Five Priorities for Advancing Integrated Care

European Diabetes Forum

EXECUTIVE SUMMARY

Integrated care is an emergent set of practices that seeks to move away from care that is fragmented, episodic, and service-based, with care that is continuous, coordinated, and outcomes-focused. As the WHO describes it, integrated care is "seamless, smooth, and easy to navigate."

For people with diabetes, the practical implications of integration are not theoretical, but fundamental to how people access and navigate the health system. Diabetes is a lifelong disease, with daily challenges requiring lifestyle adjustments and consistent engagement with therapies and technologies, a burden that can have significant physical and psychological repercussions if not properly managed. Greater integration of care therefore promotes a long-term and more holistic focus towards people with diabetes that is well suited to the complexity of the disease. Integration is about improving outcomes and improving the quality of life for people with diabetes, two aspects that are interrelated.

Nonetheless, the immensity of the topic often leads to a sense of paralysis and an uncertainty about where to begin. To make advances in integrated care, prioritisation is needed

The European Diabetes Forum, a group consisting of healthcare professions, researchers, industry representatives, and people with diabetes, have put forward five priorities to make progress in integration. These are pragmatic strategies to improve integration in all care settings, including implementing assessment models, developing patient centred pathways for diabetes care, revamping educational curricula, and putting incentives in place to encourage cooperation and teamwork within and between primary and secondary care settings.

Integration is a process more than an end state. In the diverse countries of Europe, there is no magic formula for integration. What is important is to apply a general set of principles, analytical perspectives, and tools that over time will lead to long-term shifts in the way people experience care, and the way care is provided.

PRIORITIES IN INTEGRATED CARE

1. FRAMEWORK TO ASSESS INTEGRATION
2. INTEGRATED CARE PATHWAYS
3. EDUCATION
4. FINANCIAL INCENTIVES
5. IMPLEMENTATION STRATEGIES

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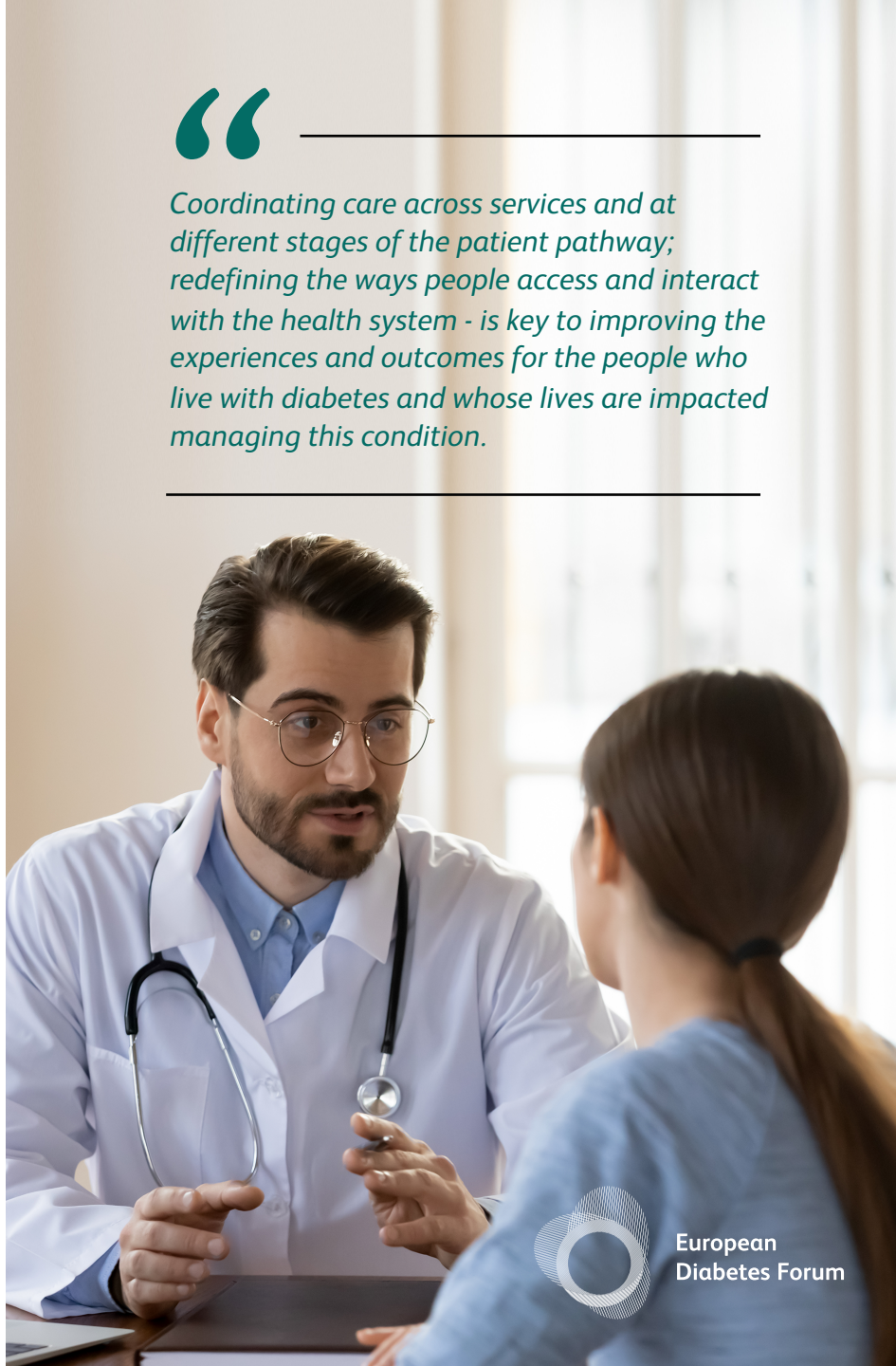
INTRODUCTION

