Integrating Health Across the Continuum of Care

Introduction

Canada’s multiple health-care systems are complex; difficult to access; involve many levels of care, practitioners and delivery mechanisms; and are a challenge for patients and families to navigate.

The case for change is clear:

• Patient care in Canada is designed from the provider’s point of view, whether this provider is a hospital, a clinic or an individual. To improve, the system needs to be redesigned to support person-centred care.

• Variations occur in quality and access to care, both across the country geographically and across socioeconomic groups.

• Canadian care providers are not integrated. Care delivery occurs in silos.

• Barriers exist in accessing the system.

• Transitions between providers are difficult for patients and family members.

• Interprofessional collaborative teams could be designed to ensure patients the right care, by the right provider, at the right time, in the right place.

How we get there

– Support health-care innovation and improvements to accessing services such as prescription medications

– Commit to innovation, collaboration and partnerships to achieve a modern, efficient, equitable system of health care

– Overcome obstacles to innovation in health-care delivery

– Fund dissemination and scale up successful new models of care

How integrated care helps patients navigate the health system

Integrated care provides seamless care pathways along and within each patient’s continuum of care. It addresses the social determinants of health, health promotion and the prevention of disease within a primary health care approach.

It is based on six key principles:

1. Person-centred care that is seamless along the continuum of care

2. Quality services appropriate for patient needs

3. Health promotion and illness prevention

4. Equitable access to quality care and multi-sectoral policies to address the social determinants of health

5. Sustainability based on universal access to quality health services

6. Accountability by stakeholders — the public/patients/families, providers and funders — for ensuring the system is effective

The Quadruple Aim concept

Expanding on the IHI Triple Aim framework, the Quadruple Aim concept offers an approach to optimizing health-system performance based on the idea that new designs must pursue four goals.

Patients will know when they have an integrated health-care system when they...

Don’t have to wait at one level of care because of incapacity at another level of care.

Can make appointments for a clinician visit, a diagnostic test or a treatment through a single request.

Have a wide choice of primary care providers who are able to give them the time they need.

Do not have to repeat their health history to each provider.

Do not have to undergo the same test multiple times with different providers.

Have a primary health care provider who knows they have undergone treatment.

Have easy-to-understand information in order to make informed choices.

Have 24-hour access to a primary care provider.

Are proactively informed about the progression of their condition.

References


