



# Cross-cutting Integrated Care Principles

## Overview

Existing health and social care systems were created in a completely different epidemiological context compared to the current situation. They were organised to deliver care to people who experienced acute adverse events and were living with diseases and existing chronic diseases at the time, such as tuberculosis, leprosy with those having mental health illnesses being secluded in institutions away from society. The profound change in the epidemiology of the diseases, disabilities, survival and life expectancy in the past decades has necessitated care authorities to rethink and redesign how care can and should be provided. There has been a shift from acute disease, episodic-orientated systems to an integrated approach designed to respond to complex situations, often with accumulating chronic conditions and disabilities with increasing disease burden over the life-course in a population with increasing life-expectancy (see Figure 1). These changes have influenced a cultural awareness and understanding of health, social care and support services and how these should be integrated with the introduction of new concepts of health and wellbeing which can take advantage of new technological evolution and the information and data revolution in the 21st century. This complex situation has resulted in the development of new integrated models of care and pathways designed to bring together all the care interventions, treatment, services and support from a care team made up of care practitioners from multiple care delivery organisations and disciplines together with the patient and family carers.

For the purpose of understanding integrated care within the Euriphi project, the following definitions were considered:

*"Integrated care"... is an organising principle for care delivery with the aim of achieving improved care through better coordination of services provided.*

Nuffield Trust, 'An overview of integrated care in the NHS. What is integrated care?' (London: Nuffield Trust, 2011., p 7).

*"Integration" is the combined set of methods, processes and models that seek to bring about this improved coordination of care.*

Chris Ham and Nicola Walsh, 'Making Integrated Care Happen at Scale and Pace' (London: King's Fund, 2013, p1).

## Care Delivery Shortcomings

### Integrated risk assessment tools

Current risk stratification strategies and tools do not consider personal or contextual capacity and capability to respond to the risk and they only detect specific risks. As a result, they do not identify the population that needs to be targeted either individually or in communities.

Existing risk assessment tools for primary prevention need to be more personalised as they tend to overestimate or underestimate the risk across different sociodemographic subgroups.



Risk assessment results need to be integrated into the public health decision making stakeholders to direct resources towards the correct subgroups to improve population health.

Risk assessment results need to be linked and integrated with an interface for care practitioners to ensure the identified person with a high risk of stroke can be monitored and followed-up.

It is necessary to create and provide tools that promote patients' comprehensive assessment, including secondary prevention assessment in social and health problems derived from the existing conditions as well as new risk identification, and make the information available to the care providers.

It is decisive to involve the patient as early as possible in any early prevention strategies as lifestyle changes are recognised to be the best approach in stroke prevention and risk management. Taking stroke as an example, primary prevention begins with making the public aware of stroke risk factors and providing information about how they can positively influence their individual (modifiable) risks. Apart from adopting a healthy lifestyle, regular control of blood pressure and controlling diabetes are important prevention strategies.

### **Integrated solutions to support information sharing and real-time communication within care provider organisations, among different care practitioners, people receiving care and their supporting community and social network**

The lack of information sharing tools and strategies among different stakeholders and care providers to ensure the care-receiver has a comprehensive assessment, continuity of care and easy navigation through the system is one of the main problems of the current health and social services. Strategies to share information and the development of new communication channels should be the main drivers to diminish the existing care and information fragmentation resulting in better care and less burden for care receivers and carers, as well as a better resource allocation and improve workforce satisfaction.

Within the organisation, the development of good information sharing and communication strategies would help to align all the effort to comply with the personalized care plan designed for each care receiver, would lessen misunderstandings about expectations with the team and within the team, and it would be helpful to reduce duplications and information errors.

Within the organisation, the development of information sharing and communication strategies would support care teams with specialists for complex case management. Centralised expert team directories and protocols to access (even remotely) should facilitate the care of complex patients and increase the confidence of the team and in the team.

