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INTEGRATED CARE

DEFINITIONS, CONCEPT, LOGIC, METHODS, EVIDENCE, CASE STUDIES

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Integration Care – No Common Definition

- Term “integrated care” used by different people to mean different things
- Terminology is rather “elastic” *(MacAdam, 2008)*
- Frequently equated with
  - managed care
  - continuity of care
  - case/care management
  - transmural care
  - patient centered care
  - shared care
  - transitional care
  - integrated delivery
- Many seemingly related and overlapping notions *(Howarth & Haigh, 2007)*

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Integration Care – No Common Framework

- Terminology important to envision, design and evaluate healthcare services
- Good framework needed to facilitate communication, hypothesis generation, policy formulation, program development and evaluation *(Kodner & Kyriacou, 2000)*
- Solid empirical framework helps to understand and scale up successful real world applications *(Goodwin et al, 2004)*
- Principles of organizational behavior and management practices in the business sector can help better understand integrated care (Suter et al, 2007)
- Field of integrated care imprecise and evolving

Integration Care – Why Integrate?

- Enhance patient-centered production and delivery of healthcare
- Balance “unbalanced” care
- Increase quality of delivery of health and life services related to aging, chronic illness and disability
- Reduce fragmentation, fill gaps and remove redundancies
- Address problems related to access, continuity, and coordination
- Improve efficiency in use of resources
- Prevent medical errors
- Contain difficult-to-control costs
- Boost public confidence in the health system

Integration Care – Different Views
(Lloyd & Wait, 2006)

Patients

- Easy access
- Seamless care

Providers

- Interdisciplinary teamwork
- Coordination of tasks and services across professional boundaries

Managers

- Oversight of funding streams
- Management of complex organizational structures

Policy Makers

- Design of integration-friendly policies and financing arrangements
- Evaluation of systems and programs

Integration Care – Types

(Nolte & McLee, 2008; Shortell, 2000; Fulop et al, 2005)

- Functional Integration
  - Degree to which back office and support functions are coordinated
- Organizational Integration
  - Relationship between healthcare organizations
- Professional Integration
  - Provider relationships within organizations
- Service Integration
  - Coordination of services in a single process
- Normative Integration
  - Shared missions and values
- Systemic Integration
  - Alignment of policies and incentives at the organizational level

Integration Care – Levels
(Kodner et al, 2000; Kodner et al, 2002)

- Funding
  - Pooling of funds at different levels
- Administrative
  - Consolidation of responsibilities
- Organizational
  - Inter-agency planning and budgeting
- Service Delivery
  - Case management
- Clinical
  - Uniform and comprehensive assessment procedures

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Integration Care – Degrees
(Leutz, 1999)

- Least Change Approach
  - Providers work together on an ad-hoc basis
- Structured coordination
  - Defines mechanisms to facilitate communication and information sharing
- Full integration
  - Creation of a new entity that consolidates responsibilities, resources and financing

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Case Study: Integrated care for Older People (1)

	Australia HealthOne	**Canada** PRISMA	**Netherlands** Geriant	**New Zealand** Te Whiringa Ora	**Sweden** Norrtalje	**UK** Torbay	**USA** MassGeneral
General description	Community-based case management	Integrated service delivery network	Community-based multidisciplinary dementia teams	Community-based multidisciplinary long-term teams	Integrated purchaser–provider organization	Community-based multidisciplinary teams older people	Intensive practice-based care management
Objectives	Integrate GP and community health services to provide continuum of care. Improve referral process to specialist and other care services. Reduce hospital readmissions	Improve co-ordination of health and social care for elderly people with chronic conditions. Improve health outcomes, empowerment and satisfaction	Improve the capacity, quality and alignment of cure and care services. Enable people with dementia to live at home for longer. Protect clients' and informal caregivers' quality of life	Improve access to care. Reduce disparities in health outcomes. Better long-term conditions management. Reduce preventable hospital admissions	Older people supported to remain in own home. Improved care continuity, quality of life and feeling of security. Improved quality of care for people with dementia and at end of life	Improve quality of care for users, simplify access, reduce number of assessments, improve referral times, improve independence, reduce hospitalizations	Improve quality of care and outcomes to beneficiaries, improve quality of working life to primary care physicians, reduce costs

Case Study: Integrated care for Older People (2)

