Health Promotion and Integrated Care

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Integrated Care is commonly understood as any endeavour to overcome the restrictions imposed by individual medical disciplines and professions and their organ-centric, mono-disciplinary and curative approach to care.

The need for such an endeavour is usually explained by the increase in complex chronic diseases and the resulting need for harmonized and co-ordinated provision across different professions and institutions. From the point of view of social legislation, integrated care is defined as a new cross-sector form of provision in the German healthcare system, and was put on a firm legal footing by the healthcare reform of the year 2000. It promotes greater networking between the various disciplines and sectors (e.g. general practice, nursing care, hospitals, rehabilitation) in order to improve quality and transparency in patient care while keeping costs under control at the same time. The health insurance funds can under the terms of the reform enter into co-operative agreements either individually or in partnership with individual healthcare providers, or groups of providers, or their management companies, as the case may be, differing from the currently used reimbursement schemes.

Until mid-2015, the framework for relevant agreements on integrated care was laid down in sections 140 a-d of the German social legislation code (Sozialgesetzbuch), volume V. Since the introduction of kick-start financing in the Healthcare Modernization Law of 2004, integrated care had made a considerable leap forward. Its expiry in 2008 was followed by a heavy reduction in the number of new contracts. The Law on the Strengthening of Health Care Provision (Versorgungsstärkungsgesetz), which came into force in mid-2015, will simplify the stipulations of sections 140 a-d and reduce them to the present section 140a, although this will retain its present heading “Special Contracting Models’ (Besondere Versorgung). Integrated Care is thereby subsumed under this “Special Contracting Models’.

The intended effect of this section, namely to promote innovation, has been used overwhelmingly for “small-scale’ co-operations primarily between the in-patient and rehabilitation sectors of care. The Advisory Council on the Assessment of Developments in the Healthcare System estimated in his study 2012 that in 2011, there were some 6,400 integrated-provision contracts between the health funds and providers, covering a total expenditure of about 1.4 billion euros.

Preventive or health-promotion aspects occasionally play a role, e.g. in extended provision programmes run by various health insurance funds on the prevention of premature births. While such partial solutions are also described as “*indication-related*’ provision models (“integrated care light’), *population-related* models are seen as “integrated care full-size’. Here we are talking about taking over all or part of the total budgetary responsibility for the members of the health insurance fund(s) involved in a particular region regardless of medical indication.

Only in the concept of such an “fully integrated (regional) care do health promotion and disease prevention have a central priority going far beyond what is usual in present-day healthcare provision. The conceptual basis is the “chronic care’ model (Wagner et al. 1996, Glasgow et al. 2001). Although in this model the community and its resources have already been incorporated, critics have said that it is too heavily curative or provider-fixated, while neglecting the need for interventions in the social environment of those affected.

By way of reaction, Barr et al. (2003) proposed a link-up between the chronic-care model and the concept of health promotion (Ottawa Charter) (health promotion I), calling it an “extended chronic-care model’. In this model, primary to tertiary preventive elements are combined with health promotion for the chronic sick and those at risk of disease. Alongside the activated patient, the activated community as part of integrated provision was underlined. Interventions within the medical care system were supplemented by, and linked to, interventions in the community. (community orientation, → Health-Oriented Community Work).

While this model, proposed in 2003, embraces the complex demands better than the original chronic-care model of Wagner et al., in turn it remains behind today's demands and possibilities, in particular in respect of the use of new technical communications. A group of researchers at the International Foundation for Integrated Care has therefore further expanded this model, and developed it into an "integrated chronic-care model' (ICCM; summarized by Goodwin and Hildebrandt 2014, see Figure 1)

http://www.leitbegriffe-en.bzga.de/pix.php?id=7365fa915db992199a03affe33c7a385

Figure 1. Created by: Helmut Hildebrandt + Nick Goodwin (© 2014), Adopted and advanced from: Victoria Barr, Sylvia Robinson, Brenda Marin-Link, Lisa Underhill, Anita Dotts & Darlene Ravensdale (2002).
The Expanded Chronic Care Model: An Integration of Concepts and Strategies from Population Health Promotion and the Chronic Care Model. Itself advancing: Ed Wagner, B Austin and M von Korff (1996) Organizing Care for Patients with Chronic Illness

In addition to the two intervention planes of the healthcare system and the community (planes 1 and 2 in ill. 2), in this most recent extension of the original model we have the meso-plane comprising household and peers. On this plane, various aspects are usefully incorporated into the monitoring of household processes: the effect of peer-to-peer trainings and communication in → Social Media, the influence of physical training, support from mobile health, e.g. smartphones, "wearable textile devices' (monitoring devices, implantable or capable of integration into clothing) and the use of "smart meters'.

