

**Home Care and Pharmaceuticals Division,
Health Policy and Communications Branch,
Health Canada**

Analysis of Interfaces Along the Continuum of Care

**Technical Report 2:
Seniors**

February 2002



Hollander Analytical Services Ltd.

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Seniors**

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EXECUTIVE SUMMARY

The growing seniors population is predicted to reach approximately five million individuals over the age of 65 by 2011. The needs of seniors can range from providing minimal assistance with activities of daily living to complex clinical, environmental, social and pharmacological needs that require coordinated and integrated care along the full continuum. Meeting the diverse needs of seniors has been hampered by pressures on the system brought about by the early discharge of acute care clients, reduced financial resources for preventative services, human resource shortages and the lack of accountability structures and information systems.

As a result, the Federal/Provincial/Territorial Deputy Ministers of Health identified continuing care and home care as priority areas. In recognition of this, the FPT Advisory Committee on Health Services (ACHS) and its Working Group on Continuing Care (WGCC) commissioned this study on the factors which contribute to more efficient, effective and seamless systems of care delivery for seniors. Specifically, Health Canada wanted a comprehensive analysis of the topic of “*a continuum of care*” to provide insight into how to improve the provision of health services, particularly community health services for seniors.

This technical report is the result of that commissioned work and represents a synthesis on the data gathered from eighty key stakeholders, and two focus groups with consumers and family caregivers.

The study findings suggest that despite the rhetoric of a shift to community-based care, the reality is that services have been cut in institutional sectors and not enhanced in the community; resources have not been transferred or created. A great deal of responsibility for ensuring that care is coordinated or even accessed is being placed on the individual and the family. For families, the task is made more difficult by the gaps in services available and the minimal amount of capacity in existing services. There is recognition by both government and community-based stakeholders that strict eligibility criteria impede access to services.

The information gathered from key stakeholders supports the existence of a two-tiered system for seniors across the country. The increased medicalization of the program has required seniors seeking home care to look for other sources to fund services including: out-of-pocket payment, insurance, family caregivers, or to go without if they are above the income eligibility levels but still in low-income brackets. Beyond these inequities is the potential to escalate lower level needs into higher, more expensive categories of care.

Based on the data gathered, this report provides the following suggestions to improve the system of care for seniors:

A National Framework

There is a need for a Canadian policy framework specifically for seniors. Several provinces suggested that a policy division or secretariat focused on seniors’ issues would help facilitate and/or improve integration.

Increased Funding

If care for seniors is to be more inclusive, that is providing both medical and social components of care, then funding for these added services must be available. In addition to more federal funding to support all aspects of continuing care, there needs to be the ability for funding to follow the client from one sector to another to ensure gaps and barriers to adequate service levels are diminished.

Formal Mechanisms with Authority to Act

Recommended initiatives to improve integration into the broader system of care, including multi-sector participation on interdepartmental committees by senior management officials at the provincial level. Inter-governmental committees need to be given a mandate “*with teeth*” in order to be effective and efficient. Any efforts to formalize mechanisms for collaboration between sectors should also be given the mandate and authority to evoke change in the system.

Ratify the Core Components of Continuing Care

In order to create a “*seamless system of care*” for seniors, the core components of that system need to be determined and ratified. The differences between acute care and continuing care systems in terms of an individual’s responsibility for the cost of services frequently emerged as an issue. In addition, there is a need for a common understanding and definition of the overall continuum of care – not just for service providers, but also for the general public. There is a need to manage expectations to recognize that home care is not the “*be all and end all*”. The effectiveness of the core and essential elements of home care should be evaluated and the results communicated to service providers. Improvements could be made to the system based on current research.

Understand the Implication of Regionalization

Regionalization has facilitated the gathering of local data to plan and delivery the most appropriate services to the region. However, research is needed to address the following questions: How has regionalization responded to cost containment? What have been the implications of regionalization for a fully integrated system of care for seniors? Collecting data at the regional /local level would provide much greater insights into the issues, gaps, and barriers to integration.

Start with the Individual – Client-Centered Approach

The underlying philosophy of the localized approach was the client-focused system of care delivery. The adoption of the Client Centered Service Approach would ensure that clients with complex needs would receive the right service at the right time by the right person. According to Veterans Affairs Canada¹, a client-centered approach to service includes:

¹ Veteran Affairs Canada: Client Centered Approach <http://www.vac-acc.gc.ca/providers/sub.cfm?source=approach/implement>

- Identifying the individual needs of the client and then determining how best to provide assistance through internal, or coordination of, departmental and community resources;
- Developing a partnership between the client and the provider as demonstrated through direct client involvement in all aspects of care planning decisions;
- Ensuring staff work with the client to meet all their needs, not just to determine their eligibility for services and benefits; and
- Delivering services.

Suggestions of Family Caregivers

Participants proposed creative and realistic strategies for improving the system. Suggestions to emerge included:

- Improving access and coordination for community-based services, particularly home care;
- Better communication between the sectors and between families and systems;
- Access to affordable medications;
- Improved training for all family caregivers;
- Attention to continuity of workers to minimize the disruption of having many workers coming in to a person's home; and
- An improved assessment process that has a holistic framework.

There is an evident willingness on the part of both community-based groups and government to work towards a better system with integration of services as a goal. For those in the public sector, this was most clearly expressed in efforts to integrate departments and jurisdictions, an approach that may be too narrow if it fails to recognize the community organizations as full partners in the system. Community agencies saw themselves playing a significant role, responding to many unmet needs, but felt that their expertise was not always recognized. The synergy of both sectors is crucial for a true continuum; neither can function fully and effectively without the other. Examples of initiatives that did bring together diverse stakeholders were evident in every province. Achieving integration will draw on new ways of working together with tangible recognition of the public sector, private/community sector and the clients as key players in the whole continuum.

Finally, this study has identified a recent growing trend towards integration that is evident in the various systems of care across the country. Such developments need further impetus and direction to ensure that the care required for seniors is seamless and responsive to their needs.

This report has identified, and confirmed from the literature, the numerous issues, gaps and barriers to integration that must be addressed. The challenge is to do this in such a way as to strategically coordinate policy changes at the macro level with the essential system features required for integration at the local, community-based delivery level.

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1. INTRODUCTION

The Federal/Provincial/Territorial Deputy Ministers of Health have identified continuing care and home care as priority areas. In recognition of this, the F/P/T Advisory Committee on Health Services (ACHS) and its Working Group on Continuing Care (WGCC) commissioned further study and analysis on the factors that contribute to more efficient, effective and seamless systems of care delivery.

As a result of the FPT deliberations, Health Canada commissioned research on interfaces along the continuum of care. Specifically, Health Canada wanted information on the continuum of care for four population groups: Seniors aged 65 or older, persons with physical disabilities, persons requiring mental health services and children with special needs. In addition to the above, a comprehensive analysis of the topic of “a continuum of care” was requested to provide insight into how to improve the provision of health services, particularly community health services for the four above noted populations.

The commissioned work resulted in the preparation of six technical reports and one overall synthesis report. This technical report, on the senior’s population, represents a synthesis of the data gathered from eighty key stakeholders and two focus groups with consumers and family caregivers.

The overall goal of the project was to contribute to a better understanding of the interfaces among the various parts of the health care system, and between the health system and other sectors. The specific objectives of the study are:

- To analyze the current explicit and implicit barriers to client flow across sectors of care and the provision of the most appropriate care in the most appropriate and cost-efficient setting by the most appropriate provider for persons over the age of 65;
- To analyze whether the funding follows services and/or individuals and if/how it flows from one sector to the other;
- To analyze the inefficiencies and gaps in service availability and utilization; and,
- To analyze ways to maximize the optimal use of available resources to achieve better client outcomes

2. METHODOLOGY

2.1 Scope

Given the constraints of time, it was important to consider the most appropriate methodology for capturing a wide range of information from a variety of stakeholders. The researchers developed a telephone interview protocol which they felt would yield the most information within a restricted time period, while still gaining insights into individuals' personal and social context related to the interfaces along the continuum of care for seniors (65+).

2.2 Sample

Key individuals and groups in every province and territory across the country were approached and asked to participate in the study. To ensure broad representation, a matrix was developed with names of individuals representing each province/ territory, government, health authorities, service providers, consumer organizations and researchers. Appendix 1 provides the breakdown of the stakeholder groups interviewed. On average, six interviews were conducted in each province, fewer in the territories, for a combined total of eighty interviews (n=80). Appendix 2 provides a list of stakeholders and their affiliations. A snowball sampling strategy was utilized to enlist names of other key informants who were felt would provide a valuable contribution and insight to the subject matter.

2.3 Interviews

The procedure used in this study involved an in-depth, semi-structured telephone interview with key stakeholders in each province/ territory using an interview protocol. The interviews took place between January 2001 and April 2001. The nature of the interview process allowed for individuals to provide their personal experiences and perspectives.

Prior to the interview, key informants were contacted and asked if they would be willing to participate in the study. A one-page project summary (Appendix 3), a list of services that seniors (65+) would typically receive (Appendix 4), and a list of questions that would provide the basis for the interviews (Appendix 5), were available for the respondents.

2.4 Focus Groups

Two focus groups were conducted: one with seniors who had recently used the health care system in Prince Edward Island and the other with family caregivers in Halifax/ Dartmouth. The focus group of seniors was organized through the PEI Federation of Senior Citizens and held in Charlottetown in early April 2001. Eight people, two men and six women, participated in the two and half hour meeting. All identified themselves as seniors, with at least two individuals over the age of 85. Many of the participants had recently been in hospital and had multiple health care problems including: cancer, high blood pressure, stroke, heart conditions, and asthma. One member of the group had also been a caregiver to his wife, who had recently died from cancer after receiving palliative care.

Seven women participated in a focus group in the metro region of Nova Scotia (Halifax/Dartmouth). The session focused on their experience with a senior family member who had accessed the health care system within the last year. These women were well-educated, middle-to-upper middle class and thus were not representative of either the province or the Atlantic region as a whole. Nevertheless, their experiences offer an insightful perspective on how things are operating at the grassroots level. Several family relationships were reflected, offering a diverse perspective on the extent of family involvement. Women spoke of their experiences with spouses and ex-spouses, parents, parents-in-law, siblings, and aunts. Three of them were assisting more than one person. All of the seniors receiving help from their family members had complex chronic health care needs.

Through the use of these focus groups the views of the current system of care for seniors and consideration of how the system should evolve were obtained. Questions framing the focus group are provided in Appendix 6.

2.5 Data Analysis

The qualitative data gathered through the exploratory questions and preliminary concepts were analyzed to collect relevant themes and observe patterns in the data. Although the sample of key respondents was limited, theoretical saturation on key concepts, categories and relationships related to the integration of services were obtained. At two time intervals the investigative team discussed, explored and challenged the observed patterns in the data to ensure that the stakeholders' viewpoints were accurately interpreted. Although this report does not relate the findings to prevailing social theories, the findings remain consistent with the information reported in the literature review (Technical Report 1).

3. FINDINGS REGARDING PERCEPTIONS OF AN EXISTING SYSTEM OF CARE

Respondents were asked to review the list of services provided in the table (Appendix 4) to determine which were core or most frequently used, and which should be core. It was generally felt by most respondents, regardless of their backgrounds and affiliations, that a “*system of care*” for seniors has not been developed to its full capacity in Canada. Although there have been dramatic changes in health care delivery, there have been insufficient advancements in the coordination and integration of health and social service sectors to meet the often complex and diverse needs of seniors in today’s health care environment.

Respondents stated that the degree of integration within various parts of the health care system, and between the health system and other sectors, was often organized around specific clinical pathways such as dementia, hospice/ palliative care, stroke, mental illness etc., rather than for seniors as a specific sub-population². In addition, the degree of integration is often predicated on several factors including: geography (rural, urban, rural remote), fiscal and human resource availability, and organizational factors (information technology, accountability structure).

Although there exists a wide range of services and programs available to seniors across the country, respondents perceive the ‘system’ to be composed of discrete and often disjointed parts of the whole. A consistent theme emerging from the data was the need to ratify the core or “most frequently” used services as part of the continuum of care system to achieve a dynamic and influential service delivery continuum. In the absence of the identified clinical and non-clinical core services, inequities in access and delivery are stated to exist particularly once a senior leaves the acute care sector, an insured service under the Canada Health Act, and enters the continuing care system.³ While there are generally core services considered to be part of the continuing care system, variation exists between jurisdictions as to what other services are also to be included. Given the lack of standard definition of what constitutes the continuum of care and the onset of regionalization/ decentralization, the variability between and among regions and continuing care remains an issue.

² A **continuum of care** would include: institutional services, community care services, non-institutional services (public health, primary care, population health, housing, education etc.)

³ Definition of **Continuing Care**: A vertically integrated system of service delivery with a broad community base for people with functional disabilities and chronic illnesses. It includes assessment and case management, long-term care, home care (including short term hospital care), home support, palliative and respite care and other related services.

4. FINDINGS RELATING TO SERVICE GAPS AND ADEQUACY OF SERVICES

4.1 Service Availability and Limitations

4.1.1 Assessment and Case Management

Most respondents viewed the initial assessment process and the ongoing case management functions as critical components of the continuing care system. While the policy of publicly funding assessment and case management services was endorsed, respondents expressed concern about the unreasonable expectations of case managers due to high caseloads. Many believed that the number of clients currently on home care caseloads impedes the success of the case manager in accessing, coordinating and integrating services for the client.

4.1.2 Nursing

Staff shortages in nursing, in both the acute care sector and the community-based sector were identified as a major impediment to the provision of professional clinical care. In Ontario, the reported shortages in professional staff have resulted, in some cases, in agencies under contract with the CCAC being forced to refuse referrals, thus jeopardizing their contractual agreements and limiting access and availability to care. In addition, shortages in personnel have created a major issue with continuity of care. Consumers interviewed, more so than government or provider stakeholders, identified the lack of continuity as a substantive issue for seniors who place a high value on the need to develop a trusting relationship with their care provider⁴.

The literature relates the lack of nursing manpower to adverse affects on patient outcomes including increases in: hospital length of stay⁵, infections⁶, falls^{7,8} medication errors⁹, mortality¹⁰, and an overall decrease in the quality of care¹¹. Although identified as a core service, the shortage of nursing staff, particularly in remote regions, has resulted in waiting lists in the community, substitution of nurses with para-professionals, and decreased quality of care.

