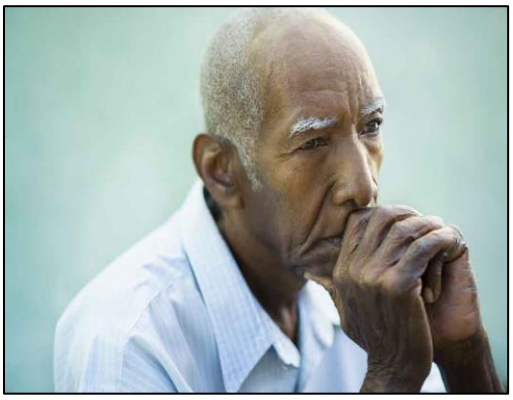
HAMILTON SENIORS ISOLATION IMPACT PLAN

Introducing the Connector Program in your Community

The Hamilton Seniors Isolation Impact Plan (HSIIP)



A guide of resources and suggestions shared by collaborating organizations in the Hamilton Seniors Isolation Impact Pan (HSIIP)

January 2020

Canada

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Introduction and background

Social isolation is a pressing and serious issue that is pervasive throughout contemporary society. Isolation can affect anyone but disproportionately impacts older adults. It is important to differentiate between social isolation and loneliness as one frequently hears the terms used interchangeably. While related, they are not the same.

Social isolation is “a state in which the individual lacks a sense of belonging socially, lacks engagement with others, has a minimal number of social contacts and they are deficient in fulfilling quality relationships” (Nicholson, N. 2009. Social isolation in older adults: An evolutionary concept analysis. Journal of *Advanced Nursing, 65, 1342-1352.*). Please refer to Appendix A for a list of risk factors for social isolation.

Loneliness is often described as the subjective counterpart to social isolation (Windle, K., Francis, J. & Coomber, C. 2011. Preventing loneliness and social isolation: interventions and outcome. *Social care institute for excellence.*) In experiencing loneliness, one can have an unwelcome feeling of a lack or loss of companionship.

It is important to remember that not everyone who is isolated feels lonely. In addition, you can feel lonely even in the presence of others.

As aforementioned, individuals who are socially isolated lack meaningful roles and relationships, they don’t usually participate in activities with others, and they typically are not well connected to supports. Canada’s National Seniors Council has estimated that up to 16% of people 65+ experience isolation, or nearly 950,000 seniors across the country (Statistics Canada, 2017).

A growing aging population is one reason why it is imperative that we find ways to encourage inclusion, meaningfully engaging older adults in our communities. In the City of Hamilton, between 2006 and 2016, the proportion of the population 65+ increased from 14.9% to 17.3%; the number 65+ increased from 75,400 to 92,910; and the number 65+ living alone increased from 19,815 to 23,135 (Statistics Canada, 2014 & 2018). Similar trends can be observed throughout the province and across the country.

The impacts of isolation are profound. In addition to the impact it can have on emotional well-being, social isolation has been shown to influence negative health behaviours, increase risk for many conditions and lead to faster decline in functional and cognitive capacities in older age. It is also associated with high costs to health and social service systems. Recognizing the importance of seeking solutions to address isolation, in 2016 the federal government, through the New Horizons for Seniors Program, funded 9 projects across the country to form collaboratives that would seek strategies for reducing social isolation. Hamilton was the recipient of one of these grants.

The overall goals of the Hamilton Seniors Isolation Impact Plan (HSIIP) (2016-2019) were to:

- measurably **reduce social isolation** among adults 55+
- to build the community’s capacity to **identify, reach and connect** isolated older adults
- to **prevent** social isolation in the future

A comprehensive evaluation report of the first three years of the Hamilton project, as well as related resources, is available on the 'Social Inclusion Matters' page of the Hamilton Council on Aging (HCoA) website. https://coahamilton.ca/ Should you require additional information about anything else related to the HSIIP project, please contact the HCoA directly. You will find contact information on the website.

The Connector guidelines will briefly describe the Hamilton project and highlight a few select results. More important, the guidelines include suggestions and sample resources contributed by the collaborative partner organizations who implemented the project and contributed to its evaluation. This is not meant to be a 'rule' book; every community has unique needs and wants. With that in mind, we encourage you to pick and choose suggestions and/or adapt sample tools that work for you.

While it is possible for an individual organization to implement the Connector model, it should be noted that, in Hamilton, a collaborative was formed that was integral to the success of the initiative. Social isolation among older adults persists as one of the most complex social challenges facing Canadian society and we recommend working within a collaborative to address this and other social issues. Together we are stronger.

Partner Organizations

The 7 organizations identified in the following diagram formed a collaborative that guided the project from May 2016 – April 2019. Funding support was provided through the New Horizons for Seniors Program, an initiative of the federal government. Additional funding from the federal government supported the project for an eight-month extension, from May 2019 – December 31st 2019. During the first three years, funding support from the Retired Teachers of Ontario (RTO) provided an opportunity to encourage the participation of adults 55+ in social activities.

Throughout the whole project, collaborating organizations liaised with individuals, groups and organizations throughout the Greater Hamilton Area (GHA) to support adults 55+ who were experiencing or, were at risk of experiencing, social isolation. The focus of the Hamilton project was older adults living on a low income.

The Hamilton Collaborative

The 7 formal HSIIP partners worked within a collective impact model. The collective impact process (Innoweave 2016) enables a group of organizations to address a major challenge by developing and working toward a common agenda that fundamentally changes population level outcomes in a community. The process gives communities an opportunity to solve complex challenges (e.g. youth unemployment, low graduation rates, poverty) or to make substantial societal shifts (e.g. more sustainable food systems) by creating a shared multi sector understanding of the problem, a common vision and an action plan with shared measurements and reinforcing activities.

Collective impact emphasizes 5 key elements: 1) a common agenda, 2) shared measurement, 3) mutually reinforcing activities, 4) continuous communication and 5) having an independent backbone (in this instance, the HCoA) providing guidance and support.

The 7 HSIIP partners shared six project objectives:

1. build a collaborative
2. identify isolated adults 55+
3. connect isolated adults 55+
4. improve and coordinate supports
5. better understand isolation and facilitate a response
6. evaluate and scale what works.

Four overall population level goals were targeted: 20% of isolated adults 55+ in Hamilton would have improved access to help and support; 10% would participate more regularly in activities; 20% would feel more connected to people; and 10% would feel more valued by people.

The collaborative structure consisted of a Steering Committee, an Outreach Team (the Connectors) and the Seniors Inclusion Coalition. In Appendix B, you will find the Terms of Reference for the Steering Committee. They may be a helpful resource if you are drafting operational guidelines for your project. The Steering Committee consisted of one Project Lead and one Designated Alternate from each of the HSIIP funded partners. The members were jointly responsible for the achievement of shared goals and outcomes.

The Outreach Team included HCoA backbone staff and the Connectors. The Connectors tracked data and reported on activities and outcomes. Regular meetings provided an opportunity for the Connectors to share lessons learned and to problem solve some of the more difficult client situations that they encountered.

In addition to the implementation of individual HSIIP projects, all partners were expected to:

- work with the HCoA to support its activities and outcomes
- attend regular meetings and communicate frequently
- participate in semi-annual evaluation sessions and occasional strategic planning meetings
- develop indicators to measure achievement of shared goals and outcomes
- track and share data for agreed upon indicators

- contribute to and utilize tools for shared measurement
- use common branding, terminology and promotional materials to promote HSIIP in the community
- champion older adult isolation and enhance public understanding of the issue

Although the collaborative projects included the CareDove Referral System (Thrive Group) and a participatory research project (Gilbrea Centre for Studies in Aging at McMaster University)), the guidelines in this document focus primarily, but not exclusively, on the Connector model.

