Volume III

Scenarios

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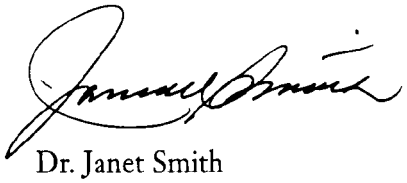
Foreword

One of the things the Task Force learned from the case studies and the conversations with many practitioners and decision makers was that a precursor to significant change toward citizen-centred service was a clear picture of the current situation that needed to be improved. In other words, a mirror had to be held up and looked at before change was seriously considered. In the case of Services New Brunswick, it was the by-now famous story of the 13 forms and permits required in a specific but unknown order, from seven different departments, for a person wanting to open a corner store/gas bar. Similarly, the organizational inertia in Health and Social Services was broken in P.E.I. by painting a clear picture of what it was like, from a youth's point of view, to obtain services from government.

To recognize the range of complex government roles and activities, the Task Force selected four topical areas of service that overlapped jurisdictional lines, challenged citizens and users of government service, and touched on both transactional types of services and the regulatory, public good, role of government. Exploratory discussion papers were developed in the areas of government services to youth, senior citizens and mining companies, as well as the intergovernmental co-operation to provide clustered and convenient transactions to citizens.

It must be made clear that the authors of these studies were asked to explore the particular client group's or citizen's point of view only. In the case of the mining industry, for example, there are many other important viewpoints, such as those of naturalists, economic developers and environmentalists, that were not examined but certainly could have been.

The discipline of examining services from the citizens' point of view rather than from the point of view of the service provider was sometimes uncomfortable and challenging for many people. This convinced me even more of the importance of becoming citizen-centred in our approach to government activity.



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Senior Service Delivery Project

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1.0 INTRODUCTION

1.1 Objective

The objective of this report is to examine the current state of delivery of services -- particularly government services -- to seniors, and to evaluate options for enhancing the quality and efficiency of service delivery by adopting a concerted client focus. This will entail a review of the needs of seniors, describe the current services and service providers, and propose a model for future service delivery which includes strategies for both integrating access to, and clustering of, services for seniors.

1.2 Context

This is a challenging task at any time, but the current environment makes it even more so: a rapidly aging population, a baby boom generation poised to take on the responsibilities of caring for their parents, changing family support structures, changing roles of women and governments, a retrenching public sector leading to fiscal restraint and so on.

This environment is further complicated by a number of other factors: the concept of a "seniors" client group is far from having a clear definition; there is no generally agreed upon age threshold, although 65 is often considered to be an "entry" point into the cohort; the "needs" of seniors can vary dramatically across the full range of social, health and economic requirements; the nature of these needs is typically correlated, although not perfectly, with an age-dependency continuum; services are provided by all levels of government, the voluntary sector and the for-profit sector; this broad range of service providers lacks coordination; and quality standards are often poorly defined, particularly across community and provincial boundaries.

From the perspective of the senior and their immediate advocates – family, friends and caregivers – the prospect of accessing required services in the current system can appear daunting. With age, the senior faces the prospect of growing reliance on others for their well-

being. This reliance can start with friends and family but ultimately is likely to evolve into the realm of institutional and community based-care. In 1993, the National Advisory Council on Aging (NACA) estimated that 500,000 seniors required substantial support for daily living activities either in their community or in institutions. Up to 80% of seniors received help with at least one activity, including grocery shopping, housework, meal preparation, yardwork, managing money and personal care (1985 data). By 2031, NACA estimates that 1.5 million seniors will require substantial support. [1]

At the same time that needs for increased support are emerging, the system may grow more difficult to comprehend from the client's perspective. The increasing complexity relates to the increased needs of the seniors and therefore the number and scope of service providers which must be accessed to meet those needs. This necessitates a better understanding of the myriad of service providers.

There is often a tendency by policy and program stakeholders to carve seniors' issues out of the broader societal context within which they actually fit. This can lead to programming and service delivery which provides only partial solutions and serves to create the perception of a system that is meant for seniors but in fact does not fully integrate services to meet their real needs.

The delivery of services to seniors has been examined by many organizations -- government, academic, service providers, seniors' advocates -- but typically not from a comprehensive client focus. Many studies have looked at the issue from the perspective of cost reduction or fiscal restraint, regulatory reform, organizational structures of service providers, role of the public vs. private and third sectors and so on.

While these dimensions of the issue are critical to the perspectives put forward in this paper, from an analytical perspective they are here subordinated to the focus on the client.

At the most basic level there are four simple elements in the seniors' service delivery equation:

1. The definition of the client group and their needs. For the purposes of service delivery, is the seniors cohort to be defined on the basis of an age threshold or on the basis of some broader group of characteristics?
2. The mechanisms by which seniors, their families and other parties access the services they require.

[1] National Advisory Council on Aging, 1993. Aging Vignettes.

3. The range or clusters of services that fit within the service delivery framework.
4. The actual delivery of services.

Focus of This Paper

While this paper addresses all four of these elements, when it comes to new approaches, it focuses on the middle two, integrated access to services and clustering of services, rather than the actual delivery of services; that is, from the senior's perspective, how can a wide range of services be accessed in a convenient, reliable and efficient fashion?

This is not in any way to suggest that the actual delivery of services is optimal. Rather, it is recognized that the issue of quantity and quality of services is constantly changing and the outcome of many competing pressures within the public sector, and between the public and private sectors. It would be beyond the scope of this paper to attempt to comment on that delicate balance. This being said, it is apparent that in many cases resource efficiency could be enhanced through rationalization of services and coordination among service providers.

Implementation of an integrated access and clustered services model would require detailed planning across jurisdictional boundaries as well as coordination among levels of government and service providers outside the public sector realm. Implementation raises important funding issues as well. While these issues are noted, there is no attempt to deal with them exhaustively or to provide implementation plans. Both are seen to be largely beyond the scope of this paper.

The remainder of the paper is organized as follows. The next section addresses the nature of the problems encountered in currently accessing services for seniors. It asks, Who is the client? What are their needs? And how are they currently serviced? The answers to these questions form the basis for the discussion of new service delivery principles and parameters in the third section. This section of the paper examines an integrated access model which builds on an infrastructure that exists to greater or lesser extents in many communities. The final section of the paper addresses next steps and implementation issues.

2.0 SERVICES TO SENIORS: CURRENT STATE

In order to consider new approaches to accessing seniors' services, it is imperative to first understand how service delivery currently works from the seniors' perspective. In this section we briefly review the client needs, who the clients are, and how their needs are serviced. This section ends with an analysis of the problems and issues in the service delivery process and infrastructure, setting the stage for a discussion of service access parameters and principles and new approaches in the following sections.

i) What are the clients' needs?

Seniors have a full range of needs covering the health, social, financial and other service areas. Many of these are similar to the needs of any member of society: shelter, food, income, transportation, health care, leisure, entertainment and so on.

Others are specific to the needs of the aged person: retirement planning, assistance with activities of daily living (personal hygiene, dressing, physical movement), socialization and role readjustment, bereavement counselling, assisted home support and so on.

Chart 1 illustrates the full range of service needs of seniors; it is designed to be indicative rather than exhaustive. For illustrative reasons, the chart begins to cluster services into groups – institutional care, transportation, pensions and income, discretionary activities and so on.

What is perhaps most important about the chart is what it implies but does not illustrate directly: the composition of service needs changes with the degree of dependence of the senior.

ii) Who is the Client?