⁴ Moore K., Lynn MR, McMillen BJ and S. Evans (1999). Implementation of the ANA report card. *J Nursing Administration* June; 29 (6): 48-54.

⁵ Lichtig LK, Knauf RA, DK, Milholland (1999) Some impacts of nursing on acute care hospital outcomes. *J of Nursing Administration* Feb;29(2): 25-33.

⁶ Lichtig LK, Knauf RA, DK, Milholland (1999) IBID

⁷ Blegen MA, & Vaugen, TE, Goode CJ (2001) Nurse experience and education: effect on quality of care. *J Nursing Administration* Jan;31(6):33-9.

⁸ Dungen JM, Brown AV, MA Ramsey (1996) Health maintenance for the independent frail older adult: can it improve physical and mental well-being.

⁹ Dungen JM, Brown AV, MA Ramsey (1996) IBID

¹⁰ Al-haidar AS, TT Wan (1991) Modeling organizational determinants of hospital mortality. *Health Services Research*. Aug; 26(3): 303-23.

¹¹ Blegen & Vaughn (2001) IBID

4.1.3 Occupational and Physio Therapies

The risk of a sub-optimal level of functional ability increases with age.¹² Closely tied to declining functional abilities as a risk factor for seniors, is illness. According to 1996/97 Statistics Canada data, 82% of all seniors were reported having at least one chronic illness.¹³ Occupational and physiotherapy have been shown to have positive outcomes related to improving functional abilities while facilitating clients' ability to remain in the community as long as possible with a positive quality of life.^{14,15}

While therapists play a crucial role in the delivery of rehabilitative services, they are increasingly under pressure. According to most respondents, the number of new referrals is increasing steadily, making it difficult to meet the demand.

Respondents generally agreed that a greater role should be played by rehabilitative therapists to help improve seniors' functional capacity and to obtain their optimal level of self-care following an acute episode or to manage exacerbations of a chronic illness. Again, while all agreed that these services were necessary, rehabilitative services were not always included in the services available through the provincial/territorial home care program . Such is the case in Nova Scotia. Even where they were part of the program, labour shortages and insufficient budgetary allocations reduced their availability.

4.1.4 Home Support Services

Advances in medical science are enabling people to survive more illness and disability. As people live longer, physical or mental disability and other chronic diseases may reduce their mobility and/or ability for self-care. It may become unreasonable or impractical for seniors to access ambulatory services. For example, one respondent raised the issue of the increasing numbers of dentate elderly people who have a higher expectation for maintaining good oral health than earlier cohorts of elderly people. This trend has brought about an increased demand for both professional and para-professional oral care. With the reduction in home support services, oral preventative care for seniors in non-institutionalized settings is posing a serious challenge and, therefore, should be considered a core component of the continuum of care.

Not surprisingly, when discussing the current trend in rationing and prioritizing home support services in Canada, respondents focused largely on the impact of the fiscal, demographic and political imperatives that underlie the development of home care and the subsequent prioritization of home care services. The movement of home care programs towards medical/clinical services and away from social support services has occurred by restricting eligibility, limiting hours and eliminating access to elements of the home support service

¹² Statistics Canada (1999). A Portrait of Seniors in Canada. 3rd Edition. Ottawa, Canada: Minister of Industry.

¹³ IBID pg. 62.

¹⁴ Clarke, F. Azen S, Zemke R, Jackson J, Carlson M, Mandel D, Hay, J., Josephson K., Cherry B. Hessel C., Palmer J. Lipson L. (1997) Occupational therapy for independent-living older adults: A randomized controlled trial. Journal of the American Medical Association, 278, 1321-26

¹⁵ Clarke, F. Azen S, Carlson M, LaBree L, Hay, J, Zemke R Jackson J, , Lipson L. (2001)

(housekeeping). Although a core function by definition,¹⁶ home support services have, by tradition, been cost-shared. The increased privatization of the service has created a noticeable shift in funding and access. The study findings found a contrast between the opinions held by many government and health authorities respondents and the consumer and service provider respondents. The latter group placed greater utility on home support services for providing the necessary supports to maintain seniors in their communities and improve their quality of life. Government and Health Authority respondents found the rationing of home supports were a necessary austerity measure that represented the “*lesser of all possible evils when compared to rationing acute care substitution services*”.

Funding for home support services must compete with other parts of the system, such as physicians’ services, hospitals and drug medications. Hollander (2001)¹⁷ notes that in the British Columbia system in the 1980s, few home based clients required services that equaled or exceeded the cost of facility care. Without adequate attention directed to providing home support services, there is, according to the stakeholders, more likelihood that seniors will have to go into hospital or long-term care facilities because of health and safety reasons.

4.1.5 Palliative Care

Although the evidence shows that, when their time comes, people generally prefer to die at home, research on end-of-life care in Canada indicates that the majority of deaths occur in hospitals with provincial and territorial proportions ranging from 87% in Quebec to 52% in the Northwest Territories.¹⁸

In a recent report by the Senate Subcommittee in June 2000¹⁹, many features of an integrated palliative care model were identified. Study respondents discussed the difficulty in providing access to the full-range of palliative/ end-of-life care services and supports in the community-based setting. Clients facing end-of-life decisions must weigh personal preference against limited availability in professional or para-professional support, out-of-pocket costs for medical equipment and supplies, and limited respite for family caregivers. Saskatchewan has implemented policies to remove fees for end-stage palliative care in an effort to promote client and family preferences. In general, palliative care is provided along the full continuum of care in every province, but can be limited in scope in the community-based setting.

4.1.6 Respite Care

Respite care, both in the home and in facility-based care, was considered a core service to seniors and their caregivers, but limited in its availability and lacking in flexibility. Adult Day Programs

¹⁶ Canadian Institute for Health Information, Statistics Canada (2000). *Health Care in Canada: A First Annual Report*.

¹⁷ Hollander, M. (2001) Evaluation of the Maintenance and Preventive Function of Home Care. Home Care/ Pharmaceuticals Division, Policy and Communication Branch, Health Canada.

¹⁸ Heyland DK, Lavery JV, Tranmer JE, Shortt SE, Taylor SJ. (2000) Dying in Canada: is it an institutionalized, technologically supported experience? *J Palliat Care* Oct;16 Suppl:S10-6.

¹⁹ National Advisory Committee: Responsible for the development of a guide to end-of life care for seniors *Quality End-of-Life Care: The Right of Every Canadian*, (2000) Senate Subcommittee Report.

in particular were recognized as having immense value, but only limited availability in many areas (in the rural areas they were virtually non-existent).

A study released on Adult Day Care by the Centre on Aging in Manitoba²⁰ looked at the role of adult day care centers as a vehicle for promoting socialization of seniors and caregiver respite. Findings from the Manitoba study concur with and validate comments heard from study respondents suggesting a greater level of coordination and cooperation between provincial home care programs. Adult Day Care was required to ensure an interface between home care and ADC was maximized to its fullest potential.

4.1.7 Equipment and Supplies

Technical aids and equipment and supplies were clearly a gray area in the continuum of services. They were often available for acute home care or palliative care programs, but were not considered to be part of the provincial home care programs. In these cases there was often a mix of availability through support agencies, or no service at all, leaving seniors and their families to cope with the costs privately. Exceptions often occur when clients receive social assistance allowing supplies to be purchased through the welfare benefit program.

4.1.8 Rehabilitative/ Restorative Care

The need for more rehabilitative/ restorative care in which to recover/ improve, delivered in a timely manner to ensure people are functioning at their optimal capacity soon after an acute care episode, was identified by respondents. Seniors in the focus group felt that this unit was a positive example of how a continuum of care existed. Participants who had used the services of this unit believed that they received better quality of care than they had in the hospital – although one person mentioned they were still a long way from having sufficient physiotherapy and occupational care. This latter point was consistent with interviews with the key informants. Even in provinces where there is a care unit, comments indicated that insufficient OT /PT resources were allocated and/ or available to patients.

4.1.9 Support for Family Caregivers

It is becoming increasingly apparent that there is more support required for family members to continue in their capacity as an essential part of the 'care team'. Formal services and programs, such as respite and adult day programs, were generally seen as lacking across the country. Again, this is especially evident in rural and remote areas. Support groups for caregivers were not considered to be part of the systems but may exist depending upon the nature of the community in which they are based. Other supports, such as various forms of financial support from government were also considered to be lacking or insufficient.

²⁰ Strain, L., and Payne, B, (1997) An Evaluation of Adult Day Care in Manitoba: Final Report. Centre on Aging, University of Manitoba.

4.1.10 Transportation

Transportation services for seniors, especially in the rural communities, were seen as a major gap in services across the country. This is a significant issue for the health and well-being of seniors in both urban and rural areas, because the lack of transportation contributes to social isolation and affects quality of life, access to community-based services, health-related appointments (e.g., with doctors), shopping, and so on. If a senior is no longer able to drive (e.g., because of a stroke, or age restrictions) then there is an immediate dependency placed on the formal and informal transportation supports for daily functioning. Recognizing these needs, there is a growing trend towards collaboration among the formal and volunteer sectors to ensure access to transportation services for seniors.

4.1.11 Supportive Housing

Supportive housing was identified consistently across the country as a service that needed to be expanded and enhanced. Living arrangements can provide 24-hour support and a degree of security for seniors. In Ontario approximately \$100 million is spent annually on supportive housing for 10,000 people, 7,000 of whom are seniors. In spite of this, there are “*miles long waiting lists*” to access these supportive housing arrangements. Key informants recognized that a continuum of housing options is integral to the system of care for seniors, but there are major disparities in service provision for people living in rural communities.

4.2 Under-Utilization of Services

A number of services were considered to be under-utilized. Adult day programs are not used as much as they could be, in part because many people are hesitant to do so. It has been suggested that a stigma related to the perception of poor programming has resulted in fewer referrals.²¹ And yet, from a provider’s perspective, they are extremely useful because they provide opportunities for many other services (e.g., recreation and socialization, foot-care, taking of blood pressure). Respondents also felt that respite services were both under-utilized in some places and insufficient in other areas, given the needs of the population.

4.3 Disparities in Rural and Remote Areas

Gaps in the system were often identified as a regional issue. For example, it was noted that the availability of services varied considerably depending upon where someone lived in a province or territory. While geography was a significant issue, it should be noted that this had various levels of intensity. For example, the case of a senior with dementia having to relocate two hours (by car) from his rural home to the city to access a long term care bed, is significantly different from a similar case in Goose Bay, Labrador where the client would have to move to the Island of Newfoundland, an eight hour expensive plane trip away from family and social support.

²¹ Strain, L., and Payne, B, (1997) An Evaluation of Adult Day Care in Manitoba: Final Report. Centre on Aging, University of Manitoba pg. Xviii.

The resilient nature of rural residents was evident in the focus group. One senior expressed the opinion that living in PEI with less advanced health care was one of the “*prices you paid*” for choosing to live there. This senior recognized that, within such a small province, one could not expect to have the same access to specialists as in “*downtown Toronto*”.

In the territories, where remote regions are the norm, the major gaps concern a lack of supportive housing, limited respite services, and inadequate transportation services. Improved training for palliative care is also considered to be critical. Some communities in the NWT, meanwhile, do not have home support workers, and some have no home care nurses. In these communities, nurses will fly in on a regular basis to see clients. The isolated and distant communities have caused problems with the discharge of clients from the major hospitals (i.e., in Whitehorse in the Yukon and Yellowknife in the NWT). Respondents felt that there was a lack of coordination and poor information sharing: “*a big chasm of communication*”. Language can also be a barrier and can create inefficiencies; if a social worker does not speak the language then there will be a need for two individuals to enter the home. Many communities are “*not good socially*”, and it was stated that seniors can be at high risk for financial, emotional and physical abuse.

On a positive note, because of the small size of the population, people generally know where to go, and providers have good collaborative working relationships. But equally, because of the small size, it is simply not feasible to provide all services to every community in the remote northern areas. Most communities have a nursing station that provides a wide range of services to accommodate whatever needs or emergencies may arise. Currently the NWT is developing a continuing care strategy that will have three streams: home and community-based care, facility-based care, and supportive housing. One of the hopes is that the home care program will be expanded significantly.

The development of a full continuum of services for seniors in rural areas has been a constant challenge in most jurisdictions in Canada with its significant geographical size. Issues include referral patterns, service accessibility, professional recruitment and the development of service in rural regions. Disparities in service availability in rural areas, such as the availability of transportation and the availability of a range of housing options for residents, emerged again and again in this study and others.

4.4 Perspective From the Front-Line on the Adequacy of Services: Focus Group with Seniors and Family Caregivers

In the focus group of seniors, participants’ experience with the home care program was limited—not because it may not have been warranted, but because of the limited availability of services. As a result, it is unclear whether the participants were cognizant of the different types of professionals involved. For example, while hospitalized seniors are supposed to be reviewed by the discharge planning department, in reality they did not see them. A couple of participants lamented the lack of home care services—that its “*availability on paper looked good, but in practice, there were too few services to support the number of seniors requiring care in the community.*” The lack of follow-up after a hospital visit was a problem. With day surgery increasing, there was often the expectation that there was family present to support clients. However, this was not always the case. Barriers to discharge from hospital have been recently

cited by Arundel & Glouberman (2001)²² and include: role delineation, human resource availability, resistance to discharge by the family, geographical barriers, rigid systems and management and the lack of human and fiscal resources (p.iii).

From the perspective of the family caregivers there seemed to be a divide, however, between the medical and social aspects of the system. The greatest challenges emerged when the senior had to be supported in the community. Family members were expected to cobble together services with very little public sector support offered. Difficulties arose in accessing reliable, consistent support. Even when a senior lived in residential care, family members continued to offer a significant amount of support to supplement what was available in the residence. Usually, family support was critical in ensuring that medical appointments could be kept (or made) and ensuring that quality of life issues were addressed. Not only did family members provide direct care, they were also mediators, advocates, service monitors, emotional supporters, and navigators for their relatives. This perspective was an experiential reflection of what was learned in interviews with community groups in the four Atlantic Provinces. In all cases, shortcomings were evident in the community-based supports required to maintain seniors with chronic needs.

