



South West LOCAL HEALTH INTEGRATION NETWORK

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Aging at Home Strategy for 2008/09
**Guidelines for Developing
Collaborative Proposals**

November 5, 2007

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South West LHIN Aging at Home Strategy for 2008/09 Guidelines for Developing Collaborative Proposals

1. Aging at Home Strategy Background

On August 28, the Ontario government announced the Aging at Home strategy to help seniors live healthy, independent lives in their own homes. This three-year, \$702-million initiative will be led by the Local Health Integration Networks, with each LHIN receiving a specific funding allocation to meet the needs of local communities.

As our population ages it will become increasingly important to ensure there are services and programs in place that enable seniors to remain in their homes for as long as possible. Our goal in the South West LHIN is to create opportunities for seniors to select their personalized lifestyle options through the Aging at Home strategy. Services that could be strengthened as part of this strategy could include enhanced home care and community support services such as meals, transportation, shopping, snow shovelling, friendly home calling, adult day programs, homemaking services and caregiver supports.

Twenty per cent of the funding will be applied to innovative projects. Expectations are that the strategy will offer new possibilities for Ontario's culturally diverse populations and other community organizations, like service clubs and groups of seniors that enable seniors to help each other. Innovative thinking combined with health care solutions that encourage prevention and health promotion will play a large role in our plans to support Ontario's seniors and their caregivers.

The Aging at Home Strategy aims to keep seniors healthy through a comprehensive mix of both traditional and innovative services for seniors and their caregivers by:

1. Increasing the overall supply (range and quantity) of services (represents up to 80% of LHIN allocation) for seniors to stay healthy and live with independence and dignity in their homes with Aging at Home services, *such as*:
 - Community support services
 - Home care
 - Assistive devices
 - Supportive living
 - Long-term care beds
 - End-of-life care

2. Providing opportunities to leverage change through innovation (represents 20% or more of LHIN allocation over three years) for example:
 - Innovative approaches to keeping seniors healthy, through preventive and wellness services and partnerships with non-traditional providers
 - Community economic development approaches for service delivery that will increase access and equity for marginalized and at risk seniors and engage people from communities (e.g. cultural, linguistic) who can identify and connect with service providers and build capacity for helping each other
 - Linkages to primary care such as community health centres and family health teams

1.1 About Innovation

Innovation refers to the introduction of services, programs, service providers, or methods of service delivery that are new, unusual, or in other ways different from those previously used.

In the context of the Aging at Home Strategy, the intention is to use innovation in an integrated service system to help seniors live at home or in their own communities with dignity and independence.

Examples of innovation:

- Modification of an existing program or service for a new type of client (such as preventative participation in day programs for seniors who are essentially well), or to provide service in a new way (offering a meal program at a restaurant instead of in a seniors centre);
- Introduction of a proven program or service from another jurisdiction or discipline;
- Formalization of a program or service that has been tried on an informal basis, but has not been funded;
- Piloting a completely new service or program;
- All-encompassing change, which involves changing the complete structure of service delivery.

Innovation applies not just to new/different/unusual programs or services, but to policies and procedures, methods of service delivery, and people delivering services. It may apply to:

- Products (such as medical equipment and supplies, assistive devices)
- Services (such as therapeutic procedures, models of care, types of programs)
- Processes (administrative procedures, treatment protocols, information technology)

- Organization (strategy/policy, governance, system interaction such as collaboration with new partners)

The criteria for innovation will evolve over the three-year implementation of the Aging at Home Strategy. In the initial phase, to be approved for Aging at Home funding by the LHINs, proposals must meet the following innovation criteria.

