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DOI:

[10.1177/1355819618788100](https://doi.org/10.1177/1355819618788100)

Document Version

Accepted author manuscript

[Link to publication record in Manchester Research Explorer](#)

Citation for published version (APA):

Stokes, J., Riste, L., & Cheraghi-Sohi, S. (2018). Targeting the 'right' patients for integrated care: Stakeholder perspectives from a qualitative study. *Journal of Health Services Research and Policy*.
<https://doi.org/10.1177/1355819618788100>

Published in:

Journal of Health Services Research and Policy

Citing this paper

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Journal:	<i>Journal of Health Services Research & Policy</i>
Manuscript ID	JHSRP-17-144.R1
Manuscript Type:	Original Research
Keywords:	Health policy, Primary/secondary interface, Demand
Keyword:	Integrated care, Models of care, Health systems

Targeting the 'right' patients for integrated care: Stakeholder perspectives from a qualitative study

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Abstract

Objective:

To explore the perceptions of relevant stakeholders in terms of targeting the 'right' patients for integrated care.

Methods:

Secondary analysis of qualitative interviews with relevant stakeholders (including programme managers, programme initiators, a representative of the payers, medical and social care professionals, and allied health services staff) from two integrated care sites in England. A thematic analysis was conducted of cross-cutting themes.

Results:

Both sites focused on individualized management of 'high-risk' patients through multidisciplinary team case management. The data-driven approach to targeting patients, recommended in the policy literature, did not align with stakeholders' experience of selecting patients in practice. The 'right' patients were at lower risk than those

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3 recommended by policy, and their complexities were identified as comprising mostly social
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5 rather than medical issues.
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8 Conclusions:
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11 These findings raise timely questions about the individualised management approach. They
12
13 potentially explain why management of high-risk patients has not been found to be
14
15 effective using quantitative measures, undermining the assumption that this approach will
16
17 lead to cost savings. There is a need to expand beyond an individually targeted approach to
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19 incorporate prevention and to address social issues.
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31 **Introduction**

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36 Health systems internationally face common sets of challenges, with ageing populations,
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38 increasing multimorbidity, and severe pressure on health and care budgets threatening the
39
40 sustainable delivery of services.¹ 'Integrated care', posited as new models of care which
41
42 integrate services across different providers and sectors (for example, health and social
43
44 care), is hailed as a potential solution to these challenges.²⁻⁴ In this paper, we set out the
45
46 policy context for integrated care in England, the study setting. We outline the importance
47
48 of potential cost savings in this setting and the policy shifts required to achieve cost savings.
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51 We use qualitative methods to explore the perceptions of relevant stakeholders in terms of
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1
2
3 targeting the 'right' patients for integrated care and discuss the policy implications of our
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5 findings.
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7

8 9 10 Background

11 12 *Policy context*

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14
15 The National Health Service (NHS) in England currently faces a large gap between health
16
17 care funding and spending, with an estimated deficit of £30 billion a year by 2020/21.³ It is
18
19 argued that integrated care will simultaneously generate significant health gains alongside
20
21 improvements in patient satisfaction and cost-effectiveness, a bundle of aspirations known
22
23 as the 'triple aim'.^{2,5} With its hypothetical potential for cost-saving, integrated care is
24
25 envisaged as playing a key part in tackling the funding gap. Integration features heavily in
26
27 the strategic vision outlined in the NHS 'Five year forward view' (FYFV)³ and the resulting
28
29 exemplar new care models enacted via 'Vanguard' sites.⁶ It is hoped that increased cost-
30
31 effectiveness, by reducing overall costs, might allow funds to be reallocated to other parts
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33 of the system in most financial trouble, such as social care. Better integration, then, may not
34
35 necessarily lead to overall system savings.⁷
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41
42 In practice, the dominant application of integrated care in England (and internationally) has
43
44 been via multidisciplinary team (MDT) case management.¹¹ This involves the identification
45
46 of 'high-risk' patients – those thought to be at most risk of unplanned hospital care^{8,9} – at
47
48 the service delivery-level and provision of individually-tailored care to these patients. The
49
50 evidence for the effectiveness of this approach in terms of the health system's 'triple aim',
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52 however, suggests that not all goals are positively or equally met. In particular, compared to
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54 usual care, cost is not significantly affected (that is, total cost of care, and utilization of
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1
2
3 secondary care services).¹⁰ Self-reported health status may be slightly improved in the
4
5 short-term, but not in the long-term.¹¹ Patient satisfaction is, however, consistently
6
7 improved by case management in both the short- and long-term.¹¹
8
9

