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Moving Toward Health Service Integration: Provincial Progress in System Change for Seniors

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CPRN Research Report | May 2009

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This report, *Health Service Integration: Provincial Progress in System Change for Seniors*, has been funded by The Change Foundation. The Ontario Ministry of Health and Long-Term Care funded the initial literature review and the survey of provincial ministries of health.

The views expressed in the report are the views of the author and do not necessarily reflect those of the Ontario Ministry of Health and Long-Term Care or The Change Foundation.

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Acknowledgments

This report would not have been possible without the assistance of staff from the provincial ministries of health, the Winnipeg Regional Health Authority and the Agence de la Santé et des Services Sociaux de l'Estrie. Marcus Hollander, Hollander Analytical Services, is thanked for his comments.

Executive Summary

Introduction

The need to improve the quality of care for those with chronic conditions and the continued sustainability of Canada's publicly funded health care system are critical and ongoing challenges for health policy-makers and service providers. The issues are interrelated. People with chronic conditions are the most frequent users of health care services, but the system is not designed to maximize the use of appropriate health resources for this group. Moreover, those over age 65 (seniors) are much more likely to have chronic conditions than those younger.

Improved service coordination and integration in the delivery of elderly chronic care are viable ways to reduce wasted resources, fragmented care and patient dissatisfaction while improving cost-effectiveness. However, the implementation of integrated service models for chronic care represents a complex shift for systems that are well structured to provide episodic care within traditional health care frameworks.

Project Purpose

The purposes of this research project were to review the conceptual understandings underlying integrated care, to examine models of cost-effective care for the elderly, to identify their features and then to ascertain to what extent Canadian provinces were implementing these features.

The study consisted of three parts: a literature review, a survey of provinces' activity in implementing an integrated model for elderly care and a roundtable. The roundtable was held on February 25, 2009, and included the participation of government policy-makers, representatives of community-based service providers and academics.

Literature Review[1]

One of the key findings from the literature review was that integrated care is a process through which health policy goals can be accomplished; it is not an end in itself. It follows that there is no single approach to integrating health care; the approach taken depends upon the policy goal. Successful efforts are those that have, from the outset, a clear goal. Typically, goals include improving access, quality and financial sustainability.

Trials of Integrated Models of Care of the Elderly

There have been few large trials of integrated care for seniors. We found only seven studies that met our inclusion criteria. They are briefly summarized in Section 2 of the report. Each used a formal evaluation process including randomized assignment of subjects or developed a comparison group. The outcomes of interest in these projects included reductions in hospital and nursing home use, improvement in client satisfaction, and cost-effectiveness or cost savings, respectively.

[1] A more detailed report on the literature review is available at www.cprn.org (MacAdam, 2008).

Reviews of Programs of Integrated Health and Social Care of the Elderly

Kodner and Kyriacou (2000) compared the features of two large, multi-site American models of integrated care, the Program for All-Inclusive Care of the Elderly (PACE) model and the Social Health Maintenance Organization (SHMO) model. Six key features influenced the efficiency and effectiveness of comprehensive models of care for the elderly:

- longitudinal care management, spanning time, setting and discipline;
- intensive interdisciplinary team care;
- geriatric philosophy, meaning a commitment to a holistic approach to care of the elderly, and focus, including a central role for the primary care physician;
- organized provider and clinical arrangements to achieve horizontal and vertical alignment;
- appropriate targeting (i.e. serving the right population and keeping the size of patient load within management limits); and
- mechanisms to pool funding streams to assure administrative and clinical flexibility.

To be effective, integrated models of care need to ensure that the features listed above are supportive of each other.

In summary, no single element of integrated models of care has been shown to be effective in and of itself. However, at a minimum, all successful programs of integrated care for seniors use multidisciplinary care/case management for seniors at risk of poor outcomes supported by access to a range of health and social services. The strongest programs often include the active involvement of physicians. Decision tools, common assessment and care planning instruments and integrated data systems are commonly listed infrastructure supports for integrated care.

Reports of International Surveys of Features of Integrated Care Models

Survey findings indicate that policy-makers in many countries are developing a consensus about the features of integrated health and social care models. In particular, the surveys indicate a number of similarities congruent with the findings from evaluated integrated care programs: for example, the importance of cross-sectoral and cross-professional linkages for collaborative care planning; the use of multidisciplinary case/care management supported by shared assessment information, information technology and decision support; and, lastly, the development of appropriate financial and other incentives to encourage the involvement of organizations and professionals in shared program goals.

Frameworks of Integrated Care

Frameworks of integrated care are tools that can be used to guide the implementation of health reforms. Frameworks do not dictate how a health reform must be structured. Local or regional integration models should include framework features but combined in ways that are appropriate to the goal(s) of reform and local contextual features of care. We found the following frameworks for integrated care: Leutz (1999); Hollander and Prince (2008); Kodner and Spreeuwenberg (2002); and Banks (2004).

Based on a review of the literature and data collected from Canadian jurisdictions, Hollander and Prince (2001; 2008) developed a framework for continuing care for people with disabilities (the elderly, those with mental illness, and adults and children with disabilities). It has three parts: philosophical and policy prerequisites that underlie ongoing support for integrated systems of care for those with disabilities; a set of best practices for organizing service delivery; and a set of mechanisms for coordination and linkage across the range of organizations and professionals involved in delivering continuing care services.

The Hollander and Prince framework is the most developed and nicely summarizes the relationships among integration features identified in the international literature. Therefore, it was selected to form the basis of a survey of provincial ministries of health in Canada.

Results of a Survey of Canadian Provinces

We collected new information about the extent to which Canadian provincial governments are moving toward implementing integrated care systems for the elderly. The items of the Hollander and Prince (2001, 2008) framework for integrated care were used as a guide for survey questions. Contextual information on the utilization of nursing home and home care services was collected in the initial survey questions. The list of possible home care services for seniors was developed from Hollander and Prince (2001). The section of the framework on linkage mechanisms was adapted to be more specific about linkage techniques as they apply to services for seniors.

Nursing Home[2] Bed Supply and Utilization

There are about 151,979 nursing home beds in the nine provinces responding to the survey.[3] Manitoba appears to have a larger supply of nursing home beds per senior (aged 65 and over) than other provinces. All provinces, except Ontario, reported that they are increasing their nursing home bed supply.

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[2] The provinces use a variety of terms to describe their residential long-term care services. In this survey, the term *nursing home* is used to refer to licensed regulated facilities that provide medical, nursing and personal care services in addition to meals, housekeeping, laundry, social, spiritual and other services. Some provinces (British Columbia and Alberta, for example) provide public support for a residential option that includes supportive services for seniors who do not need the more intensive care provided by nursing homes (assisted living); others, such as Ontario, also have a more intensive level of care called a "chronic disease hospital." This survey does not capture the availability of other residential care options such as assisted living or chronic disease hospitals.

[3] This figure does not include beds in other types of residential facilities such as chronic disease hospitals, assisted living facilities or mental health facilities, or any data from Quebec. Based on the 2006/07 Residential Care Facilities Survey, Statistics Canada reports that there were 207,274 beds in residential facilities that primarily serve the aged in Canada; this figure includes Quebec.

Home Care Services

Some provinces (British Columbia, Nova Scotia and Prince Edward Island) serve less than 10% of their senior population in their home care programs, while Ontario and New Brunswick serve about 18.4% of those aged 65 and above. Among the list of home care services that the literature indicates should be part of the basket of services, all provinces offer nursing, personal support, respite care and palliative care. Most also offer rehabilitation services, equipment and supplies, day programs, homemaking/housekeeping, meals, and self-directed care. Few offer transportation as part of the home care program or supportive housing. Every province indicated that there are waiting lists for one or more home care services.

Framework Features in Practice

The second section of the survey assessed the extent to which provinces are implementing the features of the Hollander and Prince framework. It also asked questions about how important each of the framework features are to provincial decision-makers.

In summary, some of the provinces are quite far ahead in their implementation of the best practice features of integrated care systems. However, in the areas of administrative best practices and linkages with other sectors, there has been slower progress. The area of weakest implementation is the development of linkage mechanisms across service sectors. Given the importance of effective linkages across hospitals, primary care and other human services, it would appear that this is an area for greater attention by provinces. Additionally, the results of the survey indicated that, while all provinces are making progress, it is uneven across the provinces and sometimes within provinces.

Roundtable

The final step in this project was to convene a group of invited experts to review the results of the study. The three objectives of the meeting held in Toronto on February 25, 2009, were:

1. to discuss the findings of the survey report;
2. to examine current practices against the integrated care framework proposed by Hollander and Prince; and
3. to create a set of policy recommendations for provincial policy-makers.

