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Candesic

analysis

Can integrated care save our healthcare system?

Candesic's **Dr Leonid Shapiro** discusses how the current system is not up to the job of delivering modern medicine

"Medicine is not what it used to be" is a common saying, usually linked to the great scientific advances of our times. However, the saying now describes how the current medical system is not fit for purpose for an ever increasing segment of our population, namely those with complex long term conditions. When you couple the rising costs of healthcare with demographic changes, we as a society cannot continue with the current system. A dramatic rethink of how we deliver medicine is therefore essential for the sustainability of our nation's healthcare.

As recently as a generation ago, when our parents were our age, medicine was much simpler. GPs were responsible for the bulk of our medical care and specialist doctors were used only for the most serious and, usually, acute conditions, such as cancer. Furthermore, specialist doctors and the GPs who referred to them often were well known to each other; they practiced in close-knit communities, and spoke often about the patients they jointly treated. Today, this has all changed. GPs have less than 10 minutes per appointment to see patients and process them like a factory assembly line. Specialist doctors have multiplied several-fold because we now know so much more about medicine than before. It is impossible for the GP to adequately treat patients on his or her own anymore. Many of the specialists, as well as the GPs themselves, are now foreign doctors without a long history in the UK nor an established network of colleagues in the local areas where they practice.

Add to this the trend of patients living longer and with long term conditions which must be managed but cannot be cured. The result is that GPs are no longer capable of looking after their most needy patients and referring these patients to specialists in the current system is troublesome because there is no coordination in their long-term care. This has resulted in patients with long term conditions receiving not only poor care but also having it delivered inefficiently and wasting resources.

Take for example the case of Mrs Confused (*figure 1*). She is a 75-year-old diabetic with high blood pressure who has recently fallen and fractured her hip. She has been ferried around no less than 15 different services delivered by 10 different organisations paid for by five different budget holders. Her GP only gets letters weeks after she is seen by specialists and is incapable of coordinating her care. We've all heard of patients like Mrs Confused, like the patient who collapsed because two separate specialist doctors prescribed two different but similarly biologically active drugs against high blood pressure. This example of poorly coordinated prescriptions was so bad that the NHS introduced Medical Use Reviews (MURs) for pharmacists to periodically check the totality of patient's medications. MURs are now the largest non-prescription revenue source for pharmacists in the UK.

Integrated care: the new delivery model

It is not enough now to patch up our broken system, we must deliver care differently to be able to afford to sustain our nation's healthcare. The model of integrated care (IC) has been used in many countries successfully not only to improve outcomes but to reduce costs. Pilots in the UK have so far only shown the former, but we believe that if more and more care (including social care) is integrated, we will see economic benefit to the system as a whole as well. .

