Frameworks for Assessing Integrated Care:
The Building Blocks for Successful Implementation and their Implications in the Australian Context

Dr Nick Goodwin, CEO, IFIC
Jubilee Room, NSW Parliament House, Sydney
20 March 2018
Introduction to IFIC Australia
IFIC Australia was founded in November 2015 as a collaborative venture between IFIC and the Centre for Rural and Remote Mental Health, University of Newcastle.

**Mission**

To develop capacity and capabilities in Australia and the Asia Pacific Region in the effective design, implementation and delivery of integrated care. IFIC Australia seeks to achieve this by providing a platform to develop and exchange of ideas and promote activities in the Region in keeping with IFIC’s mission.

**Partnership Scheme**

From July 2017 onwards, IFIC Australia has sought to develop an inaugural group of corporate partners to help take forward IFIC’s mission and aims across the Region on a more sustained basis.

Corporate partners have a mutual commitment to support the adoption of integrated care in policy and practice. IFIC Australia and its Corporate Partners work together to develop projects, educational activities or material of mutual benefit that meet the aims and objectives of IFIC Australia.
Want to know more?

https://integratedcarefoundation.org/ific-australia

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Outline of Workshop

Dr Nick Goodwin is CEO of the International Foundation for Integrated Care

IFIC is a non-profit members’ network that crosses organisational and professional boundaries to bring people together to advance the science, knowledge and adoption of integrated care policy and practice.

The Foundation seeks to achieve this through the development and exchange of ideas among academics, researchers, managers, clinicians, policy makers and users and carers of services throughout the World.

- Introduction: Understanding the integrated care challenge
- Session 1: The Need for Assessment Frameworks
- Session 2: A Rapid Review of Assessment Frameworks
- Session 3: Management and leadership
- Session 4: Assessing the Maturity for Adopting Integrated Care in Australia
- Take Home Messages
Introduction: Understanding the Integrated Care Challenge
What does integrated care mean to you?
The Challenge: Designing Better Care

Frontier Economics (2012) Enablers and barriers to integrated care and implications for Monitor -
This Figure depicts a real-life context of a patient with advanced Alzheimer’s disease (Malcolm) and his principle carer and spouse (Barbara).

The web of care was drawn by Barbara to illustrate, over a seven year period, the range of clinical and non-clinical services required to support their needs.

The illustration shows how care support to people with complex needs comes from a highly diverse and largely unconnected web of care services.
Barbara has supported her husband, Malcolm, to live with Alzheimer’s disease for 16 years.

Together, they faced daily challenges in navigating the health system (e.g. primary, community and hospital-based care), the social care system (e.g. respite and day services for the elderly, welfare benefits, at-home care support), and a myriad of other services from the statutory, private and voluntary sectors.

At any one time, over a dozen ‘touch points’ were held with different care professionals,

Care and support services were not always available and/or were poorly co-ordinated.

Barbara has reported increasing feelings of isolation, depression and an inability to cope.
The real-life experience of Malcolm and Barbara in the UK context is not unique but illustrates a number of key problems that fragmented health and care systems create, including:

- **a lack of ownership** from the range of care providers to support ‘holistic’ care needs, driven by silo-based working and separate professional and organisational systems for governance and accountability;
- **a lack of involvement of the patient/carer** in supporting them to make effective choices about their care and treatment options or enabling them to live better with their conditions through supported self-care and empowerment strategies;
- **poor communication between professionals** and providers, exacerbated by the inability to share and transfer data, silo-based working, and embedded cultural behaviours;
- **care and treatment by different care providers for only a part of their needs**, rather than seeing the person as a whole and managing all of the needs;
- the resultant **simultaneous duplication of care** (e.g. repeated tests or re-telling of a person’s medical history) and **gaps in care** (e.g. as appointments are missed or information and follow-up is not applied);
- **a poor and disabling experience for the service users** as information is hard to get hold of, differing advice and views are presented, confusion is created in the next steps of a course of illness;
- **reduced ability for people to live and manage** their needs effectively; and ultimately
- **poor system outcomes** in terms of the inability to prevent unnecessary hospitalisations or long-term residential home placements.

