concerns, perceptions, ideas and recommended solutions for strengthening our local health system to better support people, communities and populations as they age.

We are fortunate to live and work in a region known for its strength in innovation and technology; an area where creativity and leadership come together to solve local challenges, rally around progress and achieve results.

Assessment

General areas for action in which the WWLHIN can show bold and courageous leadership emerged, including the need to:

- Optimize competencies for non-physician health providers
- Deepen the integration of health and social services to improve health equity and reduce health disparity
- Intensify prospective needs-based planning
- Address persistent barriers to information sharing
- Facilitate clearer communication within the health system and with the general public
- Advance regional and whole-of-community approaches to better support population aging and quality of life
- Reorient systems, services and supports around functional areas to reduce structural complexity

Recommendations

Driving purposeful change at the health system level will mean bringing together health and social services in a more coordinated and responsive way to better address the very real needs that older adults and their families are facing, not only today but into the future.

Resting upon a series of priority pillars and key enablers, this Framework offers six overarching and interrelated goals for consideration as foundational to the Waterloo-Wellington Older Adult Strategy:

1. Waterloo-Wellington citizens age well within communities that celebrate their life in society and contributions to their communities, thriving through dignity, purpose, belonging and inclusion.
2. All people living in Waterloo-Wellington are exposed to the conditions and experiences that support optimal health throughout the lifecourse/lifespan.

3. The Waterloo-Wellington health system is designed and coordinated in a way that realizes deep functional integration and the appropriate use of health resources to achieve optimal system capacity in support of an aging population.

4. The Waterloo-Wellington health system fully leverages and capitalizes on intra and intersectoral collaboration, offering a whole-of-community orientation to health, well-being and quality of life.

5. Older adults living in Waterloo-Wellington have universal access to the highest quality of care, services and supports — those that emphasize excellence in safety, effectiveness, person-centredness, timeliness, efficiency and equity.

6. The Waterloo-Wellington health system plays a pivotal and functional role in enabling the empowerment of people as they age, their caregivers and the health and social service providers they rely upon.

**Actions**

In developing this Framework, the WWLHIN has demonstrated the type of collaborative leadership that will be required to realize sustained movement on key structural, process and outcome improvements.

Moving forward, efforts to catalyze the integration of ideas and collaborative efforts will go far to normalize a new way of working to best serve older adults and their families for years to come. This can begin now, by:

- Better targeting health policy, services and social supports to reduce exposure to the conditions that predispose vulnerability will better support optimal aging in our communities.
- Further confirming and validating the Framework as the basis for a comprehensive strategy.
- Articulating strategic directions and outcomes, including the development of an integrated service delivery implementation plan and a measurement and reporting framework that maps to a series of strategic objectives to achieve measurable improvements for older adults, caregivers, providers and the overall health system in Waterloo-Wellington.
- Harnessing and building strategic leadership to mobilize a coalition of the ready, willing and able
- Ensuring system stewardship and accountability.

**Conclusion**

This report represents the beginning of a movement that has sparked momentum and captured the wealth of goodwill, insight, effort and expertise that exist across Waterloo-Wellington. It proposes the next step in a journey toward a transformed health system that supports healthy aging and ensures a better quality of life for all people in our region.

At a regional level, collaborative leadership will mean figuring out the most effective and efficient way to cluster services according to functional roles and service dimensions. Indeed, reducing gaps and fragmentation will serve to improve multilevel outcomes related to health, patient and family experience and value. Community-based planning at the sub-LHIN region level will help to determine leadership and accountability, oversight and a model of integration appropriate to the local context.
Executive Summary

In February 2018, the Waterloo Wellington Local Health Integration Network (WWLHIN) engaged the Research Institute for Aging (RIA) to lead the development of the Waterloo-Wellington Older Adult Strategy (WWOAS). This work was guided by the WWOAS Advisory Committee and informed by the WWOAS Reference Group.

Report I, released in June 2018, presented a series of priority pillars, propositional statements and key enablers related to the development of the WWOAS. Importantly, the report was informed by the experiences, perspectives and voices of citizens residing within Waterloo and Wellington, including older adults themselves, their families and their caregivers. This report laid the groundwork for the next phases in the WWOAS development process and captured salient themes that emerged through a robust engagement process and environmental scan.

Foundational elements presented in Report I included:

**Priority Pillars**

1. Availability and accessibility of care, services and supports where and when they are needed
   - *Promote and Support Healthy Aging*
   - *Prevent and Manage Chronic Disease*
   - *Promote Optimal Aging at Home for Older Adults with Multiple Chronic Conditions*
   - *Provide Specialized Care for those Living with Frailty*
   - *Support Caregivers*

2. Performance, productivity and efficiency
   - *Communication*
   - *Transitions*
   - *Health Human Resources*

3. Linkage, coordination and navigation (includes provider awareness)

4. Equity, diversity and inclusion
   - *The case for an income-adjusted sliding scale for community services*

5. Health empowerment

**Key Enablers**

A. *Governance and System Stewardship*
B. *Clinical Leadership*
C. *Innovation*
D. *Digital Health*
E. *Education and Training*
F. *New and existing models for potential partnership and service integration and expansion (i.e. integrated health campuses and community hubs, for example)*
Approach

As outlined in the Waterloo-Wellington Older Adult Strategy project charter, the co-sponsors and Advisory Committee members agreed that moving forward with strategy development and implementation be contingent on a series of grounding assumptions—a shared understanding.

Four primary lenses were used to explore potential opportunities for better health and system strengthening. They included: Lifespan; Orientation; Improvement; and, Evidence. RIA relied on guiding principles for the Strategy development process, and those offered by WWLHIN related to system design and engagement (below). Evidence to inform transformation have respected *multiple ways of knowing*.
**Recommendations**

Resting upon the preceding priority pillars and key enablers, Report II was finalized in November 2018. Report II was envisioned as a Strategy Framework, articulating six overarching and interrelated goals for consideration as foundational to the Waterloo-Wellington Older Adult Strategy. These important goals are offered to better support the health of an aging population, improve care experiences and increase value for the health system, those who function within it and those who rely upon it.

The goals presented as part of the Strategy Framework include:

- **Goal 1: Age-Friendly Society/Communities.** Waterloo-Wellington citizens age well within communities that celebrate their life in society and contributions to their communities, thriving through dignity, purpose, belonging and inclusion.

- **Goal 2: Healthy Aging.** All people living in Waterloo-Wellington are exposed to the conditions and experiences that support optimal health throughout the lifecourse/lifespan.

- **Goal 3: Health System Capacity.** The Waterloo-Wellington health system is designed and coordinated in a way that realizes deep functional integration and the appropriate use of health resources to achieve optimal system capacity in support of an aging population.

- **Goal 4: Collaboration and Coordination.** The Waterloo-Wellington health system fully leverages and capitalizes on intra and intersectoral collaboration, offering a whole-of-community orientation to health, well-being and quality of life.

- **Goal 5: Quality.** Older adults living in Waterloo-Wellington have universal access to the highest quality of care, services and supports — those that emphasize excellence in safety, effectiveness, person-centredness, timeliness, efficiency and equity.

- **Goal 6: Empowerment.** The Waterloo-Wellington health system plays a pivotal and functional role in enabling the empowerment of people as they age, their caregivers and the health and social service providers they rely upon.

**Conclusion**

This Framework represents the beginning of a movement that has sparked momentum and captured the wealth of goodwill, insight, effort and expertise that exist across Waterloo-Wellington. It proposes the next step in a journey toward a transformed health system that supports healthy aging and ensures a better quality of life for all people in our region.

At a regional level, collaborative leadership will mean figuring out the most effective and efficient way to cluster services according to functional roles and service dimensions. Indeed, reducing gaps and fragmentation will serve to improve multilevel outcomes related to health, patient and family experience and value. Community-based planning at the sub-LHIN region level will help to determine leadership and accountability, oversight and a model of integration appropriate to the local context.

The next phase of this important work involves the articulation of the final Strategy — a series of strategic directions, objectives, outcomes and a measurement framework designed to optimize the health and well-being of older adults in Waterloo-Wellington and strengthen the performance of our health system.

The final phase of this work is expected to build toward an integrated service delivery model and implementation plan.
Introduction

In February 2018, the Waterloo Wellington Local Health Integration Network (WWLHIN) engaged the Research Institute for Aging (RIA) to lead the development of the Waterloo-Wellington Older Adult Strategy (WWOAS).

Report I, released in June 2018, presented a series of strategic pillars, propositional statements and key enablers related to the development of the WWOAS. Importantly, the report was informed by the experiences, perspectives and voices of citizens residing within Waterloo and Wellington, including older adults themselves, their families and their caregivers. This report laid the groundwork for the next phases in the WWOAS development process and captured salient themes that emerged through a robust engagement process and environmental scan.

Foundational elements presented in Report I included:

Priority Pillars

1. **Availability and accessibility of care, services and supports where and when they are needed**
   - Promote and Support Healthy Aging
   - Prevent and Manage Chronic Disease
   - Promote Optimal Aging at Home for Older Adults with Multiple Chronic Conditions
   - Provide Specialized Care for those Living with Frailty
   - Support Caregivers

2. **Performance, productivity and efficiency**
   - Communication
   - Transitions
   - Health Human Resources

3. **Linkage, coordination and navigation (includes provider awareness)**

4. **Equity, diversity and inclusion**
   - The case for an income-adjusted sliding scale for community services (Appendix A)

5. **Health empowerment**

Key Enablers

- Governance and System Stewardship
- Clinical Leadership
- Innovation
- Digital Health
- Education and Training
- New and existing models for potential partnership and service integration and expansion (structures and functions, including integrated health campuses and community hubs, for example)
Building on the strategic pillars, propositional statements and key enablers outline in Report I, this Report II, released in October 2018, presents a series of important goals and related action statements to better support the health of an aging population, improve care experiences and increase value for the health system, those who function within it and those who rely upon it. In essence, Report II represents a strategy framework designed to guide the development of the final WWOAS, the strategy itself.

The goals presented in this report are interrelated and stand best in concert. They include:

**Goal 1: Age-Friendly Society and Communities.** Waterloo-Wellington citizens age well within communities that celebrate their life in society and contributions to their communities, thriving through dignity, purpose, belonging and inclusion.

**Goal 2: Healthy Aging.** All people living in Waterloo-Wellington are exposed to the conditions and experiences that support optimal health throughout the lifecourse/lifespan.

**Goal 3: Health System Capacity.** The Waterloo-Wellington health system is designed and coordinated in a way that realizes deep functional integration and the appropriate use of health resources to achieve optimal system capacity in support of an aging population.

**Goal 4: Collaboration and Coordination.** The Waterloo-Wellington health system fully leverages and capitalizes on intra and intersectoral collaboration, offering a whole-of-community orientation to health, well-being and quality of life.

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**Goal 6: Empowerment.** The Waterloo-Wellington health system plays a pivotal and functional role in enabling the empowerment of people as they age, their caregivers and the health and social service providers they rely upon.

We are fortunate to live and work in a region known for its strength in innovation and technology; an area where creativity and leadership come together to solve local problems and achieve progress. As this relates to the care of older adults, Specialized Geriatric Services is recognized for the key role they have played to find local solutions and strengthen a network of relationships that have provided better care for older adults and their families in Waterloo-Wellington. Leveraging these strengths and relationships will be essential as we move forward with the implementation of the WWOAS.

People experience variable levels of need as they age. A holistic orientation toward healthy aging can reduce needs and optimize health across the lifespan. Preventative and restorative care approaches can prolong functional health status in older adults and reliable nursing and personal care and community support services can help people age well in their home and community.
Functional loss and frailty in older age is often triggered by episodic events rather than a predictable steady decline. That is, health decline is less often gradual but rather punctuated by events as people age. The good news is that most of these are preventable. However, when these events occur, timely access to the right services can support recovery.

Indeed, policy and programming decisions related to the what, where and how we provide care, services and support to an aging population will have widespread economic and social implications for those living within Waterloo Wellington. Better targeting health-care services and social supports to reduce exposure to the conditions that predispose vulnerability will support optimal aging in our communities.

Clearly, there is both need and desire for a substantive, transformational and sustainable vision to support the health of local people and communities as they age. The ongoing development of the WWOAS will serve as a catalyst to realize solutions for optimizing the health and well-being of our older adults and their families within our communities and improving the performance of our health system.

The next phase of this important work involves the articulation of the final strategy – a series of strategic directions, objectives, outcomes and measurement framework designed to optimize the health and well-being of older adults in Waterloo-Wellington and strengthen the performance of our health system. The final phase of this work will culminate in the development of an integrated service delivery Implementation Plan.

The WWOAS project represents the beginning of a movement that has sparked momentum and captured the goodwill, insight, effort and expertise that exist across Waterloo-Wellington. It marks the next step in our journey toward a transformed health system that supports healthy aging and ensures a better quality of life for all people in our region. Based on existing knowledge of facilitators and barriers to implementation, it will help to shape systems, services and supports for aging populations across the WWLHIN sub regions – one that will best meet the evolving needs of all older adults in Waterloo Wellington over the next 10 years.

