HOW DO YOU DESIGN AND BUILD SUCCESSFUL APPROACHES TO INTEGRATED CARE?

Dr Nick Goodwin & Dr Lourdes Ferrer
on behalf of the Project INTEGRATE consortium

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Workshop Agenda

1. What is integrated care and why is it needed?
2. What makes for success in deploying integrated care?
3. The Project INTEGRATE evaluation: discussion
What is Integrated Care?
A new idea?

The idea is not new – concern about lack of integrated care, particularly physical/mental health, goes back thousands of years.

This concern today focuses on fractures in care systems and service delivery that allow individuals to ‘fall through the gaps’ in care – e.g. primary/secondary care, health/social care, mental/physical health care.

Approaches that seek to address fragmentation of care are common across many health systems, and the need to do so is increasing as more people live longer and with complex co-morbidities.
Who is integrated care for?

• Integrated care is an approach for any individuals where gaps in care, or poor care co-ordination, leads to an adverse impact on care experiences and care outcomes.

• Integrated care is best suited to frail older people, to those living with long-term chronic and mental health illnesses, and to those with medically complex needs or requiring urgent care.

• Integrated care should **not** be solely regarded as a response to managing medical problems, the principles extend to the wider definition of promoting health and wellbeing

• Integrated care is most effective when it is population-based and takes into account the holistic needs of patients. Disease-based approaches ultimately lead to new silos of care.
Integrated care is centred around the needs of service users

Integrated care means different things to different people – there is no universally accepted definition.

‘The patient’s perspective is at the heart of any discussion about integrated care. Achieving integrated care requires those involved with planning and providing services to ‘impose the patient’s perspective as the organising principle of service delivery’ (Shaw et al, 2011, after Lloyd and Wait, 2005)
Integration and Integrated Care

**Integration** is the combination of processes, methods and tools that facilitate integrated care.

**Integrated care** results when the culmination of these processes directly benefits communities, patients or service users – it is by definition ‘patient-centred’ and ‘population-oriented’

**Integrated care** may be judged successful if it contributes to better care experiences; improved care outcomes; delivered more cost-effectively

‘Without integration at various levels [of health systems], all aspects of health care performance can suffer. 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 and Spreeuwenburg, 2002, p2)
Key forms of integrated care

- Integrated care between health services, social services and other care providers (horizontal integration);
- Integrated care across primary, community, hospital and tertiary care services (vertical integration);
- Integrated care within one sector (e.g. within mental health services through multi-professional teams or networks);
- Integrated care between preventive and curative services;
- Integrated care between providers and patients to support shared decision making and self-management;
- Integrated care between public health, population-based and patient-centred approaches to health care. This is integrated care at its most ambitious since it focuses on the multiple needs of whole populations, not just to care groups or diseases.

Source: adapted from International Journal of Integrated Care
Integration without care co-ordination cannot lead to integrated care

Effective care co-ordination can be achieved without the need for the formal (‘real’) integration of organisations. Within single providers, integrated care can often be weak unless internal silos have been addressed. **Clinical and service integration matters most.**
Why Integrated Care is Needed
Ageing society = greater demand

By 2034, >85s will represent c.5% of the population in Western Europe.
Care Systems in Europe are Failing to Cope with Complexity

The complexity in the way care systems are designed leads to:

- lack of ‘ownership’ of the person’s problem;
- lack of involvement of users and carers in their own care;
- poor communication between partners in care;
- simultaneous duplication of tasks and gaps in care;
- treating one condition without recognising others;
- poor outcomes to person, carer and the system

Frontier Economics (2012) Enablers and barriers to integrated care and implications for Monitor
The promise of integrated care

The hypothesis for integrated care is that it can contribute to meeting the “Triple Aim” goal in health systems

• **Improving the user’s care experience** (e.g. satisfaction, confidence, trust)

• **Improving the health of people and populations** (e.g. morbidity, mortality, quality of life, reduced hospitalisations)

• **Improving the cost-effectiveness** of care systems (e.g. functional and technical efficiency)
The Integrated Care Challenge in Europe