Many of the barriers encountered in receiving services were created by system constraints. For example, the VON may come in to take blood but then the blood needs to be transported to a lab by the family. One participant described home care as a “*disaster*”, with no continuity and no consistency. One participant’s parents moved from a rural area to an urban area to access services, as there was no transportation available. Even in the urban area, unless family members can offer transport, the cost may be prohibitive. Lack of access to equipment was a major challenge, involving efforts to borrow, rent or purchase from various sources.

Despite the guise of service availability and a system of care, individual experiences revealed many gaps in the accessibility of these services. Both seniors and their family members identified significant challenges in obtaining services and supports to remain in the community.

²² Arundel, C and S. Glouberman (2001) An Analysis of Blockage to the Effective Transfer of Clients from Acute Care to Home Care. A Report Prepared for the Health Transition Fund.

5. RESOURCE ALLOCATION AND FUNDING

The regional variation in access and availability of services noted early in the report was further identified as an issue related to the nature of resource allocation at that level. The key issue is the variability in available programming as delivered by each region. The nature and extent of the financing of services for seniors is reflected in the blockages and barriers to service integration, and in the many gaps identified in the array of services. These barriers and gaps can be related to priority setting at the regional level. One respondent from Québec discussed the difficulty in having sufficient resources for home care, often considered the “*little service*”, compared with medical and/or hospital services.

A good example of priority setting comes from many of the regions where the rationing of homemaking services has allowed for the funds to be reallocated to other programs in the community where it was felt there were more benefits to be had. At the same time, as there was concern expressed by the stakeholder that the region did not want to compromise the health of the individual, it was also made clear that if individuals wanted housekeeping one option would be to pay for it privately. As the respondent commented, the services are “*here to supplement you, not to be all things to you*”.

There were many innovative ideas for improved resource allocation through more appropriate and cost-effective services to seniors, but often this is seen as a one-way valve. One respondent, for example, discussed how home care had developed Home Intravenous IV and Anti-coagulant treatment programs, which meant individuals did not have to spend as much time in the hospital. This saved money for the hospital, but it meant the home care budget had to absorb the additional costs. This speaks to the need to develop more macro perspectives on financing that address the need to acknowledge savings in one sector while not harming the budget of another.

Within the system of care for seniors, the movement of financial resources was relatively limited. In two Atlantic provinces, home care and facility-based long term care were part of a regional system, but even within the regional system, the feeling was that money taken out of the acute care system should allow the maintenance of the current number of beds without additional cost. As in other parts of the country, there were no transfers of funds to other parts of the system to recognize the shift in the site of care. There were some exceptional circumstances (e.g., a psychiatric hospital where money followed the client in to the community for a short-term basis).

Money following individuals through the system was a rare occurrence. In the Atlantic Provinces the cost of the nursing component in a long-term care facility is not a public responsibility. Monies are only allocated to individuals if they have insufficient income and resources to pay the per diem rate. Once a person is deemed eligible for financial support by the government the money will then “*follow the client*” into the nursing home of his/her choice in three of the Atlantic provinces (NS, NB and P.E.I.). In Newfoundland, however, funding is allocated to the nursing home, thus the individual must choose the nursing home where subsidized beds are available. In other jurisdictions across the country, there exists a co-payment for long term care services by both the government and the individual receiving care. In all provinces except the Atlantic region the government typically covers the nursing costs of long-term care. The participants’ contributions are based on a sliding scale and usually do not exceed the maximum

amount of OAS/ GIS. Consequently, the amount paid by the individual varies across all jurisdictions, thereby reducing continuity across and within the continuum of care.

Funding models across jurisdictions are relatively consistent. Provincial ministries provide global funding envelopes to the regions to allocate and deliver the major components of the health systems through their regional structures. In the Yukon, where services are not regionalized, funding of services occurs through the government budget cycle. Differences rest with the determination of the budget. The majority of budget allocations are based on historical data, while some are based on population statistics.

6. FINDINGS REGARDING BLOCKAGES AND BARRIERS TO INTEGRATION WITHIN THE SYSTEM OF CARE

There were numerous barriers to an integrated system of care for seniors identified by the key informants. This section will focus on the barriers within the system of continuing care, but further consideration of the challenges with developing interfaces between the system of care, other health systems and other sectors will be discussed in Section 7.

6.1 Importance of and Support for Community Based Care

One of the major conclusions to emerge from this study is the importance of community-based care to the health and well-being of seniors. The respondents concurred that an integrated system of care needs to have this strong community component but recognized that the shift to community based alternatives needs to be supported. The family caregivers were most vocal, at least in the Nova Scotia region, about the limited availability of community-based services available to help facilitate the transition from the hospital to the community.

Moving care into the community has created a “*state of confusion*” among clients and their families. Once a relatively straightforward process when care was provided under one roof, clients are now trying to navigate a fragmented system of service. Many respondents stated that it was beyond the capacity of frail elderly and suggested that an “*intermediary*” be available to assist with client movement and coordination through the system. Research by Lillis and Mackin (2001)²³ have found that seniors in the US are taking a proactive stance, seeking health care advocates to assist them with the coordination of their care.

In family focus group, participants felt that it was incumbent on them as family members to advocate and support seniors. However, a key theme to emerge in the discussions with family members was the lack of “*navigational aids*” - family members did not know where to go for information or what services were available.

This need for information was evident among consumers as well. Indeed, in one region where services were clearly integrated and a truly seamless system of care was in place, many clients of the system, and those who participated in our focus group, were not even aware of the system. They did not know about a discharge planner at the hospital, and most had no access to home support because of its limited availability. Consequently, as the seniors rightly argued, it may be a great structure, but unless there are resources allocated to it, it is “*all fluff and no substance*”.

Regardless of the reported strained relationship between the federal and provincial governments, it was felt that both levels of government need to realign their thinking to be more responsive to community needs and values. There is no common vision or strategy in general, or for seniors specifically, between the federal/provincial and now regional authorities. Although principles of a national framework on aging were prepared for the Federal/ Provincial/Territorial Ministers

²³ Lillis M. Mackin, K. (2001) The New Navigators. Geriatric care managers forge paths for seniors. Caring April;20 (4):28-9.

Responsible for Seniors in March 1998²⁴, this voluntary guide for provincial jurisdictions has not appeared to influence the development of policy initiatives to the extent it was intended. Further work is required to operationalize the principles made to realize the full potential and utility of the framework.

6.2 Operating in “Silos” versus “Spheres”

A key barrier to integration within the health care sector is the focus on protecting existing programs and services and attempts to increase budgets rather than transfer to other departments or divisions. This silo approach has been discussed extensively in the literature in terms of models of resource allocation. Three themes: funding, accountability and regionalization, emerged from the interviews that identify why these silos remain.

6.2.1 Funding

Constraints on funding have created disincentives to developing collaborative programs and/ or more flexible funding arrangements. The challenge becomes how to live within your budget, which creates incentives to shift budget liability when/where possible. Currently, there is no direction at the provincial or regional levels to indicate that current policies and regulations for funding will change to support a more integrated delivery system.

Funding becomes an issue when regional health authorities are allocated monies to deliver services to their regions that address local priorities, but little funding is allocated towards developing a broader health agenda from a provincial perspective. One respondent stated that *“the system is built on an institutional basis and we need to adopt a population basis of funding. The transition is very difficult and supposes a big change in budget allocation”*.

6.2.2 Accountability

Government ministries aim to be accountable for “their piece of the health agenda” and not the whole health agenda. This has created an atmosphere, in many instances, of fragmented policy strategies that neither support nor complement each other. Respondents talked about the difficulty in holding the system accountable, in particular when *“nobody is responsible for the entire delivery of services”*.

6.2.3 Regionalization

There are regional ‘systems of care’ delivery in almost all provinces and territories across the country. Nova Scotia would be an exception, but plans to devolve continuing care to the nine District Health Authorities are underway. Regional models of care have the ability to direct funding to various sectors depending on the perceived need within that regional context; there can be wide variability in the level of funding allocated to programs which seniors use.

²⁴ Principles of the National Framework on Aging: A Policy Guide (1998). Health Canada Division of Aging and Seniors

The overall thrust of regionalization was to be more responsive at the local community level. In theory this policy objective has been met, however, in reality regionalization has created issues of variability, portability, and access between and among regions. In some instances, where regional authorities are situated on provincial borders, clients have gone to their neighbouring province/ regional authority to get what they believe is a “*better deal*” for community-based services. In response, some regional authorities are restricting access to care for clients only within their own catchment area to ensure dollars are allocated to local needs first.

It was suggested that provincial governments should clarify their role and function vis-à-vis regional authorities and perhaps play a greater role in developing a provincial vision, and goals and objectives, for the ‘collective’ planning and resource allocation that is mindful of local priorities.

6.3 Competition for Funding

The current environment has, in some cases, prevented the development of affiliations and alliances that are necessary for efficiency gains. It was often stated that the efficiency gains came primarily from eliminating services or limiting access. It has been a “*community-arms race*” where each community entity is competing against the other to retain resources. This was of particular concern to non-government organizations both in the private and voluntary sectors. Disincentives to work together are numerous, resulting in inadequate communication within sectors and between sectors, and between providers and clients and families.

6.4 Limited Data for Comparisons

Communication and comparison among specific programs and across provinces and territories are also hampered by the lack of IT infrastructure. Not only are a variety of data gathering tools utilized, the architecture is not in place to share a minimum data set for cross-jurisdictional comparisons to avoid duplication and client burden. Beyond collecting and analyzing data within Canada, it was felt that efforts to gather common data for identifying gaps in the systems would allow for international comparisons that could facilitate the uptake of best practices.

6.5 Labour Instability

In many parts of the country there are reported shortages of home support staff, nurses and therapists, which has meant that some clients have not been able to receive services in a timely manner. In addition, family physicians were also an identified group that had reported shortages. The lack of supply and lack of an integrated labour force in most provinces and territories, create a major barrier to overall system integration. The wage and benefit disparity between institutions for professionals and paraprofessionals has created serious problems with recruitment and retention of staff. Quality of care as measured by responsiveness, continuity, availability and access were also said to be compromised.

An additional labour issue was the availability of effective leaders. Government policy makers suggested that integration – vertically and horizontally – takes bold leadership and a re-engineering of the way departments and ministries fund, allocate and deliver services. It was felt

that “*in some smaller regions the kind of leadership required was hard to find*”. In other cases, less populated rural areas, where key players tend to know one another, offer a positive alternative to the process of integration. Where innovation and leadership exist, efficiencies are apparent, and despite the challenging times, individuals, regardless of where they work along the continuum of care, express enthusiasm for efforts made by the regions towards integration.

6.6 Accessing Information

Information about accessing services is essential regardless of whether a system is integrated or not. As one respondent put it, “*seniors need time to explain, listen and talk*”. It is absolutely critical that information be provided to seniors in an appropriate way (e.g., listings in the telephone book are of little use to the frail elderly, as is Internet access availability for seniors). This was reiterated in the focus group of family caregivers, who recommended that information on available services and how to use them be available in a user-friendly format to family caregivers.

6.7 Lack of Informal Support

The changing nature of the family, the increased presence of women in the workforce and the out-migration of many young people, have made the government expectation that families can “*pick up the responsibility*” for care, out of touch with reality, placing many individual clients and their informal caregivers at social, mental and economic risk.

Several respondents commented that informal caregivers could be better supported and integrated with the formal care system. One respondent from a Health Authority in British Columbia commented that “*we haven’t developed the informal community very well, such as seniors’ support groups ... we need people to help sustain them*”. Similar views were expressed by respondents in Ontario, “*There is a huge capacity for volunteerism – it’s under-utilized ... we need to train and support them properly*”.

6.8 Restrictive Eligibility Criteria

Many seniors do not want to submit to a financial assessment to apply for home care services. Government officials in the Atlantic provinces spoke about the frustration of seniors who had worked hard all their life and saved for retirement – only to be penalized when compared to their neighbour by having to pay the total cost for home support services, other non-nursing services in home care and for long term care placement.

7. FINDINGS RELATED TO LINKAGES WITHIN THE SYSTEM OF CARE AND INTERFACES BETWEEN THE SYSTEM OF CARE, OTHER PARTS OF THE HEALTH SYSTEM AND SOCIAL SERVICES

7.1 Linkages Within the System of Care

There are five components that are needed to insure integration along the continuum of care (Hollander, 2001): Mechanism for single entry, a coordinated assessment and placement process, a coordinated and ongoing case management function, a single administrative and funding structure and a consistent client classification system. The information provided from our key informants will be compared and contrasted to these five components.

7.1.1 Single Entry

Hollander (2001) outlines the single entry assessment model as one of five best practices, which are used to promote an integrated continuum of care. The single entry assessment model provides care only for those with assessed needs, ensuring that unnecessary services are not offered. Further, the single entry model provides the consumer with a single entry point into an integrated system offering comprehensive services across the health care continuum.

Single entry assessment models to a full continuum of care are used across the country. Regardless of the model of care (e.g., RHA, CCAC, Health District, CLSC), a single point of access was seen as a pivotal infrastructure for the integrated delivery of care. There were many examples of improvements in linkages throughout the provinces. The Single Entry Access model underway in Nova Scotia is a prime example of significant strides being made in integration across home care and long term care – one that has been developed over the past few months. In Newfoundland, the devolvement of home care to a regional system, the single entry system to home and long term care with one assessment process, and the current proposal to integrate home support for both seniors and adult with physical disability are considered by some as a great improvement. The extent to which single entry facilitates integration across service sectors is predicated, on the most part, on availability, access and regional policies.

7.1.2 Coordinated, Integrated Case Management

Case management is an integral part of a coordinated and integrated system of care to ensure regular monitoring and reviewing that the client obtains the right amount of care in the right place. Key informants also spoke about the centrality of case management in an integrated system. Case management as a publicly funded core service is meant to facilitate integration within the health and continuing care system as well as among health/continuing care and other sectors. Informants were quick to provide the reality check that the concept of case management did not always ensure integration. The high caseloads of care managers were viewed as a deterrent to connecting the individual client to appropriate resources. Study respondents felt that a large gap existed between the “*perceptions and the discourse*”²⁵, between what case managers

²⁵ Davies, B., Fernandez, J., and Saunders, R. (1998) Community Care In England and France: Reforms and the improvement of equity and efficiency. PSSRU, University of Kent.

systematically assessed as needed by their clients and what the circumstances, policy priorities, and prevailing organizational ideology allow.

