International Foundation for Integrated Care
Together for Health

Retos de gestion clinica en Atencion Primaria: cronicidad y envejecimiento

Meeting the Challenge of Chronicity and Ageing

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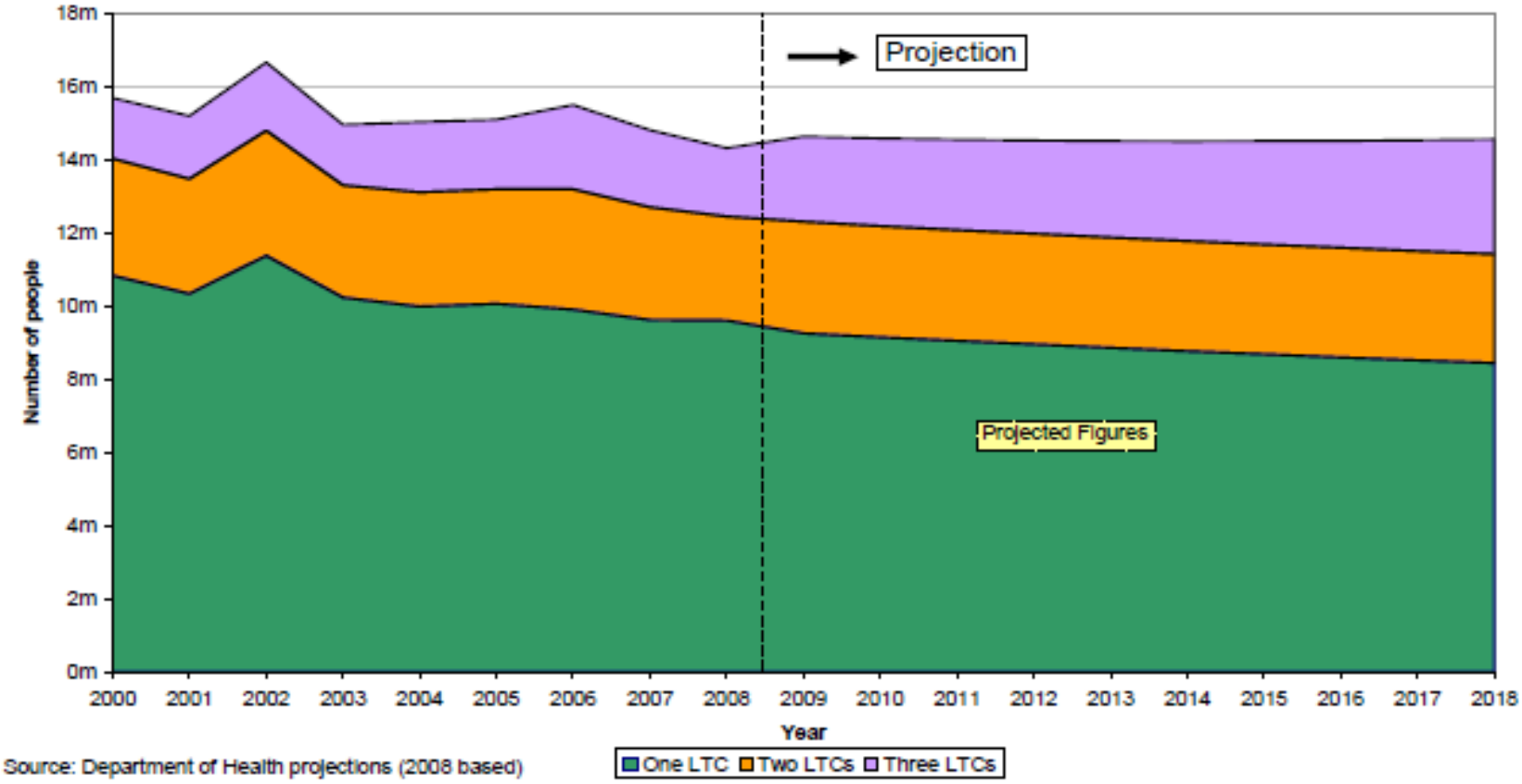
Paper to III Symposium Internacional de Gestion en Atencion Primaria, Barcelona, 23-24 May, 2013

