Strait Richmond/Richmond County
Centre for Well-Being of Seniors
Proposed Model- Research

March 31, 2017

NOVA SCOTIA
Government of Nova Scotia

Dr. Kingston
Memorial Community
Health Centre

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Executive Summary

In this document, we present our literature-based, evidence-informed proposal for the establishment of a Richmond County Centre for the Well-Being of Seniors (the Centre). In our quest for a Centre, we are embarking on a *complex* journey. Therefore, we need to pursue an exploring, sensing/understanding and then responding approach; we are not pursuing a journey where we can accurately predict needs or results. We are undertaking a journey which must adapt as we explore our options and opportunities.

Briefly, the proposed Centre will be for all seniors (age 55 years +) of Richmond County (and potentially, the Strait Richmond Area), volunteers of all ages and younger participants in intergenerational programming. It is conceived as a not-for-profit, charitable organization. The stakeholders/builders of the Centre will be the population of Richmond County working together through a collective impact approach[1], forming cross-sector partnerships with a common agenda, performing mutually reinforcing activities and connecting through continuous communication to achieve enhanced health of Richmond County seniors.

The Centre will be a virtual entity with a fixed location only for the Centre administrative staff. The Centre will function through vertical and horizontal collaboration/integration. Services and programs will be provided through linking with other partners and collaborators. Partners and collaborators will undertake united actions based on the platforms and pillars illustrated below.

All services and programs will be evidence-informed and based on best practices. All services and programs will be monitored and evaluated to ensure their effectiveness and relevance. Specific services and programs will evolve in accordance with the needs of the communities of Richmond County. A volunteer mentoring and education program will support community volunteers of all ages; these volunteers will be critical for the success of the Centre.

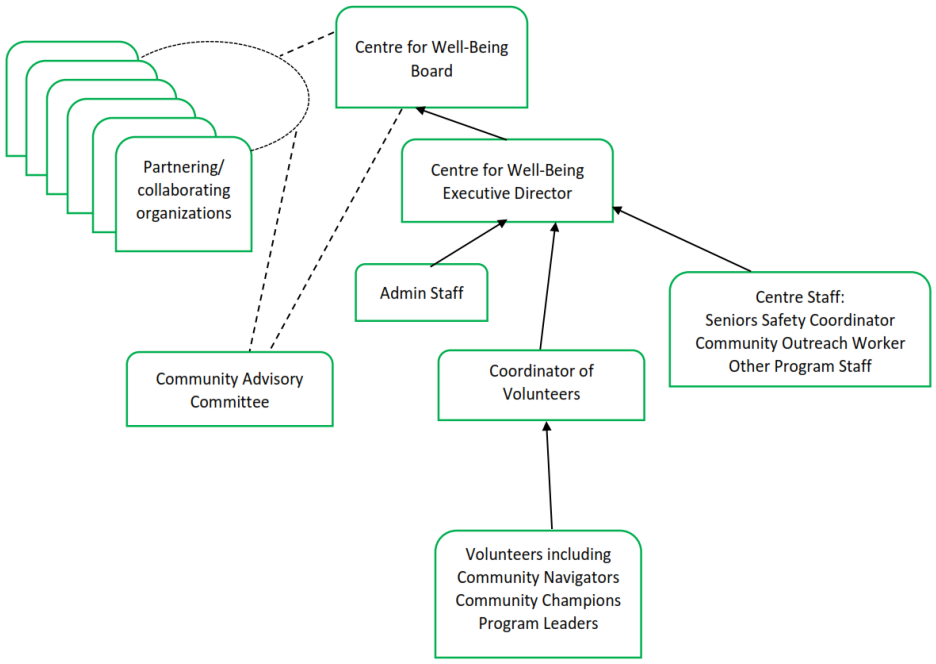
Expected long-term outcomes include:

- seniors are engaged in endeavours that decrease the impacts of frailty, illness and disability on independence and quality of well-being of themselves and other seniors
- seniors increasingly identify and contribute to the community their knowledge and skills
- increasing numbers of seniors are physically active and receive proper nourishment
- upstream endeavours to decrease the impact of the social determinants of health are undertaken
- more seniors who were previously unengaged and inactive within their community are participating
- caregivers who feel supported and have access to needed resources.

Funding for the Centre will be sought through:

- nominal membership fee for participants to provide access to Centre programs and services; membership fee would be waived when circumstances required;
- grants- federal, provincial, foundations, etc.;
- Municipality of Richmond County/Town of Port Hawkesbury subsidies;
- fund raising;
- bequests, sponsorships, etc.;
- social enterprise (snow removal, yard maintenance, etc.);
- provision of training/education programs for others (for example, mental health first aid)

A preliminary collaborative governance structure is illustrated below.

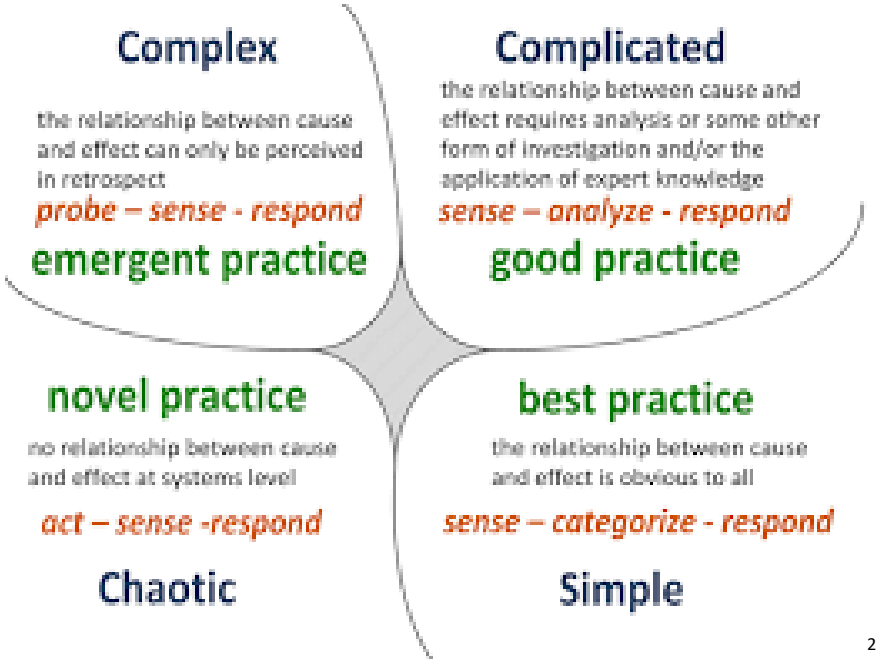


As we travel further along the journey to achievement of our Centre for Well-Being of Seniors in Richmond County, we "need to change our mindset from activities, strategies and programs to what is the change state we desire for our community".[1] The input received through our two community Think Tanks has informed and modified the proposed model.

[1] *Putting collective impact into practice in Maine communities- Workbook*, October, 2012; p. 6.

Introduction

In our quest for a Centre of Well-Being for Seniors, we are embarking on a ***complex*** journey. Therefore, we need to pursue an **exploring, sensing/understanding and then responding approach**. As per the diagram below, we are pursuing a journey where we cannot accurately predict needs or results.



[2]

Briefly, the proposed Centre for Well-Being of Seniors (hereafter referred to as the Centre) will be for all seniors (age 55 years +) of Richmond County, volunteers of all ages and younger participants in intergenerational programming. It is conceived as a not-for-profit, charitable organization. The stakeholders/builders of the Centre will be the population of Richmond County and Strait Richmond Area working together through a collective impact approach, forming cross-sector partnerships with a common agenda, performing mutually reinforcing activities and connecting through continuous communication to achieve enhanced health of Strait Richmond Area seniors.

Presently, there is no system in place to comprehensively research, plan and integrate efforts to preserve and improve the well-being of our seniors. Our challenges include our sparsely populated, rural geography (approximately 9,300 persons[3], population density of 7.5/km^2). In Richmond County, approximately 24% of citizens are seniors (above the age of 65) and 38% are above the age of 55 (2011 census data). The expectation is the percentage and number of seniors will increase significantly over the next decade. Many experience material (food, shelter, financial) deprivation (4 out of a rating of 5, where 5 indicates the greatest level of deprivation[4]). Twenty-two percent of our population are Francophone.

