Integrated Care Solutions ©
Supporting the effective and sustainable implementation of integrated care
The Implementation Model for Integrated Care
Past innovations have not often been successful

People want to be a part of something when they feel that what they are doing aligns with their attitudes, values and beliefs and improves peoples healthcare

- Integrated care programmes are fragile for many reasons:
  - Politics
  - Finance and incentives
  - Governance and accountability
  - Professional tribalism
  - Social norms and values
  - Evidence and belief
  - Time

- They require constant effort to nurture
  - Building social capital is a necessity
  - Culture and values are important
Implementation science is weak

- There is a lack of evidence supporting ‘how’ to design, pilot, implement, assess, and scale-up innovations that support integrated care;
- Most existing diagnostic frameworks set out the key building blocks of an integrated care system, but are unable to articulate or untangle the highly complex dynamics and interrelationships between key factors;
- The dynamics of integrated care is akin to a “multiple simultaneous equation” that requires simultaneous effort at a number of different levels;
- There is a lack of appreciation of this complexity;
- There are few effective tools to support implementation in practice. A number of promising approaches are developing but our understanding of what it takes to implement integrated care effectively is at an early stage of development.
Emerging key lessons from practical experiences

Box 1: Key lessons for implementing integrated care from practical experiences

• Finding common cause with partners.
• Developing a shared and bold narrative to explain why integrated care matters, written in a way that is tailored to meet local circumstances and conditions.
• Creating a compelling and persuasive vision for change that sets out an urgent case for why ‘business as usual’ will not work, and describes what integrated care can achieve, especially to the potential benefits of patients.
• Identifying services and user groups where the potential benefits of integrated care are the greatest.
• Understanding that there is no ‘one model’ of integrated care and supporting a process of discovery rather than design.
• Building integrated care from the bottom-up in a way that is supported from the top-down, whilst avoiding structural solutions with an over-emphasis on cost-containment.
• Aligning financial incentives, or removing financial disincentives, for example, through pooling resources to enable planners and purchasers to use resources flexibly.
• Innovating in the use of contracting and payment mechanisms.
• Supporting and empowering patients to take control over their health and wellbeing.
• Sharing information about patients with the support of appropriate information governance.
• Using the workforce effectively and to be open to innovations in skill mix and staff substitution.
• Restructuring care delivery assets, for example through less hospital-based care and more primary and community-based care.
• Setting specific objectives and measures to stimulate integrated care delivery, enable the evaluation of progress, and supported by a performance and quality management system.
• Establishing a strategic communications plan that enables a clearly defined message to be provided and understood across all stakeholders.
• Being realistic about the costs of integrated care.
• Integrated care is a long-term agenda, and represents an ongoing system-wide transformation.
• Acting on all these lessons together as part of a coherent strategy.

Sources: 15, 19–25

Available at: http://carewell-project.eu/fileadmin/carewell/deliverables/d8.6_v2.0_carewell_guidelines_for_deployment_printable_version.pdf
“The experience of organisations that have made the transition from fragmentation to integration demonstrates that the work is long and arduous. [Managers responsible for achieving change] need to plan over an appropriate timescale (at least five years and often longer) and to base their actions on a coherent strategy”

[Ham & Walsh, p.7]
Key Components of an Implementation Strategy

1. **Needs assessment**
2. **Situational analysis**
3. **Value case**
4. **Vision and mission statement**
5. **Strategic plan**
6. **Ensuring mutual gain**
7. **Communications strategy**
8. **Implementation and institutionalisation**
9. **Monitoring and evaluation: continuous quality improvement**

Needs Assessment

➢ Develop an objective understanding of population health needs to support the underlying rationale for integrated care
➢ Identify gaps in care and priorities for action that frame future decision-making
➢ Derive the data that supports the effective targeting of population cohorts who would most benefit from care coordination
➢ Establish the ‘common cause’ as a means to develop partnerships

