Creating Rural Foundations for Elder Independence in Tay Valley Township: Age-Friendly Community Planning

Tay Valley Township Age Friendly Working Group
February 27, 2017



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1. Introduction

What is an Age-Friendly Community?

The World Health Organization (WHO) developed a *Guide for Global Age-Friendly Cities* in 2007 to help plan for Age Friendly communities using eight topic areas:

The WHO defines age-friendly communities as “supportive physical and social environments that enable older people to live active and meaningful lives that continue to contribute to all areas of the community”.

An Age-Friendly Community is further defined as one in which service providers, public officials, community leaders, faith leaders, business people and citizens:

- recognize the great diversity among older persons,
- promote their inclusion and contribution in all areas of community life,
- respect their decisions and lifestyle choices, and
- anticipate and respond flexibly to aging-related needs and preferences.



In an Age-Friendly community, policies, programs, services and infrastructure related to the physical and social environment are designed to enable older people to live in security, enjoy good health and continue to participate in society in a meaningful way in order to enhance quality of life as people age. An Age Friendly community takes into account the biological, psychological, behavioural, economic, social and environmental factors that operate over the course of a person's life to determine health and well-being in later years.

Land use planners recognize that well planned physical environments benefit all ages. The *8 80 Cities* organization emphasizes, "If everything we do in our public spaces is great for an 8 year old and an 80 year old, then it will be great for all people." *8 80 Cities* has done work mostly in urban areas but Tay Valley Township shares their aim to improve the quality of life for people by bringing people together to enhance mobility and public space to create more vibrant, healthy, and equitable communities.

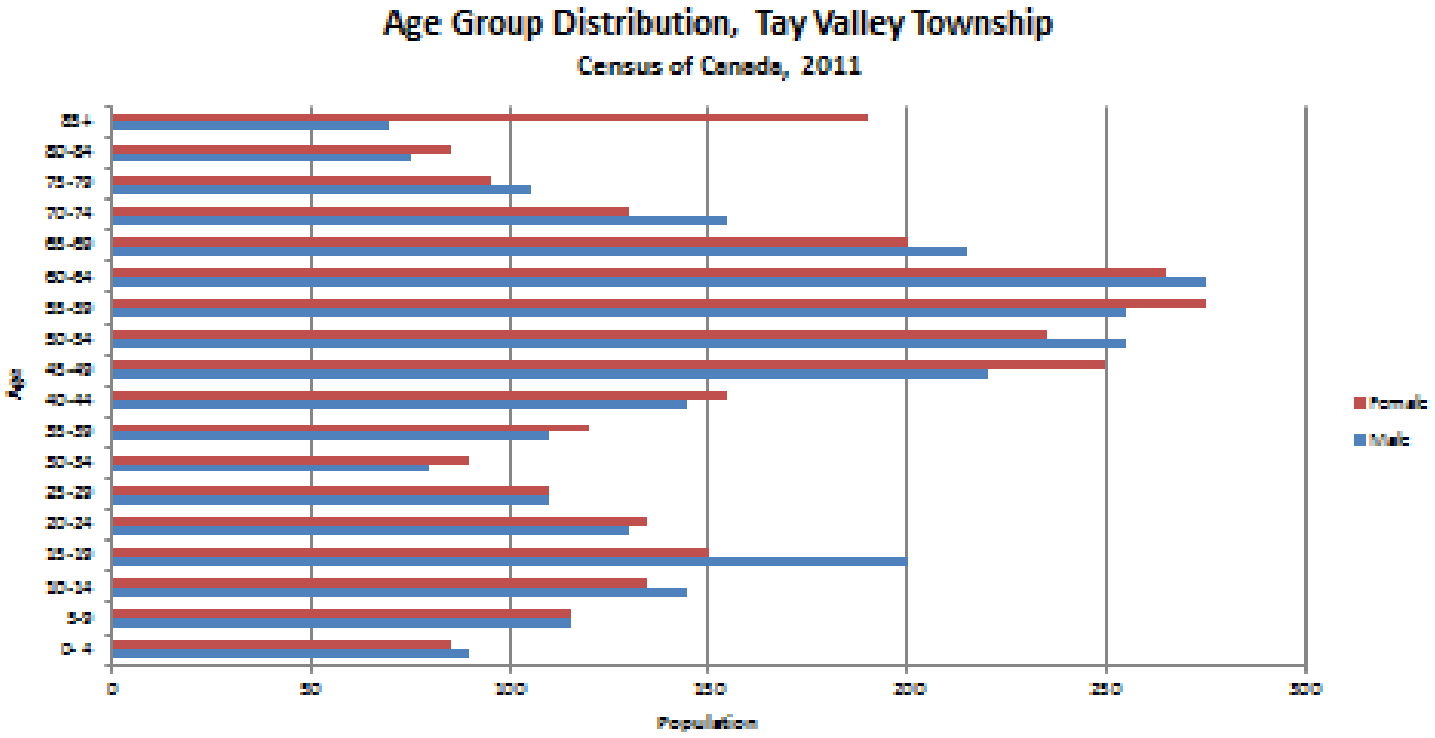
Why do We Need an Age Friendly Community Plan?

Tay Valley Township is a geographically large rural township in Eastern Ontario with a small population of 5,500 permanent residents which swells to approximately 8,000 residents in the summer. The Township recognizes that its population is aging and wants to be prepared for the "Grey Tsunami" and build on the potential "Boomer Bonanza" that may be represented by the demographic shift toward an aging population occurring in North America.

Rural areas in general have older populations than urban centres. However, the demographics of Tay Valley make planning for an age friendly community a top priority. According to the 2011 census, Tay Valley Township had **1.5 times the provincial average** of people above 55 years of age. Residents 55 years and older made up 42% of Tay Valley's population in 2011, while that age group only represented 27% of the population province-wide.

The bar chart below visually shows a spike in the population between 45 to 70 years old in Tay Valley Township and proportionately fewer residents in their 30s.

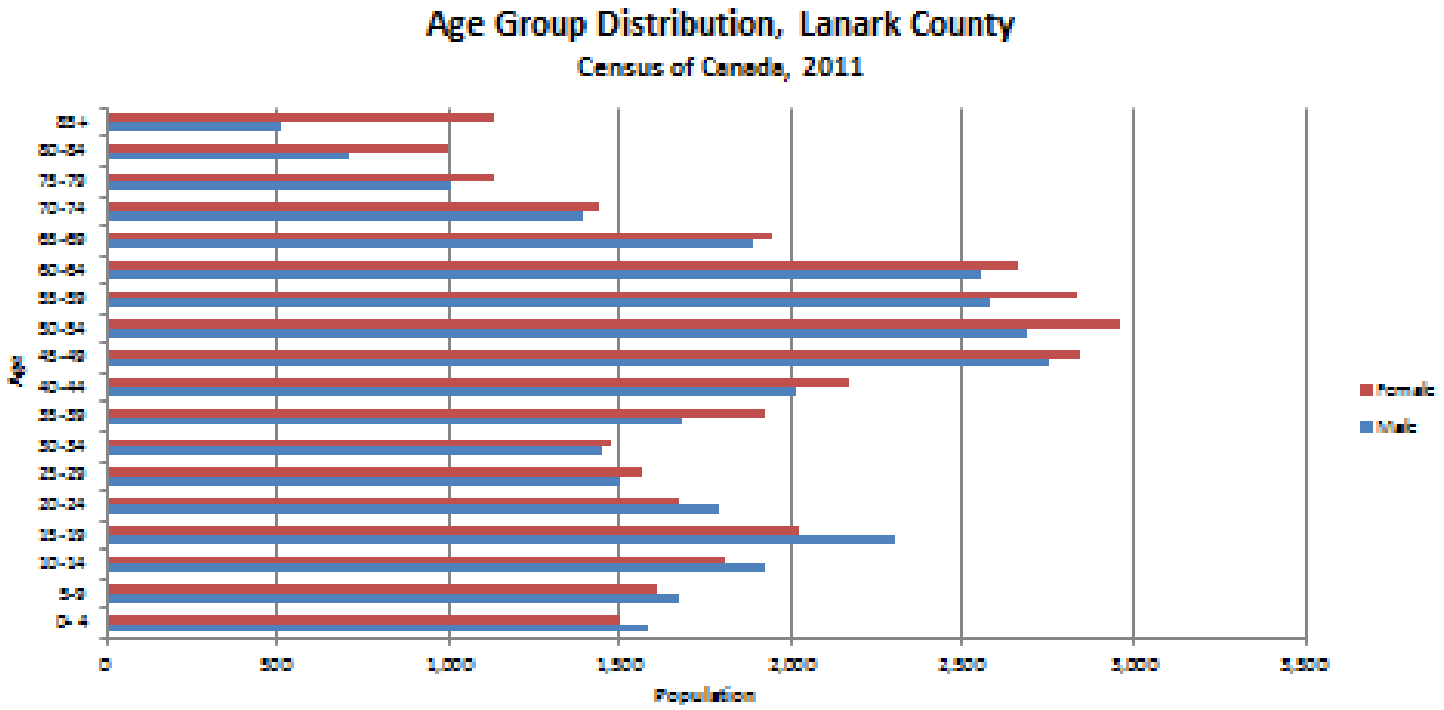
Tay Valley Township Community Profile





The following bar chart shows the population age distribution for all of Lanark County which while still representing an older population than the provincial average, is less skewed toward aging than Tay Valley Township.

Lanark County Profile





Developing the Plan

Tay Valley Township received an Ontario Senior Secretariat Grant that provided $24,117 in funding from October 2015 to December 2016. Through the Grant, Tay Valley Township undertook a number of activities to develop this Age-Friendly Plan including:

1. Established an Age-Friendly Working Group of residents from different parts of the Township chaired by a member of Council to act as a steering committee for the development of the Plan;

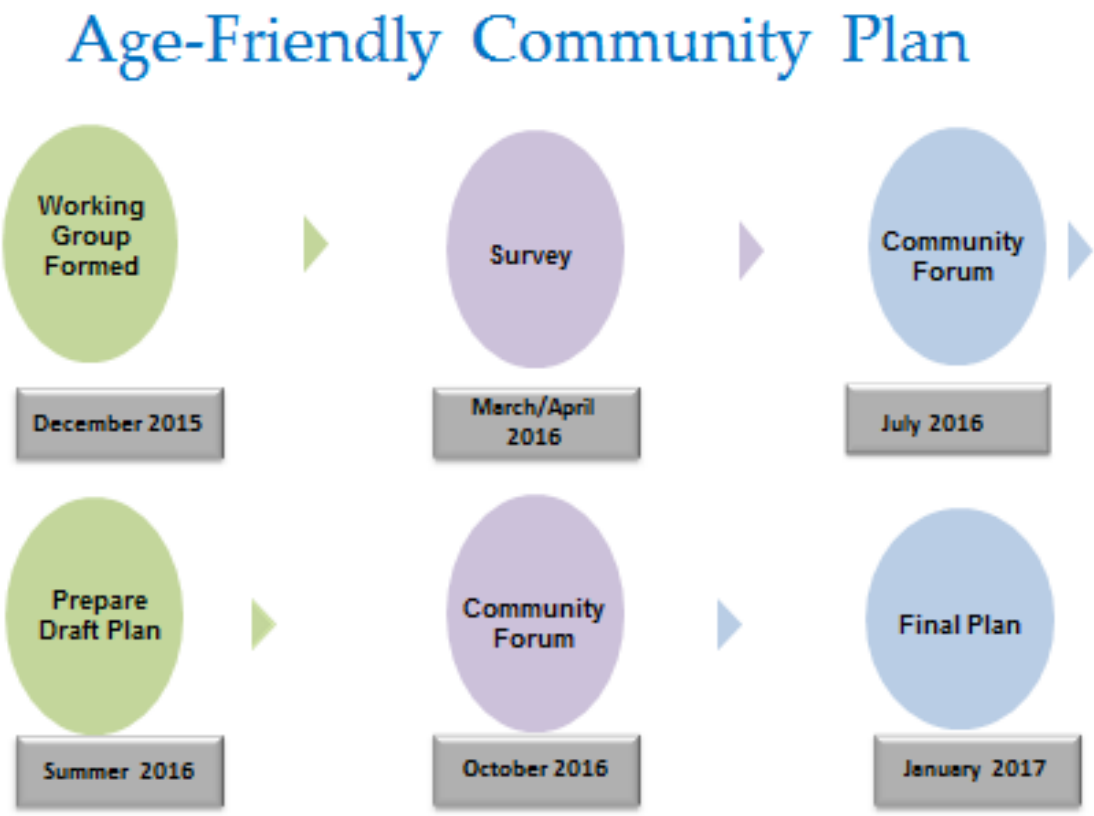
2. Established principles of an Age-Friendly Tay Valley Township;

3. Developed and distributed a survey for township residents assessing community services and needs of older residents;

4. Analyzed survey results and presented them to the public; and

5. Held five (5) public meetings and two community forums to develop an Age-Friendly Plan.

The Age-Friendly Plan will be part of the Township's Strategic Plan renewal in late 2016. The Plan will help to ensure the needs of older adults are considered at every stage of community planning and development.



The aim of this report is to capture the voices of older adults, explore what is working in Tay Valley Township to facilitate older residents to remain in Tay Valley as they age, and to identify gaps and opportunities for improvement.



2. What Our Residents Told Us

A survey of Tay Valley's 5,500 permanent residents was undertaken in April 2016 through internet and mail formats. The Township was pleased to receive 205 responses. (See survey results in Appendix B.) Eighty percent of the respondents were between the ages of 55 and 75. There was a proportional response from the three geographic wards (North Burgess, Bathurst, and South Sherbrooke). Twelve percent of the respondents were born in Tay Valley, 42% had retired to Tay Valley, 6% had moved away and returned.

Overall, residents were fairly satisfied with the services currently provided by the municipality. However, the area of most concern was the lack of alternative housing arrangements available in the Township for co-housing options or other innovative arrangements to allow older adults to remain in their homes as they age.

The lack of transportation options followed as a close second as an area of concern.

Cultural and recreational activities that overcome the issue of isolation are provided in various communities in the Township (through the Maberly Agricultural Society, the Althorpe/Bolingbroke Community Hall, the Brooke Valley community, St Bridget's Church in Stanleyville, and other churches throughout the Township). However, there are gaps in community gathering spaces and in the transportation needed to access them.