Tip: It takes a significant investment of time to create, support and maintain a collaborative. The HSIIP project required a greater ramp up period (3-6 months) than might have been anticipated. If you are considering a collaborative model, this needs to be considered, particularly if organizations do not have a history of working together

The Connector Model

A key foundational piece of the Hamilton strategy was the Connector model with Connectors (front-line staff) affiliated with 4 of the partner organizations (AbleLiving Services, St. Joseph's Home Care, Wesley Urban Ministries and the YWCA Hamilton).

In the Hamilton project, there were three types of Connectors with some similar and some different but, complementary, roles.

Community Connectors (Wesley Urban Ministries)
Activities:

- identifying isolated seniors through outreach and engagement in targeted neighbourhoods
- assessing needs and opportunities
- creating plans to agreed upon supports and activities
- working one-on-one over a period of about 6 months to ensure seniors are anchored and sustaining connections

Hospital Connectors (St. Joseph's Home Care and AbleLiving Services)
Activities:

- identifying isolated older adults being discharged from hospitals
- assessing needs and opportunities
- creating plans to link to agreed upon supports and activities
- following up to ensure seniors are anchored and sustaining connections

Peer Volunteer Connectors (YWCA Hamilton)
Activities:

- identify isolated seniors
- assessing needs and opportunities
- linking to support and activities
- recruiting and training peer volunteers
- matching isolated seniors with per volunteers to provide in-home social support and/or accompaniment to activities in the community

Challenges and barriers

While there were many positive and encouraging results, the Connectors also met with challenges and barriers.

Some of these include the following and represent a snapshot of lessons learned that another community may want to consider when introducing the program to their community.

- Isolated older adults are difficult to find. They are, by definition, isolated. It takes time to establish trust in order to begin to understand client issues.
- Rural areas are frequently challenged with inadequate transportation although transportation can also present a barrier in urban core areas.
- Connectors initially may have anticipated that their primary role would be to connect isolated older adults with social activities. In reality, they identified many individuals with complex, unmet basic needs and poorly managed health conditions – must address basic needs before trying to link older adults to social activities.
- There is a need to develop increased expertise about mental health and addictions with community workers.
- Older adults are often unaware of their financial entitlements. Helping them to complete applications to receive financial support contributes to their independence.
- There is no one size fits all when it comes to supporting older adults who are experiencing, or are at risk of experiencing, social isolation. Milton Friesen, Program Director, Social Cities says *'a common problem does not equal a generic solution or response'*. In other words, a community needs multiple strategies to respond to different needs and interests, different age groups (older adults do not represent a homogeneous group), different life stages, different health concerns and different socioeconomic statuses.

Additional factors not unique to Hamilton include the reality that age segregated organizations, funding streams and service delivery systems can limit a community's ability to work together. This point is referenced here to reflect one of the positives of delivering Connector services as part of a collaborative. The Connectors were able to not only problem solved more challenging situations together but were able to refer clients to one another.

Using an example of an older adult being discharged from the hospital, an 'ideal' flow of services is represented in Diagram 1, moving from the most intensive to the least intensive level of support. The process isn't always linear and there might be flow back and forth between these various levels of support.

Diagram 1.

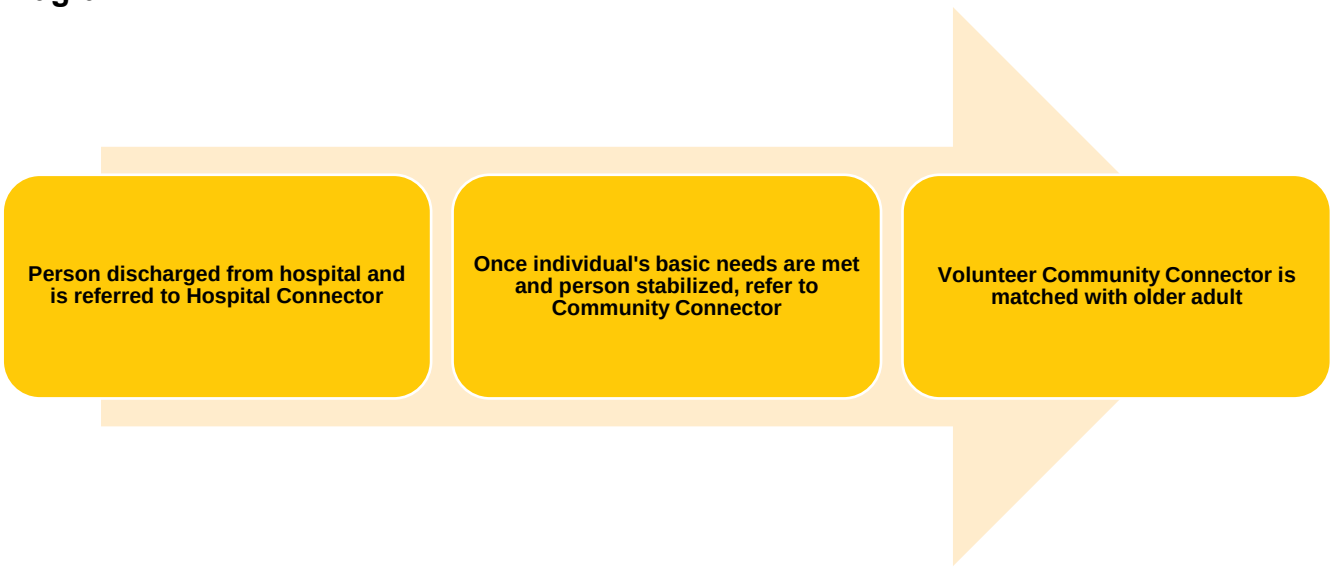
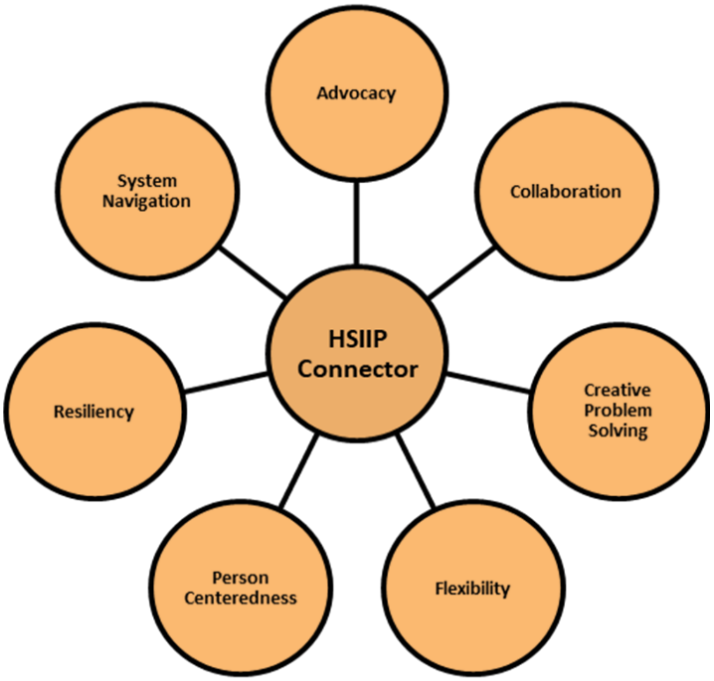


Diagram 2

This diagram depicts, in a broad way, the various roles of the Connectors.



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- Fill a gap in the current social support services
- Break down barriers that result in social isolation
- Invest the time to build trust and rapport with clients.
- Ensure basic needs are met, then link to social activities
- Instill confidence, motivation and opportunity for older adults to become involved outside of the home.
- Help prevent unnecessary emergency room visits and hospital admissions.

