“Ontario Long Term Care Homes – can they become Community Care Hubs”

Submitted for consideration as the Leadership Project for
Canadian College of Health Leaders Fellowship Program

March 4, 2017

Carolyn Clubine

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Verification

This leadership project is my own work. As a member of the Canadian College of Health Leaders, I have adhered to the College's Code of Ethics as required. Any assistance I had in writing this manuscript was ancillary and within the limits defined by the Fellowship Program Requirements and Guidelines.

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Submitted March 6, 2017

Carolyn Clubine

Key Messages

There is a pressing need to seek and implement community care models to meet the well documented increase in the seniors population. This will demand significant expansion of healthcare and social support services for the next twenty-five years.

Long Term Care Homes are a valuable community resource that can support service models that deliver services to community dwelling seniors, and enable independence and support for complex chronic disease management. A wrap around support provided across the full social and healthcare needs of a senior is needed. Residential beds should be part of this continuum for the right period in the senior’s care experience, providing a fully integrated LTC and Community Care Hub.

A Policy framework does not exist in Ontario for an integrated service model. Leaders and Innovators need to create their own integrated service frameworks, and the Collective Impact Framework for Change is a useful tool for development of changes of this magnitude.

Executive Summary

Context

In 2015 for the first time, the number of Canadians over the age of 65 exceeded the number under the age of 15 (Statistics Canada, 2015). Long-term Care (LTC) Homes provide accommodation and nursing and personal care services to a predominantly seniors demographic who require twenty-four hour assistance with activities of daily living. In 2012 Ontario's Ministry of Health and Long Term Care released a seminal report "Living Longer, Living Well" written by the Provincial Lead for Ontario's Seniors Strategy, Dr. Samir Sinha. Dr. Sinha proposed new roles for the six hundred and thirty Homes operated in the Province, "exploring the ability of Long Term Care (LTC) Homes to serve as Community Care Hubs that could provide community oriented services, including home care that may further assist local residents to age in place." (Sinha, 2012)

Problem Statement

This paper explores the community care hub concept, discusses the challenges and opportunities that might be taken and discusses the mechanisms that support the creation of these hubs.

Approach and Methodology

This leadership project has incorporated extensive literature review, program analysis, site reviews including tours, informal surveys, legislation scans, consideration of policy frameworks, and personal interviews to gain a comprehensive picture and to consider opportunities for Community Care Hubs. Several colleagues have been helpful in the validation of key elements, both in theory and in practice. Current design work, and workshop facilitation with several operators and advocacy/planning bodies has allowed valuable critique and improved knowledge translation.

Literature Review and Evidence

Dr. Sinha urged the province to take a fresh approach to the role that LTC Homes can provide in developing Ontario's Seniors Strategy in 2012. He saw the potential of these valuable community assets to play an important role in serving the greater community beyond the walls of the LTC Home. However, today no fully integrated LTC Home and Community Care Hub has yet been created. In 2014 the Premier commissioned a review of public assets launching a Community Hubs Advisory. LTC Home operators overwhelmingly support the delivery of community services alongside their core service, and they recognize that there are numerous advantages to the integration of Community Care Hubs. However there are regulatory challenges to this integration.

Results

There is a range of Community Care Hub options; Campus Continuum, Hub with site based services, Hub and Spoke outreach, and Integrated inclusive Care Hub. While this paper sets out a proposal on *'the better way'* many incremental improvements can and should be made as the opportunity is presented to each LTC Home operator and their community. Different communities and owners, whether for profit, non-profit/charitable or municipal, will be well served with individual solutions that connect and maximize LTC services with community residing seniors, to create a better flow and utilization. Additionally, as many Ontario LTC Homes enter into a redevelopment of their physical infrastructure in the next five years, now is the best time to consider the opportunities for community care hub inclusion.

'*The better way'* is an opportunity for bold innovation where there is no path to follow today. Agencies that currently provide specific services that would choose to be part of an integrated model of social and healthcare services would work together in a new form of collaboration,

consciously releasing autonomy of practice for the benefit of achieving a shared vision for seniors care. A new approach to collaboration between service delivery partners and funders is needed, to ensure that all parties are valued and strengthened. Collective Impact has been cited as the best and most effective change model in recent years in community development for health and social services (P. Born, personal communication November 30, 2016).

There are five conditions in the Collective Impact Framework; common agenda/shared aspiration, shared measurement, mutually reinforcing high leverage activities, continuous and authentic community engagement, and backbone structure or container for the change. Communities and LTC Home providers which are redefining their services, others who of necessity must explore new approaches, and organizations which forecast sustainability challenges will do well to draw on this framework to create bold conversations about how service delivery can be changed for the future.

Transferability

The spread and scale of options for LTC Homes to become Community Care Hubs is limited in the current Ontario milieu. To implement *'the better way'* innovation at the local level through a partnership may be the only means to create the change that will realize the potential of LTC Homes as an integral component of a Community Care Hub.

Contributions to Health Leadership

This paper identifies opportunities for both modest and substantial change to create Community Care Hubs in LTC Homes. The Collective Impact approach is a useful tool in gathering momentum for change in a community and to find new service models. There is significant alignment between Collective Impact and the Canadian College of Health Leaders LEADS Leadership Framework (CCHL, 2017).

Future Work

Additional opportunities to use the concepts and models discussed in this paper to achieve deep community change lie ahead, including broader application beyond LTC Homes.

Frequently Used Acronyms

AMO – Association of Municipalities of Ontario

CCAC – Community Care Access Centre

CCHL – Canadian College of Health Leaders

iADL – Instrumental Activities of Daily Living

LHIN – Local Health Integration Network

LTC H – Long-term Care Homes

MOHLTC – Ministry of Health and Long-Term Care

M SAA – Multisector Service Accountability Agreement

OANHSS – Ontario Association of Non-Profit Homes and Services for Seniors

OLTCA – Ontario Long Term Care Association

Context

In 2015 for the first time, the number of Canadians over the age of 65 exceeded the number under the age of 15 (Statistics Canada, 2015). While the typical young – old (ages 65- 74) Canadian leads a generally healthy life, the likelihood of need for support to maintain ones independence increases over the years. Currently, in Ontario 9% of the senior population will be cared for in a long-term care setting, however the simple growth in this demographic will quickly outstrip both the physical and financial resources that are available over the next twenty-five years. It is estimated that the cost of seniors continuing care today is $28.3 B and by 2046 will grow to $177.3 B (Conference Board of Canada, 2015). This same report found that seniors are demanding options for community living, which allow them to retain their autonomy, so that a mix of housing and service options are needed.

Long-term Care (LTC) Homes provide accommodation and nursing and personal care services to a predominantly seniors demographic who require twenty-four hour assistance with activities of daily living. "The likelihood of LTC Home admission increases with age and the age groups at highest risk are those that are growing the fastest over the next 20 years; over the next 20 years the number of people age 85 years and older in Ontario is expected to double" (Preyra, 2014).