Focus groups, community conversations and seniors' groups and organizations have identified that many seniors in our County are not meeting recommended guidelines for physical activity and nutrition, many are socially isolated and not engaged in our community, many have inadequate housing and

[2] Cynefin, http://www.collaborationforimpact.com/collaborative-approaches/
[3] 2011 census data
[4] *Data & Information Working Group/Department of Health and Wellness*, 2015

limited/ inadequate income and many have more than one chronic disease. These same sources have also identified that there are many seniors in our communities with untapped skills and knowledge that could benefit our communities' health and well-being; that with collaboration, we all could make significant contribution to the well-being of our communities.

Centre objectives for seniors of the Strait Richmond Area:

- decrease the number of seniors who feel socially isolated
- build on the talents and resources of seniors to enhance the health and well-being of community members
- increase the number of seniors who are physically active and properly nourished
- decrease the adverse effects of the social determinants of health
- improve access to programs and services for those presently unable to participate in community-based programs of their choosing
- provide support to caregivers (volunteer, family and professional)

Expected outcomes for Centre:

- seniors are engaged in endeavours that decrease the impacts of frailty, illness and disability on independence and quality of well-being of themselves and other seniors
- seniors increasingly identify and contribute to the community their knowledge and skills
- increasing numbers of seniors are physically active and receive proper nourishment
- upstream endeavours to decrease the impact of the social determinants of health are undertaken
- more seniors who were previously unengaged and inactive within their community are participating
- caregivers who feel supported and have access to needed resources

This literature-, evidence-informed proposed model for a Centre for Well-Being of Seniors is founded in the concept of a virtual centre, with interlocking networks and sites throughout the area radiating from a fixed administrative hub at the Dr. Kingston Memorial Community Health Centre or other physical location. The roles of the Centre for Well-Being will include provision of evidence-informed programs and services, community engagement and education, connecting resources, community capacity building/ development, forming partnerships/collaborations and advocacy. Programs and services will be based on community member input and community health needs assessment mapping.

An interlaced network of partners will be established, each having a commitment to five framing pillars (age-friendly communities, social determinants of health, collaborative practice/community health centres, social enterprise and attention to all aspects of well-being)(see below). The Centre's network of partners will enable breaching of traditional boundaries and sector siloes. It will view the health and well-being of seniors from a population-based, overarching system perspective (an umbrella organization)- one that links with all pertinent levels of government, sectors and health care components. It will serve to link and increase awareness of all efforts to improve the well-being of seniors within Richmond County and to plan from a systemic viewpoint. It will celebrate the strengths of seniors and evolve organically to seek to address the needs of seniors.

Background

Dr. Kingston Memorial Community Health Centre

The Dr. Kingston Memorial Community Health Centre began as a rural community physician practice and has grown into an evolving Community Health Centre where clinicians with varied professional backgrounds practice collaboratively together. The surrounding communities raised the funds to build the new Centre in 2015. Since its opening, clinicians of varied backgrounds have come to practice. The Centre Board has three employees (two medical receptionists and a Managing Director). The clinicians rent space in the building. Otherwise, financed largely through community donations and participation, the mission of the newly built Kingston Centre is to encourage and support activities that promote health and wellness in our communities.

Other initiatives underway/proposed for our area

In 2012, an advisory committee struck by the **Municipality of Richmond County** oversaw community conversations related to the development of age-friendly communities in our area. However, the recommendations of the advisory committee remain largely unimplemented. More recently (2016), the Municipality received an Age-Friendly grant to 1) build a Leadership Team of representatives from varied backgrounds and sectors. This Leadership Team will function as an Age Friendly Advisory Committee and will be responsible to oversee the entire project; 2) prepare the Community for age-friendly community development; 3) develop an Age-Friendly plan: this final step will be to undertake a strategic planning process to develop a plan for the next five years; this process will include involving key stakeholders.

Initiated by Strait Richmond Public Health, a **Seniors Take Action** conference was held October, 2015. This conference was attended by approximately 165 people who helped to identify actions to advance the health of seniors. The momentum from this conference has continued and in January, 2016, a Seniors Take Action Coalition was developed for Richmond County/Strait Richmond Area.

In the winter and spring of 2014-2015, the **Community Health Boards** in the former GASHA Health Authority completed a series of community consultations on the health of communities (Community Conversations: "Hope for the Health of our Communities"). Over 300 people attended these sessions with seniors representing one-third of participants (www.gashachb.ca/index.php). From these community consultations, priority areas of social isolation, food security, poverty and early childhood education and care were identified.

The **Community Outreach and Support Worker** (COSW) Project began in October, 2014. The need for a Community Outreach and Support Worker was identified through conversations with community members and representatives of various agencies involved in health service delivery. The COSW provides guidance to community members by linking them with the contacts and support needed to access resources available to them. Often these resources are inaccessible because of difficulty in contacting the applicable agency or unawareness of potential resources available. Individuals of all ages and economic status can access the services provided by the COSW. The most frequent and urgent needs the COSW has addressed include support with housing grants, obtaining caregiver benefits, assisting with homecare concerns and completion of government application forms.

As of January 30, 2017, 424 clients (319 families) accessed this invaluable, cost effective service. With assistance from the COSW, over $715,000 was secured through various grants and caregiver benefits.

Twenty-eight individuals have avoided admission to a full-time care facility (cost of ~$40,150/person/ year). That is a potential saving of over $1,000,000 to the Province of Nova Scotia.

In 2012, the **Municipality of Richmond County** conducted community consultations to determine the age-friendliness of communities within Richmond County. Whereas most seniors wanted to remain in their communities, they cited challenges with transportation, affordable housing, services such as mowing/snow removal/home repairs or modifications and lack of communication/information about available resources.

Recently the Municipality of Richmond County received funding for a project entitled **Mind, body and spirit: a collaborative community approach to addressing seniors' mental health and addictions in the Strait-Richmond Area**. The project will include a number of initiatives that will utilize and strengthen a collaborative approach to addressing mental health and addictions of seniors in our communities. It will involve multiple partners and address the issue using a population health approach. The programs and services will address the gaps in our communities and will be based on best practices. Using a grass roots approach, this project will enhance existing assets in our communities while building capacity of both providers and program participants.

Presently, several community-based **wellness projects** are underway including a study of abuse and neglect of seniors, social isolation, community education through theatre art and feasibility of a social enterprise to address some of the everyday needs of seniors and those living with disabilities (for example, housecleaning, yard maintenance, snow removal). Our proposed Centre for Well-Being of Seniors model will learn from, incorporate as appropriate, and complement these endeavours.

Foundational Pillars

The proposed model for a Richmond County Centre for Well-Being is founded on the following five frameworks: age-friendly community, social determinants of health, well-being, philosophy of community health centres and social enterprise. The **first pillar** is that of an age-friendly community. The eight essential components of an age-friendly community are illustrated in the figure below.

WHO (2007) Global Age-Friendly Cities: A Guide, pg. 9

The emphasis of the Centre for Well-Being of Seniors will be on respect and social inclusion, civic participation, communication and information, community support and outdoor spaces for physical activities.

The **second pillar** is that of the social determinants of health (with particular emphasis on highlighted areas). The social determinants of health include the following:

- Income and Income Distribution
- **Education**
- Unemployment and Job Security
- Employment and Working Conditions
- Early Childhood Development
- **Food Insecurity**
- Housing
- **Social Exclusion**
- **Social Safety Network**
- Health Services (**community-based**)
- Aboriginal Status
- Gender
- Race
- Disability **(accessibility)**[5].

The **third pillar** proposes that a social enterprise endeavour be undertaken to contribute to the funding for the Centre. "Social enterprises are businesses owned by nonprofit organizations, that are directly involved in the production and/or selling of goods and services for the blended purpose of generating income and achieving social, cultural, and/or environmental aims. Social enterprises are one more tool for non-profits to use to meet their mission to contribute to healthy communities." -Social Enterprise Council of Canada.