Diabetes is a growing burden for individuals and for societies across Europe. It is estimated some 60 million people in Europe currently live with diabetes, putting strain on individuals, societies, and health systems to manage the demands and complexities of this chronic illness. Against this backdrop, fresh ideas and new solutions are urgently needed to grapple with an escalating public health crisis.

Advancing patient-centred integrated care models in diabetes is an essential to meet this challenge. Coordinating care across services and at different stages of the patient pathway; redefining the ways people access and interact with the health system – are key to improving the experiences and outcomes for the people who live with diabetes.

The concept of integrated care is often described using complex theoretical models. But for people with diabetes, integrated care is not theoretical as it defines the care they experience and how they engage with that care. Diabetes is a lifelong disease, and people with diabetes must deal with daily challenges. Diabetes self-management can be wide ranging and complex encompassing: lifestyle adjustments (diet and exercise); and engagement with diabetes therapies and technology (medications and blood glucose monitoring). Self-management needs to be supported by healthcare providers though effective education.

Living with diabetes can also induce psychological distress and impact the social context of the person with diabetes (employment and interpersonal relationships). Hence, to reduce the burden of diabetes complications and help people live positively with diabetes, it is necessary to bring multiple care dimensions together (technology, education and psychosocial support). This is essential in helping people with diabetes activate and sustain their self-management behaviors.



However, proving this support in a coherent way can be challenging. People with diabetes experience care from multiple providers at different times and healthcare settings (primary, secondary and specialist care). In this context it is important that people with diabetes experience care continuity within the health system, and that providers are not delivering isolated, packaged solutions. It is also important for providers to ensure that care is tailored to individual needs and circumstances of each person as far as possible. Care integration provides a framework for addressing these challenges and offers the potential to enhance the experience, effectiveness and efficiency of diabetes care.

