A Health Care Model for Community Seniors:

A Community-Systems Approach

THE CHERRYHILL HEALTHY AGEING PROGRAM: SIX-YEAR OUTCOMES

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. . . building a self-sustaining community system of health support for the elderly

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Executive Summary

Canada is faced with an aging population at a time when health care budgets are under restraint. A new way of doing things is needed. The trend is to move health care from the hospitals into the community, a trend which has raised many questions about the community health system's ability to cope. In turn, greater emphasis is being placed on communities to become more self-sufficient in providing their own care, especially in the areas of supportive services. A particular challenge is to find ways of supporting the frailer members of a community whose capacity to be their own advocates can be very limited.

Program Overview: The *Cherryhill Healthy Ageing Program* is a participatory action project that utilizes a community capacity building process, and specifically a community-systems approach, to foster long-term commitment and partnerships among community members, health professionals, businesses and health policy makers. These community partners are working together to collaboratively develop, implement and evaluate an innovative new model of community health for the seniors that will, over time, evolve in response to the changing needs of frailer older individuals living in the community.

Program Goals:

- to help older individuals living in the community successfully age in place and remain active, independent and in their own homes for as long as possible
- to create a *sustainable* system of shared decision-making between communities and the formal health system
- to create a community Centre for *Healthy Ageing/Centre for Healthy Ageing Research* in partnership with the Division of Geriatric Medicine, University of Western Ontario, local communities of seniors, community health agencies, and health and academic institutions
- to explore how seniors can become more involved in the planning and provision of their own health services
- to build community capacity to respond to community and system- identified health issues
- to build and strengthen existing, untapped informal community health resources

Program Timelines:
Phase I: Information Collection Phase - August 1996-December 1997
Phase II: Community Action Phase - January 1998-August 1998
Phase III: Growth & Sustainability Phase - September 1998-September 2002

Conceptual Framework: The program uses a community capacity building process to facilitate change and is guided by a theoretical framework that includes change theory, theories of individual and community empowerment, theories of volunteerism, psychosocial theories and theories of aging.

Discoveries & Insights

The Cherryhill Healthy Ageing Program has, over the past six years, used a community-systems approach to bring about the beginnings of a new approach to the health care of seniors. The model has, firstly, required the development of community capacity to allow the community to take its place as a partner in health care planning and development. Secondly, the program has involved providers from the health care sector to explore both the needs of the community and the degree to which community members can become involved. As a result a potential model for future provision of geriatric care in the community is proposed.

It has become clear that the present institutionally-based geriatric care and rehabilitation programs, and the community-based programs concentrating on supportive service delivery, are not meeting the needs of seniors, particularly the frailer older and frequently homebound seniors. We have identified many gaps regarding identification and assessment of clients in need, diagnosis, rehabilitation and follow-up that the present system has no hope of meeting.

The Cherryhill Healthy Ageing Program has demonstrated the degree to which the community can be involved, where their comfort level is, and what they cannot, and don't wish to be part of. The need for continued support for the volunteers, and space and operating costs is identified. Volunteers are the backbone of any such community capacity building endeavour. Over the six years we have learned a great deal about the skills and willingness of frailer older volunteers to be involved, as well as the limitations on their level of involvement. Volunteering in a community-systems project is different from the usual volunteering and requires much more active involvement, leadership and sharing decision-making with the health system in planning and implementing health-related programs. Such an approach emphasizes the responsibility of citizens to be involved in their own health care, and that of their neighbours and their community, rather than just passively receiving health care in our universal health care system. We believe this represents an essential component of future health care for seniors, a challenge we doubt the system alone can meet. Involvement of recipients of service to the degree shown in the Cherryhill community is rare in health care.

A successful and critical component of our program has been the Cherryhill Health Promotion & Information Centre which is operated by trained seniors on a volunteer basis. The Health Centre provides information on seniors' health issues and is a highly visible "storefront" for the health promotion and clinical health programs offered. This visibility, we believe, is essential. This report contains a review of our experience as well as a review of the published evidence regarding the provision and utilization of information by seniors.

We have discovered many gaps in the current system, especially in meeting the needs of frailer older individuals living in the community. There is, we believe, a strong need for the development of a specialized community-based system for the care of seniors that can function outside the walls of institutions. We believe the institutions and agencies where the expertise is housed should be showing leadership in this regard. We recommend a geriatric nurse practitioner (GNP) be placed in the community to work closely with the family physician and Community Care Access Centre (CCAC). This will help over come the problem of access and trust identified in this report, extend the reach of over-stretched, and sometimes missing, family physician, improve assessment and diagnosis, coordinate management and permit a confidential case management model when appropriate.

Rehabilitation is sparse in the community and the needs are great. Our physiotherapist has identified many issues of mobility, falling, inappropriate gait aids, and other needs that are not being addressed. It seems the current physiotherapy educational model may not be ideal, particularly for frailer older individuals individuals. There is evidence that occupational therapy is also needed in the community. A model of therapy in the community is proposed, entailing the use of therapy assistants working under the supervision of specialized therapists.

We are proposing a network of specifically designed therapeutic recreation intervention that is evidence-based and properly designed to meet the rehabilitation and maintenance needs of the community. We believe this can mostly be provided by current resources, but would benefit from the input of a degree-trained therapeutic recreation specialist.

The governance structure of such an initiative is problematic. It requires a breaking down of the current vertical "silo" system to produce a horizontal continuum that can deal with the problems of frailer older individuals as they move (which they do) across system sectors. There are too many interfaces and too little continuity of care and information flow. The willingness to achieve a new model needs to be in place, with commitment over the long-term sufficient to allow its development and fine tuning. Within the governance structure the community needs to be an equal partner in planning and decision-making.

We hope that this report will provide ideas about how the Cherryhill Healthy Ageing Program can be sustained and perhaps become a model for the community care of seniors that can inform developments elsewhere.

Recommendations for Sustainability

The Cherryhill Healthy Ageing Program

We are now at a critical decision-point. In order to sustain what has been collaboratively built in the Cherryhill community, the key geriatric service partners in the health system must come together, pool their resources and collaboratively determine how to best implement the new model of care that is required to meet the rapidly increasing needs of frailer older people living in the community. The change in governance must begin in September 2002 when existing research funding for the GNP and therapy support ends. Based on the evidence and our experience we recommend:

① a collaborative multi-agency governance structure be developed with includes the community as an equal partner

② a common philosophy must be used and the community capacity building approach must be continued

③ VON Canada assume responsibility for volunteer and psychosocial program coordination, and the day-to-day operation of the Cherryhill Health Promotion & Information Centre beginning September 2002

④ annual operating costs for the health centre (approximately $10,000) should be shared by VON, CCAC, SGS, MOH and community fund raising efforts

⑤ funding be made available for a part-time GNP (2 days/week); no extra funding should be required as this role already falls under the mandate of SGS

⑥ funding be made available for a full-time therapy assistant to run exercise/ maintenance/therapy programs; this might most appropriately be done through the CCAC but could also be done as an outreach component of the Parkwood Geriatric Day Hospital

⑦ funding be made available for a part-time physiotherapist (1 day/week) and occupational therapist (1 day/week) to work in the Cherryhill community; CCAC therapist funding could be used to provide the physiotherapist through a re-assignment of current therapy funding; SGS could provide funding for the occupational therapist through an expanded day hospital role

⑧ London Housing should be approached to provide space through apartment rental within several high-use and strategically placed buildings; this will provide the requisite meeting, therapy and personal locker space required to implement and maintain flex care programs and a multi-agency team structure

⑨ ESAM (Cherryhill property owners) will be asked to provide a further 5-year commitment for appropriate space in the Cherryhill mall for the Health Promotion & Information Centre

What Others Have to Say . . .

"What a wonderful program! Let's see how we can do this in other parts of Ontario."
Dalton McGuinty, Leader
Liberal Party

"Thank you for sharing your wonderful program. This program should be in every community."
Dr. Laura Gaitlin, U.S.A.

"Excellent health & wellness facility. Wonderful complement to this community."
Canadian Blood Services, London

"What a wonderful service! Storefront service is the key to access for all. Keep up the excellent work in the Cherryhill community."
Veterans' Affairs Canada

"Excellent selection of information and great services. Keep up the good work!"
Executive Director, Central Park Lodge

"What a wonderful & informative establishment. Way to go!"

"This has to be one of the greatest places. It is a good location for seniors & others who cannot travel far for the health information they need."

"Received very personal, excellent, friendly & informative service. Need more of this for seniors."

"The Health Centre is in a terrific location and is easily accessible and helpful. It is wonderful to have it here in Cherryhill."

"Remarkable amount of help and friendly staff. A true gift to the neighbourhood. Thank you."

"Fantastic service! I'm sure the residents of Cherryhill truly appreciate it. Thanks for all the help."

"What a wonderful community! I am very impressed with all the Health Centre offers."

"This mall has everything you need. Full of information and useful health equipment. The seniors are happy and full of life! Keep up the good work!"

". . . . . found staff very helpful . . . . . PLEASE open a branch in Westmount Mall!!!"

"We have appreciated coming to the Foot Clinic; it is much closer to home and the service is great!"

"This place is amazing - staff are super - volunteers deserve a medal!"

". . . . . the Health Centre provides a unique service and is another example of why Cherryhill is such a great place to live. Thank you volunteers for you dedication."

"Excellent!"

"Lots of help and take home information. A great service to those in the area."

"A great support service for people in this, and adjoining communities."

"Thanks so much for the pamphlets on Alzheimer's! What a great location - a wonderful service for seniors!"

Table of Contents

List of Tables

List of Figures

Chapter 1

Community Geriatric Care: *The Challenges*

- changing demographic & population trends
- health & aging
- cost of health care
- health service utilization & the elderly
- health care trends & other models: what works & what doesn't based on available evidence
- the way of the future in geriatric care
- references

What the Evidence Tells Us . . . . .

- the number of older individual living in the community is rapidly increasing; the most significant increase will be in individuals 75+ years who are major consumers of health services; a 115% increase in individuals 85+ years is expected by 2016
- in Canada & particularly in Ontario the health care of older individuals is fragmented into independently funded "silos" & planning & delivery is through a bureaucratic structure; there is currently no "true" community involvement
- individuals 75+ years have unique & different health service needs & for many instability & recurrent crises emphasize the need for continuity of care
- a new coordinated & integrated model of service which involves health consumers & their communities is needed
- many of the problems of seniors are amenable to prevention but at the moment this is, generally, poorly done

Our Experience . . . . .

- the health care system has not evolved to meet the needs of the rapidly growing older population living in the community
- this population's health instability across time mandates a continuity of care; the current "items of care" approach does not work
- assistance with activities of daily living (ADLs) such as personal care, homemaking & meal preparation is increasingly required with advancing age
- this is the component that is becoming increasingly more difficult for the health system to provide; it is also the component most readily sacrificed when funding is short
- currently there is little appreciation or inclusion of available evidence in either the development of models of care or the implementation of preventive programs by many health providers
- there is no conceptual model underlying health service delivery or development

Community Geriatric Care: *The Challenges*

Population Projections & Demographic Trends

Current statistics suggest a significant increase in the number of older individuals living in the community by the year 2011, with a particular emphasis on individuals 75 years of age and older who have significantly greater health problems and health service needs.[1-3] The number of individuals 85 years of age and older, who are major consumers of health services is expected to increase 115% by the year 2016[1], and many health professionals are questioning the community health system's "readiness" to cope with this influx of frailer older individuals with multiple and complex health problems. These individuals are characterized not only by the multiplicity of health problems they experience but also by the unique nature of those problems.[4] A significant proportion of these individuals will be older women living alone. Unless the system is prepared to provide over twice as many nursing home beds in the next 10 to 15 years, many more frail, dependent older people will be living in the community. It is unlikely that the present institutional-based geriatric programming will meet the increasing need. There is much that needs to be done to develop community-based geriatric care which will embody the lessons learned from both institutional-based and community-based research. The time scale is short, especially in terms of health care planning. The response has to be at the local community level with an underlying principle of working with communities in order to recognize, respond to, and incorporate in the model, the specific characteristics of the community. No solution will apply to all settings but there are some general principles which will help guide the development of a new model of community geriatric care. It is hoped this document will help elucidate those principles while proposing a model for a specific community, the Cherryhill community.

Health & Aging

In 1991, 11.7% of the Canadian population were over 65 years of age. Of these, 56% were women, and an even greater percentage of those over 75 years are female. A second important fact is that most of the women at the extreme of life, live alone and have limited personal supports. In the Cherryhill community, which is at the centre of this report 77% of the community over the age of 55 years is female and of those 71% live alone.

The National Population Health Study[5] showed that one third of Canadians 65-74 years had health problems that restricted their activities to some degree, rising to over 50% at age 75 and above. Similarly, over the age of 75, about 40% need help with the heavier housework, and over 25% help with routine housework and shopping. Over the age of 75, being homebound becomes increasingly common.

The problems of old age cross many systems. For example, in women 65-74 years the most common medical problems were arthritis, hypertension and non-arthritis back problems. Over 75 years of age, the most common problems were heart disease and cataracts. The proportion of those who rate their health as poor to good (as opposed to very good or excellent) increases with age. However, most older people *perceive* their health as good to excellent despite the presence of limiting conditions. There seems to be a readjustment of expectations with aging, individuals seeing themselves as well despite problems, and as a rule considering their health as being better than most of their peers. For example, in the National Population Health Study only 9% rated it as worse than their peers. Within the Cherryhill community our experience concurs with this National Survey. This perception of good health occurred despite the rising prevalence of chronic conditions. Although Cherryhill residents admit to declining health with age they still, on average, perceive their health as good to very good (Figure 1). While this may be a laudable adaptive mechanism, it's potential impact on the individual's failure to seek help for treatable conditions is a concern. In some areas it may be a cause of under treatment with, for example, most cases of urinary incontinence in seniors being unknown to the physician.[6]

Disease & Senescence . . . .

Disease: *heart attacks, cancer, dementia, emphysema, etc.*

Senescence: *frailty, loss of muscle bulk, poor homeostatic control, reduced immune system leading to falling, hypothermia, susceptibility to infection, inability to withstand stress, etc.*

Remove disease: gain 11 years

Remove senescence as well as disease: live to 550 years

There are several unique elements to the provision of care for the older section of the community. Firstly, and most obviously, the care of seniors implies the care of chronic conditions. Most of the problems are not curable and do not go away, but most are treatable and reversible to some extent. Secondly, there is no limit to the number of chronic problems one can acquire, and seniors frequently have many. Important is the impact of chronic problems on the seniors' capacity to access help. Thirdly, many of the problems fall poorly into the standard medical model, reflecting the decline in vitality associated with senescence and presenting with the well recognized geriatric syndromes, such as incontinence and falling. The declining physical and mental health of old age, especially extreme old age, offers a challenge to the client while simultaneously reducing their capacity to meet that challenge. The ability to seek help may be compromised. Those who are cognitively impaired are particularly at a disadvantage and may lose insight into the care they need.

They lose the capacity to be their own advocate.

Instability characterizes the health and functional integrity of many older individuals. Instability across time mandates a continuity of care. The job is never done. These individuals can move from acute crisis to rehabilitation to discharge, and back to crisis again. Such instability probably characterizes the situation of at least 10% of older seniors. This specific sub-group of seniors has been the focus of several investigations of systems models which will be discussed later. Of note, is the distribution of seniors in the Cherryhill community (Figure 2). They are not only older, but nearly half of them are over 80 years of age, the age when frailty and instability become exponentially common.

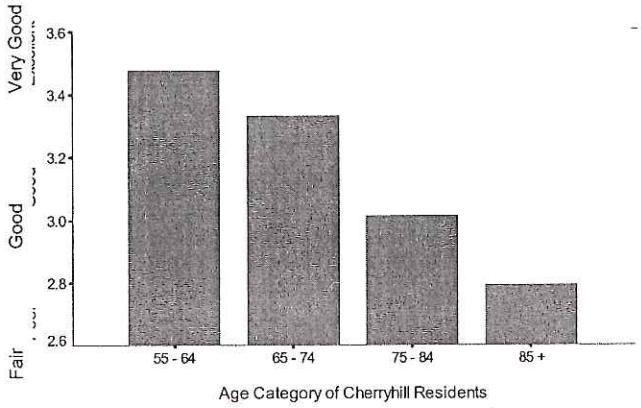


Figure 1: Perceived health of Cherryhill residents by age categories (rated with a Likert-type scale ranging from 1 (poor), through 3 (good), to 5 (excellent).

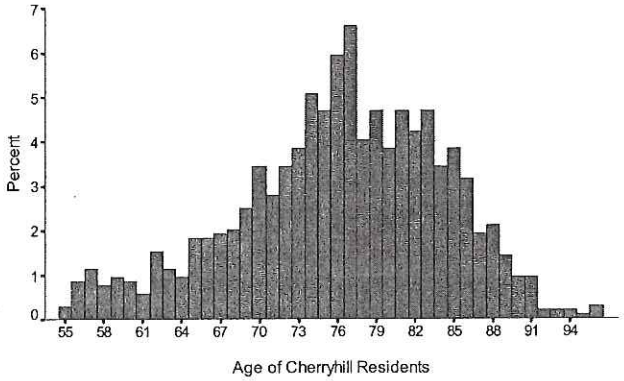


Figure 2: Age distribution of Cherryhill residents in 1997.

ARTHRITIS

- *37.4% of seniors have arthritis*
- *by age 70, 84% of Canadians have arthritis*
- *25% of all long-term disability is caused by arthritis*
- *of those with arthritis, 90% have trouble with mobility*
- *35% of seniors have chronic pain & of these 64.5% rate the pain as moderate or severe*

OSTEOPOROSIS

- *25% of women over 65 have osteoporosis*
- *by end of life 40% have had an osteoporotic fracture*
- *by 90, 30-40% have had a hip fracture*
- *50% of those who fracture a hip don't return to previous level of function*

FALLS

- *a third of seniors fall each year*

DEMENTIA

- *the probability of suffering from dementia rises with age:*
  2.4% among those 65-75
  11.1% among those 75-80
  34.5% among those 85+
  (1991 data)
- *it is estimated that dementia is present in:*
  23% of seniors aged 85-89
  40% of seniors aged 90-94
  55% of seniors aged 95-99
  85% of seniors aged 100+

Many older people respond to declining capacity with an attempt to reduce the demands that life places on them, the so-called "environmental press". Moving to a supportive community such as Cherryhill is probably such a response. This means that many people in this and similar communities are experiencing a limitation in their capacity. For some the degree of reduction in environmental stress that they need to preserve energy for essential functions is such that they become apartment bound. Any attempt to increase their involvement in the community, their activity level or even their socialization can easily overwhelm their limited reserves. Sometimes it appears that even the offer of help by the health system can be seen as just one more stressor, leading to its rejection. This underlines the necessity to ensure the clients' health problems are appropriately identified and managed through the process of comprehensive geriatric assessment and management so that their reserves for other activities can be maximized. The withdrawal of supportive services by the system is particularly troublesome here as it means that any energy an individual has left for other health-supporting activities is spent on basic self-care. Please see Chapter 3 for more detailed information on the competence and environmental press and selective dependency theories.

The Cost of Health Care

Canada has one of the most expensive health care systems in the world. It has been suggested that the expensiveness of Canadian health care has relatively little to do with demographics and the aging population, and more to do with how we respond to health care needs. For example, 9.8% of Canada's Gross Domestic Product (GDP) is spent on health care, more than countries such as the United Kingdom or Sweden, both of which have a greater proportion of older citizens. It has been estimated that the growing expenditure on health care in Canada is only one third due to the growing older population, and two thirds due to excessive health care expenditure per capita. Declining length of stay in hospital has affected all ages but seniors less so, and the total number of days spent in hospital has declined even less in the older segment of the population due to frequent re-admissions. Older individuals have come to

occupy a greater proportion of acute care beds with very old individuals in hospital a long time. This is said to result from community issues such as social isolation and lack of family supports. A thorough review of this area is provided by Leibowich, Bergman and Beland.[7] A critical conclusion of their analysis is that countries such as Sweden and the United Kingdom provide cheaper health care for an even greater proportion of old people by having better co-ordination and integration at the community level. In Canada, and particularly in Ontario, the health care of older people is fragmented into various independently funded silos such as family physicians paid through Ontario Health Insurance Plan (OHIP), the Community Care Access Centre (CCAC) which brokers services based on what is largely an administrative type assessment, day hospitals and other geriatric services based in provincially funded institutions and long-term care establishments funded either privately, municipally or provincially. There is no specific accountability for the optimal care of older individuals over time, or for keeping them in the community. Although the CCAC is, for example, responsible for both community supportive care and access to long-term care, there appears to be no formal process in place to fully evaluate the older client functionally and medically either before service provision or placement. There are no formal links to the Specialized Geriatric Services, although these are being explored, and CCAC involvement with those failing at home and at risk of placement is fortuitous. Efforts elsewhere to avoid these problems have led to such projects as the Darlington Project in the United Kingdom[8], the well known "On Lok" Project in San Francisco and its attempted duplication elsewhere, including Edmonton, in the form of the "Choice Project". These observations indicate how the system elsewhere is feeling its way forward. It is accepted

CURRENT TRENDS IN THE HEALTH CARE SYSTEM:

HOSPITALS

- *pressure on the acute care system; shorter lengths of stay; for sicker individuals this can mean more admissions*
- *shortage of rehabilitation beds*
- *passing the "buck" to the community*
- *discharged quicker & sicker*

Hospitals have not evolved to meet the needs of the elderly.

COMMUNITY CARE

- *receiving sicker clients*
- *budgets being cut*
- *need to focus on hard core issues*
- *creation of a prioritization scale*
- *loss of peripheral supportive services*
- *loss of any OHIP funded community-based rehabilitation*

THE HEALTH SYSTEM AS A WHOLE

- *constructed & funded in silos*
- *agency mandates & regulations create barriers & issues around control & ownership*
- *communication across the sytem is not good*
- *no overall case management; little or no team structure*
- *no cross flow of funds; a hospital surplus will not benefit the community*
- *hospital CEOs & agency directors are very protective of their budgets & their mandates*
- *institutions & agencies own the expertise*

that the current approach could be improved and there is a need for a new and more coordinated way.

Much thought, energy and money is being expended on finding better and more cost-effective ways of delivering health care. Recent changes have seen a systematic move from institutional care to community care, and some movement of dollars to support this. It is less clear if the necessary expertise is being transferred along with the client. Traditionally, institutions have been the repositories of expertise, operating by way of a referral system, where clients or patients are sent to hospitals for advice and guidance. The weakness of this model, particularly in the care of older persons, is that such care cannot be satisfactorily provided in "piece-meal" fashion. The best outcomes are obtained by a process of care based on assessment and ongoing management provided by the same team with the necessary expertise. Expert input limited to times of crisis, with generalist management between times, has significant shortcomings.

Health Service Utilization & Seniors

Many researchers have demonstrated that advanced age results in increased mental health problems,[9] increased chronic illnesses, increased functional limitations, decreased independence, and increased health care costs.[5, 10-14] Specific predictors of service utilization included age, sex (being female), health, functional ability and living arrangements. Older individuals with increased social support were found to be less apt to use formal system-provided health services.

Older individuals are major consumers of health services, and it has been reported that seniors, in particular those aged 75 years and older, have different patterns of health service utilization than younger individuals. Assistance with activities of daily living such as personal care, housework and meal preparation is increasingly required with advancing age. According to Home Support Canada, as cited in a position paper prepared by the National Advisory Council on Aging[3], the number of home support workers and services to seniors increased by at least 50% during the past decade. Homemaking and personal support have been identified as possibly delaying or preventing premature institutionalization of frail older people who might otherwise have little capacity to manage, but this is precisely the component most readily sacrificed when funding is short.

The health support services required by older individuals on a daily basis such as house cleaning, meal preparation, personal care and assistance with shopping, are also the services that are becoming increasingly difficult for the health care system to provide. Families and friends play a critical role in the overall health and welfare of older persons living in the community, providing over 80% of all daily care, often at great emotional and financial expense.[11, 15] Older individuals, themselves, have identified the ability to carry out day-to-day activities, freedom of choice, and the ability to be involved in

personally meaningful activities as being a priority to help them remain in their own homes and living in the community for as long as possible.[1, 16]

With communities of seniors, not only mobilization and capacity building, but also stabilization, support and ongoing monitoring of frailer older individuals, are important considerations to prevent a downward spiral of ability, and subsequently a potentially costly impact on an already taxed health care system.

Health Care Trends & Other Models: What Works & What Doesn't Based on Available Evidence

The challenges of dealing with a steadily aging population, funding constraints and decreasing health care resources have led to major changes in emphasis on how health care services should be delivered. Most notable changes include an increased emphasis on: (1) *community* health services and supports[1, 17-21]; and (2) community mobilization and collaboration around health issues, with a particular emphasis on *self-help models of community development*[22-26]; that is, putting some of the responsibility for health care planning and provision into the hands of individuals and their communities. While the need for this new approach has been identified, very few health studies and projects have explored how this might be done. In a local initiative, the CCAC is currently exploring and evaluating a model whereby the client has increasing responsibility for directing their own home care.

The challenge is to bring together the evidence base for best practices in care of older individuals with the community capacity building that is needed to broaden the care and support segment of the treatment plan. The methodology regarding geriatric care has been much explored, moving as it has from the narrow focus on what became known as the comprehensive geriatric assessment (necessary to improve diagnosis and increase attention to issues outside the medical model), to the broader issues of what to do with the increased information obtained (how to achieve the best outcomes for the client).

A straightforward comprehensive geriatric assessment service has shown improved diagnostic accuracy, but inconsistent outcomes.[27] This seems to be due to the fact that most studies focus on assessments but rely on others to implement the recommendations, and this occurs in a "hit and miss" manner. Better results are obtained when the assessment is linked to control of the intervention.[28] Within the acute care environment this has led to the development of acute care for elders (ACE) units, which have shown improved outcomes[29, 30] while for the less acutely ill but frail seniors with complex problems the process of geriatric evaluation and management (GEM), where the team is responsible for both the assessment and management of client outcomes tend to be better. The effectiveness is greater when control is greatest, as in an inpatient unit, and less consistent in the outpatient setting.[27] The challenge then becomes how to implement such an intervention in the community in a cost-effective manner. There have been three

randomized controlled trials of an in-home inter-disciplinary intervention, all of which have been shown to be cost-effective with such improved outcomes as better function and fewer hospital admissions.[31-33] These findings emphasize the need for a collaborative, interdisciplinary, expert specialized geriatric service model to achieve the best possible outcomes for frail older people in all settings, including the community. The operationalization of an expert geriatric service model within the community remains a challenge. For the younger old a multi-dimensional model of prevention has shown a reduction in institutionalization and functional decline, dependent upon the essential multi-dimensional nature of the intervention as well as the frequency of intervention.[34]

One potential method of bringing expertise and the community together has been in existence for many years, and that is using nurses in the community. Although the concept of nursing centres originated with the visiting nurses' associations more than 100 years ago, nursing centres are a relatively new development.[35] Nursing centres emerged in the late 1960s and early 1970s, as nurse practitioner education programs prepared nurses to assume responsibility for clients' health maintenance, evaluation, and referral, and to provide primary care as a client's first contact in episodes of illness.[36] The types of nursing centres that exist in the United States are (1) community clinics, (2) centres associated with institutions such as hospitals, health maintenance organizations, and academic centres operated by schools of nursing, and (3) private nursing practices operated by nurse entrepreneurs.[37]

Nursing centre models have established their ability to affect the cost, access and quality issues so vital to health care reform.[36] Profiles of nursing centre clients demonstrate that nursing centres address the needs of an unusually high proportion of the most vulnerable populations, such as racial minorities, the very old, and the poor.[36] The question remains whether such an approach, using well trained geriatric nurse practitioners could achieve the required outcomes.

A residential retirement community in Chapel Hill, North Carolina, utilizes a GNP to provide management of minor, acute issues for the 320 residents living in the apartments and nursing home within the community.[38] Longer term management of chronic issues, such as incontinence, wounds, pain, etc. is not provided by the GNP. In this model, as with the other aforementioned models, residents are not involved in the planning or delivery of care at any level.

Case management as a way of co-ordinating care for specific groups is not new. In the United States, most managed care organizations employ case management. The process includes screening to identify potential clients, assessment, care planning, implementation, and monitoring. Little by way of evaluation has been published. The use of intensive case management for a very selected group of clients discharged from hospital with congestive heart failure showed a significant reduction, by 56%, in further hospital admissions, less cost and improved quality of life.[39] However, a less structured

and intensive form of case management is of no value.[40] The precise essential elements of case management remain to be defined.

Community development and community capacity building approaches imply that community members collaboratively participate in the planning, development, implementation, delivery and evaluation of services, and share equally in the decision-making around these processes. A community nursing centre, guided by community development theory, was implemented in Charlottesville, Virginia. The population served by this nursing centre was predominantly young minority women with children. Not only were the clients included in the planning phase of the clinic (e.g., identifying their major health concerns), but one of the primary goals for the project was to assist clients to help themselves and their neighbours. Clients at this nursing centre were also encouraged to work in the clinic as volunteers, and in paid positions such as receptionists, secretaries, and clinic aides.[41]

More extensive service delivery models have been developed and evaluated in recent years. The Program of All-Inclusive Care for the Elderly (PACE) is modeled after the "On Lok" model in San Francisco (which focused on keeping elderly Chinese who were at nursing home level in the community), and utilizes geriatric nurse practitioners (GNPs). There are, however, limitations to each of these models. The PACE and "On Lok" models, although considered an innovative approach to providing long-term care services for frail older people, do not use community development or community capacity building approaches. Rather the care of residents is determined and provided by professional staff[42] and the ability of the community to participate in and expand the program was not included.

In May 2001 the Montreal initiative "SIPA" published a preliminary evaluation of the program after the first phase, June 1999 to May 2000. This initiative is exploring the advantages of having the care of frail seniors under the umbrella of a single clinical, organizational and financial model. In this model all the responsibility for the care of these people is in the hands of a single organization, including community, institutional and acute care. In part the underlying philosophy of this program is based on the evidence that in order to achieve goals with frailer older individuals and ensure compliance with recommendations, those who assess should also be responsible for the interventions. In practice the project never achieved the unified financial model. Embodying many of the principles discussed above, with the exception of the community capacity element, the SIPA project is already showing trends toward fewer acute care admissions, reduced institutionalization, coupled with improved access to physicians, increased use of social and paramedical services and improved access to home care services.

Community involvement in health care planning has been tried in the past, particularly in the USA, frequently through the model of health system agencies (HSA).

This seems to have functioned rather like our District Health Council (DHC) but with decision-making power. This development was seen as a threat to the local medical establishment and the legislation was eventually repealed. Other examples as well as the obstacles to getting meaningful community input are provided by Sleath and Rucker.[43]

The Way of the Future in Geriatric Care

Partnerships between institutions, community-based care and the community itself are emerging as the way of the future in health care of older individuals. Different models of care have been tried, and are being tried, particularly in the USA. A necessary basis for any intervention in the care of a high risk senior population is appropriate targeting, assessment and integrated care provision, and there is evidence that this can be successfully done. Figure 3 outlines key issues in community care for seniors.

It is clear that issues concerning the older and frailer seniors have challenged care planners for years. The ideal model of care has yet to be invented, but some elements of the ideal model have begun to emerge. The following points can be supported in the literature:

- continuity of care within a program of a single philosophical approach provides better outcomes
- avoidance of the "silo" approach seems to be important; "Silo" systems, such as are found in Canada, lead to re-admissions and to the clients falling through the cracks; examples of the latter are clear from the Cherryhill experience (see Chapter 4)
- approaches which avoid the short comings of the silo-type system, which tend to deliver items of care lacking continuity, seem to deliver better outcomes; models with greater levels of interventions, moving from assessment through the crafting of recommendations, to the development and carrying out of a strategy to ensure their implementation have been more positive in their outcomes (e.g., delayed loss of independence; delayed admission to long-term care)
- multi-disciplinary assessment by itself is of limited value; usually more problems are identified but the overall outcome is dependent on subsequent action; assessment has been emphasized by geriatric programs as a critical first step; this has helped focus attention of syndromes and conditions frequently missed; it has, however, to some extent acquired the characteristics of an end in itself; such comprehensive geriatric assessment coupled with a more involved team, partly and temporarily assuming

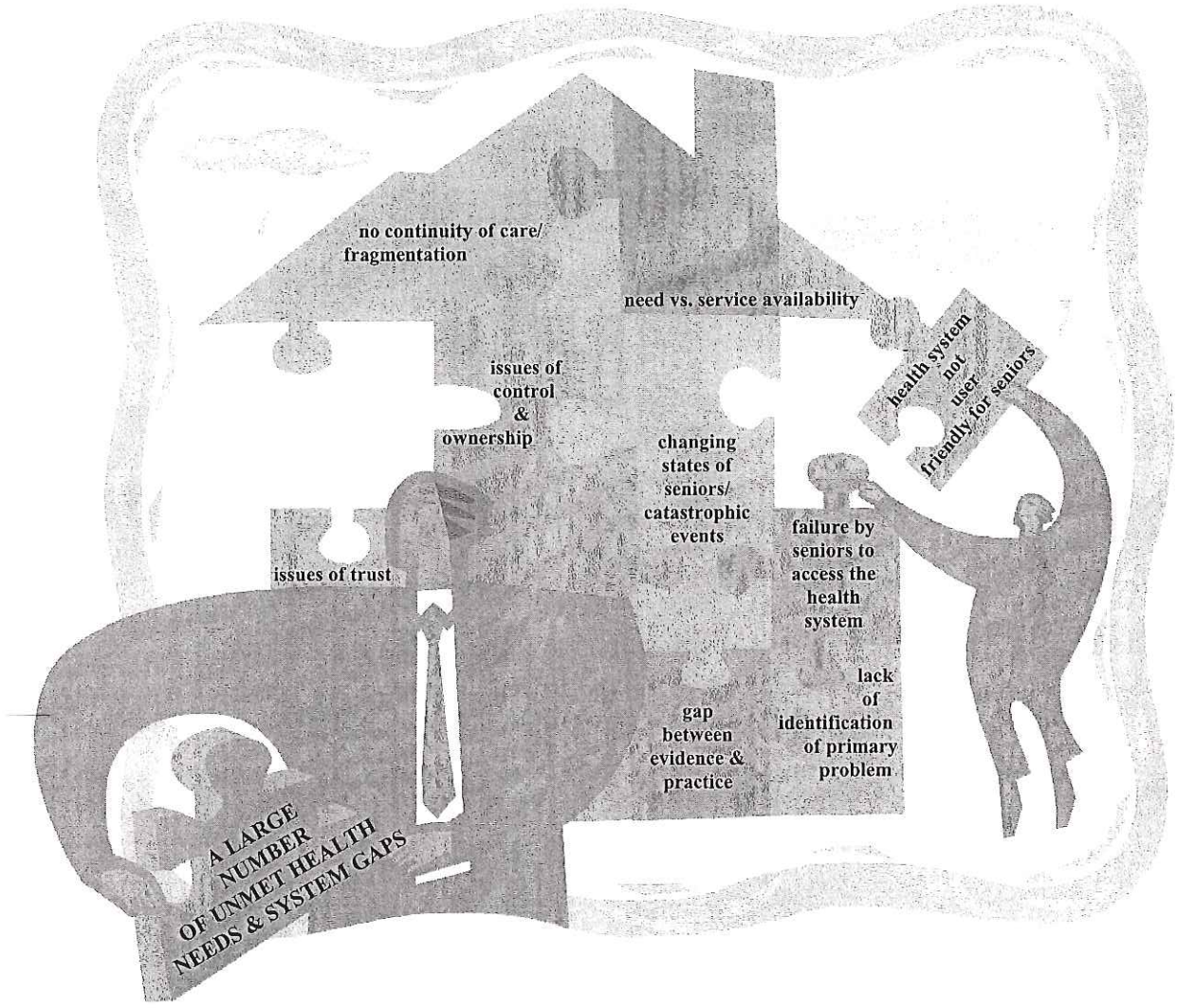


Figure 3: Key issues in community care for seniors as identified through the Cherryhill Healthy Ageing Program.

responsibility for the client produces better but still erratic results; a case management model, coupled with an inter-disciplinary evaluation and co-ordination of services seems to be more successful when working within a team structure

- expertise is essential, whatever the structure and the need for adequate training of staff has been emphasized; it has been convincingly shown that the provision of care through a simple clinic setting, with a focus on frailer older individuals, and run by primary care physicians and practice nurses with little or no expertise in the care of older individuals, does not work;[44] the ideal model must include a high level of expertise, appropriately offered through assessment, management and follow-up, and with a sufficient base of support (both formal and informal) to make it work in a cost-effective manner

It can be concluded that the more comprehensive and all-inclusive the assessment and management approach, and the more long-lasting or ongoing the intervention, the better the outcomes. A deficiency in any area, be it lack of geriatrician input, exclusion of the family physician, or short duration of the intervention leads to a weakening or loss of effect. Such a conclusion is a challenge to our system of stand alone, independently funded segments communicating by mail, telephone and by referral of clients from one segment to another, rather than collaborating in continuous program delivery. It is a challenge to the institutional/community divide, particularly where geriatric expertise is housed within the walls of the institutions. A method of erasing the boundaries must be sought.

Community Involvement in Health Care . . . . . Why Bother?

There are two primary reasons to propose greater involvement of citizens in health care planning, delivery and governance, and community capacity building around health issues.

Firstly, health care in Canada is seen as a right, available to all on the basis of need and independent of financial resources. It has been pointed out that "rights" also bring responsibilities, and while one can receive "rights" as a function of passive citizenship, responsibilities require more active involvement. This is particularly true when resources are rationed, as they always will be. However, as has also been pointed out, the Canadian system of government which requires the government to collect taxes and spend a proportion on health care, keeps government in a strong executive role. The process of fiscal responsibility is passed down through a system structure of agencies and institutions, each responsible for their "slice" of the health care budget. This situation of citizen rights and responsibilities versus executive authority invites contradiction and conflict.

Any trend toward increased community engagement in Canada is small and late, and lags behind development elsewhere.[45] Ontario seems to be particularly backward in this regard.[46] Redden points out that progress in this direction may be occurring without any clear model of development to guide it. Likewise she suggests health care decisions in general are made without a theoretical framework to guide them. An example Redden points to is the recent health care reform which took place in most provinces (Nova Scotia being a possible exception) without either a conceptual model or citizen/public involvement beyond a superficial level.

The move toward community health boards is viewed as preferable to a structure ruled by provincial bureaucracies. Ontario, however, seems to be moving in the other direction, as happened with the recent change in CCAC governance to a government appointed, rather than a locally selected, board. The responsibility of citizenship should require citizen supervision of their rights. Where resources are limited citizens should have a decision-making role to play, and not just "input", in the selection of services to be protected. Furthermore, the citizen has a right to monitor the quality of the service provided and act accordingly. Under the current bureaucratic process neither right can be exercised.

A second reason for involving the community in health care planning and delivery further emphasizes the citizen responsibility element. It is a perpetual balance between how much the population is prepared to pay in terms of taxes and how much health care it feels it needs and deserves. Local community resource mobilization through volunteering is the citizen responsibility side of community capacity building. Not only will such an endeavour expand the potential pool of services available within a local setting, but it allows each community to determine both its needs and how much the system, the community, the individual (and their family) should contribute to meeting those needs.

As financial and health care resources become even more scarce, the formal health system will become increasingly dependent on building community capacity and mobilizing community resources in order to meet the health care needs of older individuals living in the community.[46, 47]

References

1. Hollander, MJ. (1997). Assessing the impacts of health reforms on seniors: a model for analyzing health care reforms: a structure, process and outcome approach. Canadian Policy Health Research Networks. A report prepared for the National Advisory Council on Aging.

2. Canada Health. (1998). Canada health action: building the legacy (2nd vol.). Ottawa: National Forum on Health.

3. National Advisory Council on Aging. (1993). Canada's oldest seniors: maintaining the quality of their lives. Policy paper no. 13. Ottawa: Author.

4. Archer, J. & Hebel, L. (1996). There's more to health than health care. Thames Valley Community Health Status Report. London, Ontario: Thames Valley District Health Council.

5. Rosenburg, MW. & Moore EG. (1997). The health of Canada's elderly population: current status and future implications. Canadian Medical Association Journal, 157, 1025-1032.

6. Borrie, MJ., Bawden, M., Speechley, M. & Kloseck, M. (2002). Interventions led by nurse continence advisers in the management of urinary incontinence: a randomized controlled trial. Canadian Medical Association Journal, 166(10), 1267-1273.

7. Leibowich, E., Bergman, H. & Beland, F. (1997). Heath care expenditures and the aging population in Canada. In MJ Hollander (Ed.). Report on five puzzling issues, and fact sheets, on Canadian health services in an international context. Report prepared for the National forum on Health. Ottawa: Minister of Public Works and Government Services, 283-305.

8. Challis, D., Darton, R., Johnson, L., Stone, M., Traske, K. (1991). An evaluation of an alternative to long-stay hospital care fro frail elderly patients: II. Costs and effectiveness. Age and Ageing, 20(4), 245-254.

9. Harper, MS. (1992). Home and community-based mental health services for the elderly: In MG Ory & AP Duncker. (Eds.). In-home care for older people: health and supportive services, pp. 126-135. Newbury Park: Sage.

10. Arnold, SB. (1991). Measurement of quality of life in the frail elderly. In JE. Birren, JE. Lubben, JC.,Rowe & DE. Deutchman (Eds.). The concept and measurement of quality of life in the frail elderly, pp. 50-73. New York: Academic Press.

11. France, AI. & Alpher, VS. (1995). Structural analysis of social behaviour and perceptions of caregiving. The Journal of Psychology, 129(4), 375-388.

12. Kane, RL., Ouslander, JG. & Abrass, IB. (1984). Essentials of clinical geriatrics. New York: McGraw-Hill.

13. Kemp, B., Brummel-Smith, K. & Ramsdell, JW. (Eds.). (1990). Geriatric rehabilitation. Massachusetts: College-Hill.

14. Mulder, C. (1996). Chronic health problems and long-term disability. In R. Alder, E. Vingilis & V. Mai. (Eds.). Community health and well-being in southwestern Ontario: a resource for planning, pp. 217-234. London, Ontario: Middlesex-London Health Unit and the Faculty of Medicine, University of Western Ontario.

15. Stone, LD. (1988). Family and friendship ties among Canada's seniors. Ottawa: Statistics Canada.

16. Mack, R., Salmoni, A., Viverais-Dressler, G., Porter, E. & Garg, R. (1997). Perceived risks of independent living: the views of older community-dwelling adults. Gerontologist, 37(6), 729-736.

17. Archer, J & Hebel, L. (Eds.). (1996). There is more to health than health care: Thames Valley community health status report. Ontario: Thames Valley District Health Council.

18. Health Services Restructuring Commission. (1997). A vision of Ontario's health services system. Toronto, Ontario: Author.

19. Ontario Ministry of Health. (1993a). Moving forward: strengthening health planning in Ontario. A report by the joint task force of the Ministry of Health. Willowdale, Ontario: Queen's Printer.

20. Ontario Ministry of Health (1993b). A healthier Ontario: progression in the '90's. Toronto, Ontario: Queen's Printer.

21. Thames Valley District Health Council. (1996). Multi-year plan for long term care: 1996-2001. London, Canada: Author.

22. Green, LW. & Higgins, J.W. (1995). Strategies, guidelines, policies and standards: the search for direction in community health promotion. Health Promotion International, 10(1), 75-76.

23. O'Hagan, MF. (1995). Optimizing capacities in a rural community: West Elgin seniors' project. Research report prepared for Elgin County Homes for Senior Citizens Supportive Housing Initiatives. Ontario Ministry of Health, Long-Term Care Division.

24. Shields, C. (1997). Building community systems of support. A discussion paper for the October 28, 1997 Children at Risk Symposium. Toronto: Laidlaw Foundation.

25. Shiell, A. & Hawe, P. (1996). Health promotion, community development and the tyranny of individualism. Health Economics, 5, 241-247.

26. Wolnik, S. (1996). Evaluation of the wellness pilot project. Report prepared for the Steering Committee Wellness Pilot Project, London, Ontario.

27. Boult, C., Boult, L., & Pacala JT. (1998). Systems of care for older populations in the future. Journal of the American Geriatrics Society, 46, 499-505.

28. Stuck, AE., Siu, AL., Wieland, GD., Adams, J. & Rubenstein, LZ. (1993). Comprehensive geriatric assessment: a meta-analysis of controlled trials. The Lancet, 342, 1032-1036.

29. Landefeld CS., Palmer RM., Kresevic DM. et al. (1995). A randomized trial of care in a hospital medical unit especially designed to improve the functional outcomes of acutely ill older adults. New England Journal of Medicine, 332, 1338-1344.

30. Covinski KE., King JT., Quinn LM. et al. (1997). Do acute care for elders units increase hospital costs? a cost analysis using the hospital perspective. Journal of the American Geriatrics Society, 45, 729-734.

31. Cummings, JE., Hughes SL., Weaver FM. et al. (1990). Cost-effectiveness of Veterans Administration hospital-based home care. A randomized controlled trial. Archives of Internal Medicine, 150, 1274-1280.

32. Melin A,., Hakansson S. & Bygren L. (1993). The cost and effectiveness of rehabilitation in the home: a study of Swedish elderly. American Journal of Public Health, 83, 356-362.

33. Zimmer JG., Groth-Juncker A. & McCusker J. (1985). A randomized controlled trial of a home health care team. American Journal of Public Health, 75, 134-141.

34. Stuck, AE., Egger, M., Hammer, A. & Minder, CE. (2002). Home visits to prevent nursing home admission and functional decline in elderly people: a systematic review and meta-regression analysis. Journal of the American Medical Association, 287(8), 1022-1028.

35. Yoder, MK. (1996). Starting a nurse-managed center for older adults: the needs assessment process. Geriatric Nursing, 17, 14-19.

36. Barger, SE. & Rosenfeld, P. (1993). Models in community health care: findings from a national study of community nursing centers. Nursing Health Care, 14, 426-431.

37. Lockhart, C. (1994). Community nursing centers: an analysis of status and needs. Paper presented at NLN Council for Nursing Centers, Annual Meeting, June 2, 1994, Los Angeles.

38. Branch, LG., Coulam, RF., & Yvonne, AZ. (1995). The PACE evaluation: initial findings. The Gerontologist, 35(3), 349-359.

39. Rich MW., Beckham, V., Wittenberg, C. et al. (1995). A multidisciplinary intervention to prevent the readmission of elderly patients with congestive heart failure. New England Journal of Medicine, 333, 1190-1195.

40. Weinberger M., Oddonne EX. & Henderson WG. (1996). Does increased access to primary care reduce hospital readmissions: Veterans Affairs Co-operative Study Group on primary care and hospital readmission. New England Journal of Medicine, 334, 1441-1447.

41. Henderson, M. (1984). A GNP in a retirement community. Geriatric Nursing, March/April, 109-112.

42. Glick, DF., Hale, PJ., Kulbok, PA., & Shettig, J. (1996). Community development theory: Planning a community nursing center. Journal of Nursing Administration, 26(7/8), 44-50.

43. Sleath, B. & Rucker, TD. (2001). Consumer participation in health policy decisions: empowerment or puffer? Journal of Health Care for the Poor and Underserved, 12(1), 35-47.

44. Coleman, EA., Grothause, LC, Sandhu, N. & Wagner, EH. (1999). Chronic care clinics: a randomized controlled trial of a new model of primary care for frail older adults. Journal of the American Geriatrics Society, 47, 775-783.

45. Saltman, R. & Figueras, J. (1997). European health care reform: analysis of current strategies. World Health Organization Regional Publications. European Series no. 72. Copenhagen: World Health Organization.

46. Redden, CJ. (1999). Rationing care in the community: engaging citizens in health care decision making. Journal of Health Politics, Policy and Law, 24(6), 1363-1389.

47. Gamm, LD. (1998). Advancing community health through community health partnerships. Journal of Health Care Management, 43(1), 51-66.

Chapter 2

Facilitating Community Change: *Strategies for Success*

- what the evidence tells us
- an overview of change theory & societal guidance theory
- critical factors impacting success in bringing about change
- strategies for optimizing community & system change
- getting buy-in
- lessons learned
- references

What the Evidence Tells Us . . . . .

- there is much evidence-based information about working with communities, facilitating community & systems change, & factors that both enhance & constrain change initiatives
- facilitating change involves many issues that must be addressed, including communication, control, power & decision-making
- four key factors have been identified as being critical to optimizing change & minimizing levels of resistance:
  - the relationship between community & agency
  - the degree to which the community is involved in planning, goal setting, determining time lines, action planning, etc.
  - the degree to which the community's priorities are consistent with those of the agency
  - developing "true" partnerships & sharing decision-making
- hospitals working with communities present unique challenges & problems

Our Experience . . . . .

- issues of power, control & ownership present the greatest challenge & require the greatest time, energy, commitment & resources to resolve
- rarely, if ever, do agencies & institutions allow the community to share equally in decision-making
- partners for the most part are willing to think creatively, be flexible & collaboratively develop new programs & ways of operating; follow-through & implementation have proven more difficult
- securing the required funds to work with a community for an adequate period of time is difficult; community capacity building & systems change is time intensive & cannot be done with "soft" funding; a minimum of a 4 to 5 year time commitment is required
- seniors & the communities within which they live have a great deal to offer the health system if the right approach is used & adequate support & resources are provided to build community capacity

Facilitating Community Change: *Strategies for Success*

There is much evidence-based information about working with communities, facilitating community and systems change, and factors that both enhance and constrain change initiatives.[1-8] Community and systems change is defined as change resulting in new and/or improved programs, practices and policies.

Change Theory & Societal Guidance Theory: An Overview

Societal guidance theory[1] outlines an interactive process in which both the preferences of a community and the preferences of a system (agency or organization) result in negotiated and changing consensus that drive the change process (Figure 4). Societal guidance theory, in particular, emphasizes factors impacting the mobilization and action capacities of communities. It addresses community members' involvement in planning social change and the factors influencing the change process (e.g., power; resistance; communication; decision-making strategies at critical points; knowledge; etc.). Etzioni[1] argues that external organizations attempting to initiate change (e.g., health agencies; etc.) are often hierarchical in nature, and bring with them issues of "power" and control that set into motion community "resistance" factors. Critical factors identified by Etzioni as influencing the extent to which a community is amenable to change are: (1) the relationship between the community and external body initiating change, (2) the degree to which a community participates in goal setting and action planning, and (3) the degree to which the priorities or goals of the community are compatible with those of the organization initiating change (Figure 5).

A key concept in this theory is the "consensus forming process" which is achieved through increased communication and information. This process encourages voluntary community participation in change and action planning and a greater focus on building consensus, thus relying less on the use of "power" and control. This collaboration, in turn, impacts the level of community resistance and the external agency's capacity to guide change. This theory also emphasizes that detailed, systematic planning for change is a complex and demanding process that requires a very high ability on the part of the individuals involved to collect, process and evaluate information, and to choose alternative courses of action. Etzioni argues that it is important to tailor decision-making strategies to the intellectual capabilities of any given community. He also argues that it is

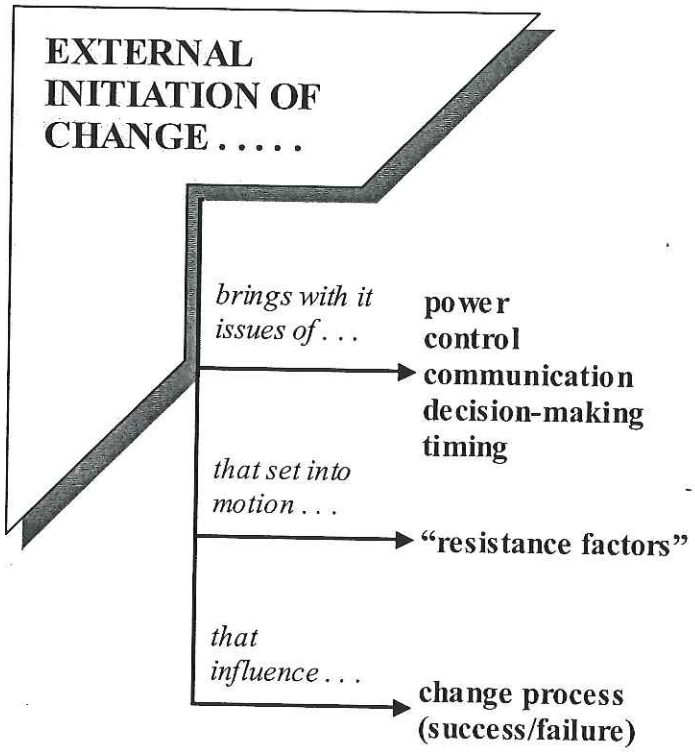


Figure 4: Change theory and change processes based on the work of Etzioni[1] and Shields[2].

important to ensure that the approaches used are compatible with community members' level of education and skill, and that approaches are adaptable to changing circumstances. For more detailed information on societal guidance theory please refer to Etzioni's 1991[1] publication: A responsive society: Collected essays on guiding deliberate social change.

Additional information on successful change processes can be found in Senge's[3, 4] work. Senge pioneered a collaborative concept which he calls "the learning organization". This concept encourages individuals to work together in a sustained effort to bring about innovative organizational change within, and among, major international business corporations. Senge, too, points out the value and importance of the concepts of collaboration and empowerment in achieving long-term, competitive advantages in international business. Consistent with a community development approach and societal guidance theory, Senge's approach builds trust and enhances organizational capacity by: (1) building employee knowledge and skills, (2) linking individual aspirations with company interest so that employees move beyond working for self-interest to working for a broader, collective purpose, (3) involving employees as active participants in creating

the future of their organization, (4) moving "top-down"decision-making to shared decision-making at a more local, front-line level, and (5) fostering feelings of "connectedness" and commitment (instead of compliance) among individuals and their organizations. Integral to building "learning organizations", according to Senge are the concepts of "systems thinking", "personal mastery", "participative and reflective openness", and the building of shared visions. Senge's approach has resulted in extraordinary successes for numerous high-profile international corporations, and confirms the potential of capacity building across a variety of diverse settings and sectors of society.

Facilitating change and building community capacity related to health, with communities of frailer older adults depends very much on both individual and collective action. Many factors influence an individual's willingness or ability to voluntarily participate in health-related community action. Theoretical frameworks outlined in Chapter 3, and the six year research findings of the Cherryhill Healthy Ageing Program will hopefully help clarify why some older individuals and communities become involved in the planning and provision of their own health services, while others do not.

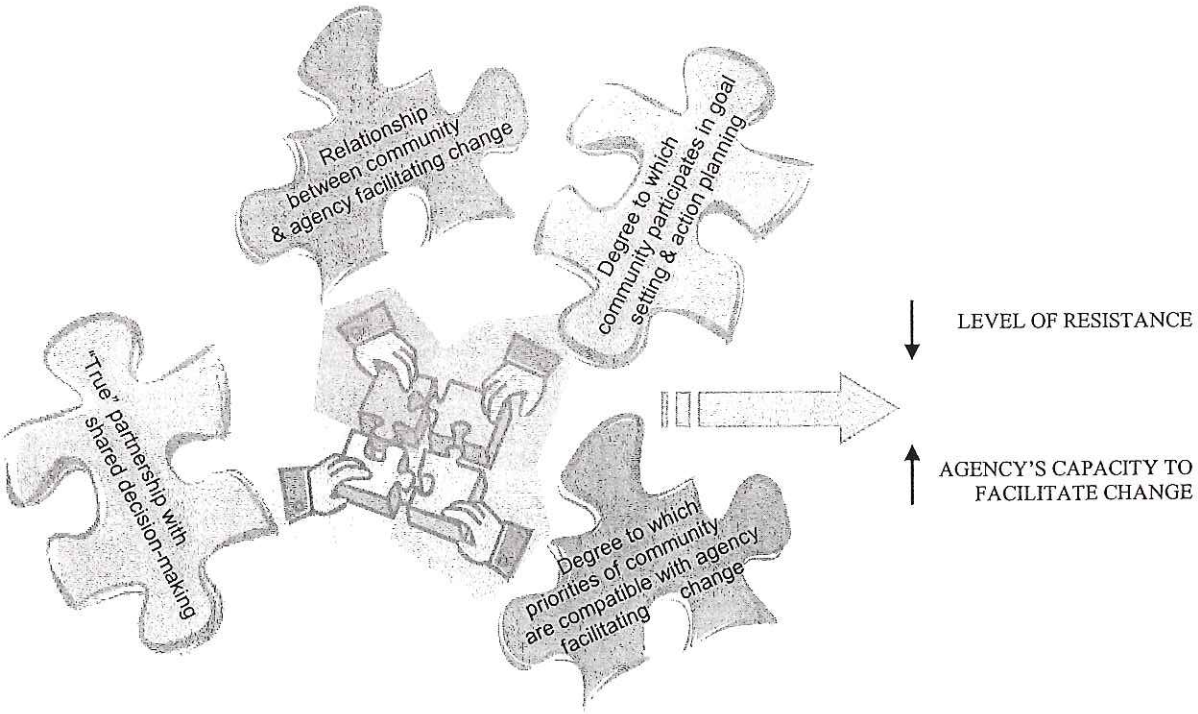


Figure 5: Critical factors found to influence the outcome of community and systems change (modified from Etzioni[1]).

To optimize one's success in working with communities and facilitating change there is consensus that it is important to:

Step 1: develop a clear, precise & very focused vision regarding what the issues are & the change that is needed

Step 2: identify community characteristics (demographics, socio-economic status, etc.), key community leaders (formal & informal), patterns of communication & information sharing within the community, favourite gathering places for community members, past experiences with health agencies & other "outsiders"; identify community strengths & potential barriers

Step 3: provide the community & key community leaders with detailed information about the issues, project, change required, etc.

- enough information to allow the community to process & evaluate the information
- enough time to determine whether it is of relevance to the community &/or to come up with options or alternatives

Step 4: build trust - make a commitment to work *with* the community, share decision-making, allow adequate time & resources to build a solid relationship with the community, & solid foundation within the community; get buy-in from formal & informal community leaders

Step 5: identify issues of importance to the community

Step 6: ensure that the interests of the community are consistent with those of the agency; identify potential barriers

Step 7: identify community leaders who are interested in working with you; collaboratively develop strategies to gain support from others & to minimize resistance

Step 8: develop formal processes to ensure shared decision-making & the reaching of consensus

Step 9: collaboratively involve the community in the planning process from the start; ensure active involvement in determining priorities, setting goals & time lines, action planning, evaluating progress, etc.

Step 10: ensure adequate time & resources to support community initiatives

There is some evidence[7] that suggests that professional staff hired by collaborating partners results in an increased rate of change. Chapters 3, 6 and 7 will provide additional information and specific strategies on optimizing community involvement.

Getting Buy-In: Our Approach

Facilitating buy-in from all potential partners and stakeholders is critical, yet somewhat daunting. Each potential partner comes to the planning table with unique attitudes, beliefs, skills, capabilities, and agency mandates, all of which influence behaviour, willingness to become involved, and openness to change. Facilitating "systems thinking" that optimizes buy-in requires careful planning and a carefully thought out process. We used Kolb's Learning Wheel[9] to facilitate our collaborative partnership process, and to ensure a common vision and goals (Figure 6).

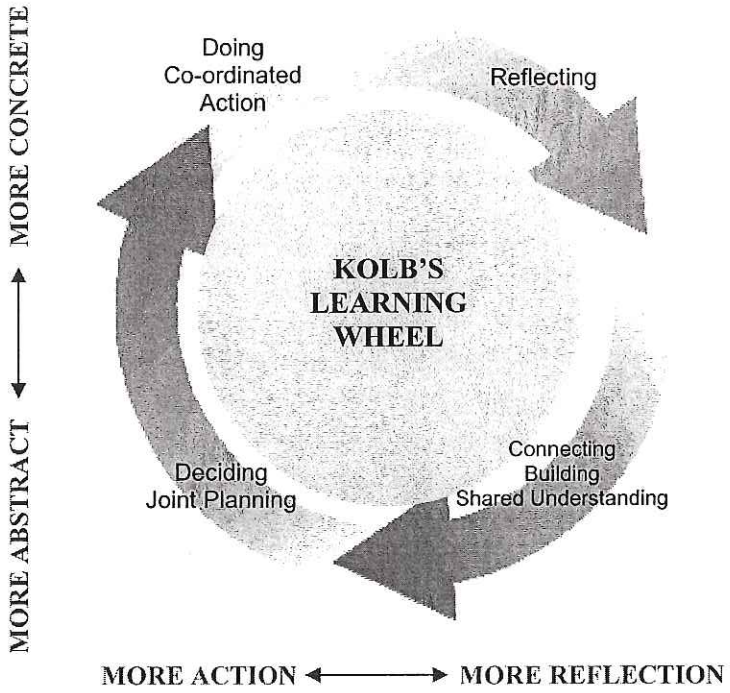


Figure 6: Moving from individual thinking to collaborative action (modified from Kolb's Learning Wheel, Senge[4]).

The Cherryhill Experience

Our experience working with the Cherryhill community was consistent with the findings and experiences reported by other researchers. Facilitating change and building community capacity and partnerships requires continuous flexibility, dedicated resources for an adequate period of time, and a commitment to allow the community and community members to share equally in decision-making. While we have had many "challenge/crisis" points during our more than six years of operation (Appendix C) that have caused a slow down in our work and caused community members to become frustrated, we have however, experienced wonderful success and "high points". Our challenges ranged from:

- significant changes in staffing/partner agency involvement
- reluctance of health professionals to become *actively* involved & to be a part of the actual capacity building process; many were only willing to consult
- issues of ownership
- lack of follow-through on promises made by health professionals
- using the right language (specific example: during the growth phase of the project, a community volunteer overheard a health professional from a partner agency say "*the ____ owns this project now*"; word quickly spread among the volunteers, some of whom threatened to resign; morale was impacted & significant time was required for "damage control"
- loss of key community leaders
- personality conflicts among volunteers
- resistance to "outsiders" by the Cherryhill community
- challenges required to raise enough funds to carry on with the project

". . . the period of funding was too short. It takes time to build trust & get buy-in from the community & others. While we were in the middle of building partnerships, we constantly had to worry about how we were going to survive. This side tracked us & took away from our work with the community."

". . . in the beginning there were a lot of "turf" issues & issues of ownership. It took a while to work through, but then everyone began to work better together."

Our high points included:

- watching the passion, energy, commitment & tremendous amount of work volunteer community members devoted to something they believed in
- watching volunteer neighbours quickly identify, respond to & activate an emergency response for neighbours in need, in particular individuals who had fallen in their apartments, unable to get up or call for help & without family nearby, who would otherwise not have been discovered for 3 to 4 days until their health care worker was due
- seeing community leaders slowly & steadily emerge
- hearing a community member say "*I didn't ever think I would be able to do this!*"
- seeing much needed resources "mysteriously" appear on our desks & doorstep with no explanation
- everyone, especially community volunteers,willingly "chipping in" to do whatever needed to be done
- the support & encouragement of property owners, local businesses & others
- breaking through the fear & trust issues so common in the community
- the general public, from other communities, asking for help to implement something similar in their communities
- the calls of thanks from family members & other relatives of Cherryhill residents

". . . we lost our momentum for a while. The health care system was restructuring & there were so many changes affecting the agencies with whom we were working. People were being moved around. With one agency we had six different contacts, one after the other! It was like starting over again & again! We lost a lot of time."

". . . it took a little while, but then you could really see a change in the confidence, professionalism & involvement of community members. Now there's no stopping them!"

Other key factors:

- Gaining access to the community initially was difficult. Many other researchers had approached the Cherryhill community in the past, and it was reported that most come, collect their information and leave. We were asked how our project would be different and what benefit the community could expect.

- Building trust and getting buy-in was critical, but difficult and time intensive. With our work it took approximately 1½ years, almost the entire period of initial funding, to establish a solid framework within the community from which to move forward collaboratively. There were a limited number of "tangible" outcomes to report to our funders. Thankfully they, and others, believed in the potential of the Cherryhill Healthy Ageing Program.

- The Cherryhill community and community members were actively involved in all aspects of the program from the start including:

    - determining program priorities
    - developing, pilot testing, distributing & collecting
    - a community-wide survey
    - determining goals & timelines
    - monitoring progress, etc.

  This was much more time intensive up front, but well worth the effort over the long-term.

References

1. Etzioni, A. (1991). A responsive society: collected essays on guiding deliberate social change. San Fransico: Jossey-Bass Inc.

2. Shields, C. (1997). Building community systems of support. A discussion paper for October 28, 1997 Children at Risk Symposium. Toronto: Laidlaw Foundation.

3. Senge, PM. (1990). The fifth discipline: the art & practice of the learning organization. New York: Doubleday.

4. Senge, PM., Kleiner, A., Roberts, C., Ross, RB. & Smith, BJ. (1994). The fifth discipline fieldbook: strategies and tools for building learning organizations. New York: Doubleday.

5. Lauderdale, ML. (2001). Issues in securing the community's sanction before making an intervention. Family & Community Health, 23(4), 1-8.

6. Fawcett, SB., Francisco, VT., Paine-Andrews, A. & Schultz, JA. (2000). A model memorandum of collaboration: a proposal. Public Health Reports, 115, 174-179.

7. Roussos, ST. & Fawcett, SB. (2000). A review of collaborative partnerships as a strategy for improving community health. Annual Review of Public Health, 21, 369-402.

8. Wolff, M. & Maurana, CA. (2001). Building effective community-academic partnerships to improve health: a qualitative study of perspectives from communities. Academic Medicine, 76(2), 166-172.

Chapter 3

Building Community Capacity: *Strategies that Work*

- community development, community mobilization, community-based programming & the community-systems approach . . . what is the difference?
- are you really working *with* a community? . . . different levels of community involvement
- building community capacity
- hospitals working with communities . . . an added challenge
- community capacity building & frailer older individuals
- related theoretical frameworks
- the Cherryhill experience:
  - making contact
  - increasing & measuring involvement
  - demonstrating success
  - developing breadth
  - a place at the table
  - challenges
- references

What the Evidence Tells Us . . . . .

- the terms community development, community mobilization, community-based programs & the community systems approach are often incorrectly used interchangably; these terms in fact have very different meanings
- there is consensus among researchers that most current community health programs are provided *in* a community or *for* a community, but rarely *with* a community; rarely are decisions shared equally & rarely is there a transfer of power & control
- there is a growing body of evidence that suggests hospitals working with communities create an added challenge and that consistently the endeavours initiated by hospitals are not successful
- it is suggested that this is due to hospitals & communities working from two very different philosophical & operational frameworks & due to issues of locus of control & locus of power
- a substantial number of theoretical & conceptual frameworks exist & should be used to guide community capacity building initiatives

Our Experience . . . . .

- the community-systems approach is particularly well suited to capacity building initiatives related to health
- the community-systems approach requires organizations/stakeholders & communities to become equal partners from the beginning, to collaboratively identify potential barriers & strengths & to share equally in decision-making & negotiating change
- the current governance structure & operational practices of hospitals & health agencies *do* create issues of control, power & ownership that significantly impact the community capacity building process
- knowledge & use of existing theories, in particular the theories of aging, individual & community empowerment theories & social psychological theories, can mean the difference between success & failure of community capacity building endeavours; this is particularly true when working with communities of very old individuals

Building Community Capacity: *Strategies that Work*

There are many different approaches one can take when working with communities. Before discussing community capacity building it is important to examine the related concepts of community development, community mobilization, community-based programs, and the community-systems approach, and to understand the similarities and differences among these constructs. These terms tend to be used interchangeably when in fact they have very different meanings. It is also important to define one's community.

Many different conceptualizations of the term "community" are found in sociological, health promotion and other literature. For example, community has been defined as a group of people, operationalized as a particular location or place, used to refer to relationships (i.e., common interests, experiences; etc.), or operationalized as collaborative action related to political or social change.[1-4] We have defined community as being more than a shared geographic area and, consistent with health promotion literature, use the term to refer to a neighbourhood with an established social network and support system that is responsive to both individual, as well as broader neighbourhood needs.[3-5] Inherent in this definition is the notion of citizens caring about one another and working together on individual, as well as community, concerns.

Community Development, Community Mobilization, Community-Based Programs, Community-Systems Approach . . . . . What is the Difference?

Community development has different meanings to different people. The terms "community development", "community mobilization" and community-based" are often operationalized in different ways in the literature and many times, incorrectly used interchangeably. These terms in fact have very different meanings.[4, 6] For example, Shiell and Hawe[4] argue "community development programs in their purest form start with no fixed agenda or health issue". Inherent in community development are such concepts as:

- self-determined & driven action by a community (vs. professionally determined action)
- the notion of empowerment & transferring of control
- voluntary collective action to produce change
- capacity building

- broad-based action that strengthens the community as a whole (i.e., empowers citizens, strengthens economic & environmental resources within the community, etc.); it is a process that, in general, improves the quality of life in one's community.[1, 4, 7-9]

Community mobilization is typically viewed as falling under the "umbrella" of the broader concept of community development (Figure 7). While community mobilization shares many similarities with the concept of community development (i.e., a process that is community-driven and sustained, relies heavily on the concept of empowerment, leads

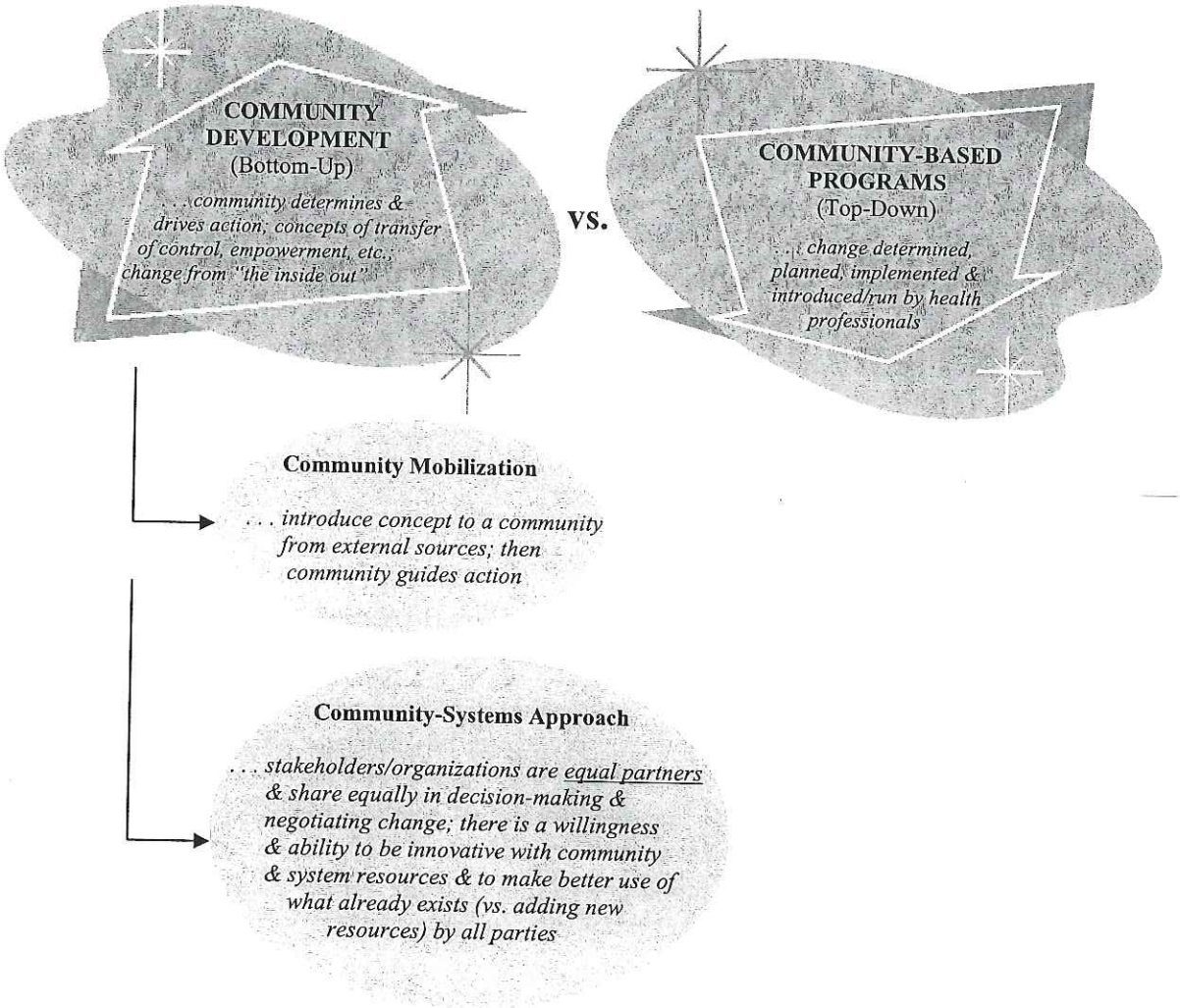


Figure 7: The difference between community development, community mobilization, the community-systems approach and community-based programs.

to a better community, etc.), the fundamental difference is that with community mobilization an issue is introduced to a community (possibly from external sources) and then the community building process begins from that point onward. A community is mobilized around a particular issue (Figure 8). Community mobilization or action typically involves introducing a particular project or issue of interest to a community, determining the degree of willingness of the community to become involved, collaboratively establishing mutual goals, fostering and gaining community-wide, long-term commitment, collectively identifying community strengths, barriers, challenges and possible solutions, the community assuming ownership of previously identified and

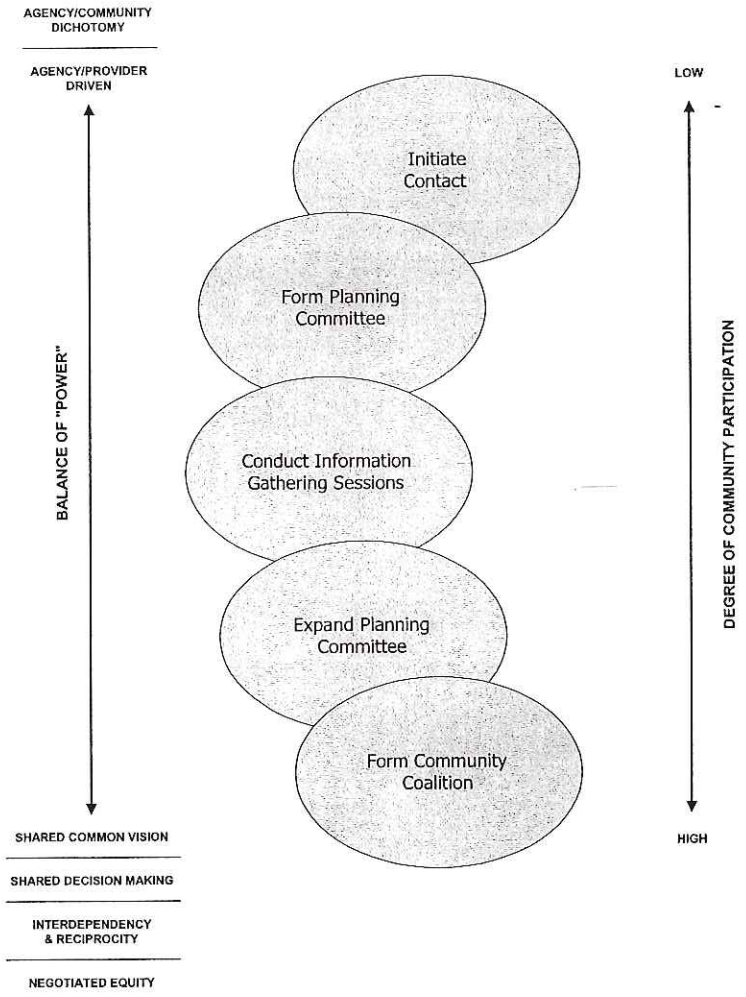


Figure 8: Key components and process of community mobilization. Modified from: "The Path to Community Action" framework, Community Health Promotion in Action, Ontario Ministry of Health, Toronto, Canada.

evolving issues and the formation of a solid community base from which future action is generated.[10-13] Much like community development, community mobilization is a dynamic, ever evolving process that is responsive to the particular needs of a community at any given point in time.

Community-based programming or service provision, on the other hand, is an entirely different concept that is externally driven and more individually focused, with specific services being provided (based on professionally identified need) in the community.[6] Community-based programs or services are typically determined, planned, implemented and run by health professionals. The focus, for example, might be on health promotion.

