International Comparison of Specialist Care Organization: Innovations in Five Countries

England • Germany • Italy • The Netherlands • The United States

Pioneer Integrated Care Teams in Geriatric and Respiratory Services

Lucie Michel, Zeynep Or (IRDES)

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Case studies

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About this study

Under pressure of increasing demand for healthcare from an ageing population with multiple chronic conditions, France, as other countries, seeks to advance care coordination and integration across primary, hospital and long-term care sectors. Specialists play an essential role in treating patients with chronic conditions, but little attention is given to their organization out of hospital, and their role in enhancing care coordination and patient-centered care provision. *France Stratégie* (French High Council for the Future of Health Insurance, *Haut Conseil pour l'avenir de l'Assurance maladie*, HCAAM) asked the Institute for Research and Information in Health Economics (IRDES) to provide an international perspective on the subject. In collaboration with researchers and experts in five countries (England, Germany, Italy, the Netherlands, and the United States), we identified examples of specialist care delivery models. In order to understand the actual organization of care around specific health conditions, we carried out case studies in these countries between June 2018 and March 2019. These case studies do not aim to provide an overall description of ambulatory care provision in each country. Rather they look at the organization around patients with specific conditions, examining the division of roles and tasks between specialists and other professionals involved, innovative features of the care model, and its funding.

The two case studies in this report describe the organization and functioning of two pioneer integrated care models in England where hospital specialists work closely with primary and long-term care providers and provide services outside hospital. The first study describes the development and functioning of Integrated geriatric services at Leeds and the second the Whittington Health integrated respiratory services in London. They are based on visits organized in Leeds and in London in September 2018 with the collaboration of the King's Fund. During visits, we interviewed all major actors involved in care provision, the specialists and nurses who are central in these initiatives, other healthcare professionals involved in integrated care teams, those in hospitals and in primary care settings, managers, local commissioners and patients.

THE ENGLISH HEALTHCARE SYSTEM *in a nutshell*

The running of the National Health Service (NHS) in England is the responsibility of NHS England, a distinct body which oversees the NHS budget, manages 209 local Clinical Commissioning Groups (CCGs) and ensures that the objectives set out by the Department of Health concerning both efficiency and health goals are met (Thorlby and Arora, 2019). The majority of funding for the NHS comes from general taxation, coverage is universal for all residents and services are largely free at the point of use (Cylus et al., 2015).

General practitioners (GPs) act as gatekeepers for secondary care and are responsible for care coordination as part of their contract. Most of them work in group practices with at least five other GPs, employing nurses and administrative staff. Nurses provide routine care (monitoring blood pressure, etc.) under physician prescription but are also increasingly responsible for the monitoring of patients with long-term conditions. Most GPs are private contractors and more than half of the practices are paid using a mixture of capitation to cover essential services (about 60% of income), optional fee-for-service payments for additional services (about 15%), and optional performance-based payments. However, the proportion of GPs employed on a salaried basis is increasing.

Nearly all specialists are salaried employees of NHS hospitals. They are free to engage in private practice within specially designated wards in NHS or private hospitals. The engagement in private work (about 50% of the specialists) is decreasing since the earning gap between private and public sector has narrowed (Cylus et al., 2015). Public hospitals are organized as trusts (large hospital groups with autonomous management) and contract with local CCGs to provide services. They are reimbursed by nationally determined diagnosis-related group (DRG) rates which are increasingly adjusted for the quality of care and coordination across sectors. There is no cap on hospital incomes.

The volume and scope of health services provided (including prevention, rehabilitation, long-term care, home visits by community-based nurses, etc.) are decided at the local level by CCGs, but the NHS Constitution states that patients have a right to drugs or treatments evaluated and approved by the National Institute for Health Care Excellence (NICE).

The 2012 Health and Social Care Act charged NHS England and CCGs with promoting integrated care, which is improving the connection between hospital- and community-based primary and social care. Since 2015, the Better Care Fund (about 4 billion pounds), pooled from existing health and social care budgets, supports local projects integrating health and social care.

1. LEEDS – INTEGRATED GERIATRIC SERVICES

1.1. Background

- The increasing number of frail elderly patients engenders a growing demand for pluriprofessional care that is tailored to the specific health and social needs of older people.

- NHS England supports a population-based stratification approach in order to systematically identify older people (65 years and over) who live with moderate and severe frailty.

- Frailty is identified using standard validated tools such as the electronic Frailty Index (eFI) based on routine health record data which automatically calculate a score to detect whether a person is likely to be living with mild, moderate, or severe frailty.

- Since 2017, the GP contract (funding) has been modified in order to introduce routine frailty identification for patients who are 65 and over. GPs are required to detect and manage patients with frailty and provide targeted interventions for those most at risk of adverse events including hospitalization, nursing home admission and death (NHS, 2017).

