APPENDIX 2

INTEGRATED CARE: LESSONS AND OPPORTUNITIES

Backgrounder – Strategic Session 2

Objective

To review the evolving interest in integrated care in Canada in light of the experience of the United States (US) and to identify strategic implementation questions.

Background

The Oxford Dictionary defines integration simply as "combining one thing with another to form a whole".[1] Over the past few decades there has been growing interest in the concept of an integrated health system, or as it is more commonly called in the US an integrated delivery system (IDS). The World Health Organization (WHO) has put forward one definition as "the management and delivery of health services so that the clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system".[2]

Canada is often criticized for not having a health system but rather a collection of 14 sets of silos (at least from a budgeting perspective) of hospital care, medical services, prescription drug programs, home and community care, mental health and addiction services, cancer care and long-term care. These services are far from seamless for patients and there are significant gaps in publicly funded services beyond the hospital and medical care that fall under the *Canada Health Act*.

Numerous national and provincial/territorial reports have expressed a desire for an integrated health system(s) in Canada. In 1997, provincial/territorial health ministers put forward a *Renewed Vision for Canada's Health System*, in which they stated:

> "We envisage a system that integrates the full range of health services to better meet the needs of patients. This will be a system that integrates prevention of illness, promotion of healthy lifestyles, as well as assessment, diagnosis and treatment services so that they are better matched to peoples' needs."[3]

Similarly, in their 2000 Health Accord, Canada's First Ministers made a commitment to a vision of health care that will "provide greater integration of hospital, primary, home and community care, more emphasis on health protection and promotion, and more effective information sharing within and across jurisdictions."[4]

Fifteen years later, the Advisory Panel on Healthcare Innovation lamented the lack of progress on integration in its 2015 final report, stating "health care remains disjointed, with poor coordination and alignment within and across the various professions, acute and chronic care institutions and community care".[5]

Experience to date with integration

Based on the experience to date, there have been two broad goals of health system integration. One goal is to provide an accessible and seamless experience for the patient. From this perspective the WHO defines integrated service delivery as "the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money".[6]

The second goal has been to enable and promote financial risk management through the use of capitation payment. Capitation payment generally refers to the situation where a provider or group of providers receives a prospectively fixed payment to provide all health services that a patient will require over a defined period of time, typically one year. The US has had the longest experience with this approach, where employers provide health insurance coverage for a sizable proportion of the working population and their families. Probably the best-known example is Kaiser Permanente, which began in the 1930s as a health care program for workers in the Kaiser industrial companies and was opened to the public in 1945.[7] The Cleveland Clinic is another well-known example that began in 1921.[8] The Pennsylvania-based Geisinger health system, which was acclaimed in a recent book[9] as the best system anywhere among 60 countries, was established in 1915.[10]

A variety of approaches have been used to promote these goals of integration in Canada and elsewhere. Horizontal integration refers to the consolidation of delivery points of a particular service. A Canadian example would be the consolidation of hospital facilities and services under a single governing body that occurred during the regionalization movement of the 1990s. Some provinces have also attempted horizontal integration of primary care service through the introduction of new models that bring together primary medical care with other services such as social work, physiotherapy and dietetics. Vertical integration refers to the alignment of different levels of service such as primary, secondary and tertiary care, and also the insurance function itself in IDSs in the US.

Evolution of integrated care in the US

Although, as noted previously, there are longstanding exemplars of integrated care in the US, the great expansion occurred in the 1970s and 80s. The first paper on the US National Library of Medicine's PUBMED database with "integrated delivery" in the title (of the 330 listed in December 2015) was published in 1985. This short paper described the proposed merger of a hospital chain with a major hospital in Houston, Texas and the offer of a health care insurance package.[11]

As Shortell and others have described it, the first generation of integrated delivery was called "managed care" and focused on controlling costs under capitation payment through discounts from established charges, utilization review and second opinions. Writing in 1994, they described a new world "that creates incentives for keeping people well by emphasizing prevention and health promotion practices and, when people become sick, treating them at the most cost-effective location in the continuum of care".[12]

Fast forward to 2010, US President Obama's *Patient Protection and Affordable Care Act* introduced the concept of the Accountable Care Organization (ACO) for the US Medicare program that covers seniors 65+. ACOs are defined as "groups of doctors, hospitals and other providers who come together voluntarily to give coordinated high quality care to their Medicare patients".[13] These organizations assume responsibility for the cost and quality outcomes of a defined population. The US Centers for Medicare and Medicaid Services (CMS) has introduced several innovative risk sharing payment schemes that are intended to promote coordinated care while enhancing quality:

- Medicare Shared Savings Program – ACOs can share in savings if they reduce costs year over year while meeting quality metrics. There are two risk sharing models. In the one-sided model, ACOs share savings but no losses. In the two-side model, ACOs share both savings and losses, and the sharing percentage is higher in the two-sided model to make it more attractive.[14]
- Bundled Payments for Care Improvement – This model links payments for the multiple services that patients receive during an episode of care. There are presently 48 clinical episodes that participants are able to choose from (e.g., acute myocardial infarction, major joint replacement of lower extremity).[15]
- Comprehensive Primary Care Initiative – This program provides population-based care management fees and shared saving opportunities to primary care practices to support five comprehensive primary care functions (e.g., planned care for chronic conditions and preventive care, patient and caregiver engagement).[16]

There has been rapid uptake of each of these initiatives and private insurers are also establishing ACO partnerships.[17] In terms of the growth of ACOs, the number has increased from 157 in March 2012 to 782 in December 2015.[18] One projection has shown that the number of lives covered could as much as quadruple from 23 million lives covered in 2015 to 105 million by 2020; roughly one in three Americans.[18]

In 2015, the US Joint Commission, a major body that accredits health care facilities and programs, has introduced an Integrated Care Certification that assesses the coordination of care between health care settings (e.g., between hospital and ambulatory settings).[19]

CMS has ambitions goals for Medicare. The target is to have 30% of Medicare payments tied to quality or value through alternative payments by the end of 2016 and 50% by the end of 2018.[20]

Curnow has set out four implications of ACOs for physicians and the practice of medicine:

- The foundation of reimbursement will shift from volume-based payments such as fee-for-service (FFS) to value-based payments linked to quality and outcomes.
- Physicians (primary care physicians in particular) will have to deal with numerous sources of clinical and claims data.
- Physicians will have to move beyond history-taking, diagnosis and treatment as they will be incentivized to persuade patients to make lifestyle changes and improve adherence.
- Physicians will have to embrace team-based care.[21]

Something that is striking about the integrated delivery movement in the US is the extent to which it has embraced the "population health" concept that was pioneered in Canada in the 1990s.[22] Population health emphasizes the importance of non-medical determinants of health such as income and education. Increasingly IDSs are moving to "population health management" which has been defined as "purposeful actions taken to achieve one or more desired health outcomes in a defined group of persons by coordinating and integrating health care, public health activities and the social and environmental determinants of health".[23] Some IDSs have bought into this approach to the extent of making significant investments outside the health sector such as nutrition education programs in schools.[24] In a 2015 report, the United Kingdom King's Fund has drawn on the experience of Kaiser Permanente and elsewhere to propose seven elements of a population health system, including:

- pooling budgets to enable resources to be used flexibly to meet population health needs, at least between health and social (continuing) care but potentially going much further
- paying for outcomes that require collaboration between different agencies in order to incentivize joint working on population health.[25]

If the US continues along this path it may eventually arrive at a place envisioned by Kindig in 1997 whereby by 2020 (unlikely at this point) IDS providers would be compensated, at least in part, on the basis of aggregate health status improvements in their populations.[26] Good and timely integrated health information systems will be a critical success factor in advancing toward this. Stine has put forward a proposal on how a population health outcome information system could be built up from the patient's clinical record.[27]

Canadian thinking about integrated delivery

Canadian thinking and action about integrated delivery have been much slower to develop. Indeed, in some measure it has come about accidentally as a result of a preoccupation that governments developed in the early 1990s with eliminating FFS payment for physicians. At the January 1992 meeting, where health ministers agreed to reduce medical school enrolment by 10%, they adopted eight coordinated provincial/territorial policy directions, the second of which was "to replace FFS wherever that method of payment aligns poorly with the nature or objective of the services being provided".[28]

Ontario proposed to establish a Comprehensive Health Organization in the early 1990s, building on its experience with Community Health Centres and Health Service Organizations (a capitated payment model for family physicians) but this did not advance beyond the planning stage.[29]

A few years later, University of Toronto Professor Peggy Leatt and colleagues looked south to the US experience with IDSs and published a proposal for a Canadian Integrated Delivery System (CIDS). The key elements of the CIDS proposal were:

- capitation funding with an allocation to a risk pool to fund deficits or to provide bonuses to providers
- an explicit gatekeeping role for primary care physicians and physician affiliates
- the CIDS would provide a full spectrum of care including acute and chronic institutional and ambulatory care, rehabilitation and home care services
- a governing body that would be accountable for overall financial and clinical performance.[30]

