Health Systems Integration

Synthesis Report

Canadian Home Care Association

About the Canadian Home Care Association

The Canadian Home Care Association (CHCA) is a not-for-profit membership association dedicated to ensuring the availability of accessible, responsive home care and community supports to enable people to stay in their homes with safety, dignity and quality of life. Members of the Association include organizations and individuals from publicly funded home care programs, not-for-profit and proprietary service agencies, consumers, researchers, educators and others with an interest in home care. Through the support of the Association members who share a commitment to excellence, knowledge transfer and continuous improvement, CHCA serves as the national voice of home care and the access point for information and knowledge for home care across Canada.
For more information, visit our website at www.cdnhomecare.ca

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Key Messages

- Integrated models of care come in many different forms – one model or strategy for integrated care does not fit all.
- Progress is being made toward greater integration in jurisdictions across Canada and worldwide, as evidenced by initiatives in various sectors of the health care system.
- Integration must be built around the needs of people.
- Successful integration requires a fundamental philosophy shift, clear policy direction and incentives that promote collaboration and emphasize team work and the delivery of patient-focused care.
- Successful integration models reduce duplication and improve efficiency, clinical outcomes and quality of life.
- Improved quality of care that is delivered in the most cost effective way is an important measure of integrated care systems.
- The home care sector plays a vital role in integrated systems to enable a shift from acute, episodic care to long-term care that meets the chronic care needs of an aging population.
- Clinical partnerships and case management (including the systems navigation function) are being successfully used in many jurisdictions to better integrate care, leverage the skills of all health team members and improve patient outcomes.
- A redistribution of resources within the health care system is necessary to support the time and tools required to develop a fully integrated system.

Executive Summary

Over the past few years there has been continued progress in moving toward greater integration of health systems. As the population ages and the prevalence of chronic diseases continue to rise, the concept of integration is being viewed with increased interest and urgency. A growing body of evidence supports integrated models of care as critical frameworks for improving health outcomes and quality of life, and for producing efficiencies within the system.

Canadians want to remain at home as long as possible — integrated care is a key strategy for helping them to realize this goal. There is a growing urgency to move to a better coordinated, fully streamlined system to meet the increasingly complex health needs of an aging population. The demand for home care services in Canada can be expected to grow dramatically in the coming years as the prevalence of age-related conditions rises. Providing an adequate supply of services, however, is an ongoing challenge across the country. As researcher Margaret MacAdam observes, "While it is promising that so many provinces are starting to break down the silos amongst types of health care service providers, much remains to be accomplished. These issues are at the core of integrating care and are among the challenges being faced by other countries" (MacAdam, 2011). Although there is a range of different models and approaches to integration, there are several key elements that make some models more effective than others. Collaboration, a focus on the individual (person-centred care), and the appropriate use of technology are just some of the essential ingredients to an effective integration model. Importantly, successful integration models require team work at all levels across the health continuum.

The integration of health care has been a gradual process. There is still much to be done. Challenges to integrating home care within the broader health system include developing a coordinating mechanism; identifying and targeting those individuals most in need of integrated care; ensuring access; providing case management; creating coordinated provider networks; educating providers; and making a compelling business case for increased integration to policy makers (Lum, 2008).

The CHCA's vision of health care is an integrated system that provides accessible, responsive services which enable people to safely stay in their homes with dignity and independence and quality of life.

Integration success stories are continuing to emerge in jurisdictions across the country. Many initiatives are being expanded or replicated in other regions as new evidence is published and knowledge is shared among practitioners and policy makers. From the ***Home is Best***™ in Fraser Health Authority, British Columbia (identified as a CHCA High Impact Practice) to Prince Edward Island's ***Integrated Palliative Care Initiative***, the concept of integration and recognition of its benefits are gaining momentum.

Within this integrated system, the home care sector will provide services that encompass health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for the family caregiver.

Introduction

Canadians value remaining independent at home for as long possible, and if given a choice would prefer early discharge from hospitals followed by the provision of home care.

An aging population and the associated rise in the prevalence of chronic diseases are key drivers of the evolution of our health care system. These dual forces are transforming the way health care is organized and delivered in Canada. Health care delivery is evolving from an episodic, acute care system to a continuing care approach that focuses on health promotion, disease and illness prevention and chronic disease management. It's not surprising that this shift is also seeing greater recognition of the vital role that home care plays within the broader health care continuum.

