

Canada: Application of a Coordinated-Type Integration Model for Vulnerable Older People in Québec: The PRISMA Project **30**

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30.1 Integrated Care in Québec and Canada

Canada is a confederation of ten provinces and three territories. In the province of Québec, the population is mostly French speaking. The health care system in Canada was developed in the sixties, based on a Beveridgian model of universal, public, tax-funded coverage of hospital and physician services. Under the Canadian constitution, health care is the responsibility of the provinces and territories. However, in 1966, the federal government set out four principles for implementing a national health care system: public administration, comprehensiveness (all “medically necessary” services), universality, and portability (between provinces). The Canada Health Act (1984) consolidated the four original principles and added a fifth: accessibility (without any financial barriers). Although not responsible for delivery of health care, the federal government used its spending power to introduce the public health care system and committed to partially fund provinces that complied with those principles. Originally, the federal share was 50%; now it is around 25%. The health care system in Canada covers hospital and physician services (“medically necessary”). Dental care, professional services (other than from physicians) provided outside hospitals, and drugs are not included, except in the province of Québec which introduced a universal mixed pharma care program in 1997. Hospital services are delivered through public or not-for-profit organizations. Physicians work mostly in private clinics and are paid directly by the government without overbilling.

The province of Québec set up its system in 1971 (Act Respecting Health and Social Services) with full integration of health and social services at the local, regional and provincial level. There was a Ministry of Health and Social Services, Regional Authorities for health and social services, and local institutions that

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integrate those services. Québec is still the only province in Canada to integrate health and social services. The Ministry sets policy, pays for physician services and allocates budgets to the 18 Regional Authorities. Regional authorities were responsible for adapting services to their particular population and allocating budgets to the local institutions. Locally, services are provided via hospitals, rehabilitation centres, youth centres, and nursing homes. In addition, Local Community Services Centres (Centres locaux de services communautaires, CLSC) were designed to be the primary care portal for health and social services in the community.

Private for-profit operations are virtually non-existent in the Québec health care system, except for residential facilities for older people. Voluntary agencies are well developed, particularly for home services. Social economy agencies (not-for-profit) are also very active in providing support for domestic tasks and personal care.

30.2 Integrated Care in Practice

30.2.1 Problem Definition

The population of Canada and Québec is aging quickly. In 2014, 17% of the population in Québec (1.4 million people) was over 65 years old. Since the baby boom in the fifties, particularly in the French-speaking Québec population, it is expected that older people will make up over 25% of the population by 2031 (Azeredo and Payeur 2015). Despite the integration of health and social services, delivering services to a growing vulnerable older population was a challenge. Prior to 2003, many public organizations (hospitals, nursing homes, rehabilitation centres, CLSCs), together with social economy and voluntary agencies, delivered care, without coordination. Multiple assessments, delays, redundant services, gaps in services and multiple providers created inefficiencies, compromised service quality and increased costs probably unduly. There was a pressing need to integrate those services (Hébert 2010).

To address these challenges, two large experiments were carried out simultaneously from 1997 to 2001. First, the SIPA (Integrated Services for Older People: Services intégrés pour les personnes âgées) project in Montreal was an attempt to test a fully integrated model in the Québec context. Experimental implementation took place from 1999 to 2001 across two sites in Montréal. The SIPA team of professionals (case managers, nurses, physicians, physiotherapists, social workers) was responsible for the care of frail older people at home, with some services outsourced to the usual health care organizations. An evaluation of SIPA using a prospective randomized controlled trial demonstrated its efficacy in improving the use of home services instead of institutions (Béland et al. 2006). However, the capitation funding that was part of the model was never implemented in the experiment. Since the SIPA organization operated in parallel with the usual health care system, generalization of such a model was deemed difficult within the universal health care system in Québec. The SIPA model was abandoned after the experiment.

