Guide on Implementing Integrated Care

Implementing Integrated Care as a Challenge

In many health systems, **integrated care** is seen as a possible solution to the growing demand for improved patient experience and health outcomes of multimorbid and long-term care patients. During the last decade different models and approaches to integrated care have been widely applied and documented across a variety of settings, which has resulted in the multiplicity of definitions and conceptual frameworks.[1]

Importance of Implementing Integrated Care for Transforming and Supporting Person-centred Care

Implementing integrated care is a long-term and complex task which requires "simultaneous innovation" including both the technological components of service delivery (i.e. ICT) and the functional/work-related components of health and care services.
Implementing integrated care has a complex mandate, which goes way beyond the development and deployment of ICT solutions, and encompasses a range of at least five strategic considerations:

- the ability to engage and empower people to encourage self-care strategies or support shared decision making between patients and providers,
- the creation of well-functioning inter-disciplinary teams of care practitioners supporting care delivery that are effectively coordinated,
- the management of effective networks between partners in care,
- the alignment of financial flows and organizational governance, and
- the promotion of action at political and practical levels to support innovations that embed ICT-enabled integrated care as a legitimate, and accepted, approach to care delivery.

Key Issues Regarding the Implementation of Integrated Care

A guidance on an appropriate implementation strategy to navigate this complicated transformation. There is not yet a dedicated guide which encompasses all aspects of the entire integrated care implementation process. However, some valuable insights were
found from the lessons learnt in the CareWell project on delivering integrated care to frail patients, reported on in "Guidelines for implementing integrated care in policy and practice.[2]
The key to success in integrated care is **change management** *(there is also a Blueprint guide on change management)*. This is particularly the case because change needs to occur at four levels or scales: the "**nano**- (e.g. with patients), **micro-** (e.g. with multi-disciplinary teams), **meso-** (e.g. through organizations of physician networks), and macro-scale (e.g. by alignment of government policies)".[3] **Whole system change is therefore required.**[4] The management of change at whole systems level is challenging and complex.
It is important to develop good relationships among partners working together, such as through finding shared goals; documenting why integrated care is needed according to particular local circumstances; co-creating a vision for change which contains explicit explanations as to why the current solutions are insufficient; and building integrated care from the bottom-up (although naturally with support flowing from the top-down).
The following additional key issues will also be addressed:

- Determinants of sustainability and scalability of the services,
- Assessment of the technological support,
- Enhanced health risk assessment,
- Factors modulating service transferability.

Supporting Mechanisms and Tools that Help Address the Topic

Eight core components have been identified to enable these relationships and achieve successful management of integrated care programs.
1. **Needs assessment** is a strategy that recognizes the seriousness of the challenges faced by health and care systems to meet current and future demands. It is the first step in the process of developing an objective understanding of population health needs, which in turn can be used to support the underlying rationale for integration and for setting priorities
2. **Situational analysis.** Managers can apply diagnostic tools to assess the current situation in relation to what is trying to be achieved. Situational analysis provides insights on the 'strategic fit' of new approaches, such as integrated care, amongst key stakeholders, and can be used to justify change management program and/or to priorities the focus of change.
3. **Value case:** these cases are built by applying a methodological approach (such as logic modelling, described below) to assess the "value", i.e. the benefits, of introducing changes to a system and predict the outcomes of these changes. A value case is a means of assessing the value that an intervention brings. It is useful at the planning stage, as it helps to calculate the benefits

that would be brought about by a change to a system and enable them to be balanced against the cost. In the case of introducing integrated care, the "value" in the value case is not just about potential financial returns but also the benefits to patients and whole communities brought by the approach. The value case helps to identify cause and effect relationships, supports the development of relevant outcome indicators, and brings stakeholders together in understanding the rationale for change. For this reason, the assessment for building the integrated care value case is based on the needs of local populations (whereby benefits are achieved through a pro-active process which seeks to engage care partners, build social capital and improving care and outcomes for people). A value case helps to develop a shared vision and a set of common goals to different providers or teams.

A common method for building a value case is "logic modelling", which assesses assumptions about the strength of interventions and identifies cause and effect relationships. Moreover, it aids in building relevant performance indicators whilst considering the consistency of interventions. It could be considered as a step by step approach which helps with, first, the need to consider the integrated care plan as a whole before, second, the focus on and analysis of the steps of the plan in more detail (questions, topic of concerns, needs, factors involved, outcomes etc.)