However, integrated care while logical is not always easy to achieve for multiple reasons. There are many disincentives in the way diabetes services are organised and funded, and under pressure of meeting current demands health care providers often lack the capacity to address or realise the potential benefits of integrated care.

In face of all these challenges, it is easy to feel either powerless by the scale of the problem, or to succumb to the opposite temptation – to be over-ambitious and try to change everything at once. Therefore, what is required are simple, achievable, and pragmatic strategies to improve integration in all care settings exclusive of their economic context. Hence, to make advances in integrated care in diabetes, prioritisation is needed.

The EUDF Forum on Integrated Care has therefore identified priorities in the following five areas.

1. **Assessment:** Create frameworks to assess integration
2. **Patient Pathways:** Develop new patient centred pathways for diabetes care
3. **Education:** Expand and focus educational efforts on integrated care (methods and strategies)
4. **Incentives:** Develop financial incentives and models to support integration
5. **Outreach:** Engage with stakeholders in diabetes to advance solutions in integrated care

Making progress in these five areas will require the sustained efforts of all stakeholders in the diabetes landscape. Even then, integration will not be “solved,” as integration is not an end state, but a continual process. But generating forward momentum can kickstart a process that can lead to truly, innovative and transformative directions.

Therefore, what is required are simple, achievable, and pragmatic strategies to improve integration in all care settings exclusive of their economic context.

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WHY INTEGRATED CARE?

The concept of integrated care has been debated widely and while it presents as an obvious solution to many of the challenges facing diabetes care (excess demand and increasing technology), developing sustainable integrated care models has been elusive. Integrated care is less a unifying theory than an emergent set of practices, one that seeks to supplant old supply-based health models with a system in which all components are working together and aligned, on all parts of the care pathway.

Integrated care is often defined by its contrast, the provision of fragmented and episodic care centred around medical interventions and clinical outcomes; rather than care provision that is continuous and coordinated across all providers focussing on holistic and patient-centred outcomes.

Integration is an especially crucial tool for diabetes, given it is such a complex disease, with numerous potential complications, and thus requires support across the healthcare landscape, from screening to technical care to self-management assistance.

The WHO describes integrated care as “health care that is seamless, smooth and easy to navigate.” For all the talk of the role of systems and organizations, about the potential benefits of health efficiencies and cost savings, the principle aim of integrated care is to meet the demands of people with diabetes for better experiences and outcomes. There are also obvious efficiencies to be had with an integrated approach, maximising available resources and improving care outcomes.

Objectives of Integrated Care in Diabetes

- Support for self-management
- Focus on quality of life for people with diabetes
- Provide efficient value-based health care
- Ensure clinical care is integrated with psychological, emotional and social support and clinical intervention.
- Maximise timely care accessibility
- Address health inequalities
- Identify care inefficiencies