10 11 *Case management and cost saving: the assumptions* 12 13

14
15 The policy context outlined above highlights the importance placed on the theoretical ability
16
17 of case management to achieve reductions in costs. The process by which this aim is to be
18
19 achieved rests on two assumptions.
20
21

22
23 The first assumption relates to the target group. It is well-recognized that a very small, high-
24
25 risk segment of the population accounts for the majority of health care costs (that is, 5% of
26
27 patients are estimated to contribute to up to 50% of spending).¹² Targeting this group of
28
29 ‘super-utilizers’ has the potential to reduce costs if their utilization of services were to
30
31 decrease.¹³ It is worth noting, however, that in practice this is an ever-shifting group at an
32
33 individual-level, with on average a regression to the mean. At least some of these high-cost
34
35 individuals would return to a lower level of spending without additional long-term
36
37 intervention; for example, those with a short-term acute episode of high need. Therefore,
38
39 the potential savings from targeting this group are debatable.¹⁴
40
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44

45 The second assumption relates to the mechanisms through which reduced costs may be
46
47 generated. Generally, it is assumed that better clinical management and increased co-
48
49 ordination between primary care and social care services can prevent deterioration and
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51 emergency admissions and/or can substitute for more costly secondary care services.¹³ This
52
53 is an intuitive but largely untested assumption. Assuming care needs remain constant, any
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3 savings rely primarily on the difference between the large overheads in secondary care
4
5 compared to primary care; for example, the costs of additional expensive medical
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7 technologies typically found in hospitals, larger premises, and twenty-four hour service
8
9 delivery.
10

11 12 13 *Aims of this study*

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18 As outlined, assumptions that case management will save costs do not appear to be borne
19
20 out by current evidence. One potential reason that the cost-savings are not being delivered
21
22 is that the wrong people are being targeted. We aimed to explore the perceptions of
23
24 relevant stakeholders in terms of targeting the 'right' patients for integrated care, focusing
25
26 on how patients are being targeted and why.
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31 **Methods**

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36 This paper draws on the qualitative component of the 'Sustainable intEgrated care modeLs
37
38 for multi-morbidity: delivery, FinanCIng and pErformance' (SELFIE) project being undertaken
39
40 by a partnership of European nations.¹⁵ Specifically, the paper draws on qualitative work
41
42 from the two UK sites in the SELFIE project: 1) Salford (using secondary analysis of
43
44 transcripts from the Comprehensive Longitudinal Assessment of Salford Integrated Care
45
46 [CLASSIC] study)¹⁶ and 2) South Somerset (with interviews and transcripts conducted
47
48 specifically for SELFIE).
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Sampling and recruitment

Salford and South Somerset are both 'Integrated primary and acute care system' (PACS) Vanguard sites in England. The sites were selected and funded by NHS England to join up general practice, hospital, community, and mental health services.⁶

The models at both sites aim to shift towards a population health management approach; that is, targeting all population 'risk' levels in some respects, not only the highest-risk. This includes a major emphasis on interventions delivered by MDT case management of high-risk patients, as outlined above, but also less targeted interventions aimed at lower-risk patients for the purpose of prevention. Both sites began their integration models with the roll-out of a range of service delivery interventions (Table 1).

