Developing a structured approach to furthering integrated care for the population of the Midland Health Board, Republic of Ireland: the ICON project / Susan Tucker, Veronica Larkin and Martina Martin

Developing a Structured Approach to Furthering Integrated Care for the Population of the Midland Health Board, Republic of Ireland

The ICON Project

Helen Tucker - Secta Consulting and Visiting Fellow in the University Of Warwick

Veronica Larkin – Project Manager for Integrated Care, Midland Health Board

Martina Martin – ICT Specialist, Midland Health Board

Email: integratedcare@mhb.ie Website: www.mhb.ie

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Summary

A structured approach to integrated care, known as ICON, has been developed in the Midland Health Board in Ireland. The model covers primary and community care for health and social services across a population of 225,000. The design of the model benefited from extensive consultation with over 750 participants, and has received significant investment in time and resources. The process builds on good practice, and seeks ways of furthering integrated care in a more consistent and managed way by valuing and recognising integrated working. ICON has generated enthusiasm and provided a clear focus and structure to support a way of providing services that participants describe as more appropriate to patients and clients and more efficient for staff. A three-phase programme is being implemented within a five-year plan known as the "ICON Road Map" to design and implement systems and structures to facilitate and support integrated care. ICON is described as a journey, and this paper presents the challenges, learning and the progress made in furthering integrated working in this part of Ireland.

Strategic Context

In 2003 the Midland Health Board committed to developing integrated care throughout primary and community care. Although health and social services are combined within the structure, the Board recognised that there was scope to further integration across its services on an inter-professional, multi-disciplinary and multi-agency basis. In order to prepare for the project, preliminary research was undertaken on definitions and models. A discussion paper set out the strategic framework and evidence-base for integrated care.

Two definitions were influential from the World Health Organisation. The WHO Study Group on the Integration of Health Care Delivery (1) sees integration in terms of "*virtue in its ability to encourage more holistic and personalised approaches to multi-dimensional health needs".* Another definition focused more on outcomes (2): *"Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency".* We referenced work by Kodner et al (3) who describes integration as *"A step in the process of health care systems and health care delivery becoming more complete and comprehensive".* Models from Kodner's work (4) such as PACE (Programmes for All Inclusive Care for the Elderly) and SHMO (Social Health Maintenance Organisations) were helpful in highlighting issues and challenges.

The project was set in the context of the national plan "Quality and Fairness" (5) which promotes *"A new comprehensive model of care to meet the needs of patients and clients in an integrated way based on close teamwork between health professionals and direct access to services."* The strategic priorities for the Board fitted within the national framework and needed to be incorporated into the model. The challenges in striving for working within these principles such as "equity" were recognised, particularly in a mixed health economy.

The health system for Ireland is a mix of private and public sector. 30% of the population are eligible for medical cards, qualifying holders to free access to services. Of those not eligible, 9 out of 10 people will have health insurance to cover hospital care, although very few have cover that extends to visits to the GP or clinics.

The population of the Midland Health Board is 225,000 and is the second smallest of the eleven Health Boards in Ireland. The Board has a responsibility to commission, purchase and provide both health and social care. The Board is facing the challenge of catering for a rapidly increasing population and in particular older people. Employment is typically farming, public services or light industry. The area is mainly rural and consists of towns and villages, with the nearest city being Dublin 50 miles away.

Drivers for Change

The way that health and social care has been planned, delivered and managed in Ireland has relied on the strength of informal links within small tight-knit communities. However, the implementation of the Freedom of Information Act in 1998 and 2003 has presented a logistical challenge in making records available given the absence of a formal system for coordination and management of care. There is no national care management system in Ireland. So although there would often be a common sense approach to providing a service based on good local knowledge, there were limited systems to support, manage and record this. Examples of fragmentation and duplication across the statutory and voluntary sector have been exposed in responding to the Act, providing a strong case for change.

A second key driver was the opportunity presented by developments in Information Technology. There was a multiplicity of requests for a variety of systems from professionals across the Board, reflecting the disparate nature of the service. It was recognised that the IT system would need to be designed to be suitable for integrated working and therefore would be service-led not IT–led.