The *community-systems approach*[14] (Figure 9) brings together the top-down and bottom-up approaches. It is similar to other community approaches (e.g., community development; community mobilization; health promotion and prevention; etc.) in that it also incorporates the concepts of community capacity building. However, this approach differs from the others in that it also includes all levels of stakeholders or community partners (e.g., funders; community planners; service providers; etc.) as well as the community from the *onset* as equal partners sharing decision-making around health

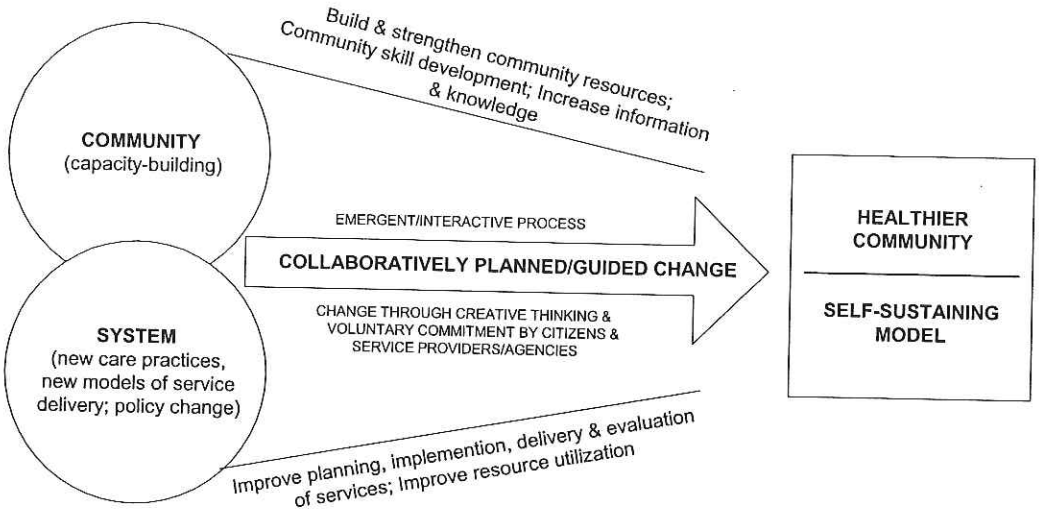


Figure 9: A community-systems approach to planned social changes (Kloseck[61]; adapted from Shields[14]).

issues. This approach ensures the best use of resources (informal and formal system-provided) to build the capacity of local communities to improve the health of all individuals residing in those communities. Integral to the community-systems approach is the willingness and ability to be innovative with available community and system resources, and to make better use of what already exists (rather than adding new resources) by linking all partners in the planned change process. The community-systems approach is particularly well suited to community capacity building related to health.

The community-systems approach[14] involves both the community and formal health system early on in planned community change processes. This approach has been identified as crucial to overcome identified barriers and to ensure the sustainability of health-related community capacity building initiatives. For example, Shields[14] suggests there is only so much a community can do to mobilize and strengthen it's resources to bring about desired change before eventually encountering roadblocks such as organizational procedures or policies that severely hinder progress. For community efforts to last, it is important to create an environment, from the outset, that is conducive and open to change at all levels. This requires both "health systems" and "communities" to work hand-in-hand to collectively identify barriers and mutually determine suitable action throughout the entire planned change process. Otherwise, it has been argued, the sustainability of projects may be compromised.[14]

Checkoway,[2] in his work on strategies of community change and empowerment, identifies "citizen participation" as one of the most popular approaches used to facilitate change today. He concurs that if there is commitment to the sharing of decision-making and the transfer of power and control from agencies and professionals facilitating the change to the communities involved, this approach can be very effective. Checkoway, however, goes on to argue that "true" commitment to shared decision-making and the transfer of control and power is not typical among many of the current public participation initiatives undertaken. He argues that often community participation is used for other reasons such as gathering information and not to develop "true" collaborative partnerships between communities and agencies. Checkoway points out that many of the community development initiatives today do not result in the transfer of power and control to communities:

> *". . . . . some agencies favor participation that is not disruptive of program management, and oppose participation that results in citizen control over key aspects of programs. They thus favor "safe" methods that provide information without transfer of power to a community."* [2 (pg.10)]

True community participation involves collaboration and negotiated consensus that drives the change process (Figure10).

Are You Really Working *With* a Community? The Different Levels of Community Involvement

There is consensus among researchers in the social and gerontological literature that many of the programs currently being provided are provided *in* a community, or *for* a community, but rarely *with* a community. Working with communities requires a commitment, among other things, to:

- share decision-making
- share power
- transfer more and more decision and program control/ownership to the community (non-professionals)

There are many levels of community involvement, and while program facilitators often use the right "language" these concepts are rarely carried out in actual practice.[15-17]

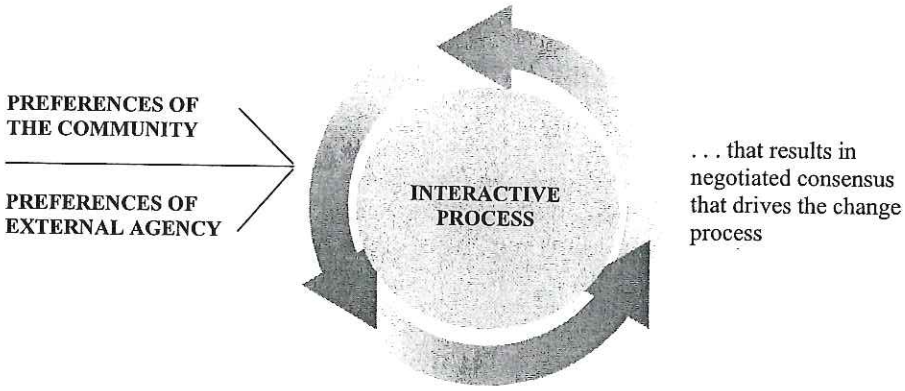


Figure 10: Change theory and the community-systems approach.

Community involvement ranges from the provision of information, to education and consultation, to true community empowerment (Figure 11). A growing body of evidence has identified that the majority of community partnerships tend to stop with client-consumer satisfaction surveys, and that the much higher levels of involvement (i.e., true participation and community empowerment) are rarely undertaken or accomplished. It has been suggested by some[17] that governmental policies that promote community empowerment are necessary to ensure active community/consumer participation in actual practice.

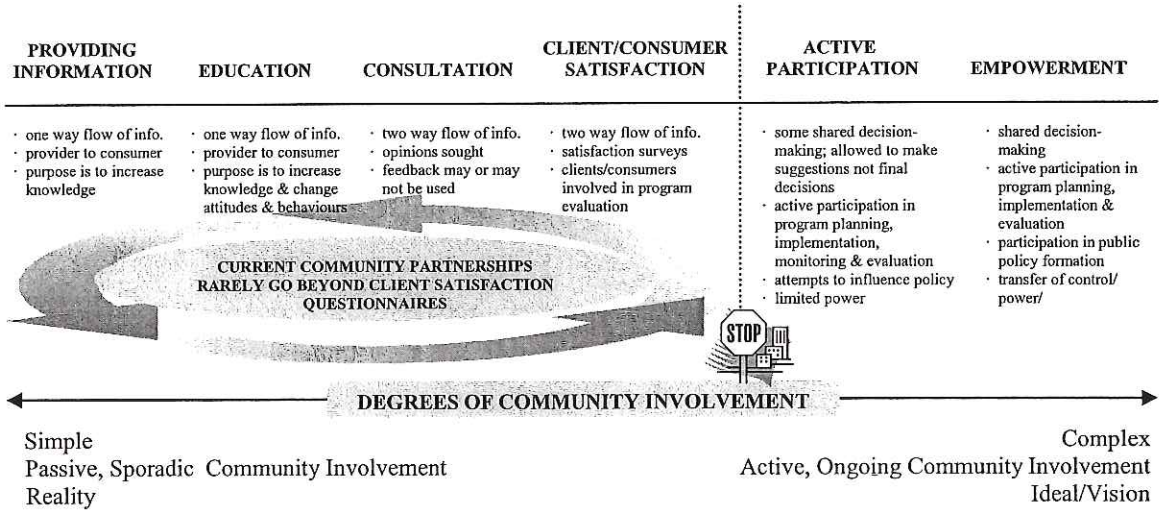


Figure 11: Levels of community involvement (modified from Poulton[17]).

Building Community Capacity

Community capacity refers to the ability of a community to harness its skills, knowledge and resources to collectively work with, in this case, the formal health system to determine action around community- and system-identified health issues. Community capacity implies a shift of "power" from the traditional "top-down" approach (health system/professional driven approach) to shared and equal decision-making, negotiating and problem solving among all partners (i.e., community and formal health system). It also implies long-term community management of community-identified issues.

Working with communities to build capacity is a time intensive and challenging process that facilitates new learning and changes in attitudes and behaviours by all partners involved, including community residents and partner health agencies. While time intensive up front, community capacity building has many paybacks and benefits over the long-term. Working with communities to build capacity requires skills and knowledge of relevant theoretical frameworks that enhance/constrain capacity building initiatives (e.g., change theory; theories of aging; social gerontological theories; theories of motivation and volunteerism; etc.) and perseverance. An overview of these theories is provided later in this chapter.

Often, during capacity building initiatives, there is pressure from the various partners (e.g., community; agency partners; funders; etc.) for immediate action and tangible results and outcomes. This was experienced many times during the more than

six years of operation of the Cherryhill Healthy Ageing Program. Knowledge of the key factors impacting the success/failure of change initiatives (e.g., timing; communication processes; unique characteristics of one's community; etc.) as identified in the various theories is very important in order to establish realistic time lines, identify community leaders, establish the required working committees and determine communication processes based on the unique needs of the particular community one is working with. Each of these factors will impact the short-term success and longer term sustainability of community initiatives. Core components of the community capacity building process include[15]:

- identifying common issues, needs, goals, etc.
- working collaboratively & co-operatively
- building inter-agency & cross-sector partnerships

Sustainability of community capacity building initiatives is dependent upon many factors, both internal and external, to the communities with which one works. Increasingly, available evidence suggests that success is dependent upon having adequate time to work with a community, the ability to mobilize community resources, stable and visible community leaders, a formal leadership structure and general leadership facilitated by someone with knowledge and training in community development and the various related theoretical frameworks. The greater the perception of collaboration, connectedness and involvement in decision-making, the greater the community's sense of ownership and the more positive the outcomes.

Hospitals Working With Communities . . . . . an Added Challenge

While community capacity building literature is somewhat sparse, there is a growing body of evidence that suggests hospitals working with communities to build capacity creates a unique problem and that, consistently, community partnership building led by hospitals is not successful.[18, 19] It has been suggested[18-22] that this is due to:

- hospitals/the formal health care system and community development initiatives operating from two very distinct philosophical frameworks; in contrast to the community empowerment approach, hospitals often "use control as a method of management"[18]
- the issues of locus of control and locus of power, two concepts critical to the empowerment process
- senior management typically does not believe that it is in their best interest, or that of the hospital, to share operation & delivery of health care
- the collaborative involvement of other partners, including the community (non-professionals) creating a barrier for hospitals due to the sharing of leadership that is required
- resistance by holders of organizational power to share

- the right "language" & catch phrases often being used; but hospitals/senior management teams rarely going beyond the current "catch phrases" to committed action & the provision of dedicated resources

The "culture" or environmental context of an organization has been reported as significantly influencing the success or failure of community partnership building initiatives. Collaboration and participation are all about sharing decisions, control and power, the environment within which the change process occurs is critical

The same researchers[18, 19] suggest that successful and positive relationships are possible. However, they are dependent upon commitment by hospitals' senior managers and senior management teams. It is not enough to have enthusiastic and innovative-thinking professionals on the front lines, senior management teams must drive the process by showing an interest in learning, active involvement and allocating the required resources. It must be recognized that new and innovative approaches are required to meet community health needs and to extend health programs and services out of hospitals and into the community. Communities must share in decision-making and program ownership, and hospitals must recognize when, and be willing to "let go" of successful programs that have been built. Without this management commitment to share information, expertise and power, it is not possible to achieve sustainability.[18]

Building community capacity and cross-sectoral partnerships is time intensive and brings many challenges including, among other things, individual agency agendas and "turf" issues. In addition, many new and innovative programs are initially developed using "soft" money or funding, and continuing successful programs once research funding ends is a constant challenge. There is still a great deal of resistance to involving communities in health care planning and delivery, and much disagreement about the communities' level of participation. From a community capacity building perspective, participation is not just community input, rather it should be an underlying operational principle.[20]

Much of the research to date, especially community development and community building initiatives, have focused on healthy, active and independent older individuals living in the community.[8, 23] There has been little emphasis on community members who are over the age of 75, who are much more dependent, have a greater number of health problems, and who are among the heaviest users of health services.

Community Capacity Building & Frailer Older Individuals

Applying the concept of community capacity building in a predominantly older population provides additional challenges. The accumulation of age and disease has been identified as eroding the capacity of older individuals. Not only are older individuals

faced with the normal physiological decline that occurs with increasing age (e.g., increased health problems; reduced functional ability; reduced ability to cope with stressful events; etc.), but also with numerous additional losses imposed by society (e.g., loss of employment; loss of one's role in society; reduced income; etc.).[24] During a time in life when psychological stresses are high, biological changes coupled with negative life events often lead to the inability of frailer older individuals to cope. The greater the losses or decline, the less able older individuals are to cope, and the less involved they are in community and/or societal activities. Numerous theories of aging support this concept.[25-27]

Maintaining capacity in an aging community where the health of even the most active and involved members is somewhat precarious will be an ongoing challenge. A system of advocacy by "healthier" older community members on behalf of their weaker neighbours is needed.[28] The frail, older individual, for example, may have an external locus of control, while the locus of control for the community remains internal. For example, the problems experienced by frail older individuals are often seen as problems for the health care system to solve. If the care for frail older individuals is abdicated to the system the locus of control is outside the individual. With community capacity building, where the healthier community members help care for and advocate on behalf of the frailer members of their community, the locus of control may be outside the individual but at least it remains within the community. While the aging process itself is not reversible there are many factors in the lives of older individuals, which with the appropriate intervention and supports, can optimize the health, functional ability and involvement of older individuals. From a community development context, it is important to examine "modifiable" factors which compromise the health and functional ability of older individuals and influence volunteer behaviour that are receptive to change by the individual themselves, by others such as friends, family members and neighbours, and through the intervention of health professionals and community planners.

Theoretical Frameworks to Guide Community Capacity Building

A substantial amount of evidence generated over the years across a variety of disciplines (including gerontology, psychology, health and sociology) (Table 1) is available to guide community capacity building initiatives. These conceptual and theoretical frameworks provide useful insights into the constraints and enhancers of community involvement, change processes and community capacity as it relates to older individuals. The following is an attempt to highlight some of the available theories, in particular those used to guide the Cherryhill Healthy Ageing Program. For more detailed information please go directly to the work of each of these authors.

Table 1: Theoretical frameworks that are relevant to community capacity building and older individuals.

CONCEPTUAL & THEORETICAL FRAMEWORKS
Planned Change
Societal Change Theory ¤ interactive; negotiated change; addresses issues of "power" & "control"; particular emphasis on factors influencing the change process (e.g., involvement of community members; power; communication;decision-making strategies; timing; resistance factors; etc.) (Etzioni, 1991)[32]
Capacity Building ¤ collaborative concept; "learning organizations"; building organizational capacity; systems thinking; building shared visions (Senge, 1990)[18]
Empowerment ¤ individual & community empowerment (Chavis & Wandersman, 1990[1]; Eisen, 1994[29]; Hawe, 1994[3]; Labonte, 1989[34]; Wallerstein, 1992[35]; Rappaport, 1981[30] & 1984[31]; Zimmerman, 1990[36] & 1988[37])
Community-Systems Approach ¤ particularly useful for health-related community capacity building projects; community & health system share equally in decision-making; this is the key to overcoming barriers & sustainability (Shields, 1997)[14]
Disability
World Health Organization ¤ conceptualization of disability; classification of impairment, activity & participation (WHO, 1980[38] & 2001[39])
Theories of Aging
Competence & Environmental Press Theory ¤ impact of the environment on individuals who have experienced losses & decline (Lawton & Nahemow, 1973)[27]
Loss-Continuum Concept ¤ aging, loss & level of engagement in society (Pastalam, 1982)[40]

Selective Dependency Theory
- increasing age & vulnerability force reduction in involvement in certain activities so that performance can be maximized in others
(Baltes, 1988 [25]& 1993[26])

Social Gerontological Theories

Social Cognitive Theory
- addresses the declining memory capacity of older adults; older individuals can learn just as well as younger individuals if there are no time limitations; success in retaining new information learned depends on retrieval ability; familiarity with new tasks increases confidence; new learning should be done in a meaningful way to facilitate quick retrieval of information
(Bandura, 1989)[41]

Continuity & Activity Theories
- interests & skills are developed over the life span; adaptation is key; a lifetime of experience to draw on
(Atchley, 1988[42] & Havighurst & Albrecht, 1953[43])

Subculture Theory
- symbolic interaction; "young" old different than "old" old; interaction with same age group key; shared commonality of experience; more realistic goals therefore feeling of failure lessened; use of peer facilitators; stresses the importance of knowing your cohort
(Caserta, 1995)[44]

Social Psychological Theories

Motivation Theory
- impact of internal & external factors on behaviour
(Deci, 1975[45]; Maslow, 1943[46]; White, 1959[47]; Harter, 1978[48])

Self-Determination Theory
- links self-determination to intrinsic motivation; emphasizes notions of control & choice
(Deci & Ryan, 1985)[49]

Self-Efficacy Theory
- suggests perceived self-efficacy of an individual influences behaviour & directly impacts the effort an individual will expend & the length of time an individual will persist with any given activity; key to this theory is belief in personal abilities & mastery experiences
(Bandura, 1977[51] & 1986[51])

Locus of Control Theory
- addresses the importance of perceived control
(Rotter, 1966)[52]

Learned Helplessness

- if a situation is perceived as uncontrollable, or that one's actions will make no difference, feelings of helplessness will result & the likelihood of following through with actions will decrease; learned helplessness has been associated with depression & this theory supports the importance of perceived control
  (Seligman, 1975)[53]

Independence

Determinants of Independence

- perceived control; physical functioning; confidence; self-esteem; coping; physical & social environmental factors
  (Nosek & Fuhrer, 1992[54]; Nosek, Fuhrer & Howland, 1992[55])

Theories of Volunteerism

Volunteer Behaviour

- the impact of socio-economic factors, social networks, personality & demographic characteristics -Pearce, 1993[56]
- the impact of environmental, social, personality, attitude & life situation factors-Pearce, 1983[57] & Smith, 1994[58]
- the impact of the environment, health, function, well-being, activity level, social resources & personality-Kloseck, 1999[59]
- Dominant Status Model-Lemon, Palisi & Jacobson, 1972[60]
- General Activity Model-Smith, Macauley, et al., 1980[61]
- Inter-Disciplinary Sequential Specificity Time Allocation Lifespan Model (ISSRAL)-Smith, Macauley, et al., 1980[61]
- Needs Theory-Harter, 1978[48]; Maslow, 1954[46]; White, 1959[47]
- Expectancy Theory-Moore, 1985[62]
- Theory of Motivation in Volunteerism-Knowles, 1972[63] includes service & learning & planned change

Individual vs. Community Empowerment

While there is much discussion about "empowerment" as it relates to community development in recent literature, "empowerment" tends to be a loosely and somewhat inconsistently used term.[29] The definition of empowerment has evolved over the years. Initially, Rappaport[30] described empowerment as a process used "to enhance the possibilities of people to control their own lives" (p. 15). This definition was later broadened to describe empowerment as "a process by which people, organizations and communities gain mastery over their lives".[31] It is now generally recognized that the

concept of empowerment refers to a process whereby individuals, organizations or communities exert control over factors that influence their lives; a process that includes individual, psychological and/or collective growth.[31, 36, 37]

Much of the current community mobilization literature focuses on community empowerment. This differs from individual empowerment, in that it is a *collective* process that facilitates social action and brings about change for large numbers of individuals in a given geographic area.[29] Eisen,[29] in differentiating between empowerment concepts in the context of community mobilization, argues "successful programs require community ownership and community ownership requires leadership and control by the target population" (p. 241). Thus, building the skills and knowledge of individuals is an essential requisite to building capacity at the community level.

Social Psychological & Individual Empowerment Theories

Many theories exist to guide the building of individual knowledge and skills that are required to optimize the independence and participation of individuals (see Table 1). These theories have been identified as being particularly relevant for frail older individuals, many of whom, due to increasing pathologies and multiple losses with advancing age, become increasingly dependent on others (i.e., have external loci of control). Examining individual characteristics such as locus of control, self-efficacy, participation patterns, along with social and environmental influences are critical and will provide greater insight into how frail older individuals feel and why they behave the way they do. It has also been suggested that "reciprocity" is an important factor to consider when working with older individuals in order to increase their control and independence.[5] Without the ability to "give back" frail older individuals quickly "lose self respect and acknowledge their dependence". Recognizing and creating opportunities for "giving back", based on individual capabilities, is particularly important for achieving successful and sustainable outcomes in community capacity building initiatives in neighbourhoods of frailer older individuals, and is a central tenet of the Cherryhill Healthy Ageing Program.

Theories of Aging

Physical and social environmental factors have been linked to higher rates of involvement and volunteering. In particular, social connectedness, one's sense of community, length of time lived in the community, knowledge of community resources, satisfaction with community resources, neighbours and safety, as well as the frequency with which one leaves the home have all been shown to influence involvement and volunteer behaviour. The increasing importance of an individual's living environment with advancing age is well documented. For example, Patalam[40] stresses the increased importance of the home and immediate personal environmental factors, and the impact of these factors on behaviour, for older individuals experiencing an increased number of losses and greater dependency. Lawton and Nahemow[27] also stress the added

importance, in their competence and environmental press theory, of external physical and social environmental factors, and how dependent the involvement and participation by older individuals is on these factors. Lazarus' theory of stress and coping[64] addresses, in particular, how social support systems affect perception, coping and involvement. The concept of subcultures and subculture theory is discussed by Caserta.[44] This theory reinforces that not all older individuals are alike, and that the needs of the "young" old are very different from the "old" old. He emphasizes that interaction with the same age group and the shared commonality of experience impacts new learning, skill development, and psychological and social outcomes. Knowing your cohort can facilitate successful and efficient skill development, program development, capacity building and marketing. Baltes'[25, 26] theory of selective dependence argues that with increasing age and biological vulnerability frail older individuals are forced to reduce their involvement in certain activities so that they may maximize performance in others. For example, those individuals who have greater personal and self-care needs (which are required for everyday living) will, out of necessity, be unable to participate fully in other community or societal activities.

Knowing the characteristics of one's community is critical, as is a carefully planned and targeted approach to community capacity building. The knowledge and use of existing theoretical and conceptual frameworks can mean the difference between success and failure. It can also ensure optimal and timely outcomes and responsible use of stakeholders' resources and funds, an important consideration with increasingly scarce availability of research and program funding. The Cherryhill Healthy Ageing Program utilized these theoretical and conceptual frameworks to guide capacity building and program development in the Cherryhill community. The issues addressed by these theories were experienced in the Cherryhill community, a community of very frail older individuals, on an ongoing basis. These evidence-based theories allowed us to modify our approach quickly and successfully when required.

Theories of Volunteerism

There are several theoretical frameworks that help us to better understand why individuals volunteer, how to identify potential volunteers, and what motivates individuals to continue volunteering. The success and sustainability of community capacity building initiatives depends on voluntary community involvement, committed and dedicated community leaders, and a stable pool of community volunteers over time. Thus it becomes critically important to maximize recruitment and retention of volunteers, and to create an environment that provides both an opportunity for learning (development of new knowledge and skills) and for service. Theories of volunteerism provide useful information regarding how to best achieve this. Predominant motives for volunteering include:

- the opportunity for social contact
- self-interests (e.g., the opportunity to learn; recognition; personal growth; etc.)
- interest in, and perceived importance of, project goals
- a desire to help others
- the need to feel useful

In the majority of studies conducted, humanitarian or altruistic motives tend to outweigh other reasons given, particularly for seniors and community volunteers. This was also true for Cherryhill volunteers. Pearce[56] outlines three types of commitment and subsequent techniques that have been shown as necessary to build volunteer commitment. These three factors, in order of importance, include:

- *cohesion commitment* (defined as the development and importance of social and personal relationships)
- *continuance commitment* (defined as an individuals' belief in the value of, and commitment to, the project's purpose)
- *control commitment* (defined as an individual's belief in the project's values and that the proposed action is possible and likely to result in the desired change)

As was the case with the Cherryhill Healthy Ageing Program, recognizing these factors can assist in structuring volunteer recruitment, training and service opportunities to maximize ongoing involvement and commitment of community members. A detailed account of the experience of the Cherryhill Healthy Ageing Program and the role of volunteer community members is outlined in Chapters 6 and 7.

The purpose of this section was to highlight the many theories and conceptual frameworks available to help guide community capacity building initiatives. A great deal of evidence across many disciplines is available to help guide one's work with communities, but is very rarely used. This information can help save time and money,

and ultimately impacts the outcomes achieved. It is recommended that those interested, go directly to the work of the individual researchers for more detailed information in relevant areas.

The Cherryhill Community Capacity Building Experience

Making Contact

The Cherryhill community is a relatively closed and "protected" community. The community is aware of their relative uniqueness and have had many experiences with "researchers" coming and going, taking what they need and leaving nothing of value behind. The process of developing a successful working relationship with the Cherryhill community was very slow, requiring persistence, a great deal of time, and a consistent message and approach. When the Cherryhill Healthy Ageing Program began there was, despite the strong sense of community, no residents' association. There was, therefore, no generally accepted representative body through which to work. It was a private housing complex, containing 13 controlled and locked apartment buildings. The only access to the community was through the Activity Club. The Activity Club was housed in one of the locked apartment buildings and served the activity needs of a proportion of the community (the most independent). This club was the closest to any community structure available and provided initial access to the community as a whole.

Initiating & Building Involvement

The initial community survey conducted very early in the project in 1997 served both to get the community involved, build trust and get buy-in. A commitment was made from the start to use participatory action research and community-systems approaches in all phases of the Cherryhill Health Ageing Program. Thus, from the start, community members were actively involved, and shared equally in, all aspects of survey and program planning, implementation and evaluation. With strong community input into the design and content of the survey, and total involvement in the distribution and collection, not only was the needed information collected, but the community was provided with a challenge that contained two critical components (1) it was doable, and (2) it was worthwhile. The former, we felt , was important as not only can older individuals be overwhelmed by extra tasks in the face of limited reserve (mean age of Cherryhill residents in 1997 was 78 years), but so can communities. Caserta[44] makes the point that learning occurs when the demand exceeds capacity but by a reasonable degree. The community survey served to "stretch" the community and was a learning experience in collaboration and organization.

Increasing & Monitoring Involvement

One outcome of the survey, the desire for a "health centre" within the Cherryhill community was achieved with the generosity of the property owners, the ESAM corporation. This centre provided the community with tangible "proof" of achievement. It also created new challenges, especially the creation of a formal structure to handle the day-to-day operation of the centre in a very public, highly visible location in the community mall. As virtually none of the community members involved had experience in anything similar, it was necessary to teach not only the basic rudiments of running committees but also how to manage and operate a business. The day-to-day operation of the health centre presented many challenges to the volunteer community members many of whom had little or no work experience (most had been housewives most of their lives). Formalizing a process for recruiting, training and placing (and replacing) volunteers, and developing work and business standards led to a core of skilled and capable volunteers. The health centre is now operated 5½ days per week by trained community members, with background support of professionals as required. Over the course of this development period the increasing involvement of community members was charted with the use of a weighted involvement scale.

Tackling Community-Wide Issues & Demonstrating Success

It was felt that the increasing capacity of the community needed to be demonstrated. Community members selected two areas of importance, neither specifically health-related, that they felt were important and which they could have an impact on. One was the relative inaccessibility of the postal box at the end of the mall farthest from the grocery store, the second was speeding traffic (the Cherryhill community was being used as a "short-cut" to avoid traffic lights at a nearby intersection) and the fear of an impending injury or fatality. In attempting to have the postal box moved or another installed at the more frequented end of the mall, the community was ultimately not successful despite persistent efforts. The post office management were particularly unresponsive, letters from the community were not answered and when contact was finally made and a meeting promised, no further communication was forthcoming from the post office despite numerous attempts to contact them. The issue of speeding traffic resulted in much more positive outcomes. Despite initial refusal by the City of London to deal with the issue, community members persisted and were successful in persuading the City to formally conduct a traffic survey within the Cherryhill community, and ultimately having 3-way stop signs installed to slow traffic and give slower residents a safer place to cross. The confidence in community members and their belief that they have the power to facilitate change was noticeable. The property owners now call on the community to lobby for change and to collaboratively take on any city-related issues that arise. Goal Attainment Scaling was used to define the goals and monitor progress and goal achievement. The community was actively involved in goal setting, monitoring progress and scoring goal achievement.

Developing Breadth

These initial activities led to a wider awareness of community issues outside the health field. To preserve the focus on health within the Cherryhill Healthy Ageing Program, a separate development was encouraged and took place. A formal Residents' Association was developed to deal with general non-heath related community issues. The Cherryhill Healthy Ageing Program continued to grow (with a representative sitting on the Residents' Association to represent health issues and facilitate reciprocal flow of communication and information), and community capacity continued to increase. Shortly thereafter safety was identified as a concern by the community. A Resident Safety Program with a 4-tiered response system (see Appendix D) was collaboratively designed and implemented in most of the 13 apartment buildings. All aspects of this program are now completely operated by trained volunteer community members, and their work has been recognized by the City of London police department and other emergency responders.

While operation of the health centre and some of the programs have been assumed by volunteers from the Cherryhill community working largely independently with "behind the scenes" input from professionals, we have come to realize that ongoing support is necessary. The age structure of these volunteer community members, the nature of the programs being provided and the frailty and complex health problems of their neighbours necessitates ongoing involvement by health professionals. The role of community members is outlined in detail in Chapter 7.

A Place at the Table

It was necessary to incorporate the health centre as a business to meet the needs of the property owners. A board of directors was established consisting of representation by three key partners (1) community members, (2) local businesses, and (3) health professionals, with all sharing equally in decision-making and all having equal voting rights.

It has become clear that good communication is essential for smooth operation of programs. Currently our volunteer community leaders (health centre volunteer coordinator and program facilitators) and our safety program building representatives provide an effective communication link to the greater Cherryhill community. The safety program building representatives, in particular, facilitate efficient 2-way communication flow in and out of each of their respective buildings. We have also discovered that there needs to be a reasonable balance between acting too quickly and taking too long. Community members are usually enthusiastic, and thus impatient for action but much damage can be done by imprudent haste. This is a continuous balancing act.

Challenges

There have been many challenges to building capacity and maintaining community involvement (see Appendix C). For further details please also see Chapters 6 and 7.

References

1. Chavis, DM. & Wandersman. A. (1990). Sense of community in the urban environment: A catalyst for participation and community development. American Journal of Community Psychology, 18(1), 55-81.

2. Checkoway, B. (1995). Six strategies of community change. Community Development Journal, 30(1), 2-20.

3. Hawe, P. (1994). Capturing the meaning of 'community' in community intervention evaluation: some contributions from community psychology. Health Promotion International, 9(3), 199-210.

4. Shiell, A. & Hawe, P. (1996). Health promotion, community development and the tyranny of individualism. Health Economics, 5, 241-247.

5. Lloyd, P. (1991). The empowerment of elderly people. Journal of Aging Studies, 5(2), 125-135.

6. Pedlar, A. (1996). Community development: What does it mean for recreation and leisure? Journal of Applied Recreation Research, 21(1), 5-23.

7. Hellman, E. (1996). Signs of progress, signs of caution: How to prepare a healthy sustainable community progress report card. Toronto, Ontario: Ontario Healthy Communities Coalition.

8. Kretzmann, JP. & McKnight, JL. (1993). Building communities from the inside out: A path toward finding and mobilizing a community's assets. Illinois: ACTA Publications.

9. Ontario Healthy Communities Coalition. (1998). Healthy communities: Made in Ontario. Toronto, Canada: Author.

10. Ontario Ministry of Health. (1991). Community health promotion in action. Toronto, Canada: Queen's Printer

11. Ontario Ministry of Health. (1996). Community health promotion in action. Health Promotion Branch. Toronto, Ontario: Author.

12. Ontario Prevention Clearinghouse. (1996). Community action handbook. Toronto, Ontario: Author.

13. Ontario Round Table on Environment and Economy. (1995). Sustainable communities resource package. Toronto, Ontario: Author.

14. Shields, C. (1997). Building community systems of support. A discussion paper for the October 28, 1997 Children at Risk Symposium. Toronto: Laidlaw Foundation.

15. Moyer, C., Coristine, M., Maclean, L. & Meyer, M. (1999). A model for building collective capacity in community-based programs: the Elderly in Need Project. Public Health Nursing, 16(3), 205-214.

16. Berkowitz, B. (2000). Community and neighbourhood organizations. In J. Rappaport & E. Seidman (Eds.). Handbook of Community Psychology, (pp. 331-357). New York: Kluwer Academic Press.

17. Poulton, BC. (1999). User involvement in identifying health needs and shaping and evaluating services: is it being realised? Journal of Advanced Nursing, 30(6), 1289-1296.

18. Senge, P.M. (1990). The fifth discipline: The art & practice of the learning organization. New York: Currency Doubleday.

19. Revenson, TA. & Schiaffina, KM. (2002). Community-based health intervention. In J. Rappaport & E. Seidman (Eds.). Handbook of Community Psychology, (pp.471-493). New York: Kluwer Academic Press.

20. Morgan, LM. (2001). Community participation in health: perpetual allure, persistent challenge. Health Policy and Planning, 16(3), 221-230.

21. Gamm, L.D. (1998). Advancing community health through community partnerships. Journal of Health Care Management, 43(1), 51– 64.

22. Redden, CJ. (1999). Rationing care in the community: engaging citizens in health care decision making. Journal of Health Politics and Law, 24(6), 1363-1389.

23. O'Hagan, MF. (1995). Optimizing capacities in a rural community: West Elgin seniors' project. Research report prepared for Elgin County Homes for Senior Citizens Supportive Housing Initiatives. Ontario Ministry of Health, Long-Term Care Division.

24. Birren, JE. & Schaie, KW. (Eds.) (1977). Handbook of the psychology of aging. New York: Van Nostrand Reinhold Company.

25. Baltes, MM. (1988). Etiology and maintenance of dependency in the elderly: Three phases of operant research. Behaviour Therapy, 19, 301-319.

26. Baltes, MM., Mayr, U., Borchelt, M., Maas, I. & Wilms, H. (1993). Everyday competence in old and very old age: An inter-disciplinary perspective. Aging and Society, 13, 657-680.

27. Lawton, MP. & Nahemow, L. (1973). Ecology and the aging process. In E. Eisdorfer & M.P. Lawton (Eds.), The Psychology of Adult Development (pp. 619-674). Washington: American Psychology Association.

28. Kloseck, M. & Crilly, RG. (1998). The Cherryhill Community Project (Phases I & II): Final report for the St. Mary's Reserve Fund, St. Joseph's Health Centre. Unpublished report prepared for the St. Mary's Reserve Fund, St. Joseph's Health Centre, London, Canada.

29. Eisen, A. (1994). Survey of neighborhood-based, comprehensive community empowerment initiatives. Health Education Quarterly, 21(2), 235-252.

30. Rappaport, J. (1981). In praise of paradox: A social policy of empowerment over prevention. American Journal of Community Psychology, 9, 1-25.

31. Rappaport, J., Swift, C. & Hess, R. (Eds.). (1984). Studies in empowerment: Steps towards understanding and action. New York: Haworth.

32. Etzioni, A. (1991). A responsive society: Collected essays on guiding deliberate social change. San Francisco: Jossey-Bass Inc.

33. Senge, P., Kleiner, A., Roberts, C., Ross, KB & Smith, (1994). The fifth discipline field book: strategies and tools for building a learning organization. NewYork: Doubleday.

34. Labonte, R. (1989). Community and professional empowerment. The Canadian Nurse, 23-29.

35. Wallerstein, N. (1992). Powerlessness, empowerment, and health: Implications for health promotion programs. American Journal of Health Promotion, 6 (3), 197-205.

36. Zimmerman, MA. (1990). Taking aim on empowerment research: On the distinction between individual and psychological conceptions. American Journal of Community Psychology, 18, 169-177.

37. Zimmerman, MA. & Rappaport, J. (1988). Citizen participation, perceived control& psychological empowerment. American Journal of Community Psychology, 16, 725- 750.

38. World Health Organization. (1980). International classification of impairments, disability, and handicaps: a manual of classification relating to the consequences of disease. Geneva: Author.

39. World Health Organization (2001). International classification of functioning and disability. Geneva: Author

40. Pastalam, L.A. (1982). Research in environment and aging: an alternative to theory. In M.P. Lawton, P.G. Windley & T.O Byerts (Eds.), Aging and the Environment: Theoretical Approaches (pp. 122-131). New York: Springer.

41. Bandura, A. (1989). A human agency in social cognitive theory. American Psychology, 44, 1175-1184.

42. Atchley, R. (1988). A continuity theory of normal aging. The Gerontologist, 29, 183-190.

43. Havighurst, RJ. & Albrecht, R. (1953). Older people. New York: Longmans, Green and Co.

44. Caserta, M. (1995). Health promotion and the older population: expanding our theoretical horizon. Journal of Community Health, 20(3), 283-292.

45. Deci, EL. (1975). Intrinsic motivation. New York: Plenum.

46. Maslow, A.H. (1943). A theory of human motivation. Psychological Review, 50, 370-396.

47. White, R.W. (1959). Motivation reconsidered: The concept of competence. Psychological Review, 66(5), 297-333.

48. Harter, S. (1978). Effectance motivation reconsidered: Toward a developmental model. Human Development, 21, 34-64.

49. Deci, EL. & Ryan, R.M. (1985). Intrinsic motivation and self-determination in human behavior. New York: Plenum.

50. Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. Psychological Review, 8, 191-215.

51. Bandura, A. (1986). Social foundations of thought and action: A social cognitive theory. Englewood Cliffs, New Jersey: Prentice-Hall.

52. Rotter, JB. (1966). Generalized expectancies for internal versus external control of reinforcement. Psychological Monograph: General and Applied, 80, 1-28.

53. Seligman, MEP. (1975). Helplessness: On depression, development and death. San Francisco: Freeman.

54. Nosek, MA. & Fuhrer, MJ. (1992). Independence among people with disabilities: I. A heuristic model. Rehabilitation Counselling Bulletin, 36(1), 6-20.

55. Nosek, MA. & Fuhrer, MJ. (1992). Independence among people with disabilities: II. Personal Independence Profile. Rehabilitation Counselling Bulletin, 36 (1), 21-36.

56. Pearce, JL. (1993). Volunteers: The organizational behavior of unpaid workers. New York: Rutledge.

57. Pearce, JL. (1983). Participation in voluntary associations: How membership in a formal organization changes the rewards of participation. In D.H., Smith, J. Van Til, D. Bernfeld & D. Zeldin, (Eds.), International perspectives on voluntary action research (pp. 148-155). University Press of America.

58. Smith, DH. (1994). Determinants of voluntary association participation and volunteering: A literature review. Non-profit and Voluntary Sector Quarterly, 23(3), 243-263.

59. Kloseck, M. (1999). Building a self-sustaining community system of health support for the elderly: determinants of individual participation in voluntary community action. Dissertation: ISBN No. 0612512053.

60. Lemon, M., Palisi, BJ. & Jacobson, IE. (1972). Dominant status and involvement in formal voluntary association. Journal of Voluntary Action Research, 1(2), 30-42.

61. Smith, DH., Macaulay, T. & Associates. (1980). Participant in social and political activities. San Francisco: Jossey-Bass.

62. Moore, LF. (Ed.).(1985). Motivating volunteers: How the rewards of unpaid work can meet people's needs. British Columbia, Canada: Vancouver Volunteer Centre.

63. Knowles, MS. (1972). Motivation in volunteerism: Synopsis of a theory. Journal of Voluntary Action Research, 1(2), 27-29.

64. Lawton, MP. (1977). The impact of the environment on aging and behavior. In JE. Birren & KW. Schaie (Eds.), Handbook of the psychology of aging (pp. 276-301). New York: Van Nostrand Reinhold Company.

Chapter 4

The Cherryhill Healthy Ageing Program: *An Overview*

- the Cherryhill Healthy Ageing Program . . . our history
- the Cherryhill apartment complex
- the Cherryhill population
- the prevalence of health problems in the Cherryhill community
- the challenges & problems faced by apartment building managers
- building the framework . . . our approach & time lines
- Cherryhill Healthy Ageing Program core components
  - . the provision & management of health information
  - . health promotion, prevention & clinical health programs
    - . Community Response Team
    - . Resident Safety Program
    - . Community Connections Program
    - . "Parkwood in the Community" Project
    - . Osteoporosis Self-Referral Screening Program
  - . program innovation, research & learning partnerships
- references

Our Experience . . . . .

- the Cherryhill community has a high concentration of seniors (2,500+) and is an area of high health service utilization
- the mean age of Cherryhill residents was 78 years in 1997
- a large number of unmet health needs were discovered in the Cherryhill community; it has been estimated that approximately 400 residents have *significant* cognitive impairment, with over 1000 having some degree of memory impairment; mental health & depression, as well as social isolation & loneliness were also identified as major concerns in the Cherryhill community
- building managers identified behavioural problems & confusion as their greatest challenges
- consistent with community development literature, building the Cherryhill Healthy Ageing Program was time intensive; building trust & getting buy-in took 1½ years, tangible results were seen at 2 years & the entire process (community mobilization & building of a stable & committed community base from which to operate) took approximately 5 to 6 years
- for the first 2 years (1996-1998) a community mobilization approach was used; once a stable & committed community base was formed (1998 onward) the community-systems approach was used
- in addition, a "train-the-trainer" model was used with community volunteers & a "neighbours helping neighbours" model was used to guide the Cherryhill Healthy Ageing Program
- the Cherryhill Healthy Ageing Program has 3 primary components:
    1. the provision & management of health information (the Cherryhill Health Promotion & Information Centre)
    2. health promotion, prevention & clinical health programs; currently this includes a community response team, resident safety program, community connections program & a community osteoporosis self-referral program
    3. program innovation, research & learning partnerships
- the Cherryhill community provides a perfect "test" site; property owners, building managers & residents are enthusiastic & involved; what is developed & "fine-tuned" here can easily be moved to other communities of older individuals

The Cherryhill Healthy Ageing Program: An Overview

In 1996, the Cherryhill Community Project was initiated in London, Ontario and made possible through a small grant from the St. Mary's Hospital Reserve Fund, St. Joseph's Health Centre, London, Ontario. The study grew out of an initiative implemented under the auspices of the District Health Council Long-Term Care Planning Committee (DHC-LTCPC) which was charged with developing a plan for the restructuring of the long-term care system in the area. This government-mandated process was to include the development of a Multi-Service Agency to co-ordinate the delivery of community-based home care. With a change in government, this concept was subsequently superceded by the Community Care Access Centre currently in operation.

A subcommittee of the DHC-LTCPC was established to design the Multi-Service Agency (MSA). The committee contained representatives of many of the health service provider agencies. Significant conceptualization and collaborative planning had been undertaken before the MSA concept was shelved in 1995 when the new government was elected. The planning explored the development of a co-ordinated service delivery model to attempt to incorporate the principles of teamwork in the community. When the MSA was canceled, and without clear direction immediately forthcoming, the committee decided to continue to explore the idea of a collaborative model of service delivery that would include significant input from consumers of health services. The concept was formulated as a project and funding was sought and received, in a competition for the distribution of the St. Mary's Reserve Fund, St. Joseph's Health Centre, London, Ontario. The Cherryhill community was selected as a suitable testing site as it was the recipient of significant amounts of community-based health care. The project began as a community mobilization project with a focus on health service delivery, the goal of which was to coordinate delivery and explore the degree to which a community comprised of very old and fail individuals can participate in decisions around their service needs. Initial project steering committee members consisted primarily of health service providers from a variety of agencies throughout London, Ontario.

Since its initiation, the project has grown significantly from essentially an attempt to co-ordinate service, with increased consumer input, into a major initiative to collaboratively create an innovative integrated model of community health in the Cherryhill complex that will evolve in response to the changing needs of the community. In November 1996 the initial Cherryhill Community Project Steering Committee was

expanded to ensure representation by all community partners including residents, local businesses, building managers, the ESAM corporation and city-wide health service providers. This revised steering committee was the beginning of the formation of a stable and committed base from which to collaboratively plan, develop, co-ordinate and evaluate future action around community- and health service provider-identified health issues. The project then formally became known as the Cherryhill Healthy Ageing Program.

To further the program, the concepts of healthy cities and healthy communities were drawn upon. These concepts can be traced back to the Lalonde Report.[1] This report addressed the importance of environmental and social issues and highlighted the need to encourage preventive approaches, health promotion and decentralized community care. It suggested that the health sector should work to influence decisions in public, private and community sectors that influence health. The initiative was espoused at the national level in the Health Promotion Directorate in 1976. In 1974 the World Health Organization (WHO) established a Health Promotion Program which led, in 1986, to the first international conference on health promotion in Ottawa, Canada. This conference produced the "Ottawa Charter for Health Promotion" which defined a health promotion strategy that consisted of the following five areas:

- building healthy public policy
- creating supportive community environments
- strengthening community action
- developing personal skills
- re-orienting health services to foster collaborative responsibility among individuals, communities, health professionals, health service agencies & governments

Under the item "strengthening community action," the Ottawa Charter employed the definition *"the process of enabling people to increase control over, and to improve their health"*. That is, building community capacity. The basis of this is developing personal skills in citizens to enable them to effectively identify and deal with threats to health and the design and operation of health care services. It is also pointed out that health care organizations can assist communities by providing them with space and assistance with relatively small but critical matters such as photocopying and mailing costs.

Hancock[2] discusses the role that hospitals, and other health care organizations, can play in creating healthy communities. He points out that it is important that the health sector not "own" the process and that ownership must be shared by the coalition of interest that comes together. This is consistent with the change theories, empowerment theories and community capacity building processes outlined in Chapters 2 and 3. As discussed in Chapter 3, active involvement of health care institutions is an exception. Several articles in the literature point out the difficulty hospitals have in working with the

different paradigm that characterizes community capacity building.

This trend to share the responsibility for health planning and provision with communities has had limited success at all levels of the health care system. Consistent with this intention, the Cherryhill Healthy Ageing Program expanded it's goals to include community-capacity building, with particular emphasis on building a self-sustaining model with long-lasting potential.

The Cherryhill Apartment Complex

The Cherryhill community has a high concentration of seniors and is an area of high health service utilization. The Cherryhill apartment complex consists of 13 apartment buildings with 2325 units (total population approximately 3000) and 64 businesses under a single management group, the ESAM corporation. Approximately 2500 of the 3000 individuals living in the Cherryhill community are over the age of 65 years. Many are elderly women living alone.

The Cherryhill community has a "sense of community" and a warm community atmosphere that is unique to the city of London. Development of the Cherryhill complex (Figure 12) began in 1959 when the ESAM Construction Company was formed by Sam Katz and Ewald Bierbaum. Westown Plaza was developed first, opening in 1960 with 18 stores. A few years later, in 1966, development of the apartment complex began. Support for the plaza was so great that in 1974 the plaza expanded to become an enclosed mall with 50 stores. Over the years Sam Katz, and now the ESAM management team (including sons Harvey and Howard Katz) have earned a reputation, by both residents and merchants, as being caring, friendly and compassionate, with a "people come first" attitude. It is for this reason, that many of the existing stores are long-term merchants, some having been with the mall for over 20 years. Many residents have also chosen to stay in the community for many years, with quite a number of residents living there over 30 years. The mall has grown into a vibrant community gathering place, and the ESAM management team continues to be particularly supportive of the unique needs associated with an aging population.

There are 45 businesses in Cherryhill Village Mall, as well as an additional 19 businesses and professional services located in the 101 Cherryhill office building. All merchants in Cherryhill Village Mall provide special services for tenants of the Cherryhill apartment complex if the need arises (i.e., the food court merchants deliver if an order is called in; flowers are delivered; etc.). The ESAM management, in 1997, identified crisis intervention as a priority, reporting that at any given time 10-15 tenants in the apartment complex require crisis intervention. Preliminary information from citizens, city-wide health service providers and local businesses identified major concerns within their community; in particular issues of co-ordination and fragmentation of health services, difficulty accessing the health system and problems of communication. On the otherhand

Figure 12: The Cherryhill community.

an initial community capacity inventory revealed a plethora of informal, untapped community health resources in the Cherryhill community (158 citizens offered to share their skills with others in their community requiring assistance; skills offered spanned 58 different categories). Services offered ranged from, for example, emergency and caregiving assistance, after-hospital support, to grocery shopping, house cleaning assistance, friendly visiting and help with home safety, to teaching English as a second language, and many more (see Appendix E).

The 13 apartment buildings in Cherryhill, owned by the ESAM corporation, include a total of 2325 units:

- 105 Cherryhill Boulevard (176)
- 115 Cherryhill Boulevard (185)
- 140 Cherryhill Drive (183)
- 170 Cherryhill Circle (197)
- 190 Cherryhill Circle (194)
- 201 Westfield Drive (151)
- 695 Proudfoot Lane (212)
- 110 Cherryhill Circle (151)
- 120 Cherryhill Drive (226)
- 160 Cherryhill Drive (226)
- 180 Cherryhill Circle (183)
- 200 Westfield Drive (183)
- 230 Platts Lane (58)

The Cherryhill Population

The Cherryhill community contains approximately 2500 individuals over the age of 65 years. The majority are elderly women living alone. The Cherryhill community is a stable community with residents remaining for many years. The Cherryhill community is very popular and there are rarely vacant apartments. The following provides a profile of the characteristics of the Cherryhill community at the time of the community survey conducted in May 1997 (response rate =53%; n=1231):

- mean age = 78 years (1997: see Figure 13)
- approximately one third of these individuals (approx. 500) have significant memory impairment
- average time lived in the Cherryhill community was 10 years (SD = + 7.56 years)
- the oldest individuals (those 85+ years) have lived in the community longest (14+ years)
- the community is stable, with residents "aging in place"
- 21% of residents over the age of 65 (>500 individuals) reported having a caregiver
- 11% of residents over the age of 65 (approximately 300 individuals) reported that they were providing care to someone with whom they lived
- approximately 600+ veterans and/or veterans' spouses live in the Cherryhill community

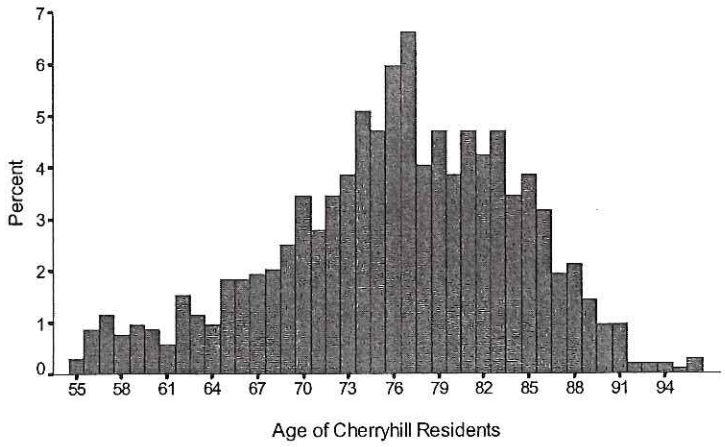


Figure 13: Age and population distribution of Cherryhill residents in 1997.

The Prevalence of Health Problems

The following are conservative estimates of health concerns in the Cherryhill community based on known prevalence from the literature:

- 700-800 residents fall each year
- 8-10 hip fractures occur per annum
- approximately 300 women have urinary incontinence
- approximately 400 residents have significant cognitive impairment; extrapolating from the survey we can estimate over 1000 have some degree of memory impairment
- even greater numbers have milder cognitive impairment
- mental health is a major concern
- depression is one of the most missed diagnoses; affects 5% of women over 65 years (approximately 125+ residents in Cherryhill) & rises further with age
- suicide is a concern; in 1-1½ years 4 suicides occurred; the needs of individuals were recognized too late & system failed to respond; several people who were suicidal received help through the Cherryhill Healthy Ageing Program
- an increasing number of residents are unable to leave their apartments either to shop or access health care (15% of Cherryhill residents; approximately 300 very frail individuals)
- there are enough residents in the Cherryhill community requiring specialized geriatric services to keep the Parkwood Geriatric Day Hospital busy for two years simply evaluating & treating

As it is the oldest members of the community who have the greatest health service and support needs, and given that the oldest residents tend to remain in the community the longest, these findings have significant implications for the Cherryhill community in the very near future. As residents age in place, increasing numbers will be in their mid 80s and it can be expected that health service needs will increase substantially. We have become increasingly aware of the numbers of Cherryhill residents who are unable to leave their apartments, either to shop or, in many instances to access health care. In addition, using population data and given the age structure of the Cherryhill community we are able to make predictions regarding the prevalence of health problems in the Cherryhill community. For example:

***Osteoporosis*:** is extremely common in older women. The World Health Organization defined osteoporosis as a state of risk, a concept which has been operationalized by the use of bone density measurements. Osteoporosis is now defined as a bone density measurement more than 2.5 standard deviations below the mean density of young people. This means that over 50% of the female population of Cherryhill will have osteoporosis .

By the end of life 40% of women will have had at least one osteoporotic facture. Untreated 30% of women will have suffered a hip fracture by the age of 90. Osteoporosis is preventable and the risk of fracture can be greatly reduced by appropriate prevention approaches. For example the simple provision of calcium and vitamin D in older life will significantly reduce the rate of fracture. It is, however, rarely done. For those with established osteoporosis the risk of further fractures can be halved by one year of treatment and further reduced to very low levels by continued treatment. This, again, is one of the most under treated problems of old age. The consequences of a hip fracture in particular can be dire, especially from the point of view of continued mobility. Fifty percent of victims of hip fracture can never return to their prior level of independence. Given the age structure of the population we can estimate that there will be about 8-10 hip fractures in the community each year and this likely contributes to residents having to leave the community.

***Urinary Incontinence*:** has traditionally been one of the most unrecognized problems of the elderly. Over the age of 65 approximately 18% of women report some degree of urinary incontinence, with about half of these experiencing it on a daily basis. It rises rapidly with age such that by the age of 85 and above, 24% experience incontinence on a daily basis. From the age structure of the population it can be estimated that about 300 of the female population in this community will have this problem. Incontinence has a major impact on the social life of the victims and leads to the individuals becoming reclusive. It is a major risk factor for institutionalization. Saltmarche[3] showed that 10% of incontinent individuals cope with the problem by staying at home. Recent studies in Ontario have confirmed the degree to which a nurse-led intervention can make a significant difference to these people, with a cure or substantial improvement in 70%.[4, 5]

***Cognitive Impairment*:** prevalence can be estimated from the data gathered by the Canadian Health and Aging Study, which found that over the age of 80 about 25% of citizens had evidence of a significant dementing process, with up to 40% having some evidence of cognitive decline. In our survey of the population, about 40% admitted to memory problems. As a conservative estimate we can calculate that in this community about 400 residents will show signs of *significant* memory impairment, with even greater numbers having milder deficits. Much can be done both regarding the prevention of cognitive decline in those with vascular dementias, provided they are identified and treated through the appropriate use of cognitive enhancers now available, and in the construction of a community-based supervision and response system for the resident.

***Mental Health*:** is an important concern in the Cherryhill community. Depression is one of the most missed diagnoses in this population. It affects approximately 5% of women over the age of 65 and rises further with age. It's impact on function and independence can only be surmised. Suicide is a major issue here and is a recognized concern within the Cherryhill community. During the past 1 to 1½ years four suicides have taken place in which the system response was both inadequate and too late.

The community-identified health needs in the Cherryhill community and the sources of information to support these needs are outlined in Table 2.

Table 2: Health needs in the Cherryhill community.

	HEALTH NEEDS	SOURCE(S) OF INFORMATION
₪	a community health centre staffed by health professionals and/or a community nurse, housed in the Cherryhill community, to whom the Cherryhill community could turn for assistance, guidance, and/or answers to health-related questions	①②
₪	more health information & better access to health information	①③⑩
₪	a safety check system for residents with decreased capacity	①③
₪	the mobilization of community health resources	①③⑥⑨⑩
₪	support for caregivers	①
₪	prevention & health promotion programs	①③⑥⑦⑨⑩
₪	education & awareness sessions on community-identified & evidence-based topics of interest	①③⑥⑧
₪	quicker access to health system services; earlier identification of need & rapid response	①②⑥⑦⑧⑨⑩
₪	medication issues/polypharmacy	①
₪	cognitive impairment/confusion/problem behaviour	①②④⑤⑥⑦⑨⑩
₪	mental health issues/social isolation/depression	③⑤⑥⑦⑧⑨⑩
₪	falls	①②④⑦⑧
₪	general frailty/pain/physical limitations; residents with mobility/balance problems; decreased ADLs; residents at risk to themselves & others	①②③⑤⑥⑦⑧⑨⑩
₪	alcohol abuse/addiction	②④⑥⑦⑩
₪	nutrition concerns	②③⑥⑩
₪	driving concerns	②③⑥⑦⑩
₪	paranoia/suspiciousness	②⑤⑥⑧⑨⑩
₪	assistance with transportation	⑥⑦⑩

SOURCES OF INFORMATION

① 1997 community survey (n=1231)
② 1997 building manager & ESAM management surveys & interviews (n=32)
③ community meetings (n=55)
④ local business concerns (ongoing)
⑤ focus group with safety program co-ordinators & monitors (n=44)
⑥ feedback from community response team partners (n=12; ongoing)
⑦ 2000 building manager interviews (n=13)
⑧ Cherryhill Health Promotion & Information Centre (daily log statistics; ongoing)
⑨ analysis of GNP assessments (n=76)
⑩ health centre volunteers (n=62; ongoing)

The Challenges & Problems Faced by Apartment Building Managers

In January 1997 the ESAM corporation property manager requested that a committee be established to come up with a procedure to assist the ESAM corporation to respond to, and if possible, resolve, health crises occurring in the Cherryhill apartment complex. From January to May 1997 this committee collaboratively designed a questionnaire for building managers in an attempt to profile tenants and to identify physical and cognitive problems that building managers are required to deal with on a regular basis. This was followed by interviews with building managers in 9 of the 13 apartment buildings, as well as two separate focus groups with all building managers, one held in 1997 and the other in 2000. An "occurrence report" was also developed to assist the ESAM corporation in tracking the nature, frequency and duration of health-related incidents occurring in the Cherryhill community.

Building managers were asked to estimate the number of tenants in their apartment buildings requiring assistance on a regular basis (Table 3). They were also asked to identify the number of tenants, who in their opinion, were:

- physically incapable of taking care of themselves
- confused or exhibit troublesome behaviour that requires their involvement
- a safety risk to themselves
- a safety risk to others in their building

Building managers were asked for specific examples of situations requiring their direct involvement (Table 4). In addition they were asked to rate approximately how often

Table 3: Summary of building manager concerns regarding tenants in 1997.

Building	Estimated No. of Tenants Requiring Assistance	Problems with Physical Functioning	Behavioural Problems & Confusion	Risk to Personal Safety	Risk to the Safety of Others
105 Cherryhill Boulevard	5	2	1	2	2
110 Cherryhill Circle	-	-	-	-	-
115 Cherryhill Boulevard	3	2	3	1	1
120 Cherryhill Drive	3	2	3	2	-
140 Cherryhill Drive	-	-	-	-	-
160 Cherryhill Circle	7	2	5	2	2
170 Cherryhill Circle	7	1	6	1	1
180 Cherryhill Circle	-	-	-	-	-
190 Cherryhill Circle	6	12	4	19	3
200 Westfield Drive	-	1	2	-	-
201 Westfield Drive	3	1	1	1	1
230 Platts Lane	-	-	-	-	-
695 Proudfoot Lande	No concerns identified				

Note: it was reported that tenants with physical problems required intervention approximately 5-6x/month; those with confusion & behavioural problems daily/weekly.

during the past year it was necessary for them to deal with, or respond to, these incidents (Table 5). Difficulties faced by building managers in responding to the problems of their tenants are outlined in Figure 14.

Table 4: Examples of situations encountered by building managers in 1997.

PHYSICAL PROBLEMS

- falls
- difficulty with toileting
- occasional lifts into bed
- ambulation and mobility concerns
- other physical assistance required (e.g., adjusting chair positions; cleaning burned pots; etc.)

BEHAVIOURAL PROBLEMS

- confusion
- disruptive behaviour that is bothersome to other tenants
- chronic complaining & constant calling
- paranoia re: strangers, locks to apartments, storage areas, etc.
- depression leading to suicide threats

RISK TO PERSONAL SAFETY

- falling & unable, or unwilling, to call for help
- burning things on the stove
- leaving the stove on & leaving the apartment/apartment building
- confusion
- returning home after recent hospitalization/surgeries & requiring assistance, etc.
- difficulty walking or seeing, yet still driving
- the suspected number of tenants who are driving without licenses
- tenants who are not eating properly; nutrition concerns

RISK TO THE SAFETY OF OTHERS

- leaving the stove unattended
- combination of drinking alcohol & smoking; burning carpets, etc.
- waving canes in a threatening manner at other tenants
- tenants driving without a license

Building managers reported that their greatest challenges are:

- when new tenants move in or when older individuals move to a different apartment within the complex (a significant increase in confusion was noted during these times)
- dealing with confused tenants
- the disruptive behaviour of confused tenants
- lack of family support
- obtaining tenants consent to provide assistance

- responding to the unique needs of seniors
- trying to be patient and pleasant
- cleaning apartments
- small jobs on a daily basis such as changing light bulbs, opening jar lids, setting clocks, running VCRs, etc.
- responding to personal safety issues such as calling the ambulance, responding to calls from LifeLine, and picking people up after falls and not knowing for sure whether they are hurt or not

". . . one lady kept us up every night for eight days. Every night we called the ambulance and opened her apartment door for them. Each night they put her on the toilet, got her a drink of water, and put her to bed. It took us two months to finally get her to move into a nursing home."

". . . she fell three times in one day."

One of the concerns with the building manager questionnaire is that information and results obtained may, in fact, underestimate the problems experienced by building

Table 5: The nature and frequency of health-related situations requiring building manager involvement in 1997.

Building	Responding to Physical Needs	Responding to Behavioural Problems	Responding to Safety Issues	Incidents Affecting the Safety of Others
105 Cherryhill Boulevard	5	*	1	1
110 Cherryhill Circle	-	-	-	-
115 Cherryhill Boulevard	20	20	3	3
120 Cherryhill Drive †	24	28	2	2
140 Cherryhill Drive	-	-	-	-
160 Cherryhill Drive	20	**	5	5
170 Cherryhill Circle	12	***	1	1
180 Cherryhill Circle	-	-	-	-
190 Cherryhill Circle	20	65	2	1
200 Westfield Drive	1	1	1	-
201 Westfield Drive	24	****	1	1
230 Platts Lane	-	-	-	-
695 Proudfoot Lane	No concerns identified			

† information based on situations occurring during 7 (not 12) months

* difficult to estimate on an annual basis as there are "good" and "bad" periods; it was reported that at times behavioural problems requiring attention occur almost daily (approximately 3-4x/week) and sometimes 3-4x/day

** an estimated 5 tenants who require the building manager's involvement weekly

*** an estimated 6 tenants who require the building manager's involvement weekly

**** daily; have had as many as 4 calls/situations requiring assistance in one hour

The Cherryhill Healthy Ageing Program

Over time the Cherryhill Healthy Ageing Program has grown steadily. It now has three major components, all provided through the Cherryhill Health Promotion & Information Centre in Cherryhill Village Mall:

1. the provision & management of health information
2. health promotion & prevention programs, & clinical health programs
3. program innovation, research & learning partnerships

Details of each of the components of the Cherryhill Healthy Ageing Program follow.

Provision & Management of Health Information

The *Cherryhill Health Promotion & Information Centre* was opened September 8, 1999 in response to a community-identified need reported in the Cherryhill Community Survey. The Health Centre is operated 5½ days per week on a volunteer basis by elderly community members. Trained volunteers, in partnership with city-wide health professionals, are working together to provide accurate, up-to-date, timely and specialized health information on a wide variety of topics and conditions associated with growing older. Geriatric health and service information is provided through a variety of sources including telephone, walk-in, print and computerized web technology resources. A formal system to identify, collect, display, track and maintain health information and to determine the scope of information to be provided, is being collaboratively developed under the direction of the Cherryhill Health Information & Community Development Co-ordinator.

A "train-the trainer" model is used to provide elderly community members with the information, knowledge and skills to become "first contacts" on a variety of health issues for their peers in the Cherryhill community, as well as the general public. Elderly community volunteers are trained using "*Standards for Professional Information & Referral*" guidelines (Alliance of Information & Referral Systems, 2000). Volunteer training includes, among other things, skill development in answering direct inquiries, the ability to determine more complex, underlying needs of elderly community members who come into the Health Centre, determining single needs vs. a multiplicity of needs of consumers, linking consumers with the necessary community and health resources and providing informal supports as needed. Due to the large number of mental health issues in the Cherryhill community and a recent suicide, a day long training session was conducted for all community volunteers, building managers and ESAM management on the topic of mental health and suicide prevention. This training day was funded by the Ontario Ministry of Health (Long-Term Care Division) and facilitated by the Canadian Mental Health Association, Geriatric Mental Health Services and the London Distress Centre.

Health Promotion, Prevention & Clinical Health Programs

The *Cherryhill Healthy Ageing Program*, through the *Cherryhill Health Promotion & Information Centre*, is building health promotion programs to meet the needs of frail older Cherryhill community members. The major clinical focus is to identify the community members in danger of losing their independence and to respond with a variety of formal health system & informal community services, resources and supports to help the "at-risk" community members remain safely within their homes and the community for as long as possible. To aid in identification a variation of the gatekeeper model is being used. As many residents are apartment bound they have little contact with outside individuals. Accordingly a "neighbours helping neighbours" model is being used, with well trained community members identifying individuals who are at risk in their community, gathering information, building trust and gaining the individuals' permission to link them with the formal health system and/or informal community supports required to meet their needs, to help them remain independent and in their own homes for as long as possible. The response is based on geriatric principles of assessment and care and is encapsulated within the concept of the Community Response Team.

Community Response Team: The Cherryhill Community Response Team is a free and confidential service, available to all Cherryhill residents. It provides rapid response to meet the health needs of Cherryhill residents. This program responds to the health needs of Cherryhill residents by linking residents with the required assessment and management coupled with the health supports and services they need to enable them to remain independent and in their own homes for as long as possible. The team is comprised of an inter-agency, multi-disciplinary group of service providers, and includes all the major geriatric service partners city-wide. Referrals can be made by anyone including family physicians, city-wide geriatricians, apartment building managers, institutions who are discharge planning, local businesses, family members, concerned neighbours or community members, or can be a self-referral. Once a referral is received the Cherryhill Geriatric Nurse Practitioner (funded by the Parkwood Hospital Foundation) arranges a home visit to explain the program, gather additional information, build trust and obtain permission to conduct the necessary assessment and provide the individual with the assistance they need through either formal health system provided services or informal community supports. Follow-up visits are scheduled with the resident and/or the resident's family to monitor progress and satisfaction. The Cherryhill nurse works closely and collaboratively with the resident, their family, the resident's family physician & a representative from the ESAM corporation to ensure that everything possible is done to allow the individual to remain in their own home for as long as possible. To date 15+ city-wide geriatric service providers and family physicians have made a commitment, and partnered with the Cherryhill Healthy Ageing Program, to provide quick response, monitoring & follow-up to the health needs of residents using a community team process. As part of the response, and recognizing the need for

continuity of surveillance and treatment, other developments also have taken place. The most frail members of the Cherryhill community can sign on for the Resident Safety Program, while more active members can participate in a variety of community programs designed to maintain function and opportunities for ongoing involvement. These programs are offered through the Community Connections Program (Appendix F).

Resident Safety Check Program: The Resident Safety Check Program provides safety checks twice daily to ensure that residents who have signed up for this program are safe. A 4-tiered response system is in place to provide immediate assistance & emergency help to those in need. This program is in place in 12 of the 13 apartment buildings in the Cherryhill community. It is completely organized and operated on a daily basis by community volunteers, in collaboration with health professionals. Residents living in the 13 apartment buildings, who wish to help their neighbours, sign up and are trained to become safety monitors. Safety monitors have responded to a variety of emergency situations and provided assistance to neighbours who might otherwise not have been found for 4 to 5 days. The Resident Safety Check Program is being offered by the ESAM corporation to all new tenants as part of their rental agreement. The program is available free of charge to all Cherryhill residents. Linkages have been established with the City of London Police Department, and other emergency responders in the City of London. Requests have been received from other neighbourhoods and communities for assistance in establishing similar programs.

Community Connections Program: The Community Connections Program is being offered in partnership with the Parkwood Geriatric Day Hospital, the City of London, Meals on Wheels, Chelsey Park, and Partners in Leisure. This program is designed to meet the psychosocial needs of elderly individuals living in the Cherryhill community. The need for this program was identified through a community survey conducted in 1997. Issues of loneliness, social isolation, depression, and mental health concerns have also been consistently identified, during the past three years, as a priority by both community members and health professionals working with other programs offered through the Cherryhill Healthy Ageing Program. Development of the program began in January 2001 when 2-year funding was provided by the Parkwood Hospital Foundation, in response to a collaborative proposal *"Parkwood in the Community"* submitted by the Parkwood Geriatric Day Hospital and the Cherryhill Healthy Ageing Program. Programs currently being offered include a friendly visiting program (PALS), the strength, tolerance & exercise program (STEP), Joint Fit Program, Community Dining Program, Book Lovers' Club, and more.

"Parkwood in the Community" Project: The "Parkwood in the Community" project is a partnership between the Parkwood Geriatric Day Hospital and the Cherryhill Healthy Ageing Program. The purpose of this project is threefold:

- to expand Parkwood Hospital's established expertise in assessment, treatment & education in the area of specialized geriatric services for the frail elderly into the community

- to provide Parkwood Geriatric Day Hospital health services in a new, proactive role with an emphasis on prevention, monitoring, early identification & rapid response

- to provide a "seamless" link between institution & community by operationalizing the rehabilitation role of the Parkwood Geriatric Day Hospital in the community

This project is also exploring whether existing formal health services (institution and community) and informal community supports can be mobilized and integrated to better meet client needs regardless of "ownership" of these resources. In addition to the above generic programs some special focus programs are provided in an attempt to lessen the care gap in the management of seniors' problems. These prevention programs are collaboratively run by health care professionals and well trained volunteer community members. Community prevention programs include:

Cherryhill Osteoporosis Self-Referral Screening Program for Seniors: The purpose of this program is to provide osteoporosis and fracture risk assessment, and education to community-dwelling seniors to prevent osteoporosis-related fractures in a population at the greatest risk for hip and fragility fractures. The program is offered in partnership with the London Regional Osteoporosis Program. It is held the first Monday of every month, and accommodates 10-12 people for each 2-hour session. The program involves an education and information component, as well as a an Osteoporosis Risk Questionnaire and calcaneal ultrasound to identify individuals at low, moderate and high risk.

Other programs being collaboratively run and/or developed include a falls prevention program, annual flu clinics, continence clinic and a community geriatric clinic.

Program Innovation, Research & Learning Partnerships

Numerous initiatives are currently underway to build learning opportunities and collaborative research initiatives identified as a need by both the community and health professionals. The focus on learning opportunities is, we believe, particularly important if the new generation of health care workers are to develop positive attitudes to the care of frail older individuals, and be open innovative approaches.

Learning Partnerships: Placement opportunities have been created for students in the undergraduate nursing program, School of Nursing, University of Western Ontario (see Appendix G) to learn about, and experience "first-hand", health promotion and prevention programming in a community development setting. Fall and winter student placement experiences are in place. Planning is also underway with the School of Occupational Therapy, U.W.O regarding placement opportunities for their students. We hope to make learning opportunities available for other allied health professionals in the near future. In addition to "on-site" learning opportunities, an annual half day lecture/ classroom workshop is also provided to undergraduate students in collaboration with faculty in the School of Nursing, U.W.O.

Collaborative Research Initiatives: A number of collaborative research proposals have been submitted, and several collaborative research initiatives are underway in the Cherryhill community. Research funding, proposals, abstracts and presentations are outlined in Appendix H.

Collaborative research initiatives include:

- evaluating an educational initiative for medical students with a focus on learning more about medication use in elderly individuals living in the community (with Shoppers Drug Mart)
- exploring the involvement of community seniors in the planning and provision of heath services and the predictors of volunteerism and leadership (with the Division of Geriatric Medicine, U.W.O and the University of Waterloo)
- examining predictors of health service utilization of seniors living in the community (with the Division of Geriatric Medicine, U.W.O)
- examining satisfaction with community health support services for seniors (with the Division of Geriatric Medicine, U.W.O)
- investigating the consequences of falls in community dwelling seniors (with the Southwest Region Health Information Partnership Program-S.R.H.I.P)
- investigating the influence of falling and fear of falling on engagement in self-care, productivity and leisure activities for community-dwelling seniors (with the School of Occupational Therapy and School of Nursing, U.W.O)
- evaluating the use of Goal Attainment Scaling (GAS) in health-related community development projects (with the Division of Geriatric Medicine, U.W.O)
- evaluating a self-referral program for osteoporosis using a calcaneal densitometer (with the London Regional Osteoporosis Program)

References

1. Lalonde, M. (1974). A new perspective on the health care of Canadians. Ottawa: Office of the Canadian Minister of National Health and Welfare.

2. Hancock, T. (2001). Moving beyond healthcare: the role of healthcare organizations in creating healthy people in healthy communities in a healthy world. Hospital Quarterly, 4(4), 20-26.

3. Saltmarche, A. (1988). A potential expansion of ADP incontinence category: a report to the Ontario Ministry of Health.

4. Borrie, MJ., Bawden, M., Speechley, M. & Kloseck, M. (2002). Interventions led by nurse continence advisers in the management of urinary incontinence: a randomized controlled trial. Canadian Medical Association Journal, 166(10), 1267-1273.

5. Saltmarche, A. & Reid, DW. (1992). ADP incontinence program (Incontinence Rehabilitation Projects). Consultant's report prepared for Assistive Devices Branch, Ontario Ministry of Health.

6. Ontario Prevention Clearinghouse. (1996). Community action handbook. Toronto, Ontario: Author.

Chapter 5

The Health System: *Discoveries & Insights*

- the current system
- the current system & Cherryhill
- issues of client identification & access
- issues of assessment
- issues of management, support & follow-up
- provision of therapy
  - . occupational therapy
  - . physiotherapy
  - . treatment in the community
- a specific challenge . . . dementia
- suggestions
- prevention
- references

What the Evidence Tells us . . . . .

- currently *home support services* are provided by the CCAC through a brokerage model which employs contracted private service providers; service provision requires a family physician; *specialized geriatric services* are currently provided through St. Joseph's Health Care & include a Geriatric Assessment Unit, Geriatric Rehabilitation Unit, Geriatric Day Hospital & an outreach service
- few individuals living in the Cherryhill community currently attend the Parkwood Geriatric Day Hospital & few are referred to the outreach service; this represents a marked degree of under-servicing; there are a large & increasing number of unnoticed & unmet health needs in the community
- there is no continuity of care for frailer older individuals within the current system; the current system also lacks a method to implement evidence-based prevention & management programs at the population level
- dementia presents a major challenge in the community & many individuals are unrecognized by the system; the educational model does not work with these individuals but is still being used

Our Experience . . . . .

- many older people have little insight into how the health system works & are suspicious of the system; many also find accessing the system too overwhelming; relationship building is key to facilitate access, assessment, care planning & service provision by older individuals; continuity of care & surveillance following management is critical
- identifying community members at risk presents a particular problem in a private housing complex; trained community managers (e.g., building managers; neighbours; etc.) provide an effective means to identify those in need
- specialized geriatric assessment is lacking in the community; diagnosis & treatment opportunities are missed; personal support resources are prematurely exhausted; many common issues (e.g., depression; incontinence; immobility; etc.) are missed; a GNP housed in the community works well to provide a single access point to a complex health system
- there are many unmet rehabilitation & therapy needs in the community, of particular concern are mobility & gait aid issues; programs initiated by CCAC therapists are discontinued as soon as therapists leave; specialist PT & OT expertise is required in the community; a broad-based continuum of programs to maintain function is also required

The Health System: *Discoveries & Insights*

Funding was provided by the Parkwood Hospital Foundation to support a part-time Geriatric Nurse Practitioner (GNP) and a recreation therapist, physiotherapist and kinesiologist on a limited basis. This allowed us to have a first-hand look at community health and system issues from the "inside out", as well as the rehabilitation and psychosocial issues experienced by frail older individuals living in the Cherryhill community. The following section highlights our findings.

