



HEALTH
AND WELFARE
COMMISSIONER

ENHANCING
OUR HEALTH
AND SOCIAL
SERVICES SYSTEM

2010

APPRAISAL REPORT ON THE
PERFORMANCE OF THE HEALTH AND
SOCIAL SERVICES SYSTEM

ADOPTING AN INTEGRATED
APPROACH TO CHRONIC
DISEASE PREVENTION
AND MANAGEMENT:
RECOMMENDATIONS, ISSUES
AND IMPLICATIONS



SUMMARY

Québec 

> Foreword

THE MISSION OF THE HEALTH AND WELFARE COMMISSIONER IS TO PROVIDE PERSPECTIVE RELEVANT TO PUBLIC DEBATE AND GOVERNMENT DECISION MAKING IN ORDER TO ENHANCE THE HEALTH AND WELFARE OF THE QUÉBEC POPULATION. TO DO SO, HE APPRAISES THE RESULTS ACHIEVED BY THE HEALTH AND SOCIAL SERVICES SYSTEM. EACH YEAR THE COMMISSIONER PUBLISHES AN APPRAISAL REPORT ON THE SYSTEM. HIS WORK APPROACH IS BASED ON ENGAGEMENT, DIALOGUE, COLLABORATION WITH STAKEHOLDERS IN QUÉBEC SOCIETY, AND CITIZEN PARTICIPATION.

The Commissioner's 2010 appraisal report on the performance of the health and social services system addresses chronic disease care and services. This appraisal report consists of four volumes, which reflect the Health and Welfare Commissioner's four functions: appraise the performance of Québec's health and social services system; consult citizens, experts and system stakeholders; inform the Minister, the National Assembly and the public of the results achieved; make recommendations and discuss their attendant issues and implications.

Each of the four volumes in the 2010 appraisal report on the performance of the health and social services system has a specific purpose and is designed for readers with potentially different objectives and concerns. Each of these volumes has been summarized in a separate issue to provide a broad overview of its content.

This issue is a summary of Volume 4 of the 2010 appraisal report *Adopter une approche intégrée de prévention et de gestion des maladies chroniques: recommandations, enjeux et implications (Adopting an Integrated Approach to Chronic Disease Prevention and Management: Recommendations, Issues and Implications)*. This final volume concludes the performance appraisal exercise. It presents the Commissioner's recommendations, which emerged from his appraisal process, and analyzes some of their implications.

What is meant by “chronic disease”?

Chronic diseases encompass a series of health conditions that share certain characteristics. They are not contagious: rather, they result from certain lifestyle habits or from biological processes related to genetic endowment or aging. Clinically, they are characterized by a generally slow and insidious onset, their symptoms appear gradually and they are long-lasting. Lastly, they do not resolve spontaneously and generally may not be completely cured.

It is widely recognized that chronic diseases include several health problems affecting the circulatory, respiratory and musculoskeletal systems, along with diabetes and several forms of cancer.

> Introduction

THE OVERALL OBJECTIVE OF THE HEALTH AND SOCIAL SERVICES SYSTEM IS TO PROMOTE HEALTH, PREVENT DISEASE, MAINTAIN AND IMPROVE PEOPLE'S HEALTH AND WELFARE, AND REDUCE INEQUALITIES BETWEEN INDIVIDUALS OR POPULATION GROUPS. IT IS THEREFORE VITAL TO APPRAISE ITS PERFORMANCE IF WE HOPE TO CONTINUALLY IMPROVE IT.

In Volume 4 of the 2010 appraisal report, the first section briefly illustrates the process adopted by the Health and Welfare Commissioner to integrate all the knowledge he gathered and to formulate his recommendations. The second section reports on proposed actions to improve the system's chronic disease management performance and to increase the benefits that this could yield, in light of local and international studies and experiences. This is followed by a snapshot of Québec's current situation for each of the proposed actions and a summary of the key points raised by the Commissioner in support of his recommendations. Each part in the second section ends with a recommendation emerging from the synthesis of the information collected. The third and final section explores the links between the recommendations and their potential for improving the performance of the health and social services system.

> How Did the Commissioner Formulate His Recommendations?

