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Expedited knowledge synthesis on factors affecting implementation of integrated services networks for the elderly

THE EXPERTS' VIEWPOINT

AUTHORS

Léo-Roch Poirier

Sarah Descôteaux

Jean-Frédéric Levesque

André Tourigny

Institut national de santé publique du Québec

RESEARCH TEAM

Jean-Frédéric Levesque, Institut national de santé publique du Québec

André Tourigny, Institut national de santé publique du Québec

Réjean Hébert, Centre hospitalier universitaire de Sherbrooke (until July 2012)

Léo-Roch Poirier, Institut national de santé publique du Québec

Sarah Descôteaux, Institut national de santé publique du Québec

Danièle Francoeur, Institut national de santé publique du Québec

Christian Bocti, Centre hospitalier universitaire de Sherbrooke

Maude Chapados, Institut national de santé publique du Québec

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Introduction

In Québec, as elsewhere in the world, aging forces a reflection as to its impacts on the health and services systems. Although the elderly nowadays are generally in better health than before, it remains that the prevalence of chronic diseases will continue to increase, thereby exerting added pressure on the organization of services. Moreover, the presence of multiple chronic diseases affecting one individual further complicates treatment plans and requires the participation of many professionals. A discussion on how to adapt the provision of health care and services is required.

Since 2002, the implementation of Réseaux de Services Intégrés pour les Personnes Âgées (RSIPA) (Integrated Services Networks for the Frail Elderly) is a ministerial priority in Québec and is aimed at offering an adequate response to the expectations and the needs of seniors. The chosen model was adapted from the PRISMA project (Research Program for Integrating Services for the Maintenance of Autonomy; see among others Hébert et al., 2003) developed in the Bois-Francs region and in the Eastern Townships in Québec.

RSIPA encompasses nine components:

- Development of local coordination mechanisms;
- Implementation of a single entry point;
- Electronic patient records;
- Development of the case management function;
- Use of a personalized service plan;
- Presence of an accountable person;
- Access to geriatric care;
- Access to a family physician;
- Application of a single assessment and management tool.

The CIHR' Evidence on Tap program

This document stems from work carried as part of an expedited knowledge synthesis financed by the Canadian Institutes of Health Research (CIHR) within a program called *Evidence on Tap*, created to provide Canada's provincial and territorial health ministries with health research evidence to help inform their decision making processes and develop policies. This program's section called Expedited Knowledge Synthesis aims at accelerating the realisation of all phases of a knowledge synthesis - application, review, research, knowledge translation – to offer timely, accessible and relevant

evidence to decision-makers in a 6 to 9 months timeframe.

Research questions and methodology

For the 2011-2012 competition, we submitted a proposal on the following question, which had been proposed by Québec's ministry of health and social services: How can we optimize the implementation of strategies, the modes of intervention and the provision of services to adapt the organization of local services to the reality of an aging population?

In our research proposal, which was accepted and financed, this question has been reformulated as follows:

- 1) What are the factors associated with the integration of services offered to the elderly suffering from functional decline?
- 2) Which factors in the implementation of an integration model based on coordination promotes operational linkage with other services networks?

In addition to consulting experts, the synthesis called upon an overview of scientific and grey literature, on case studies describing the experience of implementing RSIPA in six territories of health and social services centres, and on a deliberative forum during which the preliminary results were submitted for discussion to twenty participants representing various types of actors involved in the field in Québec.

In total, six experts participated in the study by sharing their experience in a semi-directed telephone interview which lasted an hour. The selection of those experts was based on various criteria: place of residence/location of experimentation environments, thorough knowledge of the issues related to the implementation of integrated networks for the elderly and, ideally, having contributed to the evaluation of implementation projects of such networks¹.

Presentation of the document

This document summarizes the main observations delivered by the experts² on the implementation processes involved for RSIPAs, thus constituting a part of the expedited knowledge synthesis we realised on this subject. We grouped the comments under six themes: a general appreciation of the model (even if this aspects extended beyond the object of the synthesis), questions

¹ See "The Experts" box at end of document.

² See the interview grid, appendix 1.

related to the general governing of the system (at the ministerial level), those concerning appropriation at the local level, special considerations implied by the function of case manager, incentives to consider and the various elements to take into account in monitoring implementation.

