CASE STUDIES ON INTEGRATING HEALTH AND COMMUNITY-BASED SERVICES FOR OLDER ADULTS

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INTRODUCTION

WHAT IS INTEGRATED CARE?

The concept of integrated care has been promoted as a means to improve the performance of services and delivery of care for older adults. While there are many ways to define integrated care, the commonality among definitions is the focus on coordination and collaboration across a continuum of services (Leatt, Pink, & Guerriere, 2000). Integrated care initiatives usually incorporate a combination of funding, clinical, administrative, organizational and/or service delivery strategies in order to "create connectivity, alignment and collaboration within and between the cure and care sectors." (Kodner & Spreeuwenberg, 2002, p.3). Common goals of integrated care initiatives are enhancing quality of care and improving system efficiencies (Kodner & Spreeuwenberg, 2002).

Integration exists on a continuum, and there are different levels of integration that occur between service providers (Leutz, 1999):

- Linkage: Providers link with other providers on an as needed based.
- Coordination: Structures/individuals are in place to coordinate care across the continuum.
- Integration: Resources or services from multiple providers are pooled.

Traditionally, integrated care models have focused primarily on improving coordination between formal health care services and providers. However, there is growing recognition of the need for integration to include other sectors, community-based organizations, and local community resources. These organizations can play important roles in supporting aging in place, self-care, independence, and prevention (Social Care Institute for Excellence, 2019). The King's Fund, a leading think tank on integrated care, has highlighted the need to broaden the focus of integrated care models. Models need to be developed that go beyond providing health care for individuals, and improve the health of populations by addressing lifestyle factors, social determinants of health, and other factors that impact the health of older adults (Alderwick, Ham, & Buck, 2015).

Older adults in particular may benefit from integrated care initiatives that incorporate a broad range of services due to the complex and long-term nature of their needs (e.g., care for multiple chronic conditions, social support, healthy lifestyle supports, etc.). Support often is required from multiple sectors, services, and providers. Integrated care not only has the potential to integrate services from multiple partners from the health care sector and beyond, but also can be used to advance broader social determinants of health approaches.

Reviews by Kirst et al. (2015) and Threapleton et al. (2017) have identified a number of factors that contribute to the success of integrated care initiatives for older adults: building trusting relationships; dedicated leadership and champions; communication; flexibility; clear roles, responsibilities, and processes; organizational culture; funding facilitators; time to build

infrastructure and relationships; adequate resources; staff training and engagement; co-location of team members; frameworks for collaboration; and electronic information sharing.

RESEARCH PROJECT

The purpose of this research project was to examine how service delivery organizations have been able to successfully engage in integrated working to meet the needs of older adults in their communities. This project differs from past research as it focuses on integrated care initiatives that have taken broad approaches to integration and incorporated a wide range of organizations and/or services for older adults, including community-based organizations.

This report presents four case studies of integrated care initiatives for older adults (though not all exclusively served older adults). The cases that were selected integrated both health and community-based services and adopted comprehensive approaches that reflected the social determinants of health model. The first two cases studies are examples that focus more directly on service delivery for local populations, while the latter two represent broader strategies for meeting population needs on a large-scale. The cases were chosen to represent a range of different contexts and models of integrated care:

- Galiano Health Care Centre: A community health care centre that provides primary and community wellness services to the population of Galiano Island and has developed a range of services to meet the needs of the large older adult population on the island.
- Partners Advancing Transitions in Healthcare (PATH): A partnership between 12 health, social care, and community organizations in Northumberland that focused on improving transitions from hospital to home for older adults with multiple health conditions.
- Healthy Aging: A department of the United Way of the Lower Mainland that in partnership with other stakeholders supports older adults in British Columbia through program delivery, sector strengthening, and community engagement initiatives.
- Orange County Strategic Plan for Aging (OCSPA): A county-wide initiative that brings together a range of partners to address the needs of older adults in Orange County.

To inform each case study interviews were conducted with 2-6 key informants and relevant documents, websites, and research were also reviewed. The case studies examine challenges, facilitators, and lessons learned from the implementation and operation of these initiatives. A specific focus of the case studies is how diverse groups of organizations and providers have successfully engaged in integrated working in order to meet the needs of older adults in their communities.

In this report, first each case study is described and unique lessons from the case study are highlighted, then the experiences of all the case studies are brought together in a discussion of common challenges and facilitators of integrated care.

GALIANO HEALTH CARE CENTRE

CASE STUDY DESCRIPTION

Galiano Island is a small island community in British Columbia (BC) with a population of approximately 1,044 people (~40% of which are older adults) (Statistics Canada, 2017a). The primary provider of health and social care services for residents on Galiano Island is the local community health centre, the Galiano Health Care Centre. Community health centres (CHCs) represent a unique model of primary care delivery that integrates primary care, health promotion, and prevention services (see Box 1 for more information on the CHC model).

The Galiano Health Care Centre officially opened its doors on April 27, 1991. This was the culmination of over six years of planning, advocacy and fundraising work by the Galiano Health Care Society (GHCS), a non-profit society formed by Galiano Island residents in 1985. The GHCS is a community-driven organization and is governed by a board of directors made up of 12-15 people. The GHCS owns and manages the Galiano Health Care Centre and pays for its operating costs and upkeep (e.g., housekeeping, utilities, repairs, etc.). Core sources of funding for the centre include revenue from local property taxes, fundraising, and leasing space to health care providers.

Box 1. What is a Community Health Centre?

The Canadian Association of Community Health Centres (CACHC, 2009) defines community health centres as "not-for-profit organizations that provide primary care together with health promotion, community programs and social services in one-on-one and group settings." They have identified five defining characteristics of the CHC model (CACHC, 2016):

1. CHCs provide team-based interprofessional care;
2. CHCs integrate health and social services;
3. CHCs are community-centred;
4. CHCs actively address social determinants of health; and
5. CHCs are committed to ensuring health equity and social justice.

CHCs provide a broad range of programs and services such as primary care, health promotion, community development, mental health, seniors' services, and food security (CACHC, 2016). Research evidence from both Canada and the United States has emerged on the benefits of the CHC model. For example, a 2009 literature review found CHCs were associated with lower health care costs and less acute care utilization by their patients (Streeter, Braithwaite, Ipakchi & Johnsrud, 2009). Research also suggests the CHC model is particularly effective for delivering care to vulnerable populations and patients with chronic and complex conditions (i.e., frail older adults) (Glazier, Zagorski, & Rayner, 2012).

The Galiano Health Care Centre provides primary and community wellness services in response to local community needs on the island. The health centre is an essential facilitator for the provision of medical care on the island, as it provides a space where health care providers can provide care to residents. Health care providers working at the centre are either contractors/employees of the regional health authority Island Health (e.g., physician, nurse practitioner, home and community care nurse, and public health nurse) or independent practitioners, and lease space or have a turnkey contract with the health centre.