At the micro level, the clients viewed case management as a critical factor to enabling successful outcomes. The general consensus in the focus group was that integration was highly dependent on individuals. As one senior stated – “*if you were lucky enough to come across someone who was willing to go to bat for you, you would be all right*”. Obtaining the ‘right’ case manager was viewed as a major factor in being able to navigate services. A representative of voluntary agencies noted “*it depends who you get*” suggesting the concept of case management is only as good as the case manager involved.

7.1.3 A Single Administrative and Funding Structure

Hollander (2001)²⁶ described the positive aspects of a single, system level funding structure to achieving an integrated system of care. He noted that a single system level funding structure would allow funds to be transferred between services to reduce compartmentalization of funds and improve efficiencies within the system as a whole. Results from the interviews revealed that within the system of care for seniors, the movement of financial resources was relatively limited. In most provinces, home care, facility-based long term care and hospital based care were part of a regional system, but even within the regional system, the feeling was that money taken out of the acute care system should allow the maintenance of the current number of beds without additional cost. As in other parts of the country, there were no transfers of funds to other parts of the system to recognize the shift in the site of care. There were a few exceptional circumstances, (e.g., when a psychiatric hospital closed over a decade ago, the money followed the client into the community on a short-term basis).

7.1.4 Coordinated Assessment, Placement and Classification

Effective communication and coordination of services along the continuum of care is required to meet the often complex and time-consuming needs of the elderly client. Several respondents discussed having to coordinate clinical, social, environmental, and pharmacological supports for clients being discharged from the hospital or being referred directly to home care by physicians or family members.

A clear and coordinated care pathway involving assessment, care planning and continuity is paramount at the interface of change between services. A coordinated system level assessment and placement practice work to ensure that the care plan developed for the client closely matches the determination of need of services, reducing duplication of services and providing seniors with the opportunity to remain in their home for as long as possible. To facilitate this all the provinces have implemented a coordinated assessment and placement practice. Nova Scotia is currently rolling out their single entry access (SEA) assessment and placement process for seniors.

²⁶ Hollander, M. & Pallan, P. (1995) The British Columbia continuing care system: Service delivery and resource planning. *Aging: Clinical and Experimental Research*, 7(2), 94-109.

Concerns were articulated about the lack of a standardized assessment tool agreed upon at the regional/ provincial levels. Currently, there are a myriad of assessment tools that range from “*home grown*” to those that have been “*rigorously tested for validity and reliability*” in each of the care settings between provinces, regions and sectors. For many respondents the first step was to have an assessment protocol that would reduce duplication and facilitate information sharing and communication.

To ensure that an analysis of clients can occur between and among service/sector components, a consistent client classification system is necessary to promote and measure efficiencies. The classification system matches resident information system with variables for classifying residents into homogeneous resource utilization groups for equitable payment and for quality monitoring of process and outcomes adjusted for case mix.

7.2 Interfaces Between the System of Care, Other Parts of the Health System and Social Services

In addition to the factors identified above as facilitating integration within a system of care, the interfaces between the system of care, other health systems and social services were analyzed from the responses to the key informant interviews. Respondents provided positive and negative examples of interfaces across the systems—highlights from the data are provided below.

7.2.1 Coordinated Interaction Among Different Providers

There are many examples from the key informant interviews where specific RHAs or Provincial Governments had initiated and coordinated interaction among different providers or levels of government. In Alberta, for example, one regional health authority has a Care in the Community team with providers from different care sectors (geriatricians, home care, long term care acute care) collaborating with one another (e.g., Falls Assessment Clinic). This reflects a noticeable shift in the past few years towards greater levels of collaboration among providers. Further efforts in Alberta through their *Cross Ministry Seniors Policy Initiative 2001-02*²⁷ being lead by the Ministry responsible for seniors (the only Ministry dedicated solely to meet the priority needs of seniors), involves 16 other ministries and government entities.

Seniors Secretariats or Ministries were highlighted as opportunities to bring ministries together to review the impact of policy proposals and implementation on existing programs and services. In PEI a government Population Strategy Working Group for Seniors identified the need for more coordinated efforts across government and recommended the creation of a designated office reporting to the Minister Responsible for Seniors. In Nova Scotia, government informants suggested “*Integration is helped by putting the basket of services to seniors under one administration*” in reference to the recent transfer of the Office of the Senior Secretariat, adult protection and other seniors services to the Department of Health.

In addition to cross-departmental initiatives, cross-jurisdictional initiatives were viewed as contributing to the overall integration of services. In Newfoundland, the integration of regional

²⁷ Internal Document. Moving Forward with Confidence. Alberta Seniors. Cross Ministry Seniors Policy Initiative 2001-01

systems of care with federally funded programs for various aboriginal groups differed depending on the group involved. Within PEI, the home care program and the Veteran Affairs program have a collaborative case management system in place to reduce duplication and overlap of services.

7.2.2 Governance

Governance was viewed as both a barrier to, and a facilitator of, integration. New regional governance structures assist with local planning and coordination. The governance and accountability mechanisms between regions and the provincial governments, however, appear to be more problematic and unclear. It has been stated that true clinical integration will only be possible when solid governance, management, and systems infrastructures are in place.²⁸

7.2.3 Enhanced Communication

The enhanced role of communication, which facilitates respect and understanding of the varying perspectives of different system components, was clearly identified as a critical success factor for integration. One example is the transition staff in Calgary that work to improve the transition from the acute care to the home for an individual. These workers spend a day out ‘*in the field*’ with a home care nurse—again to enhance understanding.

7.2.4 Learning from the Rural Experience

The initiatives developed in rural communities may provide insight as to how the total system of care can enable more linkages with other health care sectors and with social services. In the interviews with representatives of both government and voluntary organizations in the Atlantic region, mention was made of the small pool of professionals working in the region and how this may or may not facilitate integration. In some cases, for instance, the OT was hired by the RHA to work in the acute care setting, the facility and with home care clients. In this way not only was there continuity of care, there was also continuity of personnel. Seniors in the focus group recognized the innovative approaches to integrated systems by physically locating services under one roof in the community. One participant spoke about how the integrated services in the community health centre in his region help to bring related services together under the same roof as the doctor’s office.

7.2.5 Coordinated Case Management

“There is an increased recognition of the need to work together, but we’re a long way from being seamless without the need for a strong client advocate”

Across sectors a coordinated and integrated case management process is an important system feature to help individuals and families to navigate and coordinate their desired care regardless of the nature of the service—housing, income support, home care, long-term-care, etc. There is a need to *“have better accountability through integrated case management ... we need to know*

²⁸ Labb DA (1999) Healthcare Executive: Integrated healthcare delivery. How are we shaping up? Jul-Aug;14(4):8-12

whose responsibility is this client anyway". Case management emerged as an important link between sectors through the coordination of care. It was felt that more expansive coordination would lead to an even more effective array of services provided to seniors.

In New Brunswick the partnership among the Extra Mural Program, Family and Community Services and Mental Health in their single entry assessment model was identified as a model to help facilitate an integrated case management approach. In Saskatchewan the same case manager follows the client even after the client is discharged.

7.2.6 Discharge Planning

Discharge planning (or admission planning) was seen as a critical link between the acute care systems and continuing care systems. In many cases the hospital discharge planner was either an employee of the home care program or was integrated with the home care program by various means, such as the use of common assessment tools.

7.2.7 Community Health Boards

Single entry advisory boards and community health boards have representation from various sectors, such as housing and community services, which assist with integration. In some areas these local board may also have representatives from constituents' groups (for example, representatives of various aboriginal groups - Métis, Inuit and Indian, seniors, and people with disabilities). One Newfoundland informant suggested *"In a totally integrated board with acute care, continuing care and home care [among others], integration works when the board and the senior management are community minded – otherwise the acute care will dominate"*

7.3 **Challenges with Interfaces Among the Sectors**

One of the same challenges to integration within the health and continuing care system also affects the interfaces between and among various components of the health care system is the ability to see the service spectrum as a single unit and not as a number of different silos. There needs to be a clearer vision as to what the service system for seniors will look like. *"If you look at the two ends of the continuum there is good service. It's the mid-area that gets really clouded – it's still a major struggle for the different services to work together"*.

7.3.1 Silos Continue

Almost all respondents recognized the challenges that were in place because of these bureaucratic models of service delivery. *"We need to get out of the silos that bind departments"* or a similar statement –was articulated by almost all the respondents as a major barrier to integration along the continuum of care. Because of limited resources and the need to protect what some feel is their territory or area of expertise, discussions at the senior policy level may be construed as theoretical in nature. Indeed, the data suggest that it is the government informants who are more likely to highlight the initiative underway to promote cross-departmental and cross sector integration. True cooperativeness with various levels and types of services for seniors

were often only successful in areas where the senior policy makers themselves were able to come to agreement prior to sending it out to the front lines.

7.3.2 Communication Problems

There is a “*lack of communication between various components of the system – turf is a factor*”. While initiatives have been outlined above which highlight attempts to improve communication, there continues to be a lack of understanding across sectors. As one government official exclaimed “*hospital workers have no idea of what people are coping with in the community*”. It was felt that the system failed to recognize the expertise in the community for providing care and support to seniors.

7.3.3 Different Philosophies Underlying the Medical and Social Sectors

In several provinces it was noted that there were different philosophies underlying the eligibility criteria for accessing support. These philosophies range from a model of universal access based on need in the hospital and for the nursing/professional home care services, to one with ‘generous’ sliding scale subsidies for home supports, to one that provides income-tested support for long-term care and home care. These differing philosophies cause significant tensions in the system and across the system. For example, in New Brunswick the strength of the linkages within the health care sector is exemplified by the integrated assessment between mental health and the extra mural hospital. While this provides for greater integration, there are also some key weaknesses related to the fact that two systems are based on different values– one follows a medical model and the other a social welfare model.

Analysis of the focus group with family caregivers also pointed to this divide between the medical and social aspects of the system. Despite their positive experiences with the medical system, their greatest challenges emerged when the senior had to be supported in the community. Family members lamented the lack of community-based services and the pay-out-of- your-pocket approach to any that were available.

7.3.4 Role of the Family Physician

The family members and the seniors viewed the role of the family physician as essential to the interfacing of the systems of care. As the main point of entry and referral, family physicians play a pivotal role in facilitating access. For the most part, family members reported excellent experiences with the medical system, citing the family doctor as being extremely important, and specialists and hospital services as being very good. Family doctors offered coordination and ongoing monitoring as well as keeping the family informed. Site teams, such as the stroke team, were also excellent resources to both the senior and the family, offering diverse expertise and information.

There is a continuing trend to discharge people out of hospital quicker, an expectation that the required services can readily be provided in the home, or that there are empty beds waiting in long term care facilities. One respondent felt that doctors were not well integrated into the home care system and this created problems because they did not understand the assessment process

involved in home care. *“They can write the orders in hospital and these services will be provided - it is not the same in home care where an assessment is made. The doctor doesn’t write the order for [home care] services (at least not in most provinces).*

Another difficulty for rural seniors, in particular, was the limited availability of physicians in certain areas. Many seniors in the focus group on PEI focused on the limited availability of physicians and the increasing number of people who had no family doctor. They felt that this was an added cost to the system. Seniors (and others) sometimes had no alternative but to go to the hospital emergency room and wait for hours to see a physician. Also contributing to the misuse of high cost services was the limited availability of hospital beds – getting a bed was often only viewed as possible by going by ambulance – this approach was viewed (even by doctors) as the only way to be admitted to the hospital.

The family physician is a significant player in the continuum of care as they were often reported as the primary point of entry into the system for seniors. And to date, physicians have not been considered as part of the ‘care team’ for seniors in the community-based setting. Respondents commented that that should change, but the question was *“how”*? Efforts in Quebec to improve the interface between family physicians and CLSC involve the implementation of ten units of the Groupe de médecine familiale. Each group will be associated with a CLSC. The notion of greater physician involvement and improved client outcomes is supported by the literature. The composition of the physician workforce, with an appropriate balance of primary care and specialty physician supply, is an important predictor of health outcomes²⁹.

²⁹ Jeanne M. Ferrante, MD, Eduardo C. Gonzalez, MD, Naazneen Pal, MPH, Richard G. Roetzheim, MD, MSPH, (2000) Effects of Physician Supply on Early Detection of Breast Cancer *J Am Board Fam Pract* 13(6):408-414

8. HOW TO IMPROVE INTEGRATION ALONG THE SYSTEM OF CARE

Overriding all the concerns and suggestions for improvements is the issue of whether the system is adequately funded in the first place. If not, then the ability of an integrated system to realize its full potential will be compromised, as will any evaluation of its effectiveness compared to the current models of delivery.

When asked how to improve the nature and extent of integration both within the system of care for seniors and across the broader health and social services sectors, respondents recommended a range of specific and more systemic changes. Some respondents focused on points and processes whereby the entire system could become (and in many cases was attempting to become) more integrated, while others expressed a desire for integrated approaches solely by how the system works cohesively for each individual client. A synthesis of the respondents' suggestions is outlined below.

8.1 A National Framework

Most provinces had undergone policy reviews and self-examination of how to improve their system of care for seniors. Although a voluntary policy framework for seniors does exist at the national level, several respondents were not aware of its existence. They re-emphasized the need for a Canadian policy framework for seniors specifically, and several provinces suggested that a policy division or secretariat focused on seniors' issues would help facilitate and/or improve integration.

8.2 Increased Funding

If care for seniors is to be more inclusive, that is providing both medical and social components of care, then funding for these added services must be available. In addition to more federal funding to support all aspects of continuing care, there needs to be the ability for funding to follow the client from one sector to another to ensure gaps and barriers to adequate service levels are diminished.

8.3 Formal Mechanisms with Authority to Act

At the provincial level, there is increasing recognition of the need to understand how proposed policy changes in one sector (e.g., housing) will impact upon other sectors in the overall continuum of care. Recommended initiatives to improve integration among the broader system of care included multi-sector participation on interdepartmental committees by senior management officials at the provincial level. As one respondent aptly explained, some people think 'structure' will result in integration - "*build it and it will happen*". However, it was often felt that inter-governmental committees were often given a mandate "*without teeth*", which was not proving effective or efficient. Any efforts to formalize mechanisms for collaboration between sectors should also be given the mandate and authority to evoke change in the system.

