The role of hospitals in the integrated care systems of the future across the world

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Introduction

Integrated care has historically been defined conceptually by the problems it has aimed to solve, namely fragmentation of services, health systems not designed for the needs of an aging population living with multiple chronic diseases, and under-resourced primary care.

We have seen the term adopted widely by politicians, policymakers, and practitioners globally over the last decade alongside such terms as "person-centred care;" "population health management;" "case management" and "chronic care / long term condition management" to name but a few. At the International Foundation for Integrated Care, we have developed the nine pillars of integrated care, based on our body of work and collaboration in the development of frameworks for integrated care. We know from implementation studies that the interdependencies between different moving parts of any integrated care system are multiple and complex. We also know that when integration happens at the level of the person and community this is where it has greatest impact.

The central defining features of integrated care which cuts across all stakeholders (people and communities, individual providers, a system of organisations, and policymakers) are continuity and coordination. Continuity occurs temporally and coordination occurs spatially. For the person at the centre of care, their experience is seamless across formal and informal care, professional, organisational, and sectoral boundaries and continuous over time. For providers, they design care to effectively manage transitions from one profession, organisation, or sector to another over multiple episodes of care. For policymakers, integrated care requires them to ensure that the wider context supports continuity and coordination and does not work against them (Lennox-Chhugani, 2021).

Continuity and coordination alone require multiple interventions to be put in place. Our health and care systems have come to rely on specialisation and compartmentalisation (Britnell 2011). This approach to design has introduced fragmentation across time and space and all the risks that come with that. The pandemic has exposed the fragility of our current systems of prevention, care, and cure.

These system components have multiple dependencies. The fragmented design of our systems means that in normal times, public health, long term social care, primary care and community services and hospital care find ways to manage these dependencies. This does not often work in favour of the person at the centre of care but does manage to paper over the cracks from a system perspective. In the pandemic, the dependencies have been thrown into sharp relief.

Hospitals withstood the worst of the pressure in the first and second waves of the pandemic around the world. They are now dealing with the ongoing pressures from Covid-19 infections as well as the pressure of delayed treatment. Models of integrated care can and should be part of the solution to the challenges facing hospitals across the world today.

Much of the focus for integrated care internationally up until now has been around integrating community-based, out-of-hospital services. There are some notable and growing exceptions to this. In the US, the Affordable Care Act (2010) focused on horizontal integration of primary and hospital care. Many states and systems have incorporated prevention and social care services into their models to help manage increasing demand for healthcare.

There are tensions between what we are trying to achieve through care integration and population health and the historical financial and operational models of hospitals. For hospitals, there can be systemic disincentives to taking an active role in wellness and prevention.

In Oregon, when they implemented their model of integrated care under the Coordinated Care Organisations (International Foundation for Integrated Care 2021), they found that the financial model of basing annual funding for hospitals on a retrospective actuarial analysis of the previous years expenditure, effectively penalized those systems that were successful in prevention and keeping people out of hospitals.

How can we resolve those tensions and realize the benefits of care integration?

The contribution hospitals can make to care integration

Hospitals that have shown greater resilience in the pandemic are well-resourced yes, but are also more connected into their wider community.

The concept of being an 'anchor institution' is new but growing. Hospitals are hugely important and influential local employers and economic contributors in their communities. How they operate can have a profound effect on the wider determinants of health in their locality (Reed et al, 2019).

This means being a collaborative local system partner. The risk for hospitals is they are seen by other system partners as a dominant partner because of their size and the scale of resources over which they have control.

Hospitals that recognise their social responsibility to act as a network facilitator and to provide leadership and stewardship to the system, are more successful in building trusted relationships leading to realising the value benefits of integrated care.

An example from Queensland, Australia

Health services in the State of Queensland, Australia operate within a devolved system of governance.

They are delivered through a shared approach involving multiple jurisdictions (Commonwealth, State and Local) and a broad range of healthcare professionals and private and public sector entities. The relationships between the key components of the system are complex and overlapping. It is a federated model where 16 Hospital and Health Services (HHSs) provide hospital and health services within their defined remit per the Queensland Hospital and Health Board Act 2011. The Queensland Department of Health is the system manager. This federated approach has inherent strengths in such a diverse and vast geographical jurisdiction. It offers flexible and efficient structures that provide greater engagement and ownership from employees over their specific hospital and health service outcomes, it accommodates diversity and difference; and combines the benefits of collaboration and collective action with the capacity to design and deliver services tailored to the needs of local communities. Hospitals have a high profile within the structure and have played a vital role Queensland's response to the COVID-19 pandemic.