The Challenge

The Rising Challenge of Co-Morbidity



Source: Department of Health projections (2008 based)

In the UK, the additional cost to the health and social care system is likely to be **£5 billion** by 2018 compared to 2011 rising from 1.9 million to 2.9 million patients

Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study

Karen Barnett, Stewart W Mercer, Michael Norbury, Graham Watt, Sally Wyke, Bruce Guthrie

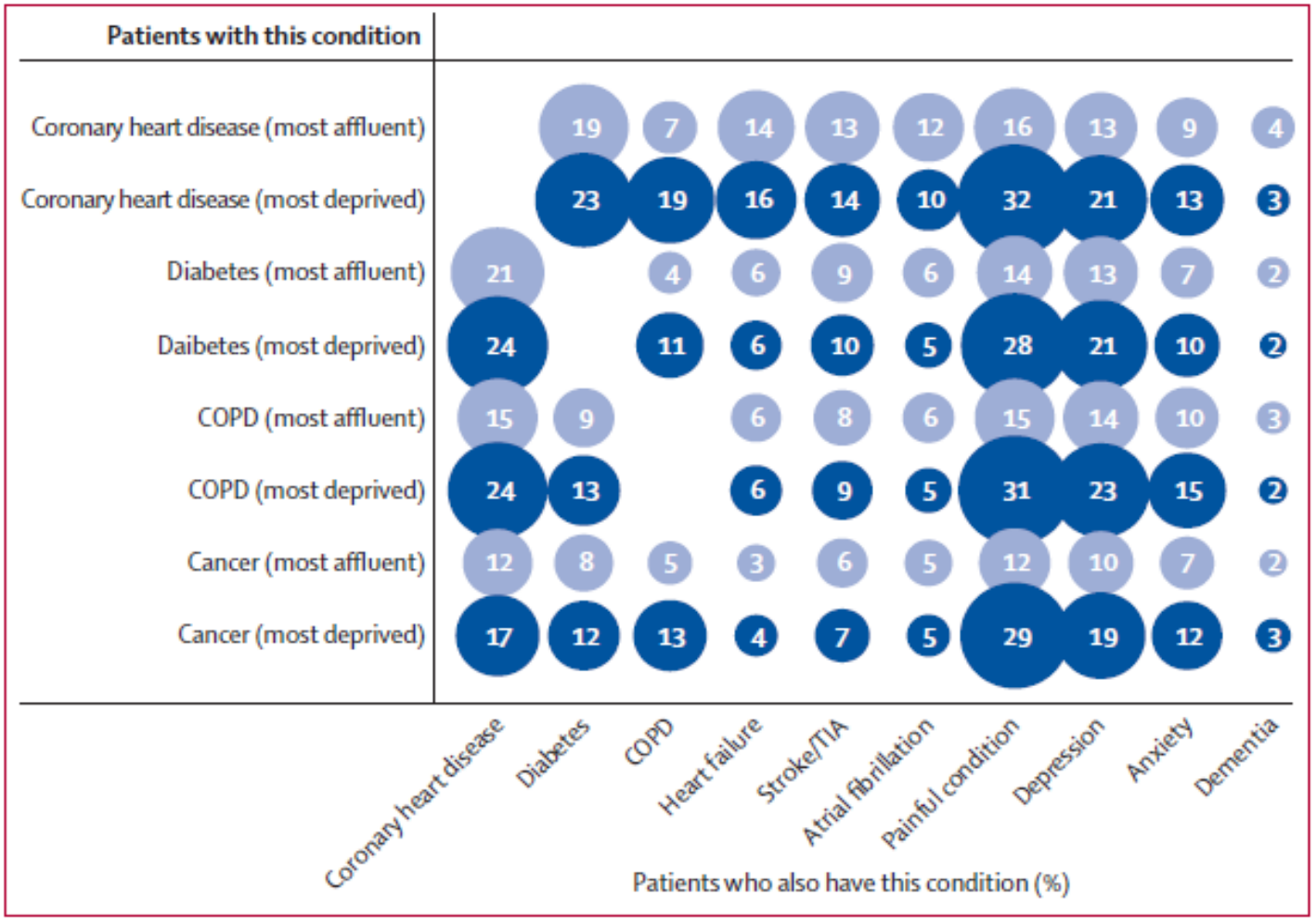


Figure 4: **Selected comorbidities in people with four common, important disorders in the most affluent and most deprived deciles**

COPD=chronic obstructive pulmonary disease. TIA=transient ischaemic attack.

Ageing societies is a major factor

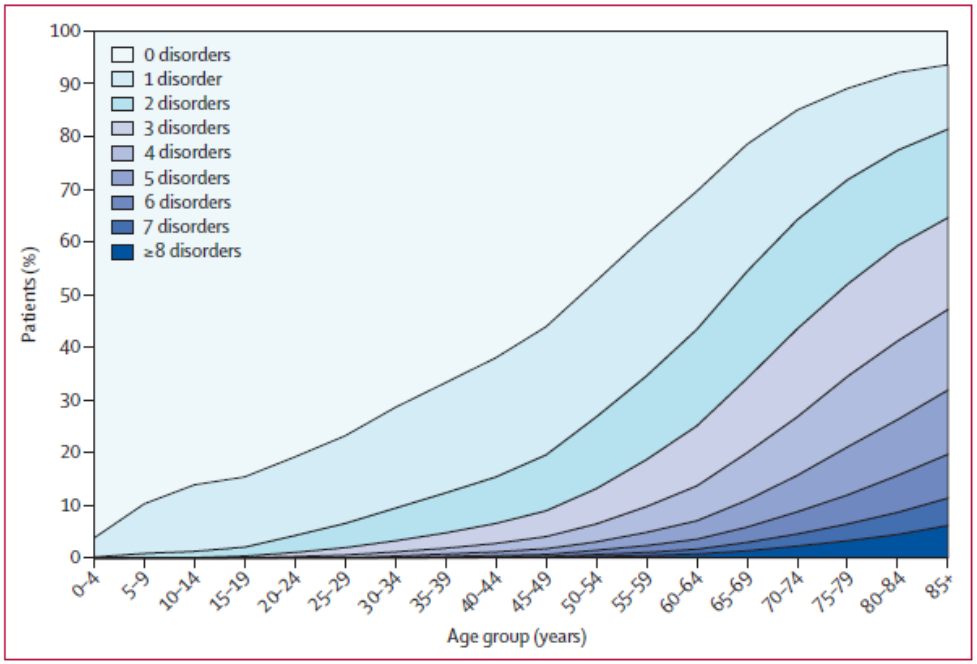
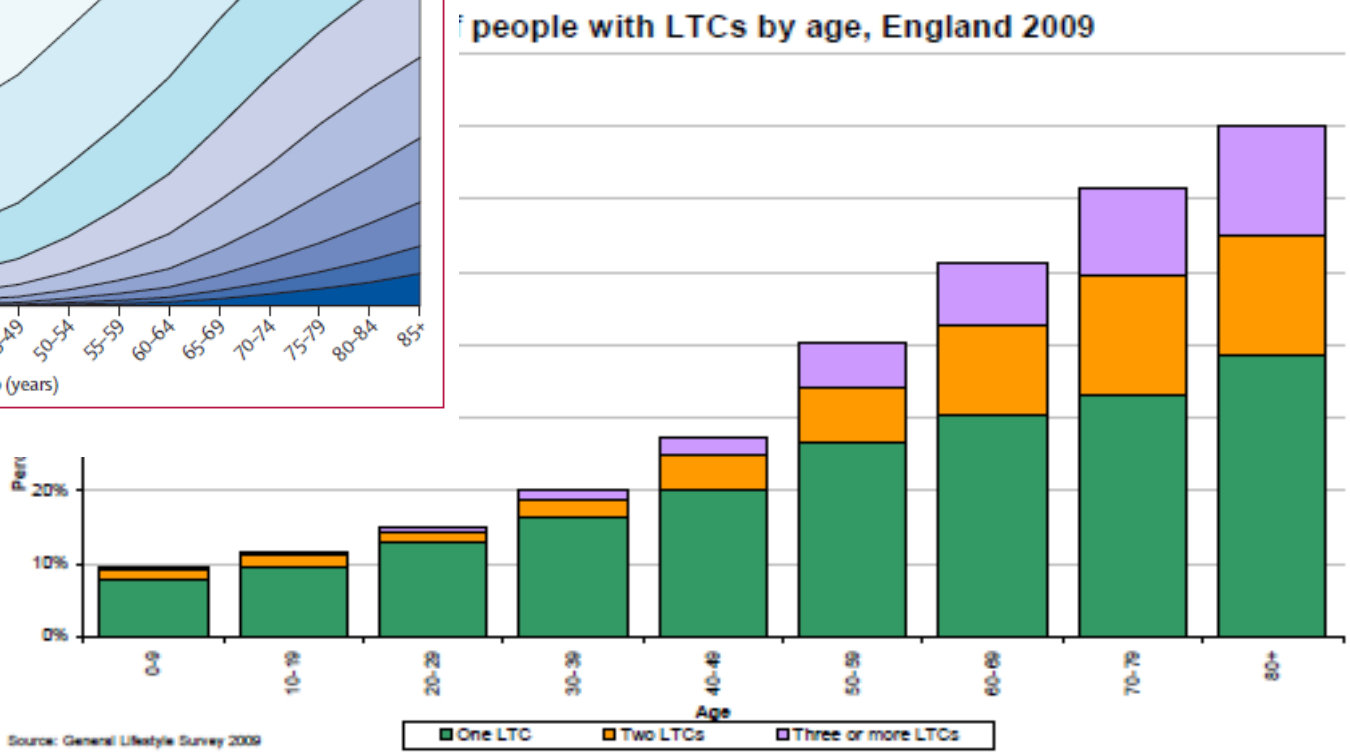


