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Conference Abstract

The implementation of integrated care for diabetes mellitus type 2 by two Dutch care groups: context, mechanisms and outcomes

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Abstract

Introduction: Previous research has shown that integrated care can lead to improved processes and patient outcomes. However, this is not always the case and there is a lack of evidence regarding the reasons why and in which cases integrated care works. This study contributes to filling this knowledge gap by examining the implementation of integrated care for type 2 diabetes by two Dutch care groups.

Methods: An embedded single case study with two units of analysis was conducted, including 26 interviews with care group staff and health care providers. The CMO model (context + mechanism = outcome) was used to study the relationship between context factors (as categorised by the Implementation Model), mechanisms (as defined by the Chronic Care Model) and outcomes (operationalised as aspects of quality of care).

Results: Dutch integrated care reflects five of the six chronic care model components, namely health system, self-management support, delivery system design, decision support, and clinical information system. Barriers were found at all levels of the IM and included decreases earnings, too many innovations, the negative role of some health insurers, yearly changes in insurance policies, the funding system incentivising the provision of care exactly as described in the care protocols, patients' insufficient medical and policy-making expertise, disease-specific care management, resistance by GPs and GP assistants, too much care provided by PNs, and insufficient integration between the various patient databases. Facilitators were also found at all levels of the IM and included increased earnings, care group management and support, financial incentives for care innovations, health insurer cooperation, financial pressure in the health sector, increased focus on self-management, GP support, innovators, tradition of transmutal cooperation, integrators, performance monitoring via the care chain information system, and financial incentives for guideline adherence.

Discussion/Limitations: The implementation of integrated care led to perceived improvements in certain aspects of quality of care such as improved communication and cooperation but also to perceived deteriorations in others such as insufficient and unnecessary care provision and the preconditions for person-centred care. With so many diverse factors impacting on the outcomes achieved, respondents' opinions varied on whether, overall, integrated care had led to improved or deteriorated quality of care. Moreover, having been conducted in a single country and for a single chronic condition only, the results are still too context-specific to claim generalizability to other settings and conditions.

Conclusion/Lessons Learned: Evaluation research benefits from an increased focus on 'how' and 'why' questions in combination with 'what has been achieved' questions using the CMO model, which will be necessary if scientific research is to provide valuable recommendations to integrated chronic care practice.

Suggestions for future research: To achieve generalizability, future research should focus on the development of an integrated framework for analysing the implementation of integrated care interventions for people suffering from chronic conditions, focusing on the different mechanisms by which and context in which these are implemented and linking those factors to the outcomes achieved.

Keywords

integrated care; diabetes; cmo model; chronic care model; implementation model

PowerPoint presentation

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