Enabling Aging in Place Participating Teams

Healthcare Excellence Canada is supporting 26 organizations through the Enabling Aging in Place collaborative, a program designed to support organizations to plan and implement practices that enable older adults with health and social needs to age where they call home with formal support.

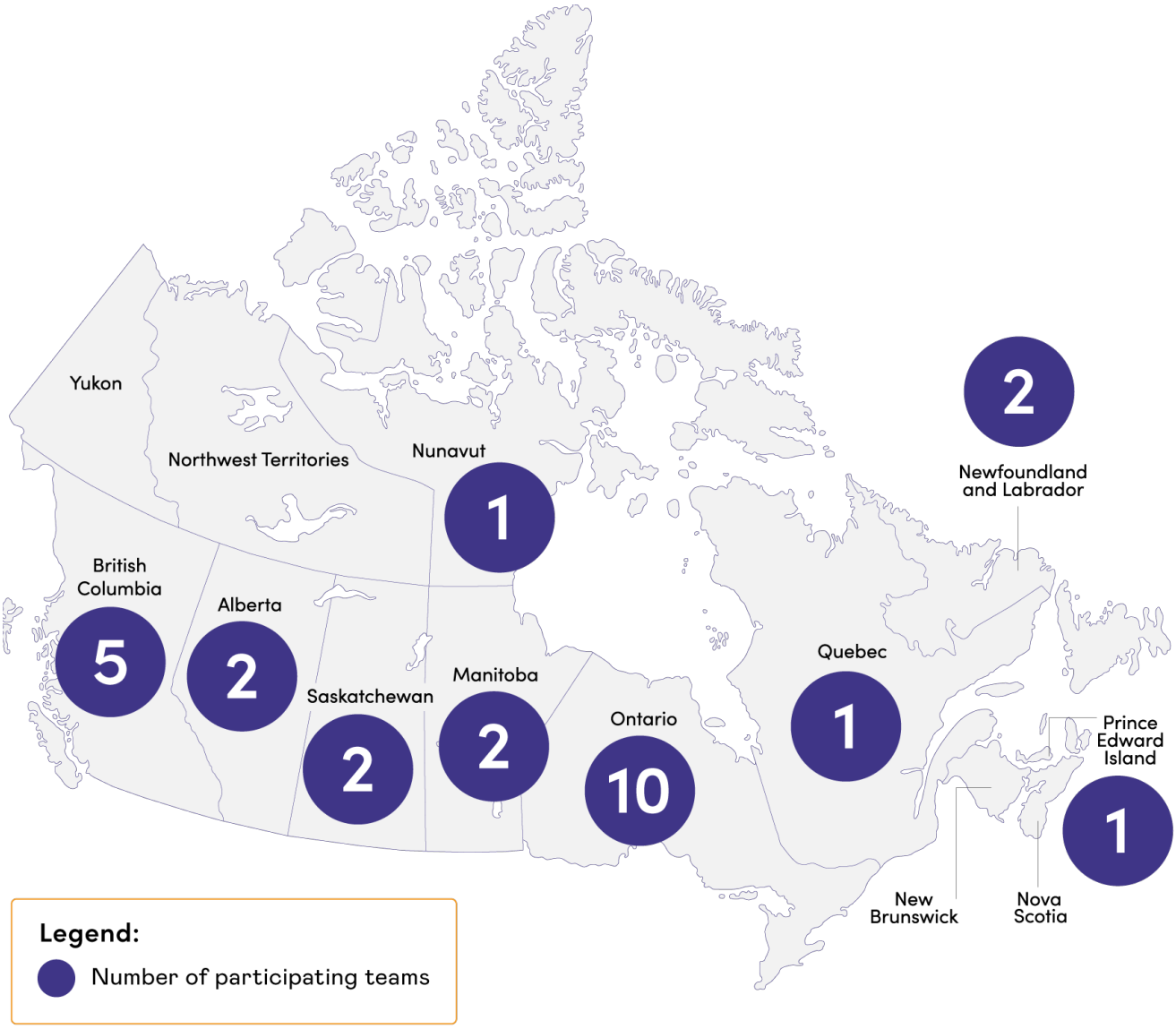

Figure 1: Map of Canada representing the communities invited to participate in Healthcare Excellence Canada's Enabling Aging in Place collaborative.

Meet the teams

The following organizations and communities have been invited to participate in the Enabling Aging in Place collaborative.

Actionmarguerite

At a Glance

Region: Manitoba

Setting: Urban

EAIP program principle(s):

- Access to specialized healthcare services
- Access to social and community supports
- Access to system navigation and support

Implementation (new, spread, and/or expand): Expand

Team Profile

This initiative is led by Actionmarguerite, a not-for-profit organization providing a range of health and social services to the Francophone and larger community within the City of Winnipeg. Team members include leadership and administrative staff from Actionmarguerite and Charités Despins who provide project leadership and evaluation support, as well as a Chief Nursing Officer in the role of Clinical Lead. Representatives from Réseau Compassion Network provide project management expertise, knowledge of the francophone and aging community.

Community

This initiative is based in Winnipeg, Manitoba, a city with a population of approximately 750,000.

A total of 96 individuals living in one of three Supportive Housing environments will benefit from the efforts of this initiative. Actionmarguerite offers supportive housing in two locations for 48 individuals while Charités Despins provides this program to 48 individuals in one living environment. Beyond the Supportive Housing program, Actionmarguerite operates three (3) Personal Care Homes with a combined capacity for 553 people and an adult day program. Charités Despins also supports 239 older adults in two Independent Living environments.

Program Focus

Program Description

The Supportive Housing program in Winnipeg, operated by Actionmarguerite and Résidence Despins, aims to enhance its existing services by adopting a person-directed living approach and ensuring the evolution of this program to better meet the more complex needs of the population. The program will focus on improving continuity of care, fostering stronger relationships between staff and tenants, and offering timely, flexible

services, including care in French. By addressing issues such as loneliness and ensuring culturally appropriate care, the program seeks to increase tenant satisfaction, extend their stay in supportive housing, reduce emergency visits and hospital admissions, and delay admissions to personal care homes, ultimately improving the overall quality of life for tenants and the effectiveness of the local health system.

Implementation Approach:

Education and Training on Personal Outcome Measures (POM) and Person-Directed Living: All staff will undergo training on Personal Outcome Measures and person-directed living through in-person and online sessions to improve the understanding of older adult needs and enhance caregiver work satisfaction.

Expand Roles and Build Capacity Among Staff: Tenant Companions will be trained to transition into Health Care Aide roles, providing more consistent and higher quality care to all 96 tenants at the three locations.

Introduce a New 24-Hour Enhanced Supportive Housing Model: Implement a new integrated care model where on-site staff provide 24-hour personal care, replacing the external Homecare model, to ensure timely, flexible, and higher quality care for all 96 tenants.

Introducing the Nurse Consultant Role: A full-time Nurse Consultant will be available to train Health Care Aides, offer daily health consultations, and assist with new referrals and advocacy, ensuring comprehensive and responsive care for all 96 tenants.

Algonquin Family Health Team (NOSM)

At a Glance

Region: Ontario

Setting: Rural

EAIP program principle(s):

- Access to specialized healthcare services
- Access to social and community supports
- Access to system navigation and support
- Implementation (new, spread, and/or expand): New

Team Profile

This initiative is led by the Algonquin Family Health Team (AFHT) within a new clinic for individuals without a primary care provider (unattached patients), The Annex. The team includes representatives from AFHT, including physicians, clinic leadership, IT support, and a research coordinator from the Huntsville Education Group.

Community

This initiative is targeted towards older adults without a primary care provider in Huntsville, Ontario, and surrounding areas.

Huntsville, is the largest municipality within the District of Muskoka, covering 711 square kilometers. According to the 2021 Census, it has a population of approximately 21,147 residents, with a significant portion being seniors.

Individuals without a primary care provider represent more than 30% of the community population.

Program Focus

Program Description

The Algonquin Family Health Team (AFHT), through its new program "Aging in Place at The Annex," aims to provide continuous, comprehensive care to unattached older adults in Huntsville, Ontario. This initiative addresses the critical need for primary care among seniors who currently rely on emergency departments, leading to long wait times that could be mitigated with comprehensive, ongoing care. The program aims to reduce hospitalizations and emergency department visits while supporting seniors in managing chronic illnesses, navigating the healthcare system, and aging at home. With a multidisciplinary team including physicians, a Nurse Practitioner, Community Paramedics, and mental health support, The Annex will provide unattached seniors with a health home, ensuring comprehensive health management and reducing the need for, and demand on, acute services.

Implementation Approach:

- **Specialized Geriatric Assessment:** Expand existing services to offer specialized geriatric assessments for frail older adults at The Annex, addressing dementia, delirium, mental health concerns, falls, and mobility issues. Targeting all geriatric patients, this service mobilizes community assets like home care, remote monitoring, and palliative providers.
- **Continuity of Care:** Provide continuous, quality primary care for older adults without access to primary care at The Annex. Targeting all older adults presenting or referred, this service mobilizes community resources, including a multidisciplinary team and partnerships.
- **Specialized Referral and Follow-up Care:** Facilitate patient referrals for specialist care and diagnostics, which are challenging to access without a primary care provider. The AFHT geriatric care team will provide and facilitate referrals based on comprehensive assessments.

