Why the Buzz About Integrated Care?

- Patients with chronic conditions typically require care from a variety of health and social care providers for an extended period of time. They are the most costly users of health services.
- Those over age 65 comprise the largest subgroup of chronic care patients but younger adults and children with disabilities are included in this patient group.
- Integrated care is widely viewed as one way to address issues arising from poor quality/wasted resources because of the siloed, fragmented care systems in many developed countries.
Integration Goals of Health Policy Makers

- The rationale for interest in integration is driven by concerns that existing health systems are not well positioned to care for people with chronic conditions.

- The system goals of integration efforts are to improve access, quality and financial sustainability.

- These goals can be mutually exclusive but in some demonstration projects, all three goals have been achieved.

Purpose of our Study

- To understand the potential benefits of integrated care systems;
- Identify the features of successful models of integrated care for seniors;
- To assess the extent to which Canadian provinces are implementing these features.
Methodology

- Literature review
- Survey of the provinces

Clarifying the Language:

- **Linkage:** referrals to independent providers
- **Coordination:** explicit agreements to smooth transitions among providers
- **Full integration:** new organizational and pooled funding mechanisms to achieve a shared goal
What do Integration Programs for the Elderly Try to Achieve?

- **Cost-Effectiveness** --- reduced hospital days, avoided or delayed LTC home placements while maintaining quality and access to care at no additional cost or less cost than the traditional system

- Only 3 projects (in RCTs) have achieved cost-effectiveness to date: SIPA (Canada), Integrated Care (Italy), Hospital Admission Risk Program (Australia)

Characteristics of Successful Models

- Targeted admission criteria
- Case managed team approach
- Access to a wide range of services to meet client needs, and often
- Active involvement of physicians
Infrastructure supports

- Shared clinical and administrative information systems
- Financial incentives to change behavior
- Shared vision and goals
- Excellent leadership

Are Canadian Provinces Implementing Features of Successful Integration Models?

The Hollander and Prince framework contains 4 sections:
- Philosophical and Policy Prerequisites
- Administrative Best Practices
- Clinical Best Practices
- Linkages with:
  - Acute care
  - Primary care
  - Other social and human services
  - Across population groups
Survey of the Provinces

- Used the features of the Hollander and Prince framework to develop a questionnaire to the provinces
- Administered in the summer/early fall 2008
- All provinces responded except Quebec
- Quebec RHA responded
- The Winnipeg RHA provided material to supplement the material from the Manitoba Ministry of Health

Results

Philosophical and Policy Prerequisites
Most provinces supported most of them

Administrative Best Practices
None has implemented all of the administrative best practices
- **Four provinces did not think having a single funding envelope was important**
- None has implemented an integrated information system but Quebec is very far ahead
- None has an incentive system for evidence-based management
Results

- **Clinical Best Practices**
  - This is the best developed area of the framework
  - Seven provinces indicated that they have a single or coordinated entry system
  - Nine have province-wide assessment and care authorization instruments
  - Seven have system-level classification systems
  - Six have ongoing care management
  - All have mechanisms for communicating with families

Results: Linkages Mechanisms

- Least developed area among the framework features
- **Linkages across Population Groups**
  - 50% do not think this is important
  - 50% have staff whose job includes acting as access points to people from other systems
• **Linkages with Hospitals**
  - Eight provinces have case managers co-located in hospitals
  - Only two provinces reported that they have physicians responsible for coordination between hospital and home care
  - Three provinces have hospital-based nurses who provide specialized services in LTC homes to prevent avoidable hospitalizations
  - Five provinces have community physicians who make home visits to frail elders to avoid hospitalizations

• **Linkages with Primary Care**
  - Only one province (Ontario) reported that it has case managers co-located in physicians offices.
  - Two reported that there are physicians associated with the home care program who coordinate with primary care physicians
  - Five reported that physicians are remunerated appropriately for care of the frail elderly
  - Four reported that physicians are adequately remunerated for home visits
Linkages with Other Social and Human Services

- Only three reported that they have financial arrangements for purchase of transportation services
- Five reported that there is an organized approach to various levels of housing with supportive services
- Six reported that there is a system for high level planning of services for seniors

Conclusions

- Building from province-wide home and community care programs, Canadian provinces are well positioned to improve the delivery of care for seniors
- However, progress has been slow in some areas:
  - Implementing shared information systems
  - There is weak implementation of linkages among hospitals, primary care and the home and community care system
Case Study: The PRISMA Project in Quebec

- PRISMA is a system-wide health reform in the Eastern Townships region of Quebec to improve the quality of care for the frail elderly
- It is the first coordination-type model being implemented in a large region

Coordination Integration Model

- Features include:
  - Co-ordination between decision-makers and managers at regional and local levels
  - Single entry point
  - Case management
  - Individualized service plans
  - A single assessment instrument coupled with a case mix management system
  - A computerized clinical chart
Results to Date: 2001-2004

- After 4 years there is on average an 80% implementation rate of the features of the model
- Functional levels of treatment area elders are holding steady while those in the comparison area are increasing
- Unmet needs in the comparison area is double that of the treatment group
- Treatment area elders now have significantly fewer visits to ERs and fewer hospitalizations
To date, no statistical difference on deaths, physician visits, repeat ER visits, or nursing home placements but indicators are trending in the right direction

Client empowerment and satisfaction levels are higher in the treatment area

Cost data are not available yet

At least one hospitalisation

- $p = 0.185$
- $p = 0.027$
- $p = 0.027$
- $p = 0.204$
- $p = 0.364$
- $p = 0.953$
- $p = 0.449$

$T$ - $C$
At least one visit to ER

Next Steps

- The PRISMA model is now being implemented in France
- The Ministry of Health in Quebec has required all regional health authorities to implement PRISMA-type models
Lessons for Canada (and maybe other countries)

- System-wide reform takes time and requires:
  - Dedicated leadership among decision-makers
  - Authority to implement infrastructure supports such as inter-operable electronic charts; staff training and change management systems; ongoing performance management and quality assurance systems
  - Mechanisms to engage primary care physicians, most of whom work in solo or small group practices

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