	Australia HealthOne	**Canada PRISMA**	**Netherlands Geriant**	**New Zealand Te Whiringa Ora**	**Sweden Norrtalje**	**UK Torbay**	**USA MassGeneral**
Coverage	125 active chronic and complex patients enrolled in programme in August 2011	Service delivered across one Canadian province. Each case manager aims to have between 40 and 45 clients	In 2011, the organization cared for 2,860 clients	The average caseload is 60 patients per team	All older people in Norrtalje (12,000 people over 65 in 2011)	All older people in Torbay. Team caseloads vary from 60 to 90 persons	Between 2006 and 2009, cared for 2,600 enrolled patients
Funders	State **government** – publicly funded programme	Multiple: including **research, state and regional** authorities, local health/social	Multiple and annual **contracts with health care insurers**, plus client contribution	**Provider alliance** purchases and provides care – contract from Healthcare New Zealand	**Integrated purchaser–provider organisation** – contract from county council and local authority	**Pooled funds from NHS clinical commissioning group and local authority**	**Contract with federal government's centers** for Medicare and Medicaid

Case Study: Integrated care for Older People (3)

	Australia **HealthOne**	**Canada** **PRISMA**	**Netherlands** **Geriant**	**New Zealand** **Te Whiringa Ora**	**Sweden** **Norrtalje**	**UK** **Torbay**	**USA** **MassGeneral**
type (organizational integration)							
Breadth of integration	Contractual – supports both vertical and horizontal integration	Contractual – emphasis on agency co-ordination to support vertical and horizontal integration	Real integration. Horizontal (multi-disciplinary teams)	Virtual with multiple providers. Horizontal (multidisciplinary teams)	Real integration. Vertical (hospital– home) and horizontal integration (home care)	Real integration. Vertical (hospital–home) and horizontal (multi-disciplinary teams)	Real integration. Vertical (care transitions) and horizontal (case management)
Degree of integration	Linkage model connecting to multiple care providers – **no formal integration**	Co-ordinated model – agencies share responsibility for clients – **no formal integration**	**Fully integrated provider model for team**; co-ordinated model other care providers	Co-ordination model connecting to multiple care providers – **no formal integration**	**Fully integrated health and social care provider (prime contractor) with integrated funding**	**Fully integrated provider model for team**; co-ordinated model other care providers	**Integrated delivery system** – large co-ordinated network of care providers
Information management (functional integration)							
Use of shared electronic medical record	No	Yes – computerised client chart accessible by all affiliated health professionals, excluding some primary care physicians	No	No	Limited – joint medical documentation, moving towards shared records in future	Limited – integrated community health and social care information system (not GPs)	Limited – hospital electronic medical records (EMR) and case management system
Use of risk	No	Yes, based on a	No	No	No	Yes	Yes

Case Study: Integrated care for Older People (4)

	Australia HealthOne	Canada PRISMA	Netherlands Geriant	New Zealand Te Whiringa Ora	Sweden Norrtalje	UK Torbay	USA MassGeneral
Approach to Care							
Single point of referral	Yes – referrals from multiple sources	Yes – referrals from multiple sources, including self-referral	Yes – referrals from GPs only	Yes – referrals from multiple sources	No – focus is on building 'chains of care'	Yes – referrals from multiple sources	Yes – voluntary enrolment pre-selected beneficiaries
Eligibility criteria	Yes – inclusion criteria	Yes – inclusion criteria	Yes – any person diagnosed with dementia	Yes – detailed inclusion criteria	No – available to all people over 65 in locality	Not defined – deal with all 'vulnerable' patients	Yes – detailed inclusion and exclusion criteria
Single assessment	No – based on previous assessments	Yes	Yes	Yes	Yes – home care service only	Yes	Yes
Care planning	Yes	Yes	Yes	Yes	Yes – 'meeting points' to share records, home care	Yes	Yes
Care coordinator or case manager	Yes	Yes	Yes	Yes	Yes – home care workers	Yes	Yes

Case Study: Integrated care for Older People (5)

