Rapid Response Brief
JANUARY 2020

What can research evidence tell us about:

Integration of Health Services Delivery for the Elderly within the Existing Structures

Key messages

- Integrated care is not an end, it is a means of achieving set objectives of the care provision model.
- Integrated care can occur at four different levels; Organisational, functional, service and clinical levels. Some models have integration spanning across all these levels.
- The different models of integration are; individual models, group-and disease-specific models, and population-based models of integration.
- There is no one-size-fits-all model for use in the integration of care.
- The chosen model of implementation has to be country-led; responding to the context of a particular country.
- The components to consider in integration of care for the elderly are; (1) care continuity/transition, (2) enabling policies, shared values/ goals among patients and care providers, (3) person-centred care, (4) multidisciplinary services, (5) effective communication, (6) case management and (7) needs assessment for care and discharge planning.

Where did this Rapid Response come from?

This document was created in response to a specific question from a policymaker in Uganda in 2020.
It was prepared by the Center for Rapid Evidence Synthesis (ACRES), at the Uganda country node of the Regional East African Community Health (REACH) Policy Initiative.

+ Included:

- **Key findings** from research
- **Considerations about the relevance** of this research for health system decisions in Uganda

✕ Not included:

- Recommendations
- Detailed descriptions

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Summary

Background:
The Ministry of Health is drafting a policy that aims at integrating health services delivery for people above 60 years within the existing delivery structures in Uganda. To inform their decision-making process, the committee responsible for the process requested for a rapid response brief detailing the evidence on integration of health services.

Rapid Response Question:
How best can the Ministry of Health integrate health services delivery for individuals above 60 years within the existing service delivery structures?

Findings:
Integrated health care is defined by World Health Organisation as "health services that are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course"[1]. The integration has to be based on a specific objective and can take place at the clinical, service, functional and organisational levels of service delivery.
In order to achieve successful integration, there are different components of the process at different levels of the health system that have to be considered, for example;

Micro-level (clinical level of service delivery to the individual)

a. Shared values and understanding
b. Engagement of patients
c. Engagement of providers
d. Communication for multidisciplinary teams
e. Case management
f. Systematic risk factor screening
g. Home visits
h. Prescription review

Miso/Meso-level (organisation level of service delivery)

a. Funding
b. Leadership
c. Structure of existing services
d. Culture
e. Intervention complexity
f. Patient and provider education
g. Resources
h. Buy-in
i. Coordination

Macro-level (broader system level and the external factors that influence service delivery)

a. Culture
b. Political stability
c. Enabling environment including policies and structures

There are several models for integration that have been implemented; however, this has mainly been in developed countries. These models can broadly be categorised into (1) individual models, (2) group and disease-specific models and (3) population-based models of integration of care. Drawing lessons from the implementation of these different models, there is no single model that can be cited as the best model for integration. However, successful implementation has to be country-context specific, leveraging on the different facilitators that are available and addressing the different barriers that could prevent the integration process. Government has to intentionally provide a conducive environment for the integration process as well as build an atmosphere for multi-stakeholder involvement. It is crucial to use evidence to inform all decisions going into the integration process as well as the deliberate collection of data to inform the continuous improvement of the integrated health services delivery.

Conclusions:
There is no one-size-fits-all model that can be used to achieve the integration of service delivery for the elderly. The chosen model has to be evidence-informed, country-led, context-specific for a particular country, leveraging on available facilitators for integration while addressing the potential barriers.

Background

The Ministry of Health (MoH) is a government body mandated to formulate policies and dialogue with different health development partners, mobilise resources for health, budget, strategically plan and regulate the health sector in the country. In addition, MoH has the mandate to advise other ministries on health matters, set standards and develop quality and capacity among other roles. In line with her mandate, the MoH is drafting a policy on the integration of health services for individuals above 60 years of age in Uganda within the existing health systems structures. The integration is premised on the benefits that it provides to the targeted population and the nation at large. To have a more informed decision-making process in drafting the policy on integrated health care for the elderly, the working committee on the policy requested for a Rapid Response Brief providing evidence on the integration of health services delivery for the elderly in the country.