The Current System

Home Support Services: Within our current system, home support services are provided by the Community Care Access Centre (CCAC) through a brokerage model which employs a number of private service providers who compete every few years for the contracts. The CCAC case managers are responsible for the selection and monitoring of the services provided. Service provision requires a family physician to be in place, and the communication between family physicians and case managers is normally by phone or fax.

Specialized Geriatric Services: Specialized geriatric services (SGS) are currently provided through St. Joseph's Health Care. SGS services consist of (1) a 14-bed acute Geriatric Assessment Unit, (2) a 30-bed Geriatric Rehabilitation Unit, (3) a Geriatric Day Hospital which is able to accommodate approximately 40 clients at a time, and (4) an outreach service, which again requires a family physician to be in place. The latter provides assessment and, more recently, some follow-up but no treatment. All treatment is provided within the institutions, either at St. Joseph's Hospital or Parkwood Hospital.

An analysis of day hospital attendances showed that very few individuals living in the Cherryhill community attend. Day Hospital experience has shown that many clients are reluctant to leave their own homes, and that many are reluctant to attend because of transportation issues or other difficulties. This was confirmed by, and was also the experience of, the physiotherapist working in the Cherryhill community. Even referrals to the outreach service from Cherryhill have been few. There were only 27 referrals in 1997 and 25 in 1999. From a pool of over 2500 seniors, almost half being over the age of 80, this is low. It is clear from the data presented in Chapter 4 that this represents a marked degree of under-service. The evidence, and our experience, suggest that there are a large and increasing number of unmet health needs in the Cherryhill community.

Another service provided at Parkwood Hospital, the physical maintenance program, is designed to help maintain function in those clients who have been through the Day Hospital program. A recent analysis of the impact of this program has shown that 2/3 of clients offered the maintenance program at time of discharge, decline the offer for a variety of reasons. Of those who attend, there is a high drop-out rate. Those who remain appear to do well, but are a highly selected group. The fate of those who decline or drop-out is unknown. A study is beginning in the Day Hospital to elucidate the longer term outcomes of clients discharged from the program. The aim of this study is to explore whether those clients who ultimately do badly, and who might potentially benefit from a continuous case-management model, can be identified at time of discharge.

One major problem with the current system is that there is no sense of continuity. How clients work through the system to a successful outcome, or fall by the wayside, is totally unknown.

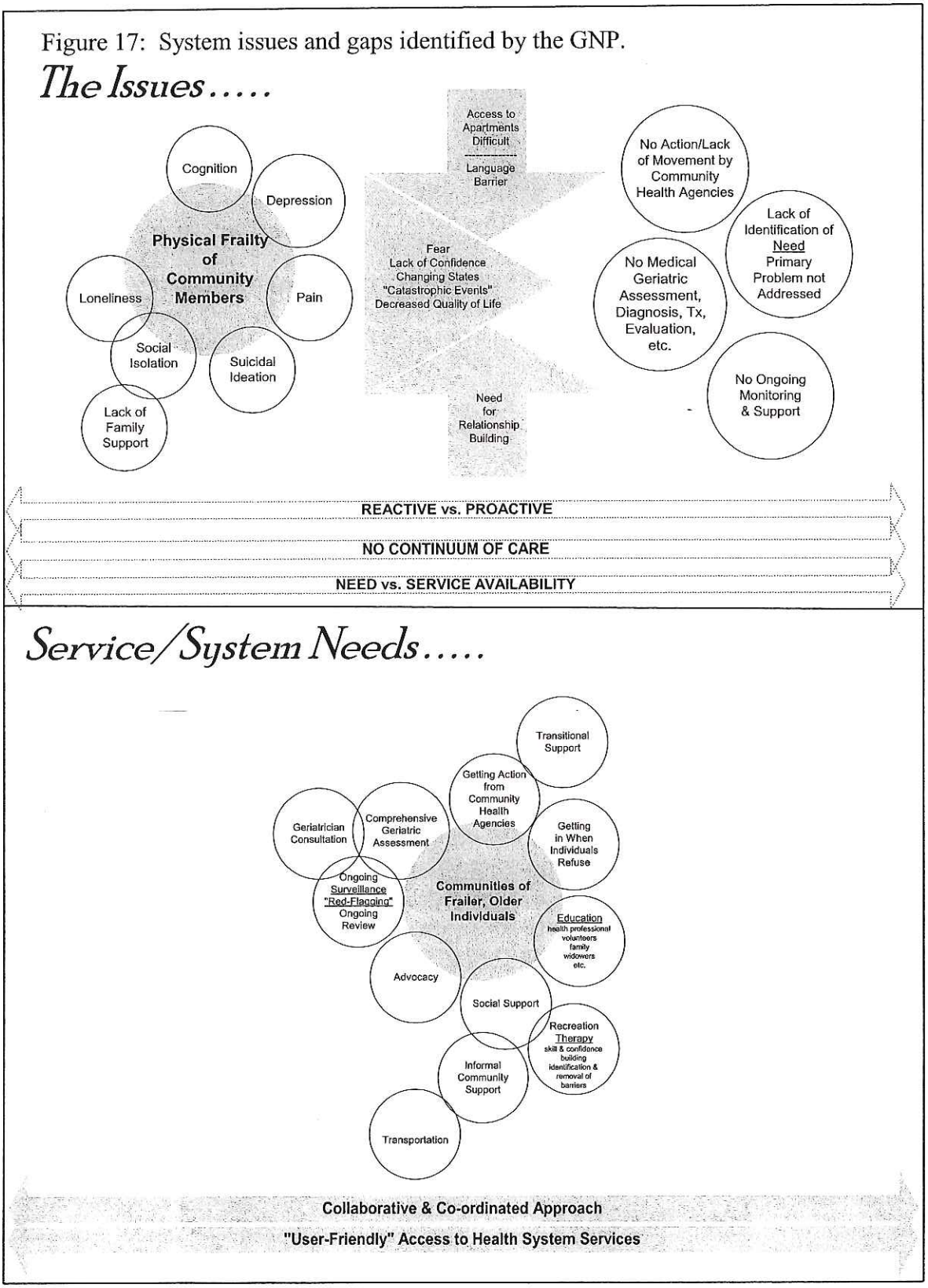
The Current System & Cherryhill

As part of the "Parkwood in the Community" project, funded by the Parkwood Hospital Foundation, we have attempted to identify gaps in identification, treatment and management of the frailer seniors living in the community. A GNP was placed in the Cherryhill community two days per week for approximately two years. The GNP worked through the Cherryhill Health Promotion & Information Centre, and was charged with creating a collaborative working relationship with the community to evaluate any gaps in system processes and health services. The GNP conducted:

- a comprehensive geriatric assessment of clients referred to determine problems and review the management of their care. As time passed, referrals increased, in particular those received from community members and businesses in the mall. The GNP, free of agency mandates, was able to follow-up with clients who were referred but didn't have a family physician. One very obvious issue, identified by all, was the lack of availability of family physicians. For many older clients this is a major obstacle to accessing the system.

- a qualitative analysis of all comprehensive geriatric assessments to determine common themes (Figure 17), including the diagnoses, functional issues and system responses and gaps. Examples of actual client cases are provided in Appendix B. Conclusions from this analysis are incorporated in the remainder of this section.

Figure 17: System issues and gaps identified by the GNP.



A physiotherapist and therapy assistant joined the project for one and two days a week respectively. We had planned and budgeted for more physiotherapy involvement but resources were not available. This is another important issue to bear in mind in the development of any model. The physiotherapist and physiotherapy assistant were charged with the same mission as the GNP. They were to see a variety of clients living in the Cherryhill community and to use the clients' expectations, needs and experiences to gain insight into the current system's community rehabilitation gaps.

Several areas related to rehabilitation have been identified as important. While generic to the community as a whole, many of the issues identified apply more to those with mental and physical frailty. This is reflected in impaired cognition, loneliness, social isolation, suicidal ideation, depression, and pain. Many of the residents seen were apartment-bound. Three main categories of residents have been identified:

- the well, active and mobile; usually the younger community members
- those limited in their mobility but still able to access their immediate community, including the mall
- the apartment-bound, and those whose excursions from the apartment are limited to a visit to the garbage shute

This last group is the main concern here. They are largely out of sight and their problems are neither assessed, diagnosed nor managed.

Issues of Client Identification & Access

It was discovered that many older people, and indeed many younger people, have little insight into how the health system works. We were surprised to find that the building managers had little idea about where to turn for help when presented with failing residents in their buildings. The GNP developed relationships with the building managers, provided education regarding system support available, and worked through difficult cases with them. The GNP, as a single access point to a complex system, seems to work very well. This was evidenced by the increasing number of referrals received from community sources over time. Building a relationship with the community was key. It was discovered that:

- the public storefront (Cherryhill Health Promotion & Information Centre) in the mall is critical and has helped to establish trust and visibility
- meeting with both community members (residents, building managers, store keepers) and care providers (CCAC case managers, psychogeriatric service) and becoming identified with the community as opposed to the system has helped the GNP identify issues and gain access where previously it was resisted

- a de-emphasizing of formal procedures has helped in building relationships with clients suspicious of the system; dysfunctional residents are frequently suspicious of the motives of the system and fear being forced into a nursing home if their shortcomings are recognized; as a result, problems are hidden

It was discovered that relationship building with such clients is important to facilitate access, assessment, care planning, and service provision. Someone is needed to work with clients, despite their unwillingness, to prevent the most difficult cases falling through the cracks. This requires extra effort and the development of a level of familiarity between the health professional and client. The planned geographic focus for CCAC service delivery may give more of a community focus to care and encourage therapeutic relationship building. This is important, not only for case managers, but also for contracted nurses and therapists. The current CCAC system of assessment for service provision adopts the philosophy that the client should be in full agreement with the care plan offered. For the demented and depressed, this presents problems. Presentation of an overly complex plan to an impaired client risks refusal based on poor understanding and suspicion. Although not currently fashionable, a more "expert" approach is required for some of these clients. It was also discovered that care was rejected by the client in need of help for hygiene and activities of daily living, when the plan was presented in a way that was too complicated for the client's understanding. The real issue here, that of providing support for the spouse or care provider under stress, was thus not addressed. Similarly the failure of such clients to receive the specialist geriatric assessment needed, leads to unresolved problems and continued stress on the caregiver.

Conducting assessments free of restraints (e.g., the need for an identified family physician) is an asset. It was noticed that family physicians, when available, are reluctant to make decisions about a patient he/she has not seen for several years. When the client (1) is cognitively impaired, (2) unable to make or remember to keep an appointment, (3) the family physician does not make house calls, or (4) the client refuses to admit the doctor (or anyone else) when a call is made this soon leads to an impasse. A GNP functioning as a case manager can, at times, broker a solution. The GNP working with community members/volunteers who function as senior advocates and/or "buddies", can also facilitate a solution. We have learned that community members, while comfortable in an advocacy role, are not comfortable being involved directly in the assessment process (see Chapter 6). Initially we wanted to explore whether some residents might be more open to discussing their issues with their peers rather than a professional.

Identification of Potential Clients: This presents a particular problem. Educating informal "case finders" has been part of the so-called gatekeeper model. Originally developed within the mental health field,[1] this model trains employees who in their day-to-day jobs come into contact with the public. Individuals, such as the mailman, are attuned to signs of dysfunction in people they encounter, and educated on how to mobilze

the system. The concept has been extended to include the aged and it has been shown that clients so identified tend to live alone and be more socially isolated.[1] The Cherryhill Healthy Ageing Program also developed a similar approach. Older people living in private housing apartments present a special challenge as they may have little contact with external businesses. The main focus of the Cherryhill Healthy Ageing Program has been to educate the apartment building managers, safety monitors and community volunteers to watch out for residents and neighbours. Contact with the businesses in the local mall has also occurred, and relevant referrals have been received by numerous businesses on a regular basis. By and large, the building managers required little education as they were only too well aware of the residents in trouble. Their main problem was difficulty in accessing, and getting a response from, the system.

Our "in-the-community" approach led to 45 referrals in the first six months, more than four times the previous rate. An analysis of the source of referrals for clients shows how the base of referral sources has been expanded:

building managers & property owners (ESAM)	7
family physician	8
Specialized Geriatric Services (e.g., GAU)	4
CCAC	3
health centre volunteers	3
safety monitors	2
store managers	1
neighbours	1
self-referrals	1

This represents 30 referrals from the community, as well as an additional 15 referrals from the formal system during the first six months. The age breakdown of the referrals from the community suggests that the older frailer members are the focus of attention:

age 70-79 years	8
age 80-89 years	19
age 90-99 years	3
unknown	5

The reason for referral are shown in the Table 6. Initially psychiatric services were found difficult to access. The wall of confidentially by the system was a hindrance for effecting action. It is hoped that the relationship now built, by the GNP with the psychogeriatric services, will go some way to resolving this. The expected unification of geriatric and psychogeriatric services can only help communication.

Table 6: Reasons for community referrals to the GNP.

REASONS FOR REFERRAL (N=35; first 6 months only)*	NO. OF REFERRALS
cognitive changes	14
query ability of residents to remain in apartment	8
medical issues	8
safety risks (e.g., fire; smoking; alcohol; etc.)	7
functional decline	7
assess the need for additional services	7
falls, weakness & poor mobility	7
weight loss & poor nutrition	6
social isolation	5
odour; poorly maintained apartment	5
caregiver stress	5
request for information	5
fecal, urinary incontinence	3
poor hygiene	3
pain	3
medication concerns	3
suspiciousness	3
family dynamics	2

* many times there were multiple reasons for referral

Overall, the physical and mental frailty of many of the residents represents a challenge. Some specific issues follow:

- the private housing apartments can be difficult to access, requiring as it does gaining admittance to the apartment block by the intercom system and key number access on the part of the resident, as well as access to the apartment itself

- many clients are reluctant to become involved with the system, either because they are suspicious of the system's motives, or because it just seems overwhelming; there is a need for a more time involved therapeutic relationship building, acquiring of trust and familiarity in order to break down the barriers erected by the unwilling clients who represent the most difficult cases and who can easily "fall through the cracks" as a result

- many clients are isolated from their family physicians, incapable of making or remembering to keep appointments; a method of maintaining the link and lines of communication is needed; in this, as in many areas, transportation is an eternal problem; a system to provide care for those without a family physician is needed

- many clients have moved into the community and have failed to reconstruct any social support system; many seem to drift in the community; a system to help build a life structure would help overcome this disconnectedness which allows people to fail unnoticed

- individuals frequently have cognitive impairments, poor insight into their needs, and may refuse services; they are poor self-advocates and fail to make use of the supports available; an advocacy system is needed; a protocol for involving the public guardian and trustee when needed would help as this is a source of confusion for many

- further educating the community and others (e.g., PSWs) along the lines of the gatekeeper model would help

- catastrophic events occur regularly and need to be responded to; a major change in the client's needs can occur quickly; clients can be returned from the emergency room at 3 a.m. and need help; a system to meet this need, providing emergency home support, exists in London housing buildings and needs to be implemented here

Issues of Assessment

It is a basic tenet of geriatric practice that a comprehensive assessment, to identify all relevant issues in the broadest way, is an essential preliminary to care plan development. This requires involvement of specialist assessors (from the SGS) or through an extension of the role of the CCAC case managers. For reasons outlined previously, a specialist geriatric assessor dedicated to the site would be advantageous.

It was discovered that conducting a full comprehensive geriatric assessment is cumbersome and too time intensive to meet all community assessment needs. A way of shortening the process is required. As demand grows, the full assessment which takes two or three hours will become an impractical luxury. A more targeted method is required to find and focus on the relevant issues. A two-tiered approach, with a limited involvement of a specialist to deal with specific problems, is an option to be tested. An initial risk screening tool has been collaboratively developed with our partners, but remains to be validated (Appendix I). It has to be recognized that dealing with primary issues in half the time for all the clients is more valuable than dealing with all the issues in twice the time for half the clients.

Following the initial assessment other specialties may need to be involved. In October 1999, in partnership with the Middlesex-London Health Unit, we collaboratively developed and pilot-tested a community response team to provide quick response to community members at risk. The role of volunteer community members was explored at

that time and terms of reference and a training package for volunteer community assessors and seniors' advocates were developed. Subsequently, in October 2001 with funding for the GNP from the Parkwood Foundation, this model was further refined. At that time a two-tiered, inter-agency approach to assessment (and subsequently to the management of clients) was collaboratively built with the support and involvement of the key geriatric service providers from the City of London. This increased involvement by city-wide geriatric service and community response team members has led to a greater understanding of the function of each provider and opened communication channels particularly between the geriatric and psychogeriatric providers. With recommendations from the community, the role of volunteer community members as part of the response team has changed. Older community members felt uncomfortable being actively involved in the assessment process and preferred to focus primarily on the advocacy aspect of this program (see Chapter 6). Thus, the role of volunteers in this particular program was modified, with a move toward a community role in identification (see above) rather than direct assessment.

The lack of assessment is important on several fronts:

- lack of full geriatric medical assessment means diagnosis and treatment opportunities are missed
- even when assessment is done there is frequently a delay in referral until breakdown is imminent or present; opportunities to prevent breakdown are missed
- lack of timely assessment, diagnosis and management can lead to a failure to resolve the issue before personal support resources are exhausted
- there is frequently lack of family involvement and support based on lack of understanding of the problem such as the dementing process; families who live at a distance are as dependent upon "referral" as the system, as they frequently get inaccurate information from the person themselves
- there are many common issues that are poorly recognized; these include nutrition concerns, depression, pain control, incontinence, immobility and falling, medication mismanagement, financial abuse and other financial concerns; special focus programs for some issues are needed

Issues of Management, Support & Follow-Up

Management of frailer older clients is a challenging and specialized task. Standards of knowledge and practice should be designed for, and met by, the various levels of professionals involved.

We discovered that it was difficult to know when, or if, action had been taken. This was particularly felt by the informal system members, such as the building managers. Residents identified by the building manager and sent to the emergency room in crisis, returned many hours later with no apparent resolution of the problem. Frequent re-referrals followed. Similarly lack of feedback on what supportive services were being provided left concerned individuals uncertain what, if anything, was being done. To help resolve this confusion if is important to build an integrated community-based, community-specific system which can take ownership of a client's problems and follow it, as far as possible, to resolution. A case manager model seems to be the best strategy for this.

Mrs. S.

Mrs. S., an 88 year old widow, refused CCAC services and Meals on Wheels. She told her distant family, who spoke to her by telephone, that she purchased food and ate regularly at the mall. The family were somewhat frightened of her because of her suspiciousness, and her statements that they had stolen her rings, cheque book and money. On occasion she had insisted that the police be called. With the insistence of her family and CCAC, Mrs. S.'s family physician referred her to the GNP in Cherryhill. It was noticed, during the assessment, that Mrs. S.'s apartment had few working lights, and that there was no food in the refrigerator which could be made into a meal. Spoiled food (a square of spinach) sat in the frying pan. Mrs. S. had $5.00 in her purse to purchase her evening meal at the mall. She wore 3 heavy knit sweaters and complained of being cold. The GNP completed the comprehensive geriatric assessment, which indicated significant cognitive decline, poor recall, minimal insight and judgment. After the assessment, and with several telephone calls to the family, they were able to accept that her statements were not true, and that her cognitive deficits were affecting her perceptions. They realized that they needed to become more involved in her every day life, and in particular to check her refrigerator and purchase groceries. They needed to work with her family physician to determine a medical plan and initiate papers for an alternative living setting for the future. Recommendations were provided to her family physician regarding her cognitive decline and to CCAC regarding her health needs. This woman was identified and assessed before a crisis occurred.

Lack of a family physician is a large problem in the Cherryhill community. This continues to be one of the most common requests received by the Health Promotion and Information Centre. Practices are full, and care of fragile older patients is time consuming and not lucrative for family physicians. A GNP providing support to several practices could help to extend the physician's reach. The concept of a community GNP, rather than a specific practice GNP, is proposed. This could also help provide some on-site management as many of the residents have family physicians situated across the city, near to where they used to live, prior to moving to Cherryhill. The shortage of family physicians makes it impossible for clients to find doctors near their new residence. With homebound people it is a particular problem. The challenges surrounding the provision of care to the housebound have been discussed by others.[2] It was found in the Montreal area that 50% of family physicians did not do home visits. Other issues discovered in the Cherryhill community include:

- lack of family and social support; most Cherryhill residents live alone and, if they have families, their families are frequently too far away to be of day to day assistance; surprisingly, and to the concern of health centre volunteer and safety monitors, many families didn't seem to care when contacted, and provided limited input and support, even if nearby

- falling and incontinence are endemic; we urgently need to design and operationalize evidence-based falls prevention, fracture prevention, and continence programs to ameliorate these and other issues; many of these areas have special representation within the SGS; continuation of a model of community implementation that could serve the common needs of these programs should be possible

- nutritional concerns were identified in those who rarely leave home; this has, in part, been helped by implementing a congregate dining program centrally in the community with volunteers helping clients get to the site; in working collaboratively with the Meals on Wheels dining program it was discovered that they had already identified the apparent under-servicing of the Cherryhill community

- medication issues; failure to take medications is a problem; a small focus group with family physicians identified poor medication compliance as one problem they would like to have addressed; this applies not only to such medications as those for heart failure where not taking medication is a well-identified reason for hospital re-admission, but also to treatment for cognitive impairment where the under-prescribing of medication is due, in part, to skepticism about whether it will be taken.

Surveillance following management is important for frailer residents. Early intervention helps prevent further possibly irreversible decline. Many people can potentially have contact with a client in the long-term. These contacts range from friends and neighbours, through personal support workers to case managers and the family doctor or the GNP. Under the current model, where clients can be discharged from CCAC care, or from follow-up by SGS, a vital link is lost and clients fall by the way side. Expecting the client to arrange follow-up with their physician and geriatric outreach worker if they are declining is not realistic. Identification of risk factors for subsequent failure would help select those at highest risk who could remain on the case load. An educational initiative to teach all involved the "red flags" that should trigger re-assessment will be needed. The construction of a team in the community comprising CCAC workers (case managers, PSWs, nurses and therapists as needed), SGS personnel, patient, family and friends, as appropriate, with input from family physicians and geriatricians (as required), and with someone acting as case manager and carrying ultimate responsibility for client outcomes across sectors will facilitate follow-up tracking and rapid response. For those being followed, a simple communication channel between the person involved with the client (e.g., community resident; personal support worker) and the case manager will suffice if things go smoothly. In all aspects of care of seniors where many issues are involved, and which can change over time, good communication between the various providers is essential.

Mrs. X.

An apartment building manager made a referral to the GNP. He was concerned about an 84 year old married woman who was frequently weepy and who complained of generalized weakness, poor mobility, falls, dizziness, poorly controlled diabetes, medication problems and caregiver stress issues. When the GNP visited the couple, the husband indicated that his wife was too unwell to be seen but that she was not able to visit her family physician because of her "poor condition". She had rejected services from the CCAC and wanted only her husband to care for her. After assessing the overall situation and conducting a basic comprehensive geriatric/medical assessment, the GNP contacted the family physician and placed Mrs. X.'s name on the bed waiting list for the Geriatric Assessment Unit, St. Joseph's Health Care. Mrs. X required a more thorough assessment and treatment of her diabetic condition, depression, urinary incontinence, deteriorating generalized physical condition, weakness and declining mobility. She required the services of an acute care center. She was admitted for four days and treated over two weeks at which time she was discharged home with CCAC services including physiotherapy. Her name was placed on a waiting list for psychosocial programs being developed in Cherryhill.

As part of the maintenance process in the community, a system of programs is required to meet the wide variety of needs. Such programs must be evidence-based, function focused, and targeted to specific outcomes. These programs should range from psychosocial support programs to physical maintenance programs. These programs can also be used in a preventive way.

With the restrictions on service provided by the CCAC, an alternative means of providing ongoing support services is needed. The 1997 community survey identified many skills in the community that people were willing to offer. This talent and willingness needs to be further explored. It is important to understand who is responsible for what, and where the system's responsibilities end, and when patient, family, friends and community as a whole can, and should be expected to step in. The potential for sharing and working together should be explored as part of standard community geriatric practice, and further emphasizes the need for a collaborative approach with the community.

It has become apparent from focus group discussions with residents and inquiries received at the information centre, that there are areas of support from which residents could benefit. Many clients have a lack of confidence. Follow through on suggestions can be poor. Support or encouragement through a time of change will not only help, but may be essential. The literature supports the conclusion that the outcomes are dependent upon the frequency of contact by the professionals directing the care. Questions which recur are related to:

- access to the system
- availability of financial support for services and aids
- assessment for gait aids
- personal financial guidance
- teaching self-support skills, especially cooking, to widowers
- the system receiving and supporting clients returning from hospital

Again, a collaborative venture with community and other partners is feasible.

Provision of Therapy

The present model involves provision of in-home therapy by the CCAC. Anyone considered able to leave their home is ineligible for this service. The mandate of the CCAC is to teach clients and their families to do the exercises. There is little information on the success of this approach. The physiotherapist in the Cherryhill community, funded by the Parkwood Foundation, discovered that may clients discontinued the exercises shortly after discharge. However, the representativeness of these clients, as a whole, is not known. If not already done, an evaluation of the current approach, particularly its effectiveness with a frailer, much older population, should be

carried out. Therapy is also available in outpatient clinics in acute care hospitals, or through private clinics. These programs probably meet the needs of "single issue" clients well, but will be of limited value to frailer older individuals with complex and ongoing needs. The Parkwood Day Hospital, with it's outpatient multi-disciplinary approach specifically designed for the frail complex person provides another option. This, however, is an expensive resource with limited capacity. Our conservative estimate, given our research findings and experience in the Cherryhill community, was that there are enough clients in the Cherryhill community to keep the Day Hospital fully occupied for two years just assessing and treating. Very few Cherryhill residents, however, actually reach the Day Hospital. The final therapy option is in-patient rehabilitation. This is generally reserved for the most complex cases in need on an intensive approach. At times, it is also the only option for those for whom transportation problems prove insurmountable or excessively tiring.

The practice of rehabilitation has advanced over recent years and, especially for occupational therapy, a new mode of practice has emerged.

Occupational Therapy

In recent years occupational therapy has moved from the old notion of the re-training of lost functions through learning specific actions in isolation from the specific activity of daily living. Now the old tasks employed within OT departments (referred to in a somewhat derogatory fashion as "pegs and cones") have given way to more holistic approaches wherein the clients' function within their specific environment is the focus. Whereas the assessment of mobility appears to be more independent of the home environment, the assessment of activities of daily living (ADLs) and the instrumental activities of daily living (IADLs) has been found to be context sensitive. The clients' performance in their own homes can differ greatly from their performance in a formal and artificial setting, such as the OT department. The profession has moved very much in the direction of assessment and re-training of the clients within their own homes. For example, occupational therapists in the Day Hospital have abandoned the re-training of lost function in a deconstructed manner. Much more assessment and training (rehabilitation) now takes place in the clients' home. The concept is supported by motor learning theory which supports the view that the client's environment offers advantages over rote exercise in terms of acquiring or re-acquiring motor skills. The view has grown that the client, the environment and the activity are inseparable. This conclusion supports community-based treatment and forces a move away from department-based programming. The challenge is, of course, how to deliver a service which is not only individualized to the client, but individualized to the client's specific geographic setting, in a cost effective manner.

Physiotherapy

The physiotherapist in the Cherryhill community, supported by Parkwood Foundation funding, assessed clients in their own homes. Most of these clients were referrals from the CCAC caseload, and most of these clients were cognitively intact (MMSE of 27 and above). It was discovered by the physiotherapist that the mobility of many of these individuals is so limited that they rarely go further than the garbage shute. This immediately raises issues of communication and identification of problems, especially for those with little social and/or family contact. Incontinence also appeared to be a major issue for these individuals.

In her assessment of community rehabilitation needs, the physiotherapist discovered that most clients have basic equipment (e.g., grab bars; raised toilet seats; etc.). However, any issues outside of these "basic three" was neglected or not addressed. There were, in particular, major issues concerning gait aids. Many individuals had a variety of gait aids that seemed to have been obtained or inherited from anywhere. Most were at the incorrect height. Within their homes many residents had unsuitable seating (too low; no arms) that they struggled to get out of. It was identified by the physiotherapist that education, especially regarding mobility aids, is very much needed.

Many of the clients seen by the physiotherapist had been given a PT program after teaching by the CCAC therapist. It was discovered that the program was usually discontinued by the clients as soon as the CCAC therapist pulled out. It was also discovered that some of the programs did not include standing or balance components. One older client had a program (outlined on paper) provided following a total knee replacement. The program was determined to be inadequate for the client's needs. Research findings show that, unlike OT, physiotherapy involving gait training is not context sensitive and can be done out of the home. However, as clients are unwilling to travel, the community becomes the preferred site for therapy. For physiotherapy gait retraining, therefore, a group program within the community is needed. Most clients assessed by the physiotherapist expressed an unwillingness to attend the Day Hospital.

Treatment in the Community

The rehabilitation/therapy needs of Cherryhill residents ranged from specialized rehabilitation needs to general maintenance programs. Some of the specialized needs will continue to be met in the specialized settings such as the Day Hospital. This may particularly apply to difficult mobility problems in need of one-on-one treatment and which appear to be relatively site independent.

The maintenance of function post-rehabilitation is a further concern. The ideal way of avoiding the revolving door phenomenon has not yet been found. The physical maintenance program, run as an adjunct to the Day Hospital, has shown continued

improvement in the clients who choose to accept referral and who continue to attend. As noted previously, many choose not to attend and the fate of the drop outs is unknown. Nonetheless the inherent logic of the approach seems sound and the implementation of maintenance programs in the community is necessary. Several rehabilitation/therapy-related suggestions can by made:

- specialist occupational therapist expertise is required in the community to assess & supervise therapy programs
- specialist physiotherapist expertise is required in the community, to assess the client (in the client's home) & to carry out mobility re-training at a common community site
- a therapy assistant is required in the community to work under the supervision of both the OT and PT; on therapist could supervise several assistants in different communities
- further research will be needed to determine the degree to which therapy can be devolved to the assistant & what has to remain the responsibility of the trained therapist; liability implications will need to be addressed
- a broad base & a continuum of programs (designed with the specific purpose of maintaining function, especially mobility are required in the community; these do not have to be in the client's home but should be geographically convenient to minimize transportation issues; these programs can be designed collaboratively by the OT, PT & a degree-trained therapeutic recreation specialist (TRS) to meet a wide range of physical & psychosocial needs

Clients in need of specialist one-on-one therapy, especially PT, can access the Day Hospital as per the current model.

A Specific Challenge: Dementia

The Canadian Study of Health and Aging has emphasized the magnitude of the problem in Canada (and world-wide). The prevalence of significant dementia in those 80 years of age and over (the fastest growing segment of the population and nearly half of the Cherryhill population) is over 25%, with 40% having some cognitive deficits. The management of dementia in the community represents an enormous challenge to the health care system. It raises issues of prevention (particularly for vascular dementia which involves the management of vascular risk factors), diagnosis, the management of the disease and its consequences (behavioural problems) to the alleviation of its impact on others (e.g., caregiver stress; etc.). In many ways the dementing individual stresses the systems' ability to cope as they lose their ability to organize their own care. The nature of the disease is such that the victim may either lack insight into their needs or be unable to seek help if the need for that help is recognized. It raises many issues regarding the ethics

and the right to self-determination and privacy. The role or responsibility of the community in the care of the dementing member poses many questions.

The experience in Cherryhill is relevant. On the basis of demographics we can estimate that there are approximately 400 individuals with dementia in various stages of development. The experience of the GNP in the community has highlighted several issues:

- many individuals with dementia are unrecognized by the system
- many individuals with dementia do not receive a diagnostic work-up
- many individuals in need do not receive the services required; in part this is an insight issue and in part it is the failure to develop a particularly effective approach to such residents; the normal process of assessment, explanation of available services and required "signing-on" by the resident frequently does not work; in the face of confusion and lack of understanding, the resident too often says "no"; this will leave the resident at risk and the caregiver, if there is one, still under stress
- many residents do not receive cognitive enhancers which could help them function better; although the improvement from them is rarely dramatic, they can improve not just cognition but behaviour which could help alleviate caregiver stress; there may be long-term benefits to such treatment; evidence is emerging that early treatment may prevent some of the more troublesome behaviours emerging later; several reasons for the shortfall in treatment have emerged:
    - lack of assessment & diagnosis
    - lack of family physician belief in the efficacy of the treatment & the clients' ability to take it
    - lack of contact between the client and their family physician, in part due to the impact of the changes on the clients' ability to consult the physician

Residents with dementia have been discovered with problems in the areas of depression, loneliness, under nutrition, hygiene issues and safety issues, and incontinence. Dementia causes much collateral damage.

Suggestions:

These residents need a very comprehensive and coherent care program. Essential components include:

- earlier diagnosis; it is now recognized that prior to the usual diagnosis point, many symptoms had emerged but their implication went

unrecognized; thus many symptoms from personality change to depression to apathy can precede the diagnosis by months or years; education of physicians, professional care providers, and the general public could help; earlier diagnosis would help alleviate the risk factors in the vascular dementias and earlier treatment with cognitive enhancers is needed where indicated; significant improvement in many dementia types (e.g., AD; vascular dementia; mixed types; Lewy Body dementia; etc.) has been reported

- educational initiatives for the physician to encourage the use of appropriate medications; some strategies have been shown to improve physician practice (e.g., quality circles)

- a more sensitive approach to clients is needed; clients fearful of being institutionalized might not welcome assessment and help; we believe the building of a "neighbourhood" system of care can help where a community can come to know and trust familiar providers; taking the time to get to know the client and building a relationship is critical for the clients' acceptance of care; this is important for all, from physicians to PSWs, to community volunteers

- recognition of the client's limitations in insight, initiative, executive or decision-making capacity requires the system and others to assume some of the decision-making role; a somewhat "top-down" approach is needed; the client is not capable of, or cannot be relied upon to act in his or her best interests

- the GNP has recognized the need to slowly build a relationship with the client even to the extent of sitting in the mall having coffee before broaching the idea of access to the home and assessment; this has gained access where previously the doors were kept shut from suspicion; likewise, when offering help a simple explanation of the plan to obtain consent works; too much detail overwhelms the client and encourages the catastrophic reaction of refusal

- involvement of the community in the clients' care; the volunteers are happy with the role of supervising, monitoring, helping with shopping, taking residents to the mall, and so on (all activities which might help keep the resident in their home); the Cherryhill Safety Check Program is less suitable for the clients as they forget to place their tags out, or take them in; an educational program for lay support workers is required

Community-based programming can help with certain problems, for example:

- a community dining program has been established which meets the combined needs of nutrition and psychosocial stimulation; the more able community members help the other less able residents to attend

- a caregiver relief program, for example, a satellite program of the Alzheimer Community Support Service (ACSS) is needed; an in home "sitting" service will allow caregivers to leave for a while; this will require added screening and training of volunteers

Residents with dementia can benefit from other components of a screening and prevention programs (e.g., falls prevention; prevention of vitamin D deficiency (a known risk); etc.) to help with some of the problems which have been shown to be common with these individuals.

Prevention

It has been said that the Health Care Financing Administration (HCFA) which overseas the Medicare program in the United States, is not a health program, but a health care insurance program. The same can be said of the Canadian system, providing as it does acute care for those who fall ill, for example, CCAC home-based program for those recuperating or in need of support for chronic conditions, specialized geriatric programs for seniors with multiple problems, and so on. The programs mostly exist to catch the failing client rather than prevent the failure in the first place. In Ontario, one third of the budget is spent on treatment-oriented, institutional-based medical care. What is urgently needed, some critics suggest, is a shift toward less costly prevention-oriented, community-based programs.[1]

There are many examples of potentially beneficial prevention programs that could improve health outcomes. Shortfalls in the management of diabetes and hypertension are well recognized, with fewer than 15-20% reaching acceptable management guidelines. The care gap for the management of osteoporosis in Canada is thought to be between 50 and 70%, this being the population of people with the disease who go untreated.

The system currently lacks a method to implement evidence-based prevention and management programs at the population level. There is current debate in the area of clinical trials about the ethics of randomized placebo controlled trials. The recent re-vamping of the Helsinki Declaration has declared that it is unethical to deprive an individual of the best available treatment in order for them to participate in a placebo controlled trial. Such trials serve to move science and medicine forward, producing evidence of efficacy for various interventions in multiple fields.

Little debate has, however, centred on the lack of implementation of the evidence that is available, be it in the area of osteoporosis, dementia, hypertension or diabetes. This leaves many preventable adverse outcomes unaddressed. Discussions with, for example, University of Western Ontario-based nephrologists have revealed major concerns for the future of the dialysis service which is seeing an increasing number of old people in renal failure. Some, at least, of this is preventable, and in established cases of renal impairment, its progress can be slowed.

The implementation of evidence-based management is one thing, for here at least the intervention is relatively simple. The implementation of programs to maintain function or prevent dysfunction (such as falling) are in some ways easier to implement but more difficult to achieve and maintain the required standards of practice. One example can be highlighted, the provision of a program to prevent falls.

There is evidence to guide the development of a falls prevention program. Many programs, however, don't reflect the evidence. It is what we could call the "scatter-mat" phenomenon. The provision of services and programs that are not based on evidence is to be discouraged. In our considerations regarding a falls prevention program, it was soon realized that the exercise programs available might or might not have been based on evidence. Without an evaluation, there is no way of telling. We feel that any program purporting to improve health outcomes should be evaluated and accredited. That is not to say that each program should be specifically targeted to a specific need. Client compliance with such an exclusively therapeutic approach tends to be poor. Programs need to be fun and probably need to meet multiple needs of different clients. Nevertheless they need to be constructed of components known to work. Guidelines are not available upon which programs can be built. There is a need for the development of such guidelines.

There is an urgent need to conduct research in the overall area of prevention for seniors. The Cherryhill community offers an ideal opportunity for the exploration of a methodology that will improve management and prevention seniors, establishing an evidence-based healthy aging program. We are starting to build links with various faculties at the University of Western Ontario to further develop the concept of a Healthy Ageing Program.

The failure to implement evidence goes well beyond the medical model. It is interesting to read the report prepared for the Division of Aging and Seniors, Health Canada by Linda MacLeod and Associates. This reviews the evidence accumulated by over 90 projects funded by Health Canada in the area of seniors' health. Although some of these lessons have been incorporated in the Cherryhill Healthy Ageing Program, we see little sign of them being implemented in our locality generally. This failure to pass research findings through to inform practice makes the research redundant. It has to be accepted that, in the future, most care of seniors, even the frail seniors, must take place in

the community. This inevitably means the community, community-based resources and the institutions, the repositories of expertise, must come together. The outcome is likely to be a culture-shock. The concept of a collaborative practical research and implementation interest group, as occurred with the now defunct "Practical Research in the Care of the Elderly" initiative, should be re-floated. One current local example is the Hip Fracture Interest Group which has made significant progress in this focused field.

References

1. Florio, ER, Rockwood, TH, Hendryx, MS., Jensen, JE, Raschko, R. & Dyck, DG. (1996). A model gatekeeper program to find the at-risk elderly. Journal of Case Management, 5(3), 106-114.

2. Clarfield, AM. & Bergman, H. (1991). Medical home care services for the housebound elderly. Canadian Medical Association Journal, 144(1), 40-45.

Chapter 6

The Community Perspective:
What are Older Community Members Willing & Able to Do?

- what does the evidence tell us?
- what is our experience?
- what do community members tell us?
- greatest successes experienced by community members
- greatest challenges experienced by community members
- the potential role of older individuals & communities in health service planning & decision-making
- using the right language . . . what do older people prefer?
- references

What the Evidence Tells us . . . .

- older individuals with greater health & self-care needs will, out of necessity, be less able to participate as fully in community activities, including volunteering
- there is general consensus that community development with older individuals, particularly communities of very old people, presents many challenges but that collaborative partnerships are possible
- successful partnerships require a commitment by health professionals to shift power away from the traditional "top-down" role of the "professional" or "expert" providing intervention, to sharing decision making with older individuals & ensuring active & ongoing involvement by older individuals
- the provision of a supportive environment & services will help older seniors preserve enough energy to allow them to be meaningfully involved in their communities, including health-related volunteering

Our Experience . . . . .

- community capacity building with communities of frail, older individuals works, however it is time intensive upfront & commitment must be made & adequate time allocated to work with community members
- seniors have valuable insight into the operation & short-comings of the health system; their feedback is valuable & underscores the importance of the contribution they can make by actively becoming involved in health service planning & delivery
- seniors have different levels of comfort in dealing with the personal & health issues of their clients; seniors are most comfortable in providing information, being involved in the day-to-day operation of a health promotion centre, monitoring the health status of their neighbours & working with psychosocial & maintenance programs; they are not comfortable being directly involved in the medical & health problems experienced by their neighbours
- seniors are resourceful & derive much satisfaction from what they do & the opportunity to learn & grow
- seniors like to be called "seniors" & "senior citizens"; they do not find the term geriatric acceptable & they do not like the term elderly

The Community Perspective:
What are Older Community Members Willing & Able to Do?

What Does the Evidence Tell Us?

Community development initiatives with communities of predominantly older individuals, particularly the "old" old, present somewhat of a challenge and there are many issues to consider. Existing theories suggest that with increasing age and biological vulnerability older individuals are forced to reduce their involvement in certain activities so that they may maximize performance in others.[1] For example, those individuals who have greater health and self-care needs which are required for everyday living will, out of necessity, be unable to participate fully in other community activities.[2] Maintaining capacity in communities of aging individuals where the health of even the most active and involved members is somewhat precarious will be an ongoing challenge for researchers.

Building capacity in communities is dependent upon volunteerism. A substantial amount of evidence generated over the years across a variety of disciplines including health, gerontology, community and social psychology, suggests that there are key factors that influence volunteer involvement and behaviour by older individuals.[3-11] These key factors include:

- age
- health
- education
- income
- social supports
- environment
- personality
- recent life events
- length of time living in community

These key factors are also consistent with variables repeatedly identified as determinants of the health, well-being and health service utilization patterns of elderly individuals.

Much of the volunteer-related research conducted to date has focused on an adult population in general, or on volunteer patterns of "younger" old individuals. Very little has been done to examine the volunteer patterns of older individuals at the other end of the spectrum, those who are much older, frailer and more dependent. Some researchers, for example, even believe that developing collaborative partnerships with this group of individuals may not be possible; that their level of dependency necessitates a "top-down"

approach.[12] Reciprocity is an important factor to consider when working with frail older individuals in order to increase their control and independence. Without the ability to "give back", older individuals quickly "lose self respect and acknowledge their dependence".[1,2,13-17] Recognizing and creating opportunities for "giving back", based on individual capabilities, is particularly important for achieving successful and sustainable outcomes in community development initiatives in neighbourhoods of frailer, older individuals. It is also extremely effort and time intensive.

While the general consensus supports the notion that community capacity building with frail older individuals presents many challenges, it is also agreed that workable partnerships are possible. The critical factor seems to be the *interaction between* older individuals and those providing health care services and the subsequent relationships established. To maximize individual control it is important to ensure individual input and involvement on an ongoing basis and to shift power relationships. Successful partnerships require a shift away from the traditional "top-down" role of the health worker as the "professional" or "expert" providing intervention *for* those with health-related needs. Rather, health professionals must become resource people who share information and work *with* individuals to build on existing strengths, knowledge and skills, build awareness and confidence (of both individuals and their communities) and help older individuals believe that they have the capacity to bring about change in their communities. It is important for health professionals and other stakeholders to recognize the unique situation of older individuals with advancing age and increasing health needs, and the added time and effort that is required to encourage "true" partnerships based on individual capabilities.[18, 19]

While the aging process itself is not reversible, there are many factors in the lives of older individuals, which with the appropriate intervention and supports can optimize volunteer involvement. A number of specific social *environmental* and community-related factors have been specifically linked to higher rates of volunteering. These include:

- social connectedness
- one's sense of community
- length of time lived in the community
- knowledge of community resources
- satisfaction with community resources
- neighbours & safety
- frequency with which an individual leaves their home

Four widely used theories of person-environment interaction exist to help better understand the action of older individuals, particularly the actions of frailer and more dependent individuals. These include Lawton and Nahemows' Competence and Environmental Press Theory,[15] Kahana's Congruence Model,[20] Lazarus' Theory of Stress and Coping,[21] and Pastalam's Loss-Continuum Concept.[16] The more dependent one is, the more important the environment becomes. A supportive, safe and accessible

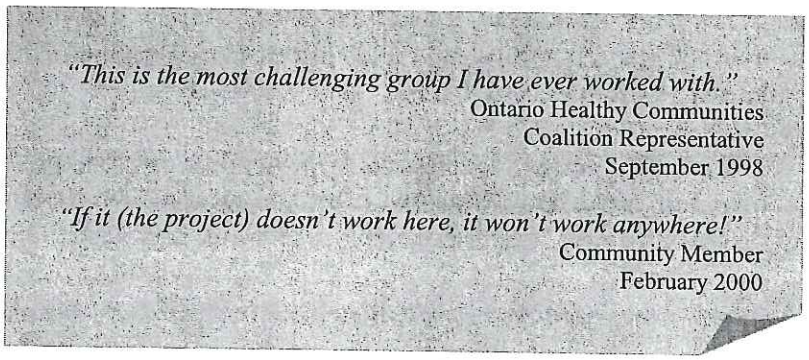
environment will allow frail older individuals to meet their basic needs and still have energy left for other things such as volunteering. In addition, other researchers have found that a "sense of community" defined as social interaction among neighbours was directly linked to, and significantly increased, individual volunteer involvement. For more detailed information on a wide variety of theoretical and conceptual frameworks that may be drawn on to guide community capacity building, and to increase and maintain involvement of older individuals please see Chapter 3.

Consistent with community development principles is Knowles'[22] theory of motivation in volunteerism which uses Maslow's[23] "hierarchy of needs" as a framework. Knowles suggests that volunteer opportunities which are structured with both opportunities for service and opportunities for learning and self-development, and those with collaboration in planned change processes, will foster the involvement of individuals on an ongoing, long-term basis. Knowles suggests that if volunteer opportunities are structured strictly around providing a service, without opportunities for individuals' learning and personal development , volunteer positions will not meet the needs of individuals over the long-term. He argues that once a volunteer's immediate needs are met in a "service-oriented" volunteer program, volunteers will, as their needs change and/or their skill level increases, withdraw and seek other volunteer opportunities which they will find more fulfilling. Knowles argues that by coupling the service needs of an organization with learning opportunities for the volunteers it is possible to shift an individual's motivation for volunteering from externally driven service needs, to intrinsic reasons which will keep volunteers involved for much longer periods. Additionally, Smith[24] in his synthesis of volunteer research conducted between 1975 and 1992, found, among other things, that perceived benefit to the volunteer was important. Of interest is the fact that the receiving of services from the organization also increases the likelihood of volunteering. Smith also identified methods of recruitment (specifically being asked to volunteer), and the characteristics of the organization (i.e., a community self-help organization vs. other public organizations) as being important.

There are numerous theoretical frameworks available, including change theory, theories of aging, theories of volunteerism, theories of individual and community empowerment, and psychosocial theories that may be used to facilitate community capacity building with older individuals (Chapter 3) The examples provided here are only a few highlights of the theoretical and conceptual frameworks used to guide community capacity building processes within the Cherryhill Healthy Ageing Program.

From the literature it is clear that there are some important conclusions that can be drawn. Firstly, when dealing with frailer seniors the environment plays an increasingly important role, and directly impacts whether an individual has the energy or reserve left (after completing basic self-care needs) to become involved in other things. Similarly, unless the system can provide some support for frailer individuals (e.g., homemaking; cleaning; cooking; etc.) they will unlikely be able to give back in the form of volunteering.

Finally, once volunteers are recruited it is important that their role and positions not be overwhelming, yet provide sufficient stimulation and challenge that they will remain involved over the long-term.



The Perspective of the Community

Actively involving older community members in the planning and provision of their own health services on an ongoing basis is a complex process, with many factors to consider. It is a process that evolves and changes over time, depending upon the characteristics of the community and community members at any given point in time. Initial process development and community capacity building is time intensive, however there are many long lasting rewards if the process is carefully planned, timed and implemented. The following section outlines our experience in working with older individuals living in the Cherryhill community and the perspective of community members themselves in terms of their involvement in the planning and provision of their own health services. We asked community members how well they feel the health needs of older people living in the community are being met by the current health system and services. Consensus is that:

- home care is too limited; the perception is that the amount of home care available to seniors is not enough in most cases

- this lack of home care forces people to make alternative arrangements, either relying on their families or paying for services, two options which are not feasible for many individuals; most don't have the resources (either financial or social) to draw on, and many individuals don't have the capabilities to organize their own support system; added to these challenges is the fact that in today's society "extended families" are limited

- the perception is that many older individuals are institutionalized prematurely; this leads to fear and mistrust of the system
- the health care system is inflexible and does not support unique, individual situations; rules are too rigid
- the greatest challenge is to assist older people in finding a family doctor; the majority of family doctors are not taking new patients
- surprisingly it is perceived that health care providers lack compassion and time, and that the health system has little interest in the problems of older people
- advocacy for people who don't have family support is needed; the support of family and/or friends is critical in helping older individuals to remain independent, active and in their own homes as long as possible
- the health system is currently not "user-friendly" for seniors; seniors need to access many types of health and related services; need more information on what is available; this is especially true for the very old individuals

Characteristics of Cherryhill Community Volunteers

The following provides a description of community members living in Cherryhill who have been actively involved in the Cherryhill Healthy Ageing Program. The average number of years lived in the Cherryhill community was 8 years. Years of involvement in the Cherryhill Healthy Ageing Program for current community volunteers ranged from 1 to 6 years (mean =3 years). The differences between volunteers and non-volunteers is discussed in detail in the next chapter. The characteristics of volunteers from 1996-1998 when community capacity building and program development began, and four years later in 2002 are outlined in Table 7. Other than for growth in numbers of volunteers there were no differences.

Table 7: Characteristics of volunteers involved at program inception 1996-1998 and four years later in 2002.

VOLUNTEER CHARACTERISTICS	1996-1998 (start)	2002 (at 4 years)
Age	74	74
Range	66-82	66-84
Number of Community Volunteers	28	62

To determine the level of involvement of volunteers as the project developed, the degree of involvement and individual responsibility adopted by each volunteer was tracked over time. Table 8 shows the change in level of involvement by community members over the years with a growing number taking on a leadership role.

Table 8: Differences between levels of volunteer involvement in 1996-1998 and 2002.

		LEADER	COMMITTEE MEMBER	GENERAL HELPER
1996-1998	(n=28)	2	18	8
2002	(n=62)	12	4	46

Differences in characteristics between community members who volunteered to work with the Cherryhill Healthy Ageing Program versus those who did not are described in detail in Chapter 7, along with specific strategies to optimize volunteer involvement as experienced in our work with the Cherryhill community. This Chapter focuses specifically on the *perceptions* of community volunteers as it relates to the health system and their level of comfort in becoming involved in health planning and care delivery from a community capacity building perspective.

"Go to the people
Live amongst them
Start with what they have
Build on what they know
And when the deed is done
The mission accomplished
Of the best leaders
The people will say
We have done it . . . . Ourselves."
Lao Tzu

Type of Involvement

Types of activities community members are actively involved in include:

- daily operation of the Cherryhill Health Promotion & Information Centre, 5½ days per week (Monday-Saturday)
- providing & managing health information
- organizing health-related window displays
- volunteer co-ordination
- fundraising
- helping to plan & run social programs (e.g., exercise programs; friendly visiting; etc.)
- planning & operating the Resident Safety Check Program
- representing their apartment buildings
- representing the Cherryhill community on the Board of Directors

"We had a young man, a homeless person come in once. I think he'd been "drinking"; there was an awful smell. He just came in, laid down on the floor behind our desk. We couldn't get him to move!"

"A woman came in. It looked like there was something wrong with her. We were concerned. We wondered if she'd had a small stroke. We offered to call an ambulance but she refused. We asked her for her family doctor's name. He was close by so we called, put her in the car and took her over. We brought her back home to her apartment. Shortly afterward she had multiple small strokes and ended up in hospital for 2 days."

Consensus by Cherryhill Healthy Ageing Program volunteers is that trained community members/volunteers should also be able to help plan & run health programs (e.g., keeping an eye on neighbours & alerting professionals when help is needed; reminding someone to take their medication; etc.).

"It's very comforting to know that the nurse is here. I've called her many times about different situations."

Community Feedback

Approximately half (48%) of volunteers reported that they are comfortable having some involvement with the personal, health and medical issues that arise with their neighbours, 24% of volunteers reported being comfortable under certain circumstances and 6% reported being uncomfortable with this type of involvement. Both community members and health professionals realize there is a fine line between being a caring neighbour and being perceived as being a "busybody" who is intruding. When asked if confidentiality of information was a concern, consensus among Cherryhill Healthy Ageing Program volunteers was that this was not a concern,

"A lady came into the health centre. She was using a walker. She was short of breath and in pain. She couldn't talk. I managed to get her doctor's name. I phoned him and he suggested I call an ambulance. She refused, but I called anyway. The ambulance came and she was taken to the hospital. "

"I got a call at 6:30 a.m. Tuesday morning. It was from a lady I'm monitoring on the safety program. She was crying. I told her I would be right down. I put on my housecoat and went to her apartment. She had only lived in Cherryhill for a short period of time. When I arrived, she was sobbing, saying: "I don't like it here!". "Nobody talks to me.", I just feel like killing myself." "I've lost all my hair!" "Look at me!" "I'm ugly!" I stayed with her for a little while to calm her down. I told her to come to the health centre at 10:00 a.m. when it opens. She came. One of the staff talked to her. We called her doctor, then called a cab and went with her to the hospital. She was admitted right away,and ended up staying in hospital for more than 2 weeks. It turned out that she had psychiatric problems in the past. But things turned out alright . . . . . now she enjoys life. She's doing great! She "pops" in to the health centre all the time. She has made friends, goes out to dinner, and goes to the Activity Club."

"Two family doctors came in to the health centre. They looked very young. They were collecting a huge stack of information. When I asked them why they were taking so much information, and to please only take 1 copy, one of them replied "I'm opening up my own office; these are great!". Then they marched out of the centre, with their arms loaded up! But one of our volunteers chased after them and brought many of the brochures back!"

given the rigorous procedures in place to ensure privacy of information of residents being served by the Cherryhill Healthy Ageing Program. When asked if they themselves would accept help from a neighbour 75% reported that they would, particularly practical day-to-day assistance, monitoring to ensure safety and whatever assistance is needed from volunteers on the health care team to help them remain in their apartment independently. There was more reluctance to accept help from neighbours for personal care. All volunteers reported that they feel they are providing a useful service. Volunteer comments included:

"With anyone I have helped, I feel quite comfortable doing so."

"Reasonably comfortable. Preferably I would like to have been in contact with this person for a while and have some form of trust established."

"Personal issues, okay; medical issues I don't have the training."

"I don't feel uncomfortable. I just listen and try to comfort the person."

"I don't like getting involved in people's personal affairs, but would report if someone was ailing."

"I don't feel comfortable (dealing with people's personal issues and medical problems). I would listen, not give any advice and refer them to the appropriate person."

"No, I don't feel uncomfortable. Some people just need someone to talk to."

"I feel very comfortable talking and have no problem taking charge when needed."

" I sometimes feel a little uneasy. It's a great responsibility. I don't mind pointing people to the people who can help."

"I don't feel uncomfortable as I always relate to things I did for my mother. Clients then feel "Oh, she's done this before." Also, I just say you decide and I'll help or tell the family where they can get more information."

Cherryhill Healthy Ageing Program volunteers were also asked to provide feedback about the role of citizens and communities in decision-making related to community health needs, as well as whether community members should have a responsibility in raising the funds necessary to meet community health needs. The majority of volunteer community members feel that older people should be involved in decision-making regarding their health needs and those of the health needs of their neighbours. Likewise, the majority of volunteers reported that community members should take an active role in fundraising to support the health programs and services required within their communities, and to complement funding provided by the government.

Suggestions from Community Volunteers

- better advocacy is needed for seniors without families
- need information first, then trust will follow
- need staff visibility & consistency; minimize the number of different staff coming & going; have the same staff in at a regular time, on regular days; 2 days per week of staff support is not enough
- need a very clear picture of what is expected from volunteers in each position; need standards & clear processes
- volunteers must feel confident that professional support is readily available
- volunters need to get along better; if they have a personality difference, they should overcome it

"The biggest problem is finding a family doctor! So many people are coming in and asking for help finding a doctor. Doctors just aren't accepting new patients!"

"A lady came in to the health centre. She said "Can I bring my friend in? She had a fainting spell in the library." We told her yes. The nurse was here and spent nearly an hour with her. Her blood pressure was very low . . . . way down! The nurse provided advice, and talked to the woman's daughters."

"A young man came in and asked if he could rent a shower. We said no and suggested he try the health club or the YMCA. He said that wouldn't do, that he'd had an operation and needed to cleanse the wound. We gave him information on who could help him."

"They come in and they pour their hearts out to you!"

"A man came in for help. He'd had heart surgery in the past and his wife was disabled. He asked for help with his wife. He said "the only thing the CCAC will do is bathe my wife. That's the only thing I can do. I need help with other things."

"A couple came into the health centre. He was in a wheelchair. His wife could hardly push him. He had a rash. On his arms, hands, face . . . all over! He was covered. He pushed up his shirt, it was every where! She had it too. He was begging for some kind of help."

"The 'bag lady' came in one afternoon at 3:45 p.m. We call her that because she won't tell us her name or where she's from. She's here all the time with all her belongings in a shopping cart. She came in and started loading all our brochures into her shopping cart. One of the volunteers said "Can I help you?" She said "I need these". She kept on loading her cart. It was 4:00 p.m. and we had to close. She just kept going. She was quite rude and said "well, I'm not finished!" She was beligerant; her tone was threatening. Her cart was just full of stuff. She got very nasty but finally she did leave. We've had a few more incidents with the 'bag lady'. She hangs around. She camps out on one of the benches. She smells and she can become violent.

When new programs are being implemented care should be taken:

- to ensure that programs are well organized & that a formal system is in place to share program information with all volunteers
- to ensure that programs are self-contained if provided by external partners (e.g., they bring their own supplies; clean up after the program; etc.) so that volunteers who happen to be in the health centre are not suddenly & unexpectedly pressured to do things
- to share information in the most effective way; printed information is not the same as information that is verbally presented; verbal presentations are more effective
- when money is involved; volunteers should not be asked to handle or collect money
- to communicate well; good communication is essential

Vounteers also recognized the need for more involvement by others but were not sure how to best facilitate this.

A force-field analysis (Figure 18) was used to track community-identified factors that influence capacity building in the Cherryhill community. Community volunteers were asked to identify the driving forces (greatest successes) and restraining forces (greatest challenges) they experience in their work with the Cherryhill Healthy Ageing Program. Community members were also asked to reach consensus on what they believed older individuals are willing and able to do as it relates to their own health, and the health and independence of their neighbours.

"Seniors want to live independently as long as possible. I know a lady whose hip was broken and she kept falling because of this break in her hip and she thought she shouldn't tell anybody because she didn't want to go into hospital because they always put them into a nursing home for recovery and she thought I'll never get back to my home again".

Figure 18: Greatest successes and challenges experienced by community volunteers.

+ **GREATEST SUCCESSES** DRIVING FORCES			**GREATEST CHALLENGES** - RESTRAINING FORCES
HELPING PEOPLE			COMMUNICATION & DIRECTION
being of service	→	←	lack of communication with Parkwood
being able to help people find the best information for their particular problem	→	←	keeping up with changes when there is not a full-time person to turn to
knowing where to refer & rerfering people who need help	→	←	too many different staff coming & going; not knowing which staff is on for the day you are
having a place where people can come on an ongoing basis	→		working; there is no one with whom to discuss day-to-day issues
		←	lack of communication about who is doing what
ENSURING SAFETY		←	volunteers who do not read or use the communication book
helping people feel more secure in their homes	→	←	finding a spare volunteer at the last minute
knowing I am able to help my neighbours	→	←	not knowing what you should do in some cases
helping someone in distress	→		
checking on neighbours twice a day to make sure they are safe	→		WORKING TOGETHER
		←	working with volunteers who have a "bone to chew" with another volunteer & bringing personal issues into the conversation
BUILDING TRUST			
at first people were hesitant, but now I know they trust me	→	←	listening to volunteers' petty differences & their way of trying to be boss
being able to answer the many questions people have who won't ask anyone when they need help	→	←	need an ongoing report of financial situation
meeting people & creating a feeling of trust between us	→	←	government should be more financially involved; we should not have to worry about finances
improving trust	→		
		←	financial help is needed from the Ontario Ministry of Health
ALLEVIATING LONELINESS & SOCIAL INTERACTION			
			HEALTH SERVICE GAPS
talking to people, many of them are very lonely	→	←	helping people that are lonely; we can talk to them but sometimes this is not enough
visiting neighbours who are lonely	→	←	knowing there are many people that should be monitored to ensure they are safe, but they refuse to become involved or accept help
providing the necessary communication for elderly people who are on their own	→	←	need to facilitate more of a community atmosphere in the apartment buildings; people are so isolated & it is difficult to make contact generally
the new programs that have been started to bing people out of their apartments	→		
meeting people from all walks of life	→		
getting to know the people in my building	→		
making new friends	→	←	inability to help people who have lost their home care & don't know where to turn
meeting other volunteers & feeling a part of the group at the Health Centre	→	←	need more safety monitors to meet the needs

+ GREATEST SUCCESSES DRIVING FORCES			GREATEST CHALLENGES - RESTRAINING FORCES
LEARNING			FINDING RESOURCES
learned a great deal working in the Health Centre	→	←	not being able to find the resources someone is looking for
learning much more about health problems & the problems associated with aging	→	←	provide more infomation on programs being offered
the Health Centre has become my focal point each & every day; when I first came to Cherryhill I felt down & out; the Health Centre has opened my mind to many things	→	←	easier referencing for health brochures
		←	trying to find space for brochures & keeping the rack neat; it is difficult to find space for new brochures
FEELING APPRECIATED & MAKING A DIFFFERENCE			OTHER SERVICE PROVISION ISSUES
		←	the presence of many people (even 1 extra person) in the Health Centre prevents clients from asking questions; sometimes it seems like a social club rather than a helping service; the client should be the priority & privacy & confidentiality should be maintained; however too professional an atmosphere would make it less inviting
information that we provide at the Health Centre is so useful, informative & appreciated by our clients	→		
how great it feels to help someone	→		
seeing satisfactory outcomes	→		
seeing how successful the programs have been so far	→		
being able to make a difference in someone's life	→	←	phoning family members or contact persons to locate a resident on the Safety program
		←	more use of the phone by safety monitors to check on residents because some don't like to be found in their nightwear by the monitor
OTHER			
the regularity of shifts keeps my day in order	→		
enabling us to meet more of our neighbours & to make life a lot busier & enjoyable	→		HEALTH CENTRE CLEANING & MAINTENANCE
the co-operration of building managers	→		
fund raising is very rewarding; it is enjoyable raising money for our cause	→	←	dirty carpets & mouthpiece on phone (which is covered in lipstick, etc.)
you get back more than you give	→	←	need to replace the vacuum

"Many seniors are afraid to ask about things because they don't think they have enough money to pay for what they need".

"Money should be available to keep the health centre clean. This is a public place. We need a new vacuum cleaner, and it really would be nice if the centre could be professionally cleaned".

"There are so many people who need help here. More people need to be monitored through the safety program, but they don't think they need help. How do you persuade them?"

The Community's "Comfort Zone": *What Older Community Members are Willing & Able to Do*

During the more than six years the Cherryill Healthy Ageing Program has been in operation it has become evident that there is a clear role for volunteer community members in health planning and care delivery. It is also evident that there are roles and functions that they do not feel comfortable with and do not wish to be involved in (Figure 19). In general Cherryhill community volunteers feel very comfortable providing health information, being involved in the day-to-day operation of the health centre, being involved with social programs, operating the safety check program, providing feedback related to the health needs of the Cherryhill community and advocating on behalf of their frailer neighbours. Community volunteers do not feel comfortable being directly involved in the health and medical issues of their sicker, and usually apartment bound, neighbours.

". . . the more "health" you put in, the more uncomfortable volunteers feel, and the more reluctant they are to become involved."

". . . the sicker people are, the more uncomfortable volunteers are to be involved."

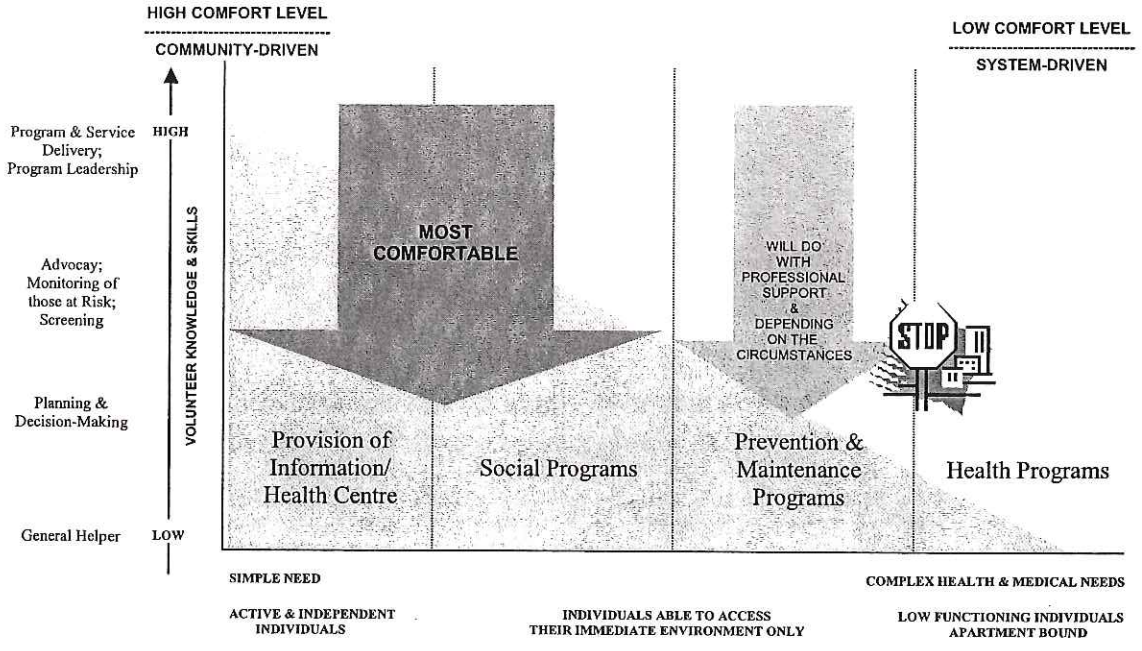


Figure 19: The shifting role of volunteers and their comfort level.

There was consensus among community volunteers that they could play a valuable role in identifying community members at risk, monitoring the health status of their neighbours over time, building relationships and trust regarding the health system, and linking residents in need with the health system. It was agreed that they would be willing to be involved in this. When asked how to best do this, consensus among community volunteers was that this role would best fit with the social programs currently offered, in particular with an expansion of what is offered through the Community Connections Program (Figure 20).

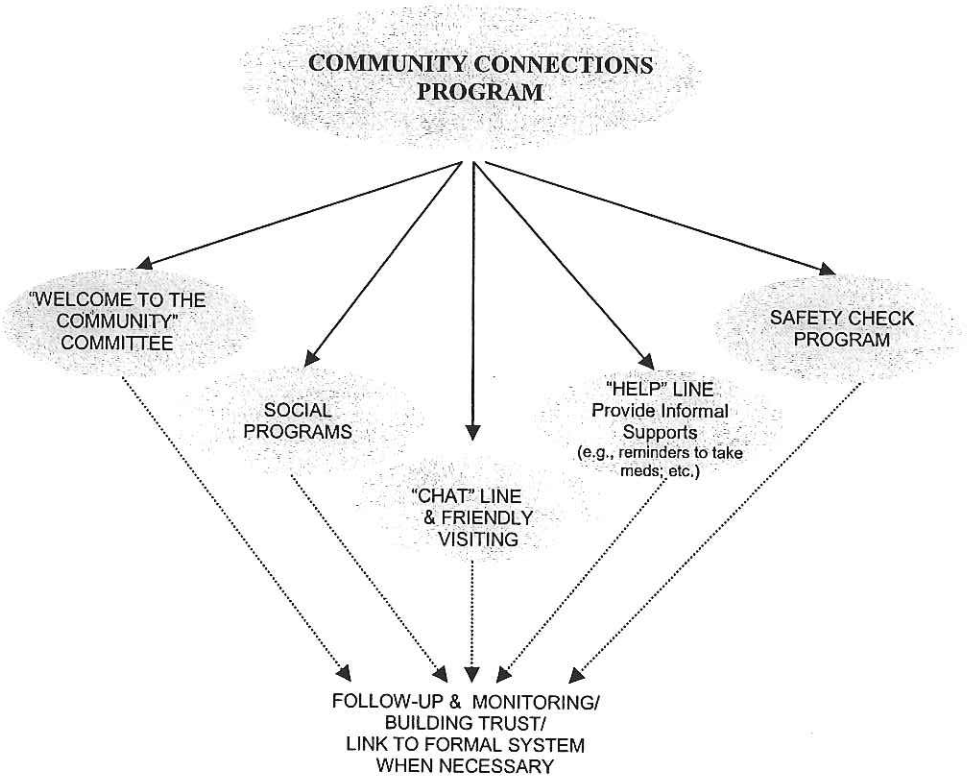


Figure 20: A system proposed by community volunteers that would facilitate monitoring, early identification of those at risk, and quick access to the system when required.

It was agreed that a number of specifically designed programs could be added to the Community Connections Program to address the issues of monitoring, trust and relationship building, and to track the changing health status of individuals over time.

Community volunteers said the following:

> *" YES . . . we can be a "good neighbour' and keep an eye out for people who are not doing well. We can let health professionals know, but they have to take it from there."*
>
> *"People who need help most, don't like the intrusion. Neighbours and volunteers are sometimes viewed as "busy bodies" . . . the key is the relationship you have with the person who needs help."*
>
> *"Providing assistance is different than monitoring . . . we can watch for signs of someone failing, reassure people and let a professional know, but we will not go in to assist in a formal way."*

Using the Right Language . . . What do Older People Prefer?

Many terms are used to describe older individuals. The most commonly used terms include titles such as elderly, geriatric, senior and senior citizen. How these terms are perceived by the individuals themselves was not known. We decided to ask individuals who are growing older how they feel about these designations and how they, themselves wished to be identified. A specific study was designed to identify the preferred language.

Study participants (n=108) were individuals 55 years and older living in the community (mean age=78 years $\pm$ 8.08 years S.D.; range 60-98 years). Sixty-two percent of study participants were females and 38% males. Sixty percent of respondents lived in the Cherryhill community, while the remaining 40% lived elsewhere in the City of London. Cross-sectional survey methodology was used to measure responses to different terms using a 6-point Likert scale ranging from 1 (totally unacceptable) to 6 (prefer it). Respondents were also asked what other terms had been used to describe them, and how acceptable the terms were.

Overwhelmingly respondents preferred the terms "seniors" (m=4.80; S.D.=1.40) and "senior citizen" (m=4.50; S.D.=1.46). The term least liked was "geriatric" (m=1.89; S.D.=1.19). Fifty-four percent of respondents listed this term as totally unacceptable and an additional 20% stated they tolerate it but don't like it. Conversely, 42% of respondents stated they prefer the term "seniors". This finding was consistent with sub-analysis results across sub-categories of "young" old (55-64 years; n=13), "middle" old (65-74 years; n=40) and the very old (75+ years; n=55).

Although "geriatrics" is generally used to describe the medicine of later life, it is clear that this term is very unpopular with all individuals who are growing older. These

findings raise the possibility that seniors' acceptance of services may be adversely affected by the terminology used.

References

1. Baltes, MM. (1988). Etiology and maintenance of dependency in the elderly: Three phases of operant research. Behaviour Therapy, 19, 301-319.

2. Baltes, MM., Mayr, U., borchelt, M., Maas, I. & Wilms, H. (1993). Everyday competence in old and very old age: An inter-disciplinary perspective. Aging and Society, 13, 657-680.

3. Kloseck, M. (1999). Building a self-sustaining community system of health support for the elderly: Determinants of individual participation in voluntary community action. Doctoral Dissertation , University of Waterloo, ISBN. No. 0612512053.

4. Chavis, DM. & Wandersman, A. (1990). Sense of community in the urban environment: A catalyst for participation and community development. American Journal of Community Psychology, 18(1), 55-81.

5. Golant, SM. (1984). A place to grow old: The meaning of environment in old age. New York : Columbia Press.

6. Ishii-Kuntz, M. (1990). Formal activities for elderly women: Determinants of participation in voluntary and senior center activities. Journal of Women and Aging, 2(1), 79-97.

7. Pearce, JL. (1993) Volunteers: The organizational behavior of unpaid workers. New York: Rutledge.

8. Pearce, JL. (1983). Participation in voluntary associations: How membership in a formal organization changes the rewards of participation. In D.H. Smith, J. Van Til, D. Bernfeld & D. Zeldin, (Eds)., International Perspectives on Voluntary Action Research (pp. 148-155). University Press of America.

9. Perkinson, MA. (1992). Maximizing personal efficacy in older adults: The empowerment of volunteers in a multipurpose senior centre. Physical and Occupational Therapy in Geriatarics, 10(3), 57-71.

10. Smith, DH., Van Til, J., Bernfeld, D. & Zeldin, D. (1983). (Eds.), International perspectives on voluntary action research. University Press of America.

11. Wan TTH. & Odell, BG. (1983). Major role losses and social participation of older males. Research on Aging, 5(2), 173-196.

12. Lloyd, P. (1991). The empowerment of elderly people. Journal of Aging Studies, 5 (2), 125-135.

13. Abeles, RP. (1991). Sense of control, quality of life and frail older people. In J.E. Birren, JE. Lubben, JC. Rowe & DE. Deutchman (Eds.), The Concept and Measurement of Quality of Life in the Frail Elderly (pp. 297-314). New York: Academic.

14. Carstensen, LL., Hanson, KA. & Freund, AM. (1995). Selection and compensation in adulthood. In RA. Dixon & L. Backman (Eds)., Compensating for Psychological Deficits and Declines: Managing Losses and Promoting Gains (pp.107-126). New Jersey: Erlbaum Associates.

15. Lawton, MP. & Nahemow, L. (1973). Ecology and the aging process. In E. Eisdorfer & MP. Lawton (Eds.), The Psychology of Adult Development (pp. 619-674). Washington: American Psychology Association.

16. Pastalam, LA. (1982). Research in environment and aging: An alternative to theory. In MP. Lawton, PG. Windley & TO. Byerts (Eds.), Aging and the Environment: Theoretical Approaches (pp.122-131). New York: Springer.

17. Schulz, R., Heckhausen, J. & O'Brien, AT. (1994). Control and the disablement process in the elderly. Journal of Social Behaviour and Personality, 9(5), 139-152.

18. Clark, PG. (1989). The philosophical foundation of empowerment: Implicatins for geriatric health care programs. Journal of Aging and Health, 1(3), 267-285.

19. Labonte, R. (1989). Community and professional empowerment. The Canadian Nurse, 23-29.

20. Kahana, E. (1982). A congruence model of person-environment interaction. In MP. Lawton, PG. Windley & TO. Byerts (Eds.), Aging and the Environment: Theoretical Approaches (pp. 97-121). New York: Springer.

21. Lawton, MP. (1977). The impact of environment on aging and behavior. In JE. Birren & KW. Schaie (Eds), Handbook of the Psychology of Aging (pp.276-301). New York: Von Nostrand Reinhold Company.

22. Knowles, MS. (1972). Motivation in volunteerism: Synopsis of a theory. Journal of Voluntary Action Research, 1(2), 27-29.

23. Maslow, AH. (1943). A theory of human motivation. Psychological Review, 50, 370-396.

24. Smith, DH. (1994). Determinants of voluntary association participation and volunteering: A literature review. Non-Profit and Voluntary Sector Quarterly, 23(3), 243-263.

25. Abbott, M. (2000). Cherryhill Community Response Team: Summary of the Six Month Pilot Phase. An unpublished report prepared for the Middlesex-London Health Unit and the Cherryhill Healthy Ageing Program.

