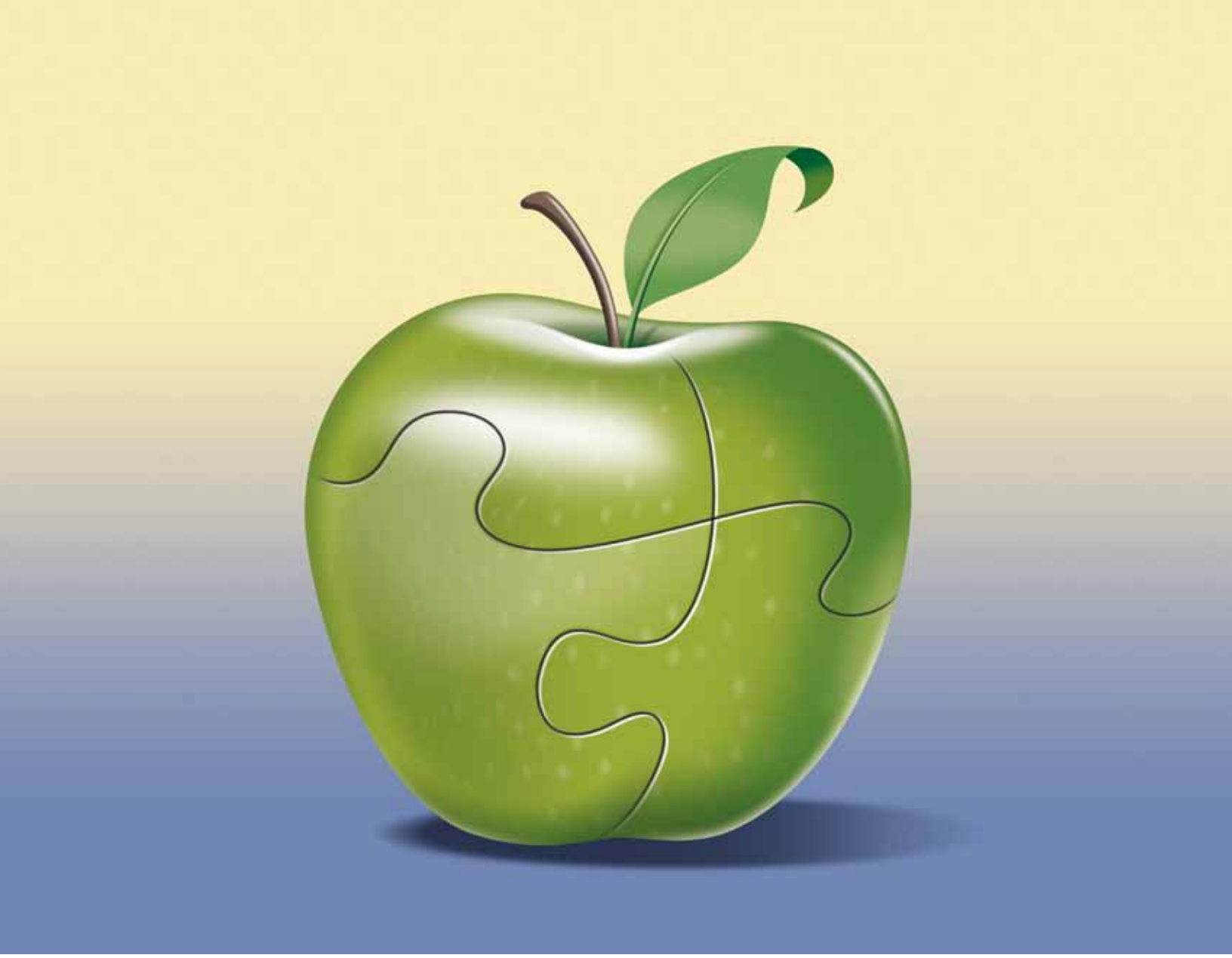

What it takes to make integrated care work

New McKinsey research shows that integrated care can be implemented in virtually any health system. However, three elements are necessary to ensure success.