Children's Health Queensland Hospital and Health Service
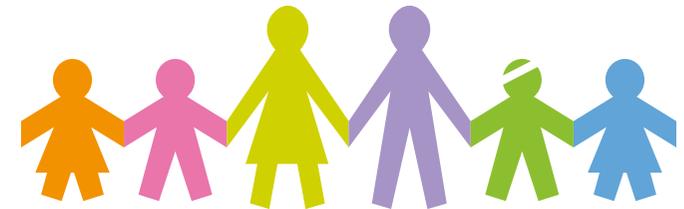
Based in Queensland's most populous city, Brisbane, Children's Health Queensland Hospital and Health Service (CHQ HHS) is unique among the 16 HHSs as it is a dedicated Paediatric Hospital and Health Service which cares for children and young people from across Queensland and northern New South Wales.

With a staff of over 5,000 full time equivalent (FTE) based at the Queensland Children's Hospital (QCH) and in a range of community locations across metropolitan Brisbane and state-wide. CHQ HHS provides a comprehensive range of hospital based secondary, tertiary, and quaternary services and Child Health, Child Development and Child and Youth Mental Health services from community-based locations both in the Brisbane metropolitan area and throughout the state.

Families frequently experience the hospital system as hard to navigate. Integrated models that are good for children, young people and families fall into the gaps between programme and organisational silos and are confounded by barriers to true collaboration for improved shared outcomes. The hospital leaders recognise that they still struggle to deliver a joined-up system for supporting families and communities.

To effectively deliver on its vision of 'leading life-changing care for children and young people – for a healthier tomorrow,' CHQ places significant emphasis on the 'network' characteristics of system advocacy, leadership and collaboration across the health, education, and social care system. This work is anchored by a set of core values – Respect, Integrity, Care, and Imagination which are in turn embedded in a suite of strategic and operational plans informed by a population health and social determinants of health perspective. Service delivery is underpinned by a person-centred care philosophy.

It is from this stance that CHQ engages with the fifteen other Hospital and Health Services (HHS's), community-controlled sector (Non-Government Organisations), Primary Care, Government Departments including Education, Housing, Children, Youth and Women and Multicultural Affairs, Child Safety and Youth Justice, charity partners, Tertiary Education Institutions, the Mental Health and Child and Family Commission's and crucially families and community.

Based on the work of Himmelman's (2002) articulation of 'the 'collaboration continuum', CHQ developed a 'collaboration and partnership process guide' which provides a framework and operational guidelines for the support and facilitation of the multiple cross system relationships that are key enablers for impactful collaboration. Each level of the continuum builds on the previous level.

Networking or shared information

...where information is exchanged for mutual benefit. It is the most informal of the inter-organisational linkages and often reflects an initial level of trust, limited time availability, and a transactional relationship.

Coordinating including shared action

...where information is exchanged, and activities altered for mutual benefit and to achieve a common purpose. Coordinating requires more organisational involvement than networking and is a crucial change strategy. Coordinated services are "user-friendly" and eliminate or reduce barriers for those seeking access to them. Compared to networking, coordinating involves more time, higher levels of trust but continues to hold the respective organisations operational silos intact.

Cooperating including shared resources

...where information is exchanged, activities altered, and resources shared for mutual benefit and to achieve a common purpose. This way of working requires greater organisational commitments than networking or coordinating and, in some cases, may involve written (a header agreement or memorandum of understanding) and usually legal agreements (e.g., contract). Shared resources can encompass a variety of human, financial, and technical contributions, including knowledge, staffing, physical property, access to people, money, and others. Cooperating requires a substantial amount of time, high levels of trust, and significant access to each other's organisational structure including infrastructure and assets.

Collaborating including shared benefits

...where information is exchanged and activities altered, resources shared, and the capacity of another is enhanced for mutual benefit and to achieve a common purpose. This includes sharing risks, responsibilities, and rewards. The qualitative difference between collaborating and cooperating in this definition is the willingness of organisations (or individuals) to enhance each other's capacity for mutual benefit and a common purpose. In this definition, collaborating is a relationship in which each organisation wants to help its partners become the best that they can be at what they do. This definition also assumes that when organisations collaborate, they share risks, responsibilities, and rewards, each of which contributes to enhancing each other's capacity to achieve a common purpose. Collaborating is usually characterised by substantial time commitments, very high levels of trust, and extensive areas of shared working and shared outcomes.

