Understanding Integrated care

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IFIC & Edge Hill University Webinar Series
www.integratedcarefoundation.org
Outline

1. The integrated care challenge
2. Defining and understanding integrated care
3. Key approaches to integrated health and social care with case examples
4. Conclusions

Dr Nick Goodwin is CEO of 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.
The Integrated Care Challenge
The Impact of Multiple Conditions

% of people with activity limitations

<table>
<thead>
<tr>
<th>Number of Chronic Diseases</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>none</td>
<td>4</td>
</tr>
<tr>
<td>one</td>
<td>15</td>
</tr>
<tr>
<td>two</td>
<td>28</td>
</tr>
<tr>
<td>three</td>
<td>45</td>
</tr>
<tr>
<td>four</td>
<td>52</td>
</tr>
<tr>
<td>five+</td>
<td>67</td>
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Living with increasingly complex conditions

X has heart failure and so is on a complex mix of medicines
and has atrial fibrillation, and so is also on warfarin
and has depression,
and diabetes,
and cares for his demented wife,
and is already on simple analgesics, including codeine which has made him constipated
and has increased pain in his knee meaning increasingly he cannot cope with his duties as a carer...
The Challenge: Summary

• Age-related chronic conditions absorb the largest, and growing, share of health/social care activities in high-income economies
• Increasing complexity of people with multiple health and social care problems
• People with multiple needs are much more likely to utilise health and long-term care services

BUT

• Care systems are increasingly struggling to cope
• They remain largely built around an acute, episodic model of care that is ill-equipped to meet the requirements of effective chronic illness care
• Fragmentation of services leads to poor co-ordination of care for people with long-term/complex illnesses leads to poor care experiences and adverse outcomes
• Primary and community care systems lack strength
• Practical solutions to tackle the socio-determinants of ill-health and pathology of the complex patient are needed
Designing Better Care for Malcolm and Barbara

Alzheimer Web of Care

Frontier Economics (2012) Enablers and barriers to integrated care and implications for Monitor
Designing Better Care for Malcolm and Barbara

- This Figure depicts a real-life context of a patient with advanced Alzheimer’s disease (Malcolm) and his principle carer and spouse (Barbara).
- The web of care was drawn by Barbara to illustrate, over a seven year period, the range of clinical and non-clinical services required to support their needs.
- The illustration shows how care support to people with complex needs comes from a highly diverse and largely unconnected web of care services.
Designing Better Care for Malcolm and Barbara

- Barbara has supported her husband, Malcolm, to live with Alzheimer’s disease for 16 years.
- Together, they faced daily challenges in navigating the health system (e.g. primary, community and hospital-based care), the social care system (e.g. respite and day services for the elderly, welfare benefits, at-home care support), and a myriad of other services from the statutory, private and voluntary sectors.
- At any one time, over a dozen ‘touch points’ were held with different care professionals,
- Care and support services were not always available and/or were poorly co-ordinated.
- Barbara has reported increasing feelings of isolation, depression and an inability to cope.
Designing Better Care for Malcolm and Barbara

The real-life experience of Malcolm and Barbara in the UK context is not unique but illustrates a number of key problems that fragmented health and care systems create, including:

• **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
A Different Approach is Needed

<table>
<thead>
<tr>
<th></th>
<th>Acute disease</th>
<th>Chronic illness</th>
</tr>
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<tbody>
<tr>
<td>Onset</td>
<td>Abrupt</td>
<td>Generally gradual and often subtle</td>
</tr>
<tr>
<td>Duration</td>
<td>Limited</td>
<td>Lengthy and indefinite</td>
</tr>
<tr>
<td>Cause</td>
<td>Usually single</td>
<td>Usually multiple and changes over time</td>
</tr>
<tr>
<td>Diagnosis and prognosis</td>
<td>Usually accurate</td>
<td>Usually uncertain</td>
</tr>
<tr>
<td>Technological intervention</td>
<td>Usually effective</td>
<td>Often indecisive, adverse effects common</td>
</tr>
<tr>
<td>Outcome</td>
<td>Cure possible</td>
<td>No cure</td>
</tr>
<tr>
<td>Uncertainty</td>
<td>Minimal</td>
<td>Pervasive</td>
</tr>
<tr>
<td>Knowledge</td>
<td>Professionals knowledgeable, patients inexperienced</td>
<td>Professionals and patients have complementary knowledge and experiences</td>
</tr>
</tbody>
</table>
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)
Understanding integrated care
What is Integrated Care?
A new idea?

The idea is not new – concern about lack of integrated care dates back thousands of years.