PRISMA (Program of Research to Integrate Services for the Maintenance of Autonomy) was the second large project designed to better fit the health care system in developing a coordinated-type integration model. PRISMA was developed by a steering committee including policy-makers at the provincial and regional levels, health care managers, clinicians and researchers. The coordination level of integration was originally suggested by Leutz (1999) as one of three types of integration (in addition to liaison and full integration), but at that time there was no model developed to operationalize it. Unlike fully integrated systems such as SIPA, this model includes all public, private and voluntary health and social service organizations involved in caring for older people in a given area. Each organization keeps its own structure but agrees to participate under an umbrella system and to adapt its operations and resources to the agreed requirements and processes. At this level, the integrated service delivery system is not just nested in the health care and social services system (like fully integrated models); it is embedded within it.

30.2.2 Description of the PRISMA Model

The PRISMA model comprises six components: (1) coordination between decision-makers and managers at the regional and local levels, (2) single entry point, (3) case management, (4) individualized service plans, (5) single assessment instrument coupled with a case-mix management system, and (6) computerized clinical chart.

Coordination between institutions is at the core of the PRISMA model. Coordination must be established at every level of the organizations. First, at the strategic level (governance), a Joint Governing Board (JGB) is created involving all health care and social services organizations and community agencies (public, private and voluntary) and the decision-makers agree on policies and orientations and what resources to allocate to the integrated system. Second, at the tactical level (management), a service coordination committee, mandated by the JGB and comprising public and community service representatives together with older people, monitors the service coordination mechanism and facilitates adaptation of the service continuum. Finally, at the operational level (clinical), a multidisciplinary team of practitioners surrounding the case manager evaluates patients' needs and delivers the required care and services.

The **single entry point** is the mechanism for accessing the services of all health care institutions and community organizations in the area for a frail senior with complex needs. It serves as a unique portal that older people, family caregivers and professionals can access by phone or written referral. A link is established with the Health Information Line available 24/7 to the general public in Québec. Callers are screened using a brief 7-item questionnaire (PRISMA-7) (Raïche et al. 2008) that has shown good levels of sensitivity and specificity in identifying older people with significant disabilities. PRISMA-7 is also used by health professionals in physicians' offices, emergency rooms, and flu shut clinics to screen older people. A detailed assessment of disabilities is then undertaken for those screened positive; individuals deemed eligible for the integrated service delivery are referred to a

case manager. The eligibility criteria are to be over 65 years old and present significant disabilities as defined by a SMAF score over 15 or an Iso-SMAF Profile over 4 (see Box 30.1).

Box 30.1 Functional Autonomy Measurement System: SMAF (Système de mesure de l'autonomie fonctionnelle)

The SMAF (Hébert et al. 1988, 2001; McDowell 2006) measures functional ability in five areas:

- Activities of daily living (ADL) (seven items)
- Mobility (six items)
- Communication (three items)
- Mental functions (five items)
- Instrumental activities of daily living (IADL) (eight items).

For each item, the disability is scored on a 5-point scale:

- 0: independent
- -0.5: with difficulty
- -1: needs supervision
- -2: needs help
- -3: dependent

The resources available to compensate for the disability are evaluated and a handicap score is calculated. The stability of the resources is also assessed. A disability score (out of -87) can be calculated, together with sub-scores for each dimension.

A case-mix classification system based on the SMAF has been developed (Dubuc et al. 2006). Fourteen Iso-SMAF profiles were generated using cluster analysis techniques in order to define groups that are homogeneous with regard to their profile.

- Profiles 1–3: slight disabilities in instrumental activities of daily living only.
- Profiles 4, 6 and 9: moderate disabilities predominantly in motor functions.
- Profiles 5, 7, 8 and 10: moderate disabilities predominantly in mental functions.
- Profiles 11–14: severe disabilities (those people are usually cared for in nursing homes).

The Iso-SMAF profiles are used to establish eligibility criteria for different services and to calculate the organizations' required budget, based on the disabilities of their patient groups (Tousignant et al. 2003, 2007).

