Integrated Primary, Community & Continuing Care
Bunchúram, Cúram Pobal agus Cúram Leanúnach Iomlán

An Bord Sláinte Lár Tíre
Midland Health Board

Midland Health Board

"Developing a Model for Integrated Primary, Community and Continuing Care in the Midland Health Board"

Phase I

Executive Summary

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Secta
PARTNERS FOR CHANGE

ICON
Integrated Care One Network

An Bord Sláinte Lár Tíre
Midland Health Board

Executive Summary June 2003

Introduction

The Midland Health Board (MHB) wanted to develop a model for integrated care for primary, community and mental health services as a way of avoiding current problems of fragmentation and duplication. The Board identified a need to develop a model for integrated care so that existing levels of integration between professionals and agencies could be further developed and endorsed within a formal structure. A business case was prepared based on the requirement to develop Information and Communication Technology appropriate to current primary and community care. The MHB made a decision to develop a service model based on the knowledge and experience of staff, which would reflect their service delivery needs as well as meeting management and reporting functions. The focus of the study would be on identifying and developing an integrated way of working. Subsequent to this, IT systems that could support this way of working would be explored.

The MHB commissioned Secta to design and support a process, which would build on good practice and be inclusive. This report sets out the way that the project was undertaken, the outcomes of the work, and recommendations for taking the work forward. The MHB identified a team of 3 staff designated to manage the process internally, and this was matched by 3 Consultants from Secta. In order to maximise the contributions from staff, non-statutory organisations and national bodies, interviews were offered to key personnel. 63 questionnaires were completed by individuals or groups of staff and were analysed in order to provide a body of knowledge about the current level of integration and suggestions for future action. 6 client-specific workshops were held, followed by a collective workshop. These stakeholder events gave an opportunity to share good practice, be creative about future models and to network. In themselves, the events have prompted further integrated working. The Steering Group and a wider Consultative Group, including service users, have had the responsibility for assessing the outcomes of the work and agreeing the shape of the future model that would be appropriate for the Midland Health Board overall.

Context

The report starts by setting the international, national and local context for integrated care, drawing on policy and practice. This section develops ideas around the commonality of integration, and concludes that integration is a principle espoused by many. The translation of this simple principle into complex health and social care structures creates significant challenges. The incentive for pursuing integrated health and social care is clear, and the benefits have been illustrated through international studies and supported by national and local strategies. The challenge is to develop a model for integrated care that is appropriate and relevant for those working and living within the region.

The model of integration to be developed for the MHB needs to support the policy shifts within the local and national health strategies, which have been informed by international strategies. The focus on the shift in service provision from acute hospital and institutional care to primary and community care is common to all. The creation of community capacity in order to provide for extended services locally will need the cooperation and support of many agencies and

professionals working together. It should enable primary and community care to develop and extend their services so that admission to hospital is prevented, discharge from hospital is accelerated, and that referral for long term or institutional care is avoided or delayed. The increase in capacity and competency within primary and community care, supported by effective team work, improved facilities, new technologies and efficient systems will enable acute hospitals within secondary care to concentrate on specialist services.

Definition

The report sets out the definitions and descriptions of integrated care provided by staff working in the MHB concluding with a definition that is an amalgamation of key contributions.

- *"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.*
- *Team working across disciplines and agencies is based on trust and unity of purpose.*
- *Integrated care is facilitated and supported through good communications, well-developed ICT and a robust system of care management.*

Questionnaires

Staff were asked in the questionnaire to describe the strengths, weaknesses, opportunities and threats facing them with regard to integrated working. The report summarises the top five themes that emerged from the analysis of 63 questionnaires.

