National Collaborating Centre for Determinants of Health

Centre de collaboration nationale des déterminants de la santé

National Collaborating Centre for Infectious Diseases

Centre de collaboration nationale des maladies infectieuses

# LEARNING FROM PRACTICE:

## JOINT ACTION FOR EQUITY – FOSTERING HEALTHY AGING THROUGH PARTNERSHIPS AND SOCIAL PRESCRIBING

### WHAT'S INSIDE...

What follows is a story that illustrates how primary care and community organizations collaborated to improve population health and health equity, and how public health partnerships can be enhanced. This and other Joint Action for Equity stories in the Learning from Practice Series highlight principles and practices that support improved relationships between public health and primary care, and the important role of communities in strengthening health systems.

This case study highlights how the Community Action and Resources Empowering Seniors (CARES) program supports older adults by focusing on social determinants that impact their health. CARES partners primary care providers in the Fraser Health region of British Columbia with health coaches within community organizations to provide an evidence-based program that integrates health promotion, injury prevention, and multisectoral and community partnerships.[1] The CARES program is an example of a primary health care program that works to enhance population health and well-being through local-scale interventions and connecting people with community-based organizations and services to improve key determinants of health.

This practice example is based on reflections from Dr. Grace Park and Margaret Lin from the CARES program. Perspectives and lessons should be considered within the context of what was distilled from an interview conducted in August 2022.

## PROJECT BACKGROUND

The goal of public health is to improve the health of populations through protection, promotion, prevention, disease and injury surveillance and responses, and emergency preparedness. Primary care supports first-contact, accessible, continued, comprehensive and coordinated patient-focused care.[9] Primary care and public health tend to operate independently, but the World Health Organization (WHO) recommends greater integration through ***primary health care***.

The WHO and United Nations Children's Fund (UNICEF) describe primary health care as a holistic approach to strengthen relationships and integrate public health and primary care services locally, with multisectoral actions to empower communities, promote population health and improve health equity.[4]

The ***Joint Action for Equity*** project — a collaboration of the National Collaborating Centre for Determinants of Health (NCCDH) and National Collaborating Centre for Infectious Diseases (NCCID) — highlights examples of sector integration and primary health care. The project profiles stories of how public health programs, primary care service providers and community members created innovative partnerships to respond to local health issues and achieve greater equity in health outcomes.

## SETTING THE STAGE

Investing in healthy aging is a key public health priority, especially as the life expectancy and proportion of older adults in Canada is increasing.[2] In response to the growing need for health promotion to address the health and wellness priorities among older adults, Dr. Grace Park and her team developed the Community Action and Resources Empowering Seniors (CARES) program. The CARES program "looks at how can we identify seniors at the primary care level who may be approaching early frailty. Not yet frail but getting to the point where we can say they may need help somewhere down the road in the next several years," stated Dr. Park.

Dr. Park's passion for health promotion in older adults stems from over 30 years as a family physician. For the last 13 years, she has been the Regional Medical Director for Home and Community Health Services in the Fraser Health Authority in British Columbia. Her clinical work informs her interest in frailty prevention and management. "Being from the world of primary care, we felt that there was a whole lot of opportunity to identify and measure frailty before people became so debilitated that they needed health authority services and ended up in acute care systems and community health authority systems services," reflected Dr. Park.

Margaret Lin is the Project Lead for the CARES team. She is a registered nurse with a background in geriatric medicine and a Master of Health Leadership and Policy in Seniors Care. She is also the Social Prescribing Change Lead working with other team members in Fraser Health to try to implement social prescribing and other initiatives throughout the Fraser Health region. Lin described **social prescribing** as a way to reach and provide support to those who are not connected to resources, thereby advancing health equity.

In this practice example, Ms. Lin and Dr. Park reflected on the facilitators and barriers to implementing, delivering and expanding the CARES program as a primary health care

**Social prescribing**, according to the Canadian Institute for Social Prescribing, is a "global movement of people bringing community capacity and healthcare services closer together by directly addressing the social determinants of health, from loneliness and social isolation to racism and ageism to income and housing and much more".[7] Primary care providers give non-medical prescriptions that refer people to their local community and social services to support their non-clinical needs (e.g., housing, transportation, food security, better income, social belonging and connection).

initiative. The CARES program demonstrates the levers identified by the WHO and UNICEF for achieving primary health care in practice: (1) integrated health services with an emphasis on primary care and public health functions, (2) multisectoral policy and action, and (3) people and communities engaged and invested in their own health.[3,4]

## GETTING STARTED

### Program development

CARES started in 2014 as an implementation program as part of the Canadian Foundation for Healthcare Improvement leadership development program.[a] Dr. Park and her team did a thorough literature search for programs that supported promotion of healthy aging and prevention of frailty. They identified that there were challenges for older adults to equitably access health and social services in Canada, such as gaps in knowledge about programs, services and benefits or not having a means of transportation or finances required to participate in programs. For example, "In some other parts of the world they have programs that reach out to older adults at a certain age like 70. They then inform the older adults about community programs and health services that may be of benefit to them. We don't have that in our system of care," reflected Dr. Park. The CARES program was developed to address these gaps, taking a more upstream approach aiming to identify, measure and prevent frailty and support healthy aging.

