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Organizational Innovation in Long Term Care Enabled by Collaboration Between Government Agencies: A Critical Realist Case Study

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Abstract

Long term care for older people is a highly regulated sector providing accommodation, health, and social care to vulnerable older adults. Older adults in New Zealand are among the highest users of long term care services globally. Traditionally those requiring specialist care for dementia are housed apart from other residents. In an example of organizational innovation, 1 provider relocated residents to a secure village where residents requiring specialist dementia care would be desegregated. We utilized a critical realist case study to explain the role of intersectoral collaboration among government agencies in supporting the transition while managing risk and ensuring regulatory compliance

Keywords

long term care, intersectoral collaboration, aged, aged 80 and over, government agencies, organizational innovation, dementia, organizational case studies.

What do we already know about this topic

Innovation in ARC service delivery is needed to enable residents to continue to maintain their lifelong identities. Collaborative networks in public policy can support innovation in service delivery.

How does this research contribute to the field.

The study explains how a collaborative governance network supported the development of a service providing an innovative model of care in ARC.

What are the research implications toward theory, practice or policy?

The study adds to existing theory about the role of collaborative governance networks in supporting innovation in services for older people. We advise service providers considering similar innovations to seek the opportunity to collaborate with high level bureaucrats at the beginning of the process.

Introduction

The Aged Residential Care (ARC) sector provides long term accommodation and support with health and social care needs for older people who cannot live at home independently. It is estimated more than 47% of older New Zealanders utilize ARC facilities, with 66% of those 85 and older doing so. In New Zealand, at the time of data collection, ARC services were funded by the Ministry of Health through the 20 local District Health Boards (DHBs) and delivered by providers from the private (for-profit) and not-for-profit sectors under contract to their local DHB. In March 2022 78% of facilities were operated by private providers, 21% by charities, and 1% were owned by DHBs.[1] There were a total of 35,254 people living in ARC facilities in September 2022.[1] In July 2022 the DHBs were replaced by Te Whatu Ora (Health New Zealand) and the Māori Health Authority. There are 2 national contracts relevant to the provision of ARC services.

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The Aged Residential Hospital Specialized Services Agreement covers specialized psychogeriatric hospital services. The Age-Related Residential Care Services Agreement (the contract hereafter) covers rest homes for people who have low care needs, private hospitals for people who have high care needs, and specialist dementia services, a subset of rest home care. It is the second of these contracts that is relevant to this article. Under the terms of the contract, residents, who have had their care needs assessed by a specialist needs assessor, are funded for 1 of those 3 levels of care. Residents who require rest home level care need some support with personal care and are generally not able to live at home safely, while those who require hospital level care have more complex health and mobility needs. The contract specifies that residents who require each of those levels of care be housed together but apart from each other. Specifically, those residents who need specialist dementia services must be housed in a separate secure unit for their own safety. The levels of care in NZ ARC are summarized in Appendix 1.

People who live in ARC have their needs for housing and health, and social care met, at a standard required under the terms of the contract and meets the standards set out in the Health and Disability Services (Safety) Act 2001.[2] Facilities are also required to meet the social needs of residents, with specialized staff employed for this purpose. However, for many residents, life in ARC is boring and devoid of meaning.[3] The World Health Organization recommends ARC settings be dementia-friendly, encompassing inclusive social and physical environments for people with dementia[4] and government policy in New Zealand and internationally calls for care in ARC to be person-centered.[5,6] For care to be person-centered, several elements must be present; these include valuing people and treating them as individuals.[7,8] Despite the best efforts of well-intentioned staff, there are barriers to the provision of person-centered care in the ARC environment. These include ongoing issues related to lack of staff and resources in the sector and lack of leadership for sustained change.[9] Despite these challenges, there is a movement to shift cultures in ARC to be more person-centered.