The social enterprise business would provide needed services to seniors while generating income to reinvest in the operations. This will serve a dual purpose in that it will meet an unmet need in the community, while also contributing the financial sustainability of the Centre. An additional benefit will be the opportunity to potentially employ seniors as well as explore other inter-generational projects.

(Illustration by Common Good Solutions)

[5] Mikkonen, J., & Raphael, D. (2010). *Social Determinants of Health: The Canadian Facts.* Toronto, Canada: York University School of Health Policy and Management

The **fourth pillar** embraces the dimensions of well-being. Well-being is a broader concept than health as it is generally conceived. Individuals, groups and communities may have many areas of potential well-being: social, emotional, spiritual, environmental, occupational, intellectual, physical, aesthetic and civic engagement. Implied in this definition is the understanding that people can have many areas of well-being even if one or more areas are compromised. Well-being implies a self-perceived sense of satisfaction with one's life. Most people value feeling secure, belonging, having a purpose, being of significance, achieving fulfillment and continuity of persons and place (Nolan, 2006).

The **fifth pillar** adopts the approaches of community health centres as defined by the Canadian Association of Community Health Centres. They define a Community Health Centre as a place where high-quality primary care is offered by a collaborative team of clinicians; where team-based, person-centered primary care is integrated into health promotion and illness prevention programs as well as community development initiatives; where planning occurs with community members to ensure the most appropriate and accessible services are available; where the social determinants of health are tackled from a root cause perspective; and where health equity and social justice are foundational beliefs.

Collaborative, interdisciplinary, person-centered practice is embedded in the functioning of community health centres. The Canadian Medical Association describes person-centered care as care that "considers the (persons') cultural traditions, their present preferences and values, their family situations, and their life style. It makes (the person) and their loved ones an integral part of the care team who collaborate with health care professionals in making clinical decisions"[6]. They define collaborative care as entailing "physicians and other providers using complementary skills, knowledge and competencies…working together to provide care to a common group of patients based on trust, respect and an understanding of each others' skills and knowledge. This involves a mutually agreed upon division of roles and responsibilities that may vary according to the nature of the practice personalities and skill sets of the individuals. The relationship must be beneficial to the (person), the physician and other providers" (p. 3).

All of the pillars overlap to some extent thus strengthening the organizational structure.

Evidence and recommendations: services and programs

The specific services and programs to be delivered will be determined as the Centre evolves. The choices will be guided by principles of evidence-based/informed interventions and inclusiveness; by determining those interventions expected to have the greatest positive impact; through building on established programs and services; and with adaptation to changes as these occur. Potential areas for programming and services are discussed under chronic disease, physical activity, social isolation and civic engagement, intergenerational approaches and other. None of these areas is truly separable from the others; all are intertwined.

[6] Putting Patients First: patient-centred collaborative care. A discussion paper, 2007. Canadian Medical Association; p. 1

Chronic disease

Chronic diseases have multifactorial causes, many of which are not under an individual's control. Thus, we, as a society and a community, have a responsibility to seek ways to prevent and ameliorate chronic illnesses.

> Society-level factors affecting maintenance of a healthy lifestyle include the built infrastructure and services, health system, social policy, cultural perceptions and norms towards older persons. Community-level factors include interpersonal relations, social networks, and the local physical environment, as well as services and facilities. Individual factors that may impact on the success of interventions in this age group include self-efficacy, knowledge and beliefs, perceived health benefits, and health literacy (Hector et al, 2012).

Community/society level circumstances that contribute to unhealthy behaviours include limited access to transportation, low neighbourhood walkability, negative perceptions and norms towards older persons and lack of built infrastructure and services specifically designed for older persons.

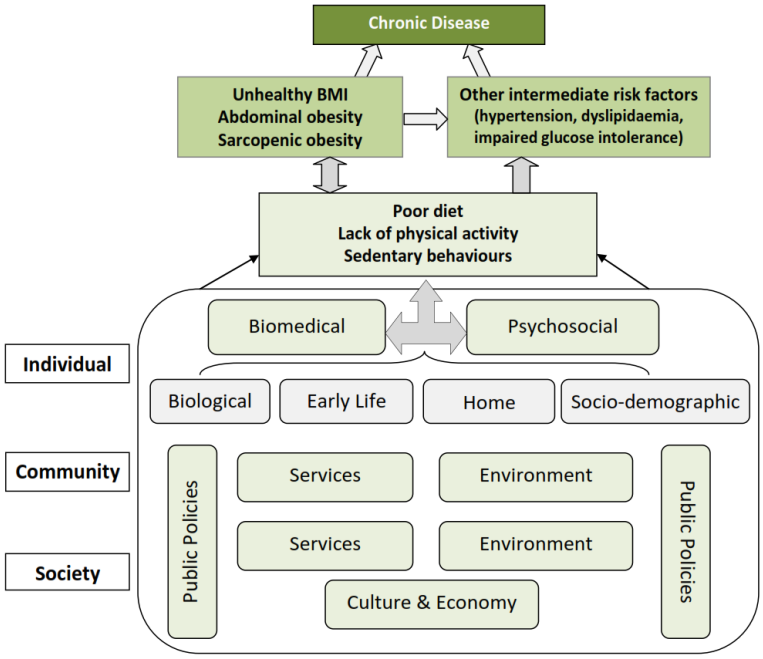


Figure 1 Framework of factors contributing to chronic disease in adults aged 55-74 years

(Hector et al, 2012)

In addition, our area has been identified as an area with a high percentage of high-cost healthcare users because of our older demographic and high incidence of people with chronic disease in our communities (Kephart et al, 2016). In Richmond County, 30% of individuals and 10% of families live on a low income (a risk factor for chronic disease)[7]. There is a high incidence of people with diabetes, chronic obstructive lung disease and ischemic heart disease in our area. Many of our seniors have more than one chronic health condition resulting in interference with daily activities of living. Many experience social isolation.

[7] Community Counts, 2006.

The Public Health Agency of Canada has identified primary potentially reversible risk factors for chronic disease as tobacco use, harmful use of alcohol, hypertension, physical inactivity, raised cholesterol, overweight, unhealthy diet and raised blood glucose[8]. Physical activity and proper nutrition will be emphasized in our services and programs. In addition, the Public Health Agency of Canada has identified five key focus areas to improve healthy ageing- social connectedness, physical activity, healthy eating, falls prevention and tobacco control[9]. Improving social connections and falls prevention will be integral elements in our programs and services.

Social isolation is a modifiable risk factor for chronic disease and is associated with a higher risk of disability, mental illness, addiction, and death from cardiovascular disease and stroke[10]. **It is interwoven into all major risk factors for chronic disease.** Addressing social isolation and the social aspects of chronic disease will be a major focus of the services and programs of the Centre. These interventions will span the spectrum of identification of those at risk, risk assessment, health promotion, disease prevention to remediation of the effects of chronic conditions on activities of daily living. Importantly, to reach those not usually involved in counselling, groups or community activities, our approach must include outreach, nursing home and home visits (or other location of the person's choice). We will provide services and programs that are a mix of universal and those targeted to specific at risk groups.

Recommendations

1. Interventions should include those focussed at a society/community level as well as those focussed at the level of an individual,
2. Efforts to deepen understanding of prevention and amelioration of chronic disease in seniors could include walking with a senior through her/his community to understand challenges and opportunities, a "walk in the shoes" of a senior with a chronic condition(s) and/or the use of photographs, theatre, poetry and art to expand the ways seniors can express the realities of their lives.

<u>Physical activity</u>

Beneficial physical activity combines aerobic exercise as well as exercises to enhance endurance, strength, flexibility and balance. Research evidence demonstrates that physical activity throughout our life span has a significant influence on health, chronic illness, social resilience, psychologic well-being, bone mass and independence (for example, Pereira et al, 2006; Wieckowski & Simmons, 2006). Bock et al (2014), in their systematic review of community-based interventions to promote physical activity, found that tailored, face-to-face counselling and group sessions were effective and that interventions prolonged over time were more effective than shorter programs. Programs that included behavioural, educational, cognitive and social strategies had greater efficacy. However, most programs reached only those already engaged in community activities.