Goodwin N, Alonso A (2014) Understanding integrated care: the role of information and communication technology in Muller S, Meyer I, Kubitschke L (Eds) Beyond Silos: The way and how of eCare, IGI Global
Understanding Integrated Care

Nick Goodwin

Box 1: Four Commonly Used Definitions of Integrated Care

A health system-based definition
“Integrated health services: health services that are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course.” [4]

A managers’ definition
“The process that involves creating and maintaining, over time, a common structure between independent stakeholders ... for the purpose of coordinating their interdependence in order to enable them to work together on a collective project” [5]

A social science-based definition
“Integration is 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 care and cure sectors. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for people by cutting across multiple services, providers and settings. Where the result of such multi-pronged efforts to promote integration lead to benefits for people the outcome can be called ‘integrated care’” [adapted from 6]

A definition based on the perspective of the patient (person-centred coordinated care)
“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.” [7]
What is integrated care? A summary

There are three distinct dimensions to what integrated care means in practice:

- Integrated care is necessary where fragmentations in care delivery mean that care has become so poorly co-ordinated around people’s needs that there is an adverse, or sub-optimal, impact on care experiences and outcomes.

- Integrated care therefore seeks to improve the quality and cost-effectiveness of care for people and populations by ensuring that services are well coordinated around their needs. It is by definition, therefore, both ‘people-centred’ and ‘population-oriented’.

- The people’s perspective thus becomes the organising principle of service delivery, whether this be related to the individual patient, their carers/family, or the wider community to which they belong.
Session 1: The Need for Assessment Frameworks
The Need for Assessment Frameworks to Support Integrated Care

- 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;
- There is some understanding of this complexity, but approaches lack the ability to untangle complex relationships;
- There are many existing tools to support measurement of processes and outcomes, but very few are specifically tailored to integrated care;
- There are few effective tools to understand support implementation in practice. Our understanding of what it takes to implement integrated care effectively is at an early stage of development;
Assessment Frameworks May Help Overcome Avoidable System Failures

• 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

• Integrated care projects are often established in isolation
  – Projects often start and remain as time-limited pilots and fail to be sustained, to be replicated, or to grow to the necessary scale and maturity to have impact

• Organisations and systems usually have limited knowledge of, or access to, grounded implementation practice

• There is often a lack of investment in research and evaluation to assess the ability of care systems to adopt integrated care successfully
“Our findings highlight a continued gap in tools to measure foundational components that support integrated care … Continued progress towards integrated care depends on our ability to evaluate the success of strategies across different levels and context”

Key Points:

- Despite far reaching support for integrated care, conceptualizing and measuring integrated care remains challenging
- From 114 unique tools reviewed, most sought to measure care coordination, patient engagement and team effectiveness/performance.
- Few tools examined performance measures and information systems, alignment of organizational goals and resource allocation.
- The search yielded 12 tools that measure overall integration (‘multiple domains’)

https://www.ijic.org/articles/10.5334/ijic.3931/
Domains for Measuring Integrated Care (Care Co-ordination)

Co-ordination activity:
- Establish accountability/negotiate responsibility
- Communication – informational and inter-personal
- Facilitate transitions – e.g. across settings or as coordination needs change
- Assess multiple needs and goals
- Pro-active care planning
- Monitor, follow-up, review
- Support self-management
- Link or refer to community resources
- Align resources to meet individual or community needs

Service delivery approaches:
- Care management
- Medicines management
- Healthcare at Home
- Multi-disciplinary teams
- ICT-enabled integrated care (e.g. telehealth)

Three Key Perspectives:

Family/patient
Professional
System/organisation
Evidence from Practical Experiences

Co-ordinated care for people with complex chronic conditions

Key lessons and markers for success

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Supporting the effective and sustainable implementation of integrated care
Session 2: Assessment Frameworks for Integrated Care Systems
Guess these examples ....
WHO Global Framework for Integrated People-Centred Health Services

Strategic direction 1.
Empowering and engaging people

- Seeing people and communities as assets
- Empowerment, engagement and co-production
- Self-management
- Health education
- Focusing on the most disadvantaged

Figure 1: continuum strategies to support self management

Source: The Health Foundation
Strategic direction 2. Strengthening governance and accountability

- Regulatory frameworks
- Aligning finances and resources
- Strengthening public reporting and involvement
Strategic direction 3. Reorienting the model of care

- Rebalancing health services towards primary and community-based care
- Creating new ways of coordination and cooperation
- Defining roles and responsibilities

Source: “Pathways for long-term care provision in Austria, Interlinks, European Centre 2009"
Effective care co-ordination can be achieved without the need for the formal (‘real’) integration of organisations. Within single providers, integrated care can often be weak unless internal silos have been addressed. Clinical and service integration matters most.

