The Project Integrate Framework

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S. Calciolari, L. González, N. Goodwin, V. Stein

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About the 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

Dimension 5: Systemic Integration

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

Further Information

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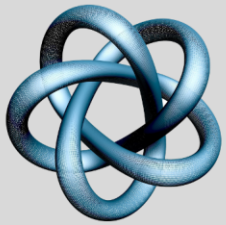
Contact:

Stefano Calciolari stefano.calciolari@usi.ch

Nick Goodwin nickgoodwin@integratedcarefoundation.org



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