European Health Management in Transition

How to Deliver Integrated Care: A Guidebook for Managers

Edited by
Axel Kaehne and Henk Nies

HOW TO DELIVER INTEGRATED CARE

European Health Management in Transition

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Healthcare is currently undergoing an unprecedented period of change, which is presenting a challenge to the fundamental tenants of health management and policy established over the last decades. The differentiated nature of the change agenda and the pace of change has been such that there has been limited space or time to provide a structured or comprehensive response, or to consider at a strategic level how health management teaching and practice should evolve and develop. This then is the focus for the European Health Management in Transition series, published in alliance with the European Health Management Association (EHMA).

Books in the series investigate how changes to the health and social care environment are leading to innovative and different practices in health management, health services delivery design, roles and professions, architecture and governance of health systems, patient engagement and all other paradigmatic shifts taking place in the health context.

The books provide a roadmap for managers, educators researchers and policy makers to better understand this rapidly developing environment.

Books in the series:

Axel Kaehne and Henk Nies (eds): *How to Deliver Integrated Care: A Guidebook for Managers*

Federico Lega and Usman Khan: *Health Management 2.0: Meeting the Challenge of 21st Century Health*

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HOW TO DELIVER INTEGRATED CARE: A GUIDEBOOK FOR MANAGERS

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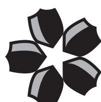

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TABLE OF CONTENTS

List of Tables and Figures *ix*

List of Contributors *xi*

About the Contributors *xiii*

Foreword *xix*

1. Integrated Care – An Introduction 1
   Axel Kaehne and Henk Nies

2. Financing Care Integration: A Conceptual Framework of Payment Models That Support Integrated Care 15
   Eric van der Hijden and Jeroen van der Wolk

3. Leadership in Integrated Care 39
   Helen Dickinson and Catherine Smith

4. Engaging Patients for Integrating Care 59
   Rachael Smithson, Christina Wicker and Kimberley Pierce

5. Social Dimensions of Care Integration 75
   Karin Kee, Henk Nies, Marieke van Wieringen and Bianca Beersma

6. Values in Integrated Care 95
   Nick Zonneveld, Henk Nies, Elize van Wijk and Mirella Minkman

7. Digital Health Enabling Integrated Care 115
Carolyn Steele Gray, Dominique Gagnon, Nick Guldemond and Timothy Kenealy

8. Implementing Integrated Care 137
Axel Kaehne

9. Evaluating Integrated Care 161
Walter Wodchis, Carolyn Steele Gray, Jay Shaw, Kerry Kuluski, Gayathri Embuldeniya, G. Ross Baker and Maritt Kirst

Index *183*

LIST OF TABLES AND FIGURES

Table 2.1.	Overview of Payment Models by Type of Integrator.	21
Table 3.1.	IC Leadership Competencies.	44
Table 3.2.	Desirable Personal Characteristics of IC Leaders.	46
Table 3.3.	Mechanisms for Change in Complex Systems.	51
Table 7.1.	Non-adoption, Abandonment, Scale-up, Spread and Sustainability Domains and Guiding Questions Adapted for Integrated Care.	124
Table 7.2.	Recommendations for Implementing Digital Health Solutions in Integrated Care.	127
Table 9.1.	Summary of Selected Evaluation Approaches.	164

Figure 1.1.	Framework for Integrated Care.	5
Figure 3.1.	Medical Leadership Competency Framework.	43

Figure 3.2. Different Levels of Care Integration and Associated Leadership Styles and Tasks. 48
Figure 4.1. Design Thinking Process. 63
Figure 4.2. Workshop and Validation Flowchart. 66
Figure 6.1. Value Mapping Exercise. 107
Figure 7.1. Digital Health Technologies to Support Components of Integrated Models. 117
Figure 7.2. Steps in User-centred Co-design of Technology. 121
Figure 8.1. Kotter's 8 Steps of Implementation. 146
Figure 9.1. Example Logic Model. 165
Figure 9.2. Summary of Evaluation Steps: The Evaluation Framework. 176

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FOREWORD

European Health Management in Transition

When the discussion to develop this series on European Health Management in Transition began two years ago the world was a very different one to that which faces us as the first volume of the series is published. The seed for those early discussions emanated from the community of European health policy and management academics and practitioners, who regularly met under the auspices of the European Health Management Association. Established over forty years ago during the early days of collaborative European engagement on matters relating to health management and practice, discussion had turned to a consideration of how best to bring together current thinking in a form readily accessible to a policy, practitioner and academic audience.