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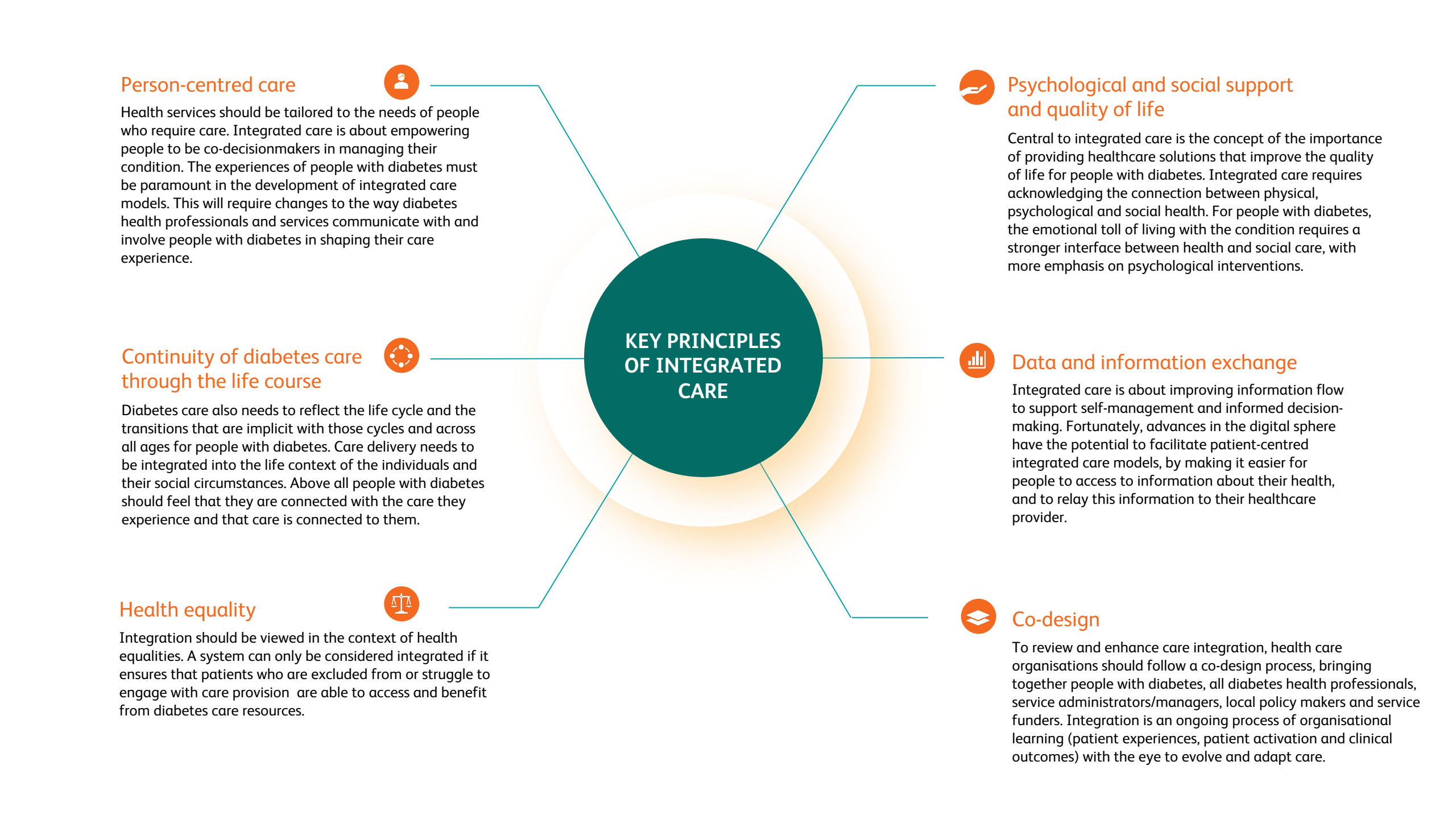

KEY PRINCIPLES OF INTEGRATED CARE
Person-centred care
Health services should be tailored to the needs of people who require care. Integrated care is about empowering people to be co-decisionmakers in managing their condition. The experiences of people with diabetes must be paramount in the development of integrated care models. This will require changes to the way diabetes health professionals and services communicate with and involve people with diabetes in shaping their care experience.
Continuity of diabetes care through the life course
Diabetes care also needs to reflect the life cycle and the transitions that are implicit with those cycles and across all ages for people with diabetes. Care delivery needs to be integrated into the life context of the individuals and their social circumstances. Above all people with diabetes should feel that they are connected with the care they experience and that care is connected to them.
Health equality
Integration should be viewed in the context of health equalities. A system can only be considered integrated if it ensures that patients who are excluded from or struggle to engage with care provision are able to access and benefit from diabetes care resources.
Psychological and social support and quality of life
Central to integrated care is the concept of the importance of providing healthcare solutions that improve the quality of life for people with diabetes. Integrated care requires acknowledging the connection between physical, psychological and social health. For people with diabetes, the emotional toll of living with the condition requires a stronger interface between health and social care, with more emphasis on psychological interventions.
Data and information exchange
Integrated care is about improving information flow to support self-management and informed decision-making. Fortunately, advances in the digital sphere have the potential to facilitate patient-centred integrated care models, by making it easier for people to access to information about their health, and to relay this information to their healthcare provider.
Co-design
To review and enhance care integration, health care organisations should follow a co-design process, bringing together people with diabetes, all diabetes health professionals, service administrators/managers, local policy makers and service funders. Integration is an ongoing process of organisational learning (patient experiences, patient activation and clinical outcomes) with the eye to evolve and adapt care.

