

Innovative Strategies for Inter-sectorial Collaboration between Mental Health, Housing, and Health Care

Report of a Stakeholder Dialogue

December 2018

PREPARED BY:

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(WIHV) *in collaboration with:*

Population Health Solutions Lab

VHA Home HealthCare

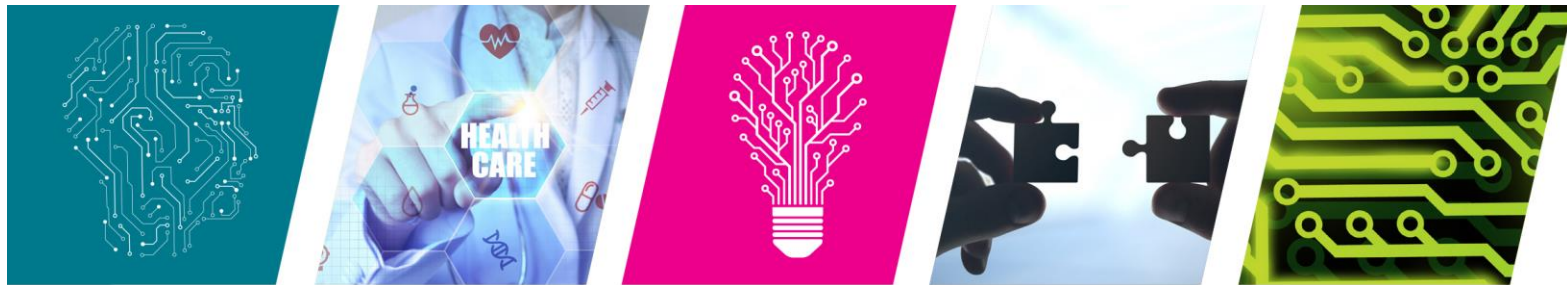
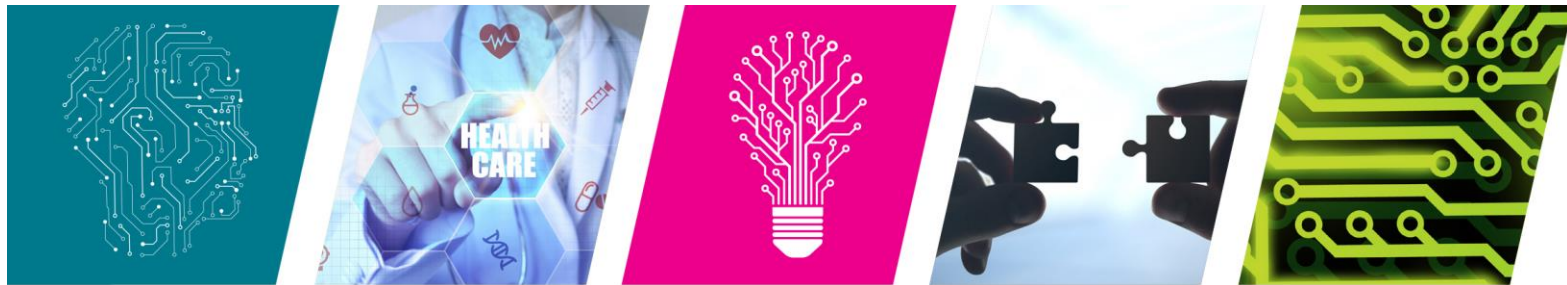


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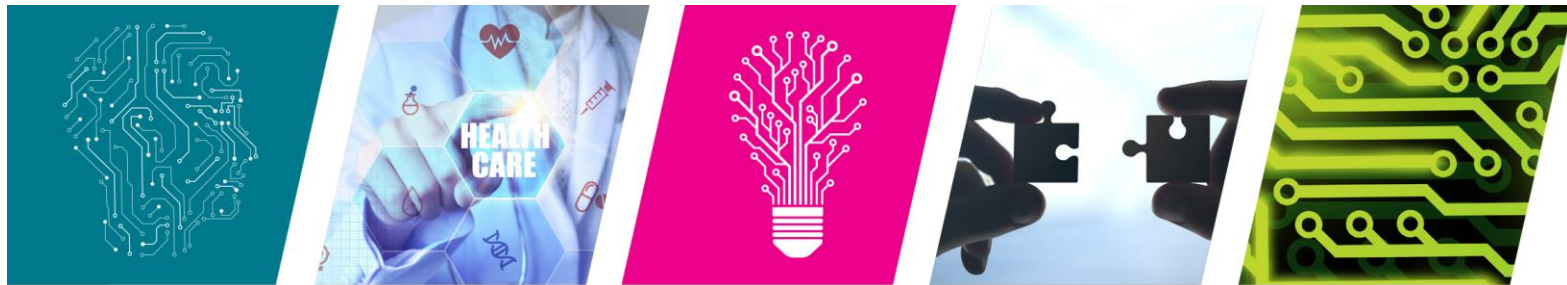


ACKNOWLEDGEMENTS

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With special thanks, the organizing committee included:

- Pauline Pariser
- Sophia Ikura
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EXECUTIVE SUMMARY

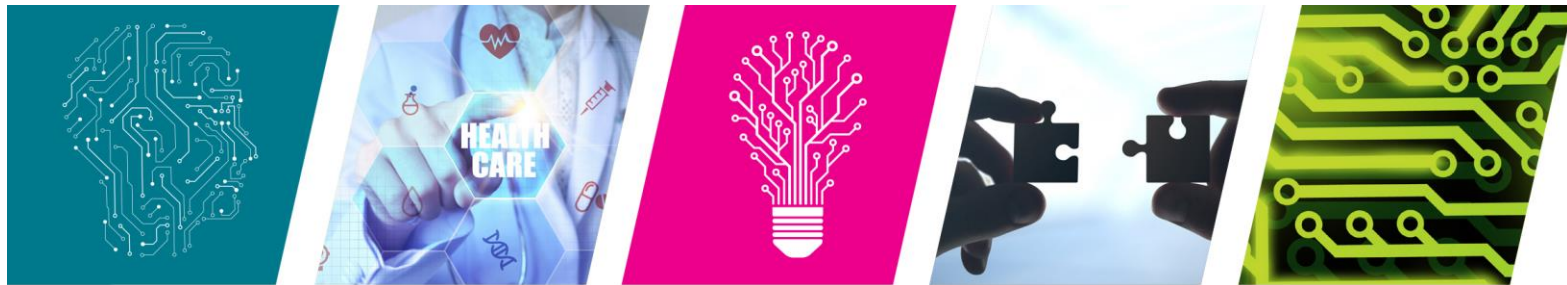
There is growing consensus that the key to achieving better system and health outcomes in part depends on our ability to address the complexity of circumstances for people whose needs are characterized as both medical and social. People who have multiple medical diagnoses including mental illness, difficulty finding and maintaining a stable housing situation, and who lack other social supports are often not well served by the health system. For example, a 2015 report published by the Ontario Hospital Association (OHA) suggested that among those patients designated Alternate Level of Care (ALC) who waited longer than 30 days for more appropriate care, 16% occupied mental health beds¹.

The solution to this challenge lies in supporting these people better *outside* of hospitals, and our paper presents concrete steps for stakeholders in our system to work toward achieving that goal. In order to realize adequate housing for populations who require care for complex health and social needs, we also echo the call of the Wellesley Institute in their 2017 report and others in Ontario for much greater investment in supportive housing²: Adding 30,000 supportive housing units over the next 10 years.

This paper reports on a symposium co-hosted by the Women's College Hospital Institute for Health System Solutions and Virtual Care (WHV), VHA Home Healthcare and the Population Health Solutions Lab to address policy and system issues associated with the interface between health care, mental health, and housing. The **purpose** of this paper is to present the important insights that emerged from the symposium, describing concrete action items that will help to improve care for people with complex needs in the community.