An appreciation of the RSIPA model

A recognized model

Experts agree that the RSIPA model incorporates most of the best practices recognized in the health care sector, as much on the administrative side (a clear policy statement; a single highly-coordinated administrative structure linked with financing) as on the clinical side (a single entry point, a standardized patient assessment, case management). With its various components, this type of model was shown to offer cost-efficient benefits in regards to non-integrated networks of services. The aim is to reorganize the services offered around the needs of the population rather than around a mission. It fosters the interdependency of the various stakeholders who intervene at a given point in the provision of care and services and encourages them to work collaboratively.

Models of integration

According to Leutz (1999), there are three models of integration: linkage, coordination and full integration.

- **Linkage** is the weakest level of integration; it is essentially translated by the articulation of protocols between various health and social services organizations in order to facilitate references and transfers of patients between services.
- In **fully integrated systems**, an organization is solely responsible for the whole array of services required by patients. Experts told us that, in the case of fully integrated systems, where these models were implemented (On Lok or PACE³ in the United States), there was no impact on the whole health and services system, despite the successes observed with the clientele served. This would question their long-term impact. Within such structures, it is also more difficult to exert control over the different parts of the system or to have access to all the services which may be needed by the frail elderly (with regard to housing, for example).
- RSIPA corresponds to a **coordination model**. It is based on sharing competences and dialogue, which implies the implementation of mechanisms and tools between health and social services organizations involved with the elderly in order to answer patients' complex needs and to ensure continuity of care. Most of the discussions revolved around this model.

³ Program of All-inclusive Care for the Elderly – see lexicon at end of document.

The challenges of implementation

According to experts, most evaluations of services integration focused on outcomes rather than implementation processes. Yet, as they mentioned, each integrated model poses unique challenges. The implementation process of coordination models may seem at first glance simpler to implement since in the opinion of some stakeholders, they are less threatening for their autonomy and require fewer structural adjustments compared to fully integrated systems. This would be especially true in a system where organizations operate relatively independently from each other. As a result, the implementation of coordination structures must call upon numerous decision-making levels as well as various instances involved in the planning and services delivery. Numerous agreements must also be signed between the providers of care and services and various organizations. One of the experts considers that it takes more time and is more difficult to implement coordination models than fully integrated or strictly dealing with clinical aspects ones. But, once put in place, these models may have a change capacity far more significant. In order to do so, the targeted needs and populations must be well identified.

The fact that the RSIPA model rests on coordination which is outside the field of medical care is a benefit since the training of physicians, their means of remuneration and their ways of thinking all favour an approach less adapted to the follow-up of people exhibiting chronic diseases and functional decline.

Large-scale systems implementation

In principle, a universal health system with centralized financing is more conducive to the implementation of a coordination model. Furthermore, the creation of health and social services centers in Québec allowed for a certain vertical integration, which might support the development of efficient coordination models. However, the risk of an overinvestment in second- or third-line services still exists in such an integration context and may be detrimental to the injection of primary healthcare resources needed to implement integrated models for the elderly.

Aspects related to central governance

The need for a strong commitment

All experts mentioned that a strong political will is paramount in order to prompt institutions involved to act. In this sense, always according to the experts, future cohorts of aging people will be more demanding with regards to services offered, a fact which is perceived as prodding policymakers to tackle the problems of continuity and integration of health care and services.

A balance between prescription and innovation

In the experts' view, core principles and the underlying values of the model must be stated clearly to avoid it from being modified according to individual preferences or questions arising at the time of its implementation. The challenge here is to preserve the characteristics associated to the model's efficiency. From this outline, one must **allow local appropriations of the model which respect its foundations** and leave room for adjustments on characteristics which are less fundamental to the model's efficiency. However, at the central level, one often sees fears of losing control over decisional processes and the allocation of resources, which entails a rigid prescription of the model (top-down approach). As mentioned by some experts, government authorities fear the risk of failure. According to them, highly centralized systems, such as the one in England, are less likely to be conducive to innovation and tend to call upon a top-down approach, contrary to the less-integrated systems, like those in place in the US, which foster social entrepreneurship.

Notwithstanding the predominant top-down approach, experts have outlined the fact that the local context is a major determining factor in the effective implementation of models of integrated services, which means that the bottom-up approach, the implementation and adaptation of the model by local partners, is essential. Ideally an appropriate balance should be sought after between a prescriptive and innovative way in the approach. The main decision-maker must then clearly expose the purpose and targets as well as the problems to be addressed and all specific expectations. A detailed legislation should specify the main dimensions and key parameters of the integrated model within the existing legislation, along with amendments should the need arise. The local network would then have the

responsibility, in collaboration with users and service providers, to propose a system which would align itself with the desired framework while conferring local characteristics to the system.

