Healthcare Excellence Canada

Excellence en santé Canada

Enabling Aging in Place Promising Practices: Naturally Occurring Retirement Communities (NORCs)

NORC Innovation Centre at UHN

The following promising practice was prepared following interviews with the NORC Innovation Centre at University Health Network in the summer of 2023. Healthcare Excellence Canada would like to formally acknowledge their generosity in sharing their skills, knowledge, expertise and experiences to inform this promising practice.

About Healthcare Excellence Canada

Healthcare Excellence Canada (HEC) works with partners to spread innovation, build capability and catalyze policy change so that everyone in Canada has safe and high-quality healthcare. Through collaborations with patients, essential care partners and people working in healthcare, we turn proven innovations into lasting improvements in all dimensions of healthcare excellence.

HEC focuses on improving care of older adults, bringing care closer to home and supporting pandemic recovery and resilience – with quality and safety embedded across all our efforts. We are committed to fostering inclusive, culturally safe and equitable care through engagement with different groups, including patients and essential care partners, First Nations, Métis and Inuit, healthcare workers and more.

Launched in 2021, HEC brings together the Canadian Patient Safety Institute and Canadian Foundation for Healthcare Improvement. We are an independent, not-for-profit organization funded primarily by Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

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HEC honours the traditional territories upon which our staff and partners live, work and play. We recognize that the stewardship of the original inhabitants of these territories provides for the standard of living that we enjoy today. Learn more

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Model description

Naturally occurring retirement communities (NORCs) are geographical communities that house a large concentration of older adults. NORCs can exist within a residential building (vertical NORC) or a neighbourhood covering a larger geographical area (horizontal NORC).

Unlike retirement homes, assisted living facilities and long-term care homes, NORCs are not purpose-built to care for people as they age. Rather, they include a wide range of intergenerational housing types – for example, single-family homes in one geographical area, a multi-resident building or complex, or condos and co-ops – that have evolved with changing population dynamics to have a high percentage of older adults.

Ontario has 1,941 NORC buildings (apartments, condos or co-ops) where 30 percent or more of individuals are older adults (65+). These buildings house 214,345 older adults. NORCs provide an opportunity to leverage the density of older adults living in one place with enhanced health, social, and physical programs and supports that enable older adults to age in place.

The NORC Innovation Centre (NIC) at University Health Network (UHN) is advancing a 21st-century model of integrated health and social care in NORCs by developing community-led solutions that provide new options for aging in place with dignity and choice. NIC is learning how NORC programs can support various communities with the goal of creating a model that can be customized to diverse contexts and integrated into Canadian healthcare systems.

The objectives of the UHN NORC Model are to do the following:

- Address social isolation by providing opportunities for social relationships and connections between older adults and their local community.
- Reduce a wide range of unmet health needs by increasing access to services, information and resources.
- Provide opportunities for community and civic engagement.
- Re-imagine the community's physical environment by providing a common shared space that is accessible, provides meaningful activities and programs and fosters social interactions.

The **core elements** of the UHN NORC Model includes two delivery models.

Ambassador Model

Participatory design is the key feature of the Ambassador Model and is the essential ingredient for designing services that value end-users. Older adults are partners who co-design and activate aging in place initiatives. UHN supports co-design by bringing interested older adults living in the buildings together as ambassadors to form an aging in place community, growing

local leadership through skill-building workshops and training, and identifying local service providers willing to facilitate activities. Examples of ambassador programs and activities include:

- health talks and workshops
- drop-in wellness classes
- computer and digital literacy training
- social activities and events
- group health clinics (for example, mobile dental hygienist, foot care)

Staffed Model

The Staffed Model includes the key features of the Ambassador Model and is enhanced by the integration of health and social care for older adults with higher needs. The Staffed Model includes an onsite NORC coordinator and access to the integrated care lead (ICL) to support the escalation of care to a nurse practitioner (NP). The NORC coordinator, ICL and NP form the NORC team to support care planning when needed. The NORC coordinator becomes the person onsite who can ensure that the older adult understands the plan and is having their needs met. In addition, the UHN's Connected Care Hub model, which is NP-led, enables rapid access to diagnostic testing, specialist referrals and specialized programs.

The NORC coordinator:

- links older adults with higher needs to one-on-one services
- is the primary point of contact for older adults living in the building
- works with older adults living in the building to understand their needs
- develops personal relationships with the older adults living in the building
- supports older adults with information and navigation
- facilitates group programs in partnership with ambassadors to:
    - help support change and decline among older adults over time
    - support older adults living in the building so they feel safe enough to disclose concerns or changes related to their health/security (for example, changes in memory, running out of money, abuse)

The NORC integrated care lead:

- collaborates with older adults experiencing challenges to support individualized coordination, communication and continuity of care
- provides in-person, values-based assessments screening to determine the need for further in-depth assessment
- creates a personal wellness plan and then brings together health and social care providers as one team. Where available, this work is guided by primary care (for example, family doctor, NP, UHN's Connected Care Hub).
- makes referrals and supports access to necessary services and resources

The NORC nurse practitioner:

- provides enhanced assessment and acts as a point of escalation where needed
- collaborates with the NORC team to create tailored care plans
- makes referrals and supports access to necessary services and resources when needed and in consultation with primary care, if available
- provides transitional care for individuals who do not have or cannot access a family physician

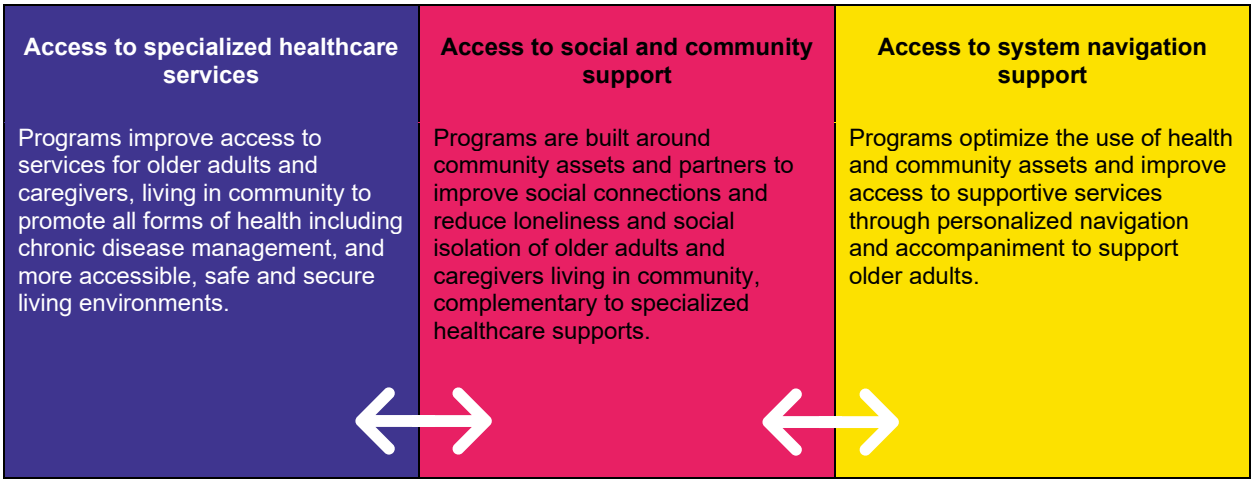
Older adults with high needs may be linked to a wide range of community programs and services that can respond to their individual needs – for example:

- Crisis Outreach Services for Seniors
- falls prevention and home assessments
- financial support and credit counselling
- Toronto Grace – Remote Care Monitoring
- Toronto Paramedic Community Paramedicine (TPS-CP)
- primary care – Telemedicine Impact Plus
- palliative care
- poison control
- Specialized Program for Interdivisional Enhanced Responsiveness to Vulnerability from Mental Health
- expedited access to assistive devices

As of summer 2023, there were 16 Ambassador Model sites and three Staffed Model sites. UHN expects to include a third delivery model in 2024–2025. The Fixed Site Model is expected to include the components of the Staffed Model with the addition of dedicated spaces for community building, programs and services.

Enabling Aging in Place Principles

Person-centredness is a core philosophy of HEC's Enabling Aging in Place program. All the principles must be implemented in a person-centred way and reflect a deep understanding of community assets and needs of older adults and their caregivers.



Adaptive and responsive

Programs are tailored to the specific, individualized needs and preferences of older adults and caregivers living in community. Programs adapt and respond to emerging needs as they evolve.

Equitable

Programs integrate a health equity lens, with a focus on the structural and social determinants of health, that support older adults aging in place in community.

High value

Programs optimize resources used on health and social services relative to outcomes that matter to older adults and care partners over the course of their care journey.

The following reflects how the UHN NORC Model fulfils HEC's Enabling Aging in Place program principles:

Access to specialized healthcare services – The UHN NORC Model provides a continuum of integrated health and social care with a strong focus on upstream prevention and self-management and comprehensive access to one-on-one health and social care interventions.

Access to social and community support – The UHN NORC Model strongly emphasizes decreasing social isolation, loneliness and helplessness by building social connections and networks. Programs focused on health promotion and education, mutual support and social connection are designed for older adults and open to people of all ages living within the NORC buildings, recognizing the benefits of intergenerational networks to support aging in place.

Access to system navigation support: NORC coordinators and ICLs build relationships with older adults and are a single point of contact who offer personalized navigation to community resources and healthcare services.

Adaptive and responsive: The UHN NORC Model emphasizes participatory co-design of services and programs. Older adults are empowered to shape services to meet the evolving needs of their community. Integrated health and social care assessment, care planning and coordination are tailored to individual needs and preferences.

Equitable: The UHN NORC Model is free of charge and inclusive of all older adults living in NORC buildings. Programs are designed to capture the needs of all older adults by examining the needs of the healthiest and those with multiple chronic conditions or accessibility barriers. When new NORC buildings are selected, equity and diversity are prioritized.

High value: The UHN NORC Model optimizes system resources by capitalizing on the resources available in local communities and leveraging the existing services within the health system.

