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Unraveling care integration: Assessing its dimensions and antecedents in the Italian Health System

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ABSTRACT

In recent decades, consensus has grown on the need to organize health systems around the concept of care integration to better confront the challenges associated with demographic trends and financial sustainability. However, care integration remains an imprecise umbrella term in both the academic and policy arenas. In addition, little substantive knowledge exists on the success factors for integration initiatives.

We propose a composite measure of care integration and a conceptual framework suggesting its relationships with three types of antecedents: contextual, cultural, and organizational factors.

Our framework was tested using data from the Italian National Health System (NHS). We administered an ad-hoc questionnaire to all Italian local health units (LHUs), with a 60.4% response rate, and used structural equation modeling to assess the relationships between the relevant latent constructs.

The results validated our measure of care integration and supported the hypothesized relationships. In particular, integration was found to be fostered by results-oriented institutional settings, a professional culture conducive to inclusiveness and shared goals, and organizational arrangements promoting clear expectations among providers. Thus, integration improves care and mediates the effects of specific operating means on care enhancement.

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1. Introduction

In developed countries, health systems are pressured to reconsider the organization and set of services provided to new clusters of patients with complex needs [1,2], as growth in clinical specialization – due to the rapid expansion of medical knowledge and technologies – tends to fragment patient care. Integrated care initiatives endeavor to align healthcare provision with evolving patient needs. These initiatives extend beyond the boundaries of any single organization and emphasize coordinated service delivery across health and social care providers [3,4].

This topic is echoed in the organization theory (OT) literature, which considers differentiation and integration as key principles shaping organizational behavior. In particular, Lawrence & Lorsch [5] define integration as the quality of the collaboration that exists among subsystems and seeks to realize unity of effort in the accomplishment of specific organizational tasks. However, applying this principle to healthcare is challenging, as this sector has specificities that must be addressed.

There remains no consensus on a definition of care integration [6]. However, the unifying denominator of integrated care concepts is the goal of improving care and outcomes for patients with diverse, complex needs

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[7]. In addition, Kodner and Spreeuwenberg's [8] widely cited definition suggests another aspect emerging from the literature: care integration results from a range of interdependent interventions, or conditions, at different institutional levels.

The literature provides several conceptualizations to assess this complex construct. However, a recent systematic review [9] showed that only a few assessment approaches rely on parsimonious data collection and do not apply to a specific disease or care setting. In particular, Minkman et al. [10,11] and Valentijn et al. [12] validated, respectively, a quality management model with 89 elements grouped into nine clusters and a taxonomy that specifies 59 items grouped in six dimensions. Both the models do not focus on chronic patient groups, like the Chronic Care Model (CCM) [13], but they are rather demanding in terms of data collection and the former model is designed for improvement purposes rather than exploring conditions of integration. In addition, the two mentioned conceptualizations are not designed to test the relationships between the different considered factors of care integration. Finally, both the context and the culture are considered important conditions for care integration [7,14,15], but they are not fully accounted in existing conceptualizations.

The present study had two main objectives. First, it tests the construct validity and reliability of a parsimonious instrument aimed to assess the phenomenon of care integration. Second, it proposed a conceptual framework designed to analyze the conditions or antecedents of integration, including the context and culture. Using this framework, we derived hypotheses tested in the Italian National Health System (NHS). Finally, we conducted an exploratory analysis of the relationship between care integration and selected, generally desired consequences of its implementation.

The study relies on perceived measures collected from informed professionals and adopts a perspective adapt for managers and policy makers by considering the conditions of integration up and downstream from the processes. The following two sections present our conceptual framework, the hypotheses, and the methods. The last two sections are dedicated to the results, discussion, and conclusions.

2. Conceptual framework and hypotheses

2.1. Dimensions of care integration

The OT literature interprets integration as an effort intended to resolve both cooperation and coordination problems [5]. The former are addressed by providing the necessary motivation to the actors involved, while the latter are best addressed through information sharing [16]. In particular, care integration can be interpreted as a "balancing act", intended to align care processes with patients' complex and evolving needs. The academic literature has elaborated on this construct along five core dimensions: continuity, flexibility, information availability, role complementarity, and responsiveness.

Integration is associated with care processes that are continuous in time [8,17–19]. Such processes should be also sufficiently malleable to adapt to various care needs [8,17,20]. In fact, experimental evidence indicates that groups working on uncertain, complex tasks tend to perform better with less formalized structures [5,21]. Therefore, as care integration addresses complex needs, flexibility is likely an important attribute of its processes. In addition, integrated care processes involve health providers who can easily exchange/access relevant information [17,20,22]. In this respect, we can parallel our construct of care integration with that of "patient-centeredness" in Minkman et al. [10], which includes flexible adjustment to the clients' needs, information sharing/provision—we considered the other elements (e.g., protocols, self-management) as operating means (see Section 2.2.5) in order to distinguish the phenomenon of integration from its antecedents.

The next two dimensions specify that integrated care processes involve health providers with matching expertise/roles [8,13] and facilitate rapid responses to changing needs and emergencies [17,23]. The former aspect (complementarity of roles) is important because it minimizes competition and is a prerequisite for cooperation between differentiated subsystems. The latter dimension is a further specification of flexibility indicating the capacity of managing the unexpected developments associated with unstable conditions.

2.2. Antecedents of care integration

A variety of international experiences support the interpretation of care integration as the result of a complex combination of contributing factors [24–28]. We grouped the influential factors into four categories: contextual traits, transition management culture, organizational arrangements, and operating means (Fig. 1).

2.2.1. Contextual traits

Contextual traits are manifestations of the regulative structures imposed on organizations. They are not within the purview of managers and cannot be altered in the short or medium term. The CCM refers to such aspects by specifying that its four components are set in a health system context linking them with community resources and policies [7]. We focused on the structure of incentives and impediments that are most likely to influence the dynamics occurring at the organizational level: 'institutional adequacy' and 'focus on results'.

Institutional adequacy focuses on the input-side and considers the number of providers involved in care processes and their level of specialization, the availability of resources for care integration, and the flexibility of financing sources. The number and degree of specialization of providers involved in care processes have been increasing to manage knowledge complexity [29]. On the one hand, this trend might lead to fragmentation, due to strong professional identities and norms that hinder collaboration and information flows among professional groups [30,31]. On the other hand, a clear differentiation of roles set the conditions for comprehensive care approaches based on integrating providers from various disciplines in the care process of each patient.

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