“The objectives of the AHS [Aging at Home Strategy] have been difficult to achieve, in large part due to the imbalance between the mainstream and marginal subsectors. The Ontario AHS failed to realize significant shifts in the balance of resources from the mainstream to the marginal community care subsector. Even with ongoing stated objectives noting a desire to structurally reform the funding and delivery of community care services, competing policy agendas developed into contradictory policy outcomes.”

**Approach**

Guided by the Waterloo-Wellington Older Adult Strategy Advisory Committee and informed by the Waterloo-Wellington Older Adult Strategy Reference Group, the Research Institute for Aging (RIA) embarked on an extensive stakeholder engagement process (Appendix B). Through a series of focused dialogues and key informant interviews, RIA sought to *listen to understand* the needs, concerns, perceptions, ideas and recommended solutions for strengthening our local health system.

Evidence to support transformation has been respectful of the importance to access multiple ways of knowing. The stories and experiences shared have been truly informative.

RIA has relied on the guiding principles for the Strategy development process, and those offered by WWLHIN related to system design and engagement.

Four primary lenses have been used to date to explore potential opportunities for better health and system strengthening. They include:

- Lifespan
- Orientation
- Improvement
- Evidence

Examples of the questions used to foster an open exchange of ideas included:

1. What sorts of things are meaningful to older adults and their caregivers in your community?
2. Who are we serving well? Who are we not serving well? Where are we excelling and where do we need to make improvements?
3. What do we need to do differently? What should we be offering that we are not currently?
4. What system/service/support models should we be considering to better the meet needs of older adults and their families?
5. In which area of our system/services/supports must we place the greatest emphasis going forward (resources and attention)?
6. Do viable opportunities exist for service realignment or reorientation?

The implementation of a framework to encourage solution-focused dialogue has been extremely helpful in making efficient and effective use of time, allowing stakeholders to present best thinking in a logical manner, from problem to root cause to recommendation (Appendix C).
Grounding Ourselves in a Shared Understanding

As outlined in the Waterloo-Wellington Older Adult Strategy project charter, the co-sponsors and Advisory Committee members agreed that moving forward with strategy development and implementation is contingent on the following assumptions:

- That partners will participate and want to work collectively from the perspective of system and service co-design.

- That there is a need for an overarching strategy and that the strategy will provide direction for future funding decisions and target efforts towards system redesign, as appropriate.

- That gaps, redundancies and pressures exist in the current health system.

- That work forward should be guided by efforts to increase appropriateness by reducing the miss-use, under-use and over-use of resources, including health human resources, for example. This entails stronger emphasis on - the right care - for the right patient/client/resident/community - by the right provider- in the right place - at the right time - and at the right cost.

- That based on identified gaps and redundancies, opportunities and pressures, innovative solutions and models for improvement exist and that these should be approached through strategies and tactics that are either incremental or transformational, as appropriate.

- That when a solution is identified, there is a will and a commitment to optimize and leverage current system structures, processes and resources, as well as pursuing new funding opportunities when they arise. The availability of funding will influence the pace and scope of strategy implementation.

- That we have identified appropriate stakeholders and if people are missed along the way that efforts will be made to hear from them.
Alignment

Consistent with Patient’s First, the WWLHIN Integrated Health Services Plan 2016-2019 lays out the following commitments. 1

Access
Providing faster access to the right care.

▪ Ensure timely, accessible, supportive primary health care for all, including enhancing access for specific populations
▪ Provide seamless, high quality service delivery in the four Sub-LHIN geographies
▪ Improve access to timely mental health and addictions services
▪ Transform palliative and end-of-life care

Connect
Delivering better coordinated and integrated care in the community, closer to home.

▪ Integrate hospital care to deliver consistent, evidence-based best practice as a specialized resource on the health journey
▪ Strengthen home and community care
▪ Modernize the provision of long-term care through infrastructure renewal and quality improvement
▪ Support caregivers’ health and well-being

Inform
Support people and patients – providing the education, information and transparency Ontarians need to make the right decisions about their health.

▪ Increase access to linguistically and culturally appropriate services and care that is welcoming for all
▪ Enhance transparent access to information to support professional, patient and caregiver decision-making and transitions of care
▪ Promote access to information to support self-management and illness prevention

Protect
Protect our universal public health care system – making evidence-based decisions on value and quality, to sustain the system for generations to come.

▪ Engage patients, caregivers and community stakeholders in the design and implementation of health system improvement
▪ Reduce duplication in testing, assessment and service delivery to create a sustainable system of care
▪ Integrate services and pursue new models of care to reduce inefficiencies and redirect funding to front-line care

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1 Integrated health services plan 2016-2019 (WWLHIN, 2015)
Goals
This report acknowledges some of the vexing challenges and persistent barriers facing system transformation, including those that threaten the betterment of society. Opportunities exist for service reorientation, better alignment and deeper integration. The following goals and related action items are offered to help guide future directions. There is both room and opportunity for all sectors to demonstrate leadership and creativity in advancing transformational improvements. In the absence of a willingness to adapt, disruption may be necessary.

Goal 1: Age-Friendly Society and Communities
Waterloo-Wellington citizens age well within communities that celebrate their life in society and contributions to their communities, thriving through dignity, purpose, belonging and inclusion.

An age-friendly society values the contributions older adults have made, and continue to make, to strong, diverse and inclusive communities. It honours personal legacy, respects autonomy, self-determination and independence, and celebrates life purpose across the lifespan, allowing citizens to experience a sense of belonging to the broader community. And indeed, age-friendly societies ensure that older adults are exposed to an environment and conditions that enable them to enjoy the best quality of life and a breath of opportunities to prosper and thrive.

Inclusive communities respect diversity and differences and are places where neighbours look out for one another. They respect the uniqueness of lived experiences, offering opportunities for social connection, intergenerational engagement and lifelong learning. They offer secure places and safe spaces for people to live, work, learn, play, worship and do business irrespective of age and level of function. Individuals enjoy fulsome lives in their community of choice.

Age-friendly communities are those that have programs and resources in place for seniors to lead healthy, active, independent and engaged lives and continue to learn, contribute and be safe. It is important to create social and environmental conditions that support secure housing, safe mobility, access to appropriate and reliable transportation, and opportunities for civic engagement and participation. This may be especially so as rural dwelling residents in Waterloo-Wellington report an increase in the number of older adults moving to their communities upon retirement, while others are being left with no other option than to leave their community due to a lack of affordable seniors housing and transportation.

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2 PHAC, 2012
The following action ideas support movement toward the realization of *Age-Friendly Communities*, a whole-of-community approach:

- **Work with cities and sub-regions to support the development of age-friendly neighbourhoods, including those around apartment buildings or housing developments that house a high concentration of seniors.**

- **Work with cities and sub-regions to support the development and expansion of community hubs, including those in informal retirement communities, including apartment buildings or housing developments that house a high concentration of seniors.**

- **Work with cities and sub-regions to support the development and expansion of Seniors Active Living Centres (Ministry of Seniors Affairs).**

- **Create physical and virtual spaces for groups of community members who have typically felt marginalized to feel safe and confident about connecting to services.**

- **Increase the number and scope of intergenerational partnership programs in LTC and other care settings (i.e. East Wellington has an adult day program held within a public school).**

- **Identify opportunities and partners to promote intergenerational housing as a viable solution to support seniors remaining healthy and in their own homes. One model could involve college/university students and seniors living together – very plausible in a region with three universities and a community college.**

- **Double the capacity of supportive housing across Waterloo-Wellington.** There exists a pressing need to secure more options for affordable housing in rural areas as many are experiencing pressure to leave home community (Elmira). Good examples exist for housing and living options that integrate seniors and people of other ages in need of a variety of levels of living assistance. One example of an integrated living model is Field of Dreams in Elmira.3 Enhancing social models of living and increasing community-based options and supports for older adults, their families and those who care for them, should be a policy imperative to support seniors living in the community.

- **Co-locate housing with senior’s health and social services.** There is growing interest across Waterloo-Wellington to move toward supporting the co-location of housing with senior’s health and social services, particularly as this relates to infrastructure investments and community development projects. This needs to be done in collaboration with all levels of government and

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3 Jackson, 2018
with participation from the private sector. These can be seen as taking the form of community hubs, health and wellness campuses and seniors active living centres.

- **Address social isolation, especially in rural areas.** Sustaining existing successful programs and fostering innovation to better support seniors at risk of social isolation are important, given its pronounced negative impact health, quality of life and longevity. One idea to increase the engagement of older adults in meaningful ways is to encourage their participation in society such as can be offered through the voluntary sector. Implementing a regional volunteer program to connect older adults and harness generativity could be a good place to start. Social determinants of health challenges are pronounced in rural areas, especially income, housing, transportation and access to care, services and supports. For this reason, securing reliable and affordable access to transportation services for all older adults living in Waterloo-Wellington is important, irrespective of where they live.

- **Ensure that policy, programming and service decisions include attention to the unique needs of aging members of all populations.** These include low income residents, Indigenous persons, people who do not communicate in English, new immigrants and refugees and members of the LGBTQ2 (Rainbow) community.⁴

- **Implement a public facing social marketing campaign to reduce ageism.** Supporting the advancement of a culture of respect and civility for all aging members of our communities can help create the conditions for older adults in Waterloo-Wellington to remain valued, productive and engaged members of our communities.⁵ This often starts by addressing ageist attitudes through formal and informal networks and strategies.

- **Implement a public facing social marketing campaign to prevent elder abuse and neglect.** Encouraging citizens to take collective action on preventing, reporting and intervening in situations where elder abuse and/or neglect are suspected.

- **Connect with, and communicate through, community-based social networks.** Supporting opportunities for sharing and interaction when communities gather during times of celebration and healing is important to recognize in an area as diverse as Waterloo-Wellington. Often, these can be the best opportunities to leverage knowledge exchange and information sharing through well-connected informal networks.

Communities should help people to remain healthy, active, safe and socially connected at all stages of their lives. Older adults should be supported to age well and with independence, able to take advantage of the opportunities that arise in their later years, and to be supported through their challenges.

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⁴ Mapping the future of our local health care system (WWLHIN, 2015)
⁵ Alliance for a National Seniors Strategy (2016).
Goal 2: Healthy Aging

All people living in Waterloo-Wellington are exposed to the conditions and experiences that support optimal health throughout the lifecourse/ lifespan.

A transformed health system offers innovative ways to optimize health outcomes for all and solutions to help older adults remain independent, healthy and out of hospital for as long as possible. It recognizes the social determinants of health as inextricably linked to the health of a community and assumes a population health promotion orientation to supporting wellness and relies on upstream investments to reduce the burden of injury and disease. And, it supports patient and public involvement in personal health-care decision-making and health system decisions.

A transformed health system better supports older adults and their caregivers by acknowledging and addressing the influence of the social determinants of health, such as the cost of transportation, housing and medications, and the availability of affordable fresh food, as factors influencing the ability to optimize and manage one’s health.

Drs. Jenny Ploeg, Maureen Markle-Reid and other researchers from McMaster University’s Institute for Research on Aging (MIRA) share eight ways to age well, according to their findings.

1. Move it or lose it
2. Advocate for your own well-being
3. Stay engaged in the arts and social activities
4. Listen, with empathy
5. Prepare for later retirement
6. Address disadvantages and inequalities
7. Learn from the past
8. Seek joy, purpose and enlightenment

Read more about what they have to say here: https://mira.mcmaster.ca/news-events/news-item/2018/10/01/on-international-day-of-older-persons-mcmaster-experts-weigh-in-on-what-it-takes-to-age-well
An adequate, and perhaps broadened basket of services is necessary to provide early supports for healthy aging, including healthy eating and physical activity programs to improve, maintain or restore function, in-home assessments, physical space modifications and stable opportunities for social connection. Emphasizing aging in place and the role played by primary health care, home and community-based care and services can support this end, including respite, restorative, rehabilitative and convalescent care. Having said that, helping older adults make connections between health promotion activities and the benefits they have in terms of maintaining and improving their health and function should be considered a priority for all working within the system.

We know that preventing illness can be achieved in part by promoting healthy lifestyle choices, encouraging residents to be active participants in their health, and coordinating preventative programs that include community partnerships to address local needs. Improving health literacy can serve to create better conditions to support health, wellness, resilience, independence, and above all, quality of life and death. Improved health literacy allows health providers to work together and actively involve older adults and their family caregivers in care and goal planning. This starts by making sure that information about services and supports is both available and accessible and will be beneficial for improving their involvement in both self-management and self-care, before situations reach the point of crisis. Ideally, the goal is for older adults and family caregivers to be active participants in planning for their own care.

