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PRACTICE GUIDE

How can organizations IMPLEMENT INTEGRATED CARE?

CREDITS

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FOREWORD

Four practice guides for Ontario Health Teams

Four practice guides were prepared for Ontario Health Teams (OHTs). The guides are relevant for any group of providers and organizations aiming to implement a connected health care system centred around patients, families and caregivers. Each of the four guides focuses on a different aspect of a more connected and better integrated approach to care and has a slightly different emphasis and target audience. The guides can be read independently but achieving the overall implementation of OHTs will require attention to all dimensions presented.

This is the first guide which focuses on essential aspects of implementation. It outlines key activities that are necessary at the organizational and inter-organization levels and activities required of senior management across organizations in order to enable managers and providers to reorganize around patient and family/caregiver-centred care. The implementation of OHTs will not be successful unless organizations think differently about care and set parameters so that providers and managers realign their care to think across organizational lines to encompass the patient's journey. The primary audience for this guide is organizational leadership.

The second guide focuses on what it means for care to be centred around patients, families and caregivers and highlights 6 essential attributes of patient and family/caregiver-centred care. Two case vignettes are presented that characterize when a care system is well organized around a patient, and when the care system is fragmented. Achieving the well-coordinated system is a common thread that runs through all of the guides with specific mention in 3. This guide is central to the overall focus of Ontario Health Teams and is relevant to all leaders, providers, patients and the public.

The third guide focuses on the activities of providers and managers that are necessary to achieve patient and family/caregiver-centred care. The activities are organized around the 6 attributes and specific vignettes are provided that demonstrate what providers and managers have to do to enable the well-organized system in contrast to the fragmented case. The audience for this guide is primarily providers and managers though it is relevant to senior leadership that need to create the context that enables providers and managers to focus on these new activities and to create the space and time required for change.

The fourth guide focuses on governance. This guide outlines the internal and external changes that have to occur to create sustainable systems of connected care. The audience for this guide is organizational leadership and governors.

While there are many important aspects to implementing integrated care, this starter set provides a basis for understanding important new ways of working and fundamental shifts in collaboration across health and social care providers. Many more topics are important including population-based management, co-design, human resources and workforce transformation to name just a few. The most important guidance is to retain a focus on what is important to patients and caregivers; gather together the people you need to work with; agree to a common vision and principles that support your planning and implementation work; and build and support trusting relationships with all your team members. These essential ingredients, blended with courageous action, will accelerate your success.

HSPRN
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1 PRACTICE GUIDE SUMMARY

How can organizations implement integrated care?

In this practice guide, we review lessons learned in implementing integrated care in Canada and other countries and offer some guidance for leaders and boards on change management strategies.

What are the steps involved?

Reviews of experience elsewhere have outlined four phases in the development of integrated care:

1/ **Initiative and design phase**

2/ **Experimental and execution phase**

3/ **Expansion and monitoring phase**

4/ **Consolidation and transformation phase**

Success in moving forward through these four stages rests on a number of critical success factors, including a compelling common vision for improving care for specific populations, trust and collaboration among key stakeholders, strong clinical engagement, effective care coordination, well-designed care protocols, care coordination and follow up, involvement of patients in the co-design of care, and ensuring staff possess appropriate skills and expertise. Leaders must make long-term commitments to a shared vision and common principles.

> Leaders must recognize that the changes required for successful integrated care are not just technical (e.g., new information systems or new care protocols) but also adaptive (e.g., new relationships, new role and team assignments, and shared accountabilities for care and coordination). Adaptive changes require coaching and support, not just training.

> Change needs to be guided from the top, but led by front-line team members who understand the challenges of care delivery and coordination and whose experiences inform the design of new work flows, effective information and coordination strategies, and the maturation of new teams across agencies.

What are the 3 key takeaways?

1 The literature on integrated care includes a diverse set of models that have performed well, and a number of critical success factors are common to most of these models.

2 Critical issues in early stages of integrated care include the identification of target patient groups who will benefit from integrated care, the development of trusting relationships and agreements among service delivery partners, and the recruitment of clinical team members who have the competencies and support needed to test and refine new models of care.

