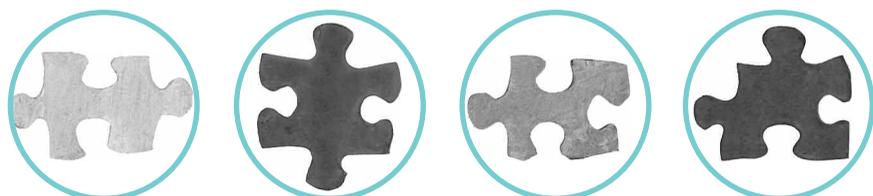


FINAL REPORT  
MAY 2008



# Integration of Care

Exploring the potential of the alignment of home care  
with other health care sectors

### **About the Canadian Home Care Association**

The Canadian Home Care Association (CHCA) is a not-for-profit membership association dedicated to ensuring the availability of accessible, responsive home care and community supports to enable people to stay in their homes with safety, dignity and quality of life. Members of the Association include organizations and individuals from publicly funded home care programs, not-for-profit and proprietary service agencies, consumers, researchers, educators and others with an interest in home care. Through the support of the Association members who share a commitment to excellence, knowledge transfer and continuous improvement, CHCA serves as the national voice of home care and the access point for information and knowledge for home care across Canada.

For more information, visit our website at [www.cdnhomecare.ca](http://www.cdnhomecare.ca)



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# Executive Summary



Many studies have identified the potential benefits of greater integration of care for the client, the providers and the health care system; and initiatives to better integrate health care are evident across the country and indeed around the world. The Canadian Home Care Association (CHCA) believes that home care is uniquely positioned within the health care system as a bridge between the health care sectors, including acute care, long term / chronic care, and primary health care. Examples of some of the roles home care plays in an integrated approach to care include:

- Home care integration with pharmacy for medication management
- Home care and primary health care partnerships for the management of chronic conditions
- Home care integration with acute care emergency departments (ED) to support appropriate usage of ED resources.



Believing that there is enormous value in sharing knowledge and experience as a catalyst to further action, the CHCA undertook, with funding from Health Canada, to increase awareness, uptake and implementation of integration models involving home care and other health care sectors in communities across Canada. The response to the project was enthusiastic and positive. Integration is clearly top of mind; but the approaches and applications are widely varied. Through stakeholder surveys and interactive workshops, a number of home care related integration initiatives were identified and explored. Participants shared thoughts about how to sustain their projects and transform the health system to one where there is a shared accountability (both fiscal and clinical) for the outcomes of the population served.

This report is a summation of the observations and findings arising from the project. The CHCA has posted additional information, tools and reports on its website, [www.cdnhomecare.ca](http://www.cdnhomecare.ca), in order to serve as a resource to those interested in learning from the experience of others. Arising from this dialogue on integration, a number of recommendations to build and sustain the momentum are offered:

- The Federal government should promote knowledge transfer and mentoring through roundtables, workshops and funding of demonstration projects to advance integration across providers and jurisdictions
- Governments must articulate a vision for an integrated health care system as it addresses specific patient population needs, be they disease, age or health utilization specific, and then move quickly to make the necessary policy and funding changes to enable providers to achieve the vision
- Health care organizations need to be supported to adopt new leadership competencies that promote continued learning and foster integration
- Health regions should leverage the home care capacity to provide case management as a strategy for health systems integration
- Jurisdictions must invest in technology solutions to enable improved communication and collaboration across professions and health sectors
- Governments should institute planning, operating and monitoring practices that are population based and measure outcomes achieved by the integrated health team as opposed to specific organizations or disciplines.



# Introduction



Health system integration is essential to serving Canadians and effectively addressing their health and social care needs of today and tomorrow. While models of integration span all ages, integration is, to a large extent, driven by an aging population which typically develops long term chronic conditions. Those with chronic conditions require the health system more often and for a greater length of time. The nature of chronic conditions is that they are complex, often having many co-morbid health issues, and they are not “fixable”. The knowledge base about the condition is with the patient and the expertise of the health professional is only effective when coupled with the patient’s knowledge and experience. Furthermore, because of the multiplicity of health care issues, the full scope of the health care team is typically required.

This emerging picture of health care is in stark contrast to our past experiences serving a younger population that avails itself of the health care system periodically for short-term acute episodes. These health interactions are typically for conditions which are readily “reparable” and rely heavily on the expert health practitioner’s knowledge and skill. The limited nature of this type of interaction with the health system does not create a compelling need for an integrated health system.

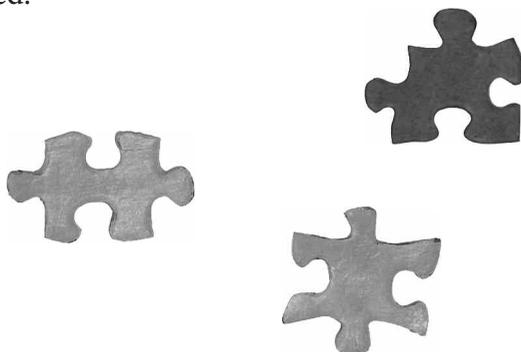
“Integration is better  
than it was five years  
ago but not as good  
as it can be”

- Workshop Participant

The population is aging, ergo so are the members of the health care team. It is predicted that demand for health care professionals will exceed supply for years to come. Therefore it is increasingly imperative that duplication and redundancies be eliminated from the health system and that providers be supported to do the work for which they were trained. This requires effective collaboration, communication and respect amongst the health care team so that members know when and how to transfer care. It also requires a knowledgeable and engaged consumer – someone who knows their health information, clinical targets, results and plans and actively engages with the health care team.

The health consumer is increasingly more demanding and sophisticated. There is an expectation of being treated as a valued customer and low tolerance for less than excellent service. This translates into the necessity for seamless, timely care where information is accessible, not only to providers but the clients as well.

With escalating health costs, governments are interested in the efficiencies that can be achieved through integration of services. Duplication of processes and under-utilization of the health team is not acceptable. There is urgency to ensuring that every opportunity to improve the operating approach to health care is leveraged.



# Defining Integration



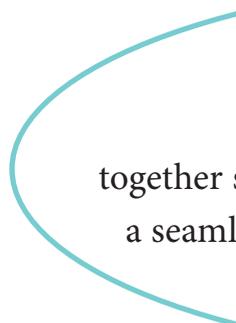
Without exception, individuals contacted for this project were interested in integration and undertaking work to advance integration within their jurisdiction. Overall there was a sense of awareness of the concept of integration but no single definition of integration was provided by any of the participants.

There is no commonly accepted definition for integration. Webster's dictionary defines integration as "bringing parts into a whole". Within health care, integration typically refers to removing the "silos" and improving the coordination of services. Concepts central to integration in health care found in the literature and reported by stakeholders include: *across the continuum, coordination, complementary, seamless, unified and system*. While there are various definitions of integration it was commonly understood that integration is not an outcome but rather a process, or strategy to achieving specific outcomes.

