Toronto Seniors Housing Corporation

Aging at Home

Service Delivery Models Review

Lessons to Strengthen TSHC's Integrated Service Model (ISM)

Final Report – September 2025

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Background

Toronto Seniors Housing Corporation (TSHC) was created to do more than just provide clean, safe, affordable housing. The Integrated Service Model, which underpins its work, means TSHC must also offer access to services and support so seniors can age at home with dignity. It is well accepted that access to housing, social services, and healthcare services are key social determinants of health. For TSHC to deliver on its full mandate, strong and mutually beneficial partnerships are required with various parties across diverse sectors.

In December 2023, TSHC initiated a Partnership Table to advise the organization on how best to align existing health and social care resources to better support the 15,000+ tenants, aged 59-100+, who call TSHC home. This table, made up of leaders from hospitals, Ontario Health Teams (OHTs), community services organizations, the City of Toronto, Ontario Health, Ontario Health at Home, and tenant volunteers, comes together about six times a year to offer guidance and advice to TSHC leaders. In early 2024, the table agreed on six key priorities to begin to build stronger bridges across the various sectors:

- Transition in care from hospital to home
- Intergenerational program support
- Education
- Improving language support
- Data analytics
- Building healthier communities

In subsequent meetings later in 2024, the table acknowledged the importance of all areas but agreed to refine its priorities due to capacity constraints, focusing instead on the following:

- Transition in care from hospital to home
- Data analytics
- Education

In the short term, the table agreed that immediate steps could be taken to support its education priority. In consultation and co-design with tenant volunteers at this table, three learning modules were developed with table partners on how to navigate topics deemed important to seniors by the Partnership Table volunteers. In the summer of 2024, those modules were delivered at TSHC's Regional Volunteers Meetings. It was very well received by the over 100 tenants in attendance, and they asked for more. The table once again stepped up in 2025 to provide more education sessions to give tenants more agency on how to access the services and support they may need. This work will continue as tenants value growing their knowledge and retaining their independence.

Transitioning care from hospital to home is the Partnership Table's key longer-term priority as it impacts the use of scarce system resources and outcomes for all involved. Many TSHC seniors are high users of health and social care services. Transitions across various providers and services can be difficult for older adults. There was also recognition that areas for improvement could be made in transitions in care across providers with social housing tenants. The table further agreed that transitions are tied quite closely to the Data Analytics priority, which assists system planners in understanding the current state and setting future goals for better outcomes.

To support these two longer-term priorities, in January 2025, the table agreed that the next step was to investigate existing service delivery models, including those currently being used at TSHC, and develop and pilot a project for TSHC to support more coordinated service delivery. While the current models work, they are limited to certain geographies, modalities, and populations, causing inequities across the 83 buildings that TSHC manages. The model review would look at a range of factors and seek to strengthen ties between providers, TSHC, and tenants. It would also seek to improve person-centred outcomes, system reporting, and improve system benefits for all parties. The Partnership Table has representatives from several OHTs which include North Toronto and North York OHTs through Baycrest, the East Toronto OHT through East Toronto Health Partners and the West Toronto OHT, through Unity Health. These, along with other models across the province, were put forward for consideration.

In February 2025, work began to learn more about the following models:

- Community Wellness Hub, Burlington
- East Toronto Health Partners
- North Toronto OHT/Baycrest's Neighborhood Care Team
- NORC Innovation Centre, University Health Network
- iHelp, Toronto Community Housing
- Ottawa Community Housing
- Oasis

Concurrently, discussions were held between Ontario Health, Toronto Community Housing, and Toronto Seniors Housing to develop a Performance Dashboard that links health indicators to housing indicators, showcasing the broader system impact of collaborating between housing and healthcare. When developed, this would be the first of its kind for both sectors in the province. A Performance Dashboard feeds directly into the Partnership's Table priority of Data Analytics.

Housing, health and social care currently have different outcome measures related to efficacy and impact, focusing on tenant/patient outcomes that improve quality of life and enable seniors to age at home with dignity and comfort. The following pages outline the findings from the model review.

Areas of Review and Approach

The review gathered information in the following areas, from the organizations and programs noted previously. An at-a-glance view of how each program manages service and system planning, can be seen later in the report.

Service Planning

- Volume of people served
- Types of people accessing services and what services are not used (needs-based) vs. what they requested
- What did they have before
- Serving the community or building only
- Space needed, and what other services are available in the area
- Intended and unintended outcomes
- Impact from the tenant, provider and staff perspectives

System Planning

- How they work with their partnership agreements
- Adoption and change management approach
- Measurement and evaluation criteria
- Human and financial resources to support project implementation and ongoing operations
- How is Ontario Health or Ontario Health at Home involved
- Legislative challenges
- Privacy

Members of the Partnership Table, including tenants, were invited to participate in the learning opportunities. Those who were able to attend included:

Tenants	• R. Butler • K. Fines
Delivery Partners	• Melissa Chang, University Health Network • Einat Danieli, Baycrest • Jagger Smith, Baycrest • Margery Konan, East Toronto Health Partners • Tory Merrit, Unity Health
TSHC Staff	• Darryl Spencer • Arlene Howells

Onsite in-person discussions were held with team members (and in some cases participants) for each program with TSHC staff, tenants, and partners attending, as they were available. Being able to see the sites, and in some cases, meet program participants, and meet with providers, offered insights that cannot come from reading a report.

The staff and participants in each of the programs that made themselves available were welcoming, open, and generous with their time and sharing lessons learned. We are deeply appreciative of each and every person who took the time to meet with us to share their knowledge and experiences. Special thanks to the primary contacts within each program, who helped to gather partners and participants to enrich the discussions and learning.

For each of the programs, the overview gleans information gathered from websites or program collateral to ensure the best possible representation of their purpose and intended outcomes. Discussion notes inform the themes and key takeaways.

Consistent Themes

While each program may have a slightly different approach to service delivery, there were some consistent themes across all those interviewed. Those themes have been distilled into three buckets: People, Delivery and Policy.

People Related

One Team – One Voice – A Coalition of the Willing

- Each program said that alignment and managing the people side of change, particularly amongst providers, including housing, is pivotal to success
- Change management work to develop trust and collaboration takes time, but each team puts in the time, understanding that this work is relationship-based

Guided by Community Voices

- Designing solutions with tenants/members is important and necessary
- Voices that shape solutions can be voices that share good news stories and give you insights into how programs are being received
- Approach to engagement varies from program to program, but co-design is key

Onsite Accessible Coordinators Are Vital

- Each program has some type of coordinator role, be it a Care Coordinator, a Community Connector, or some other name
- Individuals stay in these roles for some time; have set onsite hours for tenants/members to access individuals with whom they develop trusting relationships
- Those relationships can lead to better conversations about health and care needs, which can guide the Coordinator/Navigator/ Connector in better supporting the person
- Posted hours for coordinators and programs are needed
- Having access to a service and support coordinator from outside of housing is highly recommended

Delivery Related

One Site at a Time

- Most recommended to undertake no more than one pilot at a time
- Grow from initial pilot, capture lessons, tools, evaluation methodology, and then work to spread and scale
- Develop a strong governance structure and ensure people understand the implications of working as one team

Dedicated Space

- Having an accessible, dedicated space for both private and group programs is important
- Housing providers seek solutions whenever possible to create or adapt space to offer what the service providers need

- Space needs include office space for providers to complete desk work

Managing Service Provision Costs

- Through reallocation and reassignment of existing dollars, health and social care organizations are finding ways to deliver community-based care and support with existing dollars
- Housing providers play a vital role by providing in-kind offices and spaces for program delivery
- Housing is a key program promoter for tenants/members

Develop Minimum Standards – One Size Does Not Fit All

- While each community may have variations in needs and desires, some minimum standards should be in place
- Basic services should include access to primary care, access to community paramedics, access to community-based social activities, and capacity-building programs for tenants

Governance Models May Differ

- Having a clear governance model from the outset is necessary
- Determining acceptable governance takes time and a shared vision
- Governance depends on each team's collective appetite to support strategic and operational pathways to moving their work forward

Anchor Agency

- Designating an anchor agency can increase time and cost savings to the health and care systems
- Tenants/members would have better and more coordinated access to services to age at home
- Housing providers also gain efficiency by working with a single agency instead of navigating a complex network of service providers
- In anchor agency models, aggregate reporting between providers and the housing partner is managed by the anchor agency

Policy Related

Privacy

- Tenants/members prefer a third party rather than the landlord being involved in their care needs or concerns
- Privacy restrictions across multiple government agencies make information sharing challenging from a person-centred approach
- Providers have developed and use guidelines to manage consent protocols

Evaluation and Value for Dollar Metrics Differs

- There is no standardized evaluation assessment tool to measure and demonstrate impact and results across all programs
- Healthcare has some lagging indicators related to hospital visits and use of community paramedics

- Housing has indicators primarily related to bricks and mortar to show the impact of programs on stabilizing tenancies and helping people to age in their homes
- Social care indicators appeared intertwined with health indicators
- There are metrics on quality of life used by some providers that can inform the impact of housing, health, and social care providers working together

Fragmented Funding

- Services are funded in a fragmented way, making coordination across sectors challenging
- Partners from across many systems are finding workarounds to support aging at home

Summary of Observations

One Team – Anchor Agency in many cases focused on collective impact

Trust

On-site non-housing coordinators build trust and uptake

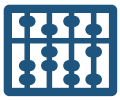
Housing focuses on space and supporting communications – stabilizing tenancies

Providers focus on program delivery and reporting

Community-driven, co-design, asset-based community development

Governance and managing people are change key levers

All are willing to collaborate to support aging at home



Using similar but not the same measures – quality of life indicators are key

Programs Overview

Community Wellness Hub, Burlington

Primary Contact: Adeeta Aulakh, Program Manager
Burlington OHT

About

The Community Wellness Hub (CWH or sometimes just called the Hub), developed in Burlington, is an innovation in integrated care. It brings health, housing, and social service providers to work together as one team. It also enables preventative and maintenance care for vulnerable seniors in the community.

