

INDEX

- Accountability, 101–102
- Activation, 47
- Activity-based payments, 24–26
- Actors, 82–83, 90
- Adaptation, 3
- Adaptive approaches to leadership, 53–54
- Additional payment, 19–20
- Adoption, 116–117, 120
- Ageing Well in Digital World AAL programme, 119
- Agency, 141
- Alternative funding, 23, 26, 29, 31
- Alternative payment, 19–20
- Asset-based approaches, 4
- Base funding, 20, 23–25
- Base models, 29–30
- Base payment, 19–20
- Behaviour, 44
 - prosocial, 83–84
- Beta test, 121–122
- Better Evaluation
 - collaboration, 176
- Boundaries, 78
- Brainstorming, 63–64, 68
- Brainwriting, 86
- Budgets, 19
 - capitated budgets, 25
 - pooled budgets, 28
- Bundled payments. *See* Episode-based payments
- Capitated budgets, 25
- Care
 - community care, 13
 - hospital care, 31, 168
 - nursing care, 26
 - primary care, 25, 65
 - social care, 15, 18–19
- Care integration, 4, 13, 75
 - practice example, 76, 80–81, 84, 87, 89
 - social dimension, 76
- Care organizations, 79
- Case management, 95–96
- Case rates, 24–25
- Centres of Excellence, 30
- Change, 71
 - non-linear change, 139
 - organisational change, 138

- Change programmes in
 - health care
 - organizations, 139
- Clinical nature of change, 144
- Co-design models, 120
- Co-ordination, 99
- Co-production, 99
- Collaboration, 3, 45, 100, 105
- Collaborative values
 - session, 107–109
- Combined commissioning, 31
- Commissioner or payer
 - model, 18–19, 30, 33–34
- Commissioning, 15
- Communication, 150–151
- Competence framework, 78
- Competencies, 40, 42–43
- Competitors, 82
- Complex adaptive systems, 177
- Complex intervention, 161, 163
- Complexity, 177
 - emergence, 69
 - feedback loop, 152
- Comprehensiveness, 100
- Conditional cash transfers, 20–23
- Context, 95–96
- Context and Capabilities for Integrating Care (CCIC), 165–166
- Contingency, 142
- Continuity, 99
 - of care, 8
- Convenor model, 28–29
- Coordinated networks, 8
- Core problems, 63
- Core values underpinning integrated care, 98–101
- Cost
 - and benefits across organizations, 144
 - of care, 174
 - savings, 28
- COVID-19
 - crisis, 6–7
 - pandemics, 3
- Craft, 138–139
 - skills, 41–42
- Critical thinking, 89–90
- Culture, 50–52
- Data capture, 175
- Decision making, 79–80
 - shared decision making, 7
- Delphi methodology, 98–99
- Design thinking, 59, 62–63, 70
 - example of using design thinking to involving patients in integrated care, 64–69
 - in health care, 62–64
- Developmental evaluations, 162–163
- Developmental Model of Integrated Care, 165–166

- Diagnosis Related Groups-based payments (DRGs-based payments), 24–25
- Difference, 54
- Digital assets, 120
- Digital health
 - implementation
 - challenges, 123
 - in integrated care, 116–118
 - solutions, 115
 - technologies, 117
 - technology, 119–123
 - tools, 116
 - ‘users’ of, 118–119
- Diversity, 54
- ‘Doing for’ patients, 60
- Dutch care organization, 97
- Effectiveness, 101
- Efficiency, 100
- Emergence. *See* Complexity
- Empathy, 63
 - mapping, 67
- Empowerment, 100
- Enablers and inhibitors of change, 71–72
- Episode-based payments, 27
- EuroQOL EQ-5D-5L scale, 173
- Evaluation, 162–163
 - developmental, 162–163
 - dynamic, 162–163
 - formative, 162–163
 - realist, 163
 - summative, 162–163
- Evaluation design, 163
- Evidence, 11–12
 - evidence based practice, 39
- Fee-for-service, 24–25
- Feedback loop. *See* Complexity
- Financial incentives, 18, 27
- Fixed payments, 24
- Flexibility, 99–100
- Follow through, 54
- Formative evaluations, 162–163
- Framing, 47
- Full integration, 8–9
- Functional integration, 7
- Fund holding, 28
- Funding, 15–16
 - models, 17–18
- Gainsharing, 28
- General practitioner, 25, 98
- Gold Coast Health, 64–65
- Gold Coast Primary Health Network, 64–65
- Governance, 10, 101–102
 - shared governance, 101–102
- Health
 - impact bonds, 31
 - plans, 23
 - savings accounts, 23
 - systems, 2
- Health care
 - organization, 3

