What’s integration got to do with it?

Observations and Lessons from the Franciscus Gasthuis & Vlietland Study Trip to North-West London

By Mudi Kadu
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INTRODUCTION

About the Integrated Care Visit from the Netherlands to North-West London

On March 31th, 2017, delegates from the Franciscus Gasthuis & Vlietland (FG&V) regional hospital visited North-West London as part of an international learning exchange. The FG&V delegation team comprised of thirty-four Dutch physicians (a mix of general practitioners and medical specialists) and three policy advisors. The study trip was in collaboration with the Integrated Care Academy; designed to support clinicians, managers and policy-makers with a demonstrated interest in the successful adoption of integrated care policy and practice.

The purpose of the trip was to bring together key physicians from the FG&V region to learn about essential approaches to the design, implementation and funding of integrated care. Organized as a mix of plenary lectures, facilitated discussions and a site visit, the trip sought to promote knowledge exchange from the North-West London (NWL) Integrated Care System and FG&V. This report provides an overview of this international learning experience and highlights key challenges and lessons identified by the delegates.

Programme

09.00: Welcome and Introduction in the hotel
09.30: Presentation on competencies/cultures and values for integrated care:
10.30: Transfer to St. Charles’s hospital
11.00: Presentation and discussion about North West London (NWL) experience

Key Questions: How do you build networks among service providers?

12.30: Visit to integrated care clinic followed by lunch
14.00: Small group work: what can Franciscus Gasthuis & Vlietland learn from NWL/What are the key challenges? What needs to change? Who is in charge of the change?
15.00: Plenary discussion and summarizing presentation on leading and managing change
16.00: Break and walk back to hotel
17.00: Small Group discussion: roles and responsibilities between hospital, GPs and other stakeholders in the new network
Franciscus Gasthuis & Vlietland’s (FG&V) Perspective on Opportunities for Integration

Franciscus Gasthuis & Vlietland (FG&V) is a healthcare organization with facilities located across the Dutch regions of Rotterdam and Schiedam. As one of the leading care providers in the region, they are comprised of two hospital sites and four outpatient clinics. In the Dutch health system, the general practitioners (GPs) in primary care play a significant professional role as gatekeepers for individual care, particularly for those living with chronic diseases (Wammes et al, 2014). While FG&V reported positive informal relationships with other health services such as nursing homes and primary care groups in the region, they predominantly operate as separate entities. Duplication of services and funding issues between primary care and hospitals were identified as challenges for professional collaboration and care coordination across the care continuum.

The seamless transition and integration of services across the acute, primary and secondary sector was a significant priority for FG&V. To begin this journey, the organization mobilized key physician delegates in the region, and sought insight from the International Foundation for Integrated Care (IFIC) and North-West London (NWL) Integrated Care System.

A snapshot of some identified challenges:

- Building professional capacity for integrated care within organizational, systems and financial barriers
- Lack of clarity on the respective roles of primary care and hospital clinicians in sharing patient care - unpacking who should be responsible for what and whom?
- Cultures and attitudes hindering change - “Sometimes we (doctors) are so focused on the structure and processes (of care delivery) that we forget to look at the person and the professionals” (GP quote, 2017)
- Fragmentation of care due to lack of structural support for care coordination (e.g.:lack of cross-sectoral shared care plans and/or accessible electronic records)
Drawing inspirations from the NWL experience, they were interested in tackling the following questions:

1. How does the process of integration look like from the planning and design, to the implementation phase?

2. What are the necessary contextual (including financial, cultural, professional & organizational) factors that enable a successful integrated care system? How do you work past the barriers?

3. How scalable and transferable is the NWL model to a different care context like that of FG&V’s regional service area?

The North-West London (NWL) Whole System Integrated Care (WSIC)

The WSIC programme in NWL is one of the leading integrated care pioneers in England, piloting various collaborative care delivery. With a catchment population of over two million, the WSIC serves a region with significant gradients of socio-economic and health disparity. Implemented as an integrated care pilot through pooling community budgets in 2011, it has since evolved to establish a network of over 30 organisations (including 24 GP practices) from the health, social services and third sector, as well as community and lay partners (Curry et al, 2013; Wistow et al, 2014).

