Policy brief
Integrated care for non-communicable diseases: A comprehensive overview of definitions, key elements, leadership and management for change

June 2017

1. EXECUTIVE SUMMARY

Integrated care has long emerged as a viable approach to overcome deficiencies in the care management for people with chronic diseases, while at the same time improving efficiency, quality and effectiveness of the health services provided. The focus thus has been on better coordination and integration among health providers to manage specific diseases. However it has become evident that in order to provide truly person-centred services that promote health, the scope of integrated care needs to be expanded to bridge the gaps not only within the health system, but also between the health and social system, among others. These aspirations necessitate the overcoming of many boundaries, most notably between different professions, different organisations and different organizational and professional cultures.

The many experiences across Europe and around the world have demonstrated that it does not suffice to tackle only one of these barriers, but that sustainable solutions need a multi-faceted approach, which changes the processes and structures of service delivery just as much as the culture and attitudes of the professionals involved. Most importantly, patients, families and communities need to be actively involved in this process in order to ensure that their needs are met and their voices heard. And while a lot of efforts are put into the technicalities of integrated care, building the competencies necessary to work in and manage an integrated environment are often neglected.

This policy brief summarises the definitions of integrated care, introduces an evidence-based framework for integrated care, and provides an Annex with practical examples from around the world, which illustrate the concepts.

The key messages are:

- Integrated services must be organised around the needs of the people, not the providers or the institutions. This necessitates the bridging of gaps between health, social and other services to provide the care necessary for people and communities.
- This requires a population health management approach, and a look towards the social determinants of health. At the core lies the bio-psycho-social approach to health, which views the person holistically and not by disease or deficiency.
- A key element therefore is a comprehensive look at the data available to analyse the outcomes, identify needs and define priorities. This analysis provides the “burning platform” for change highlighting for example lack of resources, inadequate access or below-average health outcomes.
- The burning platform provides the basis for a clear change narrative, mission and measurable objectives.
- Integrated care can only happen when all levels and all stakeholders are actively involved in the design, management, implementation and evaluation of the initiatives.
- Thus, there needs to be a parallel top-down and bottom-up approach.
- Integrated care needs to be nurtured, lead and managed actively, which in turn necessitates a clear buy-in from policy makers and decision makers.

- This transformational change towards integrated care requires a change in cultures and values from everyone involved.
- While there are a lot of examples from which to learn, integrated care needs not only to be adapted to the local context, but actually developed by the local communities and providers to guarantee ownership, buy-in and responsibility.

2. DEFINING INTEGRATED CARE

Over the past decade many definitions, concepts and theories have emerged trying to explain what integrated care is and what the main building blocks for successful integration of services across sectors and professions may be. Integrated care is not an end in itself, but a means to improve quality of care (Stein 2010). Many authors have also stated, it is a means to achieve the Triple Aim approach (Bengoa 2013, Nolte and McKee 2008, Groene et al. 2016). The following, widely used and cited, definitions illustrate the complexity of the task at hand.

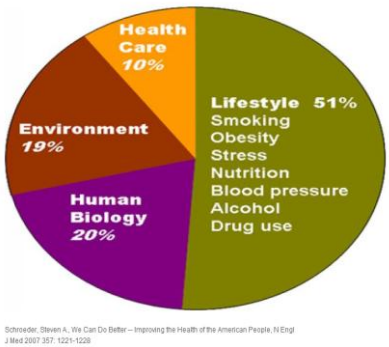
2.1. INTEGRATED CARE IS A SYSTEMS APPROACH

The WHO global strategy for people-centred integrated health services (2015) adapted PAHO's (2011) definition as follows:

> *"Integrated health services are health services that are managed and delivered in a way that ensures people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, at the different levels and sites of care within the health system, and according to their needs throughout their life course."*

When taking a system's perspective it becomes clear, that health is not by any means only achieved in and influenced by the health system. On the contrary, the health system only accounts for about 10% of a persons' health status (see figure 1). Social determinants of health, transport and infrastructure, lifestyle choices, etc. all have a greater influence than the provision of health services. This underlines the importance of taking a whole-of-systems and whole-of governance approach (RC/EURO 2008) and enforcing the concept of health in all policies, as any decision taken by government, whether on the national, regional or local level, may influence the health and wellbeing of the people.

Figure 1. Factors influencing health.



Source: Schroeder, Steven A. We Can Do Better – Improving the Health of the American People. N Engl J Med 2007;357:1221-1228.

2.2. INTEGRATED CARE IS A PROCESS IMPROVEMENT STRATEGY

For a long time, integrated care was considered a process improvement strategy, influenced by its roots in managed care, to design a better through-flow of patients along a defined pathway and with well-defined transitional nodes between sectors and systems. Kodner and Spreeuwenberg's definition (2002) reflects this approach:

> *"Integration is a coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for people by cutting across multiple services, providers and settings. Where the result of such multi-pronged efforts to promote integration lead to benefits for people the outcome can be called 'integrated care.'"*

The merit of this perspective lies in the emphasis on management tools and principles to align the services provided in the cure and care sectors. It also highlights the importance of back office functions, such as funding mechanisms and reporting systems, as drivers for fragmentation or collaboration, respectively.

2.3. INTEGRATED CARE IS PERSON-CENTRED CARE

While from the very early days integrated care has professed to consider the patient as the centre of every effort to improve service delivery, the patients' perspective, needs and demands have only very recently been added into the discussion on integrated care. And it is still very rarely that patients, their families and caregivers as well as the wider communities are actively and meaningfully engaged in the decision making, design and delivery of services. Active participation, engagement and empowerment of patients and populations, however, is key to successful services delivery along the life course, whether one takes a stewards', managers, or providers' perspective. As illustrated in Figures 1 (above) and 2 (below), it is the individual, who takes care of themselves most of the time, who has the most influence over their own health and wellbeing – not including them in every step of the way is grossly negligent and a main driver for the rise of chronic diseases and the decrease of healthy life expectancy.

Figure 2. The importance of self-care.

While the exact numbers vary from system to country, the main message is clear. It is the patient who is the primary care provider, and the professionals and system administrators need to not only acknowledge that fact, but act upon it, so that the following statement can become true:

> *"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me." (National Voices 2013)*

In order for integrated care to work, all of the above perspectives need to be taken into account and contextualised as they reflect the different stakeholders' aims.

3. A FRAMEWORK TO GUIDE DESIGN, ASSESSMENT AND IMPLEMENTATION OF INTEGRATED CARE

Based on a comprehensive literature review and an analysis of published frameworks, among them Valentijn (2015), Minkman (2012), WHO global strategy (2015), and WHO Europe's Framework for Action (2016a), a framework was developed during the EU-funded Project Integrate, which aimed at providing a tool for managers and decision makers to look at the key elements of integrated care and assess their relevance, importance and status within their context. This framework identified seven dimensions, and within each key items, which need to be in place in order to create integrated care.

Project Integrate Conceptual Framework (Calciolari et al. 2016, unpublished)

Person-centered care
Perspective of improving someone's overall well-being - and not focusing solely on a particular condition/disease - through the active engagement of service users (patients, carers, etc.) as partners in care. Key items are:

- Health literacy
- Supported self-care
- Carer support
- Shared decision-making
- Shared care planning
- Feedback
- Health data access

Clinical integration
It refers to how care services are coordinated and/or organised around the needs of service users. Key items are:

- Multidisciplinary assessment and plan
- Care coordinator
- Care transitions management
- Case management
- Single point of entry
- Community involvement
- Integrated care pathways

Professional integration
It refers to the existence and promotion of partnerships between professionals to work together (e.g., in teams). Key items are:

- Shared accountability
- Collaborative agreeements
- Inter- and multi-disciplinary teamwork
- Continuous training

- Collaborative attitude

Organisational integration
It refers to how providers come together to deliver care services in a linked-up fashion across partner organizations. Key items are:

- Performance assessment
- Incentive schemes
- Learning and quality improvement
- Shared strategic goals and policies
- Governance and accountability

Systemic integration
It refers to how the care system provides an enabling platform for integrated care, such as through the alignment of key systemic factors (e.g., financing mechanisms, regulation). Key items are:

- Performance assessment
- Regulatory framework
- Financing and incentive arrangements
- Supporting policies
- Workforce
- Stakeholders involvement

Functional integration
It refers to the capacity to communicate data and information effectively within an integrated care system. Key items are:

- Single common identifier
- Stakeholder communication
- Shared decision making
- Shared care records

Normative integration
It refers to the extent to which different partners in care developed and shared a common reference frame (e.g., vision, norms, values) on care integration. Key items are:

- Vision
- Population health management
- Social capital
- Leadership
- Shared vision
- Trust

(The full framework development with an explanation of the key items is available from the author.)