> Home care is "an array of services for people of all ages, provided in the home and community setting, that encompasses health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration and support for the family caregiver".
> — Canadian Home Care Association

The pace of change has become intensified in a health care sector with limited resources. There is also growing recognition among governments and policy makers that coordination and collaboration across the health care system is necessary in order to provide individuals with timely access to quality health care. Improving care through the effective collaboration of health care teams presumes a commitment to quality at all stages of care and as such reduces duplication and improves efficiency, clinical outcomes and quality of life.

Integration requires a new way of thinking and working (CHCA, Integration of Care, 2008). Indeed, integrated care is widely viewed as the essential framework required to meet the increasing demands placed on the health care system by an aging population and the rising prevalence of chronic diseases.

There have been a number of studies and reports produced over recent years on the subject of health system integration. The goal of this report is to synthesize the current body of research on the integration of health systems in the context of home and continuing care to support greater understanding of the issues and opportunities for governments, policy makers, providers and individuals.

The home care sector has experienced a dramatic transformation over the past decade. The demand for home care is rising — all provinces report waiting lists for at least one or more home care services (MacAdam, 2011). This demand for home care services has been fuelled by changes that have occurred in the acute care sector (e.g., bed closures, increase in ambulatory care clinics and day surgery) as well as limitations in the long-term care sector (e.g., waiting lists for beds). Over the past 10 years alone, home care programs in Canada have experienced a 51 percent increase in the number of care recipients; there are now over one million recipients each year, with approximately 70 percent of those individuals aged 65 and over (CHCA, Portraits of Home Care in Canada, 2008).

Home care has a crucial role in health care restructuring, primary health care renewal, chronic disease management and 'aging at home' strategies across Canada. Providing care closer to home, however, is not always supported by appropriate resources.

According to Statistics Canada, the demand for home care services in Canada can be expected to grow in the coming years as the prevalence of age-related conditions rises. Consider, for example, the following:

- The 65-and-over demographic comprised 13.7% of the total population of Canada in 2006 (Statistics Canada, 2006).
- Chronic conditions are more prevalent among elderly people and the proportion of seniors with a disability or handicap also rises with age.
- An estimated four in five seniors living at home have at least one diagnosed chronic condition compared to one in ten of those between the ages of 25 and 54. (Statistics Canada, 2006)
- Vulnerable individuals have a greater chance of 'falling through the cracks' or suffering unnecessary or premature institutionalization.

Understanding Integrated Care

Integrated care refers to a process or strategy for improving the coordination of health services to better meet the needs of patients and providers. There is no single definition or best practice model for integration. It can mean different things in different contexts, and it can take many forms. Integrated models require flexibility and a focus on removing the barriers to integrated care rather than being prescriptive in structure (National Health Services-Future Forum Report, 2011). What matters most is clinical and service-level integration that focuses on how care can be better provided around the needs of individuals, especially where this care is being provided by multiple professionals and organizations (Curry and Ham, 2010).

Integrated Care Models Vary – But People Come First

Maintaining the needs and perspectives of the individual is a guiding principle of integrated care. At its core, integration is about people and systems working together more effectively. Successful integration models require team work at all levels across the health continuum and an unwavering commitment to putting the patient's needs first.

Accreditation Canada defines integration as "services, providers and organizations from across the continuum working together so that services are complementary, coordinated, in a seamless unified system, with continuity for the client." It is important to note that integrated care is not an outcome, but a dynamic way or strategy for coordinating health services delivery. The end goal of integration is ultimately to provide a better care experience for the health care consumer (CHCA, Integration of Care, 2008).

At its core, integration is about people and systems working together more effectively.

The integration of care varies greatly across different settings and contexts. The UK-based King's Fund (2011) notes that a distinction can be made between *real integration*, in which organizations merge their services, and *virtual or contractual integration*, in which providers work together through networks and alliances. In some instances integration may align responsibility for commissioning and providing care. This allows clinicians the flexibility to use budgets to provide services directly or to commission services from other partners. In fact, many integrated medical groups in the United States use this model. It has been shown to have a positive impact on service utilization (e.g., reduced use of hospital beds) and improves the quality of care.