This section of the report summarizes the survey results and as well as the results of the first Community Forum held on July 11th, 2016. The forum was attended by 35 residents and service providers including Lanark County, the Lanark Leeds Grenville Health Unit, Perth Co-housing, Perth Enrichment Program, and the Mills Community.

Input was gathered after the Community Forum from other service providers who could not attend including CARP Lanark, and the Alzheimer Society of Lanark County.



Priorities	What's working	What we need to improve
Outdoor Spaces and Public Buildings	Public Buildings are accessible Green spaces and outdoor seating are well maintained and safe	Lanes for scooters and bicycles Accessible trails, parks Safety for pedestrians
Transportation	Road signs are easy to read	Affordable and accessible transportation for people with disabilities Availability and affordability of taxis Car pool, shuttle and volunteer options Create Public Transit
Housing		Supports of adults to remain in homes e.g., meals, housekeeping, personal care Amount of subsidized (rent geared to income) living spaces Options for innovative housing The number of long term beds available



Priorities	What's working	What we need to improve
Health	Most health care providers are sensitive to the unique needs of aging adults Health services are generally available when you need them	Mental health care for men and women
Social and Recreational	Clubs and social groups in the Township and surrounding area offer a wide variety of activities Activities are largely affordable There are good volunteer opportunities for aging adults	Respite care Variety of types of recreational activities Educational opportunities Employment opportunities
Other Necessary Services	This is a safe and secure community Retail staff are courteous to older people Older adults are welcomed at community events Older adults are recognized by the community for their past and present contributions and achievements	Short term financial relief options Garbage pick up Information on services



3. Principles of an Age-Friendly Tay Valley Township

Vision and Principles

Tay Valley Township values each of its residents. The Township further recognizes that many of our older residents can contribute to our community through their experience, wisdom, mentoring capabilities, economic capacity and other vital attributes.

Our vision is for a community where people can live healthy and active lives well into their senior years; where older people are valued for their skills and life experiences, and where they participate in the community in ways that they choose.

Principles endorsed by Tay Valley's Working Group:

Identifying opportunities for older residents to provide input into municipal decision-making.

Ensuring older residents are included in community activities including decision-making processes and events by following the Ontario guidelines for *How to Make Your Event Accessible* and by ensuring adequate transportation or technological innovations are available.

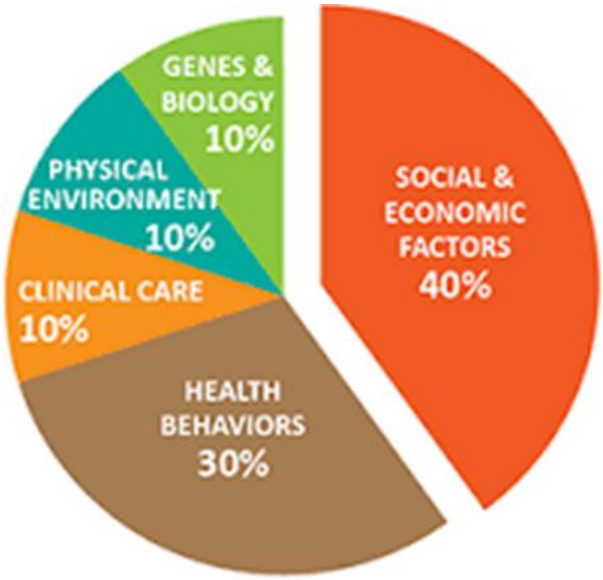
Ensuring opportunities for access to appropriate housing, medical care, preventative programs, and recreation opportunities are available in community hubs or nearby towns/urban centres.

One of the participants in the Township's first Community Forum said, "Our focus should be on not leaving anyone behind".



4. Goals for Creating an Age-Friendly Tay Valley Township

One of the interesting ideas to come out of the first Community Forum was the idea that health is not only the responsibility of doctors and hospitals. In fact, research has determined that access to health care only represents about 10% - 20% of a person's health.



DETERMINANTS OF HEALTH

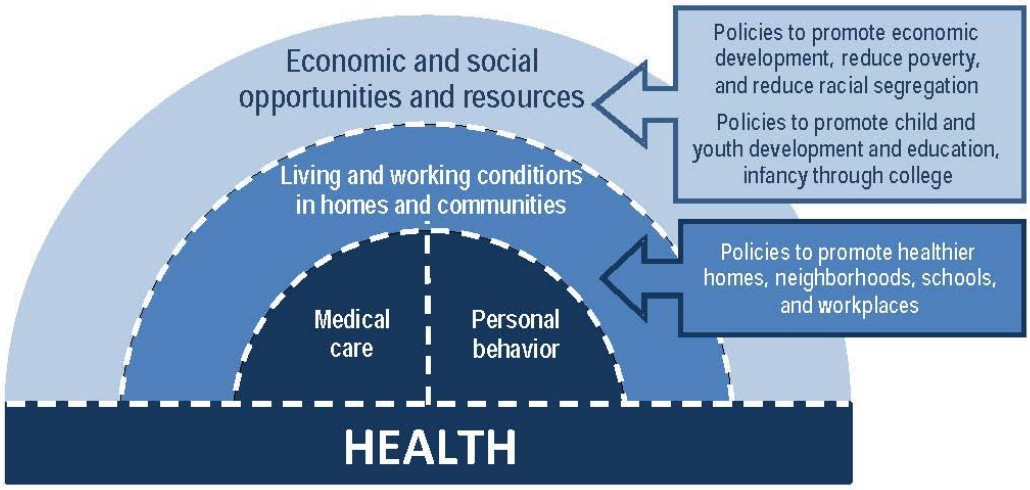
One of the participants at the first Community Forum introduced the topic of the social determinants of health and how they influence the health of populations. These factors include:

- income and social status;
- family/social support networks;
- education; employment/working conditions;
- social environments; community safety;
- built environment; environmental quality;
- personal health practices and coping skills;
- access to care; quality of care;
- gender; culture.

A report on Canada's health written in 2010 called *Social Determinants of Health: The Canadian Facts* makes the following powerful statement on the effect community policies can have on health:

> "The truth is that Canada – the ninth richest country in the world – is so wealthy that it manages to mask the reality of poverty, social exclusion and discrimination, the erosion of employment quality, its adverse mental health outcomes, and youth suicides. While one of the world's biggest spenders in health care, we have one of the worst records in providing an effective social safety net. What good does it do to treat people's illnesses, then send them back to the conditions that made them sick?"

The impact communities can have on health is shown in the diagrams below:





This report was written in the months leading up to Habitat III, a major global summit, formally known as the *United Nations Conference on Housing and Sustainable Urban Development*, to be held in Quito, Ecuador, on 17-20 October 2016.

The first UN conference on human settlements was held in Vancouver in 1976. At that time Prime Minister Pierre Trudeau stated, “Human settlements are linked so closely to existence itself, represent such a concrete and widespread reality, are so complex and demanding, so laden with questions of rights and desires, with needs and aspirations, so racked with injustices and deficiencies, that the subject cannot be approached with the leisurely detachment of the solitary theoretician.”

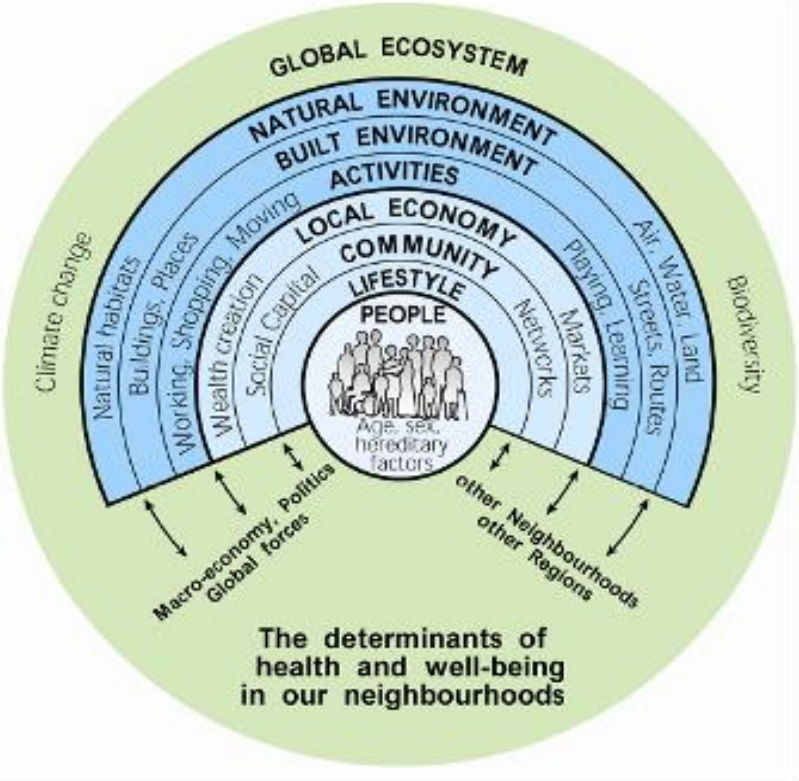
This report strives to take seriously the responsibility to shape human settlements that work for people and to build on the optimistic approach embodied in Habitat III to see the “senior surge” as a generative force providing opportunities for new forms of community.

Participants in the first Community Forum suggested that Tay Valley Township has a number of assets either owned and operated by the municipality or owned and operated

by community groups that could help improve the health of senior residents when looked at through a broader definition of community and health.

For example, the township's Re-use Centre, strong artistic community amenities, the collaborations for the 200th Anniversary that could be continued into 2017 for Canada's 150th celebrations, recreation programming (intergenerational choir, Blue skies Community Fiddle Orchestra), the public swimming pool shared with the Town of Perth, Public Library, Hospital resources, 13 lake associations, Maberly Post Office, and the Maberly Agricultural Society. All of these amenities represent social opportunities that can overcome a negative impact on health - isolation.

The first Community Forum also identified a number of areas that could be improved including: the lack of a single community centre in Tay Valley, the underservicing of Perth with medical staff, additional areas of collaboration between municipalities, the demand on Perth Hospital as it is the last hospital between Carleton Place and Bancroft, the underserving of mental health, the underutilization of some of our assets (Burgess Hall and ABC Hall).





While the title of the grant application for this project was *Creating Rural Foundations for Elder Independence in Tay Valley Township,* the Working Group members and participants in the first Community Forum have suggested innovative approaches to land use for housing, transportation options and social supports that promote independence through **interdependence**.

At the 2016 OPPI conference, Dr. Lewis stated that this trend toward interdependence is an emerging one around the world. Older people are no longer calling for aging in place (in senior "ghettos" isolated in suburbs or on farms) but aging in community. It is the hope of Tay Valley's Working Group that the suggestions to follow would become part of the Township's *Strategic Plan* to deliver a better Tay Valley Township.



5. Implementations

PRIORITY ACTIONS & LONG-TERM GOALS

CATEGORY – HOUSING

Priorities	Deliverables	Potential Partners	Timing
Zoning and Building By-Laws	Change Zoning & Building By-Laws to allow secondary suites, co-housing options, tiny homes (energy efficiency and water conservation), modular homes, and estates.	*Canada Mortgage and Housing Corporation* *County of Lanark*	1 year maximum
Adaptable Guidelines	Enable guidelines for new residential development and classifications of residential construction.	*Algonquin College* *Chief Building Official*	2-3 years
Model Development	Develop a Co-Housing model for the township.	*County Associations* *Adjacent Townships*	2-3 years
Income and Affordability	Deliver solutions for income and affordability issues.	*County of Lanark* *Statistics Canada* *Builder's Associations*	1 year



PRIORITY ACTIONS & LONG-TERM GOALS

CATEGORY – TRANSPORTATION

Priorities	Deliverables	Potential Partners	Timing
Public Transit System	Follow up on Lanark County's Transportation Master Plan in relation to what applies to Tay Valley's aging residents.	*County of Lanark* *Adjacent Townships*	1-2 years
Roadway Facilitation	Implement paved or widened shoulders for pedestrians or those using assisted devices (scooters), with emphasis on access to community hubs, including clearly marked roads.	*Trail Organizations* *Adjacent Townships*	December 2017
Infrastructure and Demarcation	Provide pedestrian/cycle infrastructure to increase kms (active transportation to annual commitments), safe bus shelters/carpools defined with demarcation for pedestrians and cyclists, ID priority locations with public, improvements to streetscapes for safety and visibility at crossings (Fallbrook).	*Provincial (Funding)* *County of Lanark* *Public Works Dept.*	August - December 2017
Physical Transport Options	Pursue VIA Rail opportunity for high speed connections to Ottawa, rural hub connections (Maberly to Perth), BUDD train car on existing rural track, self-driving electric cars and charging stations, drone deliveries, and Uber.	*Provincial Levels* *BUDD train car (Sault Ste. Marie - Sudbury)* *Trail Organizations* *Adjacent Townships*	2 years



Township Services	Provide garbage pick-up and keep one waste site open, selective pick-up at door; range of possibilities required, not a blanket approach.	*Public Works Dept. - Waste Management Plan* *Adjacent Townships* *Non-Profit Organizations* *Service/Private Companies*	1 year

During the October 31st Community Forum, the group discussing transportation added further comments that were not previously illustrated.