Given this age-dependence continuum, it is useful to pause and ask who the client is. At the broadest level, are we working with <u>all</u> seniors regardless of their ability (and desire) to fully

Chart 1 - SENIORS' SERVICE NEEDS

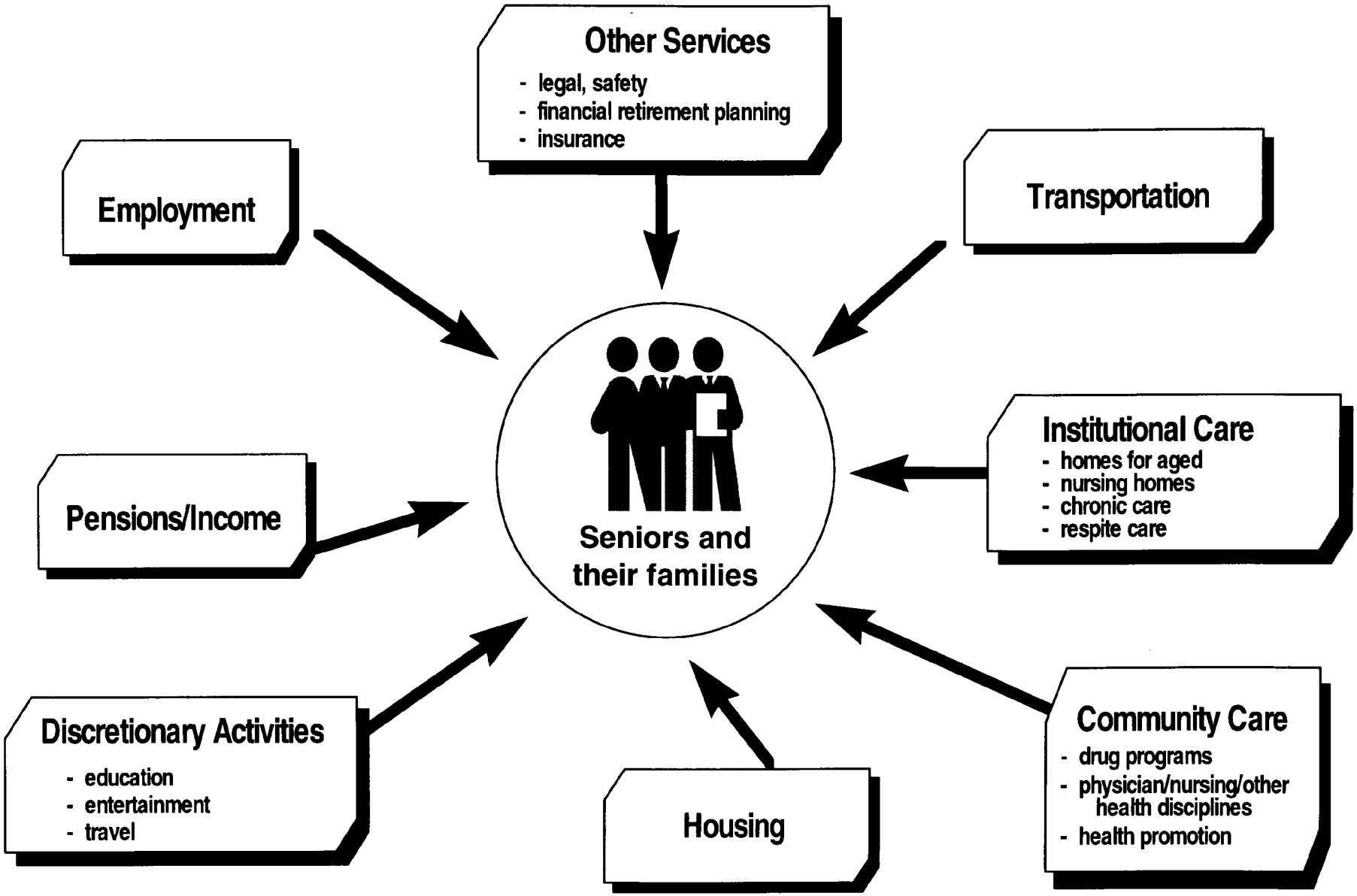
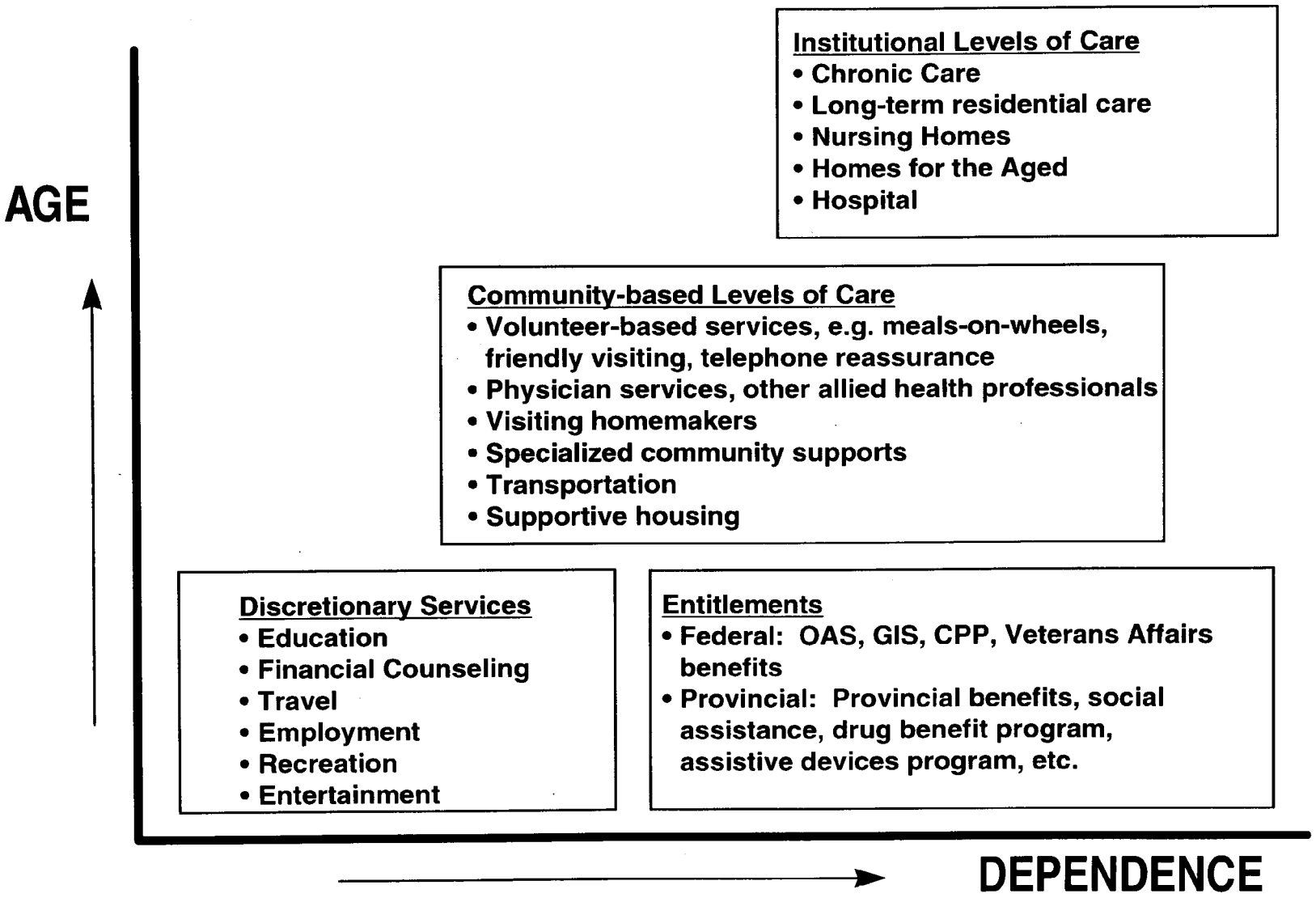


Chart 2 - SENIORS CONTINUUM



service their own needs? Or are we speaking of some subset of seniors that is identified by particular age (in this context what is the age of entry into the seniors' cohort?) and/or needs characteristics?

From the perspective of needs, it is apparent that the "seniors" cohort -- or for the purposes of this paper, the seniors' client group – as defined by some specific age threshold, is not a homogenous group.

