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CONFERENCE ABSTRACT

A Theoretical Logic Model of Integration in Health Care

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Michaela Kerrissey[1], Russell Phillips[2], Anna Sinaiko[3], Tsega Tamene[3], Bethany Maylone[3], Mark Friedberg[4], Sara Singer[3]

1: Harvard Business School, United States;

2: Harvard Medical School, United States;

3: Harvard TH Chan School of Public Health, United States;

4: Rand Corporation , United States

Introduction: Recent literature has described key dimensions of integration within health care organizations but has not explored relationships among them. Clarifying these relationships can improve efforts to compare and contrast studies of "integration" in health care.

Methods: To construct a novel theory of integration, we reviewed existing publications from health care and management literature. We synthesized and adapted elements from disparate integration frameworks in order to provide a more complete and contemporary representation relevant to the US healthcare context. The theoretical model was refined based on feedback from academic experts and clinical practitioners.

Results: We defined integration as "planned, thoughtful design of the care process for the benefit and protection of the patient" (Bohmer, Lawrence, & Singer, 2012), and we considered patient care to be integrated when it is coordinated (across professionals, facilities, support systems, over time, between visits) and tailored to patient and family needs, values, and preferences (Singer et al., 2011). We developed a logic model identifying five forms of integration as well as contextual factors that might affect integration and the outcomes that integration should theoretically produce. The five forms of integration include structural, functional, normative, interpersonal, and clinical. Structural and functional forms refer to organizational features such as governance structures and financial management, respectively, while interpersonal and clinical forms describe people and processes, such as teamwork and use of shared care plans (Nolte & McKee 2008; Shortell et al., 2008; Singer et al., 2011; Valentijn et al., 2013; van der Klauw et al. 2014). We define normative integration as the establishment and maintenance of a common culture and norms across units and organizations within a health system, and depict it as cutting across the other forms of integration (Valentijn et al., 2015). Contextual factors that might affect integration include external factors such as market structure and internal organizational factors like financial arrangements. Outcomes that integration might theoretically produce relate to health outcomes, clinical cost, patient experience and provider satisfaction. We suggest empirically testing a set of resulting hypotheses about the relationships among these dimensions of

integrated care: (1) contextual factors are typically precursors to structural, functional, normative, and clinical integration; (2) greater structural and functional integration are associated with greater integration involving people and processes (interpersonal and clinical integration); (3) interpersonal and clinical integration produce better-integrated patient care, yielding superior health outcomes. We explore why results may be mixed for clinical cost, patient experience and provider satisfaction.

Discussion/conclusions: We present a novel, comprehensive logic model of care integration. As provider organizations in the US and elsewhere seek to better integrate care amid limited budgets, understanding relationships among elements of integration, context, and outcomes will inform decisions about resource allocation, implementation, and evaluation.

Limitations: This model is theoretically derived and requires empirical testing.

Suggestions for future research: This integration model can serve as a theoretical basis for future empirical research exploring the relationships among elements of integrated care and outcomes.

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