It is important for residents to be able to:

- get to a bus stop
- safe walking to a bus stop
- collector service to a bus stop
- safe, comfortable place to wait
- taring and chipping the edges of the roadways has not been previously helpful as there is no white indicator line on the right-hand side of the road (for drop-offs and self-driving cars)
- utilize township map to draw priorities for community members



PRIORITY ACTIONS & LONG-TERM GOALS

CATEGORY – HEALTH & SOCIAL INCLUSION

Priorities	Deliverables	Potential Partners	Timing
Communication Services	Good cell phone and broadband service for all Tay Valley residents. Information communicated by the township on health services, recreation, interesting places and activities, and internet accessibility. Create bi-weekly seniors' column in the local newspapers and township webpage with social media dedicated to seniors. Provide 211 magnet (i.e. Kingston). Provide rural mail delivery as opposed to community mailboxes that freeze in winter. Publish senior's magazine.	*County of Lanark* *Eastern Ontario Warden's Caucus* *Sustainable Economic Development Working Group* *Adjacent Townships* *Local Newspapers* *Clerk's Department* *Canada Post* *Various Chamber of Commerce resources*	1-2 years
Health & Recreation	Promote available health resources & programs (Stay on Your Feet, Falls Prevention, SafeTalk, etc.) Encourage intergenerational story writing in schools (publish in papers & website on National Senior's Day); bring seniors and teens together. Offer senior's programs & seminars (guided walking, gardening, food & food security, sports supported by the	*Clerk's Department* *School Boards* *Newspapers* *The Table* *Recreation Committee* *Treasurer*	2017



Health & Recreation (Continued)	Town of Perth, fire safety, elder abuse and fraud awareness). Review fee structure for senior's programs. Support a sesquicentennial trails project. Continue support for Blue Skies Fiddle Orchestra (intergenerational opportunity). Partner with Community Alliance for Refugee Resettlement (CARR) to promote recreation for new immigrant seniors. Promote transportation (trail & bus stop construction), companion shopping & income tax assistance volunteer service programs.	*Lanark County Trails* *Health Units* *Hospitals* *CARR* *YAK* *Churches* *County of Lanark* *Fire Services* *Perth Enrichment Program* *Town of Perth*	2017
Policy	Waive building permit fees for Lanark Lodge Trail and subsequent related work. Continue Community Asset mapping project. Participate in Local Health Integration Network reorganization to ensure there is a Mississippi Rideau Tay Health Hub. Co-ordinate with Upper Canada District School Board on use of Glen Tay School as intergenerational community facility.	*Clerk's Department* *Local Businesses* *Lanark County Community Groups* *Township Committees* *Adjacent Townships* *County of Lanark* *Mills Corporation* *UCDSB* *Doctors*	2017



Policy (Continued)	Develop smaller centres for drop-in activity or use current local facilities (St. Stephen's Church) and rethink updating to 21st century. Provide senior's centre housed in an active elementary school or daycare (west end of township). Continue to monitor accessibility requirements at recreational facilities. Provide infrastructure for pop-up stores, mobile clinics and retail, and include in township Asset Management Plan. Involve seniors in advisory committees and task forces.	*Local Developers* *Community Care Groups* *Local Health Units* *Ministry of Municipal Affairs and Housing*	2017

During the October 31st Community Forum, the group discussing health and social inclusion categorized the following comments below:

Communications
Council needs to develop a communications policy/strategy and a staff member's percentage of time dedicated to keep the website up to date on senior's information.

Program and Service Delivery
Council needs to support and facilitate connecting all ages 8-80 (+/-) for gardening and reading with students and support a volunteer coordinator (check with local residents for support staff options).

Policy
Support a community use of the Glen Tay School and all township halls to insist and enable the integration of regional health services; Local Health Integration Network focus.

Next Steps: The Working Group suggested that building awareness of this report and identifying opportunities for volunteers should be the immediate next steps.



6. Appendices

A Community Service Inventory
B Survey Results
C Rural Health Hubs
D Co-housing Resources
E Eden Aging



Appendix A

Age-Friendly Community Service Inventory

Tay Valley Township & Area

Service	About	Phone #	Website	Service Area
CarePartners Mobile App	An App that assists Caregivers in taking care of their Loved ones.	N/A	N/A	World-wide
South East Community Care Access Centre	Central Hub with available information on various topics.	613-310-2222	www.southeasthealthline.ca	South-East Ontario
Perth Enrichment Program	Day Program for Older Adults	613-201-7172	www.morepep.ca	Perth & Area
Community and Primary Healthcare Caregiver Support Service	- Supports: Alzheimer's/Dementia, frail adults, physically challenged 18+ - Leeds, Grenville, Lanark	613-342-3693 Toll Free 1-800-465-7646	www.cphcare.ca	Leeds, Grenville, Lanark
Community Home Support-Lanark County	Services for Seniors & Adults with Physical Disabilities.	613-267-6400	http://www.chslc.ca/	Lanark County
Bereavement Support & Resource Centre	-Grieving Support Group. - Run by Community Home Support-Lanark County - 2nd Tuesday of each month	613-267-6400	http://www.chslc.ca/	Lanark County
211	Phone service that helps people find the right community and social services.	211	www.211ontario.ca	Ontario
Perth Seniors Fellowship	"Serving social, intellectual and recreational needs of our mature adult community…"	613-267-5531	http://www.perthseniors.ca/	-Perth & Area -McMartin House
Town of Perth- Events Calendar	-Shows the various events going on in the Town of Perth. - Ex. Bingo every Wednesday	(613) 267-3311	http://perth.civicwebcms.com/calendar	Perth & Area
Tay Valley Township-Events Calendar	Shows the various events going on in Tay Valley Township.	613-267-5353		Tay Valley Township & Area
Leeds, Grenville & Lanark District Health Unit	Offers wide range of services that help promote healthy living and growth.	Paula Stewart -Medical Officer of Health -613-345-5685	http://www.healthunit.org/	Leeds, Grenville Lanark County
Perth & District Union Public Library	Offers Services for Seniors.	613-267-1224	http://www.perthunionlibrary.ca/seniors.html	Perth & Area
Maberly Agricultural Society	Provides regular social gathering.	613-268-2589	N/A	Tay Valley Township & Area
ABC Hall	Hosts various social, recreational and physical activities for members of the community.	(613) 273-5717	http://abchall.ca/	Tay Valley Township & Area
CARP	National, non-partisan, non-profit organization that advocates for financial security and improved health care for Canadians as we age.	Tom Baumgartner - 613-259-2201	carplanark@gmail.com	-Canada -Lanark County Chapter
Alzheimers Lanark Lodge	-Long Term Care Facility -Hosts Alzheimer's Society of Lanark County	613-267-4225	http://www.county.lanark.on.ca/Page1950.aspx	-Located in Perth -Serves Lanark County
Lion's Hall	Social Community Group that participates in various are events.	613-264-8449	http://e-clubhouse.org/sites/perthon/	Perth & Area
The Table	-A Community Food Centre which serves as a Food Bank and offers Community meals. -Offers various events throughout the year.	613-267-6428	http://thetablecfc.org/	Perth & Area



The Probus Club of Perth	An organization of retired men & women who want to maintain a social network with those of similar interests.	613-264-2609	www.probusperth.ca	Perth & Area
Perth Cohousing Initiative	A community of seniors who look forward to living independently in an atmosphere of neighbourly caring & support.	613-264-8590	www.perth-cohousing-initiative.com	Perth & Area
Lanark Transportation Association	-Transportation to and from medical and other specialized service. -Free subsidy available to qualifying clients	613-264-8256	http://www.southeasthealthline.ca/displayservice.aspx?id=72697	Lanark County



Appendix B

Age Friendly Community Plan- Survey Results

Celebrating Our Heritage
TAY VALLEY
200
1816 • 2016

Ontario

Q1: Outdoor Spaces and Buildings within Tay Valley Township

- 1. Green Spaces & Outdoor seating are sufficient in number, well maintained and safe.
- 2. Services are situated in convenient locations.
- 3. Public buildings are accessible for handicapped individuals
- 4. It's not easy for aging adults to get around as pedestrians.
- 5. There are no adequate lanes for bicycles and scooters



Q2: Transportation

- 1. Township road signs are easy to read and understand.
- 2. A Public Transit system is needed.
- 3. Public transit to get to Perth or Carleton Place.
- 4. Affordable and accessible transportation is not available for people who are disabled.
- 5. Taxis are not accessible nor affordable.
- 6. There are no/few good options for volunteer, shuttle or pooled driving.

Q3: Housing

- 1. There are no sufficient supports to allow aging adults to remain in their homes (e.g. meals, housekeeping, personal care).
- 2. There is not an adequate amount of subsidized (rent geared to income) accommodation.
- 3. There is not an adequate number of retirement homes in the community.
- 4. There is not an adequate number of long-term care beds in the community.
- 5. Sufficient housing appropriate to the needs of aging adults is not available in Tay Valley Township.



Q4: Health

- 1. There is an adequate range of medical services available in the area.
- 2. Health services are available when you need them.
- 3. Most health care providers are aware and sensitive to the unique needs of aging adults.
- 4. Accessibility to meal arrangements is available and well-coordinated (e.g. Meals on wheels, the Table, Food Bank).
- 5. There is not enough adequate mental health care for women.
- 6. There is not enough adequate mental health care for men.

Q5: Social and Recreational

- 1. Clubs and social groups offer a wide variety of activities of interest to aging adults in the Township.
- 2. Clubs and social groups offer a wide variety of activities of interest to aging adults in the surrounding area (e.g. Perth).
- 3. Activities and attractions in the area are affordable.
- 4. There are a lot of ways to meet other aging adults.
- 5. There are enough volunteer opportunities for aging adults.
- 6. There is not adequate respite/hospice care in the area
- 7. Recreation facilities are not meeting the needs of aging adults.
- 8. There are not enough educational opportunities for aging adults.
- 9. There are not enough employment opportunities for aging adults.



Q6: Other

- 1. This is a safe and secure community for aging adults to live in.
- 2. There is a good variety of shopping options for aging adults in the area (e.g. groceries, clothing).
- 3. Retail and store service staff are courteous and helpful to aging adults.
- 4. Aging adults are welcomed at community events, activities and settings.
- 5. Aging adults are recognized by the community for their past and present contributions and achievements.
- 6. There is adequate information about services and resources readily available to aging adults.
- 7. Decision-making bodies welcome and use input from aging adults (e.g. Council, local health acre departments).

Q6: Other Cont'd

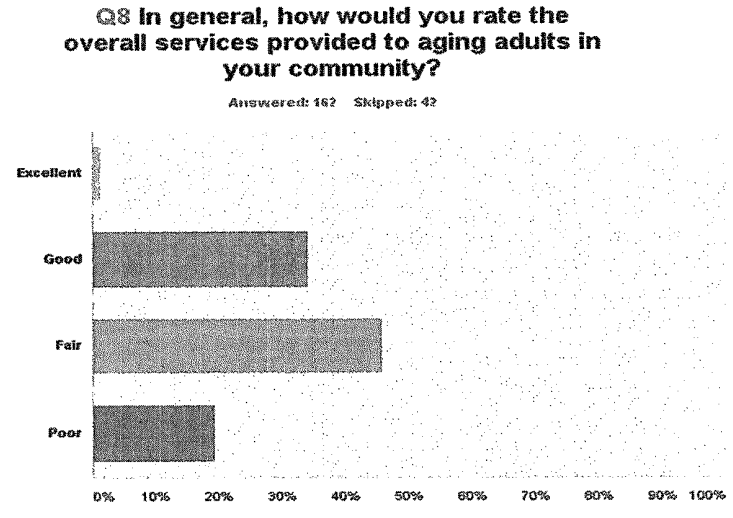
- 8. Cost-relief and financial support is not available to aging adults who need it.
- 9. There is not enough adequate services available for seasonal outdoor home maintenance (e.g. snow removal, landscaping).



Q7: Necessary Services that do no Exist in Tay Valley Township

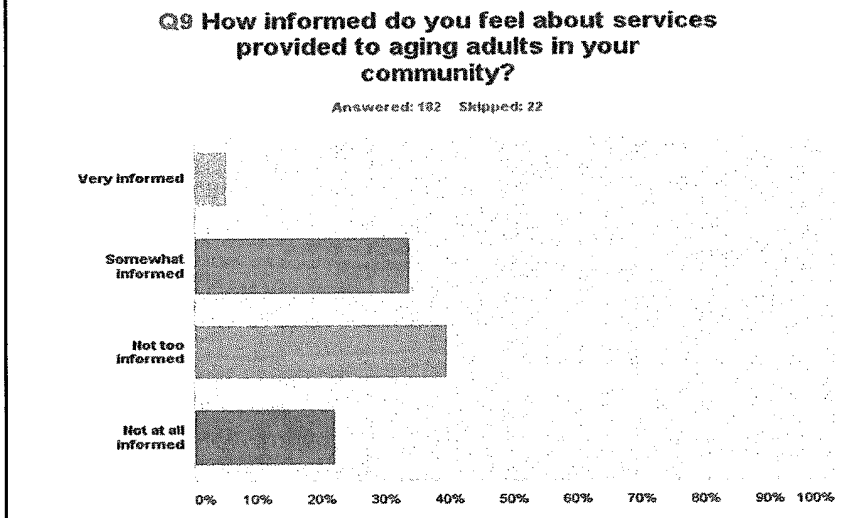
- This question was comment based. Here are the main topics of the comments:
- 1. Garbage/Recycling Removal
  - "Garbage pick up"
  - "Garbage pick up/ recycling for those house bound is needed"
- 2. Make information more easily available
  - People don't know about the services offered
  - "More information on what services are available"
  - "More promotion to the community of the available local services"
- 3. Lack of Public Transit:
  - All the services are in Perth and hard to get to.
  - Difficult to get to appointments.

Question 8





Question 9



Q10: A number of barriers to aging adults are presented below.

