Integrated Care in Practice

2 December 2014, Swedish Permanent Representation to the EU

On 2 December EUREGHA (European Regional and Local Health Authorities) organised its Annual High Level Conference. The theme of this year's conference was "Integrated Care in Practice", and it gathered speakers from the European Commission, the World Health Organisation and the International Foundation for Integrated Care. Innovative local and regional models of integrated care were also presented and discussed. Please find below the minutes from the conference. For any further questions, please contact the EUREGHA Secretariat, secretariat@euregha.net. For more information on EUREGHA, please see www.euregha.net.

Welcome by Toni Dedeu, Chair of EUREGHA and Director of Knowledge Exchange and Research, Digital Health Institute, Scotland

Toni Dedeu welcomed the attendees to the Annual EUREGHA High Level Conference, Integrated Care in Practice. He especially thanked the Brussels based officers of the regional offices in attendance for the great job they do in representing regional interests in the health area in Brussels. Mr Dedeu briefly introduced EUREGHA, presenting the 15 full members and the network's seven wroking streams; cancer screening, mental health, cross-border health care, e-Health, health equity, research and innovation, and integrated care.

Mr Dedeu continued in motivating the focus on integrated care, mentioning that there are many innovative initiatives on integrated care that are being implemented in EUREGHA's member regions. Lastly, he welcomed the speakers and expressed great joy in welcoming high level representatives from stakeholders working on integrated care - the European Commission, the World Health Organisation (WHO) and the International Foundation for Integrated Care (IFIC).

Integrated Care and the European Innovation Partnership on Active and Healthy Ageing, Loukianos Gatzoulis, Economic and Policy Analyst, DG SANCO, European Commission

Loukianos Gatzoulis from the Innovation for Health and Consumers Unit, of the European Commission's Directorate General for Health and Consumer Affairs, gave the first key note speech. In his presentation, Mr Gatzoulis focused on the scope of integrated care of the European Innovation Partnership on Active and Healthy Ageing (EIP-AHA). Mr Gatzoulis started by presenting integrated care as a concept, mentioning that it includes a variety of familiar terms such as shared care, managed care, patient-centred care, telehealth, telecare and independent living. He mentioned that integrated care is a key component in the management of chronic diseases and co-morbidities, as the integration of care is central in helping chronic patients maintaining their functional ability in the long run.

Mr Gatzoulis proceeded in presenting some early evidence from regions that are in the process of implementing integrated care. Evidence shows that integrated care brings benefits to the care systems and to patients as it improves the efficiency of healthcare systems. In the future, it will be important to focus on how integrated care models can be deployed more generally. A wider deployment of such models also demands further research related to healthcare systems, and Mr Gatzoulis mentioned that this is an area of research that can be funded through Horizon 2020.

Links with the B3 Group on Integrated Care of the EIP-AHA were also discussed. The action plan of the B3 Group focuses on several key components of integrated care such as; organisational models, care pathways, finance and funding, change management and workforce development. The B3 Group has developed concrete deliverables such as practical toolkits which can be implemented at the regional and local level. Altogether, the group has further collected more than 100 good practices on integrated care, whereof 50 percent target one or several chronic diseases. Several of the good practices also include comprehensive regional programmes on integrated care.

Mr Gatzoulis further presented the European Commission's latest initiative regarding the EIP-AHA; the scaling up strategy. It is currently under development by the Commission and will be implemented within the framework of the EIP-AHA. It will be based on the good practices' database that has been developed, and the Commission will present a strategy on how these innovative good practices can be scaled up. During 2015, a roadmap on scaling up will be presented and its first action will be to collect assessment tools and frameworks on what works well. The aim is to collect the assessment tools by February 2015. The European Commission hopes that member states and regions will be able to finance the deployment of the scaling up strategy by the end of next year.

Mr Gatzoulis concluded his presentation by discussing the assessment of integrated care, stating that it is difficult as integrated care programmes are not yet implemented widely enough. Further, most integrated care programmes are applied in parallel with traditional care programmes, which is very negative from a resource point of view. Integrated care is also rather complex as it often leads to that more specialists are involved in the care of patients than before. Mr Gatzoulis also mentioned that although assessment models exist, they often focus on individual aspects of integrated care, and that merging individual models will not be enough. Rather, one assessment model looking at entire integrated care programmes needs to be developed.

The WHO and Integrated Care in the European Region, Viktoria Stein, Roadmap Co-ordinator, Integrated Health Services Delivery, WHO Regional Office for Europe

Viktoria Stein, from the WHO's Unit on Integrated Health Services Delivery, gave the second key note presentation on the WHO's work on integrated care. She started by presenting the core foundation of the work of WHO Europe; the Health 2020 strategy, promoting primary and universal health coverage and equity in health.

