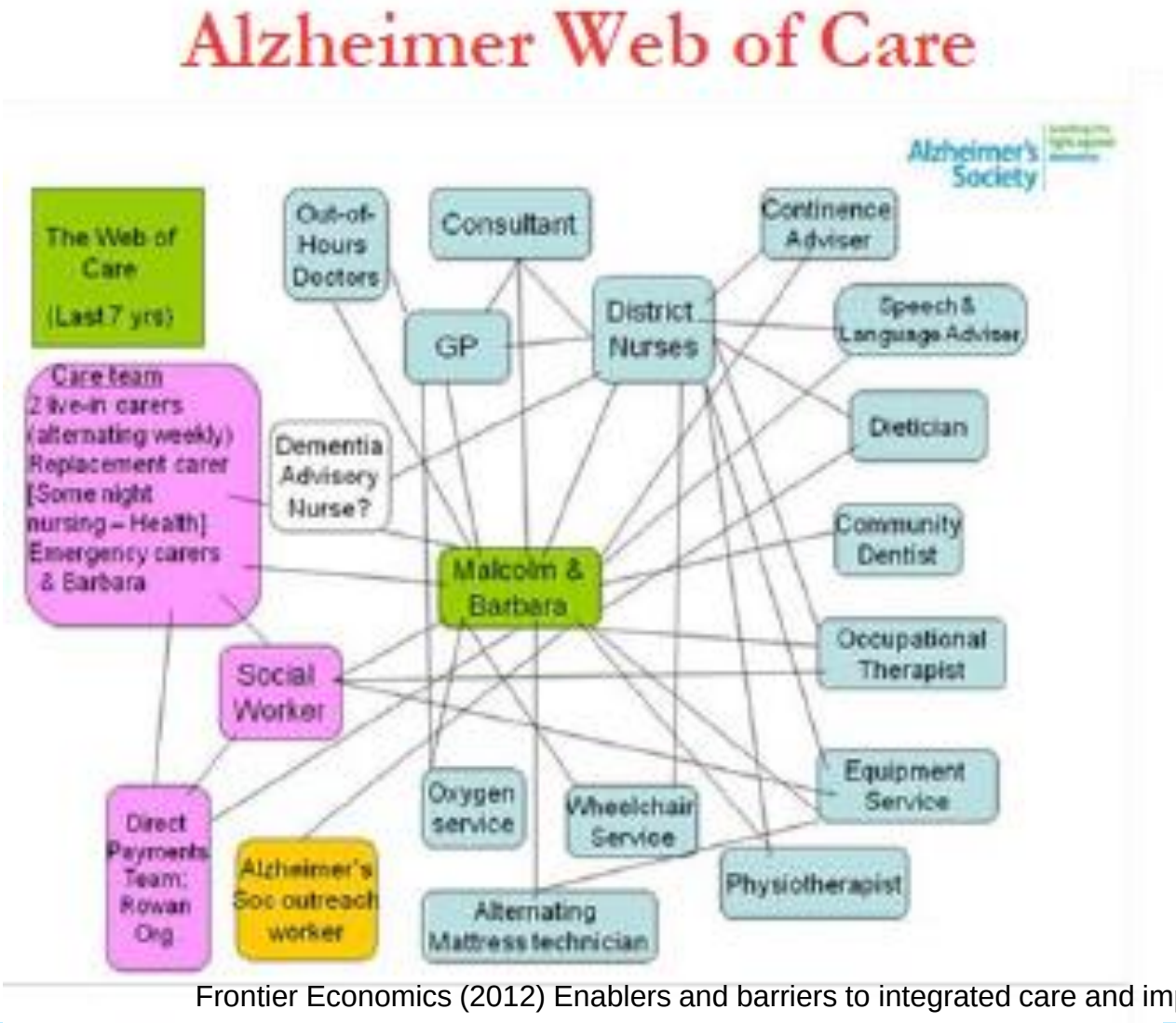
Key principles of integrating care: evidence, lessons and examples from around the world

Dr Viktoria Stein
Head of the Integrated Care Academy©
International Foundation for Integrated Care

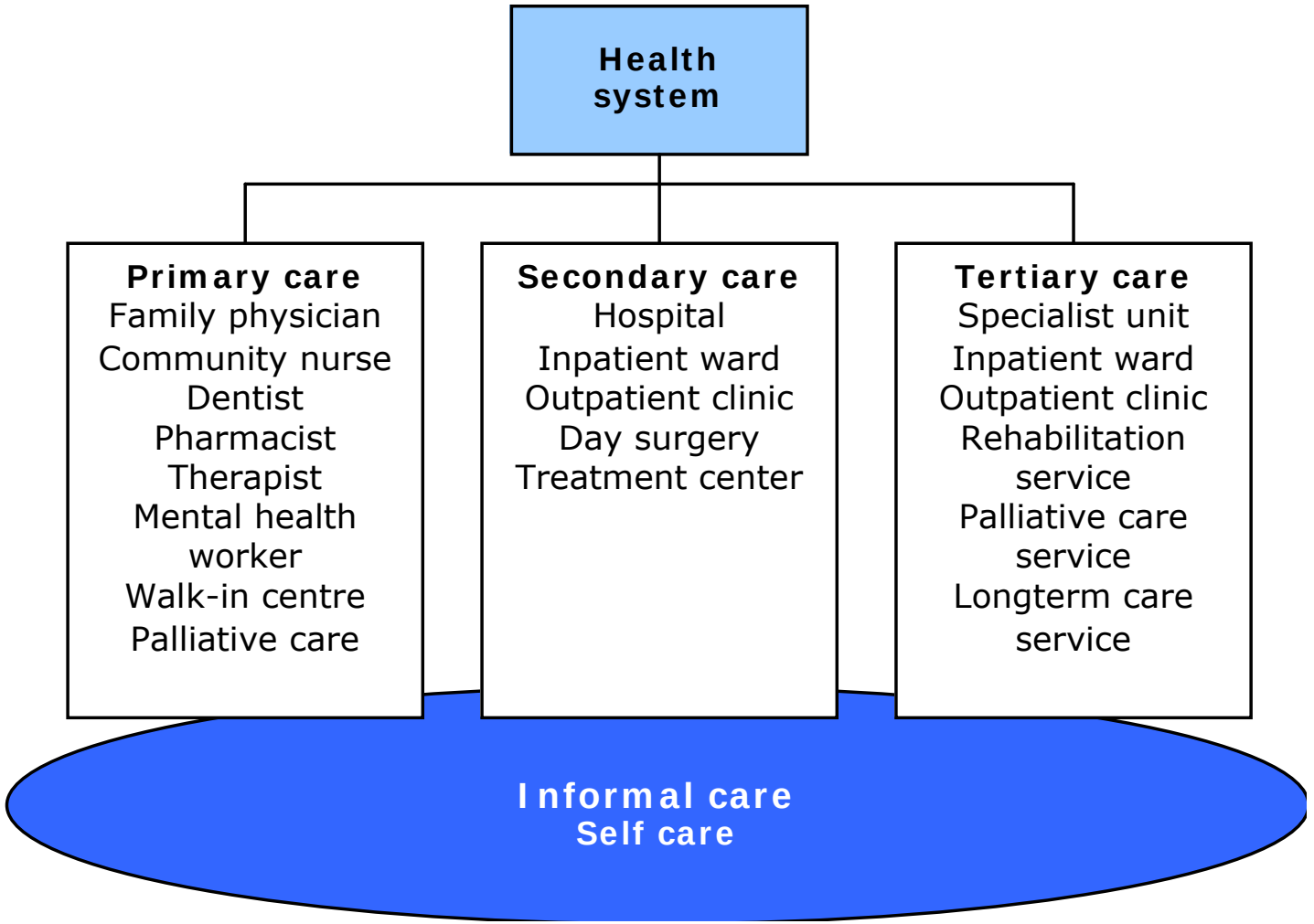
Problem statement

Designing Better Care for Malcolm and Barbara



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

The traditional health system structure



Adapted from Goodwin 2008 and 2014

The social services

DEFINING SOCIAL SERVICES

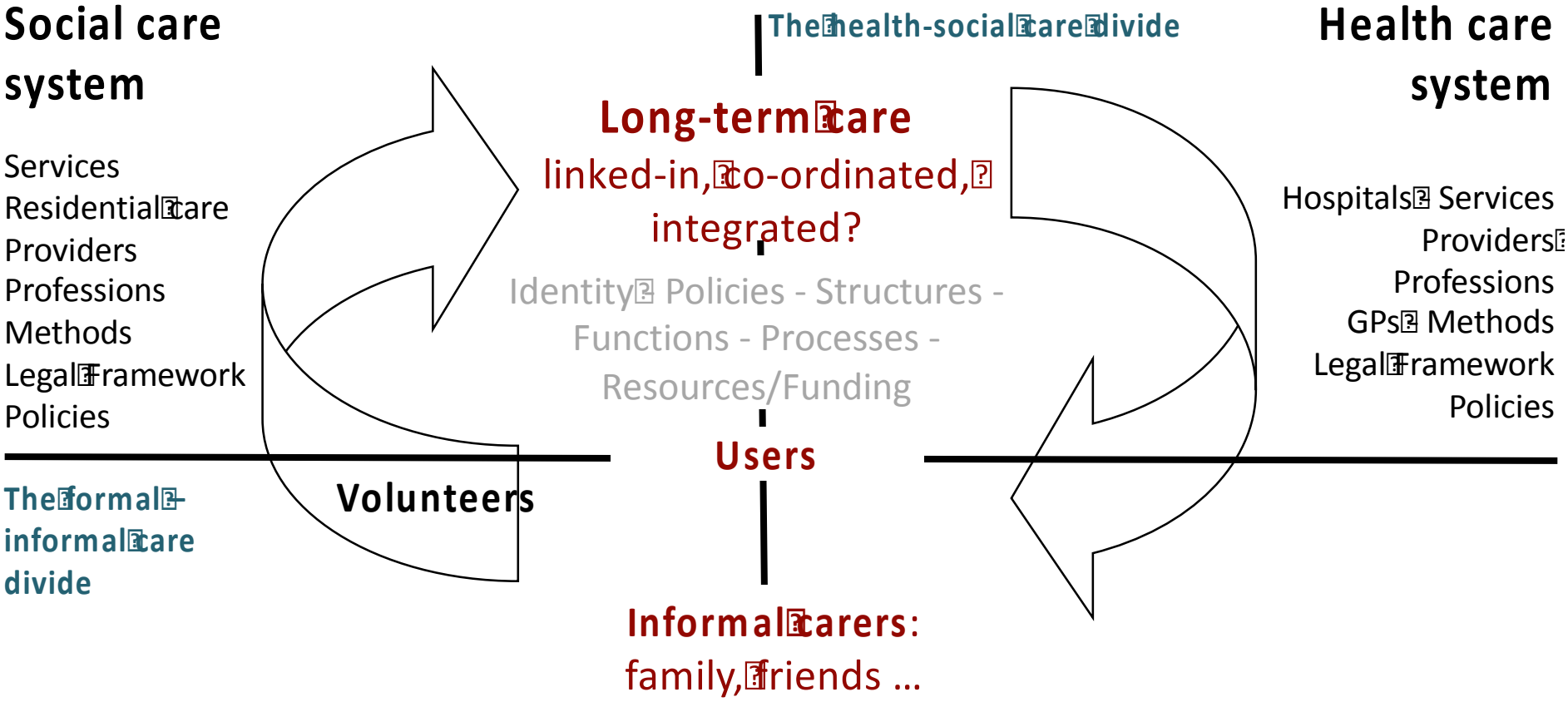
Social services, social welfare, social protection, social assistance, social care, social work, 'personal social services'

Emphasis on **'personal services'** designed to meet an individual user's needs (foster care placement) VS. social services for categories of citizens (unemployment benefit)

Why integration?