### Primary care uptake

Once developed, the CARES team connected with all 10 divisions of family practice[b] within the Fraser Health region. This was achieved through the relationships Dr. Park already had developed in her role at Fraser Health.

The CARES program and social prescribing has had excellent physician uptake. "The physicians are very aware of the need to do that social planning as part of their wellness planning and health planning and do as much as they can to address social determinants of health," explained Dr. Park. The work has extended beyond family physicians to other primary care providers such as nurse practitioners and other allied health professionals. The CARES team has also looked for ways to connect to older adults beyond primary care clinics, like assisted living facilities and acute care sites at time of discharge.

*Screening for frailty risk*

The CARES team created an evidence-based frailty screening tool, based on the validated Rockwell Clinical Frailty tool,[5] that can be embedded directly into electronic medical records (EMRs) for point-of-care use by primary care providers. This improves frailty surveillance and frailty prevention program efficiency and enables evaluation processes. When people screen as having a higher risk of experiencing frailty, the primary care provider and their team then conducts a comprehensive geriatric assessment that was also developed by CARES to measure a person's level of frailty as well as possible health and social wellness needs.

a EXTRA™: Executive Training Program, now offered by Healthcare Excellence Canada, is a team-based, bilingual program that focuses on building the capabilities of leaders to improve quality and safety in health care.

b Divisions of family practice are community-based non-profit groups that provide infrastructure support for family physicians to work together to address common health care priorities in their regions.

Social inclusion and community belonging are **social determinants of health** and wellbeing.[6] Social isolation was identified by the CARES team as a key risk factor for frailty. Through a review of the literature the CARES team found that sense of belonging could be strengthened by connecting older adults with community organizations. However, there were financial, physical, cultural and psychological barriers that needed to be addressed in order to foster and enhance connections and build community belonging.

Reflecting on life circumstances experienced by older adults, such as loss of independence, living alone and being isolated, Dr. Park identified concern about how certain events can negatively impact health. Primary care providers can work with older people experiencing circumstances that increase their risk of isolation and negative health impacts to address their needs, including through a full geriatric assessment and referral to CARES.

**According to the NCCDH:**
The **social determinants of health** are the interrelated social, political and economic circumstances in which people are born, grow up, live, work and age.[10] The social determinants of health do not operate in isolation. It is how these determinants intersect that causes conditions of daily living to shift and change over time and across the life span, impacting the health of individuals, groups and communities in different ways.[11]

*This description is from the National Collaborating Centre for Determinants of Health's Glossary of essential health equity terms,[6] which supports action on the structural and social determinants of health and health equity through the use of clear and consistent terminology.*

*Referring older adults to CARES social prescribing*

Time constraints often prevent physicians from engaging in the full geriatric assessment and wellness care planning, which can take a full hour. To help address this challenge, a social prescribing referral process was integrated into the CARES program. Primary care providers can refer people through a single intake phone number where they can be enrolled in the CARES social prescribing program, which then facilitates care planning and goal setting to address gaps in wellness. "It might be a community resource, like appropriate exercise, and in order to get there they might need help with transportation or finances to cover the cost, and that's where the idea of social prescribing was born," explained Dr. Park.

## Partnering with community organizations

Addressing the complex wellness needs of older adults is fundamentally a work of partnership among organizations and the people themselves. The social prescribing aspect of the CARES social prescribing program is delivered in partnership with community non-profit organizations. Funding is provided through a provincial government grant delivered through United Way British Columbia to community non-profit organizations that employ health coaches.

In each of the 10 divisions of family practice within Fraser Health, a local non-profit organization partners and works with the primary care providers through health coaches referred to as seniors' community connectors or simply connectors. These connectors are also sometimes called link workers, navigators or wellness coordinators in other countries implementing social prescribing.[7] Connectors work out of the non-profit organizations and coordinate the social prescribing, working directly with older people who are referred to them and supporting them to identify their own priorities and create their own health and wellness goals based on their lived experience and strengths.