That the Connectors filled a gap is without question. One Hospital Social worker writes "*The Connector role is a unique one and honestly I think it is vital. That continuity of care and warm handover, it makes such a difference for people's outcomes and follow through…..if I did not have the Connector there, I would be making referrals, they would leave and I would never really know if they had received adequate support".*

Select Results

This section will profile select results of the 3-year project *(*does not include data from the 8-month extension period)* to demonstrate to the reader the positive impact that the Connector model can have on adults experiencing or, at risk of experiencing, social isolation. As aforementioned, for more complete results, please refer to the HCoA website to access the HSIIP Evaluation Report: May 2016 - March 2019 (published on April 30th, 2019).

The Hamilton project connected over 1556 isolated seniors - 13.7% of isolated seniors in Hamilton. In addition, many more people (e. g. family, neighbours) would have positively benefited from the support from to older adults.

- 8.8 % of isolated seniors in Hamilton now participate more in social and physical activities achieving 88% of our population target.
- 8.7% of isolated seniors feel more valued by people equating to 87% of our population goal.
- 9.5% of isolated seniors feel they were more connected to people achieving 48% of our population goal.
- 996 older adults had improved participation, which represented 88% of the target.
- Specifically, the proportion that felt that they participated in social and recreational activities a few times a year or less fell from 67% to 33%.

  It should be highlighted that, during the first 3 years of the project, a $50,000 grant from the Retired Teachers of Ontario (RTO) was used as a social participation fund to facilitate opportunities for individuals to participate in social activities. This fund was well used and really made a difference in terms of access to services.
- On intake, 44% of respondents reported feeling lonely often or always; upon exit, this was reduced to 16%.
- On intake, 41% reported feeling isolated; upon exit, this was reduced to 13.5%.
- In exit survey data, a majority (73%) felt the program was helpful, while 26% felt it helped somewhat. Over 98% gave an overall rating of ‘Excellent; to the program
- The proportion of older adults who reported usually having enough help or having plenty of help increased from 45% to 81%.
- The proportion who felt they did not have enough help fell from 20% to 3%.

Creating a network – referral pathways

It is important to note that, whether you introduce the Connector model in your community as an individual organization or as part of a collaborative, to be effective you will still need to design/implement a referral pathway(s).

The Hamilton Community Support Services (HCSS) website by CareDove is an online portal that linked people to health and community services for older adults in the Greater Hamilton Region. It provided information about not-for-profit and government services and enabled agencies to exchange referrals. In order to receive referrals, an organization had to pay a monthly subscription to CareDove, the website's parent company *(*please note that the subscription to CareDove ends December 31st. Other systems are being explored.).*

In the Hamilton collaborative, the Thrive Group, one of the partner organizations, was responsible for the CareDove referral system. Activities included:

- continually developing, maintaining and improving the CareDove referral system
- orienting and training HSIIP partners and other Hamilton agencies to use CareDove
- answer questions and provide ongoing implementation support for agencies subscribing to CareDove
- ensure Connectors were using CareDove appropriately and consistently

In working to establish the HCSS website, the collaborative listed 815 services from 127 organizations.

Staff/volunteer training and support

As expressed by one Connector:

"I can't believe the gaps in the system. They are missing many basic services in the home. They need food, transportation, medical assistance, a doctor or a dentist, eyeglasses….I thought the program would be about helping people get to the recreation centre, but that is not even the need for these people, it is basic necessities….It may take three months to stabilize the medical and mental health pieces, before starting to get any registrations done for the social piece'.

Recognizing these challenges as well as the fact that many isolated older adults were living with mental health and/or addiction problems, substandard housing, financial and food precarity, it seems clear that it is important to orient, train and provide ongoing support to all Connectors including Volunteer Peer Connectors.

YWCA Hamilton Volunteer Peer Connectors were supported through a 2-day comprehensive training prior to being matched with an isolated older adult. Once matched, the Peer Connectors received ongoing day to day support by the Community Coordinator who shared resources and planned and delivered professional development workshops on relevant topics such as Elder Abuse Training.

In the previous *'Challenges and Barriers'* section, mention was made of the need to develop increased expertise about mental health and addictions with community workers.

While it wasn't a component of the HSIIP project, please refer to Appendix C for one example of a two-day training program designed for those supporting individuals living with mental health challenges. There are other training opportunities that a community may want to consider. Suffice to say that it is important to both train and offer ongoing support to Connectors working with individuals living with mental health and addiction challenges.

Client stories

This section will profile a few of the clients with whom Connectors worked to provide the reader with a window into examples of Connector roles. The first story, Mrs. Y. describes the role of a **Hospital Connector.**

Mrs.Y is a 73-year-old widowed female who has been living in a one-bedroom apartment for the past 10 years. Previously, she reported living out of province with her late husband and said that, after his passing, she moved to Ontario to be closer to friends. Mrs. Y reports that her only child, a son, passed away 20 years ago, and her only family contact is her brother who lives two hours away. Mrs. Y reports feeling isolated and lonely as most of her friends have passed away.

Mrs. Y wishes to move back to Alberta to be closer to the remains of her late husband and son but states that, due to her unstable health, she is unable to travel. Mrs. Y was referred to the HSIIP from …….. where she attends the outpatient COPD clinic. Our Hospital Connector was able to meet Mrs. Y at home to complete a needs assessment and the following care connections were made:

- *Attended medical appointments for health concerns and to complete paperwork for transportation services and special supports funding for mobility devices.*
- *Completed applications for accessible transportation through DARTS (*Hamilton's parallel transit system) and Special Supports to apply for funding for repairs to an electric wheelchair.*
- *Provided information for grocery and meal delivery services and assisted client in setting up services.*
- *Provided support and information to Mrs. Y regarding care services and Long-Term Care. Advocated to the Local Health Integration Network (LHIN) for support services and eligibility for long term care. Arranged tours with long-term care homes and attended with client for support.*

Mrs. Y is continuing to live independently while she waits for admission into long- term care and she feels more connected to services. Mrs. Y continues to receive ongoing support through weekly telephone calls to ensure she is continuing to remain safe and connected to services.

Community Connector

Mrs. W. is a 68-year old woman introduced to a HSIIP Community Connector after her landlord called with concerns about her welfare. The Connector met with her and discovered she was isolated, and had no living family or friends. Mrs. W. was struggling with a physical disability that prevented her from washing and caring for herself. She was not receiving

medical or home care, had no ambulatory devices, and had very little furniture or food in her home. The Connector worked closely with Mrs. W. over a few months. In this time, the Connector secured a family doctor, connected her to services including home care, helped her to purchase a walker, and registered Mrs. W. for a subsidized transportation service for people with disabilities. They taught her how to use the booking system to access low-cost rides to appointments and linked her to a grocery program, which now regularly delivers groceries to her door for a small fee. In addition, the Connector advocated with Mrs. W. landlord to address a bug infestation in her apartment, and helped her to obtain some furniture. Mrs. W. is now surrounded by more of the supports and resources she needs to be active and well.

