Chapter 14
Clinical Continuity by Integrated Care

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ABSTRACT

The fragmented delivery of healthcare and social services was put on the research agenda by WHO in 2002. Integrated Homecare (IHC) combining efficacy with net savings represents a prototype of integrated care for better clinical continuity. Frequent chronic conditions as stroke, heart failure and chronic obstructive pulmonary disease exhibit parallel results as explained by a common neuroeconomic framework. A SWOT analysis of IHC emphasizes: 1) Strength: health economic dominance; 2) Weakness: fragmented financial conditions; 3) Opportunity: low-tech patient benefits affordable to European countries facing tight finances as the elder share grows; 3) Threat: low levels of trust across professions and settings. A meso-strategy for EU recommends: 1) A health technology assessment (HTA) of IHC by multidisciplinary teamwork across the hospital and primary care interface synthesizes existing research for health care decision-makers. 2)Dissemination focuses on a regional level with direct contact between the clinical and financial level, see information on practical implementation guides at www.integratedhomecare.eu.

INTRODUCTION

A number of studies from the 1990s focused on healthcare problems related to the lack of clinical continuity. The fragmented delivery of healthcare and social services was put on the agenda as a major problem by WHO (Gröne, 2002) and was followed up by the European Commission and Council (Joint Report, 2003, p.15). However, a FP5 project on integrated health and social care for older persons (Leischenring, 2004) concludes that 'Integrated care (IC) 'by law' as a top-down implementation will certainly not suffice, and market mechanisms as bottom-up approaches

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are less likely to improve joint working and the development of shared visions'. What could then be done to overcome the problems of a fragmented delivery of healthcare?

Fragmented delivery and lack of clinical continuity is more relevant to chronic conditions (CC) than to time limited acute episodic care (Holman, 2004).

This chapter aims to review the present state of research on integrated care (IC) specific to chronic conditions (CC) focusing on the efficacy regarding Activities of Daily Living (ADL) in order to develop an effective and economic strategy for clinical continuity.

METHODS AND MATERIALS

General Strategy of Evaluation

The essence of IC is 'overlapping' services in the secondary/primary interface after discharge in contrast to coordination at the management level alone (Gröne, 2002, p. 2). IC should apply only as far as quality outcomes are improved with the overall aim to improve equitably distributed population health (Gröne, 2002, p. 3). He illustrates the causal relationships derived from IC as reproduced in figure 1.

Operational quality outcomes are crucial for the design of IC. Mortality is seldom a major indicator for IC. Typically, studies of effectiveness on IC address activities of daily living (ADL) as:

1. Referrals to permanent institutional care (i.e. nursing homes)
2. Independence in ADL as indicated by functional indices as Barthel Index (BI) or Functional Independence Measure (FIM)
3. Shortened length-of-stay at hospitals / less readmissions

Evaluation of the relationship between IC and outcomes will follow best international practice as formalised in the international operation of Health Technology Assessment (HTA). According to the definition of HTA by EUnetHTA:

Health technology assessment (HTA) is a multidisciplinary process that summarises information about the medical, social, economic and ethical issues related to the use of a health technology in a systematic, transparent, unbiased, robust manner. It aims to inform the formulation of safe and

Figure 1. Action model for integrated care (IC)