- **Ensure that older people benefit from comprehensive health assessments.** These consider physical, cognitive and mental well-being, health-related behaviours, access to health and social services and the social determinants of health, such as income, housing, transportation and social inclusion. Some groups are more at risk of being in low-income situations than others. They include older women (over 85 years) who are living alone, Indigenous seniors and recent immigrants. The highest incidence of low income for immigrant seniors is for those who arrived in Canada between 1991 and 2000). Efforts that target the reduction in inequities and disparities in health status between older adults in these population groups and others should be bolstered.

- **Advocate for movement toward a province-wide and transparent funding and fee schedule – based on an income-adjusted sliding scale.** In a system that does provide formal mechanisms to gear service fees to income level, lower income seniors, even those living in poverty, often end up paying disproportionately high costs for community-based services and support, such as for healthy meals and transportation. Many older adults, especially those living in rural areas, experience barriers related to costs associated with public or private transportation. Collaborative efforts to address this persistent barrier could improve access to health appointments, recreational programs, etc. Certainly, efforts can be taken to develop more progressive alternatives to better promote equitable supports for better health outcomes. Indeed,

6 https://achru.mcmaster.ca/sites/achru.mcmaster.ca/files/Study%201%20Infographic_caregivers.pdf
7 https://achru.mcmaster.ca/sites/achru.mcmaster.ca/files/Study%201%20Infographic_caregivers.pdf
• **Encourage the full participation and contributions of older adults through both paid and unpaid work.** We know that there is a direct correlation between social connectedness and well-being — that is, having family and friends and a feeling of belonging to a community contribute to good health. ⁹ Older adults who are not able to access, or do not participate in, social support networks may lack a sense of belonging and become isolated or lonely. Seniors benefit from and contribute significantly to life through both paid and unpaid work. ¹⁰ In fact, ongoing involvement in volunteer activities has been shown to moderate the negative psychological impacts associated with developing functional limitations (Greenfield & Marks, 2007).

Many older adults in Waterloo-Wellington rely on local service clubs that work to provide for the needs of those living in deeply rural settings (i.e. Kiwanis, etc.). They are established and committed to civic responsibility and accountability within their communities and are a valued resource to many.

More directly, informal caregivers provide a breadth of supports to help meet the complex needs of community-dwelling older adults with multiple chronic conditions including the provision of physical care, meals, transportation, housework, managing medications and observing for side effects, assisting with exercise, providing, and accompanying older persons to medical and other appointments. Caregivers also provide emotional support, cognitive stimulation, assistance with social outings and personalized care. ¹¹

In order to remain in their own home, many older adults require access to personalized home solutions that promote mobility (ramps, stair rails) and home safety and comfort (bathroom safety, lift chairs). Those without private insurance coverage often face financial barriers in accessing these supports, especially those resources required over the longer term.

• **Intensify training for health and social service providers to ensure the provision of culturally safe and competent care and support.** Efforts to better address the needs of Indigenous peoples, members of the Rainbow community and French-speaking and linguistic minority communities should be made a system-level priority. For instance, collaborating with Spectrum Prime, Aging with Pride and other community partners to develop a public awareness and education campaign addressing homophobia and transphobia affecting seniors for all WWLHIN-affiliated agencies could offer a starting point.

• **Continue to engage local community-based seniors’ groups.** Examples that engage older adults in Waterloo-Wellington and support local priority program initiatives related to health and well-being include the Cambridge Council on Aging and the Woolwich Seniors Association and Ideas Exchange, to name but a few.

• **Emphasize quality of life.** When health providers interact with older adults and their families it is important that they emphasize quality of life in discussions and explore options that are

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⁹ Edwards & Mawani, n.d
¹⁰ MacEwen, 2012
¹¹ Ploeg, et al., 2017
acceptable to them with respect to time, place and cost of these care, service and support alternatives.

**Goal 3: Health System Capacity**

The Waterloo-Wellington health system is designed and coordinated in a way that realizes deep functional integration and the appropriate use of health resources to achieve optimal system capacity in support of an aging population.

In a modernized health system, communities and citizens benefit from improved access to primary care and reasonable wait times to see a specialist. Older adults across Waterloo-Wellington receive mental health and addictions services, home and community care, acute care and LTC of similar quality, no matter where they live. Health providers function in interprofessional collaborative teams to provide holistic person-centred care, build bridges, strengthen connections across the system and lead from within. They acknowledge and respect the voice of lived experience.

In a transformed health system, areas for improvement consider opportunities to strengthen structural and functional capacity and integration from a regional systems perspective, supported by regulatory and legislative frameworks that foster the alignment of incentives and disincentives to achieve system goals. Efforts are taken to optimize strategic vertical and horizontal alignment across priority programs and initiatives, with an emphasis on scaling up both incremental and transformational innovation and improvement in care and service provision for older adults.

In so doing, we must collectively work towards realizing appropriateness in all that we do. This includes considerations about how we can work to reduce the miss-use, under-use and over-use of resources, including health human resources. This means placing a stronger emphasis on — the right care — by the right provider — in the right place — at the right time — and at the right cost. This often requires frank conversations, creative considerations, a collective willingness to act in the best interest of patients of patients and the system, and above all, bold leadership.

- **Finalize the review and mapping of all senior’s programming and services in Waterloo-Wellington.** This is currently being led by the WWLHIN. This process represents an opportunity to better understand the adequacy of service provision, and areas of service duplication, to ensure that an appropriate breadth of service is available and accessible where they are most needed in Waterloo-Wellington. This review should be conducted in collaboration with those organizations and providers who have existing formal agreements with WWLHIN and those who do not, including important services upon which older adults, families and caregivers currently rely.

- **Hasten movement toward the realization of an integrated system and service model that emphasizes functional integration.** The rising costs associated with acute, episodic and hospital-based care are, in part, the result of policies and funding decisions that have overemphasized
illness care at the expense of promoting health and wellness.\textsuperscript{12} Primary areas for action include access to home and community-based care, primary care, specialist services and community support services.

**Innovation**

Beyond technological innovation, there are opportunities to adopt, adapt or develop team-based models of care that can be implemented to respond to rapidly changing needs related to where, how and by whom care is delivered. This transformational shift must move us toward systems and services that emphasize appropriateness \textsuperscript{13} and that are informed by rigorous evidence of health impact and performance improvement. The move toward integrated models of care remains a priority. These models would improve access to the broadened range of services, including health care, home and community services, and residential care services; improve access to comprehensive care; increase emphasis on health promotion and chronic disease prevention and management; and provide appropriate care through multidisciplinary teams.\textsuperscript{14}

- **Capitalize on Waterloo-Wellington’s innovation culture to improve health and social service delivery, communication with citizens and collaboration within the health system.** This can be achieved by directly engaging within the WWLHIN Health & Social Innovation Ecosystem and with its affiliates to solve the most pressing challenges facing individuals, organizations and the health system that supports them.

- **Improve continuity of care for community-dwelling older adults with chronic and/or complex health-care needs by integrating nurse-led models of care that are proactive, comprehensive, coordinated and targeted, whether nurses are operating alone or as part of interprofessional teams.** Strong evidence exists to in support of this recommendation.\textsuperscript{15}

**Digital Health**

The current technology environment has existing and evolving solutions to help older adults live independently, travel less, and get better access to the services they need, where and when they need them. Integrating digital health components into a system that serves all residents in Waterloo Wellington will ensure that we are more effective and efficient in communicating and making available the best options to support their health and well-being.

For these reasons and others, digital health is viewed as a key enabler of the Older Adult Strategy. Digital Health is expected to be instrumental in supporting and making improvements, including but not limited to the following action items:

\textsuperscript{12} CNA. (2015).
\textsuperscript{13} The Council of the Federation Health Care Innovation Working Group achieved provincial/territorial consensus on a working definition for appropriateness: “In the context of health care, appropriateness is the proper or correct use of health services, products and resources. Inappropriate care, in contrast, can involve overuse, underuse and/or misuse of health services, products and resources.”
\textsuperscript{14} Carstairs & Keon, 2009
\textsuperscript{15} Browne, Birch & Thabane, 2012
• Provide older adults with better supports to better manage their health challenges;
• Make it easier for people to understand and find services that are available to them;
• Enable technology to support enhanced access to, and movement through, points of care in the system;
• Increase formal targeted partnerships through MOUs/collaboration agreements and problem-solving challenges in key strategic areas of priority;
• Improve access to care in the home, or closer to home; and,
• Make it easier and timelier to access clinicians, care, services and supports.

Health Human Resources

• Intensify prospective needs-based planning efforts. Efforts to ensure reliable and stable workforce capacity into the future should be guided by prospective needs-based health human resource planning processes that consider the production, distribution, utilization, deployment, recruitment and retention of our providers. Understanding current health needs and anticipating emerging health needs of the population, as determined by demographic, epidemiological, cultural and geographic factors should be considered necessary inputs for a robust needs-based planning model.

• Further support and drive community-based and collaborative team-based models of care. Planning efforts should also be responsive to emerging policy priorities and contextual realities by strengthening the health system to deliver better care at home and in the community. Developing a system-wide levels of care framework, similar to that which has been developed for home and community care in Ontario — a seven-level framework designed to help identify and meet the functional needs of adults who require home and community care services for a longer period of time and their caregivers — can serve as an input into needs-based planning frameworks.\(^{16}\)

• Determine local requirements as they relate to differentiation and specialization within the health workforce. Actions addressing workforce capacity must consider efforts to increase differentiation and specialization across professional and vocational care and service providers. So too must they explore creative options to integrate international health professional graduates into care and service sectors as appropriate (i.e. community health workers).

Begin with promoting health

While Goals 1 and 2 presented arguments to support the promotion of health and wellness in the older adult, assisting people to build personal skills and develop healthy behaviors is also an upstream focus of health promotion and disease and injury prevention. Sometimes providers are left asking the question: How can we best break down silos that hinder innovation, collaboration, and transparency to promote patient referrals to different programs? After all, is it not the responsibility of all health providers to support older members of our community and their families and caregivers through transitions in health and care.

- **Increase system capacity to identify those at risk for frailty and vulnerability.** Efforts should be made to identify the priority needs for older adults most exposed to conditions that predispose vulnerability, including but not limited to First Nations, Inuit, and Métis; racialized minorities; immigrants; linguistic minorities; members of the LGBTQ2 community and those who are homeless or living in poverty. It can, at times, be challenging to identify people at risk for isolation, neglect or abuse. In some cases, people may not trust the health system, while others may not be formally connected to it. This can often mean that we should think differently about leveraging the right person’s relationship with the older adult and about the approaches we take to build and strengthen bridges between sectors.

  “Currently, we have little evidence to guide the care of older adult living with frailty. We don’t know if current therapies are beneficial or cause harm, are cost-effective or waste scarce healthcare resources. As well, the healthcare system is ill equipped to deal with frailty:

  - Healthcare systems are organized to manage illness based on single body systems and diseases, not the complex multi-system problems of those living with frailty.
  - Frailty is poorly understood, pervasively under-recognized, and under-appreciated by healthcare professionals and the public.
  - Few healthcare professionals have expertise in caring for the frail elderly.
  - Poor system integration causes poor outcomes for older adults living with frailty.”

  Source: Canadian Frailty Network
  http://www.cfn-nce.ca/frailty-matters

- **Build stronger collaborations between the primary care and public health sectors.** It has long been suggested that primary health care systems can be enhanced by building stronger collaborations between the primary care and public health sectors.17 This position is supported in a report from the Institute of Medicine that states “the integration of primary care and public health could enhance the capacity of both sectors to carry out their respective missions and link

17 CIHR-IPPH, 2003
with other stakeholders to catalyze a collaborative, intersectoral movement toward improved population health". For instance, it is easy to imagine that screening and risk assessment clinics could be established, either in fixed locations of through mobile outreach units. These clinics could serve as an information source to help people learn about community programs and resources. This model is similar to that which has been done in Ontario's Healthy Babies Healthy Children Program. Perhaps it is time to ask the question, could seniors outreach teams offer a viable model for collaboration between public health and primary care going forward?

Primary Health Care

A variety of primary care models exist within Waterloo-Wellington. Not all offer the same model of care, colocation of services, or access to resources offered through interprofessional collaborative practice teams. While it is generally accepted that upstream and proactive approaches to health promotion and chronic disease prevention and management are best achieved through primary care, not all have the same capacity to deliver holistic person-centred care, offer health promotion and prevention (primary, secondary and tertiary) or address the management of multiple chronic conditions and frailty.

- Increase the number of team-based primary care clinics and develop capacity and tools to better support navigational and care coordination functions at the level of primary care across Waterloo-Wellington. It is often difficult for older adult patients to make their way in to see their primary care provider, given logistics related to required family supports (availability to accompany) and transportation. When they are able to see their primary care provider, many arrive with multiple issues to discuss, which can often lead to a 30- to 45-minute visit in order to address their concerns and/or those of their family members. Situations like this are becoming more common, and place primary care providers in a difficult situation, one that pits time against their interest in listening to the patient to best support shared goals of care. In some cases, primary care providers are making visits to see older persons in their home, as are some geriatricians.