The intent of integration is to provide a better care experience for the health care consumer. Canadians want the right service at the right time by the right provider. They expect that the health system has accurate information that is accessible to providers and to themselves when needed wherever that provider is located. They also expect that providers work collaboratively and that there is a good communication between the team members.

Integration at the clinical level affords an opportunity for the health care provider to maximize their skills and abilities and deliver better care thereby enhancing their self-worth and sense of providing quality health care.

From a system perspective, integration of care is cost effective as the teams work consistently and effectively so that staff have the right information when they need it and are called upon to provide care based upon a recognition of their expertise.



**INTEGRATION:**  
 "Services, providers and organizations  
 from across the continuum working  
 together so that services are complementary, coordinated, in  
 a seamless unified system, with continuity for the client."

- CCHSA, 2006



# Integration in Home Care

Home care plays a vital role within the health care system. Home care programs, in collaboration with other health care sectors, are implementing successful integration models along the continuum of care in order to bridge natural boundaries and enable seamless care. Project participants indicated that the model of integration depends on the situation; however 77 percent indicated that their approach is patient/client population specific and 70 percent stated that it involved linking of providers to improve the care delivery to all clientele. A number of these approaches are summarized below.

## Home Care & Primary Care

Home care and primary care integration has been demonstrated to achieve improved client outcomes through more proactive comprehensive care for those with chronic conditions.<sup>1</sup> Initiatives integrating home care and primary care are occurring across the country in **British Columbia, Alberta, Manitoba** and **Ontario** to name a few.

1. **Alignment of home care personnel** (including case managers, nurses, therapists and home support) with **family health teams** and / or primary health care teams.
2. Establishment and support of **collaborative partnerships between family physicians and home care case managers** to enhance communication, collaboration, system utilization and ultimately patient care.
3. Implementation of a **Community Access Model**<sup>2</sup> representing a community-based team structure.
4. **Supporting interdisciplinary team within primary care** in order to provide clients with multiple services at one location.
5. Establishment of community resources and **seniors clinics** within primary care (Manitoba)

*The key components identified by stakeholders who have undertaken this type of integration include:*

<b>Philosophy</b>	<ul style="list-style-type: none"> <li>• Clients are able to have their health care needs addressed in a seamless, user friendly system</li> <li>• Members of the team work together to integrate care services, leverage capacity and knowledge and adopt flexible approaches to health service delivery</li> </ul>
<b>Partners</b>	<ul style="list-style-type: none"> <li>• The core partnership is between the family physician and the home care case manager. Additional partners complement/enhance the collaborative approach, including: direct service providers, public health, wellness facilitators and health educators, pharmacists and community support programs</li> </ul>
<b>Principles</b>	<ul style="list-style-type: none"> <li>• The focus is on engaging and support the client to achieve the best care possible</li> <li>• Participants work together to move from simple "co-location" to a truly integrated, approach</li> <li>• The client is the focus of the service delivery model and there is flexibility for services based on the client needs and preferences</li> </ul>
<b>Key Elements</b>	<ul style="list-style-type: none"> <li>• The client is the focus of the care delivery</li> <li>• Team approach - All members of the team have a valuable role to play and are included in the development and implementation of any changes</li> <li>• Shared Accountability - Each team member is aware of their responsibilities and the roles and responsibilities of the other team members</li> <li>• Transparent Communications - Stakeholders are consulted and included in development and implementation of the model</li> </ul>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• Seamless care</li> <li>• Staff feel part of one large, integrated team and work extremely well together to address care needs and services</li> <li>• Decreased duplication, especially around assessments, and transfer of information between services.</li> <li>• Homebound clients are able to have some medical services they previously did not have access to in the home</li> <li>• Proactive home care intervention</li> <li>• Decrease in the medication complications</li> <li>• Decrease in the number of emergency visits and hospital admissions due to medication issues</li> </ul>



## Home Care & Acute Care

A significant number of referrals to home care programs across the country are from acute care.<sup>3</sup> With the continued emphasis on appropriate utilization and managing hospital beds in order to increase access, contain health costs and provide health care at the right place, at the right time, the home care and acute care sectors have undertaken to strengthen their working relationships. Efforts to provide more seamless service both pre and post admission have been undertaken in most jurisdictions. Two CHCA High Impact Practices<sup>4</sup> specifically profile integration of home care and the hospital in order to improve patient care – *Hip & Knee Joint Replacement* and *Partnering for Patients*, which describes an emergency room initiative. In **Ontario**, a province wide initiative to better integrate home care and acute care is seen in the FLO Project.

1. Home care personnel are placed in the acute care settings to support effective discharge particularly for the ‘**alternate level of care**’ (ALC) patients
2. **FLO initiative**<sup>5</sup> intended to expedite the transition of acute clients into the community

*The key components of this and similar projects include:*

<b>Philosophy</b>	<ul style="list-style-type: none"> <li>• To put the client first and design and improve existing processes to better serve clients</li> <li>• Adopt a system (integrated) versus provider (individual) approach</li> </ul>
<b>Partners</b>	<ul style="list-style-type: none"> <li>• The core partnership team is between the hospital service providers and the home care staff.</li> <li>• Additional partners that ensure effective transitions include Nursing Service Providers - Medical Supplies, Community Support Agencies, Long Term Care Homes</li> </ul>
<b>Principles</b>	<ul style="list-style-type: none"> <li>• Transparency • Client Centric • Outcomes based • Standardized work</li> <li>• Process based • Accountability • Evidence-based</li> </ul>
<b>Key Elements</b>	<ul style="list-style-type: none"> <li>• Regular and frequent communication</li> <li>• Visual triggers</li> <li>• Joint transition / admission protocols</li> <li>• Partnerships among care providers</li> <li>• Engagement with other organizations</li> <li>• Quality improvement approach based on international experience</li> <li>• Improvement advisor certification for each collaborative</li> <li>• Action based learning opportunities for participants on the improvement teams</li> <li>• Standardization of processes</li> <li>• Timeliness</li> </ul>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• Reduction in Length of Stay (acute) for clients discharged into the community</li> <li>• Increased client satisfaction for clients being transitioned between healthcare settings</li> <li>• Coordinated communication and enhanced data flows between home care and hospitals</li> <li>• Improved processes between home care, long term care direct service providers and acute care</li> <li>• Increased staff satisfaction</li> <li>• Reduction in LTC Home application process time</li> </ul>



In **Alberta, Ontario** and **New Brunswick**, other integration initiatives included home care and acute care with the focus on emergency department utilization and preventing inappropriate hospital admissions.

1. Home care staff, typically a case manager<sup>6</sup> in the **emergency department**
2. **Home care and emergency medical services (EMS)** in order to enable referrals to home care instead of transport to hospital where appropriate. The model in Ontario is *community referrals by emergency medical services (CREMS)*.