3 Developing new information strategies to share clinical data, collaborate on care plans and coordinate activities facilitates better teamwork and better patient outcomes and experiences.

INTRODUCTION

Why this is important

Designing and implementing integrated care requires collaboration across care delivery partners, including front-line clinicians, and program and organizational leaders. Lessons from international experiences highlight the key implementation activities, developmental milestones and critical success factors involved in effective integrated care. Implementation approaches using adaptive leadership styles that encourage engagement in service design and improvement will promote more effective designs and sustainability. This section provides an overview of integrated care and implementation strategies setting the groundwork for the more specific advice in the sections that follow.

Lessons from international experiences with integrated care

Integrated care is complex, involving multiple care interventions, new teams, increased communications among providers and greater coordination of care. Different approaches to integrated care have been undertaken in various countries, such as Accountable Care Organizations in the U.S., and Integrated Care Systems in England and Europe. Successful efforts in Canada have also been demonstrated. A variety of policy levers have been used to shape these integrated care efforts in different jurisdictions. The common denominator for these integrated care initiatives is the focus on improving outcomes for specific populations defined in terms of health status (e.g., frail elderly), disease groups (e.g., COPD, CHF, multi-morbid) or specific services (e.g., hip and knee surgery patients) (Nolte and McKee, 2008; Nolte, 2017). Our guidance on the implementation of integrated care starts with understanding the key implementation activities involved and the characteristics of successful initiatives. Despite differences between models of integrated care, there are some common characteristics and similarities in the developmental paths for integrated care initiatives.

How this relates to Ontario Health Teams

The Ontario Ministry of Health and Long Term Care have outlined a Maturity Model for Ontario Health Teams (OHTs) that identifies the expectations for OHTs from initiation to maturity. The materials included here provide a more granular focus on critical issues based on the evidence base for integrated care.

INSIGHTS

Key implementation activities

Based on a literature search and expert review, Minkman and colleagues (2016) identified 9 clusters of activities that contribute to the development of integrated care. They labelled these clusters as: commitment, roles and tasks, inter-professional teamwork, delivery system, client-centredness, quality care, performance management, results-focused learning, and transparent entrepreneurship (see Figure 1). Minkman argues that integrated care initiatives follow a developmental pathway beginning with an initiation and design phase, an experiment and execution stage, an expansion and monitoring phase and a consolidation and transformation stage. These stages have been validated in other studies. The key implementation activities are listed in Table 1.

Development of integrated care can be grouped into four phases...

1/ **Initiative and design**

2/ **Experiment and execution**

3/ **Expansion and monitoring**

4/ **Consolidation and transformation**

Table 1/ Key implementation activities in the developmental model of integrated care

(Adapted from Minkman, 2016)

Phase 1/ Initiative and design

- Delivery system partners identify a targeted patient group and relevant services and care processes
- A multidisciplinary team designs a new care model for the targeted patient group
- Delivery system partners sign agreements to work together

Phase 2/ Experiment and execution

- New initiatives and projects are designed and tested to improve care for the target population
- Care protocols and pathways are developed based on the initial experience
- Care coordinators are embedded to facilitate navigation by patients and caregivers
- Information protocols are developed to exchange data on patients and their care and to facilitate collaboration among the team members
- New ways of working are tested to improve care and care coordination
- Evaluation metrics are used to assess the scale and impact of integrated care programs