Between organisations and care providers, the communication and information-sharing tools are needed to ensure the continuity of care, reduce gaps in care provision and ensure better use of available resources. Transitions from hospital to home or community setting have been pointed as high risk for care discontinuity especially in conditions in need of high care provision. The requirement of high care needs



can happen either to return to previous wellbeing conditions or to adapt to new strategies and adopt a new support system to face new, transitory, permanent or accumulative disabilities. These conditions demand seamless coordination and communication among all parties involved in care provision on rehabilitation, social support, care management, and community resources.

### Integrated (remote) monitoring solutions for people living with complex need

Existing tools are too simple, they are not personalised and they lack integration. Existing tools do not record important information about physical status and activity, nutritional information, capacity and capability progression or the existence of social support. Improved and user-friendly tools and strategies would allow carer receivers and carers to detect and manage their own needs as well as record the progression of their status and detect care needs.

Lack of existing devices and tools to allow direct and real-time communication between care receiver and care providers which hinders the capacity for a prompt, adequate and proportionate response to problems.

Medical devices, supportive aids, and health monitoring tools should be user-friendly, and users and care providers should receive adequate training in their use and response strategies.

The information from the monitoring tools should be integrated into the existing care record and available to all the care providers involved in the care with an adequate response strategy in place.

## Integrated Care Procurement Objectives

1. Intervention strategies should be personalised in terms of timing, frequency, composition, content, etc. according to contextual changes (change in behaviours, lifestyle, health state, and knowledge) throughout life. Choices will be offered in terms of psychological strategies such as rewards for quick wins, celebrating the small successes, or gamification. The solution is to clearly help identify strategies on how to implement healthier behaviour in day to day situations. The solutions, therefore, will enable the patient to set realistic, measurable and achievable goals and offer measurement criteria that indicate success.

#### Related Integrated Care keywords :

- DIGITAL HEALTH
- HOLISTIC AND COMPREHENSIVE APPROACH
- PERSONALISED CARE
- PERSON-CENTRED

2. Address the need to improve risk assessment strategies with a holistic approach to identify patients and families beyond disease-specific risk stratification tools. There is a need to integrate disease-interaction and drug-drug interaction risk, rapid progression risk, risk of high need of resources, social exclusion risk, the risk of unbearable treatment burden or the risk of psychological difficulties. The interface to patients and their access to services should, amongst others, capitalise on the fact that pharmacies can be in frequent contact with at-risk patients and thus can play a strong role in prevention and early detection.



**Related Integrated Care keywords :**

- CARE TEAM BUILDING
- HOLISTIC AND COMPREHENSIVE APPROACH

3. Provide multiple communication channels (e.g. portals, APPs, secure chat, videoconference), in addition to the usual paper-and-pencil and phone calls,e.g.

- To share the individual's care plan and the notes on its delivery among the care team members;
- To facilitate the remote contacts (e.g. WhatsApp-like) between the care team/stakeholders;
- To manage a patient's feedback on the appropriate execution of his/her planned self-management tasks;
- To generate/notify/rank alerts in case of need, perhaps after a filter made by a Contact Centre."

**Related Integrated Care keywords :**

- DATA AND INFORMATION SHARING
- DIGITAL HEALTH
- PERSONALISED CARE
- SELF-CARE AND SELF-MANAGEMENT
- SERVICE, FUNCTION AND CARE INTEGRATION / COORDINATION – TRANSITIONS

4. Create easy-to-understand and adaptable, personalised educational and motivational materials reflecting local languages, and contexts, cultures, and capacities to empower patients and family carers in the self-management and decision-making process.

**Related Integrated Care keywords :**

- CO-PRODUCTION
- SELF-CARE AND SELF-MANAGEMENT
- WORKFORCE RESOURCES, TRAINING AND CAPACITY BUILDING

5. Address the need to improve information sharing between patients and care practitioners, regarding both the monitoring process of patients' conditions as well as more informal communication on decision-sharing or difficulties during treatment.

**Related Integrated Care keywords :**

- CO-PRODUCTION
- DATA AND INFORMATION SHARING
- DIGITAL HEALTH