Discussion of the Findings of the Survey Report

After a presentation about the results of the literature review and the survey in the form of an environmental scan, Dr. Marcus Hollander highlighted the evidence that the potential for cost-effective integrated care models can be realized when certain conditions described in his framework are met. He noted that it was surprising that, in a country with a commitment to a universal health care system, only 50% of the provinces supported a commitment to a full range of health and social care services to meet client needs. He also emphasized the importance of a single funding envelope and a coordinated administrative structure to achieving value for money. Without these features, it is much more difficult to make trade-offs across service sectors to achieve the goals of a program.

Current Practices against the Integrated Care Framework

The environmental scan highlighted shared progress across Canadian provinces while indicating that some provinces have implemented more of the best practice features than others. New provincial initiatives designed to improve coordinated care for seniors are being implemented in several provinces. Examples of different provincial approaches, such as the Integrated Health Networks of British Columbia and the PRISMA model in the Eastern Townships of Quebec, underscore the organizational and structural variations inherent in integrated care models. They also indicate that the best practice features of the Hollander and Prince framework remain very germane to health system reform for those with chronic conditions.

Discussion of the Findings of the Presentations

Participants agreed that there was growing Canadian evidence that supports increased investment in improving the coordination of care for seniors because it has the potential to improve quality of care while not increasing system total costs. A key question that arose was about the barriers that might be preventing provinces from moving more quickly to implement such key features as shared information systems. These barriers include, but may not be limited to, competing pressures for funding from other health care sectors, human resource issues, difficulties in implementing linkages with the primary care and hospital sectors, lack of flexibility over budget allocations across sectors, and lack of coverage of home and community support services under the *Canada Health Act*.

Creating a Set of Policy Recommendations for Provincial Policy-Makers

Due to the rich discussion that occurred during the day, it was not possible to develop and agree upon a set of policy recommendations. It was recommended that a further session be held with a focus on this objective.

Conclusion

All Canadian provincial governments are investing in home and community care services as one part of their health reform agendas. In doing so, they are responding to a number of factors: the aging of the population, the need to provide support for family caregivers, the need to reduce over-utilization of both acute and residential long-term care resources, and the need to make the most effective use of technological advances that have made it possible to care for people in the community who once would have had no option but to be in hospital or residential long-term care. However, the results of this survey indicate that a faster rate of investment should be made in order to ensure quality of care for seniors while reducing fragmentation and waste. The canary in the mine is our finding that supply is not keeping up with demand: all provinces except Ontario report that they are building more nursing home beds, and every province reports waiting lists for one or more home care services.

Moving Toward Health Service Integration: Provincial Progress in System Change for Seniors

"We have to skate toward where the puck is going to be, not to where it has been."[4]

1. Introduction

For some time, the health system policy-makers and some providers have been concerned with two related issues: poor quality of care for those with chronic conditions and the continued sustainability of the publicly funded health care system. These issues are related because those with chronic conditions are the most frequent users of health care services, and inefficient use of resources in the treatment of chronic conditions contributes to higher health care spending. Those over the age of 65 (seniors) are much more likely to have chronic conditions than those younger than 65. With a rapidly growing elderly population in many countries, the challenge of adjusting health care delivery systems to improve care for those with chronic conditions is the primary focus of many reform efforts.

Among the challenges of improving care for those with chronic conditions is the need to provide care across a long period of time, using a variety of service interventions that cross traditional boundaries of commonly understood "health" services. Improved service coordination and (or) integration are frequently cited as mechanisms to reduce wasted resources, fragmented care and patient dissatisfaction while improving cost-effectiveness. Thus, improving the delivery of care for those with chronic conditions represents a complex shift in health care systems that are well structured to provide episodic care within traditional "health" care frameworks.

The purposes of this research project were to review the conceptual understandings underlying integrated care, to examine models of cost-effective care for the elderly, to identify their features and then to ascertain to what extent Canadian provinces were implementing these features. The complete project comprised three components: a literature review, a provincial survey and a roundtable meeting.

[4] Attributed to Wayne Gretzky by L Martin. *The Globe and Mail.* November 20, 2008.

2. Literature Review[5]

The following research questions were used to guide a review of the literature:

- What features characterize integrated models of care for seniors that have been evaluated and published in peer-reviewed journals?
- What features of integrated health and social care models are reported in national and international studies of system-level approaches to improving integration of care for seniors?
- What frameworks of care have been published, and what are their shared features and differences?

Studies and papers were sought through the academic health electronic databases (AgeLine, CINAHL, MEDLINE and Google Scholar), followed by a limited snowballing exercise, using a wide range of terms combined with "integration," "frameworks of care," "models of care," "coordination" and "care of the elderly" or "care of those with chronic conditions" or "continuing care of the elderly." In addition to articles from scholarly journals, the grey literature was searched through general electronic databases. The term *grey literature* refers to papers or reports published in non-peer-reviewed journals. Lastly, personal calls were made to experts in the field in search of additional reports.

Inclusion criteria for this review included:

- studies and review articles of the effectiveness of models of integrated health and social care for seniors in peer-reviewed journals, government websites or official evaluation reports;
- surveys of opinion leaders about features of integrated health and social care models; and
- articles about frameworks of health and social integrated care for seniors.

The main results of the literature review are reported below.

2.1 Conceptual Understandings about Integrated Care

One of the key findings from the literature review was that integrated care is a process through which health policy goals can be accomplished; it is not an end in itself. It follows that there is no one approach to integrating health care; the approach taken depends upon the policy goal. Successful efforts are those that have, from the outset, a clear goal. With regard to care of the elderly, frequently there are multiple goals, some of which can be mutually exclusive. Typically, goals include improving access, quality and financial sustainability.

2.2 Trials of Integrated Models of Care of the Elderly

There have been few large trials of integrated care for seniors. We found only seven studies that met our inclusion criteria. These studies are briefly summarized in Table 1. Each used a formal evaluation process including randomized assignment of subjects or developed a comparison group. The outcomes of interest in these projects included reductions in hospital and nursing home use, improvement in client satisfaction, and cost-effectiveness or cost savings, respectively. The subjects were elderly people with chronic conditions.

[5] A more detailed report on the literature review is available at www.cprn.org (MacAdam, 2008).

Table 1. Evaluated Trials of Integrated Health and Social Care Projects for the Elderly

Study Author(s), Date and Article Title	Program Name and Location	Goal	Intervention	Results
Bernabei et al. (1998). "Randomised Trial of Impact of Model of Integrated Care and Case Management for Older People Living in the Community."	Integrated Care in Italy, Rovereto, Italy	To test impact of program of integrated social and medical care among frail elderly on LTC admission, use of health care services, physical and cognitive functioning	-Case management -Geriatric multidisciplinary evaluation unit -General practitioners -Access to range of health and social services	Reduced admissions to LTC homes, hospitals and primary care. Improved physical functioning and reduced decline of cognitive functioning. Cost-effective.
Bird et al. (2007). "Integrated Care Facilitation for Older Patients with Complex Needs Reduces Hospital Demand."	Hospital Admission Risk Program, Australia (Coordinated Care Trials, Round 2)	To reduce use of hospital services	-Assessment, care coordination and facilitation (case management) -Facilitated access to health and social services -Self-management education	20.8% reduction in ER visits, 27.9% reduction in admissions, 19.2% reduction in LOS among treatment group. Cost-effective by $1M over existing system.
Béland et al. (2006). "A System of Integrated Care for Older Persons with Disabilities in Canada: Results from a Randomized Control Trial."	SIPA (System of Integrated Care for Older Persons), Canada	To reduce use and costs of institutional services (defined as hospitalizations, ER visits, days waiting for an NH bed and NH placement)	-Case management -Multidisciplinary teams -Home support services -Use of clinical protocols, intensive home care, 24-hour on-call availability and rapid team mobilization	Substitution of community-based for institutional services at no additional cost to the system. Increased client satisfaction, with no increase in caregiver burden or out-of-pocket expenses. No cost savings but cost-effective.

Table 1. Evaluated Trials of Integrated Health and Social Care Projects for the Elderly (Continued)

US Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2007). "Intervention Summary: Program of All-Inclusive Care for the Elderly (PACE)." In National Registry of Evidence-Based Programs and Practices [database].*	Program of All-Inclusive Care of the Elderly (PACE), United States	To reduce use of hospitals, NHs, ERs	-Case management -Interdisciplinary team including physician -Use of adult daycare -Access to wide range of supportive health and social services -Capitation payment	Lower rates of hospital use, NH and ER visits, higher use of ambulatory services, lower mortality, better health status and quality of life than controls. No strong evidence of cost savings.
Newcomer, Harrington and Friedlob. (1990). "Social Health Maintenance Organizations: Assessing Their Initial Experience."	Social Health Maintenance Organization (SHMO), United States	To reduce acute care service and NH use	-Insurance model of acute and primary care services with a defined benefit of community-based care and case management -Capitation	Fell short of achieving full integration and cost-effectiveness. No consistent effects on hospital and NH admissions and LOS, but there were variations across sites. Enrollees were more satisfied than those in usual Medicare system.
Fischer et al. (2003). "Community-Based Care and Risk of Nursing Home Placement."	Social Health Maintenance Organization (SHMO), United States	To improve health of vulnerable seniors, reduce institutional use	-Case management -Access to full array of health and social services -Capitation payment	Over time, the availability of home and community care services reduced the risk of institutional placement of at-risk elders compared with senior HMO enrollees not enrolled in the SHMO.
Battersby and the SA HealthPlus Team. (2005). "Health Reform through Coordinated Care: SA HealthPlus."	SA HealthPlus, Australia (Coordinated Care Trials, Round 1)	Improved client outcomes within existing resources	-Assessment and care planning -Disease-specific guidelines	Improved well-being was achieved but not enough to be cost-effective. Self-management capacity was a key factor in achieving care coordination. A second round of these projects is reported above in Bird et al. (2007).