The **Case Manager (CM)** model included in PRISMA draws directly from those described as a Clinical CM (Scharlach et al. 2001), Neighborhood Team (Eggert et al. 1990), or Basic CM (Phillips et al. 1988). The case manager is responsible for conducting a thorough assessment of the patient’s needs, planning the required services, arranging patient access to these services, organizing and coordinating support, directing the multidisciplinary team of practitioners involved in the case, advocating for, monitoring and reassessing the patient. The CM is legitimate by the JGB for working in all institutions and services. The CM can be a nurse, social worker or other health professional and should be specifically trained. An ideal caseload is around 40 patients per CM. Figure 30.1 summarizes the flow of patients through the coordinated PRISMA model.

The **Individualized Service Plan (ISP)** results from the patient’s overall assessment and summarizes the prescribed services and target objectives (Somme et al. 2009). The ISP is led by the CM and established at a meeting of the multidisciplinary team including all the main practitioners involved in caring for the older person. The ISP should be confirmed with the patient and informal caregivers so that they are empowered in the decision-making process.

The **single assessment instrument** is used to evaluate the needs of clients in all organizations and by all professionals working in home care organizations or in hospitals and institutions. The instrument implemented in the PRISMA model is the SMAF (French acronym for Functional Autonomy Measurement System),

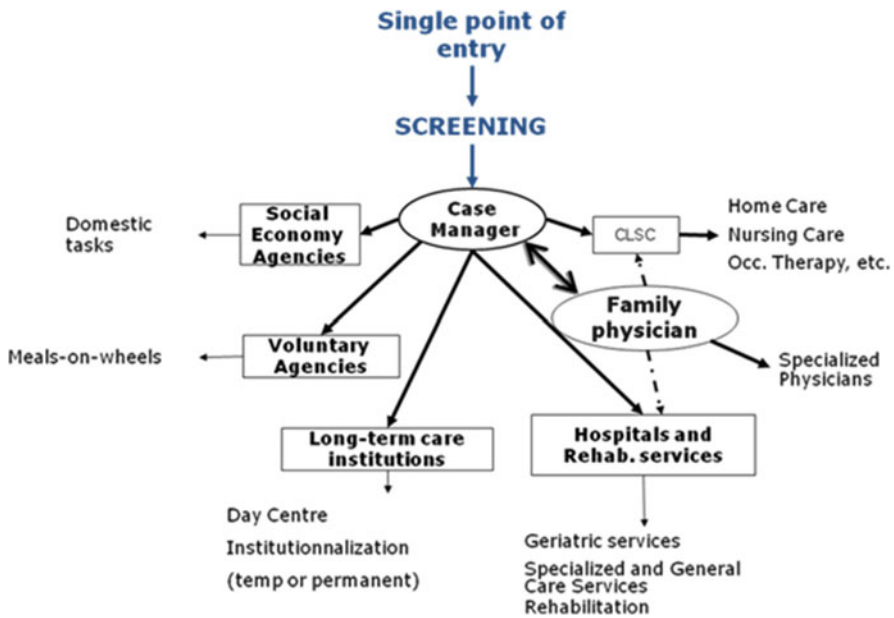


Fig. 30.1 Flow of patients through the coordinated PRISMA model (reproduced with permission from the Journal of Integrated Care—Emerald Group)

a 29-item scale developed according to the WHO classification of disabilities (see Box 30.1) (Hébert et al. 1988, 2001).

Finally, the PRISMA model includes a **Computerized Clinical Chart (CCC)** to facilitate communication between organizations and professionals. This shareable clinical chart specific to the care of elderly people uses the Québec Ministry of Health and Social Services Internet network and is interconnected to other clinical electronic records (hospitals, physicians' offices).

30.3 Experimental Implementation and Impact

After being pretested in the Bois-Francs area with promising results (Tourigny et al. 2004), the PRISMA model was implemented in July 2001 in three regions of the Eastern Townships in the province of Québec: (1) the city of Sherbrooke, an urban area (population: 144,000 of which 18,500 were over 65 years of age) with many institutions (university regional hospital, university geriatric institute, regional rehabilitation institution, and many nursing homes); (2) the rural Coaticook region (population: 16,500 of which 2300 were over 65) with no local hospital; and (3) the Granit region a rural area (population: 22,000 of which 3300 were over 65) with a local hospital.

