INTEGRATED CARE AND CARE PATHWAYS: HOW TO MANAGE IT ?

Jean Macq

Jean.macq@uclouvain.be

IRSS-FSP UCLouvain

INTEGRATED CARE TOMORROW?

First line territorial organisation in Flanders, Brussels and Wallonia

Interfederal plan for integrated care (teams, coordination and case managers, care pathways)

Hospital networks and payment reform

Revised professional boundaries

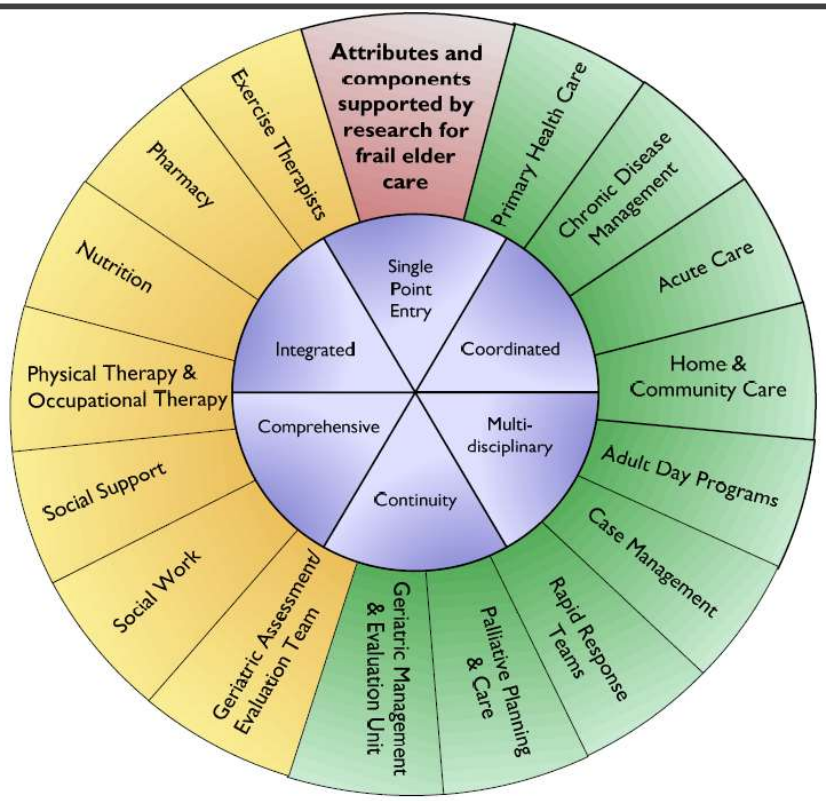
STRUCTURE

- Older people health
- Clinical or operational integration
- Professional and organisational integration
  - Care pathways
  - Advocacy, case manager
  - Territories
- Combination of the three logics

OLDER PEOPLE HEALTH

MULTIPLICITY OF SERVICES NEEDED

Interventions and services

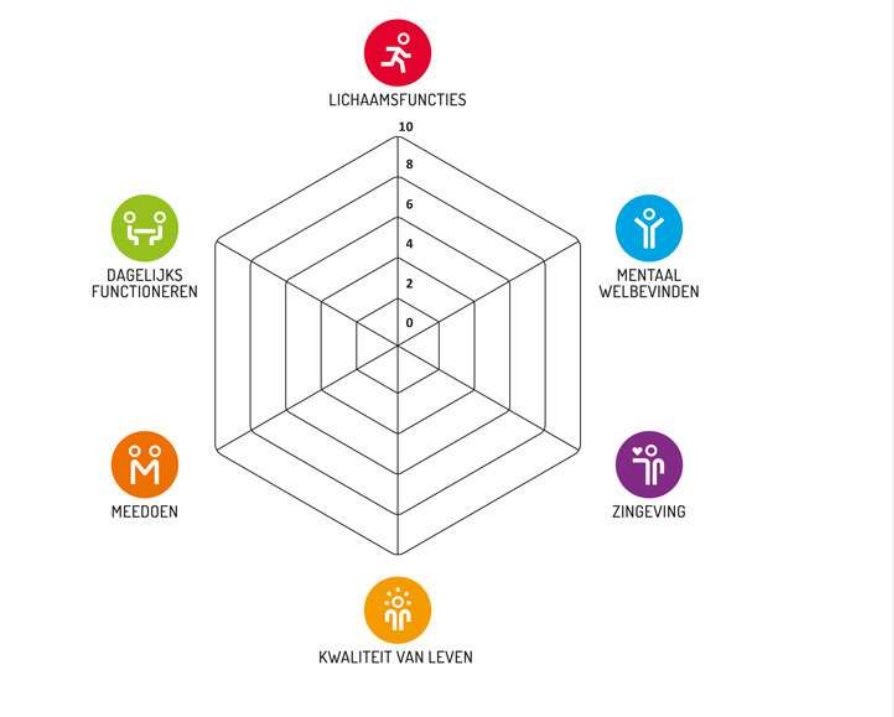


Modalities of HC provision

Figure 1: Attributes and components supported by the research for frail elder care

A POSITIVE APPROACH OF HEALTH (CFR [HTTPS://IPH.NL/](https://iph.nl/))

INSTITUTE FOR POSITIVE HEALTH



"Health as the ability to adapt and self-manage, in light of the physical, emotional and social challenges of life".

CLINICAL OR OPERATIONAL INTEGRATION

CLINICAL OR OPERATIONAL INTEGRATION

Care integration

- Comprehensiveness
- Continuity, …

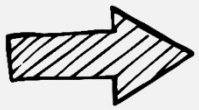
CARE INTEGRATION

Capacity to express life goals?

Why health care?

Beneficiary caracteristics

People needs and resources?



Care integration

Package of services

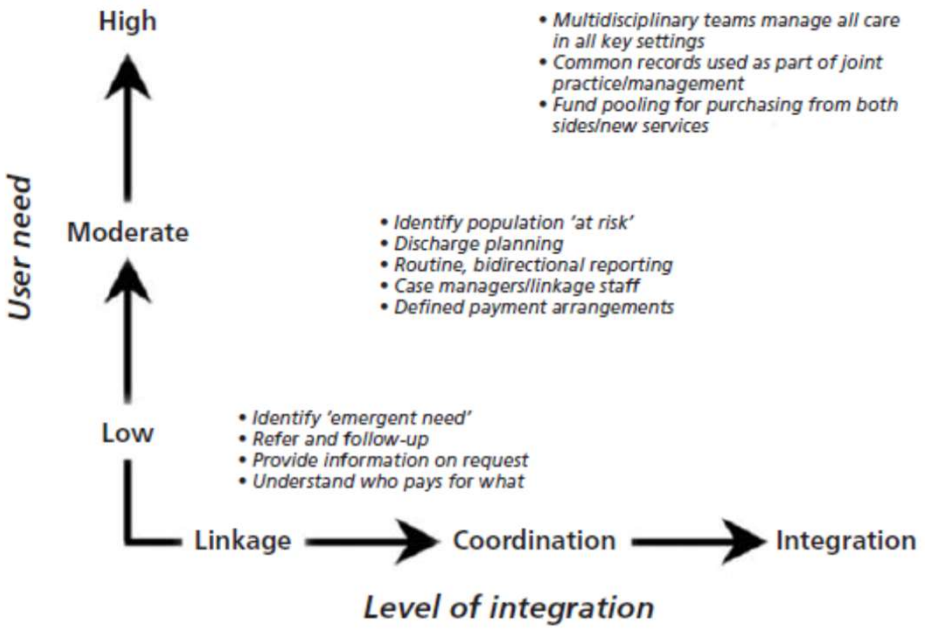
Number of professionals and organisantions?

Comprehensiveness

Continuity, …

DIFFICULTY OF INTEGRATION AND OLDER PEOPLE NEEDS IN GERIATRICS?

Fig. 1 Levels of integration and user need as described by Leutz (1999).