Source: adapted from Leutz 1999 in Nolte & McKee (2008)
“to create an enabling environment for change that promotes population health in a participatory and inclusive manner…. adopting and managing strategic approaches that facilitate the large scale, transformational changes that are needed to support people-centred and integrated health services for all.”

WHO Europe’s Framework for Action on Integrated Health Services Delivery: an overview. WHO Regional Office for Europe, Copenhagen 2016
Optimity Advisor’s Health Check Readiness Domains

- Based on a review of evidence from implementation models
- The evidence says that each of the 10 domains contribute to the success of accountable integrated care
- A system is assessed against an evidence-based checklist for each of the domains identifying areas of risk, local priorities and action plans
- The profile across all domains results in a picture of system resilience to deliver the triple aim
Optimity Advisor’s Health Check Readiness Domains

The Health Check Self-Assessment Levels

1. An aspiration
2. A commitment to turn the aspiration into reality
3. A critical mass and plans are in development
4. Whole system working is delivering accountable care

Immature

Maturing

Critical Gaps
The Project INTEGRATE Framework

- The following slides show the dimensions and items of the conceptual framework developed and validated within the WP11 of the EU-funded Project INTEGRATE that concluded in August 2016 (www.projectintegrate.eu)
- The methodologic aspects in the development and validation of the framework are explained in the official Project report to the EU and will be published in forthcoming academic papers.
- The framework provides an evidence-based understanding of the key dimensions and items of integrated care that the research showed were associated with successful implementation.
- The different framework dimensions and items were see to be both relevant and important in different country-contexts and to different disease- and condition-specific population groups.
- The framework aims to provide a conceptual basis for reflecting on the design and implementation of new integrated care programs/projects.

Dimension 1: Person Centered Care

Perspective of improving someone’s overall well-being – and not focusing solely on a particular condition/disease – through the active engagement of service users (patients, carers, etc.) as partners in care.

1.1 Health literacy: service users and care professionals work together to obtain and understand basic health information needed to make appropriate health decisions

1.2 Supported self-care: service users are empowered to self-manage the symptoms, treatments, physical, social, emotional, and behavioural consequences of living with long-term conditions

1.3 Carer support: caregivers are supported in a way that builds their capacity of caring and managing the burden of their care relationship

1.4 Shared decision-making: service users are actively involved in decisions about their care and treatment options

1.5 Shared care planning: service users are actively involved in establishing a holistic care plan

1.6 Service users are supported to give regular feedback on quality and continuity of care received

1.7 Service users have access to their own health care records
Dimension 2: Clinical Integration

It refers to how care services are coordinated and/or organized around the needs of service users.

2.1 Care professional work together to undertake care assessments and planning

2.2 Named care coordinators ensure continuity of care to service users over time

2.3 Co-ordination between care professionals enables seamless care transitions for service users across care settings

2.4 Professionals work together to proactively manage the needs of defined service user groups (e.g., case management with precise inclusion criteria)

2.5 There is a single point of entry for service users when accessing multiple services from different professionals/providers (centralization of referrals)

2.6 Volunteers and the community are actively involved in coordinating care around people’s needs

2.7 Partners in care follow defined care pathways to help understand and direct the process of care integration
Dimension 3: Professional Integration

*It refers to the existence and promotion of partnerships between professionals to work together (e.g., in teams).*

| 3.1 | Professionals recognize and enact shared accountability and responsibility for care outcomes |
| 3.2 | Formal agreements exist that support collaborative working between care professionals |
| 3.3 | Care professionals work in inter-disciplinary or multi-disciplinary teams with agreed roles and responsibilities |
| 3.4 | Multi- and inter-professional training and education is continuously supported |
| 3.5 | Care professionals have a long-term commitment to leading, developing and delivering integrated care in partnership with others |
Dimension 4: Organisational Integration