Connectors come from a variety of backgrounds such as nursing, mental health and social work, and they also include long-term volunteers who have no formal health care training. All connectors receive motivational interviewing education and learn how set SMART (specific, measurable, attainable, realistic, timely) goals with the people they support. The CARES team regularly follows up with community connectors to support them in their work and provide them with education and training as needed.

Dr. Park provided an example how equity is improved as not all people are able to equally access services, for example, "because of transportation needs, financial needs or they don't have the technology to be able to go online to find those resources," and the connectors are able to bridge gaps and support people to overcome barriers. Connectors develop relationships with the older adult over several months, often involving new links with organizations and services in the community.

Since the CARES social prescribing program has grown, the team recognizes the need for increased funding, particularly to increase the program's capacity to support more older people living in the community. One way is through signposting, which aims to ensure that the connectors' time with people is preserved and not rushed and dedicated to those with the highest needs. It is a related yet distinct initiative that recognizes that not everyone needs a full referral and comprehensive assessment to identify their social needs, yet many would still benefit from receiving enhanced but more targeted information and guidance. Building on the existing BC211 helpline, signposting directs people and care providers to resources and support services. CARES supports primary care providers to work with older people to decide which approach is best suited for them.

## BRIDGE-BUILDING AND EDUCATING

A big part of the role of the CARES team is to bridge between primary care, community non-profit organizations, community members and partners. CARES collaborates with older adults in program development, for example, by involving clients as members of the planning team. Providing education is a component of bridge-building. CARES staff teach primary care providers about social prescribing concepts, benefits and processes. The CARES team developed posters and worked with the divisions of family practice to build awareness of social prescribing and signposting.

> "We want to create messaging for healthy aging that starts really upstream, from when you're still able to manage but needing a little bit of navigation, all the way through social prescribing for the population that need more hands on help, and finally for those that need in home care as well, along with support for their caregivers."
>
> DR. PARK

Moving forward, CARES recognizes the need for a standardized process for social prescribing. They have been connecting with the Canadian Institute for Social Prescribing, which is a brand-new Red Cross-managed organization that aims to develop education support and resources for social prescribers across the country. This is an opportunity for collaboration across many sectors and groups that have an interest in social prescribing and enhancing action on the social determinants with a primary health care lens.

The CARES team also recognizes that their work requires an intersectoral approach that is "full spectrum of what you need to age well and all the services that can be there to help you," said Dr. Park, "So that will be a huge partnership between health authority, community, public health and community practitioners." Thus, CARES has also begun building relationships with publicly funded health practitioners in Fraser Health, for example through connections with home support. Through her involvement in home and community health service portfolios Dr. Park has seen how practitioners are often "doing their different kinds of work and often in siloes." She looks forward to finding ways to enhance multisectoral collaboration.

The CARES leaders are excited to foster and deepen relationships with public health and to act as a bridge to support connections between community organizations and public health. In particular, CARES leaders are working so that social assessments and further upstream primary care work will support and amplify the work of public health in promoting healthy aging at a population level.

Health inequities are experienced by older adults. A top priority for policy change affecting older adult health is for "local public health agencies to place greater emphasis on meeting the needs of older adults and leading a cultural shift."[8(p7)] Establishing healthy aging as a priority in official public health mandates and cultural competence training in healthy aging are ways of supporting action on a comprehensive health promotion strategy for healthy aging.[8]

## LESSONS LEARNED

### Organizational support is essential to advance upstream work

At the time CARES started, the Fraser Health CEO expressed concern about the growing health needs of an aging population and provided organizational support for interventions that are focused on prevention and health promotion. This included sponsoring Dr. Park and her team to travel to Ontario to build leadership capacity through the EXTRA™: Executive Training Program. Dr. Park recalled how organizational support was essential to starting CARES: "We have a message here that this is a priority for the organization and is a strategy for the health system that we live in. That opened a lot of doors. I think you need that level of commitment, that level of support." Having physician champions was critical to enabling program success, and securing funding.

### Integrated data, surveillance and digital systems strengthen individual and population health approaches

Essential to CARES is the ability to share data among service providers. CARES conducted a privacy impact assessment with the United Way and established organizational structures, guidelines and systems to ensure privacy while supporting people to understand referral consent and sharing information with their care providers. The use of the EMR as a digital system makes it possible to aggregate data with no identifying information, which enables surveillance of frailty at a population level and an ability to evaluate the impacts of social prescribing as an intervention.