- provider, 17–18, 32–33
 - services, 97–98
 - workers, 3
- Health maintenance
 - organization (HMO), 30
- Holism, 99
- Housing, 98
- Human service
 - organizations, 17–18
- Humility, approach with, 53–54
- ICT, 140–141
- Impact, 10, 59
- Implementation, 137–138, 140
 - characteristics, 138
 - frameworks of change, 145, 157
 - integrated care, 142–144
 - key domains of implementing change, 140–141
 - Kotter’ framework for change, 145–157
- Incremental payment, 19–20
- Individual interviews, 68
- Informal care, 7
- Informal caregivers, 173–174
- Innovation, 155–156
- Institute of Medicine model (IOM model), 17
- Insurance, 18–19
 - health insurance, 30
- Integrated care (IC), 1, 4, 39, 95–96
 - analysis, feedback and reporting, 175–176
 - approaches to evaluation, 162–163, 168
 - approaches to summative evaluation, 178–179
 - challenges and enablers in leading and managing in, 40–42
 - comparative effectiveness, 179–180
 - consortium, 104–105
 - data capture, 175
 - dealing with complexity, 177
 - digital health in, 116–118
 - dynamic evaluation, 177
 - framework for, 5
 - leadership competencies, 44
 - logic model development, 169–172
 - measurement, 172–176
 - mechanisms, 47–54
 - nuts and bolts of, 8–9
 - person-oriented outcome measurement, 173–175
 - personal characteristics of IC leaders, 46

- practice, 6–7
- programs, 161
- qualitative approaches to evaluation, 177–178
- settings, 40
- solutions, 142
- theory, 165–166
- Integrated Care Alliance (ICA), 64–65
- Integration, 105
 - framework, 19
 - horizontal, 4–5
 - model, 105
 - theory, 165
 - vertical, 4–5
- Integrators of care, 17–19
 - base payment *vs.* alternative payment, 19–20
 - commissioner or payer model, 18–19
 - health care provider, 17–18
 - patient, 17
- Joint decision-making, 78
- Kotter’s model, 138, 145, 156–157
 - change, 155–156
 - communicating vision, 150–152
 - creating urgency, 146–147
 - empowering action, 152–154
 - frameworks of change, 145–157
 - powerful coalition, 147–149
 - quick wins, 154–155
 - vision for change, 149–150
- Leadership, 39–40, 101–102
 - competency frameworks, 42–47
 - IC leadership
 - competencies, 44
 - shared, 107
- Learning, 53
 - shared learning, 156
- Line-item budget, 24
- Linkage, 8
- Listening, 53
- Local authorities, 95–96
- Logic model
 - constituting, 169–170
 - development, 169–172
 - importance for
 - evaluating integrated care, 167–168
 - program activities/processes, 171–172
 - program inputs and resources, 172
 - program outcomes, 170–171
 - program outputs, 171
- Lump-sum
 - or global budget, 24
 - payment for professionals, 24
- Macro-Level mechanisms, 5–6, 50

- Management, 39–40
 - competency frameworks, 42–47
- Managers, 62
- Maturation, 179–180
- Measurement, 172–176
- Measures, 172–173
- Medical Leadership
 - Competency Framework, 42–43
- Meso-Level mechanisms, 5–6, 50, 52
- mHealth, 118
- Micro-Level mechanisms, 5–6, 53–54
- Mission statement of organizations, 97
- Mobilizing, 47
- Model of effect. *See* Logic model
- Monetary cash transfers, 20–23
- Motivation, prosocial, 79–80, 83–84
- Multiagency interventions, 1
- Multidisciplinary teams, 69–70
- Multiprofessional
 - character of integrated care, 143
 - episode-based payment, 27
 - service, 102–104
- Municipalities, 88
- Needs assessment, 17–18
- Networks, 29–30
- Non-adoption,
 - Abandonment, Scale-up, Spread and Sustainability framework (NASSS framework), 122–123
- Normative integration, 6–7
- Norms, 6–7, 97
- Nuka System of Care, 60–61
- Nursing, 65
 - community, 137–138
 - district, 88
- Off-the-shelf technology,
 - adopting and adapting, 122–123
- One sided risk model, 28
- ‘One-size-fits-all’ model, 2
- Organizational
 - changes, 138, 144
 - level, 5
- Outcome accountability, 90–91
- ‘Outside the box’ approach, 72
- Parallel governance, 143–144
- Partial capitation, 25
- Partners, 82
- Partnership, 86–87
- Patient, 17, 31–32
 - patient engagement, 59, 62
 - patient involvement, 10
 - patient participation, 60
 - workshops, 68