Barriers	Not a Concern	Somewhat a Concern	Large Concern	N/A
Operating hours for support services	**38.10 %**	34.01%	6.12%	21.77%
Geographic location of services	22.97%	**46.62%**	15.54%	14.68%
Stigma related to accessing services	**43.54%**	24.49%	7.48%	24.49%
Long wait lists/ wait times	11.49%	26.49%	**33.78%**	18.24%



Q10: Cont'd

Barriers	Not a Concern	Somewhat a Concern	Large Concern	N/A
Prohibitive admission criteria	**28.08%**	22.60%	16.44%	32.88%
Lack of awareness of services	11.41%	**44.30%**	35.57%	8.72%
Financial out-of-pocket expenses	14.86%	**33.11%**	30.41%	21.62%
Physical mobility	27.70%	**29.05%**	21.62%	21.62%
Transportation	21.48%	27.52%	**35.57%**	15.44%
Language/Cultural Differences	**62.42%**	8.05%	5.37%	24.16%

Q11: Obstacles that interfere with aging adults receiving services

- This question was comment based. Here are the main topics of the comments:
- 1. Road condition
  - Due to state of the roads an individual has to have constant vehicle repair
- 2. Size of area
  - Large geographical area.
  - Difficult to get the services needed. Majority of services are located in Perth
  - Example, Doctor appointments
- 3. Make information more easily available
  - Don't know about services offered or how to get access to them
  - "Communication to the public"



Q12: One Suggestion to improve healthy aging

- This question was comment based. Here are the main topics of the comments:
- 1. Transportation
  - Accessible transportation opportunities
  - Transportation for shopping and health care services
- 2. Lower Taxes/other expenses
  - "Lower taxes or defer taxes for seniors"
  - "Lower my taxes. For my small home they are too high"

Q13: Additional Comments

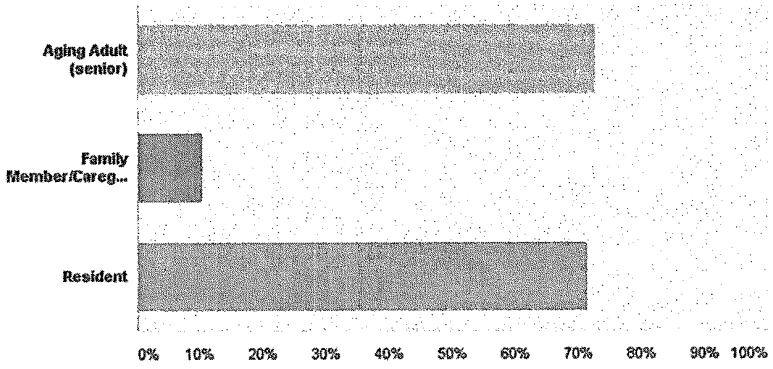
- This question was comment based. Here are the main topics of the comments
- 1. The majority of services are in Perth. Possibly provide services to peoples home?
- 2. Make the services/information more readily available
- 3. Promote the services that are offered. Hard to know of the services available
- 4. Affordable and accessible public transportation for seniors



Question 14

Q14 Did you answer this survey as an: (Check all that apply)

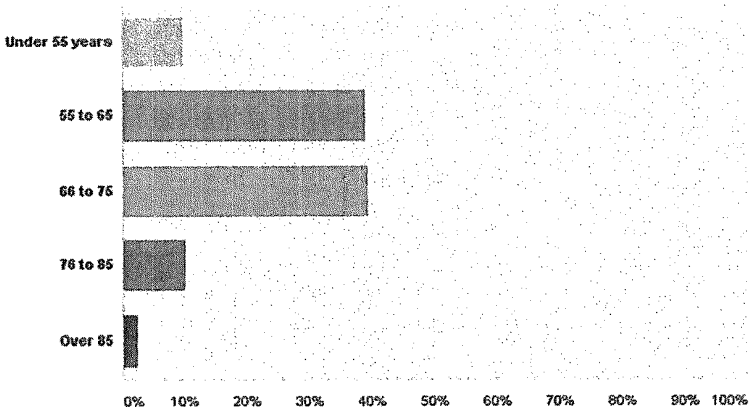
Answered: 175 Skipped: 29



Question 15

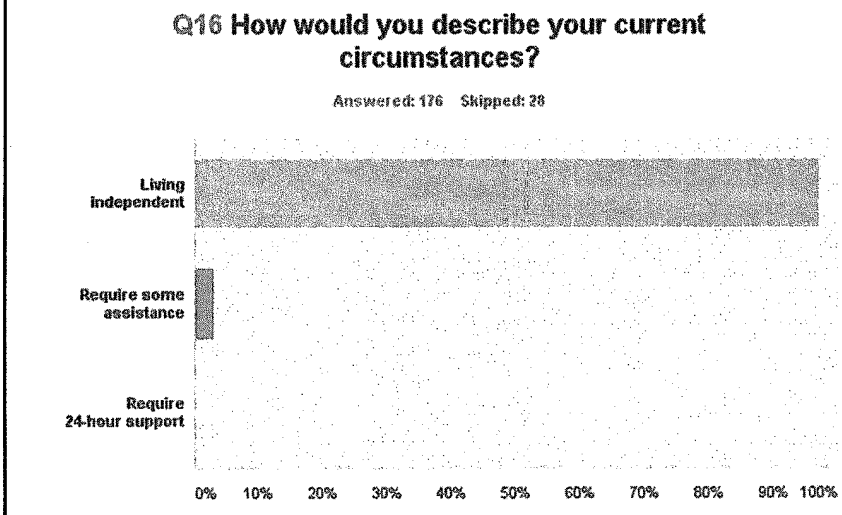
Q15 Your age:

Answered: 178 Skipped: 26

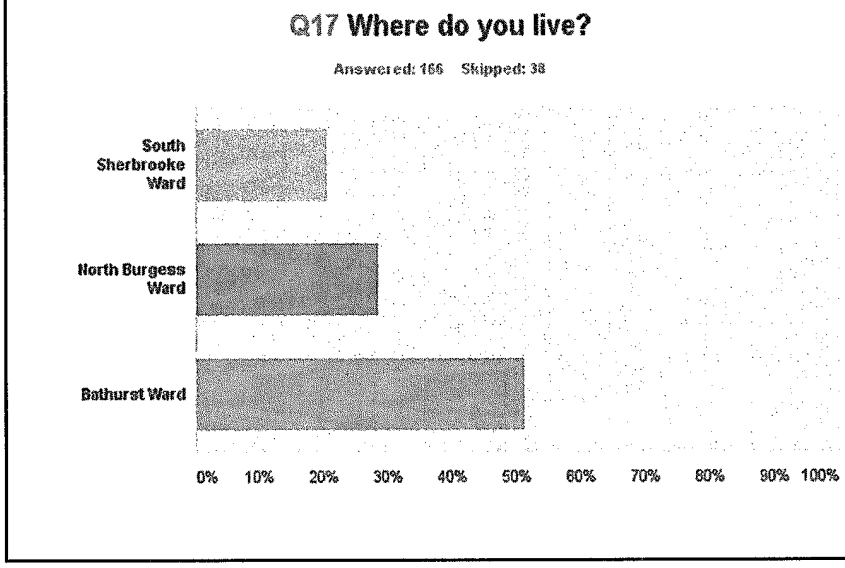




Question 16

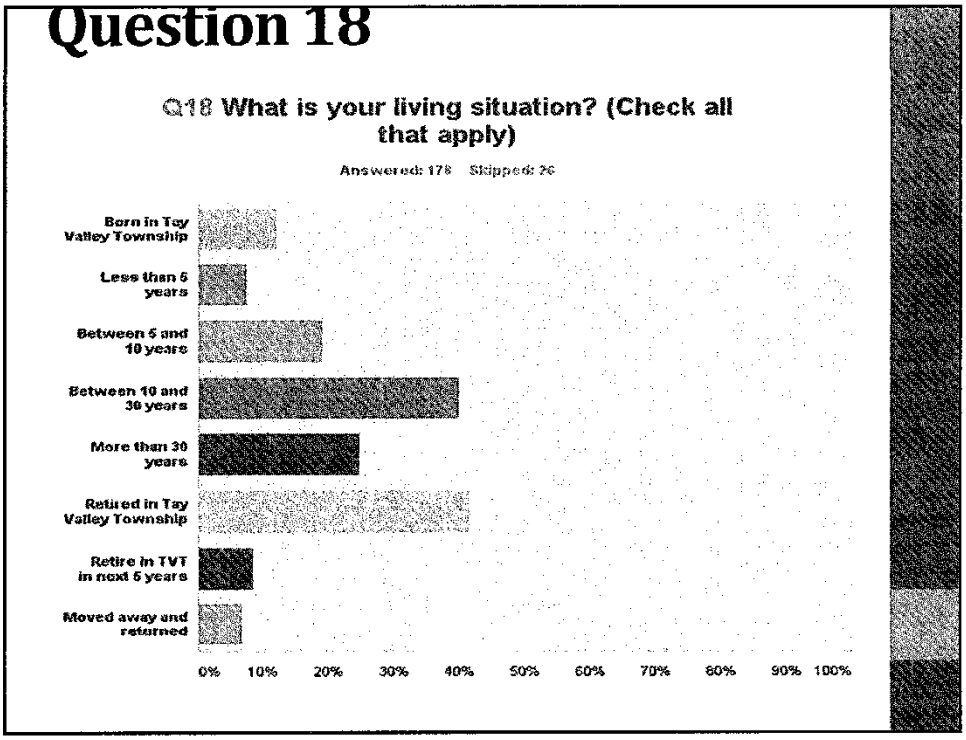


Question 17





Question 18

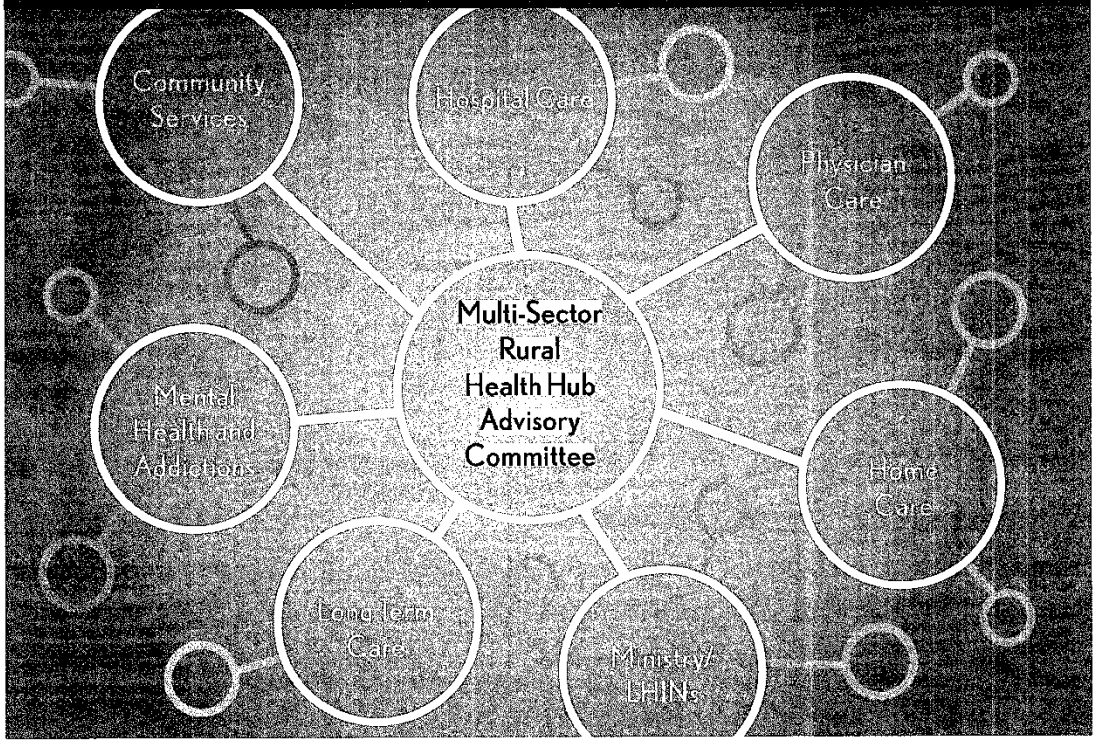

Q18 What is your living situation? (Check all that apply)
Answered: 178 Skipped: 26
Born in Tay Valley Township
Less than 5 years
Between 5 and 10 years
Between 10 and 30 years
More than 30 years
Retired in Tay Valley Township
Retire in TVT in next 5 years
Moved away and returned
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%



Appendix C

Rural Health Hubs Framework for Ontario

By: Multi-Sector Rural Health Hub Advisory Committee
January 2015



afhto association of family health teams of ontario

aohc acso Association of Ontario Health Centres Community-governed primary health care Association des centres de santé de l'Ontario Soins de santé primaires gérés par la communauté

HOME CARE ONTARIO

aaccac acasco

OANHSS ONTARIO ASSOCIATION OF NON-PROFIT HOMES AND SERVICES FOR SENIORS

OCSA Ontario Community Support Association

OHA ONTARIO HOSPITAL ASSOCIATION

OLTCA

OMA ONTARIO MEDICAL ASSOCIATION

Ontario Local Health Integration Network



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Introduction

Rural communities face unique challenges in delivering high-quality care due to lack of critical mass and economies of scale. Over the years, these communities have worked to overcome these challenges by creating sustainable health care systems through innovative local solutions. They are, therefore, well-positioned to continue to improve access to care as part of health system transformation. It is the existence of these local solutions that led to the establishment of the Multi-Sector Rural Health Hub Advisory Committee (Advisory Committee).

This Advisory Committee was established by the Ontario Hospital Association (OHA) and the Ontario Medical Association (OMA) with broad stakeholder representation to learn from existing rural health hubs in Ontario and to develop a framework to support rural communities in moving forward with the implementation of successful rural health hubs.

As rural health hubs are not a "one size fits all" model, this framework document features a process and recommendations that promote collaborative relationships and flexibility in design tailored to meet the unique needs of the communities being served.



Background

Rural local health care providers are facing unprecedented challenges in ensuring the right mix of services is available to meet the health care needs of their local communities. These communities are often located in remote settings and have many gaps in clinical services and other health social services. They also tend to have both a high prevalence of chronic disease and mental health conditions which result in a high burden of care and difficulty attracting and retaining qualified clinical, inter-professional and administrative staff.

In response to these challenges, many rural local health care providers have developed innovative solutions and have begun to work collaboratively to improve access, strengthen efficiencies and enhance the quality of health care for their communities. With the work that has already been accomplished, rural communities are well-positioned to leverage these existing collaboration and relationship-based referral processes towards the establishment of a rural health hub. Some rural communities have not yet initiated a rural health hub process and other communities have gone as far as they can without the support of government policy and/or legislation.