The PRISMA model was subject to rigorous evaluation, including an implementation study that sought to monitor the degree and the process of implementation, and an outcome study, using a population-based quasi-experimental design.

The implementation evaluation study was carried out using an embedded multiple case method (Yin 1994), with each region being a case. Mixed methods, quantitative and qualitative, were applied using multiple sources of evidence (policymakers, managers, clinicians, patients, caregivers, and administrative data). Multiple data collection methods were used: documentation analysis (minutes, charts, CCC data), individual interviews (policymakers, managers, clients, caregivers), focus groups (CM, clinicians), postal questionnaires (physicians), and standardized questionnaires. Detailed results from these studies can be found elsewhere (Hébert et al. 2005, 2008a, b). Postal questionnaires were used to measure the opinion of family physicians regarding the integrated service delivery network and CMs. The response was very positive, with CMs being perceived as very useful by family physicians (Milette et al. 2005).

A method was developed for monitoring the degree of implementation, based on specific indicators for each of the six elements of the PRISMA model (Hébert and Veil 2004). The indicators were weighted according to their importance and the different elements of the model were also weighted to obtain a score out of 100. Overall, the degree of implementation reached 70% after 2 years. This was the a priori threshold set for defining a significant degree of implementation. After 4 years of implementation, the rate reached 85% in Sherbrooke, 78% in Granit and 69% in Coaticook (Hébert et al. 2008a).

To evaluate the impact of the PRISMA model on health, satisfaction, empowerment and services utilization of frail older people, a population-based, quasi-

experimental study was conducted with the three experimental and three comparison areas. From a random selection of people 75 years and over, 1501 persons identified as at risk for functional decline were recruited (728 experimental, 773 comparison). Over 4 years, participants were measured for disabilities (SMAF), unmet needs, satisfaction with services and empowerment. Information on utilization of health and social services was collected via bi-monthly telephone questionnaires (Hébert et al. 2010).

Over the last 2 years (when the implementation rate was over 70%), there was a 6% reduction of functional decline (62 fewer cases per 1000 individuals) in the experimental group ($p < 0.05$). In the fourth year of the study, the annual incidence of functional decline dropped by 14% in the experimental group (137 cases per 1000; $p < 0.001$), while the prevalence of unmet needs in the comparison region was nearly double the prevalence observed in the experimental region ($p < 0.001$). Satisfaction and empowerment were significantly higher in the experimental group ($p < 0.001$). For health services utilization, fewer visits to emergency rooms ($p < 0.001$) and hospitalizations ($p = 0.11$) than expected were observed in the experimental cohort (Hébert et al. 2010). Using growth-curve analysis, Dubuc et al. (2011) showed that the needs of elders living in the area where PRISMA was implemented were better met over time. An economic analysis comparing the cost of care in the experimental group, including the cost of the PRISMA component, to the comparison group showed that the costs were similar. This means that the PRISMA model was more efficient than the usual care.¹

30.3.1 Dissemination and Replication

During the study in 2003, the Québec Minister of Health was convinced that the model would be successful (even before the results were formally published) and decided to undertake the major health care reform merging the different public organizations involved in caring for older people within a local area (hospitals, nursing homes and CLSCs) in the CSSSs (Health and Social Services Centres) (Levine 2007). This structural integration was seen by the Minister as providing strong support for improving the coordination of services. However, as demonstrated in other contexts, structural integration does not necessarily foster functional integration (Demers 2013). The reverse was actually observed in Québec over the first 4 years of the reform. According to the Québec Ministry of Health, the implementation rate of the PRISMA model, based on the same indicators developed in the experiment, was only on average 38% in 2008, although wider roll-out of the PRISMA model was included in the Ministry's 2005–2010 action plan (Gouvernement du Québec 2005). It was noted that the newly created CSSSs (health and social service centres) struggled to implement the strategic planning

¹All the publications on the PRISMA model and experiments, in both French and English are available on the following website: <http://www.prisma-qc.ca/cgi-cs/cs.waframe.index?lang=2>

process and the reorganization of services. The roll-out of the PRISMA model was slowed considerably and even stopped momentarily in many regions because, first, the CSSSs' different programs continued to work in silos and, second, this new big organization in the system (the CSSS) no longer prioritized coordination committees and collaboration with the voluntary agencies, social economy enterprises and private providers also involved in delivering services for frail older people (INSPQ 2014).

