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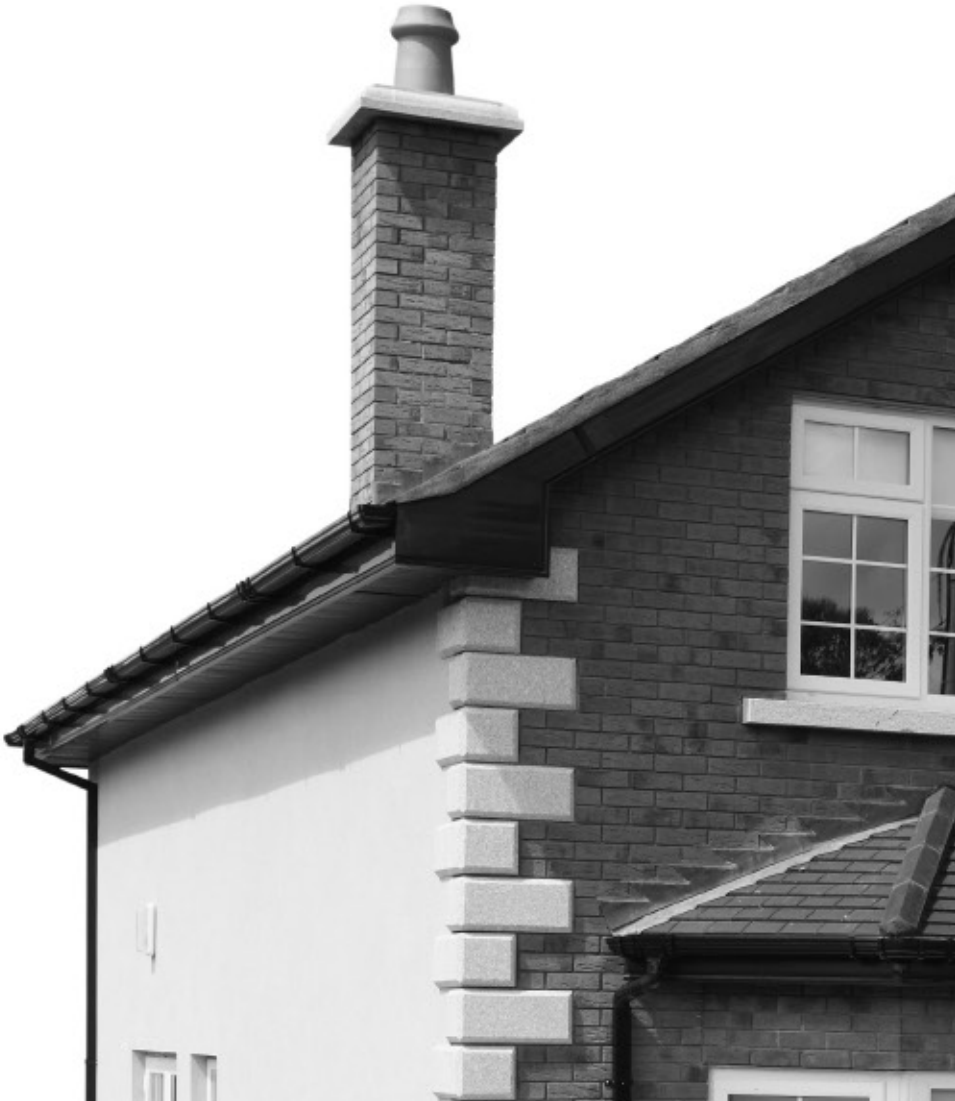
LHINs and the housing system



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The **Ontario Non-Profit Housing Association** (ONPHA) represents 760 non-profit housing providers in 220 communities across Ontario. ONPHA's members house approximately 400,000 Ontarians such as seniors, low-income families with children, Aboriginal people, the working poor, victims of violence and abuse, people living with disabilities, mental illness, addictions, or HIV/AIDS and the formerly homeless / hard-to-house.

ONPHA's *focusON* series examines key issues facing Ontario's affordable housing sector, presenting a variety of perspectives to encourage thoughtful and reflective discussion on the development of sound housing policy and the future of the community-based housing sector in Ontario.

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Background and recommendations

Supportive housing providers house many of Ontario's most vulnerable residents, including individuals living with mental illness, addictions, acquired brain injuries, physical and developmental disabilities, HIV/AIDS and concurrent disorders. With over 11,000 units, Ontario's supportive housing sector helps tenants stabilize their lives and achieve wellbeing. It does so by providing permanent housing with support. Supportive housing removes pressure from resource-intensive public services frequently accessed by individuals with complex needs. The stability and growth of the sector is vital to Ontario.

Since their creation by the Province in 2006, Ontario's 14 Local Health Integration Networks (LHINs) have taken on a significant role in the funding and administration of supportive housing. As Ontario's new regional health system managers, LHINs have adopted the former Ministry of Health and Long-Term Care (MOHLTC) role funding community-based support services, including services delivered in supportive housing.[1] LHINs have approached supportive housing as a component of the health system's community support sector as they attempt to achieve better-integrated local health care systems. In addition to their role in the supportive housing sector, LHINs also at times engage with social housing by funding site-based support services for tenants.

Over 200,000 households benefit from the affordable accommodation offered by Ontario's social housing sector. But social housing, unlike supportive housing, generally does not come with support services. Social housing providers are increasingly concerned about the number of social housing tenants with unmet support needs. The outcomes of lacking support have too often reached the front pages in recent years, from fires caused by hoarding and poor housekeep-

1 This report does not delve into the overarching funding framework for MOHLTC and Ministry of Community and Social Services (MCSS) dedicated supportive housing—which is a subject of ongoing ONPHA study.

ing, to terrible outcomes for vulnerable seniors unable to live independently in the absence of assistance.

Similar to LHINs' role as Ontario's regional health system managers, Consolidated Municipal Service Managers and District Social Service Administration Boards—herein collectively referred to as "service managers"—are Ontario's regional housing system managers. LHINs and service managers are engaged in issues, such as homelessness, which meet at the margins in important ways, but necessary connections are often lacking.

This *focusON* begins with recommendations designed to improve collaboration and coordination between supportive housing providers and LHINs and between the housing and health systems more broadly. The following two sections—which form the basis for these recommendations—profile supportive housing provider experiences working with and being funded by LHINs and examine key issues in housing and health system coordination. Appendix 1 provides an introduction to LHINs and how they fit in the health system. Appendix 2 provides background information on social and supportive housing. Reading these two appendices first may be helpful to some readers. Appendix 3 provides information about this *focusON* and the ONPHA LHINs Task Force, which was the impetus for its creation.

The following recommendations are intended to improve LHIN-supportive housing provider collaboration and to begin building necessary connections between the housing and health systems:

- There is a general and pressing need for LHINs to enhance their housing policy capacity. LHINs should have designated staff to "hold the housing file" and actively liaise with supportive and social housing providers, service managers, and the Province.
- Supportive housing providers will continue to enhance coordination with the health system, but the health system should acknowledge that supportive housing differs legally and philosophically from sites of medical care.
- Integration in the supportive housing context and community support sector more generally should not be advanced as a simple end-in-itself or in a manner that can destabilize existing working relationships between service providers.
- Integration should focus on coordination between funders, in addition to between funded agencies.
- There is a frequent assumption that small agencies and community support sectors composed of small agencies are inherently inefficient. This "small agency inefficiency assumption" should be reconsidered and thoughtfully debated.
- LHINs should ensure that measurement and accountability mechanisms are not overly burdensome so as to detract from direct service delivery. Data collected

from supportive housing providers should be relevant to their operations and should be returned to them in a useful, comparative format.

- Development of new supportive housing is challenged by the division of responsibility for limited available funding between service managers (capital) and LHINs (support services). Funding streams should be coordinated and enhanced to smooth the path to new development of much-needed supportive housing.
- LHIN-funded services delivered in social housing can help stabilize unsupported tenants and improve social housing communities, while reducing unnecessary use of resource-intensive components of the health care system. Such building-based services in social housing and collaboration between LHINs and social housing providers should be expanded on a province-wide basis, with Provincial financial support.
- LHIN-service manager collaboration will be required to reach province-wide goals for the housing and health systems, including ending and preventing homelessness and reducing costs associated with the top one per cent of health system users. Collaboration should be enhanced with Provincial financial support to build necessary linkages.

Supportive housing and LHINs: Provider experiences

This section reviews major themes that emerged in interviews with supportive housing providers about their experiences working with, and being funding by, LHINs.[2]

Positive experiences working with LHIN

Some supportive housing providers reported positive experiences working with LHINs.

One provider reported that ideas for collaboration that have existed for years have finally come to fruition as a result of LHIN-driven processes. Another credited the LHIN system with connecting her to local hospital leadership, which she previously could not access. For these providers, LHINs have stimulated system-wide collaboration and conversations.

One provider commented: "We have a very good relationship with the LHIN. They are very supportive and have a very good understanding of supportive housing. We are very lucky in that respect. Some of the staff at the LHIN came from organizations that had supportive housing."

According to another provider, "Our LHIN I think is different than other peoples'. I hear LHIN stories all the time and I don't have those stories. People are open and honest. They have tried to work with us. They have tried to do a lot with community support."

One provider spoke of taking part in a successful integration: "We did actually integrate a program from another agency with LHIN support and it worked well. Everyone was pleased. It was quite cordial and easy to make work. It was a case of a small organization that couldn't meet the requirements of the LHIN. They didn't have the capacity. It made sense to them and us."

2 See Appendix 1 for background information about LHINs and their role in the health system.

The same provider noted: "I think we have a wonderful working relationship with our LHIN. We have what I would call a partnership arrangement. That is partly our doing because we wanted it and put in the measure of work needed. This provider offered the following advice: "Get to know your LHIN. Work with your LHIN. The LHIN needs our support because they do a lot with a small staff. Their informants will be those they can call on and trust."

However, positive provider experiences were often contingent on deviation from common challenges. For example, many providers reported that their LHIN does not have a good understanding of supportive housing. One provider, quoted above, linked her satisfaction to being "very lucky" that local LHIN staff members have experience working with supportive housing. Her satisfaction was linked to divergence from a general trend.

Understanding of supportive housing

Many supportive housing providers reported that they believe their LHIN does not understand supportive housing and its mission. One approach to getting a handle on this gap in understanding (and ultimately bridging it) is to look at the differences between how supportive housing providers view their housing and how it is often viewed through a medical model lens.

