WINDSOR-ESSEX COMPASSION CARE COMMUNITY
Statement of Values

OUR SHARED VALUES:

- A fully compassionate community connects, contributes and creates together. Our compassion is holistic and encompasses all aspects of being human:
  COMPASSION = Spiritual (relates to the core values that drive every human being)
  PASSION = Emotional (relates to the primary energy that supports our belief and actions)
  PASS = Mental (relates to the process of deciding to be involved and what we do)
  COMPASS = Physical (relates to how we act and the environment in which we act)
- The character and social fabric of our community is built on pillars of: Trust; Respect; Responsibility; Fairness; Compassion; and Citizenship
- We believe every human service interaction should be characterized by similar fundamental human values: compassion, respect for persons, commitment to integrity/ethical practice, responsibility for excellent outcomes, fairness/equity, and trust in the community and the team.

As a community, we choose to embrace aging, end of life, death, dying and loss as a normal aspect of social life that involves the whole of this community. We will work to be a community that offers genuine and authentic support for all our aging, frail and vulnerable citizens and their families, wherever and whenever they need us, according to their preferences, abilities, and what's most important to them. We will ensure that ALL adults and children in our community with long-term care needs, their families and their caregivers (especially those that are marginalized and isolated) are offered the holistic, proactive, timely and continuous care and support they need, through their entire journey both preceding and following death, to help them live as they choose, and to optimize their quality of life, comfort, dignity and security.

SETTING OUR COMPASS (REVEAL OUR HEART):

Our community, citizens and caregivers are our heart. We will work towards being a compassionate[i], intelligent, solution-based community that empowers and helps all citizens and their families (of any definition) from cradle to grave to:

1. Be in charge of their own wellness so they can live their life to the fullest at every stage of their aging and end-of-life journey
2. Be prepared for aging and loss and know where to go and how to ask for help
3. Be authentically supported, in their preferred way, both through formal programs when they need care as well as in their homes in their day to day lives
4. Express their wishes now and for the future and make progress in realizing their most important goals, as they define them
5. Live with dignity, and have support to die in their preferred circumstances and location

And, through its culture, services, and volunteers, acts to ensure that:

1. All citizens, partners in care, and care workers can easily get the education, information, coaching and understanding they need
2. All citizens have access to appropriate personalized, outcome-based, joined up care, where and when they need it

3. Community partners work together to make creative use of the full range of community assets to optimize care to aging, frail and vulnerable citizens to achieve their highest quality of life, within a non-judgmental framework, and to deal with grief
4. Compassion and kindness permeates all levels, all services, and all generations
5. Equitable outcomes are achieved for all citizens, regardless of their health, social or economic status

[NOTE: our goal is not to save system costs or resources; however, we believe that the care that people want will cost the system less, and as a result improved sustainability of public assets and reduced sub-optimal resource use is a key expected outcome.]

BUILD OUR ENGINE:

The engine for the Compassionate Community (as well as the accelerator, the care integrator, the communicator, the root of feedback and systematic intelligence, and the naturally occurring, positively disruptive force for inevitable improvement) is a community owned, open source, social enterprise-based, Information Communication Technology (ICT) system in the hands of citizens, built from components and information that largely already exist, that are combined as a complete ecosystem for more powerful impact. To understand aging and truly move forward for real public benefit and betterment, we need to both shine the light in different spaces and develop our interpretative capacities more fully. The enablers we need are the things we already have or can easily acquire: volunteers, putting more information, education and coaching in the hands of citizens (where getting it right matters the most), and access to low cost e-health/e-wellness technology solutions.

This is both a small change, and a sea change. The Windsor-Essex Compassionate Community represents a flexible, interconnected, multi-faceted, multi-dimensional, powerful, low-cost and sustainable community response to improve human development and wellness for aging populations. It sets us up to work better and smarter today, using all the assets we have; to improve ourselves for tomorrow; and to know whether what we're doing is good enough. It puts citizens truly at the centre of care and in charge of their journey. It reflects a true convergence of systems medicine, big data, citizen and community driven priorities, social networks, and community-based human development. Through careful orchestration, we believe we can achieve this quickly, organically and in a way that is transferable and easily spread.