¹ Ontario Hospital Association. (2015). Long-Stay Alternate Level of Care in Ontario Mental Health Beds. Toronto, ON: Ontario Hospital Association.

² The Wellesley Institute. (2017). A Supportive Housing Strategy for Mental Health and Addictions in Ontario. Toronto, ON: The Wellesley Institute.



KEY THEMES

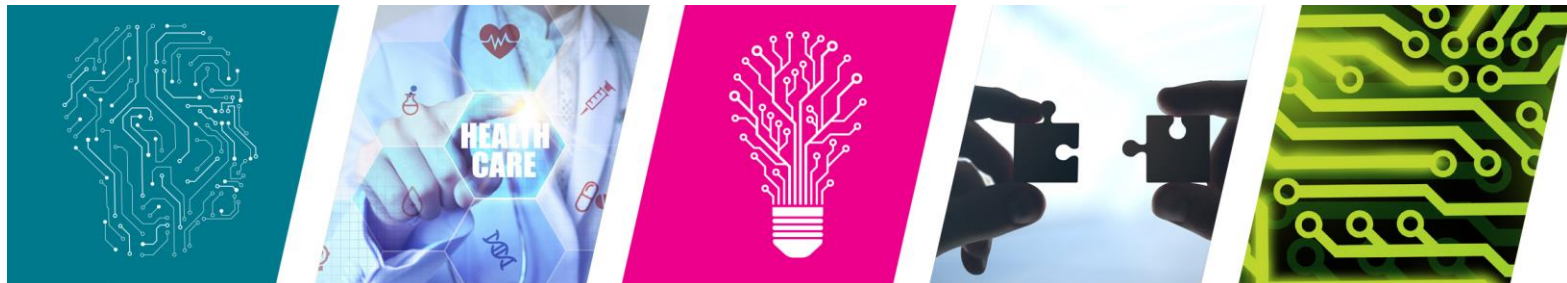
Over the course of the symposium several themes emerged highlighting possible solutions to some of the most pressing issues identified.

1. *Employ people with lived experiences and work with them to co-design services.*

1. Support and fund peer worker programs. Peer education accelerates the recovery of those with lived experiences by providing them with valuable and meaningful work opportunities. It also has the dual benefit of supporting the people they work with as well as informing providers, who often do not have personal experience to inform their practice.
2. People with lived experience of complex health and social needs should be engaged in any innovative initiative involving community support services, including those intended to contribute to ending hallway medicine.
3. Where people with lived experience of complex health and social needs are engaged in innovation initiatives, the engagement process should follow a culturally safe, trauma-informed approach to ensure that people feel safe engaging and sharing their stories and insights. Engaged populations should always be compensated for their time contributing their experiences and insights.
4. The best approach to ensuring that solutions address the complexity of the lived experience, is to include service users in both problem definition and the development, testing and refinement of solutions.

2. *Review or simplify institutional policies and rules that do not support people-centered care.*

1. Organizations should engage their boards of directors and senior management teams in an effort to identify operational rules and procedures that might interfere with people-centred care and innovation. Where appropriate, leaders can promote discussion about rules that present as a barrier to effective care for individuals and families. This dialogue should include a willingness to contravene rules or remove rules altogether when they clearly interfere with innovation, as long as staff and service users remain safe and their work protected.
2. Managers from different ministries and social service sectors should convene to discuss and resolve policy challenges that might unintentionally inhibit the



progress of service users. For example, eligibility for housing and social supports are linked, such that changes in eligibility for one service might affect the other. Reviewing instances where such connections between policies lead to negative unintended consequences can inform more innovative approaches to managing supportive services.

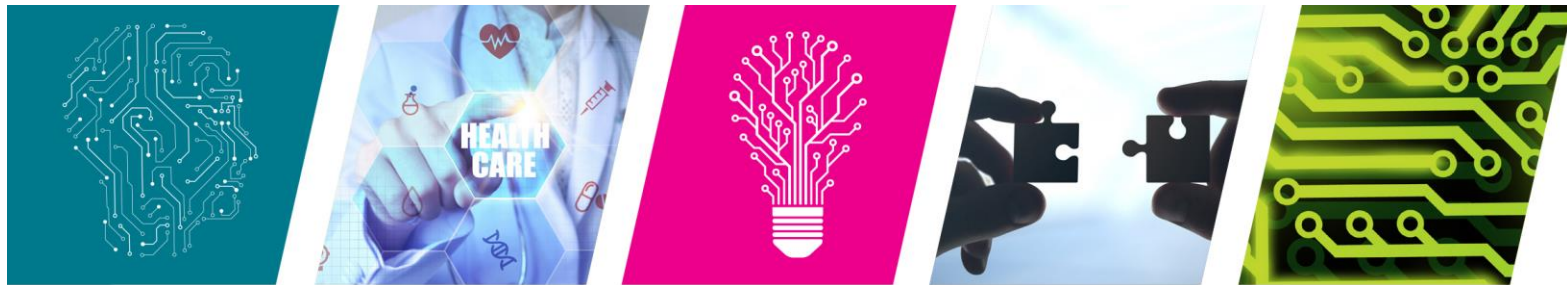
3. The provincial and municipal governments should commit to reviewing privacy policies. This would include clarifying policies related to information sharing, and particularly the transfer of information about people. In cases where information sharing does not breach policy and would promote improved care, education about how to do so should be provided. In these instances, data should be shared with appropriate controls.

3. Look at novel ways of working together (Governance).

1. Health, mental health, and community-based organizations should identify concrete opportunities to work together, bidding on particular projects as collaboratives. Trust is often built through such collaboration, which can then lead to more formal collaborative arrangements.
2. Organizations should identify opportunities for “street level” collaboration between health care providers and social service providers. Ultimately, providers working together to better serve people will drive better outcomes for people with complex needs.
3. Governments should seek to promote collaborative approaches to bidding for contracts for services and other new programs arising to meet complex needs. Such collaborations could include health care providers working with community-based organizations and municipally organized services.

4. Use innovative funding models that more efficiently enable improved outcomes.

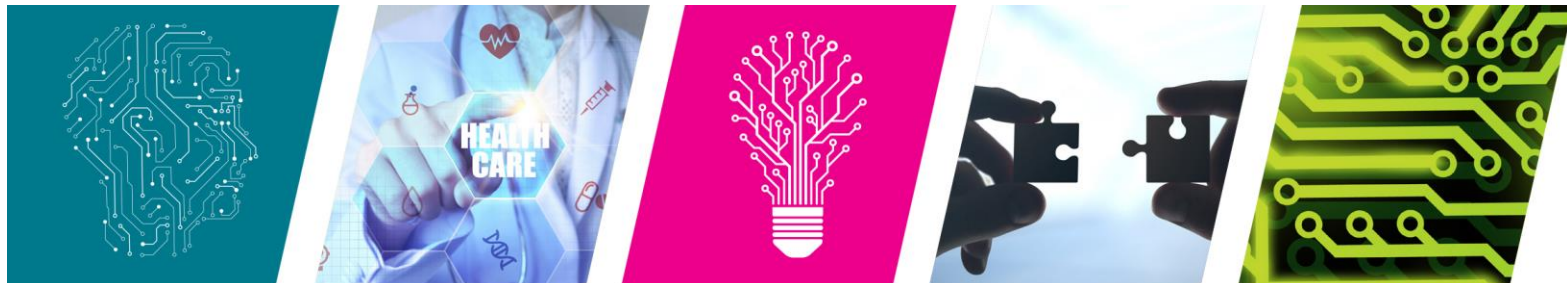
1. Strike a working group comprised of governmental agencies (including municipal, sub-regional, LHIN, provincial, or federal organizations) with the specific focus of identifying possible strategies to align funding programs across those agencies. Tasks could include identifying possible instances where Requests for Proposals (RFPs) from different agencies can be aligned during the calendar year to encourage collaboration.
2. Where possible, identify strategies to invest in upstream funding that can reduce the burden on hospitals by better meeting peoples’ complex needs. Upstream



interventions that would benefit from additional funding include affordable and supportive housing, mental health and addictions programs and community-based skills and education programs. By investing in these strategic upstream areas, it will be possible to complete small tests of change that serve to justify larger future investments.

