EPIC Eldercare Partnership in Cowichan 2026

What does the Eldercare Partnership in Cowichan (EPIC) mean to its members?

EPIC is the place where regional strategies designed to improve the lives of older adults are developed and implemented using the strengths and assets of its members who choose to voluntarily come together. EPIC is a place where partners in health and community can bring forward questions, identify emerging issues, and surface priorities as they arise; When community agencies have questions, needs, or concerns come up, this is the place where we can name them, discuss them, get them answered, and/or determine what follow-up or action is needed. EPIC is an open forum where everyone benefits at different times. We participate with the shared understanding that we are supporting collective action as well as other agencies, and receiving the benefits of being supported.

Historical Context

Using the Collective Impact Framework partners in health and community came together in 2015 to address improving the health and wellbeing of older adults in the Cowichan Region.

We recognized that in order to achieve our goals and tackle deeply entrenched and complex problems, it would require an innovative and structured approach to making collaboration work across not only Island Health, but with our many partners in the community including the Cowichan Valley Division of Family Practice, specialists, Aboriginal people, Our Cowichan Communities Health Network and many other organizations. In Cowichan, we believe that through using the Collective Impact framework methodology, we will be able to achieve significant and lasting change by using five agreed conditions to partnership:

- All participants have a **common agenda** for change including a shared understanding of the problem and a joint approach to solving it through agreed upon actions.
- Collecting data and **measuring results consistently** across all the participants ensuring shared measurement for alignment and accountability.

- A plan of action that outlines and coordinates **mutually reinforcing activities** for each participant.
- Open and **continuous communication** is needed across the many players to build trust, assure mutual objectives, and create common motivation. Our **relationships are the foundation** of all we do.
- A **backbone organization(s)** with staff and specific set of skills to serve the entire initiative and coordinate participating organizations and agencies. In our case this role is fulfilled by Our Cowichan Communities Health Network.

Building a Framework to Establish Priorities 2026

Island Health, in partnership with the Cowichan Valley Division of Family Practice (CVDFP), completed extensive mapping of health services. In 2016, service gaps identified through this process along with results coming from community consultations conducted by Our Cowichan Communities Health Network were compiled, prioritized and themed into categories which have guided the direction of EPIC. In the winter of 2026 EPIC partners again undertook a deep dive to review where we are today. Projects and actions developed will fall within one or more of the priority categories identified below.

Guiding Actions in 2026 are as follows:

Improve Access to services within health care and community services across Cowichan communities
Enhance Continuity of care and referrals from one service to another
Strengthen Integration of services with the community
Assist with System Navigation to the right resources for the identified need
Promote Prevention programs and services that support prevention and enhanced self-responsibility to mitigate increasing frailty
Provide Education including information to improve and maintain wellbeing, prevention and access to services and resources

Priority Areas

- Access to Information – Promotion of Pathways
- Identifying Frailty- prevention
- Social Isolation- Living alone
- Falls prevention
- Education for service providers and seniors
- Advocacy
- Enhancing referral pathways

Population – Who are we serving?

In 2021 Census, in the Cowichan Communities, 24,610 people are over the age of 65 which is 23-24% of the region's population. There are 9,625 people aged 75 and older.