The rapid response brief, therefore, addresses the question; **How best can the Ministry of Health integrate health services delivery for individuals above 60 years within the existing delivery structures?**

How this Rapid Response was prepared

After clarifying the question being asked, we searched for systematic reviews, local or national evidence from Uganda, and other relevant research. The methods used by the SURE Rapid Response Service to find, select and assess research evidence are described here: www.evipnet.org/sure/rr/methods

Summary of findings

In this rapid response brief, we summarise evidence on reasons why integrated health care should be considered, the different types of integration, the components to consider in planning for the integration of care for the adults, the different models of integration and the factors that can affect (both barriers and facilitators) of its implementation. Most of the evidence on integrated health care is from developed countries[2]; however, several lessons can be drawn from it to inform the process of integration of care in Uganda.

Definition of Integrated Health Care

Integrated health care has been defined by World Health Organization as health services that are managed and delivered so that people receive health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services in a continuum, coordinated across the different levels and sites of care within the health sector and beyond, and according to their needs throughout the life course[1]. It brings to the forefront the concept of bringing together inputs, management, organisation and delivery of services related to the full continuum of health care, with the aim of providing a population with good health services, improve system efficiency and foster patient satisfaction with the service [3, 4].

Why consider Integrated Health Care?

Integrated care was fronted as a solution to fragmented health care services delivery to patients. It has been shown to directly contribute to a better distribution of health services and health outcomes, improved quality of care, leading to enhanced well-being and better quality of life for the patients in the targeted population. Furthermore, integration has been associated with improved access to services, fewer unnecessary hospitalisations and re-admissions, better treatment outcomes, improved patient satisfaction, better health literacy and self-care among the patients and more involvement of the community in their health care. Among the health workers, integration of health care has resulted in better job satisfaction [4-9]. Therefore, integration is not an end, but a means of achieving the reasons behind choosing integration of care.

Integration crucially requires an empowered community. When the community is empowered, the target population or patients are more involved in the health care decisions concerning their health, and thus can hold the service providers more accountable. The improved accountability among the health care providers to the community has a ripple effect of improving care delivery [8].

Types of Integration

There are basically four types of integration as shown in the table below [4];

Type	Description
Organisational	Integration of organisations are brought together formally by mergers or through 'collectives' and/or virtually through coordinated provider networks or via contacts between separate organisations brokered by the purchaser
Functional	Integration of non-clinical support and back-office functions, such as electronic patient records
Service	Integration of different clinical services at an organisational level, such as through teams of multidisciplinary professionals
Clinical	Integration of care delivered by professional providers to patients into a single or coherent process within and/or across professions, such as through the use of shared guidelines and protocols

Components to consider in the integration of care for the elderly

The integration of care can broadly be looked at from three levels of care that is; [2, 6, 8, 10]

1. The Micro-level – This looks at the clinical level of service delivery to the individual (the health services providers and researchers) such as;
    j. Shared values and understanding
    k. Engagement of patients
    l. Engagement of providers
    m. Communication for multidisciplinary teams
    n. Case management
    o. Systematic risk factor screening
    p. Home visits
    q. Prescription review
2. The Miso/ Meso-level – This looks at the organisation level of service delivery for example;
    a. Funding
    b. Leadership
    c. Structure of existing services
    d. Culture
    e. Intervention complexity
    f. Patient and provider education
    g. Resources
    h. Buy-in
    i. Coordination
3. The Macro-level – This looks at the broader system level and the external factors that influence service delivery, including;
    d. Culture
    e. Political stability
    f. Enabling environment including policies and structures

The above components can be broadly summarised into eight elements as shown below, together with the accompanying brief descriptions [10];