Definitions

Emerging long-term care systems



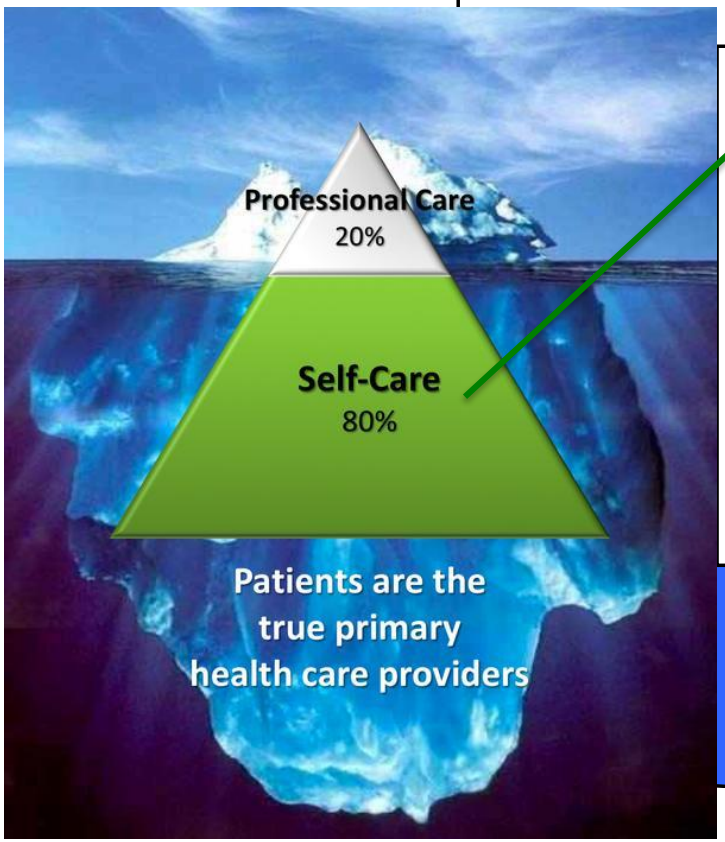
Leichsenring et al., 2013; http://interlinks.euro.centre.org

The reality of care: patients manage themselves already

Hours with professional / NHS = 3 in a year

Health system

- Need for people engagement
- Need for patient empowerment



Secondary care
Hospital
Inpatient ward
Outpatient clinic
Day surgery
Treatment center

Tertiary care
Specialist unit
Inpatient ward
Outpatient clinic
Rehabilitation service
Palliative care service
Longterm care service

Informal care
Self care

Hours of self care = 8757 in a year

Adapted from Goodwin 2008 and 2014

The Situation of carers in Europe: The personal is political

- Across Europe, unpaid family carers and friends are the largest providers of health and social care support
- As demographic change increases demand, the ‘balance of care’ increasingly shifts to informal care
- Women are disproportionately affected and are more likely to give up employment to care
- Estimates on the economic value of unpaid informal care in EU Member States range from 50 to 90 percent of the overall costs of “formal” long-term care provision
- Estimated value of contribution made by carers in the UK: 140 billion € per year
- Estimated value of contribution made by carers in Ireland: 5,3 billion € per year (27% of Dept. of social protection’s budget)

Source: Eurocarers, Stecy Yghemonos, Alpbach 2016

Key problems of fragmented systems

- **a lack of ownership** from the range of care providers to support 'holistic' care needs, driven by silo-based working and separate professional and organisational systems for governance and accountability;
- **a lack of involvement of the patient/carer** in supporting them to make effective choices about their care and treatment options or enabling them to live better with their conditions through supported self-care and empowerment strategies;
- **poor communication between professionals** and providers, exacerbated by the inability to share and transfer data, silo-based working, and embedded cultural behaviours;
- **care and treatment by different care providers for only a part of their needs**, rather than seeing the person as a whole and managing all of the needs;
- the resultant **simultaneous duplication of care** (e.g. repeated tests or re-telling of a person's medical history) **and gaps in care** (e.g. as appointments are missed or information and follow-up is not applied);
- **a poor and disabling experience for the service users** as information is hard to get hold of, differing advice and views are presented, confusion is created in the next steps of a course of illness;
- **reduced ability for people to live and manage** their needs effectively; and ultimately
- **poor system outcomes** in terms of the inability to prevent unnecessary hospitalisations or long-term residential home placements

Goodwin N, Alonso A (2014) Understanding integrated care: the role of information and communication technology in Muller S, Meyer I, Kubitschke L (Eds) Beyond Silos: The way and how of eCare, IGI Global

What is integrated care?

Many definitions for Integrated Care

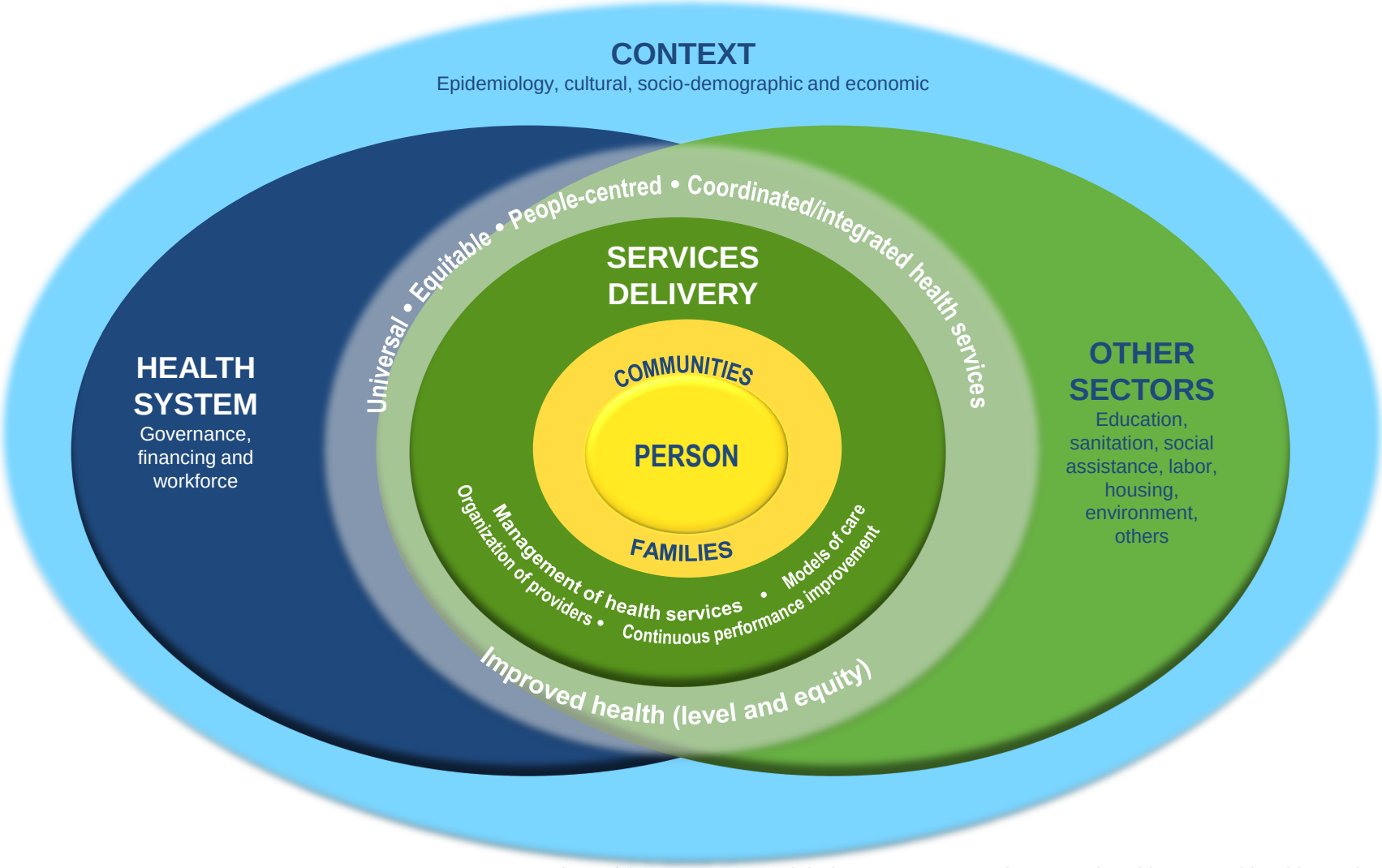
A "Systems" Definition

"...the search to **connect the healthcare system** (acute, primary medical, and skilled) **with other**

human service systems (e.g., long-term care, education, and vocational and housing services)
to improve clinical outcomes (clinical, satisfaction, and efficiency)."

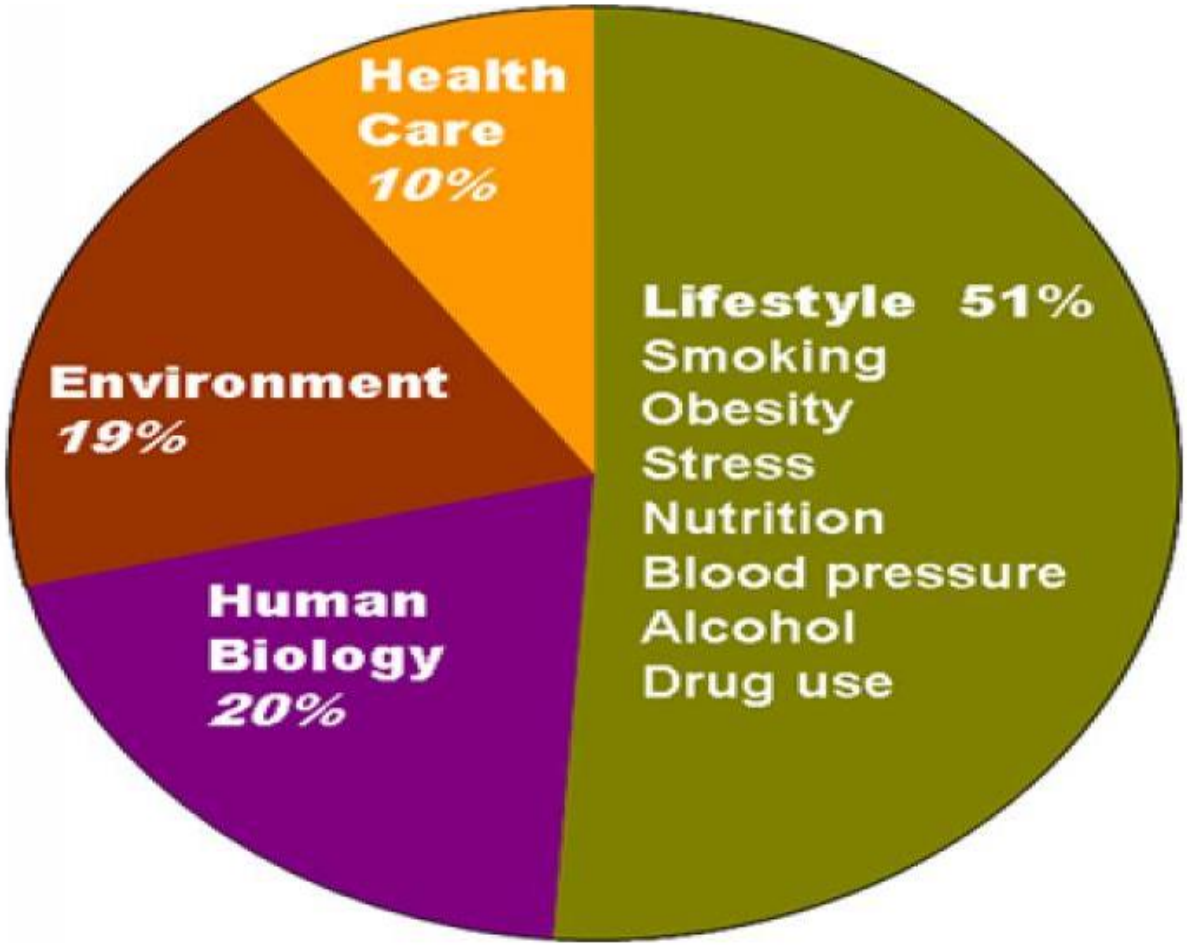
Leutz 1999

Whole-of systems and health in all policies approach for integrated care



Source: Adapted from WHO-HQ Global Strategy on people-centred and integrated health services 2015