4. An effective **strategic plan** helps to link care professionals and otherwise separate organizations into a collective agreement; sets the terms of engagement between the different parties, their key roles and responsibilities; and outlines the range of outcome and performance indicators that can be applied to assess whether integrated care strategies are a success.

5. Ensuring **mutual gain** hangs on the development of effective partnerships however, it is not only dependent on the development of a 'shared vision'. What appears to be just as important is the ability to ensure that all partners in care fully understand and accept their roles and responsibilities, to the extent that a high degree of trust and respect exists between partners.[5] Therefore, all partners must recognize and value the level of commitment and reciprocity of actions of others; specifically, they must understand the mutual gain obtained from working together.

6. A **communication strategy** needs to deliver clear and consistent messages by multiple channel (e.g. interne and social media) to all key stakeholders, but specifically to organizations and professionals delivering change at the clinical and service levels. An experienced communications manager is required to engage and align teams due to the complex nature of proposed changes for care integration which will have a direct impact on vested interests.[6]

7. **Monitoring and evaluation** framework are crucial to measure: user experience, service utilization, staff experience, and the costs of delivering care. Monitoring is applied most successfully when enough time and effort has been planned for agreeing specific objectives for integrated care with all the relevant stakeholders. To benefit effectively from monitoring and evaluation, managers need to engage service providers, communities and service users appropriately. Additionally, 'rapid cycles' of building and re-building strategies for change, and progress assessment, need to become standard. To foster this relationship and strategies, it is also critical that an enabling environment is established to support the implementation and act as a catalyst for change.

8. **Scaling-up strategy** to upgrade the overall quality of care and life and particularly to improve system efficiency for patients with complex or chronic disorders that require multiple services.[7] The European Commission and World Health Organization (WHO) have defined the main steps for setting up an effective scaling-up as such:

- Firstly, identify a credible, observable, relevant, easy to install and understand, compatible, testable and flexible objective to expand that is also applicable to patients with complex conditions and in an evolving setting;
- Choose the institutions or organizations which will be involved in scaling up

A strategic choice must be made as to which type of scaling-up strategy to pursue vertical or horizontal. A vertical strategy includes specialized and primary care under one management structure and requires knowledge related to health systems planning, budgetary cycles, financing, programmed structures, management, human resources, logistics and ICT. A horizontal strategy links community-based service and refers to expansion and replication in different geographic area or can be extension to serve larger or different population groups.[8]

Main Stakeholders Concerned

Stakeholders involved in the process of implementation of integrated care cover a diverse spectrum of sectors: national and local government, health and social care providers, technology producers, organisations representing healthcare professionals, patient and carer advocacy groups and third sector and charity organisations are to name only the most obvious. However, the main player in this process will be the local authorities responsible for delivering health and social care.

Examples, Good Practices and Evidence of Impact Relevant to the Topic

- In Catalonia, to ensure quality, sustainability and transferability of both healthcare policies and services in the transition toward a coordinated service delivery scenario, four integrated care programs aimed at assessing large-scale implementation of integrated care, which are developed

within the umbrella of the regional project Nextcare (2016–2019). One of the assessment protocols was designed to evaluate population-based deployment of care coordination at regional level during the period 2011–2017, the other three were service-based protocols addressing: Home hospitalization; Prehabilitation for major surgery; and Community-based interventions for frail elderly chronic patients. All three services have demonstrated efficacy and potential for health value generation. They reflect different implementation maturity level.[9]

• Ireland's Health Services provide four integrated-care programs (older Persons, children, patient flow, prevention and management of chronic disease) which work with the National Clinic Program to deliver seamless person-centred, coordinated health and social care services. Each of the programs is developing a framework for the management and delivery of health and social care services, and an implementation plan to be followed over the coming two to five years.[10]

References and Guidance Documents

- Guidelines for Implementing Integrated Care in Policy and Practice: The Journey to Deploying Scaleable Integrated Healthcare Services. Carewell project (2017): http://carewell-project.eu/fileadmin/carewell/deliverables/d8.6_v2.0_carewell_guidelines_for_deployment_printable_version.pdf
- Nine steps for developing a scaling-up strategy (2010): https://www.who.int/immunization/hpv/deliver/nine_steps_for_developing_a_scalingup_strategy_who_2010.pdf
- Integrated care models: an overview (2016): http://www.euro.who.int/__data/assets/pdf_file/0005/322475/Integrated-care-models-overview.pdf

Endnotes

1. World Health Organization. (2016). *Integrated care models: an overview.* http://www.euro.who.int/__data/assets/pdf_file/0005/322475/Integrated-care-models-overview.pdf.

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