Elements of effective integrated healthcare	**Brief description**
Care continuity/ transitions	Care needs for elderly or frail patients are complex and span different care locations or providers. Connected service networks and effective referral systems can ensure patients receive quality care and continuity when they transit between locations or providers
Enabling policies/ governance	Enabling policy is needed to align stakeholder goals/outcomes and provide financing structures to facilitate integration. The processes require facilitation through integrated systems of care to enable providers to work within common governance structures or work towards incentives, for example, professional engagement, leadership, credibility and shared values. Cooperation across care provider organisations and the integration of health and social care at the clinical level is also essential.
Shared values/ goals – among care providers and patients	Meso-(organisational) or Micro-(individual) level integration of values and goals among different providers can facilitate staff motivation and service integration. Shared values and

	goals are facilitated through formal policies and changes in the culture at clinical and managerial levels.
Person-centred care	The care that is holistic and respectful should be delivered with a specific focus on the individual. It should also be geared towards enabling patient autonomy by empowering individuals to be involved in their care.
Multi/inter-disciplinary services	Providers of all services must work together in a flexible way to provide coordinated care so that patients can benefit from multidisciplinary expertise.
Effective communication	Communication is a vital component for all who are involved in the care and extends to the communication between healthcare professionals by providing integrated electronic record management.
Case management	An individual is identified and designated as a care coordinator/case manager and is responsible for supporting users of the service by coordinating care, engaging patients in their own care and providing care directly.
Needs assessment for care and discharge planning	Using a comprehensive multidisciplinary assessment approach to evaluate needs and develop care plans for the elderly. Personalising plans for patients aiming at improving the efficiency and quality of healthcare surrounding the discharge process. It also ensures appropriate and coordinated services are in place to support the patient.

One of the main elements in the integrated care delivery is interdisciplinary collaboration in effecting the program. The interdisciplinary collaboration includes home carers who might or might not be qualified medical personnel, the community health workers, nurses, general practitioners and specialists. These have to understand and appreciate each other's roles and come together as a team to deliver a service to the elderly in the way of mutual trust and respect. Below are some of the considerations in fostering interdisciplinary work in integrated care [1, 11];

- Fostering a culture of collaboration (requirements, training, team building)
- Inter-professional exchange/ development/agreement about views on care and pathways
- Transfer of information (joint care plans, registers/ files)
- Accountability, responsibilities, dealing with hierarchies and professional-cultural clashes
- New ways of involving older people and/ or informal carers

Liesbeth and Dirk have developed a policy guide for integration of care which suggests three building blocks [12]; The mission, the vision and the strategy.

- The mission – This navigates the transition from a focus on healthcare to optimising health for individuals or a population.
- The vision – This is made up of the following components; (1) context of change for example understanding change among the population, health workers, health managers, insurers and policymakers (2) core principles that underpin integrated care, problems and societal challenges that can be addressed with integrated care.
- The strategy – This mainly looks at the strategies that have to be put in place to achieve integration such as; regulatory frameworks for collaborative entities and teams, regulatory frameworks for population health managers, regulatory frameworks for educational and professional reforms and a life course approach to the development of health literacy.

Models of integration [4]

Several models have been proposed for health care integration programs. These models of integration of care can be categorised in accordance with the level or scale at which integration happens. This categorisation caters for the overlap of models with an increase in scale, for example, a model based on the population level of care provision would most likely incorporate disease-specific models. Most of these models are general and can be applied to any age-group except for a few that have been specifically designed for application to elderly and frail population. Below are the models, with a few examples of each of the models;

Individual models of integration of care:

This group of integrated care models focuses on individual coordination of care for a specific group or population. These models aim to overcome the fragmentation of care delivery and facilitate appropriate, approachable and acceptable care to individual patients.

- Case management

This is a collaborative process encompassing communication and facilitates a continuum of care for effective resources coordination aiming to achieve optimal health and access to care coupled with patient empowerment in decision making about their health. The major components of case-management are selecting target individuals, individual care plans, and regular monitoring of patients.

- Individual care plans

This is majorly designed for patients with multimorbidity and chronic conditions. It aims to deliver personalised care, targeted and creating plans that map care processes. The roles of each provider and patient are clearly articulated. There is a deliberate collection of patient information since the health providers always base on individual care plans as a starting point for care for the patients.

- Patient-centred medical home (PCMH)

This was developed as a response to the challenges of the elderly population accessing primary health care. It is a physician-directed group of health care providers which provides accessible, continuous, comprehensive and coordinated care delivered in the context of family and community. It provides an alternative to individual care plans were patients are assigned to particular physicians in medical homes. Its key attributes are comprehensiveness, patient-centeredness, coordination, accessibility, quality and safety.