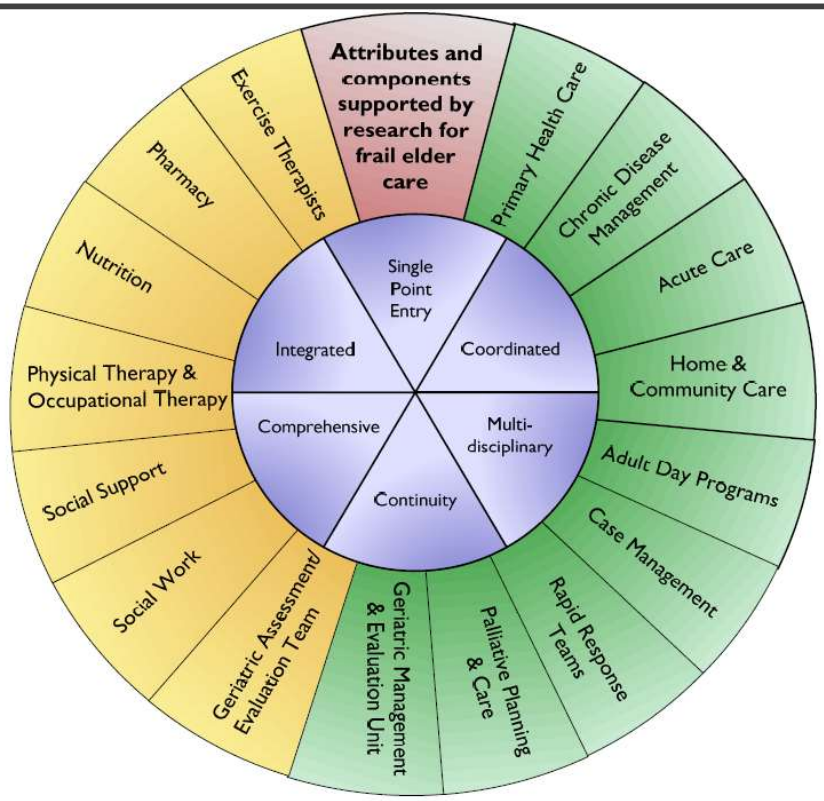
Source: Nolte & McKee (2008b).

PROFESSIONAL AND ORGANISATIONAL INTEGRATION TO SUPPORT CLINICAL INTEGRATION

CARE PATHWAY LOGIC

STARTING POINT

Interventions and services



Modalities of HC provision

Figure 1: Attributes and components supported by the research for frail elder care

CARE INTEGRATION

Care integration

- Comprehensiveness
- Continuity, …

DEFINE THE PACKAGE OF CARE NEEDED: POPULATION STRATIFICATION

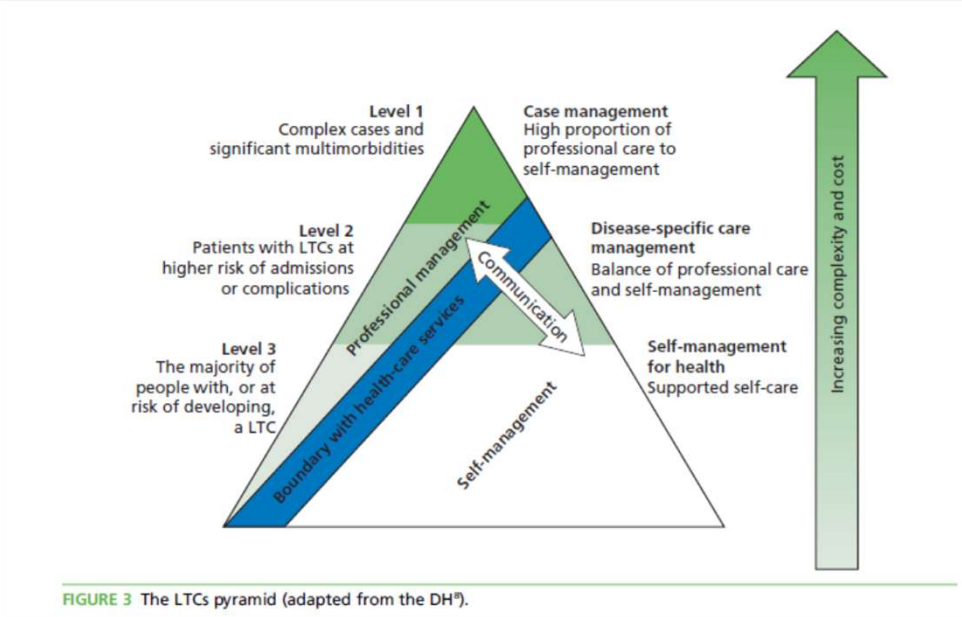


FIGURE 3 The LTCs pyramid (adapted from the DH[9]).

- Dependency levels
- Autonomy

DEPENDENCY PROFILES

5 Profiles of dependancy within 65 ans and +

Méthode : Créer à partir d'échelles cliniques collectées via une évaluation gériatrique globale (BelRAI)

Identification of need for specific services

Faible limitation

IADL, léger trouble cognitif  → family help / ménagère

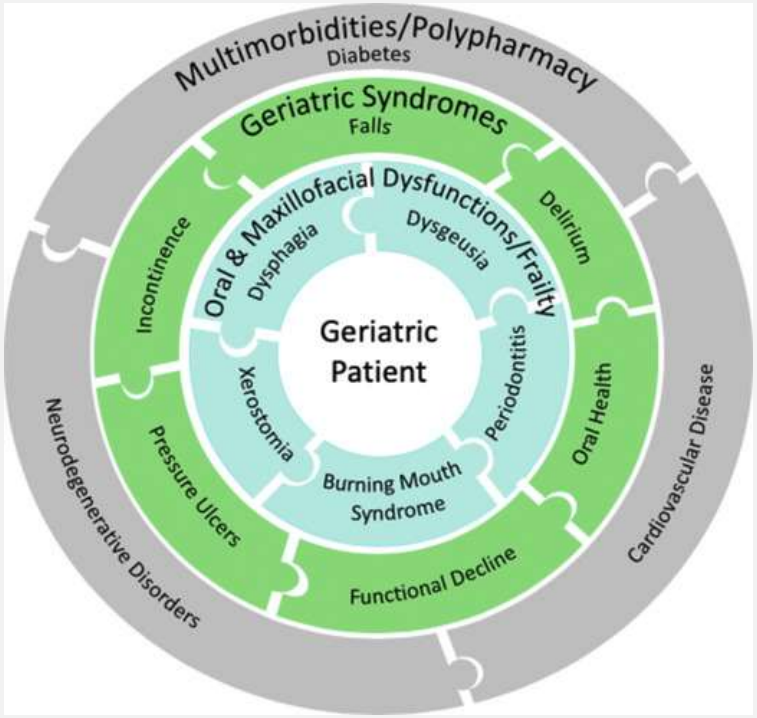
ADL functional limitation +  → nursing at home

ADL functional limitation & cognitives +  → nursing at home + surveillance

ADL functional limitation cognitives & Behaviour troubles +   → nursing at home + surveillance 24h/24

Adéquation entre les besoins et les services fournis

GERIATRIC SYNDROMA



CARE INTEGRATION

Capacity to express life goals?

Why health care?

Beneficiary caracteristics

People needs and resources?