- In Leeds it is estimated that 32,000 people are living with frailty, of which 90% are over 60 years old, and approximately 2000 people receive end of life care (NHS Leeds, 2018). The geriatrics team at Leeds Teaching hospital has been working with community teams (in primary and social care) for providing services beyond traditional acute care in order to maintain patients at home and reduce hospitalizations.

- This case study highlights these initiatives that unite specialists with primary and social care providers around frail older patients.

1.2. Overview of the Leeds Geriatric Services across settings

In Leeds, the approximately 70,000 people aged 65 and over are managed by three Clinical Commissioning Groups (CCGs). The CCGs in Leeds have long been working to implement population-based integrated services focusing on frail elderly adults. Leeds is divided into 12 neighborhoods, each of which has an integrated health and social care team (Core team). Since 2013, the geriatrics teams at Leeds Teaching Hospitals NHS Trust (grouping 7 hospitals in Leeds, including a dental teaching clinic) work with Leeds Community Healthcare NHS Trust (group of providers for outpatient and community care). Together, they provide a number of services beyond the traditional acute treatments, with the following objectives (Robertson et al., 2014):

- Anticipating the needs of the frail elderly population.
- Keeping patients out of hospital (where the number of beds are decreasing).
- Engaging geriatricians to work across secondary, primary and community care settings.
- Improving care continuity and communication between different health and social care providers.

A community-based multidisciplinary team

The "CORE" community teams are comprised of social workers, district nurses and community matrons, with strong links to primary care providers. Community matrons (CM) are highly qualified nurses specialized in the case management of high-risk patients. The CMs manage patients at home. They provide a global assessment of patient needs and evaluate home risks for frail elderly patients. They systematically evaluate nutritional habits, check the skin, assess fall risks, revise prescriptions, etc. They are in direct contact with social services which can intervene when necessary. CMs are key actors in the organization of elderly care working as case managers in direct contact with specialists and GPs. Their qualifications and autonomy allow them to take responsibility for a large number of tasks, including prescriptions, drug conciliation, etc. They ask for advice from specialists or GPs when needed. Both specialists and GPs appreciate their role, recognize that CMs help them to better use their time, and entirely trust the decisions made by community matrons.

The role of the Community matron

The position of "Community matron" was created in 2000 under an NHS plan that recognized the need to invest in care provided out of hospital. This plan pushed towards a global expansion of community health care services and a better integration of primary, secondary, and social care, which was traditionally provided in silos (https://www.nursingtimesjobs.com/news/community-matron-guide).

A community matron is a senior specialist nurse with extended skills, clinical expertise and curriculum (she is a practice nurse at a Master's degree level) who is able to demonstrate case management skills. She usually manages 30 to 50 patients at home with the objective of avoiding hospitalizations and other adverse events. She is able to provide complete patient education, and improve medication concordance and observance. Community matrons receive specific training and a certification to provide prescriptions.

They work according to a holistic approach emphasizing the need to consider the overall condition of the patient, where they believe that the best "care is what the patient tells you it is".

Since 2012/13, the geriatricians from Leeds Teaching Hospital have supported the integrated health and social care community teams. Each team has a dedicated geriatrician who attends multidisciplinary team meetings and provides home visits when necessary. Today, the team in Leeds also includes a physiotherapist, an occupational therapist, healthcare assistants and social workers.

At the primary care level, GPs and practice nurses work directly with the community matrons, geriatricians and hospital nurses. Communication between these healthcare professionals is facilitated via a common vision of care pathways and protocols defining the roles and responsibilities of each professional. When/if necessary, the community matron can refer a patient directly to a specialist without going through the GP. The geriatrician can be reached by team members via telephone.

Common shared tools for defining the referral pathway

Frailty is defined as a syndrome of physiological decline, characterized by marked vulnerability to adverse health outcomes. NHS England advocates that frailty should be treated as a long-term condition, and therefore requires prevention and early identification[1].

In order to identify frail older people in the community that are at risk of being unstable, a common risk stratification measure taking into account physical (activities of daily living) and cognitive frailty is used by nurses. Hence the frailty assessment is not only medical; it is based mainly on cognitive and psychosocial criteria. Globally, patients can be categorized into one of the three following groups, either in primary care settings or by the Core team:

- **Minor or no medical problem.** These patients are readily managed in primary care and by community health care workers.
- **Medically stable with complex social problems.** These patients may get a home visit from social workers and/or other members of the pluriprofessional team.
- **Complex medical and social problems.** These high-risk patients, identified by the Risk Stratification Tool, are closely followed by the pluriprofessional team. The patient's evolution is monitored in weekly case management meetings. They may get a home visit from the interface geriatrician, be sent to a clinic for testing, and/or receive an admission to an intermediary care bed.