- Personal health budgets

This model utilises the assumption that patients are in the best position to coordinate their own care. When patients control the budget, they can coordinate their own care provision by deciding how, where, and when they purchase services.

Group- and disease-specific models

These models are designed for a group of individuals who share a given characteristic, which is typically a disease or a condition.

- Chronic care model (CCM)

This model was built to address the health care needs of people with chronic diseases, averting the fragmentation of care while providing a comprehensive framework for health services organisation to improve care outcomes for this group. It advocates for care that embraces longitudinal, preventive, community-based integrated approaches rather than episodic and reactive care. CCM has six main domains; community, health system, self-management support, delivery system design, decision support and clinical information systems.

- Integrated care models for elderly and frail

These are specifically designed with a high specificity of service delivery to the elderly, paying due attention to the extent to which care requires integration between health and social services.

PRISMA – Canadian model is a model that was designed to integrate service delivery for community-dwelling people who have moderate to severe impairment and need coordination between two or more services. The model provides a single entry point to the system, followed by coordinated care across a network of different health care providers. PRISMA incorporates health and social care for the patients in one package. Case-management and Information Technology (IT) are essential in the successful implementation of a model similar to PRISMA. There is a board of qualified members who determine what strategies to use as well as allocating resources to different providers within the network and managing the providers.

Torbay's Care Trust – Health and social care teams were established and organised according to territorial principles and aligned with general practices within those territories. It also incorporated both health and social care, with budgets allocated according to the needs of the population. It is highly commended for its proactive discharge from health facilities and transitional care.

- Diseases-specific integrated care models

These are strategies devised to address fragmentation in care for people with certain diseases and long-term conditions such as cardiovascular diseases, diabetes mellitus and COPD. This is the most used model of integration, with some examples listed below;

Chains of care – Used in Sweden with the aim of linking primary, hospital and community care through integrated pathways informed by agreements with and between patients and providers. A typical example is the screening done in a primary care facility, treatment plan drawn in a specialist facility and follow up and rehabilitation is done in the community.

Managed clinical networks – Developed in Scotland with the vision: "linked groups of health professional and organisations from primary, secondary and tertiary care, working in a coordinated manner, unconstrained by existing professional and health board boundaries to ensure equitable provision of high quality clinically effective service".

Disease Management Programs – This was rolled out in Germany in 2002. It is defined as "the coordinated treatment and care of patients during the entire duration of a chronic disease across boundaries between providers and on the basis of scientific and up-to-date evidence." It was designed to foster the use of evidence in designing treatment plans, promote service delivery across all levels of care provision, patient self-management and introduce new quality assurance mechanisms.

Population-based models

- Kaiser Permanente (KP)

KP is in the USA and is composed of three interrelated entities; a non-profit health plan that bears insurance risks (Kaiser Foundation Health Plan), self-governed for-profit medical groups of physicians (Permanente Medical Groups), and a non-profit hospital system (Kaiser Foundation Hospitals). It is based on the stratification of the population and care delivery according to needs. It covers a spectrum of care from population empowerment for disease prevention, empowerment for self-management of patients with chronic illnesses, and health care provider's provision of diseases and case management. KP focuses on chronic care and multispecialty rather than primary and secondary care.

- Veterans Health Administration (VA)

This system provides integrated services for the elderly in the USA who have chronic conditions. The VA employs physicians, owns and runs hospitals, medical offices and manages services within the network.

It should, however, be noted that there is no one-size-fits-all model. No single model can be cited as the best model to employ to achieve integrated care [6, 9, 13, 14]. In places were integration has been successful, it has been built upon country contexts, drawing on the facilitators already present, and working to address the barriers identified. It is, therefore, key to pay very close attention to the implementation of the chosen model of integration [14].