These differences are expressed in language. They reveal tensions around the perceived role of supportive housing, which lead to a variety of practical and legal challenges. While everyone agrees that supportive housing should exist to provide quality service to communities, there is sometimes real divergence surrounding what that means.

Table 1: Medical language and supportive housing language

Medical model language	Supportive housing language	Purpose of supportive housing
Patient/Client	Tenant / Client	*Medical model perspective: Providing care in a residential setting, often time-limited and meant to address acute challenges.*
Flow-through	Security of Tenure	
Discharge	Tenant-Directed Moves	*Supportive housing perspective: Providing permanent affordable housing with support to promote long-term wellbeing and quality of life.*
Health Service Provider	Housing Provider / Landlord / Support Provider	

Supportive housing providers approach their operations from a different legal and philosophical framework than hospitals or other health service providers. Traditionally, most supportive housing providers have not thought of themselves as delivering, in a conventional sense, health services.

According to one provider who has had a generally positive experience with the local LHIN: "Our relationship with the LHIN is very good... But I truly don't think they understand what we do. Part of that is because we have been doing this for 30 years and it's hard to understand that it is not a medical model. We do very complex care, but it is non-medical. Viewing what we do through a medical lens is costly, not required, and causes clients to lose independence."

Since LHINs only fund support services, they can lack awareness of what makes supportive housing providers different from other deliverers of outreach or assisted living services: the fact that they deliver housing and support under one roof. According to one provider, "On an individual basis our staff at the LHIN understands us and our uniqueness. But I don't think they fully grasp what supportive housing is: they just aren't used to the interplay between being and landlord and support service provider."

In 2006, as the LHINs were being created, ONPHA called for adequate representation of supportive housing providers in LHIN governance to ensure that LHINS understood the mission, orientation, and legal position of the supportive housing providers they were to begin funding.[3] Today the level of understanding is inconsistent across LHINs.

Tenants as"patients"

Supportive housing providers are landlords. People who live in supportive housing are tenants (also referred to as clients). The *Residential Tenancies Act* (RTA) governs the relationship between supportive housing providers and their tenants. But even with this legal framework—discussed below—there are practical reasons why supportive housing providers focus on their role as landlords. These reasons revolve around how tenants feel about their home, which is a primary determinant of their ability to thrive.

As one provider put it, "Our tenants don't want to see themselves as patients. They want to see themselves as tenants. It's about stigma and labeling... When you live in housing, with the permanency of it, you don't want to be a patient all your life and always be someone seen as receiving and needing care". A mental health supportive housing provider similarly commented that in applying a medical model lens to supportive housing, "what is lost in the dialogue is the attempt to normalize the mental health client experience."

The current health system approach to determining where patients should receive care is where the level of care provided best fits their needs, neither leaving them with unmet needs or in an

3 ONPHA Resolution 2006-15.

inappropriately invasive environment - which would signal their being designated as "alternative level of care" (ALC).[4] Patients with an inappropriate level of care (either too intensive or not extensive enough) are referred to as "being ALC". The focus on ALC is intended to improve health system efficiency and effectiveness by providing most-appropriate levels of care to each patient.

There are other considerations that arise from a housing perspective. While tenants of supportive housing want to live in a place that offers them an appropriate level of support, particularly when it is needed to help them maintain their housing and quality of life, it must be remembered that housing is permanent. Tenants may also want to live near their job or in a place that is close to friends and family. People living in supportive housing want to apply the same set of criteria in deciding where they live as any other individual would. Choice is an important factor in successful tenancy.

Permanent housing

While housing providers emphasize security of tenure, LHINs are focused on "flow through" as a means to reducing ALC and pressures on the health care system. According to one LHIN representative, "we are trying to deal with a structural deficit in the hospital sector, trying to emphasize flow." Following another LHIN representative, "A big problem we have with our mental health agencies is that they are really reluctant to discharge individuals. They have people there for eons. Based on a recovery model, the care plan should focus on medium and long term goals and increasing independence."

According to one supportive housing provider, "Flow-through is seen as the answer to wait times and ALC days in hospital. Permanent housing and security of tenure do come into conflict with the flow-through idea… There is a lack of understanding about people needing permanent housing and permanent support."

Several providers reported that creating flow-through in the supportive housing sector to reach ALC reduction objectives could run into conflict with the legal structures surrounding supportive housing, as well as its philosophical orientation. According to one provider, "The fear is that there would be pressure to move people out who are more stable. This is just rumbling I hear. There is no actual directive. But the very fact that they are stable is because they are in our affordable, secure housing. Where would you send them?"

Another provider noted, "When someone has lived in our housing for 20 years we see that as success. The Ministry of Health could see that as dependency. Some LHIN staff understand this, but overall the LHIN thinks moving on would be 'recovery'. Recovery is not an end state. It's a journey that is about sense of hope and waking up in the morning and having purpose."

4 See Appendix 1 for a discussion of the alternative level of care (ALC) concept, which is vital determinant of how LHINs engage with the supportive housing sector.

Another provider similarly noted, "We have a strong view on permanent housing. It is a success that many individuals have lived with us for more than 10 years. [The current environment] feels like a threat to agencies that see security of tenure and permanency as a core value."

Providers do agree that ALC is an important issue. Some providers have created newer housing with LHIN support aimed specifically at addressing ALC. Providers do not object to creating new supportive housing that sources tenants based on ALC reduction objectives. The main concerns surround pressure to re-arrange the mandates of existing housing. Providers do not want to pressure existing tenants to "move along," nor can they. Even new housing targeting ALC reduction will be subject to the natural cycle of tenant moves with minimal potential for flow-through, unless the housing is made explicitly transitional in character and RTA-exempt.

The *Residential Tenancies Act* (RTA)

According to one provider, "From a hospital lens, you get people treated, you triage, you move them out. That thinking is in real conflict with the RTA."

The RTA balances landlord and tenant responsibilities and subject to reasonable limitations, ensures that tenants are secure in their housing in perpetuity. Some forms of housing are exempt from the RTA and its requirements, for example, "living accommodation occupied by a person for the purpose of receiving rehabilitative or therapeutic services..." Housing can qualify for this exemption if:

(i) the parties have agreed that,

  (a) the period of occupancy will be of a specified duration, or

  (b) the occupancy will terminate when the objectives of the services have been met or will not be met, and

(ii) the living accommodation is intended to be provided for no more than a one-year period.[5]

This exemption does not apply to supportive housing in most cases. First, tenants are only sometimes in supportive housing explicitly for the "purpose of receiving rehabilitative or therapeutic services." Rather, support services help tenants maintain their permanent housing and achieve quality of life. Second, tenants of supportive housing generally do not have leases that specify conditions around temporary occupancy or specified objectives, the achievement of which would result in termination of occupancy. Lastly, tenants of supportive housing generally remain in their housing for longer than one year - often for the duration of their lives. As well, supportive housing providers are subject to operating agreements signed with government funders which specify their role as providers of housing, which is regulated by the RTA.

5 *Residential Tenancies Act*, 2006, sec. 5(k), http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_06r17_e.htm.

Some supportive housing providers do operate programs in addition to their permanent housing that are explicitly rehabilitative or therapeutic, do involve residency of less than one year, and are RTA-exempt. While there is a distinct role for transitional housing, large-scale conversion of existing supportive housing into this model is generally not considered feasible or desirable.

According to one provider, "The LHIN sees supportive housing as a very valuable resource. Where they don't get it is that we in the field all have agreements with government to deliver housing, we are all under the RTA, and we tend to see our housing as our housing. When new clients join us, our view is they will be with us for life unless they want to move on." A medical facility can, in theory, be re-tooled and repurposed with relative ease. Other components of the health system can be leveraged to help ease transitions with patients re-directed. Housing cannot be treated in the same manner.

Lack of affordable housing

Supportive housing providers are not adverse to tenants moving, but they strive for moves that are tenant-directed. A tenant could decide that they no longer require support services and wish to move, but it must be remembered that supportive housing also offers housing affordability.

Individuals who live in supportive housing are often marginalized in the labour market and unable to secure incomes that would allow them to access housing at market rents. More supportive housing tenants would perhaps choose to leave the supportive context if there were other affordable housing options available.[6]

Absent solutions to the affordable housing shortage—or targeted assistance to facilitate supportive housing tenant moves when desired—it will generally not be possible to create more "flow" in the supportive housing sector. According to one LHIN representative, "Flow-through is a really difficult one. In order to do it you need other options, and other options cost money." Supportive housing tenants, who mostly rely on income supports, cannot be "discharged," and certainly not to unaffordable housing or substandard housing that would impact their health. Long waiting lists similarly make social housing an unrealistic option in many cases.

One provider recognized a major overarching challenge: "To be fair, the LHIN is facing pressure to move people through the system without building new things." This is a revealing comment. Conflicts over how to use supportive housing are an outcome of the shortage of affordable housing and no commitment by senior government to fund an adequate supply. Similar disagreements play-out in the world of social housing regarding who should have priority access and why. In both cases, scarcity of necessary community resources leads to conflicts over their use.

6 There is a general shortage of affordable housing. See: ONPHA, *Waiting Lists Survey 2013* (Toronto: Ontario Non-Profit Housing Association, 2013), http://www.onpha.on.ca/waitinglists; ONPHA, *Where's Home 2013: Looking Back and Looking Forward at the Need for Affordable Rental Housing in Ontario* (Toronto: OPHA, 2013), http://www.onpha.on.ca/whereshome.

Housing policy capacity is key

As noted, some of the frustrations that supportive housing providers expressed were a result of lacking LHIN understanding of housing. LHINs do not have specified staff members who could be said to hold the "housing file." Rather, providers interact with LHIN staff responsible for the client groups they serve, e.g. mental health and addictions, seniors, or acquired brain injury.

According to one provider, "There has been an exodus of the people who have the history, the corporate memory piece. That is missing for the LHINs". Another commented, "Because of the fact that the LHIN is not responsible for the bricks and mortar, I don't think they have an understanding of supportive housing. I don't think they have the solid understanding that the Ministry staff had prior to moving funding to the LHINs."

Another commented that program administration requires knowledge of the programs delivered: "LHINs needs to understand housing better. You don't have a policy branch in government without analysts who understand the area: if you are going to serve housing, get housing resources in there".

One somewhat exasperated provider pointed out this lack of knowledge while calling for coordination amongst her funders: "The LHIN is saying you're over budget if you access capital reserve funds. They don't understanding what we are doing at all. They don't understand mortgages. They don't understand the business of housing. People in the Housing Ministry don't even know what the LHINs are doing. You're all the same government, you're all my funder!"

