The Role of Local, Regional, and Ministerial Actors in the Integration of Services for Frail Elderly People

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Finally, we would like to acknowledge the contribution of the 66 anonymous respondents who generously agreed to speak with us despite their busy schedules. We dedicate this report to these experts who built Quebec’s health and social services system.
Key Implications for Decision Makers

General Message. Enhancing the integration of services for frail elderly people is an innovation that must be brought about locally. The success of this complex undertaking is not only contingent upon the willingness of local actors to collaborate but also upon the structuring decisions made at the regional and provincial levels. These decisions each deal with one of five dimensions of integration: normative, clinical, informational, organizational, and financial. The process of translating each one into concrete action does not follow the same logic nor does it proceed at the same pace, which creates consistency and timing problems that must be dealt with.

Normative integration. To achieve service integration, it is essential that affected actors understand and accept the integration model. Actors at all levels can help promote this model and change the way other actors view its practicality and relevance. This way, the involvement of credible and dedicated individuals (that is, researchers), the prioritization of service integration by senior executives, and the allocation of budgets by these executives to expedite testing will facilitate integration.

Clinical integration is the rationale for the other dimensions, as well as the dimension over which local actors have the most control. It is essential that actors at other levels allow them to adapt the service integration model to their specific context.

Informational integration is essential to the smooth operation of a service integration system. It is vital that the varying concerns of local and ministerial actors in this area be reconciled to build on experiments conducted in the field. It is also crucial that clinical concerns be taken into consideration when designing information systems and tools.

Organizational integration. The integration of services by area requires the introduction of a sub-regional governing body and vertical and horizontal co-ordination mechanisms linking senior executives, managers, and practitioners in partner organizations.

Financial integration. The move from an institution-based logic to a population-based logic is more easily achieved by combining the budgets required for co-ordination activities.

Integration of dimensions. As a rule, setting up a shareable clinical file, the amalgamation of institutions and the signing of protocols, and budgeting based on client programs are conducive to clinical integration. However, the impact of these measures is contingent upon the concurrence of affected actors. From this perspective, it is essential that service integration reforms do not succumb to a bureaucracy-based logic that would undermine the willingness of local actors to achieve this integration.
Executive Summary

Mrs. Gagnon, a 78-year-old widow, suffers from arthritis, high blood pressure, and the onset of dementia. She is cared for by her daughter Lucie, who must also rely on several other practitioners for support: a family doctor, a nurse, and a visiting homemaker. These practitioners are not automatically notified when her mother’s health deteriorates, which means that Lucie must repeat the same story to each one of them. Mrs. Gagnon was recently rushed to hospital, where the staff did not have all the information required to determine their care plan. Mrs. Gagnon was weaker when she returned home and required more extensive services. Staff from the local community service centre (LCSC) completed a second assessment of her needs, which delayed treatment.

This case illustrates the difficulties faced by several frail elderly people and their loved ones in obtaining appropriate services in a timely manner. For a number of years now, improved service integration has emerged as a suitable solution for overcoming these obstacles. But how do we go about enhancing the integration of services for frail elderly people in a multi-tier public system? What supports or restricts this approach? How do we explain the variations found from one area to the next?

To answer these questions, we conducted empirical research at the Ministère de la Santé et des Services sociaux du Québec (MSSS), in three regions, and in a sub-region of each of these regions. The lessons drawn from these studies are based on the analysis of 66 interviews, extensive documentation, and direct observation.

Our research indicates that the enhanced integration of services for frail elderly people is not only contingent upon the willingness of local actors to collaborate but also on the structuring
decisions made at the regional and provincial levels. These decisions each deal with one of five dimensions of integration: normative, clinical, informational, organizational, and financial. The process of translating each one into concrete action does not follow the same logic nor does it proceed at the same pace, which creates consistency and timing problems that must be dealt with.

Various organizational models can help improve the integration of services for frail elderly people. We observed two of these models during our study: the improved linkage model and the integrated services network. The first stems from efforts by clinical or administrative actors in a hospital or LCSC to improve case management for frail elderly people in their respective institutions. The co-ordination of area partners — hospital, LCSC, community organizations — is, for the most part, based on bilateral agreements. A computerized, unidirectional information system forwards homecare requests from hospital to LCSC.

The integrated services network requires a high degree of collaboration from all organizations providing services to frail elderly people in a given area. In fact, it must rely on sub-regional co-ordination mechanisms and solid normative integration. The establishment of an integrated services network 1) centres above all on the involvement of competent, credible, and dedicated individuals who will demonstrate the practicality and relevance of the new service co-ordination system; 2) requires the support of senior executives of organizations involved with the selected co-ordination model; 3) must be introduced to these executives as an appropriate solution to problems related to setting up services they feel are a priority; and 4) takes time so that managers and practitioners affected by the change can establish collaborative ties and adopt the selected co-ordination model. In terms of information, the effectiveness of an integrated services network depends on the use of a shareable clinical information system that is both interdisciplinary and inter-institutional. The organizational aspect of establishing an
integrated services network implies the introduction of governing and co-ordination procedures based on trust and mutual respect.

Regional actors can contribute to the enhanced integration of services at the local level by adopting policies that are both clear and flexible, allowing local actors to choose the specific methods of implementing their selected integration model, by adopting measures in accordance with these policies, particularly in terms of information systems, and by strengthening the internal co-ordination mechanisms used by the ministry to improve the consistency and timing of its actions.

Regional actors can also promote service integration by setting out their own policies in this area and by supporting desired changes rather than unilaterally imposing them. In particular, this support involves freeing up staff to develop and implement sub-regional service co-ordination systems. These individuals facilitate collective learning by sharing achievements.

Researchers and research officers can also contribute significantly to the integration of services by providing other actors with a different perspective of the type of problems involved in setting up services for frail elderly people and by offering possible solutions to these problems. They can exercise their influence at each level and within each group of affected actors: senior executives, managers, and practitioners. To become true agents of change, researchers and research officers must not only impart evidence-based knowledge or gain new knowledge but must also establish their credibility among the actors they are looking to support.