The information from the questionnaires and workshops provides the MHB with a strong evidence base and a mandate to proceed with developing and implementing its new model for integrated care. For instance, its SWOT analysis provided an opportunity to build on the strengths and opportunities being presented, and to address the weaknesses and threats. Of the top five strengths, staff attitude was most commonly referred to, with a client-centred approach and staff skills also being seen as strengths. Top five weaknesses included the infrastructure, communication and information. The findings were supported by discussions within the workshops. The process has helped to identify good practice on which to build the new model, as well as the challenges facing the MHB. This has helped to identify the agenda for action.

Michael aged 45

I have a chronic lung condition and am unable to work. In recent times I have become more and more immobile and as a result have also become quite depressed. A number of different professionals call to my home regularly to provide treatment. They include the Doctor, Physiotherapist, Occupational Therapist, Public Health Nurse, Psychiatrist and Community Mental Health Nurse I have also had a visit from the Community Welfare Officer since I stopped working. They all have separate files. I wonder why it can't be one, as I often fear that important pieces of information will get lost or will not be conveyed accurately from one to the other. There must be simple solution to this.

With Integrated Care

Within an integrated care model Michael will be encouraged to be an active participant in his own care. In consultation with all of the relevant care providers an agreed care plan would be drawn up setting out the appropriate care pathway. This information would be inputted onto a system for access by all of the relevant professionals with Michael's permission. He could now be reassured that all of his information was stored safely and available to the relevant professionals as appropriate. His care plan would also be regularly reviewed with him by the team to ensure that he was receiving the best possible care.

"Integration means that you collaborate and cooperate with other providers in order that client's needs are met in the most effective way" Quote from Staff member.
"Ciallaíonn Cúram Iomlán go mbíonn tú ag comhoibriú agus ag caint le soláthróirí eile ionas go sásófar riachtanais an chliaint sa chaoi is fearr" Deir Ball Foirne.

Building on Good Practice

Staff contributed 18 case studies of good practice in workshop presentations. In addition, suggestions for good practice were made within the questionnaires. The report gives an illustration of integrated working currently taking place. There were many examples of good practice presented and discussed including the Springfield Centre, the CRU (Community Rehabilitation Unit), the Diabetes Structured Care Project and Mental Health Services. An evidence-based self-assessment tool developed by Kodner et al is proposed as a useful basis for developing a self-assessment or peer assessment system of appraisal of levels of integration leading to accreditation using agreed criteria by the MHB.

Mary aged 29

My husband is in hospital following a road traffic accident. He also suffers from depression. We have had no income for the last four weeks as he is self-employed, so I got a part-time cleaning job. Now a Social Worker has called as someone reported that the children, aged 13, 11 and 9, were at home alone. I am afraid to meet this Social Worker as I don't know what will happen to us. We need help with our problems.

With Integrated Care

Support for this family will be required from the following services: Child Health, Mental Health, Community Welfare, Primary Care and Acute Services. A co-ordinated approach will be taken to the management of this case, in order that Mary and her family will be able to cope with this crisis in the best possible way. A key worker will be appointed who would have access to an electronic file. Using this as support, he/she will be able to inform all of the other service providers of the family's needs and ensure they were met with, in the most efficient and effective manner possible

"A unified approach to treatment encompassing a holistic approach with the patient as an active participant" Quote from Staff member.
"Dearcadh aontaithe ar chóir leighis ina bhfuil an t-othar mar pháirtí gníomhach agus go bhfuil cur i láthair iomlán i gceist" Deir Ball Foirne.

An Inclusive Approach to Designing the Model

Within the workshops, over 160 staff from the MHB and the non-statutory organisations were invited to create their own systems model for integrated care in diagrammatic form. Nine models were presented as examples of how staff and agencies see the model for integrated care developing. These diagrams or systems maps have helped to illustrate the elements required for a potential model for integrated care and how staff see the system working.

Examples included a "Network Model," an "Open Referral Model" and a "Jigsaw Model". The models contain common elements of information to patients/clients, open referral, ease of access, a managed care system, regular review and shared practices and information. Each of the models start with the patient, client or person at the centre. The models illustrate the complexity of health and social care support, and also the range of disciplines

and agencies that may be involved in a person's care. The over-arching themes from the models have been analysed and applied within the design of the proposed model for the MHB.