Integration may be seen at the *micro* (individual level) where multidisciplinary teams work together to meet the needs of individual users and caregivers, and at the *meso* level, where providers work in collaboration to meet the needs of specific populations such as the elderly or populations with the same diseases or conditions.

The Kings Fund notes that "Integrated care should become the main business for health and social care". Kodner and Spreeuwenberg (2002), meanwhile, comment, "Without integration, all aspects of care can suffer. Patients can get lost in the system, needed services fail to be delivered or are delayed or duplicated, the quality of the care experience declines and the potential for cost effectiveness diminishes."

There is a growing body of research that underscores the benefits of integrated care — for individuals and providers. Integrated models in various stages of development are yielding positive results in regions across Canada and worldwide. There is much to be learned from these success stories. Integrated models are resulting in better health outcomes and improved quality of life for patients. From a systems context, the integration of care is also cost effective because it reduces duplication and leverages specific skills and expertise at the right time, and in the right place.

Key Ingredients of Integrated Care

There are a number of core elements for improving the integration of health services. Together these elements contribute to the positive health "outcomes that integrated systems achieve, almost regardless of the particular form being used" (The King's Fund, 2011). Integration depends upon collaboration among providers at all levels across the health care continuum. Indeed, collaboration is the foundation for achieving a successful model of integration.

The following are widely acknowledged as the key characteristics of successful integrated care models:

DEFINED POPULATIONS that support relationships between health care teams and a specific population or local community. This targeted approach allows health care teams to target individuals who would most benefit from a more coordinated approach to the management of their care.

ALIGNED FINANCIAL INCENTIVES that support providers to work collaboratively. This includes the promotion of joint responsibility for the management of financial resources and a focus on health promotion and prevention to prevent admissions to hospitals and nursing homes.

SHARED ACCOUNTABILITY FOR PERFORMANCE through the use of data to improve quality and account to stakeholders through public reporting.

INFORMATION TECHNOLOGY that supports the delivery of integrated care (e.g., electronic medical records and tools to identify and target 'at risk' patients).

THE USE OF GUIDELINES that promote best practice, support care coordination across care pathways and reduce gaps in care.

EFFECTIVE LEADERSHIP at all levels with a focus on continuous quality improvement.

A COLLABORATIVE CULTURE that emphasizes team work and the delivery of highly coordinated patient-centred care.

MULTIDISCIPLINARY TEAMS of health and social care professionals in which, for example, generalists work with specialists to deliver integrated care.

PATIENT ENGAGEMENT in making decisions about their own care and support in enabling self-management.

Source: Kings Fund (2011), adapted from Curry and Ham (2010).

Where Does Home Care Fit?

Home care is uniquely positioned within the health care system as an integrative bridge between different health care sectors, including acute, long-term/chronic care and primary health care (CHCA, Portraits of Home Care in Canada, 2008). Integration recognizes the interdependencies of the patient/client, the provider and the system (CHCA Integration of Care, 2008). In collaboration with other health sectors, home care programs are realizing important successes in improving care delivery and outcomes through integration. Progress is being made in a number of areas, including palliative care, chronic care, primary health care and acute care, among others. The pace of integration of home care in chronic disease management has become increasingly urgent among policy makers and providers as the population ages.

Simply, integration requires a new way of thinking and behaving.

According to researcher Peter Tsasis, who looked at the role of home care in chronic disease management in Ontario, integrated systems must be built around the needs of individuals (Tsasis, 2009). "A focus on putting the individual's needs first, involves providing services at home or as close to home as possible". He concluded that a population health approach, chronic disease management, system integration and home care all need to be coordinated so that home care services are integrated with primary health care, and primary health care practitioners can link patients directly to local hospitals, thereby enhancing access to outpatient and diagnostic services without having patients go through emergency departments.

Meeting the Needs of an Aging Population

The demand for health care has risen dramatically as the population has aged. Governments, policy makers and family caregivers are grappling with the issue of how to provide quality care to meet the complex and continuing needs of the elderly. A number of key questions need to be addressed:

- Who will provide care to meet the needs of this population cohort?
- How can an already stretched health care system better allocate resources?
- How can the skills of health care team members be better leveraged to meet the needs of the individual?
- How can the system transition more rapidly and effectively from a focus on acute care and episodic treatment to continuing care, disease and illness prevention, and health promotion?
- What are the human and financial implications of non-integrated care?