A defining characteristic of CHCs is that they actively address social determinants of health. The GHCS partners with local organizations and volunteers to provide a range of community wellness programs at the Galiano Health Care Centre that address the holistic needs of the individual. While the health centre provides services to residents of all ages, a slate of programs targeting older adults has been developed in response to the needs of the large older adult population. Several of the community wellness programs targeting older adults were initiated under the umbrella of the Aging in Place Program. The Aging in Place Program began in 2010 with a grant from the United Way of Greater Victoria that allowed the GHCS to conduct a survey on aging in place on Galiano Island and identify gaps in services for older adults. Working with local community organizations, the GHCS now offers workshops and education programs for older adults on topics such as technology and advance care planning. The Aging in Place Program also operates a volunteer driver program to assist residents to get to their medical appointments. Other key community wellness programs offered in partnership with local groups/community volunteers include:

- Walk and Talk: The Walk and Talk is a free weekly social and fitness program for older adults (though people of all ages are welcome to attend) that was started in 2010. Participants meet at the Lion's Field to walk around the track, and afterwards go to the nearby Community Hall to enjoy snacks and socialize. The Walk and Talk is attended by approximately 24-30 people each week.
- Galiano Food Program: The Galiano Club provides healthy frozen meals for older adults and other island residents. The meals are available at the Community Hall after the Walk and Talk and at the Galiano Health Care Centre. Meals can be purchased for $5 but are also available free of charge for those who need it. The health centre has worked with the Galiano Club to develop meals to meet the needs of people living with specific chronic conditions (e.g., diabetic meals, heart smart meals).
- Better at Home: The Galiano Better at Home program is a provincially funded program, administered by the United Way of the Lower Mainland and locally operated by the GHCS. The program provides non-medical home supports to older adults on Galiano (e.g., light housekeeping, grocery shopping, minor home repairs, etc.).
- Transitions in Dying and Grieving: This team-based palliative care program provides counselling, respite, and other forms of support for individuals in late stage illness and their families.

GHCS also plays a key role in advocating for the health care needs of residents on Galiano Island with the regional health authority and province. For example, several years ago when their resident physician left the island, GHCS advocated to the health authority to ensure a full-time replacement was found. GHCS is also a member of local (Southern Gulf Islands Community Health Advisory Committee), provincial (British Columbia Association of Community Health Centres) and national advocacy bodies (Canadian Association of Community Health Centres), and strongly believes in the effectiveness of the CHC model.

The presence of the Galiano Health Care Centre, and the services and programs delivered through it, positively impact the health and wellbeing of local residents and the vitality of the community on Galiano. As there are no long-term care facilities or assisted living residences on the island, it is essential that residents have primary and community services available to assist them to age in place on Galiano. Currently the Galiano Health Care Centre is undergoing an expansion and renovations (most of which are community-funded) to provide more office space, a new emergency room, an ambulance bay and other additions to ensure the health centre will continue to be able to meet the needs of residents on Galiano Island for years to come.

KEY INTEGRATED CARE LESSONS

Co-location of Services and Supportive Work Environment

Co-location of many key health and social care providers at the Galiano Health Care Centre provides easy pathways for formal and informal communications about the needs of clients and care planning. Despite the fact people working at the health centre may be employed by GHCS, the regional health authority or be independent practitioners, they were described as all working collaboratively in order to ensure the full range of needs of residents on Galiano Island are met. Health centre staff, health and social care providers, and board members operate with open door policies and the workplace is a supportive environment where people feel comfortable discussing matters with each other. While GHCS and the health centre have formal governance and management structures in place, they do not operate as a rigid hierarchy but instead operate in a collaborative manner. Informants also praised the dedication and skills of the people working at the Galiano Health Care Centre, noting that they are passionate about their jobs and normally there is very little turnover in staff.

> *I'd say it's more of a circle than a triangle here.*
>
> Galiano Health Care Centre Informant

> *People with incredible skills, and also organizational skills, and you know keeping all these things balanced with a smile.*
>
> Galiano Health Care Centre Informant

Strengths and Challenges of Delivering Services in a Small Community

Informants described both the advantages and disadvantages of delivering services to older adults in a small community. The small size of the community makes collaboration necessary and facilitates relationship-building among different organizations and providers on the island. The term "interlocking directorships" was used to describe how there is often overlap between the board members of various organizations on the island. GHCS works closely with a number of local organizations such as the Galiano Club, Galiano Library, and the Lions. Galiano Island was also described as a community where while family may not be living close by, there is a lot of neighbourliness and support from friends.

> *I don't want to make, be Pollyanish about this…but there is a lot of neighbourliness and looking after. People know who might be somewhat vulnerable or lonely and efforts are made.*
>
> Galiano Health Care Centre Informant

However, the small size of the community can also present challenges for the integration and coordination of care, as specialized health and social service organizations (e.g., hospital, home care provider, long-term care) are located off the island. The significant geographic separation means that communication and coordination with these organizations can be challenging, and residents may have difficulty travelling to or accessing these services. The small size of the community also means Galiano Island lacks infrastructure that is commonly found in larger communities and is dependant on fundraising and community efforts to support certain essential services. For example, one of the most significant gaps on Galiano Island is the absence of a public transportation system. While the non-profit Galiano Community Transportation Society receives funding from Island Health for the capital costs of operating a small community bus in the summer, with a growing older adult population transportation is a need that cannot solely be met by volunteers on a shoestring budget.

> *I always think the needs are exactly the same – it doesn't matter if you're living in the city or living in the country – but the resources are vastly different.*
>
> Galiano Health Care Centre Informant

Need for Funding to Support Unique Service Delivery Models

While CHCs can be found across Canada, government funding and support for CHCs varies significantly by region. For example, in Ontario 100% of CHCs receive core operational funding to provide a full basket of services (primary care, health promotion and community development), while in BC only 8% do (CACHC, 2016). As there is no dedicated funding stream in BC to fund organizations like CHCs that provide a broad range of health, social and community wellness services, CHCs must be creative when seeking funding. On Galiano Island, the GHCS successfully worked with the Capital Regional District (regional government) in 2014 to pose a referendum question to the residents of Galiano asking whether the community would

be willing to introduce a property tax to support the health centre. The community overwhelmingly (over 90%) voted in favour. GHCS had to be creative and think outside of the box when they introduced this property tax to help fund the health centre (a strategy which several smaller communities in BC are now seeking to emulate). However, funding for the health centre remains siloed, as the property taxes levied through the regional government cannot be used to fund health services, while the regional health authority will only fund certain health services and not the daily operations of the centre.

PATH CASE STUDY

CASE STUDY DESCRIPTION

Partners Advancing Transitions in Healthcare (PATH) was a project in Northumberland, a County in Ontario made up of several small size communities with a total population of about 86,000 (Statistics Canada, 2017b). PATH focused on identifying ways to improve the transition from hospital to home for older adults with multiple health conditions. The project was funded by a three-year grant from The Change Foundation awarded in 2012 to the Northumberland Community Partnership, a partnership of 12 local health, social care, and community organizations. The lead partner for the project was the Northumberland Hills Hospital, and other partners included: Central East Community Care Access Centre, Central East Local Health Integration Network, Community Care Northumberland, Golden Plough Lodge, Health Systems Performance Research Network, Northumberland Family Health Team, NHH Community Mental Health Services, Northumberland YMCA, Palisade Gardens Retirement Residence, Patients Canada and QoC Health.

The PATH project was guided by a Steering Committee made up of the community partners, as well as a Patient and Family Caregiver Advisory Council (known as the RISE Team) made up of 15 patients and caregivers. A key requirement of the project was that patients and caregivers be actively involved. PATH used an approach called experience-based co-design to bring together service providers and service users (older adults and caregivers) to identify problems and work together to implement solutions. The experience-based co-design process allowed service providers to recognize not only opportunities for improvements to health care services for older adults with multiple chronic conditions, but also the need for a broad range of supports to address the social determinants of health. In particular, providing social support and supporting access to resources in the community were identified as priority areas.