Investing in the change

Experts consulted believed that **the time and the resources required for an adequate implementation are generally underestimated**. In fact, a few years are often needed before the personnel adhere to the proposed model, agrees upon protocols and services plans, etc. Rather than trying to implement all the components of the model simultaneously, **it would be beneficial to do so progressively and, as experience is gained, to proceed with the necessary adjustments** as was the case in Wisconsin. This state is recognized as a leader in the integration of long-term care services. It gradually implemented the PACE program to its whole territory and has built upon each and every experience.

Appropriation at the local level

Framing the change

Experts consider that **integrated networks must be implemented at the local level by beginning with less complex elements that engage all partners, such as shared processes**. Partners must also be involved as the implementation proceeds without taking short cuts and while having efficient monitoring tools.

They estimate that **the personnel in charge of implementation must have a very clear idea of their responsibilities and their degree of autonomy** to solve problems at the local level, providing the general framework of the integrated model is respected. Decisions agreed upon must be closely monitored within a formative approach.

Implementing a coordinated model entails a different way of dealing with patients and with other health professionals: it requires teamwork which, in and of itself, is a major challenge. Our experts also wished to highlight the fact that professionals often only understand the implications of the required changes when they are confronted daily with new ways of working. It then becomes important to maintain a dialogue and to remind the stakeholders of the goals pursued and the means at their disposal.

Always according to our respondents, the need to implement a specific model leaves the local actors with the impression that the services they offered previously were worthless. The systems' inertia requires a need for communicating clearly the reasons why the change is required, and this message must be reinforced. The fact that some organizations have a stronger tendency to take risks and have a more entrepreneurial approach must be taken into consideration, just as the reality that others tend to resist change must also be weighed in the balance. In any case, there is a predisposition to consider that the situation at the local level is unique and to believe that it would be difficult for them to subscribe to a model imposed from above.

The consultation challenges

Consultation is the most difficult component to implement, but it is also the one at the centre of the model. What is sought after here is a true consultation, one which brings partners to make decisions collectively and to apply them. **Incentives must be put in place so that usual practices may change and in order to implement a true consultation**; otherwise, organizations have a tendency to concentrate their efforts on their own objectives rather than aligning themselves with those of their partners.

Once consultation is established, processes of needs assessment must be shared, common information and communication tools must be implemented and common tools must also be shared – this will set the stage for the case management function. This last component can only be set in place when integration is fairly well advanced. Sharing of information is absolutely essential, particularly in the form of electronic patient records. One of the experts believes that the use computerized functional autonomy measurement system is a step in that direction, and other provinces are moving along the same direction. However, intercommunication between information systems remains problematic.

Denmarks' example

Electronic patient records were introduced for the whole population and these records are made available to various health organizations (hospitals, primary care clinics and pharmacies) (Harrell, 2009). This has an impact both on the work of professionals and on patients. For the professionals, they have real-time access to medical information and care history of their patients. This accessibility prevents patients from having to undergo unnecessary tests; this, in turn, saves time and resources for the health care system. For the patients, it offers better consistency and saves them the trouble of having to repeat their medical history.

Accompanying and supporting the change

When planning the implementation of an integrated services network, **it is strongly recommended by some experts to have a steering committee in place to solve implementation problems as they arise. A "champion" must also be identified; he or she has the authority on all aspects of policies, budgeting and operations while following closely how things evolve on a daily basis.** This person must have a strong and clear support from higher political and administrative levels. The champion works full-time on implementation, develops the interdependency needed for the integration and ensures that all actors understand what is expected of them. **The most successful projects are those where quality leadership was observed through time.** In England, The King's Fund offers such a training program⁴.