These are just some of the questions driving the shift toward a more coordinated and collaborative approach to providing health care. And integrated care is increasingly being recognized as an essential strategy for putting people first, improving health outcomes and quality of life — and for improving the allocation of resources. Researcher Marcus Hollander notes that "integrated care delivery systems for the elderly – whether they are continuing care systems, primary healthcare based systems or other systems of integrated care – are the best solutions when it comes

to increasing the efficiency and effectiveness of care delivery for the elderly" (Hollander, 2007:10).

An aging population and the rising prevalence of chronic diseases represent an ongoing challenge for health policy makers, service providers, individuals and their caregivers. Those living with chronic conditions are the highest users of health care services, but the system is not designed to maximize the use of appropriate health services for this group. And yet those over age 65 are more likely to have chronic conditions than younger people. "Improved service coordination and integration in the delivery of chronic care [for seniors] are viable ways to reduce wasted resources, fragmented care and patient dissatisfaction while improving cost effectiveness" (MacAdam, 2008). Despite growing demand for access to health services among the elderly, to date there have been few large-scale trials of integrated care for this population.

A 2009 research project conducted by Margaret MacAdam for the Canadian Policy Research Network reviewed the conceptual understandings underlying integrated care to examine models of cost-effective care for the elderly, and to identify the models' key features and determine to what extent Canadian provinces were implementing these features. The project comprised three parts: a literature review, an environmental scan of provinces' activities implementing an integrated model for elderly care and a roundtable discussion. In the literature review just seven studies were identified as meeting the project's inclusion criterion. Based on a formal evaluation process it was shown that these studies of integrated care reported reductions in hospital and nursing home use, improvement in client satisfaction and cost savings or cost-effectiveness.

"Improved service coordination and integration in the delivery of chronic care [for seniors] are viable ways to reduce wasted resources, fragmented care and patient dissatisfaction while improving cost effectiveness"
— MacAdam, 2008

Flexible Frameworks for Integrated Care

Successful models are not prescriptive or rigidly defined; rather, the approach taken depends on the end policy goal. Margaret MacAdam's findings indicate that policy makers in Canada and in many countries worldwide are developing a consensus about the key features of integrated health and social care models.

These include 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 that include a mix of integrated care tools are also being used successfully to guide the

implementation of health reforms. While a framework does not dictate structure it can still be combined in ways that meet specific policy goals and fit different contexts. The Hollander and Prince (2008) framework is the most developed framework for continuing care for the elderly, those with mental illness and adults and children with disabilities, and was thus used as the basis for MacAdam's survey of provincial ministries of health in Canada. The framework has three components: philosophical and policy prerequisites that underpin ongoing support for integrated systems of care; a set of best practices for organizing service delivery; and a set of mechanisms for coordinating and linking organizations and professionals involved in delivering care services.

Integrating care is a particularly important strategy for meeting the needs of frail older people who may have several chronic diseases and thus are in contact with a range of health and social care professionals.

The MacAdam research concluded that some of the provinces have progressed quite far in their implementation of best practice features in integrated care systems. In the areas of administrative best practices and linkages with other sectors, however, progress has been slower. While all provinces are making progress in moving toward greater integration of health systems, the progress is uneven across the provinces, and sometimes even within the provinces.

Investments need to be increased to ensure quality of care for seniors is maintained or improved while reducing duplication and silos. Supply is not keeping up with demand – all provinces except Ontario report that they are building more nursing homes and making more nursing home beds available. Every province is reporting waiting lists for one or more home care services.

Reports from other countries (e.g., The King's Fund 2011) observe that integrating care is a particularly important strategy for meeting the needs of frail older people who may have several chronic diseases and thus are in contact with a range of health and social care professionals. The benefits, for example, are illustrated with the success of an integrated model of care implemented in Torbay, England. Health and social care for older people in Torbay is delivered through integrated teams, which were first established on a pilot basis in 2004 and have since been extended throughout the region. Each team serves between 25,000 and 40,000 people and is aligned with the general practices in the locality.

Budgets are pooled and used by integrated teams who commission services to meet clients' needs. A major priority has been to increase spending on intermediate care services [supportive care] that enable patients to be supported at home and help reduce hospital admissions. Results include reductions in the daily average number of occupied beds (from 750 in 1998/9 to 502 in 2009/10), the lowest emergency bed day bed use in the population aged 65 and over in the region, and negligible delayed transfers of care (Thistlethwaite, 2011).