THE PRIORITY RECOMMENDATIONS RETAINED BY THE COMMISSIONER TO IMPROVE THE PERFORMANCE OF CHRONIC DISEASE CARE AND SERVICES ARE BASED ON SEVERAL PARAMETERS. FIRST, THE COMMISSIONER'S COMPREHENSIVE AND INTEGRATED ANALYSIS OF MONITORING INDICATORS AND SURVEYS (THE FOCUS OF VOLUME 1 OF THE 2010 APPRAISAL REPORT) AND HIS STATUS REPORT ON THE TOPIC (THE FOCUS OF VOLUME 2) BROUGHT OUT THE NATURE AND MAGNITUDE OF THE PROBLEMS AFFECTING CARE AND SERVICES. SECOND, THE CONSULTATION PROCESS (THE FOCUS OF VOLUME 3) IDENTIFIED ACTIONS CONSIDERED NECESSARY TO IMPROVE THE SYSTEM'S PERFORMANCE. THESE VARIOUS SOURCES OF INFORMATION WERE ANALYZED IN CONSIDERATION OF A VAST BODY OF QUÉBEC AND INTERNATIONAL SCIENTIFIC EVALUATION STUDIES TO DOCUMENT THE POTENTIAL EFFECTIVENESS AND BENEFITS OF THESE ACTIONS. THE STAKEHOLDERS CONSULTED, INCLUDING DECISION MAKERS, PROVIDED INSIGHT INTO THEIR APPROPRIATENESS AND FEASIBILITY. LASTLY, THE CONSULTATION FORUM'S DELIBERATIONS ON THE ISSUES AND IMPLICATIONS ASSOCIATED WITH THESE ACTIONS WERE TAKEN INTO ACCOUNT.

Findings from the Quantitative Data Analysis

The findings that emerged from the monitoring indicator analysis showed that, on a provincial level, the overall performance of Québec's health and social services system ranks below that of several other Canadian provinces. Problems with structuring resources—especially in terms of earmarking financial resources—and productivity problems place Québec at the bottom of the pack in this regard. Regionally, large variations can be observed, especially in the adaptation and production functions. Some remote regions have improved their ranking year after year for all the performance functions. Lastly, analysis specifically of chronic disease indicators revealed that Québec's situation has improved concerning the lifestyle habits adopted by individuals.

Findings from the Analysis of Québec's Situation

Québec's health and social services system is currently having difficulty providing the most appropriate care and services for people with chronic diseases. The system is in fact oriented primarily to responding to the acute and specific health problems of well-defined diseases that can be managed with periodic and time-limited care. Comprehensive and coordinated chronic disease prevention and management are therefore more challenging. Moreover, some aspects of the current organization of the health and social services system are either inadequate or lacking altogether, which makes it more difficult for it to be responsive to the needs of people with chronic diseases. Needless to say, our system's performance does display some strengths, especially the principle of access to care and services free of financial barriers.

Findings from the Consultations

As part of his work of appraising chronic disease care and services, the Health and Welfare Commissioner consulted experts (clinicians, researchers and analysts in the health and social services system), decision makers (administrative or clinical policy makers) and citizens through his Consultation Forum. These consultation sessions enabled participants to identify different aspects that could have an impact on system performance; to formulate a vision for a high-performance system; to target potential actions to achieve that vision; to determine priority actions to be undertaken in Québec; and to discuss their feasibility. Additional consultations with different health professional groups (GPs, nurses, etc.) were also conducted to enhance, expand or confirm previously gathered information.

Recommendations Based on the Synthesis of the Collected Information

The Commissioner's work addressed a set of possible recommendations, and especially their interrelations. Priority was given to recommendations whose combined action would guarantee positive benefits for the entire system's performance and whose adoption could facilitate the implementation of a broader set of measures. Accordingly, the Commissioner proposed ten recommendations related to five core aspects: health promotion and disease prevention; organization of care and services; clinical practices and care and service delivery; clinical activity planning and management; and financing.

> How to Enhance the Performance of Chronic Disease Care and Services?