One LHIN representative reported frustration at not having a stronger grasp on the complex Ontario housing landscape, mirroring reported experience on the provider side:

> *Sometimes I don't know who owns this supportive housing. We've worked with MOHLTC. We've worked with the County. It always seems like hands are tied. It seems like there are a lot of pieces of the puzzle and it seems like we are not all on the same page. For the hospital, you know you go to the capital investment branch. But sometimes with housing it is through MMAH or through the county. It seems like it is not as coordinated as it could be... There is that line between supportive and social. We don't have a full handle on the picture. Even at the Ministry level it is disjointed and it filters down from there.*

One provider suggested a remedy: "I think it would be helpful if the Province would contribute to educating the LHIN and being clearer about what their expectations are around supportive housing."

Pushing for higher needs

To address pressures on the health care system, LHINs are often pushing for supportive housing providers to house tenants with greater needs than they have traditionally accommodated. One LHIN representative reported that "We have been working with housing providers to start looking at placing clients who would have complex needs, for example, concurrent disorders."

Many providers accept this challenge, but they need additional funding to support individuals with more complex needs. LHINs need to be careful not to create situations in which supportive housing providers are pushed to do more than they can with existing resources, creating the potential for negative consequences for tenants. Tenants with inadequate support are at greater risk of not upholding tenant responsibilities and of losing their housing as a result.

Sufficient staff-to-tenant rations are critical, especially when new tenants with different intensities of support-need become part of existing tenant communities. This is especially the case where tenants live in close proximity and share common space. In such situations, behaviours of one tenant can trigger renewed challenges for others.

Integration to what end - and how?

Integration is a technique of system organization, albeit one with a very broad definition. Too often it seems that integration is treated as an end-in-itself. LHINs at times drive toward integration without a clear understanding of the end destination or a road map to get there. This phenomenon has manifested itself in a variety of consultations, planning processes, visioning exercises and roundtable sessions. These are often held for the entire LHIN-funded community support sector.

One provider described a "value mapping exercise" in which 150 people (providers, clients, and their families) were convened for a five-hour session during which they were charged with coming up with a three-year plan for the community support sector. The provider emphasized the absurdity of expecting that a large and disparate group of agencies, clients, and stakeholders would develop a coherent approach for the entire sector in a five-hour session: "We were lectured on how grateful we should be because we are allowed to participate. They had only 40 minutes scheduled for strategy, performance measures, and outcome targets!"

Following another provider:

> *The CEO of the LHIN came to our network meeting and told us verbally what needed to happen and the deadline. People went into shock. Beginning in August we had to meet every single week with orders to have an entire integration plan for our whole sector in six weeks. 36 different agencies—all community support service agencies—were involved. This was an attempt at a complete restructuring of the sector. No one took holidays. It was quite a horrific experience. All the ground that the network had gained in terms of understanding each other's services and collaboration over the years was undermined. People went into their*

own corners. There were secret proposals and take-over bids. We submitted three different plans. The LHIN rejected all of the ideas. The end product wasn't good at all. One proposal was to take down the whole sector and make it into one organization. This was a very stressful period with the LHIN. The LHIN said: 'we don't want 36 of you. We don't want 36 MSAAs.'[7] *They would not help us aside from giving us money for a consultant. They had no idea what we were doing until we submitted the plans. Now the LHIN is in a fury-state because they didn't get what they wanted. 150 people attended the LHIN board meeting. The CEO was very upset with our sector. The LHIN has this whole thing where they can never tell us what they want. It is very autocratic without support to get to an end result, except describing the big picture. There is no collegial connectivity. It has been very frustrating for everyone.*

This seems like a clear case of the LHIN simply directing the community sector to "make integration happen" without clearly specified goals or reasons for beginning such a process, beyond the legislative imperative to do so.

LHINs use forceful language about integration, which is anxiety-causing for providers in many cases. LHINs' forceful language is often not coupled with clear direction—which has the effect of multiplying anxieties. At times the end goal seems to be essentially, "having fewer of you." This leads to a constant feeling of upheaval that can be harmful to the sector.

When LHINs do have a clearer idea of where they are going there is concern that decisions are frequently made before engagement exercises occur.

One provider described how, "Under the guise of transparency they are meeting with providers, meeting with clients, meeting many different people. Whether I'd call them town halls, I don't know. Really and truly they have a direction they are going with the community support sector. In today's world the LHINs are being directing by the Ministry of Health. They have what they must do. It gets to a point of them just telling us, 'This is what we are doing now.' They have a plan, but they don't have a well thought out plan and they don't leave enough time to make it a well thought out plan."

Another noted, "The community engagement meetings are not community engagement. They meet with us and give out glossy handouts, and then next time they say that we are all in agreement about everything that was discussed at the previous meeting. They will do things like ask to have our board members come for an 8am to 4pm session. I have a volunteer board. People work!"

7 An MSAA is a Multi-Sector Accountability Agreement, the type of agreement that structures a funding relationship between a LHIN and agency.

Another provider described tension with the LHIN around planning:

> *This is not traditional funder-agency tension. I was a funder for many years. I get that. This is beyond the pale. There is always tension between funder and agency. That's a normal, healthy tension. You've got the money and we want it. It is an acknowledged power relationship. The problem is they are pretending they are not in a power relationship with us while making strong claims on us. We know there is a crisis in funding and what they can actually pay for. Let's stop the fake warm fuzziness and actually plan for it.*

This provider had reached a point of frustration with engagement and consultation exercises framed as there to collaboratively develop plans, while she perceived that these plans, to the extent they would exist at all, were already written.

Some providers reported a breakdown of collegial and cooperative relations within the community support sector as a result of LHIN approaches to integration, leading to outcomes that are antithetical to official LHIN objectives. According to a recent study on integration from the Mowat Centre, "If an integration agenda is the path forward, it must avoid unintended consequences that would destabilize the community sector more broadly."[8] Careful adoption of such a 'first, do no harm' principle seems in order.

One provider reported that, "Our relationship with other service providers has really declined. Two or three years ago we talked to each other and helped each other and partnership was good. That was in the years when the LHIN was encouraging partnership and collaboration. Since we received the message that we could be forced to amalgamate there is much less openness and willingness to share with each other. That makes for a tense relationship".

One provider contrasted the prevalence of committees and working groups focused on integration with a seeming lack of clear process around how money will ultimately flow:

> *I think the big confusion in the current system is around how to make an application for funding to the LHIN. There doesn't seem to be a clear path for that. There isn't a call for proposals. Money arrives and it gets distributed to different providers... We are inundated with committees at every level, but where is the application for funding when a group identifies a need they want to address? The LHIN keeps saying it is open and transparent, but there doesn't seem to be an application process to make it transparent. That creates a certain level of mystique... the agencies that get the funding are always suspect. There is this push toward collaboration, but if the collaborative partners don't feel they are equal players, it's hard to be collaborative. I see this across LHINs.*

Successful integration and collaboration requires willing agencies. LHIN approaches to the sector have the power to shape the conditions that determine whether integration and collaboration can be successful.

8 Elizabeth McIssac and Carrie Moody, The Integration Agenda (Toronto: Mowat NFP, February 2013).

LHIN-to-LHIN differences

While LHINs focus on integration internally, the evolution of differing practices across LHIN areas poses challenges for existing provider networks that span LHIN boundaries. One provider reported that, "I struggle most with the lack of consistency between the LHINs. The variance causes turmoil. Since the LHIN system has been in place our homelessness network has lost a lot of its strength because there is such disparity in what has happened from LHIN to LHIN. I'll put a question to my peers in another LHIN and they'll say, 'Well that's not how it works here at all'."

One-sided integration

"Integration" is a theme that is hot on the agenda across the non-profit and social service sector. It is seen as a potential means to better and more cost-effectively deliver services.

The LHINs are charged with integrating services. But the providers they fund often have multiple funders—and there is little-to-no focus on funder-side integration of program objectives or administrative requirements. According to the Mowat Centre, "Consideration must also be given to integration and coordination at the funder level. When funders do not coordinate they risk cross-messaging and incompatible community planning."[9]

MOHLTC funds supportive housing to provide housing in accordance with the Ministry's responsibility to uphold operating agreements signed by providers with government. LHINs, on the other hand, have been given a broad mandate to reshape the health and community care landscape. Their agenda is focused on making supportive housing fit within a more nimble health care system. Many providers face the challenge of trying to stay true to their core mandate while adapting to new LHIN direction.

As well, many supportive housing providers have multiple funders who all apply their own accountability structures and reporting responsibilities. One provider commented that:

> *There is an unrelenting drum beat on administrative costs. We are forced to be in a 9 per cent range, but that doesn't allow for the level of administrative costs required to run a multi-funded organization. The LHIN struggles with understanding the complexity of community-based agencies that cobble together different funding streams to make everything work.*

9 Ibid.

Another provider concurred:

> *We collect rents, supplement rents. There is a lot of book keeping. We interact with boards and landlords [for our rent supplement units]... They don't recognize that the administrative costs go beyond what is required just for [support] service delivery.*

There is a need for the integration focus to move beyond the agency level to the funder level as well.

The small agency inefficiency assumption

There is a two-part assumption in play at times in how LHINs view and attempt to achieve integration. It is apparent, first, in the view that small agencies are by definition less efficient and effective. And second, in the view that a community care sector which contains a smaller number of total agencies will be by definition more efficient and effective. These views are not apparent in all LHIN decision making processes, but they are present with sufficient frequency to merit focus.

According to one supportive housing provider:

> *"Organizations are very committed to their group and culture, so the amalgamation discussion puts them more in protection mode than creative mode. The smaller organizations are the most worried, but these are often the most creative with best value per dollar. That needs to be recognized that they do a lot for very little... The talk is all 'bigger is better', being bigger does not always produce efficiency. That is an important piece that needs to be reviewed. That doesn't mean that small organizations can't collaborate and find efficiencies. They can. But it is hard for them to come to the table feeling in a position of power like the big ones [with amalgamation pressure on the table]".*

Another provider questioned the efficiency gains of a recent merger of agencies and the motivation behind it: "They had to harmonize staff salaries [to the standards of the higher paying agency]. They don't have a second executive director, but they do have more program directors. Is there a cost savings, or is it just that the LHIN now doesn't have to deal with as many community-based agencies?"