This framework comprehensively summarises the complex interventions on various levels, which need to be put in place in order to achieve sustainable change towards integrated care and at scale. The discussion around the different perspectives and levels of integrated care underlines the significance of considering integrated care horizontally (i.e. across sectors and systems), as well as vertically (i.e. from the systems to the personal level). While it is clear that not all items will need equal attention at all times and in all countries, if any one of them is left out, integrated care will sooner or later stall, as key stakeholders will feel left out or subsystems are not able to coordinate and collaborate effectively.

4. LEADING AND MANAGING CHANGE

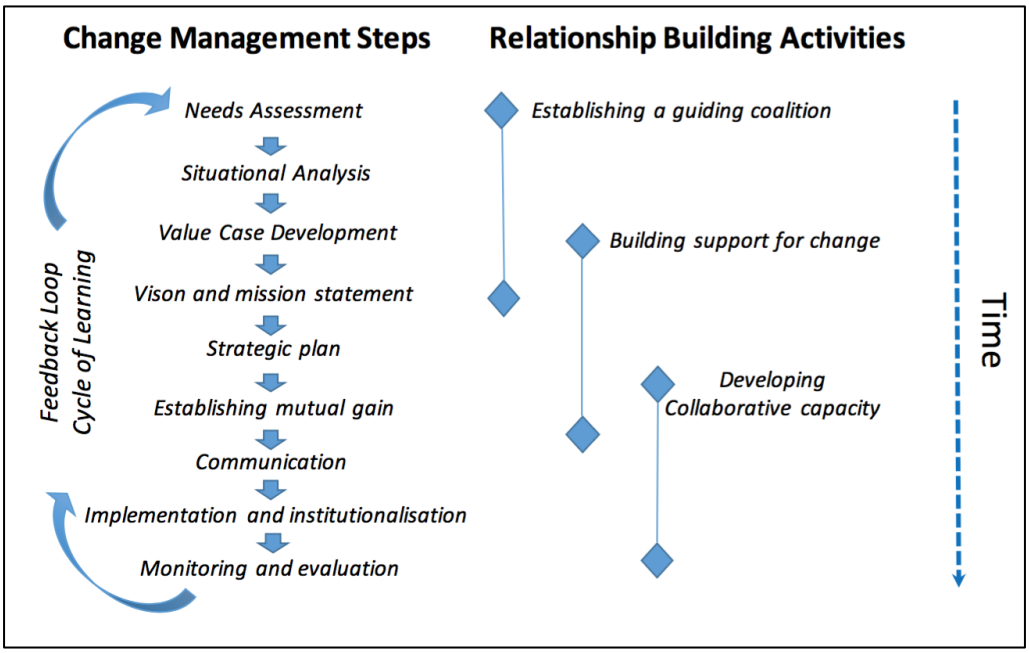
Building integrated care systems is a complex and long-term task. Whilst there is knowledge and evidence available on the key elements of integrated care there is still a lack of understanding on how to lead and develop such models. Moreover, it is commonly recognised that there is ‘no one

model' for integrated care, and that integrated care does not appear to emerge naturally in any system of care – rather, it has to be managed and nurtured. Indeed, the barriers to integration are significant at a system-level due to misaligned governance, financial and regulatory practices and the subsequent conflicts of interest in tasks and roles of key organisations. These conflicts mix with a range of professional and cultural barriers and poor systems of information and communication exchange to create significant inertia. As a result, too much emphasis is placed on local innovators and key leaders to drive change forward and the underlying business model for new ways of working is not developed. This fuels the tendency for integrated care to remain localised around small-scale projects with little scope or ambition for scaling-up activities.

4.1. TRANSFORMATIONAL CHANGE TOWARDS INTEGRATED CARE

Supporting the development of integrated systems of care requires transformational change. Yet, the implementation science to support the successful adoption, spread and sustainability of integrated health and social care systems is underdeveloped. Nonetheless, there is experiential evidence from many case examples to suggest some of the key components of such a strategy (WHO Europe 2016a, Ham and Walsh 2013, Suter et al. 2009). For example, the complexity of integrated care does not lend itself to business redesign processes that have been used elsewhere in health care reform, so change management strategies need to recognise the key issue of complexity. This is further underlined by the many different dimensions and elements for change that are observed as core attributes of integrated care systems (as described above). However, several reviews of the literature and experiential evidence provide some guidance on the key success factors and management steps required to make change happen, specifically in the articulation of a common vision that is based on a clear articulation of the needs of people in local communities, which then can develop into a shared strategy for change. (WHO Europe 2016a, Ham and Walsh 2013, Suter et al. 2009) Summarising these findings, Goodwin (2017) illustrates the need for a dual-pronged approach for transformational change: there needs to be a step-by-step change management process, which eventually leads towards a continuous improvement cycle, while at the same time relations and networks need to be established, nurtured and grown to garner the necessary support from stakeholders and overcome the resistance to change (see Figure 3).

Figure 3. The dual approach for the transformational change process.



Source: Goodwin N. Change Management, in Amelung et al. Handbook for Integrated Care. (2017, forthcoming).

Summarising the experiences of 85 integrated care initiatives from across the WHO European Region, the authors identified 10 lessons for successful implementation of change towards integrated care (WHO Europe 2016b):

1. Put people and their needs first
2. Reorient the model of care
3. Reorganize the delivery of services
4. Engage patients, their families and carers
5. Rearrange accountability mechanisms
6. Align incentives
7. Develop human resources for health
8. Uptake innovations
9. Partner with other sectors and civil society
10. Manage change strategically

Again, these lessons highlight that the change process towards integrated care needs to happen on all levels of a system, include the involvement of people and communities, professionals and other sectors as part of the process, and create the necessary structural, regulatory and financial frameworks to support the transition.

4.2. MONITORING AND EVALUATION: DEVELOPING SYSTEMS FOR CONTINUOUS QUALITY IMPROVEMENT

It cannot be emphasised enough that integrated care is a strategy towards better provision of services for patients and populations and is thus a means to an end, not an end in itself. It is a strategy to improve quality, and not to reduce costs. This strategy may be applied on different levels, and needs to permeate all – from the system to the individual level – in order to be sustainable and effective. When one accepts that, there is a lot to be learnt from classic management literature and practical experiences in other sectors (6 P et al. 2006).

Identifying measurable objectives

A common weakness in approaches to integrated care is that not enough time and effort has been placed to agree the specific objectives for integrated care and how to measure and evaluate outcomes objectively. In particular, it is common that the lack of evidence for cost and impact can lead to significant problems (and programme failures) when seeking to embed programmes within wider health system funding streams (Ham and Walsh 2013). In practice, therefore, managing change requires the ability to measure and monitor outcomes in a number of areas including: user experience, service utilisation, staff experience and the costs of delivering care. Progress towards these goals must be measured frequently to support learning and inform implementation.

Defining suitable measures and indicators

For health care systems it is important to adopt and use a set of measures that align with the main elements of a national, regional or local strategy for integrated care. However, the complexity and the necessary variety in how integrated care strategies need to be developed means that outcomes and measures need to be chosen to suit local and national priorities. Many countries and regions have sought to establish a set of key measures and indicators for people-centred and integrated health services as a means to monitor and manage performance (e.g. New Zealand 2013, Raleigh et al. 2014) and a summary of the range of measures that have been used has been usefully summarised through work supporting WHO's Global Framework on People-Centred and Integrated Health Services (2015).

