The Capital Health Region's Early Experiences: Moving Towards Integrated Healthcare

COMMENTARY

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IN "TOWARDS A CANADIAN MODEL OF INTEGRATED HEALTHCARE," Leatt, Pink and Guerriere conclude that "although [the move to regional health authorities] may have reduced some of the problems of uncoordinated care among organizations, it is not clear whether it has improved integration of many patient-care processes." The authors provide a variety of frameworks to assess the extent to which "integration" has been achieved. They also propose strategies for moving forward to achieve integrated care.

This paper provides an "on the ground" perspective by the CEO of one regional health authority, the Capital Health Region, regarding its early experi-ences in moving towards integration as described in the authors' paper. It also provides a commentary regarding the authors' proposed strategies for achieving integrated care. The Capital Health Region (CHR) provides hospital, community, home, environmental and public health services to approximately 350,000 people living in a geographic area of approximately 2,300 square kilometers centred in Victoria, British Columbia. The CHR also provides referral services for an additional 380,000 people who live throughout the rest of Vancouver Island. The CHR is an amalgamation of seven organizations, which occurred in April 1997.

Frameworks

Several frameworks are provided by the authors to assess health systems including those by Shortell et al. (1996), Coddington et al. (1997) and Enthoven and Vorhaus (1997). I have chosen for this commentary to use the Shortell framework to assess the progress made by the CHR.

1. Focuses on meeting the community's health needs

The CHR has established its vision to be "Healthy People in a Healthy Community." In pursuit of its vision, the mission of the Capital Health Region is to achieve positive outcomes in the following areas, which are essentially the Health Goals of British Columbia (British Columbia 1997):

- Positive and supportive living and working conditions exist in all our communities.
- Individuals develop and maintain the capabilities and skills needed to thrive and meet life's challenges and to make choices to enhance health.
- A diverse and sustainable physical environment with clean, healthy and safe, air, water and land.
- An effective, efficient, innovative and respectful health service system that provides equitable access to appropriate services.
- Improved health for aboriginal peoples.
- Preventable illnesses, injuries, disabilities and premature deaths are reduced.

The roles of the CHR in achieving each of these outcomes vary. For some outcomes the role is simply advocacy, while for others they include public policy development, service delivery and/or the enforcement of regulations.

Extensive work has been undertaken by the CHR to measure the health status of the Region's population and the performance of the Region's delivery systems compared to other jurisdictions. Based upon this analysis and community input, the CHR Board of Directors has established priorities to meet the population's health needs including, for example, "effective early childhood nurturing and parenting." These priorities guide the operational plans and resource allocation of the Region.

2. Matches service capacity to meet the community's needs

The CHR is in the process of developing a 15-year plan to project the volume and configuration of many of the services that will be required in its various communities in the years 2005, 2010 and 2015. This plan will provide directions aimed at achieving the appropriate capacities and mix of facilities and community and home-based services required for these three planning horizons. The projections, where possible, are based upon best practices in other jurisdictions. These best practices and other performance targets are applied to the demographic projections for the Region. Twenty advisory panels comprising more than 500 providers, advocacy group representatives and consumers offered advice on, and reaction to, service delivery best practices and benchmark performance targets. This and further community consultation will enable the CHR to set directions to match its service capacity to community needs.

3. Coordinates and integrates care across the continuum

Coordination and integration are the essence of the purpose of regionalization and the focus of the paper prepared by Leatt, Pink and Guerriere. As they suggest in their paper, this is the area where we will likely "move ahead with the Canadian tradition of incremental change."

The CHR has a budget of approximately $550 million to serve its local community and Vancouver Island referrals. It provides services directly from approximately 30 sites and in people's homes, and it funds over 150 other agencies to provide direct services. Services include public health, acute care and rehabilitation, long-term care in facilities and in homes and a variety of community-based services including those for people with mental illness. Noticeably absent in this list of services, as the authors suggest, is pharmacare and non-hospital medical services.

Despite not directly providing or even funding all health services in the Region, the critical mass and breadth of services that CHR provides creates a solid platform to initiate strategies to coordinate and integrate care. In these early years of regionalization in the CHR, major strides have been made in areas such as mental health and child and youth services to better coordinate and integrate services. For example, in mental health we now have a centralized intake process that ensures clients are connected with the appropriate service, and a clinical database is now used on inpatient units as well as in outpatient and community services. In child and youth services, children in the Special Care Nursery (SCN) often require follow-up services, many of which are provided through our paediatric rehabilitation team at the Queen Alexandra Centre for Children's Health (QACCH). The SCN and QACCH staff have worked together since regionalization to ensure a seamless transition from one service to the other. In another example, children who are exhibiting severe behavioural and emotional distress are often admitted through the Victoria General Hospital (VGH) Emergency to VGH inpatient. There is no other community alternative, hence the use of Emergency. These children will often be referred to mental health services at QACCH. Through effective teamwork across both sites, this transition has been greatly improved, with reduced length of stay on the inpatient VGH unit. Other areas will follow in time as all the Region's providers gain more experience in working together in this new model.