This natural experiment showed that it is not always desirable or necessary to structurally integrate different providers into a common organization in order to implement a functional integration model like PRISMA. Nevertheless, after 10 years, implementation of the PRISMA model reached 70% across the province in 2014 (Fig. 30.2). Implementation of the computerized clinical chart, the sixth element of the PRISMA model, was delayed because the Ministry wanted to develop new, more powerful Web-based software. This allowed for the utilization of the management tool (Iso-SMAF Profiles) and completed the implementation of the fifth element of the PRISMA model. In 2014, a module to support the elaboration of the Individualized Service Plan and the allocation of services was added to the software, boosting the implementation of this element.

In 2015, a new structural reform was implemented in Québec, merging all the public institutions in a region, including rehabilitation and youth centres this time. These new Integrated Health and Social Services Centres (CISSSs) replaced also the regional authorities. From a three-tiered system (provincial, regional, local), Quebec moved toward a two-tiered system by abolishing the regional level. In each region, only one public institution provides all the health care and social services to the population. Although improving integrated services was one of the reasons for the reform, this new structural integration will likely have negative impacts on functional integration as it was the case in the 2003 reform.

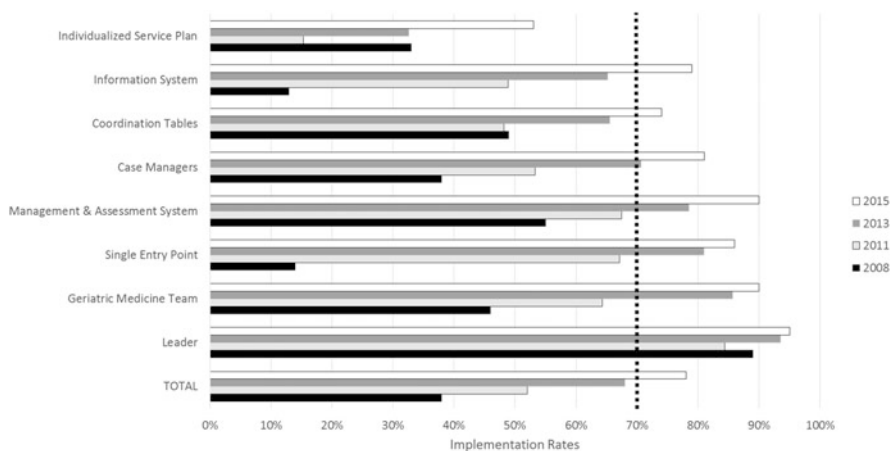


Fig. 30.2 Implementation rates of the PRISMA model in Québec, Canada from 2008 to 2015

The experience of the PRISMA model influenced integrated care models beyond Quebec. For example, in France, where the comparatively high number of actors involved in funding and delivering care to older people was seen to be a challenge for coordination, the PRISMA model was adapted in three experimental implementations (Somme et al. 2008). Following this experiment, the model was applied to people with dementia in the so-called MAIA model of care (Maison pour l'autonomie et l'intégration des malades d'Alzheimer) as part of the 2008–2012 Alzheimer Plan (République française 2008). In 2013, the MAIA model was extended to cover all frail older people, and over 350 MAIA homes were set up across France. The acronym MAIA was then used for *Méthode d'Action pour l'Intégration des services d'aide et de soin dans le champ de l'Autonomie*. The PRISMA model is also being implemented in several areas in Spain.

30.3.2 Lessons Learned and What's Ahead

The PRISMA model can be seen to be a good illustration of an effective transfer of scientific knowledge to public policy. The continuous presence, right from the beginning, of representatives from the Ministry of Health and Social Services and regional authorities on the PRISMA steering committee was one of the factors that led to this success.