The CWH is part of the Burlington OHT team's work in managing population health for seniors. It is inspired by the American PACE model, which has been adapted to support Canada's publicly funded health and social care systems. Currently, programs are underway in Burlington and Oakville, with inquiries from other municipalities within Ontario and other parts of eastern Canada to bring this program to their community. The CWH provides tenants and community members with health and social care by professional community partners. It is open to both tenants and non-tenants. "Services provided in a CWH are at the intersection of four systems: health, wellness, social services, and housing. Each CWH is co-designed with its local community members to provide services specific to the needs of the local target population." (Burlington Ontario Health Team, 2025)

The Hub improves access to community support services for seniors, improves preventative care, reduces reliance on institutional care, and honours seniors' wishes to age in their homes. It is strategically

embedded within senior housing complexes owned and operated by Halton Housing. The CWH reduces barriers to access, recognizes the value of housing partners in addressing social determinants of health, and enables a relationship between housing and community support services that benefit seniors. (News, OHA, 2025)

Vision (OHT, Burlington, 2024-25)

To keep seniors who are at risk of hospitalization or institutional care living healthily and happily at home for as long as possible.

Mission

To offer care and support through trusting relationships and an integrated approach that proactively identifies and responds to physical, mental, and social “flags” before individuals get into crisis, where they require acute care resources.

Motto

“One Team, One Vision, One Plan”

Services Include

- One-to-one support to connect to local health and wellness services.
- A community connector who helps coordinate care.
- Social events, exercise classes, and recreational activities to stay active and make new friends.
- Workshops about healthy living, mental health, managing medications, etc.
- Tablet device loans and Internet, so you can keep in touch with friends and loved ones.

Their metrics tell a story of meeting the needs of the population they serve: (OHT, Burlington, 2024-25)

- 307 people served between two hub locations
- 94% felt safe at the hub
- 81% made friends at the hub
- 93% have unlocked services they need through the hub
- 92% agreed that the hub will help them age at home
- 99.8% gained knowledge
- 99.3% will apply that knowledge

Site Observations

The Burlington Community Wellness Hub has three sites in the service area for the Burlington OHT. There are plans to expand to other sites in their service area. The model is also being used at two sites served by the Greater Hamilton Health Network (OHT) and two other sites are served by Connected Care Halton OHT. The model review team visited the John Street location in Burlington. We met with Hub partners and toured the site. We were impressed with the purpose-built spaces, such as the reception area, an adult special needs bathroom, a large community room, offices, and access to outdoor spaces for activities. That location also has a dedicated dining hall where meals are served, or groceries can be ordered for a nominal fee. For those unable to come down to the dining room/servery, food can be ordered and will be delivered to their home. This service is only available to tenants.

Partnerships and Collaboration

In conversation with the Hub partners, they spoke warmly of their relationships with each other and stressed that they are better and stronger together. Partners work as one team, with one voice. Partners noted that there were obvious challenges at first about boundaries, roles, and responsibilities for individuals and organizations; however, there was also a deep commitment to being better together. A team-based approach is taken in working with tenants, with clear lines drawn around protecting tenant/member privacy.

Halton Community Housing Corporation (HCHC) provides space in the buildings and coordinates communications between providers and tenants. They are also responsible for any capital investments and maintenance needed to support access to services. HCHC benefits in this partnership by being able to offer access to a range of supports

that meet the needs of vulnerable tenants. This can aid in stabilizing tenancies so that tenants can age at home. HCHC provides meeting rooms for private appointments and community rooms for group activities. As HCHC adds buildings to its portfolio, it includes purpose-built space to support more programming and activities for tenants.

The Community Connector Role

There is a lead organization for the Hub (an anchor agency) that employs the Community Connector, who is key to building trusting relationships with tenants regarding their health and wellness needs. The Community Connector can come from a health or social service organization. The Community Connector has fixed hours in the building and is on-site for those hours. This consistency aids in building trusting relationships with tenants. The Community Connecter acts as a system guide or navigator to external supports while also working with the building providers to further support members. “An on-site Community Connector is foundational to the CWH model. They work closely with the Hub’s members (i.e., residents and community members who access the Hub) and service providers.

The Community Connector is responsible for onboarding members, identifying member needs through goal-based care planning, connecting members with the CWH’s service partners, leading interdisciplinary rounds or individual care conferences, and fostering an environment for person-centred holistic approaches to care. The result is one intake point for services, one coordinated care plan for members, and one interdisciplinary team made up of staff from a range of services that work together to provide wrap-around health, wellness, social, and housing services.” (Burlington Ontario Health Team, 2025)

Frameworks and Tools

The Hub has a well-developed implementation playbook as well as an evaluation framework built around best practices in care and community development. The Hub has a Memoranda of Understanding (MOU) and Letters of Intent to support their partnerships. Those delineate roles, responsibilities, resource allocation, reporting parameters, and governance structure for the Hub. They also have operational tables for local and regional decision-making, communities of practice, and an evaluation framework. Some of their developed tools include:

- Operational metrics data collection sheet
- Hub partner and external data collection sheet
- Acute care data collection sheet
- CWH member experience survey
- CWH provider experience survey
- CWH data tracking dashboard

Demonstrated Outcomes and Benefits

Over time, Hub members have reported an improved sense of health or wellness. Hub members use the emergency department less than non-Hub members, have shorter lengths of stay in the hospital, and get hospitalized less often. These are benefits not only to the members but also to the health, housing, and social care sectors.

According to Dr. Reham Abdelhalim, Manager, Population Health and Evaluation, Burlington OHT, speaking in a video about the impact of the program on tenants, she notes, “They have longer average tenancies in the building, compared to non-members…members report feeling safe and respected in the Hub”. Tamara Warwick, Support Services Coordinator, Services for Seniors, Halton Region, says, “We provide wrap-around services to help our clients live more independently, which has led to improvements in their mood, mobility, and overall well-being.”

Implementation Challenges and Learnings

For their initial implementation, it took about five years to create an integrated vision that all partners could support. A lot of personal and organizational change was required. They alluded to this being one of the biggest challenges. Going from thinking about your work and your organization to thinking about other organizations and your role in a broader, multi-sector, multi-disciplinary team is considerable change. Once they figured out the roles, responsibilities, and navigated the inevitable change management issues, they created a playbook that allows future implementations to happen in a matter of months.

Key Takeaways

- **Improved outcomes:** Demonstrated benefits for members and service providers
- **Evaluation framework:** Structured assessment validates the outcomes
- **Onsite coordinator:** A dedicated, trusted coordinator builds rapport and continuity with members
- **Member-driven programming:** Services are tailored to identified needs
- **Dedicated spaces:** Housing provider allocates appropriate physical space for service provision and activities
- **Hub and spoke model:** Combines on-site services with broader community outreach
- **One team:** Emphasizes a collaborative, “better together” mindset across partners
- **Housing as liaison:** Housing staff play a key role in allocating space and communicating with tenants
- **Playbook for scale:** A proprietary implementation playbook with tools and templates supports efficient rollout
- **Phased development:** Sites are developed one at a time
- **Change management:** Significant effort is needed to navigate concerns from staff, partners, and tenants/members

East Toronto Health Partners Ontario Health Team (OHT), Thorncliffe Park Community Hub

Primary Contact: Margery Konan, Manager, Integrated Care, East Toronto Health Partners, Member of TSHC Partnership Table

About

East Toronto Health Partners Ontario Health Team (ETHP OHT) is a group of more than 100 community, primary care, home care, hospital, and social services organizations in East Toronto working together to create an integrated system of care across our communities. (East Toronto Health Partners, 2025). They are represented at TSHC's Partnership Table and have shared their experiences, insights, and guidance.

The ETHP OHT serves over 20 neighbourhoods, with the following being the top priority areas identified by the City of Toronto: Thorncliffe Park, Flemingdon Park, Taylor-Massey, Victoria Village, and Oakridge. As an OHT, their focus is on population health and care in the community, serving over 300,000 people.