Hospital Connector

Mr. X is a 72-year-old Indigenous male that had been renting a hotel room for the past 15 years. Mr. X was admitted to hospital, severely deconditioned, after sustaining multiple injuries from a fall where he had spent 10 days laying in his bathroom tub. Unable to move or call for help, hotel staff became concerned when they had not seen Mr. X, and emergency services were called. Mr. X was referred by Social Work at St. Joseph's Hospital to assist with community referrals and alternative housing arrangements. Mr. X is extremely isolated and lives with mental health, due to trauma experienced as a residential school survivor. Mr. X is extremely fearful of government, medical and financial institutions, and had been living "off the grid" for many years. Mr. X did not have any identification and during investigation it was discovered that Mr., X's birth was never registered which had made him ineligible for OAS/GIS and government identification. Mr. X receives ODSP, and would cash his cheques at Money Mart, as he did not have a bank account. Our Hospital Connector was able to meet Mr. X in hospital to complete a needs assessment. The following care connections were made:

· Advocated and assisted Mr. X in obtaining a temporary Health Card through the local MPP's office.

· Provided housing intervention support, by making alternative arrangements for rental payments. Provided advocacy between Mr. X and hotel staff, to keep Mr. X's belongings safe, while Mr. X remains in hospital and until alternative housing arrangements can be made.

· Provided advocacy to Mr. X regarding ODSP and assisted Mr. X in obtaining a pre-paid debit card that ODSP will load monthly, so that Mr. X no longer has to cash his cheques at expensive money marts.

· Referred Mr. X to the Patient Navigator Program at the Aboriginal Health Centre, who is assisting Mr. X in obtaining his Birth Certificate and Indian Status Card.

· Provided support and information to Mr. X regarding services at Indigenous Affairs Canada.

Mr. X has made tremendous improvements in his health and social wellbeing, he has become more trusting with staff and support services. Mr. X is continuing to receive ongoing support during the process of obtaining identification and his Indian status. Once obtained, Mr. X will be provided assistance in applying for OAS/GIS, as well as alternative housing arrangements.

Volunteer Peer Connector

Joe is a 57-year old man who was somewhat new to the community after moving here a couple of years ago. He was not connected to support services and was not aware of what support services were available in the community. Most of his family and friends lived in a town a few hours away. During Joe's intake process he stated that he felt isolated all the time and left his house only a few times a month.

Joe had limited access to transportation in the community which prevented him from going out. He had difficulty leaving the house independently. He does not drive and also experiences learning challenges such as difficulty understanding instructions and is unable to read and write.

When the Community Coordinator of the YWCA first met with Joe and his family, they discussed the barriers he faces because he is unable to read and write. His family described to staff that he enjoys cooking and can identify food items in the kitchen easily even though he is unable to read the actual labels. The Community Coordinator mentioned she thought he would be great at volunteering in a foodbank. Joe and his family actually said they never considered that as something he could do in the community. He then wanted to pursue this option. Staff assisted Joe in connecting with a local foodbank where he could volunteer. Staff accompanied the client to meetings with the foodbank administrator and assisted with filling out forms. Staff also accompanied him on his first day volunteering at the foodbank. It was a great day. Staff provided ongoing support on how to use Accessible Transportation Services since he wanted to use this service to get to the foodbank every week. Staff assisted him with making phone calls to book rides, showed him how to book regular scheduled rides every week and also rode to the foodbank with him a few times in DARTS as support. The client now goes to the foodbank and other places in the community independently without the assistance of staff.

YWCA then matched Joe with a Peer Connector volunteer who provided weekly visits for 2-3 hours. Joe was very interested in getting back into hiking and walking but did not want to do this activity on his own. The Peer Connector Volunteer took Joe to a new place for a hike or a walk every week, even in the winter time, and Joe said he was much more motivated to continue doing this activity after having the support of the Peer Connector. The Peer Connector also encouraged Joe to participate in more community activities such as day trips and supported him with making phone calls to reserve spots and get information on these outings. The Peer Connector still stays in touch regularly with Joie and coincidentally, the Peer Connector Volunteer also has family and friends in the small town that the client is originally from where his family and friends live. When the Peer Connector Volunteer is driving out that way, he offers to drive Joe as well so he can visit his parents.

Joe was a client in the program for 9 months and received 8 hours of support from the Community Coordinator, 70 hours of Peer Connector Volunteer support through weekly visits and was connected to 5 new supports and services through his participation in the program.

Hospital Connector

Mr. X is a 67-year-old single male, that reports living in a bachelor apartment for the past 15 yrs. Mr. X identifies as a Christian Iraqi refugee and a former prisoner of war. Mr. X

lives with significant mental health issues due to PTSD and has a rare genetic disorder that affects his nervous system, requiring the use of a motorize wheelchair for mobility. Mr. X reports having no family or friends and prefers to live in seclusion due to his health and mobility. Despite all of Mr. X`s challenges Mr. X reports lives independently alone in the community with the support of daily PSW`s for ADL`s. Mr. X was referred to HSIIP during his stay in hospital after receiving treatment for pressure ulcers. Mr. X was met in hospital several times by the Hospital Connector, who worked with Mr. X to coordinate services upon discharge. Mr. X was assisted by the Hospital Connector during his discharge and continued to be followed in the community. The following care connections were made:

- *Provided advocacy of tenant rights and referrals to legal aid and the landlord tenant board.*
- *Coordinated with public health and landlord: apartment repairs and pest control treatment for bedbugs prior to discharge.*
- *Assisted with the coordination of multiple repairs: repair of telephone line and assisted Mr. X in buying a new phone; repair of motorized wheelchair and delivery to Mr. X in hospital.*
- *Assisted with the coordination of personal support services, delivery of medical supplies, meal delivery services, grocery delivery, DARTS transportation and medical appointments.*
- *As per recommendation from hospital staff, provided information regarding alternative living arrangements and offered assistance to arrange and accompany Mr. X on tours.*
- *Advocated for LHIN care coordination and Social Work to assess risks of living arrangements.*
- *Provided daily telephone check-in`s during the initial week after discharge and continued with weekly visits to ensure on-going delivery of services.*

Mr. X continues to live independently and is receiving ongoing support from a Social Worker through the LHIN to pursue alternative living arrangements. Mr. X continues to receive biweekly visits from the care connector to ensure he is continuing to remain safe and connected to services.

Top 10 Tips for Launching the Connector Model in Your Community

All Steering Committee members and Connectors were invited to submit their top tips for introducing a Connector model in other communities. Based on their experience, they had lots of great ideas. What follows below is the best of the best!

1. Plan, plan and plan! Start with as complete a plan as possible for your referral pathway and client data collection. It is much easier to have all the necessary information at your fingertips later on if you collect it from the outset. You can't access and use information you don't have!

2. Once you decide on your target population, conduct an environmental scan to pull together a comprehensive list of community resources so that the Connectors can easily identify supports to meet the needs of the older adults you are serving.

3. Take the time to really listen to each older adult. What the referring agency thinks the clients needs may not always reflect what the older adults wants and needs.

4. Talk to everyone about the Connector program! Doctors in hospitals and family practices, bank tellers, social workers, pharmacists, building superintendents – talk with people in apartment lobbies and even elevators! Raise awareness outside of the traditional service system to identify older adults who may need support.

5. In a collaborative model, respect, utilize and build on the unique contributions that each partnering organization brings to the table. Together you are more.

6. Recognize that you will very likely meet older adults who have unmet basic needs and poorly managed health conditions. Build in extra time to provide support in these areas and to build trust before focusing on social engagement.

7. It is recommended that you have a mental health worker on the team or, at least, easy access to someone with this expertise.

8. Partnerships are key. Your success is very much dependent on the connections you make and the relationships you develop with other organizations. To the extent you can, get rid of silos and a fragmented approach.

9. One size does not fit all. While social isolation may represent a common problem, every individual is unique and requires supports that work for him/her. Build the relationship until the individual feels comfortable and ready to participate in activities. Help them to build confidence so that their progress can be sustained. All of this takes time but it is an investment in the individual's success.