Home Care and Primary Health Care Integration

The integration of home and community care and primary care is essential to meet the needs of seniors who want to remain at home as long as possible. The benefits of increased collaboration and coordination are evidenced by the ***Home is Best***™ philosophy which was first implemented in the Fraser Health region of British Columbia and is now being rolled out province-wide. This practice, indentified as a CHCA High Impact Practice is a system-wide approach to health care involving a strengthened and structured partnership between home and community care services, acute care and primary care to improve a seniors' experience within the health care system. ***Home is Best***™ is a bundle of system enablers, including proactive discharge planning, expanded community support services, increased access to home care services and telephone outreach.

Guided by the ***Home is Best***™ philosophy, seniors are being supported to remain in their homes with their care being coordinated by a health care team working in collaboration with a family physician. "The new philosophy and approach to care has resulted in reductions in the time it takes to admit a client to community services; a decrease in the number of patients designated as alternate level of care, a shorter hospital length of stay; and reduced emergency room visits" (CHCA, High Impact Practice, 2012). What's more, health care providers report greater satisfaction and efficacy as this new approach supports them in practicing to their full scope to better meet the needs of clients. The partnership supports clinicians to leverage existing hospital and residential care capacity. This coordinated approach, enabled by the ***Home is Best***™ philosophy, is helping seniors to stay healthy and remain at home longer, return home sooner after a hospital stay and prevent or delay admission to hospital or residential care until necessary.

Other home care and primary care integration initiatives are yielding positive outcomes across the country; in British Columbia, Alberta, Manitoba and Ontario to name a few. These approaches are patient/client population specific and involve the linking of providers to improve care delivery to all clientele. Specific initiatives highlighted in the 2008 CHCA Integration of Care report include:

- Alignment of home care personnel (including case managers, nurses, therapists and home support) with family health teams and/or primary health care teams.
- Establishment and support of partnerships between family physicians and home care case managers to enhance communication, collaboration and system utilization.
- Implementation of a Community Access Model representing a community-based team structure.
- Support of interdisciplinary teams within primary care to provide multiple services at a single location.
- Establishment of community resources and seniors clinics within primary care.

In Ontario, the ***Integrated Client Care Project*** (ICCP) was established to develop and assess a model that encourages true integration across the entire health care continuum. ICCP is a multi-year initiative that involves developing, implementing and evaluating Community Care Access Centre sites to plan the transition to a more integrated client care model, including payment for specific outcomes.

The project aims to ensure people, including those with complex needs, receive the care and support they need to live successfully in the community. "ICCP's

unique value proposition champions integrated care, payment for outcomes (alternative reimbursement) and system navigation." (Bell and Foley, 2011)

The Integrated Client Project's unique value proposition champions integrated care, payment for outcomes (alternative reimbursement) and system navigation.

To date, the model is showing promise for achieving greater integration and ultimately better patient outcomes and cost effectiveness. The first phase of the ICCP focused on wound care. At four weeks, all project sites exceeded the target wound reduction of 30 percent, and 72 percent of clients reported better ability to self-manage using a program provided to them during the integrated client care assessment. The ICCP model is currently being applied to the palliative care sector and future projects are planned for frail seniors and medically fragile children.

Home Care and Acute Care Integration

Similar successes are being realized with the acute care sector. A significant number of referrals to home care programs are from acute care (CHCA, Portraits of Home Care in Canada, 2008). The home care and acute care sectors are strengthening their working relationships, fuelled by the need for better utilization and management of hospital beds and the need to contain health costs. Examples of successful integration between home care and hospital include ***Hip and Joint Knee Replacement*** and P***artnering for Patients***. These 'CHCA High Impact Practices' involve placing home care personnel in acute care settings to support effective admission and discharge.

Introduced in 2008, in Ontario, the ***"FLO" initiative*** is helping to expedite the transition of acute clients into the community. The *"FLO"* initiative is based on a philosophy that puts the client first and improves existing processes to better serve clients. The core partnership team is between the Local Health Integration Networks (LHINs), hospitals and Community Care Access Centres (CCACs). Additional partners that support effective transitions include Nursing Service Providers, Community Support Agencies and Long-Term Care Homes. The initiative's success is based on standardized processes, regular and frequent communication, joint transition/admission protocols and partnerships among care providers, among other things (Ontario Ministry of Health and Long-Term Care, 2008).