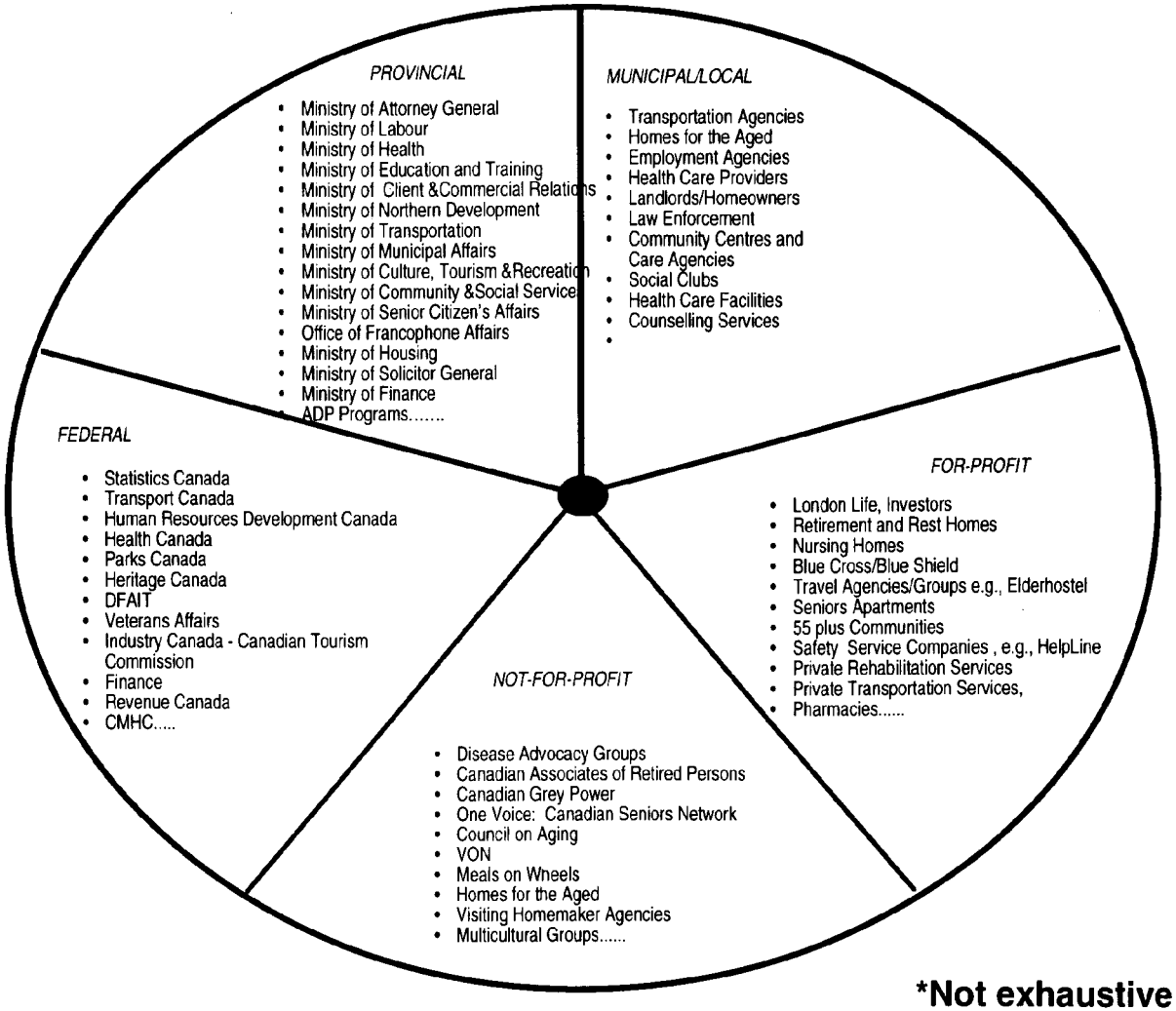
While age is the most commonly cited indicator of a senior there is little broad consensus as to what the age threshold should be. Some individuals categorize themselves as seniors when their age provides them with commercial "seniors' discounts," and this can be as early as age 55 in some cases. Others see the definition being aligned with the age of retirement, which is also variable. For purposes of receiving public pensions, the threshold is typically considered to be age 65. Financial institutions offer a variety of "freedom 55" retirement programs which set age 55 as a "target" retirement age.

While age is an important defining characteristic of the seniors' cohort, whatever the entry threshold, needs will vary significantly from the normal requirements of a physicially fit senior, to potentially greater institutional requirements of an incapacitated individual. Ages for this may be anywhere from 55 to 105 years. More generally, within any age boundaries, seniors will be heterogeneous with respect to financial status, educational and cultural background, physical and mental capabilities, and family/community support needs and so on. An age threshold, while useful in general terms for defining the cohort, is likely to be less helpful in terms of directing the design of an integrated service access capability.

To begin to bring this heterogeneity into relief in a way that it can be used in considering integrated service access models, it is useful to look at the way needs change, in general, with age. Although there are a number of ways to look at this, one which is very relevant to the service delivery issue is dependence. Typically, for seniors, age is positively correlated with growing dependence – the age dependence continuum – and growing dependence is associated with particular needs.

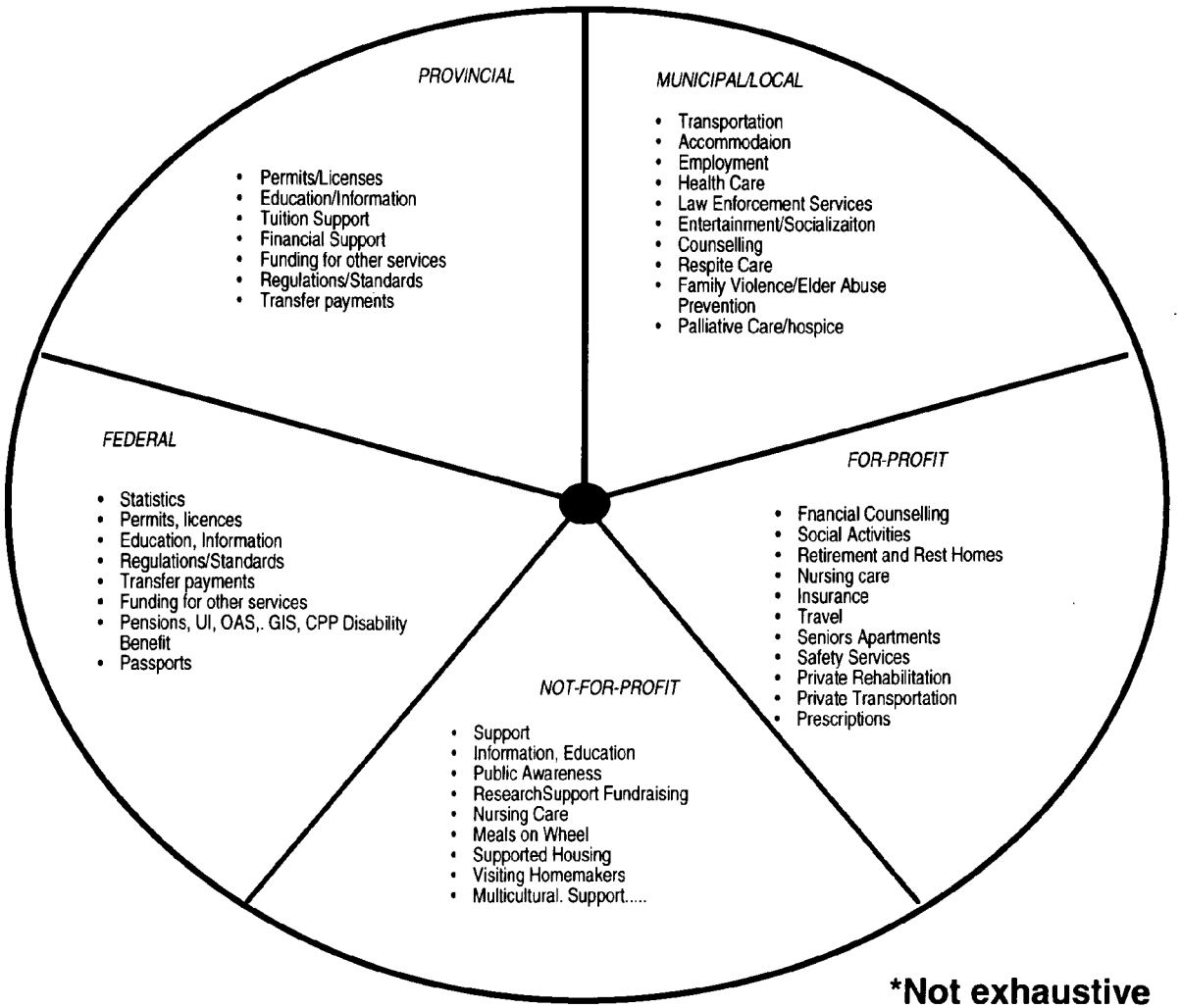
Functional dependence/physical and mental well being, can be characterized by the level of assistance required from others for routine activities of daily living. Within the seniors cohort, there are individuals, typically at the lower end of the age spectrum, who are healthy and have no functional impairments. With age, individuals begin to require assistance with activities such as home making and grocery delivery, they need certain and simple access to their financial means, including public pensions, and ultimately they may become fully dependent on others for cognitive and bodily functions. With increased dependence, the client may become the senior's family or other caregivers who are accessing resources on behalf of the client.