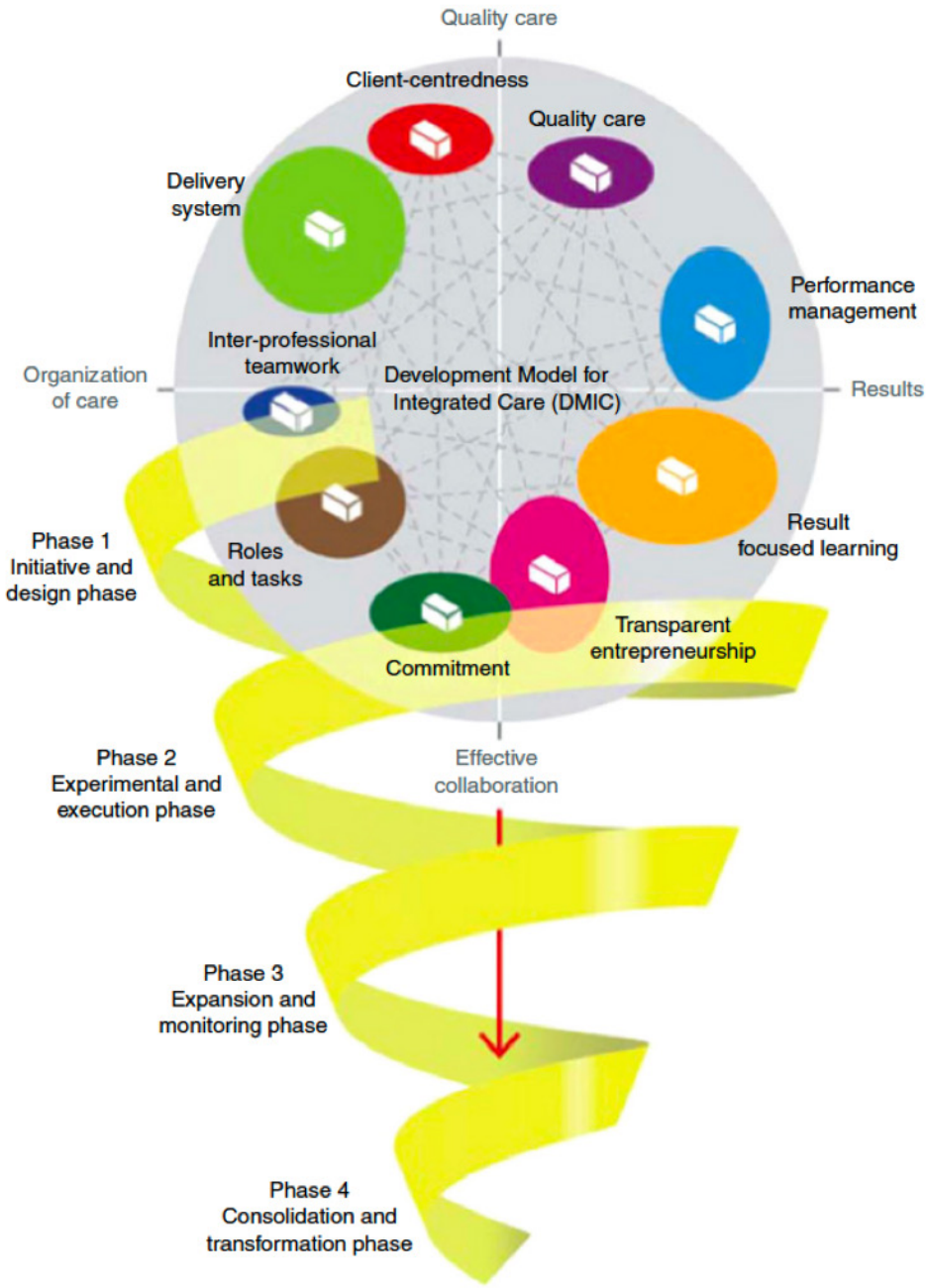
Phase 3/ Expansion and monitoring

- Integrated care projects are expanded to new sites or patient groups
- Agreements on the content, tasks and roles of delivery system partners are revised and approved
- Outcomes, including patient experiences, are systematically monitored and used for improvement
- Delivery system partners examine inter-organizational barriers and suboptimal financial arrangements to improve care delivery

Phase 4/ Consolidation and transformation

- The integrated care program is no longer seen as a pilot, but rather the established way of delivering care to target patient groups
- Coordination has been extended across the continuum of care and information is shared on outcomes and experiences across sites and care delivery partners
- Performance monitoring provides ongoing results and informs improvement efforts
- Organizational structures are shifted to support the new integrated delivery processes
- Financial agreements are shifted to support new care models and desired outcomes
- Care delivery partners seek new opportunities for collaboration with current or new partners.