Establishing a continuous improvement cycle

An important aspect of developing a monitoring and evaluation framework is that it can be used to bring relevant stakeholders together to define the outcomes through which integrated care strategies should be judged and, as a result, promote joint ownership and collective responsibility to achieving key goals. Including key stakeholders in how care systems will be held to account supports the inclusive process of developing a vision and driving change forwards. A final key element of a change strategy is to utilise data and information from the monitoring and evaluation process to build-in a process for continuous quality improvement. For example, to identify 'high impact' changes that would most benefit patients, or reduce variation in standards between provider teams. In essence, an 'improvement process' is needed to help clarify or re-frame objectives, redesign processes, address capabilities, integrate risks, develop performance measures, learning from performance measures and, crucially, create a feedback loop for improvement over time. Two key aspects for this include: first, the need for managers to properly engage service providers, communities and service users; and, second, the need to build in 'rapid cycles' of building and re-building strategies for change following their implementation and assessment of progress.

4.3. LEADERSHIP IN INTEGRATED CARE

Integrated care initiatives can be described as complex adaptive systems which can hardly be managed and organized in detail (Reinertsen et al., 2008). From different sources of success factors for integrated care (Suter et al. 2009, King's Fund 2011) it can be derived that "*leadership*" is a pivotal factor to implement change. When viewing integrated care as strategy to increase quality of care, leadership should be regarded as key. The leader is responsible of putting into place resources and infrastructure. Here, communication technology seems to be a driving force. Leadership in integrated care also entails to transform and reconcile processes, professional cultures, and governance structures with a new vision and narrative for service delivery. Finally, leadership in integrated care needs to invest heavily in the development of relationships with professionals, policy makers and the population.

Amelung (2016) concludes that leadership in integrated care does not fundamentally differentiate itself from leadership roles in other systems, but needs special attention as it is often overlooked as a critical success factor for the transformational change process. He summarises the lessons from the literature and experiences in seven aspects:

1. **Integrated care concepts are strategic assets**
   Integrated care concepts have to be recognized as strategic assets by the relevant institutions. Independent of their actual importance for the business model, integrated care concepts need strategic tailwind. This tailwind can be fostered by leadership.
2. **Leadership in integrated care is necessary**
   Leadership structures should be implemented detached from already well-established structures; meaning, the implementation should not be carried out solely by physicians or other service provider along the way but has to be organized separately and professionally, ideally within a management company.
3. **Leadership in integrated care requires investment**
   The expenditures for leadership need to be priced and not taken as granted. Leadership is an integral field of activity and has to be remunerated separately. The expenditures for management are often looked at as negligible. Through the budget assignment, the appreciation for leadership and management will be documented.

4. **Leadership in integrated care must build a culture of shared values**
   Expert knowledge and professional authority are indispensable for the leadership of integrated care concepts. Leadership should be embedded in existing structures – nearly invisible - and occur indirectly through pointing out direction and growing a culture of shared values. Otherwise resistance will build up.
5. **Leadership in integrated care needs time**
   Leadership needs to motivate all parties concerned to change their beliefs. The longer structures have been in place, the longer it needs to force them open.
6. **Leadership in integrated care needs to be focused**
   Leadership needs to focus on the components and occupational groups that are most difficult to integrate. Generally, this is the medical profession. But leadership should also initiate local activities (e.g. regional conferences, workshops, quality circles, groups of regulars) in order to strengthen and document the solidarity within and between the groups and the involvement of the broader community.
7. **Leadership in integrated care needs to be data-based**
   Medical care is strongly influenced by data. Therefore, in order to lead successfully, a comprehensive Data-Warehouse is inevitable. All data needs to be transparently accessible for all partners.

These conclusions reiterate the messages of change management towards integrated care outlined in the previous section, and thus underline the importance of actively leading and managing change towards integrated care and recognising these aspects as key success factors for the sustainable implementation of integrated care solutions. As such, they need dedicated people, time and resources to be realised.

5. CONCLUDING REMARKS

As has been mentioned throughout the policy brief, designing and implementing integrated care needs considerable investment of human resources, knowledge and time to make it happen. It also needs a burning platform, whether that is a lack of money, new legislation or bad health outcomes, and in most cases, it is a combination of these and more factors. The numerous examples from around the world also highlight that integrated care is a strategy for continuous improvement, which takes a long-term perspective and is never at an end. In order to garner support and buy-in from people, professionals and policy makers, the integrator needs to identify mutual gains and build a coalition for change. Having clear and measurable objectives and an evaluation framework in place from the very beginning is another must, and in relation to that establishing external (scientific) evaluation and publication of results. Furthermore, education and training for professionals, patients and communities supports the cultural changes necessary as well as building the skills to deliver and actively participate in these new approaches to care. Clinical and administrative leadership, strong management structures and aligned incentives are needed to make the transformation sustainable and withstand external changes, such as changes in policies or budget cuts. Finally, integrated care is about building trust and realising that the status quo of service delivery is detrimental for everyone involved. Focussing on the holistic needs of the people has to be the guiding principle on all levels of the system, where supportive regulatory, legal and financial structures foster local innovations according to the needs of and developed with the local people and communities.

6. REFERENCES

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ANNEX 1. EXAMPLES FOR A COMPREHENSIVE INTEGRATED CARE DELIVERY SYSTEM

This annex will give a detailed description of how the different elements came together in selected and well-documented examples. The examples are:

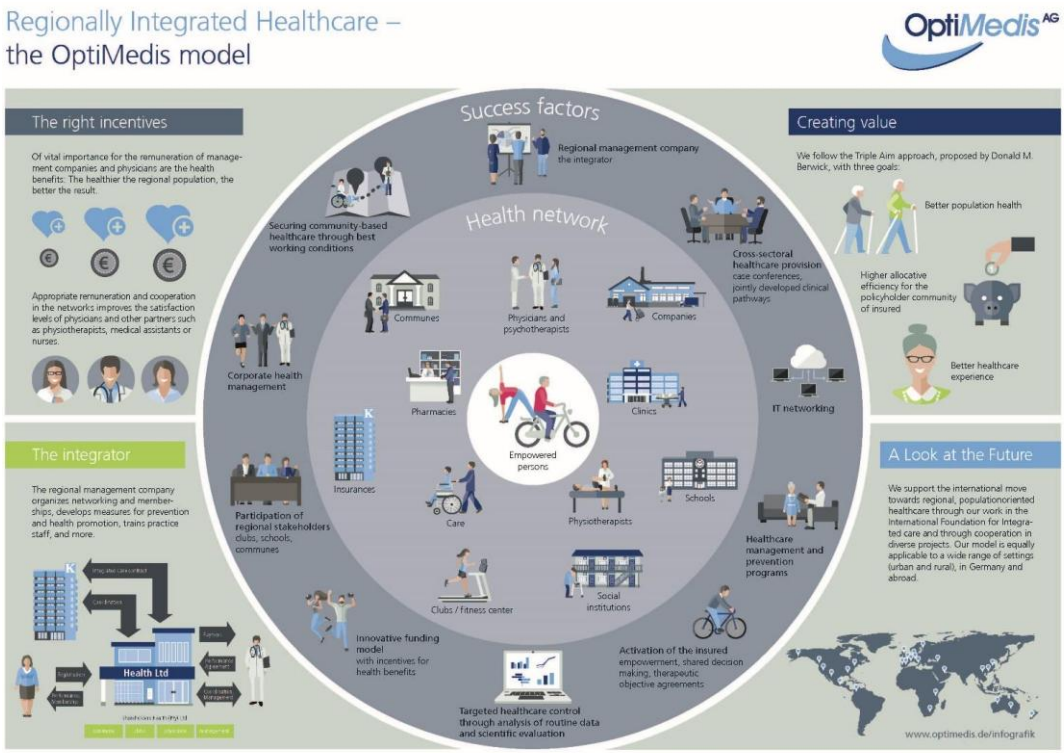
- Gesundes Kinzigtal: remote, high-income rural community, provision of all health services, management organisation in an insurance-based system.
- NorthWest London Whole System Integrated Care: very diverse urban community, provision of all health and social services, merger of health and social services in an NHS system.
- Canterbury, New Zealand: semi-urban district, provision of all health services, tax-based (NHS) financing.

All of the examples follow a population health approach, are primary-care lead and have considerably evolved over time. They have been evaluated from the very beginning, and there is sufficient literature available to prove their value.

1. GESUNDES KINZIGTAL, GERMANY

Since 2006 the Gesundes Kinzigtal (GK) model has demonstrated how a people-centred focus on population health management can lead to significant gains in achieving the Triple Aim of better population health, improved experience of care, and reduced per capita costs. Through a strong management organization, a sophisticated data management system, and a trusting relationship between network partners and the communities, the GK model has been able to provide better outcomes for all partners involved. As such, elements of it are being transferred to other regions in Europe, such as the Netherlands and Belgium.