The ICON Project

The scope of the project was primary and community care, excluding acute and specialist hospitals. 3,000 whole time equivalent employed staff provide these services, as well as primary care practitioners on contract to the Board. Services are also provided by Non-Governmental Organisations (NGOs) who have service agreements with the Board. The budget for primary and community care for the Board exceeds 222 Million Euro.

The aim of the project was to develop a model of integrated care so that existing levels of integration between professionals and agencies could be further developed and endorsed within a formal structure. This required the development of a base line assessment of practice in integrated care and to build on this, to encourage new

thinking on models of service delivery, and to prompt change. To support integrated working, systems and processes would need to be designed and developed, and supported by IT. The Midland Health Board made a strong commitment backed with a financial investment to progress integration in a robust and sustainable way. To date the ICON project is in 3 phases. Phase 1 was carried out from January to October 2003 and focused on the design of the model. Phase 2 covers October 2003 to May 2004 and includes further testing, refinement and development of the model and specifications for systems. Phase 3 starts in June 2004 and will focus on further implementation of ICON and the further development of systems.

Designing the Model

Over 750 people have actively participated in the project. A Steering Group and a Consultative Group has directed and progressed the project through a Project Team consisting of three Board employees and three staff from Secta Consulting.

Participants were invited to make their contributions to the design of the model through a range of methods such as questionnaires, individual and group interviews, email, telephone, workshops and conferences. Staff were asked to define what integrated care meant to them, and to set out the strengths, weaknesses, opportunities and threats presented by integrated working. We invited participants to make presentations about their experiences in integrated care. Staff from the Board and those from other agencies, including advocacy organisations and voluntary agencies, helped to design systems maps to identify the key features that would be common across all client groups and services. This methodology supplied rich material to inform and inspire the model

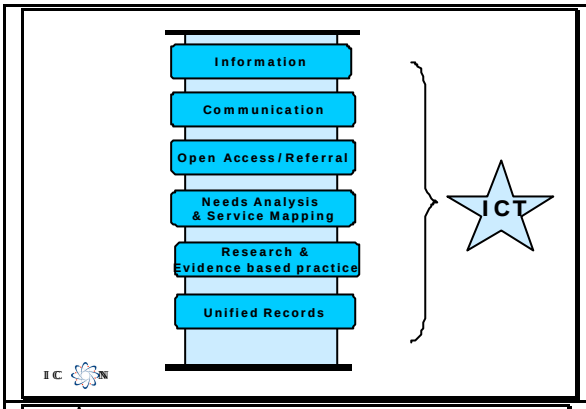
Seven themes were identified in the process, including person centred, needs-based, seamless and accessible. A quotation from participants described integrated person-centred care as: *"A unified approach to treatment encompassing a holistic approach with the patient as an active participant."* Another participant summed up as *"Integrated Care means nothing if it is not needs-led."*

The top seven features included flexibility, transparency, timeliness and measurability. Staff expressed this as: *"Integrated care is a system of providing care where the patient is at the centre of the process. Care is delivered in a co-ordinated and a timely fashion".*

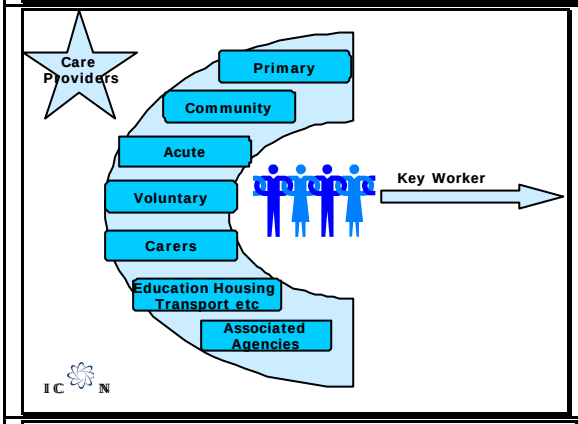
Participants recognised that the very simple principle of integration was a challenge to translate into practice within the complex environment of supporting people across their health and social care needs. Participants have described a service which *"Appears seamless to the user but is in fact backed by services to meet their many needs working closely together, giving a unified and holistic service to the client."* And a plea that: *"The system should be easily navigated by all."*