It is clear from these models that the process of planning, managing, delivering and monitoring health and social care needs to be structured and managed on a shared basis, integrating all of those concerned with improving the health and well being for the local population.

Olive and Peter aged 30 and 35

We have twin girls aged 5, both have a moderate learning disability. Jenny also has Autism. We are totally confused with all of the different professionals and agencies we have to deal with. The following are some of the people we deal with on a regular basis; General Practitioner, Counselling Nurse, Speech and Language Therapist, Occupational Therapist, Psychiatrist, Psychologist, Teacher, Classroom Assistant, Ophthalmologist, Audiologist and Administrators to name but a few. We are so confused sometimes we don't understand the different roles and have so many appointments that clash. Can nobody or no system sort everything out?

With Integrated Care

Olive and Peter will be invited to a case conference which will be attended by all of the relevant disciplines involved in the care of their daughters. A programme of care will be planned collectively and a key worker agreed whose responsibility will be to act in the best interest of the children and to coordinate their care and support by communicating with the many professionals involved using a shared IT system. The programme of care will be reviewed at regular intervals by the team involved in consultation with the parents to ensure that the best possible care is given to the girls.

"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." Quote from Staff member.
"Ciallaíonn sé labhairt go soiléar agus go hionraic le daoine, muinín a chur i ndaoine eile agus bheith soiléar faoi chonarthaí. Ciallaíonn sé breathnú amach ónár gceirtlín féin agus cur ina luí ar dhaoine an réiteach is fearr a sholathar dhúinn". Deir Ball Foirne.

External Agencies

The process of developing a model for integrated care has engaged not only the staff and managers within the Health Board, but also external stakeholders such as the non-statutory organisations and Government bodies. The representatives of the Non-Statutory Sector stressed that they wanted to be treated as equal partners in an integrated care model, with a formal recognition of their role and contribution to the overall health and well being of the population. The NSOs' noted that there was some progress to be made for them to integrate within their own organisations and also externally. Main issues addressed by the Government bodies and agencies interviewed included the need to coordinate with other initiatives, the need to ensure compatibility with national projects and to promote the work on developing integrated care widely.

John aged 67

I am 67 and live with my wife Mary who is 70. I have diabetes, high blood pressure and recently had a mild stroke. Mary has early onset dementia which I feel is deteriorating rapidly. We don't want to go into a nursing home if at all possible. I feel so confused having to attend so many different clinics and have so many different people to speak to. Most of the time I can't remember all of the details. Who or what can sort this out?

With Integrated Care

A care coordinator will be appointed to support John and Mary in planning a care programme which will suit their needs. John has expressed confusion about the number of people he has to deal with and the number of clinics they have to attend and has also expressed anxiety that they might have to go to a nursing home. The care coordinator will organize the appointments with the relevant clinics using a shared IT system to ensure that they are given at the most convenient times and the most appropriate locations possible. He or she will also work with the relevant services to ensure that John's and Mary's wishes to remain at home are respected and that the appropriate services are provided in a coordinated and integrated manner.

"Services working closely together to produce a holistic, coordinated and easily accessible service where service user's best interests are paramount." Quote from Staff member.
"Seirbhísí ag feidhmiú go dlúth le chéile chun seirbhís iomlán, comhordaithe atá éasca teacht air agus ina bhfuil leas an úsáidire seirbhíse ar an gcloch is mó ar an bpaidrín." Deir Ball Foirne.

Key Features and Elements of a Potential Model

The key features of the model have been analysed and are presented under seven main themes: Value-Based, Person-Centred, Accessible, Flexible, Transparent, Timely and Measurable. The themes link with the definitions and descriptions of integrated care given by those completing the questionnaires, referring to person-centred accessible services.