Care integration

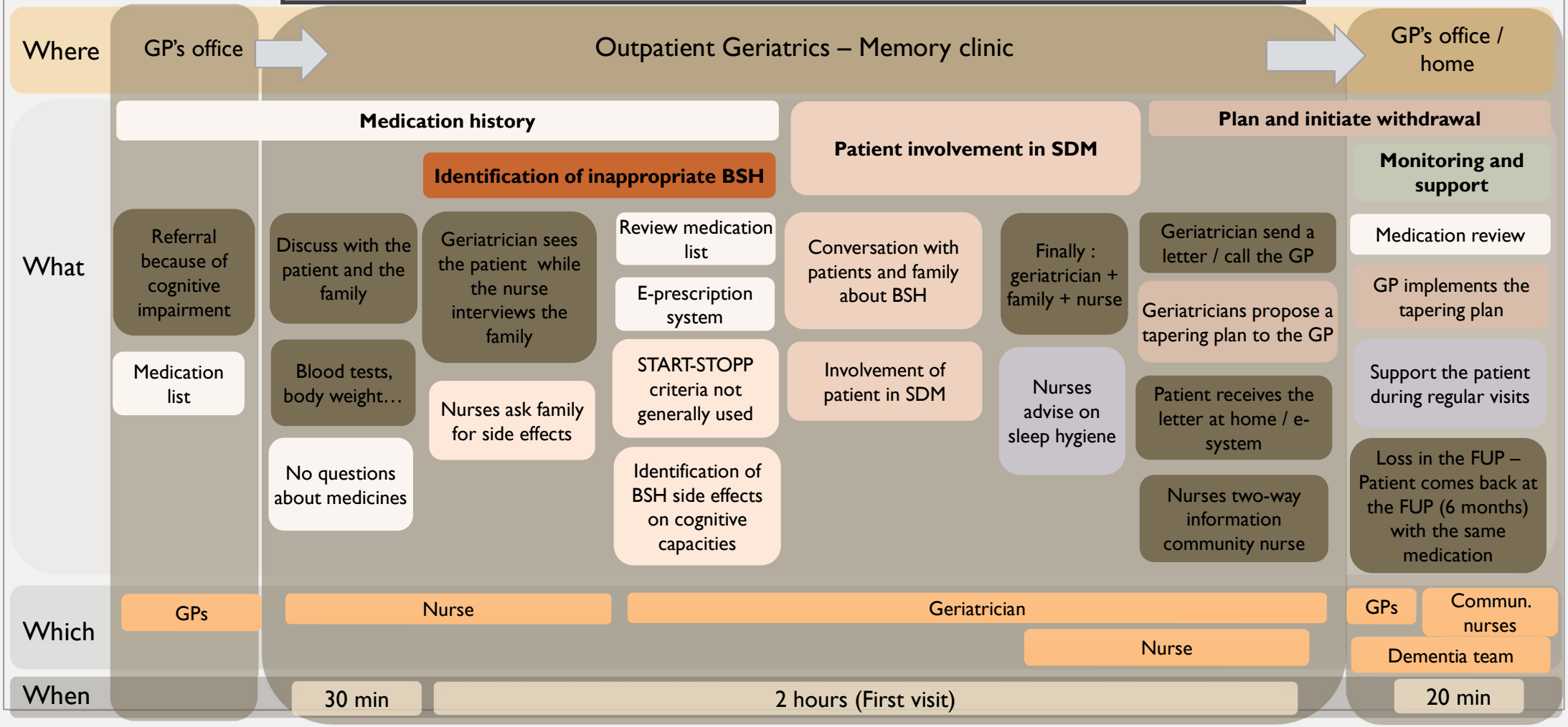
Package of services

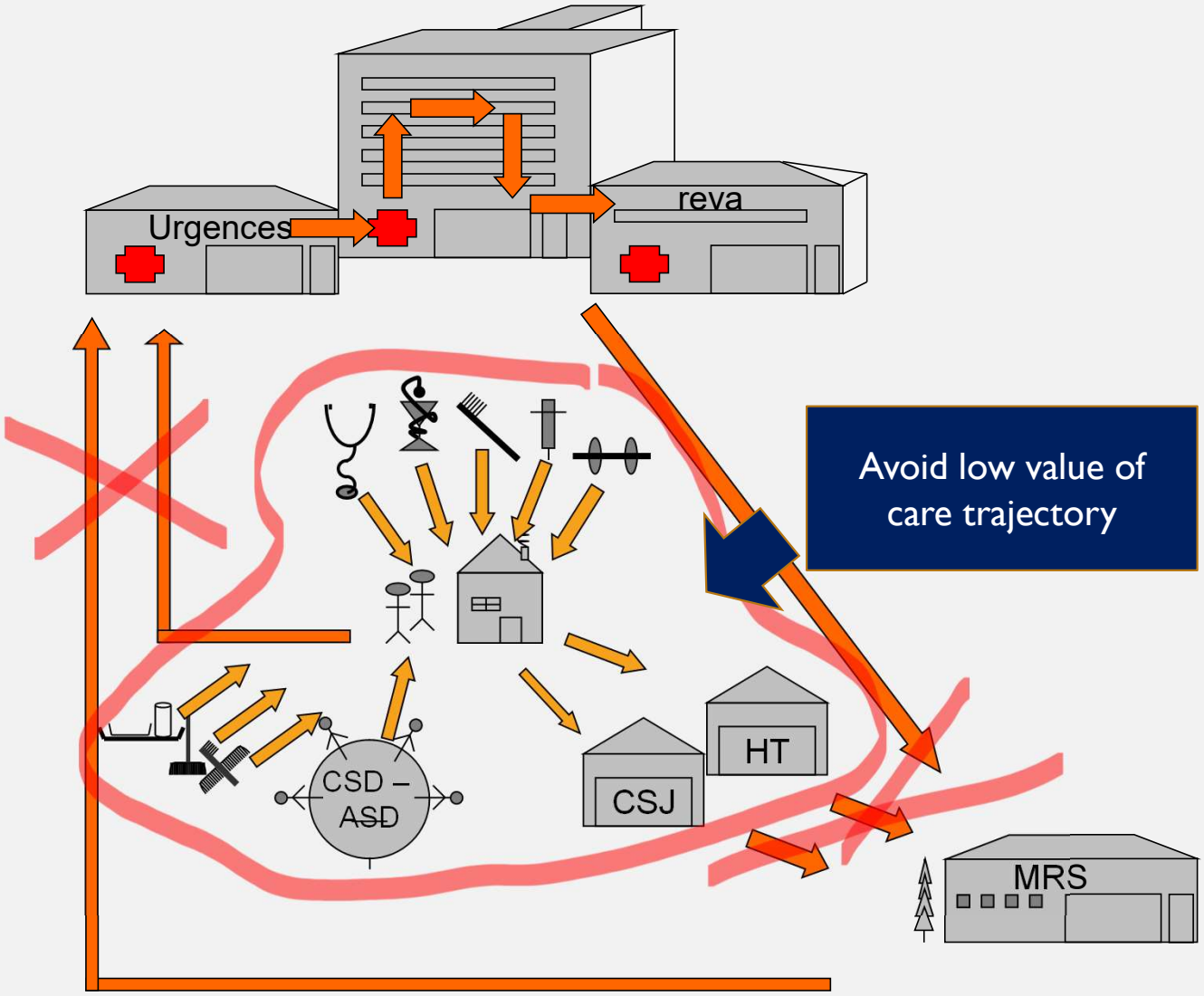
Number of professionals and organisantions?