* The results reported above are based on a series of reports comparing the experience of PACE enrollees with seniors who did not enrol in PACE.

Note: ER = emergency room; LOS = length of stay; LTC = long-term care; NH = nursing home / long-term care home / continuing care facility.

Table 2 groups the outcomes against the features that the projects had in common.

Table 2. Summary Table of Project Features and Outcomes

Outcomes	Features in Common	Projects	Comments
Reduction in hospital use	- Case management - Facilitated access to range of health and social services	Hospital Admission Risk Program (Coordinated Care Trials, Round 2), Australia SIPA, Canada PACE, United States Integrated Care, Italy	SIPA, PACE and Integrated Care (Italy) all included active physician involvement and multidisciplinary case management team.
Reduced use of nursing homes / long-term care homes	- Case management - Multidisciplinary team - Active physician involvement - Access to range of health and social services	SIPA, Canada PACE, United States SHMO, United States Integrated Care, Italy	PACE and SHMO use capitation payment. SIPA planned to evolve to capitation payment.
Cost-effectiveness or cost savings	- Case management - Facilitated access to range of health and social services	Hospital Admission Risk Program, Australia SIPA, Canada Integrated Care, Italy	There were indications of cost-effectiveness in the Coordinated Care Trials, Round 2.
Increased client satisfaction, quality of life	- Case management - Facilitated access to range of health and social services	SIPA, Canada PACE, United States SHMO, United States SA HealthPlus (Coordinated Care Trials, Round 1), Australia	SIPA involved no additional cost to informal caregivers.

Table 2 reveals that, at a minimum, successful projects use case management and facilitated access to a range of health and social care services to achieve their goals. Otherwise, they vary in their key features (such as payment systems, roles of physicians, organization of participating providers, use of patient education and self-management, etc.).

The programs with the strongest results (SIPA in Canada, Integrated Care in Italy, PACE in the United States and the Hospital Admission Risk Program in Australia) actively included either geriatricians or general practitioners (or both) in the projects.

Supporting the role of physicians are the results of a comparative study of outcomes of the PACE model and those of the Wisconsin Partnership Program (WPP) [Kane et al., 2006]. One of the barriers to more widespread use of PACE is the requirement for clients to use primary care physicians employed by the PACE site. The WPP is similar to PACE in some features, but it allows clients to retain their own physician and does not emphasize the use of a day centre among service options. Using a cross-sectional longitudinal approach, the use of hospital services was compared among enrollees in the two programs. Adjusting for numerous variables (such as gender, race, age and diagnosis), the PACE model was more successful than the WPP in reducing hospital admissions, preventable hospital admissions, hospital days, ER visits and preventable ER visits.

Kane and his colleagues concluded that, when community physicians serve only a small number of seniors in a project (the average primary care physician had only six patients enrolled in the WPP), they are unlikely to change their practice patterns to meet the needs of these patients.

Both rounds of the Coordinated Care Trials in Australia found that increased physician involvement in care planning was critical to the success of coordinated care (Commonwealth Department of Health and Aged Care, 2001; Department of Health and Ageing, 2007).

2.3 Reviews of Programs of Integrated Health and Social Care of the Elderly

Kodner and Kyriacou (2000) compared the features of two large, multi-site American models of integrated care, the PACE model and the SHMO. Six key features seemed to influence the efficiency and effectiveness of comprehensive models of care for the elderly:

- longitudinal care management, spanning time, setting and discipline;
- intensive interdisciplinary team care;
- geriatric philosophy, meaning a commitment to a holistic approach to care of the elderly, and focus, including a central role for the primary care physician;
- organized provider and clinical arrangements to achieve horizontal and vertical alignment;
- appropriate targeting (i.e. serving the right population and keeping the size of patient load within management limits); and
- mechanisms to pool funding streams to assure administrative and clinical flexibility.

To be effective, integrated models of care need to ensure that the features listed above are supportive of each other. For example, provider arrangements should support intensive interdisciplinary case management; funding arrangements must ensure that the required package of care services can be provided (Kodner and Kyriacou, 2000).

Subsequently, Kodner (2006) expanded his research outside of the American health care systems by comparing PACE with the Canadian SIPA and PRISMA models. (The early PRISMA model was not included in the trials above because, although it showed promising results, it was not evaluated for cost. See Section 4.2.2 for further description of this model.) Table 3 compares the key features of each of these models.

Table 3. Key Features of PACE, SIPA and PRISMA

PACE	SIPA	PRISMA
- Pooling of revenues - Case management, multidisciplinary team including primary care - Service delivery using day centre as focus - Focus on prevention, rehabilitation and supportive care	- Control over pooled funding - Case management with multidisciplinary team including primary care - Use of clinical protocols, intensive home care, 24-hour on-call availability and rapid team mobilization	- Inter- and intra-organizational coordination provided by joint governing board and a service coordination board - Single point of entry - Clinical management and service coordination through a team of case managers who work with providers, including physicians - Common assessment instrument - Clinical chart and service plan - Budgeting of services - Integrated information system

Source: Adapted from Kodner, 2006.

Four key elements emerged from Kodner's review of these models:

- umbrella organizational structures to guide integration of strategic, managerial and service delivery levels; encourage and support effective joint/collaborative working; ensure efficient operations; and maintain overall accountability for service, quality and cost outcomes;
- multidisciplinary case management for effective evaluation and planning of client needs, providing a single entry point into the health care system, and packaging and coordinating services (The team triages or allocates clinical responsibility among team members.);
- organized provider networks joined together by standardized procedures, service agreements, joint training, shared information systems and even common ownership of resources to enhance access to services, provide seamless care and maintain quality; and
- financial incentives to promote prevention, rehabilitation and the downward substitution of services, as well as to enable service integration and efficiency (Kodner, 2006).

In summary, no single element of integrated models of care has been shown to be effective in and of itself. However, at a minimum, all successful programs of integrated care for seniors use multidisciplinary care/case management for seniors at risk of poor outcomes supported by access to a range of health and social services. The strongest programs often include the active involvement of physicians. Decision tools, common assessment and care planning instruments and integrated data systems are commonly listed infrastructure supports for integrated care.

2.4 Reports of International Surveys of Features of Integrated Care Models

There have been two recent international surveys addressing features of integrated care models: a survey of 38 countries (including Canada) by the Organisation for Economic Co-operation and Development (OECD) and a European Union survey of nine countries.

Given the very diverse national health systems included in these surveys, the findings focus on high-level results.

The OECD (Hofmarcher, Oxley and Rusticelli, 2007) findings include these:

- Targeted programs appear to improve quality, but evidence on cost-efficiency is inconclusive.
- Care coordination would be facilitated by better information transfer and wider use of information and communications technology.
- The balance of resources going to ambulatory care may need to be reviewed.
- New ambulatory care models need consideration.
- Care coordination may benefit from greater health system integration.

The findings from the PROCARE survey of the European Union revealed a set of strategies being used to overcome "the bottlenecks at the interface between the health care and social care realms" (Leichsenring, 2004: 6). They are:

- case and care management;
- intermediate care strategies to improve the hospital/community care interface;
- multiprofessional needs assessment and joint planning;
- personal budgets and long-term care allowances;
- joint working or partnerships among health and social care sectors;
- admission prevention and guidance;
- moving toward the integration of housing, welfare and care;
- supporting informal (family) care;
- independent counselling;
- coordinating care conferences; and
- quality management as an instrument of mutually agreed outcomes.

Denmark was the most developed country in using these strategies, having implemented four of the strategies, and at the time of the survey was in the process of implementing five others. The United Kingdom was the only country in the process of implementing or testing all of the strategies.

Leichsenring (2004) concluded that, given the diversity among countries, it is unlikely that a shared vision and strategy to achieve integration will be developed within the European Union. However, he came to the following conclusions about promising pathways to integration:

- Reforms that intend to integrate health and social care should be founded on pooled financing systems and overcoming institutional barriers, especially between outpatient and inpatient care, between professionals and informal care providers, and between health and social care services.
- Geriatric screening and multidisciplinary assessment are important tools for communication among providers and can be implemented without too much opposition.
- Demand-driven integrated care must increase clients' control over the care process through individual budgets that increase client decision-making.
- Innovative programs initiated by central governments can stimulate local and regional initiatives that cut across housing, health and social services.
- A central service point for advice, counselling and other forms of assistance is needed to support clients' understanding of their care needs and to improve coordination among local service providers.