Implementation of the integration

The WHO report on the Framework on integrated, people-centred health services [1] sets five strategies, which it presupposes that their proper implementation and attainment, cumulatively, lead to more effective health services, and a failure in any one of the aspects might derail or undermine the progress in others. These strategies are; (1) strengthening governance and accountability; (2) empowering and engaging people and communities; (3) reorienting the model of care; (4) creating an enabling environment; and (5) coordinating services within and across sectors. The barriers and facilitators to the implementation of integrated health care are shown in the table below [8-10, 15];

Factor Level	Barriers to integrating care	Facilitators for integrating care
Macro-level contextual factors *External factors*	• Cultural inertia • Health system instability • Regulatory challenges	• Strategic direction for improving services • Wider health system stability • Laws and regulation regarding professional competency, scope of practice, care standards and safety • Shifting regulations over a continuum or a care package
Miso-level factors *System organisation*	<u>Funding/finances</u> • Funding silos • Competitive funding among stakeholders • Unclear financial attribution • Insufficient funding <u>Organisational leadership</u> • A barrier occurs when organisation leaders are not in charge of interventions, and changes are implemented from outside groups • Weakness in commissioning to support innovations and collaborative work and lack of sustained project management • Lack of commitment from organisations involved <u>Structure of existing services</u> • Divides between primary and secondary or health and social service provision • Time pressure and staffing levels • Complexity in the care system <u>Philosophy/ culture</u> • Poor institutional philosophy • A permission-based and risk-averse culture • Bureaucratic environment; management approach based on command and control	• Common governance • Incentives for integration • Funding realignment, ring-fencing and pooling • Funding systems for integration • Integrated funding • Ensure strong project management and ties between implementers and the organisation where changes will occur • Strong leadership and clearly communicated strategic visions • System-level policies and procedures should be made that detail how care works and who is eligible • Infrastructure such as IT to link patient records • Encourage innovation • Enable an adaptive system and focus on the system's capacity to self-organise
Miso-level factors *Intervention organisation*	<u>Intervention size and complexity</u> • Large, multi-component interventions take longer and are harder to implement • Complex interventions require cooperation with multiple stakeholders—getting agreement and implementing change can take longer and is more difficult • Monitoring of care quality and performance	• Small/ focused teams can make fast decisions, implement changes and drive the project forward • Preliminary work to promote mutual understanding and clarify roles is useful • Less complicated strategies are simpler to introduce and implement • Invest in IT for real-time indicators of performance

	<u>Intervention resources</u> • Insufficient additional resources/ extra funds mean new tasks will simply be added to existing ones, staff will not have enough time and new tasks will not be done <u>Credibility</u> • Interventions may lack credibility, e.g. GP endorsement was critical for pilot study credibility on integrated care within a primary care setting in the UK	• Success can be supported by a general framework for suitable conditions and funding must be in place • Staff must be confident that senior management/team leaders are strongly committed to implementing lasting change
Micro-level factors: *Providers and research staff*	<u>Shared values and understanding</u> • Staff attitudes, lack of shared values and disagreement over the goals or benefits of interventions • Lack of understanding may cause staff to feel their role is being eroded and are therefore not happy to help with changes • Sites, teams and members disagree over the aims or benefits of the proposed intervention and their roles and responsibilities <u>Engagement</u> • Lack of professional engagement is a barrier. For example, a particular barrier is when GPs were not involved and committed to community interventions. Changes lacked credibility and others did not engage in change • Staff may feel uninvolved, underprepared and 'thrown in' to projects • Lack of training for integrated care service delivery <u>Communication</u> • Insufficient communication, in general, is a major barrier to integrated care • Lack of existing working relationships between individuals/ groups • Teams and team members are not located together • Lack of robust record sharing across services	• Training is needed on the objectives of change • Joint training (different professional groups) may be useful • Staff consultation promotes feelings of involvement and understanding of aims • Identify or appoint 'champions' who act to remind and encourage staff. Champions may be more effective when they exist among peer groups, i.e. GPs to encourage GPs • Engage the workforce with a simple vision and enable people on the front line to 'feel involved' in changing the service to ensure they effectively engage • Some staff autonomy and being motivated helped to make changes possible • Allow time for relationships to develop • Co-location increases frequency and quality of communication and gives better access to the appropriate professional knowledge • Regular, ongoing and pre-planned communication between senior partners in the relevant organisations is important for success