WHO has recently started to focus more on integrated care and are in the process of developing a framework for action towards coordinated/integrated health services delivery. During 2015 this focus will be further strengthened. The process started last year, with the publication of a concept note on integrated care. WHO is currently collecting field evidence from the European region on integrated care, which will be presented in a first draft by the end of next year. As a part of the process, a change manual will be developed, presenting policy options relating to integrated care adapted after the local, regional and national levels. A wide range of stakeholders are involved in the process, including scientific organisations and Non-Governmental Organisations (NGOs). The result of the process will be presented at the WHO European Regional Committee in 2016.

Ms Stein proceeded in presenting the methodology and the work with collecting field evidence in detail. WHO has specified three key areas of integrated care that they will focus on:

- The motivation behind implementing integrated care and the design of integrated care models
- Experiences in transforming services delivery - who, how and which elements were changed?

- Lessons learned from leadership and change processes.

So far, 45 countries are involved but the aim is to include one story from all 53 countries of the WHO European region. In total, nine researchers are involved in conducting informant interviews. Ms Stein continued with naming a few examples of the field evidence collected so far:

- The development and implementation of a new eHealth system in Croatia
- The integration of health and social care sectors in Finland, with the main driver to ensure the accessibility of care in the most remote areas
- The development and implementation of community intervention teams for acute discharge in Ireland, with the purpose to better manage the transition period from hospital care to home care
- Enhancing local management capacities in Romania.

Ms Stein further discussed which factors that facilitate for the implementation of integrated care, stating that there needs to be a clear problem/issue which can be measured, a known solution to the problem with an existing climate for change. Several drivers for change also need to be present in order to achieve change in the care system. For instance, there needs to be an acknowledgement that it takes time to achieve change, good advocacy for change and conditions for creativity. However, even with a positive environment for change there are several barriers that need to be overcome. Ms Stein especially highlighted the following:

- The health workforce is under pressure and it needs to be emphasised that integrated care can facilitate their working conditions
- Insufficient investment in research
- Insufficient investment in Public Private Partnerships (PPPs)
- Budgetary restrictions
- Limited focus on health in all policies
- Lack of leadership to foster synergies
- Insufficient focus on primary care
- Lack of an integrated information system.

Ms Stein concluded by presenting two take away messages. Firstly, that there are minimum requirements for implementing integrated care, related to for instance the organisation of providers, care pathways, accountability, communication and leadership. Secondly, that one needs to define people centred health services delivery by empowering and engaging the patients.

Testimonies of Local and Regional Models of Integrated Care

Nicola Wilson, Senior Health Specialist at North of England EU Health Partnership, introduced the attendees to the first panel discussion where three local and regional models of integrated care from Sweden, Italy and Spain were presented. She also welcomed the first speaker, Amira Donlagic from Region Västra Götaland.

1. Amira Donlagic, Project Manager Interacting Care, Region Västra Götaland (SE)

Amira Donlagic, Project Manager of Interacting Care, presented the project which is implemented in the Fyrbodal area, consisting of 15 municipalities belonging to Region Västra Götaland. Interacting Care targets 270 000 people and involves the participation of 2 hospitals, 39 primary care centres and 24 ambulances. The actors involved are; ambulances, SOS Alarm, primary care centres, the national Telehealth services, the geriatric medical ward and home care nurses. All participating care providers

but the municipal home care has a joint budget, however there are no shared medical records as the care providers have different journal systems.

The project is focusing on treating patients with chronic conditions, to answer to the challenges posed on the healthcare system by chronic diseases and to challenge traditional care patterns. The project aim is to better respond to the needs of patients living at home with chronic conditions. More specifically, integrating care aims to:

- Providing quality care
- Providing the right care at the right place
- Co-ordinate healthcare resources
- Develop and improve the collaboration between healthcare actors in the municipalities.

Interacting care is building connections between the traditional care sectors and has set up a collaborative healthcare model which reinforces the municipalities' resources. Through the project, both the telehealth- and SOS alarm services communicate with home based nurses and ambulances, in order to better decide what type of assistance a patient needs. In order to avoid unneccesary hospitalistions, the home based nurses can visit the patients first and if the patient is in need of emergency care the ambulance is called.