	Australia HealthOne	Canada PRISMA	Netherlands Geriant	New Zealand Te Whiringa Ora	Sweden Norrtalje	UK Torbay	USA MassGeneral
Results							
User and professional experiences	Clients feel supported/ less anxious. GPs have high satisfaction	Increase in client satisfaction and empowerment	Informal carers provided positive assessments	GPs evaluate service positively	Improved information and communication among professionals	Increased staff motivation and positive evaluations from GPs	High patient/physician satisfaction
Care outcomes	–	Lower incidence of functional decline. Lowered unmet needs	Longer time spent at own home	Longer time period between COPD events post-enrolment	Easier and faster access to care	Shorter waits to receive social care support	Annual improvements in mortality
Utilisation of services	Reduced emergency room (ER) visits and lengths of stay post-intervention.	Reduced ER visits and hospitalisations. No increase in consultations with health	Reduced dementia-related hospital care and reduced lengths of stay in nursing	Reduced hospital bed days for COPD patients	Reduction in nursing home placements among elder adults	Reduction in emergency admissions, bed days and lengths of stay. Fewer residential	Reductions in inpatient admissions and use of emergency departments

Case Study: Integrated care for Older People –

The role of primary care physicians

Australia HealthOne	Two GP liaison nurses operate across the locality and connect with up to 90 local primary care physicians. Primary care physicians involved in the steering committee are directly remunerated for their involvement. Otherwise, **GPs did not benefit financially from the program but did appreciate the extra support** for managing complex patients.
Canada PRISMA	Primary care physicians work closely with case managers to support needs assessment and care planning. Governance arrangements are in place that set out their role in this regard but levels of commitment are variable if 'mostly proactive', in part due to the lack of payments to attend multi-disciplinary teams and for providing care co-ordination.
Netherlands Geriant	The organization only takes referrals to its dementia home care service from GPs, as **GPs have a role as gatekeepers to specialist care** in the Netherlands. While GPs are kept informed of how care is progressing, they are not directly involved in the dementia care process unless patients are referred back to them for a separate medical problem. The GP remains responsible throughout the process. For non-dementia-related care, the GP still has a central role. Across these domains, Geriant practitioners and GPs share relevant information and consult each other if required.
New Zealand Te Whiringa Ora	Case managers (registered nurses) and community support workers (kaitautoko) support the process of holistic assessment and care planning. **Primary care physicians are informed of care plans but are not directly involved in the process**, though the service may gain referrals from them and they may be contacted where GP support is identified.
Sweden Norrtalje	**Primary care physicians work for and on behalf of the integrated health and social care provider** and so are integral to the care provided to older people locally. A single chief physician supports the home care service.
United Kingdom Torbay	Health and social care teams operate in localities linked to the registered populations of local general practices, but **GPs are rarely involved directly as part of the 'core team' in managing patients** in the

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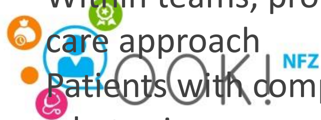
Case Study: Integrated care for Older People – Why did different models work

- HealthOne (Australia)
  - Better care planning and case management of older people with complex health needs supports more appropriate signposting and links to the right care providers, so reducing unnecessary hospital admissions
- PRISMA (Canada)
  - Intelligent co-ordination of care using real-time data and information between care providers enables earlier, faster and more effective delivery of care and cure services
- Geriant (the Netherlands)
  - Intensive multidisciplinary care support to dementia sufferers and their informal carers allows users to remain at home for longer
- Te Whiringa Ora (New Zealand)
  - Strong focus on education and supported self-care enables people with long-term conditions to better manage their conditions and reduces acute episodes of care needing hospitalization
- Norrtalje (Sweden)
  - Integrated communication and co-ordination between care providers enables earlier, faster and more effective delivery of care and cure services. Intensive home-based service allows users to remain at home for longer and so reduces home care placements
- Torbay (United Kingdom)
  - Multidisciplinary care support to older people reduces acute episodes of care needing hospitalization, and allows users to remain at home for longer, which reduces home care placements
- MassGeneral (United States)
  - Intensive case management of high-cost patients with strong self-care support and close working relationships with primary care physicians reduces acute episodes of care needing hospitalization.