Chart 3 - CURRENT SERVICE PROVIDERS



***Not exhaustive**

Chart 4 - CURRENT SERVICES



***Not exhaustive**

Chart 2 further refines the clusters of seniors' service needs identified in Chart 1– grouping them into four categories – and plots them against an "age-dependence" continuum. The clusters of needs which then translate into service requirements are positioned along the continuum. Moving up into the northeast quadrant of the continuum, the nature of service needs moves away from *discretionary* type services – education, travel – and towards the less *discretionary* types of care services such as nursing homes and homes for the aged. The chart reinforces the notion that seniors are not a clearly defined or homogenous client group in terms of their service needs.

For the purposes of this paper, it is sufficient to raise the issues around the definition of the client group. There are two reasons that there is no need to precisely delineate boundaries for the cohort: first, the integrated access model which will be proposed below is predicated on access to clusters of services which depend on need not upon age (for example, a person in their mid fifties could access the service, as could a grandchild to meet the needs of their senior); second, the proposed model would allow for direct access to service providers therefore not fostering a senior classification system which limits client access.

iii) Accessing Services - Who provides what services now?

Charts 3 and 4 present a scan of existing service delivery organizations (categorized by level of government, the for-profit and the not-for-profit sectors) and the range of services provided.

Chart 3 illustrates organizations or individuals involved in providing services to seniors. The chart presents the organizations as they are captured within their jurisdictional or sectoral boundaries. Chart 4 presents the services that these same organizations provide. It is the latter aspect which is often most important to seniors. By the accounts of these two charts, a comprehensive set of services and service providers are available to seniors.

The delivery of services has shifted in recent years towards increasing emphasis on meeting the holistic needs of the senior. Holistic, in its broadest definition, means a comprehensive range of services which meets emotional, physical, social and financial requirements. Given such a wide range of requirements, needs often continue to be met, out of necessity, by a large number of distinct service providers. This wide number of providers has been fostered by specialization and "turf" protection.

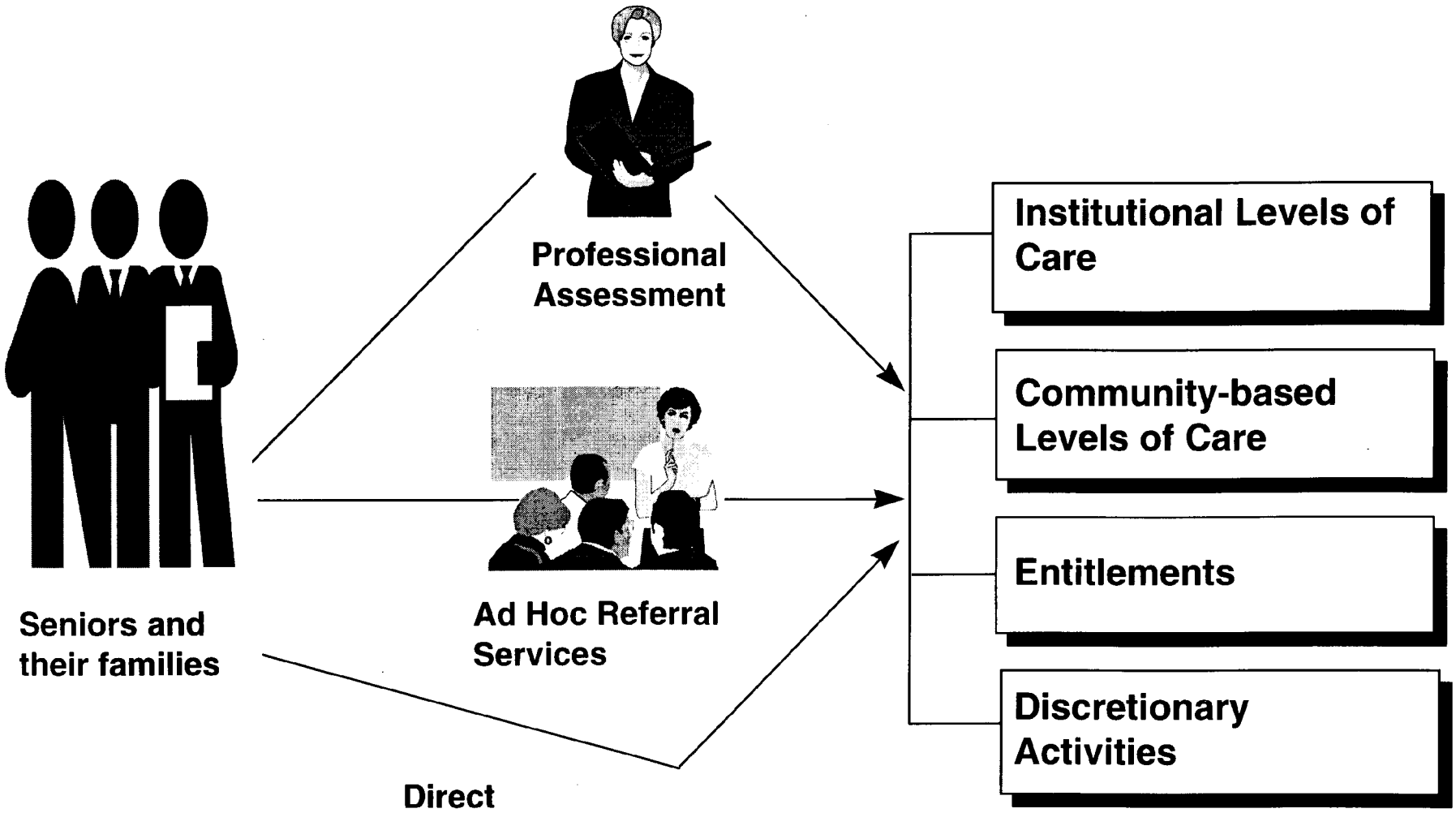
Clusters of Services

Generally, services or service providers have not been grouped or clustered. The providers have remained largely independent with often competing or overlapping services. To aid in the discussion of this report we propose a new classification system to group service

Chart 5: CLUSTERS OF SERVICE NEEDS

Institutional Levels of Care
• Chronic Care • Long-term residential care • Nursing Homes & Homes for the Aged • Hospital
Community-based Levels of Care
• Volunteer-based services, e.g. meals-on-wheels, friendly visiting, telephone reassurance • Physician services, other allied health professionals • Visiting homemakers, nurses, etc. • Specialized community supports • Transportation • Supportive housing
Entitlements
• Federal: OAS, GIS, CPP, Veterans Affairs benefits, UI, CPP Disability Benefit • Provincial: Prov. benefits, social assistance, drug benefits, assistive devices program, etc. Municipal: social assistance
Discretionary Activities
• Education • Employment • Recreation • Entertainment • Financial Counselling • Travel

Chart 6 - Current System of Direct, Assessment, Ad Hoc Referral Access



providers in four clusters. These clusters were presented in Chart 2 and are again identified in Chart 5 to assist in understanding what services may be provided at different phases in the age/dependency continuum. The four clusters are *institutional care*, *community based care*, *discretionary* services, and *entitlements*. While it should be recognized that certain service providers may provide services in more than one of the clusters, the service clusters illustrate the complexity of services which are necessary to meet the client needs.

