Reducing Seniors Isolation in Hamilton, Ontario

Evaluation Report:
May 2016 - March 2019

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Executive Summary

Since May 2016, with support from the Government of Canada's New Horizons for Seniors Program, seven organizations in Hamilton collaborated to deliver innovative projects that addressed seniors' isolation in Hamilton, Ontario. The overall objective was to measurably reduce rates of seniors' isolation in the population and to build our community's capacity to identify, reach and connect isolated seniors and to prevent isolation in future. The partners of the Hamilton Seniors Isolation Impact Plan (HSIIP) shared six project objectives: build a collaborative; identify isolated seniors; connect isolated seniors; improve and coordinate supports; understand isolation and facilitate response; and evaluate and scale what works. Guided by the Collective Impact Model for sustained community development and change, four overall population level goals were targeted: 20% of isolated seniors in Hamilton will have improved access to help and support; 10% will participate more regularly in activities; 20% will feel more connected to people; and 10% will feel more valued by people. Achieving these outcomes was challenging; Connectors encountered many unmet basic needs and unmanaged health conditions, and the process of anchoring seniors was more time intensive than anticipated.

Overall Achievements

Identify and Connect Isolated Seniors:

- The HSIIP Collaborative received in excess of 1875 referral contacts through extensive outreach and the establishment of a broad network of relationships. Key needs identified included transportation, primary care health services and supports in the home, meals programs, home help/maintenance services, access to financial entitlements, and other services to meet basic needs.
- Over 1556 isolated seniors were served with an additional 390 family members and/or friends indirectly benefiting from supports. Therefore, as its first population level outcome, the HSIIP reached 13.7% of isolated seniors in Hamilton or about 70% of target. This was felt to be a very positive outcome considering the challenges of establishing new programs, identifying isolated seniors in the population, facing issues around program accessibility in the community, augmenting existing referral networks and case complexity. Overall the HSIIP Collaborative determined that over 90% of the clients served were significantly connected to services through the HSIIP project.
- The HSIIP Collaborative met three other important population level outcomes:
    - 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 are more connected to people achieving 48% of our population goal.
- The HSIIP Collaborative was delighted to learn of significant improvements at the client level based on exit survey results:
    - 92% of seniors feel they have more help and support.
    - 90% of seniors feel they are more connected to services.
    - 69% feel they are more connected to people.
    - The majority of seniors (73%) found the program very helpful and 26% felt it helped somewhat.

- Over 98% gave the program an excellent rating.
- Our pre and post survey showed very positive improvements for isolated seniors such as reduced levels of self-reported loneliness; reduced levels of self-reported isolation; improved connections to friends and family; improved access to help; and improved levels of participation.

Build a Collaborative

The seven HSIIP partners formed a Steering Committee comprised of project leaders with staff support from the Backbone organization (Hamilton Council on Aging). The Steering Committee met monthly to share information, opportunities and to resolve issues. In addition, an Outreach Team was established for those in direct program delivery. The Collaborative was guided by the Collective Impact model (see Section 1.2) whose key attributes include a common agenda and objectives; a shared measurement system; mutually supportive activities; consistent and open communication; and backbone support. As evident in annual surveys, the Steering Committee was very pleased with the process and structure. Staff teamwork across the projects was a success. The Health of the Collaborative Survey revealed the following:

- Partners share a common sense of purpose;
- The Collaborative is making a meaningful difference in addressing isolation;
- The Collaborative promotes shared learning and adopts approaches accordingly;
- The Collaborative's governance structure is serving it well;
- The Collaborative's internal communication systems are serving it well;
- Decision-making processes encourage members to contribute and collaborate; and
- Partners are creating new knowledge and insights together.

As noted by one respondent, "*It was a pleasure being part of a group of agencies that reached so many vulnerable adults and seniors in a cost-effective and collaborative manner!*".

Together with the Outreach Committee, over 244 presentations were given in the community across the partnership; over 228 external agencies and programs were reached over the three-year period; and over 14,000 information brochures were distributed.

Improve & Coordinate Supports

The Hamilton Community Support Services platform website was launched to share information about services and to enable the exchange of referrals. Over 40 training sessions were delivered in the community. While the diffusion and uptake of the technology in the early stages was a challenge, at the end of the third year 27 organizations had signed on reflecting 144 user accounts. A total of 525 referrals had come through the system. Thirty-one peer support volunteers had been trained by the YWCA Hamilton, and 73 isolated seniors were successfully matched to a peer volunteer. Through events/activities and direct support, the YWCA as served well over 400 seniors over the three years. The Collaborative was also supported by the Social Participation Fund, a grant received from the Retired Teachers of Ontario in the amount of $50,000. The fund helped seniors to access goods, services and activities to help reduce their social isolation.

Understand Isolation & Facilitate Response

Through the Gilbrea Centre for Studies in Aging (Section 7.2), the HSIIP Collaborative conducted research with organizational stakeholders and isolated seniors and developed a variety of knowledge translation materials. Educational materials have been successfully deployed to train the Collaborative and produce content for outreach activities. At the end of three years the Centre reported over 5,000 web site users and over 15,000 web page views. Total downloads of research and information items totalled over 1,300. Focus groups with 65 stakeholders and isolated seniors reaffirmed strategies to reduce risk factors for social isolation:

- Safe and affordable housing options with proximity to social and practical supports.
- Improved transportation service in rural areas.
- Improved accessibility of programs, services and public spaces.
- Sustainable funding for community programs such as the Connector Program that focus on addressing barriers to social engagement.

Hamilton stakeholders identified a few key strategies for reducing seniors' isolation:

- Improve outreach strategies to identify and engage socially isolated seniors.
- Provide time and resources to address basic life needs of the most vulnerable seniors.
- Provide sustainable funding for programs and services that address social isolation among seniors.
- Improve coordination of social support services for at-risk seniors.

Evaluate & Scale What Works

The HCOA as the backbone organization collaborated with partners to design and implement data collection tools. Client surveys and databases produced robust data about the target population and the impacts of HSIIP Connector services. Indicators submitted by each partner agency were tracked. Interviews and focus groups were conducted that provided rich qualitative insights. Focus groups with Connector services identified some of the key roles the connectors played in the system. These roles included advocacy, collaboration, creative problem solving, flexibility, person-centeredness, resiliency, and system navigation. Focus groups with key stakeholders identified key system impacts of the HSIIP project:

- Effective hospital discharge outcomes and improved transitions to the community with supports.
- Flexible, responsive and personal referral pathway.
- Crisis intervention, crisis support and ED avoidance.
- Effective resource supporting stabilized housing and independence in the community.

The HSIIP Connector services improved and coordinated supports for isolated seniors by acting as advocates, being flexible, spending the time, and building referral networks in the community. In so doing they also increased capacity within the system by working alongside other agencies, improving wait list management and coordinating services in an integrated way (the right service at the right time in the right place). Connectors operated outside of the traditional mold, increasing collaboration among providers and addressing gaps in the service system by taking on clients and tasks that others did not have capacity for. A literature review (Section 6.4) supports the notion that system navigation prevents over use of the health care system

and encourages proper use of health care for preventive services. Older adults who have social supports are more likely to use the healthcare system more effectively (those who are isolated tend to have less effective access). Therefore, isolated seniors who have a healthy social network helps them to utilize appropriate health and social services.

Lessons Learned

The population of seniors who are isolated and lacking supports is growing steadily. These seniors have been falling through the cracks of the current system and need help to access services. The consequences of not intervening are expensive; unmet needs lead to preventable declines in health and functional capacity, increasing the number of isolated seniors who will require access to emergency and acute care in the future. Addressing isolation is an effective preventative measure that requires upstream investment in innovative and collaborative solutions. The HSIIP Collaborative came close to reaching 20% of isolated seniors in Hamilton. Many lives have been positively impacted as evident in the data and in client success stories. As important, through the diligent efforts of our Collaborative partners, the profile and awareness of social isolation among seniors is now high in Hamilton. More community members are educated about risk factors and more organizations are now in the habit of identifying isolated seniors – it is appropriate now to build on this momentum. The hard part has been done.

The partners faced several challenges. It took time to raise awareness, cultivate relationships, and understand the challenges and success factors involved in connecting isolated seniors. We offer a few suggestions for those contemplating similar projects relating to seniors' isolation in Canada:

- Incorporate more front-end lead time (3-4 months) prior to working with seniors to establish the necessary community service partnerships, program awareness, program referral mechanisms, staffing needs, etc.
- Isolated seniors are difficult to identify. Community workers need to establish trust to begin to understand client issues. As well, more innovative outreach approaches are needed to help to identify isolated seniors (e.g., co-locating outreach workers in City Housing, partnering with postal and EMS community workers).
- Rural areas are often challenged with inadequate transportation. Future models should combine outreach services with dedicated transportation.
- Connectors identified many isolated seniors with complex and unmet basic needs. Significant time was spent working with seniors (often at the expense of reaching utilization targets), to access and coordinate a wide range of supports. Once the basic needs were resolved, then some of the social activities could be addressed. Working with other organizations and developing agreements beforehand would help to better integrate services for the most complex clients.
- Expertise among community workers in mental health and addictions is recommended
- Often seniors are unaware of their financial entitlements - working with them in completing applications for them to receive financial support helps promote independence.
- For knowledge mobilization to be successful more lead time and resources would be required for maintaining a web site, as well as the logistics and potential delays in obtaining ethics approval. Generally, the overall amount of resources and time involved with knowledge translation and exchange can be underestimated.
- To support evaluation, careful planning is required to identify and streamline data needs and automated systems to support data collection.

- To alleviate some of the most time-consuming activities for community workers (e.g., accompaniment to appointments), hiring a personal support worker for these activities would alleviate considerable time to enable more clients to be served.

In closing, the HCOA as the backbone project lead catalyzed the development of a Seniors At-Risk Community Collaborative (SARCC). The SARCC was developed to address systemic issues and barriers for seniors at risk in Hamilton. It has taken a leadership role in this new collaboration as a successful way to raise the profile of isolation and engage a broader group of stakeholders. As we discussed earlier the “hard part is done”. We as a community are in a good position to keep the momentum going. Hospitals, for example, with high levels of alternate level of care (i.e. ALC) have come to rely on our program. They have shared many examples of improved transitions to community and more effective discharging (i.e., with adequate supports). The cost effectiveness of the program has been demonstrated and therefore makes a strong case for sustainability.

1. Introduction

People 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. Although there is a lot of stigma surrounding isolation, it is surprisingly common in older age. The National Seniors Council has estimated that up to 16% of people aged 65 plus experience isolation, or nearly 950,000 seniors across the country (Statistics Canada, 2017). Isolation becomes even more prevalent as age increases; it tends to deepen over time because the longer we live, the more chance there is for the risk factors to stack up.

The rapidly aging population is one reason why this issue has become more prevalent. For example, in the City of Hamilton between 2006 and 2016 the proportion of population aged 65 plus increased from 14.9% to 17.3%; the number aged 65 plus increased from 75,400 to 92,910; and the number aged 65 plus living alone increased from 19,815 to 23,135 (Statistics Canada, 2014 & 2018).

The impacts of isolation are profound. In addition to the strong effects it can have on emotional wellbeing, it 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 (see literature review in Appendix 1).

The forces giving rise to this issue are not going away any time soon and acting to improve the health and resiliency of isolated seniors makes sense ethically and financially. Moving the needle on isolation requires upstream investment in collaborative and innovative solutions. In 2016, the Government of Canada put forth a call for proposals through the New Horizons for Seniors Program to form collaboratives that would reduce isolation in cities across Canada. This gave rise to the Hamilton Seniors Isolation Impact Plan (HSIIP), a team of seven organizations funded to reduce isolation in Greater Hamilton between May 2016 and April 2019.
The HSIIP partners and projects included:

- **AbleLiving – Hospital Connector Project**. Hospital Connectors are staff who help isolated seniors being discharged from a hospital to transition back home successfully with supports. They assess needs and opportunities, create a care plan, and follow up to ensure seniors get connected.

- **Gilbrea Centre for Studies in Aging – Research Project**. Researchers work alongside various stakeholder groups to better understand social isolation in Hamilton and to share knowledge that improves project outcomes, informs policies, and affects public attitudes.

- **Hamilton Council on Aging – Backbone Project**. The Backbone role supports collaboration by coordinating meetings and activities, offering guidance, developing shared tools, overseeing evaluation, sharing information, promoting HSIIP, and developing partnerships in the community.

- **St. Joseph's Home Care – Hospital Connector Project**. Hospital Connectors are staff who help isolated seniors being discharged from a hospital to transition back home successfully with supports. They assess needs and opportunities, create a care plan, and follow up to ensure seniors get connected.

- **Thrive Group – CareDove Project**. The Hamilton Community Support Services website by CareDove is an online portal that links people to health and community services for seniors in the

Greater Hamilton region. It provides information about services and enables agencies to exchange referrals.

- **Wesley – Community Connector Project**. Community Connectors are staff who seek out and engage isolated seniors throughout Greater Hamilton. They assess needs and opportunities, create a care plan, and follow up to ensure seniors get connected. They also organize social outings.

- **YWCA Hamilton – Peer Connector Project**. Peer Connectors are volunteers aged 55 plus that get matched to isolated seniors for friendly home visits and can accompany seniors to activities. Staff of the project also help to connect isolated seniors to supports in the community.

A steering committee for the collaborative, comprised of leaders of each underlying project, met monthly to share information across the projects, identify opportunities and resolve issues. The individual project staff also met monthly as an outreach team to share information, resolve issues, and to invite external partners to attend to learn about the program. The steering committee reviewed annual evaluation outcomes.

The Collaborative partners received a grant from the Retired Teachers of Ontario for $50,000 to support a social participation fund. The fund helped seniors to access goods, services and activities that reduced their social isolation.