The Mowat Centre's integration research speaks volumes to the concerns of many providers: "Small organizations, particularly those with niche programs and services, are... wary of integration. They are concerned that if they are forced to merge with large organizations the community will lose the unique programs they offer, and that the sustainability of a vibrant ecosystem of services will be put at risk."[10]

10 Ibid.

Many supportive housing providers see a definitive benefit to tenants of having a diversity of providers. According to one provider, "At LHIN board meetings and governance meetings they are saying we want to see fewer doors that people have to go through. They want to see more integration. All the examples they give are merger examples. Does it make sense? It depends on your philosophy. Some think mega-agencies make sense. Others think you lose something in the community by not having a number of providers that each have their own circle of support".

Though reality is often more complex, some LHINs may simply believe that having fewer agencies will create greater efficiency through economies-of-scale. However, there are also pressures internal to LHINs' administrative structure that providers and experts identified as driving belief in the merit of having fewer and larger agencies.

Each LHIN carries a significant mandate with a small staff. The community support sector takes up a very small percentage of LHINs' total budget, but because the agencies are smaller and more numerous, the sector is administratively intensive. Regardless of its size, every agency requires its own funding and accountability agreement. There is a natural pressure for LHINs to equate how easy the sector is to administrate with how well it functions. The two are not the same thing. Providers are generally committed to working together to achieve a more integrated system that works better for tenants. What they don't want is a process surrounding integration that begins with the straight-forward assumption that having fewer agencies means a better system.

A consultant familiar with LHIN-supportive housing relationships across several LHIN areas noted that "Some existing supportive housing providers that are smaller are feeling pressure to amalgamate. The LHINs' primary client is hospitals, taking up 90 per cent of their budget. Then there are a million support service agencies taking up the other 10 per cent of their budget. These agencies are not as sophisticated and to the LHINs they are a bother. The return on investment seems smaller, so the LHINs think to create efficiency they need the small agencies to amalgamate".

Providers are not uniformly opposed to integration. Many just want a more nuanced approach. One noted that, "When we talk integration, people go right away to amalgamation. If we focus on outcomes, it could look any number of ways... we could share all kinds of things."

LHINs are agencies too: They can't act purely like a government funder

LHINs fund agencies through agreements that establish an accountability relationship. The LHINs find themselves in a similar accountability relationship with MOHLTC, with metrics they are expected to achieve. However, the level of MOHLTC involvement in guiding the LHINs' activities stretches beyond measuring their performance. Some providers feel that they are now at arms length from MOHLTC—the locus of much decision making.

This is a problematic situation. When agencies lack the ability to speak directly with funders who understand their programs and who make ultimate funding decisions, they can be left without partners that are able to help troubleshoot unexpected situations and plan for the future.

One provider commented that, "The worst part is that the LHINs are subject to same tensions with the MOHLTC as we have with them. They are in some ways like an agency too, having to justify and rationalize what they are doing for their funder". There is a feeling that no one—not MOHLTC or the LHINs—is fully in the driver's seat. Another noted that, "The LHINs are simply transfer payment agencies. Too much is made of them as policy making entities. Our LHIN struggles with staff turnover which impacts their knowledge and they are not good at asking what they don't know".

We put the following question to a health system expert who has followed the development of the LHINs since their inception: How independent are LHINs from MOHLTC?

The answer was: "The legislative powers are very strong. There are some very, very substantive policy instruments that were wheeled out for the LHINs but very few examples of use. The Ministry has kept LHINs on a very short leash in terms of integration. Most people would say they are just a pass-through agency by and large. Quite a large ministry presence has continued. Bureaucracy inevitably finds something to do, so what they do is tell the LHINs what to do".

We posed similar questions to six LHIN representatives: "To what degree is the LHIN's approach to the community sector a result of local decisions within the LHIN? To what degree is it an outcome of province-wide MOHLTC policy?" The answers were:

> *It's a combination of both.*
>
> *Policy is 100 per cent provincial, then planning is at the local level.*
>
> *I would say it's a 50/50 split.*
>
> *I would say it's probably 50/50.*
>
> *It's a lot more local than provincial at this moment... It is fair to say we are reacting to crisis situations more than having a cogent plan for where things need to be. We have been a little bit in crisis mode, because our emergency departments are so backed-up.*
>
> *Both. The reason I say that is the funding is dedicated to certain areas of care provincially, and obviously that will influence service delivery, but we do work with our local partners on the gaps.*

The outcome of this mixed control for funding decisions was characterized by one provider as such: "In some ways I think there are good opportunities now because you are dealing more directly with people on the planning front. The downside is that the LHIN can start down a path and then the Ministry will come around and say no, we want to go this way." The Provider continued: "The LHIN may think what you are doing is great and want to do more, but the

Ministry can come in and change things. Originally LHINs were supposed to have full autonomy. I think it would be better if that had happened. On the one hand they've been given some powers; on the other hand they are quite disempowered". This incomplete devolution of responsibility for system design can leave providers wondering to whom to turn.

Communication issues

Several providers outlined problems with maintaining necessary levels of communication with their LHINs. Many believed that understaffing is the source of the problem. But other providers have had positive experiences.

Comments such as the following were quite common in interviews with providers:

> *There is no contact unless we initiate it. There is no relationship.*
>
> *Anywhere with LHINs, they don't answer emails or phone calls.*
>
> *If I phone MOHLTC I get definitive answers in writing, from the LHIN side, no answer at all.*
>
> *The support people are changing all the time. We keep getting new people we don't know, though the director and senior leads are consistent, the problem is they are so swamped. It can be very difficult to talk to them.*
>
> *They had a simple thought: 'the big providers take up more of our money so we should pay more attention to that.' The smaller situations seem secondary.*

A separate issue is the content of communications:

> *I wish we could have more open lines of communication and I wish their message was not so punitive. The individuals are nice but the overall message is threatening and negative.*
>
> *There is a lot of political bafflegab, but you can't get a word of real advice or direction. I will read an email from them twice and have no idea what it is actually saying.*

However, the same provider who saw official LHIN communications laden with "bafflegab" also saw some positives: "[In the past] there was the relationship with the program supervisor, the ease of picking up the phone to talk, the consultation. There was the possibility of unique funding for unusual circumstances. There was a mentoring and support role. But we did not have any cross-sectoral relationships or partnerships. We didn't know any better. Now I sit with six hospital CEOs. In days past I wouldn't even know how to knock on their door".

Another provider has had positive experiences and has some specific insight regarding how communications in today's system differ from the past: "We have a community support services network. I am the Chair there. The LHIN is very responsive to meeting with our networks and councils. Sometimes people are frustrated because they want the LHIN to solve a problem for

them and whether a Ministry staff did or didn't do that in the past, there is a perception now that they would have done so. Having been a Ministry staff, I'm not sure we did solve all these problems, but we did have more time to interact so that is what people are remembering perhaps".

Measurement and accountability

Several providers reported challenging and uncoordinated measurement and accountability processes. One source of frustration is not knowing why data are collected. Several providers noted that they submit quarterly reports to MOHLTC and to their LHIN. There is significant overlap between the two reports, but enough dissimilarity to ensure that each is a project in its own right.

According to one provider, "Some of the reporting and accountabilities are more hospital based. They use units of service: one interaction of a staff with a client within a 24 hour period". This form of measurement does not make sense in a supportive housing context. The provider continued:

> *Staff and volunteers may interact with an individual due to a crisis 10 times in the day. That intensity is never captured. They could spend all day with someone, but it is counted in the same way as if a doctor sees one patient... Other supports are voluntary and used on an as-needed basis. There may be 80 people who could potentially be using services, but they may not if they don't need us. Success for us in this case would be not having an interaction. My fear is that they [the LHIN] would come one day and say, 'why are there not enough units of service?'*

According another provider, "There is a fictitious, artificial construct around data. What does 40,000 face-to-face contacts mean?" The provider continued:

> *Number of Face-to-face visits is a useless measure without context and qualifiers. It's like saying how many times did you go to the grocery store. The real questions are: What did you buy? How healthy is your diet? Is there another grocery store that is a better value? Just how many times did you go to the grocery store is useless information. There is no quality measure, just quantity.*

This provider added: "No one can explain where this data goes and why it is collected... How can I prove that I need funding if they are barely asking me to prove that I provide valuable service? A better accountability structure will make this an honest and transparent relationship and could provide us with a narrative for public engagement."

Another provider commented, "They want a greater focus on targets and indicators. It can be a bit of a challenge at times in terms of wanting to find the right measurements to ensure that we are accountable for funding, yet flexible to the people we serve". Some providers reported that

meeting administrative, measurement, and accountability requirements is challenging their ability to serve clients:

> *The administrative part, reporting is at least 75 per cent more now than it ever was before and very complex. And it has caused more time away from clients.*
>
> *It's much more beneficial for me to have face-to-face contact and do direct service then to make sure stats are being collected. We work with it. We're not saying, 'No way, we won't do it.' but it is a challenge.*
>
> *We have had no budget increases and are expected to meet our responsibilities. There are all kinds of things we have to comply with in order to just upload our budgets. We are getting squeezed really tight. That's made it very difficult for us as service providers.*

While most providers reported challenges stemming from accountability and reporting processes, one noted that the in their LHIN the "measures make sense" and are aligned with the provider's objectives. One LHIN representative noted that while "accountability measures in place now are more about days and service units, the LHINs are looking at more measures of outcomes." Other providers have similarly noted that their LHINs are in the process of developing quality or outcome measures, which could address some of the concerns expressed.

Housing and health system collaboration

The 14 LHINs are Ontario's regional health system administrations. Ontario's 47 service managers are responsible for administering the bulk of the province's non-profit housing.[11]

While LHINs have been tasked by the Province with designing and funding integrated local health systems, Ontario's service managers have been similarly tasked with planning for and delivering locally coordinated housing and homelessness services. The responsibilities of LHINs and service managers touch at the margins in important ways.

LHINs and service managers have much to gain from collaborating on housing and homelessness issues. The effects of housing on health–and health system usage and costs—are well documented. As well, housing alone cannot end homelessness. Many tenants cannot maintain their housing without support services funded by LHINs.

Following consultations geared at gauging Canadians' views on the social determinants of health, the Canadian Medical Association concluded that four factors stood out: income, nutrition and food security, early childhood development, and housing.[12] The public understands the connections. The question is how to achieve these proven connections in policy.

Inconsistent collaboration between the housing and health systems is perhaps best symbolized in high-level planning exercises: in LHINs' Integrated Health Services Plans and service mangers' Local Housing and Homelessness Planning.

11 This excludes most supportive housing which is administered by the Province directly. Appendix 2 provides additional information about service managers and Ontario's non-profit housing landscape.

12 Canadian Medical Association, *Health Care in Canada: What Makes Us Sick? Town Hall Report* (Ottawa: Canadian Medical Association, July 2013).