### Primary care is multidisciplinary, intersectoral and preventative and supports public health

As the CARES program has spread throughout the Fraser Health region, community health and allied health professionals have been an integral part of the team. Health promotion, chronic disease prevention and acting on the social determinants of health are pillars of public health. Dr. Park reflected on their work and how it "actually gets us into the world of population health and healthy aging" and into the work of public health.

> "The partnerships were really, eye-opening. Also recognizing that each of us in each of our sectors have a lot to offer, and it's by connecting and integrating that we can actually develop a more robust system and way forward for healthy aging."
>
> DR. PARK

### Partnerships and relationships are key levers for successful primary health care programs

Dr. Park recommended that developing a program like CARES should start with establishing strong partnerships and champions. Such partners "can actually open doors for people and speak to their colleagues and speak to the leadership." She described these partnerships and champions as the systems-level levers that catalyzed the success of the CARES program. By connecting with like-minded organizations and thinkers, such as with the Ministry of Health, United Way and the Canadian Institute for Social Prescribing they have been able to raise awareness of social prescribing to a national level.

Margaret Lin emphasized the importance of willingness to be flexible and reflective when engaging in partnerships for health equity: "Because it's just so diverse that a lot of times, if we do a one size fits all, it just never works and it's not going to stick because people can clearly know that you're not really caring about what matters to them, especially when everyone has a different perspective and different needs and different barriers." Lin encouraged practitioners to look "wherever the needs are, meeting them wherever they are and bridging the gaps and overcoming the barriers. That's been our way of addressing health equity."

## LOOKING AHEAD: ADVANCING PRIMARY HEALTH CARE

Building infrastructure for healthy aging requires health system reorientation towards upstream interventions and services and multisectoral collaboration. Primary health care provides a framework for health system renewal in Canada and envisions health system transformation towards health for all.

According to the WHO and UNICEF, "Better health outcomes, improved equity, increased health security and better cost-efficiency make primary health care the cornerstone of health systems strengthening."[4(pXIX)] The CARES program provides an example of primary health care programming through integrated health services with a life-course orientation: strategically prioritizing primary care services to address the broader determinants of health, integrating public health functions of health promotion and injury/illness prevention, and enabling people to optimize their own health.

Deepening partnerships and collaboration between public health, primary care and community is essential to strengthening health equity and improving health for all. The CARES program demonstrates there are many opportunities for public health and primary care to work together at the community level to improve health equity.

## QUESTIONS FOR REFLECTION

- **Where is work happening within primary care to shift interventions further upstream towards health promotion and illness and injury prevention? How can public health collaborate with primary care and the community to support such work?**
- **Where are other areas, outside of public health, that are building population health and health promotion interventions?**
- **What does it look like to put communities at the centre of health equity work? What are the opportunities and challenges?**

# REFERENCES


1. Healthcare Excellence Canada. Community Action and Resources Empowering Seniors (CARES) program [Internet]. Ottawa (ON): HEC; [cited 2023 Jul 28]. [about 3 screens]. Available from: https://www.healthcareexcellence.ca/en/what-we-do/all-programs/advancing-frailty-care-in-the-community/community-action-and-resources-empowering-seniors.
2. Edwards P, Mawani A. Healthy aging in Canada: a new vision, a vital investment [Internet]. Ottawa (ON): Federal, Provincial and Territorial Committee of Officials (Seniors), Healthy Aging and Wellness Working Group; 2006 [cited 2023 Aug 23]. 21 p. Available from: https://www.phac-aspc.gc.ca/seniors-aines/ alt-formats/pdf/publications/public/healthy-sante/vision/visioneng.pdf
3. World Health Organization; United Nations Children's Fund (UNICEF). A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals [Internet]. Geneva (Switzerland): WHO; 2018 [cited 2023 Jul 28]. 46 p. Available from: https://apps.who.int/iris/handle/10665/328065.
4. World Health Organization; United Nations Children's Fund (UNICEF). Operational framework for primary health care: transforming vision into action [Internet]. Geneva (Switzerland): WHO; 2020 [cited 2023 Jul 28]. 106 p. Available from: https://apps.who.int/iris/rest/bitstreams/1321790/retrieve.
5. Dalhousie University, Geriatric Medicine Research. Clinical frailty scale [Internet]. Halifax (NS): GMR; [cited 2023 Jul 28]. [about 3 screens]. Available from: https://www.dal.ca/sites/gmr/our-tools/clinical-frailty-scale.html
6. National Collaborating Centre for Determinants of Health. Glossary of essential health equity terms [Internet]. Antigonish (NS): NCCDH, St. Francis Xavier University; [updated 2022 Mar; cited 2023 Jul 28]. Available from: https://nccdh.ca/learn/glossary.
7. Canadian Institute for Social Prescribing [Internet]. Toronto (ON): CISP; [cited 2023 Jul 28]. [about 9 screens]. Available from: https://www.socialprescribing.ca.
8. National Collaborating Centre for Determinants of Health. Learning from Practice: Promoting well-being and health equity among older adults [Internet]. Antigonish (NS): NCCDH, St. Francis Xavier University; 2023 [cited 2023 Jul 28]. 11 p. Available from: https://nccdh.ca/resources/entry/promoting-wellbeing-and-health-equity-among-older-adults
9. Jimenez G, Matchar D, Koh GCH, Tyagi S, van der Kleij RMJJ, Chavannes NH, et al. Revisiting the four core functions (4Cs) of primary care: operational definitions and complexities. Prim Health Care Res Dev. 2021;22:e68 [9 p.]. doi: 10.1017/S1463423621000669.
10. Solar O, Irwin A. A conceptual framework for action on the social determinants of health [Internet]. Geneva (Switzerland): World Health Organization; 2010 [cited 2023 Jul 28]. 75 p. Available from: https://apps.who.int/iris/handle/10665/44489.
11. Raphael D, Bryant T, Mikkonen J, Raphael A. Social determinants of health: the Canadian facts [Internet]. 2nd ed. Oshawa (ON): Ontario Tech University, Faculty of Health Sciences; 2020 [cited 2023 Jul 28]. 93 p. Available from: https://www.thecanadianfacts.org/The_Canadian_Facts-2nd_ed.pdf