In recognition of the opportunities offered by existing rural health hubs, in 2012, then Ontario Minister of Health and Long-Term Care, Deb Matthews, requested advice from the OHA on rural health hubs. This led to the release of a report in 2013 entitled, ***Local Health Hubs for Rural and Northern Communities: An Integrated Service Delivery Model Whose Time Has Come (Report).***

Some of the key benefits of moving to a rural health hub model which were highlighted in the Report include:

- Improvements to health care access based on a "care closer to home" philosophy
- Support for a person-centred approach to coordinating local health services with improved patient navigation and shared clinical pathways amongst service providers
- Support for quality improvement planning for local health systems in rural and northern Ontario

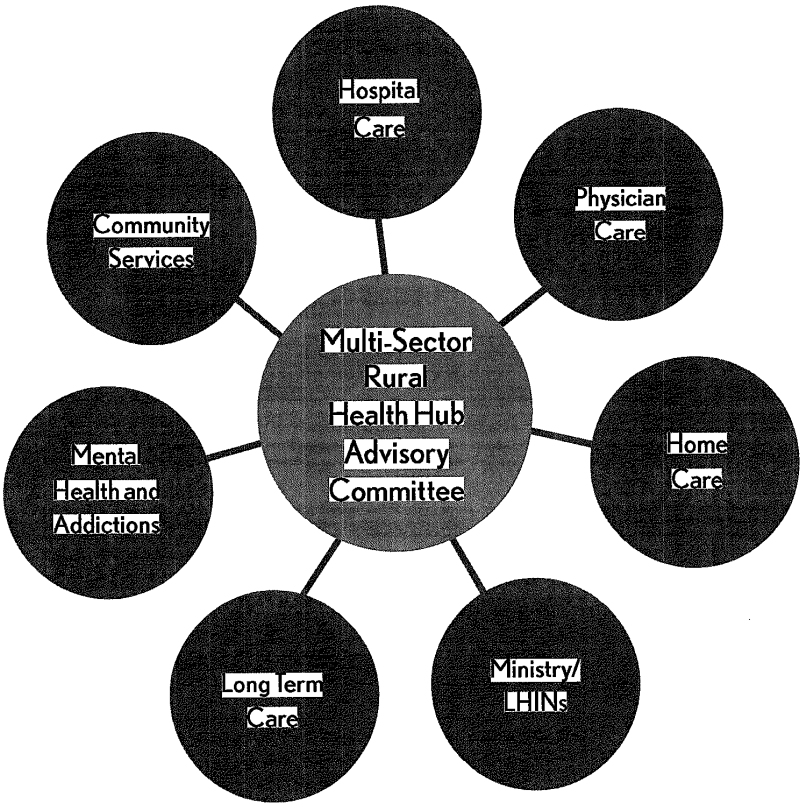
Following the release of this Report, the OHA met with key health system partners, including Local Health Integration Networks (LHINs), community health care providers and the OMA to discuss how to obtain needed support from rural communities and other key health care associations in terms of moving forward with a rural health hub.

It was agreed that rural health hubs and improved health and social service integration are important to all local providers, including physicians in rural and remote practice. Therefore, the OHA and the OMA agreed to establish a Multi-Sector Rural Health Hub Advisory committee (Advisory Committee) with broad stakeholder representation (Table 1) to develop this framework to encourage the implementation of rural health hubs in Ontario (Terms of reference).

This framework was developed using insights from existing rural approaches to collaborative local health care, including the work of some LHINs and the recommendations of the 2010 *Rural and Northern Health Care Panel Report* (RHCPR). The RHCPR recommends "a 'local hub' model of health planning, funding and delivery in rural, remote and northern communities, which integrates services across health sectors at the local or multi-community level, and includes broader social services, where feasible."

The Advisory Committee recognizes the government's mandate and vision to improve health care for patients with high-cost needs through the implementation of Health Links across the province. Similar to the rural health hubs approach, the Health Links' vision encompasses the need to foster collaboration across the continuum of local health and social service providers. Given the similarities between the two models and their potential contribution toward a sustainable local health care system, the Advisory Committee is hoping for a similar commitment from government that will support the implementation and sustainability of rural health hubs. (See Appendix C for a Health Link/ Hub comparison chart)

Figure 1: Multi-Sector Advisory Committee Representation





Rural Health Hubs in Ontario

Vision

The creation of rural health hubs will encourage and enable local health care and social service providers such as hospitals, health centres and physicians in rural communities to work together to create a rural health hub tailored to their local community's needs in a way that enhances seamless, sustainable service integration and the effective delivery of person-centred, equitable, high-quality, timely health care, whether it is delivered locally or referred to a regional partner.

Principles

1. Person-Centred and High-Quality Care

A rural health hub will:

- ✓ Be designed with and for the community
- ✓ Be accessible, safe, effective and informed by evidence
- ✓ Be informed by and be supportive of research within the rural health care context
- ✓ Meet the diverse needs of people in the community along the continuum of care using a health equity lens
- ✓ Enhance the person's experience by providing well-coordinated care, taking into consideration the needs of patients including the delivery of care as close to home as possible, while supporting effective access to care outside the hub when needed.
- ✓ Support physical and mental wellness and health promotion within the community

2. Enhanced Collaboration and Efficiencies

A rural health hub will:

- ✓ Be appropriately resourced and efficiencies will be realized where possible
- ✓ Recognize the contribution of each of the independent providers in the continuum
- ✓ Deliver care collaboratively based on trusting relationships, using inter-professional teams
- ✓ Maximize the effectiveness of local human resources and service delivery capacity
- ✓ Enhance communication and transparency
- ✓ Be supported by an integrated Information Technology strategy
- ✓ Be supported by shared capital and building infrastructure, where possible

3. Accountability

The health and social service providers will:

- ✓ Ensure viability of the rural health hub
- ✓ Adhere to good governance standards
- ✓ Support timely, relevant and transparent data analysis and reporting in support of decision making, quality improvement and accountability (performance and reporting)



Key Characteristics of Rural Communities

The Advisory Committee identified a number of unique features of rural communities that may impact the provision of health care services.

- Geographically remote and isolated
- Low population density
- Long travel times for services not locally available
- Weather extremes and inadequate public transportation impact access to care
- High density of elderly, Aboriginal and other distinct populations (such as francophone, migrant workers, etc.)
- High burden of chronic disease
- High use of tobacco, alcohol and other substances
- High prevalence of mental illness and social isolation factors
- Limited health service options
- Limited health care provider availability
- Gaps in secondary/tertiary level clinical services and limited community and support services available
- Limited mental health and addiction services
- Requirement to maintain service capacity in spite of lower volumes
- Pressure from service regionalization initiatives that may impact critical mass and stability of clinical service provision
- Recruitment and retention:
  - Staff providing service at multiple organizations that have competing obligations
  - Salary/income differentials among local health service providers limiting ability to recruit and retain
  - Community economics that may not support employment opportunities for family members
  - Lack of competitive salaries and incentives to attract system leadership
- Low service volumes and small data sample sizes make meaningful statistical analysis difficult

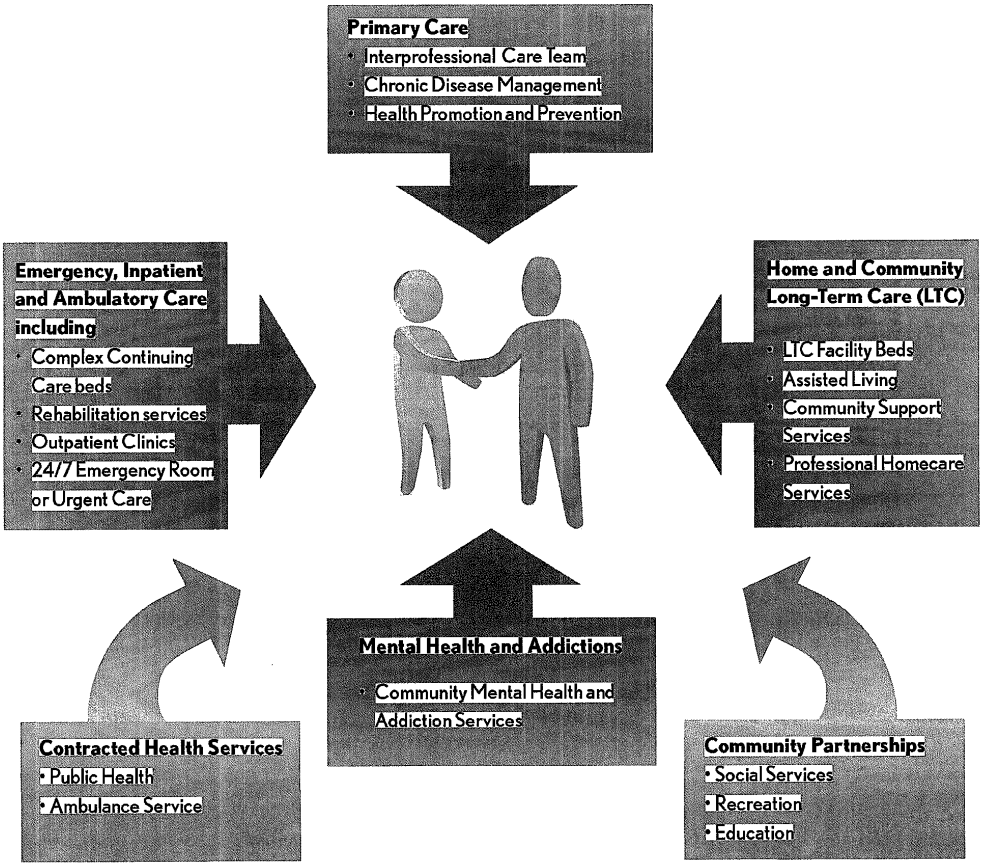


Defining a Rural Health Hub

The Advisory Committee agreed on the following definition of a rural health hub:

"Rural Health Hubs will allow local health and social service providers, through formal agreements and partnerships, and on-going community consultation, to improve the coordination and effectiveness of care for a defined population and/or geographic area. Each rural health hub will be locally defined and tailored to the community. A rural health hub is flexible, not one size fits all, is innovative, based on local need and provides coordinated access to care. (Figure 2 lists services that may be included in a rural health hub)

Figure 2: Services That May Be Included In A Rural Health Hub

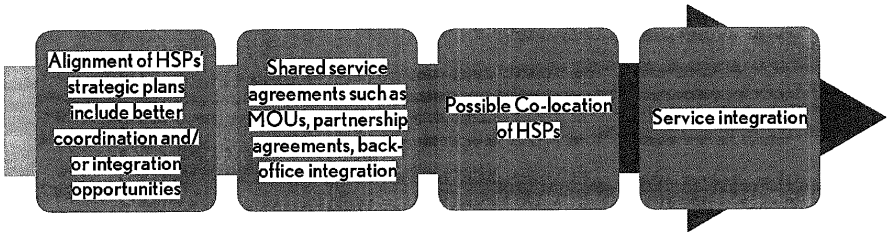




There are many examples of rural health hubs across the province that tends to vary along two dimensions:

1. The **degree of service integration** describes how formalized the clinical and support linkages are between health and social service providers. The service integration continuum below outlines possible options available.

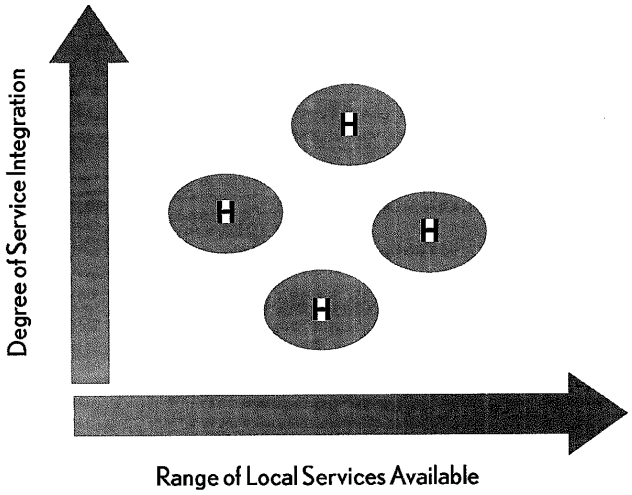
Figure 3: Degree of Service Integration



2. The **range of local services available** in the hub describes the number and type of services that are locally available and the extent to which they are coordinated and/or co-located.

These two dimensions create a potential strategy map for communities seeking to implement a rural health hub. A summary of some of the existing rural health hubs is available in Appendix A.

Figure 4: Rural Health Hub Strategy Map





Key Elements of a Rural Health Hub

The Advisory Committee studied and met with representatives of existing local health hubs in Ontario (Appendix A). This review provided a good deal of insight into the current environment and allowed the Advisory Committee to summarize the following critical success factors and potential barriers to the implementation of a successful rural health hub.

Critical Success Factors

- An identified shared need for local health and social system providers to work together to provide high-quality health care for the community
- Local history of successful collaboration and an opportunity to build on existing collaborative relationships
- Local credible champions/leaders who support a common vision and the need for increased collaboration
- Shared clinical pathways, including the need for smooth access to urgent/emergent and specialized care only available outside of the hub
- Access to reliable and timely patient and/or sample (i.e. laboratory) transportation
- Strong community/regional supports including resources and expertise (i.e. change management) that enable enhanced local collaboration and dialogue
- Existing collaboration that aligns with local, regional or provincial strategic goals or initiatives such as:
  - care planning and coordination
  - formal quality plans
  - quality best practices
  - shared back office (information technology, payroll etc.),
  - facilities planning and management (shared campus and/or facilities)
  - shared management structures
- Development of a local Community Health Plan which:
  - Includes a common vision and shared goals
  - Is people-, community- and patient-centred
  - Includes capacity planning and service mapping
  - Builds on local demographics and assets
- Strong community consultation and communication strategy
- Existing advanced information technology
- Consolidation of IT bandwidth among health service providers



Implementation Barriers

Many of these barriers are not unique to rural communities. However, the impacts of each may be magnified in these communities. They include:

- Lack of an all government (municipal and provincial) approach to the provision of health care services and a lack of a strategy for rural and remote communities
- Lack of alignment between and within federal and provincial ministries and municipal governments continues to be a barrier to integration and coordination of services, as it impedes health and social service organizations from achieving funding efficiencies
- Lack of local health care labour supply in rural and remote communities
- Complexity related to relevant policy and regulatory differences between providers (for example, *Public Hospitals Act, Excellent Care For All Act,* Broader Public Sector procurement directives, *Public Sector Labour Relations Transition Act, Local Health System Integration Act, Long-Term Care Homes Act* and its Regulations and the *Occupational Health and Safety Act*)
- The risks related to integration, such as:
  - Unequal organizational financial capacity and/or stability
  - Organizational salary differentials
  - Lack of coordinated, formal planning across the continuum
  - Different organizational missions and cultures
  - Lack of agreement on the relative priority of integration activity
  - Multiple accountability agreements, licenses and service agreements
  - Multiple data reporting requirements and different performance indicators
  - Lack of standardized performance/outcomes measurements
  - Risk to benchmarks, accountabilities and funding formulas due to statistically insignificant data given the low volumes
  - Legislative wage freeze not applied consistently across all employee groups
  - Scarce leadership resources with limited capacity to take on incremental major project work
  - Lack of change management expertise/resources
  - Potential impact on local economy and human resources
- Community capital barriers:
  - Limited fundraising capacity
  - Government capital funding does not adequately support integrated solutions
  - Lack of existing infrastructure and facility space for co-location



Guidance for Developing a Rural Health Hub

The following high-level suggestions were provided by the Advisory Committee to support the further development of rural health hubs in rural Ontario communities.