Brightshores Health System

At a Glance

Region: Ontario

Setting: Rural

EAIP program principle(s): Access to system navigation and support

Implementation (new, spread, and/or expand): New

Team Profile

Grey Bruce Ontario Health Team is leading this initiative in collaboration with Brightshores Health System, Bruce County Paramedic Services, and the Grey Bruce Design & Implementation Working Group. The team comprises representatives from each organization, including interdisciplinary staff such as paramedics, nurse practitioners, specialized geriatric nurses, a project manager for evaluation and measurement support, and patient/caregiver advisors.

Community

- All four partner organizations serve Grey and Bruce counties in the South West Region of Ontario, covering a total area of 8,601 sq km. The region is bordered by Georgian Bay, Lake Huron, and several other counties.
- Grey and Bruce counties consist of 17 municipalities (8 in Bruce, 9 in Grey) and two First Nation reserves: Saugeen First Nation No. 29 and Chippewas of Nawash First Nation No. 27. The Grey Bruce population is split between rural areas (53%) and small population centres (47%).
- In 2021, Grey Bruce had 47,725 residents aged 65 and older, projected to increase to 63,895 by 2040. There were an estimated 10,904 frail older adults in 2021, expected to rise to 19,248 by 2040.
- Regional demographic data suggests that geographical isolation, socio-economic status, and other social determinants of health may elevate the risk of isolation and impact overall mental and physical health.

Program Focus

Program Description

- This initiative aims to address the challenge of health and social system navigation by empowering older adults in the Grey Bruce Community with knowledge and information about local health services, social and community support, and personalized system navigation. This will be achieved through the creation and distribution of a “Wise and Well” calendar, co-designed in collaboration with older adults from the Grey Bruce community along with health and social service providers.
- Additionally, the project will promote awareness of the newly available telephone navigation service. This helpline is available to older adults and caregivers in Grey Bruce who require more personalized navigation support including warm transfers, additional support, and follow-up calls.

Implementation Approach:

- **Community Engagement:** Deepen connections with the older adult community using asset-based community development (ABCD) through community conversations, surveys for feedback, and engaging groups facing participation barriers.
- **Creation and Distribution of the "Wise and Well" Calendar:** Informed by engagement with healthcare providers, project partners and older adults, the "Wise and Well" calendar resource will highlight existing programs and services for older adults in Grey Bruce. The calendar will be distributed by Community Paramedics, local businesses, groups, and community centers.
- **Access to Navigation Line:** The Grey Bruce Ontario Health Team (GBOHT) navigation line, staffed with dedicated navigators, uses referral pathways co-designed with partner agencies and community members. Available from 8 AM to 8 PM, this service offers a "warm transfer" experience, directly

connecting users to the needed services or programs. Follow-up occurs within one week to ensure needs are met, provide additional resources, and collect feedback.

Conne River Health & Social Services (Miawpukek First Nation)

At a Glance

Region: Newfoundland and Labrador

Setting: Rural

EAIP program principle(s):

- Access to specialized healthcare services
- Access to social and community supports
- Access to system navigation and support

Implementation (new, spread, and/or expand): Expand

Team Profile

The organization leading this program is Conne River Health and Social Services (CRHSS), a department of Miawpukek First Nation. They will be partnering with other departments of Miawpukek First Nation such as housing, culture and tourism and recreation through this program.

Community

- This program is in Conne River, Newfoundland located on the south coast of Newfoundland.
- The program serves Miawpukek First Nation, a rural community with a population of less than 1,000 people with many members of the community being Miawpukek Mi'Kamawey Mawi'omi.
- There is a higher incidence of chronic diseases and co-morbidities at younger ages in this community that has encouraged them to provide wellness visits to younger individuals in addition to those 75 and older.

Program Focus

Program Description

CRHSS will expand services to include regular Wellness Visits to community members 65 years old and older. Home visits will be provided at least once a month by a community health nurse (CHN) and will include a general overall assessment including vital signs, medical history, home safety checks, nutrition and other assessments. Referrals will be made by the CHN to other appropriate services based on needs identified during the Wellness visit and clients will be supported to navigate these services. For example, mental health counsellor, nurse practitioner, footcare nurse, housing manager and/or patient navigator/advocate.

Implementation Approach:

- **Wellness Visit Processes:** Develop intake, assessment and referral forms to be used by CHN with clients. Information to be documented and used to support clients in navigating required services.
- **Capacity Building Collaboration:** Build a group of representatives from different Miawpukek First Nation departments, Elders and youth from the community and outside partners to take part in an Elder Advisory Committee. The committee will support communication with Elders in the community to ensure they are aware of available programs and services in the community as well as regional and provincial opportunities.
- **Programming and Community Awareness:** Continuously evaluate and adapt the program based on progress and feedback received from clients, Elder Advisory Committee, staff and community members.

County of Renfrew

At a Glance

Region: Ontario

Setting: Rural and Remote

EAIP program principle(s):

- Access to social and community supports
- Access to system navigation and support

Implementation (new, spread, and/or expand): New

Team Profile

The Ottawa Valley Ontario Health Team (OVOHT) is leading this initiative, in collaboration with Pembroke Regional Hospital, Renfrew County Community Paramedics, and Barry's Bay and Area Home Support Services. Collaborating closely, leaders from these organizations, along with advisors from The Regional Geriatric Program of Eastern Ontario, Eganville & District Seniors, The Dementia Society of Ottawa and Renfrew County, The Upper Ottawa Valley Community Living and the Algonquins of Pikwàkanagàn First Nation, make up a robust team serving a large catchment area. OVOHT Patient, Family and Caregiver network (PFaC) will also act as partners and advisors to this project.

Community

- All organizations across the OVOHT operate in a rural setting, and some also work in remote areas, bordering northern communities.
- OVOHT is a large rural catchment area with a population of approximately 78,000 residents. The area has one of the highest rurality population rates in the province, resulting in significant challenges in accessing care.
- 23% of the population are over 65 years of age.
- Approximately 9% self-identify of community members identify as Indigenous, and 12% are Francophone.
- OVOHT has a high rate of patients unattachment to primary care provider, nearing 25% of the population. For older adults, this creates greater risk for unexpected or poor health outcomes as there is limited access to preventive or consistent care opportunities.

Program Focus

Program Description

Informed by partners and individuals with lived/living experience, the team plans to develop and implement a Comprehensive Falls Pathway within community paramedicine. This pathway will utilize a first-contact, inter-professional, cross-sector collaborative approach to identify and implement a common and consistent, evidence-informed Falls Pathway across OVOHT for older adults at risk or post-fall. Building on identified practices, the local pathway will bring together clinical and volunteer groups to ensure a consistent and responsive experience for patients and community members.

Implementation Approach:

- **Self-screening Tool:** The Community Intervention and Falls Prevention Programs Self-screening Tool will be made available online, 24/7, through Ottawa Valley Health Connect (ovhc.ca) for individuals and/or caregivers to complete, identify their risk of fall and directing the user to the most appropriate program in the user's location, based on screening results, raising awareness of the availability of local programs.
- **Cross-sectoral Collaborative Pathway and Working Group:** The development of a cross-sectoral collaborative pathway ensures equitable access to timely services and programs for patients through a consistent approach. By building on existing pathways, enablers, and technology, this cross-sectoral working group aims to clarify, streamline, and simplify access to services related to falls. The team plans to consolidate existing services, promoting integration, and enhancing coordination to optimize resource utilization and support older adults in accessing the most appropriate services when needed. Once developed, the team plans to test, launch, and evaluate.
- **Communication:** The team plans to develop and implement a communication and engagement plan across the region targeting the public, social, and health sectors. This plan will inform key partners about the project and its expected outcomes.

Department of Health, Government of Nunavut

At a Glance

Region: Nunavut

Setting: Remote and Northern

EAIP program principle(s): Access to specialized healthcare services

Implementation (new, spread, and/or expand): New

Team Profile

The organization leading this initiative is the Department of Health, Government of Nunavut. Collaborative team members include a variety of organizational staff, including administrators, consultants, team leads (home care, nursing, pharmacy), and an evaluation and measurement lead.

Community

- Nunavut is the largest territory in Canada, and with population of approximately 40,692 residents as of 2023, it is also the most sparsely populated. Nunavut is accessible year-round solely by air, and more than 80% of the residents in Nunavut are Inuk (Inuit).
- As of 2021, Nunavut was home to a significant Elder population, with over 4,000 individuals aged 55 and above, comprising approximately 12% of the territory's total population and the largest proportion of Elders the territory has had to date. This number is expected to grow by approximately 6% in the next 20 years.
- Due to Nunavut's remote location, many communities in the territory have limited access to healthcare services and resources, often having to travel out of community to receive care.

Program Focus

Program Description

- To pilot and implement Continuous Ambulatory Delivery Device (CADD) systems, specifically CADD-Solis Ambulatory Infusion pumps, within communities across the territory. This program aims to enhance the homecare program for individuals with life-limiting illnesses. By facilitating adequate comfort measures (e.g., effective pain management), the goal is to provide comprehensive support and access to care, minimizing the need for long-term care respite beds and enabling individuals to receive the care they need in their home and community.
- By implementing the CADD-Solis Ambulatory Infusion pumps, the team aims to achieve several long-term outcomes. These include reducing the need for medical travel to access palliative services outside the community, decreasing the reliance on long-term care respite beds, and enhancing the capacity to repatriate individuals who have received palliative care outside the territory.

