The Role of Supportive Housing for Low-Income Seniors in Ontario

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Abstract

Low-income seniors' ability to age at home, with supports available to accommodate their changing needs, is an issue of critical importance to all Canadians. This research investigates housing and care options for low-income seniors in Ontario, a population at higher risk of poor health outcomes as they age. The study investigates a continuum model that integrates social housing, health care and community supports through comprehensive and flexible programs. The report focuses on supportive housing for low-income seniors who can no longer function entirely independently due to declining health. The research draws on current literature including gerontology, housing and health related studies, to examine the benefits and costs of "aging in place" for low-income seniors. Ontario's health and housing policy contexts highlight challenges to integrated supportive housing provision for seniors. The research draws on three case examples of seniors' supportive housing in Ontario in rural and mid-size regions. Seniors' supportive housing programs in British Columbia provide a provincial example of seniors' support services and social housing integration. Policy recommendations are offered based on lessons learned from current literature, case studies and interviews with key informants.

Executive Summary

Ontario has arrived at a crucial policy juncture in seniors' housing and care. Dramatic changes to Ontario's seniors' composition pose complex challenges for policy-makers, practitioners, families and seniors themselves. This research investigates housing and care options for low-income seniors who can no longer function entirely independently. Implementing more holistic, integrated policies and programs along a continuum of housing and care will be essential to low-income seniors' ability to age in place safely and affordably in the future.

Supportive housing frameworks that define common terms can clearly identify providers' roles and responsibilities and outline seniors' available choices, while acknowledging the need for flexibility. Low-income seniors require *consistency* as well as *choice.* Holistic, client-centred care recognizes the multiple dimensions that impact seniors' health and housing needs. Fragmentation between and within sectors is a consistent barrier to the coordinated care required to supply supportive housing. A holistic approach focuses on a comprehensive model that draws on health, community and social service sectors.

Seven common themes emerged in the literature and are identified as crucial to the combination of seniors' health and housing needs: *a philosophical shift, integration between sectors, an implementation framework, funding of all options along the continuum of care, case management, supportive housing program expansion* and *the preventive nature of home care and community support services*. These interrelated themes are examined using three Ontario case examples. North Renfrew Long-Term Care Centre, Peel Senior Link and Halton Municipal Coordinated Services Strategy represent a good cross-section of supportive housing programs in the province and offer insight into the partnerships necessary to ensure their success. British Columbia's Independent Living BC and Seniors' Supportive Housing programs, widely cited as models, were selected based on effective provincial housing and health partnerships that allocate funding for bricks and mortar and support services along a continuum of care.

Fifteen policy recommendations are offered from a synthesis of the case studies, interviews with key informants in the social housing, health and support services fields, as well as from the literature review. The key policy recommendations emerging from this research are:

1. **Form an inter-ministerial committee to address both housing and support services** for new supportive housing development for seniors. The Ontario Ministry of Municipal Affairs and Housing (MMAH) and the Ontario Ministry of Health and Long-Term Care (MOHLTC) should work closely to coordinate programs and funding to expand Ontario's current supportive housing stock.

2. **Develop policy initiatives through the MMAH and the MOHLTC that bring together social housing providers and Local Health Integrations Networks (LHINs)** to facilitate greater coordination and integration of care for low-income seniors.

3. **Coordinate funding for capital, operations and support services and release it as a package**, similar to British Columbia's supportive housing program examples.

4. **Review the MOHLTC Supportive Housing Program and revise it to increase flexibility.**

5. **Disburse the MOHLTC home and community care funds for wrap around, client-centred services that encourage aging at home.** Allocate funding appropriately and adequately to home care, prevention programs, community support services, supportive housing, long-term care and post-acute care.

6. **Continue to build partnerships between supportive housing programs and universities.**

7. **Create a consistent indicator system** for province-wide implementation that measures outcomes and builds data on supportive housing benefits and costs in Ontario.

8. **Implement a moderate supportive housing program**, such as the Seniors' Supportive Housing Program in BC, to retrofit existing social housing stock for accessibility and add community support services such as homemaking and meal preparation.

9. **Develop a standardized system to track existing supportive housing and new development** that complements municipal governments' tracking of their seniors' housing portfolios. A centralized information system with accurate information that uses consistent terminology would serve seniors, local governments, health care providers, policy-makers and social housing managers.

10. **Consider conversions to supportive housing**, particularly in rural areas that may be "over bedded" with long-term care and retirement home beds. Private rooms can be converted to subsidized supportive housing units and are more cost-effective to maintain.

11. **Review the home and community care selection process in rural areas** to ensure that providers are chosen that are best suited to the community.

12. **Assess needs for supportive housing in rural areas and other underserved areas of Ontario** and prioritize new development in these locations. Diverse partnerships are needed to make supportive housing possible in rural locations and should be encouraged to reduce the financial deficit due to a lack of economies of scale.

13. **Encourage local, cross-sectoral partnerships for supportive housing education and awareness, planning and operations.** The more that housing, health and support service sectors are actively engaged in supportive housing development, the more that integrated, holistic models can be realized at the local level.

14. **Avoid substitution of one housing and care combination for another.** Support for the essential role of all housing and care options along the continuum is crucial to a successfully integrated health, housing and support services system for seniors.

15. **Consult with supportive housing providers, health and support services professionals, housing managers, seniors and other stakeholders to develop a common framework** that can be applied consistently across the province for supportive housing implementation.

There are many subject areas related to low-income seniors' aging at home that could be further investigated. They include immigrant seniors' housing and care needs, the unique needs of rural seniors' populations for aging in place, creating and tracking supportive housing outcome measurements and a feasibility study for a national supportive housing framework.

In order for a transformation in Ontario's approach to seniors' supportive housing to occur, a fundamental philosophical and methodological shift is needed. Political leadership that demonstrates a commitment to low-income seniors' rights to age in place can lay the groundwork for consistent, unified priorities on senior-centred housing and support provision. Ultimately, a shift in the Canadian approach to seniors' care would not only enable low-income seniors to age in place but also recognize seniors' rights to live in the community while valuing their contributions to society.

The Role of Supportive Housing for Low-Income Seniors in Ontario

1. Introduction

Supportive housing provides a combination of housing and support services that can promote "aging in place." Supportive housing for seniors is a viable policy option that can foster integration between the health, housing and community support sectors. Seniors' supportive housing can also benefit low-income seniors with health impairments who require assistance with daily activities. This research explores the missing link between health, housing and support services, a particularly pressing gap as we see increased numbers of older population cohorts across Canada. The research also makes the point that housing policy, especially that which recognizes the intersections of housing and health, is good social policy. As the population of low-income seniors over the age of 75 grows throughout Ontario and the number of low-income, unattached, frail women vulnerable to health problems continues to rise, cost-effective, sustainable housing and care solutions that support seniors' independence are necessary. In light of the need for viable housing and support options along a continuum of care, consistent terminology needs to be used that is also Ontario-specific. Supportive housing research is timely as financial and human resource strains on long-term care, emergency care and alternate levels of care in hospitals coincide with a transition to a more integrated health and community support services approach across the province. As rural, mid-size and urban centres have severe shortages of subsidized seniors' housing options, the social housing sector is under pressure to respond to the growing number of aging seniors' tenants who can no longer function totally independently. Coordination between sectors can make supportive housing a more readily accessible, well-known and respected option for low-income seniors in Ontario.

1.1 The Demographic Push

Seniors are at the centre of an unprecedented demographic shift in Canada and around the world. In 2006, one in seven Canadians was a senior over the age of 65. By 2031, that number will grow to nearly one in four (Statistics Canada, 2006a). In 2003, the province of Ontario was home to approximately 1.5 million seniors, representing 40 percent of all senior Canadians. An even more notable transition will occur in seniors' population growth when baby boomers turn 65 (Government of Canada, 2002b) starting in 2011. This research report investigates housing and care options for low-income seniors in Ontario who can no longer function entirely independently due to declining health. More and more older senior Canadians will have health and mobility restrictions that require support with day-to-day routines. For many, this requires in-home assistance, some of which must be paid for out-of-pocket. For others who have substantial savings or assets, private retirement homes offer an array of support services. But for low-income, frail, elderly Ontarians with health and support needs, subsidized supportive housing may be the most viable option to "age in place" as independently as possible.

Seniors are living longer than ever before in Canada and are generally healthier and financially better off than in previous generations. Seniors in Ontario accounted for 12.9 percent of the population in 2006 and almost half of those seniors were 75 years or older (see Figure 1). In fact, the group aged 85 years and older or the "oldest olds" was the fastest growing population in the province, with an increase of almost one-third (28 percent) between 2001 and 2006 (Ontario Ministry of Finance, 2006). This population is also overwhelmingly unattached (often widowed),

female and low-income. There are a disproportionate number of low-income women in older age groups, who are more vulnerable to health problems and in higher need of services and supports (Ontario Human Rights Commission, 2001). They are also the population that may benefit most from a closer look at supportive housing options along a continuum of care.

Figure 1. Ontario Seniors Population by Age Group 2006
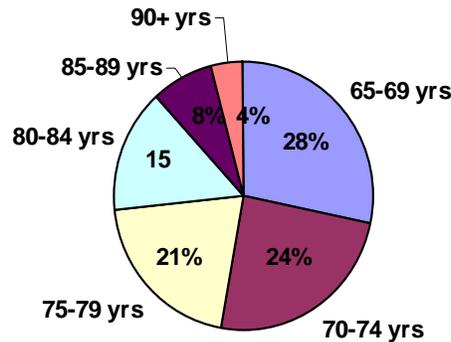
Source: Ministry of Finance, Census Highlights, 2006

Of all seniors aged 65 and older, 18.4 percent of senior women and 9.8 percent of senior men were living below the low-income cut-off in 2005 (Ontario Office of Francophone Affairs, 2005). Patterns indicate that the most elderly, unattached seniors are also the poorest. For example, according to the City of Ottawa's Council on Aging, two-thirds of seniors over 75 were female and of those, half lived alone on annual incomes of less than $16,000, well below the low-income cut-off (Ontario Human Rights Commission, 2001). According to a 2005 study, 56 percent of unattached female seniors in Canada were in core housing need or paying more than 30 percent of their income to housing (Government of Canada, 2005). Older female seniors have less income due to a range of factors including longer life expectancy, less frequent participation in the labour force and wage inequality. A more proactive response by government to this population's health, housing and support needs is required to ensure their safety and well-being.

In Ontario, the number of seniors is expected to double by 2028 to nearly 3 million people (Ontario Seniors' Secretariat, 2005). The low-income seniors' population has actually decreased in recent years across Canada. But for the oldest old, unattached seniors who are usually female, securing affordable accommodation and support and health services is still a significant burden. Low-income seniors' security is further compromised by poor health outcomes. Seniors admitted unnecessarily to long-term care homes are in danger of losing their independence and often share certain characteristics such as low-income, oldest age groups, unattached (widowed or single) and disproportionately female (Trottier et al., 2000).

The number of seniors 75 years and older are projected to increase dramatically in the next 25 years (Ontario Ministry of Finance, 2007). Frail, low-income women with health impairments who require support to maintain their independence are disproportionately represented in the oldest age groups. In 1998, about half of senior women (48 percent) lived in a low-income situation, compared with 35 percent of unattached senior men (Ontario Human Rights Commission, 2001). This percentage only increases as older seniors' financial resources dwindle.

1.2 Policy Context for Ontario's Health and Housing Approaches

1.2.1 Limited Funding for Supportive Social Housing Units

Funding from the federal and provincial levels for new supportive social housing construction is extremely limited. Responsibility for administration, management and maintenance costs for social housing fall on Ontario's 47 municipal service areas. While supportive housing units have limited availability in some areas, they are non-existent in other regions of Ontario. Low-income seniors often wait years for an existing supportive social housing unit to open up. This study examines three case examples of seniors' supportive housing delivery in Ontario operating within these financial constraints.

1.2.2 Fragmented Service Delivery

At present, the Ontario health, support services and affordable housing sectors are quite fragmented. The Ontario case studies demonstrate how organizations in rural and mid-size centres and municipalities themselves have overcome the fragmentation to successfully deliver seniors' supportive housing with limited resources. All of the cases illuminate the importance of partnerships and coordination between health and housing services.

1.2.3 Limited Funding for Supportive Housing Services

Supportive housing services such as meals, transportation, homemaking, social visiting, case management and respite are available on a fee-per-use basis or are provided by non-profit agencies funded, in part, by the Ministry of Health and Long-Term Care (MOHLTC). A very small proportion of Ontario's $28 billion health care budget was allocated to supportive housing services in 2005 (McReynolds and Young, 2005). The pressure on emergency and acute care in Ontario could be partially alleviated if supportive housing services for seniors were more adequately funded.

1.2.4 Creation of the Local Health Integration Networks (LHINs)

There have recently been significant changes to the Ontario health care system. The MOHLTC created 14 Local Health Integration Networks (LHINs) in 2006 in a move to bring health care decision-making to the regional level. LHINs have delegated responsibility for the majority of health care funding and local health care priorities. Seniors' health care has figured prominently as a priority for all the LHINs. Supportive housing will likely play a central role as regional LHINs pursue more integrated service provision for seniors. Community support service agencies will also play a critical role for seniors' "aging in place" as they help maintain individuals' independence and moderate demand for more costly hospital and institutional care (Bhasin and Williams, 2007). The changing nature of Ontario's health care system is crucial to ensuring seniors' access to community support services. A shortage of affordable housing for low-income seniors is a significant obstacle to increasing options along an integrated health and housing continuum. In order for seniors' changing needs to be effectively addressed, the social housing sector, LHIN health care authorities and community support services will need to work together toward integration.

This report looks to British Columbia for a comprehensive model of seniors' supportive housing along the continuum of care. A joint program between the health authorities and the provincial housing body presents solutions for seniors who are in need of assistance to maintain their independence. Although Ontario and BC's health and housing policy contexts are different, BC's commitment to multiple options along the seniors' housing continuum shows "aging in place" to be a viable policy option and creates the infrastructure necessary to implement it. The BC case example can offer lessons for Ontario as the health care system continues its transformation into the immediate future.

1.2.5 Aging at Home Strategy

Research shows that seniors overwhelmingly prefer to stay at home as they age (Kucharska, 2004; Canadian Association of Gerontology, 2006). "Aging in place" refers to assisting seniors to remain in their own homes in safety and dignity as long as possible. "Aging in place" is an attractive policy option because it can potentially decrease health care costs, decrease the demand for long-term care home beds and stabilize seniors' physical and psychological well-being by avoiding disruption to seniors' personal lives.