Taking into account professional cultures

This strong leadership is even more necessary as cultural differences between partners may present a challenge. Integrating health and social services requires a cultural integration and the development of a common vision. The fragmentation of the social and health sectors, as is the case in France, is a major stumbling block. But even in Québec, the social and health sectors consider themselves as irreconcilable. Part of the problem stems from how each sector views how to solve problems: the health sector tries to deconstruct complex issues in very simple elements and resolve them one after the other;

⁴ <http://www.kingsfund.org.uk/leadership/leadership-development-individuals>.

the social sector is inimical to simplification and wants to deal with issues as a whole. Yet, according to some respondents, both are not only reconcilable, they are complementary. There is a tendency to think that medical or health services are the most important ones for maintaining the elderly in their own home. Experts questioned do not necessarily agree. Social problems may have an impact on senior's health, as demonstrated by the On Lok (in the United-States) and CHOICE⁵ (in Alberta) programs.

Engaging the hospital community

If relations between stakeholders are crucial, **the role of the hospital is a major one since it is where a large proportion of patients with complex needs are treated.** In health systems where the financing of hospitals rests on admission volumes, this element may restrain full cooperation. Implementing an integrated services network may even be perceived as a menace.

Another difficulty lies in the coordination and the incentives in place so that post-hospital services become easily accessible after an acute episode. Denmark is cited again as an example. If establishments charged with providing those services cannot make them available in a timely manner, they are financially accountable to the hospital. Thus they must reimburse the costs related to any additional length of the stay of the patient in the hospital. This is a strong incentive to force these establishments coordinate themselves.

The urban world challenge

Coordination efforts are higher in large urban areas because of the number of concerned partners and the presence of university hospitals which tends to make their own decisions for themselves. Ethnic communities are also more prevalent in those areas, and their characteristics add to the complexity of the challenge. If it may be easier to implement such a network in rural areas because of the proximity of concerned partners, other problems arise, particularly when recruiting human resources: qualified professionals are not as prevalent in rural or remote areas.

Engaging the medical community

Aside from those organizational actors with whom coordination is required, physicians also play a major role and have some autonomy of action which must be taken into consideration. The involvement of family

⁵ See lexicon at the end of the document.

physicians is problematic almost everywhere. **Experts recommend that physicians be called upon early in the process while taking into account their own constraints.** If medical primary care is absent, implementing the proposed reforms will fail.

Experts call our attention upon the fact that family physicians often fail to understand the complexity of chronic diseases and the crisis management element they call upon. They still adopt the old model of fixing problems one after the other. The PACE program had bypassed this problem by hiring its own physicians who could take as much time as required with persons in need. CHOICE, a Canadian version of the PACE program, has never really been evaluated as such even though its long-term financing seems to suggest that it would bring about the expected effects.

In British-Columbia, financial incentives were introduced to further the involvement of physicians. Thus some procedure codes for physicians participating in case management were proposed. Furthermore, ongoing training activities recognized by medical authorities may also help consolidate participation. In Singapore, training on integrated services is now part of the family medicine teaching program. It is important to support physicians with regards to their patients with more complex needs in order to encourage them to cooperate. But in order to do so, mechanisms must be put in place to simplify their tasks and ensure good feedback. One of those mechanisms is the introduction of a case manager.

The specific case of case management

The case manager: the heart of the solution

The case manager is a health professional who ensures the coordination of care and services in order to improve the coverage of care for the frail elderly. He or she acts as liaison between the various stakeholders working for the well-being of a person. In order to ensure continuity of cares and the participation of physicians, **it is important to have a case manager assigned to a particular group of physicians, to organize preparatory meetings and to establish communication channels and links.** Experts have also underlined the fact that the best satisfaction predictor for physicians involved in such a model is the fact of knowing the case manager's name since this person is an essential go-between for the patient and the physician. The feeling

of being useful and having more extended powers are also very satisfying from a professional standpoint for case managers.

Experts have claimed that identifying those professionals who may better play the role of case managers and the implementation of mechanisms to ensure the quality of case management are very important. Moreover, the caseload assigned to case manager is probably not a good indicator to evaluate his or her activity.

The importance of training

According to the experts, it is absolutely essential that training of an adequate level be offered to candidates for this position. Its nature is different from that of nurse or social worker, who both also do coordination, but more often linked to particular or specific situations in a less intensive manner. It may be the reason why case managers still find it difficult to have the specificity of their role recognized by professionals who come from the same professional body.

Case management and coordination

We have already established that the implementation of consultation and of a shared clinical information system between health and social services organizations are mechanisms which must be operational prior to successfully implementing the function of case manager. Some experts want to specify that **case managers' accountability must also be defined. They must not be accountable to only one partner.** Feedback must be shared by the whole network. **He or she must not only be a manager of possible organizational or institutional help, he or she must also manage informal help.** The personalized service plan can really only be conceived as a whole, meaning taking into account any informal help given to people.