Implementation Approach:

- **Development of an implementation plan:** The team will collaborate with regional leadership to select the initial participating communities. These communities will be based on several criteria including population size, clinical need, recommendations by regional homecare managers, available healthcare resources, and the ability to transport medications safely. Discussions will cover logistical aspects such as medication compounding and preparation, as well as quality assurance measures. The selection of communities for the pilot program is expected to be finalized by late 2024.
- **Education, training, and resource development:** Development of the CADD pump drug library will occur in collaboration with stakeholders and additional supports (e.g., Ottawa Hospital) to ensure quality assurance and functionality of the pumps prior to deployment. Furthermore, comprehensive training programs for both pharmacy and homecare nursing teams will be developed.
- **CADD-Solis Ambulatory Infusion Pump rollout:** The team will facilitate the distribution and implementation of CADD pumps starting with the initial pilot communities. The anticipated rollout for these communities is early 2025. The pilot program will begin with a small subset of communities in the Baffin region, with the aim to roll-out the program across the territory as the logistics of procurement/transportation are established. Currently there are 13 devices available for distribution throughout the territory, 5 of which will be used in the pilot communities. As logistics for program expansion are identified, the remaining pumps will be distributed.

- **Spread, expansion, sustainability, and evaluation:** An evaluation of the program will be completed, incorporating feedback from program participants and their caregivers, to inform adjustments and ensure sustainability. This feedback-driven approach aims to support the sustainability and expansion of the program to additional communities.

Dignity Seniors Society

At a Glance

Region: British Columbia

Setting: Urban

EAIP program principle(s):

- Access to social and community supports
- Access to system navigation and support
- Access to specialized healthcare services

Implementation (new, spread, and/or expand): New

Team Profile

The organization leading this initiative is Dignity Seniors Society (DSS), a non-profit focused exclusively on the needs of 2SLGBTQIA+ older adults and seniors in BC. The team includes DSS representatives who provide project guidance, coordination, and volunteer support. Additionally, the team is supported by an advisory group of community members and experts who contribute their specific knowledge and training regarding best practices for the 2SLGBTQIA+ community.

Community

- DSS is committed to having diverse communities within the 2SLGBTQIA+ community lead the board. This includes people who identify as Black, Indigenous and trans/non binary. DSS's work focuses exclusively on the needs of 2SLGBTQIA+ older adults and seniors in BC. They have a provincial mandate and have built collaborative alliances with multiple organizations.
- DSS works diligently to connect with seniors in regions where the needs of 2SLGBTQIA+ older adults have not been identified and where it could feel less safe for older adults to disclose their sexual and gender identities. 2SLGBTQIA+ can often experience discrimination in the healthcare system, are at greater risk of mental and physical health problems, isolation from community, and less familial support.
- 2SLGBTQIA+ people are more likely to have chosen family, however, contemporary aging policies tend to support an "intergenerational support system of informal caregiving". Chosen family likely to become infirm at the same time.

Program Focus

Program Description

The "We Are Familee" program by Dignity Seniors Society (DSS) is a pilot volunteer initiative aimed at supporting 2SLGBTQIA+ seniors to age in place. DSS will conduct an environmental scan of Metro Vancouver to assess existing services, identify gaps, and recommend improvements. In partnership with Haro Park Centre Society, volunteers will be recruited to support seniors using a circle of support model. The program will develop video training modules focusing on the specific needs of 2SLGBTQIA+ seniors, incorporating a strength-based, trauma-informed approach to reduce stigma and discrimination while promoting cultural and intersectionality awareness. By creating a sustainable, volunteer-led initiative, the "We Are Familee" program aims to address the systemic challenges faced by 2SLGBTQIA+ seniors, particularly those experiencing social isolation, poverty, and health inequities. If successful, DSS plans to replicate the initiative across BC, offering specialized training for other "Aging in Place" programs, leveraging their history of providing education to health authorities and non-profit organizations in the healthcare field.

Implementation Approach:

- **Environmental Scan:** Conduct an environmental scan of Metro Vancouver to assess current services for 2SLGBTQIA+ seniors, identify gaps, and provide recommendations for improvement.
- **Pilot Volunteer Program in Collaboration with Haro Park Centre Society:** Volunteers will support 2SLGBTQIA+ seniors at Haro Park Centre through comprehensive services including weekly/bi-weekly social visits, appointment accompaniment, emotional support, advocacy, and connecting clients to community groups, events, and online support systems.
- **Develop Video Training Modules:** Create online training modules covering cultural and intersectionality awareness, best practices for supporting aging 2SLGBTQIA+ seniors, volunteer safety, boundaries, and self-care. These modules will be based on advisory member feedback and ongoing volunteer input, initially for pilot project volunteers, with future expansion to other organizations providing aging in place services.

Dixon Hall

At a Glance

Region: Ontario

Setting: Urban

EAIP program principle(s):

- Access to specialized healthcare services
- Access to social and community supports
- Access to system navigation and support

Implementation (new, spread, and/or expand): New

Team Profile

The team leading this initiative is McMaster University, in collaboration with Dixon Hall, a multi-service agency that supports individuals in the Downtown East Toronto community. Team members include academic staff (Professor and Research Associate) from McMaster University, and research support and management staff from Dixon Hall.

Community

- This program will be implemented in a Toronto Seniors Housing (TSH) building in Downtown East Toronto. The building houses over 50% women (110 out of 196 residents) and 96% are aged 55 years and older. While 50% of residents prefer spoken English, other commonly spoken languages include Vietnamese (12%) and Cantonese (11%), with a total of 13 different languages spoken within the building.
- Downtown East Toronto includes neighborhoods such as Moss Park, St. James Town, Church Wellesley Village, and Cabbagetown. It is bounded by Bloor Street to the north, Front Street to the south, Bay Street to the west, and the Don Valley Parkway to the east. This area faces challenges related to low socioeconomic status, homelessness, mental health, and substance use.
- Dixon Hall Neighbourhood Services offers a range of services including housing support, employment services, and programs for seniors and youth, addressing the diverse needs of the community.

Program Focus

Program Description

- The Community Paramedicine at Clinic (CP@clinic) program will be adapted for older adults and immigrant seniors living in social/supportive housing or who are precariously housed, serviced by Dixon Hall Neighbourhood Services. This adaptation, named Healthcare Provider at Clinic (HCP@clinic), will complete a needs assessment to tailor the evidence-informed intervention for different populations and conditions. The goal is to generate knowledge to inform the potential scale-up of HCP@clinic to other sites within Dixon Hall Neighbourhood Services, promoting health and health equity.
- The program aims to improve access to primary healthcare and social/community resources, enhance health measures and quality of life, keep participants healthy at home longer, reduce transfers to long-term care, and prevent progression to more intensive interventions. Initially targeting residents of Toronto Seniors Housing at 252 Sackville, this adaptation will involve other healthcare professionals instead of community paramedicine, as the target population for Toronto Paramedic Services differs from the program's target group.

Implementation Approach:

- **Conduct Interviews with Dixon Hall Staff:** Interview case workers to assess suitability of skills for delivering the HCP@clinic program and gather insights for implementation.
- **Complete Needs Assessment:** Conduct a needs assessment of TSH tenants to understand their health and social needs, and tailor the HCP@clinic program accordingly.
- **Onboard Health Navigators:** Hire Health Navigators with knowledge of local community supports and challenges, multilingual abilities, and social skills to help clients navigate the system.

- **Establish HCP@Clinic:** Hold an initial planning meeting with key partners, schedule HCP@clinic sessions based on needs assessment and resource capacity and facilitate referrals to health education and promotion resources.

Flagstaff's Informed Response Sharing Team Society (FIRST)

At a Glance

Region: Alberta

Setting: Rural

EAIP program principle(s):

- Access to social and community supports
- Access to system navigation and support

Implementation (new, spread, and/or expand): Expand

Team Profile

The organization leading this initiative is the Flagstaff Informed Response Sharing Team (FIRST). Collaborative team members include employees and representatives of FIRST, including a director, board chair, and direct care provider, as well as a community volunteer. Evaluation support is provided by researchers from the University of Alberta and the Network of Excellence in Seniors Health & Wellness, and a community assessor.

Community

- Flagstaff Region, with an approximate population of 8,463 residents, is a rural area in East Central Alberta, consisting of two hamlets, four village, four towns and the rural county residents. Major urban centers, Red Deer and Edmonton, are located approximately a 2-to-3-hour drive away.
- With 23.2% of its population aged 65 and older, totaling 1,960 individuals as of March 2021, Flagstaff Region's older adult population is higher than the provincial average (14.1%), and is projected to increase to 2,220 by 2026.

Program Focus

Program Description

FIRST is expanding a smaller Nav-CARE program that primarily focuses on health needs to address both health and social needs of older adults. They are building connections between older and younger adults who can volunteer and those who are needing support. Volunteers will provide friendly visiting, support participation in existing recreational activities and help with navigation to more formal supports (e.g., transportation, Service Options for Older People program). The supports also include assistance with travel in and outside the region for medical appointments. The expanded supports reflect comprehensive community engagement where reducing social isolation, system navigation and transportation were voiced as primary concerns for older adults in the community.

Implementation Approach:

- **Gain insights from the community:** Volunteers within the Older People Choices/Nav-Care program will actively engage with older adults at community centers, events, and through home visitation services to understand their current strategies for aging in place. Additionally, perspectives from staff and volunteers will be explored to identify potential enhancements for supporting aging in place in Flagstaff Region. The gathered information will be utilized to raise awareness of community assets and preferences, informing the development of future programs.
- **Enhance participation in the Older People Choices/Nav-Care Program:** FIRST will collaborate with the existing Older People Choices/Nav-Care Program to facilitate its expansion, and to research ongoing funding models, linking older adults with necessary supports to address community-identified needs while also fostering increased engagement of older and younger adults in volunteer activities.