The Aging at Home Strategy (AAH), introduced by the MOHLTC in August 2007, is an example of provincial policy to support aging in place. The strategy will be pursued through LHINs' funding mechanisms that are empowered to fund supportive services in seniors' housing, among other health services. The objectives of the Aging at Home Strategy are:

- to provide seniors with *a continuum of supports that enables independence and dignity* in their homes;

- to provide a *comprehensive plan for an integrated continuum of care* that includes community support services, home care, supportive housing, long-term care beds and end-of-life care; and

- to offer *preventive supports* to sustain the healthiest population of seniors possible.

This initiative dedicates $702 million dollars from 2007 to 2010 to an integrated continuum of community-based services. The goal is simple: to keep seniors healthy and living independently in their homes (Ontario MOHLTC, 2007) for as long as possible. It will also alleviate pressure and financial constraints on the long-term care and emergency services sectors. The funding package also includes a $15 million dollar allocation for an assistive devices program to aid seniors with technology that enhances their mobility and safety at home. The actual new funding totals approximately $345.6 million (OCSA, 2007b). Leaders in the community support services field stress the importance of retaining the majority of the funding for home and community care services.

Supportive housing is a key solution along the continuum of care in the Aging at Home Strategy and many of the LHINs' integrated service plans. However, no funding for the bricks and mortar capital costs of new housing development is earmarked within the AAH Strategy. Therefore, expansion of supportive housing units will require policy and funding provisions by both the Ontario Ministry of Municipal Affairs and Housing (MMAH) and the MOHLTC for the Strategy to be a viable solution for aging in place. The British Columbia example examined in Section 4

demonstrates a policy that combines the need for capital costs, operating and service funding in a coordinated package to increase the supply of supportive housing across the province.

1.3   Project Goal and Objectives

One goal of this research is to offer viable policy options that provide missing links between the social housing, health care and supportive services sectors and illuminate connections between housing and health care policies. Another goal of this research is to investigate how low-income seniors can age in place in supportive housing. Aging in place has become a central policy concept that seeks to address how the seniors' population across Canada will be accommodated. Ontario's Minister of Health and Long-Term Care introduced an Aging at Home Strategy in August 2007 that reinforces a provincial priority to encourage seniors to "age in place." The aging in place concept is straightforward as it simply requires that enough support and health care services are provided in seniors' residences so that they may remain in familiar surroundings for as long as possible while maintaining their independence. Actual implementation is more complicated. The health care, community support and housing systems in place need to be coordinated and integrated so that they can respond to individual seniors' needs as they change over time.

This research builds on a substantial body of work on supportive housing for seniors and "aging in place" and investigates the potential for better integration in the support services, health and housing fields in Ontario. It is hoped that the research can benefit low-income seniors' ability to age in the place of their choice and live independently for as long as possible. Three objectives guide this study:

1) to present lessons from three Ontario case examples;

2) to explore what obstacles remain as barriers to the implementation of a comprehensive, integrated housing and supportive services strategy; and

3) to examine how policies can be shaped to enable low-income seniors in Ontario to live in their communities safely and affordably.

1.4   Methods of Data Collection and Analysis

Research methods included a literature review of significant reports on seniors' supportive housing as one desirable option along a continuum of care. The literature reviewed was international in scope. Relevant reports were reviewed in the context of Ontario's seniors' health and housing policy initiatives such as the recently introduced Aging at Home Strategy, the MOHLTC's Supportive Housing Program established in 1994, the Canada-Ontario Affordable Housing Program codified in 2005 and the decentralization of decision-making power from the Ontario Ministry of Health and Long-Term Care to fourteen Local Health Integrations Networks legislated in 2005. Seniors' census data, supportive housing conference webcasts, health and housing conference presentations and legislation, municipal, provincial and federal reports about seniors, and examples of supportive housing frameworks were also reviewed. Recurrent themes in the literature guided the Ontario case selection.

The research methodology uses Ontario case examples that highlight three strategies guided by integration and coordination of seniors' support service, health and housing sectors. Through consultation with professionals in the field, these case examples were identified as leading the way for supportive housing in other municipalities in Ontario. Efforts were also made not to duplicate research that investigates other important Ontario supportive housing programs. Internet research on each case's history and operational structure was conducted followed by qualitative interviews with managers from each program with the exception of North Renfrew Long-Term Care Centre in Deep River. North Renfrew information was entirely accessible through on-line webcasts. British Columbia was selected as a case example that has been widely cited as a model of supportive housing programs that rely on housing and health partnerships to provide seniors with housing and support options along a continuum of care.

Key informant interviews were conducted by telephone based on the study's research objectives. Interview schedules were adjusted slightly depending on the interviewee's area of expertise. A sample interview schedule is included in Appendix A. Through snowball sampling, non-profit supportive housing providers, municipal housing directors, municipal community support services managers, seniors' health care consultants, housing policy analysts and regional health care representatives were identified and interviewed. Their responses helped shape the report's recommendations. Interview findings also inform future research directions and ground the study in the experience of professionals working in the seniors' supportive housing field.

1.5 Limitations

The study is limited by some factors beyond the researcher's control. The breadth and depth of seniors' aging-in-place literature, both practical and academic, was scanned for the research report. However, only a small fraction of the materials informed the literature review and were selected on the basis of their relevance to Ontario's low-income seniors' population. Many lessons can be learned from international models of health and housing approaches to seniors' care. Due to time restrictions, these informative models cannot be explored in any depth in this report.

There are many subject areas related to low-income seniors' aging at home that are outside the scope of this research. They include the crucial topic of unregulated personal support workers who are often overworked, underpaid and lack the qualifications necessary to provide consistent, high quality home care. Ethnoculturally sensitive support services for older Canadians, especially for those for whom English is not the first language, are also of particular importance as immigrant seniors' populations who are disproportionately below the low-income measure are rising across the country (Veall, 2007). In-home and long-term home services fall outside the jurisdiction of the Canada Health Act and are fundamental to seniors' care. Without provisions in the Canada Health Act or under a separate piece of legislation that covers continuing care, analysts point out that there is no guarantee that the provinces will continue to subsidize in-home health services indefinitely. The potential for a two-tiered, means-tested home care system with high quality, in-home care only available to those who can afford it is attainable. This is implied in the research report but is not addressed directly. As well, housing as a social determinant of health is widely recognized to be integral to the foundation of health and housing research. Although the basis for this research recognizes the necessity of housing security to vulnerable

seniors' long-term health conditions, an examination of the social determinants of health lie outside the research scope.

1.6   Organization of the Report

First, the terms that are most relevant to seniors' supportive housing used throughout the report are defined. In Section 2, the study identifies key themes that emerged in the literature review and offers an analysis on issues such as funding, case management and integration between health and housing in supportive housing developments. In Section 3, health and social housing provincial policy contexts frame the discussion of case examples. Challenges to supportive housing provision in rural areas are brought to light in this section as well. Interview findings from key informants enlighten the analysis throughout the report. For each case example, a brief overview of the local context is followed by a description of each supportive housing program, including guiding principles, funding and partnerships. The report then looks west in Section 4 to British Columbia's supportive housing programs. These models offer different options along the continuum of care and are relevant to changes in health and housing provision in Ontario. BC's government programs demonstrate lessons to be learned in light of collaboration between ministries. Section 5 offers conclusions and recommendations for supportive housing in Ontario. These suggestions may guide future research in the seniors' supportive housing field.

1.7   Seniors' Supportive Housing Terms

Relevant terms must be defined for this study, particularly those most commonly used in Ontario's seniors' housing and support services lexicon. Supportive housing definitions vary notably across Canada. Many policy documents and academic studies have pointed out that inconsistent definitions in the supportive housing field create uncertainties for seniors in need of services and amongst practitioners in the health care, community support services and housing sectors. Clarity and consistency are essential components in the development of a seniors' supportive housing framework, as noted in Alberta's Supportive Living Framework released in 2007. Indeed, it will be necessary to streamline terminology for future Canadian policy development on national seniors' supportive housing initiatives. However, this report will narrow the terms to those used only in Ontario.

1.7.1   Seniors

Seniors are Canadians over the age of 65. However, seniors are not one monolithic group and there is incredible diversity amongst them. Based on their age group, urban/rural location and gender, as well as culture and race, people experience aging differently. For example, a 90-year old, frail, low-income, unattached female with a disability lives a vastly different life than an able-bodied, fit, married 65-year old male who is still working. Seniors' literature often refers to different categories of seniors as "young" old, "middle" old and "oldest" old. Young old are seniors who are healthy, fit and relatively financially secure. Middle old are seniors who are beginning to slow down, have access to less money and may develop health problems. The oldest old are seniors who are very elderly and frail and need physical and community support assistance for day-to-day routines (Government of Canada, 2007). This report focuses primarily on those low-income seniors who have health and mobility impairments and require support services to maintain their independence.

1.7.2 Social Housing

Ontario's Ministry of Municipal Affairs and Housing defines social housing as any housing for which the owner receives a subsidy. There are four broad types of social housing: public housing owned and operated by the municipality; non-profit housing; co-operative housing; and privately owned housing where the landlord receives a government issued rent supplement for low-income tenants. Government subsidies ensure that social housing tenants pay rent-geared-to-income (RGI) and do not spend more than 30 percent of their total monthly income on rent.

1.7.3 Seniors' Subsidized Buildings

In 2007, a provincial waiting list report conducted by the Ontario Non-Profit Housing Association determined that almost one-quarter of all people on waiting lists for social housing were seniors. Approximately 28,200 seniors were waiting for subsidized units across Ontario at that time (ONPHA, 2007a). In 2006, 12,646 seniors were on the social housing waiting list in Toronto (Housing Connections, 2006) while in Peel Region 2,090 seniors were waiting between three to seven years to get into a seniors' only apartment building (Region of Peel, 2007a).

1.7.4 Seniors' Supportive Housing

Seniors' supportive housing, broadly defined, is housing that allows seniors to live as independently as possible with the supports they need to ensure their individual safety and comfort. Supportive housing may also be characterized by *integrated* and *comprehensive* services and programs that support the *changing* needs of seniors as they age in place.

Canada Mortgage and Housing Corporation (CMHC) defines supportive housing as that which helps seniors in daily living. Supportive housing allows residents to maximize their independence, privacy, dignity and decision-making abilities (CMHC, 2000). According to CMHC, for housing to be supportive it must have the following five components:

- residential character
- supportive physical environment
- access to necessary supportive services
- progressive management philosophy
- affordability and choice.

The Ontario's MOHLTC Supportive Housing Program requires the provision of personal support and essential homemaking services available 24-hours a day on-site for frail or cognitively impaired seniors. All tenants are responsible for paying their own rent, food, clothing and living allowances. The MOHLTC supportive housing can be selected units in mixed buildings, public housing apartment buildings, seniors only residences or congregate housing environments. Supportive housing providers can be charitable foundations (often ethnoculturally or religiously based), non-profit agencies, cooperatives or municipal social housing corporations.

1.7.5 Aging at Home or "in Place"

"Aging in place" has become a popular phrase in the home and community care sector, with policy analysts, as well as in recent election platforms. Aging in place is the process by which seniors are able to grow older in the familiar and comfortable surroundings of their homes while being provided with the assistance necessary to maintain a relatively independent lifestyle (Heumann and Boldy, 1993). Aging in place or, more aptly, at home, is an attractive policy alternative for multiple reasons. First, research has shown it to be cost-effective for seniors who receive the same levels of care at home as opposed to in long-term care homes or hospital (Chappell et al., 2004). Second, aging at home recognizes seniors' desire for independence. Third, aging at home is of particular significance in Canada at present as the seniors' population is projected to increase to 20 percent by 2026 (Statistics Canada, 2007). Long-term care homes and acute hospital care are hard pressed to accommodate the number of seniors in need of supports now, let alone in the near future.

1.7.6 Assisted Living

For the purposes of this study, the term "assisted living" will only be used in reference to British Columbia's Independent Living BC program, discussed in section 4.2. In fact, Ontario's Supportive Housing Program cited above is also referred to as "assisted living in supportive housing" (Ontario MOHLTC, 2007). In BC, seniors' assisted living residences provide housing with a range of supportive services for people who can live independently but require help with day-to-day activities, such as bathing and dressing.

1.7.7 Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

Seniors' needs for assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) often determine the type of supportive housing environment that they require. Activities of daily living include any activity that involves self-care such as bathing, toileting, getting out of bed, dressing and feeding oneself. Instrumental activities of daily living are personal activities that seniors may lose the ability to perform as they age. IADLs include transportation, shopping and meal preparation, laundry and light housekeeping, as well as money and medication management.

1.7.8 Long-Term Care Homes

Long-term care homes are referred to as nursing homes, residential care facilities, special care homes, continuing care centres or personal care homes depending on where you are in Canada. Long-term care homes are designed for people who require supervision and for whom 24-hour nursing care must be available in a secure setting. In general, long-term care homes offer higher levels of personal care and support than what is provided in supportive housing or retirement homes. Long-term care homes receive the vast majority of their funding from the government. They can be run privately or by non-profit organizations and can cost upwards of $4,000 to 6,000 per month per resident. Increasingly, long-term care homes house seniors with complex ongoing care needs, multiple chronic conditions and cognitive impairments such as dementia.

1.7.9 Low-Income

As low-income seniors are the focus of this report, low-income will be defined as at or below the annual low-income cut-off (LICO). According to Statistics Canada, $18,371 is the LICO for single persons who live in urban centres of more than 500,000 residents. The LICO is based on the cost of food, clothing and shelter for a given region. People who spend 20 percent or more of their income on these basic needs are living under the LICO. In 2005, 20.3 percent of unattached senior women and 13.4 percent of unattached senior men were at or below LICO in Canada (Statistics Canada, 2005).

1.7.10 Delinked and Linked Models of Supportive Housing

There are two types of seniors' supportive housing. In a delinked model, one organization builds, owns and/or operates the housing component while another organization, generally a non-profit or municipal seniors' support agency, provides programming and support services. Delinked models of supportive housing offer clearly delineated services. Although housing staff and support service workers maintain separate roles, they often coordinate and communicate information regarding residents' needs.

In a linked supportive housing model, the landlord and the service provider are the same entity. Linked models are often operated by non-profit organizations that specialize in seniors' support. The same organization acts as the landlord as well as the support service provider (Lum et al., 2006b). The Seniors' Supportive Housing Program in BC, discussed in section 4.3 is a case example of a linked supportive housing model.