Examples and tools:
• Joint Strategic Needs Assessments (JSNAs) by Health and Wellbeing Boards in England;
• Health care needs assessments using ACGs in Veneto, Italy
Situational Analysis

➢ Provides an in-depth understanding of the issues to be resolved in building new skills competencies
  ➢ e.g. on the existing and future human, technical and financial resources available
  ➢ e.g. on the local context of implementation (e.g. geography; politics; culture; economics)

➢ Uses diagnostics tools

➢ Takes a whole-system focus

➢ Provides insight on the ‘strategic fit’ of different approaches to integrated care

➢ Prioritises the focus of change and helps justify the case for an integrated care programme

Examples and tools:

➢ SWOT;

➢ Root Cause Analysis;

➢ Five Whys;

➢ The 7S Model;

➢ PEST / PESTELI;

Specific diagnostic tools for integrated care:

➢ Development Model for Integrated Care (Minkman);

➢ Rainbow Model for Integrated Care (Valentijn)

➢ Project INTEGRATE (Calciolari et al)

➢ SCIROCCO/EIP-AHA Integrated Care Maturity Model (Pavlickova)
Value Case

- An approach that attempts to understand the level of investment required, and the return on that investment
- Essential to release resources from funders
- Focus on ‘value’ created rather than costs contained – so focus on patient and staff experiences (inclusive of patient views)
- Establish ‘added value’ resulting from combing resources and expertise
- Establishes compelling case for change

Examples and tools:
- Integrated care ‘value based tool-kit’ in England developed by the Local Government Association;
- Simulations and modelling;
- Xcelere8 & Collabor8 initiatives in Canterbury DHB, NZ
- Logic Models
Logic modelling, or programme logic, is an approach for representing the way a programme’s various components are expected to fit together to achieve its outcomes. It is widely used, for example in England, to shape integrated care strategies.

The approach requires in-depth thinking about what outcomes are being sought, over what time-scale, for whose benefit, with what resources and investments. It crucially requests evidence behind the logic of why integrated care models might provide a solution.

### Value Case: Use Logic!

**INPUTS**
- Workforce
- Funding
- Facilities
- Technology

**ACTIVITIES**
- Develop and deliver training
- Design operating model
- Coordinate the office move
- Implement new systems

**OUTPUTS**
- Trained staff
- New care Models
- Co-location
- Data sharing

**WHOLE SYSTEM OUTCOMES**
- Patient experience

**BENEFITS**
- Delivering person centered coordinated care through
- Improving service user experience
- Achieving health and well being outcomes
- Using resources effectively

**INPUTS**
- Improving service user experience
- Achieving health and well being outcomes
- Using resources effectively
**Vision and Mission Statement**

- Articulates compelling case for change
- Developed in an inclusive way with key stakeholders, including patients, to promote ownership of vision
- Defining narrative to confer meaning and purpose of change, especially to patient benefits (often written from point of view of patients)
- Promotes understanding, builds legitimacy, guides action and decision-making, motivates staff

**Examples and tools:**
- The ‘narrative’ developed by National Voices and adopted by the National Collaboration on Integrated Care in England;
- The ‘Esther project’ in Jönköping, Sweden
- The ‘Mrs Smith’ story in South Devon and Torbay (repeated in many different parts of England)
Strategic Plan

- Gains signed and formal commitments to change from partners in care
- Establishes the rules of engagement
- Defines the roles and responsibilities of partner organisations
- Creates the key goals and outcomes to be achieved, including performance indicators
- Develops a time plan for action
- Builds collaboration and consensus in strategic decision-making

Examples and tools:
- National Strategy for Integrated Palliative Care in Serbia
- Belgian Chronic Care Strategy
- Results based accountability (RBA) during the Chronic Care Demonstrator programmes in Wales
A movement for change

