

CONTEXT

Internationally, a growing number of models of integrated, patient-centred care are being implemented to improve quality and outcomes, particularly for individuals with complex needs who are high volume users of the healthcare system. Some of these programs also have the potential to reduce system costs by minimizing the occurrence of adverse events, and by creating efficiency through reduction in fragmentation and duplication of services.

OBJECTIVES

This paper offers recommendations for action by government, providers, and patients to better integrate care.

METHODS

A review of the aims and achievements of ongoing, integrating initiatives in Ontario and other jurisdiction resulted in the consideration of three key design dimensions to inform the integration of initiatives in Ontario: (1) *whom* to target, (2) *what* services to integrate, and (3) *how* to integrate.

FINDINGS

Integrated care programs should be targeted to high-need and high-risk populations. Though any coordination among providers should be leveraged to ensure effective care provision, multimorbid patients with complex care needs would most benefit from coordinated services from an array of service providers. Integrated care has not matured in any health system in a way that fully encompasses an entire population of providers and patients to address all degrees of integration (systemic, organizational, functional, professional, and service). The best system integration example is likely Denmark, where it is compulsory for each region to establish a health-coordination board with representatives from the region (responsible for medical care) and the municipalities (responsible for social care) within the region.

Most successful integrated care programs originate at the micro level and focus on coordinating services for individual patients/users. Many programs started with a patient vignette to inspire front-line providers to jointly develop a common care plan. Across programs, patient-centred care that enables coordinated care management across providers and care settings is foundational for integrated care programs to ensure service integration. Notably, the engagement of patients offers opportunities to increase self-management, empowering patients to focus on self-identified priorities. Higher level integration (in contrast to service integration) becomes increasingly complex to implement. Integration appears to be a “bottom-up” undertaking, but systematic supports (the sharing of health records and financial supports, and the implementation of care coordinator roles) are “top-down” factors enabling the sustainability and reach of integrated care models.

CONCLUSIONS/RECOMMENDATIONS

1. Policy makers need to establish a “top-down” mandate (to innovate from the “ground-up”) focused on person-centred care, with emphasis on prevention of exacerbations and resultant healthcare costs. Local, community-based organizations need greater freedom to innovate, and build strong connections within and across sectors. Where local leadership is insufficient to generate “ground-up” integration, more regional involvement may be required.
2. Providers should support service level integration by (a) implementing interdisciplinary and inter-organizational teams around the care of complex needs individuals, with a central role for care coordinators in the articulations of the healthcare team; (b) standardizing assessment, goal setting and care planning (for physical, mental, and social conditions, and specific self-care components) among providers of social and medical care, patients, and caregivers; and (c) engaging patients in care planning.
3. Programs also require payer support for integrating care functions, ie: capitation-based budgets, and the implementation of shared electronic health information for the same patients from multiple providers.