1.7.11 Home Care and Community Support Services

Home care generally includes both in-home nursing care and community support services and is a provincial responsibility. Home care in Ontario, delivered by Community Care Access Centres (CCACs), is comprised of a limited basket of medically related services that include nursing, palliative care, some rehabilitation services, personal support, medical supplies and equipment (MacAdam, *pers. comm.*, 2007). Fourteen Community Care Access Centres oversee the selection of home care providers in their regions based on managed competition and requests for proposals (RFPs).

A wide array of other community services is provided through many local organizations, outside of the CCAC system. Community support services can range from focused programs for seniors with special needs, such as those with acquired brain injury or aphasia, to the provision of meal programs, transportation, supportive housing, friendly visiting and others.

Ontario is the only province in the country where all home care services, delivered by the CCACs, are provided free of charge (MacAdam, *pers. comm.*, 2007). However, community support services such as meals on wheels, day care programs, homemaking, companionship visiting and transportation assistance—all vital components of community support services—fall outside CCAC's domain. It is generally accepted that a combination of home care and community services enhances seniors' quality of life, is cost-effective and can prevent unnecessary hospitalization (Hollander and Chappell, 2002).

1.7.12 Continuum of Seniors' Care

Figure 2. Continuum of Seniors' Care

Source: Author, 2007

A continuum of care refers to a range of housing and care options that require different levels of supervision and health and personal supports. The continuum, depicted in Figure 2, spans from *health promotion and wellness*, where seniors receive education and information on healthy living but do not need assistance to live independently, to the other end of the spectrum of *palliative care* where pain management, emotional, psychological and spiritual support and 24-hour supervision are provided. Palliative care focuses on comfort and respect of the individual to ease him or her into the end of life.

Home care is delivered by visiting health professionals like nurses, occupational therapists and personal support workers. Home care is needed in post-acute circumstances when patients have recently been discharged from hospital after a stroke, heart attack or other acute health episode. It is also used to adjust to ongoing health impairments such as chronic conditions like cancer, arthritis, diabetes and heart disease. It does not usually provide 24-hour on-call care and requires some level of seniors' independence or requires the availability of informal support, because home care clients are unsupervised most of the day.

Supportive housing provides a moderate level of support for seniors to live independently. On-call 24-hour emergency services and personal and homemaking services (ADLs and IADLs) are features of supportive housing programs in Ontario. Supportive housing units are private apartments where residents can lock their doors for privacy and live surrounded by their personal belongings.

Long-term care, the next stop on the continuum, is designed for people who require 24-hour nursing care and supervision within a secure setting. In general, long-term care homes offer higher levels of personal care and support than what is offered in retirement homes or supportive housing. In Ontario, residents of long-term care pay a share of the total cost and may pay an additional monthly fee based on the style of accommodation. Basic accommodation, which is not private and can house more than two people per room, does not require a fee in Ontario, while semi-private and private accommodation does require an additional fee. Residents in long-term care cannot lock their doors and often have complex care needs that require a high level of supervision (Ontario MOHLTC, 2007).

Hospitals are not included on the continuum because people go in and out of hospital regardless of their type of housing and care along the continuum.

1.8 Summary: The Importance of Consistency of Information

An array of terms is used for seniors' housing and care options in different provinces and territories across Canada. As stated in a report to the Special Senate Committee on Aging, it is often confusing for seniors, family members and policy-makers to wade through varying definitions on the complex array of options offered to seniors:

> The current multi-departmental, multi-jurisdictional responsibility for programs and services can result in confusion for seniors attempting to gain information and access to services. Witnesses noted the difficulty in updating and coordinating one-stop information centres for seniors given the complexity of the system (Government of Canada, 2007: 19).

The literature specific to seniors' housing and care confirms the above point (Croucher, Hicks and Jackson, 2006; Lum, Ruff and Williams, 2005; Kucharska, 2004). From clients to governments, from health care providers and housing corporations to policy-makers, confusion about types of available seniors' services is reflective of a fragmented, multi-sectoral system where the lines of responsibility for seniors' long-term housing and care are sometimes blurry (Hayward, 2001). Clear definitions that can be used across the province and, ideally across the country, would reduce confusion in the professional seniors' health and support care sectors and simplify relocation to supportive housing for seniors. Although partial devolution of power from the MOHLTC to LHINs in Ontario is intended to address health and support service fragmentation, there is an underlying danger that exclusively locally based solutions will result in different approaches that vary significantly from region to region.

Standardized terms for housing and care combinations should not equate to a rigid supportive housing framework. Flexibility in supportive housing delivery is a vital component to client-centred, integrated care. In the creation of a long-term supportive housing and aging at home strategy, clear terminology that reflects the types of services offered along the continuum of seniors' housing and care is necessary. In order for seniors to make informed decisions, they must have access to reliable information. Consistency of information can facilitate a more coordinated system of housing and care in Ontario and across Canada.

2. Connecting Housing and Health: What Will It Take?

This section of the report focuses on seven common threads identified in the literature review that can significantly impact frail, elderly seniors' needs for supportive housing, home care and aging in place. Recurrent themes in the literature are instructive as they offer consistent and robust directions for future seniors' supportive housing policy in Ontario.

2.1 A Philosophical Shift

It is puzzling that despite the extensive amount of research on seniors' health and housing needs in Ontario, across Canada and internationally, few significant policy shifts have centred on seniors' rights to choose housing and support combinations that meet their specific needs. Although there is substantial evidence that demonstrates how client-centred care improves quality of life, maintains independence and increases cost efficiencies (Hollander, 2007;

Heumann and Boldy, 1993), a shift from acute health care and long-term care homes to a holistic housing and support continuum approach has been an evolving theme in Ontario health policy. The term holistic implies that health, social, physical, spiritual and all other dimensions of life are blended and coordinated to foster individuals' maximum self-development regardless of age, gender, race and culture (Heumann and Boldy, 1993). Holistic, client-centred care is coordinated: it recognizes the entire system and the multiple dimensions that impact seniors' health and housing needs.

In order for a transformation in Ontario's approach to seniors' aging at home or in supportive housing to occur, a philosophical and methodological shift is required. Hollander (2003), in his framework for organizing health-related services, points to the pivotal importance of a philosophical commitment to client-centred, supportive care that must then be enshrined in policy. He notes that the traditional Canadian health care system is based on a curative health care model that focuses on acute care for crisis intervention and cures for short-term illness. Alternatively, supportive health care is a more holistic approach and focuses on long-term needs with a comprehensive model that draws on health, community and social service sectors. This is the mandate of the LHINs, but it is too early to say whether they will be successful. Success will be more likely if provincial ministries such as Health and Long-Term Care, Municipal Affairs and Housing and Transportation are able to effectively collaborate to support a philosophical commitment to community-based continuing care.

In the early 1980s, this type of philosophical and ideological shift occurred in Denmark regarding seniors' home care and supportive housing. Denmark's seniors' policy has since gained international recognition. Denmark's Commission on Aging formulated principles that were adopted into legislation. A significant philosophical shift acknowledged a change in societal perceptions of seniors. Rather than losing their roles as parents, workers and "productive" members of society, seniors' ongoing roles and contributions were viewed to hold value (Hansen, 2007).

This paradigm shift led to implementation of health and housing policies that encouraged the ability of seniors to participate in daily community life. The intention was to allow seniors' to age at home, in familiar surroundings, rather than move to a long-term care facility. Care for older people was shifted out of institutions and back into the community (Hansen, 2007).

The policy change was accompanied by aging-at-home features such as physical unit design modifications and government-funded home and community-based care. Experienced professionals provide the vast majority of home care support to the elderly who pay nothing for ADL and IADL services. In terms of implementation, the Commission's efforts to shift care into the community resulted in very few new long-term care homes built in Denmark since the 1980s. In fact, the number of nursing home beds decreased by almost half by 2001 (Lewinter, 2004). By 2006/2007, new long-term care beds were needed because of population growth and were added to the system (MacAdam, *pers. comm.,* 2007).

Denmark successfully moved away from a long-term care model through strengthening the home care sector, expanding supportive housing options and institutionalizing prevention as part of seniors' health care. For example, a letter is sent to all Danes at age 75 that offers a home visit by

a nurse. The Home Prevention Act mandates twice yearly home visits for the elderly, regardless of health status. Health professionals can then connect seniors to appropriate services and increase awareness of and access to available services (Stuart and Weinrich, 2001). The Denmark example is an illustration of implementing an enablement model of care for the frail elderly.

A curative model has long guided seniors' health care in Ontario but that approach is changing. The steady increases that the MOHLTC has been making in new funding for home and community-based care are important steps in moving to a more balanced approach for those with chronic conditions. Establishing the correct mix of long-term care home beds and in-home and community care services is difficult because of funding constraints, other problems in health care supply such as long waiting lists for some hospital-based services, physician shortages, changes in disability levels over time and changes in care methods that affect use of continuing care services.

Local health integration networks (LHINs) may provide platforms to pursue a philosophical shift in low-income, frail seniors' housing and care because of the LHINs' mandate to develop integrated care models. A renewed approach to seniors' health care would include an increased commitment to the home and community care sectors. But any philosophical shift in the context of LHINs has the potential to be fragmented. Political leadership that demonstrates a commitment to seniors' right to age in place is needed from a higher level. A philosophical shift in Ontario can lay the groundwork for consistent, unified priorities on client-centred supports and a holistic model that links housing, health and community services. The larger point here is the need for a societal move in the way that seniors are viewed. Ultimately, a shift in the Canadian approach to seniors' care would not only enable home care and aging in place, but also recognize seniors' rights to live in the community while valuing their contributions to society.

2.2 Integration

Low-income seniors' ability to age in place comfortably and affordably will require an integrated approach to health, housing and support services (Lum, Ruff and Williams, 2005; Pynoos, Hollander Feldman and Ahrens, 2005; Heumann and Boldy, 1993). Often lauded by academics, policy-makers and practitioners, the quality and coordination of services and resultant cost efficiencies from sectoral integration efforts are advantageous for various reasons outlined below. However, integration is easier said than done. Although it has the potential to impact seniors' quality of life and their ability to access choices along a continuum of care, it may also be difficult to implement. Integration of health and housing sectors can potentially ensure:

- continuous care and less disruption in seniors' lives;

- increased communication between sectors and reduction of silos;

- reduced administrative costs through coordinated services;

- recognition that seniors' housing and care choices are multidimensional; and

- safety and affordability that meet individual needs.

Ideally, integration inspires close communication, flexibility and innovation to meet the supportive housing needs of low-income seniors between sectors. Housing and health care have traditionally been fairly distinct in their approaches. Health care deals directly with immediate health concerns, while housing focuses mainly on building maintenance and administration, tenant turnover and occupancy rates, and the bricks and mortar development where low-income people find refuge. Recently, health care reform in Ontario has made integration central to its model. It is hoped that the local health integrated service plans will ensure that clients and seniors in particular, receive better quality, continuous care which is responsive to their changing health needs.

More effective health and housing integration can fill a gap that has been widely cited by experts in the field (Applebaum, 2007; Cressman, *pers. comm.,* 2007; Obrecht, 2007). Governments at all levels approach seniors' supportive housing from fragmented, isolated departments that make housing and care combinations challenging to implement. The role of seniors' supportive housing in the province could be elevated (Humphries, *pers. comm.,* 2007) so that both sectors view it as a viable integrated model that can reduce unnecessary placement in long-term care, reduce the incidence of frail seniors' living at risk as tenants in social housing, and increase seniors' options for independence. Integration of health and housing may prove to be the best approach to seniors' aging in place as it harnesses social and health benefits of each sector more productively and moves away from silos of responsibility. Integration may also be the most user-friendly option for low-income seniors with health impairments to access the supports they need in a coordinated manner.

2.3   A Common Framework for Supportive Housing Implementation

Much of the literature suggests that a common framework is essential for standardization and consistency that can be easily navigated by seniors' supportive housing stakeholders. Frameworks identify and define common terms, clearly specify providers' roles and responsibilities, acknowledge the need for flexibility and, most importantly, clearly outline choices available to seniors and their families to determine an appropriate supportive housing environment. In Alberta, for example, a framework was recently adopted in March 2007 which clearly outlines four levels of supportive housing options (Alberta Ministry of Seniors and Community Supports, 2007).

One outcome of the creation of LHINs in 2006 is that Ontario health care providers are entering an exciting time where decision-making power has been delegated to the local level. In this context, it is crucial to develop overarching principles and specifically design supportive housing and service guidelines that are standardized and coordinated across the province. If not, each region may pursue seniors' care through different models and with different funding and care priorities depending on community needs. This could create administrative and logistical hurdles, especially when low-income seniors and the programs that provide low-income seniors' services require *consistency* as well as *choice.* A provincial housing, health and supports framework for seniors' care can see that both objectives are met. A framework that would specifically fast track supportive housing projects and provide coordinated policy and procedural guidelines for supportive housing partnerships can ensure service continuity and consistency (OCSA, 2007a). This type of guidance for housing and support service providers encourages

effective working relationships and would be useful to streamline supportive housing developments in the future.

2.3.1 City of Ottawa Framework and Action Plan for Seniors' Supportive Housing

An Ontario example of a seniors' supportive housing framework is found in the City of Ottawa's action plan released in late 2007. Represented in Figure 3, the framework clearly shows that client-centred care for seniors at risk depends on the holistic integration of all aspects of seniors' lives. Ottawa's framework identifies the number of low-income seniors who require supportive housing and the priority neighbourhoods where units are most urgently needed. It also recognizes the pivotal importance of collaboration across sectors.