On the basis of the value of collaborative European engagement and exchange having been established, our series provides a platform to consider how this prism maybe used to highlight how health management could best respond to this rapidly evolving health policy arena; the underpinning contention being that in order to successfully respond to the dynamics of a rapidly evolving health policy environment, health management systems and processes must rapidly evolve. The rationale for such thinking stems from the contention that health management evolved out of the systems of health

administration introduced in the post war period to support the substantive widening of publicly funded healthcare. Hence, while health management was evidently more dynamic and purposeful in form, the connector between them was that both were orientated around the same predict and provide public service model, where the parameters of economic growth, sociodemographic change and health need were to a greater extent linear and foreseeable.

Such assumptions held for a period, but came to be challenged as the balance between infectious and non-communicable disease tipped firmly towards the latter; manifest not only through well-established post war trends relating to smoking, cancer and coronary heart disease, but latterly with obesity, diabetes and Alzheimer's disease accounting for a greater proportion of health need. The complex, multi sectoral and interdisciplinary nature of need did not lend itself well to single domain management practice, versed at it is in the centrality of the hospital and the healthcare professional. This is not to say that the discipline of health management has not offered significant value to those seeking to establish efficient and effective health systems, able to meet fundamental population health need. Rather as the new century replaced the old, it was becoming increasingly apparent that traditional health management practice, was finding the challenge of delivering patient centred value-based healthcare a significant one.

Developments within health systems, as the planning, organizing and delivering of health services were experiencing a never before achieved level of complexity and challenge. Population health management and medicine of initiative are substituting the traditional 'reactive' posture of medical environment. Co-creation and co-production of services are replacing the notion of patient empowerment. Integrated care, from a sterile discussion among academics and policy-makers,

has morphed into managed clinical networks, hub & spokes systems, hot & cold structural solutions, multi-discipline and multi-professional clinical services lines, and much more. Less 'shuffling boxes around', more management on the 'shop floor'. New professions are gaining turf as the hierarchical relationship between doctors and rest of the health professionals is slowly but steadily moving toward a more horizontal positioning.

Doctor-manager roles are reconfigured toward clinical-leaders, as health systems are aware that sustainability is not just a matter of controlling costs, but rather an exercise of priority-setting, engagement and collective and individual accountability. Universalism is now widely re-conceptualized in selective universalism. Universal Payer systems are moving quickly toward mixed systems, with increasing levels of health care intermediated by private third payors. Health services consumerism is reality, if not a want of patients. For sure, it's not any more an ideological or abstract thinking. Hence, health management is more central than ever, being pivotal to this revolution.

Additionally, we have the poignant irony of the COVID-19 pandemic, as a twenty-first century manifestation of the type of public health calamity that had been thought to have been consigned to a chapter of medical social history, returns to further challenge the fundamental tenants of traditional healthcare management. Equally, whilst many aspects of the health management response to the pandemic were highly laudable, it has also been evident that traditional health management often appeared to lack the flexibility necessary to respond to medial and political direction efficiently and effectively.

The *European Health Management in Transition* Series tackles all the 'disruptive' changes that are re-framing the way management needs to develop within health systems and

organizations. It includes a scene setting volume, which sets health management practice to be at a turning point. This imagining of European health systems facing a dynamic and rapidly evolving need profile, fuelling a radical change in health management practice, forms then the central horizontal pillar of the Series. Rest of the volumes of the series then consider how the principal domains of health policy and practice are evolving in the light of these changes. Themes identified as vertical columns in the wider structures of modern day health and social care are integrated care, patient engagement, personalization and value based care, digital health and the future governance of health systems.

The *European Health Management in Transition* series comes then at a timely juncture. Health systems are having to rapidly respond to the now common notion of the new normal, where the challenge of meeting the real and present danger of the existing pandemic continuing to impact on healthcare for the foreseeable future. Combined with the challenge of non-communicable disease remaining in the health policy 'pending tray', leaves today's healthcare manager seeing challenge coming from every side. Our Series will address these challenges head on, providing foundations to frame the new context and adopting a forward (and lateral) looking perspective in order to help those working in this field to more fully understand and to be better prepared to respond to these challenges ahead.

1

INTEGRATED CARE – AN INTRODUCTION

Axel Kaehne and Henk Nies

WHY INTEGRATED CARE?

Over the last decades, the health of populations has improved dramatically. As life expectancy is increasing all across the world, chronic and complex conditions are becoming a key issue for care systems everywhere. Where, previously, interventions for acute infections constituted the bulk of care related tasks, now, continuing and long-term health conditions are the norm for many people. These ongoing health conditions require the collaboration of many different staff, often across professional and organizational boundaries. However, our health systems are often ill prepared for this shift from acute to long-term care. Where single specialties used to be sufficient, now multi-professional and multi-agency interventions are often needed. This calls for flexible person-centred services that can deliver effective care to individuals, often across the life course.