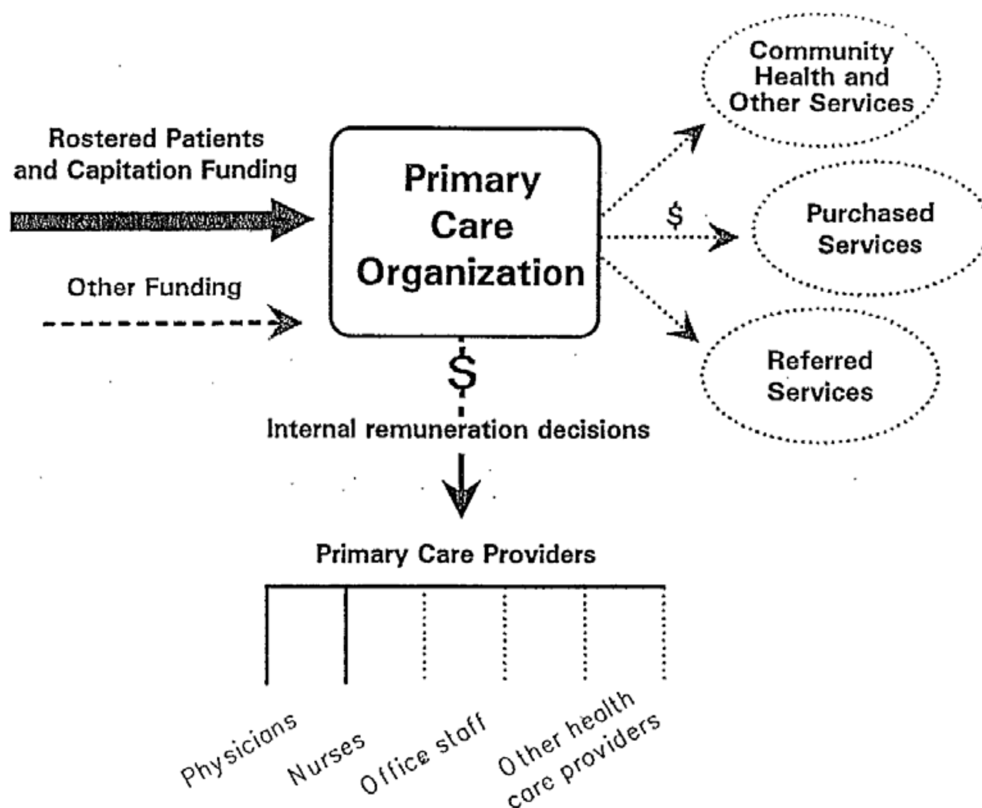
In a further paper, Leggat and Leatt set out a comprehensive evaluation framework for assessing the performance of an IDS that covered structure, process and outcomes.[31] However in the mid-1990s, the federal government unilaterally reduced the health transfer beginning in April 1996, and this had a destabilizing effect that was not conducive to bold health reforms.

In 2000, Leatt and colleagues revisited the 1996 paper in light of international experience and Canadian developments and once again promoted the case for integrated care. The paper also set out nine indicators of how patients will know when an integrated health care system exists. Many, if not all of them remain issues to this day, and it is worth repeating the list below. They suggest that patients will know that an integrated health care system exists when they:

- do not have to repeat their health history for each provider encounter
- do not have to undergo the same test multiple times for different providers
- are not the medium for informing their physician about care received from other delivery settings (e.g., hospitalization, diagnostic tests, prescribed medications, etc.)
- do not have to wait at one level of care because of incapacity at another level
- have 24-hour access to a primary care provider
- have easy to understand information about quality of care and outcomes to make informed choices about providers

- can make an appointment for a visit, diagnostic test or treatment with one phone call
- have a wide choice of primary care providers
- if they have chronic disease, are followed up proactively and provided with in-home assistance and training in self-care.[32]

As noted above, the concern about FFS remuneration has given rise to a lot of attention on the horizontal integration of primary care services. In 1995, a discussion paper prepared for the Federal/Provincial/ Territorial Advisory Committee on Health Services recommended the rapid phase-out of FFS and the enrolment (rostering) of the population in capitation-funded Primary Care Organizations (PCOs). (See figure below.)



These organizations would provide multidisciplinary team practice. The paper further proposed that PCOs might evolve to the point where they might hold the budget for services such as prescription drugs, diagnostics and other referred services, including some specialist care.[33] This paper was followed by an extensive national consultation in 1996 and contributed to the rise of a sustained interest in primary reform among the provinces and territories. The 2000 Health Accord included an $800 million Primary Health Care Transition Fund that contributed to the development of capitation funding in Ontario and Alberta.[4] Ontario introduced Family Health Teams in 2005 that feature a blended capitation model for physicians[34] and an additional funding envelope for other health professionals.[35] At roughly the same time, Alberta introduced Primary Care Networks (PCNs). These are networks of physicians and other providers such as nurses, dietitians and pharmacists working together.[36] For the most part, physicians continue to be paid FFS, and the other health professional services are funded through a capitation payment of $62 per enrolled

patient in the PCN. In their formative years these models have focused on providing a more comprehensive basket of primary care services.

