Integrated Care Academy©
Essential Skills Part I
What is integrated care?

UNIVERSITY OF BIRMINGHAM

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ICIC17, Dublin, Republic of Ireland
3 questions to the audience

1. What is integrated care to you?
2. How does it take shape (tools, instruments, models, etc.)?
3. What is your burning platform?
Why is it so complicated?
A little reminder of who we are working for…
Designing Better Care for Malcolm and Barbara

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

Courtesy of Prof. Richard Antonelli, Boston Children’s Hospital, Harvard Medical School
Gabe’s map of care
A family with complex needs

Zac, 8
- ADHS
- Problems at school
- Problems making friends
- No regular GP visits

Dorothy, 65
- Minimum pension
- DM II
- Hypertension
- Hip replacement
- COPD

Stella, 10
- No regular GP visits
- Healthy?

Sandra, 46
- Irregular employment
- Mental health issues, self harm
- Smoker
- DM Type II

Courtesy of Dr Dan Ewald, North Coast PHN, NSW, Australia
And then there’s me and YOU
A movement for change

The reality of care settings

Hours with professional / NHS = 3 in a year

Primary care
- Family physician
- Community nurse
- Dentist
- Pharmacist
- Therapist
- Mental health worker
- Walk-in centre
- Palliative care

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

Need for people engagement
Need for patient empowerment

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.

Source: Eurocarers, Stecy Yghemonos, Alpbach 2016
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
“Getting It Right For Every Child (GIRFEC) is the national approach in Scotland to improving outcomes and supporting the wellbeing of our children and young people by offering the right help at the right time from the right people. It supports them and their parent(s) to work in partnership with the services that can help them.”
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 health services delivery

The Austrian LTC allowance (non means-tested)

<table>
<thead>
<tr>
<th>Level</th>
<th>Care needs per month</th>
<th>Amount in € per month</th>
<th>Benefit in % per level</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>&gt; 75 hours</td>
<td>€ 1.154.50</td>
<td>31.8</td>
</tr>
<tr>
<td>II</td>
<td>&gt; 50 hours</td>
<td>€ 1.064.00</td>
<td>31.9</td>
</tr>
<tr>
<td>III</td>
<td>&gt; 25 hours</td>
<td>€ 846.90</td>
<td>28.7</td>
</tr>
<tr>
<td>IV</td>
<td>&gt; 15 hours</td>
<td>€ 663.00</td>
<td>22.7</td>
</tr>
<tr>
<td>V</td>
<td>&gt; 10 hours of home care</td>
<td>€ 492.00</td>
<td>21.9</td>
</tr>
<tr>
<td>VI</td>
<td>&gt; 100 hours of home care</td>
<td>€ 1.025.00</td>
<td>30.0</td>
</tr>
<tr>
<td>VII</td>
<td>Extremely complex care + LTC allowance &amp; Social Assistance</td>
<td>€ 1.623.00</td>
<td>40.0</td>
</tr>
</tbody>
</table>

Total number of beneficiaries: about 450,000 (4.4% of total population)

Private out-of-pocket expenses
- Max. 80% of pension
- Dependent = convertible personal property in case of permanent institutional care

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

A movement for change
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: adapted from Leutz 1999 in Nolte & McKee (2008)
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:

Almost 5 mio inhabitants

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

Integration of GPs and Case--manager nurse in management of patients with CHF and multimorbidity in 21 LHUs

care management based on team work.
- The nurse follows a limited number of patients
- 20-30 patients from care management lists
- Scaling up to 70 patients followed with continuity

Care plan shared by GP and Case-manager Nurse
- Action Plan for patient and care-giver
- Active monitoring with calls, home visits and outpatient visits.
- Team meeting and follow-ups
- No deadline.
A patients 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
Self care for maintenance of good health and lifestyle and prevention of ill health

Self care for acute illness

Self care of minor ailments

Self care of long term conditions

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
South Karelia, Finland: supporting people to support themselves

- Established integrated organisation in 2010 combining primary/secondary care with elderly/social care
- Goal was equal access across a rural municipality
- Focus on prevention and citizen responsibility in own care
- Remote monitoring and health coaching
- Mobile health units – use of webcams, broadband and video phones
- Pilot phase had 185 patients
- Care team was a GP, 2 FTE nurses, part-time home care workers, IT engineers and data analysts
- Patients felt less isolated and more secure

Health coaches and an electronic database support the planning of care and monitoring of the health status

View the project at: https://www.youtube.com/watch?v=9VAiEeODsPl
Key elements and lessons learned
Know your populations' needs and support accordingly

Kaiser model

- Evercare & Pfizer models

Highly complex patients

High-risk patients

70-80% of people with chronic conditions

Source: own illustration based on Singh and Ham, 2006
Many Frameworks Have Been Developed to Understand The Key Elements for Successful Integrated Care!

Better Outcomes for Chronic Conditions

Organisational and supporting processes

Empoderar e involucrar a las personas

Coordinar servicios

Crear un contexto facilitador

Fortealecer la gobernanza y la rendicion de cuentas

Reorientar el modelo de cuidados
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
Focus on holistic approach to health

The ‘Rainbow Model‘: Interventions on all levels

Integrated care does NOT mean loss of individualised care.
Culture of a Learning Healthcare System Builds Value

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

Intermountain Healthcare
Healing for life®
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)