*The key elements of these integration models are:*

<b>Philosophy</b>	<ul style="list-style-type: none"> <li>• The concept of integration assumes that by working together health care professionals can deliver a better product to clients and to each organization</li> </ul>
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- Partners**
  - The key partnership is between home care and acute care – home care case managers, community supports and direct service providers (nurses, therapists and home support) with emergency room personnel
- Principles**
  - A collaborative working structure between home care and hospitals to facilitate and support positive working relationships and optimal utilization of resources
- Key Elements**
  - Home care staff are located in the emergency room
  - Co-location strategy support greater knowledge and understanding of client needs and system capacity
  - Home care staff identify and expedite discharges from the ED
- Outcomes**
  - Decrease in length of stay in the emergency room
  - Decrease in inappropriate admissions to emergency
  - Increase in support to assist hospital staff with referrals to home care

A stakeholder in **Manitoba** identified a variation of the home care – acute care ED integration model.

### 1. Home Care **Hospital Based Coordinators**

- Philosophy**
  - To reduce fragmentation and improve the effectiveness of service delivery through the development of coordinated holistic approaches to service delivery that are responsive to each person or family's unique situation
  - Clinical integration facilitates a seamless transition for patients with chronic conditions from an acute care facility to the community
- Partners**
  - The primary integration is between Acute Care - Home Care Team Managers and Hospital Based Home Care Coordinators. Community supports, service providers and educators are key to ensuring seamless transitions
- Principles**
  - Person / family /community / population centred service
  - Accountability
  - Outcome based service
  - Accessible, Coherent, Comprehensive, Responsive, Flexible and Seamless Service Delivery
  - Commitment to a Shared Vision & Culture
  - Integration is a Process
  - Open 2-way Communication and Reciprocal Responsibility
  - Staff are valued
  - Continuous Quality Improvement & Evaluation
- Key Elements**
  - Improve case coordination between care sectors
  - Enable community living & independence
  - Use of evidence to drive change
  - Recognize the value of community partners
  - Client input to new models of care and service is critical
  - Focus on social model that promotes independence and client engagement
- Outcomes**
  - Improve resource utilization
  - Reduce over dependence on acute care service delivery
  - Reduce long Length of Stay (LOS) in acute care
  - Decrease waiting times

*Service Excellence*

  - Enhanced access to information about the full range of health services available
  - Simplified information and referral processes
  - More continuous service provision
  - Coordinated provision of service for citizens and families requiring a number of health services
  - More responsive population specific services through improved partnerships with community, other agencies and sectors

*Quality of Work Life*

  - Staff share a common understanding of the vision and goals of integration
  - Staff ability to work successfully in an integrated environment





- Policies and procedures are streamlined
- Common work processes
- Staff collaborate and share information between programs

Other integration models between home care, acute care and the community were identified in **Ontario** and **Quebec**.

1. **Co-location of home care, hospital and community support** services
2. **Comprehensive community services** based on supporting seniors in their own homes to avoid or delay placement in a long term care facility.
3. **System of Integrated Care Services for the Frail Elderly (SIPA)**<sup>7</sup> optimizing use of community, hospital and institutional resources

*The key elements of these integration models are:*

<b>Philosophy</b>	<ul style="list-style-type: none"> <li>• Seniors would prefer and are better served in their own homes</li> <li>• When a senior has an acute exacerbation of illness they often are unable to go home because they require supervised transportation and some immediate home support</li> </ul>
<b>Partners</b>	<ul style="list-style-type: none"> <li>• Hospital, home care (CCAC, CLSC), and community service agencies</li> </ul>
<b>Principles</b>	<ul style="list-style-type: none"> <li>• Patients in acute care that are at high risk of future LTC placement require a discharge plan that aims to prevent future placement.</li> <li>• The discharge plan is based on an integrated service model that supplements home care services with additional personal care, homemaking and caregiver respite at no additional cost to the senior</li> </ul>
<b>Key Elements</b>	<ul style="list-style-type: none"> <li>• Community partnerships</li> <li>• Seamless services across the continuum</li> <li>• Case managers are pivotal to coordination and follow-up of interdisciplinary protocols, discharge planning and ongoing evaluation</li> <li>• Active participation of family physicians</li> </ul>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• Reduced utilization of acute care beds</li> <li>• Decreased ALC in acute care</li> <li>• Increased satisfaction of patients</li> <li>• Improved continuity of care</li> <li>• Safe care in the community</li> </ul>



Supporting acute care home care is also the goal of integrated models of care in both **Manitoba** and **Ontario**.

1. **Community IV Expansion** to enable those with short term acute needs to be cared for at home
2. **Wound management** support

*The key component of these programs include:*

<b>Philosophy</b>	<ul style="list-style-type: none"> <li>• Collaboration to develop of clinical guidelines and processes</li> </ul>
<b>Partners</b>	<ul style="list-style-type: none"> <li>• Regional Pharmacy Program, Regional Medicine Program</li> <li>• Expert clinicians, home care staff</li> </ul>
<b>Principles</b>	<ul style="list-style-type: none"> <li>• Multi-disciplinary teams provide effective care</li> <li>• Client empowerment and involved in the care plan</li> <li>• Transparent communications</li> <li>• Optimization of clinical roles and scope of practice</li> </ul>
<b>Key Elements</b>	<ul style="list-style-type: none"> <li>• Multidisciplinary holistic approach to clients who require IV anti-infective therapy including wound care management</li> <li>• Education of program clients and their care givers in the administration of IV ant-infective therapy</li> <li>• Comprehensive pharmaceutical care including drug counseling and allergy identification</li> <li>• Evaluation of treatment modalities by a physician</li> </ul>



## Outcomes

- Increase in number of clients receiving intravenous antibiotic therapy at home
  - Decreased hospital length of stay
  - Reduced number of emergency room visits
  - Improved wound healing
- 

## Home Care & Chronic Care

Canadians want to live at home in their communities as they age and accordingly require health and social care to assist them to remain independent for as long as possible. An integrated coordinated system of care decreases fragmentation and helps to avoid premature admission to a facility. Models from **Manitoba** and **Ontario** were identified.