1.1 Goals and Objectives

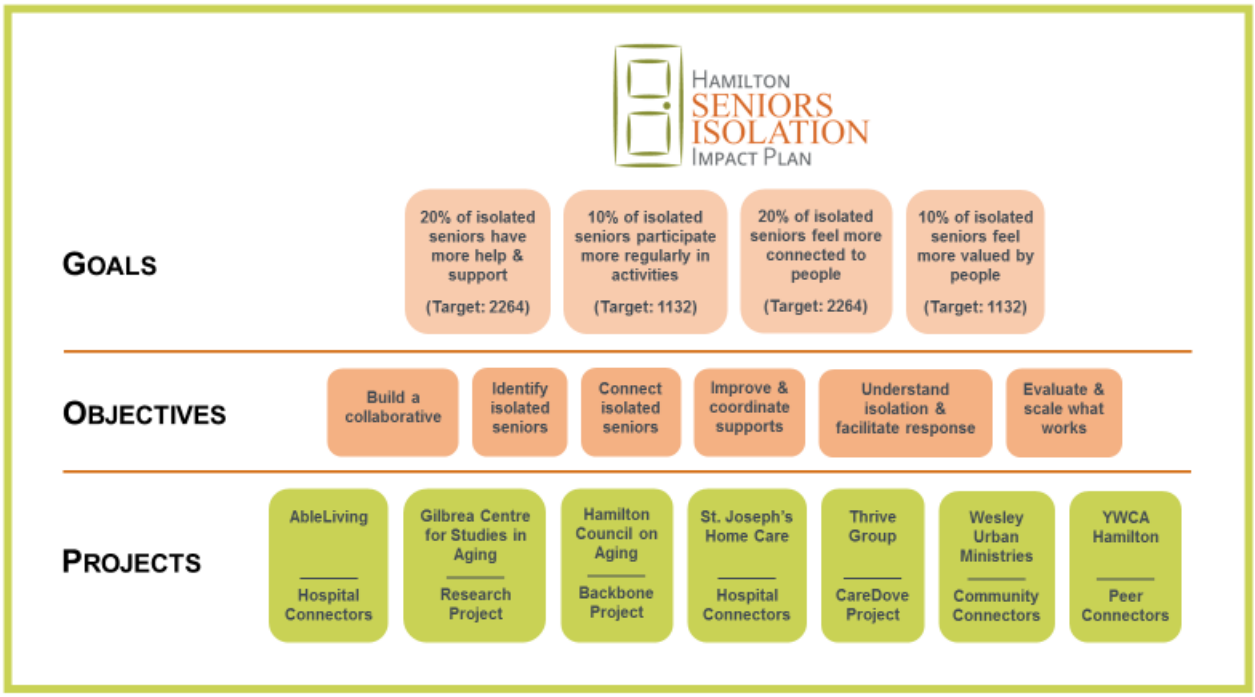
The HSIIP partners shared the following six objectives: (Figure 1)

- Build a collaborative;
- Identify isolated seniors;
- Connect isolated seniors;
- Improve and coordinate supports; and
- Understand isolation and facilitate response; and
- Evaluate and scale what works.

Additionally, they shared four population level goals:

- 20% of isolated seniors have improved access to help and support (Target: 2264 seniors);
- 10% of isolated seniors participate more regularly in activities (Target: 1132 seniors);
- 20% of isolated seniors feel more connected to people (Target: 2264 seniors); and
- 10% of isolated seniors feel more valued by people (Target: 1132 seniors).

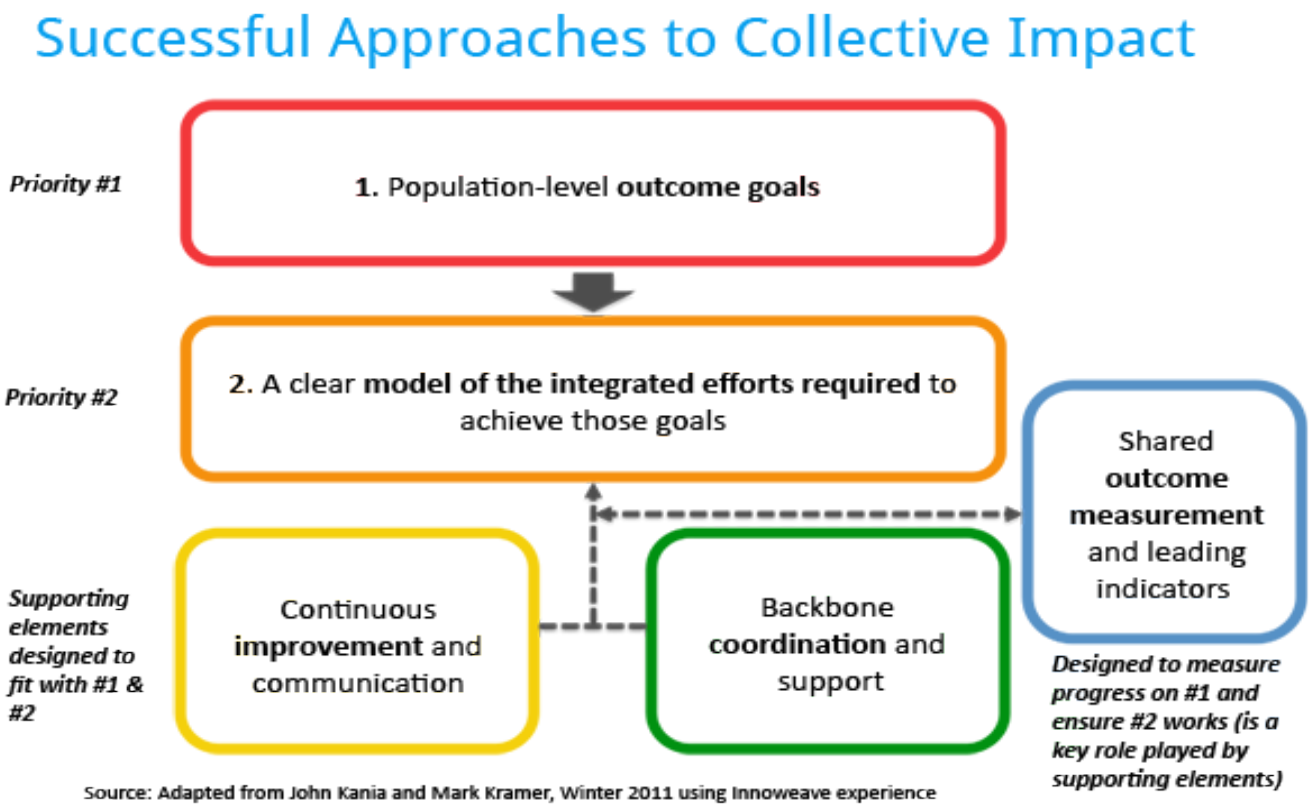
Figure 1: HSIIP Goals and Objectives



1.2 Collective Impact Model

The HSIIP was guided by the Collective Impact model for sustained community change. The Collective Impact process according to 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. When successful, communities solve big complex challenges (e.g., youth unemployment, low graduation rates, poverty) or 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. Figure 1b below is a summary of the CI process:

Figure 1b: HSIIP Successful Approaches to Collective Impact



In 2015 the Collective Impact Model was adapted for use by communities across Canada in their approaches to reduce seniors' isolation. In Hamilton the Model was adopted as a collective response to seniors' isolation and closely followed the approach in Figure 1b. The original objective was to measurably reduce seniors' social isolation and to build the community's capacity to identify, reach and connect isolated seniors and prevent isolation in future. Collective impact is based on the idea that organizations must work collectively — not in isolation — to create social change and solve complex dynamic problems like social isolation. The model requires 5 conditions to be implemented successfully: 1) a common agenda and objectives shared among partners; 2) a shared measurement system; 3) acknowledgement that each individual project is mutually supportive of collective goals and objectives; 4) consistent and open communication; and 5) backbone support – dedicated staff to support and help coordinate activities across participating organizations.

2. Methods

Data contained in this report was collected for the period of May 2016 to March 2019 (three fiscal years of the HSIIP). To ensure sufficient lead time for data analysis and reporting, data base and indicator reports were finalized in mid-February of 2019. The Collaborative used a variety of methods to collect data:

Focus Groups & Interviews

To explore system impacts, the evaluation consultant conducted focus groups and interviews with a selection of professionals who referred to the HSIIP Connector services. To explore lessons learned, the evaluation consultant conducted focus groups and interviews with each of the HSIIP projects. All focus groups and interviews were audio recorded and analyzed to extract themes and quotations.

Health of the Collaborative Survey

The evaluation consultant circulated an anonymous online survey to Steering Committee members at the end of years one, two and three. This survey asked multiple-choice questions to determine perceptions about the work of the Backbone and the health of the Collaborative. It also provided opportunity for qualitative feedback.

Indicator Reports

Each partner of the Collaborative submitted an indicator report to the Backbone on a semi-annual basis. These reports tracked common measures across the projects, for example the number of promotional materials distributed in hardcopy. They also tracked some project specific indicators, for example the number of seniors contacted through the Connector projects.

Intake & Exit Surveys

Connectors helped seniors to fill out an intake survey in order to receive service. This survey asked about demographic characteristics and attempted to identify the degree of isolation and needs. Connectors also helped seniors to fill out an exit survey upon discharge. The intake and exit surveys contained some identical questions for pre and post comparison purposes. The exit survey also asked for opinions about the HSIIP services. Each Connector project maintained a survey database, and these were submitted to the Backbone on a semi-annual basis to be merged and analyzed.

Case Studies

The project included the compilation of client case studies to help illustrate system impact, lessons learned, and case complexity/resource intensity. The main purpose was to bring a perspective of the “real” challenges facing those who are isolated and in need of supports. As important are the challenges faced by connectors in establishing relationships with clients, gaining trust, and navigating the health and social networks on behalf of the client. These situations were often time consuming and difficult. The case studies compliment the reader’s understanding of the hard data.

Sections three to eight of this report address each of the Collaborative’s objectives in turn. This is followed by recommendations of the Backbone in section nine, and conclusions in section ten.

3. Build a Collaborative

The seven HSIIP partners formed a Collaborative, with a membership that included all project leaders and staff. These partnerships were guided by the collective impact model, which emphasized a common agenda, a shared measurement system, mutually reinforcing activities, continuous communication, and backbone support. The Backbone project took the lead in fostering these conditions.

3.1 Activities

The Backbone oversaw many foundational activities such as developing common understandings and agreements, forming a Steering Committee (project leaders) and an Outreach Team (staff), planning the work to be undertaken, and establishing tools to evaluate progress.

Once the foundations of the Collaborative were established, the Backbone maintained core functions such as facilitating regular meetings, preparing agendas, taking minutes, liaising between the Steering Committee and Outreach Team, promoting communication online, sharing news and resources, and following up on action items to provide support to the projects. The Backbone also oversaw evaluation activities (see section 8) and consulted with the Steering Committee to develop a sustainability plan.

At Steering Committee meetings, the Backbone guided strategy, encouraged partners to share updates, and facilitated consensus-based decision-making. At Outreach Team meetings the Backbone provided opportunities for staff across the projects to engage in team-building, training, information sharing, and case conferencing. The Backbone also used these meetings to promote best practices for data collection and to develop relationships with external stakeholders by inviting them to be guest presenters.

In addition to supporting the HSIIP Collaborative, a key role of the Backbone was to engage the broader community. As one of multiple strategies to achieve this, the Backbone collaborated with the City of Hamilton's Healthy and Safe Communities Department to convene and co-chair the 'Seniors At-Risk Community Collaborative' (SARCC). This systems level table brings together stakeholders from across community, health and municipal sectors to improve inclusion and access to supports for at-risk seniors in Greater Hamilton. The Backbone has been co-facilitating these meetings and using the SARCC to leverage partnerships, information and advice.

3.2 Outputs (May 2016 – March 2019)

The Backbone helped the Steering Committee to develop and adopt the following shared agreements and strategies: a memorandum of understanding; a Steering Committee terms of reference; a shared work plan; a communication strategy; and an evaluation strategy. The Backbone facilitated 63 HSIIP Collaborative meetings (29 of the Steering Committee, 31 of the Outreach Team, three of the full Collaborative) and invited 32 external stakeholders to present at Outreach Team meetings. The Backbone co-facilitated four meetings of the Seniors At-Risk Community Collaborative and 13 meetings of the SARCC Steering Committee. Through SARCC the Backbone engaged 32 stakeholders external to the HSIIP.

3.3 Lessons Learned

The initial work of building the HSIIP Collaborative was front-loaded and took longer than anticipated. With the partnerships and projects being completely new, everyone had to 'hit the ground running' and learn what they were doing as they moved along together. The Connector projects felt it was challenging to provide services to seniors at that point, due to the time required to participate in the collective impact process, and some lack of clarity that resulted from not having all the details worked out. It was also difficult to focus on outreach while internal partnerships were still forming. The Collaborative recommends that new initiatives based on this model should have a short period dedicated to laying the foundations of collective impact, without the expectation of service delivery during that time.

3.4 Health of the Collaborative Survey

At the end of each year, the evaluation consultant circulated a Health of the Collaborative survey to Steering Committee members. The results were intended for members to reflect upon its function, to celebrate what was working and to identify areas for improvement. Ensuring a healthy network increased the probability it would add value to community-based efforts to achieve outcomes that a single individual, organization or sector could not achieve alone.

At the first annual evaluation, the survey identified communication as a weakness. The Backbone responded by implementing an online project management tool called BaseCamp, which allowed users to share information and discuss topics. The Backbone used Basecamp to share documents, reports, event flyers, and news articles. The Outreach Team used it to ask questions about community resources and to troubleshoot situations. The Steering Committee used it to make decisions between meetings.

After having more experience working together, all respondents agreed to the following Survey points:

- The Collaborative is making a meaningful difference in addressing isolation;
- The Collaborative promotes shared learning and adopts approaches accordingly;
- The Collaborative's governance structure is serving it well;
- The Collaborative's internal communication systems are serving it well;
- Decision-making processes encourage members to contribute and collaborate;
- Partners are creating new knowledge and insights together; and
- Partners share a common sense of purpose.

Some respondents felt somewhat neutral about the following points:

- Mechanisms to promote accountability are working well;
- All partners are contributing adequate time/resources; and
- Partners have the resources needed to contribute to goals and objectives.