In 2012 Ontario's Ministry of Health and Long Term Care released a seminal report "Living Longer, Living Well" written by the Provincial Lead for Ontario's Seniors Strategy, Dr. Samir Sinha. It was the launch of a comprehensive Seniors Strategy, which continues to provide significant guidance for the development of effective strategies and service implementation across the Province. In Chapter Six, Enhancing Ontario's Long Term Care Home Environments, Dr. Sinha proposed new roles for the six hundred and thirty Homes operated in the Province. He envisioned a new service model design for these valuable community resources, and to extend

their service capacity. Specific recommendations included delivery of Short Stay/Convalescence, care for more complex needs, and "exploring the ability of Long Term Care (LTC) Homes to serve as Community Care Hubs that could provide community oriented services, including home care that may further assist local residents to age in place" (Sinha, 2012). These services are options that would make the best use of LTC Home capacity to meet needs and reduce the need for growth in LTC Home beds.

Problem Statement

Consideration of this vision of an expanded role for LTC Homes is worthy of thoughtful examination. What is a "Community Care Hub"? What are the challenges that confront both the system, and the operators? What opportunities might be taken as close to fifty percent of Ontario's Homes are expected to invest in new infrastructure in the next ten years? What outcomes will be achieved that are worthy of the effort required, and what mechanisms will serve to support the creation of these hubs?

Approach and Methodology

Over the past six years since the proclamation of Long Term Care Homes Act in 2010, healthcare leaders in Ontario have continuously raised their concerns about how to maximize the effectiveness of care and services for the frail and elderly in and through LTC Homes. Ontario Long Term Care Association (OLTCA) commissioned a report in 2010 on the potential of innovation in LTC Homes, and then convened an expert panel, which this author sat on, and produced a recommendation dense report "Why Not Now? A Bold Five-year Strategy for Innovating Ontario's System of Care for Older Adults", in early 2012. Ontario Association of

Non-profit Homes and Services for Seniors (OANHSS) also added its voice to the discussion in 2016 calling for the LTC Home to be integrated into discussions of system capacity planning.

At the local level, service providers and seniors groups had been undertaking strategic future oriented planning through various municipal and community level Aging Population initiatives, such as the Halton Seniors Plan, and Peel's Aging Population Strategy. For the first time in 2012, the government of Ontario began an intensive planning effort to address the future needs of the senior population. A convergence of interest and momentum has given room for the discussion and development of new models of service.

This author was commissioned to create a new service model for the consideration of Peel Region Council both for the purpose of considering the options for a building which had become dated and costly to maintain, and to address the increase in the aged population that would soon outstrip the resources available. Our team was successful in presenting a conceptual model to the governing body of Peel Council, which continues to be viewed as a robust model. My continued pursuit of solutions for effective care and support models has extended considerably further than the initial proposal, and now offers an opportunity to contribute to a pan-Ontario discussion and planning efforts.

This leadership project has incorporated extensive literature review, program analysis, site reviews including tours, informal surveys, legislation scans, consideration of policy frameworks, and personal interviews to gain a comprehensive picture and to consider opportunities for Community Care Hubs. Several colleagues have been helpful in the validation of key elements, both in theory and in practice. Current design work, and workshop facilitation with several

operators and advocacy/planning bodies have allowed valuable critique and improved knowledge translation.

This project is a timely opportunity to cultivate expertise amongst healthcare leaders, and to lend support to many organizations examining their future role, whether to redevelop an outdated building or to amalgamate services with agencies that share a service vision. Innovation is needed, and even in small increments this will serve to benefit the service system. Ultimately seniors will be better served by opportunities taken to place services in an accessible and community oriented setting that supports their maximum independence and connectedness.

Literature Review/ Evidence

Historical context

Historical evidence of the concept of integrated service hubs for the elderly can be found as far back as 1997 in work undertaken by the Ontario Health Services Restructuring Commission. This was documented by Dr. Paul Williams in a recent paper that discussed the potential for moving from “beds” to “places” (Williams et al. 2016). This comprehensive review of the health system signaled significant changes that were needed in the hospital system, and recognized that community resources would be required to successfully streamline and improve hospital efficiency to focus on acute care services. A significant infusion of new long-term care was delivered to the health system with twenty thousand new licensed beds constructed and opened between 2000 and 2005. The encouragement by the Restructuring Commission to introduce similar resources into the community support and homecare sectors was not, however, embraced by the government of the day. In the ensuing years significant problems in utilization of hospital beds arose, with a large percentage of beds occupied by persons ready and waiting for

appropriate alternate levels of care spaces (Walker, 2011). While many took the view that the greatest need was for residential long-term care accommodations a growing voice of reason suggested that community care options needed to be sought and developed.

Canadian Models

A range of services partnered with LTC Homes are operated throughout Canada, some of which offer lessons for Ontario. Regional Health Authorities, which are well established in most other jurisdictions, provide a single governance model that allows alternative services delivery systems to be implemented more nimbly than in Ontario. All provinces are grappling with growing continuing care costs, and "the provision of continuing care supports to seniors… represents an important and complicated piece of the overall healthcare puzzle for governments" (Conference Board of Canada, 2015). Bundled funding and client controlled funding are gaining momentum in some sectors. Alberta has operated a program Comprehensive Home Option of Integrated Care for the Elderly (CHOICE), since 1996 based from a shared building that operates on site long-term care. This model benefits from the round the clock building operations particularly beneficial to their overnight respite and caregiver relief service (The Good Samaritan Society, 2014).

Ontario's Seniors Strategy

Dr. Samir Sinha, in his role as Expert Lead to inform the government's senior care strategy urged the province to take a fresh approach to the role that LTC Homes can provide in developing Ontario's Seniors Strategy in 2012. He saw the potential of these valuable community assets, which are located in almost every town in Ontario, to play a valuable role in serving the greater community beyond the walls of the LTC Home (Sinha, 2012).

His report validated think tank findings published by Ontario Long Term Care Association (OLTCA) following an expert panel's consultation, titled "Why Not Now". The expert panel which I was fortunate to participate in called forward the opportunity to make long-term care more available increasing the number of clients served by reducing length of stay and increasing options for episodes of care of short duration (OLTCA, 2012). However, barriers do exist in substantial ways; legislatively, physically and financially. Today, no fully integrated LTC Home and community care hub consistent with Dr. Sinha's vision has yet been created.

While researchers are quick to dispel the view that the rapid aging of our population will overwhelm the health system (Chappell, 2016), they do advocate for better development of continuing care approaches. The Canadian Medical Association has consistently voiced its objection to the health system's focus on acute illness, sounding alarms that the rate and depth of chronic illness has been overlooked. More people die today from heart disease or dementia than at any time in the past (Canadian Medical Association, 2016). Cause of death statistics in one large urban community identified heart disease as the number one killer in 2009 (Ontario Ministry of Health and Long-term Care, 2009). In a call for urgent attention to the need for development of a Federal Health Plan for seniors Neena Chappell observed that far too much focus in the health system is placed on a physician's role, whereas there is a great opportunity to use less costly services including homecare and preventive programs (Chappell, 2016).

