Greater Hamilton Health Network

Building community health together.

Deep Dive: Older Adults and Caregivers in Haldimand

Population health review

February 2025

Summary

A collection of health and social service providers alongside community members within the Greater Hamilton Health Network (GHHN) convened in early 2025 to address the adverse health outcomes of older adults and their caregivers in Haldimand County, identifying upstream causes and developing actionable solutions within a 3–5-year timeframe. Participants identified three primary root causes of poor health outcomes: isolation, access to healthcare, and economic factors. Isolation was linked to inadequate transportation and societal attitudes towards aging, while healthcare access issues were driven by service gaps and difficulties in navigating the healthcare system. Economic strains, including income inequality and shifting demographics, exacerbated these challenges. Many solutions were proposed by participants based on these root causes: including ways to better connect residents to services and to each other, new programs and service models, and targeted supports and education.

Health and social service providers working in Haldimand gather regularly to plan and coordinate services through a collective known as the Haldimand Stakeholders Council (HSC). The HSC fits within the broader structure of the Greater Hamilton Health Network (GHHN), one of 53 Ontario Health Teams (OHTs) that take a population-health perspective to the delivery of health and other human services and address the broader social determinants of health for these populations.

One population, older adults and caregivers, feature prominently in conversation through the HSC. Ontario Health (OH) identifies this population as "frail and elderly," operationalized as adults 65 years or older with a variety of medical conditions (see Appendix A). According to Ontario Health, there are 4,235 adults in this population living in Haldimand. Using data collected through OH, this population living within the GHHN region, which includes Haldimand, 1) spends some of the fewest days at home relative to this population in other OHT regions (or, stated conversely, spends some of the most time in hospital, inpatient rehab, emergency rooms, or complex continuing care) and 2) is experiencing a more rapid decline in health status relative to this population in other OHT regions. Further, 3) caregivers for this population in the GHHN region are reporting some of the highest rates of distress in the province. This is particularly relevant for Haldimand, as 20.6% of residents in Haldimand County are over 65 (compared to a provincial average of 18.5%).

In 2025, a group of health and social service providers and members of the community gathered together to ask: what are the upstream factors producing these health outcomes, and what creative solutions could be applied over the next three to five years to address these factors?

Methodology

In February 2025 GHHN facilitated two sessions – one virtual and one in-person – that were advertised as an opportunity to brainstorm the unique healthcare experiences of older adults and their caregivers living in Haldimand. Invitations were sent to a wide range of health and social service agencies identified by the working group as well as community members

identified through GHHN patient advisors and program staff. A total of 22 participants attended either session, representing community, hospital, primary care, long-term care, social services, and other sectors, including community members.

Participants began by reviewing the characteristics of this segmented population and the data pertaining to the health outcomes of that population in Haldimand specifically. After a brief orientation to the expected outcomes of the session, participants were led through a modified "5-why" exercise to collectively identify preliminary first order causes for the health outcomes identified previously. Once these first order themes were identified and approved by the group, participants identified upstream "root" factors that produced these first order factors or enabled their expression in such a way that led to the unfavourable health outcomes for older adults and caregivers in Haldimand. Participants used stickers to vote on the proportional weight that each cause should be assigned. In the final portion of the event, the group was able to use the root cause diagram to generate feasible, realistic, specific goals that health service providers and other sectors could reasonably take on within a three-to-five-year time frame. At each stage of exploration mentioned above there was time given for discussion at each of these stages of exploration and the responses were collated, themed, and reflected back to the group for validation.

Root Causes

Both groups independently coalesced around similar root causes, though there was some variation in the discussion of these topics that are reflected below. In total there were three first order causes – isolation, access to healthcare, and economics – each with two root causes, identified by the groups.

Isolation: a function of a lack of transportation and a set of beliefs & worldviews. (Weighted at a factor of roughly 2x).

Both groups identified the outsized role that physical and social isolation plays in driving these health outcomes for older adults and caregivers in Haldimand. The geography – largely rural, with small communities that have unique identities and have limited connection to each other – was discussed more in the context of a lack of accessible transportation options than a barrier in and of itself. Acknowledging that this was a longstanding issue for the community, the lack of public transportation or ridesharing options was frequently described as a barrier for all stakeholders: patients and clients unable to access services, caregivers being able to get to their families, existing healthcare staff having difficulty accessing community members, and prospective healthcare staff overlooking employment in Haldimand because of the lack of transportation. Accessible transportation options such as wheelchair- and mobility device-friendly vehicles were also identified as gaps in the community.