Figure 1: Number of chronic disorders by age-group

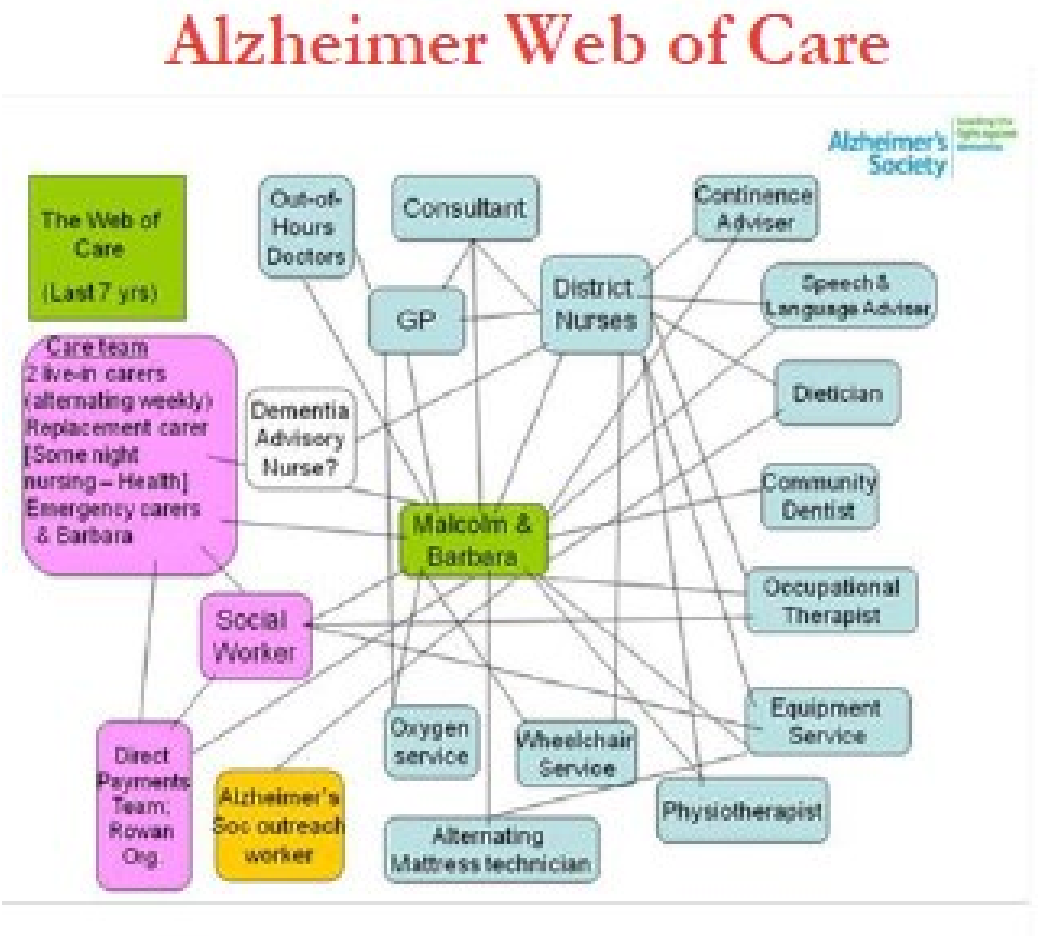


By 2034, >85s will represent c.5% of the population in Western Europe.