Table 1 is a systematic representation of the most important elements of the model and its relationship to the Ottawa Charter (relevant concepts for health promotion are italicized).

Functional elements of the Integrated Chronic-Care Model (ICCM) and its relationship to the action fields of the Ottawa Charter (italicized)

…1. on the healthcare system plane, i.e. the plane of traditional healthcare provision

Shaping of care provision (*re-orientation of the healthcare services)*

Provision more strongly geared to the needs of the chronically ill (interdisciplinary teams prepared for chronic care provision), re-thinking of provision processes, e.g. consultations for the chronically ill, or case management; delegation of doctors' work to other professional groups; introduction of group consultations (on the basis of Canadian experience).

Provision of decision-making assistance both for doctors and patients

Mutual support between general practitioners and hospital doctors, using and locally adapting general guidelines; consultations on specific problems in co-operation with specialists; provision of video services, brochures or internet information for patients/telephone hotlines/getting a second medical opinion for the chronically ill

Information systems / telemedicine

Reminder and support systems, appointment planning, provision of information, performance measurement, therapy plans and telemedical technologies to monitor clinical patterns; option for patients and family members to access central patient files

Activation, consolidation of self-management and personal skills

Gearing the provision system towards strengthening patients´ health literacy , e.g. by preparing information on the possibilities of *precautionary measures* to slow down, stop or reverse disease *(nutrition, movement, giving up smoking)*, provision of means of self-monitoring progress; possibilities of contact and exchange with other patients (*self-help*, social forums, group consultations)

… 2. on the plane of households, families, the immediate neighbourhood and others similarly afflicted

Mobile healthcare services and technical assistance systems to preserve independence and domestic *autonomy* (mobile health / ambient assisted living)

Mobile digital health services e.g. from apps and “wearable textile devices’ such as clothing or footwear with integrated movement sensors; support technologies designed to preserve the ability to live at home, using sensors to detect any deviations from normal routines and thus need for assistance/linking these sensors to gradually increasing support.

Promotion of *health competence* and training services through *peer trainers* (health literacy/peer-to-peer, developing personal skills)

Continuation of personal information services also in the context of the respective local or regional neighbourhoods, *promotion of knowledge and the competence to preserve one’s own health, establishment of CDSM programmes* (chronic disease self-management), in which the chronically ill can train other chronically ill individuals according to a precisely defined concept.

… 3. on the local, regional or neighbourhood plane

Building up a *supportive environment (creating health-promoting habitats)*

Building up *health-promoting measures in the human habitat* (social networks, transport, town planning, natural environment), incl. old-age-friendly redesign of footpaths, direction systems, public transport etc.

Reinforcing local government activities and initiatives (support for health-related community action)

Work with local government groups, in order to agree priorities and goals to achieve health in the community.

Table 1. *Elements of the ICCM and their relationship to the fields of action covered by the Ottawa Charter. (Source: Goodwin and Hildebrandt 2014; our own presentation)*

The goal of the integrated chronic-care model consists in activating patients and making them managers of their own illness, while actively integrating family members and the social environment. A current study from the USA shows that the lower their activation score, the higher the costs that patients cause (between 8% and 21%) (Hibbard / Greene 2013). Further additional elements are the training of the doctor and the interdisciplinary team and winning them over as coaches and supporters for improved health competence on the part of the patient, building up “peer-to-peer’ approaches, and intervening systemically in the whole region, e.g. in co-operation with local authorities, welfare associations and clubs. At the same time sports and exercise, along with mobile health solutions - should be exploited and integrated into the treatment process as far as possible and as far as the cost-benefit relationship is convincing.

The integrated chronic-care model recommends the establishment of regional development agencies which for their part will link up with local networks of, in particular, primary care providers, regional grass-roots initiatives and local government committees. After a temporary initial investment, these resulted in savings for the health funds because of the improved results. The development agencies share in the financial success, and thus have a commercial interest of their own in the benefits achieved, and to that extent a long-term incentive for ongoing optimization and increase in efficiency.

