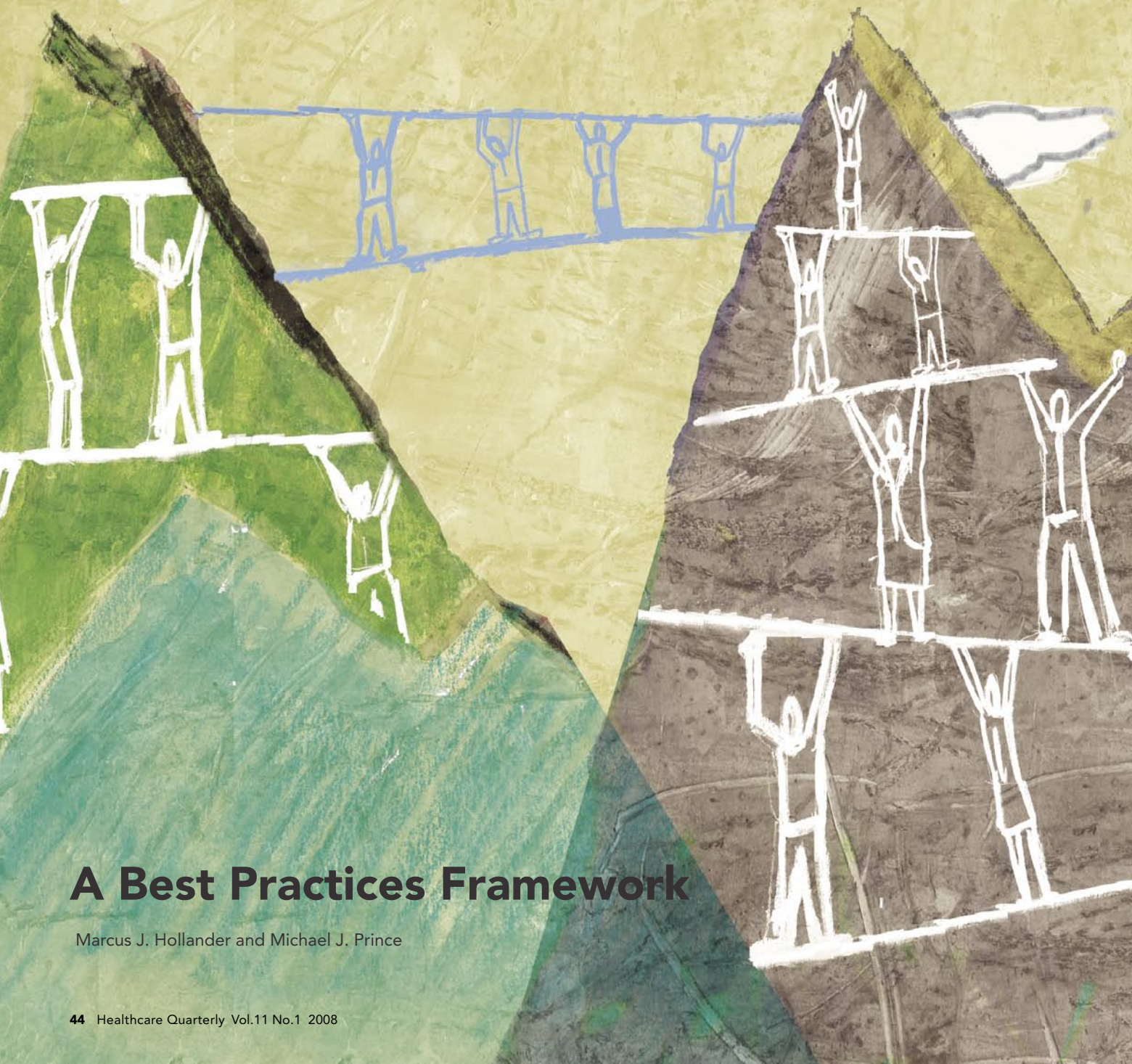
Organizing Healthcare Delivery Systems

for Persons with Ongoing Care Needs and Their Families:



A Best Practices Framework

Marcus J. Hollander and Michael J. Prince

How systems of care delivery are structured can have a major impact on their relative efficiency and on the quality of care provided to individuals. As the population continues to age, as more people are able to continue to live with disabilities or chronic conditions for longer periods of time and as demands continue from consumers and lobby groups to allow individuals to be more fully integrated into customary Canadian life, pressures to deal with the needs of persons who require ongoing care will only continue to mount. However, organizing care delivery systems for such persons is particularly complex: care must be coordinated and provided over long periods of time, often measured in years and even decades; care needs may require services from all levels of the healthcare and human services systems; and many of the appropriate responses to organizing services for such persons often go beyond strictly medical or professional health services to supportive and family care. To stimulate discussion about this important topic, we are presenting a proposed best practices framework for structuring and organizing care delivery systems for persons with ongoing care needs and their families.

Our formulation derives from the results of a Canadian project to study systems of care delivery for four populations with ongoing care needs – the elderly, persons with disabilities, persons with chronic mental health conditions and children with special needs. It builds on, and extends, the Western Canadian continuing care model discussed by Hollander and his colleagues in their article titled "Providing Care and Support for an Aging Population: Briefing Notes on Key Policy Issues," published in the June 2007 edition of *Healthcare Quarterly*.