The themes provide a useful building block for the development of a potential model. The elements of the model have been taken from the analysis of the questionnaires, interviews and workshops. The elements or components of the infrastructure needed to be in place to support and facilitate integrated care are described as: Prevention, Access and Referral, Common Assessment, Care Co-ordinator, Care Design and Care Plan & Review.

Catherine aged 17

I am 17 years old and am three months pregnant. While in school I had many problems and was very disruptive. I have been taking drugs for the past two years and now feel very lonely and depressed. My family doesn't want to know about me so how will I get through this and look after my baby? I am not capable of sorting everything out myself.

With Integrated Care

To support Catherine the primary care, community care, community welfare, mental health and acute services will work in a co-ordinated and integrated manner. A specific Care Plan will be agreed with Catherine in conjunction with all of the relevant service providers. A key worker will be appointed who will record all details. These will be logged onto a system for access by relevant professionals with Catherine's permission .To replace the informal system of staff communicating with each other, the formal team operating in an I.C.O.N. integrated care system will be in place, providing Catherine with the reassurance that everyone is working together in the interest of her and her baby.

"A seamless service with a case management approach." Quote from Staff member.
"Seirbhís gan siúnta le cur i láthair ar bhonn cás bhainistíochta." Deir Ball Foirne.

Developing the Infrastructure for an Integrated Model of Care

The development of this model requires a significant investment in the design and development of systems, processes, policies, procedures and protocols. Such a development requires consultation and cooperation on a multi-agency and multi-disciplinary basis. The analysis of the interviews with staff within the questionnaires showed that the shared values, style, staff, skills and overall strategy for the organisation for integrated care were well developed. The gaps or deficiencies could be labelled systems and structure. Seven aspects of the management infrastructure in terms of systems and structure required to support integrated care provide key themes to the points made within questionnaires and workshops, and were drawn from research material from elsewhere. These were: Strategy and Business Plan, Clinical and Social Governance, Systems and Processes, Structure, Information System, Communication Systems and Training and Development.

"Good communication systems which support links, electronic patient records and having one database for every client with one identification number." Quote from Staff member

Identifying Action Points for Progressing Integrated Care

A major Collective Stakeholder Workshop was held by the MHB in April, involving over 100 people. The day was structured with presentations, plenary discussion and group work. Participants in the process identified some key issues that would need to be addressed before progressing with the development of a model for the MHB. The topics were: Information, Teambuilding, Referral, Streamlining Input, Communication, Public / Private Health care, GPs and Primary Care, Managing the Change, Access and Managing Care. The collective workshop gave an invaluable opportunity for staff to work constructively on some identified "hot topics" that could potentially hinder the successful development of integrated working. The topics emerged from the earlier client-specific workshops and included sharing information whilst maintaining client confidentiality, providing an inclusive team approach whilst not overwhelming the client, and opening and managing the referral process. The outputs from this session were action orientated. An emerging theme common to all groups was the need to carry out a needs analysis and service mapping exercise and share information on what services were available and how to access them.