One respondent commented that 'the Backbone function has been effective and supportive'. In addition, comments were made about sustainability of the model beyond the three-year funding period. These results were discussed with the Steering Committee at an evaluation meeting. Partners reconfirmed that the ability to share learnings, resources and support with the help of a Backbone had been a definite strength of the model.

The online survey was again circulated to Steering Committee members towards the end of year three. The survey data identified similar outcomes as the 2nd year survey – partners shared a strong sense of purpose supporting common goals and objectives. The governance structure allowed for equal opportunity for shared decision-making, shared learning and conflict resolution. A few celebratory comments highlighted the successes of the collaborative:

- *The development and successful implementation of a strategy to reach isolated seniors*
- *Developed new partnerships working together across a wide spectrum of providers.*
- *Working toward a common goal. Building knowledge about the services and approaches in Hamilton.*

As before, suggestions were made to improve the overall process:

- *That you need to build in the front-end time to develop a cohesive collaborative.*
- *Take the time to put in the work to develop relationships and understanding amongst the collaborative early.*
- *Keep the lines of communication open and work towards solutions to overcoming systemic barriers.*

Concerns were raised over the time needed to establish relationships, and that there was an underestimation of the time required to implement and sustain individual projects. For example, the need for more connectors, more time to carry out community participatory research initiatives, more time to engage stakeholders to educate them on the system for online referrals, and the labour intensity of reporting requirements, were all considered challenges. Balancing these challenges was the overall impression shared by most members that the project was a significant success:

- *It was a pleasure being part of a group of agencies that reached so many vulnerable adults and seniors in a cost-effective and collaborative manner!*

Connectors, peer support and research representatives of the project also met as a group through outreach team meetings monthly. They identified their ability to work cohesively as a team as a major strength and that the meetings were highly successful. In regard to weaknesses, they felt the process for accessing the Social Participation Fund was burdensome and that some of the data collection tools could be improved.

3.5 Summary: Building a Collaborative

The Backbone project cultivated a set of supportive partnerships that improved the reach, learning, and capacity of the projects. Feedback demonstrated that partners shared a sense of purpose, approved of the governance structure, and learned from each other. The teamwork of Connectors across projects also came across as a testament to the success of this model. Overall, the partners were eager to sustain the Collaborative they had built. At the same time, some partners felt more resources were needed and that mechanisms for accountability could be improved.

The Backbone project also catalyzed an unexpected outcome, which was the development of the Seniors At Risk Community Collaborative. Taking a leadership role in the development of SARCC was a successful way for the Collaborative to raise the profile of isolation, inform stakeholders about the projects, and develop broader

partnerships. The SARCC was developed to address systemic issues and barriers for seniors at risk in Hamilton. It is expected to be a lasting legacy of the HSIIP.

4. Identifying Isolated Seniors

Identifying isolated seniors required extensive community outreach to improve awareness and encourage referrals. It also involved conducting intake surveys to assess needs and develop a set of baseline data. The network established relationships with hospitals, City Housing, Catholic Family Services and others to establish an integrated and seamless network to support isolated seniors.

4.1 Activities

Various outreach activities to encourage referrals included:

- Attending events and delivering presentations;
- Developing and maintaining a HSIIP website;
- Distributing promotional and educational materials;
- Encouraging word-of-mouth referrals;
- Listing HSIIP services in local information directories;
- Meeting in person with managers and staff of targeted organizations;
- Networking with professional contacts;
- Publishing media posts and news articles;
- Knocking door to door in targeted neighbourhoods;
- Reaching out to other programs operated by HSIIP; and
- Spending time in seniors' buildings.

Examples of those targeted included community service providers, emergency service providers, faith groups, food banks, health care providers, housing providers, libraries, neighbourhood associations, property managers, retiree groups, retirement residences, and seniors' recreation centres.

The HSIIP partners contributed to outreach in different ways. The Gilbrea research project played a specialized role in providing graphic design skills and developing an online presence, while the Backbone and Connector projects performed outreach 'on the ground'. Initially the Backbone focused on networking with community service providers. When some of those relationships became established it shifted attention towards seniors and community groups. The Hospital Connector projects focused on engaging staff of hospitals, and the Community and Peer Connector projects prioritized engagement with seniors and community groups, but later came to rely more on referrals from organizations as well.

4.2 Outputs (May 2016 – March 2019)

The Collaborative engaged over 228 stakeholders (a range of non-profit service providers, municipal departments, community groups, and businesses); distributed 14,300 promotional and educational materials in hardcopy; delivered 244 presentations and sent representatives to events 124 times. The www.socialisolation.ca website generated 5175 users and 19,682 page views. As a result of raising awareness about isolation and HSIIP services, the Collaborative was able to gather 1875 referrals. All of these seniors

were contacted and 1556 received service. We estimate that an additional 389 individuals (25%) were indirectly positively impacted through a multiplier or spillover effect (see Section 5.4).

4.3 Referral Sources

About 83% of seniors who filled out an intake survey were referred by organizations (through programs managed by HSIIP partners and through relationships built with other service providers). About 15% were self-referrals or from family, friends, and acquaintances.

For the Hospital Connectors, most referrals came from staff of Hamilton Health Sciences and St. Joseph's Health Care, as well as the HNHB Local Health Integration Network. Some referrals came from programs managed by HSIIP partners. Over half of all referrals (57.8%) came from hospitals. Hospitals provided a steady stream of clients reducing the need for Hospital Connectors to spend time case-finding.

For Community and Peer Connectors, 49% of referrals came from hospitals and community organizations (including a small proportion of HSIIP partners themselves); a large proportion were self-referred (34.7%), and a significant number were from friends, family or acquaintances (10.1%). Community and peer connector services, in contrast to hospital connector programs, relied on smaller volumes of referrals from a wider variety of sources. Overall, they had to spend more time doing outreach to help identify isolated seniors.

4.4 Demographics & Risk Factors

The intake tool included several variables describing client characteristics. This enabled connectors to identify client risk factors and needs and to develop care plans mutually agreed to between client and connector. The following briefly summarizes characteristics of intake respondents.

- **Age:** 18% were under 65 years, 30% were 65-74, 31% were 75-84, 10 % were 85-89, and 11% were 90 plus.
- **Gender:** 59% were female and 41% were male.
- **Language:** 91% spoke English as their primary language.
- **Living Children:** 66% of clients have children – about 61% would be considered close by in Hamilton, 16% within an hour's drive, and about 20% further away (about equally distributed within and outside Ontario).

The proportion of males to females was similar across most age groups up until and beyond 70 years of age, when females outnumbered males (ratio of 60/40).

Living Environment

- **Marital Status:** 27% were either married or in common-law relationships, 24% were divorced, 33% were widowed, and 22% were single and had never married.
- **Caregiver Status:** 10% were primary caregivers to another person.
- **Living Arrangement**: 67% lived alone and 28% lived with at least one other person.
- **Condition or Disability:** 84% had a condition or disability that impacted their ability to participate.

- **Sensory Loss:** 33% had a vision impairment and 25% had a hearing impairment.
- **Ability to Participate in Activities:** 81% felt that their ability to participate in activities was limited.

The data reveal high proportions of clients living alone with high levels of disability (>80%). Almost 79% were either divorced, widowed or single (never married). We can conclude that the connector and peer programs appropriately targeted persons at risk of social isolation. Below we summarize client self-reports on family and social connectedness.

Social Connectedness

- **Contact with Family:** 78% stated they had contact with family monthly, weekly or daily, and 22% stated it was less than once a year or only a few times a year.
- **Contact with Friends:** 65% had contact with a friend(s) weekly, monthly or daily, while 22% had contact only a few times or less than once a year - about 13% reported having no friends.
- **Connectedness to Family:** 23.5% stated they were only somewhat connected to family members, and 29.4% stated they were not connected to family at all.
- **Connectedness to Friends:** 30.1% stated they were only somewhat connected to friends, and 35.6% stated they were not connected to friends at all.

While the data suggest clients are in contact with family and friends (less so with friends), almost half stated they were only somewhat or not connected to family at all. An even larger number (almost 67%) stated they were only somewhat or not connected at all to friends.

Interpersonal Dimensions

- **Feeling Isolated:** 41.4% stated they always or often felt isolated.
- **Feeling Lonely:** 44% stated they always or often felt lonely.
- **Someone to Confide In:** 26.6% felt they did not have someone to confide in.

Significant levels of social isolation and feelings of loneliness among clients were reported. Another marker for social isolation was the inability to have someone to confide in (almost 27%).

Resources

- **Participate in Activities:** 22% stated they participate in activities only a few times a year while 45% participate only once a year or less.
- **Access to Services:** 35% were not accessing any other services.
- **Transportation Difficulties:** 59% had difficulty accessing transportation.
- **Have Enough Help:** 35% stated they sometimes have help while almost 20% did not have enough help.
- **Guaranteed Income supplement:** 47% received the income supplement.

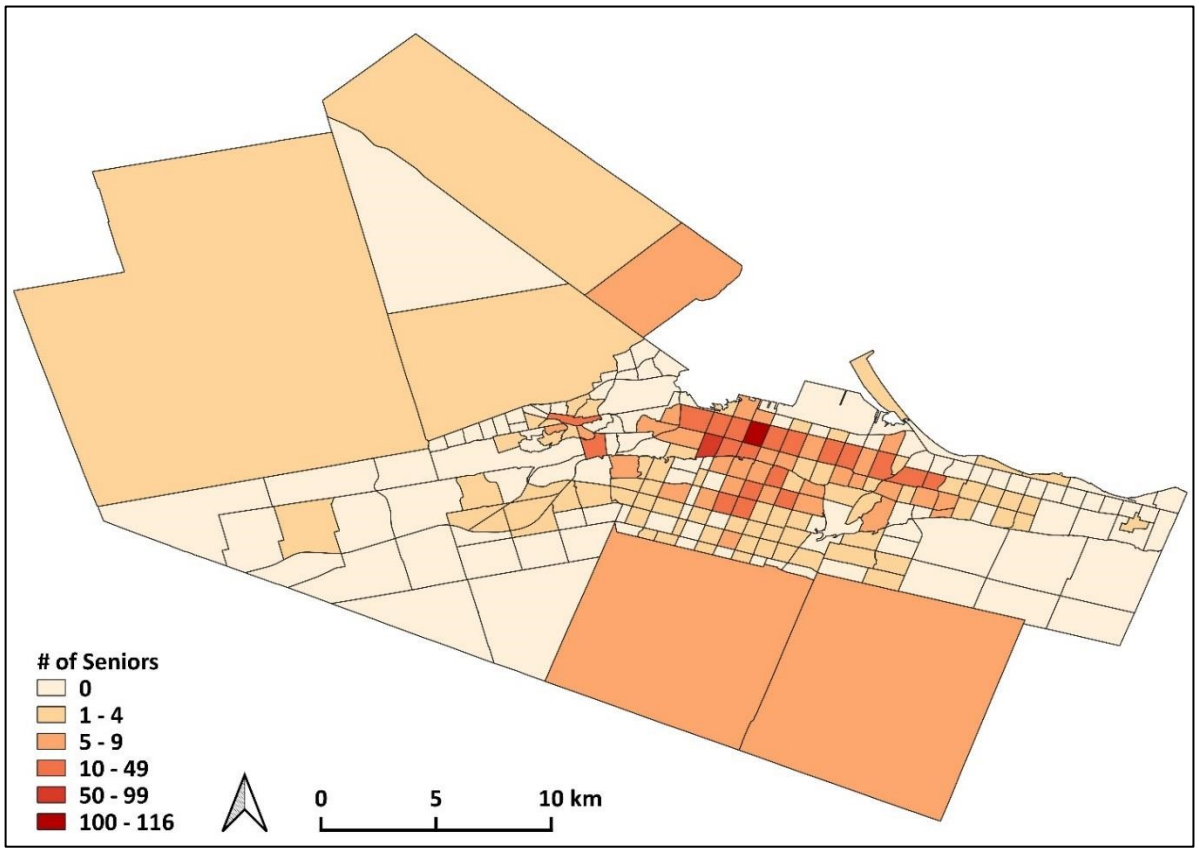
The data suggest that the group of seniors targeted for services have difficulties accessing needed resources such as transportation, social and recreational activities. About half receive the income supplement to assist

with daily living. While most can access help as needed about 1/3 sometimes have help and 20% do not have enough help.

Geographic Distribution

In regard to geographic distribution, postal codes were used to produce a map (see Figure Two). The data are valid for the period up to March 2018. The majority of intake survey respondents resided in the urban core, with 86.1% living within the old municipal boundary for the City of Hamilton. Another 5.0% resided in Stoney Creek, 4.0% in Dundas, 1.8% in Flamborough, 1.6% in Ancaster, and 1.5% in Glanbrook. A closer examination of planning units demonstrated that most were living in downtown neighborhoods (below the escarpment). A significant number were also concentrated in the central mountain area (above the escarpment) and in the east end.

Figure 2: Number of Seniors Served by Planning Unit (May 2016 to March 2018)



4.5 Lessons Learned

Building Referral Pathways with Organizations

The HSIIP Collaborative built a strong network of referral pathways with organizations throughout Greater Hamilton. External organizations that referred to HSIIP included:

- Ancaster Community Services;
- Bethel Church;
- Cancer Assistance Program;
- Catholic Family Services;
- CBI Health Care;
- City of Hamilton;
- City Housing Hamilton;
- Flamborough Connects;
- Good Shepherd Food Bank;
- Hamilton Health Sciences;
- Hamilton Paramedic Service;
- Hamilton Police Service;
- Hamilton Social Medicine Response Team;
- HNHB Local Health Integration Network;
- St. Joseph's Health Care; and
- St. Matthew's House.

These relationships were a valuable asset, but they did not come easily. Many staff in these organizations were becoming more aware about isolation and HSIIP Connector services. In addition to educating about risk factors, Connectors had to prove themselves and create a niche in the system. Strategies that helped included:

- Achieving great outcomes for the seniors and communicating those outcomes to referrers;
- Being responsive and timely with referrals;
- Demonstrating they were complimenting services and filling gaps, rather than duplicating;
- Maintaining a consistent, visible presence in hospitals (Hospital Connectors);
- Meeting with managers and front-line staff to make a personal connection; and
- Repeating the message to the same staff groups multiple times.