The culture change movement in ARC began in the United States of America in the 1990s[10,11] and has since become a worldwide movement. Broadly, the movement aims to make life better for ARC residents by shifting organizational cultures from being organization and staff-centered to being person-centered.[11] Culture change requires innovative leaders who work with staff to communicate their vision for resident life in their facilities.[12] Additionally, many ARC providers who are part of the culture change movement have changed the physical environments in their care settings to enable residents to live in domestic-scale environments. In these environments, empowered, semi-autonomous, staff support residents to continue with the lifelong activities that affirm their identities. Evidence suggests this intersection of person-centered care and domestic-scale environments contribute to resident quality of life.[13]

The Need to Consider a New Model of Care

The management team at Whare Aroha CARE ARC facility had worked with their staff to change the workplace culture, enabling staff to provide person-centered care to residents. However, management remained dissatisfied with the way residents could live their lives in their traditional facility. The facility had 22 specialist dementia, 21 rest home, and 36 hospital level beds, housed in 1 building, a former nurse's home. When they had to move out of their premises due to the expiry of their lease, it provided an opportunity to explore innovative care options. Instead of building another traditional ARC facility, they developed a village inspired by de Hogeweyk in the Netherlands. The new village consists of a hub containing staff offices and a store and tea rooms. There are 13 houses, each with either 6 or 7 residents who are supported to participate in activities of daily living. The timeline for the transition is summarized in Appendix 2.

Residents in de Hogeweyk live in small group homes with peers who share common ideas about how to live life. The residents, who all have dementia, are free within the secure village that contains a theatre, pub and restaurant, hairdresser, and supermarket.[14] At Whare Aroha CARE not all residents were living with dementia, rather, they required a mix of rest home, private hospital, and specialist dementia services. The development of a village where residents would be housed with peers requiring different levels of care including some residents needing specialist dementia services was innovative and required approval by high-level government bureaucrats via a collaborative governance network process.

While there are a variety of terms used to refer to collaborative governance networks in the literature, there is agreement among scholars about some common features. These are the inclusion of multiple actors from across sectors, collaborating to achieve policy consensus and implementation to benefit the public. Leadership in collaborative governance networks is usually held by the public sector.[15] Collaborative governance networks have a role in supporting public sector innovation, however there is limited evidence about their effectiveness in achieving innovative outcomes.[16] This article explains the role of a collaborative governance network in supporting the transition from a traditional model of care to an innovative model of care in ARC in New Zealand. The data reported on in here is part of a larger study that aimed to explain the process and outcomes of the transition of ARC residents from a traditional facility to a dementia-friendly village inspired by de Hogeweyk in the Netherlands. The research questions for the study are:

- How has the transition of Whare Aroha CARE residents to The CARE Village been accomplished
- What is the effect of the transition of Whare Aroha CARE residents to The CARE Village on the lives of the residents?

The sub-question relevant to this article, is:

- What was the role of the service development group in the accomplishment of the transition of Whare Aroha CARE residents to The CARE Village?

Methodology and Methods

The findings explaining the role of the service development group, a collaborative governance network, in supporting the transition of ARC residents to a dementia-friendly village draw from the results of a critical realist case study.[17] Critical realism is a philosophical perspective in social science, developed by the English philosopher Roy Bhaskar. Bhaskar proposed a stratified ontology, consisting of 3 overlapping domains of reality.[18] These are the domain of the real, corresponding to the world that exists independently of human experience; the domain of the actual, corresponding to events that occur in the world; and the domain of the empirical, corresponding to human experience of events. The identification of unseen mechanisms, acting in the domain of the real, to cause events, is a key feature of critical realist research and enables critical realist researchers to explain the causes of phenomena in society.[18] Case study methodology and methods as described by Yin[19] were utilized for the study, the study methods are described below.

Data Collection

Data relevant to this article included organizational documents, publicly available audit reports, and transcripts of interviews with key informants, who were members of facility management or high-level government bureaucrats. Informed consent was obtained from participants. Key informants participated in semi-structured interviews conducted in person or by telephone. The in-person interviews took place in the participant's workplace, home, or in cafes. Interviews, lasting from 40 minutes to 2 hours and 33 minutes, were digitally recorded with the participant's permission and transcribed by the first author. In alignment with Yin's[19] guidance for case study research, interview guides were deductively derived from the 2 beginning theoretical propositions for the study, with relevant inductively derived questions added as data collection progressed. The beginning theoretical proposition were:

- the need to move to new premises created an opportunity for Whare Aroha CARE management to explore alternative models of care for residents.

AND

- the desire to improve the lives of Whare Aroha CARE residents led to Whare Aroha CARE management using their industry knowledge and networks to accomplish the transition to a new model of care.