Table 1: Interventions in Salford and South Somerset to enhance integration, MDT case management interventions outlined in bold

[insert Table 1]

As PACS Vanguards, both sites are also looking to introduce organizational changes to help support their service delivery interventions. Both are planning to establish Accountable Care Organization (ACO)-inspired changes, with a number of providers coming together (either as a fully integrated body, or through alliances/networks) to assume responsibility for the cost and quality of care for a given population.¹⁷

In this paper, we focus on interviewee views on targeting, and on the needs of the most complex high-risk patients, that is, we focus on the MDT case management intervention in

1
2
3 each site. More details of each model can be found in the thick description reports on the
4
5 SELFIE website.¹⁸
6
7

8
9 Initially, the two sites set out to target slightly different 'high-risk' patient populations:
10
11 Salford initially targeted those over the age of 65 (but now expanded to all adults), while
12
13 South Somerset focused on those with multimorbidity (particularly, those with three or
14
15 more long-term conditions). Both sites were at slightly different stages of their envisioned
16
17 integrated care models at the time of this research (as shown in Figure 1 below), but both
18
19 began with implementation of their MDT case management interventions.
20
21

22
23 *Figure 1: Timeline of integrated care interventions in the two selected sites. Service delivery: MDG = Multi-*
24 *disciplinary group; CoC = Centre of Contact; CA = Community Assets; CCH = Complex Care Hub; EPC = Enhanced*
25 *Primary Care. Organizational: ICO = Integrated Care Organization; IP Ltd = formation of a Ltd company of*
26 *Integrated GP Practices. * = Vanguard status awarded to both sites.*
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31
32 [insert Figure 1]
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36 *Data collection*

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40 The interviews took place at the early implementation phase at each site, with the roll-out
41
42 of service delivery waves ongoing, and organizational changes still in the planning stages.
43

44 Individual semi-structured interviews were conducted face-to-face with a range of
45
46 professional stakeholders (including programme managers, programme initiators, a
47
48 representative of the payers, medical and social care professionals, and allied health
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50 services staff) in both sites (total, n = 18).
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3 In Salford, in order to minimize the research burden on the site and to avoid duplication of
4
5 data, the transcripts were a subsample of relevant interviews conducted by researchers,
6
7 including LR as part of the CLASSIC study.¹⁶ JS liaised with the CLASSIC researchers to select
8
9 relevant transcripts and categorized the participants' data in order to identify which of the
10
11 participants would fall within the purposive sampling frame, ensuring 'data fit' (that is, the
12
13 data fit the new questions being asked);¹⁹ namely, those who had significant narratives
14
15 around the introduction and implementation of integrated care covering an array of
16
17 stakeholders. The topic guide focused on questions relating to implementation of the
18
19 model. Ten stakeholder interviews meeting the SELFIE selection criteria were selected from
20
21 those interviewed between November 2014 and October 2015.
22
23
24

25
26 South Somerset interviews were conducted (by JS) face-to-face with eight stakeholders in
27
28 August 2016 and complemented the Salford interviews. The topic guide was formulated by
29
30 the SELFIE work package leaders in Austria, and covered a broad range of topics around
31
32 implementation and enactment of the model in practice;¹⁸ it was therefore comparable with
33
34 topics covered in the Salford interviews.
35
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38
39 All interviewees provided written informed consent and were reassured that interviews
40
41 were confidential and voluntary, and data was anonymized. Ethics approval was granted by
42
43 the NHS Health Research Authority Research Ethics Committee (SELFIE REF: 16/WM/0295;
44
45 CLASSIC REF: 14/NW/0206). For both locations, interviews were audio-recorded and
46
47 transcribed using 'intelligent verbatim' (that is, recorded speech to text, editing out
48
49 pauses/repetition that distract from content) by an external agency. Recordings were re-
50
51 checked for accuracy by the authors.
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Data analysis

We analysed the transcripts using thematic analysis.²⁰ Initial familiarization with the data via reading and re-reading of transcripts was followed by initial open coding of the data which led to theme formulation as themes emerged from the data, using Microsoft Word for data management. Each site's data was independently analysed and reported separately.¹⁸ For this paper, however, we pooled the data across both sites and re-analysed the composite dataset with respect to the aims of this study. All authors discussed and reached consensus on the final analysis and presentation of the data.