In summary, these survey findings indicate that policy-makers in many countries are developing a consensus about the features of integrated health and social care models. In particular, the surveys indicate a number of similarities congruent with the findings from evaluated integrated care programs: for example, the importance of cross-sectoral and cross-professional linkages for collaborative care planning; the use of multidisciplinary case/care management supported by shared assessment information, information technology and decision support; and, lastly, the development of appropriate financial and other incentives to encourage the involvement of organizations and professionals in shared program goals.

2.5 Frameworks of Integrated Care

Frameworks of integrated care are tools that can be used to guide the implementation of health reforms. Frameworks do not dictate how a health reform must be structured; local or regional integration models should include framework features combined in ways that are appropriate to the goal(s) of reform and local contextual features of care. We found only four frameworks for integrated care (Leutz, 1999; Hollander and Prince, 2008; Kodner and Spreeuwenberg, 2002; Banks, 2004).

Based on the experience of reform efforts in the United Kingdom and the United States, Leutz developed nine "laws" of integration (Leutz, 1999; Leutz, 2008). The "laws" provide a foundation for thinking about integration frameworks by drawing attention to the kinds of decisions that need to be made in developing integrated care:

1. You can integrate all of the services for some of the people, some of the services for all of the people, but not all of the services for all of the people.
2. Integration costs before it pays.
3. Your integration is my fragmentation.

4. You can't integrate a square peg and a round hole.
5. The one who integrates calls the tune.
6. All integration is local.
7. Keep it simple, stupid.
8. Don't try to integrate everything.
9. Integration isn't built in a day.

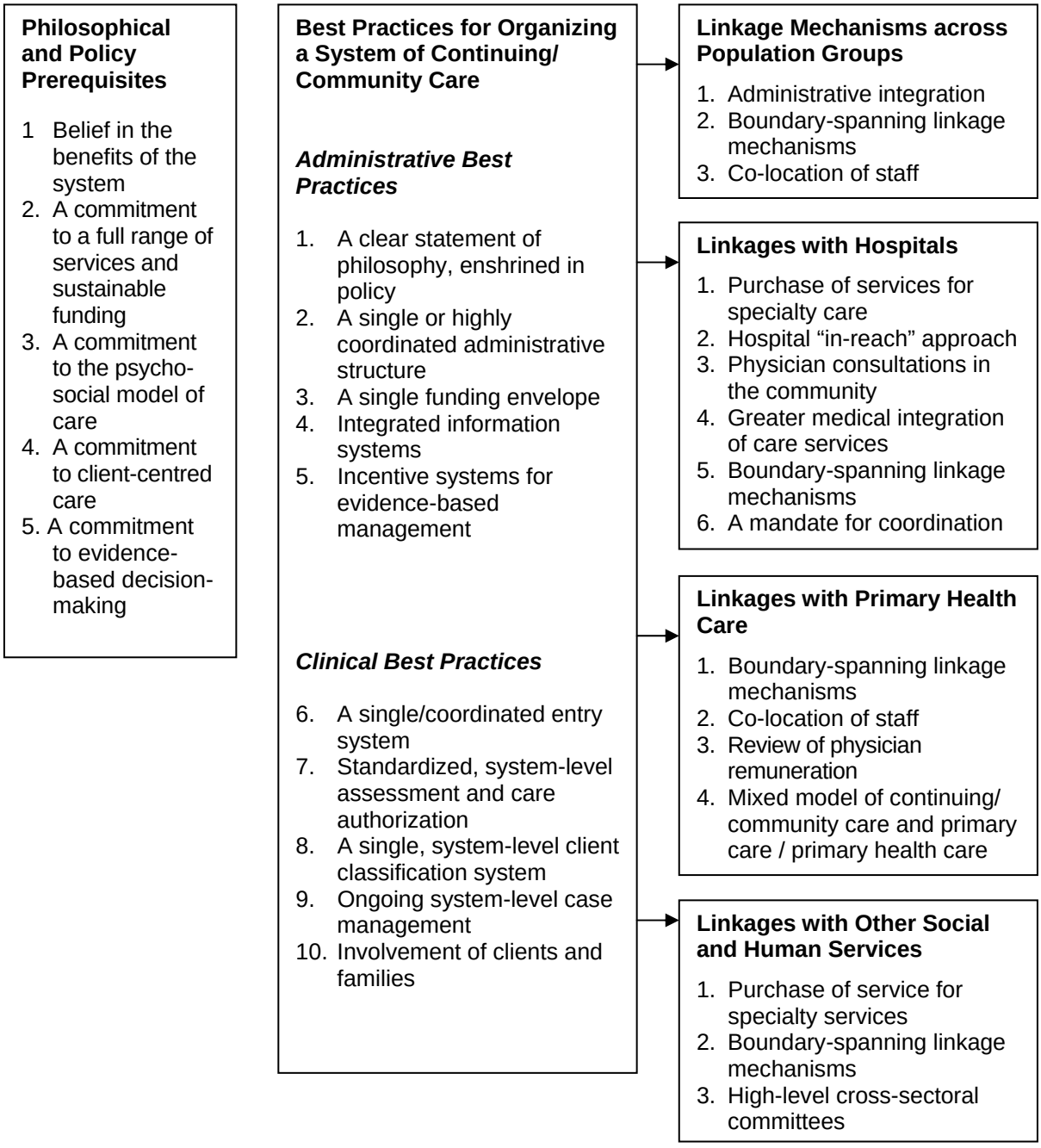
In the first conceptualization of an integration framework, Leutz (1999) listed the means of integration as joint planning, training, decision-making, instrumentation, information systems, purchasing, screening and referral, care planning, benefit coverage, service delivery, monitoring and feedback.

In 2002, Kodner and Spreeuwenberg published a discussion paper on integrated care in which they presented a continuum of integrated care strategies, adapted from the literature (including from Leutz above). The strategies were organized into five domains (funding, administrative, organizational, service delivery and clinical) that influence each other. Kodner and Spreeuwenberg's paper also identified two different approaches to integration. One is a "top down" process driven by the needs of funders or organizations to become more cost-effective and responsive to patients with continuing care needs. The other approach is "bottoms up" and takes the needs of patient groups in the context of existing systems to determine the features of integrated care.

Based on a review of the literature and data collected from Canadian jurisdictions, Hollander and Prince (2001; 2008) developed a framework for continuing care for people with disabilities (the elderly, those with mental illness, and adults and children with disabilities). The best practices component of the framework was developed from 250 interviews with provincial policy-makers and service providers in Canada. The framework has three parts: philosophical and policy prerequisites that underlie ongoing support for integrated systems of care for those with disabilities; a set of best practices for organizing service delivery; and a set of mechanisms for coordination and linkage across the range of organizations and professionals involved in delivering continuing care services. Figure 1 presents the Hollander and Prince framework.

The fourth framework was developed by the Care Management of Services for Older People in Europe Network (CARMEN), a project funded by the European Commission to advance ways in which integrated health and social care can be achieved in EU countries. One of the products of the Network was the development of a policy framework for integrated care for older people (Banks, 2004).

Figure 1. Hollander and Prince Framework



Source: Hollander and Prince, 2008.

These frameworks have many features in common, although they are organized differently. Because the Hollander and Prince framework is the most developed, it was used as an organizing tool to compare the features of all four frameworks (Table 4).

Table 4. Comparison of Integration Frameworks

Hollander and Prince	Leutz	Kodner and Spreeuwenberg	Banks
Philosophical and Policy Prerequisites 1. Belief in the benefits of the system 2. A commitment to a full range of services and sustainable funding 3. A commitment to the psycho-social model of care 4. A commitment to client-centred care 5. A commitment to evidence-based decision-making	No mention	No mention	Yes
Administrative Best Practices 1. A clear statement of philosophy, enshrined in policy 2. A single or highly coordinated administrative structure 3. A single funding envelope 4. Integrated information systems 5. Incentive systems for evidence-based management	1. No mention 2. No mention 3. No mention 4. Yes 5. No mention	1. No mention 2. Yes 3. Yes 4. Yes 5. Common decision support tools	1. Not mentioned as such but implied 2. No mention 3. Coherent funding systems 4. Yes 5. Yes, incentives and sanctions
Clinical Best Practices 6. A single/coordinated entry system 7. Standardized system-level assessment and care authorization 8. A single, system-level client classification system 9. Ongoing system-level case management 10. Communication with clients and families	6. Yes 7. Yes 8. No mention 9. Yes 10. No mention	6. Yes 7. Yes 8. No mention 9. Yes 10. Yes	6. No mention 7. No mention 8. No mention 9. No mention 10. Support for caregivers

Table 4. Comparison of Integration Frameworks (Continued)