3. Pilot innovative funding models that are geared towards the outcomes of stable and appropriate housing and improved mental health. Allow local provider organizations more flexibility to collaborate and deliver services in innovative ways. Align evaluation of outcomes with the approach to the innovation determined by local parties.

Accomplishing these goals is no simple task, but will be a part of any successful initiative to invest in people with complex health and social needs who are not well served by the health system. Doing so successfully will require a combination of efforts to scale and spread known innovations, along with the promotion of locally-driven, collaborative innovation. Ultimately, striking this balance requires strong leadership and commitment to addressing the overarching challenges associated with truly complex health and social needs.



INTRODUCTION

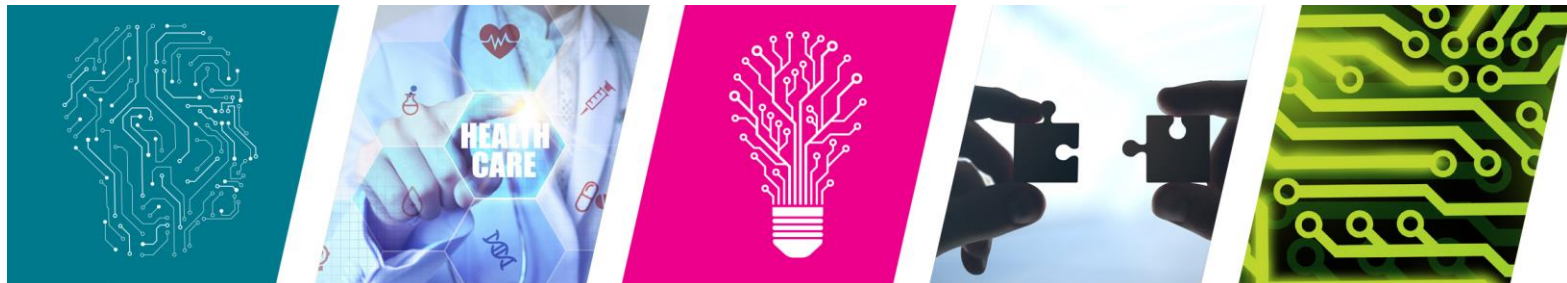
Making improvements to the provincial health care system is a persistent priority for Ontarians. There is growing consensus on a number of the mounting challenges to large-scale improvements in health care, many of which are rooted in the complex medical and social needs of those people who require the most care. Where people have multiple medical diagnoses, less support at home, mental health challenges, and difficulty finding affordable or sustainable housing, they are more likely to frequent emergency rooms and are repeatedly readmitted to hospital³. This basic scenario contributes to the “hallway health care” challenge facing Ontario hospitals. However, with improved upstream community-based care and support, most notably improved access to housing, these people could better manage their needs in the community.

Research from Ontario shows that people who cost the health system the most money are more likely to be from lower socio-economic status groups³. People who are homeless in Ontario are 8 times more likely than non-homeless people to visit emergency rooms, 4 times more likely to be admitted to hospital for medical or surgical reasons, and 9 times more likely to be admitted for psychiatric reasons⁴. The needs of people who are homeless and have other complex social challenges contribute to overreliance on emergency departments and subsequently lead to unplanned admissions which burden already resource constrained hospitals. In this white paper, we address these complex challenges, with a special focus on how stakeholders across the health care system, mental health services, supportive housing, and other social services can work together in innovative ways to improve access to housing, improve health outcomes and reduce the strain on the health care system. The current Government’s announcement of investments of \$1.9 billion over 10 years in mental health care in Ontario is an excellent start, and this investment will need to be used wisely in order to maximize its impact on the system.

This paper reports on a symposium co-hosted by Women’s College Hospital Institute for Health System Solutions and Virtual Care (WHV), VHA Home Healthcare and the Population Health Solutions Lab to address policy and system issues associated with the interface between health care, mental health, and housing. This symposium built on the previous work of these groups and others, situating the dialogue in recent health policy developments in Ontario and around the world related to taking a stronger focus on population health at local levels. Four overarching themes representing the dialogue

³ Rosella, L., Fitzpatrick, T., Wodchis, W., Calzavara, A., Manson, H. and Goel, V. (2014). High-cost health care users in Ontario, Canada: demographic, socio-economic, and health status characteristics. *BMC Health Services Research*, 14(532).

⁴ Hwang, S., Chambers, C., Chiu, S., Katic, M., Kiss, A., Redelmeier, D., and Levinson, W. (2013). High utilizers of emergency health services in a population-based cohort of homeless adults. *American Journal of Public Health*, 103(2).



that took place at the symposium, were identified. This paper represents a summary of those themes, and outlines essential steps to ending hallway medicine by properly addressing the needs of people who require the most care.

BACKGROUND

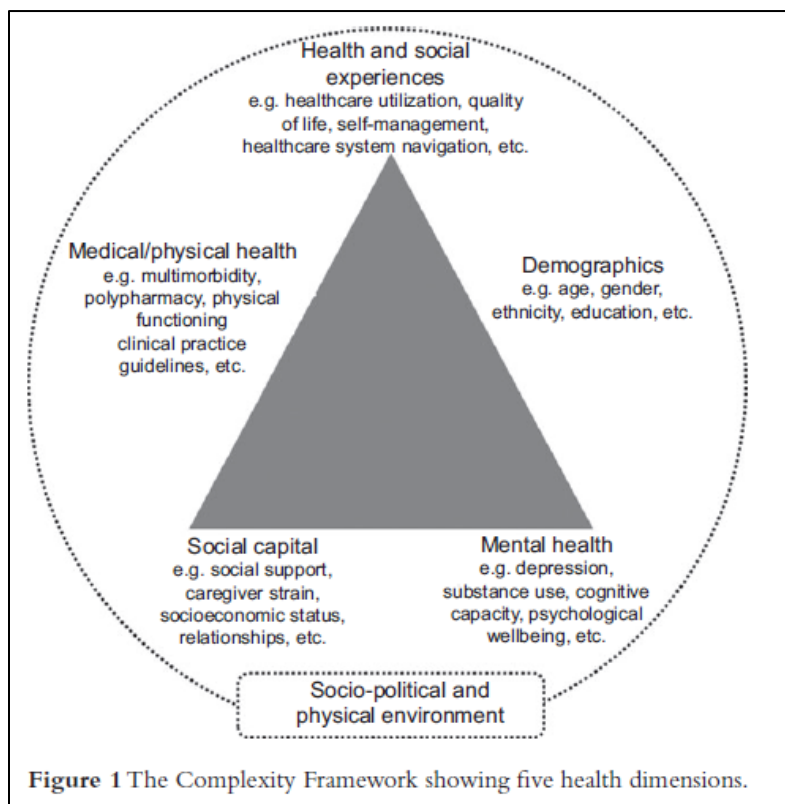
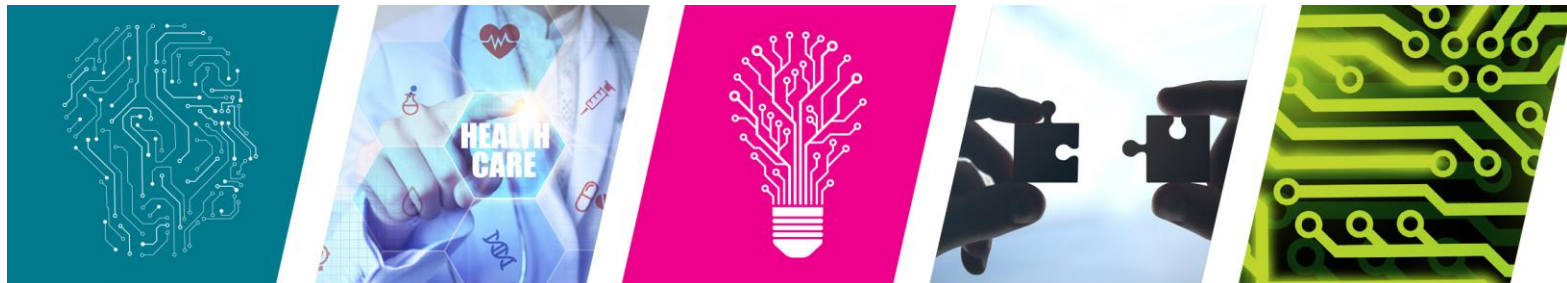
The term “multi-morbidity” is used when a person has two or more chronic health conditions, a concept that is distinct from “co-morbidity”. Co-morbidity is defined as “the co-occurrence of multiple long-term or chronic conditions where no single disease is considered the index condition”.⁵ In this scenario, no single condition is most important, and there may be an interaction between physical, mental health, and life circumstances that further complicate the severity of any given condition.