Results

We identified four main themes emerging from the discussion, relating to 1) the motivation for case management; 2) the 'right' patients as a shifting target; 3) the actual needs of the patients; and, 4) the possible outcomes and scope of the intervention. Below, we discuss each of these in turn and relate these perspectives to the policy context.

Motivations

Overarching motivation narratives amongst stakeholders in both sites appeared to align with the 'triple aim' of the policy. Both sites constructed a number of more specific performance measures based on these aims, using reduced emergency admissions and re-admissions as a proxy for costs. Linked to this, the aim to 'stop people slipping' (who would then require high-cost and intensive hospital care) emerged as a primary motivation, with maintaining these patients' ability to self-manage a goal of both programmes.

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2
3 So the bottom of the triangle [referring to the Kaiser risk pyramid, where the top of
4 the pyramid are a small number at highest risk, with larger numbers at the bottom at
5 lower risk] [...] the key role there is about doing everything we can with the patients
6 so that they're activated to manage their own health and they stay in that bottom
7 one [...] if they're in the middle part of the triangle then again it's about working a bit
8 more intensively with them, because what you don't want them to do is to go up to
9 the top part of the triangle. (IP02_02, South Somerset)

20 21 *Shifting targets: the 'right' patients*

22
23
24 Across both sites, participants described a gradual shift over time and with experience
25 gained, moving away from the policy recommendations of focusing on the highest-risk
26 patients, and towards a more flexible approach. Both shifts appear to have been bottom-up,
27 but have occurred through different methods. In Salford, this shift occurred due to
28 perceived need once the initial formal patient quotas had been filled:

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37 So the way it started out [the managers] wanted everybody with a code of three
38 [high-risk]. I suppose part of the cynical side of me was, well, we know they're all
39 okay because they've [already] got all the services involved but I understood that we
40 needed to get the care plans done [...] fortunately, we got through ours fairly quickly.
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And it's your twos and your ones even [less high-risk], because in the blink of an eye
things change, don't they? (IP09_1, Salford)

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3 In South Somerset, this shift appeared to have been led by the experience of those
4
5 professionals interacting with the patients and comparing the initial selection criteria with
6
7 the reality of their 'complex patients'.
8
9

10 [the clinicians] were really specific about [...] three or more comorbidities,
11
12 polypharmacy, high admissions. But then, again, they've had to look at, actually, you
13
14 might have somebody that meets the criteria of all of those, but is managing their
15
16 condition really well [...] they might have COPD [alone], and they're coming into ED
17
18 every other week, because they're not managing. So we've had to just be a bit more
19
20 flexible [...] So, you could have 450 patients in the service, tick a box, and say, great,
21
22 but actually, they might not be the right patients, and we might still end up with the
23
24 other patients being admitted, so our admission rate hasn't been impacted. (IP07_2,
25
26 South Somerset)
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31

32 In practice, both sites found selecting 'complex' patients from a purely formal data-driven
33
34 approach difficult. Participants identified problems with risk stratification tools based on
35
36 hospital data and which emphasises health care utilization. Such patients were described as
37
38 well-known to health care services, frequently with little room for doing more to support
39
40 reduced utilization (utilization may be necessary, so was not always seen as preventable).
41
42 Additionally, other important 'unobservables' (for example, social circumstances) not
43
44 present in the data were described as having more of an effect on defining patient
45
46 complexity/their utilization of secondary care (see also the section on patient needs, below).
47
48
49
50

51 [...] what you find is the high-risk people that are identified by these risk stratification
52
53 models that are promoted nationally, is that the only data that's easy to count is the
54
55 hospital data [...] so the people that were at the top are the people who have most
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1
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3 support from services, that because they have a lot of support from services they're
4
5 usually quite well managed, and so therefore they are more reasonably stable.