A program of research approach was used for the project discussed in this article. National studies of care delivery systems for each of the four population groups were performed. Some 270 interviews were conducted with leading experts across Canada, and focus groups were held with clients and family members in the four population groups. In addition, an extensive literature review on models of care delivery systems was also conducted. In total, six technical reports and an overall synthesis report were produced for the project. These reports are listed in the bibliography; interested readers can also access these reports at www.hollanderanalytical.com. This article presents an updated and revised summary of the overall synthesis report for the project.

Services Provided to the Four Population Groups

Key respondents (provincial and regional officials, service provider representatives and consumer representatives) were asked to comment on what services should be part of the service delivery system for each of the four populations. The list of services they identified is presented in Table 1. While some services are unique to one or two of the four population groups, there was a high degree of similarity in the services used by the four groups.

Key Challenges to Care Coordination and Integration

The following summarizes the key challenges noted by respondents in organizing seamless, integrated models of care delivery for persons with ongoing care needs. Some of these issues may have been addressed by ministries of health and/or regional health authorities since the research for our project was conducted.

Differences in philosophy. Differences in underlying philosophies can pose formidable barriers to appropriate and integrated care, for example, a philosophy of medical care versus one of psychosocial enablement and personal independence. Another difference across services is that many health services are viewed as universal entitlements, while other services, such as income and home support, are often guided by a residual welfare philosophy, that is, services are provided based on income or asset tests.

Turf and power issues. Turf protection and issues of relative power were seen to inhibit the smooth flow of clients across sectors. Concerns about losing power and resources might even take precedence, in some cases, over matters related to the needs of clients, particularly when one is trying to access resources outside the existing system of care designated for the client.

Lack of communication and integrated information systems. Clients having to apply for service and to be reassessed at each point in the care continuum was seen as onerous and as delaying timely access to services. Inadequate information technology infrastructures also applied to all four populations.

Organization of services. A consistent message in all the studies in this project concerned the negative effects of organizing services in bureaucratic silos. Each organizational entity tends to focus on its own areas of responsibility and may not work to reduce duplication or to enhance broader systems efficiencies.

Human resources issues. Respondents noted that issues regarding the sufficiency of workers, and training and turnover, were seen to constitute barriers to clients receiving good-quality and timely care services.

Regionalization. When people move from one region to another, the same set of services may not be available, or people may not be eligible for some services in the new region for which they had been eligible in their former region. There may also be poor inter-regional communication that can complicate or delay care coordination and timely access to services.

Eligibility for care and user fees. In some parts of Atlantic Canada, individuals with adequate financial means, as defined by public policies and regulations, may have to pay the full cost of residential care; in the rest of Canada, user fees are capped to reflect room and board costs and generally do not exceed $50 per day. Concerning home support, some jurisdictions provide these services without user fees, while others use income or asset tests. There is generally no user fee for professional home care services.

Table 1. Types of services by type of population group

Type of Service	Seniors	Persons with Disabilities	Mental Health	Children with Special Needs
Community/home-based services				
System-level case management	X	X	X	X
Information/referral services	X	X	X	X
Meal programs	X			
Self-managed attendant services		X		
In-home nursing care	X	X		X
Home/community Community rehabilitation (PT/OT) (physiotherapy and occupational therapy)	X	X	X	X
Homemakers, home support services, care aids and attendants	X	X	X	X
Daycare/day support (special and integrated)	X		X	X
Group homes		X	X	X
Respite care	X	X	X	X
Palliative care	X			
Technical aids, equipment and supplies	X	X		X
Supportive housing	X	X	X	
Life and social skills training and support groups	X	X	X	X
Outpatient/ambulatory care services			X	X
Primary care/family physicians			X	X
Day hospitals	X		X	
Community emergency services/crisis support	X	X	X	X
Specialty transportation services	X	X	X	X
Foster care	X			X
Mental health services for children				X
Buddy programs				X
Summer camps				X
Drug benefits services	X	X	X	X
Physician specialists (psychiatry, pediatrics)	X		X	X
Residential services				
Institutional services/residential care	X	X	X	
Extended or chronic care facilities	X	X		X

Table 1. Types of services by type of population group, continued

Type of Service	Seniors	Persons with Disabilities	Mental Health	Children with Special Needs
Specialty hospital services (pediatrics, geriatrics, rehabilitation)	X		X	X
Children's hospital				X
Psychiatric hospital/beds			X	
Palliative care	X			X
Hospital-based emergency services	X		X	
Regular hospital services	X	X	X	X
Respite care	X	X		
Educational/vocational services				
Special integrated preschool programs				X
Integrated school programs				X
In-home teachers and tutors				X
Vocational training and support		X	X	X
Income support programs				
Financial assistance to purchase equipment and supplies for home renovations	X	X		X
Income assistance	X	X	X	
Judicial/criminal justice services				
Judicial/criminal justice services				X

Single entry, assessment and case management. Gaps and insufficiencies exist in the area of case management. While most jurisdictions have single entry systems for seniors and persons with disabilities, this is less often the case for clients with mental health needs and for children with special needs. The issue of standardized assessment is also important because it would save people from having to go through an assessment each time they enter a new type of service. Common classification systems to determine care needs, irrespective of the site of care, are essential elements for the planning and management of complex systems of care.

Rural/urban differences. Access to fewer types of services in rural areas was a common theme in our findings. In addition, there are issues of transportation for medical care and proximity to family members for residential care in rural areas.

Care coordination across health and human services. Coordination of services for each of the four population groups was a particular challenge. Problems of cross-sectoral communication persist, and different models and philosophies may guide administrators and policy makers (e.g., the medical versus the psychosocial model of care). However, respondents believed that cross-jurisdictional, cross-sectoral, cross-ministry and cross-department/division coordination mechanisms could facilitate the provision of services.