The prevalence of multi-morbidity is growing in Ontario. Researchers in Toronto, Ottawa and Waterloo showed that the prevalence of multi-morbidity in the Ontario population grew from 17.4% in 2003 to 24.3% in 2009, stating that this rate would likely continue to rise with an aging population⁶. However, as mentioned with the term co-morbidity, multiple health conditions are only part of the story. The most complex patients are those that not only have multiple health conditions, but also experience challenges in other domains. Based on a review of the literature, another group of researchers explained that “patient complexity” really depends on multiple domains, including demographics, mental health, social supports, medical health, and health-related behaviours⁷. Their proposed model is presented in Figure 1.

⁵ Boyd C. and Fortin M. (2010). Future of multimorbidity research: How should understanding of multimorbidity inform health system design? *Public Heal Rev.* 32(2).

⁶ Pefoyo, A., Bronskill, S. Gruneir, A., Calzavara, A., Thavon, K., Petrosyan, Y., Maxwell, C., Bai, Y., Wodchis, W. (2015). The increasing burden and complexity of multimorbidity. *BMC Public Health*, 15(415).

⁷ Schaink, A., Kuluski, K., Lyons, R., Fortin, M., Jadad, A., Upshur, R., Wodchis, W. (2012). A Scoping Review and Thematic Classification of Patient Complexity: Offering a Unifying Framework. *Journal of Comorbidity*, 2(1).

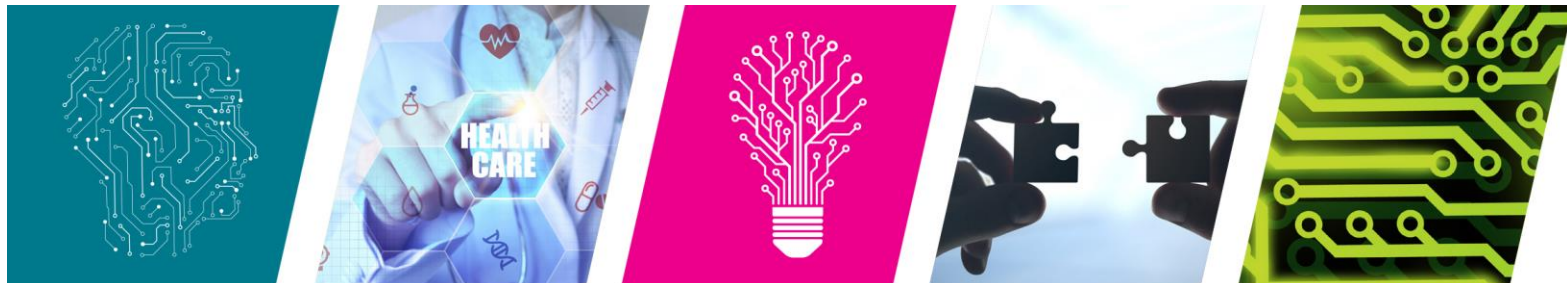


As greater numbers of people experience health-related challenges across more than one of these domains, the capacity of Ontario’s health care system to serve the needs of these populations will need to be enhanced. One challenge that will be particularly important to address is persistent discrimination against people living with mental health and addictions, both within and outside of the system⁸. Educating health and social service providers about stigma and a “trauma-informed” approach to care can help to address this important challenge.

Access to safe, good quality housing is a requisite for achieving improved health and mental health; the World Health Organization’s Ottawa Charter for Health Promotion considers housing to be a “fundamental condition and resource for health”⁹. However, affordable and transitional housing is limited across Ontario and especially in dense urban areas such as Toronto. *Turning the Key*, a Mental Health Commission of Canada report from 2012 indicated that there were between 40,000 and 134,000 people in Ontario with a serious mental illness who were inadequately housed or in core housing

⁸ Canadian Mental Health Association Ontario. (2014). Housing and Mental Health. Retrieved from: <https://ontario.cmha.ca/documents/housing-and-mental-health/>.

⁹ Wellesley Institute. (2012). *Housing and health: Examining the links*. Toronto, ON: Wellesley Institute.



need.¹⁰ In 2017 over 4000 new people applied for supportive housing but it was granted to less than 600 people¹¹. While shelter systems are critical intermediary resources for homeless populations to receive crucial services, improving access to subsidized, affordable and transitional housing is paramount in order for people to achieve improved health and stability and ultimately require less support from acute services such as hospitals.

Health care across Canada was developed on a model that focuses primarily on hospitals and doctors¹², meaning that many of the issues mentioned above are not considered to be the business of the formal health care system. However, greater integration between health, housing and social care is critical in addressing the factors which shape health and can prevent inappropriate use of the health system from the outset.

Over the past several years, policy initiatives have been developed in countries around the world in order to enhance the ability of health care and social services to address these growing demands. Furthermore, recent research shows that the greater the amount of spending on health and social services, the better the outcomes for these and other people^{13,14}. However, the challenge is not simply to find more funds to devote to these important public services; instead, it is to identify innovative ways to organize and deliver services that better address the complex needs of the people who most require help, including the redirection of funding towards upstream interventions such as housing. These innovations were the focus of our symposium and this white paper. Below are three examples of past and current innovative delivery models, which meet the specific needs of these populations through thoughtful organization of services, program coordination, and more in-depth engagement with these populations.

Innovation Spotlight #1: Housing First (Chez Soi)

“Housing First” was an innovative approach to addressing the needs of homeless people living with mental health or addictions issues. The program developed out of the

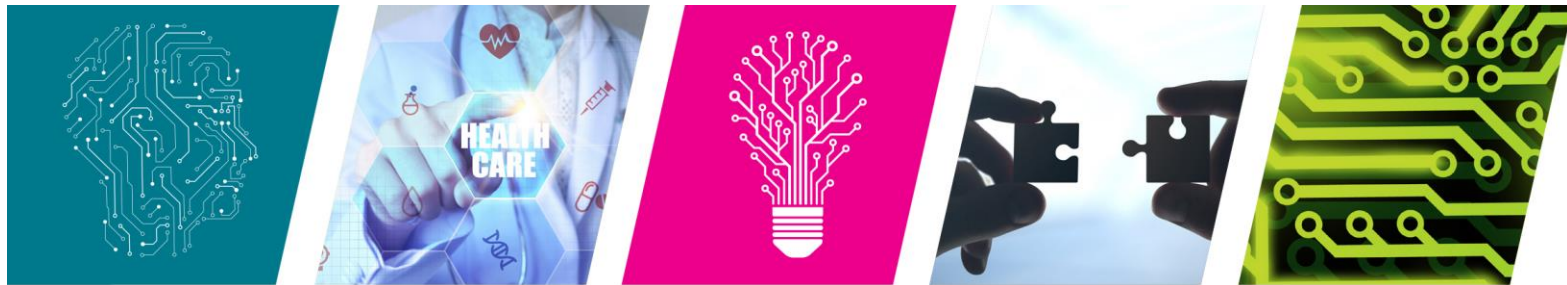
¹⁰ Mental Health Commission of Canada. (2012). *Turning the Key*. Toronto, ON: Mental Health Commission of Canada.