The ICON Model

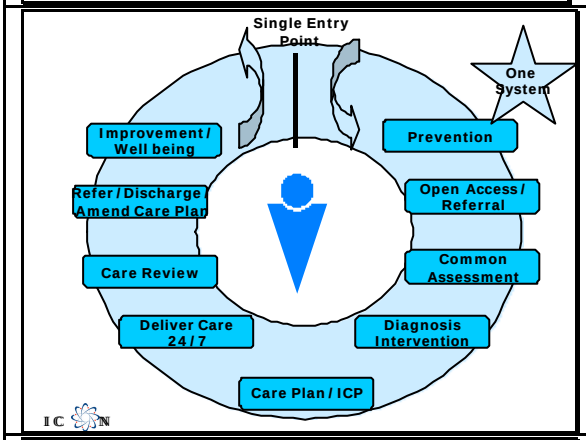
The model is built around the four letters of ICON, namely **I**nformation, **C**are Providers, **O**ne Care Management System and **N**ational Principles.



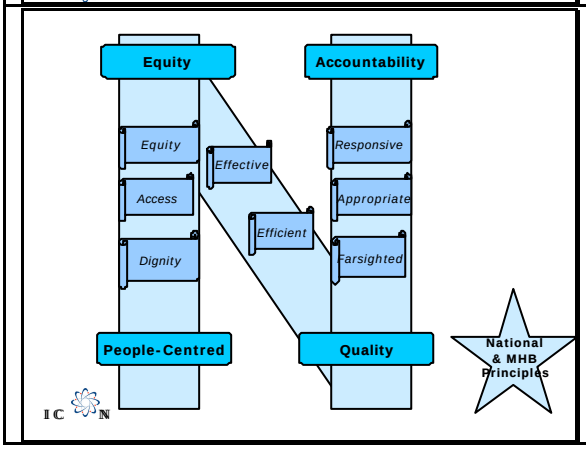
Integrated care needs to be supported by a robust and integrated IT system. Improvements to sharing information at all levels need to be made. The need for a culture of openness and transparency, unified systems and open communication across agencies and disciplines needs to be fostered.



This shows the range of individuals and agencies who may be involved in the care of an individual. The diagram shows how the various agencies need to form an appropriate team that can proceed to support an individual requiring care and support, with care coordinated by a key worker. Within this part of the model needs to be built in role clarity and accountability for individuals and the team as a whole.



The circle represents a care management system. The integration starts at the level of prevention and health promotion. Entry into the care management system is open and this represents a single entry point. From here an individual is assessed using a common assessment framework and referred on as appropriate. A diagnosis is made and a care plan designed with the person to be supported. The plan is regularly reviewed. The goals set within the plan are owned by the client, and the person is supported in achieving these. The circle of care shows the person being discharged if appropriate, although many clients will continue to require a level of care and support, particularly those with chronic ill health and degenerative conditions.



Principles in the national strategy and the Board underpin the model. The principle of being person centred is fundamental. Measures of quality will be built into the design and monitoring of the system. It is an intention that the service is open and equitable, and people supported to access the services that they require. The accountability systems will be designed for individuals and teams, and within clear quantative and qualitative performance measures. These values and principles will inform the design of services, and will be continually measured and monitored.

The Board has used this diagrammatic representation of the themes, features and components of integrated care as a way of gaining a common understanding of integrated care, and promoting further discussion. Discussions with participants has raised issues and concerns such as confidentiality, funding, training, implementation, impact, roles and relationships. These discussions have been represented in a fact sheet of "Frequently Asked Questions" which has been widely distributed.

Project Outcomes

Fundamentally, there is a hope that people who use the service and their families will be the ultimate beneficiaries. Improvements in clinical and care practice across health and social care have been identified such as less duplication, increased efficiency, and more appropriate care. We are establishing systems for sharing in good practice to demonstrate the impact of ICON such as through pilot sites, workshops and the website.

The most frequently quoted client group where furthering integrated care has had most impact is older people.

Case Study 1

Maeve O'Sullivan looks after her 85 year old husband who has Alzheimers. She has attended a Carers clinic, and received training and support through a new Carers Project. The project also offers mediation. Maeve has said that she appreciates the out-of-hours service to meet her needs, opportunities to meet other carers, and to feel part of the team responsible for her husbands care. In this project carers sit on committees in what is termed "real" partnership. Over ten agencies are in the project with the Board including the Irish Red Cross, Alzheimers Society and the Carers Association. The integration of care involves the patient, carer, and staff from statutory and voluntary agencies.