- Implement screening tools in the community by making better use of community-based pharmacists, home and community care nurses and even freestanding community-based nurse-led chronic disease prevention and management centres. It is becoming increasingly clear that there are limits to how much time family physicians can afford to spend during scheduled visits with older adults. Having said that, most people living with frailty live in the community, so strengthening primary healthcare for adults living with frailty is crucial. Given time constraints of physicians during primary care visits, some feasibility and good results have been demonstrated in the assessment of older adults for frailty using a subset of screening tool indicators, such as gait speed and hand-grip strength. While this may work well in certain primary care settings (more so in FHT and CHC models) and can be incorporated into certain types of visits (influenza immunization and memory clinic assessments), much of this could be accomplished in the community, using community-based pharmacists, home and community care nurses and even freestanding community-based nurse-led chronic disease prevention and management centres.

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18 Institute of Medicine, 2012, p. 1

Prepared for the Waterloo Wellington Local Health Integration Network by the Research Institute for Aging
• **Bolster the capacity for enhanced comprehensive geriatric care in primary and specialty care.**
  This could include establishing multidisciplinary teams and specific programs such as the Hospital Elder Life Program (HELP).\(^{19}\)

• **Expand and integrate Advanced Practice Nurse–led transitional care services.** Better connecting and/or embedding this model can assist more older adults with complex health challenges.\(^ {20}\) Nurse practitioners, some of whom function as case managers/coordinators in primary care, need assistance to collate and send salient portions of the health record, especially those related to discharge and care planning.

• **Take fuller advantage of the competencies and capabilities of non-physician professionals by utilizing all to their fullest scope of practice.** Registered nurses are currently underutilized in primary care settings. For instance, promoting team-based primary care with greater emphasis on making registered nurses and nurse practitioners leaders in after-hours care may well be an option worth exploring further (Appendix D).

• **Explore opportunities to introduce community-based RN-led clinics for underserviced rural environments** (i.e, Dundalk). Similar models have been in place for decades, including the Comox Valley Nursing Centre in BC.\(^ {21}\) and in Caledon. Consider this and other models that would allow nurses and PSWs to be hired and deployed into home settings locally in rural areas.

• **Redirect investments toward more community health clinics and the expansion of community-based ambulatory care services.** This can be seen as an important way to achieve clinical efficiencies, strengthen linkages to community support services and provide a more comprehensive range of services to older adults. Working to cultivate relationships that engage interprofessional providers can help to realize truly integrated models of care for frail seniors.\(^ {22}\)

• **Accelerate the implementation of electronic referral mechanisms in primary care that are integrated across systems.** Priority should be given to rural communities so that primary care providers can refer directly to community support services for services such as outreach, congregate dining, foodbank, supportive housing, adult day programs, transportation, etc.

• **Further integrate the management of mild frailty through closer collaboration between primary care and other sectors.** These include, but are not limited to, Public Health Units, pharmacists, and providers of recreation, exercise and physical activity programs in the community.\(^ {23}\)

• **Further integrate specialty care capacity with primary care.** This may serve to strengthen local practices to more proactively manage frailty and prevent further decline leading to Emergency Department (ED) visits, hospitalization, and ultimately premature institutionalization.

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21 [https://www.viha.ca/comox_valley_nursing_centre](https://www.viha.ca/comox_valley_nursing_centre) and [https://www.youtube.com/watch?v=wx_Uvyyh-4k&feature=youtu.be](https://www.youtube.com/watch?v=wx_Uvyyh-4k&feature=youtu.be)


• **Capitalize more fully on the existing capacity of geriatricians, geriatric psychiatry and cognitive neurologists by increasing e-consultation referrals in primary care.** Specialty clinics embedded in primary care team-based practices are demonstrating great promise. Examples include GeriMedRisk and Primary Care Collaborative Memory Clinics, which have both been successful at improving outcomes for older adults with complex needs and the health system. This is in part because they have been working to address the most influential factors that facilitate collaboration and establish acceptable remuneration models for physicians. These types of models can help to diagnose dementia in primary care earlier, prevent health deterioration and reduce the potential for future crisis. These specialist consultation models should be expanded beyond primary care and long-term care and serve to extend specialist expertise to services in rural remote areas.

• **Bring GeriMedRisk to scale within and beyond WWLHIN as an interdisciplinary geriatric pharmacology and psychiatry consultation service that supports physicians, pharmacists and nurse practitioners to optimize their older adult patients' medications.** GeriMedRisk provides consultations and supplementary educational materials to further enhance geriatric pharmacology and psychiatry capacity among all referring clinicians. This clinical process provides enhanced expertise to the patient's circle of care without introducing another prescriber since multiple prescribers are a known risk factor for adverse drug events.

• **Support primary care practices with the structural and operational capacity to fully participate in eConsultations.** In order to create more value among adopters of these innovative models, they must be seen as accessible, timely and efficient by those who are being asked to use them. There are opportunities for technological and process improvements, such as having a system in place to synthesize information from multiple sources into a report for eConsults.

This section elicits some general questions worth considering with respect to technology and innovation, including:

• How can technology be better leveraged to design an algorithm to pull salient information from multiple sources into a single document to support e-consultations between primary care and specialists?

• How can simple screening tools be embedded into the electronic health record, decision support tools and patient intake processes at the level of primary care? Examples include screening tools and feasible early detection protocols/processes to identify those at risk of poverty, abuse, neglect, physical and cognitive functional decline, social isolation, mental health and addiction problems and frailty.

• How can technology challenges related to e-consultations be minimized for primary care physicians and specialists? Could introducing this new function to existing roles help? Or should this be part of a new role situated at the level of primary care, such as an RN care coordinator/navigator?

• How can registered nurses be utilized to full effect at the level of primary care, not only with respect to evolving scopes of practice (i.e. RN prescribing), but to fully optimize the competencies and capabilities they possess in the areas of population health promotion and chronic disease prevention and management?

• How can EMS remote patient monitoring be expanded in rural settings and better integrated at a systems level?
Home and Community Care

Home and community care play a vital bridging role in a functionally integrated health care system - enabling safer transitions from acute care back to the community and better meeting the chronic care needs of community-dwelling seniors and their families.

The medical complexity and associated care needs of residents living at home is increasing as the population ages. In fact, 33% of older adults in the community are living with multiple chronic conditions (MCCs), that is, two or more.\(^{24}\) Modern health systems are not longer designed to treat single diseases, but rather the whole person. This is especially important for older adults with multiple chronic conditions, who use three times the amount of healthcare.\(^{25}\) We also know that the health status of residents living in retirement homes is shifting toward a greater complexity of need. Given this, it is suggested that more focus and supports be provided by retirement homes, such as frailty screening.

- **Directly link home and community care with a primary care coordinator, where the coordinator makes the initial referral for home care services.** Once assigned, home health-care organizations would develop, monitor and refine a personalized care plan for the client while maintaining information sharing with primary care. Once home-health care services are discontinued, a discharge summary should be sent to the primary care co-ordinator. It is widely agreed that there are opportunities for deeper alignment between home and community care and primary care services in the areas of assessment, care and discharge planning.

- **Ensure adequate numbers of personal support workers (PSW), continuity of care and continuity of caregiver.** The WWLHIN is working to ensure that agreements with home and community care service providers/agencies emphasize continuity of care and caregiver irrespective of where older adults live within Waterloo-Wellington, while focusing on adequate and reliable levels of in-home personal support, nursing and therapy visits and respite care. Having said that, the availability and care coverage of PWSs remain some of the most vexing issues for WWLHIN, and despite a number of newly implemented mitigation strategies, this trend continues to worsen. In the face of rising service requirements, in 2017/18 home and community care services providers in Waterloo-Wellington remained unable to meet provincial service performance targets on a series of indicators, including: 1) PSW Referral Acceptance Rate; 2) PSW Missed Care; and, 3) 5-Day Wait Time - Nursing & PSW for Complex Patients. Trends in these areas continue in the wrong direction, with all areas falling below provincial averages. Local and provincial efforts to review compensation, working conditions and alternative supplementary roles are urgently required and must form part of the solution going forward.

- **Consider different community-based roles and models of care to help address existing resourcing pressures in home and community care.** An important question here is, to what extent can the existing workforce, including PWSs, developmental service workers (DSW), occupational therapy assistants (OTA) and physiotherapy assistants (PTA), community health

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\(^{24}\) [https://achru.mcmaster.ca/sites/achru.mcmaster.ca/files/Study%201%20Infographic_caregivers.pdf](https://achru.mcmaster.ca/sites/achru.mcmaster.ca/files/Study%201%20Infographic_caregivers.pdf)  
\(^{25}\) [https://achru.mcmaster.ca/sites/achru.mcmaster.ca/files/Study%201%20Infographic_caregivers.pdf](https://achru.mcmaster.ca/sites/achru.mcmaster.ca/files/Study%201%20Infographic_caregivers.pdf)
workers, senior support workers and supportive care providers, for instance, be better utilized to meet health-care needs, both today and beyond?

- **Develop system- and organizational-level strategies and engagement approaches to better involve PSWs.** PSWs are considered the backbone of the home and community care services and LTC. We must find better communication process and mechanisms to share clinically relevant information required to improve care and properly integrating them as valued members of health teams. This will result in positive outcomes related to job satisfaction, empowerment and retention.

- **Enhance, diversify and expand Adult day programs (ADP) across Waterloo-Wellington to offer more appropriate options that better meet the existing needs.** While admission wait times are longer than desirable, ADPs are helping to serve the needs of persons living with dementia, including younger people living with dementia. Appropriately tailoring and diversifying ADPs will be important going forward, such as has been done by embedding a French Adult Day Program “pod” within a larger and existing ADP for English-speaking participants. Offering a diverse range of programs and services by differentiating day programming will help to better meet the needs of those with early stage dementia; those needing opportunities for social connection; those with functional needs and developing new day programming options that support the more physically frail client. These clients require more health-care support (i.e. insulin injection, support in bathroom, feeding, med reminders etc.). Currently, they are integrated into existing day programs. Alternative models of service are required.

- **Expand regional-wide programming for people with dementia and their caregivers.** This should include dedicated funding for “Peer Connections” programming.

- **Explore community-based and person centred models that support seniors living in the community as potential alternatives to costlier LTC placement options.**

- **Expand the availability and accessibility of services to prevent functional decline and frailty by offering more community-based programs that target maintaining functional health and well-being, preventing and restoring functional decline and coping with functional loss.** A regional approach to scaling up ambulatory care capacity, with outreach options, is considered a good place to begin.

**Acute Care**

- **Work with Chief Nursing Executives in Waterloo-Wellington and the Research Institute for Aging to develop and implement a comprehensive quality assurance framework for Seniors Friendly Hospitals, one that identifies a standardized series of indicators and metrics and a protocol for collection, analysis and reporting.** Waterloo-Wellington hospitals have a continued leadership role to play in advancing the Senior Friendly Hospital Strategy.

- **Improve emergency department screening for those at risk for ALC and strengthen early supported discharge processes.**
- **Intensify work to safeguard the safety of older adults while receiving care in hospitals.** At an absolute minimum, this will be achieved by preventing avoidable complications (i.e. delirium), potential injuries (i.e. falls) and functional decline.

- **Build on efforts to increase the integration of hospital and Home and Community Care teams for smooth patient discharge from hospital should accelerate.** Discharge checklists should include connection to care coordinators to ensure that services are in place in advance of discharge.

- **Improve Hip and Knee Replacement Wait Times in the WWLHIN in accordance with provincial targets.**

**Long-Term Care**

- **Reduce extended waiting periods for LTC placement as a matter of urgency, given implications related to inappropriate resource utilization and quality of life.** Limited discharge options from acute care exist for older adults with complex needs. In cases such as these, and while no longer in crisis, older adults are experiencing prolonged stays in hospital. Active facilitated discharge planning should be implemented in advance of transfer of care and accountability, which can be especially problematic with discharge from acute care to LTC facilities. Fully apprising the receiving care team to the nature of behavioural problems, including history, precursors and successful interventions need to be communicated.

- **Ensure that long-term care infrastructure and capacity investments are informed through a needs-based planning process and allocated according to necessity.**

- **Explore and expand LTC spaces and programs that best serve the cultural and language needs and preferences of older adults in Waterloo-Wellington.** Cultural and language differences can be precursors for isolation in later years, especially when social networks diminish. Further exploring the introduction and expansion of LTC spaces and programs that best serve the cultural and language needs and preferences of older adults in Waterloo-Wellington should be considered, such has been done in other places (Shalom Village, Baycrest, Yee Hong Geriatric Care Centre and Fudger House, for example).

- **Introduce more specialized behavioural support units and expand Behavioural Supports Ontario (BSO) initiatives.** Going forward, there is a need to ensure the safety and security of LTC residents. The introduction of more specialized behavioural support units and expansion of BSO initiatives at local levels is recommended to ensure better access to geriatric psychiatrists and teams equipped with the specialized skills necessary to care for older persons with complex behavioral needs.

