

EDITORIAL

Building Competencies for Integrated Care: Defining the Landscape

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As the discussion in integrated care moves from “what needs to be done?” to “how do we achieve sustainable change?” one of the key questions is “how do we get people to change?”. Electronic health records, budgetary processes and governance structures are all important building blocks but achieving the transformation required will ultimately stand or fall on changing how we act. Transformation does not only involve gaining new knowledge and skills but a more fundamental shift in our conceptual paradigms about our roles, responsibilities and relationships. Supporting the professionals, practitioners and managers to understand and embrace such change requires us to understand how people gain such competences and the values that are associated with them. Therefore at the heart of this complexity are two more simple, yet profound questions: how do we learn? And who do we learn from? Integrated care is a highly complex intervention and adopting its principles can take time, flexibility and understanding. Think of it as moving to a foreign country, where you don't speak the language, are not familiar with the legal system, and struggle to pick up the cultural norms and customs. Furthermore you will come with your own frame of reference which may or may not be helpful – assuming a similarity which is not the case could lead to a major ‘faux-pas’. Reading, watching documentaries or even a language class will provide some preparation but there will be a myriad of small but significant norms that will not be understood from a distance. Whether it is finding similarities in words, processes, or customs, you will start by recognizing patterns, which fit and those, which don't. Watching others, experimenting with the language and trying to find a friendly mentor will be important supports to becoming more embedded. And if you don't encounter such supports, you will find it very difficult to adapt and will become homesick for what you knew and understood.

Uni-professional education is a vital part of preparing us to develop the competences that we need to safely practice as social worker, nurse or doctor. This process involves a socialization into professional cultures which is often

implicit but deeply influences what is seen as appropriate behavior for one undertaking such a role. Such learning does not only take place during our formal training, but continues throughout our professional lives. Indeed as we grow more experienced we will ourselves become educators of others through explicitly sharing knowledge or through tacit sharing of attitudes and behaviours. This is not just in relation to those of our own profession, but those of other groups that we come into contact with – this can confirm or refute the ‘general’ view of what is admirable and less so about different professions. To achieve the transformation required by integrated care, this means three things: we need to include the principles of integrated working into our formal education and training systems; we need to recognize that learning continues in our workplaces; and accept that we ourselves will be informal educators throughout our careers.

This continuous engagement with education is reflected in the competency consolidation cycles developed by Langins and Borgermans [1]. They define the changing roles and responsibilities of the professional from a novice learner through to a senior mentor and quality assurer of integrated care. This continuous learning cycle [2] should be supported by professional (e.g., standards, evidence-based practice), organizational (e.g., CPE programmes as integral part of job profile) and system functions (e.g., accreditation, regulatory frameworks). In common with the broader integrated care transformation learning needs to happen on all levels. Several recent frameworks have defined these levels from the clinical to the system (e.g., Valentijn 2016, WHO 2015, WHO Regional Office for Europe 2016) [3–5]. The most recent conceptualization of this whole system approach is represented in the Project INTEGRATE Framework [6]. Based on research, theory and current practice the Framework outlines the roles and interventions pertaining to each of seven dimensions. Five of these correspond to different levels of the system and two are cross-cutting:

Dimension 1. Person-centred care (i.e. the improvement of someone's health and wellbeing through the active engagement of service users as partners in care)

Dimension 2. Clinical integration (i.e. care services are coordinated and/or organised around the needs of service users)

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Dimension 3. Professional integration (i.e. existence and promotion of partnerships between care professionals that enable them to work together)

Dimension 4. Organisational integration (i.e. the ability of different providers to come together to enable joined-up service delivery)

Dimension 5. Systemic integration (i.e. the ability of the care system in providing an enabling platform for integrated care, such as through the alignment of key systemic factors like financing and regulation)

Dimension 6. Functional integration (i.e. the capacity to communicate data and information effectively within an integrated care system)

Dimension 7. Normative integration (i.e. the extent to which different partners in care have developed a common frame of reference of vision, norms, and values on care integration)

For each of the dimensions key items have been defined and validated which are relevant and insightful for different countries, populations and conditions. We now need to understand how to reflect these dimensions within the practices of those who must implement them. This will require combining our knowledge of how to achieve implementation of integrated care, with our knowledge of professional behaviour to develop a clearer definition of competencies for integrated care [2]. Having done so we can then create education approaches and programmes which enable the current and future workforce to practice integrated care. Reflecting both the evidence and our core principles such development must have at its heart people, families and communities, with active engagement in design and delivery of such opportunities.

For example, we know teams will be a central component of a more integrated system. At a professional system level, each team member needs – to know their own (and other's) roles and responsibilities; to demonstrate the skills to communicate and to challenge responsibly; to use information and technologies available; and to ensure that the team remains focused on the needs and interests of the people that it supports. Clinical leadership and as importantly 'followership' will also be a vital dynamic of such teams. This will require team working to be central

to under-graduate curriculum, reflected in professional accreditation and incentivized in promotion and reward processes. Furthermore good team working will be at each level of the system, involve a range of professional roles and functions, and require vertical and horizontal engagement with teams at other levels. Front line teams will not thrive in a partnership environment in which senior leadership teams do not reflect the principles of integrated care in their visions, behaviors and organizational cultures.

IFIC is committed to supporting the global community with the implementation and sustainability challenges that are faced as we move to this new landscape of integrated care. An accurate description of the competences required, the training and development that can support them, and the environment that will foster their development is urgently needed. We look forward to working with our members, colleagues and critics in defining this landscape.

Competing Interests

The authors have no competing interests to declare.

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