Chapter 7

Optimizing the Involvement of Older Community Members: *Strategies for Success*

- what our evidence tells us
- potentially modifiable predictors of volunteerism
- non-modifiable predictors of volunteerism
- predictors of leadership
- moderating effects of non-modifiable variables
- standards of volunteer involvement
- essential components of volunteer management & unique considerations for working with senior volunteers
  - recruitment, screening & placement
  - orientation, training & development
  - supervision & recognition
- is your organization ready for volunteers?
- unique considerations when involving older volunteers
- benefits & challenges of managing volunteers
- building trust & getting buy-in
- the shifting roles of volunteers . . . . . from helper to leader
- building volunteer capacity
- neighbours as volunteers
- volunteers managing volunteers
- building the partnership
- lessons learned
- references

Our Experience . . . . .

- younger, active, independent seniors are more likely to volunteer
- certain personality traits are more prominant in those who volunteer
- within the volunteer group, age & personality traits also predicted a willingness to lead
- although poorer health & functional ability inhibited volunteering in many, these were not obstacles in older individuals who had a long history of volunteering
- functional ability, activity level & social support resources are potentially modifiable factors which, if improved, could lead to a greater willingness to volunteer
- there are limits to what older volunteers can be expected to do; ongoing staff support is critical
- belief in the project & a phsyical visible presence in the community are essential
- a strong volunteer support structure is necessary if volunteers are to understand their role, perform at a "professional" level, display leadership & take an equal place alongside the formal health service providers

Optimizing the Involvement of Older Community Members: *What does the Evidence Tell Us?*

In proposing a role for older community members in health program development we felt it important to explore the factors which determined why some seniors volunteer and others do not. In part this was to determine if any of the obstacles were amenable to modification. Additionally the challenge of finding volunteers to take on a leadership role was an important challenge that required elucidation.

Many older individuals, once retired, volunteer their time and skills and many do not. As part of the Cherryhill Healthy Ageing Program we examined the factors in people's lives that influence health volunteerism and volunteer leadership. In particular we were interested in those factors over which individuals themselves, and others (e.g., health professionals; community planners; etc.) have some influence. In 1999 we sampled 100% of Cherryhill community residents 55 years of age or older who were volunteering or had made a strong commitment to volunteer with the program (n=107). A comparative sample of non-volunteers (n=74) was randomly drawn from the remainder of the Cherryhill apartment complex in order to determine whether individual differences exist between those who volunteer and those who don't. Cross-sectional survey methodology was used to measure six potentially *modifiable* variables (health, functional ability, well-being, activity level, social resources, environmental conditions). Bi-variate and multi-variate analyses were used to determine predictors of volunteerism and leadership. Moderating effects of non-modifiable variables (age, gender, socio-economic status, personality, life changes, past volunteering) were also examined. Data were collected by means of a questionnaire containing 44 sets of items and scales, administered by a trained research assistant in a face-to-face interview format.

The mean age of participants was 74 years ($\pm$ 9.53 years S.D.); participants' ages ranged from 55 to 86 years. Eleven percent were male and 89% female, and participants had lived in the Cherryhill community an average of 8 years ($\pm$ 7.19 years), with the number of years ranging from 1 to 25 years. Seventy-nine percent were elderly women living alone. Fifty-seven percent of participants reported high school as the highest level of education attained. Other education levels varied from public school (23%), college (16%), bachelor's degree (3%), to master's degree (2%). In terms of income, 34%

reported that with careful planning they usually have enough income to do the things they want, 21% reported that they usually have enough, while 12% reported they have more than enough. Descriptive analyses for the total sample (n=181), the volunteer sub-sample (n=107) and the non-volunteer comparative group (n=74) are outlined in Tables 9 and 10.

Table 9: Socio-demographic differences of total sample, volunteer sample and non-volunteer respondents in the Cherryhill community.

Characteristics	Total Sample	Volunteers	Non-Volunteers
Sample Size (n)	181	107	74
Mean Age	76	74	78
S.D.	8.45	8.4	8.12
Sex			
Male	11%	10%	12%
Female	89%	90%	88%
Number of Years Living at Cherryhill	9	8	10
Marital Status			
Single	11%	12%	10%
Widowed	54%	50%	59%
Separated	4%	6%	3%
Married	17%	15%	20%
Divorced	13%	17%	8%
Common-Law	-	-	-
Living Arrangements			
Alone	79%	79%	78%
With Spouse	16%	15%	19%
With Relatives	3%	3%	3%
With Friends	2%	3%	-
Education			
Standard	79%	84%	73%
Higher	21%	16%	27%
Sufficient Income			
Mean	3.9	3.9	4.0
S.D.	1.4	1.2	1.5

The results indicated that volunteers and non-volunteers were highly similar with regard to demographic and socio-economic characteristics. It was found that elderly individuals who were younger, more active, received fewer health services, experienced fewer limitations in their day-to-day functioning, and those with higher levels of affective

Table 10: Recent life changes experienced by the total sample, volunteer and non-volunteer respondents

Characteristics	Total Sample	Volunteers	Non-Volunteers
Sample Size (n)	181	107	74
Recent Life Changes in the Past Year			
Retired			
Yes	2%	3%	1%
No	98%	97%	99%
Lost a Child			
Yes	3%	3%	4%
No	97%	97%	96%
Lost a Friend			
Yes	38%	36%	41%
No	62%	64%	59%
Lost a Spouse			
Yes	3%	2%	5%
No	97%	98%	95%
Moved			
Yes	9%	10%	7%
No	91%	90%	93%
Diagnosed with a Major Illness			
Yes	18%	16%	22%
No	82%	84%	78%
Required to Provide Primary Care to a Family Member			
Yes	8%	7%	8%
No	92%	93%	92%

(short-term) well-being were more predisposed to volunteering. Likewise, it was found that individuals whose personality characteristics included being extroverted, open to change and agreeable were more likely to volunteer. The majority of elderly volunteers did not take on positions requiring leadership.

These findings compare closely with the National Survey of Giving, Volunteering and Participating which found that 23% of Canadians 65 and over volunteer for a charitable and non-profit organization, and those who volunteer tend to be the younger seniors. While this was the lowest percent of all age groups volunteering, seniors in the National Survey contributed the highest number of volunteer hours of all age groups.

NO DIFFERENCES BETWEEN VOLUNTEERS & NON-VOLUNTEERS IN:

- demographic & socio-economic characteristics including:
  - gender
  - marital status
  - length of time living in the Cherryhill community
  - education
  - income
  - occupational skill
  - recent life changes
- health (subjective & objective)
- well-being (disposition)
- environmental satisfaction (physical & social)
- past volunteer behaviour (pre-retirement)
- social resources (number of social supports & social support satisfaction)

SIGNIFICANT DIFFERENCES BETWEEN VOLUNTEERS & NON-VOLUNTEERS IN:

Potentially Modifiable Factors

- functional ability
- well-being (affect)
- social resources (support available when upset)
- activity level

Non-Modifiable Factors

- age
- personality

Potentially Modifiable Predictors of Volunteerism

Functional Ability:

There was a significant difference in day-to-day functioning of volunteers and non-volunteers, t(175) =-2.58, p=.01. Non-volunteers reported receiving a greater number of health services than volunteers, chi-square=12.49, p=.002, df=2, n=181. Non-volunteers required significantly more assistance with light housecleaning than volunteers, chi-square=7.68, p=.005, df=1, n=181. These findings are consistent with the selective dependency theory outlined in Chapter 3.

Well-Being (Affect):

Volunteers were more positive and satisfied with their life during the past month (m=11.11, S.D.=1.26) than non-volunteers (m=10.70, S.D.=1.38), p=.05.

Social Resources:

Volunteers reported a greater number of individuals to support them when they are upset (m=2.14, S.D.=1.23) than non-volunteers (m=1.61, S.D.=1.23), p=.01.

Activity Level:

A statistically significant difference in activity level was found for volunteers and non-volunteers, t(155) =2.13, p=.03. (Figure 21).

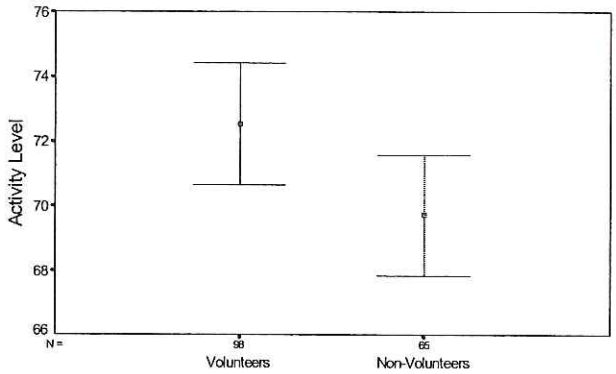


Figure 21: Error bar chart showing the means and standard deviations in activity participation by volunteers and non-volunteers as measured by the Activity Checklist.[1]

Non-Modifiable Predictors of Volunteerism

Age:

Volunteers were younger (m=74 years, S.D.=8.39) than non-volunteers (m=78 years, S.D.=8.12), t(180)=-2.82, p=.005 (Figure 22).

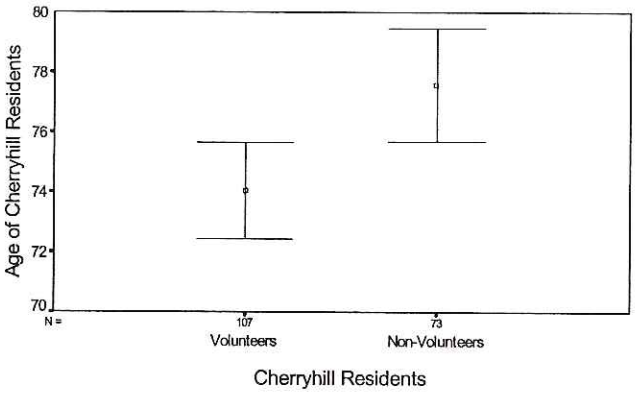


Figure 22: Error bar chart showing the means and standard deviations in age of volunteers and non-volunteers.

Personality:

Statistically significant differences between volunteers and non-volunteers were found for three of five personality characteristics: extroversion (t(179)=2.75, p=.01); openness to experience (t(178)=2.55, p=.01); and agreeableness (t(178)=1.96, p=.05) (Figure 23). Personality was measured on a 6-point Likert scale ranging from 1 (not at all like me) to 6 (exactly like me) based on the work of McCrae and Costa.[2]

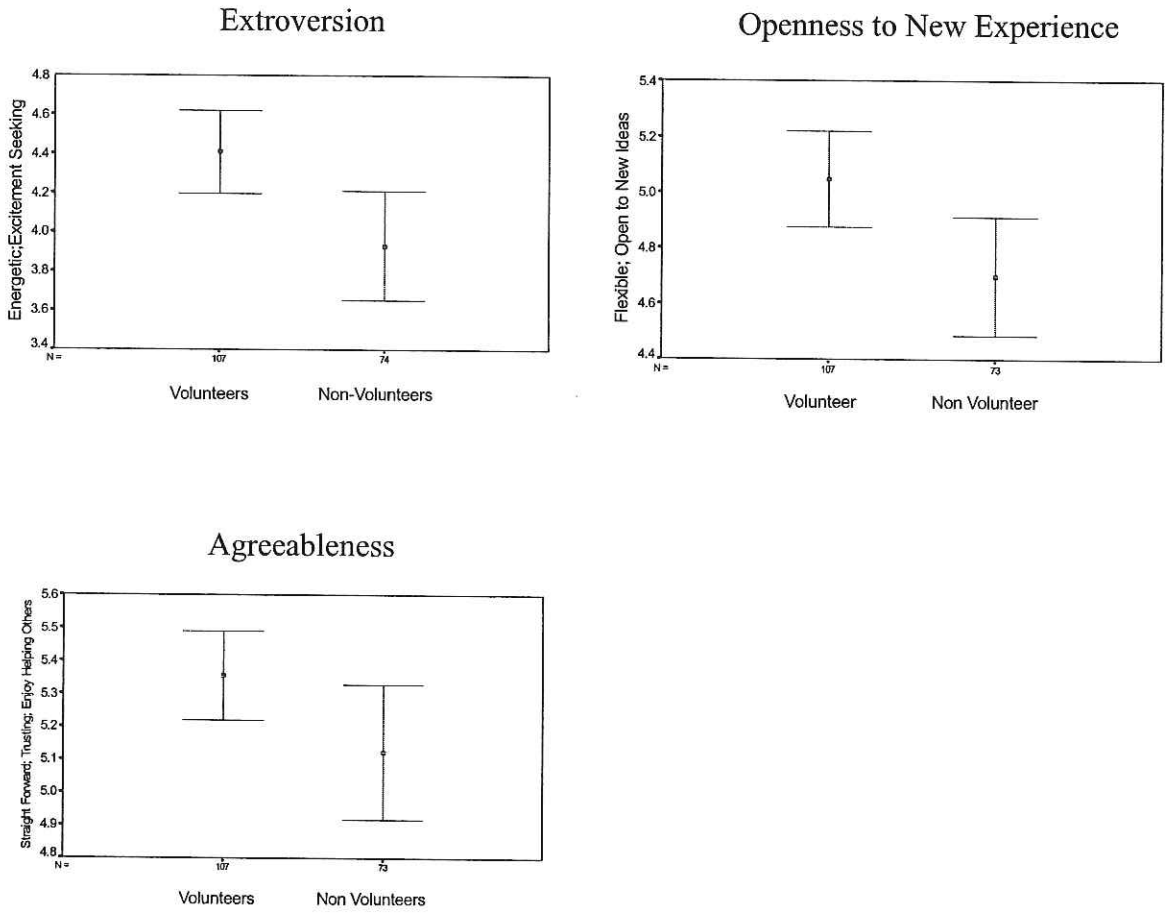


Figure 23: Error bar charts showing the means and standard deviations in extroversion, openness to new experience and agreeableness of volunteers and non-volunteers.

Predictors of Leadership

The majority of volunteers reported they would *not* assume a leadership role. Only about 2% of volunteers expressed a willingness to take on a leadership position in 1999. There were no significant relationships between modifiable variables and willingness to take on a leadership position. Significant relationships were found with three of the non-modifiable variables:

- age was significantly negatively correlated with volunteer leadership ($r=-.25$, $p=.02$)
- personality ("extroversion" trait dimension) was significantly positively correlated with volunteer leadership ($r=.24$, $p=.02$)
- personality ("agreeableness" trait dimension) was significantly positively correlated with volunteer leadership ($r=.28$, $p=.01$)

Moderating Effects of Non-Modifiable Variables

Exploratory factor analysis with varimax rotation was used to reduce modifiable variables to two factors. The factor analysis supported a 2-factor structure: Factor 1 psychosocial/environmental factors and Factor 2 health/functional ability factors. All factor loadings exceeded the .51 level for Factor 1 and the .65 level for Factor 2, both factors having Eigenvalues greater than 1.00. These two factors were then used in a series of hierarchical regression analyses to examine potential interactions between modifiable and non-modifiable variables. Four interaction effects were found to be significant. Older individuals with *little past volunteer involvement* are more likely to volunteer when they are in good rather than poor health and when their functional ability is good. For older individuals with *high past volunteer involvement* the state of their health and functional ability did not seem to matter; they were equally involved whether their health and functional ability was good or poor (Figure 24). A person's personality ("conscientiousness" trait) moderated the influence of health/functional ability on health volunteerism (Figure 25). Likewise a person's age (Figure 26) and personality ("openness to new experiences" trait) (Figure 27) interacted with health service utilization to influence volunteer leadership, such that those younger and more open to new experiences were more willing to take on a leadership role even if they required health service support.

Overwhelmingly, the ability of older individuals in the Cherryhill community to get out of their apartments on a day-to-day basis influenced involvement. Thus, consistent with the theories in Chapter 3, maximizing older individuals' independence may facilitate greater volunteer involvement in health planning and care delivery.

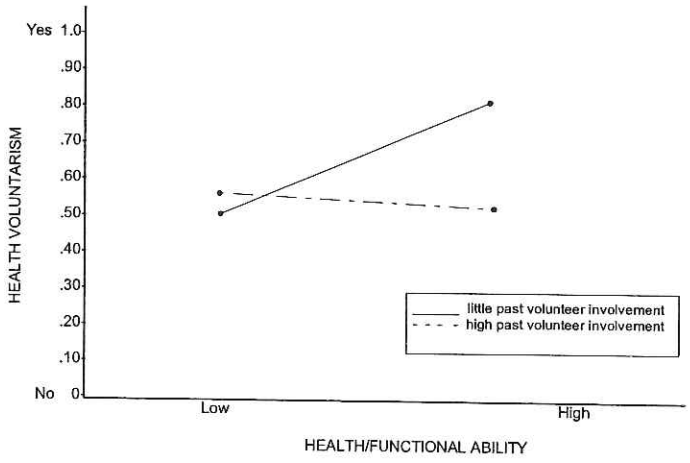


Figure 24: Health volunteerism of Cherryhill residents as a function of past volunteer behaviour and health/functional ability.

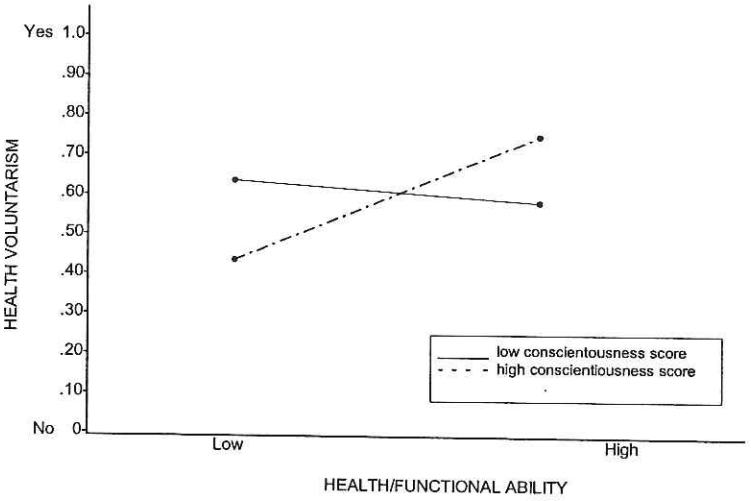


Figure 25: Health volunteerism of Cherryhill residents as a function of the "conscientiousness" trait dimension of personality and health/functional ability.

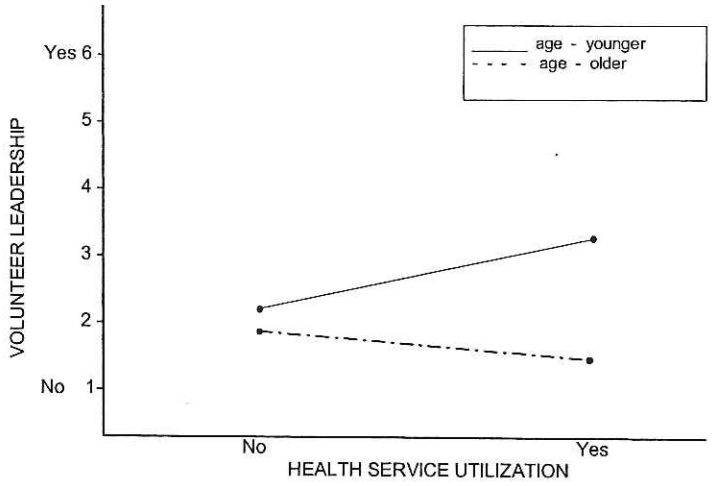


Figure 26: Volunteer leadership by Cherryhill residents as a function of age and health service utilization.

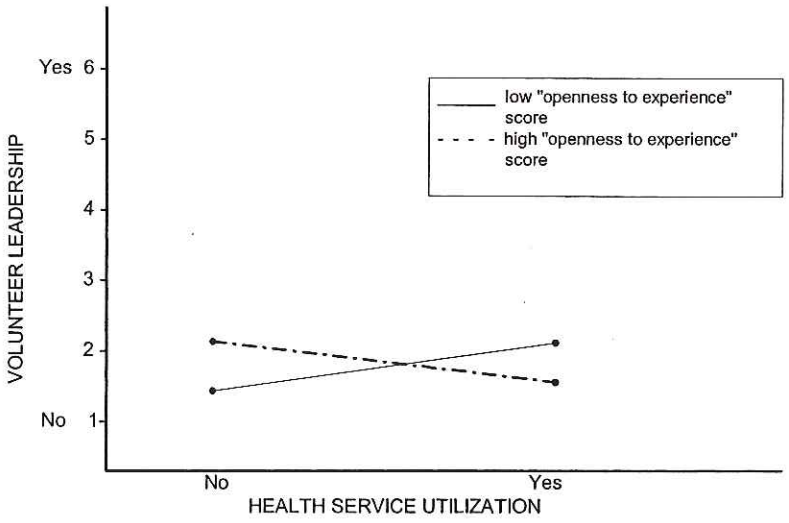


Figure 27: Volunteer leadership by Cherryhill residents as a function of the "openness to new experiences" trait dimension of personality and health service utilization.

Standards of Volunteer Involvement

Volunteers are a vital human resource. Volunteer involvement mutually benefits both the volunteer and the organization by increasing the organization's capacity to achieve their mission and goals, and by providing volunteers with opportunities to develop and contribute.[3] This unique relationship gives rise to many considerations that should be addressed by organization leaders before they begin their work with volunteers. Questions to ask about volunteer involvement include: What is the best fit for volunteers within the organization? What can volunteers expect from the organization? What resources need to be in place to support them? How can volunteers be effectively managed and recognized for their efforts from day to day?

> *"By adopting standards, organizations make a public statement about the importance of volunteers and the necessity to manage this important resource effectively."* [3]

Standards for volunteer involvement help an organization ensure that its volunteers are sufficiently supported and treated with respect, that their involvement is aligned to organizational goals, and that, in turn, the organization is committed to its volunteers and the appropriate infrastructure is in place. The *Canadian Code for Volunteer Involvement*[3] defines standards that uphold the important values and benefits received from volunteer involvement, and provides a framework for decision making by an organization. The code consists of three elements:

1) statements around the importance and value of volunteer involvement
2) principles detailing the exchange between voluntary organizations and volunteers
3) standards that organizations should consider in developing or reviewing how volunteers are currently involved

Highlights of the standards[3] pertaining to organization infrastructure are:

- volunteers are acknowledged and treated as valuable and integral members of the organization's human resources
- volunteer management policies and procedures are in place that define and support volunteer involvement
- volunteer assignments reflect the needs of the organization and engages volunteers in meaningful ways

Essential Components of Volunteer Management & Unique Considerations for Working with Senior Volunteers

An organized effort is required to provide an environment within which volunteers may contribute and excel. Effective volunteer management practices need to be put into place. The fundamentals of volunteer management are:

- recruitment, screening & placement
- orientation, training & development
- supervision and recognition
- volunteer program evaluation

A volunteer program is a framework for the ongoing management of an organization's volunteer resources. The program should address a diversity of management issues such as volunteer screening, matching, record keeping and evaluation, legal issues/risk management, volunteer/staff relations, conduct, ethics, delegation, communication, training, motivating and recognizing volunteers, etc. Policies and procedures are developed to provide overall guidance and direction to staff and volunteers about all aspects of volunteerism. Volunteer materials, such as posters, handbooks, position descriptions and manuals, are used to recruit and inform volunteers about the organization and their assignment. Forms such as for application, consent for photography and confidentiality are developed for volunteer intake processing. Volunteer programs are governed by federal and provincial *Human Rights Codes*. They must comply with the *Freedom of Information and Protection of Privacy* and *Provincial Employment Standards* legislation.[3] All relevant legislation should be reviewed by volunteer program leaders and incorporated into policies. Practical advice for the development and implementation of a volunteer program can be readily found in the literature on volunteerism.

The volunteer program for the Cherryhill Healthy Ageing Program was developed over time. As a starting point, several working principles were identified:

- to build on existing tools and processes
- to adhere to industry standards
- to work within limited resources
- to be adaptive to changing needs

A committee was struck to handle the development and operation of the volunteer program. To help coordinate the combined administration efforts of both volunteers and staff, a volunteer intake process was charted that details procedures and responsibilities from the recruitment stage, through to the development and retention stages (Appendix J).

Recruitment, Screening & Placement

Recruitment involves letting the community know about the organization's volunteer opportunities and making direct overtures to people to volunteer. Recruitment may be targeted to a specific group of people or skill area, or targeted to a broader population. An understanding of what will motivate people to volunteer for the organization is helpful. Position descriptions providing details of what the activities entail should be drawn up for every opportunity offered. Strategies for getting the word out include brochures and flyers, posters and media advertisements, volunteer directories and referral services and networking with community groups and leaders. Many people volunteer for organizations they already know and have an interest in. Often friends and relatives make a recommendation. In fact, the volunteer management literature indicates that word-of-mouth is one of best ways to recruit volunteers.[4]

Screening potential volunteers helps an organization determine their suitability and risk to the organization and to the assignment. Standard screening steps involve application, interview and reference check. A completed formal application (Appendix K) gives the organization useful information about the potential volunteer such as skills, experience and interests to help the organization understand how best to use the individual's talents. The ensuing interview is an opportunity for organization leaders and the individual to meet one-on-one and have questions answered of one another. Depending on the organization and nature of the volunteer position, a criminal or police records check and a medical check may be undertaken if appropriate.[5] The higher the level of risk assessed of the assignment, the more in-depth the screening process. For example, volunteers working with vulnerable people (i.e., a child or an elderly person) in an unsupervised setting (i.e. the client's home) would constitute a high risk. The *National Campaign on Screening Volunteers and Employees in Positions of Trust with Children and Other Vulnerable Individuals* (Volunteer Canada) makes available training and other resources about screening volunteers that are Canadian relevant.

Police Records Check The *National Campaign on Screening Volunteers* documentation[6] describes the use of police information systems as an important screening measure. A police records check secures information from the police about potential volunteers and may include a check of national or local police records. A report is issued that at a minimum identifies whether or not someone has a criminal record, or it may provide details of actual offences. Police use different procedures from region to region.

Placement occurs upon successful completion by a candidate of the screening process. Based on information acquired during the screening process, a volunteer is assigned to an opportunity that both parties agree is suitable to skills and interests. Some volunteer opportunities require that a volunteer be matched to a client who shares similar interests. Placement and matching help to ensure that a volunteer will be able to contribute in a way that is not only meaningful to them, but also to the organization.

Orientation, Training & Development

Orientation ensures that the volunteer has a thorough understanding of the organization, its goals, history and structure. Training ensures that a volunteer is well prepared to undertake the volunteer responsibility. Training can include acquiring communication skills (e.g., active listening), technical skills for performing duties (e.g., information and referral, computer, etc.) and enhanced knowledge of relevant topics (e.g., health services, aging, etc.). Additional training may be provided on occasion to increase understanding of a specific topic area.

During this stage, volunteers are introduced to the policies and procedures that will guide their decision-making, including conduct and other ethical issues. A confidentiality agreement, non-discriminatory policy, non-judgmental policy (addresses the need to withhold personal value judgments) and code of conduct may all be presented to the volunteer for signature. Special forms may also be prepared to give the organization permission to act on the volunteers' behalf such as the use of photographs and video images in publications and other promotional materials.

Confidentiality Agreement When volunteers are required to interact with clients, a Confidentiality Agreement should be developed and put into practice. The agreement addresses the importance of confidentiality with respect to handling the personal information of clients. This agreement can be witnessed by a third party and signed by the volunteer early in the intake process, usually at the time of orientation.

Supervision & Recognition

As a human resource, volunteers require supervision and coaching on a daily, ongoing basis. Someone within the organization with the appropriate skills and interest should be designated to be responsible for the volunteers and the volunteer program. This volunteer leader should be there to listen, communicate, motivate and problem-solve and delegate tasks and responsibilities. Most importantly they must encourage volunteer feedback. A confidential volunteer program record keeping system should be put into place to track volunteer involvement over time. This file could store applications and other forms signed by a volunteer as well as performance reports. Volunteer data can include total time volunteered, positions held, duties performed, achievements, etc. The volunteer program leader should have an awareness of legal, accountability and legislative issues in the area of human resource management.

Volunteers should be formally recognized for their contributions on a regular basis through such methods as awards, certificate of achievement, gifts, appreciation dinner, and other recognition activities. However, even more important is informal recognition of contributions on a daily basis by colleagues, staff and program leaders.

Outright dismissal of volunteers is a challenging proposition at Cherryhill because of the strong community ties and importance of citizen participation. Difficult situations are diffused over time by offering alternative duties, providing one-on-one guidance and reinforcing policies and procedures. Resolution often comes when the volunteer realizes that a change is necessary. Volunteers are extremely dedicated to the project and usually resign because they feel they are unable to maintain the same level of commitment.

Volunteer Program Evaluation

Evaluation of the volunteer management program helps program leaders understand whether it is effective and identifies areas for improvement to help the organization better involve volunteers. There are two types of evaluation:

- measuring a volunteer's performance
- measuring volunteer program effectiveness

The former gives the volunteer important feedback so that they may work closer to their potential. The latter examines the programs strengths, weaknesses, recommendations and future plans. Indices of performance and success can be developed to use as measurement tools. Data used in evaluation include measuring program performance against goals and activities, volunteer records, and data from informal volunteer feedback and volunteer satisfaction surveys. In addition, program leaders may want to evaluate specific programs run by volunteers and whether volunteers are operating as an effective force (for further details see volunteer capacity section).

Is Your Organization Ready for Volunteers?

An *Organization Readiness Checklist*[3,4] (Table 11) will help your agency determine whether all the key components are in place to begin working with volunteers. There are many things to consider when working with volunteers. For example:

- ensure that volunteer skills are matched to volunteer opportunities
- apply a consistent approach across all programs and/or volunteer opportunities
- include a learning and capacity building component to facilitate volunteer retention
- apply relevant legislation & current best practices in human resources (e.g., oath of confidentiality; police records check; etc.)
- enable & ensure frailer older community members (and other minorities) take an active part in volunteering
- facilitate linkages & collaborate with partner agencies
- provide a structure within which volunteers can successfully contribute & thrive

Table 11: An Organization Readiness Checklist [3,4]

- ☐ organization leaders have shown their support
- ☐ a volunteer program budget is allocated
- ☐ expectations for, and the role of, volunteers are clearly articulated and understood by everyone within the organization
- ☐ a qualified person is designated to manage the volunteer program
- ☐ legal and liability issues pertaining to volunteer involvement are resolved such as a screening process and necessary insurance
- ☐ policies, procedures and record keeping systems are in place
- ☐ the logistics of where, how and when have been worked out pertaining to volunteers' performance of duties
- ☐ volunteer materials (recruitment ads, position descriptions, handbooks) are developed and produced.
- ☐ everyone who will be involved in working with volunteers is supportive, trained and knowledgeable about the intake process, able to answer questions

Unique Considerations When Involving Older Volunteers

Some of the specific issues that arise when working with older volunteers, as well as helpful tips for the volunteer program leader are as follows:

- ₪ older volunteers have a vast wealth of life experiences to share; make use of the knowledge and skills they possess
- ₪ older volunteers are not a homogeneous group; "young" older volunteers have very different life experiences and needs than "old" older volunteers
- ₪ ill health is cited frequently in the peer support literature as having a detrimental impact on the volunteer involvement of the elderly[7-12]

- one to two years can have a major impact on a volunteer's health, changing interests and abilities and the amount of time they can contribute[13]

- be flexible; create a variety of opportunities, such as temporary and casual, to allow for changing interests and abilities; maintain a ready supply of back-up volunteers to fill gaps

- recognize that volunteers may themselves become short or long-term clients of the health programs offered; during and after an illness, respect a volunteer's desire to return to the volunteer program

- older adults may not have worked outside the home consequently may lack general business skills

- set a reasonable pace; change and the introduction of new ideas can be difficult to handle and take time to become comfortable; the project's community setting may make for slow acceptance of outsiders

- pay attention to the introduction of programs! Too many new programs introduced in quick succession can be overwhelming for elderly volunteers; a time-limited funding grant to the Cherryhill program necessitated the development and implementation of many new service programs; communication between staff and volunteers was especially critical during this time; a process was charted to ensure volunteers were informed and fully able to participate in service planning and delivery

- partner if you can; working with volunteers is time intensive; coordinating the volunteer management program with that of another organization not only brings additional resources, but expertise as well; the Cherryhill program partnered with a community dining program (Meals on Wheels, London) to recruit, train and supervise volunteers for a friendly visiting program; this partnership enabled a police records check screening process to be implemented quickly

- mobility and transportation issues can seriously affect the ability of elderly volunteers to participate; combat this by holding volunteer activities in accessible locations and introducing decentralized programs; a good example of the latter is a telephone chatline service where volunteers call a housebound senior from their own homes; if possible, the work location should be on a bus route and have disability parking; check to see if accessible transportation services are available; a community bus in Cherryhill provides door-to-door service between the apartment buildings and the mall

- younger older adults are excellent helpers to frailer colleagues; volunteers are willing to compensate for the deficits of their fellow volunteers; this is an effective way in which those with disabilities associated with aging, even mental incapacities, can be accommodated so that the individual can continue to volunteer and be a part of the program

- remember that just like younger people, older adults volunteer for a variety of reasons including altruism, skill building and a sense of belonging; however, the social aspects of volunteering are particularly important to the latter group, with acquiring of new skills and networking for employment reasons much less so; older volunteers also tend to have much more time to give

Benefits & Challenges of Managing Volunteers

One of the strengths of the Cherryhill Healthy Ageing Program are the loyal and dedicated volunteers, who are very committed to the project and identify strongly with its values and goals. Their vast wealth of experience and their knowledge of and familiarity with the community are particular strengths of note. Harnessing this enthusiasm can, however, be challenging for the volunteer program leader. Table 12 outlines some additional challenges that were faced along the way.

A part of the challenge of working with volunteers is losing them to other interests. There are various reasons as to why volunteers resign. Some are unavoidable and should be recognized as part of the nature of volunteerism. For example:

- acute and chronic ill health
- extended travel
- relocation to another community
- full-time work after retirement

However, others can be mitigated through good management practices. For example:

- incompatibility with new direction or growth of program (e.g., new responsibilities such as fund raising, change in duties, etc.)
- personality conflicts
- desirable of a change from the type of work available
- over commitment with neglect of family life, caregiving or other leisure activities

Table 12: Challenges in volunteer management experienced by the Cherryhill Healthy Ageing Program

MANAGING CHANGE

- it is difficult to keep up with the rapid growth of a program
- communication must be constant for volunteers to continue to contribute meaningfully and feel they are a valuable part of the program
- planning flexible approaches that can be adjusted as needed is essential when dealing with uncertainties

ENSURING CONTINUITY OF SUPERVISION

- ill health and a general reluctance to serve in a leadership capacity can create gaps in supervision
- volunteers and program leaders bond with the result that changes to leadership can to be difficult for volunteers to handle

PROVIDING ADEQUATE TRAINING

- program leaders should be sensitive to a volunteer's background and skill level
- never put volunteers at risk of failure because an incorrect assumption has been made about their capabilities, even for the simplest of tasks

ENCOURAGING VOLUNTEERS TO TAKE ON NEW ROLES (ESPECIALLY POSITIONS OF LEADERSHIP)

- volunteers are generally reluctant to take on positions of leadership
- leaders are usually experienced volunteers with special skills and abilities

DEFINING THE ROLE OF VOLUNTEERS vs. STAFF

- misunderstandings about expectations can result in tensions and an "us vs. them" mentality

MANAGING INTERPERSONAL DYNAMICS

- volunteers are human
- not everyone has the same beliefs, interests and approaches to life
- providing an organizational culture that encourages mutual respect and the striving for a common goal can help to dispel personality conflicts

WORKING WITH INSUFFICIENT HUMAN & MATERIAL RESOURCES

- a lack of resources is a constant challenge when there is no secure funding
- there are many operational costs to involving volunteers that should not be overlooked
- it is wise to develop a budget for the volunteer program early in the planning stages

Building Trust & Getting Buy-In

Building and strengthening relationships among community members and other partners to help them to help themselves is the cornerstone of community capacity building. And establishing trusting relationships is an essential first step. Trusting relationships, which are based on an environment of mutual respect, honesty, confidence and reliance, are necessary when people of differing backgrounds and perspectives work together collaboratively. Building trusting relationships takes considerable time and effort. Trust in group situations is more difficult to form than trust between individuals. For this reason, effective group trust involves working on a personal level with individuals in the community.

The introduction of new staff members and other service providers can present challenges. Building trust, respect and commitment can be a long, slow process. This is especially the case in a neighbourhood of elderly residents where there is a strong sense of community and an inherent mistrust of the health professional. The initial approach in a trust building process is critical and can significantly impact a service provider's acceptance by the community. Friendly, respectful, caring and committed are attributes that make favourable impressions. Younger people, in particular, because of the disparity in age, attitudes and behaviour need to ease slowly into a senior-oriented community. A combination of patience and persistence was necessary for the community planner to become accepted by the community. Effective strategies employed in Cherryhill include initially meeting with one or two community members to listen to their point of view, gain an understanding of their experiences and to build consensus around possible direction. Significant changes should be made over time with the support of volunteers. Trust is reciprocal and means sharing control. An understanding that many volunteers have held positions for a long time and are used to doing things a certain way is helpful.

STRATEGIES FOR ESTABLISHING PERSONAL CONTACT[14]

- ☐ Establish personal relationships with people in the community; identify,work with & support individuals who are key community leaders whom seniors already trust & respect.
- ☐ Use curent volunteers to become close to the social network.
- ☐ Develop & maintain open lines of communication.
- ☐ Speak to community groups, make phone calls & have seniors contact other seniors.
- ☐ Stay in touch & repeat contact as often as necessary.

A sense of ownership on the part of community members must be present for buy-in and sustainability to occur. Seniors must identify with the project and have a strong belief in its values, which, in turn, contribute to their willingness to come forward and participate. Credibility is also important and can be enabled by integration into community life.[15] The location of a storefront in a neighbourhood setting, such as the mall with the Cherryhill Health Promotion & Information Centre, increases the opportunity for the program to become a part of that community[16], as does partnership with neighbourhood programs like the activity centre and residents' association. Credibility can be borrowed through close association with other established and respected programs or institutions. For example, the Cherryhill project is affiliated with a large health care institution, partners with other established community agencies and is endorsed by health care professionals.

There must be highly motivated volunteers within the community that are willing and able to carry out the project.[17] Most new candidates are referred by current volunteers who are friends or neighbours. This is consistent with research evidence which shows that most volunteers participate as a result of having been personally asked rather than self-initiating their involvement.[18, 19] A sense of inclusion is extremely important for most volunteers. The social aspects of volunteering are of particular value to seniors, many of whom live alone. Social activities offer a great way to sustain individual contact and encourage participation. Open houses have been held to introduce new programs; parties to celebrate holidays, give recognition and say farewell. Senior volunteers are usually willing to help organize these fun and enjoyable types of activities. Activities that suit the unique nature of the community work well. An event can be integrated into traditional activities.[14] Bake sales for raising funds are enjoyed by everyone and are easy to provide within a mall setting. Encourage teamwork, build on successes and word will spread quickly.

TIPS FOR BUILDING TRUST & GETTING BUY-IN

- ☐ Be respectful and show you genuinely care. Show you are worthy of receiving trust.
- ☐ Listen to and acknowledge community members.
- ☐ Create a non-threatening (physical and emotional) environment.
- ☐ Keep the lines of communication open and apply a consistent message.
- ☐ Share control and foster teamwork. Do collective group planning and problem-solving.
- ☐ Trust is reciprocal. Allow opportunities for community members to give back.
- ☐ Recognize similar goals.
- ☐ Foster personal connections.

The Shifting Roles of Volunteers . . . From Helper to Leader

Cherryhill volunteers are involved at all levels of the organization and fill varied roles. The majority of Cherryhill volunteers serve as helpers while a few serve in a leadership capacity. Helpers deliver services and may take on special assignments such as minute taking, processing of statistics and pamphlet organization, or may serve on task-oriented committees such as fundraising. Although all volunteers have a voice in decision-making, leaders assume a greater responsibility for the direction and implementation of the project. They coordinate programs, represent members of the community, serve on committees and boards and are a vital link between volunteers and staff as well as other partners who represent the formal system. Theoretically, volunteers can progress through the ranks from helper to positions of increasing responsibility. The continuum of volunteer involvement at Cherryhill, from non-participant to leader, is shown in Figure 28. With increased responsibility, comes greater influence in governance and policy issues.

Individuals seldom come forward on their own to take on additional responsibilities or new roles. New volunteers first need to establish a familiarity with the project, their colleagues and role expectations. For this reason, volunteers who take on positions of more responsibility are usually drawn from the existing volunteer pool. They must be approached and encouraged on an individual basis. Recognizing each volunteer's potential is important for suitable matching to leadership opportunities. A full understanding of the requirements of the position or task and knowledge that ongoing support is available increases the volunteer's comfort level and is helpful in their decision-making around acceptance of new positions. Often individuals who are willing and able to serve in a leadership capacity are 'natural leaders' in the community. Natural leaders are individuals who are actively engaged in their community and are sensitive to the beliefs, traditions and needs held within it.[17] Natural leaders are usually people of influence and are able to stimulate the support and enthusiasm of their fellow community members.

Cherryhill volunteer leaders play an instrumental role in providing support to fellow volunteers. Program coordinators, in particular, work closely with volunteers who deliver services. Coordinators not only direct work, but because they are readily accessible within the community, they serve as the first point of contact for volunteers. Good supervision, people and organizational skills are required. Because of the level of responsibility, the multiple positions held, and other community commitments, leaders can easily become overburdened. Combined with the decrements of aging, the result can be increased fragility. Beyond the obvious detrimental impact on the health of the individual, the continuity of program leadership is impacted as well. Leaders are highly motivated with a strong desire to get things done sooner rather than later. This tendency can lead to the exertion of unwarranted control. Too directive a leadership style, wherein personal opinions and desires are emphasized over common goals and teamwork, can

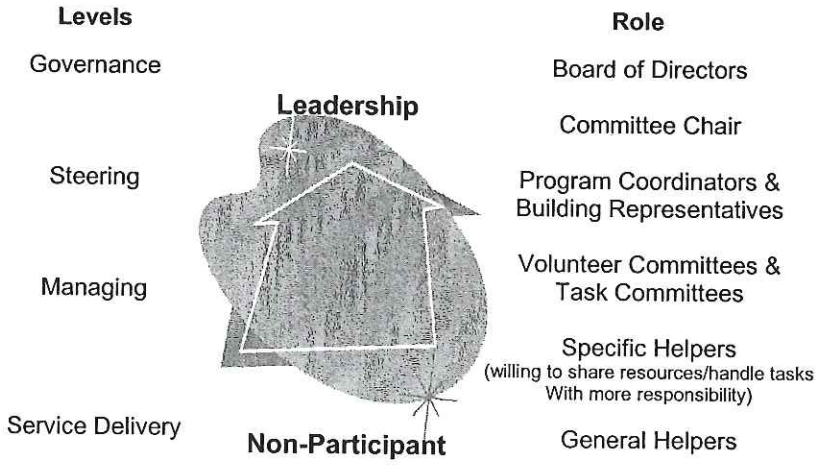


Figure 28: Levels of volunteer involvement in the Cherryhill Healthy Ageing Program.

A recent survey of volunteer community members (n = 57) reveals that a majority (75%) carry out helping activities only, while a smaller number (13%) take on positions of more responsibility and leadership. Leaders are far more likely to hold several positions (m = 8), either simultaneously or over the duration of their time with the program.

create difficulties in a participatory action style project. Personality conflicts can surface when colleagues object to the direction provided by a peer. Volunteer leaders work closely with staff, sharing responsibility for volunteer management and project leadership. Staff support leaders in their role, help to resolve issues and encourage the development and maintenance of leadership skills.

WHAT VOLUNTEER LEADERS CAN DO

- ☐ ask questions to involve others
- ☐ help others to accomplish goals
- ☐ encourage others to assume new responsibilities
- ☐ help to recruit new volunteers
- ☐ collect information
- ☐ confirm and monitor commitments
- ☐ recognize contributions and offer praise

Building Volunteer Capacity

Capacity building is different from developing a volunteer program. Capacity building entails involving community members in decision making and planning. The ensuing sense of ownership is what, in particular, distinguishes this approach from volunteerism. To build capacity, a clear sense of belonging needs to be established early in the process. A point or points of identity help to accomplish this. A point of identity can be a concept, structure and/or physical presence. For example, the Cherryhill Healthy Ageing Program provides a physical facility in a neighbourhood mall. The stated value of the project to help one's neighbour is very compelling for community members, as is improving the community in which one lives. Capacity building in a community setting is inherently different from a volunteer program in an institutional setting.

> *"Staff need to involve volunteers as much as possible from the beginning of the project, encourage them to have real power in determining the direction and pace of the project and use the knowledge and insights developed by the people in their own communities."*[20]

> *"Senior volunteers are more comfortable taking direction than being in charge. However, with time and support they are soon comfortable making decisions on their own with minimal professional support."*[21]

For a hospital, identity with the institution is easy. For a community health system it is more difficult for the "organization" to attain a level of identity similar to that of an institution. Institutional volunteers "serve", community capacity volunteers "share control" with partners.

A transition to shared control must begin at an early stage of program development. This transition can be a long and slow process, and a pace should be set that is comfortable for community members. Securing feedback can in itself take time as most of the concepts are new to the majority of the volunteers. Proven success builds confidence and encourages involvement, and shared decision-making. As confidence increases, so too does professionalism. The committee structure is a good way of building ownership and commitment to the process. Community members have a tendency to become overwhelmed by the bits and pieces of the program, losing sight of the bigger picture. Volunteers often see their capacity to help on a very personal level. Empathy for the client, the volunteer's neighbour in crisis, compels them to provide immediate assistance, even outside the program structure. As a result, there must be ongoing work to achieve an understanding that the volunteer role is different from that of an interested friend or neighbour. (see volunteers as neighbours section).

Cherryhill volunteers struggled with the increasing complexity of their responsibilities as the project grew at a rapid rate with the creation of new programs.

Too many areas developing simultaneously over the entire project can disable volunteers, particularly those that take on multiple positions. This environment made it difficult for volunteers to keep up with program information and receive adequate training to deliver services. In general, volunteers respond well to rules and guidelines. They experience comfort in knowing the parameters of what they can or can't do. This reduces the chance of error in judgment, prevents subjection to peer criticism, and contributes to the feeling of a job well done. One challenge is keeping the process simple as a plethora of forms, instructions and procedures can quickly emerge. The staff person linking with the volunteers is therefore a vital role (see section building partnerships).

> *"There is a great potential for overextension to have a negative effect on health and, ultimately, the capacity to stay involved."*[13]

Neighbours as Volunteers

As residents of the neighbourhood, Cherryhill volunteers have a strong connection to the community they serve. There is a longstanding tradition of neighbours helping their elderly neighbours with activities of daily living, enabling them to remain in the community. Neighbours provide companionship, transportation, run shopping errands, check on safety, serve as a contact for family and provide other social supports. The Cherryhill programs build on this existing informal helping network. For example, the Resident Safety Check Program developed from an existing grassroots effort by concerned neighbours in several of the apartment buildings. When neighbours join the project they become volunteers of a more formalized support system. In keeping with a community capacity building model, the Cherryhill project uses a peer-to-peer model in much of the programming that it provides. Volunteers who reside in the community are peers in relation to the people they help.

Stevenson[22] defines the peer help process as "people seeking help from and providing help for those much like themselves with regards to age, and/or culture, and/or experiences, etc." Peer help offers accessible and informal assistance by individuals who have similar values or experiences in life. Peer help is a generic term; other labels are peer support, peer assistance, peer facilitation, peer counseling, etc. The nomenclature used can be dependent on the designated role. The peer help literature mentions a wide variety of roles including companions, self-help group facilitators, interviewers, counselors, educators, mediators and advisors. The growth of the peer help movement in health care for the elderly is largely a response to health system constraints.[23] When there are not enough available resources to provide an extra support system for this population[22], peer help is viewed as a cost-effective approach to filling this gap. There is a growing body of literature dealing with peer help programs involving older adults in

both community-based and institutional settings.[25] However, the majority of literature on elderly peer helpers is in the area of meeting psychosocial needs. Much of this is applicable for a population that is dealing with losses, mental health, depression, loneliness and other related issues.

> *A recent poll of current volunteers (n = 19) revealed that close to half helped their neighbours in some capacity prior to joining the Cherryhill Healthy Ageing Program. All agreed that as a neighbour it was their business to let someone know that their neighbour needed help, and their responsibility to make their neighbour aware of available service supports such as the Resident Safety Check Program.*

A peer help systems approach offers some advantages over a strictly professional approach. The main advantages capture the unique abilities of peer helpers and are summarized under the following three points.

Establishing a Rapport Based on Shared Experiences

Peer helpers have an ability to identify with the people whom they are helping because of shared life experiences, common social backgrounds, and other commonalities. Helping occurs through mutual sharing of experiences[26] as well as through activities such as listening, empathizing, providing feedback and reassurance. Senior peers can exhibit empathy for the painful experiences of old age[10] and are supportive, active listeners to the frail elderly who have limited social supports.[24]

Time to Offer Services in a Personal & Caring Manner

Peer helpers are able to go beyond the constraints that can limit an agency's ability to help its clients because of heavy caseloads and depleted resources.[10] In comparison to professionals, peer helpers are able to give assistance more frequently[7], as well as spend longer periods of time with their clients[27]. Because of this, they are in a good position to monitor a client's situation and progress, and can listen to lengthy reminiscences. Peer helpers offer a personal touch, often providing extra help than that originally prescribed.[10,12]

Positive & Credible Role Models

Peer helpers are usually active, engaged people with a positive attitude. These attributes set an example to their clients for encouraging health-enhancing behaviours.[8]

Peer volunteers appear to display more positive attitudes toward seniors than providers assigned to work with this age group.[28] The help provided by the formal system can be authoritative thereby putting the seniors in positions of dependency.[12] With a peer approach, clients maintain respect and self-esteem that is sometimes absent in services provided by health care professionals.[29] Senior peer helpers in Cherryhill offer support for practical and emotional needs. Along with this peer volunteers have become more involved in the provision of health information and linkages with the formal system. For example, by linking at risk neighbours with the community nurse.

Extension of Formal Health Care System Supports: Peers provide practical help such as friendly visiting, telephone reassurance, monitoring and safety checks, assistance with exercises and community dining.

> *"At times, a peer is able to persuade a client to accept service while the professional is unable to do so."*[12]

Providing Access Through a Trusting Relationship: Often frail seniors live with the fear that they may lose their independence. As a result, they may be reluctant to reveal difficulties they encounter with their health or daily living activities. For instance, disclosure of issues like incontinence happens infrequently because institutionalization or surgery is the feared outcome.[30] Therefore, the elderly person may be more amenable to accepting assistance from a peer helper rather than from a service provider.

Psychosocial Support: Peers help clients deal with emotional distress concerning such issues as loneliness and bereavement by sharing experiences and providing a compassionate ear.

Information Provision: Peer helpers are a natural source of information. Peer volunteers with the Cherryhill Health Promotion & Information Centre learn about health issues and services and share the knowledge gained with others in the community, where it is passed from neighbour to neighbour. Peer volunteers provide a community link to professional staff and services. Through constant contact, they are able to identify situations in which clients might need more skilled professional help and refer them to the appropriate service.

Although effective in many health care situations, there can be challenges to a peer help systems approach. For discussion purposes, two interfaces can be identified:

- between the volunteer and the professional
- between the client and volunteer

The relationship between the informal care of peer helpers and the formal care of the health system is a major issue.[25] The relationship calls for a pooling of experiential and professional knowledge.[23] There is a definite role for the volunteer as distinguished from role of the professional. The capacity of peer volunteers needs to be determined and supported. Peers are excellent providers of simple direct help that help to improve quality of life. They cannot be expected to provide the more specialized care of professional such as diagnosing and treating medical problems.[27] With medical interventions, the peer volunteer acts in an accessory capacity with fully trained professionals. Volunteers do not want to take full responsibility for the client. A challenge experienced in Cherryhill revolved around that fact that peer volunteers became too personally involved with clients and did not remain as objective as they should have. There is also a tendency to give premature advice.[7,21] Volunteers should only offer wisdom from their own experience after careful identification of the client's problems. Issues like these can be overcome by training and ongoing support in appropriate protocols.

Peer volunteers must deal with issues related to their unique role. Helping individuals through challenging health issues may remind them of similar difficult and stressful experiences they have faced or are currently facing. They must be strong enough to withstand the stress of losing client neighbours through death or transfer.[7] Occasionally the volunteer is concurrently both a provider and recipient of service. Volunteers who participate in both informal and formal types of voluntary work may confuse their dual roles. Furthermore, peer pressure to succeed is rampant in Cherryhill. Unlike individuals who do not volunteer in the same community in which they live, volunteers who are residents cannot entirely leave work issues behind and they are carried over into daily life. Errors made by individuals can soon become the knowledge of the vast majority of the community. Interestingly, senior volunteers gain a level of prestige amongst their neighbours. The knowledge they gain through volunteering coupled with their connection to the formal health system put them in a position of power and influence.

Additionally, barriers to receiving help from a peer neighbour may be posed by the client. Chapman[31] discusses a number of client-imposed factors:

- Peer help has the potential to dramatically affect the principles of confidentiality and the right to privacy. Residents may feel uncomfortable sharing problems with individuals they are acquainted with in their daily lives. On occasion, Cherryhill residents have expressed concern that personal information divulged during the course of seeking help will be spread on the neighbourhood grapevine.

- They may be concerned that they will lose status in the community by seeking help, indicating that they are no longer valuable and capable members.

- They may have a personal preference to receive help from the formal rather than the formal system, or they may have a general dislike of depending on others, especially their neighbours with whom they feel they should reciprocate but can't.

- Finally, the client receiving help from the formal system may forbid the health professional to discuss matters with peer volunteers, thus complicating the process.

Volunteers Managing Volunteers

A unique aspect of the volunteer management program at Cherryhill is its shared administration by community members. Experienced volunteers are involved in the selection, training and supervision of other volunteers and in developing the volunteer program. Key requirements for the program identified by volunteers were: to be straight-forward and practical in application, to have good documentation and that staff would be available to provide ongoing support. Management structures put into place to facilitate community members' participation include:

Volunteer Intake & Management Committee: This committee, comprised of several interested volunteers and a staff advisor, governs all aspects of the volunteer program. During the program development stage, the committee undertook four tasks:

- to review and modify the volunteer intake process
- to create new volunteer positions for existing and new programs
- to modify and/or create volunteer management tools, including the application form and position descriptions
- to develop an orientation and training program

The committee handles the ongoing recruitment, intake and coordination of volunteers, and oversees their orientation and training. The committee selects the volunteer coordinator and provides direction to them.

Volunteer Coordinator: A volunteer position that helps with the daily management of volunteers and liaises with staff.

Although a process is in place for the selection of the volunteer coordinator, the reality is that few people have the requisite skills, interest and time, and are willing to serve in this capacity. As a result, the coordinator is usually selected from the current volunteer pool and no term of office is set. The volunteer coordinator plays a pivotal role. This person must work alongside their peers as well as staff and community partners. They are the first point of contact for volunteers, serving as their "voice and ears". Because of this unique vantage point, the coordinator is often the first to identify

concerns and recognize opportunities. They are called upon to represent the interests of volunteers to program coordinators and staff, and, in turn, to convey program policy and direction to volunteers. Volunteers value having someone on hand to consult with on day-to-day matters. At the individual level, the volunteer coordinator does much problem solving and conflict resolution. There is a potential for some volunteers to not accept the authority of their peer leader and this can cause tension and conflict. The boundaries of this newly created position are left purposely flexible so there is a potential for too much influence and control to be exercised. In addition, the position is very demanding and it is easy for the coordinator to become overburdened, especially since the individuals who fill this position are very capable and committed and active in many other areas of the project, usually holding other leadership positions.

Building the Partnership

The community capacity building model requires that health professionals and community members work in partnership. Building and maintaining a healthy relationship between the two parties involved is essential. Good rapport, trust and collaboration contribute to success. Partnership necessitates role clarification, shared goals, risk taking and flexibility.

Although there is a partnership between the volunteer and the professional, there remains a clear demarcation. The ongoing presence of the professional is essential as volunteer involvement has its limits. There are things the volunteers do not want to do and these remain the domain of the professional (see box below). These include the provision of the more medical interventions, the source of content expertise, evaluation expertise (although the process itself can be shared) and overall coordination of the programs. Financial accountability of the community project can be shared and should be. Community members can be involved in fund raising and need to know how the money is being spent. However, financial accountability of the professional's performance remains with the professional's home institution.

The health professional has an important role to play in facilitating the community action process each step of the way as the project unfolds. A sense of partnership and shared control must be maintained throughout the entire process. The professional ensures that community members continue to have influence over the project. The role of a facilitator in this context is to help the community to help themselves with regards to the planning and delivery of health services. The professional is accountable to the formal system and maintains much of the responsibility in ensuring that the project remains in line with its principles and achieves its goals. Consequently, the professional lays the framework, provides continuity and introduces a systems approach. Health professionals not only act as facilitators, but as consultants and problem-solvers. Volunteers often seek the advice of staff in service provision and policy

RESPONSIBILITIES OF HEALTH PROFESSIONALS

- ☐ ongoing support to volunteers in their helping role
- ☐ professional (medical) advice & intervention
- ☐ lead in tasks that volunteers find challenging or are not ready to take on
- ☐ advanced training for volunteers
- ☐ develop policies & procedures based on volunteer feedback
- ☐ handle issues requiring client confidentiality by other agencies
- ☐ liaise with formal system, community agencies &health professionals
- ☐ develop record keeping & program evaluation system
- ☐ grant writing & financial accountability to program funders
- ☐ legal accountability for project
- ☐ overall project management

issues. At certain times, the presence and objective perspective of an outside leader is beneficial in quelling conflict amongst community members and resolving differences in opinion by providing direction.

> *Staff need to involve volunteers as much as possible from the beginning of the project, encourage them to have real power in determining the direction and pace of the project and use the knowledge and insights developed by the people in their own communities.*

Although the professional has many responsibilities, a primary role is to provide support and encouragement. The professional must be aware at all times of the need to ease professional control. This can be especially difficult during the transition to shared control when volunteers are more comfortable taking direction than being in charge. The community must view the professional as not only competent, but compassionate as well. The professional must be respectful, accessible, helpful and flexible. They must be knowledgeable about the formal health care system, community development approaches and volunteerism, and have an interest or expertise in working with seniors.

The skill and personality of staff determine the morale of volunteers and their willingness to perform their activities.

Lessons Learned

Many lessons have been learned during our more than six years of working with the Cherryhill community, in particular:

- start slowly and set a reasonable pace that is comfortable for senior community members
- if the project has inherent value to the community, community members are motivated and dedicated participants
- volunteers cannot be expected to do it all; there are limits to what they are willing and able to do; volunteers require ongoing support from staff and other professionals
- involving volunteers (the volunteer management process) requires a significant commitment of time and material resources
- a storefront operation in the community lends creditability and increases program awareness and accessibility; relocation of the facility to a busy section of the mall significantly increased business
- there are definite advantages of locating a community capacity building project in a high density seniors' community; a large social network provides access to a natural pool of clients and volunteers; resource support is forthcoming in such a setting and a comfortable, familiar environment makes it easier to for seniors to access service

Other volunteer management resources are provided in Appendix L.

References

1. Arbuckle, TY, Gold, DP., Chaikelson, JS & Lapidus, S. (1994). Measurement of activity in the elderly: the activities checklist. Canadian Journal on Aging, 13(4), 550-565.

2. McCrae, RR. & Costa, PT. (1987). Validation of the five-factor model of personality across instruments and observers. Journal of Personality and Social Psychology, 52, 81-90.

3. Weaver, L. (2000). Canadian code for volunteer involvement. Ottawa: Author.

4. Rehnborg, SJ., Clubine, B., et al. (1998). Volunteer recruitment: tips from the field. A project for the Charles A. Dana Center at the University of Texas, Austin. (posted on the Texas Commission on Volunteerism and Community Service web site, www.txserve.org)

5. Volunteer Canada and Canadian Centre for Philantrophy (2000). Volunteering: a booming trend. Ottawa: Canadian Centre for Philantrophy.

6. Street, L. (1996). The screening handbook: protecting clients, staff, and the community. Ottawa: Canadian Association of Volunteer Bureaux and Centres.

7. Gallagher, E.M. (1985). Capitalize on elder strengths. Journal of Gerontological Nursing, 11(6), 13-17.

8. Glanz, K., Marger, SM. & Meehan, EF. (1986). Evaluation of a peer educator stroke education program for the elderly. Health Education Research, 1(2), 121-130.

9. Havir, L. (1986). An evaluation of older volunteers as telephone interviewers. Journal of Voluntary Action Research, 15(3), 45-53.

10. Hoffman, S.B. (1983). Peer counsellor training with the elderly. The Gerontologist, 23(4), 358-360.

11. Losee, N., Auerbach, S.M. & Parham, I. (1988). Effectiveness of a peer counselor hotline for the elderly. Journal of Community Psychology, 16, 428-435.

12. Morrow-Howell, N. & Ozawa, M.N. (1987). Helping network: seniors to seniors. The Gerontologist, 27(1), 17-20.

13. Abbott, M. (2000). Cherryhill Community Response Team: summary of the six month pilot phase. Prepared for the Middlesex-London Health Unit.

14. Centre for Health Promotion, University of Toronto & New Horizons: Partners in Aging Program, Health Canada (1997). Experience in action: community programming for health aging, series of nine fact sheets. Ottawa: Health Canada.

15. Spatz, MA. (2000). Providing consumer health information in the rural setting: Planetree Health Resource Center's approach. Bulletin of the Medical Library Association, 88(4), 382-390.

16. Bartman, J., Mummery, V., Poppe, M., Robbins, B. & Robertson-Palmer, K. (1982). Shopping for health? Maybe this storefront health information centre can help. The Canadian Nurse, 78(2), 48-50.

17. Roberto, KA., Van-Amburg S. & Orleans, M. (1994). Caregiver empowerment project: developing programs within rural communities. Activities, Adaptation and Aging, 18(2), 1-12.

18. Carr, J. (2001). Health Human Resources: Role of the Voluntary Sector. Ottawa: Health Canada.

19. Chappell, N. (1999). Volunteering and healthy aging: what we know. Paper released at the Canadian Forum on Volunteering by Volunteer Canada, Health Canada and Manulife Financial.

20. Ellis, C. & Matheson, W. (1995). Seniors serving seniors: volunteers promote healthy aging. Project Concern, 24(5), 28-29.

21. Petty, BJ. & Cusack, S. (1989). Assessing the impact of a seniors' peer counseling program. Educational Gerontology, 15, 49-64.

22. Stevenson, J. (1999). The London Seniors Peer Help Service Manual. Unpublished report prepared for Information London.

23. Stewart, M. & Reutter, L. (2001). Fostering partnerships between peers and professionals. The Canadian Journal of Nursing Research, 33(1), 97-116.

24. Grossman, EH., Rizzolo, PJ. & Atkinson, V. (1992). Geriatric peer-counselling pilot project provided support for the homebound elderly. North Carolina Medical Journal, 53(6), 296-298.

25. The Peer Resources Annotated Bibliography. (On the Internet at www.peer.ca/SearchB.html)

26. Gillen, L. (1995). Elder abuse peer support partners: a family violence prevention strategy utilizing volunteers. Journal of Volunteer Administration, 13(2), 26-29.

27. Hayes, K & Baginski, Y. (1992). Bringing home mental health care: in-home peer counselling benefits the elderly. Health Progress, 73(1), 66-68.

28. Portnoy, EJ. (1985). Communication and the elderly patient. Activities, Adaptation and Aging, 7(2), 25-30.

29. Robertson, G. (1990). Elderly minority peer counseling for health education. Journal of Health Care for the Poor and Underserved, 1(2), 211.

30. Skelly, J. & Boblin-Cummings, S. (1999). Promoting senior's health: confronting the issue of incontinence. Canadian Journal of Nursing Leadership. 12(3), 13-17.

31. Chapman, NJ. & Pancoast, DL. (1985). Working with the informal helping networks of the elderly: the experiences of three programs. The Society for the Psychological Study of Social Issues, 41(1), 47-63.

Chapter 8

Health Information & Seniors:

- consumer health information
- barriers & aids to seeking health information
- who uses health information & why
- impact of health information & the concept of literacy
- production & dissemination . . . issues & strengths for information providers
- written health information . . . producing senior-friendly print communication
- distributing the information
- the Cherryhill Health Promotion & Information Centre
- components of a consumer health information centre
- information needs . . . the nature of information requests & help received
- health information needs . . . what are seniors looking for?
- lessons learned
- references

What the Evidence Tells Us . . . . .

- the demand for consumer health information is increasing & its scope has become diverse; health information is an essential component of health promotion, patient education & self-care decision-making
- seniors use a variety of formal & informal sources of information, often in combination; a multitude of influences affect their information seeking behaviour
- there are many barriers to seeking & using health information for seniors
- community health information centres are highly valued by their users as trusted, accessible & accurate sources of health information; it has been demonstrated that the knowledge gained from their use leads to positive outcomes such as changes in health behaviour & reduction in anxiety
- many older adults read at a limited level such that they cannot be expected to read most commonly used written materials
- there are effective techniques to improve the readability and comprehension of written material for a senior audience

Our Experience . . . . .

- the type of health information seniors seek is wide ranging & includes medical issues & service access topics; however, the majority of requests are disease-specific while few are geriatric system related
- the Health Information Centre is used by the general public, not just seniors; older adults seek information for dealing with the health issues of younger relatives & younger relatives use the Health Information Centre to seek information for their elderly parents
- the peer-to-peer model of assistance has contributed to the recognition of the Health Centre as a trusted resource & a friendly door to the formal system
- the health promotion, prevention & clinical programs offered through the Health Centre are complementary to the provision of health information & have increased use
- seniors are a diverse population; different communication methods should be employed to reach the well active versus the frailer housebound population

Health Information & Seniors: *What Does the Evidence Tell Us?*

Consumer Health Information

> *"Our health depends on change in our behaviour as individuals and communities, change which can only be achieved if ordinary people have access to health information".*[1]

Health information for consumers is a fast growing phenomenon. It has become a part of everyday life and an essential element of health care today. People learn new health facts from the newspaper, from the Internet and from conversation with friends that help them to make healthy lifestyle decisions or to cope with a particular ailment they are experiencing. Health care workers provide information to individual patients and clients or to whole communities to educate them about improving their health and treating diseases. The rise of informed health care consumerism can be attributed to three inter-related factors:[1,2]

- the increasing demand for health information in society generally; the self-care movement is encouraging people to take charge of their own health; consumers are taking a more active interest in their health and are no longer content to just be told what to do; this is encouraged by the broad dissemination of health information in the media
- there is a growing recognition that the traditional medical system cannot answer all health needs and has limits in producing further real advances in the health status of the population; this is coupled with consumers' concern about cost, accessibility and quality of care
- these trends are encouraged by government health policies, which support the trend towards health promotion, adapting healthy lifestyles and environments and health literacy; additionally, there is growing research evidence on risk factors, as well as research evidence demonstrating that provision of information to patients can have significant benefits

> *"Health information is the single largest subject for popular and professional consumption."* [3]

The literature on health information spans the fields of medicine and library science. Research has been conducted in such diverse disciplines as nursing, psychology, pharmaceuticals, aging and human development, sociology, information science and librarianship. Health information is a key element in studies on health promotion, health education, patient education, communications, health literacy and information technology. Prevalent areas of research are:

- the sources of health information
- information-seeking patterns
- impact of health information on consumers
- readability testing for written materials

Discussion on the unique considerations of seniors is predominately found in patient education, communications and health promotion literature. The focus is often on specific diseases, health issues or communication problems and strategies. Little is specifically found on this special population in the consumer health information literature. Cawthra[4] gives an overview of the health information needs of seniors and Roberts and Fawcett[5] on health literacy and the elderly.

What is Consumer Health Information?

> *"...health information is not a single, homogenous commodity."* [6]

Health information for the general public is generally referred to in the literature as *consumer health information.* Consumer health information is as any information pertaining to health that is presented at the lay level and is intended for consumption by the public, including patients.[1,7] Patrick and Koss in their Consumer Health Information White Paper (1995) define consumer health information as "information that enables individuals to understand their health and make health-related decisions."[3] Consumer health information is broad in scope and encompasses information on clinical matters such as the symptoms, diagnosis and treatment of disease and drug information; wellness and prevention information; and practical matters such as coping information and accessing and using health care services and systems information.[1,8] Health information can occur in various settings and can support health within medical, community or personal contexts: [3,7,9]

Medical Context: Health information can be used in *patient education*. Patient education is a planned activity wherein health care practitioners teach or counsel patients about their individual health needs. Patient education programs use a variety of techniques including dissemination of health information. This form of health information, intended specifically for use within the patient education context, is often referred to as *patient information.* Patient information is health information, which is provided by health care practitioners to their patients to teach them about a disease or medical treatment and to help them cope and comply with treatment.

Community Context: Health information can be used in *health promotion* or *health education* activities that encourage consumers, both individuals and groups, to optimize their health by making them aware of health risks, informing them of preventive measures and promoting a healthy lifestyle.

Personal Context: People use health information to support *self-care*, that is, decisions and actions an individual takes in the interest of their own or family members' health.[10]

Sources of Consumer Health Information

Health information reaches people in many ways. People use a wide variety of sources for health information. Individuals may actively seek information in answer to a question, it may be relayed during the patient-health worker interaction or from public health promotion campaigns. The literature mentions many and varied sources of health information. These sources may be divided into five broad categories:

- *Health Care Professionals & Services:* a family doctor or practice, pharmacist or pharmacy, hospitals and health authorities
- *Information Services*: libraries, telephone services, the Internet
- *Health Publications & Materials:* books and journals for lay people, newsletters and pamphlets
- *Media*: magazines, newspapers, television and radio
- *Social Support Networks:* family, friends and self help groups

Several studies undertaken to determine the most frequently used sources of health information by the general public and seniors reveal that physicians, the media and friends and family are the most popular (in any order).[11-14] The popularity of these sources is due to the fact that they are either very convenient or delivered in relation to medical consultation. Physicians, particularly family physicians, are authorities on health and a point of contact for medical consultation. It is generally acknowledged that medical services and health information go hand-in-hand. Social support networks offer practical tips based on first-hand experience and are familiar and trusted sources. The media is a convenient and widespread source of contemporary information. Magazines, newspapers and television provide consumers with the latest health facts on a daily basis and take a

minimal amount of effort to consume (e.g., watching television is a passive activity). Goodman's[15] in-depth study of the seniors and their choice of communication channels for information on a broad range of areas of interest to seniors (e.g., community services, financial information and leisure in addition to health) also included brochures and organizations, which were rated third overall after television and newspapers, but before radio, magazines and professionals. Professionals were least selected here possibly due to limited accessibility; see following section for discussion of influences on source selection. Crane[11] categorizes additional sources as previous learning, self-knowledge and actively seeking knowledge from others during treatment.

Barriers & Aids to Seeking & Assessing Health Information

> *"The appropriateness, adequacy and desire for different sources of information may be partly influenced by the nature of the information as well as the circumstances of the individual."*[16]

A consumer has many choices about where to obtain information. People use multiple resources at once as well as various sources at different times depending on the particular circumstance.[3,12] Their preference is dependent on a number of factors, both external and internal to themselves. The specific information need, the availability and accessibility of information, social and economic circumstances, capacity, motivation and other variables can influence, either encouraging or discouraging, ways in which people seek information. Highlights of influences and barriers as presented in the literature are summarized according to the following six categories:

Consumers' Perception of their Disease & the Anticipated Result of Seeking Help: Seniors may be embarrassed about a particular condition or consider it a normal part of the aging process and consequently not think to seek help or fear that it may result in institutionalization or surgery.[17] In addition, they may be reluctant to ask questions and challenge a provider's authority.[10]

Ability to Process Information & Base Level of Knowledge: Literacy can have a major impact on information seeking patterns. Roberts[5] reports that the Canadian data from the 1994-95 International Adult Literacy Survey (IALS) reveals that only 62% of Canadian seniors with low literacy levels read newspapers or magazines everyday. Reading books, listening to radio and audiotapes were also less common in seniors with low literacy. However, prolonged daily exposure to television is apparent. Both high and low literacy seniors rely on their social support networks. Few Internet sites are appropriate for low literacy adults.[18] Age-associated conditions such as physical, vision, hearing and

cognitive impairments can have a negative impact on the ability to process information as can diminished skills due to lack of use over time.[19] An intermediary may be necessary to interpret information. Health care practitioners often find that patients lack a base level of knowledge about their medical condition or the nature of the treatment upon which to build.

Nature of Need: Deering & Harris[3] report that when people need medical treatment, the first choice and major source of information is the health care provider. Stoller et al.[13] found that seniors who reported some physician consultation rely on their physician more frequently than on other sources of information, while seniors who reported no need for medical contact did not rank physicians highly as a source of health information. An individual's level of concern about a certain health matter, for example, a health crisis may prompt them to seek information more quickly than they otherwise would.[12] There can be a difference between sources consulted for a personal need as opposed to a generic need.

Socio-Economic Factors: Goodman[15] examined the effect of audience variables, such as education, age and income, on source selection. He found that the elderly with lower education and income tended to have lower information-seeking orientation. This was also noted in people over 80 years of age (this group tended to have lower incomes). Being older had a negative effect on the use of print media, brochures and organizations as well as being associated with less daily radio listening. Higher education and income levels and younger age were factors influencing the selection of a wider range of information sources. Seniors with higher education tended to use brochures more frequently than those with lower education. Higher income was a factor in increasing the use of newspapers, magazines and organizations. Gollop[12] found that age (i.e., younger seniors), education, self-reported literacy and accessibility had a positive influence on the use of the library and reading print materials. Older Internet users have higher levels of education and income than other older people. Being female, living alone or among the older old was related to a lower incidence of use of the Internet.[20]

Lack of Awareness of Help & Degree of Access to Health Information: For people to seek help, they first have to be aware that help is available. In a recent focus group session (May 2002), Cherryhill volunteers pointed out that many seniors in the community do not know what help is available to them and that this is a deterrent to seeking help. The need for more effective promotion of the Health Centre programs was also identified. Where to get information is not thought about until it is needed.[21] However, the more accessible information is to people, the greater its potential for use. This is especially the case with seniors many of whom face mobility challenges due to increased impairment and disability. The cost of certain information resources, such as magazines, can also influence selection. There can be a discrepancy between the specificity of the information available and the information needed. For example, people seeking to access a service usually require information about *what is offered locally.*

Problems Associated with Specific Sources & Information Overload: An over reliance on informal sources can be problematic. Informal sources often provide conflicting or ambiguous advice [11,14], and lack range or depth[4]. For older people there is also a decline in their support network due to death, retirement, disability, and other factors associated with growing older.[4] With the mass media there is a question of quality and unsuitableness for conveying complex messages.[14] The cost can also be prohibitive.[15,22] Even though they are perceived as the most believable source[12], reliance on the health care provider as a source of health information can also be problematic[21]. Ageism can be a barrier in communications between the health practitioner and the patient.[19] Convenience may be an issue as an appointment must be made and travel is usually involved.[15] In the 1997 Cherryhill Community Survey a neighbourhood source of health information was suggested partly because doctors were inaccessible. People may be hesitant to ask for help because of shyness, a perception that their need is trivial or they should be able to manage on their own. The fact that information is given during the consultation process can lead to difficulties with comprehension. This is often a time when people are anxious or defenceless and least capable of taking it in or causing them to forget the information given.[2,4,22,23] Information may be presented in ways that are difficult to understand; jargon may be overused, the medical information too complex or only given verbally without follow-up in writing. Alternatively, the information may be too vague and non-specific resulting in confusion.[11] There may be a lack of information given and follow-up may be necessary due to insufficient time to fully explain the health issue or answer questions. Although authorities on medical care issues, doctors have been found to lack knowledge about community resources[4], and are therefore unable to refer people to the supportive assistance they require.

Only 17% of thehealthline.ca *users, a health service web portal for Middlesex County, Canada, are seniors 60 years of age and over.*

The Internet, primarily the World Wide Web, is a rapidly growing source of health information. There are thousands of web sites on consumer health information. Because the time between posting and viewing is minimal, the web is a good source of current information. However, out-of-date information is also prevalent. This factor, combined with the vast amount of information available, lead to an inordinate amount of time for the user to sort out and process information.[6] Furthermore, there is no quality control of information. Many different information providers, with varying interests and expertise, post to the Internet. Although people, including seniors, are accessing the Internet in increasing numbers, ready access can be problematic for those who do not have it installed in their homes or place of work. The rapidity of change within the field is

also a factor making it difficult to keep abreast of new technology.[6]

Who Uses Health Information & Why?