This concern has been about fractures in systems and 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.
Perspectives Shaping Integrated Care

(Shaw et al, 2011, p.13)
A health-system based definition

“Integrated health service delivery comprises the management and delivery of health services such that people receive a continuum of health promotion, health protection and disease prevention services, as well as diagnosis, treatment, long-term care, rehabilitation, and palliative care services through the different levels and sites of care within the health system and according to their needs”

(adapted from PAHO, 2011)
A process-based definition

“Integration is 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. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for people by cutting across multiple services, providers and settings. Where the result of such multi-pronged efforts to promote integration lead to benefits for people the outcome can be called 'integrated care'”

(adapted from Kodner and Spreeuwenberg, 2002)
A user-led definition

“My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and delivery services to achieve my best outcomes”

(National Voices, 2012)
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)
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.
**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)
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.**

Source: Curry and Ham, 2010
Types of Integration

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)
Intensity of integration

(Shaw et al, 2011, p.15; after Leutz, 1999)
A ‘scale’ of functional clinical integration and care networks

Source: Ahgren & Axelsson (2005)

Setting the level of integration against user need to optimise care

Source: adapted from Leutz 1999 in Nolte & McKee (2008)
Matching client needs with approaches to integrated care

The intensity with which organisations and services need to integrate with each other depends on the needs of the client. Full (organisational) integration works best when aimed at people with severe, complex and long-term needs (Leutz, 1999)

<table>
<thead>
<tr>
<th>Client Needs</th>
<th>LINKAGE</th>
<th>COORDINATION</th>
<th>FULL INTEGRATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEVERITY</td>
<td>Mild to Moderate</td>
<td>Moderate to severe</td>
<td>Moderate to severe</td>
</tr>
<tr>
<td>STABILITY</td>
<td>Stable</td>
<td>Stable</td>
<td>Unstable</td>
</tr>
<tr>
<td>DURATION</td>
<td>Short to long-term</td>
<td>Short to long-term</td>
<td>Long-term to terminal</td>
</tr>
<tr>
<td>URGENCY</td>
<td>Routine/non-urgent</td>
<td>Mostly routine</td>
<td>Frequently urgent</td>
</tr>
<tr>
<td>SCOPE OF NEED</td>
<td>Narrow to moderate</td>
<td>Moderate to broad</td>
<td>Broad</td>
</tr>
<tr>
<td>SELF-DIRECTION</td>
<td>Self-directed</td>
<td>Moderate self-directed</td>
<td>Weak self-directed</td>
</tr>
</tbody>
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Integrated Care & Population Health

Integrated care between public health, population-based and patient-centred approaches to health care.

A pro-active ‘life-course approach’ to improving health outcomes that seeks to tackle the socio-determinants of ill-health, not just episodes of care or care transitions.

A focus on the multiple needs of whole populations, not just to care groups or diseases.
The Imperative to Invest in Health Promotion and Ill Health Prevention

“The Future Health of Millions of Children, the Sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health”
NHS 5 Year Forward View

“Those who suffer most from under-coordination are the poor, vulnerable, old and those from ethnic minorities. The avoidable deterioration of their health results in high costs for public systems”
Integrated Care as Part of a Public Health System

SOCIOECONOMIC AND POLITICAL CONTEXT
- Governance
- Macroeconomic Policies
- Social Policies
  - Labour Market, Housing, Land
- Public Policies
  - Education, Health, Social Protection
- Culture and Societal Values

Socioeconomic Position
- Social Class
- Gender
- Ethnicity (racism)

Material Circumstances
- (Living and Working, Conditions, Food Availability, etc.)

Behaviors and Biological Factors

Psychosocial Factors

Impact on Equity in Health and Well-Being

STUCTURAL DETERMINANTS
SOCIAL DETERMINANTS OF HEALTH INEQUITIES

Social Cohesion & Social Capital
- Education
- Occupation
- Income

HEALTH & SOCIAL CARE
Integration Strategies at Every Level

The Rainbow Model for Integrated Care

Final taxonomy contained 21 key features that support integrated care across 8 domains


http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4446832/table/Tab5/
The Rainbow Model: Final Taxonomy Summary

- **Clinical integration**: case management, continuity of care, multi-disciplinary care plans, supportive relationship with client
- **Professional integration**: interprofessional education, interdisciplinary teams
- **Organisational integration**: shared governance and accountability; shared strategy; trust
- **System integration**: aligned regulatory frameworks to support care coordination and team work;
- **Functional integration**: shared information systems; collective learning and joint research; regular feedback on performance measures
- **Normative integration**: shared vision; reciprocity of behaviour; mutual gain; visionary leadership; distributed leadership; shared norms and values

Finally, does integrated care have values?