ETHP OHT's shared purpose is to build a healthier and more equitable East Toronto, enabling every person and neighbourhood to thrive. They focus on four key areas.

- **Collaboration**: Every organization and provider has a responsibility to help create an integrated system of care and work collaboratively in the best interests of the community
- **Equity by design**: By mobilizing our community and amplifying the voices of those not typically heard, we can co-design a more

inclusive system that delivers high-quality care and equitable health outcomes for everyone

- **Community-led change:** Our community inspires us to be bolder, push harder, overcome systemic barriers, and create the conditions to achieve and sustain positive change
- **Collective impact:** The strength of our relationships is our greatest asset. Together, we are #OneEastToronto

ETHP OHT strategic priorities are to:

Enable an equity-based approach to population growth.

Build structures and systems that connect us.

Advance a connected and sustainable system centred around primary care.

Partner with our communities to co-lead change.

Neighbourhood Access Model

Many programs within ETHP OHT are designed for those who experience language and cultural barriers, low income, or who are newcomers, to name a few areas of focus. ETHP OHT is advancing a neighbourhood health access model grounded in primary care. The neighbourhood health access model focuses on team-based primary and community care that is integrated with multiple providers and services within a neighborhood so that it is easy for local residents to access. The model aims to improve health outcomes, reduce barriers to care, and address health inequities. They integrate health services with

community services, like social supports and mental health resources, enabled by low-barrier access points for the community, often featuring a physical hub location.

Services offered by ETHP OHT partners at Health Access sites include: (Flemingdon Health Centre, 2020)

- Primary Health Care
- Nutrition and Food Security
- Social Work
- Health Education and Promotion
- Foot Care
- Community Resources and Referrals
- Family Support
- Home Care and Chronic Disease supports

The Health Access teams include several key roles including:

- Community Health Ambassadors
- Holistic Intake and Navigation Counsellors
- Care Coordinator(s) - employed by Ontario Health at Home and embedded within the neighbourhood team
- Primary Care Providers
- Broader community and social care teams

Thorncliffe Park Community Hub Site Visit

Unlike some Neighbourhood Care Teams (NCTs), which might only deliver services to a specific building or buildings, the neighbourhood health access models serve the larger communities where they are situated. We visited with ETHP OHT representatives at the impressive

Thorncliffe Park Community Hub, which serves as the main site for one of two Health Access Teams within ETHP OHT (the other being Health Access Taylor-Massey). Thorncliffe Park Community Hub is surrounded by over 90% vertical housing. Clients can access services directly where they live or in one of the hubs where ETHP partner organizations deliver services.

The Neighbourhood Organization's (TNO) Integrated Services for Seniors Program has its home base at Thorncliffe Park Community Hub and is a core program within the Health Access Thorncliffe Park offerings. There are two TSHC buildings nearby, 12 Thorncliffe Park and 10 Deauville, that have access to this program. In each building, over 100 tenants benefit from the services offered through TNO's Integrated Services for Seniors Program.

Programs include weekly onsite sessions for fitness, balance, body strength, and wellness along with special workshop topics and offsite outings. There are social/recreational components included in onsite programming, with activities selected by tenants on each day of programming, for example Mahjong, armchair travel, or arts and crafts. Typically, 50-75 tenants attend each session.

Personal support services provided by TNO are provided to help tenants with household needs and personal care. Personal Support Workers also bring clients into the lower-level recreational spaces and support residents in participating in group programming. Partners noted that their programs would benefit from having more space in TSHC buildings for program delivery. This would also enable more collaboration between housing staff and their team, and greater community engagement to support tenants.

Below is data from April 1st, 2024, to March 31st, 2025, specific to TSHC tenant interactions with the Integrated Services for Seniors Program.

	Program Facilitation Interactions	Personal Support Services - Interactions	Case Management – Hours of Support	Personal Support Services – Hours of Care
10 Deauville Lane	1,281	582	1,543	1,269
12 Thorncliffe Park Dr.	1,041	1,662	1,056	3,500
Total	**2,322**	**2,244**	**2,599**	**4,769**

Key Roles in Service Delivery

As part of their service delivery model, the Health Access teams have Community Health Ambassadors (CHAs) who are community members with lived experience. Many CHAs come through TNO. They help other community members who may experience inequities, such as those in the TSHC buildings. Community Health Ambassadors are also hosted at Flemingdon Health Centre, WoodGreen, The Neighbourhood Group, and Access Alliance Community Health Centre.

The Ambassadors have supported:

- Vaccine Engagement (volunteers at the vaccination clinic; outreach in the community, information sessions, mobile clinics, door-to-door appointments, food delivery, provided free testing kits)
- Community events e.g., virtual art sessions to help reduce isolation and address mental health
- Cancer Screening – generating blueprints around culturally specific supports for cancer screening conversations

Connecting the dots:

- CHAs know their communities
- CHAs are champions for health promotion

The Community Health Ambassador initiative has been recognized as a "Leading Practice" by the Health Standards Organization, highlighting its innovative and people-centred approach.

The Holistic Intake Navigation Counsellor (HINC) role is another essential role within ETHP that provides direct client care involving connections to primary care, social care services, and the broader determinants of health. They ensure clients with complex, overlapping needs receive coordinated, holistic care that includes intake, tailored care plans, referral and follow up and ongoing advocacy and monitoring. The HINC role is accessible at several access points within the ETHP's Neighbourhood Care Model, including within the Health Access models, within primary care practices, and within the local hospital Emergency Department, where clients who do not have access to primary care and social services can become connected to services close to home.

Partnership and Philosophy

In speaking with partners, they said they focus their energies on solutions built by the team, not any one organization. Acknowledging that they do not have a lot of extra resources to work with, they support their communities by aligning their efforts and pooling their resources. In doing so, they are seeing the value of their collective impact. They do not have one legal entity for their collective work, but they do have formal agreements between partners to guide the work.

Through the Health Access approach, all partners speak to their clients with one voice as one team. In digging deeper into this idea of creating one team, it was noted that teams had to give up some of their own way of doing things to be part of this team. While the transition may have had personality, jurisdictional, privacy, and organizational challenges, they continued to strive for one voice, one vision to support one team.

Thorncliffe Park Community Hub Details

The Thorncliffe Park Community Hub, as one of the two Health Access Hubs within ETHP OHT, provides a clean, safe, and easily accessible location for the members of that East Toronto community to get the services and support they need, closer to home.

The Thorncliffe Park Community Hub is a bright, welcoming, and beautifully designed, state-of-the-art, accessible space with different provider amenities available in a “one-stop shop” model for many services. It launched in February 2025 after many years of consultation, planning, coordination, and collaboration.

The Thorncliffe Park Community Hub serves over 30,000 people in its catchment area. They serve a very large immigrant population with

diverse values, beliefs, languages, and histories. The hub is a cradle-to-grave service provider that supports all ages from newborns to older adults. The anchor agencies for this hub are The Neighborhood Organization, Flemingdon Health Centre, and Michael Garron.

Hub programs include (not an exhaustive list):

- Integrated Services for Seniors
- Personal Support Services for Low Acuity Home Care Seniors
- Youth and Youth Employment Programs
- Maternal and Newborn Programs
- EarlyOn Family Resource Centre
- Resettlement Services
- Primary Care, Mental Health Services
- Housing Supports
- Food Collaborative
- Legal and Notary Services

Subsequently, they have space in the hub to offer programs. They also use the hub to reach out to the surrounding vertical housing communities to offer programs that community members want in their buildings. Community members have the benefit of many health, wellness, education, social, and other government services available within walking distance of their homes.

ETHPs was pivotal in launching the Thorncliffe Park Community Hub. A newer hub location in the Taylor-Massey neighbourhood is being developed, following the Health Access Thorncliffe Park model.

Key Takeaways

- **Broader scope:** ETHP's model appears more expansive than some of the Neighbourhood Care Teams currently used at TSHC
- **Outreach and hub models:** TSHC tenants can access support both in-building and through the Thorncliffe Park Hub
- **Direct tenant engagement:** They use co-design to understand tenant/client goals and needs, to improve population health outcomes
- **One Team philosophy:** Ideally, this would include TSHC staff in solutions planning while respecting privacy boundaries as they seek broader collective impact
- **On-site TSHC programming:** More space is desired in TSHC buildings to expand on-site service delivery
- **Care coordination:** A consistent and trusted care coordinator is key to building strong, lasting relationships along with Community Health Ambassadors and Holistic Intake and Navigation Counsellors
- **Evidence of improved outcomes:** Their evaluation framework shows that they are seeing improvements in health and wellbeing for those they serve

North Toronto OHT/Baycrest's Neighbourhood Care Teams (NCT)

Primary Contact: Einat Danieli, Clinical Manager, Ambulatory Care Services, Baycrest Hospital and Neighbourhood Care Team Lead in North Toronto Ontario Health Team and North York Toronto Health Partners, Member of TSHC Partnership Table

About

The Baycrest Neighbourhood Care Team (NCT) works with two OHTs to support TSHC tenants in eight buildings in North Toronto. The North York Toronto Health Partners and North Toronto Ontario Health Teams collaborate as one team with Baycrest Hospital serving as a coordinating and integrating entity for the delivery of health and wellness programs to tenants in the North Toronto and North York regions. They bring health and social service providers together to strengthen aging in the community. Baycrest is a member of TSHC's Partnership Table, serving a dual role, representing both its organization and two Ontario Health Teams.