Base Improvements on an Integrated View of Chronic Disease Prevention and Management

International assessments have demonstrated several positive outcomes from applying an approach that:

- > combines and integrates actions aimed at care delivery, patients and their families, and the organization itself of care and services;
- > engages people with chronic diseases in managing the care and services appropriate to their health and welfare;
- > offers evidence-based care and services to help providers achieve better adherence to recommended clinical practice guidelines, better control of diseases and greater patient satisfaction;
- > ensures that care and services are better suited to the needs of patients with chronic diseases;
- > capitalizes on interdisciplinary care teams working together to offer responsive and high-quality chronic disease care;
- > is better structured for patients with health conditions that are difficult to manage.

This type of approach was proposed by the authors of the Chronic Care Model (CCM), among others. The CCM is designed to foster more productive interactions between informed, well-equipped patients capable of self-care and well-prepared care teams well-equipped to respond proactively to chronic care needs.

Effects of Integrated Chronic Care Prevention and Management Models

The health systems and organizations that have applied elements from the CCM have in fact improved patient care. Owing to these innovative organizations, we now know the following facts:

- > Self-management support, beyond the provision of information, requires actions enabling patients to acquire knowledge that will help them develop the necessary skills and confidence to better manage their illnesses.
- > Clinical decision support starts chiefly with the actual application of recommended guidelines in daily clinical practice.
- > Clinical information systems that effectively support clinical practice must not only gather data but also make them easier to use so that clinical actions can be readjusted when necessary.

Beyond Integrated Chronic Disease Management: Role of Prevention

The numerous senior executives of systems and organizations that have selected the Chronic Care Model (CCM) and adapted it to their situations have found that chronic disease management involves elements that are part of affected people's lives. These elements are known to have an impact on the development and course of chronic disease and on the way to respond to patient needs. For its part, the Expanded Chronic Care Model (CCM-E), while encompassing these contextual aspects (environmental, social, political, etc.), adds the perspective of health promotion and disease prevention to the CCM. It therefore completes the CCM's clinical perspective and embraces a more population-based approach. That is why the Health and Welfare Commissioner opted to use the CCM-E to build his recommendations on chronic disease management in Québec.

> 1. PROMOTE HEALTH AND PREVENT CHRONIC DISEASES IN COMMUNITIES

While it is recognized that people play a central role in improving and maintaining their health, interventions based solely on getting them to modify their behaviours are limited in effectiveness. Promoting health therefore implies adopting policies, creating healthy environments, increasing people's capacity to improve their health, and integrating preventive practices in primary care and secondary care settings.

1.1 Adopt Policies and Create Healthy Living Environments

Public policies and the creation of healthy living environments are aimed at taking action early in people's lives to prevent or delay the onset of chronic disease and to potentially decrease the burden they place on society. Acting on living environments supports sustainable changes to health determinants and fosters recognized protective health factors. These living or work environments might include neighbourhoods promoting physical activity, workplaces free of health risks, and schools offering nutritious food. Incurring little in the way of costs beyond those needed to apply them, these measures have the advantage of reaching many people, regardless of their socio-economic status.

Although viewed as essential, adopting public policies and creating healthy living environments nevertheless raise questions about the balance to achieve between health priorities and those of an economic, social, political or other nature that may emerge at the same time. The effects of public policies on lifestyles are not solely positive. Some policies contribute to unhealthy behaviours, such as lottery games and the development of polluting industries.

In Québec, the government has put in place mechanisms for analyzing the health impacts of public policies. Section 54 of the Public Health Act is an important legislative tool that governs the appraisal of public policies in relation to their health effects. Various stakeholders are working toward creating environments that foster the adoption of healthy behaviours. They include the Ministère de la Santé et des Services sociaux (MSSS) and the public health network composed of the Institut national de santé publique du Québec (INSPQ), public health directorates (DSPs) of health and social service agencies (ASSSs), and local public health committees of health and social service centres (CSSSs) whose actions are regulated by the national public health program (PNSP) and its ensuing regional and local action plans. Outside the system, key stakeholders include coalitions, private foundations, and associations.

Recommendation 1

Adopt policies and create healthy living environments

- 1.1 The application of the public policy health impact assessment strategy should be extended more systematically to encompass all the ministries and government organizations, and strategies to raise awareness of the importance of such assessments should be implemented.
- 1.2 Intersectoral public policy analysis mechanisms composing the government policy health impact assessment strategy should be evaluated.
- 1.3 The role of public health leaders in preparing health-promoting policies across the province and in coordinating local and regional intersectoral initiatives should be strengthened.
- 1.4 A province-wide prevention policy designed to support local chronic disease prevention programs should be developed.

