Taking integrated care forward in Quebec, Canada: the PRISMA experience

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- Pop tot: 7.9 millions
- >65 ans: 1.3 million (16%)
- 30% (65+) long-term care
  - Home care
    - Individual homes (16%)
    - Private collective housing (8%)
  - Intermediate facilities (3%)
  - Nursing Homes (3%)
Quebec Health Care System

• Tax-funded Beveridge-type
• Publicly funded & universal:
  – Integration of funding
• Integration of health and social services
  – National, Regional and Local
• No direct payment nor reimbursement by clients (Health Insurance Card)
• State: funder, manager, principal provider
Comparison of two models of Integrated Care

Coordination model (PRISMA)
- Single entry
- Triage
- Home Care
- Hospital & Rehab.
- Long-term Care Inst.
- Case-Manager

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 (Case-load: 40-45)
4. Individualized Service Plan
5. Unique assessment tool (SMAF) and Case-mix classification system (Iso-SMAF Profiles)
6. Information tool (Computerised Clinical Chart)
7. Financing
Single point of entry

SCREENING

Case Manager

Social Economy Agencies

Voluntary Agencies

Long-term care institutions

Hospitals and Rehab. services

CLSC

Family physician

Home Care
Nursing Care
Occ. Therapy, etc.

Specialized Physicians

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

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Implementation of Integrated Networks by Regions
Implementation Evaluation
(Québec 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
Population vs Disease – oriented integration

- Population-based (PRISMA) vs Disease-based (Chronic Care Model)
  - “Your integration is my fragmentation” (Leutz)

- < 70 yo: disease-oriented integration could work

- > 70 yo (or when more than 1 CD)
  - Population-based: primary line
    - Case-manager in direct contact w patient
  - Disease-based: second line
    - Contact with Case-Manager, not patient
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
Public Long-term care social and health service expenses in 2008 (%GDP)

Source: OECD, 2010
Distribution of Public Long-term Care expenses

Canada 14% Institution, 86% Home Care
Netherlands 32% Institution, 68% Home Care
France 43% Institution, 57% Home Care
Denmark 73% Institution, 27% Home Care

Source: Huber et al. Facts and figures on Long-Term Care, 2009
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
L’AUTONOMIE POUR TOUS
Livres blanc sur la création de l’assurance autonomie

Parlementary Commission: Fall 2013
60 days - 61 reports & groups
General support.
Quebec Autonomy Insurance

• Objectives:
  ▪ Ensure equitable public funding
  ▪ Establish a public management of LTC
  ▪ Ensure quality of services
• Adults with permanent and significant disabilities (aged AND handicapped)
• All living environments
• Universal: means-adjusted
Process

• Assessment by Case Manager (with the SMAF)
• Benefits
  ▪ According to the Iso-SMAF Profile
  ▪ Means-adjusted
  ▪ In-kind (public), by contract (private) or cash (with caution)
• Individualized Service Plan and Service Allocation
  ▪ Formal approval by the user and relatives
• Contract with service providers (private & NFP)
  ▪ Accreditation process (quality)
• Follow-up and quality control by CM
Services covered

• Professional Care
  ▪ Nursing
  ▪ Nutrition
  ▪ Psychosocial
  ▪ Rehabilitation (PT and OT)

• ADL support
• IADL support
• Services to informal caregivers
  ▪ respite, support services
• Technical Devices
Funding

• Tax-funded (income)
• Transfer of the actual budget in a specific programme (no transfer)
• Additional significant budget for Home Care (doubling)
• Prevision for annual increase in budget to deal with aging of the population
• Allocation managed by the medicare agency
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
• All is about Politics 😊