Kara Carter; Elissa Chalouhi; Sorcha McKenna, PhD; and Ben Richardson

Population aging, the rising rate of chronic diseases, and the growing prevalence of multimorbidity are taking their toll — on patients' health and health system economics — in countries around the world. But as the preceding article ("Providing better care at lower cost for multimorbid patients") makes clear, integrated care can help health systems cope with these issues by enabling them to offer patient-centric treatments that improve outcomes and control costs. It is hardly surprising, therefore, that an increasing number of organizations are exploring the use of integrated care. Many of these groups have found, however, that getting integrated care right can be difficult.

We interviewed executives at more than 40 of these systems to identify the factors that can allow integrated care to succeed. Some of these groups, such as Kaiser Permanente and Geisinger Health, have been delivering integrated care for many years. Others, including Prosper Knappschaft and NHS North West London, implemented integrated care more recently. By talking to executives at both types of systems, we were able to understand what it takes to get integrated care off the ground and what is needed to make it work over the long term.

We found that successful integrated care systems share three traits (Exhibit 1): They focus their efforts on the patient segments most likely to have high health care spending (e.g., the elderly and those with chronic diseases). They change their core care delivery processes to enable multidisciplinary teams to function effectively. And they put in place several crucial components to support their integrated care efforts. As a result, they create strong partnerships among all participants that enable a "virtual" integrated health system to develop — even in countries that actually have fragmented health systems.

This last point may be one of the key findings of our research: integrated care can be implemented successfully in practically any type of health system. It does not depend on the presence of a single payor or single point of control. Implementation is difficult, and success cannot be achieved quickly. But if the elements we describe below are in place, integrated care can work almost anywhere.

Clear focus on specific segments/diseases

Many health systems have found that a small minority of patients account for a disproportionately large share of total costs; often, half or more of those costs are spent providing care for only 10 percent or 20 percent of the population. Successful integrated care efforts are designed to address this discrepancy in spending. They stratify patients based on their health care needs and then carefully tailor the interventions they offer to each group. In particular, they focus their most intensive interventions on the patients at the highest risk of needing recurrent hospitalizations or other expensive treatments. As a result, they are able to target resources where there is the greatest opportunity to reduce subsequent costs.

This approach makes good clinical sense — comparatively healthy people do not require the same level of services as do patients with multiple poorly controlled conditions, for example. However, varying the level of service intensity also makes good economic sense, because it avoids the possibility that expensive services are delivered to those who are unlikely to derive much benefit from them.

Exhibit 1

Three sets of elements help support successful integrated care

COPD, chronic obstructive pulmonary disease.

Emphasis on multidisciplinary care

The executives we spoke with from successful integrated care systems agreed: simply redesigning care pathways on paper is not sufficient to make change stick. To make integrated care work, all participants must be willing to redesign their core processes to create — and sustain — a multidisciplinary care delivery system that includes several specific features. By working together to change their core processes, and then by working together on an ongoing basis to provide multidisciplinary care, the participants form the partnerships that permit a virtual health system to develop.

One of the key changes they typically make is to introduce patient registries. Because integrated care requires a deep understanding of patients' risk status and needs, the participants pool their data to ensure that care is appropriately coordinated and patients' needs are met. Our research demonstrated, however, that sophisticated IT tools are not a prerequisite for using patient registries. Although fully functioning electronic health records are probably the optimal way to share information, a number of the systems we investigated achieved strong results with very simple IT or even paper-based methods. It is sharing, understanding, and using the information in the

patient registries that is critical, not the format through which the information is delivered.

In addition to its role in direct patient care, the registry information can be used in a second way: it can be analyzed regularly to identify the patients likely to have complex and expensive care needs — especially a high risk of recurrent hospitalizations — in the near future. To risk-stratify patients accurately, the best integrated care efforts combine algorithmic predictive modeling with clinical judgment. Because no perfect predictive modeling method exists, the algorithmic models are used to screen patients' records initially and then a physician reviews the results to check for false positives and false negatives. As an added assurance, the physician's results are reviewed regularly by a multidisciplinary team.