Figure 3. Affordable Supportive Housing Framework for Seniors at Risk
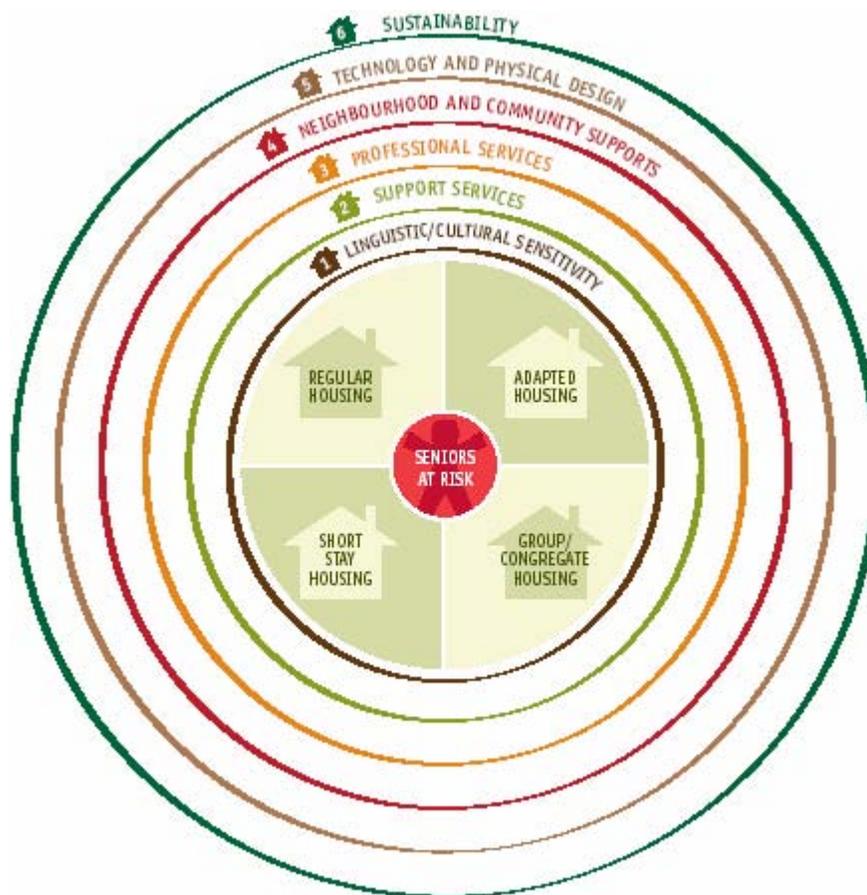
Source: United Way Centraide/Ottawa and the City of Ottawa

The framework's five components—linguistic/cultural sensitivity, support services, professional services, neighbourhood and community supports, technology and physical design, and sustainability—rest on four supportive housing typologies to meet the different levels of housing and care need: regular, adapted, group/congregate and short stay housing. An issue of critical importance that is often overlooked in the housing and community care sectors is cultural sensitivity. Bilingual staffing and services, as well as client-specific programming that responds

to seniors' various ethnocultural backgrounds, are central to the framework. These aspects of supportive housing will continue to be critical to seniors' care as the immigrant seniors' population increases and is disproportionately represented below the low-income mark across the province (Veall, 2007). This framework and action plan were developed to address the regional LHIN priorities including an increasing low-income seniors' population and a shortage of affordable housing for seniors. The framework presents recommendations that emphasize coordination and innovation across the health, housing and community support service sectors (Social Data Research and Flett Consulting Group, 2007). The Ottawa example offers an integrated supportive housing framework that can serve as a model for other municipalities.

2.4   Funding Along the Continuum of Care

Aging in place that supports seniors' independence has been shown to decrease health care expenditures. For seniors receiving the same levels of care, it is more costly to house seniors in institutional long-term care than it is to provide them sufficient support for home care (Hollander and Chappell, 2002) or to provide supportive housing (Applebaum, *pers. comm.*, 2007). Until recently, funding for supportive community services such as day programs, laundry, housekeeping and meal delivery were very poorly funded. Ontario's recently announced Aging at Home Strategy will bring new funding to the community support sector which may help to reduce growing lists of seniors applying for admission to long-term care homes, and the unnecessary use of hospital resources.

In 2003, Ontario's MOHLTC allocated funding for 20,000 new long-term care beds. This allocation was a response to an urgent need for 24-hour care facilities for frail and chronically ill seniors. The MOHLTC's lump allocation of $1.2 billion is equivalent to roughly $60,000 per bed (Ontario MOHLTC Business Plan, 2001-2002). Within just two years of the opening of these 20,000 new beds, long waiting lists have developed again (MacAdam, *pers. comm.*, 2007). While there must be a sufficient supply of long-term care homes for those who require 24-hour nursing care, the community care sector must also receive adequate funding. Without coordinated service delivery options such as supportive housing in place, long-term care homes will be the only option, even for seniors who do not need such intense levels of care. Low-income seniors with weak, informal social support systems, such as elderly widows, are most at risk of premature or unnecessary admission to long-term care homes. These women lack the financial resources to purchase private care and support services (MacAdam, *pers. comm.*, 2007). Affordable housing options with more moderate supports along the continuum are in short supply.

Academic and policy reports affirm the necessity of a strong home care sector (MacAdam, 2000; Hollander and Tessaro, 2001; Romanow, 2002) both provincially and nationally. Hollander and Tessaro (2001) point out the preventive nature of home care, which includes community care, in a 2001 study sponsored by Health Canada:

> Given the interconnected nature of the health system, home care is clearly not a 'frill' or 'boutique' program. Rather, it is central to the success of health reform and to making the overall health care system function more efficiently and effectively. Home care is central to the health care system because it can often prevent or delay, and substitute for, admission to acute care hospitals and long-term care facilities, at a lower cost of care. Thus, it appears to be central to the

achievement of future efficiencies which arise from providing lower cost home care services instead of higher cost institutional services (Hollander and Tessaro, 2001: 28).

Conversely, home care has limitations in terms of cost efficiencies, quality of care and social isolation (Aronson and Neysmith, 2001). When low-income seniors' needs are great and their resources are limited, the problem lies in how best to house them and support their independence given limited personal and public resources. Supportive housing is one option along a continuum of care and is touted by many health and housing officials as a viable alternative, in addition to home care, to the current over-reliance on long-term care homes.

In order to increase supportive housing supply, funding for bricks and mortar construction is greatly needed. While long-term care beds came on-line at a cost of $60,000 *per bed* to the MOHLTC, Ontario's Ministry of Municipal Affairs and Housing dedicates just $75,000 *per unit* to new social housing construction projects. Given the high cost of land, materials and labour, and the limited municipal tax bases available to supplement provincial funding, new social housing construction allocations are positively inadequate. The social housing supply needed to house tens of thousands of people on waiting lists in Ontario will never be built given current funding commitments. The BC cases discussed in section 4 exemplify the substantial funding commitments allocated by two ministries to build new supportive housing stock for frail seniors. Without sufficient funding for bricks and mortar, long-term care and hospitals will continue to inappropriately house seniors who could be better served in other locations.

2.5   Supportive Housing as a Coordinated, Cost-Effective Solution

Supportive housing is a pragmatic and holistic alternative to premature institutionalization of seniors. A supportive housing symposium sponsored by the Canadian Research Network for Care in the Community (CRNCC) in 2007 indicated that supportive housing is gaining momentum in Ontario as a coordinated health and housing option that is particularly attractive to health care providers and the community and support services sectors. Supportive housing has been referred to as a "hidden gem" that is a winning combination for all levels of government (Humphries, *pers. comm.,* 2007). Supportive housing can be any type of seniors' housing along the continuum of care between independent living and long-term care homes. Opportunities for the expansion of supportive housing for low-income seniors in Ontario are emerging.

Supportive housing is often cited as a housing model that is not well understood in Ontario but is extremely effective in supporting frail seniors (OCSA, 2007a; Lum, Ruff and Williams, 2005; Humphries, *pers. comm.,* 2007; Applebaum, 2007). Supportive housing provides a flexible and integrated approach to support service delivery where residents select from a menu of options. Supportive housing case managers accommodate seniors' changing needs over time and often integrate supportive housing services with other services in the community or on-site to address all aspects of seniors' care, within limits. Supportive housing offers a potential solution to many of the current dilemmas faced by the overtaxed health care system. When located in close proximity to other forms, such as long-term care or congregate care, supportive housing offers the choice of independence for seniors who are able to direct their own care and live self sufficiently. When located within seniors' only residences, supportive housing can allow for aging in place without disruption.

The distribution of supportive housing across the province is uneven. Although the MOHLTC funds 185 supportive housing programs in Ontario, there are some communities that have no supportive housing units for seniors at all. In areas with supportive housing programs, there is not enough supply to meet low-income seniors' needs (MacAdam, *pers. comm.*, 2007). A supportive housing shortage exists province wide but most acutely affects rural areas where the only housing and care option for many low-income seniors may be long-term care homes. Supportive housing projects often consist of partnerships between local, provincial and federal governments as well as non-profit providers and private donations.

In rural areas, securing the necessary resources to develop new supportive housing is often impossible. However, as the North Renfrew case example will illustrate in section 3.2.1, creative partnerships that draw on non-traditional funding sources can lead to innovation in supportive housing development in rural areas. Planning supportive housing projects differs from planning for independent social housing projects since operating costs are more expensive and ongoing. Labour costs for supportive housing are often the greatest operating expense because buildings are staffed 24-hours a day by personal support workers. The operational efficiency of supportive housing projects is therefore essential to their viability and sustainability (Mancer and Holmes, 2004). Funding and operational partnerships between housing and support service providers can encourage integration, cost efficiency and client-centred care.

Finally, supportive housing is proven to be cost effective when support services are adequately funded. In a recently published Canadian costing analysis of different levels of supportive housing for persons at risk of homelessness (where seniors figure prominently), overall costs were proven to be significantly higher for institutional care than for community-based residential options (Pomeroy, 2006). Even when high levels of support in housing were provided, emergency services still proved more costly than the supportive housing options. For example, in the Region of Peel, Peel Senior Link's Executive Director points out that the agency can provide support services to seniors for half the cost ($35 to 40 per day) of the minimum daily long-term care home fee (at least $80 per day) (Applebaum, *pers. comm.*, 2007). And in a 2005 comparison study of seniors who live in social housing versus supportive housing in Toronto, the frequency of emergency care and support service use was shown to be higher for seniors in social housing with no supports. Seniors' use of emergency services in supportive housing declined, attributable to the security of 24/7, on-call emergency response systems in their buildings. Seniors in supportive housing were also reluctant to rely heavily on support services beyond what they needed (Lum, Ruff and Williams, 2005). Conversely, seniors who are prematurely placed in long-term care homes often lose independence and confidence when they receive too much assistance. This "over-caring" is a costly consequence both fiscally and psychologically when alternative options for low-income seniors are proven to be effective.

2.6 The Case Management Imperative

A crucial aspect of successful supportive housing provision is the critical role of case managers. Supportive housing case managers that develop strong linkages to outside support and community groups such as health and wellness, recreation groups and counselling services help direct seniors to appropriate avenues, outside of supportive housing programs, when necessary. Case managers committed to integrated service delivery can coordinate smooth and "seamless" care, especially when funding is flexible enough to respond to clients' changing needs

(Hollander and Prince, 2002). This approach differs significantly from the fragmented and overtaxed health and support services system with which seniors presently contend. Case managers who coordinate efforts between housing providers, supports and other health care services are essential actors in the development of a supportive housing legislative framework (Robinson et al., 2002).

Research studies and practitioners alike have found that part-time, on-site tenant support coordinators who link residents to needed services make a positive impact on the lives of seniors living in social housing. In an Ottawa study, a public health nurse present on-site, five days per week in a supportive housing building resulted in significantly fewer hospital admissions than in buildings with no such support (Flett, 1980). In Halton Region, seniors not currently living in supportive housing, but in need of support services, can meet with a part-time life enrichment therapist who provides referrals to community supports and identifies seniors' barriers to accessing the services they need (Aikman, *pers. comm.*, 2007).

Seniors' support needs will change over time. In some instances, seniors may need a higher level of support when they have just been released from hospital, but may gradually reduce the reliance on such as they recover. Case managers play a fundamental role in moderating and monitoring services for supportive housing residents. Their presence and expertise alleviates stress that many seniors and their families experience when they must manage support services on their own. Intensive case management as a central piece of the housing and supports arrangement provides the flexibility to adjust client care as needed.

2.7   Home and Community Care as Tools for Preventing Seniors' Health Decline

The Romanow report cites home care in Canada as the "next essential service" (Romanow, 2002). Although Ontario's home care is delivered free to all those in need, it consists of a limited basket of services that excludes homemaking. Until 1997, the home care package in Ontario included help with IADLs and recognized their preventive benefits (Barth, *pers. comm.,* 2007). There has since been much reform in the home care sector. The priority in more recent years has been on nursing, palliative and medically necessary services for post-acute clients. Empirical support for the value of community supportive services is growing slowly. Many analysts assert that community support services, when applied from a holistic, client-centred perspective, can actually contribute to the health care system's long-term sustainability. while having a positive impact on seniors' aging in place.

In one study conducted in British Columbia, the fiscal and psychological effect on seniors whose home care was reduced was tested over time. After the first two years that home care services were eliminated, seniors' health care costs increased substantially. Home care service cuts not only exacerbated cost inefficiencies, they also left seniors isolated and compromised in terms of their personal safety and well-being. The Hollander and Tessaro study also revealed that many of the people who had their home care services cut back re-entered the continuing care system, often with worse health conditions than if the cuts had never been made in the first place (Hollander and Tessaro, 2001). With less and less home care offered to seniors with ongoing support service requirements, support needs are often offloaded onto family, friends or private service delivery outfits, when seniors can afford to pay. As a result, those without informal support systems and/or low-income seniors often enter long-term care homes when they might

have been able to remain in the community with an adequate community support system available to them (Challis, 2007; Williams, 2007).

3. Ontario Case Studies

A brief overview of social housing and home and community support service policies provide the context to understand the selected Ontario case examples. There is a notable lack of any comprehensive policy that promotes aging in place across Canada, although policies to address the dual issues of housing and health have emerged since the late 1990s in the provinces of Manitoba, Québec, British Columbia and Alberta. Seniors' health and housing needs have gained some recognition as demonstrated by the National Framework on Aging developed in 1998 based on the principles of dignity, independence, participation, fairness and security. However, policies accompanied by implementable solutions have not evolved to accompany them. Fragmentation between and within sectors is a consistent barrier to the coordinated care required to supply supportive housing to frail, low-income seniors. Funding for bricks and mortar and sufficient home and community care service delivery remain the primary obstacles to increasing seniors' supportive housing supply in Ontario.

3.1 Policy Context

The federal government plays a limited role in the areas of health, housing and social policy for seniors. Health and social services for seniors have remained the prerogative of the province under the MOHLTC and the Ministry of Community and Social Services. Local planning for the integration of health and social services was delegated to District Health Councils in Ontario from 1975 to 2005. The newly created Local Health Integration Networks are expected to form liaisons with local municipalities and planning bodies to reduce fragmentation. Housing policy does not explicitly address issues associated with aging. The Ministry of Municipal Affairs and Housing more generally focuses on creating opportunities to provide affordable housing across the province and provides limited funding and cost sharing with municipalities to do so (Hayward, 2001).