Gaining Referrals from Seniors & Community Members

The proportion of referrals that came from seniors and community members such as family, friends, and acquaintances was relatively small (15%). It was difficult to gain these referrals for a few reasons.

Connectors commented that admitting to isolation was an emotionally difficult or embarrassing experience:

> "Sometimes seniors are in denial. They say they are not isolated but have not spoken to someone in six months… There is a pride factor." (*AbleLiving Staff, 2018*)

Another Connector gave an example of a senior who believed their isolation meant they had failed as a parent; they would downplay their situation to cope with that pain. Fear was also an obstacle, as some seniors worried that admitting to needing help would lead to institutionalization. These personal barriers likely prevented some seniors from coming forward. In addition, neighbours and acquaintances reported feeling hesitant to refer a senior, stating they didn't know them well enough or were afraid to offend them.

Other reasons related to outreach. The fact that isolated seniors tend not to leave their homes made it hard to find and communicate with them. The Backbone placed greater emphasis on engaging service providers in the initial stages, when Connectors needed to increase their caseloads. For the purpose of gaining referrals, it was simply more effective to target a pool of professionals that come across seniors on a regular basis and who did not face the same social barriers to making a referral.

With that being said, the HSIIP Collaborative recognizes the value of engaging seniors and community members and was successful in doing so. The proportion of referrals from seniors and community members increased over time; in year one, 10.6% of seniors either referred themselves or were referred by a community member, while in year three that proportion grew to 15%. Connectors explained the most effective way of doing this was by asking seniors to suggest the services to another senior at risk of isolation. They were also able to gain referrals by networking informally with property managers and neighbours in seniors' buildings. The Backbone project reached seniors by having pamphlets attached to Meals on Wheels invoices and to medication deliveries through Shoppers Drug Mart. Other strategies for engaging community groups involved presenting to faith groups, neighborhood associations and retiree associations.

Neighbourhood Approaches to Gaining Referrals

Initially the Collaborative planned to serve two neighbourhoods in year one, and then scale up; these included the 'east mountain' and the rural community of Flamborough. However, this would not enable Connectors to identify a sufficient number of isolated seniors to be on track for reaching targets. At the same time, referrals were being received from across the city. Therefore, Connectors were eventually encouraged to serve seniors throughout Greater Hamilton.

The Community and Peer Connector projects still performed additional outreach in the targeted neighborhoods. These areas consisted almost exclusively of single-detached homes. Community Connectors attempted knocking door to door with no success. They reported that seniors were distrustful of having a stranger come to their door unexpectedly. Eventually the boundaries of targeted neighbourhoods were expanded to include some seniors' apartments. Connectors were able to visit those buildings and have property managers introduce them, which was more successful. A social worker employed in the housing sector commented in an interview that it would be ideal if Connectors could visit the buildings regularly:

> "Tenants like it when you have rapport with them, especially seniors. They need to have a comfort level with people who come to their door… if they don't know you, they are not going to tell you if they feel isolated. So, having Connectors in the building… it's nice for my seniors to see their faces… If they could come more often… Once every week or every two weeks and have a time when the seniors know they are coming here, that would be good." (*Housing Social Worker A, 2017*)

The Connectors learned that trust was a necessary factor for success in neighborhood-based approaches. A project focused on embedding Connectors into seniors' buildings could be a good opportunity in the future.

Expanding Outreach

Although the HSIIP Collaborative engaged many people, efforts could still be expanded. There were many more faith groups, family health teams, pharmacies, and people working in the for-profit sector (e.g. postal workers, hairdressers, PSWs) that could be reached. The main barriers are time and capacity.

Connectors became less able to perform outreach as their caseloads grew, and the Backbone was limited to one staff person with multiple responsibilities. With overstretched resources the amount of outreach work that the Collaborative could undertake was restricted.

In addition, the Collaborative struggled with gaining referrals from rural and non-English speaking communities. This work would require dedicated resources. Reaching more rural seniors could involve a mail-

out of promotional and educational materials or providing the incentive of transportation. Reaching more non-English speaking seniors would require funds for language interpretation and translation.

Taking on the 'Right' Referrals

The Collaborative wasn't only interested in increasing the quantity of referrals, they also wanted to attract a specific type of referral. The Steering Committee implemented the following eligibility criteria:

- Individual resides within the City of Hamilton;
- Individual is aged 55+;
- Individual reports lack of social support; and
- Individual needs help connecting to community, programs or services.

Within those boundaries, Connectors used their discretion to determine which seniors to serve. They knew it was important to serve seniors who were truly isolated. At the same time, they had to be capable of supporting them within the limits of their time and resources. The target population, therefore, was identified as being significantly isolated but not too complex.

Once the referral pathways grew, finding seniors with a significant level of need was not an issue. Data collected from intake surveys confirmed that seniors faced numerous risk factors and significant levels of isolation. While Connectors received the odd referral for a senior who did not seem to be isolated, they were able to screen out those individuals. They also learned to 'suss out' if a senior was more isolated than they may have initially appeared. Staff of the Peer Connector project emphasized that meeting a client in-person helped to determine the real situation, as opposed to reading a referral. For example, on paper it may have seemed like someone had a fair number of connections, but when speaking to them it became clear those connections were of low-quality. A key lesson was that isolation can appear many ways and can show up where you least expect it.

The main challenge with referrals was seniors with complex needs. The HSIIP service was not designed to provide intensive ongoing support, however this was what many isolated seniors needed. This was the result of existing intensive case management services being over-burdened or having strict eligibility criteria. In the words of Connectors:

> "We have to get this person out (of the hospital), they need help as soon as they get home. But they don't qualify for Health Links… the other intensive case management service will not accept due to a waitlist, so they give them back to the Connector. We can try but these people have complex issues." (*St. Joseph's Home Care Staff, 2018*)

> "Many seniors can be isolated, but how we actually can help the client is the biggest issue because we are not intensive case managers." (*Wesley Staff, 2018*)

Connectors did accept a considerable number of complex referrals and tried their best to serve those individuals within the constraints of the projects, because it did not feel right to turn away isolated seniors in need. However, Connectors did eventually develop an extra set of screening questions to be discussed with the referrer over the phone prior to agreeing to meet the senior for a full assessment. This enabled them to filter out some of the most intense cases that the projects were not designed to support.

Having to help seniors with complex needs took time away from reaching more seniors at the beginning stages of isolation. A Hospital Connector emphasized this:

> "We are getting people who have been probably isolated for 10 to 15 years… We get extreme cases… People who have lost their limbs due to not managing their diabetes as they've been isolated… This is the last straw that has brought them to the hospital… (Then there is) a person who comes into the hospital with a broken arm, but their issue is not severe yet. They end up going home isolated… (We need to) look for the quiet people who don't raise a lot of red flags... Catch those people before it becomes a crisis." (*St. Joseph's Home Care Staff, 2018*)

Ideas for shifting more towards prevention could be to focus on increasing referrals from emergency departments. However, reaching more of these seniors is a resource issue as many Connectors seemed to have their hands full with seniors that needed help more urgently.

To illustrate case complexity thirteen (13) case studies were reviewed for themes relating to client personal challenges which were considered a marker for case complexity. The case studies highlighted the major personal challenges that lead to case complexity:

- 11 clients with limited mobility and physical challenges;
- 9 clients with mental health challenges; and
- 5 clients with low income.

Clients with dementia or learning disabilities tend to require more connector involvement. Needs are carefully assessed and matched to referral partners. Clients are less independent and may require intensive support such as accompaniment to appointments, completing applications, etc. Clients discharged from hospital with physical limitations are often challenged in terms of transportation and appropriateness of the home environment. Often there is a need for home supports (e.g., supports and safety needs). Their ongoing care is important as they continue to rehabilitate after discharge.

4.6 Summary – Identifying Isolated Seniors

The Collaborative gained 1875 referral contacts for seniors thought to be isolated by the end of March 2019. Extensive outreach activities were undertaken, a large amount of information was shared, and a network of relationships was established with key service providers. As a result of these efforts, more members of the community were aware of risk factors and resources, and more organizations were in the habit of identifying and referring isolated seniors.

The most fruitful strategies for gaining referrals seemed to involve relationship building. The relationships in hospitals and in seniors' buildings were effective and Connectors found isolated seniors through relationships established with other seniors as well. Overall, the amount of outreach required to identify isolated seniors was underestimated - more could be done with additional time and resources.

Many of the referrals that Connectors received were for seniors with complex needs. Although a lot of these would have been more appropriately referred to intensive case management, it was unavailable, and it was

difficult to deny service when a senior had no one else to turn to. Still, extra screening precautions were implemented to filter out some of the most extreme cases that were not appropriate for Connectors.

5. Connect Isolated Seniors

The Community, Hospital and Peer Connector projects worked with isolated seniors to encourage social participation and anchor them to supports.

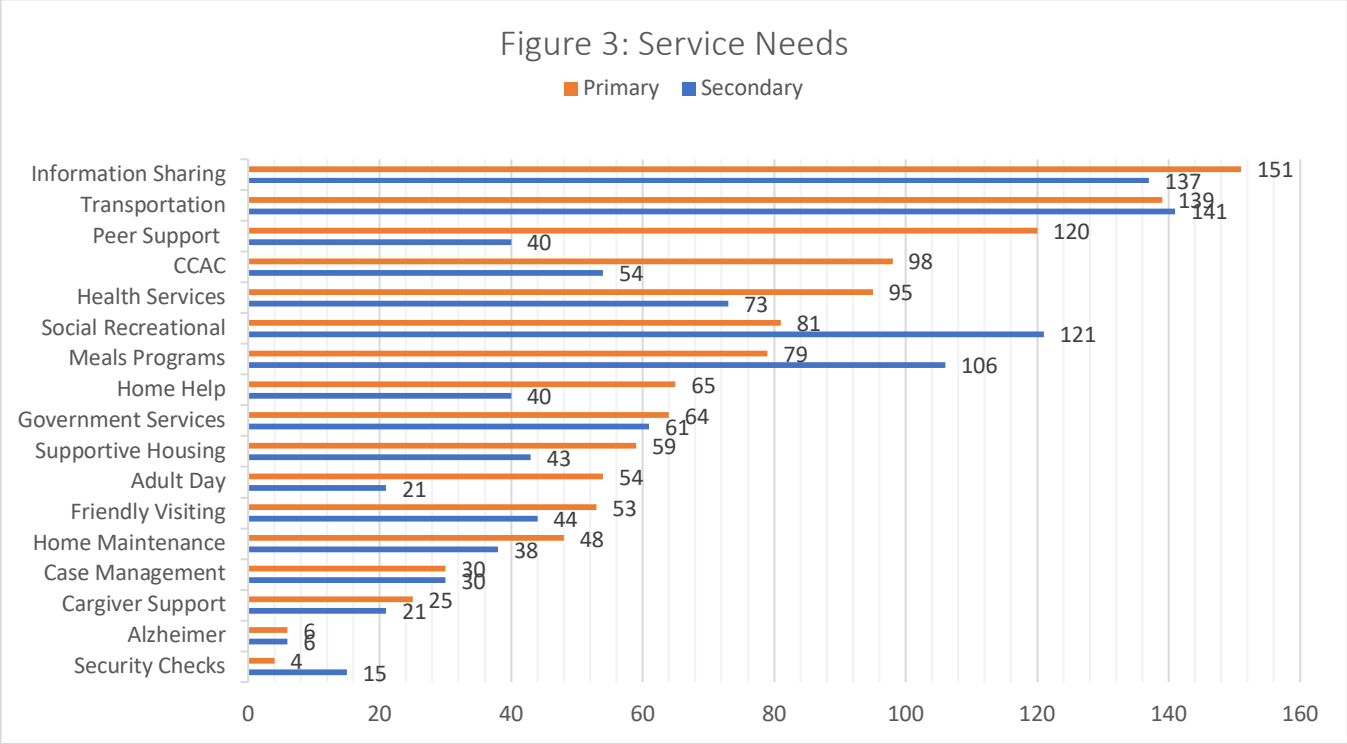
5.1 Activities

Connecting isolated seniors involved:

- Assessing needs and developing care plans;
- Delivering financial assistance through the Social Participation Fund;
- Discussing options and helping seniors to make decisions;
- Encouraging seniors to accept help and to participate in activities;
- Providing personal and emotional support;
- Helping seniors to navigate the service system and follow through on referrals;
- Hosting social events and trips;
- Matching seniors to volunteer Peer Connectors for friendly visiting; and
- Recruiting, training, and managing volunteer Peer Connectors.

5.2 Service and Support Needs

The types of programs that Connectors commonly suggested and/or anchored seniors to are described in Figure 3. Connectors selected up to three priority service needs to begin the process of supporting the senior (in addition to the one on one support directly provided by the connector to the client). The most common primary service needs included transportation, peer support, CCAC, health services, social recreational, meals programs, government services, home help, supportive housing, etc. It is evident that connectors strived to put in place services and supports to address the most fundamental needs to support the client. Then social supports were introduced once basic living needs were met. It is evident as well that connectors relied more and more on the YWCA peer connector program to match seniors with a senior volunteer. The advantage was to provide additional one on one support and accompaniment to the client to many other health and social services.



To help illustrate connector resource use, Table 1 summarizes aspects of connector support based on thirteen case studies:

Table 1: Summary of 13 Case Studies – Resource Intensity

Gender	Average Age	Average Duration of Connector Support	Average Connector Direct Support Time	Average # of Connections Made
9 Females 4 Males	74 years	5.8 Months	18-19 hours	6.7

The Client ages ranged from 57 to 94 years. Duration of active cases ranged from 2 to 12 months (mean 5.8 months). Connector time ranged from 8 hours to a high of 30 hours of direct contact. This would include one on one contact or telephone support. The number of connections made ranged from 3 to a high of 12. The case studies submitted did not quantify the number of individual visits or personal contacts made.

