How to scale up and implement integrated care?

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112 programmes, 25 countries

Innovating care for people with multiple chronic conditions in Europe

Selection of 17 integrated care programmes

Population Health Management
Frail Elderly
Persons with Problems in Multiple Life Domains
Palliative & Oncology Patients

AT	Health Network Tennengau (Gesundheitsnetzwerk Tennengau) Sociomedical Centre Liebenau (Sozialmedizinisches Zentrum Liebenau)
HR	GeroS System Palliative Care System
DE	Casaplus Gesundes Kinzigtal
HU	Onconetwork Palliative Care Consulting Service (Mobile) Team
NO	Learning network Medically Assisted Rehabilitation (MAR) Bergen
ES	Badalona Serveis Assistencials (BSA) Barcelona Esquerre (AISBE)
NL	Better together in Amsterdam North (BSiN) Proactive Primary Care Approach for Frail Elderly (U-PROFIT) Care Chain Frail Elderly (previously called KOMPLEET)*
UK	South Somerset Symphony Programme Salford – Salford Integrated Care Programme (SICP)/ Salford Together

Sustainable intEgrated care modeLs for multi-morbidity: delivery, FInancing and performancE

1) Adopting a community-based approach to achieve person centered care

Place the patient at the centre of all stages of the care process; involve informal carers in the planning of care, Performing needs assessments with all stakeholders in the community

OnkoNetwork – Hungary

- Personalised pathways developed
- Discussions with all stakeholders (patients included)
- Planning and implementation based on concensus
- Continuous information sharing (also with patient) during the implementation

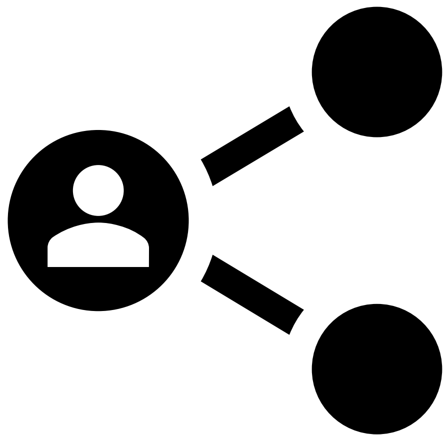
2) Engaging stakeholders, gain their trust, agree on a common problem definition and way forward

Developing a shared narrative and persuasive vision, bringing in the right stakeholders, continuous investment in good communication and consensus

Health Network Tennengau – Austria

- Involvement of all major players in health and social care
- Shared motivation and interests
- Frequent communication
- Building trust

3) Overcoming fragmented leadership and responsibilities



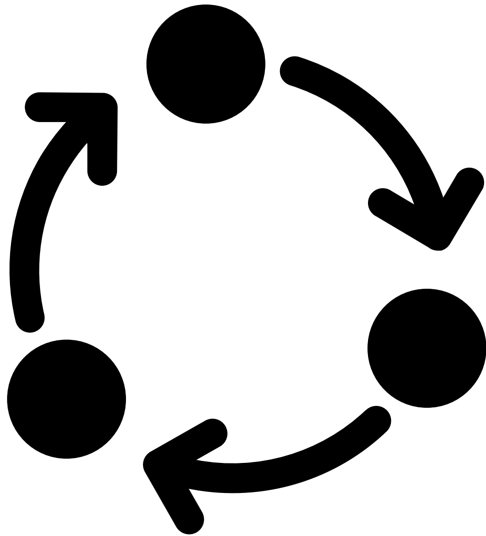
Understanding which type of leadership fits best

Leadership can be distributed across different levels: national, regional, organisational and unit level.

Examples:

- Making one organization responsible for implementation
- Elected management board of programme with rotating chairs
- Local champions within teams

4) Create feedback loops & continuous monitoring



Feedback is key for improvement

- Requires culture of openness and willingness
- A seat at the table for patients

Involvement of research institutes

- Quality improvement
- Robust evidence on outcomes

Creating a Learning Health System

- Bringing together stakeholders to improve through learning cycles. Knowledge sharing to determine how new evidence fits into policy and practice

5) Secure long-term funding and adopt innovative payment that overcome fragmentation

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HEALTH SYSTEMS AND POLICY ANALYSIS

POLICY BRIEF

How can we strengthen financing mechanisms to promote care for people with multiple chronic conditions in Europe?