¹¹ Sirotych, F., Durbin, A., Suttor, G., Um, S., and Fang, L. (2018). Seeking Supportive Housing: Characteristics, Needs and Outcomes of Applicants to The Access Point. Toronto, ON: The Access Point.

¹² Tuohy, C. (1999). *Accidental Logics: The Dynamics of Change in the Health Care Arena*. New York: Oxford University Press.

¹³ Papanicolas, I., Woskie, L., and Jha, A. (2018). Health Care Spending in the United States and Other High-Income Countries. *Journal of American Medical Association*, 319(10).

¹⁴ Dutton, D., Forest, P.G., Kneebone, R., and Zwicker, J. (2018). Effect of provincial spending on social services and health care on health outcomes in Canada: an observational longitudinal study. *Canadian Medical Association Journal* 190(3).



Pathways to Housing Program in New York City in the 1990's, and is based on four central principles (Aubry et al, 2015):

1. Program recipients are given access to housing as a first priority, regardless of whether they choose to adopt treatment or eliminate substance use.
2. Medical services are offered to program recipients, but their housing is not dependent on whether they obtain medical care.
3. There is a “recovery” orientation to services, meaning that health and social services providers recognize that progressing away from addiction or mental health challenges requires time and particular kinds of ongoing support.
4. Identifying ways to integrate program recipients into the community is a priority.

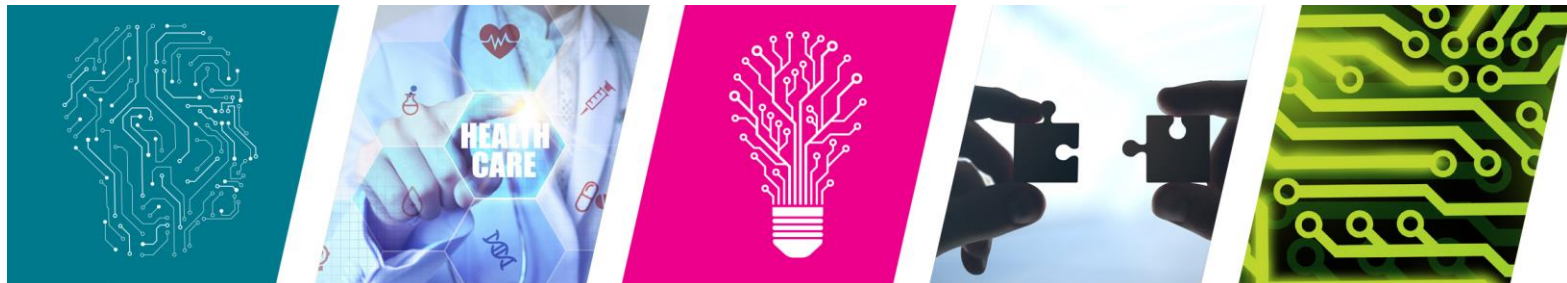
Housing First was implemented in five Canadian cities over the course of several years, beginning in 2008 and funded by the Conservative Federal government in power at the time. The program has been celebrated for its successful implementation, leading to significant improvements in housing stability, community functioning, and quality of life.¹⁵ These outcomes all help to reduce the likelihood that people with the complex needs described above will end up in hospital with nowhere to go. Housing First has been adopted as a best practice across Canada at the federal, provincial and municipal levels.

In order for a program like housing first to be successful, a great deal of collaboration between sectors is necessary. Health care providers must be armed with the knowledge of existing social support programs in place when people with complex needs show up to hospitals and other health care facilities, so that they are readily able to refer these populations to the right resources at the right time. Mental health providers must commit to collaborating with community support agencies, and both types of organizations must work together to support people with histories of sleeping on the streets to seek out new habits when housed. Across the entire spectrum of health and social services, people must try to build relationships with people seeking services and acknowledge the complex challenges in changing lifestyles and sustaining that change.

Innovation Spotlight #2: Ottawa Inner City Health

A second innovative example highlights the importance of collaboration, but in a different way. Ottawa Inner City Health provides a highly unique service for people experiencing chronic homelessness alongside mental health and other medical issues. A multisectoral team of health and social care providers established this program having

¹⁵ Aubry, T., Nelson, G., and Tsemberis, S. (2015). Housing First for People With Severe Mental Illness Who Are Homeless: A Review of the Research and Findings From the AT Home-Chez soi Demonstration Project. *Canadian Journal of Psychiatry* 60(11).



witnessed that the formal health care system could simply not address the real needs of people living with homelessness. In order to better understand what people needed to promote their health under such conditions, people with lived experience were engaged in the planning and governance of this service. The service would help to reduce the harms of substance use and make medical care available when necessary, all under the guidance of a committee of community members who could help to make decisions about the structure and function of the service. This service model has been scaled up across Canada and has been implemented successfully in the Netherlands.

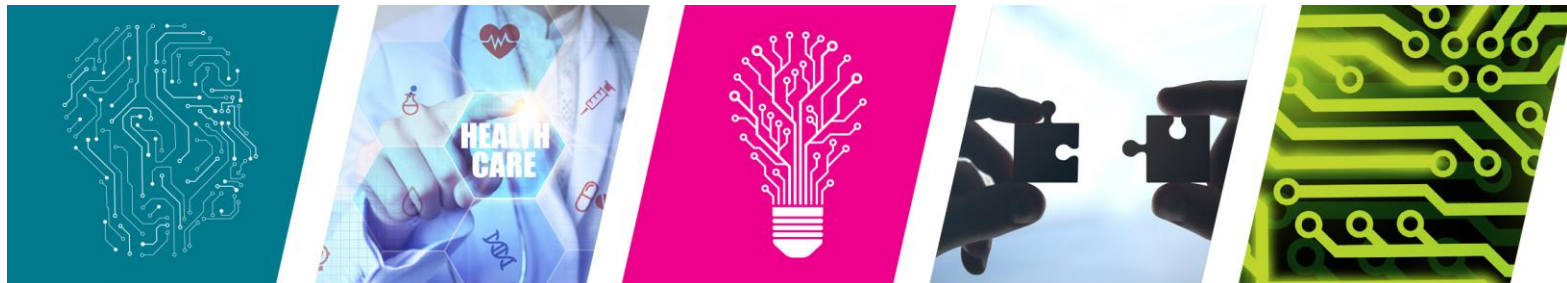
This program was operationalized by health and social care providers and administrators who undertook the planning and set up of the service, but it emphasized as a first priority a deep commitment to embedding the narratives and ideas of people living under the conditions of homelessness. This collaborative approach is a fundamental underpinning for successful efforts to end hallway medicine.

Innovation Spotlight #3: The Toronto Supportive Housing Growth Plan

A current partnership between the Toronto Alliance to End Homelessness (TAEH), the Canadian Mental Health Association (CMHA) Toronto Branch, and the Wellesley Institute is working to develop a comprehensive, evidence-based, consensus-based plan to expand the supportive housing system in Toronto over the next 3 years. This stakeholder group recognizes the need for a collaborative and integrated approach, and spans the health and housing sectors. Jointly, they aim to identify ways to coordinate activity across sectors and resource inputs such as planning, funding and the municipal approval process. Specifically, they will review existing research and propose supportive housing solutions; identify policy linkages and engage relevant LHIN, provincial ministry and City staff; identify the capital and operating funds required for this work and propose an implementation plan that takes into account the need for a robust municipal approval process. The planning phase of this work is expected to be carried out in 2019, and will be a crucial next step for action on enhancing the collaboration between health care, mental health, and supportive housing.