Figure 1/ Development model of integrated care
(Minkman, 2016)



Critical success factors

In addition to the developmental phases of integrated care, a number of authors have identified critical success factors (see reference 1) for integrated care. These factors reflect leadership and contextual supports necessary for successful integrated care. This list of critical success factors is based on research on Accountable Care Organizations in the US, integrated care initiatives in the UK and Europe, and recent research on 3 successful integrated care efforts in Ontario undertaken by as part of a larger project examining integrated care in 3 jurisdictions. Table 2 lists these factors in 6 categories: leadership and governance, strategy and design, provider and manager activities, teamwork, funding and performance monitoring and improvement.

Table 2/ Critical success factors for integrated care

1/ Leadership and governance

- Trust and collaboration established among key stakeholders in development of integrated care
- Building on a history of successful partnerships
- Compelling vision for change especially around potential benefits for patients
- Transparency and communication among partners
- Partnerships that span a comprehensive range of social and community-based as well as healthcare services that specific populations require
- Strong leadership and governance that is fully committed to clearly defined goals and helps to facilitate change
- Strong physician and other clinical leadership who support quality improvement and cost and help engage front-line staff in service redesign
- Create a strategic communications plan to provide clear messages to internal and external stakeholders
- Recognize that integrated care is a long-term agenda

2/ Strategy and design

- Create a coherent strategy that incorporates the key implementation issues
- Identifying patient groups where benefits are greatest through population-based needs assessment (segmentation and stratification)
- Supporting clinician involvement in service planning, and implementation of new initiatives
- Strong care coordination, embedded and/or linked to physician practices
- Restructuring care to deliver services in different sites/sectors
- Contracts or agreements with all participating partners (e.g., on data sharing, co-location of services)
- Geographic coverage to maximize access and reduce duplication of services

3/ Provider and manager activities

- Following clear and consistent criteria to identify patients who will benefit from integrated community-based health and social care services
- Giving patients and caregivers opportunities to share what is most important to them in their care and including these preferences

in individual care planning and decision making

- Involving patients and caregivers in service (co)-design and organizational decision-making processes
- Supporting and empowering patients to take control of their health (self-care)
- Using the workforce effectively and seeking innovations in skill mix and substitution
- Adopting standardized care protocols, pathways and care plans, adapted to local settings
- Identifying a single point of access for onboarding and assessing new patients
- Ensuring effective flow and tracking of patient referrals (i.e. referrals are accepted, sent and followed up on, within your organization and across other organizations in the health and social care continuum)
- Regular patient follow-up and case management, particularly for the most complex patients
- Facilitating transitions across care settings for patients and caregivers
- Addressing broader determinants of health that impact patient and caregiver's experiences
- Linking patients, families and/or caregivers to informational/educational and community resources
- Ensuring case managers have appropriate skills and expertise to execute their roles
- Developing approaches to manage the cost of delivering integrated care services
- Promoting and supporting self-management practices
- Ensuring that patients and caregivers have someone they can contact if health and social care needs arise

4/ Teamwork

- Building effective professional and interpersonal relationships with providers and other members of each individual patient's healthcare team
- Creating multidisciplinary provider teams with clearly defined roles and tasks
- Sharing patient information among providers
- Developing information strategies and technology such as EMRs and shared communications tools

5/ Funding

- Funding mechanisms that promote teamwork and distribute resources to needed services

6/ Performance monitoring and improvement

- Use a well-developed performance measurement and quality improvement system including feedback to physicians and other staff about results and performance accountability
- Supporting experimentation in design and delivery of collaborative, patient-centered care
- Continued and regular inter-organizational knowledge sharing
- Creating forums and opportunities for learning from external experts and organizations

Change management strategies

The list of critical success factors in Table 2 underlines the complexity of integrated care and the range of changes needed in developing new or expanded roles, expanding program and organizational supports, creating collaborations and improving teamwork and engaging patients and caregivers, clinicians and leaders. Successful integrated care initiatives require transformations at several different levels: between patients and providers; among inter-professional team members; and in developing strategies and approaches for communication and coordination among a network of agencies and organizations.