Services for children cross a range of statutory and voluntary agencies.

Case study 2

Grainne Kelly is 4 years old, and her parents are concerned that she may have a "lazy eye". They are reassured that she has been tested during school hours by an experienced community orthoptist, who has referred their daughter onto the eye clinic. This cooperation between professionals in health, social care, education and community ophthalmic services has led to the piloting of eye screening for all schoolchildren to enable prompt referral and early intervention. This has led to improved detection by experienced orthoptist in schools, and more appropriate use of Eye clinics. Such examples of collaboration are well established elsewhere, but are new in Ireland.

Good progress is being made in mental health services with strong alliances with organisations such as the Irish Advocacy Network. Another example is the Primary Care Team in Portarlington, which is one of ten pilot PCTs in Ireland. Currently many GPs work as single-handed practices without extended team support.

Case Study 3

Patrick Flanagan has been in hospital for many months having had a dense stroke at the age of 50. The PCT was alerted to his impending discharge, and arranged a joint assessment involving the GP, OT and Physiotherapist in the patient's home. Patrick's views were represented at the weekly clinical meeting of the full team, and support arranged to suit him and his wife. His records are retained on a single file, and his review will be coordinated within the team.

There is a high level of awareness of ICON throughout the Board, which is being sustained through the further phases and continued investment. This enthusiasm continues as teams put themselves forward for implementation sites and are contributing to tasks such as the appraisal of IT requirements and developing a measurement tool. There are posters, leaflets and reports which widely publicise ICON, as well as ICON being available on the website and through the newsletter. Spontaneous enthusiasm was shown when inviting volunteers to make presentations on ICON to staff groups throughout the Board as part of a "roll out." A training day was offered for those prepared to lead the roll out and discussions, and in addition to the 20 people invited a further 15 people put themselves forward. Staff included Consultant Psychiatrist, therapists, public health nurses, clerical staff and staff from voluntary agencies. These "champions" gave presentations to staff throughout the Board in the Autumn of 2003 and are continuing to do so.

In assessing the impact of ICON throughout the Board, one of the clearest measures is the way that this has impacted on the service planning process. The Board's Service Plan is a compilation of individual plans prepared by service managers. Managers commit to specific targets and deliverables, and the Board is accountable for its annual financial allocation on the basis of these plans. In 2003 the plan had only one reference to Integrated Care. In 2004, Integrated Care and ICON was featured 20 times, across all client groups, services and functions. The design of the ICON model was reported as one of the main achievements of the organisation in 2003 as is evident in the planning for 2004.

Lessons Learnt

There are some real challenges within the detail to implementing integration, and there have been some strong debates amongst participants about aspects of ICON where traditional practice may be challenged. What has helped to smooth the way is to bring discussion back to the principle of what is best for the benefit of the patient or person concerned. This principle has helped to focus discussion, and has provided the starting point for the redesign of services. This is illustrated by the quote: *"It means communicating clearly and honestly with people, trusting others and being clear on agreements. It means looking beyond your professional stomping ground and encouraging others to provide the best service solutions with you."*

One of the strongest message is the fact that integrated care is "person-centred" and not "patient-centred" or "client-centred." There is a strong case for integrated care starting with education, prevention, screening and health promotion, and therefore team-working needs to be evident before a person ever becomes a patient or client.

A key lesson was the value of building on good practice and learning from the local successes and challenges. An appraisal of the base-line with regard to practice in

integrated care led to a few surprises with regard to how far staff had managed to integrate their services in particular areas, given the lack of structure and systems to specifically support integrated care. A particular issue was that performance measures for staff covered individual professional autonomy, but not team achievements. The assessment of current practice proved a reminder of the importance of creating a supportive culture where staff feel able to be innovative. It also led to questions about why integrated care practice was further developed in some areas or teams and not others.

We have learnt that the very process of focusing attention on integrated care has been a catalyst for change throughout the project. We know that the process of completing questionnaires, discussions in interviews, workshop activities and listening to presentations generated ideas for improvements that could be made through individual initiatives. In a conference for 120 participants, those present were asked to identify what changes they could make immediately to improve integrated working, thus prompting and endorsing changes straight away.