Most data available on consumers of health information come from user surveys of health information services. These can be somewhat limited in scope due to confidentiality issues. Findings from surveys reveal women are far more likely to be consumers of health information than men[7,24,25]. They are in a younger age bracket[7,24] and tend to have a higher socio-economic status[7,26]. Deering and Harris's[3] review of surveys found that women use health care services more than men, are more likely to be caregivers, and for these reasons are more frequent consumers of health information for themselves and others. Sweetland's[21] and Buckland's[16] review of the literature reveals that users of consumer health information services tend to be highly motivated and are people who actively seek advice. Furthermore, only a small proportion of people use such information services. There is reasonable agreement in the literature about the reasons why people seek health information. Healthy people seek prevention and general maintenance information; people who think they might be ill or are newly diagnosed seek information about a health condition; and people living with an illness, including those who are chronically ill or with disabilities, seek information on treatments and how to cope.[8,16,25] Pifalo and his colleagues[25] suggest there are three situations that stimulate the need for information (1) when caring for someone else, (2) to raise questions with a doctor, and (3) to assist in making decisions about treatment.

Cawthra[4] points out that seniors' view of health is holistic spanning medical information and community-based supportive services. Some of the common topics identified for which seniors seek information are dentistry, optometry, podiatry, physiotherapy, occupational therapy, mental health and incontinence. Winn and Bradford[14] found that people over 70 years of age wanted information and programs on stress, diet and caregiving, which were different concerns to those of younger people. These findings vary somewhat from the top categories requested at the Cherryhill Health Promotion & Information Centre. The five highest ranked categories were cardiovascular disease, arthritis, bone disease including osteoporosis and diabetes. However, similar to Cawthra's observations and Winn and Bradford's findings, vision and nutrition requests ranked in the top ten. Deering[3] points out that as people grow older, their health information needs increase in relation to their use of health care. Also, if a health condition is being experienced, then the information need is more complex. The individual can move quickly from someone with a casual interest on seemingly straightforward issues, to a senior with an urgent need for specific information on very complex issues.

Impact of Health Information & the Concept of Health Literacy

> *"Information may not automatically lead to health, but without information consumers cannot take the first step."*[1]

Research has shown that providing consumers with access to health information can have a significant effect on health outcome. Provision of health information leads to more informed consent, increased understanding and satisfaction, increased compliance with treatment, and quicker and less stressful recovery from illness and surgery. Once again, most evidence on the impact of health information comes from user surveys of health information services. Moeller[8], Pifalo and his colleagues[25] and Sweetland[21] found that the provision of consumer health information did far more than just increase consumers' knowledge about illness or treatment, but that it led to action and also reduced fear and anxiety levels. Action taken was described as seeking further information from a health care provider; promoting communication between patients and their health care provider by suggesting questions to ask and by reinforcing information received from a provider; encouraging compliance with instructions; assisting with choosing treatment options; and feeling more comfortable during treatment. In addition, consumers often share information with others thereby extending its impact further.[1]

> *"Health literacy ought to be the common 21st century currency we all share that values health as a central tenet of individual and community life."* [27]

To be effective, people not only need access to health information, they must also be able to understand and process it. The National Library of Medicine[28] defines health literacy as "the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions." Health literacy is a form of functional literacy, which, as described in the 1994-95 International Adult Literacy Survey (IALS), not only includes the ability to read, write and speak, but also to process and problem solve to proficiently function in society.[5,18] Health literacy encompasses all the ways people communicate, including reading, writing, the spoken word, pictures and technology. It is about the entire process for exchanging information.[29] Health literacy may be subdivided into three categories[18]: basic, interactive and critical. Basic literacy is the ability to comprehend factual information and comply with instructions (e.g., understanding medicine labels and

directions for care). Interactive literacy is the ability to participate in action and decision- making (e.g., partnerships with professionals). Critical literacy involves analysis and action (e.g., engagement in social action).

> *"Literacy is one of the major influences of health status."* [30]

Why is health literacy important? Low health literacy means that a person is compromised when it comes to their health. Literacy skills enhance knowledge and the flexibility to cope with change and unfamiliar contexts.[30] People with inadequate literacy have less knowledge of disease, less understanding of medical procedures, don't ask questions, fail to follow instructions and seek medical intervention at a more advanced stage of disease.[5,18,31] Low literacy is generally associated with a greater use of health care services including hospitalization.[30]

> *"Eight in ten senior citizens have literacy skills at the two lowest levels, making seniors especially at risk in medical situations that may demand high literacy ability."* [5]

The literacy level of seniors is much lower than other age groups and many do not realize their literacy abilities are inadequate.[30] Although education level may be the strongest socio-economic predictor of health for seniors, it is not a proxy for literacy.[5,30,31] An individual's literacy level may be lesser or greater than their level of education might suggest. Seniors may experience a loss of literacy skills because of the great length of time they have spent outside the education system. In addition, the complexity and specialization of health information make it difficult to understand even for people with high literacy skills.[32] The context within which the information is presented can also have a negative impact on comprehension such as situations of high stress.[29] In the patient education setting, comprehension can be impeded by factors such as anxiety, physical discomfort, unfamiliarity with hospital, environment, *as well as other factors.*[33] Older patients, in particular, tend to become anxious about new experiences.[34] People process information through previous knowledge and cultural and personal beliefs that have been gained through a lifetime of experience.[13,30] The extent to which the information is related to what one already knows can have a positive effect on comprehension. Both consumers and health care providers share a mutual responsibility for how effective health information is.[29] Health information providers must target written health

information to reading skills and should consider alternative forms of health communication.

Production & Dissemination: Issues & Strategies for Information Providers

> *"Quality, delivery and presentation of information were key elements in its effectiveness and helped to improve knowledge, understanding and emotional state."* [21]

There is much that health information providers can do to improve the effectiveness of health information. Consumer health information must be tailored to the interests and literacy level of its intended audience. Special factors should be considered when communicating with the senior population. Sensory, physical, cognitive function, social and emotional changes associated with aging can impede the use of, level of interest in and capacity to process and understand information.[35] Helpful tips for maximizing the usefulness of information provided to consumers are mentioned in the literature. Highlights are:[4,10,33,36,37]

- tailor information and the amount of information to the specific needs of the client
- pay attention to the timing of information giving; information may as well not be given if the individual is unprepared for or not in need of it at that particular point in time; this is especially true of information given orally
- involving users in the production of information can do much to improve its efficacy
- consider duplicating information in a variety of formats to allow for variations in the characteristics of the intended audience; for example, the web is a good medium for people with hearing difficulties; non-traditional forms may help surmount barriers caused by language, literacy, physical impairments
- people must be aware of available information before they can use it; some authors suggest creating awareness by high impact media such as television and following up with print material

- distribute information in a way that is accessible to its audience; this may include more than one avenue; for example, housebound seniors are unable to access a community health information service and a strategy such as specially developed information packages tailored to their needs may be a way of providing them with needed information; people with low literacy skills, limited vision or those literate in another mother tongue require other methods than written communication (see the written health information section for more practical advice on producing print materials)

Research shows that seniors prefer face-to-face personal contact as opposed to other methods of information-giving.[4] Advocacy, discussion, verbal reinforcement and repeated contact are more effective than just information alone in encouraging seniors to act on the information provided and to change health behaviours.[3,4,9,10,11,31,38]

Written Health Information: Producing Senior Friendly Print Communication

> *"Written materials are an essential part of comprehensive health education in the population in general, including older patients."*[39]

Written materials are a popular format for distributing health information. Many types of print health information materials exist, including medical forms, patient instructions, consumer-oriented books and periodicals, magazines, medication information, food labelling and pamphlets. Written materials are often used in patient teaching situations where the information relates to an illness, medication or diagnostic test. Pamphlets produced by government, medical associations, health organizations and information services usually provide an overview of a health topic and are a good source of prevention and screening information. They can be found, usually free-of-charge, in pharmacies, health care practitioners' offices, voluntary health associations, consumer health information centres and increasingly on the Internet. Pamphlets tend to be well received by consumers.[40,41] They are ideal for browsing, reviewing information, and can conveniently be taken for reference at a later date. Additionally, health professionals and other service providers appreciate being able to hand a print resource about a health topic under discussion to their patients or clients. Pamphlets are one of the most affordable methods of communicating health information.

Print materials rate highly as a source of self-care information such as improving a patient's knowledge about a particular health issue.[40] Although not generally perceived as a vehicle that encourages patient motivation, print materials may influence health behaviour, provided that the message is presented appropriately.[40,41] Bryne and Curtis[37] found that written information was the most effective medium for communicating complex information, primarily because it has fewer distractions than visual and auditory methods. Written materials have a valued place in patient education interventions. Health professionals often use written information to reinforce verbal instructions. Written information has a stronger retention value than oral, which can be too vague and is frequently forgotten by patients. Print materials are viewed as time efficient[40] and are relied upon when time is short[41]. However, within the patient education context, print material has limitations and should not be used alone and never as a replacement for teaching.[40,42] People with low literacy require other methods.[33]

Just as with any communication method, there are factors that should be taken into consideration when producing written materials. Print materials must first be read. Appropriate distribution ensures that materials reach their intended audience. Techniques to capture the audiences' attention invite people to begin reading. Their interest must then be maintained through good messaging and presentation. Written materials must be properly prepared in terms of readability, content and layout to have a positive effect. They should be tailored to the particular needs of their target population. Seniors, in particular, face a number of obstacles to reading and comprehending due to age related decrements. Poor visual acuity, poor short-term memory, use of medicines, multiple medical conditions and tremor or arthritis that make it difficult to turn pages can detrimentally affect a senior's ability to use and understand written information.[39,42] For understanding to occur, it is important that written information be matched to the reading level of the audience. There can be a significant discrepancy between audience reading levels and the readability of written material. Numerous studies[31,33,39,43] show that tested written material is often at a much higher reading level than the intended audience. In general, the appropriate reading level recommended for print materials for the majority of the population is lower than an eighth grade level, with some recommending lower than a fifth grade level. The research is contradictory about the reading abilities of older versus younger age groups although it is generally acknowledged that factors related to aging affect reading ability. While some studies [39,44] indicate that reading ability declines with advancing age and that older patients read significantly worse than younger people, others[31,33] reveal no difference in the reading scores of younger and older age groups. The reason for these varied findings may be attributed to a small sample size, the subject area and the specific population tested (e.g., one study eliminated seniors with visual impairments). In addition, low literacy individuals may refuse to participate in these types of studies. The best advice is to target the specific audience when testing for reading ability.

It is recommended that the first step to producing print materials is to identify the target audience, then test for reading ability. It has been found that socio-demographic variables are not a reliable predictor of reading ability and direct testing is the only means.[39] Therefore, it is best to determine a patient's reading ability through the use of an objective measure.[33] There are several tests available to assess reading levels, the results of which are indicated in grade level. These include the Peabody Individual Achievement Test – Revised[39], Wide Range Achievement Test (WRAT-R)[33,45], Rapid Estimate of Adult Literacy in Medicine (REALM)[45]. The readability of developed written materials can be tested using standard readability formula such as the Dale-Chall readability formula[37], Gunning Fog Test[41], Flesch Reading Ease (available with Microsoft Word) and SMOG readability scale.[45] These formulae estimate a reading age needed to read the materials and are based on word and sentence length. There are noted limitations to these tests, for example, reading ability does not predict how well a patient understands health information. Another tool such as the Cloze test can be used to assess comprehension levels.[33] Readability formulae take no account of layout or typeface. For these reasons, the print materials developed should be consumer tested on the intended audience.[35,46] User involvement in the production process is a good strategy for ensuring that the finished product is meaningful and useful. Petterson[41] advises the following steps when planning a brochure: take time, get advice from those skilled in this process, show draft copies to advisors for feedback, and pilot documents on real consumers.

> *"The language and layout of leaflets must reflect the particular needs of the elderly if communication is to be effective."* [41]

Careful attention to layout, content and language is necessary when producing print materials. Some general guidelines for layout and design include a least a 12-point type size (larger if the audience has visual impairments), bold headings, both upper and lower case letters, bullets and information boxes, illustrations that depict seniors and put across a specific message, and extensive space between sentences and paragraphs. Information sequencing should follow a logically order. A step layout helps with problem recognition and check boxes help in selection of personally relevant information.[40] The topic should be relevant to seniors and should be written from the audience's point of view.[46] Avoid stereotyping seniors and include positive images. Health information can be challenging because of the complexity of its nature and the vocabulary is foreign.[33] Try to avoid jargon and when technical terms are necessary, provide definitions. Use plain language techniques such as short words, sentences and paragraphs and write in the active tense. Illustrate ideas by using concrete examples. Use terms such as seniors and older adults. Excessive detail, abbreviations and complicated calculations can be confusing. These and other guidelines are summarized in the following table. Two examples of announcements are provided (Figures 29 and 30) to

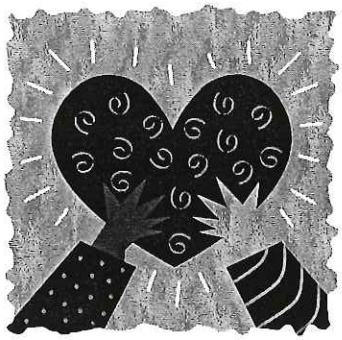
illustrate the benefits of following suggested guidelines. Figure 22 uses a large font size and simple language. The graphic does not detract from the message and serves to create interest and a sense of fun. Figure 23 does not apply the principles of senior-friendly communication. The attempt at an eye-catching heading is overdone and difficult to read, as is the choice of a small display style font for the main body of the text. There is too much use of medical terminology and the lecture topics would be better presented in bulleted point form. The inclusion of a border graphic unrelated to the message is superfluous.

"Be careful of reading health books. You may die of a misprint" Mark Twain

Five Principles of Senior-Friendly Written Material [33,35,37,47,48,49]

- **Know Your Audience:** characteristics; motivation level; reading abilities; cultural background, etc.; what do they want to know and when do they need the information?
- **Create a Meaningful Message:** high impact - attention-grabbing; essential information only; base on audience's current knowledge and capabilities consistent approach and positive tone
- **Choose the Right Presentation Format:** pamphlet, flyer, checklist, charts? consider accessibility and distribution; complementary to other materials used (e.g., to reinforce verbal instruction)
- **Use Clear Writing:** short, simple words and familiar or well-defined language; simply constructed sentences of varied length; active voice; appropriate reading level (lower than a grade eight level is a useful guideline)
- **Use Good Document Design:** strong contrast between paper and ink; plain, clear typeface in at least 12-point type size; plenty of white space; avoid excessive detail

Figure 29 on the opposite page provides an announcement produced in line with best practice guidelines for senior-friendly written material.



The PALS Friendly Visiting Program

Volunteers Needed

. . . to share friendship and provide companionship, support and resource information to seniors living in the Cherryhill community.

As a volunteer you will be matched to a Cherryhill senior who shares similar interests for weekly in-person visits or telephone chats. It's your choice!

Become a PAL today!

Inquire inside or call 675-1094 for more information.

We are open: 10 - 4 Monday to Friday
10 - 1 Saturday

LIVING WELL WITH ARTHRITIS

Arthritis is a serious disease consisting of more than 100 different conditions. These can be anything from relatively mild forms of tendinitis and bursitis to crippling forms such as rheumatoid arthritis. There are pain syndromes like fibromyalgia and arthritis-related disorders, such as systemic lupus erythematosus, that involve every part of the body. This session will address topics that encourage a self-care approach such as chronic pain and depression, health-related quality of life, alternative and complementary health, rehabilitation, nutrition, role of exercise and benefits and risk of drug therapies.

Join us on for a free information session on arthritis and strategies to help you cope.
TUESDAY, MARCH 28, 2:00 p.m.
Cherryhill Health Promotion & Information Centre
675-1355
All welcome!

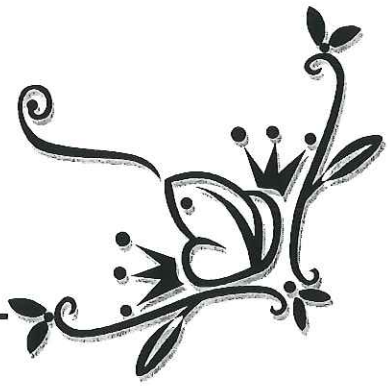


Figure 30: An announcement that does not follow the guidelines for senior-friendly written material.

Consumer Health Information Services: Distributing the Information

The shift to a focus on self-care has led to the establishment of consumer health information services (CHIS), that is, services that provide people with access to health information so they can make their own decisions and manage their own health.[26] CHIS are an important contribution to quality and consumer choice in health care.[1] They promote individual responsibility for health through provision of information and promote the principle of free, open access to health information for all.

CHIS are defined as services that formally disseminate and collect consumer health information. CHIS can take many forms. They may be library operated (consumer-oriented services offered within public, medical, patient or academic libraries) or non-library services offered by the voluntary or statutory sector. They may be independently governed or associated with an institution. They may be offered in an institutional or community-based setting. They may be a walk-in facility or a telephone information service. Beyond information they may offer a various outreach programs such as a health education or health promotion component. Services are usually offered free of charge and even if targeted to particular audience, open to all. Staffing of CHIS can vary depending on their nature and include in any combination of librarians, nurses and other health care practitioners, and communication and marketing personnel. Gann[1] provides a detailed history of CHIS from their origins in the United States and the United Kingdom in the 70s to the present time.

Examples of types of CHIS:

- patient education resource centres
- library services
- community information centres
- health care services
- voluntary health care associations
- help lines

Two well-known examples of Canadian consumer health information services include the Toronto Public Library, Consumer Health Information Service and Telehealth, the Ontario government's nurse advice telephone service. The Cherryhill Health Promotion & Information Centre is a community-based CHIS with the additional components of health promotion and clinical programs (see Chapter 4).

CHIS offer the user a wide choice of materials in a range of formats on a variety of subjects.[50] Collections may be offered on a circulating basis (i.e. borrowing or non-borrowing). Users vary depending on the nature of the service, but can generally be categorized as the:

- public seeking information on behalf of themselves or others
- students
- nurses and other health care practitioners[7]

Other service providers and community members such as mall vendors are frequent users of the Cherryhill Health Promotion & Information Centre.

Managers of CHIS must be aware of issues and trends in consumer health information to ensure a quality and timely service. Some key points for consideration are:

- making medical information accessible to the public in a user-friendly manner
- being careful to only provide information on health resources and referrals to health services as opposed to medical advice
- keeping abreast of new information technology
- ensuring level of service and collection quality
- garnering support from the medical community
- understanding the relationship to the broader scoped community information

Asked in the Cherryhill Community Survey if they could change one thing in the community, what would it be, seniors indicated, as one of the top three responses, a place to go to ask questions and get answers about their health.

Winn and Bradford's[14] study of the needs of potential users of a health promotion centre reveals that easy access, an informal approach, and a central base for all health information were highly desired. The 1997 Cherryhill Community Survey identified a similar need for a neighbourhood source of health information for questions that did not require a doctor's help. Spatz[51] points out that a community-based centre is far less intimidating then one situated in a hospital or other institution. Speak[52] found the elderly to be a potentially enthusiastic group of library users, with a special need for individual help from staff in gaining access to resources.

The Cherryhill Health Promotion & Information Centre

The Cherryhill Health Promotion & Information Centre is a neighbourhood source for health information on a wide variety of topics associated with growing older. It offers a welcoming place where people can access information about:

- a health problem or condition
- available health and supportive services

WHAT IS THE VALUE OF CHIS TO CONSUMERS?

CHIS offer consumers:

- a comfortable, confidential and trusted place
- accessibility to a variety of information through a single location
- reliable source of up-to-date quality information
- one-on-one assistance with finding answers to information needs
- an intermediary to sort through and interpret the vast amount of
- information resources available
- information in a variety of formats
- information presented in an organized manner
- comprehensive, central-base of information for intended audience
- integrated information for comparative purposes
- continuity of service ensures information is available to individuals when they need it
- a link to other information services and resources

- where to obtain a health publication
- upcoming health lectures, prevention programs, clinics and support groups
- the other programs and services offered through the Cherryhill Healthy Ageing Program

Please note that the Centre *does not* itself provide medical treatment or advice.

The Cherryhill Health Centre opened its doors to the public on September 8, 1999. After several years of community planning, the Centre was created in response to a community-identified need for improved access to health information. In 2001, the Centre handled 3,302 requests for information (direct inquiries and browsing) from residents of the Cherryhill community and their families, providers of neighbourhood services, health care providers and students, and the general public.

The Cherryhill Health Centre uses a peer-to-peer model to provide free and confidential access to health information in person and by telephone 39 hours a week, 5½ days a week. Senior volunteers staff a help desk and provide personal assistance to clients with their health information requests. Volunteers offer help by active listening, locating information resources, calling services to verify information or on behalf of a client, making service referrals, giving directions, ordering publications, following-up, and consulting the professional health care staff. Information is available in the form of

pamphlets, videos, posters and flyers and a reference collection. Internet searches are conducted on a special basis to supplement the information on hand. Clients are invited to browse the extensive collection of pamphlets. Over 350 current titles are maintained and displayed according to forty-plus topics. Each year approximately 10,000 pamphlets are distributed to clients. Various health topics, services and issues are featured in rotating window displays.

The Centre, situated in the Cherryhill Village Mall, the commercial and social hub of the Cherryhill Complex, serves as a storefront operation for the many programs and services offered through the Cherryhill Healthy Ageing Program including the Community Connections Program, Community Response Team, and Resident Safety Check Program. As an integral part of the health care community, meeting and program space is available for health promotion workshops, lectures and clinics hosted by other agencies. The multi-disciplinary staff use the Health Centre as a base for their work in the Cherryhill community.

The Cherryhill Health Promotion & Information Centre is operated on a voluntary basis by senior (65 years of age and over) community members. Trained volunteers, in partnership with city-wide health professionals, work together to provide quality service. A "train-the-trainer" model is being used to provide senior volunteers with the information, knowledge and skills to become "first contacts" on a variety of health issues for their peers. A formal system to select, track and provide health information is followed applying the Alliance of Information and Referral Systems' *Standards for Professional Information and Referral* (2000).

The Centre is a registered not-for-profit organization with charitable status and depends almost entirely on donations from caring individuals. Several fund raising activities are planned each year.

Components of a Consumer Health Information Centre

1. The Collection

A wide array of resources is made available through consumer health information centres. The centre may choose to offer materials on a loan basis while some free materials may be available for clients to pick up. The centre may arrange its collection in closed stacks or have open shelves accessible to the public for browsing. The collection may be acquired from external sources or developed internally. Examples of the latter are a subject file of press cuttings and a file of commonly used numbers for quick reference. A part of the collection can be for staff reference only. These resources should include a local telephone directory, medical dictionary, an encyclopaedia of the human anatomy, a handbook on treatments and bibliographic resources. Typical resources included in a consumer health collection are[1,7,8,22,24]:

- health books for lay people, including textbooks in the major medical specialities
- consumer health newsletters
- popular medical journals
- complementary therapy publications
- subject files on current medical and health literature
- newspaper clippings
- directories of health care practitioners, voluntary health organizations and services and support groups
- audiotapes and videotapes on health topics
- bibliographic CD-ROM databases
- pamphlets, booklets and posters
- television to convey health promotion messages
- special displays on health topics
- magazines
- web access

2. Other Programs

A variety of programs may be offered by the centre to promote health such as theme weeks and information sessions.

3. Management Issues

Key management issues include defining users, budgeting, staffing, promoting services, evaluating and policy development. The *Standards for Professional Information and Referral*[52], published by the Alliance of Information and Referral Systems, is an excellent reference for service delivery, collection, reports and measures and organizational requirements for an information service.

Service Standards

Measures need to be put into place to ensure a quality information service. The parameters of information giving should be defined, especially to safeguard against giving medical advice or counselling and recommending a particular health care provider or service.[8] Information and referral to resources and services is a preferred approach to health information giving. The information is intended to supplement and support the advice and information given by health care practitioners. Complicated issues or those requiring medical advice should be referred back to the health care provider.[2] A written policy should be developed to ensure that all inquiries are treated in confidence.

Collection Development & Organization

Collection development involves the identification, selection, acquisition, donation, weeding and evaluation of a collection. Materials should be selected for the particular user community and should be from reputable and well-known sources. Attention should be given to ensure that medical information is research-based and up-to-date. Is the work designed for a lay audience? A written policy should be developed to guide collection development. The arrangement of the collection is also important. The Cherryhill Health Centre organizes its pamphlet collection according to diseases and conditions and independent living topics. For larger collections a classification scheme can be developed or adopted. An excellent example of a consumer health information classification scheme is included in an article by Cosgrove.[22]

Record Keeping

A request record form should be developed and used to track information about the inquirer and the nature of the inquiry. Although confidentiality precludes recording client details, it may be possible to collect information on some variables such as gender and whether they are a member of the general public, a student or a service provider. Typical items tracked include date and time of inquiry, subject area, action taken and mode of inquiry. An individual client's request may be about multiple problems and clients may visit the centre in groups making it difficult to accurately reflect the number of inquirers as opposed to inquiries.[1]

Information Needs . . . the Nature of Information Requests & Help Received

Italicized text denotes information requests as recorded in the daily log of the Cherryhill Health Promotion & Information Centre, September 1999 to February 2002.

Health Conditions & Diseases

Clients request information on diseases they are experiencing. They wish to learn about treatment options and how to cope. Cherryhill residents may be caregivers for a spouse or other relative. Free pamphlets are available for people to take with them.

> *"A man was interested in finding out more about hip replacement before he underwent the surgical procedure.'*

> *"A man whose wife had recently been diagnosed with Alzheimer's was seeking more information on the disease and how to cope."*

"A woman came in to see if the Centre had anything to help her keep track of the multiple medications she was taking."

"A man wanted information on how to get to sleep. His wife had died recently."

Health & Related Services

The Centre provides clients with information on available health and community services.

"A woman wanted a new physician because she didn't like the one she had."

"A man asked about the length of time OHIP allows you to be out of Canada and still retain eligibility."

"A man telephoned to make an appointment for the flu clinic being held at the Centre later in the week."

Building Trust & Multiple Requests

Clients often have multiple but related requests. Sometimes the request begins with a straightforward and less personal topic, and after a sense of comfort and trust is established with the volunteer, the client will mention a more serious health concern.

"An elderly man came into the Centre to use the table to write on. In conversation with the volunteer on duty, he stated he had been a widower for six years and could not adjust to being alone."

"A man in his 80s came in to inquire about transportation. During the transaction, he said he was confused as to which month it was and thought he might have Alzheimer's. He was reluctant to consult his doctor because he did not want to annoy anyone."

Information to Support Independent Living.

Elderly Cherryhill residents turn to the Health Centre for practical information to help them cope with daily living situations such as security, home help, transportation, dealing with family members, and more.

"Two women were looking for someone to stay with their mother overnight because she no longer felt safe being on her own."

"An elderly woman inquired about help to take her frail husband to a doctor's appointment."

"A 94-year old woman who recently had to give up driving wanted to know about transportation alternatives."

"A woman came into the Centre very distressed that younger family members had moved in with her. She wanted to know how she should handle the situation."

Practical Assistance to Support Independent Living

Many elderly Cherryhill residents live by themselves, without family nearby. Clients will seek practical assistance to help them do something they cannot do on their own.

"An elderly woman asked for assistance to read a form."

"A woman who recently had cataract surgery asked a volunteer to help her administer her eye drops."

Social Support

The social aspect of the service is very important to Cherryhill residents. Clients often drop in primarily for socializing. Sometimes they stay to chat after a request for information. The active listening skills of the volunteers are particularly important. They rely on their experience and knowledge to provide empathy. The sense of familiarity gained during the social interaction increases the likelihood that a senior will return if and when a need for health information arises.

"A man came in just to chat and receive empathy for ten minutes. He was lonely."

Information to Support Families

Clients ask questions on both their own and others behalf (e.g., a daughter for her elderly mother who was undergoing cancer surgery; a son for his parents who were moving to London; etc.). Older adults inquire on behalf of younger relatives such as a niece or grandson.

"Two brothers from out of town were closing up their late mother's apartment. They relayed what a stressful time this was for them and that they would be grateful for any suggestions on where they could take her belongings."

"An eye doctor came in to find information for a patient."

Medical Requests

Requests pertaining to medical and/or clinical matters are frequent. Clients with very specific or complex health concerns are directed to the community nurse or other health care professionals (e.g., family doctor; pharmacist etc.) On occasion, the need is urgent and requires emergency care.

> *"A woman telephoned who was concerned because her elderly mother was ill. She wanted to know if it was best to take her to the hospital or to the family doctor."*

> *"Two women came into the Centre, one feeling very faint. The community nurse checked her blood pressure and the two women sat and rested for a while."*

A Trusted Resource

Many Cherryhill residents soon establish a sense of trust and familiarity with, even reliance on the Centre and the volunteers who provide assistance. The Centre's location in the community makes it easy and convenient for clients to visit as frequently as they need, and for the volunteers to track a client's progress if appropriate or provide advocacy and reassurance. Residents with heart problems will come into the Centre to rest and take their medication secure in the knowledge that someone is keeping a watchful eye on them. Clients request specific publications that they have learned of elsewhere and volunteers will follow up. Clients return to tell of how they made out with the information provided and/or their health issue.

> *"An elderly woman with a walker came in to the Centre to pick up some pamphlets, but discovered she had left her list at home and would have to return another day."*

> *"A frail elderly woman was a frequent visitor to the Centre while she was waiting for admission to a nursing home. She described herself as a "lost sheep" that no one cared about, convinced that she would soon be forgotten. During her repeated visits she expressed various needs and requests for assistance including trouble with her eyes, lost apartment keys, help with a letter and a bankbook, worry that someone would break in, and sure people were stealing from her. One time she came in to reminisce about her early years bringing along pictures of her homeland to share with the volunteers."*

"A woman came in to thank a particular volunteer for the information given to her on breast cancer. She informed the volunteer that the surgery was successful and she was feeling well."

Health Information Needs . . . What are Seniors Looking For?

The Cherryhill Health Promotion & Information Centre makes available a variety of health information to seniors. Free pamphlets from various health organizations and government services are available for clients to browse and take with them. The pamphlets are arranged by topic covering approximately fifty diseases and conditions and independent living topics. Peer volunteers are available to provide assistance with information requests. Window displays feature a health topic of relevance to seniors on a rotating basis. Flyers and posters announcing upcoming health promotion events are posted on the wall. In addition, a variety of clinical and health promotion programs are run from the facility.

The Health Centre handles a variety of information requests, both health and non-health related, from seniors, students, health service providers and the general public. Because of its location within a mall, information orientation, and serving as a storefront venue for the Healthy Ageing Program, the Health Centre receives non-health related inquiries. Volunteers provide directions to businesses within the mall and community and also handle questions related to the administration of the Healthy Ageing Program. Health-related information inquiries are specific and non-specific in nature. Visitors are welcome to browse the display rack and many leave without asking a specific question of the volunteers. These are recorded as non-specific inquiries. Specific health-related requests are those that concern the Health Centre programs (e.g., When is the incontinence lecture series being held) and questions concerning health topics about diseases or conditions (e.g., What is the best diet for lowering cholesterol levels) or health system access (e.g., Which agency can be contacted to arrange home support services). The majority of information requests fall into the specific health-related category (Table 13). As evidenced in the preceding section (Nature of Health Information Requests and Help Received), health information requests can be diverse, ranging from practical help and medical assistance to social support. This diversity necessitates that volunteers be prepared for any type of question or situation and that the resource collection be adequate to assist with these requests.

Table 13: Information requests for the year 2001 (n=3,302)

Health-Related	Specific	1,851	56%
	Non-Specific	634	19%
	Health Centre Programs	263	8%
Non-Health Related	Directions	360	11%
	Administration	194	6%

Our Study to Examine Health Information Needs

We conducted a study to determine what information is being requested most often and what factors influence seniors' requests for health information. Specific requests received by the Cherryhill Health Promotion & Information Centre were tracked from September 1999 to February 2002 (n=3,298). Disease-specific information was requested most often (59%). Fewer requests were received about prevention (17%), system access (16%), and common topics related to growing older (8%). We discovered that the programs offered directly influenced requests. We also discovered that the primary requests from the general population are for disease-based information (medical model). This raises questions about seniors' knowledge of treatable and preventable geriatric issues.

Method

Visits by clients to the Health Centre for information were (and still are) recorded in a daily log. The daily log records each information request, the date and time, mode of inquiry (i.e., walk-in or telephone), whether the client is a resident of Cherryhill and if they are first time visitors, the nature of the request and the action taken, and follow-up if required. Health topics are recorded in the 'nature of request' and 'action taken' columns of the form. Entry of topics is open-ended according to the request received or assistance provided rather than by a set scheme. More than one health topic may be addressed per recorded request. Inquiries are recorded by request rather than by number of visitors. For example, clients visiting the Health Centre in a group but only asking one question would be recorded as one request.

A list of all the health topics as they were recorded in the daily log between September 1999 and February 2002 was created along with their frequency. Based on this list, 53 topics were identified (Table 14). The health topics from the daily log were then grouped under these identified topics. The 53 categories were, in turn, arranged according to four identified themes:

- disease/anatomical system
- geriatric syndromes
- system access
- prevention

Results

From September 1999 to February 2002, specific health-related information was requested with great frequency by clients of the Health Centre (n=3,298). The health topic most frequently requested was cardiovascular disease (9.1%, n=303) followed by

arthritis (7.4%, n=246). Flu vaccination (5.9 %, n=196), bone conditions including osteoporosis (5.7%, n=188) and diabetes (4.8%, n=160) were among the top five topics. Excluding flu vaccination, which comes under the prevention theme, the remaining four are under the disease/anatomical system theme. In contrast, dementia (.3%, n=10), pain (.3%, n=9) and falling (.2%, n=5), all topics under the geriatric medicine theme, rank the fourth lowest, third lowest and lowest over all respectively. Furthermore, of the 12 geriatric topics, 9 (75%) are ranked in the lower half of the frequency range, and 7 (53%) in the lower quarter. Although few prevention topics were requested (n=7), they were ranked high (5 or 71% were in the top half of the range). Information was requested on a wide range of health topics (n=53), the numbers recorded per month range from 26 to 76 different topics (m=49). The number of health topics requested per month increased substantially after March 2001 (m=40, September 1999 and March 2001 (19 months) to m = 68 between April 2001 and February 2002 (11 months) with the move of the Health Centre to a busier section of the mall. Analysis of the four themes reveals that disease/anatomical system information was requested most often (56%, n=1,853, 27 topics). Fewer requests were received about prevention (17%, n=570, 7 topics), system access (16%, n=523, 10 topics) and common geriatric syndrome topics (11%, n=352, 12 topics).

Discussion

This study found that the Cherryhill Health Promotion & Information Centre receives requests for health information on a wide range of health topics. However, the majority of requests are disease/anatomical system related, with few geriatric syndrome related requests. Few prevention topics were requested and along with system access topics are ranked only slightly above geriatric topics. It appears that Health Centre clients' perception of health is largely consistent with a medical model where the focus is on illness and treatment rather than wellness, prevention and access to services.

The relocation of the Health Centre to a busier section of the mall caused the number of health topics requested per month to increase substantially (along with an increase in the total number of inquiries). Several other factors were found that directly influence information requests:

- the programs offered by or through the Health Centre; for example, the introduction of an Osteoporosis Screening Program was the impetus for a significant increase in questions on this topic; similarly, a flu clinic increased questions about flu vaccinations, and a Weight Watchers program about obesity

- the monthly window display featuring a health topic; topics have included thyroid disease, heart and stroke and osteoporosis

- services offered in the Cherryhill community; questions are asked in relation to the ear clinic, home medical supply store, health promotion programs offered through an activity club and branch library located in the neighbourhood

- the arrangement of information materials within the Health Centre; the main display of pamphlets is arranged alphabetically by disease and condition with a smaller display on independent living topics; system services are represented under these topics; for example, the Diabetes Association appears under 'Diabetes'; this influences not only the way people seek information at the Health Centre, but also the way volunteers record requested topics

- local health care trends; the lack of local family doctors has increased requests for doctor referrals

- perception by public that Health Centre provides medical services; the Centre receives a number of requests for medical treatment and testing such as blood pressure testing and wound management

Another factor to consider is the client population who are making these requests. The general population, including younger people, may have different health information needs than seniors. An accurate profile of Health Centre clients is not available because of confidentiality issues. Based on observation, it is known that people of all ages visit the Health Centre, not just older adults who live in Cherryhill. Although it can be surmised that the majority of requests are related to healthy aging issues (younger-aged clients often ask questions about the care of older relatives, and service providers often seek information on behalf of their elderly clients), it remains unclear as to what degree client characteristics have an impact on the study findings.

Conclusion

There is much the Health Centre and similar projects can do to educate seniors about prevention and healthy aging issues. It is encouraging that the health promotion and prevention programs already in place at the Health Centre have been found to have a positive impact on the nature of information requests. Further training will help volunteers to more readily recognize the health needs of an aging population and careful consideration should be given to how information is displayed and presented. Tables 15 and 15 outline, in detail, health topics requested.

Table 14: Health topic information requests from September 1999 to February 2002.

Topic		Total Topic Requests	Theme Totals
DISEASE/ANATOMICAL SYSTEM			1853 (56%)
Skin		29	
Dental		28	
Vision		117	
Hearing		65	
Breast Disease		23	
Cancer		62	
Cardiovascular		303	
Respiratory System		41	
Genitourinary		56	
G-I system:	Bowel	50	
	Liver	39	
	Miscellaneous	52	
Blood System		20	
Endocrine:	Thyroid	134	
	Diabetes	160	
	Miscellaneous	21	
Bone (Osteoporosis)		188	
Arthritis		246	
Brain:	Parkinson's	51	
	Shingles	24	
	Addictions (Alcohol & Drug)	13	
	Depression	21	
	Psychiatric Discorders	40	
	Brain Disorders	70	
GERIATRIC			352 (11%)
Falling		5	
Incontinence/Bladder Problems		64	
Foot Problems		61	
Sleep Problems		13	
Elder Abuse		13	
Medical Alarms		20	
Death & Dying		16	
Pain		9	
Medication Issues		25	
Loneliness/Social Isolation		33	
Alzheimer's Disease		83	
Dementia		10	

Table 14: cont'd

Topic	Total Topic Requests	Theme Totals
SYSTEM ACCESS		523 (16%)
Assistive Devices & Medical Supplies	76	
Medical Laboratories	8	
Doctor Referrals	83	
Caregiver Issues	11	
Transportation	43	
Long-Term Care	28	
Home Care/Support	137	
Health Insurance/Drug Plan	48	
Rehabilitation/Therapy/Wellness	22	
System Access - Miscellaneous	67	
PREVENTION		570 (17%)
Obesity	80	
Cholesterol	72	
Exercise	71	
Nutrition	114	
Flu Vaccination	196	
Smoking Cessation	18	
Alternative Health	19	
TOTAL:	3298	100%

Table 15: Health topics (n=53) ranked by frequency of request (n=3,298)

Rank	Topic	Frequency	Percentage
1.	Cardiovascular	303	9.1
2.	Arthritis	246	7.4
3.	Flu Vaccination	196	5.9
4.	Bone	188	5.7
5.	Diabetes	160	4.8
6.	Home Care/Support	137	4.2
7.	Thyroid	134	4.1
8.	Vision	117	3.5
9.	Nutrition	114	3.5
10.	Doctor Referrals	83	2.5
11.	Alzheimer's Disease	83	2.5
12.	Obesity	80	2.4
13.	Assistive Devices & Medical Supplies	76	2.3
14.	Cholesterol	72	2.2
15.	Exercise	71	2.2
16.	Brain (Miscellaneous)	70	2.2
17.	System Access (Miscellaneous)	67	2.2
18.	Hearing	65	2.0
19.	Incontinence/Bladder Problems	64	1.9
20.	Cancer	62	1.8
21.	Foot Problems	61	1.8
22.	Genitourinary	56	1.7
23.	GI System (Miscellaneous)	52	1.6
24.	Parkinson's	51	1.5
25.	Bowel	50	1.5
26	Health Insurance/Drug Plan	48	1.5
27.	Transportation	43	1.3
28.	Respiratory System	41	1.2
29.	Psychiatric Disorder (Miscellaneous)	40	1.2
30.	Liver	39	1.2
31.	Loneliness/Social Issues	33	1.0
32.	Skin	29	.9
33.	Dental	28	.8
34.	Long-Term Care	28	.8
35.	Medication Issues	25	.8
36.	Shingles	24	.7
37.	Breast Disease	23	.7
38.	Rehabilitation/Therapy/Wellness	22	.7
39.	Endocrine (Miscellaneous)	21	.7
40.	Depression	21	.7
41.	Medical Alarms/Bracelet	20	.6
42.	Blood System	20	.6
43.	Alternative Health	19	.6
44.	Smoking Cessation	18	.6
45.	Death & Dying	16	.5
46.	Sleep Problems	13	.4
47.	Elder Abuse	13	.4
48.	Addictions (drug & alcohol)	13	.4
49.	Caregiver Issues	11	.3
50.	Dementia	10	.3
51.	Pain	9	.3
52.	Medical Laboratories	8	.2
53.	Falling	5	.2

Lessons Learned

Many lessons were learned about health information during the more than six years working with the Cherryhill community. Specifically:

- window displays on a featured health topic significantly increased requests for information on that topic as well as interest in related health promotion programs
- the peer-to-peer model of information giving needs to be supported by health care professionals; professionals give medical advice and more in-depth information about the health care system
- resources of time and material are needed to run a health information centre; budget for resource acquisition is particularly important
- other methods beyond a storefront centre must be employed to reach the housebound elderly; the health information centre can serve as a neighbourhood information clearinghouse and publisher of customized information packages that address local needs

References

1. Gann, R. (1991). Consumer health information: the growth of an information specialism Journal of Documentation, 47(3), 284-308.

2. Freedman, Z. (1989). Setting up a Seniors Health Information Program (SHIP): a pilot project. Bibliotheca Medica Canadiana, 11(2), 97-100.

3. Deering, MJ. & Harris, J. (1996). Consumer health information demand and delivery: implications for libraries. Bulletin of the Medical Library Association, 84(2), 209-216.

4. Cawthra, L. (1999). Older people's health information needs. Health Libraries Review, 16(2), 97-105.

5. Roberts, P. & Fawcett, G. (2001) At risk: A socio-economic analysis of health and literacy among seniors. Ottawa: Statistics Canada.

6. Wagner, TH., Hu, T. & Hibbard, JH. (2001). The demand for consumer health information. Journal of Health Economics, 20(6), 1059-1075.

7. Barker, AL. & Polson, RG. (1999). Best of Health: evaluation of a high-street consumer health information shop in a rural area. Journal of Information Science, 25(1), 15-26.

8. Moeller, KA. (1997). Consumer health libraries: a new diagnosis. Library Journal, 122(12), 36-38.

9. Bartlett, EE. (1987-1988) Patient education and clinical outcomes. Journal of Geriatric Drug Therapy, 2(2-3), 115-125.

10. Bouchard Ryan, E., Meredith, S.D., MacLean, M.J. & Orange, J.B. (1995). Changing the way we talk with elders: promoting health using the communication enhancement model. International Journal on Aging and Human Development, 41(2), 89-107.

11. Crane, PB. (2001). I want to know: exploring how older women acquire health knowledge after a myocardial infarction. Journal of Women and Aging, 13(4), 3-20.

12. Gollop, CJ. (1997). Health information-seeking behaviour and older African American women. Bulletin of the Medical Library Association, 85(2), 141-146.

13. Stoller, EP., Forster, LE., Pollow, R., & Tisdale, WA. (1993). Lay evaluation of symptoms by older people: an assessment of potential risk. Health Education Quarterly, 20(4), 505-522.

14. Winn, S. & Bradford, M. (1991). What people want to know about health. Health Visitor, 64(10), 331-333.

15. Goodman, RI. (1992). The selection of communication channels by the elderly to obtain information. Educational Gerontology, 18, 701-714.

16. Buckland, S. (1994). Unmet needs for health information: a literature review. Health Libraries Review, 11(20), 82-95.

17. Skelly, J. & Boblin-Cummings, S. (1999). Promoting senior's health: confronting the issue of incontinence. Canadian Journal of Nursing Leadership. 12(3), 13-17.

18. Rudd, R. (2002). Health Literacy Overview Slide Presentation. Boston: National Center for the Study of Adult Learning and Literacy, Harvard School of Public Health. (on the Internet)

19. Bouchard Ryan, E. & Butler, R.N. (1996). Communication, aging and health: toward understanding health provider relationships with older clients. Health Communication, 8(3), 191-197.

20. Statistics Canada (2000). Internet use among older Canadians. The Daily. Ottawa: Author. (on the Internet)

21. Sweetland, J. (2000). Users' perceptions of the impact of information provided by a consumer health information service: an in-depth study of six users. Health Libraries Review, 17(2), 77-82.

22. Cosgrove, T. (1994). Planetree health information services: public access to the health information people want. Bulletin of the Medical Library Association, 82(1) 57-62.

23. MacDougall, J. (1999). Community access to health information in Ireland. Health Libraries Review, 16(2), 89-96.

24. Bartman, J., Mummery, V., Poppe, M., Robbins, B., & Robertson-Palmer, K. (1982). Shopping for health? Maybe this storefront health information centre can help. The Canadian Nurse, 78(2), 48-50.

25. Pifalo, V., Hollander, S., Henderson, CL., De Salvo, P. & Gill, GP. (1997). The impact of consumer health information provided by libraries: the Delaware experience. Bulletin of the Medical Library Association, 85(1), 16-22.

26. Bang, DL., Farrar, S., Sellors, JW. & Buchanan, DH. (1998). Consumer health information services: preliminary findings about who is using them. Journal of Medical Systems, 22(2), 103-115.

27. Ratzan, SC. (2001). Health literacy: communication for the public good. Health Promotion International, 16(2), 207-214.

28. Selden, CR., Zorn, M., Ratzan, S. & Parker, RM. (2000) Health literacy: current bibliographies in medicine. Bethesda, Maryland: National Library of Medicine.

29. Saling, J. (2000). What is Health Literacy? Health Literacy Toolbox 2000. (on the Internet)

30. Perrin, B. (1998). How does literacy affect the health of Canadians?: a profile paper. Presented to the Policy Development and Coordination Division, Health Promotion and Programs Branch. Cat. H39-444/1998E. Ottawa: Health Canada.

31. Hayes, KS. (2000). Literacy for health information of adult patients and caregivers in a rural emergency department. Clinical Excellence for Nurse Practitioners, 4(1), 35-40.

32. Estey, A., Musseau, A. & Keehn, L. (1991). Comprehension levels of patients reading health information. Patient Education and Counseling, 18(2), 165-169.

33. Estey, A., Musseau, A. & Keehn, L. (1994). Patient's understanding of health information: a multihospital comparison. Patient Education and Counseling, 24(1), 73-78.

34. Portnoy, EJ. (1985). Communication and the elderly patient. Activities, Adaptation and Aging, 7(2), 25-30.

35. Health Canada. Division of Aging and Seniors (1999). Communicating with seniors: advice, techniques and tips. Cat. H88-3/26-1999E Ottawa: Health Canada.

36. Baker, LM. & Pettigrew, KE. (1999). Theories for practitioners: two frameworks for studying consumer health information-seeking behaviour. Bulletin of the the Medical Library Association, 87(4), 444-450.

37. Bryne, M. & Curtis, R. (2000). Designing health communication: testing the explanations for the impact of communication medium effectiveness. British Journal of Health Psychology, 5(2),189-199.

38. Luptak, MK. & Boult, C. (1994). A method for increasing elders' use of advance directives. Gerontologist, 34(3), 409-412.

39. Jackson, RH., Davis, TC., Murphy, P., Bairnsfather, LE. & George, RB. (1994). Reading deficiencies in older patients. American Journal of Medical Sciences, 308(2), 79-82.

40. Jamison, JR. (2000). A survey to evaluate chiropractic patients' preferences for health information brochures. Topics in Clinical Chiropractic, 7(4), 35-42.

41. Petterson, T. (1994) How readable are the hospital information leaflets available to elderly patients? Age and Ageing, 23(1), 14-16.

42. Petterson, T., Dorman, TL., Albert, T. & Lee, P. (1994). Are information leaflets given to elderly people with diabetes easy to read? Diabetic Medicine, 11(1), 111-113.

43. Baker, FM., Johnson, JT., Velli, SA. & Wiley, C. (1996). Congruence between education and reading levels of older persons. Psychiatric Services, 47(2), 194-196.

44. Byrd-Bredbenner, C. & Kiefer, L. (2000). The ability of elderly women to perform nutrition facts label tasks and judge nutrient content claims. Journal of Nutrition for the Elderly, 20(2), 29-46.

45. Duffy, MM., Kotch, MJ. & Ordelt, K. (1999). It's on paper, but do they under stand it? Hospital Case Management, 7(4), 75-76.

46. Dickinson, D., Raynor, D\K. & Duman, M. (2001). Patient information leaflets for medicines: using consumer testing to determine the most effective design. Patient Education and Counseling, 43(2), 147-159.

47. Health Canada. Division of Aging and Seniors (1991). Communicating in print with/about seniors. Cat. H88-3/7-1990. Ottawa. Health Canada.

48. Huron County Health Unit. (1991). Clear language guidelines for developing written material. Clinton: Author.

49. Kimble, CS. & Longe, ME. (1989). Health promotion programs for older adults: a planning and management guide. Chicago: American Hospital Publishing.

50. Grier, V. (2000). Health information for the millennium and beyond. Health Libraries Review, 17(1), 32-36.

51. Spatz, MA. (2000). Providing consumer health information in the rural setting: Planetree Health Resource Center's approach. Bulletin of the Medical Library Association, 88(4), 382-390.

52. Speak, M. (1991). Promoting library resources in Age Concern day centres. Health Libraries Review, 8(1), 21-28.

53. Alliance of Information and Referral Systems (2000). Standards for Professional Information and Referral. Seattle: Author.

Chapter 9

Summary & Recommendations:

- governance structure
- current health & population trends
- health system gaps & suggestions for improvement
- the role of seniors & volunteers
- using the right language
- recommendations for sustainability of the Cherryhill Healthy Ageing Program
  - governance & committee structure
  - staffing
  - space
  - evaluation
- references

Summary & Recommendations: *Key Conclusions*

The following are a combination of evidence-based and experiential conclusions reached as a result of our more than six years collaborative work with the Cherryhill community. Information and data sources are listed in Appendix A, community case studies in Appendix B.

Governance Structure

We strongly believe that a system of care for seniors requires a unity of governance to begin to overcome the problems of system interfaces, agency and institution specific standards and charting practices, and to encourage the formation of a team structure to improve coordinated care and communication.

The acute care system largely evolved to meet the needs of acutely ill younger persons, who, if they survived, would return home. The care of the client was, and still is usually undertaken by a team consisting of a physician, nurses, almoner (social worker), therapists, etc. The team typically functioned under the unbrella of a single organization. It would have seemed foolish to have had each team member, or each part of the process (e.g., surgery; wound care; etc.) under a different structure. Now we have moved into an age of chronic disease, and the reach of the care team needs to stretch beyond the walls of the hospital, in which, these days, the client may never occupy a bed. A structure with greater horizontal reach, and over longer times is needed. No true team exists and there is no unity or philosophy of structure or practice. Each provider may have a different reporting agreement to different agencies and there is no clearly defined unity of purpose, responsibility, and financing across the system.

We feel the ideal structure would be a unified model of delivery under a single management and financial framework. This will not happen as it would require an agency or hospital to give up part of their budget to the new structure. Failing this, a commitment of staff time to a unified model for a defined period ($\geq$ 5 years) could work. Each agency keeps nominal control of the finances over the long-term, but contributes to a unified model which falls under a specific independent management umbrella. The program would be run by a manager who reports to a committee of partners in the

program. This model keeps longer term financial control with the agencies and/or institutions but relinquishes some control of the staff over the short term. We do not believe this will prove realistic either.

Finally, and hopefully more realistically, agencies and institutions will agree to collaborate, through a memorandum of understanding, as proposed by SWOGAN, in the development of an evidence-based continuum of care for frailer older perople by involving the community as an equal partner, and contributing support to meet the community's needs (e.g., running costs; etc.).

Gauthier[1] reviewed the literature of networks, as a potential goverance structure for the delivery of geriatric care. Although networks can range from (a) loose voluntary collaborations through (b) a self-governing organization composed of cooperating but autonomous organizations, to (c) a greater level of integration, it appears that there are some key elements that apply to all network structures. These key elements are:

- a clear mission, indicators of success and an understanding of each contributor's role
- information management (communication)
- a continued re-assessment of needs and performance
- accountability to the funders and, especially, accountability to the community served

Current Health & Population Trends

There is a great deal of evidence regarding current health and population trends which suggests:

- the number of seniors in the community requiring health services is growing quickly and a significant increase in future health service needs is predicted

- there appears to be no clear model in place whereby these growing needs can be met; simply limiting services through fiscal restraints does not constitute a model of successful health care planning

- it is unlikely that the system will provide other than the narrow medical model needs & some rehabilitation needs; the peripheral services so critical for seniors with limited reserves will remain unmet; health is a holistic concept of which disease-based service provision is an important but insufficient part

- a collaborative approach involving the system and community is needed to fully meet these growing needs; the community contributions will vary from community to community but have been defined for the Cherryhill community

- in order to achieve the necessary collaborative model, a community capacity building approach, and in our experience, specifically a community-systems approach is needed to build the system to meet these growing health care needs

- the community-systems approach is a process that puts some of the responsibility for health and health services into the hands of consumers themselves and the communities within which they live; inherent in this approach is *true* shared decision-making and shared control in identifying issues of importance in their community, and in planning, implementing and evaluating health care services to address the collaboratively identified issues

- the geriatric expertise required to address the health needs of frailer older individuals living in the community continues to be housed behind the walls of institutions; these institutionally-based services (e.g., Parkwood Day Hospital) are already at saturation levels

- for senior care a way of duplicating the institutionaly-based expertise in the community is needed

- an essential element of senior care, especially for frail seniors is continuity across time; there is evidence that such an approach produces better outcomes, this being dependent upon the intensity of follow-up; however, intensive professional follow-up is expensive and probably not feasible; this again emphasizes the need for consumer and community collaboration

- currently there are a large number of unmet health needs, as well as system gaps in the community; the health system has not evolved to meet the needs of the increasing number of frailer older individuals living in the community, for example:
    - the health system as a whole continues to be funded in silos
    - there is no cross-flow of funds or resources between hospitals and communities (e.g., a hospital surplus does not benefit the community)
    - hospitals are discharging elderly patients "quicker & sicker"

- communities are receiving sicker patients while at the same time losing peripheral supportive services and provincially funded community-based rehabilitation services
- communication across the health system is not great; much time is spent accumulating information at each new interface
- a reactive, crisis intervention approach is being used rather than a health promotion & prevention framework

- overall the system is a health insurance system; it picks you up when you fall, but does too little to prevent the fall in the first place

- there is currently a gap between evidence & practice; we lack a methodology for the implementation of research into practice; such a preventive approach must range from simple interventions such as flu clinics, through a more intensive effort to implment evidence-based medicine at the population level (reduce the care-gap) to more complex interventions to prevent such negative outcomes as falls and malnutrition

There is a significant mismatch between the governance and accountability structure of institutions/hospitals and the collaborative capacity building principles required to work with the community. There are frequently, if not always, issues around ownership and control that create major roadblocks and impact community involvement. A willingness to let go and accept joint ownership of programs and policies with the community and with other collaborative partners is essential by all involved in order to sustain change. Most institutions/hospitals feel that it is not in their best interest to provide resources beyond the walls of the institution or to allow cooperative health planning and care delivery. Community capacity building works with communities of frailer older individuals if community development principles and appropriate theoretical frameworks are utilized to ensure "true" active participation by the community that includes shared decision-making and a shift in "power" and equal ownership of programs when the time is right.

A commitment of adequate time and resources is critical to develop, implement and evaluate a new model of care. Community capacity building is time intensive up-front and community development literature suggests that five years is not unreasonable to operationalize the concept and achieve sustainability. It is very difficult, if not impossible, to build a sustainable model with "soft" funding. Commitment and adequate resources have been identified as critical elements. To successfully build and create a new model using a community capacity building approach it is important to work from the "inside out"; visibility, office space and a storefront in the community all impact the building of trust, getting buy-in and optimizing the involvement of community seniors.

Health System Gaps & Suggestions for Improvement

- there is presently no continuum of care for community seniors; currently a referral and discharge ("items of care") approach is being used; this fragmentation of care leads to a "revolving door" phenomenon; the system exists in vertical silos with no horizontal continuity of care
- no one carries responsibility for the care of the frail senior across the system
- such a responsibility would seem to be best met by a case management approach; there is no overall, ongoing case management in place and little or no team structure
- fear is one of the biggest issues identified by older individuals living in the community; fear of being institutionalized and lack of trust of the system; a more user-friendly system is needed
- in addition to physical frailty, a significant number of community seniors have moderate to severe cognitive impairment and many are house-bound making identification of those at risk difficult; a case finding/gatekeeper model is required
- although care of frail seniors needs to be based on adequate assessment, the comprehensive geriatric assessment is cumbersome and too time intensive; a more targeted assessment process is needed
- information sharing is problematic because of confidentiality and varying standards between agencies; a collaboratively developed process that is acceptable to all, including assessment tools, data base, etc. is needed
- there are many problems of access for potential clients in need; a need for a family physician can be an obstacle and the need for the client to formally consent - in the face of limited insight - can be an obstacle to service provision; a different process is needed
- the current shortage of family physicians, limited home visits, lack of a system to deal with those incapable of self-determination and a very medical model focus fails to meet the needs; family physicians are too few and too busy to meet all the needs; the simple model of physician assessment, providing prescriptions which the client may or may not fill and may or may not take, does not work well for seniors

- a geriatric nurse practitioner working in collaboration with CCAC could function across several family practices, adopt a caseload that relieves the family physician's time and may permit expansion of the physician's caseload in a manageable way, provide care management and work with the community to provide supervision (e.g., of medication taking) to improve outcomes

- in-home rehabilitation, as provided through CCAC, is limited to an educational model; our impression based on anecdotal individual client experience is that this may not be the best approach for seniors

- in-home rehabilitation is very sparse and many seniors are unable or unwilling to get to institution-based programs; thus many do not receive the rehabilitation they need

- a new approach to rehabilitation is needed; an in-home and in-community treatment model needs to be developed; the needs of the housebound must be met

- psychosocial and physical function maintenance programs need to be provided as part of the continuum of care
  - a continuum of evidence-based *therapeutic* psychosocial and physical function maintenance programs (vs. activity programming) needs to be provided by, or at least planned by, degree-trained therapists
  - a system is required to ensure that programs are capable of doing what they are purported to do

- a system whereby therapy programs can be run by a trained therapy assistant working under supervision of a specialist therapist would allow extension of the therapist's expertise

- a flex care program utilizing personal support workers (PSWs) is missing in the community; this would provide a level of continuity and supervision, and can be the conduit for maintenance activity programs such as provided by the Canadian Centre for Activity and Aging but will be of limited value if clients are discharged from the CCAC caseload and not linked into a case management model providing ongoing supervision

- a team approach with multidimensional components would work better and is supported in the literature; a way to develop this is needed; within the Cherryhill community it will be dependent upon both the availability of space and the funding of therapist and personal support worker time to attend team meetings

The Role of Seniors & Volunteers

- the system cannot meet all the increasing needs of frailer older individuals in the years to come; a community-integrated practice, using a community capacity building approach, is one way to meet the needs of the growing senior population

- a great emphasis on community self-sufficiency is required to compensate for the shortfall in formal health service provision; community capacity building is key; cutbacks in the system in recent years have occurred in the absence of a conceptual framework for the development of an effective and efficient system; the proposed collaborative community-systems approach provides a framework for future planning

Frailer older community members (volunteers) and communities can contribute meaningfully to a model of care for community seniors. There is much that seniors can do to help support their frailer neighbours to remain active, independent and in their own homes, and out of costly insitituions, for as long as possible. There are clear parameters regarding what community members are willing and able to do. The concept of "environmental press" applies to the volunteer as well as the client. Seniors feel most comfortable on the periphery of patient care helping with information provision, social program support, monitoring of their frailer neighbours and senior advocacy. There is great potential for participatory action research. The community has a major potential to contribute to the training of medical students, nurses and other health professionals. Ongoing and consistent on-site professional support is required to retain volunteers and optimize involvement. Creating "true" partnerships with communities of individuals with advancing age and increasing health needs requires commitment and a unique approach that is time and effort intensive.

Using the Right Language

Many terms are used to describe older individuals including titles such as elderly, geriatric, senior and senior citizen. Overwhelmingly the preferred terms are seniors and senior citizens. The least liked term is geriatric. This term was very unpopular with all individuals who are growing older. Seniors' acceptance of geriatric services may be adversely affected by the terminology used.

Recommendations for Sustainability of the Cherryhill Healthy Ageing Program

The primary purpose of the Cherryhill Healthy Ageing Program to date has been to determine whether a community of seniors could participate meaningfully in their own health care planning and delivery, and whether the community systems approach was a feasible methodology for achieving this collaborative relationship between the community and the formal health care delivery sector. The focus, during these six years, was on building a new and innovative model of community health for seniors and to explore potential evaluation indicators that might prove useful in measuring change in community capacity once this new model is implemented. Community capacity building, and specifically the community systems approach, has proven effective and it is clear that a community of seniors, including frailer older seniors, can share responsibility for the planning and delivery of their health care.

We are now at a critical decision-point. The Cherryhill Healthy Ageing Program has grown and evolved significantly during the past six years, with an increasing number of health partners and community members becoming interested and involved. We are now in a time of transition. In order to sustain what has been collaborative built in the Cherryhill community, the key geriatric service partners in the health system must come together, pool their resources and collaboratively determine how to best implement the new model of care that is required to meet the rapidly increasing needs of frailer older people living in the community. The change in governance must begin in September 2002 when existing research funding for the GNP and therapy support ends. Based on the evidence and our experience we recommend the following:

1. Governance & Committee Structure

1.1 Create a board/governance body with representation of each of the following major partners:

- Community Care Access Centre (CCAC)
- Specialized Geriatric Services (SGS)
- Victorian Order of Nurses (VON)
- Ministry of Health (Long-Term Care Division)
- Cherryhill community

There must be a common philosophy, *true* collaboration with the community and a community capacity building approach must be continued. It is imperative that the community be included in this process with appropriate representation and equal voting rights with the system. Given the limitations of the system to

provide comprehensive care beyond a very focused medical/rehabilitation model the involvement of the community is critical.

1.2 Create permanent sub-committees to collaboratively focus on the development and maintenance of the main components of the Cherryhill Healthy Ageing Program:

- health information & communication (including day-to-day operation of the Cherryhill Health Promotion & Information Centre)
- clinical programs including the community response team, and the adjunct supportive programs (e.g., safety check program; gate keeper training; development of specialist clinics; etc.)
- rehabilitation & maintenance; build the required programs, their evidence-based content & determine the division of responsibilities between specialist therapist & therapy assistant
- psychosocial programs, in response to defined needs & as far as possible evidence-based
- prevention requires a special focus; a working relationship with UWO academics to create an evidence-based prevention program needs to be developed; common threads or vehicles to implement prevention strategies across different themes are needed
- an education sub-committee is needed to expand on the academic/ education links created with UWO departments (nursing, PT, OT, medicine); involvement of other universities and community colleges for training of recreation therapists, personal support workers, etc. can be explored

1.3 A temporary sub-committee structure is proposed to deal with specific issues. Within the Cherryhill context these could range from the assessment process, to setting information standards. Sub-committees could be struck to achieve a specific task and folded when tasks are completed.

2. Staffing

2.1 Responsibility for volunteer and psychosocial program co-ordination, and the day-to-day operation of the Cherryhill Health Promotion & Information Centre, will pass to VON Canada in September 2002. The funds are in place to hire someone for 2 days a week, the minimum time required. However, funds will be required for the approximately $10,000 annually required to operate the health centre. These costs should be shared between VON, CCAC, SGS, MOH and community fund raising efforts.

2.2 Funding is required for a *part-time GNP* dedicated to the Cherryhill community (2 days/week). It is clear that the work is there and it already falls under the mandate of Specialized Geriatric Services (SGS). No extra funding should be required. The GNP will adopt a case management model for selected clients. This should be done in collaboration with CCAC case managers.

2.3 Funding is required for a *full-time therapy assistant* to run the exercise/ maintenance/therapy programs. Maintenance program costs could be offset through user fees. This might most appropriately be done through the CCAC, but could equally be an outreach component of the Geriatric Day Hospital.

2.4 Funding for a *part-time physiotherapist and occupational therapist* (1 day/week) is needed. It is recommended that CCAC therapist funding be provided for the physiotherapist through a re-assignment of current therapy funding and that SGS provide funding for the occupational therapist through an expanded day hospital role.

2.5 An *on-site geriatric clinic(s)* should be considered with a focus on both GNP/geriatrician clinics and home visiting, as well as special focus clinics (e.g., falls; incontinence; dementia; etc.).

3. ***Space***

3.1 The Cherryhill complex should become a neighbourhood initiative for the CCAC, with dedicated case managers, flex care in buildings, and a few select therapists (working collaboratively with the therapy assistant and SGS funded specialist therapist). This will allow for efficient service and creation of an integrated inter-agency team structure, but will require physical space.

3.2 London Housing should be approached to provide space, through apartment rental, within at least several high-use and strategically placed buildings. This will provide the requisite meeting space for staff, personal locker space and limited therapy space. This is particularly critical for the initiation and maintenance of flex care programming and creation of a functional team structure.

3.3 ESAM (Cherryhill property owners), as part of this overall sustainability plan, will be asked to provide a further 5-year commitment for appropriate space in the Cherryhill mall for the Health Promotion & Information Centre.

4. Evaluation

4.1 It is suggested that an evaluation committee be formed to ensure outcome measurement related to community capacity building, program evaluation and

and overall data gathering and analysis. When the new model is operational, funding for a fuller comparative evaluation with other models of service delivery can be sought.

References

1. Gauthier, N. Building successful networks. A presentation to SWOGAN Advisory Committee, June 14, 2002.

About the Authors . . .

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Marita Kloseck is the Manager of Program Development, Evaluation & Research for the Cherryhill Healthy Ageing Program, and a researcher in the Division of Geriatric Medicine, University of Western Ontario (UWO). She has a joint Ph.D. in Health Studies and Gerontology, and Leisure Studies from the University of Waterloo. Her areas of specialization are health program evaluation and community development. Marita is also Assistant Professor, Faculty of Health Sciences, UWO and a scientist in the rehabilitation and geriatric program with the Lawson Health Research Institute (LHRI). Marita has 22+ years experience in the health care field as a practitioner, researcher , manager and consultant. She is recognized for her work in the area of health-related outcome measurement and program evaluation, and provides training to health and social service agencies in Canada and the United States.

Dr. Richard G. Crilly

Richard Crilly is the Program Director for the Cherryhill Healthy Ageing Program, and is Associate Professor in the Division of Geriatric Medicine, Department of Medicine, UWO. He did his medical and research training in the United Kingdom before moving to Canada. His interests range from osteoporosis to community development related to care of the elderly. In the past he has been Chair of the Division of Geriatric Medicine and Director of the Regional Geriatric Program (RGP) of southwestern Ontario where his main interest was the development of community independence in geriatric assessment and management, and program evaluation.

Lisa Misurak

Lisa Misurak is the Health Information and Community Development Coordinator for the Cherryhill Healthy Ageing Program. She has a Master's degree in Library Science from the University of Western Ontario and over fifteen years experience in information and project management, including database management and publication production. She is Information Manager for Information London and a web portal, *thehealthline.ca*. Lisa has served as a representative for the Council for Seniors and the London and Area Association of Volunteer Administration. She has applied her information science background to a variety of social service and health care programs that help link people to community and health services.

Appendix A: Information & Data Sources

INFORMATION & DATA SOURCES

During our 6+ years working in the Cherryhill Healthy Ageing Program numerous quantitative and qualitative research methods were used to gather evidence related to the health and psychosocial needs of older persons living in the community, health system gaps, building community capacity, how to optimize involvement by older individuals, and the potential role of older community members in the planning and provision of their own health services. In keeping with community development and capacity building principles we used a participatory action research approach. Our findings are summarized from the following:

- community survey - 1997 (n=1231)*
- community survey - 1998 (n=181)*
- analysis of actual Geriatric Nurse Practitioner (GNP) referrals & full comprehensive geriatric assessments (n=76)
- ongoing feedback from community health service partner agencies (n=12)
  community meetings (n=55)
- focus group with Cherryhill resident safety monitors - 2001 (n=44)
- focus group with city-wide community developers - 1997 (n=12)
- focus groups on specific topics (osteoporosis; memory; bowel & bladder issues; hearing loss; vision; falls prevention) (n=34)
- deconstruction & analysis of actual case studies (n=7)
- Cherryhill Community Response Team: Six-Month Pilot Testing with the Middlesex-London Health Unit, 2002
- building manager surveys - 1997 & 2000 (n=25)
- ongoing feedback from health centre volunteers (n=48)
- volunteer retreat - 2002 (n=37)
- community rehabilitation needs analysis - 2002 (n= 17)
- exploratory analysis of Community Care Access Centre (CCAC) Middlesex-London, Regional Geriatric Program (RGP), and Cherryhill community geriatric nurse practitioner service & intervention patterns - 2002
  Cherryhill Health Promotion & Information Centre staff, volunteers & daily information statistics (ongoing)

* Note: Consistent with community development and community capacity building principles the surveys were collaboratively developed with community residents. A resident committee was establidhed to develop the surveys and to put in place processes for survey distribution. This committee organize a 3-tiered "help" system that included: (1) a help table in the lobby of each of the apartment buildings, manned by community members during the morning and afternoon, each of the days that were designated for survey completion; (2) community residents who were "on-hand" to provide one-on-one assistance in residents' apartments if they were unable to come to the lobby help table; and (3) community volunteers (non-residents) who were "on-hand" if any of the residents expressed concern regarding anonymity and confidentiality and did not want assistance from fellow community members.

Appendix B: Actual Case Studies from the Cherryhill community

Cherryhill

Healthy Ageing Program

Case Study 1: Mrs. C.

Level 1: unable to leave apartment and/or apartment building

Mrs. C., aged 80 years, widow x 15 years, of European background, was referred by the apartment building manager. Reasons for referral included increased cognitive and physical decline, weakness, poor nutrition, weight loss and social isolation. The referral was supported by the Community Care Access Centre (CCAC) case manager who was aware of the case but had not completed an assessment. Concerns had been raised that this lady would refuse services. Mrs. C's cognitive deterioration occurred in the past 6 months. She had seemingly been managing in her apartment but recently required reminding to pay the rent. She stated she could not find her cheque book and thought that someone had stolen it. She later located the cheque book in her apartment. Mrs. C. had none to minimal food , some of which was spoiled, in her apartment. She was having to be returned or re-directed to her apartment by neighbours. At least 2-3 months prior, Mrs. C. indicated that she had experienced periods of not feeling well and only wanted to sleep. Mrs. C. is increasingly becoming suspicious of others and is aware that her memory is "not as good as in the past".

The Cherryhill Geriatric Nurse Practitioner (GNP) contacted her family who lived in the Niagara region, but no telephone calls were returned by the family to either the GNP or CCAC case manager. The CCAC assigned a personal support worker (PSW). Unfortunately no one could be found who spoke this lady's language, and although it had been proposed that relationship building was critical first, the PSW insisted on wanting to bathe this client. It was arranged for a translator (social worker who has much experience working with cognitively impaired clients) to be present at the initial contact with the PSW. The Public Guardian and Trustee office was contacted by the CCAC for consultation. Other organizations with ethnic connections such as with Inter-Community Health Centre and churches were contacted with no success. The social worker started to provide food but this was becoming costly. contacted with no success. The social worker started to provide food but this was becoming costly. The social worker was not able to determine financial sources and arrangements. CCAC called a conference to discuss the situation with the client's family doctor and others. The Public Guardian and Trustee viewed the client as a low priority - 2-3 months to conduct a review. A letter was written by a geriatrician to the Public Guardian and Trustee to facilitate the process.

<u>Issues of concern include</u>:

- cognitive decline (e.g., forgetting to pay rent; wandering in the hall; etc.)
- not receiving any health services (initially)
- suspiciousness
- minimal to no food in the refrigerator (weight loss; concerns expressed by safety monitor in the building)
- complaints of feeling as if she needed to sleep much of the time
- social isolation

Cherryhill

Healthy Ageing Program

Case Study 2: Mrs. S.

Level 1: unable to leave apartment and/or apartment building

Mrs. S. aged 80 years, lives alone. She was referred by the property owners because of frequent tenant complaints that she was harassing them and the building managers were unable to reason with her. Mrs. S. was hearing loud voices in her apartment and blamed other tenants as deliberately making noises to annoy her. She did not feel that she could leave her apartment and she had not done so for several weeks to months. During the assessment she frequently referred to herself in the third person (i.e., "Susan needs a friend!"). She was conferenced with a geriatrician and outreach team, and a direct referral was made to Third Age Outreach. A social worker is currently visiting. A referral was made to Geriatric Mental Health. She was started on Olanzapine and will be followed over the next 5 months. Recently changed to Risperidone.

Issues of concern included:

- many physical, social & emotional issues
- 24 diagnoses (fibromyalgia; diverticulosis, osteoarthritis; hypothyroidism; ?MI; angina; etc.)
- 20 medications noted and several allergies (had been on antidepressants in past with no effect; on Bromazepam and Amitriptyline presently)
- scores on depression scales suggest a mild to moderate depression
- complains of hearing voices increasing over past year (has been hearing voices for 4 years; in reality voices from neighbouring apartments could be heard, although somewhat muffled; during the assessment complaints were somewhat out-of-proportion to the noise; in addition she feared that the female making the noise was being abused and this may have brought back memories which Mrs. S. alluded to during the assessment)
- poor, disruptive sleep
- irritable with increased anxiety and nervousness; frightened of dying alone
- indicated she had a history of "bad nerves"
- some financial issues; had considered moving to another location but "just not able to"
- known to CCAC for years & receives 3 hours/week for homemaking (finds self too weak when peeling vegetables and has a neighbour come in to prepare meals)

Cherryhill

Healthy Ageing Program

Case Study 3: Mrs. M.

Level 2: able to access the immediate Cherryhill environment

Mrs. M., age 88 years, is living alone. She was referred by her family physician with much support and encouragement from the CCAC case manager who was concerned about this lady's cognition and capability of managing in the home. Specific reasons for referral included increasing disorientation and confusion, paranoia (accuses others of stealing her possessions) and input as to appropriate living arrangement. Concerns were raised as to whether Mrs. M. could/should remain in her apartment given cognition issues. It was indicated that she often put furniture in front of her door so that others could not come in. Cognitive decline had been noted 4-5 years and recently there were more incidents in which she indicated that people had stolen from her. She had even called the police on occasion about her best friend, relative and power of attorney from Toronto stealing her rings. There were also incidents of her not being able to locate her purse. She indicated that she always eats out at the mall, but not much food was found in her apartment. On the day of the assessment there was no food in her refrigerator. She resists relatives' offers of groceries or to purchase food. She rejected CCAC involvement and was suspicious of what and why she needed services. She was observed eating at the mall, but people who had known her in the past remarked on her significant weight loss and confusion. She did not recognize her previous work colleagues. She had also been found in the lobby of her apartment wearing only a nightgown.

Family education was provided to help them understand the dementing process and next steps re: nursing home options. Considerable support was provided to the power of attorney as she moved along the health care system (navigated it) and dealt with legal issues re: capacity.

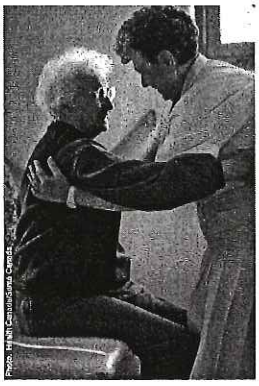
Issues of concern include:

- cognitive decline, disorientation, wandering, and misplacement of personal possessions
- weight loss; "skin & bones"; no food in refrigerator
- paranoia; angry with family if asked too many questions or she felt they were checking on her
- poor nutrition; spoiled food on the stove

Cherryhill

Healthy Ageing Program

Case Study 4: Mrs. J.



