

MASTER'S THESIS

Change and Integration in Senior Health Care Systems:

The Case of Sault Ste. Marie

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Abstract

This thesis organizes information that will assist a community in the selection or construction of a context sensitive integrated senior healthcare system model. The senior healthcare system within Sault Ste. Marie, Ontario is used as a case study. Institutional Ethnography is used to collect data guided by a change management model adapted from the literature. Data sources were non-participant observations, key informant interviews, focus groups, and texts. Institutional ethnographic local and high level analyses methods were used to analyze this data. Results identified many more restraining than driving forces for integration within Sault Ste. Marie's senior healthcare system. Study findings indicate that macro level activities are perpetuating micro level obstacles to integration. These results can be used to identify where improvements need to be made at the macro level in order for successful change to occur at the micro level.

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1.0 Introduction

This chapter provides an overview of the background and motivation for this thesis. It will present a problem statement followed by the study objectives and methodology, as well as a description of how this thesis is organized.

1.1 Problem Statement

The demand for healthcare services to meet the needs of seniors within Canada is growing as the aging population continues to increase (Hollander et al, 2009). To address this demand, numerous services have been developed, however no one organization is accountable for elderly care causing fragmentation in service delivery (Bergman et al, 1997). This fragmentation has caused: "...continuity-related problems that compromise both service accessibility and efficiency of healthcare needs" (Hebert et al, 2008). The lack of continuity among senior healthcare organizations and service providers has not gone unnoticed as several integrated senior healthcare system models have been developed to identify how to create connections among these entities. Examples of such models include: the 'System of Integrated Care for Older Persons' (SIPA), the 'Program of Research to Integrate Services for the Maintenance of Autonomy' (PRISMA), the 'Program of All-Inclusive Care for the Elderly' (PACE), and the 'Social Health Maintenance Organization' (SHMO). Although these models have been somewhat successful in increasing continuity among senior healthcare services, common implementation problems have limited their effectiveness including: lack of participation from organizations and service providers; difficulty building inter-organizational relationships; and significant financial and human resources required for model implementation (Bergman et al, 1997; Beland et al, 2006; Hebert et al, 2003; Hollander et al 2007; Hebert et al, 2008; Kodner, et al, 2000; Reuben et al, 1997).

The literature that reviews the above models does not provide insight into the causes of the implementation problems, nor does it explain the processes that were used to select the models for the specific communities that they were implemented within (Bergman et al, 1997; Beland et al, 2006; Hebert et al, 2003; Hollander et al 2007; Hebert et al, 2008; Kodner, et al, 2000; Reuben et al, 1997). This lack of information creates two issues: 1) In order for the above models to be more effective, the root causes of the implementation problems need to be addressed; and 2) It is difficult to determine how to transfer the above models to other communities because there is no selection or implementation process to follow. These issues act as barriers to communities such as Sault Ste. Marie, Ontario that have identified the need for an integrated senior healthcare system model to address gaps in continuity of care (Sault Ste. Marie & Area Health Care Committee (SSMAHCC), 2011; Clarke; 2010).

1.2 Study Objectives and Questions

Change management literature indicates that the above implementation problems are common in change initiatives that take place within the healthcare setting, and suggests that they align with the two major issues that change management processes are meant to prevent including ‘stakeholder resistance’ and ‘environmental inappropriateness’ (Kotter, 1995, Golden, 2006, Balogun and Hailey, 2008). Therefore, to address these problems and provide a process that will assist with integrated senior healthcare system model selection/construction, this thesis has the following objectives:

- 1) Use change management concepts as a lens to depict the current state of a specific community that is in need of an integrated senior healthcare system model.
- 2) Format/refine the information gathered from the first objective so it is useful for stakeholders in selecting or constructing a model that meets their specific needs.

To achieve the above objectives, this thesis asks the following questions:

- 1) What are some of the system gaps within communities that are in need of an integrated senior healthcare system model?
- 2) What vision and goals for an integrated senior healthcare system are suggested by stakeholders within these communities?
- 3) What are the enablers of and obstacles to integration? How can the enablers be leveraged and the obstacle’s be overcome to achieve a more integrated senior healthcare system?

Through the above objectives and questions, this study will assist a community that is in need of an integrated senior healthcare system model in understanding local system gaps, resources, as well as enablers and obstacles to integration. This information will act as a stepping stone towards the selection or construction of a context sensitive model, as stakeholders will have a clear awareness of the resources and behaviours that can be leveraged, as well as the barriers that need to be addressed in order for the change to be successful.

1.3 Methodology

To achieve the above objectives, this study uses Dorothy Smith’s Institutional Ethnography (2005) as a method of inquiry to depict of the current state of a senior healthcare system that is in need of an integrated model from the perspective of local administrators and front line service workers (Devault and McCoy, 2002). Through this methodology I situate myself as the researcher in the environment under study in order to provide additional insight into how the system is organized by taking the ‘standpoint’ of

study participants (Devault and McCoy, 2002). Institutional ethnographic studies are ‘for the people’ as they assist in helping those who work within a specific institutional environment (e.g. healthcare system) to determine where change can occur to improve their everyday lives (Smith, 2005). Therefore, this method of inquiry provides momentum for the change towards senior healthcare system integration as the stakeholders who will be asked or require to change are involved in ‘diagnostic’ activities that serve to encourage change readiness (Schein, 1990; Armenakis and Harris, 2009).

Using an IE approach, data is collected through non-participant observations, key informant interviews, and focus groups. This data is first analyzed at the local level to form an understanding of how the environment of interest is organized based on the collective experiences of study participants. This is accomplished through within and cross analysis of data sources by coding for emergent themes guided by change management concepts. The data is then further analyzed by comparing the local level analysis to relevant texts to form an understanding of how the environment of interest is organized at the macro level. This analysis resulted in the following:

- Identification of Sault Ste. Marie senior healthcare system gaps; establishment of a vision and goals for an integrated Sault Ste. Marie senior healthcare system; depiction of diversity within the Sault Ste. Marie senior continuum of care; and identification of enablers and obstacles to achieving the established integration path.
- Identification of high level obstacles to integration through the application of IE ‘fault line’ analysis methods.
- Presentation of a force field analysis which identifies the driving and restraining forces for integration within the Sault Ste. Marie senior healthcare system.
- Discussion of the macro-micro chasm that currently exists within the Sault Ste. Marie senior healthcare system.
- Development of a general approach that can be adapted by other communities to assist in selecting a context sensitive integrated senior healthcare system model.

1.4 Thesis Organization

This thesis begins with a literature review that describes existing integrated senior healthcare system models and the common problems that they encountered during implementation. It will then make a case for the use of change management processes to assist in addressing these problems. The study design and methodology are described, followed by the presentation and discussion of the results. Finally, the study will conclude with an overview of its contributions to the literature, limitations, and recommendations for areas of future research.

2.0 Literature Review

To describe the background of this research study, the following literature review will provide an overview of the continuum of care; continuity issues in the continuum of care; healthcare system integration; existing prominent integrated senior healthcare system models, analysis of these models; gaps and problems found in the literature; and change management processes that can be used to address these gaps and problems.

2.1 Continuum of Care

Because it is the objective of this study to depict the current state of stakeholders and the continuum of care within a specific community that is in need of senior healthcare system integration, it is necessary to provide a description of what is meant by the 'continuum of care'. The 'continuum of care' is a holistic view of the senior healthcare system including different levels of care, types of services, and organizations within a given region. Hollander and Prince (2008) provide a general example of the continuum of care which divides the system into four levels: primary (community based services), secondary (residential services), tertiary and quaternary (acute care services). It is important to note because no two environments are the same (Balogun and Hailey, 2008), the continuum of care may change based on geographical region. For example, the continuum of care in Ottawa will look much different than the continuum of care in Sault Ste. Marie as each location will have access to different levels of care and services. In each geographical region, these services could be provided by numerous organizations that are not necessarily connected with each other. This creates continuity of care issues as Bergman et al (1997) explain: "since each institution is a distinct entity with its own funding mechanism, budget, jurisdiction and criteria for patient selection, services are not coordinated across patient needs".

2.2 Continuity Issues in the Continuum of Care

The lack of continuity among senior healthcare services becomes problematic as senior's needs may fall within or across multiple levels and organizations along the continuum of care. An example of this problem is the Alternative Level of Care (ALC) issues facing many Canadian communities (Walker et al, 2009). ALC patients are those who no longer require the acute care services that hospitals are meant to provide, yet they remain in hospital beds waiting for the appropriate level of care to become available within the community (Cancer Care Ontario, 2011). Part of the ALC problem can be attributed to the lack of continuity among senior healthcare services as one of the reasons why seniors become ALC patients in the first place is because they use the emergency department as a 'one stop shop' for all of their care needs, rather than trying to navigate their way through various organizations that provide senior care services in the community (Aminzadeh and

Dalziel, 2002). Furthermore, ALC issues indicate that service providers also find it difficult to navigate the senior healthcare system, as seniors are often designated ALC because hospital care providers lack knowledge and confidence in services within the community, and therefore only discharge their patients to institutionalized care settings (NE LHIN-Home First Implementation Guide and Tool Kit, 2011). This necessity to discharge seniors to institutionalized care has caused the wait lists for these facilities to become over 400 people long in certain communities (First Interview, MGT 5150 Pilot Project, 2011). This backlog forces ALC patients to remain in hospital beds for prolonged periods of time which contributes to the deterioration of their conditions and causes them to require higher levels of care than they did when they first were designated ALC (Gillick et al, 1982). Therefore, the ALC issue decreases the quality of care that both seniors and the overall population receives as it forces seniors to seek care in unsuitable settings and cripples the hospitals' ability to provide care to acute patients (Starr-Hemburrow et al, 2011).

Because of such problems, most healthcare financial resources are directed towards higher, more costly institutional levels of senior care such as long term care facilities and hospitals (Hollander et al, 2009). A study conducted by Veterans Affairs Canada (Miller et al, 2008) examined the potential of home and supportive housing services as alternatives to these higher levels of care within Halifax, Ottawa, Victoria, and Toronto. The findings suggest that: "...continued funding of preventative home care may be providing savings to provincial healthcare systems by reducing the rate of deterioration of the health of veterans, thereby reducing the use and costs of hospital services and long term care facilities" (Hollander et al, 2009). In addition, study participants in community settings reported a higher level of satisfaction with the care that they were receiving than institutionalized clients (Miller et al, 2008). Although these studies provide evidence that shifting resources from higher to lower levels of care could increase the quality of senior care while decreasing healthcare system costs, Hollander et al (2009) caution that these resource shifts will only be effective if they are made within an integrated senior healthcare system that provides funding for service providers and organizations spanning the continuum of care.

2.3 Senior Healthcare Integration

The need for integrated senior healthcare systems has received much attention and support from Canadian and international researchers (Expert Panel on Alternative Level of Care, 2006; Bergman et al, 1997; Beland et al, 2006; Hebert et al, 2008; St. Joseph's Health Care London, 2010; Rubenstein et al, 1984; Starr-Hemburrow et al, 2011; Kodner et al, 2000; Hollander et al, 2007; Hollander and Prince, 2008; Hollander et al, 2009; Costa and Hirdes, 2010; MacAdam, 2008; MacAdam, 2009). Leutz (1999) reinforces this perspective by explaining that: "integration could address cross-system care problems, including poor coordination of services and benefits, cost shifting, and frustration for users in accessing services". Based on this literature, using integration as a solution to the need for senior healthcare system continuity appears to be a favourable idea, however the question then

becomes, ‘what is integration?’ A systematic review by the Canadian Policy Research Network that evaluates integrated senior healthcare system frameworks indicates that the term ‘integration’ takes on many meanings (MacAdam, 2008), and provides examples of the various definitions through three concepts including ‘type’, ‘level’, and ‘form’.

Within this review, ‘type’ of integration is explained using Leutz’s (1999) description of linkage, coordination, and full integration:

- *Linkage* allows individuals with mild to moderate health care needs to be cared for in systems that serve the whole population without requiring any special arrangements.
- *Coordination* requires that explicit structures be put in place to coordinate care across acute and other health care sectors. While coordination is a more structured form of integration than linkage, it still operates through separate structures of current systems.
- *Full Integration* creates new programs or entities where resources from multiple systems are pooled (MacAdam, 2008).

‘Level’ of integration is explained through a description of system integration, intra and inter-organizational integration, and clinical integration:

- *System Integration* includes activities such as strategic planning, financing, and purchasing system, program eligibility and service coverage, within a geographical area or across a country or province.
- *Intra Organizational Integration* refers to the coordination and management of activities among the entities (departments, staff, etc.) within the same organization or service provider.
- *Inter Organizational Integration* refers to the coordination and management of activities among various organizations and service providers that span across the continuum of care.
- *Clinical Integration* concerns the direct care and support provided to older people by their direct care givers (MacAdam, 2008).

The ‘form’ of integrated care is referred to as vertical and horizontal integration:

- *Vertical Integration* refers to the delivery of care across service areas within a single organizational structure.
- *Horizontal Integration* refers to improved coordination of care across settings (MacAdam, 2008).

Because there are numerous meanings of integration, MacAdam (2008) explains that the definition of integration used should be dependent upon the end goal of the change. Therefore, because it is the end goal of this study to highlight the context and circumstances

of stakeholders and the overall continuum of care within a specific environment, the term ‘integration’ will refer to formal or informal activities and relationships among organizations and/or service providers that span across the senior continuum of care as a whole.

2.4 Integrated Senior Healthcare System Models

As a result of the need for senior healthcare system integration, several integrated senior healthcare system models have been developed. The systematic review of integrated senior healthcare frameworks by the Canadian Policy Research Network has identified that there are hundreds of published articles that deal with the integration of care for specific diseases such as diabetes or cancer, as well as specific sectors such as primary care, secondary care, and tertiary care (MacAdam, 2008). Because the objective of this study is to illuminate the context and circumstances of stakeholders and the overall senior continuum of care within a specific environment, these types of models will not be reviewed. Rather, the following review concentrates on studies that evaluate the most prominent senior healthcare system models that create connections among all levels, organizations, services, and stakeholders across the senior continuum of care as whole (Table 1, Table 2, Table 3, and Table 4). Where possible, this review will explain the model objective and design, how it was developed, the results of the implementation, and finally the obstacles that each of these models faced during development and implementation.

Table 1: Review of the System of Integrated Care for Older Persons (SIPA), Quebec

Model One	Key Features: Objectives/ Description	Method of Model Development
<p>System of Integrated Care for Older Persons (SIPA), Quebec</p> <p>Sources: Bergman et al, 1997; Beland et al, 2006.</p>	<p>Model Objectives:</p> <ul style="list-style-type: none"> • A system based on the delivery of all senior services across the continuum of care (health, social, acute, long term). • One SIPA organization would be responsible for the entire population of frail elderly in a given region. • Public financing for health and social services is integrated; new SIPA organization is responsible for all costs. • Includes elderly who are waiting for LTC institution placement, as well as those who need assistance to remain in the community. <p>Model Description:</p> <ul style="list-style-type: none"> • Single entry point (based on specific eligibility criteria) • Geriatric assessment and management through the use of interdisciplinary protocols. • Case managers (authorized to intervene in decision making, responsible for inter-disciplinary team, and inter-organizational coordination of patient care, responsible for clients regardless of location within the system). • Care provided by an inter-disciplinary team. • Primary care physicians play key role in multi-disciplinary team. • Inter-organizational coordination (across continuum of care). 	<p>Who and Where?</p> <ul style="list-style-type: none"> • Developed by the McGill University (Quebec) Research Group on Integrated Services for the Frail Elderly. <p>How?</p> <ul style="list-style-type: none"> • Multi-disciplinary group consulted for model development including managers, practitioners, and academics. • All stakeholders in the Quebec health and social services network were consulted at each stage in model development. • International experts also consulted.
	<p>Result of Implementation</p>	<p>Identified Development & Implementation Obstacles</p>
	<p>Implementation and Evaluation:</p> <ul style="list-style-type: none"> • SIPA demonstration project in several hospitals and Centres Locaux de Services Communautaires (CLSCs) in the Montreal region. • Implementation led by the Montreal Regional health Board, the Quebec Ministry of Health and Social Services, the Agence de developement de reseaux locaux de services de santé et des services sociaux de Montreal, and the Solidage group. • Regional model implementation monitoring committee formed with representatives from the CLSCs, hospitals, nursing homes, and rehabilitation centres. • Quasi-experimental design with an experimental (SIPA demonstration project) and control group (services offered by local CLSCs). <p>Results</p> <ul style="list-style-type: none"> • Success in substituting institutional based services for community based services. • Experimental group had less than half the hospital admissions than the control group. • Reduced the number of hospital waits for LTC home placement by half. • SIPA reduced institutional costs by \$14,500 for those living independently in their homes with chronic illnesses as compared to the control group. • SIPA reduced short term hospitalization costs for those living with activities of daily living disabilities by \$4,000 as compared to the control group. 	<p>Development:</p> <ul style="list-style-type: none"> • Situational analysis of the environments where the model was implemented is not mentioned in the literature. • Although stakeholders were involved in model development, the extent of their involvement and buy in to the model is not clear (this is evident when looking at the implementation obstacles). <p>Implementation:</p> <ul style="list-style-type: none"> • SIPA did not perform as well as expected. • Recruiting elders to be admitted to the SIPA program for this trial was difficult as this process required the cooperation of already overworked CLSC staff. • Incorporating the SIPA model into the work processes of the various clinicians was a difficult process (no time to adapt to model after training). • Case managers faced difficulty in coordinating with hospital care units because of high staff turnover, poor information transmission, and lack of coordination with hospital physicians. • Case managers faced difficulty coordinating with primary care physicians. • Incentives for physicians to participate in SIPA were inadequate. • Hiring team members was continuous, many necessary positions remained vacant, union issues were present (i.e. nurses strike) that affected staff and team stability.

Table 2: Review of the Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA), Quebec

Model 2	Key Features: Objectives/ Description	Method of Model Development
<p>Program of Research to Integrate Services for the Maintenance of Autonomy (PRISMA), Quebec</p> <p>Sources: Hebert et al, 2003; Hollander et al 2007; Hebert et al, 2008.</p>	<p>Model Objectives:</p> <ul style="list-style-type: none"> • Coordinates all organizations and services across the continuum of care (public, private, voluntary) for seniors in a given area. • Every organization keeps its own structure but agrees to participate in an umbrella system and to adapt its operations and resources to agreed-upon requirements. • No new infrastructure or financing mechanisms • Embedded within the current healthcare system. • Includes elderly who are waiting for LTC institution placement, as well as those who need assistance to remain in the community. <p>Model Description:</p> <ul style="list-style-type: none"> • Inter-organizational coordination at every level (governance, management, clinical). • Single point of entry (accessed through telephone or written referral) • Case manager (authorized to intervene in all institutions or services, central to program). • Individualized service plans (developed by multidisciplinary teams, led by case manager) • Single assessment instrument (evaluates clients' needs and resources). • Computerized clinical chart (allows all care providers across organizations access to client information). 	<p>Who and Where?</p> <ul style="list-style-type: none"> • PRISMA group which is a Canadian partnership between two research teams (Research Centre on Aging in Sherbrooke and Laval University Geriatric Research Team in Quebec City). • Health organizations in the Province of Quebec: Ministry of Health and Social Services, five Regional Health and Social Services Agencies and the Sherbrooke Geriatric University Institute. <p>How?</p> <ul style="list-style-type: none"> • Developed based on the premise that integrated senior healthcare across the continuum would improve the quality of care and costs. • The method of model development and stakeholder involvement is not mentioned in the literature.
	<p>Result of Implementation</p>	<p>Identified Development and Implementation Obstacles</p>
	<p>Evaluation and Implementation (2003)</p> <ul style="list-style-type: none"> • Bois-Francs Pilot Project in two CLSC territories in the Victoriaville region, Quebec. • Quasi-experimental design with an experimental group (received PRISMA services) and a control group (received regular CLSC services). • Followed over a three year period after implementation. <p>Results (2003)</p> <ul style="list-style-type: none"> • Fewer people in experimental group experienced functional decline. • Desire to be institutionalized less in experimental group. • Caregivers' burden was less in experimental group. • Experimental and control group use of hospital was the same. • The control group had a higher chance of going back to the hospital after discharge and a higher chance of being institutionalized. <p>Evaluation & Implementation (2008)</p> <ul style="list-style-type: none"> • A more recent study by Herbert et al that tests the effectiveness of PRISMA in three new sites in still being conducted, the base line data does not show conclusive results at this time. 	<p>Development:</p> <ul style="list-style-type: none"> • There is a lack of information concerning how the model was developed and what level of stakeholder participation was involved. • There is a lack of information concerning why the specific model was chosen for the sites that it was implemented within. <p>Implementation:</p> <ul style="list-style-type: none"> • There is a lack of information on the effectiveness of PRISMA, however Hebert et al (2008) acknowledge that because this model is embedded within the current healthcare system, a significant change in current work process is needed, as well as the need for coordination among organizations.

Table 3: Review of the Program of All-Inclusive Care for the Elderly (PACE), USA

Model 3	Key Features: Objectives/ Description	Method of Model Development
<p>Program of All-Inclusive Care for the Elderly (PACE), USA</p> <p>Source: Kodner, et al, 2000; Reuben et al, 1997.</p>	<p>Model Objectives</p> <ul style="list-style-type: none"> • Integrated system of care for the elderly that coordinates services across the continuum of care through and around an adult day health centre. • Includes elderly who are waiting for LTC institution placement, as well as those who need assistance to remain in the community. <p>Model Design</p> <ul style="list-style-type: none"> • Day health centre is the primary care setting for most services. • Geriatric inter-disciplinary approach to team care and assessment (primary care providers, nurses, personal care assistants, social workers, rehabilitation therapists, nutritionists, etc.). • Automated data system used across all sites. • Care plan developed through data system by all team members' bridges internal and external resources. 	<p>Who and Where?</p> <ul style="list-style-type: none"> • In 1971 San Francisco's community leaders received funding from the Administration on Aging and the State of California, Department of Health Services to initiate On-Lok model that eventually developed into the PACE model. • Now a well-established model in the United States. <p>Funding:</p> <ul style="list-style-type: none"> • Federal- Medicare/Medicaid. <p>How?</p> <ul style="list-style-type: none"> • Developed based on the premise that integrated senior healthcare across the continuum would improve the quality of care and costs. • Each PACE site develops a panel of specialist consultants to obtain support for the model from the community and healthcare professionals.
	<p>Result of Implementation</p> <p>Evaluation and Implementation:</p> <ul style="list-style-type: none"> • According to Kodner et al 2000 four major studies have evaluated the PACE model which has been implemented by various organizations in numerous cities throughout the United States. • Numerous methods of have been used to evaluate the effectiveness of the PACE model. The results from Kodner et al 2000 provides a synthesis of these studies as presented below. <p>Results:</p> <ul style="list-style-type: none"> • Effective in integrating financing and delivery of services, as well as effective clinical integration. • Enrolment in PACE decreased hospital use (admissions and days spent in hospital) by 50% compared to a control group. • Enrolment in PACE decreased admission to LTC homes (20% less than control group). • PACE participants used more community based services than control group (93% vs. 74%). • PACE participants are in good health and report that their quality of life has increased. 	<p>Identified Implementation Obstacles</p> <p>Development</p> <ul style="list-style-type: none"> • There is a lack of information concerning how the model was developed and what level of stakeholder participation was involved. • There is a lack of information concerning why the specific model was chosen for the sites that it was implemented within. <p>Implementation</p> <ul style="list-style-type: none"> • PACE did not perform as well as expected. • Takes time and financial commitment (roughly 3 to 5 years and 1.5 million dollars). • Difficultly with recruitment of specialized staff and physicians. • Requires a change in culture (i.e. staff must be trained in new model, patients and families must be educated).

Table 4: Review of the Social Health Maintenance Organization (S/HMO), USA

Model 4	Key Features: Objectives/ Description	Method of Model Development
<p>Social Health Maintenance Organization (S/HMO), USA</p> <p>Source: Kodner et al, 2000.</p>	<p>Model Objectives:</p> <ul style="list-style-type: none"> • To branch together social and acute senior healthcare services. • Connects services and organizations throughout the continuum of care in various sites. • Includes elderly who are waiting for LTC institution placement, as well as those who need assistance to remain in the community. <p>Model Design:</p> <ul style="list-style-type: none"> • Individual assessments performed (include patient and family consultation). • Care management multi-disciplinary team (nurses, social workers, primary care physician, other healthcare workers). • Clinical management tools used to develop Comprehensive Care Plan. 	<p>Who & Where?</p> <ul style="list-style-type: none"> • Four SHMO sites: Seniors Plus, Minneapolis, Minnesota, Medicare Plus II, Portland, Oregon, Elderplan, New York City, and SCAN Health Plan, Long Beach, California. <p>Funding:</p> <ul style="list-style-type: none"> • Federal- Medicare/Medicaid. <p>How?</p> <ul style="list-style-type: none"> • Developed based on the premise that integrated senior healthcare across the continuum would improve the quality of care and costs. • Each site given the flexibility to implement the SHMO model in their own manner (not stated how or why models were adjusted).
	<p>Result of Implementation</p> <p>Evaluation and Implementation:</p> <ul style="list-style-type: none"> • According to Kodner et al 2000 many different studies have been conducted to evaluate this model the findings of which are discussed below. <p>Results:</p> <ul style="list-style-type: none"> • Integration at the financing, benefit, and administrative levels but not at the clinical level. • S/HMO's associated with an increase in hospitalization and LTC home admissions. • 80-95% of S/HMO patients expressed satisfaction (same as regular HMO patients). • Family members are greatly satisfied with moral support and coordination of care that they did not receive through other programs. 	<p>Identified Development and Implementation Obstacles</p> <p>Development:</p> <ul style="list-style-type: none"> • There is a lack of information concerning how the model was developed and what level of stakeholder participation was involved. • There is a lack of information concerning why the specific model was chosen for the sites that it was implemented within. <p>Implementation:</p> <ul style="list-style-type: none"> • SHMO did not meet expectations. • Difficulty in developing new delivery systems. • Difficulty in establishing effective provider relationships. • Newness of the program was not appealing to many seniors and thus it was difficult to get them to enrol in the program.

2.5 Analysis of Existing Literature

Each of the above integrated senior healthcare system models have been somewhat successful in substituting higher levels of care for lower levels of care, decreasing elderly hospital admissions and lengths of stay, increasing access to senior healthcare services, and reducing overall costs to the healthcare system (Bergman et al, 1997; Beland et al, 2006; Hebert et al, 2003; Hollander et al 2007; Hebert et all, 2008; Kodner, et al, 2000; Reuben et al, 1997). However, the literature also indicates that the models did not perform as well as expected for the following five reasons:

1. lack of participation from organizations and service providers,
2. difficulty building inter-organizational relationships,
3. significant financial resources required for model implementation,
4. human resource constraints, and;
5. difficulty integrating the models into current work processes (Bergman et al, 1997; Beland et al, 2006; Hebert et al, 2003; Hollander et al 2007; Hebert et all, 2008; Kodner, et al, 2000; Reuben et al, 1997).

In addition to the above problems, each of the models claims to have the ability to be transferred to other communities that are in need of senior healthcare system integration, yet there is a lack of information that describes how to do this (Bergman et al, 1997; Beland et al, 2006; Hebert et al, 2003; Hollander et al 2007; Hebert et all, 2008; Kodner, et al, 2000; Reuben et al, 1997). Furthermore, in order to ensure that the models are effective within other communities, the existing implementation problems need to be addressed prior to transfer. To do this, an in-depth understanding of why the above five problems occurred is necessary. For example, why did the models encounter financial and human resource constraints? Why couldn't existing resources support them? Why didn't stakeholders participate in the models? How were these models selected for the communities that they were implemented within? When reviewing the literature for answers to these questions, explanations were not provided (Bergman et al, 1997; Beland et al, 2006; Hebert et al, 2003; Hollander et al 2007; Hebert et all, 2008; Kodner, et al, 2000; Reuben et al, 1997). This lack of information is an issue because the selection process is essential to the overall success of change initiatives, as stakeholder behaviours and resources need to be able to adequately support the them (Balogun and Hailey, 2008; Armenakis and Harris, 2009). Based on the common issues that existing models encountered, it appears as though the significance of the change selection process was not taken into consideration as the issues stem from the following two problems:

1) Problem One: Stakeholder Resistance to Change

Stakeholder resistance to existing integrated senior healthcare system models can be seen through the lack of stakeholder participation in the models and difficulty building inter-organizational relationships (Bergman et al, 1997; Beland et al, 2006; Hebert et al, 2003; Hollander et al 2007; Hebert et al, 2008; Kodner, et al, 2000; Reuben et al, 1997). Change management literature suggests that one reason why resistance occurs is because of the lack of stakeholder participation in the change selection process (Golden, 2006). Armenakis and Harris (2009) explain that without stakeholder participation, ‘genuine’ buy-in cannot be accomplished as stakeholders may not understand why the change is occurring. This lack of understanding may cause change recipients to feel a loss of control over: “...their influence, their surroundings, their source of pride, and how they have grown accustomed to living and working” (Jick et al, 2011). These negative reactions to change can have a significant impact on the success of new initiatives, and thus change recipients’ understanding and acceptance of the change is extremely important (Jick et al, 2011). Armenakis et al (1993) suggest that decreasing stakeholders’ negative reactions to change can be accomplished by increasing their ‘readiness for change’ which could lead to more effective change efforts. Readiness for change is defined as: “...the extent to which an individual or individuals are cognitively and emotionally inclined to accept, embrace, and adopt a particular plan to purposefully alter the status quo” (Holt et al, 2007).

1) Problem Two: Inappropriateness of Change for Specific Environment

The environmental inappropriateness of existing integrated senior healthcare system models can be seen through the following problems: significant financial resources required for model implementation, human resource constraints, and difficulty integrating the models into current work processes. According to Balogun and Hailey (2008), these problems may have been caused by the lack of evaluation of the intended change environments prior to model selection as the problems indicate that the environments could not support the model designs (Bergman et al, 1997; Beland et al, 2006; Hebert et al, 2003; Hollander et al 2007; Hebert et al, 2008; Kodner, et al, 2000; Reuben et al, 1997). Change management literature outside healthcare supports Balogun and Hailey’s (2008) theory by indicating that proper ‘organizational diagnosis’ is required to understand the specific needs of the stakeholders and environment of interest: “...in order to minimize the likelihood of making a mistake in implementing an intervention that is not appropriate” (Armenakis and Harris, 2009).

2.6 Summary of Gaps and Problems in Literature

Based on the above review of literature the following gaps and problems have been identified:

- **Gaps:** Lack of information that describes how to implement existing models in other communities that are in need of senior healthcare system integration; Lack of

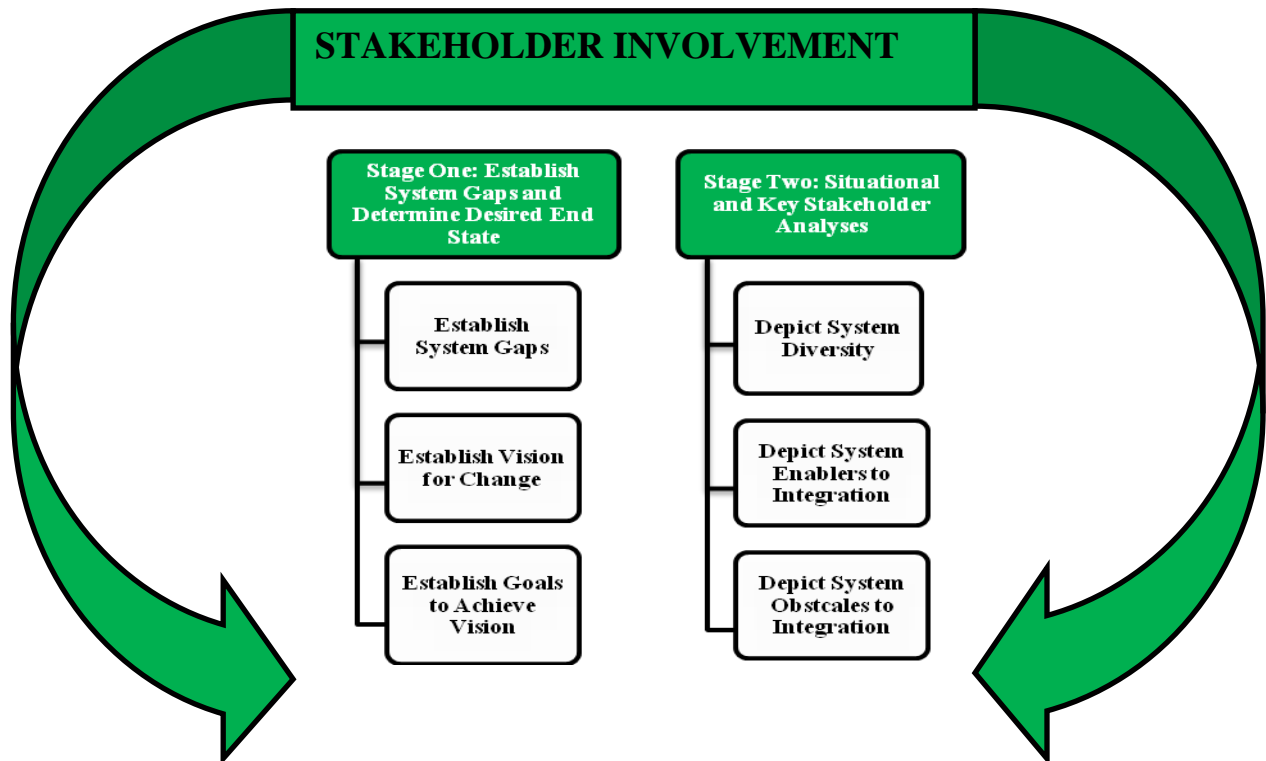
information that describes why integrated senior healthcare system models were chosen for the specific communities that they were implemented within.

- **Problems:** Stakeholder Resistance towards existing integrated senior healthcare system models; Environmental inappropriateness of existing integrated senior healthcare system models.

2.7 Using Change Management Concepts to Address Integration Problems

Based on the above gaps and problems, it would be beneficial to establish an integrated senior healthcare system model selection/construction approach that assists in addressing the issues that existing models have faced. Therefore, because it is the goal of change management process to address issues of stakeholder resistance and environmental inappropriateness (Kotter, 1995, Golden, 2006, Balogun and Hailey, 2008), this section suggests using these concepts to guide the selection or construction of integrated senior healthcare system models for communities that are in need of this change. Through this approach, stakeholder resistance can be addressed by using concepts within the first two stages of Golden's (2006) healthcare change management framework to involve stakeholders in determining the change design. Armenakis and Harris (2009) explain that involving participants: "...in the diagnostic process actually begins to sensitize them to the possibility of an impending organizational change, and can serve to encourage change readiness". Further to this, adding concepts from Balogun and Hailey's (2008) 'change kaleidoscope' to Golden's (2006) framework can assist in addressing the second problem that existing models faced of 'environmental inappropriateness'. These additional concepts identify the specific aspects of the intended change environment that should be examined when determining the change design. Figure 1 depicts these concepts in a framework that has been adapted from the literature (Golden, 2006; Balogun and Hailey, 2008).

Figure 1: Adapted Change Management Framework



The concepts within figure 1 are described further below.

Stakeholder Involvement:

The overarching theme of stakeholder involvement within the adapted change management framework is being applied because studies by Cochrane et al (2009) and Ducharme et al (2009) showed that involving stakeholders in selecting or constructing the change design increased the overall success of the initiative as stakeholders were able to identify a design that matched their needs. Furthermore, as Holt et al (page 245, 2007) explain: "...those who participate often have greater access to change-related information than those who do not. This access to information makes it possible for participants to better understand the justification for change and its ultimate objectives". Therefore, stakeholder participation in gathering the information in the adapted change management framework is essential to building stakeholder understanding and acceptance of the change towards an integrated senior healthcare system model. When considering this type of change the stakeholders may include: government bodies (federal, provincial, municipal), administrators and all levels of management, front line workers, specific professional groups, patients, families, and the community. With so many stakeholders affected by and involved in the change towards an integrated senior healthcare system model, the question now becomes 'which stakeholders should participate in selecting the change design?'

Certain change management literature suggests that a ‘top-down’ or management-led approach to change is favourable (Kotter, 1995), whereas other change management literature suggests that a ‘bottom-up’ or employee-led approach to change is more appropriate (Armenakis and Harris, 2009). However, because the change towards an integrated senior healthcare system model involves numerous stakeholders that have varying views of what the healthcare system looks like, as well as limited ability to lead the change alone, a collaborative or ‘distributed leadership’ approach to change seems appropriate (Chreim et al, 2010). This approach: “...attends to change visioning and implementation as a collective enterprise, involving a variety of actors (individuals and/or groups) sharing in change agency roles” (Chreim et al, 2010). Therefore, when taking a collaborative approach to change, the stakeholders involved in constructing the change design should include representatives from different stakeholder entities. The overarching theme of ‘stakeholder involvement’ can be applied in stage one and two of the adapted change management framework as described below.

Stage One: Determine Desired End State

The first stage within the adapted change management framework (figure 1) ‘determine desired end state’ focuses on gathering information from stakeholders concerning their views of system gaps, visions for a future integrated senior healthcare system model, as well as goals that would assist in achieving this vision. The purpose of doing this is to show that there is a gap between the current state of the senior healthcare system and the desired end state which signifies the need for change and focuses: “...the attention of change leaders and those who will be asked (or required) to change” (Golden, 2006).

Stage Two: Situational and Key Stakeholder Analyses

Stage two of the adapted framework (figure 1) ‘situational and key stakeholder analyses’ focuses on gathering information from stakeholders using concepts from Balogun and Hailey’s (2008) change kaleidoscope to develop a detailed description of the stakeholders and the continuum of care within the intended change environment. These concepts include:

- **Diversity:** The diversity within a senior healthcare system is explored by depicting the organizations, service providers, and services that currently exist within the continuum of care. Understanding the diversity of a change environment is vital to assisting stakeholders in selecting or constructing a change design that includes existing resources. This is important to ensure that the design does not add another layer of confusion into the system by duplicating what already exists. Furthermore, selecting/constructing a design that takes advantage of existing resources will assist in the success of the change by ensuring that the design can be supported by the

current system, rather than requiring new resources that the community may not have access to.

- **Capability:** Determining stakeholder's capability of managing the change of an integrated senior healthcare system model is explored by identifying the current activities that are taking place to enable integration.
- **Readiness for Change:** Determining readiness for change occurs on two levels, the first is identifying affected stakeholder's awareness for the need for change, the second is identifying the level of commitment that affected stakeholders are willing to put towards the change. This information is identified through stakeholders' vision for an integrated senior healthcare system and experiences with obstacles to integration.

The purpose of gathering information concerning diversity, capability, and readiness for change is to form an in-depth understanding of the existing resources and behaviours present within the intended change environment from the perspective of stakeholders. This level of understanding is important as it will assist change leaders in selecting or constructing integrated senior healthcare system model that is appropriate for their community (Balogun and Hailey, 2008). The following chapters will describe how this thesis applied these change management concepts to assist a community that is in need of senior healthcare system integration.

3.0 Methods

The subsequent chapter describes how the thesis questions and objectives were explored through the use of a case study combined with institutional ethnography as a method of inquiry. These data collection and analysis approaches were used to gather and explore information about the concepts within the adapted change management framework (Figure 1).

3.1 Case Study

To answer the questions and achieve the objectives of this research project, the senior healthcare system within Sault Ste. Marie, Ontario has been used as a case study. This specific region has been chosen because the senior healthcare system within this city of 75,000 has been under stress for some time due to the ongoing ALC issues facing the community's acute care centre. On March 6th, 2011 Sault Ste. Marie's acute care centre moved 1500 staff and most of their in-patients to a brand new single site facility. Prior to this date, the facility was continuously operating over capacity as 40% of their beds were filled with ALC patients who were 65 year of age and older (NE LHIN-Media Release, 2010). Some of the causes for this ALC issue include the lack of capacity and resources for senior care within the community, as well as the lack of continuity among acute and community services (First Interview, MGT 5150 Pilot Project, 2011). In moving to a new facility, the acute care centre recognized that they could not bring their ALC issues along with them, and thus in their New Hospital Improvement Plan identified that they would maintain an ALC rate of 15% in the new hospital site (Sault Area Hospital- Hospital Improvement Plan, 2011). To achieve this objective, 68 transitional ALC beds were left behind at the old acute care centre. Although this provided some relief, the acute care centre is continuing to provide services to non-acute ALC patients. Therefore, these 68 beds are only a temporary solution, and the ALC crisis in Sault Ste. Marie continues to be a problem.

The North East Local Health Integrated Network (NE LHIN) and many of the leaders of senior healthcare organizations in Sault Ste. Marie recognized that the ALC issues at the community's acute care centre needed to be addressed at both the community and acute care level, and thus formed the Sault Ste. Marie & Area NE LHIN ALC Solutions Group (ALC Solutions Group). The main priorities for this Group include:

- Developing a community plan to move ALC patients from hospital beds to beds available in the community.
- Strengthening community support/assisted living with a focus on a home-first strategy to enhance home care services and improve existing processes so that seniors receive the care they need faster and more effectively (NE LHIN- ALC Solutions Group Terms of Reference, 2010).

Although these plans are in place, and some actions have been taken towards increasing the amount of in-home care and personal support services within community, the members of the ALC Solutions Group continued to identify the need for an integrated senior healthcare system model that creates continuity among senior care services across the continuum (SSMAHCC, 2010). A report titled *Annual District Service Plan for Long-Term Care Community Services by the Algoma, Cochrane, Manitoulin, Sudbury (ACMS) District Health Council* explains that: “in all districts, key stakeholders continue to acknowledge the need for continued improvements in interagency communication and service coordination to provide a continuum of service to clients/patients” (2002).

The following sections will describe how I have undertaken research that organizes information to assist the community of Sault Ste. Marie in understanding system gaps, diversity, enablers, and obstacles of integration. This information can be used as a stepping stone for choosing or constructing a context sensitive integrated senior healthcare system model.

3.2 Institutional Ethnography

To achieve the first study objective, a change management framework that has been adapted from the literature (Figure 1) was used as a lens to determine the specific information that was gathered from study participants and to organize this information in a way that would be useful for their planning purposes. This data has been collected and analyzed using Dorothy Smith’s Institutional Ethnography (IE) as a method of inquiry (2005). A qualitative IE approach has been chosen because it reflects the overarching theme within the adapted change management framework of ‘stakeholder involvement’, as well as the overall study goal of depicting the current state of a senior healthcare system that is in need of an integrated model to provide stakeholders with information that will assist them in selecting/constructing a design that corresponds to their needs. IE studies mirror these goals because they aim to discover how and why an institutional environment is organized based on the collective experiences of those working within it. This is done to extend their knowledge to assist in determining where change can occur to improve working conditions (Devault and McCoy, 2002). Some of the other studies that have used IE to explore the organization of a specific group of people’s experiences within the healthcare system include: Mykhalovskiy and McCoy (2002), Sinding (2010), and McCoy, (2005).

IE studies have two underlying assumptions, the first being that ‘social happening’ occurs in the activities of people which are coordinated: “...on a large scale, as this occurs in and across multiple sites” (Devault and McCoy, 2002). Dorothy Smith explains that these: “...social relations coordinating across time and distance are present but largely unseen within the everyday/every night worlds of people’s experiences” (2005). To increase participants’ awareness of their interconnected activities, IE studies provide a platform for them to discuss and analyze the organization of the system that they work within during the

journey of the research. This method of inquiry can be compared to ‘Participatory Action Research’ which is described as: “... promoting critical consciousness where through cyclical stages of dialogue participants attain a greater understanding of their situation, which in turn may result in political or major social change” (Mullett and Fletcher, 2011). Scott (2012) explains that these two methods of inquiry share important goals such as: “...a particular interest in making sure the standpoint of those about whom the research is conducted is at the centre of the study” (Scott, 2012). However she also explains that they differ because: “...Institutional Ethnography recognizes that scholarly researchers bring something methodologically useful to research... -Leadership of that sort interferes with the control exercised by participants in classical Participatory Action Research” (Scott, 2012). Therefore, IE is chosen as the method of inquiry for this study because it roots the research in the experiences of study participants, but also allows me to apply methodological approaches such as drawing the ‘fault line’ which may not have been suggested by study participants.

The second underlying assumption that IE studies have is that many of the coordinated activities of study participants are mediated by texts such as policy and promotional material which are produced and circulated by ‘ruling relations’ (i.e. government bodies) (Devault and McCoy, 2002). One of the most important aspects within an IE study is the content analysis of these texts which is accomplished by reviewing and comparing them to the experiences expressed by study participants in the data collected through interviews, focus groups, and observations. (Devault and McCoy, 2002). The purpose of these comparisons is to analyze how the environment under study is organized at a ‘higher level’ by ruling relations. This is accomplished by finding disagreements between the experiences of the participants and the ideological expressions of them by ruling relations in the texts that they produce (Devault and McCoy, 2002). These disagreements are defined by IE researchers as ‘fault lines’. ‘For example, the results of this study showed that front line service workers believe that the quality of care that they are providing is decreasing because their time is being spent on Ministry of Health and Long Term Care (MOHLTC) reporting, rather than spending time with patients. However, MOHLTC media releases state that the quality of healthcare is increasing because of the added accountability requirements. This example shows that there is a distinct disagreement between what the front line service workers are experiencing, and what the MOHLTC is portraying to the public. These ‘fault lines’ are important to illuminate because they demonstrate the true impact of government decisions on patient care by identifying how they are actually impacting care and service delivery at the micro level. The identification of these root causes may assist in addressing the actual problem, rather than fixing the surface problem by attempting to increase awareness between the macro and micro levels. The following sections will go deeper into the description of IE and how it has been used to collect and analyze data within this study.

3.3 Data Collection

The following section describes the study participants, as well as the IE data collection methods that have been used within this research project.

3.3.1 Participants

An IE study: “...begins in the actualities of those who live their everyday lives within the environment of interest and builds accounts of their concerns and experiences which organize the direction of the researcher’s investigation” (Smith, 2005). This method of developing an area of research interest is in keeping with this study as the focus grew out of my own experiences as the former coordinator for the Sault Ste. Marie and Area Health Care Committee (SSMAHCC). During my time as the coordinator for this group, the members continued to identify the need for an integrated senior healthcare system model to address the problem of service fragmentation within Sault Ste. Marie’s senior healthcare system. In order to focus on this need, as well as the ALC issues within Sault Ste. Marie, another group was formed called the ‘Sault Ste. Marie NE LHIN ALC Solutions Group (ALC Solutions Group). This group is comprised of administrative representatives from organizations that deliver care to seniors within Sault Ste. Marie (NE LHIN Media Release, 2010). Therefore, because the identification of the need for an integrated senior healthcare system model in Sault Ste. Marie has been the driver for this research project, the members of the ALC Solutions Group are the study’s primary participants. These participants are in line with a collaborative approach to change as they are intended to be representative of the various stakeholder entities within the Sault Ste. Marie senior healthcare system. Nevertheless, because the ALC Solutions Group is primarily comprised of organizational leadership, their perspective of the Sault Ste. Marie senior healthcare system may be different than other stakeholder groups. To address this issue, this study also consulted a group of front line service worker representatives from various Sault Ste. Marie senior healthcare organizations. Further information about the role of these participants within this study is described in the following sections.

3.3.2 Ethics Approval

To ensure that this study was conducted in an ethical manner, ethics approval was obtained from the University of Ottawa Human Research Ethics Committee, the Sault Area Hospital and Group Health Centre Research Ethics Board, and the North East Community Health Ethics Network (see Appendix A for copies of approval letters). Consent to participate was obtained from study participants for each method of data collection. This was accomplished by sending each individual participant a ‘letter of information’ (Appendix B) to determine their interest in participating in the study. Once interest was established, participants were then provided with ‘consent to participate’ forms (Appendix B) which they signed and gave back to me prior to the commencement of each data collection event.

3.3.3 Non-Participant Observation

Within many IE studies non-participant observation in the research site is a key method of inquiry that occurs throughout the duration of the data collection process. It allows the researcher to position themselves within the environment under study by taking the ‘standpoint’ of the study participants. Non-participant observation means that the researcher maintains the role of the observer and listener. They do not provide their own input during the activities that are observed, rather they remain silent and record the information that is within the realm of their study (Creswell, 2007). To apply this approach I observed 2 meetings with the 13 members of the ALC Solutions Group, and 1 meeting with 3 members of this group over a period of 4 months. During each of these meetings I took detailed field notes of the information pertaining to the concepts within the adapted change management framework (figure 1) (Creswell, 2007). See Appendix C for a copy of the non-participant observation field note collection tool that was used. Each meeting lasted approximately 3 hours, resulting in a total of 30 pages of field notes. This data was analyzed as described in the ‘data analysis’ section of this chapter.

3.3.4 Interviews

IE interviewing: “...is typically organized around the idea of work, defined broadly, or “generously” (Smith 1987). Whether it is the paid work of an organizational position- (...), the point of interest is the informant’s activity, as it reveals and points towards the interconnected activities of others” (Devault and McCoy, 2002). To apply this approach, over a period of 5 months, 10 semi-structured qualitative key informant interviews were conducted with administrators of organizations that provide care to seniors in Sault Ste. Marie. Out of these 10 interviews, 9 were with members of the ALC Solutions Group who were chosen through purposeful sampling based on access which was gained through my past employment with the SSMAHCC (Miles & Huberman, 1994; Creswell, 2007). These interviewees were recruited by emailing the ‘key informant interview letter of information’ (Appendix B) to each individual member of the ALC Solutions Group. Interviews were then scheduled with the members who decided to participate. The remaining interview was conducted with an administrator of an organization that provides care to seniors within Sault Ste. Marie, and was recruited through a snowball sampling method based on recommendations from a number of the other interviewees (Miles & Huberman, 1994). Two of the interviews took place via teleconference, and the remaining eight interviews took place at the participant’s place of work.

The interview process focused on gathering information about the concepts within the adapted change management framework (Figure 1) through a semi-structured interview protocol (Appendix D) (Patton, 2002). This protocol included questions to address the concepts in the first stage of the framework ‘determine desired end state’. Example questions for each concept are provided below:

- 1) Establishing system gaps: “Based on your experiences, what are some of the major gaps in accordance to continuity of services within Sault Ste. Marie’s senior healthcare system?”
- 2) Determining a vision: “How would you like to see the Sault Ste. Marie senior healthcare system change?”
- 3) Goals to achieve vision: “What steps do you think should be taken to achieve the changes that you suggested in the previous question?”

Coming to understand the interviewee’s individual experiences in accordance to the above questions is an important step that assisted in gaining an understanding of the participant’s views towards the change of an integrated senior healthcare system model.

Questions concerning the second stage ‘situational and key stakeholder analysis’ were asked to gain an understanding of the context and circumstances of the specific organization that the interviewee is the administrator of, as well as their view of the overall Sault Ste. Marie senior healthcare system. The following are examples of these types of questions:

- 4) Diversity: The diversity within the Sault Ste. Marie senior healthcare system was illuminated by asking questions that were geared to the organization where the interviewee is the administrator. This was done by obtaining a list of their services prior to the interview, either through their website site or through the interviewee themselves. An example of this type of question is: “what types of services do you provide within your organization?”
- 5) Capability: To understand what people or bodies of people have the ability to the manage change of an integrated senior healthcare system model, ‘capability’ questions focused identifying on enablers of integration within the Sault Ste. Marie senior healthcare system. An example of this type of question is: “What activities are currently happening within Sault Ste. Marie to assist in creating connections among senior healthcare service providers and organizations?”
- 6) Readiness for Change: To assess readiness for change towards an integrated senior healthcare system model within Sault Ste. Marie, questions concerning the participant’s perception of the need for change and obstacles to integration were asked. Examples of these types of questions include: “Do you believe that your (patients, clients, customers) would benefit from integrating the services that your organization offers and other services in the community?” and ‘Based on your experiences, what are some of the obstacles of integration within Sault Ste. Marie’s senior health care system?’

To get at the root of the experiences of the interviewees in relation to the above concepts, additional ‘probing’ questions were asked throughout the interview process (Devault and McCoy, 2002). Saturation was achieved during the interview with the 10th and final key informant as no new information arose (Creswell, 2007). Rather, this interviewee provided additional examples of their own experiences that contributed to the themes identified by previous 9 interviews and the 3 non-participant observations. The interviews were audio recorded and lasted between 1 and 2 hours to get through the interview protocol, as well as any additional information that the interviewee decided to provide. Along with the assistance of a hired transcriptionist, the audio recordings were transcribed verbatim resulting in a total of 273 pages of written transcript. This data was then analyzed as described in the ‘data analysis’ section of this chapter.

3.3.5 Focus Groups

Focus groups are another common method of data collection used by IE researchers and are the design aspect in IE studies that create a platform for discussion among participants: “through informants’ stories and descriptions, the research begins to identify some of the trans local relations, discourses, and institutional work processes that are shaping the informants’ everyday work” (Devault and McCoy, 2002). To apply this method of data collection, after the individual key informant interviews and non-participant observations were complete, two focus groups were held with Sault Ste. Marie senior healthcare system administrations and front line services workers as described in the following sections.