Review of Current State

A core group of local providers and community members should work together to address their shared need for improved health care service integration and undertake the following review:

1. What is the size of the community and the population density?
2. What are the health and social service needs of the population?
3. Who are the current health and social service providers in the community and what services do they provide (inventory of providers and services)?
4. What are the critical gaps in available service?
5. What types of relationships and collaborations already exist among these service providers?
6. Beyond the local providers, what are the linkages to other levels of care and care providers? For example:
   - Patients leaving for specialized services and/or diagnostics
   - Physicians visiting community for specialists clinic and/or services
   - OTN and/or other Telehealth services for access to specialists and/or services
7. Are there formal relationships with larger centres for referrals and/or repatriation of patients?
8. Bring together willing participants/stakeholders for facilitated local strength, weakness, opportunity and threat (SWOT) analysis related to hub implementation.
9. Consider health equity using available validated tools.

Implementation

The steps to begin implementation of a rural health hub include the following:

1. Establish a community/provider engagement process.
2. Using a health equity lens, engage the community and all local health and social services providers in the development of a local Community Health Plan, including:
   a. A common vision and shared goals;
   b. Capacity planning and service mapping; and
   c. The desired end state (Figure 3).
3. Build on local demographics and assets.
4. Form a local working group and identify local champions.
5. Obtain formal agreement for local health service providers and agencies to work together.
6. Develop a project charter and work plan.
7. Ensure each organization's strategic plan is updated to include better coordination and/or integration opportunities and/or strategies for co-locating services.
8. Identify and obtain required change management resources.
9. Develop a communication and information management strategy.



Recommendations

The Advisory Committee also developed the following recommendations in support of rural health hubs in Ontario.

Short-Term Recommendations

To Rural Communities:

1. Establish a core group of local champions/leaders, including LHINs, to:
    a) Develop a local Community Health Plan that is responsive to the local context and uses a robust, ongoing community engagement process inclusive of both community members and all providers
    b) Where appropriate, embrace a rural hub approach to local health and social service planning
    c) Develop a communications strategy that uses consistent messaging among health and social service providers

To the Ministry of Health and Long-Term Care:

2. Recognize rural health hubs as a key approach to service delivery for rural communities by supporting policy change that:
    a) Provides for flexible community funding for rural hub development in support of sustainability of the health care system, which will lead to local innovation, stable service capacity and a sustainable work force.
    b) Creates incentives for health and social service providers who choose to participate in a rural health hub.
    c) Establishes an implementation approach similar to Health Links in Ontario that supports a voluntary approach that brings individual providers together, with the engagement of the community, to create innovative local solutions that address the unique needs of their respective communities.
    d) Supports capital planning and facility redevelopment requirements to enable co-location, where appropriate.
    e) Creates an accountability process that is aligned (where appropriate), simple to manage, facilitates shared learnings among communities and supports the monitoring of health outcomes.

Long-Term Recommendations

To the Ministry of Health and Long-Term Care:

3. Undertake an extensive, inclusive consultation process on the Rural and Northern Health Care Panel Report.
4. Using feedback from the consultation process, establish a Rural and Northern Health Care Strategy to enable the development of an effective health care system for Rural and Northern Communities.



Appendix A

Health Hub Examples

These are examples of health hubs from across the province that demonstrate the range of possible local solutions to better coordinate and integrate care.

Organization	Population/ Community	Services Available	Success Factors	Barriers To Success
Manitouwadge Community Care One campus Integrated governance	5 hour drive to Thunder Bay Catchment population: 2,100	Acute care Emergency Diagnostics Rehabilitation Family Health Team (FHT): Primary Care CCAC Social Work Mental health Public Health Outpatient Long-term care	Shared governance Shared campus Shared IT Shared staff Shared back office One or % of FTE programs	FHT Program managers and MOH oppose hospital-based FHT Silo program funding, i.e. mental health
Guthrie House (satellite of Country Roads Community Health Centre) Health and social services hub (co-location and coordination of services)	Total population 10,000 with no community larger than 800 20 minutes to main CHC site, 40 minutes to nearest hospital High senior population with significant access issues	Guthrie House enhances access to primary care and social services for rural residents of Rideau Lakes Township. Primary care services Prevention and wellness	Funded with assistance of United Way who have evaluated the pilot as successful Numbers of residents accessing services has greatly increased Increased numbers of volunteers involved	Operating with part-time coordinator It is important to find ongoing dollars for this role as it is key to success and growth of the hub



Organization	Population/ Community	Services Available	Success Factors	Barriers To Success
		Chronic disease management OTN-Telemedicine Employment services Ontario Works Adult mental health Geriatric psychiatry outreach Alzheimer's support Children's mental health Chiropractic treatment Hearing society Community meeting rooms for local groups Community development	Evident community engagement and support from municipal council Patient feedback overwhelmingly positive Tenant feedback overwhelmingly positive Collaborative governance	
Waasegiizhig Nanaandawe'iye wigamig Health Access Centre Integrated, comprehensive core services plus partnerships	10,000 Anishaabe people in Kenora and surrounding First Nations communities Urban Rural Remote On-reserve	Prevention/wellness Health promotion (including oral health) Primary health care Diabetes education Venipuncture clinic Chronic disease management OTN/telemedicine Traditional healing Oral health outreach Mental health, including intergenerational trauma	Formed as a partnership of stakeholder communities Voluntary and consensus-based Range of integration solutions, including co-location, partnerships (formal and informal) Community-driven, population needs based planning Each scenario unique, in order to respond to community's specific needs	Salary differential Recruitment and retention No volunteer base Ministry restrictions on spending to achieve full efficiencies Lack of standardized performance/ outcomes Meeting demand within limited budgets Funding to address client complexity (staff training and other costs)



Organization	Population/ Community	Services Available	Success Factors	Barriers To Success
		Hostel Healing Lodge All services (except residential) available through outreach in partner communities	Shared operational efficiencies Improved access to breadth of health and social services, and care coordination Information Management System – including a common Electronic Medical Record for all Community Health Centres and Aboriginal Health Access Centres Expanded, collaborative, interprofessional team, with everyone working to full scope	Capital policies that are barriers to integration Funding silos
Community Care City of Kawartha Lakes Multi-service agency (fully integrated, including governance) plus partnerships	3,083 sq. km catchment area, High proportion of seniors, children living in poverty, low education levels, high chronic disease prevalence	Prevention/wellness Health promotion Primary care Community development Hospice Oral health/low income dental Social services Community support services Non-urgent transport OTN/Telemedicine Chronic disease management	Improved client-centred care coordination and access to care Integrated quality improvement plan (QIP) Back office efficiencies Access to volunteers Collaborative partnerships	Silo funding/ funding restrictions Recruitment/ retention Salary differential with acute care and long-term care Limited IT resourcing to make improvement with partners Capital policies that are barriers to integration



Organization	Population/ Community	Services Available	Success Factors	Barriers To Success
		Assisted living Adult day programs Specialized geriatric services Occupational Therapy and Physical Therapy		
Espanola Regional Hospital and Health Centre Integrated health campus	80km west of Sudbury Catchment 14K High proportion of seniors, aboriginals and chronic disease	Acute care Ambulatory care Long-term care Assisted Living Seniors' apartments Physiotherapy Pharmacy CCAC office FHT, primary care	Integrated governance (acute, long-term care, primary care) Require trust and legal framework Operational efficiencies: communications, purchasing, IT, etc. Improved care coordination and access Integrated QIP	Developing board and staff skills Risk of assuming other entity liabilities Salary differential
Dryden Regional Health Centre	320km to Thunder Bay Catchment 15K 3 communities 3 First Nations	Acute care Emergency care Ambulatory care Visiting specialists Complex Continuning Care Ontario Telemedicine Network consults with specialists Community Mental Health and addictions FHT (multiple services) Community rehabilitation	Skills-based Board Several board committees Single management Shared support services FHT/Acute care integration Mental health crisis response Less duplication, increased critical mass Coordination around patient needs	Funding silos, various funding sources Regulatory differences Compensation/unions Local vs. district vs. regional governance



Organization	Population/ Community	Services Available	Success Factors	Barriers To Success
OHA hub model (proposed 2013)	10k – 40k is a guideline for rural, southern Ontario. For more remote communities, there needs to be flexibility with respect to the size of hub.	Emergency and inpatient care Comprehensive primary care Home and community long-term care Mental health and addictions.	Supports a patient-centred approach to coordinating local health services with stronger patient navigation and shared clinical pathways Strong synergies between service providers in the hub Improves client access Supports quality improvement planning for local health systems in rural and northern communities	
North Dumfries Community Health Centre, a satellite of Langs	Catchment: 10,000 North Dumfries Township and Plattsville, Drumbo, New Dundee	Primary care Social work Registered dietician Diabetes education Health promotion Community programs, especially youth and seniors Early years program Venipuncture clinic Care coordination, including for Health Links	Increased access for region Providing services identified by the community that were previously unmet Community-driven process from inception to ongoing operations, including a community advisory committee Co-located within a recreation complex with access to NHL-sized ice rink, senior's lounge, walking track, youth room, community meeting rooms	Capacity to expand services exist with additional resources Limited to non-existent mental health services Difficulty accessing locums High degree of part-time staff Salary differential between health sectors Limited IM/IT resourcing LHIN targets difficult to achieve with limited resources



Appendix B

Tools and Resources

Resources

1. North West LHIN Health Services Blueprint. Please see www.northwestlhin.on.ca
2. North East Rural Communities Framework for Health System Improvement – to help stakeholders at the community level determine the appropriate service delivery model. Please see www.nelhin.on.ca
3. Governance Collaboration. Please see www.thegce.ca

Tools

Examples of templates include:

1. Lease Agreement
2. Letter of Understanding for services and payment terms for non-emergency transportation
3. Purchase of Service Agreement
4. Amendment to Agreement for Privacy and Billing



Appendix C

This section highlights the differences between Health Links and rural health hubs. It is important to note that the two can easily and beneficially co-exist with health hubs being a very local model of care delivery within, and supporting the goals of, a Health Link.

Criteria/ Prerequisites	HEALTH LINKS:	Rural Health Hub:
Population Size	Minimum 50,000	Less than 20,000. However, there may be some exceptions depending on the remoteness of some communities.
Focus	High cost/user i.e. top 5% who need extra care coordination	All
Providers/ Services	Minimum hospital, CCAC, primary care, specialists	Could include: emergency and inpatient care (i.e. acute, rehab and complex continuing care), comprehensive primary care (e.g. FHTs, CHCs), home and community support services, long term care, social services, and mental health and addictions. The hub could partner with local municipalities in order to contract with EMS and public health
Primary Care	Minimum 65% of primary care providers in the defined region	No threshold
Connectivity	Ability to share information (via EHR) between all Health Link participants	Ability to share information (via EHR) between all hub participants
Quality Improvement	n/a	Clinical integration through pathways and quality improvement (QI) processes to support inter-professional, team-based care among core services
Data Reporting	Ability to report on 12 indicators selected by the Ministry of Health and Long-Term Care	Simplified and valid
Governance and accountability	One "Lead Organization" with partnership agreements with other health service providers. Leadership, governance and degree of integration is flexible and based on local requirements and relationships	Leadership, governance and degree of integration are flexible and based on local requirements and relationships.



Appendix D

Acknowledgements

Multi-Sector Rural Health Hub Advisory Committee:

Dr. Adam Steacie, Family Physician (OMA Co-Chair)

Wade Petranik, CEO, Dryden Regional Health Centre (OHA Co-Chair)

Dr. Sarah Newbery, Chief-of-Staff, Wilson Memorial General Hospital

Adrianna Tetley, CEO, Association of Ontario Health Centres

Leah Stephenson, Director, Association of Ontario Health Centres

Candace Chartier, CEO, Ontario Long Term Care Association

Chantale LeClerc, CEO, Champlain Local Health Integration Network

Tuija Puiras, CEO, North West Community Care Access Centre

Deborah J.K. Simon, CEO, Ontario Community Support Association

Laura Kokocinski, CEO, North West Local Health Integration Network

Martha Auchinleck, Senior Director, North East Local Health Integration Network

Mary Wilson Trider, President & CEO, Almonte General Hospital

Ray Hunt, CEO, Espanola General Hospital

Dr. Stephen Cooper, Chief-of-Staff, Manitoulin Health Centre

Randy Belair, representative, Association of Family Health Teams of Ontario

Susan VanderBent, Executive Director, Ontario Home Care Association

Donna Rubin, CEO, Ontario Association of Non-Profit Homes and Services for Seniors

Kathryn Pilkington, Ontario Association of Non-Profit Homes and Services for Seniors

David Kelly, Past CEO, Addictions and Mental Health Ontario

Gail Czukar, CEO, Addictions and Mental Health Ontario

Observers

Tamara Gilbert, Director, Ministry of Health and Long Term Care

Michael Robertson, Manager, Ministry of Health and Long Term Care

OHA and OMA staff:

Susanne Bjerno, Senior Advisor, Hospitals and Health System Funding, OMA

Maggie Keresteci, Executive Director, Engagement and Program Delivery, OMA

Elizabeth Carlton, Vice President, Policy and Public Affairs, OHA

Lou Reidel, Chief System Planning and Performance Officer, OHA

Michelle Caplan, Policy Advisor, OHA



Appendix E

Multi-Sector Rural Health Hub Advisory Committee

Terms of Reference

Approved - June 27, 2014

Background

In the spring of 2013, the OHA released a paper entitled *Local Health Hubs for Rural and Northern Communities: An Integrated Service Delivery Model Whose Time Has Come,* which was developed in response to a request made by the Honourable Deb Matthews, Ontario's Minister of Health and Long-Term Care. This paper presented the Health Hub Model as a concept rather than a rigid framework, one that can serve as a springboard for discussion and collaboration among health system partners towards the development of an action plan.