1.2 Build People's Capacities to Adopt Healthy Lifestyle Habits and to Prevent Chronic Diseases

Building people's capacities to adopt healthy lifestyles has the primary effect of significantly changing public opinion and expectations, given that the population is more empowered to demand health-promoting public policies and living environments. Health literacy, which is increasing in Québec, is one of the core aspects of developing healthy behaviours because it promotes information sharing and access. Another major aspect involves having the health and social services system create venues that provide self-management support and information tools.

Québec is undergoing dramatic changes in the area of adopting positive health behaviours. The prevalence of multiple risk factors is even declining. Various public groups or bodies are highly active in this respect. First, **integrated care networks** are chiefly dedicated to specific health problems or lifestyle habits. **Health education centres** are oriented toward people presenting with chronic disease risk factors but not necessarily with established chronic diseases.

Education institutions are actively involved in developing information courses or sessions that are centred on health and specific diseases, open to the general public and often publicized by stakeholders in the health and social services system. The system is responsible for organizing **large-scale educational awareness campaigns**, including the 0-5-30 program (0 smoking, 5 fruits and vegetables a day and 30 minutes of physical activity a day). Lastly, over the past few years, we have seen the emergence of Web portals dedicated to increasing people's capacities to manage their own health, such as the *Health Guide*.

Recommendation 2

Build people's capacities to adopt healthy lifestyle habits and to prevent chronic disease

- 2.1 Each of the health and social service centres should establish education centres offering information to the general public, along with evaluation and intervention services accessible either directly or on professional referral to people with chronic disease risk factors. Personal health diaries consisting of individualized tracking sheets should be available in health education centres to allow people to keep track of the health actions they take.
- 2.2 The Québec government's *Health Guide* should be advertised to the general public and service providers. Moreover, it would be important to increase its interactive tools so that people can target personal health aspects requiring specific action.
- 2.3 Regional and local roundtables should be established among the different community groups, health education centres, patient associations and system stakeholders concerned to ensure the coordinated planning and communication of actions, promoting healthy lifestyle habits and preventing chronic diseases.

1.3 Promote the Integration of Preventive Clinical Practices into Primary-care Settings

Currently, very little is being done in the area of integrating preventive clinical practices (PCPs), the implementation of which helps bridge the gap between public health and clinical practice settings. The use of PCPs builds clinician-patient relationships that provide opportunities for information and education about health, risk factors or preventive factors, together with healthy behaviours to adopt and unhealthy behaviours to avoid. This relationship must nevertheless be supported by more systemic policies and programs to stimulate and encourage the preventive actions advocated by clinicians.

In the current Québec Public Health Program 2003–2012, PCP promotion and support are objectives in the “Lifestyles and Chronic Diseases” component. Yet recent Commonwealth Fund surveys have indicated that care and services are not optimally structured to foster health promotion and counselling in Québec. These findings are linked to the under-developed organizational structure of primary-care clinics. Even so, various initiatives in Québec are currently under way to change PCP provision.

Recommendation 3

Promote the integration of preventive clinical practices into primary-care settings

- 3.1 Nurses mandated to apply preventive clinical practices (PCPs) should be present in all primary-care clinical settings.
- 3.2 Tools enabling the use of PCPs in care and services should be put in place in clinical settings throughout the prevention continuum (primary–secondary–tertiary prevention). These should include clinical decision support tools, such as electronic preventive care reminders and guidelines integrated into clinical records.
- 3.3 Initial education and continuing professional development programs for both physicians and other health professionals should systematically include components on recommended PCPs and the most effective methods and approaches to ensure their use.

> 2. REVIEW THE ORGANIZATION OF CARE AND SERVICES FROM THE PERSPECTIVE OF CHRONIC DISEASES

2.1 Update Local Care and Service Network Practices

Network practices have been shown to be effective in promoting interprofessional collaboration, knowledge transfer and coordination of care in highly integrated health systems. This type of practice improves service delivery to people with chronic diseases: it improves the coordination of the actions performed by multiple professionals and different service providers to meet diversified needs and to reduce the complexity of navigating through the system. Network practice is even more effective if it is founded on primary care providers able to rely on an organizational structure that allows them to act as hubs.