10. If you are working with partner organizations, you need to allow a ramp up period of up to 6 months to share information about the program. Don't expect referrals on day one. You will need a well-developed marketing plan.

Appendices

Appendix A: risk factors for social isolation

The following risk factors are documented in a 2017 National Seniors Council publication titled *'Who's at risk and what can be done about it? A review of the literature on the social isolation of different groups of seniors*.' For the purposes of these guidelines, the General Risk Factors section has been copied verbatim. For additional information, please refer to the Council's website.

https://www.canada.ca/en/national-seniors-council.html

"Age and gender: being 80 or older; being a woman (since women, on average, live longer).

Ethnicity: being an immigrant (specifically, having a different cultural and linguistic background from the general Canadian population or community in which you live); being from an official language minority community.

Geography: living in a rural or remote area where service provision and distance between individuals and families is less proximate; living in a deprived neighbourhood; living in a community where there has been a loss of community or neighbourhood values; living in a low-density neighbourhood.

Health and disability: having health issues (mental and/or physical) including having multiple chronic health problems (e.g., vision, hearing, incontinence, speech/cognitive impairment); lifelong health problems or late-onset or age-related condition such as incontinence; mental illness (e.g., dementia, depression); stigma associated with mental illness, poor health or a disability; low access to health care; minimal walking time; poor perception of one's own health.

Knowledge and awareness: challenges relating to technology (costs, literacy, comfort); lack of information on services; lack of awareness or access to community services and programs

Life transitions: loss of a spouse; loss of sense of community; disruption of social networks; lack of family and friend supports; loss or restriction of drivers' license; entry into care; care-giving and associated factors (intensity of care-giving, low levels of care satisfaction, inability to leave the care recipient alone); divorce; living in a nursing home.

Poverty and lack of access to resources: lack of affordable housing and care options; living with low income; lacking access to transportation (no license or public bus system); financial dependence; living in a deprived neighbourhood (also considered a geography factor).

Sexual and gender identity: being lesbian, gay, bisexual or transgendered (LGBT); history of discrimination; having a weak primary social network; lack of social recognition; discrimination in the health-care system; fear of coming out in older age.

Social relationships: low quality of relationships; having no children or contact with family; living alone (greater likelihood among women, gay men and lesbians); not being married or common-lawed; loss of friends and social network; experiencing ageism."

In addition, the HSIIP project encourages readers to be aware of the following broader societal trends and their implications for potentially contributing to social isolation.

- A growing, aging population. The 2016 Canadian census documented more centenarians (age 100+) that ever before and the fastest growing age group is 85+. While one can experience social isolation at any age, the risk factors increase with age.
- A growing number of people live alone.
- Families are more geographically dispersed.
- People don't always know their neighbours. As a side note, from August – November 2019, the Hamilton project piloted a multigenerational model titled 'Do You Know Your Neighbour?'. For information about the model and downloadable tools, please refer to the Hamilton Council on Aging website. https://coahamilton.ca/
- Social exclusion of marginalized groups.
- Neighbourhoods that are inaccessible or unsafe. A growing group of older adults in Hamilton identified fear of crime and safety for their reluctance to leave their homes. That choice to stay in can result in social isolation.
- Stigma surrounding isolation.
- Lack of capacity in the community to provide support.

Appendix B: Steering Committee Terms of Reference

Hamilton Seniors Isolation Impact Plan

Steering Committee - Terms of Reference

1. Background

The Hamilton Seniors Isolation Impact Plan (HSIIP) is a collaborative effort to build our community's capacity to identify and connect isolated seniors in Hamilton. It originated in response to a recognized need in the community, and funding provided through the Government of Canada's New Horizons for Seniors program. HSIIP partners believe that long-term commitment and collective action are essential to develop community-driven solutions that can impact this complex issue.

HSIIP is guided by an overarching Population Impact Plan (PIP) that contains shared outcomes for reducing social isolation among seniors in Hamilton. Progress is driven by seven mutually reinforcing agency-level projects. These are led by AbleLiving, Gilbrea Centre for Studies on Aging, Hamilton Council on Aging, St. Joseph's Home Care, Thrive Group, Wesley Urban Ministries, and YWCA Hamilton. HSIIP also seeks to involve other key partners in the community, to strengthen the service system as a whole.

2. Shared Goals & Outcomes

Four Population Level Goals
Increase the proportion of isolated seniors in Hamilton that:
- Have support and help when they need it by 20%.
- Participate regularly in activities by 10%.
- Feel connected to family, friends and acquaintances by 20%.
- Feel valued by family, friends and acquaintances by 10%.

Seven Project Level Outcomes
- Build a supportive collaborative and mobilize public will.
- Understand social isolation and facilitate community response.
- Identify isolated seniors.
- Connect seniors with community.
- Improve and coordinate current supports.
- Evaluate and scale what works.

3. Governance Structure

- **Steering Committee**

Each funded agency appoints one Project Leader and one Designated Alternate to represent their respective projects at a Steering Committee. This group is accountable for the success of HSIIP goals and outcomes. Roles of the Steering Committee include working with the Backbone; managing governance and decision-making; ensuring alignment of activities; refining the common agenda; tracking progress using agreed upon indicators; managing collaboration and communication; and ensuring proper grant compliance and reporting.

- **Seniors Inclusion Coalition**

The Seniors Inclusion Coalition is comprised of HSIIP partners, other leaders in the community that serve seniors, and seniors with lived experience. Roles of the Coalition coordinating and improving supports for isolated seniors; identifying challenges and opportunities; recommending ways to improve practice and outreach; and taking collective action.

- **Outreach Team**

The Outreach Team is comprised of HSIIP Connectors and Backbone Staff. The roles of the Team include reporting on activities and outcomes; problem solving; sharing lessons learned about working with isolated seniors; and recommending ways to improve practice and outreach.

4. Steering Committee Membership

Each of the seven projects appoints a Project Lead. Project Leads make up the primary membership of the Steering Committee, in addition to the Project Manager of the Backbone. Each Project Lead may appoint a Designated Alternate to represent their project and make decisions in their absence.

5. Membership Expectations

Steering Committee members are responsible for the success of HSIIP. As such, they are expected to:

- Adopt, support and align with the Population Impact Plan;
- Collaborate and break down silos to achieve shared outcomes;
- Participate in-person in regularly scheduled meetings (quarterly);
- Review materials prior to meetings and come prepared for engaged discussion and listening;
- Communicate regularly through email and BaseCamp;
- Track and share necessary data (based on agreed upon indicators);
- Use data to inform strategy and practice; and
- Serve as a vocal champion of the initiative in the community.

Although Project Leads should try to operate in the best interest of the group, they are not required to do anything that prevents them from upholding their funding agreements with the Government of Canada.

6. Chair

The Project Manager of the Backbone will chair meetings of the Steering Committee.

7. Meeting Frequency

The Steering Committee will meet in-person quarterly in March, June, September and December. These meetings will take place on the first Thursday of the month, from 1:30-

3:30PM. The Steering Committee will meet by phone quarterly in January, April, July and October. This will also occur on the first Thursday, from 1:30 to 2:30 PM.

8. Agenda & Minutes

Agendas will be distributed one week in advance of meetings. Project leaders may contact the Chair prior to this to request that items be added to the agenda. Minutes will be recorded at Steering Committee meetings and distributed within one week following meetings.

9. Quorum

A quorum of at least five Steering Committee members must be met in order to make decisions. If a Project Leader sends a Designated Alternate in their place, this individual will be empowered to make decisions and will count towards quorum.

10. Decision-Making

The Steering Committee will attempt to make decisions using a consensus-based model. If consensus cannot be reached the process will revert to a simple majority vote.