1. Linking of **respiratory and home care teams** in order to provide more comprehensive and consistent care to patients with respiratory illness at home
2. **Community stroke program** as a service option to hospital-based care

*The key components of these programs include:*

<b>Philosophy</b>	<ul style="list-style-type: none"> <li>• The approach is transferable to other diseases and has implications for the Primary Care Chronic Disease Management Strategy</li> </ul>
<b>Partners</b>	<ul style="list-style-type: none"> <li>• Regional Respiratory Therapy Services, Home Care, Primary Care</li> <li>• The Community Stroke Service team consists of a Team Manager Case Coordinator, Resource Coordinator, Occupational Therapist, Physiotherapist, Speech-Language Pathologist, Rehabilitation Assistants and Home Care direct service staff</li> </ul>
<b>Principles</b>	<ul style="list-style-type: none"> <li>• Improve comprehensiveness and availability of staff education related to management of chronic respiratory disease for case coordinators, home care nurses and non professional care providers</li> <li>• Enhance collaboration between acute and community, adult and children's respiratory services</li> <li>• Enhance multi-disciplinary team approach that will optimize management of complex respiratory cases i.e. ventilator client and non invasive ventilation</li> <li>• Flexible service and seamless transition of care</li> </ul>
<b>Key Elements</b>	<ul style="list-style-type: none"> <li>• Enhanced clinical assessment</li> <li>• Appropriate service delivery package</li> <li>• Education strategy to improve chronic disease management</li> <li>• Follow up assessment for home oxygen clients</li> <li>• Management of services by a case coordinator</li> <li>• Home based rehabilitation</li> <li>• Utilization of rehab assistants</li> </ul>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• Fewer clients on oxygen inappropriately</li> <li>• Earlier intervention to prevent acute exacerbation</li> <li>• Fewer hospital admissions or ED visits</li> </ul>



In **British Columbia, Saskatchewan, Quebec** and **New Brunswick** models of integrated care support long term conditions and at risk populations.

1. **Seniors at Risk Integrated Health Network (SARIN)** program which is based on the expanded Chronic Care Model and designed to support seniors with two or more chronic conditions to remain safe at home (Victoria Island Health Authority, British Columbia)
2. A collaboration with Community Pharmacists to improve **medication safety**<sup>8</sup>
3. **PRIISME**<sup>9</sup> – a program designed to improve the management of chronic obstructive pulmonary disease (COPD) and diabetes
4. **Diabetes** and home care teams integrating in order to provide improved and consistent diabetes care



*The key components of these integration models are:*

- |                     |   |
|---------------------|---|
| <b>Philosophy</b>   | <ul style="list-style-type: none"> <li>• Based on the value of the inter-professional team and the need to improve communication and collaboration between the Health Care providers</li> <li>• Home Care is the perfect community based service to facilitate continuum of care for secondary and tertiary prevention and management of chronic conditions</li> </ul>  |
| <b>Partners</b>     | <ul style="list-style-type: none"> <li>• Primary Care Physicians, Home &amp; Community Care (Case Managers, Nurses, Social Workers, CHF Nurse), Geriatric Out Patient staff (PT, OT and Dietitian), Mental Health Nurse, Chaplain, and Pharmacist</li> </ul>  |
| <b>Principles</b>   | <ul style="list-style-type: none"> <li>• Based on the Expanded Chronic Care Model.</li> <li>• Improved health outcomes are the result of productive interactions between informed activated patients and prepared proactive health care teams and community partners</li> <li>• Collaboration - communication between providers is essential to maintain patient safety</li> <li>• Earlier detection, treatment and self care management are the keys to better chronic disease management</li> </ul>   |
| <b>Key Elements</b> | <ul style="list-style-type: none"> <li>• Delivery system redesign - focus on teamwork and an expanded scope of practice to support chronic care</li> <li>• Education for all stakeholders (patients, families and professionals) on chronic disease management</li> <li>• Decision support - integration of evidence based guidelines into practice Clinical Information Systems - creating client registries, recall systems Self-Management support - emphasis on the role that patients/families have in managing their own care</li> <li>• Community resources - developing partnerships with community organizations</li> <li>• Home &amp; Community Care Nurses and Case Managers complete a medication risk assessment and a complete list of meds including over the counters and herbals which they share with the Community pharmacist. The Pharmacist completes an in-depth medication review and collaborates with the Nurse/Case manager and Physician to mitigate the risks</li> <li>• Medication risk assessment and complete medication profile - most physicians and pharmacists are not aware of the over the counter meds and herbals that the clients are taking as well as the adherence to the prescribed medication regimes</li> <li>• Home Care nurses are the points of contact and provide basic diabetes education and refer on the diabetes team for intense education with the community based diabetes education team. The clients are followed according to stages of readiness and client centered goals by the most appropriate provider. Home Care provides care coordination through the continuum with an integrated team</li> <li>• Remote clinical monitoring using telehealth technology<sup>10</sup></li> </ul> |
| <b>Outcomes</b>     | <ul style="list-style-type: none"> <li>• Decreased hospital admissions, length of stay and emergency room encounters - PRIISME achieved a decrease of greater than 30% for asthma-related illnesses<sup>11</sup></li> <li>• Improved provider and patient satisfaction</li> <li>• Medication risks are identified and actions are taken to mitigate these risks. These actions are anticipated to prevent adverse drug events and possible hospitalizations or emergency room encounters</li> <li>• Improved diabetes care</li> <li>• Improved quality of life</li> <li>• Improved knowledge of the disease and its treatment among health professionals</li> </ul>   |



**Ontario** has implemented an integration of care model focused on addressing the unique needs of individuals with cancer and their requirements for ongoing support and services. Specifically:

1. Assignment of home care personnel in the **cancer clinic** in order to improve the communication and coordination of services for this patient population



*The key components of this model include:*

- |                     |  |
|---------------------|--|
| <b>Philosophy</b>   | <ul style="list-style-type: none"> <li>• Client centre approach that allows for flexible service plans</li> <li>• Staff function more effectively when working with dedicated and consistent partners</li> </ul>                                     |
| <b>Partners</b>     | <ul style="list-style-type: none"> <li>• Home Care, family physicians, oncology specialists, Cancer Centre staff</li> </ul>  |
| <b>Principles</b>   | <ul style="list-style-type: none"> <li>• Working as a team is more effective</li> <li>• Collaboration and communication between team members is essential</li> </ul>   |
| <b>Key Elements</b> | <ul style="list-style-type: none"> <li>• Role clarity</li> <li>• Assigned home care staff to the clinic</li> <li>• Regular structured communication</li> </ul>   |
| <b>Outcomes</b>     | <ul style="list-style-type: none"> <li>• Decreased number of “dropped” clients</li> <li>• Improved access to home care</li> <li>• Improved communication and sharing of information</li> <li>• Increased client and provider satisfaction</li> </ul> |

## Home Care & Palliative Care

In the 2004 10-Year Plan to Strengthen Health Care a commitment to hospice palliative care services in the home was made. Accordingly, jurisdictions have been enhancing the way care is delivered to those with life-threatening illnesses. The CHCA's High Impact Practice, Enhanced Palliative Care Program<sup>12</sup> describes an integrated approach to supporting palliative patients in the community. Models of integrated service delivery approaches for palliative care were identified in **Saskatchewan, Manitoba and Ontario.**

1. **Interdisciplinary palliative care** services that provide care to the person at home, hospital or other care facility