8.4 Ratify the Core Components of Continuing Care

The differences between acute care and continuing care systems in terms of an individual's responsibility for the cost of services frequently emerged as an issue. Respondents in the Atlantic region, in particular, outlined the differential costs for the individual associated with receiving care in the hospital where services, supplies, medication etc. were insured, compared to the costs associated with receiving this care in the community where they could be considerable. One approach suggested by a respondent would be to separate the care (nursing) costs from other costs (i.e., the shelter or room and board costs in the long-term care facilities). Another suggestion was "*to find a more equitable funding mechanism - an alternative to means testing*" such as a co-payment system based on income levels and not on an individual's assets. There was also a need expressed for a common understanding and definition of the overall continuum of care – not just for service providers, but also for the general public. There is a need to manage expectations to recognize that home care is not the "*be all and end all*". The effectiveness of the core and essential elements of home care should be evaluated and the results communicated to service providers. Improvements could be made to the system based on current research.

8.5 Understand the Implication of Regionalization

In order to provide more detailed suggestions on how to ensure a greater level of integration, respondents felt more in-depth research at the regional level was required. Regionalization has facilitated the gathering of local data to plan and delivery the most appropriate services to the region. However, research is needed to address the following questions: How has regionalization responded to cost containment? What have been the implications of regionalization for a fully integrated system of care for seniors? Collecting data at the regional /local level would provide much greater insights into the issues, gaps, and barrier to integration

8.6 Start with the Individual – Client-Centered Approach

The underlying philosophy of the localized approach was the client-focused system of care delivery. While this approach was far more common in interviews with officials working with adults with physical disabilities, its philosophy and language were evident in seniors as well. Indeed, in Ontario it was noted that the role of the Community Care Access Center case manager, working within a hospital, is vital to an integrated system. It was suggested that these case managers could play a greater role in the discharge process in hospitals to improve integration between the sectors. This would realign the nature of care towards 'admission planning' to home care as opposed to 'discharge planning' from the hospital; a subtle but significant change in phraseology and approach to care. The adoption of the Client Centered Service Approach (CCSA) would ensure that clients with complex needs would receive the right service at the right time by the right person. Veterans Affairs Canada³⁰ has adopted a client centered approach to service that includes the following:

- Identifying the individual needs of the client and then determining how best to provide assistance, through internal, or a coordination of, departmental and community resources;

³⁰Veteran Affairs Canada: Client Centred Approach <http://www.vac-acc.gc.ca/providers/sub.cfm?source=approach/implement>

- Developing a partnership between the client and the provider as demonstrated through direct client involvement in all aspects of their care planning decisions;
- Ensuring staff work with the client to meet all their needs, not just to determine their eligibility for services and benefits; and
- Delivering services.

8.7 Suggestions of Family Caregivers

Participants in the focus group with family caregivers proposed creative and realistic strategies for improving the system. Some would increase the availability of particular services and “*raise the bar*” for the actual level of services provided to maintain people at home. Others would like to see more options available, such as convalescent homes and respite. Some suggestions that emerged were:

- Improved access and coordination for community-based services, particularly home care;
- Better links and communication between the sectors and between families and systems;
- Case management model;
- Access to affordable medications;
- Improved training for all caregivers;
- Attention to continuity of workers to minimize the disruption of having many workers coming in to a person’s home;
- Improve assessment process; and
- Education at all levels, starting in the schools.

9. CORE COMPONENTS OF AN INTEGRATED SYSTEM OF CARE FOR SENIORS

Based on the information gathered from a variety of stakeholders across the country, several core components were identified are depicted in Figure 1 clustered under the following 3 headings:

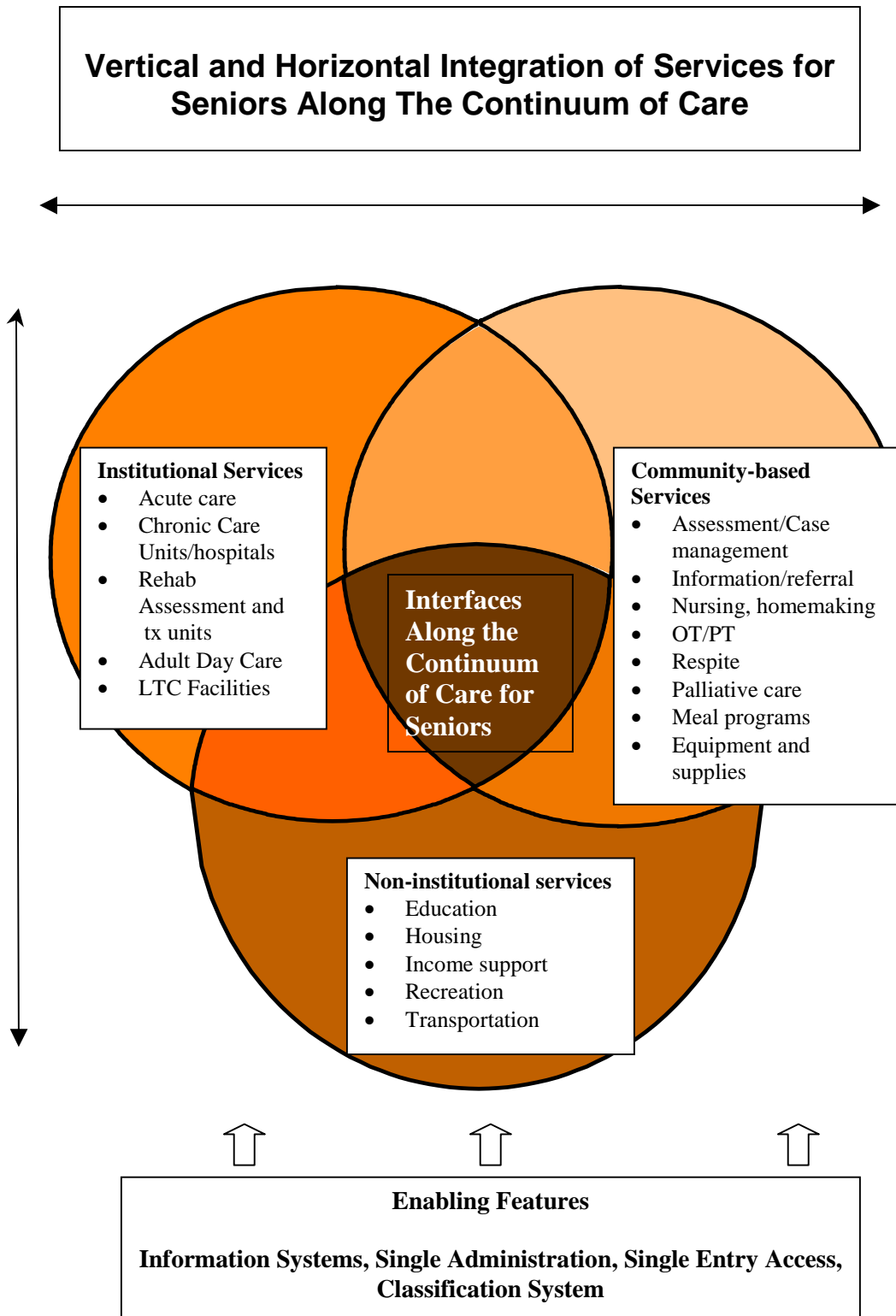
- *Institutional services*: acute care, chronic care units/ hospital, rehabilitation assessment and treatment units, chronic-care units/ hospitals, rehabilitation assessment and treatment centres, Adult Day Care, long-term-care facilities;
- *Community-based*: assessment and case management, information/referral, nursing, homemaking, occupational and physiotherapy, respite, palliative care, meal programs, equipment and supplies, and;
- *Non-institutional services*: education, housing, income support, recreation, and transportation.

Definitions:

Horizontal integration: refers to a network of organizations within one sector (health) that provides or arranges to provide a coordinated continuum of services (institutional, community-based, non-institutional) to a defined population and is clinically and fiscally accountable for the outcomes of health status of the population served.

Vertical Integration: refers to the joining together of “disparate” and differentiated social systems (health, education, social, recreation, housing) organizational elements to achieve a unity of purpose.³¹

³¹ Finding the Seams (2001): A Report Prepared by the System Linked Research Unit, McMaster University. Page 4



Note: Figure Adapted from the work of Marcus Hollander and McMaster University: System Linked Research Unit.

10. SUMMARY AND CONCLUSIONS

Despite the rhetoric of a shift to community-based care, the reality is that services have been cut in institutional sectors and not enhanced in the community; resources have not been transferred or created. A great deal of responsibility for ensuring that care is coordinated or even accessed falls on families. Their task is made more difficult by the gaps in service availability and the minimal amount of capacity in existing services. There is recognition by both government and community-based stakeholders that strict eligibility criteria impede access to services.

The evidence supports the existence of a two-tiered system for seniors across the country. For community dwelling seniors, those who can afford to pay can access scarce support services and those who cannot pay are restricted to a minimal level of publicly funded services, or none at all if they are above the income eligibility levels but still in low-income brackets. Beyond the inequities is the potential to escalate lower level needs into higher, more expensive categories of care. The Atlantic region is somewhat unique in that it does not have the economic base to pay for such services as universal nursing care in long-term care settings as is done in other parts of the country.

Issues related to human resources are of great concern to all stakeholders. The shortage of qualified professionals, particularly family doctors who traditionally have been the gatekeepers, presents a challenge to seniors who are having difficulty finding someone willing to take on complex care or to advocate for them in accessing services. Other shortages such as rehabilitation professionals and qualified home support workers seem to disproportionately disadvantage seniors as well. Respondents referred to inequitable access, scarcity, and underfunding of rehabilitation personnel as being evident at all points along the continuum. The biggest gaps in the continuum of care as identified by those who work in the community based sector and the focus group of family members assisting seniors are in the community support services. This presents a major challenge, as it is this very support that often mitigates use of other parts of the system.

In operationalizing a holistic approach to seniors' services, which seems to be a shared objective, both the government and community-based groups struggle with different constraints. For the government, these constraints are often apparent in the 'institutional' organization of departments with different budgets and accountabilities. Community agencies, on the other hand, are often organized to offer specific services and may be unable to expand their mandates, because of lack of human or financial resources and expertise.

Community-based organizations play two roles as advocates and as providers of services for their populations, and are recognized and valued by all stakeholders. These roles have grown over the last number of years as community-based organizations have found themselves responding in more extensive ways as a result of system changes and client demand. The significance of these agencies as advocates was illustrated by respondents in one province (New Brunswick) who indicated that the lack of a strong voice for seniors at the provincial level was a concern, as their needs may not get reflected in policy decisions. In some provinces, seniors were directed to community-based groups for services. However, these groups usually did not receive any – or additional – funding for an expanded responsibility.

Case management is seen as a pivotal component for an integrated system, with the pivotal person being the case manager. However, the effectiveness of this key role was highly dependent on “*who you got*”. In fact, a common theme for both government and community based respondents was acknowledgment that a great deal of success in navigating the system and accessing services depended on the person within the system with whom the client worked. From a system perspective, individual personalities are quite influential in moving integration ahead (or hindering it). A person’s acceptance of broad client-focused goals and a willingness to let go of “*turf*” are enabling factors. At the community level, particular people were viewed as strengths in the system and were seen as having the ability to work across components of the system to put things in place.

There is evident willingness of both community-based groups and government to work towards a better system, with integration of services as a goal. For those in the public sector, this was most clearly expressed in efforts to integrate departments and jurisdictions, an approach that may be too narrow if it fails to recognize the community organizations as full partners in the system. Community agencies saw themselves playing a significant role, responding to many unmet needs, but felt that their expertise was not always recognized. The synergy of both sectors is crucial for a true continuum; **neither can function fully and effectively without the other**. Examples of initiatives that did bring together diverse stakeholders were evident in every province. Achieving integration will draw on new ways of working together with tangible recognition of the public sector, private/community sector and the clients as key players in the whole continuum.

Overriding the discussions on an integrated system is consideration of what integration can actually facilitate. Our key informant interviews confirmed that an integrated system should contribute to the independence of seniors in the community. It is clear that the provision of services and support in an individual’s home is critical, hence the growing concern about the reductions in home support services.

There appeared to be interest and support from our informants that the system of care requires a local community-based approach that enhances community development and prevention. These would be coupled with enhanced information sharing regarding services available on the local level. The backbone of such a system would be information technology that would:

- 1) Enable coordinated assessment and care among providers; and
- 2) Could provide information, not always via computer, that would facilitate seniors and family caregivers as they navigate the system.

Finally, this study has identified a recent growing trend towards integration that is evident in the various systems of care across the country. Such developments need further impetus and direction to ensure that the care required for seniors is seamless and responsive to their needs.

This report has identified, and confirmed from the literature, the numerous issues, gaps and barriers to integration that must be addressed. The challenge is to strategically undertake this in such a way that coordinates policy changes at the macro level with the essential system features required for integration at the local, community-based delivery level.

Appendix 1 - Stakeholders Interviews Conducted

Province/Territory	Government	Health Authority	Service Provider	Consumer Organization/ Research
Alberta	1	1	4	4
British Columbia	1	2	2	3
Manitoba	2	2	1	1
New Brunswick	2	1	2	1
Newfoundland	2	2	1	1
Nova Scotia	2	0	1	2
Nunavut		1		1
NWT	1	2		3
Ontario	2	1	2	3
Prince Edward Is.	2	1	1	1
Quebec	1	2	1	4
Saskatchewan	2	1	1	3
Yukon	2	1	0	0

Appendix 2 –Stakeholder Affiliations

Nova Scotia

NS Department of Health- Home Care Division
NS Department of Health- Long-term Care Division (2 respondents)
NS Group of Nine-Coalition of Seniors Organizations
NS Heart and Stroke Foundation
Shannex Inc.