CARE BY THE NUMBERS (80/20 revisited):

- ***100% of citizens can benefit from compassionate support - in all their roles*:** 100% of us care for ourselves as we age or become ill; at least 80% of us at some point in time will become a care giver for others who are old, frail or vulnerable; 20% of us are also professional care providers, care managers, or health or social service system managers who want to see the best care possible for the people we serve.
- ***More than 80% of the day to day care people need is provided by family and friends:*** 20% of the population consumes 80% of health and social care resources. However, <u>less than 20%</u> of the human capital invested in their daily care comes from formal health systems.
- ***People make most health decisions without help:*** In any given month, 80% of people will experience a health problem; of these, even amongst people with serious illness, <u>3/4 deal with symptoms without ANY medical assistance</u> (the ecology of care revisited). And each year, 1 in 16

home clients experience preventable injuries caused by non-disease related errors or complications.

- ***At least 80% of helping behaviour starts with a specific request:*** People help themselves and our care systems by seeking the help they really need, as this will prompt caring environments where everyone finds it easier to give, and natural to receive
- ***By helping 80% of citizens and families' who are able to better help themselves, community and public social safety nets can be better preserved for the 20% who are truly the most vulnerable.***

OUR FORMULA FOR CARING:

$3C^2$ + 5P =$Triple^3$ *(Acting today with what we have and knowing whether this is good enough)*
+ Innovation *(Improving tomorrow)*

$\propto$ Human Development and Population Well-being

Where $3C^2$ = (citizens, caregivers and communities) (connecting [to] co-contribute and co-create)
5P = predictive, preventative, personalized, participatory and population-based care[ii]
get $Triple^3$ [value] = experience, population well-being, and cost/resources, exponentially improved setting up communities to be more prosperous and more well

We seek GREAT care for everyone who needs it in our community. Our hypothesis is that the extent to which communities deliver care that is based on the $3C^2$ + 5P =$Triple^3$ formula, and that support innovation in a wide range of areas, is proportionate to both specific value creation measures related to population aging in the short term as well as broader community development and population well-being measures in the long-term.

REDEFINING COMMUNITY, POWER, AND CREDIT

Community: Community space is significant. Local context shapes people's life chances. Building the high quality places where people want to live, age and die is the foundation for jobs and prosperity in a global age.[iii] Community is both an underutilized resource and the well- spring of amazing strength. Only community can come together to fully embrace:

- The culture of giving, kindness and collaboration
- The social, emotional, practical, cultural and spiritual experience of dying for each of us when we die and when our loved ones die
- Support for 95% of the time a person is not with their formal health care providers
- 80% of the long-term care people receive that comes from outside the formal system
- 75% of the health decisions people make without any formal assistance
- 20% of caregivers who feel overwhelmed and distressed
- 10% of citizens who are unfriended and truly vulnerable
- Authentic support and true social connections over an entire aging and end-of-life journey.
- Public discourse to tackle wicked questions and root causes
- The boundaries between health, civic life, municipal, social care, education and the economy
- Innovation and experimentation, linking individuals and institutions for social gain
- True equity when it counts, in the end, when we all need an equal shot at getting to what's most important to us, despite the barriers and challenges of where we started
- The quality and meaning of living

- Power: A community does not need permission to be a community. A community does not operate outside the system. The systems we have are a convenience we created and we are a part of. We have the power to choose how we behave, to demand systems that are good enough for all of us, and to work towards something better. This is the only power we need, and the only power that matters.
- Giving the Community Credit: We recognize that if we give a little of ourselves now, there will be significantly more to take when we need care, or our parents or our children need it. Caring now improves the quality and meaning of our own lives, as well as others, along with building prosperity and our competitive advantage for our community now and for future generations.