6
7 (IP02_1, Salford)
8
9

10 Due to these insights, there has been a transition to a more fluid, active process of selection
11
12 via iteration and team consensus. Stakeholders described the relative importance of getting
13
14 the 'right patients' (that is, those with *unmet* and *actionable* needs), rather than simply
15
16 quota filling.
17
18

19
20
21 Over time, it's become much more refined, really, because we've realized
22
23 that some people do benefit and some people don't benefit [...] it's not a
24
25 strict criteria of referral in or not referral in. It's who would best have their
26
27 needs met by that service. (IP03_2, South Somerset)
28
29

30
31 So the MDGs started to work to try and find these people [...] because that is
32
33 ideally what you want an MDG to do, if you see somebody slipping, that you
34
35 put a little bit extra in to keep everybody afloat for X or Y amount of time
36
37 longer. (IP02_1, Salford)
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39

40 41 *Patient needs* 42 43

44
45
46 The unmet needs of complex patients were described as extending beyond the medical
47
48 domain. Frequently, medical practitioners felt needs were primarily related to social factors
49
50 in terms of isolation, poor housing or living arrangements, and other socio-economic issues.
51

52 Clear pathways were described between these social issues and patients presenting in the
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3 emergency room. Linked to this, mental health needs were highlighted as being particularly
4
5 challenging to address, complicated by a lack of effective treatment options.
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8 People get very, very isolated, and when they're very isolated, they're not very
9
10 resilient [...] If you're happy as Larry, and you've got loads of social interaction, and
11
12 your family seem to care about you, and you have day-to-day contact with people,
13
14 you might have something wrong with you, but you deal with it... Whereas if you
15
16 have nobody crosses your path, and you're as miserable as sin, and it blooming
17
18 hurts. Well, what shall I do - I'll call the doctor, or go to A&E. (IP05_1, Salford)
19
20
21
22

23 I think anxiety and depression are huge and I certainly didn't realize how much that
24
25 impacts on a person's health and wellbeing and, you know, some people can have
26
27 three, four long term conditions and can manage quite well, somebody that could
28
29 have anxiety and depression could have one long term condition and it's, you know,
30
31 they don't manage at all. (IP08_2, South Somerset)
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33
34

35 Some patient needs were identified around acceptance of a chronic illness that would not
36
37 alleviate, or acceptance of approaching the end of life. While some of these issues were
38
39 potentially addressable, this was not the case for all.
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43 [...] you have other patients who are bouncing in and out of hospital. What is quite
44
45 evident is actually they've got a chronic health problem that's deteriorating but
46
47 nobody is really having those conversations. They are constantly feeling unwell, they
48
49 are constantly feeling they need to be in hospital and of course they never get
50
51 better, so they think the hospital has not done it right so they go back in and do it
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1
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3 again. It's [...] being able to talk through and explain that actually it's a natural
4
5 progression of the condition and that's where life is now. (IP05_2, South Somerset)
6

7
8 I've got an alcoholic bloke, who refuses to accept he's got an alcohol problem. And
9
10 he must have had about 75 A&E attendances in the last three years. And we've had
11
12 multidisciplinary professional meetings [...] It's not made a jot of difference [...] he
13
14 won't accept he's got problems, and he won't stop drinking. (IP05_1, Salford)
15
16
17