Funding issues. Blockages to client transfers occur if there are gaps or insufficiencies in funding. One cannot coordinate care between two service components if one component does not exist, is not accessible in a timely manner, or has a limited capacity to admit new people. Different patterns of co-payments across types of services may also inhibit a smooth transfer of clients between services.

The Proposed Best Practices Framework

In light of the significant challenges to providing care to the four population groups, this section presents a best practices framework for organizing systems of care for these popula-

tions (see Figure 1). The best practices constitute a template for developing and implementing new systems of care. Once implemented, they can be seen as characteristic of such systems.

Our formulation is a framework, rather than a model, because it represents a higher level of abstraction than a model. It is an approach that allows, within an agreed-upon set of principles or parameters, for a number of variations to address unique circumstances. We are presenting a framework that is sufficiently flexible to be applicable to all four population groups. Based on this framework, models that are more specific could also be developed for each separate population group. There are three major components to our framework, which are discussed below.

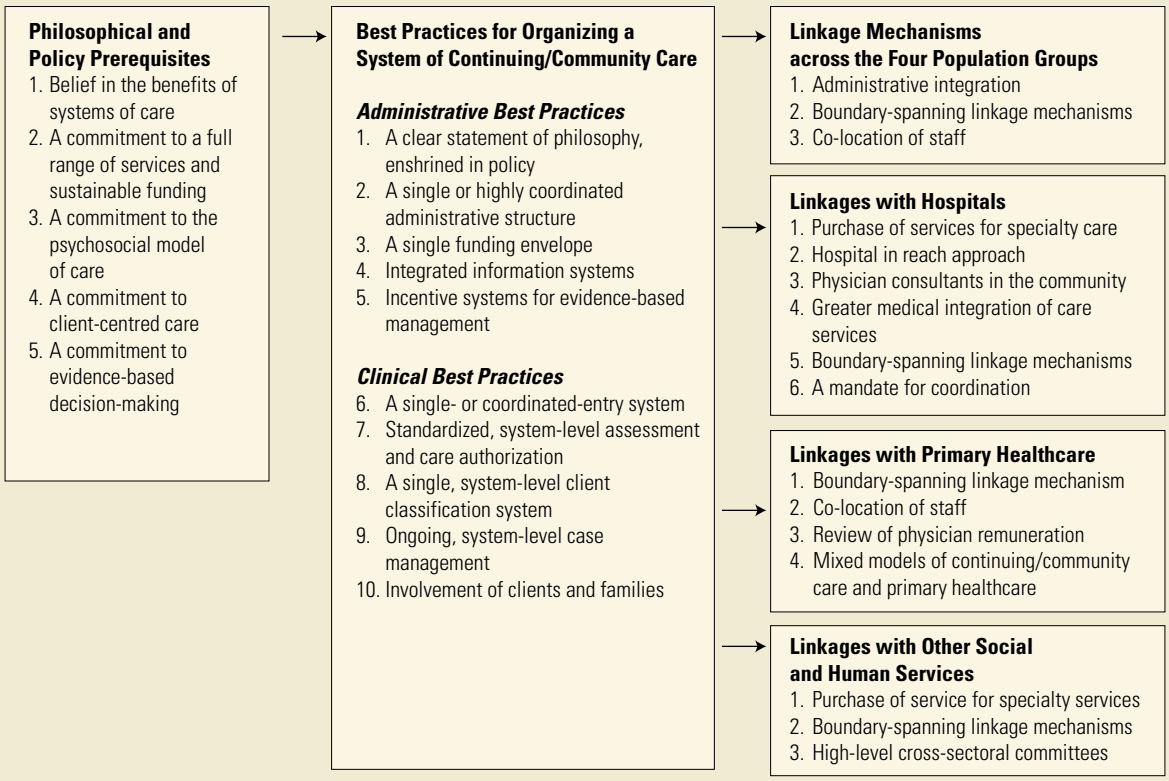
Philosophical and Policy Prerequisites

The prerequisites we present in this section reflect a series of values and ways of thinking and constitute the *first component* of our framework. How these prerequisites gain expression in the real world may vary across jurisdictions. Nevertheless, they are important principles and commitments and are seen as critical to the successful adoption of our proposed best practices framework of service delivery.

We propose five philosophical and policy prerequisites for our framework:

1. *Belief in the benefits of integrated systems of care.* To develop best practices for organizing systems of care delivery for people with ongoing care need, one should first have a belief in the benefits of a system of care. Members of each of the population groups have particular sets of challenges that are best met with specific sets of care responses, combined in an integrated system of care to meet their particular needs.
2. *A commitment to a full range of services and sufficient, sustainable funding.* If there is general agreement that the populations noted above should have seamless systems of care to meet their needs, the next step is to agree that a full range of services, with sufficient and sustainable funding, is a prerequisite for care systems to function effectively. We suggest the need for commitments in principle that are enshrined in policy. How far one can go in achieving these commitments involves operational matters that obviously depend on a number of practical considerations. What is important is a public commitment to the goals of providing a comprehensive and coordinated range of services and to providing sufficient and sustainable funding.