Institutional care providers are typically accessed within an institution or facility. An institution may be a building, a hospital or long-term care facility such as a nursing home, home for the aged (in Ontario these two groups are called long-term care services) or group homes. Often health care and assisted living services are provided in institutions.

Community-based health care providers include community health centres, adult day care programs, homemaker services, home nursing services, and so on. The medical and multidisciplinary providers are geared to deliver services geared to health promotion, active assessment and treatment, and maintenance or supportive care. The "community-based" social service providers include community centres, not for profit and volunteer organizations and are geared to ensuring support for seniors in the community. These may include meals on wheels, social outings, friendly visiting, transportation etc.

Entitlement programs/providers provide services such as public pensions, welfare, unemployment insurance and drug benefits.

Discretionary programs and services include travel, education, recreation, social, financial, employment, entertainment. These programs while tailored to the needs of seniors, are often similar to programs targeted in the broader population.

Access to Services

Services may be accessed directly, via a referral or via a professional assessment. See Chart 6 for Current Service. Direct access means that an individual can go directly to the service provider to receive service. Referral to a service implies that an individual or agency must forward the name to a provider and that the provider can not be accessed directly.

Assessment access means that the client must be seen by a designated professional prior to accessing the service. This assessment may be done for a particular purpose, for example an evaluation of health status, physical or emotional needs, occupancy requirements, age or income. Often assessments are done to see if a person really needs the services they are requesting (e.g. a long-term care bed) or could other volunteer or community services be provided (e.g. home making visits to assist the individual to stay out of an institution).

Institutional care services previously have not been accessed in a comprehensive manner. Seniors accessed the services directly, via a referral from a friend or an assessment through their family physician or hospital. In an acute hospital, assessments are performed by physicians, social workers and other health professionals. These determine the immediate service needs of a client and what further action needs to be taken either for health care services or for community supports for return to the prehospitalization accommodation. If long-term institutional care is required, waiting lists are often long and unmanaged. Previously financial compensation influenced the location of a vacant institutional bed rather than actual need.

Community-based services include financial and employment counseling, education, transportation, recreation/entertainment, socialization support, supportive housing and home support. The latter may include congregate or delivered meals, housekeeping and yard work, household repairs and maintenance, and shopping assistance. These providers may be accessed directly or via a referral from another individual or organization. Some of these service may only be accessed through a professional assessment and may have age or income eligibility criteria.

Entitlements programs like public pensions, welfare, unemployment insurance, some drug programs and so on must be accessed through application by the senior. Typically there is little coordination among levels of government or between government departments in the provision of these entitlements to seniors. Moreover, when the senior moves, a number of government organizations need to be notified of the move separately by the senior.

The senior may identify their service needs independently or in conjunction with their family, other supportive persons, or through professional relationships such as their family physician or their visiting nurse. When the senior or their advocate tries to access the necessary services to meet their needs they are confronted with the confusion of a wide range of providers and access requirements. This confusion may grow as the senior proceeds along the age-dependence continuum. Access may not be straightforward.

For example:

> Professional health care, counseling and homemaking staff must be accessed through a professional assessment. In many instances professional practitioners may be gateways to other practitioners where an assessment is performed again (as in the case of a physician being required to refer someone to a physiotherapist).
>
> For services that require eligibility criteria an assessment may also be done to confirm the information documented on the application form. This may require a review of

occupancy status (checking your utility bill address), confirmation of age (viewing of your birth certificate) and determination of income (verifying of your income tax status).

There are a great many services which require no assessment of any sort. Access is accorded via the ability to pay.

Other agencies may not charge a financial fee but expect a return exchange of services; for example, in the Brandon Seniors Coop you are expected to perform a specific number of hours of service in return for services received.

This variety of service providers and different methods of accessing them may be confusing, inefficient and frustrating.

In a number of communities or agencies there are activities occurring which foster some orderly and coordinated approach to accessing services. Health care facilities and community-based agencies (e.g. VON) have initiated case manager or discharge planner positions which help a senior and their family decide what services are best for them.

In July 1994, Ontario finished phasing in 36 Placement Co-ordination Services designed to approve and co-ordinate admissions to nursing homes and homes for the aged, now renamed "long-term care" facilities. Other provinces have considered similar services to improve the coordination of access to necessary resources.

In addition, seniors are often referred to Regional Geriatric Assessment Programs or Regional Geriatric Rehabilitation Programs. These programs include a review of the patients physical status, and recommendations for additional services which may enhance the client's status. In the latter program rehabilitation services are provided to assist the client become more functionally independent and return to their previous environment with home supports or an environment which requires less professional support.

In the community, there are a number of ad hoc needs assessment and referral activities. These include: Seniors Centres Information Booths, Advocacy groups (Seniors Home Support, Seniors Outreach Services, Senior Citizen's Council, Disease specific organizations) and informal networking such as at a community card game. These may direct seniors to the professional services but also to meal services, social/recreational activities or organize friendly visiting, safety telephone calls or homemaking assistance.

In a number of provinces Community Information Centres (CICs) have been established. CICs are voluntary organizations that exist in varying degrees of formality and comprehensiveness in most communities. They are typically funded by grants from

local/regional governments, charities, foundations and service clubs and can also generate some revenue through the sale of materials such as manuals and publications.

CICs typically provide information to local residents on available programs and services, usually on the telephone. CIC staff receive training in providing information and referral and have access to a wide variety of information on-site that they can provide to callers. CICs have brochures, guidebooks and manuals available to provide to callers, in addition to a self-maintained electronic data interchange system. This listing of resources is upgraded yearly for print copies and on an as needed bases for the electronic records. CICs have experienced reductions in their levels of funding, and have increased their reliance on volunteers.

iv) Conclusions – The Diagnostic

Demographics are driving a change imperative. Not only is the population aging rapidly, but expectations among this aging population are also high – expectations about the quantity and quality of services and about how they are accessed in an efficient manner. Pressures are emerging as a result of financial constraints, complex jurisdictional/responsibility issues, quality care issues, the changing role of formal and informal service providers and the emergence of and growing reliance on a private sector presence.

The relationship amongst service providers is complicated due to the number and type of providers involved. According to NACA and Home Support Canada, in 1991 there were 1000 home support agencies in Canada. The number of home support workers and services increased by at least 50% in the past decade and is expected to continue to rise. The informal network has historically, and continues to, provide 80% or more of all the care used by older persons and enhances the professional services available in the community.[2] With the increasing demographics, there will be more informal providers accessing services. All seniors are involved in some form of entitlement assistance and therefore at some point either directly or indirectly access the entitlement service providers. It is difficult to determine the number of discretionary service providers who cater to seniors. Overall, it can be seen that there is a very wide scope and large number of service providers trying to meet seniors' needs.