Criteria for Innovation

The following criteria have been developed for use by all LHINs to identify innovative initiatives that will qualify for the innovation funding component of the Aging at Home Strategy:

- Unusual, different or new concept
- May not be proven; could have an element of risk
- Variation on an existing service that includes a new method of service delivery, a new target population, or a service provider that has not traditionally provided health care services to the LHIN
- May include a program that has demonstrated effectiveness in another jurisdiction, but has not yet been used in the LHIN
- May include a program that has been tried on an informal basis, but not been formally funded or evaluated
- May involve a process or technology from another discipline (such as education) that has not previously been used in health care or senior care
- May require adjustments or innovations in other aspects of the system, such as policy, legislation, procedures
- Intuitive, i.e. likely to provoke the reaction “That’s a good idea!” from both funders and consumers

2. South West LHIN Aging at Home Strategy

The South West LHIN’s Integrated Health Service Plan (IHSP) identified “Building Linkages Across the Continuum for All Seniors, and Adults with Complex Needs” as an integration priority. The IHSP included an action plan to advance this priority.

Nine Priority Action Teams (PATs) comprised of consumers, health service providers, community partners, and members of the public were created in February, 2007. Three Priority Action Teams focus on the needs of seniors and adults with complex needs in the following areas:

- Creating a Continuum of Care for Seniors and Adults with Complex Needs

- Improved Access to Long Term Care Services for Seniors and Adults with Complex Needs
- Rehabilitation for Seniors and Adults with Complex Needs

The Aging at Home direction of the South West LHIN is based on the work of these three PATs in addition to areas of alignment with other Priority Action Teams such as Hips and Knees, Chronic Disease Prevention and Management, Mental Health and Primary Care.

The South West LHIN will receive one time funding in the amount of \$236,000 for planning purposes in 2007/08 in addition to ongoing funding for health services as follows:

2008/09	\$ 7,005,606
2009/10	\$ 17,409,869
2010/11	\$ 30,748,507 (base funding going forward)

The South West LHIN is encouraging the Area Provider Tables to leverage our existing resources in addition to our new Aging at Home funds to create the greatest impact possible to enable seniors to stay healthy and live with independence and dignity in their homes. Traditional services combined with innovative practices by providing a comprehensive client-centred bundling of services that also address caregiver needs is key to keeping seniors healthy.

Please visit the South West LHIN website at <http://www.southwestlhin.on.ca> on a regular basis for updates on our Aging at Home Strategy.

2.1 South West 2008/09 Priority Directions for the Aging at Home Strategy

The three key priority directions for 2008/09 for the Aging at Home Strategy in the South West are:

- Promoting Wellness and Healthy Living
- Supporting and Caring for Caregivers
- Supporting Individuals at Risk of Hospitalization or Long Term Care Home Placement

2.1.1 Promoting Seniors Wellness and Healthy Living

As with many other communities in Ontario, the South West LHIN will see a dramatic increase in the proportion of people 55 and over in the next 10 years. Since age is one predictor of increased health service utilization, the South West LHIN is committed to contributing to the enhancement of wellness services that will help to maximize the health potential of individuals in the LHIN.

The South West LHIN aims to strengthen wellness opportunities for seniors to improve or maintain their current health. This strategy benefits the majority of the seniors population (70-80%) that self manage their supports but would also certainly benefit those with more chronic conditions to prevent further deterioration. Through the collaborative efforts of health service providers and community partners, the goal is to provide opportunities for accessing information, education, services, and self management tools/techniques to prevent disease and engage in a healthy lifestyle to maintain or enhance current levels of health. This includes, but is not limited to, promoting and providing enhanced opportunities for exercise, rehabilitation, improved nutrition, and social and emotional wellbeing.

2.1.2 Supporting and Caring for Caregivers

It is a well known fact that informal caregivers provide the majority of care to individuals. It has also been identified that “improving caregiver well-being delays nursing home placement of patients with Alzheimer disease” (Mittelman et al, 2006). It is for these reasons that the South West LHIN is focusing its attention on enhancing supports to caregivers.

Through the collaborative efforts of health service providers and community partners, the South West LHIN aims to strengthen supports to caregivers with the goal to enhance opportunities to access information, education, counselling, enhanced respite and other supportive services, such as transportation and housekeeping, to enable caregivers to continue to care for their family member, neighbour or friend for as long as possible.

2.1.3 Supporting Individuals at Risk of Hospitalization or Long Term Care Home Placement

Most people want to live out their lives in their own homes and not in institutional settings. Some people do not need to be in institutional settings but because the level and type of resources needed to support people in their homes is not always available they are limited to options such as long term care homes or hospitals.