KEY CHALLENGES IN IMPLEMENTING INTEGRATED CARE

Workforce sustainability

In the coming years, there will be critical workforce shortages that will put additional pressures on access to care, and current healthcare systems are not ready to sustain these shortages, thereby amplifying the need to bring services together with a more integrated model of delivery.

Healthcare inequalities

The prevalence of diabetes complications show that many people with diabetes are not accessing preventative care, increasing the burden of disease in some segments of the diabetes population.

People with diabetes from disadvantaged groups are disproportionately likely to develop advanced complications, particularly people from low socio-economic background and those from minority ethnic populations. There is also unequal access to health and social care in primary and specialist care settings. Primary and specialist care services need to identify those who are not currently accessing or benefiting from services and find remedial strategies to tackle these deficits. Primary care has a particularly important role to play in assessing inequalities and in working with local communities to provide solutions.

Designing care

Too often there is a mismatch between the perspective of people with diabetes, and their healthcare providers. It is important to listen and to reconcile the everyday concerns of people with diabetes to bridge this gap.

Financial Incentives and healthcare budgets

Funding models and incentives for diabetes care are not often aligned with the goal of integrated care delivery. Financial incentives to support integrated diabetes systems are not present in many European countries. Reimbursement mechanisms are a barrier to integration. Systems respond to incentives, and thus payment mechanisms should be designed in ways that advance integrated care solutions.

Implementation of technology

There are a lot of promising developments in digital health technologies. The potential of IT infrastructure and e-health soltions have not yet been fully realised in diabetes. There is a lack of national diabetes registries in many European countries, which limits the ability to have a more holistic and systematic picture of the links between different risk factors and diabetes complications. Without such systems, it is also challenging to identify areas in need of a more targeted approach.

Fragmentation of care

Integrated care is about overcoming fragmentation. A major weakness in the typical care delivery system is that diabetes health professionals, other related healthcare specialities (renal, foot care, psychological care and ophalmology), primary care professionals, and home care and social service providers function independently in unintegrated silos. This leads care fragmentation, a lack of coordination, variability in care quality and health outcomes, and unnecessary costs. The traditional divisions between primary and secondary care are particularly problematic for patients, leading to frustration and delays in providing care when it is required.

Patient support and education

The time and resources available to healthcare professionals (HCPs) to support patient care can be challenging. Diabetes also poses a significant burden on quality of life, and as such, there must be more focus on psychological and social support in addition to medical interventions. HCPs should better understand the psychological impact of diabetes (distress, feat, anxiety and depression), as psychological factors can have a significant mediating effect on patient's self-management behaviours.

CASE STUDY

Despite these formidable challenges, there are many actors and institutions working hard to advance integrated care solutions in diabetes. Continued experimentation, and sharing emerging best practices will be critical if progress is to be made in integration.

Joint Action CHRODIS and CHRODIS Plus is an initiative funded by the EU and participating organisation that seeks to identify, validate, exchange, and disseminate good practices to reduce the burden of chronic diseases. The joint action advanced 17 policy dialogues and 21 implementation projects across four cornerstone areas: health promotion and prevention, patient empowerment, tackling functional decline and quality of life, and sustainable and responsive health systems.