Furthermore, experts add that **case management should not be confined to home care.** When a person is admitted in a long-term care facility, he or she may still benefit from case management: to ensure an objective needs assessment; to have a reassuring presence to facilitate transitions (for hospitalization, among others), and to present his or her point of view to the organization.

For an effective case management, efficient liaison mechanisms must be implemented with the health care system's components; they must also be part of the evaluation process for the integrated model. To that end,

the boundary spanner⁶ functions played particularly by case managers are essential.

A model akin to that of the RSIPA allows the case manager to operate a form of triage. Thus, if a person urgently requires a given service, he or she will have priority over another one who is already on the waiting list. Case managers who are more attuned to preventive aspects and who might have wished that services be provided before functional decline becomes too important may often have the impression that their point of view is not being considered.

Financial incentives

Experts advise that **financial incentives are powerful levers for change** although resources are finite. Should authorities decide to use them, **experts suggest that they be targeted to specific objectives and on a temporary basis** (during the first or second year of implementation or on a decreasing basis for a longer period of time). Financial incentives can support learning sequences in terms of management, case management or stakeholder compliance towards the integrated model to be implemented.

According to one of the experts, a universal autonomy insurance plan⁷, along the lines of what the Québec government is contemplating, would facilitate the implementation of such a model of service coordination. Other systems are used in the case of financing.

Implementation follow-up

Good quality information systems are essential to monitor activities. Ideally, the system should already be in place when the model is implemented, but a more rudimentary system for this phase can also provide the required information. Over and above the evaluation of processes and results, an analysis of the logic model and an analysis of the implementation are also important. Most integrated projects are evaluated too soon with regard to their efficiency, before the desired changes have actually been implemented. Aside from academic evaluations, **it may also be useful to have what we may call a Rapid Response Action Research Model based on administrative data and surveys, which**

would allow for a quick detection of what works well, what does not work and what needs to be fixed.

Some experts also propose the implementation of a clearing house where all results of this nature coming from various territories may be grouped together.

Conclusion

To round off this summary of the main observations shared by those experts consulted on their appreciation of the RSIPA model, aspects of governance, appropriation by local stakeholders, case management, financial incentives and follow-up mechanisms to be implemented, **five key messages emerge:**

- 1- Implementation must rest on a balance between the rigidity of applying some aspects of the model, in order to ensure its efficiency, and the flexibility needed on other components in order that it may take into account the local context's characteristics. The presence of a local champion is an asset to maintaining this balance and successfully implementing a RSIPA.
- 2- The time required to implement each of the components of a RSIPA is usually underestimated. In the implementation strategy, case management should be introduced after consultation mechanisms have been well developed.
- 3- Physicians are important stakeholders within a RSIPA and means must be set in place to involve them at the start.
- 4- The presence of a computerized clinical information system is essential for sharing data, supporting the stakeholders and contributing to a better continuity of care.
- 5- Thorough follow-up and an evaluation of the implementation, in a timely manner, are mandatory, as well as support and a training program for all actors, in particular case managers – these aspects are too often underestimated.

⁶ "Actors whose primary job responsibilities involve managing within multi-organizational and multi-sectoral arenas" (Williams, 2010).

⁷ "Separate public funding for [long-term] care on the basis of a universal insurance covering both home care and institutions" (Hébert, 2012).

A success story

The example of Torbay, in England, is rich in lessons even if it is now being reconfigured – The King's Fund made an excellent case study out of it⁸. Torbay is a small county in England which encompasses three large cities: Torquay, Paignton and Brixham, and which is home to a larger population of elders than elsewhere in the country. Since 2002/2003, various organizational changes were seen as opportunities to modify the health system in order to ensure a better cooperation between first and second line actors. Other evaluations in progress, always involving The King's Fund and the University of Toronto but dealing with other experiences elsewhere in the world, will also be useful. Other studies on the PACE project may also be used for inspiration.

The Experts

In Canada, Marcus Hollander and Margaret MacAdam participated in the investigation.

Marcus Hollander is founding president of a British-Columbia consulting firm specialized in issues related to the structure, the organization, the management, the provision and the financing of health and social services. He has over thirty years' experience in health services' research, evaluation and administration.