Working groups of service providers and service users were formed to develop project elements to address challenges identified in the experience-based co-design process. Some of the key components of the project included:

- Planning Ahead/Aging Well: A PATHway to Aging Well community website was developed to provide information on health topics, local resources, and aging services.
- My Health Experience: An electronic tool was developed and implemented that allowed older adults, caregivers, and health care providers to track and share their health data and directly communicate about health needs.
- Person-Centred Care: PATH partner organizations identified opportunities to improve their own organizational practices based on feedback from older adults and caregivers.
- Volunteer Transition Coach: A volunteer peer coaching model was developed and implemented to assist older adults and their caregivers navigate their transitions in the

health care system. The Volunteer Transition Coaches provided peer support, information, and help accessing the necessary health care and community resources as they transition from hospital to home.

The PATH project included both local and system-level evaluation components to measure the value and impact of the project. Some of the key findings from the project included:

- Partners reported on average an increase of 75% in the number of relationships they had with other partners, individual care providers and patients/caregivers (The Change Foundation, 2016).
- By the end of the evaluation period 100% of patients reported they did not have to unnecessarily repeat their story to providers (The Change Foundation, 2016).
- The number of acute care days remained the same over time for PATH participants, while they significantly increased for controls. No statistically significant differences were found for other health care utilization measures (Budhwani et al., 2017).

The PATH Project was completed in 2015, however, certain components of the project were able to be sustained through local support:

- Volunteer Transition Coach: The volunteer transition coach program was extended for a brief period beyond the completion of the PATH project funding. Based on feedback from the community on the value and need for the program, there are plans to relaunch the program.
- Patient and Family Advisory Council: Northumberland Hills Hospital has formed a patient and family advisory council to continue to engage patients and family in their care.
- Spin-off Experience-Based Co-design Projects: As a result of their experience with PATH and the relationships developed, spin-off experience-based co-design projects and initiatives emerged involving PATH partners, older adults and caregivers in areas such as chaplaincy at Northumberland Hills Hospital and capacity development at the Central East Community Care Access Centre.

The PATH project is also credited as being one of the inspirations for the Health Links Model in Ontario (see Box 2 for a description of the Health Links). It was noted by informants though that the Health Links model has some key differences from PATH, as it does not require the use of experience-based co-design with patients/caregivers and is strongly focused on the development of coordinated care plans.

Box 2. Health Links Model

The first Health Links were established in 2013 as local networks that integrate and improve care coordination of health, social care and community services for high needs patients, including those with complex needs and older adults. By 2015, 82 Health Links had been established across the province (Government of Ontario, n.d.). Health Links are led by a lead organization and include health, social care, and community partners. A key focus for the Health Links has been the development of coordinated care plans for high needs patients, and since their inception 84,707 care plans have been developed (Healthy Quality Ontario, 2019).

KEY INTEGRATED CARE LESSONS

Experience Based Co-Design Process

Integrated care initiatives often require bringing together a diverse range of partners who represent a wide range of perspectives and experiences. In the Northumberland PATH project, the experience-based co-design process assisted the service users (older adults and caregivers) and service providers to develop shared understandings of the issues faced by older adults in Northumberland and actions that could be taken to address them. At the beginning of the project, The Change Foundation arranged for the PATH partners to receive two days of training on the experience-based co-design process from the Point of Care Foundation.

> *They [older adults and caregivers] shared their experience which provided a lot of understanding and growth for the service providers. To hear it from a patient's experience was very, very impactful.*
>
> PATH Informant

Personal stories from older adults and caregivers were used as starting points for co-design processes. These stories illuminated for service providers the need for comprehensive, coordinated interventions that address the whole person and their range of health, social, emotional, economic, and other needs.

> *When you have experienced-based co-design as your platform, the determinants of health care in all aspects become revealed.*
>
> PATH Informant

Facilitating Older Adult and Caregiver Involvement

Central to the experience-based co-design process was meaningfully engaging older adults and their caregivers in all steps of the project. In the PATH project, a Patient and Caregiver Lead (who was a patient/caregiver themselves) was hired to lead the RISE Team which stands for Respect, Information, Support, Empowerment (representing what patients and caregivers need

the most from our health care system). The Patient and Caregiver Lead facilitated the involvement of the patients and caregivers in the PATH project. This role was created in recognition of the power imbalance between patients/caregivers and service providers, and the fact patients and caregivers may need accommodations or support to facilitate their participation. The Patient and Caregiver Lead ensured that the patients and caregivers felt valued, accepted, and supported in their roles on the various PATH project teams, and that their voices were respected and heard by the other project members. The Patient and Caregiver Lead was also instrumental in identifying and addressing potential barriers that might prevent their involvement (e.g., arranging transportation for RISE team members).

> *Historically, when caregivers or patients were invited as tokens to be present, there wasn't that outside the box accommodation being made for them. It was like "Well we invited them, and we let them know this is what's happening." But we had to take that further.*
>
> PATH Informant

Funding to Support Integrated Working

The funding from The Change Foundation provided the PATH partners with an invaluable opportunity to experiment and engage in integrated working. Though some of the partners had already worked together previously, the funding served as an important lever that encouraged the organizations to engage in integrated working and incorporate older adults and caregivers into their work. The challenge with funding for time-limited projects though is how to sustain the project when the funding runs out. Northumberland Hills Hospital and partners were able to provide funding to sustain the project for a fourth year, but after that only select components of the project were sustained. This points to the importance of sustainability planning and the challenges of securing funding for innovative models and integrated working.

HEALTHY AGING

CASE STUDY DESCRIPTION

BC is a Canadian province that is home to approximately 850,000 older adults spread out over 922,500 square kilometres (Statistics Canada, 2017c). United Way of the Lower Mainland (United Way) is a provincial non-profit organization that serves families, children, seniors, and communities. United Way's Healthy Aging Strategy was developed in 2016 in order to support healthy aging for older adults across the province of BC. The strategy was developed in conjunction with work United Way was undertaking in partnership with the Raising the Profile Project, a provincial network of non-profit and municipal community-based seniors' services (CBSS) (see Box 3 for more information on the Raising the Profile Project).

Healthy Aging has three overarching goals: 1. Increasing physical activity; 2. Reducing social isolation; and 3. Fostering meaningful engagement. While originally a strategy, Healthy Aging has now transitioned into a service delivery department at the United Way. Healthy Aging recognizes the broad range of determinants that may impact the health of older adults and seeks to address these through initiatives that support program delivery, sector strengthening and community engagement. United Way delivers these initiatives in partnership with CBSS, academics, municipalities, the Provincial Government, the health care sector, and senior community leaders and volunteers. A community development approach, embracing working "in community, by community, with community" has been central to the development of initiatives under Healthy Aging (see Box 4 for a description of community development approaches). United Way engages in regular community engagement activities across the province and a CBSS Leadership Council made up of non-profit representatives and senior community leaders supports and guides the community engagement initiatives of Healthy Aging.

Box 3. Raising the Profile Project

The Raising the Profile Project was an independent community-led project operating over 2016-2017 in BC. The project coined the term community-based seniors' services (CBSS) to refer to non-profit and municipal agencies that offer low-barrier programs to seniors in seven core areas: nutritional supports; affordable housing; health and wellness; physical activity; cultural, educational, and recreational programs; information, referral, and advocacy; and transportation. The purpose of the project was to raise the profile and build the capacity of the CBSS sector in BC. A provincial network of CBSS was formed and research and capacity-building activities were undertaken, including: producing a literature review on the role and impacts of the CBSS sector, profiling programs offered by the sector, and hosting regional consultations and the first Provincial Summit on Healthy Aging. The United Way was one of the key partners involved in the Raising the Profile Project, and after the completion of the project was able to continue the CBSS sector capacity-building and engagement work through Healthy Aging.