The biggest challenge that the CHR will have with integration is to develop effective partnerships and linkages with the approximately 400 family physicians in the Region. These physicians operate in a highly autonomous manner, mostly in solo practice or small groups. Nevertheless, many of these family physicians admit patients to our four acute care hospitals. To receive admitting privileges they must participate in the Region's continuing medical education and quality improvement processes. The CHR is beginning to work on strategies to provide value-added services to these physicians to help strengthen the processes for clinical integration.

4. Has information systems to link consumers, providers and payers across the continuum of care

Progress in implementing information systems in health regions in British Columbia has been impaired during the 1990s by a significant reduction in provincial funding for capital projects (CIHI 1999). Comparative statistics from a national survey (HayGroup 1999) suggest that B.C. regions such as Simon Fraser and the Capital Health Region spend less on information systems as a percentage of operating budget, 1% to 2% versus 2% to 3%, compared to other communities across Canada. Moreover, there has been limited progress in implementing electronic health records on a large scale across sectors anywhere in Canada (Closson 2000) due to barriers such as:

- Lack of a clear business case.
- Lack of common standards.
- Fear of loss of personal privacy.
- Inadequate incentives and training for providers to participate.
- Poor technology solutions.
- Ineffective leadership.

In spite of these barriers, there are examples of information initiatives in the CHR that flow out of the formation of the Region. The first is a self-care, patient education initiative that combines a self-care manual, a nurse call line and access to materials on the Internet. The evaluation of this initiative suggests that a population's behaviour can be modified positively by information strategies linking provider agencies and consumers (B.C. Health Research Foundation 1999). A second initiative is a diabetes information strategy. Using physician billing claims, the CHR has identified the people in the Region who have a confirmed diagnosis of diabetes. Working closely with approximately 30 family physicians and their diabetic patients, we are helping patients better manage their disease. The results have been remarkable,with 95% following national guidelines for diabetic management versus less than 50% for diabetics generally throughout the Region.

5. Provides information on costs, quality, outcomes and consumer satisfaction to multiple stakeholders

Regionalization is quite new to British Columbia. Individual regions, including the CHR, and the Ministry of Health have done considerable work to develop performance indicators, particularly in the areas of health status, costs, utilization, quality and outcome. Benchmarking is also occurring, allowing comparison of regions to each other and to other jurisdictions throughout Canada. To this point, very little information has been made publicly available by the province or the regions comparing health status and system performance across regions. Recent Ministry documents (British Columbia 1999) suggest that these regional "report cards" will be made available soon.

6. Uses financial incentives and organizational structure to align governance, management, physicians, and other providers to achieve objectives

As a Region, the CHR focuses on the health of the populations it serves. While we must serve a very wide range of needs, we are attempting to achieve alignment by organizing ourselves to address the most significant health needs of the

population in the most effective and efficient manner. Building upon an analysis of regional healthcare utilization and outcome data and the health literature, the CHR has carried out a process to obtain provider and agency input to define a program structure centred around each of the major healthcare needs of people living in the Region. This process led us to organize into nine programs, including Cancer Care, Child/Youth and Maternal Health, Community Health, Digestive Health, Health Restoration, Heart Health, Lung Health, Mental Health and Seniors' Health. This program management model will help the CHR to focus its energies through strategic planning, performance measurement and resource allocation to achieve the alignment necessary to be successful.

7. Is able to continuously improve the care it provides

All health organizations should be able to continuously improve the care they provide. This is facilitated in health regions such as the CHR because of critical mass and breadth. Critical mass and breadth provide a base for regions to initiate and implement strategies to coordinate and integrate care across multiple sectors. This is much more difficult in a province such as Ontario where service governance is fragmented by sector (e.g., hospitals, continuing care and public health).

8. Is willing and able to work with others to ensure objectives are met

The situation here is similar to that referred to under point 7 above.

Strategies for Achieving Integrated Care

In their paper, the authors propose six strategies for achieving integrated care. I will comment on each of these strategies based upon my experience to date in the CHR.

1. Focus on the individual

Focusing on the individual is a key strategy for successful clinical integration. In the old world of greater fragmentation of providers, prior to regionalization, the focus of each provider tended to be on episodic care rather than the health of the individual or the management of chronic illness. I have provided examples in this paper of how regionalization has placed a focus on the individual. Some of these are: the self-care initiative, which provides individuals with access to knowledge about their health and how to maintain or improve it; the development of a 15-year regional service plan to enable the Region to provide health services in the home or as close to home in the community as possible; and regional health goals that focus on keeping people healthy as well as treating disease.

