Approaches to supporting older people to maintain autonomy

The PRISMA Model in Quebec, Canada

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Leveraging the Culture of Performance Excellence in Ontario’s Health System

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- PRISMA Leads: Rejéan Hebert, Michel Raîche and colleagues
PRISMA is a French acronym for:

Program of Research to Integrate the Services for the Maintenance of Autonomy

PRISMA focuses on integrating health and social services in alignment with medical management.
A Brief Overview of PRISMA Results

1. **By year 3**, the rate of implementation of all of the key features of the model approached 80%. Physician participation was 73%.

2. **After four years**, the PRISMA model produced significant reductions in the prevalence and incidence of functional decline, reduced ER visits, increased client satisfaction and empowerment.
3. There was no statistically significant effect on rates of nursing home placement, consultations with health professionals, use of home care services, or costs - indicating that PRISMA produced *improved results at no additional cost*.

4. The PRISMA model has been adopted by the Ministry of Health and Social Services in Quebec as the standard of care for older adults in all regions across the entire province.
The PRISMA Program
The PRISMA Program

• Began as a research project in one region in Quebec to improve emergency department and other hospital utilization problems among older people.
• Initially spread for implementation to 3 intervention with 3 control regions (urban, suburban & rural)
• Goal was to improve continuity in care experienced by older people with chronic conditions.
• An integrated service delivery network was established using a coordination-type model of care.
The PRISMA Model

Figure 1: Flow of Patients Through the Co-ordinated PRISMA Model

- Single point of entry
- Screening

- Domestic tasks
- Meals-on-wheels

- Social economy agencies
- Voluntary agencies

- Case Manager
- CLSC

- Home care
  - Nursing Care
  - Occupational therapy etc.

- Family physician
  - Specialised physicians

- Long-term care institutions
  - Day centre
  - Institutionalization (temporary or permanent)

- Hospitals and rehabilitation services
  - Geriatric services
  - Specialised and general care services
  - Rehabilitation
6 Components of PRISMA

1. Coordination among services.
2. Single point of entry
3. Case Management
4. Unique Assessment Tool
5. Individualized Service Plan
6. Information Tool
6 Components of PRISMA

1. Coordination among services.

**Strategic**: Local Governance Table for structures, financing and protocols comprising hospital CEOs and CEOs/chairs/directors of community care agencies.

**Operational**: Local management committee to ensure mechanisms for coordination

**Clinical**: multidisciplinary teams
2. **Single point of entry**

- Clients may self-refer, be referred by their physicians or by other professionals in the community, such as hospital discharge planners, home care providers or housing and social care providers.
- Clients are screened at the time of initial contact with the program using a seven question screening tool developed to quickly identify seniors who should receive the full assessment.
3. Case Management

- Functions include: assessment, referral to other professions, planning of services with patient and family, service ‘broker’, follow-up.
- Distributed by territory/neighbourhood.
- Nurse, social worker or other with special training.
- Accountable to Local Governance Table (not agencies/providers).
- Case load target: 40-45
4. Unique Assessment Tool

- The SMAF (French acronym for Functional Autonomy Measurement System) is a 29 item assessment tool used to measure functioning in five areas: Activities of Daily Living (ADLs) and Instrumental ADLs (IADLs), as well as mobility, communication and mental abilities.
- Uses: Service allocation, monitoring, management and financing.
- Admission criteria SMAF score 15+ (out of 87)
5. Individualized Service Plan

- Prepared based on assessment
- Lead by case-manager
- Consensus among providers
- Approved by patient and family (empowerment)
- Includes management plan for each provider
- Periodical revision
6. **Information Tool**

- Computerized clinical chart
- Facilitates information flow
- Accessible by all professionals and institutions
- Data generator for monitoring and research

*However, accessing the computerized system among independent physicians in the community is still an issue.*
Contextual Success Factors

Collaboration and leadership:

- partnership among university researchers, the provincial government and regional health and social service planning and funding authorities as well as managers from the home and community care service centres sustained over 15 years.

Sustained incremental change within a broad vision

- Over time, the key elements of integrated networks were put into place as recommended by the researchers involved with the design of the PRISMA project
How was it spread

• In the original Region (Estrie), PRISMA was not viewed as a one-time research project, but rather as part of a larger system change designed to improve care for the frail elderly.

• A range of Provincial changes were initiated while PRISMA was implemented and evaluated:
  ✷ Regional structure with local Area Networks and Health and Social Care Centres
  ✷ Guidelines for coordinated care of the elderly
  ✷ Standardized assessment tool for all local services
  ✷ Centralized single-access points for care established in all regions
Flexibility for local implementation:

A key decision has been to allow regions flexibility in implementing the features of PRISMA in ways that are appropriate for local areas.

Co-ordination type model is flexible:

PRISMA does not require either vertical or horizontal mergers or the creation of a new or greatly modified entity.
Performance Accountability Measures directly linked to implementation fidelity (see next slide).

Primary focus has been on process measures for quality assurance while measuring and monitoring outcomes. This approach was taken because it is difficult to attribute outcomes to a particular provider or intervention when so many variables are involved.
## Sustainability & Spread Mechanisms

### Degree of Implementation of Network Integration Features in Quebec: 2008-2011

<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>
</tr>
<tr>
<td>Coordination mechanism</td>
<td>26.9%</td>
<td>48.1%</td>
</tr>
<tr>
<td>Single Entry point</td>
<td>36.0%</td>
<td>64.3%</td>
</tr>
<tr>
<td>Case Management</td>
<td>31.1%</td>
<td>53.3%</td>
</tr>
<tr>
<td>Assessment Tool</td>
<td>54.5%</td>
<td>67.4%</td>
</tr>
<tr>
<td>Individualized Service Plan</td>
<td>15.6%</td>
<td>15.3%</td>
</tr>
<tr>
<td>Information Tool</td>
<td>26.5%</td>
<td>40.4%</td>
</tr>
<tr>
<td>Availability of a family physician</td>
<td>27.5%</td>
<td>48.9%</td>
</tr>
<tr>
<td>Availability of a specialized geriatric service</td>
<td>36.9%</td>
<td>67.1%</td>
</tr>
</tbody>
</table>
Sustainability & Spread 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 the PRISMA Project achieved 73% participation among physicians by 3 years, *spread* is slower.

- **Ongoing Training and Coaching**
  - Individual health professionals do not automatically consider the possible role of other providers, especially those at the home support level.
  - Case managers need training in the coordination features of their roles.
  - The pace of change and staff turnover can quickly result in redirection of staff away from PRISMA goals.
Successful implementation takes time:

- One of the key lessons learned is that integration programs need time to develop because of the range of service providers (from the very large, such as hospitals to the very small, such as local home delivered meals programs).

- The PRISMA evaluation was a four year longitudinal study. The wisdom of the choice of four years was seen in the fact that it took until year 3 to reach a 70% implementation rate of all the features (including physician participation). The impact of the model was not apparent until year 3.

- PRISMA has now been taken to scale as the standard of care for older persons in all of Quebec under the name RSIPA.
Questions?

Further information can be found at:
http://www.prismaquebec.ca/cgi-cs/cs.waframe.index?lang=2

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