Focus on holistic approach to health



Schroeder, Steven A., We Can Do Better -- Improving the Health of the American People, N Engl J Med 2007 357: 1221-1228

Project CHAIN, Wales

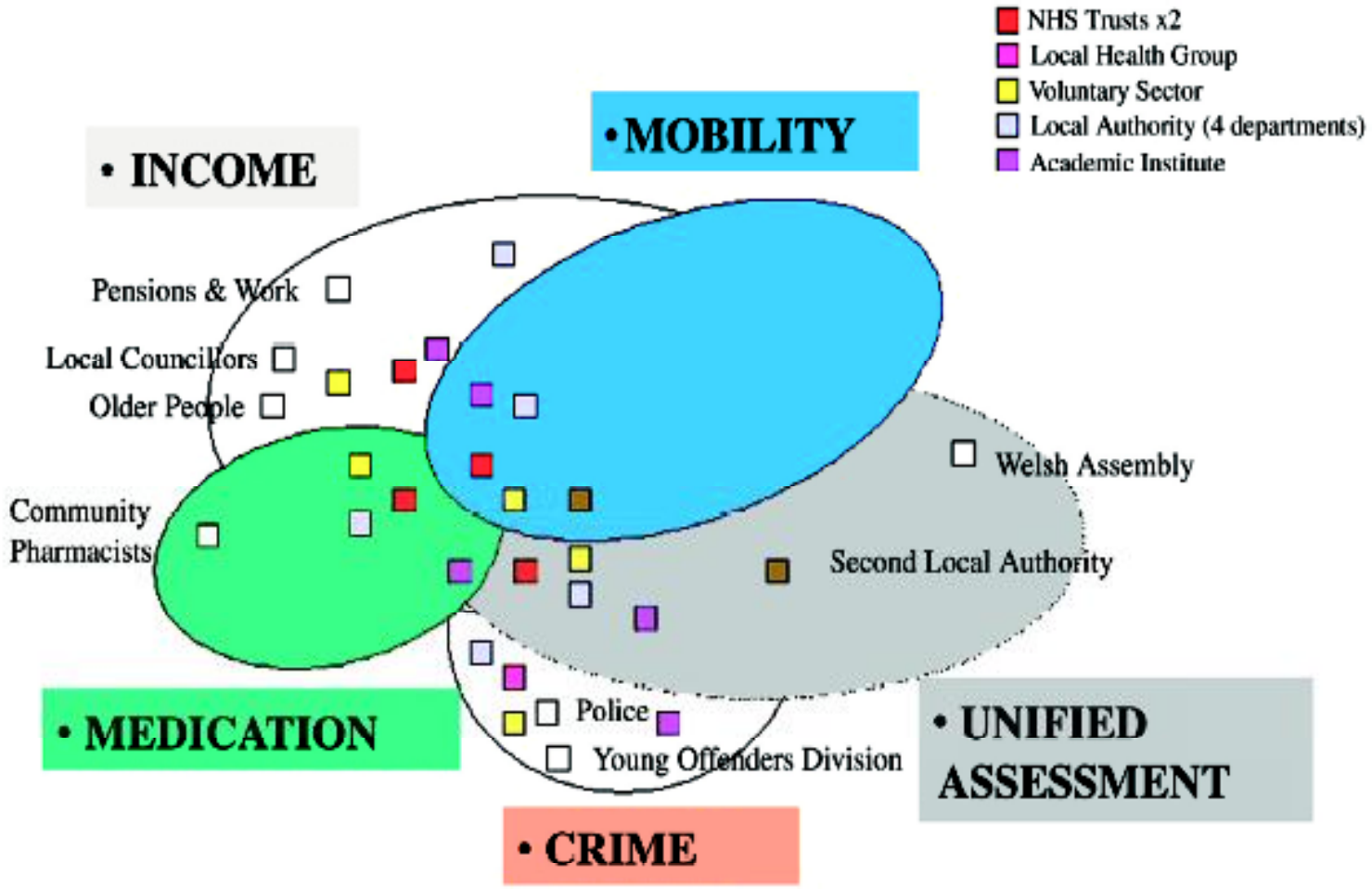


Figure 3. Integrating the Integrated Networks.

Warner M, Gould N. Integrated care networks and quality of life: linking research and practice. IJIC 2003

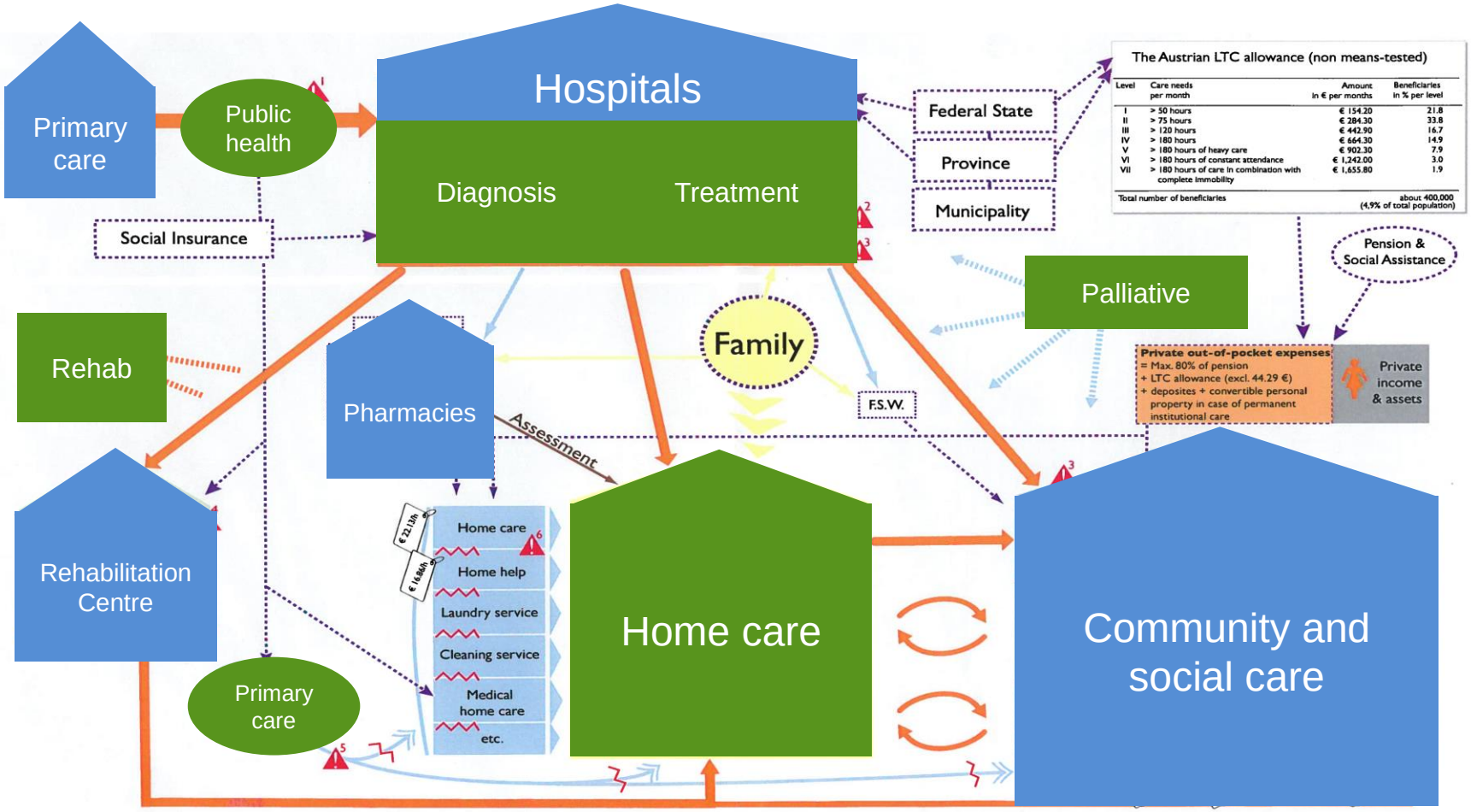
Many definitions for Integrated Care

A "Process" definition:

"...a coherent **set of methods and models** on the **funding, administrative, organizational, service delivery and clinical levels** designed to create **connectivity, alignment and collaboration** within and between the **cure and care sectors**...[to]...enhance **quality of care and quality of life, consumer satisfaction and system efficiency** for **patients with complex problems** cutting across multiple services, providers and settings."