As health systems developed historically in response to acute intervention models, they are not set up to cope well with patients with long terms care needs. Worse, funding, infrastructure, and organizational structures are often not geared toward the new models of care necessary to address ongoing care requirements. 'One-size-fits-all' is often still what is routinely offered by many health services. Yet it is not just the personalization of services that poses a problem. The interprofessional nature of today's care means that different organizations need to work together to create smooth care pathways for patients often suffering many different conditions at the same time. It makes collaboration across professions with different status, training and values essential, something for which medics, nurses and care staff have been ill prepared in their education and training. Moreover, funding systems and legislation are poorly adjusted to this new reality.

Integrated care takes up this challenge around the significant demographic change and its attendant shift in patient needs from acute to long term care. It tries to design services that provide holistic and seamless care for individuals, taking their specific needs into account. This is not a simple thing to do. As a recent study pointed out care integration is

> *…an emergent set of practices intrinsically shaped by contextual factors, and not as a single intervention to achieve predetermined outcomes.*
>
> (Greenhalgh, Shaw, & Hughes, 2020)

It makes integrated care an endeavour requiring and, in turn impacting on, policy, clinical practices as well as the care organizations themselves. This shift to collaborative care models demands a sea change in how we organize care for patients in the long run.

As pandemics like COVID-19 are turning health systems across the world upside down, managers and service directors may temporarily have to fight sudden health system emergencies. Yet the long term trend in health systems remains orientated towards providing person-centred, well-coordinated services to people with chronic and complex conditions.

Collaboration and adaptation have therefore become bywords for the urgent demands on health management and policy. This book will help managers identify and implement innovative integrative solutions for care services stretched by rising demand, rapid change and soaring costs.

The magnitude of change currently occurring in health systems is humbling. Our notion of health itself is being revised in the face of unprecedented challenges. Huber et al. (2011) argue that resilience and self-management will play key roles in our understanding of what health is. As resilience, asset based approaches and self-management take centre stage for all services contributing to health of individuals, the notion of quality of life, as a way for framing health as a holistic concept, becomes ever more important. Although, many health care organizations and health care workers recognize this implicitly, traditional single disease oriented approaches of health care are still being employed routinely, in particular with people with long-term, chronic and multiple conditions. It speaks to reason that the traditional 'silos' of specialties need to give way to collaborative, integrative, cross-sectoral approaches to care.

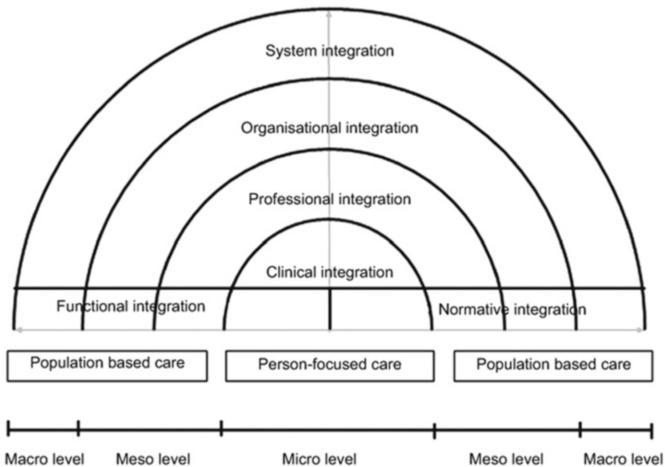
The debates around how to bring about person-centred care illustrate this clearly. Standardized, off-the-shelf solutions come increasingly under pressure to be replaced by specifically tailored and individual care management approaches which take into account multiple care needs of patients and service users.

What person-centred care, resilience, asset-based approaches and self-management have in common is that they require multi-professional and inter-organizational interventions and support mechanisms to achieve the best outcomes for patients and users. This is what integrated care is all about.

WHAT IS CARE INTEGRATION?

In this book, we will provide directions for answers to the question of how to deliver integrated care. But first, we need to define what we mean by integrated care. Care integration is defined as 'a coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors' (Kodner & Spreeuwenberg, 2002). It relates to connectivity, alignment of, and collaboration between social services, public health, citizens and communities (van Duijn, Zonneveld, Lara Montero, Minkman, & Nies, 2018). It may extend to issues of substance abuse, addictions, mental health, old age and frailty, or social exclusion of people with disabilities. At present, most integrated care research is generated by studies in acute and long-term care, but the knowledge about integration in other sectors is growing. The main purpose of integrated care is to reduce 'fragmentations in service delivery and to foster both comprehensiveness of care and better care co-ordination around people's needs' (González-Ortiz, Calciolari, Goodwin, & Stein, 2018).