The semi-structured interview questions focused on the role the participant played in the process of the transition to the new facility, including supporting compliance with regulatory requirements to enable the transition to be successful. For example, questions included:

- What has your role in the transition been?
- What collaborations between the organization and other organizations or government bodies have been needed to accomplish the transition?
- Can you talk about the process of achieving regulatory compliance?
- I have been told about the process of changing the culture within the organization that started when the new management team took over. Can you talk to me about that process?

The data underlying this article will be shared on reasonable request to the corresponding author.

Data Analysis

Consistent with the explanatory aim and critical realist theoretical perspective guiding the research, the flexible and iterative 5 step process of explanation building aligned with a critical realist theoretical perspective, described by Danermark et al[20] was undertaken, to identify the generative mechanisms, acting beneath the surface of events, causing the transition to an innovative model of care in ARC. Data analysis began with initial code development, grouping of codes together to form themes, comparing the themes to extant theory, identifying causation of events, and assessment of the explanatory ability of the theories that have been identified in previous stages. The generative mechanism relevant to this article is; they formed a governance network to support the transition.[17] During the analysis of the data the first author developed a matrix displaying the roles of the people and organizations comprising the governance network, in accordance with the recommendation of Miles et al[21] The matrix assisted with understanding of the organizations and roles of the high-level government bureaucrats comprising the collaborative governance network.

Results

While there were 42 participants in the overall study, the interview data relevant to this aspect of the study was contributed by 7 key informants. The key informants were managers in the organization and high-level government bureaucrats from regulatory and funding organizations supporting the transition. The demographic characteristics of the 7 key informants are described in Table 1.

The study found the transition to a dementia-friendly village was accomplished at the intersection of 3 generative mechanisms. Those encompassing workplace culture change

Table 1. Participant Demographic Data.

Participant number	Ethnicity	Age range	Role
28	NZ European/Māori	50-59	Key informant
34	NZ European/Dutch/Scottish	40-49	Key informant
35	NZ European	60-69	Key informant
37	NZ European	50-59	Key informant
38	NZ European	50-59	Key informant
41	NZ European	60-69	Key informant
42	NZ European	50-59	Key informant

and a change in the physical environment will be reported elsewhere. This article reports the results of the study regarding the formation of a governance network to support the transition.

The Support of a Collaborative Governance Network

A high-level government bureaucrat formed a collaborative governance network to support the transition to an innovative model of ARC service delivery. The network comprised managers from the service provider and high-level bureaucrats from government, regulatory and funding bodies. The Chief Executive of Whare Aroha CARE approached a high-level bureaucrat at the local DHB, who then approached a high-level bureaucrat at Central TAS, an organization providing high-level services to the Ministry of Health, who formed the collaborative governance network. Participant 42 has questioned the timing of the organizations approach to the DHB bureaucrat.

> *"They could and should have gone out earlier to people like Participant 41 and the DHBs who would be interested in a partnership."* (Participant 42).

The network enabled a successful transition by gaining acceptance of the model of care by a group of senior clinicians, supporting a change in the national contract for ARC service delivery, managing risk, and facilitating regulatory compliance. The themes in the study data, relevant to the support of a collaborative governance network in ARC service innovation are; managing risk, working together, changing the contract, regulatory compliance, and readiness to consider a model of care encompassing person-centeredness and a dementia-friendly environment.

Readiness to Consider a Model of Care Encompassing Person-Centeredness and a Dementia-Friendly Environment

The high-level government bureaucrats who were members of the network were receptive to considering innovative models of ARC service delivery. At the time, the NZ Ministry of Health had recently collaborated with gerontologists to develop guidelines for secure ARC environments for people with dementia.[5] The guidelines advocate for care that is person-centered, culturally sensitive, and respectful of the dignity and human rights of people with dementia who require a secure care environment. As evidenced by the data extracts below, while there was growing acceptance for small-scale living facilities in ARC, desegregation of people requiring specialist dementia services within ARC facilities was untested in NZ.

> *"Absolutely the smaller environments, no problem at all, and we are well researched on that. I think what we're really test-casing here is mixing specialist dementia services with other models. We need to see whether that works for everybody.* (Participant 37, key informant)."[22]

> *"Because traditionally when you need dementia level care all of a sudden you go into an area that there is keypad access to or it's locked and people can't get out and walk out around on their own outside or out of that unit or out of that area, so this is a really, it's a really big challenge for them thinking about how that might operate differently".* (Participant 28, key informant).