Figure 1. A best practices framework for organizing systems of continuing/community care services



3. *A commitment to the psychosocial model of care*. Medical services are clearly important, and often life saving, and their significance should be fully recognized in a continuing/community care system of care. However, what distinguishes the needs of the people in these four population groups is their need for ongoing and long-term care, support and enablement. It is this range of services that enables people to function as much as possible and for as long as possible in their own environments. Thus, there should be a clear recognition of the importance of these non-medical services.
4. *A commitment to client-centred care.* For integrated systems of care to be effective, decision-makers, administrators and care providers should review each policy, practice and action through a lens that asks, "How does what I am doing, or what I am proposing, benefit the client or consumer of service?" If few benefits are noted, or if the actions have a detrimental effect, they should be changed to actions that do benefit clients. Case managers should be allowed to focus primarily on ensuring the best possible care response to client needs and, within existing fiscal realities, to be guides and advocates for clients. It is very important *not* to shift fiscal responsibility to front-line staff thereby making them, in effect, "fiscal police officers." Doing so produces role conflict and engenders mistrust by clients in the overall system of care.
5. *A commitment to analysis and evidence-based decision-making.* Further research and analysis are required across the health system but are particularly required in the continuing/community care sector as relatively little Canadian research on the organization, structure, efficiency and effectiveness of this sector has been conducted to date.

Decision-makers, administrators and care providers should review each policy, practice and action through a lens that asks, "How does what I am doing, or what I am proposing, benefit the client or consumer of service?"

Best Practices for Organizing a System of Continuing/Community Care

Following on these conceptual prerequisites, this section presents the *second component*, a set of 10 best practices for organizing service delivery systems. The first five best practices relate to administrative best practices, and the second five relate to best practices for service delivery.

Administrative Best Practices

Best Practice 1: A clear statement of philosophy enshrined in policy. To clearly indicate an understanding and acceptance of the philosophical and policy prerequisites noted above, a best practices system should enshrine, in policy, a vision statement that affirms decision-makers' beliefs in these prerequisites.

Best Practice 2: A single or highly coordinated administrative structure. A major problem with current systems is the negative impact of silos for different components of care. All services for a given population group should be under the administrative and financial control of one administrative entity; or, if there must be two or more entities, a highly coordinated administrative structure must be in place. This may mean shifts in administrative responsibilities to bring a range of services together under one administrative umbrella. While in some cases it may not be feasible to move a particular service under a given administrative umbrella, administrative control can still be realized through the coordination and/or purchase of services. This could be done, for example, for supportive services for children with special needs provided in schools. A single administrative entity allows one to allocate resources, develop strategic plans and rationalize human resources issues at the systems level and develop information systems for the whole system. A single administrative structure also has positive clinical benefits with care providers being more aware of the myriad of available services and how to access them.

Best Practice 3: A single funding envelope. A single funding envelope is critical to maximizing the efficiency, effectiveness and quality of care provided. Control over funding allows for resource transfers between system components and allows administrators to resolve many practical problems across system components such as different limits or caps on funding, varying user fees, different eligibility requirements, and policies about inconsistent remuneration for similar services or providers. Single-envelope funding rewards good boards and good managers since savings generated through effective management can go into new or enhanced services for clients.

Best Practice 4: Integrated electronic information systems. An integrated electronic information system eliminates the need for multiple assessments with clients and families having to tell their stories repeatedly. Regularly collected information on clients, service utilization and costs, with population data, can be used as the basis for sophisticated research and analysis on a range of clinical and administrative issues. It can serve as the basis for quality improvement initiatives, for accreditation and for clinical reviews of the efficacy of current practices. It can also provide the basis for regular reporting of key indicators about the nature and scope of services provided in a given geographic area.

Best Practice 5: Rewards and incentives for evidence-based management. Appropriate incentives are required to promote effective and evidence-based management. Decision-makers, officials and care providers should be encouraged to be "analytical managers" looking for ways to further improve and enhance the services and activities for which they are responsible, based

on evidence. In addition, it would be helpful to build in reward systems to recognize excellence in evidence-based management and care provision.

Clinical Best Practices

Best Practice 6: A single- or coordinated-entry system. Single entry provides for a consistent screening mechanism that ensures that only those with appropriate needs are provided services. This increases overall systems efficiencies because it minimizes the possibility that unnecessary care may be provided. In addition, single entry provides a focal point in local communities for care services. This means that individuals do not have to speak with multiple sources to find out what services are available and how they are obtained, increasing the level of user-friendliness of the care system. In systems without single entry, people may not obtain care, or the most appropriate care, because of a lack of knowledge about what is available to them. Given our four population groups, it may or may not be possible to establish single-entry systems for each group. Where this may not be feasible, at least in the short term, a system of *coordinated* entry could be developed. A limited set of care providers could be authorized to conduct standardized assessments and go through the appropriate procedures to register a new or returning client into the system of care.

Best Practice 7: Standardized system-level assessment and care authorization. Coordinated system-level assessment and care authorization (the process by which care from a given provider is authorized) ensures an appropriate determination of need and that an initial care plan is developed that is closely suited to the needs of the client and uses the full range of services available in the system of care. Care plans are a statement of the range and approximate volume of services to be delivered by one or more types of service providers. Based on a care plan, a client is "placed" – that is, provided access to care in *any* of the components or sets of components of the service delivery system whether these services are provided in institutions, the community or the client's own home. System-level assessment should use a standardized assessment tool tested for validity and reliability that provides the information case managers or care coordinators need to develop the best possible system-level care plan. Coordinated assessment and care authorization increase system efficiencies during this process, with consideration given to whether clients can be cared for in the community as opposed to a facility. In most cases, community-based care is less expensive. The system-level assessment and care authorization process maximizes the probability that the most appropriate services are provided based on the needs of the client.