3.3.5.1 Administrator Focus Group

The first focus group was held with 3 members of the ALC Solutions Group who provided administrative representation from 3 different levels of care, as well as representation from an overall Sault Ste. Marie senior healthcare system perspective. (The number of participants is a reflection of the poor timing of the focus group as it took place in July when most of the ALC Solutions Group members were unable to attend due to vacation or previous commitments. Those who were unable to attend continued to express their interest in the study by requesting to remain in contact with me to receive progress updates. Based these behaviours, as well as the agreement among the administrative and front line service worker focus groups in relation to the need for change, there is no indication that the number of participants reflected resistance of any kind). These participants were recruited through a purposeful sampling method (Creswell, 2007; Miles & Huberman, 1994) by emailing the individual members of the ALC Solutions Group the ‘administrator focus group letter of information’ (Appendix B). Those who decided to participate were then emailed the location of the focus group along with a copy of the data that would be reviewed during this session.

The purpose of this focus group was to create a platform for discussion among participants around the analyzed results from the semi-structured qualitative key informant interviews and non-participant observations. These results were presented to the participants in a PowerPoint format that mirrored the adapted change management framework sequence. During this presentation, ‘member checks’ were conducted by asking the participants to fill in any missing information that was left by the interviews (Linclon and Guba, 1985). To do this, participants were asked to collectively review, revise and add to the identified system gaps, enablers to integration, and obstacles to integration. Furthermore, participants were asked to collectively develop a vision and goals for an integrated senior healthcare system in Sault Ste. Marie by revising and adding to the themes identified in the interviews and non-participant observations. Through these activities, participants were able to discuss the data and share information about their experiences within the Sault Ste. Marie senior healthcare system. For example, information was shared by one participant about specific policy that restricts the transition of clients from their organization to other sectors. This sharing of information increased the awareness of existing cross-sector circumstances among focus group participants. Furthermore, by bringing stakeholders together in a collective format to discuss the change towards an integrated senior healthcare system, this focus group began to address some of the obstacles that existing integrated senior healthcare system models faced such as ‘lack of participation from organizations and service providers’ and ‘difficulty building inter-organizational relationships’. The process of breaking down these barriers was initiated as cross-sector focus group participants began to collectively agree on a vision and goals for the change towards an integrated senior healthcare system in Sault Ste. Marie (as presented in Chapter 4.0). In addition to the above activities, participants were asked to provide input on how to organize the study results so that they are useful for their planning purposes. The outcome of this discussion is mirrored in the structure of the ‘results’ section of this study (Chapter 4.0).

The administrator focus group lasted for a total of 3 hours and was both audio and video recorded. This recording was transcribed verbatim by a hired transcriptionist resulting in 30 pages of written transcript. This data was analyzed as described in the ‘data analysis’ section of this chapter.

3.3.5.2 Front Line Service Worker Focus Group

In order to follow a ‘collaborative’ approach to change (Chreim et al, 2010), another focus group was conducted with 5 front line service worker representatives to assist in depicting the current state of the Sault Ste. Marie senior healthcare system from the perspective of an additional stakeholder group. These participants provided representation from four different levels of care and were recruited through a snowball sampling method (Miles and Huberman, 1994) by asking the key informant interviewees to recommend front line service workers that would be interested in participating in the project. The email addresses of these individuals were obtained from the interviewees and emails with the

‘front line service worker focus group letter of information’ (Appendix B) were sent to determine their interest in participating in the study. Those who expressed interest were provided with the location of the focus group and as well as a copy of the data that would be reviewed).

The purpose of this focus group was to again create a platform for discussion among participants around the analyzed results from the semi-structured qualitative key informant interviews and non-participant observations. To remain consistent with the first study objective, the same PowerPoint presentation that was given to the administrator focus group was presented to the front line service worker focus group. During this presentation ‘member checks’ were conducted again by asking the front line service workers to revise and add to the identified system gaps, problems, enablers to integration, and obstacles to integration. In addition, participants were asked to contribute to the development of a vision and goals for an integrated senior healthcare system in Sault Ste. Marie by revising and adding to the themes identified in the interviews and non-participant observations. Furthermore, providing both focus groups with the same results allowed the opportunity to find common and diverging experiences among the stakeholder groups (as described in Chapter 4.0). The front line service worker focus group also allowed participants from various sectors within the Sault Ste. Marie senior healthcare system to share their experiences. This activity increased front line service worker awareness of services that exist within the Sault Ste. Marie senior healthcare system more so than what was experienced in the administrator focus group. This finding may contribute to addressing some of the obstacles that existing integrated senior healthcare system models faced including ‘difficulty building inter-organizational relationships’, as stakeholders began to see how their work processes could interconnect with services and stakeholders outside their own organizations.

The front line service worker focus group lasted for a total of 3 hours and was both audio and video recorded to allow for easy identification of the speakers. Along with the assistance of a hired transcriptionist, this recording was transcribed verbatim resulting in 49 pages of written transcript. This data was analyzed as described in the ‘data analysis’ section of this chapter.

3.3.6 Texts

Texts are the key data sources within IE studies that explain how the environment is organized by ruling relations because they are recognized as the: “...central nervous system running through and coordinating different sites” (Devault and McCoy, 2002). Therefore, researchers need to gain an understanding of the texts that are present within the environment under study in order to fully understand how that system is organized. Texts can come in many varieties such as documents: “...on paper, on computer screens, or in computer files; it can also be a drawing, a photograph, a printed instrument reading, a video, or a sound recording” (Devault and McCoy, 2002). The way that an IE researcher determines

which texts to review is through the discussions that take place during non-participant observations, interviews, and focus groups. Therefore, researchers must be: "...alert to catch informants' references to texts or textual-mediated processes" and ask informants for copies or locations of these documents (Devault and McCoy, 2002). The specific texts that were identified by the study participants during the data collection process include: websites and information pamphlets of all the organizations that provide care to seniors in Sault Ste. Marie; MOHLTC and NE LHIN websites; MOHLTC and NE LHIN public announcements and/or communiques; the Alternate Level of Care Plan for the City of Sault Ste. Marie (May 2011, revised February, 2012); the Long Term Care Homes Act (2007), and the Assisted Living Services for High Risk Seniors Policy (2011). This data was analyzed as described in the 'data analysis' section of this report.

3.4 Data Analysis

Data analysis within IE studies takes on many forms as it is driven by the objectives of the study and the environment of interest (Devault and McCoy, 2002). Therefore, the analysis within this study focused on depicting the current state the Sault Ste. Marie senior healthcare system using a change management lens (Figure 1) and IE approaches as described below.

3.4.1 First Layer of Analysis

Using an IE approach, the first layer of analysis within this study focused on analyzing the data at the 'local level' which assisted in forming an understanding of the environment of interest based on the collective experiences of the study participants. As explained above, the data from the interviews and the non-participant observations was presented during both the administrator and front line service worker focus groups, and therefore this information was analyzed first. To do this, within and cross analysis was conducted with the 10 transcripts from the interviews and 3 field notes from the non-participant observations using Atlas T.I. Version 6.2.25 (Creswell, 2007). Within interview and non-participant observation analyses were carried out by coding for emergent themes based on the concepts within the adapted change management framework (Figure 1). For example, themes emerging from the interviewee's responses to the questions concerning 'system gaps' were categorized under this heading and coded using the language of the interviewees. In order to further condense the codes that emerged from the within interview and non-participant observation analyses, a cross analysis was conducted by comparing the data to find common and diverging themes (Creswell, 2007). This analysis resulted in the organization of the descriptive themes that were uncovered from the within analyses into abstract categories (Miles and Huberman, 1994). These results are presented in table 5.

Table 5: Coding Results of Cross Interview and Non-Participant Observation Analyses

Category	Themes
<i>System Gaps</i>	Lack of Human Resources
	Lack of Administrative Funding for Programs
	Lack of Affordable Seniors Apartments/ Assisted Living Units in Sault Ste. Marie
	Lack of Focus on Importance of Social Aspect of A Senior’s Life to Their Health
	Wait Lists/Times
	Incompatible Assessments/Assessment Tools
	System shift from Institutional to Community Based Care
<i>Enablers of Integration</i>	Existing Inter-Organizational/ Cross-Sector Relationships
	Existing Senior Healthcare Projects
<i>Obstacles to Integration</i>	Organizational Silos
	Inter-Organizational Philosophical/Treatment Differences
<i>Vision</i>	Accountable
	Seamless Access
	Single Point of Access
	A System that Looks at the Person Holistically
	A System that Realizes the Importance of All Levels Along the Continuum of Care
	A System that Is Designed for Seniors
<i>Goals</i>	Electronic Medical Record
	Interagency News Letter
	Interagency Meetings
	One Place to Go to Access Information About All Services
	Education, Support, Communication
	Conduct Senior Consumer Needs Assessment
	Establish Appropriate Needs Identification Processes

To determine the accuracy of the initial findings within Table 5, a PowerPoint presentation of these results was developed and presented to the administrator and front line service worker focus groups (as described in the data collection section of this chapter). Once this was complete, within and cross focus group analyses of the transcribed video and audio recordings were conducted using the same methods to analyze the interviews and non-participant observations. This analysis resulted in the restructuring of the findings within Table 5 which is mirrored in the results chapter of this study (Chapter 4.0). Also included in the final results are analyses from ‘memoing’ that I conducted throughout the data collection and analysis process (Creswell, 2007).

Note: Data that was collected during the interviews concerning ‘diversity’ was not coded as it was mainly descriptive of the programs and services within the Sault Ste. Marie senior healthcare system. This information was used to fill in any missing information left by the participant’s websites and/or organization pamphlets. These results are reflected in system inventory and maps in Chapter 4.0.

3.4.2 Second Layer of Analysis- Drawing the Fault Line

A second layer of analysis has been conducted through the content analysis of the texts that were highlighted by the participants during the interviews, focus groups, and non-participant observations (as identified in the ‘texts’ section of this chapter) (Devault and McCoy, 2002). This was done by reviewing the texts and comparing them to the themes that were uncovered through the within and cross interview, focus group, and non-participant observation analyses. Through this comparison, disagreements or ‘fault lines’ among the participant’s experiences and the texts were found. The purpose of these comparisons is to analyze the root causes of the local level themes identified by study participants by exploring the impact of macro level decisions on the micro level activities. These results are presented in Chapter 4.0.

3.5 Trustworthiness/Credibility

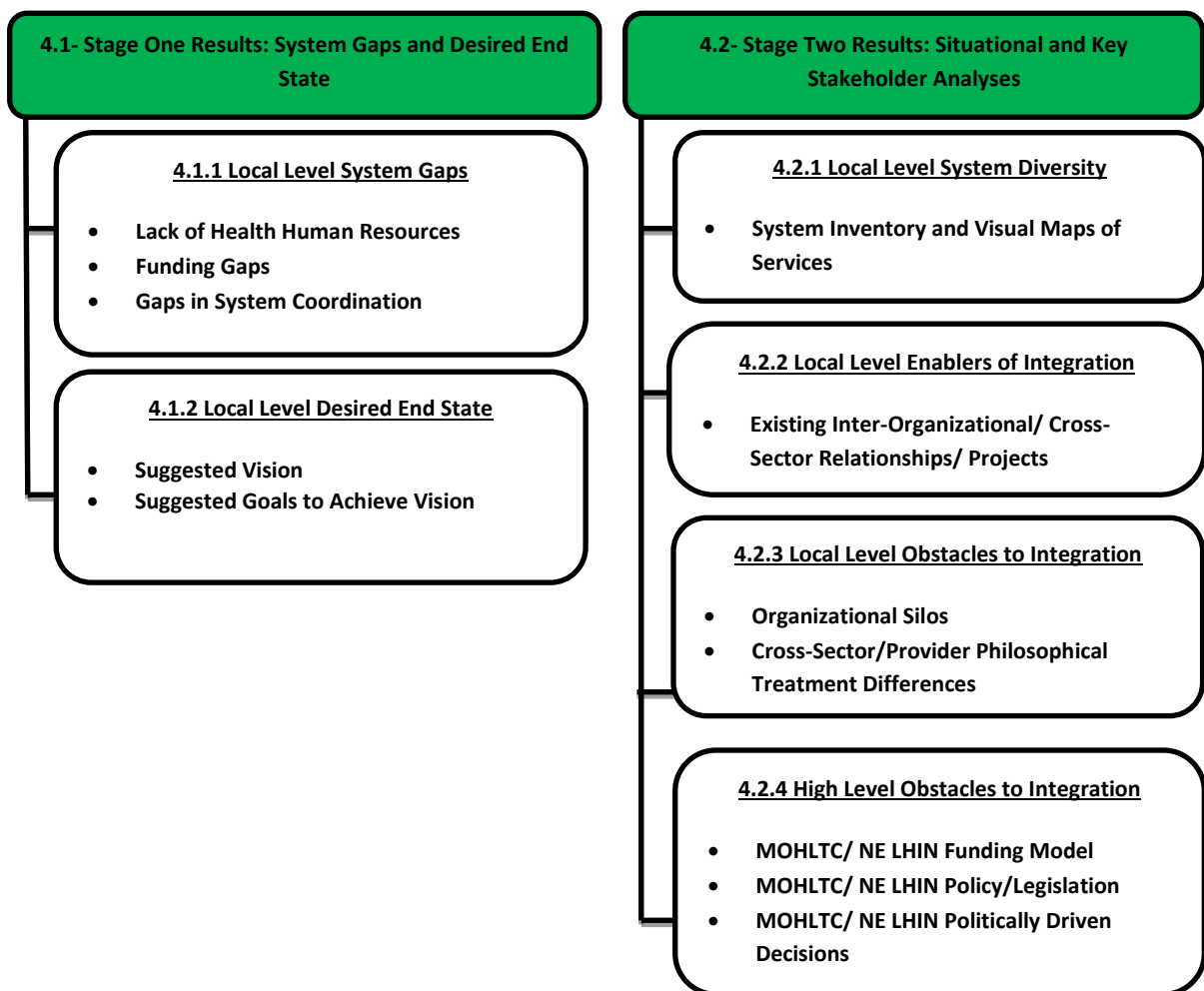
This research study obtained trustworthiness and credibility through three methods including the triangulation of data sources, member checks, and inter-coder agreement (Lincoln & Guba, 1985). To establish trustworthiness of the study’s findings, the data from all sources (interviews, focus groups, and non-participant observation) was triangulated and determined to be consistent with the results presented in Chapter 4.0. Credibility was established by obtaining member checks through the focus groups with the members of the ALC Solutions Group and front line service worker representatives to ensure the credibility of the findings. Furthermore, to ensure that the analysis of the data was consistent, inter-coder agreement was established by the co-supervisors of this thesis project (Creswell, 2007). This was accomplished by providing the co-supervisors with transcripts that I had coded along with a codebook that described the codes, which allowed them to review the analysis to determine their agreement. Where there was disagreement, a discussion was had and common ground was found. Establishing trustworthiness and credibility of the findings is an essential step in this study as the information gathered will only be useful to those who work in the Sault Ste. Marie senior healthcare system if it is reflective of what is actually happening within that system.

The following chapters will present the study’s findings which are a result of the data collection and analysis processes described above.

Chapter 4.0 Results

This chapter will present the local and high level results that were derived from the data collection and analysis processes explained in Chapter 3.0. The presentation of the results within IE studies is driven by the research objectives as well as the identified needs of the study participants (Devault and MCCoy, 2002). Therefore, to achieve the first and second objectives of this study, the following section is organized in the sequence of the adapted change management framework (Figure 1) which is a method that was approved by study participants. Figure 2 provides a summary these findings.

Figure 2: Summary of Results



As identified in Figure 2, the results presented in sections 4.1.1 to 4.2.3 are derived from the first layer of analysis of the data from the interviews, focus groups, and non-participant observations. This layer of analysis depicts how the Sault Ste. Marie senior healthcare system is organized at the ‘local level’ based on the interconnected experiences of

the administrators and front line service workers that participated in this study Overall, the two stakeholder groups agreed on the identified themes. In instances where there were inconsistencies among the two stakeholder groups, data and explanation are provided. Section 4.2.4 provides the results of the second layer of analysis which describes how the Sault Ste. Marie senior healthcare system is organized at the 'high level' by drawing the 'fault line' between study participant's local experiences and the texts identified in Chapter 3.0. The following sections will describe these results in further detail.

4.1 Stage One: System Gaps and Desired End State

The goal of the first stage of the adapted change management framework is to signify that there is a need for change by establishing that there is a gap between the current state of the Sault Ste. Marie senior healthcare system and the desired end state (Golden, 2006). To fulfill this stage, the following section provides the results of the identified system gaps, as well as the established vision and goals that depict the desired end state for an integrated Sault Ste. Marie senior healthcare system.

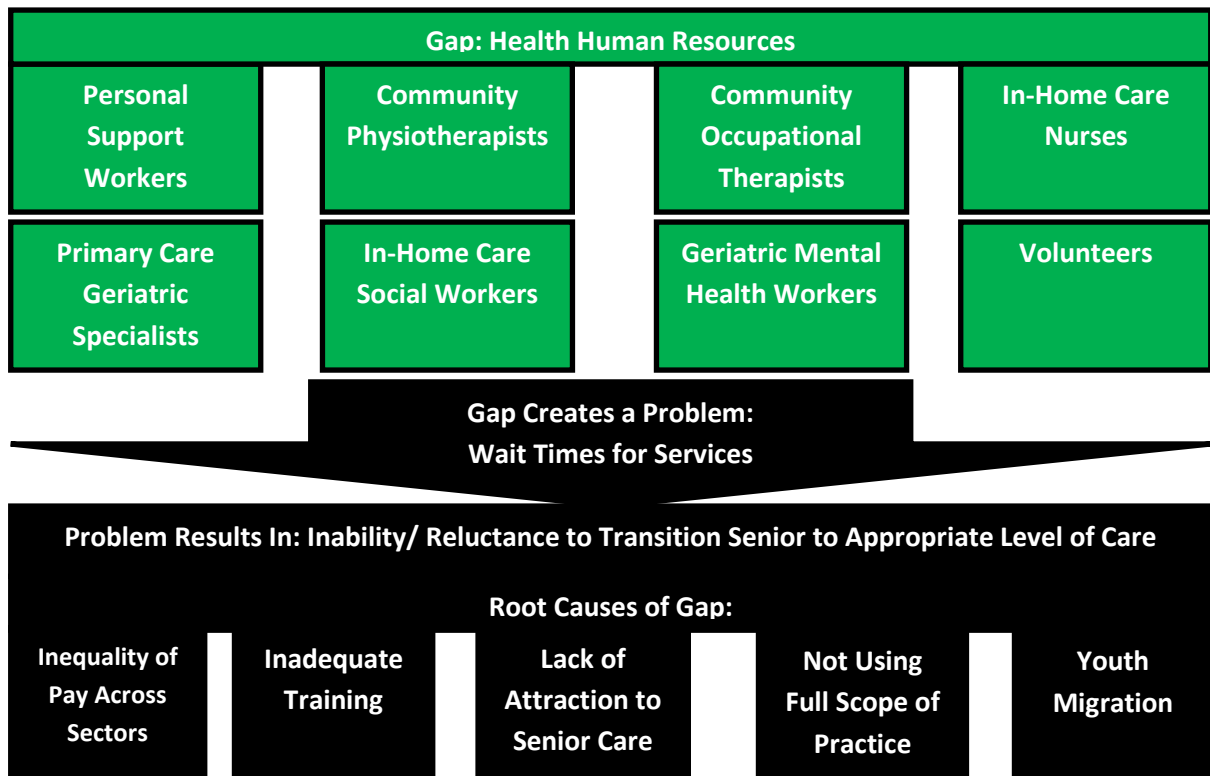
4.1.1 Local Level System Gaps Results

System gaps are defined as missing resources/aspects within the Sault Ste. Marie senior healthcare system that are contributing to system fragmentation and poor quality of care for seniors. Three key gaps were identified by study participants including: lack of health human resources; funding gaps; and gaps in system coordination.

4.1.1.1 Lack of Health Human Resources

The first gap that study participants identified was the lack of health human resources within the Sault Ste. Marie senior healthcare system. Figure 3 provides a summary of this gap.

Figure 3: Summary of Gap- Lack of Health Human Resources



As depicted in figure 3, study participants identified that there are gaps in the following health human resources: personal support workers; community physiotherapists; community occupational therapists; in-home care nurses; primary care geriatric specialists (includes both general and nurse practitioners); in-home care social workers; geriatric mental health workers; and volunteers. These gaps in health human resources lead to increased wait times for services which often cause service providers to be reluctant or unable to transition seniors to the appropriate level of care. For example, the lack of community physiotherapists creates an increased wait time for this service, which causes service providers from other sectors to be reluctant to transition their client to the community because the necessary supports are not in place. One study participant provides an example: “.... *It makes our allied health and physicians more reluctant to discharge a patient before they’ve gotten them to the nth degree, because they know that there isn’t someone that’s going to be ready to go in*” (Interview, 2012). This reluctance to transition the client across sectors results in continuity of care issues as seniors often remain in inappropriate and more expensive care settings for longer periods of time.

Study participants identified five underlying causes for the lack of health human resources including: inequality of pay across sectors; inadequate training; lack of attraction to senior care; not using professionals to their full scope of practice; and youth migration. These underlying causes are described as follows:

- **Inequality of Pay Across Sectors:** Inequality of pay for professionals across sectors is a contributing factor to the lack of health human resources within the Sault Ste. Marie senior healthcare system. Participants explain that as the level of care increases the wages also increase, which makes it difficult for the various sectors to maintain staff for long periods of time as they tend to leave for the higher paying positions. One study participant explains: “...if you look at community and institutional there is quite a gap in wages. -...workers are drawn to long term care on the personal support worker level because the wages are better” (Front Line Service Worker Focus Group, 2012). This inequality of pay across sectors was also identified in other professions including physiotherapists, occupational therapists, and nurses.
- **Inadequate Training:** Another reason for the lack of health human resources within the Sault Ste. Marie senior healthcare system is the difficulty that stakeholders are having with hiring qualified professionals due to inadequate training. This issue was particularly evident with personal support workers: “...the training for the community personal support workers and the training for the long term care personal support workers has been amalgamated into one program and that program isn't proving the best resource to either (sector) because it is too generic to be effective” (Administrative Focus Group, 2012). Previously, the personal support worker program was provided in two streams, one specific to community needs, and one specific to long term care needs. These programs were combined into one general program, which has resulted in graduates that do not have the necessary skills or training to work in either care setting. Participants identified that the personal support worker program needs to be evaluated as these professionals are a key resource to sustaining quality care for seniors.
- **Lack of Attraction to Senior Care:** Health professional's lack of interest in working with the senior population was identified as another contributing factor to the lack of health human resources within the Sault Ste. Marie senior healthcare system. Participants described that this issue can be seen in the lack of primary care practitioners that specialize in geriatrics, the lack of interest in personal attendant and personal support worker professions, as well as the lack of volunteers for senior care services. One study participant explains: “... We are seeing a lack of volunteers, they are getting older, we are not seeing younger people volunteering... - When you think if we had paid staff for all these things that volunteers do, there's nowhere near enough money” (Front Line Service Worker Focus Group, 2012). Without sufficient specialized geriatric primary care practitioners, personal attendants, personal support workers, or volunteers, existing services that assist in maintaining seniors in their homes will decrease dramatically.
- **Not Using Professionals to their Full Scope of Practice:** Another cause of a lack of health human resources within the Sault Ste. Marie senior healthcare system is the notion that existing healthcare professionals are not working to their full scope of

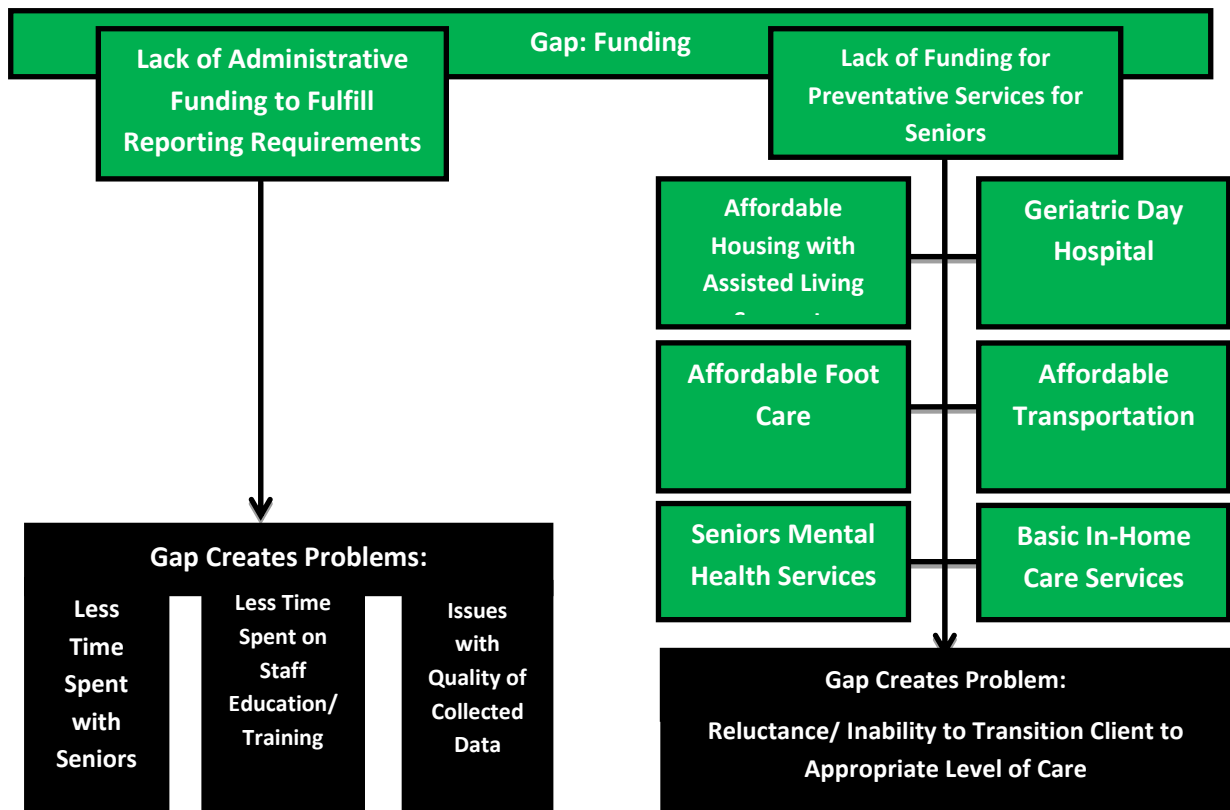
practice. One front line service worker describes their experience: *“One of the things that I see from primary care is that we are not utilizing nurses (RNs) or registered practical nurses (RPNs) to their full scope of practice. Because a lot of the time we think about the doctor’s office, his or her nurse is usually the first person to maybe identify that there is a problem. -So they can do maybe a quick screen that identifies there is a problem...-So I think a lot of the time we are not utilizing our professionals that way that we really could be”* (Front Line Service Worker Focus Group, 2012). Within this example, not using health professionals to their maximum scope of practice creates a gap in human resources as it increases wait times to see physicians for care that could easily be provided by nurses, while simultaneously creating delays in needs identification and referral.

- **Youth Migration:** Another reason for the gap in health human resources within the Sault Ste. Marie senior healthcare system is youth migration out of the community: *“We have a high senior population and youth are leaving, so if you look down the road, even if you look at the number of people working compared to the number of people who are retired, you look at the demographics and understand what is ahead, it’s really scary but 2030 they are estimated one person working for every 2 retired people”* (Front Line Service Worker Focus Group, 2012). As the senior population is increasing in Sault Ste. Marie, the working population is decreasing which is causing a deficiency in the available human resources.

4.1.1.2 Funding Gaps

Study participants identified two specific areas where funding has caused issues within the Sault Ste. Marie senior healthcare system including; lack of administrative funding to fulfill reporting requirements; and lack of preventative services for seniors. Figure 4 provides a summary of this gap.

Figure 4: Summary of Funding Gaps



The following sections describe figure 4 in further detail.

4.1.1.2.1 Lack of Administrative Funding to fulfill Reporting Requirements

As depicted in figure 4, study participants identified that there is a lack of administrative funding attached to North East Local Health Integration Network (NE LHIN) funded programs. These programs are primarily funded for the front line human resources that are required to support them, and lack administrative funding to fulfill the NE LHIN reporting and accountability requirements. One participant provides an example of their experience:

I know in long term care the MOHLTC has just created a brand new regulation/policy/procedure and it's just horrendous, the reporting requirements that are demanded from us in long term care. And with the new regulations it's probably doubled the work load. Yet, no extra funding coming in, no extra human resources coming in (Front Line Service Worker Focus Group, 2012).

This gap in administrative funding for NE LHIN programs was also identified by study participants in other sectors including in-home care and assisted living. This problem results in the following issues:

- **Front Line Staff Spending Less Time with Seniors:** The administrative burden that is being put on front line service workers is causing them to have to make decisions between providing care to their client, or completing the paper work that is required by the MOHLTC and the NE LHIN: “...workers to have to make that choice of toileting their resident or completing their care plan, and that should be a no brainer. But if that care plan isn’t met the Ministry would be down your throat and if the resident wasn’t toileted the only one who knows is me and you, right?” (Administrative Focus Group, 2012). Because front line service workers are forced to make these types of choices, various sectors are seeing high staff turnover, burnout, and moral distress.
- **Less Time Spent on Staff Education/Training:** The administrative burden being put on service providers is also creating a situation where there is no time for additional education or training. One study participant explains: “I think that you do see less time on staff education and training, it’s pretty much almost at the (organization omitted), it is non-existent. -If you want to attend something it is on your own time outside of work hours because the staff really can’t get away from what they are doing. -...so I think that there is a huge problem when it comes to keeping staff current on education and best practices” (Front Line Service Worker Focus Group, 2012). The inability of staff to attend educational or system planning sessions creates barriers to providing the best possible care to seniors as service providers are unable to remain apprised of best practices.
- **Quality of Data Collection:** By not providing adequate administrative support for NE LHIN funded programs, study participants identified the data that is being collected may be incorrect because the workload of the front line service workers who are collecting the data is too heavy. One study participant explains: “...we are detailing things to death without the resources to support it. So who knows if even the data that we are collecting is valid. It’s not being done with careful thought” (Administrative Focus Group, 2012). If the data that is being collected is not valid, the MOHLTC and the NE LHIN may be making misinformed system decisions.

4.1.1.2.2 Lack of Preventative Senior Services

As depicted in figure 4, study participants identified that there is a lack of funding for the following services in the Sault Ste. Marie senior healthcare system: affordable housing with assisted living supports; geriatric day hospital; affordable foot care; affordable transportation; seniors’ mental health services; and basic in-home care services. These services specifically focus on assisting seniors to age in place within the community to prevent them from going into long term or acute care settings. However, because of these gaps in preventative services, study participants identified there is a reluctance to transition clients into community services, and therefore seniors may end up in inappropriate, often more expensive levels of care. The gaps in services are described in further detail as follows:

- Lack of Affordable Seniors Housing with Assisted Living Supports:** The lack of affordable senior's housing with assisted living supports was identified by the majority of participants as the most significant problem within Sault Ste. Marie's senior healthcare system. One participant describes this issue: *...we don't have enough housing. So we could get people to appropriate settings if we have appropriate settings. We have the hospital, long term care, and a little bit in the middle. No assisted living, not sufficient assisted living. So we could be fighting this as long as we want, but if we don't have that physical structure in between, we won't change anything* (Administrative Focus Group, 2012). This gap creates situations where seniors are referred to higher, more expensive, and often inappropriate levels of care such as long term or acute care. One study participant provides an example: *"I have six people here that could go tomorrow, and want to go, be there's nowhere for them to go. And they couldn't go into independent living, they would still need some sort of support system, but they certainly don't need long term care"* (Interviewee, 2012). Although the lack of senior's affordable housing with assisted living supports was identified by the majority of participants as one of the major gaps within Sault Ste. Marie's senior healthcare system, certain study participants identified that they do not actually believe that this gap exists: *...it's not a question that there is not a place for people to go, because certainly some of these folks could apply and put their name on the waiting list to get into seniors housing and move to seniors housing.- ...there is seniors housing, affordable housing available, they have to wait but they can move in that direction...* (Administrator Focus Group, 2012).

Currently there are approximately 100 people on the waitlist for an affordable senior's apartment, which is perceived by housing providers to be appropriate because a balance is required in to maintain occupancy levels. However, based on the accounts of other study participants, the wait for an affordable senior's apartment is too long. One reasons for this dichotomy among participants could be because service providers are not referring to certain organizations because they assume that the senior will not obtain timely access. One study participant explains: *"Sometimes though, when there's wait-list for community service agencies, people stop referring. For example, the (organization omitted) used to have a two-year wait-list for their attendant care apartments, or outreach attendant care. I think people tended to not refer, but that doesn't help the agency show the need for funding. So we're not doing the greater public at large, the community at large, a service by not referring"* (Interviewee, 2012). This lack of referral begs the question, 'are there more than 100 people in need of an affordable seniors apartment in Sault Ste. Marie, and have they not applied because they perceive the waitlist to be too long?' If the answer to this question is yes, then this creates issues with expanding affordable seniors housing because of the fear that the supply will outweigh the demand. One study participant

explains: *“It’s not to say that we couldn’t build another senior unit, but you have to watch for that balance, because all of a sudden now you build too many units and you have some seniors that are between 80 and 85 years old, well you could end up with an empty building”* (Interviewee, 2012). This indicates that referrals need to be made to the appropriate level of care, even if service providers assume that there is a long wait list, in order to show the demand to promote funding and expansion for the service.

- **Geriatric Day Hospital/Link to Primary Care:** Study participants identified that there is a gap in the link to primary care services for seniors in Sault Ste. Marie and that this gap may be contributing to the presence of seniors in higher levels of care: *“I think when people always had family physicians, there probably weren’t as many people lining up in ‘emerge”* (Interview, 2012). Participants explained that this gap is perpetuated by the lack of a geriatric day hospital within the community as this resource would assist in increasing the link to primary care and early detection of chronic diseases.
- **Affordable Foot Care:** Participants identified that there is a lack of affordable foot care for seniors in Sault Ste. Marie: *“I think the fee now is \$35 or \$38... If they’re on a very limited income, they look at that and say ‘-oh no, I could buy groceries for the whole week’, so they stall. It’s long between appointments, if they even do it at all, and then they trying doing it on their own, and they can’t see, and they cut something too short, next thing you know we have an infection...”*(Interview, 2012). Affordable foot care for seniors is necessary to prevent their needs from escalating to the point where they need to go to the hospital.
- **Lack of Affordable Transportation/Difficulties with Existing Transportation:** Study participants identified that there is a lack of affordable transportation for seniors in Sault Ste. Marie. Some existing transportation options include the Para-Bus, Red Cross Volunteer Drivers, taxis and Gateway Mobility, however cost and scheduling creates access barriers for many seniors. One participant explains that scheduling barriers for the Para-Bus prevent seniors from participating in social activities: *“...the Para-bus, I don’t know what order it is in, but it’s medical appointments, it’s people who work, social is last on the list... the practice should be looking at things and recognizing that social shouldn’t be so far down on the list. Because if you’re looking at the big picture in terms of your hospitals or your nursing homes or your whatever, the longer you keep people out of those places, seems to me the more money you’re saving. It’s far cheaper to transport ten people here, than it is to admit one to the hospital for a day”* (Interviewee, 2012). If access to affordable transportation was increased, more seniors may be able to age in place longer.
- **Lack of Appropriate Care for Seniors with Mental Health Needs:** There are a lack of services for seniors with mental health needs in Sault Ste. Marie. This lack of

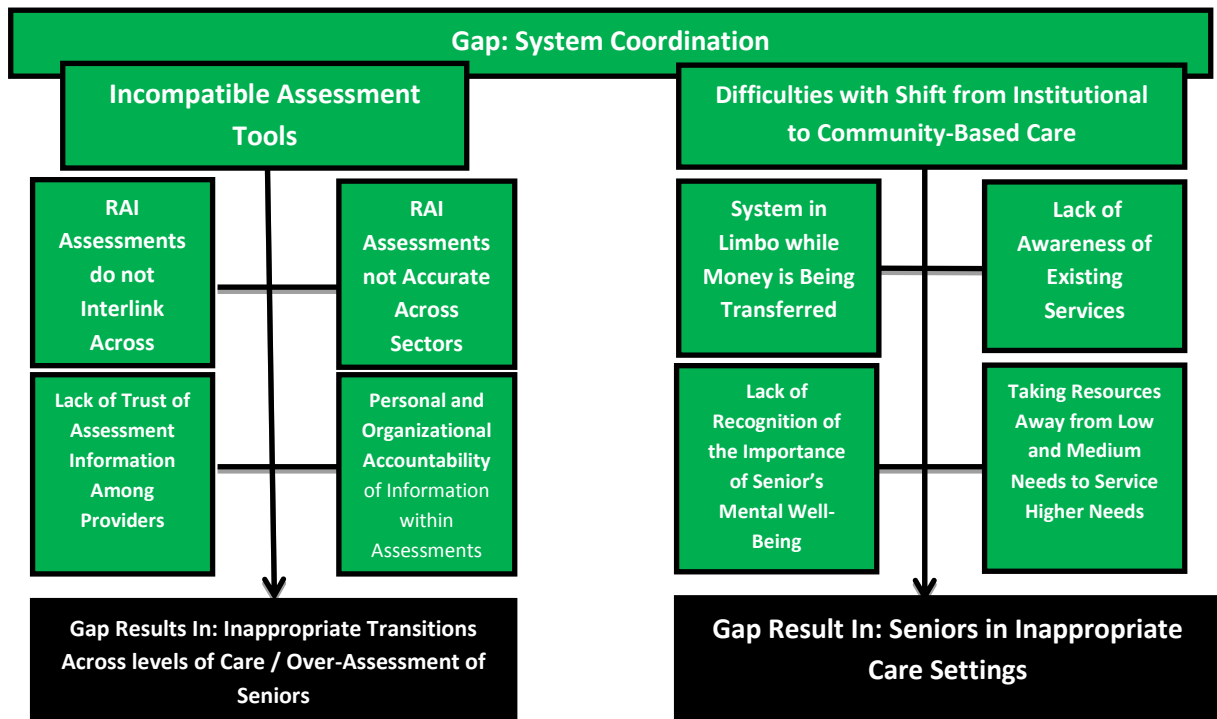
service causes them to be sent to long term care and/or the hospital which is not the appropriate place for them to be. The acute care centre in Sault Ste. Marie runs a Seniors Mental Health program however the wait list for this service is 7 to 8 months. A new NE LHIN funded initiative called Behavioural Supports Ontario is meant to assist in meeting the needs of older adults with responsive behaviours, however this program is currently in the process of being implemented and the effects have not yet been realized.

- **Lack of Funding for Basic In-Home Care Services:** Participants identified that there is a gap in funding for basic in-home care services within the Sault Ste. Marie senior healthcare system. One study participant explains: “...he sold his home because he no longer had the energy to do all the yard work and house work, and he couldn't clean his bathroom because he couldn't get down to clean the tub, the toilet, all of that kind of stuff, and that was when the decision was made, and this was years ago, to cut housekeeping out of the community based service delivery options. I will tell you that it just spiralled after that, because people couldn't stay in their homes, and it can be as simple as that. You have people that are in very complex situations, expensive situations for reasons such as this” (Interviewee, 2012). If resources for basic in-home care services such as laundry, house-keeping, and snow shoveling were increased, many more seniors would be able to stay in their homes for longer periods of time, thereby preventing the use of higher levels of care.

4.1.1.3 Gaps in System Coordination

Study participants identified that there are gaps in system coordination which are negatively affecting continuity of care within the Sault Ste. Marie senior healthcare system as follows: gaps in sector specific assessment tools; and difficulties with the system shift from institutional to community based care. Figure 5 provides a summary of this gap.

Figure 5: Summary of Gaps in System Coordination



The following sections provide further details about the gaps outlined in figure 5.

4.1.1.3.1 Incompatible Assessment Tools

Within the Sault Ste. Marie senior healthcare system, sector specific standardized ‘Resident Assessment Instrument’ (RAI) tools are currently being used to assess the needs of seniors within the following levels of care: acute care, long term care, home care, and community support services. Although these tools are developed by the same company and are meant to increase connections across levels of care, study participants explain that they create issues with transitions across sectors for the following reasons:

- RAI Assessments do not Interlink Across Sectors:** The various sector specific RAI assessments do not inter-link or auto-populate across sectors. This means that information that is collected in a RAI-HC (home care) for example, cannot be viewed or used in a RAI-MDS (long term care) if the senior needs to change care levels. One participant describes this problem: *“There’s a, it’s called PCC, Point-Click-Care; it’s a repository where the RAIs are held, but who has access to what RAIs, that varies. And there’s a variety of RAIs for different sectors now. Community Service Sector, say assisted living, they started to use a RAI-CHA. How they interlink, they don’t. They don’t all auto-populate each other”* (Interview, 2012). This problem creates issues with information sharing and the over-assessment of seniors across sectors.

- **RAI Assessments are not Accurate Across Sectors:** Study participants identified that RAI assessments are not accurate across sectors in terms of the level of care that they are identifying the senior requires. For example, a senior may be deemed ‘moderate care’ by one assessment and ‘light care’ by another. One study participant explains this dilemma: *“You heard her (name omitted) say yesterday that when they do an assessment the resident is at moderate care. So moderate care in their assessment is light care in our assessment. So they don’t even speak the same language back and forth. I mean...they’re looking at different levels of care from different viewpoints. But when they cross systems, it doesn’t match at all”* (Interview, 2012). This causes continuity issues as seniors are being transitioned into inappropriate levels of care due to the incorrect information within the assessments.
- **Lack of Trust of Assessment Information Among Service Providers:** In addition to the above two problems, study participants identified that there is a lack of trust of the information within the RAI assessments among service providers across sectors: *“We certainly don’t trust the information that we get from the (organization omitted) currently, the RAI-MDS is only as good as the coders, and so if you don’t have good coders, then the information isn’t trustworthy”* (Interview, 2012). This participant explains that this lack of trust is perpetuated by experiences that they have had with sectors not being fully forthcoming about the severity of the condition of the senior within the RAI assessment: *“...because it appears that the (organization omitted) staff aren’t forthcoming, because they know that if they identify too many behaviours, the homes are going say no to them”* (Interview, 2012). This creates difficulties with transitions because staff at the receiving organization are not prepared to provide the appropriate level of care to the senior because the assessment did not reveal the true level of care required. This not only creates dangerous situations for both staff and the senior, but it also causes the need to reassess the senior once they are transitioned through levels of care.
- **Personal and Organizational Accountability of Information within Assessments:** Study participants identified that another reason for reassessing a senior is due to the need for the service providers to ensure their own personal accountability. One study participant explains: *“...if I notice an assessment was done, I don’t even look at it, I do my own because I am accountable. I need to show what I have done. So it just becomes about me and I know a lot of nurses work like that. I need to show my own accountability”* (Front Line Service Worker Focus Group, 2012). This need to show personal accountability for the senior is not only perpetuated by the individual service provider, but also through the individual organizations that they work for: *“...maybe it’s not the individuals in the organizations but it’s the agency itself. I hear different things, saying you know you must do it yourself, this is your client, you must have that assessment, you can’t trust someone else’s assessment”* (Front Line Service Worker Focus Group, 2012). The issue of organizations and service providers

wanting to show their own accountability in relation to assessments greatly contributes to the poor use of existing human resources and the over-assessment of seniors: “...clients are being assessed to death and they can take hours. You wonder, I wouldn’t want to be going through an assessment for 2-3 hours myself, that would be draining. Imagine what it is like for a senior” (Front Line Service Worker Focus Group, 2012).

4.1.1.3.2 Difficulties with System Shift from Institutional to Community-Based Care

Within the Sault Ste. Marie senior healthcare system there is a system-wide initiative to shift resources from institutional (acute and long term care) to community based care (assisted living and in-home care). This shift can be seen through the numerous initiatives that the MOHLTC and NE LHIN have implemented (as outlined in the ‘enablers to integration’ section of this chapter). Although this shift is identified by study participants as a positive and necessary initiative, they also identified the following issues which are perpetuating gaps within the system during this transition:

- **System is in Limbo While Money is Being Transferred:** When the acute care centre within Sault Ste. Marie moved to their new location in March 2011, 68 temporary ALC beds remained open at the old acute care centre site to assist with ALC pressures. The plan for these beds has been to gradually decant them and move the funding (approximately 6 million dollars) into community-based services to prevent hospital visits from seniors and allow them to age in place in the community. Along with this transition process, there are challenges with getting the community-based services ready to support the patients who are being discharged as the system is in limbo while the money is being transferred. One study participant describes this process as a trapeze act: “So you are holding onto the one trapeze which is the hospital, long term care, bricks and mortar, and the other trapeze that is out there swinging towards us is all of the right care in the right place at the right time, and supporting people in the community in their homes. So we have to let go of this trapeze (bricks and mortar) to hurdle through the air for a while to grab on to that other one (community-based), and you can’t grab onto the other one until the dollars start to flow. – as you are sailing through the air, going from one trapeze to the other, the money is still at the hospital trapeze” (Interviewee, 2012). To address this transition issue, study participants identified community capacity will have to be increased prior to decreasing the capacity at the old hospital site.
- **Lack of Awareness of Existing Services/Lack of Stakeholder Cultural Shift:** Although the MOHLTC and the NE LHIN are now focusing on shifting resources from institutional to community-based care, study participants identified that seniors are continuing to go to the hospital for service. This issue has partially been attributed to the lack of awareness among stakeholders of all available services

within the Sault Ste. Marie senior healthcare system. This lack of awareness contributes to the presence of seniors at the hospital as they may be given misinformation about various care options available within the community. For example, a physician's lack of awareness of all available services may cause them to only refer to the services that they are familiar with even though the service may not be appropriate for the needs of the senior: *"...people don't know what all the services are. You don't know what every place offers and so I know with some physicians they get stuck referring to a place that they are really familiar with but my it is not the best place for the patient"* (Front Line Service Worker Focus Group, 2012).

Participants explain that these situations may be contributing to the presence of seniors at the hospital as they are not being referred to the appropriate level of care within the community which may cause their conditions to escalate to the point where they must go to the hospital for service. Study participants identified that a significant cultural shift needs to occur in order to address the lack of awareness among stakeholders of existing services to redirect seniors to appropriate community-based services for their healthcare needs. As one participant explains: *"The education shift, it needs to happen with potential consumers, but also doctors, nurses, discharge planners, ambulance drivers... These people need to be giving consumers the right information so that they can make rational decisions with their families"* (Interviewee, 2012).

- **Taking Resources Away from Lower and Medium Needs to Service Higher Needs Seniors:** Study participants also identified that with the shift from institutional to community based care they are seeing community resources being taken away from low and medium needs seniors to service higher needs seniors in the community. One study participant explains: *"And I know we are looking at additional funding going back into the community for high risk seniors, where I see a gap and I think that they are going to look at that, are people who haven't quite achieved the high risk senior status, they are compromised, they need more help than they can get right now and without that help they will deteriorate, they are going to end up in hospital in ALC maybe sooner than someone who is a high risk senior"* (Front Line Service Worker Focus Group, 2012). This lack of focus on low and medium needs seniors may create situations where these senior's care needs escalate at a faster pace than if they had minimal care supports in place. Furthermore, it creates situations where seniors who are living independently fall through system cracks and get into dangerous, sometimes life threatening situations: *"She had an electric chair- Well the power went out- when it came back on, the chair didn't come back on. So she, she couldn't come down in the chair. She had tried to wiggle herself down- then she was afraid of falling, she was a day and a half, she was soaking wet, hungry... I forget what we called her for. She'd signed up for something and didn't come or something. The phone rang and rang and rang, and we, I went up there."*

Banged on the door, and it was, 'Get the custodian', so I had to get down to him, he came up, unlocked the door for us, to get in, and 'Thank God you're here!' She was caught in her chair. She couldn't reach her phone" (Interview, 2012). In this story, the senior was only found because a member of her social circle called her to see if she was ok. What would have happened if that senior was not a part of a social circle? How many other seniors are falling through system cracks because of the lack of focus on low and medium needs individuals?

- **Lack of Recognition of the Importance of Senior's Mental Well-Being to their Overall Health:** As identified in the above bullet, with the shift from institutional to community-based care, resources are being taken away from low and medium needs seniors. This gap is creating a system that does not recognize of the importance of seniors' mental well-being to maintaining their overall physical health. Ensuring senior's mental well-being requires the system to look at seniors in a holistic manner by considering their social, emotional, and security needs. One study participant explains: *"...she still lives in her own home and worries about keeping the place clean and making bread and what her garden looks like, and if she didn't have those things, the really basic things, she would deteriorate mentally very quickly, and soon after that it would be physical"* (Interview, 2012). Without mental well-being a senior's physical state may begin to wane at a faster pace which in turn puts more strain on the healthcare system.

This lack of focus on the importance of senior's mental well-being to their overall health can be seen in current change to the assisted living service delivery structure. Previously, assisted living services were delivered in a more client-based format where each senior would have the same person coming into their home to provide a range of services. Now, these services are provided through a task-based format where the senior has numerous people coming into their home to provide each specific service. One study participant explains how this change has upset many seniors because they are no longer able to build a relationship with the person who is coming into their home to assist them: *"Now you're putting the deed before the person, and you know, sometimes it doesn't really matter if the floor gets swept, but if Mrs. Smith has somebody exchanging a few pleasant words, perking her up, so there's a couple of crumbs"* (Interview, 2012). The relationships that seniors were able to build with assisted living providers contributed to maintaining their mental well-being and assisted in helping them to age in place for longer periods of time.

Participants also identified that the previous assisted living service delivery structure created an environment where providers were able to flag when they saw changes in senior's healthcare needs because of the relationship that they were able to build with the senior. One study participant explains: *"Quite often an average visit is 30 minutes, you know 'hi how are you?' I'm going to check the chart, I'm going to talk*

to you, let's give you a quick shower, see you later.' And not really seeing that person as a person, you know years ago that was a huge piece of the care plan, the eyes on the social interaction. Because if people have deteriorating cognitive abilities, they can hold it together for 15-20 minutes, but if you are there longer you are going to see some issues that are being identified and sometimes it comes at a surprise 'the client's at this level? Why did no one report it'? Well because we are so task oriented when we go in that we are not really seeing the person as a whole” (Front Line Service Worker Focus Group, 2012). Now that assisted living workers are unable to build strong relationships with the seniors that they serve, will more seniors who are receiving this service end up in higher levels of care because their deteriorating conditions were not flagged?

Summary of Section 4.1.1- System Gap Results

The above section clearly demonstrates that administrative and front line service worker stakeholders have and are continuing to experience significant gaps within the current Sault Ste. Marie senior healthcare system that are contributing to continuity of care issues, inappropriate transitions across levels of care, seniors being in inappropriate care settings, and administrative/front line service worker burnout. The following section provides the results of how study participants believe that the structure of the Sault Ste. Marie senior healthcare system should change in order to address the identified system gaps.

4.1.2 Local Level Desired End State

The next step in stage one of the adapted change management framework is to determine the desired end state of the Sault Ste. Marie senior healthcare system by establishing a vision and measureable goals in light of the gaps identified in section 4.1.1. These results are presented below.

4.1.2.1 Vision for An Integrated Senior Healthcare System in Sault Ste. Marie

To establish a vision for an integrated senior healthcare system in Sault Ste. Marie, participants were asked explain their ideas for an improved senior healthcare system during the key informant interviews. This information was cross-analyzed and presented to the participants in both focus groups where revisions and additions were made. All of the results were compared and the following vision was formed:

“A system that is designed for seniors, looks at the senior holistically, provides a coordinated single point of access, and recognizes the importance of all levels along the continuum of care”.

This vision along with the goals outlined in section 4.1.2.2, will guide the change towards an integrated senior healthcare system in Sault Ste. Marie.