Supported strongly by interface geriatricians

The geriatrician's role is redefined within the multidisciplinary team involving GP practices, community matrons, district nurses and other community-based health and social care professionals. The interface geriatricians, responsible for their local population, have an important role in managing frail elderly patients. They are available:

- For telephone advice to community matrons and GPs.
- To facilitate direct access to other specialists and exams in hospital.
- To attend community multi-disciplinary meetings to discuss high-risk patients.
- To consult in the community/outpatient clinic settings.
- To provide home visits when needed, for a comprehensive geriatric assessment.

1 https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/

1.3. Shared vision: keeping older patients out of hospital

> *...we all have to ask, why not home, why not today? »*
>
> Head of Quality Improvement, Leeds Teaching Hospital

Reducing hospital use for older patients has been a shared objective of all local and national policies. While specialists have been reaching out of hospitals to prevent hospitalizations, the Leeds Hospitals Trust has also invested in discharge planning teams, creating an interface for community nurses within the hospital in order to reduce readmission rates and lengths of stays in hospital.

The discharge planning team is composed of hospital nurses and a community nurse manager who is financed by the community (CCG) but works inside the hospital. This team manages discharge organisation across different levels and works hand in hand with the geriatricians.

Discharge planning nurses evaluate each patient's file every day,and can sometimes challenge senior specialists if a patient has been in the hospital for too long. The discharge nurse manager, as a community employee, has direct access to all the community resources for social care, physical therapy, rehabilitation, etc. The team can provide solutions regarding patient transport, social issues, home care organisation, family information and education. They have recently been developing a stratification tool for better planning discharges, options varying from a green path for patients needing very little home care to a red path for more complex home care needs. They make sure that electronic discharge forms are sent to the community matron and the local team (with instructions for nurses and GPs), or to nursing homes. The discharge form is sent to an online platform accessible by each professional.

Geriatrician input in the emergency room. Furthermore, a geriatrician attends the emergency department five afternoons a week and provides geriatric assessments for elderly patients within an hour of them visiting emergency services. They work with other emergency staff to help them in their diagnosis and treatment, and to foster the understanding of geriatric issues. The cost of this geriatric care in the emergency department is absorbed by the hospital.

1.4. Role of commissioning/financing

> *It is very difficult to change the way providers work... You need to financially encourage specialists and generalists to work together. »*
>
> CCG, commissioner and GP

Since April 2013, Clinical Commissioning Groups (CCGs) have replaced Primary Care Trusts (PCTs) in England. They are clinically-led (mostly by GPs) statutory NHS bodies responsible for the planning and contracting of health care services in their local area. The

three CCGs in Leeds have been instrumental in pushing clinicians to invest in system transformation. For example:

- Specialist (geriatrician) input into local integrated care teams is funded via a direct agreement between the three Leeds CCGs and Leeds Hospitals Trust, which pays for the geriatricians' time out of hospital for 12 programmed activities per month.
- The community matron is salaried by the community, and so is paid directly by the CCGs.
- GPs are paid for their time spent in collaborating with other healthcare professionals, particularly specialists (half an afternoon/week).

At the national level, there are also incentives for general practitioners, within the QOF (Quality and outcomes framework)[2], to invest in care coordination for chronically ill patients, and in particular for the coordination of services for frail elderly patients.

Hospitals are paid by an activity-based payment scheme (ABP) and have direct incentives for reducing the length of stay in hospital, but also for avoiding short-term (30 day) readmissions which are used as a non-quality indicator and are financially punished. Part of the hospital's budget is linked to a number of quality indicators including structure, process and outcome measures. Nevertheless, under ABF, hospitals' main funding is linked directly to their volume of activity. Preventing hospitalizations means reduced funding for the hospitals. Therefore, the Leeds Hospitals Trust has signed a contract with the CCGs guaranteeing them a stable income, and that they will not lose any revenues because they improved the quality of patient care. This implied a specific definition of quality of care beyond hospital, including services that should benefit the health system collectively, financially and from the point of view of patients involved.

Aligned Incentives Contract

The Aligned Incentives Contract is an alternate contracting and payment mechanism to Activity-based payment enabling financially sustainable (from both a commissioner and provider perspective) services for the local population. The objective is to provide a stable level of income to providers, allowing them to retain cost savings obtained through better care pathways and reduced hospitalizations. For hospitals, this agreement allows for a more flexible budgeting, freeing up personnel to contribute to service change and investment in new activities in order to enhance patient experience. For the commissioners, this facilitates contracting across the care pathway which crosses inpatient and outpatient, specialised and primary care.

The motivation is that financial incentives should be aligned with system-wide objectives, and that individual providers should not lose money because they improved overall care provision. For example, in St James hospital, the multidisciplinary work of geriatricians and the discharge team allowed reducing hospitalizations which represented a loss of income of about 2 million pounds under the activity-based payment scheme. With the new contract, the hospital kept the savings made and invested in new services, covering the cost of geriatricians out of the hospital, etc.

