

Moving Toward Health Service Integration: System Change for Seniors in Canada

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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.

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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.

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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.

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Methodology

- Literature review
- Survey of the provinces

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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

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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)

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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

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Infrastructure supports

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

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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

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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

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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

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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

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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

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- **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

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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

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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

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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

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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

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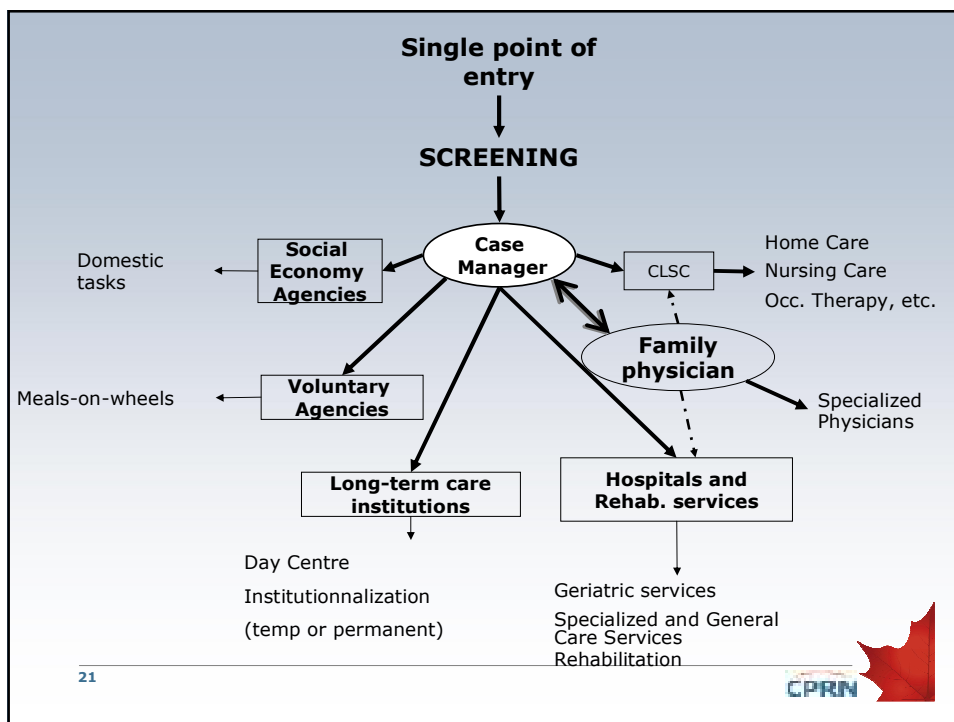


Coordination Integration Model

- 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

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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

Results (Continued)

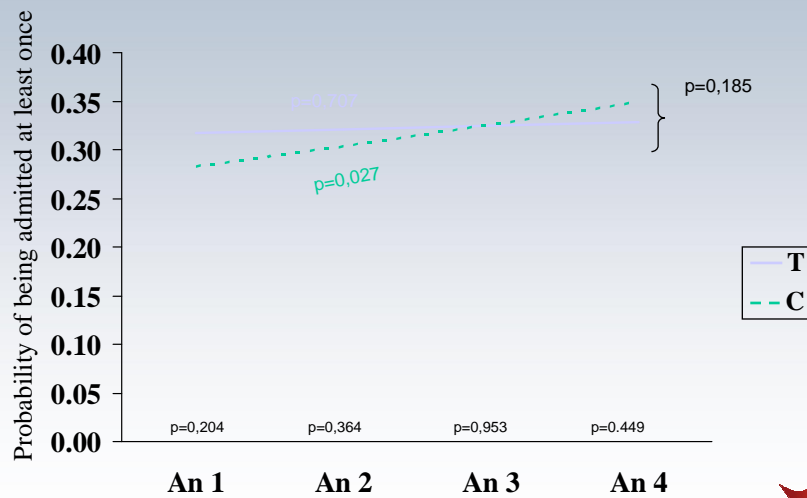
- To date, no statistical difference on deaths, physician visits, repeat ER visits, or nursing home placements but indicators are trending in the right direction
- Client empowerment and satisfaction levels are higher in the treatment area
- Cost data are not available yet

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At least one hospitalisation

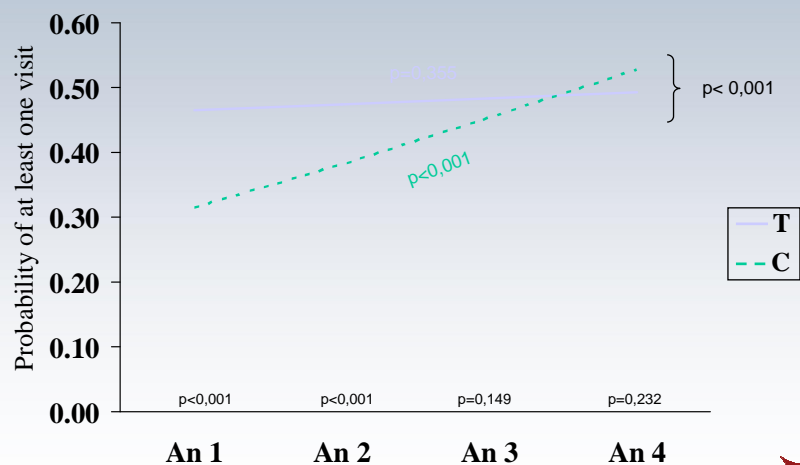


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At least one visit to ER



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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

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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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