Comprehensiveness

Continuity, …

UNDERSTAND CARE TRAJECTORY (MARIA LOPEZ TORIBIO) PER PROFILE OR PER GERIATRIC SYNDROMA

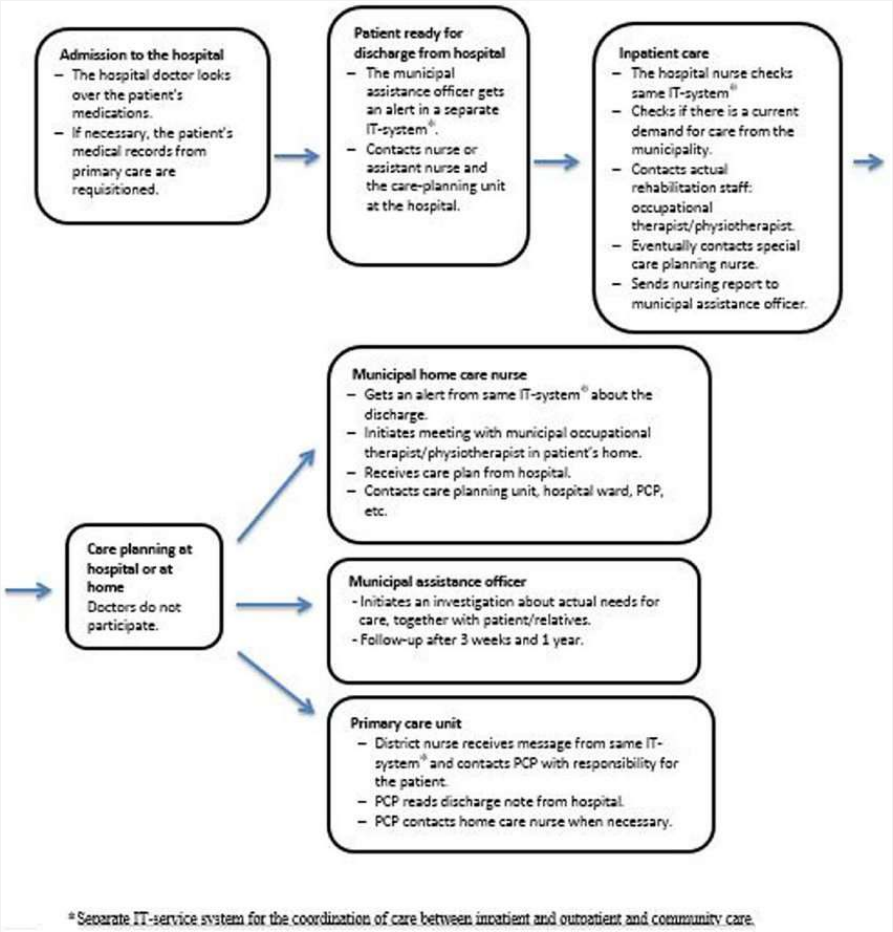




Inspired from Pierre Blaise

FROM HOSPITAL TO…

Hansson, A., et al. (2018). "Flawed communications: Health professionals' experience of collaboration in the care of frail elderly patients." Scandinavian journal of public health **46(7): 680-689.**

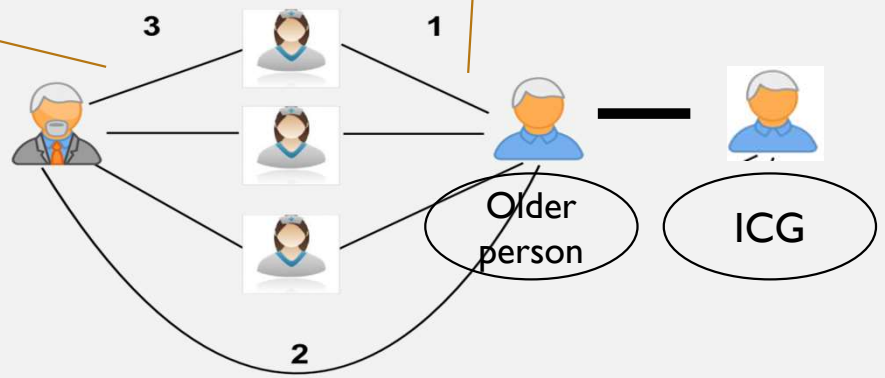


ADVOCACY ROLE, COORDINATION AND CASE MANAGER

ADVOCACY RÔLE → CASE MANAGERS?

Coordination of providers

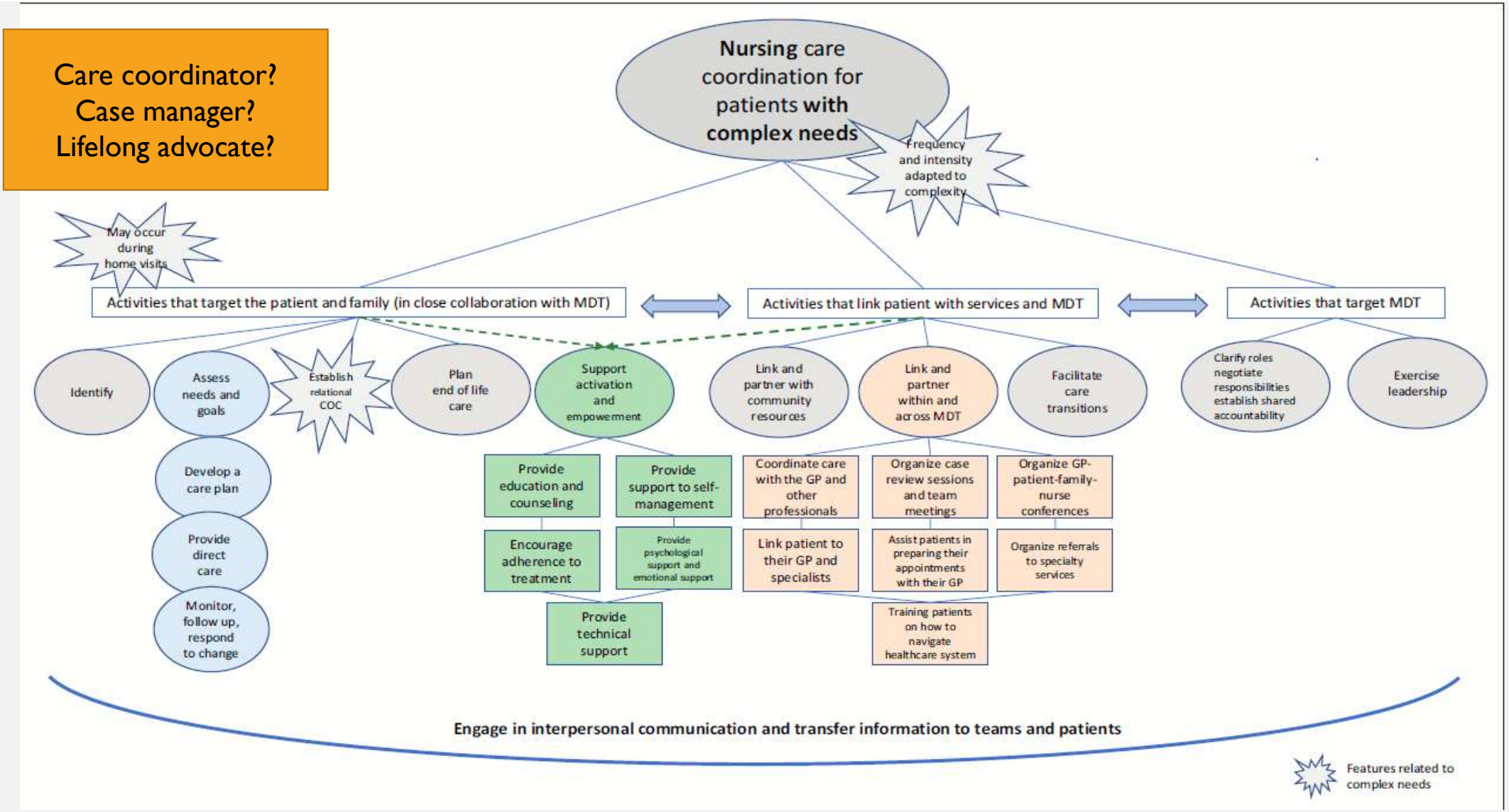
Care provision



- Knowledge of life, preferences, needs, resources
- Advocacy role

Chiem et al, 2013

Care coordinator?
Case manager?
Lifelong advocate?



A model of nursing care coordination activities for patients with complex needs.