Wieckowski & Simmons (2006) noted that, for the frail elderly, a supervised home-based or a combination of home- and group-based format had greater adherence (although there were few high-quality studies available to review). Ongoing contact also enhanced adherence. Most successful programs included the participant as an active decision maker. Provision of home-based programs (or those based in a location of the participant's choice) may enable more difficult to reach community members to become more physically active. In their article, Wieckowski & Simmons (2006) describe an evidence-based physical activity program. The New Zealand Ministry of Health, as well as others, have

[8] http://www.phac-aspc.gc.ca/cd-mc/risk_factors-facteurs_risque-eng.php

[9]https://www.phac-aspc.gc.ca/seniors-aines/publications/public/healthy-sante/vision/vision-bref/chap04-eng.php.

[10] *Promising approaches to reducing loneliness and isolation in later life*, AgeUK, 2015.

developed evidence-based guidelines for physical activity for persons over 65 years[11]. In addition, the Community Links evidence-based falls prevention program, which has integrated components of physical activity, will be incorporated into the Centre's programming.

The second evidence-based component of Wieckowski & Simmons' program was based on a stages of change model. Using this model, the clinician assesses the participant's readiness for change and adapts the approach to the participant's readiness. With the participant, the clinician identifies potential barriers and explores solutions. The participant identifies challenges, sets goals and outlines an action plan. Motivational coaches recruited from community members worked with clinicians to support and reinforce the action plan with participants.

However, whereas there are guidelines for recommended physical activity amount and duration, there is little information on evidence-based interventions to engage and motivate seniors to achieve the recommended physical activity. This is an area we will explore further.

Recommendations

1. Undertake theory-/literature-based novel interventions to engage and motivate seniors to become physically active and meet the appropriate age-related standard for exercise,
2. Evaluate (quantitative and qualitative methods) any interventions piloted,
3. Use methods to evaluate a participant/potential participant's change readiness,
4. Involve participants and potential participants in decision-making related to programs and services,
5. Use interventions that include theory-/evidence-informed approaches to motivation, mentoring and ongoing monitoring,
6. Incorporate physical activity action plan into participant's wellness/health home record.

Social inclusion and civic engagement

Social isolation may result from factors external to the person (racism, ablism, geographic) or internal to the person (shyness, aggressive behaviour, lack of social skills, disinterest in social relationships). There are many compelling reasons to prevent, address and remediate social isolation within our communities. Within the context of a Centre of Well-being, there are significant impacts on health. A systematic review of studies examining social isolation and coronary artery disease and stroke found a 29% increase in coronary artery disease and a 32% increase in stroke in persons with limited social relationships (Valtorta, Kanaan, et al, 2016). As stated in *Social isolation in Bristol (2014); risks, interventions and recommendations report*, "weak social connections carry a health risk that is more harmful than not exercising, twice as harmful as obesity, and is comparable to smoking 15 cigarettes a day or being an alcoholic" (p. 12). To achieve sustainable and significant decreases in the social isolation of our community members, the interventions must be based within a social determinants of health framework (socio-economic-environmental approach). Outreach must be an essential component of any intervention.

Although social isolation has been identified as a major challenge in our geographic area through surveys, community dialogue and other interactions with seniors, successful evidence-informed interventions to address social isolation are rare (for example, Findlay, 2003; http://www.cpa.org.uk/information/reviews/CPA-Rapid-Review-Loneliness.pdf). The thorough CPA review found that group interventions with an educational component, targeted interventions to meet

[11] Ministry of Health (2013). *Guidelines on physical activity for older people (aged 65 years and over)*. Wellington: Ministry of Health.

the needs of specific populations, involvement of participants in designing, setting up and running a group, interventions with a sound theoretical basis and interventions with videoconferencing or use of internet were most effective. Interventions that foster independence, ongoing relationships, and where activities are personalized have been demonstrated as effective[12].

A number of common characteristics of rural seniors include a strong work ethic, need for independence, deep religious beliefs, disenchantment with formal services and programs, limited transportation/geographic access to needed resources/supports, reliance on informal support networks and discomfort with sharing personal information[13]. Although seniors are not a homogeneous group, any program to decrease social isolation must respect these characteristics as well as address differences between healthier and frailer seniors.

In our communities, seniors are a relatively untapped source of expertise, knowledge and resources (social capital). As volunteering is associated with a decreased incidence of diabetes and cardiovascular disease[14], we plan to engage seniors as volunteers for the benefit of their own well-being as well as that of others. A volunteer program will be an essential component of our Centre.

Recommendations

1. Have an outreach component to every service and program were feasible and beneficial,
2. Incorporate interventions that foster independence, interdependence, relationships, learning and participant involvement in their creation and content,
3. Integrate volunteers into services and programs wherever appropriate.

<u>Intergenerational programming</u>

Intergenerational activities are vital for the development of compassionate, age-friendly communities. Using an intergenerational framework to approach building healthy communities can "strengthen the social compact, promote understanding of generational interdependence across the life course, recognize the contributions of all ages and highlight health disparities and inequities"[15]. This approach fosters interdependence, reciprocity, recognition of individual worth and inclusion. It improves community cohesion, development of inclusive policies and diversification of volunteering. Intergenerational activities are associated with improved cognitive functioning, as well as emotional and social well-being (Park, 2014a). Seniors reminiscing or reading stories with children report improved health; seniors volunteering with children were more physically active and had better physical functioning than non-volunteering peers (Park, 2014b). All ages experienced increased understanding of others, friendship, enjoyment and confidence. Springate et al (2008) reviewed peer-reviewed and grey literature on intergenerational practice. Key factors for success included projects having a long-term approach, staff with appropriate skills and training to interact with young and old, preparation of participants prior to any intervention, activities that are focussed on developing relationships, activities that are shaped by participants and activities that include mutual benefits for participants. United Generations Ontario has developed a 'tool kit' for connecting generations[16].

[12] Raymond in Levasseur et al. (2016). Personalized citizen assistance for social participation (APIC): a promising intervention for increasing mobility, accomplishment of social activities and frequency of leisure activities in older adults having disabilities. Arch Geront Geriat 64:96-102.
[13] *Aging well in rural places: literature synthesis.* Atlantic Health Promotion Research Centre.
[14] Community Development Halton (2005). *Inclusive Cities, Canada-Burlington, Community Voices, Perspectives and Priorities.*
[15] Brown C, Henkin N (nd), *Intergenerational approaches to building healthy communities*. Intergenerational Center, Temple University.
[16] United Generations Ontario (2006). *Connecting generations tool kit*. www.unitedgenerations.ca

Group-based intergenerational physical activity programs have improved general participation in physical activities in those who were previously inactive (Sowle, 2015). Many programs offer a mix of activities suited to various ages and levels of fitness but all have an interactive component. For example, United Generations Ontario[17] has written guidelines for implementing an intergenerational physical activity program. They stress that individual risk factors for physical activity adverse events be assessed and that all involved in these programs receive education about the developmental stages of life. Communication and involvement are key in the development of programs.

Recommendations

1. Services and programs adopt a long-term approach,
2. Associated staff have or receive education to acquire appropriate skills and training to interact with young and old,
3. Young and old participants understand what is expected prior to any intervention,
4. Activities should be focussed on developing relationships,
5. Activities should be shaped by participants and include mutual benefits for all participants,
6. Involve schools in starting programs.

<u>Other components of outreach programs</u>

Other programs and services will be based on community input. Prior evidence of success will be sought for all proposed interventions. If none exists, the program or service will be undertaken on a trial basis if the concept seems likely to have impact. All programs and services will have ongoing evaluation to determine their success and relevance.