As noted on their website, "Baycrest is an academic health sciences centre providing a continuum of care for older adults, including independent living, assisted living, long-term care, and a post-acute hospital specializing in the care of older adults, all within one campus.

Baycrest is a global leader in geriatric residential living, healthcare, research, innovation, and education, with a special focus on brain health and aging. They offer a full spectrum of specialized inpatient care services for the older adult population, from inpatient to ambulatory rehabilitation patient needs."

For Toronto Seniors Housing, Baycrest is an anchor agency that works with over 20 other organizations to bring services and support to TSHC tenants in north Toronto. Partners include Sunnybrook Health Sciences and Family Health Team, SPRINT Senior Care, LOFT, Circle of Care, and VHA, among others. For the past three years, NCT partners provided vaccines, wellness clinics, falls prevention training, attachment to primary care providers, diabetes education, foot care, social recreation, and other essential services to tenants at eight TSHC buildings.

As of February 2025, they reported the following about their programs at TSHC:

- Accessible to 1,219+ tenants across eight buildings, with an average of 350-400 visits per quarter
- Tenants co-design the care and services
- 20 delivery partners; structures for collaboration
- 80 tenants connected to primary care

Neighbourhood Care Team Structure and Responsibilities

Baycrest organizes collaborating clinicians and organizations into "one team" called the Neighbourhood Care Team. Baycrest is the primary point of contact for the NCT and TSHC, where they:

- Oversee model of care development and implementation, including partner engagement and structures for collaboration

- Coordinate tenant engagement to ensure health services are tenant-driven
- Broker services for each building are based on the identified and expressed needs of tenants.
- Serve as the primary contact for TSHC leadership and as the representative at the Partnership Table
- Hold the Use of Space agreement with TSHC to establish and manage space for OHT providers to use for program delivery and use sub-leases to integrate services seamlessly
- Centralize evaluation and metrics collections and provide quarterly reports to TSHC and partners to demonstrate service utility, impact on health, and use of health system resources, complemented by impact stories
- Identify funding envelopes and serve as lead author for funding proposals

Their materials noted that: “The North Toronto Ontario Health Team co-created a Neighbourhood Care Team. It is an integrated geriatric model of care that unites dedicated health care organizations, providers, and their clients (patients, families, and caregivers) to improve integration and coordination of care as one team. This outlook was also adopted by the North York Ontario Health Team.”

Baycrest's NCT team's mission is to establish neighbourhood wellness centres in Toronto Seniors Housing buildings. Their goals include:

- Improving health outcomes and quality of life.
- Supporting attachment to primary care.
- Increasing access to health and social services.
- Promoting early identification of needs.
- Facilitating an appropriate level of care based on tenant needs.

Program Model and Community Integration

Baycrest's NCT model treats each TSHC building as a unique community/population. Programs are designed to meet the needs of TSHC tenants, not those who live outside of the building. This can create cognitive dissonance for some providers who are funded to deliver services to the entire neighbourhood and wish to use TSHC's community space to support the larger community.

For some tenants, where programming support has been offered to others in the community, this has given rise to fears and anxieties. For clarity, this practice is not widespread. It should be noted that the majority of TSHC tenants do not wish to have others coming into the buildings. There are fears related to safety, security, and unwanted visitors because many feel more vulnerable as they age. As part of the NCT, they work to balance these expectations while emphasizing

tenants' safety and input. NCT intends to continue to serve each building as a unique community/population, and at the same time, will work with OHT and City Developer partners to establish hubs and service solutions outside of TSHC buildings to support the rest of the community.

Collaboration and Communication

Further work is needed to structure pathways for communication and information sharing between NCT providers and TSHC to allow a more seamless collaboration and coordination on the ground.

Innovative Approaches

Baycrest's NCT has had the opportunity to test new approaches for capacity building with tenants, such as the implementation of their Health-Bay kiosks. They developed and implemented a self-serve health kiosk in common areas. It is a digital enabler that allows tenants to access information about their health and wellness. This helps tenants to better manage their health, self-assess their own health and risk factors. It also helps the team to identify when a tenant needs support in a specific area once a tenant brings the information forward. Tenants were engaged in the design and trained on how to use the kiosk.

Comprehensive Services Provided

Collectively NCT partners provide many services, such as (not an exhaustive list):

- Attachment to Primary Care
- Fall Prevention
- Exercise

- Farmers Market
- Transportation
- Social Workers
- Nursing Wellness Check
- Ontario Health at Home Coordinator
- Dental Hygiene
- Hearing checks
- Chronic Disease Management
- Brain Health
- Foot Care

Integrated Care Approach

Baycrest works closely with social service providers as well as other healthcare providers, such as primary care physicians. Together, they support tenants in getting as many of their needs met in their buildings rather than having to go outside or use an emergency room or Emergency Medical Services.

Evaluation Framework and Outcomes

The NCT evaluation framework includes four main pillars:

1. Population health outcomes – using a quality of life questionnaire and attachment to primary care
2. Quality of care – self-reported access, service utility, and early identification
3. People's experience – self-reported tenant and provider experience surveys

4. Value for money – reduction in avoidable admissions and institutional care

Their money for value evaluation highlights these key findings:

- 11.65% reduction in avoidable emergency room visits
- 4% reduction in re-admission rates within 30 days
- 25% time savings for providers
- Just over a 2% increase in hospital re-admission rates within seven days

They rely on their well-developed governance model to manage the relationships with provider organizations. Here are some reported results:

- 100% of tenants rated their experience with the team as good to very good.
- 85% of tenants reported that they can access the care they need. They have shared results internationally on their work with TSHC tenants.
- 100% of NCT providers reported they felt this model was effective in helping tenants to better manage their care and stated that they liked working on the team.

During our interview process, they noted that having a primary care provider should be core to each team, along with a care coordinator. Having a presence in the buildings allows them to grow trusting relationships. It also contributes to the team's ability to reach those who are at risk but are not yet seeking care. This allows for earlier support.

Key Takeaways

- **One Team:** Redistributing existing system resources across systems can improve health outcomes and reduce care costs sustainably
- **Minimum standards:** Establish baseline service standards for all support teams, including guaranteed access to a primary care provider and a care coordinator
- **Holistic care:** Address both social and health needs of tenants to eliminate barriers to care
- **Local presence:** Teams embedded in the community foster trust, early issue identification, and smoother access to services
- **Cross-sector collaboration:** Strengthen partnerships between housing, health and social care with a renewed commitment to shared goals
- **Proven impact:** Evidence shows improved outcomes for both tenants and service providers
- **Infrastructure challenges:** Lack of dedicated space limits the ability to expand services to more buildings
- **Partnership expansion:** Engage more closely with the NORC Innovation Centre and include social service providers in planning and decision-making
- **Privacy barriers:** Privacy regulations (e.g., MFIPPA, PHIPPA) complicate cross-sector interventions
- **Tenant engagement:**
    - Use pre-engagement and co-design events to shape services
    - Establish clear guidelines for tenant interaction
    - Begin with social events to build trust and familiarity

- Maintain ongoing tenant involvement in all stages

NORC Innovation Centre (NIC), University Health Network

Primary Contact: Melissa Chang, Senior Director, Connected Care and NORC Innovation Centre at University Health Network, Member of TSHC Partnership Table

About

Naturally Occurring Retirement Communities (NORCs) are popping up in many jurisdictions globally. A NORC is a neighbourhood or area where a significant number of older adults live. It is not a purpose-built space for aging adults. It makes the most of what already exists, whether it is a cluster of single-family homes, condos, or apartment buildings. The NORC Innovation Centre (NIC) taps into these developed communities and offers support to residents through health and social service providers so that people can age in their homes rather than in other institutions of aging.

In Toronto, the NIC, part of the University Health Network, Canada's largest academic and research hospital, is playing a pivotal role in creating NORCs as a new option to age at home.

The NIC acts as:

1) a resource to older adults and health and social system partners, providing access to important data, research, and training, and

2) is implementing a "first-of-its-kind" community-led integrated model of care, which is redefining community leadership capacity for the formal health and social care system. (NORC Innovation Centre, 2022)

The NIC is a member of TSHC's Partnership Table and currently works alongside tenants in five TSHC buildings. They have provided resources to advance TSHC's work in tenant capacity building, addressing gaps and access to health and social supports, education, and overall leadership on strategic partnership opportunities.

Unlike most programs, the NIC is supported through a combination of philanthropic contributions and grant funding. It collaborates with care providers in the publicly funded system, complementing their efforts. While the NIC's approach is inclusive and not based on income or social status, it prioritizes regions with the greatest need, particularly those lacking adequate services and resources.