## ACKNOWLEDGEMENTS

Written by Hannah Mahar-Klassen, Knowledge Translation Specialist, at the NCCDH. Special thanks to our internal reviewers Kristia (Tia) Maatta, Dianne Oickle and Myrianne Richard, and to our external reviewers Margaret Haworth-Brockman (NCCID), Harpa Isfeld-Kiely (NCCID) and Claire O'Gorman for their thoughtful feedback.

The National Collaborating Centres, NCCID and NCCDH, extend thanks to Dr. Grace Park (Regional Medical Director for Home Health, Specialized Community Health Services and Complex Care, Fraser Health) and Margaret Lin (CARES Project Lead and Social Prescribing Change Lead, Fraser Health) with the Community Action and Resources Empowering Seniors (CARES) program for providing their stories of partnership and lessons learned.

The NCCDH is hosted by St. Francis Xavier University. We acknowledge that we are located in Mi'kma'ki, the ancestral and unceded territory of the Mi'kmaq people.

NCCID is hosted by the University of Manitoba. We acknowledge that Treaty 1 territory and the land on which we gather is the traditional territory of Anishinaabeg, Cree, Oji-Cree, Dakota and Dene Peoples, and is the homeland of the Métis Nation.

National Collaborating Centre for Determinants of Health
Centre de collaboration nationale des déterminants de la santé

**NATIONAL COLLABORATING CENTRE FOR DETERMINANTS OF HEALTH**
St. Francis Xavier University
Antigonish, NS B2G 2W5
(902) 867-6133
nccdh@stfx.ca
www.nccdh.ca
Twitter: @NCCDH_CCNDS

National Collaborating Centre for Infectious Diseases
Centre de collaboration nationale des maladies infectieuses

**NATIONAL COLLABORATING CENTRE FOR INFECTIOUS DISEASES**
Rady Faculty of Health Sciences,
University of Manitoba
tel: (204) 318-2591
nccid@umanitoba.ca
www.nccid.ca

The National Collaborating Centre for Determinants of Health (NCCDH) and the National Collaborating Centre for Infectious Diseases (NCCID) belong to a group of six National Collaborating Centres (NCCs) for Public Health in Canada. Funded by the Public Health Agency of Canada, the NCCs produce information to help public health professionals improve their responses to public health threats, chronic disease and injury, infectious diseases and health inequities. Learn more at www.nccdh.ca and at www.nccid.ca.

Please cite information contained in the document as follows: National Collaborating Centre for Determinants of Health. (2024). *Learning from Practice: Joint Action for Equity – Fostering healthy aging through partnerships.* Antigonish, NS: NCCDH, St. Francis Xavier University.

ISBN: 978-1-998022-12-0

Production of this document has been made possible through a financial contribution from the Public Health Agency of Canada through funding for the National Collaborating Centre for Infectious Diseases and the National Collaborating Centre for Determinants of Health. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada.

This document is available in electronic format (PDF) on the NCCDH and NCCID websites: www.nccdh.ca, www.nccid.ca.

Une version électronique en français de ce document est également disponible sur les sites web suivant: www.ccnmi.ca et www.ccnds.ca.