Level 2: able to access the immediate Cherryhill environment

Mrs. J., aged 79 years, was referred by her family physician, although an indirect referral was received from a bank employee, as well as her daughter. The reason for referral included memory loss, confusion, poor insight and potential financial abuse over 4 years because of issues with her poor insight and judgment. In the past Mrs. J. had spent large amounts of money on having her apartment cleaned, and bought golf clubs (for sentimental reasons; she does not play golf). She presents herself as socially appropriate but becomes very angry with family. According to her daughter, there is a 60-year history of alcohol abuse, with physical abuse in the past. Mrs. J is becoming increasingly forgetful, but she denies this, although she admits that her memory is not as good as in the past. She eats most meals at the Cherryhill Mall and is often not at home. She has developed a routine of going and coming to and from the mall throughout the day. She has had small fires in her apartment and for this reason does not cook. She denies the fires. Mrs. J's daughter is concerned about potential financial abuse since her mother is alone and vulnerable. Mrs. J's medical history includes several risk factors which could contribute to changes in cognition and unusual behaviours (atrial fibrillation; pacemaker insertion; aortic and mitral valve replacements; cerebral vascular accidents involving the frontal lobe and cerebellum; cerebral hemorrhage secondary to Coumadin in a fall; alcohol overuse). She has been seen in the past by Dr. Harris re: cognition and behaviours. He had recommended a capacity assessment which she refused, and as a result was very angry with her daughter. A few times the daughter was in tears about the gravity of the situation as she perceived it. Support was provided to Mrs. J's daughter who felt isolated and at a loss. It was difficult to get Mrs. J. to agree to a comprehensive geriatric assessment.

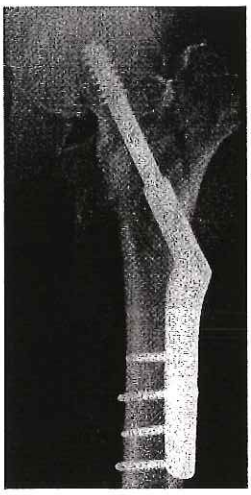
Issues of concern include:

- cognitive decline noted by family although MMSE remains stable
- spends most of her time in the mall; does not remain at home
- at risk financially because of poor insight (financial vulnerability)
- unusual behaviours related to lack of insight & cognitive decline
- weight loss related to poor nutrition & forgetfulness to eat; does no cooking at home but snacks
- takes medication irregularly

Cherryhill

Healthy Ageing Program

Case Study 5: Mr. H.



Mr. H. was born in 1906. He was living independently in Cherryhill. In 2001 he was admitted to hospital with abdominal pain. He was found to have an obstructed hernia, and had surgery which went well. Post-operatively he had a heart attack. Mr. H. went into congestive heart failure. He was started on evidence-based medications. These medications caused his blood pressure to drop. Mr. H. got out of bed, felt dizzy, fell and factured his hip.

He had surgery; a dynamic hip screw was inserted. Post-operatively Mr. H. became confused and went into urinary retention. He was put on more medications. Mr. H. was given:

Ramipril
Atenolol
Furosemide
Slow K
Olanzepine
Trazodone
Terazosin
Tylenol No. 2
Colace

These medications were all new to him. One acute problem was turned into several chronic problems.

Cherryhill

Healthy Ageing Program

Case Study 6: Mrs. B.

Mrs. B. was living alone. Recently she fractured her hip. She had no social supports. Mrs. B. was using a walker, but was unsafe on her feet. She was seen by the Cherryhill Geriatric Nurse Practitioner (GNP) in her home. It was determined that Mrs. B. needed therapy. She was referred to the Parkwood Geriatric Day Hospital, but refused to go. There was no community-based rehabilitation. Mrs. B. fell again, and was again admitted to hospital.

Cherryhill

Healthy Ageing Program

Case Study 7: Mrs. R.

Mrs. R. is referred to the Cherryhill Geriatric Nurse Practitioner (GNP) by her apartment building manager. He complains that Mrs. R. is confused, and that there is an odour coming from her apartment. There are numerous complaints from other residents.

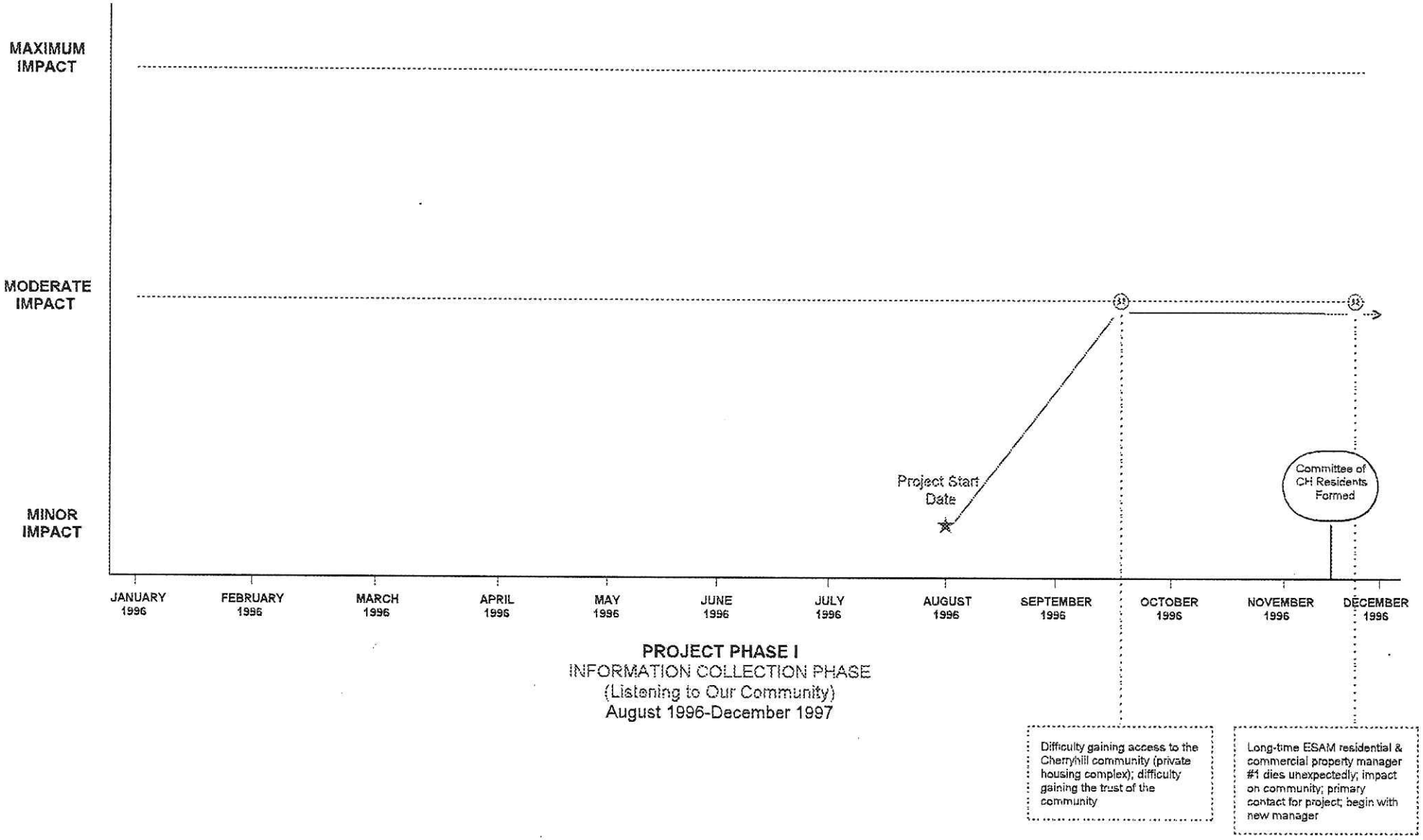
Mrs. R.'s family physician won't refer her because he hasn't seen Mrs. R. in several years. The CCAC is blocked from doing anything. Mrs. R. can't self-refer and can't get herself to her family physician because she is cognitively impaired. Mrs. R.'s family is not willing to become involved. Mrs. R. is at risk of being evicted from her apartment.

The Cherryhill GNP makes a "cold call", assesses Mrs. R., builds trust, and bridges the gap between Mrs. R. and the system.

Appendix C: Cherryhill HealthyAgeing Program

Challenges & Crisis Points

CHERRYHILL COMMUNITY PROJECT - CHALLENGE/CRISIS POINTS

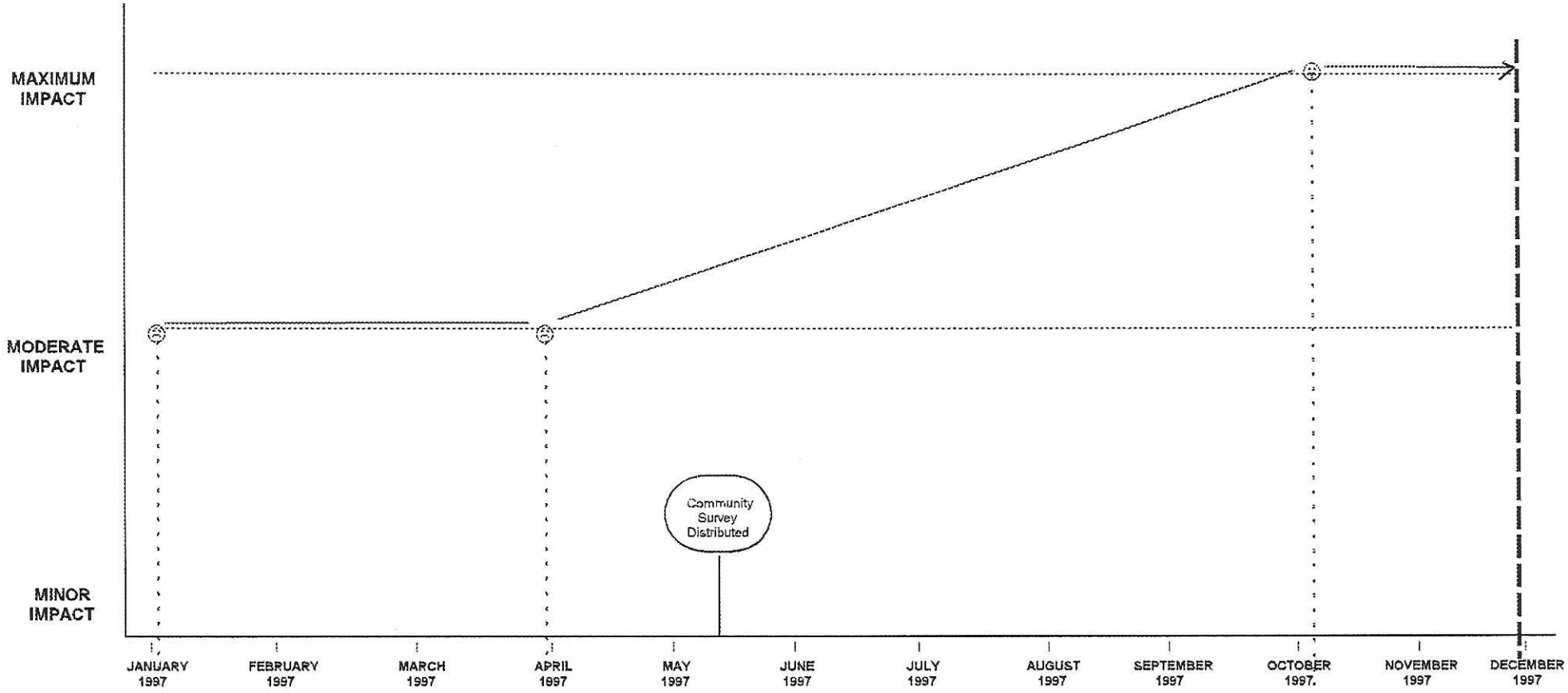


PROJECT PHASE I
INFORMATION COLLECTION PHASE
(Listening to Our Community)
August 1996-December 1997

LEGEND

Maximum Impact: Incident seriously compromises the continuation of the project
Moderate Impact: Incident significantly affects project time lines but does not put the project at risk
Minor Impact: Incident affects project operations

CHERRYHILL COMMUNITY PROJECT - CHALLENGE/CRISIS POINTS



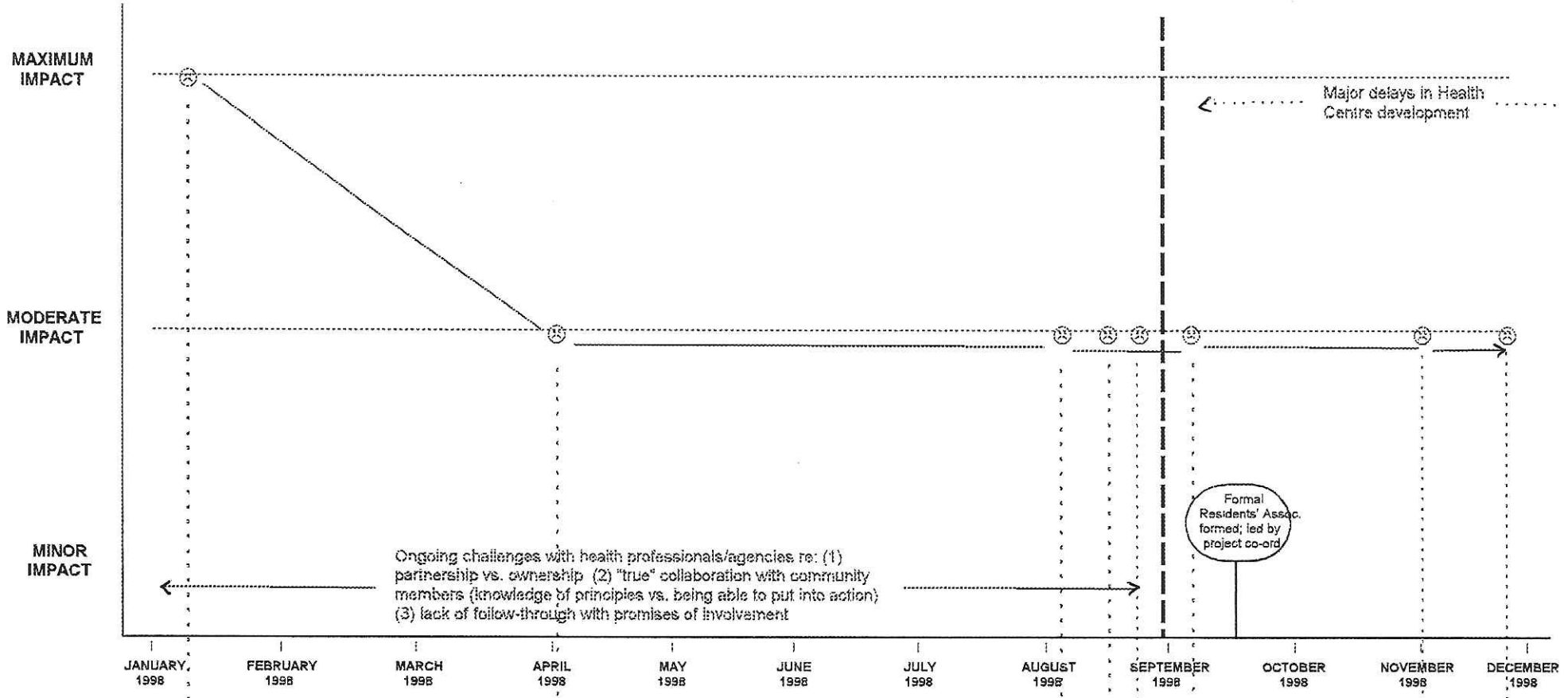
PROJECT PHASE I
INFORMATION COLLECTION PHASE
(Listening to Our Community)
August 1996-December 1997

New ESAM residential & property manager #2; very different style from manager #1; all previous project agreements & procedures terminated; new project plans & procedures put in place in collaboration with manager #2; community survey which was collaboratively developed with residents, health professionals & manager #1 & which was in final draft form halted; manager #2 requested major revisions in survey & procedures; significant delay; community members becoming increasingly frustrated; some volunteers lost; new volunteers recruited; 3 month delay in getting the community survey out

Delays cause frustration among community members; personality conflicts arise between community members; resident committee members threaten to quit if chair stays on; continuing to build trust & increase community involvement

UWO research assistant falsifies survey data; student is terminated; all data (n=1231) have to be re-entered into data base; 2 months lost plus an additional month required to re-enter data; cost to hire 2 new individuals for data entry; project co-ordinator required to focus time on data entry; total project time lost 3 months; community members become increasingly frustrated by delay in dissemination of survey results & delay in community action; community interest & support decreases

CHERRYHILL COMMUNITY PROJECT - CHALLENGE/CRISIS POINTS



PROJECT PHASE II
COMMUNITY ACTION PHASE
January 1998 - August 1998

PROJECT PHASE III
SUSTAINABILITY PHASE
September 1998 - July 2000

When action phase begins many health professionals are reluctant to take on anything requiring active involvement; only interested in providing consultation; not interested in working directly with community members;; future of project uncertain; only 3 health professionals from the original organizing committee volunteer to lead community action teams; project moves forward

Lose a number of key community action team committee members; resident representative moves out of the Cherryhill community & out of the London area; Alzheimer Society representative relocates to Ottawa; no immediate replacement

CCAC restructuring; lose long-time CCAC representative; new CCAC contact becomes involved

Services of an architect offered by St. Joseph's Health Centre to maximize use of available mall space; St. Joseph's architect resigns; new partnership sought with a community-based architect

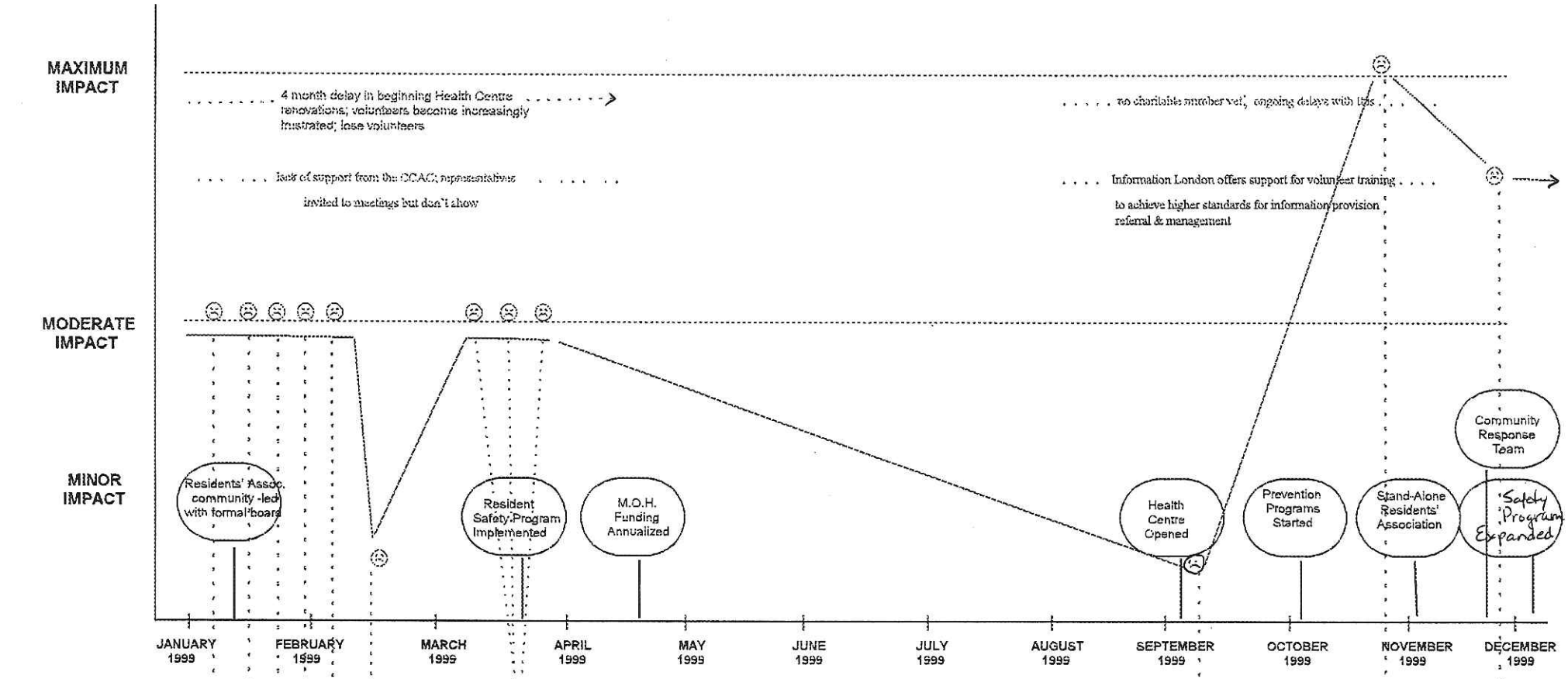
Availability of location & space in mall for Health Centre changes; new location has upper & lower levels; 2nd floor not accessible; accessibility options explored; community members unable to use 2nd floor meeting

Ontario Healthy Communities rep. & facilitator of the comm capacity bldg. action team terminates her involvement; too time intensive; most difficult grp. she has worked with; only wishes to be involved in a consultative role; replacement sought; project co-ord. fills in

2 new ESAM managers; residential property manager #3 & commercial property manager #3; different management styles again; Health Centre planning & development halted; new managers oriented to project; major delays with Health Centre Development; 4 months lost

ESAM residential & commercial property manager #2 resigns; additional restructuring by ESAM; delays in Health Centre development

CHERRYHILL COMMUNITY PROJECT - CHALLENGE/CRISIS POINTS



Residents bicker among themselves; delays causing increasing frustration

Ongoing delays with Health Centre planning & new ESAM managers

Renovations finally begin with lease pending

No follow-through with health prevention/ education responsibilities by some of the health professionals; increasingly frustrated community members

Health Centre renovations halted again; incorporation required by ESAM

Residents begin planning for grand opening of Health Centre; assistance promised by Director of Communications, St. Joseph's Health Centre; planning meeting arranged; Communications Director does not show; calls near meeting end; new meeting date confirmed; again no show; no explanation provided; 3rd meeting scheduled; no contact from Communications Director, project co-ordinator called x2 to confirm meeting time & location (answering machine & secretary); no contact by either; meeting day no show for the 3rd time; no communication of any kind; follow-up by telephone by project co-ordinator; message left; no communication or explanation by Communications Director; Residents Association writes a letter expressing disappointment & frustration & that they no longer wish to work with this individual; grand opening plans put on hold

PROJECT PHASE III
SUSTAINABILITY PHASE
September 1998 - July 2001

CCAC representative retires

Day of Health Centre opening that entire end of the mall blocked; no access for 3 days; 2 months of pre-planning for opening; no communication re: mall construction; community members/volunteers extremely frustrated

Very few (no) volunteer "leaders", frail elderly, mean age 76 years; resistance to outside leaders; those willing to help become impatient

Volunteer skill building & training VERY time intensive; much more than expected; volunteer skills, knowledge & ability limited; very willing but limited ability; for everything require constant assistance/reminders x7+++ for 1 task (e.g., to use volunteer communication book); communication problem among volunteers; personality conflicts among volunteers; ongoing bickering among volunteers; lack of interest or ability to assume positions requiring leadership

"piece-meal" funding; cobbled together; proposal & report writing time intensive

1 position only throughout; responsibility for volunteer co-ordination, training & evaluation; program development; evaluation; research; funding proposal developments & report writing; administrative requirements; housekeeping; Health Centre promotion; etc.

Appendix D: **Cherryhill Resident Safety Check Program**

Cherryhill Resident Safety Program

"Neighbours Helping Neighbours"

December 2000

Introduction:

The Cherryhill Resident Safety Program is offered through the Cherryhill Healthy Ageing Program. The need for this program was identified through a community survey conducted in 1997. Development of the program began in 1998, and pilot testing and program implementation followed shortly thereafter.

The Cherryhill Resident Safety Program provides safety checks twice daily to ensure that residents who have signed up for this program are safe. A 4-tiered response system is in place to provide immediate assistance and emergency help to those in need. This program is in place in 12 of the 13 apartment buildings in the Cherryhill community. It is completely organized and operated on a daily basis by community volunteers, in collaboration with health professionals. Residents living in the 13 apartment buildings, who wish to help their neighbours, sign up and are trained to become safety monitors. To date safety monitors have responded to numerous emergency situations and have provided assistance to neighbours who might otherwise not have been found for 4-5 days. The Cherryhill Resident Safety Program is being offered by the ESAM Corporation to all new tenants as part of their rental agreement. The program is available free of charge to all Cherryhill residents.

Purpose:

To collaboratively build, implement and evaluate a program that, on a daily basis, monitors the safety of residents living in the Cherryhill community. Specifically, the Cherryhill Resident Safety Program will:

- ensure that residents who have signed up for the program are safe, by monitoring twice daily, morning and evening
- activate a 4-tiered response system if there is concern regarding a resident's safety
- identify "at-risk" residents who live in the Cherryhill community and link them with other health and social supports available through the Cherryhill Healthy Ageing Program

Cherryhill Healthy Ageing Program

The UNIVERSITY of WESTERN ONTARIO
Department of Medicine • Division of Geriatric Medicine

TERMS OF REFERENCE

Cherryhill Resident Safety Program

"Neighbours Helping Neighbours"

Guiding Principles:

The Cherryhill Resident Safety Program will work in partnership with the Cherryhill Healthy Ageing Program to create a safety program that evolves in response to the changing needs of frail elderly individuals living in the community. In keeping with community development principles and established pocesses developed through the Cherryhill Healthy Ageing Program the *Cherryhill Resident Safety Program* will:

1. use participatory action processes to facilitate change
2. use a participatory evaluation framework involving community members and community partners that is consistent with the existing Cherryhill Healthy Ageing Program evaluation model

Existing safety programs in other seniors' communities and apartment buildings will be explored to determine their strengths and limitations, and to determine the most suitable program for the Cherryhill community.

Outcomes:

Expected outcomes fall into 2 categories. Outcomes for (1) individuals living in the Cherryhill community, and (2) program outcomes:

INDIVIDUAL OUTCOMES:

1. quick response to residents who need help
2. sense of security for individuals who live alone, have no family, or have family and/or relatives who live a great distance away

PROGRAM OUTCOMES:

1. a volunteer-run safety program, with enough volunteer safety monitors in each of the 13 apartment buildings to meet the needs of residents wishing to sign up for this program
2. a sustainable safety program, that responds to the changing needs of the community over time
3. a safety program that has well-trained volunteer safety monitors who can identify elderly individuals who are "at-risk", and link these individuals with other health and social supports available through the Cherryhill Healthy Ageing Program

Cherryhill Resident Safety Program

"Neighbours Helping Neighbours"

4. a safety program that has formal, standardized procedures in place in all 13 apartment buildings, that are collaboratively developed, and recognized by the ESAM Corporation, the apartment building managers, the City of London Police Department, as well as other city emergency response services

5. a safety program that uses a "train-the-trainer" model, where new volunteer safety monitors are trained by existing safety monitors and/or apartment representatives for the safety program

6. a model safety program that is of interest to, and adopted by, other communities elsewhere

7. ongoing education and training on topics and areas of interest identified by the safety monitors

Integration of:

- ☺ Resident Safety Program & the Community Response Team Community Connections Program Other Prevention Programs
- ☺ Community & Health Professionals
- ☺ Formal Health System Supports & Informal Community Resources

To:

- ☺ Identify Residents at Risk
- ☺ Detect Problems & Needs
- ☺ Provide Quick Response
- ☺ Provide Links to Other Health & Social Supports

OUTCOMES

Profile of the Cherryhill Community:

THE APARTMENT COMPLEX:

The Cherryhill community has a high concentration of seniors and is an area of high health service utilization. The Cherryhill apartment complex consists of 13 apartment buildings with 2325 units (total population approximately 3000) and 64 businesses under a single management group, the ESAM corporation. Approximately 2500 of the 3000 individuals living in the Cherryhill community are over the age of 65 years. Many are elderly women living alone.

The Cherryhill community has a "sense of community" and warm community atmosphere that is unique to the city of London. Development of the Cherryhill complex began in 1959 when the ESAM Construction Company was formed by Sam Katz and Ewald Bierbaum. Westown Plaza was developed first, opening in 1960 with 18 stores. A few years later, in 1966, development of the apartment complex began. Support for the plaza was so great that in 1974 the plaza expanded to become an enclosed mall with 50 stores. Over the years Sam Katz, and now the ESAM management team (including sons Harvey and Howard Katz) have earned a reputation, by both residents and merchants, as being caring, friendly and compassionate, with a "people come first" attitude. It is for this reason, that many of the existing stores are long-term merchants, some having been with the mall for over 20 years. Many residents have also chosen to stay in the community for many years, with quite a number of residents living there over 30 years. The mall has grown into a vibrant community gathering place, and the ESAM management team continues to be particularly supportive of the unique needs associated with an aging population.

There are 45 businesses in Cherryhill Village Mall, as well as an additional 19 businesses and professional services located in the 101 Cherryhill office building. All merchants in Cherryhill Village Mall provide special favours for tenants of the Cherryhill apartment complex if the need arises (i.e., the food court merchants deliver if an order is called in; flowers are delivered; etc.) It was reported by the ESAM corporation that ⅓ of Cherryhill Village Mall customers are "walk-ins" from the Cherryhill apartment complex. The ESAM management, in 1997, identified crisis intervention as a priority, reporting that at any given time 10-15 "tenants in the apartment complex require "crisis intervention".

Cherryhill Resident Safety Program

"Neighbours Helping Neighbours"

THE PEOPLE:

The Cherryhill community contains approximately 2500 individuals over the age of 65 years. The majority are elderly women living alone. The Cherryhill community is a stable community with residents remaining for many years. The Cherryhill community is very popular and there are rarely vacant apartment.

The following provides a profile of the characteristics of the Cherryhill community at the time of a community survey which was conducted in May 1997:

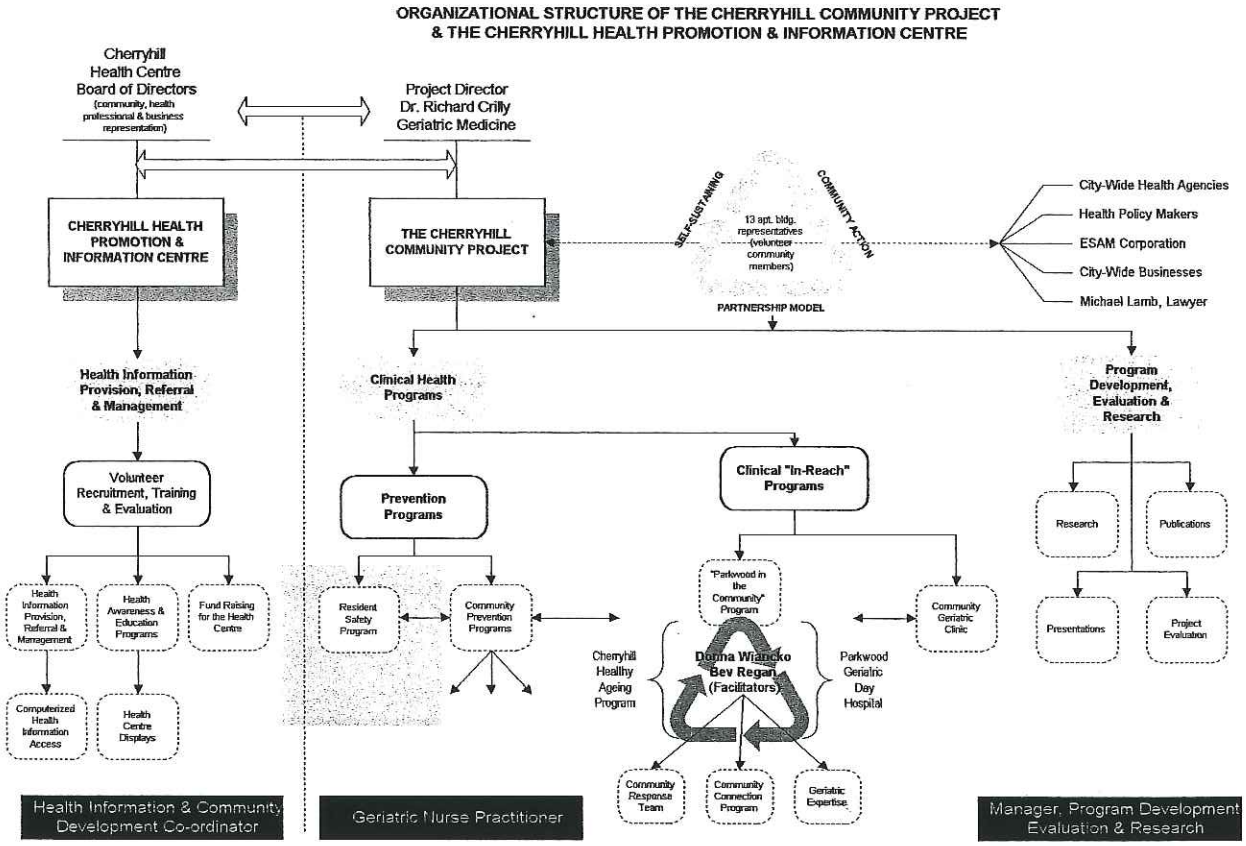
- mean age = 78 years (1997)
- now it is projected that 54% of the population is >80 years of age
- approximately ⅓ of these individuals (approx. 500) have significant memory impairment
- average time lived in the Cherryhill community was 10 years (SD = ± 7.56 years)
- the oldest individuals (those 85+ years) have lived in the community longest (14+ years)
- the community is stable, with residents "aging in place".
- 21% of residents over the age of 65 (>500 individuals) reported having a caregiver
- 11% of residents over the age of 65 (approximately 300 individuals) reported that they were providing care to someone with whom they lived
- it is estimated that more than 800 individuals fall each year, resulting in 8-10 hip fractures per year
- approximately 300 elderly women experience urinary incontinence
- depression (which affects at minimum 5% of women over the age of 65), loneliness and suicide is prevalent in the community
- it is estimated that there are enough residents in the Cherryhill community with unmet health needs to keep a geriatric day hospital busy for 2 years providing assessment & treatment

Cherryhill Resident Safety Program

"Neighbours Helping Neighbours"

"Fit with the Cherryhill Healthy Ageing Program:

The *Cherryhill Resident Safety Program* is one of many programs offered through the broader Cherryhill Healthy Ageing Program. The organizational chart below shows the "fit" of the Safety Program within the broader framework.



ORGANIZATIONAL STRUCTURE

Cherryhill Resident Safety Program

"Neighbours Helping Neighbours"

Organizational Structure:

The organizational structure of the *Cherryhill Resident Safety Program* is as follows:

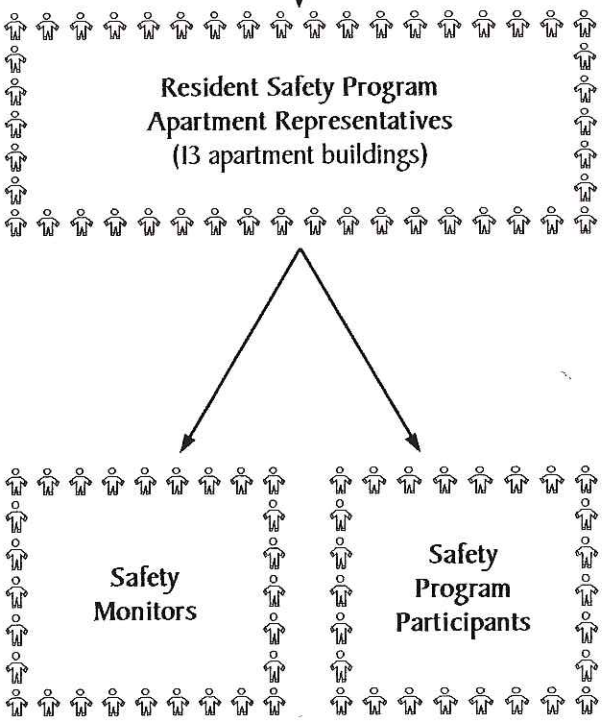
1. Program Director → Cherryhill Healthy Ageing Program
2. Health Information & Community Development Co-ordinator
3. Manager, Program Development, Evaluation & Research
4. Community Nurse

Cherryhill Healthy Ageing Program

↓

Resident Safety Program Co-ordinator

↓



ORGANIZATIONAL STRUCTURE

Cherryhill Resident Safety Program

"Neighbours Helping Neighbours"

Role Descriptions:

RESIDENT SAFETY PROGRAM **CO-ORDINATOR**:

The Co-ordinator, in collaboration with Cherryhill Healthy Ageing Program staff, has overall responsibility for co-ordinating the Cherryhill Resident Safety Program. Specifically, the Co-ordinator will:

- be the direct link to Healthy Ageing Program staff, the ESAM corporation, and safety program apartment representatives
- ensure a standardized approach in each of the 13 apartment buildings
- orient and train apartment representatives
- in collaboration with apartment representatives, orient and train safety monitors collect and summarize monthly statistics for the safety program
- in collaboration with apartment representatives, safety monitors & safety program participants, the co-ordinator will forward referrals to other health & social support programs offered through the Cherryhill Healthy Ageing Program
- in collaboration with apartment representatives, safety monitors & safety program participants, will make recommendations for improvement of the safety program in response to the evolving needs of residents living in the Cherryhill community

RESIDENT SAFETY PROGRAM **APARTMENT REPRESENTATIVES**:

The apartment representatives will work closely with the co-ordinator, safety monitors in each building, and safety program participants. Specifically, apartment representatives will:

- in collaboration with the co-ordinator, be responsible for the recruitment, orientation & training of safety monitors
- support & supervise safety monitors
- have direct contact with apartment building managers, city of London police (in emergency situations), safety monitors and the co-ordintor
- in collaboration with the co-ordinator, make recommendations for improvement & problem solve when necessary

RESIDENT SAFETY PROGRAM **MONITORS**:

Once residents residing in the Cherryhill community volunteer and make the commitment to become safety monitors in their apartment buildings, they will:

- check on the safety of their assigned residents, twice per day, as per established procedures
- be familiar with, and when necessary follow, the established 4-tiered emergency response procedures

- advise their apartment representative (or the co-ordinator), with sufficient notice, if the are planning to be away on vacation, are unavailable, or wish to terminate their involvement so that coverage may be arranged, or if they experience difficulties with resident(s) who have signed up for the program
- identify residents "at risk" so that support may be provided to these individuals through other health and social support programs offered through the Cherryhill Healthy Ageing Program

RESIDENT SAFETY PROGRAM **RECIPIENTS**:

The Resident Safety Program is heavily dependent on residents who volunteer their time to ensure the safety of their neighbours. Thus it is important that recipients of this program:

- follow established procedures, and hang their tag out in the morning, and take it in in the evening, within the predetermined time frames
- notify their safety monitor if they are out for the evening or away for extended periods so that the emergency response system is not activated while they are away
- if they find it difficult to remember to put their tag out (or take it in), to work with their safety monitor to come up with a way that will help them remember
- communicate ideas for what might work better to their monitor, apartment representative and the safety program co-ordinator so that this program can best meet their needs

Recipients of the Resident Safety Program must not ask their monitors to run errands for them, or ask them to visit because they would like company. This is not the role of the safety monitors, and other types of support is available through the different programs offered through the Cherryhill Healthy Ageing Program.

Safety Program Implementation:

Timelines for implementation of the Cherryhill Resident Safety Program in the 13 apartment buildings in the Cherryhill apartment complex are as follows:

Safety program in place:

Building 180	March 1998
Building 110	January 2000
Building 200	February 2000
Building 105	March 2000
Building 120	March 2000
Building 115	April 2000
Building 170	April 2000
Building 140	April 2000
Building 190	September 2000
Building 160	November 2000
Building 230	November 2000
Building 695	November 2000

No safety monitors available in:

Building 201

PROGRAM IMPLEMENTATION

Cherryhill Resident Safety Program

"Neighbours Helping Neighbours"

Safety Program Recipients & Monitors:

PROGRAM RECIPIENTS:		SAFETY MONITORS:
Building 105	9	3
Building 110*	31	5 (+ 1 spare)
Building 115	12	3 (+ 4 spares)
Building 120*	9	3
Building 140	12	3
Building 160	17	4
Building 170	35	4
Building 180	31	5 (+ 2 spares)
Building 190	30	3 (+ 1 spare)
Building 200	14	3 (+ 2 spares)
Building 230	5	1

* includes younger individuals with physical disabilities

COMMUNITY INVOLVEMENT

Apartment Representatives:

Building 105
Building 110
Building 115
Building 120
Building 140
Building 160
Building 170
Building 180
Building 190
Building 200
Building 230
Building 695

Cherryhill Resident Safety Program

"Neighbours Helping Neighbours"

Overview of the Resident Safety Program:

The Cherryhill Resident Safety Check Program is a volunteer, community-run safety check system that is available, at no charge, to all residents living in the 13 apartment buildings in Cherryhill Village. The Cherryhill Resident Safety Check Program uses a "neighbours helping neighbours model" and relies on volunteer safety monitors in each apartment building to check on the safety of their neighbours who have signed up for this program. Safety checks are done twice daily, morning and night, and a 4-tiered response system has been developed.

The Cherryhill Resident Safety Check Program is completely voluntary and free of charge. Interested residents must sign up for the program. This can be done by contacting the Apartment Representative in their building. Residents who sign up will be given a door tag and a detailed instruction sheet. The door tag should be hung on the outside of the door every evening by 6:00 p.m. and taken in every morning by 9:00 a.m. If the door tag is not displayed or taken in at those times a resident safety monitor will ensure the safety of the resident by:

1. knocking on the resident's door to make sure they are safe (if the safety monitor hears a call for help, they will contact the building manager immediately)
2. if there is no answer, the safety monitor will return to their own apartment and telephone the resident to make sure they are safe
3. if there is still no answer, and consent forms have been signed, the safety monitor will contact the local friend or relative whose name has been given by the resident to make sure the resident is safe
4. if the friend or relative is worried and gives permission, the safety monitor will contact the building manager to contact police or ambulance.

Safety monitors **will not** run errands, take messages or perform other tasks for residents on the program. The role of the safety monitors is strictly to ensure that residents are safe. This safety check is performed twice daily, morning and evening.

The Cherryhill Resident Safety Check Program is offered through the Cherryhill Healthy Ageing Program and the Cherryhill Health Promotion & Information Centre.

Cherryhill Resident Safety Program

"Neighbours Helping Neighbours"

Example Emergencies Situations:

To date, safety monitors have responded to 7 emergency situations: 6 falls and 1 individual who died in their apartment between morning & evening monitoring times. The following cases provide insight into situations encountered by the safety monitors:

Case 1:

Building 180

On Friday morning of a long weekend the safety monitor, during her safety check rounds, discovered that a tag had not been taken in. The safety monitor followed established procedures and knocked loudly on the resident's door. She heard a cry for help and immediately notified the apartment building manager. The apartment building manager, with the safety monitor, entered the apartment. They found the resident, injured, on the floor in her living room with her walker on top of her. Although she subscribed to the Lifeline service, her unit was in the bedroom and of no help to her. Emergency services were called and the resident was taken to hospital. Her health care worker was not due to return until Tuesday of the following week. Without the safety program, the resident would have been on the floor, without assistance for $4\frac{1}{2}$ days.

Outcome: Resident was hospitalized with a broken hip. She is now back in her apartment in Cherryhill.

Case 2:

Building 110

One of the safety monitors in building 110 was doing his rounds, checking for tags. During his rounds he heard a cry for help from someone not on the safety program. He immediately contacted the building manager (who though not on duty happened to be home), and they entered the woman's apartment together. The resident had fallen and was unable to get up. The safety monitor called 911 to summon an ambulance, and the woman was taken to hospital.

Outcome: Resident was hospitalized with a broken hip. The safety monitor (also the building representative) had spoken to this woman previously about joining the Cherryhill Resident Safety Program. The woman flatly refused stating that she was quite capable of looking after herself. Upon return from hospital she immediately signed up for the program.

Cherryhill Resident Safety Program

"Neighbours Helping Neighbours"

Case 3:

Building 180

A safety monitor was doing rounds and noticed a tag had not been put out. When the safety monitor knocked on the door she heard a scream for help. She immediately called the building manager, they entered the apartment and found the woman on the floor in her bedroom. 911 was called and she was taken to hospital.

Outcome: It was reported by the paramedics that the woman had a stroke. She is now back in her apartment in Cherryhill.

Case 4:

Building 120

During morning rounds a safety monitor noticed that a tag had not been taken in. She followed safety procedures and there was no answer. The safety monitor contacted the friend listed as a contact. The friend came over within 15 minutes and with the building manager, they entered the apartment. The resident was found on the floor in the bathroom semi-conscious. 911 was called. She was admitted to hospital.

Outcome:

Cherryhill Resident Safety Program

"Neighbours Helping Neighbours"

Case 5:

Building 200

An elderly male resident was identified by a neighbour as being a good candidate for the safety program. The man was initially not interested and refused to become involved. Eventually the neighbour persuaded him to join. He joined on Tuesday, and later in the same week (Friday) a safety monitor was doing rounds and noticed a tag had not been taken in. She followed safety procedures but there was no answer. She telephoned the emergency contact provided by the resident (his sister), who was worried and said she would be right over with a key to check the apartment. She lived nearby in building 230. The sister was met by the safety monitor, and together they entered the apartment. The resident was found dead, on the toilet in the bathroom. The safety monitor consoled the distraught family member and activated the emergency response system. The police and coroner arrived. With the assistance of the safety monitor and a neighbour (who picked up the resident's newspapers) the coroner determined that the time of death was between the two safety checks, approximately 2:00 to 6:00 p.m.

Outcome: The resident died. The neighbour immediately signed up for the safety program. The resident's sister immediately organized a safety program for her building (230 Platt's Lane) and was the first one to sign up.

Case 6:

Building 180

A safety monitor was doing rounds and notice that a tag had not been taken in. She followed safety procedures and there was no answer. She contacted the family/friend emergency contact provided by the resident. The contact was an elderly neighbour (85 years), who upon being contacted stated: *"She is always falling! She falls 2-3 times per week between her bed and side table. I have been regularly going over anywhere from 1-3 times per week to pick her up. I can't continue to do that, I'm 85 years old! I think that she has probably fallen again!"* The safety monitor contacted the building manager and together with the friend, they entered the resident's apartment. They found the resident on the floor between her bed and side table. The ambulance was called, and arrived. However, the woman refused to go to hospital and refused any assistance from ambulance staff. One week later, the woman's tag was missing again. The same procedures were followed. Again, the woman was found on the floor between her bed and side table. The ambulance was called and again the woman refused all assistance. The safety monitor insisted she be taken to hospital, and finally (after 20 minutes) managed to persuade the woman to go.

Outcome: Resident's arm was broken during one of the two falls. She remained in hospital awaiting placement in a long-term care facility. She is now in a nursing home.

Cherryhill Resident Safety Program

"Neighbours Helping Neighbours"

Case 7:

Building 190

A safety monitor conducted evening safety rounds at 6:00 p.m. and found everything to be fine. At approximately 9:00 p.m. the same evening one of the residents on the program tripped over her telephone cord and fell. She knew the number of another safety monitor in the building and could reach her telephone from where she was lying on the floor. She called the other monitor who immediately contacted the building manager, and then came over to help. The safety monitor called 911 and the woman was taken to hospital.

Outcome: The resident was hospitalized with a broken hip. She is now back in her apartment.

Outcomes:

The 6 falls resulted in 4 broken hips & 1 broken arm.
One resident was found dead in his apartment.

Other Situations Requiring Intervention:

Situation 1:

Building 180

Safety monitor was approached by a resident on the safety program. The couple had signed on a few months earlier, they are both in their 90's. The husband was hospitalized, and the wife requested the assistance of the safety monitor. She was frantic. Her husband had been in hospital for a week. She was lonely and frightened that she wouldn't be able to cope when he returned home. Safety monitor visited resident every day.

Outcome: The woman's husband died. She is moving to Kitchener to live with her son. They are looking for a nursing home.

Situation 2:

Building 120

A safety monitor (also apartment representative) has repeatedly been told by a resident on the program that she believes someone is stealing from her. The resident is very suspicious. She has requested that someone stay with her overnight.

Outcome: The apartment safety program representative notified the safety program co-ordinator who initiated a referral to the Community Response Team for assessment and follow-up. The community nurse is now actively involved.

There have also been numerous "false alarms" where residents have forgotten to put out their tags, or have gone out without notifying their safety monitors, and the emergency response system was activated. It was reported by safety monitors that this sometimes happens 14 times or more per month.

Cherryhill Resident Safety Program

"Neighbours Helping Neighbours"

What Others Have to Say About the Program:

EMERGENCY RESPONDERS:

". . . this is an excellent program! Better safe than sorry. We don't mind coming out at all."
police officer

". . . yes, I've heard about this program. We'll have a cruiser there in 5 minutes."
911 operator

". . . I've heard about this program. I think its great. Can you tell me more about it?"
police officer

FAMILY MEMBERS:

". . . this is the best program ever"
family member

". . . don't tell my mother it was me, but I want her on this program! Would you (safety monitor) please talk her into it!
daughter

". . . this is a wonderful program. All apartment buildings should have this. A special thanks to the safety monitor!
granddaughter

". . . this is the best thing since sliced bread!"
family member

". . . this is a wonderful program! It should be offered city-wide."
family member

Cherryhill Resident Safety Program

"Neighbours Helping Neighbours"

VOLUNTEER SAFETY MONITORS:

". . . I can't keep on taking, I have to start giving back."

safety monitor

Safety monitor's response when asked "Isn't this too much for you"?
". . . somebody's looking after me. So it's up to me to look after someone else."

safety monitor

PROGRAM RECIPIENTS:

A resident approached a safety monitor in her building and asked:
". . . I saw tags on all the doors, and someone with a badge walking around looking at them. Can you explain that to me?
Then the next day:
". . . I told my daughter about the program and she said "you get on that program right away!"

program recipient

WHAT OTHERS HAVE TO SAY

Resident Safety Program Forms:

Cherryhill Resident Safety Program

"Neighbours Helping Neighbours"

FORMS

Cherryhill Health Promotion & Information Centre

Cherryhill Village Mall, Unit 6, 301 Oxford Street West, London, Ontario N6H 1S6
Tel: (519) 675-1094 Fax: (519) 675-9963

RESIDENT SAFETY CHECK PROGRAM

Request for Resident Safety Check Service

I would like to participate in the Cherryhill Village Resident Safety Check Program and have a Resident Safety Monitor check to make sure that I am safe. If a Resident Safety Monitor checks on me but does not get an answer when they knock on my door or when they telephone me, I give my permission for the Resident Safety Monitor to contact a local friend or relative to make sure that I am safe, or the building manager to contact police or ambulance. If the Safety Monitor hears a call for help when knocking on your door they will contact the building manager immediately to make sure that you are safe.

Detailed information will be provided to you once you sign up for this service.

Name: _____

Signature: _____

Address: _____

Telephone: _____

Date: _____

Local Friend or Relative to Contact in the Event of an Emergency:

Name: _____

Address: _____

Telephone: _____

Relationship to You: _____

If you would like more information please call:

Cherryhill Health Promotion & Information Centre

Cherryhill Village Mall, Unit 6, 301 Oxford Street West, London, Ontario N6H 1S6
Tel: (519) 675-1094 Fax: (519) 675-9963

RESIDENT SAFETY CHECK PROGRAM

What your safety monitor will do for you:

① Every evening the safety monitor will check to make sure your tag is out and every morning the safety monitor will check to make sure that your tag is taken in. Tags should be put out and taken in at the following times:

Evening:	tags should be put out by 6:00 p.m.
Morning:	tags should be taken in by 9:00 a.m.

② If your tag is not out, or taken in, the safety monitor will knock on your door to make sure you are safe. (if the safety monitor hears a cry for help he/she will contact the building manager immediately).

③ If there is no answer, the safety monitor will telephone you to make sure that you are safe.

④ If there is still no answer, the safety monitor will contact the family member or friend that you provided as a contact in the event of an emergency.

⑤ If your family member or friend is worried and gives permission, or if there is no answer when the family member (or friend) is called, the safety monitor will contact the building manager to contact the police or ambulance.

Safety monitors <u>will not</u> run errands, take messages or perform other tasks for residents on the Safety Check Program.

Cherryhill Health Promotion & Information Centre

Cherryhill Village Mall, Unit 6, 301 Oxford Street West, London, Ontario N6H 1S6
Tel: (519) 675-1094 Fax: (519) 675-9963

RESIDENT SAFETY CHECK PROGRAM

Step 1: Hang the "Safety Program Tag" on your door every evening by 6:00 p.m. (or earlier if you are going out for the evening).

Step 2: Take your "Safety Program Tag" in every morning by 9:00 a.m.

Step 3: Notify your safety monitor if you are going to be away (so that they do not activate the emergency response system).

Your safety monitor is:

Cherryhill Health Promotion & Information Centre

Cherryhill Village Mall, Unit 6, 301 Oxford Street West, London, Ontario N6H 1S6
Tel: (519) 675-1094 Fax: (519) 675-9963

RESIDENT SAFETY CHECK PROGRAM

Resident Safety Monitor Registration Form

I would like to help with the Cherryhill Village Resident Safety Check Program and would consider being a Resident Safety Monitor in my building. I understand this will require a 3 month commitment on my part, and that "back-up" coverage will be provided for me if I need to be away for any reason.

Name: _____

Signature: _____

Address: _____

Telephone: _____

Date: _____

Our goal is to have a monitor for each floor. However, a final Resident Safety Monitor schedule will be drawn up when we have a list of residents who wish to sign up for this service. If you would like more information please call:

Cherryhill Health Promotion & Information Centre

Cherryhill Village Mall, Unit 6, 301 Oxford Street West, London, Ontario N6H 1S6
Tel: (519) 675-1094 Fax: (519) 675-9963

RESIDENT SAFETY CHECK PROGRAM

SAFETY MONITOR PROCEDURES

STEP 1: Every evening at 6:00 p.m. (or later) check to make sure the door tags for your residents are out. Every morning at 9:00 a.m. (or later) check to make sure door tags are taken in.

STEP 2: If a door tag has not been put out, or taken in, knock (loudly) on the resident's door to make sure they are safe.

- ☺ If they answer, remind them about their tag
- ☺ If you hear a cry for help, notify the building manager immediately
- ☺ If there is no answer, go to Step 3

Note: If you are out for the evening and return after 10:30 p.m. and a door tag is not out please skip to Step 3 and telephone the resident instead of knocking.

STEP 3: Telephone the resident to make sure they are safe. If they answer, remind them about their tag. If there is no answer, go to Step 4.

STEP 4: Contact the family member or friend the resident has provided. If the family member or friend is worried and gives you permission, or if there is no answer when you call the family member or friend, contact the building manager so that they can contact police or ambulance. (If the building manager is not there to help, or unable to help, the safety monitor should call 911).

(over)

Note: If, when you call the family member, relative, friend or neighbour, they are close by and come over to enter the apartment with you and help is **urgently** required, the safety monitor should help the family member, relative, friend or neighbour make the 911 call, then notify the building manager as soon as possible. If, upon entering the apartment, it is obvious that the resident is deceased the safety monitor should assist the family member, relative, friend or neighbour in calling police (911) and then notify the building manager as soon as possible.

Safety monitors **should not** run errands, take messages or perform other tasks for residents on the safety program. The safety monitors' role is strictly to ensure that residents are safe by checking on them twice daily, morning and evening.

YOUR BUILDING MANAGER IS:

Cherryhill Health Promotion & Information Centre

Cherryhill Village Mall, Unit 6, 301 Oxford Street West, London, Ontario N6H 1S6
Tel: (519) 675-1094 Fax: (519) 675-9963

RESIDENT SAFETY CHECK PROGRAM

Procedures

Resident Safety Check Co-ordinator:

① All 13 apartment buildings in Cherryhill Village must use the same standardized forms for the Resident Safety Check Program. These forms are available through the Resident Safety Check Co-ordinator.

② If there is an incident safety monitors are required to deal with, an **Occurrence Report Form** must be filled out and forwarded to the Resident Safety Check Co-ordinator. One "Occurrence Report Form" should be filled out for each incident safety monitors encounter. This form should be completed and forwarded to the Resident Safety Check Co-ordinator immediately after the incident occurs and the situation has been resolved.

③ At the end of each month, a **Monthly Statistics Form** should be completed and forwarded to the Resident Safety Check Co-ordinator.

④ It is the responsibility of the Resident Safety Check Co-ordinator to co-ordinate the Resident Safety Program in all 13 apartment buildings in Cherryhill Village and to ensure that safety monitors are trained in procedures that are to be followed. If you have any questions, or have recommendations for change to the program or any of the forms used, please contact the Resident Safety Check Co-ordinator.

Cherryhill Health Promotion & Information Centre

RESIDENT SAFETY CHECK PROGRAM
MONTHLY STATISTICS

MONTH: **BUILDING:**

RESIDENTS USING THE SAFETY PROGRAM

TOTAL NO. OF RESIDENTS IN PROGRAM: _____	NO. OF NEW RESIDENTS THIS MONTH: _____	NO. WHO DROPPED OUT OF PROGRAM THIS MONTH: _____ REASONS FOR DROPPING OUT: _____

SAFETY PROGRAM MONITORS

NO. OF SAFETY MONITORS: _____	NO. OF NEW SAFETY MONITORS THIS MONTH: _____	NO. OF MONITORS ASKED TO LEAVE THIS MONTH: _____ REASONS: _____

NO. OF MONITORS LEAVING VOLUNTARILY: _____

REASON(S): _____

INCIDENTS & OCCURRENCES

NO. OF OCCURRENCES REQUIRING SAFETY MONITOR INTERVENTION THIS MONTH: _____

TYPE OF OCCURRENCES: ① _____ ② _____

③ _____ ④ _____

⑤ _____ ⑥ _____

NO. REQUIRING EMERGENCY RESPONSE: _____	NO. WHO DIED: _____	NO. TRANSFERRED TO NURSING HOME: _____	OTHER: _____

FAMILY MEMBER COMMENTS	SAFETY MONITOR COMMENTS
_____	_____
_____	_____
_____	_____

Cherryhill Health Promotion
& Information Centre

Cherryhill Village Mall, Unit 6, 301 Oxford Street West, London, Ontario N6H 1S6
Tel: (519) 675-1094 Fax: (519) 675-9963

RESIDENT SAFETY CHECK PROGRAM

OCCURRENCE REPORT FORM

Date: _____ **Building:** _____ **Apt.** _____

Safety Monitor: _____ **Phone:** _____

Resident: _____ **Time of Incident:** _____

Incident: _____

_____

_____

_____

_____

_____

_____

Who detected the problem? _____

(over)

Action Taken: _____

_____

_____

_____

_____

Response: _____

_____

_____

_____

_____

Outcome/Follow-up: _____

_____

_____

_____

_____

Issue Resolved: ❑ Yes ❑ No

Comments: _____

_____

_____

_____

_____

Date: _____ **Signature:** _____

Cherryhill Health Promotion & Information Centre

Cherryhill Village Mall, Unit 6, 301 Oxford Street West, London, Ontario N6H 1S6
Tel: (519) 675-1094 Fax: (519) 675-9963

COME AND FIND OUT WHAT THE Resident Safety Check Program IS ALL ABOUT!

This is a voluntary and **FREE** program for residents in this building. Through the Resident Safety Check Program you will be monitored twice a day, 7 days per week by volunteer safety monitors. This program is presently working well in other apartment buildings in Cherryhill Village. Our hope is that each of the 13 apartment buildings in Cherryhill Village will take advantage of this free service.

Come to an Information Meeting to be held in your lobby on:

We will be on hand to answer any questions you have.

COME & BRING A NEIGHBOUR!

CHERRYHILL/WESTOWN COMMUNITY PROJECT

. . . . . seniors, service providers and local businesses working together to build a partnership for the future

120 CHERRYHILL DRIVE, UNIT 614
LONDON, ONTARIO N6H 4N9
TEL: (519) 670-1456
FAX: (519) 438-7776

08 February 1999

Dear Resident,

In the Cherryhill Community Survey that was completed approximately 2 years ago, the number one issue identified by residents in Cherryhill Village was the need for a Resident Safety Check Program.

With ESAM's support, the Cherryhill Village Residents' Association has developed a "pilot" Safety Program to be tested in apartment building 180. If successful, we hope to put this program in place in all apartment buildings in Cherryhill Village.

The Resident Safety Check Program is completely voluntary and will:

- ✔ require interested residents to sign up on the attached ***pink*** form
- ✔ residents who sign up will be given a door tag & a detailed instruction sheet
- ✔ the tag should be hung on the door every evening at 6:00 p.m. and taken in by 9:00 a.m. the next morning
- ✔ if the tag is not displayed or taken in at those times a resident safety monitor will ensure the safety of the resident by:

① knocking on the resident's door to make sure they are okay
② if the safety monitor hears a call for help when knocking on your door, they will contact the building manager immediately
③ if there is no answer to the safety monitor's knock, the safety monitor will return to their own apartment and telephone the individual to make sure they are safe
④ if there is still no answer and consent forms have been signed, the safety monitor will contact the local friend or relative whose name has been given by the resident, to make sure the resident is safe
⑤ if the friend or relative is worried and gives permission, or if there is no answer when the friend or relative is called, the safety monitor will contact the building manager to contact police or ambulance.

We need your support to make this work. If you would like to help your neighbours and ***become a Safety Monitor*** in your apartment building, please fill out the enclosed ***blue form***. If you would like ***to use the Resident Safety Check Program*** and have someone check on you to make sure that you are safe, please sign up on the enclosed ***pink form***. Forms can be returned to any of the Cherryhill Village Residents'

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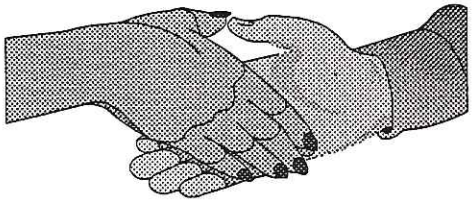
Association representatives listed below or to your building manager. If you have any questions about the Cherryhill Village Resident Safety Check Program please feel free to contact any one of us.

Yours sincerely,

Appendix E: Examples of Informal Support Offered by Cherryhill Community Members

158 citizens living in the Cherryhill community voluntarily provided their names, addresses and telephone numbers to offer the following services, in their community, free of charge or for a very small fee:

Cherryhill Community



HEALTH SUPPORT SERVICES

- Emergency assistance
- Assistance with visits to doctor
- Assistance for those who are sick
- Assistance for those returning home from hospital
- Buddy system/safety check system
- Caregiving assistance
- Adaptive equipment advice
- Counselling
- Therapeutic touch

HOMEMAKING

- Grocery shopping assistance
- General shopping assistance
- Light catering and baking
- Assistance with house cleaning
- Assistance with laundry
- Home maintenance and repairs
- "Odd" jobs
- Watering plants
- House "sitting"
- Cat "sitting"
- Sewing and mending
- Clothing repair
- Sewing machine repair
- Cleaning windows
- Putting in air conditioners
- Snow and ice removal from cars

TRANSPORTATION

- Assistance with general transportation needs
- Driving a mini-bus/shuttle service

SOCIAL SUPPORT

- Friendly visiting
- Telephoning those who are lonely
- Writing letters
- Mailing or getting letters
- Reading to individuals
- Library book pick-up and drop-off
- Assistance with library usage

RECREATION/FITNESS

- Travel advice and recommendations
- Foreign currency recommendations
- Fitness consulting
- Fitness "partnering"
- Beginner music lessons
- Playing cards
- Playing scrabble
- Line dancing
- Tai Chi
- Knitting
- Crocheting
- Needlepoint
- Ceramics

SPIRITUAL SUPPORT

- Church visiting
- Introduction to specific churches

SAFETY & SECURITY SERVICES

- Assistance with safety and security needs
- Home protection
- Safety and security information seminars

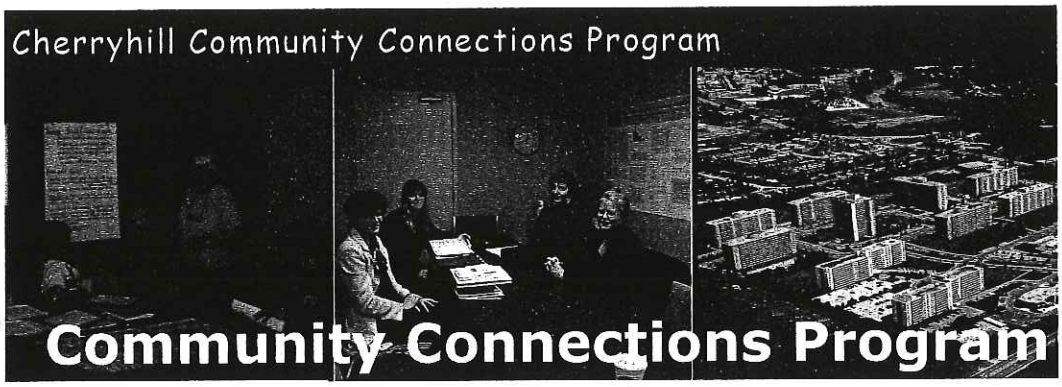
ADMINISTRATIVE & FINANCIAL SERVICES

- Financial advice
- Income tax preparation
- General record keeping
- Computer advice and assistance

EDUCATION

- Teaching English as a second language
- Teaching arts and crafts
- Safety and security seminars

Appendix F: Community Connections Program



January 2001

Introduction:

The Community Connections Program is offered through the Cherryhill Healthy Ageing Program in partnership with the Parkwood Geriatric Day Hospital. Other community partners include the City of London and Partners in Leisure London Middlesex. The Community Connections Program is designed to meet the psychosocial needs of elderly individuals living in the community. The need for this program was identified through a community survey conducted in 1997. The need for this program was also consistently identified, during the past 3 years, as a priority by both community members and health professionals working with existing Cherryhill Healthy Ageing Program initiatives such as the Resident Safety Check Program, Community Response Team, the Cherryhill Health Promotion & Information Centre, and other prevention and health promotion programs.

Development of the program began in January 2001 when 2-year funding was received from the Parkwood Hospital Foundation, in response to a collaborative proposal *"Parkwood in the Community"* submitted by the Parkwood Geriatric Day Hospital and the Cherryhill Healthy Ageing Program. The community-identified need to address mental health and social issues was identified as one of the three priorities of the *"Parkwood in the Community"* proposal.

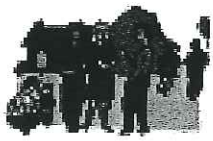
Purpose:

To collaboratively build, implement and evaluate a sustainable system of social support for frail, elderly individuals living in the Cherryhill community that responds to the changing needs of the community over time. Specifically the Community Connections Program will:

- in partnership with other community stakeholders, provide a continuum of programs to meet the social, recreation, mental health and emotional needs and interests of frail, elderly individuals living in the Cherryhill community

- provide or link frail, elderly individuals with programs at multiple levels including 1:1 therapeutic and/or small group programs for frail, elderly individuals who are unable to leave their home or apartment, specialized programs in the Cherryhill community and the City of London, and general city-wide recreation and community programs

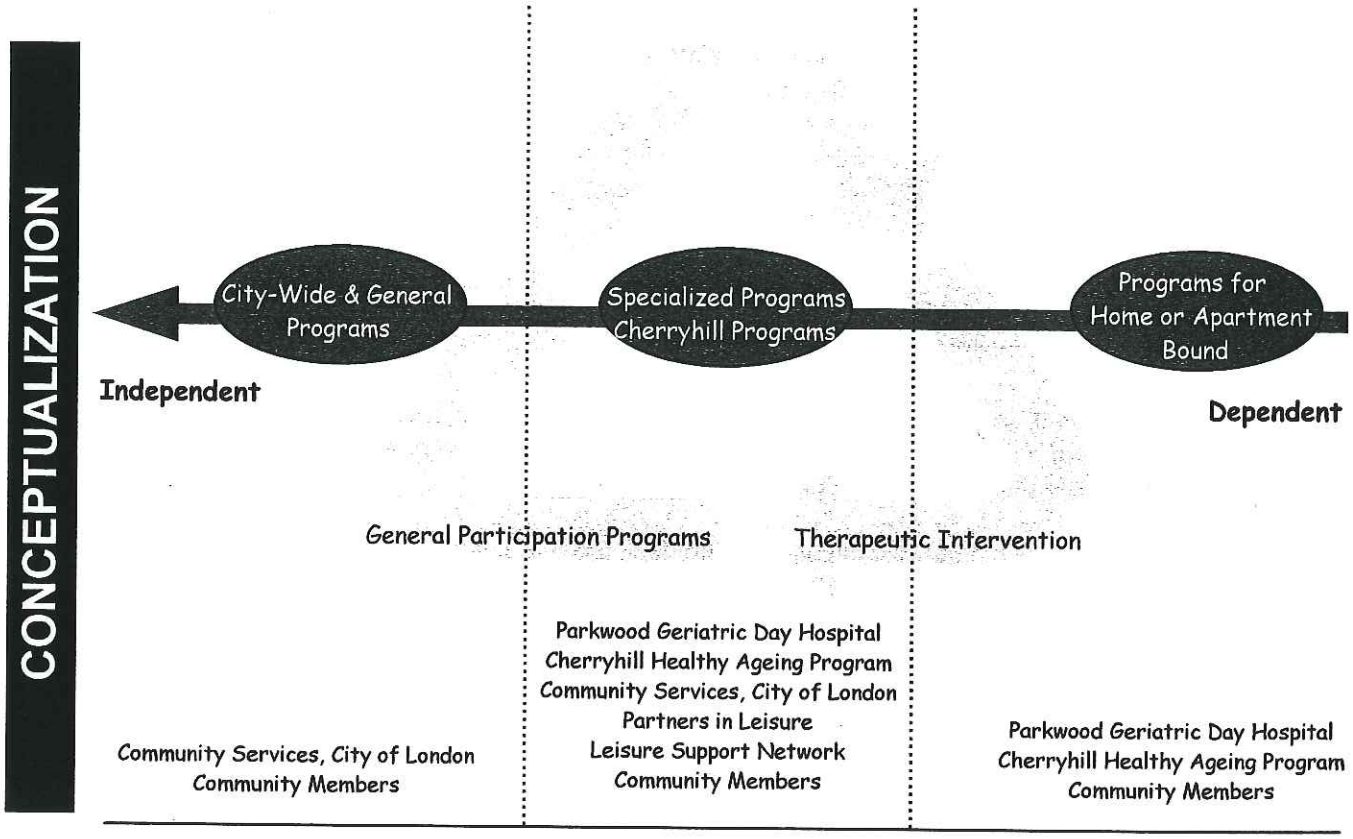
TERMS OF REFERENCE



Cherryhill Community Connections Program

- improve the functioning of frail, elderly individuals living in the community so that individuals can become more independent in their life-style and daily activities (i.e., includes rehabilitation element)
- identify and strengthen existing, untapped community social resources and identify any gaps
- build a community system of support using the "seniors helping seniors" or "neighbours helping neighbours" model
- collaboratively build the information, knowledge & skills of volunteer community members
- build a system that facilitates quick access to psychosocial programs, resources and supports within Cherryhill Village and city-wide
- collaboratively build formal linkages with other existing programs
- move frail, elderly individuals from the right of the continuum (dependence) to the left (increased independence)

Conceptualization:



Cherryhill Community Connections Program

Guiding Principles:

All community stakeholders will work in partnership, drawing on the geriatric, health and community development experience of each partner to collaboratively build, implement and evaluate a sustainable system of social support for frail, elderly individuals living in the Cherryhill community. In keeping with community development principles, partners will:

1. use participatory action processes to build community capacity to respond to community-identified psychosocial issues

2. use a participatory evaluation framework involving community members and community partners that is consistent with the existing Cherryhill Healthy Ageing Program evaluation model

Multiple community partners will work together, using evidence and experience to conceptualize and build the sustainable social support system.

Program Goals:

1. collaboratively build & operationalize a system (new and innovative model) that will address the psychosocial needs of frail, elderly individuals

2. create a tiered system of support that provides:

    - assessment-based individual & therapeutic programs
    - therapeutic & generic programs within the Cherryhill community geared to the needs of frail, elderly individuals
    - access to city-wide programs

3. strengthen untapped community resources using a "neighbours helping neighbours" model

4. explore the appropriateness of city social & recreation programs in meeting the needs of frail, elderly individuals living in the Cherryhill community, modify programs if necessary & bring into the Cherryhill community

5. increase information, knowledge & skills of frail, elderly individuals regarding psychosocial programs & resources available

6. collaboratively build & strengthen formal linkages between the Cherryhill Healthy Ageing Program, the Parkwood Geriatric Day Hospital, Southwestern Ontario Regional Geriatric Program & the City of London

7. produce a print & computerized directory of psychosocial information, programs & resources for frail, elderly individuals living in the Cherryhill community

Outcomes:

Expected outcomes fall into 2 categories. Outcomes for (1) frail, elderly individuals living in the Cherryhill community, and (2) program outcomes:

INDIVIDUAL OUTCOMES:

1. improved quality of life of frail, elderly individuals living in the Cherryhill community
2. improved function (physical & cognitive) of frail, elderly individuals living in the Cherryhill community including:
   - mobility
   - ADL
   - MMSE
   - depression, etc.
3. improved social contact of frail, elderly individuals living in the Cherryhill community
4. improved socialization by frail, elderly individuals living in the Cherryhill community
5. increased activity level/engagement in daily activities by frail, elderly individuals living in the Cherryhill community

PROGRAM OUTCOMES:

1. individual assessment
2. referral based on assessment findings
3. outcomes established for frail, elderly individuals based on assessment findings
4. quick access to psychosocial supports, programs & resources based on individual need
5. collaborative, multi-partner, sustainable continuum (new & innovative model) of psychosocial supports, programs & resources for frail, elderly individuals living in the Cherryhill community
6. formal community-driven "neighbours helping neighbours" support system which includes a model for the administration of volunteers

Cherryhill Community Connections Program

7. strong reciprocal communication & program linkages between the Cherryhill Healthy Ageing Program, the Parkwood Geriatric Day Hospital, Southwestern Ontario Regional Geriatric Program & city-wide recreation & social community agencies

8. print and computerized directory of psychosocial information, programs & resources for frail, elderly individuals living in the Cherryhill community

The Partners:

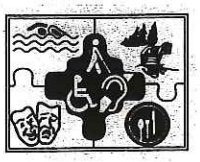
St Joseph's Health Care London

The University of Western Ontario
Department of Medicine • Division of Geriatric Medicine

The Community Connections Program is a sub-program of the "Parkwood in the Community" project, a collaborative proposal submitted to the Parkwood Hospital Foundation by the Cherryhill Healthy Ageing Program & the Parkwood Geriatric Day Hospital. Funding was received and priority issues were identified. Planning for the Community Connections program formally began in January 2001.

London CANADA

The City of London, Community Services Department has made a commitment to work with the Parkwood Geriatric Day Hospital and the Cherryhill Healthy Ageing Program to build a community system of social and recreation support, that includes a continuum of programs designed to meet the needs of elderly individuals unable to leave their home or apartment, those requiring specialized services, as well as those individuals who can access city-wide or general community programs.



Partners in Leisure London Middlesex is a consortium of service providers, funders and consumers in London and Middlesex working together to develop a co-ordinated and responsive leisure system for people with disabilities. Partners in Leisure London Middlesex has made a commitment to work with the Parkwood Geriatric Day Hospital and the Cherryhill Healthy Ageing Program to build a community system of leisure supports and programs for people of all abilities.

PARTNERS

Profile of the Cherryhill Community:

THE APARTMENT COMPLEX:

The Cherryhill community has a high concentration of seniors and is an area of high health service utilization. The Cherryhill apartment complex consists of 13 apartment buildings with 2325 units (total population approximately 3000) and 64 businesses under a single management group, the ESAM corporation. Approximately 2500 of the 3000 individuals living in the Cherryhill community are over the age of 65 years. Many are elderly women living alone.

The Cherryhill community has a "sense of community" and warm community atmosphere that is unique to the city of London. Development of the Cherryhill complex began in 1959 when the ESAM Construction Company was formed by Sam Katz and Ewald Bierbaum. Westown Plaza was developed first, opening in 1960 with 18 stores. A few years later, in 1966, development of the apartment complex began. Support for the plaza was so great that in 1974 the plaza expanded to become an enclosed mall with 50 stores. Over the years Sam Katz, and now the ESAM management team (including sons Harvey and Howard Katz) have earned a reputation, by both residents and merchants, as being caring, friendly and compassionate, with a "people come first" attitude. It is for this reason, that many of the existing stores are long-term merchants, some having been with the mall for over 20 years. Many residents have also chosen to stay in the community for many years, with quite a number of residents living there over 30 years. The mall has grown into a vibrant community gathering place, and the ESAM management team continues to be particularly supportive of the unique needs associated with an aging population.