Programs and services will be focussed on continuity and coordination of dignified, person-centered care. Potential evidence-based programs and services include:

- Screening to identify health risks (for example, sending out birthday cards with an offer of an annual health and well-being review, Clark et al, 2013)
- Assessment of activities of daily living, mental/emotional functioning, social and environment embedded in other routine visits
- Development of personal health and well-being goal plans (co-produced by participant and health professional)
- Referrals as required
- Individual interventions
- Group interventions
- Ongoing monitoring and evaluation of health and well-being of Centre participants
- Education/information
- Review of medications in consultation with local pharmacists
- Document and regularly update action plan (link with health record)
- Help to find resources to support ageing in place (housework, laundry, shopping, yard maintenance, etc.)
- Collaboration with acute care facilities for discharge planning and post-discharge support
- Re-ablement /rehabilitation in homes/community (focus on independent functioning rather than resolving health issues)(Arksey et al, 2013)
- Provision of support and education for family and volunteer carers
- Volunteer and health champion recruitment, mentoring and education

[17] Wright S (2008). *A guide to intergenerational physical activity: a practical guide to implementing IGPA programs.* www.unitedgenerations.ca.

- Improving interventions for common conditions of ageing
- Supports for independence/involvement in own and family members' care

(Oliver et al, 2014)

Evidence and recommendations: structure/organization

Whereas the definitive organizational structure will evolve and be determined by partners/collaborators and community members, it is expected to incorporate the framework and foundational pillars illustrated below.

Volunteers/community champions

Volunteers/community champions will surround and enable the Centre to thrive. There are many documented benefits of volunteering for seniors. These include improvements in physical, cognitive and emotional health; enhanced social inclusion and civic engagement; maintenace of self-esteem, self-worth and feelings of usefulness[18]. However, significant challenges and barriers have been identified that hamper the ability of seniors to vounteer. These include rural geography, transportation, scheduling (for example, night time driving), length and time of commitment required, scarcity of supports to enable participation (for example, caregiver respite), language and culture, changing cognitive and physical abilities, comfort with technology, access to learning about opportunities to volunteer, not having been asked and negative past experiences[19].

In keeping with evidence from literature reviews, for the Centre for Well-Being of Seniors to thrive, a strong volunteer recruitment, mentoring, support system and ongoing engagement program must be

[18] Cook SL, Speevak Sladowski P (2013). *Volunteering and Older Adults*. Human Resources and Skills Development Canada, Community Development and Partnership Directorate.
[19] Ibid.

incoporated. The Centre will recruit volunteers for leadership roles in programs and activities as well as Community Champions. The volunteer program will be overseen by a Coordinator of Volunteers.

Integration

Integration of health and social care for seniors has been shown to improve health outcomes, reduce utilization of nursing homes and hospitalization, decrease emergency room visits, improve the quality of professional services and enhance satisfaction of users (for example, Ham & Curry, 2011). Collaboration, communication and continuity of care are enhanced through integration. Integrated care at the person level (incorporating the use of shared care plans and planning) is most effective when it involves multiple approaches to care coordination.

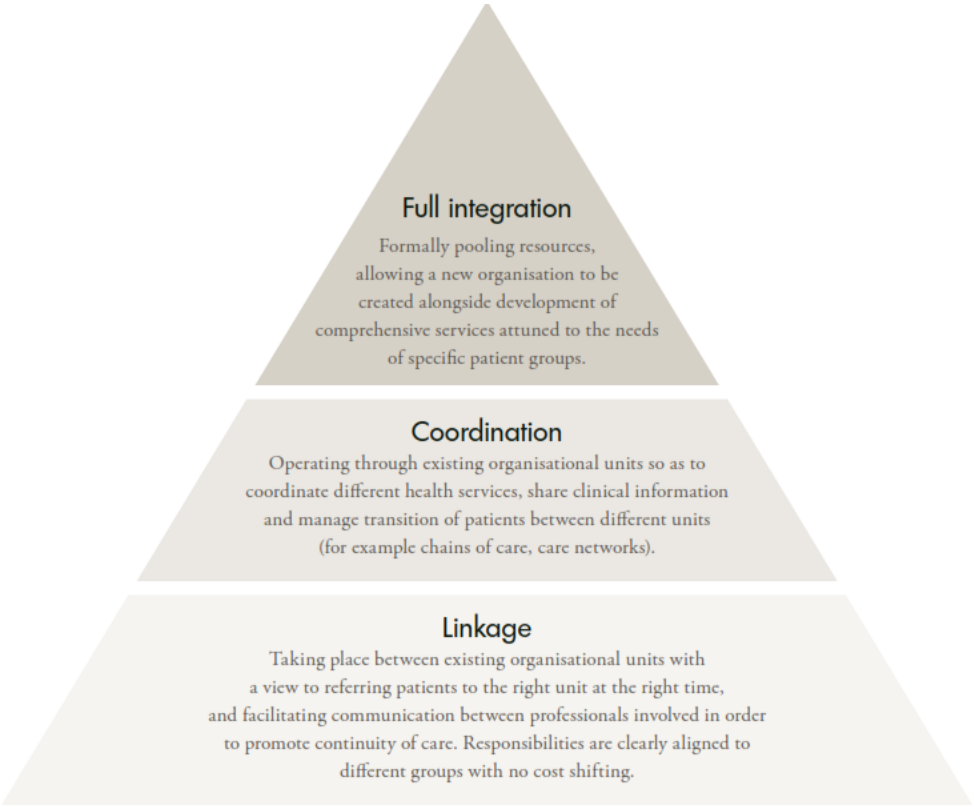
In the long-term, we propose the programs and endeavours undertaken through the Centre become fully linked (and in some cases, integrated) with those of primary health care providers to develop a seamless system of health and social care. Integration is "concerned with the *processes* of bringing organisations and professionals together, with the aim of improving *outcomes* for patients and service users through delivery of integrated care" (italics as in original)(Clark et al, 2013; p. 106). In our model, integration will be largely virtual rather than physical. Clark et al stress that "being person-centred needs to be both a starting point and continuing focus for integration efforts" (p. 115). Research evidence has shown that approaches to integrated care that cover large populations, use a programmatic approach, include primary/secondary care and health promotion/primary prevention and link with community-based services are more likely to be successful (Goodwin et al, 2012). In order to be effective in improving access to care and patient/person outcomes, integration efforts should be focussed on the service/program users' pathway of care rather than organizational structure. In *Building on integrated care: lessons from the UK and elsewhere* (The NHS Confederation), the authors note there are several dimensions of integration: organizational, functional, service, clinical, normative and systemic. Our emphasis will be on functional, service, clinical, normative (shared values) and systemic (coherence of policies and procedures).

Virtual integration is facilitated by:
- central co-ordination (if possible, by a neutral body)
- clear goals and reasonable boundaries
- inclusiveness in design and development
- not being too large – smaller groups work better
- cohesion increased through the development of 'boundary spanning individuals'
- by using IT and shared guidelines and protocols
- professional leadership
- avoiding over-regulation and instruction
- avoiding 'network capture' by one professional group or institution
- having a clear business plan and mandate for management
- engagement and connectivity
- adding value to members and others.

(Goodwin et al, 2004)

Within our proposed Centre model, there will be varying 'levels' of integration that include both horizontal and vertical integration. For example, horizontal integration is a key component of an integrated, interdisciplinary collaborative practice founded in the model of a 'health or wellness home', a practice approach the Dr. Kingston Community Health Centre is pursuing. This approach is being promoted and supported by the Nova Scotia Health Authority (NSHA). Examples where program

components would be integrated into the practice of clinicians include screening for nutritional health, poverty[20], social isolation and physical activity. An example of vertical integration is the administrative/ organizational structure of the proposed Centre model (see below).



(Shaw & Rosen, 2011)

Care coordination

Care coordination is an example of horizontal and vertical integration. Although normally used in reference to 'medical' care, in the context of the Centre, care is defined as any intervention to enhance the well-being of individuals.

> *'Care coordination' is a person-centered, assessment-based, interdisciplinary approach to integrating health care and social support services in a cost-effective manner in which an individual's needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an evidence-based process which typically involves a designated lead care coordinator* (National Coalition on Care Coordination 2011)(italics as in original)(see below for parameters of care coordination).