Joint Action Chrodis developed an Integrated Multimorbidity Care Model (IMCM) which proposed a set of 16 multidimensional recommendations to improve the care of persons with multimorbidity in Europe. The model sought to address many issues related to fragmentation between primary and hospital services, and different specialities and disciplines. Experts highlighted the importance of patient-centred, integrated and tailored care and elements like support, teamwork, and information exchange.

More initiatives like CHRODIS will be needed to exchange best practice examples and key learnings on integrated care across Europe.

FIVE PRIORITIES IN INTEGRATED CARE

1

Develop a framework to assess implementation

Rationale

Integration needs to be a central consideration in designing and reviewing diabetes services. All diabetes organisations should review and assess how well their care systems and delivery processes connect with patients and impact on their clinical performance and efficiency.

For that reason, it is essential to develop practical and flexible tools to support healthcare teams to assess the performance of integrated care, to identify areas where integration might be enhanced, and to build tools and methodologies to assess performance and added value.

Solutions

- Endorse the EU Commission's Expert Group on Health Systems Performance Group's work to assess pillars of integration, which can be used to assess and to measure progress on integrated care (see page 14).
- Develop analytical models to understand which areas to prioritise in integrated care.
- Reassess the variables used to measure progress in integrated care, including metrics to quantify patient experience and individualised care governance, funding, capacity building, e-health services, and more.
- The experience of people with diabetes should be central determining which indicators and variables to evaluate with respect to integration.
- Leverage data to inform and compare service performance. Curate analytics to optimise and coordinate care. Ensure that all organizations involved in diabetes develop new ways to assess performance and apply insights back towards improving care.

2

Develop integrated care patient pathways

Rationale

Integrated care patient pathways establish protocols for delivering the appropriate health services at the right time and place. The aim of a pathway is to enhance the quality of care by improving patient outcomes and cost-effective interventions.

People with diabetes live in a multimorbid context. And yet disease management programs, guidelines and integrated care models remain far too mono-disease centric.

Patient pathways identify key pivot points in the patient journey, clarifying when, for example, doctors should refer people with diabetes to a specialist. Pathways help ensure people with diabetes are familiar with the services available to them, and what they can expect from their healthcare professionals. Pathways also help clarify to HCPs the roles of primary, specialist, and clinical and community resources in providing care.

Solutions

- Map an integrated patient pathway in diabetes, taking into account social and economic dimensions.
- Invite stakeholders including people with diabetes to contribute which outcomes are important, and to develop and analyse new metrics such as finance, time horizon, risk factors, quality of life.
- Visualize pathways with clear guidelines in the form of a tool that stakeholders could use to measure the progress and impact of integration. The patient pathway should resemble a tree, with outcomes, care, and access representing the branches.
- HCPs should adapt pathways to individual needs of people with diabetes. Choice should be built into the system.

3

Education

Work with professional institutions to provide educational materials and opportunities on integrated care, and incorporate integration into the curricula for health professionals working in diabetes

Rationale

Implementing integrated care is a long-term process. We need to plant the seeds for reform and change mindsets around how healthcare is delivered. A trained workforce prepared for the future is critical to the success of integration.

An important challenge in providing integrated care from the patient perspective is to ensure that HCPs have the skills and tools necessary to understand the wider context of diabetes, including psycho-social models, other than just the clinical parameters and metabolic targets.

Solutions

- Conduct a formal needs assessment to understand where to focus educational efforts.
- Develop an integrated care curriculum including comprehensive best practice educational materials.
- Incorporate integrated care into curricula of medical schools and all healthcare professional and specialist training.
- Commission a survey to help to define what other kinds of education are needed to promote and advance integrated care.
- Include the development of psycho-social skills in medical curricula to enable richer discussions with people with diabetes related to social/wellbeing.
- Train HCPs to help them optimise their communication skills to rapidly engage patients in productive conversations about their health needs and self-management priorities.
- Target educational efforts to all people involved in the implementation of integrated care – physicians, nurses, nutritionists, counsellors, payers.
- Focus on organisational learning. Assign dedicated point persons and “ambassadors” within teams in hospitals and clinics to promote integrated care models both within and across organizations.