Health Links which was designed by Associate Deputy Ministry Helen Angus in 2012 (MOHLTC, 2012) has some features that attempt to address case management needs of the highest needs patients in the province. It is highly clinical in its nature and has served to identify those who incur the greatest costs in the range of $135,000 per year. While it has some elements

that may assist with the discussion of service coordination for the seniors population it has a limited application due to its primary focus on clinical intensity and medical protocols.

Community Hubs – a New Approach

The Liberal Government under Premier Kathleen Wynn received a new electoral mandate in late 2014 and the Premier committed to a meaningful review of the use of public assets by launching a Community Hubs Framework Advisory Group. Karen Pitrie, the Chair of this advisory stated in her 2016 status update “community hubs are bringing together multiple services to meet local needs” (Pitrie, 2016). While this is a broad based approach that is different from Dr Sinha’s vision for LTC community care hubs, it is noteworthy that support for a more integrated approach to service delivery is gaining momentum.

Community hubs that serve a seniors population have developed organically in many communities through the commitment of local citizens clustered around an ethnic, religious or geographic identity. In many communities, campus or continuum settings have been created, although the design of most is dedicated services to on-site clients. Additionally, local municipalities provide a broad range of services that are intentionally for seniors or by virtue of the types of services offered serve a dominantly aging sector of their community. This includes the mandatory operation of a LTC Home (Government of Ontario, 2007), various community support services ranging from Adult Day Programs to snow removal, community paramedicine, Elderly Person Centres, public health programs, affordable housing and disabled transit to name a few (Association of Municipalities in Ontario, 2016).

Some municipalities have bundled and operate their own unique hubs and services as in the example of Dufferin Oaks LTC Home and the Mel Lloyd Centre in Shelburne, a small town

northwest of the Greater Toronto Area (Sullivan, 2016). In a survey conducted by the author with Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS) members at the annual convention in April 2016, over ninety percent of the respondents expressed their support or plans to expand into care and service opportunities beyond the traditional LTC Home operation. Much of the motivation for this interest is reportedly based on the organization's core mission and values (See Appendix 1 and 2).

Legislative Context and Changes

Current legislation forces services into silos, both for funding and process reasons. This further erodes natural community or neighbourly care as evidenced by current Community Care Access Centre (CCAC) wait listing rules for LTC. A person who has lived ten years in a neighbourhood with friends has no better chance of being placed in a nearby LTC Home in their last days amongst people who know and care for them than a person who is forced by hospital protocols to move into a strange place which may be forty-five minutes' drive from their own caring community. Additionally, Assisted Living Services For High Risk Seniors – a policy introduced into the community support services sector in 2011 – specifically prohibits seniors receiving these services to be deemed eligible for LTC admission (MOHLTC, 2011). This creates a definitive control over the use of the assisted living program that prevents the natural flow of services for seniors between and amongst service types.

Ontario's Local Health Integration Networks (LHIN) were established ten years ago, to prioritize and plan local solutions for the delivery of healthcare that most effectively addresses needs and capitalizes on the skills, expertise and partnership of provider organizations. While they were designed to direct the service system, the government did not extend the direct operations of health services to the LHIN mandate at that time.

The recently proclaimed Patients First Act (Government of Ontario, 2016) has attempted to improve the function of case management and service brokerage performed by CCAC for homecare patients. This new direction will bring the system designers at the LHIN closer to the service delivery that CCAC previously organized at arm's length, by folding CCAC into the LHIN, and creating more local neighbourhood or sub-LHIN region planning districts. It will not, unfortunately, change the funding model to support the continuum or seamless transition potential that could leverage the effectiveness of the Community Care Hub concept.

LHIN officials are excited about the prospects of the implementation of sub-LHIN region planning. It will look at mapping of services against demographics dealing with 'citizenry'. The whole of a community's attributes will be mapped together; income/crime/health and others using the concept of social determinants of health, and Population Health frameworks to plan specific services at the local level (M. Edmonds, personal communication, November 2, 2016).

Additionally the Elderly Persons Centres social supports entity in Ontario was recently reviewed. Elderly Person Centres offer a range of social, cultural, learning and recreational programs. They are unique in each community offering particular programs, locations and partnerships that meet local needs (Ontario Seniors Secretariat, 2016). Elderly Persons Centres have been recognized for their value in the contribution to seniors wellness, naturally offering elements of the community hub concept. New proposed legislation referred to as Seniors Active Living Centres, 2016 has positioned them consistent with the urging of Dr. Sinha to strengthen their role in preventive and wellness tools for seniors.

There are several regulatory challenges to the integration of the Community Care Hub into a LTC Home. Examples include regulations in the LTC Homes Act which specify that the LTC

Home must be designed to be fully independent of all other collocated services (MOHLTC, 2015), funding streams which force the segmentation of services, admission and flow provisions that are managed to assure equitable access but often prevent transitions between community services and LTC beds (Government of Ontario, 2007).

There are specific criteria to the right fit for a LTC Home to incorporate Community Care Hub elements and not all six hundred and thirty Homes in Ontario should be targeted for this type of service. They include suitable location near a critical mass of community dwelling seniors, LTC Homes Act alignment, space or available land, clarified conflicts and loyalties, capital funding, partnerships and their mechanics, lead agency and information sharing, and clinical records management (Clubine, 2016).

Ontario's LTC Sector

Ontario's LTC sector is comprised of three different ownership types. Fifty seven percent of the Homes are operated by for-profit firms, which includes both independent single businesses and chains which range in size from two to more than twenty. Non-profit Homes which comprise twenty six percent are generally operated by faith organizations or ethnic/cultural charitable institutions. Municipalities operate seventeen percent (Government of Ontario, 2015). In southern Ontario there may be as many as eight Homes operated by the municipality under this mandate in a single Region. Operating agreements referred to as Long-term Care Service Accountability Agreements are signed between the operator and the LHIN.

Community services that are funded by the LHIN, and play a role in community care hub service offerings sign operating agreements known as Multi-sector Service Accountability Agreements M SAA), and only non-profit organizations (including municipalities) are permitted to hold these

agreements. Consequently, it is easier for non-profit and municipal partners to enter into community care hub planning initiatives. However, this does not prohibit the opportunity for participation of a privately operated LTC Home, as the flexible nature of the proposed approach introduced later in this paper may account for unique design considerations that would arise. A greater concern for the participation of private LTC Homes is the additional resources both human and physical that must be actively contributed to the hub, (D. Biernes, personal communication, November 6, 2016) competing with investor return on investment priorities.

The appeal of Hubs

As system planners grapple with service design the model for Community Care Hubs that can become a valuable asset has the following broad features:

- part of the community as a whole, but be focused on serving older adults
- will target all older adults in the catchment area,
- provide coordinated services across health and social services including primary care, pharmacy, recreation, rehab, social clubs and meeting space
- provide information, support and education to the community (Clubine, 2015).