Mutual Gain and Reciprocity

- A common vision and an understanding of providers’ interdependencies in achieving outcomes is not enough
- Building trust requires commitment and reciprocity
- Reciprocity requires an understanding and development of ‘mutual gain’ to overcome key organisational barriers to participate
- *Tie-ins* are important
- Mutual gain is often financial and contractual, but may also refer to quality of working life, intellectual property, advancing knowledge, improving quality of care and so on

Examples and tools:
- Care Group development in the Netherlands to support multiple agencies tackle chronic illness;
- Alliance contracting in Counties Manakau, New Zealand to support population health
- Shared gain contracts with primary care professionals in Gesundes Kinzigtal, Germany
- Managed care organisations in the USA with affiliated networks (e.g. Kaiser Permanente)
Communications Strategy

- Delivery of clear and consistent messages to all stakeholders, but especially to those at a clinical and service level
- Educate and inform people, so building awareness, engagement and understanding
- Develop relationships and conversations with ‘end users’ to build alliances – make change relevant to local people
- Ensure messages promote the mission and vision – avoid ‘bad news’ stories (e.g. Switzerland)

Examples and tools:
- Communication strategy development that is co-produced with end users (e.g. in Finland for the development of new nurse roles)
- Public events and workshops
- Networking – growing communities of interest (e.g. Better Care Exchange, England)
- Multiple channels of communication including social media
Implementation

- An in-depth understanding of the clinical and service delivery model that is needed through robust joint planning
- Testing phase through pilots and pioneers
- Supporting learning development to support the implementation of change and the roll-out of best practice
  - Best practice
  - Networks
  - Expert support / mentorship
  - Dragon’s Den
- Innovation in funding and contracting
- Maintaining momentum – expert management support and investment

Examples and tools:
- Scaling-up integrated diabetes pilots in Belgium
- Learning network / integrated care collaborative (e.g. Joint Improvement Team, Scotland; AQuA discovery communities, England; Basque Country; CLALIT system in Israel etc)
- Professional support from ‘experts’ (e.g. Better Care Fund Task Force, UK)
- Maturity model, EIP-AHA B3
Monitoring, Evaluation and Quality Improvement

- Clear and co-produced measures and indicators through which to judge and drive performance
- Aligning measures to guidelines for clinical governance as well as pay for performance
- Evaluation frameworks and scorecards
- Utilising data for peer-review and transparent reporting
- Improvement process to address high impact changes
- Build and re-build strategies for change based on evaluation results (rapid cycle change)

Examples and tools:
- Using monitoring and information in Belarus to improve infant mortality
- Research and evaluation built in to system architecture – e.g. Clalit, Israel; Basque, Spain; Intermountain, USA
- Lean Thinking in Managed Care Organisations of the USA (e.g. Mayo Clinic)
- Quality Dashboards (e.g. Whole System Integrated Care, NW London)
Developing an Enabling Environment

1. Developing a guiding coalition
2. Building support for change – network management
3. Developing collaborative capacity
4. Clinical and system leadership
Developing a Guiding Coalition

- The need for a guiding ‘mind’ to oversee the implementation strategy
- Development of co-operation and agreements at level of policy-making,
- Teams (and leaders) at a senior decision-making level with credibility and ability to take change agenda forward
- Both within health but also with other sectors, including the community

Examples and tools:
- MoH in Basque country supporting regional research institute and convening high-level meetings to take agenda forward;
- Creation of National Collaborative for Integrated Care in England leading to a £5.3bn funding stream to drive integration agenda
Building Support for Change

- Integrated care will mean different things to different people – different motivations, priorities, prejudices and understanding
- Attitudes to change at a local level need careful handling as it’s a high relational task
- Invest in the development of ‘social capital’ required – awareness and adaptation of strategies in the face of key norms, values and cultures
- Being inclusive at all stages of design and delivery, avoiding top-down mandates for partnership working