It refers to how providers come together to deliver care services in a linked-up fashion across partner organizations.

| 4.1 | Care organisations participating in integrated care use a shared set of measures and indicators to monitor outcomes and performance |
| 4.2 | Collective incentives (shared gain) exists between care organisations to support care integration |
| 4.3 | Care organisations regularly engage the staff in a process of joint learning and continuous quality improvement |
| 4.4 | Care organisations have shared strategic objectives and written policies and/or procedures to promote integrated care (inter-organisational strategy) |
| 4.5 | Care organisations have shared governance and accountability mechanisms to ensure that they are formally interdependent to deliver integrated care |
It refers to how the care system provides an enabling platform for integrated care, such as through the alignment of key systemic factors (e.g., financing mechanisms, regulation).

| 5.1  | The care system uses a set of common measures and outcomes to monitor and assess performance |
| 5.2  | The care system aligns its regulatory framework with the goals of integrated care |
| 5.3  | The care system has financing and incentive arrangements that directly promote the provision of integrated care |
| 5.4  | National/regional policies pro-actively support and promote multi-sectoral partnerships and person-centred care |
| 5.5  | The care system has invested in an adequate workforce in terms of the numbers, competences and distribution of key staff to support the goals of integrated care |
| 5.6  | All stakeholders (e.g. service users, professionals, managers) are actively involved in the design, implementation and evaluation of integrated care programs and policies |
Dimension 6: Functional Integration

It refers to the capacity to communicate data and information effectively within an integrated care system.

6.1 A uniform patient/user identifier shared between the different care organisations

6.2 The communication of data and information between care professionals and service users is effective

6.3 Decision-support systems are available and foster shared decision making between professionals and service users

6.4 Shared care records (e.g., single electronic health record) enable data and information to be shared for multiple purposes (e.g., needs assessment, performance management and evaluation)
Dimension 7: Normative Integration

It refers to the extent to which different partners in care developed and shared a common reference frame (e.g., vision, norms, values) on care integration.

7.1 Existence of a collective vision on person-centred, holistic care (i.e., not disease-centred)

7.2 Collective practice puts emphasis on population health management aiming to improve access and care experiences as well as outcomes of specified populations

7.3 Building awareness and trust in integrated care services with local communities

7.4 Presence of leaders with a clear and common vision of integrated care

7.5 All stakeholders (e.g. professionals, managers of organisations, service users) share a clear vision of integrated care

7.6 Partners in care have a high degree of trust in each other’s reputation and in their ability to deliver effective care through collaboration
Supporting self-assessment and quality improvement to support implementation

The framework is intended to be a means both to support the design and implementation of integrated care programmes and to compare or benchmark initiatives.

In 2016, we undertook work with case sites in Barcelona, Berlin & Norrtalje to test out the framework with multi-disciplinary teams of managers and professionals.

In 2017, further work has been done in a formative evaluation of Central Coast’s Integrated Care Programme in NSW, Australia.

In 2018, development of an Integrated Care Initiative Tool in supporting PHNs and LHDs in their integrated care planning and design (developed in collaboration with CRRMH, University of Newcastle) and to support HSE in Ireland undertake an assessment of readiness for integrated care nationally.
Analysis of context-dependence

We examined context-dependency in two ways:

- similarity/difference between contexts
- the connections between Framework dimensions (e.g. taking person-centred care as the outcome measure)

Positive scores on clinical integration (i.e. how care is co-ordinated around people’s needs) was the key factor associated with higher scores across the Framework when holding for context

- This potentially corroborates other research findings that suggest it is integration at the clinical and service-level that matters most

Positive scores in person-centred care (as the outcome) was correlated most closely with functional dimensions

- This potentially corroborates other research findings that suggest that relational continuity – i.e. how information is shared and the way in which it is shared through good clinical integration – supports better system outcomes

System-level factors seemed to be negatively associated with achieving person-centred care

- This potentially corroborates that a focus on system reform and structures is NOT as important in achieving integrated care outcomes when compared to other aspects such as person-centredness, care co-ordination and functional integration
Established integrated care organisation in 2010 combining primary/secondary care with elderly/social care.