Karam, M., Chouinard, M. C., Poitras, M. E., Couturier, Y., Vedel, I., Grgurevic, N., & Hudon, C. (2021). Nursing care coordination for patients with complex needs in primary healthcare: A scoping review. *International Journal of Integrated Care*, *21*(1), 1–21. https://doi.org/10.5334/ijic.5518

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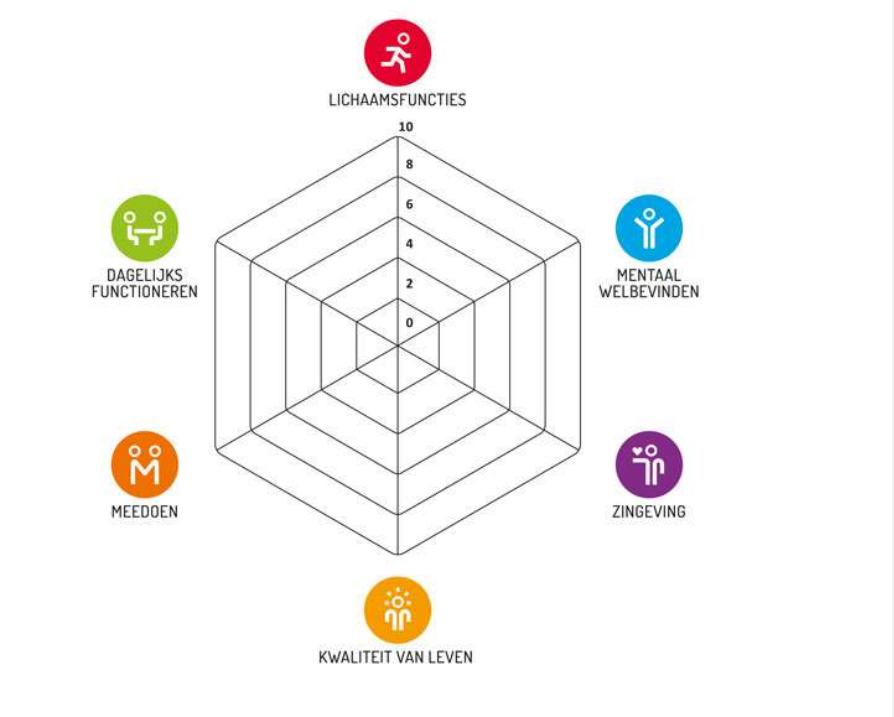
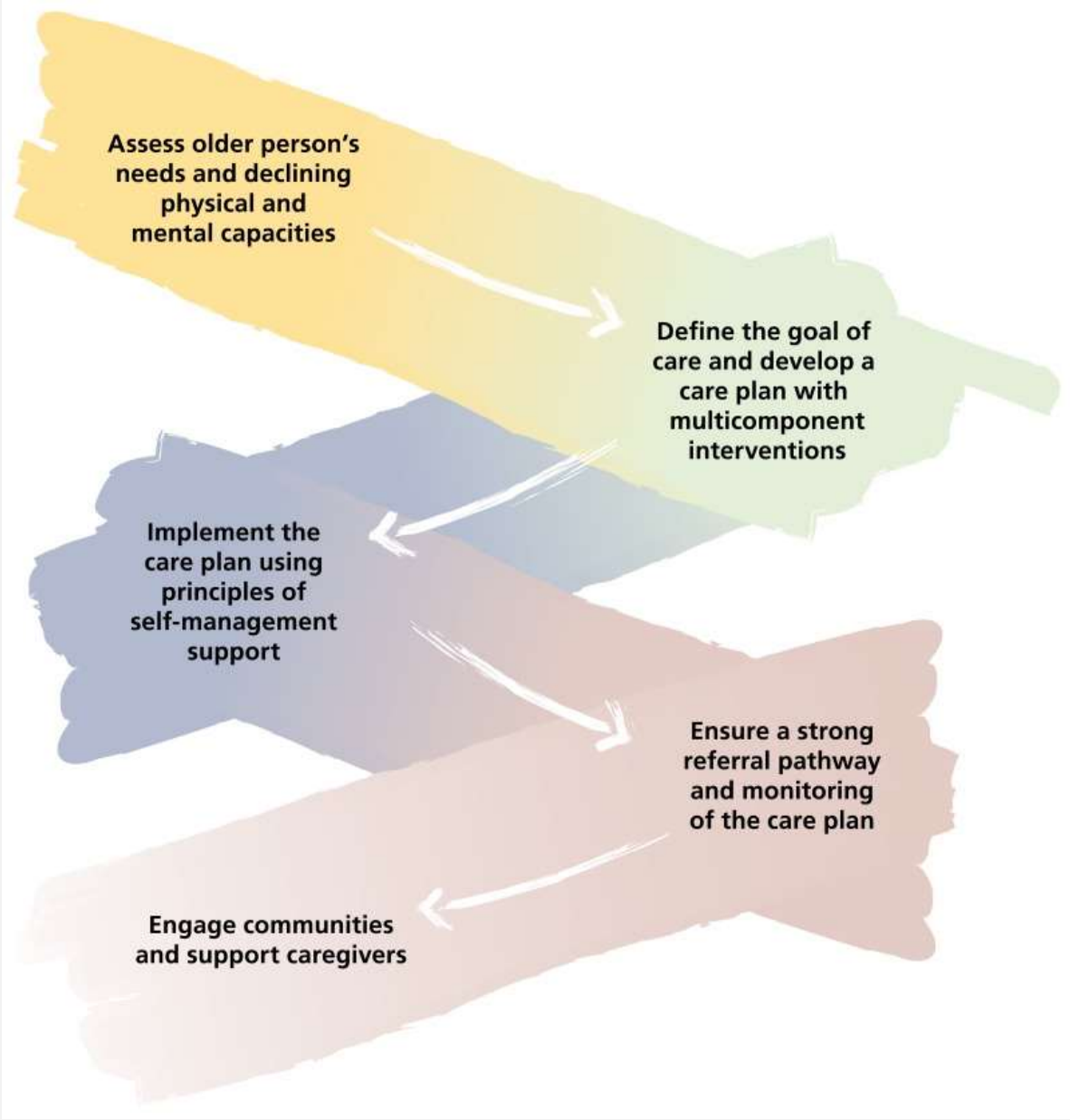


"Health as the ability to adapt and self-manage, in light of the physical, emotional and social challenges of life".

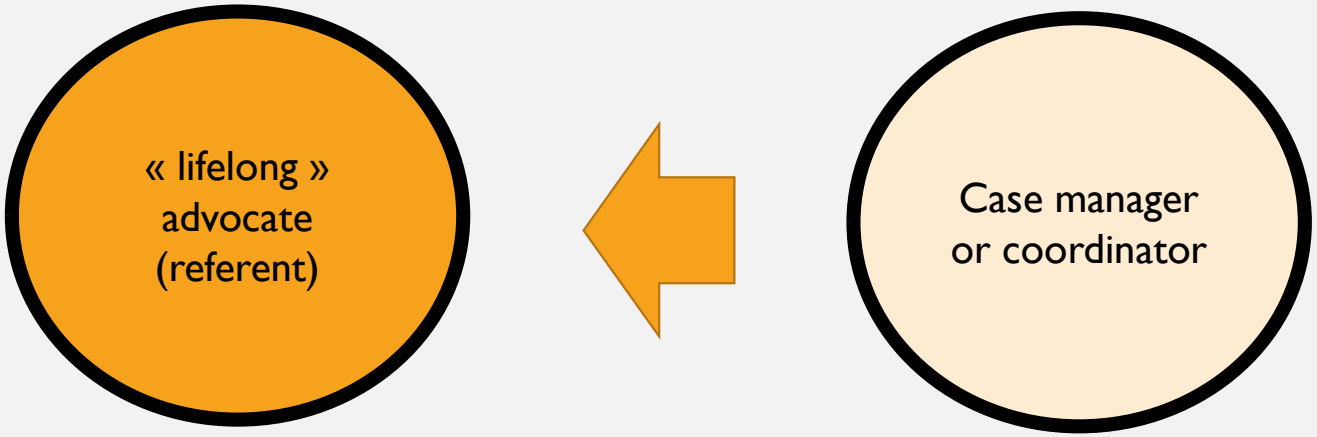
EXAMPLE OF PAERPA IN FRANCE

ICOPE - WHO

Integrated Care for Older People: Guidelines on Community-Level Interventions to Manage Declines in Intrinsic Capacity. Geneva: World Health Organization; 2017. 4, Implementation considerations. Available from: https://www.ncbi.nlm.nih.gov/books/NBK488249/