To comment the duration of active cases appears to be in line with expectations (about 6 months). However, average connector time appears to be significant (18-19 hours per client). While we do not have comparisons to hospital social work case intensity or case management programs, we have anecdotal evidence from discussions with connectors that considerable time is spent with clients in assessment, goal setting, establishing trust, making referrals, and organizing supports for clients (e.g., form filling for finances, transportation, social clubs, meals, homemaking etc.). Clients may also face personal challenges including

mental health, physical limitations, and low income. Therefore, significant time was spent with each client that was beyond original expectations, which may have had an impact on overall targets.

5.3 Outputs (May 2016 – March 2019)

By the end of March 2019, the Collaborative provided Connector services to 1,556 seniors. Every senior served was connected to some level of support in the form of visiting and information sharing, and most of them were also anchored into other services and activities. As noted in Section 5.4 below, the Collaborative Steering Committee conservatively estimated that an additional 390 individuals (caregivers, family members, friends) are estimated to have benefited from Connector services due to a multiplier effect (estimated at 25%). As well a range of broader system impacts are discussed in Section 6.4.

Other 'connection outputs' for this period included assisting over 200 seniors through the Social Participation Fund, hosting 96 recreational group activities/trips, training 31 volunteer Peer Connectors, and spending 1,504 home visiting hours with seniors through the Peer Connector project.

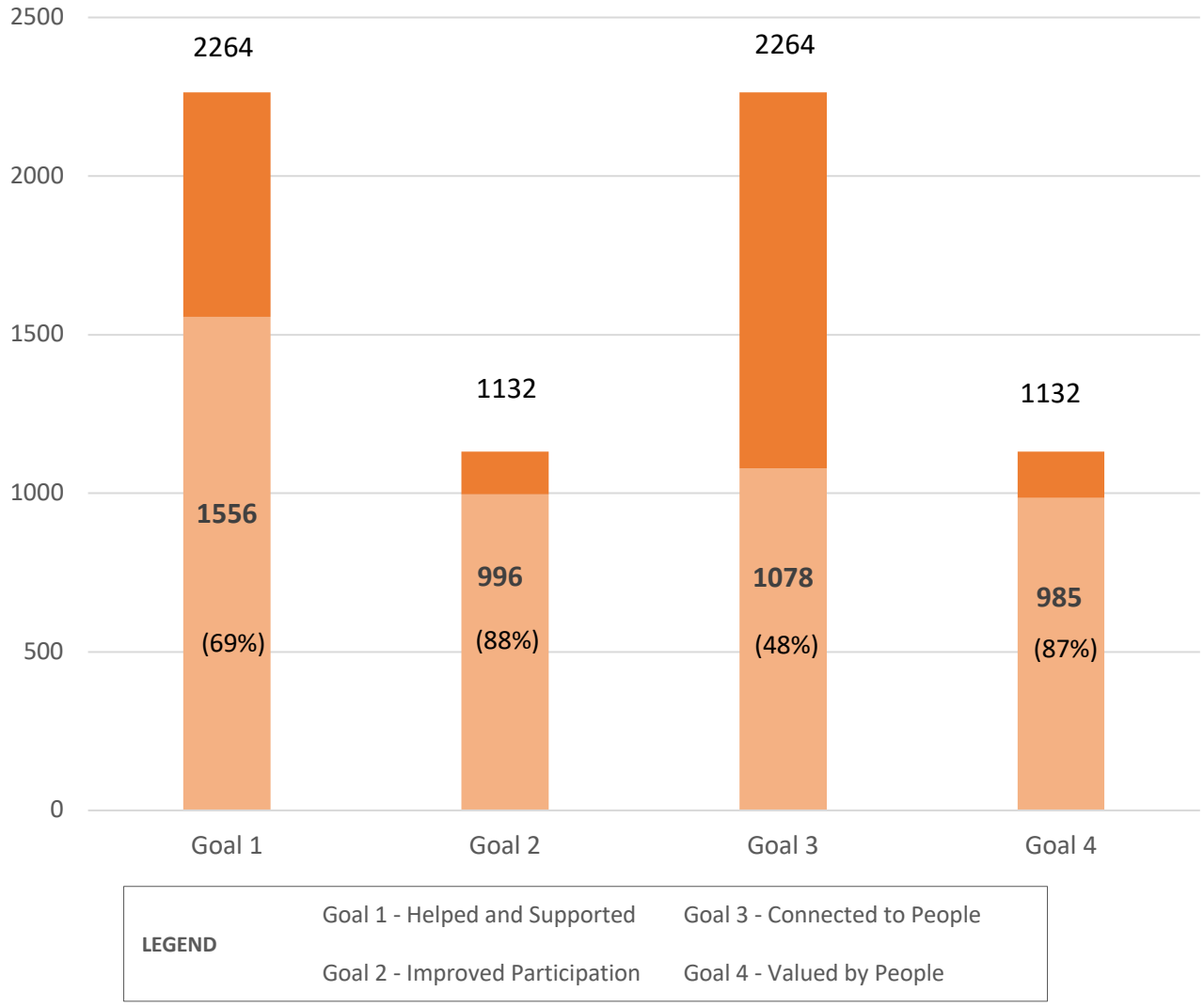
5.4 Population Outcomes

The isolated senior population in Greater Hamilton was estimated to be 11,318, which is 15% of the total senior population from the 2006 census. The Collaborative aimed to achieve four population goals in the period of May 2016 to March 2019:

- **Goal One** - 20% of isolated seniors have improved access to help and support (Target: 2264 seniors).
- **Goal Two** - 10% of isolated seniors participate more regularly in activities (Target: 1132 seniors).
- **Goal Three** - 20% of isolated seniors feel more connected to people (Target: 2264 seniors).
- **Goal Four** - 10% of isolated seniors feel more valued by people (Target: 1132 seniors).

Figure Four demonstrates progress towards each goal by the end of March 2019.

Figure 4: Progress towards Shared Population-Level Goals (May 2016 to March 2019)



Progress towards the first goal was measured by summing the number of seniors served by Connectors. Based on this method, the HSIIP improved access to help and support to 1556 isolated seniors. This was 69% of the three-year target and was estimated to represent about 13.7% of the isolated senior population in Greater Hamilton. The Collaborative Steering Committee was aware that persons in the individual's immediate social network (family, friends, caregivers) would also have benefited from Connector services. This concept is known as the "spillover" or "multiplier" effect (Al-Janabi et al, 2016). We conservatively estimate that an additional 390 persons (+25%) would have benefited, bringing the total to 1,946. Although it is difficult to quantify the impact of health spillovers in a rigorous manner, there is validity in including some estimate of its impact. By including the 25% estimate about 86% of the original target would have been reached (with the caveat that not all individuals who indirectly benefited would have been isolated seniors).

Progress towards other goals was estimated using exit survey results. Not all seniors served filled out an exit survey, so it was necessary to make some assumptions. The proportion of exit survey respondents that demonstrated improvement in a goal area was determined, then extrapolated to the full client database. For

example, 60-67% of seniors who completed an exit survey showed improvement in participation[1], so it was assumed that 64% of seniors served had improved participation. Using this method, it is estimated that:

- 996 seniors had improved participation, which was 88% of the target, and represents about 8.8% of the isolated senior population;
- 1,078 seniors felt more connected to people, which was 48% of the target and represents about 9.5% of the isolated senior population; and
- 985 seniors felt more valued by people, which was 85% of the target and represents about 8.7% of the isolated senior population.

The partners reached close to 70% of Goal One at the end of the funding period. Goal Two achieved 88% of target and Goal Four 85% of target. While it was hoped that the project would lead to more connections with people, this was felt to take more time. Having seniors supported and actively participating was a significant achievement.

Overall, the Collaborative was proud of serving 13.7% of isolated seniors in Greater Hamilton given what they learned about the needs of this population and the challenges involved. The partners gained a more realistic understanding of what it took to connect isolated seniors, and this is reflected in recommendations.

5.5 Client Outcomes

Stories are an effective way to demonstrate how seniors were helped by the projects.

Community Connector Story

A 78-year-old man was referred to the Community Connectors by his landlord. He had been living alone for about a year, since his spouse passed away. Connectors discovered that a physical disability was preventing him from caring for himself. He wasn't accessing any services and wasn't able to get around in the city. The Connector met with him at home to fill out an intake survey and discuss resources available to him. After forming a plan, they began by scheduling and attending an appointment with his family doctor, who he hadn't been to see in years. The Connector then helped him to access in-home care services through the HNHB Local Health Integration Network; set up a grocery delivery service; registered him for DARTS Transit and trained him how to use that system; and accessed the Social Participation Fund to purchase an annual seniors bus pass.

Hospital Connector Story

A 66-year-old woman was referred to the Hospital Connectors by a hospital social worker. She was returning home with limited mobility after spending three months recovering from an injury. Although she had an adult child, they were estranged. She had low-income, was behind on filing taxes, and was facing eviction due to not paying rent during the hospital stay. The Connector met with her a few days prior to her release, then advocated with her landlord to arrange payment of the arrears. They assisted her with filing taxes, so she was eligible to receive the Guaranteed Income Supplement. They also helped her to access an Occupational Therapist through the HNHB Local Health Integration Network, who assessed the safety of her home. Finally,

[1] Showing improvement in participation meant they either agreed that they participate more on the exit survey, or they reported an increased frequency of participation when comparing intake and exit survey responses.

they registered her with the City of Hamilton's Accessible Transportation Services and assisted her with the Social Participation Fund to access the City's discounted taxi program.

Peer Connector Story

A 70-year-old woman was referred to the Peer Connector project by another HSIIP partner. She had been married previously but was divorced. One of her children had passed away, while the other lived in a different province. A Community Connector had already put some basic services in place and now she was ready to consider some social opportunities. Despite wanting to be involved, she had very few connections and spent most of her time alone. Staff of the Peer Connector project met her at home to provide some emotional support and assess her suitability for a match. They linked her to a volunteer Peer Connector who came to visit a few hours per week and accompanied her to a monthly cooking club. They also accessed the Social Participation Fund to purchase a Seniors Recreation Membership from the City of Hamilton, along with yoga and pottery classes. The woman is now participating in activities a few times per week.

Exit Survey Data

Client outcomes is demonstrated through an analysis of intake and exit surveys. Exit survey respondents were asked to indicate their opinions about the following impact statements:

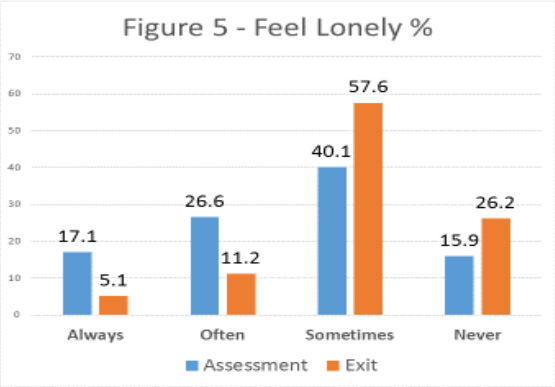
- I have more help and support – 92% agreed;
- I participate more regularly in activities – 60% agreed;
- I am more connected to services – 90% agreed;
- I feel more connected to people – 69% agreed; and
- I feel more valued by people – 63% agreed.

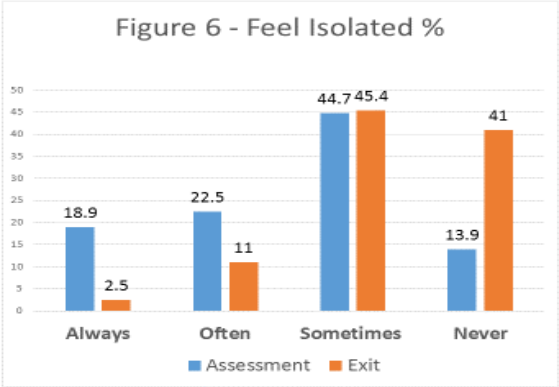
A majority (73%) felt the program was helpful, while 26% felt it helped somewhat. Over 98% gave an overall rating of "**Excellent**" to the program.

These results illustrate very positive results for clients when concluding the program. Some results were less than anticipated but were not surprising. For example, many isolated seniors do not wish to be connected to social/recreational activities at the outset or did not have the ability to do so. That would take more time. For many the primary goal was often to ensure that basic needs were being met and that they have someone to call in an emergency. Clients were often found in a crisis scenario or lacked the necessary supports to sustain independence. Therefore, it was anticipated that more time would be required to connect socially.

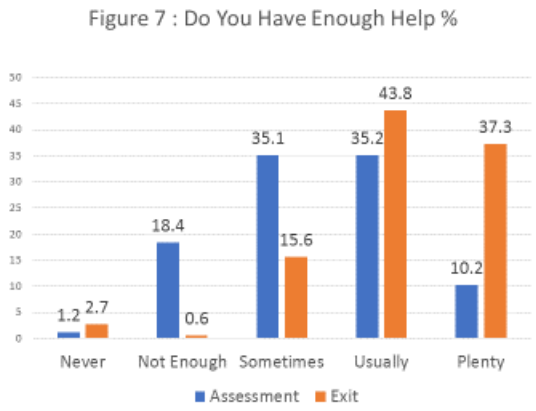
The Steering Committee selected three impact statements they felt best represented the outcomes that the HSIIP services were designed to achieve: I have more help and support; I participate more regularly in activities; and I am more connected to services. Of these statements, 89.6% agreed to at least two statements demonstrating significant connectedness and 10.4% were felt to be somewhat connected.

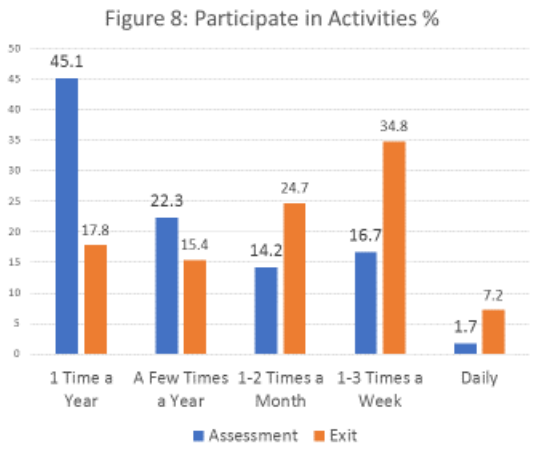
A comparison of pre and post questions also demonstrates impacts, as shown in Figures 5-8 below.