Some provinces are seeing success with integrated initiatives that focus on emergency department utilization. Alberta, Ontario and New Brunswick, for example, have implemented programs that aim to reduce emergency department utilization and prevent inappropriate hospital admissions. Key features include the use of home care staff (typically a case manager in the emergency department), and collaboration between home care and emergency medical services to enable referrals to home care instead of transport to hospital where appropriate. Home care staff also work to identify and expedite discharges from the emergency department. This co-location strategy supports enhanced understanding of client needs and system capacity (CHCA, Integration of Care, 2008).

Home First, identified as a CHCA High Impact Practice in 2010, is based on a new philosophy used by the hospitals and the Community Care Access Centre (CCAC) in the Mississauga Halton Local Health Integration Network area. The ***Home First*** strategy was developed to address patient flow issues within hospitals. As in many jurisdictions, too many individuals were waiting in hospital beds for alternate levels of care (ALC), particularly for Long-Term Care (LTC). An ALC designation is applied to a patient when s/he occupies a bed in a hospital and does not require the intensity of resource/services provided in this care setting. High ALC rates mean that patients are receiving care in an inappropriate setting; and that the system is potentially overloaded, creating a backlog in emergency rooms. ***Home First*** is based on maximizing enhanced investments in community care services; creating operational processes to enable access to community care services; and promoting a shift in culture to committing to care options outside of hospital.

At Halton Healthcare Services, the number of new referrals monthly to LTC from one hospital dropped from 25 to 14 and has been sustained at this rate. The ALC to LTC patients within this hospital dropped from 87 in September 2008 to 30 in June 2009. The acute ALC percentage in hospital, which reflects patient days, has dropped from 28% to 3-5% where it is sustained. The CHCA describes ***Home First*** "a big win for the hospitals and community; and especially for the frail seniors within the Mississauga Halton Local Health Integration Network."

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Home Care and Chronic Care Integration

Greater integration is also occurring in the context of chronic care, driven by an aging population who want to live at home for as long as possible. An integrated and coordinated system of care decreases fragmentation and helps avoid premature admission to a facility (CHCA, Integration of Care, 2008). For example, the *Seniors at Risk Integrated Health Network* (SARIN) is based on the expanded chronic care model and aims to support seniors with two or more chronic conditions to remain at home (Vancouver Island Health Authority, British Columbia).

In Quebec, the *Program of Research to Integrate the Services for the Maintenance of Autonomy*—or PRISMA—has aimed to improve continuity and access of services for the frail elderly. The PRISMA program has been operating in the region around Montreal for the last ten years. Its goal is to help the frail elderly stay at home as long as possible. PRISMA uses an integrated service delivery model to help assess, co-ordinate, maintain and evaluate the full range of home care services delivered by medical practitioners, public service providers and volunteer organizations. Results on the efficacy of this model showed a decreased incidence of functional decline, a decreased burden for caregivers and a smaller proportion of older people wishing to enter institutions. The program philosophy and approach have been integrated into the Centres de Santé et de Services Sociaux (CSSS) service delivery model across the province of Quebec.

In the United Kingdom the National Health System (NHS) has also emphasized the need to improve long-term care. The NHS noted in its 2005 report: *Supporting People with Long-Term Conditions,* that care for the majority of this population has "traditionally been reactive, unplanned and episodic."

For the majority of people with long-term conditions, significant benefits come from getting better, more integrated support for managing their own symptoms and medication.

This has resulted in the heavy use of secondary care services (e.g. medical specialists, acute care). Based on its research, the NHS recommends a model based on existing successes and innovations to help local health communities to develop a more integrated and systematic approach. The NHS identifies three components for matching care to the specific needs of the individual: case management, disease-specific care management and supported self-care. "Matching care to need is key. For the majority of people with long-term conditions, significant benefits come from getting better, more integrated support for managing their own symptoms and medication" (NHS, 2005).

Home Care and Palliative Care Integration

Palliative care is another area where improved integration with home care programs is yielding positive results. As a result of the commitments in *2004 10-Year Plan to Strengthen Health Care*, jurisdictions have been working to enhance the delivery of home based care to end-of-life patients. The ***Enhanced Palliative Care Program***, identified as a CHCA High Impact Practice is one example of an integrated approach to supporting palliative patients in the community.