Box 1. Suggested core principles guiding people-centred and integrated health services

1. Comprehensive - a commitment to universal health coverage to ensure care is comprehensive and tailored to the evolving health needs and aspirations of people and populations
2. Equitable - care that is accessible and available to all
3. Sustainable - care that is both efficient, effective and contributes to sustainable development
4. Co-ordinated - care that is integrated around people’s needs and effectively coordinated across different providers and settings
5. Continuous - continuity of care and services that are provided across the life course
6. Holistic - a focus physical, socio-economic, mental, and emotional wellness
7. Preventative - tackles the social determinants of ill-health through intra- and inter-sectoral action that promote public health and health promotion
8. Empowering - supports people to manage and take responsibility for their own health
9. Goal oriented - in how people make health care decisions, assess outcomes and measure success
10. Respectful - to people’s dignity, social circumstances and cultural sensitivities
11. Collaborative - care that supports relationship-building, team-based working and collaborative practice across primary, secondary, tertiary care and other sectors
12. Co-produced - through active partnerships with people and communities at an individual, organisational and policy-level
13. Endowed with rights and responsibilities - that all citizens should expect, exercise and respect
14. Governed through shared accountability - between care providers for quality of care and health outcomes to local people
15. Evidence-informed - such that policies and strategies are guided by the best available evidence and supported over time through the assessment of measurable objectives for improving quality and outcomes
16. Led by whole-systems thinking
Key Forms of Integrated Care
Key forms of Integrated Care - 1

- **Integrated care between health services, social services and other care providers in the community (horizontal integration);**
  - **EG CASE MANAGEMENT USING MULTI-DISCIPLINARY TEAMS TO SUPPORT PEOPLE TO LIVE AT HOME**
    - Usually based on specific client group with inclusion criteria, but rarely have defined packages of care. Flexibility in care pathway arrangements in order to be responsive to needs
    - Funding: usually capitation-based with a focus on outcomes, pooled budgets
    - Organisation: networked organisations under some form of collective governance, moving towards integrated care organisations with single governance. Rarely includes hospitals, but can build in third sector and other community-based groups

- **Integrated care across primary, community, hospital and tertiary care services (vertical integration);**
  - **EG CARE PATHWAYS FOR DISEASES LIKE DIABETES AND COPD**
    - Protocol driven (best practice guidelines/map of medicine) and can use lean thinking and system process design to develop quality improvements
    - Funding: bundled payments and/or payment by specific contribution to elements of the care pathway
    - Organisation: ties between organisations usually agreed between organisations with a focus on hand-offs and transitions - general movement towards care organisations with specific focus on managing specific diseases (e.g. Netherlands). Rarely involves social care and the community
Example 1:
Norrtälje North Stockholm, Sweden

- Joint governing committee between local authority (social care) and Stockholm County Council (health care) with joint funding (56k)
- Focus on health promotion and prevention
- Development of new health care company with a joint health and social care teams e.g. including intensive home-based case management for older people for better transitions to/from hospital
- Moving to a shared care record
- Professional report improved care coordination and patients get faster access to care
- Reduction in nursing home placements
- Lower costs for home care support
Norrtälje, North Stockholm, Sweden

- Primary, community and long-term care providers work together within an integrated health and social care provider that provides comprehensive care to older people.
- *TioHundra Forvaltiningen* is the financial arm of the model, established to administer pooled budgets (from Stockholm and Norrtälje municipality) for all care services. It also collects payments and pays providers.
- *Tio-Hundra* is jointly owned by the Stockholm county council and the Norrtälje municipality to deliver health and social care services for the citizens in Norrtälje.
Key forms of integrated care - 2

- Integrated care within one sector (e.g. within mental health services through multi-professional teams or networks);
  - EG PROGRAMME BUDGETING FOR DEFINED CLIENT GROUP
    • Range of care services delivered across the spectrum of needs with multiple forms of delivery
    • Funding usually pooled (though in reality mainly health care) and so develops a central strategic centre for planning and contracting care
    • Delivery tends to be knitted together from range of providers, but potential to develop ACO-type models of care like DMPs

- Integrated care between preventive and curative services;
  - EG FOCUS ON PRIMARY AND SECONDARY PREVENTION TO IMPROVE HEALTH AND WELLBEING AND REDUCE DEMAND
    • Focus on public health needs socio-determinants of ill-health
    • Often a separately funded and delivered activity, rarely integrated care into the clinical pathways of care
    • Delivery also tends to be outside existing care systems, but needs to be better integrated
Case Example 2: Gesundes Kinzigtal, Germany

