Models of Health and Social Care Integration for Older People: Examples and Comparisons across Europe

Jenny Billings
Centre for Health Service Studies
University of Kent (UK)
Features of PROCARE

- Explore the realm of integrated care activity in nine partner countries (Austria, Denmark, Finland, France, Germany, Greece, Italy, Netherlands, UK)

- Search for and evaluate best practice models in each country

- Provide recommendations for integrated care based on identified elements of best practice and sustainability

- Lessons learned and questions tackled
the project phases:

- inventory of the state of the art
  - literature reviews
  - search for model ways of working
  - national reports
  - European overview

- in-depth analysis of two selected model ways of working in each country
  - interviews, focus groups (n=464 participants)
  - data sheets
  - transnational and transversal analysis (papers)
what are the issues at stake?

▶ definitions
  ▶ integration vs. co-ordination, transmural care, intermediate care, seamless care, person-centred care, etc. etc.

▶ policies and governance
  ▶ decentralisation, privatisation, financing

▶ “new” methods
  ▶ multidimensional needs assessment, hospital discharge management, intermediate care, case management, coordinating care conferences

▶ pathways to integrated care
  ▶ networking, coordination, integration, management
### the relative importance of different methods in selected European countries

<table>
<thead>
<tr>
<th>Method</th>
<th>A</th>
<th>D</th>
<th>DK</th>
<th>EL</th>
<th>F</th>
<th>FIN</th>
<th>I</th>
<th>NL</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case and care management</td>
<td>ө</td>
<td>ө</td>
<td>өө</td>
<td>өө</td>
<td>өө</td>
<td>өөө</td>
<td>өө</td>
<td>өөө</td>
<td>өөө</td>
</tr>
<tr>
<td>Intermediate care</td>
<td>ө</td>
<td>ө</td>
<td>өө</td>
<td>өө</td>
<td>өө</td>
<td>өөө</td>
<td>өө</td>
<td>өөө</td>
<td>өөө</td>
</tr>
<tr>
<td>Multiprofessional needs assessment and joint planning</td>
<td>өө</td>
<td>өө</td>
<td>өө</td>
<td>өө</td>
<td>өө</td>
<td>өөө</td>
<td>өө</td>
<td>өөө</td>
<td>өөө</td>
</tr>
<tr>
<td>Consumer directed services</td>
<td>өө</td>
<td>өө</td>
<td>өө</td>
<td>өө</td>
<td>өө</td>
<td>өөө</td>
<td>өө</td>
<td>өөө</td>
<td>өөө</td>
</tr>
<tr>
<td>Joint working</td>
<td>ө</td>
<td>ө</td>
<td>өө</td>
<td>өө</td>
<td>өө</td>
<td>өөө</td>
<td>өө</td>
<td>өөө</td>
<td>өөө</td>
</tr>
<tr>
<td>Admission prevention and guidance</td>
<td>ө</td>
<td>ө</td>
<td>өө</td>
<td>өө</td>
<td>өө</td>
<td>өөө</td>
<td>өө</td>
<td>өөө</td>
<td>өөө</td>
</tr>
</tbody>
</table>
clustering of models: pathways to integrated care?

1
the interface between nursing home care and other social services

Greece - UK - Germany
Austria - Finland - NL
France
The case of Helsinki (Finland): Integrated home care for older persons living at home

- **Type of integration**
  - a multi-professional team of 6-10 nurses, home helps, a home-care nurse and a chief home care officer (case manager) in a district of 350 clients

- **Methods**
  - first visit (assessment) at the home of the older person (family members)
  - care and service plan: medication, home care services to be provided, frequency (days and tasks), rehabilitation plan
  - defined carer: every client has his/her ‘own’ carer
  - regular team meetings, documentation
  - common space for formal and informal meetings
  - continuous assessment of the care process
clustering of models: pathways to integrated care?

the interface between acute and long-term care

Italy - UK - Denmark - Austria - Finland - NL - France
The case of Schio (Italy)
The Working Unit for Continuous Care

- **Type of integration/coordination**
  - organising and providing continuous health and social care, departing from the hospital

- **Methods**
  - use of instruments and forms readable by professionals at every level (nurses, doctors, social worker, ...)
  - communication of the multi-dimensional assessment results to the territory (local district and general practitioner)
  - team meetings to define an individual project in short time
  - second assessment to evaluate results
  - motto: “Always a solution before discharge”
3
the access problem:
one-stop-shops,
multidimensional assessment and guidance

France - Greece – Italy
The case of France: Local Information and Gerontological Co-ordination Centres (CLIC)

- **Type of coordination:**
  - single point of entry to social and medical care in the community

- **Methods:**
  1) welcoming, informing, advising and supporting
  2) assessing needs, compiling personalised care plans
  3) implementing, monitoring and adapting care plans

- **A small team** (case manager, assistant, secretary) to promote a common gerontological culture with all stakeholders in the community
clustering of models: pathways to integrated care?

the (almost) consolidated direct service model: 24-hours community care centre

Denmark
The case of Skævinge (Denmark): The Health Centre ‘Bauneparken’

- **Type of integration:**
  - 24-hour integrated health and social care
  - consolidated direct service model
  - single, public provider

- **Methods:**
  - person-centred integration of cure, care and social inclusion of older citizens in the municipality
  - a single point of contact for potential users of health and social/personal care in the municipality
  - case-management
  - concepts of self-care and prevention
eight transversal themes: elements of best practice

- definition of integrated care
- access and pathways
- professional cultures and joint working
- key innovations
- role of the family
- quality of service, person-centredness,
- working conditions
- financial issues
From the onset, involve all stakeholders in defining goals, procedures, target groups, and rules of working.

Develop a clear statement of objectives and strategies for their achievement to foster shared communication.

Develop a clear definition of ‘client-orientation’ for daily work – e.g. seamless functioning, role of the family.
Promoting Joint Working

Sharing premises

Daily/weekly meetings

Active management support: working and training

Investing time in the integration process
Making Use of Key Innovations

- Multi-professional teams for needs assessment
- Use of IT and common database
- Quality management system to monitor goals, procedures and outcomes
- Case management
- Joint seminars/conferences
Basing Decisions on Users’ Needs

Organising care to include social contacts and community participation

Deciding and choosing

Sustaining autonomy, independence, and self-respect

Flexibility affordability continuity of service

Deciding and choosing

Sustaining autonomy, independence, and self-respect

Flexibility affordability continuity of service
some lessons learned and questions to be tackled

▶ experiences rarely used for follow-up activities
  ▶ few organisational or institutional learning processes
  ▶ model ways of working are still in a pioneering phase
  ▶ dependent on personalities (‘pioneers’, champions)
  ▶ no sound financial and structural basis, exception: DK

▶ define target groups and regulate access
  ▶ multidimensional needs assessment across boundaries
  ▶ which tools are best suited to define needs?
some lessons learned and questions to be tackled

- define the role and functions of integration
  - coordination as a profession: the care manager
  - professional hierarchies and cultures a problem

- investment
  - budgets for training, infrastructure
  - beware of shifting money from long-term to acute care

- involve users and carers
  - the more integration, the more professional control
  - how can users/carers gain influence?
pathways to integrated care

Social care system

Services
Institutions
Providers
Professions
Methods
Legal Framework
Policies

Integrated care system

Vision - Culture
Strategies - Policies
Methods
Processes
Quality criteria
R&D, Training

Users/clients/patients/citizens

Health care system

Hospitals
Services
Providers
Professions
Methods
Legal Framework
Policies