CHQ's Strategy 2020–2024 the impact of COVID-19

In mid 2019 CHQ engaged with the broader system to develop the organisations four-year strategic plan (2020–2024). In this process families told CQH about the importance of communication and coordinated compassionate care. Partners across the system stressed the value of responsiveness and support.

In early 2020 the CQH's consultation response was impacted by the emergence of the COVID-19 pandemic. An additional set of factors and risks needed to be considered. Work was undertaken with the system to develop a 'Paediatric COVID Response Plan' that would be agile and flexible enough to allow CHQ to respond to the challenges of a COVID outbreak and enable delivery accessible, safe, effective, and efficient care to children and young people across the state.

COVID-19 has emphasised the value of systems thinking to achieve the best outcomes for individuals and communities. From a systems-thinking perspective a key takeaway is the notion that small changes can have significant impacts. **CQH managed to safely support COVID-19 positive children and young people in their homes (where clinically appropriate) through a tailored 'hospital in the home' (HITH) program rather than admitting them to a hospital bed.** While logistically challenging in the initial stages, this approach allowed the hospital system to maintain the limited available inpatient bed capacity which in turn allowed access to beds and care for patients post elective and emergency surgery thereby resulting in the avoidance of compounding, and potentially acute demand, and increased risk for children and young people.

A remarkable characteristic of the COVID-19 response has been the sheer pace of reform, with major developments in vaccine production, the expansion of telehealth, the creation of COVID-19-specific clinical services within hospitals, the significant levels of cooperation between private and public hospitals, collaboration with Government Departments (e.g.,

Education in relation to vaccinating children) and state and federal governments. **Innovation has flourished and hospitals have played a vital role in leading this response.** As a result of facing the challenges of implementing rapidly evolving policy, CHQ has demonstrated flexibility as a strength that can be a legacy of the current crisis. An example in practice is the use of telehealth solutions in the clinical setting which has now become 'business as usual' for some services and has proven a valuable tool that provides a choice for clinicians in how best to deliver care and for children and their families a choice of how to access care in a way that suits them best. Initial feedback from families and colleagues from external partner organisations indicates that CHQ's response to the COVID–19 pandemic is perceived as value adding which has enhanced trust within the community and strengthened the collaboration and partnership work. An evaluation of the response has provided CHQ with valuable insights into how hospitals (and health services) can learn together, join-up effort, translate knowledge into practice and innovate to create an integrated networked system that will drive widescale collaboration and improve health, educational and social outcomes for children and young people.

Conclusion

CHQ has shown that by focusing on operationalising collaboration during the pandemic, through the heroic and selfless efforts of its staff, it has positioned itself credibly as a trusted community anchor.

Other hospitals should not waste the opportunity of harnessing the momentum that the pandemic has provided to sustain stronger collaboration in the longer term. Hospitals, with their unique human, estate, intellectual and social capital can reward and facilitate innovation. They can provide an agile, networked, and integrated response to the very real life and death challenges of public safety through prevention, early intervention, and acute care.

References

1. Lennox-Chhugani N. Integrated Care – Defining for the Future through the Eye of the Beholder. International Journal of Integrated Care. 2021;21(3):13. DOI: http://doi.org/10.5334/ijic.6427

2. Britnell M. The role of the 'specialist' in healthcare. Clin Med (Lond). 2011 Aug;11(4):329-31. doi: 10.7861/clinmedicine.11-4-329.

3. Legislating for integrated care in the UK: Lessons from abroad (2021) International Foundation of Integrated Care, https://integratedcarefoundation.org/publications/legislating-for-integrated-care-lessons-from-abroad

4. Reed S, Göpfert A, Wood S, Allwood D, Warburton W, 'Building healthier communities: the role of the NHS as an anchor institution'. Health Foundation; 2019.

5. Realising the True Value of Integrated Care: Beyond Covid-19 (2020) International Foundation of Integrated Care, https://integratedcarefoundation.org/publications/realising-the-true-value-of-integrated-care-beyond-covid-19-2

6. Slaughter, Anne-Marie (2017), The chessboard and the web: strategies of connection in a networked world, New Haven, Yale University Press, p. 49.

7. Himmelman, Arthur T. (2002), Collaboration for a Change: Definitions, Decision-making Models, Roles, and Collaboration Process Guide, Himmelman Consulting, Minneapolis, MN.

8. Children's Health Queensland, Strategic Plan 2020 – 2024: https://www.childrens.health.qld.gov.au

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IFIC Knowledge Tree

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