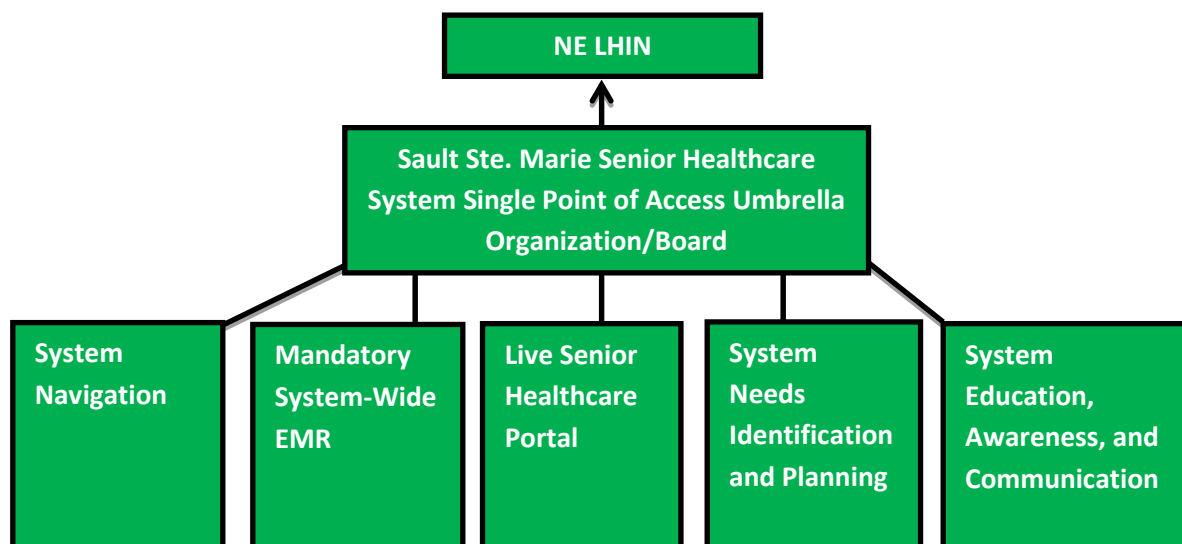
4.1.2.2 Goals to Achieve the Vision for an Integrated Senior Healthcare System in Sault Ste. Marie

Study participants were asked to identify goals that would assist change leaders in achieving the established vision in section 4.1.2.1. The overarching goal that was identified is the creation of an independent umbrella organization/board that would overlay the entire senior healthcare system and be the single point of access for senior healthcare in Sault Ste. Marie. This organization/board would work with the NE LHIN and existing senior healthcare service providers to accomplish the following goals:

- **Establish a Single Point of Access and System Navigation:** This single point of access would be one place for seniors, their support networks, and service providers to go to get assistance with system navigation and information. All levels along the Sault Ste. Marie senior continuum of care would be included and seniors would be attached to ‘care coordinators or system navigators’ to assist them in obtaining the appropriate level of care.
- **Implement a Mandatory System-Wide Electronic Medical Record:** A key component of the single point of access and system navigation would be the implementation of a mandatory system-wide electronic medical record. This record is necessary to allow information sharing across sectors, to track senior care processes, and to reduce the over-assessment of seniors.
- **Develop a Live Senior Healthcare Portal:** An additional key component of the single point of access is a live senior healthcare portal that would house information about all existing services within the Sault Ste. Marie senior healthcare system. In addition to this inventory, a live bulletin or dashboard of current system events would be on the home page. For example, if there was an outbreak at the hospital, the dashboard would display this information along with other care pathways that stakeholders could use.
- **System Education, Awareness, and Communication:** The single point of access umbrella organization/board would be accountable for ensuring public and stakeholder education and awareness about the appropriate actions to take when moving through the Sault Ste. Marie senior healthcare system. They could also create a campaign that promotes awareness of all of the existing services within the Sault Ste. Marie senior healthcare system.
- **System Needs Identification, Planning, and Resource Allocation:** The single point of access umbrella organization/board would also be accountable for identification of Sault Ste. Marie senior healthcare system gaps, problems, and duplications. They would work with the NE LHIN and existing providers to implement and realign resources where necessary.

Study participants explained that the umbrella organization/board described above would differ from the NE LHIN as it would only be accountable for the senior healthcare system in Sault Ste. Marie, whereas the NE LHIN is accountable for: "...planning, integrating and funding health care services for more than 550,000 people across an estimated 400,000 square kilometers" (NE LHIN Website- About Us, 2012). This accountability includes the oversight of 186 health care providers that fall under the following categories: "...hospitals, community support services, mental health and addictions, community health centres, long-term care homes, and the Community Care Access Centre" (NE LHIN Website-About Us, 2012). With this large range of accountability, many of the initiatives that the NE LHIN implements are regional (e.g. Behavioural Supports Ontario; Specialized Geriatric Services; Slips, Trips, and Falls Prevention, etc.). Study participants identified that these regional-based initiatives may not always meet the specific needs of seniors within Sault Ste. Marie as this community has access different resources than other communities within the NE LHIN planning area. Therefore, the single point of access umbrella organization/board described by study participants would assist the NE LHIN with the development of local plans for regional initiatives to ensure that the resources within the Sault Ste. Marie senior healthcare system are being used as efficiently and effectively as possible. Figure 6 provides a draft diagram of the potential structure of this organization:

Figure 6: Draft Structure of Sault Ste. Marie Senior Healthcare System Single Point of Access Umbrella Organization/Board



Summary of Section 4.1- Stage One: System Gaps and Desired End State

The results presented in Stage One (section 4.1) clearly demonstrate that there is a gap between the current state of the Sault Ste. Marie senior healthcare system and the desired end state which signifies the need for change. The specific change direction that participants identified is the need for a single point of access umbrella organization/board to oversee the Sault Ste. Marie senior healthcare system to assist in achieving the established vision and addressing the identified system gaps. The following section describes the results of Stage Two of the adapted change management framework.

4.2 Stage Two: Situational and Key Stakeholder Analyses

The following section presents the results of the situational and key stakeholder analyses within Stage Two of the adapted change management framework by identifying system diversity, as well as perceived enablers and obstacles to integration.

4.2.1 Local Level System Diversity: Inventory & Visual Maps of Organizations and Services

Determining the diversity within the Sault Ste. Marie senior healthcare system is the first step of the second stage within the adapted change management framework. The concept of diversity focuses on conducting a situational analysis that depicts the organizations and services that currently provide care to seniors within Sault Ste. Marie. The purpose of this is to increase stakeholders' awareness and understanding of the existing resources within their system. This increased awareness will assist stakeholders in selecting/constructing a change design that takes advantage and includes their existing resources, rather than a design that excludes or does not make connections among valuable services. The results of this analysis have been organized in a system inventory (Appendix E) which includes in-depth descriptions of Sault Ste. Marie's senior healthcare services, as well as visual maps that summarize this information by sector under the following headings: Acute Care, Long Term Care, Retirement Residences, Independent Living, Assisted Living, In-Home Care Services, Community Support Services, Primary Care/Allied Health/Specialized Services, and System Planning/Navigation. Figure 7 provides a summary of the information within Appendix E and depicts a holistic picture the Sault Ste. Marie senior continuum of care.

Figure 7: Sault Ste. Marie Senior Continuum of Care (not to scale)

SAULT STE. MARIE SENIOR CONTINUUM OF CARE					
Acute Care	Long Term Care	Retirement Residences	Independent Living	Assisted Living	In- Home Care Services
<ul style="list-style-type: none"> Sault Area Hospital 	<ul style="list-style-type: none"> Extendicare-Tendercare Extendicare- Van Daele Manor F.J Davey Home Mauno Kaihla Koti Nursing Home Extendicare Great Northern 	<ul style="list-style-type: none"> Collegiate Heights Great Northern Retirement Residence Pathways Retirement Residence 	<ul style="list-style-type: none"> Italian Housing Corp. Lions Club Corporation Suomi Eesti Maja St. Gregory's 615 Bay Street 55 Chapple Heights 101 Chapple St. Georges Ave. East St. Villa Vista 	<ul style="list-style-type: none"> Red Cross Kotitalo (Ontario Finnish Resthome Association) Ontario March of Dimes- 	<ul style="list-style-type: none"> North East Community Care Access Centre Revera Home Health Victoria Order of Nurses Canadian Red Cross Bayshore Home Health Care F.J. Davey Home Shoppers Home Health Care We Care Home Health Services Alzheimer Society
Community Support Services					
TRANSPORTATION <ul style="list-style-type: none"> City of SSM Transit Services Canadian Cancer Society Canadian Red Cross 	SPECIFIC NEEDS <ul style="list-style-type: none"> Alzheimer Society Sault Area Hospital Seniors Mental Health Services Canadian Cancer Society 	EMERGENCY PLANNING <ul style="list-style-type: none"> Vulnerable Persons Registry 	ADULT DAY CARE <ul style="list-style-type: none"> F.J. Davey Home Victoria Order of Nurses 	SOCIAL/ RECREATIONAL <ul style="list-style-type: none"> Senior Citizens' Drop-In Centre Steeltown Senior Citizens' Drop-In Centre Royal Canadian Legion, Branch 25 	EDUCATION, AWARENESS, PREVENTION <ul style="list-style-type: none"> We Care Home Health Service Victoria Order of Nurse Algoma Public Health
Primary Care/Allied Health/Specialized Services					
PHARMACY <ul style="list-style-type: none"> Shoppers (3 Locations) Metro (2 Locations) Rexall (4 Locations) IDA (6 Locations) The Medicine Shoppe; Prescriptions Centre, Rome's, Wal-Mart; Group Health Centre 	ALLIED HEALTH/PRIMARY CARE <ul style="list-style-type: none"> Group Health Centre Algoma Nurse Practitioner-Led Clinic Sault Care Walk In Clinic Superior Family Health Team Baawaating Family Health Team Sault Area Hospital Walk-In Clinic (Fast Track) 	GERIATRIC SPECIALIS SERVICES <ul style="list-style-type: none"> North East Specialized Geriatric Services Group Health Centre 	PUBLIC HEALTH <ul style="list-style-type: none"> Algoma Public Health 		
System Planning			System Navigation		
North East Location Health Integration Network			North East Community Care Access Centre		

Based on the results presented in Figure 7 and Appendix E, there are a total of 37 organizations that are currently providing care and support to seniors within Sault Ste. Marie (organizations may appear in Figure 7 and Appendix E numerous times as they may be providing services in numerous sectors, however they are only counted once to reflect the total of 37 organizations). This information is based on data gathered from the key informant interviews and focus groups conducted within this study, as well as an exhaustive search for data in the texts identified by study participants (i.e. organization websites and pamphlets). Another source that was used to fill in information gaps is the service database developed by the North East Community Care Access Centre (2013) called the ‘NorthEasthealthline’. Although a thorough search for Sault Ste. Marie senior healthcare services was conducted, there may still be other services or organizations that are currently providing care to seniors within Sault Ste. Marie that have not been captured. Therefore, the inventory of services and visual maps should be used as a base tool by stakeholders that can be expanded should additional organizations and/or services be discovered. This tool, along with other results presented in this chapter will assist change leaders in developing an informed and inclusive plan when operationalizing the established desired end state (section 4.1.2). The following sections present the results of the enablers and obstacles to integration.

4.2.2 Local Level Enablers to Integration

Depicting the enablers of integration is the first step in the key stakeholder analysis portion of the adapted change management framework. The purpose of depicting ‘Enablers of Integration’ is to identify key stakeholder strengths and resources/activities that be leveraged to assist in achieving the established vision and measurable goals. These results are presented below.

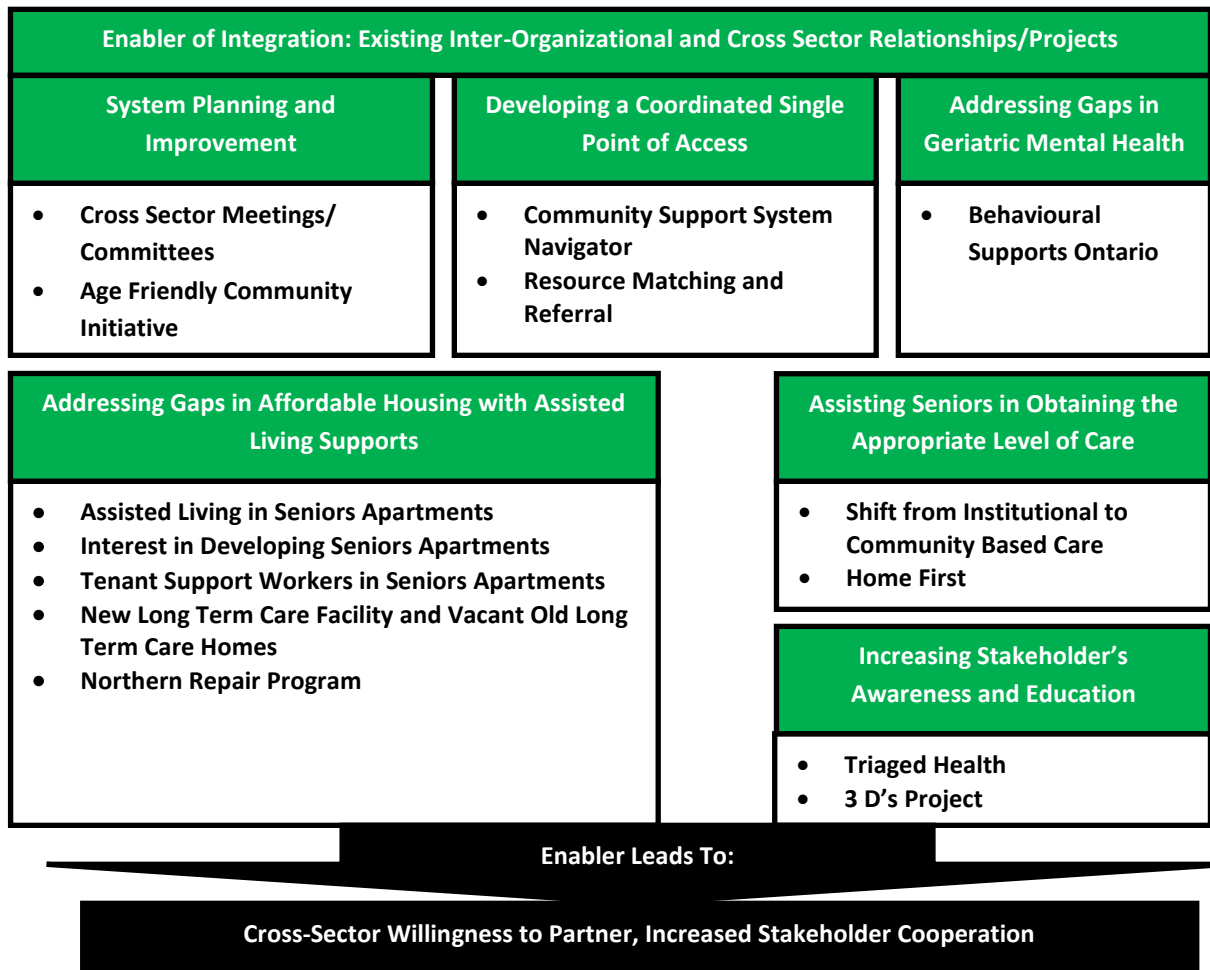
4.2.2.1 Existing Inter-Organizational and Cross Sector Relationships/ Projects

The overarching enabler to integration that study participants identified are the inter-organizational and cross-sector relationships and projects that currently exist within the Sault Ste. Marie senior healthcare system. These relationships/projects fall under six main categories including: system planning and improvement; developing a coordinated single point of access; addressing gaps in geriatric mental health; addressing gaps in affordable housing with assisted living supports; helping seniors to obtain the appropriate level of care; and increasing stakeholder’s awareness and education. Study participants identified that these activities have started to create more discussion and more willingness to partner among service providers. One study participant explains: *“I find that people have a better understanding of each other’s roles, and there seems to be a willingness to share resources, and to come up with solutions that help each other. So I think that willingness to work as a team is really positive”* (Interview, 2012). Participants explain that this willingness to partner and work together is a positive change from previous circumstances, and that this behaviour may assist in providing momentum for the established vision and measurable

goals as inter-organizational and cross-sector cooperation will be necessary to accomplish the change. Figure 8 provides a summary of this enabler to integration.

The aspects of the identified relationships and partnerships that may act as enablers to integration include the notion that they are beginning to bring stakeholders from various sectors to the same planning table; they are beginning to address some of the identified system gaps (i.e. geriatric mental health, affordable housing with assisted living support); and they are beginning to fulfill some of the measurable goals identified by participants (i.e. system planning and improvement, developing a coordinated single point of access, helping seniors to obtain the appropriate level of care; and increasing stakeholder’s awareness and education). Although this positive shift in behaviour has been identified as an enabler to integration, participants also explained that there is still significant room for improvement, and that the relationships and projects identified below are just breaching the surface of the actual change that needs to occur. This notion became evident as participants described ‘obstacles to integration’, presented in section 4.2.4.

Figure 8: Summary of Existing Inter-Organizational and Cross Sector Relationships/Projects



The following section provides a description of the projects and relationships outlined in figure 8.

4.2.2.1.1 System Planning and Improvement Relationships/Projects

- **Cross Sector Meetings/Committees:** There are many cross-sector meetings and committees within the Sault Ste. Marie senior healthcare system that bring service providers from all sectors to the same table to discuss new initiatives and/or how to address system problems. One study participant explains: *“I think the fact that everybody’s at the table at LHIN meetings is helpful. Like, not just ALC Solutions, but, for example, today we’re talking about potentially extending hospital crisis designation. It used to be either the LHIN would have that discussion with us, or they’d have it with the hospital; now we have it as a group. And everybody’s time is valuable now, right? So we rarely have isolated sector meetings anymore”* (Interview, 2012). Study participants identified the following committees that are focused on senior healthcare system planning in Sault Ste. Marie: Regional ALC Committee; Sault Ste. Marie ALC Solutions Group; Sault Ste. Marie Assisted Living Committee; Partners In Care Committee; Sault Ste. Marie Long Term Care Committee; Community Support Network; Behavioural Supports Ontario Committee; and the Dementia Network. These cross-sector committees can be leveraged when moving forward with the established change as the relationships and provider familiarity that is being established within them will be necessary successfully operationalize the change.
- **Age Friendly Community:** The City of Sault Ste. Marie is in the process of taking steps to become part of the World Health Organization’s (WHO) network of Age-Friendly Cities. In order to achieve this standing: *“Sault Ste. Marie’s current status will be assessed against a series of requirements set out by the WHO in order to become a part of the network. A written 5 year plan that adheres to those requirements and addresses where the city falls short will be put in place and continuously followed with ongoing revisions and considerations to meet the needs identified by the community”* (Age-Friendly Sault Ste. Marie-Phase One, 2012). To follow through with these requirements, a number of volunteer steering committees have been established and a series of research in consultation with seniors and system experts is being conducted. Obtaining Age-Friendly Status within Sault Ste. Marie will greatly benefit seniors by addressing issues within the community to assist in improving their quality of life. This project can be leveraged when moving forward with established desired end state as it provides an existing platform for discussion with seniors to ensure that the umbrella organization is designed for their needs.

4.2.2.1.2 Developing a Coordinated Single Point of Access

- **Community Support System Navigator:** A community support system navigator position has been created in Sault Ste. Marie. The goal of this position is to address healthcare system issues and create connections among services to assist seniors in accessing the appropriate level of care through a coordinated single point of access. In addition to beginning to address some of the identified goals to achieve the established desired end state, this position will be essential to move the change towards an integrated senior healthcare system forward as it is currently acting as the common thread through the senior healthcare planning committees. This common thread is essential to ensure integrated planning among various initiatives. Although this position is shown to be a positive initiative, the results of ‘obstacles to integration’ demonstrate that additional work needs to be done in terms of breaking down organizational silos and philosophical treatment differences to achieve true system coordination and planning.
- **Resource Matching and Referral:** Study participants also identified that the NE LHIN is in the process of conducting a ‘resource matching and referral’ project to assist in increasing connections to community support services from the hospital by reducing the number of referral forms that are currently being used. This project is essential to use when moving forward with the desired end state as it is focusing on the operational aspect of integration in terms creating coordinated referrals throughout the system.

4.2.2.1.3 Addressing Gaps in Geriatric Mental health Resources

- **Behavioural Supports Ontario:** Behavioural Supports Ontario (BSO) is a NE LHIN and MOHLTC initiative to develop: “...*a comprehensive system of support to improve care for older adults with behaviours associated with complex and challenging mental health, dementia or other neurological conditions, and also for their care givers*” (NE LHIN Website-BSO, 2012). This initiative is currently being implemented within the Sault Ste. Marie senior healthcare system and has been identified by study participants as a resource that will assist with addressing gaps in services for seniors with mental health needs.

4.2.2.1.4 Addressing Gaps in Affordable Housing with Assisted Living Supports

- **Assisted Living in Seniors Apartments:** Three assisted living service providers have been providing assisted living for seniors in existing seniors’ independent living apartment buildings. One service provider has been given funding to expand their services in the downtown area to additional apartment buildings where there is a high density of seniors living in subsidized housing. This initiative should be sustained

when moving forward as it is a successful project that is beginning to address gaps in assisted living with affordable housing supports.

- **Interest in Developing Seniors Apartments:** Study participants have identified that there are existing organizations and private developers that have an interest in building seniors apartment complexes in Sault Ste. Marie. These organizations and developers would be open to creating a space for assisted living service providers within the building. This interest is an excellent opportunity for the Sault Ste. Marie senior healthcare system as it may assist in addressing one of the major gaps that has been identified, ‘lack of affordable seniors housing with assisted living supports’.
- **Tenant Support Workers in Seniors Apartments:** The Sault Ste. Marie Housing Corporation has three tenant support staff that work with individuals in subsidized apartments to facilitate referrals and access to community services based their identified need. These additional supports are helping seniors to age in place longer by assisting them with healthcare system navigation to get them into the appropriate supports.
- **New Long Term Care Facility and Vacant Old Long Term Care Homes:** Within Sault Ste. Marie a new 264 bed long term care facility is currently being built. This facility is not creating any new long term care beds, rather it is upgrading existing B and C beds to A beds. This means that certain existing long term care facilities will move their residents to the new long term care facility, leaving the old buildings vacant. This creates an opportunity as there will be space that could be transformed into affordable seniors’ apartments, however no plans have been created for the anticipated vacant space to date.
- **Northern Repair Program:** The City of Sault Ste. Marie Housing Corporation has a Northern Repair program that has assisted seniors in retrofitting their existing homes which has enabled them to age in place longer. One study participant describes the successful program: *“Well there was one individual, it was just before Easter, I think last year or the year before, and they were in that predicament. So we went there and we made that house accessible, put ramps in it, redid the washroom and the shower, did other things, and that person was able to get out of the hospital and go home. So, it’s a great program, and it really, of course stimulates the economy, local contractors are now working all year round, suppliers are supplying these guys and the money stays in the community”* (Interview, 2012). This program should be expanded when moving forward with the established change as it assists seniors in aging in place within their own homes, which may take some of the pressure off of the need to build additional affordable seniors housing complexes.

4.2.2.1.5 Assisting Seniors in Obtaining the Appropriate Level of Care

- **System Shift from Institutional to Community Based Care/Plummer Site Transition Plan:** Although study participants identified that there are certain issues

with the transition phase of the shift from institutional to community based care, all study participants see the benefit in this change: *“I think as transformation occurs and funding is shifting to the community, I think there will be some natural improvements in gaps in service”* (Interview, 2012). With the shift from institutional to community based care, the old acute care centre site which houses 68 ALC beds is in the process of being decanted: *“So as they downsize the (organization omitted), you will hopefully see the uprising of community supports. Because there is 6 million dollars tied up in that program, they are saying as that program shrinks because it was an interim thing, that 6 million dollars will flow to the community and this is huge for the community”* (Interview, 2012). This additional funding resource will assist in addressing the identified service gaps, and should be harnessed when moving forward with the established change.

- **Home First:** Home First is *“...a significant shift in health care thinking. When a person enters a hospital with an acute episode, every effort is made to ensure adequate resources are in place to support the person to ultimately go home on discharge. Only when returning home with care is not possible or safe to do so, are other options considered”* (NE LHIN Website- Home First, 2012). In August, 2010 the Home First philosophy was implemented in partnership with the NE CCAC in Sault Ste. Marie. It is an ongoing program that participants identified as beneficial to the Sault Ste. Marie senior healthcare system in assisting seniors to obtain the appropriate level of care.

4.2.2.1.6 Increasing Stakeholder’s Awareness and Education

- **Triaged Health:** *“Triaged Health is a free service created for the people living in or visiting Sault Ste. Marie and surrounding area. Through a virtual navigation system, this site is intended to assist you connect with the health care service(s) you are inquiring about and/or require”* (Triaged Health Website, 2012). This resource could be used when moving forward with the desired end state as it may address the goal to establish a ‘live senior healthcare portal’. Additional resources such as this that could also be used include 211 and 310 CCAC, however study participants identified that these tools need to be reworked so that they are user friendly and have accurate information.
- **Three D’s:** The Group Health Centre is currently undertaking a project focusing on assisting physicians and nurses to improve identification and screening of dementia, depression, delirium within elderly care through the development of educational tools and implementation of best practices. Projects such as these can be continued when moving forward with the established change as they demonstrate ways to increase stakeholder education and awareness of senior’s needs.

Summary of Section 4.2.2- Enablers of Integration

The above section provides a description of the various projects/ relationships that currently exist within the Sault Ste. Marie senior healthcare system that can be used and expanded on when moving forward with the change towards an integrated senior healthcare system. However, as indicated, although these initiatives are a step in the right direction, there continue to be issues within the Sault Ste. Marie senior healthcare system that may impede the change towards the established desired end state. These issues are described below in sections 4.2.3 and 4.2.4.

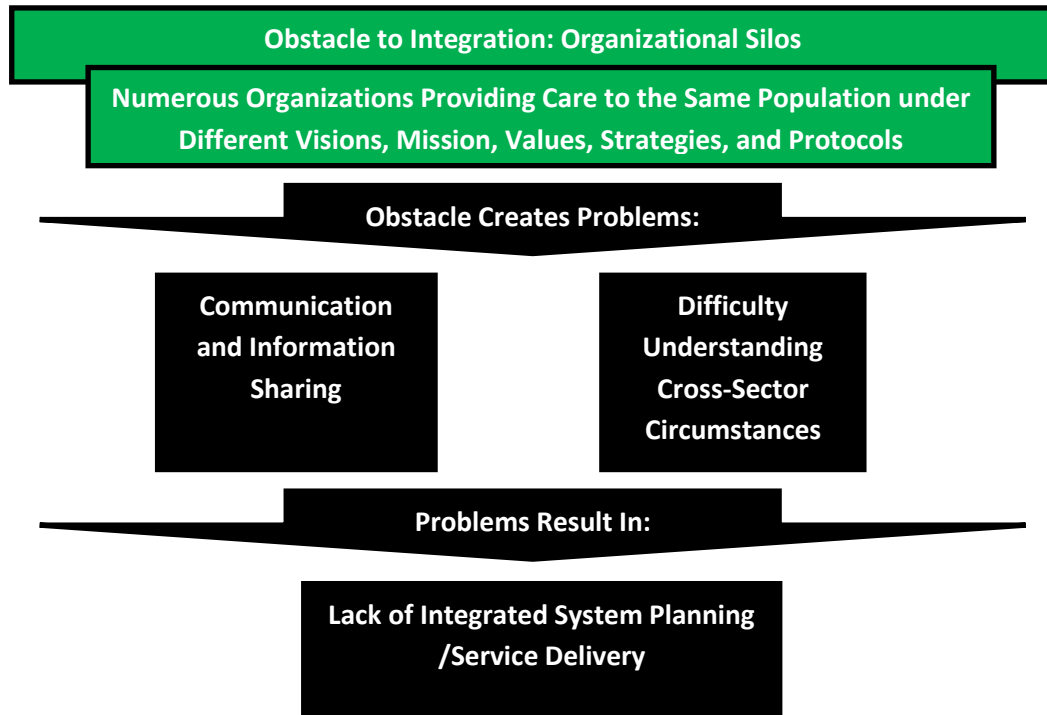
4.2.3 Local Obstacles to Integration

Describing stakeholders' perception of obstacles to integration is the second step in the key stakeholder analysis portion of the adapted change management framework. Obstacles to integration refer to existing behaviours/aspects within the Sault Ste. Marie senior healthcare system that may inhibit change leaders from achieving the vision and goals set out by study participants. It is important to identify and acknowledge perceived obstacles to integration when moving forward with change initiatives to show what issues need to be addressed in order to increase stakeholder readiness for change. Participants identified two main obstacles to integration including: organizational silos and inter-organizational/professional philosophical treatment differences. These obstacles to integration demonstrate the issues that are still occurring within the Sault Ste. Marie senior healthcare system despite the existing relationships and projects that were identified as enablers to integration in section 4.2.2. These results are described below.

4.2.3.1 Organizational Silos

The main obstacle to integration that study participants identified was 'organizational silos'. A summary of this obstacle is outlined in figure 9.

Figure 9: Organizational Silos as an Obstacle to Integration



As depicted in figure 9, within the Sault Ste. Marie senior healthcare system there are numerous organizations providing care for the same population (as identified in Appendix E), however they have different visions, missions, values, strategies, and protocols for delivering this care. As one participant explains: “...everybody probably has the same general agreement about the way things should be, but sometimes... -they’re off doing their own thing based on their own strategy and those strategies don’t necessarily blend” (Primary Care Interview, 2012). Study participants identified that the presence of organizational silos within the Sault Ste. Marie senior healthcare system create obstacles to integration because they perpetuate an environment where there are problems with inter-organizational/cross-sector communication and information sharing, as well as difficulty understanding cross-sector circumstances. These obstacles are described further below:

- **Problems with Inter-Organizational and Cross-Sector Communication and Information Sharing:** Study participants identified that organizational silos contribute to problems with inter-organizational and cross-sector communication and information sharing. For example, stakeholders may find out about various initiatives, projects, funding opportunities, and relationships by happenstance. One participant provides an example: “I don’t know how this is going to work at all. You know, you have one nursing home that has a relationship with the hospital-so they work together-...to enable the nursing home to access the progress notes and consult records and X-ray, etcetera results. So if you’re going to do that, why wouldn’t you

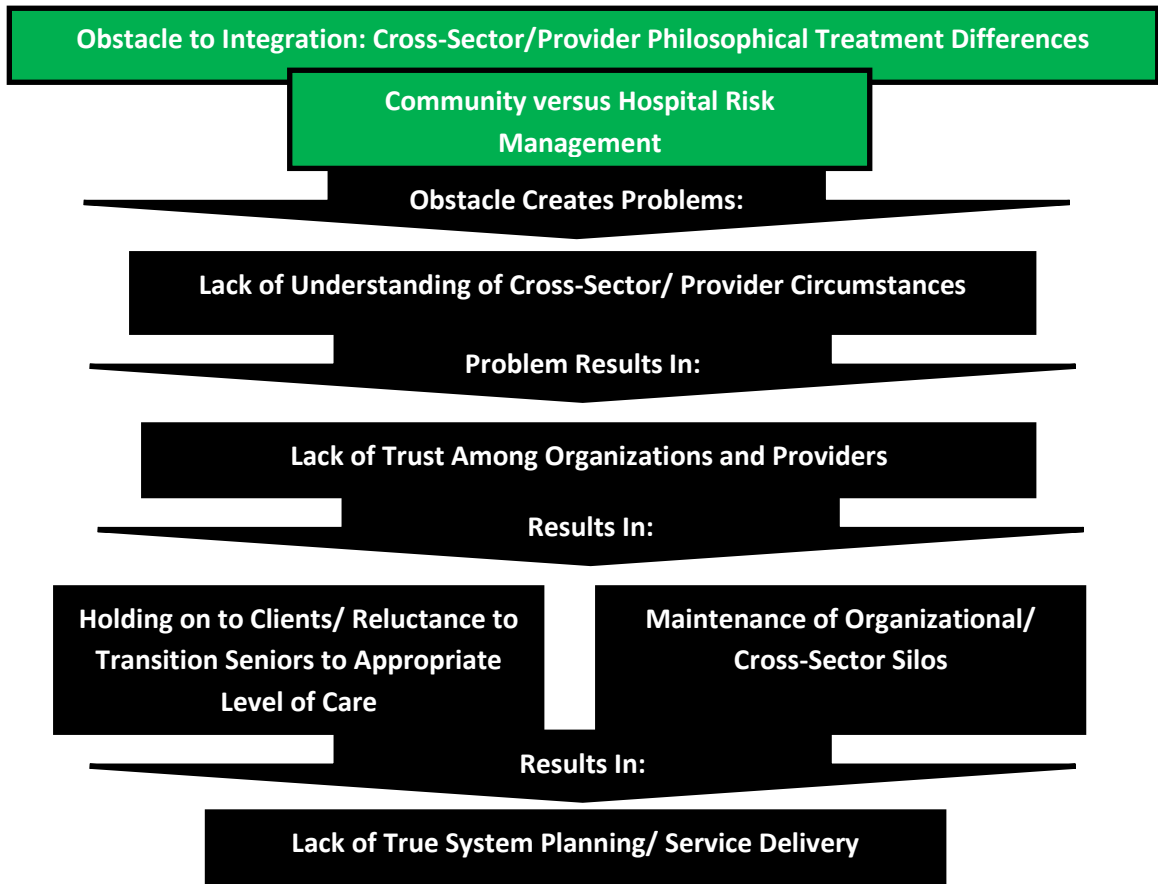
do it for all of the homes? Why do you find out in a meeting that one home has got it and nobody else does? I mean, that's the frustration in the system" (Interview, 2012). The above experience indicates that there is no formal protocol for information sharing across organizations, even though they are providing the exact same care within the same sector. This difficulty with communication and information indicates that although there are existing positive cross-sector/organization projects and relationships, there continue to be initiatives within the Sault Ste. Marie senior healthcare system that are being implemented in a siloed manner. This acts as an obstacle to achieving the desired end state because it inhibits system-wide planning and initiative implementation. This results in certain organizations having advantages over others, which results in seniors receiving inequitable care across organizations within the same sector.

- **Lack of Understanding of Inter-Organizational Circumstances and Impact of Decisions on Other Sectors:** In addition to the above issues, participants also explained that organizational silos cause obstacles to integration because they create barriers to understanding the impact that decisions made in one sector may have on another. One study participant provides an example: *"Well, obstacles to integration are staffing models. And partner visions. You know... I'm just going to speak honestly here, but one example, when there's a director at the (organization omitted) who felt the case-the discharge planning functions were more value-added to the client, she removed the utilization piece from that case reviewer, so they could do more discharge planning. She's gone, and now someone who's there... finds utilization more value-added-and one isn't necessarily better than the other, but it's shifted the case reviewer's role, but it has an impact on us, and so sometimes decisions are made in one sector without looking on the impact to the other sectors. Just like us, if we decide to standardize our utilization in the community, and anybody that was maybe grandfathered with some previous services is now brought into line with the norm for equity, I'm not saying that person ends up in the hospital, but if they do, we need to understand that that may be having the impact on more people in the hospital. So both ways, sectors need to understand the impacts of their decisions to their partners."* (Interview, 2012). As the study participant identified, decisions that are made in one organization or sector are often made based on the needs of that specific entity. This demonstrates that although there are existing cross-sector improvement projects in place and relationships being built, organizational silos continue to preserve an intra-organizational rather than system method of service delivery and planning. This acts as an obstacle to achieving the established desired end state because in order to have true system planning and integration, the impact of decisions need to be looked at across sectors/organizations to avoid negative ripple effects throughout the system.

4.2.3.2 Cross-Sector/Provider Philosophical Treatment Differences

In addition to organizational silos, another obstacle to integration that study participants identified are the philosophical treatment differences among sectors and providers within the Sault Ste. Marie continuum of care. Figure 10 provides a summary of this obstacle.

Figure 10: Cross-Sector/Professional Philosophical Treatment Differences as an Obstacle to Integration



As depicted in figure 10, the main treatment differences that study participants identified were among the acute and community sectors/providers in terms of their philosophies on risk management. This difference is described by the following community sector study participant:

...and that's the difference...-there is a higher risk tolerance in the community than there is in the hospital. So the hospital wants everything pretty pretty, and the community is like, this person doesn't need 24 hour care, they need someone checking in on them regularly throughout the day, but it is two totally different philosophies on risk management (Administration Focus Group, 2012).

In contrast to the views of the above study participant, a front line service worker provides their insight as to why the acute care sector and staff may be more materialistic in their approach to care:

Well the hospital, you're probably going to do more for the senior just because it makes your life easier as a nurse. So in the long term care or ALC unit, you'll go in and you know, give them the proper, give them the medications, maybe do the bath, when really they could be doing that for themselves. Because it makes your life on the unit easier, because you have so, you're taking on more complex patients, you're dealing with more patients now (Front Line Service Worker Focus Group, 2012).

The above varying views among study participants indicate that service providers from various sectors may not fully understand each other's situations and why care is being delivered in a certain manner.

Study participants identified that this lack of understanding of cross-sector/provider circumstances leads to a lack of cross-sector/professional trust among health service providers. This lack of trust causes providers to be reluctant to transition seniors among levels of care. One study participant provides an example: *"I tell ya, in my (organization omitted) days, I pulled out 2-3 people that were living in the (organization omitted), like living there for years, who absolutely had the ability to live independently and I mean, I damn near had to kidnap them. The ('organization omitted') said 'They can't do that, they'll be back here in six months'"* (Administrator Focus Group, 2012). As this study participant identifies, providers are reluctant to transition clients from their own level of care because they do not trust the receiving sector/organization to properly care for the senior. This lack of trust perpetuates organizational and cross-sector silos as they continue to provide care within their own realm, even if the level of care that they are providing may not be appropriate for the senior. These issues act as obstacles to achieving the desired end state because they act as barriers to transition among levels of care. Therefore, if an umbrella organization was established, would stakeholders even participate in the model? Or would philosophical treatment differences stand in the way of allowing seniors to reach the appropriate level of care through a single point of access and system navigation? Would it matter if stakeholders were aware of all the existing senior care services in Sault Ste. Marie if these stakeholders don't trust other providers to care for their patients/clients? These questions demonstrate how the issue of philosophical treatment differences could be a major barrier to achieving the established desired end state, and therefore is an obstacle that will need attention and action by change leaders.

Summary of Section 4.2.3- Local Obstacles to Integration

The above section depicts the obstacles to integration that exist on the 'local level' within the Sault Ste. Marie senior healthcare system. It will be important for change leaders

to address these obstacles, as they indicate that the stakeholders within the intended change environment may not fully be ready for the established change direction. However, the identified ‘enablers to integration’ do indicate that stakeholders are capable and able to change, and therefore this behaviour should be harnessed to assist in breaking down the identified obstacles to integration and increasing stakeholder’s readiness for change. The following section describes the ‘high level’ analysis of the ‘local level’ results presented in the above sections.

4.2.4 High Level Obstacles to Integration-Drawing the ‘Fault Line’

The following section delves deeper into the analysis of the local level results presented in the above sections by comparing participant’s local experiences to the texts identified in Chapter 3.0. This analysis has resulted in the finding that there are ‘fault lines’ between certain aspects of what the MOHLTC and NE LHIN intend, and what is actually being experienced by study participants on the front lines. These ‘fault lines’ are found in relation to MOHLTC and NE LHIN funding models; MOHLTC and NE LHIN policy/legislation; and MOHLTC/ NE LHIN politically driven decisions. The following sections provide further explanation of these findings.

4.2.4.1 MOHLTC/NE LHIN Funding Models

With the creation of Local Health Integration Networks (LHINs) and the continued promotion of integration as the solution to Ontario healthcare system fragmentation (Ministry of Health and Long Term Care- Ontario’s Action Plan for Health Care, 2012), the presence of organizational silos seems ironic based on the results within this study that identify organizational silos as an obstacle to integration at the local level. Therefore, the question then becomes, why do organizational silos continue to exist? When further analyzing this question, the experiences of study participants reveal that the way the MOHLTC and NE LHIN fund certain programs and services perpetuates the presence of organizational silos through reactive and individualized funding methods. Reactive funding is a result of ‘unexpected’ cost savings that arise at the end of the fiscal year. In order to maintain this money within the community, it must be allocated to an initiative or project as quickly as possible so that the MOHLTC does not claw the money back and place it in a general pot that may be allocated elsewhere in the province. One study participant describes their experience with this method of funding:

There’s money in the system maybe by saving the amount of days a person is in a bed at the hospital, so you have all this wealth but they don’t do anything with it until right at the end. Then it’s like well now we have \$500,000 what can we do? But it’s too late to do anything. So, there should be more forecasting, if there is going to be a huge savings somewhere in the system, then you should have choices. -But don’t call me on a Friday at 1:00pm and say ‘(name omitted) can you put a proposal together

by Friday at 4:30pm and you know we will see what we can do for you, because we have some extra money'. I put the proposal together and you give me change, what am I going to do with that? You know, so it's kind of like if you are forecasting better and you see a trend you are going to know that you are going to have some money so that you can take a chance, and you say 'we are going to have 5 million dollars, do you have a project that you can get going?' (Interview, 2012).

As depicted above, the funder may often reach out to individual organizations that they are aware of (which may not necessarily be the appropriate organization for the funding initiative), and request a quick proposal to ensure that the unexpected funding stays within the community. This method of reactive funding perpetuates organizational silos as it does not allow time to assess the needs of the system as a whole, and determine where funding should be allocated to enhance existing services and create connections across silos.

In addition to the reactive funding methods described above, study participants identified that individualized funding methods are also preserving the presence of organizational silos. Individualized funding methods are a result of programs and services being funded through the request from the NE LHIN for project proposals from individual organizations, rather than requiring that health service providers come together to develop integrated proposals for funding. This method of funding perpetuates organizational silos because it creates an environment of competition and turf building among service providers. One study participant describes their experience:

Because I've sat on a few committees now...-I was very active. Good ideas, we were doing things, whatever, and along came a scenario with the money, ok? And this organization wanted to be the one that applied for the funding, and no this one thought they were the best ones to apply for the funding, this one thought they were the best ones to apply for the funding; I finally said 'I'm going home', because you know what? Nobody's going to get it. And guess what? It went another six or seven months, they died a natural death. And I'm not saying they weren't sincere at the table, but I think what it is, is the people that come to the table for those things as part of their job, as part of their mandate, they have to be out there hustling dollars to keep their organization (Interview, 2012).

This experience provides an example of how individual organizations were at the same table discussing how to improve care for seniors in an integrated manner, however when a funding opportunity was introduced, this integrated planning was lost.

When comparing the above experiences to the promotional material that the MOHLTC and NE LHIN provide to the public through their websites and media releases, the 'fault line' can be drawn as the way the MOHLTC and NE LHIN fund the healthcare

system does not match what they are portraying to the public/stakeholders. For example, the MOHLTC promotes that they are: "...working to establish a patient-focused, results-driven, integrated and sustainable publicly funded health system" (MOHLTC-About the Ministry, 2010), and the NE LHIN describes that their reason for being is: "To advance the integration of health care services across Northeastern Ontario by engaging our local communities" (NE LHIN- About Us, 2013). Based on the experiences that study participants described above, what the MOHLTC and NE LHIN say is very different from what they actually do, as the way that they fund services and programs maintains the presence of organizational silos which has shown to prevent integrated system planning at the local level. This method of funding at the 'high level' maintains an environment of system fragmentation at the 'local level' as service providers continue to plan and implement initiatives in an intra-organizational manner in order to gain access to funding. Based on this finding, the questions then become: How can integration occur at the 'local level' if it is not being supported and demanded through funding methods at the 'high level'? If providers are continuing to get funding while operating in a siloed manner, why would they change their behaviour?

4.2.4.2 MOHLTC and NE LHIN Policy/Legislation

Further to the above 'fault line', discrepancies have been found between the intentions of legislation that is developed and supported at the 'high level' by the MOHLTC and the NE LHIN including the 'Long Term Care Homes Act (2007) and the Assisted Living Services for High Risk Seniors Policy (2011), and study participants' experiences at the 'local level'. These 'fault lines' are described further below:

4.2.4.2.1 Long Term Care Homes Act (2007)

The 'fault line' between the intentions of the Long Term Care Homes Act (2007) which was implemented in July 2010 and the effect that it is actually having within the Sault Ste. Marie senior healthcare system can be seen through participants' experiences identified in the 'system gaps' section of this chapter. Specifically, study participants from the long term care sector explain that the intention of the Long Term Care Homes Act (2007) has been to increase the quality of care that seniors are receiving, however the idealistic nature of the Act is inhibiting administrators and front line service workers' from providing quality of care for seniors. One study participant explains: "*I mean the new Long Term Care Act is very idealistic, you can't argue with it, it's motherhood and apple pie, but it is really taking away resources from the bedside*" (Administrative Focus Group, 2012). This indicates that in addition to the lack of administrative funding attached to NE LHIN programs, the unrealistic nature of the reporting requirements within the LTCHA (2007) is also contributing to front line service workers being taken away from providing resident care. Further to these issues, study participants also indicated that the increased documentation

which is a result of the changes within the LTCHA (2007), has taken away the ability of long term care stakeholders to participate in system planning initiatives because of time constraints. The ‘fault line’ can be drawn here as the messaging that the MOHLTC and NE LHIN portray to the public concerning their mission to integrate the Ontario healthcare system (MOHLTC-About the Ministry, 2010; NE LHIN-About Us, 2013) contradicts the policy that they implement and support as it takes away from the ability for key stakeholders to participate in system planning initiatives. Although study participants explain that they do not believe that this was the intention of the LTCHA (2007), they report it as a negative unintended side effect.

4.2.4.2.2 Assisted Living Services for High Risk Seniors Policy (2011)

When reviewing the local experiences of study participants and comparing them to the Assisted Living Services for High Risk Seniors Policy (2011), the ‘fault line’ can be drawn as the intentions of this policy contradict some of the results that it is producing within the Sault Ste. Marie senior healthcare system. Specifically, this policy indicates that its intent is to:

Enable local communities to address more fully the needs of high risk seniors so that they are able to remain safely at home; Expand cost-effective and accessible options for community care; Reduce unnecessary and/ or avoidable hospital utilization and wait-times of acute care services, emergency room (ER) use, and admission to LTCHs; Provide Local Health Integration Networks (LHINs) with the flexibility to adapt to clients’ changing care requirements; and Strengthen assisted living services to achieve a more functional continuum of care for Ontario’s high risk seniors within each LHIN (MOHLTC- Assisted Living Services for High Risk Seniors Policy, 2011).

Although this policy has been successful in increasing services for high risk seniors, it has had two major unintended side effects at the local level including: creating a gap in service for low and medium needs seniors; and creating a healthcare system that does not recognize the importance of senior’s mental well-being. These gaps have been attributed policy influenced cuts to basic in-home care services, and changes to the structure of assisted living service delivery. These side-effects of the policy, although presumably unintended, have created a situation where seniors who were previously able to be maintained in their home with minimal supports, are no longer able to receive those supports. This issue results in these seniors needs escalating at a faster pace, which may cause them to end up in the hospital. Once again, this ‘fault line’ between the intentions of policy and the realities of policy shows how the MOHLTC and the NE LHIN say that they are implementing initiatives to improve care for seniors within the Ontario healthcare system (NE LHIN-Value

of the NE LHIN to Fellow Northerners, 2013; MOHLTC- Ontario's Action Plan for Health Care, 2011), but the legislation/policy that they implement contradicts this promoted goal.

4.2.4.2.3 Different Cross Sector Legislation

Further to the above two issues, study participants' local experiences indicate an additional 'fault line' between the MOHLTC and NE LHIN messaging/goals and the sector specific legislation that they implement/support. For example, the long term care sector is guided by the 'Long Term Care Homes Act (2007)', hospitals are guided by the 'Public Hospitals Act' (1990), and Community Care Access Centres are under the 'Community Care Access Corporations Act' (2001). Study participants identified that these acts can often contradict one another: *"So that's where the dichotomy sort of comes up between the Community Care Access Centre and the hospital, because we're under two different acts. And they sort of contravene one another"* (Interview, 2012). An example of how these two pieces of legislation clash can be seen in the messaging that they require service providers to give to seniors about care options when leaving the acute care sector: *"-Well, what messages they're hearing from the hospital, 'You have to make a choice. And if this bed's available at this long-term care facility, you must go'. The CCAC will come in and say, 'Well no, you don't have to go. You have a choice'"* (Interview, 2012). The 'fault line' can be drawn as the different messaging that these two sectors give to seniors contradicts the MOHLTC and NE LHIN goals of service integration and coordination because they create issues with integrated discharge planning. Because of legislative contradictions such as these, integrated system planning and initiative implementation can become difficult as each sector is focused on meeting the requirements of their own legislation, thereby promoting intra-sector planning and service delivery methods.

4.2.4.3 MOHLTC and NE LHIN Politically Driven Decisions

Further to the issues described above, a 'fault line' can be drawn between the messaging that the NE LHIN expresses about developing system priorities based on local stakeholder engagement (NE LHIN- About Us, 2013), and the experiences that study participants have had where system priorities are determined by politically driven decisions. An example of this 'fault line' can be seen within the Sault Ste. Marie senior system through the change in the 'Alternative Level of Care Plan for the City of Sault Ste. Marie' (May, 2011, revised February 2012). This plan was a collaborative report developed by the members of the ALC Solutions Group which identified a local plan for the transition of funding from institutional to community-based services. However, after the plan was submitted to and approved by the MOHLTC and the NE LHIN there was a change in political priorities which caused the new Behavioural Supports Ontario (BSO) initiative to take front stage. Without consultation from the ALC Solutions Group, the BSO initiative was moved from year four of the plan to year one of the plan in order to provide immediate funding. This resulted in resources being pushed aside that would have ensured a smooth

transition for patients from the old acute centre site to the community. One study participant explains:

I thought that the day hospital with the occupational therapy and physiotherapy resources might have helped with some of those people, but for all the reasons of political direction and needs I understand that the dollars went to BSO instead. But there are still the big concerns about the assisted living resources... (Non-Participant Observation, 2012).

This politically driven decision to change a community based plan which was developed in an integrated manner demonstrates how the NE LHIN and the MOHLTC ask stakeholders to participate in ‘integration’ (NE LHIN- We Want to Hear from You, 2013), but contradict the notion with their actions. One study participant voices their frustration:

You guys did say that you wanted to mention that you weren’t happy with the way that the BSO got rolled into it. ...if we are going to act as a committee, they have to listen to the committee, they can’t come and change the plan. It is community based, all the community hours into planning this, then they change it. Why bother asking us? (Non-Participant Observation, 2012).

This ‘line of fault’ creates a situation where stakeholders may be reluctant to come together to develop plans to improve the Sault Ste. Marie senior healthcare system because they may believe that the MOHLTC and the NE LHIN will end up going in their own direction, regardless of the identified needs of the community.

Summary of Chapter 4.0

The above chapter depicts the results of the research conducted within this study including local Sault Ste. Marie senior healthcare system gaps, diversity, enablers and obstacles to integration, as well as the desired end state established by study participants. Furthermore, this chapter presented high level obstacles to integration that were uncovered by comparing study participant’s local experiences to texts produced by government bodies. The following chapter will present a discussion of these findings.

5.0 Discussion

This chapter provides a discussion of the study results in relation to how they addressed the thesis objectives. It also provides an evaluation of these results through the conduct of a force field analysis (Lewin in Schein, 1996) including a proposed action plan for Sault Ste. Marie senior healthcare system leaders; a discussion of the chasm between macro level activities and micro level experiences; as well as a summary of the process that was used within this study to organize information to assist communities in constructing/selecting an integrated senior healthcare system model.