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On behalf of the ICARE4EU consortium

ICARE4EU

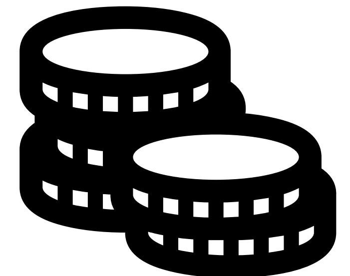
European Observatory on Health Systems and Policies

Take advantage of start-up funding from national or European funds to help initiation and development

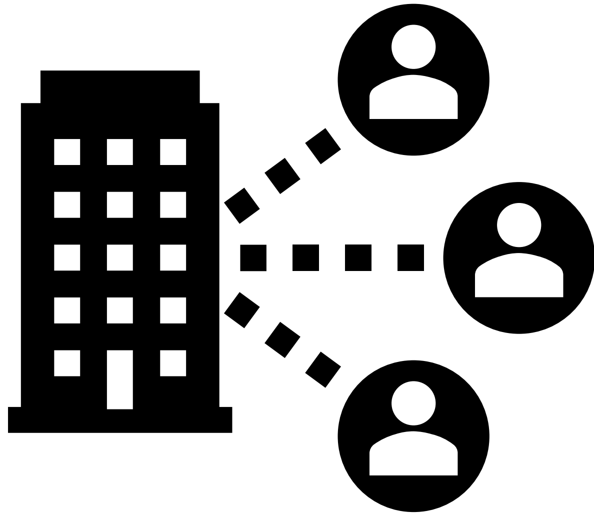
- Financial security is necessary for sustainable implementation
- Long-term contracts give security, empower continuity and avert time-intensive budget negotiations. Tie eventual renewal to quality metrics with capable ICT systems

Payment models incentivizing integration

- Encompassing care delivery by multiple sectors and with shared savings/loss agreements



6) Identify solutions to include patient-centredness in training and continuing professional development



Interprofessional education for the next generation of health and social care workers to understand each other's skills and responsibilities, as well as the role of caregivers

Sensibility training for complex health problems and vulnerable groups so that frontline workers and managers alike can collaborate and reduce fragmentation

Patient-focused coaching in South Somerset (UK)

- A new role (health coach) to assist in patient education and link patients to community services

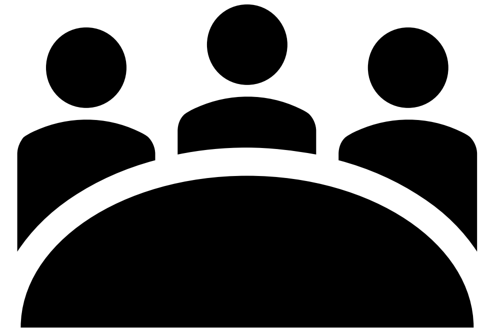
7) Build a multidisciplinary team culture with mutual recognition of each other's roles

Regular meetings to discuss specific patients and their personalised treatments

- Strengthens collective responsibility
- Building team culture through physical proximity

Silkeborg Hospital (Denmark)

- Lunchtime meetings for all actors involved in a patient's care to brief one another
- Eschewing of traditional hierarchies (MDs, care coordinators and physiotherapists sitting together in open exchanges)



8) Develop new roles and competencies for integrated care

Catering to local needs

- New roles (e.g. advanced nursing roles, care navigators), task-shifting and task differentiation to improve coordination at all levels

To adapt to changing role of the patient

- self-management support, patients as active partners

Casaplus (Germany)

- Nurses take on the additional role of case managers to coordinate health and social care. They consult with everyone from GPs to specialist to sickness funds and informal carers

9) Implement ICT to support collaboration and communication rather than administrative procedures

Technological interoperability, full engagement across teams and data sharing

- Useful for monitoring processes and outcome data
- Involve professionals and end-users in development

Badalona Serveis Assistencials (Spain)

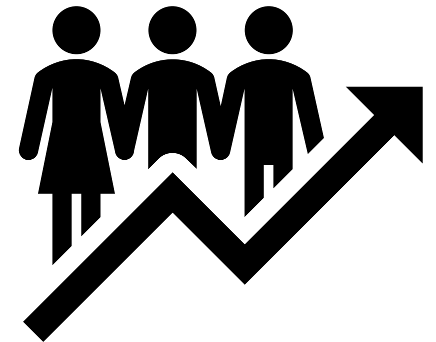
Electronic Health Record

Catalan Shared Medical Record

10) Adopting a growth model that strikes a balance between gradual expansion and disruption

Stepwise changes and adding new interventions enable providers to scale care

- Build off of existing structures without jeopardising how carers perform their existing duties
- Strong patient voice (and that of informal carers) as a check on major interruptions to delivery of essential care



11) Balance between flexibility and formal structures

Operate between mandatory guidelines and micro-level worker discretion

- Striking the right balance between formalization of responsibilities and providing enough flexibility to deviate

Gesundes Kinzigtal (Germany)

- Coordination on care delivery between doctors, hospitals and other partners at the micro-level with regional stakeholders

12) Engaging in alignment work

Concluding thoughts

- There is no single blueprint available for policymakers
- Policymakers should foster a supportive macro level environment
- Post-pandemic opportunity

Thank you!