2 QOF is the performance-based payment scheme for GPs.

1.5. Shifting attention from the sickest to the whole population: A community-based proactive approach

> *We have a community of people, they are our patients no matter if they are sick or not, so looking at the whole population and responding to that [their need] is our duty. »*
>
> GP and Clinical Commissioner

Initially, community-based care has concentrated on identifying the frailest older adults who are high users of the system, and monitoring/satisfying their care needs. Now, commissioners are increasingly interested in developing a more proactive approach by stratifying the population to provide care and counseling for the whole population over 65 years in order to promote health and well-being. Leeds is therefore on a journey to population health management, which means that primary and community care providers are targeting the whole population, and not only those that are the most ill. This vision is also very different from the traditional way specialists cared for their patients, which mostly took place during the acute phase of a specific condition, and did not involve the monitoring of other stages of the disease.

The involvement of all health care professionals at all levels of care is at the heart of this new approach. Health care professionals are thinking of how to be proactive and manage a condition instead of being reactive to a health problem as a consequence of bad management.

The project "Live well Leeds" is a good example of linking all health care professionals, from specialists to community matrons, in order to co-produce ground level services in the community. The project finances a designated team to oversee the whole population in an area and not just those who had an acute episode, and to test new ways of helping frail adults through proactive care. The team works without referral from a physician, they use medical records for identifying older persons (65+) who may need specific attention using simple algorithms (those with more than four chronic conditions including COPD and high score of EFA electronic frailty index[3]). The people who are identified are contacted by mail, and if they accept, are assigned a health advisor who works as a health and social care navigator. The health advisor works with the patient to understand his/her needs and preferences and tries to provide the best possible solutions to maintain the health and well-being of the person without using the healthcare system. The interventions can go from organizing physical activities to arranging a family meeting. Advisors also educate patients on their conditions so that they know what to do when and who to call in the event of an acute episode. When every option has been covered, the health advisor can contact the Core team. This project has been very positively received by the patients who valued the services, but also by the health care professionals involved who seem to feel rewarded by long-term involvement in a patient's life, rather than during just a quick episode. On a small panel they tested, the evaluation revealed a reduction in the use of GP services, as well as in the number of hospitalizations.

3 http://tvscn.nhs.uk/wp-content/uploads/2018/03/7.-Martin-Vernon.pdf

> *Integration has a cost. But if we don't make any changes, the system is not sustainable. »*
>
> GP, Clinical Commissionerr

In order to reinforce communication and exchanges between health care professionals, CCGs have been promoting local care partnerships. Local areas are defined with a group of GP practices, nurses, community matrons, and other health care workers identified for a population. Currently, there are also specialists associated with each local area in Leeds. For instance, in one of Leeds' 12 areas, one GP is identified as a frailty specialist working with two specific community matrons. This is a way of bringing the right physician around to the right population (which in this case is a frailty specialist, but could also be pediatrician).

Moreover, CCGs recognize the importance of clinical leadership in promoting new care models and changing medical practices. They invest massively in local leaders (GPs, nurses, specialists) in order to facilitate their job of building local care partnerships. The healthcare professionals identified as local leaders are employed as "clinical leaders" by the community (CCG) and have a budget to carry out activities linked to "leadership".

2. WHITTINGTON HEALTH INTEGRATED RESPIRATORY SERVICE

2.1. Background

- Respiratory diseases affect the lungs and other parts of the respiratory system. The most common conditions include asthma and chronic obstructive pulmonary disease (COPD), which affect about 6 million people in England (Department of Health, 2012).

- COPD and asthma are chronic inflammatory lung diseases that are characterized by airflow obstruction or limitation causing breathing difficulty, cough, and wheezing. People with COPD are at increased risk of developing heart disease, lung cancer and a variety of other conditions (British Lung Foundation, 2014).

- COPD is the second most common cause of emergency hospital admissions in England and is very costly in terms of acute hospital care. Over 50% of people diagnosed with COPD are under 65 years old (Department of Health, 2012).

- Data from the 2000s showed that in Islington (North London), emergency admissions for COPD were significantly higher than expected, compared with other London neighborhoods. Most of the patients admitted to the hospital with an acute exacerbation had never been diagnosed before in the community (Bastin, 2010).

- In 2008, a COPD audit in Islington suggested that the diagnosis and management of COPD needed improvement (Islington, 2010).

- Whittington Health, an integrated care trust, was formed in 2011 by merging the Whittington teaching hospital with community services in the districts of Islington and Haringey in North London (Cornwell et al., 2016).

- The integrated trust provides services across hospital and community care settings for a socio-economically diverse population of 460,000 in these two districts.

- In this case study, we describe the development and functioning of the Whittington Health integrated respiratory services, which has been a pioneer model in England (Robertson et al., 2014).