*The key components of this model include:*

- |                     |  |
|---------------------|--|
| <b>Philosophy</b>   | <ul style="list-style-type: none"> <li>• Addresses the psychological support, assistance in interpersonal relations, coordinated service delivery, symptom control, bereavement, independent living, legal and financial issues, matters of spirituality, life style, culture and religion</li> </ul>  |
| <b>Partners</b>     | <ul style="list-style-type: none"> <li>• Medical personnel, nursing staff, support staff, volunteers, allied health professionals, pastoral care personnel, administrative staff, pharmacists, personal care home operators, family, friends the individual, palliative care consultants</li> </ul>  |
| <b>Principles</b>   | <ul style="list-style-type: none"> <li>• Individual and family control decisions that determine care</li> <li>• Coordinated service</li> <li>• Leverage individual and family capacity</li> <li>• Promotion of autonomy and functional independence of the individual and family</li> <li>• Interdisciplinary team</li> <li>• Symptom control</li> <li>• Home-based service is preferred option</li> <li>• Bereavement follow-up</li> <li>• Ongoing education for care providers and the public</li> <li>• Evaluation</li> </ul> |
| <b>Key Elements</b> | <ul style="list-style-type: none"> <li>• Assessment</li> <li>• Case management</li> <li>• Medical care</li> <li>• Care</li> <li>• Support</li> <li>• Counselling</li> <li>• Spiritual/religious support</li> <li>• Legal/financial</li> <li>• Emergency services</li> </ul>  |





## Outcomes

- Volunteerism
- Bereavement support
- Education
- Terminally ill person is able to live and dies in comfort and dignity
- Autonomy and functional independence of the individual is respected
- Community caregivers and volunteer services are leveraged
- Provision of education
- Coordinated seamless service
- Care is provided in the appropriate environment
- Bereavement care is provided
- Physical, psychosocial and spiritual needs are addressed
- Pain and symptom control is achieved
- Legal/financial counseling is provided as requested
- Care is cost effective and efficient

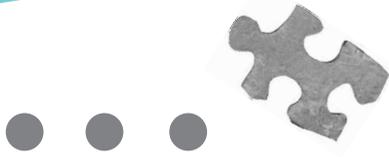
## Home Care & Pediatric Care

There has been a significant increase in the number of children requiring extensive health supports in their home and communities.<sup>13</sup> 15 % home care recipients in Ontario are children.<sup>14</sup> An overview of initiatives for children was produced by the CHCA in 2006 - *Home Care for Children with Special Needs: An Environmental Scan across Canadian Provinces and Territories*. An integrated model of care to address the unique needs of children and their families was identified in **Ontario**.

1. **Children's Treatment Network (CTN)** linking over 40 healthcare, education, recreation, social and community services organizations so they can take a team approach to each child's care

*The key components of this model include:*

- |                     |   |
|---------------------|---|
| <b>Philosophy</b>   | <ul style="list-style-type: none"> <li>• The Network coordinates services needed and monitors each child's progress through all the phases of their development</li> </ul>  |
| <b>Partners</b>     | <ul style="list-style-type: none"> <li>• Home Care providers, Community Support Services, Hospital, home care (CCACs), School Boards, Child and Family Services, Social Services, Brain Injury Services</li> </ul>  |
| <b>Principles</b>   | <ul style="list-style-type: none"> <li>• <b>Family Centred</b> system - where the entire family is supported. CTN Participants respect the pivotal and primary role of the family in the lives of children and youth, and promote normal patterns of living at home and in the community, ensuring that parents are partners in decision making, as equal members of the child/family teams</li> <li>• <b>Holistic</b> — CTN Participants will work together to establish a single client service plan. The plan will include the supports provided to the child/youth and family across health, social, developmental, psychological, educational, recreational and other needs including transition into adulthood. CTN Participants work with all services involved in the care of a child/youth with special needs, integrating its "core" rehabilitation services with the wider circle of services for children with disabilities</li> <li>• <b>Integrated</b> — CTN Participants are part of the system of care across Simcoe and York for children and youth with rehabilitation and habilitation needs. CTN Participants will work in partnership with all stakeholders in the care and support provided to children with disabilities and their families</li> </ul> |
| <b>Key Elements</b> | <ul style="list-style-type: none"> <li>• Access Mechanism, Service Navigation, Service Coordination, 10 Local Teams, Child &amp; Family Teams, 10 Local Team Sites, Single Plan of Care, Specialty Services</li> </ul>  |
| <b>Outcomes</b>     | <ul style="list-style-type: none"> <li>• Increased coordination, service integration, system capacity, staff satisfaction</li> <li>• Improved access</li> <li>• Reduced waiting for services</li> <li>• Increased participation of kids in school, community, family, recreation</li> <li>• Increased family satisfaction, functioning, reduced problems, improved child/family quality of life</li> </ul>  |



### Making it Work

As previously stated, integration is a process to improve care through effective collaboration of the health care team. It presumes a commitment to quality at all stages of care and as such achieves reduced duplication, improved efficiency, improved clinical outcomes, improved quality of life and appropriate system utilization. It requires a new way of thinking and working that takes time to develop and, at least initially, more effort to implement.

Operationalizing integration varies from team to team and jurisdiction to jurisdiction. “Who does what” is a reflection of the context – from legislation and regulation, to supply of staff and organizational resources. The differences in health care systems and delivery models, particularly within home care<sup>15</sup> make it difficult to compare approaches and/or draw conclusions about the most successful model. To date, few respondents have quantitative evaluative data.<sup>16</sup>

### Themes

The integration initiatives all have a number of commonalities. These include:

- A desire to improve patient outcomes, satisfaction and/or quality of life
- An assumption that the preferred place of care is the home
- Inter-professional collaboration through multidisciplinary teams
- Establishment of measurable outcomes
- Standardized approaches to care



“Integration happens  
in rural settings out  
of necessity”

- Workshop Participant



“Realize that we are  
measuring the wrong things –  
we need to focus on the  
population and the  
system’s performance....”

- Workshop Participant



# Stimulating Integration



The Canadian Home Care Association (CHCA) project, called the Integration of Care Project, was funded by Health Canada and designed to facilitate integration of care through the alignment of home care with other health care sectors.

The purpose of the Project was to enhance the integration of care by identifying successful integration models involving home care and to support applied dissemination of these approaches through day-long workshops facilitated by ‘integration coaches’. There were four key components to the project:

1. The identification of successful integration models
2. The identification and deployment of “integration coaches” (representing the successful integration model) who would travel to interested communities (receptor sites)
3. The provision of 1 day information sessions on integration of care at the receptor sites
4. Follow-up consultation as needed

“It’s hard to feel comfortable delegating because as doctors we are ultimately accountable”

- Workshop Participant

## Integration of Care Workshops

Three home care sites, “receptor sites” were selected to participate in a one day workshop where information sharing and discussion integration initiatives. Determination of the sites was made based on consultation with the Project Advisory Group<sup>17</sup> and the Project Reference Group<sup>18</sup>, expressed interest, geographic representation, and availability to work within our timelines and

align schedules with the integration coaches. This proved to

be much more difficult than originally anticipated. Home care providers are busy, engaged in many initiatives and, while enthusiastic about the opportunity, most struggled to work within the timeframes. This issue was reinforced in the event evaluations where participants indicated their appreciation of the opportunity and their observation that there are “not enough of these information sessions”. The participating jurisdictions for the workshop were:

- South West Local Health Integration Network, Ontario
- Department of Health, Prince Edward Island
- North Simcoe Muskoka Integration Network, Ontario

## South West Local Health Integration Network (LHIN), Ontario

The South West LHIN covers an area from Lake Erie to the Bruce Peninsula and is responsible for the planning, integration and funding of more than 200 health service providers, including hospitals, long-term care homes, mental health and addictions agencies, community support services, community health centres, and the South West Community Care Access Centre (CCAC). The South West LHIN’s integration priorities are:

- Strengthening and improving primary health care
- Preventing and managing chronic illness
- Building linkages across the continuum: all seniors and adults with complex needs
- Accessing the right services, in the right place, at the right time, by the right provider
- Two enabling priorities – e-Health and health human resources<sup>19</sup>





The South West LHIN had embarked upon a process with its provider partners of articulating a model for an “integrated approach to person centred care” and had been working hard to advance a new approach to chronic disease prevention and management involving the CCAC as a key partner on the primary care team. The integration workshop was an opportunity for the health partners to continue the discussion about integration within their communities.

### **Department of Health, Prince Edward Island (PEI)**

Home care services in PEI fall under the Department of Health and are delivered through a provincial program. This structure is the result of a significant restructuring in 2005 where the regional health authorities were disbanded and health services were brought together under a centralized model.<sup>20</sup> While provider practices are by nature and necessity highly integrated, the articulation of a model and development of a framework for integrated care is sought by the leadership team.

The timing of the integration project was perfect to support the work on case management and clinical integration.

### **North Simcoe Muskoka Local Health Integration Network (NSMLHIN), Ontario**

The NSMLHIN serves a population of approximately 425,000 by working with local providers to plan fund and integrate health services. The LHIN boundaries encompass the northern portion of Simcoe County, the District Municipality of Muskoka and the communities of Craigeleith, Feversham, Maxwell and Badjeros in Grey County. The integration priorities for the NSMLHIN are to:

- Improve the health of residents
- Provide the right care, in the right place, at the right time
- Use our resources effectively to help ensure a sustainable health care system

Clinical integration and creating a patient-friendly integrated health care system are key activities embedded in the plan to ensure the priorities are realized.<sup>21</sup>

The North Simcoe Muskoka CCAC had recently undertaken a comprehensive review of their case management function within an integrated health system. The integration workshop opportunity was enthusiastically embraced by the LHIN and CCAC and the health system partners responded. Registration for the day long session was closed at 100 participants who attended and actively participated over the full day long workshop.

Identification of “**integration coaches**” was based on recommendations from the Project Advisory and Reference groups, availability, expertise, knowledge, ability to travel and presentation skills. It was decided to proceed with consistency of coach at all three sites so that the evaluation of the impact to the workshop at the sites would not be influenced by differences in coaches. The coaches came from the Calgary Health Region, the Dorval Family Medical Centre in Ontario and Toronto, Ontario. A brief description of the coaches is available at Appendix 2.

The **workshop session** format was consistent between the three sites. The morning was lecture format to the plenary and the afternoon was for small group work to allow for application of the concepts.





- Opening remarks and context setting made by the host site
- Overview of the project
- Integration applied to chronic disease management
- Experience integrating home care and primary health care to serve patients with chronic disease in Calgary
- Lessons in the Model for Health Improvement using PDSA cycles
- Application of PDSA cycles
- Wrap-up and next steps

The day was well received. Over two thirds of participants completed the session evaluation and 91 to 92 percent at the three sessions indicated that it “was a good use of their time”. 78 to 94 percent of respondents indicated that they “learned new information/approach about integration from the presentations”. 80 to 88 percent “agreed” or “strongly agreed” that the workshop influenced their thinking about integration.

While enthusiasm was high on the day of the event, experience suggests that it is hard to sustain the momentum once back in the workplace. An invitation to respond to a questionnaire about integration and the workshop posted on the CHCA site was sent two weeks after the event. 71 percent of respondents indicated that their knowledge of integration was “improved” and the same number agreed that the workshop helped to stimulate discussion on integration within their region and/or with their partners. 50 percent indicated that the workshop helped to stimulate action.



“We are compensated and structured to focus on the issue that the patient presents and not on supporting self management.”

- Workshop Participant



“There is a myth out there that physicians are not available.....Physicians have that same perception of specialists...”

- Workshop Participant



# Lessons Learned



## Barriers to Integration

A number of seemingly simple issues that are in fact complex to resolve make integration within health care difficult. Project participants identified the following challenges:

- Reimbursement models that support management of symptoms and do not support prevention
- Regulations that prescribe how care is to be provided, ie in person visits only
- Ownership of the patient record – there are organizational and professional guidelines that need to be reconciled in order to eliminate duplication
- Technology – the absence of technology to support the timely sharing of information; and/or the presence of poorly developed information technology systems that simply reflect a paper process and serve only to “speed up the chaos in the system”
- Professional resistance
- Physical space in which to work and meet
- Geography
- Assumptions about others that are based in misinformation
- Absence of a framework – sometimes integration occurs because colleagues make it work but it is not sustainable or transferable



“We cannot ask patients  
to fix our broken system”

- Mike Hindmarsh, 2008

## Enablers to Integration

While there is general agreement that improving patient care through integration makes sense, health care systems and providers across the country struggle with the challenge. There is a long history of treating individuals episodically and creating hand-offs between providers. Integration requires a new way of thinking and behaving. Integration is not an outcome but rather a process or way of operating that recognizes the interdependencies of the patient/client, the provider and the system. Integration strategies evolve and vary in response to patient needs and system goals. No one person or profession is responsible for integration. Rather, it is the professional duty of all on the health care team to practice differently, in a way that demonstrates a commitment to patient/client outcome as contrasted with a task-based orientation where the emphasis is on promptly and efficiently completing an activity and transferring responsibility to the next practitioner. The approach must consider the unique circumstances of the patient and their context which includes their environment and the local health and community structure. Integration in rural and remote communities, for example, where resources are more limited, will occur differently than those in larger urban settings where there may be more stakeholders to consider.

Notwithstanding the recognition for variation, there is benefit to understanding the experiences of others. 94 to 97 percent of participants “agreed” or “strongly agreed” that “learning about integration from other parts of Canada was a good approach to supporting local initiatives”.