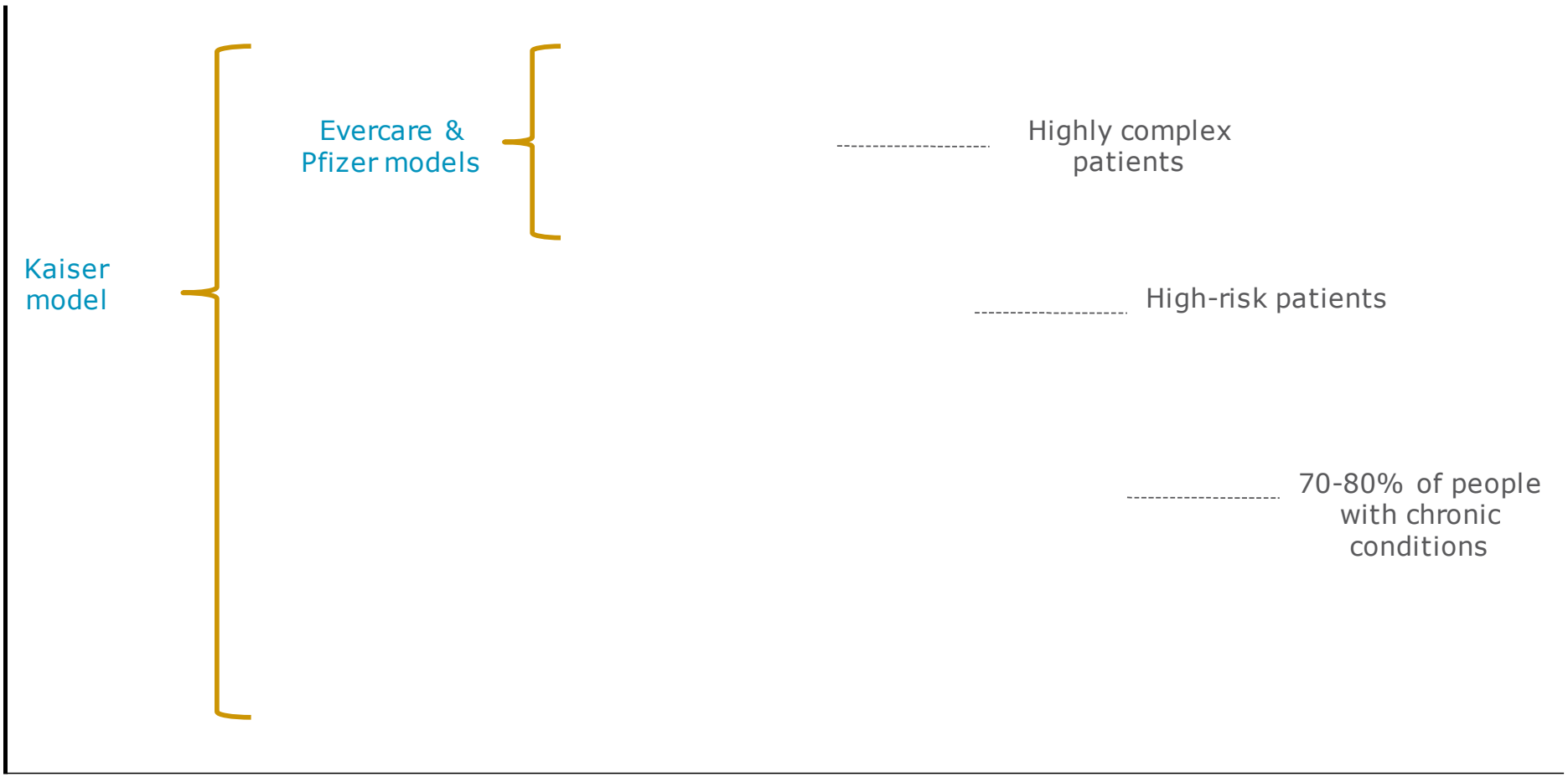
Kodner & Spreeuwenberg, IJIC 2002

The complexity of modern long-term care delivery



Source: Pathways for long-term care provision in Austria, Interlinks, European Centre 2009

The Kaiser Triangle



Source: Goodwin, based on Singh and Ham, 2006

Many definitions for Integrated Care

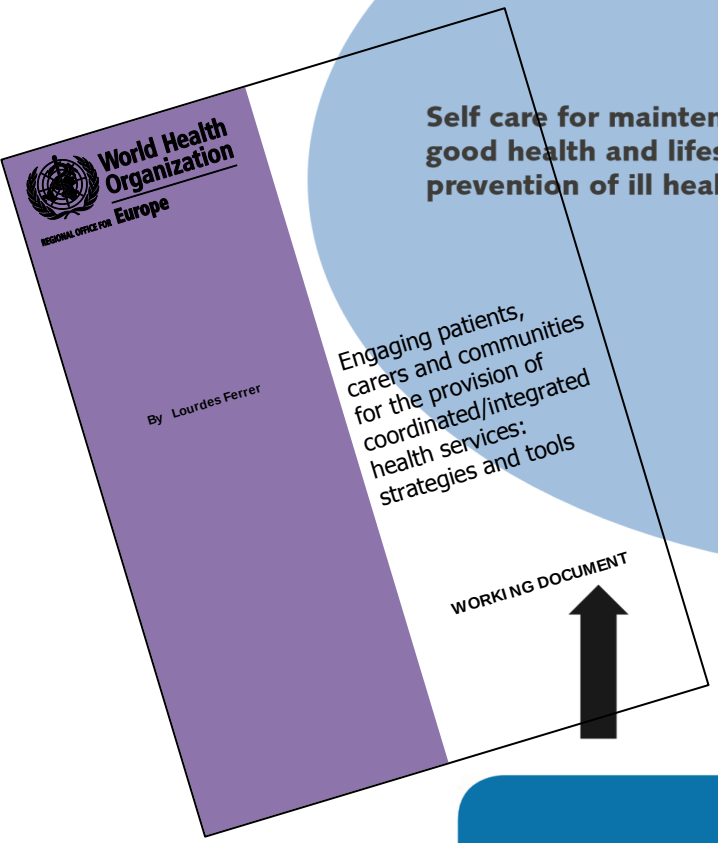
A patient's definition:

"**I can plan my care** with people who **work together** to **understand me** and my carer(s), **allow me control**, and **bring together services** to achieve the **outcomes important to me**."

National Voices 2013

“Apprehension, uncertainty, waiting, expectation, fear of surprise, do a patient more harm than any exertion.”

(On Nursing, Florence Nightingale, 1820-1910)



Self care for maintenance of good health and lifestyle and prevention of ill health

Self care of minor ailments

Professional care of minor ailments

Self care of long term conditions

Professional care of long term conditions

Self care of acute illness

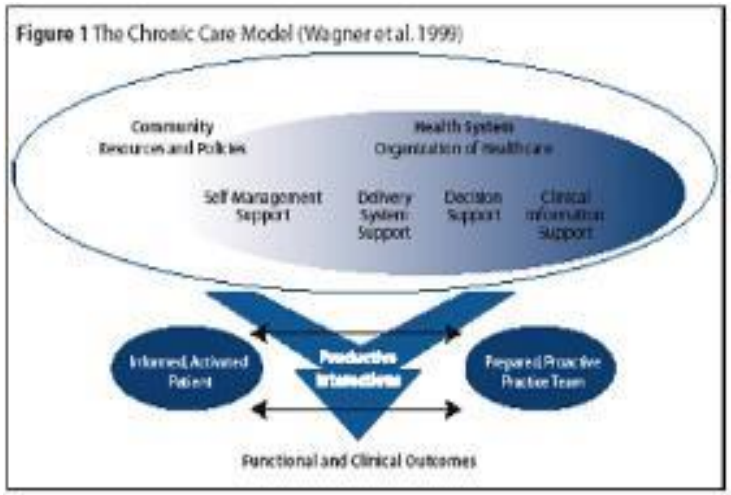
Professional care of acute illness

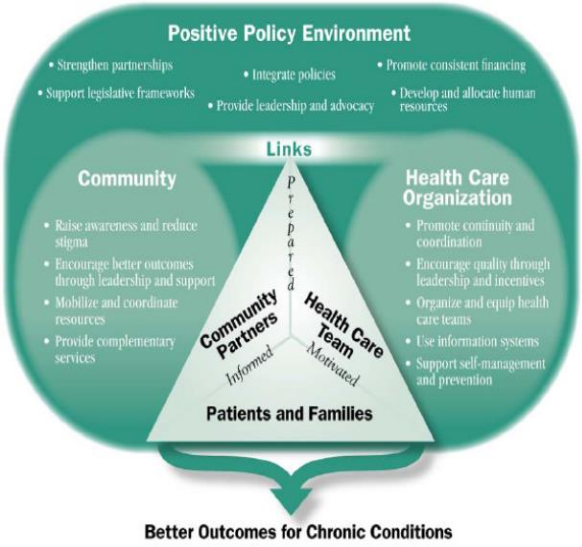
Self care support

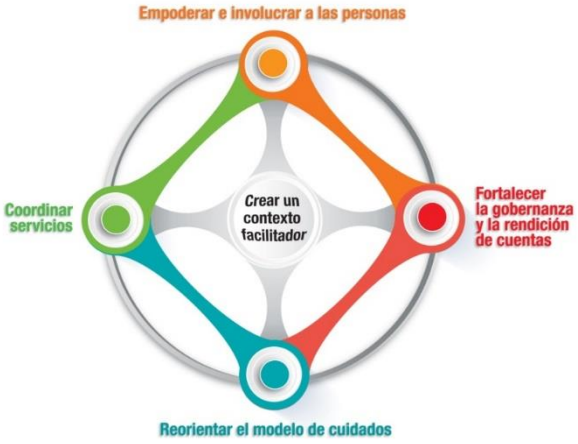
- Patient education
- Self care skills training
- Health & social care information
- Care plan approach
- Self diagnostic tools
- Self monitoring devices
- Peer support networks
- Home adaptations

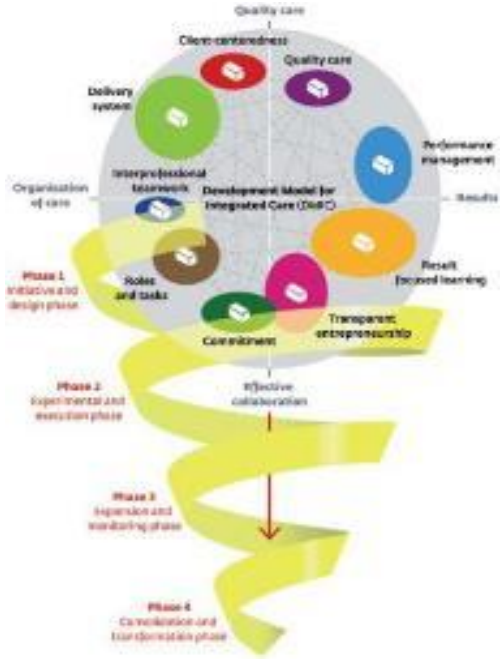
Key ingredients for integrated care: lessons learned and evidence

Many Frameworks Have Been Developed to Understand The Key Elements for Successful Integrated Care!









The WHO European Framework for Action on Integrated Health Services Delivery

PEOPLE

- Identifying health needs
- Tackling determinants
- Empowering populations
- Engaging patients

SERVICES

- Reorienting the model of care
- Organizing providers & settings
- Managing services delivery
- Improving performance

SYSTEM

- Rearranging accountability
- Aligning incentives
- Preparing a competent workforce
- Promoting rational use of medicines
- Innovating health technologies
- Rolling out e-health

CHANGE

- Strategizing with people at the centre
- Implementing transformations
- Enabling sustainable change

The European Framework for Action on Integrated Health Services Delivery: an overview. WHO Regional Office for Europe, Copenhagen 2016

The WHO European Region:
53 Member States – 900 Mio inhabitants
10 Lessons learned from 85 cases across the Region

1. Put people and their needs first
2. Reorient the model of care
3. Reorganize the delivery of services
4. Engage patients, their families and carers
5. Rearrange accountability mechanisms
6. Align incentives
7. Develop human resources for health
8. Uptake innovations
9. Partner with other sectors and civil society
10. Manage change strategically

WHO Regional Office for Europe. Lessons from transforming health services delivery: Compendium of initiatives in the WHO European Region. WHO, Copenhagen 2016

Focusing on Quality of Life

- **More effective approaches:**
  - Population management
  - Holistic, not disease-based
  - Organisational interventions targeted at the management of specific risk factors
  - Interventions focused on people with functional disabilities
  - Management of medicines
- **Less effective approaches:**
  - Poorly targeted or broader programmes of community based care, for example case management
  - Patient education and support programmes not focused on managing risk factors

BMJ

BMJ 2012;345:e5205 doi: 10.1136/bmj.e5205 (Published 3 September 2012) Page 1 of 10