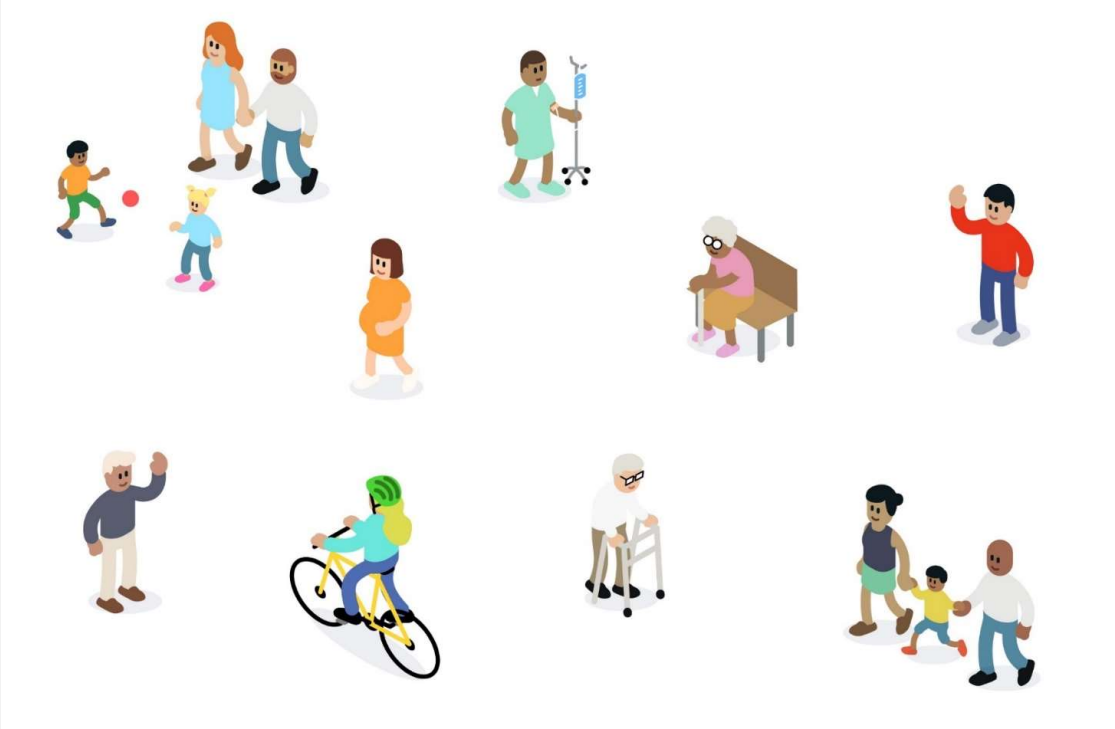


LIFELONG ADVOCATE AND CASE MANAGER

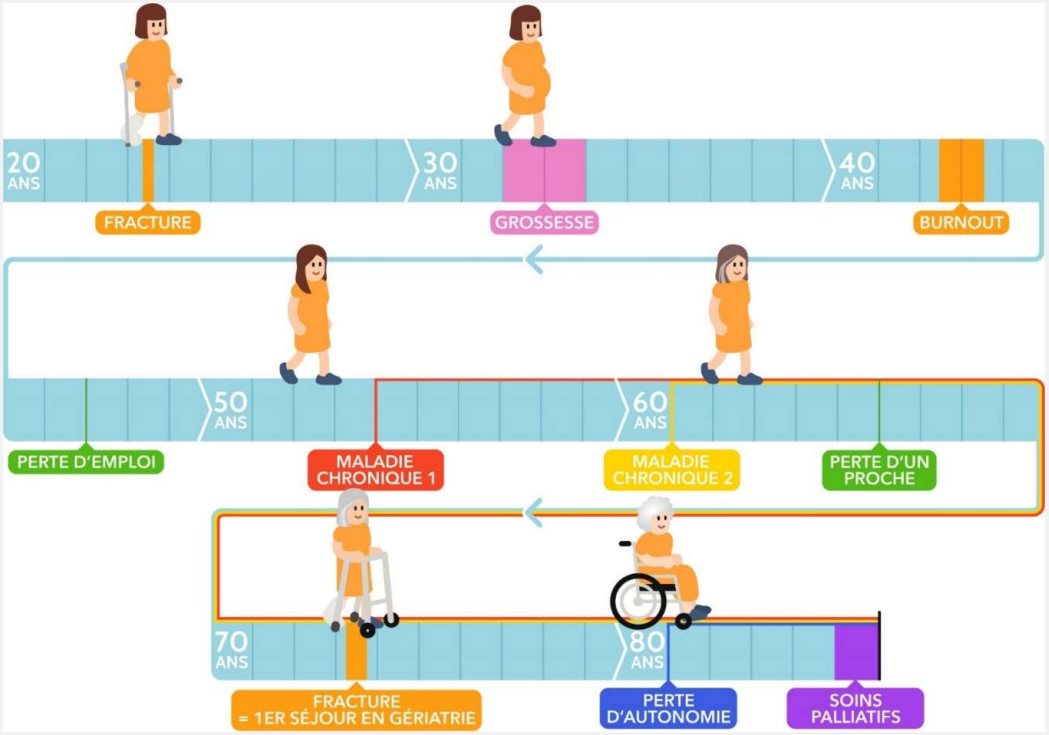


TERRITORIAL LOGIC

DIFFERENT LIFE SITUATIONS



DIFFERENT LIFE COURSES



DIFFERENT END OF LIFE

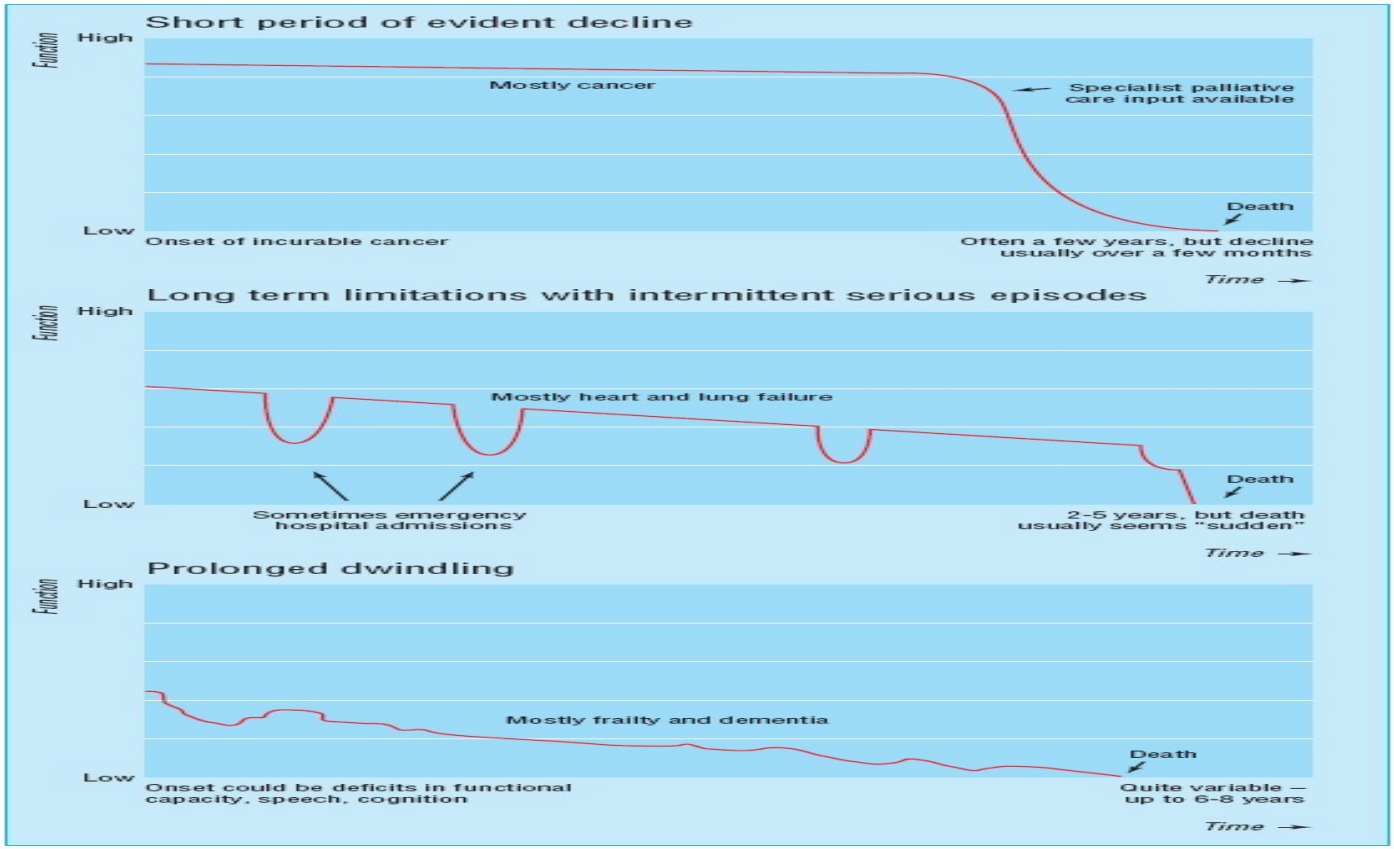