• Age-related chronic conditions absorb the largest, and growing, share of health/social care activities
• Poor co-ordination of care for people with long-term/complex illnesses leads to poor care experiences and adverse outcomes
• There is growing evidence in favour of different approaches to integrated care in improving care experiences and outcomes for people more cost-effectively
• As a result, strategies of care co-ordination to create more integrated, cost effective and patient-centred services are growing internationally
• However, there is a lack of knowledge about how best to apply care co-ordination in practice
• Many integrated care programmes have not been successful in meeting their objectives and the failure rate amongst them is high
European Strategies
Key Examples

- Denmark & Norway: Coordination Reform
- Sweden: Joint agencies link funding and delivery (e.g. Jönköping & Nortallje)
- England: The National Collaborative for Integrated Care and Support (Pioneers)
- Germany: Versorgungsstrukturgesetz (care structure law) supports interdisciplinary and cross-sector models of care
- Netherlands: Managed care organizations and bundled payments for certain diseases
- Health and social care integration in Northern Ireland, Scotland and Wales
- Spain: vertically and horizontally integrated care organizations to support better chronic care (e.g. Basque Country, Catalonia, Valencia)
- Switzerland: physician networks and HMOs

http://ec.europa.eu/research/innovation-union/index_en.cfm?section=active-healthy-ageing
## European Innovation (Kluge, 2013)

<table>
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<tr>
<th>Country</th>
<th>Aims</th>
<th>Description</th>
<th>Outcomes</th>
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| Estonia | To fully integrate communication between providers through a national electronic health records | • National HER hosting 3000+ services with companion service for insurance system and claims  
• Costs $10USD per person to operate | • Efficiency gains through direct communication between providers  
• Increased patient engagement via personal records and mobile telehealth |
| Germany | To implement care pathways for selected treatments and focus on rehabilitation so people can return to work | • Prime contractor model – managers, case manager, care professionals  
• Selected procedures | • Patients treated in integrated networks return to work 72 days earlier than those on conventional care pathways |
| Hungary | To coordinate the delivery of health and social care services at a primary care-level using capitated budgets | • Capitated budget for group practices  
• Incentives based on savings for reinvestment in care | • Improved collaboration  
• Decrease inappropriate service use  
• Increase preventative care |
| Israel | To develop an integrated people-centred network of primary, secondary and specialist care incl. pharmacies | • Services adapted to population sub-groups  
• Priority investment in continuity of care, care transitions | • Prevention of hospital re-admissions  
• More care at home  
• Meets patient preferences better |
Understanding How to Implement Integrated Care Successfully is Complex
The complexity of integrated care

• No 'best practice' model of integrated care exists for all situations.
• Integration in care is unlikely to follow a single path and variations are likely to be important dependent on the context in which they are delivered (no one size fits all).
• Multiple modalities and degrees of integration can coexist within a single system.
Understanding integrated care’s complexity: many taxonomies

Different taxonomies of integrated care include:
• types of integration (e.g., organisational, professional, functional);
• breadth of integration (e.g., vertical, horizontal, virtual);
• degree of integration (i.e., across the continuum: linkage, co-ordination to full integration); and
• processes of integration (i.e., cultural and social as well as structural and systemic).

However, few attempts seek to understand the full complexity of integrated care – i.e. that it results from activities undertaken at multiple levels (e.g., systemic, organisational, professional)
Figure 1 Fulop’s typologies of integrated care (from Lewis et al 2010)

- Organisational integration, where organisations are brought together formally by mergers or through ‘collectives’ and/or virtually through co-ordinated provider networks or via contracts between separate organisations brokered by a purchaser.

- Functional integration, where non-clinical support and back-office functions are integrated, such as electronic patient records.

- Service integration, where different clinical services provided are integrated at an organisational level, such as through teams of multidisciplinary professionals.

- Clinical integration, where care by professionals and providers to patients is integrated into a single or coherent process within and/or across professions, such as through use of shared guidelines and protocols.

- Normative integration, where an ethos of shared values and commitment to co-ordinating work enables trust and collaboration in delivering health care.