- **First round of consensus:** An issue is discussed and a recommendation is made. Everyone is given opportunity for input. The Chair then repeats the recommendation and asks if the group has reached consensus. If everyone raises their hand the recommendation is approved. However, members may also choose to:
  - Express reservations or abstain (this is noted, but doesn't block consensus); or
  - Block the decision (consensus isn't reached).

- **Second round of consensus:** In the event that a decision is blocked in the first round of consensus, the discussion is re-opened. A revised recommendation is made or the previous one is posed again. Another attempt is made to reach consensus using the same process.

- **Reverting to a vote:** If consensus still cannot be reached after the second attempt, the decision-making process reverts to a simple majority vote. Each Project Leader has one vote. In the event that six Project Leaders are present and the vote is split evenly, that decision will be postponed until the absent member has an opportunity to vote by email.

- **Decisions between meetings:** In the event that a decision must be made between meetings, the Leads will discuss an issue by email. A period of one day will be given to provide opportunity for input. The Chair will then pose a simple majority vote by email. At least five of the seven leads must participate in the vote for a decision to pass.

11. Conflict of Interest

A conflict of interest is defined as something that causes either a negative or positive financial or other significant impact for the organization or the individual. When a Steering Committee member thinks they may have a conflict of interest in the discussion at hand, they must make the group aware of this and give them the opportunity to discuss privately whether a conflict does exist. If there is a conflict, the member must refrain from decision-making in regards to that matter.

Appendix C: Mental Health First Aid Seniors

MENTAL HEALTH FIRST AID SENIORS

Supporting the mental health of *Canada's aging population*

Mental Health First Aid Seniors trains participants to effectively respond to an emerging mental health problem or crisis, until the situation is resolved or appropriate treatment is found.

A recent study of residential facilities revealed 31% of residents showed signs of depression. 10 seniors(60+) die by suicide every week in Canada. Adults 65 years and over with mental health problems and illnesses can account for as many as one-quarter of emergency department visits

- **Recognize the symptoms of mental health problems or crises as they develop**
- **Provide initial help when dealing with a mental health problem or crisis**
- **Guide a senior and/or caregiver toward appropriate professional help**
- **Provide strategies and resources to support both seniors and their caregivers.**

"[Mental Health First Aid Seniors] was a real eye-opener for me. I learned so much. I will now have a more open view on what a substance-related disorder could be." Course participant

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Service providers and informal caregivers, including:

- **Spouse/partner**
- **Family members**
- **Friends and neighbours**

TOPICS COVERED

- Seniors
- Anxiety and trauma-related disorders
- Mental Health First Aid
- Dementia
- Substance-related disorders
- Delirium
- Psychosis
- Mood-related disorders

Mental Health Commission de

CRISIS FIRST AID INTERVENTIONS FOR

- Substance overdose
- Acute stress reaction
- Suicidal behaviour
- Psychotic episode
- Delirium
- Panic attack

To learn more, register, host a course or become an instructor:

- mhfa@mentalhealthcommission.ca
- 1-866-989-3985
- www.mhfa.ca

Mental Health First Aid Canada is a program of the Mental Health Commission of Canada (MHCC). The MHCC collaborates with hundreds of partners to change the attitudes of Canadians toward mental health problems and to improve services and support. Over 200,000 people in Canada have trained in MHFA.

Commission of Canada la santé mentale du Canada

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info@mentalhealthcommission.ca • www.mentalhealthcommission.ca
@MHCC_ /theMHCC /1MHCC @theMHCC /Mental Health Commission of Canada

Mental Health First Aid Canada

To learn more about the MHCC: www.mentalhealthcommission.ca

Appendix D: sample forms

The following section contains samples of a number of forms used throughout the HSIIP project. In some cases, identifying information has been removed. The forms may prompt ideas about what information you would like to collect in your community. Please adapt according to your unique needs.

i. This first form is a **referral form** used by one of the Hospital Connectors.

Referring Community Contact	
Contact:	Tel:
Agency:	

Client Information			
LN:	FN:		☐ M, ☐ F, ☐ X
OHIP#:		DOB: M | D | YYYY	Age:
Home Address:		Unit #:	
City:	Postal:	Tel:	
Health Diagnosis:		Languages: English: ☐ Yes, ☐ No	

Support Contacts - Family/Medical/Community	
Family Doctor:	Tel:
LHIN Coord.:	Tel:
NOK/POA:	Tel:
NOK/POA:	Tel:
Community:	Tel:

Hospital Information & Discharge Plan	
Admission: M | D | YYYY	Bed Location:
Discharge: M | D | YYYY	Destination:
Please indicate the number of previous hospital admissions the patient has had in the past 3 years:	

Safety Issues that the connectors should be aware of?					
☐ Lives Alone	☐ Suspect Abuse	☐ Smoker	☐ Pets	☐ Home Infestations	☐ Infectious Diseases
If Yes, provide details:					

Goals of Referral		
☐ Info. Sharing/Caregiver Support	☐ Government Services/Financial	☐ Special Supports/Supplies
Other:		

When completed, please fax to: XXX-XXX-XXXX	
Completed by:	**Date:** MM / DD / YYYY

ii. **Intake survey**

Administrative Details	
Date (M/D/Y):	**Client Unique ID:**
Agency:	**Connector:**
Referral Source:	**Meets Eligibility?** ☐ Yes ☐ No
Emergency Contact (Name & Phone):	
Client Details	
Last Name:	**First Name:**
Date of Birth: MM/DD/YY	**Gender:** ☐M ☐F ☐ Other:
Postal Code:	**Phone Number:**
Marital Status: ☐ Married ☐ Common-Law ☐ Widowed ☐ Divorced or Separated ☐ Single - Never Married	
Primary Language: ☐ English ☐ French ☐ Other:	
Living Environment	

How many years have you lived in your neighbourhood? ☐ Under 1 year ☐ 1 to 5 years ☐ 5 to 10 years ☐ 10+ years
Do you feel safe in your neighbourhood? ☐ Always ☐ Usually ☐ Sometimes ☐ Never
Are you able to access the shops and services that you need? ☐ Yes ☐ No ☐ Somewhat
What type of housing do you live in? ☐ Detached Home ☐ Apartment ☐ Townhouse ☐ Condominium ☐Other
Who do you live with? ☐ Alone ☐ Spouse/Partner ☐ Family ☐ Friend ☐ Caregiver ☐ Other
Do you have any safety concerns in the home? ☐ Yes ☐ No If yes, please specify:

Physical Ability

Do you have a chronic condition or disability that limits your activity? ☐ Yes ☐ No	
Do you have a vision problem? ☐ Yes ☐ No	**Do you have a hearing problem?** ☐ Yes ☐ No

Social Connection

Are you taking care of another person who is unwell or requires support? ☐ Yes ☐ No

Do you have any living children? ☐ Yes ☐ No **If yes, how many?** _____

If you answered one or more, does at least one of them live close to you?

☐ Same home ☐ Same neighbourhood ☐ In Hamilton ☐ Within an hour's drive ☐ In Ontario ☐ None in Ontario

Do you have contact with any family members? ☐ Yes ☐ No

If yes, how often are you in contact with a family member?

☐ Daily ☐ 1-2 times per week ☐ 1-2 times per month ☐ Few times per year ☐ Less than once a year

Do you have contact with any friends? ☐ Yes ☐ No

If yes, how often are you in contact with a friend?

☐ Daily ☐ 1-2 times per week ☐ 1-2 times per month ☐ Few times per year ☐ Less than once a year

How often do you feel lonely? ☐ Never ☐ Sometimes ☐ Often ☐ Always

How often do you feel isolated from others? ☐ Never ☐ Sometimes ☐ Often ☐ Always

Do you have enough help with daily living activities?