Best Practice 8: A single system-level client classification system. A consistent client classification system across all sites of care allows for the analysis of clients across service delivery components, by level of care – that is, an "apples to apples" comparison. This permits analysts to determine the extent to which greater efficiencies may be possible, for example, to what extent clients who could be cared for at less cost in the community are being admitted to residential care. Being able to compare levels of care allows one to determine the extent to which similar types of clients are served across service components and permits a ministry or region to easily plan for an efficient and effective mix of services on a system-wide basis.

Best Practice 9: Ongoing system-level case management. As client needs change, care plans are adjusted to ensure that there is a continuing match between the needs of the client and the range of care services provided. This increases system efficiencies by not allowing clients to deteriorate, from lack of regular monitoring, to the point where more costly services such as admission to an acute care hospital may be required. Our view is that most clients are best served if they continue to have the same case manager over time, across all components of the system. That is, the same case manager continues to assist a client even when she or he moves from home care to residential care. As care responses evolve, there may be more use of short-term residential stays or people in residential care may return to the community more often. As a result, the facilitation of the best care response, over time, requires ongoing system-level case management.

Best Practice 10: Involvement of clients and families. A common complaint of clients and families is the lack of information and communication from care providers and agency administrators to clients and families. Many things can be done to address this concern. Clients could refer to existing websites for information. Governments or service provider organizations could set up their own websites to provide information about the most common conditions and issues faced by clients and families. Continuing/community care organizations, and clinicians themselves, could take greater care to ensure that appropriate information, in alternate formats and plain language, is provided to clients about their condition and the care provided. This material should be available in the most common languages spoken in the community where care is provided.

Our view is that most clients are best served if they continue to have the same case manager over time, across all components of the system.

Coordination/Linkage Mechanisms

How can systems of care for our four population groups be better linked to other health services such as hospitals and primary care and to other social and human services? These linkages are vital if we are to ensure the best possible care response to meet client needs, and they constitute the *third component* of our frame-

work. System-level case managers are not only responsible for coordinating care across service components *within* the system of care, but also, for ensuring optimal linkages and transfers *between* the clients' system of care and other health, social and human services. It is recognized that regional structures already constitute a framework in which some of the linkages noted below can readily be achieved.

Linkages across Systems of Care for Our Four Population Groups

Several methods of more closely linking services across our four population groups are suggested, including the following:

- *Administrative integration.* Some of our population groups may have relatively small numbers of clients in a given jurisdiction; thus, it may not be feasible or advisable to have separate systems of care for each group. Various sets of population groups with ongoing care needs can be combined into a single administrative entity.
- *Boundary-spanning linkage mechanisms.* It is important to designate boundary-spanning positions where staff members are access points in their systems to people from other systems. Specific people are then responsible and accountable for addressing issues where a client's needs require a response from more than one system. A suitable position for these contact points would be a manager or director of care. In addition, chief executive officers (CEOs) or designated senior persons could regularly liaise with their counterparts in other systems to resolve issues and bring about greater complementarities in policy and practice.
- *Co-location of staff.* If there are separate systems of care for different combinations of population groups, it would be helpful to co-locate people from the different systems and, as appropriate, actively facilitate the development of informal networks. It may be particularly helpful to co-locate service providers and case managers where possible. This option might be most feasible in circumstances where the organizational entity responsible for the system of care directly employs care staff such as nurses and home support workers.

Linkages with Hospitals

There are numerous potential mechanisms for linking the service delivery systems for persons with ongoing care needs to hospitals. These include the purchase of specialty care services, a hospital "in reach" approach, having community physician consultants to liaise with hospital physicians, greater integration of physical and mental health services, boundary-spanning linkage mechanisms, and a mandate for coordination.

- *Purchase of specialty care services.* A degree of administrative control can be achieved through purchase of service agreements. Specialty services, such as geriatric units, psychiatric wards, chronic care wards and specialty pediatric services, can be funded by continuing/community care organizations. Hospitals would still house these services but would be required to adjust policies and practices to ensure greater conformity with the mandates of the continuing/community care organization that funds these specialty services. This model gives such organizations "the power of the purse." Putting budgets for hospital specialty services into the budgets of continuing/community care organizations provides the latter with a significant budget base and allows them to try to achieve efficiencies through service substitutions.
- *Hospital in reach approach.* In a hospital in reach approach, integration is achieved because the people doing discharge planning are home care staff who are in a sense "admitting" clients into home care while they are still in the hospital, as opposed to having hospital staff "discharge" people to home care organizations. Thus, hospital discharge staff are replaced by, or converted into, home care staff who are located in the hospital.
- *Having physician consultants in the community to liaise with physicians in hospitals.* Some home care agencies in Canada employ community physicians, or physicians with formal positions in hospitals such as chiefs of family medicine, to be part-time consultants to home care. The role of these physicians is to facilitate relations with other physicians about clients in hospitals and in the community. Physician-to-physician discussions can facilitate client discharge and identify problems related to policy and practice between hospitals and home care.
- *Greater integration of physical and mental health services.* A major issue in mental health is the current dichotomy between care for mental illness and care for physical illness. This presents problems for people who have both mental and physical illnesses/impairments and may mean that it is difficult to obtain admission to a medical ward in a hospital for a psychiatric client. Even if a bed is made available, hospital staff may not be trained to deal with such clients. Steps to better integrate care in hospitals and in the community for people with both mental and physical illnesses would be a significant step to more integrated care for this population.
- *Boundary-spanning linkage mechanisms.* It would be helpful if the responsibilities of managers and directors of care in the hospital were expanded to specifically include coordination activities between the hospital and continuing/community care organizations. Having senior staff from the two organizations sit on each other's committees and having regular meetings of CEOs would greatly assist in achieving better coordination of services across the two types of providers.
- *A mandate for coordination.* Fiscal restraint of health and

social systems over the past decade or more has forced administrators to maximize the use of their resources for the care of their own clients, leaving few resources for coordination activities. Even in the current age of government budget surpluses in Canada, this trend may continue unless senior decision-makers mandate service coordination as a critical organizational function. Potential strategies may be to provide funding for boundary-spanning linkages and related activities and to make intersectoral and cross-agency collaboration a key requirement and performance indicator.