- Patient engagement, 59, 62
 - design thinking in health care, 62–64
 - enablers and inhibitors of change, 71–72
 - example of using design thinking to involving patients in integrated care, 64–69
 - existing models and approaches to, 61
 - findings and reflections, 70–71
 - with lived experiences in service design, 60–61
 - outcomes, 69–70
 - value of, 59
- Pay for performance, 27
- Payer, 18–19, 33–34
- Payment models, 16, 20
 - activity base payment, 20
 - actor specific limitations to integrating care, 31–34
 - alternative payment, 19–20
 - base payment, 19–20
 - with commissioner or payer as integrator, 29–31
 - incremental payment, 19–20
 - key elements of framework, 16–20
 - with patient as integrator, 20–23
 - pay for performance, 27
 - with provider as integrator, 24–29
 - top up payment, 19–20
 - value based payment, 27
- Person-centred care, 4
- Person-centredness, 100
 - person centred services, 3
- Person-oriented outcome measurement, 173–175
- Personal budgets, 20–23
- Personal or clinical level, 4–5
- Personal values session, 109–111
- Personal vouchers, 20–23
- Plan-Do-Study-Act framework (Deming), 138
- Planned implementation, 139
- Planning, 12
- Pooled commissioning, 31
- Population-based payments, 25–26
- Post-Study System Usability Questionnaire, 121–122
- Power imbalances, 86–87
- Prerequisites, 78–79, 83–84, 87
- Prevention, 100
- Primary care budget, 25
- Prime contractor model, 28–29
- Principal agent problem, 18
- Principles, 10

- Private funding of care, 20–23
- Problem solving behaviour, 81
- Process accountability, 90–91
- Professional level, 5
- Program
 - activities/processes, 171–172
 - inputs and resources, 172
 - outcomes, 170–171
 - outputs, 171
 - theory, 165–166
- Programme theory, 153
- Proself motivation, 79–80
- Prosocial motivation, 79–80, 83–84
 - increasing actors, 81–84
- Protocols, 6
 - assessment protocols, 7
 - care protocols, 7
- Prototyping, 64, 68
- Provider, 15, 17–18
- ‘Quadruple-Aim’ set of outcomes, 170–171, 174–175
- Qualitative approaches to evaluation, 177–178
- Quality of care, 17
- Rainbow Model of Integrated Care (RMIC), 60, 98, 105, 109, 133, 166
- Readiness, 140
 - readiness for change, 153
- Realistic evaluations, 163
- Reciprocity, 100–101
- Regional stakeholders, 107–108
- Resilience, 3–4
- Respect, 100
- Retainer fee, 25
- Risk, 18–19
 - pooling of risk, 18–19
- Roles, 3
- Scale, 122
- Self-management, 3–4, 169
- Service commissioning, 16
- Service design, 60–61
- Shared governance, 101–102
- Shared responsibility and accountability, 99
- Shared risk, 28
- Shared savings, 28
- Short window of opportunity, 144
- Skills, 7
- Social dimension of care, 76
- Social motivation, 79
- Social motives, 81
- Social services, 4
- Social stakeholder alignment, 76–78
- Specific, measurable, assignable, realistic and time-related measurement approach (SMART measurement approach), 172–173

- Staff
 - development, 152–153
 - training, 154
- Stakeholders, 97–98
- Standards, 6
 - standards of behaviour, 96
- Status, 2
- Strategy, 102
- Structural elements, 75–76
- Summative evaluations, 162–163, 178–179
- Supervision, 101–102
- Sustainability, 138
- Sustaining, 48
- SWOT analysis, 141, 146–147
- Synthesizing, 47–48
- System level, 5
- System Usability Questionnaire, 121–122
- Technology, 11
- Testing phase, 64
- Theory of change, 169
- Third-party funding, 31
- ‘Tick the box’ method, 173–174
- Tokenism, 60–61
- Tool, 7
 - tool development, 121
- Top up payment, 19–20
- Transformation, 12
- Transparency, 101
- ‘Triple-Aim’ set of outcomes, 170–171
- Trust, 99
- Two-sided model, 28
- Usability testing, 121–122
- User
 - service user, 13
 - user-centred co-design approach, 120
- Validation, 65
- Value-based payment, 27
- Values, 96–98
 - core values underpinning integrated care, 98–101
 - dealing with value conflict as manager, 105–111
 - in integrated care governance, 101–105
 - mapping exercise, 106–107
- Variation, 24–25
- Veterans Rand VR-12 scale, 173
- Vision
 - programme vision, 152
 - statement of organizations, 97
- Voice behaviour, engaging in, 84
- Voucher, 20
- WHO-QOL-BREF scale, 173
- Whole-systems thinking, 100

- Willingness
and ability to speaking,
85–87
- increasing actors, 85–87
to understanding, 89–91
'Win-win' agreements, 81