Immediately following the release of the paper, the OHA hosted a Small Hospital Working Session which was attended by hospitals, a number of health system partners and LHINs, where ideas for moving forward with the implementation of Health Hubs were discussed. In addition to identifying a number of challenges respecting the creation of such Hubs, participants expressed the need for a provincial-level, multi-stakeholder advisory committee to refine the model and address the barriers that could potentially affect implementation. Because these issues are critically important to physicians in rural practice, the OHA and the OMA have partnered to convene this table.

Purpose

Within the context the Ministry of Health and Long-Term Care's Action Plan for Health Care and Health Links, the Multi-Sector Rural Health Hub Advisory Committee (Advisory Committee) will assist rural and northern communities to design and move forward with the implementation of Rural Health Hubs.

Rural Health Hubs are comprised of health service providers, working together through formal agreements and partnerships that improve the coordination and effectiveness of care for a defined population and/or geographic area.

Strengthening and creating the coordination of health care organizations in rural communities will support the delivery of effective and high quality health care to people living in those communities as envisioned by strategies such as Health Links (there are other programs such as CCO initiatives and Senior Health Initiative which would benefit from effective rural health hubs).

As many rural and northern communities, across the province, have already implemented their own models of a Rural Health Hub, the lessons learned from these models and others will inform the development of principles, and enabling tools and also help identify and address barriers that are impeding integration.

Key deliverables will include:

1. The examination of existing local coordinated health care delivery models (such as a Rural Health Hub) within rural and northern communities to help:
    - Inform the development of a common vision and principles of a coordinated health care delivery model;



- Identify the policy and regulatory barriers impeding integration; and
- Identify successful models and leading practices across the province that can be profiled

2. A mapping exercise to examine the alignment of Rural Health Hubs with Health Links Model and how it fits at the Provincial and LHIN level
3. Consensus on guiding principles and a new framework for enhanced coordinated health care delivery within rural and northern communities and an action plan to address the policy and regulatory barriers impeding integration
    - The development of tools to assist communities with implementing the new model(s)of coordinated health care delivery
    - Provide advice on strategic investments related to the multi-year $20 million Transformation Fund for Small and Rural Hospitals (informed by lessons learned)

Membership

Membership to include, but not limited to the following:

- Ontario Association of Community Care Access Centres
- Addictions and Mental Health Ontario
- Ontario Hospital Association
- Ontario Long Term Care Association
- Association of Ontario Health Centres
- Ontario Medical Association
- Association of Family Health Teams of Ontario
- Ontario College of Family Physicians
- Ontario Home Care Association
- Ontario Community Support Association
- Association of Non-Profit Homes and Services for Seniors
- North East LHIN
- North West LHIN
- South West LHIN
- Champlain LHIN
- Ministry of Health and Long-Term Care

As the Advisory Committee works through their key deliverables, there may be opportunities to engage with other stakeholders as needed.

Chair Position

The Advisory Committee will be co-chaired by the OMA and the OHA.

Meetings

Meetings of the Advisory Committee will be held in-person on a bi-monthly basis or at the call of the co-chairs.

Support

The OHA and OMA staff will provide support and guidance to the Advisory Committee.

Reporting Relationship

Members will report through the appropriate internal structures within each organization and to the Board of Directors of each organization in advance of the final report's presentation to the Ministry of Health and Long-Term Care.

Working Group

Co-Chairs may wish to appoint an ad-hoc Working Group with defined Terms of Reference, as appropriate, to work through key deliverables.

Timelines

The first meeting will take place January 2014 and deliverables will be completed by the end of 2014.



Appendix D

Perth Co-Housing Initiative Web Link

Co-Housing Web Link

Canadian Senior Co-Housing Web Link

Solterraco Housing Web Link

Planet Friendly Community Web Link

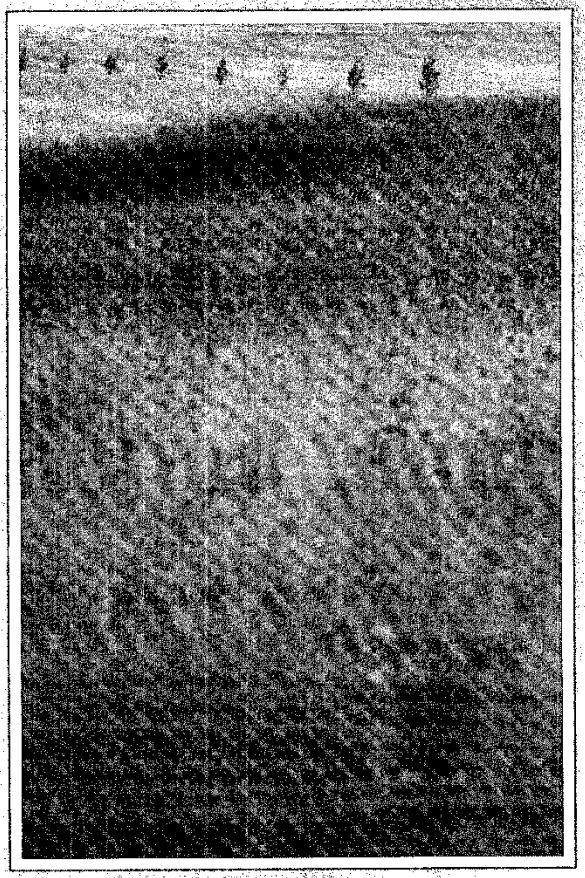
Canopy Co-Housing Web Link

Everything Zoomer - Happy Together Web Link



Appendix E

EDEN ALTERNATIVE®



IT CAN BE DIFFERENT!



DR. BILL THOMAS, CO-FOUNDER OF THE EDEN ALTERNATIVE® WILL NEVER FORGET THE WORDS OF AN ELDER, OR THE BEAUTIFUL BLUE EYES THAT STARED UP AT HIM, AS SHE REACHED UP TO DRAW HIM NEAR AND WHISPER, "DOCTOR, I AM SO LONELY."

A Harvard-educated physician and Board Certified Geriatrician, Dr. Thomas searched his medical texts and found nothing to heal loneliness. This inspired him to watch and listen to life in the nursing home where he worked. Over time, he witnessed that the institutional model of care breeds three deadly plagues of the human spirit: Loneliness, Helplessness, and Boredom.

And so he began to think about a different kind of world. He envisioned a care environment where people could live and thrive, not just wait to die. Working together, with his wife, Judith Meyers-Thomas, this vision of a Human Habitat began to unfold and change the lives of Elders and their care partners across the country and beyond.

AND SO BEGAN THE STORY OF THE EDEN ALTERNATIVE...

The philosophy and work of The Eden Alternative is guided by The Ten Principles:

The Eden Alternative Principle # **1**

The three plagues of loneliness, helplessness, and boredom account for the bulk of suffering among our Elders.



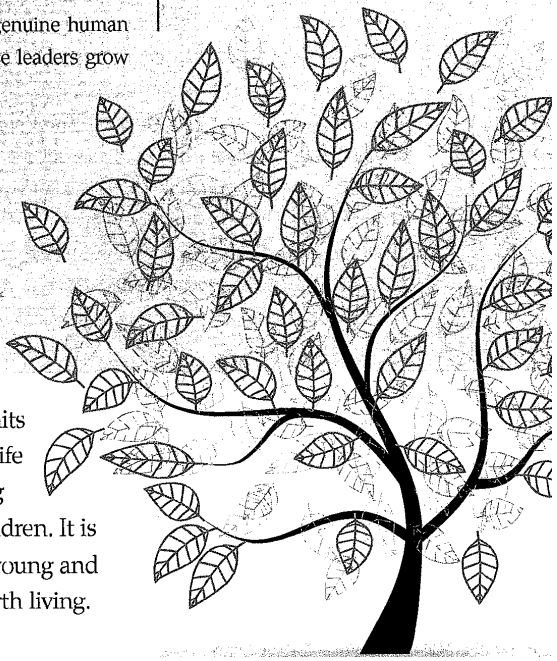
The Eden Alternative is Culture Change...

"Culture change" is the common name for a global initiative focused on transforming care, as we know it, for Elders and other individuals living with frailty and different cognitive, developmental, psychological, and physical abilities. It advocates for a shift from institutional models of care to person-directed values and practices that put the person first. Person-directed care is structured around the unique needs, preferences, and desires of each individual. Through this approach, decisions and actions around care honor the voices and choices of care recipients and those working most closely with them. Core person-directed values include choice, dignity, respect, self-determination and purposeful living.

Culture change values drive the transformation of both long and short-term living environments, as well as home and community-based settings. The transformation process involves changes in personal growth, the development of relationships, organizational practices, and physical environments at all levels and in all workforce models. The ultimate goal of culture change is better outcomes and quality of life for all involved in the giving and receiving of care.

As a comprehensive culture change model, The Eden Alternative focuses on creating Elder-centered communities — wherever Elders live — that thrive on close and continuing relationships, meaningful interactions, opportunities to give as well as receive, and a rich and diverse daily life. Elder-centered communities are places where treatment is the servant of genuine human caring, Elders are the daily decision-makers, and where wise leaders grow other leaders.

The Eden Alternative recognizes that promoting person-directed care means offering a philosophy based on guiding principles. Principle-based approaches offer both a shared language and direction, while providing the flexibility to respond to unique needs and circumstances. When it comes to person-directed care, step-wise approaches simply don't deliver, as they do not take into consideration how different and unique every individual is.



The Eden Alternative Principle #

2

An Elder-centered community commits to creating a Human Habitat where life revolves around close and continuing contact with plants, animals, and children. It is these relationships that provide the young and old alike with a pathway to a life worth living.

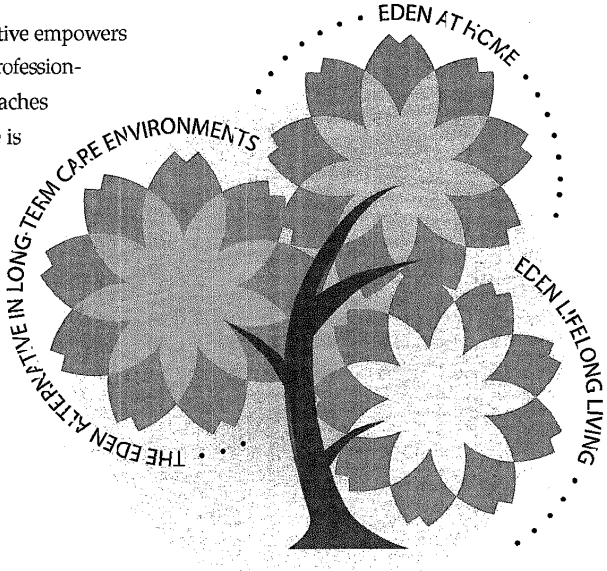


Wherever Elders Live...

The Eden Alternative is an international not-for-profit organization dedicated to transforming care environments into habitats for human beings that promote quality of life for all involved. Our philosophy is a powerful tool for creating well-being for Elders, wherever they live, and those who collaborate with them as care partners. Research has shown this leads to improved quality of care and higher rates of satisfaction for everyone involved, while also benefitting the bottom line of provider organizations.

As a principle-based philosophy, The Eden Alternative empowers care partners, whether they are family members, professionals, or volunteers, to transform institutional approaches to care into the creation of communities where life is worth living.

We firmly believe that culture change unfolds one relationship at a time, and that deep change can only take root when the entire continuum of care is involved. A highly adaptable philosophy, The Eden Alternative currently offers three different applications of its Principles and Practices that acknowledge and support the unique needs of various living environments, ranging from the nursing home to the family homestead.

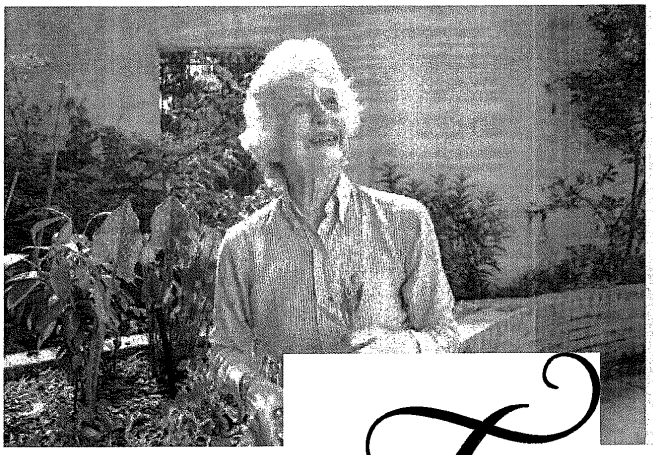


THE EDEN ALTERNATIVE PHILOSOPHY

The Eden Alternative is well-known for its original mission to transform the organizational culture of nursing homes and other institutional settings. Going strong for more than twenty years, we have over 30,000 Certified Eden Associates and Certified Eden at Home Associates worldwide committed to inspiring change in the organizations where they work. Based on the belief that care is part of a continuum, regardless of where it is provided, we have created Eden at Home to apply the Eden Alternative's Ten Principles to home and community-based care. And finally, Eden LifeLong Living promotes quality of life and well-being for individuals living with cognitive, developmental, psychological, and physical challenges.

The Eden Alternative Principle # **3**

Loving companionship is the antidote to loneliness. Elders deserve easy access to human and animal companionship.



"At Mission Health Services, we are dedicated to creating a vibrant living experience for Elders using the Eden Alternative Philosophy. All of the care communities in our Utah-based non-profit organization are Eden Registry Members and more than 250 employees are Certified Eden Associates. We attribute excellent resident and family satisfaction ratings, low staff turnover (14% in 2010), and cultivated Elder-choice to our commitment to The Eden Alternative."

Gary Kelso, President & Chairman
Mission Health Services, Salt Lake City, Utah

The Eden Alternative: Transforming Long-Term Care Environments...

In the early 1990s, Dr. Bill Thomas received a grant from the State of New York to pilot his vision for breathing new life into nursing homes. Originally called "The Dementia Project," this grant-funded initiative was his first opportunity to translate the Ten Principles into meaningful action. For three years, Bill and Jude Thomas worked side by side to fine tune the Eden Alternative Philosophy. Their efforts laid the foundation for the development of Certified Eden Associate Training, as a means for sharing this inspiring approach to care with other nursing homes. As demand grew for Certified Eden Associate Training, the Thomases realized that their mission to eliminate the plagues of loneliness, helplessness, and boredom could be achieved on a much broader scale.