Linkages with Primary Healthcare

We propose four linkage mechanisms with primary healthcare:

- *Boundary-spanning linkage mechanisms.* Contact between senior executives of the continuing/community care organization and primary care physicians, on both formal and informal bases, should help to facilitate greater coordination and integration of care. Chronic disease management provides a particularly good vehicle around which care coordination can be facilitated between continuing/community care and primary healthcare.
- *Co-location of staff.* It may be useful to co-locate continuing/community care staff with primary healthcare staff. This option may be more appropriate for larger group practices or community health centres, with each organization respecting the other's distinct roles. Co-locating professionals who are responsible for the care of common clients is potentially a powerful way to increase the coordination and integration of client care.
- *Review of physician remuneration.* As the people in our four population groups have complex care needs, it can take longer for physicians to discuss care requirements and explain care provision options and treatments. To ensure that people in these groups receive adequate care and are not rushed, appropriate reviews of fee schedules or methods of compensation should be conducted for family physicians and specialists. Community service providers also find that having a physician assist them in relating to physicians in hospitals and in the community is helpful in improving client care. This type of activity may, however, not be adequately covered in existing fee schedules, particularly in regard to compensation for consultations between general practitioners and other care providers. Thus, a major issue that should be addressed is a review of fee schedules and methods of compensation for physicians.
- *Mixed models of continuing/community care and primary healthcare.* We believe that continuing/community care and primary healthcare are best seen as separate but complementary components of the healthcare system. Yet, it may be appropriate in some circumstances to consider mixed models. This is particularly true in Quebec, which already has well developed primary healthcare networks.

Linkages with Other Social and Human Services

It is also important to coordinate care with a range of other social and human services. The following are potential linkage mechanisms:

- *Purchase of service for specialty services.* If given services cannot be brought under the administrative umbrella of the continuing/community care organization, it may be appropriate to facilitate service coordination and integration through the purchase of service agreements. This approach might be particularly appropriate for specialty transportation services, educational programs for children with special needs and vocational rehabilitation programs. Adequate funding would need to be provided for the purchase of these services in the single-envelope funding provided to the continuing/community care organization.
- *Boundary-spanning linkage mechanisms.* Specific staff could be given responsibilities for coordination activities, and there could be formal links through cross-appointments to key committees and informal linkages through regular meetings between senior executives.
- *High-level cross-sectoral committees.* As noted above, high-level, cross-sectoral coordinating committees within government could play an effective role in developing policy and resource allocation frameworks that would facilitate the coordination and integration of services at the field level.

Schematics Related to Our Proposed Framework

Our proposed continuing/community care framework combines aspects from both integrated health systems (vertical integration) and primary healthcare (a broad, horizontal base of home and community services) into one system. Our model has components of primary care, secondary care and tertiary/quaternary care that link both horizontally and vertically through case management. To help visualize our framework, we offer a series of schematics.

Figure 2 presents the structure of a generic system that could apply to all four population groups. It should be noted that a schematic similar to Figure 2 can be developed for each of the four population groups using the sets of services noted in Table 1. Figure 3 presents a sample application of the approach used in Figure 2 for the care of the elderly.

Figure 4 illustrates how clients would flow through a system of continuing/community care. Clients can refer themselves to the system or be referred by family members, professionals or other concerned persons. The referral is made to the local organization that is the single point of entry. Typically a telephone screening is done to provide information, ask about care needs and inquire

about eligibility. If it appears that the client is a potential candidate for care, the client is assessed using a system-level assessment tool (preferably with a built-in classification system).

A care plan is developed based on the assessment, a discussion with the client and his or her family, and discussions with the family physician and/or a specialist. The client then enters the care system. If the client has complex problems, he or she may be seen in a hospital-based specialty service, such as a geriatric assessment and treatment unit or a psychiatric evaluation unit. Once assessed in the specialty unit the client may be admitted to a hospital-based service such as a psychiatric ward or an extended care/chronic care ward in the hospital, or may be referred to a residential facility or a community agency.

Clients who do not go to a specialty acute care service (most clients are in this group) may be admitted to a residential facility or receive one or more health, social and/or human services in the community, and may be referred for additional care to health and human services outside the system of care. Clients would be reassessed by their system-level case managers on a regular basis, and their care plan would be revised, as necessary. Clients may also leave the system but can be referred back to it at any time. This client flow schematic can be adapted to any of the four population groups using the services noted for the respective population group in Table 1.

Discussion

This paper has identified a large number of similarities in the needs of, and commensurate care responses for, four different populations. Seniors, adults with physical disabilities, persons requiring mental health services and children with special needs may have characteristics that are unique, yet they also have a broad commonality in regard to the services they need and the challenges their respective service delivery systems face.