Measures of effectiveness of integration and care coordination will include structural, cultural and process aspects. For example, structural aspects include guidelines, electronic health record, referral mechanisms and interlinked chains of care. Cultural aspects could assess participant comfort and willingness to change to a new system. Process aspects would examine what is done to assure coordination (Strandberg-Larsen et al, 2009).

[20] For example: *Poverty Intervention Tool*. Divisions of Family Practice. www.divisionsbc.ca

In particular, care coordination must target transitions in care and care providers. This requires identification of transitions and processes to evaluate care at each transition (for example, from community-based to hospital-based care; from acute to chronic care needs).

Characteristics of successful approaches to care co-ordination

System level

- Universal coverage or an enrolled population with care free at point of use
- Primary/community care-led
- Emphasis on chronic and long-term care
- Emphasis on population health management
- Alignment of regulatory frameworks with goals of integrated care
- Funding/payment flexibilities to promote integrated care
- Workforce educated and skilled in chronic care, teamwork (joint working) and care co-ordination

Organisational level

- Strong leadership (clinical and managerial)
- Common values and a shared mission
- Aligned financial and governance structures
- Integrated electronic health records
- Responsibility for a defined population or service
- A focus on continuous quality measurement and improvement

Clinical and professional integration

- Population management
- Case finding and use of risk stratification
- Standardised diagnostic and eligibility criteria
- Comprehensive joint assessments
- Joint care planning
- Holistic focus, not disease-based
- Single or shared clinical records
- Decision support tools such as care guidelines and protocols
- Technologies that support continuous and remote patient monitoring

Service integration

- Assisted living/care support in home
- Single point of entry
- Care co-ordination and care co-ordinators
- Case management
- Medications management
- Centralised information, referral and intake
- Multidisciplinary teamwork
- Inter-professional networks
- Shared accountability for care
- Co-location of services
- Discharge/transfer agreements to manage care transitions
- Supported self-care

Sources: Bodenheimer 2008; Coleman *et al* 2009; Curry and Ham 2010; Goodwin *et al* 2010; Ham 2010; Hofmarcher *et al* 2007; Kodner 2009; McDonald *et al* 2007; Øvretveit 2011; Powell Davies *et al* 2006; Smith *et al* 2012; Tsai *et al* 2005

21

[21] Goodwin N, Sonola L, Thiel V, Kodner D (2013). *Co-ordinated care for people with complex chronic conditions: Key lessons and markers for success.*

Navigation

Facilitating navigation through care systems is another form of integration. 'Navigation' positions have been shown to be cost-effective and valuable (Walkinshaw, 2011; Capital Health, 2012; Enard & Ganelin, 2013). Patient navigators provide emotional support, prepare patients for their treatment journey, provide continuity, aid with coordinating appointments, facilitate referrals to community supports, assist with travel logistics, find funding sources for needed supplies and help to decrease health disparities in underserved populations (Natale-Pereira et al, 2011). Patients are better prepared for their treatments, collaboration amongst team members is improved, services are provided more efficiently and appropriately, service gaps are identified, duplication of services is reduced, care in home communities is facilitated and patient/family satisfaction is increased when patient navigators are involved (Cancer Care Nova Scotia, 2004). Navigation support should be offered whenever transitions in care occur.

Within Nova Scotia, there are several initiatives underway utilizing navigators. The Chebucto Community Health Team is piloting a wellness navigator (Moore, 2016) and the Rural Communities Foundation of Nova Scotia is piloting a seniors' navigator project. Navigators come from a varied background including occupational therapy, nursing, nurse practitioner, social worker, recreation therapist and volunteer. The evidence of efficacy is strongest for those with a professional background. As indicated above, the Strait Richmond Area Community Outreach and Support Worker position pilot demonstrated significant positive outcomes both for users and financially for our communities.

Initial navigation positions in our proposed model would include both a community outreach and support worker as well as a seniors' safety coordinator. According to the Nova Scotia Department of Seniors, a "Seniors Safety Program is a community-based program that…addresses the safety concerns of seniors by:

- promoting awareness about senior abuse prevention, crime prevention, and safety and health issues
- enhancing communication between seniors and the police
- providing information, educational sessions, and referral services to seniors
- offering direct contact with seniors through the seniors safety coordinator"[22].

It is envisioned that our Seniors Safety Coordinator will also be certified to provide the evidence-based falls prevention program developed by Community Links (Nova Scotia) and mental health first aid. The Seniors Safety Coordinator will partner with local pharmacists to address issues related to medication safety. As the Centre evolves, the need for more navigation positions may be identified.

Social safety/well-being home (our fifth pillar)

The province of Nova Scotia very recently adopted the model of a health home, a model in keeping with our model of a wellness home. They define a health home as one that

- is **person and family centred**
- **provides timely access**
- assigns every patient a **most responsible provider**
- has a **comprehensive scope** of services carried out by teams or networks of providers
- **enables continuity and coordination of** relationships and information
- is an ideal sites for **training and research**
- uses electronic health records (EHR)

[22] http://novascotia.ca/seniors/senior_Safety_Programs.asp

- is committed to **continuous quality improvement and safety**
- is strongly **supported** by governance structures, practice management, public, etc.

Health homes work in **collaboration** with other health homes to foster collaboration across the broader network[23].

In our 'social safety/well-being home model', we plan to purposefully incorporate consideration of social determinants of health, an individual-centered orientation, a community-wide health approach, collaboration across sectors, addressing health inequities and a prevention/health promotion mindset to avert and remediate the impact of social isolation/exclusion: a life-course model. This model is based on the concept of a 'medical home' and will be integrated into individual's medical care. A medical home "is best described as a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety"; "a patient-centered medical home…is not a place…It's a partnership with primary care provider(s)"[24], health team, and for our purpose, community. A 'medical home' model of care shares many features in common with the goals and objectives of community health centres to provide integrated, comprehensive, collaborative, interdisciplinary team-based, individual-focussed, evidence-informed care to embrace all aspects of wellness. These are all goals the Dr. Kingston Memorial Community Health Centre is striving to facilitate. The niche for this approach, amongst other efforts to increase inclusion/civic engagement, is the integration of social inclusion program elements into the evolving collaborative team practice of health professionals.

<u>Organizational/administrative structure</u>

The Centre is conceived as a virtual web of outreach, interactions and collaborations with a physical location for administration of the Centre. The sparsely populated Richmond County precludes centralization of services within one physical location. However, patient/family/participant convenience will be a priority when scheduling or facilitating visits to multiple sites.

The Centre is conceived as an integrating link for community-based services and programs, primary care practices, long-term care facilities and acute care. It will strive to decrease accessibility and availability barriers and to increase relationships and partnerships among individuals, families, friends, community resources and groups, health services and support organizations. There are two evidence-based best practices to improve access to available services and programs which are incorporated into our model (FCSS, 2010). There will be an "every door is the right door" approach (including self referral), with a number of program referral options. An "every door is the right door" approach has been adopted by Ontario mental health programs[25].

Secondly, an integrated approach to care is a basic principle as indicated above. Services and programs will be provided through a care coordination approach (as described above) to enhance integrated care. Services and programs will be provided in the home, community and various agencies involved. Once a participant joins the Centre, a community well-being coordinator will assess the participant, collaboratively design with the participant appropriate, tailored community-based health and well-being interventions, develop a well-being action plan, refer to applicable resources and provide ongoing monitoring and evaluation. As suggested in the following quote, professionals presently involved in the

[23] *Adapted from: A Vision for Canada: Family Practice - The Patient's Medical Home* (College of Family Physicians of Canada, 2011)
[24] Patient-centered Primary Care Collaborative (https://www.pcpcc.org/about/medical-home)
[25] *Every door is the right door: towards a 10-year mental health and addictions strategy, a discussion paper*, 2009.

well-being of community members, as well as volunteers, may function as 'community well-being coordinators' as our Centre evolves.