3.1.1 Social Housing Policy

There is no national housing policy in Canada. The federal government's principal legislative instrument for housing policy implementation is the National Housing Act (NHA) adopted in 1938. The NHA was a tool used by the federal government to stimulate employment and promote construction through private sector housing development after World War II (McNiven, 2004). Canada Mortgage and Housing Corporation (CMHC), established in 1946, administers the federal government's housing priorities. Although CMHC originally distributed resources more equally between owner and rental properties, its focus is now largely on mortgages and financing for people in the home ownership market. There have been several significant shifts in the federal government's housing policies that ultimately resulted in the disentanglement of federal responsibility for social housing entirely in the early 1990s.

From the 1960s through the 1980s, a commitment to social housing construction was demonstrated in federal programs. The Neighbourhood Improvement Program (NIP) was focused on urban renewal with some provisions for social housing. The Multiple Unit

Residential Building (MURB) Program stimulated rental apartment building construction using tax deferrals that enabled owners certain soft cost write-offs. In the mid 1970s, large numbers of senior citizens units were built across the country, as funding was readily available for provincially and municipally-sponsored housing projects. Many of the non-profit seniors' social housing buildings in existence today were created at that time (McNiven, 2004).

3.1.1.1 Social Housing Reform Act (SHRA)

By 1993, the federal government had completely discontinued funding for new social housing development and had effectively left the business of public housing. The federal government's withdrawal was followed by the devolution of social housing administration, management and operational responsibilities to the provincial level in 1996. In 2000, the Social Housing Reform Act (SHRA) legislated social housing responsibility to Ontario's 47 municipal service managers. A general criticism of the SHRA is that it places significant expectations on social housing providers in terms of efficiency and fiscal restraint that is subject to rigid benchmarks, while it also requires a great deal of added administration and paperwork. SHRA reform has been widely recognized as necessary to ease pressures on municipalities struggling to maintain and operate existing social housing buildings (ONPHA, 2006).

3.1.1.2 Canada-Ontario Affordable Housing Program (AHP)

In November 2001, the federal government signed affordable housing agreements with each province and committed a moderate level of funding ($680 million over five years) with the stipulation that provinces must match funds for new housing construction. While provinces such as British Columbia and Québec maintained strong support and funding for their provincial social housing sectors, social housing responsibility was devolved even further in Ontario to the municipal level placing the financial risk on local governments. From 2003 to 2005, the pilot phase of the Canada-Ontario Affordable Housing Program (AHP) was severely under-funded by all levels of government. Since then, about 4,300 units of social housing have been constructed under the pilot phase of the program up to 2007.

Although an investment of $301 million from the federal and provincial government provides some additional resources for development, the cost sharing provision is seen as a barrier to construction by many in the industry (O'Brecht, *pers. comm.*, 2007). The goal of the 2005 AHP agreement that provides $734 million in federal, provincial and municipal funding is to accommodate 20,000 households in Ontario (Ontario Ministry of Municipal Affairs and Housing, 2007). However, a requirement that an 80 percent average market rent be achieved for all projects means that the groups most in need and least likely to pay above RGI rents will not be sufficiently served by new social housing projects (ONPHA, 2007a).

The most recent report from the Ministry of Municipal Affairs and Housing showed that 41 percent of the 8,793 committed housing units up to 2007 were targeted for priority groups including seniors, people with mental illness, victims of domestic violence and immigrants. The largest proportion was dedicated seniors' social housing at 54 percent (1,947 units). While housing built under the AHP is intended to be affordable, it is not necessarily subsidized on a rent-geared-to-income-basis. Additional funds for rent supplements were dedicated to just 29 percent of the new social housing units being built across the province (OANHSS, 2007b).

Although some development is occurring, for the lowest-income seniors, access to affordable housing is still extremely limited.

3.1.1.3 Devolution of Social and Supportive Housing

Affordable housing for seniors and for all residents is a central concern for many communities in Ontario as evidenced by municipal affordable housing strategies being adopted in many regions. Since devolution, the funding structure to build new social housing infrastructure is lop-sided and relies heavily on municipal tax bases that are static with no incentives for developers to enter the affordable housing market. In Peel Region, for example, only five new buildings have been constructed since devolution in 2001 despite the fact that Peel has a long-standing commitment, approved by council, to social housing development (Obrecht, *pers comm.,* 2007). The funding allocations from higher levels of government for bricks and mortar and ongoing operations are simply insufficient.

Over half of Ontario's supportive housing has been devolved to the municipal level (ONPHA, 2007b). The remainder is funded and administered by the MOHLTC and the Ministry of Community and Social Services. The MOHLTC Supportive Housing Program was started in 1994 and funds 185 programs across the province. Housing and support services are administered separately. The housing portion is governed by the Tenant Protection Act of 1997. The support service portion of supportive housing is funded by the MOHLTC and is covered by the Long-Term Care Act of 1994 (Ontario MOHLTC, 2007). Home and community care policies are critical to the supportive housing policy context and have changed continuously in Ontario depending on the provincial administration in office. In the following section, a basic outline describes significant changes in home and community care in recent years as they relate to seniors' supportive housing.

3.1.2 Home and Community Care Policy

No national home care policy exists in Canada. Disparities in regional home care provision across the country suggest that many people, particularly low-income people and seniors living in rural communities, currently have unmet needs. The Romanow report pointed out that provincial spending on home care needs to expand as the sector becomes an increasingly important component of the continuum of care for elderly Canadians (Romanow, 2002).

3.1.2.1 Home Care: Not Governed by Legislation

Home care is not covered by the Canada Health Act. Home and community care comprised 4.25 percent of the overall spending on health care within provincial budgets in 2002 across Canada. This still represents a small amount of funding when compared to hospitals, drug expenditures (44 and 7 percent respectively) and spending in other health care areas (Government of Canada, 2002a). Although each region knows how best to supply home care that meets the specific needs of its residents, many analysts conclude that a national home care policy would serve to fill gaps, foster accountability, mandate consistency and ensure that all Canadians have access to an equal quality of care regardless of their location (MacAdam, 2000; Romanow, 2002). The incorporation of home care into the Canada Health Act or a separate piece of national legislation to govern home and community care is widely endorsed by organizations such as the Ontario

Health Coalition, the Ontario Public Health Association and the Registered Nurses of Ontario as a necessary next step in home care policy direction.

Ontario's provincial home care policy changed dramatically in 1995. Extensive restructuring of community based long-term care shifted priorities from non-profit community care providers, formerly guaranteed 80 percent of home and community care contracts, to a market competition model where for-profit and non-profit providers compete for contracts on a "level" playing field. This series of wide reaching changes has received extensive criticism for its negative effects on the quality of care and its implications for shifting care from the professional to the informal, volunteer sector (family and friends of frail and elderly seniors now bear the brunt of home care reform). Personal support workers' livelihoods in terms of job security and salaries have suffered as a result of the policy shift (Skinner and Rosenberg 2006; Cloutier-Fisher and Joseph, 2000). However, in January 2008, the MOHLTC indicated that the process for selection of CCAC provider agencies would be revised.

3.1.2.2 Community Care Access Centres (CCACs): What Do They Do?

The Community Care Access Centres were developed to operate home care services and to better coordinate service delivery for those with continuing care needs. CCACs have played two primary roles in Ontario: they serve as one-stop access points for seniors' coordinated home care services and case management; and they manage placement of seniors in LTC homes. There were formerly 43 CCACs in Ontario. In 2007, the number was consolidated to 14 to align with the 14 Local Health Integration Network boundaries (see below).

Home care under CCACs consists of a limited basket of medically related services discussed in section 1.7.11. Community support services such as meals, transportation, homemaking, social visiting and respite fall outside the scope of CCAC services and are often available on a fee-per-use basis only. Community support agencies received about 60 percent of their funding from the MOHLTC in 2005 ($300 million). The remainder came from client co-payments, fundraising and community donations ($120 million). This represents just one percent of Ontario's $28 billion health care budget (McReynolds and Young, 2005). It is important to illustrate the context of community and home care funding and provision as it determines how and what levels of services can be offered in the development of additional seniors' supportive housing.

3.1.2.3 Local Health Integration Networks (LHINs)

LHINs identify local health care priorities and fund hospitals, mental health agencies, long-term care homes, CCACs, community support services and community health clinics. LHINs are governed by the Local Health Integration Act and respond to the specific health needs of their areas through consultative, integrated management. Fourteen LHINs were established to facilitate the pressing need for health care integration, coordination and reform:

> LHINs are a critical part of the evolution of health care in Ontario from a collection of services to a true system that is patient-focused, results-driven, integrated, and sustainable. The legislation places significant decision-making power at the community level and focuses the local health system on the community's needs, improving health results for patients in every part of the

province. The LHINs will facilitate the effective and efficient integration of health care services and make it easier for people to get the best care in the most appropriate setting, when they need it (Ontario MOHLTC, 2007).

LHINs' timelines for health care planning are ambitious considering the reformed system involves significant change and restructuring across the province (Teplitsky, *pers. comm.*, 2007). All LHINs place seniors' care as a top funding and health care priority, particularly for higher age groups. LHINs are mandated to improve the functioning of the health care system along the continuum from primary care, to home care, to access to supportive housing services. Increased funding for community support services can facilitate aging in place. Specific allocations for support services in low-income housing may contribute to supportive housing prioritization in the housing sector as well.

3.1.3 Policy Effects on Rural Locations

Low-income seniors in rural Ontario are particularly vulnerable to policy changes in health and housing. Rural areas operate on fewer resources with more disparate seniors' populations that are growing faster than in other parts of the province. In Ontario, in towns and villages with populations below 5,000 residents, seniors' populations are often as high as 20 to 35 percent (Canadian Centre for Justice Studies, 2001). This indicates the latent demand in rural and small town Ontario for home and community care services (Skinner and Rosenberg, 2006). Circumstances in rural communities pose unique challenges for service provision as they receive lower per capita funding, are faced with limited service options, consist of small and dispersed aging populations and have small tax bases (Cloutier-Fisher and Skinner, 2006).

The managed competition model used by CCACs to select home and community care providers—based on the "quality of care for the best price"—has had detrimental effects on rural areas. Prior to long-term care restructuring in the mid 1990s, non-profit providers, familiar with small town and rural challenges, secured 80 percent of home and community care contracts (Skinner and Rosenberg, 2006). With the establishment of CCACs, larger, for-profit providers are more often awarded contracts based on cost efficiencies and for-profit competitive contract bidding experience (Cloutier-Fisher and Skinner, 2006). Home care restructuring placed the volunteer, non-profit sector at a disadvantage and limited choice for seniors in rural areas (Cloutier-Fisher and Joseph, 2000).

Small, rural seniors' populations are easily ignored by policy-makers as they hold less political weight than in more populous urban areas. However, more effective solutions to rural seniors' housing and care is a growing concern as populations increase and the policies that currently guide the long-term care system are insufficient to address rural issues. For example, CCACs' consolidation and centralization of services to urban centres has exacerbated the already challenging situations of under-funding, human resource shortages and distance and weather that influence the frequency of service delivery for seniors in rural locations (Cloutier-Fisher and Skinner, 2006). Although some innovative partnerships have emerged that supply supportive housing in the same building as long-term care homes such as the North Renfrew case example, further innovation toward increasing supportive housing supply will be necessary to address the transportation, clientele dispersion and cost inefficiencies associated with individual home and community care delivery in rural areas in the future.

3.2 Introduction to Three Ontario Case Examples

The study now looks at three Ontario case examples to investigate the linkages between housing and supports for low-income seniors. One rural delinked supportive housing and long-term care service provider in Deep River, one non-profit agency that provides delinked support services in Peel Region, and one coordinated municipal services strategy that serves low-income seniors in Halton Region were selected. The case examples represent a good cross-section of the variety of programs that provide supportive housing for seniors in the province. In particular, the Halton municipal coordinated service strategy illuminates the importance of local government commitments to integrated, client-centred service delivery. The case examples were not, however, chosen as "best practices." Best practices should be evaluated as exceptional based on standardized outcome measurements that were not available to the author. Best practices should also be determined by local health and housing authorities according to criteria that best suit local needs.

The study does not examine Toronto's supportive housing portfolio for two reasons. First, the Toronto supportive housing context has been assessed in previous reports by the Toronto District Health Council (Robinson and Teplitsky, 2001 and 2002) and the United Way (Lum, Ruff and Williams, 2005). Second, Toronto's seniors' population, the quantity of its social and supportive housing infrastructure, and the variety of supportive housing programs available there are unique in Ontario. The study looks at smaller mid-size regions, with rapid seniors' population growth, to address the challenges that many similarly sized regions may face. The rural case example is selected because, throughout the literature review and in key informant interviews, rural areas were cited as woefully lacking in seniors' supportive housing options. The selected case examples demonstrate a commitment to supportive housing and innovative approaches to provide it as a viable solution. The guiding principles, funding sources, integration strategies and partnerships for each case study are explained in the following section.

3.2.1 North Renfrew Long-Term Care Centre, Deep River

Deep River is a small, rural community in Eastern Ontario. Located in the Upper Ottawa River Valley, it is a two-hour drive from the nation's capital. In 2006, the total population in Deep River was 4,215 (Statistics Canada, 2006b). The seniors' population (65 and older) was 21 percent in 2006 while 10.2 percent of Deep River's population was 75 years and older. Results from a 2007 United Way seniors' needs assessment survey show that, aside from a doctor shortage in the area, supportive housing for seniors is the most needed service in Renfrew County (Gutzman, 2007).

The North Renfrew Long-Term Care Centre in Deep River, Ontario is a well-known rural non-profit project that contains 21 long-term care beds and 10 self-contained supportive housing apartments. Seniors can qualify for supportive housing if they require 24/7, on-site personal support in addition to two support services, congruent with the MOHLTC requirements for supportive housing. Seniors are supported in their own apartments through community support services that range from adult day service programs, to meals-on-wheels to respite and transportation services.

3.2.1.1 North Renfrew Long-Term Care Centre History

The North Renfrew Long-Term Care Centre opened in 1994 after six years of planning and development. It filled a significant gap along the seniors' housing continuum in Deep River. Supportive housing units created needed alternatives to long-term care beds in the region. Funding allocated for long-term care beds was redirected for supportive housing with an eye towards offering different options for frail seniors who wanted to live independently. Due to the small population, it was not possible to develop and operate an exclusively supportive housing facility based on economies of scale. The Mayor of Deep River, Ann Aikens, was instrumental in planning and directing this innovative client-centred program that provides a continuum of seniors' care under one roof. Advocates on projects such as North Renfrew are crucial to the creativity and commitment involved in matching supportive services to seniors in rural areas.

North Renfrew's long-term care centre is guided by three main principles: flexibility, client focus and a commitment to reduce emergency admissions and long-term care bed occupancy. The client-centred approach is particularly apparent in the governance structure of the centre. A supportive housing tenant is represented as an active member on its board of directors. The guiding principles frame program implementation and ensure flexible care that helps seniors get what they need in an integrated manner.