Developing appropriate, caring, responsive, sustainable and efficient care delivery systems is challenging. It is particularly so for people with ongoing care needs who, due to their health conditions, require a range of health, social and human services. It is hoped that this paper will

Figure 2. The structure of the continuing/community care service delivery system

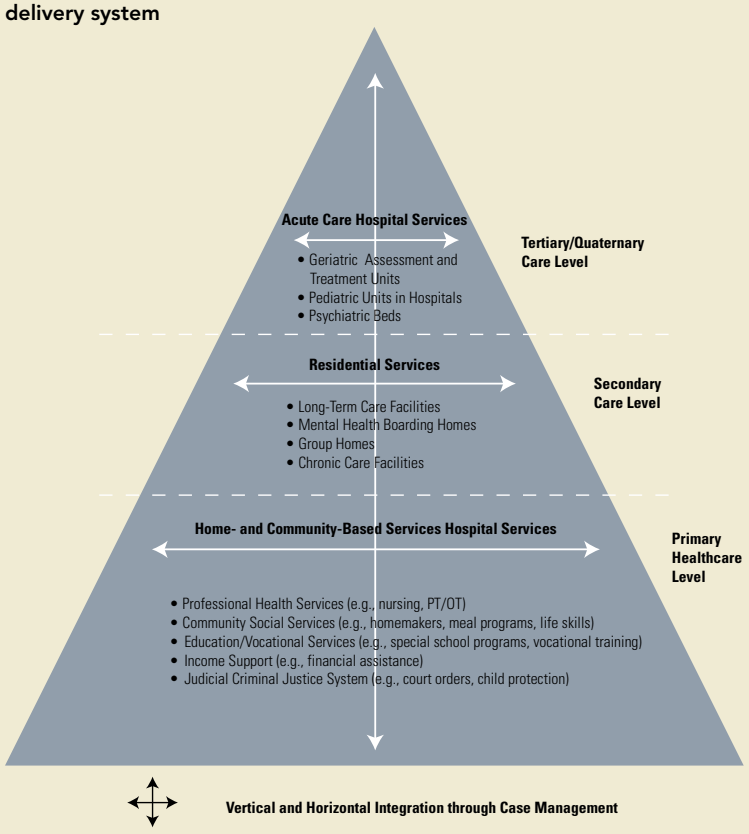


Figure 3. Application of the framework to the elderly

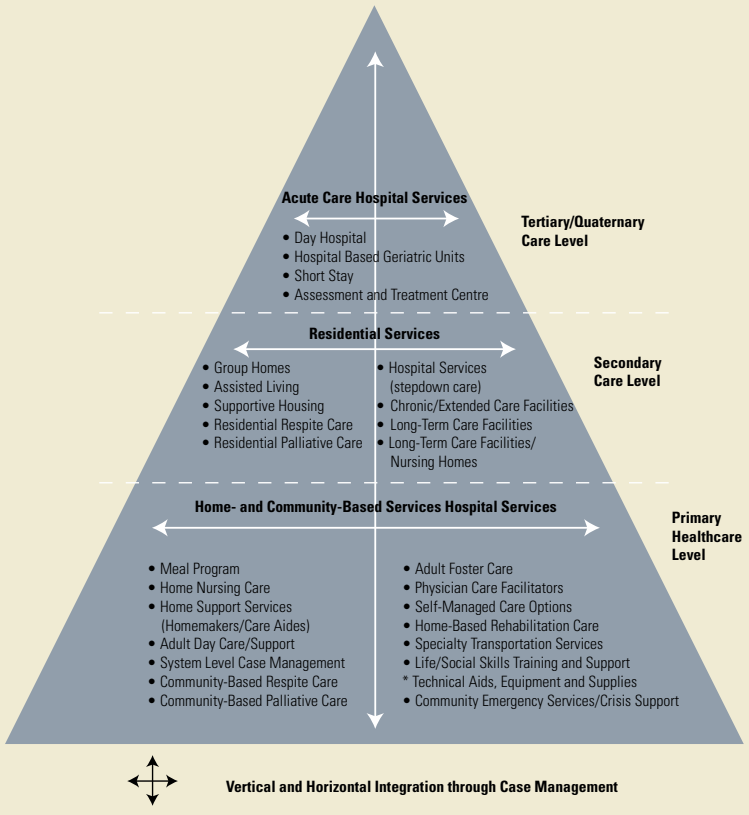
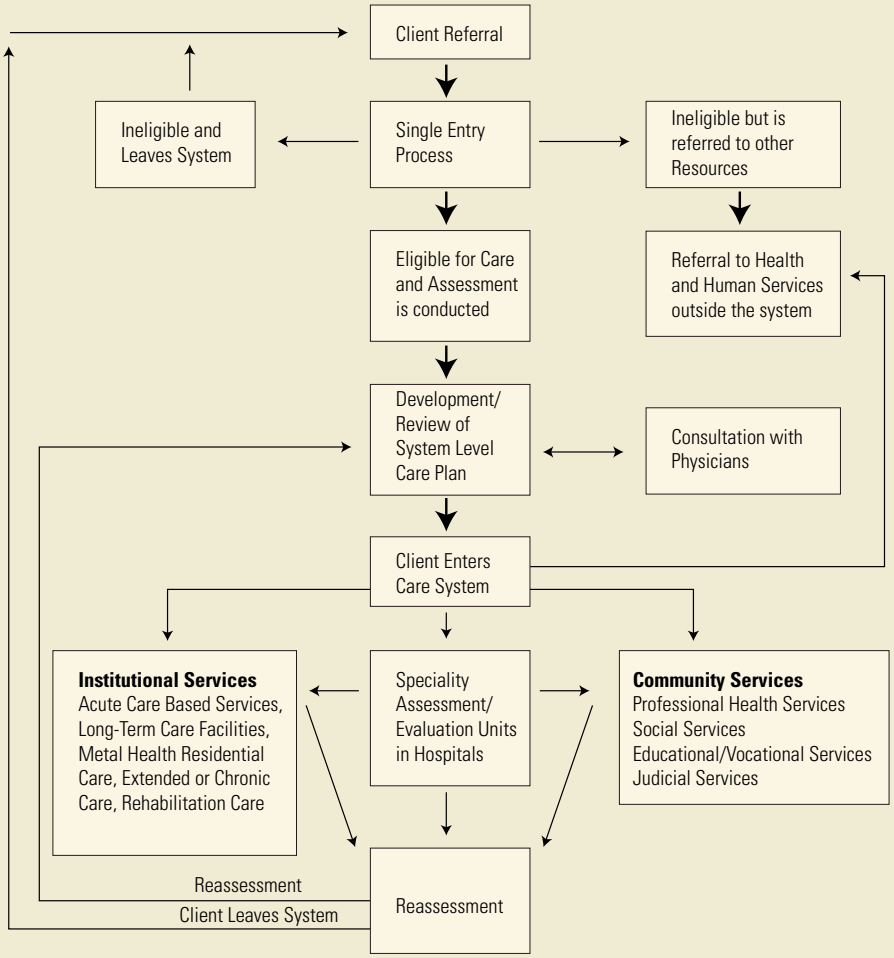