2. Antonio Addis, Head of Governance for Research Department, Health Agency of Emilia Romagna Region (IT)

The second presentation was on the "Case delle Salute", or Healthcare Homes project, implemented in Emilia Romagna in Italy. The project started in 2010, as a response to the challenges posed by the ageing population. The objective is to assure appropriate and quality answers to chronic disease needs and to social and health frailty, and to make the healthcare system more efficient.

The healthcare homes are "one-stop homes" for patients. They target all healthcare levels and all types of patients, and they gather all healthcare actors in one place as opposed to spread around the region. The healthcare homes provide general medical help, specialist services, general medical services and social care services and they are based on strong collaboration among professionals from the different services, so to guarantee full care and continuity of care. There are currently 61 healthcare homes in place, spread over three local districts in the Emilia Romagna region, and another 59 homes are planned.

The introduction of the Healthcare Homes has facilitated the care process for both patients and professionals, and has lead to several benefits for the Emilia Romagna Region:

- Strengthening of primary care
- Professional integration between general practitioners, nurses and specialist doctors etc.
- Introduction of a chronic care model
- Introduction of more proactive medicine
- Improved management of chronic conditions.

3. Juan Carlos Contel, Chronic Care Programme and Integrated Health and Social Care Plan, Department of Health, Catalonia

The last presentation was on the Catalan Chronic Care Programme and the Catalan Integrated Health and Social Care Plan, by Juan Carlos Contel from the Department of Health in Catalonia. Catalonia is currently implementing several innovative plans and programmes which are promoting integrated

care. The Catalan Health Plan 2011 – 2015 is implemented since 2011 and targeting chronic patients is a key component of the plan. In order to do so, the Catalan Chronic Care Programme has been created and it is functioning as a catalyst for integrated care, through the setting up of for instance integrated care pathways and the use of ICT solutions. The Integrated Health and Social Care Plan on the other hand, was launched in February 2014 and will establish an integrated care model in the region. The programmes target the entire region, which includes 369 primary healthcare centres, 69 acute hospitals, 96 long-term care centres and 49 mental health centres.

Integrated care pathways are implemented as a formal agreement among professional clinical leaders at the local level and are based on reference clinical guidelines and best practice evidence. Critical variables are also uploaded in shared clinical records. Two profiles of chronic complexity have been created to better monitor the patients; PCC. i.e. complex chronic patients (multimorbidity, severe unique disease and advanced frailty) and MACA. i.e. patients with advanced chronic diseases (limited life prognosis, palliative approach and advanced care planning). Patients are "classified" into the profiles based on stratification which is validated by clinicians.

Other features implemented in Catalonia include the Shared Individual Intervention Plan (PIIC), including information on health problems/diagnosis, medications, advanced care planning, recommendations in case of emergency situations, and the carer who is delegating the decisions. A multimorbidity unified data base and shared clinical records have also been set up, together with an expert patient programme. The expert patient programme targets 3200 patients, 233 expert patients and 649 professional observers that meet in groups of 12 patients for 9 sessions (1 session per week). The aim is to empower and help patients monitor their chronic disease.

A future challenge is to implement a shared outcome framework for the health and social care sectors. Including indicators on health outcomes, avoidable hospital admissions, home care programme coverage and readmissions of chronic patients.

Panel Discussion: Challenges and Benefits of the Implementation of Integrated Care at the Local and Regional Level

The last session included three additional presentations of innovative regional models of integrated care. The session was moderated by Leo Lewis, Senior Fellow at the International Foundation for Integrated Care. Ms Lewis started off the session by showing a video, produced by the Bradford Care Trust in the UK, on the benefits of integrated care and how it is the right tool for providing citizens with "the right care, at the right place, for the first time". The video can be seen here.

The first presentation of the session was by **Toni Dedeu, Chair of EUREGHA and Director of Knowledge Exchange and Research, Digital Health Institute, Scotland**. Mr Dedeu presented the Scottish model for integrated care, which has been introduced through the Public Bodies (Joint Working) Act 2014. Before the act was passed, health and social care was implemented through 32 local authorities and 14 NHS boards. With the new act, 32 health and social care partnerships will replace the local authorities and the NHS boards and this is to be implemented by April 2015.

The aim of the act is to support people to live well at their homes for as long as possible, and to give patients a positive experience of health and social care whenever they need it. The act introduces principles for integrated health and social care services, nationally agreed outcomes for health and

wellbeing, integrated governance arrangements for health and social care, integrated budgets, integrated services delivery, and joint strategic and locality planning.