THE SYMPOSIUM

The symposium was held on March 21st, 2018 at Women's College Hospital. The symposium took place under Chatham House Rules, and as such, the identities of the people in attendance at the symposium were withheld in order to promote honest, and constructive dialogue. There were 62 people in attendance throughout the day, representing the following groups and sectors:



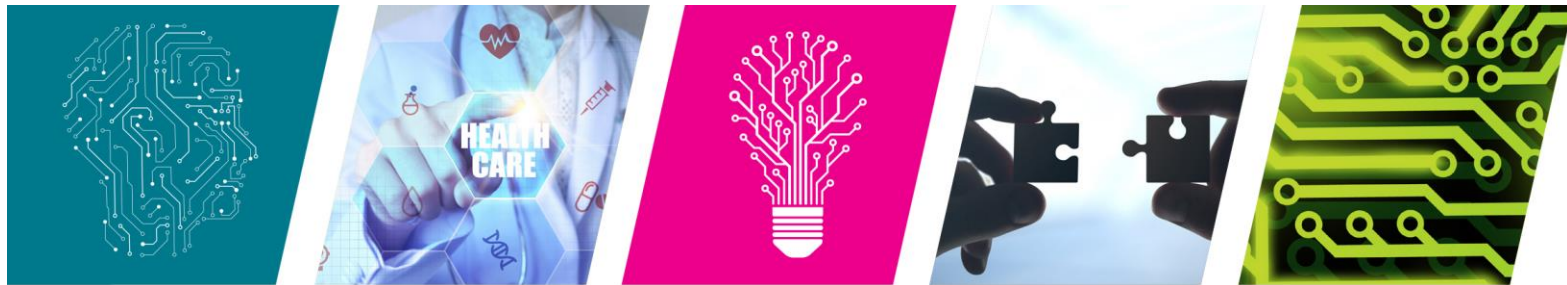
- People with lived experience of homelessness, addiction, and mental health challenges
- Mental health advocacy groups
- Hospitals
- Local Health Integration Networks
- Ministry of Health and Long Term Care
- City of Toronto and Toronto Public Health
- Community support agencies
- Home health care agencies
- Primary care health centres
- Researchers

The day began with a moderated panel discussion, featuring people with lived experience of homelessness in conversation with community-based support workers. This session grounded the remainder of the symposium in the actual lived experiences of people with complex needs. The rest of the morning sessions focused on sharing innovations in policy and practice that had been put in place by leaders in social services, pointing out the ways in which the formal health care system could best support and collaborate on such innovations. The afternoon consisted of breakout sessions focused on identifying meaningful solutions to engaging people with lived experience, organizational collaborations, and policy-level innovations to better support people with complex needs. Following the symposium, the team of hosts analyzed in-depth notes that had been taken throughout the day to identify a series of themes that characterized the day's discussion. Those themes are presented here:

RESULTS

The results of our symposium are presented in this paper as a series of four themes that represented the most important points of discussion during the day. We follow each theme with specific action items that are targeted to service providers, organizational leaders and governments.

1. Employ people with lived experiences and work with them to co-design services.



It is now widely acknowledged that service users should be involved in the planning of new services and improvement of existing services that will affect their lives. Patient engagement in health care has led to successful innovations, and governments and large health care organizations have embraced patient engagement around the world.¹⁶ At the symposium, there was a clear acknowledgement among participants that in the case of people with complex health and social needs, different approaches to engaging users are necessary as compared to the rest of the health care system. People with complex needs are subject to different influences, have different considerations, and require time and consistency to build dependable trusting relationships in order to share openly when compared with some other users of health care.

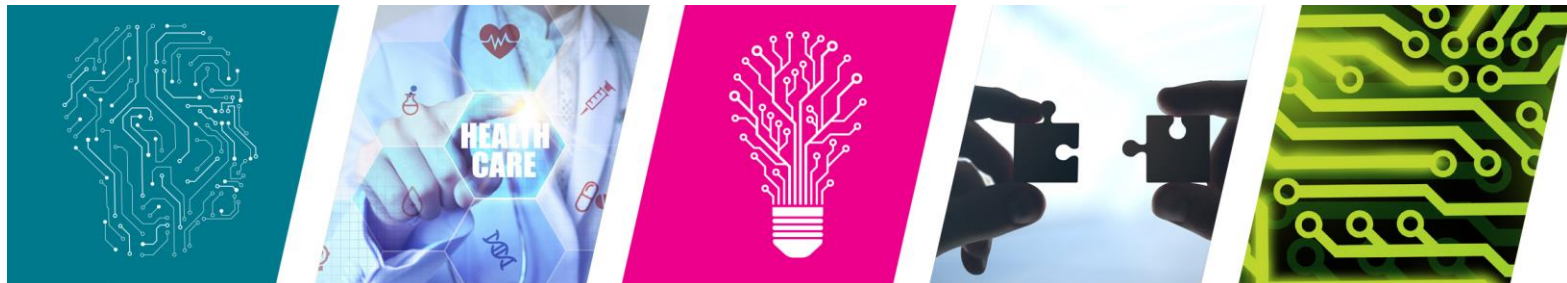
Thoughtful engagement of people with lived experiences has been practiced by many community organizations across sectors for some time and it is critical to build on the lessons that they have accumulated regarding strategies to better support people with lived experience. For example, many people with lived experiences contribute to social service organizations in the capacity of peer workers. Peer work has many benefits for the peers themselves (and is considered an effective form of treatment for them), the people the peers are working with, the community agency and the community itself. Peer work can be defined as paid temporary, supported employment for current or recent service users of service organizations¹⁷. Peer work is a temporary opportunity that is meant to complement the services a person receives to increase their overall growth and stability, and/or employability and/or support their recovery, build skills and leadership and/or alleviate the impact of poverty.

In the effort to inform the panel that included people with lived experience of homelessness at the symposium, the Population Health Solutions Lab hosted a half-day engagement session where support workers, peer workers, and people with lived experience could meet, build trust, and share early insights. The day involved an explicit trauma-informed approach, ensuring that participants were only asked to share after trust had been established. People were invited to share their stories when they felt comfortable, and maintained control over the ways in which their stories were messaged to the audience and any details that were shared or withheld. This experience, along with discussion during the symposium, led to the following action items:

1. Support and fund peer worker programs. Peer education accelerates the recovery of those with lived experiences by providing them with valuable and

¹⁶ Carman, K., Dardess, P., Maurer, M., Sofaer, S., Adams, K., Bechtel, C., and Sweeney, J. (2013). Patient and Family Engagement: A Framework For Understanding The Elements And Developing Interventions and Policies. *Health Affairs*, 32(2).

¹⁷ St. Stephen's Community House. (2018). *Peer Handbook*. Toronto, ON: St. Stephen's Community House.



meaningful work opportunities. It also has the dual benefit of supporting the people they work with as well as informing providers, who often do not have personal experience to inform their practice.