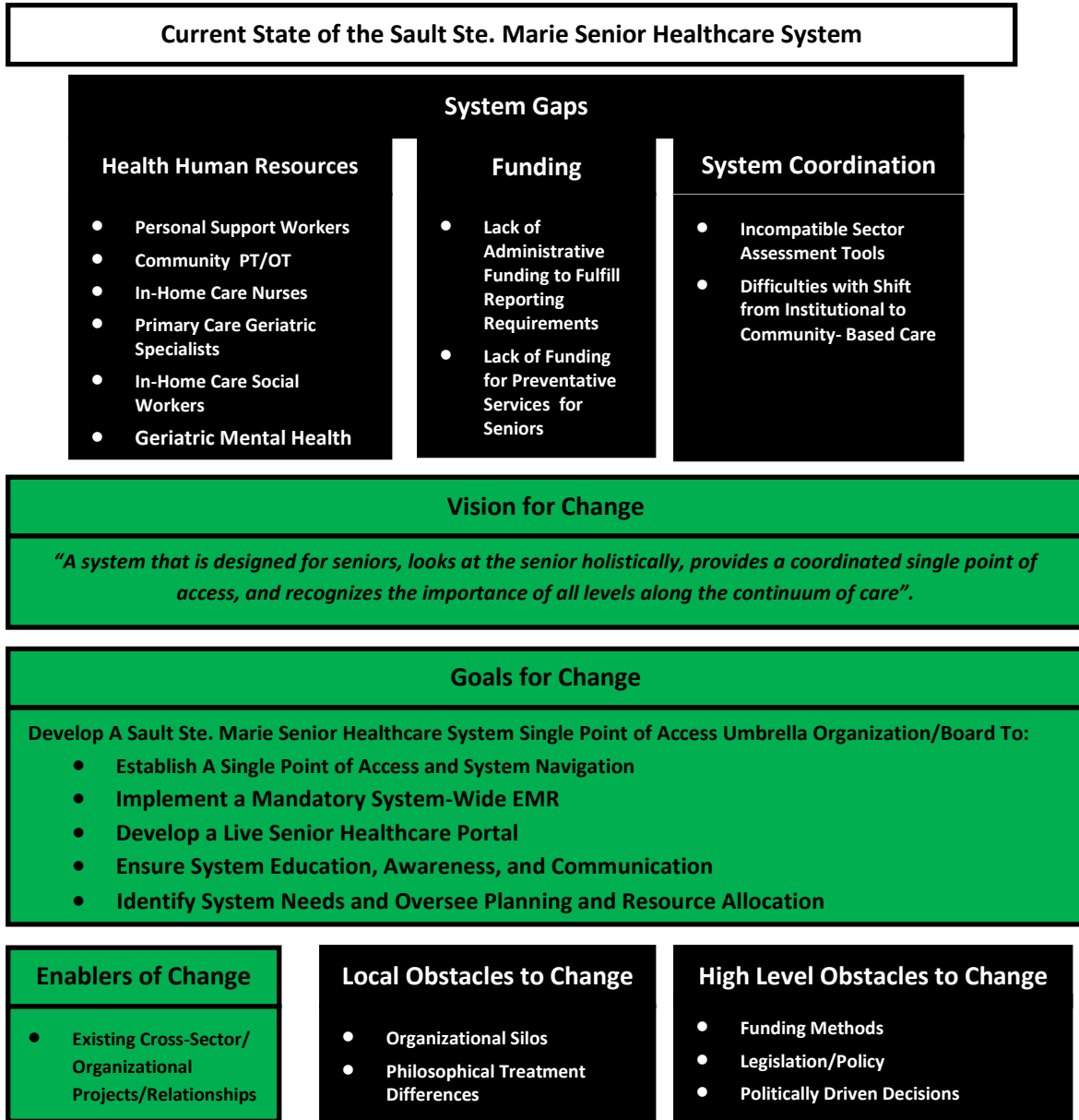
5.1 Review of Study Objectives

The overarching goal of this study has been to assist communities that are in need of senior healthcare system integration in developing an understanding of existing system gaps, diversity, and enablers and obstacles to integration within their local environments. This information is meant to accomplish two tasks: 1) Assist these communities in selecting or constructing a context sensitive integrated senior healthcare system model; and 2) Assist these communities in understanding the aspects that can be leveraged, and barriers that need to be addressed to enhance the success of the change effort. This process is intended to begin addressing gaps and problems found in literature that evaluates existing integrated senior healthcare system models including: the lack of a description of how to transfer the models to other communities; and difficulties that the models had with stakeholder resistance and environmental inappropriateness. To accomplish this, this study had the following objectives:

- 1) Use change management concepts as a lens to depict the current state of a specific community that is in need of an integrated senior healthcare system model.
- 2) Format/refine the information gathered from the first objective so it is useful for stakeholders in selecting or constructing a model that meets their specific needs.

To achieve these objectives, a change management framework adapted from the literature (Figure 1) was used to explore the senior healthcare system within Sault Ste. Marie, Ontario using an Institutional Ethnographic approach (Smith, 2005). Figure 11 provides an overview of the results of this exploration.

Figure 11: Overview of the Current State of the Sault Ste. Marie Senior Healthcare System

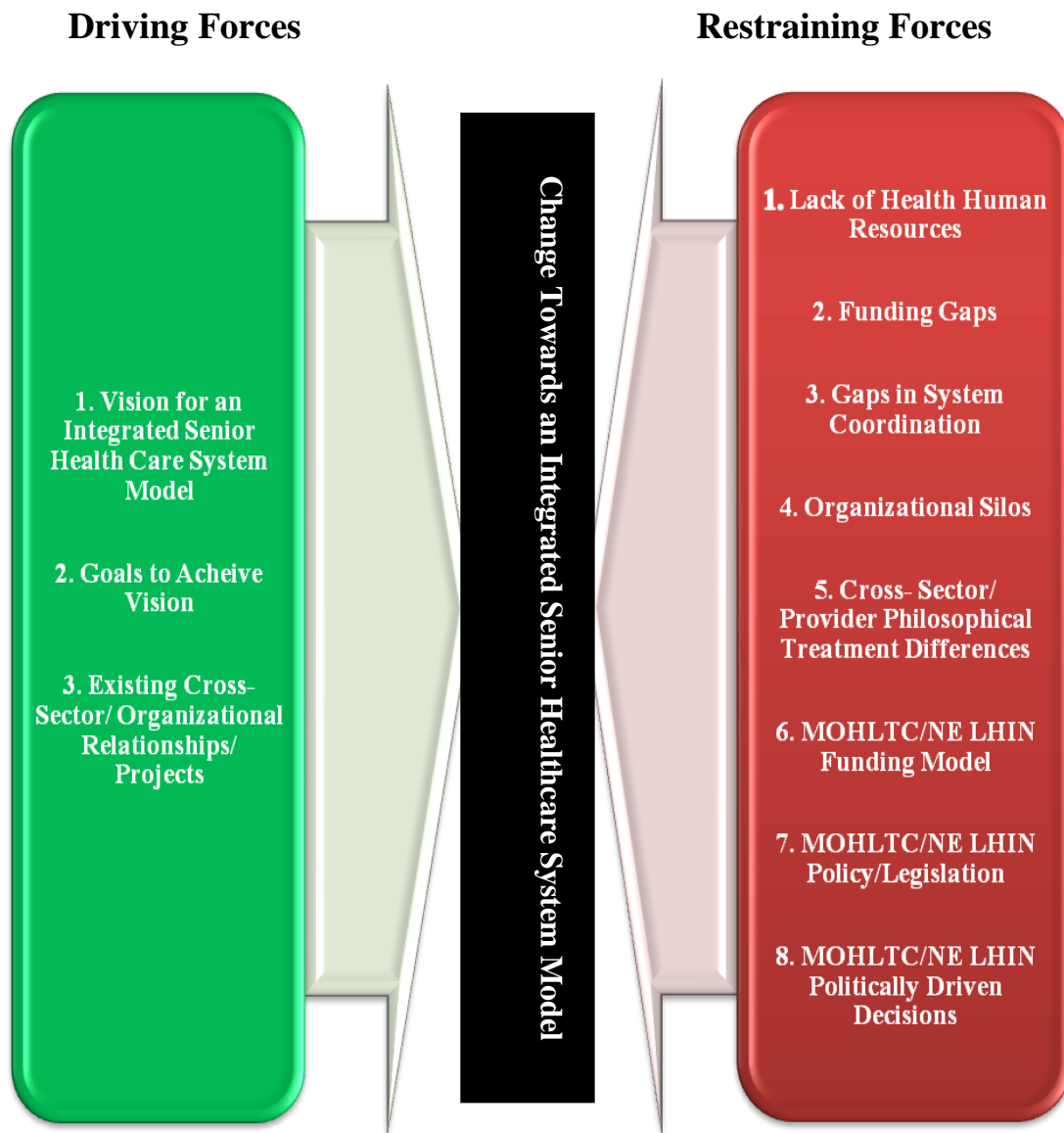


The data within figure 11, along with the inventory of services that has been developed (Appendix E) provides change leaders within Sault Ste. Marie with information that will assist in making informed decisions when moving forward with the established desired end state. To go beyond these results and provide change leaders with additional information, the following section presents an assessment of the driving and restraining forces surrounding the change towards an integrated senior healthcare system model within this community (Lewin in Schein, 1996).

5.2 Force Field Analysis

Lewin's force field analysis model (Lewin in Schein, 1996) provides a method of assessing the 'readiness' of the current Sault Ste. Marie senior healthcare system to accept the change towards an integrated model through the identification of the driving and restraining forces encircling this change. Driving forces: "...move toward a positive region and encourage the change to occur. Static forces that attempt to maintain the status quo are identified as restraining forces" (Bozak, 2003). Figure 12 provides a summary of this assessment.

Figure 12: Force Field Analysis



Based on the results depicted in figure 12 it is evident that there are many more restraining than driving forces, which indicates that the current Sault Ste. Marie senior healthcare system may not be ready for the change towards an integrated model. To address this problem and establish an environment for successful change: "...the driving forces must be strengthened in favour of the change while the restraining forces are weakened or eliminated" (Bozak, 2003). Therefore, to assist in moving forward with the identified vision and goals established by study participants, the following section proposes an action plan that focuses on strengthening the driving forces and weakening the restraining forces that are currently present within the Sault Ste. Marie senior healthcare the system.

5.3 Moving Forward- An Action Plan for the Sault Ste. Marie Senior Health Care System

This section proposes an action plan for moving forward with the change path identified by study participants in Chapter 4. This plan is based on the third and fourth stages of Golden's (2006) healthcare change management framework, and applies a collaborative approach to change by outlining the macro and micro level activities that should occur simultaneously in order for the proposed change to be successful. Table 6 provides a visual summary of the action plan.

Table 6: Sault Ste. Marie Senior Health Care System Action Plan

Stage	Step	Micro Level	Macro Level
Stage Three Part One: Broaden Support	Establish Project as a Priority and Change Leader Selection	X	X
	Communicate and Build Change Collation	X	X
Stage Three Part Two: System Redesign	Create an Operational Plan and Identify of Required Resources	X	X
	Establish Connections	X	
	Education and Awareness	X	
	Integrated Applications for Funding		X
	Forecasting of Cost Savings		X
	Reform of Existing Policy and Legislation	X	X

Implement, Reinforce, and Sustain the Change	Implement	X	X
	Monitor Performance	X	X
	Showcase Successes	X	X
	Reward Supporters	X	X
	Fine-Tune Systems	X	X

The following section describe table 6 in further detail.

5.3.1 Stage Three Part One: Broaden Support

The first part of stage three within Golden’s (2006) healthcare change management framework focuses on Broadening Support for the change which includes: establishing the change as a priority; change leader selection; communicating the vision; and building a coalition. The following section provides further description of how to apply these steps at both the micro and macro levels.

5.3.1.1 Establish Project as a Priority and Change Leader Selection:

- Micro Level:** The first step to begin moving forward with the identified vision and goals at the micro level is to establish this project as a priority among local level stakeholders. This can be accomplished through the review of this thesis by the ALC Solutions Group. Once the review is complete, the group can determine whether to move forward with the identified change design. If the review is favourable, the ALC Solutions Group should establish the project as a priority and begin selecting the change leaders who will drive it forward. As identified in the ‘enablers to integration’ section within the results, there are six different committees that are currently focusing on improving senior healthcare in Sault Ste. Marie. The membership of these committees should be reviewed to determine if there are existing change leaders that can be selected for this system-wide project. If change leaders cannot be pulled from existing committees, an expanded search should be conducted. The ‘change leaders’ who are selected need to be representative of each sector along the continuum of care. They need to have the ability to be ‘system thinkers’ who have significant influence within their respective sectors. Once the change leaders are selected, a committee for this project should be formed. This committee will need to be interconnected with the other existing committees within the Sault Ste. Marie senior healthcare system to ensure cooperative planning and communication. The new committee will need to be supported by a ‘project coordinator’ in order to ensure that the project moves forward. It is recommended that Community Support System Navigator fill this role.
- Macro Level:** The first step to move this project forward at the macro level will be to ensure that it is established as a priority with the NE LHIN and MOHLTC. This

project is aligned with current macro level strategic direction outlined in the following reports: NE LHIN 2013-2016 Integrated Health Service Plan (IHSP); Ontario's Action Plan for Health Care- Let's Make Healthy Change Happen (2012); Caring for Our Aging Population and Addressing Alternative Level of Care (2011); and Living Longer, Living Well (2013). Once this project is established as a NE LHIN priority, a change leader from the NE LHIN should be selected to be a part of the committee.

5.3.1.2 Communicate Vision and Build Change Collation:

- **Micro Level:** At the micro level, once the change leaders are selected and the committee is formed, the current vision and goals can be refined and expanded. This exercise is important as Kotter (1995) explains that the original vision in many change projects is the initial creation of a few key people: "But after the coalition works at it for 3 or 5 or even 12 months, something much better emerges through their tough analytical thinking and a little dreaming". Once the vision and goals are refined, the selected change leaders should begin communicating them to other key stakeholders in order to build a coalition for the change (Golden, 2006). Kotter (1995) explains that it is essential to have a powerful collation: "– in terms of titles, information and expertise, reputations and relationships", as these key stakeholders need to be able to convince other stakeholders that the change is necessary. The coalition and change leaders should continue to communicate the vision and goals through all available methods so that all stakeholders have a clear understanding of the change and why it is occurring (Kotter, 1995). This exercise will assist in increasing support and decreasing resistance among those who will be asked or required to change (Golden, 2006).
- **Macro Level:** To maintain and encourage ongoing support for the change at the macro level, the selected NE LHIN change leader should begin to build a guiding collation for the change within the NE LHIN by communicating the revised vision and goals to senior management and other colleagues. This process will ensure that the initiative remains a priority at the macro level and that the necessary connections among existing macro level projects are established.

5.3.2 Stage Three Part Two: System Redesign

System Redesign occurs simultaneously with the process of Broadening Support. It focuses on operationalizing the selected change design by ensuring that the system: "...is sufficiently aligned to support the change" (Golden, 2006). This is accomplished through the development of an operational plan and the identification of the resources necessary to support the plan. These processes are described further below.

5.3.2.1 Create an Operational Plan and Identify Required Resources

Creating an operational plan for the change focuses on identifying how the selected change path will become a reality. Developing this operational plan will be the responsibility of the selected change leaders and the project coordinator. Although the development of this plan occurs primarily at the micro level, it should be reviewed by the NE LHIN to ensure that it can be supported through alignment with macro level priorities. Golden (2006) explains that the operational plan should include the following elements:

- **Goals and Tasks:** What is the project trying to achieve and what are the specific tasks that will be undertaken to achieve it? What is the sequence of implementation? What are the timelines and deliverables for each phase of implementation? Who is accountable for these tasks?
- **Structure:** How will the single point of access umbrella organization/board be organized? Is the suggested structure (identified in Chapter 4) appropriate? Does it need to change?
- **Culture and Values:** What behaviours (culture and value) within the system will need to change in order for the project to be successful? How will this be accomplished?
- **People and Human Resource Management:** Will additional human resources be required? How can existing system resources be realigned to support the change? How will stakeholders current work processes need to change in order for this project to be successful? Are the necessary resources available?
- **Information and Decision Support:** How will this operational plan be communicated to all stakeholders?
- **Rewards:** What will stakeholders gain from this change? How will this value be expressed to them?

In addition to the above components, the findings of this study indicate that the following activities should be included within the operational plan in order to take advantage of the driving forces and address the restraining forces that are currently present within the Sault Ste. Marie senior healthcare system.

- **Establish Connections:**
 - **Micro Level:** As part of the operational plan, the single point of access/umbrella organization should take on the role of beginning to build connections among the existing senior healthcare projects outlined in the ‘enablers to integration’ section of Chapter 4. This is important as study

participants have identified that there is duplication in planning within the current system, which has resulted in the inefficient use of existing resources. Through the establishment of these connections, the umbrella organization/board can include and leverage existing projects by aligning them with the goal of establishing a single point of access.

- **Education and Awareness:**

- **Micro Level:**

- **Community of Practice:** In order for the single point of access umbrella organization/board to be successful, philosophical treatment differences among acute and community stakeholders will need to be broken down to encourage successful transitions across levels of care. To accomplish this, the literature suggests establishing a ‘Community of Practice (CoP)’ to create opportunities to enhance quality of care among providers through sharing of information and experiences (White et al, 2008). Through CoPs service providers from different health professions meet to discuss: “current practice and to identify areas for improvement” (White et al, 2008). This type of platform can serve to strengthen inter-service provider understanding of cross-sector circumstances, which in turn could begin to build trust and communication among these individuals (White et al, 2008). A specific entity that could assist the single point of access umbrella organization/board in establishing a CoP within Sault Ste. Marie is the ‘Seniors Health Knowledge Network” (see Appendix F for further information about this organization).
- **Inter-Service Provider Training Sessions:** Another activity that will be essential to the success of the single point of access/umbrella organization is the increase of trust among providers in relation to the cross-sector RAI Assessment Tools. Therefore, an activity that should be included in the operational plan is inter-organizational/service provider RAI training and education sessions (Reeves et al, 2008; Suter et al, 2009). These sessions should focus on creating understanding of cross-sector circumstances in relation to the information that is recorded in the RAI Assessment Tools. For example, long term care providers should attend RAI-MDS sessions with hospital and Community Care Access Centre staff so that service providers can begin to build an understanding of how these assessments are completed in various settings. Staff can then provide

insight into what information is needed in order for successful transfers to occur across sectors.

- **Community Education Conference:** In addition to the above activities, the success of the single point of access umbrella organization/board will be enhanced by increasing awareness of the services that currently exist within the Sault Ste. Marie senior healthcare system. To accomplish this, the operational plan should include a ‘community education conference’ where stakeholders from across the system are able to present and share information about their existing services. During this event, a ‘brainstorming’ period may want to be held where stakeholders are able to sit together in groups and come with up ideas for cross-sector/organization linkage. The inventory of services that has been produced through this study (Appendix E) can be used as an information starting point to organize this event. These activities may assist in increasing system coordination, thereby weakening this restraining force.
- ***Integrated Applications for Funding:***
 - **Macro Level:** To weaken the presence of organizational silos and increase the success of the single point of access umbrella organization/board, the NE LHIN may want to consider asking organizations to develop integrated applications for funding when new initiatives are implemented within the system. Through this activity, organizations may achieve a greater understanding of how their services inter-connect, while at the same time, being able to obtain funding to implement initiatives that will assist in making these connections a reality.
- ***Forecasting of Cost Savings:***
 - **Macro Level:** The NE LHIN may also want to implement a process that forecasts the estimated cost savings that will be realized at the end of each fiscal year within the Sault Ste. Marie senior healthcare system. This information would allow macro level system planners to be proactive in the reinvestment of the funding within the community. This proactive approach would enable the assessment of the system as a whole, which could result in funding of initiatives that would move the integration of the system forward. The single point of access umbrella organization/board will be an excellent resource that the NE LHIN could use to determine where the additional funding could applied, as this organization would be responsible for

identifying local system-wide gaps and potential integration initiatives to address them.

- ***Reform of Existing Policy and Legislation:***

- **Micro and Macro Level:** Using the data produced within this study, the single point of access umbrella organization/board should take on the role of alerting the MOHLTC about the issues that the LTCHA (2007) and the Assisted Living Services for High Risk Seniors Policy (2011) are causing on the front lines. It will be important for Sault Ste. Marie change leaders to bring these issues forward in a united manner, indicating that it is not just one organization or service provider that is experiencing them. This united voice may have more impact on the willingness of the MOHLTC to review and revise the policies.

Once the operational plan is developed and approved at both the micro and macro levels, the process of implementation and sustainability begins. The following section describes the activities involved in this process.

5.3.3 Implement, Reinforce, and Sustain the Change

The fourth stage within Golden's (2006) healthcare change management framework focuses on implementing, reinforcing, and sustaining the change. Because establishing a single point of access umbrella organization/board is a large system wide initiative, the tasks and activities outlined in the operational plan will need to be implemented in phases to ensure proper uptake by all stakeholders. It will be important to implement 'quick wins' first, so that stakeholders are able to see the valuable impact of the change right away. This recognition of value will increase buy-in to the initiative and allow leaders to move forward with larger portions of the change as time goes on. When a phase is successfully implemented, it will be important to showcase successes at both the micro and macro levels to continue to broaden support for the initiative. Stakeholders who have participated in the success of the change should be rewarded to encourage similar behaviour in future phases. After each phase of implementation, the process should be evaluated and adjustments made according to the needs of the stakeholders.

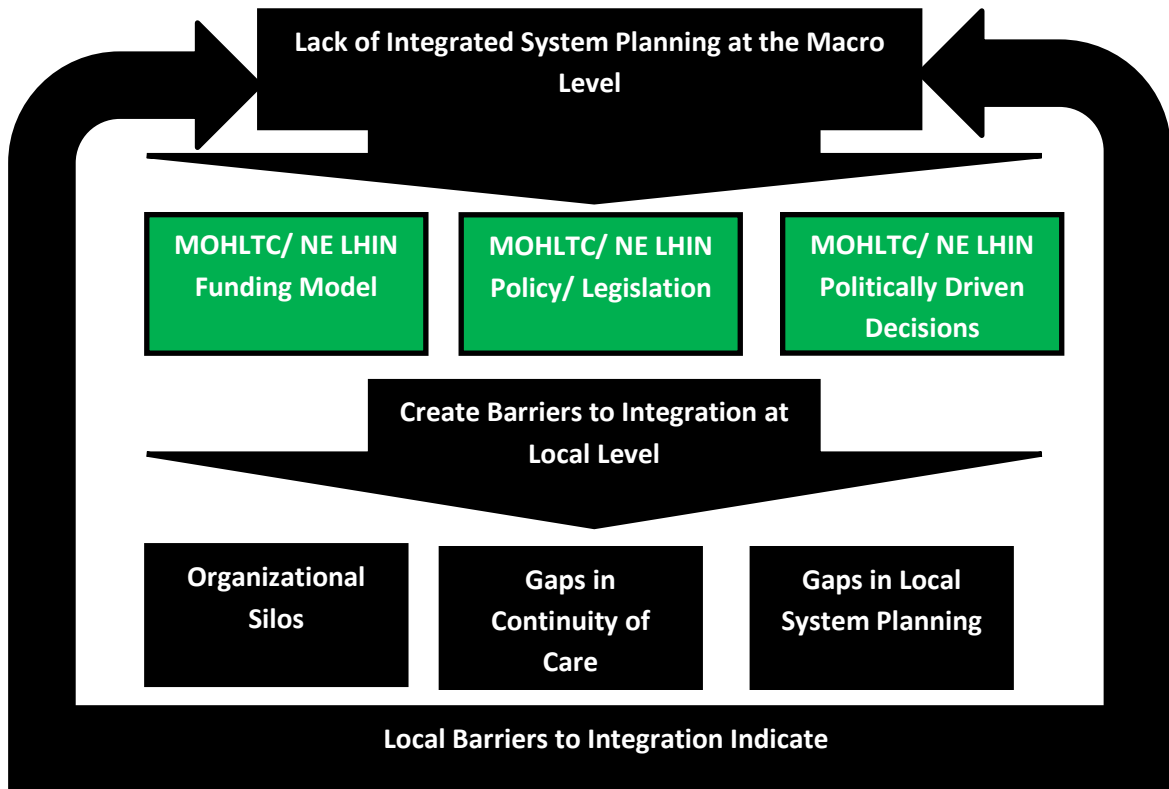
Section 5.3 describes the steps that change leaders in Sault Ste. Marie should embark upon in order to proceed with the operationalization of the vision and goals identified by participants within this study. Although this action plan will assist stakeholders in achieving the desired end state, the significance of the macro level obstacles to integration need to be recognized as they may be the largest issue that change leaders will have to overcome. The following section provides further insight into this issue.

5.4 The Macro-Micro Chasm

Within section 5.3, many of the identified restraining forces to change and the suggestions for addressing them are commonly found in change and integration literature (Hollander, 2009; Kotter, 1995; Suter et al, 2009). What is lacking in this body of knowledge is information that provides detailed examples of some of the changes that need to occur at the macro level in order for successful integration to be accomplished at the micro level (Hollander, 2009; Kotter, 1995; Suter et al, 2009). This study extends this knowledge through the ‘fault lines’ that were uncovered in relation to the discrepancies between study participants’ experiences and the texts that are produced by government bodies. These findings indicate that macro level activities are continuing to preserve the following obstacles to integration at the local level: 1) Local organizational/cross-sector silos are being maintained through macro level funding methods; 2) Implementation/ support of specific legislation/policy is creating continuity of care issues at the local level; and 3) Politically driven decisions are impeding local integrated planning initiatives.

The creation and maintenance of the above local obstacles to integration through high level activities indicates that there may be a lack of integrated system planning at the MOHLTC and NE LHIN level, as some of the decisions that they are making are causing negative ripple effects throughout the micro system. Based on this insight, the question then becomes: *“How can you have an integrated micro system when you don’t have integrated planning at the macro level?”* The answer to this question can be mirrored in the following quote from Kotter (1995): “Nothing undermines change more than behaviour by important individuals that is inconsistent with their words”. This meaning that the MOHLTC and NE LHIN need to ‘walk the walk’ in terms of integrated macro level planning and initiative implementation in order to create an environment where integration can successful occur at the local level. Without this macro level change, it will be difficult to break down the local barriers to integration as ‘integration behaviour’ is not a requirement to receive funding, continue to exist as an organization, or deliver care within the present micro environment. Rather, the current reward system continues to preserve a local behaviour of intra-organizational planning and service delivery, and as Wilson (1995) explains, without a rewards system that reinforces the desired behaviour, change is not likely to occur. Figure 13 provides a summary of this problem.

Figure 13: How Macro Level Activities Impede Micro Level Integration Capability



5.5 Solutions to the Macro-Micro Chasm

To begin addressing the problem outlined in figure 13, the suggestions for the MOHTLC and NE LHIN presented in the section 5.3 may be a possible starting point. However, the questions become: *“How easy is it to create change at the macro level?”* and *“What are the barriers to change?”* One thing that needs to be taken into consideration when exploring these questions is the notion that the Ontario healthcare system is rooted in a four year political cycle. This means that every four years there is the potential that the political party in power may change, which means political priorities will also change (Joyce, 2000). For example, under the current government, ‘Ontario’s Action Plan for Health Care’ (2012) identifies that the MOHLTC should focus on system integration through the reform of the LHINs. However, what will happen if this party gets voted out and the Conservatives come into power? Will the focus of ‘integration through the LHINs’ be lost? Based on current media, the answer to this question is ‘yes’ as the Conservatives state that: *“The province should get rid of them, along with 2,000 “middle managers,” and use that money to hire more doctors and nurses”* (CBC News, September 2012). Therefore, the significant investment that the current government has made in the LHINs will be lost. This example indicates that the macro level healthcare system is an environment of constant change and uncertainty, and because of this, the changes suggested within this study may be

difficult to achieve. As Kotter (1995) explains, successful change takes time: “Until changes sink deeply into a company’s culture, a process that can take five to ten years, new approaches are fragile and subject to regression”.

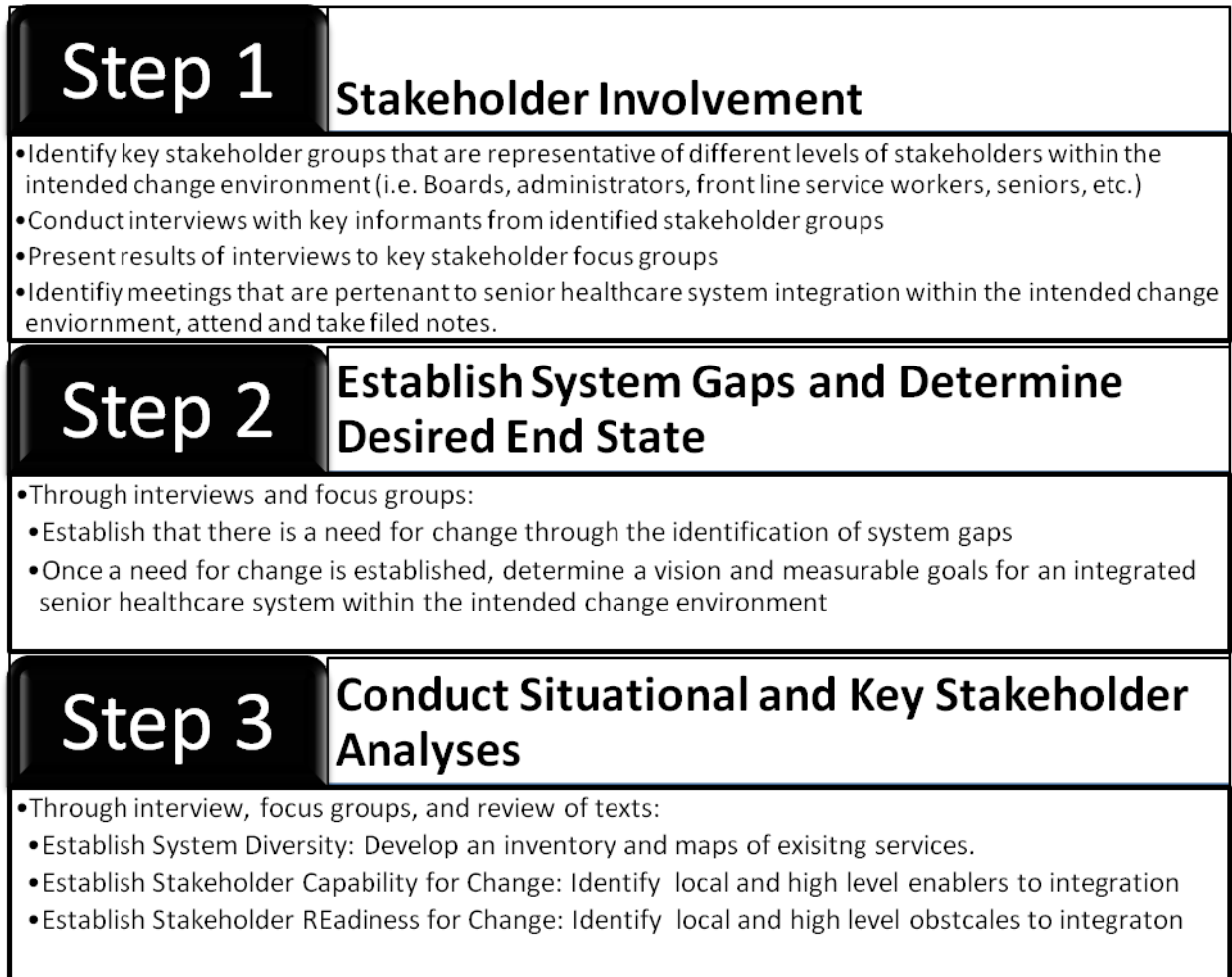
Because Ontario healthcare system costs are consuming the majority of the current budget (Commission on the Reform of Ontario’s Public Services (Drummond Report), 2012), parties who are attempting to gain or maintain power within this four year political cycle continue to use it as their main bargaining chip for voter affection. The New Democratic Party (NDP) says they will: “ensure the system is sustainable” (NDP, 2012), the liberals say they will build a: “successful Aging at Home strategy to reform the health care system” (Forward Together, 2011), and the Conservatives say they will: “...enhance patient quality and satisfaction, improve the health of the population” (Paths to Prosperity, 2012). However, if these political parties truly believe in the words that they are saying, wouldn’t they work together to create a long-term consistent plan for sustainable healthcare in Ontario that is not influenced by political will, but is rooted in the healthcare needs of Ontarians? This long term plan is exactly what has been suggested by the Drummond Report (2012) which explains that healthcare reform needs to include financial incentives from the government that will encourage change towards integration, and that the first step to doing this is: “...a long-term view. The government must set out a 20-year plan with a vision that all Ontarians can understand and accept as both necessary and desirable—a plan that will, though it involves tough decisions in the short term, deliver a superior health care system down the road”. This type of plan must transcend the political nature of the healthcare system and be supported by all parties to ensure that change towards integration can be successfully sustained over time at both the micro and macro levels.

The above sections describe the complexity of change and integration within healthcare by presenting in-depth information about the current state of the Sault Ste. Marie senior healthcare system at both the local and high levels. This information will assist change leaders in understanding the issues that should be taken into consideration when moving forward with the development and implementation of the established desired end state. The approach used within this study to gather and organize this information may be a process that could be applied by other communities who are in need of senior healthcare system integration. In light of this, the following section presents a general overview of the study phases.

5.6 General Approach for Organizing Information for Senior Healthcare System Model Construction/Selection

This section outlines the general approach that was used within this study to collect and organize information to assist in making informed decisions during senior healthcare system model selection/construction (Figure 14).

Figure 14: General Approach for Organizing Information for Senior Healthcare System Model Construction/Selection



Although the approach depicted in figure 14 is not superior to others suggested within the literature (Golden, 2006; Balogun and Hailey, 2008), this study has provided an in-depth example of how it has been applied in a real life setting. Therefore, this thesis may act as a useful road map for other communities who are interested in gathering and organizing information that will assist them in making an informed decision when selecting or constructing an integrated senior healthcare system model.

6.0- Conclusion

The need for integration within senior healthcare systems has received much attention and support from Canadian and international researchers. As a result, several integrated senior healthcare system models have been developed such as PRISMA, SIPA, PACE, and S/HMO. Although these models have been somewhat effective in increasing continuity of care, they did not perform as well as expected due to implementation problems relating to stakeholder resistance and environmental inappropriateness. Furthermore, descriptions of these models currently lack information that explains how they were selected or constructed for the specific communities that they were implemented within. These issues create barriers for regions that are in need of a model to support senior healthcare system integration, as they lack an implementation road map to follow that describes how to overcome the problems that existing models have faced.

To address these issues, and to assist the community of Sault Ste. Marie in making an informed decision when moving forward with the change towards an integrated senior healthcare system model, this study accomplished the following:

- 1.** Identified Sault Ste. Marie senior healthcare system gaps, diversity, and obstacles and enablers to integration.
- 2.** Established a preliminary vision and goals for an integrated senior healthcare system within this community.
- 3.** Presented a force field analysis that identified the specific aspects within this system that can be leveraged, and the barriers that need to be addressed to encourage a successful change effort.
- 4.** Proposed an action plan that outlines steps that Sault Ste. Marie change leaders can follow to implement and sustain the selected change path.
- 5.** Uncovered macro level obstacles to integration that are currently impeding the change towards an integrated senior healthcare system model in Sault Ste. Marie.
- 6.** Provided a general approach to assist in integrated senior healthcare system model selection/construction that can be adapted to other communities in need of this change.

Through the above research, this study has provided in-depth examples of the challenges to achieving integration within healthcare. Using institutional ethnography as a method of inquiry allowed me to gain further insight into these challenges and provide richer descriptions of them by rooting the research in the experiences of study participants, and situating myself within the environment under study.

6.1 Research Implications

Through the connection of the trans-local relations of study participant's experiences within the Sault Ste. Marie senior healthcare system, this thesis has provided in-depth descriptions of system gaps, enablers, and obstacles integration. Through these descriptions, this research offers a deeper understanding of these aspects than is present within the current literature (Hollander, 2009; Suter et al, 2010) by adding context to the notion of integration through the application of a diagnostic change process in a real life setting. Furthermore, by taking study participant's experiences and comparing them to texts produced by the MOHLTC and the NE LHIN, this study provided an in-depth analysis of some of the macro level activities that are impeding healthcare integration at the local level. Because many of the identified obstacles to integration within this study are common in the literature (Hollander, 2009; Suter et al, 2010), it can be assumed that the same type of problems will be found in other communities. However, what would be interesting to explore is the presence of macro level obstacles to integration in other communities, as the literature indicates that 'politics' can be a barrier to change (Joyce, 2009), but lacks in-depth descriptions or examples that explain why. Questions to ask in future research might include: Would the macro level obstacles experienced by study participants be mirrored in other communities? Would a larger urban setting have different experiences than the smaller community of Sault Ste. Marie? Are the MOHLTC and NE LHIN aware of the impact that some of their decisions are having on the front lines?

6.2 Stakeholder Implications

This thesis has produced rich information that will assist the community of Sault Ste. Marie in making informed decisions when moving forward with the change towards an integrated senior healthcare system model. Through this research, study participants identified the following vision and goals to direct this initiative:

1. **Vision:** *"A system that is designed for seniors, looks at the senior holistically, provides a coordinated single point of access, and recognizes the importance of all levels along the continuum of care"*.
2. **Goals:** To achieve the above vision, an umbrella organization/board should be created that would provide direction to all organizations and stakeholders within the Sault Ste. Marie continuum of care through:
 - The establishment of a single point of access and system navigation;
 - The implementation of a mandatory system-wide electronic medical record;
 - The development of a live senior healthcare portal;
 - System education, awareness, and communication; and

- System needs identification, planning, and resource allocation.

In addition to the above recommendations from study participants, further assessment of the driving and restraining forces to change within the Sault Ste. Marie senior healthcare system resulted in the following recommendations for change leaders:

3. Establish the project as a priority and select change leaders;
4. Communicate and build a change coalition;
5. Create an operational plan and identify required resources;
6. Establish connections among existing senior healthcare relationships/projects;
7. Create a Community of Practice and hold a community education event to increase awareness and understanding of existing services and delivery methods among stakeholders;
8. The NE LHIN should require integrated applications for project funding from senior healthcare organizations to promote an environment that encourages ‘integration behaviour’;
9. The NE LHIN should begin forecasting potential year end cost savings to ensure the proactive use of funds;
10. Sault Ste. Marie change leaders should alert the MOHLTC about the issues that existing legislation is causing on the front lines; and
11. Implement, reinforce, and sustain the change by monitoring performance, showcasing successes, rewarding supporters, and fine-tuning systems.

Further to the above information, stakeholders within the community of Sault Ste. Marie now have access to an inventory of their existing services. This inventory should be further analyzed to determine how the current system can be realigned using their existing resources as efficiently and effectively as possible (Balogun and Hailey, 2008).

This study can also be beneficial to stakeholders outside the community of Sault Ste. Marie who are in need of senior healthcare system integration as it has provided the following:

- 1) Identified areas to explore when organizing information to select/construct the appropriate integrated senior healthcare system model. For example, exploring the intended change environment and stakeholders within that environment.
- 2) Illuminated the specific information that should be extracted from the identified areas. For example, using a change management lens to depict the diversity,

capability of stakeholders to manage the change, and stakeholders' readiness for change.

- 3) Demonstrated how to increase readiness for the change towards an integrated senior healthcare system model during the diagnostic phase of this change by involving stakeholders in the process.

6.3 Policy Implications

The results of this study have identified that macro level activities within the Ontario healthcare system are impeding integration at the local level by preserving organizational silos, creating continuity of care issues, and obstructing local integrated planning. Through the identification of these issues, this study has been able to provide specific examples that can be used to describe the problems to the MOHLTC and the NE LHIN. It is the hope that through this understanding, it will become clear that the Ontario healthcare system requires a long term political vision and not one that is continually influenced by political upheaval.

6.4 Patients, Families, Community Implications

Many communities within Canada are still in need of continuity among senior healthcare services to increase quality of patient care, access to care, and patient flow through the various levels of care (MacAdam, 2008). This study has produced an inventory of services that depicts the general organization of the Sault Ste. Marie senior healthcare system which may assist patients, their families, and members of the community in navigating that system. This ability to navigate the system may create awareness of what services exist along the continuum of care, which may assist in helping system users to find the appropriate level of care for their needs rather than going to the hospital for these services.

6.5 Limitations

This thesis has several limitations that should be noted. First, the data collected within this study is only a snapshot in time of the experiences and beliefs of stakeholders with the Sault Ste. Marie senior healthcare system. Overtime, as situations change, the beliefs and experiences of stakeholders will change as well. Therefore, before stakeholders use the data within this study, it may be beneficial to review it again to ensure that it is still relevant to the current situation. A further limitation of this study is the limited number of participants within the administrative focus group. Although this session provided rich data that confirmed much of the results from the key informant interviews, it would have been beneficial to have all of the members of the ALC Solutions Group there to provide their input. Furthermore, this study did not include all stakeholder groups that would be affected by the change towards an integrated senior healthcare system model. Groups that were not consulted include government officials, patients/clients, and friends/families. Therefore, it

would be beneficial to review the results of this thesis with these other stakeholder groups to determine common and diverging experiences. Specifically in relation to patients/clients, the city of Sault Ste. Marie is currently attempting to achieve 'Age Friendly' status from the World Health Organization, and has conducted a study with seniors which reviewed their experiences with the current healthcare system. It would be beneficial to do a cross analysis of the results these two projects.

6.6 Future Areas of Research

To build on the results of this study, three future areas for research should be considered. The first being the exploration of macro level activities that are impeding integration within other communities. The institutional ethnographic approach of drawing 'fault lines' is an excellent way to identify these macro activities through the analysis of local stakeholders' experiences in relation to text produced by government bodies. The second area for future research could be to apply the approach summarized in figure 14 within other communities that are in need of an integrated senior healthcare system model and compare the results to those within this thesis. The third area for future research would be to actually use the results within this study to implement the established desired end state in the Sault Ste. Marie senior healthcare system. For example, the inventory of services could be used to develop a model of service delivery under the new umbrella organization. Furthermore, the results of the force field analysis could be used to develop a strategic plan for model implementation. These implementation processes could be studied and reviewed to determine if the results of this thesis actually assisted in decreasing stakeholder resistance and environmental inappropriateness.

6.7 Reflection of Contributions

This thesis has provided in-depth insight into the experiences that administrative and front line stakeholders are having within the current healthcare climate. Reflecting on these experiences has resulted in adding context to the ideal of integration by providing real life examples of how this change can impact stakeholders. Although this thesis resulted in the identification of many barriers to integration at both the micro and macro levels, it also demonstrates the commitment and drive of stakeholders to improve the current healthcare system for the benefit of their clients/patients. When moving forward, we need to recognize and leverage these activities through appropriate reward systems and integrated planning at the macro level. Those who spend their everyday lives working with seniors deserve a healthcare system that allows them to do their jobs more effectively in order to provide the best possible care for Ontario's aging population.

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Appendix A: Ethics Approval Letters

University of Ottawa Research Ethics Board

File Number: H08-11-12

Date (mm/dd/yyyy): 10/26/2011



Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

Ethics Approval Notice

Health Sciences and Science REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Craig	Kuziemy	School of Management / School of	Supervisor
Samia	Chreim	School of Management / School of	Co-Supervisor
Jennifer	McKenzie	School of Management / School of	Student Researcher

File Number: H08-11-12

Type of Project: Master's Thesis

Title: Change and Integration in Senior Health Care Systems: The Case of Sault Ste. Marie

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
10/26/2011	10/25/2012	Ia

(Ia: Approval, Ib: Approval for initial stage only)

Special Conditions / Comments:

N/A

1

550, rue Cumberland, pièce 154
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Université d'Ottawa **University of Ottawa**
Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove subjects from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at: http://www.rges.uottawa.ca/ethics/application_dwn.asp

Please submit an annual status report to the Protocol Officer four weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at: http://www.rges.uottawa.ca/ethics/application_dwn.asp

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: ethics@uOttawa.ca.

Joint Group Health Centre/Sault Area Hospital Research Ethics Board

February 6, 2012

Ms. Jennifer McKenzie, MSc Health Systems Candidate
Telfer School of Management
University of Ottawa
55 Laurier Avenue East
Ottawa, ON K1N 6N5

Dear Ms. McKenzie;

The Joint Group Health Centre/Sault Area Hospital Research Ethics Board met on January 5th, 2012 to review the study identified as **Change and Integration in Senior Healthcare Systems: The case of Sault Ste. Marie**. The Letter of Information: Semi-Structured Interview, Letter of Information: Focus Groups, Focus Group Guide received unconditional, unanimous, full board approval.

Conditional approval was given for The Joint Group Health Centre/Sault Area Hospital Research Ethics Board Protocol, the Semi-Structured Interview Protocol, Semi-Structured Interview Consent Form, and the Focus Group Consent Form upon the following changes.

Addition of the contact information below to the:

Semi-Structured Interview Consent Form, and the *Focus Group Consent Form*: Insert on the last page, prior to signatures.

- If you have any questions about your rights as a research participant or the conduct of the study you may contact “(omitted for privacy reasons).

Correction of the word ‘Confidentially’ to ‘Confidentiality’ in 3 locations:

1. Semi-Structured Interview Consent Form:
 - First page under “**Risks:**” at the end of the paragraph: “...your organization as described in the ‘~~confidentially~~ “confidentiality” and anonymity’ section below.”
 - Second page under “**Confidentiality and anonymity**” “The ~~confidentially~~ “confidentiality” of the information that you share will be ensured...
2. Focus Group Consent Form:
 - under “**Confidentiality and anonymity**” within the paragraph: ... “The ~~confidentially~~ “confidentiality” of the information that you share will be ensured...

3. Page 12 of the “Joint Group Health Centre/Sault Area Hospital Research Ethics Board Protocol”
 - under “**Focus Group:**” While ‘~~confidentially~~’ “confidentiality” cannot be guaranteed...

The chairperson of the Joint GHC/SAH Research Ethics Board has received the above-submitted revisions. The conditions for approval have been met and expedited approval has been given for the Joint Group Health Centre/Sault Area Hospital Research Ethics Board Protocol Version 2, January 5, 2012, Semi-Structured Interview Consent Form Version 2 January 5, 2012, and Focus Group Consent Form Version 2 January 5, 2012. Approval is valid for the period of one year ending January 5, 2013.

No changes, amendments or addenda may be made in the protocol or the consent form without the Research Ethics Board review and approval.

The Joint Group Health Centre/Sault Area Hospital Research Ethics Board is constituted and functions in accordance with the ICH GCP and the Tri-Council Policy Statement guidelines.

Yours sincerely,

Dr. Brian Mitchell, Delegated Chair
Joint Group Health Centre/Sault Area Hospital
Research Ethics Board

BM/ml

North East Community Health Network Ethics Committee Approval

Dear Jennifer Mckenzie:

On behalf of Robert Barnett, Chair of the North East Community Health Network (NECHEN), I wish to advise you that our members have reviewed the documents related to the Change and Integration in Senior Health Care, the case of Sault Ste Marie.

There were no questions regarding your proposed study.

NECHEN therefore gives your proposed research study a positive ethical review.

Best of luck in your research and Regards,

Micheline Groulx
Executive Assistant, Strategic Planning and Integration
for

Robert Barnett, Director, Strategic Planning and Integration

Chair, NECHEN (the Ethics Committee)

North East Community Care Access Centre/
Centre d'accès aux soins communautaires du Nord-Est
40 Elm Street, Suite 41C Sudbury, Ontario P3C 1S8
Tel./tél: 705-522-3460 x 4426
Toll

Appendix B: Letters of Information and Consent to Participate Forms

Non-Participant Observation Recruitment and Consent Forms

Dear Member of the Sault Ste. Marie & Area NE LHIN ALC Solutions Group,

At the next Sault Ste. Marie & Area NE LHIN ALC Solutions Group meeting on November 17th, 2011, Jennifer McKenzie, a Masters Student in the Health Systems Research program from the University of Ottawa will begin to conduct research for her study that is investigating integration within Sault Ste. Marie's senior health care system using change management concepts. During this meeting, Jennifer will be taking detailed filed notes of her observations. As a member of the Sault Ste. Marie & Area NE LHIN ALC Solutions Group you are being asked to become a participant in this study. If you choose to participate please read, sign, and email Jennifer the attached consent to participate form. If you do not wish to participate in the study you do not have to sign the form, and Jennifer will not record any of her observations of your conduct or input during the meeting. Should you choose not to participate, please email Jennifer to let her know. Your participation in this study is strictly voluntary. Further information about the non-participant observation that will be conducted by Jennifer during Sault Ste. Marie & Area NE LHIN ALC Solutions Group meetings can be obtained by contacting Jennifer using any of the methods listed below.

Thank you very much,

Jennifer McKenzie
MSc Health Systems Candidate
University of Ottawa
Telfer School of Management

Invitation to participate: You are invited to participate in the above mentioned research study conducted by Jennifer McKenzie in fulfillment of the requirements for the Masters of Science in Health Systems Program at the University of Ottawa.

Purpose of the study: The purpose of this study is to use change management concepts to overcome implementation obstacles from existing integrated senior healthcare system models, and to organize information that will assist communities in selecting an integrated senior healthcare system model that meets their unique needs.

Participation: You are asked to participate in non-participant observation sessions that will be conducted during the Sault Ste. Marie & Area North East Local Health Integration Network Alternative Level of Care Meetings that take place from November 17, 2011 until the completion of the data collection phase of this research project. Your participation will consist of allowing the researcher to take field notes of the conversations that occur during the meeting.

Risks: Your participation in this study will entail that you volunteer all of the information that you express during the meeting. You may also volunteer information about your organization, the services that are offered, as well as information about your organization's relationships with other organizations. In addition, you may also volunteer your opinion concerning the enablers and obstacles of integration in Sault Ste. Marie's senior healthcare system. Because the name of Sault Ste. Marie will be used in the final written report, your anonymity may not be able to be guaranteed because of the small sample size. In an effort to mitigate these risks, if requested, pseudonyms will be used for your name and the name of your organization in written reports as described in the 'confidentiality and anonymity' section below.

Benefits: Your participation in this study will benefit you organization as well as the community by providing information that will assist in selecting an integrated senior healthcare system model that will create continuity of services to increase access and quality of care for seniors, their families, members of the community, and service providers.

Confidentiality and anonymity: Please fill out the section below to indicate your preference concerning anonymity:

Use pseudonyms for my name	Yes	No
Use pseudonyms for the name of my organization	Yes	No

Since it is common for research based on non-participant observations to report quotations from participants, if requested, your name and the name of your organization will be disguised through the use of pseudonyms in written reports. However, because the name of Sault Ste. Marie will be used in the final written report, your anonymity may not be able to be guaranteed because of the small sample size. If you have indicated that you do not wish for your identity and the identity of your organization to be concealed, your anonymity and the anonymity of your organization will not be guaranteed. The confidentiality of the information that you share will be ensured by keeping the non-participant observation field notes on the student researcher's password secured computer in the locked office of the student researcher throughout the duration of the project (November 1, 2011 to September 30, 2012). Only the student researcher and the thesis supervisors will have access to the field notes.

Conservation of data: The data collected consisting of the non-participant observation field notes will be transferred to a flash disk and secured in a locked cabinet in the thesis supervisor's office located on the University of Ottawa Campus for a period of five years (October 1, 2012 to October 1 2017) and then it will be deleted.

Voluntary participation: You are under no obligation to participate and if you choose to participate, you can withdraw from the study at any time. If you choose to withdraw, all data gathered until the time of withdrawal will be used for the purpose of the analysis. Should you choose not to participate this choice will not be revealed to anyone.

Acceptance: I, _____, agree to participate in the above research study conducted by Jennifer McKenzie of the Telfer School of Management, University of Ottawa under the supervision of Professor Craig Kuziemsky and Professor Samia Chreim.

If I have any questions about the study, I may contact the researcher or his/her supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5
Tel.: (613) 562-5387
Email: ethics@uottawa.ca

There are two copies of the consent form, one of which is mine to keep.

Participant's signature

Date

Researcher's signature

Date

Semi-Structured Interviews Recruitment and Consent Forms

Hello (insert name),

My name is Jennifer McKenzie and I am a Master's student in the Health Systems Research program from the University of Ottawa Telfer School of Management. I am currently conducting a research project that focuses on the integration of services in Sault Ste. Marie's senior health care system from a change management perspective. I am requesting your participation in this project to gain your perspective on this topic. Would you be available to participate in a one hour one-on-one interview with me at a time and place of your convenience? Your participation is strictly voluntary. You may be asked to participate in up to two interviews. I can be contacted for more information using any of the methods listed below.

Thank you so much and I look forward to hearing from you,

Jennifer McKenzie
MSc Health Systems Candidate
University of Ottawa
Telfer School of Management

Invitation to participate: You are invited to participate in the above mentioned research study conducted by Jennifer McKenzie in fulfillment of the requirements for the Masters of Science in Health Systems Program at the University of Ottawa.

Purpose of the study: The purpose of this study is to use change management concepts to overcome implementation obstacles from existing integrated senior healthcare system models, and to organize information that will assist communities in selecting an integrated senior healthcare system model that meets their unique needs.

Participation: You are asked to participate in up to two interviews that will last approximately one hour each. Your participation will consist of providing your opinion of the gaps in Sault Ste. Marie's senior healthcare system, changes that need to be made to address these gaps, as well as steps that need to be taken to achieve the changes you suggest. In addition, your participation will consist of providing information about the services within your organization, and your views concerning any possible enablers and/or obstacles to integration in Sault Ste. Marie's senior healthcare system. Each of the interview sessions will be audio recorded. All audio recordings will be transcribed (typewritten) and analyzed. This ensures the information collected is accurate.

Risks: Your participation in this study will entail that you volunteer detailed information about the services and programs that your organization provides to seniors. You may also volunteer sensitive information about your organization's relationships with other organizations who also deliver senior care services. Because the name of Sault Ste. Marie will be used in the final written report, your anonymity may not be able to be guaranteed because of the small sample size. In an effort to mitigate these risks, if requested, your anonymity will be guaranteed by using pseudonyms for your name and the name of your organization as described in the 'confidentiality and anonymity' section below.

Benefits: Your participation in this study will benefit your organization as well as the community by providing information that will assist in selecting an integrated senior healthcare system model that will create continuity of services to increase access and quality of care for seniors, their families, members of the community, and service providers.

Version 2 January 5, 2012

Confidentiality and anonymity: Please fill out the section below to indicate your preference concerning anonymity:

Use pseudonyms for my name	Yes	No
Use pseudonyms for the name of my organization	Yes	No

Since it is common for research based on semi-structured interviews to report quotations from participants, if requested, your name and the name of your organization will be disguised through the use of pseudonyms in written reports. Because the name of Sault Ste. Marie will be used in the final written report, your anonymity may not be able to be guaranteed because of the small sample size. If you have indicated that you do not wish for your identity and the identity of your organization to be concealed, your anonymity and the anonymity of your organization will not be guaranteed. The confidentiality of the information that you share will be ensured by keeping the audio recordings and transcripts of the interviews on the student researcher's password secured computer in the locked office of the student researcher throughout the duration of the project (November 1, 2011 to September 30, 2012). Only the student researcher and the thesis supervisors will have access to the focus group video/audio recording and transcript.