2.2. Overview of the development of an integrated respiratory team

> *We want to see our patients live rather than die, and live better, breathe better, feel good and do more. »*
>
> Integrated consultant physician

The creation of an integrated CORE respiratory team at the Whittington trust has been a long journey. The need for a specific respiratory service came up in the winter of 2001 as a result of difficulties in delivering demanded care and because of strong financial pressure to reduce lengths of stay. In 2002, an innovative pilot project was implemented at the Whittington hospital by two respiratory specialists, the Rapid Early Discharge Model (REDS), in order to reduce inpatient bed days. The service recruited a respiratory nurse specialist as project manager who was in charge of collecting data and helping patients discharge as soon as it was safe to do so. GPs were also involved in the pilot, so that patients discharged could be well-managed outside the hospital. They were given direct access to hospital specialist teams via telephone and e-mail. In its first year, the REDS model saved 150 bed days and was successful in improving GP and patient satisfaction (Cornwell et al., 2016). The service model improved over time to meet patients' needs and evolved when the Whittington Hospital became an Integrated Care Organization in 2011. Since the beginning, the physicians' motivation for changing the service model was a desire to improve patient care by achieving better outcomes but also to reduce the pressure on the hospital by reducing bed days. To do this they adapted patient's perspective with a willingness to understand patients' needs and to improve their experience with the illness.

Today's respiratory service is organized around two communities (Islington and Haringey), representing approximately half a million people. The respiratory service is based at Whittington Health trust and is funded by two local clinical commissioning groups (Haringey CCG and Islington CCG).

The service operates across hospitals and the community. It is comprised of:

- A specialist outpatient respiratory clinic based at the Whittington hospital.
- A 21-bed acute inpatient ward, including a 4-bed high dependency unit.
- The Whittington Integrated Community Respiratory (CORE) team.

The hospital respiratory team provides several services beyond traditional acute care, with the aim of supporting patients outside the hospital (Roberson et al., 2014). Notably, there is strong discharge planning support, accompanied by case management for vulnerable patients to help with self-management, and to address anxiety and/or social issues. Patients have access to telephone support and home visits from a designated healthcare professional and specialist while they are followed regularly by a generalist (GP).

Integrated specialists working in and out of hospital

The position of integrated consultant developed within the multidisciplinary team is a new one. Integrated specialists play an essential role in the CORE team, working across community, primary and secondary care settings. They provide medical leadership for the CORE team and other health professionals (including GPs) to help them to diagnose patients with COPD, deliver care outside the hospital in community and primary care setting, and encourage/help patients to manage their condition. The senior position and leadership from the first integrated specialists have been instrumental in promoting this new role.

One of the specialists spends two afternoons a week visiting GP practices to help them improve the treatment and diagnosis of their patients. Despite initial resistance to specialists in their practice, the GPs we met were very satisfied with this new organization and valued this long-term relationship with the specialists. The specialists also valued this collaboration since they can now have direct access to GP files and can see all GP reports, patients' lab results, etc.

The CORE team

The Integrated Community Respiratory (CORE) team is a multidisciplinary service which supports patients before and after hospitalization, and is led by two integrated respiratory specialists. It comprises:

- Two integrated respiratory specialists: one based in hospital and one working exclusively as outpatient in two hospitals in the area, with visits to primary care providers.
- An integrated respiratory resident (called a registrar).
- Nurses.
- A pharmacist.
- A physiotherapist.
- A psychologist.
- Smoking cessation advisors.

This team is divided into three branches:

- A hospital-based team: they support patients in the ward and follow up on them in the community after discharge.
- Two community-based teams in Islington and Haringey: they accept patient referrals from GPs to provide short-term support or ongoing case management.

The team works very closely with 36 GP practices and they provide education, training and support to about 1400 patients each year. The hospital-based team meets once a week to share patient information and review treatment strategies beyond.

The integrated specialists also have a strategic role in pushing for new services to enhance the management of patients in community. The integrated specialist registrar (see Box 2) creates a career pathway for clinicians interested in working across care settings and developing skills for providing integrated care.

… supported by a large number of health and allied professionals

An important part of patient care is provided by **nurses and allied health professionals**. For instance, the **lead respiratory pharmacists** play a strong role in supporting the CORE team: they provide specific protocols for identifying the best inhaler and for adjusting oxygen prescriptions. They also manage patients' pharmaceutical data (drug consumption), help drug conciliation and, if necessary, organize home oxygen therapy. GP practices also tend to work increasingly with their own pharmacists, who help them manage prescriptions, take blood pressure, etc.