- **Continue to evaluate the impact of the Integrated Assisted Living Program (IALP) on improving population health outcomes as well as easing local health system pressures.** This program addresses the basic activation, recreation and social needs of frail, high risk senior clients.
through access to appropriate services and programs that maintain or enhance their health outcomes.

- **Critically review existing system capacity for transitional care.** In so doing, proceed with needs-based planning models as they relate to infrastructure and allocation to ensure the adequacy of this level of care for the next decade.

## Mental health and addiction

**Increase access to comprehensive geriatric assessments and psychogeriatric outreach teams.** People with persistent life-long mental illnesses, such as schizophrenia and chronic depression, are living longer, thanks in part to the advent of newer medications like second-generation antipsychotics. Traditionally, their physical needs have not been met as well as they could and should by the health system, due in part to the vertical silos (disease-specific orientation) that have existed in the past, and still do to some extent today.

- **Support residential school survivors and their families.** This policy and practice imperative can be achieved, in part, by ensuring that older adults living in Waterloo-Wellington with lived experience have appropriate access to mental health and emotional supports.

- **Implement Seniors ACT teams.** This model is appropriate for those requiring intensive follow through will be an important consideration going forward as many older persons requiring this level of care and treatment may lack personal support systems.

There is an acute need for greater acknowledgement and understanding of substance use disorders among older adults as well as their healthcare providers. In this regard, the Canadian Centre on Substance Use and Addiction recommends action in the following areas:

- **Increase awareness of substance use in older adults among healthcare providers, caregivers and older adults;**
- **Provide more education and training for healthcare professionals and students on substance use disorders in older adults;**
- **Improve the availability and accessibility of age-specific substance use disorder treatments and individualized care;**
- **Develop and implement guidelines and recommendations on substance use in older adults that are tailored to the unique nature of this demographic; and,**
- **Develop and implement guidelines and treatments for older adults that are communicated to healthcare professionals and the general public.**

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26 CCSA, 2018
Alcohol-related problems are often an unrecognized challenge in working with older adults. Older adults can experience increased effects of alcohol due to age-related physiological changes and alcohol-drug interactions, and/or increased reliance on alcohol as a coping strategy with significant life changes.

- **Introduce the Senior Alcohol Misuse Indicator (SAMI)**27 as a brief senior specific screening tool. This tool provides a gentle, non-confrontational approach to elicit information to determine if there are concerns related to alcohol use/misuse.

What is clear is that age-specific services for the treatment of substance use disorders need to be made available and accessible to older adults. It is further suggested that strategies and interventions designed to promote healthy aging could hold the key to reducing problematic substance use among older adults, with patients, caregivers and healthcare providers all having important roles to play in ensuring positive outcomes for older adults.

**Palliative Care and End-of-Life Care**

- **Improve access to community-based palliative care and community-based end-of-life services to those living in Waterloo-Wellington.** This should include the extension of more non-medical supports to patients and caregivers in the community, such as those offered through visiting hospice volunteer services. Ensuring the adequacy of culturally appropriate services in rural areas should serve as a policy and practice imperative and remains a priority for the health system.

- **Hasten the earlier introduction of a palliative approach to care for persons living with chronic kidney disease, COPD, CHF, dementia (for example) and other life-limiting illnesses through the expanded uptake of Advance Care Planning.** Ideally, primary care teams could be incented to drive this forward, such as has been done with the systematization of the memory clinic model. Having said that, the importance of beginning such a conversation and documenting it is important, irrespective of the role of the provider.

- **Support the recruitment of community agencies and organization in the expansion of the Compassionate Communities initiative.** Efforts should be supported at all levels of community and clinical leadership. Leveraging the skills and capacities of local health care providers and community members to ensure that patients and caregivers receive holistic care that optimizes quality of life, helps them deal with loss and improves population health.

- **Streamline efforts with residential hospice palliative care organizations and services.** This will serve to ensure coordinated and appropriate placement for those in need of end-of-life care, thereby better serving the needs of all residents of Waterloo-Wellington.

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Caring for Caregivers

Recommendations are emerging from a local review of caregiver distress and supports.\(^{28}\) Related action items include:

- Include caregivers as standard process in assessment process
- Screen caregivers for levels of distress and identify need for further assessment and attention. Respite advisors or care coordinators are well positioned to perform a caregiver needs assessment.
- Identify caregivers during client admission to health services
- Screen for caregivers with poor wellbeing and perform an assessment to determine which intervention(s) would most benefit them.
- Minimize challenges related to system navigation by developing a virtual team (with a designated lead) to provide coordinated care.
- Define a single point of access at home and community care agencies as staff are familiar with local services and are often trained to assist caregiver along their journey.
- Establish and maintain clear communication between health providers and caregivers. When there is a change in care recipient health status, a caregiver assessment should be completed.
- Health-care agencies should offer training to ensure their team members are capable of responding appropriately to the care recipients needs – especially when needs are likely to fluctuate over time.
- Provide opportunities for caregivers to request the type and amount of services they need, in addition to using resources in the community (frequency and duration matter).
- Further review of local respite services may point to the need for expansion in this area. Opportunities may include additional resources to support emergency respite, out-of-home respite (short stay), adult day respite (day, evening and bathing service), caregiver counseling, knowledge exchange and support and/or in-home respite.

Targeted Education and Training

- Harness local educational partners who can deliver programming that strengthens workforce capacity and readiness and practice and capacity development within the WWLHIN sub-regions
- Work collaboratively with local post-secondary education partners to improve outcomes and impacts at societal, community, organizational, provider, care and service recipient and informal caregiver levels.

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• Engage local post-secondary education partners as legitimate partner to increase opportunities for education and training for workforce development, competency assessment, collaborative program delivery and targeted practice development. A comprehensive response will require collaboration with the WWLHIN, service delivery agencies, providers of direct care and the post-secondary education sector. Harness local educational partners who can deliver programming that strengthens workforce capacity and readiness and practice and capacity development within the WWLHIN sub-regions.

• Offer more continuing education, training and competency attainment opportunities for health-care providers in the prevention and management of chronic disease and frailty for older adults. A few promising examples are mentioned directly below.

Project ECHO Care of the Elderly (ECHO COE), a telehealth program being offered by Baycrest Health Sciences, in partnership with North East Specialized Geriatric Centre, that aims to help primary care providers build capacity in the care of older adults through weekly 90-minute videoconference sessions.

https://www.echoontario.ca/Echo-Clinic/Care-of-the-Elderly.aspx

Excellence in Resident-Centered Care (ERCC) initiative, a train-the-trainer model offered through a collaboration between the Schlegel Centre for Learning, Research and Innovation and Conestoga College. This ministry-funded initiative is intended to build capacity, predominantly with PSWs in retirement and long-term care, but not exclusively in these sectors. Training content is viewed to be largely transferable to, and appropriate for, home and community care organizations and providers.

https://the-ria.ca/resources/excellence-in-resident-centred-care-ercc

Regional Geriatric Program Central Geriatric Certificate Program consists of educational programming that is aimed at improving quality of care for our aging population. The Program consists of core educational courses/workshops that are already being delivered across the provinces as well as a number of courses/workshops that are specific to this program. In addition, Regional Geriatric Program Central offers multiple opportunities for training and knowledge translation.

https://www.geriatriccp.ca

• Build on, strengthen collaborations and further support the development of strategic partnerships, services and outputs associated with community-based organizations and local institutes. Focusing on stronger research-education-practice partnerships can serve to stimulate innovation and catalyze transformation. Importantly, opportunities for collocating seniors’ community programs (i.e. recreation and activation); clinical services; formal education and...
learning; and, community information sessions, etc., should be viewed as a unique opportunity in Waterloo-Wellington, given the existence of the following, for example

- Seniors Active Living Centres, Community Hubs to support Healthy Aging, Seniors Health Campuses
- Regional Centres of Excellence in Seniors Care
- Research Institute for Aging
- Centre of Excellence for Innovation in Aging
- Schlegel Centre for Learning, Research & Innovation in Long-Term Care

**Goal 4: Collaboration and Coordination**

The Waterloo-Wellington health system fully leverages and capitalizes on intra and intersectoral collaboration, offering a whole-of-community orientation to health, well-being and quality of life.

A transformed health system champions intersectoral, interorganizational and interprofessional collaborations and public engagement efforts to develop whole-of-community solutions and bring societal gains to some of the most pressing issues facing older adults, especially those exposed to conditions that predispose vulnerability. In so doing, it serves as a catalyst to develop and expand partnerships between traditional aging services sectors, health-care and social sectors, community-based organizations, and payers so that all can work to better offer gains in the areas of health promotion and risk reduction.

A transformed health system intensifies efforts in the areas of health system integration and performance, evidence-informed decision making, healthy public policy, organizational policies and procedures to optimize person-centred approaches and information sharing to achieve better health outcomes and experiences for older adults and those who care for them, regardless of who they are or where they live. It finds creative ways to expedite the pace of change where it is needed the most and

An intersectoral collaborative approach to planning, designing, delivering and evaluating has long been known as an effective way to best support the health of populations.29 Collaborative engagement strategies can best support efforts to reduce health disparity, while upholding the principles social justice and health equity, allowing all to capitalize on the richness of strengths, contributions and resources available.

- **Deepen whole-of-community and whole-of-government approaches to build value, equity and access for all older adults in Waterloo-Wellington.** It has become increasingly clear that there are limits to what the health-care system can accomplish on its own. Many would agree that cost increases in line with recent trends in health-care spending are unattainable. Achieving

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optimal health outcomes for older adults requires whole-of-community and whole-of-government approaches. For instance, working hard to facilitate better partnerships between health and social services, community supports, faith-based organizations, local recreation centres and service clubs can help older residents stay in their homes longer.

- **Streamline and coordinate equitable access to community-based care, services and supports across Waterloo-Wellington.** As has been mentioned, optimal care for the majority of older adults could and should be provided at the community level. Ideally, access to community-based care, services and supports should be streamlined, coordinated and equitable across Waterloo-Wellington. When the system does not function well for people, they are, simply speaking, exposed to a great number of conditions that predispose vulnerability. Thankfully, given the right leadership, a high level of commitment and an authentic willingness to collaborate, these conditions are modifiable. Bundling health and social services in different ways, and in accordance with the needs and expectations of our aging population and communities is achievable. Where appropriate, there may be opportunities to reallocate funds that currently exist in the system to support living well in our community for all, knowing that people have a variety, and evolving set of needs.

- **Accelerate the shift to providing more care in community-based settings.** This will involve addressing the persistent disconnects between formal and informal care, especially as it relates to keeping people healthy within their community and more effectively supporting transitions from hospital to home.

- **Exhaust opportunities to align systems, funding mechanisms and processes.** This will help to facilitate better and deeper continuity between acute, primary, and community care, especially as they relate to formal and informal service integration. Flexible models that produce strong outcomes are increasingly important.

- **Adopt and implement community development initiatives to build the awareness and benefit from contributions of local citizens.** Collective efforts to mobilize actions of broader community partners will help to better meet the needs of older persons in Waterloo-Wellington. This is especially so for older adults who are exposed to conditions that predispose vulnerability, including those who are frail, persons living with life-limiting illnesses and their caregivers.

- **Fully leverage existing processes, accountability agreements and service plans, partnerships and collaborations.** Going forward, these should be explicit about commitments to deepen expectations and broaden willingness to collaborate for better health outcomes, value and experiences at the level of the person, community and population.

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30 Mapping the future of our local health care system (WWLHIN, 2015)
Goal 5: Quality

Older adults living in Waterloo-Wellington have universal access to the highest quality of care, services and supports — those that emphasize excellence in safety, effectiveness, person-centredness, timeliness, efficiency and equity.

In a transformed health system, efforts are taken to harness existing and anticipated investments to leverage innovation and technological advances in care. Leadership fosters a system-wide culture of quality, normalizing a steadfast commitment to continuous quality improvement and removing barriers to innovation and improvement in areas requiring action.

- **Spark, scale-up, and spread innovative care delivery models and digital solutions.** Sparking, scaling-up, and spreading innovative care delivery models and digital solutions will make accessing care easier for patients, more effective for health care providers and more efficient for the health system by increasing timely access to evidence to guide and support innovation, individual clinical decision-making and system quality improvement.

- **Reduce the variability in service models across the region, and as a result, improve equitable access to care and services for older adults residing in our communities.** A high-performing health system offers health and social services that are coordinated. They and provided collaboratively by a team of providers. These are organized around the needs of patients and delivered close to home and centred in high-performing and accessible primary care. Having said that, Waterloo-Wellington has an opportunity to reduce the variability in service models across the region, and as a result, improve equitable access to care and services for older adults residing in our communities. Universal access to quality (primary) care for all older adults living within this region is considered an ethical imperative, especially in those areas characterized as underserved.