Conservation of data: The data collected consisting of the interview audio recordings and transcripts will be transferred to a flash disk and secured in a locked cabinet in the thesis supervisor's office located on the University of Ottawa Campus for a period of five years (October 1, 2012 to October 1 2017) and then it will be deleted.

Voluntary participation: You are under no obligation to participate and if you choose to participate, you can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If you choose to withdraw, all data gathered until the time of withdrawal will be used for the purpose of the analysis unless you request otherwise.

Review of Transcripts: If you choose to review the semi-structured interview transcripts it will be sent to you via email. The security of this document will be ensured as it will be password protected. The password will be told to you in confidence by the student researcher at the time of the first interview. Please indicate below whether or not you would like to review the semi-structured interview transcript(s):

I would like to review the semi-structured interview transcript(s)	Yes	No
---	-----	----

Acceptance: I, _____, agree to participate in the above research study conducted by Jennifer McKenzie of the Telfer School of Management, University of Ottawa under the supervision of Professor Samia Chreim.

If I have any questions about the study, I may contact the researcher or his/her supervisor.

Administrator Focus Group Recruitment and Consent Forms

Hello (insert name),

This is a follow up letter to the interview that was recently conducted concerning the research study that is investigating integration within Sault Ste. Marie's senior health care system using change management concepts. I would like to thank you very much for your participation, and as discussed during the interview I would like to ask you to participate in one focus group collectively with the other members of the Sault Ste. Marie & Area NE LHIN ALC Solutions group. Your participation in this focus group is strictly voluntary. Should you choose not to participate, the reason for your absence will not be revealed to any of the focus group participants. During this focus group the data that has been collected from the interviews will be presented, and the group will be asked to develop a collective vision and measureable goals for a future integrated senior health care system model, as well as review the initial situational and key stakeholder analyses to determine accuracy of the data. Please let me know if you are available to participate in this important focus group on _____ (insert date and time). Further information about the focus group can be obtained by contacting me using any of the methods listed below.

Thank you so much and I look forward to hearing from you,

Jennifer McKenzie
MSc Health Systems Candidate
University of Ottawa
Telfer School of Management

Invitation to participate: We are inviting you to participate in the above mentioned research study conducted by Jennifer McKenzie in fulfillment of the requirements for the Masters of Science in Health Systems Program at the University of Ottawa.

Purpose of the study: The purpose of this study is to use change management concepts to overcome implementation obstacles from existing integrated senior healthcare system models, and to organize information that will assist communities in selecting an integrated senior healthcare system model that meets their unique needs.

Participation: We are asking you to participate in one focus group that will last approximately two to three hours. Your participation will consist of providing your opinion of the gaps in Sault Ste. Marie's senior healthcare system, changes that need to be made to address these gaps, as well as steps that need to be taken to achieve the changes you suggest. In addition, your participation will consist of providing information about the services within your organization, and your views concerning any possible enablers and/or obstacles to integration in Sault Ste. Marie's senior healthcare system. You will also be asked to review and confirm the trustworthiness of the data that is presented during this focus group. The focus group will be video and audio recorded. The video/audio recording will be transcribed (typewritten) and analyzed. This ensures the information collected is accurate.

Risks: Your participation in this study will entail that you volunteer detailed information about the services and programs that your organization provides to seniors. You may also volunteer sensitive information about your organization's relationships with other organizations who also deliver senior care services. Your anonymity cannot be guaranteed as the focus group will occur in a group setting. Furthermore, because the name of Sault Ste. Marie will be used in the final written report, your anonymity may not be able to be guaranteed because of the small sample size. In an effort to mitigate these risks, if you request it, pseudonyms will be used for your name and the name of your organization as described in the 'confidentiality and anonymity' section below.

Benefits: Your participation in this study will benefit your organization as well as the community by providing information that will assist in selecting an integrated senior healthcare system model that will create continuity of services to increase access and quality of care for seniors, their families, members of the community, and service providers.

www.telfer.uOttawa.ca

Confidentiality and anonymity: Please fill out the section below to indicate your preference concerning anonymity:

<u>Use pseudonyms for my name</u>	<u>Yes</u>	<u>No</u>
<u>Use pseudonyms for the name of my organization</u>	<u>Yes</u>	<u>No</u>

Since it is common for research based on focus groups to report quotations from participants, if requested, your name and the name of your organization will be disguised through the use of pseudonyms in written reports. Your anonymity cannot be protected from participants in the focus group. Furthermore, because the name of Sault Ste. Marie will be used in the final written report, your anonymity may not be able to be guaranteed because of the small sample size. If you have indicated that you do not wish for your identity and the identity of your organization to be concealed, your anonymity and the anonymity of your organization will not be guaranteed. The confidentiality of the information that you share will be ensured by keeping the video/audio recording and transcript of the focus group on the student researcher's password secured computer in the locked office of the student researcher throughout the duration of the project (November 1, 2011 to September 30, 2012). Only the student researcher and the thesis supervisors will have access to the focus group video/audio recording and transcript.

Conservation of data: The data collected consisting of the focus group video/audio recording and transcript will be transferred to a flash disk and secured in a locked cabinet in the thesis supervisor's office located on the University of Ottawa Campus for a period of five years (October 1, 2012 to October 1 2017) and then it will be deleted.

Voluntary participation: You are under no obligation to participate and if you choose to participate, you can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If you choose to withdraw, all data gathered until the time of withdrawal will be used for the purpose of the analysis. Should you choose not to participate in the focus group, the reason for your absence will not be revealed to any of the focus group participants.

Acceptance: I, _____, agree to participate in the above research study conducted by Jennifer McKenzie of the Telfer School of Management, University of Ottawa under the supervision of Professors Craig Kuziemyk and Samia Chreim.

If I have any questions about the study, I may contact the researcher or his/her supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5
 Tel.: (613) 562-5387
 Email: ethics@uottawa.ca

There are two copies of the consent form, one of which is mine to keep.

 Participant's signature

 Date

 Researcher's signature

 Date

Front Line Service Worker Focus Group Recruitment and Consent Forms

Hello (insert name),

My name is Jennifer McKenzie and I am a Master's student in the Health Systems Research program from the University of Ottawa Telfer School of Management. I am currently conducting a research project that focuses on the integration of services in Sault Ste. Marie's senior health care system from a change management perspective. As a front line service worker who provides services to seniors in Sault Ste. Marie, Ontario, I am requesting your participation in this project to gain your perspective on this topic. A member of your organization has provided your name as a potential participant in this study. I would like to ask you to participate in one focus group with other front line service worker representatives that provide care to seniors in Sault Ste. Marie. Your participation in this focus group is strictly voluntary. During this focus group data that has been collected from other sources within this project will be presented. You will be asked to review this data and compare it to your own experiences as a front line service worker who provides services to seniors in Sault Ste. Marie. Please let me know if you are available to participate in this important focus group on _____ (insert date and time). Further information about the focus group can be obtained by contacting me using any of the methods listed below.

Thank you so much and I look forward to hearing from you,

Jennifer McKenzie
MSc Health Systems Candidate
University of Ottawa
Telfer School of Management

Invitation to participate: We are inviting you to participate in the above mentioned research study conducted by Jennifer McKenzie in fulfillment of the requirements for the Masters of Science in Health Systems Program at the University of Ottawa.

Purpose of the study: The purpose of this study is to use change management concepts to overcome implementation obstacles from existing integrated senior healthcare system models, and to organize information that will assist communities in selecting an integrated senior healthcare system model that meets their unique needs.

Participation: We are asking you to participate in one focus group that will last approximately two to three hours. Your participation will consist of providing your opinion of the gaps in Sault Ste. Marie's senior healthcare system, changes that need to be made to address these gaps, as well as steps that need to be taken to achieve the changes you suggest. In addition, your participation will consist of providing information about the services within your organization, and your views concerning any possible enablers and/or obstacles to integration in Sault Ste. Marie's senior healthcare system. The focus group will be video and audio recorded. The video/audio recording will be transcribed (typewritten) and analyzed. This ensures the information collected is accurate.

Risks: Your participation in this study will entail that you volunteer detailed information about the services and programs that your organization provides to seniors. You may also volunteer sensitive information about your organization's relationships with other organizations who also deliver senior care services. There may also be an emotional, psychological or professional risk associated with participating in this study. Your anonymity cannot be guaranteed as the focus group will occur in a group setting. Furthermore, because the name of Sault Ste. Marie will be used in the final written report, your anonymity may not be able to be guaranteed because of the small sample size. In an effort to mitigate these risks pseudonyms will be used for your name and the name of your organization as described in the 'confidentiality and anonymity' section below.

Benefits: Your participation in this study will benefit your organization as well as the community by providing information that will assist in selecting an integrated senior healthcare system model that will create continuity of services to increase access and quality of care for seniors, their families, members of the community, and service providers.

Version 4 April 27, 2012

Confidentiality and anonymity: Since it is common for research based on focus groups to report quotations from participants, if requested, your name and the name of your organization will be disguised through the use of pseudonyms in written reports. Your anonymity cannot be protected from participants in the focus group. Furthermore, because the name of Sault Ste. Marie will be used in the final written report, your anonymity may not be able to be guaranteed because of the small sample size. The confidentiality of the information that you share will be ensured by keeping the video/audio recording and transcript of the focus group on the student researcher's password secured computer in the locked office of the student researcher throughout the duration of the project (November 1, 2011 to September 30, 2012). Only the student researcher and the thesis supervisors will have access to the focus group video/audio recording and transcript.

Conservation of data: The data collected consisting of the focus group video/audio recording and transcript will be transferred to an encrypted flash disk and secured in a locked cabinet in the thesis supervisor's office located on the University of Ottawa Campus for a period of five years (October 1, 2012 to October 1 2017) and then it will be deleted.

Voluntary participation: You are under no obligation to participate and if you choose to participate, you can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If you choose to withdraw, all data gathered until the time of withdrawal will be used for the purpose of the analysis. Should you choose not to participate in the focus group, this decision will not be revealed to anyone.

Acceptance: I, _____, agree to participate in the above research study conducted by Jennifer McKenzie of the Telfer School of Management, University of Ottawa under the supervision of Professors Craig Kuziemsky and Samia Chreim.

If I have any questions about the study, I may contact the researcher or his/her supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5
Tel.: (613) 562-5387
Email: ethics@uottawa.ca

Appendix C: Non-Participant Observation Field Note Collection Tool

Date and Time: Of Observation		Location: Of Observation
ALC Solutions Group Members Present:		
Name	Organization	Sector

Field Notes:

Notes were taken pertaining to each theme listed below:

- System Gaps
- Vision for an Integrated Sault Ste. Marie Senior Healthcare System
- Goals to Achieve Integrated within Sault Ste. Marie`s Senior Healthcare System
- Information About Existing Services within the Sault Ste. Marie Senior Healthcare System
- Enablers of Sault Ste. Marie Senior Healthcare System Integration
- Obstacles to Sault Ste. Marie Senior Healthcare System Integration

Researcher`s Observation Memos: Additional thoughts that were noted in relation to the above themes during observation period.

Appendix D: Semi-Structured Interview Protocol

Study Title: Change and Integration in Senior Health Care Systems: The Case of Sault Ste. Marie

Primary Investigator: Jennifer McKenzie

Interview Purpose: The purpose of this interview is to gather specific information about your perspective of integration within Sault Ste. Marie's senior health care system. I am interested in gathering information about where you think gaps in services exist, what your vision for a future model of integrated senior care would look like, and measurable goals to achieve this vision. In addition, I am interested in gathering information about the function of your organization and the specific services that it provides, as well as any enablers and/or obstacles to integration that you experience. This interview will be audio recorded to ensure accuracy of transcription, however if at any time during the interview you would like me to turn the recorder off, please let me know and I will do so.

Request for Further Documentation: Any extra documentation that you can provide concerning the function of your organization, the services that you provide, as well as the policies that your organization is guided by would be greatly appreciated.

Section One: Interviewee Background Information

1. This first set of questions will focus on your position within this organization.
 - 1) What is your current position within this organization?
 - Guides/Probes:
 - What are your responsibilities?
 - 2) How long have you been in this position?
 - 3) How did you come into this position?

Section Two: Organization Background Information

2. The purpose of this next set of questions is to allow me to get a sense of your organization.
 - 4) How do you determine what services you will provide within your organization?
 - Guides/Probes:
 - NE LHIN guidelines
 - MOHLTC guidelines
 - Patient demands
 - Community demands
 - 5) How is your organization funded?
 - Guides/Probes:

- NE LHIN
 - MOH
 - Fundraising
 - Fee for service
- 6) How do you refer to the people that you provide services to?

Section Three: Patient Needs Assessment Process

3. The purpose of the next set of questions is to understand how client's needs are determined.
- 7) How do you determine which services your (clients, patients, customers) receive?
- Guides/Probes:
 - Needs assessment (internal/external)
 - No assessment

Section Four: Services and Programs Provided within the Organization

4. The next set of questions is focused on creating a detailed inventory of all of the services that are provided by your organization. If you could provide extra documentation concerning your services and programs it would be greatly appreciated.
- 8) Please describe the services that are provided within your organization.
- Guides/Probes for Each Services Mentioned:
 - Does your organization or an outside organization administer these services?
 - How do clients get referred to this specific service?
 - Do you know of any other organization in Sault Ste. Marie that provides this service?
- 9) How many (patients, clients, customers) do you currently have within your organization?
- 10) Is there a waiting list?

Section Five: Service/Performance Gaps, Vision and Measurable Goals for an Integrated Senior Health care System Model

5. The next set of questions will focus on illuminating the gaps that you see in the Sault Ste. Marie senior health care system, illuminating your vision for an integrated senior health care system model to fill these gaps, and establishing measurable goals to reach this vision.
- 11) Based on your experiences, what are some of the major gaps in accordance to continuity of services within Sault Ste. Marie's senior health care system?

- 12) How would you like to see the Sault Ste. Marie senior health care system change?
- Guides/Probes:
 - Do you believe integration of senior health care services could assist in filling the gaps that you mentioned above?
 - If so, how?
 - If not, what approach do you think should be taken to fill the above gaps?
- 13) What steps do you think should be taken to achieve the changes that you suggested in the previous question?

Section Six: Enablers and Obstacles to Integration

6. This next set of questions will focus on the enablers and obstacles to integration that you experience within Sault Ste. Marie's senior health care system.
- 14) Do you believe that your (patients, clients, customers) would benefit from integrating the services that your organization offers and other services in the community?
- Guides/Probes:
 - If so, how do you think it would benefit them?
 - If no, why do you think it would not benefit them?
- 15) Based on your experiences, what are some of the enablers of integration within Sault Ste. Marie's senior health care system?
- 16) Based on your experiences, what are some of the obstacles of integration within Sault Ste. Marie's senior health care system?

Section Seven: Conclusion

- 17) What should I have asked that I didn't think to ask?
- 18) May I contact you in the future if I have any further questions?
- 19) Would you like a copy of the transcript? Should I send it to you via email?
- 20) What other administrators of senior health care organization do you think should be involved in this study?
- Guides/Probes:
 - Contact Information
- Thank you for your participation!**

Appendix E: Inventory of Sault Ste. Marie Senior Healthcare System Programs and Services

Description of Document: This document provides an overview of the services that are available to seniors in Sault Ste. Marie, Ontario. The services are organized under the following sectors: Acute Care, Long Term Care, Retirement Residences, Independent Living Affordable Seniors Apartments, Assisted Living Services, In-Home Care Services, Community Support Services, Primary Care/Allied Health/Specialized Services, and System Navigation/Planning. Each sector begins with a visual map that summarizes the organizations that deliver care within the sector, and follows with an inventory that provides a description of each of the services delivered by the organizations within the visual map.

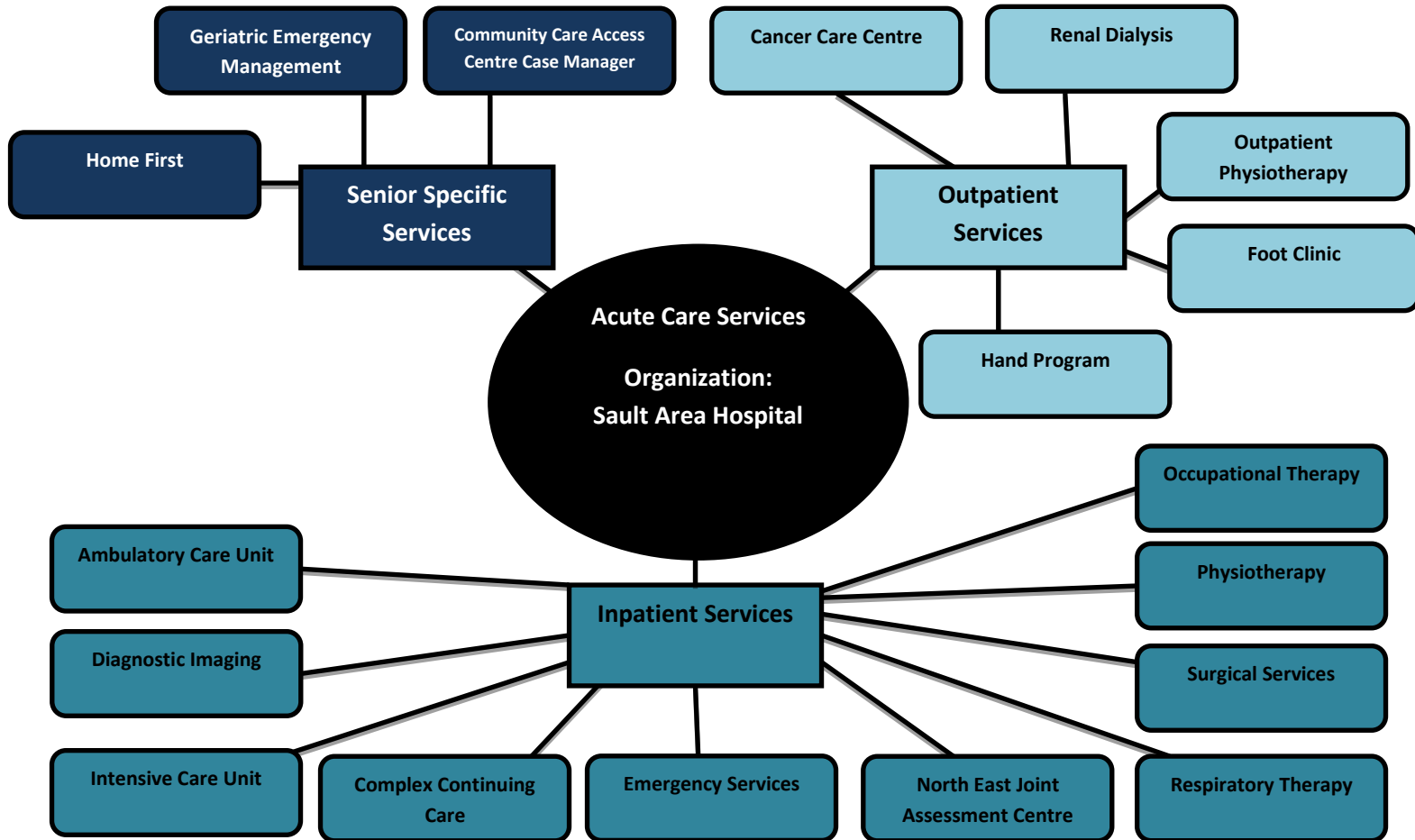
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Sector 1: Acute Care Services Map



Sector 1: Acute Care Services Inventory

Acute Care Organization: Sault Area Hospital

Address:
750 Great Northern Rd N
Sault Ste. Marie, ON
P6A 0A8

Phone: 705-759-3434
Fax: 705-541-7810
Email: publicaffairs@sah.on.ca
Website: www.sah.on.ca

Hours of Operation: 24/7
(unless otherwise stated)

SENIOR SPECIFIC SERVICES

Service	Description
Community Care Access Centre (CCAC) Case Manager	The CCAC Case Managers work in the emergency department to provide information to the physician about the services that patients are already accessing within the community, and/or to determine what services can be put in place to allow the patient to be safely discharged back into to the community.
Geriatric Emergency Management (GEM) Nurse	This service is for patients over 75 years of age, or between the age of 65 and 75 who are presenting at the emergency department with an age-related diagnosis. The GEM nurse has a specific assessment tool to determine how at risk the patients are and what services they may need. They also work closely with the CCAC case managers to determine what services the patient is already accessing in the community, and what community services can be put in place to allow the patient to be safely discharged back into the community.
Home First	When a person enters a hospital with an acute episode, every effort is made to ensure adequate resources are in place to support the person to ultimately go home on discharge. Only when returning home with care is not possible or safe to do so, are other options considered (NE LHIN-Home First, 2012).

INPATIENT SERVICES

Service	Description
Ambulatory Care Unit	<p>Referral: The ACU operates completely on a referral basis, and appointments to all clinics are made directly through the physicians' offices. Patients do not directly book appointments with the ACU.</p> <p>Hours: Hours of operation of the ACU depend on volume and the day of the week, but generally reception is open from 8:00 am to 5:00 pm Monday to Friday. Individual clinics within the ACU operate on their own schedules</p> <p>The Ambulatory Care Unit (ACU) at Sault Area Hospital provides services for eight separate clinics: Colposcopy; Cystoscopy; Endoscopy; Medical Surgical (Minor Medical/Surgical Procedures); Minor Procedures Clinic; Ophthalmology; Orthopedic Clinic; Pre-Admission (Pre-Surgery Preparation, Diagnostics and Patient Education). Specialists at each clinic rely on the ACU to coordinate a variety of Sault Area Hospital resources</p>

	including nursing and support staff, special equipment and examination rooms, x-ray, and lab tests for procedures that need to be performed in a hospital setting. The ACU is primarily an outpatient unit for patients who do not require admission for their procedures and tests.
Diagnostic Imaging	The Department of Diagnostic Imaging includes X-ray, ultrasound, computerized tomography scan (CT Scan), magnetic resonance imaging (MRI), mammography, nuclear medicine and angiography. The diagnostic imaging department performs more than 80,000 exams yearly. No analog film is used in the department. All diagnostic equipment is capable of digital imaging with the results viewed on computers. This process allows for all images to be sent from the Diagnostic Imaging Department to all the other departments throughout the Sault Area Hospital for instant viewing.
Intensive Care Unit	<p>Caring for the Critical Patient: Care in the Intensive Care Unit is provided by a multidisciplinary team, which is composed of specially trained physicians, nurses, and other professionals. Each professional brings his or her particular expertise to the team, collaborating on a plan of care and treatment for each patient, based upon his or her individual needs and conditions.</p> <p>Family of Critical Patients: The Intensive Care Unit Care Team also provides support for families of critically ill patients. We know that being in the Intensive Care Unit, or having a relative in in critical condition is a frightening and sometimes overwhelming emotional experience. You want to know what is happening, and what to expect. As an important part of our care, we try to make ourselves as accessible to you as possible, listen to your concerns and answer your questions. We consider you a team partner, and will communicate with you on your relative's condition, changes and ongoing plans.</p>
Complex Continuing Care	This service is for patients who have ongoing complex healthcare needs that cannot be addressed through community or long term care services. For example, patients who require long term IV therapy; patients with severe responsive behaviours; etc.
Emergency Services	Sault Area Hospital's Emergency Department and Fast Track Clinic treat over 60,000 patients per year. On average, almost 150 patients come through our Emergency doors every day. We are here to care for you when you need it the most – during an emergency. In the Emergency Department, patients who are the sickest are treated first. Less urgent patients are sent to the Fast Track Clinic for treatment where they are usually seen in order of their arrival.
North East Joint Assessment Centre (NE JAC)	The NEJAC (North Eastern Joint Assessment Centre) is part of the Surgical Program at SAH. NEJAC is a LHIN (Local Health Integration Network) sponsored initiative, in cooperation with the Ontario Wait Times Strategy. The main goal of the program is to decrease wait times for patients awaiting hip and knee replacement surgery. Under the new system, patients needing an orthopedic consult for hip or knee replacement will be directed to NEJAC by their family physician, rather than directly to the orthopedic surgeons as is currently the practice. During the Assessment

	<p>Centre visit, patients will receive a comprehensive assessment by an Advanced Practice Physiotherapist (APP). The APP, who has received specialized training in the assessment of joint replacement candidates, will act as a liaison between the surgeon and the family physician. The NEJAC process will ensure that patients get on the right treatment path faster. Approximately 30-50% of patients are not quite ready for the hip/knee replacement surgery and the APP will help manage these patients through more conservative management options such as physiotherapy. The remaining patients will be referred to the orthopedic surgeons for either medical management or joint replacement surgery. Surgical patients will be seen by the surgeons in a more timely fashion, to discuss the next steps.</p>
Respiratory Therapy	<p>Contact: Main Respiratory Therapy Dept. 705-759-3434 ext. 5478 Pulmonary Function Lab 705-759-3434 ext. 4243. Hours: Respiratory Therapy 24 hours/day, 7 days per week, 365 days per year. Pulmonary Function Lab 7:30-3:30 Monday – Friday.</p> <p>The Respiratory Therapy Department provides 24 hours service to patients with respiratory illness. This includes mechanically ventilated patients in Critical Care, Neonatal Intensive Care and Emergency. As part of the multidisciplinary team, we are involved with all patient populations in all areas of the hospital including Labour and Delivery, Medical Units, Surgical Units, Pediatrics, Critical Care, NICU, Emergency and Long Term Care Units. By performing various diagnostic testing, patient assessment, and evidence based treatments we help patients understand and overcome their symptoms and disease process. The Pulmonary Function Lab performs in depth lung studies on both inpatients and outpatients including spirometry, diffusion capacity and lung volumes using state of the art diagnostic tools.</p>
Surgical Services	<p>The inpatient surgical service provides comprehensive care delivered by a skilled team of physicians, nurses, physiotherapists, occupational therapists, dietitians, respiratory therapists, social workers, utilization co-ordinators, pastoral care and other support staff. The service promotes an interdisciplinary learning environment, often teaching a variety of students from medical residency, nursing, respiratory, physiotherapy and ambulance programs. These students are enrolled from a variety of university and colleges throughout the community, region and province. We work closely with our community partners to ensure that services we provide are meeting the needs of the community and organization. Through the planning and providing of both preoperative and postoperative assessments, patients will have a positive outcome.</p>
Physiotherapy	<p>Physiotherapists are members of the College of Physiotherapists of Ontario. Physiotherapists manage and prevent many physical problems caused by trauma, illness, disease, sport and work related injury, aging and long periods of inactivity. The Physiotherapist has a number of roles in the process of rehabilitation which include:</p> <ul style="list-style-type: none"> • Performing neuromuscular assessments related to patient function and potential for recovery

	<ul style="list-style-type: none"> • Performing initial assessments regarding range of motion, strength, mobility aids, assistance required and patient safety during ambulation, stairs and functional skills • Provide gait and balance training • Prescribe and utilize electrotherapeutic modalities as required • Assign patients to physiotherapy assistant as required • Provide hands on manual therapy • Provide physiotherapy outpatient services in both hand and general outpatients for clients with a variety of diagnoses including post-surgical, post-fractures, amputees, post-stroke etc. • Provide physiotherapy inpatient services working with interdisciplinary healthcare team members to provide patient centered care on medical, surgical, intensive care, paediatric, oncology, palliative, rehabilitation and long term care units.
Occupational Therapy	<p>Referral: A physician’s referral is required for service. Referrals can be faxed to the Rehabilitation Department at (705) 759 – 3692.</p> <p>Occupational Therapy is concerned with promoting health and well-being through everything that people do during the course of everyday life. Following an acquired brain injury (i.e. CVA, Brain Tumor, etc.), individuals may have difficulties which interfere with their functional abilities and which impact on their participation in roles and meaningful activities. In the Outpatient Neuro service, the Occupational Therapist provides assessment, treatment, education, and consultation to clients requiring additional intervention for specific rehabilitation goals in the areas of self-care (i.e. bathing, dressing), productivity (work, housework) and leisure (sports, hobbies). Together with the client, an individualized treatment plan is developed targeting client identified goals towards a desired outcome. The overall goals of this service are to facilitate community reintegration and optimize functional independence in the client’s activities of daily living. Services include:</p> <ul style="list-style-type: none"> • Cognitive assessment & treatment • Perceptual assessment & treatment • Upper extremity assessment & treatment • Activities of Daily Living (ADL) assessment & treatment • Instrumental Activities of Daily Living (IADL) assessment & treatment • Consultation with other services (i.e. Social Work, Physiotherapy) is conducted, when necessary.

OUTPATIENT SERVICES

Service	Description
Cancer Care Centre	<p>Referral: Most referrals we receive are from your surgeon once he/she has diagnosed your cancer. Referrals to the Algoma District Cancer Program occur by telephone, fax or mail. The oncologist then reviews the chart and a first appointment is made for you. Our New Patient Referral Clerk registers you and prepares your chart by gathering information such</p>

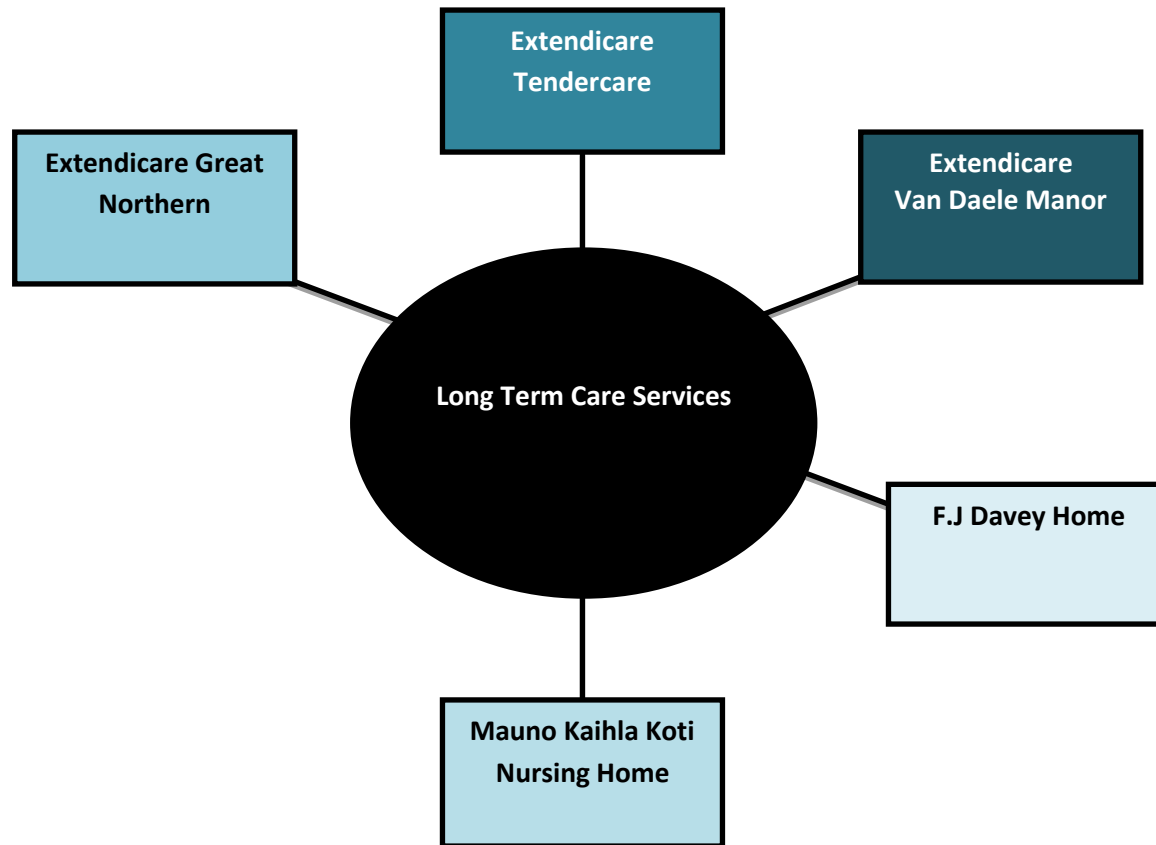
	<p>as your diagnostic tests. All new referrals are triaged according to the urgency of your diagnosis. A referral can be held up if all the tests results are not available when a referral is made.</p>
Renal Dialysis	<p>Contact: 705-759-3813</p> <p>Healthy kidneys clean your blood by removing excess fluid, minerals, and wastes. Renal failure (kidney failure) is a situation in which the kidneys fail to function adequately causing fluid retention, a rise in blood pressure, toxin build up, and lack of red blood cells (known as anemia). Renal dialysis is the act of removing the wastes, minerals, and excess fluids from a patient's blood using a machine known as a dialysis unit. The specific types of services offered are listed below with specific hours of operation.</p> <p>Home Hemodialysis: Patients who are able to do their own hemodialysis at home with support from family can be trained through a centre in Toronto or Sudbury. Slow Nocturnal Hemodialysis is performed about five to six nights a week, for eight to nine hours at a time, while the patient sleeps. Short Daily Hemodialysis is done five to seven days per week for four to five hours at a time. You will still need to attend regular appointments every six weeks or so with your dialysis centre.</p> <ul style="list-style-type: none"> • Home Hemodialysis Hours: Weekdays: 7:30am - 3:30pm. During off-hours, contact the Hemodialysis unit during their hours of operation. • Hemodialysis Hours: Weekdays: 7:00am - 11:00pm. Weekends: 7:00am - 7:00pm <p>Continuous Ambulatory Peritoneal Dialysis (CAPD): This type of dialysis is performed at home every day; waste products are removed from the body by filling and draining the abdomen with clean solution four or five times daily. Sault Area Hospital can train patients to perform their own CAPD treatments. Regular appointments for checkups will be scheduled in the Renal Clinic.</p> <p>Cycler Treatment: This is peritoneal dialysis that is performed by a small machine called a cycle which performs the CAPD exchanges over a 10-hour period at night. Not everyone who can do CAPD can do cycler treatments due to medical limitations. Sault Area Hospital can train patients to perform their own cycler treatments, and regular follow up appointments will be scheduled.</p> <p>Renal Health Clinic: You also have access to the staff at the Renal Health clinic, who can assist you with all aspects of renal health, such as diet, renal information, and medications.</p> <ul style="list-style-type: none"> • Renal Health Clinic Hours: Weekdays: 7:00am - 5:30pm
Outpatient Physiotherapy	<p>Contact: 705-759-3634</p> <p>Hours: Monday – Friday 8 a.m. – 4 p.m.</p> <p>Referral: Outpatient physiotherapy services are provided to clients with referrals from: orthopaedic surgeons; patients discharged from hospital with neurological problems, cva, tumors, etc.; amputee clinic for pre and post prosthetic training; plastic surgeons for post hand surgery therapy.</p>
Hand Program	<p>Referral: Referrals are required from a plastic surgeon, orthopaedic surgeon or family physician. Contact 705-759-3634.</p>

	<p>Hand therapy is provided by physiotherapists and occupational therapists. A variety of upper extremity conditions are treated including:</p> <ul style="list-style-type: none"> • Acute trauma: crush injuries, fractures, burns, lacerations and tendon, ligament and nerve injuries. • Repetitive overuse injuries: carpal tunnel, tendonitis • Acquired conditions: arthritis, Dupuytren's <p>Hand therapy may provide:</p> <ul style="list-style-type: none"> • preventative, non-operative or conservative treatment • management of acute or chronic pain and/or edema • desensitization following nerve injury or trauma • scar management techniques • range of motion, active and passive, to gain or maintain movement • sensory re-education after nerve injury • design and implementation of home exercise programs to increase motion, dexterity and strength • custom splint fabrication for preventative or correction of injury • training in performance of daily life skills through adaptive methods and equipment • conditioning prior to returning to work
Foot Clinic	<p>Referral: Physicians with privileges can refer their patients to the Foot Clinic by faxing a prescription to 705-759-3692 or by forwarding the referral to the Outpatient Rehabilitation Office at 705-759-3634.</p> <p>The Sault Area Hospital Foot Clinic is an outpatient service located in the Outpatient Rehabilitation Department (Room E2028). Foot Clinic services are available to patients with diagnoses such as:</p> <ul style="list-style-type: none"> • Diabetes • Peripheral Vascular Disease • Chronic Wounds (Ulcers, Amputations) • Compromised Immune Systems (Lupus, Rheumatoid Arthritis, Psoriatic Arthritis, CREST Syndrome) • Chronic Renal Failure • Osteoarthritis (Traumatized Joints, Joint Deformities, Nerve Impingements) <p>The Foot Clinic is staffed by a Registered Occupational Therapist and services provided include:</p> <ul style="list-style-type: none"> • Advanced Foot Care • Wound Care • Off-Loading Devices • Custom Insoles/Orthotics • Ambulatory/Non-Ambulatory AFO's • Deflective Padding • Remedial Footwear Modifications

(Sault Area Hospital Website- Programs & Services, 2011)



Sector 2: Long Term Care Map



Sector 2: Long Term Care Inventory

Long Term Care Organization: Extendicare- Tendercare

Address: 770 Great Northern Rd
Sault Ste Marie, ON
P6A 5K7

Phone: 705-949-3611
Fax: 705-945-6303
Email: cnh_tendercare@extendicare.com
Website: www.extendicarecanada.com

Office Hours: Mon-Fri 8am-4pm

Service Hours: Mon-Sun 24 hours

Application: Must apply through your local Community Care Access Centre.

Eligibility: Applicants must meet the Ministry of Health and Long Term Care eligibility requirements.

Languages: English

HEALTH SERVICES

Service	Description
24-Hour Nursing Care and Supervision	Residents can be assured that our competent team of registered nurses, registered practical nurses and personal support workers, who are on staff 24-hours per day, will manage their health-related needs. In keeping with our Gentlecare Philosophy, individuals with Alzheimer's disease and related dementias have the opportunity to live life to its fullest in a safe and caring environment. Our specially trained staff continue to promote resident independence by providing them with the assistance that they require. We value knowledge and skills and promote continuous education for team members, residents and their families. The knowledge and skills acquired by all are used to improve our standards of practice as we continue to Help People To Live Life.
24- Hour On Call Physician	As committed members of our interdisciplinary team, our physicians play an integral role in contributing to our philosophy of care and ensuring that residents' needs are being met.
Optometry	A valuable component of our interdisciplinary approach to resident care is the in-house optometry services. Vision testing and repairs to glasses are done on-site, in the comfort of the resident's home.
Denturist	An in-house denturist conducts individual assessments. Recommendations from the denturist are discussed with the resident and family, and together they decide the best course of action.
Dentistry	In-house dentistry consultations are available to all residents.
Specialists	In partnership with the Sault Area Hospitals as well as with private practitioners throughout our community, residents of Extendicare Tendercare have access to specialized services such as cardiologists, urologists, and ophthalmologists. While our in-house physicians and specialists are available to all residents, we recognize the importance of the physician/client relationship, and will respect your decision to have your family physician continue to provide for your health care needs

	while living at Extendicare Tendercare.
Pharmaceutical Services	Our consultant pharmacist is an excellent complement to Extendicare Tendercare's professional health services. As a member of the interdisciplinary team, our pharmacist works with the nursing staff and the physicians to ensure that each resident's pharmaceutical needs are met.
Foot Care Services	If desired, a foot care nurse will provide each resident with personal nail and foot care every eight weeks, in the comfort of his or her own room.
Respiratory Care	Registered respiratory therapists are available in conjunction with our home oxygen suppliers and ExtendicareTendercare to ensure that residents' needs are being met. Support and education is provided to our team members on an ongoing basis.
Physiotherapy	In partnership with a registered physiotherapist, our kinesiologist, residents and their family members are able to develop a therapeutic plan of care that best suits the needs of the resident. Continuing therapeutic needs are provided in the comfort of Extendicare Tendercare via our rehabilitation/restorative care programs.
Resident Programs	Through the natural aging process, we find some residents may experience such conditions as general weakness, gait problems, de-condition from recent hospitalization, contractures, decreased range of motion, fractures, depression due to decrease in independence, and social isolation. At Extendicare Tendercare, we believe that physical conditioning increases residents' feelings of independence and self-worth as they work "hand in hand" with our rehabilitation team. Working with the rehabilitation team, a staff restorative care worker conducts assessments and together with residents and family members, develops a suitable rehabilitation or restorative care program. In the comfort of Extendicare Tendercare, residents actively participate in walking programs, strengthening exercises and speech language therapy.
Social/Therapeutic Programs	Extendicare Tendercare recognizes the importance of providing our residents with social, as well as therapeutic programs. Certified activity aides are busy ensuring that residents' physical, emotional, intellectual, social and spiritual needs are being met. Extendicare Tendercare values your choice and lifestyle, which play a major role in program planning. Activity programs are offered seven days a week and include: dances, social dinners, shopping excursions, movie nights, bingo, discussion groups, cards and games, theme parties, bowling league, art classes and much more. Special occasions, holidays and seasonal events also contribute to the diversity of our programs. We also offer programs that include family involvement. We believe that these types of programs help create wonderful memories that will last a lifetime. All in all, our aim is to enhance the quality of life for our residents as we Help People To Live Life.

SUPPORT SERVICES

Service	Description
Dietary Services	At Extendicare Tendercare, we pride ourselves in providing nutritious home-cooked meals. Our Resident Food Committee consists of a dedicated group of residents who meet regularly to discuss and review the current menu. Changes to our menu are made as a result of the feedback that we receive from this committee. Our in house registered dietician assesses the nutritional requirements of our residents and together with them, their families and registered team members, creates a best-suited nutritional plan of care.
Environmental Services	Extendicare Tendercare’s environmental services department is responsible for ensuring that our residents are safe and secure both within and outside of their home as well as ensuring that Extendicare Tendercare maintains its welcoming atmosphere. Our environment team members are key personnel who focus not only on the housekeeping and laundry needs of our residents, but in fostering a trusting relationship with our residents, families, and team members.
Social Work Services	Extendicare Tendercare recognizes the fact that admission into a long-term care centre can be very difficult for you and/or your loved one. Our social worker can help you and your family to become acquainted and accustomed to this new living environment. The social worker, a member of our interdisciplinary team, provides supportive counselling, information and education with regard to adjustment, psychosocial issues, financial issues, and referrals to appropriate community resources. Social work services strive to enhance the quality of life of all those who live, visit and work at Extendicare Tendercare.
Religious and Spiritual Services	Extendicare Tendercare understands the diversity of spirituality. Our chaplain oversees all pastoral services and spiritual care at our home. This is done in part by outreaching to the community on behalf of our residents, i.e., the chaplain liaises with the Native Friendship centre on behalf of our aboriginal First Nations residents, and with clergy for sacraments and prayer. Inter-denominational spiritual programs are provided within Extendicare Tendercare. Spiritual programs include bible study, praying the rosary, and multi-faith prayer. Weekly church services are held in an inter-denominational setting as well as a denominational setting. Our chaplain and volunteers make regular pastoral visits.
Business Office	Extendicare Tendercare believes in the importance of personal contact and recognizes the fact that our residents' and family members' schedules often vary. Our courteous receptionists are available to assist you between the hours of 8:00 a.m. and 8:00 p.m. daily.
Beautician Services	Our wheelchair accessible salon is located on the main floor and caters to all of our residents hairstyling needs. Appointments can be arranged at the business office.

(Extendicare-Extendicare Tendercare, 2013)

Long Term Care Organization: Extendicare- Van Daele Manor

Address: 39 Van Daele St
Sault Ste Marie, ON
P6B 4V3

Phone: 705-949-7934
Fax: 705-945-0968
Email: cnh_vandaele@extendicare.com
Website: www.extendicarecanada.com

Office Hours: Mon-Fri 8am-4pm

Service Hours: Mon-Sun 24 hours

Application: Must apply through your local Community Care Access Centre.

Eligibility: Applicants must meet the Ministry of Health and Long Term Care eligibility requirements.

Languages: English

HEALTH CARE SERVICES

Service	Description
24-Hour Nursing Care and Supervision	Increasing care needs of our residents, families and our community. Residents can be assured that our competent team of registered nurses, registered practical nurses and personal support workers, who are on staff 24-hours per day, will manage their health-related needs. Our team also includes a nurse practitioner who assists the team in delivery of care to our residents. In keeping with our Gentlecare philosophy, individuals with Alzheimer's disease and related dementias can live life to its fullest in a safe and caring environment. Our specially trained staff promote resident independence by providing them with the help they require. We value knowledge and skills and promote continuous education for team members, residents and their families. The knowledge and skills acquired by all are used to improve our standards of practice.
Resident Programs	At Extendicare Van Daele we believe it is important for each resident to be physically and socially active. The Resident Program Department provides a variety of programs that recognize our residents' physical, intellectual, emotional, social and spiritual well-being. Some of our regularly scheduled activities include group exercises, discussion groups, baking and cooking programs, pet therapy and intergenerational programs. The Resident Programs Department also provides goal-oriented therapeutic services geared towards the restoration of physical function and/or psychosocial ability. Restorative care programs include grooming/dressing training, eating training, ambulation training, weight bearing exercises, strengthening and range of motion exercises and a mobility/comfort aids program.

SUPPORT SERVICES

Service	Description
Dietary Services	At Extendicare Van Daele, we pride ourselves in providing nutritious home-cooked meals. Our Resident Food Committee consists of a dedicated group of residents who meet regularly to discuss and review the current menu. Changes to our menu are made as a result of the

	feedback that we receive from this committee. Our in house registered dietitian assesses the nutritional requirements of our residents and together with them, their families and registered team members, creates a best-suited nutritional plan of care.
Environmental Services	Extendicare Van Daele's environmental services department works diligently to ensure that our home maintains its welcoming atmosphere. Our team members are key personnel who focus not only on the daily housekeeping or laundry needs but also provide a listening ear when someone is lonely or a hug when someone is down. Our environmental services department is also responsible for ensuring that our residents are safe and secure both within and outside of their home.
Religious and Spiritual Services	Extendicare Van Daele understands the diversity of spirituality. Our chaplain oversees all pastoral services and spiritual care at our facility. This is done in part by outreach to the community on behalf of our residents and with clergy for sacraments and prayer. Inter-denominational spiritual programs are provided within Extendicare Van Daele. Spiritual programs include bible study, praying the rosary, and multi-faith prayer. Our chaplain and volunteers make regular pastoral visits.
Business Office	Extendicare Van Daele believes in the importance of personal contact and recognizes the fact that our residents' and family members' schedules often vary. Our courteous receptionists are available to assist you between the hours of 8:00 a.m. and 7:00 p.m. daily.
Beautician Services	Our wheelchair accessible salon is located on the main floor and caters to all of our residents hairstyling needs. Appointments can be arranged at the salon.

(Extendicare-Van Daele Manor, 2013)

Long Term Care Organization: F.J Davey Home

Address: 733 Third Line East
Sault Ste Marie, ON
P6A 7C1

Phone: 705-942-2204
Fax: 705-256-4207
Email:
Website: www.fjdaveyhome.org

Office Hours: Mon-Fri 8am-4pm

Service Hours: Mon-Sun 24 hours

Application: Must apply through your local Community Care Access Centre.

Eligibility: Applicants must meet the Ministry of Health and Long Term Care eligibility requirements.

Languages: English.

HEALTH SERVICES

Service	Description
Nursing & Medical Care	<p>The Davey Home recognizes that residents will have a wide range of health related needs. These are responded to on an individual basis, through the provision of the following services:</p> <ul style="list-style-type: none"> • Medical Director • Associate Medical Directors for specific levels of care if former family doctor does not have Home medical privileges • Registered Nurses (RN's) as our Charge Nurses • Registered Practical Nurses (RPN's) as our Team Leaders • Health Care Aides (HCA's) as our direct care providers • All levels of nursing staff are available and on duty twenty-four hours daily • Infirmaries and palliative care suites are available where required • Dietitian services with nutritional counseling provided and therapeutic diets planned as required • Restorative care services providing individual exercise according to the Doctor's request as well as group activities
Resident Care Planning	<p>Upon admission, a resident care plan is developed in consultation with the resident and their representative (if appropriate), the interdisciplinary team and the attending physician. An interdisciplinary care conference is held within six weeks of admission and then annually thereafter. If there is a change in the resident's medical status or a change in their functional or cognitive capacities, the resident representative (if appropriate) is called and a care conference is held to respond to the changes. Our physicians notify the Home of their absences and their medical delegate.</p>
Medications	<p>On admission, any medications brought into the Home are reviewed by the Team Leader and after the details have been recorded, the representative will be asked to take them away. All of your medications will be ordered by your physician, provided by MediSystem Pharmacy and administered to you by the Team Leader for your Home Area. A one week supply of any one drug is kept on hand. Prescriptions not covered by the Ontario Drug Benefit Program will be billed to residents or their</p>

	alternate by the pharmacy. A payment drop box is available to residents and families at the Reception Desk.
Palliative Care	Palliative care, also called comfort care, is primarily directed at providing relief to a terminally ill person through symptom management and pain management. The goal is not to cure, but to provide comfort and maintain the highest possible quality of life for as long as life remains. At the Davey Home palliative care is provided by caring staff who have received specialized palliative care training. On each level, a palliative care/Infirmary room has been decorated and furnished through the generous efforts of the Home's Auxiliary. These rooms provide a private, comfortable atmosphere for residents and their families during this difficult time.
Restorative Care/ Therapy	Restorative Care services are organized to ensure the therapy needs of residents are met and to assist them in achieving their optimum mobility. The Restorative Care staff have the assistance of one full-time and one part-time physiotherapist to complement the program, along with a full-time kinesiologist. Residents have the opportunity for individualized therapy as well as group exercise programs, based on the assessed needs of the participating residents. Occupational therapy and speech therapy can be accessed through the local Community Care Access Centre as required and, in addition, the local Hearing Society and CNIB contribute their services. Provided, as well, are equipment assessments for residents requiring adaptive devices. The ultimate goal of the Restorative Care program is to encourage wellness, activation and create a sense of well-being amongst our residents.
Dental Care	Residents or their representative must make arrangements and assume the cost of visits to a dentist and for the purchase of dentures if required.
Advanced Foot Care	Advanced foot care is not a basic nursing service and may be required for some residents. When this type of care is required, the Resident or their representative must make arrangements with an external provider and assume the cost. Advanced nursing skills in foot care include services provided by specially trained RN's and RPN's and include non-invasive measures beyond basic skills. Information on a variety of local agencies with which service contracts have been developed is available upon request.
Recreation & Leisure	The recreation and activities department is organized to provide age appropriate recreational, creative and educational opportunities based on and responsive to the abilities, strengths, needs, interests and former life style of the resident. Residents are also encouraged to remain active in any clubs or activities with which they were previously associated. Within the Home there is a daily program of activities such as fun & fitness, card parties, bingo, music, sing-a-longs and parties for special events. A handicap accessible bus is available for staff to take residents on outings away from the Home. These outings include scheduled regular shopping trips and luncheons. Craft/Activity rooms are available in each resident home area for resident use and are geared to individual abilities of the residents. The programs operate every day and offer a variety of crafts

	and activities. A monthly newsletter, "Home Happenings", is prepared to provide residents and families with schedules of events and interesting news items and information.
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SUPPORT SERVICES

Service	Description
Dietary	Menus are planned to meet nutritional needs while taking into consideration personal preferences and seasonal specialties. Resident food preferences are considered and a checklist is provided upon admission. Nutritional assessments are completed by the onsite dietitian. Therapeutic diets are provided when ordered by the resident's Physician or the Dietitian. Meal service includes three meals daily with snacks between meals and at bedtime. Meals are prepared onsite in a full service kitchen and served in the dining room located on each of the twelve Resident Home Areas. Residents are able to celebrate special events, such as birthdays, anniversaries, Christmas and Mother's/Father's Day with their family in the Home. A room may be reserved by contacting the Director of Resident & Volunteer Activities at extension 221. Advance notice should be provided to ensure availability, as rooms are offered on a first come, first serve basis. Although the RHA dining room does not accommodate guests, families may join a resident for a meal in the RHA Activity Room or Lounge, as available, or in Pine Court or Maple Court, as reserved. The Home is unable to provide meals for guests and family, but they are more than welcome to bring in their own meal.
Spiritual & Religious	The Home has a beautiful, dedicated multi-faith worship center which is accessible to residents, families and staff for private worship and other individual or group religious activities. The Home employs a Chaplain who co-ordinates regular denominational and inter-denominational services which are held in the worship centre. The schedule is available outside the worship centre door and in the Home newsletter. The residents also have access to spiritual companion volunteers who visit for prayer, study, companionship and friendship. In addition, the chaplain offers pastoral counseling, grief and bereavement support, palliative care support, arranges memorial services and individualized contact when needed.
Environmental Services	Cleaning, laundry and maintenance services are provided to residents. All personal items are marked with the resident's name upon admission. Machine washing and drying of personal clothing is provided at no charge. Items requiring dry cleaning are not recommended, however dry cleaning services are supplied by a local service. These services are paid for by the resident. In accordance with Home policy, placement of furniture, mounting of pictures, replacement of light bulbs and connection of electrical appliances are performed by our maintenance department.
Beautician	Onsite hairdressing services are offered by qualified hairdressers. Hairdressing shops are located on each level and are open weekdays as required. A complete range of services are provided and prices vary according to the service. (F.J. Davey Home-Our Services, 2010)

Long Term Organization: Mauno Kaihla Koti Nursing Home

Address: 723 North St
Sault Ste Marie, ON
P6B 5Z3

Phone: 705-945-9987
Fax: 705-945-1217
Email: info@ontariofinnishresthome.ca
Website: www.ontariofinnishresthome.ca

Office Hours: Mon-Fri 8am-4pm

Service Hours: Mon-Sun 24 hours

Application: Must apply through your local Community Care Access Centre.