On intake, 44% reported feeling lonely often or always, while upon exit this was reduced to just 16%. Similarly, on intake 41% reported feeling isolated, while upon exit this was reduced to 13.5%.





The proportion of seniors who reported usually having enough help or having plenty of help increased from 45% to 81%. Furthermore, the proportion who felt they had plenty of help increased from 10% to 37%, while the proportion who felt they did not have enough help fell from 20% to 3%.

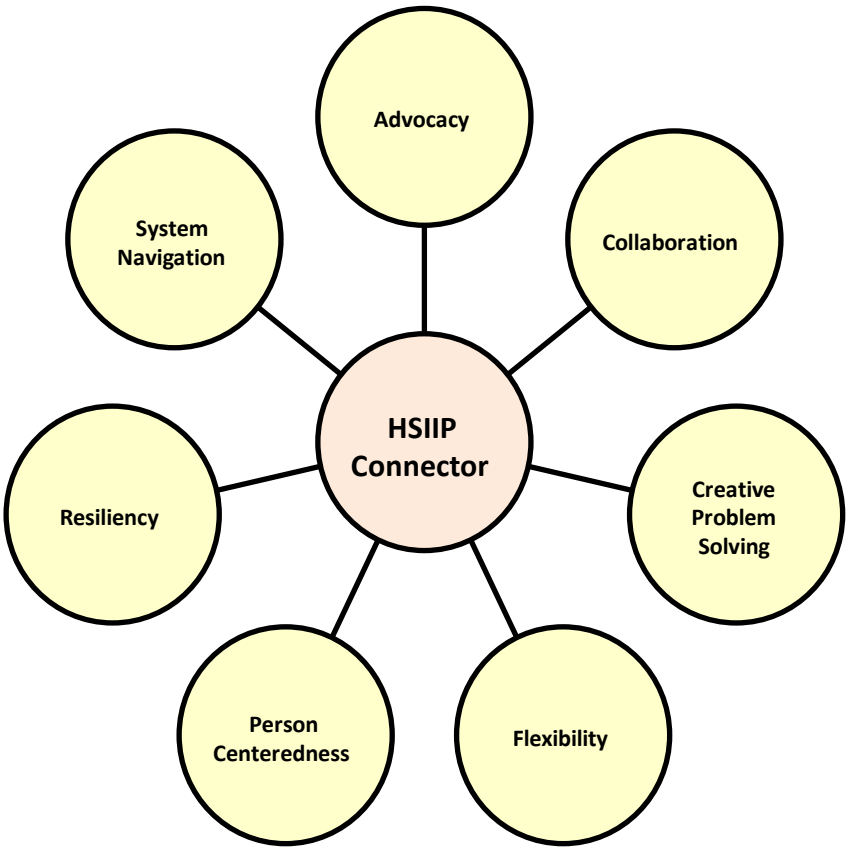
The proportion that felt they only participated in social and recreational activities a few times a year or less fell from 67% to 33% while those participating monthly, weekly or daily increased from 33% to 67%.

Overall, the evidence for positive impacts on clients was strong and Connectors felt they were making a meaningful difference in seniors' lives.

5.6 Lessons Learned Connecting Seniors

Strengths of the HSIIP Connector Services

The Connectors were asked to describe defining features of their roles and factors that helped them to achieve positive outcomes for seniors. Their responses illustrated the strengths of the HSIIP Connector model.



Connectors identified **advocacy** as a key part of their work. They often found themselves negotiating on behalf of a senior to solve a problem or to help them access something they badly needed.

A strong emphasis on **collaboration** was essential to finding and connecting isolated seniors. A high priority was placed on forming strong partnerships, communicating frequently with other service providers, and putting in place a 'circle of care' around a senior.

Connectors viewed themselves as **creative problem solvers**. Every new client came with a unique set of barriers and circumstances. Connectors were able to circumvent road blocks with inventive solutions and often went beyond what was expected of them to do so. A simple example was convincing neighbours to check in on seniors and to allow them to borrow a phone from time to time.

Flexibility was identified as a success factor. Connectors were able to help seniors in a wide variety of ways and felt their ability to 'do a little bit of everything' was a huge asset. In addition, Connectors were highly mobile and could visit or accompany seniors anywhere in the community.

The Connectors described the HSIIP services as **person-centered**. This meant being patient, taking time to listen, and getting to know each senior's needs and wishes. It also meant giving them freedom to decide what they wanted help with and not pushing any sort of agenda. Connectors strived to be open-minded about different lifestyles and non-judgemental about seniors' decisions.

Connectors built **resiliency**. Seniors received encouragement and supports that improved their independence. Resiliency was also a necessary trait of a Connector; they managed heavy demands with limited resources, and the work was emotionally draining at times.

The principal role of the Connector was **system navigation**. Many seniors did not know what was available to them or how to access them. As one Hospital Connector put it, "There is so much red tape. It is confusing just signing up with so many forms. It should be more accessible for seniors, but it's not. The Connector helps them get through it." (St. Joseph's Home Care Staff, 2018). Connectors gained a broad knowledge of resources and learned the best

'pathways' to solving common issues. They shared this information with seniors, helped them to create goals, and supported them to follow through on referrals.

Needs of Isolated Seniors

The Collaborative learned that the needs of isolated seniors were not just social. It became clear that risk factors for isolation are more prevalent among socially disadvantaged groups, and that a strong link exists between isolation and other social determinants of health (e.g. income, housing insecurity).

The majority of seniors identified through the HSIIP projects had a variety of unmet needs and barriers. Some common themes reported by Connectors included issues with addiction, family breakdown, bug infestations, food insecurity, hoarding, homelessness, lack of life skills, lack of transportation, low-income, unaffordable housing, and unmanaged physical and mental health conditions.

Mental health issues were especially prevalent, and seniors with these issues were difficult to serve. A Community Connector explained:

> "Many agencies are not prepared to work with seniors with mental health problems… it is a big piece. That is the main reason why they are isolated. Mental health issues cause them to hoard, have decision problems, housing problems… There is a big connection between mental health and the problems we see. They may not be taking their medications, they get out of control, the police get involved… and they won't go to mental health providers because of past experiences." (*Wesley Staff, 2018*).

Meeting the basic needs of isolated seniors became the first priority. In many cases seniors did not want (or were not able) to participate in social activities; they were ok with being isolated from people but still needed services. In other cases, basic needs had to be met first in order to make the social piece possible. Connectors spoke about recreational referrals as the 'cherry on top' or 'icing on the cake'. A Hospital Connector explained:

> "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." (*AbleLiving Staff, 2018*).

The Collaborative learned that a vulnerable subset of the senior population has been 'falling through the cracks' of the service system. Connectors were often the only advocates available to these people. This unanticipated level of need and complexity became a strain on time and resources, impacting the ability to reach targets.

Some strategies were developed for managing this complexity. Connectors learned to expect new cases to be intensive at first and prepared themselves to front-load the services. They would spend more time with a senior for the first few weeks, then back off and follow up over time to see how things were working. They also learned to ensure that referring organizations would not immediately discharge a senior into a Connector's care, but instead would negotiate splitting up the workload. A Community Connector elaborated:

> "When we got there the agency had discharged them, but they had mental health issues, no psychiatrist, no family doctor, and they didn't tell us any of that stuff. Now we have to help them with all of that… So now we say before they discharge 'we will help with this and this, but your responsibility should be to help with that'." (*Wesley Staff, 2018*).

The Steering Committee also set boundaries; a 6-month limit was placed on service delivery. A Hospital Connector estimated that about 10% of their clients would hit the six-month limit and still be in a precarious situation that required support.

Time Required to Anchor Seniors

Anyone can hand over a stack of brochures, but that does not equate to access. Connectors found that there were many steps involved in helping seniors to follow through on referrals. Even for the less complex cases, it could take about four months to 'anchor' a senior and create meaningful outcomes.

Developing trust was essential to this process and could not be rushed. In an interview, a hospital social worker commented that many seniors would have refused the service if Connectors had not come to chat face to face with them in the hospital (St. Joseph's Health Care Staff, 2017). Connectors offered similar sentiments:

> "You don't get a lot out of the intake sometimes. They don't know you or the program and they think you're going to put them into a nursing home. The more you go to see them the more stuff comes out. There's a need for face to face contact to build trust, more than one visit to build trust. If you say you are going to do something, you also need to follow through." (*Wesley Staff, 2018*)

> "You really have to go into the home and be patient, explain how the services work, provide a lot of emotional support… You have to be prepared to do a home visit for two plus hours. A person may be so lonely that they haven't talked to anyone in months, so they just tell you everything. When you get a better understanding of their personal stories you can better help them." (*YWCA Hamilton Staff, 2018*)

Strategies used to build trust included being intentional about building a relationship, making multiple visits, taking the time to listen and ask questions, having some casual conversations, and letting the senior take the lead. Connectors found if they could get some helpful services in place quickly those small wins would build trust and make the senior more willing to try other things. Another strategy was having the person who referred the senior come to the intake meeting to help develop rapport.

In addition to trust, seniors required a great deal of encouragement and logistical support in order to follow through on referrals. Staff of the Peer Connector project explained why this is:

> "Getting people out is so exhausting for them. Just getting ready and leaving their house is exhausting enough, and then going to a program, it is so tiring. Some people are not up for it or they are not ready. A lot of people have depression and low energy levels, a lot of health needs or declining health, lack of transportation." (*YWCA Hamilton Staff, 2018*).

Some examples of logistical support included making phone calls, locating and filling out documentation, scheduling and reminding seniors about appointments, arranging transportation, training them how to use

services, and accompanying them to appointments and activities. Many seniors could not or would not do these tasks on their own. A hospital social worker provided an example:

> "Many patients will not want to initiate a phone call. Having the Connector there to help the senior make the call, ask the right questions, get the right answers, and then explain things after. That is more beneficial for them." (*Hospital Social Worker A, 2017*).

Other stories from Connectors demonstrated the amount of time that these kinds of support took:

> "Clients have hesitation to join things. But with reassurance and support they are sometimes willing to go. If you just dropped the catalogue off I don't think they would follow through. Same thing with doctors' appointments. It is a strain to accompany seniors. We could use a secondary person to rely on just for appointments, maybe a PSW as part of our team, because an appointment takes three hours out of your day." (*AbleLiving Staff, 2018*).

> "I have to train them, take them on DARTS, go with them for the first time. Then when they are comfortable with DARTS they go on their own to the activity and I meet them there. They might have become independent with that activity, but now we have to repeat this with another three or four other activities. That is time consuming… If these clients want to do the social activities it takes training them to go." (*Wesley Staff, 2018*).

Because the process of anchoring seniors was slower than anticipated, Connectors struggled with balancing quality and quantity. Towards the third year the projects were operating at or over capacity. Some Connectors felt like they could either reach their targets or do a good job, but not do both.

Waitlists & Lack of Services

Long waitlists and a lack of certain services in the community meant that seniors with low-incomes could not always be connected to what they needed. There were lengthy waitlists for affordable housing, friendly visiting, grocery delivery, housekeeping, and intensive case management. Resources for excessive hoarding and bug infestations were inadequate. It was difficult to serve rural seniors due to a lack of transportation in those areas, and it was difficult to serve non-English speaking seniors due to a lack of language translation and interpretation.

The Collaborative attempted to address some of these gaps with the Social Participation Fund. This grant of $50,000, donated by the Retired Teachers of Ontario Foundation, was used to provide up to $300 to each HSIIP client to help them access services and activities. This turned out to be an important asset to overcome many barriers to connecting seniors, especially transportation. Connectors also helped seniors to pursue other financial resources. For example:

> "We are always searching how to pay for something, how to help them get the most out of their income sources… Because of poverty they trade off medication for their housing expenses. Many have not done their income taxes in years. They are not getting any pension, they are living off of family members. They don't know how to apply. They don't understand or don't even know about it, so we're providing that education piece as well." (*AbleLiving Staff, 2018*).

The intake survey screened for receipt of the Guaranteed Income Supplement and Connectors helped seniors to access this financial entitlement when possible.

Volunteer Peer Connectors

A total of 73 isolated seniors were matched to Volunteer Peer Connectors, which resulted in 1,504 hours being spent by the end of year two. In those hours, seniors received a great deal of personal and emotional support. The volunteers were especially successful in encouraging seniors to participate in recreational activities outside of the home. In addition to creating quality matches, the project evolved beyond friendly visiting by providing additional supports to many seniors (some of which were not suitable for or did not want a Volunteer Peer Connector). The program also hosted 30 structured social activities for seniors. Over 434 care connections were made for the program.

The 73 seniors matched with volunteers reported very positive outcomes, accounting for some of the Collaborative's best success stories. The project struggled to recruit older adults as volunteers, those they did recruit were of very high quality and were retained for long periods of time. To increase recruitment, the minimum age of volunteers was reduced to 50 years. Some suggested reducing this further, but it was decided that peer element of the project should be maintained. Seniors reported feeling more comfortable meeting with someone in a similar age range. They viewed these individuals as more like a friend that they could relate to based on similar interests or life experiences. Staff of the project believed this helped them feel more open to trying new activities.

In addition to the challenge of recruitment, the project took extra time to experiment with different approaches. A smaller scale neighbourhood model was tested, and although there were benefits to this, they found it would not accommodate sufficient numbers of clients to meet targets. In addition, staff found that some clients were not suitable for volunteer matches; in these situations, staff had to step into the role of a Peer Connector, which took extra time.

Staff of the Peer Connector project also explained that it was challenging to limit matches to six months. For some seniors this was sufficient time to get them anchored into on-going supports and activities. However, others did not want to be connected in this way and just preferred to socialize with someone in their home. In these cases, the match would end at the six-month limit. This would often leave a gap as other supports would be lacking due to waitlists and lack of affordable friendly visiting services.