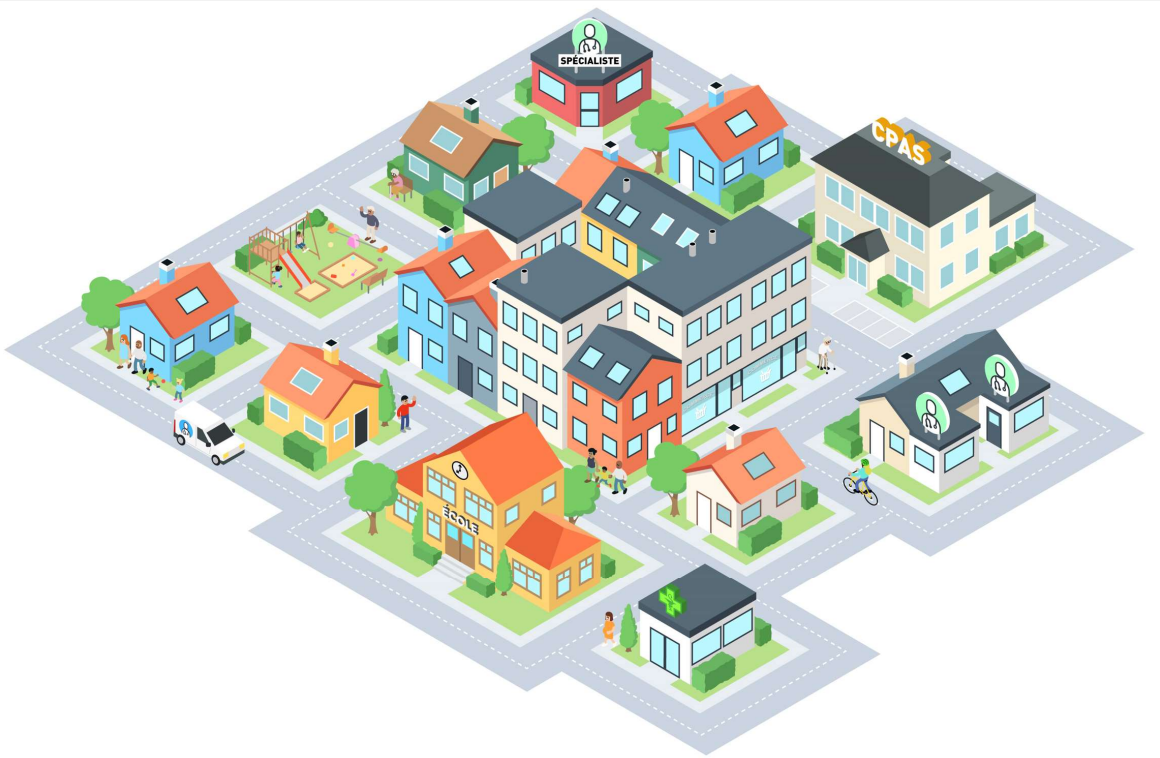
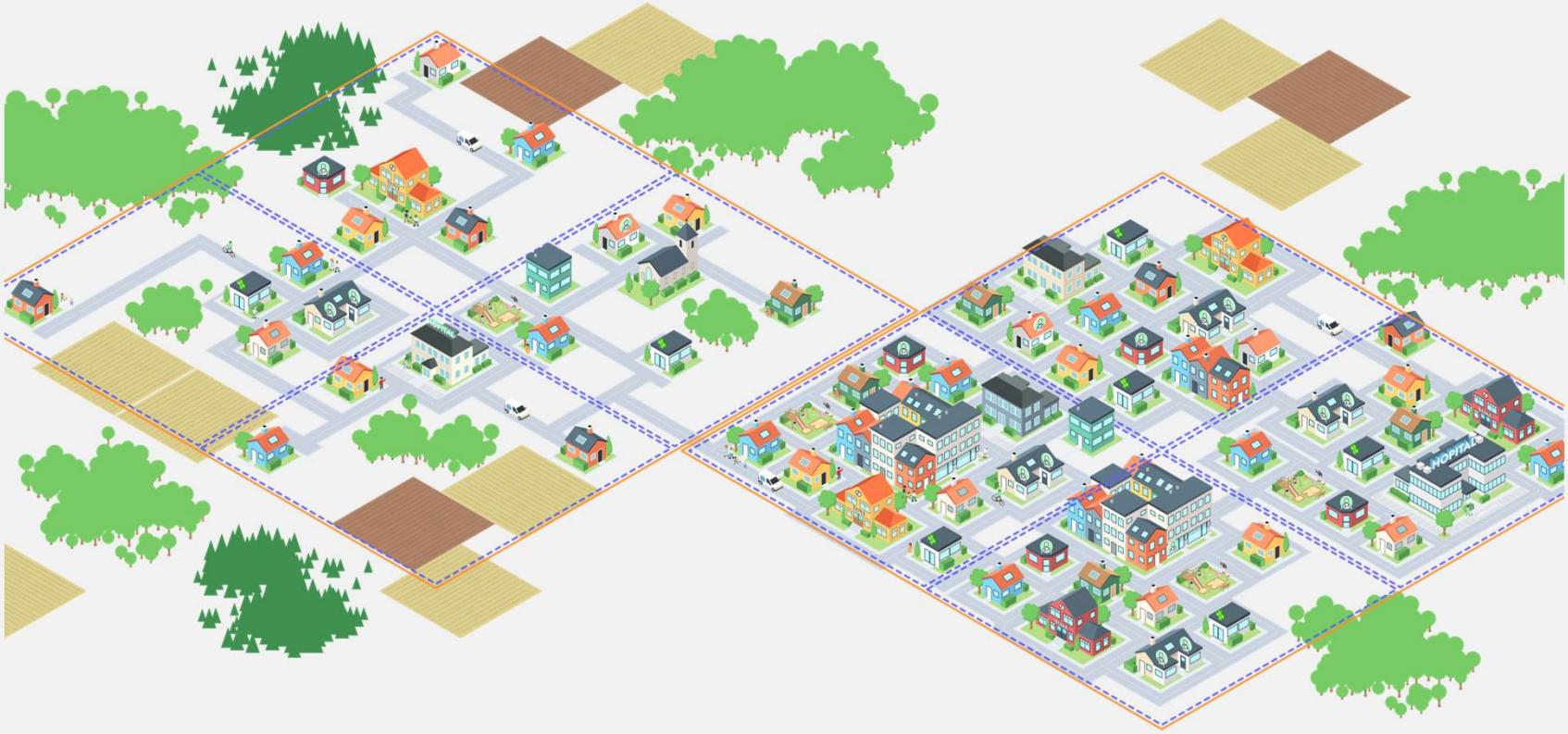


Fig 1 Typical illness trajectories for people with progressive chronic illness. Adapted from Lynn and Adamson, 2003.[7] With permission from RAND Corporation, Santa Monica, California, USA.