Competencies and /or strategies to support integration of health care services identified by the project participants include:

- **Leadership** – a new paradigm that moves from hierarchical approach to one that is flexible and adaptable and values the leadership contributions and potential of all team members. Leaders are also needed to champion and support integration efforts
- **Governance** – supportive of integration agenda and committed to facilitating supportive policy
- **Vision** – a well articulated purpose for the integration effort and description of the outcomes that are anticipated; shared values and commitment to the outcomes
- **Commitment to patient** – putting the needs of the patient first, before the needs of the organization helps to erode silo thinking and territorialism



- **Understanding the professionals' case management capacity** – recognizes that all members of the health team have a responsibility to help patients bridge boundaries and transition to the next care context – be that part of the formal system or self-care
- **Physician engagement** – the medical home for the patient is typically the family doctor who must be involved in the planning and design of the integration initiative
- **Technology** – to support the ability for providers to communicate and share information in a timely manner and avoid duplication of effort. Computer technology is envisioned; however information systems are only as good as the people behind them
- **Partnering** – health providers typically refer to their colleagues as partners in care, however the partnership relationship can range from contractual where information and expectations are prescribed and hand offs are made; to collegial where there is a strong sense of trust and shared accountability for the patient experience<sup>22</sup>
- **Quality improvement culture** – which recognizes that improvement requires change and where small tests for change can be implemented throughout the organization to see if they result in improvement.<sup>23</sup>
- **Change management** – helping individuals through the change management cycle in order to transform the system
- **Policy, regulation and funding** - to support integrated care, encourage collaboration and reinforce the role of government as stewards of health care
- **Role clarity** – all members of the team, including the patient, need to clearly understand what each brings to the care framework (and divest themselves of the historical assumptions about how each practices) so that their respective contributions and capacities can be appropriately and effectively maximized; and duplication minimized



## Outcomes of Integration

Health care stakeholders anticipate a number of outcomes as a result of successful integration.

### For the patient

- Increased consumer satisfaction with the quality of their interaction with the providers within the system and the care received
- Increased confidence in the health system
- Increased quality of life, greater self-management and support for the client/patient and family caregiver
- Improved access – getting the right service at the right time and place; improved navigation of the system
- Healthier populations and communities.

### For the provider

- Increased health care provider satisfaction and professional fulfillment resulting in increased recruitment and retention
- Increased provider knowledge through cross training and greater understanding, maximizing skills and fostering mutual respect for complementary skills
- Increased communication, collaboration and shared accountability for both client/patient outcomes.

### For the system

- Appropriate use of resources and greater systems efficiencies through elimination of redundancies (e.g. reduce client/patient assessments, streamline communication, etc)
- Improved support of patients at health transition points
- Reduced reliance on acute care for preventable health issues (better chronic disease management and proactive care in the community)
- System evaluation leading to evidence based resource allocation and more effective health care spending



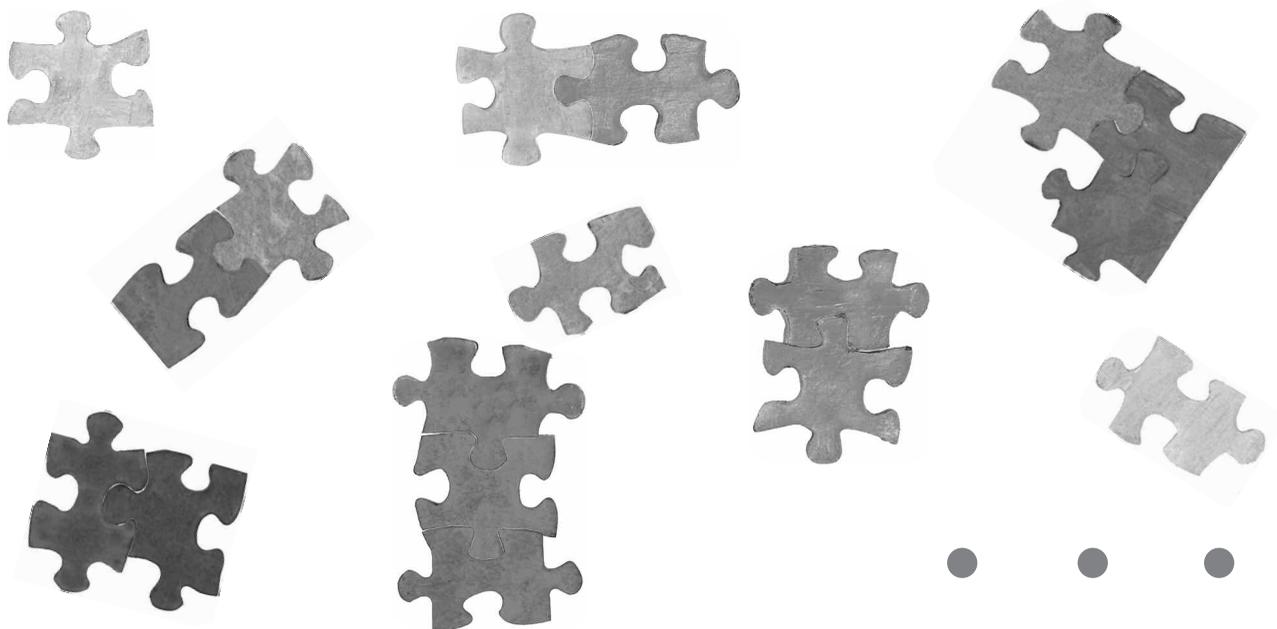
# Conclusion and Recommendations



Canadians expect health and social care at the right time in the right place by the right provider. The aging population and those with complexity health care needs are increasing creating challenges for the system. Integration of care is generally accepted as being the most appropriate approach to responding to this increasing demand and yet system change is difficult to effect and slow to happen. The implementation and sustainability of integration strategies requires a willingness to change throughout the system – from policy to practitioner.

The CHCA offers the following recommendations to overcome the barriers to integration of home care with the broader health care system:

- The Federal government should promote knowledge transfer and mentoring through roundtables, workshops and funding of demonstration projects to advance integration across providers and jurisdictions
- Governments must articulate a vision for an integrated health care system as it addresses specific patient population needs, be they disease, age or health utilization specific, and then move quickly to make the necessary policy and funding changes to enable providers to achieve the vision
- Health care organizations need to be supported to adopt new leadership competencies that promote continued learning and foster integration
- Health regions should leverage the home care capacity to provide case management as a strategy for health systems integration
- Jurisdictions must invest in technology solutions to enable improved communication and collaboration across professions and health sectors
- Governments should institute planning, operating and monitoring practices that are population based and measure outcomes achieved by the integrated health team as opposed to specific organizations or disciplines



# Appendix 1 - Project Overview



## Background

A recent thematic scan of Canadian and international literature on health system responses to aging populations conducted by Hollander Analytical Services Inc.<sup>24</sup> noted that integrated systems of care for the elderly are both appropriate and effective and that the focus of policy on care delivery for the elderly should be on integrated models of care delivery. Additionally, results from a background paper commissioned by Health Canada on the “Integration of Primary Health Care and Home Care Services in Canada” (March 2006) supported a need for better integration between the primary health care and home care sectors; and a workshop hosted by Health Canada in March 2007 reinforced the need to pursue integration among the health sectors and explore ways to move the agenda forward.