5.7 Summary Connecting Isolated Seniors

Connectors helped isolated seniors to identify needs and opportunities, make decisions, and follow through on referrals to access services and activities. This usually began with making sure basic needs were met, then moving on to social or recreational activities if the senior was able and willing. Strengths of the HSIIP Connector model were defined as: advocacy, collaboration, creative problem solving, flexibility, person centeredness, resiliency, and system navigation.

The Collaborative made considerable progress towards the population goals; by the end of year two, 13.7% of isolated seniors in Hamilton had increased access to help and support, 8.8% had increased their participation in activities, 9.5% felt more connected to people, and 8.7% felt more valued by people. It was estimated that an additional 390 individuals were helped due to a multiplier or spillover effect resulting in 1,946 individuals being

supported overall. The evidence for achieving positive impacts at the client level was also very strong. As a result of the HSIIP Connector services, most of the seniors served felt less isolated, had more help, and participated more in activities. A significant number also felt more connected to and valued by people.

The Collaborative learned that many vulnerable seniors have been 'falling through the cracks' of the current system. It became clear that isolation is not just social but is intertwined with other unmet basic needs and barriers. Connectors also learned that it takes considerable time and trust to successfully 'anchor' an isolated senior; accompanying them to appointments was especially time consuming. A lack of availability of intensive case management and other services further complicated the process. The Collaborative over three years developed a better understanding of the needs of isolated seniors and what it took to connect them.

6. Improve & Coordinate Supports

The Collaborative improved and coordinated supports by developing the Hamilton Community Support Services (HCSS) platform and the HSIIP Connector services.

6.1 Activities

The HCSS platform (CareDove) provided information about non-profit and government services available to seniors in Greater Hamilton and enabled organizations to exchange referrals. Anyone was able to use the platform to search for information or create an account to submit referrals. In order to receive referrals an organization had to pay a monthly subscription to CareDove (the website's parent company). The Collaborative set out to establish the platform as a useful tool for the community by:

- Learning the many features of the website;
- Populating and maintaining a database with detailed information about local services;
- Training HSIIP Connectors how to use the platform to send and receive referrals;
- Promoting the platform to increase usage and subscriptions among organizations; and
- Helping organizations to register and train their staff.

6.2 Outputs (May 2016 – March 2019)

In working to establish the HCSS platform, the Collaborative listed 815 services from 127 organizations, registered 27 organizations with 144 user accounts, and provided 40 training sessions to staff groups. Approximately 525 referrals were processed through the platform.

6.3 Lessons Learned

The HCSS platform offered powerful tools for collaboration. Participating organizations created an electronic version of their referral form, which simplified the process by eliminating the need to call, email or fax documents. When a referral was made, a confirmation would be sent to both parties and private messages could be exchanged to provide additional details or to follow up about outcomes.

Although Connectors found these features to be convenient, they did not have a lot of opportunity to take advantage of them due to lack of uptake in the community. In order for the platform to be useful required

multiple active users, but convincing other organizations to participate was difficult. Despite advertising the platform on promotional materials and making appointment times available online, few referrals were received this way. Likewise, there were only a few services that Connectors could use the platform to refer to. Most referrals made on the platform were mostly between HSIIP services.

Many people were resistant to adopting a new technology. Even though 144 user accounts were registered on behalf of 27 organizations, these accounts were mostly inactive beyond registration. The project targeted managers of key services, secured their approval, registered and trained their staff, offered to provide ongoing support, and still those staff would not use the platform. Connectors asked referrers to use the platform and many would respond that they did not want to learn another system and preferred to speak over the phone. Some also viewed the platform as being in competition with a local information listing service that was already well known and liked. The hospitals raised privacy concerns.

Considerable staff turnover also impacted the establishment of the platform, with four individuals taking responsibility for the project at different points in years one and two. Staff changes put the project in an unfortunate position. Each new staff person needed to undergo significant training. These factors made it difficult to promote the platform consistently.

Despite these challenges, considerable progress was made in the latter half of year two. Responsibility for the project was transferred to a dedicated member of the HSIIP team. Under this new leadership, the project was able to convince the hospitals that the platform met their privacy requirements and they then became monthly subscribers to the platform. With these partners on board, Hospital Connectors were instructed not to accept referrals by phone. Since then the number of referrals exchanged through the platform increased.

6.4 System Impacts of Social Isolation and HSIIP Services

The HSIIP services were innovative and resulted in system level improvements. Many existing services were found to be overburdened, inflexible and fragmented; Connectors were able to address these gaps by operating outside of the traditional mould using an adaptive, collaborative, person-centered approach. This improved outcomes for seniors and resulted in increased prevention and community resilience. A review of literature was conducted highlighting impacts on health and social services:

- Social isolation, and high risk of social isolation, is a significant predictor of delayed hospital acute care discharge (Landeiro et al, 2016).
- Social Isolation in Canadian Older Adults (Khamisa, 2016). From a systemic perspective, social isolation in older adults can translate into health and social care systems being improperly utilized. Data within the U.K. points to older adults accessing emergency care because they are overwhelmingly lonely or because isolation and loneliness have altered their ability to manage illness.
- Health and Social Service Usage (B.C., 2004). Social isolation and exclusion are associated with increased rates of premature death, lower general well-being, more depression, and a higher level of disability from chronic diseases.
- Higher levels of loneliness were found among women who had more admissions to hospital, longer stays in hospital, more physician visits, more pharmacy claims, and more use of homecare services (Havens and Hall, 1999).

Social supports tend to prevent over use of the health care system and encourage proper use of health care for preventive services. Older adults who have social supports are more likely to use the healthcare system more effectively for disabilities (those who are isolated tend to have less effective access). Social isolation and loneliness can be associated with reduced service usage when seniors are unaware of services. The health system may also be inappropriately utilized when seniors use it as a substitute for companionship. Isolated seniors who have a healthy social network helps them to utilize appropriate health and social services.

Table 2 summarizes key themes relating to system benefits of the Connector and Peer Volunteer programs. Focus groups and one-on-one interviews were conducted with agencies that had experience with the program.

Table 2: Focus Groups – System Impact Key Themes

HOSPITALS	CITY HOUSING
• Our Eyes in the Home/Community • Effective Discharge Outcomes • Improved Transitions • Personal, Flexible Referral Pathway	• Effective Resource Supporting Independence • Building Trust and Relationships • Stabilized Housing, Support and Crisis Prevention • Flexible and Responsive
HOME SUPPORT SERVICE	**MOBILE OUTREACH PROGRAM**
• Full Circle Improved Transitions • Flexible and Responsive • Crisis Intervention ED Avoidance	• Crisis Avoidance • Full Circle Improved Transitions

The Connectors played a vital service for hospitals by improving transitions to community-based care and relieving pressures on hospital beds and emergency services. Often cited was the responsiveness and flexibility of the program. The Connectors often stabilized a crisis and enabled the isolated senior to manage better in their own home.

The HSIIP services improved collaboration among providers. At first, others were discharging seniors without much communication, so Connectors took on the work of developing better relationships. They asked referrers not to discharge right away, took time to explain roles clearly, negotiated to split the workload, and continued to communicate about needs as a senior's case progressed. Vise-versa, when they referred, they did not discharge right away but collaborated to ensure needs were met. As one Connector explained:

> "Everyone does their part to create a rounded service model… There is no longer a mindset of dumping and running, we work as a team. If there are three of us working in tandem, then the senior gets what they need and no one person gets overwhelmed." (*St. Joseph's Home Care Staff, 2018*).

Connectors also served as a central contact, liaising between multiple providers to coordinate services. They found that creating a circle of care around a senior produced a better outcome.

The HSIIP services relieved pressure on an overburdened system and responded to limitations by taking on clients and tasks that others did not have capacity for. The relationship between Connectors and hospital social workers was a prime example. In interviews, hospital social workers explained their limitations: they struggle to serve the number of isolated seniors they find; they do not have time to help follow through on referrals; they are confined to hospital property; their involvement ends when a senior returns home; and they can't rely on intensive case management services due to waitlists and strict criteria. While all these barriers exist, seniors still need help to navigate the service system. The social workers explained how Connectors filled this gap, becoming like an extension of themselves with "one foot in the hospital and one foot in the community" (Hospital Social Worker C, 2017). Social workers would identify the isolated seniors, assess needs, and suggest a care plan, and the Connectors would follow these seniors into the community to turn that plan into a reality. This improved the ability of hospital social workers to successfully discharge seniors:

> "I know there are patients who would not have been discharged if there was not a Connector involved… They are like eyes in the home, helping with things that we can't do here from the hospital." (*Hospital Social Worker B, 2017*).

> "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." (*Hospital Social Worker C, 2017*).

> "The Connector very nicely fills a gap… There are a lot of patients who don't fully fit criteria for programs but still need somebody. Patients who are not likely to follow though, or are unable, or are overwhelmed. Plus, they don't always hear everything on discharge, or don't know how to talk to community programs, how to advocate for themselves." (*Hospital Social Worker D, 2017*) .

Connectors also improved the flow of information between hospitals and community. Intensive case managers from Catholic Family Services reported that they received more communication about seniors being discharged from hospital through Connectors and Connectors reported that they were able to educate hospital social workers about a wider range of community resources.

The relationship between Connectors and housing social workers was another example of how the HSIIP bridged gaps in the service system. These social workers explained that they are responsible for assisting a very large number of tenants, which does not allow them to provide much one-on-one support. When they did become aware of a senior who was isolated and needing support, they were able to rely on Connectors to help those individuals. For example, a housing social worker stated:

> "I deal with a lot of administrative things… I can do referrals too, but I can't do them as these guys can. They are not rushing the tenant into anything. They begin by developing a relationship, they are showing them options, bringing them information… meet them anywhere they want. I don't have that kind of time. I'm putting our fires, that's it. They are really getting these seniors involved and away from here." (*Housing Social Worker B, 2017*).

A separate focus group was held with Catholic Family Services of Hamilton. Their intensive case management programs focus on seniors at risk, seniors with dementia, seniors at high risk for self-neglect, and support for socially isolated seniors. The various HSIIP connector and peer programs came to work closely with CFS case

managers in an integrated model – often sharing similar caseloads. Below a short description of system benefits is described based on the organizations working together on behalf of isolated seniors:

- Connectors have helped with our wait list.
- Excellent responsiveness, social participation fund, improved access to social activities (Wesley).
- Hospital connectors are great – in the past CFS never got information from hospitals. Connectors are right there (we get discharge information).
- We coordinate our services – we do case management, you do the connections.

As expected, a few weaknesses were identified including the need for more timely communication. Many clients require accompaniment, and this is an ongoing resource issue. Finally, the need for mental health training and connector coverage 7 days a week were identified as gaps. The question was also raised about the 6-month period for connector support – what will happen to the client after this timeframe.

As a final example, intensive case managers from Catholic Family Services (CFS) explained how Connectors helped them to manage their waitlist more effectively:

> "If a Connector is involved at the outset, they will do many of the needed community connections. So, what we do is put the client on the CFS waitlist for now because the main concerns are being addressed. There is no extreme urgency like abuse or dementia wandering risk… In the meantime, I say here is my phone number, if the situation changes call me and we will update the file. Let me know when you are discharging the client… sometimes we will close it as a non-admit because we know all of the referral requests were met." (*Catholic Family Services Staff, 2018*).

Connectors also reported coordinating with CFS frequently:

> "Although we don't provide the same level of support, we do bridge that gap until someone from CFS comes into the circle of care. Our experience has been to use a team approach – 'we will take on these goals, you take on those goals'… I have a client now that is on the CFS waitlist and probably will be for another two months. Every two weeks I call in to CFS to tell them where we are at and ask where they are at." (*AbleLiving Staff, 2018*).

In this relationship the staff of CFS prioritized the most complex cases, while Connectors supported those seniors who were not in as deep a crisis but still needed help to access services and activities.

As a result of the HSIIP, service delivery was improved across the community and seniors who otherwise would not have received adequate support had their needs met. This increased resiliency among seniors, prevented decline and reduced unnecessary service usage, resulting in cost-savings in many areas.

While Connectors were proud of the important role they had in Greater Hamilton's continuum of supports for seniors, it was important that other providers understood that the Connectors were not an unlimited resource. They reported having to set boundaries around what they could help with. For example, Hospital Connectors placed a limit on the number of appointments they could accompany a senior to, which helped to avoid being overwhelmed beyond their capacity.

6.5 Summary

The Connector services improved and coordinated supports for vulnerable seniors in Greater Hamilton. Connectors operated outside of the traditional mould, using a flexible, collaborative, person-centered approach to address gaps in the community's service system. They increased collaboration among service providers, relieved pressure on overburdened services, and responded to limitations by taking on clients and tasks that others did not have capacity for. Through this model, the Collaborative was able to meet the needs of many seniors who otherwise would not have received adequate support. This improved resiliency of seniors and the community, limiting the growth of people who will need critical care.

To improve and coordinate supports in Greater Hamilton, the Collaborative launched the Hamilton Community Support Services (HCSS) platform and used the Connector services to fill systemic gaps.

Although the HCSS platform had great potential, the number of referrals exchanged through the website was lower than expected. The Collaborative promoted it and provided training, but still struggled to convince others to adopt this new technology. Staff turnover also impacted results. These challenges were addressed through a change in staffing in year two; new partners came to the table and the number of referrals exchanged through the platform increased. Overall, the Collaborative learned that agencies are not eager to adopt a web-based platform and in future influential champions and other strategies are needed to ensure similar platforms are adopted.

7. Understand Isolation & Facilitate Response

To improve understanding of isolation, the Collaborative undertook a research and knowledge translation project in partnership with the Gilbrea Centre for Studies in Aging at McMaster University. The objectives of the participatory research project were as follows:

- To identify high priority issues for socially isolated seniors and community stakeholders.
- To work alongside six organizations of the Hamilton Seniors Isolation Impact Plan (HSIIP) Connectors program to train community workers about social isolation and to share knowledge about how to identify, connect and anchor isolated seniors in Hamilton, Ontario.
- To co-create innovative solutions to reduce social isolation across Greater Hamilton.