Providers cross numerous organizational and jurisdictional lines; from public sector to the private sector; from municipal/local/provincial to federal governments; services span needs ranging from employment, through retirement planning to bereavement counseling and home care. Factors such as jurisdictional boundaries and conflicts, political will, tradition and

[2] National Advisory Council on Aging, 1993. Aging Vignettes.

multiple government department involvement have contributed to slow development of policies and procedures for coordinating the seniors access system.

While efforts have been made at improving the interface between seniors and the services they require, at this time there is no formal mechanism for coordination on a broad basis, although at the local level there appear to be some successful experiments. The bottom line is that a large number of seniors with a wide variety of service needs must negotiate the maze of an even wider body of providers.

The fact that the seniors cohort is not a homogenous group creates some difficulty in the establishment of a comprehensive service access mechanism. First, it raises issues about the target client group. And second, as the Canadian population ages the characteristics of the seniors cohort (such as education, technological literacy, family support framework, income and so on) are changing.

3.0 CLIENT CENTRED SERVICES: FUTURE STATE

The discussion above suggests that the current service delivery structures raise two fundamental problems for the client. First, within the four main clusters, the senior faces a wide range of choices in the services or products available. While in general consumer choice is a positive, when seniors are confused by the choices, from their perspective choice becomes a problem.

Second, given the wide range of service providers, and the general lack of coordination among them, from the seniors' perspective accessing services can be a time consuming, complicated and confusing task. While this may be a relatively minor issue in the context of accessing some *discretionary* services, it becomes considerably more urgent with respect to *institutional* and *community-based* care services.

Designing a new seniors' centred service delivery model should ultimately take these two problems – lack of rationalization/coordination among services, and the absence of an integrated access capability – into account. In a "perfect" world, a comprehensive model would address both.

However, from the seniors' perspective the crucial issue is access, and that is the larger focus of the remainder of this paper. The potential benefits from rationalizing programming and services across organizations, jurisdictions and sectors are important on a number of counts, but from the client's perspective it may be possible to provide integrated, reliable, efficient access without fully rationalizing the service delivery side of the equation. Our proposed model of clustering these services may be the initial, necessary step in integrating and aggregating service providers and will be expanded upon in the following discussion.

3.1 Objective and Principles

An integrated access model must be designed around a clearly articulated objective or vision.

While much refinement and discussion can go into the objective statement, for purposes of the following discussion, we set the objective as "providing seniors with the option of integrated, reliable and efficient access to a pre-determined set of services."

The actual access and service delivery vehicle needs to be developed around specific policy and service principles. As an overarching guide to these principles, seniors expect that they will be serviced in an efficient manner, treated with dignity, and in a way that respects their privacy and desire for autonomy. In addition, the following principles should be reflected in any new approach to integrated access:

- allow for family involvement with, and on behalf, of the senior;
- reflect the need for full social integration of seniors;
- focus on the senior as an individual;
- provide for equitable access to service;
- build on existing strengths and mechanisms;
- become more responsive to the changing needs of the client in society;
- encourage comprehensiveness, integration and coordination;
- ensure effective and efficient use of resources;
- encompass professional management;
- allow for stakeholder input and direction of the system, and
- encourage portability, mobility and consistency across boundaries.

3.2 Existing Models to Coordinate Care

Many cities, regions and provinces are reviewing the way in which organizations provide service and are experimenting with organizational changes to enhance service.

A recent example of provincial activity has been the Ontario announcement of Community Care Access Centres (CCACs). These centres are designed to coordinate the services of Placement Coordination Services and community agencies (e.g. VON). Other service agencies will not be included. The goal of the new system is easier access to long-term care services. The CCACs will purchase services from community providers with the "objective of obtaining the highest quality service at the best price" while maintaining the valuable contributions made by existing community-based providers and volunteers. This model contains significant opportunities to improve the linkages of nursing care, community

supports, homemakers and long-term care facilities. However, it does not fully integrate all of the services available, nor does it appear to take advantage of existing information systems.

While some jurisdictions have decided to combine all seniors health care under one administration, it does not necessarily mean that jurisdictions that are split are suboptimal. If there is an established split, well-established mechanisms to coordinate services may be present.

3.3 Integrated Access Model Parameters

Research suggests that market segmentation is an essential component in targeting services to meet population needs. These market segments may be defined by age, service needs, income, knowledge/educational experience and so on.

In the case of seniors, this notion of segmentation is important. Earlier in this paper, it was suggested that seniors are not a homogeneous group: within any defined age boundaries, service needs can vary significantly. Moreover, there can be any number of stakeholders accessing services on behalf of the senior, ranging from the senior herself to a family member, a friend, an organization or an institution. It may also be that different access points are appropriate depending on who is doing the accessing.

This report proposes an innovative, generic model for accessing seniors' services in a more integrated fashion. The model is based on three key elements of the service equation that were discussed earlier: client delineation, clusters of services and access mechanisms.

The **client group** is defined, in effect, to be anyone requiring access to those (clusters of) services that are determined to be within the scope of the integrated access model. In this sense, and for the purposes of this paper, the seniors' client group is defined through a process of self-selection – those that seek services through the integrated access window.

The **clusters of services** are based on the four groups outlined above – *institutional care, community-based care, entitlements* and *discretionary* services. While the services within each of the clusters have natural affinities, there are many ways to cluster and there is no inherent reason why the number of groups or the specific services within them could not be modified.

Access mechanisms are the ways in which seniors or their families reach the services they need. As was noted above, currently the means and quality of access are highly

variable by service, community, region and province. In some communities there may be no integrated access whatsoever – seniors are on their own to access services directly; in others access may be somewhat coordinated, but within a range of services that is not comprehensive; finally, there have been attempts at establishing integrated access points – most recently and previously described, the Ontario announcement to establish 43 Community Care Access Centres (CCACs). Client choice must be considered when establishing an access system. Integrated access has many benefits to offer. Nevertheless, some seniors may prefer to seek out information and make autonomous decisions on the identification of their needs and desired services. The model presented below allows for client choice between integrated access and direct access.

3.4 A New Approach to Integrated Access: Building on Strengths

A proposed approach to integrated access is set out in Chart 7.

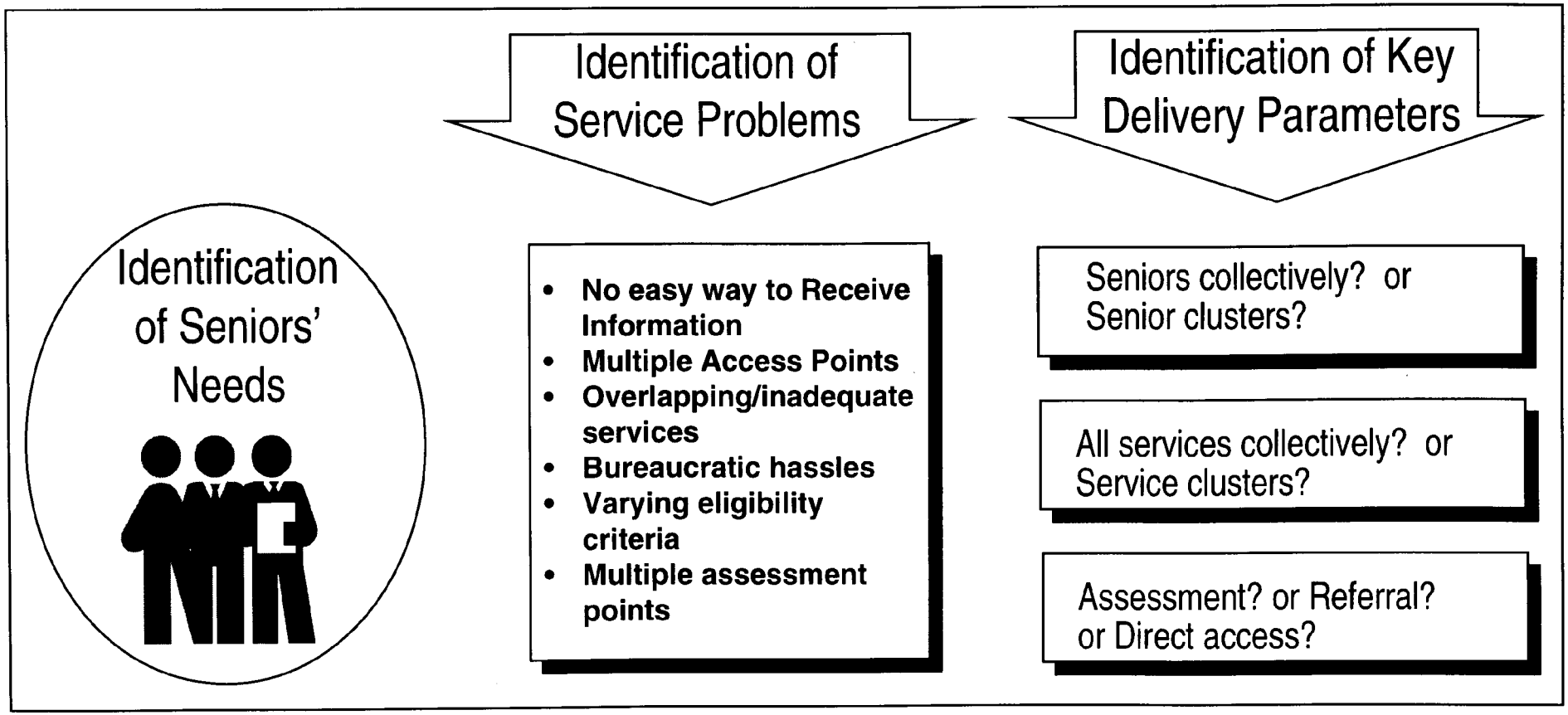
The proposed model is based on a significantly enhanced role for community information centres (CICs). CICs were previously described in this paper as community based service providers. The rationale for enhancing CICs is the following:

- long history of providing information to the community;
- organizations are already in existence therefore do not need to be established;
- agencies are community based and nonprofit;
- agencies have some of the community data bases already;
- avoids creating more layers or bottlenecks.

In order to provide true integrated access, CICs in many cases would have to be strengthened to provide four main functions: they would assess needs, provide information, make referrals and house the professional assessment services often required for access to *institutional care* (e.g. long-term care where admission to a bed is required) or for more intensive *community-based care* (e.g. seniors' day care). This being said, the intent would be to build on existing capabilities by establishing generic service standard parameters for CICs while encouraging communities to develop structures suited to local conditions and needs.

A critical question in the design and work-up of the integrated CIC model is what services could be accessed through such a mechanism. Here there is a balance to be struck between tailoring to local conditions and needs on the one hand, and, ultimately, establishing some broad national conditions that would enhance mobility of seniors and bring some consistency

Chart 7 - What are the key factors in planning Future Senior Services Delivery Models?



to the issue on the other. In this regard, there is, to some extent, a natural ordering of the service clusters identified in Chart 2.

For an integrated CIC to be effective, it should focus on those service clusters which, from the client's perspective are most necessary and most complicated in terms of access. At a minimum, this would include access to the *institutional* and *community-based care* clusters. Integrated access to *entitlements* might also be seen as a major improvement by many seniors. With regard to *discretionary services*, many of these are provided by the private sector and while integrated access may be seen in a constructive light, the role for public funds to support access to such services may be more questionable.

As shown in Chart 7, in an enhanced role the CICs would be a gateway to service providers, although, as noted earlier, the intent would not be to eliminate a direct access capability for those more comfortable with such a system.

It is proposed that a senior or their family could access the CIC directly in person or electronically (phone, fax or internet). The CIC service representative would provide immediate answers/information for straightforward requests, or move to a more detailed needs assessment where necessary.

On the basis of the needs assessment, contacts could be made on the seniors' behalf with appropriate organizations and institutions – as discussed below, an important dimension of this system would be rapid access to information about service providers through on-line data bases. The system could be set up in such a way that the senior agrees to an individually designed action plan – pre-agreed with the service providers – at the time of the needs assessment.

As noted above, certain kinds of institutional and community-based care require professional assessments. Currently these assessments may be arranged and provided in different ways and through various windows. To the extent possible these services could be provided on site in the CIC or, at a minimum, arranged directly and scheduled through the CIC.

The proposed model would also include the enhanced use by the CIC of on-line information systems, linked to service providers in all the clusters. One could develop an integrated computer network with four knowledge servers coordinating information from the CIC and each of the *institutional and community-based service* providers as well as to *entitlement* programs and *other discretionary* activities. At present, all service providers have their own information systems and any sharing of information with other service providers in their clusters or a across clusters takes place on an ad hoc basis. There are no requirements for these organizations to be linked to a central information service with up-to-date information

on services, costs, availability, waiting lists, information on the quality of service (e.g. accreditation results, complaints) and so on.

This model has been discussed with CIC staff in a local community. They are familiar with current directions to improve access to information but at this time have not knowingly been included in any proposals.[3]

How will this Approach Affect Seniors, Families and Communities

Integrated access to services holds the potential for substantially improving the delivery of senior services through the development of increased senior and family involvement, increased integration and coordination, and improved effectiveness in the allocation/coordination of resources to meet local needs of seniors and their families.

- Seniors will get more coordinated and integrated service in terms of institutional health, community assistance and entitlements.
- Local community service providers will be better able to provide a consistent and cohesive approach to service delivery.
- Local accessibility will improve the coordination for seniors who require assistance in correctly identifying their needs and negotiating the maze of service delivery providers.
- Increased reporting of quality measures will lead to a greater concern with outcomes, customer service mentality and costs, and thus provide more effective use of limited resources.
- Increased coordination of services will provide the opportunity to identify gaps or overlaps thereby assisting in the establishment of a full continuum of services offered.
- The frustration experienced with multiple referrals will be reduced as one service coordinates the assessment requirements of service agencies.

Moreover, if such a model were to be replicated across community and provincial boundaries, it could hold the potential for easing cross boundary difficulties when seniors want or are required to move.

[3] Interview with Katlyn, Community Information Centre, Ottawa April 4.

4.0 NEXT STEPS

Achieving integrated access CICs would require a number of steps. A comprehensive workplan would include not only the requirements for setting up an individual CIC, but the broader service and evaluation parameters for establishing a CIC network. Some of the issues that would need to be addressed will be discussed. These include jurisdictional issues, training, funding, catchment area definition, service coverage, service standards and evaluation parameters.

We believe that the idea of enhancing the role of community information centres is an warrants further investigation. It is generally an untested concept. From a hypothetical model and our limited testing we believe this concept is feasible. It requires an assessment of the capacity and capabilities and government and service provider.

Funding

Funding for CICs is currently derived from a number of sources. As was noted earlier, they are typically funded by grants from local/regional governments, charities, foundations and service clubs and can also generate some revenue directly. The model proposed here would require incremental funding for setup and for operations. In a period of ongoing fiscal restraint the sources of this funding would need to be determined among the stakeholders. It is important to realize that current funding to CICs is being cut and therefore any increase in their services would require additional dollars.

Jurisdictional Issues

A CIC model would require the cooperation of all levels of government at the level of coordinating service delivery, funding, sharing of data and so on. A mechanism would be required for achieving this cooperation. In this regard, it should be noted that the federal government would have relatively little leverage in encouraging the establishment of a CIC network; its funding is indirect and its jurisdictional responsibility is limited.

In addition, the issue of mobility and portability between provinces would need to be addressed.

Training

The CIC must ensure professional and technical staff for program development and evaluation, information and financial systems, human resources planning and training, management and service to the senior.

There are three target audiences for training:

Seniors and their families:

Seniors will need education regarding what services are available and how to access these services. This may include:

- description of the service;
- location of the service;
- eligibility/access requirements e.g. must have referral from family physician, restricted to residents of province, etc.;
- cost structure e.g. hourly fee for service rate, cost per photocopy page, etc.