> New roles to support integrated care by working across organisational boundaries are only effective when they are part of a system-wide process of integration. The support of senior leaders is crucial for establishing a framework for integration, legitimising new ways of working, and ensuring a climate and processes are established that enable practice to develop in the desired direction…Building effective relationships and establishing a shared commitment to developing care around an individual's needs can support this process. The skills needed to deliver integrated care often already exist within the workforce; the issue is how these skills are shared and distributed as part of an overall integrated system of care that spans organisational boundaries. Skills in communication, management and creating relationships are vital, and may be required by professional and non-professional groups more broadly (Kodner & Spreeuwenberg, 2002; pg. 4).

Thus, the importance of the organizational/ administrative structure of our Centre model. Our organizational structure will begin with linkage and work towards coordination with sharing of resources whenever feasible. It will include linkages with the Nova Scotia Health Authority through local Public and Primary Health and well as the Strait Richmond Community Health Board and Richmond County Municipality (and, potentially, the Town of Port Hawkesbury Municipality). An early linking intervention could be the incorporation of screening and prevention into health and well-being programs to reduce health disparities, morbidity and mortality (Ogden et al, 2012). Examples of evidence-based screening include screening for depression, nutrition, home safety, health literacy and social isolation (for example, Harmirudin et al, 2015). Local resources are available (for example, effective approaches to the provision of education about proper nutrition by Amos & Cavan, 2014).

Ten key principles for successful health systems integration were identified in a literature review (Suter et al, 2009). Although designed for integration of acute care and ambulatory services, many of the principles apply to our Centre model. Services and programs to embrace the continuum of (ambulatory/community) care, planned on a population base; person focus; geographic coverage; standardized care delivery through inter-professional (including volunteers and community members) teams; ongoing system evaluation; information systems in common; shared culture and values and visionary leadership; inclusion of physicians; a "flatter, more responsive organizational structure" (p. 5); and a system for financial management.

<u>Financing the Centre</u>

As for many similar not-for-profit, charitable organizations, we expect that funding would come from a variety of sources. Potential sources include:

- nominal membership fee for participants to provide access to Centre programs and services; membership fee would be waived when circumstances required;
- grants- federal, provincial, foundations, etc.;
- Municipality subsidies;
- fund raising;
- bequests, sponsorships, etc.;
- social enterprise (snow removal, yard maintenance, etc.); (see attached document re social enterprise endeavours)
- provision of training/education programs for others (for example, mental health first aid).

Monitoring and evaluation processes

The monitoring and evaluation processes will be based on the framework of the Canadian Index of Well-Being (see below) as well as the expected outcomes for the programs and services provided and evidence-informed recommendations for the development of the Centre. In addition, the UK NHS has many useful resources as potential evaluation models including http://clahrc-gm.nihr.ac.uk/demonstrator/.

[26]

Expected outcomes for Centre:

- Seniors are engaged in endeavours that decrease the impacts of frailty, illness and disability on independence and quality of well-being of themselves and other seniors
- Seniors increasingly identify and contribute to the community their knowledge and skills
- Increasing numbers of seniors are physically active and receive proper nourishment
- Upstream endeavours to decrease the impact of the social determinants of health are undertaken
- More seniors who were previously unengaged and inactive within their community are participating
- Caregivers feel supported and have access to needed resources

Recommendations

1. Interventions should include those focussed at a society/community level as well as those focussed at the level of an individual,
2. Efforts to deepen understanding of prevention and amelioration of chronic disease in seniors could include walking with a senior through her/his community to understand challenges and opportunities, a "walk in the shoes" of a senior with a chronic condition(s) and/or the use of

[26] https://uwaterloo.ca/canadian-index-wellbeing/sites/ca.canadian-index-wellbeing/files/uploads/images/CIWcommunityvitalityEN_0.PNG

photographs, theatre, poetry and art to expand the ways seniors can express the realities of their lives.

3. Undertake theory-/literature-based novel interventions to engage and motivate seniors to become physically active and met the appropriate age-related standard for exercise,
4. Evaluate (quantitative and qualitative methods) any interventions piloted,
5. Use methods to evaluate a participant/potential participant's change readiness,
6. Involve participants and potential participants in decision-making related to programs and services,
7. Use interventions that include theory-/evidence-informed approaches to motivation, mentoring and ongoing monitoring,
8. Incorporate physical activity action plan into participant's wellness/health home record.
9. Have an outreach component to every service and program where feasible and beneficial,
10. Incorporate interventions that foster independence, interdependence, relationships, learning and participant involvement in their creation and content,
11. Integrate volunteers into services and programs wherever appropriate,
12. Services and programs adopt a long-term approach,
13. Associated staff have or receive education to acquire appropriate skills and training to interact with young and old,
14. Young and old participants understand what is expected prior to any intervention,
15. Activities should be focussed on developing relationships,
16. Activities should be shaped by participants and include mutual benefits for all participants.

The ongoing monitoring and evaluation will include both qualitative and quantitative assessments. As well as tracking participant numbers and provider and participant satisfaction, we will use interviews, focus groups/community conversations and surveys. To enable a fuller understanding of the Centre's effectiveness, we will employ alternative ways of allowing people to express their feelings (for example, photography, story-telling, etc.).

Conclusion- concept for community action to create and develop the Centre of Well-Being of Seniors

Collective impact

In the development of our Centre for Well-Being of Seniors, we are undertaking a collective impact initiative. Collective impact initiatives have been defined as "long-term commitments by a group of important actors from different sectors to a common agenda for solving a specific social problem. Their actions are supported by a shared measurement system, mutually reinforcing activities and ongoing communication, and are staffed by an independent backbone organization" (Kania & Kramer, 2011).

Pre-conditions for a successful collective impact include a prior history of collaboration, influential champions, urgency of issue and adequate resources (www.tamarackcommunity.ca). Whereas we have established a history of collaboration with many organizations and groups related to the well-being of seniors and have several influential champions as well as recognition of the urgency to address the well-being of our ever-increasing population of seniors, we are challenged to garner adequate financial resources.

Critical initial steps in building action for collective impact include:
• creating the boundaries (issue, root causes, geographic) of the system or issue to be addressed
• community engagement and
• developing a strategic action framework to guide the activities of the initiative.

Five conditions for a collective impact have been identified (Kania & Kramer, 2011; p. 39).
• "Common Agenda: All participants have a shared vision for change that includes a common understanding of the problem and a joint approach to solving the problem through agreed-upon actions.
• Shared Measurement: Agreement on the ways success will be measured and reported, with a short list of common indicators identified and used across all participating organizations for learning and improvement.
• Mutually Reinforcing Activities: Engagement of a diverse set of stakeholders, typically across sectors, coordinating a set of differentiated activities through a mutually reinforcing plan of action.
• Continuous Communication: Frequent and structured open communication across the many players to build trust, assure mutual objectives, and create common motivation.
• Backbone Support: Ongoing support by independent, funded staff dedicated to the initiative, including guiding the initiative's vision and strategy, supporting aligned activities, establishing shared measurement practices, building public will, advancing policy, and mobilizing funding. Backbone staff can all sit within a single organization, or they can have different roles housed in multiple organizations."

Principles of practice for a collective impact are described below.