Figure 1. The Optimedis model of integrated care.



Source: www.optimedis.de.

1.1. BOUNDARIES AND MARKET STRUCTURE

The German health system is characterised by a pronounced federalisation, leaving the 'Laender' (federal states) in charge of implementing national health regulations. Strong stakeholders in the operationalization, delivery and design of the health services on the regional and local level are the health insurance companies and sickness funds, of which there are non-for profit and private ones, all competing for potential insurees. German citizens have (in principle) free choice between the public, non-profit and private insurances, but they are compelled by law to be insured (i.e. one cannot opt-out of the system). While being the originator of the Bismarck system, the modern German health (insurance) system is thus a highly competitive and at the same time highly regulated system. It is also characterised by frequent national health reforms, creating an environment of seeming constant change while maintaining the key features of a publicly funded health system, strong stakeholder organisations and fragmented governance, accountability and funding structures.

Population and organisation structure

The Gesundes Kinzigtal (GK) model is designed around the Triple Aim approach (Berwick et al. 2008) and based on promoting a strong governance compromise among all stakeholders towards population health. An independent private management organisation, Optimedis, acts as the regional integrator, brings together the stakeholders involved in service provision and systematically monitors the implementation of the GK model. Based on a powerful data management system, the GK model features a continuous learning environment, which also drives the further development of the services and programmes offered.

Desite its success, it is still a very small and local initiative, which services 33.000 of a total population of 71.000 in that area (post code). As freedom of choice of provider is a fundamental principle of the German health system, participation is voluntary from the patient's as well as the providers side. Access is granted by signing a contract with the regional integrator (provider) or a signed consent form with your chosen 'health guide' (patient). Optimedis has shared savings contracts with the AOK (the biggest sick fund in Germany and in the region) and another smaller public sick fund, so people insured with other health insurers or sick funds may not be able to access the services offered. Based on the positive outcomes of the model according to all Triple Aims, the contract with the AOK has recently been extended indefinitely.

Scale and scope of services

At the moment, services are still limited to health, but there they include everything along the continuum of care. As mentioned above public health and population health management tools are an integral part of the portfolio. That is why also fitness centres, health clubs and local community activities are part of the network and have contracts with the regional integrator.

GK is a full integration model, which in addition created a wider network of collaboration for active and healthy living in the area. For this, they partner with local city councils and other service providers, which subscribe to their ideas. Some of these partnerships are formalised in contracts, others are more informal and for specific events.

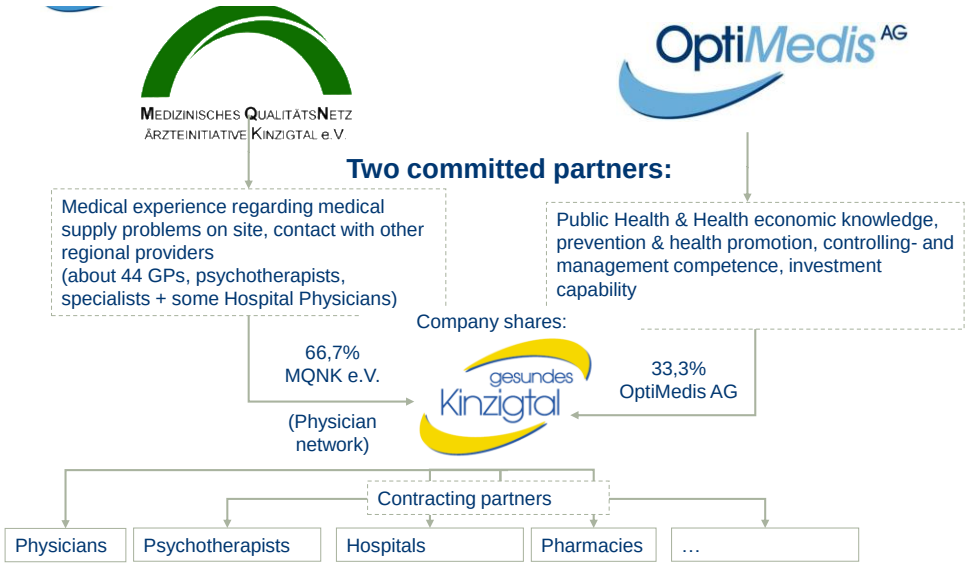
1.2. GOVERNANCE, ACCOUNTABILITY AND MANAGEMENT

As mentioned above, GK is organized following Berwick's (2008) principles. A private management company, Optimedis, works as the regional integrator and is the inventor and developer of the model. Together with a physician network and the Gesundes Kinzigtal company limited, they manage the service provision for their clients. A board of directors representing these three partners has the overall responsibility for the strategy, while the management is in the hands of GK Ltd. Human resource management is limited to the employees of the company limited as all service providers are contractual partners.

By signing a contract with GK, service providers commit to the principles of GK and become part of an extensive evaluation and performance measurement system. This technology-based tool has been developed from the very beginning and has now reached a stage where regular and detailed feedback is provided to each service provider using dashboards and comparing their outcomes and that of their patients to other providers in the model, but also the regional and national average. These eveluations are the basis for the review and feedback meetings between the regional integrator and the service providers. Moreover, GK is ISO-certified.

GK is accountable to its contractual partners, as well as to the payers: at the moment, these are the regional AOK and a smaller local sickness fund for farmers. As part of the shared savings account described below, GK has to proof its viability against the triple aim objectives, specifically that it could save the sickness fund money, while increasing quality and improving outcomes.

Figure 2. Corporate structure of the regional integrator.

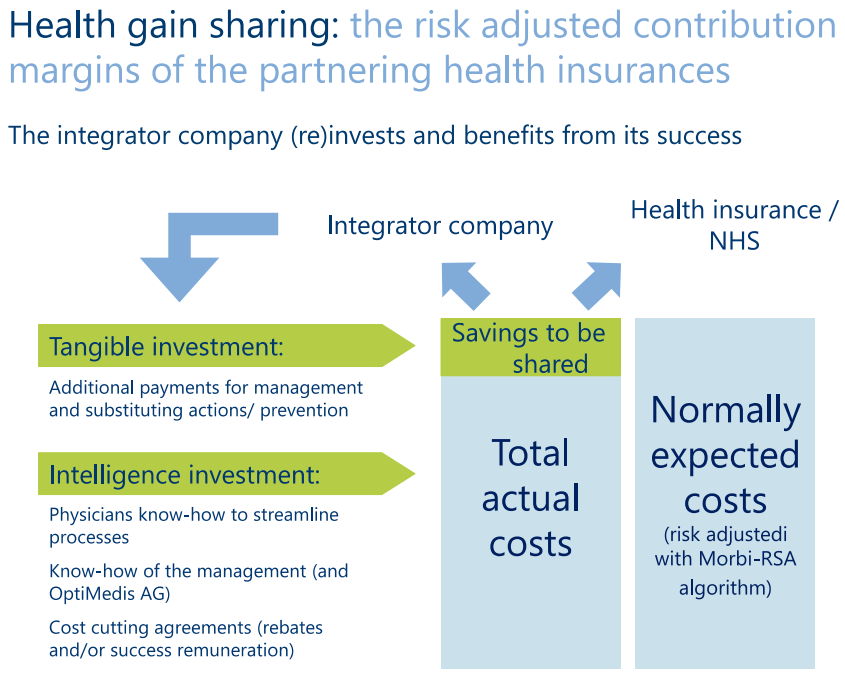


Source: www.optimedis.de.

1.3. FINANCING MODEL

In 'Shared Health Savings Contracts' the management organisation generates an economical benefit for purchasers (sickness funds or in another context the NHS) for a defined population through investments, prevention and optimized care. The surplus is shared between the management organization and sickness funds. Within GK, the surplus is used to pay the management structure, as well as financial incentives for the service providers, and reinvested into the further development of the system (e.g. the performance measurement system, the patients academy, or external research).

Figure 3. The Shared savings account of GK.