Box 4. Community Development Approaches

The International Association for Community Development (IACD, 2018) states the purpose of a community development approach is "to work with communities to achieve participative democracy, sustainable development, rights, economic opportunity, equality and social justice" (p.13), which is achieved through the "organisation, education and empowerment of people within their communities…" (p.14). Examples of common community development practices include consulting with communities, involving communities in planning programs and initiatives, and building leadership and capacity within communities.

Healthy Aging supports the delivery of programs to keep older adults active, engaged and connected in BC through the following initiatives:

- Better at Home: Better at Home is a provincial program that provides non-medical home support services to older adults (i.e., friendly visiting, transportation, light yardwork, minor home repairs, light housekeeping, grocery shopping, and snow shovelling). Better at Home is funded by the Province of BC, managed by the United Way, and delivered locally by non-profit organizations. Originally launched in 2012, Better at Home programs now operate in 67 communities across the province.
- Active Aging and Choose to Move: In partnership with Active Aging BC and the University of BC's Active Aging Research Team, United Way supports the delivery of programs that encourage physical activity, social connection and independence for older adults. Choose to Move is an evidence-based program designed to assist inactive older adults to become more physically active. Active Aging grants support the development of programs in communities that promote physical activity and social connectedness for older adults.
- Integrated Community-Based Programs for Higher Needs Older Adults: In 2020 United Way launched social prescribing, therapeutic activation programs for seniors, and caregiver support pilot programs across the province. These programs are funded by the Province of BC and offered by local non-profit organizations. The programs leverage the health promotion and preventative potential of CBSS to support higher needs older adults living in the community.

Healthy Aging also includes sector strengthening and community engagement initiatives in order to support capacity-building and cohesion within the CBSS sector. A key facilitator for these initiatives has been Healthy Aging Collaborative Online Resources & Education (Healthy Agung CORE - https://healthyagingcore.ca/) an online knowledge hub and virtual network that provides a platform for CBSS and other stakeholders across the province to engage in knowledge sharing and collaboration. United Way also hosts annual regional consultations and biannual provincial summits on aging that attract CBSS and other key partners. Healthy Aging supports capacity-building within the CBSS sector through leadership, public policy, and evaluation training programs.

Six provincial working groups have also been established to advance work in key areas: seniors' housing; nutritional supports; interfaith and intercultural communities; seniors community planning/actions committees; engagement in rural and remote communities; and information, referral, and personal advocacy. Working groups are made up of CBSS Leadership Council members, United Way staff, and other partners and engage in activities such as mapping current services and programs, identifying promising programs and practices, and collecting personal stories from older adults on service needs.

Healthy Aging has also been successful in increasing the capacity of the CBSS sector and connecting CBSS with other partners with stakes in providing services to older adults in BC. United Way identified gaps in programming for older adults and has developed and implemented coordinated approaches to address needs related to non-medical home supports, physical activity, social connection, and health and wellness. The unique network model of Healthy Aging allows United Way to mobilize and leverage the capacity of CBSS across the province, allowing for coordinated approaches, advocacy, and action to address the needs of older adults in BC.

KEY INTEGRATED CARE LESSONS

Using Technology to Facilitate Collaboration and Knowledge Sharing

Healthy Aging CORE, the provincial knowledge hub and virtual network developed by United Way, is an example of how technology can be used to facilitate collaboration and knowledge sharing among a range of stakeholders dispersed over a wide geographical area. Healthy Aging CORE provides a platform for stakeholders to share documents and resources, engage in online discussions, and stay up-to-date on news, community events, and training and funding opportunities. During Healthy Aging CORE's development phase, United Way solicited feedback from the CBSS sector on desired features and content through an online survey and regional consultations. Healthy Aging CORE was launched in February 2019 and has over 850 registered members. In addition to the online knowledge hub, Healthy Aging also utilizes other forms of technology such as webinars, online surveys, and a biweekly electronic newsletter to connect with stakeholders. While integrated care literature often focuses on the value of technologies that enable communications around shared patients, the value of technologies that facilitate higher level collaboration and relationship-building should not be overlooked.

Creating Shared Understandings of the Value of the Community Sector

In order for health, social care, and community providers to successfully work together to deliver services to older adults, it is necessary that they are able to see the value that each partner can bring to the table. The Raising the Profile Project and Healthy Aging identified the need to raise the profile and demonstrate the value of community programs and services that address the social determinants of health. Following over a year of research and consultations, in 2017 at the inaugural Provincial Summit on Aging the *Declaration of the Community-based Seniors'*

Services Sector in B.C. was presented. This declaration was signed by over 200 organizations, including the BC Ministry of Health, and defined the CBSS sector, its core service areas, and its role in supporting the health and wellbeing of older adults. The continued capacity-building and community engagement work under Healthy Aging has solidified these shared understandings among key stakeholders. The investment by the Province of BC in the Integrated Community-Based Programs for Higher Needs Older Adults has been a result of this work undertaken by United Way and the CBSS sector.

> *So, for a long time, a lot of people felt that social determinants of health or preventative health or health promotion did some airy, fairy goodwill work. And there was not a real understanding that the social determinants of health have a tangible impact on the holistic quality of life of older people. And so once they started to demonstrate that things like sedentary lifestyle, things like loneliness, things like precarious housing, things like mobility, things like access to food security, things like poverty really impacted older adults' ability to access services, thereby impacting their quality of life, thereby increasing their utilization of health care services – we decided to be very intentional on focusing on social determinants of health as it relates to the quality of life of older adults.*
>
> Healthy Aging Informant

Building the Cohesion and Capacity of the CBSS Sector

Through Healthy Aging's work with the Raising the Profile Project, the critical need to build the capacity of the CBSS sector to support the health and wellbeing of the growing older adult population in BC was identified. While CBSS have much to offer older adults, proper resources, training, and education are required for them to be effective partners in health promotion and prevention. United Way has been investing in initiatives to develop the capacity of CBSS in key priority areas such as leadership, public policy, and evaluations. For example, in 2018/19 United Way, in partnership with Dialogues in Action, welcomed its first cohort of Project Impact Healthy Aging students. This free developmental evaluation course for non-profit organizations (funded by the Province of BC) teaches staff how to conduct evaluations of their programs. United Way also provides both online (i.e., Healthy Aging CORE) and in-person (i.e., regional consultations and provincial summits on aging) forums for collaboration and relationship-building for the CBSS sector.

> *It's to connect, communicate, coordinate, build capacity, cohesion, and foster collaboration among all of the different CBSS organizations and what I sometimes call allied professionals [other organizations that have an interest or a stake in healthy aging].*
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> Healthy Aging Informant

ORANGE COUNTY STRATEGIC PLAN FOR AGING

CASE STUDY DESCRIPTION

Orange County (OC), California, is a county made up of 34 cities that is home to approximately 457,031 older adults (OCSPA, 2019). In recognition of the growing older adult population in OC and the need for coordinated efforts to meet their needs, in 2016 Alzheimer's OC and other key organizers began laying the groundwork for a county-wide initiative. In 2017, the Orange County Strategic Plan for Aging (OCSPA) was launched which brought together non-profit organizations, service providers, cities, funders and foundations, the County, and corporations to address the needs of older adults in OC.