The lack of a Provincial direction for LHINs and service managers to collaborate on a broad basis, with support to do so, is a flaw in the Provincial housing and health systems. It can result in challenges for new supportive housing development and unrealized opportunities to capitalize on the mutually reinforcing quality of housing and health services. As well, Provincial direction for the health system can be inconsistent with its approach to the housing system – this is evident in issues surrounding the expanded role of Community Care Access Centres (CCACs).

But these systemic challenges are not always evident at the local level. There are encouraging local examples of collaboration. One area of significant opportunity lies in addressing the unmet support needs of tenants in social housing.

Local housing and homelessness plans

The Province has tasked the 47 service managers with developing 10-year housing and homelessness plans. Service managers are charged with planning for the entire housing continuum and for programs to end and prevent homelessness, grounded in a housing first approach. With regard to homelessness, service managers are expected to implement measures to:

- help those who are homeless quickly access affordable housing
- help those at-risk of homelessness maintain their current housing
- provide households with access to community supports and services so that they can address their immediate and ongoing challenges and needs[13]

These first two bullets fall squarely within service managers' role as housing system managers. The last, however, will require service manager engagement with LHINs - which are significant funders of support services. While each service manager is required to develop a plan grounded in a housing first approach, they "may be unable to implement that plan unless supports... have been co-ordinated and approved in advance."[14]

According to an interviewee familiar with planning across the province, "There doesn't seem to be any directive from MOHLTC for LHINs to work with service managers. So it's up to what relationships develop between people." The interviewee continued, "It's incumbent on service managers to plan for whole housing system now and they need to be able to engage with the LHINs to do that."

The 47 service manager areas do not align geographically to the 14 LHINs. With their small staffs, LHINs may lack resources to engage with housing and homelessness planning in the multiple service manager areas located within their larger catchment areas, let alone follow-up on plans by delivering coordinated services.

13 Ministry of Municipal Affairs and Housing, *Ontario Housing Policy Statement* (Toronto: Government of Ontario, 2011).

14 ONPHA, *focusON: Housing First* (Toronto: ONPHA, 2013).

Still, LHINs are sometimes very engaged on housing and homelessness issues. One LHIN representative reported that "We've embarked on a mental health strategic plan that clearly indicates that the complexity of clients is increasing and there is a higher risk of homelessness, we are working with the City and all of our providers to put a plan in place... municipalities now have more freedom with consolidation we are working on that with them."[15]

Integrated Health Services Plans

Each LHIN is required by legislation to set out its vision for the local health system in an Integrated Health Services Plan (IHSP). A scan of the 14 LHINs' current IHSPs (which cover 2010-13) revealed varying degrees of existing and planned engagement with housing.[16]

Most LHINs mention supportive housing in their IHSP in a cursory fashion. Supportive housing is often framed as important to reaching the Province's mental health and addictions objectives. The sector is also mentioned as key to confronting the Alternative Level of Care (ALC) challenge. Supportive housing is generally mentioned in reference to the three MOHLTC health system performance indicators to which supportive housing and the community care sector overall are most likely to contribute (these are discussed in Appendix 1).

One LHIN did not mention housing at all in its IHSP. Another went into elaborate detail on the connection between developing supportive housing and relieving pressure on the health system. This LHIN commissioned its own study on how pressure could be alleviated from the health system through supportive housing development.[17] Another LHIN profiled the supportive housing access system it has funded. Several LHINs indicated that there are many individuals in long term care homes who could be better served in supportive housing. This view is strongly supported by research.[18]

15 By "consolidation" this LHIN representative was referring to the Province's Community Homelessness Prevention Initiative (CHPI), which has combined funding from separate housing and homelessness programs in a single envelope which service managers can use with greater local discretion.

16 IHSPs for 2014 on are now available, but this analysis was conducted before their release.

17 Central East LHIN, *Supportive Housing Priority Project* (CEntral East LHIN, April 2009), http://www.centraleastlhin.on.ca/uploadedFiles/Home_Page/Board_of_Directors/Board_Meeting_Submenu/Supportive_Housing_Report_-_FOR_POSTING_AND_DISTRIBURTION.pdf.

18 A study of the long term care waiting list for the Toronto Central Community Care Access Centre found that only 20 per cent of the 1,600 people waiting for long term care actually needed long term care. 35 per cent were found to be capable of living in the community if appropriate supports were available while the remaining 45 per cent would be properly served by supportive housing with case managed services: A. Paul Williams, "Aging at Home: Connecting the Dots in Ontario and Beyond" (presented at the Aging at Home: Connecting the Dots in Ontario and Beyond e-symposium, Toronto, June 22, 2009), http://www.crncc.ca/knowledge/events/pdf-connectthedots/integrationroundtablejune222009--FINAL-FINALFINAL.pdf; A further study interviewed 284 seniors successfully living in 11 supportive housing sites in Toronto and found that all 284 would qualify to be waitlisted for long term care, even though they were currently adequately served by supportive housing: Janet Lum et al., *Balancing Care for Supportive Housing: Final Report* (Toronto: Balance of Care Research Group, University of Toronto, May 2010), http://www.crncc.ca/knowledge/related_reports/pdf/Balancing per cent20Care per cent20for per cent20Supportive per cent20Housing per cent20Final per cent20Report.pdf; See also: Ontario Community

While the IHSPs provide a general sense of LHIN direction, it is important to note that they are very high-level documents. Inclusion or non-inclusion of housing in these plans should not be taken as an indication of a LHIN's understanding or commitment to supportive housing. It is, however, notable that service managers who administer the bulk of Ontario's housing stock and are mandated to plan for ending homelessness—which will require services funded by LHINs—generally do not appear in LHIN's high-level planning documents.

CCAC expanded role

Each of the 14 LHINs funds a Community Care Access Centre (CCAC) charged with conducting needs assessments and connecting community members with home care, long-term care, and other services in the community. Following 2009 changes to regulations under the Community Care Access Corporations Act (2001), LHINs are now required by MOHLTC to have their local CCAC establish a central placement service for LHIN-funded community services (including supportive housing).[19]

Changes are starting to be implemented in some communities. This is raising several concerns, including the prospect that access to supportive housing could be overly shaped by the drive for health system efficiency.

According to one supportive housing provider, "...it is no longer just about explaining housing to our funder. It's about shaping an access system that still has a housing lens. There are all kinds of reasons why people want to move, like employment, services, etc. But they are pushing that whole level of care piece." The same provider emphasized that operating access systems based on ALC and looking to hospitals and the medical system for prospective tenants can disadvantage populations that many supportive housing providers were founded to serve, such as homeless people with serious mental illness or individuals with disabilities needing to find a home as their care-giving parents age.

CCACs are focused on health. The criteria they apply to determine access priorities do not generally incorporate financial need – which is traditionally a major focus for housing providers. While many individuals in need of support services are also in financial need, this is not always the case. As the CCACs take on their expanded role, it will be crucial to ensure that the affordability objectives of housing providers are retained.

There is a special complication in the case of service manager-administered supportive housing covered by the *Housing Services Act* (HSA). While CCACs have been tasked by the Province with taking responsibility for access to some of this supportive housing, the Province, through the HSA, has also required that these same providers comply with different access priorities. For

Support Association, *Supportive Housing: The Winning Formula for Supporting People and Sustaining the Health Care System* (Toronto: Ontario Community Support Association, 2007).

19 Regulatory changes were permissive rather than prescriptive, expanding the charitable objectives of the CCACS to include centralized placement systems beyond long-term care.

example, while the HSA requires that victims of violence receive priority access, this is not the case for CCACs where concern lies principally with getting ALC patients out of needed hospital or long-term care beds.

It is unclear at this juncture how competing provincial direction will be resolved, or the degree to which conflict will materialize in communities over access priorities. It is known that the issue has come to a head in at least one area. What is very concerning, however, is the fact that the Province could issue a health policy that comes into conflict with its housing policy. This is emblematic of the need for greater coordination.

Challenges to new supportive housing development

Most new supportive housing is constructed with federal, provincial, and municipal funding that is flowed through service managers.[20] Service managers make decisions regarding what new affordable housing to build, if any, with the limited housing funding available. LHINs make decisions about where and how supportive services are delivered. This division of responsibility poses challenges to supportive housing development.

Supportive housing incorporates two elements: an affordable place to live and support services. Funding bodies are not coordinated to develop such housing. It is up to proponents to align the necessary funding streams. Proponents must be highly motivated and politically astute to build supportive housing in today's environment. They must first secure one funding stream—housing or support—and then try to secure the other before initial guarantees expire.

One provider reported a typical situation. After securing a $1 million annual budget for support services from the LHIN, the provider went to the service manager looking for capital for a building. The service manager could only come up with capital for 10 units, well below the 21 units for which the LHIN wanted to fund support services. This provider needed knowledge of how to escalate the matter beyond the local level in order to find success: "We had to go directly to MMAH to find more money and eventually built the 21 units so we could fully take advantage of all the available support dollars. It's so nerve racking. We took a huge risk but everything fell in place".

Things do not always fall into place. Another provider reported a process that began from the other side, with a guarantee of capital preceding the search for support service dollars: "Two years ago we opened an affordable housing project with 20 units. It was funded through the stimulus money... We were funded with the understanding that the support money would come from MOHLTC. When we went to talk to MOHLTC, they said talk to the LHIN. The LHIN said 'we are just told where the money should go'." The support dollars for this project never materialized.

20 This combined federal, provincial, and municipal funding flows through the Investment in Affordable Housing. Its predecessor program, which was initiated in 2003, was the Affordable Housing Program.

One service manager representative provided another perspective: "The LHIN operates based on the assumption that the housing will appear. Then I get the message that unless I can provide the units, the support service money will be in jeopardy. Well I don't have that housing to give. But then at other times if I come to the LHIN when I do have money for housing to look for support dollars to match, they don't understand what I'm talking about. They will give 15 days to respond to a supportive housing RFP, but it takes two to three years to build a building. There is a lack of synchronicity".

The service manager representative continued to emphasize that while the LHIN provides support service dollars, the service manager will continue be the route to new housing: "Dollars for new housing will flow through us, as will the land. If supportive housing providers want to grow or change models of delivery, they have to go through the service manager. Supportive housing providers will need to have a relationship with us."

One provider spoke of their local LHIN at least partially grasping the problem: "The housing component and the service could work closer together. Sometimes housing is available, but not support. This is a big issue in mental health. There is a coordination need. I think our local LHIN has at least some knowledge of that. That was one of the things I talked about with senior [LHIN] leadership".

