Transformation through Clinical and Social Integration: Meeting the Needs of High Users of Healthcare

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ABSTRACT

A minority of patients consume the bulk of health services and/or the costs of care. This group provides a focus for a number of concerns related to health system sustainability, the appropriateness and effectiveness of care and the proportion of government program spending made up by health expenditures. This introduction offers five observations. First, if Ontario's Health Links are to meet the needs of high users, local autonomy may have to be balanced with more consistent frameworks. Second, there is a need for creative approaches to evaluation, specifically in the area of rapid cycle evaluation. Third, genuine innovation will require clear role specifications in governance relationships and bold approaches to accountability that build in space for learning from "good" failure. Fourth, successful interventions will encompass social care services and broader social determinants as well as clinical factors and, fifth, we will need an approach to stewardship that facilitates intersectoral action.

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A growing number of studies in various jurisdictions have demonstrated that a small minority of patients (often identified as the top 1% or 5% of users) consume the bulk of health services and/or of the costs of care, whether the focus is a specific setting (such as emergency departments or hospitalizations) or overall healthcare costs. This group, referred to (often indiscriminately) as "high users," "high cost patients," "frequent flyers" and so on, provides a focus in which are crystallized a number of concerns related to health system sustainability, the appropriateness and effectiveness of care and the proportion of government program spending made up by health expenditures.

Of course, the idea that at any given time a small number of individuals will incur the majority of healthcare expenditures is taken for granted. It is, after all, one of the basic assumptions of health insurance programs. On the other hand, there is much to learn from an examination of disproportionate use of health services, the characteristics associated with it and where there is potential for change. While there are probably diminishing returns from research that simply calculates the proportion of healthcare resources consumed by the top 1% or 5% of a jurisdiction's population, a better understanding of this group and its complex needs may inform useful interventions. Such an understanding can highlight where there are opportunities for the experience of care to be improved, for health systems to become more responsive to the evolving needs of this population and for care to be more appropriate and more cost-effective. As part of this population, the needs of patients with multi-morbidities and of patients with mental illness and addictions are particularly poorly met.

The current interest in high users can suggest that it is an issue of recent origin. History tells us otherwise. In the years following the introduction of Saskatchewan's Hospital Services Plan in 1947, a group of researchers with the province's Department of Public Health discovered that "even among the sick fraction of the population there is an especially sick sub-fraction who account for over half of the hospital services given," and they reported the implications of their findings in language that is familiar today, concluding that "it is a challenge to public health and hospital administration to isolate that minority segment who account for a disproportionately high share of the hospital admissions and hospital days. *If they can be identified, perhaps health control efforts could be concentrated on them*" (Roemer and Myers 1956: 480, emphasis added).

Sixty years on, these messages may finally have taken hold. This issue shines a light on clinical and social care integration as a critical lever for health system transformation in jurisdictions across Canada and internationally. The issue's lead paper explores the role of clinical and social care integration within Ontario's health system reform agenda and lessons learned to date. The commentaries showcase what has been learned from efforts to identify individuals with complex needs and to improve their care in Canada, the United Kingdom and the United States. The contributions present a range of perspectives and jurisdictional experiences and we hope that the insights serve to further action on high use. We conclude, however, with five observations that we offer in the spirit of constructively critical dialogue.

First, there is no doubt that Health Links represent a welcome policy innovation. If the design of the initiative is interesting and the initial approach laudable, it seems clear that the actors involved will have different needs for support and guidance as the initiative evolves. Early adopters may have thrived in the context of a low-rules environment

because they were already formed into relatively coherent and functioning networks. Subsequent waves of participants may not be so readily self-sufficient and galvanized. If the initiative is to be successful in its goal of forging stronger links to meet the needs of high users, there may be a need to balance local autonomy for innovation with more consistent frameworks that facilitate the spread of the initiative in a way that ensures some level of consistency in practice and delivery mechanisms. It means that the government and its local agents, the Local Health Integration Networks, will have to continuously redefine their role, and create and mobilize the information and intelligence necessary to support, inform and ensure the continuous success of the initiative.

Second, although two of the contributions in this Issue speak to the issue of evaluation, there is more to say. Bardsley and Lewis and Denis, Cambourieu and Roy argue for more realistic expectations of evaluation and for enough time to be allowed for effects to be shown. The flip side of this, as Bardsley and Lewis imply, is that we also have to become more creative in our approach to evaluation. One route is to develop greater capacity and expertise in the area of rapid cycle evaluation (Hargreaves 2014) along with the flexibility and risk tolerance for innovative programs to adjust in the face of contextual, on-the-ground learning. Having access to linked data sets across the healthcare and social care continuum, in a way that is both timely and respectful of privacy, as well as to other sources of information about the high-users population and related programs implementation, is a necessary condition for the ongoing improvement of policy interventions aiming at better meeting the needs of these populations.

Third, genuine innovation in support of health system transformation will require clear role specifications in governance relationships (in Health Links' case, for example, between the Ontario Ministry of Health and Long-Term Care and its regional agents, the Local Health Integration Networks) that state clearly how each of the key players will support the success of the initiative, and the responsibility they bear for doing so. It will also require bold approaches to accountability that build in space for, and encourage learning from, the "good" failure that goes with the territory of innovation. Understanding the fundamental complexity of health systems and the fact that accountability mechanisms have to balance both responsibility and mutual learning through ongoing quality improvement, is key to the productive accountability relationships that will be instrumental to the success of policy innovations rather than hindering them.

Fourth, if it is clearly becoming de rigueur in discussions of high use to highlight the importance of social determinants and to invoke the rhetoric of social as well as clinical integration, it is less clear how much genuine commitment there really is for the integration of non-clinical services. As the recent Canadian experience with the Housing First approach demonstrates (Goering et al. 2014), for example, supported by the New York experience described in this issue, there are real health dividends to be achieved from tackling the issue of homelessness and poor housing. These are lessons to be taken seriously. In essence, identifying and better meeting the needs of high users requires applying a population health lens to an analysis of healthcare utilization and making sure that primary and secondary prevention at a minimum, and more broadly upstream interventions are in place to better meet their needs. This approach has proven more responsive to the needs of these populations, more cost-effective and to constitute better public policy in general. A focus on clinical care integration alone is likely to fail

to better meet the needs of a number of the high users. Intent and practice to expand the integration from clinical to social care services and broader social determinants are necessary conditions to successful interventions.

Finally, and more fundamentally, the Health Links initiative represents a bottom-up initiative grounded in a strong evidence base and implemented initially in a "low rules" environment that is a promising departure from a traditional, top-down approach to program implementation that has failed to deliver public value commensurate with the investments made in the healthcare sector over the past decade. This approach is consistent with a modern conception of the stewardship role of the government through which the government makes strategic use of information and evidence to empower its agents and creates space for them to innovate in delivering greater value to patients and citizens (Veillard et al 2011). This modern conception of stewardship will keep on being tested as the initiative develops because the government and its agents will have to adapt to an evolving environment and find the right balance between managing the performance of these new entities and ensuring that they set them up for success. With emerging evidence that at least a fraction of high users of healthcare are also high users of broader government services, this experiment will challenge other ministries across the government to work together to address the needs of a common fraction of high users and will show the importance of intersectoral action to deliver better services and manage costs in a way that is meaningful and effective.

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