In Québec, the reorganization of care and services has been ongoing since 2005, following the establishment of health and social service centres (CSSSs). Their mandate is to plan and coordinate services for all providers on a local level. A number of pilot projects have also been launched to improve the coordination of care for specific groups (especially older people and patients receiving mental health services). These various projects have established one-stop portals and predetermined pathways.

Network services are currently delivered in the province by local community service centres (CLSCs) and integrated university health networks (RUIS). However, the linkage between the RUIS and the local service networks (RLS) must be enhanced by means of different levers that will clarify their mandates. Primary-care models, which have more highly developed organizational structures and institutional linkages, should help expand network practice over the next few years.

Recommendation 4

Update local care and service network practices

- 4.1** The process of implementing local service networks should be pursued and intensified to integrate medical clinics and offices, community organizations, other system stakeholders in each jurisdiction and, where applicable, integrated university health networks.
- 4.2** The implementation of family medicine groups and other accredited primary-care models should be pursued so that patients with chronic diseases have access to treatment teams capable of functioning as hubs in the delivery of care and services across the network.
- 4.3** Arrangements for affiliating specialist physicians with primary-care medical clinics should be developed to ensure coverage of local population needs for specialized chronic disease management services. This would be in addition to the concept of referral specialists already highlighted in a recommendation made by the Commissioner in 2009.

2.2 Strengthen Local Care and Service Coordination Mechanisms

Coordination ensures that the same person receives consistent care and services from different organizations and multiple professionals. Coordination problems lead to added costs because of duplicate services and complications arising from services that are inappropriate or that lead to adverse interactions. For patients, these problems cause difficult access to services, and even negative health effects. Coordination also permits efficient use of available resources and improvements in some clinical outcomes.

Strengthening care coordination mechanisms requires using the case-management function, integrating nurse practitioners or pivot nurses, establishing care protocols and clinical practice guidelines, implementing information-sharing mechanisms and developing joint treatment plans. Québec's health and social services system, particularly in terms of its primary care services, is not currently organized to allow the necessary planning mechanisms to be put in place. In fact, various service interruptions persist in the continuum of care and services, regarding both the sequence and coordination of care. A number of Québec initiatives have nevertheless led to improvements to this situation. Some regions have implemented reception and referral mechanisms for their clients, while others have established a case-management function to enhance their response to the needs of people who make extensive use of services.

Recommendation 5

Consolidate local care and service coordination mechanisms

- 5.1** Patient reception and referral mechanisms should be established to direct people and coordinate their care pathways offered by health and social services centres (CSSSs) and all the partners in local service networks (RLSs). This responsibility rests with the CSSS but must be supported by the Ministère de la Santé et des Services sociaux in developing tools for implementing such mechanisms.
- 5.2** Coordinated specialist referral mechanisms incorporating predefined protocols should be implemented in all the CSSSs and health institutions to ensure that the protocols are appropriate.
- 5.3** A complex-case-management function should be introduced in primary care, and patient stratification criteria should be developed to identify which patients would best be served by this function. The upcoming Institut national d'excellence en santé et services sociaux (INESSS), the directorates of the Ministère de la Santé et des Services sociaux (MSSS) and the professionals concerned should be involved in developing such criteria.

2.3 Implement Interdisciplinary Practice Throughout the Continuum of Chronic Disease Care and Services

Interdisciplinary practice requires the involvement of different health professionals (nurse clinicians, pharmacists, respiratory therapists, nutritionists, psychologists, dentists, etc.), to varying degrees and depending on their expertise and on primary care and service needs. Increasing interdisciplinarity has a direct impact on the quality of everything surrounding the provision of care and the performance of the health and social services system. With particular respect to chronic diseases, it favours the provision of preventive services and the adoption of healthy lifestyle habits, reduces the use of some hospital and specialized resources, ensures better quality of care and better continuing follow-up, and builds patients' self-management capacities as part of the care they receive.