The OCSPA is led by a Leadership Council composed of government, funders, non-profits and other key stakeholders: County of Orange, California; Alzheimer's OC; Office on Aging OC; CalOptima; SeniorServ; OC Community Foundation; OC Senior Citizens Advisory Council; UC Irvine Health; Easterseals Southern California; Jamboree; Abrazar; Asian American Senior Citizens Service Centers; Council on Aging Southern California; OC Transportation Authority; Irvine Health Foundation; OC United Way; Fifth District of OC; and OC Health Care Agency.

The Leadership Council meets once a quarter and is responsible for the governance and overall vision of the OCSPA. The OCSPA is funded by contributions from the Leadership Council members, plus funding contributions from 17 cities that have chosen to participate in the initiative. A part-time coordinator fills the backbone role of providing support to the Leadership Council and the OCSPA pillar groups.

OCSPA pillar groups were formed to advance the agenda for older adults in ten key areas: transportation, food security and nutrition, technology, health care, elder abuse prevention, housing, social engagement, funding and sustainability, OC successful aging, and communications. Each pillar group consists of members of the Leadership Council as well as additional stakeholders (e.g., academics, cities, non-profits, businesses). Pillar groups select a goal for their work that can be achieved within 18 months, and their goal is then approved by the Leadership Council. The pillar groups completed their first round of 18-month goals over July 2017-December 2018, and began their second round of goals in January 2019. Pillar groups are provided the flexibility to determine their own structure, goals, and activities. This model was designed with the intention of leveraging the strengths and expertise of each pillar group. Pillar groups receive support from the Leadership Council and the OCSPA Coordinator, and small budgets are available to support pillar group activities.

The OCSPA has successfully created a forum for the many organizations serving older adults, and other stakeholders invested in the future of older adults in OC, to connect and take action in the key initiative areas. In addition to the short-term targeted work being undertaken by the pillar

groups, the OCSPA is also seeking to identify broader systemic issues and opportunities that can be addressed over the long-term.

Below the work of three of the pillar groups is described in more detail to highlight the wide range of impacts the OCSPA is having for older adults in OC.

Technology Pillar Group

Goal 1: Enhance and accelerate the capacity of the digital platform, IrisOC, to create a local digital hub to distribute healthy aging information, provide connections to senior-focused community resources and people, and acquire pilot users of the platform.

Goal 2: Become a local convener on the topic of "social isolation and technology solutions" by connecting the tech industry, aging services and older adults. Continue to support the successful launch of IrisOC by actively promoting awareness of the platform to their communities, and advocating for IrisOC with potential community, content or technology partners for various applications in the community.

The work of the technology pillar group has centred around the development and promotion of IrisOC (https://iris-oc.com/) a website created for older adults in OC. IrisOC promotes healthy aging for older adults by providing education and information on healthy living and community services and events. IrisOC was already in development by the Irvine Health Foundation prior to the formation of the technology pillar group, and the pillar group assisted with the testing, development of content, and promotion of the website. For their second 18-month goal, the technology pillar group is continuing to support and promote IrisOC as a key resource for older adults. The pillar group has held Community Ideathons to brainstorm with community ways technology can help to address the issue of social isolation of older adults. Many of the other pillar groups in the OCSPA are also making use of technology in order to implement their goals, and the technology pillar group provides advice when requested and works collaboratively with other pillar groups to support their use of technology to meet their goals.

Social Engagement Pillar Group

Goal 1: Reinstitute the Friendly Visitor Program Coalition to support capacity building and increased information sharing among the existing service programs, resulting in better services to isolated/homebound seniors.

Goal 2: Formalize the OC Heart to Heart Visitation Council to support capacity building and increased information sharing among the existing service programs, resulting in better services to isolated/homebound seniors.

The social engagement pillar group has been working to build the capacity of friendly visitor programs. An initial survey of friendly visitor programs for older adults in OC identified about 150 programs, many of which were small community programs or housed in faith-based organizations. The social engagement pillar group decided to organize a conference to provide an opportunity for these friendly visitor programs (and those interested in starting a program) to connect and receive education and information that would enhance and elevate their programs. The Heart to Heart Conference was held in February 2018 and at the conference the pillar group launched their *Friendly Visitor Program Toolkit*. This guide was developed in consultation with experts in the field and includes best practices and essential information on how to run a friendly visitor program (e.g., volunteer recruitment and training, logistics of running a program). Building on the success of the conference, the OC Heart to Heart Visitation Council was established and now offers quarterly educational sessions for friendly visitor programs. Each educational session is attended by about 35-40 participants and addresses topics such as visiting over the holidays and advance health care planning. The sessions last for approximately 2.5 hours and sponsored lunches are provided for the participants.

Food Security and Nutrition Pillar Group

Goal 1: Increase food security for Orange County's older adults age 60+ by enrolling new participants in CalFresh and establishing new Commodity Supplemental Food Program and Senior Grocery distribution sites.

Goal 2: Increase food security for Orange County's older adults age 60+ by enrolling new participants in CalFresh. Support education/awareness of the Restaurant Meal Program and increasing overall awareness of available food help for older adults in Orange County.

The food security and nutrition pillar group was established to learn more about food services in OC, enhance the programs already being offered, and ensure both older adults and service provider are aware of available programs. A key focus for this group has been improving access to CalFresh (equivalent of food stamps) for older adults, as lack of awareness of the program, stigma associated with using food stamps, and recent changes to the eligibility requirements for the program mean that many eligible older adults are not currently accessing the program. The members of the group have worked to establish new sites for CalFresh education and enrollment events, as well as new senior grocery distribution sites. In the first 18-month period there were 545 new CalFresh enrollees, and the pillar group is continuing to enroll new members in the second 18-month period. The pillar group has also begun work to promote the Restaurant Meals Program that allows CalFresh enrollees to purchase meals at participating restaurants using their CalFresh benefits. In OC the number of restaurants signed up to participate in the Restaurant Meals Program is quite low compared to other counties, so the pillar group is working to identify barriers to restaurant enrollment, address these barriers, and sign up more restaurants.

KEY INTEGRATED CARE LESSONS

Building Knowledge and Awareness

Having accurate knowledge and data on the older adult population and the services available in a community is essential for engaging in population level planning and developing comprehensive, integrated strategies. The OCSPA has produced a Report on Older Adults that discusses the growing needs of older adults in OC in seven key areas: health, food security, elder abuse prevention, social isolation, housing, technology, and transportation. This report provides an important tool for population planning, educating stakeholders, and highlighting the needs of older adults in OC.

Building knowledge and awareness about the needs of older adults in OC was also an important starting point for many of the pillar groups. As described previously, collecting data on OC friendly visitor programs was the catalyst for the social engagement pillar group organizing a friendly visiting program conference and developing their toolkit. Another example is the transportation pillar group, who decided they needed to learn more about transportation needs in OC, and in the process of collecting this data created a transportation guide for older adults.

> *Every year there is a report on children in Orange County, there is a lot of funding and information/news reports on the homeless population in Orange County, but the aging population was really missing. No one was paying attention to seniors. What we've done has brought awareness of the aging population, and highlighted their issues. People are taking notice finally.*
>
> OCSPA Informant

Creating Forums for Collaboration and Integrated Working

Key to the effectiveness of the OCSPA has been its ability to bring together experts, service providers and other stakeholders in each initiative area in order to identify key issues and develop the policies and initiatives that will be the most impactful for older adults in OC. Rather than the Leadership Council prescribing policies and initiatives, it is the experts and interested members in the pillar groups who drive the agenda and implement the solutions. While service providers across OC are committed to improving the lives of older adults, the OCSPA provides an opportunity for large-scale, coordinated action to take place. Participating in pillar groups allows stakeholders to work with a diversity of partners and make a difference in the areas that interest them.