Through the collaborative efforts of health service providers and community partners, the goal is to provide the required supports to reduce lengths of stay in hospital, and avoid admission to hospital and long term care homes for those individuals who have the potential to continue to live in their residential dwelling but who require additional supports and/or time to recuperate or stabilize their condition. Potential service responses for people at risk of losing their independence include, but are not limited to, enhanced care coordination or case management, enhanced combination of CCAC services and community support services such as meals-on-wheels and Adult Day Programs, or other services that provide assistance with activities so daily living. Other examples include creating supportive housing environments, enhanced respite services as well as implementing programs based on the Home at Last or Balance of Care project.

3. Aging At Home Proposal Submission Process

The South West LHIN has designed the following proposal submission process to guide Area Provider Tables in their submissions:

Process Steps:

1. The South West LHIN sets the parameters for the Aging at Home Strategy for 2008/09.
2. The South West LHIN issues the call for proposals through the North, Central and South Area Provider Tables.
3. Facilitators are appointed to assist each Area Provider Table to coordinate the submission of proposals. (see Roles)
4. Organizations need to work in partnership to help achieve the objectives of the Aging at Home Strategy. Organizations wishing to make a submission are asked to please contact their Facilitator and ensure that they are connected to their local provider table.
5. Submissions are made using the Aging At Home Health System Improvement Proposal (H-SIP) Form found at <http://www.southwestlhin.on.ca>.
6. Submissions are reviewed by the three Area Provider Tables using predetermined criteria before being presented to the LHIN. *Note: In the South area of the LHIN, the county/city tables will provide input to the South Service Providers Council review.*
7. All proposals submitted to the LHIN are reviewed by the Strategic Advisory Group using predetermined criteria.
8. All proposals that are accepted by the South West LHIN will require the completion of a detailed business plan. Note that some proposals may be accepted as submitted or with amendments, other proposals may be deferred or declined.

3.1 Roles

3.1.1 Area Provider Tables – North, Central, South

The South West LHIN works closely with three Health Service Provider networks (i.e., Area Provider Tables), one within each geographic area. Each network is unique to its geography in terms of when it was created, its purpose, membership, frequency of meetings, and how it conducts business. For information regarding a specific area provider table please contact the co-chairs below. The South Service Providers Council links with four City/County tables. Contacts have also been provided for those groups.

- North - Grey Bruce Integrated Health Coalition**
 Co-chairs – Pat Campbell (519) 372-3920 x2801
PCampbell@gbhs.on.ca
- Sandy Stockman (519) 371-4120
sstockman@gbchc.org
- Central - Huron Perth Providers Council**
 Co-chairs – Susan Rae (519) 595-8121
srae@knollcrestlodge.com
- Cathy Ritsema (519) 482-1482
cathy@alzheimerhuron.on.ca
- South - South Service Providers Council**
 Co-chairs - Jackie Wells (519) 659-2273 x3223
Jackie.Wells@von.ca
- Cate Melito (519) 768-1715 x2206
cmelito@wechc.on.ca

South City/County Tables

Elgin Health Systems Planning Group
 Chair: Paul Collins (519) 631-2030 x 2192
pcollins@stegh.on.ca

London Health Providers Alliance
 Chair: Sue Hillis (519) 434-8544 x 101
shillis@daleservices.on.ca

Middlesex Providers Alliance
 Chair: Mike Mazza (519) 245-5295 x 5593
Mike.mazza@mha.tvh.ca

Oxford Health System Integration Task Force
 Chair: Tom McHugh (519) 842-3611
Tom.mchugh@tillsonburghospital.on.ca

The role of each area provider table regarding the Aging at Home strategy is to:

- Assist with organizing members and other community partners to respond to the Aging at Home directions from a geographic community perspective.
- Prioritize proposals by using the decision criteria tool established by the LHIN to provide a general view of how the proposals are being considered by the members of the area provider tables for its consumer and population health focus, evidence-base, integration, sustainability and support to the health system, and alignment with the South West LHIN's Aging at Home directions.