At the site visit at St Charles Health Wellness Center, the FG&V group were introduced to the NWL WSIC model. It focused on delivering care to complex comorbid older adults through accessing integrated care outside the hospital. The model was enhanced through enabling effective working relationships of professionals across care organisations. The discussions that emerged from the presentation of the NWL model proved that the operational framework behind this system was of great interest to the physicians at FG&V.

Structure of the North-West London Integrated Care Pilot (from Curry et al, 2013)

The guiding principles of change behind WSIC:

1. People will be empowered to direct their care and support and receive the care they need in their homes or local community.
2. GPs will be at the centre of organising and coordinating people’s care.
3. The systems will enable and not hinder the provision of integrated care.
Observations

One of the earliest observations from the FG&V group on the North-West London experience was the importance of an enabling financial environment (e.g.: introduction of pooled budgets across care sectors) and the presence of government policies that support the piloting of innovative integrated care plans in the region. It was also clear that the cross-sectoral commitment to putting the patient at the centre of this care model was a major facilitator to its success. Further reflection also identified strong leadership from various organizations and GP champions as significant to professional buy-in and adoption.

In reflecting on the key achievements of North-West London’s WSIC, the FG&V delegation noted that this model of care delivery was much more community-based, collaborative and person-centered, compared to their more disease- and acute-care focused approaches. Many questions emerged from the Dutch delegates on the key enablers of adopting such a complex and multi-component intervention.

Particularly, there was a strong need to understand:

1. How to develop approaches for information-sharing and decision-making;
2. While building strong professional and inter-organizational relationships.

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<tr>
<th>Emerging Themes</th>
<th>FG&amp; V Questions/Comments</th>
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<tr>
<td>Design &amp; implementation</td>
<td>“This pathway seems very complicated….how does it work?”</td>
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<td>“Does the patient have a specific GP or care team?”</td>
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<td>“Is the GP the case manager and coordinator?”</td>
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<td></td>
<td>“Which diagnosis group did you (NWL) focus on?”</td>
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<td>“How do you decide on which complex group to target”</td>
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<td>“When would the patient be involved in the co-design (of the intervention) process”</td>
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<td>“How do you share patient information in this (NWL) model?”</td>
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<td>Evidence of impact</td>
<td>“Do you have proof of cost-effectiveness for the self-care (patient education for managed care component) in the NWL system?”</td>
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<td>Professional enablers</td>
<td>“how did you get buy-in from the GPs”</td>
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<td>Structural and enablers/barriers</td>
<td>“Does this create problems with hospital…when they earn less money (because of the interventions)?”</td>
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<td>“Who pays for the additional time the physicians and other clinicians spend delivering this care model?”</td>
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Key learning points and take-home messages

1. Integrated care interventions tend to be complex, adaptive and ever evolving; they can take time to mature

2. Transforming care to becoming more patient-centered might require:
   
a. early involvement of persons/population served in the design process of integrated care models, and empowering them during care delivery
   
b. Identifying the right stakeholders within and across sectors for collaboration

3. ‘Integrated Care Champions’ can play key roles in promoting the shared values and enabling buy-in from management and professionals

4. Strong clinical and organizational leadership can help create a supportive cultural, financial and structural environment for integrated care

5. Coordination of care that is patient-centered will require a commitment and cultural shift to improving working relationships within and across organizations. “Information is not the same as communication…it will require coming together to know each other” (Specialist quote, 2017)

6. Proactively prioritizing care for the population that is most complex and vulnerable can help concentrate planning efforts on where the most impact can be gained in the FG&V care region
3 CONCLUSIONS

The International study trip demonstrated that despite different care systems, population demographics and underpinning cultural values, knowledge mobilization can help draw on a shared vision for a future of health and social care integration. Of real value to the participants was the ability to learn from innovative care practices in other parts of the world and contrast this with local developments. Another added benefit of the knowledge exchange was building of close relationships between people from the same health economy through the protected time to have meaningful discussions and to generate innovative ideas. All delegates were keen to share their continuous learning experience on the complex journey towards integrated care.
REFERENCES


ABOUT US

Mudi is a Junior Associate with the International Foundation for Integrated Care (IFIC) and previously IFIC's Research and Policy Intern. She is pursuing her PhD at the Institute of Health Policy, Management and Evaluation at the University of Toronto. This report was written on behalf of the Integrated Care Academy, which delivers practice-orientated learning programmes and educational activities on integrated care delivery.