Isolation was also discussed in ways that spoke more to individual mental health and cultural attitudes: what we are calling here 'beliefs and worldviews.' At the macro level, prevailing cultural attitudes that overlook seniors and caregivers, or even hold them in contempt, drives isolation. Participants discussed how ageism manifests in the ways that infrastructure is built (one participant here referenced the urban planning framework known as 'Age Friendly Cities') or how health service providers communicate with seniors and their caregivers (often in digital ways, rather than print media). At the level of the individual, likely as a function of these cultural attitudes, participants spoke about their experience with seniors who might struggle with self-confidence in navigating the health system (or more generally) or who might delay care because of the stigma they worry they might face upon entering the health system. Participants described a value system that prides a rootedness to one's home, especially for life-long residents.

Access to healthcare: a function of a lack of services and difficulties navigating the system. (Weighted at a factor of roughly 1.5x).

Participants identified healthcare access as a major issue: both there being a lack of some critical health and social services as well as not being aware of existing services nor how to access them. Gaps in health and social services were (in order of the frequency with which they were discussed): supportive and affordable housing options (especially long-term care, nursing homes, and hospice), respite services for caregivers, services to manage high-complexity medical comorbidities, community-based programming for seniors and their families, family doctors, PSWs, and community volunteers. One participant identified the absence of "health hubs" that are capable of providing some kind of 24/7 service, and another participant identified a need for an "advocate" position for the county pertaining to health issues. There was discussion about the ways that lack of health human resources (HHR) intersects with the conversation below about socioeconomic factors: that prospective healthcare staff might choose not to live in the rural areas due to their ability to draw a higher salary in larger cities.

Navigating around existing healthcare services was also identified as a major issue. Understanding what services exist and how to access them remains a challenge. During group discussion, many highlighted how these challenges intersect with conversations about digital literacy and the ways that current communication strategies used by health service providers to communicate with the public are ineffective for this population.

Economics: financial strain and shifting demographics. (Weighted at a factor of roughly 1x).

Sociodemographic factors were identified throughout both sessions in playing a critical role in initiating, sustaining and exacerbating these unfavourable health outcomes for older adults and caregivers. Older adults were discussed as bearing the brunt of broader economic forces like income inequality, inflation, high costs of living, and a fraying social safety net. In discussion, the group spoke about how the proliferation of for-profit healthcare enterprises amplify these concerns for people living in Haldimand.

The demography of Haldimand was discussed in several ways. Participants described how health and social service workers often leave the area for high-paying jobs in nearby cities, while young adults who might otherwise provide some care in the home move out of the country to go to school elsewhere. The rapid and concentrated increase in population size within some communities in Haldimand led a few health and social service providers to explore relocations or redevelopment of their services; such as co-located "health care hub" models or mobile and outreach programs. This also led to a conversation about the need to work effectively with the County Administration to effectively future-plan around Haldimand's changing demography.

Interconnected and multidetermined

The original intent of the exercise had been to develop a fishbone diagram of the root causes impacting health for older adults and caregivers in Haldimand. However, in both the group discussion and subsequent data analysis it became clear that the underlying factors did not stem from isolated root causes but that each root cause was co-determined and mutually reinforced by the other root causes. The three upstream factors leading to adverse health outcomes for older adults in Haldimand – isolation, access, and economics – were, in fact, deeply interconnected.

For example, isolation – which again was a factor driven by a lack of transportation and a particular set of beliefs or worldviews – was driven by economic factors at the micro and macro level. However, especially for our identified population of older adults and caregivers, these sorts of economic factors were also deeply connected to problems with accessing health and social services: both in 1) older adults being able to participate in

economic or social activities as a function of unmet healthcare needs, as well as 2) the costs carried by caregivers as a function of having to take substantial time learning how to navigate the system or search for resources located far away. This itself was related to cultural attitudes and ageism, one of the two primary drivers of isolation.

As such, Figure 1 visually represents these root causes not as spokes branching out, as would be expected from a typical fishbone diagram, but as a circle of overlapping and mutually reinforcing factors.