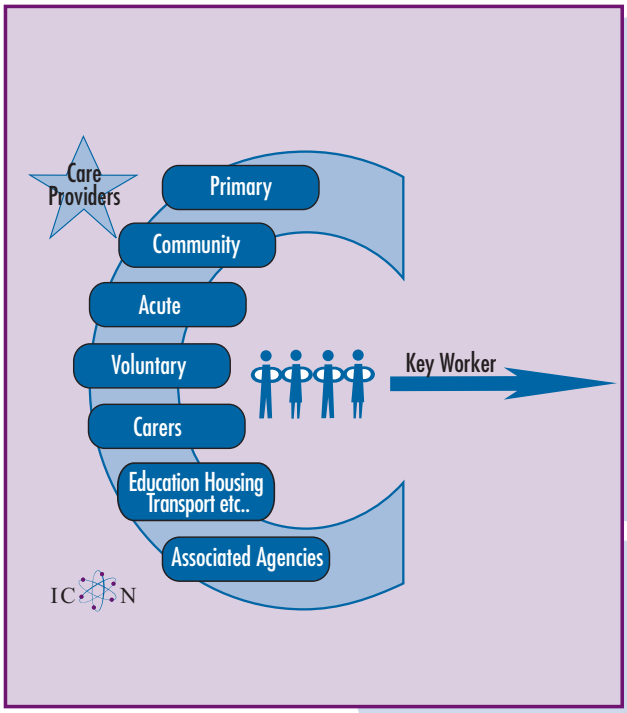
The Proposed ICON Model

"Integrated Care One Network" ICON is the Proposed Model for the MHB. This model has been developed from the contributions from staff and external agencies and informed by research and good practice internationally. It puts forward a distinctive message about connectivity and partnerships. The diagrams for the ICON model are in four stages, each representing a letter of the word ICON.

I **Information**
C **Care Providers**
O **One Care Management System**
N **National Principles**

The **"I"** is for information, and describes the communication, shared records, and service mapping needed to support integrated care. The **"C"** represents Care Providers, and lists the range of sectors within health and social care that may potentially be involved in supporting a person and their family. The diagram shows the care providers forming teams, led by the key worker otherwise known as the care co-ordinator. The **"O"** represents the care management system, with a single referral point, common assessment, care plan and regular review. The **"N"** represents the four principles as set out in the National Health Strategy Quality & Fairness and the eight MHB hallmarks of quality. Systems for implementation, monitoring and evaluation underpin the process.

Information - This element of the model runs alongside the left hand side of the model and is integral to all. The strong message from participants is that 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.

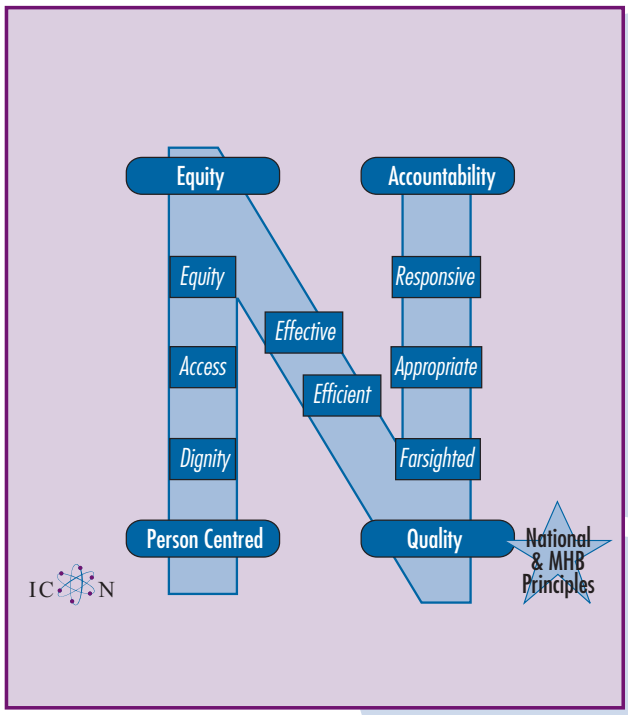


Care Providers

- This second element of the model 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. Within this part of the model there is a need to build in role clarity and accountability for individuals and the team as a whole.