Fraser Health Authority

At a glance

Region: British Columbia

Setting: Urban

EAIP program principle(s):

- Access to specialized healthcare services
- Access to social and community supports
- Access to system navigation and support

Implementation (new, spread, and/or expand): Expand

Team Profile

The team leading this initiative is the Fraser Healthy Authority. Team members include representatives from Fraser Health Authority, including a regional manager, team leader, interdisciplinary staff including a regional social worker, occupational therapist and program implementation staff. Clients and caregivers provide feedback into program development and delivery.

Community

- Fraser Health Authority (FHA) is the heart of health care for more than 1.9 million people in 20 diverse communities from Burnaby to Fraser Canyon on the traditional, ancestral and unceded territories of the Coast Salish and Nlaka'pamux Nations.
- FHA provides services to a mix of urban and rural areas, including Chilliwack, the community in which the NetCare day program is located.
- In Chilliwack, 95% of the population speaks English with small communities speaking German, Punjabi, Korean, Chinese, Spanish, Dutch, French, Vietnamese, and Romanian. The median age is 41, with 16% of the population being over 65. The population of individuals aged 75 and older is projected to grow rapidly.

Program Focus

Program Description

Fraser Health's Day Program for Older Adults (DPOA) offers in-person social connections, activities, exercise, and health checks for seniors with health challenges, supporting independent living and aging in place. The program expansion, NetCare DPOA, will introduce a hybrid in-person/virtual option for one hour daily, Monday to Friday, featuring exercise, music therapy, and "Bingocize", which combines bingo, exercise, and health promotion in each session. The program aims to help clients stay at home longer, improve their health and well-being, reduce isolation, increase caregiver skills, and delay admission to long-term care. The expansion will provide structured exercise and social time, enhance physical, cognitive, and social functioning, increase comfort with technology, and strengthen community connections. It will serve medically frail older adults, those with cognitive impairments, at-risk caregivers, and socially isolated individuals, including current and waitlisted DPOA clients and Home Health clients in the community.

Implementation Approach:

- **Initial Launch and Expansion:** Begin with "Bingocize" sessions on Tuesdays and Thursdays and music therapy on Wednesdays for 1 hour each, running 12-week sessions. Plan to start with a soft launch of 3 days per week, targeting 10-12 participants to address and troubleshoot technical and equipment issues. Expand to include Carefit exercises on Mondays and Fridays by fall, increasing to 5 days per week.
- **Program Evaluation and Growth:** Develop a process to track referrals and recommendations to and from community services by January 2025. Plan for potential expansion to other DPOAs in Fraser Health based on initial success and demand.

Golden Health Care Management inc.

At a Glance

Region: Saskatchewan

Setting: Rural

EAIP program principle(s):

- Access to specialized healthcare services
- Access to social and community supports
- Access to system navigation and support

Implementation (new, spread, and/or expand): Spread

Team Profile

The organization leading this initiative is Golden Health Care Management Inc. (GHC) in collaboration with representatives from the University of Saskatchewan and the Saskatchewan Health Authority (SHA), alongside interdisciplinary staff, and family partners. Geriatricians and Nurse Practitioners provide mentorship and advisory support to the team, as well as a health economist and a nursing informatics specialist. Additionally, a

Métis community-based researcher and various community connectors/relationship builders offer valuable support to the team.

Community

- This initiative is being piloted in Diamond House, a personal care home located in Warman, Saskatchewan.
- Warman is a small city located approximately 20 kilometers north of Saskatoon, in central Saskatchewan. With a growing population of around 12,000, Warman has a diverse demographic with a significant number of adults aged 65 and older, approximately 15% of individuals living in Warman are 65 and older.
- The community serves as a catchment area for other rural and remote communities, including surrounding First Nations and Métis communities.

Program Focus

Program Description

GHC is currently piloting 30 alternate-level care beds within Diamond House in Warman, in partnership SHA, as part of the STEPS (Short Term Enablement and Planning Suites) program. The significance of the STEPS initiative lies in its provision of transitional care outside the acute care hospital setting, supporting care to be delivered closer to home. Where possible, the STEPS program supports older adults to regain health and transition back to the community delaying entry to long-term care. The STEPS approach aligns with the principles of quality care, ensuring that individuals receive the right care, in the right place, at the right time. Simultaneously, the Nav-CARE project is being piloted within GHC (Diamond House), offering support to STEPS participants and their family caregivers in making informed decisions regarding transitions and accessing supportive care services closer to home following discharge.

Implementation Approach:

- **Cultural Integration:** As GHC engages with the community, they aim to identify ways to integrate culturally specific care into their programming.
- **Integration of SK Nav-CARE:** By collaborating with the SK Nav-Care volunteer program, individuals identified as candidates for the alternate-level care spaces, along with their families, will receive personalized support in developing transition plans and identifying goals throughout their continuum of care journey. The SK Nav-CARE coordinator will serve as a liaison between participants, families, and the SHA/GHC, ensuring seamless communication and coordination of care.
- **Utilizing Team CarePal:** GHC will utilize the Team CarePal App to enhance collaboration among care teams as individuals transition from acute care settings to their home of choice through the STEPS program.
- **Facilitating Opening Conversations:** As individuals move into the alternate-level care spaces, GHC will hold opening conversation sessions, focusing on abilitation (focusing on the person and their strengths and identified goals) and relationship-building, to actively engage participants in their care journey, promote improved health outcomes, and recognize caregiver roles within a supportive care environment.

GTA Rehab Network (UHN)

At a Glance

Region: Ontario

Setting: Urban

EAIP program principle(s):

- Access to specialized healthcare services
- Access to social and community supports
- Access to system navigation and support

Implementation (new, spread, and/or expand): Expand

Team Profile

The organizations collaborating to support this program include the GTA Rehab Network (UHN), Toronto Paramedic Services, North Western Toronto (NWT) Ontario Health Team (OHT), West Park Healthcare Centre/UHN, ESS Support Services, Black Creek Community Health Centre, Unison Health & Community Services, LOFT Community Services, Lumacare, Humber River Health, Emery-Keelesdale Nurse Practitioner-Led Clinic, Runnymede Healthcare Centre. The team members include subject matter experts, paramedicine team leads, nursing leadership, directors, and project managers who support measurement and evaluation.

Community

- This initiative supports the North and West regions of Toronto that are served by the North Western Toronto (NWT) Ontario Health Team (OHT).
- NWT OHT communities have the highest proportion of seniors in Ontario and significant visible minority and newcomer populations facing socioeconomic challenges.
- Among those living in this region, 61% of the population identify as visible minorities, while 54% are newcomers, and 50% speak English as a second language. Additionally, 22% of households are low-income, and 48% of adults aged 65 and older live alone with difficulties in Activities of Daily Living (ADLs), compared to the Ontario average of 46%.
- The number of adults aged 65 and older in this area is projected to nearly double in the next 20 years, highlighting the need to adapt programs to meet increasing demands.

Program Focus

Program Description

This secondary prevention program aims to extend the time that older adults can live healthy and independently in the community by improving access to rehabilitation services for older adults who have had a fall and did not go to the hospital, through the implementation of post-fall care pathways initiated by community paramedics. Specifically, the care pathway will:

- evaluate the rehabilitative needs of older adults who have had a fall or who report a fall, but who did not require transfer to a hospital (lift-assist/no-admit), using a set of screening tools, and;

- refer older adults to an appropriate stream of services to help prevent future falls.

Implementation Approach:

- **Pathways redesign:** Redesign community paramedic practices for lift-assist/no-admit situations by introducing a post-fall rehabilitative care pathway based on multifactorial screening evaluations. Pathway streams may include three “levels”, based on intensity of services: community intervention (level 1), Outpatient community clinic/in-home care/specialized geriatric services (level 2), or in-patient rehabilitation services (level 3).
- **Comprehensive Geriatric Orientation:** Provide comprehensive geriatric orientation and education to community paramedics (through review of Regional Geriatric Program (RGP) of Toronto e-modules and GTA Rehab Network orientation of standardized assessments).
- **Inventory of Post-fall Pathway Services:** Create an inventory of post-fall pathways in the NWT OHT for geriatric rehabilitative care services and streamline referral processes, including developing a direct access pathway to inpatient rehabilitative programs from the community.

Health PEI - Margaret Stewart Ellis Home

At a Glance

Region: Prince Edward Island

Setting: Rural and Urban

EAIP program principle(s):

- Access to system navigation and support
- Access to social and community supports

Implementation (new, spread, and/or expand): Expand

Team Profile

The organization leading this initiative is Health PEI, the health authority in Prince Edward Island. Collaborative team members include healthcare professionals from Health PEI, including administrators, managers, as well as representation from nursing and social work. As part of the team, an external consultant provides capacity building and evaluation support.

Community

- This initiative is being offered in partnership with two communities: O’Leary, a rural community in Northwestern Prince Edward Island, and Summerside PEI, a small city with a population of 20,000 in Western PEI, both situated in the Prince County region of PEI.
- In the Prince County region, individuals aged 65 and older, make up a quarter of the population (25.6%), notably higher than the national average of 18.9%.
- The local area has a mixture of English and Acadian French demographics, with two French communities in the region, who each have a community school center and active seniors’ clubs. There is one First Nations community, Lennox Island First Nation, within the Country.