3.1.2 Area Provider Table Proposal Submissions to the South West LHIN

The Health System Improvement Proposal (H-SIP) template will be modified and used for the Aging at Home process in the South West LHIN. Proposals will be reviewed by members of the Area Provider Tables and the City/County tables in the South using 2 types of proposal streams:

1. H-SIPs aligned to geographic areas of the North, Central, and South Area Provider Tables.
2. H-SIPs aligned to the geography of the South West LHIN.

H-SIPs will be reviewed and *prioritized* by Area Provider Tables using the South West LHIN H-SIP Assessment Form (Appendix A – HSIP Assessment Form) to provide a general view of how the proposal is being considered by members of the area provider tables for its consumer and population health focus, best practice evidence, integration, sustainability, and alignment with South West LHIN Aging at Home directions for 2008/09. The City/County Tables in the South will also review the H-SIP submissions using the H-SIP Assessment Form. The facilitators (see information below) will complete and submit to the LHIN a summary sheet of the geographic and LHIN-wide proposals reviewed and prioritized by each Area Provider Table in addition to the H-SIP submissions and assessment forms.

Please note: All H-SIP submissions for the Aging at Home Strategy must be forwarded to Cathy Ferrie at the South West LHIN.

Please e-mail completed form to:

**Cathy Ferrie [cathy.ferrie@lhins.on.ca]
Program Assistant, Planning, Integration and Community Engagement
South West LHIN
(519) 672-0445, ext. 211 / 1 866 294-5446**

These submissions will then be forwarded to the appropriate Area Provider Table for review and prioritization. For the South Service Provider Table, proposals will initially be forwarded and reviewed by each City/County table. LHIN-wide proposals will also be forwarded to each Area Provider Table for review and prioritization.

3.1.3 Coordination Support to Area Provider Tables

For the Aging at Home initiative, the South West LHIN has contracted with 3 individuals to assist the Area Provider Tables to respond to the Aging at Home direction of the South West LHIN for 2008/09.

Facilitators

North - Grey Bruce Integrated Health Coalition
Kathy Scanlon (519) 268-3192 (519) 670 – 9267(cell)
kathy.scanlon@sympatico.ca (available Nov.14th)

- Central - Huron Perth Providers Council**
Mary Shamley (519) 693-4903
mshamley@sympatico.ca
- South - South Service Providers Council**
Marg McAlister (519) 473-0198 (519) 670-3947 (cell)
marg@mmcconsulting.ca
(Mary Shamley will be assisting with the Oxford County Table)

The role of the Facilitator is to:

- work with the Area Provider Tables to enable the development of collaborative Health System Improvement Proposals that align with the Aging at Home direction of the South West LHIN for 2008/09
- keep groups on track
- connect providers and broader partners as needed
- act as the central repository for proposals
- facilitate the prioritization of proposals using the decision criteria tool provided by the LHIN (See Appendix A – H-SIP Assessment Form)
- develop a summary of the prioritization process and results
- create a parking lot of ideas and strategies to inform the second and third years of the Aging at Home strategy for the South West LHIN
- work together to ensure consistency of approach and messaging and to enable LHIN-wide collaboration where appropriate

Time Estimate

It is anticipated that facilitators will spend 2- 3 days/week (expect some flexibility, for example may require 1 day one week, and 4 the next) working on this project from November 5, 2007 – January 30, 2008.

3.1.4 Strategic Advisory Group (SAG)

- Review the directions identified by the Seniors and Adults with Complex Needs Priority Action Teams and those identified by other PATs at this point in time to provide advice regarding the Aging at Home directions for 2008/09 for the South West LHIN.
- Review the H-SIP submissions, assessments, and summary form submitted by the Area Provider Tables to make recommendations regarding their consumer and population health focus, best practice evidence, integration, sustainability and support to the health system, and alignment with the South West LHIN Aging at Home direction for 2008/09.

- The Strategic Advisory Group will conduct their H-SIP assessments balancing multiple interests such as the provincial Aging at Home parameters, local characteristics and preferences, provider characteristics and interests, and best available evidence to determine funding allocations.

