Developing Person-Centred and Integrated Care to People with Complex Needs: An International Perspective

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Paper to Seminar on Person Centred and Integrated Care
Menzies Institute, University of Sydney, 20 August, 2013
What do we mean by ‘integrated care’?
A new idea?

The idea is not new – concern about lack of integrated care dates back to before the start of the NHS

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
Integrated care is centred around the needs of users

Integrated care means different things to different people

‘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)
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 Spreeuwnenburg, 2002, p2)
Key forms of integrated care

- Integrated care between health services, social services and other care providers (horizontal integration);
- Integrated care across primary, community, hospital and tertiary care services (vertical integration);
- Integrated care within one sector (e.g. within mental health services through multi-professional teams or networks);
- Integrated care between preventive and curative services;
- Integrated care between providers and patients to support shared decision making and self-management;
- 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.

Source: adapted from International Journal of Integrated Care
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.**
Conceptual Framework for Integrated Care

- System integration: ‘Health in all policies’ + coherence of health policies from different levels
- Organisational integration: How and where organisations/providers are brought together
- Functional integration: Non-clinical support & back office functions to support integrated care
- Professional integration: Multi-professional teams/networks with the right skill-mix
- Service integration: Care from a range of providers that is integrated into a coherent process
- Personal integration: Bio-psycho-social approach starting from needs of service users

Adapted from Pim Valentijn et al (2013)
What problems does integrated care seek to address?
Care Systems are Failing to Cope with Complexity of Need

• The complexity in the way care systems are designed leads to:
  - lack of ‘ownership’ of the person’s problem;
  - lack of involvement of users and carers in their own care;
  - poor communication between partners in care;
  - simultaneous duplication of tasks and gaps in care;
  - treating one condition without recognising others;
  - poor outcomes to person, carer and the system

Frontier Economics (2012) Enablers and barriers to integrated care and implications for Monitor -
The Mrs Smith test...

Many people with mental, physical and/or medical conditions are at risk of long hospital stays and/or commitment to long-term care in a nursing home.

Mrs. Smith is a fictitious women in her 80s with a range of long-term health and social care problems for which she needs care and support.

Mrs. Smith encounters daily difficulties and frustrations in navigating the health and social care system.

Problems include her many separate assessments, having to repeat her story to many people, delays in care due to the poor transmission of information, and bewilderment at the sheer complexity of the system.
From a fragmented set of health and social care services...
... to a co-ordinated service that meets her needs
What is Person or People-Centred Care?
People-Centred Care

People-centred care combines a range of care strategies that seek to involve users and communities in the design of care programmes, in creating a partnership between people/professionals so that there is ‘co-production’ of health, and in supporting people to have the autonomy to make their own choices over care and treatment and enable them to feel self-empowered. (Montenegro et al, 2012)

Key aspects:

- promotes health and wellbeing,
- focus on whole-person care,
- care for all people,
- partnership and participation,
- sensitivity to social/cultural diversity and context,
- quality of relationship and communication between the system and users,
- tailored and responsive care – i.e. to individual needs
- comprehensiveness and continuity,
- rights and responsibilities approach.
INPCM – 8 Conceptual Elements

The International Network of Person Centered Medicine suggests the following eight broad conceptual elements:

• Ethical commitment,
• Cultural sensitivity;
• Holistic scope;
• Relational focus;
• Individualized care;
• Common ground for diagnosis of care;
• People-centered systems of care (population health)
• Person-centred education and research.
The relationship between people-centred care and integrated care

Scenario A: Combination of UHC and PCC – e.g. direct payments, personal budgets, community participation schemes, self-care support – but wider care delivery remains fragmented and in silos (e.g. typical in UK)

Scenario B: Combination of UHC and IC – e.g. creation of new health and social care organisations, integrated care organisations, practice federations, telehealth (surveillance model) – but no focus on supported self-care or involving people

Scenario C: Combination of PCC and IC – e.g. segmented care – advanced DMPs, self-care support, advanced care practitioners, guided care, telehealth (self-care model) – but to specific targeted groups and not universally applied to those in need
Meeting the Challenge of Person-Centred and Integrated Care
Managing Complex Patients – What Works?