Ontario's LTC Homes are in the process of a massive infrastructure redevelopment, supported by government's mandate to clean up the aging stock built in the 1970's, funded by a Redevelopment Capital Program (MOHLTC, 2015). As these buildings are replaced or renovated it makes sense to consider the opportunity for extension of the construction to allow space and resources for a community care hub. However the current financing model does not offer incentives to add space for such services whether for profit, non-profit or municipal. An assurance of a long term agreement for the operation of services is not currently permitted as the Multi-sector Service Accountability Agreement between agencies and LHIN have a duration no

longer than three years, resulting in financing risk for operators which is considered too high (D. Biernes, personal communication, November 6, 2016).

There are numerous advantages to the development of Community Care Hubs integrated with a LTC Home as these buildings offer a critical mass of infrastructure that can operate as a technical or logistics base; buildings, back of house supports such as laundry and kitchens; and healthcare skills and expertise in the form of knowledgeable nurses, dietitians, and doctors with geriatric focus. Administrative supports and back of the house functions can also be delivered more efficiently.

Additionally, business and service providers contracted to a LTC Home look for a critical volume of service that would allow them to effectively offer their core services and which encourage supplementary or enhanced service levels. Examples include pharmacy, home healthcare suppliers, and rehabilitation services. Agencies also achieve the benefit of contributing their specialty to a larger population than might be the case without these connections. Beyond the structural or business benefits, people can receive a full range of care and services in one single destination. And clients build relationships with one another aiding in the fight against loneliness and isolation.

Results

A Range of Options

There is a range of Community Care Hub options that would be appropriate for consideration in the LTC Home setting. Only those which specifically function with the LTC Home in partnership are considered in this paper. The following simplified chart briefly describes them.

Chart 1: A Summary of Community Care Hub Options

Type	Description	Strengths	Limitations
Campus continuum	A range of housing and personal support services are provided to the population residing at the LTC Home site, including independent living such as life lease, apartments and supported living	Client eligibility is clear, and services are generally managed by a single entity. Flow between forms of housing and services on the site is simplified	Services are limited to those who reside on the site. Pricing for additional services is at the discretion of operator. Current legislation does not permit access to LTC beds as a right for campus residents.
Hub – site based services	A LTC Home offers co-located services that seniors come to the site to receive	LTC Home footprint and back of house services support the delivery of programs such as Adult Day Services. Specialized needs such as bathing and diet can be accommodated efficiently. Clients develop a familiarity with the organization and future transitions are less disruptive	Services are limited to specific funded activities. Transportation is an essential component. Priority will always fall to LTC services in the event of emergency events such as Infectious Outbreaks and may result in temporary service cancellation.
Hub and spoke (outreach)	The LTC Home offers services to eligible seniors on site and at seniors own homes within a designated radius (neighbourhood)	LTC offers a level of knowledge and an infrastructure that supports geriatric needs. Services delivered through the spoke are generally within a range of personal care and home help. Clients receive the services in their own home	LTC staff may not be shared with or between the other services delivered by the spoke. Community clients receive their more intensive health services from other providers, managed by CCAC and may result in inconsistent service and caregiver burden. Transportation

			time for the workers travelling from hub is costly
Integrated inclusive care hub *'the better way'*	Seniors, regardless of home address are identified as clients such that their full spectrum of health personal care and social service needs are managed in a continuous and seamless delivery model	Programs, regardless of the agency delivering them, are designed primarily with the client's quality and maximum independence at the centre. Clients do not apply for individual services as eligibility is determined by identified need through continuous observation. Clients may receive residential care for short episodes. Funding is assigned based on service demand through global budgeting	Currently Ontario doesn't have a policy framework that allows this full integration, and regulations specifically prevent it. This means that workarounds to achieve full integration must be created and will be complex. Increased flexibility in models of care and funding that support grassroots, local capacity development is needed (Sullivan, 2016)

Relevant considerations

Across Ontario today there are many campus continuums. These are operated by both private pay and government funded organizations, or with combinations of funding. In most of these operations there is a single service provider. Seniors often choose this service model as an "insurance" against changing needs, although few likely understand the government's current policy that prohibits preferential admission to the site's LTC beds, resulting in a significant gap in the real experience through the continuum.

Hubs with site based services for community dwelling seniors are provided almost exclusively within the not-for-profit and municipal sectors. As referenced earlier, operating agreements for the funding of programs such as Adult Day Service may only be signed between LHIN and approved Health Service Providers in the community services sector (private businesses are not eligible). The funding for services and availability of the range of support services is inconsistent across the province, and some reimbursement rates had been established historically with no

rationale. The functions that are offered in each service may also be inconsistent, although recent work to develop a consistent understanding of the components required in each functional centre has resulted in improvements.

Hubs from which services are delivered to neighbouring seniors do capitalize on a limited range of the infrastructure services at the LTC Home. Some sharing such as contracted rehab companies realizing a greater service volume in a local area may improve the continuity and access, and meals on wheels service delivered in a small geographic area may drive costs lower, however expert professional support from LTC healthcare experts is neither permitted nor efficient to deliver.

LTC beds are a highly valued resource that serves the community best when they are utilized by the clients with the heaviest care demands and only for the shortest and most beneficial period in the care journey. It is possible to assess care requirements and care pathways that ensure the LTC beds are serving the right people for the right duration (OLTCA, 2012) (Williams, 2009), and tools such as interRAI Community Health Assessment are very useful in standardizing the assessment definitions and ensuring objective findings amongst clients and between assessors. Additionally, work is ongoing to develop a Levels of Care Framework and this is being led by Health Quality Ontario. When options for the use of LTC beds include long and short stay, and convalescence alternatives there is a more effective utilization available. This requires that there is a set of services, a continuum with an enrolled population and integrated in-home and community support services that can be made available as and when the client needs them to be successfully maintained in their community residence as a first priority (OLTCA, 2012).

While this paper sets out a proposal on *'the better way'* many incremental improvements can and should be made as the opportunity is presented to each LTC Home operator and their community. Different communities and owners, whether for profit, non-profit/charitable or municipal, will be well served with individual solutions that connect and maximize LTC services with community residing seniors, to create a better flow and utilization.

LTC Homes Redevelopment

As many Ontario LTC Homes enter into a redevelopment of their physical infrastructure in the next eight years, now is the best time to consider the opportunities for community care hub inclusion. This opportunity will not appear again for many years. Challenges abound and include a host of funding questions, as well as the acquisition of land, the availability of health human resources and the nature of commitments that would be required to establish and sustain these types of hubs over time. At the same time that redevelopment presents operators with these challenges it is also an opportunity that rural or smaller Homes particularly could leverage towards a more favourable design and stabilized operation if given a lifecycle commitment such as twenty-five to thirty years (D. Biernes, personal communication, November 6, 2016).