3.1.5 South West Local Health Integration Network

- Receives advice from the Strategic Advisory Group through South West LHIN staff and makes decisions regarding the Aging at Home direction and funding allocations
- Ensures that a project accountability agreement has been signed between the South West LHIN and the HSP whose Aging at Home proposal has been approved. This agreement will clearly outline the financial and performance obligations and responsibilities of both the LHIN and the HSP related to the Aging at Home approved project. The agreement will address issues related to, but not limited to, financial obligations, in-year and year-end reporting, outcomes/deliverables, measurements of success (including baseline and performance goals), a dispute resolution process, and reconciliation of HSP expenditures.
- Ensures that the service accountability agreement (SAA) between the HSP and the LHIN is amended to reflect the principal components of the financial and service deliverables identified in the Aging at Home project accountability agreement.

3.2 Process and Timelines

Timelines	Responsibility	Purpose	Format
October 29	SAG	Recommend parameters and guidelines for H-SIP call	Meeting
October 31	LHIN Board	Confirm parameters for 08/09 Aging at Home strategy	Meeting
November 5	LHIN	Release Aging at Home 2008/09 parameters and guidelines	South West LHIN Website
November 8	LHIN APTs	Describe and clarify Aging at Home Expectations and Parameters	Live Meeting Teleconference
November 26	LHIN South Service Providers	Receive feedback on high level PAT directions, clarify aging at home parameters, and stimulate innovation discussion	Full Day Facilitated Event
December 4	LHIN Grey Bruce Integrated Health Coalition	Receive feedback on high level PAT directions, clarify aging at home parameters, and stimulate innovation discussion	Full Day Facilitated Event

December 6	LHIN Huron Perth Service Providers	Receive feedback on high level PAT directions, clarify aging at home parameters and stimulate innovation discussion	Full Day Facilitated Event
January 7	HSPs and Partners	Proposals received by the South West LHIN and forwarded to the Area Provider Tables and City/County Tables in the South	Proposals forwarded to Cathy Ferrie, SW LHIN
January 8 -14	APTs	Review and prioritize H-SIP proposals for geographic community	Meeting
January 14	APT	Final date for submission of H-SIP forms, proposal assessment forms and summary to South West LHIN	Electronic Submission
January 21	SAG	Review and make recommendations regarding H-SIPs to advance	Meeting
January 24	LHIN Staff	Review input from SAG and prepare 08/09 allocation options for Board Review	Meeting
January 30	LHIN Board	Review and approve 08/09 allocations	Meeting
Early February	LHIN Staff	Request Business Case submissions regarding proposals advancing forward	Disseminate package, Video/teleconference
February – March	LHIN Staff	Negotiate 08/09 allocations and agreement with HSPs	Individual Meetings
April	LHIN Staff	Distribute 08/09 allocations	Electronic disbursement

3.3 Principles to Guide our Approach

The mandate of the South West LHIN is to improve health care by working with health care providers, other partners and the community to deliver a seamless continuum of high quality, sustainable health care that reflects local characteristics, resources, and priorities. Health care providers, other partners, and communities share the responsibility for reaching this goal. Innovations required to enhance the health care system will come from engagement among health care providers, other partners and communities. It is imperative then, to create an environment where ideas and opportunities circulate among partners in consistent, predictable and effective patterns.

Principles to adhere to include:

Consumer Focused –

- An understanding of the needs and expectations of the health care consumer must be central to collaborative efforts among health care providers and the community; initiatives must consider the impact on the entire health care system. Government or organizational boundaries should not limit health care improvements that benefit individuals and their families.
- Health care system change (e.g. integration opportunity proposals, service level changes) should be centered on the consumer and should reference, where appropriate, the impact/contribution to the Integrated Health Service Plan, especially the core goals of access, sustainability, and quality of care.

Leverages Partnership activities or Initiatives –

- Engagement of health care partners and the community must be considered to be a reciprocal arrangement. Engagement should be viewed as a source of information vital to confirming and refining collaborative opportunities.
- The LHIN should be viewed as a partner in health care system change, but not as the agency responsible for leading all coordination and engagement activities and change initiatives.
- Identification of health system improvements and integration opportunities should be viewed as an ongoing responsibility rather than an annual exercise or specific to a particular funding initiative. This requires that health service providers are receptive to, and seek out, integration opportunities at all times and from all credible sources.