The innovative aspect of the proposed village concerned the desegregation of residents who required a secure care environment within a small-scale living facility. As noted by participants 37 and 28.

The governance network was formed in an atmosphere of openness to innovation in ARC service delivery. People who live in ARC are a potentially vulnerable group, and service providers, funders, and regulators have a responsibility to ensure care is safe and risks are managed appropriately. Management of any risks inherent in transitioning to an innovative model of service delivery was one of the roles of the collaborative governance network.

Managing Risk

There was some initial resistance to the CARE Village concept among the ARC sector. The concerns were about the ability of the organization to operationalize their vision and about risks to resident safety related to residents with dementia requiring care in a separate locked area of the facility being integrated with residents who do not need to be cared for in a locked area. In the new facility residents who do not

need to be cared for in a locked area are free to enter and exit the entire facility at will, enabled by technology. Residents who do need to be cared for in a secure area are free within the facility but unable to enter and exit via the technologically enabled main entrance. The instigator of the governance network organized and chaired a meeting between a group of clinical experts and the managers of Whare Aroha CARE enabling discussion of the proposed model of care. The purpose of the discussion was to ensure a safe and appropriate level of care would be provided to all residents of the new facility. Following the meeting, the experts were reassured the transition could proceed safely.

> *"My role was to drive the change to the national agreement and sell that through the DHBs and the joint ARC steering group, which is made up of sector representatives and DHBs and ministry folk. To get that change accepted and agreed through that process. Some resistance for the sector, the sector was quite questioning about aspects that we had to surrender as a part of changes to the national agreement, particularly around secure dementia care. Some people were classical providers of secure dementia services that were quite questioning of the concept. To help with giving some comfort and background around that I pulled together a group of clinicians from around the country, psycho-geriatricians, geriatricians, ministry folk and others, to have the opportunity to meet with [facility management] and have the concept explained. Then we had a big session, pretty much a whole-day session around challenging and understanding the risks that might be inherent within that type of model because it was new for NZ. So, getting the clinical view that said, yes, some risks will be there ongoing. However, if it's done correctly, if it's done well, the model should produce a good outcome for all concerned, so it was going through all those sorts of pathways to get the people on board to accept it.* (Participant 41)."[17]

The governance network collaborated to ensure ongoing identification and management of risks related to the transition to support the transition to an innovative model of ARC service delivery.

Working Together

The high-level government bureaucrat exercised his power to form the collaborative governance network. The invited members of the network were familiar with each other due to previous interactions, as illustrated the following excerpt:

> *"Health is like this. I had worked with him in a previous life in the DHBs.* (Participant 35)."[17]

However, each member of the network brought a differing perspective to the group, dependent on their substantive role. These perspectives are evident in the participant quotes that follow. Participant 35 saw the network as supporting the transition and proactively solving problems, Participant 41 was concerned with the role of the network in engagement with the service provider and management of risks relevant to the transition and Participant 38 spoke of working together to ensure provision of safe care.

> *"He put together the group with me and made sure that it was going the way we thought it would and if there were any problems they would be quickly identified.* (Participant 35)."[17]

> *"We set up that group to keep engaged with Whare Aroha CARE and The CARE Village throughout the pilot to ensure that those risks were monitored and understood.* (Participant 41)."[17]

> *We will continue to work together to provide support to the provider a sounding board to raise issues and to be able to say this service will provide safe care.* (Participant 38).

The different perspectives of network members reflect their relevant governance expertise. Despite a difference in perspective among the network members, the network is characterized by open communication and collaboration. The basis of the network that supported the transition was respectful communication between members, who had existing or previous working relationships.

> *"I think what is important to say is that communication is very open and very transparent. I think regular contact and meetings are helpful, well I certainly hope they are helpful.* (Participant 37)."[17]

Additionally, facility managers communicated with staff and family members via regular meetings. Some staff were members of a group involved in planning details of the transition. Others were going to become home leads, the consistently-assigned staff members responsible for running each house. Participant 35 describes how each of these groups were communicated with about the transition, below.

> *"We met with home leads every week to develop the roles, we had a transition group that would meet every week, to talk and plan and discuss and do things and come back the next week, we had a lot of staff meetings, we had family meetings"* (Participant 35).