Funding

The UHN NORC Model is funded by private philanthropy and leverages publicly funded health and social supports.

Implementation

Assessing needs and assets: A data-driven approach is used to identify the NORC sites, which includes an analysis of the health profile of older adults living in NORC buildings. One-on-one interviews and ethnographic observations are used to develop a deep understanding of the community's context, needs and goals. This is followed by multiple rounds of co-design sessions with aging in place ambassadors to prototype and refine the design of programs and services.

Programs and services are designed for “extreme users.” Instead of designing for the average user, the needs and assets of the healthiest and those with multiple chronic conditions or accessibility barriers are examined carefully. When designs meet the needs of those at the margins, the needs of everyone are captured.

NORC program teams: The makeup of program teams within NORC buildings depends on the delivery model. For the Ambassador Model, ambassador committees lead the design and delivery of programs and are supported by centralized UHN staff. For the Staffed Model, each building has one half-time, onsite NORC coordinator who supports the building’s ambassador committee and develops supportive relationships with older adults. The NORC ICLs and NPs are centralized resources that offer one-on-one support for older adults with high needs within the three NORC buildings utilizing the Staffed Model. UHN is assessing the resource effort and complement required based on the early adopter phase and these initial buildings.

Target population: The UHN NORC Model targets community-dwelling older adults aged 65 and older who live in NORC buildings.

Enrollment: No formal enrollment process exists for older adults living in NORC buildings. The ambassador programs and one-on-one services are advertised through word of mouth, posters and brochures visible in NORC buildings.

Partnerships: More than 50 **informal partnerships** have been established and strengthened to provide older adults living in the buildings with community wellness programs and one-on-one support.

The following are the **formal partners** of the UHN NORC Model:

- NORC Innovation Centre – thought leaders in NORC programs
- UHN OpenLab – NORC expertise
- UHN Connected Care – integrated care strategy and delivery
- National Institute on Aging – policy
- Age-Well – technology
- Women’s College Hospital – research
- UHN@Home – care coordination

Adaptations over time: While the underlying premise of the UHN NORC Model has remained stable, it is evolving to include the continuum of delivery models at different intensities of support for aging in place. UHN NORC Model may evolve further as new information is learned about how it can be adapted to different contexts and sustained within healthcare systems.

Evaluation and impact[1]

Staffed Model achievements in one month:

- 124 types of issues resolved for older adults in the buildings, including:
  - questions related to services for older adults, such as how to apply for Wheel-Trans paratransit service and subsidized or low-cost dental care
  - information about services in the community centre
  - connection to primary care
- 35 referrals to one-on-one assessment by the ICL and connections to services, such as:
  - Complex Medical Management program
  - fall prevention, mobility issues and occupational therapy assessments
  - grief counselling
  - distress and respite care
  - housekeeping and home accessibility
- In addition to GTA-wide providers, 14 neighbourhood service providers engaged in developing a collaborative, integrated approach to care provision.

Ambassador Model achievements since 2020:

- 35 new ambassadors from seven sites graduated into the ambassador alumni network for having achieved tremendous success despite COVID-19 restrictions, including:
  - robust volunteer network in their buildings and neighbourly support initiatives
  - health talks
  - social activities such as trivia nights and coffee clubs
  - walking groups
  - computer literacy programs such as webinars, mentorship and education
- 21 new participants from five new sites joined, resulting in 84 ambassadors and 19 partnership buildings since the start of the program in 2020.

Keys to success

Community building: Community is built at the speed of trust. Thus, adequate time is needed to create relationships and build trust with older adults living in NORC buildings. Taking the lead from older adults and helping with knowledge, skills and tools to support aging in place is key.

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[1] The evaluation and impact information shared here reflects information currently available at the time of writing. HEC would like to acknowledge that evaluation activities are an ongoing process for many promising practices and the type of data collected is influenced by program goals, the length of time the program has been implemented and the resources available to support evaluation.

Synergistic partnerships: Establish collaborative and synergistic partnerships with formal and informal service providers and the management of NORC buildings to integrate existing services, delivery models and mandates.

Diverse perspectives: Bring together diverse expertise and perspectives, and provide training to ensure individuals are aware of aging in place broadly and the issues and challenges people face as they age.

Team-based approach: A one-team approach, where the NORC coordinators, ICLs and NPs collaborate and meet regularly, creates an agile, responsive model to meet an older adult's needs.

Key challenges

Digital literacy: Healthcare system siloes, inequity and inaccessibility remain major barriers for older adults. The digital age has some advantages but contributes to isolation and lack of connection, as many older adults lack digital literacy skills.

Hidden vulnerable populations: Buildings have hidden populations of isolated and vulnerable individuals. Some older adults are experiencing financial insecurity even in condos and rental buildings in higher-income neighbourhoods.

Inconsistent services: Some buildings already receive co-located services, but they are inconsistent, and funding can end as priorities shift. Limited data is available to support coordinating efforts between providers within the same building and neighbourhood.

Medical records: Lack of access to one centralized medical record challenges the delivery of truly integrated care for one-on-one service provision.