A method of analysis for these options would assist organizations in their review. Work to develop such a tool is underway with the author's contributions as part of a support service being offered to those OANHSS member Homes which have been identified by the Ontario government for redevelopment (S. Majumder, personal communication, November 27, 2016). Retroactively paid Planning Grants have been established to assist not-for profit organizations through this process (MOHLTC, 2015). Additionally, grants to these operators could be useful to construct modest infrastructure and capital projects for the purpose of enabling the launch of innovative service models (AMO, 2016).

An Innovative and Strategic Solution

The *'better way'* is an opportunity for bold innovation where there is no path to follow today. Agencies that currently provide specific services that would choose to be part of an integrated model of social and healthcare services work together in a new form of collaboration, consciously releasing autonomy of practice for the benefit of achieving a shared vision for seniors care. It will require strong but equitable leadership, inclusion of governors at all levels, and decision making about the backbone roles in functions such as lead agency and coordination roles.

A joint success goal that allows the right amount of service at the lowest intervention level (and lowest cost) would be shared between care and service partners and the elder client. When or if an intensive episode of care or services is required, the benefits of receiving this within an integrated service system include stabilization, and return home with a consistent service provider (and familiar caregivers) which has a long term relationship with the client, and is committed to help them return to optimum functioning quickly.

The model explored in this Leadership project is aimed to achieve a coordinated approach to serving the frail or elderly client. It is not a storefront, or shared real estate concept. It is an opportunity for seniors to be provided comprehensive care and services in their local community that enable and facilitate their maximum independence, deals effectively with changes in health condition, and avoids or delays the permanent move to long-term care.

Model Description

The Community Care Hub will be formed around an identifiable community asset that has the infrastructure needed to support service delivery, and in the present case would be a Long Term Care Home in a location that is central to the community to be served. It is envisioned that key community agencies which have a demonstrated expertise in delivering a range of health and social services to the aging population be called to a joint task force for the purpose of development of the Hub. The means to develop a partnership between these agencies is critical to ensure that all parties are valued and strengthened in the process.

The front facing services that are most beneficial in the pursuit of a community care hub as envisioned by Dr. Sinha include Nursing (teaching and practical), Personal care, Pharmacy and medication administration, behaviour specialist, Medicine and Advanced Practice Nursing (geriatric and psychogeriatric), Dietetics and Nutrition, escort or companion for travel and appointments, Physical and Occupational Therapy, Case Management, Recreationist, Social Work, Speech Pathologist, Chaplain and hair care. These are organized and delivered through a regular and purposeful encounter between the senior and the program centre – most often a Day Program or active drop in Centre, which includes the assignment of the client to a specific worker who monitors, coordinates support services and advocates for them.

The foundational supports include transportation, off-site or independent housing including home care services, ample instrumental Activities of Daily Living (iADL) support such as light housekeeping, meals, laundry and shopping, Medical Specialists including palliative care, and paramedical (Optometry, Dentistry and Denturist, Audiology, Podiatry or Chiropody, Dermatology, Incontinence management), Quality and Performance measurement and management, Information systems and records management, and programs management.

In order to fully manage the changing needs and health events that a frail client may encounter the Hub would be most effective if it also offers subacute care, respite and slow stream rehab and convalescent care. In the Community Care Hub located in a long-term care home setting there is an assumption that long-stay beds are also available, for those who have been a part of the community served. Additionally it is understood that there is a full contingent of Infrastructure supports such as plant management and kitchen workers (CHOICE, 2014).

Challenges

A Policy framework for this new approach is not currently available and will be very slow to catch up. Regulations have become a significant limiter to innovation, as evidenced by the Ontario Auditor General's recent criticism of reporting rigour for service volumes (M. Edmonds, personal communication November 2, 2016). It has resulted in more rigid adherence to definitions and eligibility criteria for services resulting in additional documentation and justification. This Community Care Hubs model will excel when a bundled funding approach is available. However, the implementation of bundled funding is challenging due to the bureaucratically complex accountability frameworks currently in place in Ontario and there is no indication that this is likely to be offered in the near future. LHINs will continue to have direct control over M SAA funded agencies while hospital and long-term care base funding will be directed from the Province through the service accountability agreements specifically written between the operator and the LHIN and between the LHIN and the Province, while the LHIN has full authority to establish and monitor key performance indicators that support the local community and service needs.

The creation of this Community Care Hub approach is up to bold and innovative agencies and service providers at the local community level. It is proposed that a model grounded on the intent

and collaborative spirit of a community of interest is the best means to achieve the full vision of a Community Care Hub, while administering its functions within the conventional funding and accountability streams. Ground up initiatives, and approaches are the place to start. Innovation can be undertaken incrementally and does not need to be disruptive to the entire system. Innovation at the local level is far more likely achievable than system wide change (Conference Board of Canada, 2011). What is needed to make this happen is bold and innovative leaders and a methodology to engage community and develop partnerships that is driven by client need, and a care coordination framework that multiple agencies are agreeable to work within.

One who is familiar with the Ontario context will immediately recognize that the services proposed in the integrated model are funded separately to a variety of different agencies with different admission criteria, funding rates and in some cases with duplicated services such as transportation. Many providers add unfunded iADL to their programs as specific client risks and needs are identified. Lessons taken from other provinces include the regional health authority concept wherein most services are under a single governance and funding is more likely to be global. When Ontario introduced its LHIN model, it made a decision to maintain the existing multiplicity of agencies, while providing in its legislation for the possibility of mergers or amalgamations. Few of these have occurred in the ten years since formation, and today quite a number of these small agencies have very fragile infrastructure which is vulnerable to diminishing operations support funding and lack of leadership expertise.

Without a doubt one of the significant factors that must be confronted in the discussion of the integration of services is territoriality and culture; whether at the CEO and Board level, or within an organization’s daily operations. Additionally, market share and historical funding is a threat to new approaches (A. P. Williams, personal communication, November 3, 2016). A new approach

to collaboration between partners and funders is needed. Collective Impact has been cited as the best and most effective model in recent years in community development for health and social services (P.Born, personal communication, November 30, 2016). Collective Impact may provide the context for leaders to consider an expanded service model when LTC Homes are redeveloping and as they bring community partners into their decision making. Further discussion of this approach is provided below.

It is possible for service providers to come together motivated by their commitment to the local community. A few examples of modest inroads towards this deep integration have quietly developed, as exemplified by Au Chateau LTC and Community Services in collaboration with the Community Health Centre, its satellite locations, and other community agencies in Sturgeon Falls. These organizations located in a small Francophone community in northern Ontario, have committed to core values of partnership and interdependency (J. Dupuis, personal communication November 8, 2016). Most other hub-like operations the author examined rely on a single entity delivering most or all of the services directly. Deep and broad service integration across programs and agencies is clearly one of the most daunting challenges to the establishment of Community Care Hubs.

Making Change Happen

As referenced earlier, the province is committed to a shift in the use of publically funded community assets and has created an advisory panel to pursue the concept of community hubs. In its first annual progress report the panel stated: "Collective Impact is an innovative, outcomes driven approach to making collaboration work between people, government, business philanthropic and not-for-profit sectors to achieve significant and lasting social change. It is also

a transformative service delivery approach that emphasizes integrated and longer term planning" (Pitrie, 2016).