7.1 Activities

A number of research activities took place including conducting literature reviews, geographic mapping, interviews and focus groups, literature reviews and collection of client stories. Findings were used to create knowledge translation materials that were delivered to the Collaborative including a written report about trends of isolation in Greater Hamilton, information sheets, training modules, client success stories, and academic articles.

The interviews and focus groups targeted seniors at-risk or living in isolation and organizational stakeholders. The aim was to identify their understanding of isolation in Greater Hamilton by focusing on the causes, risk factors, barriers, gaps, and strengths, as well as what could be done to help combat isolation of at-risk seniors. In addition, the Gilbrea team managed public knowledge exchange for the HSIIP project, designing and managing the socialisolation.ca website, creating and publishing numerous written materials, presenting at

events and conferences, and promoting relevant events and news items via Gilbrea's twitter feed over the three years of the project.

7.2 Outputs (May 2016 – March 2019)

As part of research activities, the team conducted four stakeholder focus groups (19 participants) and 18 stakeholder interviews. They also completed four focus groups (14 participants) and 14 interviews with seniors. In total, the study included 65 participants. Year three focussed on data analysis and report writing. The research team produced one written report and three summary briefs of the research findings, including five clear recommendations and a list of actions for policy makers. Two academic publications on themes from the study findings are in progress for submission to peer reviewed academic journals in 2019. In addition, the team created and published nine success stories, seven information sheets, five blog posts, four training modules, two literature reviews, and two reports highlighting social and demographic trends relevant to isolation in Hamilton. Gilbrea also produced and shared ten knowledge mobilization infographic summaries with ESDC, as a reader friendly method to report on knowledge exchange activities throughout the project.

Stakeholders provided insight on social isolation among seniors and catalysts that pose risks to becoming isolated. As an example, a key risk is living "behind closed doors" and not being reached through existing channels. These seniors may have multiple, complex health and social needs, and the existing service system is inadequate or inaccessible. Many isolated seniors have fallen "between the cracks". Other mitigating factors are low income, inadequate transportation, and "critical life transitions" such a losing independence through illness, mobility and/or loss of family, etc. Stakeholders identified a number of priorities to reduce isolation and the overburden on hospitals and emergency departments:

- Improve outreach strategies to identify and engage socially isolated seniors;
- Time and resources to address basic life needs of the most vulnerable seniors;
- Sustainable funding for programs and services that address social isolation among seniors; and
- Better coordination of social support services for at-risk seniors.

Feedback from seniors themselves was very enlightening. Similar factors were cited for increasing the risk of social isolation:

- Inaccessible communities and lack of suitable transportation (especially in rural areas);
- Shortage of affordable, safe and supportive housing;
- Low income;
- Language and cultural barriers; and
- Personality factors and personal preferences.

The key themes for reducing isolations and to support independence and engagement were as follows:

- Safe and affordable housing options with proximity to social and practical supports;
- Improve transportation service in rural areas;
- Improve accessibility of programs, services and public spaces; and
- Sustainable funding for community programs such as the Connector Program that focus on addressing barriers to social engagement.

The Gilbrea team prioritized knowledge exchange at the national, provincial and local levels, and worked on building partnerships with public, academic and policy audiences. Research staff presented study findings at three national conferences (with two additional abstracts submitted for conferences in 2019), and the team established links on social isolation work with CARP, Canada's largest advocacy association for older Canadians. Gilbrea Director Amanda Grenier has also been invited to speak at the House of Commons (2019) on issues related to the project. At the provincial level, Gilbrea led a webinar on social isolation in collaboration with the Retired Teachers of Ontario Foundation, and Ontario's Medical Officer of Health included HSIIP as a case study in a section of their annual report, Creating Supportive, Connected Communities, in which they highlighted examples addressing social isolation. Locally, in addition to attending and leading community events relevant to aging in Hamilton, Gilbrea staff conducted keynote addresses at two local events (2007, 2018) and led three seniors' advisory board meetings.

7.3 Lessons Learned

The knowledge translation materials provided by Gilbrea were instrumental in educating the Collaborative and providing content for outreach activities with the broader community. The website was a successful method of sharing knowledge about isolation and the information sheets and client success stories were widely distributed on the ground as well. The results of the primary research are forthcoming. The research team tapped into a wealth of valuable knowledge that will be useful to policy-makers and practitioners.

An interview with Amanda Grenier, the Director of Gilbrea Centre for Studies in Aging provided context about some factors that contributed to delays in the research process. The main challenge was staff turnover. Furthermore, the research team found the University process to be time consuming. For example, getting the ethics board to approve the HSIIP research took longer than anticipated due to the number of partners and participants involved. A final challenge was that the amount of time it took to develop and maintain the website.

7.4 Summary

In partnership with the Gilbrea Centre for Studies in Aging at McMaster University, the Collaborative conducted research with community stakeholders and developed a variety of knowledge translation materials. The resulting knowledge translation materials were successfully deployed to educate the Collaborative and produce content for outreach activities. The primary research results emanating from stakeholders and seniors themselves provided insight about the risks of isolation and mitigating factors. Key themes for reducing isolation and ways to promote better engagement among seniors were noted. The potential impact of the Centre's research activities is that policy briefs will be used to guide policy and practice decisions at all levels of government with the clear intent of helping older persons access services, becoming engaged and reducing social isolation.

8. Evaluate & Scale What Works

The Backbone collaborated with a consultant to oversee the evaluation of the HSIIP. Due to the innovative nature of this initiative, a developmental approach was adopted that focused on learning and adaptation.

8.1 Activities

The Backbone and evaluation consultant worked together in:

- Creating an evaluation strategy;
- Identifying indicators and developing data tracking tools;
- Addressing evaluation as a standing item at meetings;
- Providing guidance for data collection;
- Conducting interviews and focus groups;
- Mapping the client database;
- Compiling, analyzing and discussing data on a semi-annual basis;
- Conducting an annual 'Health of the Collaborative Survey';
- Producing annual evaluation reports; and
- Sharing findings at community events.

8.2 Outputs

The following data collection tools were produced: intake survey, exit survey, client databases, indicator reporting templates, interview and focus group guides, and a Health of the Collaborative Survey. The evaluation consultant conducted six focus groups with HSIIP partners, as well as two focus groups and six interviews with external stakeholders. The Backbone facilitated two mid-year evaluations and three annual evaluations by the end of March 2019.

8.3 Lessons Learned

Significant time was invested upfront to produce surveys and databases. Connectors were continuously engaged in the development and utilization of these tools through Outreach Team meetings. This produced a robust set of client data that was instrumental in understanding the target population and the impacts of HSIIP services. However, Connectors felt some of the data collected in exit surveys was too subjective. They reported that in some cases they provided a great deal of support to a senior and connected them to multiple resources but would still receive a negative review on the exit survey. This tended to happen when the Connector could not facilitate access to a particular service (due to a waitlist), or when seniors were upset about being discharged from the Connector's care. There are other less subjective methods that could have been implemented, for example tracking the number of connections made for a given senior. This would require specialized utilization software to be developed and a common database shared among users.

The Collaborative successfully agreed upon indicators and linked them to shared goals and objectives. The Backbone received satisfactory data for most of these indicators through the semi-annual reporting templates and this was used to assess and report on progress. The shared measurement system could be improved by defining targets for more of the indicators. It was also identified that the targets established for population goals were somewhat unrealistic. Improved epidemiological population data is required to help estimate the true number of severely isolated seniors in the population. Estimates vary widely.

Interviews and focus groups conducted by the evaluation consultant produced rich qualitative insights. The process of gathering and analyzing this data enabled the Collaborative to reflect on impacts of the HSIIP and to

distill lessons learned through each of the projects. The annual Health of the Collaborative survey was also a useful mechanism for identifying successes of the model and concerns of the partners.

Restrictions on sharing confidential information made the process of collecting and compiling data more time consuming and challenging than it needed to be. Ideally the Connectors would share one database that could be updated in real time across the projects. This would require the partners to put in place confidentiality agreements and develop or adapt specific client utilization software for this purpose.

The Collaborative found it challenging to strike the right balance between practicality and the collection of high-quality data. The evaluation demands of a collective impact initiative were considerable and partners underestimated the amount of time and resources required to participate in this type of shared data collection and reporting.

8.4 Summary

The Backbone and evaluation consultant helped partners to design and implement multiple data collection tools. Client surveys and databases produced robust data about the target population and impacts of Connector services. Other indicators were tracked with a fair degree of success. Interviews and focus groups contributed rich qualitative insights about the learnings and system impacts of the projects. Data was compiled, analyzed, and discussed on a semi-annual basis. The findings demonstrated progress towards shared objectives and helped the Steering Committee to develop strategies and adjust approaches.

9. Recommendations

The Collaborative learned a great deal about addressing isolation using a collective impact model and many of these insights can be incorporated into future projects. Based on successes and challenges outlined in this report, the Backbone offers the following recommendations:

Learning	Recommendation
Gaining referrals is challenging and requires extensive outreach. There are many more outreach opportunities.	Expand outreach efforts, recruit novel partners, and continue educating the community.
Maintaining a consistent presence in seniors' buildings is an effective way to identify isolated seniors.	Consider a future project that embeds Connectors into seniors' buildings.
Connecting isolated seniors takes more time than anticipated. Also, many have unmet basic needs and face complex barriers.	Set more realistic targets and plan for more Connectors if possible.
In particular, accompanying isolated seniors to appointments is important for outcomes but also very resource intensive.	Consider taking on students to assist with accompanying seniors to appointments, or hire a PSW to join the Connector team for this purpose.
Mental health issues are prevalent among isolated seniors and require extra supports that are lacking in the community.	Consider a future project that would provide specialized 'mental health connectors'.

Learning	Recommendation
Isolated seniors living in rural areas are difficult to find and there are few opportunities to connect them due to lack of transportation.	Consider a future project that provides transportation to isolated seniors in rural areas.
Isolated seniors who do not speak English are difficult to find and require resources to bridge the language barrier.	Acquire additional resources for language translation and interpretation.
Convincing staff of other organizations to use the Hamilton Community Support Services platform is challenging.	Recruit influential champion(s) to adopt and promote the HCSS platform.
Evaluation methods could be less subjective. More targets could be defined. Data collection would be less time consuming if confidential information could be shared.	Consider tracking some new data (e.g. number of connections made per client). Define more targets for key indicators. Explore the possibility of signing confidentiality agreements in order to share one database among partners.
Significant lead time is required to market the program, build relationships, establish partnerships, etc., before seniors are identified and connected.	Provide some developmental time beforehand (3-4 months) to establish the program in the community with stakeholders, partners, data base requirements, etc., to offset the challenges of establishing a new program.

10. Conclusion

For the past three years, with support from the Government of Canada's New Horizons for Seniors Program, partners of the Hamilton Seniors Isolation Impact Plan collaborated to deliver innovative projects that reduce isolation. The HSIIP Collaborative approached supporting 20% of isolated seniors by the end of year three and is proud of the accomplishments it achieved in three years considering the lessons learned and barriers faced.

Together the partners produced knowledge about isolation, raised awareness across the community, and provided HSIIP Connector services to 1,556 seniors. This resulted in significant population level improvements; by the end of March 2019 it was estimated that 13.7% of isolated seniors in Greater Hamilton had increased access to help and support; 8.8% had increased participation in activities; 9.5% felt more connected to people; and 8.7% felt more valued by people as a result of the HSIIP services. In the process of achieving these outcomes the Collaborative gained valuable wisdom, built a strong network of partnerships and filled important gaps in the region's continuum of supports for at-risk seniors.

The level of need for the HSIIP Connector services is high and many seniors will remain isolated without supports. Regardless of future funding, the HSIIP initiative created lasting impacts including improved resiliency of seniors served, increased awareness of isolation, better identification and referral of isolated seniors, and stronger community partnerships, including those of the Seniors At-Risk Community Collaborative.

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Appendix 1 Literature Review

Delayed Hospital Discharge

- Social isolation, and high risk of social isolation, is a significant predictor of delayed hospital acute care discharge (Landeiro et al, 2016).

Community Health Promotion and Prevention (Reduce Costs)

- Raising the Profile of the Community-based Senior Services Sector in B.C. (March 2017), provides evidence that greater emphasis on health promotion and prevention programming and interventions that foster resilience can result in significant improvements in seniors' health and reductions in the use and costs to the healthcare system.

Emergency Services

- Social Isolation in Canadian Older Adults (Khamisa, 2016). From a systemic perspective, social isolation in older adults can translate into health and social care systems being improperly utilized. Data within the U.K. points to older adults accessing emergency care because they are overwhelmingly lonely or because isolation and loneliness have altered their ability to manage illness. The author suggests that the focus for identifying and intervening with the socially isolated might occur at the common touchpoints of the healthcare system, such as primary care or emergency departments.
- Another area to monitor is "social admission" to hospital. Having systems in place for healthcare providers to recognize, monitor and respond to social isolation is an important component to any system level discussion of healthy aging. (P. 13).

Social Isolation and Exclusion Effects Health and System Utilization

- Health and Social Service Usage (B.C., 2004). Social isolation and exclusion are associated with increased rates of premature death, lower general well-being, more depression, and a higher level of disability from chronic diseases. This leads to increased use of social and health services.
- Greater utilization of hospital emergency room services is incurred among older adults without family support networks.
- Higher levels of loneliness were found among women who had more admissions to hospital, longer stays in hospital, more physician visits, more pharmacy claims, and more use of homecare services (Havens and Hall, 1999).
- Studies show a relationship between social isolation and greater homecare use (Wilkins, 2000). Persons who had a change in their households to "living alone" were three times more likely to need homecare.
- Extreme loneliness may be a predictor for rural adults entering nursing homes (Russell, 1997). Seniors who reported attending religious services were less likely to be admitted to a nursing home. Marriage, having one daughter or sibling, were protective factors from nursing home admission. Overall rural residents tended to rely more on family than homecare services compared to urban counterparts.

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