Knowledge and Expertise

There are a number of ways TSHC might be able to tap into their knowledge and expertise.

- NORC Accelerator spreading the UHN NORC Program model – this is a model that leverages knowledge from the centre and combines it with the local expertise of communities and care provider groups across the city (e.g., leveraging the work of various Ontario Health Teams). This model starts by building strong local older adult leadership (NORC Ambassadors) and partnering with local organizations to address key aging in place challenges, including social isolation, loneliness, limited access to primary care, and difficulties with care navigation. They partner with over 30 sites that deliver health and wellness support and services, serving over 4,500 older adults.
    - The UHN NORC program is adaptable with different intensity levels of support to meet the needs and preferences of the

building; there is a NORC Connector identified as a key contact for the building (some buildings have dedicated on-site support) as well as connection to a clinical team that can help with navigation and coordination. This is especially important in cases where someone may not be able to access primary care or is having difficulty navigating the health system. In all cases, primary care and local care delivery partners are involved.

- Aging in Community and NORC Ambassador Training and Engagement works with local leaders and service providers to build skills and capacity to reduce isolation, foster informal care, and build stronger peer support networks. The NORC Ambassador Program offers participants the chance to stay engaged, active and most importantly drive what and how support and services are delivered in their building. Four TSHC buildings have already taken part in the NORC Ambassadors program and a group of TSHC staff have taken the Aging in Community Training. Feedback is now being incorporated to improve the program to be able to expand more broadly.
- Presently, the NORC Ambassador program provides capacity-building skills in four TSHC buildings. The aim is to have between three to five tenant volunteers who can commit to meeting once a month for nine months for training. About halfway through their nine months of training, a wellness survey is conducted to identify gaps.
- Research and Evaluation – the Centre has developed an evaluation framework to help assess how best to implement NORC programs as well as provide a consistent way to measure

the impact of the program model. TSHC buildings that are currently participating are already involved in this research and evaluation effort.

- Data Tools and Policy Recommendations – with links to health and social system data the Centre leverages the information to help communities determine what supports and services might be most helpful to them. Where there are gaps or opportunities for innovation, they are developing policy recommendations for government leaders at all levels e.g., what supports are needed to expand NORC opportunities, improve home care services, and advocate to fund aging in place initiatives.

  For example: In a recent policy paper published by the NIC in 2024, they made a series of recommendations to the Government of Ontario to help people age at home while redistributing resources to improve service delivery: (NORC Innovation Centre, A Home Care Model for Naturally Occuring, 2024)

  - One lead home care agency per NORC
  - Dedicated PSWs with the ability to support multiple clients within the same NORC, who are able to work a full-time or part-time shift with minimal travel, and provide client visits of varying duration and frequency based on need
  - Local decision-making on day-to-day care scheduling and coordination by the lead home care agency that's responsive to client needs
  - Funded on a NORC population basis rather than an individual service episode basis

These recommendations represent a significant advancement in the delivery of community care programs.

Guiding Principles

Their guiding principles are clear and build from other models of asset-based community development:

Community Leadership: An asset-based approach leverages local strengths and existing networks to build sustainable systems led by community expertise.

System Integration: Collaboration with health, housing, and community care resources ensure seamless service delivery while avoiding duplication. Needs assessments and community mapping guide program design to align with local priorities.

Relational Care: Trusting relationships are the cornerstone of the program. By dedicating time to relationship-building and understanding community needs, the program ensures person-centred and effective solutions.

Adaptability: Flexible and modular in design, the program evolves to meet the changing needs of communities. Engagement levels range from light to high touch, depending on readiness and capacity.

Network Focus

They focus on using networks so that there are diverse perspectives, mutual support and built-in sustainability. It can be an Ambassador/Neighborhood network, a Provider Network, a NORC Connector network, or an Integrated Health and Social Care Network. Each has a distinct role in creating better overall outcomes for systems and people.

Sample TSHC experience from one building

- People value the social connections made in the building. Friendly neighbours and the social atmosphere were what people liked most about living in the building. People mentioned the friendly and helpful building staff.
- Approximately 65% of people who responded to the survey felt they had neighbours they could call on for help if needed.
- Over 60% of older adults in the building have two or more active chronic conditions.
- The average number of emergency department visits per person each year is 0.75, which is higher than the average.
- 73% of the 81 people who responded to the survey plan to live in the building for many years and would recommend living in the building to family and friends. However, many (close to 30%) have safety concerns.
- One of the largest health concerns is the potential for falls. TSHC's group is part of an NIC pilot for falls prevention programming.

NORC Program Model in Practice

The NORC Program Model focuses on working alongside tenants, not doing it for tenants. With a focus on building trust and open communications with Ambassadors, the NORC Connector uses this information to inform discussions with Ambassadors to identify priorities, set goals and plan supports. In discussions with both NORC Program staff and tenant Ambassadors, it was noted that there is a high degree of trust and respect that runs both ways. NORC staff noted an important concept that others did not: you need to go slow to go fast. They underscored that their approach to community development is built on trust, and trust takes time to develop.

NORC Connectors are full-time resources who work on a time-limited engagement with each site they support. NORC Connectors use a strength-based approach to support tenants in self-managing their health and social care needs. This includes providing guidance and resources to connect with health and other community support agencies. For some sites, NORC Connectors are available on specific days and times, interacting primarily with tenants. Tenants have access to a clinical team should they need to which includes an Integrated Care Lead and Nurse Practitioner working in coordination with Toronto Community Paramedicine.

Across all sites, Connectors work collaboratively with Ambassadors to listen deeply to the community to plan and promote programs that support aging in place needs, greater social connectivity and inclusion. This could include a need for certain things in the building. This information will be correlated with health data and networks to

confirm what services or programs could be brought in to address the need.

Advancing Partnerships and System Changes

The other vital role that the NORC Program plays is in advancing partnerships to inform system changes. They have worked with the Toronto Transit Commission to study how the distance from an apartment building to a bus, train, or streetcar stop can impact the quality of life for older people. They have used this data as part of their input into the City of Toronto's Seniors Strategy 3.0. Their advocacy work on behalf of older adults ensures that issues that matter to the aging population do not get overlooked as new programs and policies are introduced.

Key Takeaways

- **"Go slow to go fast":** Sustainable progress requires patience and trust-building while being very adaptable
- **Trust as a foundation:** Relationships grow at the speed of trust, emphasizing the need for consistent, respectful engagement that dedicates time to relationship building
- **Strategic planning:** NORC research offers valuable guidance for broad system planning to support aging at home
- **Ambassador program:** Asset-based community development model that enhances engagement and amplifies tenant voices
- **Community connectors:** They provide hands-on support and act as vital links between systems and community members, helping with practical tasks like posting information and resources

iHelp: Toronto Community Housing Corporation (TCHC)

Primary Contact: Joseph Greer, Manager, Community Safety and Support, Toronto Community Housing Corporation

About

Toronto Community Housing Corporation, in collaboration with the West Toronto OHT, created two pilot projects in 2024 to bring critical services to two TCHC buildings in West Toronto.

Their program was built on the premise that giving people access to services and support in their communities can improve quality of life, improve safety and well-being in these communities, and support better tenancies. From a health system perspective, it helps to get people connected to care closer to home to address non-urgent care in the community.

Partners and Services

The West Toronto OHT brings 38 partners together as part of their team. Partners who serve the iHelp centre include: (Toronto Community Housing, 2025)

- Progress Place/Community Place Hub (case workers; navigation)
- VHA Home Healthcare (social worker)
- LAMP Community Health Centre (onsite preventive health workers; nurse practitioner)
- Dorothy Ley Hospice (grief and bereavement services; holistic body therapy), and

- Communiticare Health (case workers; navigation – one location only)
- Unity Health

Program Development and Focus

In visiting the two sites, we had a chance to learn more about their offerings, successes, and challenges from providers, housing staff, and tenants. To develop their approach, they spent time speaking with members of each community to gather input on their needs. Three key areas were identified by both communities where support was needed:

- Mental health and addictions
- Access to primary care
- Aging in the community

They focus on hard-to-reach populations and adapt to their needs. The centres are intentionally designed to help direct people to the right place to get the right care. TCHC provides the space for service provision, and their Engagement and Community Services Coordinators work closely with tenants to identify programs and partners. Their Access and Support Community Service Coordinators help to identify tenants who would benefit most from the services provided through the OHT partnerships. TCHC has a long and strong history of working with community partners to help tenants access the services and support they want or need. How they provide services differs by location. Between the two sites, staff speak five languages, which can help to increase understanding and sharing.

TCHC has taken a targeted approach to iHelp by focusing on their top five buildings in their western region that have the highest needs as evidenced by data from housing and healthcare. With each building,

they have also sharpened their focus on safety and security, as tenants will not access services in the buildings, if they do not feel safe leaving their homes. They have collected evidence that shows that including the safety and security elements in their model encourages tenants to access services and support.