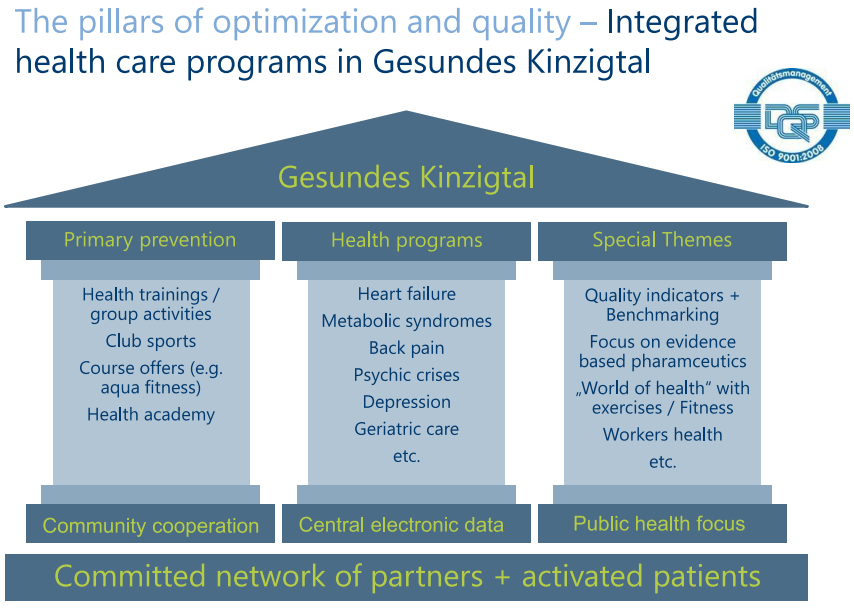
Source: www.optimedis.de.

The contract is negotiated between Optimedis and the sickness fund, and has recently been extended indefinitely. For the service providers, a standard contract is available for download on the Optimedis website.

1.4. SERVICE DELIVERY MODEL

The GK Ltd. recently moved to a new purpose-built building, which houses the operational management, the Health Academy and an education and training centre (still in development). The actual services are provided in the localities of the partners, e.g. practices, pharmacies, at home.

Figure 4. The GK services.



There are regular case conferences and partner meetings, where both service delivery as well as management and development topics are discussed. An annual minimum attendance is mandatory for the service providers and partners. The agendas are set by the partners and highly interactive.

Every patient selects a 'health guide', who functions as a voluntary gatekeeper (binding gatekeeping is legally not possible in the German system), but especially as a case and acre manager. Together they develop a health and care plan with measurable objectives. Added value and benefits for the patients are the varied programmes, which are available for free as part of the GK, such as fitness classes, community activities, and the services of the Health Academy (health information and patient education). GK also organizes annual festivals, sports and health events and similar to raise awareness of the services and engage with the local communities.

Figure 5. Example of the 'Health Services Cockpit' – feedback report to GP practice.

4. Quarter 2012 AOK/LKK	Quality indicators and key figures	Your Practice	Ø-LP-GP's (n=17)	Ø-NLP-GP's (n=22)	Min/ Max GP (n=39)
3. Outcomes: Which impacts have interventions on medical and financial outcomes and patient satisfaction?					
3.1 Economical outcomes	Allocation (Morbi-RSA) per patient	845,45 →	765,33	687,81	937,79
	- Total costs per patient	841,81	764,78	677,81	251,72
	= Contribution margin per patient	3,64	0,55	10,00	326,69
3.2 Health outcomes	Hospital cases per 1.000 patients (risk-adj.)	82,91	87,42	98,55	42,35
	Decedents % (risk-adj. mortality)	0,51%	0,57%	0,60%	0,00%
	Patients with osteoporosis & fracture %	3,64%	8,49%	12,98%	0,00%
3.3 Patient satisfaction	Impression of practice very good - exc. %	66,7%	61,0%	79,9%*	83,3%
Weisse Liste / GeKiM 2012/13	Med. treatment very good - exc. %	52,8%	53,0%	75,1%*	79,2%
*Ø-NLP here = Ø-Germany	Recommendation likely - certain %	85,2%	84,6%	88,1%*	95,6%
2. Process - Where do we have to be excellent?		↑		↑	
2.1 Diagnostic quality	Unspecified diagnoses %	20,4%	20,1%	24,1%	12,5%
	Suspected diagnoses %	1,6%	1,3%	1,6%	0,6%
2.2 Utilization	Patients >= 35 with health-check-up %	7,5%	7,8%	7,1%	17,1%
	Patients incapable of working %	39,0%	41,7%	43,8%	33,8%
	Length of incapacity for work	5,52	5,93	6,37	3,87
2.3 Improvement of Medication	Generic quota	93,0% →	88,6%	87,2%	93,0%
	Pat. with heart-fail. & guideline prescr. %	79,9%	75,4%	72,9%	100,0%
	Patients >= 65 with pot. inad. med. (PRISCUS)	14,3%	13,2%	12,5%	4,2%
	Patients >=65 with inad. prescr. (FORTA D) %	4,0%	4,8%	4,3%	0,6%

Source: H. Hildebrandt (2014).

As illustrated in Figure 13, GK has an intricate performance and quality improvement system in place, which is based on evidence. Moreover, it has been scientifically evaluated from the start. It has not only proven its success in the triple aim, but also in three other dimensions: quality of life and professional satisfaction of providers, community building and securing health care for the region, and supporting a healthy workforce in the region.

1.5. STRENGTHS AND WEAKNESSES OF THE MODEL

GK ticks most of the boxes for success as outlined in the previous sections. It has strong management and leadership, a compelling narrative, shared values and shared gains, an inclusive population health management approach and a comprehensive evaluation system and continuous improvement cycle in place. It relies on a wide variety of tools and instruments, is open to innovation and invests heavily in adding value to the community it works in. However, the number of inscribed patients is only about a third of the patients eligible (i.e. all insured of the two sickness funds in the area), and the services are limited to the health sector. Within the health sector, they provide most of the services from health promotion to palliative care, and those which are not or cannot be offered locally are arranged for. Another weakness is the lack of patient and community engagement: while the offers are extensive for them, they do not have a say in the design or

management of the services. Until recently, the uncertainty of the contractual arrangements with the sickness fund was another weakness, as it had to be extended several times. As of 2016, GK is officially a standard of care in the region.

Optimedis invests heavily in the dispersion of its model and is continuously looking for opportunities to transfer its model and lessons to other contexts. So far, this has only worked with limited success and only with very specific tools, not as a fully integrated model. It remains to be seen, how transferable the model really is.

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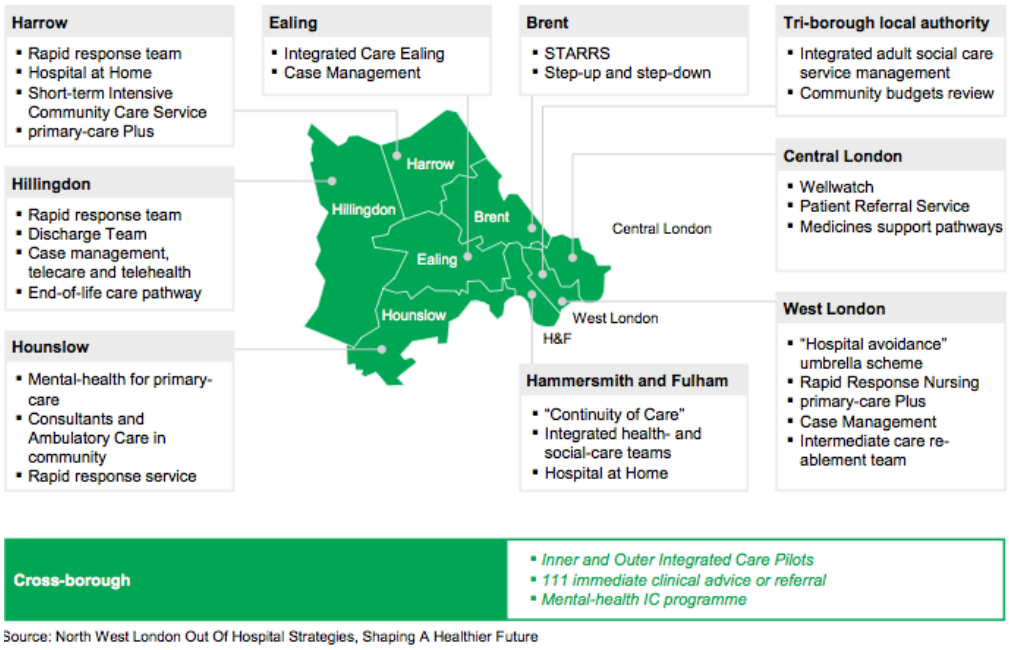
2. NORTHWESTLONDON WHOLE SYSTEM INTEGRATED CARE

North West London started its integrated care journey in 2006, when it became one of 14 Integrated Care Pilot sites in the NHS England. Since then it has rapidly evolved into the NorthWestLondon Whole System Integrated Care (NWL WSIC), and is currently a part of the Pioneer programme. It services a population of 2 million inhabitants in the 8 boroughs of Northwest London.