However, wider dissemination of the model following the experimental phase was not optimal. Implementation has been very slow, due mainly to the structural reforms, delays in designing the new computerized clinical chart, and budget restrictions that slowed the recruitment of case managers. Additional financial resources to hire case managers were spread over a long period of time. One of Leutz's laws (1999) was confirmed: "Integration costs before it benefits". Despite the experiment showing that PRISMA was cost-efficient, implementation requires investments upfront to generate the expected benefits.

The role description and training requirements for case managers were not precise enough; in many areas, case managers received only minimal training. This was not sufficient to induce a real role change away from that taught by previous professional education. In some areas, there are still waiting lists to get access to case managers and the waiting time can be very long, with inevitable consequences for frail older people. The Joint Governing Boards are no longer active in many areas, not only because of the recent structural reform but also because this mechanism is not considered critical by new managers coming on board. Contrary to the experimental setup, administrative collection of data to generate indicators is not verified independently. There is also evidence that, when completing the instrument measuring implementation, some areas reported false results. In one area, we observed that the official rate was more than 10% over the actual one.

Institutionalization of an innovation is a challenge and there is a real risk of the system returning to its previous state without sustainable change. Although the PRISMA model is not very prescriptive and elements of the model can be adapted

to the local context, it should be acknowledged that it is being implemented within complex organizations and networks in which self-regulation mechanisms can prevent any significant change (Begun 2003).

In PRISMA, a necessary seventh component was not included in the model, namely financing which is usually one component of integrated models (Kodner 2006). This was not possible since the Québec health care system is a universal, publicly funded, Beveridge-type system. Long-term care is included in the overall funding of health and social services. This arrangement makes it impossible to prioritize long-term care and home care, especially during a period of budget restrictions since with global funding, hospital care drives most of the budget. In the new CSSSs (and more so in the CISSSs) most of the funding is directed to hospitals and nursing homes, which leaves home care programs with insufficient funds to really make a difference in the way care is provided to frail older people with multiple care needs. Improving the efficacy of the PRISMA model and case managers' actions would require a specific funding scheme for long-term care modelled on the public long-time care insurance programs which are in place in many European and Asian countries (DaRoit and LeBihan 2010; Ikegami 2007). Following the needs assessment by the case manager, an allowance corresponding to the disability level of the frail older person could then be managed in order to outsource the appropriate services to the client. Such a financial incentive could give the case manager real power to obtain the necessary services from providers. Québec and Canada will have to move towards this type of funding scheme, coupled with the integration of services, in order to cope with the rapid aging of the population (Hébert 2011). An attempt to implement an autonomy insurance plan in Québec was unfortunately stopped for political reasons in 2014 (Hébert 2016).

PRISMA-type integration needs the funding model to be adapted in a Beveridgian context for long-term care by borrowing characteristics of social insurance systems. This type of integration can be facilitated in Bismarkian systems, where such funding is already in place. This was the case in France.

The PRISMA model has been adapted to other populations. In Québec, it is used for young patients with mental and physical disabilities. It could be used to meet the needs of patients with mental health problems.

Integrating services for a given population (e.g. frail older people) may conflict with disease-oriented integration (e.g. diabetes, cancer). According to another Leutz law (1999): "Your integration is my fragmentation". An older patient with diabetes, cardiovascular disease and cancer may have three different disease-oriented case managers and another from the frail older network. In such cases meta-integration mechanisms are necessary. With an elderly population with comorbidities, only the case manager from the frail older people network should get in touch with the patient and communicate with the other case managers, who would not deal directly with the patient.

The PRISMA model shows that it is feasible and efficacious to improve integration functionally without—or in spite of—structural integration and merging of organizations. Implementation of the innovation should be closely monitored and adequate resources should be allocated to support the implementation and training

for professionals and managers. Funding is a key issue in integration, and budget incentives and mechanisms should be adapted to the integration model. The most difficult challenge is to institutionalize the innovation, given the complexity of health care systems.

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