Goal is equal access to care across a rural municipality with a focus on prevention and citizen responsibility in own care.

Eksote provides all health, family and social welfare and senior services for 133,000 citizens some 200km apart. Village associations have a key part to play to promote health and wellbeing and prevent social and medical problems – e.g. themed events for the hard of hearing and with various sports federations.
Case Example: Eksote, Finland

Home-based rehabilitation services, with significant use of remote monitoring and health coaching including an ER “in your living room” rapid response service.

Nurse-led mobile health units across rural villages. Services include:

- Nurse consultation
- Health counselling
- Regular health checks
- Treating wounds
- Capillary blood work analysis (e.g. glucose)
- Vaccinations and medicines
- Dental care
- Physiotherapy

Impact includes an 88% reduction in need for hospital care; 56% reduction in the need for home-based visits; and a 30% cost reduction to the care system.
Case Example:
End of Life Care, Midhurst, England

**Awareness-raising and relationship-building**
GPs, community staff, hospital consultants, volunteers and local people strengthening its ability to ‘capture’ people nearing the end of life before, or very soon after, a hospital admission.

**Holistic care assessment & personalised care plan**
A single assessment process examines both the health and social care needs of the patient and their family. It also takes into account their personal choices about future care and treatment options.

**Multiple referrals to a single-entry point**
The service accepts referrals from any health professional and also local people. All referrals come into the service and are assigned to a clinical nurse specialist from a single-entry point.

**Dedicated care co-ordination**
The care co-ordinator has a number of roles: acting as the principal point of contact with the patient and their family; effectively co-ordinating care from within a multidisciplinary team and liaising with the wider network of care providers.

**Rapid access to care from a multidisciplinary team**
Both professionals and volunteers can be rapidly deployed by the service to provide care or support to meet the needs of people living at home. The service operates 12 hours a day, with access to an on-call clinician out of hours.
Case Example: End-of-Life Care, Midhurst, UK

Total assumed cost of 1000 patients in the last year of life under the Midhurst model was 20% less than care in other settings (hospital and hospices). The cost savings were due to fewer stays in hospital in the integrated model of care.

How would you assess the prospects for integrated care in your own context?

Discussion and Break
Session 3:
Management and Leadership
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
A movement for change

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
IN FOCUS
Culture Change: Do We Have What it Takes to Enable Collaboration?
Who said what about whom?

Social worker?

“I’m not sure they always appreciate the power that people perceive them to have. I think there’s a massive power imbalance and I think that’s both with patients but also with other professionals. I don’t know if they’re aware of that.”

Social workers about GPs

General practitioner?

“They do an awful lot of training as well, don’t they, don’t you find? (They) are either on holiday or on training, they do a myriad of training days.” "And why are they never there on a Friday?"

GPs about social workers

“...very proactive and actually search out people who might need ... extra care and actually try and put it in place rather than letting things come to a disaster phase.”

GPs about GPs

“...I’m sure they started out by wanting to help people and do something of value, that’s why they must have gone into the job in the first place.”

GPs about social workers
What is culture?

- the shared basic assumptions that an organisation learns as it solves problems of adaptation and integration. These are considered to be ‘valid’ and are taught to new members as the correct way to perceive, think, feel or act.’ (Schein)
- ‘the values and beliefs that characterize organizations, as transmitted by socialization processes that newcomers have, the decisions made by management, and the stories and myths people tell and retell about their organizations’ (Schneider and Barbera)
- ‘the interweaving of an individual into a community and the collective programming of the mind that distinguishes members … it is the values, norms, beliefs and customs that an individual holds in common with other members of a social unit or group’. (Ogbanna)
- ‘deeply held beliefs about success' (Bissell)
The Three ‘Levels’ of Culture (Schein, 2010)

**Artefacts**

Found at the surface level and including all the phenomena seen, heard and felt when encountering an unfamiliar culture.

Includes visible manifestations such as:
- architecture and environment
- language;
- style as embodied in clothing, manners of address,
- emotional displays;
- myths and stories told about the organisation etc.