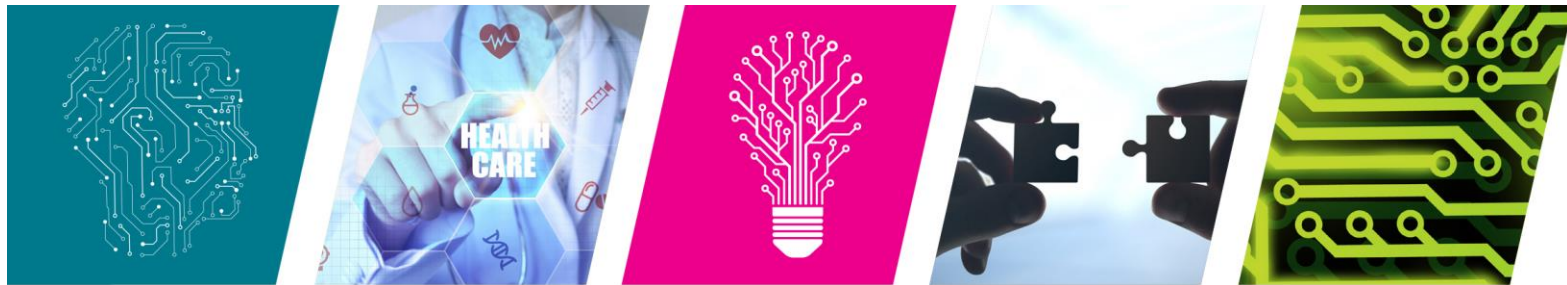
2. People with lived experience of complex health and social needs should be engaged in any innovative initiative involving community support services, including those intended to contribute to ending hallway medicine.
3. Where people with lived experience of complex health and social needs are engaged in innovation initiatives, the engagement process should follow a culturally safe, trauma-informed approach to ensure that people feel safe engaging and sharing their stories and insights. Engaged populations should always be compensated for their time contributing their experiences and insights.
4. The best approach to ensuring that solutions address the complexity of the lived experience, is to include service users in both problem definition and the development, testing and refinement of solutions.

2. Review or simplify institutional policies and rules that do not support people-centered care.

Rules and regulations are essential components of the broader health and social care system in Ontario, and serve to protect the safety of patients and the public. However, sometimes rules are misinterpreted and other times they can be barriers to access better care. For instance, policies administered by one provincial ministry can intersect with policies administered by other ministries, inadvertently causing unintended harm to people with complex social and health needs. An example of this is the loss of housing of a parent if their child is placed in social care. This practice can lead to exacerbated chronic medical and mental health challenges as well as adverse and additional burden on the healthcare system.

Although some rules that interfere with innovation are specifically designed to ensure safety and should remain in place, there are many others that could be changed or clarified in order to give stakeholders permission to be more creative and innovative. By addressing these rules or regulations that interfere with innovation, governments can enable health and social care organizations to better meet the complex needs of people that require creative, out-of-the-box thinking.

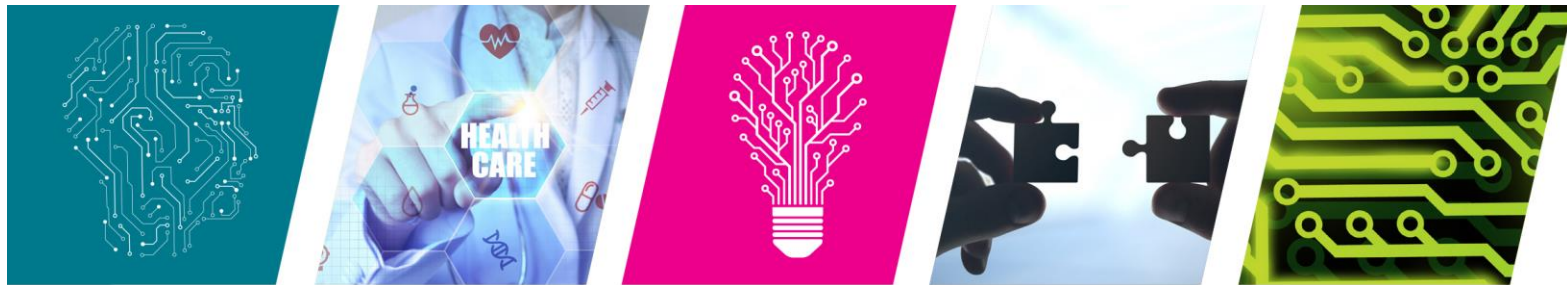
One such example is policies governing data access and sharing in Ontario. Misunderstandings of the Personal Health Information Protection Act and other personal privacy policies have prevented service providers in both the health care system and



the social sectors from accessing and sharing data about the populations they serve. Providing education about the intended meanings of these policies that emphasize the possibilities for innovative approaches to data sharing would encourage service providers across sectors to consider more innovative ways to communicate and share information about patients especially during transitions of care between the hospital and community. In addition to initiatives intended to improve data sharing across organizations, further work on a shared electronic health record across health, mental health, and social services is essential.

Access to health-related data is just one example of policies that could potentially be clarified or changed to enable more innovative approaches to addressing complex needs. A systematic approach to engage the sector and identify areas with the greatest potential for change is one important component of a policy-level strategy to promote widespread innovation across Ontario's health and social care systems. Three action items emerged based on this discussion, as follows:

1. Organizations should engage their boards of directors and senior management teams in an effort to identify operational rules and procedures that might interfere with people-centred care and innovation. Where appropriate, leaders can promote discussion about rules that present as a barrier to effective care for individuals and families. This dialogue should include a willingness to contravene rules or remove rules altogether when they clearly interfere with innovation, as long as staff and service users remain safe and their work protected.
2. Managers from different ministries and social service sectors should convene to discuss and resolve policy challenges that might unintentionally inhibit the progress of service users. For example, eligibility for housing and social supports are linked, such that changes in eligibility for one service might affect the other. Reviewing instances where such connections between policies lead to negative unintended consequences can inform more innovative approaches to managing supportive services.
3. The provincial and municipal governments should commit to reviewing privacy policies. This would include clarifying policies related to information sharing, and particularly the transfer of information about people. In cases where information sharing does not breach policy and would promote improved care, education about how to do so should be provided. In these instances, data should be shared with appropriate controls.



3. Look at novel ways of working together (Governance).

Transitions between sites of care, including discharge from hospital, remains one of the biggest challenges to inter-sectorial collaboration. One way to promote improved collaboration across sectors is to identify novel approaches to organizational governance that incorporate collaboration as a fundamental principle. For example, the “collaborative governance model” by Chris Ansell and Alison Gash is one such approach to promoting organizations to work together to solve very complex problems, particularly those in the public interest. Collaborative governance is rooted in understanding the nuanced relationships between organizations, their incentives for collaboration, and any power imbalances that apply.¹⁸ Acknowledging these challenges allows organizations to come to the table and work together to establish new ways to deliver programs, and new ways to govern that collaboratively improve program delivery.

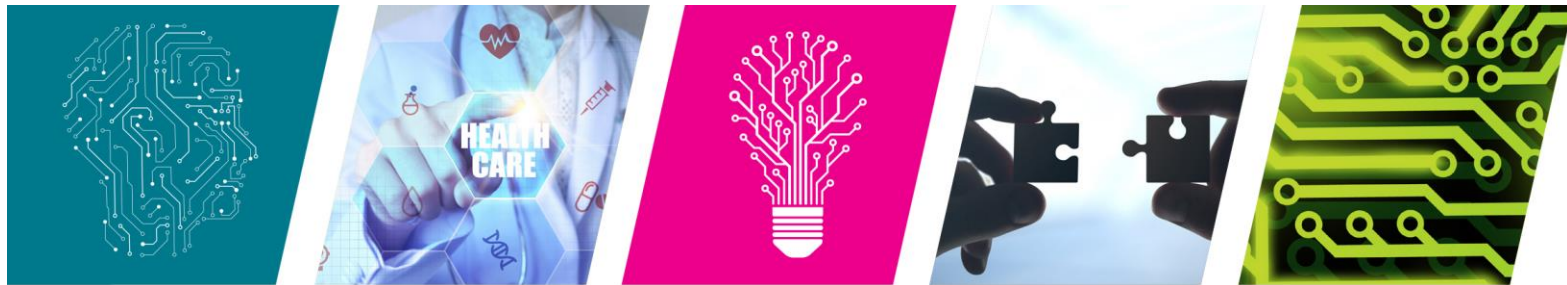
Evidence from local level collaborations such as Health Links and other regional collaborations indicate that multi-disciplinary networks of providers can achieve improvements in key system metrics, such as the provision of coordinated care plans and regular and timely access to primary care¹⁹. It is critical to recognize where these partnerships and collaborations already exist in our public systems and to continue to build on them. One example is at the municipal level, where situation tables (a model for collaborative multi-sectorial meetings) are already a regular component of efforts to address complex social issues.