PEI

PEI Continuing Care Dept of Health and Social Services (2 respondents)
Continuing Care, Queens Health Region
PEI Senior Citizen Federation
Alzheimer's Society of PEI
Connolly Home Health Care

New Brunswick

NB Family and Community Service (2 respondents)
NB Extramural Region
VON Moncton
Third Age Center, St. Thomas University - Advocacy Group for Seniors
Harvey Outreach for Seniors

Newfoundland

Home and Community Care Labrador region (Paddon Home)
Geriatric Day Hospital, L.A. Miller Centre
Home Care and Community Care St. John's region
NFLD Seniors Resource Centre

Quebec

Community Follow-up (adult respite)
Renee Cassin: CLSC
Ministere de la Sante et des Services sociaux
Universite de Laval
School of Nursing (McGill University)
Catholic Health Association of Canada
Montreal: CLSC
Council of Seniors

Ontario

Western University (2 respondents)
Canadian Pensioners Concerned
Division of Aging and Seniors
Canadian Association of Community Care
Canadian Ethno Society
Seniors and Caregivers Support Services

VON Canada
Ontario Provincial Palliative Care
Consumer (2 respondents)
Government, Seniors Secretariat, Ministry of Citizenship
CCAC National Advisory Committee member, Respite Care Project
Consumers Ass. Can
Palliative Care Prog Co-or

Manitoba

Manitoba Seniors Directorate
Manitoba Council on Aging
Ministry Responsible for Seniors (3 respondents)
Manitoba Rep. Palliative Care (St. Boniface Hospital)
Chair of Home Care in Manitoba

Saskatchewan

Health Districts (4 respondents)
Community Care Branch-Sask Health
Saskatchewan Gerontology Association
Saskatchewan District Health
Support Services Community Care Branch

Alberta

Kirby Centre (3 respondents)
Calgary Regional Health Authority (2 respondents)
Alberta Government, Seniors Services
Alberta Senior, Advocate

British Columbia

BC Government, Office for Seniors (2 respondents)
Vancouver Regional Health Board
Capital Regional Health Authority
Schizophrenia Society

Yukon

Department of Health and Social Services (2 respondents)

Northwest Territories

NWT Government (2 respondents)
Deh-cho Health Social Services
Hay River Community Health Board
Inuvik LTC Facility
YWCA

Appendix 3: Project Summary

ANALYSIS OF INTERFACES ALONG THE CONTINUUM OF CARE

Federal, Provincial and Territorial Ministries of Health, and Health and Social Services, have expressed a need to have more information about issues related to what makes for an integrated continuum, or system, of care delivery for a number of population groups including seniors, adults with disabilities, adults with mental health concerns, and children. Health Canada has recently funded Hollander Analytical Services in Victoria, B.C. to oversee the Analysis of Interfaces Along the Continuum of Care study that will examine this issue directly.

The study is being conducted by four teams. Each team will be responsible for collecting information on care delivery for one of the specified populations from across Canada. Input will be sought from policy/decision makers (e.g. federal/provincial/territorial officials) as well as individuals who are affected by the services (e.g. service providers, consumer groups).

Study information will be collected using phone surveys and focus groups. The phone interviews will take approximately one hour. They will look at what the commonly used health related services are for the population of interest, how well these services are integrated into a system of service delivery, how well they are linked to other parts of the health system, and how well they are linked to services outside of the health system. We will also ask respondents what they think makes an effective system of service delivery, what they see as blockages or impediments to an effective system of service delivery, and what suggestions they may have for improving the system of service delivery. The focus groups will take one to two hours. They will obtain information from consumers, families, and consumer groups regarding service delivery. Each team will conduct approximately 80 phone interviews and two focus groups.

Participation in the study is completely voluntary and each person has the right to refuse to participate. Respondents may also refuse to answer any questions during the study. They may also withdraw at any time, without explanation. All responses will be confidential. No information that could identify individual respondents will be reported.

The final report, which is scheduled to be completed by August 1, will include findings on each of the populations under investigation. It will also contain an analysis of the findings which will include: new or reformulated conceptual models; in depth discussion of the blockages to effective service delivery and the opportunities for more integrated care provision; and analysis of the transferability or commonality of findings across jurisdictions. The results of the study will provide federal, provincial, and territorial decision makers with the evidence they need to improve the way health services are organized and delivered across Canada.

RÉSUMÉ DU PROJET D'ANALYSE DES INTERFACES DU CONTINUUM DES SOINS DE SANTÉ

Les ministères provinciaux, territoriaux et fédéral de la santé et des services sociaux ont dit vouloir obtenir davantage de renseignements sur la façon d'unifier un continuum ou un système de soins de santé destiné à un certain nombre de groupes démographiques, dont les aînés, les adultes handicapés, les adultes ayant des problèmes de santé mentale et les enfants. Santé Canada a récemment accordé du financement à la société Hollander Analytical Services, située à Victoria, en Colombie-Britannique, afin qu'elle supervise l'Analyse des interfaces du continuum des soins de santé qui abordera directement cette question.

Quatre équipes se chargent de l'étude. Chacune a la responsabilité de recueillir des renseignements concernant la prestation, partout au pays, de soins de santé à l'un des groupes démographiques mentionnés. On demandera l'opinion de décideurs et de responsables des politiques (p. ex., les responsables des gouvernements provinciaux, territoriaux et fédéral), ainsi que des personnes touchées par les services (p. ex., les fournisseurs de services et les groupes de consommateurs).

On effectuera des sondages téléphoniques et on mettra sur pieds des groupes de discussion afin de recueillir les renseignements qui serviront aux fins de l'étude. Les entrevues téléphoniques dureront environ une heure. Elles nous permettront de savoir quels sont, pour les personnes cibles, les services de santé les plus souvent utilisés, à quel point ces services sont intégrés à un système de prestation de services, à quel point ils sont liés aux autres éléments du système de santé, et à quel point ils sont liés à des services extérieurs au système de santé. Nous demanderons aussi aux personnes qui répondront au sondage ce qui, à leur avis, permet à un système de prestation des services d'être efficace, ce qui pourrait constituer un obstacle à l'efficacité du système de prestations de services, et ce qui pourrait améliorer le système de prestations de services. Les réunions des groupes de discussion dureront d'une à deux heures. Elles permettront d'obtenir l'opinion des clients, des familles et des groupes de consommateurs au sujet de la prestation de services. Chaque équipe effectuera environ 80 entrevues téléphoniques et mettra sur pied deux groupes de discussion.

La participation à l'étude est entièrement volontaire et chaque personne peut refuser de participer. Les participants peuvent aussi refuser de répondre à toute question au cours de l'étude. De plus, ils peuvent abandonner à tout moment sans fournir d'explication. Toutes les réponses resteront confidentielles. Aucun renseignement concernant les personnes qui auront participé ne sera divulgué.

Le rapport final, qui devrait être terminé d'ici le 1^{er} août, comprendra les conclusions au sujet de chacun des groupes à l'étude. Il fournira aussi une analyse des conclusions et inclura les modèles conceptuels nouveaux ou reformulés, une analyse détaillée des éléments qui nuisent à l'efficacité de la prestation des services et à la possibilité de fournir des soins de santé plus unifiés, ainsi qu'une analyse de la transférabilité ou de la mise en commun des conclusions entre les différentes compétences. Les résultats de l'étude fourniront aux décideurs des gouvernements provinciaux, territoriaux et fédéral les éléments dont ils ont besoin pour améliorer l'organisation et la prestation des services de santé partout au Canada.

Appendix 4 List of Services

List of Services, and Definitions, the Seniors Population.

Commonly used Services	Publicly Funded Services				Comments
	1) Yes	2) No	3) Mix	3) Should be	
Home and Community Services					
Assessment and Case Management constitutes a process of screening clients, conducting assessments, determining care needs, determining eligibility, making referrals to appropriate services, admitting clients into service(s) and providing for the ongoing monitoring of care requirements, including the revision of care plans, and discharge planning. Assessors/Case Managers may also conduct financial assessments, act as client advocates in facilitating care provision and manage facility waiting lists.					
Meal Programs are generally voluntary community services that deliver a nutritious hot, or frozen, meal to the homebound client (Meals-on-Wheels) or bring the client to a congregate setting to have a meal (Wheels-to-Meals). The goal of Meal Programs is to supplement a client=s diet by delivering an attractive nourishing meal to help maintain or improve health. Governments may pay for some of the costs of this program, e.g., cost of meals, transportation subsidy.					

Commonly used Services	Publicly Funded Services				Comments
	1) Yes	2) No	3) Mix	3) Should be	
<p>Homemaker Services are provided to clients who require non-professional (lay) personal assistance with care needs or with essential housekeeping tasks. Personal care needs may include help with dressing, bathing, grooming, and transferring, whereas housekeeping tasks might include activities such as cleaning, laundry, meal preparation, and other household tasks. Homemakers may have post secondary training to the same level as Aids and Care Attendants and may provide similar types of personal care services. Specific nursing and rehabilitation tasks may also be delegated to Homemakers. Homemaking can also be provided as a respite service.</p>					
<p>Home Care Nursing provides comprehensive nursing care to people in their homes, generally by registered or psychiatric nurses. A home care nursing program coordinates a continuum of nursing services designed to support clients of all ages to remain in their homes during an acute, chronic, or terminal illness. This community based program provides nursing care in the client=s own environment. Home care nursing encourages clients and their families to be responsible for, and to actively participate in, their own care. Thus, teaching and self-care are promoted. Goals for home care nursing can be curative, rehabilitative, palliative, or supportive.</p>					

Commonly used Services	Publicly Funded Services				Comments
	1) Yes	2) No	3) Mix	3) Should be	
<p>Community Physiotherapy and Occupational Therapy provide direct assessment, treatment, consultative and preventative services to clients in their homes to monitor, rehabilitate, or augment function, or to relieve pain. Therapists may also arrange for the necessary equipment to manage the clients= physical disabilities and may train family members to assist clients. Community physiotherapy and occupational therapy programs also may provide consultative, follow-up, maintenance, and educational services to clients, families, physicians, other health providers, hospitals, and Long Term Care facilities.</p>					
<p>Adult Day Support provides personal assistance, supervision and an organized program of health, social, educational and recreational activities in a supportive group setting. Nursing, rehabilitation, and a range of other professional and ancillary services may be provided. The program is designed to maintain persons with physical and/or mental disabilities, or restore them to their optimum capacity for self-care. It can also be used to provide respite care, training and informal support to family caregivers. Adult Day Support may be provided within a residential care facility or may be provided through organizations in the community.</p>					

Commonly used Services	Publicly Funded Services				Comments
	1) Yes	2) No	3) Mix	3) Should be	
<p>Group Homes are homes or home-like residences which enable persons with physical and/or mental disabilities to increase their level of independence through a pooling of group resources. They must be able to participate in a cooperative living situation with other challenged individuals. This type of care is particularly suited for disabled young adults who are working, enrolled in an educational program, or attending a sheltered workshop. It may also be provided to seniors and others who require an alternative to facility care.</p>					
<p>Residential Services</p>					
<p>Long Term Care Facilities provide care for clients who can no longer live safely at home. Residential care services provide a safe, protective, supportive environment and assistance with activities of daily living for clients who cannot remain at home due to their need for medication supervision, 24-hour surveillance, assisted meal service, professional nursing care and/or supervision. Clients may have moderate to heavy care needs which can no longer be safely or consistently delivered in the community. They may suffer from a chronic disease, from a disability that reduces their independence and, generally, can not be adequately cared for in their homes. In some cases, all facility services, including chronic care, are provided in Long Term Care facilities.</p>					

Commonly used Services	Publicly Funded Services				Comments
	1) Yes	2) No	3) Mix	3) Should be	
<p>Chronic Care Units/Hospitals provide care to persons who, because of chronic illness and marked functional disability, require long term institutional care but do not require all of the resources of an acute, rehabilitation or psychiatric hospital. Twenty-four hour coverage by professional nursing staff and on-call physicians is provided, as well as care by professional staff from a variety of other health and social specialities. Only people who have been properly assessed and who are under a physician=s care are admitted to chronic care facilities. Care may be provided in designated Chronic Care Units in acute care hospitals or in stand alone Chronic Care Hospitals. Care requirements are typically 2.5 hours of professional nursing care per day or more.</p>					
<p>Assessment and Treatment Centres and Day Hospitals provide short-term diagnostic, assessment and treatment services in a special unit within an acute care hospital or other health facility. These centres provide intensive short term assessment services to ensure that persons with complex physical mental and social needs are correctly assessed, diagnosed, and treated. The objective of the centres is to assist the client to achieve, regain, and maintain an optimal level of functioning and independence. Centres may have beds for short-term inpatient assessment and treatment, a day hospital service, and/or an outreach capability which permits staff to assist clients, who are in care facilities or in their homes, and their families.</p>					

Commonly used Services	Publicly Funded Services				Comments
	1) Yes	2) No	3) Mix	3) Should be	
Additional Services Often Included in Continuing Care					
Equipment and Supplies may be provided as required to maintain a person=s health, e.g., medical gases or assisted-breathing apparatus, and to improve the opportunities for self-care and a better quality of life, e.g., wheelchairs, walkers, electronic aids, etc. Equipment may be loaned, purchased or donated.					
Transportation Services may be provided to persons with disabilities and others with mobility related limitations to allow them to go shopping, keep appointments and attend social functions. Some vehicles are adapted for wheelchairs and other devices.					
Support Groups may be initiated by many sources, e.g., community and institutional health services, friends, families of clients, and individuals having similar needs. The groups provide peer support and foster mutual aid. Some groups may receive government subsidies.					
Crisis Support may be available in the community to give emergency assistance when existing arrangements break down, e.g., illness of the spouse or caring for a disabled person, which could include facilitation of emergency admission to institutional care, or the provision of enhanced Home Care.					
Life and Social Skills for Independent Living may provide training and support for independent living, and for social and personal development and integration, in group settings or on an individual basis.					