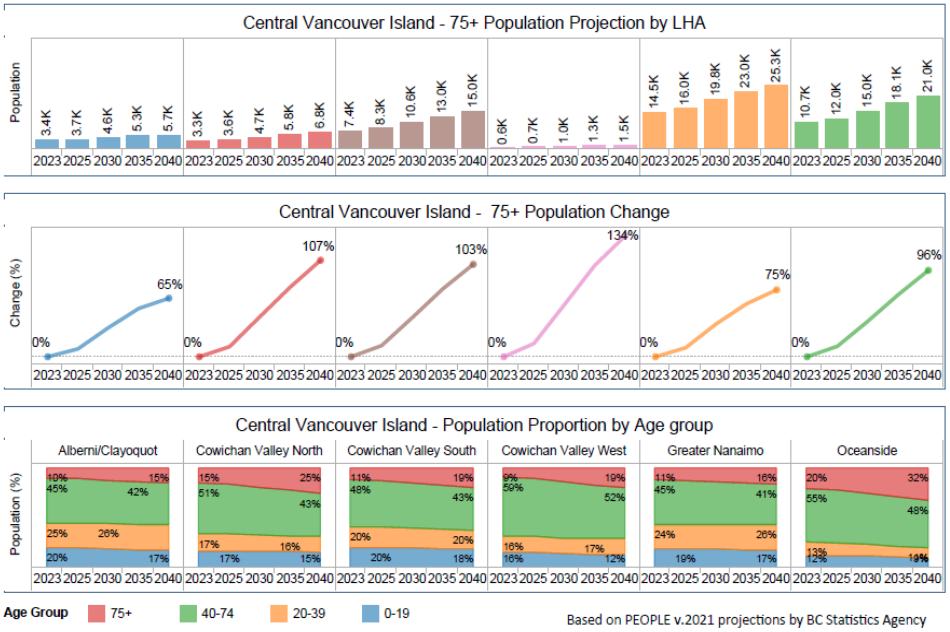
It is estimated that 5835 over the age of 75 are living with low medium chronic conditions and 3,790 people were identified with frailty or high chronic conditions. This cohort of older adults with medium to high frailty or chronic conditions are most often directly connected to health care services in the region. Our goal at EPIC is also to include a strong focus on the population with low medium chronic conditions, consequently improving the health of the senior's community overall.

Other data for consideration:

- The number of Emergency Department Visits for seniors 65+ living in Cowichan was 8473 in 2025, which accounts for 30% of all ED visits.
- The ED visits for seniors in Cowichan increases with age:
- 3668 65-74 age group visited the ED with 23% admitted
- 3276 75-84 age group visited the ED with 30% admitted
- 1441 85+ age group visited the ED with 39% admitted

Geography, population to be served by the model and demographic, needs of population

Located approximately 90 km northwest of Victoria on Vancouver Island, the Cowichan communities include Cowichan (LHA 65), Lake Cowichan (LHA 66) and Ladysmith (LHA 67) as well as the island communities of Penelakut and Thetis. 20% of BC's Aboriginal population live on Vancouver Island and over 8,500 individuals in the Cowichan Valley Regional District (CVRD) self-identify as an Aboriginal person.



Population projections for the Cowichan Region are predicted to have a significant rise in the coming years. Our ability to meet the needs of the growing number of seniors will require shifting service demands

Fiduciary Value Proposition- conceptually how does model align with goals of sustainability and scalability?

Evidence shows that supporting older adults to remain in their homes in community significantly reduces costs across the health care system. This multidisciplinary approach, case management, the engagement of primary care providers and community partners will enhance the health and wellbeing of seniors reducing the impacts on the health system. This model also ***focuses on prevention*** for those who are lower on the frailty scale and those who are the most frequent users of health services.

What has all of this collective work accomplished?

- ✓ CDH has been able to reduce their capacity and maintain a reduced occupancy between 93 to 98% for 4 consecutive years while other hospitals are operating at 110% to 125% occupancy. These drops are directly correlated to the resources put in place and supporting patients outside of the hospital.
- ✓ Actual predicted bed days have dropped significantly from what was to be a projected 186 bed days required to an average 146 beds days at Cowichan District Hospital.
- ✓ COPD patients connected to CHS COPD team have 30% reduction in hospitalization and Palliative patient admissions for those people connected to CHS palliative nursing have reduced to almost zero (receiving care at home or in hospice).
- ✓ Dementia admissions to hospital are reduced (this has been supported by the opening of the Hamlets Long Term Care, STEPS, senior's outpatient clinics, increase in home support and social work support and expansion of the adult day program.
- ✓ Falls prevention initiative resulted in 13% in falls and a reduction in estimated costs to the health care system in its first year

Our next collective initiative- 2026

To develop a roadmap for all practitioners, medical and non-medical, to follow for easy and efficient services; housed in Pathways.

Developing efficient pathways of referrals between health care and community