Program Focus

Program Description

- The Margaret Stewart Ellis Home will expand and improve an existing respite care program that aims to prevent caregiver burnout. The program team has identified that its services are under-utilized because of lack of awareness, misconceptions about the ability for institutional settings to provide person-centered care, and barriers faced through administrative processes. These barriers were identified through community engagement in Phase 1 of the EAIP Collaborative.
- To improve the respite program and its utilization, the program team will investigate centralizing the administration processes to diminish barriers of transportation, develop promotion materials, and establish a more collaborative partnership with home-based care programs. These efforts are expected to help establish Long-Term Care (LTC) as a key community organization promoting aging in place.

Implementation Approach:

- **Promotion of Respite Program:** Materials will be developed to raise awareness of the in-facility respite program, expanding promotion from home-based care service users to the public. The goal is to alleviate caregiver guilt and anxiety while reducing the stigma associated with LTC. The team plans to utilize various promotion methods (e.g., video, brochure, social media) based on input from community partners and caregivers.
- **Improve Communication and Accessibility to Respite Program:** The team aims to enhance internal communication to facilitate a safe transition from home-based care to in-facility respite care. This includes clear communication during the intake process and establishing a discharge process with follow-up reports for families/carers. Additionally, centralizing the administration and admission process will reduce administrative barriers and prevent interruptions in healthcare services during respite access.
- **Enhancement of Respite Environment:** Informed by service users, their families, and/or carers, improvements will be made to the respite environment to create a warm and welcoming setting. This may involve providing service users with private spaces and implementing design elements to encourage participation and better utilization of the respite program.

Hornby and Denman Community Health Care Society

At a Glance

Region: British Columbia

Setting: Rural and Remote

EAIP program principle(s):

- Access to specialized healthcare services
- Access to social and community supports.
- Access to system navigation and support

Implementation (new, spread, and/or expand): New and expand

Team Profile

The team leading this initiative is the Hornby and Denman Community Health Care Society, Hornby Denman Health, a multi-service non-profit organization and charity dedicated to optimizing the health and well-being of Denman and Hornby Island residents. Team members include Hornby Denman Health representatives, including interdisciplinary staff, team leads, evaluation and measurement support, and a committee of client, family, and care partners.

Community

- Hornby and Denman Islands are ferry-dependent communities off the east coast of Vancouver Island, BC. Each has about 1,300 year-round residents, with older, more isolated, and poorer populations than the provincial average.
- Local health services are crucial due to limited infrastructure, no public transport, and limited, unaffordable housing. There are no assisted living or long-term care facilities. Hospitals and specialists are on Vancouver Island.
- Hornby and Denman Islands have an older and lower-income population than the regional average. The median individual after-tax income is $27K on Hornby and $30K on Denman (2020 Statistics Canada). Additionally, 40% of Hornby residents and 39% of Denman residents are over the age of 65, compared to 19% for BC. A significant percentage of residents live alone: 46.4% on Hornby, 33.8% on Denman, and 28.7% in BC (2016 Census).

Program Focus

Program Description

Hornby Denman Health's community-based Senior Services Program supports Island seniors in maintaining independence and managing their care as they age. The program aids recovery from short-term illnesses and provides ongoing support for life-limiting conditions through end-of-life care. Services include integrated local care coordination, therapeutic social programs, and income tested supports for Instrumental Activities of Daily Living. The program's goals are to simplify care navigation, support independence, offer social and emotional support, and provide sustainable, flexible services. Primarily serving residents over 65, the program is expanding to include enhancing home support for palliative care, creating "Community Hug" care packages for those returning from the hospital, and offering education sessions on aging well at home.

Implementation Approach:

- **Home Assist with Care Coordination:** Launched in April 2023, this program serves Hornby and Denman Island residents over 65 at risk due to low income, medical conditions, or social isolation. It offers non-medical support, social engagement, and flexible services for short-term and palliative care. EAIP funding enables expansion to include rapid services for short-term illnesses, reliable daily task assistance for complex issues, and additional support for palliative care. The program, relying on volunteers and community partnerships, aims to serve 150 clients, promoting early hospital discharge and long-term independence at home.
- **The Community Hug:** This new service supports individuals with a new illness or returning from the hospital by providing care packages with local goodies, essentials, educational materials, and support contact info. It helps reduce isolation and connects individuals to local supports. Hornby Denman Health

collects and distributes packages with contributions from local businesses and community members tailor and deliver these packages.
- **Choices in Aging and Dying:** Community Nurturing and Education Program: This program targets younger seniors to encourage early planning and engagement with Hornby Denman Health. Quarterly events will feature workshops and publicly accessible sessions on aging, death, and dying, providing quality information on rights, choices, local care options, and tools for maintaining independence.

Home Hospice North Lanark

At a Glance

Region: Ontario

Setting: Rural

EAIP program principle(s):

- Access to specialized healthcare services
- Access to social and community supports
- Access to system navigation and support

Implementation (new, spread, and/or expand): New

Team Profile

The organization leading this initiative is Home Hospice North Lanark (HHNL). The collaborative team comprises representatives from HHNL, including nursing and interdisciplinary staff, an evaluation and measurement lead, an executive sponsor, and administrative support. Additional support comes from Hospice Palliative Care Ontario (knowledge experts) and community partners including Beth Donovan Hospice, Connect Well Community Health and the Mississippi River Health Alliance.

Community

- This initiative is located in Lanark County in Eastern Ontario.
- The region includes three larger towns and several rural hamlets and villages, with a population of around 70,000.
- Older adults in North Lanark, aged 55 to 90, represent the fastest-growing segment of the population in the county. Within the Lanark, Leeds & Grenville Ontario Health Team, 17.8% of the population is 65 or older.
- Many individuals living in North Lanark face challenges due to both a lack of transportation and limited access to high-speed internet, particularly the effects of social isolation.

Program Focus

Program Description

HHNL provides palliative care and support services in clients' homes, including residential homes, long-term care facilities, retirement homes, and social housing settings. HHNL is implementing a Day Hospice program to

provide early identification and support for palliative care individuals and their caregivers, mitigating risks of urgent emergency room visits and declines in condition through health and social service interventions. This weekly program, held in a friendly, social setting outside the home, offers participants the opportunity to connect with others, access complimentary therapies, and engage in life-enriching activities. Caregivers also receive support and respite. A registered nurse on site assists with system navigation, monitors client status, and ensures resource access to reduce acute care visits. The program fosters client independence, reduces social isolation, improves quality of life, ensures seamless transitions across palliative care services, and alleviates health system pressures by optimizing the use of healthcare resources.

Implementation Approach:

- **Program Design and Community Engagement:** HHNL will establish a comprehensive program model, design, and policy development framework, with ongoing community engagement.
- **Launch of Day Hospice Services:** Will be implemented in a phased approach, offering Day Hospice services once a week for 3 hours starting in September 2024, with plans to expand to a full pilot and reassess in January 2025.
- **Evaluation:** Following the pilot launch, HHNL will evaluate the program design, achievement of goals, client satisfaction, education and training needs, incident and risk management, location suitability, and potential for expansion in January 2025
- **Partner Engagement:** HHNL has arranged space sharing for the day hospice program with Connect Well Community Health. The building has adequate parking, is accessible and the space is quiet. HHNL will engage existing and potential partners to assist with referrals, policy development, data collection, and donations in kind from donors, businesses, and volunteer artists and musicians for activities.

Huron Shores Family Health Team

At a Glance

Region: Ontario

Setting: Rural

EAIP program principle(s):

- Access to specialized healthcare services
- Access to social and community supports
- Access to system navigation and support

Implementation (new, spread, and/or expand): New

Team Profile

The organization leading this initiative is the Huron Shores Family Health Team (HSFHT). The collaborative team includes a variety of interdisciplinary staff (e.g., Nursing, Geriatric Assessor, Physiotherapist, System Navigator, and Quality Improvement Consultants) from Huron Shores Family Health Team, North Shore Health Network and Algoma Ontario Health Team. The team also includes a community member as a patient advisor.

Community

- This initiative is located in the Algoma Region of Northern Ontario, where the Huron Shores FHT provides care to over 14,000 people, including three First Nations communities.
- The Algoma region has a significantly higher proportion of older adults when compared with the rest of the province. The most recent census data (2021) shows that 26% of individuals are 65+ (30,090 of a population of 113,777) in the Algoma district, and this number is projected to increase significantly in the coming years.
- Within the HSFHT's service area in East Algoma, over 30% of individuals are aged 65 and over.
- As there is a large proportion of older adults in East Algoma, transportation has been identified as a primary barrier to accessing services far from individuals' home communities.

Program Focus

Program Description

The team plans to implement the HSFHT Healthy Aging Program, aligning with the Algoma Ontario Health Team's "Healthy Aging Strategy". This program is aimed at frailty prevention and management, which consists of two parts; early frailty identification and public education. The Early Frailty Identification component includes embedding a frailty screening tool into the Electronic Medical Record (EMR) in primary care. Integrated within the EMR, the Interdisciplinary Healthcare Providers (IHPs) can efficiently identify frailty in patients aged 65 and older, as well as those with specific risk factors. The embedded tool guides the IHPs screening questions, offering resources to manage patients and facilitate referrals to appropriate services. Individuals identified as frail will be referred for a comprehensive assessment, during which providers will utilize evidence-based assessments to connect them with appropriate community supports and services, enhancing patient outcomes and experiences.