Hollander and Prince	Leutz	Kodner and Spreeuwenberg	Banks
Linkage Mechanisms			
1. Administrative integration	1. No mention	1. Consolidation/ decentralization of responsibilities	1. No mention
2. Boundary-spanning linkage mechanisms	2. Yes	2. Yes	2. No mention but implied
3. Co-location of staff	3. No mention	3. Yes	3. No mention
Linkages with Hospitals			
1. Purchase of services for specialty care	1. No mention	1. Yes	1. No mention
2. Hospital "in-reach"	2. No mention	2. No mention	2. No mention
3. Physician consultations in the community	3. No mention	3. Jointly managed care services	3. No mention 4. Awarding responsibilities to integrate services
4. Greater medical integration of care services	4. No mention	4. Jointly managed care services	
5. Boundary-spanning linkage mechanisms	5. Yes	5. Yes	5. No mention
6. A mandate for coordination	6. No mention	6. Strategic alliances or care networks	6. Awarding responsibilities to integrate
Linkages with Primary Care / Primary Health Care			
1. Boundary-spanning linkage mechanisms	1. No mention	1. Yes	1. No mention but implied
2. Co-location of staff	2. No mention	2. Yes	2. No mention
3. Review of physician remuneration	3. No mention	3. No mention	3. Resourcing integration
4. Mixed model of continuing/community care and primary care / primary health care	4. No mention	4. Strategic alliances or care networks	4. No mention
Linkages with Other Social and Human Services			
1. Purchase of service for specialty services	1. No mention	1. Joint purchasing Commissioning	1. Resourcing integration
2. Boundary-spanning linkage mechanisms	2. No mention	2. Yes	2. No mention but implied
3. High-level cross-sectoral committees	3. Yes	3. Inter-sectoral planning	3. No mention

In summary, the Hollander and Prince framework is the most developed and concisely summarizes the relationships among integration features identified in the international literature. Therefore, it was selected to form the basis of a survey of provincial ministries of health in Canada.

3. Survey of Canadian Provinces

We collected new information about the extent to which Canadian provincial governments are moving toward implementing integrated care systems for the elderly. The items of the Hollander and Prince (2001, 2008) framework for integrated care were used as a guide for survey questions. Contextual information on the utilization of nursing home and home care services was collected in the initial survey questions. The list of possible home care services for seniors was developed from Hollander and Prince (2001). The section of the framework on linkage mechanisms was adapted to be more specific about linkage techniques as they apply to services for seniors. A copy of the survey is provided in Appendix 1.

The survey was pretested by the staff of the Alberta Ministry of Health. The ministries of health in the 10 provinces were contacted to obtain contact information for the provincial responses. The surveys were distributed in July 2008.

Surveys were returned from nine of the 10 Canadian provinces. The province of Quebec did not respond to the survey; to obtain data from Quebec, the questionnaire was sent to the regional health authority (RHA) in the Eastern Townships (L'Estrie RHA). In the case of Manitoba, the provincial response was incomplete because some aspects of the survey were felt to be the responsibility of the RHAs. A survey was sent to the Winnipeg RHA, which provided information.[6]

In an effort to reduce the burden on respondents, some pieces of background information were collected from Statistics Canada and other publicly available reliable sources. Those items are identified in the table footnotes as appropriate. Appendix 2 contains additional tables with more details of the survey results than those presented in this section.

[6] With the devolution of authority to RHAs, health systems appear to be becoming more diverse within provinces. For example, provincial respondents indicated that features of integrated care vary across RHAs within their province. At the time of the survey, all provinces except Prince Edward Island had RHAs (Ontario's local area health networks [LHINs] are a version of RHAs). Since then, Alberta has collapsed its RHAs into a province-wide health service board.

3.1 Results of the Survey

3.1.1 Nursing Home[7] Bed Supply and Utilization

There are about 151,979 nursing home beds in the nine provinces responding to the survey.[8] Manitoba appears to have a larger supply of nursing home beds per senior (aged 65 and over) than other provinces (Table 5). All provinces except Ontario reported that they are increasing their nursing home bed supply.

Table 5. Nursing Home (NH) Bed Supply

	BC	AB	SK	MB	ON	QC/ RHA[9]	NB	NS	PE	NL
No. of seniors[10] (000's)	617.8	361.9	148.3	160.8	1,685.7	47.9	108.6	138.4	20.1	70.6
No. of NH* beds (000s)	29.6	14.0	8.6	9.8	75.9	1.5	4.4	5.9	1.0	2.7
Beds per 1,000 (65+ pop.)	47.9	38.7	58.0	60.9	45.0	31.3	40.5	42.6	50.0	38.2
Planning to build more NH beds	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes

[7] The provinces use a variety of terms to describe their residential long-term care services. In this survey, the term *nursing home* is used to refer to licensed regulated facilities that provide medical, nursing and personal care services in addition to meals, housekeeping, laundry, social, spiritual and other services. Some provinces (British Columbia and Alberta, for example) provide public support for a residential option that includes supportive services for seniors who do not need the more intensive care provided by nursing homes (assisted living); others, such as Ontario, also have a more intensive level of care called a "chronic disease hospital." This survey does not capture the availability of other residential care options such as assisted living or chronic disease hospitals.

[8] This figure does not include beds in other types of residential facilities such as chronic disease hospitals, assisted living facilities or mental health facilities, or any data from Quebec. Based on the 2006/07 Residential Care Facilities Survey, Statistics Canada reports that there were 207,274 beds in residential facilities that primarily serve the aged in Canada; this figure includes Quebec.

[9] L'Estrie RHA response.

[10] Statistics Canada (2007).

3.1.2 Home Care Services

Some provinces (British Columbia, Nova Scotia and Prince Edward Island) serve less than 10% of their population aged 65 and over in their home care programs, while Ontario and New Brunswick serve about 18.4% of their seniors (Table 6). Among the list of home care services that the literature indicates should be part of the basket of services, all provinces offer nursing, personal support, respite care and palliative care. Most also offer rehabilitation services, equipment and supplies, day programs, homemaking/housekeeping, meals and self-directed care. Few offer transportation as part of the home care program or supportive housing. Every province indicated that there are waiting lists for one or more home care services (see Appendix 2: Table 1).

Almost no province charges fees for the more medically oriented home care services such as nursing, rehabilitation, palliative care, and equipment and supplies (see Appendix 2: Table 2). Five provinces charge fees for personal support. There is a great deal of variation among the provinces regarding fees for other home care services. Manitoba and Ontario are the least likely to charge fees for home care services.

Table 6. Home Care Utilization

	BC	AB	SK	MB	ON	QC/ RHA[11]	NB	NS	PE	NL
No. of seniors[12] (000's)	617.8	361.9	148.3	160.8	1,685.7	47.9	108.6	138.4	20.1	70.6
No. of seniors served by home care services[13]	54,600	56,000	25,745 (60+)	27,227	310,486[14]	6,204	20,000	11,759	1,200	NA
% of seniors 65+ served by home care program	8.8%	15.5%	17.4%	16.8%	18.4%	12.9%	18.4%	8.4%	5.9%	NA

[11] L'Estrie RHA response.
[12] Statistics Canada (2007).
[13] Some provinces reported the total number of home care clients rather than the number of seniors (aged 65+). In those cases the figure was compared with data in *Portraits of Home Care in Canada: 2008* (Canadian Home Care Association, 2008), which usually presented the total home care population by age and by province. Using that information, it was possible to calculate the number of seniors being served by each province.
[14] Ontario survey information was adjusted to subtract the clients served by the placement coordination units in order to make the Ontario figures comparable with those from other provinces.

3.1.3 Framework Features in Practice

The second section of the survey assessed the extent to which provinces are implementing the features of the Hollander and Prince framework for integrated care. It also asked questions about how important each of the framework features are to provincial decision-makers. See Appendix 2 (Tables 3 to 9) for the detailed results by province.

As illustrated previously in Figure 1, the Hollander and Prince framework contains three basic sections: philosophical and policy prerequisites; administrative and clinical best practices for organizing a system of continuing/community care; and linkage mechanisms across population groups, with hospitals, with primary care and with other social and human services. The overall provincial survey results are summarized below for each framework section.

Philosophical and Policy Prerequisites

The results indicate that provincial governments are supportive of the philosophical and policy requisites of the selected integrated care framework.

Best Practices for Organizing a System

- *Administrative Best Practices:* Almost every province agreed that most of the administrative best practices are very important, but no province has implemented all of the administrative features. For example, one of the key features of integrated care systems is the availability of integrated information systems. Although all provinces reported that this feature is either very or somewhat important, none reported having a fully integrated information system. Most provinces do not have a single funding envelope for care for seniors, but those with RHAs have a single funding envelope for health services for their populations. None has an incentive system for evidence-based decision-making (but only four provinces think that this feature is very important). Only five provinces reported that they have a single administrative structure for continuing care services.

  These results seem to indicate that most provinces have yet to align their administrative structures, enablers and incentives to support a more effective integrated care system.