The ***Enhanced Palliative Care Program*** helps people with a terminal illness to receive timely access to end-of-life care. The Enhanced Palliative Care team includes a home care case manager, an advanced practice nurse (clinical nurse specialist or nurse practitioner), palliative care physician and spiritual care consultant. This core team serves as the clinical expert resource to the broader home care team, many of whom may have additional education and training in palliative care but who carry a general caseload. The Enhanced Palliative Care (EPC) team therefore helps to enhance the knowledge and abilities of the nurses, doctors and other formal and informal caregivers serving the client.

The Health Council of Canada has identified the Prince Edward Island Integrated Palliative Care Program as one of six "best practices" from across Canada. The program model is based on the standards adapted from the Canadian Hospice Palliative Care Association Standards document (see www.chpca.net). The program's coordinated point of referral through the Regional Home Care Program and shared assessment tool intended to limit overlap and duplication for the patient, and their family were instrumental in making this provincial program, a best practice for all of Canada.

Nova Scotia's Capital Health District also has an Integrated Palliative Care Service to better meet the needs of end-of-life patients. Health care providers work together as part of a team to ensure patients can move easily to the setting that best suits his/or her needs.

Home Care and Pediatric Care Integration

There has been a growing number of children requiring extensive health supports in their homes and communities (Children and Youth Homecare Network, 2002). Approximately 15 percent of home care recipients in Ontario, for example, are children (Kirby, 2002).

One example of an integrated model of care being used in Ontario is the Children's Treatment Network (CTN). This model links over 40 health care, education, recreation, social and community services organizations so they can take a team approach to each child's care. Key principles of this model include family centredness; holistic care in which CTN members work together to establish a single client service plan; and an integrated framework in which participants are part of a system of care across Simcoe and York regions for children with rehabilitation needs. An evaluation of the CTN showed improved access, reduced waiting for services, increased participation of children in schools, community, family and recreation and increased family functioning/quality of life, among other things (Children's Treatment Network, 2010).

A Case Management Approach for Systems Integration

Case management is an important element of health systems integration (CHCA, Case Management Report, 2007a). Case management is a collaborative strategy undertaken by health professionals and clients to maximize the client's ability and autonomy through advocacy, communication, education, identification of and access to requisite resources, and service coordination. Researchers Marcus Hollander and Michael Prince highlight case management as an essential strategy for achieving greater integration of care: "Our view is that most clients are best served if they continue to have the same case manager over time, across all components of the system." They add that system level case management supports a continuing match between the individual's needs and the range of services provided — even as the individual's needs change. By using a system level case management approach clients are not allowed to deteriorate from lack of regular monitoring to the point where more costly services may be required e.g. hospital admission. (Hollander and Prince, 2008:11)

> **Case management is a collaborative strategy undertaken by health professionals and clients to maximize the client's ability and autonomy through advocacy, communication, education, identification of and access to requisite resources, and service coordination.**

Case management is a common activity among all jurisdictions, although it varies in scope, access and content. Traditionally, home care case managers focused on coordination and access to services within their home and community care sector. When individuals did not meet eligibility criteria for home care they were referred to other service providers

or discharged to self-care until the next episode moved them back into the system. This episodic approach resulted in fragmented care. Members of the broader health care team worked in silos, did not readily collaborate in the provision of care and lacked understanding of each other's role.

Through the alignment of home care case managers with family health care teams, the CHCA's National Home Care and Primary Health Care Partnership Project identified a number of benefits of an enhanced role for home care managers in the management of individuals with chronic disease. The Project assessed a broadened role for home care in chronic disease management in which the client's needs were met by an integrated health team. This integrated approach, enabled through case management, resulted in improved care by reducing fragmentation, increasing coordination of complex care, and providing the necessary screening, monitoring and evaluation of clients using a holistic approach supported by linkages to the broader care community.

Key features of the home care case management function within a chronic disease management framework include:

- Regularly assessing disease control, adherence to care plan and self-management status
- Either adjusting treatment and / or communicating client needs to primary care physicians on a regular basis
- Providing support for self management
- Providing support for more intense follow-up
- Providing navigation through the health care process (Hindmarsh, 2008).