- **Balance and strengthen decision making related to policies, systems, models and programs for older adults.** Greater emphasis should be placed on addressing the triple aims as a whole: 1) better health (outcomes); 2) better care (experiences of people and their families); and 3) better value (for money). This must guide the planning, implementation and evaluation of policies, programs and services that support a strengthened system.

- **Provide quality person-centred care while emphasizing flexibility in the co-design of individualized care plans.** This includes a comprehensive range of services of comparable quality.

“If we are to commit to continuous quality improvement, we must provide access for all, regardless of how far patients live from where the services are provided, what language they speak, their health status, or other sociodemographic factors. Programs and initiatives must take into account issues of equity, address them where possible, and avoid contributing to barriers to access for marginalized populations”.

Source: Quality Matters: Realizing Excellent Care for All
— available and accessible to all, irrespective of where they live in Waterloo-Wellington. Moving toward care and service models that are relational in nature, rather than transactional, will help to normalize a system of service that emphasizes follow through over follow up.

- Provide appropriate and better access to the full health and medical history for residents in LTC. This has been noted as a particular challenge for specialists and others in that some organizational policies prevent the sharing of this information and create unintentional barriers to its access. Some wonder whether this is a misinterpretation of the intent of the Personal Health Information Protection Act (2004). This barrier results in pronounced implications for all that follows.

Effectiveness

- Balance efficiency with person-centredness in approaches to structural, process, and system redesign, as appropriate.
- Increase the implementation of quality standards and protocols, evidence-based practice guidelines and wise practices. Reducing practice variation at the levels of the provider and organization, and across the system should be a priority for all working within the health system. Continuing to support the widespread uptake of the Health Quality Ontario Quality Standards provides an opportunity to address some of the many priority health and clinical care situations facing older adults (Appendix E).
- Improve information and communication technology, digital solutions and accountability agreements to better support data sharing and improve consent protocols to support a broader system of care. Working to establish protocols for sharing information in crisis and non-crisis situations and through early supported discharge processes will mean better accountability and care coverage.

Person- and family-centredness

It is paramount that people are engaged in their care and health-related decisions. And that they have positive encounters and experiences with the system of care.

- Ensure safety, accountability and communication to support continued health and quality of life during care and service transitions for older adults.
- Consult and respect the discretion of older adults or their substitute decision makers in determining who should fall within their circle of care.

Circle of care is a term of reference used to describe health information custodians and their authorized agents who are permitted to rely on an individual’s implied consent when collecting, using, disclosing or handling personal health information for the purpose of providing direct health care.

Efficiency
- **Look to innovative models for earlier risk identification and diagnosis as a means for earlier intervention.** This proactive orientation holds promise for better health outcomes, better care experiences for patients and families and better per capita costs related to health care. Look to the not yet fully realized value offered through community-based care models such as primary care, community health clinics and ambulatory care clinics.

- **Provide older adult patients and/or caregivers with a standardized template to help them prepare for their visits with primary care teams before they arrive.** This may help improve the way in which key information is communicated and increase efficiency. The administration of screening questions to patients, for instance, using mobile tablets while they are waiting to be seen or before they arrive at the health centre, can also offer an efficient way to gather important health assessment data.

- **Accelerate improvements to enhance interprofessional teamwork and collaborative practice, care coordination and case management.** Services designed to meet the more complex needs of older adults with multiple chronic conditions would achieve gains across the triple aims should be priority areas for improvement.

Other models that should be more fully examined and expanded to better serve older adults in Waterloo-Wellington include the following.

*Community Paramedicine* programs that offer: 1) outreach services for frequent 911 callers; 2) in-home chronic disease management, including preventative care and education; 3) connection to relevant health services and social supports/resources in the community, and; 4) health care system navigation.

*Rapid Response Nursing* teams whose main goal is to improve transitions home from in-patient units, emergency departments, urgent care, or clinical assessment units for medically complex adults and help them avoid hospital re-admissions and subsequent ED visits. They also support patients in their self-management of chronic conditions at home. Ensuring communication and linkage with primary care and the provision of timely and effective rapid response nursing in an individual's place of residence.

- **Clinical leaders in the system should determine the most appropriate time, place (community-based or ambulatory care setting preferred) and providers to complete important assessments.** Some important assessments include the Assessment Urgency Algorithm (AUA). The Canadian Triage and Acuity Scale (CTAS) and the Canadian Prehospital Acuity Scale (CPAS). In order to address system pressures at the hospital front door, consideration should be given to community-based alternatives for emergency and urgent care triage.

- **Improve the timeliness and fulsomeness of communications between hospital, primary care and home and community care.**
The number of older adults receiving alternate level of care is absolutely modifiable in systems where the right levels of infrastructure and capacity exist. As has been repeated earlier, many of the solutions exist and can be affected through system realignment and reorientation, including the further expansion interprofessional collaborative teams. Related action items include:

- Increase the percentage of primary care clinics and chronic disease prevention and management centres offering after-hours care;
- Increase case management and navigational capacity in primary care;
- Increasing access to electronic health information and services;
- Focus on reducing hospital admissions for ambulatory care sensitive conditions; and
- Target interventions to reduce the incidence and prevalence of social isolation.

**Equity**

- The WWLHIN should consider funding agencies directly to cover subsidies and costs incurred to support low income cut-off (LICO) level seniors. Better yet would be arrangements that permit eligible seniors to receive an annual fixed amount of funds to purchase the services they choose; similar to the Passport funding model used by the Ministry of Children, Community and Social Services for adults with developmental disabilities.

Implement recommendations of the *Truth and Reconciliation Commission of Canada*, including the following action items:

- Work with local, provincial and federal partners to provide sustainable funding for existing and new Indigenous healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools;
- Provide cultural competency training for all health-care professionals; and,
- Increase the number of Indigenous professionals working in the health-care field.

**Goal 6: Empowerment**

The Waterloo-Wellington health system plays a pivotal and functional role in enabling the empowerment of people as they age, their caregivers and the health and social service providers they rely upon.

A transformed health system is in which people feel informed, engaged, confident and empowered. Empowerment is a product of having access to the right information, resources and power. When
people do not experience a sense of psychological empowerment they can feel helpless, and even worse, hopeless. Health-care providers use appropriate language and style when communicating with patients, families and caregivers, especially when passing on critical information. Residents who do not speak English have consistent access to interpreters.

- **Simplify communication about how the health system is structured and integrated so that everyone has a better and common understanding.** Older adults, their family caregivers and even health-care providers experience challenges in navigating the complex health and social service systems. There is a pressing need to move from a system that is characterized as structurally complex to one that is more functionally integrated, explicit and simplified — one that is understandable and one that clearly articulates who is responsible for what in the delivery of value-based services. Designing and communicating the structural and functional elements of a streamlined health system can help everyone to better navigate and interact with it.

### Older persons and their families

- **Collect, monitor and report on meaningful measures and indicators, in addition to the more traditional clinical outcomes.** A transformed health system that best supports people as they are aging involves moving forward, in a coordinated fashion, with the collection, monitoring and reporting of comparable patient-reported experience measures (PREMs) and patient-reported outcome measures (PROMs). It offers online access to personal health information to people and their caregivers, allowing them to decide who they will share this with, within their circle of care, as defined by them.

- **Facilitate access to resources that would be useful and provide guidance to older adults and their families.** Facilitating knowledge mobilization initiatives and activities to promote anticipatory guidance related to healthy aging and better care for seniors by facilitating access to resources (i.e., navigational tools, knowledge repository and respite support) so that clients and caregivers know what to expect needs to happen in a more intentional and coordinated fashion. This may begin by working with families and caregivers to design, develop and offer workshops, presentations, information sessions and access to credible information sources — reference materials, clear pathways and decision support tools. Improving awareness about community support services in all sub-regions would be a good place to start.

- **Bolster the implementation of technology, web-based communication and social media solutions to link, exchange and engage with older persons and their families.** Innovations in technology, web-based communication and social media offer a host of new options for providers and patients to access information, interact and engage in care. For this reason and others, patients are rightfully demanding greater participation, flexibility and timeliness in care.

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31 https://achru.mcmaster.ca/sites/achru.mcmaster.ca/files/Study%201%20Infographic_caregivers.pdf
32 CIHI, 2017
• **Develop better methods and tools, and a consistent approach to supported self-management.** This would serve to that directly engage people in health-related decision-making, including the expansion of services offered through the Waterloo-Wellington Self-Management Program.

• **Facilitate better understanding of how advance care planning can support local residents to become more engaged in decision-making around their health.** This has the potential to foster a sense of empowerment, allowing people to make more informed decisions and articulate wishes related to their health.

• **Offer clearly written instructions in plain language to patients and families wherever possible.** This is often valued and appreciated. It can be overwhelming when people receive too much information at once, especially when this is only communicated verbally. It is easy to become confused, experience a sense of self-doubt or simply forget what was said. This is seen to be both helpful and safer.

• **Use the language that the people are using when they refer to themselves.** The language they use is what they want the others to use in therapeutic interactions. Failing to do so may perpetuate harm and trauma.

• **In smaller rural communities, provide accessible content through a bi-weekly section printed in the weekly newspaper.** The Observer in Woolwich and Wellesley and the Wellington Advertiser are examples of papers that could include a bi-weekly section that outlines practical tips for senior’s health, how to speak with health-care providers, information on healthy aging and caregiving and local services and supports. Some suggest this be called the Senior’s Hub.

• **Make health and community support services information and educational materials more freely available at all senior’s health clinics and community centres.** Unfortunately, observational assessments indicate that for-profit services related to private insurance and health technology providers is most commonly available throughout Waterloo-Wellington. This represents a missed opportunity to inform and educate the public about the wealth of community services that could be helpful in time of need.

• **Introduce new roles and functions that better support connections, linkage and navigation within the health system.** Health leaders should consider the introduction of new roles and functions that would support connections, linkage and navigation within the health system, such as senior’s health services advisors or community health workers and integrators. Knowing where to start or where to turn during times of need can enable older adults and their caregivers to experience a heightened sense of health and empowerment. These roles may be especially important in rural areas of when working to engage certain populations.

• **Develop, in collaboration with RIA and Conestoga College (given their success with the Excellence in Resident-Centred Care [ERCC] training initiative) something along the lines of that has been developed by Alberta Health Services, referred to as Caregiver College (Appendix F and G), by:**
a) Curate and develop a collection of salient online educational and training modules and resources to improve access for those who need to learn their home

b) Deliver a series of in-person education and training sessions in a multitude of unconventional settings (closer to where people live, work, learn and play), at appropriate times, to better reach those in need and promote social activation (a civic extension of RIA’s Living Classroom, lunch & learns, workshops, knowledge/information cafes)

c) Develop and make available a suite of accessible decision support tools to assist informal caregivers to navigate health and social systems/services

Examples of potential content areas include:

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity &amp; consent</td>
<td>Communicating with the care team</td>
</tr>
<tr>
<td>Polypharmacy</td>
<td>Advocating on behalf of a loved one</td>
</tr>
<tr>
<td>Self care (minimizing distress by building and maintaining resiliency)</td>
<td>Infection prevention and control</td>
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<tr>
<td>Advance Care Planning</td>
<td>Safe medication administration</td>
</tr>
<tr>
<td>Nutrition and assisted dining</td>
<td>Assisting with mobility, transfers and repositioning</td>
</tr>
<tr>
<td>Fall Prevention</td>
<td>Pain management and promoting comfort</td>
</tr>
<tr>
<td>Preserving skin integrity</td>
<td>CPR and First Aid</td>
</tr>
<tr>
<td>Incontinence management</td>
<td>Gentle Persuasive Approaches</td>
</tr>
<tr>
<td>Considerations related to the decision to die at home</td>
<td>Mental Health First Aid - Seniors</td>
</tr>
</tbody>
</table>

Caregivers

Caregivers spend variable amounts of time on direct caregiving (hands on care), completing paper work, assisting with banking, attending meetings, appointments or conversations with health-care providers, travelling and arranging appointments. Family caregivers feel overwhelmed and do not receive the type of support they need. Recent local trends suggest that more family caregivers of long-stay home care clients have experienced challenges in the last five years (2013 to 2017 fiscal years).

- **Develop a comprehensive suite of resources and services to support family caregivers and safeguard their health and well-being.** Informal caregivers play a critical role in society and to the functioning of the health-care system. In fact, an estimated 75% of care needed is provided by informal caregivers. Given that health system sustainability relies heavily on the contributions of informal caregivers, developing a comprehensive suite of resources and services to support family caregivers and safeguard their health and well-being has never been more important. The economic stresses placed on family caregivers remain high. Apart from

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33 https://achru.mcmaster.ca/sites/achru.mcmaster.ca/files/Study%201%20Infographic_caregivers.pdf  

Prepared for the Waterloo Wellington Local Health Integration Network by the Research Institute for Aging
income and job protection, family caregivers need supports such as respite care, system navigation assistance, information and education, home care supports and bereavement care.  