THIS IS DIFFERENT FROM SYSTEM REFORM:

Health and social service systems are transforming. Now is the time for community to also step up and stand out. This approach is different, complimentary and equally important:

- Community work is to build and sustain community assets on behalf of citizens' collective well-being. Our focus is quality of life and community prosperity over the long-term. We recognize that this is a life-long community mission
- We will build care from the citizen/social network unit up, capitalizing on citizen, family and community strengths and assets to achieve quality of life
- We are not bounded by a system agenda, but are asking systems to work with us to advance community and citizen priorities, as we define them.
- Our tools are the relationships we have with each other and the assets located in the community.
- We start from an integrated view of whole citizen and whole community strength, and will work to mitigate the negative affects of system fragmentation across boundaries.
- We work both from the grass roots up and the community on down.

Our actions will improve the day to day lives of citizens and families, strengthen our neighbourhoods, enhance community social capital and innovation, smooth out cross-boundary cracks where people tend to get lost, and produce new forms of public value, because this is the kind of community we care about and want for ourselves and for our families.

GETTING STARTED:

- We will start with small, but meaningful changes. We will work to make information more open, and communication more efficient. We will open ourselves to having conversations about what's most important to the people we serve, and will try to pay more attention to what's important than what's not.
- We will permit the scope and size of the commitment to be as large or small as it needs to be, within a minimum standards framework below
    - [Citizen and families] We commit to asking for the help we really need; to make our goals and priorities known to our partners in care; and to record our outcomes and feed them into the system to help the system learn
    - [Human service provider] We commit to offering, organizing and delivering quality care to the citizens we serve so that it is a little more relevant, inclusive and impactful tomorrow than the care that was available yesterday.

- [Organizations] We believe that systemic problems belong to the community and not single organizations and we commit to do what it takes to work cross boundary ensure that citizens are not suffering needlessly because of the way our systems are set up.
- [All] We commit to being part of a movement of people who believe in a better Windsor-Essex, one that is open to new people, new ideas, new models of care, and a new economy. We commit to identifying and taking the actions we can today that can help make a stronger tomorrow.

- We will use the knowledge and tools we have collectively to make our jobs easier and our lives better. We will work existing systems to our advantage and not be stalled by their limitations.
- We will set, innovate and sustain our engine, which should act as a self-perpetuating and natural force for inevitable and irreversible positive change by increasing the visibility of care and allowing us to take stock of real, community, citizen and taxpayer outcomes.
- While the scale and scope of the initial commitment expected of individual champions is modest, we are confident this will add up to something remarkable.

INITIAL PRIORITY POPULATIONS

Recognizing that we aspire to a compassionate community that reflects our whole population, we are choosing to initially focus on those who are elderly or disabled (for example, people approaching end-of-life, with dementia, physical or mental limitations, or needing personal support), especially those who are marginalized or isolated with care needs. We estimate that at a population level, we have 60,000 Windsor-Essex citizens who comprise these groups and will work to ensure that all such citizens are attached to an appropriate model of care.[iv] Once known to the community, citizens should never become unknown.

ASPIRATIONAL AND SHARED COMMUNITY OUTCOME MEASURES

Through social dialogue and negotiated partnerships, we will broker real change for our citizens, and evaluate our success against real community, taxpayer and citizen outcomes. As a result of this initiative, all aging people in this county, especially the most vulnerable and complex among us, will receive the on-going care and support they need to live more successfully in the community

- at no increased cost to the public
- with less chance of damage to themselves or others
- using resources and structures that are currently available

For each identified priority population, the community will set annual targets and measure its progress against 5 **shared outcome** categories that cross all systems, all sectors, and all care settings (expecting measureable improvement on all measures within two years of taking action)

1. Quality of Life

a. Self-reported Community Well-being
b. Self-reported quality of life of people needing care
c. Self-reported quality of life of caregivers

2. Equity

a. Equity of Access

Reduce access gap between population level need and those in care

b. Equity across population groups

Reduce outcome gap between the population average and defined subgroups for people at similar levels of need

c. Equity within population groups

Reduce the outcome gap between citizens in the lowest socio-economic quartile within a defined subgroup and the average outcomes for that group