Margaret MacAdam is Associate Professor in the Faculty of Social Work at the University of Toronto and chair of *The Age Advantage, Inc.* Her research interests focus on issues which influence public policies and the organization of gerontological services.

Four other international experts were consulted: Walter Leutz and Dennis Kodner, from the United States, Elizabeth Ozanne, from Australia and Dominique Somme, from France.

Walter Leutz is Associate Professor at Brandeis University's Schneider Institute for Health Policy (Heller School for Social Policy and Management). He has published two seminal articles on the integration of services (1999 and 2005).

Dennis Kodner is currently an International Visiting Fellow at The Kings Fund in England as well as Adjunct Professor at McGill University's Faculty of Medicine. He has taught at New York Institute of Technology's New York College of Osteopathic Medicine and at City University of New York's Hunter College after having held management positions in various health organizations including that of chief executive officer of Elderplan S/HMO Pilot.

Elizabeth Ozanne is Associate Professor in Department of Social Work in Faculty of Medicine at The University of Melbourne. She has published widely on aged and community care in Australia and internationally, and is currently involved in the comparative analysis of long term care systems.

Dominique Somme is a geriatrician and professor at Université de Rennes. He was the principal researcher for the PRISMA pilot project in France between 2006 and 2010.

⁸ <http://www.kingsfund.org.uk/sites/files/kf/integrating-health-social-care-torbay-case-study-kings-fund-march-2011.pdf>.

Lexicon

The King's Fund: An independent charitable organization working to improve the health and health care of England's population. With its research and analysis activities, the King's Fund influences policies and practices within the health system. [<http://www.kingsfund.org.uk/>]

On Lok: A not-for-profit organization funded in the 70s by citizens concerned by the lack of long-term options for aging well in the community. The aim of On Lok is to develop health care models for the well-being and the dignity of the elderly and those living with chronic diseases through promotion and innovation in services and financing while advocating for quality and affordability in health services.

PACE (Program of All-inclusive Care for the Elderly): An American program for the integration of long-term care and services for the elderly, created by On Lok. In order to be eligible, those people must be registered within the Medicare and Medicaid programs. For most of the participants within the program, the global form of potential services allows them to receive home care rather than having to move into a retirement home.

CHOICE (Comprehensive Home Option for Integrated Care of the Elderly): A Canadian health care program (Alberta) which coordinates health care and whose mission is to promote good health among the elderly and to help them stay at home longer.

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This project is financed by the Canadian Institutes of Health Research under the *Evidence on Tap* program which aims to support collaboration between researchers associated with the project and decision-makers involved with the theme of this synthesis.

Appendix 1 – Interview Grid

Objectives	Questions
Introductory questions	<ul style="list-style-type: none"> • What is your knowledge and/or understanding of the PRISMA model or more generally of coordination models of integrated services delivery? • What do you think about this (these) model(s)? Does such a coordination model make sense for you as opposed to full integration or linkage models with regard to elderly patients? • Why is integrated care such a challenge to implement?
Assess the impact of the model's components on its implementation	<ul style="list-style-type: none"> • What is the most crucial characteristic of the coordination model that can support its full implementation? • Are all components of this model equally implementable? • What co-ordination mechanisms are more supportive to a successful implementation? • How to develop effective links with various partners of the health care system, especially with geriatric units and community care? • What are the critical elements in implementing case management? • How should a single entry be related to other access mechanisms? • How to bring all partners and services to use unique assessment tools and individualized service plans? • How to foster the implementation of computerised clinical charts?
Assess elements of context pertaining to successful implementation of the model	<ul style="list-style-type: none"> • What can be done at national, regional and local levels to support implementation of integrated care? • At the organizational level, what are the most salient structural features to consider? • What are the relevant social and cultural factors to take into account? • Are there legislative aspects to consider?
Assess the elements of process pertaining to successful implementation of the model	<ul style="list-style-type: none"> • What is known about the best way to support the implementation of such integration models? • What kind of training should be offered and to whom? • What are the essential support systems or tools? • Are there financial incentives to put forward?
Assess the role of all the actors involved	<ul style="list-style-type: none"> • What is to be expected of the following actors? How to make them more supportive of the implementation process and further their commitment? <ul style="list-style-type: none"> - service managers - general practitioners - case managers - other professionals - patients and caregivers - community services workers
Final question	<ul style="list-style-type: none"> • Are you aware of some experiments/evaluations that could be useful to our knowledge synthesis?



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