Understanding Integrated Care: Lessons from around the world

Dr Toni Dedeu, Director of Programmes, International Foundation for Integrated Care
IFIC Ireland Webinar, 12 June 2019
Representation of Integrated Care
Designing Better Care for Malcolm and Barbara

*Frontier Economics (2012) Enablers and barriers to integrated care and implications for Monitor*
Coping with Complexity

✓ **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.

✓ **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.

Frontier Economics (2012) *Enablers and barriers to integrated care and implications for Monitor*
Gabe’s map of care
Key problems of fragmented health and care systems

- A lack of ownership from the range of providers to support ‘holistic care needs’
  - Driven by silo-based working
  - Separate professional and organisational systems for governance and accountability

- A lack of involvement of the patient/carer in supporting them to make effective choices

- Poor communication between professionals and providers
  - Inability to transfer data
  - Silo-based working
  - 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

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 poor and disabling experience for the service user

- Information hard to get hold of
- Differing advise and views
- Confusion is the next steps of a course of illness

Reduced ability for people to live and manage the needs effectively

Poor system outcomes

- Inability to prevent unnecessary hospitalisation
- Inability to prevent long-term residential home placements
The hypothesis for integrated care is that it can contribute to meeting the “**Triple Aim**” goal in health and care 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 “Quadruple Aim”** goal in health and care systems

- **Improving work-life balance of health and care professionals**
There are different viewpoints and different objectives regarding integrated care.

All are legitimate.
The Building Blocks of Integrated Care
A movement for change
The Building Blocks of Integrated Care

- Creating an enabling political environment for Health and Social Care integration
- Competences for Health and Social Care. Workforce changing/swift
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Building Block „Building an enabling environment“: We need Integrated Care in all policies approach

Adapted from WHO-HQ Global Strategy on people-centred and integrated health services 2015
Integrated Care in Europe: governing, regulating, financing

• There are many different examples of policies and innovation on integrated care around Europe
• The political agendas focus on:
  – Financial reform
  – Cost containment
  – Legislative change
  – Structural reorganizations
  – Personalised care
  – New funding streams
  – Pilot programmes

**National Strategies - Examples**

• Denmark, Norway: Coordination Reform
• Sweden: Joint agencies link funding and delivery (e.g. Jönköping & Nortallje)
• England: Five Year Forward View (Vanguards)
• 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 / HMOs
Creating an enabling political environment for Health and Social Care integration

Health and Social Care Integration

Supporting people to live well and independently at home or in a homely setting in their community for as long as possible

- www.scotland.gov.uk/HSCI
- Follow us on twitter @scotgovIRC

There’s no ward like home

The Scottish Government
Creating an enabling political environment for Health and Social Care integration

Guiding principle:

“. . . effective services must be designed with and for people and communities – not delivered ‘top down’ for administrative convenience”

The Christie Commission Report
Commission on the future delivery of public services, June 2011
National Policy Drivers

- Public Service Reform
- Public Bodies (Joint Working) (Scotland) Act 2014
- Reshaping Care for Older People programme
- Telehealth and Telecare Delivery Plan for Scotland 2015
- The Community Empowerment Bill
- 8 Innovation Centres
  - Digital Health and Care
  - Stratified Medicine
  - Big Data
  - Sensors
  - Construction
  - Aquaculture
  - Bio-Technology
  - Oil & Gas
### Creating an enabling political environment for Health and Social Care integration

<table>
<thead>
<tr>
<th>Before Integration</th>
<th>AFTER April 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>32 Local Authorities</strong></td>
<td><strong>32 new “Health and Social Care Partnerships”</strong></td>
</tr>
<tr>
<td>responsible for social care, education, housing, transport</td>
<td>jointly responsible for delivery of social care, community health / primary care and some hospital services</td>
</tr>
<tr>
<td><strong>14 NHS Boards</strong></td>
<td><strong>NHS Boards and Local Authorities</strong></td>
</tr>
<tr>
<td>Acute, hospital, community, primary care health services</td>
<td>continue to provide a range of other health and care services</td>
</tr>
</tbody>
</table>
Creating an enabling political environment for Health and Social Care integration

What has helped integration?