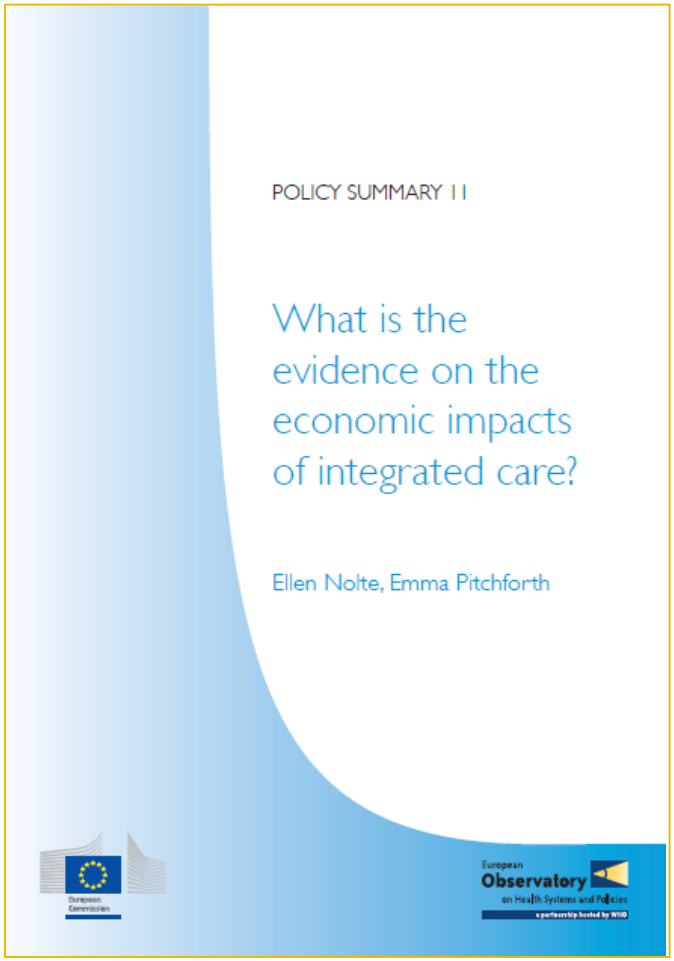
RESEARCH

Managing patients with multimorbidity: systematic review of interventions in primary care and community settings

OPEN ACCESS

Susan M Smith *associate professor of general practice*[1], Hassan Soubhi *adjunct professor of family medicine*[2], Martin Fortin *professor of family medicine*[2], Catherine Hudon *associate professor of family medicine*[2], Tom O'Dowd *professor of general practice*[3]

The Need for More Evidence



Systematic review looked at impact on utilisation, cost effectiveness and expenditure across 19 studies:

- Range of population groups (but not multiple morbidity)
- Not ‘explicit’ on nature of integrated care
- Different focus of ‘type’ of approach – e.g. horizontal and vertical
- Most focused on hospital utilisation through (re)admissions, lengths of stay and ED visits
- Cost reduction is reported, but scale of results difficult to determine as not always quantified and mostly without controls
- Evidence on cost-effectiveness poor
- Heterogeneous nature of complex service innovations mean that few conclusions can be drawn

Some lessons learned

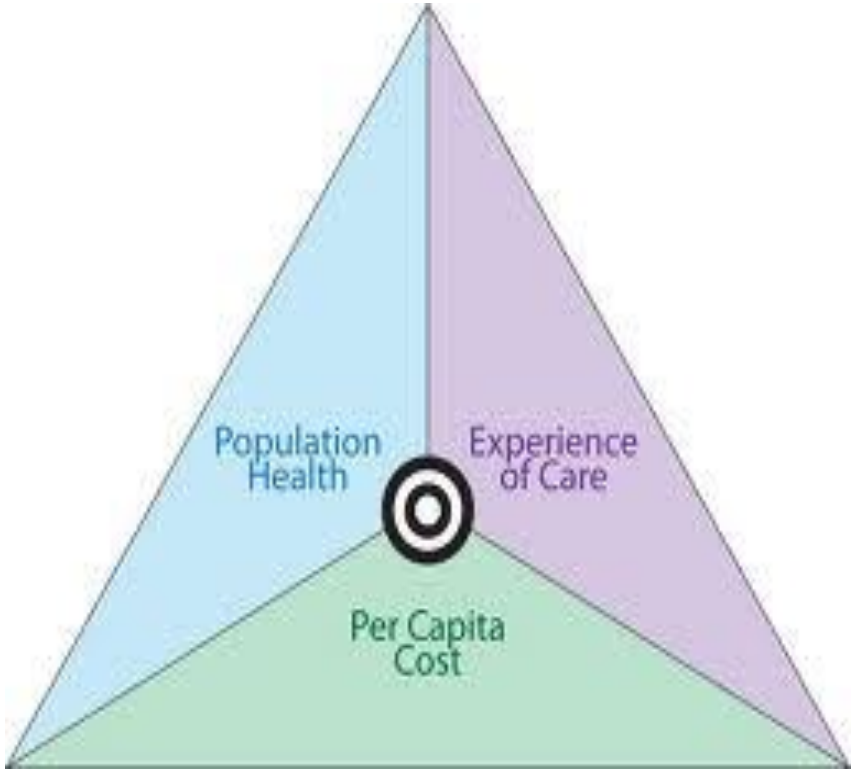
- **Structural integration by itself does not foster integrated care** – the approach needs to focus on strategies for co-ordination at a clinical and service level
- **The needs of people and populations must come first** – the people's perspective should be the organising principle through which strategies are framed
- **No one size fits all** – there is no single model for integrated care and the approach needs to work around the specifics of local contexts
- **Cultural norms and attitudes matter greatly** – building social capital through engagement and empowerment takes time and energy, but is ultimately a catalyst for sustainable change
- **Effective leadership and management for integrated care across care systems is key** – professionals and managers working together with communities to develop shared objectives, social contracts and fostering distributed leadership and commitment

The King's Fund 2014

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)



So what does it need to create sustainable integrated care?

Integrated care is a concept centred around the needs of service users

'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)

Community Engagement
Nuka Health System, Alaska

Mission:

Working together with the Native Community to achieve wellness through integration if health and other services

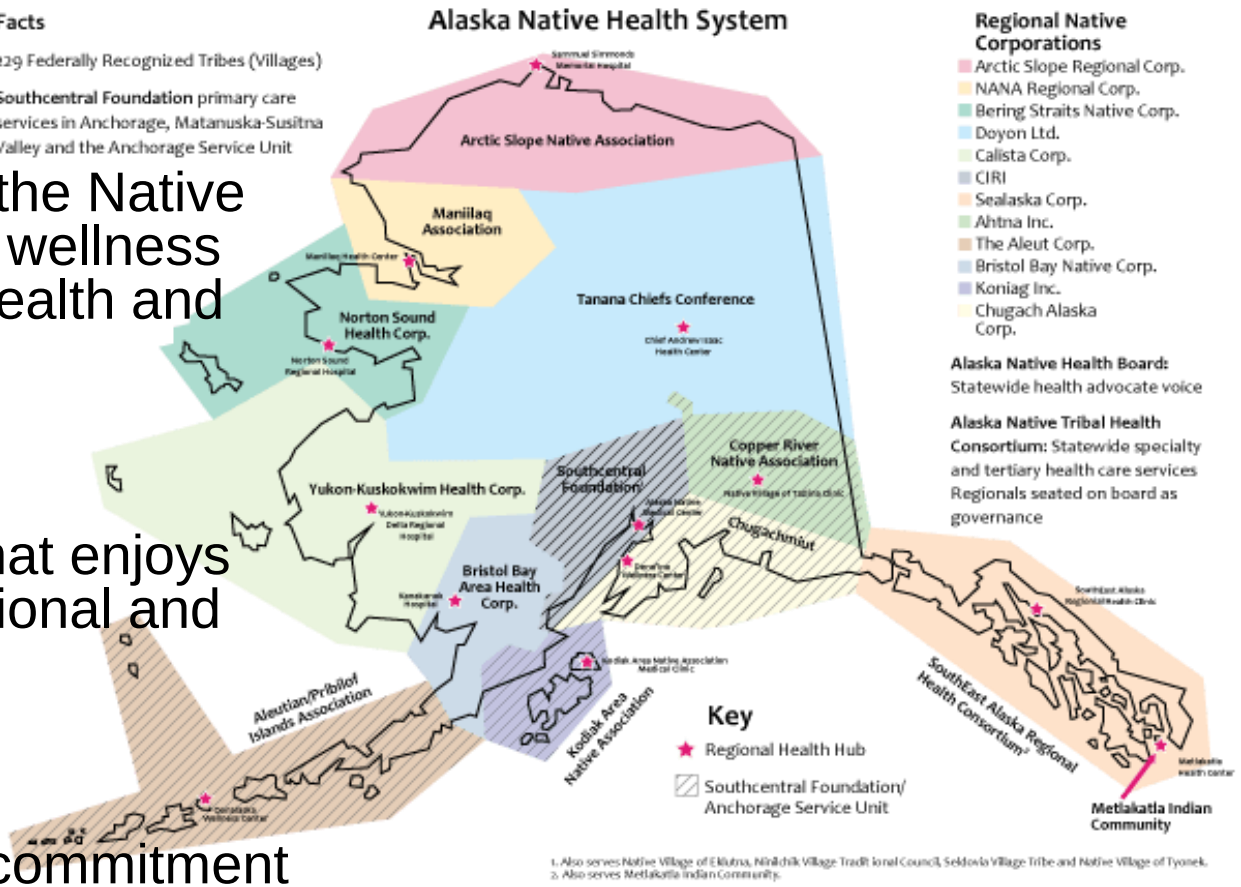
Vision:

A Native Community that enjoys physical, mental, emotional and spiritual wellbeing

Key approach:

Shared responsibility, commitment to quality, family wellness

"Consumer-owners"



FEATURED PRESENTATIONS

The Nuka System of Care: improving health through ownership and relationships

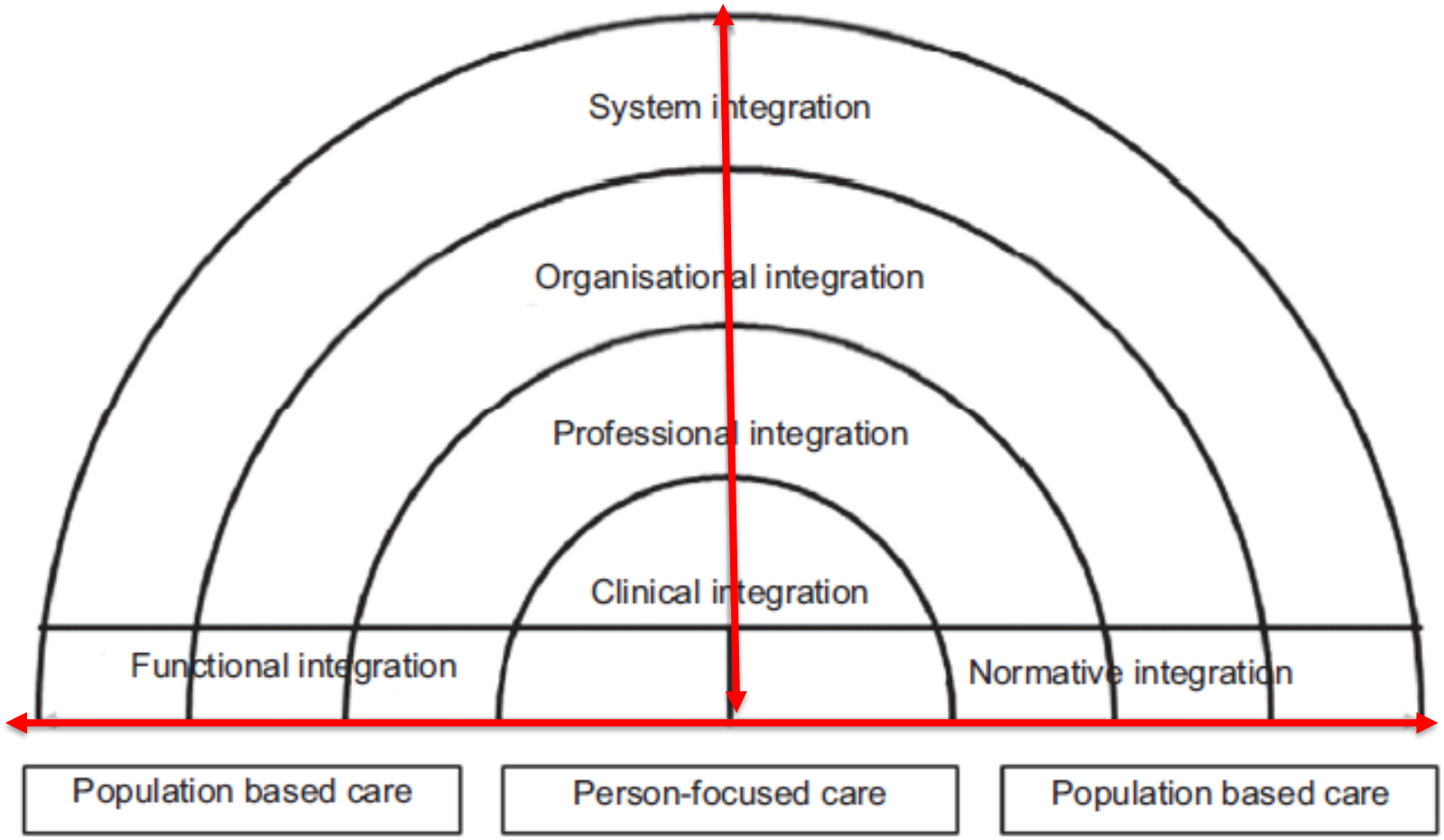
Katherine Gottlieb*
Southcentral Foundation, Anchorage, AK, USA