One LHIN representative who clearly understood the supportive housing development conundrum reported the following:

> *[Two] providers [in our area] received funding for supports under aging at home, but the capital side was a bit of a bugaboo. They went to the Capital branch at MOHLTC to try to find dollars, to a federal program, to fundraising. It has been difficult. One provider ended up serving a geographic region as opposed to being building-based. The other provider has a capital build in the works. They are still trying to secure sufficient funding to make it happen. The providers are great at recognizing the need and trying to operate the program without the units. The outreach fills one need, but without an actual tangible unit it doesn't fit the bill totally.*

One provider engaged in supportive housing development in multiple LHIN areas reported some improvement:

> *There is a lot more creativity now about how we get to an end goal. Before we would hear, 'we don't do bricks and mortar, you have to come to us with a building.' A couple LHINs are now more clearly saying, 'how do we get to this end-point?' There is a little bit more open dialogue. I feel comfortable now to say 'we don't actually have a building but this is what we're thinking.' Before it was 'we don't have a building so there's no conversation'. With the LHINs there is a general understanding of the chicken and egg scenario.*

Another provider reported success in new development: "I think they [the LHIN] understand supportive housing pretty well. We receive tremendous support, unprecedented really. For once all the stars were aligned. We could get some money from the municipality for some rent supple-

ments, then we built a new building, then we got funding from the LHIN. This is the first time in 20 years that we got more housing. This hardly ever happens. It's just so rare." The provider emphasized that this positive outcome was the result of the "stars aligning" locally, not of a co-ordinated system: "This alignment issue, we can't get it after 30 years. We can't get them to work together at the Queen's Park level."

High-level efforts to coordinate funding, not to mention increase it, are needed to expand the supportive housing stock. But there is at least the impression that some LHINs are becoming more open to working with the system we have to get the supportive housing we need.

On-site supports in social housing

There is little public understanding of the differences between social and supportive housing. The differences are generally known only to those engaged in the sector.

In a recent report, Toronto's Ombudsman noted that, "At times, the term social housing is used interchangeably with supportive housing." She clarifies, however, that supportive housing implies the delivery of needed support services while social housing is limited to providing a safe, secure, affordable home.[21] The Ombudsman's need to clarify the differences between supportive and social housing are emblematic of the increased expectations that social housing providers face.

Social housing providers across Ontario report that they are increasingly housing tenants who are aging or who require support to maintain their housing due to mental health challenges, addictions, or other issues. They are being called upon to facilitate or provide access to support. The trouble is that social housing providers have been designed, regulated and funded to house tenants who can live independently or who can coordinate access to their own supports.

In Ontario, to be eligible for rent-geared-to-income (RGI) assistance, Provincial regulation stipulates that tenants must be able to "live independently." This is defined as such: "an individual is able to live independently if he or she can carry out the normal essential activities of day-to-day living, either on his or her own or with the aid of support services that the individual demonstrates will be provided when required."[22] The onus is on RGI tenants to secure any needed supports and demonstrate their availability.

Still, social housing providers typically see themselves as more than just landlords and have a strong record of connecting tenants with needed supports whenever community resources are available to do so. Too often, however, community resources are not available. There is no

21 Fiona Crean, *Housing at Risk - An Investigation into the Toronto Community Housing Corporation's Eviction of Seniors on the Basis of Arrears* (Toronto: Office of the Ombudsman of the City of toronto, 2013), para. 105.

22 *Housing Services Act, 2011 Ontario Regulation 367/11,* sec. 24.2, http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_110367_e.htm#s24s1.

province-wide funding and delivery framework to ensure that needed supports are delivered to social housing tenants.

Social housing tenants with unmet needs pose challenges for both the housing and health systems. From a housing perspective, tenants with unmet needs are at risk of not fulfilling the responsibilities of a tenant and losing their housing. Poor housekeeping can also cause damage to social housing assets and make buildings unattractive to new and existing tenants. From a health perspective, unmet needs in-and-of-themselves can be detrimental to health and can drive inefficient health system use. And loss of housing can result in homelessness and the extreme implications it has for health and health costs.

LHIN health system goals such as reduction of unnecessary ER admissions can be reached in part by targeting support services to clustered populations most likely to use emergency components of the health system in their absence. Such populations are often found in social housing. This is a fact to which some LHINs are increasingly attuned.

On-site support for seniors

Seniors are eligible to receive support services through their local CCAC regardless of where they live. But such services often do not reach seniors who lack a network of friends and family to make the needed referrals. Many such seniors live in social housing.

In some cases, LHINs are now funding on-site services to reach out directly to seniors in social housing. One project operates in eleven seniors' buildings owned by a large social housing provider. The buildings were selected based on their having some of the highest ER usage and hospitalization rates among residential addresses in their community. The goal of the project is to reduce ER visits, reduce hospitalization, and to delay long term care admissions.

The project, which is a partnership between the local CCAC, a local support provider and the social housing provider, establishes storefront offices in each building. In each, a CCAC case manager is stationed along with a community support outreach coordinator. The take-up of CCAC services has increased with on-site staff presence. Access to nurse practitioners has also been a tremendous service to tenants.

A representative of the social housing provider reported that the project is considered highly successful, and that there is a desire to implement it in the remaining seniors' portfolio, were funding made available. The LHIN has expanded the number of buildings served since the project began.

The Province's 2011 *Assisted Living Services for High Risk Seniors Policy* tasked LHINs with establishing hubs from which to offer on-demand assisted living services to seniors who can live

independently, but whose needs go beyond services offered on a scheduled basis alone.[23] Access to services is intended to flow from referrals.[24] But experience with the project discussed above suggests that a referral process alone is insufficient. Direct outreach is required to identify clients in places where need is concentrated. Seniors' social housing buildings will be chief among such locations.

Currently, there are many cases in which seniors' social housing buildings are served by multiple CCAC case managers and various community agencies, and still, there are unsupported tenants with unidentified needs because policies remain referral-based instead of place-based.

LHINs are increasingly using a population-based approach to target on-site services. According to one LHIN representative, "I can't say it was an intentional targeting, but our high risk seniors tend to end up being in social housing." By looking to seniors' social housing buildings as bases of operation, LHINs can help advance the objectives of the *Assisted Living Services for High Risk Seniors Policy*.

LHINs and access to seniors' social housing

In some cases, LHINs have gone beyond offering support services to existing tenants of social housing, instead trying to work with housing providers and service managers to, in effect, create new seniors' supportive housing within existing seniors' social housing - with the LHIN determining access priorities. Two LHINs reported pursuing such arrangements for the purpose of housing and supporting ALC seniors.

One LHIN representative described making progress on securing priority access to some units in seniors' social housing with the understanding that the LHIN will then fund services for the new tenants, "They [the service manager] have to change their admissions policy so that individuals with high needs have first priority to a certain number of units. The municipality is quite enthusiastic about this and open to that criteria [high-needs ALC seniors] for a specific number of units. Then we can guarantee that we will have the services there for them."

Another LHIN representative reported facing difficulty establishing a role in determining access to seniors' social housing units. This representative's experience is instructive:

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23 The specific target population is "high risk seniors whose needs cannot be met in a cost-effective manner through home and community care services provided solely on a scheduled visitation basis, but who do not require admission to a long-term care home (LTCH)." See: Ministry of Health and Long-Term Care, *Assisted Living Services for High Risk Seniors Policy, 2011 (A Supportive Housing Program)* (Toronto: Government of Ontario, January 2011), 4, http://www.mississaugahaltonlhin.on.ca/uploadedFiles/Public_Community/Current_Initiatives/ALS-HRS per cent20Updated per cent20Policy per cent202011 per cent20EN per cent20FINAL per cent202012 per cent2009 per cent2024.pdf.

24 "Referrals to assisted living services may be made directly through self-referral, hospitals, CCACs, primary care providers, other health professionals, informal caregivers such as family members, neighbours or friends, or community support staff/volunteers." Ibid., 11.

We see people who are ALC and people who need additional support to be housed as a priority whereas housing providers have mandates and priorities that are not always aligned with ours. The challenge is respecting each others' priorities and trying to come up with a solution. We can come across in the health sector as arrogant and mighty and the response we get is, 'well your priority is not my priority!' Health does not get housing and they need too.... On our wish list is to get some ALC access to seniors' social housing buildings in exchange for delivering the services. It became clear that this wouldn't happen. There were too many other priorities for social housing. As soon as we backed off from wanting priority status and access, the service managers were willing to work in a much more collaborative way. But again, it all comes down to the need for more housing.

This LHIN representative's comments capture the dynamics in the sector well. Service managers and housing providers will have to determine whether any such access arrangements are right for them. The challenge underpinning such decisions is the lack of a sufficient supply of housing.

On-site support for mental health and addictions

Social housing providers report that they are increasingly challenged by the prevalence of mental health and addictions issues experienced by their tenant populations.[25] According to one social housing provider, "We're not considered supportive housing, but where do they think these folks are going? My agenda is keep my building safe and the tenants safe, but it is hard to do when you don't have a budget to do it. If 30 per cent of the building has issues, the other 70 per cent suffer."

While the needs of seniors are high on the radar—albeit not always met—there are fewer examples of LHIN engagement with determinants of health such as mental health and addictions in a social housing context. One promising example is profiled below.

Many of the factors that would lead to the label of "problem building" in a social housing context (e.g. security issues, drug dealing, hoarding, poor housekeeping, additions, and mental health issues) ultimately place a substantial burden on the health system. One enterprising LHIN has recognized as much and has taken a significant step forward, funding a pilot project targeting a "problem building" in a large social housing provider's portfolio. The LHIN-funded project is being run by the housing provider, two support agencies, and a primary health care team.

25 For example, Toronto Community Housing (TCH) houses "8,900 adults with 'serious and persistent' mental illnesses" and, "to give a sense of scale, that's more than double the annual inpatient admissions at the Centre for Addiction and Mental Heath, Canada's largest mental health facility." Joy Connelly, "It's Not Ford's Fault!," Opening the Window: Fresh Ideas for Social Housing, June 12, 2013, http://openingthewindow.com/2013/06/12/its-not-fords-fault/.