Care Systems are Failing to Cope with Complexity

•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

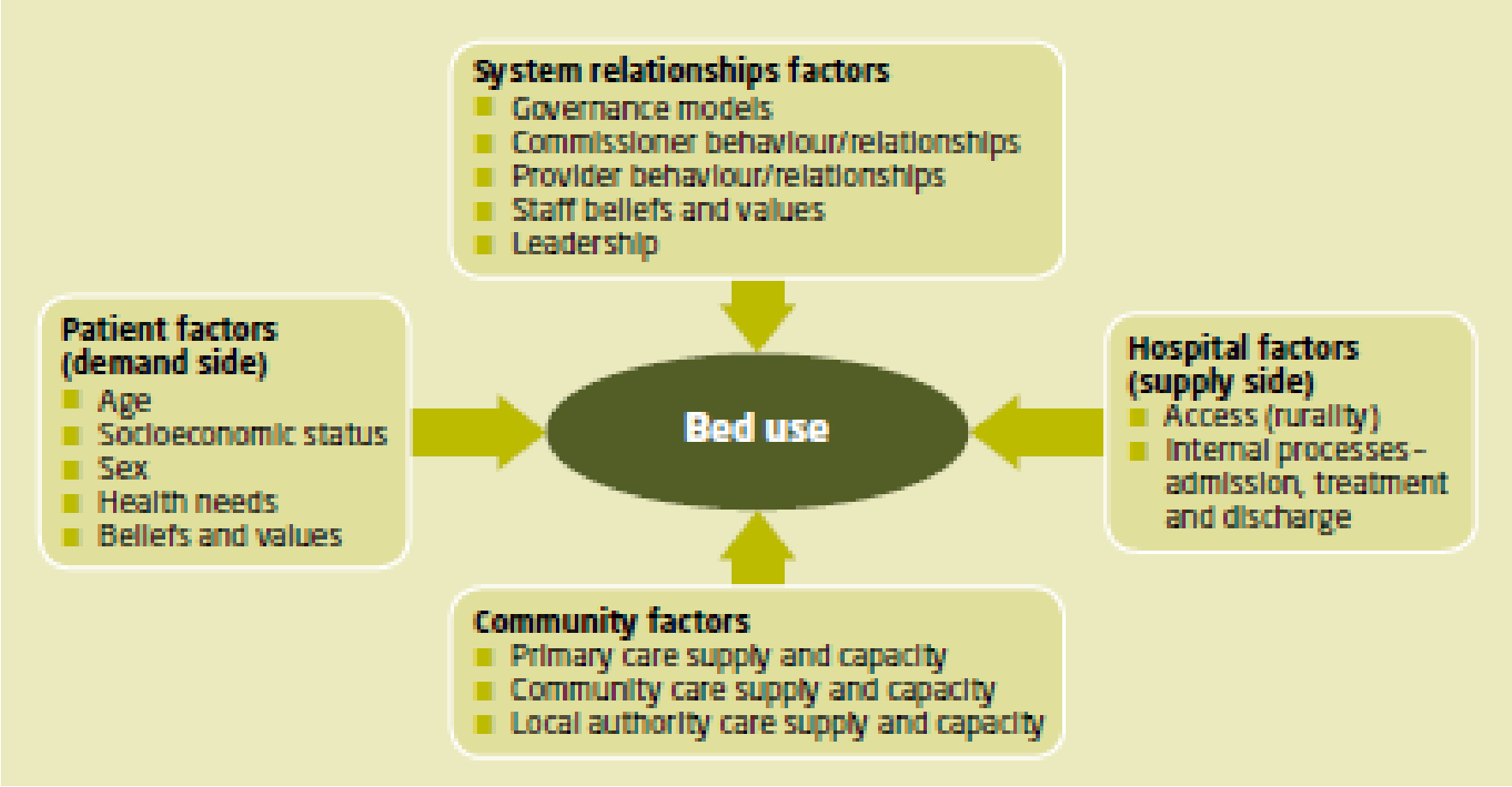


Frontier Economics (2012) Enablers and barriers to integrated care and implications for Monitor -