18 19 *Outcomes and scope* 20

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22
23 Participants indicated that the stated aims of reducing emergency admissions and costs via
24
25 case management were unlikely to be achieved, particularly in the short-term, due to the
26
27 changes occurring in patient selection, as described above. Potential cost savings were seen
28
29 as longer-term, where models could target lower-risk patients with preventable issues and
30
31 could work to prevent future admissions. Research participants also emphasized that key
32
33 intermediate steps that could lead to making savings, such as improving self-management
34
35 ability, were difficult and time consuming. Additionally, there was some scepticism about
36
37 the relative cost of acute episodes of hospital care versus long-term intensive community
38
39 management, with some questioning whether the long-term approach would ever really
40
41 save money, but recognizing it had other positive outcomes.
42
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46
47 Cost-wise, we definitely cost money, everything we're doing is costs, you will see no
48
49 savings for a long time. But quality wise, I reckon, it's through the roof. (IP04_2,
50
51 South Somerset)
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3 However, there were also some suggestions for improving the case management
4
5 intervention, in line with observed need. For example, the importance of broadening the
6
7 MDT beyond a medical focus to include professionals from housing and social work was
8
9 well-recognized. Social workers were included in the Salford team, and medical practitioners
10
11 there described learning from them. For example, social workers provided support and
12
13 advice on relocation of patients to appropriate housing to prevent falls and reduce social
14
15 isolation. Particularly in Salford, where the focus was initially on older adults, the medical
16
17 expertise of geriatricians were seen as particularly valuable for rationalizing care, for
18
19 instance to reduce polypharmacy. Relationships developed during MDTs enabled GPs to
20
21 discuss concerns about patients with geriatricians in more depth than occurred by letters
22
23 alone. Likewise, mental health practitioners were highly regarded.
24
25
26
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28

29 A number of stakeholders also highlighted the importance of a broader organizational focus
30
31 on prevention, and pointed to the supporting changes planned to incentivize prevention (for
32
33 example, towards establishing Accountable Care Organizations).²¹ They suggested that such
34
35 changes would enable efficiency improvements in the wider system, which in turn would
36
37 make the new models of care sustainable.
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39
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41 So I think the model that we're putting in will help because it's facilitating the
42
43 services to work differently in specific areas. But the real efficiencies [...] so that's a
44
45 different way of working, but the efficiencies have to come through the Integrated
46
47 Care Organization [ACO-type organisation], I believe. (IP02_1, Salford)
48
49
50

51 Importantly, despite limited impacts on costs, participants did describe some positive
52
53 effects of engaging in the MDT integration approach at both sites. For example,
54
55 professionals discovered additional social services offered by others within (or known to)
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1
2
3 the MDT that they could refer patients to. There were also examples of clear scope for
4
5 improving the quality of life of patients through additional support and services. For
6
7 example, alleviating loneliness through a befriending scheme for older people.
8
9

10
11 On the other hand, some stakeholders also described some concerns. One interviewee
12
13 highlighted an alternative to funding case management, a wider-reaching approach
14
15 provided by community services. The social engagement provided by these services was
16
17 described as a particularly important preventative measure, particularly in reducing social
18
19 isolation.
20
21

22
23 [...] we used to have the [x] Day Centre [...] So you had frail, crumbly people, mixed in
24
25 with less frail, crumbly people, who just wanted a bit of social entertainment. And
26
27 that was the most amazing service, and of course, because of the cuts, it closed [...] if
28
29 you want my absolute, honest opinion - I would much rather all this money that's
30
31 being spent on this project, was given to social care, to start actually providing social
32
33 care for patients [...] I actually think that's what makes a difference to patients' lives.
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36
37 And I don't know whether this is going to. (IP05_1, Salford)
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41 **Discussion**

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46 *Principal findings*

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48 Participants' motivations for integrating care aligned with policy in terms of achieving the
49
50 overarching 'triple aim', including cost savings. However, a shift away from formal policy
51
52 was evident in both sites in terms of identifying which patients to target, and the methods
53
54 for doing so. This shift was a result of experience gained by local professionals. The purely
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3 data-driven targeting approach recommended in policy came to be seen as inadequate, as it
4
5 resulted in the selection of patients already well-known to services whose needs were being
6
7 met, or whose needs were unresponsive to change. Over time, the sites adopted a more
8
9 fluid process of selection based on informal consensus among MDT members.
10
11