Eligibility: Applicants must meet the Ministry of Health and Long Term Care eligibility requirements.

Languages: English, French, Finnish - Staff person, no services provided.

HEALTH SERVICES

Service	Description
24-Hour Nursing and Personal Care	Nursing and personal care on a 24-hour basis, including care given by or under the supervision of a registered nurse or a registered practical nurse, the administration of medication and assistance with activities of daily living.
Physician Services	24-Hour On Call Physician. Residents may continue to have their personal physician provide care to them in the facility. These physicians will be expected to meet the standards and criteria for attending physicians
Other	Foot Care, Hairdressing/Barber Services, Laundry Services, Meals, Medication Administration, Palliative Care, Social Work Services/Family Services Coordinator, Spiritual Programs and Pastoral Care, Various Recreational Programs and Social Events.

(Ontario Finnish Rest Home Association- Mauno kaihla Koti, 2013; North East Community Care Access Centre- Mauno Kaihla Koti Nursing Home, 2013)

Long Term Care Organization: Extendicare Great Northern

Address: 860 Great Northern Rd
 Sault Ste Marie, ON
 P6A 5K7

Phone: 705-946-1215
Fax: 705-946-4684
Email:
Website: www.extendicarecanada.com

Office Hours: Mon-Fri 8am-4pm

Service Hours: Mon-Sun 24 hours

Application: Must apply through your local Community Care Access Centre.

Eligibility: Applicants must meet the Ministry of Health and Long Term Care eligibility requirements.

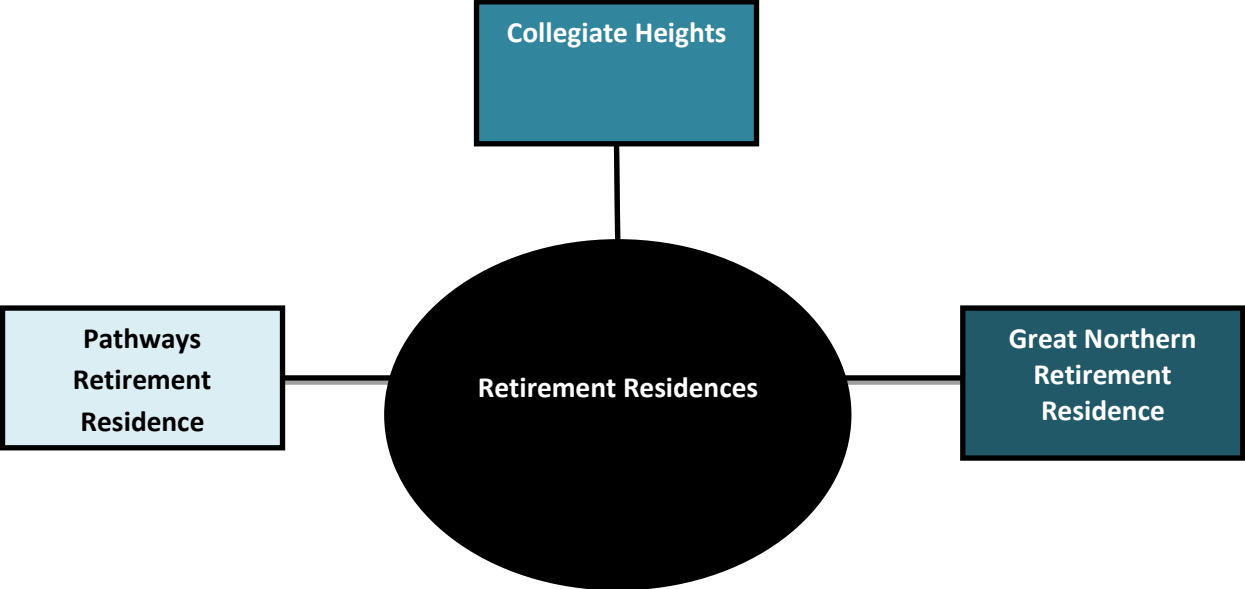
Languages: English.

HEALTH SERVICES

Service	Description
All Services	<ul style="list-style-type: none"> • 24-hour Nursing Care and Supervision • 24-hour On Call Physician • Care Conferences • Foot Care • Hairdressing/Barber Services • Laundry Services • Meals • Medication administration • Palliative care • Physician Visits • Social Work Services/Family Services Coordinator • Spiritual Programs and Pastoral Care • Various recreational programs and social events

(North East Community Care Access Centre-Extendicare Great Northern, 2013)

Sector 3: Retirement Residences Map



Sector 3: Retirement Residences Inventory

Retirement Residences Organization: Collegiate Heights

Address: 95 Fauquier Ave
Sault Ste Marie, ON
P6B 2P2

Phone: 705-253-1667
Fax: 705-253-9352
Email: collegiateheights@chartwellreit.ca
Website: www.chartwellreit.ca

Service Hours: Mon-Sun 24 hours

Application: Contact facility via phone or email for more information.

Eligibility: 60 year(s) and up. Independent well retired seniors.

Languages: English.

GENERAL SERVICES

Service	Description
Support & Wellness	<ul style="list-style-type: none"> • Health care monitoring • Professional on-site management • 24 hour security monitoring service • Concierge services • Unlimited access to scheduled life enrichment programs in recreation, leisure, social arts, entertainment and fitness • Scheduled transportation for local shopping • Weekly housekeeping including: vacuuming, light dusting, cleaning of bathrooms, kitchenette surfaces, floors and change and laundry of bed linens
Customized Support & Wellness Advantage Plus Services	<ul style="list-style-type: none"> • Medication Assistance – for persons who self-medicate & use assistance for ordering, monitoring, delivery to suite & consultation with registered staff • Medication Administration/Treatments to resident suite • Laundry Service: washed, folded and delivered to suite • Weekly assistance with one bath/shower per week in resident suite • Incontinence management • Daily housekeeping, garbage pick-up, washroom service or bed making • Assistance with activities of daily living (dressing, hygiene, dental care, etc) • Prescribed treatments, injections and blood work as per physician order • Seasonal or additional deep cleaning of suite including carpet cleaning • Customized specialized care may include; illiostomy, urostomy, colostomy, oxygen care • Escort to activities, meals or ambulation, mobilization or transfer assistance

	<ul style="list-style-type: none"> • Pet care • Other customized services may be available on discussion with Manager
Dining	<ul style="list-style-type: none"> • Access to self-serve hospitality & refreshment areas 24 hours daily • Some therapeutic diets may be available on consultation with Food Services Manager • Two meals; lunch and supper either served or buffet style as designated
Short Stay Beds	<ul style="list-style-type: none"> • Collegiate Heights Retirement Residence offers a variety of short-term stays based on your needs. We welcome short stays for a variety of reasons whether you need care after being in hospital, a break from daily chores or to see what retirement living is all about. We invite you to come and enjoy delicious meals, great company and daily activities with people just like you. With 24hr professionally trained staff on site, you can rest assured knowing help is close by.

(Chartwell, 2009)

Retirement Residences Organization: Great Northern Retirement Residence

Address: 760 Great Northern Rd
Sault Ste Marie, ON
P6A 5K7

Phone: 705-945-9405
Fax: 705-942-2063
Email: greatnorthern.longo@shaw.ca
Website: www.greatnorthernretirement.com

Office Hours: Mon-Fri 8am-4pm

Service Hours: Mon-Sun 24 hours

Application: Contact facility via phone, email, or website for more information.

Eligibility: Ages: 60 year(s) and up. Independent, well seniors. Further details listed below under accommodation type.

Languages: English.

ACCOMMODATIONS

Service	Description
Independent Living	<ul style="list-style-type: none"> • Relatively independent and self sufficient • Emergency Nursing assistance provided • 3 complete meals and snacks daily. Beverages available at all times. • Housekeeping Services once per week. • Laundry Service once per week. • Must be able to ambulate to and from dining area with or without use of assistive device. • Must be able to feed self. Third floor dining must be able to serve buffet style. • Must be able to bathe, dress self, maintain oral care and be independent with toileting. • Must be oriented to person, place and time. • Must be able to safely administer own medication.
Basic Living	<ul style="list-style-type: none"> • Relatively independent and self-sufficient. • Emergency Nursing assistance provided. • 3 complete meals and snacks daily. Beverages available at all times. • Housekeeping Services once per week. • Laundry Service once per week. • Must be able to ambulate to and from dining area with or without use of assistive device. • Must be able to feed self. Third floor dining must be able to serve buffet style. • Must be able to bathe, dress self, maintain oral care and be independent with toileting. • Assistance with one bath per week. • Must be oriented to person, place and time. • Must be able to safely administer own medication or manage with meds set up in dosette (pill organizer). Director of Care will order

	<p>medication and refill dosette weekly.</p> <ul style="list-style-type: none"> • Provisions for insulin administration, prescribed treatments. • Physician contact on behalf of resident provided with permission
Assisted Living	<ul style="list-style-type: none"> • Emergency Nursing assistance provided. • 3 complete meals and snacks daily. Beverages available at all times. • Must be able to feed self. Meal service to table. Speciality diet provisions. Assistance with presentation of food given (i.e. cutting of food for individual with physical limitations). • Daily housekeeping to assist the resident who experience difficult in maintaining a tidy/safe living environment. • Laundry Service once per week. • Must be able to safely transfer from bed to chair, vice versa- assistance to and from dining area available from staff. Assistive devices allowed on all levels. • Provisions for assistance with dressing, undressing, hs care. • Assistance with one bath per week. • Assistance with incontinence (controlled) to include daily prei care, assistance with depends. • Must be largely cognitive (slightly confused residents who are not prone to wandering to follow in house policy and procedure). • Provision for total medication administration regime including physician contract, pharmacy reordering and documenting of same on MARS for doctor’s appointments on behalf of resident. • Night check of requested by resident/responsible party. • On call emergency nursing and physician contact on behalf of resident regarding health concerns as indicated

HEALTH AND SUPPORT SERVICES

Service	Description
General	<ul style="list-style-type: none"> • Offers rooms/suites with ensuite • Provides 3 meals per day and snacks • 24 hr nursing monitoring • Housekeeping services • Provides activities including games, musical entertainment, and outings • Medication administration • Laundry Services • Assistance with weekly bathing/shower • Assistance with activities of daily living (dressing, hygiene) • Parking for residents and visitors • Pet Care

(Great Northern Retirement Home, 2013).

Retirement Residences Organization: Pathways Retirement Residence

Address: 375 Trunk Rd
Sault Ste Marie, ON
P6A 6T5

Phone: 705-759-1079
Fax: 705-759-1211
Email: pathways@bellnet.ca
Website: www.pathwaysretirement.com

Office Hours: Mon-Fri 9am-5pm

Service Hours: Mon-Sun 24 hours

Application: Contact facility via phone, email, or website for more information.

Eligibility: Ages: 60 year(s) and up. Independent, well seniors.

Languages: English.

HEALTH AND SUPPORT SERVICES

Service	Description
Health Care & Support Services	<ul style="list-style-type: none"> • Provides 3 meals per day and snacks • 24 hr staffing • Housekeeping services • Assists with medication administration • Provides assistance with personal care • Assistance with bathing/shower

ACTIVITIES

Service	Description
Regular Activities	<ul style="list-style-type: none"> • Exercise Programs • Bingo • Crafts • Movies and Videos • Evening Entertainment
Intergenerational Activities	<p>During the school year children come on the first Monday of each month to read their books aloud to a reading buddy. Each child is assigned to an adult who will listen to oral reading and assist with vocabulary when necessary. On the second Monday of each month students come to play board games in various locations throughout the building. At Christmas and again in June the students belonging to the Junior Choir present their repertoire. On Tuesday afternoons a group meets in the library to engage in word puzzle solving working co-operatively to get the answers, while other Residents play crokinole, cards, cribbage or dominoes in the Activities Room.</p>
Bible Studies- Church Services	<p>Bible study discussion group meets in the Chapel area once a week. Each participant should bring a Bible. St. Jerome's Catholic Church conducts monthly Mass on the first Friday of every month. Each Sunday there is a service for Roman Catholic Residents at 10:15 Am provided by lay persons from St. Jerome's Parish while an Interdenominational Service takes place</p>

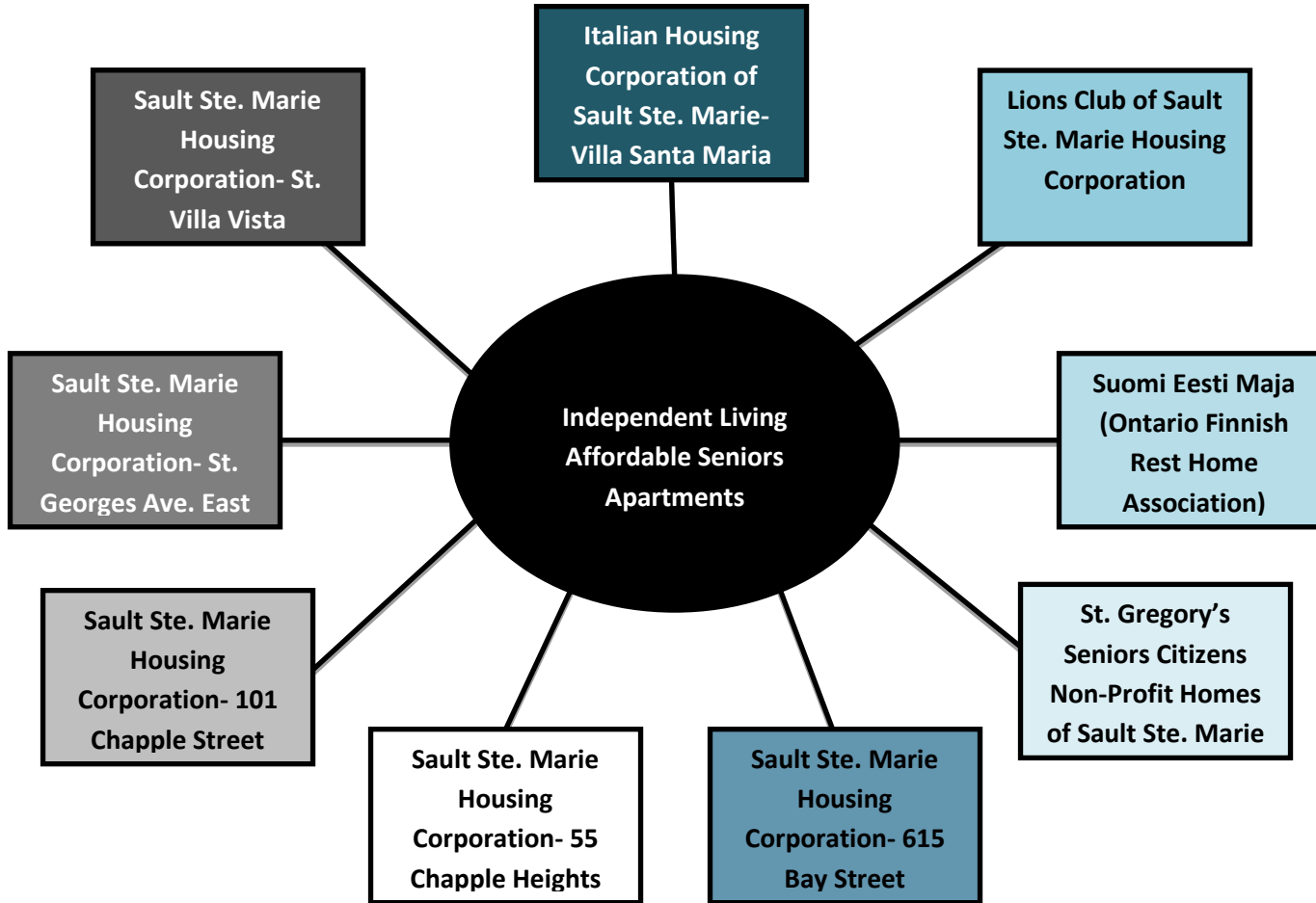
	at 10:00 AM in the Chapel. Communion Services are conducted periodically throughout the year. In addition to the services already mentioned hymn sings are held at regular intervals by various groups during the summer months.
Special Annual Events	Pathways Retirement Residence offers server special annual events that include: Mother’s Day Tea; Fall Colours Bus Trip; Halloween costume party; Christmas Lights Tour; Christmas Tea and Bazaar; New Year’s Eve Party. Evening events and some afternoon special events are made possible with the assistance of volunteers, often family members of Residents and during the school year high school students who have chosen Pathways to perform volunteer hours here. Volunteer assistance is gratefully appreciated.

BUILDING SERVICES

Service	Description
Beauty Salon	Licensed hairdresser available on Tuesdays and Thursdays. Appointments are booked through Reception and you pay charges directly to the hairdresser.
Office	The office is open from 9:00am to 5:00pm Monday through Friday and office staff will assist you and answer any questions you may have regarding monthly statements, dining guests, cash transactions, etc.
Mail	Incoming mail is placed in your private mail box by Canada Post, Monday through Friday. There is a Canada Post outgoing mail box located at the front entrance for your convenience.
Parking	Your own individual parking spot awaits you with winter block heater receptacle at no extra cost to you.

(Pathways Retirement Residence, 2013)

Sector 4: Independent Living Affordable Seniors Apartments Map



Sector 4: Independent Living Affordable Seniors Apartments Inventory

Independent Living Affordable Seniors Apartments Organization: Italian Housing Corporation of Sault Ste. Marie- Villa Santa Maria

Address: 4 East Street
Sault Ste Marie, ON
P6A 6W9

Phone: (705) 253-3866
Fax:
Email: peetster@shaw.ca
Website: <http://www.ssm-dssab.ca/HousingProviders/index.cfm>

Office Hours: Mon-Fri 1:00pm - 5:00pm
Contact: Peter Giustini, General Manager

Application: Application forms can be found online through the following link: http://ssm-dssab.ca/documents/assets/uploads/files/en/rgi_application_december_20121.pdf Application forms can also be obtained from the application centre location listed below.

- Application Centre:
Sault Ste. Marie Social Housing Application Centre
180 Brock Street
Sault Ste. Marie, ON
P6A 3B7
Phone: (705) 759-7748

Eligibility: You may be eligible for Rent-Geared-To-Income (RGI) Housing if:

1. You are: a Canadian Citizen; a landed immigrant; or a refugee claimant
2. No member of the household: owes arrears of rent to any Social Housing provider; owes money to previous Social Housing providers; has been convicted of an offence regarding the receipt of RGI assistance; has misrepresented their income for the purpose of RGI
3. All RGI tenants / members are required to pursue all possible sources of income such as: Ontario Works; Child Support Employment Insurance; Immigration Sponsorship Support
4. Meet the RGI financial needs criteria
5. A Senior is a person 60 years of age or older or will be 60 years of age within 12 months of date of application.

Languages: English.

Service	Description
Tenant Type	Senior
Location	Downtown
One Bedroom Units	52
Two Bedroom Units	8
Special Needs Units	7
Assisted Living Services	Not located on-site, however tenant may obtain assisted living services at their own discretion.
(District of Sault Ste. Marie Social Services Administration Board- Social Housing, 2013)	

**Independent Living Affordable Seniors Apartments Organization:
Lions Club of Sault Ste. Marie Housing Corporation**

Address: 623 Bay St. Suite 100
Sault Ste Marie, ON
P6A6R9

Phone: (705) 949-7426
Fax:
Email: lionsplace@on.aibn.com
Website: <http://www.ssm-dssab.ca/HousingProviders/index.cfm>

Office Hours: Mon-Thurs 9:00am - 2:00pm

Contact: Melissa Lennox, Property Manager

Application: Application forms can be found online through the following link: http://ssm-dssab.ca/documents/assets/uploads/files/en/rgi_application_december_20121.pdf Application forms can also be obtained from the application centre location listed below.

Application Centre:

Sault Ste. Marie Social Housing Application Centre
180 Brock Street
Sault Ste. Marie, ON
P6A 3B7
Phone: (705) 759-7748

Eligibility: You may be eligible for Rent-Geared-To-Income (RGI) Housing if:

1. You are: a Canadian Citizen; a landed immigrant; or a refugee claimant
2. No member of the household: owes arrears of rent to any Social Housing provider; owes money to previous Social Housing providers; has been convicted of an offence regarding the receipt of RGI assistance; has misrepresented their income for the purpose of RGI
3. All RGI tenants / members are required to pursue all possible sources of income such as: Ontario Works; Child Support Employment Insurance; Immigration Sponsorship Support
4. Meet the RGI financial needs criteria
5. A Senior is a person 60 years of age or older or will be 60 years of age within 12 months of date of application.

Languages: English.

Service	Description
Tenant Type	Senior
Location	Downtown
One Bedroom Units	57
Two Bedroom Units	3
Special Needs Units	8
Assisted Living Services	Not located on-site, however tenant may obtain assisted living/ in-home care services at their own discretion.
(District of Sault Ste. Marie Social Services Administration Board- Social Housing, 2013)	

Independent Living Affordable Seniors Apartments Organization:
Suomi Eesti Maja (Ontario Finnish Rest Home Association)

Address: 721 North Street
 Sault Ste Marie, ON
 P6B5T7

Phone: (705) 945-9987
Fax:
Email: lmassad@thefra.org
Website: <http://www.ssm-dssab.ca/HousingProviders/index.cfm>

Office Hours: Mon-Fri 9:00am - 5:00pm

Contact: Lewis Massad or Andy Koskinen

Application: Application forms can be found online through the following link: http://ssm-dssab.ca/documents/assets/uploads/files/en/rgi_application_december_20121.pdf Application forms can also be obtained from the application centre location listed below.

Application Centre:

Sault Ste. Marie Social Housing Application Centre
 180 Brock Street
 Sault Ste. Marie, ON
 P6A 3B7
 Phone: (705) 759-7748

Eligibility: You may be eligible for Rent-Geared-To-Income (RGI) Housing if:

1. You are: a Canadian Citizen; a landed immigrant; or a refugee claimant
2. No member of the household: owes arrears of rent to any Social Housing provider; owes money to previous Social Housing providers; has been convicted of an offence regarding the receipt of RGI assistance; has misrepresented their income for the purpose of RGI
3. All RGI tenants / members are required to pursue all possible sources of income such as: Ontario Works; Child Support Employment Insurance; Immigration Sponsorship Support
4. Meet the RGI financial needs criteria
5. A Senior is a person 60 years of age or older or will be 60 years of age within 12 months of date of application.

Languages: English.

Service	Description
Tenant Type	Senior
Location	Central
One Bedroom Units	134
Two Bedroom Units	0
Special Needs Units	0
Assisted Living Services	Not located on-site, however tenant may obtain assisted living/ in-home care services at their own discretion.
(District of Sault Ste. Marie Social Services Administration Board- Social Housing, 2013)	

Independent Living Affordable Seniors Apartments Organization: St. Gregory's Seniors Citizens Non-Profit Homes of Sault Ste. Marie

Address: 393 Dovercourt Road
Sault Ste. Marie, ON
P6C2A8

Phone: (705) 945-8234
Fax:
Email: stgreg@sympatico.ca
Website: <http://www.ssm-dssab.ca/HousingProviders/index.cfm>

Contact: John Cavaliere, Property Manager

Application: Application forms can be found online through the following link: http://ssm-dssab.ca/documents/assets/uploads/files/en/rgi_application_december_20121.pdf Application forms can also be obtained from the application centre location listed below.

Application Centre:

Sault Ste. Marie Social Housing Application Centre
180 Brock Street
Sault Ste. Marie, ON
P6A 3B7
Phone: (705) 759-7748

Eligibility: You may be eligible for Rent-Geared-To-Income (RGI) Housing if:

1. You are: a Canadian Citizen; a landed immigrant; or a refugee claimant
2. No member of the household: owes arrears of rent to any Social Housing provider; owes money to previous Social Housing providers; has been convicted of an offence regarding the receipt of RGI assistance; has misrepresented their income for the purpose of RGI
3. All RGI tenants / members are required to pursue all possible sources of income such as: Ontario Works; Child Support Employment Insurance; Immigration Sponsorship Support
4. Meet the RGI financial needs criteria
5. A Senior is a person 60 years of age or older or will be 60 years of age within 12 months of date of application.

Languages: English.

Service	Description
Tenant Type	Senior
Location	West End
One Bedroom Units	24
Two Bedroom Units	0
Special Needs Units	2
Assisted Living Services	Not located on-site, however tenant may obtain assisted living/ in-home care services at their own discretion.
(District of Sault Ste. Marie Social Services Administration Board- Social Housing, 2013)	

**Independent Living Affordable Seniors Apartments Organization:
Sault Ste. Marie Housing Corporation- 615 Bay Street**

Address: 615 Bay Street
Sault Ste. Marie, ON

Phone: (705) 759-5004
Fax:
Email: j.barban@cityssm.on.ca
Website: <http://www.ssm-dssab.ca/HousingProviders/index.cfm>

Contact: Jeff Barban, Operations Manager

Application: Application forms can be found online through the following link: http://ssm-dssab.ca/documents/assets/uploads/files/en/rgi_application_december_20121.pdf Application forms can also be obtained from the application centre location listed below.

Application Centre:

Sault Ste. Marie Social Housing Application Centre
180 Brock Street
Sault Ste. Marie, ON
P6A 3B7
Phone: (705) 759-7748

Eligibility: You may be eligible for Rent-Geared-To-Income (RGI) Housing if:

1. You are: a Canadian Citizen; a landed immigrant; or a refugee claimant
2. No member of the household: owes arrears of rent to any Social Housing provider; owes money to previous Social Housing providers; has been convicted of an offence regarding the receipt of RGI assistance; has misrepresented their income for the purpose of RGI
3. All RGI tenants / members are required to pursue all possible sources of income such as: Ontario Works; Child Support Employment Insurance; Immigration Sponsorship Support
4. Meet the RGI financial needs criteria
5. A Senior is a person 60 years of age or older or will be 60 years of age within 12 months of date of application.

Languages: English.

Service	Description
Tenant Type	Senior
Location	Downtown
One Bedroom Units	132
Two Bedroom Units	0
Special Needs Units	0
Assisted Living Services	Located on-site and available to residents who meet service eligibility criteria.
(District of Sault Ste. Marie Social Services Administration Board- Social Housing, 2013)	

Independent Living Affordable Seniors Apartments Organization: Sault Ste. Marie Housing Corporation- 55 Chapple Heights

Address:

55 Chapple Street
Sault Ste. Marie, ON

Phone: (705) 759-5004

Fax:

Email: j.barban@cityssm.on.ca

Website: <http://www.ssm-dssab.ca/HousingProviders/index.cfm>

Contact: Jeff Barban, Operations Manager

Application: Application forms can be found online through the following link: http://ssm-dssab.ca/documents/assets/uploads/files/en/rgi_application_december_20121.pdf Application forms can also be obtained from the application centre location listed below.

Application Centre:

Sault Ste. Marie Social Housing Application Centre
180 Brock Street
Sault Ste. Marie, ON
P6A 3B7
Phone: (705) 759-7748

Eligibility: You may be eligible for Rent-Geared-To-Income (RGI) Housing if:

1. You are: a Canadian Citizen; a landed immigrant; or a refugee claimant
2. No member of the household: owes arrears of rent to any Social Housing provider; owes money to previous Social Housing providers; has been convicted of an offence regarding the receipt of RGI assistance; has misrepresented their income for the purpose of RGI
3. All RGI tenants / members are required to pursue all possible sources of income such as: Ontario Works; Child Support Employment Insurance; Immigration Sponsorship Support
4. Meet the RGI financial needs criteria
5. A Senior is a person 60 years of age or older or will be 60 years of age within 12 months of date of application.

Languages: English.

Service	Description
Tenant Type	Senior
Location	Central
One Bedroom Units	67
Two Bedroom Units	0
Special Needs Units	0
Assisted Living Services	Located on-site and available to residents who meet service eligibility criteria.
(District of Sault Ste. Marie Social Services Administration Board- Social Housing, 2013)	

**Independent Living Affordable Seniors Apartments Organization:
Sault Ste. Marie Housing Corporation- 101 Chapple Street**

Address:

101 Chapple Street
Sault Ste. Marie, ON

Phone: (705) 759-5004

Fax:

Email: j.barban@cityssm.on.ca

Website: <http://www.ssm-dssab.ca/HousingProviders/index.cfm>

Contact: Jeff Barban, Operations Manager

Application: Application forms can be found online through the following link: http://ssm-dssab.ca/documents/assets/uploads/files/en/rgi_application_december_20121.pdf Application forms can also be obtained from the application centre location listed below.

Application Centre:

Sault Ste. Marie Social Housing Application Centre
180 Brock Street
Sault Ste. Marie, ON
P6A 3B7
Phone: (705) 759-7748

Eligibility: You may be eligible for Rent-Geared-To-Income (RGI) Housing if:

1. You are: a Canadian Citizen; a landed immigrant; or a refugee claimant
2. No member of the household: owes arrears of rent to any Social Housing provider; owes money to previous Social Housing providers; has been convicted of an offence regarding the receipt of RGI assistance; has misrepresented their income for the purpose of RGI
3. All RGI tenants / members are required to pursue all possible sources of income such as: Ontario Works; Child Support Employment Insurance; Immigration Sponsorship Support
4. Meet the RGI financial needs criteria
5. A Senior is a person 60 years of age or older or will be 60 years of age within 12 months of date of application.

Languages: English.

Service	Description
Tenant Type	Senior
Location	Central
One Bedroom Units	58
Two Bedroom Units	0
Special Needs Units	0
Assisted Living Services	Not located on-site, however tenant may obtain assisted living/ in-home care services at their own discretion.
(District of Sault Ste. Marie Social Services Administration Board- Social Housing, 2013)	

Independent Living Affordable Seniors Apartments Organization:
Sault Ste. Marie Housing Corporation- St. Georges Ave. East

Address: 345 St. Georges Avenue East
 Sault Ste. Marie, ON

Phone: (705) 759-5004
Fax:
Email: j.barban@cityssm.on.ca
Website: <http://www.ssm-dssab.ca/HousingProviders/index.cfm>

Contact: Jeff Barban, Operations Manager

Application: Application forms can be found online through the following link: http://ssm-dssab.ca/documents/assets/uploads/files/en/rgi_application_december_20121.pdf Application forms can also be obtained from the application centre location listed below.

Application Centre:

Sault Ste. Marie Social Housing Application Centre
 180 Brock Street
 Sault Ste. Marie, ON
 P6A 3B7
 Phone: (705) 759-7748

Eligibility: You may be eligible for Rent-Geared-To-Income (RGI) Housing if:

1. You are: a Canadian Citizen; a landed immigrant; or a refugee claimant
2. No member of the household: owes arrears of rent to any Social Housing provider; owes money to previous Social Housing providers; has been convicted of an offence regarding the receipt of RGI assistance; has misrepresented their income for the purpose of RGI
3. All RGI tenants / members are required to pursue all possible sources of income such as: Ontario Works; Child Support Employment Insurance; Immigration Sponsorship Support
4. Meet the RGI financial needs criteria
5. A Senior is a person 60 years of age or older or will be 60 years of age within 12 months of date of application.

Languages: English.

Service	Description
Tenant Type	Senior
Location	Central
One Bedroom Units	60
Two Bedroom Units	0
Special Needs Units	0
Assisted Living Services	Not located on-site, however tenant may obtain assisted living/ in-home care services at their own discretion.
(District of Sault Ste. Marie Social Services Administration Board- Social Housing, 2013)	

Independent Living Affordable Seniors Apartments Organization:
Sault Ste. Marie Housing Corporation- St. Villa Vista

Address:

53 Chapple Street
 Sault Ste. Marie, ON

Phone: (705) 759-5004

Fax:

Email: j.barban@cityssm.on.ca

Website: <http://www.ssm-dssab.ca/HousingProviders/index.cfm>

Contact: Jeff Barban, Operations Manager

Application: Application forms can be found online through the following link: http://ssm-dssab.ca/documents/assets/uploads/files/en/rgi_application_december_20121.pdf Application forms can also be obtained from the application centre location listed below.

Application Centre:

Sault Ste. Marie Social Housing Application Centre
 180 Brock Street
 Sault Ste. Marie, ON
 P6A 3B7
 Phone: (705) 759-7748

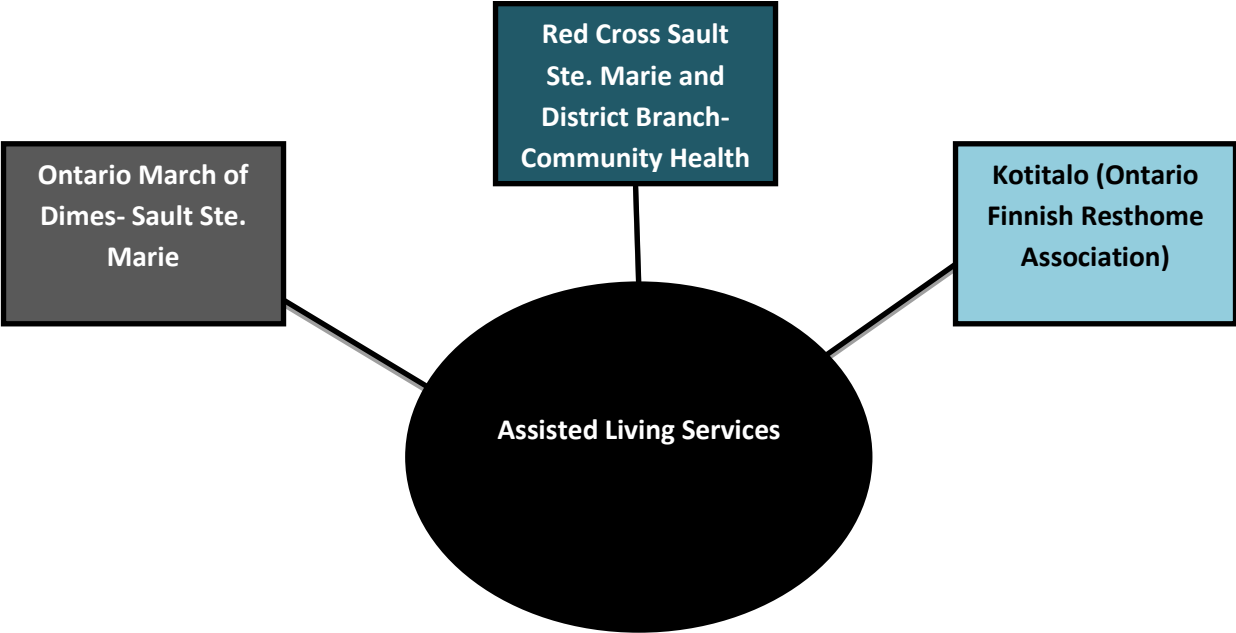
Eligibility: You may be eligible for Rent-Geared-To-Income (RGI) Housing if:

1. You are: a Canadian Citizen; a landed immigrant; or a refugee claimant
2. No member of the household: owes arrears of rent to any Social Housing provider; owes money to previous Social Housing providers; has been convicted of an offence regarding the receipt of RGI assistance; has misrepresented their income for the purpose of RGI
3. All RGI tenants / members are required to pursue all possible sources of income such as: Ontario Works; Child Support Employment Insurance; Immigration Sponsorship Support
4. Meet the RGI financial needs criteria
5. A Senior is a person 60 years of age or older or will be 60 years of age within 12 months of date of application.

Languages: English.

Service	Description
Tenant Type	Senior
Location	Central
One Bedroom Units	30
Two Bedroom Units	0
Special Needs Units	0
Assisted Living Services	Not located on-site, however tenant may obtain assisted living/ in-home care services at their own discretion.
(District of Sault Ste. Marie Social Services Administration Board- Social Housing, 2013)	

Sector 5: Assisted Living Services Map



Sector 5: Assisted Living Services Inventory

Assisted Living Services Organization: Red Cross Sault Ste. Marie and District Branch- Community Health Services

Office Address: 105 Allard St
Sault Ste. Marie, ON
P6B 5G2

Phone: 705-759-4543
Toll Free: 1-800-418-1111
Email: sharon.swain@redcross.ca
Website: www.redcross.ca

Office Hours: Mon-Fri 8:30am-4:30pm

Service Hours: Mon-Sun 24hours a day

Application: Contact office via phone or email.

Eligibility: Demonstrates a need for daily access to personal support and/or attendant services throughout a 24 hour period every day.

Languages: English.

Service	Description
Assisted Living	Assisted living Services for High Risk Seniors' services aim to focus on activities of daily living that you can no longer do or find challenging to do on your own such as: <ul style="list-style-type: none">• Toileting• Washing/Bathing• Preventative Skin Care• Transferring/Positioning/Turning• Dressing/Undressing• Assistance with Eating• Reminders re: Pre-Measured Medications• Exercising• Meal Preparation• Bed Making and Laundry• Light Housekeeping

(North East Community Care Access Centre- Canadian Red Cross - Sault Ste Marie and District Branch, 2013)

Assisted Living Services Organization: Kotitalo (Ontario Finnish Resthome Association)

Office Address:

725 North St

Sault Ste. Marie, ON

P6B 5Z3

Phone: 705-945-9987

Fax: 705-945-1217

Email: info@ontariofinnishresthome.ca

Website: www.ontariofinnishresthome.ca

Office Hours: Mon-Fri 8:30am-4:30pm

Service Hours: Mon-Sun 24hours a day

Application: May require an assessment prior to admission.

Eligibility:

- **Assisted Living Accommodation:** A new applicant must meet ALL of the following criteria in order to be approved for admission:
 - Disabled adult (55 years of age or older) or adult aged 60 year of age or older.
 - Have a medical assessment (Functional and Social Assessment) on file that has been completed within the last year and indicates that the applicant is suitable for admission to a supportive housing facility.
 - Care requirements can be met by the Supportive Housing Program.
 - Must be able to ambulate independently or by using an assistive device (e.g., wheelchair). Note that if using an assistive device, must be able to transfer self from wheelchair to chair or to bed independently. Motorized wheelchairs/scooters are not permitted.
 - Must be able to complete his/her daily personal care, such as dressing and daily washing (unless partner able to provide this care).
 - Must be mentally alert and not at risk of wandering outside or at risk of safety to self or others.
 - Must not be incontinent of bowel or bladder functioning unless able to change self.
 - Must be able to prepare own breakfast
 - Must be able to control and take his/her own medications.
- **Assisted Living Services:**
 - RN Supervisor at Kotitalo will do admission assessment to determine eligibility to supportive housing (i.e assisted living)
 - Demonstrates a need for daily access to personal support and/or attendant services throughout a 24 hour period every day.

Languages: English. Finnish - Staff member, no services.

Service	Description
General Services with Accommodation	<ul style="list-style-type: none"> • 24 Hour lifeline emergency call response • Housekeeping services • Provides activities including games, musical entertainment, and

	<p>outings</p> <ul style="list-style-type: none"> • Laundry Services • Parking for residents and visitors • Hair Salon • Blood Pressure Clinics • Foot Care (Twice per month, extra service fee) • Dental Care (extra service fee) • Lounge • Tuck shop • Library • Eye clinics • Physiotherapy • Bakery
Assisted Living Services	<p>Assisted living Services for High Risk Seniors' services aim to focus on activities of daily living that you can no longer do or find challenging to do on your own such as:</p> <ul style="list-style-type: none"> • Toileting • Washing/Bathing • Preventative Skin Care • Transferring/Positioning/Turning • Dressing/Undressing • Assistance with Eating • Reminders re: Pre-Measured Medications • Exercising • Meal Preparation • Bed Making and Laundry • Light Housekeeping

(North East Community Care Access Centre- Ontario Finnish Resthome Association - Kotitalo Sault Ste Marie, 2013).

Assisted Living Services Organization:
Ontario March of Dimes- Sault Ste. Marie

Office Address: 700 Bay St
 Sault Ste. Marie, ON
 P6A 6L7

Phone: 705-671-3188 ext 220
Fax: 705-671-6240
Email: dchisholmtullio@marchofdimes.ca
Website:

Office Hours: Mon-Fri 8:30am-4:30pm

Service Hours: Mon-Sun 24hours a day

Application: May require an assessment prior to admission.

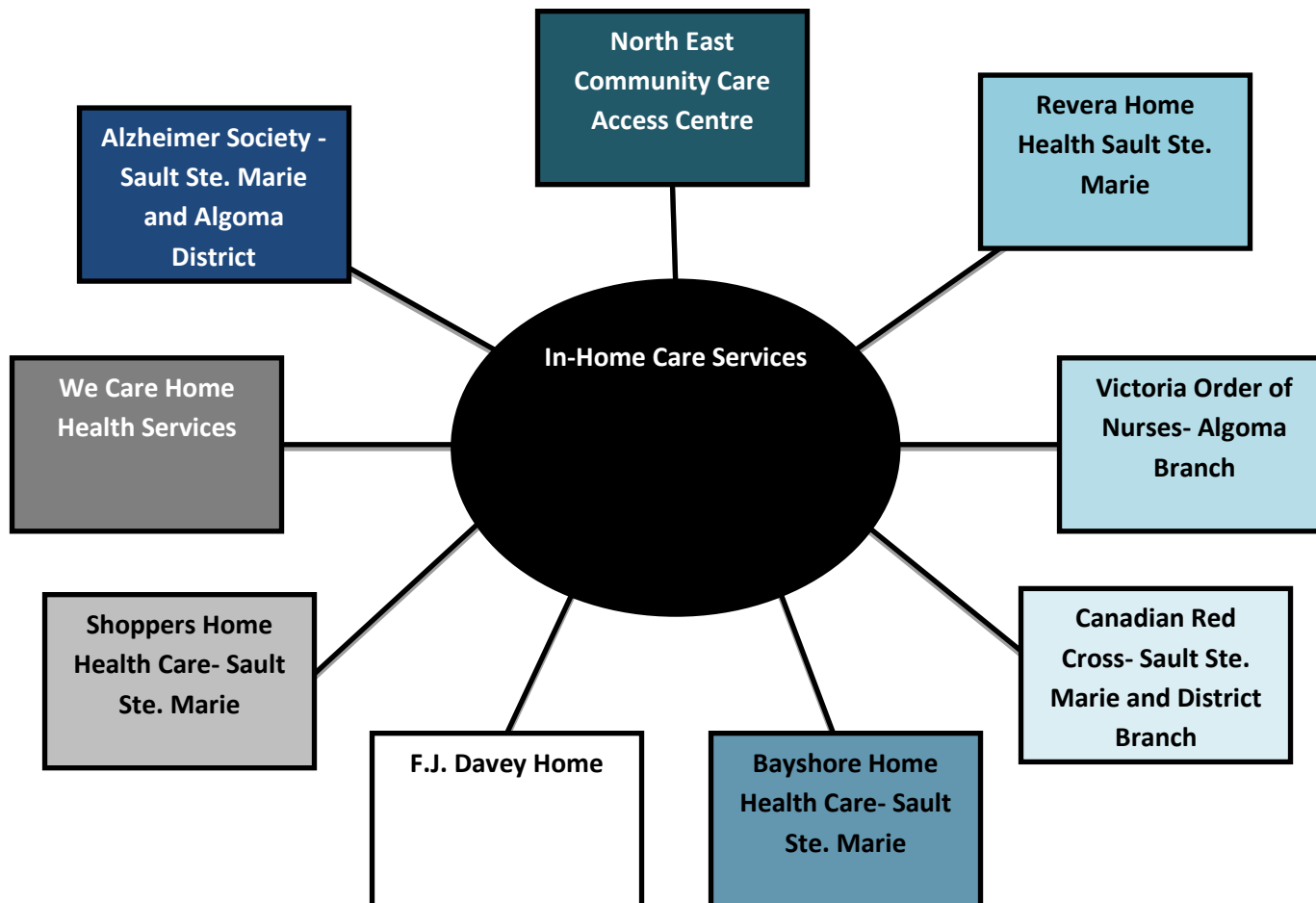
Eligibility: Demonstrates a need for daily access to personal support and/or attendant services throughout a 24 hour period every day.

Languages: English.

Service	Description
Assisted Living Services	Assisted living Services for High Risk Seniors’ services aim to focus on activities of daily living that you can no longer do or find challenging to do on your own such as: <ul style="list-style-type: none"> • Toileting • Washing/Bathing • Preventative Skin Care • Transferring/Positioning/Turning • Dressing/Undressing • Assistance with Eating • Reminders re: Pre-Measured Medications • Exercising • Meal Preparation • Bed Making and Laundry • Light Housekeeping

(North East Community Care Access Centre- Ontario March of Dimes-Sault Ste. Marie, 2013).

Sector 6: In-Home Care Services Map



Sector 6: In-Home Care Services Inventory

In-Home Care Services Organization: North East Community Care Access Centre

<p>Office Address: 390 Bay St Sault Ste. Marie, ON P6A 1X2</p>	<p>Phone: 705-949-1650 Fax: 705-949-1663 Email: janet.skuce@ne.ccac-ont.ca Website: www.ne.ccac-ont.ca Toll Free: 1-800-668-7705 Teletype: 1-866-369-3313</p>
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Office Hours: Mon-Fri 8:30am-4:30pm

Telephone Line: Mon-Sun 8am-8pm

Application: Self-referrals, friends and family, health care professionals; Waiting periods for services may vary depending on the type of service required and priority need; Must meet eligibility criteria.

Eligibility: Must be 18 years of age to access any long term care facilities; Children and youth with health needs that impact their ability to learn at school; Community clients requiring short or long term care to meet their needs.

Languages: English; French.

Service	Description
Case Management	With your participation or the participation of your family or caregivers, the North East CCAC Case Manager plans and coordinates the services that you may need at home or at school. The Case Manager will work with your physician and other members of your healthcare team to help plan your care and maximize your independence. The Case Manager monitors your services and adapts them to your needs as your condition changes.
Nursing	Based on your needs, a Registered Nurse or Registered Practical Nurse may: <ul style="list-style-type: none"> • Provide nursing services in home, school or clinic settings; • Provide/teach wound and ostomy care, intravenous therapy, catheterization, pain and symptom management; • Educate you or caregivers on your disease/health condition to manage your health and care needs; • Support you and your family in providing palliative/end of life care at home.
Personal Support/ Homemaking	Based on your needs, a Personal Support Worker may: <ul style="list-style-type: none"> • Help you with personal care including bathing, dressing and toileting needs; • Teach and assist with daily activities in order to enable you to

	<p>stay in your home;</p> <ul style="list-style-type: none"> • May provide time for your caregivers to leave the home for short periods, if you live with someone who helps with most or all of your personal care and daily activities; • May provide limited homemaking tasks (laundry and light housekeeping) if no other supports are available.
Social Work	<p>Based on your needs, a Social Worker may:</p> <ul style="list-style-type: none"> • Provide services to you and caregivers if experiencing stress, loss or difficulties resulting from illness or disability; • Provide short term confidential counselling to assist with maximizing your social and emotional functioning, and enhancing your problem-solving and coping capacities; • Recommend strategies to help you adapt to change and address barriers to assist in recovery or rehab.
Occupational Therapy	<p>Based on your needs, an Occupational Therapist may:</p> <ul style="list-style-type: none"> • Provide services if you are having problems with daily activities because of physical or cognitive challenges to promote your independence and safety; • Assess your function (moving from bed to chair, getting on/off of your chair, etc.) and your home set up and to make your daily routine easier; • Recommend modifications to the home or school environment/assistive equipment for safety and accessibility.
Nutritional Counselling	<p>Based on your needs, a Dietitian may:</p> <ul style="list-style-type: none"> • Assess if you are experiencing nutritional difficulties; • Recommend a personalized therapeutic diet or; • Recommend the appropriate use of special nutrition preparations taken by mouth or by tube feedings; and • Teach and support you and your caregivers about nutritional needs, methods to monitor intake of food and fluids, and recommend food supplements.
Speech-Language Pathology	<p>Based on your needs, a Speech-Language Pathologist may:</p> <ul style="list-style-type: none"> • Assess if you are experiencing speech and language disorders, voice or swallowing difficulties; • Recommend and teach you in the use of communication and technology aids such as symbol boards and computer programs; • Provide techniques for safe swallowing of liquids and foods; • Provide services to your child and school staff in areas of articulation/phonology, voice and fluency.
Medical Equipment & Supplies	<p>This service may be provided if you are receiving nursing, physiotherapy, occupational therapy, speech-language pathology and dietetic services from the North East CCAC:</p> <p>Medical Supplies and Dressings:</p> <ul style="list-style-type: none"> • Some limited medical supplies for specific needs for a short period of time such as wound dressings or intravenous supplies; • Information about other resources when items need to be purchased.

	<ul style="list-style-type: none">• Client pick up is needed. <p>Medical Equipment Rental:</p> <ul style="list-style-type: none">• Short-term rental of some medical equipment such as wheelchairs, walkers, or bath chairs; (If the equipment is needed for a longer period of time, you will need to rent or purchase). <p>Drug Benefits:</p> <ul style="list-style-type: none">• Prescription medications approved by the Ontario Drug Benefit Plan (paid for by the Ontario Ministry of Health and Long Term Care); and• Ontario Drug Benefit Eligibility Card for short time if you are receiving, or are on a wait list for, professional services and your medication needs are related to your reason for admission;• Information about other sources, e.g. Trillium when medications are needed for longer periods.
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(North East Community Care Access Centre-Client Care Information Booklet, n.d.)

In-Home Care Services Organization: Revera Home Health Sault Ste. Marie

Office Address: 178 Drive-in Rd, #1
Sault Ste. Marie, ON
P6B 6A9

Phone: 705-759-0110
Fax: 705-942-5447
Email:
Website: www.reveraliving.com/Home-Health.aspx
Toll Free: 1-877-750-0110

Office Hours: Mon-Fri 8:30am-5:00pm

Service Hours: Mon-Sun 24hrs

Application: Contact office via phone or fax.

Eligibility: Contact office via phone or fax.

Languages: English; French speaking staff.

NURSING

Service	Description
Elder Care	Revera's nurses have specialized training and expertise in providing home care for elderly, disabled and convalescing seniors. We will work with you and your family to develop a customized plan of care that ensures your physical and emotional needs are met. Whether it's a short visit, scheduled wellness checks or around-the-clock care, we will ensure that procedures such as IV therapy, foot care, medication administration, and ostomy care are performed in a compassionate manner that respects your dignity.
Post-Hospital Care	Have you recently had surgery and are now recovering at home? We can help you achieve a smooth and speedy recovery. Our nurses will work with you to develop a customized plan for your home care, assess the impact of your surgery on your living environment and daily activities, and deliver any support or treatments you require such as intravenous (IV) therapy.
Wound and Ostomy Management	With any wound, the goal is to prevent infection and promote healing so that you can safely return to your daily activities. Our nurses have the expertise to deal with a variety of wounds including ulcers, incisions, burns and skin grafts. We carry out treatments and monitor the condition of wounds based on best practice. We can also provide advice about which supplies and products are best suited to your wound and personal situation. Our goal is to help you maintain an ideal healing environment for the wound and prevent infection during the healing process. For more complex wounds, we use an innovative digital photography program. It generates comprehensive assessment information, and facilitates expert advice from an enterostomal therapist (ET) with specialized knowledge and clinical skills in wound, ostomy care and continence management.

Foot Care	<p>Personal independence and comfort can be greatly affected by foot pain and problems. Our nurses can help you maintain optimal foot health through our home care services.</p> <p>We will assess your feet and provide professional foot care that is tailored to your unique needs. We can treat corns, calluses, or ingrown nails; cut nails; assist with foot exercises; provide advice on proper shoes and pain management; or provide the specialized care you require if you have diabetes, arthritis, gout or other conditions</p>
Complex Care	<p>Complex health needs or multiple conditions often require specialized home care support, beyond the capabilities of family caregivers. We aim to help our clients understand and live successfully with complex conditions. For example, individuals with diabetes face the challenge of managing a complicated disease and its effect on their health and quality of life. Our nurses can help by teaching you about diabetes, how to give an injection or use your blood sugar testing device, support you in developing meal plans that suit your lifestyle, and put you in touch with diabetic resources in your community.</p>
End-Of-Life Care	<p>We understand that an end-of-life situation can be complicated and different for each person and their family. Our end-of-life home care is compassionate and responsive to each individual's specific needs while respecting their cultural, religious and personal preferences.</p> <p>We take care of the whole person - body, mind and spirit. We gently tend to their health care needs, help them understand their health situation and, in collaboration with their medical doctor, manage their pain and other symptoms. We provide physical and emotional support to help both the individual and family cope during this difficult time.</p>

PERSONAL SUPPORT & HOME SUPPORT

Service	Description
Home Health Care	Our home health care provides assistance with everyday activities like grocery shopping, meal preparation, laundry and housekeeping, as well as personal hygiene activities like bathing, brushing teeth, washing hair or getting dressed.
Caregiver Relief	On occasion, you may need and benefit from a break from caring for a loved one. Our home care team can step in to skillfully tend to her or his needs. Your loved one will get the required support, and you get the time and freedom to rest or handle other responsibilities. Services can include overnight stays.
Companion Services	For anyone, social contact and support is a vital part of health and happiness. Revera provides support and companionship so that you can continue to live life to the fullest and enjoy activities that are important to you. Whether it's a walk in the park, a trip to the theatre or a quiet night at home, companionship services are designed around your schedule and your interests.