Commonly used Services	Publicly Funded Services				Comments
	1) Yes	2) No	3) Mix	3) Should be	
Respite Services may be provided to primary caregivers to give them temporary relief or support by providing a substitute for the caregiver in the home or by providing alternate accommodation to the client in a residential setting.					
Palliative Care is an interdisciplinary service that provides active, compassionate care to the terminally ill in their home, a hospital, or other health care facility. Palliative care is provided to individuals, and their families, where it has been determined that treatment to prolong life is no longer the primary objective.					
Volunteers may provide programs of volunteer help that are utilized in addition to formal care services. Volunteer services may include, but are not limited to, friendly visiting, telephone reassurance and monitoring, doing errands and shopping, and other social and recreational activities.					
Congregate Living Residences are apartment complexes which offer amenities such as emergency response, social support and shared meals.					
Other, specify:					
Other, specify:					

Liste téléphonique — Services offerts aux aînés

Votre nom :

Organisme :

Liste des services et définitions — Aînés

Services les plus utilisés	Services financés par l'État				Commentaires
	1) Oui	2) Non	3) En partie	4) Devraient l'être	
Services communautaires et à domicile					
L' évaluation et la gestion des cas constituent un processus qui a pour objet la sélection des bénéficiaires, l'évaluation des cas, la détermination des besoins en matière de soins, la détermination de l'admissibilité des bénéficiaires, l'orientation vers les services appropriés, l'admission des bénéficiaires à un service, le suivi des soins requis, y compris la modification des plans de soins, et la planification des congés. Les évaluateurs ou les responsables de cas peuvent aussi effectuer des évaluations de la situation financière des bénéficiaires, agir comme représentants des bénéficiaires pour faciliter l'obtention de services et gérer les listes d'attente pour l'admission à un établissement.					
Les programmes de repas sont un service communautaire généralement bénévole qui a pour but de livrer des repas nutritifs, chauds ou congelés, aux bénéficiaires confinés à domicile (Meals-on-Wheels) ou de transporter les bénéficiaires à une salle à manger communautaire où ils pourront prendre un repas (Wheels-to-Meals). L'objectif de ces programmes (souvent appelés <i>popote roulante</i>) est de compléter le régime alimentaire du bénéficiaire en lui offrant des plats appétissants et nourrissants qui lui permettent de maintenir ou d'améliorer son état de santé. Les gouvernements peuvent assumer une partie des coûts de ces programmes, p. ex. le coût des repas ou les frais de transport.					

Services les plus utilisés	Services financés par l'État				Commentaires
	1) Oui	2) Non	3) En partie	4) Devraient l'être	
<p>Les services d'aide familiale sont dispensés aux bénéficiaires qui ont besoin d'une aide non professionnelle en matière de soins personnels ou de tâches ménagères essentielles. Par soins personnels, on entend l'aide fournie aux personnes pour se vêtir, prendre leur bain, faire leur toilette et se déplacer, tandis que les tâches ménagères comprennent le ménage, la lessive, la préparation des repas et d'autres activités d'entretien ménager. Les aides familiales peuvent avoir une formation postsecondaire équivalente à celle des préposés aux soins et fournir des soins personnels similaires. Certains soins infirmiers et services de réadaptation peuvent aussi être dispensés par les aides familiales. Les services d'aide familiale sont parfois offerts comme service de relève.</p>					
<p>Les soins infirmiers à domicile permettent aux bénéficiaires de recevoir, à leur domicile, un éventail complet de soins infirmiers, habituellement dispensés par des infirmières, généralistes ou psychiatriques. Ce programme assure la coordination des services infirmiers qui aideront les bénéficiaires de tous âges à demeurer à la maison même s'ils souffrent d'une maladie aiguë, chronique ou en phase terminale. Ce programme communautaire fournit au bénéficiaire des soins infirmiers dans son propre environnement. Il encourage les bénéficiaires et leur famille à participer activement aux soins; il comporte donc un volet éducation et prise en charge. Les soins peuvent être d'ordre curatif ou palliatif ou viser la réadaptation ou le réconfort du patient.</p>					

Services les plus utilisés	Services financés par l'État				Commentaires
	1) Oui	2) Non	3) En partie	4) Devraient l'être	
<p>Les services communautaires de physiothérapie et d'ergothérapie procurent des services d'évaluation, de traitement, de consultation et de prévention au domicile des bénéficiaires, afin de vérifier, de rétablir ou d'accroître leur fonctionnement, ou de soulager leur douleur. Les thérapeutes peuvent aussi faciliter l'obtention de l'équipement requis par les handicapés physiques et apprendre aux membres de la famille à prendre soin du patient. Les programmes communautaires de physiothérapie et d'ergothérapie offrent habituellement des services de consultation, de suivi, de maintien et d'éducation aux patients, aux familles, aux médecins et autres professionnels de la santé, aux hôpitaux et aux établissements de soins de longue durée.</p>					
<p>Les centres de jour pour adultes fournissent une aide personnelle, de la supervision et un programme structuré d'activités sanitaires, sociales, éducatives et récréatives dans un contexte communautaire protégé. Des soins infirmiers et de réadaptation ainsi qu'un ensemble d'autres services professionnels et auxiliaires peuvent être offerts. Le programme vise à assurer le maintien des handicapés physiques ou mentaux ou à rétablir le plus possible leur capacité personnelle de prendre soin d'eux-mêmes. Il peut aussi fournir des services de relève, de formation et de soutien informel à la famille. Les centres de jour pour adultes peuvent être situés dans un établissement de soins ou être offerts par des organismes communautaires.</p>					

Services les plus utilisés	Services financés par l'État				Commentaires
	1) Oui	2) Non	3) En partie	4) Devraient l'être	
<p>Les foyers de groupe sont des foyers ou des résidences privées qui permettent aux handicapés physiques ou mentaux d'accroître leur autonomie en partageant des ressources communes. Ces personnes doivent être capables de vivre en commun avec d'autres personnes ayant des besoins spéciaux. Ce type de service convient particulièrement aux jeunes adultes handicapés qui travaillent, qui participent à un programme d'éducation ou qui fréquentent un atelier protégé. Il s'adresse également aux personnes âgées et aux personnes pour qui on recherche une solution autre que l'admission dans un établissement.</p>					

Services les plus utilisés	Services financés par l'État				Commentaires
	1) Oui	2) Non	3) En partie	4) Devraient l'être	
Services offerts en établissement					
<p>Les établissements de soins de longue durée prennent en charge les personnes qui ne peuvent plus vivre à la maison sans mettre leur sécurité en péril. Ces établissements procurent un environnement protégé ainsi que des services de soutien et d'aide pour les activités de la vie quotidienne aux personnes qui ne peuvent rester à la maison parce que leur médication doit être surveillée ou qu'elles nécessitent une surveillance continue, de l'aide pour s'alimenter, des soins infirmiers ou une supervision professionnelle. Les soins requis par les bénéficiaires peuvent être modérés ou assez lourds, et ne peuvent plus être dispensés de façon sécuritaire ou régulière par les services communautaires. Les bénéficiaires peuvent souffrir d'une maladie chronique ou d'un handicap qui réduit leur autonomie et, en général, ils ne peuvent plus être soignés adéquatement à leur domicile. Dans certains cas, tous les services en établissement, y compris les soins aux malades chroniques, sont dispensés dans les établissements de soins de longue durée.</p>					

Services communautaires et à domicile les plus utilisés	Services financés par l'État				Commentaires
	1) Oui	2) Non	3) En partie	4) Devraient l'être	
<p>Les unités/hôpitaux de malades chroniques dispensent des soins aux personnes qui, en raison d'une maladie chronique ou d'un handicap fonctionnel lourd, nécessitent une hospitalisation à long terme, mais n'ont pas besoin de toutes les ressources d'un hôpital offrant des soins actifs, des services de réadaptation ou des soins psychiatriques. Les soins sont donnés 24 heures sur 24 par le personnel infirmier et des médecins sur appel ainsi que par d'autres professionnels de la santé et des services sociaux. Seules les personnes qui ont été adéquatement évaluées et qui sont traitées par un médecin peuvent être admises dans un établissement pour malades chroniques, qui est soit une unité de malades chroniques au sein d'un hôpital de soins actifs, soit un hôpital accueillant exclusivement des malades chroniques. On y dispense en général au moins 2,5 heures de soins infirmiers par jour.</p>					
<p>Les centres d'évaluation et de traitement et hôpitaux de jour fournissent des services de diagnostic, d'évaluation et de traitement de courte durée au sein d'une unité spéciale d'un hôpital de soins actifs ou d'un autre établissement de santé. Ces centres offrent des services d'évaluation intensive qui visent à ce que les personnes ayant des besoins complexes sur le plan physique, social et psychiatrique soient correctement évaluées, diagnostiquées et traitées. Ils ont pour objectif d'aider les bénéficiaires à atteindre, à retrouver ou à maintenir un niveau maximal de fonctionnement et d'autonomie. Les centres peuvent compter des lits pour l'évaluation et le traitement de patients hospitalisés pour une courte durée, un hôpital de jour ou un programme d'extension des services qui permet au personnel d'aider les patients, qu'ils vivent en établissement ou à la maison, et leur famille.</p>					

Services communautaires et à domicile les plus utilisés	Services financés par l'État				Commentaires
	1) Oui	2) Non	3) En partie	4) Devraient l'être	
Services additionnels faisant habituellement partie des soins continus					
De l'équipement et du matériel peuvent être offerts afin de maintenir l'état de santé des personnes qui ont besoin, par exemple, de gaz médicaux ou d'appareils d'assistance respiratoire, et d'accroître l'autonomie et la qualité de vie des personnes qui requièrent, par exemple, des fauteuils roulants, des marchettes ou des aides électroniques. L'équipement peut être loué, vendu ou donné.					
Les services de transport sont offerts aux personnes handicapées ou à mobilité réduite, qui peuvent ainsi faire leurs courses, aller à des rendez-vous et poursuivre leurs activités sociales. Certains véhicules sont adaptés pour les personnes se déplaçant en fauteuil roulant ou à l'aide d'autres appareils.					
Les groupes de soutien peuvent être issus de nombreuses sources, p. ex. les services communautaires et les établissements de soins, les proches des bénéficiaires et des personnes ayant des besoins similaires. Ces groupes favorisent l'entraide et le soutien mutuel. Certains groupes peuvent être subventionnés par l'État.					

Services communautaires et à domicile les plus utilisés	Services financés par l'État				Commentaires
	1) Oui	2) Non	3) En partie	4) Devraient l'être	
Le soutien d'urgence est parfois offert par les services communautaires pour assurer une aide immédiate aux personnes qui se retrouvent subitement démunies, p. ex. lorsque le conjoint d'une personne handicapée tombe malade, ce qui inclut les mesures prises pour faciliter l'admission d'urgence en établissement ou assurer la prestation de soins à domicile plus adéquats.					
Les programmes de socialisation et d'apprentissage de la vie autonome fournissent formation et soutien pour permettre aux personnes de mener une vie indépendante et les aider à se développer et à s'intégrer sur le plan social et personnel, dans un contexte collectif ou individuel.					
Les services de relève permettent d'offrir un répit ou un soutien temporaire aux soignants immédiats en leur procurant les services de remplaçants à domicile ou en fournissant un autre lieu d'hébergement au bénéficiaire, p. ex. dans un établissement de soins.					
Les soins palliatifs sont dispensés dans le cadre d'un service interdisciplinaire qui offre aux personnes atteintes d'une maladie en phase terminale des soins actifs et du réconfort, à domicile, à l'hôpital ou dans un autre établissement de santé. Les soins palliatifs sont donnés aux malades et à leur famille lorsqu'on détermine que les traitements visant à prolonger la vie du malade ne constituent plus l'objectif premier.					

Services communautaires et à domicile les plus utilisés	Services financés par l'État				Commentaires
	1) Oui	2) Non	3) En partie	4) Devraient l'être	
Les services bénévoles sont offerts dans le cadre de programmes d'aide qui viennent compléter les soins officiels. Il englobent, entre autres, les visites amicales, les appels téléphoniques visant à rassurer et à surveiller les bénéficiaires, l'accompagnement pour les courses et l'organisation d'activités sociales et récréatives.					
Les habitations collectives sont des immeubles à logements qui offrent des services communs, tels que l'intervention d'urgence, le soutien social et des repas communautaires.					
Autre (préciser)					
Autre (préciser)					
Autre (préciser)					

Appendix 5 – Survey Instrument

Specific to the Care of Seniors

PREAMBLE

Thank you for agreeing to participate in our survey which is part of larger study funded by Health Canada. The results of this study will provide decision-makers with the evidence they need to improve the way health services are organized and delivered across Canada.

Federal, Provincial and Territorial Ministries of Health, and Health and Social Services, have expressed a need to have more information about issues related to what makes for an integrated continuum, or system, of care delivery for a number of population groups, including adults with disabilities.

The purpose of this study is to examine what makes for an integrated continuum, or system, of care delivery for a number of population groups, including seniors, adults with disabilities, adults with mental health concerns, and children.

In this survey we wish to obtain your views about:

- § what are the essential, and/or most frequently used, health related services for seniors;
- § how well these services are currently integrated into a system of health care;
- § how well, or poorly, these services are linked to other parts of the health system (e.g., hospitals, physicians and community/public health);
- § how well they are linked to services outside of the health system, which may impact on seniors (e.g., social services, housing).

We will also ask for your views about:

- What you think makes for an effective system of care;
- What blockages or impediments to effective, integrated systems of service delivery you see in the current arrangements, and;
- What suggestions you may have for improving the system of service delivery for seniors.

Please be assured that your responses will be treated in a confidential manner, that your participation in this survey is totally voluntary and that you can choose not to participate in the survey or not to answer any questions, at your discretion. May we proceed with the survey?

Background Information

Your name:

Organization:

Province:

Region: _____

Definitions:

Integration: The combining of several services into a set or system; the interaction among health services and services outside the health system. This implies that there are definable links and interdependencies.

Interface: The ways and means that components of the health and non-health related services come together or interact with one another; sharing, softening, or touching of the boundaries or limits of service components.

System: A set of services and the interactions between them. The components of a good-functioning system have the common goal of both meeting and integrating the health care needs of people with disabilities.

SECTION 1:

Questions Related to the System of Care for the Seniors population

We have sent you a list of groups of services that may be used by seniors.

1. Could you please indicate which of these services are currently essential and frequently used services by seniors in your jurisdiction? Please feel free to suggest other services if you feel the list is incomplete.

For services which you feel are not essential services at present, please indicate whether you feel that they should be core services in a fully integrated system of care for seniors, and why.

2. How do seniors typically enter the care delivery system?

3. a) Within the range of services noted in Question 1, what:

- facilitates these services into a system of care for adults with seniors ?
- What hinders the integration of these services into a system of care?

When identifying factors, some broad topic areas you may wish to consider are clinical practice, communication within and between services, administration, evaluation, outcome and accountability, policy, finance and regional differences

b) To what extent are the services identified in Question 1 provided in the most effective manner (right setting/timing/provider)?

c) Has your jurisdiction developed any recent initiatives designed to improve integration? If so, how well have these initiatives worked?

4. Within the range of services provided to seniors noted in question 1,

- Is it possible for funders or service providers to move funding from one type of service to another in response to client needs?
- To what extent does money follow the client, e.g., if more clients are looked after at home than in residential care are facility funds shifted to community care? Are there funding incentives for particular services?