The CHCA therefore undertook, with funding from Health Canada, to facilitate integration of care through the alignment of home care with other health care sectors. The overall goal was to increase awareness, uptake and implementation of integration models involving home care and other health care sectors across Canada. Specific objectives were to:

- Gain an understanding of current successful models of integration involving home care and other health care sectors that are being used across Canada
  - Identifying and disseminating models for innovative health care service delivery specifically focused on integration of care involving home care programs
- Facilitating information-sharing amongst Canadians, health institutions, non-profit organizations, and policy makers for participation in conferences related to integration of care and effective service delivery
  - Determining the readiness (including the identification of barriers and challenges) of receptor sites to implement and support integrated models of care which include home care
  - Identify integration strategies, supporting tools and local “integration coaches”
- Supporting the uptake of best practices in home care and supporting health systems renewal through the provision of broad advice on current health care priorities, including health care integration models that involve primary care, home and community care and acute care
  - Supporting local “integration coaches” in communicating and sharing integration approaches, tools and facilitating uptake of integration models that involve home care
- Encouraging inter-sectoral (governmental, non-governmental, non-profit organizations) and interdisciplinary collaboration in health through the broad reach and depth of the CHCA in its role as the national voice of home care in Canada
  - Disseminating best practices through a final report, High Impact Practices, and the annual Home Care Summit

## Approach

The CHCA focus was on integration involving home care specifically. The approach was to:

- Identify successful integration models and gather tools and resources
- Identify “integration coaches” representing a successful integration model who would travel to interested communities (receptor sites) to share their first-hand integration knowledge and experience with others interested in pursuing a more integrated approach to care delivery
- Providing a one day information session on integration of care and be available for follow-up consultation as needed
- Work with receptor sites to host a one day workshop to share information from the integration coaches
- Document the lessons learned and the information gathered through the initiative



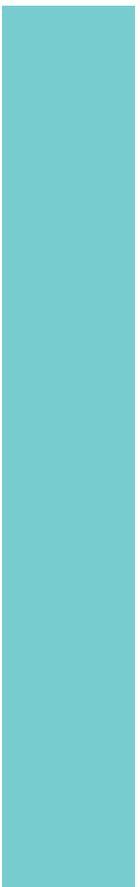
In order to determine the level of interest in this initiative amongst home care stake-holders, the CHCA conducted a surface level, pan-Canadian scan through a questionnaire posted on the CHCA's website. An email was sent to those in the CHCA database which includes members, key contacts and those who participated in the Health Canada roundtable in March 2007. Sixty-two responses were received reflective of activity in seven provinces.



## Appendix 2 – Integration Coaches



- **Carol Slauenwhite** – is a registered nurse and has worked as a clinician, educator and manager in Calgary. She led Calgary’s home care / primary care collaboration initiative in the Calgary Health Region and was a site leader in the CHCA’s National Partnership Project. Carol is currently involved with the CHR’s Outreach Seniors Program.
- **Dr. George Southey** - has been in full scope, comprehensive primary care for 23 years. He was the executive lead of Ontario’s first Family Health Network, the Dorval Medical Centre, and recently, the first wave of Family Health Teams. The group’s practice spans all facets of care, in all settings (including ER, Inpatients, office, home and LTC). The group is a provincial leader for outcomes in preventive care and chronic disease management. Dr Southey is extensively involved in quality measurement and management with the CPSO, CMPA and the Ministry of Health. He is also involved in policy analysis and development in Chronic Disease Prevention and Management, LHIN e Health and Primary Care.
- **Mike Hindmarsh** - participated as a member of the team led by Dr. Ed Wagner at the MacColl Institute for Healthcare Innovation, Group Health Cooperative in Seattle, Washington, to create the Chronic Care Model in the early 1990s in response to the need to develop a more uniform approach to chronic disease management. Since that time, Mike has worked with hundreds of health care organizations in the USA and Canada implementing the Chronic Care Model in their systems. His particular expertise is in translating health services research into interventions implemented by front-line providers, and then studying the impact on clinical and process outcomes.



## Appendix 3 – Endnotes

- 1 The National Partnership Project was a demonstration project funded through Health Canada's Primary Health Care Transition Fund and sponsored by the Canadian Home Care Association. By enhancing the integration of home care and primary health care services for a population with chronic disease, significant benefits to the health system, the providers and most importantly to patients were realized. For more information on the Project and to access CHCA's report – Partnership in Practice, visit [www.cdnhomocare.ca](http://www.cdnhomocare.ca).
- 2 The Community Access Model, a cornerstone of the integration model, represents a shift from program-based organizational models to an integrated, community-based team structure.
- 3 CHCA Portraits of Home Care, March 2008
- 4 For more information on High Impact Practices go to [www.cdnhomocare.ca](http://www.cdnhomocare.ca)
- 5 Flo is an analogy developed to highlight the story of a real patient experiencing an acute event who requires care in an alternate setting following a hospital stay. Flo is an 85-year old woman admitted to hospital from her home with multiple co-morbidities. Her frailty and declining cognitive status necessitate transfer to a nursing home. The initiative, established by the Ontario Ministry of Health & Long-Term Care, is to bring health system providers together through a collaborative learning process to develop ways to improve the flow of patient care throughout the system so that patients receive quality care in the right.
- 6 Also known as a case coordinator, care coordinator
- 7 SIPA (Services integres pour les personnes agees fragiles) is a demonstration and evaluation project based on a model of integrated care for the frail elderly developed by Francois Beland, Howard Bergman and Paule Lebel. The SIPA project was carried out on the Island of Montreal over a period of 22 months from 1999 to 2001. The project aimed to implement a model for the frail elderly living in the community and to evaluate by means of an experimental devices, its comparative advantage in regards to existing services.
- 8 Clinical Pharmacy Services in Home Care is a High Impact Practice released by the CHCA in 2007
- 9 Programs to Integrate Information Services and Manage Education, or PRIISME, is a comprehensive approach integrating every step of patient management, including prevention, diagnosis, treatment, drug compliance and follow-up. Since 1999, PRIISME has implemented more than 25 projects in Quebec, focusing on asthma, COPD and diabetes.
- 10 CHCA's High Impact Practice EMPcare@home released in 2006 is an example of this approach
- 11 Cimon, M. 2003
- 12 CHCA web – [www.cdnhomocare.ca](http://www.cdnhomocare.ca)
- 13 Children and Youth Homecare Network – Submission to the Romanow Commission, 2002
- 14 The Health of Canadians – The Federal Role, October 2002
- 15 For more information on the provincial, territorial and federal variances, home care please review CHCA's Portraits of Home Care 2008
- 16 There have been however published evaluations of SIPA and PRIISME
- 17 The Project Advisory Group provided expertise and guidance on all aspects of the project
- 18 The Project Reference Group was comprised of representatives from the broader health care system
- 19 South West LHIN Annual Report, p.7
- 20 CHCA, Portraits of Home Care
- 21 NSMLHIN Annual Report
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- 23 Institute for Health Improvement
- 24 Hollander, March 2007

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