Implementing and Scaling up Integrated Care through Collaboration

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ABSTRACT

Across the developed world, the majority of health and care systems are looking towards the integration of services within and across organizations to deliver efficiencies and enhance effectiveness and, by doing so, deliver service sustainability in an increasingly challenging environment, while a simple aspiration to articulate in reality the delivery of integrated care is proving challenging and in some cases elusive. In 2012, the European Innovation Partnership on Active and Healthy Ageing’s B3 Integrated Care Action Group carried out a high-level survey of 27 B3 Action Group members from regions and delivery organizations across Europe to determine their state of readiness for the delivery of integrated care services. This chapter highlights the common bottlenecks and barriers identified, before moving on to explore the key components that support the successful integration of services, including incentives/levers for change and technology-enabled service solutions.

INTRODUCTION

There are many definitions of “integrated care” however the European Innovation Partnership for Active & Healthy Ageing Integrated Care B3 Action Group agreed to use the following definition of integrated care for the purposes of collaboration:

The management and delivery of health services so that citizens receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system (B3 Action Group, 2012).

DOI: 10.4018/978-1-4666-6138-7.ch003
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This definition is in line with the 2008 WHO definition and is commonly used and recognized across Europe.

At its simplest, we can recognize two principle forms of integration. Firstly, the integration of hospital and community health services – which is largely being progressed to shift the balance of care from high cost hospital settings to lower cost, local community health services. Certainly, across Europe, the vast majority of regions and/or member states are pursuing this predominantly health integration agenda.

Secondly, there is horizontal integration where community health services are linking with social care provision. Usually this strategic direction is accompanied by formal engagement with patients/citizens and their personal carer network through the formalization and coordination of relationships with voluntary sector and patient/citizen representative organizations.

This form of integration is being progressed by a number of pathfinder regions across Europe as it reflects a strategy where the patient/citizen is placed at the centre of care and their relationship with health and care service providers moves from one of being a consumer or recipient of care to that of true coproduction where an individual and their carer network are enabled to actively deliver their health and care services, supported by formal health and care providers.

Most regions are using the disruptive nature of ICT deployment into the citizen’s home and other community settings as a catalyst for change. Those that appear to have been most successful are using technology solutions to support innovative service redesign rather than focusing on the technology itself.

BACKGROUND

Across the developed world, the majority of health and care systems are looking towards the integration of services within and across organizations to enhance effectiveness and deliver efficiencies and, by so doing, deliver service sustainability in an increasing challenging environment. While a simple aspiration to articulate, in reality, the delivery of integrated care is proving challenging and in some cases elusive.

The European Commission’s European Innovation Partnership for Active and Healthy Ageing Strategic Implementation Plan (SIP), published in November 2011, recognized the benefits that could be secured by supporting the integrated care agenda and identified integrated care as one of its six specific priority action areas.

The European Commission set up the B3 Action Group on Integrated Care in 2012 to progress the SIP specific action – “replicating and tutoring integrated care for chronic diseases, including remote monitoring at regional level” (European Commission, 2012).

At time of writing, the B3 Action Group is made up of over 350 representatives from 167 regions, delivery organizations, patient/users and carer organizations, academic institutions, industry and member organizations from across the European Union.

The overall objective of the Group is to “reduce avoidable and unnecessary hospitalisation of older people with chronic conditions, through the effective implementation of integrated care programmes and chronic disease management models that should ultimately contribute to the improved efficiency of health systems” (European Commission, 2012).

These activities will contribute to increasing the average number of healthy life years by two across the European Union by 2020, the overarching goal of the European Innovation Partnership, while supporting a triple win for Europe. This aspiration requires:

- Improving the health status and quality of life of European citizens, with a particular focus on older people;