Preparatory Activity 1

Description of Good practices of Integrated Care Models

Vilans, April 2016.

1. General description

Four models were described:

- e-Care network in Bologna: No longer Home Alone - a network of citizens, associations, institutions, professionals, able to offer to frail and living alone elderly people a relational, social and medical support network.
- Basque Strategy for tackling the challenge of chronic conditions in the Basque Country - a plan, divided into 5 areas, which reveal the core elements of the model of care for tackling chronicity: 1. A population approach; 2. Prevention and promotion of health; 3. Patient responsibility and autonomy; 4. Continuity of care; 5. Efficient interventions adapted to the need of the chronic patient
- Integrated Health and social Care approach – the Use of telehealth, to support and enable person to remain at home, and an Interdisciplinary approach to provide care and support to re-able or enable people.
- Commercial member services - With this member services it is possible to still have additional housekeeping next to (level 3,4,5) care. Clients pay for these services but because of arrangements with municipalities prices are kept low.

The principal and most common goal of the models is to build networks. The nature of the networks differ, models work on networks between clients, informal carers, formal carers, different organizations, in different structures. Furthermore, networks might be physical (in person meetings, integration of different services in one building) or digital (e-services or databases).

Model-specific goals are to respond to needs of chronicity, as a new challenge (care instead of cure); Maximize independence of individuals; facilitate workers (providing them with appropriate skills, (re-)employment of lower level professionals).

2. Five themes

Four themes emerged in the descriptions of activities to reach the goals as described above:

2.1. e-Health

Integrated care models are supported by e-health. Most common is a control center, either a call center or a multi-channel (phone & website) center, from where health conditions are monitored and responded to, by sending support. The center is also used for making appointments, giving health advice or to book or buy services.

Furthermore, care is integrated by designing databases or records where health information of different disciplines can be integrated or exchanged. The novel idea of these databases lies in integrating information of different care and cure disciplines, e.g. health, social and family conditions.

In addition, e-health is used to connect patients with each other. The Basque strategy includes a network of active patients, in order to promote patient responsibility and autonomy.

2.2.   Informal networks

The models include descriptions about building, supporting or strengthening informal networks, consisting of the patients, their family and friends, and/or voluntary support. Concerning patient networks, besides building digital patient networks (see 3.2.1, Basque strategy), "real life" patient networks are built to facilitate integrated care. The Bologna initiative supports their e-care network with socialization initiatives.

To strengthen patients, the Basque strategy includes a Health school for patients, with an expert patient program on self-management education.

The Dutch initiative aims to support informal networks by unburdening them. The memberservice offers accessible housekeeping services, to prevent patients to solely rely on their informal networks.

In addition, volunteers are included in the integrated care model of Bologna. On an organization level, collaboration is sought with voluntary associations. Furthermore, common standards for training the voluntary are included, and affiliated artisans are activated as volunteers for small home works.

2.3. Overview, shared information

To facilitate integrated care, the models aim to integrate information about patients and to have an overview on different aspects of care. Two models do that by arranging an in-person function that holds the overview about a patient and different aspects of care related to the patient. The Bologna initiative speaks of an ASL reference person, the Basque strategy calls an advanced skills case manager nurse, a continuity case manager nurse and a hospital link nurse.

Furthermore, overview is strengthened by stratification and targeting of the population.

2.4. Integration between organizations

Besides integration of care on a skills and information level, integration of different care organizations is included in the models. Integration between hospital care and other organizations appears the most common. The moment of discharge from hospital is a moment where integrated care is needed and where interdisciplinary approach is needed. Little is described about how this integration is shaped. The Basque model describes successfully merger of hospital and primary care organisations into one integrated health care organization. Integration between social and health care did not progress well due to fragmentation of administrative competences.