Although many caregivers find this to be a rewarding role, they often carry it out at the expense of their own health and well-being, resulting in strain. Research suggests that the level of caregiver strain increases with the number of chronic conditions the older adult has, which in turn increases negative health outcomes and health service use by caregivers.

- **Capitalize on provincial investments in caregiver education and training.** Make good use of new provincial investments in caregiver education and training by flowing funds to local community groups, post-secondary institutions and other organizations to design and develop programming that enhances the capabilities of caregivers, beginning with groups that are in highest need of more supports, including Indigenous and Francophone residents.

- **Increase the availability of services and supports that build skills for coping, adapting to change and providing care.** In an effort to prevent or minimize caregiver distress, increase the availability of services and supports that build skills for coping, adapting to change and providing care. This may include informational resources available online or workshops, peer groups and health teaching opportunities to learn about self care.

- **Develop direct one-on-one peer support and mentoring services for older caregivers, perhaps through a paid employment opportunity that could improve the social connectedness and financial status of an older person with lived experience.**

- **Make peer support groups and resources easily available by increasing community awareness.**

- **Increase locally available respite service capacity according to need.**

- **Decrease waste and frustration for caregivers by creating open access to certain information within the circle of care, as defined by clients and caregivers.**

- **Together, Ontario’s LHINs and community partners should work to develop a Provincial Caregivers Strategy with an emphasis on the needs of caregivers of older adults.**

**Health and social service providers**

In a transformed health system, health providers work together in the best interest of their patients. They are enabled to work to their full potential and benefit from conditions that promote wellness. However, many today are experience burden and challenges with respect to performing their valuable roles within the system. Some of the added stress faced by health providers today include the increased number, acuity, and complexity of patients.

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36 Dunbrack, 2005  
37 Schulz & Beach, 1999  
38 Healthy Debate. (September 27, 2018).
• **Target strategies and tactics to focus on employee wellness and engagement.** Given the rise of work-related emotional exhaustion, cynicism, traumatic stress, moral distress and burnout, and related increases in staff turnover, absenteeism and attrition, health systems and organizations are increasingly focusing on employee wellness and engagement.

• **Ensure providers are prepared with the knowledge, skills, attitudes and resources (including time).** This will serve to protect the dignity and safety of frail seniors and those exposed to conditions that predispose vulnerability. Moral distress can result from cases where conditions do not support the helping professions to do their jobs well.

• **Improve and systematize access to information protocols for all providers that are involved in the broader circle of care - more transparency is needed.** Community support services can help health service providers improve transitions by providing better supports and communication with local residents who are familiar to them to prevent crises from occurring. Granting broader access to Client Health & Related Information System (CHRIS) for community support service partners, as has been done with home care agencies, would be helpful.

• **Champion the implementation of the National Standard of Canada for Psychological Health and Safety in the Workplace with all contracted service provider organizations.** Further, supporting initiatives to improve workplace health and safety in home and community care and LTC are viewed to be of particular importance.

**Proposed Next Steps**

**Confirm and validate the Framework**

As an immediate next step, the salience of this Framework should be further confirmed and validated with local health system leaders, managers, providers, older adults and the citizens of Waterloo-Wellington. It is proposed that this be achieved chiefly through the administration of a public facing online survey questionnaire and a series of town hall meeting, co-hosted by RIA and a member of the local community in each of the sub-LHIN regions. Innovations, promising practices and exemplars will be identified (i.e. AGE-WELL, Canadian Frailty Network, Canadian Foundation for Healthcare Improvement, Aging and Community Health Research Unit, etc.).

**Articulate strategic directions and outcomes**

Following the public engagement processes and events, the final WWLHIN Older Adult Strategy will be articulated – one that maps current programs and services to the framework elements and articulates strategic directions to optimize the health and well-being of older adults in Waterloo-Wellington and strengthen the performance of our health system. The final phase of this work will culminate in the development of an integrated service delivery implementation plan and a measurement and reporting.
framework that maps to a series of strategic objectives to achieve measurable improvements for older adults, caregivers, providers and the overall health system in Waterloo-Wellington.

**Build strategic leadership**

In developing this Framework and the subsequent Older Adult Strategy, WWLHIN has demonstrated the type of collaborative leadership that will be required to realize sustained movement on key structural, process and outcome indicators.

Moving forward, the Waterloo Wellington Older Adult Strategy Steering Committee will provide oversight and direction on the planning, design, transformation and monitoring of the WWLHIN Older Adult Strategy and its responsiveness to the needs of all older adults in the WWLHIN over the next 10 years. The Steering Committee will serve as the central body in considering all initiatives with a focus on Older Adults – ensuring that all new programs, projects and services are aligned and strategically coordinated to optimize the creation of an integrated system of care.

At a regional level, collaborative leadership will mean figuring out the most effective and efficient way to cluster services according to functional roles and service dimension so as to reduce gaps and fragmentation and improve outcomes. Community-based planning at the sub-LHIN region level will help to determine leadership and accountability, oversight and a model of integration appropriate to the local context. Efforts to catalyze integrated service delivery approaches – the integration of ideas and collaborative efforts – will go far to normalize a new way of working.

Employing a collaborative approach to stakeholder/collegial engagement, partnership development and consensus building, where appropriate, will serve to promote a shared understanding and commitment to excellence in care and service. Indeed, harnessing our collective strengths and realizing our collaborative capacity is a worthy pursuit for all.

**Ensure system accountability**

System leaders will build partnerships, identify specific accountabilities and create agreements/terms of engagement with local contracted and non-contracted service organizations across Waterloo-Wellington. This will include detailed tactical planning along with the broad involvement of health-system leaders, agencies, associations, planning and service-delivery organizations, and providers who are ready, willing, able and committed to driving the WWLHIN OAS in their own communities and spheres of influence. Further, it is recommended that commitment to the spirit and intent of the final Strategy be signed and accepted by all formal stakeholders in the form of a Charter. Finally, it is suggested that a face-to-face event be hosted by the WWLHIN to mark the official launch of the WWLHIN OAS and that the signing of the Charter be celebrated at this event.
Conclusion

Transformation that provides better health outcomes and care experiences for older adults in Waterloo-Wellington and better performance and value for our health system requires that we understand “the complex, changing and changeable realities of providing health care in partnership with patients, using technologies that did not exist even a few years ago”.39

Driving purposeful change at the health system level will mean bringing together health and social services for a more responsive model to address the very real needs that older adults and their families are facing.

This report highlights key areas for action in which the WWLHIN can show bold and courageous action

- Optimize competencies for non-physician health providers
- Deepen the integration of health and social services
- Intensify prospective needs-based planning
- Address persistent barriers to information sharing
- Facilitate clearer communication within the health system and with the general public
- Advance a regional and whole-of-community approaches to better support population aging and quality of life
- Reorient system and services around functional areas and reduce structural complexity

The context within which the strategy will unfold is dependent upon a series of inter-related variables, including: need; resource availability; using the best evidence; leadership and system capacity and readiness for transformation. This report represents the beginning of a movement that has sparked momentum and captured the wealth of goodwill, insight, effort and expertise that exist across Waterloo-Wellington. It marks the next step in our journey toward a transformed health system that supports healthy aging and ensures a better quality of life for all people in our region.

References


Healthy Debate. (September 27, 2018). *More than a third of nurses have PTSD; a third of doctors are burned out. What are we doing about it?* Retrieved from http://healthydebate.ca/2018/09/topic/burnout-in-health-care


Prepared for the Waterloo Wellington Local Health Integration Network by the Research Institute for Aging


Appendix A

**Stakeholder Call to Action: The case for an income-adjusted sliding scale for community services**

Community support services are government funded, but often work on a fee for service model, especially for services with associated ‘hard costs’ such as meals or transportation. Some organizations provide subsidy – it’s totally at their discretion, so a lot do not. Many who do provide it don’t really advertise it but leave it to staff discretion to share the info – meaning that the clients who ask, get, and those who don’t, don’t.

Different organizations (not-for-profit and government funded) charge different fees for the same service, usually based on funding history. Geographical equity based on the fee schedule of the agency serving your area. In most cases, organizations try to align fees, but they also must align with other local services, so it doesn’t always work – and when budgets get tight, we often make fee decisions without consulting or coordinating. Even in the same organization, fees have often been determined based on funding history rather than equity across programs and populations.

Subsidy in and of itself is charity based, not dignity or equity based. It’s ‘doing for’ those who need it (and are bold enough to ask).

Most, if not all, organizations provide services at modest fees and use their government funding to offset – which is great – but often means that someone living below the poverty line is paying the same modest fee as someone with an annual income of $60,000.

Modest fees are a de facto subsidy for everyone but are not geared to income which means that our most vulnerable are paying disproportionate costs.

Sliding scales allow everyone to pay an appropriate portion of their income for the service provided (up to the actual cost – or in a social enterprise situation up to what the market will bear). These scales consider necessity (food is a higher need than transportation) and frequency (meals are required more frequently than rides) in the calculation of % of income.

CSC is implementing a sliding scale across all programs in September, but it is unlikely that other organizations are there yet. This result of this will increase equity in our geography but decrease it across the LHIN as CSC does not serve the whole LHIN.

Strong agreement on the need for a province-wide, transparent funding and fee schedule – based on an income-adjusted sliding scale.
<table>
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<th>Group</th>
<th>Status</th>
<th>Number</th>
</tr>
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<td>March 22, 2018</td>
<td>Ontario Age-Friendly Communities (AFC) Symposium: Aging with Confidence</td>
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<tr>
<td>May 2, 2018</td>
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### Engagement: Reference Group

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<td>By mid-October</td>
<td>Planning</td>
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Appendix C

SBAR

SBAR is an easy to use, structured form of communication that enables information to be transferred accurately between individuals. It can be particularly useful in capturing experiential accounts.

<table>
<thead>
<tr>
<th>Dimension</th>
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<tbody>
<tr>
<td>Situation</td>
<td>▪ State the issue/problem you are wanting to address or the experience you are wishing to share.</td>
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<tr>
<td>Background</td>
<td>▪ How did this issue/problem/situation arise? How did this happen?</td>
</tr>
<tr>
<td></td>
<td>▪ In your opinion, what led to this?</td>
</tr>
<tr>
<td>Assessment</td>
<td>▪ What affect is this having?</td>
</tr>
<tr>
<td></td>
<td>▪ Who is being affected?</td>
</tr>
<tr>
<td></td>
<td>▪ What is the case for doing something about this problem?</td>
</tr>
<tr>
<td></td>
<td>▪ What conclusion have you arrived at?</td>
</tr>
<tr>
<td>Recommendation</td>
<td>▪ What needs to be done address the root cause of the issue/problem?</td>
</tr>
<tr>
<td></td>
<td>▪ What action(s) do you propose be taken?</td>
</tr>
<tr>
<td></td>
<td>▪ What solution(s) are you offering?</td>
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Appendix D

Older adults – Exemplars in Nursing Care

RNss are finding new ways to serve more patients. They are implementing creative health-care delivery models, enhanced nursing roles and innovative programs in a variety of settings. They are thinking about ways to use existing resources more effectively by expanding their roles and moving into new practice areas. Together, their efforts are increasing the number of individuals accessing care.

A few examples are presented below.

**Mobile emergency nurses are reducing the wait times at EDs by making house calls to long-term care residents.**

During a year-long pilot project at Toronto Western Hospital, a team of three mobile emergency nurses responded to non-urgent calls from long-term care homes with the goal of reducing the number of transfers to emergency departments (ED). Over the course of the year, the mobile nurses made nearly 1,000 visits to long-term care residents. Care was provided for 78 per cent of the residents who would have been sent to the ED for treatment if the program had not been available (Bandurchin & Bianchi, 2010). Mobile emergency nursing services are proving to be cost-effective. According to Mary Jane McNally, director of nursing at Toronto Western Hospital, the cost of a mobile visit is 21 per cent less than the cost of having the assessment completed in the ED.

**Nurse practitioners improve care for long-term residents**

Having a nurse practitioner at Winnipeg’s Lion’s and Kildonan Personal Care Centres’ long-term care facilities means that residents are assessed more often and concerns are monitored more closely. After three years of on-site nurse-practitioner services at the two facilities, their emergency department visits decreased by 43 per cent. Anti-psychotic medication use also went down, going from 15.3 to 6.7 per cent at Lions and from 35.2 to 11.5 per cent at Kildonan (Armstrong, 2011).

**Nurse case-manager model improves treatment for osteoporosis patients**

The nurse case-manager model was shown to improve treatment results when researchers in Edmonton compared it to a proven quality-improvement process involving primary care physicians in treating osteoporosis. Among randomly assigned wrist-fracture patients receiving follow up either through a physician or nurse case-manager, approximately 30 per cent more patients received appropriate testing and medication when their care was managed by the nurse.