Site-Specific Implementations

In one location, they occupy modest retail space at the bottom of a TCHC building. At this location, access to iHelp is open to tenants and the community. It is a community hub. This location has an open door to anyone. Consultation services are delivered in this space filled with resources. An on-site coordinator, from the West Toronto OHT, assists people who come in. TCHC's Engagement, Community Services Coordinator works closely with the West Toronto OHT coordinator to understand and support tenant needs. Here, there is a need for more mental health support for older adults, who are re-integrating into housing through the Rapid ReHousing program from the City of Toronto. They understand that for most people, it can be impossible to know where to look to get what they need. Keeping the doors open, having someone on-site five days a week, full-time, encourages people to come and ask for help. Seeing a familiar face in the centre helps to encourage people to take that important first step to building trust and getting help. Initially, it served as an information and navigation hub and has evolved to emphasize the needs of Toronto Housing tenants and care services at the sites. This community's needs differ from their other iHelp location.

In their second location, services are for senior tenants only. Access to the building is controlled by FOBs, which are issued to tenants and service providers. The site was only six months old when we visited.

They had five active program participants. We were able to speak with one and generally, that participant agreed that having this new approach to access care was very helpful to him. The space they use for programming was previously occupied by LOFT, and it was also a library. TCHC worked with LOFT to repurpose the space. They also redesigned the space to create a room for group activities and another as a quieter space. Twice a week, an onsite nurse conducts outreach, encouraging building tenants to come down for services. She can make referrals to primary care. She also visits people in their homes as needed. There is an Ontario Health At Home assigned Care Coordinator onsite every day. The service office is located close to the common room to encourage tenants to come and visit. The Access and Support Community Services Coordinator for TCHC works closely with the community partners on identifying tenants with needs and moving them to the Care Coordinator for appropriate support.

Consistent Services Across Sites

Consistent to both sites, iHelp offers access to:

- Residential Support Workers
- Grief/Bereavement Counsellors
- Social/Recreational Workers
- Care Coordinators
- Nurse Practitioners
- Case Managers
- Personal Support Workers
- Counsellors
- Addiction Support Teams
- Harm Reduction Program

Tenant Engagement and Impact

At both sites, there is ongoing engagement with tenants and community members to understand their needs and concerns. They noted that their model is rooted in asset-based community development practices, and they seek co-design solutions. TCHC offers in-kind staff support, identifies tenants who could most benefit from health and social care support, they also offer outreach support and education to tenants. Health and social care agencies offer a case management approach to working with tenants. Tenants who access the services have been offering very positive feedback to TCHC. Tenants are getting out more and socializing, getting help during bereavement, or help as they navigate health challenges such as breast cancer.

TCHC's Role as Landlord and Partner

TCHC, as the landlord, can decide which spaces it can repurpose to provide services. They redesigned spaces to meet the needs of the community and the providers. They offer the space at no cost to the providers. They noted that TCHC acts only as the landlord, providing space. TCHC receives aggregated reports from the lead agency that coordinates all the partners at the site. The OHT manages the funding and delivery of services to tenants of TCHC.

Future Directions and Learnings

They are also working with the Social Development Office at the City of Toronto to test an anchor agency model and develop reporting metrics related to being a landlord+ that offers access to health and social care to TCHC tenants. Through this relationship, they are seeking to offer more consistent, recognizable yet targeted programs to meet the unique needs of each building.

In further discussions, it was noted that TCHC's call centre does not manage calls related to their iHelp program. They can, however, direct tenants to an iHelp number to get more information. TCHC does not have an iHelp specific call centre that triages and redirects caller at this time, given their current reach. That may be a future consideration.

TCHC plans to expand its program in the coming years. They are targeting four new sites, with two coming in 2025 and two coming in 2026. Staff noted that it took about four months to open a site after they completed years of gathering input and developing partnership agreements. They also noted that only one pilot site, due to capacity, should be attempted at a time and that simple, catchy branding makes their work more recognizable in the community.

Key Takeaways

- **Start small, brand well:** Launch with a memorable program identity to build recognition and trust
- **On-site presence:** Ensure a dedicated resource is available with set hours for consistent support
- **Build one team culture:** Foster trust and collaboration across housing, health, and social care sectors
- **Ongoing community engagement:** Use frequent feedback loops to align services with tenant needs and preferences
- **Purpose-built spaces:** Housing provides dedicated areas for service delivery
- **Vulnerability index:** Tools developed to assess high-needs populations from a social housing lens
- **Specialized coordinators:** TCHC has two types of Community Services Coordinators. One to support tenancy management and another to support community development
- **Safety and security:** Built-in a commitment to increasing safety and security measures to encourage participation
- **Model variations:**
    - Community-Based vs. Building-Based
    - Data shows building-based models improve community safety and reduce call centre volume
- **Joint strategy for scale:** TCHC is interested in collaborating on models to support 100,000 tenants, optimizing health and social care resources to benefit larger population outcomes

Ottawa Community Housing (OCH)

Primary Contact: Steve Clay, Senior Manager, Community Development, Ottawa Community Housing

About

OCH is the second-largest social housing provider in Ontario. It owns and manages about 15,000 homes and provides housing to over 33,000 low and moderate-income individuals in Ottawa. (OCH-LCO, 2025) For over 17 years, Ottawa West Community Support (OWCS) has been providing services and support to seniors residing in 19 Ottawa Community Housing (OCH) buildings throughout the city.

In 2007, the Aging In Place Program (AIP) was established to provide an integrated mix of services to seniors living in 5 designated Ottawa Community Housing (OCH) apartment buildings, which has subsequently been expanded to cover 19 buildings in total. The program is a partnership that began between the Champlain Community Care Access Center (CCAC), the Ottawa Community Support Coalition (OCSC), Ottawa Public Health (OPH), and Ottawa Community Housing. Ottawa West Community Support (OWCS) acts as the agency lead for the OCSC.

Aging in Place Program Goals and Services

AIP aims to reduce hospital, emergency department, and long-term care admissions in the target population through streamlined community interventions. The primary focus is on at-risk seniors and seniors facing access barriers to health care. AIP works with OCH and other partners to identify isolated and at-risk seniors and to encourage

healthy community development through integrated services, including:

- On-site, no-cost crisis intervention and support.
- Coordinated, one-stop linkages to other community resources.
- Seamless/integrated community care and community and social service provision.
- Health promotion and community development (Ottawa Community Housing, 2017).

OWCS Service Coordination

In return for no-cost program delivery space, OWCS coordinates the following services to support OCH seniors: (OWCS, 2023)

- Homemaking and Meals
- Transportation
- Nursing and Allied Health Visits
- Personal Care
- Case Management
- Rapid Community Support Referral
- Crisis Intervention

OWCS also provides emergency meal provision and coordination of health promotion, education, and social activities in partnership with other community organizations. They host special events, exercise classes, and language classes to help reduce isolation and improve socialization. They also arrange taxi chits for tenants to attend appointments.

Community Support Outreach Coordinators

OWCS also has nine Community Support Outreach Coordinators (CSOC) working across 19 buildings. They are on-site part-time, Monday to Friday, during regular business hours. Each coordinator has fixed office hours to see tenants but remains available by phone (Mon-Fri) when not on site. The CSOC role is an on-site Social Worker (or Social Service Worker) who provides support for seniors so that they can continue to manage independently. It is a half-time role with each coordinator responsible for two locations. Coordinators provide and coordinate support, rent reviews, emergency transportation to urgent medical appointments, short-term homemaking (cleaning), and foot care. Additionally, the CSOC helps to organize social and health information events for tenants. These roles focus on providing community support to tenants.

Collaboration with Ontario Health at Home

In 11 of the 19 locations, the program is a partnership with Ontario Health at Home. Tenants have access to two nurse practitioners and three Care Coordinators. In those locations, there is a Care Coordinator (Registered Nurse) who is responsible for allied health services such as Personal Support Workers, Occupational Therapy, and Physiotherapy for tenants. The Care Coordinator and nursing roles provide health care support to tenants.

Program Reach and Governance

Overall, their AIP program serves between 2,500-3,000 tenants who actively use their services. They offer services to all tenants in the buildings where AIP is offered. Their community hub is solely for tenants, not community members at large. Before 2007, there were no

coordinated services in the building for tenants, but since then, OWCS has been busy connecting tenants with services in the community or their homes.

There is a robust governance model that guides their work, along with contracts and MOUs to ensure service levels are agreed upon and delivered.

Staffing and Skill Sets

OWCS noted that the work to support aging seniors requires, in their estimation, two different skill sets. One should be able to work with seniors in a compassionate, heartfelt way because some seniors are aging alone. Another person should be a crisis worker who has stronger skills in setting boundaries while case managing challenging personalities. “Having one person trying to do both would be like finding a unicorn,” said Jennifer Lalonde, Executive Director, OWCS.