(North East Community Care Access Centre-Revera Home Health-Sault Ste. Marie, 2013; Revera Inc., 2012).

**In-Home Care Services Organization:
Victoria Order of Nurses- Algoma Branch**

Office Address: 860 Great Northern Rd, 1st floor
Sault Ste. Marie, ON
P6A 5K7

Phone: 705-942-8200
Fax: 705-942-8874
Email: jennifer.michaud@von.ca
Website:
Toll Free: 1-800-561-6551

Office Hours: Mon-Fri 8am-5pm (hours may differ for specific programs listed below)

Contact: Jennifer Michaud - Executive Director

Application: Contact office via phone, fax, in-person, or email.

Eligibility: Contact office via phone, fax, in-person, or email.

Languages: English; French speaking staff.

NURSING AND PROFESSIONAL PROGRAMS/SERVICES

Service	Description
Foot Care Services	VON nurses and other health professionals provide foot care for all ages from infants to seniors. Nurses provide assessment, care and advice for clients, including the elderly and people with diabetes, who have particular problems looking after their feet. Care includes clipping nails, treating corns, calluses, ingrown nails and thickened nails and preventative care as well as referral to other health professionals.
Private Duty Nurse and Shift Nursing	Shift nursing brings the expertise of registered practical nurses to the home. Available from a minimum of three hours to continuous 24 hours of care, the shift-nursing program is an alternative to institutional care. The program is extremely flexible and the work is paid for on an hourly basis, on contract with the individual family or caregiver.

PALLIATIVE CARE SERVICES

Service	Description
Bereavement Services	Bereavement follow-up is often a key component in palliative care. Trained staff and volunteers help people who are experiencing grief and loss. Bereavement services can be through home visits, drop-in care groups or support groups.

VOLUNTEER SERVICES

Service	Description
Palliative/Hospice Visiting	Hospice volunteers are specially trained, caring, dedicated individuals who offer their knowledge and experience to help both the client and their family through the disease process, treatment and outcome of their illness.

(North East Community Care Access Centre- VON Victorian Order of Nurses - Algoma branch, 2013; Victorian Order of Nurses, 2009)

In-Home Care Services Organization:
Canadian Red Cross- Sault Ste. Marie and District Branch

Office Address: 105 Allard St
 Sault Ste. Marie, ON
 P6B 5G2

Phone: 705-759-4547
Fax: 1-888-394-6660
Email:
Website: <http://www.redcross.ca/article.asp?id=37729&tid=067>
Toll Free: 1-800-418-1111

Office Hours: Mon-Fri 8:30am-4:30pm
Application: Contact office via phone, fax, in-person.
Eligibility: Contact office via phone, fax, in-person.
Languages: English; French speaking staff.

HEMOCARE SERVICES

Service	Description
Personal Care	Bathing, grooming, assistance with dressing, toileting, and transfers
Home Management	Meal preparation, grocery shopping, errands, light housekeeping, and laundry.
Home Maintenance	This program provides essential home repairs and upkeep for 200 seniors and disabled adults. Snow removal, yard work, major cleaning and minor exterior repairs are provided at a subsidized rate for those who qualify.

VOLUNTEER

Service	Description
Friendly Visiting	Canadian Red Cross volunteers make regular visits in the community to elderly residents who live alone. The goal of the Friendly Visiting program is to bring friendship, company, and appropriate activities to elderly or isolated people in need of a friend.

RESPIRE AND COMPANION CARE

Service	Description
Respite and Companion Care	Caregiver/family relief and accompaniment to appointments.

(North East Community Care Access Centre- Canadian Red Cross - Sault Ste. Marie and District Branch, 2013; Canadian Red Cross-Sault Ste. Marie, 2013)

In-Home Care Services Organization:
Bayshore Home Health Care- Sault Ste. Marie

Office Address: 390 Bay St, Ste 304
 Sault Ste. Marie, ON
 P6A 1X2

Phone: 705-942-3232
Fax: 705-942-7431
Email: saultstemarie@bayshore.ca
Website: www.bayshore.ca
Toll Free: 1-888-795-4447

Office Hours: Mon-Fri 8:30am-5:00pm

Service Hours: 24 Hours

Application: Referred through the North East Community Care Access Centre or a Self-referral

Eligibility: Contact office.

Languages: English; French speaking staff.

HEMOCARE SERVICES

Service	Description
Nursing	Offering pediatric to palliative care, Bayshore Home Health's nurses deliver the highest quality of care in our clients' homes. This includes: <ul style="list-style-type: none"> • Administering medication • Changing dressings • Advanced foot care • Intravenous therapy • Pain and symptom management • Chronic disease management and therapy • Ventilator care • Peritoneal dialysis • Serious injury care
Personal Care	Bayshore Home Health's personal care services enable clients to live independently in their homes. Our specially trained staff can help with: <ul style="list-style-type: none"> • Personal hygiene care such as grooming, washing and bathing • Basic hand and foot care • Dressing • Assistance with eating • Helping clients move safely into chairs, beds or vehicles
Home Support	Bayshore Home Health makes living at home easier for individuals who need assistance with routine household activities. We provide services that include: <ul style="list-style-type: none"> • Light housekeeping • Meal preparation • Laundry • Escorting clients on shopping trips and appointments

COMPANIONSHIP

Service	Description
Companionship	For individuals who live alone and are feeling isolated, our caregivers provide companionship through personal visits to the home to share a cup of tea or go for a walk. They also accompany clients on outings or special events.

RESPITE RELIEF

Service	Description
Respite Relief	Respite relief for families members or care givers caring for an individual in need of full time care

(Bayshore HealthCare Ltd., 2011)

In-Home Care Services Organization: F.J. Davey Home

Office Address: 733 Third Line East
 Sault Ste. Marie, ON P6A 7C1
Phone: 705-942-2204
Fax: 705-256-4204
Email:
Website: www.fjdaveyhome.org

Hours: Hours for each service listed below.

Application: Self-referral

Eligibility: As listed for each service below

Languages: English; French speaking staff.

MEAL DELIVERY

Service	Description
Meals On Wheels	<p>Contact: Ext 239 Lea de Vries-Bothwell Hours: Mon-Fri 9am-3:45pm</p> <p>Meals-on-Wheels provides seniors, persons convalescing and persons with disabilities with hot, nutritious meals five days a week to maintain a balanced diet, proper nutrition and to enhance their social contact and safety.</p> <p>Meals On Wheels aims to:</p> <ul style="list-style-type: none"> • Maintain a healthy and balanced diet • Increase independence and help persons remain in their home longer • Help decrease feelings of isolation and insecurity by providing persons served with regular social contact • Meals are delivered by a network of caring and dedicated volunteers and new volunteers are always welcome.

(F.J. Davey Home, 2010)

In-Home Care Services Organization:
Shoppers Home Health Care- Sault Ste. Marie

Office Address:

480 Pim St
 Sault Ste. Marie, ON
 P6B 2V4

Phone: 705-949-2524

Fax: 705-949-6090

Email:

Website: www.shoppersdrugmart.ca

Toll Free: 1-800-465-6167

Hours: Mon-Fri 8:30 am -6pm * Sat 9am-4pm

Application: Self-referral

Eligibility: Contact office.

Languages: English.

Service	Description
Medical Equipment	Sells, rents and services orthopaedic and health care aids including <ul style="list-style-type: none"> • Mastectomy products • Home oxygen and respiratory services • Hospital beds • Wheelchairs • Bathroom aids • Hydraulic lifts • Supplies for ostomate Provides consumers with the opportunity to set up a temporary, safer environment without experiencing costly renovations or the inconvenience of moving

(North East Community Care Access Centre- Shoppers Home Health Care, 2013)

In-Home Care Services Organization:
We Care Home Health Services- Sault Ste. Marie Branch

Office Address: 163 East St
 Sault Ste. Marie, ON
 P6A 3C8

Phone: 705-941-5222
Fax: 705-941-5206
Website: www.wecare.ca
Toll Free: 1-877-853-1195

Office Hours: Mon-Fri 8am-5pm

Service Hours: 24/7

Application: Apply through your local Community Care Access Centre * self-referral - telephone

Eligibility: Contact office.

Languages: English ; French ; Italian. Finish ; Ukranian Staff - no services.

HOME HEALTH SERVICES

Service	Description
Personal Care	We Care provides personal support for everyday activities such as getting in and out of bed, bathing and dressing, to dental hygiene or grooming.
Home Making	This service provides assistance with the day-to-day tasks that are required in the upkeep of a household, including dusting and cleaning, laundry and meal preparation.
Companion Services	Our Caregivers are available for individualized activities such as visiting, playing cards, reading a book, or sharing a hobby. We can also help care for a pet or take walks in the neighbourhood.
Nursing	Our qualified personnel are available to assist with administering medication, changing dressings, intravenous therapy, pain and symptom management, chronic disease management and therapy, foot care, ventilator care, and serious injury care.
Foot Care	We also have Nurses who are able to provide advanced foot care. Regular foot care will significantly improve comfort, mobility and the general health of your feet. This is particularly important for people with diabetes because regular foot care can prevent problems and assist in early identification and care if problems do occur.
Accompanied Visits	We are available to accompany and/or transport your loved ones to personal or doctor's appointments, religious or cultural events, shopping or even an unplanned outing.
Caregiver Relief	We are dedicated to providing relief for family caregivers – from a few hours a day to around the clock care. Our caregivers are trained to tend to the needs of your loved ones while you attend to other responsibilities and obligations, or just put your feet up and relax for a while to rejuvenate.
Live-In Care	If there is ever a time you require constant support, our Caregivers will provide the personal and domestic care, and the companionship you need on an around-the-clock basis.

(North East Community Care Access Centre- We Care Home Health Services - Sault Ste. Marie Branch, 2013; We Care Health Services-Health at Home Services, 2010).

In-Home Care Services Organization:
Alzheimer Society - Sault Ste. Marie and Algoma District

Office Address: 341 Trunk Rd
 Sault Ste. Marie, ON
 P6A 3S9

Phone: 705-942-2195
Fax: 705-256-6777
Email: info@alzheimeralgoma.org
Website: www.alzheimeralgoma.org
Toll Free: 1-877-396-7888

Office Hours: Mon-Fri 8:30am-4:30pm

Application: Contact office.

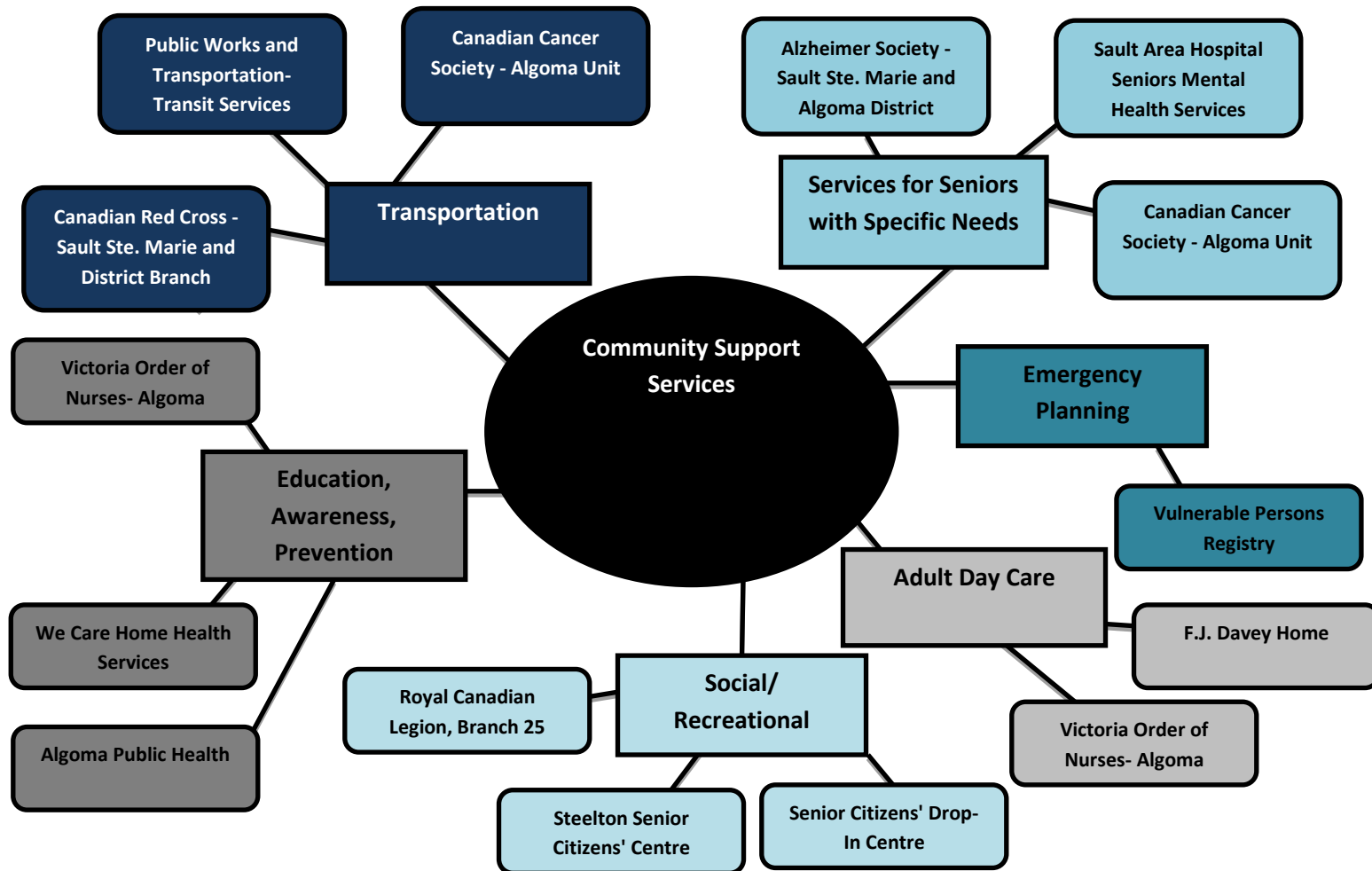
Eligibility: Contact office.

Languages: English; French Speaking staff - No Service

Service	Description
In-Home Recreational Therapy	Provides in-home individualized recreation therapy to people affected by dementia. Recreation and leisure are important for us all, and appropriate recreational activities are integral to improving/optimizing quality of life for persons with dementia. Our Recreation Therapists will work with persons with dementia and their care partners to develop a flexible, client-focussed recreation treatment program that accommodates all stages and abilities.
Volunteer Visiting program	Volunteers visit clients in their home one or two hours a week to offer socialization and stimulating activities. In this program, Alzheimer Society volunteers visit with persons with dementia to provide companionship, activation, and socialization. Volunteers are specially trained, screened, and matched in order to provide a positive experience for both parties

(Alzheimer Society of Canada, 2011)

Sector 7: Community Support Services Map



Sector 7: Community Support Services Inventory

Transportation

Community Support Services Organization (Transportation): Public Works and Transportation- Transit Services

Office Address: 111 Huron St
Sault Ste. Marie, ON
P6A 5P9

Phone: 705-759-5438
Fax: 705-759-5834
Email:
Website: www.city.sault-ste-marie.on.ca

Office Hours: Mon-Fri 8:30am-4:20pm

Parabus Hours: Mon-Fri 7:30am-12am * Sat 8:30am-12am * Sun 8am-11pm

Regular Bus Hours: Mon-Fri 5:45am-12:15am * Sat-Sun 5:45am-11:45pm

Community Bus Hours: Mon-Fri 8:45am-5:10pm

TransCab Hours: Mon-Fri, 7:15am-9:15am * 12:15-1:15pm *

Application: Self-referral

Eligibility: Parabus Transit: Must be deemed disabled by a Medical Professional.

Languages: English.

Service	Description
Parabus	Offers curb to curb transit for individuals with Physical disabilities. Provides wheelchair accessible transportation.
Regular Transit	Transports individuals to and from designated bus stops. Provides wheelchair accessible transportation.
Community Bus	Offers transportation to the public including seniors and individuals with special needs. Offers Evening preferred stop program which allows passengers to be dropped off at specific locations such as malls, libraries, casinos, grocery store etc.. Provides wheelchair accessible transportation.
TransCab	Offers transportation of individuals to and from designated stops. Offers preferred stop program transports individuals to and from their driveways.

(North East Community Care Access Centre- Sault Ste. Marie, City of - Public Works and Transportation - Transit Services, 2013)

Community Support Services Organization (Transportation):
Canadian Cancer Society - Algoma Unit

Office Address:

390 McNabb St

Sault Ste. Marie, ON

P6B 1Z1

Phone: 705-253-4781

Fax: 705-946-3020

Email: algoma@ontario.cancer.ca

Website: www.city.sault-ste-marie.on.ca

Toll Free: 1-888-930-8883

Office Hours: Mon-Fri 9:00am-5:00pm

Application: Referral from Doctors * Cancer Centre * Call ins

Eligibility: Cancer patients and their caregivers.

Languages: English; French Speaking staff - No Service

Service	Description
Transportation	A national organization of volunteers which funds research on all types of cancers and provides services such as: <ul style="list-style-type: none">• Provides transportation and to individuals travelling to local or out of town cancer-related appointments

(North East Community Care Access Centre- Canadian Cancer Society - Algoma Unit, 2013)

Community Support Services Organization (Transportation):
Canadian Red Cross - Sault Ste Marie and District Branch

Office Address: 105 Allard St
Sault Ste. Marie, ON
P6B 5G2

Phone: 705-759-4547
Fax: 1-888-394-6660
Email:
Website: www.redcross.ca
Toll Free: 1-800-418-1111

Office Hours: Mon-Fri 8:30am-4:30pm

Application: Contact office.

Eligibility: Contact office.

Languages: English; French.

Service	Description
Transportation	The Canadian Red Cross provides transportation for the frail, elderly and disabled in the community. The service is for those unable to use public transportation or private means. We provide reliable transportation to and from medical appointments, shopping and rehabilitation programs.

(North East Community Care Access Centre- Canadian Red Cross - Sault Ste. Marie and District Branch, 2013; Canadian Red Cross-Sault Ste. Marie, 2013)

Services for Seniors with Specific Needs

Community Support Services Organization (Specific Needs): Alzheimer Society - Sault Ste. Marie and Algoma District

Office Address: 341 Trunk Rd
Sault Ste. Marie, ON
P6A 3S9

Phone: 705-942-2195
Fax: 705-256-6777
Email: info@alzheimeralgoma.org
Website: www.alzheimeralgoma.org
Toll Free: 1-877-396-7888

Office Hours: Mon-Fri 8:30am-4:30pm

Application: Contact office.

Eligibility: Contact office.

Languages: English; French Speaking staff - No Service

Service	Description
Caregiver Support	Offers support to family and those with Alzheimer's to maintain and increase feelings of self-worth and control by sharing common problems
Client Support	Offers support to those with Alzheimer's on an individual or in group settings which allows people to share their experiences and concerns
MedicAlert Safely Home - Wandering Registry	<p>The Alzheimer Society is partnering with the Canadian MedicAlert Foundation to improve the Safely Home program, incorporating the best features of both Safely Home and MedicAlert services. People with dementia may lose the ability to recognize familiar places, to communicate or to remember their own name or address. They may leave home, become confused and get lost. MedicAlert Safely Home is a nationwide program designed to help identify the person who is lost and assist in a safe return home. Members receive an engraved identification (over 100 styles of IDs available including bracelets, necklaces, watches and more), which allows police and emergency responders to quickly identify the person who has wandered and bring the family back together. Call 1-855-581-3794</p> <ul style="list-style-type: none"> • to sign up for MedicAlert Safely Home • to update your existing record • for more information
Education and Awareness	In addition to the First Link® Learning Series for people with dementia and their care partners, we provide customized education programs to a wide variety of target groups. Training sessions, workshops, and public presentations are available on many dementia-related topics. Examples of various

	<p>workshops/presentations and their target audiences include:</p> <ul style="list-style-type: none"> • Gentle Persuasive Approaches (GPA) in Dementia Care – a one-day workshop for health care workers in a variety of care settings • U-First! – a one-day workshop for front-line health care workers in a variety of care settings • Healthy Brain – a one hour presentation for the members of the public who are interested in maintaining their brain health • Church groups – a presentation for members of congregations who are interested in learning about supporting their members who are experiencing memory loss • Grade 5 presentation – a one-hour presentation designed to increase children's understanding of Alzheimer's disease, methods of keeping the brain healthy, and the value of older persons in our society
First Link	<p>First Link is a program that links persons with dementia and their care partners to coordinated learning, services, and support from the point of diagnosis throughout the continuum of the disease. After a referral has been made, the First Link Coordinator will:</p> <ul style="list-style-type: none"> • Offer dementia education and ongoing support for the person with dementia and family members; • Assess for other Alzheimer Society programs (e.g., Safely Home®, Recreation Therapy, volunteer visiting, behaviour support); • Make referrals to other appropriate community services.
Supportive Counselling	<p>Our professional staff will meet with the person with dementia and/or their care partners, in person or by phone, to discuss issues such as disease progression, care options, and community services. Meetings can take place either in our office or in the individual's home.</p>
Support Groups	<p>We have groups specially designed for those with dementia, and others that are specific for care partners. Groups are an excellent way to learn more about the disease as well as receive peer support and professional guidance. Groups are normally held monthly</p>
Cogitative Assessments	<p>The Alzheimer Society does not support broad population-based cognitive screening, and therefore will conduct cognitive assessments only where risk factors have been identified. Age alone is not sufficient reason to conduct cognitive assessment. Our professional staff will provide cognitive assessment when referred by a primary care practitioner or when requested by the client as a result of a perceived change in cognitive ability.</p>
Behaviour Support	<p>Behaviour Supports Ontario is a province-wide initiative that aims to improve quality of life for persons with dementia and their care partners by helping to manage responsive behaviours. Our Behaviour Support Facilitator can assist with responsive behaviours through activities such as behaviour mapping and caregiver education.</p>

At-Risk Driver Program	The At Risk Driver Program in Sault Ste. Marie provides families and caregivers an opportunity to strengthen the safety net for the person with dementia whose license has been revoked yet continues to drive. A concerned caregiver can register the individual in the At Risk Driver Program. The person who is registered will be flagged in the police database as someone of "Special Interest to Police". The police will identify the individual as cognitively impaired and will contact the person listed on the registration form to help ensure that the driver is returned home safely.
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(Alzheimer Society of Canada, 2011)

Community Support Services Organization (Specific Needs):
Sault Area Hospital Seniors Mental Health Services

Office Address: 390 Bay St, 4th floor
 Sault Ste. Marie, ON
 P6A 1X2

Phone: 705-759-9396
Fax: 705-759-3235
Email: publicaffairs@sah.on.ca
Website: www.sah.on.ca

Office Hours: Mon-Fri 8am-4pm

Contact: Don Burditt- Manager

Application: Client, client’s family, physicians and other care providers can make referrals.

Eligibility: Anyone who is 65 years and older that is having difficulties with his/her mental health.
 The services are available within Sault Ste. Marie and the District of Algoma.

Languages: English; French Speaking staff - No Service

Service	Description
Senior Mental Health Services	Seniors Mental Health Services is a team that includes Nurses, a Social Worker, and an Occupational Therapist. The team: <ul style="list-style-type: none"> • Provides non-emergency, mental health services to older adults, their families and service providers in the community and/or long term care facility settings. • Contributes to and supports community development activities for seniors with mental health needs. • Assessments- of mental health status using approved standard screening tools. Assessments can take place I the home or long term care facilities. • Education- on topics related to mental issues in the elderly, to client caregivers and health care professionals. • Recommendations- to families and clients on how to maintain independence within a safe environment. • Liaison- with physicians, agencies, and other appropriate health care professionals.

(Sault Area Hospital- Programs & Services, 2011).

Community Support Services Organization (Specific Needs):
Canadian Cancer Society - Algoma Unit

Office Address: 390 McNabb St
 Sault Ste. Marie, ON
 P6B 1Z1

Phone: 705-253-4781
Fax: 705-946-3020
Email: algoma@ontario.cancer.ca
Website: www.city.sault-ste-marie.on.ca
Toll Free: 1-888-930-8883

Office Hours: Mon-Fri 9:00am-5:00pm

Application: Referral from Doctors * Cancer Centre * Call ins

Eligibility: Cancer patients and their caregivers.

Languages: English; French Speaking staff - No Service

Service	Description
Cancer Support	A national organization of volunteers which funds research on all types of cancers and provides services such as: <ul style="list-style-type: none"> • Offers support to individuals living with cancer, family members and friends • Offers presentations and displays to community groups focusing on healthy living, general risk reduction and cancer related information • Provides telephone support with individuals who have had similar experiences • Offers adult group support in many communities to individuals and their caregivers.

(North East Community Care Access Centre- Canadian Cancer Society - Algoma Unit, 2013)

Emergency Planning

Community Support Services Organization (Emergency Planning): Vulnerable Persons Registry

Office Address: 1520 Queen Street E. BT 100
Sault Ste. Marie, ON
P6A 2G4

Phone: 705-942-6938 ext 3041
Fax:
Email: info@soovpr.com
Website: www.sooovpr.com/

Office Hours: Mon-Fri 8am-4pm

Contact: Don Burditt- Manager

Application:

- **Community Agencies:** Clients can register in person with their agency ; Please contact the agency to learn how you can register (home visits or agency).
- **Anyone Can Register in Person at:** Accessibility Centre; Canadian Red Cross.
- Register from Home: Online
- **Mail:** Print the registration form and mail the completed form to the address provided above and to the VPR's attention.
- **Registration Kit:** If none of the registration methods above are accessible, please either contact the VPR Coordinator to request that a registration kit be mailed directly to your home or click here to email a request.

Eligibility: Any Sault Ste. Marie resident without 24-hour support who experiences severe difficulty with any of the following: mobility, vision, or hearing; developmental/intellectual, cogitative or mental health. Any resident living at home who needs any of the following: Electricity for life-sustaining equipment; life support, oxygen, dialysis, etc.

Languages: English.

Service	Description
Vulnerable Persons Registry	The Vulnerable Persons Registry (VPR) is a free, voluntary and confidential service aimed at improving the safety of Sault Ste. Marie residents living at home who would be at greater risk during emergencies. The VPR improves safety by providing key information to local fire, police, paramedics and where authorized, PUC Inc. and Canadian Red Cross, in order to help them be more aware when addressing emergencies.

(Sault Ste. Marie Innovation Centre, 2012).

Adult Day Care

Community Support Services Organization (Adult Day Care): F.J. Davey Home

Office Address: 733 Third Line East
Sault Ste. Marie, ON
P6A 7C1

Phone: 705-942-2204
Fax: 705-256-4204
Email:
Website: www.fjdaveyhome.org

Hours: Hours for each service listed below.

Application: Self-referral

Eligibility: As listed for each service below

Languages: English; French speaking staff.

RESPIRE CARE

Service	Description
Adult Day Away Program	<p>Contact: Ext 228, adultdayprogram@fjdaveyhome.org</p> <p>Hours: Monday to Friday 8:00am to 4:00pm</p> <p>The Program, operated in dedicated space within the F.J. Davey Home, provides adult day care for people with dementia (memory loss). It offers supervised activities in a home like setting under the direction of professional staff who have special education in the care of people with memory loss.</p> <p>Activities provided include games, fun & fitness, music, bowling/golf, baking, crafts and more. The Program has a secure, dedicated outdoor space with a raised garden area. Clients plant and tend the garden and produce grown is used in the preparation of lunches.</p> <p>Goals:</p> <ul style="list-style-type: none">• To meet and maintain the individual needs of the client, enhancing & reinforcing basic living skills.• To provide respite for the caregiver.• To promote active community involvement. <p>A nominal daily fee is charged to cover the cost of two snacks, lunch and activity supplies.</p>

(F.J. Davey Home, 2010)

Community Support Services Organization (Adult Day Care):
Victoria Order of Nurses- Algoma Branch

Office Address:
 860 Great Northern Rd, 1st floor
 Sault Ste. Marie, ON
 P6A 5K7

Phone: 705-942-8200
Fax: 705-942-8874
Email: jennifer.michaud@von.ca
Website:
Toll Free: 1-800-561-6551

Office Hours: Mon-Fri 8am-5pm (hours may differ for specific programs listed below)

Contact: Jennifer Michaud - Executive Director

Application: Contact office via phone, fax, in-person, or email.

Eligibility: Contact office via phone, fax, in-person, or email.

Languages: English; French speaking staff.

COMMUNITY SUPPORT SERVICES

Service	Description
Adult Day Centre	<p>Hours: Monday, Wednesday, & Friday 9:30am to 3:30pm</p> <p>Designed to provide respite for family caregivers and to support and maintain client health, ability and independence, these programs are an opportunity for the frail, elderly, disabled or cognitively impaired adult to make friends. Activity workers and volunteers coordinate activities such as exercise classes, card and word games, communal outings and crafts.</p> <p>Programs Offered:</p> <ul style="list-style-type: none"> • Crafts • Exercise • Games • Outings • Health/Wellness • Story Sharing • Socializing • Music/Songs

(North East Community Care Access Centre- VON Victorian Order of Nurses - Algoma branch, 2013; Victorian Order of Nurses, 2009).

Social/Recreational

Community Support Services Organization (Social/Recreational):

Senior Citizens' Drop-In Centre

Site Address: 619 Bay Street
 Sault Ste Marie, ON P6A 5X6
Phone: (705) 759-5441
Fax: (705) 254-4929
Email: c.johnson@cityssm.on.ca
Website: http://www.cityssm.on.ca/Article_Page.aspx?ID=278 &deptid=1

Office Hours: Monday to Friday from 10:00 a.m. to 5:00 p.m with evening and weekend bookings by request.

Application: None.

Eligibility: None.

Languages: English.

Service	Description
Senior Citizens' Drop-In Centre	<p>The Centre works in cooperation with an Advisory Council comprised of representatives from local seniors' organizations. Programs offered encompass the areas of Active Living, Arts & Crafts, Educational, Bus Trips, Special Events and Health Related Services. The Centre is easily accessible by car or city bus. There is an enclosed bus shelter at the front of the Centre and parking is available at the rear of the building.</p> <p>Services offered include:</p> <ul style="list-style-type: none"> • Trained staff who are available to answer questions regarding senior citizens services. Inquires are handled by phone or directly at the Centre. • Community Liaison with local senior groups and agencies within Sault Ste. Marie. • The Senior Circular -- A newsletter published by the Senior Citizen Advisory Council. • Health related services provided by community agencies on site. • Unique summer events are planned by students who operate the Up, Out and Away Program • Senior Games, an annual weeklong event hosting sixteen events to promote healthy active living, fun and fellowship. • Volunteers are always welcome and encouraged to ensure the success of programs. • Personal tours of the facility can be arranged upon request.

(Corporation of The City of Sault Ste. Marie- Drop in Centre, 2013)

Community Support Services Organization (Social/Recreational):**Steelton Senior Citizens' Drop-In Centre**

Site Address:

235 Wellington Street West
Sault Ste Marie, ON

Phone: (705) 759-5377**Fax:****Email:****Website:** http://www.cityssm.on.ca/Article_Page.aspx?ID=279&deptid=1

Office Hours: Monday to Friday from 10:00 a.m. to 5:00 p.m., Wednesday evenings from 6:30 to 9:30 p.m. and Thursday evenings from 6:00 to 8:00 p.m. Other evenings and weekends by request.

Application: None.

Eligibility: None.

Languages: English.

Service	Description
Senior Citizens' Centre	Programs offered encompass the areas of Active Living, Educational, Bus Trips, Arts and Crafts, Special Events and Health Services. There is an enclosed bus shelter only a few steps away from the Centre's front door. There is limited parking on site. Additional spaces are available in the city lot opposite the Centre on Wellington Street. Staff work in co-operation with the host senior club to provide programs and services relative to the needs of the seniors utilizing the facilities. Trained staff are on site at all times available to assist seniors and to answer questions about services. A monthly flyer providing information on services and upcoming programs is available free of charge.

(Corporation of The City of Sault Ste. Marie- Steelton Centre, 2013)

Community Support Services Organization (Social/Recreational):

Royal Canadian Legion, Branch 25

Site Address:

96 Great Northern Rd
Sault Ste Marie, ON

P6B 4Y5

Website: www.branch25rcl.com

Lounge: 705-256-6921

Ladies Auxiliary: 705-256-2941

Office: 705-945-8721

Fax: 705-945-6372

Email:

Office Hours: Mon - Fri 9AM to 1PM

Lounge Hours: Mon - Thu 1PM to 11PM, Fri & Sat 1PM to 1AM, Closed Sundays

Application: Can become a member by downloading a printable membership application, or visiting the office.

Eligibility: Contact office.

Languages: English.

Service	Description
Royal Canadian Legion, Branch 25	<p>Our mission is to serve veterans and their dependents, promote remembrance and act in the service of Canada and its communities.</p> <p>Types of Activities:</p> <ul style="list-style-type: none">• Senior's Dance• Acoustic Jam Night• Carpet Bowling• Bingo• Meat Draw• Pool• Karaoke Friday's• Ladies Auxiliary• Other

(Royal Canadian Legion, Branch 25, 2010)

Education, Awareness, Prevention

Community Support Services Organization (Education, Awareness, Prevention): We Care Home Health Services- Sault Ste. Marie Branch

Office Address: 163 East St
 Sault Ste. Marie, ON
 P6A 3C8

Phone: 705-941-5222
Fax: 705-941-5206
Email:
Website: www.wecare.ca
Toll Free: 1-877-853-1195

Office Hours: Mon-Fri 8am-5pm

Service Hours: 24/7

Application: Apply through your local Community Care Access Centre * self referral - telephone

Eligibility: Contact office.

Languages: English ; French ; Italian. Finish ; Ukranian Staff - no services.

COMMUNITY HEALTH SERVICES

Service	Description
Advance Foot Care	The We Care Advanced Foot Care Program significantly improves comfort, mobility and the general health of a person's feet through programs delivered in community centres, senior's homes and pharmacies. The program, which is delivered by an advanced footcare nurse, has been approved by Veterans Affairs Canada and has proven to identify problems earlier and prevent further complications. Many people are enjoying renewed mobility and higher quality of living thanks to interventions at the right time by the right provider.
Health Risk Assessment	The Health Risk Assessment is a comprehensive tool designed to assess the current health status and potential future risks of an individual. We Care's Health Risk Assessment includes: <ul style="list-style-type: none"> •A 20 minute, private interview with a Registered Nurse •A custom tailored questionnaire called the Health Risk Assessment Personal Risk Profile •Clinical measurements - blood pressure, pulse, height, weight, hip: waist ratio, blood sugar test and blood cholesterol test
Diabetes Awareness Clinics	This customized clinic aims at early identification and reduction of cardiovascular risks associated with the development of diabetes. We Care's Diabetes Awareness clinics are delivered by registered staff. These clinics can be customized with the following options: <ul style="list-style-type: none"> • Blood Glucose Test • A1C Glucose Test • Blood Pressure & Pulse • Foot Assessment

Wellness Clinics	<p>We Care’s Cardio Wellness program supports cardiac risk reduction and lifestyle management through clinical measurement and one-on-one education provided by a registered staff member. The program can be customized with the following options:</p> <ul style="list-style-type: none"> • Blood Pressure and Pulse • Total Cholesterol Screening • LDL & HDL lab quality screening • Body Fat Analysis • BMI measurement • Height and Weight Measurement
Immunization Programs	<p>Research recognizes the strong link between immunization and the prevention of serious health problems. We Care immunization clinics may include influenza, hepatitis, tuberculosis and tetanus. Our clinics offer:</p> <ul style="list-style-type: none"> • Information on the benefits and risks of the vaccination prior to the immunization clinic • All necessary documentation including a questionnaire, consent and post-clinic information sheet • Referral of high risk clients to their Family Doctor • Educational and health promotional material
Osteoporosis Screening-Bone Density & Education	<p>Osteoporosis affects 1.4 million Canadians. The We Care Osteoporosis program utilizes a Clinical Bone Sonometer, an ultrasound machine that scans the heel for bone weakness. Results are produced in 10 seconds, indicating a low, medium or high risk for developing osteoporosis. Based on the results, trained nurses provide individualized recommendations on diet, exercise and lifestyle changes or possible referral to their doctor for more detailed testing.</p>
Other Speciality and Targeted Wellness Clinics	<p>In addition to the above, We Care offers other specialty wellness solutions that address a variety of common health concerns.</p> <ul style="list-style-type: none"> •Healthy Heart - Blood pressure, body fat & cholesterol screening •Breathing Easy - Health teaching and information on Asthma & COPD •Summer Living - West Nile Virus, skin cancer and sun stroke awareness •Woman's Wellness - personal health history & individualized health teaching

(North East Community Care Access Centre- We Care Home Health Services - Sault Ste. Marie Branch, 2013; We Care Health Services-Health in the Community Services, 2010).

**Community Support Services Organization (Education, Awareness,
Prevention): Victoria Order of Nurses- Algoma Branch**

Office Address:
860 Great Northern Rd, 1st floor
Sault Ste. Marie, ON
P6A 5K7

Phone: 705-942-8200
Fax: 705-942-8874
Email: jennifer.michaud@von.ca
Website:
Toll Free: 1-800-561-6551

Office Hours: Mon-Fri 8am-5pm (hours may differ for specific programs listed below)

Contact: Jennifer Michaud - Executive Director

Application: Contact office via phone, fax, in-person, or email.

Eligibility: Contact office via phone, fax, in-person, or email.

Languages: English; French speaking staff.

COMMUNITY SUPPORT SERVICES

Service	Description
Caregiver Support Health Promotion/ Education Services	VON provides information, emotional support and education to family caregivers. Participants gain hope and insight through the experiences of other caregivers and build a network of support. A series of videos is used to encourage reflection and discussion.
Wellness and Health Promotion Clinics	Held in public places such as pharmacies or community events, VON Wellness and Health Promotion clinics offer clients screening tests and assessment of cholesterol, blood pressure, body-mass index and other indicators of potential health problems. Individual counselling focuses on education and raising awareness on topics such as heart health, diabetes, asthma, allergies and osteoporosis.
Immunization	A VON registered nurse can give vaccinations in the workplace or other community settings. Immunization programs include flu shots, hepatitis, tetanus and diphtheria, pneumonia, chickenpox, and meningitis.

(North East Community Care Access Centre- VON Victorian Order of Nurses - Algoma branch, 2013; Victorian Order of Nurses, 2009).

Community Support Services Organization (Education, Awareness, Prevention): Algoma Public Health

Site Address: 294 Willow Ave
 Sault Ste Marie, ON

Phone: 705-942-4646
Fax: 705-759-1534
Email:
Website: www.algomapublichealth.com/
Toll Free: 1-888-892-0172

Office Hours: Mon-Fri 8:30am-4:30pm

Application: Appointment required for most services

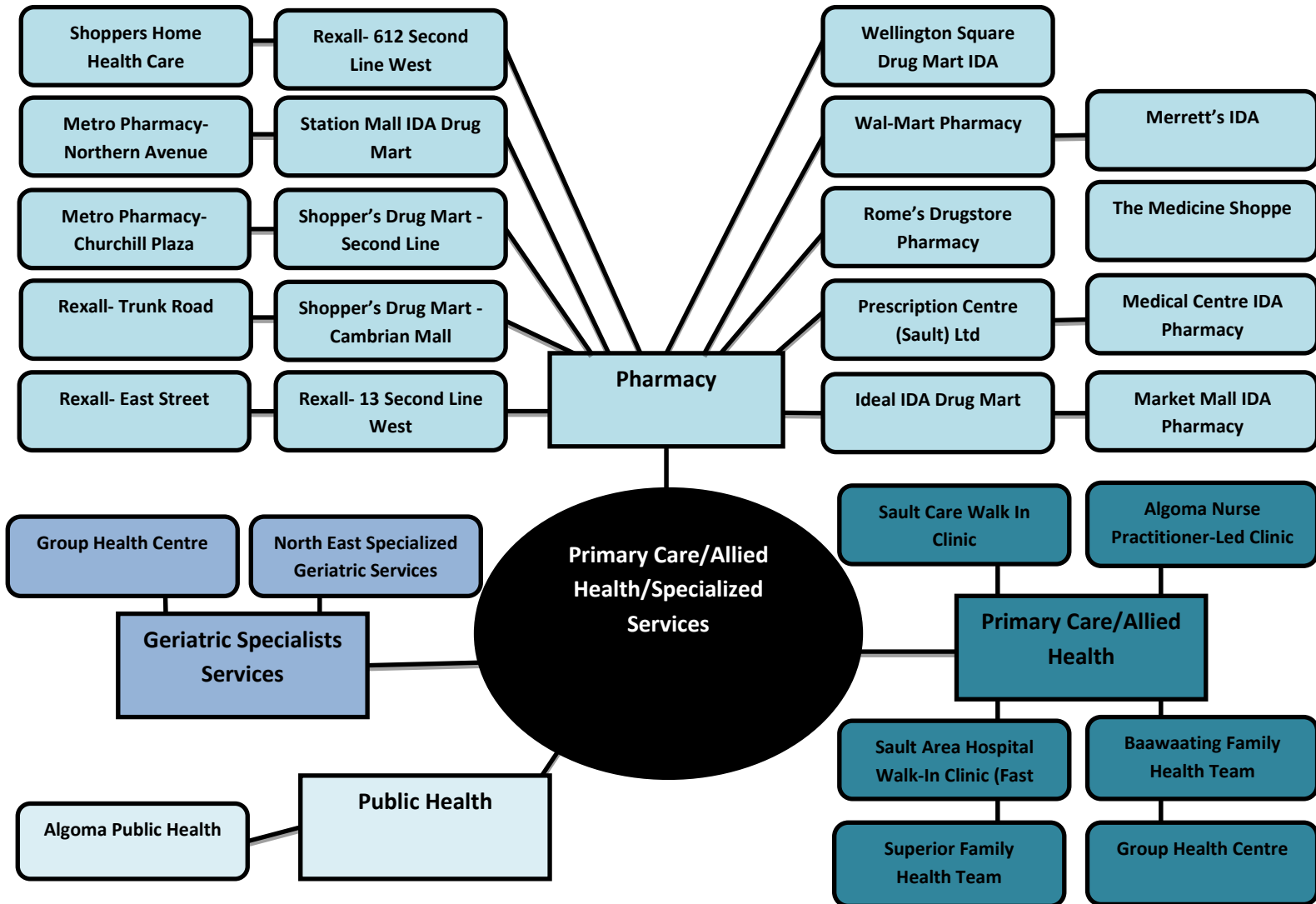
Eligibility: See description for services listed below.

Languages: English.

Service	Description
Nursing	Offers clinical nursing services focusing on health promotion, public education and a healthy lifestyle such as immunization records and clinics.
Chronic Disease Prevention	<ul style="list-style-type: none"> • Work with community agencies to provide the public with information and skills to facilitate the adoption of healthy lifestyles for the prevention of chronic diseases. • Work to implement healthy policies and programs • Help to create and enhance supportive environments to address healthy eating, healthy weights, comprehensive tobacco control, physical activity, alcohol use, stress and exposure to ultraviolet radiation.
Vaccine Preventable Diseases	<ul style="list-style-type: none"> • Work to reduce the incidence of vaccine preventable diseases in our community • Provide travel vaccines to the public • Provide publically funded vaccines to Ontario residents (influenza vaccine).

(Algoma Public Health- Programs and Services Pamphlet, n.d.)

Sector 8: Primary Care/Allied Health/Specialized Services



Sector 8: Primary Care/Allied Health/Specialized Services Inventory

Pharmacy

Primary Care/Allied Health/Specialized Services Organization (Pharmacy):

Shoppers Home Health Care- Sault Ste. Marie

Office Address:

480 Pim St

Sault Ste. Marie, ON

P6B 2V4

Phone: 705-949-2524**Fax:** 705-949-6090**Email:****Website:** www.shoppersdrugmart.ca**Toll Free:** 1-800-465-6167**Hours:** Mon-Fri 8:30 am -6pm * Sat 9am-4pm**Application:** Self-referral**Eligibility:** Contact office.**Languages:** English.

Service	Description
Pharmaceutical Services	Provides various pharmaceutical services including: <ul style="list-style-type: none">• Ontario Trillium Drug Plan application kit• Educational materials and health consultations• Basic home health care supplies• Blister packaging• Sells prescription medication as well as over the counter medication• In-store health and wellness clinics• Operated the Assistive Devices Program (ADP) with application forms available upon request• Offers van conversions for individuals with disabilities• Offer MedsCheck by appointment for those who qualify

(North East Community Care Access Centre- Shoppers Home Health Care - Sault Ste. Marie, 2013).

Primary Care/Allied Health/Specialized Services Organization (Pharmacy):
Metro Pharmacy- Northern Avenue

Office Address:
 248 Northern Ave E
 Sault Ste. Marie, ON

Phone: (705) 945-1006
Fax:
Email: info@soovpr.com
Website: <http://metro.ca/on/expert-advice/pharmacy-expert/pharmacy-services.en.html>

Office Hours: Monday to Friday 9:00am-9:00pm, Saturday 9:00am-6:00pm, Sunday 10:00am-5:00pm

Languages: English.

Service	Description
Pharmacy	<p>Our Pharmacy Team offers total patient-focused care. We are committed to serving all of your health care needs, including:</p> <ul style="list-style-type: none"> • On-site blood pressure monitoring • Personalized nutrition consultations • Personalized medication reviews • Lung function assessments • Skin hydration assessments • Medicine cabinet clean-up and disposal services • Medication reminder tools and services (blister packaging) • With each prescription you will receive a personalized up-to-date medical profile for your own records. This is useful in the event of an emergency as it helps medical personnel quickly find out what medications you are taking. • Speak to our pharmacists for more information on our health and wellness programs and find out how to transfer your prescriptions...it's easy and hassle-free.

(Metro Richelieu Inc., 2013; Group Health Centre-Pharmacies, 2013)

Primary Care/Allied Health/Specialized Services Organization (Pharmacy):
Metro Pharmacy- Churchill Plaza

Office Address: 150 Churchill Blvd.
 Sault Ste. Marie, ON P6A 3Z9
Phone: (705) 254-3923
Fax:
Email:
Website: <http://metro.ca/on/expert-advice/pharmacy-expert/pharmacy-services.en.html>

Office Hours: Monday to Friday 9:00am-9:00pm, Saturday 9:00am-6:00pm, Sunday 10:00am-5:00pm

Languages: English.

Service	Description
Pharmacy	<p>Our Pharmacy Team offers total patient-focused care. We are committed to serving all of your health care needs, including:</p> <ul style="list-style-type: none"> • On-site blood pressure monitoring • Personalized nutrition consultations • Personalized medication reviews • Lung function assessments • Skin hydration assessments • Medicine cabinet clean-up and disposal services • Medication reminder tools and services (blister packaging) • With each prescription you will receive a personalized up-to-date medical profile for your own records. This is useful in the event of an emergency as it helps medical personnel quickly find out what medications you are taking. • Speak to our pharmacists for more information on our health and wellness programs and find out how to transfer your prescriptions...it's easy and hassle-free.

(Metro Richelieu Inc., 2013; Group Health Centre-Pharmacies, 2013)

Primary Care/Allied Health/Specialized Services Organization (Pharmacy):**Rexall- Trunk Road**

Office Address:

129 Trunk Road

Sault Ste. Marie, ON

P6A 3S4

Phone: 705-253-3256**Fax:** 705-253-3534**Email:****Website:**

[http://www.rexall.ca/storelocator/results?longitude=46.4952996&latitude=-84.3453169&location=Sault Ste. Marie](http://www.rexall.ca/storelocator/results?longitude=46.4952996&latitude=-84.3453169&location=Sault%20Ste.%20Marie)

Office Hours: Mon-Fri 9:00am - 9:00pm, Saturday 9:00am - 6:00pm, Sunday 9:00am - 6:00pm**Languages:** English.

Service	Description
Pharmacy	<ul style="list-style-type: none">• A1C Diabetes Test• Beauty Consultants• Blood Pressure Screening• Digital Photo Centre• Drive Thru• Flu Shot• Groceries• HEMOCODE Food Intolerance System• Home Health Care• Lottery• Medication Reminder E-mails (eFill)• Online Refill• Open Until 9pm• Private Consultation Room• Specialty Compounding

(Katz Group Canada Ltd., 2013)

Primary Care/Allied Health/Specialized Services Organization (Pharmacy):
Rexall- East Street

Office Address: 170 East Street
Sault Ste. Marie, ON P6A 3C6
Phone: 705-759-3370
Fax: 705-759-0693
Email:
Website:
[http://www.rexall.ca/storelocator/results?longitude=46.4952996&latitude=-84.3453169&location=Sault Ste. Marie](http://www.rexall.ca/storelocator/results?longitude=46.4952996&latitude=-84.3453169&location=Sault%20Ste.%20Marie)

Office Hours: Mon-Fri 8:30am - 6:00pm

Languages: English.

Service	Description
Pharmacy	<ul style="list-style-type: none">• A1C Diabetes Test• Flu Shot• Medication Reminder E-mails (eFill)• Online Refill• Specialty Compounding

(Katz Group Canada Ltd., 2013)

Primary Care/Allied Health/Specialized Services Organization (Pharmacy):**Rexall- 13 Second Line West**

Office Address:

13 Second Line West

Sault Ste. Marie, ON

Phone: 705-942-0873**Fax:** 705-949-2775**Email:****Website:** [http://www.rexall.ca/storelocator/results?longitude=46.4952996&latitude=-84.3453169&location=Sault Ste. Marie](http://www.rexall.ca/storelocator/results?longitude=46.4952996&latitude=-84.3453169&location=Sault%20Ste.%20Marie)**Office Hours:** Mon-Fri 9:00am - 9:00pm, Saturday 9:00am - 6:00pm, Sunday 9:00am - 6:00pm**Languages:** English.

Service	Description
Pharmacy	<ul style="list-style-type: none">• A1C Diabetes Test• ATM• Beauty Consultants• Blood Pressure Screening• Drive Thru• Flu Shot• Free Prescription Delivery• HEMOCODE Food Intolerance System• Lottery• Medication Reminder E-mails (eFill)• Nutrition Consultation & Vitamin Therapy• Online Refill• Open Until 9pm• Private Consultation Room

(Katz Group Canada Ltd., 2013)

Primary Care/Allied Health/Specialized Services Organization (Pharmacy):**Rexall- 612 Second Line West**

Office Address:

612 Second Line West

Sault Ste. Marie, ON

P6C 2K7

Phone: 705-759-3216**Fax:** 705-759-3888**Email:****Website:**

[http://www.rexall.ca/storelocator/results?longitude=46.4952996&latitude=-84.3453169&location=Sault Ste. Marie](http://www.rexall.ca/storelocator/results?longitude=46.4952996&latitude=-84.3453169&location=Sault%20Ste.%20Marie)

Office Hours: Mon-Fri 9:00am - 6:00pm, Saturday 9:00am - 4:00pm**Languages:** English.

Service	Description
Pharmacy	<ul style="list-style-type: none">• Accreditation Support• Clinical Programs and Education• Continuous Quality Improvement Programs• Free Prescription Delivery• Medication Safety Initiatives• Specializing In Senior And Specialty Pharmacy Care• Specialty Compounding• State-of-the-art Medication Packaging

(Katz Group Canada Ltd., 2013)

Primary Care/Allied Health/Specialized Services Organization (Pharmacy):
Ideal IDA Drug Mart- Wellington Street W

Office Address:
1416 Wellington Street West
Sault Ste. Marie, ON
P6A 2P7

Phone: 705-759-4818
Fax: 705-759-4629
Email:

Hours: M-F 9-9, Sat 9-6, Sun closed

Languages: English.

Service	Description
Pharmacy	<ul style="list-style-type: none">• Training provided by pharmacist• Private medical counseling room or area• Insulin instruction available on pens and syringes• 3 brands of pens available at no cost• Trillium Drug Program - financial assistance program• Medication available in blister packs free of charge• Blood pressure machine, calibrated at least every six months• Delivery available anytime 9-6 daily• Canadian Diabetes Association literature available• Sells diabetic supplies (eg. socks, lotions etc.)