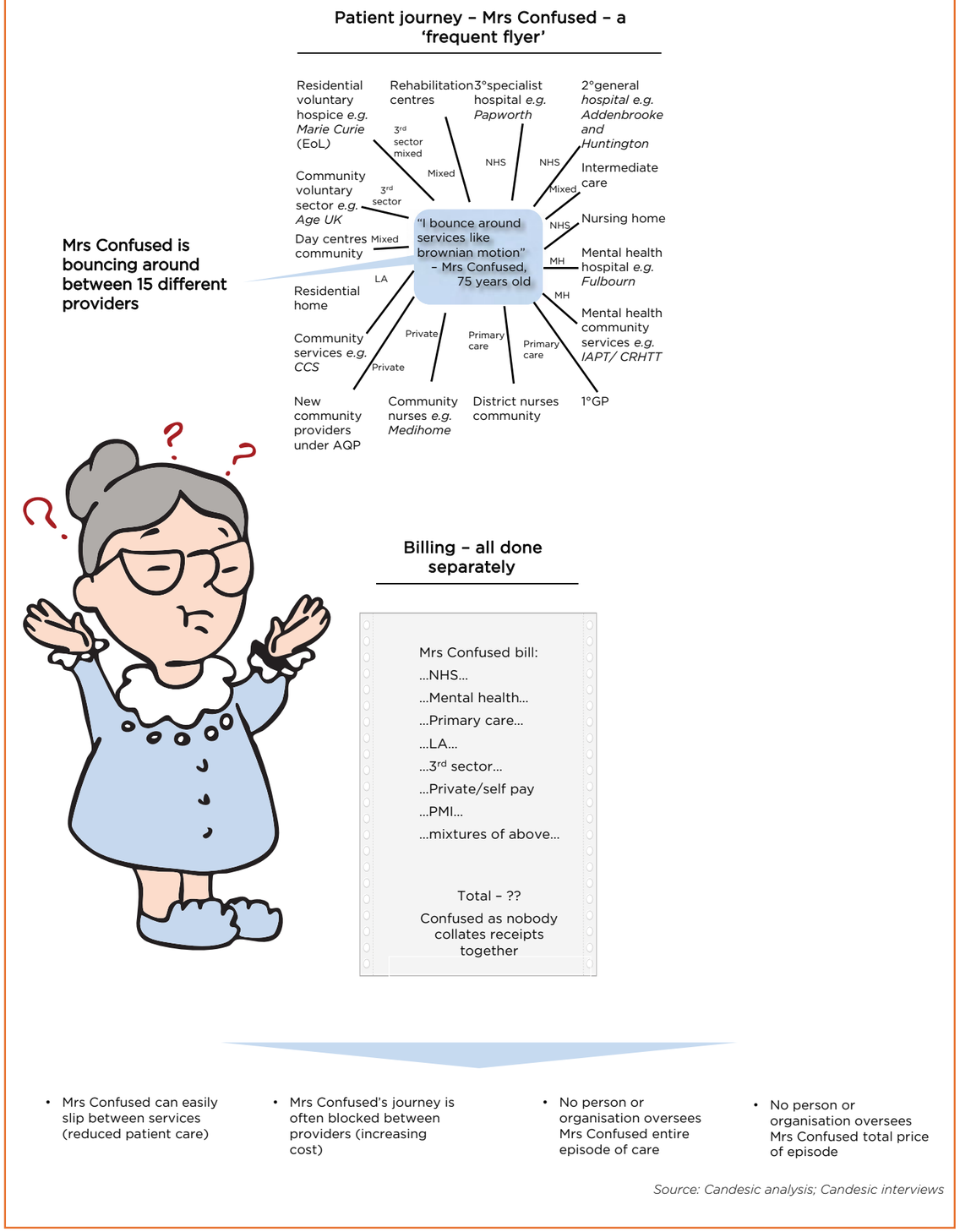
Candesic has been leading the thinking in Cambridgeshire & Peterborough on IC. Over the past three months we have developed a model of care which has the potential to deliver quality, sustainable care to the most needy patients with long-term conditions. Candesic's model brings together findings from dozens of IC deployments from all over the world. We have distilled these down into three key elements:

1) The 'Brain': a care pathway rule set
2) Local care coordination
3) Smart procurement (*figure 2*).

The 'Brain': Care pathway rule set

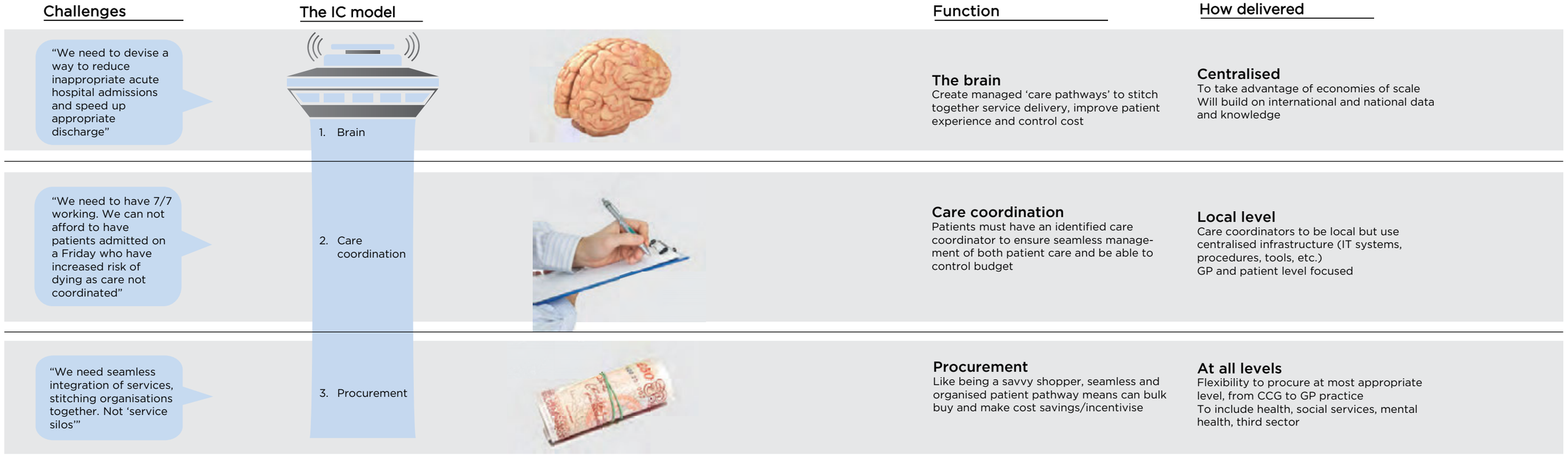
The care pathway rule set is the brain behind the IC system. These set of rules guide the care coordinators in how to handle the care of chronically ill patients. Developed by numerous organisations around the world, these pathways use hard outcomes and costing data. The key to making this part of IC work is to base the rules on clinical input and get buy-in from GPs and specialist doctors so that ▶