Another key change that participants in successful integrated care efforts make is to ensure that all patient care is delivered by teams rather than individuals. These teams include nurses, medical assistants, and other health care workers, as well as primary care physicians and specialists.

To help ensure that all care is well coordinated, regardless of where or by whom it is provided, the participants use evidence-based protocols to define best practices. All team members, including physicians, are expected to follow the protocols or note why an exception must be made. The protocols include a clear statement of the professional qualifications needed to deliver each intervention, enabling all team members to practice at the top of their license.

Each multidisciplinary team meets regularly to review its performance relative to its peers and the expectations set for it. A focused set of key metrics guides the discussion. Is the team succeeding in reducing unnecessary hospitalizations? Is it improving care quality and reducing the total cost of care for patients with specific chronic diseases? All teams have access to transparent data on costs and clinical outcomes — both their own results and those achieved at the patient-panel level (a sample large enough to be statistically significant). Team members are also given data about how well they performed individually on important process metrics. This type of review encourages improvement by raising aspirations and by increasing accountability at both team and individual levels.

Two other features are hallmarks of successful integrated care. First, each patient is given an individualized care plan designed specifically for his or her risk level and needs. The plans are developed with the patients' input and reviewed regularly with them; they are also revised periodically to allow for course corrections, when necessary.

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Second, multidisciplinary case conferences are held regularly to review the care being given to the highest-risk patients. The case conferences help ensure that the care these complex patients need is delivered as effectively as possible.

Key support components

Our research revealed that five "enablers" must be in place if integrated care is to succeed. These enablers are far from easy to establish and often take several years to set up. But they provide the base that makes long-term success possible.

Accountability and joint decision-making

In successful integrated care efforts, accountability begins at the top — the executive boards of the sponsoring organizations demonstrate strong and visible support for the efforts. The reason is simple: when multiple stakeholders with potentially conflicting interests must join together to deliver integrated care, leadership from the top and clear agreement among board members are necessary to ensure that alignment can be obtained further down.

However, joint decision-making is also crucial to achieve alignment. Because integrated care requires, at its core, a partnership among participants, all stakeholders must be made to feel that they have an equal role in decision-making. They should all be given the opportunity to voice their concerns and participate actively in crafting solutions.

Accountability and joint decision-making are equally important for the multidisciplinary teams. Although primary care physicians hold central responsibility for care delivery, all team members are accountable for patient well-being and must be given the opportunity to voice their opinions about care delivery. Appropriate clinical governance mechanisms and standing agreements must be in place to ensure that this can occur and that all team members can practice at the top of their license.

Clinical leadership

Strong clinical leadership is also paramount for integrated care. The clinical leaders must be able to articulate a clear vision about the need to improve patient care and how integrated care can produce the needed improvements — both initially (when integrated care is first implemented) and on an ongoing basis. In addition, the clinical leaders must be able to build and maintain mutual trust and collaborative relationships with others throughout the health system.

Clinical leaders must also play several other important roles. They must spearhead the development and periodic updating of the evidence-based protocols used to deliver care, work with clinicians to achieve alignment about the protocols' content, and serve as role models to encourage all clinicians to adopt the desired behaviors.