Figure 6. NorthWest London Whole System Intergated Care.



Source: North West London Out Of Hospital Strategies, Shaping A Healthier Future

It is organsied along 3 key principles:

- People will be empowered to direct their care and support and receive the care they need in their homes or local community.
- GPs will be at the centre of organising and coordinating people's care.
- Our systems will enable and not hinder the provision of integrated care.

2.1. BOUNDARIES AND MARKET STRUCTURE

NorthWest London developed out of different policies and initiatives on the national level to promote integrated care. It incorporates the transition instigated on the national level from primary care trusts (PCTs) via clinical commissioning groups (CCGs) to primary health networks (PHNs), as well as the merger of local health and social services into local health and wellbeing boards. As in the Gesundes Kinzigtal model, not all the primary health networks active in the 8 boroughs are part of NWL WSIC, but their intention is to service everyone.

While it started to target populations with diabetes and (frail) elderly (and these programmes are still running) it has since eveolved into a fully integrated system, which offers a wide range of services, including mental health and public health, and from primary to tertiary care. Importantly, it also offers all the social services the English system provides. All of the programmes are developed based on population risk stratification, targeting specific groups and addressing their individual needs. As the populations vary considerably between the 8 boroughs, representing all socio-economic strata and all age groups, the portfolio of services offered also varies to the local needs in each of the boroughs.

The integrated care management board did that by creating a shared patient registry that covered the whole population and used associated data from all settings of care to analyse the subgroups with the highest risks and costs for the system. This lead to the initial focus on diabetic and elderly patients, developing targeted care pathways. Later on COPD, and cardiac pathways were developed. Currently the NWL WSIC focuses on segmenting individual patients by risk, enabling the planning of proactive care. The aim is to provide every person in the locality with a care plan, which may be as simple as helping them to stay healthy, pointing them to educational events or wellbeind activities,

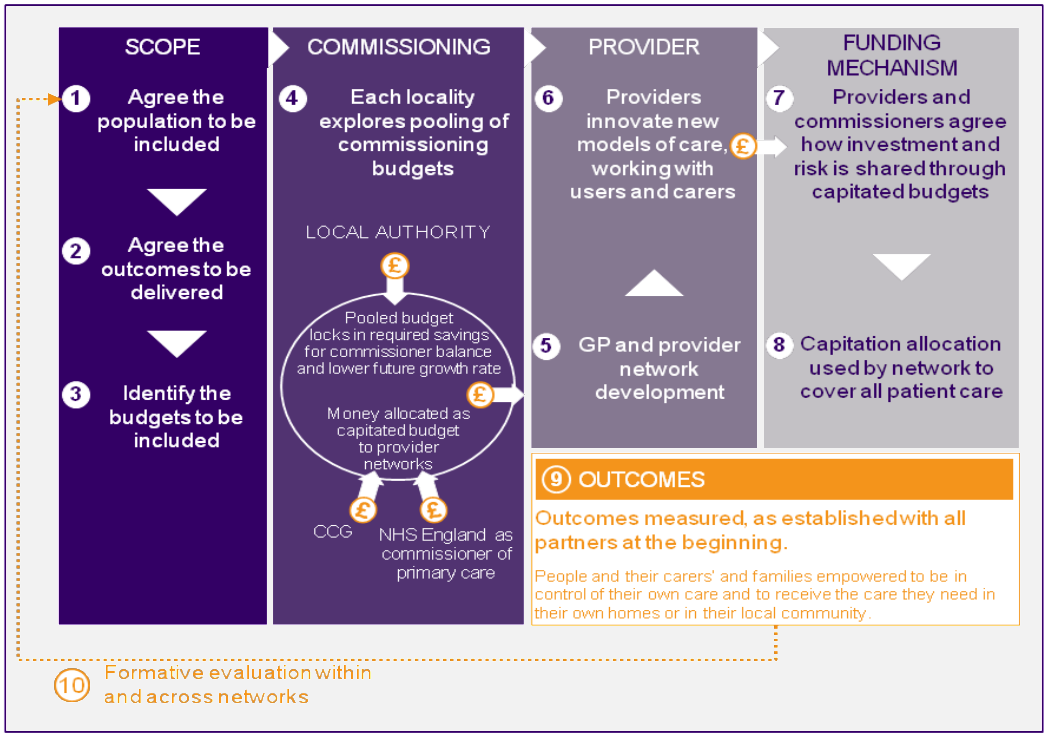
or as complex as managing a social isolated frail eldery person with multiple conditions and complex needs.

Competition is relevant as every patient can choose their GP. These have a gatekeeping function throughout the system, not only in the NWL WSIC. While competitive elements have been introduced into the NHS England, these are not specific for the Pioneer and within NorthWest London there obviously is only one provider of integrated care.

2.2. GOVERNANCE, ACCOUNTABILITY AND MANAGEMENT

The NorthWest London Whole System Integrated Care is managed by a provider-led, integrated management board, of which the Lay Advisory Group is a vital part. It has evolved its structure based on the lessons learned from the Integrated Care Pilot (see figures 14 and 15).

Figure 7. Accountability and financing mechanisms at NWL WSIC.



Source: NorthWest London Integrated Care Pilot.

NWL WSIC is accountable to NHS England for their outcomes, and within the system, GPs and provider networks (PHNs) are accountable to the integrated management board, as well as to their patients. Based on shared records and a pooling of the data from all settings, a comprehensive performance improvement framework monitors and evaluates the outcomes. These found the basis for commissioning and distribution of incentives. NWL has developed its own measures and indicators to monitor success. They align incentives through case conferences, enhanced care plans and innovation funding. NWL WSIC also tracks and evaluates the performance of GP's surgeries and MDTs to drive competition and share best practice. As such, each MDT is reviewed based on patient experience, clinical outcomes, financial performance and team effectiveness. Clinical protocols and care packages (including activity and resource requirements) were developed for each group, ensuring standardisation of best practice.

A key success factor throughout the development of the WSIC was the active involvement of patients and the local community. From the very beginning, 150 third sector organisations, NGOs,

and civil society organisations were included in the design, implementation and evaluation of the integrated car initiative. This lead to the foundation of the Lay Partners Advisory Group, which is part of every meeting, gives feedback and monitors implementation as well as being actively involved in the further development of the system.

2.3. FINANCING MODEL

As shown in the above figure, NWL WSIC uses a pooled budget for health and social services to commission the services needed in the locality. The service providers are paid on a mix of capitation and fee for services. The global budget received a huge cut last year, as government obliged the NHS and the social services to reduce costs significantly until 2020. This means that also for NWL WSIC less money is available to commission services. There was no seed money for the integration pilot, but as part of the Pioneer programme, NHS England promised to pay some exra money in 2018, if the Pioneer can prove cost savings and quality improvement.