5a. Within the range of services provided to seniors do you feel that there are **gaps** in the availability of these services? If so, could you please elaborate?

5b. Within the range of services provided to seniors do you feel that there are existing services that are **under-utilized**? If so, could you please elaborate?

6. Within the range of services provided to seniors (**noted in question 1**), what are your thoughts on what would need to be done to achieve an integrated continuum, or system, of care which would maximize the use of resources to achieve better care and better health outcomes?

SECTION 2

Questions related to how the system of care for seniors is integrated with other health and social services

The following questions relate to the how the services above interact with other major components of the health care system. as acute care hospitals physicians, and community services such as community health centres, and public health preventative services.

7a) To what extent do you feel that the set of services for seniors identified in Question 1 are **integrated with this broader health care sector**? (Hospitals, physicals & community services)

7b) What are the **strengths and weaknesses** of the linkages with the broader health care sector?

7c) To what extent do you feel that the set of services for seniors (Question 1) is **integrated with services outside the health system**, such as social services, housing, transportation and education?

7d) To what extent are services for seniors **integrated for informal caregivers** (for example, family members)?

7e) What are the **strengths and weaknesses** of the linkages with services outside the health system?

7f) To what extent can **clients move** between types of services and locations of services?

7g) To what extent is care within the broader context being provided in the most **cost-effective** way (that is, in the most appropriate setting by the most appropriate provider).

8). Within the broader health and social services sector:

- Is it possible to move funds between the system of care for (population) and other components of the broader system (e.g., hospitals, physicians, social services)?
- To what extent does funding follow the client in the larger health and social service system?

9a. Within the range of services provided to seniors do you feel that there are **gaps** in the availability of services in the broader health and social service system? If so, could you please elaborate?

9b. Within the range of services provided to seniors do you feel that there are existing services that are **under-utilized**? If so, could you please elaborate?

10. Considering the larger health and social service system *and* the system of care for seniors, what are your thoughts on what would need to be done to develop an **overall continuum**, or system of care for seniors?

A system which maximizes the available use of resources to achieve better care and better health outcomes)

11a) **What supports** in other sectors are essential to achieving the best possible system of health and social services for seniors?

11b) **What policy initiatives** (if any) would strengthen the interface and level of integration or coordination between the set of services for seniors and other components of the broader health and social service system?

11c) Are any of these initiatives underway in your jurisdiction? If so, can you describe the stage at which these initiatives are underway.

11. Are there major contextual issues that currently exist in your region which may help us to better understand your responses to our questions?

Thank-you very much for taking part in this telephone interview. If you have any further comments or questions about the research please let me know.

Soins de santé pour les aînés

Merci d'avoir accepté de participer à notre sondage qui s'inscrit dans le cadre d'une importante étude financée par Santé Canada. Les résultats de l'étude fourniront aux décideurs les renseignements nécessaires pour améliorer la manière dont les soins de santé sont organisés et offerts au Canada.

Les ministères fédéraux, provinciaux et territoriaux de la Santé et des Services sociaux ont demandé de plus amples informations sur des questions pouvant leur permettre de déterminer ce qui constitue un continuum, ou système, intégré de soins de santé pour un certain nombre de groupes démographiques, dont les aînés.

Ce projet a pour objectif d'examiner ce qui constitue un continuum, ou système, intégré de soins de santé pour un certain nombre de groupes démographiques, dont les aînés, les adultes handicapés, les adultes ayant des problèmes de santé mentale et les enfants.

Dans cette enquête, nous aimerions que vous répondiez aux questions suivantes :

- § Quels sont les soins essentiels de santé pour les aînés et (ou) ceux qu'ils utilisent le plus?
- § Actuellement, ces soins sont-ils bien intégrés dans un système de santé?
- § Ces soins sont-ils bien reliés à d'autres services du système de santé (p. ex., hôpitaux, médecins et santé communautaire et publique), ou y sont-ils mal reliés?
- § Ces soins sont-ils bien intégrés aux services hors du système de santé dont peuvent bénéficier les aînés (p. ex., services sociaux et hébergement).

Nous aimerions également que vous répondiez aux questions suivantes :

- Qu'est-ce qui constitue un système efficace de prestation des soins de santé?
- Le système actuel présente-t-il des obstacles à l'intégration efficace des soins de santé? Le cas échéant, lesquels?
- Quelles solutions proposez-vous pour améliorer le système de prestations des soins de santé pour les aînés?

Soyez assuré que vos réponses demeureront confidentielles, que vous êtes tout à fait libre de participer ou non à ce sondage, et que vous pouvez décider à tout moment de vous retirer de l'étude ou de ne pas répondre à certaines questions. Pouvons-nous commencer le sondage?

Renseignements de base

Votre nom :

Organisation :

Province :

Région : _____

Définitions

Intégration : la combinaison de plusieurs services au sein d'un ensemble ou système; l'interaction entre les soins de santé et les services hors du système de santé. Cela signifie qu'il existe des liens bien définis entre ces services.

Interface : les moyens par lesquels les divers soins de santé et les services hors du système de santé sont réunis ou liés; partage, assouplissement ou atteinte des limites des services.

Système : une série de services et leurs interactions. Les éléments d'un système efficace ont pour objectif commun de répondre aux besoins des aînés en matière de soins de santé, et d'intégrer les services qui leur sont offerts.

SECTION 1

Questions relatives au Système de santé pour les aînés

Nous vous avons envoyé une liste de catégories de soins dont peuvent bénéficier les aînés.

1. Actuellement, quels sont les soins essentiels et fréquemment utilisés par les aînés de votre région? Si vous croyez que la liste est incomplète, quels soins proposeriez-vous d'ajouter?

Selon vous, les soins que vous ne considérez pas comme essentiels pour l'instant devraient-ils le devenir dans un système intégré de santé pour les aînés? Précisez.

2. En général, comment les aînés accèdent-ils au système de santé?
3. a) Pour les soins précisés à la question 1, quels sont les facteurs qui :

- favorisent l'intégration de ces soins dans un système de santé pour les aînés?
- empêchent l'intégration de ces soins dans un système de santé?

Les facteurs que vous préciserez pourraient toucher aux grands domaines suivants : pratique clinique, communication relative à un service ou à un ensemble de services, administration, résultats et reddition de comptes, politiques, finances et différences régionales.

b) Dans quelle mesure les soins précisés à la question 1 sont-ils fournis avec efficacité (milieu adéquat/rapidité de l'intervention/fournisseurs compétents)?

c) A-t-on récemment mis sur pied des initiatives gouvernementales visant à améliorer l'intégration des soins dans votre région? Le cas échéant, ont-elles été efficaces?

4. Au sujet des soins offerts aux aînés précisés à la **question 1** :

- Ceux qui financent ou fournissent les soins peuvent-ils répartir différemment les fonds d'une catégorie de soins à une autre en fonction des besoins de la clientèle?

- Dans quelle mesure les fonds sont-ils liés aux besoins de la clientèle? Par exemple, si les clients reçoivent davantage de soins à domicile plutôt qu'en établissement, les fonds alloués aux soins en établissement sont-ils transférés aux soins communautaires? Existe-t-il des incitatifs de financement pour certains soins?
5. a) Croyez-vous qu'il existe des **lacunes** au niveau de la disponibilité des soins offerts aux aînés? Le cas échéant, pourriez-vous préciser?
5. b) Croyez-vous que certains des soins actuellement offerts aux aînés sont **sous-utilisés**? Le cas échéant, pourriez-vous préciser?
6. Relativement aux soins offerts aux aînés (**précisés à la question 1**), comment pensez-vous qu'il serait possible d'établir un continuum, ou un système, intégré de soins de santé qui puissent utiliser toutes les ressources à sa disposition pour assurer de meilleurs soins et résultats dans ce domaine?
-

SECTION 2

Questions relatives à la façon dont le système de santé pour les aînés est intégré à d'autres soins de santé et services sociaux

Les questions suivantes portent sur la manière dont les soins précisés ci-dessus sont liés à d'autres services importants du système de santé, notamment les suivants : hôpitaux de soins actifs, médecins, soins communautaires comme les centres de santé communautaire, promotion de la santé publique et services de prévention des maladies.

7. a) Selon vous, dans quelle mesure les soins offerts aux aînés, précisés à la question 1, **sont-ils intégrés à l'ensemble du secteur de la santé** (c.-à-d. hôpitaux, médecins et services communautaires)?
7. b) En quoi consistent **les forces et les faiblesses** de l'intégration des soins de santé à l'ensemble du secteur de la santé?
7. c) Selon vous, dans quelle mesure les soins offerts aux aînés (Question 1) sont-ils **intégrés aux services hors du système de santé**, à l'instar des services sociaux, de l'hébergement, des transports et de l'éducation?

7. d) Dans quelle mesure les soins offerts aux aînés sont-ils **intégrés pour les soignants improvisés** (par exemple, les membres de la famille)?
7. e) En quoi consistent **les forces et les faiblesses** de l'intégration des soins aux services hors du système de santé?
7. f) Dans quelle mesure **les clients peuvent-ils passer** d'un programme de soins et d'un établissement de soins à un autre?
7. g) Dans quelle mesure les soins de santé en général sont-ils **rentables** (c.-à-d. les soins offerts dans le meilleur milieu qui soit par le fournisseur le plus compétent)?
8. Dans l'ensemble du secteur de la santé et des services sociaux :
- Peut-on répartir différemment les fonds entre le système de santé pour les aînés et d'autres services de l'ensemble du système (p. ex., hôpitaux, médecins et services sociaux)?
 - Dans quelle mesure le financement est-il réparti en fonction de la clientèle dans l'ensemble du système de la santé et des services sociaux?
9. a) Croyez-vous qu'il existe des **lacunes** au niveau de la disponibilité des soins offerts aux aînés dans l'ensemble du système de la santé et des services sociaux? Le cas échéant, pourriez-vous préciser?
9. b) Croyez-vous que certains des soins actuellement offerts aux aînés sont **sous-utilisés**? Le cas échéant, pourriez-vous préciser?
12. En ce qui concerne l'ensemble du système de la santé et des services sociaux *ainsi que* le système de santé pour les aînés, comment pensez-vous qu'il faudrait s'y prendre pour élaborer un **continuum global**, ou un système de santé pour les aînés?
11. a) **Quels appuis** faut-il rechercher dans d'autres secteurs pour assurer le meilleur système de santé et de services sociaux qui soit pour les aînés?
11. b) **Quelles initiatives stratégiques** (s'il en existe) renforceraient l'interface et le niveau d'intégration ou de coordination entre l'ensemble des services offerts aux aînés et d'autres services de l'ensemble du système de la santé et des services sociaux?

11. c) Certaines de ces initiatives sont-elles actuellement mises en oeuvre dans votre région? Le cas échéant, pourriez-vous préciser à quel stade sont rendues ces initiatives?

12. Existe-t-il d'importants enjeux propres à votre région dont vous pourriez nous faire part pour nous aider à mieux comprendre vos réponses à nos questions?

Merci d'avoir participé à cette entrevue téléphonique. Si vous avez des commentaires ou des questions supplémentaires au sujet de cette étude, n'hésitez pas à m'en faire part.

Appendix 6- Focus Group Protocols

Generic Questions for Focus Groups for the Analysis of Interfaces Along the Continuum of Care Project for *People Receiving Services*

Preamble

Thank you for agreeing to participate in this focus group. The focus group is part of a large national study funded by Health Canada. We would like to obtain your views regarding the services that are available for seniors. Your input is very important because it will help to identify the strengths and weaknesses of the services currently available to seniors from the perspective of people receiving services. Your input will be used to inform decision makers about what is working well, and what needs some improvement, from the perspective of people receiving health related services.

Participation in this focus group is totally voluntary. You can choose not to participate in the focus group or not to answer any specific questions. No individually identifiable data will be included in the report of this focus group. Your responses will be anonymous.

Questions

1. What services are you currently receiving?
2. What are the two or three best things about the services you are currently receiving?
3. What are the two or three areas that need the most improvement with respect to the services you are currently receiving?
4. Do you feel that you are receiving the services that you need? That is, are there services that you feel you need which are not currently available because:
 - the services do not exist
 - there are long waiting lines to access service
 - the services are not affordable
 - other?
5. If you need a range of services, how are those services arranged and coordinated? That is:
 - do you have to try to access services directly?
 - is there someone who helps to coordinate services? If so, who does this coordination?
6. Are there any existing programs, financial or other rules or policies which you feel get in the way of you receiving the best possible care?
7. What are the top three or four suggestions you have for improving how care services are provided to:

- you as an individual?
- seniors in general?

8. If you were in charge of providing health services to seniors and were given new funding, how would you spend the money to improve the system?

Generic Questions for Focus Groups for the Analysis of Interfaces Along the Continuum of Care Project for *Family Members of People Receiving Care Services*

Preamble

Thank you for agreeing to participate in this focus group. The focus group is part of a large national study funded by Health Canada. We would like to obtain your views regarding the services that are available for seniors. Your input is very important because it will help to identify the strengths and weaknesses of the services currently available to seniors from the perspective of family members of people receiving care services. Your input will be used to inform decision makers about what is working well, and what needs some improvement from the perspective of family members of people receiving services.

Participation in this focus group is totally voluntary. You can choose not to participate in the focus group or not to answer any specific questions. No individually identifiable data will be included in the report of this focus group. Your responses will be anonymous.

Questions

1. What services is your family member currently receiving?
2. What are the two or three best things about the services your family member is currently receiving?
3. What are the two or three areas that need the most improvement with respect to the services your family member is currently receiving?
4. Do you feel that your family member is receiving the services that he/she needs? That is, are there services that you feel your family member needs which are not currently available because:
 - the services do not exist
 - there are long waiting lines to access service
 - the services are not affordable
 - other?

5. If your family member needs a range of services, how are those services arranged and coordinated? That is:
 - do you or your family member have to try to access services directly?
 - is there someone who helps to coordinate services? If so, who does this coordination?
6. Are there any existing program, financial or other rules or policies which you feel get in the way of your family member receiving the best possible care?
7. What are the top three or four suggestions you have for improving how care services are provided to:
 - your family member as an individual?
 - seniors in general?
8. If you were in charge of providing health services to seniors and were given new funding, how would you spend the money to improve the system?