*Integrated Care Experiences And Outcomes In Germany, The Netherlands, And England*

**Abstract**
Care for people with chronic conditions is an issue of increasing importance in industrialized countries. This article examines three recent efforts at care coordination that have been evaluated but not yet included in systematic reviews. The first is Germany’s Gesundes Kinzigtal, a population-based approach that organizes care across all health service sectors and indications in a targeted region. The second is a program in the Netherlands that bundles payments for patients with certain chronic conditions. The third is England’s integrated care pilots, which take a variety of approaches to care integration for a range of target populations. Results have been mixed. Some intermediate clinical outcomes, process indicators, and indicators of provider satisfaction improved; patient experience improved in some cases and was unchanged or worse in others. Across the English pilots, emergency hospital admissions were reduced by an average of 25%. Therefore, our second conclusion is that the German integrated care program, which targeted roughly 50 percent of the population in a well-defined area regardless of people’s age or health status, deserves to be more closely studied by researchers and policy makers in the United States as they search for solutions to help accountable care organizations overcome the weaknesses of fragmentation, find appropriate financial incentives, and meet the needs of people with chronic conditions.
A ‘Shared Gain’ Model

- Since 2006, GK has held long-term contracts with two German not-for-profit sickness funds to integrate health and care services for their insured populations in Kinzigtal
- Joint venture between a network of physicians and a management company
- Responsible for organising care and improving the health of nearly half of the 71,000 population of Kinzigtal
- GK holds ‘virtual accountability’ for the health care budget for this population group.
- If the sickness funds spend less on health care for this group than standardised, risk adjusted costs, GK shares the benefits
- Targeted care management programmes for people with chronic illness
- A focus on improving population health

- Enrolled patients have significantly longer survival times compared to risk-adjusted control group
- Emergency hospital admissions increased by 10.2% for patients in Kinzigtal compared with a 33.1% increase in Baden-Württemberg.
- High patient satisfaction
- 6.6% comparative budget saving since 2006

4.65m € of margin improvement for the AOK in 2013 (= 148€ per insuree living in the Kinzigtal region)
Public Health and Community Interventions in Gesundes Kinzigtal

- Cooperation contracts with 38 community organisations like local sports clubs, associations for people with handicaps, dancing and hiking clubs, women’s groups, and kids clubs
- Cooperation with about 14 local municipalities, for instance to
  - joint development of two walking trails for memory training (with small tasks),
  - joint partnership for hiking trails for kids and parents,
  - development of a community center with nurses and housing options
- Cooperation with about 10 self help organisations
- Health Literacy to about 3,900 participants through 400 local lectures on health and self management for a whole variety of diseases and health problems, including establishing a “Health Academy Kinzigtal” with courses and classes for self management training
- Employee health management – especially for Small and Medium-sized Companies (SME)
- Health magazine and TV channel in 22 physician practices with information slots on activities, courses, classes and health improvement programs
- Health festivals – in different locations in Kinzigtal around once a year – including Aqua fitness classes with around 1,900 participant
Key forms of integrated care - 3

- **Integrated care between providers and patients to support shared decision making and self-management;**
  - EG SUPPORTED SELF CARE, ACTIVATED PATIENTS AND CARERS, TELEHEALTH
    - Essential component to integrated care effectiveness and can be an added capability to both vertical and horizontal models of care

- **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
  - EG POPULATON-BASED ACCOUNTABLE CARE ORGANISATIONS
    - Use of capitation-based prime contractor/alliance contracting models
    - Provision by networked group of providers working to risk sharing and outcome-driven shared goals
The quest for integrated health and social care
A case study in Canterbury, New Zealand
Key Lessons from Canterbury

• 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”

Conclusions
What is integrated care?
A summary

There are three distinct dimensions to what integrated care means in practice:

• Integrated care is necessary where fragmentations in care delivery mean that care has become so poorly co-ordinated around people’s needs that there is an adverse, or sub-optimal, impact on care experiences and outcomes.

• Integrated care therefore seeks to improve the quality and cost-effectiveness of care for people and populations by ensuring that services are well coordinated around their needs. It is by definition, therefore, both ‘people-centred’ and ‘population-oriented’.

• The people’s perspective thus becomes the organising principle of service delivery, whether this be related to the individual patient, their carers/family, or the wider community to which they belong.
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