Physiotherapists also play an important role: they lead pulmonary rehabilitation, and as a member of the CORE team, they follow up on patients in the ward and back at home. Respiratory physiotherapists are working at the top of their license and have high levels of education: some of them have a special diploma allowing them to prescribe treatments within the limits of their practice (they can prescribe seven specific drugs for respiratory problems). They can do home visits to understand the patient's environment and may change the prescription to limit the fall risk, for example. Some physiotherapists rotate every 4 months between home and hospital care. They work hand in hand with **occupational therapists** who follow up patients and organize their discharge, and make sure that the right equipment will be installed at home. They can also organize a package of social care with the community.

A psychologist is embedded in the CORE team to provide integrated psychological input across inpatient, outpatient and group settings (Box 3). This is justified by the fact that many people with respiratory conditions such as complex COPD or asthma have high prevalence of anxiety and depression linked to the difficulty and fear of breathlessness. The physical symptoms are exacerbated by anxiety in a vicious circle of escalating breathlessness (Lunn et al., 2017). The psychologist, using psychological therapy models such as cognitive-behavior therapy (CBT), supports the CORE team in improving patients' self-management skills and helping patients to better cope with their condition and treatment. The respiratory team refers patients experiencing significant distress and those with high tobacco dependency to the psychologist.

A stop smoking specialist works in the ward and provides patients with a comprehensive set of interventions about smoking cessation and support for housebound COPD patients.

A data manager was recruited in 2018 to work for the ward and the team. He enters patient information (including from each checklist) into a computer database system and calculates quality indicators. His work is considered as essential in valuing the outcomes of CORE teamwork.

A dietician also works with the CORE team alongside a **language therapist**, especially for helping with swallowing and obesity issues. She works with the dieticians in the community.

The integrated respiratory registrar

In 2013, the first integrated respiratory registrar training was funded. It was born form the necessity to optimize the management of respiratory conditions across different teams working in hospital and in the community. It is the only respiratory consultant registrar in England, and it creates a new role or, as expressed by the consultant themselves, a "new professional status", since this is the first time a hospital-based consultant (specialist) is employed to deliver close support to the community.

During this unique training in integrated respiratory medicine, the registrar works directly with the GPs, with community services, as well as with acute patients in the hospital outpatient department. The program has been approved by the London Training Committee and a specific training, mentorship and job plan has been designed. This integrated training includes (Heightman et al., 2015):

- Supervision of community respiratory team meetings (virtual ward rounds).
- Home visits for complex patients.
- Delivering practice-based GP respiratory education and case-based specialist advice (virtual clinics).
- Training practice.
- Service development training (community management of acute patients).

A consultant sees about 40 patients per week in outpatient clinic, works regularly with the primary care practices, and can also make home visits (equivalent of one day every three months).

2.3. Placing patient engagement and "self-management" at the center of care

We need to know what matters to patients... but it requires training to change the mind set: ask what the patient wants. »

Integrated respiratory specialist

The integrated respiratory team members share the same values as to what should be considered better patient care. They strongly believe in patient empowerment and the

A psychologist supporting both patients and the CORE team

A psychologist works full time in the ward. She has the double duty of supporting the patients as well as the CORE team. She follows patients both in the community and in hospital, and helps them cope with the chronicity of their disease and its side effects. For instance, she can help patients to manage the fear of breathlessness.

She also provides psychoeducation to the team members. She helps them to better understand patients' point of view, but also to cope with death, loss of patients, end of life conversations with families, etc. She organizes the initial training in motivational interviews and following reflexive sessions for all team members.

importance of self-managing respiratory conditions. They have developed several interventions aimed at improving self-health behaviors and self-management skills. For example, each health care professional needs to have training for improving how they converse with patients as equals and for integrating patients' views into the care plan. They use an evidence-based tool called a "motivational interview" which aims to cultivate a patient-centered counseling style in which the patient can be active and learn how to manage problems, understand available resources, decide what's best for him/her and engage in his/her treatment and healing. The therapeutic relationship becomes more like a partnership rather than the former expert/recipient role. The members of the team are trained by a psychologist and meet every 6 weeks to work on their reflexive practice according to practical cases they must handle.

Patients are at the center of this holistic vision of the care provided across hospital, primary care and community settings. Patient feedback has been an important part of the project's development, their views and advice are actively sought and integrated in shaping services. Each service innovation is tested directly with patients in the ward or at home, and their feedback is collected through monthly surveys and interviews.

2.4. Collective leadership in an integrated team

> *For a physio, working in an integrated team is a great challenge; integration means you are within a team and you feel safe, but at the same time you have responsibilities when you are on your own in the community. »*
>
> Physiotherapist in the CORE team

One of the key elements of the integrated team's organization is its non-hierarchical structure. The multidisciplinary team, including the integrated respiratory consultant, the registrar, the nurses, the physiotherapist and the occupational therapist meet once a week and share information on each of their patient files. As some of the health care workers mainly work in the community, they can share access to their respiratory patient files; they also use the NHS secure e-mail system to share information. There is no common data base linking together patient information from hospital, primary and social care settings, but the team uses all the ways at its disposal to connect patient information. The meetings take place in a room where there is a computer with access to hospital data, another one for primary care records, and the occupational therapist completes any missing information on a patient's home situation with data from their iPad.