In 2012, Ontario announced its intention to develop a model to integrate primary care into the province's 14 Local Health Integration Networks (LHINs) to bring "planning and accountability for the full patient journey under the LHINs".[37] As a first step, a primary care physician lead was appointed in each LHIN. Also in 2012, Ontario launched its Health Links program, an initiative to bring together a range of providers in the community to collaborate in the development of coordinated care plans for complex patients with a view to improving the quality of care while at the same time reducing their requirements for care.[38] Since the launch, 69 Health Links have been established across Ontario.[39]

In 2015, Ontario issued a report that set out 10 steps to strengthen home and community care. Step four is a commitment to move forward with bundled payments for care.[40] A bundled care pilot has been in place at St. Joseph's Health System in Hamilton since 2011 and in September 2015, the health ministry announced plans to expand the pilot across the LHIN and to five new communities. This project involves teams that support a seamless journey from hospital to home for patients with chronic conditions such as chronic obstructive pulmonary disease and patients requiring nursing interventions.[41]

In terms of the potential for a broader approach to bundled payment beyond hospital and home care, Sutherland and colleagues have established the technical feasibility of implementing a bundled care payment approach in Ontario's health system that includes all acute inpatient care, physician services, rehabilitation care and home care costs for an episode of care.[42]

In spring 2015, the Ontario Primary Health Care Expert Advisory Committee came forward with a proposal for the establishment of Patient Care Groups (PCGs) across the province. In this model patients will be assigned to a PCG and rostered to a primary care provider. The PCGs would be funded on a capitated basis and will contract with local primary care providers. Physicians would be paid through a contract between the PCG and their existing delivery model. PCGs would be accountable to the health Ministry through the LHIN. It was proposed that each PCG would have a board of directors that includes patient representation. In terms of integration, the PCG would be responsible for coordinating care through relationships between the local hospital, long-term care facilities the Community Care Access Centres (home care) and other providers. Each LHIN would have a Primary Health Care Council and it was suggested that services shared by all PCGs could be managed at the LHIN level (e.g., population needs assessments, indicator development and monitoring).[43]

In December 2015, the health ministry responded to this proposal with a discussion paper that proposes to give the LHINs much more responsibility. The LHINs would become responsible for the integration and improvement in primary care, home and community care, acute care, mental health and addiction services and public health. It proposes that specialist physicians would benefit from the use of technology such as e-consult and e-referral and shared care using telemedicine for complex patients in distant locations. The paper is currently out for consultation with citizens and stakeholders.[44]

These initiatives in improving integration in primary care have not focused much on community and hospital-based specialty care. In research based on Ontario administrative data for 2010/2011, Stukel and colleagues demonstrated that Ontario can be divided fairly naturally into 78 multispecialty physician networks, with a median population size of 134,723 residents, 125 primary care physicians and 143 specialists.[45] Subsequently Huynh and colleagues have proposed how a risk-sharing ACO could be implemented in Ontario through either a new corporate entity or a contracting model.[46]

Aside from Ontario, several jurisdictions have put forward some sort of health care reform strategy over the past few years. These are generally based on enhanced primary care and they emphasize greater

connectivity and continuity of care with other parts of the health care system. Recent examples include Alberta,[47] British Columbia[48] and Newfoundland and Labrador.[49]

Nationally, the Advisory Panel on Healthcare Innovation included two recommendations to promote greater integration in Canadian health care.

Recommendation 6.1 suggests that funds from the proposed Healthcare Innovation Fund promote integrated delivery systems across Canada in six areas such as the undertaking of large-scale projects that implement highly integrated delivery systems and to support jurisdictions in scaling up and spreading partial integration models.

Recommendation 6.2 suggests that the Canadian Institute for Health Information and interested provinces and territories pursue the following priorities:

- expedite work on methodologies to support physician capitation payment and design bundled payment
- work on patient-reported health outcome measures and costing data to create national risk-adjusted patient grouping methodologies.[5]

It will be interesting to see what direction the negotiations around the next health accord will take. The communiqué from the Jan. 21, 2016 meeting of federal/provincial/territorial health ministers states "…we will consider ways to better integrate and expand access to services at home, including palliative care at home, enhance support for informal caregivers, and continue to work to improve access to mental-health services."[50]

Strategic questions

Delegates are asked to consider the following strategic questions for discussion and debate:

1. What role should physicians play in the governance of an integrated health system?
2. What are the key considerations for physicians participating in risk-sharing in an integrated health system?
3. How can specialist care be incorporated in an integrated health system in Canada?
4. How should quality and value be measured in new payment mechanisms that might be featured in an integrated health system?
5. What would be the implications of a locally governed integrated health system for physician negotiations at the provincial/territorial level?
6. What are the essential elements of a health information system to support an integrated health system?
7. How can we ensure that locally focused funding models do not lead to inequities among communities within a province/territory?

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