The Collective Impact approach to community change, in simple terms, is emboldened policy makers and system leaders who are willing to make courageous changes by building a movement through a vision of the future based on common vision and values between diverse organizations sectors and political affiliations. This specifically includes the people most affected by an issue. Collective Impact has been quietly developed and used in communities for more than ten years, but its methods continue to evolve. Understanding of how community partners participate and how to purposefully include the client's knowledge is a continual journey of improvement. In a recent article by the Canadian expert Tamarack Institute, continuous evaluation of its effectiveness is identified to refine the model (Cabaj and Weaver, 2016).

Collective Impact - A Framework for Change

When a community becomes motivated around a specific need, and includes the persons most affected by the current situation, the conversation about what is possible begins to look different. Key organizations begin to release their power and other types of agencies and interested parties can join in.

There are five Conditions that need to be created in the Collective Impact framework:

- Common agenda / shared aspiration - bringing key stakeholders, and information/metrics together, to develop the shared vision and pathways to get to the new state that can't be realized through business as usual.

- Shared measurement - efforts remain aligned and ensure that participants hold each other accountable in the context of a strategic system of learning and evaluation that fundamentally values continuous improvement.
- Mutually Reinforcing and High Leverage activities - resulting in person centred supports that are coordinated, to achieve broad rather than discrete outcomes and which appear seamless to the client and their family.
- Continuous Communication achieving authentic and inclusive community engagement - cultivating broad ownership and long-term commitment to the change process and assuring that those most affected participate fully, and that leaders exhibit confidence and humility to navigate conflicts related to different values, interest and power.
- Backbone structure and Container for Change – acknowledging and designing change as high value It is not attempted from the side of otherwise busy people's work and includes diverse representation; letting go; and "fierce conversations around points of conflict and change" (Cabaj and Weaver, 2016).

The Collective Impact approach could provide a very useful mechanism for such an organization with its community partners to advance its work. However, the experts in Collective Impact acknowledge the potential that the approach could become superficial in its design. "The two most typical strategies co-locating of services and case management methods, offer excellent prospects for cooperation; they are relatively easy to implement and don't require co-locators to give up funds, authority or turf". It turns out that they are also low leverage; while families benefit from having services in one place and an advocate willing to help them navigate them, "the majority of programs still operate with inflexible eligibility criteria, offer cookie cutter

supports and are so poorly coordinated that accessing them is a fulltime job" (Cabaj and Weaver, 2016).

Unique Solutions

In spite of these cautionary notes, the use of the Collective Impact framework for community initiatives allows for the unique expression of the circumstances and local environment of the participating organizations. Right from the level of system planner (LHIN) determining the catchment area of a Community Care Hub, through the identification of agencies, to the design of relationships, it empowers leaders to create new solutions. Flexibility is a key attribute in applying this planning approach. Relationships will be created or reformulated to define the lines of accountability and collaboration and to deliver the agreed services that will achieve the outcomes identified at the outset.

As the Ontario system of home and community care, and the location, ownership and size of its LTC Homes is unique in each local setting, the decisions and solutions will be unique. One community may create a governance structure that establishes the accountabilities and functions between and amongst multiple agencies, while another community may reach an understanding of specific roles that allow autonomy for the service providers. Yet another community may find that contractual relationships that are managed by the lead agency is the better solution. Factors that would guide the partners to the solution that fits their environment will include geography, physical resources, availability of skilled healthcare labour, information technology, union contracts/non-union workforce, and currently funded providers (e.g. Transportation) to name a few. Additionally, the role that the municipality may choose to play will be a factor, ranging from direct partnership if the LTC Home is municipally operated, through to minor local grants for the operation of Seniors Active Living Centres. In each solution the backbone container must

include rigour that meets the realities of risk, shared financial obligations, confidentiality, mutual reporting obligations, and clearly identifies the performance measurement criteria and quality improvement commitments.

Getting Started

Program design and client flow can be successfully delivered at the local level when regulations are relaxed. “The highest level strategy is for policy makers and funders to decentralize responsibility for program design to regional and local organizations and hold them accountable for broad rather than discrete outcomes”(Cabaj and Weaver, 2016). In its 2016 paper discussing the municipal role in seniors services Association of Municipalities of Ontario proposes that municipalities are provided funding from the Province to a broad and flexible funding envelope to be used innovatively as local needs dictate (AMO, 2016). In its Position Paper on Capacity Planning, OANHSS also urges funding models that support local capacity development and flexible models of care (Sullivan, 2016).

When a provider is contemplating a new mission or purpose, an identified community of need, and well established partnerships (funded, philanthropic, and business) which could form the foundation of a Community Care Hub, their opportunities are primed for innovation of this magnitude. Necessity will drive some communities further in their exploration of new approaches than others – for example a rural or semi-rural region that cannot sustain independent agencies over a vast geography. Alternatively, an organization that is experiencing unstainable threat such as loss of core funding will hasten to enter into discussions of a new vision with organizations that share their values. The LHIN in which a group of providers is willing to come together to create this change needs to be a participant in the process. While they are compelled

to guard the Government's regulations they cannot be excluded at the risk of missing creative thinking, advocacy related to roadblocks and opportunity.

Outcomes and Measurement

Innovation must be transparent to identify where it has been successful and where the approach is not working. Measures should be formed around a balance scorecard, in order to account for a range of benefits. Simple output measures would include standard utilization metrics by type as currently defined. Outcomes that could be selected by the Collective Impact initiative may include

i. wait times for integrated services
ii. emergency department visits
iii. Long-term Care placements
iv. community client acuity
v. mental health and addictions prevalence
vi. chronic disease and palliation
vii. quality of life
viii. financial and comparative costing
(D. Buchanan, personal communication, November 28,2016)

Transferability – Where do we go from here?

The author has been an active participant at planning tables for seniors care and services for several years, both as a service provider and as an expert panel member. Sadly, the Ontario government continues to separate health services for seniors into different silos, Accountability agreements and funding streams. Not much has changed over the years, although the new legislation "Patients First Act" which was proclaimed in December 2016 has some enabling strategies that rely on LHIN leadership and local providers to come together in new ways. Regulations and other factors such as LTC Home placement regulations prevent a full commitment to integrated services across the continuum of needs that a senior will experience.

Unfortunately LTC Homes will still sit outside of the direct jurisdiction of services that can be placed in a Community Care Hub when this Act is proclaimed. The spread and scale of options for LTC Homes to become Community Care Hubs is limited in the current Ontario milieu.

Today the only means for an Ontario senior to receive a seamless integrated flow of services for their changing needs is a pay-your-own way approach. There are organizations which have opted out of the funded healthcare system and provide a full spectrum of services, inclusive of services normally delivered in a LTC Home. One such example is Christie Gardens - a fully private not for profit charitable retirement community, located in Toronto. Unfortunately this type of service is out of reach for most elderly clients on a fixed income.