3.2.1.2 North Renfrew's Funding Partnerships

Funding for new supportive housing facilities is extremely difficult to acquire, particularly because the MOHLTC funds supportive housing programs but not the bricks and mortar in which the programs exist. In the Deep River case, multiple funding sources were accessed in order to realize the project. Four municipalities contributed funds as well as three provincial ministries, none of which were the Ministry of Health. The project was funded by the Ministry of Housing, the Ministry of Community Services and the Ministry of Tourism and Recreation. Because the supportive housing operating funds were reallocated from long-term care beds in a neighbouring county, one county also was a funding partner. The Seniors' Independence Program, a federally-funded program for seniors' initiatives, also allocated resources. Finally local fundraising paid for additional costs (Aikens, 2007). This complicated funding puzzle demonstrates the commitment and ingenuity involved in implementing a supportive housing program in a rural municipality.

From the beginning, the North Renfrew Centre viewed seniors' care with an integrated health care lens. The intention was to deinstitutionalize seniors, based on a regional survey that determined that seniors wanted a range of services available close to home. The reallocation of long-term care funding went toward community care programs. The North Renfrew Centre is linked to four other community care facilities in the area and provides a streamlined, comprehensive approach to senior-centred continuous care.

This case example shows that partnerships with ministries outside of health can work well in supplying services and housing for seniors' to be able to age in place. As was the case in the diverse funding for the Deep River example, the policy directions of the Ministry of Municipal Affairs and Housing and the Ministry of Community Services guided the policy directions of supportive housing partnerships. The Mayor of Deep River points to these opportunities as

examples of where innovative partnerships can emerge that result in integrated seniors programming in non-traditional forms (Aikens, 2007). Particularly in the small town and rural contexts, partnerships and diversified funding strategies have the potential to promote greater flexibility for supportive housing initiatives.

3.2.2 Peel Senior Link (PSL), Region of Peel

The Region of Peel is a rapidly growing municipality west of Toronto in the Greater Toronto Area that includes Brampton, Caledon and Mississauga. In 2006, the total population in Peel was 1,159,405. Eleven point six percent of Peel's population lived below the low-income cut off. The population growth rate from 2001-2006 was 17 percent while there was a 33 percent growth rate in the seniors' population during the same time (Statistics Canada, 2006c). The seniors' population in Peel is expected to nearly triple by 2021 (Region of Peel, 2006).

In 2007 there were 2,090 seniors on the Peel Access to Housing (PATH) centralized social housing waiting list. Accompanying the long waiting list, poverty and homelessness among local seniors has increased. The wait time for a one-bedroom unit in a non-profit seniors' building is between three and seven years. A large percentage of the seniors' population in Peel, particularly those from cultural minorities and those with disabilities, are unaware of the housing and social support programs and services available to them (Region of Peel, 2007b) which means there may be many more seniors in need of social and supportive housing than what is reflected on the waiting list.

3.2.2.1 Peel's Commitment to Social Housing

The Region of Peel made a commitment to supportive housing in the 1980s (Obrecht, *pers. comm.,* 2007). Peel Living, the region's housing authority, prioritized the ongoing development of affordable housing units after the downloading of social housing responsibility occurred. Peel Living is committed to working in partnerships with private developers and other levels of government for new affordable rental construction. However, the province allocates only $75,000 per unit. Construction costs are at least $200,000 per unit. In light of increasing development costs, insufficient funding from higher levels of government and scarcity of developable land owned by the region, it has been and continues to be very difficult to draw enough funding together to construct new social housing buildings (Obrecht, *pers. comm.,* 2007).

In 2006, Peel Living owned and operated 7,100 housing units, 62 percent of which were RGI. One-quarter of Peel Living's buildings are dedicated seniors' buildings which translates to 1,800 seniors' units. Of the 32 total seniors' buildings, 13 contain supportive housing units (Region of Peel, 2007b). Close to 100 seniors living in supportive housing units in Brampton and Mississauga are served by Peel Senior Link (PSL). Peel Senior Link serves another 900 seniors who have heightened health risks through day programs and other support services offered in subsidized seniors' buildings in the region (Kavanagh, *pers. comm.*, 2007). Without PSL, these people could not afford to pay out-of-pocket for essential personal services. The Director of Housing at Peel Living notes the absolutely critical nature of supportive housing services and states his long-term vision of offering supportive housing services in all dedicated senior citizens buildings in Mississauga, Brampton and Caledon (Obrecht, *pers. comm.,* 2007).

3.2.2.2 PSL Partnerships

Peel Senior Link is a non-profit, delinked supportive housing services agency that has served Peel Living seniors' residents, many of whom are low-income, since 1992. Peel Senior Link formalized a partnership with Peel Living in 1999 to ensure that low-income seniors could receive the supports they need in a coordinated manner. Peel Senior Link is primarily a service coordination agency and works closely with community service providers to achieve its goals. The agency provides both personal care and homemaking services (ADLs and IADLs) to its clients. When nursing care is required, PSL works closely with the CCAC so that seniors receive both the health and social supports they need to live as independently as possible.

In addition to providing support services in subsidized seniors' buildings, Peel Senior Link developed a public-private partnership agreement with a private property management firm. The need for a combination of seniors housing and support services continues to grow despite the fact that very little new social housing has been developed in Peel. As a result, PSL entered a multi-sectoral partnership with the municipal government (for rent supplement provision) and the private sector (for market rate housing units) that enables 15 additional low-income seniors access to supportive housing (Peel Senior Link, 2007).

This public-private partnership is just one example of the many partnerships in which PSL is involved. PSL also collaborates with the City of Mississauga Recreation and Parks Division to bring active living programs to seniors who are less mobile and unable to access programs at community centres. PSL partners with agencies to provide seniors a variety of services that emphasize healthy living and facilitate aging in place. For example, a partnership with Family Services of Peel delivers professional counselling services on-site for all tenants who would have difficulty accessing the counselling independently. This coordinated partnership approach is crucial to residents' psychological well-being and fills a gap in service delivery.

Peel Senior Link operates on the basis of a simple and straightforward guiding principle: to support adults in continuing to live as independently as they can. Flexibility is also central to the way that services are provided. Although it is required that seniors be able to self-direct their care, PSL has no black and white definition of what qualifies as self-direction (Kavanagh, *pers. comm.,* 2007). A resident who is sentient and competent but who cannot speak is capable of self-direction. PSL's flexible approach allows for a wider range of seniors to continue to receive services and remain independent for as long as possible.

3.2.2.3 PSL Funding

PSL receives the vast majority of its funding from the MOHLTC. Additional agency funding comes from the United Way and private, modest corporate donations that underwrite special events (Kavanagh, *pers. comm.,* 2007). Approximately 15 units in each of 13 buildings are designated supportive housing for seniors and served by PSL. Peel Senior Link employs a day service coordinator to deliver support services to additional seniors' buildings without designated supportive housing units funded by the MOHLTC but where seniors still require services. There are two access points to apply for PSL services: either through referral and a standard application process through the CCAC; or, if a senior is already living in a building served by PSL, he or she can apply and seek approval from the building manager. All applicants then go on a waiting list

that averages 14 months. Clearly there is a need for increased funding to sustain and expand the vital services that PSL provides in social housing.

In 2005, Peel Senior Link received an additional $70,256 for its base funding allocation. This reflects that the province sees the critical importance of community support and supportive housing services along the continuum of care. Ray Applebaum, Executive Director of PSL, noted that additional funding "helps to sustain the capacity of the organization [so that we can] continue to provide desperately needed services for frail elderly to remain living independently in their community and helps prevent or delay the need for costly institutional care" (Peel Senior Link, 2007).

3.2.2.4 PSL Integration along the Continuum

Integration in the wider continuum of care is at the forefront of PSL's mission. PSL's integrated service model maximizes seniors' independence, fosters stability and allows aging in place in the community with dignity in a safe environment. Again, PSL's support services are particularly important to low-income seniors who might otherwise be placed in a long-term care home or in hospital. PSL's partnership with Peel Living requires front-line housing and support workers to communicate effectively and ensures that they are willing to perform responsibilities that may fall outside of their official job titles (Kavanagh, *pers. comm.,* 2007). PSL is responsive to the needs of seniors and their families and measures its progress through client and family satisfaction surveys. Integration is a philosophical approach that is implemented from the systems level down to individual choice and preference.

PSL has been actively involved in a variety of programs that complement and inform the agency's forward thinking approach to supportive housing service delivery. For example, in 2007, PSL has supported and partnered to deliver educational programs, safety workshops, a medication management project and a regional seniors' needs assessment to inform future directions for service delivery. The Metamorphosis project, chaired by Ray Applebaum, is a consortium project that aims to enhance client services and knowledge transfer based on a service integration model aligned with the MOHLTC's goals and objectives (Metamorphosis, 2007). PSL's flexibility and willingness to try new approaches, including public-private partnerships and mixed models of support service delivery, makes the case for the benefits of integration and highlights the necessary steps to achieve a client-centred philosophy.

3.2.3 Halton Integrated Seniors' Support Services, Halton Region

Halton Region, also part of the Greater Toronto Area, lies west of Toronto and Peel and has seen rapid population growth in the last five years. The population of 439,256 in 2006 shows a 17.1 percent growth rate since 2001 and is projected to increase another 26 percent by 2016. Halton Region is comprised of Burlington, Halton Hills, Milton and Oakville. The seniors' population in 2006 was approximately 12 percent and is projected to double by 2015. Importantly, the population aged 85 years and older and most in need of supportive housing services will almost triple, increasing from 4,000 to 11,000 in the same time period. One out of every eight unattached seniors, 85 percent of whom are women, lives below the low-income cut-off in Halton Region (Halton Region, 2007).

Halton Region has provided supportive housing for seniors for 14 years as part of the Community Support Services Programs. Halton Community Housing Corporation (HCHC) is the region's social housing service manager and was created in 2001, upon devolution of social housing, when Halton Non-Profit Housing Corporation and Halton Housing Corporation combined. HCHC owns and operates 1,816 units in the region. HCHC and Services for Seniors are programs in Halton's Social and Community Services Department. The two divisions work together under an integrated service coordination strategy that aids in providing coordinated, accessible housing and services for frail, mainly low-income seniors. This municipal service coordination strategy guides seniors' supportive housing provision in Halton.

3.2.3.1 Halton Region's Municipal Service Coordination Strategy

Although the service coordination strategy in Halton is not specific to low-income seniors, it is a municipal, client-centred model of service delivery that will likely be of interest to other regions, especially in light of the LHINs' emphasis on service coordination, partnerships and delivery. The coordination strategy's guiding principles reflect a commitment to consistency and integration and are summarized as follows:

- respect the dignity and rights of all individuals;

- make services as easy to access as possible;

- coordinate programs and services across service areas; and

- provide staff with information, skills and resources to coordinate effectively.

When asked how Halton's community and support services staff can be assured that these principles are adhered to into the future, regardless of the administration in office, it was noted that client-centred service coordination has become the way business is done here. Integration is now inherent in the working relationships between departments (Aikman, *pers. comm.,* 2007).

In the past, programs delivered by the community and social services department were governed by differing philosophical and legislative approaches at the provincial level. This resulted in many cases in "silo-ed" service delivery. Programs had a narrow view of their responsibilities and were unable to recognize and address overlap and gaps between systems. Although each individual program sufficiently met the needs of staff and clients, when regulations were strictly applied, conflicts between program areas emerged regularly. The services coordination strategy sought to address silos that too often worked in isolation.

Halton's transition to this integrated, innovative approach in 2004 has impacted the staff's capacity to coordinate service delivery efforts holistically. Now, service coordination permits and encourages more flexible interpretation of regulations and ensures that a comprehensive service plan is in place to adequately suit the needs of the client. This logical and straightforward service strategy may seem like an obvious method. However, it can be quite challenging to coordinate between multiple service situations particularly when agencies' cultures have predominantly operated within silos (Halton Social and Community Services Department, 2004).

3.2.3.2 Halton's Supportive Housing Program for Seniors

Municipal partnerships not only demonstrate a comprehensive effort at client-centred service delivery, they represent effective communication between entities that often use different techniques in addressing client needs. Partnerships between Halton's social and community services department and non-profit community agencies have developed. Despite its municipal emphasis on service coordination, Halton's housing director points to fragmentation at the provincial level. The housing director suggests provincial policies and programs should be better coordinated in order to be delivered more effectively. For example, when an affordable housing project is in the final planning stages, support service funding should be released at the same time (Cressman, *pers. comm.,* 2007).

Halton's Supportive Housing Program for Seniors offers the coordination of various support services, from personal care assistance (ADLs) to help with medication reminders. The program encourages long-term, independent living for seniors in their own apartments and offers delinked support services to supportive housing residents. Community services staff share in seniors' decision-making processes but do not direct their choices, thereby respecting seniors' self-determination. Wellness promotion and prevention is an important aspect of the Services for Seniors Division.

Beginning in 2008, to ensure that seniors around the region are as safe and comfortable in their communities as possible, the Halton Region Health Department's Older Adults Program, Services for Seniors' Supportive Housing and HCHC will work together to offer education workshops on falls prevention, alcohol and drug addiction for seniors, mental health and pharmacy information. This partnership evolved from a multi-departmental municipal recognition that preventive multidisciplinary efforts are necessary for seniors living in subsidized housing.

3.2.3.3 Halton Coordination for Seniors' Supportive Housing Placement

All applications for supportive housing go through the Halton Access to Community Housing (HATCH) and seniors are generally on the waiting list for five to six months. There are 20 seniors' non-profit housing providers in Halton Region while 13 are owned and operated by the HCHC. Delinked supportive housing services are offered in five seniors' subsidized housing buildings in the region. The delinked model keeps housing and seniors' support services separate and gives seniors peace of mind that their tenancy is safe (Aikman, *pers. comm.,* 2007). Many of Halton's social housing buildings are small-scale, housing between 12 and 36 residents. The MOHLTC Supportive Housing Program, due to economies of scale, is not available to support aging in place in the smaller buildings. It is more cost-effective and efficient to offer supportive housing in larger buildings. For example, Wellington Terrace in Burlington has 126 units, 40 of which are supportive housing units for low-income seniors and those able to pay market rent. In total, 138 seniors in Halton receive supportive housing services. The average age for supportive housing service recipients is 85 years and approximately 83 percent are female (Halton Supportive Housing Demographic Data, 2007).