• **More effective approaches:**
  – Population management
  – Holistic, not disease-based
  – Organisational interventions targeted at the management of specific risk factors
  – Interventions focused on people with functional disabilities
  – Management of medicines

• **Less effective approaches:**
  – Poorly targeted or broader programmes of community based care, for example case management
  – Patient education and support programmes not focused on managing risk factors
Managing Complex Patients – What Works?

• Better coordination of care can save money and improve quality, especially:
  – Disease management programmes
  – Case management with multi-disciplinary teams
  – Where use of good data identifies people at risk of deterioration
  – Active outreach services and self-management support

BUT
  – Lack of robust evaluation
  – Financial savings not equally shared between providers (funding problem)
  – Need for regulation and governance to create conducive environment as co-ordination neglected

“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”
Managing Complex Patients – What Works?

1. Active support for self-management
2. Primary prevention
3. Secondary prevention
4. Managing ACS conditions
5. Integrating care for people with mental and physical health needs
6. Care co-ordination - integrated health and social care teams
7. Primary care management of end-of-life care
8. Effective medicines management
9. Managing elective admissions – referral quality
10. Managing emergency admissions – urgent care
International Case Examples
International case studies of integrated care to older people with complex needs: a cross national review

• The King’s Fund & University of Toronto funded by the Commonwealth Fund

• Seven case studies:
  – Te Whiringa Ora, Eastern Bay of Plenty, New Zealand
  – Geriant, Noord-Holland Province, The Netherlands
  – Torbay & South Devon Health and Care Trust, UK
  – The Norrtalje Model, Stockholm, Sweden
  – PRISMA, Canada
  – Health One, Sydney, Canada
  – Mass. General Hospital, Boston, USA
International case studies of integrated care to older people with complex needs: a cross national review

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<tr>
<th>Case</th>
<th>Why did it work?</th>
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<td>HealthOne, Australia</td>
<td>Better care planning and case management links patients to the right care providers</td>
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<td>PRISMA, Canada</td>
<td>Care co-ordination between providers by care co-ordinators enables quicker care delivery</td>
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<tr>
<td>Geriant, Netherlands</td>
<td>Intensive multi-disciplinary care supports carers and allows users (end of life) to remain at home</td>
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<tr>
<td>Te Whiringa Ora, New Zealand</td>
<td>Education and supported self-management enables people to manager their own conditions better</td>
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<td>Norrtläje, Sweden</td>
<td>Intensive home based services allows users to remain at home for longer. Faster response times from providers to care needs</td>
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<tr>
<td>Torbay, England</td>
<td>Multi-disciplinary care teams in community and pro-active care co-ordinators reduce LOS and enable home-based care</td>
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<tr>
<td>Mass. General, USA</td>
<td>Intensive case management of high-cost patients reduced acute episodes of care</td>
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UK-based case studies of care co-ordination to people with long-term and complex needs

• The King’s Fund funded by the Aetna Foundation
  – Oxleas Advanced Dementia Service
  – Midhurst Macmillan Palliative Care Service in Community
  – Pembrokeshire – Community Care Closer to Home
  – Sandwell Integrated Primary Care Mental Health and Wellbeing Service
  – South Devon and Torbay – Pro-active case management for at-risk patients
Midhurst Macmillan Community Specialist Palliative Care Service
Delivering end-of-life care in the community

99% of those wishing to die at home do so
High satisfaction amongst family, carers, staff
Significant cost reduction (c.25%) compared to ‘usual’ care in hospices/hospital settings
Awareness-raising and relationship-building
GPs, community staff, hospital consultants, volunteers and local people strengthening its ability to ‘capture’ people nearing the end of life before, or very soon after, a hospital admission.

Holistic care assessment and personalised care plan
A single assessment process examines both the health and social care needs of the patient and their family. It also takes into account their personal choices about future care and treatment options.

Multiple referrals to a single-entry point
The service accepts referrals from any health professional and also local people. All referrals come into the service and are assigned to a clinical nurse specialist from a single-entry point.

Dedicated care co-ordination
The care co-ordinator has a number of roles: acting as the principal point of contact with the patient and their family; effectively co-ordinating care from within a multidisciplinary team and liaising with the wider network of care providers.