- Cross party support
- NHS support
- Local authority support
- Having an agreed vision about what we are trying to achieve
- Clear governance
- Single budget
- Clear outcomes
- Bespoke strategies at each Scottish territory
The Building Blocks of Integrated Care

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National Interprofessional Competency Framework
(Cihcpis - Canadian Interprofessional Health Collaborative)

Goal: Interprofessional Collaboration
A partnership between a team of health providers and a client in a participatory, collaborative and coordinated approach to shared decision-making around health and social issues.

Role Clarification
Learners/practitioners understand their own role and the roles of those in other professions, and use this knowledge appropriately to establish and meet patient/client/family and community goals.

Interprofessional Conflict Resolution
Learners/practitioners actively engage self and others, including the patient/client/family, in dealing effectively with interprofessional conflict.

Collaborative Leadership
Learners and practitioners work together with all participants, including patients/clients/families, to formulate, implement and evaluate care/services to enhance health outcomes.

Quality Improvement
Learners-practitioners from varying professions communicate with each other in a collaborative, responsive and accountable manner.

Contextual Issues
Patient/client/family/community-centered care

Complex

Simple

Interprofessional Communication

Team Functioning
Learners/practitioners understand the principles of team dynamics and group processes to enable effective interprofessional team collaboration.

http://www.cihc.ca/files/CIHC_IPCompetenciesShort_Feb1210.pdf
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Building block “Empowering people”: we need involved individuals and communities

- Hours with professional / NHS = 3 in a year
- Need for people engagement
- Need for patient empowerment

Informal care
Self care
Health system

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

Patients are the true primary health care providers

Hours of self care = 8757 in a year

Adapted from Goodwin 2008 and 2014
Integration between Health and Social care: bridging the divide, building common values. Building social capital and collaborative capacity.

Integrated Care is a People-Driven Community-Based Movement

2014
Millom Alliance was founded in a rural community of 8500 people in response to closure of community hospital and crisis in GP recruitment.

2018
Whole of Cumbria & Morecambe Bay (750k people) supported through 20 community-based alliances – were the fastest transforming integrated care system in the UK enabling 8-10% on year financial savings & turnaround in population health outcomes.

“Working as equal partners with the community resulted in improvements for healthcare locally highlighting the importance of co-creation”
Facilitating continuity of care at a health system level to support integration

- Population 4.2 million
- Entirely public system
- 4,000 family doctors and 4,000 specialists - most paid fee-for-service
- One single delivery agency: Alberta Health Services (AHS)
- Structural integration: acute care, long-term care, home care, public health, addictions and mental health, cancer care, emergency medical services
- Joint-venture relationship with primary care: 86% of family doctors belong to Primary Care Networks (PCNs), a partnership with AHS
- Most specialty services offered through Alberta Health Services
- Patients can only access specialists by referral from a family doctor
- Patients can choose or change their family doctor at will
Facilitating continuity of care at a health system level to support integration

Continuity – step 1 analyzing system data

- 9 - catastrophic
- 8 - dominant malignancy
- 7 - chronic disease 3 or more organ systems
- 6 - significant chronic disease multiple organ systems
- 5 - single dominant or moderate chronic disease
- 4 - minor chronic disease in multiple organ systems
- 3 - single minor chronic disease
- 2 - significant acute disease
- 1 - healthy
Facilitating continuity of care at a health system level to support integration

EVIDENCE SUMMARY: THE BENEFITS OF CONTINUITY IN PRIMARY CARE

Step 2 – the literature

- **Utilization**: 54/59 studies showed positive results in lower utilization and hospitalization.
- **Mortality**: 10/10 studies showed reduced mortality.
- **Preventive Care**: 8/10 studies showed improvements in preventive care.
- **Cost Savings**: 17/17 studies demonstrated cost savings.
- **Articles**: 112 articles (108 peer reviewed).
- **Caret Quality**: 7/10 studies showed positive results in overall care quality.
- **Satisfaction**: 9/11 studies showed increased patient satisfaction.
- **Adherence**: 6/6 studies showed improved self-management and treatment adherence.