There are 45 businesses in Cherryhill Village Mall, as well as an additional 19 businesses and professional services located in the 101 Cherryhill office building. All merchants in Cherryhill Village Mall provide special favours for tenants of the Cherryhill apartment complex if the need arises (i.e., the food court merchants deliver if an order is called in; flowers are delivered; etc.) It was reported by the ESAM corporation that ⅓ of Cherryhill Village Mall customers are "walk-ins" from the Cherryhill apartment complex. The ESAM management, in 1997, identified crisis intervention as a priority, reporting that at any given time 10-15 "tenants in the apartment complex require "crisis intervention".

Cherryhill

Healthy Ageing Program

Program Description

Program: **S.T.E.P. Program** (Strength, Tolerance & Exercise Program)	**Purpose:** A gentle exercise program for frailer, older Cherryhill community members with limitations (e.g., physical/health problems; those who are socially isolated; etc.) who leave their immediate environment (Cherryhill community) 1-2x per week or less, and who are unable to access community exercise classes.
Target Population in Cherryhill: ☐ Unable to Leave Apt. &/or Apt. Bldg. X Able to Access Immediate Cherryhill Environment ☐ Able to Access City-Wide Programs	**Program Timelines:** Start Date: Thursday, May 31, 2001 End Date: Thursday, July 19, 2001 Program Length: 8 weeks Program Duration: 1 hour (10:45 a.m. to 11:45 a.m.)
Program Location: Cherryhill Health Promotion & Information Centre	

Fitness Instructor(s): Anna Holman (volunteer)
Mena Duffield (student) & Program Support for Bev

Program Volunteers: Lynda Weatherbe (Cherryhill volunteer)
June Manning (community member & Community Connections Program Facilitator)

Program Support Staff:
Bev Regan, TRS, Community Connections Program Facilitator & Parkwood Geriatric Day Hospital
Susan Meyer, Physiotherapist, Parkwood Geriatric Day Hospital
Cheryl MacDonald, O.T., Parkwood Geriatric Day Hospital

Role Descriptions:

Fitness Instructors: Fitness instructor for the S.T.E.P. program; responsible for running the exercise classes; registration; monitoring of participants.

Program Volunteers: Will assist the fitness instructor with running the exercise program; registration; monitoring of participants.

Program Support Staff:

Bev Regan, TRS — Responsible for overall co-ordination of the S.T.E.P. program; arranging transportation for participants; volunteer recruitment (with Lisa Misurak, Cherryhill Health Information & Community Development Co-ordinator); facility arrangements; equipment arrangements; registration; advertising; student involvement; monitoring of participants; evaluation of psychosocial component & overall program effectiveness with Dr. Marita Kloseck, Manager, Program Development, Evaluation & Research).

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Susan Meyer, Physio	Responsible for the exercise component; training of fitness instructors & program volunteers; monitoring of program participants; evaluation of functional outcomes (with MK).
Cheryl MacDonald, OT	Evaluation of functional outcomes (with SM & MK); co-responsibility with (SM) for the exercise component.

Expected Program Outcomes:

Primary Outcomes - Individual Level (Group Amalgamation):

1. Improved Activity Level
2. Improved Quality of Life/Life Satisfaction
3. Maintained Functional Ability (strength, tolerance & balance)

Program Goals: (see Community Connection Program & S.T.E.P. Program GAS forms)

How Was the Need for this Program Identified? (evidence to support the need for this program):

1. Individual assessments conducted by TRS (Bev Regan)
2. Community Survey 1997
3. Volunteer Survey 1999
4. Geriatric Nurse Practitioner (Donna Wiancko)
5. Evidence from literature review

Admission Criteria:

1. ≥ 70 years of age
2. must reside in one of the 13 apartment buildings in Cherryhill village
3. leave their immediate environment (Cherryhill community) 1-2x per week or less
4. unable to access community exercise programs due to limitations (e.g., physical & health problems, or social limitations; environmental barriers; etc.)
5. must register & provide informed consent
6. must have the ability to understand & follow instructions from the fitness instructor
7. must have permission from their family physician, if they have checked "yes" to any question on the PAR-Q form

Discharge Criteria:

1. no longer a Cherryhill resident
2. unable to understand or follow the instructions of the fitness instructor
3. change in health status (e.g., S.O.B.; pain; dizziness; increase in blood pressure; etc.)
4. if participant is hospitalized

Note: If participant requires "hands-on" assistance to perform the Timed Up & Go or 2-minute walk test, or cannot stand unsupported for the BERG test, participant is not suitable for the S.T.E.P. Program & should be referred to the Geriatric Nurse Practitioner for further assessment.

Maximum Number of Program Participants: 10-12

Evaluation/Change Indicators:

1. Improved Activity Level: frequency of leaving apartment; frequency of leaving the Cherryhill community; barriers checklist; Activities Checklist
2. Improved Quality of Life/Life Satisfaction: SHARP; life satisfaction (Likert-type scale); (Time Intervals for Measurement: Week 1 (baseline) & Week 8 (program completion)
3. Maintained Functional Ability: Timed Up & Go (strength & tolerance); modified BERG scale (balance); 2-minute walk test (gait analysis & speed)

+ Program Satisfaction Survey (at program completion)

A COPY OF THE PROGRAM DESCRIPTION MUST BE FORWARDED TO MARTHA FOR EVALUATION RECORDS AT LEAST 2 WEEKS **PRIOR** TO PROGRAM IMPLEMENTATION

Cherryhill

Healthy Ageing Program

Psychosocial Documentation

Information Required:

1. Intake Form
2. Global Risks Assessment
3. The MOS Physical Functioning Measure
4. COOP Charts
5. Psychosocial Assessment
6. Resident Goals/GAS

Time Intervals:

All information must be completed at baseline (time of initial assessment), and then at 4 monthly intervals thereafter to monitor client progress. Programs should be developed to meet the needs of residents at each of the three identified levels:

Level 1:	Unable to leave apartment or apartment building
Level 2:	Able to access the immediate Cherryhill environment only\
Level 3:	Able to access city-wide programs

Residents should be referred to programs based on need, ability, assessment findings and interest.

Level of Measurement/Unit of Analysis: Individual

Cherryhill

Healthy Ageing Program

Intake Form

Name: _____

Address: _____

_____

Phone: _____

Family Physician: _____

Health Services Receiving:

_____

_____

_____

_____

_____

Social Services Receiving:

_____

_____

_____

_____

Unique Id: _____

Referral: ☐ yes ☐ no

Referral Source:

_____

Referral Contact:

_____

Referral Phone: _____

Referral Date: _____

Reason for Referral:

- ☐ hygiene
- ☐ nutrition
- ☐ medication
- ☐ falls/mobility
- ☐ safety risk
- ☐ mental condition
- ☐ functional decline
- ☐ finances
- ☐ abuse
- ☐ medical issues
- ☐ service need
- ☐ social isolation
- ☐ caregiver stress
- ☐ request for info.
- ☐ incontinence
- ☐ pain
- ☐ suspiciousness
- ☐ family dynamics
- ☐ other:

_____

1. Date of Birth (mm/dd/yy): ____/____/____

2. Years Living in Cherryhill: _____

3. Are you:
   - ☐ a veteran
   - ☐ a veteran's spouse
   - ☐ a non-veteran

4. Marital Status:
   - ☐ single
   - ☐ married
   - ☐ widowed
   - ☐ divorced
   - ☐ separated

5. Current Living Arrangements? Do you live:
   - ☐ alone
   - ☐ with your spouse or partner
   - ☐ with another member of your family
   - ☐ with a friend or roommate
   - ☐ other: _____

6. Frequency of Leaving Apartment:
   - ☐ daily
   - ☐ 3-5x per week
   - ☐ 1-2x per week
   - ☐ once every 2 weeks
   - ☐ 1x per month
   - ☐ almost never

7. Frequency of Leaving Cherryhill Community:
   - ☐ daily
   - ☐ 3-5x per week
   - ☐ 1-2x per week
   - ☐ once every 2 weeks
   - ☐ 1x per month
   - ☐ almost never

8. Reason for Leaving the Apartment/Community
   - ☐ activities of daily living (groceries; mail; etc.)
   - ☐ to visit friends and/or socialize
   - ☐ to participate in programs/activities
   - ☐ medical reasons
   - ☐ all of the above
   - ☐ not applicable

9. Who do you turn to when you need help? _____

Name: _____

Address: _____

Phone: _____

Relationship to you: _____

10. Are there other people to whom you can turn when you need help? ☐ yes ☐ no

If yes, who? Relationship:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

11. In general, would you say your health is (please circle the number that best describes how you feel):

1 poor 2 fair 3 good 4 very good 5 excellent

12. In general, how satisfied are you with your life at this point in time (please circle the number that best describes how you feel):

1 not at all satisfied 2 rarely satisfied 3 somewhat satisfied 4 usually satisfied 5 very satisfied

13. What are your greatest challenges?

_____

_____

_____

_____

_____

14. Do you mind if someone comes to visit you to see how you are doing?

☐ No, I do not mind. Signature: _____

☐ Yes, I do mind. I do not want anyone to visit.

30 October 2001

Cherryhill

Healthy Ageing Program

Referral Form

Client Name: _____ **Building:** _____ **Apartment:** _____

Phone: _____

Referral To:

- ☐ Geriatric Nurse Practitioner
- ☐ Psychosocial Assessment
- ☐ CCAC (Evelyn Walsh)
- ☐ Physiotherapy
- ☐ Resident Safety Program
- ☐ Community Response Team
- ☐ Osteoporosis Screening Program
- ☐ Fracture Prevention Program
- ☐ Occupational Therapy
- ☐ Other: _____

Reason for Referral: _____

_____

_____

_____

_____

_____

Source of Referral: _____ **Date:** _____

Signature: _____ **Phone:** _____

Comments: _____

_____

_____

_____

_____

Cherry Hill

Healthy Ageing Program

Global Risks Assessment

The following are examples of some "red flags" that can be identified in older adults that might be signs of a significant health or social problem:

---

1. HYGIENE

a) Personal:
Is the person generally unkempt? ..... Yes ☐ No ☐

b) Environment:
Is there an odour in the person's home (e.g., urine; feces; musty)? ..... Yes ☐ No ☐
Is the environment cluttered with paper, food, garbage? ..... Yes ☐ No ☐

2. NUTRITION

Do you notice that the person's clothes are too loose or too tight? ..... Yes ☐ No ☐

When you ask, does the person admit to having lost or gained any weight in the past year? ..... Yes ☐ No ☐

3. MEDICATIONS

Do you notice medication/alcohol bottles scattered around the person's living environment (e.g., on counters; table tops; in the bathroom; etc.)? ..... Yes ☐ No ☐

Does the person have slurred speech, appear groggy, confused or sleepy? ..... Yes ☐ No ☐

4. FALLS

Does the person appear unsteady on their feet? ..... Yes ☐ No ☐
Does the person have trouble getting out of a chair? ..... Yes ☐ No ☐
Does the person have problems with mobility? ..... Yes ☐ No ☐

5. FIRE

a) Smoking:
Are there burn marks on the furniture, carpet, clothing, person's skin? ..... Yes ☐ No ☐

...2

b) Environment:

Is there evidence of burn marks on the stove or burned pots and pans? ..... Yes ☐ No ☐
Is there a smoke detector? Does it work? ..... Yes ☐ No ☐

c) Person:

Is the person confused? ..... Yes ☐ No ☐
Is the person mobile? ..... Yes ☐ No ☐
Is the person visually or hearing impaired? ..... Yes ☐ No ☐

6. MENTAL CONDITION

a) Thinking:

Does the person repeat him/herself (e.g., tell you the same story over and over again; ask the same question over again)? ..... Yes ☐ No ☐

b) Mood:

Does the person cry a lot? ..... Yes ☐ No ☐
Does the person appear angry/irritable/agitated? ..... Yes ☐ No ☐

7. FINANCES

Do you see evidence of unpaid bills or letters from creditors/collection agencies? Yes ☐ No ☐

8. ABUSE

Financial:	Does the person give away large amounts of money to another person?	Yes ☐	No ☐
Physical:	Is the evidence of bruises, abrasions (ruling out falls)?	Yes ☐	No ☐
Emotional:	Is the person afraid of their caregiver/family member?	Yes ☐	No ☐
Neglect:	Does the person appear to be well cared for?	Yes ☐	No ☐

9. SERVICES

Is the person involved with outside agencies such as CCAC, VON? You may see their care binders in the person's home or their cards on the fridge. ..... Yes ☐ No ☐

Name: _____ Date: _____

Referral Required: Yes ☐ No ☐ Resident Informed & Agreeable: Yes ☐ No ☐

Referred to: _____

_____

_____

Cherry hill
Healthy Ageing Program

Goal Attainment Scale (GAS)
Client

What are the 3 most important things that would make things better for you and improve the quality of your life?

QUESTIONS TO ASK THE CLIENT	CLIENT GOALS			GOAL ATTAINMENT LEVELS
	1.	2.	3.	
Question 1: (GAS -2 or -1) What is your situation now? Can you image it getting worse?				**-2 much less than expected**
				-1 somewhat less than expected
Question 3: (GAS 0) What degree of improvement would you be happy with?				**0 expected level (program goal)**
				+1 somewhat better than expected
Question 2: (GAS +2 or +1) Given your age & where you are now in your life, what would be your ideal expectations?				**+2 much better than expected**
Goal Achievement Status:	Baseline: _____ 4 Months: _____ 8 Months: _____ 12 Months: _____	Baseline: _____ 4 Months: _____ 8 Months: _____ 12 Months: _____	Baseline: _____ 4 Months: _____ 8 Months: _____ 12 Months: _____	

GOAL 1: COMMENTS	GOAL 2: COMMENTS	GOAL 3: COMMENTS

Cherry Hill
Healthy Ageing Program

Psychosocial Assessment

1. What are you currently doing for enjoyment?

2. What activities have you recently stopped doing?

3. Are any of the following barriers for you that prevent you from taking part in activities you enjoy:

HEALTH

A health condition or illness that you have	Yes ☐	No ☐	Sometimes ☐

FUNCTIONAL ABILITY

Physical mobility or balance problems	Yes ☐	No ☐	Sometimes ☐
Fine motor, upper extremity problems	Yes ☐	No ☐	Sometimes ☐
Bowel & bladder problems	Yes ☐	No ☐	Sometimes ☐
Pain	Yes ☐	No ☐	Sometimes ☐
Fatigue	Yes ☐	No ☐	Sometimes ☐
Shortness of breath	Yes ☐	No ☐	Sometimes ☐
Poor vision	Yes ☐	No ☐	Sometimes ☐
Difficulty hearing	Yes ☐	No ☐	Sometimes ☐
Difficulty with communication/language	Yes ☐	No ☐	Sometimes ☐
Difficulty with concentration &/or memory	Yes ☐	No ☐	Sometimes ☐
Difficulty with thinking skills	Yes ☐	No ☐	Sometimes ☐
Loss of independence	Yes ☐	No ☐	Sometimes ☐

WELL-BEING

Feeling down or depressed	Yes ☐	No ☐	Sometimes ☐

ENVIRONMENTAL FACTORS

Inability to access the community	Yes ☐	No ☐	Sometimes ☐
Lack of, or limited, transportation	Yes ☐	No ☐	Sometimes ☐

SOCIAL FACTORS

Lack of social partners, friends or social supports	Yes ☐	No ☐	Sometimes ☐
Uncomfortable in a social setting	Yes ☐	No ☐	Sometimes ☐
Caregiver responsibilities	Yes ☐	No ☐	Sometimes ☐

...2

KNOWLEDGE, INFORMATION & RESOURCES

Lack of knowledge & information about community resources ..... Yes ☐ No ☐ Sometimes ☐

SOCIO-ECONOMIC FACTORS

Not enough money to do the things you would like ..... Yes ☐ No ☐ Sometimes ☐
Not enough time to do the things you would like ..... Yes ☐ No ☐ Sometimes ☐

PERSONALITY TRAITS & DISPOSITION

Self-conscious and often anxious or distressed ..... Yes ☐ No ☐ Sometimes ☐

LEISURE ATTITUDE & SKILLS

Lack of confidence ..... Yes ☐ No ☐ Sometimes ☐
Lack of motivation ..... Yes ☐ No ☐ Sometimes ☐
Lack of interests ..... Yes ☐ No ☐ Sometimes ☐
Don't feel I have the skills to do the things I would like to do ..... Yes ☐ No ☐ Sometimes ☐

Other: _____

_____

4. At this point in time, how involved are you in activities that bring you enjoyment & pleasure (please circle the number that best describes how you feel):

1	2	3	4	5
Not Involved at All	Rarely Involved	Somewhat Involved	Occasionally Involved	Very Involved

5. What would you like to be doing if the above barriers were removed or lessened?

_____

_____

_____

6. During the <u>past year</u> have you experienced any of the following major changes in your life?

☐ become retired?
☐ lost a spouse?
☐ lost a child (e.g., son or daughter)?
☐ lost a close friend?
☐ moved to a new place of residence?
☐ been told you have a major illness or condition?
☐ been required to provide primary care for a family member or relative?
☐ experienced any other major changes in your life? _____

7. **Initial Program Category:**

☐ suitable for 1:1 or small group programs in the client's apartment and/or apartment building
☐ suitable for specialized programs in the immediate Cherryhill community
☐ suitable for general programs city-wide

8. **Plan:**

_____
_____
_____
_____
_____
_____

9. **Referred To:**

☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

10. **Comments:**

_____
_____
_____
_____
_____
_____

Therapist: _____ Date: _____

Signature: _____

Re-Assessment Dates: 4 Months: _____
8 Months: _____
12 Months: _____

Cherryhill

Healthy Ageing Program

The MOS Physical Functioning Measure

(Stewart, 1992)

1. The following items are activities you might do during a typical day. *Does you health limit you* in any of these activities? (Please circle the number on each line that best describes how you feel.

	ACTIVITIES	Yes, limited a lot	Yes, limited a little	No, not limited at all
a.	*Vigorous activities,* such as running, lifting heavy objects, participating in strenuous sports	1	2	3
b.	*Moderate activities,* such as moving a table, pushing a vacuum cleaner, bowling, playing golf	1	2	3
c.	Lifting or carrying groceries	1	2	3
d.	Climbing *several* flights of stairs	1	2	3
e.	Climbing *one* flight of stairs	1	2	3
f.	Bending, kneeling or stooping	1	2	3
g.	Walking, *more than one mile*	1	2	3
h.	Walking, *several blocks*	1	2	3
i.	Walking, *one block*	1	2	3
j.	Bathing or dressing yourself	1	2	3

2. How satisfied are you with your physical ability to do what you want to do? (Please circle the number that best describes how you feel.)

1	2	3	4	5	6
Completely Dissatisfied	Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied	Completely Satisfied

(over)

3. When you travel around your community, does someone have to assist you because of your health? (Please circle the number that best describes how you feel.)

1	2	3	4	5
Yes, all the the time	Yes, most of the time	Yes, some of the time	Yes, a little of the time	No, none of the time

4. Are you in bed or in a chair *most* or *all* of the day because of your health? (Please circle the number that best describes how you feel.)

1	2	3	4	5
Yes, every day	Yes, most days	Yes, some days	Yes, occasionally	No, never

5. Are you able to use public transportation? (Please circle the number that best describes how you feel.)

1	2	3
No, because of my health	No, for some other reason	Yes, able to use public transportation

---

Note: Scoring on question 2 has been reversed.

From: Stewart, A.L. & Ware, J. E. Jr. Measuring functioning and well-being: the Medical Outcomes Study approach. Durham, North Carolina: Duke University Press, 1992:375-376.

Cherryhill

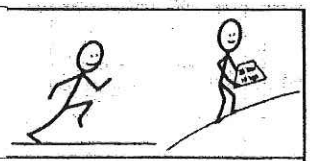
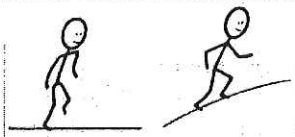
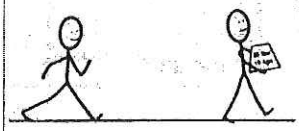
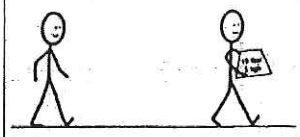
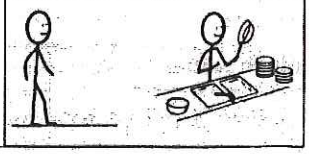
Healthy Ageing Program

COOP Charts

(Nelson, 1987)

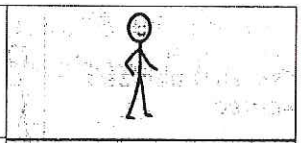
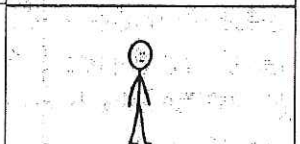
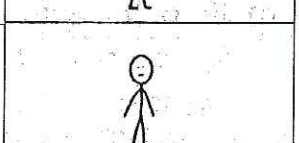
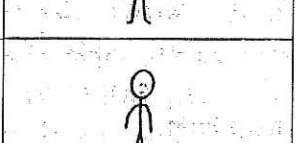
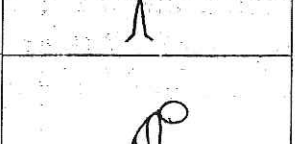
1. Physical Fitness

During the past 4 weeks what was the hardest physical activity you could do for at least 2 minutes?

Very Heavy . run, fast pace . carry a heavy load upstairs or uphill (25 lbs.)		1
Heavy . jog, slow pace . climb stairs or a hill, moderate pace		2
Moderate . walk, medium pace . carry a heavy load on level ground (25 lbs.)		3
Light . walk, medium pace . carry a light load on level ground (10 lbs.)		4
Very Light . walk, slow pace . wash dishes		5

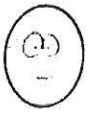
2. Daily Activities

During the past 4 weeks how much difficulty have you had doing your usual activities or tasks, both inside and outside the house because of your physical and emotional health?

No difficulty at all		1
A little bit of difficulty		2
Some difficulty		3
Much difficulty		4
Could not do		5

3. Feelings

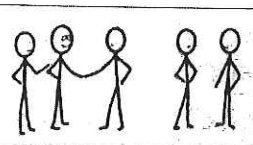
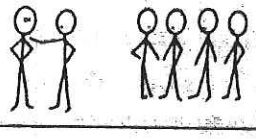
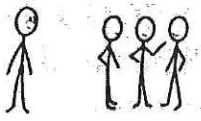
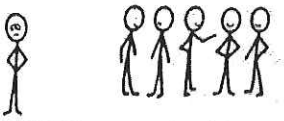
During the past 4 weeks how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable or downhearted and blue?

Not at all		1
Slightly		2
Moderately		3
Quite a bit		4
Extremely		5

---

4. Social Activities

During the past 4 weeks has your physical and emotional health limited your social activities with family, friends, neighbours or groups?

Not at all		1
Slightly		2
Moderately		3
Quite a bit		4
Extremely		5

5. Pain

During the past 4 weeks how much bodily pain have you generally had?

No pain		1
Very mild pain		2
Mild pain		3
Moderate pain		4
Severe pain		5

---

6. Overall Health

During the past 4 weeks how would you rate your health in general?

Excellent		1
Very Good		2
Good		3
Fair		4
Poor		5

7. Change in Health

How would you rate your overall health now compared to 4 weeks ago?

Much better		1
A little better		2
About the same		3
A little worse		4
Much worse		5

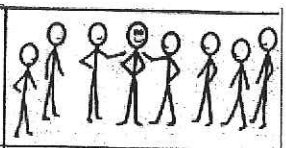
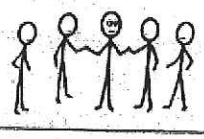
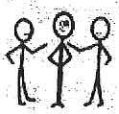
---

8. Social Support

During the past 4 weeks was someone available to help you if you needed and wanted help?

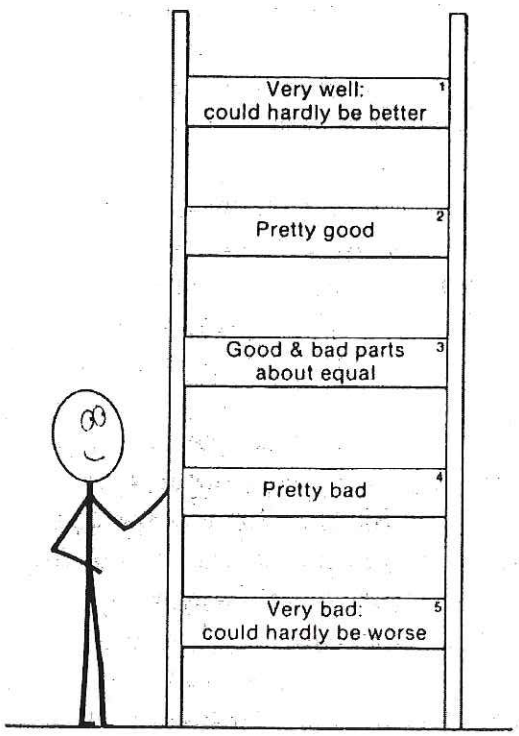
For example if you

- felt very nervous, lonely or blue
- got sick and had to stay in bed
- needed someone to talk to
- needed help with daily chores
- needed help just taking care of yourself

Yes, as much as I wanted		1
Yes, quite a bit		2
Yes, some		3
Yes, a little		4
No, not at all		5

9. Quality of Life

How have things been going for you during the past 4 weeks?



Cherryhill

Healthy Ageing Program

Frequency of Leaving Apartment & Community

6. How often do you leave your apartment building?

- ☐ daily
- ☐ 3-5x per week
- ☐ 1-2x per week
- ☐ once every 2 weeks
- ☐ 1x per month
- ☐ almost never

7. How often do you leave the Cherryhill community?

- ☐ daily
- ☐ 3-5x per week
- ☐ 1-2x per week
- ☐ once every 2 weeks
- ☐ 1x per month
- ☐ almost never

8. What is the primary reason for leaving your apartment and/or the Cherryhill community?

- ☐ activities of daily living (groceries; mail; visiting your doctor; etc.)
- ☐ to visit friends and/or socialize
- ☐ to participate in recreation programs/enjoyable activities
- ☐ medical reasons
- ☐ all of the above
- ☐ other: _____

9. In general, would you say your health is (please circle the number that best describes how you feel):

1	2	3	4	5
poor	fair	good	very good	excellent

10. In general, how satisfied are you with your life at this point in time (please circle the number that best describes how you feel):

1	2	3	4	5
not at all satisfied	rarely satisfied	somewhat satisfied	usually satisfied	very satisfied

Cherry Hill

Healthy Ageing Program

Program Description

Program:	**Purpose:**
Target Population in Cherryhill: unable to leave apartment &/or apartment building able to access immediate Cherryhill environment able to access city-wide programs	**Program Timelines:** Start Date: End Date: Program Length & Duration:
Program Location:	
Program Staff:	
Role Descriptions:	

Expected Program Outcomes:

Program Goals:

How Was the Need for this Program Identified? (evidence to support the need for this program):

Inclusion Criteria:	**Exclusion Criteria:**

Maximum Number of Program Participants:

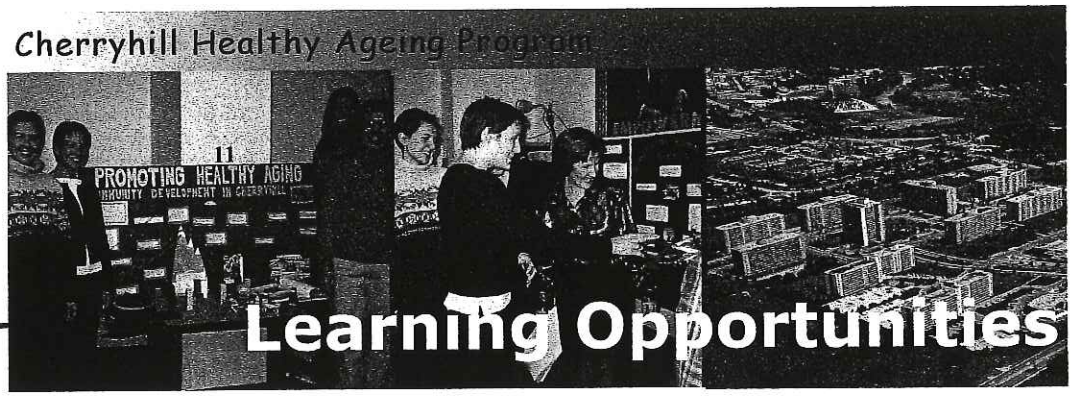
Evaluation/Change Indicators:

A COPY OF THE PROGRAM DESCRIPTION MUST BE FORWARDED TO MARITA FOR EVALUATION RECORDS AT LEAST 2 WEEKS **PRIOR** TO PROGRAM IMPLEMENTATION

Appendix G: **Learning Partnerships**

Cherryhill Healthy Ageing Program

January 2001



Learning Opportunities

Introduction:

The Cherryhill Healthy Ageing Program has developed a partnership with the School of Nursing, Faculty of Health Sciences at the University of Western Ontario, and is building partnerships with other faculties and universities elsewhere, to provide on-site and classroom learning opportunities. Placement opportunities have been created for students in the undergraduate nursing program, to learn more about, and experience "first-hand", health promotion and prevention programming in a community development setting. This partnership will provide students with the opportunity to apply the knowledge and skills acquired through text book readings, classroom lectures and other sources, in a community setting with "real" community members who are growing older.

Purpose:

To collaboratively build, implement and evaluate learning opportunities for both undergraduate and graduate students in the Faculty of Health Sciences and other faculties at the University of Western Ontario and elsewhere. Specifically, the purpose is to:

- provide learning opportunities that let students see things from "the other side", build on classroom & textbook knowledge, and allow students to experience some of the realities of working with older individuals living in the community
- provide students with an opportunity to learn or gain insight into meaningful collaboration, community capacity building, and "true" community partnerships
- provide a learning experience that is mutually beneficial for students, the university, and the Cherryhill community
- strengthen students' knowledge base in the areas of geriatrics, health and community development

TERMS OF REFERENCE

Guiding Principles:

Students, faculties and universities and the Cherryhill Healthy Ageing Program will work in partnership, drawing on the geriatric, health and community development of both partners to collaboratively build, implement and evaluate learning experiences for undergraduate and graduate students.

In keeping with community development principles, established processes developed through the Cherryhill Healthy Ageing Program and universities, the student learning opportunities will:

1. use participatory action processes
2. use a participatory evaluation framework involving community members and community partners that is consistent with the existing Cherryhill Healthy Ageing Program evaluation model

Access into the Cherryhill community will be through the Cherryhill Healthy Ageing Program and it's existing programs such as the Cherryhill Health Promotion & Information Centre, Resident Safety Check Program, Community Response Team, and other community health promotion and prevention programs.

TERMS OF REFERENCE

Outcomes:

GENERAL:

Attitude: to foster students' respect for the frail elderly and their opinions, and to create comfort with working in "true" partnerships with elderly community members and clients

Knowledge: to develop students' knowledge regarding community geriatric health issues, obstacles and resources, community development processes, and the ability to distinguish between different processes used when working with communities of older adults (i.e., community development vs. community mobilization vs. community systems approach; etc.)

Skills: to build students' communication skills, diplomacy, and the ability to identify community health needs, health promotion strategies and collaborative solution finding

SPECIFIC:

Specific outcomes are identified for individual courses and learning opportunities (see pg. 11)

Profile of the Cherryhill Community:

THE APARTMENT COMPLEX:

The Cherryhill community has a high concentration of seniors and is an area of high health service utilization. The Cherryhill apartment complex consists of 13 apartment buildings with 2325 units (total population approximately 3000) and 64 businesses under a single management group, the ESAM corporation. Approximately 2500 of the 3000 individuals living in the Cherryhill community are over the age of 65 years. Many are elderly women living alone.

The Cherryhill community has a "sense of community" and warm community atmosphere that is unique to the city of London. Development of the Cherryhill complex began in 1959 when the ESAM Construction Company was formed by Sam Katz and Ewald Bierbaum. Westown Plaza was developed first, opening in 1960 with 18 stores. A few years later, in 1966, development of the apartment complex began. Support for the plaza was so great that in 1974 the plaza expanded to become an enclosed mall with 50 stores. Over the years Sam Katz, and now the ESAM management team (including sons Harvey and Howard Katz) have earned a reputation, by both residents and merchants, as being caring, friendly and compassionate, with a "people come first" attitude. It is for this reason, that many of the existing stores are long-term merchants, some having been with the mall for over 20 years. Many residents have also chosen to stay in the community for many years, with quite a number of residents living there over 30 years. The mall has grown into a vibrant community gathering place, and the ESAM management team continues to be particularly supportive of the unique needs associated with an aging population.

There are 45 businesses in Cherryhill Village Mall, as well as an additional 19 businesses and professional services located in the 101 Cherryhill office building. All merchants in Cherryhill Village Mall provide special favours for tenants of the Cherryhill apartment complex if the need arises (i.e., the food court merchants deliver if an order is called in; flowers are delivered; etc.) It was reported by the ESAM corporation that ⅓ of Cherryhill Village Mall customers are "walk-ins" from the Cherryhill apartment complex. The ESAM management, in 1997, identified crisis intervention as a priority, reporting that at any given time 10-15 "tenants in the apartment complex require "crisis intervention".

Profile of the Cherryhill Community:

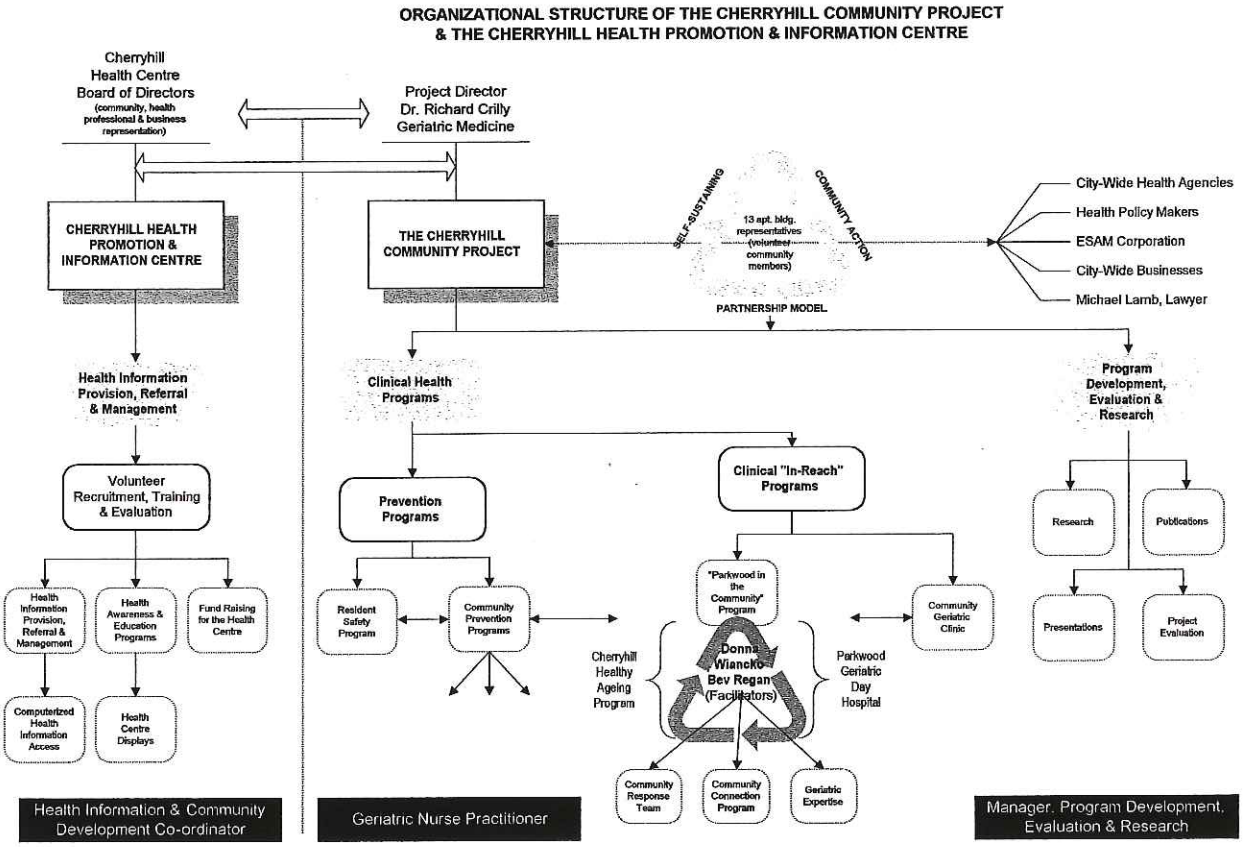
THE PEOPLE:

The Cherryhill community contains approximately 2500 individuals over the age of 65 years. The majority are elderly women living alone. The Cherryhill community is a stable community with residents remaining for many years. The Cherryhill community is very popular and there are rarely vacant apartment.

The following provides a profile of the characteristics of the Cherryhill community at the time of a community survey which was conducted in May 1997:

- mean age = 78 years (1997)
- now it is projected that 54% of the population is >80 years of age
- approximately ⅓ of these individuals (approx. 500) have significant memory impairment
- average time lived in the Cherryhill community was 10 years (SD = ± 7.56 years)
- the oldest individuals (those 85+ years) have lived in the community longest (14+ years)
- the community is stable, with residents "aging in place".
- 21% of residents over the age of 65 (>500 individuals) reported having a caregiver
- 11% of residents over the age of 65 (approximately 300 individuals) reported that they were providing care to someone with whom they lived
- it is estimated that more than 800 individuals fall each year, resulting in 8-10 hip fractures per year
- approximately 300 elderly women experience urinary incontinence
- depression (which affects at minimum 5% of women over the age of 65), loneliness and suicide are prevalent in the community
- it is estimated that there are enough residents in the Cherryhill community with unmet health needs to keep a geriatric day hospital busy for 2 years providing assessment & treatment

The Cherryhill Healthy Ageing Program:



ORGANIZATIONAL STRUCTURE

Program Overview & Program Staff:

Executive Summary: The Cherryhill Healthy Ageing Program is a participatory action project that utilizes a community systems process to build long-term commitment & foster partnerships among community members, health professionals, businesses & health policy makers. These community partners are working together to collaboratively develop, implement & evaluate a new & innovative model of community health for the elderly that will, over time, evolve in response to the changing needs of the community & improve the health of residents living in the community.

Project Goals:

- to explore how elderly citizens can become more involved in the planning & provision of their own health services
- to build community capacity to respond to community-identified health issues
- to build & strengthen existing, untapped informal community health resources
- to create a *sustainable* system of shared decision making between the community & formal health system
- to create a community *Centre for Healthy Ageing* in partnership with the Division of Geriatric Medicine, University of Western Ontario, local communities of elderly individuals, community health agencies & health institutions
- to help elderly individuals living in the community successfully age in place, and remain active, independent & in their own homes, for as long as possible

Project Timelines:

Phase I: Information Collection Phase - August 1996-December 1997
Phase II: Community Action Phase - January 1998-August 1998
Phase III: Growth & Sustainability Phase - September 1998 to present

Conceptualization: The project uses a community systems process to facilitate change, and is guided by a theoretical framework that includes societal change theory, theories of individual & community empowerment, theories of voluntarism, theories of aging, self-efficacy & motivation theories.

Evaluation: A collaborative, interactive & iterative evaluation framework involving community partners and a variety of quantitative & qualitative methods has been designed for the *Cherryhill Healthy Ageing Program.* There are 3 main categories of goals (process, impact, outcome goals) and change is measured at 3 levels (individual, community & community systems change). Goal attainment scaling is used to measure goal achievement, over- & under-achievement, as well as planned & unplanned change. This innovative evaluation model has attracted international attention.

Project Director: **Dr. Richard G. Crilly**

Dr. Crilly did his medical & research training in the U.K. before moving to Canada in 1981. He is Associate Professor in the Division of Geriatric Medicine at the University of Western Ontario, Canada. His interests range from osteoporosis to geriatric community development. In the past he has been Chair of the Division of Geriatric Medicine and Director of the Regional Geriatric Program of southwestern Ontario where his main interest was the development of community independence in geriatric assessment and management, and program evaluation.

Manager, Program Development, Evaluation & Research: **Dr. Marita Kloseck**

Dr. Kloseck has a joint Ph.D. in Health Studies & Gerontology, and Leisure Studies from the University of Waterloo. Her areas of specialization are health program evaluation and community development. She works as a researcher for the Division of Geriatric Medicine, at the University of Western Ontario and has over 20 years experience in the health care field as a practitioner, researcher, manager and consultant. Marita is a recognized expert in the areas of health-related outcome measurement & program evaluation and provides training to health care organizations in Canada and the United States. She has won numerous awards for her work.

Geriatric Nurse Practitioner: **Donna Crinklaw Wiancko**

Donna, a Registered Nurse with a Master's degree in Nursing from the University Of Western Ontario, is an acute care nurse practitioner and a certified geriatric nurse. She is an adjunct professor with the School of Nursing, U.W.O. and has worked with older adults in long-term care, acute care and community settings. Donna was a geriatric clinical nurse specialist for several years at Sunnybrook Health Care Centre in Toronto, and program co-ordinator for the Geriatric Transitional Care Unit at Oshawa General Hospital. In 1992 she joined the Southwestern Ontario Regional Geriatric Program (RGP) as nurse manager and developed the acute care Geriatric Assessment Unit at St. Joseph's Health Centre, Grosvenor Site. She transferred to the RGP Outreach Team in 1998.

Cherryhill Health Information & Community Development Co-ordinator: **Lisa Misurak**

Lisa has a Master's degree in Information & Library Science from the University of Western Ontario and 15 years experience in information program management, community services database management & publication production. She is also currently the Information Manager & Volunteer Co-ordinator for Information London, and has served as Acting Executive Director in the past. Lisa has served as a representative to the Council for seniors, Information Committee, & the London & Area Association of Volunteer Administration. She has applied her information science background to a wide variety of social service programs that help link people to community and health services.

Knowledge Based Pre-Requisites:

GERIATRIC & HEALTH-RELATED KNOWLEDGE BASE PRE-REQUISITES:

- Demographic & population projections of older persons
- Theories of ageing
- Normal ageing & clinical implications
- The ability to identify the prevalence & impact of health issues & "geriatric giants" including:
  - instability, immobility, falls
  - incontinence
  - intellectual impairment - confusion - delirium, dementia
  - mental health, isolation, depression, suicide
  - sensory impairment
  - decreased vitality, energy
  - polypharmacy, alcohol
  - infection & atypical presentations
  - common disease processes & chronic disease:
  - cardiovascular
  - neurological
  - respiratory
  - gastrointestinal
  - musculoskeletal
  - etc.
- Consider the above in relation to function, activities of daily living (ADLs) and instrumental activities of daily living (IADLs)
- Reflect on this content in relation to your selected nursing theory

COMMUNITY DEVELOPMENT KNOWLDEGE BASE PRE-REQUISITES:

- The ability to distinguish between different approaches to working with communities:
  - community development
  - community mobilization
  - community-based programming
- Community systems approach

Available Selected Readings:

Baltes, M.M. (1988). Etiology and maintenance of dependency in the elderly: Three phases of operant research. Behaviour Therapy, 19, 301-319.

Baltes, M.M., Mayr, U., Borchelt, M., Maas, I., & Wilms, H. (1993). Everyday competence in old and very old age: An inter-disciplinary perspective. Aging and Society, 13. 657-680.

Ebersole, P. & Hess, P. (1998). Toward healthy aging. Toronto: Mosby.

Kahana, E. (1982). A congruence model of person-environment interaction. In M.P. Lawton, P.G. Windley & T.O. Byerts (Eds.), Aging and the environment: Theoretical approaches (pp. 97-121). New York: Springer.

Kane, R, Ouslander, J., & Abrass, I. (1994). Essentials of clinical geriatrics. Toronto: McGraw-Hill.

Kloseck, M. (1999). Building a self-sustaining community system of health support for the elderly: Determinants of individual participation in voluntary community action. Doctoral Dissertation ISBN No. 0612512053. University of Waterloo.

Kloseck, M., & Crilly, R.G. (1998). The Cherryhill Community Project: Final report to the St. Mary's Reserve Fund, St. Joseph's Health Centre. Unpublished report prepared for the St. Mary's Reserve Fund, St. Joseph's Health Centre, London.

Lawton, M.P. (1982). Competence, environmental press and the adaptation of old people. In M.P. Lawton, P.G. Windley & T.O. Byerts (Eds.), Aging and the environment: Theoretical approaches pp. 33-59). New York: Springer.

Matteson, M.A., McConnell, E., & Linton, A.D. (1997). Gerontological nursing. Toronto: W.B. Saunders.

Ontario Ministry of Health. (1996). Community health promotion in action. Health Promotion Branch. Toronto, Ontario: Author.

Shields, C. (1997). Building community systems of support. A discussion paper for the October 28, 1997 Children at Risk Symposium. Toronto: Laidlaw Foundation.

Shiell, A., & Hawe, P. (1996). Health promotion, community development and the tyranny of individualism. Health Economics, 5, 241-247.

Learning Opportunities:

In order to emphasize the community as a client, involve the community as a "true" partner in identifying health issues and/or concerns, and collaboratively facilitate health promotion planning the following learning opportunities are available through the Cherryhill Healthy Ageing Program:

1. SCHOOL OF NURSING, U.W.O: Professional Practice Nursing III (N392)
Learning Opportunity: **1a** (page 11)
Cherryhill Resident Safety Check Program - Safety Monitors
Learning Opportunity: **1b** (page 19)
Cherryhill Resident Safety Check Program - Safety Program Recipients
Learning Opportunity: **1c** (page 25)
Cherryhill Health Promtion & Information Centre - Health Centre Volunteers

COURSE: Professional Nursing Practice III (N392)

PLACEMENT: Year III, Fall or Winter Term

LENGTH: 13 Weeks **TIME ALLOTMENT:** 12 to 16 hours per week

COURSE OVERVIEW:

This course will provide students the opportunity to use a team approach in working with a community or aggregate of a particular population. With the assistance of their faculty and agency advisors, student teams will invite/engage members of the community to participate in identifying health issues/concerns and facilitate the development and implementation of a community generated health promotion plan. Students may or may not be involved in a specific community health program; however, all students will learn how to use a variety of resources and strategies in promoting community health.

ENDS-IN-VIEW:

Nursing practice in Nursing 373b emphasizes the community as client, while building on previous practice experiences. The meta-concepts of the curriculum - *health and caring* - are expanded to the community or aggregate population. Students will explore the foundational concepts through (a) focusing on *how communities come to know* about and hold their beliefs, values and assumptions about *health, healing and health-promoting practices*, and (b) *understanding the meaning of experiences* of health, healing, and health promotion within a community over *time/transitions* and within the community's own *context/culture*.

CHERRYHILL HEALTHY AGEING PROGRAM - EXPECTATIONS:

The learning opportunities should be a mutually beneficial experience for both the students and older individuals living in the Cherryhill community. Students should come to their placement prepared, with basic knowledge in the areas of ageing, health and community development (see knowledge base pre-requisites).

GENERAL ROLES OF THE STUDENTS, FACULTY ADVISOR & AGENCY ADVISOR:

The student team, faculty advisor and agency advisor will work together to facilitate and evaluate the students' learning process.

THE STUDENT TEAM WILL:

- participate in the orientation session
- develop a learning contract
- arrange to meet/communicate with team members and advisors on a regular basis
- delegate roles and responsibilities within the student team (e.g., agency contact person)

- recognize and use student team resources
- contribute to the evaluation of student team and advisors
- participate in the mid-term and end-of-term evaluation meetings
- provide a written mid-term and end-of-term summary of the student team's performance
- each student is expected to submit a written self-evaluation of clinical performance at mid-term and end-of-the term to the faculty advisor

THE FACULTY ADVISOR WILL:

- participate in the orientation session
- meet with the students' agency advisor at the beginning of the term to establish contact, clarify roles and interpret course expectations, and as needed throughout the term, to obtain feedback on the students' progress
- participate in the development and ongoing revisions of the learning contracts
- meet with the student team on a regular basis (ie., weekly praxis seminars, scheduled appointments) for the purpose of reviewing their clinical progress and providing feedback
- facilitate students' learning by identifying relevant learning resources appropriate to their community
- meet with the student team and agency advisor to provide a written mid-term and final summary of the student team's performance
- review and evaluate individual students' learning journals and provide feedback on progress and clinical performance
- meet with individual students to provide a written mid-term and end-of-term evaluation of their clinical performance

THE AGENCY ADVISOR WILL:

- participate in the orientation session
- meet with the students' faculty advisor at the beginning of the term to review and clarify clinical expectations, and as needed throughout the term participate in the development and ongoing revisions of the learning contract
- facilitate the students' learning by identifying the specific learning opportunities available in the agency
- encourage and facilitate the students' use of agency personnel and other resources for learning
- provide ongoing feedback to the students about their performance
- meet with the student team and faculty advisor to provide a written mid-term and end-of-term summary of the student team's performance

Cherryhill Healthy Ageing Program: Learning Opportunities

COURSE: Professional Nursing Practice III (N392)

PLACEMENT: Year III, Winter Term: January 8, 2001 - April 13, 2001

LENGTH: 13 Weeks - 12 to 16 hours per week

LEARNING OPPORTUNITY: Cherryhill Resident Safety Program

COMMUNITY/AGGREGATE POPULATION:
Apartment Safety Program Representatives & Safety Monitors

PURPOSE: to (a) identify health issues and/or concerns as experienced by the Cherryhill Safety Program monitors in the 13 apartment buildings in Cherryhill Village, (b) explore how Safety Monitors come to know about these health issues and/or concerns, and (c) recommend collaborative action strategies and/or health promotion plans to address the community-identified health issues and/or concerns.

Students:	Faculty Advisor:	Agency Advisor:

KEY INFORMANTS:

1. Cherryhill Resident Safety Program Co-ordinator:
2. Cherryhill Safety Program Apartment Representatives
3. Cherryhill Safety Program Monitors

LEARNING OPPORTUNITY 1a

2001 STUDENT SCHEDULE & TIMELINES

Week:	Expectations:	Student Requirements:
Week 1: January 8-12	*January 10th: Introduction* *Meet with students at U.W.O.; provide students with (a) guidelines & expectations, (b) information package on Cherryhill Healthy Ageing Program, (c) a choice of learning opportunities.* *January 11th: Meet with students in Cherryhill* *Formal introduction to the Cherryhill community & the Cherryhill Healthy Ageing Project; students to choose learning opportunity; overview of the Cherryhill Resident Safety Program; provide students with a variety of resources & key informants; health professional perspective*	*Task: Students to familiarize themselves with information provided & select a learning opportunity.* *Task: Based on coursework to date, develop specific learning goals & objectives; use resources provided to meet the geriatric, health & community development knowledge base requirements & learn about the community & Healthy Ageing Program in general.*
Week 2: January 15-19	*January 18th: Meet with students to review learning goals & objectives; integrate student goals with agency expectations; provide students with a community contact (Resident Safety Program Co-ordinator: Dorothy Hickey); health professional & community perspectives*	*Task: Contact & meet with community contact, Safety Program Co-ordinator Dorothy Hickey; written summary of the interview; finalize learning goals & objectives; arrange follow-up contact with Donna and/or Marita if necessary.*
Week 3: January 22-26	*January 25th: Finalize learning goals & objectives; review written summary of interview with Safety Program Co-ordinator; provide students with action strategy options for achieving learning goals (e.g., focus groups, survey methodology, community meetings, etc.); discuss pros & cons of each option; students to select preferred action strategy; provide students with resources to learn more about their selected action strategy.*	*Task: Use resources provided to learn, in detail, about the action strategy selected; begin action planning; generate draft questions, themes, etc. to address learning goals; link with ageing, nursing (Neuman & Watson) & community development theories; draft time lines for action plan.*
Week 4: January 29 - February 2	*February 1st: Review action strategy techniques & requirements; review draft questions, themes & timelines; students to demonstrate/discuss fit with ageing, nursing & community development theories; recommendations for modification of action strategies & timelines.*	*Task: Modify action strategies & timelines as necessary; finalize action plans.*
Week 5: February 5-9	*February 8th: Implementation of action strategies begins; Safety Program Co-ordinator, Dorothy Hickey to attend meeting.*	*Task: Begin working with apartment representatives & safety monitors; monitor progress; document success & challenges.*
Week 6: February 12-16	*Mid-Term Evaluation*	
Week 7: February 19-23	*BREAK*	

LEARNING OPPORTUNITY 1a

2001 STUDENT SCHEDULE & TIMELINES

Week:	Expectations:	Student Requirements:
Week 8: February 26 - March 2	*March 1st: Review progress; discuss success & challenges; problem solve if necessary; Safety Program Co-ordinator, Dorothy Hickey to be in attendance.*	*Task: Monitor progress; document successes & challenges.*
Week 9: March 5-9	*March 8th: Action strategies completed; review progress, successes &: challenges.*	*Task: Analyze findings.*
Week 10: March 12-16	*March 15th: Students to present & discuss preliminary findings; continue with data analysis if necessary.*	*Task: Complete data analysis; identify health promotion strategies; develop written recommendations to collaboratively implement a community health promotion plan.*
Week 11: March 19-23	*March 22nd: Data analysis completed; health promotion strategies & recommendations formally documented; discuss findings & recommendations.*	*Task: Present findings to community (safety program apartment representatives & safety monitors); evaluate & document achievement of learning goals & objectives.*
Week 12: March 26-30	*March 29th: Presentation to the community (safety program apartment representatives & safety monitors) completed; review & evaluate achievement of learning goals & objectives.*	*Task: Prepare poster presentation as per course requirements.*
Week 13: April 2-6	*Final Evaluation*	
Week 14: April 9-13	*Final examination & poster presentation at U.W.O.*	

Student & agency advisor meetings will be held once per week on Thursday mornings from 8:30 to 10:00 a.m. in Meeting Room 2, Cherryhill Health Promotion & Information Centre

If this is not a suitable day or time, then students should negotiate with agency supervisor(s) to determine a time that is mutually agreeable

STUDENT GROUP LEARNING CONTRACT

Learning Objectives (knowledge, skills & attitude)	Learning Resources & Strategies (how are we going to learn)	Evidence (how will we know that we have learned)	Due Dates	Criteria or Verification (demonstration of knowledge)
1. To develop our knowledge, skills & understanding of the aging process with a particular emphasis on: ° frailer, older individuals with multiple health problems ° care providers ° support strategies ° communication skills & processes with frailer older individuals ° Watson's model ° theories of ageing & community empowerment	° literature review of gerontological nursing, ageing & community empowerment theories ° gain perspectives from elderly community members & health professionals ° review, & share knowledge with peers, instructors & community members	° record reflections in journals ° apply knowledge learned in project development ° feedback from faculty advisors, agency advisors, peers & community members	Mid-Term	° agency advisor feedback ° faculty advisor feedback
2. To develop a comprehensive understanding of the Cherryhill Resident Safety Check Program & how it fits with health promotion planning according to Watson's theory.	° talk with, & learn from the resources available through the Cherryhill Healthy Ageing Program, specifically the Safety Program Co-ordinator, Safety Program Apartment	° record reflections in journal ° demonstrate the ability to critique the Resident Safety Check Program using Watson's theory & community development concepts &	Mid-Term Final Exam	° agency advisor feedback ° faculty advisor feedback

LEARNING OPPORTUNITY 1a

STUDENT GROUP LEARNING CONTRACT

Learning Objectives (knowledge, skills & attitude)	Learning Resources & Strategies (how are we going to learn)	Evidence (how will we know that we have learned)	Due Dates	Criteria or Verification (demonstration of knowledge)
	Representatives, Safety Monitors & Dr. Kloseck regarding the community-systems approach to community development	strategies learned in the community setting ° outcome of focus group planning & survey development		
3. To identify key health issues (in the broadest sense of the definition of health) as experienced by the safety monitors in the Cherryhill community using carefully thought out strategies (community focus groups & survey questionnaire)that go beyond, & are more objective than "just chatting".	° gather feedback from the Safety Program Co-ordinator & agency advisors regarding pros & cons of various potential approaches& collaboratively determine the most suitable approach for this situation	° supportive evidence from research & existing literature regarding the various potential approaches ° reflective journal records ° feedback from agency & faculty advisors ° confirmation from peer group	Mid-Term	° agency advisor feedback ° faculty advisor feedback
4. Recommend collaborative health promotion action strategies for issues identified by the Safety Check Co-ordinator, Apartment Representatives & Safety Monitors using theories learned & personal experience.	° past personal experience & previous experience learned from UWO students ° use theories learned ° partner with Safety Program volunteers & agency advisors	° reflective journal records ° feedback from agency & faculty advisors	Final Exam	° oral examination ° poster presentation. ° presentation to Safety Check Program volunteers of findings

LEARNING OPPORTUNITY 1a

STUDENT GROUP LEARNING CONTRACT

Learning Objectives (knowledge, skills & attitude)	Learning Resources & Strategies (how are we going to learn)	Evidence (how will we know that we have learned)	Due Dates	Criteria or Verification (demonstration of knowledge)

Cherryhill Healthy Ageing Program: Learning Opportunities

COURSE: Professional Nursing Practice III (N392)

PLACEMENT: Year III, Winter Term: January 8, 2001 - April 13, 2001

LENGTH: 13 Weeks - 12 to 16 hours per week

LEARNING OPPORTUNITY: Cherryhill Resident Safety Program

COMMUNITY/AGGREGATE POPULATION:
Cherryhill Resident Safety Program Recipients

PURPOSE: to (a) identify health issues and/or concerns as experienced by recipients of the Cherryhill Safety Program, (b) explore how Safety Program recipient currently deal with these health issues and/or concerns, and (c) recommend collaborative action strategies and/or health promotion plans to address the community-identified health issues and/or concerns.

Students:	Faculty Advisor:	Agency Advisor:

KEY INFORMANTS:

1. Cherryhill Resident Safety Program Co-ordinator:
2. Cherryhill Safety Program Apartment Representatives
3. Cherryhill Safety Program Recipients

LEARNING OPPORTUNITY 1b

2001 STUDENT SCHEDULE & TIMELINES

Week:	Expectations:	Student Requirements:
Week 1: January 8-12	*<u>January 10th: Introduction</u>* *Meet with students at U.W.O.; provide students with (a) guidelines & expectations, (b) information package on Cherryhill Healthy Ageing Program, (c) a choice of learning opportunities.* *<u>January 11th: Meet with students in Cherryhill</u>* *Formal introduction to the Cherryhill community & the Cherryhill Healthy Ageing Project; students to choose learning opportunity; overview of the Cherryhill Resident Safety Program; provide students with a variety of resources & key informants; health professional perspective*	*<u>Task</u>: Students to familiarize themselves with information provided & select a learning opportunity.* *<u>Task</u>: Based on coursework to date, develop specific learning goals & objectives; use resources provided to meet the geriatric, health & community development knowledge base requirements & learn about the community & Healthy Ageing Program in general.*
Week 2: January 15-19	*<u>January 18th</u>: Meet with students to review learning goals & objectives; integrate student goals with agency expectations; provide students with a community contact (Resident Safety Program Co-ordinator: Dorothy Hickey); health professional & community perspectives*	*<u>Task</u>: Contact & meet with community contact, Safety Program Co-ordinator Dorothy Hickey; written summary of the interview; finalize learning goals & objectives; arrange follow-up contact with Donna and/or Marita if necessary.*
Week 3: January 22-26	*<u>January 25th</u>: Finalize learning goals & objectives; review written summary of interview with Safety Program Co-ordinator; provide students with action strategy options for achieving learning goals (e.g., focus groups, survey methodology, community meetings, etc.); discuss pros & cons of each option; students to select preferred action strategy; provide students with resources to learn more about their selected action strategy.*	*<u>Task</u>: Use resources provided to learn, in detail, about the action strategy selected; begin action planning; generate draft questions, themes, etc. to address learning goals; link with ageing, nursing (Neuman & Watson) & community development theories; draft time lines for action plan.*
Week 4: January 29 - February 2	*<u>February 1st</u>: Review action strategy techniques & requirements; review draft questions, themes & timelines; students to demonstrate/discuss fit with ageing, nursing & community development theories; recommendations for modification of action strategies & timelines.*	*<u>Task</u>: Modify action strategies & timelines as necessary; finalize action plans.*
Week 5: February 5-9	*<u>February 8th</u>: Implementation of action strategies begins; Safety Program Co-ordinator, Dorothy Hickey to attend meeting.*	*<u>Task</u>: Begin working with safety program recipients; monitor progress; document success & challenges.*
Week 6: February 12-16	*Mid-Term Evaluation*	
Week 7: February 19-23	*BREAK*	

LEARNING OPPORTUNITY 1b

2001 STUDENT SCHEDULE & TIMELINES

Week:	Expectations:	Student Requirements:
Week 8: February 26 - March 2	*March 1st: Review progress; discuss success & challenges; problem solve if necessary; Safety Program Co-ordinator, Dorothy Hickey to be in attendance.*	*Task: Monitor progress; document successes & challenges.*
Week 9: March 5-9	*March 8th: Action strategies completed; review progress, successes &: challenges.*	*Task: Analyze findings.*
Week 10: March 12-16	*March 15th: Students to present & discuss preliminary findings; continue with data analysis if necessary.*	*Task: Complete data analysis; identify health promotion strategies; develop written recommendations to collaboratively implement a community health promotion plan.*
Week 11: March 19-23	*March 22nd: Data analysis completed; health promotion strategies & recommendations formally documented; discuss findings & recommendations.*	*Task: Present findings to community (safety program recipients); evaluate & document achievement of learning goals & objectives.*
Week 12: March 26-30	*March 29th: Presentation to the community (safety program recipients) completed; review & evaluate achievement of learning goals & objectives.*	*Task: Prepare poster presentation as per course requirements.*
Week 13: April 2-6	*Final Evaluation*	
Week 14: April 9-13	*Final Examination & Poster Presentation at U.W.O.*	

Student & agency advisor meetings will be held once per week on Thursday mornings from 8:30 to 10:00 a.m. in Meeting Room 2, Cherryhill Health Promotion & Information Centre

If this is not a suitable day or time, then students should negotiate with agency supervisor(s) to determine a time that is mutually agreeable

STUDENT GROUP LEARNING CONTRACT

Learning Objectives (knowledge, skills & attitude)	Learning Resources & Strategies (how are we going to learn)	Evidence (how will we know that we have learned)	Due Dates	Criteria or Verification (demonstration of knowledge)

STUDENT GROUP LEARNING CONTRACT

Learning Objectives (knowledge, skills & attitude)	Learning Resources & Strategies (how are we going to learn)	Evidence (how will we know that we have learned)	Due Dates	Criteria or Verification (demonstration of knowledge)

STUDENT GROUP LEARNING CONTRACT

Learning Objectives (knowledge, skills & attitude)	Learning Resources & Strategies (how are we going to learn)	Evidence (how will we know that we have learned)	Due Dates	Criteria or Verification (demonstration of knowledge)

Cherryhill Healthy Ageing Program: Learning Opportunities

COURSE: Professional Nursing Practice III (N392)

PLACEMENT: Year III, Winter Term: January 8, 2001 - April 13, 2001

LENGTH: 13 Weeks - 12 to 16 hours per week

LEARNING OPPORTUNITY: Cherryhill Health Promotion & Information Centre

COMMUNITY/AGGREGATE POPULATION:
Health Centre Volunteers

PURPOSE: to (a) identify community health issues and/or concerns as experienced by the Cherryhill Health Promotion & Information Centre volunteers, (b) explore how Health Centre volunteers come to know about these health issues and/or concerns, and (c) recommend collaborative action strategies and/or health promotion plans to address the community-identified health issues and/or concerns.

Students:	Faculty Advisor:	Agency Advisor:

KEY INFORMANTS:

1. Cherryhill Health Information & Community Development Co-ordinator:
2. Cherryhill Health Promotion & Information Centre Volunteers

LEARNING OPPORTUNITY 1c

2001 STUDENT SCHEDULE & TIMELINES

Week:	Expectations:	Student Requirements:
Week 1: January 8-12	*January 10th: Introduction* *Meet with students at U.W.O.; provide students with (a) guidelines & expectations, (b) information package on Cherryhill Healthy Ageing Program, (c) a choice of learning opportunities.* *January 11th: Meet with students in Cherryhill* *Formal introduction to the Cherryhill community & the Cherryhill Healthy Ageing Project; students to choose learning opportunity; overview of the Cherryhill Health Promotion & Information Centre; provide students with a variety of resources & key informants; health professional perspective*	*Task: Students to familiarize themselves with information provided & select a learning opportunity.* *Task: Based on coursework to date, develop specific learning goals & objectives; use resources provided to meet the geriatric, health & community development knowledge base requirements & learn about the community & Healthy Ageing Program in general.*
Week 2: January 15-19	*January 18th: Meet with students to review learning goals & objectives; integrate student goals with agency expectations; provide students with a community contact (Cherryhill Health Information & Community Development Co-ordinator, Lisa Misurak); health professional & community perspectives*	*Task: Contact & meet with Cherryhill Health Information & Community Development Co-ordinator, Lisa Misurak; written summary of the interview; finalize learning goals & objectives; arrange follow-up contact with Donna and/or Marita if necessary.*
Week 3: January 22-26	*January 25th: Finalize learning goals & objectives; review written summary of interview with Cherryhill Health Information & Community Development Co-ordinator; provide students with action strategy options for achieving learning goals (e.g., focus groups, survey methodology, community meetings, etc.); discuss pros & cons of each option; students to select preferred action strategy; provide students with resources to learn more about their selected action strategy.*	*Task: Use resources provided to learn, in detail, about the action strategy selected; begin action planning; generate draft questions, themes, etc. to address learning goals; link with ageing, nursing (Neuman & Watson) & community development theories; draft time lines for action plan.*
Week 4: January 29 - February 2	*February 1st: Review action strategy techniques & requirements; review draft questions, themes & timelines; students to demonstrate/discuss fit with ageing, nursing & community development theories; recommendations for modification of action strategies & timelines.*	*Task: Modify action strategies & timelines as necessary; finalize action plans.*
Week 5: February 5-9	*February 8th: Implementation of action strategies begins; Cherryhill Health Information & Community Development Co-ordinator to attend meeting.*	*Task: Begin working with health centre volunteers; monitor progress; document success & challenges.*
Week 6: February 12-16	*Mid-Term Evaluation*	
Week 7: February 19-23	*BREAK*	

2001 STUDENT SCHEDULE & TIMELINES

Week:	Expectations:	Student Requirements:
Week 8: February 26 - March 2	*March 1st: Review progress; discuss success & challenges; problem solve if necessary; Cherryhill Health Information & Community Development Co-ordinator to be in attendance.*	*Task: Monitor progress; document successes & challenges.*
Week 9: March 5-9	*March 8th: Action strategies completed; review progress, successes &: challenges.*	*Task: Analyze findings.*
Week 10: March 12-16	*March 15th: Students to present & discuss preliminary findings; continue with data analysis if necessary.*	*Task: Complete data analysis; identify health promotion strategies; develop written recommendations to collaboratively implement community health promotion plans.*
Week 11: March 19-23	*March 22nd: Data analysis completed; health promotion strategies & recommendations formally documented; discuss findings & recommendations.*	*Task: Present findings to community (health centre volunteers); evaluate & document achievement of learning goals & objectives.*
Week 12: March 26-30	*March 29th: Presentation to the community (health centre volunteers) completed; review & evaluate achievement of learning goals & objectives.*	*Task: Prepare poster presentation as per course requirements.*
Week 13: April 2-6	*Final Evaluation*	
Week 14: April 9-13	*Final examination & poster presentation at U.W.O.*	

Student & agency advisor meetings will be held once per week on Thursday mornings from 8:30 to 10:00 a.m. in Meeting Room 2, Cherryhill Health Promotion & Information Centre

If this is not a suitable day or time, then students should negotiate with agency supervisor(s) to determine a time that is mutually agreeable

STUDENT GROUP LEARNING CONTRACT

Learning Objectives (knowledge, skills & attitude)	Learning Resources & Strategies (how are we going to learn)	Evidence (how will we know that we have learned)	Due Dates	Criteria or Verification (demonstration of knowledge)

STUDENT GROUP LEARNING CONTRACT

Learning Objectives (knowledge, skills & attitude)	Learning Resources & Strategies (how are we going to learn)	Evidence (how will we know that we have learned)	Due Dates	Criteria or Verification (demonstration of knowledge)

STUDENT GROUP LEARNING CONTRACT

Learning Objectives (knowledge, skills & attitude)	Learning Resources & Strategies (how are we going to learn)	Evidence (how will we know that we have learned)	Due Dates	Criteria or Verification (demonstration of knowledge)

Appendix H: Research & Publications

RESEARCH FUNDING RECEIVED TO DATE:

$99,900 *"Synthesis Research on Community Capacity"*
Funded by: Health Canada, March 2002
(Kloseck, M. & Crilly, R.G. & Lubell, J., Investing in Children)

$60,000 *"Evaluation of an Educational Initiative for Medical Students: Learning About Medication Use in Elderly Individuals Living in the Community"*
Funded by: Shoppers Drug Mart 1998/1999
(with the Division of Geriatric Medicine)

$137,000 *"Parkwood in the Community" Project*
Funded by: Parkwood Hospital Foundation, September 2000
(Crilly, R.G., Kloseck, M., Vickers, M. & Griffiths, N.)

$5,000 *"Consequences of Falls in Community-Dwelling Elderly"*
Funded by: S.R.H.I.P., June 2000
(Crilly, R.G., Kloseck, M. & Sharma, R.)

$10,000 *"The Influence of Falling and Fear of Falling on Engagement in Self-Care, Productivity and Leisure Activities for Community-Dwelling Elderly"*
Funded by: Canadian Occupational Therapy Foundation, September 2000
(Hobson, S., Kloseck, M., Crilly, R.G., Ward-Griffin, C., Vandervoort, T. & Robbins, B.)

$4,500 *"Bone Densitometer Screening Program: A Self-Referral Osteoporosis Program*
Funded by: Merck Frosst , January 2001
(Crilly, R.G., Platt, N., Hodsman, A. & Kloseck, M.)

$9,360 *"Community Capacity Building Evaluation Research"*
Funded by: International Year of Older Persons (Provincial Government), 1999
(Kloseck, M. & Crilly, R.G.)

$23,240 in total from community foundations *"Building the Cherryhill Healthy Ageing Program"*
Includes funding from: City of London Community Innovation Fund, Walter J. Blackburn
Foundation & the London Community Foundation, 1998/1999
(Kloseck, M. & Crilly, R.G.)

RESEARCH PROPOSALS SUBMITTED:

$42,426 *"Low Vision Rehabilitation for Seniors Living at Home: Development of a Collaborative Service Delivery Model Among Clients, Occupational Therapists & Low Vision Clinicians*
Submitted to: Canadian Institute of Health Research, March 2002
(Polgar, J., Jutai, J, Plotkin, A., Strong, J., Bossers, A. & Kloseck, M.)

PEER-REVIEWED PUBLICATIONS & ABSTRACTS

Misurak, L., Kloseck, M. & Crilly, R.G. Health information: what are seniors looking for? (submitted to Annual Scientific Meeting of the Gerontological Society of America, March 2002)

Misurak, L., Crilly, R.G. & Kloseck, M. Geriatric . . . . . a name clients don't like: what is the preferred language? (submitted to Annual Scientific Meeting of the Gerontological Society of America, March 2002).

Ward-Griffin, C., Hobson, S., Kloseck, M., Crilly, R.G. & Vandervoort, T. It's a small world after all: the impact of falling & fear of falling. (submitted to Canadian Association of Gerontology, March 2002).

Hobson, S., Kloseck, M., Crilly, R.G., Ward-Griffin, C. & Vandervoort, T. Fear of falling in older adults: causes and amelioration. (accepted for presentation at the Canadian Association of Occupational Therapy Meeting, May 2002, St. John's, Newfoundland).

Hobson, S., Kloseck, M., Crilly, R.G., Ward-Griffin, C. & Vandervoort, T. Falls, fear of falling and occupational engagement in older adults. (accepted for presentation at the World Federation of Occupational Therapy Congress, June 2002, Stockholm, Sweden).

Crilly, R.G. & Kloseck, M. Using Goal Attainment Scaling to evaluate a health-related community development project with seniors. (abstracted in International Journal of Experimental, Clinical and Behavioural Gerontology, 47(suppl. 1), pp. 184).

Kloseck, M. & Crilly, R.G. Determinants of voluntary involvement and leadership by community elderly in health services planning and delivery. (abstracted in International Journal of Experimental, Clinical and Behavioural Gerontology, 47(suppl. 1), pp. 42).

Kloseck, M. & Crilly, R.G. Involving community elderly in the planning and provision of health services: Predictors of volunteerism and leadership. (presented at the American Geriatric Society annual conference, Chicago, Illinois, May 2001).

Crilly, R.G. & Kloseck, M. (2000). The benefits of using Goal Attainment Scaling to evaluate a health-related community development project with a geriatric population. (submitted to Journal of Evaluation & the Health Professions).

Kloseck, M. (1999). Building a self-sustaining community system of health support for the elderly: Determinants of individual participation in voluntary community action. Doctoral dissertation, University of Waterloo, 1999. ISBN. No. 0612512053.

Kloseck, M. & Crilly, R.G. (1999). Predictors of health in a community dwelling elderly population. (abstracted in Clinical and Investigative Medicine, 22(4), S18).

Crilly, R.G. & Kloseck, M. (1999). Satisfaction with community health support services among the elderly. (abstracted in Clinical and Investigative Medicine, 22(4), S17).

Cumming, I., Kloseck, M. & Hinton, G. (2001). From seniors' concerns to government action: bridging the gap. (abstracted in International Journal of Experimental, Clinical and Behavioural Gerontology, 47(suppl. 1), pp. 257).

Kloseck, M. & Crilly, R.G. (1998). Building a self-sustaining community system of health support for the elderly. (abstracted in Clinical and Investigative Medicine, 31, S41).

Crilly, R.G. & Kloseck, M. (1998). Determinants of boredom in the elderly. (abstracted in The Gerontologist, 38(1), pp. 110).

NON-PEER REVIEWED PUBLICATIONS & ABSTRACTS

Kloseck, M. & Crilly, R.G. (1998). The Cherryhill Community Project (Phases I & II): Final report to the St Mary's Reserve Fund, St. Joseph's Health Centre. Unpublished report prepared for the St. Mary's Reserve Fund, St. Joseph's Health Centre.
Joseph's Health Centre, London, Ontario.

INVITED SYMPOSIA & LECTURES

July 2001 **Ministry of Health, British Columbia**
Invited (MK) by 2001 World Congress organizing committee & the Ministry of Health, British Columbia to plan a Seniors' Advisory Council Round Table forum for international seniors to explore how seniors can contribute to the development and building of supportive communities. *World Congress of Gerontology, July 6-10, 2001, Vancouver, British Columbia*

July 2001 **2001 World Congress of Gerontology**
Invited (MK) to present *"Current State of Seniors' Involvement in Program & Policy Development: What the Evidence Tells Us"* as panel members of the Round Table forum hosted by the Seniors' British Columbia Seniors' Advisory Council & the British Columbia Office Responsible for Seniors. *World Congress of Gerontology, July 6-10, 2001, Vancouver, British Columbia.*

Ongoing **University of Western Ontario, School of Nursing**
Annual half-day session for undergraduate nursing students to learn about health promotion and prevention programming in community development settings. (MK). *School of Nursing, U.W.O., London, Ontario, Canada. 1998 to present.*

April 2000 **Ontario Association of Non-Profit Homes & Services for Seniors**
Requested to provide a session on "More than Just Housing: Tenants and Mental Health Issues". (MK). *Annual Convention of the Ontario Association of Non-Profit Homes & Services for Seniors, April 4, 2000, London, Ontario, Canada.*

March 2000 **Credit Valley Hospital**
Requested to provide a day-long training session for Credit Valley Day Hospital, Rehabilitation, and "The Next Step Program" inter-disciplinary teams on Goal Attainment Scaling and the use of Goal Attainment Scaling in institutional and community settings. (MK). *Credit Valley Hospital, Toronto, Ontario, Canada. March 10, 2000.*

March 2000 **Canadian Mental Health Association**
Requested to provide a half-day session to Canadian Mental Health Association staff and their community partners on goal attainment scaling. (MK). *Canadian Mental Health Association, London, Ontario, Canada. March 2000.*

February 2002 **University of Western Ontario, Rehabilitation Sciences**
Presentation to rehabilitation sciences faculty, students & general public, as part of the Rehabilitation Sciences Seminar Series: Health Promotion & Community Care for the Elderly. (MK). *February 4, 2002, London, Ontario, Canada.*

November 2001 **University of Western Ontario, Senior Alumni Program**
Presentation: Aging in the Community: When the Body Fails and the System Falters. An Exploration of How a Community of Elders Can Participate in Their Own Health Care. (RC). *November, 2001, London, Ontario, Canada. (approx. 300 seniors & alumni in attendance).*

January 2000 **St. Joesph's Family Medical Centre**
Presentation to staff on the Cherryhill Healthy Ageing Program. (MK & RC). *January 13, 2000. London, Ontario, Canada.*

November 1999 **Association of Gerontological Social Workers of London**
Presentation on the Cherryhill Healthy Ageing Program. (MK). *McCormick Home for the Aged, London, Ontario, Canada.*

October 1999 **Ontario Healthy Communities Coalition**
Requested to present on the Cherryhill Healthy Ageing Program and building self-sustaining community systems of health support for the elderly. (RC & MK). *Annual Conference of the Ontario Healthy Communities Coalition, Strathroy, Ontario, Canada.*

November 1999 **Geriatric & Rehabilitation Research Day, Parkwood Hospital & London Health Sciences Research Institute**
Presentation: Evaluating Process & Outcome in a Community Development Setting. (MK & RC). *November 1999, London, Ontario, Canada.*

GENERAL PRESENTATIONS

September 2000 **Royal College of Physicians and Surgeons Annual Meeting - Geriatric Section** (RC & MK).

