The implementation of the PRISMA model of integrated care in Canada

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Levels of Integration according to Leutz

- **Full integration**: Formally pooling resources, allowing a new organisation to be created alongside development of comprehensive services attuned to the needs of specific patient groups.

- **Coordination**: Operating through existing organisational units so as to coordinate different health services, share clinical information and manage transition of patients between different units (for example chains of care, care networks).

- **Linkage**: Taking place between existing organisational units with a view to referring patients to the right unit at the right time, and facilitating communication between professionals involved in order to promote continuity of care. Responsibilities are clearly aligned to different groups with no cost shifting.
Comparison of two models of Integrated Care

Coordination model (PRISMA)

- Single entry
- Triage
- Case-Manager
- Home Care
- Hospital & Rehab.
- Long-term Care Inst.

Full Integration model (SIPA, PACE, CHOICE)

- Entry
- Home Care
- Case-Manager Multidisciplinary Team
- +/- Day Centre
- +/- Home care
- Hospital & Rehab.
- Long-term Care Inst.
1. Coordination between services
2. Single point of entry
3. Case-management
4. Individualized Service Plan
5. Unique assessment tool and Case-mix classification system
6. Information tool (Computerised Clinical Chart)
7. Financing
1. Co-ordination between services

- **Strategic (decision makers)**
  - Local Governance Table: structures, financing and protocols
  - Hospitals and CLSCs CEOs
  - Chairs and directors of voluntary or private agencies
  - Shift of paradigm: client-centered ⇒ population-centered

- **Tactical (services’ managers)**
  - Local Management Committee: mechanisms

- **Operational (clinicians)**
  - Multidisciplinary team
2. Single point of entry

• Common door to get access to all services
• Triage (for people not refered by prof.)
  – screening instrument: PRISMA-7
  – reference to the right service or to the Integrated Service Delivery Network
  – link to the 24/7 nursing phone line.
• Basic data collection (socio-demography)
3. Case-Manager

• Functions
  – basic assessment (functional autonomy, needs)
  – reference to other professionnals (for completing the assessment)
  – planning of services (with patient & family)
  – service “broker”
  – patient advocacy
  – follow-up (periodic re-assessment)

• Clinical (Scharlach) / Neighborhood (Eggert) / Basic (Phillips) / Intensive Case-Management (Challis)
Case-Manager

- Distributed by territory (neighbourhood)
- Nurse or Social worker or others
- Special training
- Not associated with a single institution or agency but with the Local Governance Table
  - intervenes wherever is the patient (“blue helmet”)
- May also provide direct care (in his/her field of competency)
- Case load: 40-45
4. Individualized Service Plan

- Prepared once the assessment is completed
- Lead by the Case-Manager
- Consensus amongst the providers
- Approval by patient (and/or family)
  - empowerment
- Includes the Management Plan of each provider
- Periodical revision
5. Unique assessment tool

- SMAF: disability and handicap scale
- Case-mix classification: Iso-SMAF Profiles
  - 14 different homogeneous patterns of disabilities
  - Functions:
    - Service allocation: admission criteria
    - Monitoring
    - Management
    - Financing
SMAF

- Système de Mesure de l’Autonomie Fonctionnelle (Functional Autonomy Measurement System)
- Developed according to the WHO Classification of disabilities
- 35 items on a 5-point scale
  - 0: autonomous
  - -0.5: with difficulty
  - -1: need supervision
  - -2: need help
  - -3: dependent
Items of the SMAF

- **Activities of Daily Living**
  - Eating, washing, dressing, grooming, urinary & fecal continence, using the bathroom

- **Mobility**
  - Transfers, walking inside & outside, donning a prosthesis & orthosis, propelling a wheelchair, negotiating stairs

- **Mental functions**
  - Memory, orientation, judgement, understanding, behaviour