OCH-OWCS Partnership and Benefits

OCH’s Steve Clay, Senior Manager, Community Development, noted in our discussions that the relationship with OWCS helps housing staff as much as it helps tenants. He shared that OCH makes accommodations for OWCS and their partner team members to make it easier for them to deliver services and programs to tenants. For example, if a partner requires office space at a building and space is not available, OCH reconfigures places, such as storage rooms, to provide that space. The spaces available for use range from 160 square feet for office space to 1500 square feet for dedicated programming space. Steve is the single point of contact (SPOC) for OWCS and OCH. If OWCS has concerns or wants to discuss space changes or needs an accommodation for staff access, for example, Steve is their contact for anything they need. “The

relationship has to be more than just landlord and tenants with our partners," says Steve.

Impact and Outcomes

This model has contributed directly to:

- Preventing unnecessary emergency room usage and extended hospital stays
- Delaying or deterring tenants from going into long-term care homes
- Helping people to age, and pass, in their homes, as they wish
- Stronger relationships have developed between neighbours
- Increased coordination to bring in programs between providers and OCH
- Tenants know there is someone there to help them
- The Tenant Support Centre for OCH saw a decrease in call volumes when support was in place
- OCH reported fewer arrears, an easier Annual Rent Review, fewer Landlord Tenant Board issues, and a reduction in expectations of housing staff to provide social services, particularly in mental health and addictions concerns

Key Takeaways

- **One Team philosophy:** Emphasizes a unified approach with partners
- **Relationship-driven:** Strong focus on building trust and respect between housing and service providers
- **Anchor Agency model:** A single agency brokers partnerships with health and care providers
- **Single point of contact:** One housing liaison simplifies communication for partners
- **Defined staff roles:** Recommends having separate roles for community development and crisis intervention to improve service clarity and effectiveness
- **Proven impact**: Limited data shows improved outcomes for tenants, providers, and housing
- **Long-Term indicators**: Use of 15+ years of data to track how increased health and social care support improve housing outcomes
- **Simple intake forms:** Streamlined partnership onboarding process.
- **Partner communications program:** Structured approach to keep partners informed and engaged
- **Creative space solutions:** Encourage innovative thinking to overcome space limitations for service delivery

Oasis

Primary Contact: Riley Malvern, Research Project Manager, Queen's University

About

Oasis is an innovative model that offers programming for older adults living within a NORC (naturally occurring retirement community). Oasis is unique as it seeks to empower older adults to identify their needs and determine the services and activities which best meet those needs (Donnelly et al, 2019). Oasis includes programming developed by and with members, designed to foster movement, healthy nutrition, and social connections to support older adults to age well within their communities. (Oasis, 2024) In addition to these core programming pillars, Oasis includes activities and events that increase members' awareness of and connection to health and social services and resources.

Oasis takes a community development approach that includes working with community agencies or health care organizations to bring representatives from those organizations directly to the building/neighbourhood Oasis serves to offer information or services related to the needs and interests of members. While they can seek out partnerships to support individual members to access information about health and care services as requested, the focus is largely on the community rather than individual navigation. For example, an expressed question or concern from a member about dental health, may trigger an information session on the new Canadian Dental Care Program from Public Health or a local dentist for all interested members in that community. This indirectly facilitates access for the individual member while increasing knowledge and access across the

entire community. “We help people upstream to avoid having to use emergency services or hospitals”, says Dr. Catherine Donnelly, Director, Health Policy and Research Institute, and co-Principal Investigator, Oasis.

The program began in 2011 at one site in Kingston and has expanded to 20 sites across Canada, with four emerging sites (as of July 2025). In 2019, researchers from Queen’s University, McMaster University, and Western University came together with the community Original Oasis to form the Oasis Collaborative. The collaborative set out to expand and evaluate Oasis in other communities. Funding was provided by the Centre for Aging and Brain Health Innovation at Baycrest, the Ministry of Health and Long-Term Care, and the Ministry for Seniors and Accessibility. Each grant was specifically designated to support the expansion of Oasis to a particular NORC(s).

As Oasis expanded, a network of communities formed to support the sustainability of all sites in partnership with the universities, building residents and onsite program coordinators. In 2021, a philanthropic, private donor provided funds to expand Oasis to six additional NORCs and Oasis also received a Canada Institutes of Health Research (CIHR) grant to support long-term evaluation of their work.

More recently, the team received funding from the Age Well at Home program (Employment and Social Development Canada) to support expansion to an additional six unique communities, and received an additional grant from the private, philanthropic donor to support ongoing site operations and the development of a new national not-for-profit to support and sustain the growing network of Oasis communities across the Canada. Core to this ongoing expansion and the creation of the Oasis Communities for Aging Well National Not-for-Profit includes the ongoing development and dissemination of

resources, and Communities of Practice to support communities to open, grow and sustain an Oasis Program in their neighbourhood or building.

In addition, new and existing sites will continue to be supported through a network-wide evidence-based standardized evaluation framework that includes process (e.g. participation, programming activities), experience (e.g. satisfaction, member ideas), and outcome (e.g. loneliness, physical activity, falls) related assessments. This ongoing work will provide critical insight into effective aspects of aging-in-place models to inform their design, and much-needed evidence on health and economic impacts to support their implementation and to secure funding supports. (Oasis, 2024)

Program Philosophy

Their programs aim to reduce isolation, increase physical activity participation, improve nutritional wellbeing, and build a sense of purpose, as many seniors are aging alone. Built on their three pillars of Nutrition, Socialization, and Physical Activity, they have the following underpinnings to their work (Group, 2024).

Vision

Embracing Aging

Mission

Oasis provides a member-driven approach to healthy aging and improved quality of life in neighborhoods across Canada. This is achieved through a collaborative approach to fostering safe and caring communities where everyone feels welcome.

Values

- Member-driven
- Community
- Social Connection
- Respect
- Equity
- Welcoming

Implementation and Impact

In 2024, they developed an Oasis playbook, which is part of their Ready-Set-Go program implementation guide. The playbook outlines the foundations of the program, its evaluation framework, and funding approach. It also includes some high-level data about Oasis benefits to members:

- 45% less likely to receive home care
- 26% less likely to visit an emergency department
- Can delay moving to a long-term care home by one year

Their pillars of Nutrition, Socialization and Physical Activities are supported by research. In research with the original Oasis community, older adults in the building with Oasis were compared with older adults living in buildings without an Oasis program, on a number of indicators of healthy aging (manuscript in preparation).

The research found that, adjusting for age, participants living in a building with the Oasis program were significantly less likely to report more than one fall in the past six months compared to those in buildings without Oasis, suggesting a potential protective effect of the Oasis program on fall risk. Similarly, older adults in the building with

Oasis scored significantly higher on tests of balance and mobility, and walking endurance. Finally, older adult participants living in the Oasis building were significantly less likely to report being lonely on the UCLA Loneliness Scale than those participants in buildings without the Oasis program.

Program Model and Adaptability

The model relies heavily on community engagement to determine programming. The Oasis Program has been successfully implemented in horizontal NORCs (e.g. neighbourhood, mobile home community, coop housing community) and vertical NORCs (e.g. apartment complexes, condominiums); and in a variety of ownership contexts (e.g. resident owned, market-rental, deeply subsidized rental) in large urban, small urban and rural environments in British Columbia, Ontario, and Nova Scotia.

In all settings, Oasis members determine the specific nature of the programming in their community, within the key pillars of the Oasis. Membership in any of the Oasis Communities is open to anyone who lives in that community. This may be people from the neighbourhood surrounding the common gathering space, or, to residents of the building, or complex of buildings where the programming is offered. With time, the Oasis Team has seen some communities hosting Oasis programs in an apartment building, open their doors to older adult residents from sister or neighbouring buildings. In all examples, the members and coordinators adapt their programs to best meet the needs

and interests of the communities they serve. Currently there are about 1,237 members. This does not include members who have transitioned to alternate living arrangements, or non-members served through programming not represented in this value.

Partnership and Space Management

The Oasis Team can work with multiple sites at a time to implement the Oasis model. They provide guidance and standards for new sites. The development of partnerships and relationships to create the infrastructure for a program is the responsibility of the new site.

They rely on relationships with landlords to provide in-kind space for program delivery. They are specific about what their needs are, which include exercise space, meeting space, and basic food prep space. In return, they note that landlords report seeing reduced turnover, improved building culture, fewer complaints, and more requests for Oasis Programming from other buildings in their portfolio.

On-site Coordinator Role

An on-site Oasis Coordinator is available at each site to bring programs to members. While the position is typically part-time, it could be a full-time position if adequate funding were available. Hiring a coordinator is usually done through a community partner organization, with local members involved in the process. The Coordinator works with the local members to determine programs and acts as a liaison with the housing partner and other partners on program delivery. They also become trusted voices for members. They form friendships over activities such as crafts, education sessions, exercise classes, gardening, or sharing a meal.

Member and Staff Experiences

During the site visits, members spoke of the tremendous value that the program brings to them. Members expressed warmth and appreciation for the staff and appreciation for the spaces they were able to occupy for programs. They spoke of having friendships that they never had before. Staff noted that while engaged tenants may move, the programs do not miss a beat. There is always someone in the wings who will continue to work with staff to get others involved. Staff also noted that while conflicts exist between tenants, which may involve the landlord, tenants are encouraged to take those issues to the landlord directly.