Information sharing

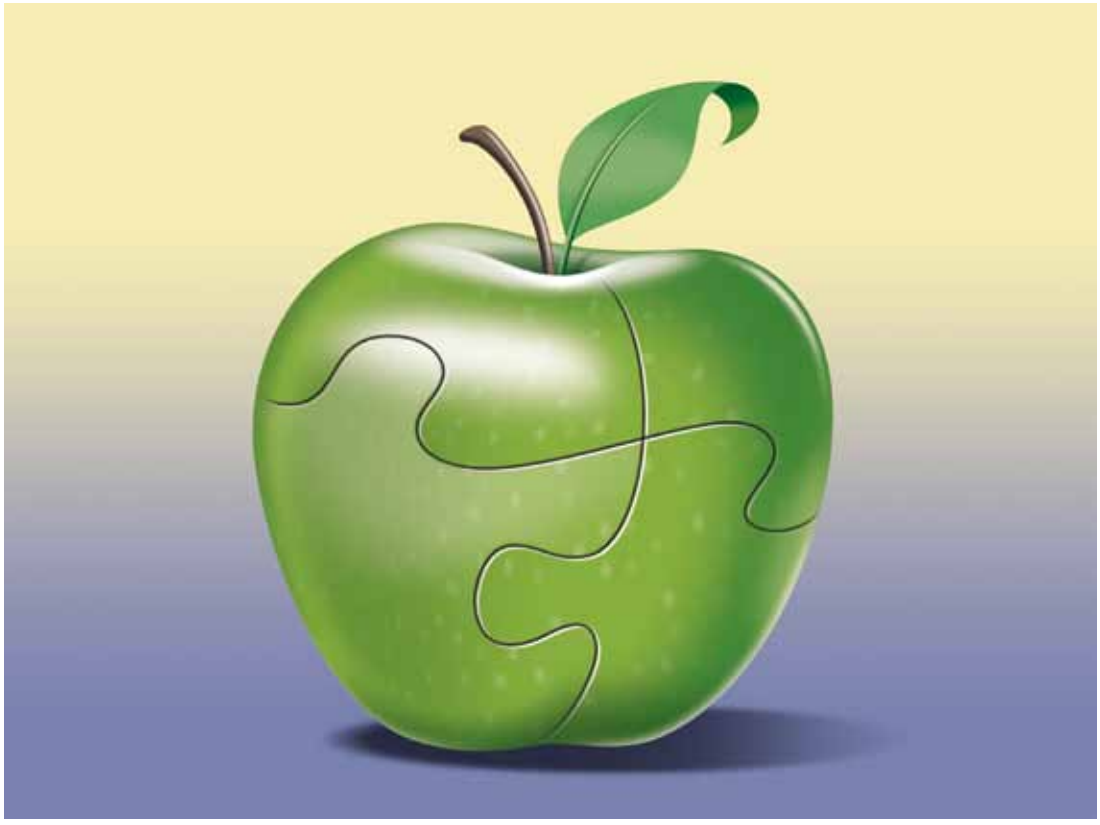
For integrated care to succeed, all clinicians who provide care to a given patient must have access to the clinical information about that patient, regardless of where previous treatments were delivered. In the best integrated care efforts, the IT systems not only enable information sharing but also include decision support mechanisms and prompts to facilitate compliance with treatment protocols. (As discussed earlier, however, full electronic health records are not a prerequisite.)

Information sharing has other benefits as well. The resulting transparency about individual clinical performance encourages improvement efforts — peer pressure is a powerful mechanism for improving care quality.[1] Information sharing also enables systems to develop clear metrics and scorecards that are sufficiently credible to drive reimbursement decisions.

Aligned incentives

Successful integrated care efforts include carefully defined incentives to ensure that incremental improvements result in economically positive outcomes for all stakeholders. For example, when integrated care leads to a reduction in the total cost of care, all parties are given a share of the savings; this offers them all an incentive to work toward the same goal.

Successful efforts also recognize that integrated care can sometimes result in revenue losses for some stakeholders; for example, hospitals often find that their income declines when certain



[1] For more information on the role of information sharing in improving care delivery, see "Transparency — the most powerful driver of health care improvement?" on p. 64.

"Financial incentives alone are not sufficient to ensure success. They must be employed in tandem with nonfinancial measures, such as peer pressure, to improve performance."

forms of care are shifted into the community and inpatient volumes drop. The sponsors therefore take steps (in parallel with their integrated care efforts) to help the hospitals reduce incremental costs and thereby improve their margins.