Meeting the Challenge

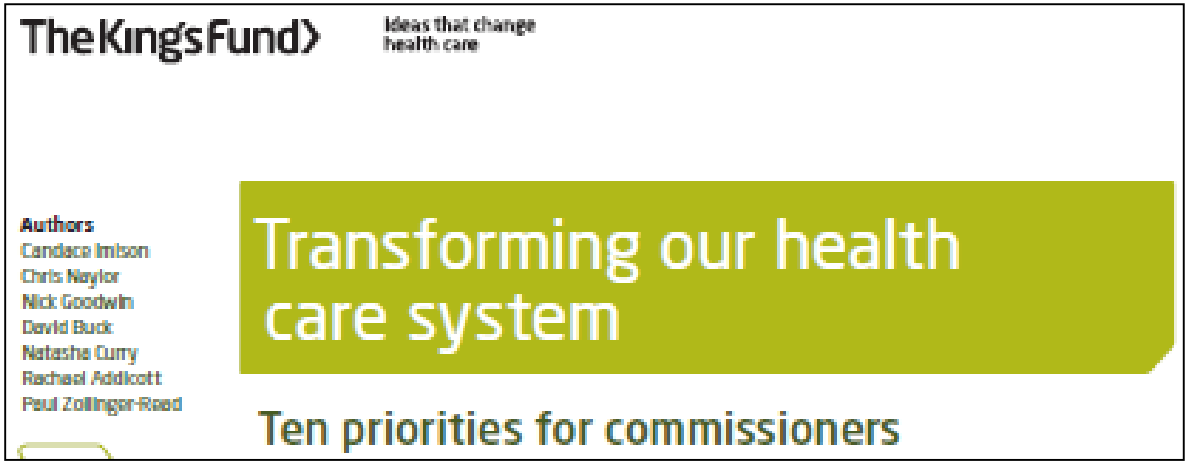
Care Systems Need to Change

Think of the hospital as a cost centre, not a revenue centre
Hospitals <u>can</u> sustain revenue as aspects of care are shifted to communities