Examples and tools:
- Engaging partners at all levels of the health system in Slovakia;
- Stakeholder analysis to understand the views of different stakeholders and so assess and create plans to overcome ‘resistant forces’ to change
- Effective communication strategies
- Network management through skilled brokers or ‘boundary spanners’
- Community councils and democratic representation at local level (e.g. Eksote, Finland)
Collaborative Capacity

• Addressing workforce competencies
• Building relationships and strengthening ties between partners in care to establish trust and a willingness to take shared accountability for outcomes;
• Developing effective teams requires the legitimacy, ability and skills to work together including the authority to act;
• Addressing language barriers through shared communication channels and common understanding

Examples and tools:
• Diagnostics tools (ITMA, POET)
• Inter-professional education and learning;
• Team-building courses and training programmes (e.g. TeamSTEPPS©);
• Relationship management and inter- personal communication skills;
• Promotion of MDTs and team working skills and competencies;
• Methods and forums for reconciling differences
Collaboration is a skill that requires effort and practice.
Leading and Managing Integrated Care Programmes

Lessons from Evidence

Long-Term Commitment

Shared / Collaborative Leadership

New Skills to Lead and Manage Networks

Transparent Entrepreneurship

Development Model for Integrated Care (Minkman, 2012)
Lessons from Experience (The King’s Fund, 2011-15)

- Start with a coalition of the willing
- Inspire vision
- Involve patients and service users
- Build an evidence base
- Provide leadership ‘across’ the system: span boundaries to promote co-operation
- Develop ‘collective’ leadership, not ‘command and control’
- Engage clinicians – get them to lead efforts for change – enable distributed leadership
- Ensure constancy of purpose yet flexibility
- Foster ‘collaborative capacity’
- Pursue stability of leadership
- Invest in system leaders as they require support in their role
Leading and Managing Integrated Care Programmes

Lessons from the Experience of Senior Leaders

Communication

Be Disruptive

Take the Agenda to a Policy Level

Promote Distributed Leadership

Be Brave

“Strong and respected clinical leadership is essential for achieving clinical integration.”
Ken Kizer, former CEO, VHA

“One can have a compelling narrative … yet have an inadequate leadership culture. Locally ‘owned’ [innovation] will tend to grow more quickly and better survive any political turnovers.”
Rafael Bengoa, former MoH, Basque

“You also need thick skin-ness, bloody mindedness and tenacity because every man and their dog who describes themselves as an ‘expert’ would probably have told you never to have started the journey”
David Meates, CEO, Canterbury DHB
The Implementation Model for Integrated Care

Change Management Steps:
- Needs Assessment
- Situational Analysis
- Value Case Development
- Vision and mission statement
- Establishing mutual gain
- Communication
- Implementation and institutionalisation
- Monitoring and evaluation

Relationship Building Activities:
- Establishing a guiding coalition
- Building support for change
- Developing collaborative capacity

Feedback Loop/Cycle of Learning

Time

Goodwin, 2015, 2017; Lewis and Goodwin, 2017
The Implementation Model for Integrated Care

Change Management Steps
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Feedback Loop
Cycle of Learning

Diagnosis
Analysis and Design
Implementation Support
Evaluation

Goodwin, 2015, 2017; Lewis and Goodwin, 2017
Implementing Integrated Care

Key Conclusions

1. Management – the step-wise progression of managerial processes that need to be addressed (i.e. a change management/commissioning cycle)
2. Environment – adaptations in the context of integrated care that are necessary to support implementation of change in practice
3. Leadership – steering the path effectively

ALL tasks have a strong relationship-building component between leaders, managers, care professionals, populations and patients in order to promote awareness, justification, agreement and support for integrated care

Key issues for success include:

➢ A sound and objective understanding of health needs of a populations and why integrated care will add value to people’s health and wellbeing;
➢ A shared vision with a common set of objectives;
➢ New ways of working with joint accountability for outcomes and mutual gain;
➢ Relationship-building and service innovation comes before structural reform
➢ An open and transparent learning system
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