

Volume 13, 23 October 2013

Publisher: Igitur publishing

URL: <http://www.ijic.org>

Cite this as: Int J Integr Care 2013; Annual Conf Suppl; [URN:NBN:NL:UI:10-1-114693](https://nbn-resolving.org/urn:nbn:nl:ui:10-1-114693)

Copyright: 

Conference Abstract

Coordinated Care Lessons Learned from the OECD: A Review of the Literature

James A. Cercone, President, Sanigest Internacional, San Jose, Costa Rica

Correspondence to: **James A. Cercone**, Sanigest Internacional, San Jose, Costa Rica, E-mail: jcercone@sanigest.com

Abstract:

Paper summary: Overcoming fragmentation in the delivery network is a critical factor in achieving better health system performance. As health systems around the world expand to meet the population's growing demand and rising expectations, the failure to address the fragmentation in care between primary care, specialists and hospital care will lead to increasing cost escalation and declining quality of care. The literature review of nearly ten years of coordinated care programs across the OECD shows that successful disease management or coordinated care efforts share a number of common design components. The paper highlights successful experiences and synthesizes the lessons learned for emerging market countries that aim to achieve greater integration.

Introduction: Fragmentation is at the heart of the ineffectiveness of our increasingly chaotic efforts to achieve improvements in health systems. As health systems around the world expand to meet the population's growing demand and rising expectations, the failure to address the fragmentation in care between primary care, specialists and hospital care will lead to increasing cost escalation and declining quality of care.

Methods: The paper reviews the experience across the OECD with the introduction of integrated delivery systems, or coordinated care, to address the issue of system fragmentation. The paper follows the definition of integrated delivery systems established by Shortell (1984), that defines them as "a network of organizations that provides, or organizes in order to provide, a continuum of coordinated services for a defined population, and that is accountable for its clinical and financial results and for the health status of the population served. These systems, widely participated and vertically integrated, offer an extensive range of ambulatory services, hospital, of acute and chronic, and home care".

Discussion: The study shows that there are a number of common features that should be developed under any initiative for coordinated care. These range from the definition of the scope of the program to the content of the coordinated care efforts and the role of the providers in the system. The OECD experience points to a number of core components:

Reference Population. Defined population and defined territory.

Priority Health Needs. Based on the health needs of the population within a defined territory; Focused on the risks or pathologies of the population

Scope of network of services. PHC based coordination strategy. Regulated access to specialists.

Integrated and coordinated model of care. PHC based coordination strategy . Mechanisms for integration and coordination among the levels, including clinical and non-clinical coordination— case management.

Organized support systems. Electronic medical record or consultation form. The strategy of contracting (and financing) aligns incentives and strengthens the integration of the network. A system of financial management devised for the network

Distribution of Roles. Mission and clear vision for the network – or specific group of patients. Have a single governance structure. Involvement of healthcare teams in the planning and management of network

Measurement of impact of services. Establish system of learning and dissemination of good practices with other networks. Information systems functioning in support of the network with EMR and data exchange for all support systems (lab, diagnostics, etc). Use of performance monitoring and audit systems.

Results: The experiences across the OECD show that significant improvements are possible in the decline in readmission rates, improvements in survival rates and small changes in outcomes, such as glucose levels for diabetics. These often come at slightly higher costs. Successful programs in the OECD show a number of common lessons learned.

Lesson 1. Integrate for the right reasons. Successful integrated systems have grown organically; situations where top-down attempts to integrate care, for example through vertical integration or mergers of service providers, have often had less happy outcomes. The objectives of integration need to be made explicit. If they include reduction in use of hospital beds, then the implications within the current payment by results system need to be addressed.

Lesson 2. Don't necessarily start by integrating organizations Integration that focuses mainly on bringing organizations together is unlikely to create improvements in care for patients. There is also the danger that integration might act only to distract local personnel. An alternative approach is to begin integration at the front line, which has a direct impact on the patient experience; the most apt organizational supports for service provision might be identified. Excessive focus on patient pathways might lead to loss of the benefits of overall service co-ordination, for example in managing comorbidities.

Lesson 3. Ensure that local contexts are supportive of integration. This review identifies several key contextual elements that are important to successful integration. They include a culture of quality improvement, a history of trust between partner organizations, existing multidisciplinary teams, integration of personnel who are open to collaboration and innovation, and effective and complementary communications and IT systems.

Lesson 4. Be aware of local cultural differences. Several cases reported in this review demonstrate the very significant challenge of bringing together organizational cultures that have, in many cases, evolved separately over decades. Clearly, this is an obstacle that must be considered when planning future integration.

Lesson 5. Ensure that community services don't miss out. One of the most valuable potential outcomes of vertical integration is better integration of community services. King et al (2001) notes the existence of longstanding power imbalances between acute and community services which make such integration a challenge.

Lesson 6. Provide the right incentives. It is important that frontline staff recognize and buy into the integration process. Shortell (2000) suggests that this requires not just persuasion from a clinical standpoint, but also financial incentives.

Lesson 7. Don't assume economies of scope and scale. Significant improvements in quality of care could follow better co-ordination of previously fragmented service providers. Potential economies of scope and scale are likely to take time to achieve, however, and much evidence

from the US (Burns & Pauly, 2002; Robinson, 2004) suggests that integration has seldom increased efficiency. This is due to factors such as the significantly different practices in the organizations that are to be integrated, and the steep learning curve inherent in joining with another organization.

Lesson 8. Be patient. The time required to implement effective integration is a recurrent theme, and is unsurprising given the complexity.

Keywords

coordinated care, integrated networks, Vertical integration, horizontal integration