Nick Goodwin (2017), who has observed integrated care efforts in many different settings, argues that beyond specific activities, the change management process must focus on 3 main goals: alignment, agility, and attitudes.

While each integrated partnership may vary somewhat in its developmental path, Goodwin suggests that success is dependent upon a long-term commitment from leaders to enable changes in work processes and relationships to mature and become embedded.

The developmental trajectory for integrated care initiatives is challenging since many of the critical changes are adaptive rather than technical (Heifetz and Linsky, 2002). While technical changes can be solved with the current skills and problem-solving methods within organizations, adaptive changes require learning new ways of working and, often, new skills for solving problems. Adaptive changes require not just new technology, but new approaches that require facing fundamental issues, in some cases they require rethinking how an organization or program works.

Front-line change

While change is necessary at all levels, the critical transformation to integrated care relies on changes in the work of front-line professionals with support from leaders to enable that change. This has several important implications for change strategies.

First it means that the rate of change is linked to the capabilities of staff (and engaged patients) to redesign care and learn new ways of working. In many cases, experienced and capable staff must learn to work differently, collaborating with staff in other programs or organizations, sharing responsibilities for patient care and support. Staff development and coaching, both in the technical skills required for their new tasks and roles, and in the adaptive process of adjusting to new challenges

The change management process should focus on...

1/ Alignment

Supporting organizations to develop integrated care as part of their core business

2/ Agility

Developing systems and processes that support staff in implementing new care processes and enabling integration to happen at different levels

3/ Attitudes

Addressing the cultural changes needed to support new ways of working

can be critical to their success. This can be frustrating for leaders who want the pace of change to move more quickly. However, accelerating these changes depends upon supporting front-line staff in changing their behaviors and skills, not simply in pushing harder for change.

Thus, the second important implication of effective change strategies is that change has to be bottom-up as well as top-down. Staff need space to develop new approaches to care and collaboration, and support to innovate and adapt improvements. Many successful integrated care initiatives have found coaching resources, practice facilitation and quality improvement expertise essential to the development of integrated services. These resources and skills help to support change from the bottom-up and contribute to an environment supporting clinician engagement, a crucial success factor for integrated care.

Beyond specific skills for designing, coordinating and improving integrated care, Evans and colleagues (Evans et al., 2016) have identified 6 competencies for leading systems of integrated care for populations with complex care needs (see opposite).

The six competencies for doing integrated care well are...

1/ Framing and reframing issues to create clarity, enable shared purpose and build consensus.

2/ Taking the perspective of others to build trust and create safe spaces for collaboration.

3/ Co-designing care with patients and caregivers to ensure systems provide care that meets patients' needs.

4/ Systems thinking to optimize the performance of the system as a whole

5/ Sharing power to enable others to make decisions and act

6/ Reflective learning that enables learning from successes and failures.

Three key takeaways

1

The literature on integrated care includes a diverse set of models that have performed well, and a number of critical success factors are common to most of these models.

2

Critical issues in early stages of integrated care include the identification of target patient groups who will benefit from integrated care, the development of trusting relationships and agreements among service delivery partners, and the recruitment of clinical team members who have the competencies and support needed to test and refine new models of care.

3

Developing new information strategies to share clinical data, collaborate on care plans and coordinate activities facilitates better teamwork and better patient outcomes and experiences.

EXERCISE: IDENTIFY PRIORITY ACTIVITIES

The guidance documents for Ontario Health Teams list multiple components that must be developed by those submitting proposals for OHTs (http://health.gov.on.ca/en/pro/programs/connectedcare/oht/docs/guidance_doc_en.pdf).

Components for OHTs include:

1/ Patient care and experience

2/ Patient partnership and community engagement

3/ Defined patient population

4/ In-scope services

5/ Leadership, accountability and governance

6/ Performance measurement, quality improvement and continuous learning

7/ Funding and incentive structure

8/ Digital health

The critical success factors for integrated care listed in this practice guide include a number of other relevant features that have contributed to the success of integrated care initiatives.

Using both of these lists, identify 3 specific priority activities for discussion and decisions for your organization and the partners engaged in your planning of integrated care.

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NOTES Use the space below to capture your thoughts and reflections.