- *Clinical Best Practices:* Provinces have been somewhat more successful in implementing clinical best practice features. Seven provinces indicated that they have a single or coordinated entry system to care; almost all (nine) have province-wide assessment and care authorization instruments; seven have system-level client classification systems; six have ongoing system-level case management; and they all have mechanisms for communicating with families.

Linkage Mechanisms

The provinces are far less developed with regard to the boundary-spanning or linkage mechanisms of integrated care health systems, as shown in the following examples.

- *Administrative Linkage Mechanisms across Population Groups:* Half of the provinces do not think that this feature of the framework is important. Only two reported that they have this feature, although four reported that they have staff whose job description includes acting as access points to people from other populations.

- *Linkages with Hospitals:* Eight provinces have implemented co-location of home care case managers in hospitals. Half reported that they have physicians who make home visits to frail elders to avoid hospitalizations. Only the RHA in Quebec reported that the home care system is responsible for paying for hospital alternative level of care (ALC) days. This is becoming a common feature of some European systems, which view ALC days as a failure of the residential and community care system.
- *Linkages with Primary Health Care:* Five provinces report that physician remuneration is appropriate for care of the frail elderly and four provinces indicate that physicians are adequately remunerated for home visits. Only Ontario reported that home care case managers are located in primary care offices, in some parts of the province. The L'Estrie RHA and PEI reported that there are physicians associated with the home care program to coordinate with primary care physicians.
- *Linkages with Other Social and Human Services:* Half of the provinces have an organized approach to eligibility for various levels of housing with supportive services. Only six report having a system for high-level planning of service supply for seniors needing coordinated care.

  Given the importance of effective linkages across hospitals, primary care and other human services, it would appear that this is an area for greater attention by the provinces.

3.1.4 Most Important Next Steps

The last survey question asked respondents to describe the single most important next step that the province/RHA could take to improve integrated care for seniors. The answers to this question provide insights into the specific issues or opportunities in each province.

- In the two provinces (New Brunswick and Prince Edward Island) with two different ministries responsible for health services (hospital and medical) and for social care services (long-term care homes, home care and other community services), respondents reported that the most important step that they could take would be to develop joint action plans between the two administrative entities.
- In Nova Scotia, which has not devolved its home care and long-term care services to the RHAs, the next step identified was the transfer of home and continuing care services to the RHAs by 2009.
- Newfoundland and Labrador, and Saskatchewan indicated a need to develop a strategy for seniors' services that could provide a template for implementation steps.
- The RHA in Quebec indicated that the most important next step would be to obtain additional funding.
- Ontario is in the process of implementing a $700-million investment over three years for the development of an integrated community care service system for seniors, the Aging at Home Strategy.
- The RHA in Manitoba reported that the most important next step would be to improve the integration of family physicians with community services.

- British Columbia stated that the implementation of pilot projects, called integrated health networks, and efforts to expand the use of technology (e.g. tele-monitoring and shared information systems) would be the most important next steps.

3.1.5 Summary of Survey Results

The table below indicates our assessment of the areas of strengths and weaknesses in provincial implementation of the best practice features of the integrated continuing care framework.

Table 7. Provincial Implementation Summary Assessment

Best Practice Area from Framework	Provincial Progress	Comments
Philosophical and Policy Prerequisites	Strong	Provinces generally support the prerequisites.
Administrative Features	Mixed	
Clinical Features	Quite strong	
Linkage Mechanisms across Population Groups	Weak	
Linkages with Primary Health Care	Weak	
Linkages with Hospitals	Weak	
Linkages with Other Social and Human Services	Mixed	

In summary, some of the provinces are quite far ahead in their implementation of the best practice features of integrated care systems. However, in the areas of administrative best practices and linkages with other sectors, there has been slower progress. Only the RHA in Quebec seems to have made significant strides in implementing integrated information systems. None of the provinces has incentives for evidence-based decision-making. The area of weakest implementation is the development of linkage mechanisms across service sectors.

Additionally, the results of the survey indicated that, while all provinces are making progress, it is uneven across the provinces and sometimes within provinces.

4. Roundtable

The final step in this project was to convene a group of invited experts to review the results of the study. The roundtable meeting held in Toronto on February 25, 2009, had three objectives:

- to discuss the findings of the survey report;
- to examine current practices against the integrated care framework proposed by Hollander and Prince; and
- to create a set of policy recommendations for provincial policy-makers.

4.1 Discussion of the Findings of the Survey Report

After a presentation about the results of the literature review and the survey in the form of an environmental scan, Dr. Marcus Hollander highlighted the evidence that the potential for cost-effective integrated care models can be realized when certain conditions described in his framework are met. He noted that it was surprising that, in a country with a commitment to a universal health care system, only 50% of the provinces supported a commitment to a full range of health and social care services to meet client needs. He also emphasized the importance of a single funding envelope and a coordinated administrative structure to achieving value for money. Without these features, it is much more difficult to make trade-offs across service sectors to achieve the goals of a program.

4.2 Current Practices against the Integrated Care Framework

The environmental scan highlighted shared progress across Canadian provinces while indicating that some provinces have implemented more of the best practice features than others. New provincial initiatives designed to improve coordinated care for seniors are being implemented in several provinces. Because certain initiatives illustrate different approaches to implementing the best practice features of integrated care, representatives from British Columbia and Quebec were asked to describe major initiatives in their provinces.

4.2.1 The Integrated Health Network Pilot Projects in British Columbia

In British Columbia, about 34% of the population who have one or more chronic conditions are responsible for 80% of total public health care costs. Providing a better health care experience for this population is the goal of 26 integrated health network (IHN) pilot projects that have been implemented in the province. The specific goal of these projects is to improve the linkage between the community care system and primary care sectors. Twenty projects are targeting patients with complex chronic health conditions; three are focused on seniors at risk; two are focused on marginalized patients, and one is providing integrated care to those with chronic mental health conditions. If each project enrols its target population, over 42,000 patients and 586 general practitioners will be involved in the networks. The projects are generally located in the southern part of the province, but some are in rural and remote northern communities. There are five outcome areas of interest: improving patient access to primary health care, improving patient health outcomes through quality improvement, improving patient confidence and experience with the health care system, improving provider confidence with the health care system and, lastly,

decreasing the average annual cost per patient. The evaluation results are not available, but already the province is thinking about how to move from the lessons of the pilot projects to system improvements. The areas for system change include system alignment, funding models and infrastructure support.

The British Columbia IHNs are designed to strengthen one of the weaker areas found in the survey of the provinces, namely, poor models of coordination with primary care practitioners.

4.2.2 The PRISMA Project in Quebec

In the Eastern Townships, there has been an organized approach to implementing improved care for frail seniors on a system level for almost 10 years. The Program of Research to Integrate the Services for the Maintenance of Autonomy (PRISMA) is a collaborative interagency model that has several best practice features: coordination among service providers, a single point of entry, case management, individualized service plans, use of a unique assessment tool and case mix classification system, and a computerized clinical chart. PRISMA services are targeted to those over age 65 with moderate to severe disabilities who show good potential for staying at home and who need two or more health and social services. Based on the positive results of an initial pilot project, the model is being implemented in Sherbrooke (urban), Granit and Coaticook (rural areas). Today the implementation rate ranges from 70% to 85% among participating agencies. Compared with seniors living in similar communities in other parts of Quebec, seniors participating in the PRISMA project are less functionally impaired, have fewer unmet needs, have higher satisfaction with services and feel more empowered. Over time, there have been fewer visits to the ER and fewer new hospitalizations, as compared with the comparison group. There have been no significant effects on rehospitalizations, use of home care services, consultations with health professionals or use of geriatric services. By year four, these outcomes had been achieved at no additional cost to the health care system.

This project implemented most of the best practice indicators of the Hollander and Prince model. Several years ago, the Ministry of Health in Quebec asked all the regional health authorities (RHAs) to develop integrated care systems. To support the RHAs, the Ministry mandated structural integration when legislation was passed requiring the merger of local hospitals, rehabilitation centres, home and community care centres, and long-term care homes into one organization (Centre for Health and Social Services). Ninety-five new organizations have been created, each one serving the residents of a designated geographic area. While it is unclear what effect the merger will have on PRISMA results, the model does not require mergers of key provider agencies.

These examples of different approaches being taken by provinces underscore the organizational and structural variations inherent in integrated care models. They also indicate that the best practice features of the Hollander and Prince framework remain the cornerstone of health system reform for those with chronic conditions.

4.2.3 Discussion of the Findings of the Presentations

Participants agreed that there was growing Canadian evidence that supports increased investment in improving the coordination of care for seniors because it has the potential to improve the quality of care while not increasing total system costs. A key question that arose was about the barriers that might be preventing provinces from moving more quickly to implement such key features as shared information systems. These barriers include, but may not be limited to, competing pressures for funding from other health care sectors, human resource issues, difficulties in implementing linkages with the primary care and hospital sectors, lack of flexibility over budget allocations across sectors, and lack of coverage of home and community support services under the *Canada Health Act*. Another issue was the extent to which demand for continuing care services could be managed. It was suggested that effective targeting of integrated and/or highly coordinated care needs to be implemented in order to prevent rapid increases in cost without achieving the policy goal of improving quality of care for those most at risk of poor outcomes.