> *The initiative has fostered affinity groups within the senior care and senior support industry as well as government. It's done a decent job of creating an overlay structure where everyone who has any kind of vested interest in the future of seniors has a reasonable way to get together and talk it out.*
>
> OCSPA Informant

Cross-sector exchanges and working are encouraged in the pillar groups, and group members bring a diverse range of perspectives and expertise to the table. For example, the social engagement pillar group brings together a diverse group of stakeholders that includes cities and government organizations, food services, health care, housing, advocacy, and Alzheimer's organizations. Pillar groups are also encouraged to learn from and work with the other pillar groups. For example, the technology pillar group has discussed with the food security and nutrition pillar group potential technologies that can be used to map out food resources across the County. The technology pillar group is also connecting with other pillar groups to identify how to promote their work on IrisOC.

> *And we definitely need the expertise of other organizations. Some may serve food to older adults, but other organizations are not yet aware of that service. There's Alzheimer's Orange County who meets the needs of older adults with Alzheimer's. A partner organization may have a client on their program who has Alzheimer's and yet are not versed in how to really have conversations with them or to understand their needs. Working with an organization that understands that disease can be a huge benefit.*
>
> OCSPA Informant

Enhancing Already Existing Programs and Resources

One of the key benefits of integrated working is being able to leverage the strengths and resources of different partners and providers. Given the limited budgets available to support their work, pillar groups have generally sought to capitalize on and enhance already existing programs and resources of partner organizations, rather than create new programs. As described previously, the food security and nutrition pillar group has centred their work around supporting and raising awareness about the State's CalFresh food program, while the technology pillar group has focused on promoting the IrisOC website. In OC there are already many valuable programs and services for older adults, and the OCSPA is helping to ensure these programs reach as many people as possible and have the maximum potential impact.

CHALLENGES AND FACILITATORS OF INTEGRATED CARE

Each of the case studies described in the previous sections (Galiano Health Care Centre, PATH, Healthy Aging, and OCSPA) highlights integrated care lessons that are unique to the different models and contexts. In addition to the lessons discussed for each case study, there were also themes that emerged from the combined case study experiences as common challenges and facilitators of integration. These challenges and facilitators are discussed below.

CHALLENGES

1. Hierarchy and Power Dynamics

Heavy top-down management by leadership was viewed as a potential barrier to successful integration. The case studies emphasized that all partners and providers should feel respected and that their voices are heard and valued. They also emphasized providing autonomy to working groups and providers/partners within the model and respecting their unique expertise and experience.

> *I think we should model inclusiveness and people being equal in the network.*
>
> Galiano Health Care Centre Informant

The need to be sensitive to community nuances and power dynamics was also highlighted by informants. Power imbalances may exist between groups of people (e.g., older adults and service providers, physicians and other health care professionals), organizations (e.g., funding organizations and community organizations), and sectors (e.g., the health care sector and the community sector). It is important for organizations and people in positions of power to be aware of these dynamics, and to step back at times in order to ensure other voices are heard. Several informants noted that additional efforts need to be made in order to welcome and involve stakeholders that may be vulnerable or marginalized. For example, in the PATH case study a number of steps were taken to ensure older adults and caregivers would feel safe and comfortable participating alongside service providers in the initiative. The leadership at Northumberland Hills Hospital were also praised for their ability to support and engage with the other partner organizations involved in the PATH project.

2. Siloes and Cultural Divides

Informants commented on the siloes and divides that can exist between different sectors, organizations, and providers. Organizations and providers may be reluctant to work with other partners due to negative perceptions and misconceptions (e.g., health care organizations may see

community organizations as unprofessional, while community organizations may see health care organizations as bureaucratic machines). Competition over turf and resources can also be a barrier. Pre-existing institutions and programs may feel threatened by new initiatives that they see as infringing on their territory. Even when organizations or providers do choose to work together, tensions and disagreements may emerge due to different perspectives on the health and wellbeing of older adults (e.g., medical model vs. social model), different mandates and priorities, and different processes for working and decision-making.

3. Funding Siloes and Gaps

Funding was identified as a potential barrier for integrated working due to: 1) Siloes of funding; 2) Lack of investment in community programs and services that address social determinants of health; and 3) Competition among organizations over funding.

> *Everybody's after predictable, stable, consistent funding.*
>
> Galiano Health Care Centre Informant

Informants noted that funding is often siloed based on sector, the services being provided, and the populations being served. This can present a barrier to integrated working and efforts to provide comprehensive supports to older adults. This was evident in the Galiano case study, where because the community health centre did not fit neatly into a specific funding box, they had to seek funding from a range of sources and were limited as to what aspects of their operations the funding could be used for.

Organizations providing care and services to older adults also differ vastly in terms of their funding and resources. While organizations in the health care sector or government tend to be relatively well resourced, non-profit and community organizations often struggle to obtain stable funding. The lack of stable funding can make it difficult to plan for the long-term and to participate in integrated working. Informants suggested that a factor contributing to the underfunding of the community sector is the lack of recognition of the value of community programs and services that address social determinants of health.

> *I think another barrier continues to be the scarce investment in the [community] sector. While we've demonstrated that this is best for the quality of life of older people – that it actually is a cost savings to government – sometimes there's a lack of foresight and understanding that investing in the sector actually saves money in the long-term.*
>
> Healthy Aging Informant

One of the results of inadequate funding is competition between organizations for scarce resources, which was identified as a potential barrier for integrated working, particularly for non-profit and community organizations. Organizations may be reluctant to share information or partner with other organizations if they see them as competition. Informants noted though that

funders increasingly are encouraging (or requiring) partnerships between organizations. For example, the PATH project was funded by a grant that specifically required a partnership between multiple organizations. Opportunities to work collaboratively can help to overcome distrust between organizations and encourage additional collaborations in the future.

4. Time-Related Challenges

Key aspects of integrated working such as relationship-building and collaborative planning take a significant investment of time. When multiple organizations and providers are involved this means decisions must go through multiple layers of bureaucracy. In the case studies it was noted components of some of the initiatives (e.g., the development of the electronic health tool in PATH, the development of the Older Adult Report in OCSPA) took longer to complete than expected. When activities progress slowly this can hamper the momentum of the initiative. Informants also highlighted the importance, even in the early stages of an initiative, of thinking of the future and planning for not just the short-term, but also long-term sustainability

> *Plan for twice the amount of time you think it's going to take.*
>
> OCSPA Informant

> *Go for it and don't go small, you know like if you're going to build something, build it looking at the future.*
>
> Galiano Health Care Centre Informant

Informants noted that staff working in the health, social care, and community sectors often have many competing interests that take up their attention and may have limited time to devote to integrated working. Staffing was identified as a key area that organizations would like to invest more money in if they had the funding available, so staff would have adequate time for their work. Older adults, caregivers, and volunteers also all have their own constraints on their time. Informants stressed the importance of making participation in integrated care initiatives as easy and appealing as possible for participants (e.g., providing food at meetings, using teleconference or online platforms for communication).

FACILITATORS

1. Passionate Leadership Teams and Staff

Informants from all of the case studies praised the vision and dedication of their leadership teams. Some of the characteristics associated with effective leaders included being committed and passionate, listening to other partners, being responsive to feedback, and creating a supportive environment. There were a core group of people behind each initiative who were

identified as playing key roles in driving the work forward. Informants also highlighted the important work of the staff involved in the coordination and day-to-day operations of organizations and initiatives.