Québec's performance is much less effective in terms of interdisciplinary care delivery. Some interdisciplinary models do exist in Québec (CLSCs, family medicine groups, etc.), and they constitute a foundation upon which to develop interdisciplinary service offerings throughout the network.

2.4 Computerize the Health and Social Services System

Implementing some of the components of the Chronic Care Model (CCM) and consequently reorganizing chronic disease care and services are greatly facilitated by computerization, especially the creation of electronic health records, which support coordination, follow-up,

clinical decisions, and interdisciplinary team work. Computerization will also reduce the use of some services, increase the number of scheduled clinical visits and enhance professionals' interactions with their patients (which increases their empowerment in self-managing their illnesses). Computer technology seems to be particularly conducive to screening, prevention, individual counselling and referral to community resources.

A set of prerequisites is nevertheless necessary for information systems to provide benefits: electronic medical records, electronic reminders, clinical management tools, decision support tools, electronic appointment software, and personalized health records. Measures must also be adopted to safeguard personal information, preventing the violation of people's right to privacy.

In Québec, computerization of clinical records is still extremely uncommon, compared with other places with similar characteristics and levels of development. This major shortcoming affects the capacity of clinical settings to generate information relevant to the planning and delivery of care and services. Over the past few years, considerable effort has been devoted to developing the Quebec Health Record (Dossier de santé du Québec – DSQ), which is designed to allow different service points in the health and social services system to share selected clinical information. Moreover, projects to implement electronic medical records in clinics and network institutions are currently under way. One such project involves computerizing FMGs and gradually implementing electronic clinical records in hospitals in some regions of Québec.

Recommendation 6

Computerize the health and social services system

- 6.1** Electronic records containing relevant clinical information should be implemented in all network institutions.
- 6.2** Protocols and arrangements for sharing information in institutions' electronic clinical records should be developed so that practitioners at other service points in the local network can have access to relevant clinical information.

> 3. IMPLEMENT CARE AND SERVICE DELIVERY METHODS RESPONSIVE TO CHRONIC DISEASE MANAGEMENT

3.1 Support the Capacities of People Affected by Chronic Diseases to Participate in Their Care and Services

Training and education provided to people with chronic diseases allow them to manage their care, which used to be the responsibility of health institutions. Besides reducing the use of some services, self-care contributes to better health outcomes by exerting a positive influence on the adoption of healthy behaviours. Patients would also be more confident in their ability to self-manage their health and care, and would be more satisfied with the services received and more likely to comply with their treatments. However, self-care would not be as effective in people less able to self-manage their chronic conditions, including people with several comorbidities, physical limitations or lower education and income levels.

The 2008 and 2009 Commonwealth Fund surveys suggested that, although Québec compares favourably in relation to several self-care aspects, it still has significant progress to make. In fact, the proportion of people who receive treatment instructions or plans or who discuss their treatment priorities or objectives remains low in absolute terms. However, certain initiatives are under way. For example, the online *Health Guide*, the services offered by health education centres, the education networks for some chronic diseases (e.g., asthma, diabetes, congestive heart failure) and interdisciplinary teams all contain a component related to developing self-care skills.

Recommendation 7

Support the development of people's capacities to participate in the care and services for their chronic diseases

- 7.1 Toolkits for developing self-care capacities should be integrated into the *Health Guide* on the *Québec Portal*, into education centre or network programs on specific diseases or risk factors, into the activities of primary-care interdisciplinary teams and into electronic health records (once implemented).
- 7.2 Each health and social service centre should make available directories of local education programs and other resources relevant to developing people's self-care capacities.
- 7.3 Methods should be developed to give people access to relevant information and to the tools contained in their electronic health records so that they can take an active part in caring for and controlling their chronic illnesses.
- 7.4 Initial education and continuing professional development programs for both physicians and other health professionals should systematically include components on self-care education and support and on the best methods and approaches to ensure that they are applied.

3.2 Review the Means to Respond to the Needs of Patients with Chronic Diseases

Various arrangements have been tested with good results in pilot projects and by different health systems around the world to modify the response to the needs of people with chronic diseases: group consultations, peer consultations, electronic and virtual consultations, advanced access programs, and telehealth and community care delivery programs. Yet the use of these new methods remains limited in Québec.