- Alaskan Native leadership has ownership and management of care system since 1997
- 60000 people south of Anchorage and spread across 1800km of land and islands
- Range of services including:
  - inter-disciplinary primary care,
  - dentistry and optometry,
  - behavioural health,
  - patient education and peer2peer health promotion
  - home care – case management
  - telehealth with self-management of chronic illness
- Focus on rights and responsibilities approach

Some results since 1996-present:

- 95% enrolled in primary care, up from 35%
- Same day access for routine appointment, down from 4 weeks
- Waiting list for behavioural health consultation eliminated
- 36% reduction in hospital days
- 42% reduction in ER
- 58% reduction in specialist clinics
- High patient satisfaction with respect to culture and traditions
- Staff turnover reduced by 75%

The ‚Rainbow Model‘: Interventions on all levels



Valentijn P et al (2015) Towards an international taxonomy of integrated primary care: a Delphi consensus approach. BMC Fam Pract, 16(1):64-015-0278-x

It needs senior leadership and a top-down/bottom-up approach

TOP-DOWN

STANDARIZABLE INTERVENTIONS

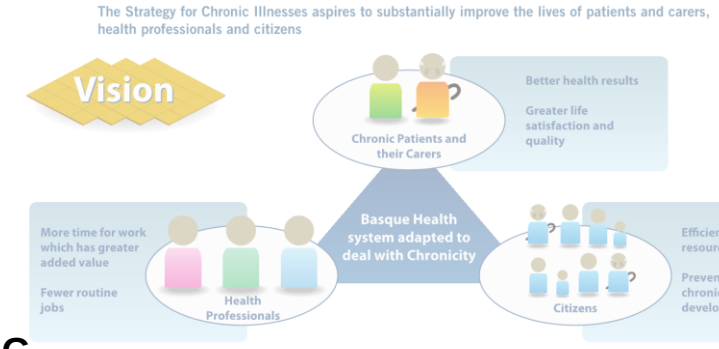
STRATIFICATION

CALL CENTER

ELECTRONIC MEDICAL RECORD

FINANCING AND JOINT COMMISSIONING

ELECTRONIC PRESCRIPTION



BOTTOM UP

LOCAL INNOVATION

CASE NURSING

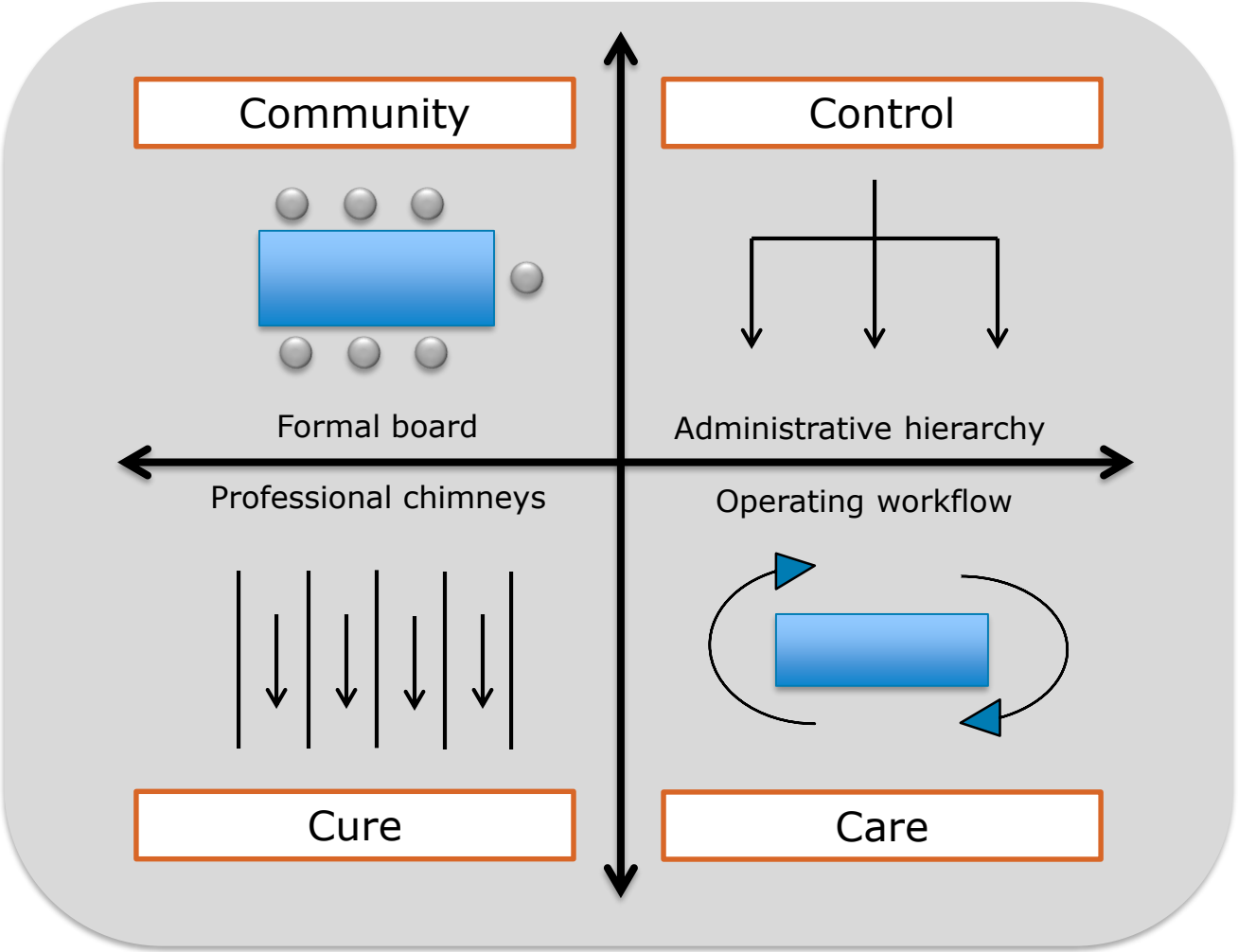
PATIENT EMPOWERMENT

HEALTH AND SOCIAL CARE COORDINATION

SUBACUTE CENTRES

INTEGRATED CARE

Different cultures, organisations and work ethics



Adapted from Glouberman/Mintzberg 2001

Changing cultures and strengthening competencies in Canterbury, NZ

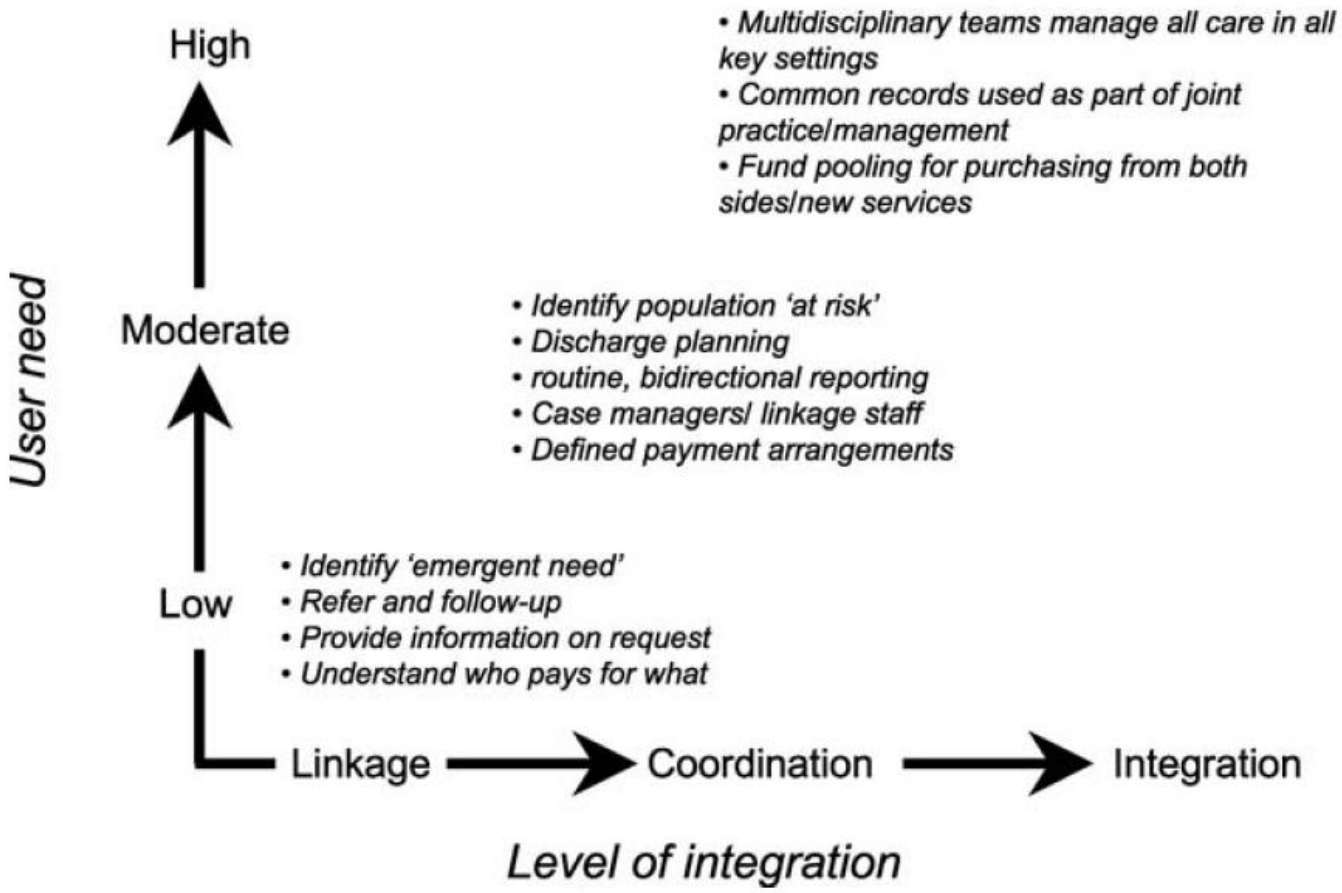
- Common goals
- Consistent leadership
- Engagement – of professionals and communities
- Quality improvement, not cost containment
- Developing skills and capacity
- Robust primary care – Pegasus Health
- Focus on care transitions
- Focus on care at home
- Information systems to support communication and used to drive quality improvement
- Effective learning strategies
- Long-term view
- Professional cultures that support team work
  - "One System, One Budget"