- **Communication**
  - Vision, hearing, speaking

- **Instrumental Activities of Daily Living**
  - Housekeeping, meals, shopping, laundry, telephone, transportation, medications, budget

- **Social functioning**
  - Free time, relationships, environment, relationships, roles, expresses desires, ideas, opinions and limitations
ISO-SMAF Profiles
(Dubuc et al, 2001)

• Case-mix classification system
  – Needs Related Groups (not resources utilization)

• Developed by Cluster analysis (n=1997) and expert consultation

• Validation
  – internal: split samples
  – external: discrimination of nursing care time and costs

• 14 groups

• Internal validation process (Euclidian distance)
PROBLEMS IN INSTRUMENTAL ACTIVITIES OF DAILY LIVING ONLY

1. Difficulties
   - ADL MOB COM MF IADL

2. Supervision
   - ADL MOB COM MF IADL

3. Help
   - ADL MOB COM MF IADL

PREDOMINANT ALTERATIONS IN MOBILITY FUNCTIONS

4. Autonomous ADL
   - ADL MOB COM MF IADL

5. Difficulties ADL
   - ADL MOB COM MF IADL

6. Help ADL
   - ADL MOB COM MF IADL

MIXED ALTERATIONS MOBILITY + COGNITIVE

7. Moderate + difficulties ADL
   - ADL MOB COM MF IADL

8. Severe + supervision mobility
   - ADL MOB COM MF IADL

9. Severe + help ADL
   - ADL MOB COM MF IADL

   (walk independently, behavioral problems)

HELP IN MOBILITY

10. Without incontinence
    - ADL MOB COM MF IADL

11. With incontinence
    - ADL MOB COM MF IADL

(Bad major behavioral problems)

BEDRIDDEN AND DEPENDENCY IN ADL

12. Severe cognitive impairment
    - ADL MOB COM MF IADL

13. Very severe cognitive impairment
    - ADL MOB COM MF IADL

(moderate behavioral problems)
Hours of care and support

Iso-SMAF Profiles

Support
Personal
Nursing

Hours per day

0 1 2 3 4 5 6 7
ISO-SMAF Profiles

• Functions:
  – Service prescription: admission criteria
  – Clientele Monitoring
  – Management of resources
    • Staff distribution
    • Patients distribution in units or services
    • New resource design (e.g. Profile 9)
  – Financing
Comparaison des Profils Iso-SMAF selon le milieu de vie

CHSLD
n=25 800

RPA
n=190 (Bravo)

RI-RTF
n=3 674

SAD
n=88 993

Pr. Iso-SMAF 1
Pr. Iso-SMAF 2
Pr. Iso-SMAF 3
Pr. Iso-SMAF 4
Pr. Iso-SMAF 5
Pr. Iso-SMAF 6
Pr. Iso-SMAF 7
Pr. Iso-SMAF 8
Pr. Iso-SMAF 9
Pr. Iso-SMAF 10
Pr. Iso-SMAF 11
Pr. Iso-SMAF 12
Pr. Iso-SMAF 13
Pr. Iso-SMAF 14
6. Information Tool

• Facilitates information flow
• Computerized Clinical Chart
  – accessible by all professionals and institutions
  – via internet (Quebec Health and Social services Network)
  – security and privacy
  – data generator: for monitoring and research
Single point of entry

SCREENING

Case Manager

- CLSC
- Family physician

Social Economy Agencies

- Voluntary Agencies

Hospitals and Rehab. services

- Home Care
- Nursing Care
- Occ. Therapy, etc.