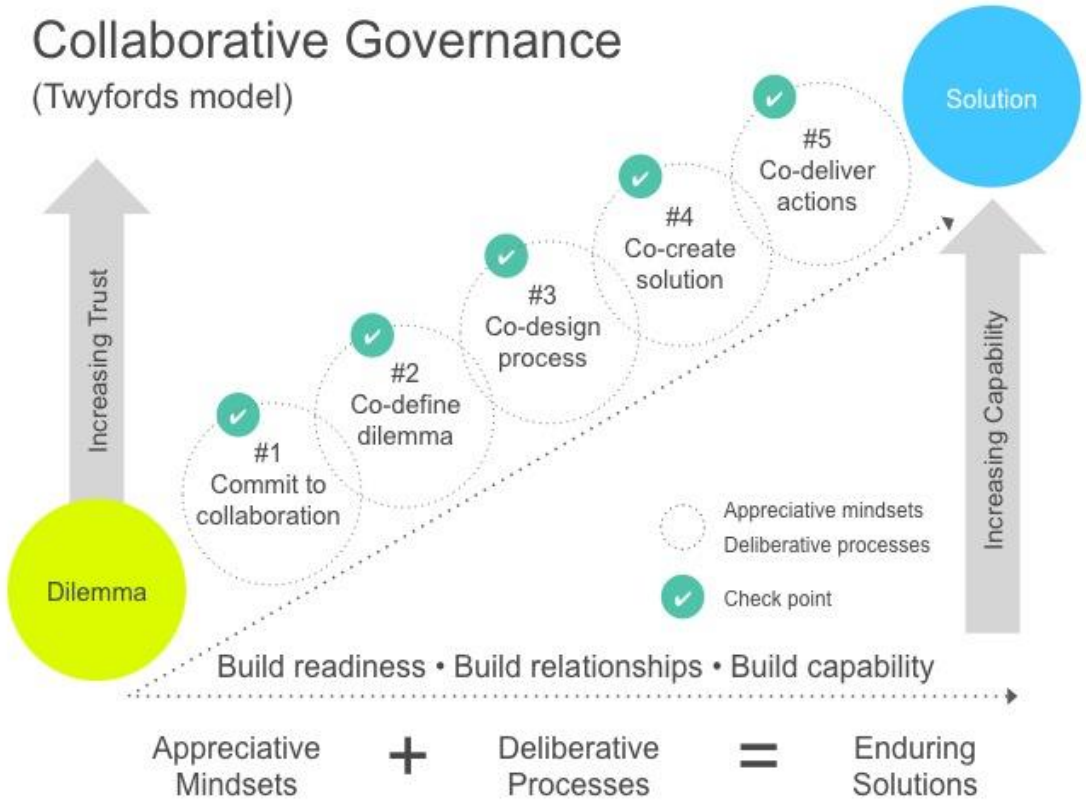
[27]

[27] (http://collectiveimpactforum.org/blogs/1301/collective-impact-principles-practice-putting-collective-impact-action)

Backbone organizations are those that guide the development of a vision and strategic priorities, support and facilitate alignment of activities, establish shared measurements with stakeholders, build public engagement, advance policy and mobilize funding.

Governance model

To facilitate the development of a virtual Centre such as the one we have proposed, a collaborative governance model is essential. A potential collaborative governance model is illustrated below.



[28]

The Centre will have a governance board of volunteers where at least fifty percent of members are seniors. In addition, the Centre will have a Community Advisory Committee composed of seniors and representatives from Centre partners and collaborators.

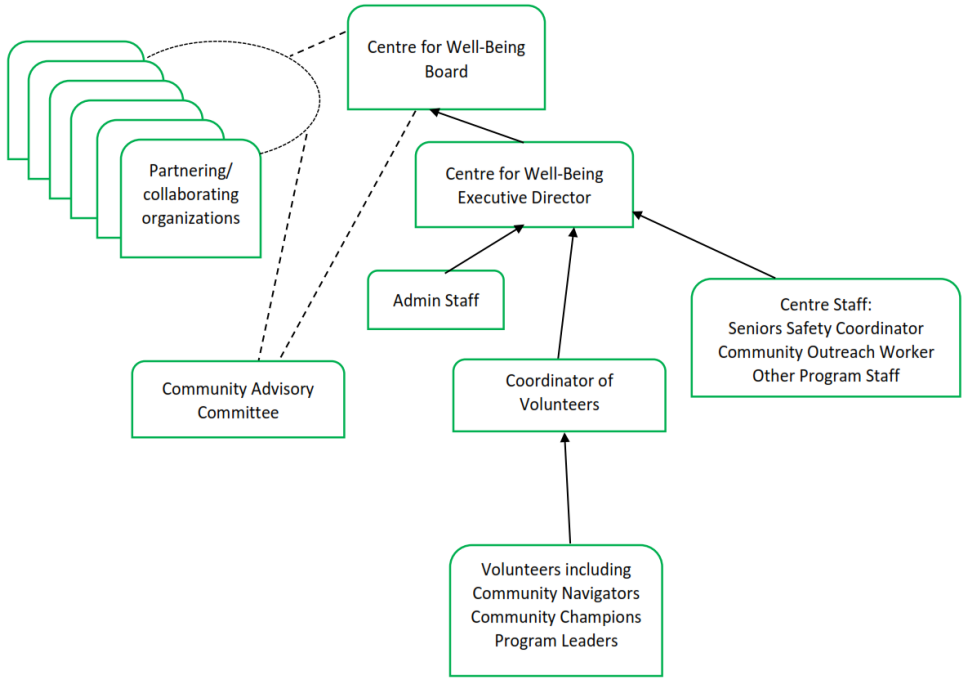
Initially, we would begin with a Board of Directors with representatives from stakeholder groups. Development of the Centre would be guided by an Executive Director. Initially the only employees of the Centre would be the Executive Director, an administrative assistant, a community outreach and support worker as well as a seniors safety coordinator.

There is little guidance in Canadian literature about a governance model for the integration of health and social care support, although the Nova Scotia Public Health emphasis on the social determinants of health and focus on upstream efforts is entirely in keeping with our proposed model. Our proposal is also congruent with the Canadian Association of Community Health Centres definition and values. A

[28] (http://www.collaborationforimpact.com/wp-content/uploads/2014/02/Collaborative-Governance.jpg)

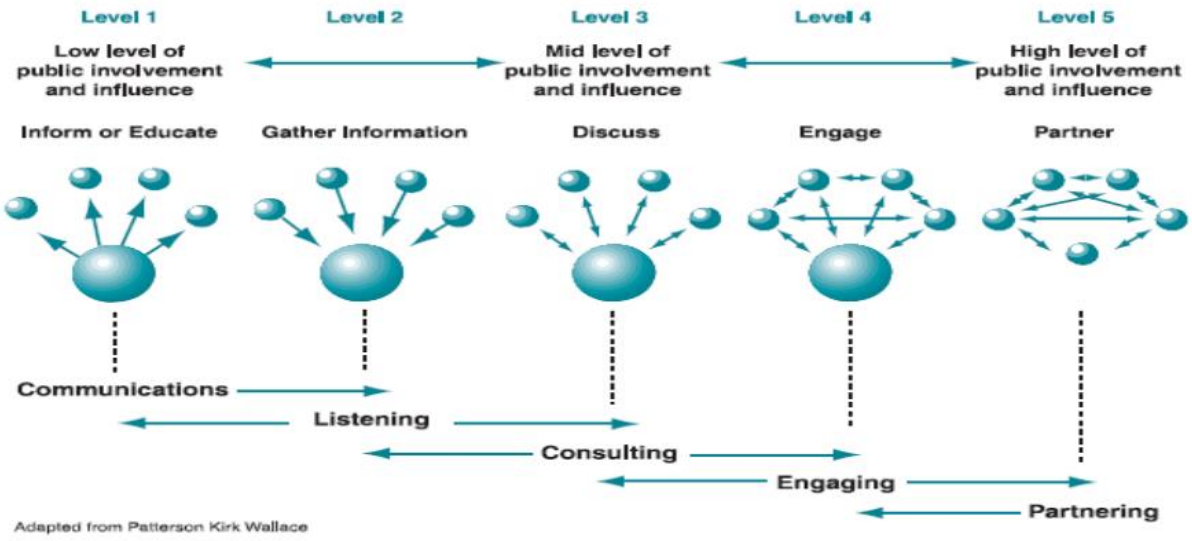
Canadian example of successful integration of acute and community health care is the East Calgary Health Services Initiative (Every, 2007).

The following is a preliminary proposal for the Centre governance structure.



<u>Community engagement</u>

We also believe that participation by community members is essential for the success of the Centre. Whereas we expect participation by community members along most of the described levels of involvement (see illustration below), we hope to emphasize consultation, engagement and in some cases, partnering.



As we travel further along the journey to achievement of our Centre for Well-Being of Seniors in Richmond County, we "need to change our mindset from activities, strategies and programs to what is the change state we desire for our community".[29]

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