The meetings are not led by the specialist; instead, they are very collegial, and the specialist tries to create a safe environment for each health care professional to express themselves. In the CORE team in general, despite differences in backgrounds and levels of experience, there is no hierarchy - relations are less formal compared to other teams. This aspect is appreciated by all team members, including the specialists who can share decision making responsibilities and can count on other team members when they need them.

Here, integration takes on a double sense of integrating competencies within the multidisciplinary team, and integration of care between hospital and home. The physiotherapist explains that in a traditional setting (before), when she used to provide rehabilitation in the community, she constantly had to play "Sherlock Holms" to find important information. In the integrated care model, she discovered how essential it is to follow up patients beyond the hospital setting: "... before and after care are as important as acute care". Being able to see the patient in the ward and then back at home also allows a strong continuity of care that, she says, makes her job more meaningful.

2.5. Role of the hospital management and financing

The Whittington hospital trust's senior management has been supporting the CORE team from the beginning. Hospital management has realized that the activity-based payment model was problematic for them since an important part of their patients were poor with many social problems, and it was difficult to reduce readmissions or lengths of stay without working outside the hospital. The status of "integrated trust" allowed them to get funding for providing care across settings.

The CORE team and management have also worked closely with the commissioners (two CCGs) who funded some extra services to support integrated care. Two specialists have four programmed activities a month funded by the Islington CCG to promote coordination of care for respiratory patients. The specialist's time for giving advice to GPs is also remunerated on a fee-for-service basis (£20/advice).

In addition, within the national-level framework of the Commissioning for Quality and Innovation (CQUIN) program, hospitals are financially incentivized to provide a set of evidenced-based interventions to all respiratory patients at discharge from hospital. These include smoke cessation advice and treatment, pulmonary rehabilitation classes, an inhaler review, and a follow-up visit with the specialist in a month. The hospital receives about £500,000 per year through the COPD bundle. In addition, since 2012 there has been a stop smoking bundle which has provided extra funding of £360,000 per year to the hospital (Robertson et al., 2014). Some of the members of the CORE team are financed thanks to this support.

2.6. Monitoring of quality and Evaluation

The value of integrated consultants and multidisciplinary team (MDT) for patient care, with several aspects of the program, were evaluated. Evaluation of outcomes from MDT discussions over 18 months covering 10 percent of patients, suggested that the patient diagnosis had been refined/clarified or a new diagnosis made following the MDT. The specialists also made changes to patients' management based on data from other settings and did important work to coordinate care across hospital, general practice and with other team members who can enhance patient experience. It is estimated that the management of patients with acute exacerbations of COPD at home reduced GP workload and generated savings through admission avoidance (Heightman et al., 2015).

Several aspects of the program such as "stop smoking" and "pulmonary rehabilitation" were evaluated as successful as well. There was a significant increase in referrals to pulmonary rehabilitation (350 per year), a significant increase in completion rate (from 50 per cent to 92 per cent) after a psychological component was added to the program (data

provided by the trust). Patients who completed pulmonary rehabilitation are expected to spend fewer days in hospital compared to non-completers (Lunn et al., 2017). Treating tobacco dependence during their inpatient stay on the respiratory ward was also considered as successful with a 4-week quit rate of 48 per cent (Ainley et al., 2014). By 2013, about 70 per cent of COPD patients had received self-management support (80 per cent of patients with severe COPD) recorded prevalence of COPD in Islington increased by 22 per cent compared to 2009/10 while standardised hospital admission for COPD fell by 16 per cent.

The Whittington COPD service had very good patient outcomes with lower in-hospital mortality rates (90-day in-patient mortality of 2.6 per cent compared to 8.6 per cent nationally) and implemented successfully the five core components of P4P scheme (CQUIN, COPD discharge bundle) achieving between 90 and 100 per cent of objectives since its introduction (López-Campos et al., 2013; Cornwell et al., 2016; NACAP, 2018; data from the hospital).

* * *

Overall, the Whittington Health Integrated respiratory service as the Integrated Geriatric services in Leeds provide an innovative, multidisciplinary service model for managing patients with a chronic and/or multiple conditions. These new care models are recognised and supported by the commissioners (funders) as innovative examples of how to achieve integrated, patient-centred model of care.

3. KEY LESSONS

Challenges

- It is difficult to change professional identities. Inviting specialists to GP practices and opening their patients' data is perceived as a financial risk by GPs. They are not all ready to "share" their patients.

- Professionals' time is limited. Most health care professionals are task-oriented and their organization does not allow changing care pathways.

- Doctors do not always know what is available to patients; there is a need for training in integration.