> *For some of our team their positions have changed a fair bit, but one of the things that really facilitated the transition was [the Director's] leadership and understanding of the need to make people feel supported. To recognize that change can be hard and to engage everybody in planning and the vision.*
>
> Healthy Aging Informant

2. Grassroots and Community Support

Informants from all of the case studies emphasized the importance of having grassroots and community support from the communities being served and providers and organizations impacted by the initiative. Both Healthy Aging and OCSPA had grassroot origins and were initiated because members of the non-profit and community sector identified gaps in services for older adults and the need for coordinated approaches. The importance of community support was particularly apparent in the Galiano Health Care Centre case study, where the residents of Galiano Island built the health care centre and chose to impose a tax on themselves to support it.

> *Because there's nothing in the medical system, in government, in legislation, that says Galiano is entitled to a health clinic. The fact that we have it is, the community has built it.*
>
> Galiano Health Care Centre Informant

Several informants discussed the value of developing champions to promote their initiative to the community and key interest groups. Champions may be members of the leadership team or other individuals who can act as a spokesperson (e.g., older adults using a service, respected professionals in the community). For example, the PATH project found a physician to champion their project and engage in outreach with general practitioners in the Northumberland community.

> *I think as long as you find the key people who believe in the cause and find the value of how it could impact the community as a whole, then you know everything will be okay.*
>
> OCSPA Informant

3. Building Trusting Relationships with Partners

Relationships were seen as being at the core of successful integrated working. Building trusting relationships with partners takes an initial investment of time and effort. In the case studies, many relationships between partners built on prior collaborations and connections. For example, prior to the development of the PATH project, Northumberland Hills Hospital had engaged in dialogue and consultations with local partners and the public when they were making changes to their outpatient services. In OC, prior to the OCSPA relationships already existed between some service providers through their participation in the Orange County Aging Services Collaborative. Having already existing relationships with other respected organizations in the community is important for establishing credibility and trust.

Informants felt that many organizations and providers had a desire to engage in integrated working and build relationships with other partners but lacked the opportunities to do so. They highlighted the value of being able to provide spaces where collaboration can occur. Examples of mechanisms to facilitate relationship-building and collaborations from the case studies included community consultations, working groups and committees, online platforms, and conferences. Several informants discussed how the impacts of building relationships between organizations and providers in their community extended beyond their specific initiative and resulted in further partnerships and collaboration.

> *And the last thing I would say is meeting this desire of partners to create space for people to get together and learn and share and network and contribute to common solutions and common problems. And often those spaces were not funded or carved out, and through things like the regional consultations, like the provincial summit on aging, like our provincial working groups, we've been able to carve out that space.*
>
> Healthy Aging Informant

When building relationships with new partners, informants discussed the need for targeted strategies to connect with key institutional partners (e.g., local government, regional healthcare organizations) and outside of the box partners who are not the usual suspects for collaboration (e.g., local businesses). An important facilitator for building relationships with a wide array of stakeholders is being able to tailor your message to let stakeholders know: *What's in it for me?* For example, informants from the OCSPA discussed the need to develop tailored messaging for audiences such as cities (i.e., to get them onboard with the strategic plan and development of an aging report) and restaurants (i.e., to encourage them to participate in the Restaurant Meals Program the food security and nutrition pillar group was promoting).

> *This collaboration has a magical component to it, in that it has brought people together who have similar missions, maybe even parallel missions – and then enhanced our ability to serve our constituents. We know what somebody else has to offer, and we know who to call for support.*
>
> OCSPA Informant

4. Leveraging Strengths of Partners

Recognizing that partners have different strengths, and leveraging these strengths is key to the success of integrated working. Partners can provide many valuable resources including subject area expertise, training and mentoring, space for events, volunteers, material goods, etc. In all of the case studies examples were provided of different partners (e.g., nutrition programs, municipal governments, libraries, local businesses, etc.) that were recruited to form partnerships with to meet the needs of older adults in the community. While in some cases partners were formally connected to the organization or network (e.g., Northumberland Community Partnership partner organizations), situational partnerships were also formed as needs or opportunities arose (e.g., Galiano Health Care Centre partnered with the Galiano Library to offer educational programs for older adults).

> *What we also found was really important was to recognize the impactful work that all partners were delivering, and acknowledging and using an asset-based approach in leveraging all of the skills as well as the ability and experiences of all of our partners.*
>
> Healthy Aging Informant

Leveraging the strengths of partners allows for the efficient use of resources and prevents unnecessary duplication. This is particularly important in the current period of economic constraint, where organizations are expected to do more with less. There may already be successful practices, programs, and knowledge available within a community to address an issue, but what is lacking are mechanisms to connect and share them with older adults and other providers. In OC there are about 150 friendly visitor programs for older adults operating, and the OCSPA social engagement pillar group has been focused on sharing the best practices of the most successful and well-established programs.

> *There's been really good collaboration between the different organizations represented in the work group. That has helped to bring things up to a higher level, because we're not trying to reinvent the wheel. Somebody else maybe has a wheel that we can use and then we work together to make it bigger and better.*
>
> OCSPA Informant

5. Shared Vision and Understandings

Developing a shared vision and understandings is essential for successful integrated working. When attempting to work with a wide variety of stakeholders, not all partners will necessarily share the same understandings of what contributes to the health and wellbeing of older adults, what the gaps and problems are with systems and services, and what actions should be taken to address the issues. In the case studies, engaging in dialogue with organizations, providers and

other stakeholders was a way to develop shared understandings and create a sense of ownership over an initiative. In the PATH project the partners spent a lot of time engaging in dialogue through the co-design process. Finding common points of agreement was an essential step for this process. In BC, shared understandings about the community-based seniors' services sector were solidified through the *Declaration of the Community-based Seniors' Services Sector in B.C.* which was signed by key stakeholders, including the Ministry of Health.

> *In advice for anybody doing this: it's true, look for points of agreement. What can we all agree on? "Well the wait times are too long." Awesome, there's a point of agreement. So find the points of agreement and then, and then develop and engage and invite and support the people to come around that, to be solution-focused together.*
>
> PATH Informant

Informants discussed the importance of developing a shared vision for integrated care initiatives, and also the importance of allowing the vision to evolve over time and checking in with partners to ensure that it continues to represent their vision for the initiative. For example, for the OCSPA after the completion of their older adult data report some Leadership Council members felt there was a lack of clarity about the direction the strategic plan was heading in and next steps for the plan. A facilitator was brought in to help the Leadership Council members review the strategic plan and come to a consensus on the vision.

Once a vision has been established, it is important that the leadership of the initiative are able to effectively communicate it to funders and potential partners. Several of the informants spoke of the important advocacy role their organizations play in trying to spread their vision and understandings to funders and the broader public. For example, Galiano Health Care Centre is a member of the BC Association of Community Health Centres and the Canadian Association of Community Health Centres and has participated in campaigns to promote the community health centre model in Canada.

> *It's fundraising, it's granting – you know writing grants, getting, trying to get people to understand that we've got this building here that needs to be funded. And not necessarily the Island people, but people off the Island. The people that are, that have the capability to give us money to keep it running.*
>
> Galiano Health Care Centre Informant

6. Building Momentum

Informants discussed the critical need to "build momentum" to support integrated care initiatives. In all of the case studies, leadership teams were laying the groundwork for the initiative prior to its official establishment (e.g., recruiting key stakeholders, building relationships with partners, and securing funding). On Galiano Island, where a physical building had to be built, it took over six years of advocacy and fundraising work for the Galiano Health

Care Centre to be built. Getting integrated care initiatives off the ground requires a significant initial investment of resources and time by a lead organization or committee of volunteers. When possible, initiatives sought to capitalize on already existing momentum; for example, Healthy Aging was able to build upon the work and momentum created through their participation in the Raising the Profile Project.