	• Staff members are concerned about data security and who is allowed to see what • Primary care physicians may not be proactive in sharing data • Staff may be unclear of purpose/ objectives of interventions and so are not motivated to engage in changes • Staff confusion about their own and others' roles and responsibilities • Staff are unsure of what they are permitted to do and who is working on the project	• Create rules and agreement in advance about how the partnership/ collaboration will work • Electronic record sharing and using an integrated information system for record sharing can help integration, with real-time data sharing • Preliminary work is needed to involve staff so they feel consulted and valued • Clear outlines of each role/responsibility are needed. Integrated care pathways can formalise multidisciplinary team-working and enable professionals to examine their roles and responsibilities • Encourage staff to make decisions autonomously

Successful implementation of integrated care needs to pay due attention to the following [1];

- Implementing integrated care programmes is about how to deal with complexity and unintended consequences, so there is a need for a robust implementation framework and the building up of a detailed implementation plan.
- Country–led; the chosen model and the barriers and facilitators to consider have to be developed by the respective countries and should be responsive to the countries' respective contexts [14].
- Equity-focused; the implementation must deliberately put emphasis on efforts that target factors driving inequitable service distribution and utilisation. These efforts should not only be limited to clinical services delivery but also encompass social, economic and political factors that drive inequitable access and utilisation of health care.
- Participatory; Successful integration of health care requires an informed and empowered target population. This will build participation in the decision making processes concerning health care among the target population, as well as fostering accountability by the system to the population [14].
- Systems strengthening; the implementation of integrated care would require alterations to the service delivery; both in structure and personnel roles and responsibilities. This requires systems strengthening and availability of resources, both financial and human.
- Evidence informed practise; The use of evidence has been credited with a reduction in resources wastage and improved efficiency. The model chosen to implement integrated care for the elderly should be evidence-informed. In addition, there should be a deliberate Monitoring and Evaluation strategy to collect information on the implementation of the program so as to learn and use evidence in improving the program [1, 11, 16].
- Results-oriented; In order to measure progress, there have to be measurable indicators set at the beginning of the program. These will push the results-oriented agenda of the program to the fore.
- Ethics-based; The program needs to abide by the ethical principles governing health care delivery such as respect of persons, professional identity and autonomy, informed consent in taking decisions pertaining to care, privacy and confidentiality, evidence-informed decision making among others [17].
- Sustainability; The program needs to be built with a sustainability plan incorporated within its implementation. The planning, management and delivery of care that is equitable, efficient, effective and that contributes to long-term development should be planned in a sustainable manner.
- Financial integration; pooling together of funds and their use to meet the care needs of the population in the integration care provision [18].

- Bottom-up approach; It is important to engage the patients and caregivers in designing the model, starting with a patient-centred model, and building up to a more integrated care delivery system [13, 14].
- Single point of entry; Having a single point of entry into the system, where screening occurs and any other information collected, and this is shared with other care providers is crucial [13].
- Stakeholder engagement; There is a need to engage different stakeholders in the development of the integration plan [16].

The government has a major role to play in the successful implementation of integrated care. The key government roles include [6, 13];

- Formation of multi-stakeholder representative leadership coalition – This leads to collaboration and leads to ownership
- Develop a model for integrated care that is informed by evidence
- Resources mobilisation – Identify money sources, pool the funds and ring-fence them for the program. Furthermore, there is a need to recruit, train and retain health workers
- Attracting health care providers to underserved regions to ensure the equitable distribution of services.
- Support the implementation of information and communication technologies that support integration.

Conclusion

Evidence from the countries that have had successful integration of health services shows several advantages for an integrated health care delivery. However, there is no model that can be cited as the best model to achieve the integration of care. It has been observed that for successful integration, the process has to be informed by evidence, country led, context-specific, and address potential barriers while leveraging on the available facilitators of the process. There is need for community empowerment so that the target population can take charge of their own care, coupled with the deliberate collection of data (Monitoring and Evaluation) of the integrated care so as to always have sufficient information on which to base improvement plans.