The goal of encouraging more collaborative approaches to governance sparked additional action items:

1. Health, mental health, and community-based organizations should identify concrete opportunities to work together, bidding on particular projects as collaboratives. Trust is often built through such collaboration, which can then lead to more formal collaborative arrangements.
2. Organizations should identify opportunities for “street level” collaboration between health care providers and social service providers. Ultimately, providers working together to better serve people will drive better outcomes for people with complex needs.

¹⁸ Ansell, C. and Gash, A. (2008). Collaborative Governance in Theory and Practice. *Journal of Public Administration Research and Theory*, 18(4).

¹⁹ Robertson, M., Bains, N., Hillmer, M., Surani, N. and Graham, P. (2016). Health Links: Meeting the needs of Ontario's high needs users. [Powerpoint slides]. Retrieved from: www.cihiconferences.ca/highusers/downloads/Michael_Robertson_EN.pdf



3. Governments should seek to promote collaborative approaches to bidding for contracts for services and other new programs arising to meet complex needs. Such collaborations could include health care providers working with community-based organizations and municipally organized services.

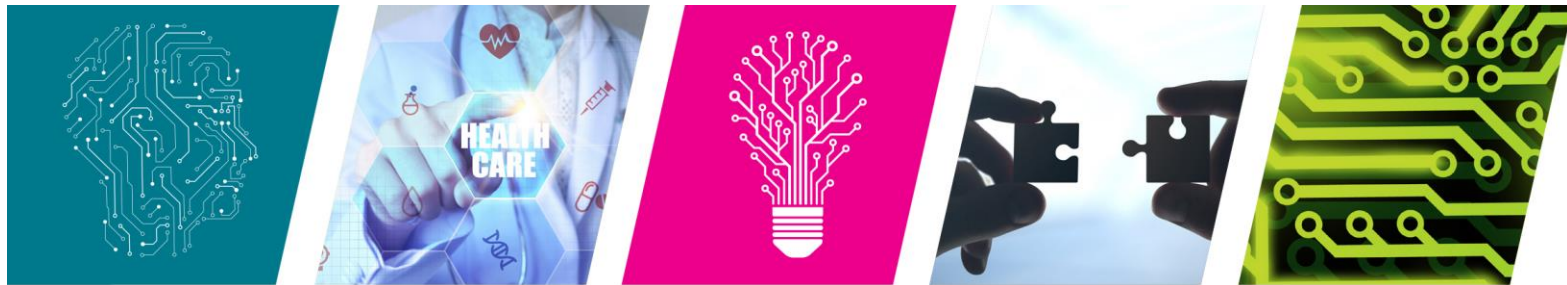
4. Use innovative funding models that enable improved outcomes more efficiently.

Funding for health and social services is supported by both the municipal and provincial governments, and non-governmental organizations. However, often funding announcements, requests for proposals (RFPs) and funding cycles are misaligned. This may lead to duplicated bids from organizations submitting proposals and makes collaboration even more challenging. Local Health Integration Networks (LHINs) and the City of Toronto have already expended substantial time and effort attempting to identify opportunities for coordinating bidding processes, but support from the wider community and provincial government is essential. With support and commitment to work together on promoting collaboration among service providers through streamlined approaches to collaborative funding, LHINs, municipalities, and the provincial government could support team-based innovations across sectors.

Secondly, it is important to acknowledge that historical underfunding of housing and mental health sectors has led to compression in the supply of appropriate housing supply and community mental health services alongside significant demand. The shortage of funding for these services has implications throughout the health care system, but poses a burden especially for case managers and front line social service staff who end up with caseloads that are impossible to manage effectively. Strategic areas should be identified for re-investment.

Ontario can also adopt more innovative approaches to funding that incentivizes the achievement of particular goals. For example, outcome-based funding approaches assess whether organizations have accomplished a specific outcome regardless of the process it took to achieve the outcome. Ring-fenced funding, which links specific funding to specific public services protects the funding from being diverted, thereby enabling more innovative approaches to promoting collaboration and preventing adverse events (such as hospital admissions). Approaches such as these provide more flexibility to service providers to identify novel ways to achieve their goals, utilizing funds as they see fit in order to enable better care for people with complex needs.

Innovative approaches to funding must also encompass innovative performance measurement strategies. For example, if organizations begin collaborating on joint proposals, then the evaluation of their work will need to reflect the work of the entire group as well.

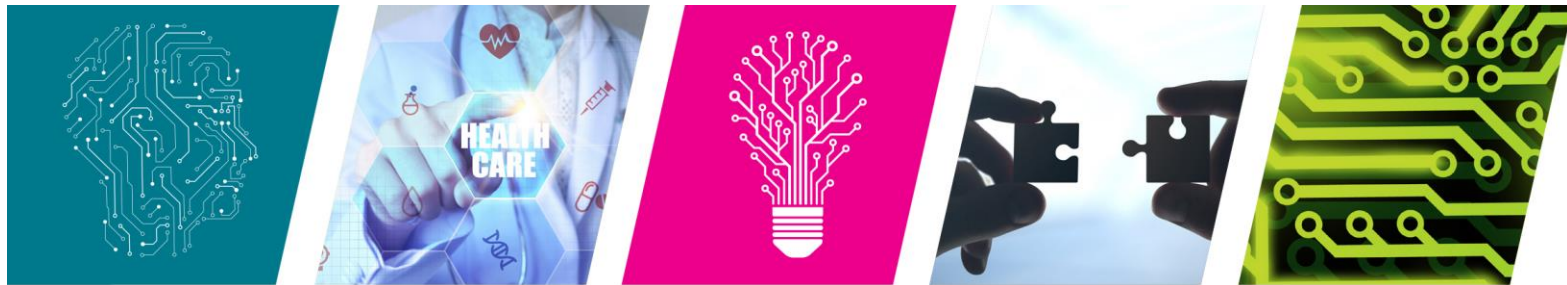


1. Strike a working group comprised of governmental agencies (including municipal, sub-regional, LHIN, provincial, or federal organizations) with the specific focus of identifying possible strategies to align funding programs across those agencies. Tasks could include identifying possible instances where Requests for Proposals (RFPs) from different agencies can be aligned during the calendar year to encourage collaboration.
2. Where possible, identify strategies to invest in upstream funding that can reduce the burden on hospitals by better meeting peoples' complex needs. Upstream interventions that would benefit from additional funding include affordable and supportive housing, mental health and addictions programs and community-based skills and education programs. By investing in these strategic upstream areas, it will be possible to complete small tests of change that serve to justify larger future investments.
3. Pilot innovative funding models that are geared towards the outcomes of stable and appropriate housing and improved mental health. Allow local provider organizations more flexibility to collaborate and deliver services in innovative ways. Align evaluation of outcomes with the approach to the innovation determined by local parties.

CONCLUSIONS

The action items described in this paper represent a collection of research evidence, personal narratives from people with lived experience, and the ideas of innovative leaders across sectors. Although a number of specific points have been raised that could be acted on immediately, we see a tension between two different strategies for achieving many of the goals raised here: one is to identify best practices and work to implement those same best practices everywhere (“spread and scale”), and the other is to promote local innovation because local providers know best (“local design”).

Ultimately, we believe success in the effort to address the complex issues raised in this paper will require strategies aligned with both approaches. Engaging people with lived experience represents an effort to understand local experience and incorporate local strengths into service planning. However, policy changes at the provincial level that remove unnecessary rules would apply to everyone, everywhere across the Province. In this way, both “spread and scale” of best practice and a commitment to “local design” are necessary to achieving the goal of improving health and social services and ending hallway medicine. One point is however clear: The effort to achieve inter-organizational



collaboration for more innovative approaches to service delivery presents an immense leadership challenge, which needs to be solved to make real progress in serving people where they live.