**Espoused values**

The ‘what ought to be’ as distinct from the ‘what is’.

**Underlying assumption**

The truth about the world (world views or paradigms)
Group Work: Considering Culture

- Working in a huddle, identify *artefacts* from everyday work/practice that suggest that integrated care / accountable care is being achieved
- Also suggest *artefacts* that suggest there is more work to be done
- What do you think are the *assumptions* that lie beneath the artefacts?
The Iceberg Model of Competencies

Technical competencies

Behavioural competencies

Can be influenced directly through education and training

What we know and can do

What we perceive and what motivates us

May be influenced indirectly through education and training and role models

Stein 2016, based on McClelland 1973
Collaborating Across Boundaries: A Confusion of Languages

**People-related challenges**
where existing professional groups and cultures have become increasingly specialized and seek to differentiate their activities rather than work together in interdisciplinary ways

**Organizational-related challenges**
where different stakeholders do not share a common goal to promote the welfare of people and where different values and goals are held by organisations and professionals working in different contexts and settings
Creating a New Culture

➢ Develop action steps for stabilizing, reinforcing, and sustaining the change:
  ➢ Give people time to mourn their actual losses.
  ➢ Provide skill and knowledge training.
  ➢ Develop new reward systems.
  ➢ Recognize and celebrate accomplishments.
➢ Develop performance measures to continually monitor the results from the change and to identify opportunities for further improvements.
➢ Make adjustments to the change vision and strategy to reflect new learning and insights.
➢ Encourage people to be open to new challenges, forces, and pressures for the next change.
Culture Change Comes First!

➢ Most alterations in norms and shared values come at the end of the transformation process.
➢ New approaches sink in after success is shown.
➢ Feedback and reinforcement are crucial to buy-in.
➢ Sometimes the only way to change culture is to change key people.
➢ Individuals in leadership positions need to be on board, or the old culture will reassert itself.
In conclusion….

➢ Culture and values are central to positive collaboration
➢ Recognising their importance and taking steps to collectively understand local variation are essential first steps
➢ Teams play a key role in any integration initiative – for better or worse…
➢ These issues are never ‘sorted’ but require continual focus and investment
➢ The ‘soft’ stuff is really the ‘hard’ stuff
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
Session 4:
Examining the Maturity for the Adoption of Integrated Care in Australia
EU’s Maturity Model: The Scirocco Project

Maturity Model and self-assessment tool to facilitate scaling-up and transfer of good practices in integrated care across Europe

Twelve dimensions

www.scirocco-project.eu/about
Please refer to your handouts
In the SCIROCCO Maturity Model, many activities need to be managed in order to deliver integrated care have been grouped into 12 dimensions, each of which addresses part of the overall effort.

Working in huddles we will consider each dimension, self-assess the current situation in Australia (in your own context), and allocate a single ‘measure’ of maturity within that domain from your huddle.

We will attempt to develop a radar diagram of the results which will reveal potential areas of strengths but also gaps in capability and areas of weakness.
Group Work:
SCIROCCO Radar Diagram for Australia

1. Readiness to Change
2. Structure & Governance
3. ICT & eHealth services
4. Standardisation & simplification
5. Funding
6. Removal of inhibitors
7. Population approach
8. Citizen empowerment
9. Evaluation methods
10. Breadth of ambition
11. Innovation management
12. Capacity building
Implementing Integrated Care: Where does this kind of assessment fit?
A movement for change

The Implementation Model for Integrated Care

Change Management Steps

- Needs Assessment
- Situational Analysis
- Value Case Development
- Vision and mission statement
- Strategic plan
- Establishing mutual gain

Relationship Building Activities

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

Feedback Loop
Cycle of Learning

Diagnosis
Analysis and Design
Implementation Support
Evaluation

Monitoring and evaluation
Communication
Implementation and institutionalisation

Goodwin, 2015, 2017; Lewis and Goodwin, 2017
IFIC’s Approach

- Diagnosis
- Analysis and Design
- Implementation Support
- Ongoing Evaluation
Dr. Nick Goodwin, CEO

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International Foundation for Integrated Care

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Want to know more?

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