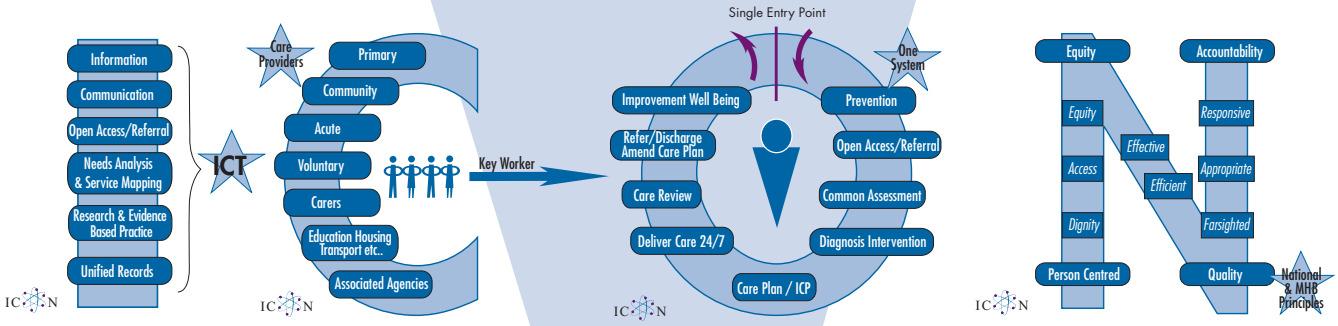
One Care Management System

- The circle represents the 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 patient/client owns the goals set within the plan, and the person is supported in achieving these. The circle of care shows the patient/client being discharged if appropriate, although many will continue to require a level of care and support, particularly those with chronic ill health and degenerative conditions.



National & MHB Principles

- The final element of the model incorporates the principles in the National Health Strategy Quality and Fairness. A person centred approach will be fundamental to the model. 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 with clear quantitative and qualitative performance measures, which will be continually measured and monitored. It is understood that these principles will be continually measured and monitored.

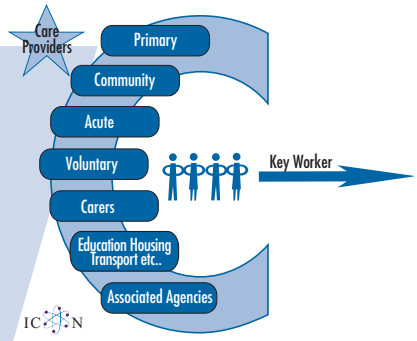


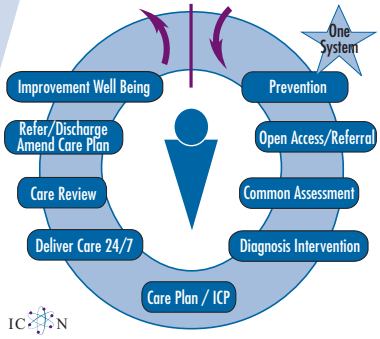
"It is the ability to hear and recognise the simple, desired outcome that users want and then to challenge the system to do something about it that makes an organisation more person centred." Quote Bob Ferguson, 2003.

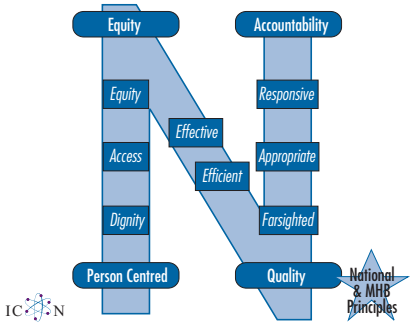
Validating the Proposed ICON Model

The model incorporates both the national principles and also the MHB Hallmarks of Quality. The National Health Strategy Quality and Fairness defines four principles: People-Centredness, Quality, Equity and Accountability. These principles have been enshrined within the new model for integrated care. These principles are incorporated in the eight "Hallmarks of Quality" of the MHB, which pre-date the strategy. The model has been tested against these hallmarks of quality, which are Equity, Accessibility, Effectiveness, Efficiency, Appropriateness, Responsiveness, Dignity and Farsightedness.

It is clear that the ICON model being developed sets out the national principles and the MHB hallmarks of quality as an integral part of the model. The ICON model is value-based, and can be successfully validated against the national and regional frameworks.







"Integrated Care means nothing if it is not needs-led" Quote from Staff member

Recommendations

The MHB is preparing to implement the following eight recommendations – the 8 "Cs".