The governance network has collaborated to enable The CARE Village to meet contractual and certification requirements to provide a mixed services model of care in ARC. In the mixed services model of care, residents who require different levels of ARC services can be housed together. Because the model of care houses people who have differing care needs together, a variation to the existing standard contract for ARC service provision was needed. The change in the contract was driven by the instigator of the governance network.

Changing the Contract

The contract between ARC service providers and DHBs was a national one, and stipulated residents be cohorted

together based on their care needs.[23] Because the model of care at The CARE Village depends on residents living in small groups with like-minded peers, the national contract needed to be varied for the new facility, to enable the service to be provided and funded. As part of the work of the governance network, a variance of the contract was instigated.

The bureaucrat recognized the need for a variance of the contract and engaged a legal firm to work on a version of the contract that aligned with the proposed new model of care. The services of the legal firm were paid for by the government agency leading the governance network.

> *"Aged Residential Care contracts with residential care providers is a national contract. I mean it is the only real national contract that exists within health, there is no variation from it at all. When you have this model proposed that does not fit within the national contracting framework, you need to find a way to adjust that to allow it to be supported.* The *journey of moving from a national contract to a special arrangement for this facility, we have managed all the work and costs that have gone into that.* (Participant 41)."[17]

The ARC services provided under the varied contract were required to meet the same standards as other contracted health services. It was agreed that the new mixed services model would be trialed as a pilot for 3 years. As noted by Participant 41, below, if the model of care was not successful, the pilot would be terminated at the end of the 3-year period.

> *"It is on a three-year pilot, it can then be established as a successful model, it can be extended beyond the three years if there is still insufficient confidence in the model requires a little bit more testing or changes, or it can be terminated and returned to the classic model where specialist dementia is not co-habiting.* (Participant 41)."[17]

The pilot was successful and the contract between the DHB and the provider was renewed. Regulatory compliance was one of the considerations impacting the decision to renew the contract. Service audits ensure the care provided for residents in ARC facilities complies with the terms of the contract and meets the standards set out in the Health and Disability Services (Safety) Act 2001.[24]

Regulatory Compliance

In NZ, ARC services have undergone certification auditing since 2002, the process was updated in 2009 after review by the Auditor General. The updated process is outcomes focused and includes unannounced audits, known as spot audits.[25] A business unit of the Ministry of Health, HealthCert administers the process and independent accredited auditors conduct the audits.[2] Audits and certification of services occur every 1 to 4 years, dependent on the results attained in the previous audit. If non-compliance issues identified at audit the service provider reported to the DHB regarding their progress addressing these. During the period of certification each service has an unannounced audit visit.

New services undergo what is known as a "provisional audit," while reconfigured existing services undergo a partial, provisional audit.[26] The CARE Village was a reconfiguration of an existing certified service, therefore, a partial, provisional audit was required and was carried out in August 2017, while residents were still living in the original facility. The audit identified some non-compliance issues, mostly documentation related. In January 2018, after residents had relocated to the new facility a spot audit was conducted and some unresolved issued were identified.

Following the audits, management, and staff of the facilities worked with the member of the collaborative governance network who was a high-level bureaucrat at Lakes DHB to resolve the issues and accurately document the provision of safe and effective care for residents of The CARE Village. Once the required corrective actions were completed, the facility was re-audited in June 2018, resulting in a 3-year certification for the facility.

> *"Those corrective actions, I sat down with [the manager] and we went right the way through all of those, and we signed those off as being either there or in progress.* (Participant 38.)"[17]

Service staff often see auditing and certification as challenging processes. During busy times, such as transitioning to a new facility based on an innovative model of care, staff can be particularly challenged by the process. However, as indicated by Participant 38, below, the audit identified an opportunity to document the model of care, contributing to sustainability of the work done by the organization to change the workplace culture to facilitate the delivery of person-centered care.

> *"It's got to be written as well as played out. Although it takes a bit of time, it's a really important part of making sure the legacy carries on rather than being person-dependent.* (Participant 38)."[17]

During the auditing and certification process, collaborative working between facility management, the DHB and the certifying organization ensured that any issues identified were appropriately managed. The governance network, formed by a high-level bureaucrat from Central TAS supported the transition to an innovative model of ARC service delivery. They accomplished this by ensuring potential risks were managed, varying the contract between the service provider and the DHB and facilitating certification of the new service. The network provided ongoing support to the facility during the 3-year pilot of the mixed services model of care. The pilot has been successful, and the service continues to operate, delivering ARC services to residents.