Development of ICON – Next Steps

The Midland Health Board has now formally agreed a local definition: *"Integrated care is care which is person-centred offering a readily accessible and seamless service based on the needs and preferences of people who use the service."* This is supported by two key statements - that team working across disciplines and agencies is based on trust and unity of purpose; and that integrated care is facilitated and supported through good communications, well-developed ICT and a robust system of care management.

Eight areas of work emerged through the project in Phase 1 which are set out in the Roadmap which sets out a 5 year plan. These include communication & ICT, collaborative advantage, clinical & social care governance, consultation and change management. A priority is being given to improving information on services and staff so that there is clarity in where they fit within the overall profile. Suggestions included compiling a directory of all services that would be easily accessible to all, with information on eligibility, referral routes, availability and contact details for queries. Information points are being installed, and consideration given to one stop shops and advice centres.

Staff are involved in the development of a measurement tool which will enable self-assessment of levels of integration for teams and services. The measurement tool is currently being written into a software programme, and is being tested throughout the Board. The emphasis on measures provides a clear message that the Board will be appraising integration as part of its performance management.

The work on the ICON project to date has demonstrated that getting agreement to the simple principle of integration is achievable, but translating this into practice within a complex health and care environment is a challenge. The Board has invested significantly in time, energy and resources in gaining the widest possible ownership of ICON, so that the model of integrated care can become integral and recognised by all.

Challenges

There have been many challenges throughout this journey that continue to prompt discussion and debate.

For instance, how do we ensure that in branding integrated care as ICON we do not present integrated care as something different to the usual way of working? In striving for creating an identity for integrated care and creating clarity of definition, there is a risk that staff view the ICON project as something distinct and separate.

Another issue is how we support staff to work in a constructive and collaborative way given major changes within the Irish health sector reforms, service developments and staff turnover. Our experience of working with our Primary Health Care team is that there is great benefit to offering specific teambuilding training to support integrated working. This works well for established teams, but there are issues for those which are rapidly changing, or those working in "virtual teams" and networks.

A key issue is whether integrated care compromises patient choice. In creating a team ethos and common way of working, there may be a reduction in choice with regard to type and style of service.

It is recognised that integrated care can challenge clinical autonomy and may dilute personal engagement. The work of the Board on supporting clinicians in changing clinical practice is raising a number of issues on professional autonomy and team accountability.

The Board has utilised the model as a mechanism for gaining a common understanding of Integrated Care and providing a structured approach to facilitate its development. A challenge is to continually test and evolve the model whilst maintaining confidence and clarity for staff.

Conclusion

The Midland Health Board believes that its structured approach to integrated care is distinctive in three ways. The first is that the model has been developed on an inclusive basis, with a process that created an opportunity for all concerned to contribute. The second is that it is comprehensive, covering the whole health and social care system across primary and community care. Finally, the process built on good practice and gave recognition and value to current examples of integrated working. The development of the ICON model has provided a visual focus for integrated care, and the clear structure has enabled staff to work towards turning the concept into a reality.

We acknowledge that change is difficult. This project is ambitious in that it is aiming to create a sea change across the whole health and care sector, aiming at making a change in culture with a level of sharing that is unprecedented. The project covers all client groups, a wide geographical area, the statutory, voluntary and private sector, and essentially service users themselves. The project aims to further integration at the level of strategy, structure, systems, services and staff. ICON seeks to empower people who use the service as well as those delivering the service.

Integrated care makes good common sense to staff on the ground. However it is complex to implement and presents challenges in many ways. When taken to its

fullest conclusion, it requires a fundamental re-engineering of the organisation and its services.

The Steering Group has concluded that *"We can now move on from referring to "Integrated Care" as a project and consider it as our established way of working"*

The ICON Project has generated considerable momentum and an enthusiasm for change. With continued commitment and an open style to addressing real issues facing those managing, delivering and receiving the service, the Steering Group hopes that ICON will prove to be an appropriate mechanism for furthering integrated care within the Board and across the Republic of Ireland.

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Helen Tucker, Veronica Larkin and Martina Martin
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