☐ I have plenty of help ☐ I usually have help ☐ I sometimes have help ☐ I do not have enough help

Do you feel connected to family? ☐ Yes ☐ Somewhat ☐ No

Do you feel connected to friends? ☐ Yes ☐ Somewhat ☐ No

Do you have someone you can confide in? ☐ Yes ☐ No

Do you use a computer to access the internet? ☐ Yes ☐ No

How often do you participate in social or recreational activities with others?

☐ Daily ☐ 1-2 times per week ☐ 1-2 times per month ☐ Few times per year ☐ Less than once a year ☐ Never

Is there anything limiting you from participating in social or recreational activities with others? ☐ Yes ☐ No

If yes, please specify:

Are there any activities that you would like to do? ☐ Yes ☐ No

If yes, please specify:

Resources

Do you receive Guaranteed Income Supplement? ☐ Yes ☐ No | **Do you receive OW or ODSP?** ☐ Yes ☐ No

Do you currently access any community support services? ☐ Yes ☐ No

If yes, please specify:

Do you have any transportation difficulties? ☐ Yes ☐ No
If yes, please specify:

Do you have any housing difficulties? ☐ Yes ☐ No
If yes, please specify:

Comments

Suggested Referral Types

☐ Adult Day Program
☐ Alzheimer Services (First Link)
☐ Caregiver Support
☐ CCAC/Services/Case Management
☐ Client Intervention and Assistance
☐ Congregate Dining/Diners Club
☐ Friendly Visiting
☐ Government Services
☐ Grocery Services
☐ Health/Mental Health
☐ Home Help/Home Maintenance
☐ Information Sharing
☐ Meals Program
☐ Peer Support
☐ Reassurance Service/Security Checks
☐ Social Recreational Activities
☐ Supportive /Supported Housing
☐ Transportation
☐ Other *(Specify):*

Action Plan

iii. **Exit survey**

Administrative Details	
Date (M/D/Y):	**Client Unique ID:**
Agency:	**Connector:**
Client Details	
Last Name:	**First Name:**
Social Connection	
Do you have contact with any family members? ☐ Yes ☐ No **If yes, how often are you in contact with a family member?** ☐ Daily ☐ 1-2 times per week ☐ 1-2 times per month ☐ Few times per year ☐ Less than once a year	
Do you have contact with any friends? ☐ Yes ☐ No **If yes, how often are you in contact with a friend?** ☐ Daily ☐ 1-2 times per week ☐ 1-2 times per month ☐ Few times per year ☐ Less than once a year	
How often do you feel lonely? ☐ Never ☐ Sometimes ☐ Often ☐ Always	
How often do you feel isolated from others? ☐ Never ☐ Sometimes ☐ Often ☐ Always	
Do you have enough help with daily living activities? ☐ I have plenty of help ☐ I usually have help ☐ I sometimes have help ☐ I do not have enough help	
Do you feel connected to family? ☐ Yes ☐ Somewhat ☐ No	
Do you feel connected to friends? ☐ Yes ☐ Somewhat ☐ No	
Do you have someone you can confide in? ☐ Yes ☐ No	
How often do you participate in social or recreational activities with others? ☐ Daily ☐ 1-2 times per week ☐ 1-2 times per month ☐ Few times per year ☐ Less than once a year ☐ Never	

Program Impact

As a result of this program…

I have more help and support disagree	☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly
I participate more regularly in activities disagree	☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly
I'm more connected to services/activities disagree	☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly
I feel more connected to people disagree	☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly
I feel more valued by people disagree	☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly

Client Satisfaction

How would you rate the services you received? ☐ Excellent ☐ Good ☐ Ok ☐ Poor

How helpful was the program in connecting you to the community?
☐ Significantly helped ☐ Somewhat helped ☐ Did not help

Comments

iv. **My Community Connections**

Name:	**Date:**
Individuals involved in Plan Creation:	

I (Name)_____agree to participate in planning meetings and information sharing for my discharge from Hospital and in creation of “My Community Connections”. I understand that information may be shared as part of that planning that may include personal and health related information. All parties involved in creating this plan with me will treat my information as confidential and share only with those identified during the plan creation.

Signed: _____ Dated:_____

Information to be shared with: _____

_____

__

Community Connector:_____ PhoneNumber:_____

CCAC Care Coordinator:_____ Phone Number:_____

Hospital Discharge Specialist/Social Worker: _____Phone Number:_____

**In the space below add any resources and tasks identified in the Discharge Planning Meeting from pre-admission and continuing.

Family and Neighbourhood Resources	Funding Resources (Including private)	Community Support Services	CCAC Services/Plan

***In the table below complete agencies identified to contact, goals and referral info, follow up and date connections made.

Community Agency & Contact	Goal of Support Service	Follow Up Needed	Date Completed

v. **Community Connector client consent and care plan**

Client Name: _____ **Date:** _____

Individuals involved in Plan Creation: _____

I (client name), _____ agree to participate in planning meetings and information sharing for "My Community Connections". I understand that information may be shared as part of that planning, that may include personal and health related information. All parties involved in creating this plan with me will treat my information as confidential and share only with those identified during the plan creation.

Signed: _____ Dated: _____

Information will be shared with the following: _____

Community Connector: _____ Tel. #: _____

* Add any resources and tasks identified during the initial meeting.

My Resources are….	
Family/Friends Neighbourhood	
Funding (incl. private)	
Community Supports	
LHIN Services & Care Plans	
Other Supports:	

* Complete agencies identified to contact, goals and referral info, follow up and date connections made.

Community Agency & Contact	Goal of Support Service	Follow Up Needed	Date Completed

E: Sample job postings

vi. Job description, Community Coordinator – YWCA

ATTN APPLICANTS: Please include the **JOB CODE** in subject line of email to be considered.

JOB CODE	42-MSC-2016

JOB POSTING

JOB TITLE		**Community Coordinator, Seniors Isolation Project**	
REPORTS TO	**Manager, Health and Wellness**	**LOCATION**	**75 MacNab Street South**
DIVISION	**Seniors Programs**	**HOURS OF WORK**	**37.5 hrs per week.** Must be able to work various shifts of days, afternoons, evenings and weekends.
POSTING DATE	**September 13, 2016**	**START DATE**	**Immediately, 2016** (Contract end date April 30, 2019)

POSITION DESCRIPTION

YWCA Hamilton is dedicated to strengthening women's and girl's voices, broadening their choices, building dynamic leadership and providing essential services that promote safe, inclusive and equitable communities.

We offer a stimulating and challenging environment that values the diversity of individuals and ideas.

- Opportunity for professional development and growth
- Staff Fitness and Aquatic membership
- Staff discounts for childcare and recreation

Key Function Areas:

The Hamilton Seniors Isolation Project will measurably reduce the rates of seniors' social isolation amongst individuals facing barriers including: living alone, disability, poor health, language barriers and poverty. The Community Coordinator in the project will work in partnership with neighborhoods and partner organizations to identify isolated seniors and to improve and coordinate current access and supports.

