Achieving Real Care Coordination: Lessons from Canada
All modern health systems have similar problems:

- Imbalance between care and cure;
- Fragmented financing, regulations and inadequate LTC coverage;
- Poor collaboration at organizational and provider levels, and between acute and LTC; and
- Increasing numbers of patients with complex chronic conditions
Why We Care

• Integrated care is seen as an initiative to increase patient satisfaction, quality of care and possibly, to contain costs.

• Promising results have been found in a small but slowly growing number of evaluated demonstration programs.
Canada is a confederation with the mandate for health and social care devolved to the 10 provinces.

The Canada Health Act provides a single payer system for hospital and physician care only. There is no option for private coverage of these services.

Home, community and residential LTC care is provided by provincial funding, based on need. There is no means testing in any province.

All other health services such as pharmaceutical care, equipment and supplies, etc., are funded through a mixture of public and private programs although not everyone is covered.
The 2004 Health Accord between the federal government and the provinces increased federal funding considerably and also provided for the first time, federal funding for home care.

The home care funding was targeted to those needing care after a hospital admission.

Post-acute home care was supported because up to 20% of hospital beds were being used by those no longer needing inpatient care, i.e. “bed blockers”.
Since 2004, there has been a significant reduction in home care services for those who need supportive assistance, i.e. housekeeping, laundry, and meal preparation.

There has been an increase in nursing care and personal care such as bathing dressing and toileting;

There has been an increase in average cost per client; and

This is the case across the country.
Today’s Situation

- All provinces recognize the need to improve patient care experience, quality and availability of services, and contain cost increases, through improved efficiency in the system.

- As a result, integrated care, especially for frequent users of hospital ERs and inpatient beds, is an important policy goal in most provinces.
Integrated Care in Canada

- There is no one definition of integrated care used by provincial Ministries of Health.
- There is no commonly accepted set of performance measures.
- But here are commonly accepted features of integration in Canada.
Clinical Features of Integration

- 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 Features

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

Map of Canada  www.trailcanada.com
PRISMA focused on integrating health and social services in alignment with medical management.

Features of the PRISMA Model:

1. Coordination among services.
2. Single point of entry
3. Case Management
4. Unique Assessment Tool
5. Individualized Service Plan
6. Information Tool
By year 3, the rate of implementation of all of the key features of the model approached 80%. Physician participation was 73%.

After four years, the PRISMA model produced significant reductions in the prevalence and incidence of functional decline, reduced ER visits, and increased client satisfaction and empowerment.
Results

✓ There was no statistically significant effect on rates of nursing home placement, consultations with health professionals, use of home care services, or cost.

✓ PRISMA produced *improved results at no additional cost*.

✓ The PRISMA model and its features have been adopted by the Ministry of Health and Social Services in Quebec as the standard of care for older adults in all regions of the province.
Patient Flow in the PRISMA Model

Figure 1: FLOW OF PATIENTS THROUGH THE CO-ORDINATED PRISMA MODEL

- Single point of entry
- Screening

- Domestic tasks
- Social economy agencies
- Voluntary agencies

- Meals-on-wheels

- Case Manager
- CLSC
- Family physician

- Long-term care institutions
- Hospitals and rehabilitation services

- Day centre
- Institutionalization (temporary or permanent)
- Geriatric services
- Specialised and general care services
- Rehabilitation
- Home care
  - Nursing Care
  - Occupational therapy etc.
- Specialised physicians
Success Factors

Unusual Level of Collaboration:
A partnership among university researchers, the provincial government, regional health and social service planning and funding authorities as well as managers from the home and community care service centres was created and sustained for over 15 years.

Sustained Regional Leadership:
Key leaders stayed in their positions and maintained the PRISMA vision throughout many other changes locally and provincially.
Other Success Factors

- PRISMA was never seen as a demonstration project but rather as a *whole system change* in care for the frail elderly.

- The model was collaborative: it did not require organizational restructuring and thus was not seen as threatening to participating organizations.
The Situation Today

- When the PRISMA model was adopted by the Ministry of Health, each region was granted flexibility for implementing the model’s features.

- But all regions are being monitored by the Ministry against a uniform set of accountability measures.
<table>
<thead>
<tr>
<th>Feature</th>
<th>% Implemented in 2008</th>
<th>% Implemented in 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointment of a person responsible for implementation</td>
<td>77.4%</td>
<td>84.4%</td>
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<tr>
<td>Assessment</td>
<td>54.5%</td>
<td>67.4%</td>
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<tr>
<td>Availability of a specialized geriatric service</td>
<td>36.9%</td>
<td>67.1%</td>
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<tr>
<td>Single entry point</td>
<td>36.0%</td>
<td>64.3%</td>
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<tr>
<td>Case Management</td>
<td>31.1%</td>
<td>53.3%</td>
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<tr>
<td>Availability of a family physician</td>
<td>27.5%</td>
<td>48.9%</td>
</tr>
<tr>
<td>Coordination mechanism</td>
<td>26.9%</td>
<td>48.10%</td>
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<td>Communications system</td>
<td>26.5%</td>
<td>40.4%</td>
</tr>
<tr>
<td>Service Plan</td>
<td>15.6%</td>
<td>15.3%</td>
</tr>
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Ongoing Issues

- **Physician Remuneration.**
  - Most primary care physicians in Quebec are paid on a fee-for-service basis which does not reimburse them for their time in care planning and service coordination. Though PRISMA achieved 73% participation among physicians, it is difficult to replicate that achievement throughout the Province.

- **On-going Training and Coaching**
  - Individual health professionals do not automatically consider the possible role of other providers, especially those at the home support/social care level;
  - Case managers need training in the coordination features of their roles; and
  - The pace of change and staff turnover can quickly result in redirection of staff away from PRISMA goals unless there is on-going accountability.
Because of the scope of change, especially among clinical and organization providers, it is very important to view integration efforts as a long time commitment.

If integration efforts are going to be evaluated, it is important to give the effort enough time to show its impacts.
Thank you very much for your attention!

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