In all cases, the incentives offered must be sufficiently attractive to appropriately compensate stakeholders for their increased clinical workload or lost revenues (once incremental costs have been reduced). Furthermore, the mechanisms used to distribute and pay out the incentives must be fully transparent. However, financial incentives alone are not sufficient to ensure success. They must be employed in tandem with nonfinancial measures, such as peer pressure, to improve performance.

Patient engagement

Active patient involvement is crucial for good integrated care. In successful efforts, team members work directly with patients to develop their care plans; this approach helps foster the patients' commitment to those plans. Successful efforts also provide patients with information and tools to enable them to take greater control over their own health (e.g., test results are sent directly to the patients as well as to their physicians). In addition, these efforts offer education programs for patients and their care givers, and they have mechanisms that enable them to track patient compliance with care.

Integrating care in fragmented systems

We have often been asked a number of similar questions about integrated care: Can it succeed only in a fully integrated, monolithic health system? Does it require that clinicians be health system employees? If not, does success depend on capitated reimbursement?

Our research proves that integrated care can be provided successfully in virtually any type of health system — even one with multiple independent payors and providers. Furthermore, it does not require specific forms of clinician employment or reimbursement. Admittedly, the challenges to implementation may be greater in fragmented health systems, but those challenges can be overcome. During our research, we identified two approaches that are commonly used to implement integrated care in fragmented systems. One is sponsored primarily by payors; the other, by provider partnerships.

Payor-sponsored integrated care is typically market-driven, and thus incentives and reimbursement schemes play an especially large role; payors use them to encourage clinicians (especially physicians) to change their behavior. In essence, the payors take advantage of their traditional, core competencies to create the right environment for clinical transformation (e.g., by developing innovative payment models to encourage change and by using their existing

databases to give providers access to patient-level information from all settings of care). The payor-sponsored approach also puts heavy emphasis on delivering timely, robust performance data to all clinicians. In addition, it usually attempts to scale up the integrated care efforts fairly quickly with relatively small investments.

Examples of payors that have created integrated care systems include AOK in Germany and CareFirst in the United States. CareFirst, for instance, has developed a patient-centered medical home program that makes members' health records available online to all providers. In addition, it gives substantial incentives to providers that achieve favorable quality and cost outcomes; however, it has also established mechanisms that enable it to mitigate against "shock claims" and avoid significant losses.

In provider-driven integrated care, by contrast, the primary focus is on promoting collaboration, building shared vision, and developing protocols for care delivery. However, robust information sharing and incentives are used to underpin these efforts. Provider partnerships (which may include payors) also emphasize clinical leadership and accountability. In addition, providers tend to take a more active role than payors do in facilitating care coordination.

Examples of such partnerships include Healthfirst Network in Australia; Kaiser Permanente, Geisinger, and ChenMed in the United States; and NHS North West London in the United Kingdom. NHS North West London, for instance, has developed joint-governance arrangements among primary, community, and hospital care providers. Its multidisciplinary teams include mental health, social care, and community care professionals, as well as health care professionals. These teams follow best-practice care pathways to deliver care and accept mutual accountability for the holistic needs of the highest-risk patients. The financial savings accruing from this approach are distributed for reinvestment among all partners.

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Given today's economic realities, all health care systems must find better ways to provide care, especially to high-risk groups such as the elderly and those with chronic diseases. Integrated care can enable these systems to improve outcomes while controlling costs. The elements described in this article take time and effort to establish. But they can help organizations develop the virtual health systems that enable integrated care to flourish.

Kara Carter, an associate principal in McKinsey's London office, focuses on improving quality, efficiency, and performance in health systems and health care organizations. **Elissa Chalouhi,** an engagement manager in that office, concentrates on strategic issues for health care organizations. **Sorcha McKenna, PhD,** a principal in the Dublin office, specializes in how health systems can improve their primary care services. **Ben Richardson,** a principal in the London office, heads the Firm's global work on integrated care.