1. **Communication & ICT** – The MHB should research and procure an IT system to support all aspects of integrated care in order to improve service delivery to the patient/client. Enhance the work practices of service providers and provide information for the effective planning, management and development of services.
2. **Collaborative Advantage –** All aspects of service delivery within the MHB should work towards achieving accreditation in integrated care through ICON thus ensuring that the patient/client receives a consistent, comprehensive and integrated service in line with best practice.
3. **Clinical & Social Care Governance** – The MHB should develop appropriate structures, systems, processes and resources to support integrated working.
4. **Comprehensive Services** – The MHB should develop a range of appropriate services which will be reflected in a consolidated directory of services that is easily accessible to all through the widest variety of means.
5. **Clinical, Care and Support Staff** – The MHB should empower and support staff in working towards a fully integrated service and that all of the necessary infrastructure would be put in place to facilitate this.
6. **Clinical Effectiveness** – The MHB should promote person-centred evidence-based integrated care, building on good practice and incorporating regular audit, evaluation and review.
7. **Consultation** – The MHB should continue to adopt an inclusive, open and transparent approach by consulting widely with all of the relevant stakeholders to ensure the effective and appropriate development of integrated care.
8. **Change Management** – The MHB should foster an appropriate culture to support integrated care and should develop a structured change management programme to facilitate improved working practices to the benefit of all concerned.

Conclusions

The Midland Health Board has invested in the development of a formal model for integrated care that its staff will sign up to. It has based the design of the model on contributions from staff, managers and associated agencies. The process has delivered a rich source of material, and provided the inspiration for the ICON model.

In particular, case studies presented gave a very clear illustration of the limitations of the current way of working, and the benefits to patient/client care with the synergy gained from professionals working collaboratively.

It was the intention of the MHB to develop a model that demonstrated collaborative advantage, and illustrated connectivity. The project sets the way forward and meets the national and social agenda ahead of its time. It provides a structured approach to working in an integrated way, with a readily identifiable ICON model to work towards. The introduction of an accreditation system whereby teams and services may achieve levels of ICON according to agreed criteria would help to formalise, recognise and value integrated working practices.

It is hoped that those who have participated in the process recognise their suggestions and contributions, and are prepared to develop this model further. The model will need to be tested for each care group, sector and locality, as well as across agencies. The MHB in commissioning this project identified that phase two of this process will be to develop the data requirements for a model for integrated care, and also to design systems for managing the change.

The Steering Group has agreed that all outputs from the project, including this report, will be available at:
www.mhb.ie
or by e-mailing
integratedcare@mhb.ie

"We can now move on from referring to "Integrated Care" as a project and consider it as our established way of working" Quote from staff member. "Is féidir linn bogadh ar aghaidh anois agus smaoineadh ar "Chúram Iomlán" ar an mbealach a fheidhmíonn muid agus ní díreach mar thionscnamh". Deir Ball Foirne.

Acknowledgments

The Midland Health Board would like to thank SECTA, the Steering Group, the Project Team, the Consultative Group and all who participated in this project. The level of enthusiasm for integrated care was remarkable, and the constructive way that this issue was addressed was commendable. The profile that this project received from the top management of the organisation helped to signal the importance of this way of working. The project has proved to be a good example of effective collaborative working, with all concerned sharing a common goal, acknowledging and valuing each other's role, and giving the project a top priority.

A significant investment in terms of time and resources into the development of a formal model has been made. There is an expectation from staff and a momentum created that will enable this work to go forward. The project has shown that there is a strong foundation to build on, and has identified champions and enthusiasts within the Board who will help to drive this forward. The MHB intends to continue to consult, and in particular with service users. It will also continue to modify and develop the preferred model for integrated working in order to benefit patients/clients and their families within the Board's area and also to improve working arrangements for staff.

NOTES

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