CIC staff:

Staff providing support to these programs will require training to become knowledge service agents. Training would include:

- description of the services available and their location;
- eligibility/access requirements;
- cost structures of the programs;
- people facilitation skills;
- understanding of social and medical terminology/programs;
- computer technology;
- health and social case management;
- sensitivity training to cultural and social differences among clients and among the various direct service providers;
- resource knowledge seeking skills, e.g. medline, database.

Service Providers:

In order for the service providers to optimize their service capabilities they will require training in:

- the requirements of the Community Information Centres;
- methods of directing seniors and their clients to other service providers;
- knowledge as to what segmentation of the service each provider is assuming and what will be provided by other staff.

Database and Systems Development

A comprehensive, networked database would need to be developed to provide accurate, up-to-date information and, the potential for actual sign-up or request for services. This data base could include descriptions of services, eligibility criteria, costs, availability/wait lists, quality scorecards/evaluation metrics of service providers(e.g. accreditation awards, number of service complaints/lawsuits, etc.).

The necessary information systems would also have to be developed to support the elecronic information sharing and access capability.

- appropriate jurisdictional mechanisms to support the interrelationship between the stakeholders involved (i.e. a clear differentiation and delineation betwen the roles, responsibilities and functions of the service providers, particularly those in the public sector

Catchment Area

It will be necessary to define the geographic catchment area that will be served by the Community Information Centres (larger sub-units are more likely to have expertise, and to be positioned to realize economies of scale; smaller sub-units ensure that the services are in closer proximity to the senior and their families); issues such as restrictions on clients from one catchment area accessing the services of a CIC in another catchment area would also have to be addressed.

Service Coverage

It will be necessary to give consideration to the scope of services to made available through the integrated access model. Will there be an effort to bring all four clusters together in a

comprehensive fashion? Or should there be a narrower focus on services that are typically more difficult or confusing to access?

Service Standards and Evaluation parameters

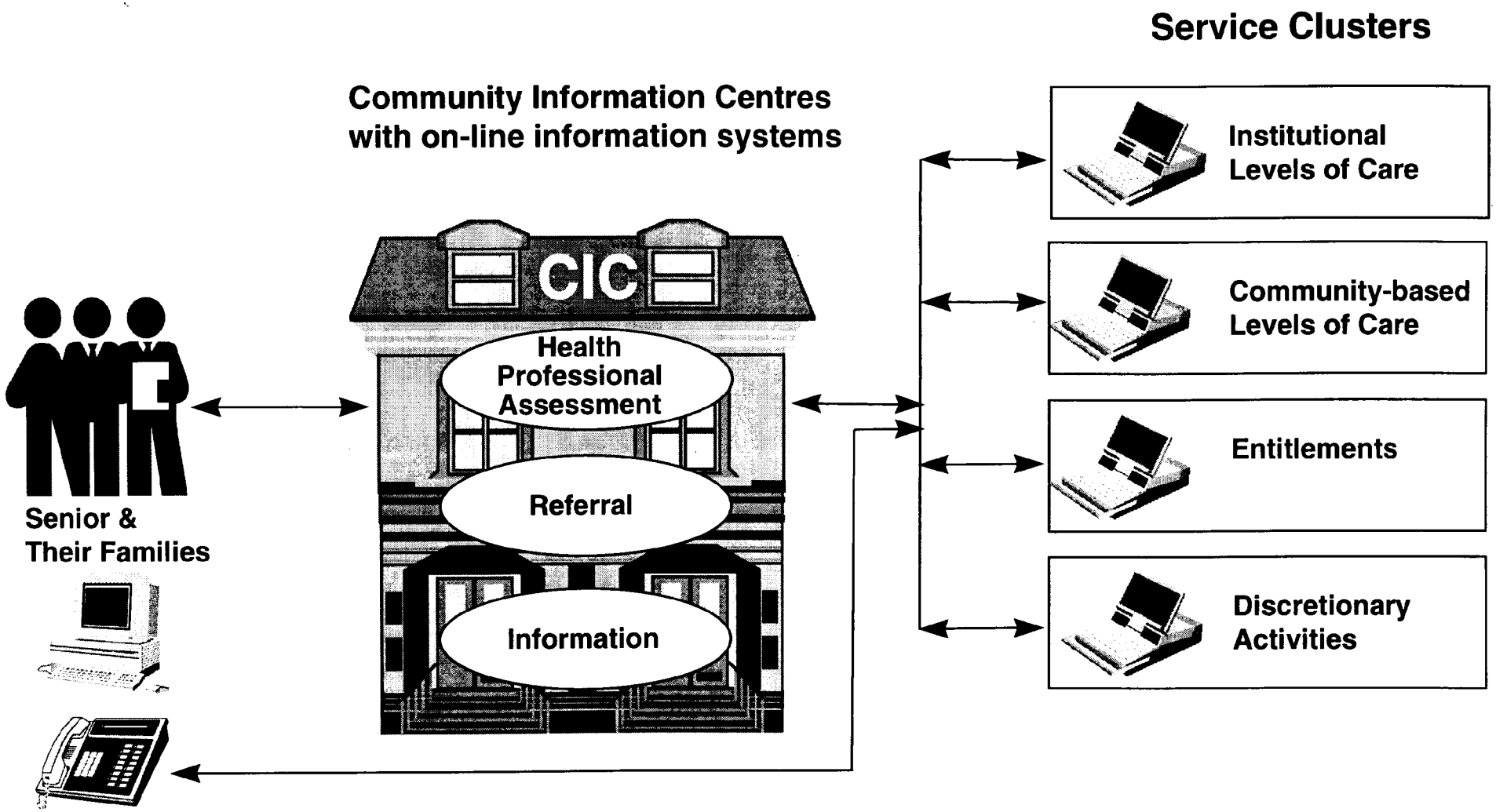
Service standards and evaluation parameters will be required, particularly if the intent is to establish a broad network of CICs. Service standards can be used to meet objectives for overall results while evaluation parameters can provide the information necessary to ensure continuous improvement for the CICs.

While service standards and evaluation parameters may be different for various stakeholders in the service delivery process, the following provide a guide, from the senior's perspective, of the kinds of elements that need to be considered:

- *Enhanced access*: user-friendly, and easily available.
- *Appropriateness:* ensuring that the right resources are available, and meet the right needs of the client be they functional, social or medical.
- *Effectiveness*: whether the right thing is done well.
- *Efficiency* in service: resources are used effectively (is there a minimum wait time to achieve necessary services, how many interventions are required for each service).
- *Respectfulness*: the client is treated with sensitivity to their personal and cultural needs.
- *Reliability*: the services are provided without error (e.g. outcome indicators such as result of current inspection/accreditation results).

These are some of the major items that would have to be considered in developing a comprehensive workplan. There are, of course, many others that would also need to be addressed.

Chart 8 - FUTURE: INTEGRATED ACCESS SYSTEM AND SERVICE CLUSTERS



5.0 SUMMARY

It is very clear that significant changes in structures and processes are needed to achieve a client-centred focus on senior service delivery. There are two ways to go about this. Reinvent the entire system of service delivery to seniors, or work with what is available and provide incremental improvements in the service.

The recommendations put forward in this report clearly follow the latter route, suggesting a more integrated and coordinated system of service delivery which would result in direct benefits to the senior. The changes would lead to improved abilities for seniors and their families to become empowered for meeting their personal needs. The approach would also use existing and well-established resources to better advantage without creating new organizations to perform the same or similar function: most communities have CICs or similar organizations that have a long history of performing this function on a limited basis for local residents.

It is clear, however, that attempting to establish a broad network of CICs with common minimum service standards would not be without its problems. For one thing, the level of development of the CICs varies across the country and the creation of this enhanced role may be difficult for some organizations. Second, incremental resources would be required and this would be difficult unless, at a minimum, offestting savings could be identified within the existing seniors' service delivery infrastructure.