..IN A LIVING AREA



IN LARGER TERRITORIES



SUPPORTIVE SPECIALIZED SERVICES

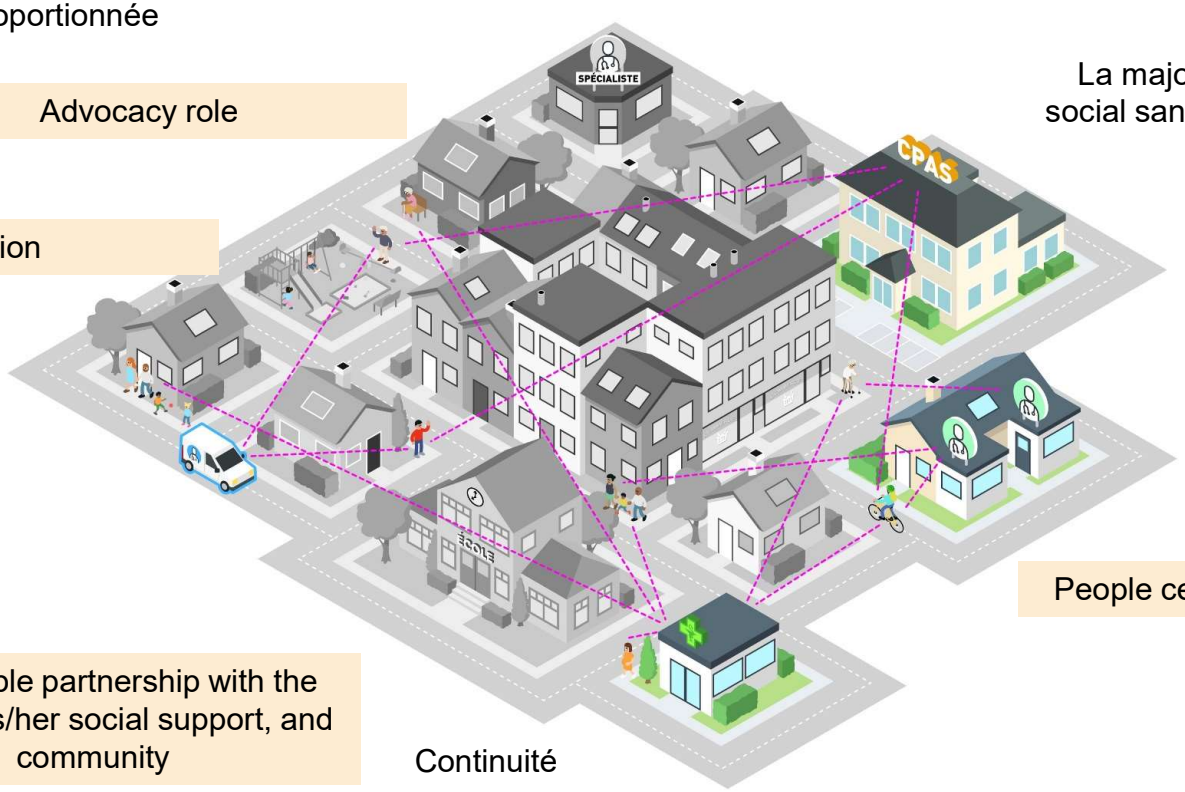
Hospital networks with «high technicity » versus proximity

MULTIDISCIPLINARY PRIMARY CARE TEAMS IN «LIVING AREA »

Accessibilité universelle proportionnée

Advocacy role

Coordination



La majorité des besoins social santé de la population

People centered care

Sustainable partnership with the patient, his/her social support, and community

Continuité

AUDACE

24 janvier 2024

Equipe de recherche :

Lucia Alvarez-Irusta
Tatiana de la Croix
Antoine Filipović-Pierucci
Anne Ledoux
Thérèse Van Durme

En collaboration avec : Emilie Jadin
Véronique Manguette
Sophie Thunus

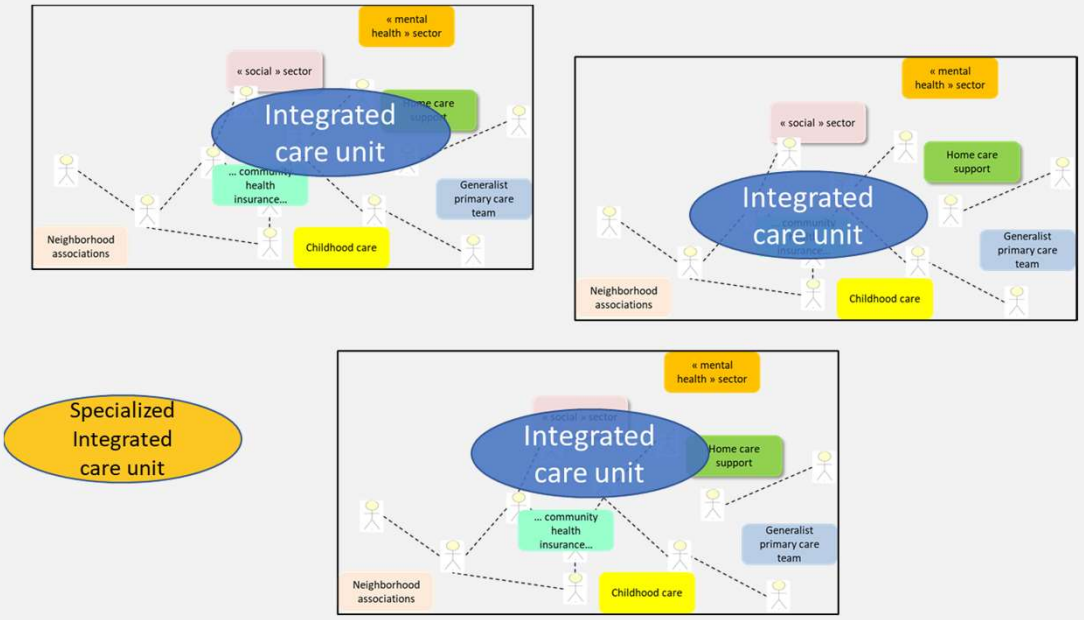
UCLouvain
Institut de recherche santé et société

Haute École Léonard de Vinci

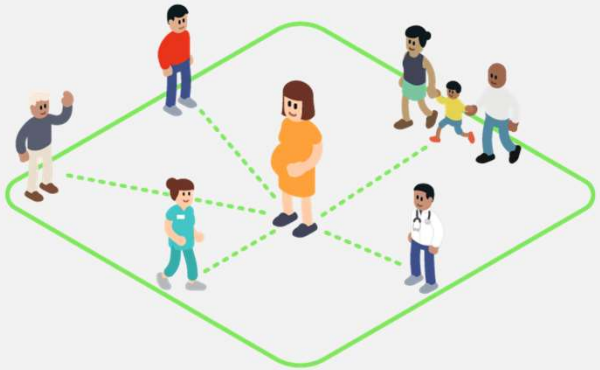
be.hive

DEFINE THE PACKAGE OF CARE NEEDED: POPULATION CLUSTERS

- Life realities
- Life course
- End of life



3 LEVELS OF TERRITORIES



TOMORROW?

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