Annex 3: Project INTEGRATE framework (16)

1. PERSON-CENTRED 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 information needed to make decisions appropriate to supporting users to manage their needs
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: Professional and informal caregivers are supported in a way that both builds their capacity for caring and helps reduce the burden of caring"
1.4 Shared decision-making: Service users are actively involved in decisions about their care and treatment options
1.5 Shared care planning: Shared decisions are included in a holistic care plan
1.6 Feedback: Service users are supported to give regular feedback on quality and continuity of care received
1.7 Health data access: Service users have access to their own health care records

2. CLINICAL INTEGRATION It refers to how care services are coordinated and/or organised around the needs of service users.
2.1 Multidisciplinary assessment and plan: Care professionals work together to undertake care assessments and planning
2.2 Care coordinator: Named care coordinators ensure continuity of care to service users over time
2.3 Care transitions management: Co-ordination between care professionals enables seamless care transitions for service users across care settings
2.4 Case management: Professionals work together to proactively manage the needs of defined service user groups (e.g., case management with precise inclusion criteria)
2.5 Single point of entry: There is a single point of entry for service users when accessing multiple services from different professionals/providers (centralization of referrals)
2.6 Community involvement: Volunteers and the community are actively involved in coordinating care around people's needs
2.7 Integrated care pathways: Partners in care follow defined care pathways to help understand and direct the process of care integration

3. PROFESSIONAL INTEGRATION It refers to the existence and promotion of partnerships between professionals to work together (e.g., in teams)
3.1 Shared accountability: Professionals recognize and enact shared accountability and responsibility for care outcomes
3.2 Collaborative agreements: Formal agreements exist that support collaborative working between care professionals
3.3 Inter- and Multi-disciplinary teamwork: Care professionals work in inter-disciplinary or multi-disciplinary teams with clearly defined roles and responsibilities
3.4 Continuous training: Multi- and inter-professional training and education is continuously supported
3.5 Collaborative attitude: Care professionals have a long-term commitment to leading, developing and delivering integrated care in partnership with others

4. ORGANISATIONAL INTEGRATION It refers to how providers come together to deliver care services in a linked-up fashion across partner organizations
4.1 Performance assessment: Care organisations participating in integrated care use a shared set of measures and indicators to monitor outcomes and performance
4.2 Incentive schemes: Collective incentives (shared gain) exist between care organisations to support care integration
4.3 Learning and quality improvement: Care organisations regularly engage the staff in a process of joint learning and continuous quality improvement
4.4 Shared strategic goals and policies: Care organisations have shared strategic objectives and written policies and/or procedures to promote integrated care (inter-organisational strategy)
4.5 Governance and accountability: Care organisations have shared governance and accountability mechanisms to ensure that they are formally interdependent to deliver integrated care

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 Performance assessment: The care system uses a set of common measures and outcomes to monitor and assess performance
5.2 Regulatory framework: The care system aligns its regulatory framework with the goals of integrated care

5.3 Financing and incentive arrangements: The care system has financing and incentive arrangements that directly promote the provision of integrated care
5.4 Supporting policies: National/regional policies support and promote multi-sectoral partnerships and person-centred care
5.5 Workforce: The care system invests in workforce in terms of numbers, competences and distribution of key staff to support the goals of integrated care
5.6 Stakeholders involvement: All stakeholders (e.g., service users, professionals, managers) are actively involved in the design, implementation and evaluation of integrated care programs and policies

6. FUNCTIONAL INTEGRATION It refers to the capacity to communicate data and information effectively within an integrated care system
6.1 Single common identifier: A uniform patient/user identifier shared between the different care organisations
6.2 Stakeholders communication: The communication of data and information between care professionals and service users is effective
6.3 Shared decision making: Decision-support systems are available and foster shared decision making between professionals and service users
6.4 Shared care records: 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)

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 Vision: Existence of a collective vision on person-centred, holistic care (i.e., not disease-centred)
7.2 Population health management: Collective practice puts emphasis on population health management aiming to improve access and care experiences as well as outcomes of specified populations
7.3 Social capital: Building awareness and trust in integrated care services with local communities
7.4 Leadership: Presence of leaders with a clear and common vision of integrated care
7.5 Shared vision: All stakeholders (e.g., professionals, managers of organisations, service users) share a clear vision of integrated care
7.6 Trust: Partners in care have a high degree of trust in each other's reputation and in their ability to deliver effective care through collaboration