Rapid access to care from a multidisciplinary team
Both professionals and volunteers can be rapidly deployed by the service to provide care or support to meet the needs of people living at home. The service operates 12 hours a day, with access to an on-call clinician out of hours.
Meeting the Challenge: Key Lessons
Meeting the Challenge at a Systems and Organisational Level

1. Find common cause
2. Develop shared narrative
3. Create persuasive vision
4. Establish shared leadership
5. Understand new ways of working
6. Targeting
7. Bottom-up & top-down
8. Pool resources
9. Innovate in finance and contracting
10. Recognise ‘no one model’
11. Empower users
12. Shared information and ICT
13. Workforce and skill-mix changes
14. Specific measurable objectives
15. Be realistic, especially costs
16. Coherent change management strategy
Meeting the Challenge at a Clinical, Service and Personal Level

No ‘best approach’, but several key lessons and marker for success that include all the following:

- Community awareness, participation and trust
- Population health planning- NOT carve-out DMPs or segmentation
- Identification of people in need of care – inclusion criteria
- Health promotion
- Single point of access
- Single, holistic, care assessment (including carer & family)
- Care planning driven by needs and choices of service user/carer

- Dedicated care co-ordinator and/or case manager
- Supported self-care
- Responsive provider network available 24/7
- Focus on care transitions, e.g. hospital to home
- Communication between care professionals, and between care professionals and users
- Access to shared care records
- Commitment to measuring and responding to people’s experiences and outcomes
- Quality improvement process
## Multiple strategies to be collectively applied

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<th>Theme</th>
<th>Problems if overlooked ...</th>
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<td><strong>Population-based planning</strong></td>
<td>Lack of understanding of local priorities and awareness of care needs leads to poorly targeted and/or late/missed opportunities to support interventions</td>
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<td><strong>Health promotion and self-care</strong></td>
<td>Inability to support and/or engage people to live healthier and more fulfilling lives fails to have any meaningful impact on the rising demand for institutional care</td>
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<td><strong>Care process</strong></td>
<td>Failure to plan and co-ordinate services with and around people’s needs leads to fragmentations in care and sub-optimal outcomes</td>
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<td><strong>Wider Network of Providers</strong></td>
<td>Inability of wider provider networks to respond to real-time needs of people means co-ordination efforts undermined and under-valued</td>
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<td><strong>Monitoring and Quality Improvement</strong></td>
<td>Inability to judge or benchmark impact and lack of evidence leads to loss of funding and professional trust, inability to influence professional behaviour, and limits ability to improve and adapt</td>
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Building a Supportive Policy Environment

Examples in Europe
European Strategies - Examples

- Denmark & Norway: Coordination Reform
- Sweden: Joint agencies link funding and delivery (e.g. Jönköping & Nortallje)
- England: The National Collaborative for Integrated Care and Support (Pioneers)
- 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 and HMOs
## European Innovation

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<th>Country</th>
<th>Aims</th>
<th>Description</th>
<th>Outcomes</th>
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| **Estonia** | To fully integrate communication between providers through a national electronic health records | • National HER hosting 3000+ services with companion service for insurance system and claims  
• Costs $10USD per person to operate | • Efficiency gains through direct communication between providers  
• Increased patient engagement via personal records and mobile telehealth |
| **Germany** | To implement care pathways for selected treatments and focus on rehabilitation so people can return to work | • Prime contractor model – managers, case manager, care professionals  
• Selected procedures | • Patients treated in integrated networks return to work 72 days earlier than those on conventional care pathways |
| **Hungary** | To coordinate the delivery of health and social care services at a primary care-level using capitated budgets | • Capitated budget for group practices  
• Incentives based on savings for reinvestment in care | • Improved collaboration  
• Decrease inappropriate service use  
• Increase preventative care |
| **Israel** | To develop an integrated people-centred network of primary, secondary and specialist care incl. pharmacies | • Services adapted to population sub-groups  
• Priority investment in continuity of care, care transitions | • Prevention of hospital re-admissions  
• More care at home  
• Meets patient preferences better |
Final Point: Integration Necessary at Every Level

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