Timmins & Ham, 2013 - http://www.kingsfund.org.uk/publications/quest-integrated-health-and-social-care

The King's Fund
Ideas that change health care

Canterbury District Health Board
Te Poari Hauora o Waitaha

Setting the level of integration against user need to optimise care



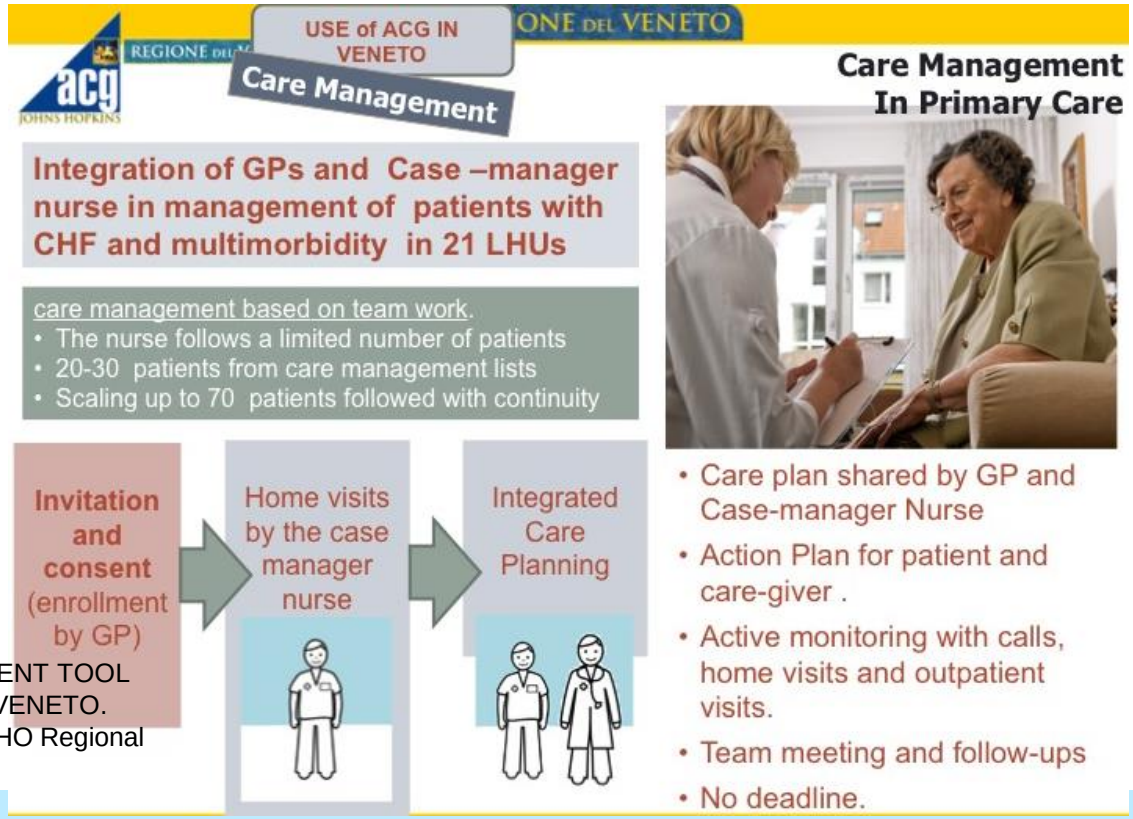
Source: adapted from Leutz 1999 in Nolte & McKee (2008)

REGIONE DEL VENETO

acg JOHNS HOPKINS

Almost 5 mio inhabitants

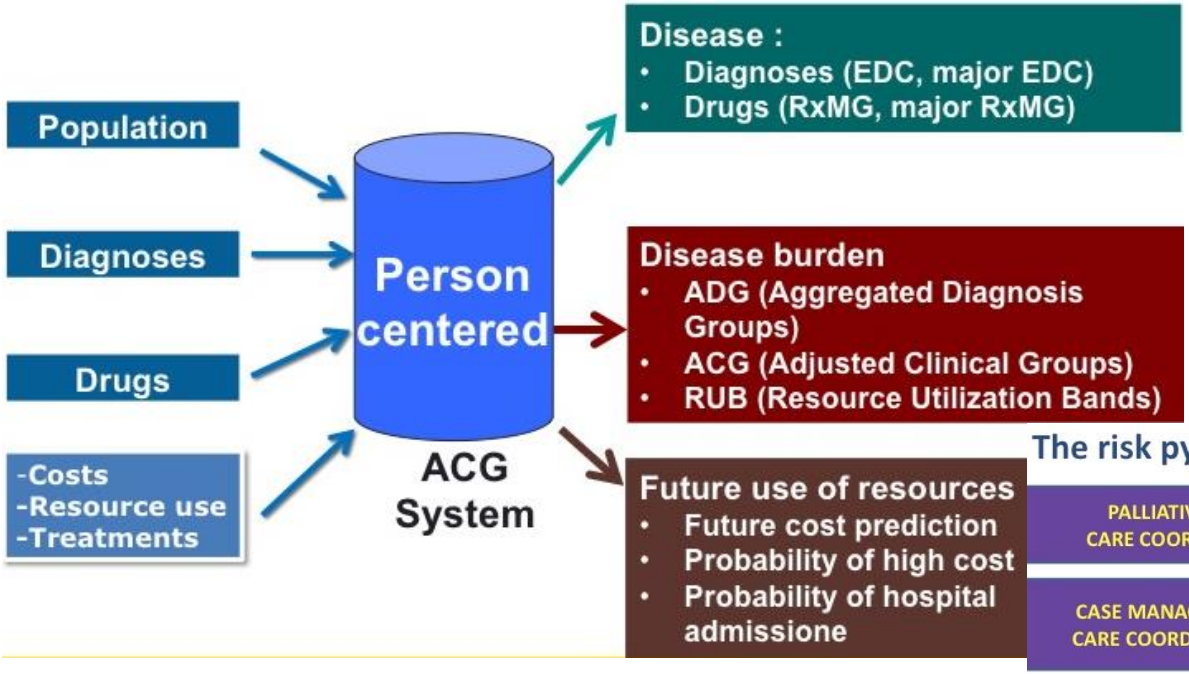
- Pilot project started in 2012 with 2 local health units, roll-out continued until 2015
- Construction of database, retrospective analysis of population, identification of risk groups and gaps analysis lead to:



Based on Corti MC. USING A POPULATION RISK-ADJUSTEMENT TOOL TO INTEGRATE HEALTH SERVICE DELIVERY IN REGIONE VENETO. Presentation during Second CIHSD Technical Meeting of the WHO Regional Office for Europe. Istanbul 2015

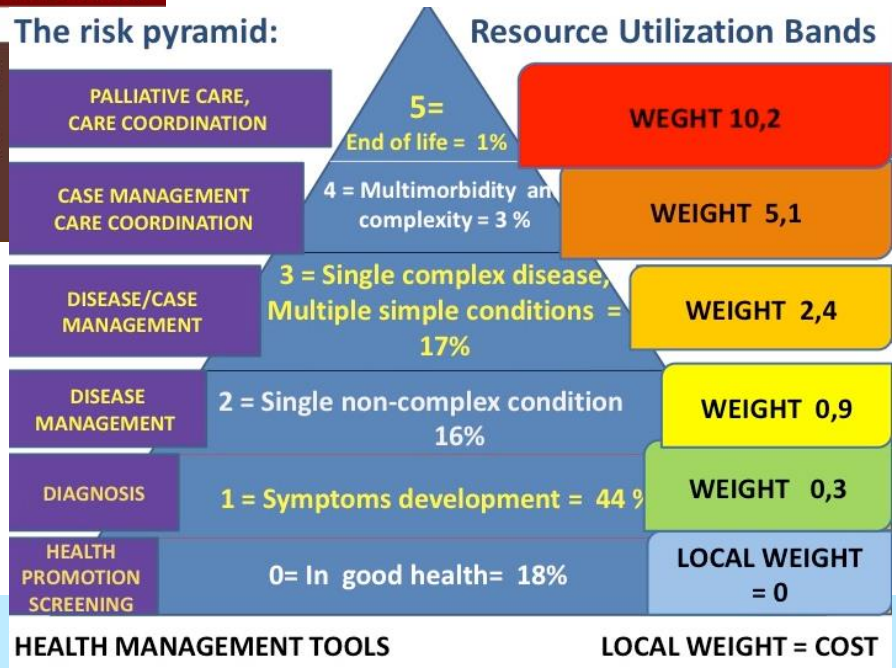
Key Lessons: population health management does not work without data analysis

Integration of data to integrate care



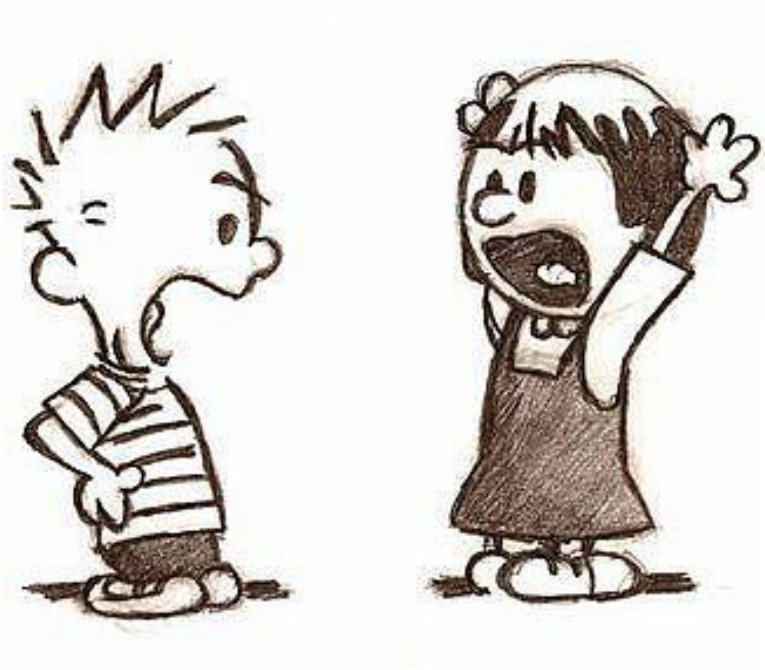
- Align all available data sets
- Invest in data quality
- Use predictive modelling