4

Financial Incentives for Integration

Rationale

Incentives shape behaviour.

We need to align financial incentives to encourage providers to work together towards integration, to move towards a model focused on health outcomes. Financial models are too focused on systems and not patient-centric.

Solutions

- Develop incentives for all providers and stakeholders to participate in the integration of care.
- Align or pool budgets to enable clinical integration, reduce fragmentation and deliver patient-centred care.
- Link payments to outcome metrics to incentivise focus on service delivery and positive patient outcomes.
- Use the European Semester to guide Member States in transitioning their healthcare systems.

5

Implementation Strategy

Engage with research institutions, patient organizations, and the wider community to advance solutions in integrated care

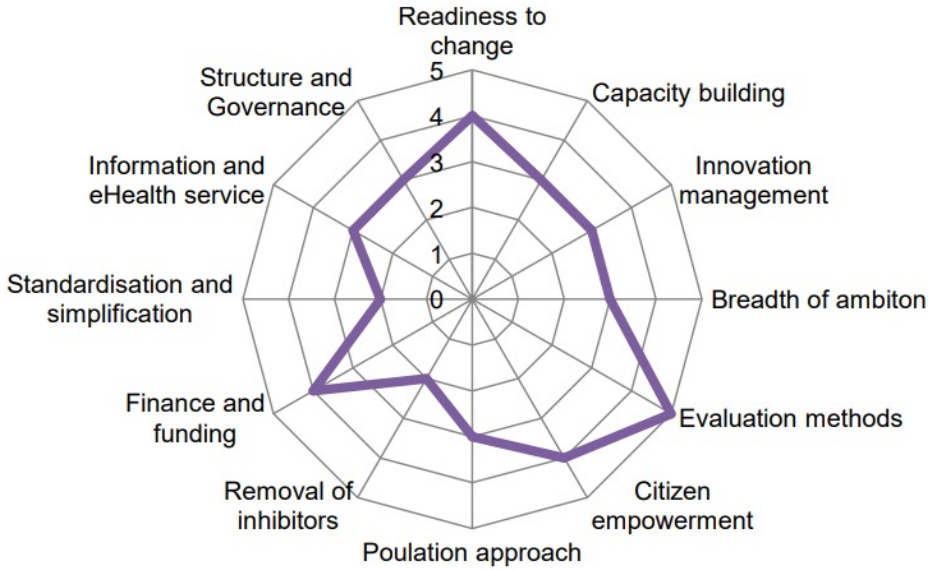
Rationale

Integrated care needs to be made more digestible and intuitive. It is important to stimulate more engagement in integrated care and convene the kind of meetings and forums that lead to the exchange of best practices and the development of new solutions.

Solutions

- Develop a clear and concise narrative to underline the value of integrated care in diabetes.
- Tailor the story of integrated care to the needs of different groups and organisations.
- Stimulate stakeholder engagement on integrated care, utilising both traditional methods (i.e. events and roundtables) but also more innovative approaches (gamification exercises, scenario-playing).
- Redefine patient satisfaction from the perspective of integrated care. Encourage more research to quantify the patient experience, to measure outcome improvements in integrated care.

CASE STUDY



Scirocco Maturity Model

The B3 Action Group on Integrated Care, part the European Innovation Partnership on Active and Healthy Ageing, developed the concept of the Integrated Care Maturity Model. The SCIROCCO Exchange in an EU programme that builds upon and further refines the achievements of this model.

In the Maturity Model, the many activities that need to be managed in order to deliver integrated care have been grouped into 12 dimensions. The SCIROCCO (scaling integrated care in context) tool was operationalised as an online self- assessment tool in order to assess a region's readiness for integrated care.

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