Integration through case management does have some challenges. Namely, there is need for greater communication and collaboration between case managers and providers, as well as a system to ensure that patients receive prescribed care (Canadian Health Care Association, 2009). The CHCA's Home Care and Primary Health Care Partnership Project developed a solution for overcoming this obstacle that resulted in enhanced care and better use of health human resources. It linked case managers with family physicians, designating them as part of the health care team. This arrangement proved beneficial to all concerned: the physicians felt more supported and had a lighter workload; the case managers were better able to coordinate care; and the patients' conditions improved. This integrated model is considered a national best practice and is currently in place in a number of jurisdictions in Ontario, Alberta and British Columbia.

Barriers to Integration

There are a number of barriers to the successful integration of health systems. The CHCA identified the following barriers from a 2011 consultation with home care experts:

- Absence of a clearly articulated person-centred vision for integration.
- Governance models and leadership that adhere to a hierarchical approach and reject flexible, adaptive, all inclusion models of care.
- Policies and funding that discourage collaboration by incenting episodic, silo-based care.
- Limited understanding of the roles and value that each team member brings to the patient care experience.
- Lack of trust and minimal communication between health care team members and no shared accountability for patient outcomes.
- Fragmented and / or no technology systems to support timely sharing of information, communication and evaluation.
- Unrealistic expectations including, the time it takes to build trusting partnerships; the need to support a systemic change process; and the initial upfront resources required to sustain the change.

A 2011 study by The Change Foundation reinforced the existence of these barriers to integration and underscored the need to better understand the perspectives and experience of community-based providers — care coordinators, regulated health professionals and personal support workers.

This context is central to understanding and improving the experience of individuals and their caregivers. The Change Foundation study was based on a survey of health professionals (e.g. nurses, pharmacists, social workers, dieticians and occupational therapists), care coordinators (case coordinators/managers) and personal support workers. The survey was modified for each group and designed to gain a better understanding of client interactions. The survey data was used to identify opportunities for quality improvement and ultimately a better patient experience. Four key themes emerged from the analysis of the survey responses:

- Human resources strategy development
- Operational design improvements
- Information exchange and communication improvements
- Improved linkages with primary care.

Conclusion

Building and sustaining an integrated system of care is not easy; if it were, all systems would be integrated. The benefits of integration, however, in terms of client outcomes, cost effectiveness and provider satisfaction far outweigh initial challenges with change management and resource allocation.

Evidence shows that the home care sector can and should play a key role in integrated health care systems. Whether this means meeting the needs of our aging population, providing necessary services to enable fragile complex care children to remain in their homes or assisting an individual to die with dignity in the setting of their choice, an integrated approach to care yields the best outcomes. Integration requires the active involvement of governments, policy planners, system administrators, providers, individuals and their families. Through its research and feedback collected from providers, policy makers and individuals across the country, the CHCA puts forward several key recommendations for overcoming barriers to integration and for achieving the seamless, cost effective health care experience we all strive for:

- Articulate a **vision and philosophy** for an integrated person-centred health care system.
- Provide clear **policy direction and funding models** that incent and promote integration and enable providers to achieve the vision.
- Design care delivery models based on **population health needs** that incorporate health promotion and disease prevention strategies.
- Adopt new **leadership competencies** and operational structures that reinforce shared accountability, and flexibility to foster and sustain integration.
- Redesign **primary health care services and build partnerships with home care**, outreach to community support, acute care and supported living.
- Leverage clinical partnerships and the home care capacity to provide **case management as a strategy for health systems integration.**
- Invest in **technology solutions** to enable improved communication and collaboration across professions and health sectors.
- Adopt an **accountability framework** that embraces a Triple Aim* approach to measuring integrated systems goals:
  1. Enhance the individual (patient) experience of care (including quality, access and reliability).
  2. Improve the health of patient populations.
  3. Reduce, or at least control, the per capita cost of care for populations.

  *(*Source: Berwick, 2008)*

Appropriate and sustained investment in home care and integrated strategies must be a priority in the evolution of the health care system. Integrating health systems is complex and multi-faceted – it is impossible to move to a new seamless, unified system of health care overnight. The transition takes time and investment for people and systems to work together differently. Progress is being made across the country as policy makers and providers identify and implement innovative ways of coordination and collaboration, and make meaningful improvements in the quality of care.

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