November 1999 **Geriatric & Rehabilitation Research Day, Parkwood Hospital & the Lawson Research Institute**
"Evaluating Process & Outcomes in a Community Development Setting" (MK & RC).

September 1999 **Royal College of Physicians and Surgeons Annual Meeting - Geriatric Section**
"Predictors of Health in a Community-Dwelling Elderly Population"
"Satisfaction with Community Health Supports and Services Among the Elderly" (RC & MK).

November 1997 **Ontario Public Health Association Annual Conference**
"Community Ownership of Health Service Provision: Is it Possible?"
November 24, 25, 26, 1997. Barrie, Ontario, Canada. (MK & RC).

INVOLVING COMMUNITY ELDERLY IN THE PLANNING & PROVISION OF HEALTH SERVICES: PREDICTORS OF VOLUNTEERISM & LEADERSHIP

Kloseck, M. and Crilly, R.G. University of Western Ontario, London, Canada

The UNIVERSITY of WESTERN ONTARIO

Department of Medicine • Division of Geriatric Medicine

ABSTRACT

Decreasing resources in the Canadian health care system have led to changes in the delivery of services, including an increased emphasis on community collaboration and self-help. This study examined modifiable factors in the lives of elderly individuals (N=181) which influence their involvement in planning and providing health services. The moderating effects of non-modifiable variables were also examined. Participants were residents of Cherryhill Village (mean age = 74 years ± 9.53 S.D.) a high-density seniors' apartment complex with an estimated total population of 3000. Volunteers over 55 years involved in the planning and provision of health services were compared with a random sample of the remaining community (non-volunteers). Six modifiable variables (health, functional ability, well-being, activity level, social resources, environmental conditions), and non-modifiable variables (age, socio-economic status, personality, life changes, gender, general volunteer behaviour) were measured using general and standardized survey items including the MOS, SHARP, Activities Checklist and Social Support Questionnaire. Bi-variate and multi-variate analyses were used to determine predictors of volunteerism and leadership. Volunteers were younger (M=74 years, S.D.=8.39) than non-volunteers (M=78 years, S.D.=6.12), t(180)=-2.82, p=.005, more active (M=72.53, S.D.=9.36) than non-volunteers (M=69.71, S.D.=7.51), t(155)=2.13, p=.03, and experienced fewer limitations in their functioning (M=2.12, S.D.=1.21) than non-volunteers (M=2.60, S.D.=1.21), t(175)=-2.58, p=.01. Volunteers were more satisfied with their life during the past month, p=.05. Non-volunteers received a greater number of health services (chi-square=12.49, p=.002, df=2, N=181). While the majority of elderly volunteers reported they would not assume positions of responsibility, volunteers who were younger (r=-.25, p=.02), extroverted (r=.24, p=.02), agreeable (r=.28, p=.01), and those more satisfied with their social supports (r=.22, p=.03) were more likely to take on leadership roles. Hierarchical multiple regression analyses were used to determine if non-modifiable factors masked the influence of modifiable factors. A history of volunteering significantly moderated the influence of health/function (p=.02). Overall, functional ability most influenced involvement. Thus, maximizing independence may significantly enhance involvement.

STUDY POPULATION

Study participants were 181 residents living in the Cherryhill community. Eleven percent of the respondents were male and 89% female with a mean age of 74 yrs. (S.D.= ± 9.53 yrs.) Participant ages ranged from 55 to 86 years. Respondents had lived in the community for an average of 8 years (S.D.=±7.19 yrs.), with the number of years ranging from 1 to 25 years. Seventy-nine percent of the respondents were elderly women living alone. Marital status varied from being single (11%), widowed (54%), separated (4%), married (17%), to divorced (13%). Live-in companions varied from living alone (79%), with a spouse (17%), with other family members (3%), to living with a friend (2%). Fifty-seven percent of the respondents reported high school as the highest level of education attained. Other education levels varied from public school (23%), college (16%), bachelor's degree (3%) to master's degree (2%). Eight percent of the respondents did not feel they had sufficient income to do the things they wanted, 6% felt they often do not have sufficient income, 18% stated that with careful planning they sometimes have enough, 34% reported that with careful planning they usually have enough, 21% reported they usually have enough, while 12% reported they have more than enough income to do what they wish.

PROCEDURES

There was 100% sampling of all Cherryhill community members who were involved in the planning of their own health services (n=107). A comparative sample of non-volunteers was randomly drawn from the remainder of the Cherryhill apartment complex 130 non-volunteers were sampled for the comparative group in order to give approximately equal sample sizes. Ten telephone numbers were randomly selected from each of the 13 apartment buildings in the Cherryhill community. Of the potential non-volunteer sample (n=130) , 17% (n=22) individuals did not meet the age requirement of 55 years or older and of the remaining 108 individuals 34 refused leaving a final non-volunteer sample of 74.

METHODS

Cross-sectional survey methodology, using general questions and a number of standardized instruments (MOS, Stewart, Hays & Ware, 1988; SHARP, Stones, Kozma, Hirdes, Gold, Arbuckle & Kalopack, 1996; Activities Checklist, Arbuckle, Gold, Chaikelson & Lapidus, 1994; Social Support Questionnaire, Sarason, Sarason & Shearin, 1987), was used used for this study. Bi-variate correlation and multi-variate analyses were used to determine predictors of health-related volunteer involvement and volunteer leadership. A series of hierarchical regression analyses were carried out to determine if non-modifiable variables modified or masked the influence of modifiable variables on health voluntarism and volunteer leadership.

RESULTS: NO DIFFERENCES BETWEEN VOLUNTEERS & NON-VOLUNTEERS IN:

- Demographic & Socio-Economic Characteristics
  - Gender
  - Marital status
  - Length of time living in the Cherryhill community
  - Education
  - Income
  - Occupational skill
  - Recent life changes experienced
- Health (Subjective & Objective)
- Well-Being (Disposition)
- Environmental Satisfaction (Physical & Social)
- Past Volunteer Behaviour (Pre-Retirement)
- Social Resources (Number of Social Supports & Social Support Satisfaction)

RESULTS: SIGNIFICANT DIFFERENCES BETWEEN VOLUNTEERS & NON-VOLUNTEERS IN:

Potentially Modifiable Factors

- Functional Ability
- Well-Being (Affect)
- Social Resources (Support Available When Upset)
- Activity Level

Non-Modifiable Factors

- Age
- Personality

Potentially *Modifiable* Predictors of Health Voluntarism:

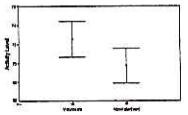
1. Functional Ability:
- significant difference in the day-to-day functioning of volunteers & non-volunteers t(175)=-2.58, p=.01
- non-volunteers reported receiving a greater number of health services than volunteers chi-square=12.49, p=.002, df=2, n=181
- non-volunteers required significantly more assistance with light housecleaning than volunteers chi-square=7.68, p=.005, df=1, n=181

2. Well-Being (Affect):
- volunteers were more positive & satisfied with their life during the past month (M=11.11, SD=1.26) than non-volunteers (M=10.70, SD=1.38), p=.05.

3. Social Resources:
- volunteers reported a greater number of individuals to support them when they are upset (M=2.14, SD=1.23) than non-volunteers (M=1.81, SD=1.23), p=.01

4. Activity Level:
- a statistically significant difference in activity level was found for volunteers & non-volunteers t(155)=2.13, p=.03

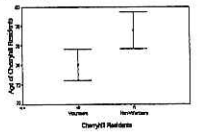
Figure 1: Error Bar Chart Showing the Means & Standard Deviations in Activity Participation by Volunteers & Non-Volunteers:



Non-Modifiable Predictors of Health Voluntarism:

5. Age:
- volunteers were younger (M=74 yrs., SD=8.39) than non-volunteers (M=78 yrs., SD=8.12), t(180)=-2.82, p=.005

Figure 2: Error Bar Chart Showing the Means & Standard Deviations in Age of Cherryhill Community Project Volunteers & Non-Volunteers:



6. Personality:
- statistically significant differences between volunteers & non-volunteers were found for 3 of 5 personality characteristics: extroversion (t(179)=2.75, p=.01); openness to experience (t(178)=2.55, p=.01); agreeableness (t(178)=1.96, p=.05) (Figures 3, 4 & 5)

Error Bar Charts Showing the Means & Standard Deviations in Extroversion, Openness to New Experiences, & Agreeableness of Volunteers & Non-Volunteers:

Figure 3:

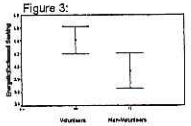


Figure 4:

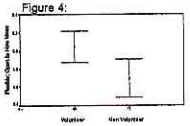
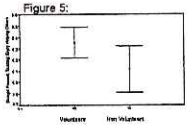


Figure 5:



RESULTS: PREDICTORS OF LEADERSHIP

The majority of volunteers reported they would not assume a leadership role. Only about 2% of volunteers expressed a willingness to take on a leadership position. There were no significant relationships between *modifiable variables* and willingness to take on a leadership Position. Significant relationships were found with 3 of the *non-modifiable variables:*

- age was significantly negatively correlated with volunteer leadership r=-.25, p=.02)
- personality ("extroversion" trait dimension) was significantly positively correlated with volunteer leadership, r=.24, p=.02
- personality ("agreeableness" trait dimension) was significantly positively correlated with volunteer leadership, r=.28, p=.01

RESULTS: MODERATING EFFECTS OF NON-MODIFIABLE VARIABLES

Exploratory factor analysis with varimax rotation was used to reduce modifiable variables to 2 factors. The factor analysis supported a 2-factor structure; Factor 1: psychosocial/environmental factors and Factor 2: health/functional ability factors. All factors loadings exceeded the .51 level for Factor 1 and the .65 level for Factor 2, both factors having Eigenvalues greater than 1.00. These 2 factors were then used in a series of hierarchical regression analyses to examine potential interactions between modifiable and non-modifiable variables. Four interaction effects were found to be significant. Elderly individuals with *little past volunteer involvement* are more likely to volunteer in health-related activities when they are in good rather than poor health & when their functional ability is good. For elderly individuals with *high past volunteer involvement* the state of their health & functional ability did not seem to matter; they were equally involved whether their health & functional ability was good or poor (Figure 6). A person's personality ("conscientiousness" trait) moderated the influence of health/ functional ability on health volunteerism (Figure 7). Likewise a person's age (Figure 8) and personality ("openness to experience" trait) (Figure 9) interacted with health service utilization to influence volunteer leadership.

Figure 6:

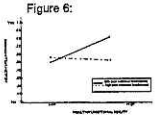


Figure 7:

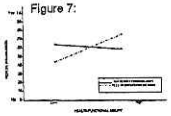


Figure 8:

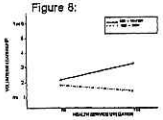
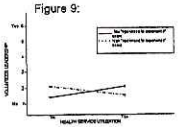


Figure 9:



CONCLUSIONS

Overwhelmingly, the ability of elderly individuals to get out of their apartments on a day-to-day basis influenced involvement. Thus, maximizing elderly individuals' independence may facilitate greater involvement in health service planning and provision.

The UNIVERSITY of WESTERN ONTARIO
Department of Medicine • Division of Geriatric Medicine

Using Goal Attainment Scaling to Evaluate a Health-Related Community Development Project with a Geriatric Population

Crilly, R.G. and Kloseck, M. University of Western Ontario, London, Canada

ABSTRACT

Goal Attainment Scaling (GAS) is a versatile, under-utilized evaluation tool that can actively involve community members and stakeholders in the evaluation process. We have used GAS in a participatory action project with seniors to evaluate seniors' involvement in the planning of their own health services. GAS provided a methodology for setting goals, a way of creating a scale (-2, -1, 0, +1, +2) to objectively measure the *degree* of achievement, over- or under-achievement of goals established for various components of the project, and a way of combining goal achievement scores for an overall project score. For example, using the formula:

$$GAS = 50 + \frac{10\sum(w_i x_i)}{\sqrt{(.7\sum w_i^2) + .3(\sum w_i)^2}}$$

The overall GAS score for community capacity building goals (one component of the project) increased from 22.62 at baseline to 50.00 at year 1. This poster will demonstrate the use of GAS in (1) creating and tracking goals to demonstrate involvement in health planning by seniors and improvement in a community's capacity to bring about change, (2) measuring progress toward goals by setting and achieving interim goals at various stages throughout the evaluation process, (3) establishing a hierarchy of goals, where the amalgamation of the achievement of lesser goals becomes a measure of the achievement of greater goals, and (4) maintaining a project "score card", with GAS being used as an ongoing measure of the performance of the project. GAS was found to be very "user-friendly" and readily understandable by elderly individuals and health professionals not familiar with program evaluation.

PURPOSE

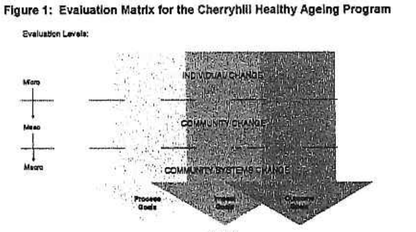
This presentation will demonstrate some of the ways GAS can be used to track the development and outcomes of a community development program. GAS has the advantage of being:

- very versatile and adaptable to a multitude of circumstance
- intuitively easy to understand and so accessible to lay community members of the program
- capable of being built into a hierarchical structure so that different levels of the program can be evaluated separately or combined to give an overall score
- capable of evolving over time such that it can reflect process as well as outcome goals
- capable of being used to provide a single measure of program growth and development

1. SETTING GOALS IN COMMUNITY DEVELOPMENT PROJECTS

Figure 1 shows how within a community development project change can be measured across a variety of levels and evaluation stages.

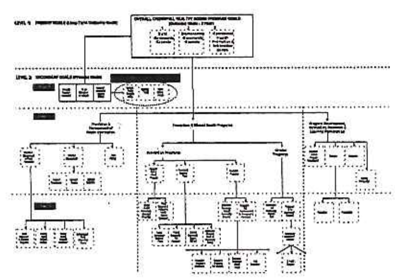
Figure 1: Evaluation Matrix for the Cherryhill Healthy Ageing Program



2. HIERARCHY OF GOALS

Independent goals can be established for each level of the program (Figures 2 & 3; Table 1). Alternatively, the performance at each level can be evaluated by an amalgamation of goals of the components of the lower level. Frequently it is appropriate to do both as they may reflect different aspects of the program. For example, the amalgamation of goals will reflect the overall functioning of the program; the stand alone goals for the higher level might be designed to evaluate issues specific to the operation of that level (e.g., space; administrative issues; funding; etc.)

Figure 2: Overview of the Cherryhill Healthy Ageing Program Hierarchical Collaborative Goal Achievement Framework



GAS Indicates an independent set of goals using a GAS scale, or scores of scales over time. The summation of GAS at one level should correlate with the changing GAS score at the next level.

Figure 3: Example of GAS Goal Setting, Achievement and Timelines for a Component of the Cherryhill Healthy Ageing Program

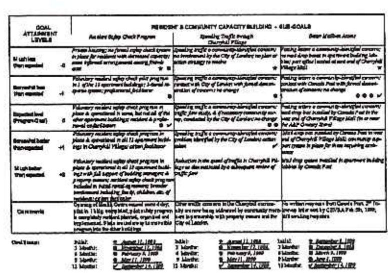


Table 1: Example of Summary GAS Scores at Baseline and at 3 Monthly Intervals for 3 Sub-Goals of the Community Capacity Building Component of the Cherryhill Healthy Ageing Program

TIME INTERVAL	Goal 1: RESIDENT SAFETY	Goal 2: SPEEDING TRAFFIC	Goal 3: BETTER MAILBOX ACCESS	SUM OF GOAL SCORES	GAS SCORE
Baseline	-2	-2	-2	-6	22.62
3 Months	-2	-1	-1	-4	31.74
6 Months	-1	0	-1	-2	40.87
9 Months	0	0	-1	-1	45.44
12 Months	0	+1	-1	0	50.00

Note (1) The summed goal achievement GAS score for these community capacity building goals was obtained using the formula:

$$GAS\ score = 50 + \frac{10\sum(w_i x_i)}{\sqrt{(.7\sum w_i^2) + .3(\sum w_i)^2}}$$

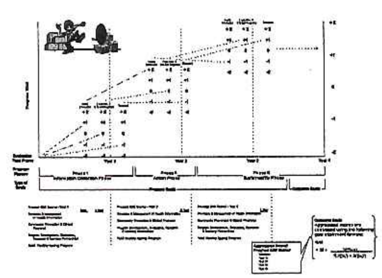
(2) The GAS score for these 3 community capacity building goals increased from 22.62 at baseline to 50.00 at 1 year.

(3) This particular set of goals was part of the "Building & Demonstrating Community Capacity" sub-group of goals (see Figure 3).

3. GOALS ACROSS TIME

It is common for community development projects to evolve over a significant period of time, frequently years. The final goals of the program might, therefore, take years to be achieved and do not give a sense of progress over the earlier stages of the program development. Although final goals need to be set, it is adviseable to set interim goals that can be achieved over the first year of the project (Figure 4). For example, one of the overall goals for the Cherryhill Healthy Ageing Program was to have a health centre within the Cherryhill community functioning at a certain level of expertise and open a certain number of hours per week. Initial interim goals focused on establishing the space and recruiting volunteers. Subsequent goals focused on the provision and management of health-related information. Thus, the essential building blocks of the centre were identified and achieved over time leading to the final goals being realized.

Figure 4: Cherryhill Healthy Ageing Program Process & Outcome Goals: *"How will we know when we've arrived where we thought we were going?"*



4. GAS & the Project Score Card

As the project develops and changes the overall GAS can change as components improve (move up the scale) or fail. A problem arises when a new component is added which begins at a score of –1 or –2. This will lower the amalgamated score, even though the addition of a new component strengthens the overall program.

We have approached this by using a score of 1-5 (rather than –2 to +2) for the goals of the different programs. This scales each program similarly and allows a single addition method to give an overall score for the program that makes intuitive sense as program change. Thus the single addition of a program, starting at 1 (rather than –2) will add to the program score, and will add more as it's goals are achieved. The removal of a program that has failed will lower the score by a small degree, while the removal of a program that was successful (but, e.g., failed to obtain renewed funding) will show a greater drop in overall score, appropriately reflecting the greater loss.

CONCLUSIONS

We feel it is important in a community development project such as this to be able to track progress both of the overall project and it's components. Such projects are, by their nature, ideosyncratic and difficult to fit into any pre-conceived evaluation framework. Nonetheless some measure is important as an evaluation framework will help both define or clarify the purpose of the project and demonstrate progress towards the desired outcome. The versatility of the GAS and it's use of the same scale for multiple purposes appears to well fit the needs of community development projects. It's intuitive simplicity appears to make it accessible to the lay public involved. This poster demonstrates some ways in which we have employed GAS in the evaluation of a multi-level and time-evolving community development project.

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PREDICTORS OF HEALTH SERVICE UTILIZATION IN COMMUNITY-DWELLING ELDERLY

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ABSTRACT

Elderly individuals are major consumers of health services. It is reported that assistance with activities of daily living such as personal care, housework and meal preparation is increasingly required with advancing age. It is not clear to what extent services are required to cope with chronic stable conditions and to what extent recurrent unstable medical problems play a role. The purpose of this study was to identify predictors of health service utilization in elderly individuals living in the community (N=1043) and to explore the extent to which these individuals were involved in the acute medical system. Participants were residents of Cherryhill Village (mean age = 76, ± 8.06 yrs. S.D., 77% female and 23% male), a compact high-density seniors' apartment complex of 13 apartment buildings with an estimate total population of approximately 3000. Cross-sectional survey methodology was used and the study was confined to those over 55 years. Subjective health was assessed by summating the 5-item health perception scale of the MOS. Potential predictor variables included subjective health, physician visits, emergency room visits and hospital admissions, having a caregiver, frequency of leaving one's apartment, difficulty in accessing the health system and age. Univariate analyses, cross-tabs analyses with chi-square tests and t-tests were used to examine the predictors of health service utilization. Of the total sample, 236 individuals (24%) reported receiving health services. Homemaking services such as cleaning, laundry and vacuuming (54%) and nursing care (32%) were reported most often by recipients. Consistent with the findings of others, health service recipients were older (M=78.47, S.D.= ± 7.9) than non-recipients (M=75.44, S.D. = ± 7.98), t(1004)=-5.11, p≤.001., perceived themselves to be in poorer health (M=15.42, S.D.= ± 5.61) than non-recipients (M=18.59, S.D.= ± 4.77), t(472)=5.62, p≤.001, left their apartment less frequently than non-recipients (p≤.001), and had more difficulty getting satisfactory answers to their health questions than non-recipients (p=.01). Health service recipients had more physician visits (M=3.52, S.D.=.64) than those not receiving health services (M=2.97, S.D.=.98), t(314)=-4.19, p≤.001. Two-way contingency table analyses were conducted to determine whether individuals receiving health services and those not receiving services differed in the number of visits to emergency rooms and admissions to hospital. Health service utilization and hospital admissions during the past six months were found to be significantly related (chi-square=7.24, p≤.007, df=1, n=325). Likewise, health service utilization and visits to emergency rooms during the past year were found to be significantly related (chi-square=7.18, p=.007, df=1, n=322).

Elderly people in receipt of supportive services were older, in poorer health and less mobile. They were also greater users of the acute health system suggesting that medical instability, rather than stable chronic conditions, may play a role in the need for health services. Further study is required to determine the medical conditions underlying this phenomenon which might give insight into interventions that could reduce utilization.

STUDY POPULATION

Study participants were residents living in the Cherryhill community (N=1043). Twenty-three percent of the respondents were male and 77% female with a mean age of 76 yrs. (S.D.= ± 8.06 yrs.) (Figure 1). Participant ages ranged from 55 to 96 years. Respondents had lived in the community for an average of 10 years (S.D.=±7.56 yrs.), with the oldest individuals (85+ years) having lived in the community longest (14+ years). Marital status varied from being single (9%), widowed (53%), separated (3%), married (25%), to divorced (9%). Seventy-one percent of respondents lived alone. With respect to those who had live-in companions, 25% lived with their spouse, 2% lived with other family members, and 2% lived with friends. Twenty-one percent of participants reported having a caregiver or helper. Caregivers included family members or relatives (20%), friends (11%), health professionals (49%) and others (20%). The results suggest that Cherryhill residents' perception of their health declines steadily with age (Figure 2).

Figure 1: Age and Population Distribution of Cherryhill Residents

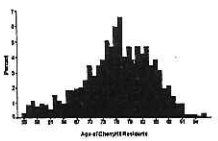


Figure 2: Perceived Health of Cherryhill Residents by Age

PROCEDURES

All residents lived in one of the 13 apartment buildings, owned by the ESAM Corporation, in the Cherryhill Village. One resident in each of the 2325 units of the Cherryhill Village apartment complex was provided with a survey. Consistent with community development principles, community residents shared decision-making around the number of surveys to be delivered and the methods of survey distribution. While not necessary, it was decided by the community to send a survey to each of the 2325 units in the Cherryhill apartment complex because of an extremely high level of community interest, good community support to deliver and collect surveys, and to save a significant amount of time later in having to explain to a large number of individuals why they were not allowed to complete a survey. The final draft of the survey was pilot tested with 15 elderly community members. Changes to the survey were made based on the feedback provided. Specifically, the language in 4 questions was modified. Community residents were mobilized to assist with survey distribution and collection. Community members had 3 days to complete the survey. A 3-tiered "help" system was organized by residents and included (1) a help table in the lobby in each of the 13 apartment buildings manned by community residents during the morning and afternoon of each of the days the survey was being completed, (2) residents "on-hand" to provide one-on-one assistance in residents' apartments if they were unable to come to the lobby help table, and (3) community volunteers (non-residents) "on-hand" if any of the residents expressed concerns regarding anonymity and confidentiality and did not want assistance from fellow community members. Boxes were placed in each of the lobbies of the 13 apartment buildings for the 3 days of the survey to make it easy for residents to return their surveys.

METHODS

Cross-sectional survey methodology, using general questions and a standardized instrument (MOS, Stewart, Hays & Ware, 1988), was used used for this study. The survey consisted of 3 parts: (1) Section A: socio-demographic questions; (2) Section B: questions regarding assets, strengths and limitations of the Cherryhill community; and (3) Section C: questions regarding residents' health (C1), community and environmental issues (C2), and the Cherryhill Village Mall (C3). Each survey contained the same sections A and B but only one of three versions of Section C. The total sample (sections A and B) and sub-sample C1 (health) of the survey were used for this study. Potential predictor variables included subjective health, frequency of leaving one's apartment, sense of community, difficulty accessing the health system and age. Univariate analyses were used to examine the predictors of the dichotomous dependent variable "health service utilization". Cross-tabs analyses with chi-square tests were used for categorical variables, and t-tests were used to examine mean differences for continuous variables.

RESULTS

Of the total sample of respondents 55 years of age or older (N=1043), 236 individuals (24%) reported receiving health services. Sixty percent of respondents receiving health services also reported having a caregiver. Homemaking services such as cleaning, laundry and vacuuming (54%) and nursing (32%) were reported as being received most often. Two-way contingency table analyses were conducted to evaluate whether Cherryhill residents receiving health services and those not receiving health services differed in number of visits to emergency rooms and admissions to hospital. Health service utilization and hospital admissions during the past 6 months were found to be significantly related (chi-square=7.24, p=.007, df=1, n=325). Nineteen percent of Cherryhill residents receiving health services had been admitted to hospital during the previous 6 months compared to 8% not receiving health services. Likewise, health service utilization and visits to emergency rooms during the past year were found to be significantly related (chi-square=7.18, p=.007, df=1, n=322). Twenty-eight percent of residents receiving health services visited the emergency room as compared to 14% for those not receiving services. Subjective health and health service utilization were found to be significantly related, t(472)=5.62, p≤.001. Cherryhill residents receiving health services perceive themselves as being in poorer health (M=15.42, SD=5.61 than did residents not receiving health services (M=18.59, SD=4.77) (Figure 3). Objective health (number of physician visits during the past year) and health service utilization were also found to be significantly related, t(314)=-4.19, p≤.001. Residents receiving health services have more contact with their physician (M=3.52, SD=.64) than did residents not receiving health services (M=2.97, SD=.98) (Figure 4). Likewise, age and health service utilization were significantly related, t(1004)=-5.11, p≤.001. Residents receiving health services were older (M=78.47, SD=7.9) than were those not receiving health services (M=75.44, SD=7.98) (Figure 5). Frequency of leaving the apartment was significantly related to health service utilization t(996)=10.14, p≤.001. Residents receiving services leave their apartment less frequently (M=6.97, SD=1.53) than did residents not receiving health services (M=7.71, SD=.73) (Figure 6).

Difficulty getting satisfactory answers to health questions was significantly related to health service utilization, t(968)=2.58, p=.01. However, counter to what might be expected, those residents not receiving health services thought it was easier to get satisfactory answers to their health questions (M=4.36, S=.92) than did residents receiving health services (M=4.18, SD=1.03) (Figure 7), possibly because they may have fewer questions. Sense of community and health service utilization were not found to be significantly related, t(934)=.58, p=.56. Residents receiving health services (M=5.93, SD=2.87) and those not receiving health services (M=6.05, SD=2.61) similarly felt they were part of the Cherryhill community (Figure 8).

Figure 3: Error Bar Chart Showing the Means and Standard Deviations of Subjective Health Ratings of Residents Not Receiving Health Services & Those Who Are Receiving Health Services

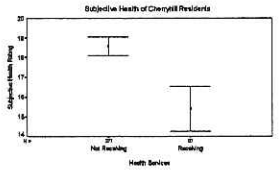


Figure 4: Error Bar Chart Showing the Means and Standard Deviations of Physician Visits of Residents Not Receiving Health Services & Those Who Are Receiving Health Services

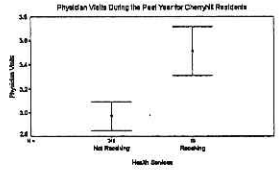


Figure 5: Error Bar Chart Showing the Means and Standard Deviations for Age of Residents Not Receiving Health Services & Those Who Are Receiving Health Services

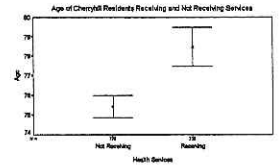


Figure 6: Error Bar Chart Showing the Means and Standard Deviations of Frequency of Leaving the Apartment of Residents Not Receiving Health Services & Those Who Are Receiving Health Services

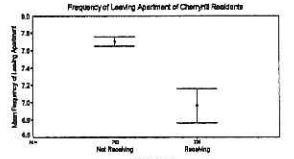


Figure 7: Error Bar Chart Showing the Means and Standard Deviations in Ease of Getting Satisfactory Answers to Health Questions of Residents Not Receiving Health Services & Those Who Are Receiving Health Services

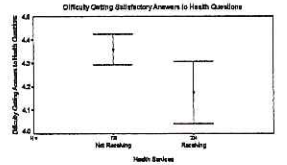
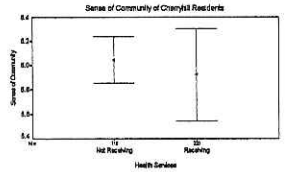


Figure 8: Error Bar Chart Showing the Means and Standard Deviations in Sense of Community of Residents Not Receiving Health Services & Those Who Are Receiving Health Services



CONCLUSIONS

Elderly people in receipt of supportive services were older, in poorer health and less mobile. They were also greater users of the acute health system suggesting that medical instability, rather than only stable chronic conditions, may play a role in the need for health services. Further study is required to determine the medical conditions underlying this phenomenon which might give insight into interventions that could reduce utilization.

SATISFACTION WITH COMMUNITY HEALTH SUPPORT SERVICES AMONG THE ELDERLY

Crilly, R.G. and Kloseck, M.

University of Western Ontario and the University of Waterloo

BUILDING A SELF-SUSTAINING COMMUNITY SYSTEM OF HEALTH SUPPORT FOR THE ELDERLY: THE CHERRYHILL COMMUNITY PROJECT.....

citizens, local businesses, health professionals & health policy makers working together to build a partnership for the future

ABSTRACT

Client-centred care delivery is frequently cited as a valid goal for home or community based health service provision. This study was conducted to explore the current level of satisfaction with both health services received by clients and input into how these services are delivered. This study was part of a larger community development project which is exploring how elderly individuals can become more involved in the planning and provision of their own health services. Residents in Cherryhill Village, London, Ontario were asked if they received health services, to rate their level of satisfaction with the services received and the degree of input they felt they had into the nature, frequency, timing and quantity of services provided. Clients were also asked how difficult it was to access services, from whom they sought information and the level of control they felt they had over their health. The study population consisted of 2953 elderly individuals living in a 13-building apartment complex (2325 units). A community health survey (response rate=53%; n=1231) was developed and delivered to each apartment unit. Of the total sample (n=1231) 85% (n=1043) were over the age of 55 years with a mean age of 76 yrs. ± 8.06 S.D. (77% female; 23%male), who had lived in the community an average of 10 yrs. ± 7.56 yrs. General level of satisfaction with services received was high, with 70% rating their satisfaction at 8 or above on a scale of 0 (not at all satisfied) to 10 (extremely satisfied). Those receiving services had a significantly lower sense of control over their health ($p<.001$). Most clients had no difficulty accessing the system, and most (88%) turned to their physician or nurse for advice. The commonest suggestions for getting information more easily were the presence of a walk-in clinic providing this service in their community or a health information "hot-line". Of those receiving services 38% would like more input into the type of service provided, 29% felt they had no input into the timing or type of services provided, and 36% felt they had no input into the frequency of the service provided, with a similar number feeling that they had a "great deal of input". These results suggest that there is much satisfaction with health services provided but there is room for improvement in the degree to which the client feels involved in the provision of these services.

INTRODUCTION

There is much emphasis these days on the client-centred approach to community-based care. Part of this philosophy entails giving the clients greater say in their receipt of services, with some client control exercised over services provided. Whether such a philosophy will ever be implemented in a meaningful manner remains to be seen. An initial step, however, is to determine the degree to which present recipients of care are satisfied with what is being provided and the degree to which they have been involved in the decisions related to the provision of their care.

STUDY POPULATION

Study participants were 1231 residents of the Cherryhill community. Of the total sample 1043 respondents (85%) were 55 yrs. of age or older. This sample was used to examine predictors of health. Twenty-three percent of study participants were male and 77% female with a mean age of 76 yrs. (SD=± 8.06 yrs.) (Figure 1). Respondents had lived in the Cherryhill community for an average of 10 years (SD=±7.56 yrs.), with the oldest individual (85+ yrs.) having lived in the community longest (14+ yrs.). Participants aged 55 or over ranged in age from 55 to 96 years. Marital status varied from being single (9%), widowed (53%), separated (3%), married (25%), divorced (9%), to common-law (1%). Live-in companions at the time of the study varied from living alone (71%), with a spouse (25%), with other family members (2%), to living with friends (2%).

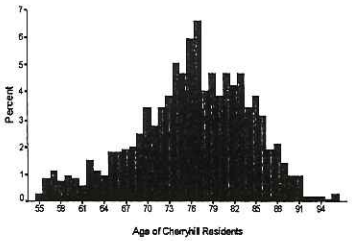


Figure 1: Age and Population Distribution of Cherryhill Residents

PROCEDURES

This study utilized cross-sectional survey methodology and was a secondary analysis of a community survey. The Cherryhill Community Survey (n=1231) consisted of 3 parts: (1) Section A: socio-demographic questions; (2) Section B: questions regarding assets, strengths and limitations of the Cherryhill community; and (3) Section C: questions regarding residents health, community and environmental issues, and the Cherryhill Village Mall. Each survey contained the same Sections A and B (n=1231) but only one version of Section C: (C1): Health (n=405); (C2): Community and Environment(n=391); and (C3): Cherryhill Village Mall (n=435). The total sample (sections A and B) and sub-sample C1 (health) were used for analyses.

METHODS

A descriptive analyses and t-tests were carried out to examine the characteristics of all respondents and the characteristics of the 3 sub-samples of respondents who completed the C1 (health version), C2 (community & environment version) and C3 (Cherryhill Village Mall) versions of the community survey to examine how representative the sub-samples were of the total sample. Descriptive and univariate analyses were used to examine satisfaction with health services.

RESULTS

Level of satisfaction with health services received was high (Figure 2). Receiving health services was found to be significantly related to perceived level of control over health, $t(-6.56)=353.07$, $p<.001$. Individuals receiving health services perceive themselves as having less control over their health ($M=3.61$, $SD=1.15$) than those not receiving health services ($M=4.13$, $SD=.98$) (Figure 3). The majority of respondents reported no difficulty in getting satisfactory answers to their health questions. On a scale of 1(usually easy to get answers) to 5(always a problem) the mean response was 1.72, $SD=.96$. A significant relationship was found, however, between receiving health services and getting satisfactory answers to health questions, $t(2.65)=371.63$, $p=.01$. Individuals who were receiving health services reported more difficulty in getting satisfactory answers ($M=1.86$, $SD=1.05$) than those not receiving services ($M=1.67$, $SD=.92$) (Figure 4). When asked where they first turn to when they have questions regarding their health, respondents reported looking to their physician or nurse (84%), family (7%), looking it up in a book (4%) and looking to friends (3%). Of respondents receiving health services 38% reported they would like more input into the types of services provided, 29% felt they had no input into the timing of, or type of, services provided, and 36% felt they had no input into the frequency of services provided, with a similar number feeling that they had a "great deal of input" (Figures 5, 6, 7 and 8).

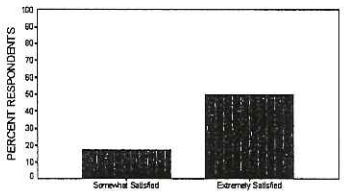


Figure 2: Cherryhill Residents' Satisfaction with Health Services Received

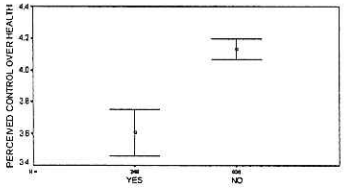


Figure 3: Error Bar Chart Showing the Means and Standard Deviations of Perceived Control Over Health of Residents Not Receiving Health Services and those Who are Receiving Health Services

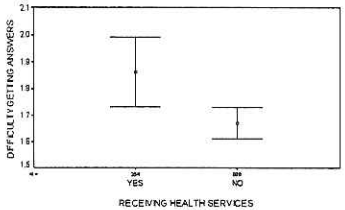


Figure 4: Error Bar Chart Showing the Means and Standard Deviations of Difficulty Getting Satisfactory Answers to Health Questions of Residents Not Receiving Health Services and those who are Receiving Health Services

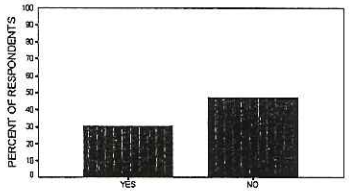


Figure 5: Percent of Cherryhill Residents who Feel they Would like More Input into the Type of Health Services that are Delivered and How Often These Services are Delivered

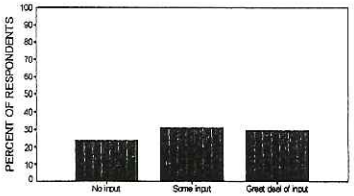


Figure 6: The Degree of Input Residents Feel they Have into the Type of Health Services Provided

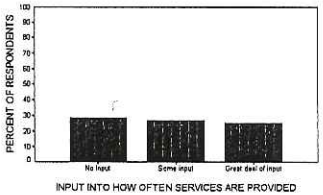


Figure 7: The Degree of Input Residents Feel they Have into How Often Health Services are Provided

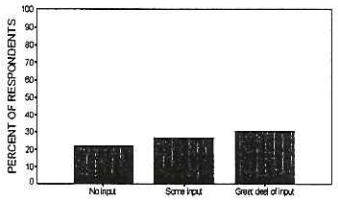


Figure 8: The Degree of Input Residents Feel they Have into the Time of Day Services are Provided

DISCUSSION

The level of satisfaction with community-based support services is high, perhaps surprisingly so. Nonetheless, those receiving services had a significantly lower sense of control over their health and a significant minority felt they had no input into what was provided, when and with what frequency. It could be argued that these results reflect a general level of gratitude with service providers who are perceived as doing their best and a general level of gratitude that some service is, in fact, available. Recipients of service are not content experts. It may well be that an increase in the knowledge of the recipients would lead to higher expectations and lower satisfaction. It is recommended that measures of client satisfaction be tempered by the evaluation of services against an objective gold standard which establishes criteria to which the service must aspire. A distinction will need to be made between evaluation of the content of the service, evidence-based and standard driven, and the willingness and tractability of those providing it.

ACKNOWLEDGEMENTS

This research was supported by funds from the St. Mary's Hospital Reserve Fund, St. Joseph's Health Centre, the Ministry of Health, Long-Term Care Division, the Walter J. Blackburn Foundation and the London Community Foundation, London, Ontario, Canada.

PREDICTORS OF HEALTH IN A COMMUNITY–DWELLING ELDERLY POPULATION

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ABSTRACT

Health is a broad concept moderated or exacerbated by societal and environmental factors, that has been identified as a key factor influencing both health service utilization and volunteer-related health behaviour. This study was conducted within the context of a broader community development project with a mandate to examine how to maximize the involvement of elderly individuals in the planning and provision of their own health services. Modifiable factors over which community development initiatives have may have some influence were of primary interest. The first phase of the study (1) explored the predictors of health to ascertain if findings of this study are consistent with those reported by others and (2) used the findings of this phase to guide further community action. A community health survey was developed and delivered to each apartment unit. Surveys were returned by 1231 residents (53% response rate). Subjective health was assessed by summating the 5-item health perception scale of the M.O.S. (Stewart, Hays & Ware, 1988). Objective health was assessed by number of physician visits, emergency room visits and hospital admissions in the previous year. Potential predictor variables included having a caregiver, frequency of leaving apartment, receiving health services, life satisfaction, control over lifestyle, free time, boredom and sense of community. Factor analysis using varimax rotation resulted in a 2-factor structure; Factor 1 well-being and Factor 2 functional ability. All factor loadings exceeded the .55 level with Eigenvalues greater than 1. These two factors plus age were used as the independent variables in the subsequent bi-variate correlation analysis to identify predictors of health. Subjective health correlated with objective health measures (number of physician visits, r=-.37, p<.001; hospital admissions, r=-.25, p=.002; ER visits, r=-.27, p=.001). Subjective health correlated with well-being (Factor 1) r=.54, p<.001, functional ability (Factor 2) r=.44, p<.001 and age r=-.21, p<.001. Objective health indicators correlated weakly with functional ability (Factor 2) (physician visits, r=-.17, p=.003; hospital admissions r=-.18, p=.002; emergency room visits r=-.15, p=.008) and were not significantly correlated with well-being (Factor 1) or age. These findings are reasonably consistent with those of other researchers. We conclude, however, that the subjective and objective measures of health are sampling different constructs and that different approaches to improving subjective health perception and to influencing objective health service utilization will be required.

STUDY POPULATION

Study participants were 1231 residents of the Cherryhill community. Of the total sample 1043 respondents (85%) were 55 yrs. of age or older. This sample was used to examine predictors of health. Twenty-three percent of study participants were male and 77% female with a mean age of 76 yrs. (SD=± 8.06 yrs.)(Figures 1and 2). Respondents had lived in the Cherryhill community for an average of 10 years (SD=±7.56 yrs.), with the oldest individual (85+ yrs.) having lived in the community longest (14+ yrs.). Participants aged 55 or over ranged in age from 55 to 96 years. Marital status varied from being single (9%), widowed (53%), separated (3%), married (25%), divorced (9%), to common-law (1%). Live-in companions at the time of the study varied from none (71%), a spouse (25%), other family members (2%), to friends (2%).

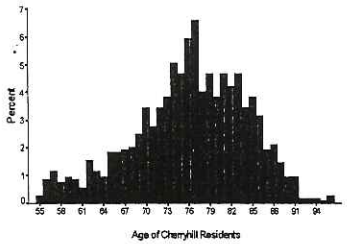


Figure 1: Age and Population Distribution of Cherryhill Residents

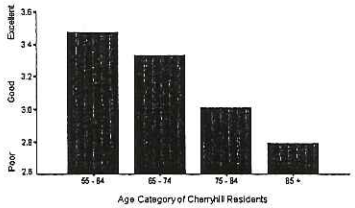


Figure 2: Health of Cherryhill Residents by Age

PROCEDURES

This study utilized cross-sectional survey methodology and was a secondary analysis of a community survey. The Cherryhill Community Survey (n=1231) consisted of 3 parts: (1) Section A: socio-demographic questions; (2) Section B: questions regarding assets, strengths and limitations of the Cherryhill community; and (3) Section C: questions regarding residents health, community and environmental issues, and the Cherryhill Village Mall. Each survey contained the same Sections A and B (n=1231) but only one version of Section C; (C1): Health (n=405); (C2): Community and Environment(n=391); and (C3): Cherryhill Village Mall (n=435). The total sample (sections A and B) and sub-sample C1 (health) were used for analyses.

WHAT OTHER RESEARCHERS HAVE FOUND

Variables found by other researchers to influence health include functional ability (Lindgren, Svardsudd & Tibbin, 1994), well-being (DeForge, Sobal & Krick, 1989; Stolar MacEntee & Hill, 1992; Struthers, Chippenfield & Perry, 1993), social resources Bienenfeld, Koenig, Larsen & Sherrill, 1995; Lindgren, Svardsudd & Tibbin, 1994), activity level (DeCarlo, 1974; Deforge, Sobal & Krick, 1989; Ferrini & Ferrini, 1986; Lindgren,Svardsudd & Tibbin, 1994), environmental factors (Wallerstein, 1992), personality (Abeles, 1992; Wallerstein, 1992; Scheier & Carver, 1987), socio-economic status (SES) (DeForge, Sobal & Krick, 1989) and age (Arnold, 1992; France & Alpher, 1995; Gentile, 1992; Harper, 1992; Kane, Ouslander & Abrass, 1984; Mulder, 1996; Rosenberg & Moore, 1997). Of the above, the following constructs were included in the initial Community Survey and were examined as predictor variables of health: (1) functional ability; (2) well-being; (3) activity level; (4) environment; and (5) age. Occupation, a SES indicator, was descriptive in nature and not used in the analyses. There were no items in the survey that measured social resources or personality factors.

METHODS

The following series of analyses were used to examine the predictors of health: (i) a descriptive analysis of respondents in the total sample age 55 years or older (n=1043) was performed using parametric and non-parametric procedures; (ii) descriptive analyses and t-tests were carried out to examine the characteristics of the 3 sub-samples of respondents of the same age who completed the C1, C2 and C3 version of the survey to examine how representative the sub-samples were of the total sample; (iii) bi-variate correlation and multivariate analyses were used to determine the predictors of health. Exploratory factor analysis with varimax rotation was used to examine whether potential predictor items on the survey represented common underlying factors consistent with major known variables identified as predictors of health by others. Input variables included: (1) having a caregiver; (2) frequency of leaving apartment; (3) health services received; (4) free time; (5) boredom; (6) life satisfaction; (7) control over lifestyle; and (8) sense of community. Age was excluded from the factor analysis; and (iv) the results of the present study were compared with those reported in other studies.

RESULTS

Descriptive analyses, chi-square tests and t-tests of mean differences confirmed that the sub-samples of respondents who completed the C1, C2 and C3 versions of the community survey were highly similar (e.g., age; gender; marital status; etc.) and that the results of analyses for the sub-samples may be used to make inferences to the total sample. The exploratory factor analysis supported a 2-factors structure: Factor 1: well-being and Factor 2: functional ability (Table 1). All factor loadings exceeded the .60 level for Factor 1 and .55 level for Factor 2, both factors having Eigenvalues greater than 1. The SPSS factor analysis program was then used to calculate factor scores based on the well-being and functional ability factors. Bi-variate correlational analyses were used to identify: (1) inter-correlations among the predictor variables; and (2) the predictors of health (Tables 2 and 3). Subjective health, as measured by the health index, was treated at the dependent variable. Three independent variables well-being (Factor 1), functional ability (Factor 2) and age were used. Age was included to confirm the directional hypothesis that health is negatively correlated with age. Consistent with known predictor variables of health reported by other researchers, subjective health was correlated with well-being (Factor 1) r=.54, p<.001, functional ability (Factor 2) r=.44, p<.001 and age r=-.21, p<.001. Objective health indicators also correlated with functional ability (Factor 2) (physician visits, r=-.17, p=.003; hospital admissions, r=-.18, p=.002; emergency room visits, r=-.15, p=.008) but were not significantly correlated with well-being (Factor 1) or age.

Table 1: Factor Analysis of Health and Health Service Utilization Predictor Variables Measured by the Community Survey

Measure and Variable	Factor I (Well-Being)	Factor 2 (Functional Ability)	Communality
WELL-BEING			
Sense of community	.63	-.10	.41
Free time	.60	.15	.39
Boredom	.70	.16	.52
Control over lifestyle	.64	.39	.56
Life satisfaction	.73	.23	
FUNCTIONAL ABILITY			
Having a caregiver	.08	.86	.75
Frequency of leaving the apartment	.42	.55	.47
Receiving health services	.09	.84	.71

Table 2: Inter-Correlations Among Subjective and Objective Health Variables

Variables	Subjective Health	Physician Visits	Hospital Admissions	Emergency Visits
Subjective Health	--	-.37***	-.25***	-.27***
Physician Visits		--	.16**	.23***
Hospital Admissions			--	.32***
Emergency Visits				--

** p ≤ .01
*** p ≤ .001

Table 3: Correlations Among Known Predictor Variables of Health

	Subjective Health Health Index	Objective Health		
		Physician Visits	Hospital Admissions	Emergency Visits
Well-Being (Factor 1)	.54***	-.06	-.04	-.08
Functional Ability (Factor 2)	.44***	-.17**	-.18**	-.15**
Age	-.21***	.08	.01	.01

** p ≤ .01
*** p ≤ .001

CONCLUSIONS

Results from this study are reasonably consistent with those reported by other researchers. As in other studies, the predictors of subjective health included well-being, functional ability and age. Contrary to what others have found, age and well-being were not found to be predictors of objective health (e.g., physician visits; hospital admissions; visits to the emergency room) in the present study. These results indicate that the determinants of objective health, represented here by physician utilization, and subjective health are different, and different approaches will be needed to influence what appear to be quite different constructs.

ACKNOWLEDGEMENTS

This research was supported by funds from the St. Mary's Hospital Reserve Fund, St. Joseph's Health Centre, the Ministry of Health, Long-Term Care Division, the Walter J. Blackburn Foundation and the London Community Foundation, London, Ontario, Canada.

BUILDING A SELF-SUSTAINING COMMUNITY SYSTEM OF HEALTH SUPPORT FOR THE ELDERLY: THE CHERRYHILL COMMUNITY PROJECT . . . .

citizens, local businesses, health professionals and health policy makers working together to build a partnership for the future

Appendix 1: **Global Risk Assessment**

Cherry Hill

Healthy Ageing Program

Global Risks Assessment

The following are examples of some "red flags" that can be identified in older adults that might be signs of a significant health or social problem:

---

1. HYGIENE

a) Personal:
Is the person generally unkempt? ..... Yes ☐ No ☐

b) Environment:
Is there an odour in the person's home (e.g., urine; feces; musty)? ..... Yes ☐ No ☐
Is the environment cluttered with paper, food, garbage? ..... Yes ☐ No ☐

2. NUTRITION

Do you notice that the person's clothes are too loose or too tight? ..... Yes ☐ No ☐

When you ask, does the person admit to having lost or gained any weight in the past year? ..... Yes ☐ No ☐

3. MEDICATIONS

Do you notice medication/alcohol bottles scattered around the person's living environment (e.g., on counters; table tops; in the bathroom; etc.)? ..... Yes ☐ No ☐

Does the person have slurred speech, appear groggy, confused or sleepy? ..... Yes ☐ No ☐

4. FALLS

Does the person appear unsteady on their feet? ..... Yes ☐ No ☐
Does the person have trouble getting out of a chair? ..... Yes ☐ No ☐
Does the person have problems with mobility? ..... Yes ☐ No ☐

5. FIRE

a) Smoking:
Are there burn marks on the furniture, carpet, clothing, person's skin? ..... Yes ☐ No ☐

...2

b) Environment:

Is there evidence of burn marks on the stove or burned pots and pans? ..... Yes ☐ No ☐
Is there a smoke detector? Does it work? ..... Yes ☐ No ☐

c) Person:

Is the person confused? ..... Yes ☐ No ☐
Is the person mobile? ..... Yes ☐ No ☐
Is the person visually or hearing impaired? ..... Yes ☐ No ☐

6. MENTAL CONDITION

a) Thinking:

Does the person repeat him/herself (e.g., tell you the same story over and over again; ask the same question over again)? ..... Yes ☐ No ☐

b) Mood:

Does the person cry a lot? ..... Yes ☐ No ☐
Does the person appear angry/irritable/agitated? ..... Yes ☐ No ☐

7. FINANCES

Do you see evidence of unpaid bills or letters from creditors/collection agencies? Yes ☐ No ☐

8. ABUSE

Financial:	Does the person give away large amounts of money to another person?	Yes ☐	No ☐
Physical:	Is the evidence of bruises, abrasions (ruling out falls)?	Yes ☐	No ☐
Emotional:	Is the person afraid of their caregiver/family member?	Yes ☐	No ☐
Neglect:	Does the person appear to be well cared for?	Yes ☐	No ☐

9. SERVICES

Is the person involved with outside agencies such as CCAC, VON? You may see their care binders in the person's home or their cards on the fridge. ..... Yes ☐ No ☐

Name: _____ Date: _____

Referral Required: Yes ☐ No ☐ Resident Informed & Agreeable: Yes ☐ No ☐

Referred to: _____

_____

_____

Appendix J: Volunteer Recruitment Process

Cherryhill
Healthy Ageing Program

Program Development Steps for Volunteer Involvement

Step	Action	Outcome
1. Inception & Planning	Ideas, from many different sources, are considered according to program guidelines. A coordinating group is formed comprised of a few staff members and interested volunteers.	• Preliminary program description. • Designated volunteer coordinator.
2. Feedback & Approval	The preliminary program description is presented to the CHAP steering committee for feedback and development of an evaluation framework. The description is then presented to the volunteer group for feedback and consensus to proceed.	• Approved program description that includes goals, timelines, evaluation framework and volunteer roles.
3. Communication & Training	The coordinating group develops methods and materials for informing all volunteers and staff about the program, recruiting and training volunteers for program delivery, and promotion to the general public.	• Information package for volunteers to use when helping clients, including registration materials. • Information package for volunteer recruitment. • Volunteer training / orientation session(s). • Promotional materials.
4. Evaluation	The coordinating group monitors the program, reviews feedback and collects statistics according to the evaluation framework. Modifications to the program are made as required.	• Statistical forms, client satisfaction surveys, volunteer feedback, etc.
5. Reporting	Evaluation findings are analysed.	• Verbal and/or written reports to the volunteer group, steering committee and governing bodies.

Cherryhill
Healthy Ageing Program

Volunteer Intake, Placement and Training Process

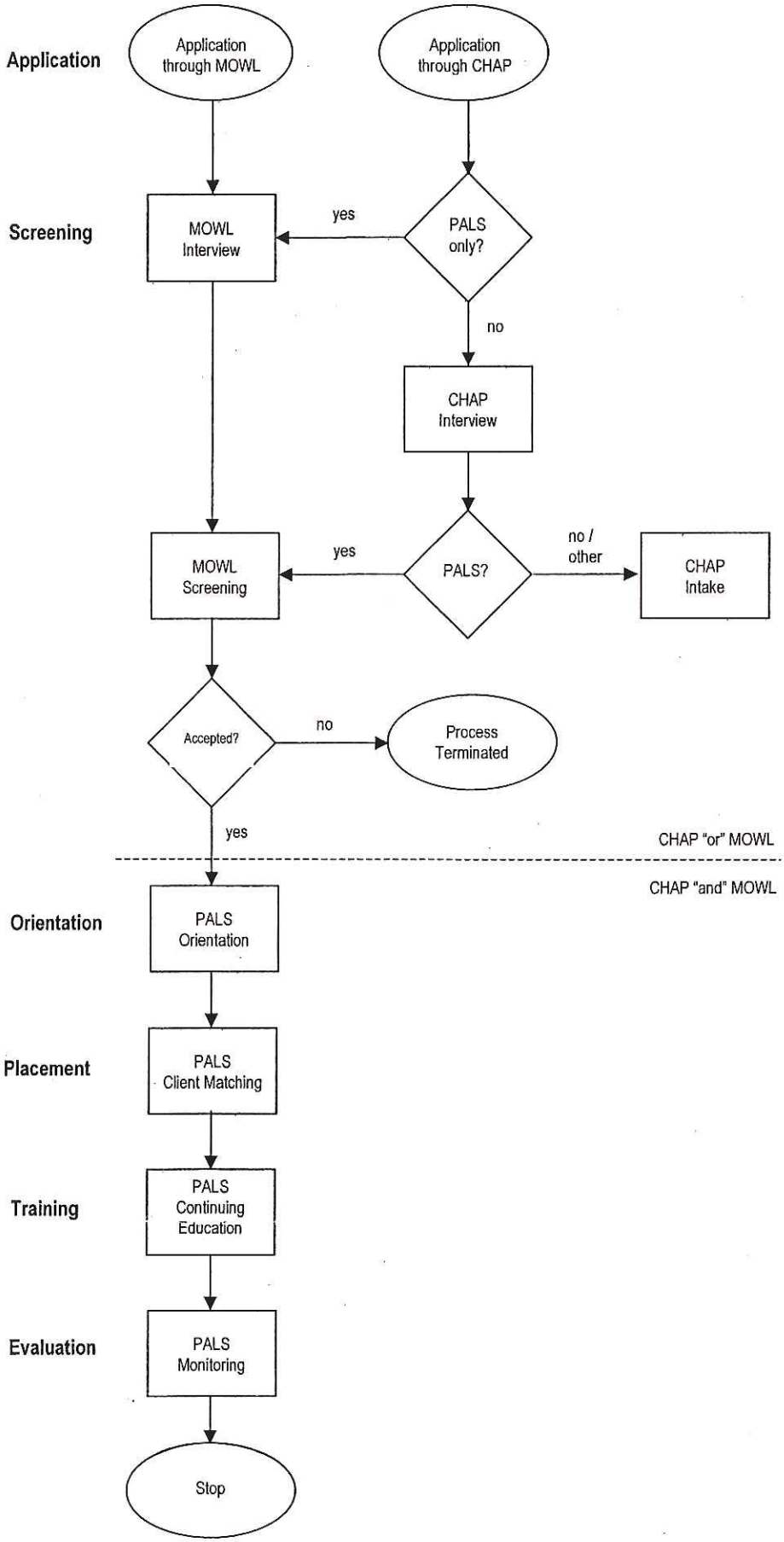
Step	Description	Responsibility
1 APPLICATION	Individuals interested in volunteering complete an ***Application Form***. Applicants are contacted within a couple of weeks of submitting their form to thank them for their interest and inform them about the volunteer process. PALS - Applicants who are only interested in the PALS program may be referred directly to Meals on Wheels, London.	Form is available at the Health Centre. Volunteer Coordinator (or substitute) contacts applicants. See *PALS Volunteer Flow Chart* for more details.
2 INTERVIEW & SCREENING	The list of applicants are reviewed at regular intervals or as the need arises. Selected candidates are interviewed, references checked and, if appropriate, arrangements are made to proceed with orientation. An application may be placed "on hold" if no suitable activities are currently available. PALS - Final processing and screening of volunteers interested in PALS is handled by Meals on Wheels, London. – a ***Police Records Check*** is mandatory.	Volunteer Coordination Committee
3 ORIENTATION (General)	Candidates are introduced to CHAP – its programs, history, policies and practices and the essentials of volunteering. An ***Oath of Confidentiality*** is taken *prior to beginning any duties*. The volunteer is also presented with a ***Consent for Photography*** form, which is optional.	Volunteer Coordination Committee. The *Oath of Confidentiality* is sworn by a retired or substitute lawyer (can be individual or group process).

...2

Step	Description	Responsibility
4 PROGRAM ORIENTATION & TRAINING	The volunteer receives orientation and training specific to the program and position she/he is involved with. Trial Placement A volunteer may be asked to participate in a trial placement (usually for a minimum of 2 weeks or 2 shifts) with a volunteer or staff person. On-the-job training is received. This hands-on experience allows the volunteer to determine whether the position is suitable and also provides CHAP with an opportunity to offer guidance.	Volunteer Coordinator, trained volunteer or staff person.
5 PLACEMENT	i) Probationary Period At a minimum, the first 2 months or 8 shifts of a placement are deemed probationary. During this time, placement is preferably with a trained volunteer or staff person. Ongoing feedback is essential. The volunteer signs a ***Position Description***. ii) Permanent Upon completion of the probationary period, the volunteer and their coordinator meet to discuss whether or not permanent placement should occur.	Monitored by the Volunteer Coordinator and/or staff person.
6 TRAINING, EVALUATION & APPRECIATION	Regular informal feedback and training is encouraged in a number of ways (one-on-one, group meetings, suggestions page, etc.). In-service sessions may be held on occasion. Advanced Training The volunteer may complete advanced training to acquire more skills and techniques. Evaluation & Appreciation Volunteers may be asked on occasion to participate in program evaluation and volunteer satisfaction surveys, focus groups, etc. Appreciation activities, both on an individual and group basis, are ongoing.	Volunteer Coordinator or staff person. Developed or approved by the Volunteer Coordination Committee.

Cherryhill PALS Program

VOLUNTEER INTAKE FLOWCHART



Appendix K: Volunteer Application Form

Cherryhill
Healthy Ageing Program

Volunteer Application Form

Office Use Only	
Contact	
Interview	
References	
Oath & Consent	
Description	
Orientation	
Trial Placement	
Prog. Referral	
Training	

Thank you for your interest in becoming a volunteer with the Cherryhill Healthy Ageing Program. Please provide us with the following background information and we will contact you in the near future.

_____

Date

_____ _____

Last Name First Name

_____ _____ _____

Address City Postal Code

_____ _____

Home Telephone Work Telephone

_____ _____

E-Mail Fax

Please describe your previous volunteer experience (where and when):

_____

_____

_____

Place and position of current Employment / Education: _____

_____

If retired, previous occupation: _____

Do you have any interests, skills or resources that might benefit your work at the Cherryhill Healthy Ageing Program? (e.g., computer, languages, etc.)

_____

_____

_____

Turn over ➡

Why do you want to volunteer with the Cherryhill Healthy Ageing Program?

_____

_____

How did you find out about the Cherryhill Healthy Ageing Program?

_____

Please indicate with a ✓ <u>all</u> of the volunteer programs that are of interest to you (please note that eligibility criteria may apply to some programs).

☐ Information and Referral	Peer-to-peer provision of information on healthy ageing resources and services.
☐ Friendly Visiting (PALS)	Provides contact, support, advocacy, outings, companionship and information.
☐ Telephone Visiting	Phone visits with isolated seniors to provide support, companionship and information.
☐ Work with Community Nurse	Assists with health assessment follow-up in Cherryhill and other clinical program assignments.
☐ Fitness Assistance	
☐ Safety Monitor	Monitors the safety of Cherryhill apartment residents twice daily.
☐ Fundraising	Serves on a volunteer committee to plan and organize fundraising events.
☐ Student Volunteer	Assigned to special projects such as research studies.
☐ Office Work	

☐ Other (specify) _____

What length of time are you available to work?

☐ Short-term (less than 6 months) ☐ Long-term (over 6 months) ☐ Occasionally

What days and times are you available?

Mon	☐ A.M.	Tues	☐ A.M	Wed	☐ A.M.	Thu	☐ A.M.	Fri	☐ A.M.	Sat	☐ A.M
	☐ P.M.		☐ P.M.		☐ P.M.		☐ P.M.		☐ P.M.		

Other (specify) _____

When are you <u>not</u> available? _____

References

Please provide a minimum of two references, either personal (do not use relatives) or business. We are unable to contact people long distance due to funding limitations.

Name: _____

Relationship: _____ Years Known: _____

Home Phone: _____ Business Phone: _____

OFFICE USE:

Name: _____

Relationship: _____ Years Known: _____

Home Phone: _____ Business Phone: _____

OFFICE USE:

Name: _____

Relationship: _____ Years Known: _____

Home Phone: _____ Business Phone: _____

OFFICE USE:

I, _____, authorize the Cherryhill Healthy Ageing Program to collect personal information appropriate to the volunteer work applied for concerning my employment history as well as any volunteer experience, and to verify the character references I have supplied. I understand that the information obtained will be confidential but may be shared with partner agencies.

_____ _____

Applicant's signature Date

VOLUNTEER OATH OF CONFIDENTIALITY

I _____ do swear/affirm that I will faithfully discharge my duties as a volunteer or staff member of the Cherryhill Healthy Ageing Program. I will protect the confidentiality of personal information of any person or persons who attend at the Program. I will not disclose such information other than as may be required by law, so help me God. I so swear/affirm.

_____

SWORN/AFFIRMED BEFORE ME AT IN THE COUNTY OF

_____

THIS DAY OF 20

_____

A PERSON DULY AUTHORIZED TO ADMINISTER THIS OATH

_____

VOLUNTEER SIGNATURE

04/09/2002

Cherry hill

Healthy Ageing Program

CONSENT FOR PHOTOGRAPHY, VIDEO/AUDIO TAPING, & TELEVISING

Name: _____

I hereby give my consent for:

- ☐ photography
- ☐ video/audio taping
- ☐ televising

and release to the Cherryhill Healthy Ageing Program, the Cherryhill Health Promotion & Information Centre, and all other partners associated with the program all rights for media products in which I appear for the following purposes:

- ☐ public relations
- ☐ education
- ☐ research
- ☐ resident/community care

This is a full release of all claims whatsoever I or my heirs, executors, administrators or assigns now or hereafter have against the Cherryhill Healthy Ageing Program, the Cherryhill Health Promotion & Information Centre, or its employees, and all other partners associated with the program, as regards use that may be made by them of said photographic reproductions, video/audio tapes, or direct transmission of television signals.

I have read this entire document, understand the content and I have willingly agreed to the above considerations.

Date: _____ Signature: _____

Name: _____

Witness: _____

Cherryhill
Healthy Ageing Program

VOLUNTEER POSITION DESCRIPTION

1. **POSITION:** Volunteer Coordinator

2. **PURPOSE:** Assists with maintaining a volunteer base and utilizing volunteers productively

3. **AREAS OF RESPONSIBILITY:**
   - Provides practical and emotional support to volunteers
   - Advocates on behalf of volunteers to ensure their ongoing positive relationship with the Program
   - Coordinates scheduling
   - Assists with ensuring procedures and policies are in place and are followed
   - Performs ongoing informal evaluation and feedback
   - Assists with volunteer statistics
   - Organizes and reports at monthly Volunteer Meetings (serving as a rotating chair is optional)
   - Assists with the coordination of the Intake, Training and Placement process
   - Serves on the Volunteer Intake and Management Committee, which oversees volunteer program development and administration

4. **QUALIFICATIONS:**
   - Ability to work in a team environment
   - Excellent interpersonal and communication skills
   - Mature adult who is familiar with the Cherryhill community
   - Volunteer and office experience, preferably volunteer experience with the Cherryhill Healthy Ageing Program
   - General knowledge of healthy ageing issues and services
   - Basic computer skills an asset
   - Background in health care or volunteer management fields an asset

5. **TIME COMMITMENT:**
   - 4 to 8 hours per week; majority during Health Centre hours, Monday to Friday
   - Attendance at one volunteer meeting per month of 1 hour duration
   - Attendance at Volunteer Intake and Management Committee meetings; approximately 2 to 4 hours per month
   - Training may require an additional time commitment as well as availability during evenings

6. LOCATION:

Cherryhill Health Promotion & Information Centre, Cherryhill Village Mall, 301 Oxford Street West, London ON

The centre is located on street level and is fully wheelchair accessible.

7. TO WHOM RESPONSIBLE:

- Reports to the Volunteer Intake and Management Committee
- Health Information and Community Development Coordinator serves as staff advisor

8. TRAINING REQUIREMENTS:

- Must take an oath of confidentiality
- Must complete the Volunteer Training program
- Must be willing to learn about healthy ageing issues and resources
- Must participate in advanced training opportunities as required

Created: October 4, 2000

Revised: February 26, 2002

Cherryhill
Healthy Ageing Program

COMMITTEE TERMS OF REFERENCE

1. COMMITTEE: Volunteer Intake and Management

2. PURPOSE: Oversees the volunteer program, which includes the recruitment, placement, training, evaluation, recognition and dismissal of volunteers.

3. AREAS OF RESPONSIBILITY:
   - Administers the intake, training and placement process
   - Holds interviews and approves placement
   - Facilitates training and evaluation
   - Organizes recognition activities
   - Resolves formal complaints
   - Reviews and approves cases for dismissal
   - Serves as a resource and advisor to the Volunteer Coordinator
   - Develops/approves policies and procedures
   - Develops volunteer tools

4. COMPOSITION:
   Minimum composition should include:
   - Volunteer Coordinator (volunteer position)
   - Director of the Board
   - Staff member (Health Information and Community Development Coordinator)

   Program coordinators should be available in an advisory capacity.

5. MEETINGS:
   Meets every one to two months or as needed.

6. TO WHOM RESPONSIBLE:
   - Board of Directors

Created: October 4, 2000

Revised: February 26, 2002

VOLUNTEER STATUS FORM

Office Use Only

Last Name	First Name

I. INTAKE

Step	Start Date	Complete Date	Comments	Initial
Application				
Interview				
References				
Orientation				
Oath of Confidentiality				

II. PLACEMENT & TRAINING

Position		**Tier**		
Program				
Step	**Start Date**	**Complete Date**	**Comments**	**Initial**
Referred				
Trial Placement				
Probation				
Permanent Placement				
Advanced Training				
Discharge				

Position		**Tier**		
Program				
Step	**Start Date**	**Complete Date**	**Comments**	**Initial**
Referred				
Trial Placement				
Probation				
Permanent Placement				
Advanced Training				
Discharge				

CHERRYHILL HEALTH PROMOTION & INFORMATION CENTRE: *DAILY LOG & INFORMATION REQUESTS*

DATE (a.m./p.m.)	CHERRYHILL RESIDENT		NEW OR REPEAT VISITOR/ PHONE CALL (N-R-P)	QUESTIONS ASKED & INFORMATION REQUESTED	RESPONSE	FURTHER INFO. REQUIRED		PLEASE INITIAL
	YES	NO				YES	NO	

RESOURCES FOR MANAGING VOLUNTEER PROGRAMS

This section provides a list of resources to help with the design and ongoing operation of a volunteer program. It includes a section on volunteerism in Canada, links to web sites, professional associations and courses that provide practical information covering many aspects of managing volunteers as well as opportunities to share ideas.

Volunteerism in Canada

An array of resources are available that support the growing volunteer industry in Canada. Reports based on recent national surveys provide insight into Canada's volunteers and current trends in volunteerism. In addition, standards and codes have been developed that govern volunteer involvement.

Volunteer Canada
430 Gilmour Street
Ottawa, Ontario K2P 0R8
Tel: (800) 670-0401
Email: volunteer.canada@sympatico.ca
Web: www.volunteer.ca

Volunteer Canada is the national charitable organization promoting volunteerism in Canada. The organization conducts training and other national initiatives to develop skills and resources within the voluntary sector. Resources are available from the National Office or can be ordered online from the web site.

Canadian Code for Volunteer Involvement. Volunteer Canada, 2000.
The Code provides a framework for involving volunteers at different levels and outlines the values, principles, and standards for effective volunteer practices within organizations. It also includes the Organization Standards Checklist to assist organizations in evaluating and improving their volunteer programs.

National Education Campaign on Screening
A variety of resources designed to assist organizations in assessing and managing risk in their volunteer programs.

Older Adult Volunteering
Volunteering and Healthy Aging: What We Know by Dr. Neena Chappell is a paper released at the Canadian Forum on Volunteering by Volunteer Canada, Health Canada and Manulife Financial on October 28, 1999. Excerpts from the paper plus an extensive literature review on the topic of seniors and the health impacts of volunteering are available online (www.volunteer.ca/volunteer/canada_adults_report_toc.htm).

Volunteering...a Booming Trend. Volunteer Canada and Canadian Centre for Philanthropy, 2000.
A free consumer booklet about volunteering in later life.

National Survey of Giving, Volunteering and Participating (NSGVP)
(www.nsgvp.org)
The NSGVP is a survey of Canadian individuals regarding their community activities. To date the survey has been undertaken twice, in 1997 and 2000. A draft paper by Jeff Carr entitled *Health Human Resources: Role of the Voluntary Sector* for Health Canada (2001) is available on the web site.

Canadian Administrators of Volunteer Resources (CAVR)
24-94 Bridgeport Road East, Suite 322
Waterloo, Ontario N2J 2J9
Email: pgillis@cw.bc.ca
Web: www.cavr.org
Publishes *Standards of Practice: Canadian Administrators of Volunteer Resources, 2001.* Please note that the complete document is currently only available to members of CAVR.

Federal and Provincial Human Rights Codes
Volunteer programs are governed by Canadian and provincial human rights codes.

Ontario Human Rights Commission, Head Office
180 Dundas Street West, 8th Floor
Toronto, Ontario M7A 2R9
Tel: (416) 326-9511; 1-800-387-9080
Email: info@ohrc.on.ca
Web: www.ohrc.on.ca

Canadian Human Rights Commission, Ontario
1002-175 Bloor Street East
Toronto, Ontario M4W 3R8
Tel: (416) 973-5527; (800) 999-6899
Email: info.com@chrc-ccdp.ca
Web: www.chrc-ccdp.ca

Authors
Prominent authors in the field of volunteer management include Susan J. Ellis, Stephen McCurley and Sue Vineyard.

Web Sites

A wealth of information about volunteer leadership is available on the Internet. Some key terms to use when conducting a search on the web are "volunteer management", "volunteer administration" and "volunteerism". To help you get started, several major web sites are listed below -- be sure to check out the links they provide to other useful sites.

Charity Village (www.charityvillage.com)

This Canada-wide online centre is for the organizations and people involved in the nonprofit sector. The site offers a range of practical resources on volunteerism, which can be found under several categories. A good way to start is to search the entire site for a volunteer topic of your choice.

Volunteer Canada (www.volunteer.ca)

This national charitable umbrella organization of Canadian volunteer centres conducts training and other national initiatives to develop skills and resources within the voluntary sector. The web site has a Volunteer Management Kiosk and provides information on Older Adult Volunteering, National Education Campaign on Screening, Ontario Screening Initiative, volunteer centre contact information and other initiatives.

NCASA (www.casanet.org/program-management/volunteer-manage/index.htm)

This is an American volunteer management site provided by the National Court Appointed Special Advocate Association. NCASA offers a range of practical information including sample volunteer agency policies and tips for volunteer management.

Energize Inc. (www.energizeinc.com)

Energize Inc. offers an online forum for volunteer managers to exchange views, find publications and broaden their skills. The site features free online books and articles on topics such as planning a volunteer center, staffing a volunteer program, general recruitment, record keeping, risk and liability, personnel policies for volunteers, etc.

Service Leader (www.serviceleader.org)

This web site provides an extensive list of online resources in volunteer management.

Management Assistance Program for Non-Profits – Free Management Library
(www.mapnp.org/library/staffing/outsrcng/volnteer/volnteer.htm)

The Managing Volunteer Programs section of this site includes an online tutorial, practice guidelines and online articles.

Professional Associations

Professional associations are operated at the local, provincial, national and international levels. They promote the profession of volunteer management by providing networking opportunities, research, publications, education and professional development, including certification and standards of practice.

London and Area Association of Volunteer Administrators (LAVA)
c/o Doug Chabot, Membership Chair
Tel: (519) 858-2774

Professional Administrators of Volunteer Resources – Ontario (PAVR-O)
RR#5, Orangeville, Ontario L9W 2Z2
Tel: (877) 297-2876; (519) 941-7329
Email: pavro@pavro.on.ca
Website: www.pavro.on.ca

Canadian Administrators of Volunteer Resources (CAVR)
24-94 Bridgeport Road East, Suite 322
Waterloo, Ontario N2J 2J9
Email: pgillis@cw.bc.ca
Web: www.cavr.org

Association for Volunteer Administration (AVA)
P.O. Box 32092,
Richmond, Virginia 23294
Tel: (804) 346-2266
Email: avaintl@mindspring.com
Web: www.avaintl.org

Volunteer Management Courses

Courses in volunteer management, both academic (certification) and continuing education, are offered at colleges and universities throughout Canada and the United States. Two comprehensive lists of available courses can be found on the Internet at the Service Leader (www.serviceleader.org/training/courses.html) and Charity Village Learning Institute (www.charityvillage.com/learn/index.asp) web sites. Additionally, PAVR-O offers a certification program for a Certified Volunteer Resource Manager – CVRM; AVA, a professional credentialing program (see section above for contact information). Fanshawe College in London, Ontario offers a continuing education course for both new and practising managers of volunteers. This course qualifies as one of the criteria required for certification by PAVR-O.

Fanshawe College
Volunteer Management Course
School of Continuing Education
1460 Oxford Street East
London Ontario
Tel: (519) 452-4441
Web: www.fanshawec.on.ca

Several universities offer online volunteer management courses. For example, the Washington State University makes available a web-based learning opportunity called the Online Management Certificate Program (vmcp.wsu.edu). A list of other online courses can be found by visiting Energize Inc.'s web site (www.energizeinc.com/prof/classon.html).