Quality Assurance

To ensure quality assurance, programming integrity and links to existing community services, Community Developers are also in place in some locations. These individuals support multiple sites on behalf of the Oasis team.

Key Takeaways

- **Proven outcomes:** Demonstrated improvements for both members and providers
- **Implementation tools:** A comprehensive guide with tools to support consistent rollout
- **Defined focus areas:** Clear impact zones and priorities are identified
- **Developed frameworks:** Research based evaluation and funding frameworks to support sustainability and scalability
- **Quantitative and qualitative data:** Information related to experience, efficacy and impact are available. This includes cross-sectional and longitudinal comparisons with further analysis planned
- **National identity:** A consistent corporate brand across the country enhances recognition and trust

Quick Summary View of Programs

	Community Wellness Hub, Burlington	East Toronto Health Partners	Baycrest's Neighbourhood Care Team	NORC Innovation Centre	iHelp, TCHC	Ottawa Community Housing	Oasis
Services/Programs							
Coordinator/Navigator	●	●	●	●	●	●	●
Access to Primary Care	●	●	●	●	●	●	
Home Care Services	●	●	●	●	●	●	
Social and Recreational Programs	●	●	●	●	●	●	●
Mental Health Programs	●	●	●	●	●	●	
Healthy Aging Programs	●	●	●	●	●	●	●
Allied Health Support	●	●	●	●		●	

	Community Wellness Hub, Burlington	East Toronto Health Partners	Baycrest's Neighbourhood Care Team	NORC Innovation Centre	iHelp, TCHC	Ottawa Community Housing	Oasis
Tools and Partnerships							
Robust Engagement Model	●	●	●	●	●	●	●
Measurement and Evaluation Framework	●	●	●	●	●		●
Governance Structure	●	●	●	●	●	●	●
Implementation Plan and Tools	●	●	●	●	●	●	●
Codesign with Members/Tenants	●	●	●	●	●	●	●
Privacy Framework	●	●	●	●	●	●	●
Ontario Health at Home	●	●	●	●	●	●	
Ontario Health	●	●	●	In Progress	●	●	

TSHC Unique Context and Considerations

For Toronto Seniors Housing, its focus on seniors may hold some unique challenges. Most providers offer services to an array of ages. TSHC's unique offering to the 59+ population is targeted to support aging at home. TSHC also serves the second largest population of aging adults at 15,000 with TCHC serving about 17,000. Most programs serve a few hundred or a couple of thousand older adults.

TSHC has the benefit of Community Connect+ and Community Activities Fund for engagement, access to tenant voices, and access to funding for tenant-led activities. The work done by its Community Services Coordinators offers tenants tools, funding, and access to program partners to create their sense of community. Tenants work with staff to secure funds to host social, recreational, and community-building events within their buildings. Staff work with tenants to understand the needs of each building and seek partners to deliver services that match the needs. This can lead to a myriad of providers being in a building, but not necessarily a coordinated approach to service delivery. The role of the Seniors Services Coordinator is important in identifying individual tenant housing or support needs, as they are on-site more often than the Community Services Coordinator. Both roles are related to providing some degree of landlord+ services,

but neither can meet the system navigation needs of tenants within the health and care systems.

Currently, TSHC benefits from having East Toronto Health Partners, Baycrest Neighbourhood Care Team, and the NORC Innovation Centre working with tenants across several buildings. Currently, these organizations do not yet collaborate on service delivery together, but there may be a desire to do so. Between the deep community engagement work that the NORC Innovation Centre does and the service delivery work that the other two partners provide, there may be an opportunity to develop stronger ties and improved coordination.

There are also more opportunities for TSHC and TCHC to work collaboratively, as TCHC already has an iHelp model that seeks to essentially do the same things TSHC is trying to achieve. Both organizations face the challenge of working with multiple Ontario Health Teams and Neighbourhood Care teams to deliver services across the City of Toronto.

Conclusion and Recommendations

The review offered TSHC an opportunity to learn more about what others are doing to help older adults age at home. The review found that all programs are working to deliver services within current funding envelopes wherever possible. All programs also rely on in-kind support from housing providers for space. Most programs have an evaluation and governance framework, but the criteria vary from program to program. All dedicate time to community engagement and co-design, and all rely on complete buy-in from a coalition of the willing or a One Team approach. Working with partners, members/tenants, and staff is the most challenging part of this shift to more coordinated, integrated service delivery: building trust is critical.

TSHC's Current Position and Opportunities

TSHC is fortunate that three of the organizations reviewed are already partners with experience, expertise, and a desire to do more. They are also members of the Partnership Table, where they can help to further guide TSHC on its mandate to provide access to services and support to help tenants age at home.

When this review began, it was envisioned that it would inform TSHC's decision about launching a pilot project(s) to deliver more coordinated services and support to tenants, per its commitment in its Integrated Service Model. The programs that were reviewed can offer insights and guidance into governance frameworks, evaluation frameworks, and engagement methodologies. TSHC, however, remains in the unique position of being the social housing provider in Ontario solely dedicated to supporting independent living for people 59+. TSHC is built on the

Integrated Services Model (ISM) to support aging at home, whereas other organizations are using similar principles to guide their work.

Unlike many housing providers in the province, TSHC must coordinate with eight Ontario Health Teams (OHTs) to deliver services across its four regions. Currently, TSHC partners with 54 separate organizations to provide health and social care to tenants. To streamline and strengthen service delivery, TSHC could consider designating one anchor agency per OHT—a total of eight anchor agencies. These agencies would serve as service coordinators, benefiting all stakeholders involved.

The health and social care sectors already have many assets to support aging at home, such as funding, mandates, and trained staff. TSHC may want to leverage a series of anchor agencies to help coordinate service delivery. Anchor agencies can:

Lead partnership development and management.

Establish unified service agreements with partner organizations.

Coordinate reporting, accountability, and associated risks and liabilities.

Address operational partnership issues and concerns.

In this model, TSHC would:

- Provide physical space for service delivery
- Support relationship-building among staff, tenants, and providers
- Gather and communicate tenant needs to inform service planning

Today, TSHC manages partnerships primarily through individual relationships with over 50 service providers across 83 buildings. Some buildings have many providers, and others may have a couple. Regardless, TSHC and providers work diligently to deliver services requested by tenants. Services, however, are not yet optimally coordinated or as timely as tenants would like. For the future, TSHC will need to determine a more coordinated path forward that minimizes fragmentation, improves timely delivery, and provides for broader reach.

While it is tempting to consider the future state as the ideal solution, it must be tempered with the reality of how quickly system change can happen. Older adults need solutions in the immediate or shorter term. TSHC will need to continue its current trajectory while working to incrementally and strategically introduce a more comprehensive and coordinated approach. As the program review has shown, a more coordinated approach has many benefits. Most importantly, older adults can retain agency over their health and well-being, given they have the right support, in the right place at the right time.

Through the Partnership Table, there is an appetite to support collective impact, or a more coordinated and comprehensive approach to working with housing, health, and social care. This represents a great opportunity for TSHC to work with existing partners to find solutions to

improve its service delivery model so that senior tenants can age at home in dignity and comfort.

Recommendations

The Partnership Table acknowledges the report and applauds the ongoing work of all partners supporting TSHC with multiple approaches to aging in place as directed by the Integrated Service Model.

1. TSHC must continue its multi-prong approach of direct engagement with smaller providers and the use of existing anchor agencies, as they both are working to meet tenant needs today.

2. To better position TSHC to meet the growing needs of its tenants in a more coordinated way across more buildings, the Partnership Table recommends that TSHC expand its approach to coordinated program delivery into a building that is currently underserved in an area with high needs.

3. The site should have available space for coordinated service delivery through an anchor agency partner. Depending on the capacity and capabilities of the anchor agency partner, the pilot would focus on results related to:

    I. Facilitating more coordinated access to services for tenants, to meet their needs, using an approach that is repeatable and can be scaled across other buildings;

II. Testing of a new housing and health dashboard to track and report on results related to stabilizing tenancies and improving care in communities;

III. Investigating specific research findings that speak to the needs of older adults in social housing; and

IV. Contributing to a larger body of evidence-based work that demonstrates positive outcomes for community and systems collaboration.

4. To support this work, and based on the findings of this report, the Partnership Table encourages TSHC to assist with the following:

    I. Creating a set of standards for what TSHC wants to build from (and systems partners can support), to build similarities across programs, such as:

        i. Neutral third party to support tenants and staff

        ii. An anchor agency approach

        iii. An evaluation framework

        iv. Complementary training for TSHC staff to support aging in place, as TSHC staff have stronger daily interactions with tenants

        v. Leverage the existing work of a local Ontario Health Team

5. Finally, the Partnership Table also supports pursuing funding to support this work between the housing and health sectors. Funding will help to deliver on the objectives articulated for this expansion, the development of a health and housing dashboard, and a standardized evaluation framework.

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