Builds on Existing Networks -

- Any plan for engaging health service providers and/or the community should take maximum advantage of existing networks (e.g. Area Provider Tables, End of Life Network, South West Ontario Geriatric Assessment Network (SWOGAN), etc.).

Outcome-Oriented and Measurable –

- Proposals for health care system changes should identify performance measures that can be used to evaluate the effectiveness of the proposal in light of health system goals. These performance measures should align to South West LHIN priorities and objectives and provincial strategic directions.

Data Driven –

- Health care system improvements should reference published research, best practice, demographic, and benchmark information to meet the standard for evidence-based decision-making, and to provide as much objective decision-making information as possible.

3.4 Possible Performance Measures and Outcomes

The South West LHIN's Integrated Health Service Plan (IHSP) identified action plans with performance measures and outcomes for each of its integration priorities. The outcomes and indicators identified in our IHSP and included in the table below are preliminary and will be discussed and refined by the Priority Action Teams. The indicators *italicized* are not represented in the Ontario Local Health System Scorecard and should be viewed as developmental until further work is complete and a determination of their ability to measure is made.

The South West LHIN has also reviewed the self reported data provided through the Canadian Community Health Survey to track health outcomes including: self reported general health, changes made to improve health, chronic conditions, health care utilization, home care services, restriction of activities, satisfaction with life, stresses -

sources and coping, social supports, healthy lifestyle practices. Health Service Providers may consider using these indicators as well as those provided in the table below or may provide others through their Aging at Home H-SIP submissions.

The South West LHIN hopes to work collaboratively with other LHINs to explore survey methods that may reflect the impact of the Aging at Home strategy. Possible approaches could be a focused topic survey on seniors as the second component of a future Canadian Community Health Survey, and working with the Public Health Units to incorporate questions related to seniors and their health/well-being in the RRUFUS survey through York University.

Short Term Outcomes (1 to 3 Years)	Medium Term Outcomes (4 to 5 Years)	Long Term Outcomes (6+ Years)
<ul style="list-style-type: none"> ○ Increased consumer and family awareness of the availability for priority population services ○ Increased referral to and seamless delivery of seniors services across all providers ○ Reduced unnecessary acute care utilization (both ED and hospital utilization) 	<ul style="list-style-type: none"> ○ Improved quality of life for priority population ○ Earlier detection of conditions of aging ○ Increased avoidance of LTC home placement ○ Maintain or slow decline in functional capability ○ Increased location of choice for end-of-life (EOL) 	<ul style="list-style-type: none"> ○ Easier movement along the continuum of care
Short Term Performance Indicators	Medium Term Performance Indicators	Long Term Performance Indicators
<ul style="list-style-type: none"> ○ Number of appropriate referrals and service utilization for seniors programs ○ Percentage of ED visits that could be managed elsewhere (Aged 65+) ○ <i>Awareness indicator</i> 	<ul style="list-style-type: none"> ○ Preventative screening for diseases of aging ○ Percentage incidence of: falls; adverse events (e.g., overmedications) ○ ALOS for ALC awaiting discharge (long term care services) ○ Percentage of the priority population reporting having a regular MD ○ Percentage of population with functional score decline ○ Percentage of palliative population reporting first choice for EOL ○ <i>Quality of life indicator</i> ○ <i>Proxy for avoidance indicator</i> 	<ul style="list-style-type: none"> ○ Percentage of priority population reporting unmet health care needs ○ <i>Consumer satisfaction measure</i> ○ <i>System navigation score/transition measurement score</i>

4. Summary

The Aging at Home Strategy provides an amazing opportunity to leverage the work of the South West LHIN Priority Action Teams comprised of health system providers and consumers engaged in a change process designed to improve our local health care system. Further, the 2008/09 Aging at Home Strategy process has been designed to encourage broad engagement across the South West to enable the development and support for collaborative initiatives that will enhance and strengthen the continuum of services accessible by seniors living at home. We look forward to the upcoming months as we continue to work in partnership to enable the implementation of this three year strategy