Implementation Approach:

- **Integration of Frailty Assessments**: Huron Shores FHT will implement a level 1 annual frailty screening for all individuals aged 65 and older, utilizing a modified version of the C5-75 screening tool and a fall screening tool. Based on these results, interventions such as referrals to community exercise classes or education may be recommended. Patients identified as frail through annual screening will undergo a multifactorial assessment to identify contributing factors. Following the assessment, a care plan, including appropriate referrals or interventions, will be developed to support the patient in achieving their care goals.
- **Healthy Aging Health Promotion:** A series of educational sessions will be offered in various communities to provide education around healthy aging. These sessions will cover topics such as modifiable risk factors, the concept of frailty, and available services. Special guests will present on different topics and resources will be made available to community members. As part of this program, the first annual Healthy Aging fair is being planned for the fall of 2024. The public education component is aimed at people of all ages, and not simply those 65 and older.

KW4 Ontario Health Team, in collaboration with Lawson Research Institute

At a Glance

Region: Ontario

Setting: Urban

EAIP program principle(s):

- Access to specialized healthcare services
- Access to social and community supports
- Access to system navigation and support

Implementation (new, spread, and/or expand): Spread

Team Profile

The KW4 Ontario Health Team (OHT) Integrated Care Team for Older Adults is a primary care-based support model that provides older adults with complex health conditions with direct access to a specialized geriatric integrated care team embedded within a primary care setting. The Integrated Care Team (ICT) provides integrated and geriatrician-supported multidisciplinary health and social care to older adults with complex care needs to provide person-centred and efficient care. The team is led by a nurse practitioner, supported by a geriatrician, geriatric psychiatrist, clinical pharmacist and other care professionals with geriatric expertise.

Community

- This initiative is targeted towards older adults who reside in the Kitchener-Waterloo region.
- Within the KW4 Ontario Health Team region there are 62, 811 people who are 65 years or older.
- Only 18% of family physicians in the region have access to a multidisciplinary care team.

Program Focus

Program Description

The KW4 OHT integrated care team aims to support the needs of older adults with complex health challenges early in their frailty journey to avoid urgent specialist intervention or institutionalization. The program aims to do this by:

- stabilizing at risk older adults,
- providing chronic disease/ geriatric symptom management and education,
- supporting system navigation and connecting patients/ caregivers to community resources
- providing mental health support for at risk older adults.

The KW4 OHT integrated care team also supports patients of primary care providers outside the New Vision Family Health Team integrated care team that do not have access to a multidisciplinary care team for older adults. By providing integrated care the program supports efficient access to necessary care and services, streamlined primary care, improved prescribing practices and reduced emergency department visits.

Implementation Approach:

- **Expedite Assessment and Referral to Community Resources:** Older adults and care partners receive supports from the ICT which significantly improves the timeliness of receiving a Comprehensive Geriatric Assessment and referral to appropriate community resources.
- **Person-Centred and Efficient Care:** The program provides integrated and geriatrician-supported multi-disciplinary health and social care to older adults with complex care needs to provide person-centred and efficient care. The co-location and interprofessional philosophy of the team ensures that care is coordinated, with the patient's goals and wishes known to all, such that care gaps, duplication, and mistakes are averted.
- **Support of Primary Care Providers:** Supports primary care providers who do not currently have access to a multidisciplinary team for older adults to reduce the primary care burden through a shared model of care provided through the integrated care team.

Mayne Island Assisted Living Society

At a Glance

Region: British Columbia

Setting: Rural

EAIP program principle(s):

- Access to specialized healthcare services
- Access to social and community supports
- Access to system navigation and support

Implementation (new, spread, and/or expand): New, expand and spread

Team Profile

The team leading this initiative is Mayne Island Assisted Living Society (MIALS) in collaboration from Mayne Island Health Centre Association (MIHCA), with support from Mayne Island Collective. Team members include representatives from MIALS and MIHCA who provide community engagement, data collection, program leadership, evaluation and advisory support.

Community

- Mayne Island, with an average resident age about 20 years older than the provincial average, faces significant challenges related to senior care and engagement.
- The island's rural and remote nature, accessible only by ferry, exacerbates feelings of social isolation and limits opportunities for seniors to age in place.
- The community includes a substantial number of older adults, a growing full-time resident population, and Indigenous peoples. This vulnerable senior population includes individuals with disabilities, mobility issues, and socio-economic barriers, all compounded by the island's isolation.

Program Focus

Program Description

The "Home Is Where The Heart Is" Improvement Bundle, jointly resourced and delivered by the Mayne Island Assisted Living Society (MIALS) and the Mayne Island Health Centre Association (MIHCA), is designed to support Mayne Island's aging population. This program includes four key components:

1. Community Bus Expansion to enhance mobility and access to healthcare services, addressing the need for reliable transportation to health specialist appointments
2. The Navigator Program to provide personalized assistance in accessing and utilizing community and health resources
3. Home Safety initiatives to ensure seniors' homes are safe, reducing the risk of accidents and improving living conditions
4. Mental Health Support for family members caring for aging islanders, offering resources and support to address support emotional and psychological well-being.
5. The program aims to build on existing community assets to improve the quality of life for older adults living on Mayne Island, providing them with supports and building capacity to age in place.

Implementation Approach:

- **Day Trippers Bus Program:** Continue and expand bus program to enhance mobility and healthcare access for older adults and community members, provided by partner organizations, with weekly trips to Sidney, Victoria, and surrounding areas with program supports, mobilizing bus drivers, ferry schedules, and volunteers.
- **Mental Health Stream:** New service offering a Caregiver Support Group, overnight respite pilot, and one-on-one therapeutic support, targeting caregivers' emotional and psychological needs, mobilizing local volunteers, retired care providers, and community venues, with limited respite offerings annually.
- **Home Safety:** Reestablish a medical equipment loan cupboard and introduce a Fall Prevention program, provided by host and partner organizations, focusing on safe home environments for seniors, mobilizing local resources and volunteers, with two to three equipment accesses per week.
- **Navigator/Advocacy Program:** Provide navigation and advocacy assistance for seniors, offered by host and partner organizations, using a NAV-CARE approach with online and in-person support, mobilizing over 42 local charities and non-profits.

Multi-Generational Housing and Community Centres Toronto

At a Glance

Region: Ontario

Setting: Urban

EAIP program principle(s):

- Access to social and community supports
- Access to specialized healthcare services

- Access to system navigation and support

Implementation (new, spread, and/or expand): New

Team Profile

This initiative is led by the Multi-Generation Housing and Community Centres Toronto, a faith-based community organization dedicated to providing information, awareness, education, services, and support to Ismaili Muslims in the Greater Toronto Area. The team includes representatives from the Multi-Generation Housing and Community Centres Toronto (specializing in seniors services, nursing, project implementation, and policy support), evaluation and research. Additionally, a community advisory group supports project development and implementation.

Community

- The program focuses on residents within a 10–15-minute drive from the Don Mills/Eglinton Road intersection, covering neighborhoods such as Thorncliffe Park, Leaside, Flemingdon, Banbury-Don Mills, and Golden Mile in Toronto.
- Thorncliffe Park, the primary target area, has a dense senior population, with approximately 10% of residents aged 65 or older and 38% of seniors living alone. Around 80% of the population belongs to visible minority groups, 46% are considered low-income, 74% have a mother tongue other than English, and 19% are recent immigrants.
- The neighborhood also features a diverse Muslim population, including the Ismaili community, with three Jamatkhanas serving as key community hubs.

Program Focus

Program Description

The Generations Toronto Integrated Seniors Health & Wellness Program (GenTO-ISHWP) targets homebound older adults with mild to moderate cognitive decline, aiming to reduce isolation and alleviate caregiver burnout. Set within a culturally and linguistically appropriate faith-based framework, the day program fosters social connections and a sense of belonging for culturally diverse, isolated, frail, and vulnerable Ismaili Muslim seniors. It promotes physical wellness, cognitive stimulation, social engagement, and emotional well-being. Additionally, the program provides information, education, navigational support, and respite care to caregivers, enhancing their capacity to offer quality care and delaying long-term care admission. Targeting individuals aged 65 and older with varying levels of mobility and assistance needs, the program encourages multi-faith family participation and primarily serves members of specific Jamatkhana locations in the Don Mills and Eglinton Crosstown corridor, with case-by-case considerations for participants from other areas in the Greater Toronto Area who can arrange transportation.

Implementation Approach:

- **Selection and Referral Process:** Develop selection criteria and intake/assessment tools for older adults with mild to moderate impairments to manage program capacity, design, expectations, and evaluation, and establish a "warm" referral process to enhanced adult day programs at partner organizations for those with moderate to complex needs.

- **Transportation and Scheduling:** Confirm community partnerships and secure paid, affordable private transportation support to ensure clients have access to transportation to and from the program. Pilot flexible day/time offerings with supported transportation to reduce barriers.
- **Staff and Volunteer Recruitment:** Recruit and orient a diverse staff and volunteer team in advance of program design, outlining anticipated roles and support options to facilitate implementation in a culturally and linguistically appropriate manner.
- **Community Advisory Group:** Establish a Community Advisory Group of diverse stakeholders to ensure the program meets the evolving needs of all involved and maintains a client-centered approach.