To implement *'the better way'* innovation at the local level with willing partners may be the only means to create the change that will realize the potential of LTC Homes as an integral component of a Community Care Hub. Local solutions rely on collaboration and partnerships for which there is no current policy framework. Bold leadership and agency partnerships in an uncharted environment will offer many innovative solutions to pave the way for the future.

Contribution to Health Leadership

This paper has identified opportunities for both modest and substantial change in creating Community Care Hubs in Ontario LTC Homes. All of these types of hub will require the collaboration of service providers and the funders. Additionally, the relaxation of regulatory restrictions is important to stimulate innovation.

The Collective Impact approach is a very useful tool in gathering momentum in a community that has the desire to change and to find new service models. It requires key leaders to put aside

their own preferences, and take risks to share responsibility with partners they have not worked with and in ways that may be unfamiliar. This requires exhaustive efforts to build relationships at the leadership level and "It requires the engagement, commitment and investment of an entire community striving to be the best it can be and willing to make whatever changes to community systems and its own behaviours that are necessary to build safe, prosperous inclusive and sustainable communities" (Cabaj and Weaver, 2016).

Collective Impact is well aligned to the Canadian College of Health Leaders LEADS Framework. LEADS is "an innovative and integrated investment in the future of health leadership in Canada. It provides a comprehensive approach to leadership development for the Canadian health sector, including leadership within the whole-system, within the health organizations, and within individual leaders" (LEADS, 2017). An examination of both frameworks demonstrates a synergy of leadership skills. While the literature offers anecdotal results, and the Collective Impact framework continues to evolve with direct experience in achieving community change it is reassuring to discover such a strong alignment (See Appendix 3).

Future Work

The foundation that this work has created will be most useful to my work in a number of areas of focus for the future. Participation in a virtual expert panel for OANHSS has enriched the Association's strategic directions, and preparation work for leadership of a forum in early 2017 for redeveloping LTC Homes has and will continue to benefit from this leadership project. Finally, the potential to utilize the use of the Collective Impact framework and approach across

Ontario will be introduced at a workshop in April 2017. Additional opportunities to use the concepts and models discussed in this paper to achieve deep community change lie ahead, including broader application beyond the LTC Homes sector.

All of these learnings will be useful in work with redeveloping LTC Homes and those which have recognized the opportunity to extend the infrastructure footprint of their Home to support the delivery of the best options in their local community, to create environments that serve both residential and community seniors on a scale that is locally effective.

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Akos Hoffer; Chief Executive Officer, Perley Rideau Long Term Care and Veterans Centre, Ottawa, October 16, 2016.

A. Paul Williams; Professor Health Policy, Institute of Health Policy Management and Evaluation, University of Toronto, June 14, 2016, November 3, 2016.

Dan Buchanan; Director Financial Policy, OANHSS, Toronto, September 5, 2016, November 28, 2016.

David Biernes; Director Financial Policy and Planning, OLTCA, Toronto, November 6, 2016.

Donna Rubin; former Chief Executive Officer, OANHSS, Toronto, June 3, 2016.

Jacques Dupuis; Administrator, Au Chateau Home for the Aged, Sturgeon Falls, November 8, 2016.

Mark Edmonds; Director Health System Integration, Central West LHIN, November 2, 2016.

Nancy Cooper; Director of Quality and Performance, OLTCA, Toronto, November 8, 2016.

Paul Born; President, Tamarack Institute, Waterloo, November 30, 2016.

Samir Sinha; Provincial Lead, Ontario's Seniors Strategy, Director of Geriatrics Mt. Sinai and University Health Network Hospitals, June 14, 2016, October 7, 2016 .

Shilpi Majumder; Director Public Policy, OANHSS, Toronto, November 27, 2016.

Appendix 1

Survey conducted with participants attending a Workshop at OANHSS Convention "Community Hubs – Opportunities for Long Term Care" April 2016

Community Care Hubs Survey
Survey conducted by Carolyn Clubine for Fellowship Paper with Canadian College of Health Leaders. Participation is voluntary and anonymous.

1. Is your organization considering the development of a Community Care Hub partnered with LTC?

- Yes
- No
- Have already established a Hub

2. What are the benefits or reasons you would create a Hub with your LTC Home?

- Not Applicable

Add Comments

3. What programs and services would you include in a Hub partnered with LTC?
Please indicate priority order (1 highest - 10 lowest)

- Social Supports
- Medical Care
- Activities of Daily Living
- Specialized Clinics/Paramedical Services
- Short Stay
- Wellness Programs or Health Teaching
- Congregate Dining/Cafe
- Personal services eg. Hair Salon
- Carry home laundry or meals
- Home help

Other (please specify)

4. What regulatory challenges have you identified in implementing a Hub?

- None

Add comments

1

5. The following concerns were identified in today's presentation.
Please rank their importance for your organization (1 highest - 10 lowest)

- ◯ Location
- ◯ LTC Homes Act
- ◯ Space / Land
- ◯ Culture of LTC
- ◯ Capital Funding
- ◯ Partnerships
- ◯ Lead Agency role
- ◯ Burden of operating costs
- ◯ Potential for revenue
- ◯ Health Information sharing
- ◯ Other (please specify)

6. Which of the following organizations would you include in a Hub partnership? (Check as many as apply)

- ☐ Social Service Agencies
- ☐ Hospital
- ☐ Other Health Service Providers
- ☐ CCAC
- ☐ Private company
- ☐ Municipality
- ☐ Other LTC Provider
- ☐ Other (please specify)

7. What are the key factors that need to be in place for your organization to create a Community Care Hub?

- ◯ Not Applicable
- ◯ Add Comments

8. Do you have any other comments?

- ◯ None
- ◯ Other (please specify)

2

Appendix 2

Survey Results

1. Is your organization considering the development of a Community Care Hub partnered with LTC?

Yes – 25

No – 1

2. What are the benefits or reasons you would create a Hub with your LTC Home?

- Utilization of existing underused space. Improve life quality for residents by bringing the community to LTC. One stop care provision to Day Clients. Revenue stream
- I am a developmental services provider interested in being part of a hub in partnership with LTC – changing needs of people with developmental disabilities in group homes in North York
- Shared services, client spousal, break down stereotypes of LTC
- Big benefit to seniors and the community, one stop model
- Providence Manor will redevelop to become part of the Providence Village being developed by the Sisters of St Vincent and Providence Care. Services for seniors and elderly – connected for accessibility and ease of navigation.
- We have the physical infrastructure, financially assist in operating cost, broaden our vision
- Community
- Fill gaps; keep clients at home,(illegible)
- Fits corporate vision, benefits community
- Access to services for population served along with the general population. Cost containment, revenue generation to support provision of full slate of services
- Better community healthcare
- Community needs not currently being met
- Meeting needs of community, building partnerships and continuum of care, generate revenue
- Only add Adult Day care services being discussed at high level
- LTC Home redevelopment provides opportunity to look beyond “four walls”
- Multigenerational hub sharing of resources
- Expanded services in the community
- Fill gaps is existing services, improve options for seniors considering LTC
- Increase interest/services for adult day program and families who use service
- Partial Hub hoping to expand; enhanced services for residents, tenants and community. Sustainability of organization and desire to play a larger role in community
- Financial/ better serve the community
- Access for seniors – bring community together, right thing to do
- We have the space, we have heard from seniors in our community