The first, most developed and best-known model of good practice in Germany is the integrated provision in “Gesundes Kinzigtal’. In 2005 a limited company called “Gesundes Kinzigtal GmbH’ was formed. The shareholders are the doctors’ network “Medizinisches Qualitätsnetz - Ärzteinitiative Kinzigtal’ (MQNK) and OptiMedis AG in Hamburg. The doctors of the MQNK and the health scientists of OptiMedis AG hope, together with two statutory health funds in Baden-Württemberg, to improve health and healthcare provision in Kinzigtal in the context of a complex integrated care model. The basic principles, as stated on its website, are:

- We invest in health and the quality of care.
- We offer preventionand health promotion programmes.
- We co-ordinate the networking of our partner providers.

The central role of “health promotion’ is clear just from these three principles.

The integration of disease prevention and health promotion into basic healthcare provision is based on a large number of programmes, for example

- “Strong heart - Targeted action against heart disease’,
- “Healthy weight - Now’s the time’,
- “Smoke-free Kinzigtal’,
- “Good prospects - Screening services for children’,
- “In balance - My blood pressure under control’,
- “Strong muscles - Firm bones’,
- “Stay mobile - Treat rheumatism early’,
- “Strong back-up - My healthy back’,
- “Better mood - Depression under control’,
- “DoctorsPlusCare’,
- “Well advised - Help, advice and support at critical times’,

- "'Prompt psychotherapy',
- social service, disease-management programmes (DMPs),
- "Liberating tones - In harmony with music'.

The range covered by these programmes shows that the Kinzigtal model is based on a broad socio-psycho-somatic understanding of health. The programmes are implemented through lectures, training sessions, agreed targets between doctors and patients, coaching, case management and other methodological approaches.

In the middle of 2011 the programme was extended to include a further area that is particularly concerned about workplace enhancement in collaboration with the local authorities, welfare associations and clubs of the Kinzigtal region. In 2012 a further area was added, concerned with health promotion at the workplace, supporting workplace health management, in particular in the field of preventive and screening measures. The most recent addition, "Health World Kinzigtal' (2014) is designed to provide not only workplaces and workers but also the public at large with a centre for health competence and medically supervised movement and strength training services. In addition, security of provision is being developed together with the local authorities in the Kinzigtal region. Together with the local mayors and doctors' surgeries, the situation in the region is being registered and discussed.
In the Kinzigtal model, the principles of the chronic-care model are being implemented in the comprehensive sense. Geared to the principle of salutogenesis, the focus is on maintenance of good health through screening and on the strengthening of patients´ positive resources, so that they are less likely to fall ill or need care in the near or distant future. While many programmes address tertiary prevention, primary prevention still has a considerable importance. In part, primary prevention is listed in self-presentations as one of the three pillars of the Kinzigtal model. There are numerous services for healthy people and those who consciously seek to promote their health (bearing the cost of screening tests at ages 7/8 and 9/10, "smoke-free Kinzigtal'; numerous nutrition and movement services, reduced subscriptions for gyms, and inclusion of sports clubs, dance clubs and choirs).

Indication-related integration models geared to widespread ailments such as cardiovascular diseases, depression or backache also occasionally take account of tertiary-prevention aspects; integration models geared comprehensively to prevention or health promotion, however, have hitherto been confined to *population-related* provision models. When prevention and health promotion take account the extended chronic-care model, then we can say that health promotion (in the sense of the Ottawa Charter) has become a core part of regular care provision. It is true that the model of good practice described here is currently unique in Germany in its comprehensiveness, but there are a number of models who in one way or another come close to it (cf. www.deutsche-aerztenetze.de).

In numerous evaluations, "Gesundes Kinzigtal' has demonstrated health benefits and economic advantages over standard healthcare provision; the prospects for further dissemination of this kind of Integrated Care can thus be seen as positive. In a public-health oriented stocktaking exercise, proposals for quality criteria in the assessment of other regions will include patient autonomy and participation on the one hand, and incentives for disease prevention and health promotion on the other. The outlook is optimistic for the importance to be given to these central concepts of the Ottawa Charter in future models of integrated regional healthcare. An optimistic assessment is also supported by the WHO, which recently launched a "Global Strategy on People-centred and Integrated Health Services'.

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Links: Health-Oriented Community Work, Social Media / Promoting Health through Digital Media

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