**Using RNAO’s nursing best practice guidelines reduces falls in long-term care**

A national falls prevention collaborative involving 32 long-term care facilities, along with the Registered Nurses’ Association of Ontario (RNAO) and the Canadian Patient Safety Institute, showed that using RNAO’s best practice guidelines in combination with a quality improvement intervention resulted in 40 per cent fewer falls and injuries from falls.
Nurse-initiated health promotion improves health and quality of life among frail older adults

A study of home care clients in Ontario’s Halton region showed improved mental-health functioning, depression scores and perception of social support among clients receiving nurse-led health-promotion interventions (compared with typical home care services). As part of their health-promotion activities, nurses conducted monthly home visits, completed health assessments, identified health risks and established opportunities for health education and coordinating services. No incremental costs were associated with these value-added nursing interventions.

Community Connect training program helps keep seniors safe and independent

Ottawa Public Health is launching a new program that identifies vulnerable seniors to keep them safe and independent. The Community Connect training program will prepare postal workers, bank tellers and other service providers who have regular contact with older adults, to recognize when an older person may be isolated or at risk for deteriorating mental or physical health so they can refer them to a public health nurse (PHN). With that referral, PHNs phone and/or make a home visit to assess the older person’s situation and use their network of community partners to address a broad range of health, social and economic concerns. An estimated 10,000 or more seniors in Ottawa are isolated and at risk of losing their independence.
Appendix E

HQO Quality Standards most directly related to the care of older adults, in various stages of development.

<table>
<thead>
<tr>
<th>HQO Quality Standards</th>
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<tbody>
<tr>
<td><strong>Being implemented</strong></td>
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<tr>
<td>Dementia: Care for People Living in the Community</td>
</tr>
<tr>
<td>Behavioural Symptoms of Dementia: Care for Patients in Hospitals and Residents in Long-Term Care Homes</td>
</tr>
<tr>
<td>Hip Fracture: Care for People with Fragility Fractures</td>
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<tr>
<td>Major Depression: Care for Adults and Adolescents</td>
</tr>
<tr>
<td>Palliative Care: Care for Adults with Progressive Life-Limiting Illness</td>
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<tr>
<td>Pressure Injuries: Care for Patients in All Settings</td>
</tr>
<tr>
<td>Schizophrenia: Care for Adults in Hospitals</td>
</tr>
<tr>
<td>Opioid Prescribing for Acute Pain: Care for People 15 Years of Age and Older</td>
</tr>
<tr>
<td>Opioid Prescribing for Chronic Pain: Care for People 15 Years of Age and Older</td>
</tr>
<tr>
<td>Opioid Use Disorder (Opioid Addiction): Care for People 16 Years of Age and Older</td>
</tr>
<tr>
<td>Venous Leg Ulcers: Care for Patients in All Settings</td>
</tr>
<tr>
<td>Diabetic Foot Ulcers: Care for Patients in All Settings</td>
</tr>
<tr>
<td><strong>Being developed</strong></td>
</tr>
<tr>
<td>Anxiety Disorders: Care in all Settings</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD): Care in the Community for Adults</td>
</tr>
<tr>
<td>Chronic Pain: Care for Adults</td>
</tr>
<tr>
<td>Glaucoma: Care in All Settings</td>
</tr>
<tr>
<td>Heart Failure: Care in the Community</td>
</tr>
<tr>
<td>Low Back Pain: Care for Adults with Acute Low Back Pain</td>
</tr>
<tr>
<td>Obsessive-Compulsive Disorder: Care in all Settings</td>
</tr>
<tr>
<td>Osteoarthritis: Care for Adults with Osteoarthritis of the Knee, Hip, or Hand</td>
</tr>
<tr>
<td>Schizophrenia Care in the Community</td>
</tr>
<tr>
<td>Transitions in Care: From Hospital to Home</td>
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Appendix F

Alberta Health Services: Caregiver College

NEW USERS: To utilize the resources, please create a user name and password by clicking on the "Take a course - create an account" above.

Caregivers: Please take a minute to complete the following short questionnaire.

Available courses

Powerful Tools for Family Caregivers
Facilitator: Carol Wilson

This course is designed to help you explore your current situation and role as a family caregiver.

40 Alberta Health Services: Caregiver College [http://caregivercollege.ca]
Appendix G

Alberta Health Services: Caregiver College – Module on Health Care Questions

Appendix H

Highlights from the Healthcare Denmark white paper on a dementia friendly society

1. Early detection and high quality in diagnostic evaluation and treatment. At the memory clinic, a multi-disciplinary team of consultant neurologists, psychiatrists, geriatricians, neuropsychologists and nurses examines the patient with symptoms of dementia. A cognitive screening test can help them to spot early symptoms of dementia.

2. Dementia friendly hospitals where geriatric nurse meet patients diagnosed with dementia at the emergency department, fully supporting their transition through the admission process.

3. Intelligent floor improves safety for residents in nursing homes. Sensors underneath the floor register movements so those monitoring can be aware of the older person’s activities in the apartment.

4. Person-centred care supported by digital care planning. The digital care plan is presented on a wall-mounted tablet that gives staff an overview of all activities during the day, including information on how residents would like these activities to be carried out.

5. Group-based physical exercise to improve physical function and cognitive/psychological well-being for people with early-stage dementia. The training consists of moderate to high-intensity exercise including both cardio and strength training.

6. Music as therapy and sensory stimulation for people with dementia. Music therapy is proven to have significant effects on people with dementia. It can reduce depression, agitation and anxiety, and it can be used in addition to medical treatment of neuropsychiatric symptoms, in some cases, it can even substitute medical treatments, such as pharmacotherapy.

7. Support and guidance for the caregivers of people with dementia. Education can improve communication and relationships between family caregivers and people with dementia, and it can also improve the involvement of healthcare professionals, because their assistance can be made timely and based on individual needs within the family living with dementia.

8. Supporting contact between people with dementia and their relatives through technology. Residents, relatives and staff are using a new tablet-based platform to communicate with each other through text messages, video and photos. They also coordinate activities through joint calendars. The platform enables sharing of information about activities and daily life of the resident and it is thereby supporting the relationship between relatives and the person with dementia.

9. Volunteers support people with dementia and caregivers through tailor-made app. The Danish Alzheimer Association has developed a concept of technology driven respite care, based on volunteers. It works through an app where family caregivers can search for volunteer “Dementia Friends” in the local community who would like to offer their help and support.

10. Communication tools to support and relieve caregivers. The Relabee App can support and relieve caregivers by gathering all relevant information and communication in relation to a person with dementia and, as a shared platform, it gives all caregivers an overview of the need for support and help.

11. Dementia friendly communities and housing. Designing villages, healthcare buildings and nursing homes based on principles of healing architecture.

12. Circadian lighting can improve life for people with dementia. People with dementia often develop circadian rhythm disorders, e.g. insomnia, night wandering and daytime sleep, which have a negative impact on their physical and mental well-being. By using a controlled flow of circadian lighting in nursing homes, residents with dementia can have an improved circadian rhythm, which can have a positive impact on their overall well-being, sleep and quality of life.

13. Improving safety for people with dementia. Sensor technology and GPS trackers can both enable people with dementia to move independently and prevent unsafe situations.

14. Increasing knowledge and professional skills. Continuing education programs, courses, certifications, workshops and modules offer specific courses to healthcare professionals in order to ensure a high level of expertise, and to increase their knowledge and skills within the field of dementia.

15. A dementia “flying squad” can improve competence and skills of dementia care staff. This dementia expert training team travels across Denmark to provide support at organizational levels and to upskill staff in nursing home facilities. The aim of this unique national initiative is to strengthen competence and skills of dementia care staff.

16. E-learning: Interactive technology-based staff education. The free Danish “ABC Dementia” e-learning concept gives professionals, who are working with people with dementia, an opportunity to improve their knowledge on dementia in a flexible way. The method is based on an interactive practice-oriented approach, which makes the process of learning authentic and meaningful.
Appendix I

*Integrated community care system: Japan*

In 2005, Japan began developing integrated community care systems to provide housing, medical care, long-term care, prevention services and livelihood support in a centralized location within each community. This improvement allows seniors to continue living independently, but near needed services should a medical event arise. Each community care system has a catchment equivalent to the local junior high school district. Challenges to the integrated community care system include administration and workforce availability constraints. Part of this has been rectified by the establishment of care manager leaders who liaise with the client, family and professionals providing the care services.

The integrated community care system has been most effective when based on the needs of the local community. However, the exchange of necessary medical information between involved parties is difficult, encumbering efforts for holistic care. Furthermore, some municipalities (particularly in rural regions) have limited capacity to provide the full spectrum of services.

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### Appendix J

**Goal 1: Age-Friendly Society and Communities.** Waterloo-Wellington citizens age well within communities that celebrate their life in society and contributions to their communities, thriving through dignity, purpose, belonging and inclusion.

<table>
<thead>
<tr>
<th>Priority Pillars</th>
<th>Key Enablers</th>
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<tbody>
<tr>
<td><strong>1. Availability and accessibility of care, services and supports where and when they are needed</strong></td>
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</tr>
<tr>
<td>Promote and Support Healthy Aging</td>
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</tr>
<tr>
<td>Prevent and Manage Chronic Disease</td>
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</tr>
<tr>
<td>Promote Optimal Aging at Home for Older Adults with Multiple Chronic Conditions</td>
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</tr>
<tr>
<td>Provide Specialized Care for those Living with Frailty</td>
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<tr>
<td>Support Caregivers</td>
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</tr>
<tr>
<td><strong>2. Performance, productivity and efficiency</strong></td>
<td>Design Principles</td>
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<td>Communication</td>
<td>Putting Patients First</td>
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<tr>
<td>Transitions</td>
<td>Making it Easy</td>
</tr>
<tr>
<td>Health Human Resources</td>
<td>Everyone has a Home Base</td>
</tr>
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<td><strong>3. Linkage, coordination and navigation (awareness)</strong></td>
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<tr>
<td><strong>4. Equity, diversity and inclusion</strong></td>
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<tr>
<td>The case for an income-adjusted sliding scale for community services</td>
<td>Seamless Collaborative Care Teams</td>
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<td><strong>5. Health empowerment</strong></td>
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<tr>
<td>Transitions through the system</td>
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<tr>
<td>Responsive to Local Resident Needs</td>
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<td>Addressing Health Equity</td>
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<tr>
<td>Meeting the specific needs of French-speaking and Indigenous Residents</td>
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</table>
Goal 2: Healthy Aging. All people living in Waterloo-Wellington are exposed to the conditions and experiences that support optimal health throughout the lifecourse/lifespan.

<table>
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<th>Priority Pillars</th>
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<td>1. <strong>Availability and accessibility of care, services and supports where and when</strong></td>
<td>✓ A. Clinical Leadership</td>
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<tr>
<td>where they are needed</td>
<td>✓ B. Innovation</td>
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<td>✓ C. Digital Health</td>
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<tr>
<td><strong>Prevent and Manage Chronic Disease</strong></td>
<td>✓ D. Education and Training</td>
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<tr>
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<tr>
<td><strong>Provide Specialized Care for those Living with Frailty</strong></td>
<td>E. New and existing models for potential partnership and service expansion</td>
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<tr>
<td><strong>Support Caregivers</strong></td>
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</tr>
<tr>
<td>2. <strong>Performance, productivity and efficiency</strong></td>
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<tr>
<td><strong>Communication</strong></td>
<td>✓ Putting Patients First</td>
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<td><strong>Transitions</strong></td>
<td>✓ Making it Easy</td>
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<tr>
<td><strong>Health Human Resources</strong></td>
<td>Everyone has a Home Base</td>
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<tr>
<td>3. <strong>Linkage, coordination and navigation (awareness)</strong></td>
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</tr>
<tr>
<td>4. <strong>Equity, diversity and inclusion</strong></td>
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<td><strong>The case for an income-adjusted sliding scale for community services</strong></td>
<td>✓ Seamless Collaborative Care Teams</td>
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<td>5. <strong>Health empowerment</strong></td>
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<td><strong>Easy access</strong></td>
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<td><strong>Transitions through the system</strong></td>
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</tr>
<tr>
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Prepared for the Waterloo Wellington Local Health Integration Network by the Research Institute for Aging
### Goal 3: Health System Capacity

The Waterloo-Wellington health system is designed and coordinated in a way that realizes deep functional integration and the appropriate use of health resources to achieve optimal system capacity in support of an aging population.

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**Goal 4: Collaboration and Coordination.** The Waterloo-Wellington health system fully leverages and capitalizes on intra and intersectoral collaboration, offering a whole-of-community orientation to health, well-being and quality of life.

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Goal 5: Quality. Older adults living in Waterloo-Wellington have universal access to the highest quality of care, services and supports — those that emphasize excellence in safety, effectiveness, person-centredness, timeliness, efficiency and equity.

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**Goal 6: Empowerment.** The Waterloo-Wellington health system plays a pivotal and functional role in enabling the empowerment of people as they age, their caregivers and the health and social service providers they rely upon.

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