References

1. Secretariat, *Framework on integrated, people-centred health services; Sixty-Ninth World Health Assembly*. 2016, World Health Organization.
2. Briggs, A.M., et al., *Elements of integrated care approaches for older people: a review of reviews.* BMJ Open, 2018. **8**(4): p. e021194.
3. Waddington, C. and D. Egger, *Integrated Health Services - What and Why?* 2008, World Health Organisation.
4. Organisation, WH, *Integrated care models: an overview*, H.S.D.P.D.o.H.S.a.P. Health, Editor. 2016: WHO Regional Office for Europe.
5. Ellen, N. and P. Emma, *What is the evidence on the economic impacts of integrated care? Policy summary 11*. 2014, World Health Organization Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies: Copenhagen.

What is a Rapid Response?

Rapid Responses address the needs of policymakers and managers for research evidence that has been appraised and contextualised in a matter of hours or days, if it is going to be of value to them. The Responses address questions about arrangements for organising, financing and governing health systems, and strategies for implementing changes.

What is ACRES?

ACRES – The Center for Rapid Evidence Synthesis (ACRES) is a center of excellence at Makerere University- in delivering timely evidence, building capacity and improving the understanding the effective, efficient and sustainable use of the rapid evidence syntheses for policy making in Africa. ACRES builds on and supports the Evidence-Informed Policy Network **(EVIPNet) in** Africa and the Regional East African Community Health **(REACH)** Policy Initiative (see back page). ACRES is funded by the Hewlett and Flora foundation. http://bit.do/eNQG6

ACRES' collaborators:

REACH
Regional East African Community Health Policy Initiative

Regional East African Community Health Policy Initiative

EVIPNet

EVIPnet

Glossary

of terms used in this report:
www.evipnet.org/sure/rr/glossary

6. Maruthappu, M., A. Hasan, and T. Zeltner, *Enablers and Barriers in Implementing Integrated Care*. Health Systems & Reform, 2015. **1**(4): p. 250-256.
7. Organisation, WH, *Integrating Health Services*, in *Technical Series on Primary Health Care*. 2018, World Health Organisation.
8. Baxter, S., et al., *Health Services and Delivery Research*, in *Understanding new models of integrated care in developed countries: a systematic review*. 2018, NIHR Journals Library: Southampton (UK).
9. Kaehne, A., *Care Integration - From "One Size Fits All" to Person Centred Care Comment on "Achieving Integrated Care for Older People: Shuffling the Deckchairs or Making the System Watertight for the Future?"*. Int J Health Policy Manag, 2018. **7**(10): p. 955-957.
10. Threapleton, D.E., et al., *Integrated care for older populations and its implementation facilitators and barriers: A rapid scoping review.* International Journal for Quality in Health Care, 2017. **29**(3): p. 327-334.
11. Billings, J. and K. Leichsenring, *Methodological development of the interactive INTERLINKS Framework for Long-term Care.* Int J Integr Care, 2014. **14**: p. e021.
12. Borgermans, L. and D. Devroey, *A Policy Guide on Integrated Care (PGIC): Lessons Learned from EU Project INTEGRATE and Beyond.* Int J Integr Care, 2017. **17**(4): p. 8.
13. Wodchis, W.P., et al., *Integrating care for older people with complex needs: key insights and lessons from a seven-country cross-case analysis.* Int J Integr Care, 2015. **15**: p. e021.
14. Harvey, G., et al., *Achieving Integrated Care for Older People: Shuffling the Deckchairs or Making the System Watertight For the Future?* International Journal of Health Policy and Management, 2018. **7**(4): p. 290-293.
15. Kozlowska, O., et al., *Barriers and facilitators to integrating primary and specialist healthcare in the United Kingdom: a narrative literature review.* Future Healthc J, 2018. **5**(1): p. 64-80.
16. Sadler, E., *The contribution of implementation science to improving the design and evaluation of integrated care programmes for older people with frailty.* Journal of Integrated Care, 2019. **27**(3): p. 232-240.
17. McKeown, A., et al., *Ethical challenges of integration across primary and secondary care: a qualitative and normative analysis.* BMC Med Ethics, 2019. **20**(1): p. 42.
18. Mason, A., et al., *Integrating funds for health and social care: an evidence review.* J Health Serv Res Policy, 2015. **20**(3): p. 177-88.

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Conflicts of interest
None known.

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