- Different initiatives in hospital and after discharge, if not well connected, can lead to an over solicitation of the patient, which can be counterproductive. For example, seeing a community matron, a practice nurse, a physiotherapist, and a social worker after discharge may be overwhelming for some patients.

- Too many (multidisciplinary) meetings could be time consuming and frustrating for health care professionals. It is necessary to build trust at the beginning of the process.

- Understaffing at the hospital. It is not possible to avoid all hospitalizations. It is important that hospitals have enough resources to provide the necessary care in good conditions for ensuring their part in the care pathway. The lack of resources in English hospitals due to significant staff cuts in the past ten years, especially in nursing, appear to create undue pressure on health professionals and undermine coordination and good patient care. Every morning, the main preoccupation of the ward's head nurse is having enough contractual nurses to fill the gaps. This was particularly pointed out during the winter crisis when many elderly were waiting (and dying) in hospital emergency hallways.

- Understaffing in the community. It is necessary to provide new funding for devlopping new services in the community.

Levers

- **Shared clinical objectives.** Both in Leeds and in Whittington, healthcare professionals join around a population-based, patient-centered approach to design pathways of care which are evidence-based and accepted by all. The holistic approach to patient care and the objective of reducing repeated hospitalizations is supported by specialists, community nurses and GPs. This nurtures a culture of collaboration between providers.

- **Using common tools** for diagnoses and risk stratification, and common protocols for decision-making. For example, all of the health and social care providers in community or primary care settings use the same frailty index for assessing patient needs. They motivate their decisions for referral and prescription with care protocols. The place/role and responsibilities of each health care professional are clear in the pathway.

- **Decision tools and services are designed simply.** The tools provided are rather intuitive to use for various healthcare providers. This is important for their acceptance and successful use by different health professionals.

- **Strong clinical leadership.** Both in Leeds and Whittington, the service model changed thanks to well-recognized, and committed specialists. The funding bodies (CCG) recognize the importance of leadership; they identify and financially support local medical leaders (specialists, GPs and nurses) to carry out activities linked to leadership.

- **The innovative workforce model** that includes staff who work across community and acute settings. In Wittington case, an integrated registrar role that creates a career path for physicians interested in working across settings, and a multidisciplinary team where all staff are trained in a series of **basic competencies** including motivational interviewing.

- **Appropriate and aligned financial incentives.** Payment system incentives are designed to encourage all parties to work towards the same objectives. The funders guarantee that the providers (both hospitals and GP practices) do not lose money by improving services or care pathways. Medical professionals are also encouraged, through extra funding, to engage in collaboration, which requires extra time and energy. Both specialists and generalists are remunerated for their collaboration time.

- **Hospital management.** The fact that hospital trusts have managerial and financial autonomy (similar to private non-profit hospitals) gives flexibility in resource use and facilitates innovation. At the national level, the NHS sets outcome objectives, yet hospitals have a lot of freedom in deciding how to use their resources to achieve the objectives set. In both examples, hospital management was very supportive of the innovations in care delivery, and encouraged the teams involved.

- **Ability of pivot healthcare providers** to make informed decisions. Nurses with advanced responsibilities can work at the top of their license with, for instance, possibility of prescribing certain drugs. The high clinical qualification of community matrons gives them a strong position in patients' care pathways. They are essential in centering care around patients, ensuring coordination between different health and social care providers, since they are able to secure patient care in direct communication and trust with specialists.

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International Comparison of Specialist Care Organisation: Innovations in Five Countries

England • Germany • Italy • The Netherlands • The United States

Pioneer Integrated Care Teams in Geriatric and Respiratory Services

Lucie Michel, Zeynep Or (IRDES)

Under pressure of increasing demand for healthcare from an ageing population with multiple chronic conditions, France, as other countries, seeks to advance care coordination across primary, hospital and long-term care sectors. Specialists play an essential role in treating patients with chronic conditions, but little attention is given to their organization out of hospitals, and their role in enhancing care coordination and patient-centered care provision.

In order to investigate different ways in which specialists are working out of hospital to integrate primary and social care, we carried out case studies in five countries (England, Germany, Italy, the Netherlands, and the United States). In each study, we examined how specialist care is organised around specific health conditions for integrating care in community. These case studies, carried out through site visits between June 2018 and March 2019, explore the organisation of care around patients by describing the coordination of roles and tasks between specialists and other health professionals involved in patient care, with a special attention to their innovative features and underlying financial models. A synthesis of results across five countries is available at: www.irdes.fr/recherche/2020/qes-248-decloisonner-les-prises-en-charge-entremedecine-specialisee-et-soins-primaires-experiences-dans-cinq-pays.html

This case study looks at the organization and functioning of two pioneer integrated care teams models in England where hospital specialists work closely with primary and long-term care providers and provide services outside hospital.

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