From a housing perspective, the targeted building faces serious problems:

> *In 2012, over 20 per cent of the building's tenants were behind in their rent. Poor housekeeping was a problem in 40 per cent of the units. And there was a steady stream of problems: 104 calls for causing a disturbance or loitering, 45 calls about trespassing, and 24 calls to deal with neighbour disputes. Naturally the apartments were hard to fill, with a 15 per cent vacancy rate.*[26]

The LHIN was drawn to engage with this building due to the hundreds of 911 calls and ER visits generated by its tenants every year, "many of the tenants have been homeless. Many have mental health or addiction issues. *All* have low incomes. In other words, they are at risk of becoming part of the 1 per cent of the population that accounts for up to 30 per cent of health spending."[27] Credit is due to this LHIN for recognizing the importance of reaching these individuals where they are, and not simply waiting for them to reach the hospital.

While still in its early stages, the project has already seen measurable gains, including a 33 per cent reduction in violent calls for service to police. Police report that this number understates the degree to which the building has changed: "According to my officers the building is 100 per cent better than last year and has been worth the effort. This is the type of feedback that is not measurable." A tenant similarly remarked that, "It's a lot calmer since the project began. People are coming out of their shells. See that lady over there? She would never help out before. She was just shy and stayed unto herself. Now she's helping. It's because it feels safer now."[28]

In social housing there is often concentrated need, or what is referred to as clustering by LHINs. But concentrated need is also an opportunity to address challenges in comprehensive way. This LHIN-funded project could be a model for a province-wide framework to address mental health, addictions, and other challenges in social housing. Doing so would be a natural extension of Ontario's *Mental Health and Addictions Strategy*.[29]

Health Links

The Province recently launched a LHIN-led initiative known as *Health Links*, the goal of which is to better coordinate the medical and community support of the top five and one per cent of health care system users, with the intention of improving their health outcomes and reducing health system costs.[30] This is a laudable initiative that could assist many vulnerable people and

26 Joy Connelly, "How to Turn Round a Building - and Save Money Too," *Turning Around Albert: One Year Towards a Safer, Healthier Home*, June 19, 2013, http://turningalbertaround.wordpress.com.

27 Ibid.

28 Joy Connelly, "We Surprised Ourselves!," *Turning Around Albert*, accessed September 24, 2013, http://turningalbertaround.wordpress.com/2013/09/10/we-surprised-ourselves/.

29 Ministry of Health and Long Term Care, *Open Minds, Health Minds: Ontario's Comprehensive Mental Halth and Addictions Strategy* (Toronto: Government of Ontario, 2011), http://www.health.gov.on.ca/en/common/ministry/publications/reports/mental_health2011/mentalhealth_rep2011.pdf.

30 Ontario Medical Association, *Health Links 101: Integrated Health Care for Patients with Complex Needs* (Toronto: OMA, 2013), https://www.oma.org/Resources/Documents/HealthLinks101Brochure.pdf.

save public resources. ONPHA recently asked an organizer of one of the new *Health Links*, anecdotally, how many top health system users in his catchment area were homeless or otherwise precariously housed. The answered, quite simply, was "all."

Not all health problems will have direct "health care" solutions. In many cases, the best medicine—or at least a foundation for it—may be a stable home with adequate support. Applying a housing lens and housing resources within the *Health Links* initiative could do much to achieve the objects of *Health Links*, while at the same time preventing and reducing homelessness.

Health and housing services are mutually reinforcing. The goal of *Health Links* is to coordinate care and reduce health systems costs, but for many individuals that won't be possible in the absence of safe, stable, supportive housing. Ultimately these two systems, housing and health, need to be linked much more closely together.

Conclusion

This *focusON* reported on supportive housing provider experiences working with and being funded by LHINs and examined questions surrounding the overall level of coordination between Ontario's housing and health systems. Recommendations for improving LHIN-supportive housing provider working relationships and for beginning to weave together Ontario's housing and health systems are provided in the background and recommendations section.

Principal recommendations focus on the need to enhance LHINs' housing policy capacity, the need to coordinate and enhance funding streams to facilitate supportive housing development, and the need to address the challenge of unsupported tenants in social housing through LHIN-housing system collaboration.

The housing system and health system both exist to serve Ontario's communities. The Province has chosen in recent years to organize these systems on a regional basis with the stated intention of improving services and government efficiency. The task now is to weave together the regionalized health and housing systems, which are presently maturing on parallel tracks.

Appendix 1 : About LHINs

There are 14 Local Health Integration Networks (LHINs) which cover Ontario's geography.[31] LHINs are mandated to "work with local health providers and community members to determine health service priorities" and "plan, integrate and fund local health services."[32] Cumulatively, LHINs disperse roughly $23.4 billion annually, which accounts for over 50 per cent of total Provincial health care spending, and roughly 20 per cent of the total Provincial budget.[33] LHINs provide funding for:

- public hospitals
- specialty psychiatric hospitals
- Community Care Access Centres
- long-term care homes
- community health centres
- community support services
- community services for persons with acquired brain injury
- assisted living services in supportive housing
- mental health and addiction agencies

31 A map of Ontario's LHINs can be found here: http://www.lhins.on.ca/FindYourLHIN.aspx.

32 *Ontario's Local Health Integration Networks FAQ- What Are LHINs?*, http://www.lhins.on.ca/aboutlhin.aspx?ekmensel=e2f22c9a_72_184_btnlink.

33 Ministry of Finance Government of Ontario, "Expenditure Estimates of the Province of Ontario for the Fiscal Year Ending March 31, 2014 VOLUME 1," accessed July 23, 2013, http://www.fin.gov.on.ca/en/budget/estimates/2013-14/volume1/MOHLTC.html.

The bulk of remaining provincial health expenditures flow through the Ontario Health Insurance Program (OHIP), which directly pays for the cost of medical procedures. LHINs mostly interact with supportive housing providers by funding "assisted living services within supportive housing."[34] LHINs provide only support service funding. They rarely engage in the bricks and mortar or "landlord" side of housing management or development. Not all supportive housing providers are funded by the LHINs.

LHINs are crown agencies and each has a nine-member board appointed by the Province. LHINs were introduced in 2007 following their authorization by the 2006 *Local Health System Integration Act* (LHSIA). They are bound by performance agreements with the Ministry of Health and Long-Term Care (MOHLTC) which specify targets for health system performance.[35] They, in turn, enter into their own accountability agreements with the local health service providers (including supportive housing).

LHINs are required to operate under locally-generated *Integrated Health Services Plans* (IHSPs). In these plans, LHINs outline the central issues facing their areas and goals for local health system planning. While LHINs do develop these expressions of local health system vision, they also work toward the achievement of province-wide health system goals set by MOHLTC and expressed in the indicators found in their performance agreements.

There is a tension between the LHINs' dual roles as policy making entities and transfer payment agencies. According to one health system analyst, "LHINs were deliberately structured to be lean and nimble- with no more than 20-25 staff. While laudable in concept, this may leave them significantly under-resourced to manage an agenda... involving over $20 billion annually of health care spending."[36] The LHINs' are at once subject to the long-term priority-setting of MOHLTC—and responsible to implement ad hoc policy initiatives stemming from the Ministry—while also mandated to take a creative, independent approach to designing local health systems, all with very small staffs relative to the amount of money they move and number of agencies with which they interact.

Ministry-LHIN performance agreements are updated every two years. They currently contain 15 performance indicators. The bulk of these 15 performance indicators are very medically focused, e.g. "wait times for cardiac by-pass procedures." Meeting targets set for other indicators, however, has clear implications for community care sector agencies funded by LHINs. These indicators are:

- Repeat unplanned emergency visits within 30 days for mental health conditions

34 As noted, LHINs enter into accountability agreements with the service providers they fund. The type of agreement that supportive housing providers are most likely to have with LHINs is a Multi-Sector Accountability Agreement - Community Support Services (MSAA-CSS).

35 Ministry-LHIN Performance Agreements can be found here: http://www.lhins.on.ca/page.aspx?id=1236.

36 John Ronson, "Integrated Health Services Plans: From Planning to Action," *Healthcare Quarterly* 10, no. 3 (May 15, 2007): 89–90.

- Repeat unscheduled emergency visits with 30 days for substance abuse conditions
- Percentage of alternate level of care (ALC) days

LHINs want to reduce the number of individuals who arrive in emergency rooms frequently due to mental illness and substance abuse. The community care sector has a role to play in ensuring that people living with mental illness and addictions can secure help before emergencies occur.

An "ALC day" is a day that a patient spends in a "level of care" that is deemed inappropriate to their level of need. If it takes 25 days from when an individual is labeled ready to leave a hospital for a long term care home to when the person actually moves, then this individual has experienced 25 ALC days. ALC days are harmful to individuals and often expensive.[37] Reducing ALC requires improving 'system flow-through', which is dependent on there being places for people to live in the community once they are discharged from hospital.

The LHINs' ultimate objective is to transform the health system, increasing cost-effectiveness and improving services. Their primary tool to achieve these goals is "integration." The word "integrate" is defined by the LHSIA. It can mean any of the following:

a. to co-ordinate services and interactions between different persons and entities,

b. to partner with another person or entity in providing services or in operating,

c. to transfer, merge or amalgamate services, operations, persons or entities,

d. to start or cease providing services,

e. to cease to operate or to dissolve or wind up the operations of a person or entity.[38]

The LHSIA mandates that, "Each local health integration network and each health service providers shall separately and in conjunction with each other identify opportunities to integrate the services of the local health system to provide appropriate, co-ordinated, effective and efficient services."[39] While the LHSIA does call on service providers to seek integration opportunities independently and contribute to system coordination, the tools to order change are granted to the LHINs. The LHSIA gives LHINs significant integration authority in the area of services. If they deem it in the public interest to do so, LHINs can make decisions requiring funded agencies:

37 Patients experiencing ALC days receive either too much or too little care. The negative impacts of too little care are clear. Receiving too much care can also be harmful, as well as unnecessarily costly. For example, patients staying in hospitals too long risk increased exposure to infection as well as possible degradation of capacity for independent living.

38 Local Health System Integration Act, 2006, sec. 2, http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_06l04_e.htm.

39 Ibid., sec. 24.

1. To provide all or part of a service or to cease to provide all or part of a service.
2. To provide a service to a certain level, quantity or extent.
3. To transfer all or part of a service from one location to another.
4. To transfer all or part of a service to or to receive all or part of a service from another person or entity.
5. To carry out another type of integration of services that is prescribed.
6. To do anything or refrain from doing anything necessary for the health service providers to achieve anything under any of paragraphs 1 to 5, including to transfer property to or to receive property from another person or entity in respect of the services affected by the decision.[40]

LHINs can also use their discretion to prevent health service providers from integrating in cases when the providers themselves initiate an integration process, should the LHIN determine the proposed integration is not in the public interest.[41] In addition, LHINs "may integrate the local health system" simply through their discretion over resource allocation, i.e. "providing or changing funding to a health service provider."[42]

Despite the wide-ranging authority over service integration that they are granted, LHINs do not have the authority to order health service providers to amalgamate, transfer all operations to another entity, change their board composition or structures, or to cease operating.[43] These powers are retained by MOHLTC, though following the legislation, LHINs can advise MOHLTC on when such decisions are considered desirable.[44] LHINs have significant authority to mandate service integration, but only an advisory capacity in the area of corporate integration.