Newfoundland and Labrador Health Services

At a Glance

Region: Newfoundland and Labrador

Setting: Urban, Northern, Rural and Remote

EAIP program principle(s):

- Access to specialized healthcare services
- Access to social and community supports.
- Access to system navigation and support

Implementation (new, spread, and/or expand): New

Team Profile

Newfoundland and Labrador Health Services leads this initiative, with team members including interdisciplinary representatives from each geographic zone (Eastern Urban, Eastern Rural, Western, Central, Labrador-Grenfell). The team comprises directors, administrative leaders, and members experienced in quality improvement and evaluation. Patient and Family Experience Advisors also support this work.

Community

- All geographic zones (Eastern Urban, Eastern Rural, Western, Central, Labrador-Grenfell) will collaborate to support the senior population in aging in place with appropriate support and resources tailored to their specific needs.
- All geographic zones (Eastern Urban, Eastern Rural, Western, Central, Labrador-Grenfell) will collaborate to support the senior population in aging in place with appropriate support and resources tailored to their specific needs.

Program Focus

Program Description

The Acute Care of the Elderly (ACE) Strategy in Newfoundland and Labrador addresses the specific healthcare needs of older adults with acute medical conditions, frailty, and age-related issues. By employing an interdisciplinary team approach, ACE units aim to reduce patient length of stay, prevent deconditioning and

social isolation, and minimize readmissions. Research supports the benefits of ACE units, including fewer falls, reduced pressure ulcers, lower delirium risk, and decreased functional decline post-discharge. The strategy aims to enhance senior-friendly care, create supportive care pathways, and enable aging in place.

Implementation Approach:

- **Education and Training**: Provide comprehensive training for healthcare staff on ACE-related care, including screening tools, geriatric assessments, person-centered care, cultural competency, and dementia support strategies.
- **Interdisciplinary Team Development**: Facilitate regular multidisciplinary reviews to assess complex cases, promote team collaboration, and develop individualized care plans recognizing social determinants of health.
- **Patient Education**: Create tailored educational materials and sessions for older adults in the ACE unit, focusing on medication management, mobility, nutrition, fall prevention, and self-care, empowering patient participation.
- **Community Connections**: Strengthen ties with community supports, ensure awareness of the Home First Philosophy, and establish partnerships to provide necessary resources and follow-up care for patients transitioning from the ACE unit.
- **Establish ACE Units**: Develop new ACE units at Western Memorial Hospital (15 beds) and St. Clare's Mercy Hospital (26 beds) to support older adults with acute medical conditions and frailty, providing comprehensive services and individualized care plans.
- **Provincial Approach**: For zones not ready for a dedicated ACE unit, leverage working groups and learnings from existing units to incorporate senior-friendly services across the care continuum, enhance staff capacity, and create care pathways and linkages to support seniors in aging in place, varying implementation according to zone readiness.

Play Forever

At a Glance

Region: Ontario

Setting: Rural

EAIP program principle(s): Access to social and community supports

Implementation (new, spread, and/or expand): Expand

Team Profile

The organization leading this initiative is Play Forever, in collaboration with Crescent Village Housing Corporation and Toronto Seniors Community Housing. Team members include representatives from each organization, including directors, and program and technology coordinators.

Community

- This initiative is planned in the city of Toronto, Ontario, the largest city in Canada, with a population of over 3 million residents.

- Approximately 17% of Toronto's population is currently over the age of 65, a figure expected to grow to 19% by 2030. The number of dependents (older adults and children) is projected to increase from 55 to 64 per 100 working-age Torontonians by 2030.
- Toronto is a multicultural city, with nearly half of its population being newcomers to Canada and 52% identifying as visible minorities.

Program Focus

Program Description

- Play Forever offers a range of activities and services in the community aimed at promoting the physical and mental well-being of older adults in Toronto. The program emphasizes personalized navigation and accompaniment, health education and promotion, and chronic disease management. It also helps reduce loneliness and combat social isolation by organizing community events, workshops, and engagement activities.
- Through the EAIP initiative, Play Forever is expanding their program to address barriers such as digital inclusion, transportation/accessibility, and health literacy while enhancing cultural competence and language support.

Implementation Approach:

The organization plans to expand their services through partnering and supporting existing community programs and organizations to reach a broader audience and meet the evolving needs of the population.

- **Health and Tech Workshops**: Continue to offer workshops to build knowledge and capacity around nutrition, fitness, and chronic disease management. As well as provide technology workshops to enhance digital skills, connecting seniors to online resources and social platforms to support their independence.
- **Combat Social Isolation and Field Trips**: Plan to partner and strengthen relationships with local organizations, healthcare providers, community centers, and senior service agencies to leverage resources, expertise, and networks for planning community engagement activities. Organize field trips and social events to provide opportunities for seniors to connect, combat social isolation, stimulate cognition, and build meaningful relationships within their community.
- **Home-based and Flexible Services**: Integrate home-based services for seniors with health issues or caregiving needs, ensuring transportation assistance for those with mobility challenges. Introduce flexible programming options to accommodate varying schedules and preferences, provide caregiver support resources, and strengthen partnerships with community organizations to expand outreach and accessibility.
- **Build Cultural Competence**: Recruit a diverse team of staff and volunteers to enhance cultural competence and language support. Prioritize cultural competency training for program facilitators, involve community leaders in program planning, and ensure that activities are sensitive to diverse cultural backgrounds.

Prairie Mountain Health

At a Glance

Region: Manitoba

Setting: Rural

EAIP program principle(s):

- Access to specialized healthcare services
- Access to social and community supports
- Access to system navigation and support

Implementation (new, spread, and/or expand): Expand

Team Profile

The organization leading this initiative is Prairie Mountain Health (PMH). The collaborative team includes a variety of interdisciplinary staff including leadership (managers, supervisors and directors), as well as an Indigenous Health Community Liaison, and a Regional Lead and Clinical Change Lead to provide evaluation and measurement support.

Community

- PMH provides programs and services in rural, remote, and urban communities for southwest Manitoba, covering 64,800 km2. It runs east to west from the Saskatchewan border to Waterhen Lake, Lake Manitoba and Treherne and south to north from the United States border to the 53rd parallel.
- Brandon is the largest urban centre with a population of 51,313 and the second largest urban centre is Dauphin with a population of 8,457.
- There are 14 First Nation communities, Métis communities, towns and villages throughout the region.
- The largest proportion of the PMH population resides in the south zone of the region (44.5%). Geography and low population densities pose challenges with sustainability of services in parts of the region.

Program Focus

Program Description

- Prairie Mountain Health's (PMH) Service to Seniors Program (SSNP) aims to support seniors and their caregivers by enhancing access to essential resources and services, enabling seniors to age at home and delay entry to long-term care. PMH's Service to Seniors program recently expanded to include community Navigation Resource Coordinators. These Navigation Resource Coordinators will adopt a community development approach, engaging with each community to identify needs and challenges while enhancing the network of resources available to support seniors and their caregivers. The partnerships built and information gathered by the Navigation Resource Coordinators will be used to support seniors and their caregivers to navigate and access services to enable them to age at home.
- Collaborating with existing PMH programs, Indigenous Patient Advocates, and community partners, the Service to Seniors Navigation Resource Coordinators will leverage opportunities for seniors to engage socially, connecting individuals with appropriate resources, activities, and services such as social groups, art or exercise activities, and learning opportunities.

Implementation Approach:

- **Ideas Fair:** An Ideas Fair will be held annually in various places that are inclusive of the 52 communities supported by the SSNP. The Fair will be a key engagement strategy used to inform the services included

in the expansion of the Services to Seniors program. Sessions are tailored to capture what is offered in each community by listening to community connectors share their stories so that the gifts and assets that support Aging in Place can be identified and supported through this program.

- **Developing of an Aging in Place Central Database**: Develop a PMH database of up-to-date local programs and services available in each community. Navigation Resource Coordinators have visited all the communities and First nation communities within Prairie Mountain Health to learn what resources and programs are available for seniors. The Database will provide information to 34,288 seniors and 633 First Nation seniors in the region.
- **Development of Senior Friendly Resources:** Develop senior friendly written resources. Ongoing revisions will take place as information is received or existing information is changed and will be informed by both the Ideas Fair and the Navigation Resource Coordinators Asset Mapping of each community.

Saskatchewan Abilities Council Inc.

At a Glance

Region: Saskatchewan

Setting: Urban

EAIP program principle(s): Access to social and community supports

Implementation (new, spread, and/or expand): Expand

Team Profile

This initiative is led by SaskAbilities, a Saskatchewan based non-profit organization with offices in Yorkton, Moose Jaw, Saskatoon, Regina and Swift Current. Team members include representatives from SaskAbilities, interdisciplinary partners, evaluation and measurement support from Saskatchewan Health Quality Council, and Care Partners.

Community

- Yorkton is an urban center located in southeastern Saskatchewan on Treaty 4 Territory with a population of approximately 17,000 residents, of which 32% are seniors aged 55 plus.
- The SaskAbilities Yorkton branch serves the surrounding area of small rural communities that range in size from hamlets of 50 residents to villages and small cities of anywhere from 300 – 5500 residents.
- Rural living presents unique challenges such as limited access to healthcare and employment opportunities, inadequate infrastructure and transportation, social isolation, fewer cultural and recreational facilities, and difficulties associated with an aging population and healthcare shortages.

Program Focus

Program Description

The Dementia Friendly Life Enrichment Program (DFLEP), delivered by the Yorkton Branch of SaskAbilities, provides recreation and leisure services to individuals living with dementia to enhance their overall well-being and social determinants of health while offering respite to care partners. The program aims to improve social

inclusion, reduce isolation and stress, enhance care partner well-being, delay illness progression, and reduce reliance on the medical system through one-on-one support and monthly group activities.