3. Experience of Care

a. Self-reported experience of people needing care
b. Self-reported experience of care partners
c. Care partner burden

4. Population Health

a. Safety

Change in adverse events measured by year over year change in adverse events per defined population subgroup (e.g. falls, medication errors, unmanaged pain, pressure ulcers, etc)

b. Prevention

Reduce sub-optimal resource use by 5 to 10% year over year for targeted priority populations (e.g. avoidable hospitalizations, avoidable hospital readmissions within 30 days, days spent in any acute care or rehab institution in the last 30 and 90 days of life, deaths in the community including Long Term Care Homes, downstream care, etc)

5. Per Capita Cost

a. Population-level cost/resource use

Change in county-level population cost-resource use measured by year over year change in total and average cost/resource use across all health care sectors per defined population subgroup

DEFINED TERMS

- **Citizen** is a person who lives in a particular place (for example, within the geography of Windsor-Essex) regardless of whether he or she has a legal status of Canadian citizenship
- **Care partners** are the people that care for us and about us. **Families** are the people we choose to be our family, and the people who step in when there's nobody else.
- **Communities** are a social unit of any size that share a common identity or purpose. Community derives from the social relationships between the people that co-exist within the same shared space. For comparable learning, communities can be measured geographically because within any macro-community, there are also multiple "nested" functional and virtual human communities, which are made up of people from a wide range of health, social, cultural, economic and political spheres. Geographical communities are stronger to the extent that virtual communities amongst its citizens are rich and thriving. There is no single right unit of geography – it can be as small as a neighbourhood, or as big as a county provided the geography and its social networks are similarly bound. For the purposes of this Charter, "community" means the county of Windsor-Essex as well as the range of cities, towns and rural areas within the county geography.
- **Health** is the capacity of an individual and a community of people to adapt and direct their own lives in the face of social, physical and emotional challenges. **Care** enables individuals to compensate for deficits, alleviating suffering and offering comfort (reactive). Where challenges are permanently present (for example, frailty in aging populations), **life-long care** is required.
- **Wellness** is the pursuit of happiness and full potential. Support enables individuals to pursue their own highest quality of life (proactive)[v]

- **Need** is individually defined, and infinite in its diversity, but can be comparably grouped in populations in 5 different bands (well, light, moderate, complex, and end-of-life). Strength is similarly diverse and infinite, even within the most needy.
- **Neighbourhood:** A person's communities of choice, such as the physical (or spacially defined) area where people live and have opportunity for considerable face-to-face interaction, as well as functionally defined social networks where members are connected through common interests and values. Includes residential buildings, neighbourhood clusters, and associations.
- **Social Network**: A network of social interactions and personal relationships. A social network is a social structure made up of a set of social actors (such as individuals or organizations) and a set of the dyadic ties between these actors.
- **5P Standard of Care** reflects a citizen-driven community-based system of life-long care that is demonstrably personalized, participatory, preventative, predictive and population-based. To achieve this standard, communities must demonstrate intersectoral and coordinated use of a range of appropriate tools and methods in each of the 5P domains

BIBLIOGRAPHY

Note: For references, source documents and bibliography informing this Charter, please see *Primer on Citizen and Community Well-being,* Selected literature synthesis February 2015, Prepared for the Windsor-Essex Collective Impact Citizens' Table

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[i] We wish to acknowledge Allan Kellehear and Denise Marshall for their work on compassionate cities, public health and end-of-life care, which informed the conceptualization of Windsor-Essex as a compassionate community

[ii] We wish to acknowledge Lee Hood for the 4P concept of medicine

[iii] We wish to acknowledge Neil Bradford for his directional work on place-based public policy, which formed the basis of our community governance model

[iv] We wish to acknowledge McMaster for their models of interprofessional teams, both through the Health Tapestry Program in primary care and Hsien Seow's Rethinking Palliative Care in the Community

[v] We wish to acknowledge Alex Jadad for his work on the definition of health and wellness