> 4. SUPPORT CLINICAL DECISION AND PLANNING RELATED TO CHRONIC DISEASE CARE AND SERVICES

4.1 Assess the Appropriateness and Effectiveness of the Care and Services Provided to People with Chronic Diseases

The substantial volume of chronic disease care and services and the search for and introduction of new technologies or associated innovative treatments emphasize the importance of assessing the appropriateness and effectiveness of care and services. The interactions between different chronic diseases relative to their causes, treatments and clinical courses lead to the need for an integrated analysis of the appropriateness of the different available therapies. Clinical decision support tools, such as clinical practice guidelines, would be useful for such a purpose. These guidelines, based on the latest evidence, help determine interventions best suited to patient needs. Practice guidelines, especially if integrated into care protocols, also promote consistent complex disease treatments provided by multiple practitioners from complementary disciplines. They also foster health professionals' continuing education and help reduce medical errors and drug interactions.

Several projects in Québec have demonstrated the benefits of implementing care protocols guiding the use of service pathways and referrals for people with chronic diseases. However, the systematic use of practice guidelines is very limited in Québec. This finding emphasizes the need to draft adapted clinical practice guidelines. These will soon be produced in Québec by an agency that will be mandated to establish practice guidelines and care pathways or protocols: the Institut national d'excellence en santé et services sociaux (INESSS), soon to be created from the merging of the Agence d'évaluation des technologies et des modes d'intervention en santé (AETMIS) and the Conseil du médicament.

Recommendation 8

Assess the appropriateness and effectiveness of the care and services provided to people with chronic diseases

- 8.1 The application of clinical practice guidelines and care and service protocols should be developed, promoted and evaluated to determine the actions to be carried out and the most effective service delivery methods for our context and also from the broader perspective of chronic diseases.
- 8.2 Clinical quality indicators integrated into electronic primary, secondary and tertiary care records should be defined and implemented.

4.2 Implement Clinical Governance Tools

Clinical governance corresponds to care and service management designed to plan and coordinate the action of the entire treatment team in a seamless and complementary way. Initiating it requires sound knowledge of different populations' health status and care and service needs.

Clinical decision support tools, especially electronic ones that offer practitioners recommendations in real time, improve the quality of preventive and curative care. Some tools, such as reminder systems and prescription drug or dosage systems, are effective for modifying clinical practices and increasing their compliance with guidelines. Other tools also fulfill several chronic disease management aspects, such as laboratory test prescriptions, patient education, and care coordination, organization and quality assurance. They help reduce the number of errors, rapidly detect potential treatment problems, and support self-management for people with chronic conditions.

Although the Commonwealth Fund's 2009 survey illustrated our network's limited clinical governance capacity, current medical practice offers a real opportunity for change. In actual fact, the Québec physicians consulted rarely considered the time they spent doing administrative tasks or obtaining medications for their patients to be a problem. This situation with its limited administrative constraints, which stands out from contexts in which insurance companies or other healthcare funding agencies exercise far greater control, makes it easier to invest in clinical care management.

Recommendation 9

Implement clinical governance tools

- 9.1 Clinical management tools should be integrated into electronic medical records throughout the continuum of chronic disease care. These clinical management tools could include practice guidelines or pharmacological profiles integrated into patient records, electronic alerts concerning aspects such as laboratory test results or potential drug interactions, chart modules allowing analysis of temporal trends in clinical outcomes, and computer-based patient information materials.
- 9.2 Indicators on patient needs and care and service outcomes should be defined and implemented to support clinical planning and governance throughout the continuum of chronic disease care and services.
- 9.3 Initial and continuing education programs for both physicians and other health professionals should systematically include components on the use of clinical governance tools promoting skill development in clinical information analysis and continuing improvements in quality care.

> 5. ENSURE ONGOING AND CONSISTENT FINANCING FOR CHRONIC DISEASE CARE AND SERVICES

5.1 Review Public Coverage of Chronic Disease Care and Services

In Québec, publicly insured care and services are those delivered by physicians, in hospitals or in CSSSs, along with some services provided by health and social service agencies. Other professional services and residential care services are only partially covered. This explains why more than one third of health expenses in Québec are paid for out of pocket.