Valentijn and colleagues have summarized the various domains of integrated care in a useful framework (Valentijn, Schepman, Opheij, & Bruijnzeels, 2013). As can be seen in Fig. 1.1, integration takes place at various levels, in a horizontal or vertical direction.



Source: Valentijn et al. (2013) under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs 4.0 Unported (CC BY-NC-ND 4.0).

Fig. 1.1. Framework for Integrated Care.

1. a personal or clinical level refers to the extent to which services are coordinated in consultation with the person.
2. a professional level refers to the extent to which professionals coordinate services across different fields of specialty.
3. an organizational level refers to the extent to which organizations coordinate services between different organizations.
4. a system level refers to the alignment of organizational structure, governance and policies in various policy domains.

Moreover, integration can occur in a vertical direction too. There, the four levels are to be aligned through measures at

clinical level, mirroring professional integration and collaboration. Systems ideally facilitate these coordinated and integrated actions at the various levels. Macro-level integration supports processes at meso level (organizational integration and professional integration) in order to deliver a coherent package of services and treatment to the individual. This demonstrates that care delivery is embedded in the social context of the particular individual, such as next of kin, family, household, neighbours and friends, work, or school.

What Does Integrated Care Look Like in Practice?

So far, we spoke about integrated care in an abstract way. It has become clear that integration is about making useful connections to serve the relevant needs of individuals. But what are 'useful' connections and what are 'relevant needs'?

As needs of patients and service users differ there are usually several solutions to one problem. There may be care quality standards or clinical guidelines for some issues, but no standard can tell us all about the quality of care an individual requires. Therefore, there is a need to align the professional and clinical protocols with the individual *needs* profile. What is the 'right' thing to do in a specific situation? How can we achieve the best result for somebody in our care? Integrated care helps us define the balance between what is most effective in terms of health and what has most value to the patients and users in our care.

The recent COVID-19 crisis amply illustrates that in order to achieve a good person-centred solution, all clinicians and care workers need to work towards what they agree to be the most effective decision. This is to align with what the person and his or hers relatives see as the most appropriate solution. Following Pim Valentijn et al. (2013), this may be called

normative integration. It takes place within the context of the professionals' standards of care quality, the norms espoused by the person involved, as well as the norms and values we bring to bear on our decisions on a daily basis. It is of considerable importance in the context of integrated care.

Besides normative consensus, functional integration of care delivery is also required. Functional integration is about the issue of 'who does what'. Questions about what patients themselves do or want may help us to define the division of labour. What are the tasks for the professionals caring for an individual, what do informal carers do and what can be dealt with by the patient him or herself? Professionals have assessment tools and protocols to coordinate across their delivery activities. They make decisions about care inputs, skills, expertise, resources and information needed to act. Aligning this with organizational and staff roles as well as responsibilities and resources is a key task for managers. Carefully calibrated integrated care packages may provide the answer to the problems of allocation and coordination. However, they are not an answer that is easy to identify, but once found, integrated services will make for better outcomes. More recently, the issues of self-management and shared decision making have received considerable attention. What a patient can and wants to contribute to the decisions about their care is critical to make the resulting care package a success. This links with the issue of informal care which now contributes the overwhelming bulk of care activities.

That is why normative and functional integration are interdependent: the choices we take as professionals when planning functional integration reflect normative principles we hold dear about quality, access and equity of care. In addition, those who receive care must be part of this conversation. They are the ultimate arbiters of care quality.

The Nuts and Bolts of Integrated Care

There are different ways of making connections between the various domains of integrated care. Leutz argued (Leutz, 1999) that there are mainly three types of integration; linkage, coordination, or full integration.

Linkage is about arranging services in line with existing divisions of labour in the health system. It is a useful approach in those situations were clinical and professional roles are well defined in the care process. For instance, in the case of stroke services, the various tasks of different services are well known and distinct from each other. Linking services focuses on providing referral routes ensuring that patients are at the right place at the right time. Linkage calls for clear communication between professionals, facilitating continuity of care when people move from one service to another.

Coordination is a way of integrating services where care provision, definitions of core tasks, patients flows and eligibility criteria require mutual adjustment. The aim is to optimize service use, share clinical information, manage transitions of patients between settings and assign responsibilities, including overall network governance and leadership. Coordination entails more shared responsibilities and resources than linkage, but operates largely with organizationally distinct structures in care services. Co-ordinating the points of friction and discontinuity between services and systems is a key objective of this type of integration.

Full integration develops comprehensive care programmes or care packages for specific client groups. It usually takes place where new programmes or units are created which pool organizational resources drawing on multiple care systems. Full integration programmes tend to define new tasks and transform professional practices and delivery for everyone involved. Fully integrated services are likely to be jointly