ECCO—A Disruptive Health-Care Innovation Whose Time Has Come

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Integration is at the heart of health reform and high-performing health systems globally (Kodner, 2009). It is essentially about creating connectivity, alignment and collaboration within and between the cure and care sectors (Kodner & Spreeuwenberg, 2002). Without integration at various levels of the health system, patients get lost, needed services fail to be delivered, or are delayed, quality and patient satisfaction decline, and the potential for cost-effectiveness diminishes (Kodner, 2011). Integrated care is what happens when the processes of integration are successfully applied on the macro (policy), meso (provider organization) and micro (patient or clinical) levels. While the meaning of "integrated care" can be elusive, most now would agree that it is a holistic, population-based, person-centred approach to addressing the multiple needs of individuals with complex conditions who frequently suffer gaps in services, disjointed care, and suboptimal quality (Kodner, 2012a).

If appropriately designed and implemented, effective efforts to bring together systems, services and care in an integrated way can achieve the 'triple aims' in health-care, i.e., improve patient experiences, enhance the health of populations, and achieve cost-effectiveness. Better integrated or coordinated care is especially crucial in enabling the frail elderly, and growing numbers of people with multi-morbid chronic conditions, severe physical disabilities,

developmental or cognitive impairments, and serious mental illness and addiction problems to live healthier, more fulfilling and independent lives.

History informs us, however, that making integrated care work is very difficult (Goodwin, Smith et al., 2012). Indeed, many integrated care programs around the world have disappeared, largely the result of poorly conceived or hastily put together policy and program designs which turned their backs on the accumulating evidence. That is why RNAO's white paper on *Enhancing Community Care for Ontarians (ECCO)* (2012) is such a compelling prescription. It sounds the alarm about Ontario's costly, inherently bureaucratic, and largely one-size-fits-all approach to integrating services and supports for patients in need of community care, and marshals the best evidence available to chart a promising new direction for the province.

The proposed ECCO model would return the all-important case management, care coordination and system navigation functions from structures external to the existing health and long term care system to community-based, inter-professional primary care organizations such as the Community Health Center (CHC), Nurse Practitioner-led clinic (NPLC), Family Health Team (FHT), and Aboriginal Health Access Centre (AHAC). These organizations, which know their patients and communities intimately, would serve as system, service and care 'integrators', that is, as health-care homes or hubs responsible for a comprehensive range of services. Primary care providers and care coordinators (case managers) would work as a close-knit team to craft care, link needed health and community services, quickly respond to changing

needs, and focus on promising population health opportunities including health promotion and prevention.

Implementation of RNAO's three year plan also promises to free-up badly needed funds to expand eligibility for home care and other support services which are currently rationed through a narrow, rules-based regime. And it would make the Local Health Integration Networks (LHINs) responsible for planning and commissioning the likes of a truly integrated health-care system, including the hospital, primary care (starting initially with the Community Health Centres), home health and community care, and long term care sectors.

ECCO comes to us as a 'disruptive innovation'—an unexpected, but potentially transformative strategy that could turn health-care in Ontario on its head. Because the new model promises to greatly improve accessibility and quality for the most vulnerable of patients and also make better use of public funding—especially during these times of fiscal constraint—it demands serious consideration by policy-makers, provider organizations, professionals, advocates and citizens alike. Therefore, it would be useful to briefly examine the strengths of the ECCO model through the evidence-based lens of integrated care.

While different approaches to integration can work depending on the particular goals and context, there are three important lessons we have learned that strongly support the ECCO framework:

Lesson #1: Focus on service solutions before structural or organizational integration.

The most common mistake in forging integrated systems, services and care is to start with organizational integration (Goodwin, 2012). Indeed, creating an organizational structure is neither necessary nor sufficient to deliver the benefits of integrated care (Ham & Curry, 2011). What matters first and foremost is designing the mechanisms to coordinate care for individual patients and caregivers. Establishing an appropriate structure—either real or virtual—to support these patient-level activities should follow. The Community Care Access Centre (CCAC) model is, unfortunately, an example of starting the integration journey with the building of a new, bureaucratic organizational layer. Not only does this excess structure represent an inefficient and costly duplication of roles and functions of the existing health-care system, but experience also tells us that it can and often does get in the way of achieving optimum performance and outcomes.

Lesson #2: A 'bottom-up' approach is the right way to foster integrated care.

This is in a way an analogue of the lesson above. Integrated care can no more be designed by the CCACs than by Kings Park. We have known for a while that one-size-fits-all approaches are anathema to integrated care, and that top-down, centralized, prescriptive approaches are less effective than those tailored to localities—with their unique needs, health-care ecosystems and cultures (Darzi & Howitt, 2012; Kodner & Spreewenberg, op cit). Integrated care demands a new set of behaviours, routines and ways of working. These can only be worked out by weaving together the many facets of health-care—especially the local professionals and provider organizations involved—within the context of neighborhood or

community and as close to the patient as possible. The promise of integrated care can only be achieved when patients, families, providers and communities are engaged collectively and as individuals in the process of integrating the health-care system from the bottom-up.

Lesson #3: Integrated care does best when aligned with the primary care system.

The most successful integrated care programs, that is, with the best outcomes, are closely aligned with primary care practitioners—family physicians, nurse practitioners, and nurses (Kodner, 2012b). In a way, one can say that primary care is one of the key foundations of integrated care. Primary care practitioners actively engaged in integrated care programs play a key role in inter-professional team care. They provide comprehensive first contact and continuing care to patients with high-risk and complex conditions, coordinate their care on an ongoing basis, and are involved in chronic disease prevention and management. By embedding the case management, care coordination and system navigation functions in the primary care setting and expanding the reach of these practices and teams to community care, ECCO would substantially enhance the integration of care, thus improving coordination, continuity and transitions, reducing service delays, avoiding costly hospital re-admissions, improving overall quality and personal health outcomes, and empowering patients and families.

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Integrated care is off and running in Ontario, but seemingly in the wrong direction. In response, RNAO has offered a bold, evidence-driven vision to transform the community care sector by strengthening it through closer collaboration with an emerging province-wide network of primary care organizations whose mission would be to provide complete care

coordination and system navigation for all Ontarians. In addition, RNAO has proposed to free up community care funds by decommissioning the CCACs, and shift responsibility to the LHINs for integrated, system-wide planning and service contracting.

There is much to be done over the proposed three-year transition period. Two additional tasks are important to mention: First, priority attention should be given to developing a more concise way of measuring the integrated outcomes of these primary care organizations—including patient experience—in order to enhance their clinical performance and effectiveness. This can be especially challenging, given the complex nature of integrated health-care delivery. Second, new payment arrangements should be considered to reward better coordinated care and improved patient experience and outcomes, particularly for complex, difficult to manage populations.

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