Halton Seniors' Services Division also works with the regional CCAC and LHIN to coordinate supportive housing services and strategies. Seniors rarely make decisions completely

independently about where they would like to grow old. Halton staff consults with family members as well as seniors to determine best options that are available based on client needs. It is widely noted that family members, particularly of low-income seniors, are hard-pressed to provide the extra supports that their elderly relations require and often cannot afford the time to supervise adequately. Supportive housing, in terms of alleviating family anxiety, is essential in meeting basic needs that are often impossible for family members to take on due to distance, time, finances and lack of professional skills. Aging at home, literally, can be complicated by the levels of home and community care services required to maintain individuals with very few resources. Halton Region's supportive housing program works with family members to determine when a move to supportive housing is the right choice. Additionally, when long-term care placement is necessary because the senior has become a danger to him or herself, families and Halton support services staff evaluate suitable options to ensure a less disruptive transition (Aikman, *pers. comm.,* 2007).

3.2.3.4 The Challenge of Measuring Supportive Housing Outcomes

Seniors' supportive housing outcomes are difficult to measure. The MOHLTC reporting requires basic cost measures and the number of people served in supportive housing programs in Halton. Formerly, Halton measured outcomes in their seniors' programs based on indicators such as accessibility, appropriateness, continuity, efficiency, effectiveness, client perspective, safety and timeliness. Some were more difficult to track than others. The introduction of the provincial management information system that will be rolled out over three years (between 2007 and 2010) will again change the outcomes measured in each program. Benchmarks and indicators that measure the intention of supportive housing to help seniors maintain their independence will be relevant and necessary to future program expansion (Aikman, *pers. comm.*, 2007).

3.3 Ontario Case Studies: Lessons Learned

A number of common lessons presented by the Ontario case examples characterize the success and limitations of each program:

- Close partnerships result in strong coordination and opportunities for innovation.

- Preventive programming for at risk seniors is highly valuable.

- Creativity and consistent leadership is a necessity for funding new projects in rural areas.

- Guiding principles that place seniors' self-determination as a central philosophical tenet positively impacts seniors' and families' satisfaction.

- Cross-sector capacity between housing and support service staff fosters integrated service delivery.

- Supply of supportive housing programs is insufficient, demonstrated by long waiting lists.

The client-centred approach in each case example likely influences the flexibility of support service provision. The less programs are hemmed in by strict regulations and the more their administrative leadership encourages freedom to interpret guidelines and make sound judgments based on seniors' needs and staff experience, the more integrated their service capacity. These Ontario case studies provide an overview of how the MOHLTC Supportive Housing Program

works in various municipal contexts. Barriers to housing and support combinations are common across jurisdictions and are fundamentally based on scarce funding to produce supply for those seniors most in need.

4. A Tale of Two Programs: British Columbia's Seniors' Supportive Housing Solutions

British Columbia's supportive housing programs offer a comprehensive model that brings together capital, operating and service dollars to expand supportive housing infrastructure for low-income seniors across the province. Independent Living BC and Seniors' Supportive Housing both fill gaps along the continuum of care. These joint efforts by provincial health authorities and the provincial housing body present potential solutions to the growing numbers of seniors in need of some level of assistance to maintain their independence. BC has been widely cited as a model for programs that foster housing and health partnerships to expand supportive housing options. Although Ontario and BC's health and housing policy contexts are different, BC exemplifies a commitment to supplying multiple options along the seniors' housing and support service continuum. A central actor facilitating this process through capital and operating cost allocations is BC's provincial housing authority. Ontario's social housing delivery, carried out at the municipal level, differs from BC in this regard as there is currently no central provincial housing authority. However, partnerships between ministries in both provincial contexts can make aging in place a viable policy option while creating the infrastructure necessary to facilitate the process. The BC case example, although not a direct parallel to the Ontario context, offers lessons for housing frail and vulnerable seniors as the Canadian health, home and community care systems continue their transformation into the immediate future.

4.1 Background

In 2001, seniors comprised 13 percent of British Columbia's population. The seniors' population is expected to increase to 1.3 million, or one in four British Columbians, by 2031 (BC Ministry of Health, 2004). This significant demographic shift reflects similar trends across Canada. Seniors in BC today are also the healthiest and most active seniors in history (Seniors' Living, 2007). To prepare for this marked population increase and its associated demand for a wider range of housing and care options, the BC government embarked on a redesign of seniors' care and housing delivery in 2001. Through consultations and national and international research on best practices, it was determined that a variety of seniors' housing options were needed which led to the widespread development of subsidized and for-profit assisted living facilities in the province. The Ministry of Health and the Ministry of Social Development and Economic Security that oversaw housing at the time released substantial funding *simultaneously* to develop new assisted living (supportive housing) facilities across the province.

British Columbia was the first province in the country to regulate public and private assisted living residences. In BC, an assisted living registrar investigates and resolves complaints regarding health and safety, administers a registry of assisted living residences province-wide and regularly reviews the health and safety operation standards of assisted living facilities.

This study introduces BC's programs for lessons and cautions in the development of a continuum of care. A range of supportive housing options make independent living for many seniors who do not need 24/7 nursing care in long-term care homes available and affordable. Assisted living is a comfortable alternative for low-income seniors who can no longer manage to live on their own and require some assistance to retain independence. BC Housing has developed a robust partnership with the regional health authorities where health and housing work together to ensure the housing, supports and health needs of frail, low-income seniors are met in assisted living facilities.

4.2 Independent Living BC (ILBC)

BC Housing is a provincial crown agency, founded in 1967 that develops, manages and administers a large proportion of the social housing portfolio in BC. Since 2001, its focus has been on housing BC's most vulnerable populations: the homeless, the frail elderly and people with mental illnesses and addictions. The Independent Living BC (ILBC) program began in 2002 and provides housing and support services to seniors who require some support with ADLs and IADLs. ILBC's subsidized assisted living facilities fill one of the gaps between independent living and long-term care for low-income seniors. ILBC is a multi-sectoral partnership between the federal government, BC regional health authorities and non-profit or private housing providers (see Figure 4). The ILBC program targets low-income seniors who want a housing arrangement that helps maintain independence while providing a secure supportive living environment. Since the program's initiation, 3,411 ILBC assisted living units have been built in BC (BC Housing, 2007).

Figure 4. ILBC's Multi-Sectoral Partnership Structure
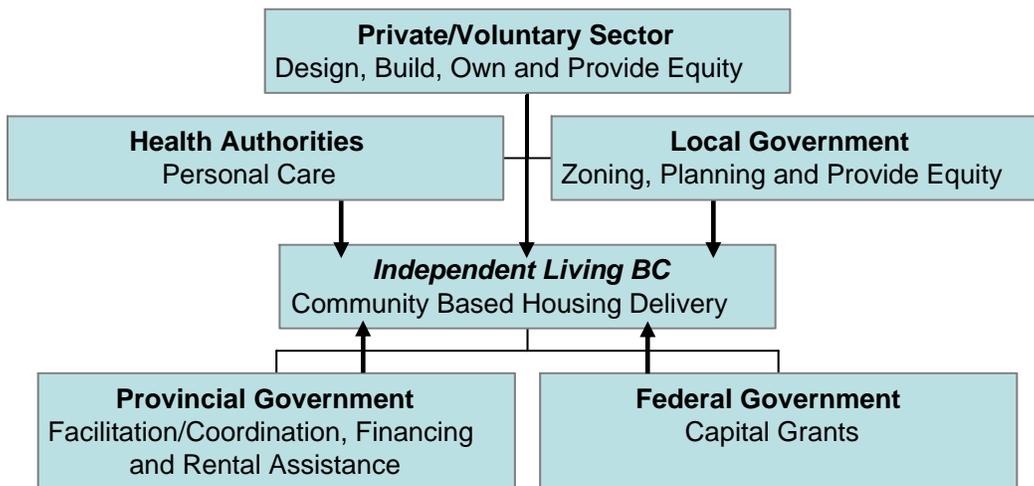
Source: McNeil, 2005

4.2.1 ILBC Partnerships

BC Housing collaborates with municipalities to identify locally driven, locally determined supportive housing development solutions. ILBC receives substantial funding for new bricks and mortar but existing infrastructure is first assessed for adaptability. ILBC, in partnership with regional health authorities, responds to community needs and works cooperatively (see Table 1) to draw resources together for assisted living project construction.

To qualify for ILBC housing, seniors must meet the minimum/maximum support service requirements. Under the Community Care and Assisted Living Act, two personal care services (ADLs) such as bathing, medication management or mobility assistance is the maximum. Much like LHINs in Ontario, the regional health authority refers low-income seniors for placement in subsidized assisted living facilities. After a needs assessment, a care plan is developed and appropriate housing, based on client eligibility, is selected (Thomas, *pers. comm.*, 2007). Seniors pay 70 percent of their after tax income to the housing provider. Any services beyond the maximum permitted must be paid for out-of-pocket (Cohen et al., 2005).

Table 1. Examples of Municipal Contributions to Supportive Housing in BC

Dawson Creek	Southview Housing Society 30 supportive seniors units	• Donated land and rezoned site • Provided new road to the site
Esquimalt	Esquimalt Lions Seniors Housing Society 40 supportive seniors units	• Equity contribution through tax exemption
Fort St. John	North Peace Health Council 35 supportive seniors units	• Donated the site • Subdivided and rezoned site at no charge
Kamloops	North Kamloops Building Society 32 supportive seniors units	• Provided a DCC refund
Midway	West Boundary Seniors Housing Soc. 20 supportive seniors units	• Donated land • Provided equity
Nanaimo	Nanaimo District Senior Citizens Housing Development Society 30 units for seniors	• Waived DCCs • Regional District also waived DCCs
North Vancouver	Quayview Housing Society 42 units for seniors, family and people with disabilities	• Leased land to Society at 50 percent of value • Contributed additional funds • Waived DCCs
Vernon	Okanagan Commemorative Pioneer Cultural Society 35 supportive seniors units	• Provided a DCC reduction • Greater Vernon Parks & Recreation District also provided a DCC reduction
West Vancouver	West Vancouver Kiwanis 77 supportive seniors units	• Provided land and equity

Source: McNeil, 2005

4.2.2 ILBC Linked Supportive Housing Model

ILBC is a linked model where seniors' rent and services are paid for at the same time. ILBC can be seen as a package deal that includes housing, case management and personal supports. Coordinated funding arrangements enable ILBC providers to offer housing and supportive care simultaneously. Linked supportive housing models are generally discouraged by Ontario's MOHLTC Supportive Housing Program, as tenancy tied to support services can cause unnecessary stress and housing insecurity. However, because the ILBC model originates in a transparent partnership between health and housing ministries and is often operated by non-profit housing providers with seniors' care expertise, it is logical and necessary for the payment formula to link housing and services.

Both the private and non-profit assisted living sectors use the phrase "hospitality services" in BC. Using this term for services such as shopping, meal preparation, laundry and homemaking implies that these are fringe or luxury services. Hollander and Tessaro's (2001) work points out that assistance with these basic personal support services is actually central to the maintenance of seniors' health, independence and dignity. Although this report will use the term "hospitality services" for consistency purposes in the BC context, the essential nature of personal support services is duly noted.

4.2.3 ILBC Outcomes

ILBC's outcome and target measurements are reported by regional health authorities. Most of the ILBC buildings are newly constructed. For example, in the Vancouver Coastal Health Authority area, only five sites had been open for more than two years in 2007. The "length of stay" indicator, which is useful to determine subsidized assisted living's role in aging in place, cannot yet be effectively evaluated. In the 2006/07 Vancouver Coastal Health Assisted Living Annual Report, half of the residents who left assisted living went into long-term care and one-third died of natural causes. The turnover rate of 15 percent indicates the relative stability of the resident population (Vancouver Coastal Health Authority, 2006-2007). Residents' profiles based on age, gender and medical conditions are also summarized in the report and confirm that the vast majority of seniors in need of housing and support services are females (73 percent) over the age of 85 (52 percent). It appears that outcome measurements for ILBC are quite broad and do not yet indicate the myriad benefits of assisted living housing options.

4.2.4 ILBC Summary

Subsidized assisted living facilities clearly fill a gap in the housing and care continuum. The ILBC program has made great strides in new development and waiting lists are minimal as many new units continue to come on stream (Thomas, *pers. comm.*, 2007). Over time however, ILBC's capacity for meeting low-income seniors' needs will be stretched in the face of a growing aging demographic. ILBC offers a case example of one synchronized housing and health strategy and implementation process that houses frail, low-income seniors. The essential nature of *all* options along the care continuum from home care to long-term care and policies to expand their implementation can lead BC to the forefront of a highly developed health and housing continuum model.

4.3 Seniors' Supportive Housing (SSH) Program

The Seniors' Supportive Housing (SSH) program was launched in the fall of 2007. It is meant to address a gap in the seniors' housing continuum (Kierszenblat, *pers. comm.,* 2007). The program modifies rental units in selected social housing buildings with the intention of allowing low-income seniors to age in place. It provides moderate levels of support services for seniors including one meal service per day if desired, "hospitality" services such as light housekeeping, laundry and grocery shopping, as well as accessibility retrofits to housing units designed to accommodate seniors' changing mobility needs. SSH also offers weekly opportunities for seniors to connect socially with other residents at game nights, movies, lectures, group outings and at seniors' centres.

The Seniors' Supportive Housing (SSH) program will be implemented exclusively in *existing* seniors' social housing buildings. The SSH will upgrade seniors' housing accessibility and safety by installing grab bars, smoke detectors, handrails and bright lighting. Whenever possible, showers will replace bathtubs as a falls prevention measure and levered handles will make doors and faucets easier to turn. SSH offers more moderate "hospitality services" than ILBC (BC Housing, 2007) and does so at minimal costs since the buildings to be retrofitted are already seniors dedicated buildings. SSH retrofits help ensure physical safety and security and may in turn decrease hospital visits due to preventable falls.

4.3.1 SSH Guiding Principles

SSH is another BC housing program designed to fill a gap along the housing and care continuum. The SSH program's guiding principles draw on the aging in place concept, in addition to these goals:

- increase supportive housing options for seniors;

- provide seniors with an opportunity to age in place;

- assist seniors to maintain their independence; and

- capitalize on existing investment in housing stock.

SSH will serve the dual purpose of retrofitting existing social housing stock and providing a moderate level of personal supports to seniors who need a bit of extra help in order to live independently. In total, 800 units will be adapted to SSH standards, depending on the needs of low-income senior residents. In 2001, the Ministry of Health and the Ministry currently responsible for housing (Ministry of Forests and Range) committed to the development of 5,000 seniors' care beds by 2008. The SSH program's renovated units will be included in that number and requires a modest budget allotment of $45 million over four years.