Mr Dedeu proceeded in presenting a few factors that facilitated the implementation of integrated care in Scotland. First of all, there has been cross party support, NHS support and local authority support to the introduction of integrated care. All the stakeholders agreed that a joint effort was needed to tackle the great challenge posed by the ageing population. Thus, there has been a joint vision of what needs to be achieved. However, there have still been difficulties regarding how this joint vision should be achieved.

The lessons learnt from implementing integrated care in Scotland highlight that integration requires an enormous amount of effort and resources and that it is crucial to keep stakeholders engaged and people informed. Mr Dedeu also mentioned that you need to be prepared for last minute changes and that stakeholders therefore need to be prepared to adapt.

The second speaker was **Maria Chiara Corti, from the Department of Health Care Resource Planning of the Veneto Region**. Ms Corti presented how the Veneto Region is using the Adjusted Clinical Groups (ACG) System to achieve integrated care. The three main goals of using the ACG system is to;

- Stratify the population and their risk
- Improve the care experience for patients with multi-morbidity
- Measure performance to improve equity in resource allocation.

The ACG system has been developed by the Johns Hopkins University in the US and it is used for risk adjustments. By using the system, the Veneto region has found that more than 60 % of its resources are used by 8 % of the population, and these 8 % has become the target for case management.

The first step towards integrated care was to integrate data on diseases, diseases burden and the use of resources. By focusing on high risk patients, and by using ACG care management tools, care management lists and patient clinical profile reports have been established. Through the system the identification and treatment of patients with chronic diseases and multi-morbidity has improved.

The use of the ACG system was first introduced in 2012, and during the first year 1 million people were included. The coverage has steadily increased and in 2014 – 2016, 5 million people are expected to be targeted by the system. During 2015, the system will target primary healthcare, focusing on involving general practitioners and case-manager nurses. By doing so, care teams will be established in order to establish integrated care planning. The case-manager nurses will conduct home visits and will, jointly with general practitioners, establish shared care plans and action plans, which will also involve the care givers. Active monitoring with calls, home-visits and outpatient visits will also be organised.

The third and last presentation was by **Sergio Garay, CEO Hälsostaden, Ängelholm Municipality, Region Skåne.** Hälsostaden is a three year pilot project for integrated care which started in 2013, Region Skåne is the mandator but it is implemented in Ängelholm Municipality. The project has 600 employees and targets a population of 150 000 people. Hälsostaden integrates one hospital, municipal elderly care and primary care which altogether have one chief executive and one budget. The objectives of Hälsostaden are:

- Improve the accessibility of care
- Provide healthcare, elderly car and nursing at the appropriate level and at the right place

- Improve the patient flow between hospital-based specialist care, primary care and municipal elderly care.

The project involves a number of stakeholders working in the healthcare sector and it covers for instance; 20 healthcare centres, primary care centres with evening and weekend opening hours and specialized departments in cardiology, diabetes, neurology, stroke and dementia care. Hälsostaden has also implemented several innovative features. A mobile emergency team was created in 2014 which makes home visits to patients who most likely would have been sent to the emergency room at the hospital otherwise. It has been successful not only from a financial perspective of reducing pressure on the emergency room and unnecessary hospitalisation, but also for the well-being of the patients. During 2015 the team will be developed to not only perform emergency visits but also planned check-ups of patients with chronic diseases.

A department for short-term stays has been introduced at the hospital, merging municipal elderly care with emergency care. The department is located at the hospital which improves patient flow by having the municipal rehabilitation as an integrated part, and the transition is smoother for the patient. It also allows for an easy transfer of patients to the appropriate specialist department, in the event of deterioration, without passing through the emergency room. A discharge planning and rehabilitation department has also been created, with the goal of improving the patient flow out of the hospital and decrease the rate of returning patients. The aim is to streamline the discharge planning process between municipalities, hospitals and primary healthcare.

Mr concluded by discussing a few challenges to integrated care, mentioning legal challenges as hospital/primary care and municipal care are regulated by different legal frameworks in Sweden. He also mentioned that as hospital, primary care and municipal services merge and challenge the established healthcare systems, there is might be a culture clash. This requires change management to turn this into an opportunity that enriches the integrated care model. Lastly, Mr Garay also mentioned that ICT solutions are key to improving patient and information flow and that systemic barriers need to be torn down. This includes for instance introducing the same electronic medical record and intranets used.

Conclusions, Toni Dedeu, Chair of EUREGHA and Director of Knowledge Exchange and Research, Digital Health Institute, Scotland

Toni Dedeu concluded by thanking the speakers, moderators and participants for attending the conference. He also welcomed everyone to attend the 15th International Conference for Integrated Care in Edinburgh on 25-27 March 2015, organised by the International Foundation for Integrated Care.