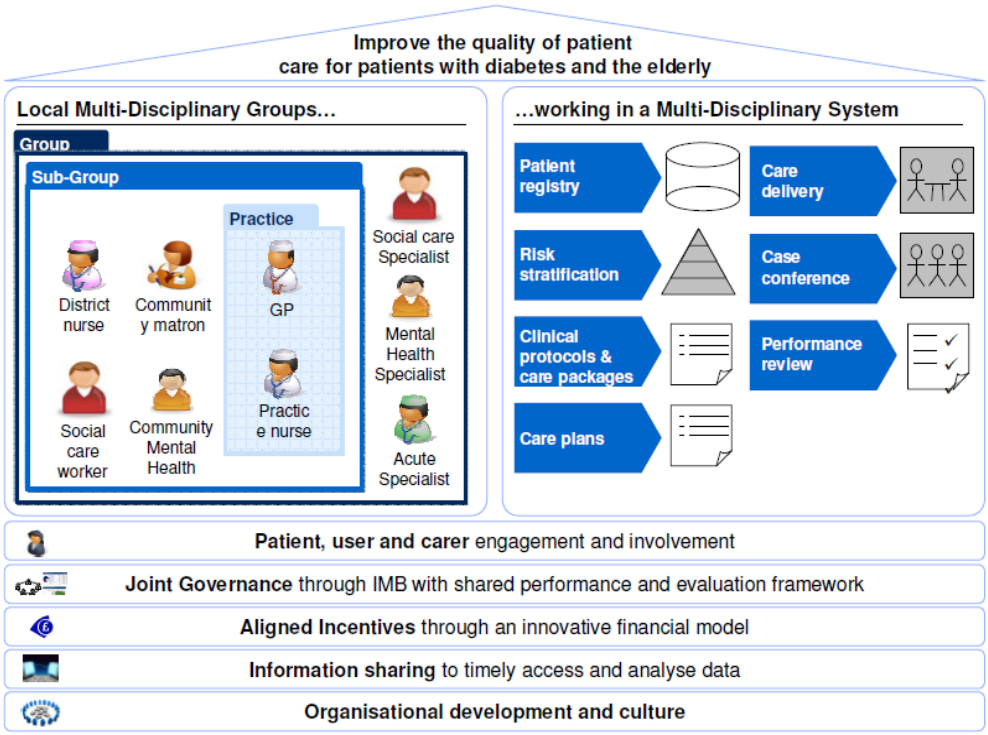
It is important to note here, that while there is a pooled budget for health and social services, the payment systems and prices still vary greatly between the two sub-systems.

2.4. SERVICE DELIVERY MODEL

At the heart of the organization are the multi-disciplinary teams (MDTs), which work together to manage the care of the patients. They include include a GP, nurse, social worker, acute physician, mental health team, district nurse co-ordinated by an MDG manager. More specialized professionals are available for consultation and services on a case-by-case basis. Care plans are developed in one-to-one meetings between clinicians and patients allowing for better doctor-patient relationship, and greater patient involvement in decision making. These care plans are delivered by the multi-professional teams through an integrated approach. The patient has one contact point in the delivery of their care plan.

Information sharing across multiple organisations is made possible by a single platform. This is an IT tool which links and shares provider information, allowing health and social care professionals to see key integrated data sets for patients that had consented to share their personal information. The most complex cases are discussed at a case conference in an MDT session. At these conferences, root cause analysis of non-emergency avoidable admissions is presented for shared learning and solutions for future avoidance of such cases are discussed.

Figure 8. Multi-disciplinary Teams at the heart of integrated service delivery.



Source: NorthWest London Integrated Care Pilot.

2.5. STRENGTHS AND WEAKNESSES OF THE MODEL

NorthWest London WSIC has seen tremendous development on all levels of integration driven by a strong change management process, which included all relevant stakeholders in regular planning and design meetings. As mentioned above, a key milestone was the creation and institutionalization of the Lay Partners Advisory Group. The manifold experience and lessons learned were also documented in the WSIC toolkit, which is available online and a living resource, as the integration process is far from being completed. The very inclusive and bottom-up approach to the service design also helped garnering the support of GPs and primary health networks, using early adopters as mediators to draw more professionals in. At the moment, the integrated management board is looking to redesign the different disease-focused care pathways into more holistic service delivery packages and ensuring that they fit into the other programmes and modules developed. Only recently, the first integrated care clinic opened in St. Charles's hospital to give a physical presence to the integrated care initiative. It is conceptualized to be a one-stop-shop for integrated primary care, offering information, consultation, triageing and transfer services. NorthWest London also boasts three world-famous hospitals, one of them being Imperial College. They are actively involved in designing intermediate care and specialist consulting services in primary care to help them achieve their DRG-led outcomes.

According to their own information however, they have not been able to achieve many of the set objectives, especially around cost-effectiveness, hospital admissions and service integration beyond the MDTs. Also, health outcomes have not generally improved, giving a mixed picture of their disease management programmes and care plans. Some of these are down to too ambitious goals, policy changes and complexity of services. They admit that they did too much too fast. So, for the

next years, the aim is to consolidate the MDTs, improve coordination between health and social services and try to shift more services into the home setting.

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3. CANTERBURY, NEW ZEALAND

In New Zealand, the District Health Board for Canterbury, the south island's largest and most populous region, has been engaged on a journey toward integrated care for almost 10 years now. It has moved from a position where, back in 2007, its main hospital in Christchurch regularly entered 'gridlock' – with patients backing up in its emergency department and facing long waits as the hospital ran out of beds – to one where that rarely happens. This was made possible through a system-wide integrated care process, which galvanized in the all-present mantra: "one system, one budget". Even though this is in effect not true, as there are various public and private sources of funding, the idea that structures, processes and cultures needed to be aligned in one thinking carried the change process until today.

The goals adopted for the health service plan were that:

- services should enable people to take more responsibility for their own health and well-being
- as far as possible people should stay well in their own homes and communities
- when people need complex care it should be timely and appropriate.

To achieve these goals a new way of working was essential and the key requirements for change were formulated as:

- those in the health system – from primary to community to hospital to social care, and whether working as public employees, independent practitioners, or private and not-for-pro t contractors – had to recognise that there was 'one system, one budget' in Canterbury.
- Canterbury had to get the best possible outcomes within the resources available, rather than individual organisations and practitioners simply arguing for more money.
- that the goal was to deliver 'the right care, right place, right time by the right person' – and that a key measure of success was to reduce the time patients spent waiting.

3.1. BOUNDARIES AND MARKET STRUCTURE

Canterbury District Health Board is responsible to provide service for around 510,000 population. The board has 9,000 direct employees. But its expenditure employs approximately 18,000 people in total, many of them on contract. Ambulance services are not provided directly but by St John Ambulance. Much out-of-hospital nursing and community care also comes on contract – and to an unusually high degree by New Zealand norms – through organisations such as Nurse Maude, Access and Health Care New Zealand. Christchurch is the main city, and at around 400,000 accounts for the

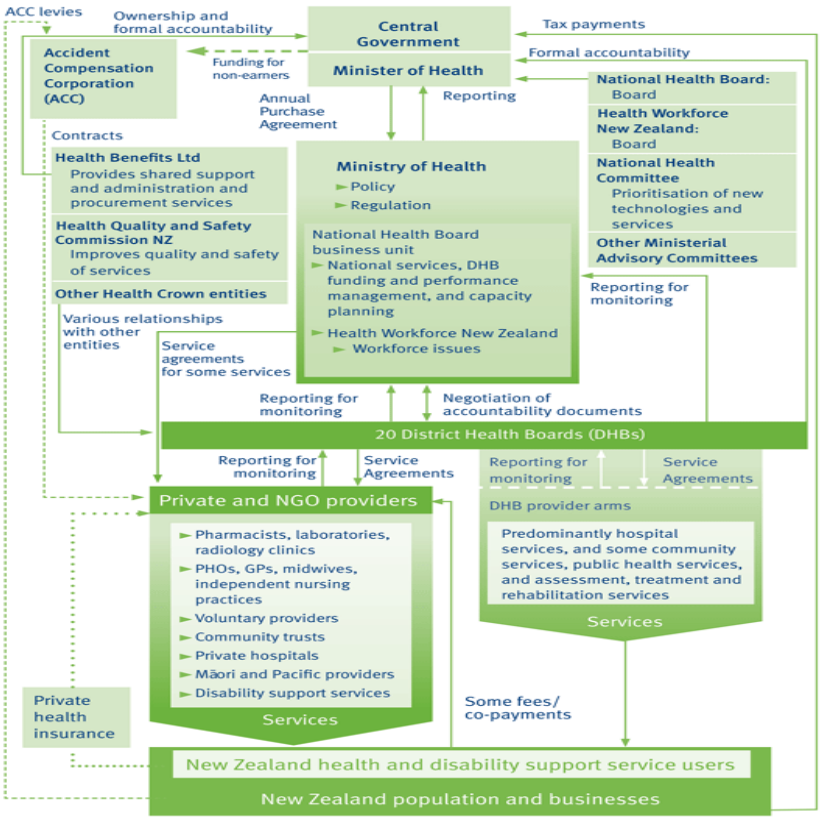
bulk of the population. But the board's geographical remit spreads westwards to the Southern Alps, about 150 miles or 240km north to Kekerengu and some 60 miles or 90km south to just beyond Ashburton. Its management team also runs the West Coast District Health Board on the other side of the Southern Alps.