12
13 The needs of complex patients were described mostly in terms of their social situations
14
15 rather than their needs for medical management. The exception was mental health
16
17 conditions, where treatment options were felt to be limited. Patients' acceptance of
18
19 deteriorating health was highlighted as another issue, but not always a solvable one.
20
21 Suggested improvements to the case management interventions were related to these
22
23 patient needs; for instance, participation of other non-medical staff.
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28 *Strengths and weaknesses*

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31 This study is based on two very different sites in England facing similar issues, which may
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33 add strength to the generalizability of the findings in terms of the commonalities they
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35 describe. However, there are limitations: data was collected from each site at different
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37 times and not for the precise purpose of answering the questions proposed here.
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41 Nevertheless, we sampled a range of stakeholders at each site, and each site was at a similar
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43 stage of implementation when interviews were conducted.
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46 *Relation to other studies*

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49 This study contributes to the published literature on targeting high-risk groups. As a
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51 qualitative article, it offers potential explanations for findings in quantitative research that
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53 case management generally fails to reduce costs.¹¹ In the view of those implementing these
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55 interventions, achieving the goal of reduced costs is unlikely in the short-term as those at
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3 highest risk are not those with addressable unmet needs. Furthermore, the unmet social
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5 issues identified are often multifaceted, deeply ingrained and linked to wider social context,
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7 and therefore highly resistant to change. However, there is a clear view (from participants in
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9 this study, and findings in the wider literature) that there is the potential for quality
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11 improvement via increased personalized contact through case management interventions.
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13 Hence, we consistently see increasing patient satisfaction with this type of intervention in
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15 the literature.^{11, 22, 23}
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20 These qualitative findings complement the work of Wallace and Roland et al.^{24, 25} who have
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22 shown, using quantitative data, the flaws in the assumption that individually targeting
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24 patients in a high-risk group will save costs: that is, studies have highlighted the extremely
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26 small number of potentially avoidable emergency admissions in this group amenable to
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28 prevention, and hence the negligible cost savings that are plausible.
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33 *Implications for clinicians and policymakers*

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35 These findings present clear implications for policymakers in terms of funding of social care
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37 and public health, both sectors where budgets have been dramatically reduced in light of
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39 austerity decisions in the United Kingdom. If the means of achieving cost savings is to be
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41 prevention of medical *and* social needs (and a resulting reduction of demand on services),
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43 then broader, population-wide approaches might prove a better use of resources rather
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45 than the current focus on selecting specific patients for intensive healthcare services.
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50 Of course, not all ill-health can be prevented, and managing the highest-risk patients will
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52 remain important (aside from the economic aim of cost-saving). If such management is
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54 carried out via an MDT, our findings in relation to the needs of complex patients have
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3 implications for the mix of professionals who might best deliver quality care to these
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5 patients. In essence, MDTs should include those with the capability to address the multiple
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7 unmet social and/or mental health needs many patients face.
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10 Both sites we observed have adapted their case management selection process to try and
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12 focus on *impactability*, that is, identifying the subgroup of patients who will tangibly benefit
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14 from the case management intervention. This may affect health inequalities. For example,
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16 focusing on those patients whose care appears suboptimal may help reduce inequalities,
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18 with suboptimal care more prevalent in deprived areas.^{26, 27} On the other hand, excluding all
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20 of the very highest-risk patients because of a belief that they are less likely to respond to the
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22 intervention may increase health inequalities, as again, risk is associated with deprivation.^{28,}
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31 *Future research*

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33 Further research is required to determine the generalizability of this study and its findings to
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35 other models of care that emphasize integration. If case management intervention
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37 continues to be delivered to high-risk patients as a means of increasing quality of care, then
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39 studies should examine the optimal delivery methods for achieving better quality (for
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41 example, how best to select patients, MDT skill-mix, and so forth). There is also a need for
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43 increasing debate on where the limits of the responsibility lie for health systems – for
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45 example, in terms of delivering increased social support. In addition, research is required to
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47 identify where a wider governmental approach is needed in order to construct a society
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49 where an ageing population can be supported in a community where their social needs are
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51 addressed without having their problems over-medicalized. It is promising that a number of
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53 new models of care in England appear to share this long-term vision.⁶
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Conclusions