Discussion

The study found that the managers of Whare Aroha CARE recognized they needed the support of high-level government bureaucrats to enable them to transition to an innovative model of ARC service delivery. They approached a high-level bureaucrat at the local DHB, leading to the formation of a collaborative governance network comprising members representing influential organizations from the healthcare, government, and ARC sectors. Although collaborative, the group was instigated and led by a powerful advisor to central government. The finding aligns with those of previous authors, noting leadership roles in collaborative governance networks are often held by representatives of central government.[27-29] The leader of the network held high-level decision-making power, identified as an essential component of successful networks by Voorberg et al.[30]

While a powerful individual brought the network together, there was a high level of trust between members, engendered during previous and current working relationships. Trust is present when one party in the relationship surrenders control to another, while remaining confident that the desired outcome will be achieved. The trusted party is likely to have previously demonstrated characteristics such as integrity, ability, and good intentions.[31] Interpersonal trust in governance networks results from members genuinely caring about each other and develops over time. When representatives of organizations know and trust each other, inter-organizational trust results.[31] Because ARC providers are responsible for providing care to older adults that meets regulatory, contractual, and legislative requirements, innovation in the sector requires a trusted provider. The positive influence of trusting relationships found in the current study is similar to the findings of Sørensen and Torfing[32] who noted the positive influence of trusting relationships within a network supporting an innovative cycling activity for older adults.

Because ARC facilities care for vulnerable people innovation in the sector must be accomplished within the regulatory requirements. As noted by Voorberg et al[30] regulations may act as a barrier to policy innovation in certain contexts. However, innovation in the ARC sector must be accomplished safely with potential risks identified and managed. One of the roles of the governance network comprising of different sectors was to manage any risks associated with the transition. The service development group includes high-level government bureaucrats from all interested organizations focused on ensuring a safe and viable pilot of a new model of ARC service delivery. The key to the success of the transition was one highly influential bureaucrat who was able to ensure regulatory and contractual elements needed were in place. This individual has the power to ensure person-centered care is supported in the new facility.

In the dementia-friendly environment of The CARE Village resident continuation of lifelong identities is facilitated at the intersection of a recognizable domestic-scale physical environment and person-centered care. Similar to facilities that are part of the GreenHouse model of care in the USA, consistently-assigned staff who know residents well support them to engage in their chosen activities of daily living.[33] The CARE Village has innovated to include residents requiring different levels of care including those with dementia requiring secure care. The elements of the collaborative governance network supporting this ARC innovation align with the argument of Torfing[34] and contribute to public administration theory by providing an example of public sector innovation supporting the delivery of appropriate health and social care for older New Zealanders. The care provided is dementia-friendly, person-centered, and culturally appropriate. Future research could evaluate the organizational culture of dementia care expressed in care contacts between staff and residents.

Study Limitations

There are potential limitations to the study. First, participants were key informants who had volunteered, therefore the sample may not be fully representative because it does not include potential participants who did not volunteer. Second, feedback on the role of the governance network was not sought from other participants in the wider study. Third, the study explains the process of the transition of Whare Aroha CARE residents into The CARE Village and may not be generalizable to other ARC providers.

Conclusion

The transition for a traditional to an innovative model of ARC service delivery has been enabled by a collaborative governance network and includes a process conducive to sustainability. The network managed potential risks and facilitated the change in the national contract, as a pilot for The CARE Village. The outcome has enabled integration of residents requiring secure care environments within the dementia-friendly secure environment. Following the example set by The CARE Village there is potential for other ARC service providers to innovate similarly.

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Ethical Approval and Informed Consent

Health and Disability Ethics Committee approval was obtained for the study. The approval number is 16/NTA/133. Following the

Health and Disability Ethics Committee approval, further ethical approval for the study was obtained from the Auckland University of Technology Ethics Committee. The Auckland University of Technology Ethics Committee approval number is 16/424. Written informed consent was obtained from all participants who were able to consent. For those who were not able to consent, consent of next-of-kin was obtained.

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Supplemental Material

Supplemental material for this article is available online.

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