INTEGRATION: A NEW DIRECTION FOR CANADIAN HEALTH CARE

CANADIAN NURSES ASSOCIATION

ASSOCIATION MÉDICALE CANADIENNE | CANADIAN MEDICAL ASSOCIATION

HEAL

Providing Integrated Continuing Care

Health care in Canada is designed from the provider's point of view, whether that provider is a hospital, a clinic or an individual. Our schedules currently suit planners more than patients* and delivery of care is generally not integrated, varying widely across provinces, territories, regions and even cities. Because health services have evolved inconsistently in different jurisdictions and organizations, we now have a wide divergence in quality and access, geographically and socioeconomically. As a result, Canada actually has multiple health-care systems, systems that are expensive, complex and challenging for patients and their families to access and move through, with wasteful duplications and dangerous gaps that carry a heavy cost for both patients and taxpayers.

For these reasons, health care in Canada needs to be fundamentally transformed. We need a functionally integrated continuum of care founded in long-term relationships between patients and their providers. Achieving this transformation will create a system where Canadians can navigate smoothly along their health journeys as they work with those who understand and address all aspects of their health and health care — including the importance of health promotion, disease prevention and the social determinants of health

But how can we realize this vision when innovative ideas about making care more efficient, effective and acceptable to patients when they have to must navigate the barriers of routines and entrenched funding?

To tackle the challenge, the Canadian Nurses Association, Canadian Medical Association and Health Action Lobby (HEAL) set out to define the elements of a functionally integrated health-care system and the first actions needed toward achieving it. The work, conducted in a three-phase summit process in 2012-2013, was grounded in two sources: (1) The *Principles to Guide Health Care Transformation in Canada*, released in 2011 by the Canadian Medical Association and the Canadian Nurses Association (since endorsed by more than 137 health organizations); and (2) the Institute for Healthcare Improvement's (IHI) "triple-aim" framework (2013).

The ***Principles*** offers the following six standards to guide the transformation of Canada's health-care system:

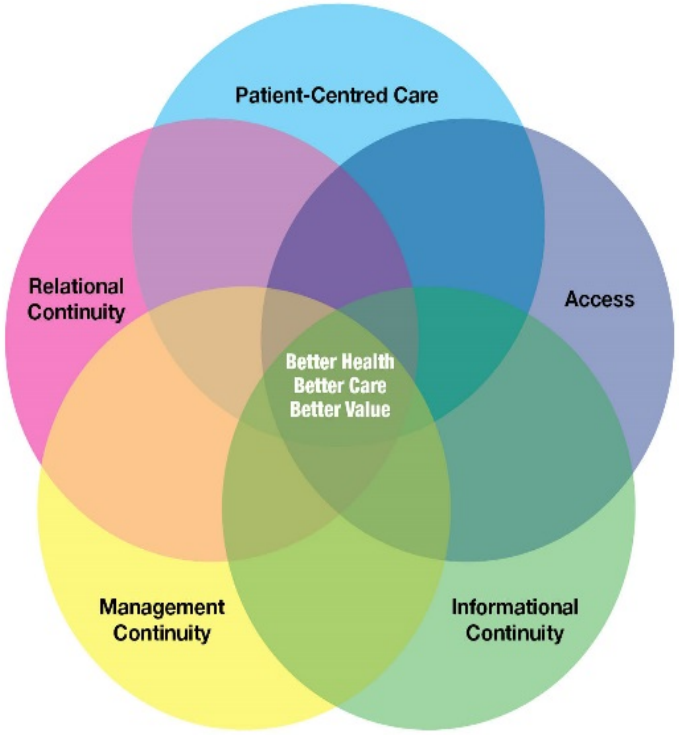
- Patient-centered care that is seamless along the continuum of care
- Quality services appropriate for patient needs
- Health promotion and illness prevention
- Equitable access to quality care and multi-sectoral policies to address the social determinants of health
- Sustainability based on universal access to quality health services
- Accountability by stakeholders — the public/patients/families, providers and funders — for ensuring the system is effective

** While recognizing various preferences for describing individuals who want to access the health-care system (including patients, clients, users, consumers, persons), for simplicity, we use the word "patients" throughout.*

IHI's Triple-Aim framework seeks to optimize health-system performance through the belief that new approaches to care must pursue three simultaneous goals:

- Better Care — improving quality of care and patient satisfaction
- Better Health — improving the health of populations
- Better Value — lower per capita costs

Participants in the summits, who came from a broad cross-section of health-related organizations, defined five foundations for integrated care, illustrated in the diagram.



They were then able to articulate, from a patient's perspective, a series of reasonable expectations of their experience in a functionally integrated health system. These are outlined in each of the foundational areas in the text below.

Patient Access

All Canadians have a right to a comprehensive, publicly funded health-care system. This right does not mean providing the same care to each patient, since we don't all have the same health, or delivering care to each patient in the same way. Rather, it means equitable access that allows for the multiplicity of ways Canadians live. Examples would be:

- Giving care in the place that is best for patients (rather than where tradition or funding usually gives it)
- Tailoring care for each patient
- Offering affordable choices for preventive care and health promotion
- Ensuring that medication is affordable

Patient-Centered Care

Patient-centered care builds its processes around the health needs and goals of patients and ensures that patients participate (as much as possible) in planning their own health journey, which they should experience as a seamless continuum. A patient-centered system offers:

- education to help patients understand their conditions and empower their decisions;
- holistic care, provided by inter-professional teams;
- standards and measures that are aligned with patient outcomes; and
- an inclusion of traditional knowledge and medicine.

Informational Continuity

Informational continuity is the link that makes patient-centered care work. It ensures that a patient's data follows them from one provider or event to another. Informational continuity also recognizes that knowing patients' preferences and values is as important as documenting the details of their health conditions, and equally necessary for ensuring that services respond to their needs. Factors that enhance continuity in information include:

- electronic health records for safe, secure and accurate patient information;
- easy access to records and information for patients; and
- an electronic medication management process.

Management Continuity

Management continuity ensures that services are timely and that they complement one another, which is especially important for chronic or complex conditions (where providers could potentially work at cross-purposes). Important features of management continuity include:

- plans and protocols that coordinate care between providers and across sectors and geographic areas;
- funding and incentives that are realigned to support new approaches to care;
- care teams and patients that collaborate to advocate for change; and
- navigators to guide patients on their care journeys or help them navigate for themselves.

Relational continuity

Ongoing relationships between patients and providers are a bridge that links past care to present and future needs. Regular contact with familiar providers improves the coordination of care and gives valuable context throughout the patient's journey. Relational continuity includes having:

- effective communication among providers and with patients;
- members of inter-professional teams who understand each other's roles, skill levels and boundaries;
- family and informal caregivers who are recognized as part of the care team; and
- better links to community services.

We then set about validating these expectations with patient groups.

We are not yet at the point where we can name concrete steps for creating our ideal of a functionally integrated system. But, to bring new concepts into practice and overcome the status quo, we will clearly need leadership at every level, along with collaboration among patients, providers, organizations and government officials.

Our summit participants agreed on several key assumptions for creating a new, integrated vision for health care, which included respecting health-care providers (crucial for maintaining their engagement) and focusing on the social determinants of health (as individual health cannot be separated from social factors such as education, wealth and emotional support). Above all, however, they told us to "keep the patient perspective front and centre." A health system should be tailored to the individual patient, not the other way around.