People – Key Lessons for Successful Adoption of Integrated Care

- **System level**
  - Recognize the importance of addressing this agenda of integrated care for frail older people
  - Provide stimulus through funding or other means to support the development of local initiatives to improve care for this group of people
  - Avoid a top-down policy that requires structural or organizational mergers
  - Remove barriers that make it more difficult for localities to integrate care, such as differences in financing and eligibility.
- **Organizational level**
  - There is no single organizational model or approach that best supports integrated care
  - The starting point should be a clinical/service model designed to improve the care that is provided rather than a model with a pre-determined design
  - It takes time for approaches to integrated care to develop and mature, with most programs constantly evolving
- **Functional level**
  - Success is related to good communication and relationships between those receiving care and the professionals and managers involved in delivering care
  - Greater use of ICT is potentially an important enabler of integrated care, but does not appear to be a necessary condition for it
  - Building relationships to support integrated care requires time to build social capital and foster trust.
- **Professional level**
  - Professionals need to work together in multidisciplinary teams or provider networks – generalists and specialists, in health and social care
  - Within teams, professionals need to have well-defined roles, and work in partnership with colleagues in a shared care approach
  - Patients with complex needs that span health and social care may require an intensity of support that is beyond what primary care physicians can deliver.



Integration Care – Evidence

- Review of 85 studies on care co-ordination experiences in six OECD countries confirmed that integrated primary care can produce positive patient health outcomes and satisfaction, especially when multiple strategies such as case conferences, care plans, training, and funding were used to co-ordinate care *(Powell-Davies et al., 2008)*
- A review of 15 randomized trials conducted in the US among Medicare beneficiaries found that costs were generally higher for patients enrolled in the co-ordination arm of the trial compared with patients in the control arm, although in most instances these differences were not statistically significant; trials showed that patients in the care coordination arm received more education services and help with arranging care *(Peikes et al., 2009)*
- A review on the impact of chronic care management found that patients with heart failure were significantly less likely to be hospitalized when their care was provided by multi-disciplinary teams and when communication between providers and patients was conducted in-person rather than by telephone *(Sochalski et al., 2009)*
- Even though care co-ordination appears to reduce the number of hospitalization, the effect on cost remains ambiguous, particularly in the short term. However, some studies find evidence of costs savings for programs that are targeted at (i) some conditions such as congestive cardiac failure and (ii) patients with higher and more complex needs *(Mattke et al., 2007; Kodner and Spreeuwenberg 2002)*
- Overall, evidence suggests that the impact on costs is dependent on the types of diseases being treated and whether these conditions are associated with high-cost unnecessary treatment or with under-treatment prior to the integrated care initiatives *(Rand Europe and Ernst and Young 2012)*

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Integration Care – New Models in OECD Countries

- **Germany – Coordination through disease management programs**
  - The 2002 reform of the German Statutory Health Insurance (SHI) introduced Disease Management Programs (DMPs) to improve prevention and care co-ordination for chronic conditions. These reforms sought to improve quality of care and foster competition between sickness funds. They were introduced in the context of an ageing population, a rise in chronic conditions and a lack of monitoring of providers' activity or implementation of clinical guideline. The German example highlights a program of horizontal integration along with a moderate degree of co-ordination that emphasized organizational, service and clinical integration, and where GPs became the coordinators of care.
- **Netherlands – Adoption of bundled payment systems**
  - In 2006, the government introduced managed competition between insurers and providers and by 2010; 90% of the Dutch population had insurance from one of four major health insurers while another six small health insurers established a purchasing cooperative. In 2007, a bundled payment for chronic diabetes care was launched on an experimental basis. In 2010, this bundled payment approach was expanded and applied to four chronic conditions: diabetes, chronic obstructive pulmonary disease (COPD), heart failure and management of cardiovascular risk factors due to relatively high prevalence of these chronic conditions and the feasibility of their implementation. The Dutch example reflects elements of vertical integration of moderate co-ordination with an emphasis again on the organizational, service and clinical integration where GPs lead the care co-ordination
- **Japan – Embarking on a system of care co-ordination**
  - Japan provides health insurance coverage to its whole population but the health insurance system divides the population into three groups: (i) private salaried workers and public officials; (ii) self-employed workers; and (iii) the elderly aged 75 and older. Patients pay an annual premium as well as co-payments that range between 10-30% of the fee when they visit the doctor. In 2008, Japan introduced a policy to encourage more cooperation between hospitals, and long-term care providers for cancer, stroke, acute myocardial infarction and diabetes. In 2013, mental health was also included. The aims are to provide high-quality care while at the same time encourage cooperation between hospitals and long-term care providers.

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QUESTIONS? COMMENTS?