- Redevelopment opportunities, meet client needs, share resources
- Responding to community

3. What programs and services would you include in a Hub partnered with LTC?
Please indicate priority order (1 highest - 10 lowest)

1. Personal services e.g. Hair Salon: 22
2. Wellness Programs or Health Teaching: 21
3. Social Supports: 20
4. Activities of Daily Living: 20
5. Short Stay: 19
6. Congregate Dining / Café: 19
7. Medical Care: 18
8. Specialized Clinics / Paramedical Services: 17
9. Home help: 14
10. Carry home laundry or meals: 12
11. Other mentions: Childcare, idea of wellness suite – pre LTC, Better integration in the community, offer broad range of services, church/spiritual, community centre, library, ethnic school, A.D.P.

4. What regulatory challenges have you identified in implementing a Hub?

None: 4

Comments: 13

- I don't think the legislation in developmental services would be a barrier. It speaks to accessing community healthcare. However some in the health sector sees it as double dipping – it by often if there is this belief it can be a barrier.
- Not sure
- Too early to comment
- Not at this point in planning
- Funding process. Would lead have to do – would they have to be in control
- Not assessed as of yet
- Silos. Conflicting regulations
- Expectations of being able to move between "housing options" given legislative considerations
- It would mean moving 100 LTC beds to a different LHIN
- This idea is at very preliminary discussions
- Still in early stages
- Admission to LTC from village/hub
- Alignment of organizations with differing constituents

5. The following concerns were identified in today's presentation.

Please rank their importance for your organization (1 highest - 10 lowest)

1. Partnerships: 21
2. Burden of operating costs: 21
3. Capital Funding: 20
4. Lead Agency Role: 20
5. Space/Land: 18
6. Culture of LTC: 17
7. Potential for Revenue: 17
8. Location: 17
9. LTC Homes Act: 16
10. Health Information Sharing: 16
11. Other:

6. Which of the following organizations would you include in a Hub partnership? (Check as many as apply)

1. Other Health Service Providers: 22
2. Social Service Agencies: 19
3. Municipality: 17
4. CCAC: 16
5. Private Company: 15
6. Hospital: 11
7. Other LTC Provider: 6
8. Other: School Boards, Family and children's services, Adult Day, Health Links

7. What are the key factors that need to be in place for your organization to create a Community Care Hub?

- Partner in LTC Home, CCAC, health provider, LTC & Social Services to begin to plan
- Leadership resources, financial resources
- Adequate funding
- Available affordable funding
- Revenue
- Stability of other operations
- Need, available resources, community support, gov't support, funding
- Remote sites – transportation. Funding
- Collaboration with community partners in care fn CCAC. Clear understanding and funders expectation – funding,
- As discovered today
- Confirmation of senior leadership direction with regards to what "we mean by a community hub" given our work with our partners/organizations
- Capital and a plan on paper
- Interest and buy – in from other partner e.g. community centre, other charitable organizations

- Leadership, vision, commitment, community engagement
- Culture of municipal structure, LHIN support
- $ for capital and operating, stronger ties to community/marketing and awareness of services
- Financial support, space, how to structure the partnership
- Council approval
- Resources, both human and financial

8. Do you have any other comments?

- This model would enable social services including developmental services to continue to keep people in their homes longer. Prevent early admission to LTC or ER visits. Social services often feel alienated by health providers. This causes health issues of their clients to be left until a crisis,
- Good concept – break down silos and improve services
- Top down controls need more flexibility and a paradigm switch

Appendix 3

Collective Impact Leadership alignment with LEADS Framework

LEADS Core Element	Capabilities	Specific Attributes in the Framework	Relationship to Collective Impact Approach
Leads Self	Manages self	Demonstrates flexibility to adjust to rapidly changing conditions, challenges and requirements	Change-makers: Bold leadership required to participate in design of service models that are new and innovative will require that the leader can function in an environment of ambiguity, accepting that not all questions will have answers. The leader will participate in discussions that ask difficult questions and can navigate conflicts between participants with a calm approach.
	Develops self	Searches for new learning opportunities to enhance knowledge, skills and abilities	
Engages Others	Fosters the development of others	Partners with peers, colleagues and other institutions to support training and development needs of staff	Authentic Engagement: The critical feature of CI is the full participation of a range of agencies, and community leaders in a positive and inviting and authentic dialogue. The art of facilitation is a useful skillset in this element of the approach. Leaders will welcome those both within their own organization and external partners, ensure open dialogue, while being clear in the expected outputs and outcomes of the collaboration.
	Communicates effectively	Models active listening as a means of understanding other perspectives,	
	Builds effective teams	Facilitates a shared strategy for teams that defines key milestones, timelines, measures of success and individual accountabilities	
Achieves Results	Sets direction	Aligns local initiatives and organizational priorities with strategic directions of other key organizations	Shared Aspiration and Strategic Learning: The leader performs a key role in assisting the participants to truly understand different perspectives and to help establish a shared vision, and pathways that will drive the work forwards. This includes the judicious use of key data to both clarify the challenge and to monitor the progress of this work, while using this primarily for learning and feedback
	Strategically Aligns Decisions with Vision Values and	Clearly describes how current decisions align with organizational strategy	

	Evidence		on the journey
	Assesses and Evaluates Results	Establishes measures and criteria to evaluate outcomes	
Develops Coalitions	Builds Partnerships and Networks to Create Results	Collaborates with other health authorities on projects and initiatives	High Leverage Relationships: The healthcare leader creates collegial relationships that link responsibility between and amongst key partners that leverage strategy rather than strict accountabilities. The leader also recognizes the adage “nothing about us without us”, capturing useful features of the input from direct recipients that demonstrates a sensitivity to the full range of experience, and not simply a test of satisfaction.
	Demonstrates a Commitment to Customers and Service	Actively seeks input from customers when planning changes that may impact the customer	
	Navigates Socio-Political Environments	Mobilizes commitment and resources from many different locations in the system to support achievement of strategic results	
Systems Transfor-mation	Encourages and Supports Innovation	Demonstrates a spirit of enquiry and innovation, Draws on different perspectives and innovative ideas from within and outside the healthcare system	Backbone Container: The leader recognizes that innovation requires dedicated attention to the opportunities as well as the realities of successful change. This is not about dreams, but rather the full attention to environmental conditions and factors that will be captured to achieve the change
	Strategically Oriented to the Future	Acts in a timely opportunistic fashion to take advantage of emerging trends	
	Champions and Orchestrates Change	Develops contingency plans for major resistance and/or unforeseen issues in implementing change	

(LEADS Canada, 2017, Cabaj and Weaver, 2016)