Specialized Physicians

Long-term care institutions

- Day Centre
- Institutionnalization (temp or permanent)

Geriatric services

- Specialized and General Care Services
- Rehabilitation

Domestic tasks

Meals-on-wheels
Estrie project

• Implementation of the Integrated Service Delivery Network within 3 areas
  – 1 urban: Sherbrooke
  – 2 rurals: Granit (Lac Mégantic) & Coaticook

• Evaluation
  – implementation (process): case-studies (3)
  – impact (outcome): quasi-exp population design (n=1500 >75 at risk; 4 years)
Conclusion for implementation

• PRISMA Model can be implemented
• Implementation Rates reached 70 to 85%
• Impact when implementation over 70%
• Degree of integration was good to very good (communication/cooperation level)
Conclusion for the impact

• Significant effect on
  – Functional Decline: prevalence (7%) and Incidence (14%)
  – Handicap (Unmet needs): ↓ by half
  – Satisfaction and empowerment
  – ER
  – Hospitalisation (nearly significant)

• No effect on:
  – Institutionalization
  – Consultations with health prof
  – Home care services

• Equal Cost: improves the efficiency
From innovation to services
“When the rubber hits the road”

• Decision to generalize the model

• Concurrent reform (creation of CSSS: merge of Hospitals, Nursing Homes, Home Care Agencies)
  – Less energy for other issues
  – Silo effect within the organizations
  – Less open to external partnerships
  – Structural ≠ Functional

• New structural reform announced !?!?!
  – Merge of all CSSS with other Health and Social Institutions (Mental Health, Rehab, Youth Protection, Public Health) in 20 Regional CISSS
Implementation of Integrated Networks
Implementation of Integrated Networks by Components

- Ind Service Plan
- Information System
- Coordination Tables
- Case Managers
- Management & Assessment System
- Single Entry Point
- Geriatric Medicine Team
- Leader

PRISMA

2011 2012 2013 2014

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Implementation Evaluation
(Quebec National Public Health Institute, 2014)

- Need of a well-identified local leader (champion)
- Case-Managers
  - Funding
  - Clarity of the role
  - Insufficient training for shifting to the new role
  - Needs for adequate professional coaching and support
- Delay in the availability of the electronic record
  - General Computerization of the Health Care Institutions
  - Specific Software for the Integrated Network (2011)
  - Individualized Service Plan and Resource Allocation Module (2014)
- Lack of interest and involvement of GPs
  - Funding issues
  - Match of one CM with a GP group
Institutionnalizing the innovation

• Turn-over of managers and decision-makers
  – Loss of institutional memory
  – Loss of commitment to the integrated network
• Training of CM: no norms and label
  – France: university diploma (140h)
• Implementation rates not validated
• Back to institution-centrered practices
• Effect of the new structural reform (2015) ??
Financing: key issue

- “We better coordinate the use of the basket of services, but the basket is leaky” (one of the CM)
- Lack of funding, especially for Home Care
  - Canada: 1.2% of GDP devoted to LTC
  - Only 14% to Home-Care
Financing: key issue

- Lack of funding, especially for Home Care
- Limitation of the Canadian Beveridge model
  - No specific funding associated with a given level of disability (Iso-SMAF Profile)
  - Difficulties for transferring funds to private or not-for-profit agencies
  - Problems in prioritizing Home Care and protecting funding (Canada Health Act: Hospital and Physicians)
- Financing: 7th element of the PRISMA model
  - Create an hybrid model (tax funded and social insurance)
  - Long-Term Care Public Insurance
Quebec Autonomy Insurance

L'AUTONOMIE POUR TOUS
Livre blanc sur la création de l'assurance autonomie

Parlementary Commission: Fall 2013
60 days– 61 reports & groups
General support.
Introduced at the National assembly on December 6th 2013

Waiting for Parlementary Commission and detailed article revision

Planned Implementation: April 1st 2015

Election triggered and parlement dissolution on March 6th

Parti Québécois defeated on April 7th

Project abandonned by the Liberals
Conclusion

- PRISMA: an example of transfer from research to public policy
- Implementation needs:
  - More time than expected
  - Adequate monitoring
  - Adequate funding: «Integration costs before it benefits» (Leutz)
  - No major concurrent competing reform
- Integration needs appropriate financing system
  - Coupling with Long-Term Care Insurance