4.3.2 SSH and Intended Continuity of Care

Although SSH creates a much-needed option and increases the number of accessible units of BC's social housing stock, it does not completely promote aging in place because it is only one stop along the continuum of care. Seniors whose support service needs increase will inevitably have to move from one location to another, a situation that is widely noted to be difficult for

seniors' adjustment (Kucharska, 2004). The proximity of seniors' buildings considered for SSH program modifications to other options along the continuum of seniors' housing and care is a consideration in the SSH RFP process. This focus on integration partially reconciles the continuum versus aging in place dilemma. Strong linkages may already be in place between supportive housing providers along the continuum of care in some communities. The capacity for smooth transitions between supportive housing options is a potential challenge to the aging in place philosophy (Kierszenblat, *pers. comm.*, 2007). Aging in place requires multiple options that should be given equal weight when funding, development and quality of care targets are set out.

4.3.3 SSH Flexibility

SSH is funded by the province and was developed in collaboration with health authorities that helped identify that housing for people with non-clinical service needs should be enhanced. In some cases, BC Housing will manage buildings directly while others will be managed by non-profit housing providers. The SSH program director points out that the payment formula, as opposed to ILBC, will initially be more flexible for seniors who already live in social housing buildings. Since many seniors may be undecided about whether or not they would like personal support services, current tenants can try services for three months and then decide if they want to participate in the long-term. This model presents administrative complications but recognizes the importance of seniors' choices. Residents will be required to pay 50 percent of their after tax household income for SSH, 30 percent of which goes to housing and 20 percent of which goes to support services. All residents in the SSH program must qualify for RGI housing (BC Housing, 2007).

4.3.4 SSH Summary

The SSH program can be seen as a natural complement to the ILBC program. It offers many of the same "hospitality services" that home care programs are intended to provide. SSH offers coordinated services managed by the housing provider in a "one stop shop". This linked housing and supports model is the first step on the seniors' care and housing continuum. It demonstrates that a range of supports can both contribute to seniors' self-sufficiency and provide opportunities for decreased isolation through social and recreational activities.

4.4 Limitations to BC's Continuum of Care Model

BC's care continuum has not evolved without criticism. The development of the assisted living model in BC followed the beginning of the Provincial Health Ministry's de-institutionalization of seniors' health care. From 2001 to 2004, the BC government closed down 2,529 long-term care beds province wide. The government's original commitment to replace 5,000 long-term care beds that were housed in outdated, unsustainable facilities was amended (Cohen et al., 2005) to include assisted living units and supportive housing units in the count. These 5,000 beds will be constructed by the end of 2008 but will only house seniors who do not require intensive medical care. Seniors' complex care needs cannot be met in assisted living environments. When 24/7, professional nursing supervision is required, long-term care beds are necessary but have been rapidly eliminated in BC without equivalent alternative options for low-income seniors who cannot afford private nursing home care.

Less expensive housing and care combinations are replacing former long-term care beds. The loss of long-term care beds between 2001 and 2004 has placed significant pressure on other sectors in the health care system including alternative care beds and acute care beds in hospitals (Cohen et al., 2005), a dilemma Ontario is also faced with for different reasons. The assisted living units will increase choices for seniors who are capable of independence and self-directed care. However, there is an inherent contradiction when expansion on the continuum of care abandons one form of care for another. One housing choice cannot substitute for another. Long-term care beds provide medical necessities for people with complex care requirements. Assisted living buildings cannot provide this level of care and are characterized by a comparably low level of supervision and assistance. This cautionary note is an important lesson learned through the BC continuum of care program.

Although many analysts agree that a continuum of care is essential to seniors' well-being as their needs increase, the implementation strategy and principles that underlie a provincially initiated shift to supportive housing should be examined. Funding for assisted living in BC was directed to frail and elderly seniors through the provincial housing corporation. It has been argued that housing funding is being misallocated to fulfill a health care need rather than address the desperate shortage of affordable housing faced by most communities in BC. As the capital costs of subsidized assisted living facilities are financed through BC Housing, critics see this as the government shirking the duties of the health care system on to the already scantily resourced social housing sector (Irwin, 2004; Spencer, 2004; Cohen et al., 2005). The connection between health and housing is worth making again here. As seniors live longer than ever before, the responsibility to house and care for them appropriately can become a divisive issue as the two sectors may be seen to be in competition for funding. However, seniors' housing and health are overlapping, interrelated issues. It may be more useful to think of funding both simultaneously as a virtuous cycle that reaps social and economic benefits.

These cautions are derived from BC's supportive housing and assisted living programs:

- Loss of long-term care beds places pressure on other parts of the health care system.

- One housing and care choice cannot substitute for another further along the continuum.

- Supportive housing programs can be seen as an unfair distribution of housing dollars to fulfill health care needs.

- The essential nature of *all* options along the care continuum from home care to long-term care must be recognized.

4.5   Summary of BC's Supportive Housing Programs

It is undeniable that there is an increasingly urgent need to supply supportive housing options along a continuum. Housing and health programs must respond in the form of comprehensive, integrated approaches that synchronize health and housing funding with development to effectively meet both needs at once. Lessons from BC's supportive housing programs can serve to guide Ontario's supportive housing development:

- Operating, capital and service funding commitments must come at the same time.

- Close partnerships between health and housing authorities in policy and implementation are crucial.

- Different types of supportive housing fill gaps along the continuum depending on ADL and IADL services provided.

- Supportive housing can be created from existing social housing stock.

- Investment in new supportive housing stock contributes to long-term sustainability of continuum of care.

- More housing and care options relieve pressure on the health care system.

- Careful consideration of location and proximity to other care options is necessary.

The experiences of the ILBC and SSH programs cautions against a search for a seniors' health and housing magic bullet. The critical role of long-term care for people with complex care needs is clear. However, programs that offer "hospitality services" and a moderate level of ADL personal supports are also vital to fill the gaps between independent living and institutionalization. Economies of scale in supportive housing facilitate a reduction in health care expenditures. As Ontario's health care transformation for seniors' care proceeds, compelling programmatic examples from BC offer insight into the many forms that supportive housing can take in the context of developing diverse choices for seniors along the housing and support service continuum.

5. Policy Recommendations

Common threads drawn from the literature reviewed, lessons from case studies in Ontario and British Columbia, and many conversations with key informants regarding the challenges they face in implementing more supportive housing programs form the basis of the policy recommendations suggested in the following section. Recommendations rely on innovative, successful and cost-effective seniors' housing and care solutions explored throughout the report. Methods employed in different regions of Ontario, in other Canadian provinces and internationally establish a diverse foundation to build future supportive housing options for low-income frail seniors in Ontario. Integration and coordination have proven themselves to be vital components in the development of a comprehensive continuum of housing and care for seniors. Supportive housing, the "hidden gem" with the potential to alleviate pressure on long-term care and alternative care beds in hospitals, can be revealed to all levels of government as an attractive solution. Low-income seniors and their families, faced with limited choices for aging in place with dignity and independence, stand to benefit from additions to Ontario's health and housing care options.

The following suggestions are informed by interview responses from key informants, provincial, national and international literature and successful case examples that can offer insight into how supportive housing can be expanded and improved province wide:

1. **Form an inter-ministerial committee to address both housing and support services** for new supportive housing development for seniors. The Ontario Ministry of Municipal Affairs and Housing (MMAH) and the Ontario Ministry of Health and Long-Term Care (MOHLTC)

should work closely to coordinate programs and funding to expand Ontario's current supportive housing stock.

2. **Develop policy initiatives through the MMAH and the MOHLTC that bring together social housing providers and Local Health Integrations Networks (LHINs)** to facilitate greater coordination and integration of care for low-income seniors.

3. **Coordinate funding for capital, operations and support services and release it as a package**, similar to British Columbia's supportive housing program examples. This will help streamline the patchwork of service delivery due to limited funds, reduce the number of seniors on waiting lists for supportive housing, and address the imbalance of supportive housing available across the province.

4. **Review the MOHLTC Supportive Housing Program and revise it to increase flexibility.** The program was established in 1994. LHINs are likely to list supportive housing as a top priority in many regions. Program revision could increase access and resources for supportive services in the future.

5. **Disburse the MOHLTC home and community care funds for wrap around, client-centred services that encourage aging at home.** Allocate funding appropriately and adequately to home care, prevention programs, community support services, supportive housing, long-term care and post-acute care.

6. **Continue to build partnerships between supportive housing programs and universities** that foster research and present empirical evidence on the impacts of supportive housing for seniors that is needed to influence policy.

7. **Create a consistent indicator system** for province-wide implementation that measures outcomes and builds data on supportive housing benefits and costs in Ontario.

8. **Implement a moderate supportive housing program**, such as the Seniors' Supportive Housing Program in BC, to retrofit existing social housing stock for accessibility and add community support services such as homemaking and meal preparation.

9. **Develop a standardized system to track existing supportive housing and new development** that complements municipal governments' tracking of their seniors' housing portfolios. A centralized information system with accurate information that uses consistent terminology would serve seniors, local governments, health care providers, policy-makers and social housing managers.

10. **Consider conversions to supportive housing,** particularly in rural areas that may be "over bedded" with long-term care and retirement home beds. Private rooms can be converted to subsidized supportive housing units and are more cost-effective to maintain.

11. **Review the home and community care selection process in rural areas** to ensure that providers are chosen that are best suited to the community. Home care organizations familiar with seniors' barriers to aging in place in rural areas have the capacity to serve seniors best.

12. **Assess needs for supportive housing in rural areas and other underserved areas of Ontario** and prioritize new development in these locations. Diverse partnerships are needed to make supportive housing possible in rural locations and should be encouraged to reduce the financial deficit due to a lack of economies of scale.

13. **Encourage local, cross-sectoral partnerships for supportive housing education and awareness, planning and operations.** The more that housing, health and support service sectors are actively engaged in supportive housing development, the more that integrated, holistic models can be realized at the local level.

14. **Avoid substitution of one housing and care combination for another.** Support for the essential role of *all* housing and care options along the seniors' supportive housing continuum is crucial to a successfully integrated health, housing and support service system for seniors.

15. **Consult with supportive housing providers, health and support services professionals, housing managers, seniors and other stakeholders to develop a common framework** that can be applied consistently across the province for supportive housing implementation.

Conclusions

Policy directions that recognize the interdependency of health and housing policies can lead to good, comprehensive social policy. Supportive housing options along a continuum of seniors' housing and care are crucial to Ontario's communities in light of a rapidly aging seniors' population, particularly in the oldest age groups. In Denmark, the same type of demographic transition started in the mid 1980s. The Danish government made a philosophical shift in the way elderly people were housed and cared for through the de-institutionalization of seniors back into the community. The shift was well planned and resourced and is noted internationally for its preventive measures as well as the value it places on seniors' independence and dignity. Ontario too may be ready for a philosophical shift that places seniors' quality and variety of care as central to an aging at home policy. Low-income seniors who often experience greater health risks and vulnerability due to their inability to privately purchase the care they need would gain safety, comfort, independence and the right to choose the housing and care that best suits their specific needs. A philosophical change in our perceptions of aging requires advocacy coupled with a government commitment to appropriate funding allocations across the housing, health and support services sectors.

We know that challenges lie ahead in how to house and support our most vulnerable seniors' populations. However, we also know that there are several options that meet seniors' housing and health needs effectively while saving taxpayers' money that would otherwise go to subsidize other more costly and more intense levels of care. If we plan ahead and allocate appropriate

resources for all of the options along the continuum of care, we can begin to realize a more integrated, holistic approach to seniors' health and housing.

Indeed, supportive housing programs cannot grow without funding for bricks and mortar development that is insufficient at present. The Ontario Local Health Integration Networks (LHINs) are largely focused on integration and coordination across a continuum of health and support services. Supportive housing figures prominently on the continuum of care and is proven to be cost-effective when providing equivalent levels of care to seniors who need support with day-to-day routines. To build more housing, the Ministry of Municipal Affairs and Housing will need to fund new supportive housing developments and work in close partnership with the Ministry of Health and Long-Term Care to build a framework that can be applied consistently across the province for supportive housing implementation. Outreach, education and prevention programs also require consistent information and communication regarding options available, in this case to low-income, frail seniors.

Although many reports and studies state the benefits of a range of supportive housing models, future research on outcome measurements can provide quantitative evidence to bolster the policy argument. Qualitative studies on aging in place for seniors in rural areas would provide insight on the unique needs of seniors' populations in rural locations and what has and has not worked could be applied to the Ontario context. When LHINs begin to implement their service plans, it would be worthwhile to investigate how supportive housing for low-income seniors is pursued and what, if any, the successes are. On a larger scale, a feasibility study for the development of a national supportive housing framework for low-income seniors in Canada could help shape less fragmented policies amongst the provinces and territories. Finally, immigrant seniors' housing and care needs to be examined, as this diverse population will continue to expand substantially in Canada.

The time to pro-actively address pressing gaps along the housing and care continuum is upon us. A combination of funding to expand options, a philosophical commitment to aging in place and coordinated integration across sectors can foster effective policy and implementation to solve the complex challenges that lie ahead as we continue to see increased numbers of older population cohorts across Canada.

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Appendix A. Sample Interview Schedule

1. What are some strategies that can assist in keeping seniors in their subsidized units and out of long-term care?

2. How do you define supportive housing for seniors?

3. Please tell me a little about the work you've done regarding supportive housing for seniors.

4. What are some trends (nationally) regarding seniors' supportive housing?

5. What is the role of supportive housing on the care continuum? Do policy-makers understand what supportive housing is and what is necessary to increase its occurrence?

6. What are the obstacles that may stand in the way of implementing a comprehensive, integrated housing and supportive services strategy (at the provincial level)?

7. What are some ways that funding for more bricks and mortar could be secured for seniors' supportive housing?

8. What role does policy have in developing evidence for seniors' supportive housing?

9. How can research on supportive housing lead to action that affects policy and implementation?

10. What is the role of the housing service manager in providing supportive housing to low-income seniors?

11. What kinds of barriers do low-income seniors face in terms of aging at home?

12. What are your thoughts on aging at home/aging in place in terms of a policy direction?

13. What are the barriers/challenges to aging in place?

14. Opportunities?

15. What are the obstacles to providing low-income seniors appropriate housing with the supports they need?

16. How are outcomes measured in supportive housing case examples that you can think of?

17. What kinds of outcomes influence policy and make a case for expansion?

18. What changes would you make to current policies in Ontario so that low-income seniors could live in their communities safely and affordably?

19. What does Ontario do well regarding supportive housing? What could we do better?