Figure 4. Client flow through the system of care



stimulate discussion about how best to respond to the needs of Canadians requiring ongoing care. HQ

Acknowledgements

We would like to acknowledge the contributions of all of the survey and focus group respondents who participated in our project. We would also like to thank the research teams that conducted the studies that form the series of technical reports on each population group. Finally, we would like to acknowledge the contribution of our funder, the Home Care and Pharmaceuticals Division of Health Canada. The views expressed in this report, and in the technical reports for this project, do not necessarily represent the views of Health Canada.

Bibliography

Baranek, P.M. 2001. *Analysis of Interfaces along the Continuum of Care. Technical Report 6: Interviews with Key Informants.* Victoria, BC: Hollander Analytical Services Ltd.

Hollander, M.J. 2001. *Analysis of Interfaces along the Continuum of Care. Technical Report 1: Literature Review.* Victoria, BC: Hollander Analytical Services Ltd.

Hollander, M.J. and M.J. Prince. 2002. *Analysis of Interfaces along the Continuum of Care. Final Report: "The Third Way": A Framework for Organizing Health Related Services for Individuals with Ongoing Care Needs and Their Families.* Victoria, BC: Hollander Analytical Services Ltd.

Hollander, M.J., N.L. Chappell, M.J. Prince and E. Shapiro 2007. "Providing Care and Support for an Aging Population: Briefing Notes on Key Policy Issues." *Healthcare Quarterly* 10(3): 34–45.

McEwan, K., R. Ritter and B. Lawrence. 2001. *Analysis of Interfaces along the Continuum of Care. Technical Report 4: Adults Requiring Mental Health Services.* Victoria, BC: Hollander Analytical Services Ltd.

Parent, K., M. Anderson, J. Keefe and M. MacLellan. 2001a. *Analysis of Interfaces along the Continuum of Care. Technical Report 2: Seniors.* Victoria, BC: Hollander Analytical Services Ltd.

Parent, K., M. Anderson, J. Keefe and M. MacLellan. 2001b. *Analysis of Interfaces along the Continuum of Care. Technical Report 3: Adults with Physical Disabilities.* Victoria, BC: Hollander Analytical Services Ltd.

Spalding, K.L., V.E. Hayes, A.P. Williams and P. McKeever. 2001. *Analysis of Interfaces along the Continuum of Care. Technical Report 5: Services for Children with Special Needs and Their Families.* Victoria, BC: Hollander Analytical Services Ltd.

About the Authors

Marcus J. Hollander, PhD, is president of Hollander Analytical Services Ltd. in Victoria, British Columbia. He can be contacted at 250-384-2776, by fax at 250-389-0105 and by e-mail at marcus@hollanderanalytical.com.

Michael J. Prince, PhD, is Lansdowne Professor of Social Policy in the Faculty of Human and Social Development, University of Victoria, Victoria, British Columbia. He can be contacted at 250-721-8043, by fax at 250-721-7067 or by e-mail at mprince@uvic.ca.

INSPIRING IDEAS & INNOVATION

OHA HealthAchieve2008

A WORLD CLASS SHOWCASE OF ACHIEVEMENT IN HEALTH CARE

Conference:
November 3, 4, 5

Exhibition:
November 3, 4

Metro Toronto Convention Centre
Toronto, Ontario, Canada

If you play an important role in health care, this show is a 'must attend' event for you. See the latest in technology, listen to the most dynamic leaders in our industry and participate in sessions highlighting many of the issues facing health care today.

Please join us at OHA HealthAchieve2008 on November 3, 4 & 5 at the Metro Toronto Convention Centre.

For more information, please call (416) 205-1434 or visit:

www.ohahealthachieve.com

EXHIBITOR INFORMATION

Isabella Wai, Director of Exhibits
Telephone: 416.205.1354
Email: iwai@oha.com

SPONSORSHIP & ADVERTISING

Susan Jacobs, Program Planner
Telephone: 416.205.1364
Email: sjacobs@oha.com