It has been demonstrated that people with chronic diseases who do not receive comprehensive services from their usual care providers incur significant expenses linked to unmet needs or delays in the provision of certain services. The decision makers and experts consulted were unanimous over the need to review the public coverage of chronic disease care and services.

5.2 Integrate Care and Service Funding for People with Chronic Diseases and Decentralize the Resource Allocation Process

Owing to the complexity of chronic disease care, which requires the intervention of several professionals across the continuum, it is necessary to integrate care and service funding and to decentralize resource allocation processes. Integrated funding would make better use of available funds, in relation to population needs, rather than funding based on the perspective of historical budget allocations.

In Québec, despite the fact that the health and social services system is funded by a single payer, several budget envelopes are managed in silos: decision makers and administrators often have little control over various chronic disease care and service funding aspects, such as physician compensation, drug funding or specific institutions' budget allocations. The lack of integration reduces the capacity to transfer funds between budget envelopes based on needs or on the relative costs of services.

5.3 Implement Financial Incentives to Improve Care and Service Quality and Responsiveness to Population Needs

In an effort to improve care and service quality and the response to population needs, the chief incentive proposed is payment to clinics based on achievement of care and service quality performance targets. However, financial incentives must be combined with other incentives of an organizational or systemic nature to maximize their impact and reduce the occurrence of negative effects.

Recommendation 10

Ensure ongoing and consistent financing for chronic disease care and services

10.1 Public coverage of chronic disease care and services should be reviewed:

1/ The upcoming Institut national d'excellence en santé et services sociaux (INESSS) should be mandated to assess chronic care medical services with a view to recommending the most appropriate publicly covered service offerings.

2/ The Ministère de la Santé et des Services sociaux should create a working group that would be composed of different stakeholder representatives and citizens and would be responsible for issuing advisory opinions on the best ways to extend public coverage for non-medical services for chronic diseases and for non-institutional services to provide an equitable response to the full range of needs of people with chronic diseases.

10.2 Steps should be taken to develop and evaluate demonstration projects on the regional integration of budget envelopes specifically for chronic diseases.

10.3 Compensation arrangements for clinics should be introduced and subject to achievement of performance targets relative to selected quality indicators for chronic disease care.

> Overview of the Recommendations

Cohesive set of recommendations

The cohesive set of recommendations set out in this fourth volume of the 2010 appraisal report contains key conditions for strengthening our health system and preserving its capacity to respond to the population's growing chronic care needs. All the recommendations formulated here take act on the onset of chronic health conditions through concerted initiatives responding both to population needs and to pre-existing health problems.

Interactive recommendations

The ten recommendations must not be considered in isolation from one another. In fact, they are often complementary because some are necessary for others to be implemented or they act together synergistically. It is worth noting that network computerization and interdisciplinary practice are key to implementing most of them. It is also necessary to innovate in order to build our capacity to act in the face of growing needs. New delivery models, such as group consultations and electronic clinical surveillance, can in fact reduce the pressure on existing resources.

Recommendations designed to increase appropriateness and quality

Being effective is not always a matter of doing more but of doing otherwise, or even less. All the recommendations are designed to enable teams to offer the services necessitated by patients' health conditions, to avoid the provision of services that are less beneficial for them and to prompt patients to receive care that they would not have asked for spontaneously but that will have a significant impact on their health.

The recommendations also strive to reduce the use of physician services for conditions that really require other professional services and to decrease the use of hospital emergency department services.

Timely implementation of the full set of recommendations

The set of recommendations must be implemented promptly and gradually if we are to make gains and consolidate the desired improvements. Making headway in each recommendation will make it easier to implement the others. We must take advantage each time a policy is amended or a change is made to a living environment to make the right social decisions, namely, those that will help create health-promoting environments. Each year, when we collectively make decisions on policies or communities, let us strive to make the right choices for sustainable development by favouring each and everyone's mid-term and long-term health.

> Conclusion

This summary presentation of the Commissioner's recommendations on chronic disease care and services provides a clearer understanding of the adjustments to be made to better equip network clinics and administrators to meet the challenge that health problems pose throughout people's lives. Chronic diseases appear in early childhood and now affect a majority of the population for several years. We are increasingly living with chronic diseases. We must ensure that the decisions we make with respect to building living environments and developing social or health policies promote everyone's health.

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