In discussion, many roundtable participants mentioned the importance of implementing shared administrative and clinical information systems. They also supported the emphasis in both of the provincial presentations about the importance of aligning policy goals with strategy and performance measurement systems.

4.3 Creating a Set of Policy Recommendations for Provincial Policy-Makers

The final objective of the roundtable was to develop policy recommendations. Due to the rich discussion that occurred during the day, it was not possible to develop and agree upon a set of policy recommendations. It was recommended that a further session be held with a focus on this objective.

5. Conclusion

All Canadian provincial governments are investing in home and community care services as one part of their health reform agendas. In doing so, they are responding to numerous factors: the aging of the population, the need to provide support for family caregivers, the need to reduce over-utilization of both acute and residential long-term care resources, and the need to make the most effective use of technological advances that have made it possible to care for people in the community who once would have had no option but to be in hospital or residential long-term care. However, the results of the provincial survey indicate that a faster rate of investment should be made in order to ensure quality of care for seniors while reducing fragmentation and waste. The canary in the mine is our finding that supply is not keeping up with demand: all provinces except Ontario report that they are building more nursing home beds, and every province reports waiting lists for one or more home care services.

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Appendix 1. The Provincial Survey

Integrated Care for Seniors Questionnaire

Contact Information

Name:
Job Title:
Organization:
Phone:
Email:

Date:

1. Are your responsibilities **provincial** ☐ or **regional** ☐?

Background Information

2. How many LTC/nursing home beds do you have?

3. Are you constructing or planning to construct more nursing home beds? Yes ☐ No ☐

4. How many unduplicated seniors are being served by your home care program annually?

5. What services can your home care case managers authorize for seniors?
(Check only the boxes that apply.)

Service	Yes	Services Limits	Are There Fees?	Are There Waiting Lists for These Services?
Nursing	☐		☐	☐
Rehab (PT, OT, Speech)	☐		☐	☐
Equipment and Supplies	☐		☐	☐
Personal Support	☐		☐	☐
Day Programs	☐		☐	☐
Homemaking/Housekeeping	☐		☐	☐
Transportation	☐		☐	☐

Service	Yes	Services Limits	Are There Fees?	Are There Waiting Lists for These Services?
Meals	☐		☐	☐
Palliative Care	☐		☐	☐
Respite Care	☐		☐	☐
Supportive Housing	☐		☐	☐
Self-Directed Care	☐		☐	☐
Other	☐		☐	☐

Integration Information

6. Has your province made a commitment to improving integration of care for seniors?

   Yes ☐ No ☐

   Is that commitment for all seniors or for some seniors? (e.g. for those at risk of nursing home admission? or those who are frequent users of hospital services? or those with multiple chronic conditions etc?)

   Yes (all seniors) ☐ No (some seniors) ☐

   If no, which seniors are the focus of integrated care initiatives?

   Has that commitment been expressed through:

   A commitment to providing access to a full range of health **AND** social services?

   Yes ☐ No ☐

   Is there a sustainable funding base for those services? Yes ☐ No ☐

   Comment:

7. Is the commitment to a psycho-social model of care? Yes ☐ No ☐

   Comment:

8. Is there a commitment to client-centered care? Yes ☐ No ☐

   Comment:

9. Is there a commitment to evidence-based decision-making in developing policy and services options for seniors? Yes ☐ No ☐

   Comment:

10. Do you have strong inter-Ministerial collaboration for services for seniors in your province? i.e. health and housing, health and transportation, or health and social care?

Yes ☐ No ☐

Comment:

Best Practices for Organizing a System of Continuing Care

Administrative Best Practices

11. Do you have a clear statement of philosophy enshrined in policy? Yes ☐ No ☐

How important do you think it is to have a statement of philosophy enshrined in policy?

☐ very important
☐ somewhat important
☐ not important

12. Do you have a single or highly coordinated administrative structure for integrated care for seniors? Yes ☐ No ☐

Can you describe the structure you have?

How important do you think it is to have a single or highly coordinated administrative structure for integrated care for seniors?

☐ very important
☐ somewhat important
☐ not important

13. Do you have a single funding envelope for continuing care services for seniors?

Yes ☐ No ☐

Are hospital and rehabilitation services included in a pooled funding envelope or are they funded separately?

How important do you think it is to have a single funding envelope for services for seniors?

☐ very important
☐ somewhat important
☐ not important

Do you think that hospital and rehab services should be included in a shared funding envelope along with the funding for continuing care services? Yes ☐ No ☐

Comment:

Do you think that primary care (i.e. GP/family physician) services for seniors should be included in a shared funding envelope? Yes ☐ No ☐

Comment:

14. Do you have an integrated information system:

Across all health providers (including primary care)? Yes ☐ No ☐

Comment:

Across social care providers? Yes ☐ No ☐

Comment:

Across health and social care providers? Yes ☐ No ☐

Comment:

Is it an electronic information system? Yes ☐ No ☐

How important do you think it is to have an integrated information system for services for seniors?

- ☐ very important
- ☐ somewhat important
- ☐ not important

15. Do you have an incentive system for evidence-based management? Yes ☐ No ☐

Comment:

How important do you think it is to have an incentive system for evidence-based management?

- ☐ very important
- ☐ somewhat important
- ☐ not important

Service Delivery Best Practices

16. Do you have a single/coordinated entry system to services for seniors? Yes ☐ No ☐

    How important do you think it is to have a single/coordinated entry system to services for seniors?

    ☐ very important
    ☐ somewhat important
    ☐ not important

17. Do you have province-wide standardized assessment and care authorization instruments being used by service providers? Yes ☐ No ☐

    If no, are you planning to implement a province-wide assessment and care authorization system? Yes ☐ No ☐

    How important do you think it is to have a province-wide standardized assessment and care authorization instruments being used by service providers?

    ☐ very important
    ☐ somewhat important
    ☐ not important

18. Do you have a single, system-level client classification system? Yes ☐ No ☐

    How important do you think it is to have a **s**ingle, system-level client classification system?

    ☐ very important
    ☐ somewhat important
    ☐ not important

19. Do you have ongoing, system-level case management? Yes ☐ No ☐

    How important do you think it is to have ongoing, system-level case management?

    ☐ very important
    ☐ somewhat important
    ☐ not important

20. Do you have mechanisms for communication with clients and families? Yes ☐ No ☐

    How important do you think it is to have communication with clients and families?

    ☐ very important
    ☐ somewhat important
    ☐ not important

Linkage Mechanisms

Administrative Integration

21. Do you have an administrative structure that is focused only on services for seniors?

    Yes ☐ No ☐

22. Do you think such an administrative structure is important in achieving integrated care for seniors? Yes ☐ No ☐

    Comment:

Boundary-Spanning Linkage Mechanisms

23. Do you have staff whose job descriptions include acting as access points to people from other systems? For example, someone whose job includes facilitating access across mental health and other health care services. Yes ☐ No ☐

    Comment:

24. Do you have staff co-located with staff from other systems? For example, home care case managers located in primary care offices, or hospitals. Yes ☐ No ☐

    Do you think this is important? Yes ☐ No ☐

    Comment:

25. What linkage mechanisms exist between the community care sector and the hospital sector? *(Check only those that apply)*

Type of Intervention	**Yes?**	**Province-Wide?**	**How Important Is This?** **1 = not important** **5 = very important**
Home care case mangers are co-located in hospitals	☐	☐	
Home care programs are responsible for payment of ALC (Alternative Level of Care) days	☐	☐	
The community sector can purchase hospital-based services such as mental health or hospital based palliative care	☐	☐	
There are physicians whose role includes coordination between hospitals and home care programs	☐	☐	
There are hospital-based nurses who provide specialized services in long-term care homes/nursing homes to help prevent unnecessary hospital admissions	☐	☐	

Type of Intervention	Yes?	Province-Wide?	How Important Is This? 1 = not important 5 = very important
There are community physicians associated with home care programs who make home visits to frail elders to help them avoid unnecessary hospital visits	☐	☐	
There is an organized approach to eligibility for various levels of housing with supportive services (from retirement living to assisted living up to nursing home admission)	☐	☐	
Home care case managers are co-located in physicians' offices	☐	☐	
There are physicians associated with home care programs whose responsibilities include coordination with primary care physicians in the community	☐	☐	
Physician remuneration is appropriate for the care that frail elders require	☐	☐	
Physicians are adequately remunerated for home visits	☐	☐	
There are financial arrangements for purchase of transportation services	☐	☐	
There is a system for high-level planning of service supply for seniors needing coordinated care	☐	☐	
Other	☐	☐	