Rather than having the authority to alter the landscape of health service providers, LHINs are charged with changing the terms under which they interact. But in doing so, they can certainly influence the viability of funded agencies. One analysis of the legislation concluded that, "wholesale transfer orders could effectively gut the current operations of particular healthcare providers who refuse to voluntarily transfer and integrate programs."[45]

Though the meaning of "integrate" is well-defined by the LHSIA, the means by which LHINs should arrive at decisions about integration are not carefully specified, nor are criteria for when to determine what forms of integration are best suited to meeting what desired health outcomes. All of these specifics are left by the legislation to local decision making.

40 Ibid., sec. 26.
41 Ibid., sec. 25.
42 Ibid.
43 Ibid., sec. 26.
44 Ibid., sec. 28.
45 John Ronson, "Local Health Integration Networks: Will 'Made in Ontario' Work?," *Healthcare Quarterly* (Toronto, Ont.) 9, no. 1 (2006): 46.

On paper, LHINs have very substantial tools. However, while their language is often strong, it is safe to say that they have moved with caution on their integration agenda. They have generally leveraged their funding authority to informally facilitate limited integration that is more voluntary in character, rather than using the specific powers outlined in the LHSIA to order integration with formal decisions. There has similarly not been a flood of LHIN recommendations to MOHLTC suggesting corporate integration of health service providers. The LHINs' limited use of the powerful tools granted to them by the legislation may be related to their lack of an appropriate staff compliment and the continued central influence of MOHLTC. The imbalance between LHIN and MOHLTC staff capacity leaves MOHLTC mostly in the driver's seat when it comes to system design.[46]

46 John Ronson, "LHINs at Five Years – What Now?," *Essays* (June 13, 2011), http://www.longwoods.com/product/22432.

Appendix 2: About supportive and social housing

Supportive housing has no fixed definition. One definition holds that supportive housing "links affordable housing to staff that provides a comprehensive and coordinated package of services and programs to help individuals maintain their optimum level of health and well-being."[47] Another definition, often heard from advocates of supportive housing, is "doing whatever it takes to keep people healthy, happy, at home, and connected to their communities".

ONPHA uses a simple definition: "Supportive housing is housing plus support—the support people need to keep their homes." Supportive housing providers have varying mandates. Supportive housing tenants can include individuals who are:

- chronically homeless and hard-to-house,
- frail and elderly,
- physically disabled,
- developmentally disabled,
- experiencing acquired brain injuries,
- seriously mentally ill,
- survivors of domestic violence,
- living with HIV/AIDS,
- youth, or
- living with addictions.

47 Janet Lum, Jennifer Sladek, and Alvin Ying, *Supportive Housing from the Ground Up: Frequently Asked Questions* (Toronto: Canadian Research Network for Care in the Community, 2007), http://www.crncc.ca/knowledge/factsheets/pdf/InFocus-SupportiveHousing-FromtheGroundUp-FrequentlyAskedQuestions.pdf.

Tenants can fit into more than one category and the range of support services differs based on each supportive housing provider's tenant mandate. Services in supportive housing can be delivered by the housing provider or by third party agencies. Tenants in supportive housing live in their own units or in "congregate" settings where kitchen, washrooms, and common areas are shared.

Supportive housing can be a foundation for processes of recovery.[48] This is often the case for people living with mental illness, additions or who have been homeless. For seniors, supportive housing plays a key role in supporting independence.[49]

Supportive housing is a sub-category of non-profit housing. Non-profit housing in Ontario has been created through government investment. These investments, predominantly committed between 1949 and 1995, were made in order to provide homes that are affordable to people with low incomes in the case of social housing and to offer support services additionally in the case of supportive housing.[50]

Non-profit housing providers—so long as they receive government funding—have operating agreements or legislation which structures their role and responsibilities as well as those of their government administrators. Supportive housing providers look to their administrators/funders for the following needs: (1) "bricks and mortar" funding to service mortgages and maintain housing, (2) funds for rent supplementation to keep tenants' housing affordable, and (3) support service funding to help tenants remain safely and securely housed. Social housing providers are not funded for this last purpose.

Non-profit housing in Ontario is now owned and operated either by municipally-owned or by community-based non-profit corporations.[51] Between 1999 and 2000 responsibility for the administration of non-profit housing changed drastically. Administration went from being a federal and provincial responsibility to being primarily a municipal responsibility.

The 1999 *Canada-Ontario Social Housing Agreement* transferred responsibility for non-profit housing under federal administration to Ontario's provincial government.[52] But this respon-

48 CAMH, Road to Recovery: *Client Experiences in Supportive Housing* (Toronto: CAMH, October 2012).

49 For that reason, expansion of supportive housing has been recommended by the Ontario's Seniors Strategy. See: Samir K. Sinha, *Living Longer, Living Well: Highlights and Key Recommendations from the Report Submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on Recommendations to Inform a Seniors Strategy for Ontario* (Toronto: Ministry of Health and Long-term Care, January 2013), 11, http://www.health.gov.on.ca/en/common/ministry/publications/reports/seniors_strategy.

50 From 1949 to 1974 most investments were in large scale public housing estates. From 1974 to 1995, most investments were in community-based housing in mixed neighbourhoods. Between 1995 and 2003 no new affordable housing was created with government assistance in Ontario. Since, 2003 very modest amounts have been constructed, some of which offers supports, but much of this new generation of housing is not as affordable as the housing that was funded in the past.

51 Community-based (private non-profit) housing providers are rooted in numerous different forms of association, such as religious congregations, ethnic organizations, veteran' organizations, and service clubs.

52 This transfer included housing developed by the federal government alone and by the federal and provincial governments jointly. Previously, the provincial government had only administered housing

sibility did not stay with the Province long. Ontario subsequently passed the great bulk of the housing on to the municipal level. The 2000 *Social Housing Reform Act* (SHRA) made this transfer of housing to the 47 newly designated "Consolidated Municipal Service Managers" and "District Social Service Administration Boards" (referred to collectively in this focusON as service managers).

The 2011 *Housing Services Act* (HSA) has now replaced the SHRA. The HSA was accompanied by the Province's *Long-Term Affordable Housing Strategy* (LTAHS). Together, the HSA and LTAHS have "completed the devolution of Ontario's social and affordable housing to municipalities."[53] Whereas the SHRA was very prescriptive, simply telling service managers what to do, the HSA regime calls on service managers to play a more active role.

When it downloaded most social housing to the municipal level, the Province retained responsibility for most supportive housing, but transferred responsibility for it from the Ministry of Municipal Affairs and Housing (MMAH) to the Ministry of Health and Long Term Care (MOHLTC) and Ministry of Community and Social Services (MCSS). This is the origin of what is now referred to as the "dedicated supportive housing portfolio" which is retained by the Province and administered by these Ministries.

Prior to this transfer, MMAH administered "bricks and mortar" and rent supplementation for supportive housing providers, while their support service funding flowed through either MOHLTC or MCSS. Then MOHLTC and MCSS took responsibility for all aspects of the supportive housing in their portfolios. For its providers, MCSS continues to directly administer funding for bricks and mortar, rent supplementation, and support services. Following the creation of the LHINs, support service funding became a LHIN responsibility for providers under MOHLTC administration. But MOHLTC retains responsibility centrally for bricks and mortar and rent supplementation.

The result was a decade of substantial change. In 1998, many supportive housing providers had their bricks and mortar and rent supplementation needs met by MMAH and support services needs met by MOHLTC. By 2008, the same providers received bricks and mortar and rent supplementation funding from MOHLTC with responsibility to fund support services transferred to newly created LHINs.

There is some LHIN-funded supportive housing that is not part of the MOHLTC portfolio. For example, some new supportive housing established with funding from the post-2003 federal-provincial affordable housing programs.[54] As well, when service managers were given

that it developed alone. This federal-to-Ontario transfer was part of a Canada-wide process in which the federal government transferred responsibility for administration of non-profit housing under its administration to the provinces.

53 ONPHA, *focusON: Local Housing and Homelessness Plans* (Toronto: ONPHA, February 2012), https://www.onpha.on.ca/focusON.

54 Funding for new construction under the post-2003 Affordable Housing Program and then Investment in Affordable Housing has flowed through service managers. Some have chosen to use their available

responsibility to administer non-profit housing, some supportive housing, which can be LHIN-funded, was devolved to them.[55]

funds under these programs to build supportive housing, though the programs are primarily focused only on addressing affordability challenges alone.

55 These housing providers are listed in Schedule 3 of the *Housing Services Act*. In total, 224 providers designated as delivering "special needs housing administrators" were transferred to service managers.

Appendix 3: About this focusON

This *focusON* is the report of the ONPHA LHINs Task Force, an initiative of ONPHA's Supportive Housing Committee. The Task Force was struck to explore the relationship between LHINs and supportive housing. This focusON was produced by Jon Medow, ONPHA's Coordinator of Policy, Research, and Government Relations. The members of the Task Force were:

Alice Radley, Physically Handicapped Adults Rehabilitation Association (PHARA)
Angela Shaw, St. Jude's Community Homes
Brigitte Witkowski, Mainstay Housing
Lisa Ker, Ottawa Salus Corporation
Mark Aston, Fred Victor
Noel Simpson, Regeneration House
Deborah Simon, Ontario Community Support Association

To complete this focusON, interviews were conducted with 21 housing providers located within 11 of the 14 LHIN areas. Representatives of six LHINs were interviewed, along with a selection of health and housing system experts. All interviews were conducted on the basis of anonymity in the fall and winter of 2012-2013. Additionally, the 14 LHINs' Integrated Health Services Plans (2010-2013) were reviewed along with relevant secondary resources and selected legislation and official documents. Quotations from interviewees were edited for readability. With the number and range of interviews conducted, it is not possible to determine whether provider experiences with LHINs differ systematically across LHIN areas or between supportive housing sub-sectors. Rather, this *focusON* considers recurring themes that emerged through the interview process.

ONPHA

400-489 College St.
Toronto, ON
M6G 1A5

www.onpha.on.ca