A growing body of evidence points to the association of provider continuity, and to a lesser extent practice continuity, with improved outcomes and satisfaction. In most cases, the greater the continuity, the better the outcomes.
Facilitating continuity of care at a health system level to support integration

The collective strategy

- Alberta Health Services (AHS) agreed to establish informational and management continuity as a priority (transitions)
- AHS also agreed to promote relational continuity wherever and whenever possible, from acute care to outpatient clinics
- The government and AHS agreed on a multi-billion dollar clinical information system to replace up to 2,000 stand-alone systems
- The Alberta Medical Association, and Primary Care governance, along with AHS and the ministry of health agreed to pro-actively promote relational continuity, particularly as part of the Patient’s Medical Home model
- Targets for 80% relational continuity in 1 year were set
- The medical association established a committee to develop what we believe is internationally the first clinical practice guideline on continuity of care

Transferability: because this initiative was done collaboratively, with local data, and using formal change management principles, it could be applied in various health care systems

- Priority: informational and management continuity (transitions)
- Relational continuity whenever and wherever possible
- Single clinical information system
- Promotion of relational continuity
- Targets
- 1st guideline on continuity of care
Facilitating continuity of care at a health system level to support integration

Continuity: the patient perspective

Facilitating continuity of care at a health system level to support integration

The collaborative efforts of many players, with strong public input, has had an impact on integration and health system outcomes. Equally important, the process and its successes have created a positive culture across the health care landscape.
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Training in the Nuka Health System, Alaska

- Development Centre with 11 Departments of Learning
- Workshops and training course for interested organisations
- RAISE programme: Designed to develop leadership skills in Alaska Native and American Indian youth 14 – 19 years old
- Community engagement and patient education programmes

Nuka: Alaskan native word meaning ‘Strong’
Community Engagement
Nuka Health System, Alaska

Mission:
Working together with the Native Community to achieve wellness through integration of 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”
Key lessons: involving patients and communities improves outcomes

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
- 60,000 people south of Anchorage and spread across 1,800km 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
**Key lessons: involving patients and communities improves outcomes**

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

**Katherine Gottlieb**
Southcentral Foundation, Anchorage, AK, USA

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%
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Financial incentives to stimulate integrated care

The Netherlands: Managed care organizations and bundled payments for certain diseases

**Dutch Bundles**
Insurers pay a bundled payment to a principal contracting entity — the care group — to cover a full range of diabetes-care services for a fixed period of 365 days.

BP = Bundled Payment
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- **Effective ICT systems**
Effective ICT systems

Political Will | Inter-Ministerial Integrated Care Programme
Catalonia

- Shared health and social care record
- Multimorbidity unified data set
- Users’ platform – My Health
- Big Data Analytics for Research and Innovation
Concluding Remarks: An Ongoing Journey
Concluding Remarks

Care systems that have effectively created

- a population health-based approach
- with the integration of multiple health and social care providers
- into new forms of collective governance arrangements
- and risk-sharing frameworks with and alongside local communities

appear to have the greatest potential for transformational change to improve
✓ care experiences
✓ care outcomes
✓ and promote system sustainability
Concluding Remarks

✓ The development of such systems is, to-date, rare.

✓ They are faced with continual and significant challenges, require committed and sustained leadership, and take considerable time to develop and mature.

✓ There are few short cuts or ‘magic bullets’ as the journey itself builds alliances and supports the right models of care to emerge in different country and regional contexts.
International Summer School Integrated Care (ISSIC)

Course dates:
23 June - 28 June 2019

Location:
Wolfson College, Oxford, United Kingdom

Facilitated by:
Dr Toni Dedeu
Director of Programmes

The International Summer School on Integrated Care, “Integrated Care in Theory and Practice”, is organised by the Integrated Care Academy® and provides a one-week intensive training on theory and practice of integrated care. It is aimed at health and social care professionals, clinicians, researchers and managers who want to strengthen their understanding of integrated care, get a comprehensive overview of the state of the art in theory and practice, and hone their competencies in analyzing, designing, evaluating and practicing integrated care. The course has been developed for those who are tasked with designing, implementing, leading and/or managing integrated care and want to learn more about the tools and instruments which are available to them with evidence from around the world.

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