2. Start with primary health care

In all provinces, except possibly Quebec, health system reform did not start with primary healthcare. Ontario started with hospital amalgamation and the linking of home care with residential long-term care. The remaining provinces formed regions and initially excluded primary health care from the regional responsibilities. There are reasons for this, some of which are referred to by Dr. Roger Thomas in a paper on primary healthcare (Thomas 1999). They include:

- Physicians not wanting to have their actions controlled through complex planning.
- Physicians currently working primarily in solo practice and small groups.
- Inadequate computer system support.
- Physicians questioning whether 24-hour access to primary care service is really necessary or advisable.
- The concern about the lack of patient accountability for remaining with one primary care physician, which could lead to economic negation of the physician.

In spite of the many barriers to address primary healthcare, it deserves high priority as a strategy for achieving clinical integration. The health system will be strengthened considerably by creating a better capacity for health promotion, the management of chronic disease and coordination of care in the primary care setting.

3. Share information and exploit technology

I have commented on this as a key strategy for clinical integration and self-care in my discussion using the Shortell framework, point 4. We will never achieve full clinical integration without the implementation of information system tools. This is particularly true in relation to maximizing the potential benefits of primary healthcare.

4. Create virtual coordination networks at local level

The creation of virtual coordination networks is already happening in the CHR and other health regions across Canada. In the CHR we currently provide services directly in over 30 sites in addition to people's homes. We also fund over 150 other agencies to provide services, including such diverse services as residential long-term care, mental health housing, home support and the "Best Babies" program, for example. In addition, because our roles to achieve our goals include advocacy, we work in virtual networks with organizations that we do not even fund, such as municipal governments, the Social Planning Council and school boards.

5. Develop practical needs-based funding methods

The British Columbia Ministry of Health has been working for years to develop needs-based funding methods to allocate funding to its regions. As the authors point out, this is a very contentious area. Strict adherence to the formulas that have been developed in British Columbia would cause a significant reallocation of funds among regions. This has been politically unappealing for the provincial government during the late 1990s when there was limited growth in money going into healthcare delivery and there were systems pressures almost everywhere.

I suggest that the matter of equitable funding be broken into two components: base funding and growth funding. Population growth and rates of aging vary widely by region in British Columbia, as in other provinces. I believe it would be easier in the short run to gain acceptance of funding methodologies to address demographic growth while the methodologies to address reallocation of the base funding levels by region can be further researched.

6. Implement mechanisms to monitor and evaluate

I have commented on this as a key strategy in my discussion of the Shortell framework, point 5. System accountability requires much better reporting to our stakeholders about how we are doing in improving health status and health system performance. We have many useful regional measures, which we can be reporting on today, that will show how we are doing as a region compared to other regions and compared to ourselves over time.

I agree with the authors that there is a question about who should perform the monitoring and evaluation. A recent report on hospitals in Ontario (OHA 1999) was done in partnership with the University of Toronto to ensure rigour in methodology and objectivity. There is also a national organization in Canada, the Canadian Institute for Health Information (CIHI), which has as its mandate to develop standards for data and performance indicators to enable interagency comparisons of health status and health system performance. CIHI has a major role to play in Canada-wide monitoring and evaluation.

Conclusion

I believe Leatt, Pink and Guerriere are overly critical of the progress and potential of regional health authorities. The authors say that "fundamental system problems have either not been addressed or have been dealt with at the margin only, usually by throwing money at them." Major system change in healthcare services is never made quickly or easily. The CHR is less than three years old, and already significant progress is being made, including the following:

- The Regional Health Board has adopted the broad determinants of population health in its goals.
- The Region directly operates and funds a critical mass and breadth of services, which provides a solid platform to initiate strategies to coordinate and integrate care.
- A program management structure has been implemented to focus the energies of the CHR on major population healthcare needs through strategic planning, performance measurement and resource allocation.
- Virtual coordination networks are being developed at the local level with agencies such as municipalities, the Social Planning Council and school boards.
- A 15-year regional service plan is being established to project the appropriate mix of facility, community and home-based services for the Region.
- A self-care, patient education initiative has been implemented and evaluated to demonstrate its effectiveness.
- The Region is working closely with family physicians and their diabetic patients to help patients better manage their disease with remarkable results.

There are, of course, major opportunities to improve clinical integration in the CHR. This is particularly true in relation to primary healthcare. Health services would be strengthened considerably in the CHR by creating a better capacity for health promotion, the management of chronic disease and the coordination of care in the primary care setting.

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