What began as a set of principles has grown into a powerful model for ongoing growth and development. Today, The Eden Alternative continues to grow a robust circle of support in the U.S. and abroad that includes thousands of Certified Eden Associates, hundreds of Eden Registry Members, and an extensive cadre of Eden Mentors and Educators. This dedicated community works together toward meaningful culture change in institutional settings through continuing education and a commitment to maximizing quality of life for Elders and their care partners.

Implementation of The Eden Alternative impacts the physical environment, organizational structure, and psycho-social interactions of the home. Individual Principles highlight and guide different aspects of the culture change journey. In establishing goals for personal and organizational growth, organizations must consider how to best live out each Principle for the benefit of the Elders and their care partners, as well as the home as a whole.

The departmentalized, task-orientation of institutional models has created a culture in long-term care that is characterized by pessimism and cynicism. By moving away from top-down bureaucratic approaches to management and moving decision-making closer to the Elders, Edenizing organizations are creating a vibrant, empowered existence for the Elders they serve and the people who work closely with them.

The Eden Alternative Principle # **4**

An Elder-centered community creates opportunity to give as well as receive care. This is the antidote to helplessness.



Eden at Home:

Applying the Ten Principles to Home & Community-Based Care...

Several years ago we began to notice that more and more people were asking what The Eden Alternative could offer people living in the larger community. Given the growing aging population and consumer preference to receive care in the home, we recognized a powerful need for creative grassroots solutions at the community level. So began Eden at Home.

Eden at Home applies the power of the Eden Alternative's Ten Principles to improving quality of life for Elder(s) living at home and their care partners. By our definition, care partners include family, friends, neighbors, volunteers, home health professionals, and the Elders themselves. Eden at Home (EAH) emphasizes building collaborative care partner teams empowered by concepts central to person-directed care. It promotes a culture of meaningful care in our communities that does not see the needs of caregivers as separate from the needs of care receivers, but rather advocates for the well being of the whole care partnership. Working together, empowered care partner teams help to ensure the independence, dignity, and continued growth and development of all involved by eliminating loneliness, helplessness, and boredom for all care partners on the team.

The **Eden At Home** curriculum conveys the nuts and bolts of translating the Eden Alternative Principles to home and community-based care, which may include non-profit, faith-based, or home care/home health organizations, adult day services, hospice, and independent living communities. Certified Eden at Home Associates function primarily as change agents within their organizations and are also empowered as facilitators of Eden at Home Care Partner Workshops. Designed to bring different stakeholders together within a single learning environment, Care Partner Workshops help create a shared language for all members of the care partner team.

Other community-based initiatives include these intergenerational offerings from The Eden Alternative:

Embracing Elderhood builds intergenerational relationships by pairing Elder Storytellers with Recording Partners, ages 16 and older. Together, they create the Storyteller's legacy, which is part life story and part gift to the world, as wisdom gained from a life fully lived.

Eden Apprentices are young people, ages 11 to 18 who are introduced to the Eden Alternative Principles. Living by example, these young change agents will play a crucial role in shifting the culture of care and perspectives on aging in our communities.

"Wind Crest, an Erickson Living independent living community, attributes our improvement in resident satisfaction to implementing Eden at Home. Wind Crest scored in the top 10% of 250 continuing care retirement communities surveyed nationwide in 2010. The Eden Alternative Philosophy supports our mission and culture, creating a richer, more meaningful experience."

Craig Erickson,
Executive Director
Wind Crest
Highlands Ranch, Colorado

"Hawaii-based Project Dana is an interfaith, compassionate care program that offers volunteer support to Elders living with frailty and disability. With a volunteer corps of 20 Certified Trainers – most of them Elders – we have delivered Eden at Home Care Partner Workshops to 336 care partners on the islands of Kauai, Maui, Hawaii and Oahu with high satisfaction ratings."

Rose Nakamura,
Administrator
Project Dana, Hawaii

The Eden Alternative Principle # **5**

An Elder-centered community imbues daily life with variety and spontaneity by creating an environment in which unexpected and unpredictable interactions and happenings can take place. This is the antidote to boredom.

Eden LifeLong Living

Creating Quality of Life for those living with cognitive, developmental, psychological, and physical challenges

In early 2006, a National Public Radio interview with Dr. Bill Thomas inspired visionaries in residential care for those living with different abilities to explore another promising application of the Eden Alternative Philosophy. Soon thereafter, an exciting collaboration took shape, focused on supporting continued growth and well-being for individuals of any age living with with cognitive, developmental, psychological, and physical challenges.

While society tends to describe the needs of these individuals in terms of "disability," the Eden Alternative Philosophy builds on strengths. This principle-based philosophy focuses on the unique ways our "different abilities" hold the promise of possibility and what we each have to offer our communities. Loneliness, helplessness, and boredom can plague anyone's life. Meaning, empowerment, and growth are essential parts of living. The Ten Principles of the Eden Alternative can foster transformation in residential care settings by overcoming the plagues and helping everyone to experience well-being through a life worth living.

Following a successful 2008 Demonstration Project of the concept's applicability, The Eden Alternative co-developed Eden LifeLong Living (ELL) with the support of the Seaton Foundation. When environments offer opportunities for growth along with a sense of community, belonging, and purpose, everyone wins!

"The Principles and Philosophy of The Eden Alternative provide a great framework to help transform long-term care settings for younger individuals, who live with different cognitive, developmental, psychological, and physical challenges. Eden LifeLong Living expands The Eden Alternative's commitment to providing a continuum of opportunities, focused on making long-term care a better place to work and live for all individuals."

David Seaton, Co-founder
Eden LifeLong Living, San Marcos, Texas

The Eden Alternative Principle # **6**

Meaningless activity corrodes the human spirit. The opportunity to do things that we find meaningful is essential to human health.

1`



The Eden Alternative: The International Journey...

In August 2010, the Australian edition of *Aged InSite Magazine* listed The Eden Alternative as one of the top ten most influential innovations in aged care. As a person-directed care philosophy, The Eden Alternative is relevant to many cultures across the globe.

We have developed an exceptional team of International Eden Alternative Regional Coordinators dedicated to sharing the Ten Principles with people around the world.

Currently, we have Regional Coordinators in Eastern and Western Canada, Australia, New Zealand, the United Kingdom, Denmark, Sweden, the Faroe Islands, Iceland, the Netherlands, and South Africa. As the world ages, the demand for innovative care solutions will continue to spread across the globe.

In the spirit of person-directed practice, Regional Coordinators work closely with the Eden Alternative Home Office to ensure that our educational offerings and materials speak to the unique needs and customs of the cultures they represent. Through a licensing agreement, Regional Coordinators are encouraged to grow The Eden Alternative in a manner that inspires change and best supports their country's distinctive system of care services.

"The Eden Alternative has been practiced throughout Scandinavia and Northern Europe for the past ten years. Several countries are overseen by International Regional Coordinators and implementation is sustained by more than 3,000 Certified Eden Associates. All resources produced, including training materials, are translated into the appropriate language and used universally. Europe has a single Register of Associates enabling movement of employment across countries. Recently, new International Regional Coordinators have joined us from the Netherlands, Sweden and Iceland and interest is growing in other countries!"

June Burgess (on behalf of Eden Alternative Europe)
International Regional Coordinator
The Eden Alternative United Kingdom & Ireland

The Eden Alternative Principle # **7**

Medical treatment should be the servant of genuine human caring, never its master.



"Human life should never be separated from human growth."

Grow & Learn With Us...

Education is at the core of everything we do. The ultimate goal of The Eden Alternative is to inspire and empower care partner teams to achieve successful application of person-directed practices across the continuum of care. It is said that education is the antidote to fear. As we face the reality of a health care system that is ill-prepared to meet the needs of a growing aging population, improving the quality of care is a responsibility we all must share. As care professionals and community citizens, we need practical tools and meaningful approaches to care that empower each of us to become part of the solution.

Recognizing that different people learn in different ways, we offer a wide variety of educational opportunities. Our offerings are designed to help organizations and individuals revolutionize the culture of aging and care in their organizations and in their wider communities.

Eden Path to Mastery™ Guides

Eden Path to Mastery Guides are qualified consultants who have firsthand experience in the successful application of person-directed care, using the Eden Alternative Philosophy and its Ten Principles. Working collaboratively with your leadership team, Path to Mastery Guides help you identify opportunities to improve and define clear goals and objectives.

Interactive Training...

At The Eden Alternative, we understand that to open minds, you must open hearts first. We offer an assortment of participatory training experiences that honor this natural evolutionary process. Our Open Hearts Series features our foundational offerings, which inspire participants to reframe perceptions and develop a solid understanding of the Ten Principles. Our Open Minds Series takes the learning deeper, by providing a powerful opportunity to refine awareness and strengthen specific skills needed to effect change.

Webinar Education...

Our webinar series is a user-friendly way to reach large numbers of people at an affordable price. We offer both free and fee-based events, including topics such as leadership, staff stability, meaningful engagement, surplus safety, teamwork, and best practices in person-directed care.

The Eden Alternative International Conference...

We host a bi-annual International Conference that attracts people from around the world to share stories and learn new skills designed to support the Eden Alternative journey. Participants have the opportunity to connect and build relationships that expand an already extensive international support network.

Consultation Services...

Our team of consultants covers issues ranging from pre-design consultation, sharing The Eden Alternative with those living with dementia, dining services, and the business case for The Eden Alternative.

Products, Materials, and Ongoing Support...

We offer a variety of educational materials through our Eden Alternative Store, including our Paradigm Buster Series, DVDs, and books by Dr. Bill Thomas and other culture change leaders affiliated with The Eden Alternative. We also provide an array of other ongoing support options that include a peer-to-peer support network; a bi-weekly newsletter; webinar conversations with Co-founder Dr. Bill Thomas; research and data; a participatory, information-rich blogstream through ChangingAging.org; and the opportunity to connect through state coalitions for culture change.

The Eden Alternative Principle # **8**

An Elder-centered community honors its Elders by de-emphasizing top-down bureaucratic authority, seeking instead to place the maximum possible decision-making authority into the hands of the Elders or into the hands of those closest to them.



The Eden Registry...

For more than ten years now, members of the Eden Registy have been implementing our Philosophy and Principles. Joining the Eden Registry highlights your organization as one that is stepping up to create a life worth living. Today, there are hundreds of Eden Registry Members from across the full continuum of care. Their best practices frame a clearinghouse of information, techniques, and support they can both learn from and share with other organizations on a culture change journey.

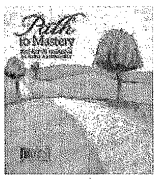
"The path is part of the journey, and is to be enjoyed as much as the destination!"

Culture change via The Eden Alternative is a never-ending process and requires a strong commitment from leadership to drive the changes over time. The Eden Registry serves as an honor society for organizations across the entire continuum of care committed to building inspired Human Habitats.

The benefits of belonging to the Eden Registry include:

- Use of our name and logo in your advertising;
- A subscription to "The Vine," a best-practices newsletter;
- Participation in a powerful peer support network;
- Quarterly teleconferences, some featuring Dr. Thomas;
- Discounts through our value-added partnerships;
- Access to an array of free resources and tools;
- Ability to assess progress on measures related to Registry peers;
- A link to your organization on our website; and
- Continuing education through the Path to Mastery™.

The Path to Mastery™ includes tools and resources designed to set up Registry Members for success, while providing a method to track progress along the way. Organizations using the Path to Mastery as a strategic tool for growth strive for the same outcomes, yet how they attain them is a unique reflection of the people who live and work there.



The word "path" refers to how the creation of a Human Habitat is a never-ending journey. The word "mastery" reflects the ongoing growth that organizations experience with the Eden Alternative Philosophy. The Path to Mastery has four Milestones, each filled with numerous outcome steps related to personal, organizational and physical transformation. Progress is taken in small steps over time, and new skills are mastered and incorporated into the whole of the organization before the next steps are taken.

The Eden Alternative Principle # **9**

Creating an Elder-centered community is a never-ending process. Human growth must never be separated from human life.



We Offer Results

In today's economy, leaders must make hard choices regarding how, when, and where to apply resources. Access to evidence-based research and data is crucial to informed decision-making. In response, we have formed the Eden Alternative International Research Committee to coordinate and disseminate research related to the impact of The Eden Alternative on the lives of individuals in a variety of care environments.

The Texas Long Term Care Institute conducted a two-year study of The Eden Alternative across six homes and yielded the following results:

- 60% decrease in Behavioral Incidents
- 57% decrease in Pressure Sores
- 48% decrease in Staff Absenteeism
- 25% decrease in Bedfast Residents
- 18% decrease in Restraints
- 11% increase in Census

"Can we show that The Eden Alternative exerts a measurable impact?
***Yes.** Our research has led us to hypothesize the existence of an 'Eden Alternative Effect.'"*
— Dr. Bill Thomas

A study performed by Elmhurst Extended Care, an Eden Registry Member in Rhode Island, revealed these additional benefits of implementing The Eden Alternative:

- Turnover decreased from 46% to 4%
- Agency nursing hours reduced to 0
- Overtime decreased by more than 50%
- Employee injuries reduced by 63%
- Fundraising increased by more than 50%

A two-year pilot project of Eden at Home in partnership with AARP revealed the following outcomes six months after 247 care partners experienced the Eden at Home Care Partner Workshop:

- 2 in 3 participating care partners said the training received was still extremely or very useful over time.
- 8 in 10 participating care partners felt they had changed their outlook on giving and receiving care.
- Over 1/2 of the participants experienced positive changes in relationships with Elder care partners
- 7 in 10 participants reported positive changes in relationships with other care partners (family, friends, volunteers, and/or professional support)

The Eden Alternative Principle # **10**

Wise leadership is the lifeblood of any struggle against the three plagues. For it, there can be no substitute.

EDEN ALTERNATIVE®

Welcome to the story...

The Eden Alternative Mission

To improve the well-being of Elders and their care partners by transforming the communities in which they live and work.

EDEN ALTERNATIVE®

It Can Be Different

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