The board has some 130 general practices in its area, 115 community pharmacies, 110 dentists, 100 or so aged care facilities (residential care homes) and more than 50 mental health providers. Christchurch is the main hospital, providing 650 out of the 800 beds that the board runs in total. It provides secondary care in Canterbury and much of the tertiary care for the whole south island, with a separately managed Women's and Children's hospital immediately adjacent to it. There is an elective orthopaedic and spinal injuries centre at Burwood. A mix of services includes day case general surgery and gynaecology at Ashburton. The Princess Margaret Hospital in Christchurch provides a range of elderly care and mental health services and beds, and Hillmorton provides mental health, including forensic mental health services.
So, the District Health Board has to provide all services along the continuum of care. In contrast to other models, it has not gone down the track of creating a new organization, but has rather built a virtual network of providers and communities to integrate and improve services.

3.2. GOVERNANCE, ACCOUNTABILITY AND MANAGEMENT

As mentioned above, Canterbury has not established any new organizational structures, but rather tries to improve the existing system by creating common values, processes and mutual trust. It is thus embedded in the New Zealand health system. This has strongly been driven by the implementation of alliance contracting.

Figure 9. New Zealand funding and regulatory structures for health and social care.



Source: New Zealand Ministry of Health.

The District Health Board (DHB) functions as the regional integrator, who has to ensure all services are provided for the population via contracts with the various service providers from the primary, secondary and third sector, as well as private sector and civil society. The key objective for everyone, and which is the primary indicator for success, is the reduction of waiting times for patients, i.e. 'reducing the time people waste waiting'. While the DHB ensures that disincentives and structural barriers are removed, service providers are given the task and the flexibility to define with each other and the local communities how and where to provide the services. This is achieved in regular meetings and events (ShowCase), education and training programmes (Xceler8) which include the development of change plans for the participants, and throught the definition of HealthPathways. Much more than just an medical care pathway, this technology-supported tool is the basis to define the 'right care, at the right time, in the right place to the right people'.

3.3. FINANCING MODEL

Following a long history of reforms, by 2009 the NZ Government released a request for new models of care, 'which see the patient rather than the institution as the centre of service delivery' (Cumming, 2011). This resulted in a re-centralization, the amalgamation of Primary Health Organizations and a re-organization in nine 'Alliances', in combination with a devolution of funding and services from District Health Boards to the community: *"The 'Alliances' must develop a single governance group and integrated operational management structure and use 'alliance' contracting mechanisms to advance their proposals; such contracts are generally set up such that all information (including financial information) is disclosed, objectives are shared, and rewards are distributed based on actual outcomes"* (Cumming, 2011).

Canterbury Health System is one of the most successful alliances. The organizational development process was guided by the conviction that those in the health system – from primary to community to hospital to social care, and whether working as public employees, independent practitioners, or private and not-for-profit contractors – had to recognize that there was 'one system, one budget' in Canterbury. Apart from the vision and a broad investment in skills development, the success of the reform was also based on new forms of contracting as an incentive to deliver the right care at the right time and at the right place – with the reduction of waiting time as a key-indicator. The involvement of stakeholders has been crucial, together with the basic agreement that greater efficiency would not result in losing resources.

Alliance contracting has its origins in the construction industry. Based on the assumption that multiple organizations can achieve better things by working together on agreed pain/gain contracts, the alliance has moved as much as possible away from fee-for-service, demand driven expenditure, into more capacity-based contracts designed to create a joint incentive for both the referrers and providers to manage the cost.

> *"All the contractors have agreed margins and a fixed amount of money to work with. Their performance is visible to the other partners in the alliance. Each can thus be benchmarked against the others and 'profits' go back into the system in ways the alliance partners agree in order to improve services. The agreement rules out litigation as far as it can. Problems and tensions – and they certainly arise within these contracts – are to be solved as closely as possible at the point of delivery and by the contract's management teams before being progressed to the alliance board. If still unresolved, mediation is preferred to arbitration."* (Timmins & Ham, 2013)

In Canterbury, this approach has also been facilitated by the fact that almost all providers are non-profit organizations and that transparency has improved.

The model's success may in particular be illustrated by its financial performance – from a $21m loss in 2006 to an $8m surplus in 2008 – and the reduction of waiting times by 1.5m days of waiting within 3 years (Timmins & Ham, 2013). A number of other, clinical and result-oriented indicators also provide evidence of the positive performance of the Canterbury Health System, even after the heavy earthquake that destroyed large parts of the county, including some hospitals and GP practices in 2011.

Alliance contracts are a new type of shaping contractual relationships and related (financial) incentives. This is a promising approach in the context of general organizational design, in particular in the perspective of coordinated/integrated health care delivery. At the moment, one can only underline the necessity of investments in building necessary framework conditions to realize such approaches, in particular (Addicott, 2014; ACEVO, 2015):

- To clarify the leeway in procurement legislation and (EU or national) competition laws;
- To support the development of financial, legal and procurement skills as well as organizational development skills;
- To allow for trust-building and appropriate time-frames to make new organizational models happen;
- To involve local communities by supporting the crucial role of the third sector (ACEVO, 2015);
- To monitor success and failure in view of a 'social business case' to be rolled out across the system.

3.4. SERVICE DELIVERY MODEL

As mentioned previously, the primary-care led services are co-designed by the service providers, using the HealthPathways as a basis to decide which services to provide when and where. All of the tools developed are technology-supported and rely on a transparent data management system and shared electronig records. The GP, as the gatekeeper, can see all the available services for a specific patient, look at the recommended interventions of the HealthPathway and request transfers, prescriptions and further interventions online.

Figure 10. The Canterbury System.

The King's Fund Ideas that change health care

Canterbury District Health Board Te Poari Hauora ō Waitaha

Key enabling tools are care pathways, case management, electronic patient records, multi-disciplinary planning meetings, process and flow analyses, medication management systems, etc. All of these tools are supported by the corresponding IT infrastructure and solution.

A key strength of Canterbury's health system is general practice. GPs take direct responsibility for out-of-hours care, with a centralised nurse triage system, along with a number of centres that provide extended opening hours. Christchurch itself has two 12-hour-a-day surgeries, which provide extended care including radiology and fracture care, while rural areas, with the support of the primary health organisations, also have 24-hour GP and nurse cover. The 'jewel in the crown' so to speak is the Pegasus purpose-built 24-hour surgery – more accurately a care facility – staffed chiefly by local GPs. Over the years – backed by HealthPathways and telephone access to hospital specialists – it has increasingly handled more complex cases. It now sees 75,000-plus patients a year, almost as many as the 80,000 attendances at the emergency department. It takes more patients out of hours and at weekends than the emergency department. This is despite a non-subsidised visit to the 24-hour surgery costing NZ$75.

3.5. STRENGTHS AND WEAKNESSES OF THE MODEL

By focusing everything on the slogan "one system, one budget" and creating a very strong leadership approach, Canterbury Health System has managed to convert its losses into a surplus, has signifcanlty reduced waiting times and avoidable hospital admissions and has developed some impressive data management and technology-driven process management tools to align structures and incentives. Some of the tools, such as HealthPathways, are now being used in other parts of New Zealand, Australia and the USA as well. The investment in building a strong coalition for change, a concerted vision and mission, in which everyone bought into and a comprehensive education and training programme for the professionals has resulted in culture and value changes which support multi-disciplinary collaboration and information sharing. This has enabled the system to use the destruction of a majority of its infrastructure by the devasatiting Christchurch earthquake of 2011 to accelerate change and firmly establish integrated care as a way of working. However, there still seems to be a considerable gap between early adopters and those having undergone the Xceler8

training programme, and those professionals who have not. The latter feeling quite disconnected from the system and unable to use the different tools available to them. There is also a feeling among professionals that the focus on technological solutions for integration has come at the cost of losing human contact. Another weak point is the lack of active engagement of patients and communities, as access for them to the tools is still restricted and the implementation of co-production tools with patient support has only just begun.

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