FIGURE 1
CURRENT SYSTEM FOR PATIENTS WITH LONG TERM CONDITIONS



Source: Candesic analysis; Candesic interviews

FIGURE 2
CANDESIC MODEL FOR INTEGRATED CARE



Source: Candesic analysis; Candesic interviews

there is no or little tension between these high-level pathways and clinical decision making at the coal face. The only way to do this is to back pathways with clinical and peer-reviewed findings that doctors cannot afford to dispute. This may sound like wishful thinking, but many countries and medical systems have done a lot of this research, so significant data exists for the main chronic illness pathways to implement this rule set effectively.

Local care coordinators

As GPs should not be spending their valuable clinical time dealing with non-clinical problems, a care coordinator role is essential for IC. This role is common in all IC systems we have examined globally. This role is often played by a nurse or a trained coordinator and deals with clinical as well as social/admin/budget type issues. A care coordinator will look after a small number of high-need patients rather than the approximately 2,000 patients each GP is responsible for. They will work with a multidisciplinary team (including social workers, occupational health workers, psychiatric nurses, physiotherapists, etc.) to case manage their patients. The care coordinator uses the rule set from the function described above to guide the patient to different providers, driving towards better outcomes and lower overall costs. This includes looking after the patient's social needs as well.

Smart procurement

Commissioners of health and social care already procure needed services, but IC sometime needs different types of services or services delivered in different, more flexible, ways. Smart procurement is essential to give care coordinators the arsenal to deliver IC efficiently. This function ensures that the right 'dishes' are on the 'menu' so that care coordinators can do their job. For example, the current contract with an acute provider for a hip replacement needs to be modified to allow the patient being discharged early (with a savings to costs) to go to a lower cost step-down facility. Furthermore, this function needs to procure the step-down facility itself, because the current system does not have this as a current provider. Smart procurement is thus about modifying existing provider contracts and commissioning new ones that make IC possible.

Funding

Funding in the current system only adds to the problems. Each funder argues with the others about who takes on Mrs Confused's costs. The local authority (LA) is incentivised to keep the patient in hospital and the NHS tries to pass the patient on to social care as quickly as possible. Decisions end up being driven by payer battles instead of what is best for patient care.

Therefore another essential for IC is a common budget pool and one organisation looking after it. Our model, again common to many international models, is based on creating a capitated budget which is then used for all patient care (health and social). We have heard of stories of elderly patients being admitted to hospital overnight because ambulance trusts do not operate non-emergency patient transport after 8pm. If one organisation was looking after the budget, instead of three (ambulance trusts are centrally funded, hospital care locally funded by NHS, and social care funded by LAs), that organisation would procure an afterhours patient transport service, or could even simply take out an account with a local taxi service to solve this problem, rather than fighting budget battles and having patients have unnecessary hospital admissions.

Opportunities for providers

Providers (public, private, and voluntary), can benefit from IC in many ways. There are many services and modes of delivery of these services that are needed for IC but are not currently available in the current system. Many are considering converting their existing facilities to deliver services focused on IC. For example, converting a nursing home into a step-down hospital by staffing it with doctors and skilled nurses: thus enabling adequate care delivery but at less than half the cost of an acute hospital.

Many providers are looking to get into the game. Care UK, Circle, Four Seasons Health Care, Serco, Spire and Virgin Care, have all expressed deep interest in IC. These and other providers, and the investors who back them, cannot only expand delivery of patient services needed in IC, but also deliver services to enable IC itself. Such services include developing proven and more effective care pathways for the 'brain' function as well as outsourced care coordinator teams at a local level.

This new integrated model of health and social care delivery will not only create sustainable and affordable care, but also create new opportunities for providers and enabler organisations. With its common funding pool, the new model will facilitate deployment of proven telemedicine solutions which to date has been restrained due to disagreements of who should fund it. An integrated care model is essential for our long term nation's healthcare and our economy. We must embrace it and lead the world, like the NHS historically has, in delivering cost effective ubiquitous care. ■

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