- Systemic integration, where there is coherence of rules and policies at all organisational levels. This is sometimes termed an ‘integrated delivery system’.

Source: Adapted from Fulop et al (2005)
‘Health in all policies’ + coherence of health policies from different levels

How and where organisations/providers are brought together

Non-clinical support & back office functions to support integrated care

Multi-professional teams/networks with the right skill-mix

Care from a range of providers that is integrated into a coherent process

Bio-psycho-social approach starting from needs of service users

Adapted from Pim Valentijn et al (2013)
What do we know about the components that are needed for the successful adoption of integrated care?
Many frameworks have ‘listed’ the components necessary to support integrated care.

e.g. Chronic Care Model (Ed Wagner et al)

![Image of the Chronic Care Model (Wagner et al. 1999)]
Some work has drawn on lessons from experience to examine key criteria for success:

1. Find common cause
2. Develop shared narrative
3. Create persuasive vision
4. Establish shared leadership
5. Understand new ways of working
6. Targeting
7. Bottom-up & top-down
8. Pool resources
9. Innovate in finance and contracting
10. Recognise ‘no one model’
11. Empower users
12. Shared information and ICT
13. Workforce and skill-mix changes
14. Specific measurable objectives
15. Be realistic, especially costs
16. Coherent change management strategy
Few framework have ‘listed’ HOW the components combine together to support integrated care.

e.g. Development Model for Integrated care (Minkman)
Approach to Evaluation

- Integrated care is a ‘complex intervention’ – multi-component, dynamic, and context/client specific
- Difficulty of understanding cause and effect
- In-depth case studies using mixed methods

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<tr>
<th>Beveridge – type</th>
<th>Disease</th>
<th>Conditions driven</th>
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<tbody>
<tr>
<td>COPD / Spain</td>
<td>B</td>
<td>Mental Health / Sweden</td>
</tr>
<tr>
<td>Diabetes / Netherlands</td>
<td>A</td>
<td>Geriatric Care / Germany</td>
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A = KSF associate with the focus: Disease / Condition
B = KSF associated with the type of health systems (Beveridge / Bismark)
C – Common Key Success Factors – Summary
Use of multi-level framework for analysis to identify transferable lessons between contexts and settings.
Methodological approach
Examination of dynamics at and between different levels

Cross-cutting themes

- Financial Flows (WP8)
- IT management (WP10)
- HR management and skill mix (WP7)
- Care process design (WP6)
- Patient involvement (WP9)

Collection of data at different levels and from different sources

Examination of interplay between different levels over time and in different contexts
Case Example: COPD

1. Home Hospitalization & Early Discharge

Key Aims

• Provide acute, home-based, short-term interventions aiming at fully (hospital avoidance) or partially (early discharge) substituting conventional hospitalisation
• Reduced number of readmissions/emergency bed days
• Shorten overall length of stay

Approach:

• Comprehensive patient assessment at ER of health and social care needs
• Individually tailored care plan
• Educational programmes to support self-management
• Home visits by nurse specialists
• Telehealth-enabled case management
Case Example: COPD

2. Prevention of Exacerbations

Key Aims

• Reduce number of exacerbations
• Decrease use of health resources (admissions, ER visits, outpatient appointments, primary care use)
• Optimise medications use
• Increase patients’ self-management skills

Approach:

• Comprehensive patient assessment at discharge of health and social care needs
• Individually tailored care plan
• Case co-ordination between specialist nurse case managers in hospital and primary care teams
• Educational programmes to support self-management
• Telehealth-enabled case management and follow-up
DISCUSSION:
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Presenters’ Contacts

Dr Nick Goodwin & Dr Lourdes Ferrer
International Foundation for Integrated Care

nickgoodwin@integratedcarefoundation.org
lourdesferrer@integratedcarefoundation.org

@goodwin_nick @IFICinfo

www.integratedcarefoundation.org
Project Integrate Contacts

Dr Magda Rosenmuller & Lucinda Cash-Gibson

magda@iese.edu
lcashgibson@iese.edu

www.projectintegrate.eu

@proj_integrate