Informants also discussed the importance of targeting key stakeholders (e.g., funders, large institutional partners, local government) and ensuring they are onboard early on in order to build credibility and gain momentum for their work. For example, before officially launching, the OCSPA leadership worked on recruiting the County and a small group of core stakeholders to support their initiative. Informants discussed how over time the participation of a small group of highly engaged and credible partners can lead to the organic growth of additional partnerships.

> *Don't start it unless you've got many organizations that will resource it with both time and money. It doesn't start by itself. [Alzheimer's OC] actually hired the first staff person and dedicated 20 hours of her time and we paid for that for about 9 months just to get it rolling, before we started getting members and income and that sort of thing.*
>
> OCSPA Informant

Informants noted that strategies and plans are commonly created, but not always followed through on which can lead to skepticism among potential partners and service users. Being able to show early successes of collaboration and integration is an important component of building momentum and buy-in from stakeholders. In the PATH project the co-design process allowed for the development of some simple solutions (e.g., redesigning forms) that could be implemented within the first few months of the project and helped participants to quickly see impacts of their participation.

> *What we also found was while not everybody was onboard, we needed to go where the momentum was. So for example, instead of engaging all 230 municipalities in the province, we identified 25-30 where there was a lot of momentum to engage. When we started up with the regional consultations about 150 of 500 organizations were onboard, two and half years later, 470 of the 500 are onboard. So we used this idea of organic development to facilitate engagement of people and, and to really work on the momentum we built.*
>
> Healthy Aging Informant

7. Balance of Structure and Flexibility

In all of the case studies informants emphasized the importance of having a balance between flexibility and structure. Having a clearly established vision, decision-making processes, and

well-defined roles are essential. Routines, schedules, and clear expectations were viewed as assets when trying to work with a diverse range of partners and providers. Participants should know the required time commitment and contributions they are expected to make. Documents such as project charters, terms of reference, strategic plans, and guidelines for groups and committees can help to clarify these expectations.

At the same time, informants noted that flexibility and being responsive to emerging needs are also critical to the success of integrated care initiatives. Leadership need to be sensitive to emerging needs and issues, as well as local and situational nuances. One of the informants noted that integrated working requires accepting that you will be working in complexity and ambiguity. Tools such as the Stacey Matrix and Minimum Specifications were mentioned as useful for decision-making and working within complex environments.

It is also important to be willing to make changes to the original plans if something is not working out as intended or new opportunities emerge. For example, PATH originally only targeted older adults with multiple health conditions, however, over time it was recognized that younger adults with multiple health conditions were experiencing similar challenges so the target audience for some of the components was broadened.

> *You know a lot of times with co-design you have more than enough to do and you've kept it kind of whittled down to three priorities, and maybe you don't have the right three by the end of the day, maybe you've got two that are working and one that is not. So, you know we allow them that flexibility to sort of say this isn't what we thought it was going to be, lets change it.*
>
> PATH Informant

8. Knowledge Creation and Mobilization

Identifying unmet and emerging needs of older adults and service providers can serve as a catalyst for integrated working and build support for new initiatives. Knowledge creation played an important role in all of the case studies. Examples of knowledge creation activities undertaken in the case studies included: community surveys, consultations with service providers, older adults and caregivers sharing their stories, mapping out current services, needs assessments, and compiling relevant statistical data on issues. In the OCSPA inventorying available services and identifying unmet needs was an important starting point for many of the pillar groups. On Galiano Island, an aging in place survey helped to identify the need for a more comprehensive range of services to help older adults to age in place and sparked the development of some new programs at the Galiano Health Care Centre.

Informants also discussed the importance of mobilizing and sharing knowledge about successful programs, best practices, and available services with service providers in order to build their knowledge and capacity to support older adults. In BC, the online knowledge hub platform Healthy Aging CORE was developed to address the issue of access to knowledge for service providers. In the case studies, online platforms were also used to disseminate information about healthy aging and services directly to older adults. PATH developed a PATHway to Aging Well website for the community of Northumberland and the technology pillar group in the OCSPA supported the development and promotion of the IrisOC website for older adults in OC.

> *What was also very important was that we didn't take away from individual, organizational and community nuances. And paying homage to and respect for existing programs, existing policies, and really facilitating knowledge mobilization and knowledge sharing, rather than utilizing a top-down approach.*
>
> Healthy Aging Informant

9. Effective Communication

Effective communication was one of the most common facilitators identified by informants. When working with a range of partners and providers, having clear structures for communication (e.g., schedule of regular meetings, deadlines for providing feedback) is essential for effective communication. Informants also discussed the value of maintaining regular communications with government and institutional structures in the area (e.g., local government, regional health organizations) even if they are only minimally involved with the initiative. While these communications may be mostly a formality rather than action-driven, they can help to keep key stakeholders in the loop and facilitate relationship-building.

> *I've been saying throughout this whole interview, communication is key. Constant communication even when it feels like you're repeating yourself, is very important to keep everyone in the loop in some way.*
>
> OCSPA Informant

Informants discussed various methods used to maintain communication with partners and providers, including newsletters, meetings, emails, and teleconferences. The value of face-to-face conversations was emphasized, particularly when initially building relationships. For example, Healthy Aging in BC is province-wide and covers a vast geographic area. While many of their communications are facilitated through technology, annual regional consultations are also held in communities across the province in recognition of the value of creating forums for face-to-face interactions.

> *So, the first thing I would say is the face-to-face conversations were incredibly important to build trust and rapport.*
>
> Healthy Aging Informant

CONCLUSION

While there were significant variations between the integrated care initiatives presented in the case studies, a commonality of all of the case studies was that they brought together a broad range of organizations and providers to address the holistic needs of older adults in their communities. All initiatives placed significant emphasis on relationship-building and adopting processes for collaboration, communication, and coordination.

Based on the case studies common challenges and facilitators of integrated care were identified, which generally complemented those from the reviews by Kirst et al. (2015) and Threapleton et al. (2017). However, some unique themes were also identified that appear to be reflective of the broad range of partners involved in these initiatives, as well as their incorporation of holistic and social determinants of health approaches. All of the initiatives had bottom-up origins and grassroots and community support were identified as key facilitators. Heavy top-down approaches were identified as a potential barrier, and the case study initiatives utilized approaches that emphasized partners feeling equal in the model and respecting their expertise and experience. Knowledge creation activities played important roles in identifying unmet needs of older adults and bringing together partners to develop creative solutions. The initiatives leveraged the strengths of a broad range of organizations and providers and created new programs and resources, but also aimed to enhance services and programs that were already being offered.

Currently there is no universal model of integrated care; success of a model is highly dependent on the local context. However, there are certain challenges and facilitators that can potentially impact the success of a model in any context. This report has elucidated some of these factors, specifically for models that involve both health and community-based services and incorporate holistic and social determinant of health approaches. Moving forward, as integrated care initiatives broaden their range of partners and objectives to meet the needs of older adults, more attention will need to be paid as to how diverse service delivery organizations can engage in integrated working to meet the needs of older adults in their communities.

REFERENCES AND FURTHER READING

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