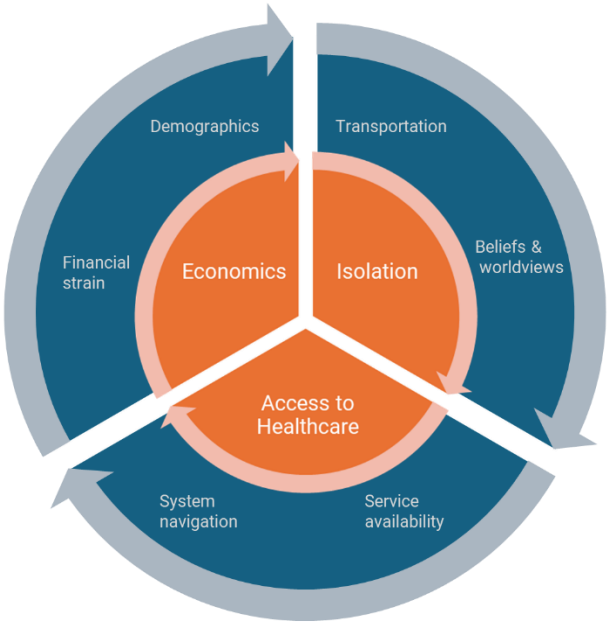

Fig. 1: a visual representation of the upstream causes leading to unfavourable health outcomes for older adults and caregivers in Haldimand.

Identified Solutions

Each of the aforementioned root causes produced a range of proposed solutions from the participants of both exercises:

Isolation.

- Develop a regional transportation strategy. Explore ways to build on existing services that provide transportation in the region (i.e. Senior Support Services, Red Cross) to develop more programming that offers transportation, or commit to other successful models of rural transportation, ensuring accessibility for seniors with mobility devices.
- Shift patterns of communication from digital media (online updates) to printed outreach (i.e. mailed promotions) or phone calls.
- Work with others to support a broader campaign addressing ageism, being cognizant of the range of intersectional identities and Indigenous ways of knowing within any calls to action.

Access: improving service availability.

- Continue with collaboratives that work together towards shared goals. Remove organizational walls and feelings of ownership in identifying solutions.
- Explore new models of care. Continued support – and expansion – of the Community Paramedics (CP) program was suggested, as well as considering partnerships between CPs and others, such as mental health workers, social workers, or community navigators. Drawing resources from the community to provide care for ageing seniors without caregivers (i.e. matching seniors with carepartners like students through internships or co-op programs) was mentioned by several participants.
- Provide services closer to individuals. Enhanced home care services, including in-home primary care, came up frequently, as did embedding services more deeply within communities (i.e. in retirement homes or through mobile outreach models).
- Several participants mentioned developing programming specific to caregivers. Respite-based services was repeatedly mentioned, especially after-hours and overnight; one participant recommended a more fulsome asset mapping and gap analysis of caregiver supports, and the development of a roadmap to fill the gaps.
- Increase the number of LTC beds and affordable retirement home options for

seniors in the communities in which they live.

Access: improving system navigation.

- Develop a community of practice or knowledge exchange for health and social service providers that can improve awareness of existing services.
- Put on more community-facing events, such as health fairs, community-sector information sessions, patient education sessions, or caregiver awareness events.
- Develop or endorse a guide of services. Publish this in digital and print format.
- Reduce duplicative services and instead identify where those services can be changed to fill existing service gaps.

Economics.

- Reduce barriers for international students or new Canadians to pursue higher education in caregiving-related fields.
- Explore ways of financially supporting caregivers, such as through subsidies. Use findings from guaranteed basic income pilots to show the impact that has on this population specifically.
- Develop education and awareness campaigns specifically for youth to promote more active involvement in caregiving as they age.

Next Steps

This report is intended as an aide to policy development within health and social service providers in Haldimand. Organizational leaders are encouraged to reflect on the ways that these findings could be embedded within strategic plans, operational reviews, or at the level of service provision. New programs and models of care, as well as existing supports and services, can engage with these findings to enhance outcomes and impact. This report will also guide the conversation that takes place within existing collaboratives such as the HSC and other places across the GHHN.

Managers and front-line staff are also encouraged to engage with the findings of this report and consider how they might use their own scope of influence to improve the health of older adults and caregivers within Haldimand. Top-down and bottom-up change processes will be essential to shifting the population health curve for this cohort.

Finally, this work should be revisited in three-to-five-years to review the effectiveness of any change practices that have been implemented through these discussions, with the aim to improve the health and wellbeing of the community in Haldimand.

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Appendix A

Ontario Health's 'Frail and Elderly' population includes adults 65 years or older with any one of the following:

- History of physician-diagnosed dementia
- Receiving palliative services in the past 1 year
- Living in a long-term care facility
- Having two or more of the following conditions: cognitive impairment, incontinence, falls, nutritional deficiencies, functional difficulties, targeted health service utilization, decline in general health status.