(Group Health Centre- Pharmacies, 2013)

Primary Care/Allied Health/Specialized Services Organization (Pharmacy):
Market Mall IDA Pharmacy

Office Address:
 275 Second Line W
 Sault Ste. Marie, ON
 P6C 2J4

Phone: 705-253-1121
Fax: 705-254-3522
Email:

Hours: Open M-F 9-9, Sat 9-6, Sun 10-5

Languages: English.

Service	Description
Pharmacy	<ul style="list-style-type: none"> • Glucose meter sales, trade in and training • Training provided by pharmacist • Private medical counseling room or area • Insulin instruction available on pens and syringes • Blood pressure machine, calibrated at least every six months • 2 brands of pens available at no cost • Trillium Drug Program and Monitoring for Health -financial assistance programs • Medication available in blister packs at no charge • Insulin pump supplies available • Delivery available - all store hours except Sundays • Canadian Diabetes Association literature available • Sells diabetic supplies (eg. socks, lotions etc.)

(Group Health Centre- Pharmacies, 2013)

Primary Care/Allied Health/Specialized Services Organization (Pharmacy):
Medical Centre IDA Pharmacy- Queen Street E

Office Address:
 974 Queen Street East
 Sault Ste. Marie, ON
 P6A 2C5

Phone: 705-759-0522
Fax: 705-759-2607
Email:

Hours: Open M-F 9-6, closed weekends

Languages: English.

Service	Description
Pharmacy	<ul style="list-style-type: none"> • Glucose meter sales, trade in and training • Training provided by pharmacist or pharmacy technician • Private medical counseling room or area • Insulin instruction available on pens and syringes • 2 brands of pens available at no cost • Trillium Drug Program and Monitoring for Health -financial assistance programs • Medication available in blister packs at no charge • Blood pressure machine, calibrated at least every six months • In store “Diabetes Day” 2-3 times per year • Delivery available 9am-6pm • Canadian Diabetes Association literature available • Sells diabetic supplies (eg. socks, lotions etc.)

(Group Health Centre- Pharmacies, 2013)

Primary Care/Allied Health/Specialized Services Organization (Pharmacy):
The Medicine Shoppe- Second Line W

Office Address:

316 Second Line W
Sault Ste. Marie, ON
P6C 2J5

Phone: 705-253-0720

Fax: 705-253-7656

Email: dalmac@shawcable.ca

Hours: Open M-F 9-6, Sat 9-2, closed Sun

Languages: English.

Service	Description
Pharmacy	<ul style="list-style-type: none">• Glucose meter sales, trade in and training• Training provided by pharmacist or pharmacy technician• Private medical counseling room or area• Insulin instruction available on pens and syringes• 2 brands of pens available at no cost• Trillium Drug Program and Monitoring for Health -financial assistance programs• Medication available in blister packs at no charge• Blood pressure machine, calibrated at least every six months• In store "Diabetes Day" 2-3 times per year• Delivery available 9am-6pm• Canadian Diabetes Association literature available• Sells diabetic supplies (eg. socks, lotions etc.)

(Group Health Centre- Pharmacies, 2013)

Primary Care/Allied Health/Specialized Services Organization (Pharmacy):
Merrett's IDA- Wellington Street W

Office Address:
 314 Wellington St. W
 Sault Ste. Marie, ON
 P6A 1J1

Phone: 705-945-8465
Fax: 705-945-8796
Email:

Hours: Open M-F 9-8, Sat 9-6, closed Sun

Languages: English.

Service	Description
Pharmacy	<ul style="list-style-type: none"> • Glucose meter sales, trade in and training • Training provided by pharmacist • Private medical counseling room or area • Insulin instruction available on pens and syringes • Blood pressure machine, calibrated at least every six months. • 2 brands of pens available at no cost • Trillium Drug Program -financial assistance program • Medication available in blister packs - regular co-pay no additional fees • Insulin pump supplies available • In store Diabetes Day 1-2 times/year • Delivery available 9am-6pm • Canadian Diabetes Association literature available • Sells diabetic supplies (eg. socks, lotions etc.)

(Group Health Centre- Pharmacies, 2013)

Primary Care/Allied Health/Specialized Services Organization (Pharmacy):
Prescription Centre (Sault) Ltd.- Queen Street E

Office Address:

955 Queen St. E

Sault Ste. Marie, ON

P6A 2C3

Phone: 705-253-3206

Fax: 705-942-9-8369

Email:

Hours: Open M-F 9-7, Sat 9-5, closed Sun

Languages: English.

Service	Description
Pharmacy	<ul style="list-style-type: none">• Glucose meter sales, trade in and training• Training provided by pharmacist or pharmacy student• Private medical counseling room or area• Insulin instruction available on pens and syringes• 2 brands of pens available at no cost• Trillium Drug Program and Monitoring for Health -financial assistance programs• Medication available in blister packs at no charge• Insulin pump supplies available by request• Delivery available 9am-7pm• Canadian Diabetes Association literature available• Sells diabetic supplies (eg. socks, lotions etc.)

(Group Health Centre- Pharmacies, 2013)

Primary Care/Allied Health/Specialized Services Organization (Pharmacy):
Rome's Drugstore Pharmacy- Great Northern Road

Office Address:
 44-50 Great Northern Rd
 Sault Ste. Marie, ON
 P6B 4Y5

Phone: 705-253-2887
Fax: 705-253-3980
Email:

Hours: Open M-F 9-9, Sat 9-6, Sun 10-5

Languages: English.

Service	Description
Pharmacy	<ul style="list-style-type: none"> • Glucose meter sales, trade in and training • Training provided by pharmacist • Private medical counseling room or area • Insulin instruction available on pens and syringes • 2 brands of pens available at no cost • Trillium Drug Program and Monitoring for Health -financial assistance programs • Medication available in blister packs \$2.00 per week • Blood pressure machine • Delivery available anytime \$3.00 charge • Canadian Diabetes Association literature available • Sells diabetic supplies (eg. socks, lotions etc.) can order things they don't have

(Group Health Centre- Pharmacies, 2013)

Primary Care/Allied Health/Specialized Services Organization (Pharmacy):
Shopper's Drug Mart - Cambrian Mall

Office Address:
 669 Great Northern Rd
 Sault Ste. Marie, ON
 P6B 4Y5

Phone: 705-949-2143
Fax: 705-949-8874
Email:

Hours: Open M-Sat 8am-midnight, Sun 10am-midnight

Languages: English.

Service	Description
Pharmacy	<ul style="list-style-type: none"> • Glucose meter sales, trade in and training • Training provided by pharmacist • Insulin instruction available on pens and syringes • 2 brands of pens available at no cost • Trillium Drug Program & Monitoring for Health -financial assistance programs • Medication available in blister packs at no charge • In store "Diabetes Day" 1-2 times yearly • Blood pressure machine, calibrated at least every six months • Delivery available daily from 11 am to 7 pm • Canadian Diabetes Association literature available • Sells diabetic supplies (eg. socks, lotions etc.)

(Group Health Centre- Pharmacies, 2013)

Primary Care/Allied Health/Specialized Services Organization (Pharmacy):
Shopper's Drug Mart - Second Line

Office Address:
 364 Second Line W
 Sault Ste. Marie, ON
 P6C 2J7

Phone: 705-945-1215
Fax: 705-945-1510
Email:

Hours: Open M-F 9am-9pm, Sat & Sun 9am-6pm

Languages: English.

Service	Description
Pharmacy	<ul style="list-style-type: none"> • Glucose meter sales, trade in and training • Training provided by pharmacist • Insulin instruction available on pens and syringes • 2 brands of pens available at no cost • Trillium Drug Program & Monitoring for Health -financial assistance programs • In store "Diabetes Day" 1-2 times yearly • Blood pressure machine, calibrated at least every six months • Medication not available in blister packs • Delivery available throughout store hours • Canadian Diabetes Association literature available • Sells diabetic supplies (eg. socks, lotions etc.)

(Group Health Centre- Pharmacies, 2013)

Primary Care/Allied Health/Specialized Services Organization (Pharmacy):
Station Mall IDA Drug Mart

Office Address:
293 Bay Street
Sault Ste. Marie, ON
P6A 1X3

Phone: 705-949-7331
Fax: 705-942-0919
Email:

Hours: Open M-F 9:30-9, Sat., 9:30-6, Sun. 1-5

Languages: English.

Service	Description
Pharmacy	<ul style="list-style-type: none">• Glucose meter sales, trade in and training• Training provided by pharmacist• Private medical counseling room or area• Insulin instruction available on pens and syringes• 2 brands of pens available at no cost• Trillium Drug Program - financial assistance program• Medication available in blister packs at no additional charge• In store Diabetes Day 1-2 times yearly• Delivery available 9:00 am - 6:00 pm• Blood pressure machine, calibrated at least every six months• Canadian Diabetes Association literature available• Sells diabetic supplies (eg: socks, lotions, etc.)

(Group Health Centre- Pharmacies, 2013)

Primary Care/Allied Health/Specialized Services Organization (Pharmacy):
Wal-Mart Pharmacy- Great Northern Road

Office Address:

446 Great Northern Rd
Sault Ste. Marie, ON
P6B 4Z9

Phone: 705-945-8364

Fax: 705-253-8454

Email:

Hours: Open M-F 9-9, Sat 9-6, Sun 9-5

Languages: English.

Service	Description
Pharmacy	<ul style="list-style-type: none">• Glucose meter sales, trade in and training• Training provided by pharmacist• Insulin instruction available on pens• Blood pressure machine• 2 brands of pens available at no cost• Trillium Drug Program -financial assistance program• Canadian Diabetes Association literature available• Sells diabetic supplies (eg. socks, lotions etc.)

(Group Health Centre- Pharmacies, 2013)

Primary Care/Allied Health/Specialized Services Organization (Pharmacy):
Wellington Square Drug Mart IDA

Office Address:

625 Trunk Rd
Sault Ste. Marie, ON
P6A 3T1

Phone: 705-945-8088

Fax: 705-946-2570

Email:

Hours: Open M-F 9-9, Sat 9-6, Sun closed

Languages: English.

Service	Description
Pharmacy	<ul style="list-style-type: none">• Glucose meter sales, trade in and training• Training provided by pharmacist• Insulin instruction available on pens and syringes• 2 brands of pens available at no cost• Trillium Drug Program - financial assistance program• In store "Diabetes Day" once yearly• Blood pressure machine• Delivery available throughout store hours• Canadian Diabetes Association literature available• Sells diabetic supplies (eg. socks, lotions etc.)

(Group Health Centre- Pharmacies, 2013)

Primary Care/Allied Health/Specialized Services Organization (Pharmacy):
Group Health Centre-McNabb

Main Site Address:
 240 McNabb Street
 Sault Ste. Marie, ON
 P6B 1Y5

General Phone: 705-759-1234
General Fax: 705-759-7469
General Email: inquiries@ghc.on.ca

Website: www.ghc.on.ca
Toll Free: 1-800-461-2407

Note: Specific address and contact information for each program/service is listed below.
Hours: Specific information about service hours for each program/service is listed below.
Application: Specific application information for each program/service is listed below.
Eligibility: Specific eligibility information for each program/service is listed below.
Languages: English.

Service	Description
Pharmacy	<p>Phone: 705.759.5578 or 705.759.5579 Fax: 705.759.6150 Hours: Weekdays (except statutory holidays) 9 am to 7 pm. Saturdays: 10 am to 2 pm. Sundays: closed Eligibility: Open to the general public.</p> <p>Description: The Group Health Centre Pharmacy provides convenient shopping hours for our members and others requiring medication and other medical supplies.</p>

Primary Care/Allied Health

Primary Care/Allied Health/Specialized Services Organization (Primary Care/Allied Health): Group Health Centre

Main Site Address: 240 McNabb Street
 Sault Ste. Marie, ON P6B 1Y5
General Phone: 705-759-1234
General Fax: 705-759-7469
General Email: inquiries@ghc.on.ca
Website: www.ghc.on.ca
Toll Free: 1-800-461-2407

Note: Specific address and contact information for each program/service is listed below.

Hours: Specific information about service hours for each program/service is listed below.

Application: Specific application information for each program/service is listed below.

Eligibility: Specific eligibility information for each program/service is listed below.

Languages: English.

Service	Description
Algoma Breast Health Program/Ontario Breast Screening Program	<p> Phone: 705.759.-5657 Toll Free: 1.888.240.3903 Fax: 705.759.5582 Hours: Monday to Friday, 8 am to 5 pm Application: OBSP appointments are available by provider or self-referral. All other mammography appointments require provider referrals. Eligibility: This program is open to the general public. </p> <p> Description: Group Health Centre, the Sault Area Hospital and the Ontario Breast Screening Program (OBSP) are partners in a unique community-based program that has reduced the time to diagnose breast diseases including cancer. Our Diagnostic Imaging Department is the site for the Algoma Breast Health Program (ABHP), a community based, comprehensive program that provides complete breast health care for residents of the Algoma District. </p>
Algoma Diabetes Education and Care Program (ADEC)	<p> Location: 83 Willow Avenue, Sault Ste. Marie, ON P6B 5B1 Phone: 705.541.2670 Fax: 705.942.9980 Hours: Monday to Friday 7:30 am to 4:00 pm Application: Self-referrals are accepted as well as referrals from your primary health care provider. Eligibility: This program is open to the general public </p> <p> Description: We offer the following services and tests for adults and </p>

	<p>children with Diabetes:</p> <ul style="list-style-type: none"> • individual or group counselling appointments if you are newly diagnosed with Diabetes or simply require more information • emergency appointments • insulin / oral medication adjustment (with a signed medical directive) • insulin starts; flexible insulin therapy (FIT) program / multiple daily injections (MDI) • insulin pump information and program • foot care • classes on a variety of topics including: stress/relaxation; cholesterol and label reading. • gestational Diabetes education/treatment. • community health promotion activities and Diabetes awareness to service groups, schools and other health care agencies.
<p>Algoma Hepatitis C Program</p>	<p>Location: 1st floor, 262 Queen Street East, Sault Ste. Marie, ON P6A 1Y7 Phone: 705.541.2235 Toll Free: 1.888.943.HEPC (4372) Fax: 705.945.7599 Hours: 8:30 am to noon and 1:00 - 5:00 pm Application: Referrals from primary care providers or self-referrals are accepted.</p> <p>Description: The Algoma Hepatitis C Program includes a specially trained social worker, support worker and two nurses who help people with hepatitis C (and co-infected patients with Hep B or HIV) get the nursing care and support that they require to complete their treatment program and lead healthier and more active lives. The goal of the Algoma Hepatitis C Program is to increase treatment capacity, particularly in under-serviced communities and where the prevalence of Hepatitis C is high, and to improve the health of Ontarians living with Hepatitis C. Studies have shown that up to 90% of patients are able to complete their treatment with support compared to only 30% who do so with no support.</p>
<p>Algoma Respiratory Education Program</p>	<p>Location: Group Health Centre's 83 Willow Avenue location [ADEC building] Phone: Janice Belanger/Suzanne MacInnis: 705.541.2303; Jennifer Zufelt: 705.759.7471 Fax: 705-541-2298 Hours: 8:30 am to 4:30 pm weekdays (except holidays) Eligibility: The Algoma Respiratory Education Program is a service provided by the Group Health Centre to the people of the Algoma District who have, or are at risk of developing, respiratory problems.</p> <p>Description: The Algoma Respiratory Education Program is a service</p>

	<p>provided by the Group Health Centre to the people of the Algoma District who have, or are at risk of developing, respiratory problems. Certified Respiratory Educators provide evidence-based screening, assessment, treatment, education and support in order to assist patients improve their quality of life.</p> <p>The Certified Respiratory Educators assist clients who have asthma, chronic obstructive pulmonary disease (COPD) or who need screening for lung disease.</p> <p>Clients with asthma learn:</p> <ul style="list-style-type: none"> • How to use puffers and how to take medication as prescribed • Warning signs and symptoms of reactions to watch for and how to know allergic and non-allergic triggers • How to avoid exposure to triggers by changing your environment • The importance of not smoking and living in a smoke-free environment • Managing asthma using an Action Plan and peak flow monitoring (meter that measures the amount of air that can be expelled from the lungs). <p>Clients with COPD work with a team of health care professionals including a Certified Respiratory Educator, Kinesiologist, Dietitian and Social Worker. This team provides education and support about:</p> <ul style="list-style-type: none"> • Causes of COPD and what you can do about it • How COPD affects your lungs • Help to quit smoking • Medications and how to take them • How to check how you are doing • Recognizing if you have a chest infection and knowing the steps to take • Exercise and conserving your energy • Managing stress in your life • Following a healthy diet • The staff of the respiratory program also provides screening for lung disease.
Anticoagulation Clinic (AC Clinic)	<p>Phone: 705.541.2240 or 1.800.461.2407 ext. 2240 (toll free in Algoma District) Fax: 705.541.2216</p> <p>Group Health Centre Anticoagulation Clinic : Monday – Friday 8:30 a.m. to 5:30 p.m. (705-541-2240) or 1-800-461-2407 and ask for extension 2240 (toll-free in Algoma District)</p> <p>LifeLabs Laboratory located in the Cambrian Mall: Monday – Friday 7:30 a.m. to 3:30 p.m. This location closes early (at 1:30 pm) the second Thursday of every month.</p> <p>Application: Group Health Centre Anticoagulation patients have to make an appointment with the LifeLabs Laboratory at the Cambrian Mall at least 24 hours in advance by calling 705-759-4444.</p>

	<p>Eligibility: This program is for GHC enrollees* only. (*Enrollee: Those who have a primary care provider [family physician, paediatrician or nurse practitioner] based with the GHC or satellite location, and who receive most of your care here.)</p> <p>Description: GHC’s Anticoagulation Clinic (AC) is staffed with registered nurses who have specialized training in the monitoring of blood work (INR).* *INR~International Normalized Ratio (INR) testing applies to patients who take Warfarin. INR testing evaluates how long it takes blood to clot and is an important test to maximize the efficiency of the treatment.</p> <p>The anticoagulation nurses work closely under the direction of the referring physician following established protocols.</p> <p>GHC’s anticoagulation nurses:</p> <ul style="list-style-type: none"> • adjust Warfarin (Coumadin) dose based on the results of INR blood testing • assess for minor and major bleeding episodes • meet with newly referred patients on anticoagulant therapy • provide education sessions regarding anticoagulant therapy throughout the year • provide education tools and literature as needed • assist patients with concerns with their anticoagulant therapy as needed • follow up with patients that miss lab visits • liaise with the referring health care provider as required • follow-up with pharmacy to provide Warfarin refills on behalf of health care provider office • coordinate anticoagulant bridging for patients requiring time off of Warfarin for surgery etc. • contact referring health care provider for any problems falling outside the protocol.
Cardiac Rehab Program	<p>Location: 83 Willow Avenue] Phone: 705. 541.2317 Fax: 705.541.2298 Hours: 8:30 am to 4:00 pm weekdays. Closed on statutory holidays. Application: Self-referral, referral by any health care provider (see PDF Referral Form on right-hand side of this page) Eligibility: Open to residents of the city and district who have in the past year experienced a Cardiac Event (eg: heart attack, heart surgery, heart failure, angina and arrhythmia [including pacemaker]).</p> <p>Description: The Cardiac Team helps patients to reduce their risk factors for vascular disease. They help to empower each patient to take an active role in self-managing their own health, while providing support for their emotional and physical well-being. Your Cardiac Rehab Team includes:</p>

	<ul style="list-style-type: none"> • YOU • Cardiologist • family physician/nurse practitioner • registered nurse • kinesiologist/physical therapist • registered dietitian • pharmacist and counsellor • Algoma Diabetes Education & Care Program (ADEC) • community agencies/programs • family & friends <p>How We Can Help You</p> <ul style="list-style-type: none"> • Cardiac Rehab will help you make healthy lifestyle changes to better manage your heart health. <p>Cardiac Rehab may include:</p> <ul style="list-style-type: none"> • an interview to review your medical history and risk factors • a medication review • various measurements, eg: blood pressure • an ECG and/or Stress Test • blood tests • supervised exercise • nutritional counselling • education sessions • referral to other programs/agencies • counselling and support in your self-management efforts.
Congestive Heart Failure Program (CHF)	<p>Location: 83 Willow Avenue Phone: 705. 541.2305 Fax: 705.541.2298 Hours: 8:30 am to 4:00 pm weekdays. Closed on statutory holidays. Application: This program welcomes referrals of new patients from the Sault Area Hospital, health provider offices, outside agencies such as North East Community Care Access Centre, and self-referrals. If a patient makes a self-referral and is NOT a GHC enrollee*, a FHW can see them for an initial CHF education in office only, and not for home visits.</p> <p>Description: Under the umbrella of GHC’s Family Health Worker Program and the direction of Dr. Lee at the time, the CHF initiative evolved into a program supporting education, disease self-management, healthy lifestyle changes and the bridging of care with other members of the health care team. Through home and office visits, and phone support, the program nurses assist patients in understanding:</p> <ul style="list-style-type: none"> • the signs and symptoms of CHF, • the importance of medication compliance, • diet and fluid restrictions and • importance of exercise.
Geriatrics Assessment Program	Phone: 705.759.7484

	<p>Fax: 705.759.7469</p> <p>Hours: 8:30 am to 4:00 pm weekdays. Closed on statutory holidays.</p> <p>Application: A referral from your primary care giver (family physician, nurse practitioner) is required. Those referred to the program have multiple complex, medical, functional and psychosocial problems.</p> <p>Eligibility: This program is open to the general public as long as they have a referral from their primary care provider (physician or nurse practitioner).</p> <p>Description: Our Geriatric Assessment Program offers a multi-disciplinary team approach to geriatric care to enhance the abilities of patients by initiating a treatment plan that maximizes the elderly's independence and well-being.</p> <p>We strive to assist the elderly in maintaining their optimal level of physical, mental, emotional and social functioning. We also strive to increase the health knowledge and skills of the caregivers of the elderly and to reduce the incidence of accident-related injuries.</p> <p>Criteria for referral to the Geriatric Assessment Program are:</p> <ul style="list-style-type: none"> • those patients who are elderly and frail; • whose independence is threatened; has complex problems (i.e. multiple diagnosis, multiple medications, etc.) failure to thrive; with nonspecific symptoms or problems; • social withdrawal; at risk for placement in long-term care facility; physical and psychiatric problems. <p>Our team of professionals include physicians with the Algoma District Medical Group, a Geriatric Case Manager and support staff with professionals from physical therapy, nutrition services, audiology, chiropody, internal medicine/surgery and family health nurses. They work together to provide comprehensive care, adjusted to the pace of the elderly.</p>
HIV, AIDS Resource Program	<p>Location: 1st Floor [front entrance], 262 Queen Street East, Sault Ste. Marie, ON P6A 1Y7</p> <p>Phone: 705.759.5690</p> <p>Fax: 705.945.9341</p> <p>Hours: 8:30 am - noon and 1:00 - 4:30 pm.</p> <p>Application: No referral needed.</p> <p>Description: H.A.R.P. does not provide medical care. Staff provide day-to-day education and support for local individuals infected, affected or at risk by HIV/AIDS and related issues.</p> <p>H.A.R.P. is funded provincially by the Ministry of Health and Long-Term Care's AIDS Bureau and federally by the Public Health Agency of Canada.</p> <p>Education and support includes: presentations, workshops, information sessions and conferences on HIV, AIDS, safer sex, and other issues. Outreach services are provided with the help of community partners by developing strategies on harm reduction for</p>

	<p>safer sex and intravenous drug users. A resource centre featuring pamphlets, posters, videos, books and fact sheets is also available.</p>
IRP Physiotherapy	<p>Location: 235 McNabb Street (based in Family YMCA) Phone: 705-759-5517 Fax: 705.759.7455 Hours: 8:00 am to noon and 1:00 to 4:00 pm Application: Referrals are usually seen within one to five days and self-referrals are also accepted. Eligibility: Open to the general public.</p> <p>Description: IRP Physiotherapy is a comprehensive exercise-based physiotherapy program aimed at getting injured workers back to work and rehabilitating clients back to normal activities and work following a motor vehicle accident. We also specialize in the treatment of orthopaedic and sports injuries. Clients with private insurance are accepted. Treatments may involve traditional physical therapy including:</p> <ul style="list-style-type: none"> • manual therapy • sports-specific training • aquatherapy • work hardening and functional retraining • preventative education • home exercise programs • prescription of braces/assistive devices • use of therapeutic modalities
Occupational Health Services	<p>Phone: 705.759.5624 Hours: Flexible hours available. Eligibility: Open to the general public.</p> <p>Description: OHS is a confidential service that promotes the highest degree of physical, mental, and social well being for your employees using a proactive team of health professionals. It offers tools and resources to improve and maintain a healthy lifestyle.</p>
Audiology	<p>Phone: 705.759.7453 Fax: 705.759.5668 Hours: 8:00 am to 4:00 pm weekdays (excluding statutory holidays) Application: Appointments are by self-referral. Eligibility: Open to the general public.</p> <p>Description: A certified audiologist provides hearing health care solutions through diagnostic evaluations, hearing prevention/protection education and individual fittings of a wide selection of the latest digital hearing aids and selective listening devices. Their goal is to provide early identification of hearing loss in order to improve the quality of life through better hearing.</p>

	<p>We use of the latest state-of-the-art equipment and technology to identify current hearing loss levels with appropriate referrals, education and rehabilitation provided.</p> <p>We strive to provide realistic expectations and education in developing suitable hearing solutions for individual lifestyles and budgets.</p> <p>Services and tests offered:</p> <ul style="list-style-type: none"> • complete audiological evaluations for all age groups • claims for WSIB, veterans affairs etc. • pre-employment/work related audiograms • central auditory processing assessments (age 6 and over) *fee attached • hearing aid evaluations - all manufacturers (trial period offered) • hearing aid fittings and follow-up • hearing aid repairs, cleaning and troubleshooting • tinnitus masking devices • ear mold fittings, custom noise and/or swim plugs available • counselling/support on care and use of hearing aids (lip reading and rehabilitation classes) • assistive listening device selections and sales (telephone amplifiers, infrared for televisions, etc.) • batteries and hearing aid accessories available
Chiroprody	<p>Phone: 705.759.5521 Fax: 705.759.7469 Hours: By appointment 8:30 am to 5 pm weekdays (excluding statutory holidays) Application: Appointments are by referral from your health care provider or by self-referral. Eligibility: Open to the general public.</p> <p>Description: Our registered Chiroprodists provide the examination, treatment, and education regarding the prevention of disease and conditions of your feet. Foot care offered through this program includes:</p> <ul style="list-style-type: none"> • nail care including ingrown nails, fungal nails, and nail surgery • callus and corn treatments • biomechanical assessments, custom-made orthotics, and shoe adjustments • foot care and footwear education • diabetic foot care, including ulcer management • wart treatments (including cryotherapy using liquid nitrogen).
Diagnostic Imaging	<p>Phone: 705.759.5556 Fax: 705.759.7477 Hours: 8 am to 5 pm weekdays. Closed on statutory holidays. Application: Appointments are by provider referrals. Eligibility: Open to the general public.</p>

	<p>Description: Approximately 30,000 procedures are performed annually in Diagnostic Imaging. There are 21 staff members and two radiologists who perform:</p> <ul style="list-style-type: none"> • x-ray, including routine radiography • barium studies • ultrasound • bone mineral density tests • echocardiography, and • mammography (see Algoma Breast Health Program/Ontario Breast Health Program).
Family Health Nurses	<p>Phone: 705-541-2305 Fax: 705.541.2298 Hours: 8:30 am to 4:30 pm, weekdays. Eligibility: This service is for GHC enrollees* only. (*Enrollee: Those who have a primary care provider [family physician, paediatrician or nurse practitioner] based with the GHC or satellite location, and who receive most of your care here.)</p> <p>Description: Our Family Health Nurse program is a supportive nursing service addressing the physical, social, emotional and spiritual needs of Group Health Centre enrollees and their families. The scope of care includes all facets of chronic disease management within a multidisciplinary approach. Key components of care include:</p> <ul style="list-style-type: none"> • geriatrics • palliative support • GHC's Congestive Heart Failure Program.
Injection Clinic	<p>Phone: 705.759.4444 Fax: 705.759.7469 Hours: Tuesday and Thursdays only: 8:45 am to 1:00 pm AND 2:00 to 4:30 pm Application: Accessible by referral from your primary health care provider. Eligibility: This service is for GHC enrollees* only. (*Enrollee: Those who have a primary care provider [family physician, paediatrician or nurse practitioner] based with the GHC or satellite location, and who receive most of your care here.)</p> <p>Description: Group Health Centre's Injection Clinic provides injections for enrollees as ordered by their primary provider (family physician or nurse practitioner). Types of injections vary and may include:</p> <ul style="list-style-type: none"> • Immunizations • allergy injections • monthly B12 injections • birth control injections • Hepatitis B • and more

Nutrition Services	<p>Location: 83 Willow Avenue Phone: 705.759.4444 Fax: 705.942.9980 Hours: Tuesday to Friday 8 am to 4 pm weekdays. Closed on statutory holidays. Application: Appointments are by referral from your primary health care provider, or by a registered nurse or dietitian. Eligibility: This service is for GHC enrollees* only. (*Enrollee: Those who have a primary care provider [family physician, paediatrician or nurse practitioner] based with the GHC or satellite location, and who receive most of your care here.)</p> <p>Description: Our registered dietitian provides care and services to patients of all ages to help them meet their nutritional needs, improve their well-being and to prevent disease. Individual and group sessions are available for the following:</p> <ul style="list-style-type: none"> • healthy eating • dyslipidemia (cholesterol class is offered twice per month) • pregnancy (poor nutrition, slow/fast weight gain) • GI (Celiac, Crohn's, Colitis, IBS, Diverticulitis) • paediatrics (food allergies), FTT, GI, Fe Deficiency anemia, BPD, CF • cancer (cachexia/malnutrition) • eating disorders (Anorexia/ Bulimia) • hypoglycemia • VIP (Vascular Intervention Program)
Phototherapy	<p>Phone: 705.759.7485 Fax: 705.759.7469 Hours: Monday, Wednesdays and Fridays, 9 - noon and 1 - 5 pm (except on statutory holidays) Application: Appointments are by referral from a dermatologist/dermatopathology.</p> <p>Description: Psoriasis is a non-contagious skin disease that affects millions of North Americans. It causes the development of various sizes of red patches covered with dry, silvery scales. Those suffering with this illness experience inflammation during different times and presently there is no known cure. Our Phototherapy service offers an Ultraviolet (UV) booth; UVB PUVA booth; and the PUVA Hand and Foot unit -- forms of artificial light used to treat psoriasis.</p>
Physical Therapy	<p>Phone: 705.759.5521 Fax: 705.759.7469 Hours: By appointment only. Application: Physical Therapy is available by referral from your health care provider or by self-referral. Eligibility: Open to the general public.</p>

	<p>Description: Our Physical Therapy Department is one of the largest in Northern Ontario! Physical therapists perform detailed musculoskeletal assessments and determine appropriate treatment for a variety of conditions, including orthopaedic (muscle, bone joint), neurological (stroke, M.S., etc.), geriatric, and cardiorespiratory.</p> <p>Services include:</p> <ul style="list-style-type: none"> • post-surgical rehabilitation, • sports injury rehabilitation, • acupuncture, • vestibular rehabilitation (Vertigo), • falls prevention classes, • osteoporosis education, • preventative education, • assistive devices assessments, • prescription of braces/assistive devices, • custom exercise programs, • pelvic therapy for urinary incontinence, dyspareunia (pain during sexual intercourse) and pelvic pain.
Primary Care	<p>Thirty-five family practitioners with the Algoma District Medical Group and nine nurse practitioners work collaboratively to provide primary care at the Group Health Centre for over 60,000 patients. Nurse practitioners currently work in family practice, obstetrics and gynaecology, our Same Day Appointment Clinic, and in women's health. Our primary care practitioners work collaboratively with specialists and a comprehensive team of allied health professionals including optometrists, chiropractors, physical therapists and audiologists.</p>
Same Day Appointment Clinic	<p>Phone: 705.759.5525 Fax: 705.759.7469 Hours: 9 am to 8 pm, weekdays by appointment only. Closed on statutory holidays. Eligibility: Available to patients of the Group Health Centre only.</p> <p>Description: Our 'Same Day Appointment Clinic' supplements services provided by family physicians of the Algoma District. Medical Group and GHC nurse practitioners. Patients are encouraged to first seek the services of your health provider at the Group Health Centre. The Same Day Appointment Clinic is intended to treat only urgent, non life-threatening medical problems. Before making an appointment with the Same Day Appointment Clinic, please read the following:</p> <ul style="list-style-type: none"> • if you are experiencing chest pain, go directly to the Sault Area Hospital Emergency department • if you've experienced a head injury, seizure, or severe pain in your chest or abdomen, go directly to the Sault Area Hospital

	<ul style="list-style-type: none"> • your primary health care provider should complete all forms including WSIB, unless it's a new injury and your provider is absent • your health care provider should order any required tranquilizers, narcotic and psychotropic drugs or prescription refills • you should receive your lab results from your health care provider or a chosen substitute • a physical should only be obtained from your health care provider • your health care provider, except in emergencies, should arrange consultations • if you require an allergy shot, make arrangements with your health care provider who will make an appointment with our Injection Clinic • if you're experiencing long-standing symptoms, see your health care provider - unless new symptoms arise.
Surgery	<p>Phone: 705.759.5651 Fax: 705.759.5659 Hours: Front reception - 8:00 am to 5 pm, weekdays, closed on statutory holidays. O.R. bookings in conjunction with the Sault Area Hospital - 8 am to 4 pm, weekdays, closed on statutory holidays. Application: Appointments are by referral from your primary care physician.</p> <p>Description: Our professional team includes an orthopaedic surgeon as well as three general surgeons, two who specialize in vascular and thoracic surgery, and a visiting neurosurgeon. They provide surgical consultation and follow-up care. A variety of procedures are conducted in this department using endoscopies for procedures not requiring general anaesthesia including colonoscopies, gastroscopies and bronchoscopies and other minor procedures. Registered Nurses provide the post-operative dressing, procedures and monitoring.</p>

(Group Health Centre- Programs & Services, 2013)

**Primary Care/Allied Health/Specialized Services Organization (Primary
Care/Allied Health): Algoma Nurse Practitioner-Led Clinic**

Main Site Address: 443 Northern Ave
Sault Ste. Marie, ON
P6A 5L3

Phone: (705) 942-4717
Fax: (705) 942-9687
Email:
Website: <http://www.algomanplc.ca>

Hours: Contact office.

Application: The Algoma Nurse Practitioner-Led Clinic is accepting patient registrations- Online or in person.

Eligibility: Contact office.

Languages: English.

Service	Description
Nurse Practitioner-Led Clinic	The Algoma Nurse Practitioner-Led Clinic provides primary care to residents of Sault Ste. Marie and surrounding area who are currently unattached to a primary care provider (physician/nurse practitioner). The clinic provides comprehensive care to its patients, including health promotion, and chronic illness management. Patients who are registered with the clinic will be registered to a nurse practitioner and will have access to the clinic's multidisciplinary team which includes a registered nurse, registered practical nurses, social worker, pharmacist and administrative support staff.

(Algoma Nurse Practitioner-Led Clinic, 2013)

**Primary Care/Allied Health/Specialized Services Organization (Primary
Care/Allied Health): Sault Care Walk In Clinic**

Main Site Address: Unit 48 - 44 Great Northern Road
Sault Ste. Marie, ON
P6B 4Y7

Phone: (705) 253-1313
Fax:
Email:

Website: <http://saultcare.ca/default.aspx>

Hours: 4 PM to 8 PM (Mon-Thu). Closed Friday to Sunday

Application: Contact office.

Eligibility: Contact office.

Languages: English.

Service	Description
Walk In Clinic	<p>The SaultCare Medical Clinic's multi-disciplinary health team is dedicated to providing quality primary care and walk-in services for the people of Sault Ste. Marie and surrounding area.</p> <p>Services:</p> <ul style="list-style-type: none"> • Unscheduled Visits: The Walk-in clinic will be available to everyone for non-emergency minor care. The visits will be based on first-come first-served basis. In order to minimize wait time; we would encourage our patients to present with one or maximum two issues per visit. We would be happy to deal with your other concerns during your future visits. • Prescription Renewal Clinic: We do not refill sedatives and narcotics; patients have to see their regular physicians who normally prescribe their sedative and narcotics for chronic use.

(SaultCare, 2011)

**Primary Care/Allied Health/Specialized Services Organization (Primary
Care/Allied Health): Superior Family Health Team**

Main Site Address: Unit 48 - 44 Great Northern Road
Sault Ste. Marie, ON
P6B 4Y7

Phone: (705) 253-6599
Fax:
Email:

Website: <http://www.superiorfht.ca/index.php>

Hours: Contact office/listed below.

Application: Contact office/listed below.

Eligibility: Contact office/ listed below.

Languages: English.

Service	Description
Family Health Team	<p>A Family Health Team is an approach to primary health care that brings together different health care providers to co-ordinate the highest possible quality of care for you - the patient.</p> <p>Designed to give doctors support from other complementary professionals, most Family Health Teams will consist of doctors, nurses, nurse practitioners and other health care professionals who work collaboratively, each utilizing their experience and skills so that you receive the very best care, when you need it, as close to home as possible.</p> <p>Services:</p> <ul style="list-style-type: none"> • Smoking Cessation • Mental Health • Osteoarthritis Education Series
After Hours Clinic	<p>Eligibility: The after-hours clinic should be used when you are unable to get a same day appointment and need medical attention. It is available only to patients registered with one of the Family Health Team physicians.</p> <p>Hours: Monday to Thursday from 4 PM to 8 PM. Saturday from 8 AM to 11 AM</p> <p>The Superior Family Health Team's After Hours Clinic offers convenient access to healthcare services for minor illnesses and injuries outside of regular work hours. We offer this service to provide extended care hours and help reduce the amount of visits to the local emergency department for non-urgent issues.</p>

(Superior Family Health Team, 2013)

**Primary Care/Allied Health/Specialized Services Organization (Primary
Care/Allied Health): Baawaating Family Health Team**

Main Site Address:

210 Gran St
Sault Ste Marie, ON
P6A 5K9

Phone: 705-575-7191

Fax: 705-575-7193

Email:

Website: <https://sites.google.com/site/baawaatingfht/>

Hours: Contact office.

Application: We are still accepting new patients into our practice. Anyone who would like to be a new patient will need to register with Health Care Connect.

Eligibility: Contact office.

Languages: English.

Service	Description
Family Health Team	<p>The Baawaating Family Health Team offers a wide range of health care services to our patients. The list below outlines some of the most popular services.</p> <ul style="list-style-type: none"> • Preventative medical care: by using the best available evidence, we provide the information and resources for patients to maintain good health and prevent disease. • Well-baby and well-child care (developmental assessments). • The annual physicals. • Complete physical examinations are performed when required for the diagnosis of complex symptoms. • Immunizations: All childhood vaccinations and adult boosters, annual flu shots, pneumonia shots (when indicated by age or medical condition), hepatitis A and B (on prescription), TB skin testing, and Tetanus Diphtheria . • Supportive and Educational Counselling or referral to the appropriate resources are provided following an assessment of the issues • Allergy Shots are provided during regular office hours • Treatment of warts, minor skin lesions and "sun-damaged" spots • Provides OTN (telemedicine) appointments

(Baawaating Family Health Team, 2013)

Primary Care/Allied Health/Specialized Services Organization (Primary Care/Allied Health): Sault Area Hospital Walk-In Clinic (Fast Track)

Site Address: 750 Great Northern Road
Sault Ste Marie, ON
P6B 0A8

Phone: 705) 759-3671
Fax:
Email:

Website:

Hours: 10:00 a.m. to 10:00 p.m. daily.

Application: The Triage Nurse decides if you will be seen in the core ED or sent to the Fast Track area.

Eligibility: Upon your arrival in the ED, you will be welcomed by a Triage Nurse who is specially trained in Emergency care. Based on your history of illness and following a standardized evaluation process used by hospitals across Canada, the nurse will determine the severity of your condition and prioritize your case accordingly.

Languages: English, other.

Service	Description
Walk-In Clinic	Fast Track area (formerly referred to as the Walk-In Clinic) provides care for patients with less serious illnesses or injuries.

(Sault Area Hospital- Programs & Services, 2011)

Geriatric Specialist Services

Primary Care/Allied Health/Specialized Services Organization (Geriatric Specialist Services): North East Specialized Geriatric Services

Main Site Address:

960 Notre Dame Ave.
Sudbury, ON
P3A 2T4

Phone: 705-688-3970

Fax: 705-670-8470

Email: nesgs@greatersudbury.ca

Website: <http://www.greatersudbury.ca/?linkServID=57C34789-0A6B-BFCF-8ED8F9AE0C579B10>

Toll Free: 1-866-551-6501

Hours: Contact office.

Application: Complete the North East Specialized Geriatric Services referral form, physicians, signature required.

Eligibility: Seniors with cognitive challenges; multiple or complex medical problems; depression with additional medical problems; falls or fear of falling; unexplained weight loss; polypharmacy; functional decline; incontinence; impaired mobility; increased use in healthcare (i.e. multiple ER visits, hospitalization, increased home care needs); Parkinson’s disease; unaddressed safety concerns; caregiver stress/burden.

Languages: English.

Service	Description
Specialized Geriatric Services	<p>A specialized team of health care providers who provide multidisciplinary clinical assessment and treatment services for older people including:</p> <ul style="list-style-type: none"> • Geriatrician • Registered Nurses • Physiotherapist • Occupational Therapist • Social Worker • Geriatric Education Resource Coordinator <p>Services:</p> <ul style="list-style-type: none"> • Telemedicine consultation • Regional outreach and education

(North East Specialized Geriatric Services Brochure, n.d.)

Primary Care/Allied Health/Specialized Services Organization (Geriatric Specialist Services): Group Health Centre- Geriatric Assessment Clinic

Main Site Address:

240 McNabb Street
Sault , ON
P3A 2T4

Phone: 705.759.7484

Fax: 705.759.7469

Email:

Website: <http://www.ghc.on.ca/about/content.html?SID=94>

Hours: Contact office.

Application: A referral from your primary care giver (family physician, nurse practitioner) is required. Those referred to the program have multiple complex, medical, functional and psychosocial problems.

Eligibility: Those patients who are elderly and frail; whose independence is threatened; has complex problems (i.e. multiple diagnosis, multiple medications, etc.) failure to thrive; with nonspecific symptoms or problems; social withdrawal; at risk for placement in long-term care facility; physical and psychiatric problems.

Languages: English.

Service	Description
Geriatric Assessment Program	<p>Our Geriatric Assessment Program offers a multi-disciplinary team approach to geriatric care to enhance the abilities of patients by initiating a treatment plan that maximizes the elderly's independence and well-being. We strive to assist the elderly in maintaining their optimal level of physical, mental, emotional and social functioning. We also strive to increase the health knowledge and skills of the caregivers of the elderly and to reduce the incidence of accident-related injuries.</p> <p>Our team of professionals include physicians with the Algoma District Medical Group, a Geriatric Case Manager and support staff with professionals from physical therapy, nutrition services, audiology, chiropody, internal medicine/surgery and family health nurses. They work together to provide comprehensive care, adjusted to the pace of the elderly.</p> <p>Patients with the Geriatric Assessment Program are also referred to other community health programs including:</p> <ul style="list-style-type: none"> ~ VON ~ Day Away program ~ Seniors Mental Health ~ Lifeline ~ Algoma Community Care Access Centre ~ Alzheimer Society

(Group Health Centre- Programs & Services, 2013)

Public Health

Primary Care/Allied Health/Specialized Services Organization (Public Health):

Algoma Public Health

Site Address:
294 Willow Ave
Sault Ste Marie, ON

Phone: 705-942-4646
Fax: 705-759-1534
Email:
Website: www.algomapublichealth.com
Toll Free: 1-888-892-0172

Office Hours: Mon-Fri 8:30am-4:30pm

Application: Appointment required for most services

Eligibility: See description for services listed below.

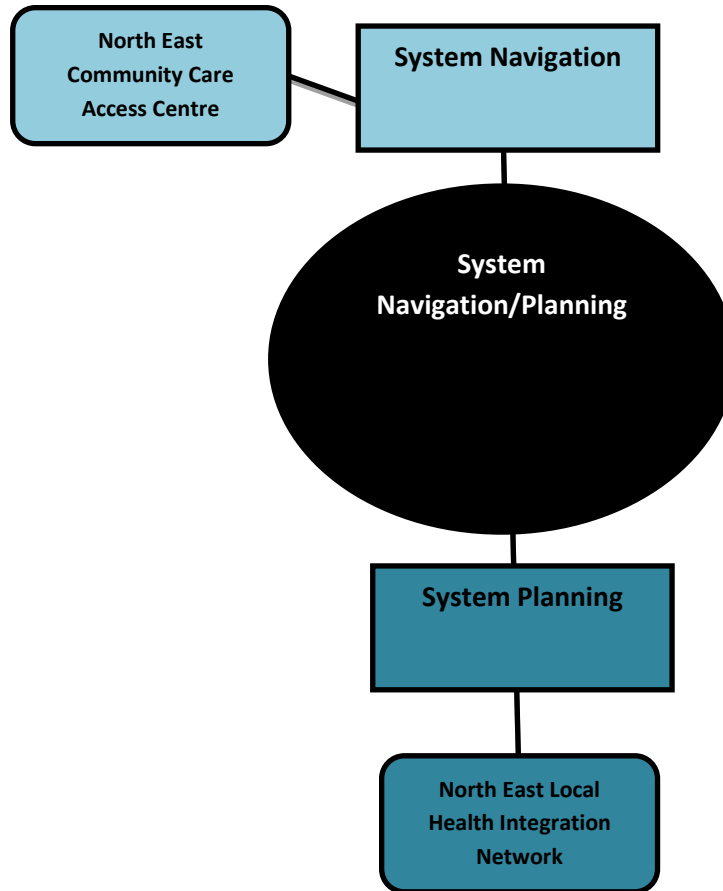
Languages: English.

Service	Description
Community Alcohol/ Drug Assessment Program	<p>Eligibility: 18 years and older seeking assistance with substance abuse programs.</p> <p>Community Drug/Alcohol Assessment Program (CADAP) provides the following services:</p> <ul style="list-style-type: none"> • Screening • Assessments • Counselling and Referrals • Methadone Maintenance • Harm Reduction Distribution • Ontario Remedial Measures (Back on Track) • Addiction Supportive Housing • Anger Solutions • Ontario Workers Addiction Services Initiative
Community Mental Health	<p>Eligibility: 16 and over who experience severe and persistent mental illness</p> <p>Community Mental Health Support Services assists individuals with severe and persistent mental illness to achieve their highest level of functioning in the community.</p>
Sexual Health Services	<ul style="list-style-type: none"> • STI/HIV counselling and testing • Access to STI treatment • Support for HIV positive persons and families • Sexual health information • Community education • Nurse practitioner services
Infection Control	<ul style="list-style-type: none"> • Investigation and management of communicable diseases and/or outbreaks • Management of infectious diseases

	<ul style="list-style-type: none">• Education to health care professionals and the community at large• Surveillance of illnesses (e.g. influenza, West Nile Virus)• Prevention, testing, management and treatment of TB• Travel clinics• Consultation for management of communicable disease in institutions (hospitals, long-term care facilities)
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(Algoma Public Health- Programs and Services Brochure, n.d.)

Sector 9: System Navigation/Planning Map



Sector 9: System Navigation

System Navigation/Planning Inventory Organization (System Navigation): North East Community Care Access Centre

Site Address: 294 Willow Ave
 Sault Ste Marie, ON

Phone: 310-CCAC
Fax: 705-759-1534
Email: janet.skuce@ne.ccac-ont.ca

Website: www.ne.ccac-ont.ca
Toll Free: 1-800-668-7705
Teletype: 1-866-369-3313

Office Hours: Mon-Fri 8:30am-4:30pm
Telephone Line Hours: Mon-Sun 8am-8pm
Application: None.
Eligibility: None.
Languages: English; French.

Service	Description
Information & Referral	<ul style="list-style-type: none"> • We can provide Information and Referral Services to assist you in finding and contacting community support services that will help you. • Information is available by calling the North East CCAC (310-CCAC) about services such as housing resources, mobile meal services, private home care, drip-in centres, day programs, culturally-specific services, cleaning services and many other community supports. • Information is available about local services and services provided elsewhere in the province.
Placement Services- Short-Stay/Long-Term Placement at Long-Term Care Homes	<p>For applicants over 18 years of age, Placement Services:</p> <ul style="list-style-type: none"> • Collects all information needed to determine your eligibility and admission to a Long Term Care Home (LTCH); • Provides information and support to you throughout the LTCH process; • Provides information about all LOCHs in your area; • Assists you with a short-stay placement at a LTCH if your caregiver requires respite; • Helps you to find a short-stay convalescent care in a LTCH in you need a place to recover; • Connects families to support services in the community; and • Works with other CCACs in the province if you want to relocate to another community. NOTE: If vacancies are not available you will be waitlisted and other options discussed.

(North East Community Care Access Centre-Client Care Information Booklet, n.d.)

System Planning

System Navigation/Planning Inventory Organization (System Planning): North East Local Health Integration Network

Site Address:
 264 McNabb Street, 3rd Floor
 Sault Ste Marie, ON

Phone: (705) 840-2872
Fax: (705) 840-0142
Email:
Website: <http://www.nelhin.on.ca/>
Toll Free: 1-866-906-5446

Office Hours: Mon-Fri 8:30am-4:30pm

Application: None.

Eligibility: None.

Languages: English; French.

Service	Description
System Planning	<p>Who We Are: The North East Local Health Integration Network (North East LHIN) is one the largest of 14 LHINs in Ontario, responsible for planning, integrating and funding health care services for more than 550,000 people across an estimated 400,000 square kilometers. From offices in North Bay, Sault Ste. Marie, Sudbury and Timmins, we are a provincial crown corporation that ensures the local health care system works when people need it. The North East LHIN brings 186 of our region’s health care partners together – hospitals, community support services, mental health and addictions, community health centres, long-term care homes, and the Community Care Access Centre.</p> <p>What We Do: We fund front-line health care work to ensure Northerners, get the right care, at the right time, in the right place, at the right cost. We integrate, plan and fund – 186 health service providers (25 hospitals) Our focus is on patient-centered care right across the health care system.</p> <p>Why We’re Doing It: To improve each Northeastern Ontarian’s health care experience. For the first time ever, the North East LHIN: Measures the delivery of health care services Sets targets based on these measures Holds organizations accountable for achieving targets Publicly reports on performance results Achieves targets that improve the lives of patients Engages with fellow Northerners on building a patient focused</p>

	<p>health care system for Northerners, by Northerners</p> <p>Our Region: 400,000 km² 550,000 people; 60% urban, 40% rural Vibrant and distinct both culturally and linguistically, our region has the highest number of Francophones (at 22% of the population) in the province and a significant number of Aboriginal and First Nation communities (9.5%).</p> <p>Our Budget: \$1.4 billion in front- line care Decision Making Framework The NE LHIN staff and board members follow a decision making framework when evaluating proposals for new programs and initiatives, changes to existing programs, or integration proposals. To view the framework, click here.</p> <p>Mission: To advance the integration of health care services across Northeastern Ontario by engaging our local communities.</p> <p>Vision: Quality health care, when you need it.</p>
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(North East Local Health Integration Network- About Us, 2008)

Appendix F: Senior's Health Knowledge Network- Communities of Practice

Communities of Practice

A Community of Practice (CoP) is a group of practitioners, caregivers, policymakers, researchers, healthcare administrators, educators and community leaders who come together to exchange information on a topic related to seniors health.

“Coming together” can mean many things, such as designing and implementing interactive educational programs, webinar series or knowledge events.

These individuals have not only made a commitment to be available to offer support and learn from one another but also to develop new knowledge.

The Network supports CoP members by providing:

- 12.** Access to an events coordinator who will partner with the CoP lead to assist with scheduling, events promotions and booking meeting space
- 13.** Access to an Information Specialist who will help identify and access information related to the CoP, and deliver education services, if eligible
- 14.** Access to a Knowledge Broker who can help capture and facilitate knowledge exchange and information
- 15.** Access to e-meeting software
- 16.** Access to toll-free teleconference line
- 17.** Interactive engagement activities
- 18.** Support for research activity and dissemination of research findings

The Network's Communities of Practice:

- 19.** Aging and Developmental Disabilities
- 20.** Communicative Access & Aphasia
- 21.** Diabetes
- 22.** Falls Prevention
- 23.** Medication Safety
- 24.** Mental Health, Addictions and Behavioural Issues (a joint AKE/SHKN CoP) *Link coming soon*

25. Nutrition

26. Oral Health

27. Wound Care

Please Note: To join any of our Communities, first you must become a member. When you log in, there will be a link on the top of each Community page that says 'Join this Community.'

Our CoPs vary from year to year. It is a competitive process and some CoPs reach a natural end of life cycle. Others become a CoI until they transition back to being a CoP. We archive their content on the site.

For more information please use the following link:

<http://www.shrtn.on.ca/community/communities-practice>

Source: Seniors Health Knowledge Network Website- Communities of Practice, 2012.