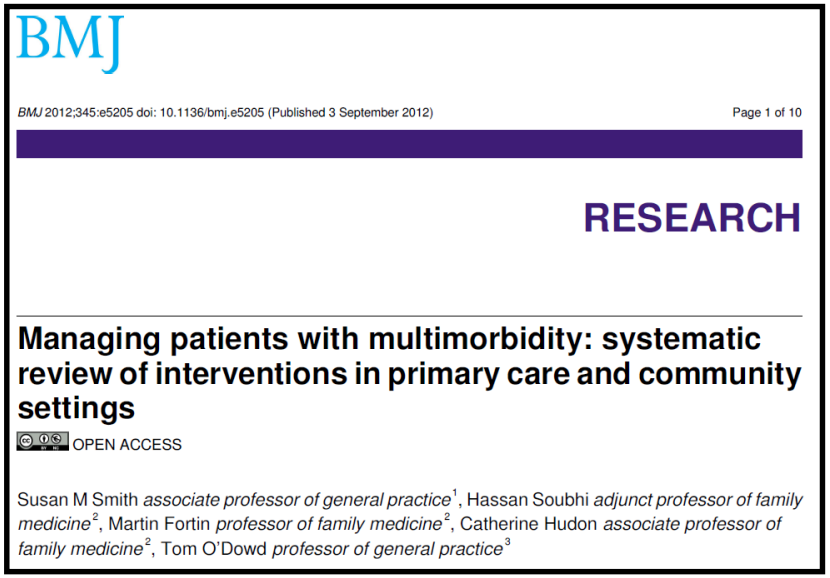
Imison et al (2012) Older people and emergency bed use. The King's Fund, London

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

Managing Complex Patients – What Works?



BMJ

BMJ 2012;345:e5205 doi: 10.1136/bmj.e5205 (Published 3 September 2012) Page 1 of 10

RESEARCH

Managing patients with multimorbidity: systematic review of interventions in primary care and community settings

OPEN ACCESS

Susan M Smith *associate professor of general practice*[1], Hassan Soubhi *adjunct professor of family medicine*[2], Martin Fortin *professor of family medicine*[2], Catherine Hudon *associate professor of family medicine*[2], Tom O'Dowd *professor of general practice*[3]

Targeting, Targeting, Targeting

- **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

Case Example: Guided Care, USA

- Trained nurses integrated into primary care practice
- Predictive modelling techniques to identify at-risk patients
- Nurse assessment of patient and carer needs
- Co-designed care plan
- Case-loads of 50-60 individuals per nurse
- Multi-disciplinary teams based in primary care
- Self-management support
- Web-based electronic health records support real-time decision-making

Peer-Reviewed Impact Includes

- High levels of satisfaction with patients and carers
- Improvements in measures related to quality of life
- Reductions in total costs to health care budgets through reduced hospitalisations and lengths of stay (up to 11%)

See: http://www.guidedcare.org/index.asp

Meeting the Challenge at a Systems and Organisational Level


The King's Fund

Ideas that change health care

Lessons from experience

Making integrated care happen at scale and pace

March 2013

Authors

Chris Ham

Nicola Walsh

Why integrated care matters

The King's Fund has been instrumental in making the case for integrated care (Ham and Curry 2011; Ham *et al* 2011; Goodwin *et al* 2012). Our argument is that the current fragmented services fail to meet the needs of the population and that greater integration can improve the patient experience and the outcomes and efficiency of care. This case was accepted by the NHS Future Forum, and the government in its response made commitments to promote integration. The challenge now is to convert policy intentions into meaningful and widespread change on the ground.

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
- Health promotion
- Identification of people in need of care – inclusion criteria
- Single point of access
- Single, holistic, care assessment (including carer.family)
- Care planning driven by needs and choices of service user/carer
- Supported self-care
- Dedicated care co-ordinator and/or case manager
- 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

Contact

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