Serving individuals with dementia and their care partners in Yorkton and surrounding rural communities, DFLEP is expanding to include new services and geographical areas. A needs assessment conducted in Phase 1 of the Enabling Aging in Place Collaborative demonstrated Swift Current is ready for expansion. The program aims to create inclusive communities where seniors can thrive and age in place. Future plans include expanding services by increasing group meet-ups, recruiting volunteer Peer Support Facilitators, and piloting and evaluating the DFLEP in a new community.

Implementation Approach:

- **Increase Frequency of Peer Support Group Meetings**: Expand peer support groups from one to four per month, held weekly in Yorkton and surrounding rural communities to improve social inclusion and reduce isolation for individuals living with dementia and their care partners.
- **Recruit Peer Support Facilitators**: Invite care partners of individuals who have transitioned to long-term care to continue participating in group meet-ups, share experiences, and assist with co-facilitating groups to maintain connections and purpose.
- **Pilot Program in Swift Current, SK**: Launch monthly Dementia Friendly Life Enrichment activities at the SaskAbilities - Swift Current main branch, starting in September 2024, to enhance social inclusion and support for individuals living with dementia and their care partners in the region.

Terrace Regional Hospice Network Society

At a Glance

Region: British Columbia

Setting: Rural

EAIP program principle(s):

- Access to specialized healthcare services
- Access to social and community supports
- Access to system navigation and support

Implementation (new, spread, and/or expand): New and expand

Team Profile

The team leading this initiative is Terrace Regional Hospice Network Society (TRHNS) in collaboration with Nav-CARE, United Way, Abbeyfield, and Pacific Northwest Division of Family Practice. Team members include caregiver navigators and coordinators, executive director, volunteers and community partners.

Community

- TRHNS is located in rural coastal Northern BC, serving an area slightly smaller than Prince Edward Island.

- Adults aged 65 and over make up approximately 15-20% of the population in many parts of Northern BC, with variations depending on specific communities and regional districts. Like other parts of Canada, Northern BC is experiencing an aging population, with the proportion of those aged 65 and older increasing.
- A significant portion of the population in Northern BC is Indigenous, with one-third of the people in this region being First Nations.
- Access to healthcare and social services can be more challenging in Northern BC due to geographic isolation and limited resources. There is a need for more senior-friendly housing and support services to enable older adults to age in place, including home care services, assisted living facilities, and community support programs.

Program Focus

Program Description

- Nav-CARE is a free program in rural coastal Northern BC, designed to support individuals with declining health through trained volunteer navigators. These volunteers assist with locating local services, providing transportation, re-engaging in hobbies, offering guidance for important decisions, and relieving feelings of loneliness and anxiety.
- The TRHNS Nav-CARE program is expanding to meet growing demand, including supporting Indigenous communities, launching a youth co-op program, and recruiting additional volunteers with comprehensive training. Recent achievements include securing a regional status, securing medical equipment donations, and developing partnerships with occupational therapists.
- New initiatives within the TRHNS Nav-CARE program include building a Dementia Connection Program, reactivating paused programs like Death Cafes and walks, and developing a circle of care with the health authority.

Implementation Approach:

- **Support Indigenous Communities**: Offer Nav-CARE and volunteer training (22 hours total) to Indigenous communities to encourage local volunteers to support aging in place.
- **Youth Co-op Program**: Provide a co-op program for local high school students with Nav-CARE training followed by volunteer training to increase care aid and nursing support in the community.
- **Volunteer Onboarding and Training**: Onboard and train at least 25 new volunteers with a comprehensive training program, including Nav-CARE and specialized volunteer training, followed by mentorship to expand capacity and meet growing referrals.
- **Expand Existing Service and Reduce Social Isolation**: Seek out funding for larger service space to expand services to social meals, hands on projects and various support groups (e.g., Book Clubs, Advanced Care Planning, Mourning Walks)

Town of Stony Plain

At a Glance

Region: Alberta

Setting: Urban and Rural

EAIP program principle(s): Access to social and community supports

Implementation (new, spread, and/or expand): Expand

Team Profile

The Town of Stony Plain is leading this initiative with the support of regional community collaborations.

Community

- The organizations serve Stony Plain, Spruce Grove, and Parkland County (Tri-Municipal Region). These areas are considered small, urban and rural.
- The target population includes vulnerable residents with diverse health and social needs and their care partners.
- Aging Population: In 2021, 13% of residents were aged 65 and older, a 72% increase since 2007, compared to 12% for Alberta. By 2027, 16% of the population will be 65 and older, compared to 17% for Alberta.
- Family Violence and Elder Abuse: In 2023, the Parkland RCMP recorded 1299 domestic violence cases, with 203 of these calls for individuals aged 60 and older.
- Poverty and Homelessness: In 2022, nearly 50 residents were houseless, and 1133 were at risk of homelessness in the Tri-Municipal area, with trends showing exponential growth.
- Newcomers: The 2021 Canada Census recorded 7,290 immigrants in the Tri-Municipal area.

Program Focus

Program Description

The Aging in Place Community Collaborative (AIPCC) envisions a safe and caring community that values the well-being of older adults, vulnerable adults, and care partners. The goal is to enable vulnerable residents with health and social needs to age well in community no matter what stage of life they are in. Key activities include:

- establishing a Community Connector position for personalized support and referrals
- continuous evaluation and improvement of programs and services
- increasing awareness through community outreach and training sessions
- building a robust collaborative with diverse stakeholders.

The overall mission is to reduce barriers, enhance access to support services, and create a supportive environment that empowers vulnerable residents to age well. AIPCC aims to foster a sense of community belonging and advocate for impactful solutions that benefit residents in the Tri-Municipal Region, ultimately improving health and social outcomes.

Implementation Approach:

- **Community Connector Program**: Establish a Community Connector role to provide personalized support and referrals, working closely with stakeholders to expand relationships, provide information on elder abuse prevention, dementia care, and aging in place, and enhance well-being and quality of life for vulnerable residents.

- **Programming and Community Awareness**: Continuously evaluate and develop programs based on participant feedback, focusing on creating meaningful connections for vulnerable residents, and providing support for care partners through community engagement and awareness initiatives.
- **Shifting Awareness and Perspective**: Increase awareness of the challenges faced by vulnerable residents, emphasizing community-based assets to strengthen resilience through initiatives like Senior Connect, Neighbourhood Connect, and training sessions on elder abuse prevention, poverty awareness and inclusion and diversity awareness.
- **Capacity Building Collaboration**: Build a robust coalition with diverse representatives from organizations and community members, consolidating efforts to improve outcomes for underserved residents by enhancing coordination, advocacy, and resource-sharing.
- **Evaluation and Continuous Quality Improvement**: On-going quality improvement using asset-based community development principles, evaluating and measuring outcomes to enhance program effectiveness, quality of life for residents, and incorporating feedback and data into program delivery.

Université Laval

At a Glance

Region: Québec:

Setting: Urban

EAIP program principle(s):

- Access to specialized healthcare services
- Access to social and community supports
- Access to system navigation and support

Implementation (new, spread, and/or expand): Spread

Team Profile

The team leading this initiative is made up of Université Laval, in collaboration with McMaster University, the VITAM research centre, the CIUSSS de la Capitale-Nationale and Dessercom. The members of this interdisciplinary team include clinical researchers, patient partners, program managers and community paramedics providing support to participants.

Community

- The Capitale-Nationale region is made up of Quebec City, six regional county municipalities (RCMs), one First Nations reserve, and one parish municipality (both outside of RCMs). The population of the Capitale-Nationale region (region 03) is approximately 760,000.
- Most of the population is urban. Initially, the initiative will focus on an urban area, before expanding to more rural regions.
- Approximately 20.8% of the population is aged 65 or over, and the region is experiencing demographic growth due in particular to increased immigration and reduced migration to other regions of Québec.

Program Focus

Program Description

In 2020, Dr. Gina Agarwal launched the CP@clinic and CP@home paramedicine programs to improve adult health and reduce 911 calls and hospital visits. The initiative, which has been successful in Ontario, will be piloted in Québec with a focus on chronic disease prevention and management, and health promotion among older adults. The program aims to improve health, reduce social isolation, and connect participants with primary care and community resources. Paramedical staff will conduct regular one-on-one meetings in subsidized housing units to provide health check-ups, training and referrals. The pilot project will target three subsidized housing buildings for a total of around 150 residents, with an ambulance and paramedical staff available one half-day per week. This free program has proven effective in reducing 911 calls, improving quality of life, and reducing the risk of chronic disease.

The main objective of the initiative is to assess the feasibility of implementing the CP@clinic program in the Capitale-Nationale region. Another objective is to explore the program's material impact on various health determinants, assess its effect on the use of pre-hospital emergency services and emergency room visits, and study its potential for delaying admission to a long-term care home.

Implementation Approach:

- **Partnerships:** Continue to develop relationships and partnerships with various organizations, providers, community members, and resident committees.
- **Training and education:** Train local paramedical staff on CP@clinic processes and protocols, and on data collection methods.
- **CP@clinic outreach:** Hand out flyers and hang posters in buildings, and post additional notices when paramedical staff are present. Use other dissemination channels in collaboration with resident committees.
- **Implement CP@clinic:** Hold a community paramedicine clinic once a week. A team of two paramedical staff will visit the three subsidized housing buildings for one half-day per week. These standardized visits will follow the CP@clinic program and will be adapted to the needs of the participants.