These findings provide evidence about how professionals identify high-risk patients and their health and care needs, conceivably forming the basis for more effective design of future models of care for such patients. However, intensive social support delivered by a highly-paid MDT of medical and other professionals alone is unlikely to lead to cost savings in the short term. There might, however, be other valid objectives for implementing new models of care.³⁰ Local NHS programmes currently face difficulties in moving beyond a focus on high-risk groups, despite additional start-up funding and a national vision to do so. With increasing financial pressure, more work is also needed to design and deliver cost-effective models of care across an ageing and increasingly multimorbid population.

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Under Review

Acknowledgements

The authors would like to thank the CLASSIC researchers who allowed us to analyse a proportion of their transcripts for the SELFIE project, and all those stakeholders across the two programmes who took the time to be interviewed. We would like to thank ‘Salford Together’ – a partnership of Salford City Council, NHS Salford Clinical Commissioning Group, Salford Royal NHS Foundation Trust, Greater Manchester Mental Health NHS Foundation Trust and Salford Primary Care Together. We would like to acknowledge all members of the SELFIE consortium for their support in the development of the project and contributions to this publication.

Funding

This SELFIE project has received funding from the European Union’s Horizon 2020 research and innovation programme under grant agreement No 634288. The content of this work reflects only the SELFIE groups’ views and the European Commission is not liable for any use that may be made of the information contained herein. The CLASSIC project was funded by the National Institute for Health Research Health Services and Delivery Research (12/130/33). The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the HS&DR, NIHR, NHS or the Department of Health.

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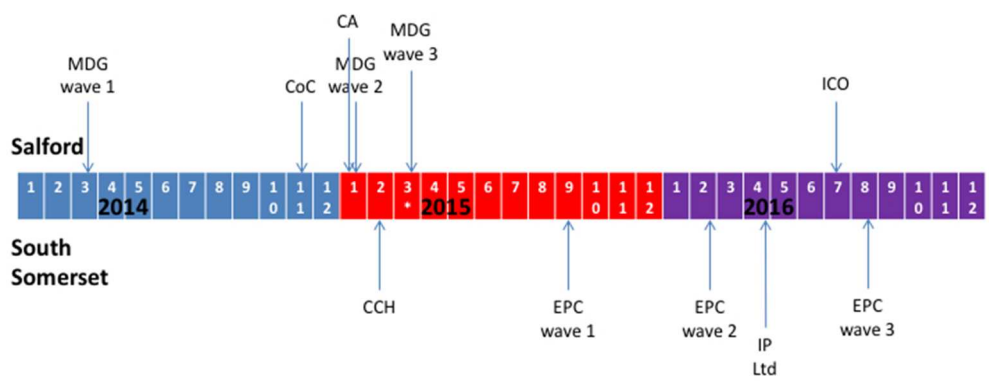


Figure 1: Timeline of integrated care interventions in the two selected sites. Service delivery: MDG = Multi-disciplinary group; CoC = Centre of Contact; CA = Community Assets; CCH = Complex Care Hub; EPC = Enhanced Primary Care. Organisational: ICO = Integrated Care Organisation; IP Ltd = formation of a Ltd company of Integrated GP Practices. * = Vanguard status awarded to both sites.

254x190mm (72 x 72 DPI)



Salford

- **MDT case management of the highest-risk patients by neighbourhood groups**
- Centre of contact – a centralised telephone hub to help with navigating services and self-management (via health coaching)
- Community assets – investment in community resources to promote social interaction and active lifestyles later in life

South Somerset

- **Complex care hubs – an ‘extensivist’ GP intervention with GPs located in a hospital hub case managing the most complex patients in MDTs**
- Enhanced primary care – co-location of health coaches in GP practices to assist with disease self-management and prevention

Under Review