QUALIFICATIONS

Minimum:

- Post-Secondary education in Social Work/Social services or related field
- Experience in project & community development
- Experience in community organization and/or outreach
- Experience working with seniors and individuals from diverse communities
- Strong knowledge of community resources available to seniors
- Experience with developing and facilitating training programs is an asset
- Excellent time management and organizational skills
- Excellent interpersonal skills that foster positive and professional working relationships, both internally and externally
- Must have excellent written and verbal communication skills
- Proficiency with MS Office Applications including but not limited to Word, Excel and Outlook
- Bilingual English/French or other languages an asset
- Must be able to work various shifts of days, afternoon, evenings & weekends and work at off site locations
- Working from a feminist, anti-oppressive /anti-racist perspective
- Must provide a current Vulnerable Sector Police Check or willingness to obtain at own cost
- Attend and participate in mandatory training such as but not limited to WHMIS, Non Violent Crisis Intervention Training (NVCI)
- Must have current Emergency First Aid/CPR Certificate or willingness to obtain one
- Must have a valid Class G Drivers' License and access to a vehicle with appropriate insurance

Please submit resume and covering letter by e-mail, mail or fax, to YWCA Hamilton.

CLOSING DATE:	**May 30, 2016**		
	jobs@ywcahamilton.org		75 MacNab Street South, Hamilton, ON L8P 3C1 Fax: 905-522-1870 **Attention: Human Resources**

As part of YWCA Hamilton's commitment to Access and Equity, we strive to represent the diverse communities that we serve. Individuals who are First Nations, Métis, immigrant, refugee, lesbian, gay, bisexual, transgendered; and individuals with disabilities and from racialized communities are encouraged to apply.

Attention Applicants:

Thank you for your interest in YWCA Hamilton.

Only those applicants selected for an interview will be contacted.

vii. **Community Connector Job Posting**

Number of Openings:	1	**Division:**	Community Support Services
Full/Part Time/Casual:	Full Time	**Program:**	CSS
Regular/Temporary:	Regular	**Location:**	Hamilton & Surrounding area
Union:	Non-Union	**Hours of Work:**	Mon-Fri, Variable hours
Posting Date:	April 20, 2016	**Closing Date:**	April 27, 2016

POSITION SUMMARY:

This position works in partnership with hospital discharge planning, social work, LHIN Home and Community teams and community support services to ensure that individuals who are identified with risk factors for isolation receive the support needed for a successful transition back into the community.
The position will support the patient by providing follow up and linking the patient with community resources identified in the planning process. The Community Care Connector will collaborate with community support service organizations and LHIN Home and Community to develop and maintain a process to ensure that relevant program and service information is up to date and available to patients in a consistent manner.

RESPONSIBILITIES:

- Participates in discharge planning with discharge team for complex patients transitioning to community.
- Attends family meetings to discuss goals for discharge and establish work plan.
- Links patient with community resources identified during discharge planning.
- Completes referral processes with client for community support services.
- Communicates regularly with client, care partners, Home and Community care coordinators and family.
- Continues to provide support to client until they are anchored into the community support service identified.
- Attends medical appointments with clients as required.
- Maintains client files for each client receiving service. Collect program data and prepare reports as required.
- Attends Stewardship Table with all Hamilton Seniors Isolation Population community planning tables to provide information on client services as required.
- Collaborates with the client and other members of the interdisciplinary team to develop, evaluate and modify plan of care to achieve identified client goals.
- Maintains an effective working relationship with all internal and external partners.

QUALIFICATIONS:

- University Degree in Health or Social Sciences field and/or relevant College Diploma
  such as a Social Service Worker Diploma
- Professional Designation is an asset.
- 1-2 years of experience working in the Community Support sector
- Experience working with seniors, and extensive knowledge of the local health care system
- Must possess strong organizational and planning abilities.
- Strong communication skills both verbal and written.
- Proven ability to pay close attention to detail.
- Proven ability to maintain a positive and professional attitude.
- Proven ability to solve frequent and complex problems.
- Proven ability in utilizing MS office software including excel spreadsheets.
- Knowledge of Community Supports, and MOHLTC funded programs, included Assisted Living for High Risk Seniors.
- Valid driver's license and access to a reliable vehicle for work purposes.
- Original and current (within 6 months) Police Check Report with Vulnerable Sector Screening.
- Demonstrates the following competencies: Service and Mission Focus, Achievement, Teamwork, Learning and Innovation, Communication, Conflict Resolution and Resilience.

Please submit resume with cover letter to careers@logo.ca

viii. **Wesley job posting**

Wesley job posting

Job Title: Senior's Outreach Worker
Program: Newcomer, Community and Residential Services
Status: Union, 35 hours/week
Job Posting #: 2093
Posting Date: October 25th, 2019
Posting Closing: November 15, 2019
Location: various
Reports to: Manger, Newcomer, Community and Residential Services
Purpose: The Senior's Outreach Program is delivered in various locations to serve some of the most marginalized and vulnerable seniors in our community. This program focuses on supporting older adults to "age in place" and reducing social isolation by: developing skills that support community participation and engagement; increasing access to information about community services; organizing events/activities that support social inclusion; and offering workshops that promote active and healthy living
Duties:

1. 1. Plan, organize and implement a monthly calendar of educational and recreational activities aimed at engaging marginalized or vulnerable seniors within the greater Hamilton area with a particular focus on seniors living in CityHousing buildings
2. 2. Foster an environment that encourages and supports community participation and engagement
3. 3. Build relationships with local service providers, social service agencies, community health/recreation centres etc. who offer free or inexpensive educational and recreational activities
4. 4. Where appropriate, plan and facilitate or co-facilitate programs and workshops
5. 5. Provide clients with information, make referrals and empower them to access local community agencies that can provide more intensive support based on their needs
6. 6. Work in partnership with City of Hamilton staff to ensure the monthly calendar of activities meets the needs of seniors living in CityHousing buildings
7. 7. Build relationships throughout the community to ensure high levels of participation in planned activities with a focus on engaging unique participants
8. 8. Attend and participate in community meetings focused on engaging vulnerable seniors
9. 9. Complete monthly statistical reports for program, contribute to annual reporting and support ongoing proposal submissions

10.10. Other duties as assigned.

Qualifications:
1. Preference given to individuals with post-secondary education in the field of gerontology. Other disciplines related to addressing the needs of older adults will be

considered on a secondary basis, along with years of experience working with population

2. At least two years' experience in social services, working with seniors

3. Experience designing and delivering community programming preferably for Seniors

4. Experience working collaboratively with a variety of community partners to deliver services

5. Strong understanding of support services in the community, specifically those related to seniors

6. Ability to build strong community partnerships through outreach and networking

7. Well-developed problem solving and critical thinking skills.

8. Strong interpersonal skills including active listening, building rapport with clients etc.

9. Good written and oral communications skills and strong computer literacy

10. Ability to work independently

11. First Aid/CPR and NVCI training is required

12. Driver's license an asset.

Competencies
Customer Service

1. Builds constructive relationships characterized by a high level of acceptance, cooperation and mutual respect

2. Helps to create and contributes to a work environment that embraces and appreciates diversity

3. Values and respects the internal and external customers to the organization

Accountability

1. Takes personal responsibility for the quality and timeliness of their work, and team work

2. Believes, respects and adheres to the vision, mission and values of Wesley Urban Ministries

Commitment

1. Demonstrates an understanding of Wesley's, Vision and Values through service delivery approach

2. Acts with integrity

3. Demonstrates a knowledge of the code of ethics of working in social services

4. Adapts to changing program requirements, conditions and work responsibilities

Please Apply Via: **Our Wesley Breezy Portal**:

1. 1. Click on this link: https://wesley.breezy.hr/
2. 2. Press the employee tab – top right of the page
3. 3. Please sign in with your Wesley email
4. 4. Breezy will send you a sign in confirmation email
5. 5. From there you can access all of Wesley's internal job postings

Wesley is an equal opportunity employer. We encourage applications from all qualified applicants. Only candidates selected for an interview will be contacted. No phone calls please. More information about Wesley can be found on our website at www.wesley.ca.