26. What is the single most important step your province/RHA/LHIN could take to improve integration of care for seniors?

Other Comments

Appendix 2. Detailed Tables

Table 1. Home Care Services: Service Offered and Wait List

	BC		AB		SK		MB/ RHA[15]		ON		QC/ RHA[16]		NB		NS		PE		NL	
SERVICE	***S***	***WL***	***S***	***WL***	***S***	***WL***	***S***	***WL***	***S***	***WL***	***S***	***WL***	***S***	***WL***	***S***	***WL***	***S***	***WL***	***S***	***WL***
Nursing	X		X		X		X		X		X		X		X	X	X	X	X	
Rehabilitation	X		X		X		X	X	X	X	X	X	X	X			X			
Equipment and Supplies			X		X		X		X		X	X	X		X	X		X	X	
Personal Support	X		X		X		X	X	X	X	X	X	X		X	X	X		X	
Day Programs	X		X	X	X		X	X			X		X		X	X	X			
Homemaking/ Housekeeping					X		X	X	X	X	X		X		X	X	X		X	
Transportation									X[17]		X				X					
Meals	X		X		X	X	X	X			X		X		X	X				
Palliative Care	X				X		X		X		X		X		X		X			
Respite Care	X	X	X		X		X	X	X		X		X		X	X	X	X	X	X
Supportive Housing			X	X			X	X			X									
Self-Directed Care	X		X	X	X	X					X				X		X		X	
Other					X[18]				X											

Note: RHA = Regional Health Authority, S = Service provided, W = Wait List.

[15] Winnipeg RHA response.
[16] L'Estrie RHA response.
[17] Under limited conditions.
[18] Home maintenance.

Table 2. Home Care Services by Service Offered and Fees

SERVICE	BC	AB	SK	MB/ RHA[19]	ON	QC/ RHA[20]	NB	NS	PE	NL
Nursing	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Rehabilitation	Y	Y	Y	Y	Y	Y	Y		Y	
Equipment and Supplies		Y	Y	Y	Y	Y	Y	Y		X
Personal Support	X	Y	X	Y	Y	Y	X	X	Y	X
Day Programs	X	X	X	X	X	Y	X	X	Y	
Homemaking/ Housekeeping		X	X	Y	Y	X	X	X	Y	X
Transportation					X[21]	X[22]		Y		
Meals	X	Y	X	Y		X	X	X		
Palliative Care	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Respite Care	Y	Y	X	Y	Y	X	Y	X	X	X
Supportive Housing		X		Y		X				
Self-Directed Care	Y	Y	X	Y		X		Y	Y	Y
Other			X		Y					

Note: X = Service is offered and fees are charged; Y = Service is offered and no fees are charged.

[19] Winnipeg RHA response.
[20] L'Estrie RHA response.
[21] Limited service for medical appointments,
[22] Refer for transportation services.

Table 3. Philosophical and Policy Requisites

	BC	AB	SK	MB	ON	QC/ RHA[23]	NB	NS	PE	NL
Provincial commitment to integrated care for seniors	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Commitment to full range of health and social services	No	No	Yes	Depends on region	No	Yes	Yes	No	No	Yes
Commitment to psycho-social model	Yes	Yes	Yes	Some-what	Yes	Yes	Yes	No	Yes	Yes
Commitment to client-centred care	Yes	Yes	Yes	Some-what	Yes	Yes	Yes	Yes	Yes	Yes
Commitment to evidence-based decision-making	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Strong inter-ministerial collaboration	Yes	In some areas	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

[23] L'Estrie RHA response.

Table 4. Administrative Best Practices

	BC	AB	SK	MB	ON	QC/ RHA[24]	NB	NS	PE	NL
Clear statement of philosophy	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	No
How important	VI	VI	VI	VI	VI	VI	VI	VI	VI	VI
Single administrative structure	No	Yes	Yes	Yes	No	Yes	No	Yes [25]	No	no
How important	SI	VI	VI	VI	SI	VI	SI	VI	VI	VI
Single funding envelope for services for seniors[26]	Yes	No	No	No	No	Yes	No	Yes	No	Yes
How important	NI	SI	SI	NI - SI	NI	VI	SI	NI	SI	VI
Integrated information system	No	No	No	No	No	Yes[27]	No	No[28]	No	No
How important	VI	VI	VI	VI	VI	VI	SI	VI	VI	VI
Incentive system for evidence-based management	NA	No	No	No	No	No	No	No	No	No
How important	NA	SI	SI	VI	VI	VI	SI	VI	SI	SI

Note: VI = Very Important, SI = Somewhat Important, NI = Not Important, NA = No Answer.

[24] L'Estrie RHA response.
[25] Within the Continung Care Branch.
[26] Single funding envelope does not include hospital services.
[27] Most private medical clinics do not have access to shared information systems, but hospitals, rehabilitation centres, daycare, CLSCs and other community services have a shared information system.
[28] Have electronic assessment and long-term care wait list.

Table 5. Clinical Best Practices

	BC	AB	SK	MB	ON	QC/ RHA[29]	NB	NS	PE	NL
Single/coordinated entry system	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No
How important	SI	VI	VI	VI	SI	VI	SI	VI	VI	VI
Province-wide standardized assessment and care authorization instruments	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
How important	VI	VI	VI	VI	VI	VI	VI	VI	VI	VI
Single system-level client classification system	Yes	No	Yes	No	Yes	Yes	Yes	Yes	No	Yes
How important	SI	VI	VI	VI	VI	VI	VI	VI	VI	VI
Ongoing system-level case management	Yes	No	Yes	NA	Yes	Yes	Yes	Yes	No	No
How important	VI	VI	VI	NA	VI	VI	SI	VI	SI	VI
Mechanisms for communications with families/clients	Yes	Yes	Yes	NA	Yes	Yes	Yes	Yes	Yes	Yes
How important	VI	VI	VI	NA	VI	VI	VI	VI	VI	VI

Note: VI = Very Important, SI = Somewhat Important, NI = Not Important, NA = No Answer.

[29] L'Estrie RHA response.

Table 6. Administrative Linkage Mechanisms across Population Groups

	BC	AB	SK	MB/ RHA[30]	ON	QC/ RHA[31]	NB	NS	PE	NL
Admin structure focused only on seniors	No	Yes	No	No	No	No	No	Yes	No	No
Is this important?	No	Yes	NA[32]	Yes	No	Yes	No	Yes	Yes	No
Do you have staff whose job description includes acting as access points to people from other systems?	Yes	No	Yes	Yes	NA	Yes	No	No	No	No

[30] Winnipeg RHA response.

[31] L'Estrie RHA response.

[32] Saskatchewan replied: "While an administrative structure that is focused only on services for seniors would likely assist in achieving integrated care for seniors, integrated care for seniors can be achieved without such a structure provided communication among programs is good."

Table 7. Boundary-Spanning Mechanisms: Linkages with Hospitals

	BC	AB	SK	MB/ RHA[33]	ON	QC/ RHA[34]	NB	NS	PE	NL
Home care case managers are co-located in hospitals	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Home care programs are responsible for payment of ALC days						Yes				
Community care sector can purchase hospital-based mental health care or hospital-based palliative care								Yes		
There are physicians whose role includes coordination between hospital and home care						Yes	Yes			
There are hospital-based nurses who provide specialized services in long-term care homes to prevent avoidable hospitalizations	Yes	Yes			Yes					
There are community physicians who make home visits to frail elders to avoid hospitalizations	Yes				Yes	Yes	Yes		Yes	

Note: Blank = No, ALC = Alternative Level of Care.

[33] Winnipeg RHA response.
[34] L'Estrie RHA response.

Table 8. Boundary-Spanning Mechanisms: Linkages with Primary Health Care

	BC	AB	SK	MB/ RHA[35]	ON	QC/ RHA[36]	NB	NS	PE	NL
Home care case managers are co-located in physicians' offices					Yes[37]					
There are physicians associated with home care programs to coordinate with primary care physicians						Yes			Yes	
Physician remuneration is appropriate for care required for frail elderly	Yes			Yes	Yes	Yes	Yes			
Physicians are adequately remunerated for home visits				Yes	Yes	Yes	Yes			

Note: Blank = No.

[35] Winnipeg RHA response.
[36] L'Estrie RHA response.
[37] Not province-wide.

Table 9. Boundary-Spanning Mechanisms: Linkages with Other Social and Human Services

	BC	AB	SK	MB/ RHA[38]	ON	QC/ RHA[39]	NB	NS	PE	NL
There are financial arrangements for purchase of transportation services.		Yes			Yes	Yes				
There is an organized approach to eligibility for various levels of housing with supportive services.	Yes	Yes		Yes		Yes				Yes
There is a system for high-level planning of service supply for seniors needing coordinated care.	Yes		Yes	Yes	Yes	Yes	Yes			

Note: Blank = No.

[38] Winnipeg RHA response.
[39] L'Estrie RHA response.

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