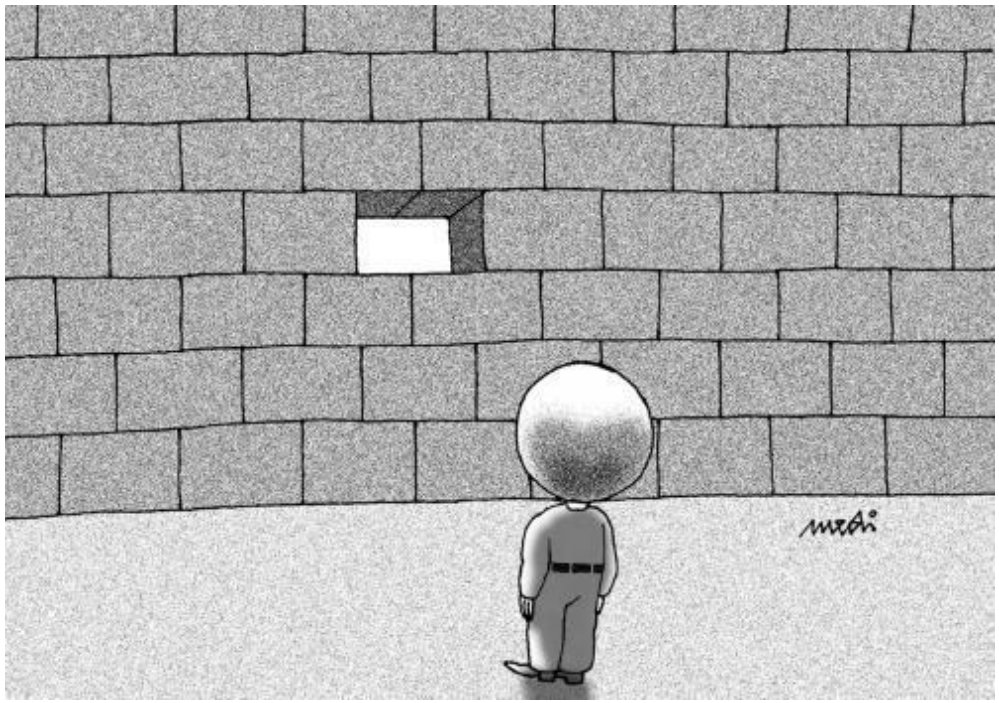
- Concentrate on quality improvement of service delivery NOT cost reduction



Based on Corti MC. USING A POPULATION RISK-ADJUSTEMENT TOOL TO INTEGRATE HEALTH SERVICE DELIVERY IN REGIONE VENETO. Presentation during Second CIHSD Technical Meeting of the WHO Regional Office for Europe. Istanbul 2015

Breaking down the walls in heads and systems





Changing roles and responsibilities

In need of additional competencies to deliver integrated care

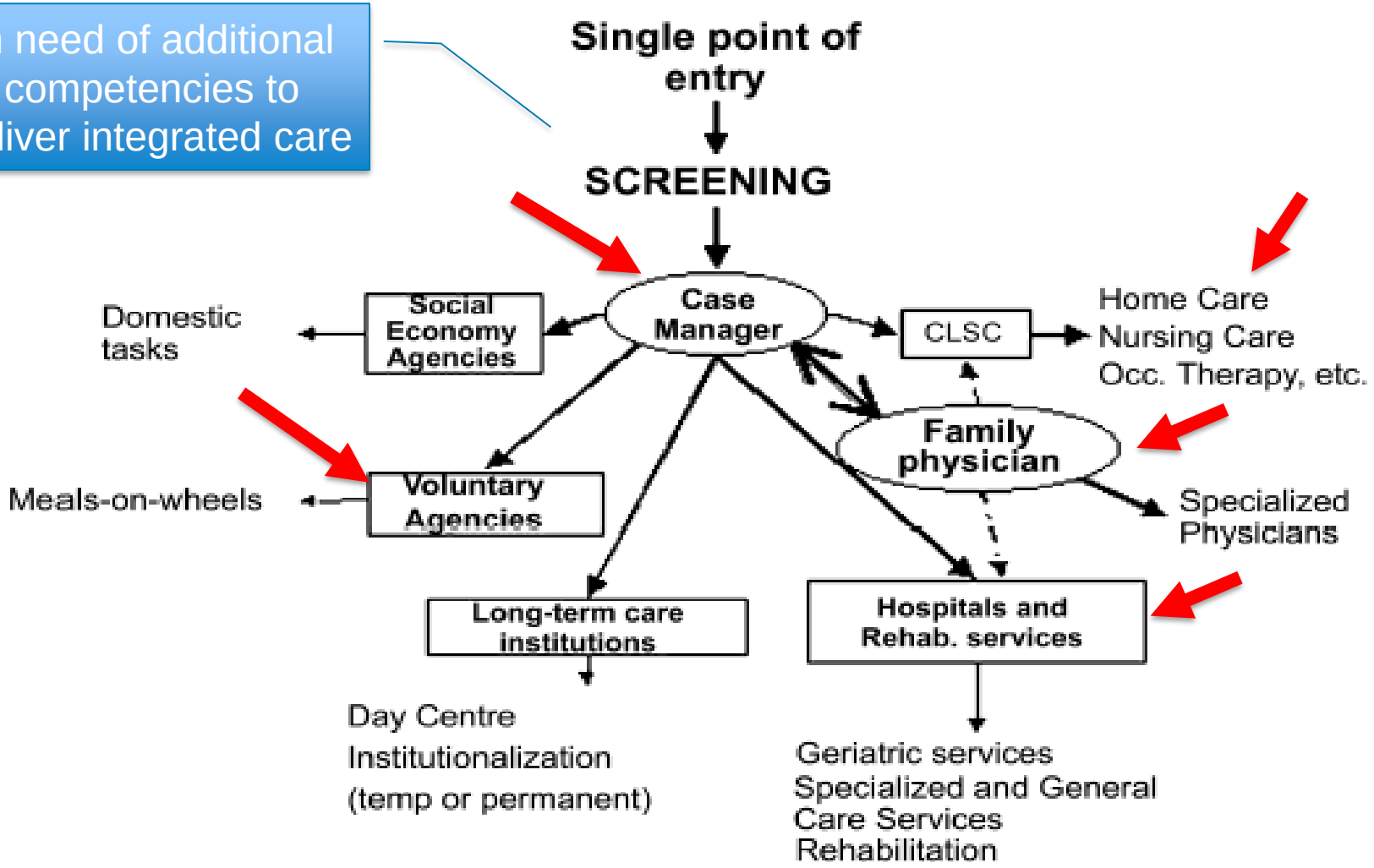


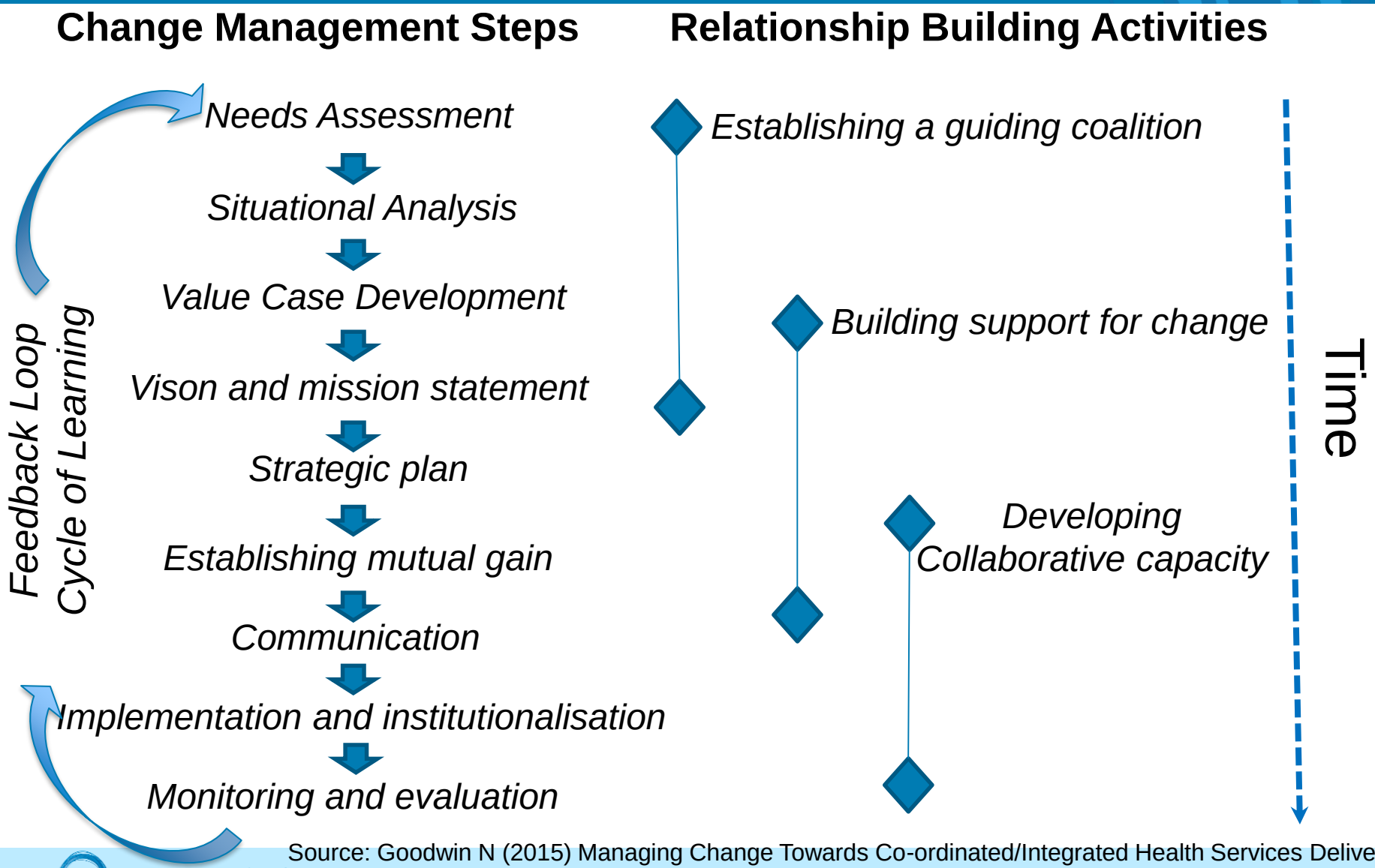
Figure 2. The PRISMA model of Integrated Service Delivery System.

Hébert R, Durand PJ, Dubuc N, et.al. PRISMA: a new model of integrated service delivery for the frail older people in Canada. IJIC 2003

Focusing on the competencies necessary on different levels

System	• Education and training systems • Regulatory bodies
Organisation	• Management • Leadership
Professionals	• Interdisciplinary, cross-sectoral work • Implementation of integrated care tools • Shared-decision making
People	• Patient and community engagement • Self management and support

Integrated care needs transformational change



Source: Goodwin N (2015) Managing Change Towards Co-ordinated/Integrated Health Services Delivery
WHO Regional Office for Europe, November 2015

Culture of a Learning Healthcare System Builds Value

- Common Vision
- Clinical Work Processes
- Data and Evaluation
- Transparency

Intermountain Healthcare

Healing for life®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The International Foundation for Integrated Care

IFIC is a non-profit members' network that crosses organisational and professional boundaries to bring people together to advance the science, knowledge and adoption of integrated care policy and practice.

The Foundation seeks to achieve this through the development and exchange of ideas among academics, researchers, managers, clinicians, policy makers and users and carers of services throughout the World.

IFIC's portfolio includes the International Journal for Integrated Care (IJIC), the ICIC and WCIC conferences, the Integrated Care Academy© and a strong members platform.

ICA© Portfolio

- Webinar series
- Essential skills courses
- Short courses and professional programmes
- International Summer School on Integrated Care
- Postgraduate programmes
- Study tours and exchange programmes
- Special Interest Groups
- Fellowships

To conclude

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."

National Voices 2013

K. Viktoria Stein, PhD

Head of the Integrated Care Academy©

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